PD-ABI-848

SAVE THE CHILDREN
BOLIVIA FIELD OFFICE
CHILD SURVIVAL 5
FINAL EVALUATION REPORT

Agency for International Development
Grant # AID-OTR-0500-A-00-9149-00
June 1994

Save the Children
54 Wilton Road
Westport, CT 06880

(203) 221-4000

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Child Survival 5 project was implemented by Save the Children/Bolivia (Desarrollo Juvenil Comunitario, DJC) from September 1989 to March 1994 and financed by USAID/W; a total of $499,849 was awarded. The project area serving 15,850 people in Inquisivi Province, Department of La Paz, includes three zones: Inquisivi, Licoma and Circuata.

The objectives of the project were to reduce child morbidity and mortality rates within the project area covering the following interventions: to increase the coverage of immunizations (EPI); to decrease the incidence of diarrheal diseases; to promote growth monitoring, nutrition and breast-feeding; to increase Vitamin A consumption; to reduce the incidence of acute respiratory infections; and to improve maternal health through prenatal visits, safe birth practices and supplementary Vitamin A, ferrous sulfate and iodine intake.

Project strategies included women's groups' organization and active community participation in all activities. Currently, integrated development fairs have become a new strategic option which offers an important perspective for community mobilization.

At the end of the project's activities two final evaluations were carried out; a quantitative evaluation and a qualitative one. The first evaluation was done utilizing a rapid assessment of Knowledge, Practice and Coverage following the methodology and using indicators developed by the Johns Hopkins University (please refer to Final Evaluation Report Part I for the complete survey report). The qualitative evaluation emphasized opinions, expectations and attitudes of the beneficiaries through focus groups and individual interviews with women's groups, community authorities and project staff (please refer to Final Evaluation Report Part II for the required sustainability questionnaire and pipeline analysis and Final Evaluation Report Part III for the Qualitative Survey Report).

The main findings of the quantitative evaluation can be summarized as follows: the goals established for polio3 and TT2; management of diarrheal diseases (use of ORT, adequate feeding with breast milk and fluids); identification of ARI signs; knowledge and practice of growth monitoring; colostrum administration within the first hour postpartum; adequate weaning practices, consumption of iodized salt and food rich in Vitamin A; and deliveries attended by trained staff were reached and/or exceeded.

Results were low related to maternal identification of signs of dehydration and knowledge about when to receive treatment during a diarrheal episode (although practice was adequate) and ARI episodes; exclusive and prolonged breast-feeding; distribution of capsules of Vitamin A (although there was a high level of Vitamin A rich vegetable consumption); and prenatal control.

The qualitative evaluation emphasized the following important findings. In the field of institutional and human resources development SC/B achieved an organization that allowed efficient coordination of the various institutional activities. Adjustments were made to overcome those staff problems observed during the mid term evaluation.

Regarding the strategy, one can say that the implementation of integrated development fairs is a success; however, the possibility of diversifying this strategy in the future in order to avoid supersaturating the population must be considered. Likewise, methodological alternatives must be emphasized to make training more active and more responsive to the target population's characteristics (adult education).

Appraisals made by women's groups and community authorities regarding the project's programs coincide, in general, with the quantitative evaluation's findings. People are satisfied with achievements of EPI, diarrheal diseases management and, especially, with the production of food rich in Vitamin A (vegetable gardens). The results achieved regarding growth monitoring and iodized salt consumption were also confirmed and criteria about the interruption of breast-feeding before the age of two and obstacles to prenatal control were collected.

The community authorities emphasized problems related to health promoters or VHWs and suggested that an alternative strategy for community outreach should be found. It was made clear that VHWs are not sustainable resources since they are resisted within their own communities.

In relation to the health information system, we can say that the methodology used for returning the information to the community has proved to be extremely useful since it increased motivation within the communities. However, we could perceive that the VHW was not motivated to participate in data collection any longer.

On the other hand -- regarding management of information -- we could see that SC/B is duplicating activities carried out by the National Secretariat of Health. In the future, there should be better coordination to overcome this deficiency.

Regarding administrative fund management the budget assigned has been spent almost in its totality and it will be fully spent at the conclusion of the project. The flow of information between La Paz and Inquisivi has generally been regular and efficient as well as that between Inquisivi and the other zones.

The most important counterpart of the project has been the Regional Secretariat of Health through the Tres Cruces District. Several obstacles were found in the mid-term evaluation to smooth working relationships between SC/B and the project and the District Director due in part to personal factors. Currently, those relations have greatly improved and both SC/B and the Regional Secretariat of Health are very open and collaborative.

As to the project's sustainability we can say that the project (and therefore SC/B) played an important role influencing decisions at the policy level. Formal community authorities -- such as general secretaries of agrarian unions -- became part of the project. SC/B has also been working on a continuous basis in order to institutionalize the project's key components by strengthening the capacity of the Regional Secretariat of Health in its different areas. Another noticeable achievement of SC/B that affects the overall sustainability of the project is its integrated activities that responds to community needs. This is evidenced by the coordinated activities that exist between the Child Survival 5 Project and other projects that meet additional local needs such as education, economic opportunities and agricultural production.

Project efforts in health promotion and education based on cultural respect also contributed to the sustainability of health actions. The project used local resources in decision making, implementation of and support of all activities involving change, thereby increasing the possibility of successful adoption of new behaviors. Finally, SC/B is working to empower communities economically through other systematic actions. This is helping to improve the economic basis of the communities in order to support desired social change.

PART I

KNOWLEDGE AND PRACTICE
FINAL EVALUATION SURVEY REPORT

SAVE THE CHILDREN
BOLIVIA

SAVE THE CHILDREN
BOLIVIA FIELD OFFICE
CHILD SURVIVAL 5
KPC FINAL EVALUATION SURVEY REPORT

Agency for International Development
Grant # AID-OTR-0500-A-00-9149-00
June 1994

Save the Children
54 Wilton Road
Westport, CT 06880

(203) 221-4000

5

TABLE OF CONTENTS

KPC Final Evaluation Survey Report

SAVE THE CHILDREN/BOLIVIA

CHILD SURVIVAL 5 PROJECT
USAID Cooperative Agreement OTR-0500-A-00-9149-00

KNOWLEDGE, PRACTICES AND COVERAGE SURVEY

Evaluation Team - Quantitative Study:

Dr. Marcelo Castrillo	Johns Hopkins University, Team Leader
Karen LeBan	Health Unit, Save the Children/Westport
Dr. Fernando Gonzales	Health Advisor, Save the Children/Bolivia
Oscar Borda	Project Advisor, PROCOSI
Sister Aracely Revuelta	Supervisor, Regional Secretariat of Health
Dr. Ruth Calderón	Women, Child Health and Nutrition Division, Nat. Secretariat of Health
Rosmery de Rivas	CARITAS/Bolivia
Dr. Adolfo Martinez	Quime and Inquisivi Coordinator, Save the Children/Bolivia
Elsa Ramos	Licoma and Circuata Coordinator, Save the Children/Bolivia

Knowledge, Practices and Coverage Survey
Carried Out in Three Zones of the Inquisivi Province: Inquisivi, Licoma and Circuata

Child Survival 5 Project
Save the Children/Bolivia

EXECUTIVE SUMMARY

A Survey on Knowledge, Practices and Coverage (KPC) was carried out in 73 communities covering a total number of 16,729 people in the three Child Survival 5 Project zones- Inquisivi, Licoma and Circuata - of the Inquisivi Province, in the south-east part of the Department (State) of La Paz, Bolivia. The survey was carried out from February 16 to 28, 1994. It was the first part of the final evaluation of the Child Survival 5 Project executed by Save the Children/Bolivia and financed by USAID/BHR/PVC. The overall goal of the project was to reduce child morbidity and mortality through multiple health interventions for 15,850 people. Additionally, the project proposed to implement interventions of immunization for Arcopongo, an isolated community of 6,200 inhabitants; this EPI intervention could not be evaluated due to time limitations and due to difficult access to the community.

The instrument used for this evaluation was developed by USAID/BHR/PVC and the PVO Child Survival Support Program-PVO CSSP of the Johns Hopkins University. The survey was conducted by a team formed by personnel of the PVO-CSSP, Save the Children/Bolivia, Save the Children/Westport, the National Secretariat of Health (at national, district and local levels), CARITAS (a local NGO), and members of the community. The objectives of the survey were to obtain information about knowledge and practices of women with children under two years of age regarding child survival activities; to measure the objectives of the project; and, to identify what factors of health care should be strengthened during the next phase of the project.

A survey cluster evaluation methodology was used with an appropriate sample size based on the multiple child survival interventions of the project -- thirty clusters, each one of them formed by 10 women with children under 24 months were randomly chosen; the survey questionnaire (in Spanish and in Aymara) was designed by Save the Children/Bolivia and revised with input of the team members; a two-day training workshop on the survey methodology was carried out; and ten teams of three members each interviewed a total number of 299 women. Data was analyzed using the EPI Info 5 program

The following are the most important results of the evaluation: The goals were achieved or exceeded in the EPI program (Polio3 and TT2); as well as diarrheal diseases management (use of ORS and adequate feeding with breast-milk and fluids); identification of signs of ARI; activities on and knowledge about growth monitoring; colostrum administration immediately after birth; adequate weaning practices; consumption of iodized salt; consumption of food rich in Vitamin A (especially considering that at the beginning of the project there was a very low percentage of vegetable consumption); and deliveries attended by trained personnel.

Results were low related to maternal identification of signs of dehydration and knowledge about when to receive treatment during a diarrheal episode (although practice was adequate) and ARI episodes; exclusive and prolonged breast-feeding; distribution of capsules of Vitamin A (although there was a high level of Vitamin A rich vegetable consumption); and prenatal control.

I. INTRODUCTION

A. Background

The Save the Children/Bolivia's (SC/B) Child Survival 5 Project in Inquisivi Province, financed by USAID/Washington, started in September 1989.

The Inquisivi Province is located in the South-East part of the Department of La Paz. The extension of the province is 5430 Km2 and includes regions of different altitudes and characteristics; the Altiplano (highlands) at an altitude of 3900 m. above sea level; valleys, at 2500 m. and the subtropical regions at 1000 m. Therefore, agricultural production is varied and includes potato and other tuberous crops in the highlands; wheat and maize in the intermediate areas; and citrus, coffee and coca leaves in the lowlands.

The Province is about 5 hours by car south-east of La Paz. The population are mostly Aymaras in the highlands and Quechua migrants in the low valleys; the total population is 22,055 distributed in dispersed rural villages.

Roads are deficient and means of transport scarce; one can reach many of those communities only after long walks. Most families are geographically, culturally and socially isolated.

A retrospective case-control study conducted by Save the Children/Bolivia in 1991 showed that the mortality rates were extremely high: over a study period of two years the perinatal mortality rate was estimated at 103/1000 births and maternal mortality was 140/10,000 births.

Health services in the province are provided by the Regional Secretariat of Health (S.R.S.) All three zones of the project (Inquisivi, Licoma and Circuata) are served by health posts; two of them are attended by a doctor who is completing his one-year obligatory service in a rural area. The other 3 posts are attended by auxiliary nurses. The equipment and supplies of the posts are very poor. The Quime referral hospital is attended by two doctors, a nurse, and a dentist; the hospital does not fill the requirements established by the WHO for a referral center and there is always new staff since changes are frequent.

SC/B implemented the CS 5 Project within this context. Its goals and objectives were the following:

B. Objectives of the Child Survival 5 Project

The purpose of this project was to reach a sustainable reduction of infant mortality and morbidity.

The specific objectives of the project to be achieved by the end of March 1994 were:

Expanded Program of Immunization (EPI)

* 70% of children between 12-23 months will have completed their immunization: BCG, DPT3, OPV3, measles

* 80% of children between 0-59 months will have completed their immunization: BCG, DPT3, OPV3, measles

* 70% of women between 15-49 years will have received at least two doses of Tetanus Toxoid

Acute Diarrheal Diseases

* 60% of families with children under 5 years will be able to demonstrate their knowledge about Oral Rehydration Therapy and the preparation and administration of ORS, child's feeding and follow-up as well as identification of three signs of dehydration (little or no urine, sunken eyes. no reaction to pinching) and they will also be able to take actions (reference and treatment)

Growth Monitoring

* 60% of children under 5 will have at least 3 weight controls/year

* 60% of mothers will be able to interpret the growthcurve through different colors of wool (green=adequate growth; yellow=slow growth; red=deficient growth) and will be able to act adequately in each case

* 68 communities will have all instruments needed to carry out growth monitoring

Breastfeeding/Nutrition

* 30% of registered puerperal women will administer colostrum to their children within the first hour postpartum

* 80% of registered puerperal women will continue breast-feeding their children until the age of two years

* 40% of mothers will start giving their children supplementary foods at the age of 4 months

* 80% of families within the impact area will be consuming iodized salt

Vitamin A

* 60% of children between 1-5 years will receive two megadoses of Vitamin A per year

* 60% of families will include in their daily diet vegetables rich in vitamin A

Maternal Health

* 75% of pregnancies will be registered in the women's roster

* 50% of registered women will receive at least 3 prenatal control visits

* 30% of deliveries will be attended by trained persons (midwife, husband, health staff)

* 100% of registered pregnant women will be given iodized oil preferably during the first three months of pregnancy

* 100% of registered pregnant women will receive ferrous sulfate starting during the second quarter of pregnancy

* 40% of puerperal women will receive a megadose of Vitamin A

Acute Respiratory Infections (ARI)

* 30% of mothers will know about preventive actions (immunization, prevention of malnutrition, prevention of polluted atmosphere)

* 30% of parents will identify ARI signs and will know where to go for treatment and follow-up

Tuberculosis

* 30% of families will know preventive actions, signs and symptoms of TB and will also know where to go for diagnosis and treatment

C. Objectives of the final survey

The main objectives of the quantitative phase of the Child Survival 5 Project Final Evaluation were:

* To measure the achievements of the project comparing them with the objectives established in the Detailed Implementation Plan (DIP)

* To make recommendations for the qualitative phase of the evaluation of the project, using data produced by the survey

* To make global recommendations for the future of the project, which will continue with other financing until, at least, December 1995.

The specific objectives of the survey were to provide practical information to the SC/B team for planning and management of the continuation of the project, especially in:

//

* Knowledge of mothers with children under two years about methods of prevention of preventable diseases; oral rehydration therapy (ORT); adequate nutritional monitoring and introduction of complementary foods; importance of growth monitoring and of information about maternal health and birth spacing.

* Practices of the above-mentioned knowledge carried out by mothers.

* Priority groups (age groups, communities, mothers, and others) that need more interventions and messages about health education.

* Coverage of BCG, DPT3, OPV3 and measles immunization for children between 12 and 23 months of age, and TT coverage among women of reproductive age.

D. Location and Target Population

The Inquisivi Province has a rural and dispersed population of 57,345 inhabitants (1992 Census). The project area includes 100 communities with a population of 22,055. The largest communities within the impact area are: Inquisivi (1,100 families); Licoma (1,000 families); and, Circuata (1,000 families), and other smaller communities whose population varies between 15 and 100 families each one.

In March 1990, SC/B completed the registration of 100% of families in 58 communities, from which 12 were registered for the first time. Through September 1993 a total of 73 communities were registered (The Implementation Plan had anticipated to register and to implement interventions in 68 communities of the three zones.)

An additional 32 communities (with approximately 6,500 inhabitants) are very dispersed in the Arcopongo zone. They are of difficult access, requiring, in some cases, a three-day walk. Therefore, in theses communities (according to the DIP) only immunization campaigns and Vitamin A administration were carried out; in 1990 and 1991 two immunization campaigns per year were carried; in 1992 and 1993 the number of immunization campaigns was increased to three per year.

Due to the difficult access to these communities, the excessive cost in terms of time and resources, and the reduced magnitude of the interventions, this evaluation does not include the Arcopongo zone, although it is anticipated to evaluate the coverage of the EPI and Vitamin A activities during the next immunization campaign.

E. Chronogram of activities

Feb 16	Start-up training for the SC/B field team.
Feb 17	Meeting to orient external representatives and preparation for trip to Inquisivi.
Feb 18	Trip to Inquisivi.
Feb 19	Training for supervisors and interviewers on the child survival knowledge and practices survey.
Feb 20	Continue training and field test in three communities included within the Child Survival 5 Project area, and preparation for trip to different communities where interviews were applied; reproduction of questionnaires and materials needed.
Feb 21-23	Interviews carried out in 30 clusters within the project area
Feb 24-25	Return to the meeting point; review and discussion of field information; data entry in computers and data tabulation.
Feb 26	Data analysis, conclusions and completion of study report.
Feb 27	Return to La Paz.
Feb 28	Submission of a draft report and results to SC/B senior staff.

II. METHODOLOGY

A. The Questionnaire

The questionnaire (Annex 1) consists of 44 questions; it was designed for collecting relevant information about SC/B's Child Survival 5 interventions for the Final Evaluation. The questions were developed and selected by the Johns Hopkins University's PVO-CSSP office; experts from the University and external consultants participated in the development of each intervention as well as in the elaboration of the methodology.

The questionnaire is for mothers with children under two years, exclusively.

The first two questions are addressed to obtain information about the mother to be interviewed and her family; questions 3 to 9 are related to breast-feeding and weaning practices; questions 10 and 11 are related to knowledge about Vitamin A; questions 12 to 16 are related to the child health card utilization in growth monitoring; questions 13 to 15 are used for transcribing data from the child health card (weight control and immunizations) (please refer to Annex 4 for a copy of the Road to Health Card); questions 17 to 24 are oriented to detect what the mother knew about and what actions had been taken during her child's last episode of diarrhea; questions 25 to 29 are related to maternal practices about symptoms of acute respiratory infections; questions 30 to 32 are related to the mother's knowledge about immunizations required for a child under two years; and, finally, questions 33 to 44 are addressed to collect information about prenatal care, delivery and family planning (please refer to Annex 4 for a copy of the Maternal Health Card).

The questionnaire was originally written in English and sent to the SC Bolivia Field Office where it was translated into Spanish and Aymara, a native tongue of the zone. Dr. Castrillo spent the first days discussing with the SC/Bolivia team the reasons or logic of including those questions in the questionnaire and responding to the field team's expectations regarding some adjustments done to the questionnaire.

The first days of work were also useful for correcting questions translated into Spanish and Aymara and for including specific questions for the SC/B's CS 5 project.

B. Defining the Sample Size

The requirements of the sample size for this study consider multiple child survival interventions. The sample size was therefore selected based on the requirements of the intervention that demanded the largest sample. The formula used for calculating the sample is the following:

$$n = z^2 \, pq/d^2$$

Where n = sample size; z = 95% limit of confidence = 1.96; p = rate of coverage or prevalence; q = 1 - p; and d = the desired accuracy, which is usually 10%.

The p value was defined as .5 (or 50%, equal probability to obtain yes or no). The d value is the desired margin of error, in this case .1 was used. In the case of the study bv clusters, the formula was replaced as follows:

$n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)$
$n = (3.84)(.25)/.01$
$n = 96$

In the case of EPI, 96 individuals are needed for establishing the coverage rate within a simple aleatory study. But, in the case of a study by conglomerates the number was doubled in order to break the bias originated when interviewing individuals from the same place or conglomerate (according to Henderson); the final number is 192, but it was rounded at 210 for an easier management (7 x 30).

In the case of the Child Survival studies, a sample size of 300 is used since sub-samples are taken for observation of trends.

The limits of confidence are estimated through the following formula:

95% limit of confidence = $p \pm z\_(pq/n)$

Where: p = proportion of population; and z = constant value, according to the normal statistical curve.

C. Selecting the target population

A sample was taken of women with children under 24 months of age within the impact area of the Child Survival 5 project, located in the "Tres Cruces" Health District of the La Paz Regional Secretariat of Health.

The SC/Bolivia team prepared a list of all the communities of the project area with their corresponding total population. Once the list of communities was ready (refer to Annex 3), together with the field team 30 clusters/communities were selected following a technique described in a manual of the WHO (Household Survey Manual: Diarrhea Case Management, Morbidity and Mortality. WHO, Geneva, 1989).

10 working groups with 10 supervisors and 21 interviewers were selected; they mostly were formed by two interviewers and one supervisor, and in some cases the ratio was 1:3 and 1:1. Each group interviewed 10 mothers in selected communities of the Inquisivi, Licoma and Circuata zones completing 30 clusters and 300 mothers with children under two years.

For selecting the first household two different techniques were applied depending on whether it was a village or a rural community. In the villages the area was divided in blocks and these were

selected by choosing a number randomly; the rule for the next households was the closest door until the 10 questionnaires per conglomerate were completed.

In rural communities the technique started by going to the center of the community, then the direction the study would follow was randomly chosen rotating a bottle or a pen and choosing a household located in that direction, then the next households were selected by the closest door until the 10 interviews per conglomerate were completed.

D. Training for interviewers and supervisors

Training for field supervisors and interviewers was carried out during three days. The process started in La Paz and was concluded in Inquisivi with the participation of all support staff.

SC/Bolivia had pre-selected 20 interviewers among field volunteers and personnel from the Regional Secretariat of Health. The supervisors were:

- Fernando Gonzales, Health Advisor, SC/Bolivia
- Oscar Borda, Projects' Advisor, PROCOSI (PVO Network)
- Sister Aracely Revuelta, Supervisor, Regional Secretariat of Health
- Ruth Calderon, National Direction of Woman and Child Health and Nutrition
- Rosemary Rivas, CARITAS/Bolivia
- Adolfo Martinez, Zonal Coordinator, SC/Bolivia
- Elsa Ramos, Zonal Coordinator, SC/Bolivia
- Basilio Cachi, Field Supervisor, SC/Bolivia
- Teresa Huarachi, Field Supervisor, SC/Bolivia
- Gregorio Quispe, Field Supervisor, SC/Bolivia
- Romelia Antonio, Field Supervisor, SC/Bolivia
- Yola Flores, Field Supervisor, SC/Bolivia
- Basilia Laime, Field Supervisor, SC/Bolivia
- Macario Laura, Field Supervisor, SC/Bolivia

Ms. Karen LeBan from the head office in Westport, Connecticut, participated in the whole process of the study.

The representatives of external organizations formed the supervising team, the team for information analysis, and also participated in the final discussion about results, as well as in the elaboration of conclusions and recommendations of the study.

During the first day there were negotiations of time and involvement of the field staff and the participants. Responding to a requirement made by the team and the project's responsible staff, the methodology of the study and the logic behind each question were discussed. Also, the Spanish version of the questionnaire was refined and adjustments were made to the Aymara version.

Training for interviewers and field supervisors emphasized the questionnaire and the way to fill it in. For this type of studies one must always take into account that questions should always be done in the same way to detect mothers' knowledge and practices. Potential bias is due to the different educational levels of the interviewers and their number (21), although much emphasis was made to standardize the interviewers' level.

Some interviewers could speak Aymara and they interviewed those selected communities which are Aymara-speaking.

The training program (see Annex 2) was developed in the Johns Hopkins University by Dr. Richard Arnold during a session of training of trainers (TOT) addressed to those individuals sent for providing technical support to PVOs.

E. Conduction of interviews

Interviews were carried out during three days, February 21 to 23, 1994.

The area selection, the logistics support, and the chronogram for visiting each community, were developed by the supervisors and the SC/Bolivia team. A great motivation was noted both among interviewers and field supervisors; this motivation allowed them to cover large extensions of territory in the three days programmed for the interviews. All mothers agreed verbally to participate in the survey. Please refer to Annex 1 for the consent form that was used.

F. Data Analysis Methodology

As soon as questionnaires were delivered to the SC/Bolivia Office in Inquisivi, four teams introduced the data obtained in four computers using the EPIInfo 5.1b program; this task required three days - working after hours every day. The program is especially designed by the CDC for studies, its cost is low, it is easy to operate even for individuals with little experience in computer operation, and provides a simple type of analysis adequate for this kind of studies.

A part of the training for the SC/Bolivia staff consisted in data tabulation and writing conclusions immediately after the survey was carried out. The main objective of the survey is to do a final evaluation of the project financed by AID/Washington, but it also is to provide recommendations for continuing the project in the area with other financial resources.

For the first draft of the survey the distribution of frequencies for each question was done. In some cases, crossed tables were done in EPIInfo by children's age groups to obtain second order indicators.

Once tables with frequencies distribution and crossed information were completed, some other tables were printed for inclusion in the report and finalization of the survey's report.

III. RESULTS

299 surveys were obtained; the distribution of the interviewed mothers' and their children's appear in the following tables:

1. Mother's age

AGE	NUMBER	PERCENTAGE
15 - 20 YEARS	44	15 %
21 - 25 YEARS	88	30 %
26 - 30 YEARS	64	21 %
31 - 35 YEARS	49	16 %
36 - 40 YEARS	35	12 %
41 - 46 YEARS	13	4 %
DATA MISSED	6	2 %
TOTAL	299	100 %

2. Age of Children Under the Age of Two

AGE/MONTHS	NUMBER	PERCENTAGE
0 A 6	100	33 %
7 A 12	86	29 %
13 A 18	62	21 %
19 A 23	51	17 %
TOTAL	299	100 %

Tables of results are presented in two parts; the first part contains standard indicators for evaluating Child Survival programs; these tables represent essential information for AID. The second part contains additional specific indicators useful for evaluating the Child Survival 5 Project.

STANDARD CHILD SURVIVAL INDICATORS

Data for the standard indicators required by USAID follow. Percentages are according to the definitions of practice and coverage established by the Johns Hopkins University in its Guide for Surveys (November 23, 1993).

1. Adequate practices for child feeding: Breast-feeding initiation.

   Percentage of children under 24 months who were breast-fed within the first 8 hours of life:

   56% (118+49/299 x 100)

BREASTFEED. BEGINN	Freq	Percentage
FIRST HOUR	118	39.5%
FIRST 8 HOURS	49	16.4%
AFTER 24 HOURS	53	17.7%
MORE THAN 24 HOUR	70	23.4%
DOESN'T REMEMBER	5	1.7%
DATA MISSED	4	1.3%
TOTAL	299	100.0%

2. Adequate practices for child feeding: exclusive breast-feeding

   Percentage of children under 4 months who are fed exclusively with breastmilk: 38% (25/65 x 100)

AGE/MONTHS	Freq.	Percentage
0	16	24.6%
1	14	21.5%
2	22	33.8%
3	13	20.0%
TOTAL	65	100.0%

AGE IN MONTHS AND EXCLUSIVE BREAST-FEEDING

AGE/MONTHS	N	Y	TOTAL
0	5 31.3%	11 68.8%	16 24.6%
1	9 64.3%	5 35.7%	14 21.5%
2	17 77.3%	5 22.7%	22 33.8%
3	9 69.2%	4 30.8%	13 20.0%
TOTAL	40 61.5%	25 38.5%	65

3. Adequate practices of child feeding: introduction of complementary food (weaning)

Percentage of children between 5 and 9 months who receive solid and semi-solid food: 94% (45/48 x 100)

AGE/MONTHS	Freq.	Percentage
5	10	20.8%
6	11	22.9%
7	16	33.3%
8	11	22.9%
TOTAL	48	100.0%

AGE IN MONTHS AND WEANED CHILDREN

AGE/MONTHS	N	Y	TOTAL
5	2 20.0%	8 80.0%	10 20.8%
6	1 9.1%	10 90.9%	11 22.9%
7	0 0.0%	16 100.0%	16 33.3%
8	0 0.0%	11 100.0%	11 22.9%
TOTAL	3 6.3%	45 [3] 93.8%	48

4. Adequate practices of child feeding: Duration of breast-feeding

Percentage of children between 20 and 23 months who still receive breast milk: 47% (20/43 x 100)

AGE/MONTHS	Freq.	Percentage
20	10	23.3%
21	12	27.9%
22	9	20.9%
23	12	27.9%
TOTAL	43	100.0%

AGE IN MONTHS AND DURATION OF BREAST-FEEDING

AGE/MONTHS	N	Y	TOTAL
20	5 50.0%	5 50.0%	10 23.3%
21	7 58.3%	5 41.7%	12 27.9%
22	5 55.6%	4 44.4%	9 20.9%
23	6 50.0%	6 50.0%	12 27.9%
TOTAL	23 53.5%	20 46.5%	43 100.0%

5. Management of diarrheal diseases: Continuance of breast-feeding

Percentage of children (under 24 months) with diarrhea episodes during the last two weeks, who received the same quantity of or more breast milk:
79% (22+75/135-13 x 100)

CONTINUED BREASTFEED	Freq.	Percentage
MORE	22	16.3%
SAME QUANTITY	75	55.6%
LESS	21	15.6%
INTERRUPTED	4	2.9%
WEANED	13	9.6%
TOTAL	135	100.0%

6. Management of diarrheal diseases: Continued administration of fluids.

Percentage of children (under 24 months) with diarrhea episodes during the last two weeks, who received the same quantity of or more fluids:
63% (42+41/135-3 x 100)

FLUIDS	Freq.	Percentage
MORE	42	31.1%
SAME QUANTITY	41	30.4%
LESS	36	26.7%
INTERRUPTED	13	9.6%
EXCLUSIVE BREASTFE	3	2.2%
TOTAL	135	100.0%

7. Management of diarrheal diseases: Continued administration of solid foods

Percentage of children (under 24 months) with diarrhea episodes during the last two weeks, who received the same quantity of or more solid/semi-solid food:
52% (19+51/135-1 x 100)

SOLID FOOD	Freq.	Percentage
MORE	19	14.1%
SAME QUANTITY	51	37.7%
LESS	47	34.8%
INTERRUPTED	17	12.6%
EXCLUSIVE BREASTFE	1	0.7%
TOTAL	135	100.0%

8. Management of diarrheal diseases: Use of ORT

Percentage of children (under 24 months) with diarrhea episodes during the last two weeks, who were treated with ORT (ORS, home-made fluids or solutions prepared with cereals): 69% (93/135 x 100)

DIARRHEA	Freq.	Percentage
YES	135	45.2%
NO	164	54.8%
TOTAL	299	100.0%

USE ORT	Freq.	Percentage
NO	42	31.1%
YES	93	68.9%
TOTAL	135	100.0%

9. Control of Pneumonia: Medical treatment

Percentage of mothers who looked for medical treatment (or personnel trained by the project) for their children under 24 months who presented cough and difficult breathing/respiratory frequency growth:

22% (16/72 x 100)

CHILDREN WITH ARI TWO WEEKS BEFORE THE SURVEY

RESP.FREQ.GROWTH	Freq.	Percentage
YES	72	75.0%
NO	24	25.0%
TOTAL	96	100.0%

CHILDREN WITH ARI TWO WEEKS BEFORE THE SURVEY WHO RECEIVED MEDICAL TREATMENT

RESP. FREQ. GROWTH	Freq.	Percentage	Cum.
YES	56	77.8%	77.8%
NO	16	22.2%	100.0%
TOTAL	72	100.0%	

10. Coverage of Immunizations (according to cards): Access to EPI

Percentage of children between 12 and 23 months who received DPT1: 68% (87/128 x 100)

AGE GROUP	D P T 123 1	2	3	TOTAL
0-11 MONTHS	77	38	13	171
	45.0%	22.2%	7.6%	57.2%
12-23 MONTH	87	79	69	128
	68.0%	61.7%	53.9%	42.8%
TOTAL	164	117	82	299
	54.8%	39.1%	27.4%	

11. Coverage of immunizations (according to the health card): Coverage of the EPI

Percentage of children between 12-23 months who received OPV 3: 59% (76/129 x 100)

AGE GROUPS	OPV 123 1	2	3	Total
0-11 MONTHS	83 48.6%	41 24.0%	15 8.8%	171 57.2%
12-23 MONTHS	91 71.1%	81 63.3%	76 59.4%	128 42.8%
Total	174 58.2%	122 40.8%	91 30.4%	

12. Coverage of Immunizations (according to the health card): Coverage of measles vaccine.

Percentage of children between 12-23 months who received the measles vaccine: 56% (72/128 x 100)

AGE GROUPS	MEASLES VACCINE 0	1	Total
0-11 MONTHS	161 94.2%	10 5.8%	171 57.2%
12-23 MONTHS	56 43.8%	72 56.3%	128 42.8%
Total	217 72.6%	82 27.4%	

13. Coverage of immunizations (according to cards): Rate of desertion

Number of children who received DPT1 minus the number of children who received DPT3 divided by the total number of children (between 12-23 months) who received DPT1: 21% (87-69/87 x 100)

Rate of desertion of complete series of vaccines: number of children who received the BCG minus the number of children who received measles vaccine divided by the total number of children (between 12 to 23 months) who received BCG: 16% (86-72/86 x 100)

14. Maternal Health: Women's Health Card*

Percentage of women with women's card (SC/Bolivia or Government of Bolivia Secretariat of Health): 49% (145/299 x 100)

WOMEN'S CARD	Freq.	Percentage
YES	145	48.5%
NOT PRESENTED	104	34.8%
NEVER HAD	50	16.7%
TOTAL	299	100.0%

* To have a women's health card was not an objective of this project.

15. Maternal Health: Coverage of Tetanus Toxoid (TT)

Percentage of women who received two or more doses of TT, according to Women's Health Cards:

44% (132/299 x 100)

TT	Freq.	Percentage
NONE	5	3.5%
ONE	8	5.5%
TWO OR MORE	132	91.0%
TOTAL	145	100.0%

16. Maternal health: one or more prenatal visits before the delivery of the last child:

19% (38+18/299 x 100)

According to information provided by mothers: It can also be calculated according to whether the mother reports having received prenatal care: 43%

PRENATAL VISIT	Freq.	Percentage
ONE OR TWO	38	26.6%
THREE OR MORE	18	12.6%
NONE	87	60.8%
TOTAL	143	100.0%

If data were reviewed considering only those mothers who had the women's health card (145) and those who never had it (50) there would be an estimation of 29% of prenatal visits (38+18/195 x 100). In this case, mothers who did not have the health card (104) because it was at home or because they lost it, were not taken into account so that data would not vary. One must note that information provided by mothers is higher, reaching 43%.

The objective established by the DIP was that 50% of registered pregnant women would have at least three prenatal check-ups. This objective was not measured by the methodology applied by this evaluating study.

17. Maternal health: Use of modern contraceptive methods (for readers' information, this was not an objective of the project):

Percentage of mothers who do not want to have another child during the next two years (265 mothers) who are using any modern contraceptive method: 6% (1+11+1+2/2654 x 100)

FP METHOD	Freq.	Percentage
PILLS	1	2.4%
IUD	11	26.2%
CONDONES	1	2.4%
VAGINAL FOAM	2	4.8%
BREASTFEEDING	3	7.1%
RHYTHM	19	45.2%
ABSTINEN	1	2.4%
INTERUCOITUS	1	2.4%
OTHERS	3	7.1%
Total	42	100.0%

QUESTIONNAIRE ON KNOWLEDGE, PRACTICES AND COVERAGE OF CHILD SURVIVAL PROJECTS INQUISIVI, FEBRUARY 1994

OTHER INDICATORS FOR CS 5

Breastfeeding/Nutrition

1. Are you breast-feeding (name of the baby)?

BREASTFEED	Freq.	Percentage	Cum.
YES	256	85.6%	85.6%
NO	43	14.4%	100.0%
Total	299	100.0%	

2. Have you ever breast-fed (name of the baby)?

BREAST-FED	Freq.	Percentage	Cum.
+	39	90.7%	90.7%
-	4	9.3%	100.0%
Total	43	100.0%	

3. After the delivery, when did you breast-feed (name of the baby) for the first time?

FIRSTBREAS	Freq.	Percentage
FIRST HOUR	118	40.0%
FIRST 8 HRS	49	16.6%
AFTER 24 HR	53	18.0%
MORE 24 HRS	70	23.7%
DON'T REMEM	5	1.7%
Total	295	100.0%

4. The baby is being given (percentage):

AGE GROUP MONTHS	TEA/ WATER	MILK/ BOTTLE	MUSH./ MAIZE	FRUIT/ JUICES	CARROT/ PUMPKIN	MEAT	VEGETAB	BEANS/ SOYA	EGG/ YOGURT
under 3	47.7	18.5	15.4	20.0	15.4	20.0	10.8	4.6	12.3
4 to 6	71.4	31.4	31.4	62.9	51.4	45.7	40.0	17.1	37.1
7 to 9	89.1	37.0	41.3	80.4	77.5	87.0	63.0	26.1	91.3
Total									

5. Prepares (name of the baby)'s food with:

AGE GROUP MONTHS	SUGAR	OIL/ FAT
under 3	46.2	23.1
4 to 6	77.1	62.9
7 to 9	95.7	95.7
Total		

6. What type of salt do you consume?

TYPE OF SALT	NUMBER	PERCENTAGE
Iodized	269	90 %
Iodized and non-iodized	2	4 %
non-iodized	18	6 %
Total	299	100 %

7. At what age should your child start consuming other type of food?

AGE/MONTHS	Freq.	Percentage
BEFORE 4	116	38.8%
BETWEEN 4-6	122	40.8%
AFTER 6	52	17.4%
DON'T KNOW	9	3.0%
Total	299	100.0%

8. What vitamin protects your child's sight?

PROTECTSIGH	Freq	Percentage	Cum.
VIT A	184	61.5%	61.5%
DOESN'T KNOW	115	38.5%	100.0%
Total	299	100.0%	

9. Which food contains Vitamin A?

FOOD	Freq.	Percentage
GREEN VEGETABLES	127	42.6%
CARROT	212	71.1%
LIVER	26	8.7%
BREAST MILK	15	5.0%
YOLK	52	17.4%
DOESN'T KNOW	65	21.8%

Growth Monitoring

10. Does (name of the baby) have a road to health card (or graphic)?

HAS ROADTOHEALTH	Freq.	Percentage
YES	197	65.8%
NO	51	17.1%
DIDN'T SHOW IT	51	17.1%
Total	299	100.0%

11. Weighed during the last 4 months:

WEIGHED	Freq.	Percentage
YES	174	88.3%
NO	23	11.7%
Total	197	100.0%

12. What does a red string on the road to health card mean?

RED STRING	Freq.	Percentage
IS FINE	11	3.7%
IS REGULAR	3	1.0%
IS BAD	214	71.6%
DOESN'T KNOW	70	23.4%
OTHER	1	0.3%
Total	299	100.0%

Diarrheal Diseases

13. When (name of the baby) had diarrhea, did you ask for help or advise?

ASKED HELP	Freq.	Percentage
YES	50	37.0%
NO	85	63.0%
Total	135	100.0%

14. Whom did you ask for help or advise?

	Freq.	Percentage
HOSPITAL	6	12.0%
HEALTH POST	19	8.0%
DOCTOR	4	8.0%
PHARMACY	4	8.0%
PROMOTER	12	24.0%
HEALER	1	2.0%
MIDWIFE	2	4.0%
RELATIVES	10	20.0%
OTHER	0	0.0%

15. How do you realize your child is in danger because of diarrhea?

	Freq.	Percentage
NAUSEA	74	24.8%
FEVER	69	23.2%
DEHYDRATION	130	43.5%
DIARRHEA >14D	50	16.8%
BLOOD/HECS	10	3.4%
LOST APPETITE	91	30.5%
WEAKNESS	96	32.2%
OTHER	46	15.4%
DOESN'T KNOW	38	12.8%

Acute Respiratory Infections

16. Has (name of the baby) had cough or respiratory difficulties during the last weeks?

HAD COUGH	Freq	Percentage
YES	96	32.1%
NO	203	67.9%
Total	299	00.0%

17. Did (name of the baby) have rapid respiration or did he breath as if he was tired?

RESPFREQGROWTH	Freq.	Percentage
YES	72	75.0%
NO	24	25.0%
Total	96	100.0%

18. Did you ask for help or advice when (name of the baby) was sick?

ARI TREATMEN	Freq.	Percentage
YES	27	37.5%
NO	45	62.5%
Total	72	100.0%

19. Whom did you ask for help or advise for (name of the baby)?

	Freq.	Percentage
HOSPITAL	4	14.3%
HEALTH POST	12	44.4%
DOCTOR	1	3.7%
PHARMACY	2	7.4%
PROMOTER	2	7.4%
HEALER	1	3.7%
MIDWIFE	1	3.7%
RELATIVES	10	37.0%
OTHER	2	7.4%

20. How do you realize your child is in danger because of a respiratory infection?

	Freq.	Percentage
RAPID RESPIRATION	99	33.1%
TENSE INTERRIB SPACE	6	2.0%
LOST APPETITE	51	17.1%
FEVER	152	50.8%
COUGH	167	55.9%
DOES NOT KNOW	58	19.4%
OTHER	39	13.0%

Immunizations

21. Has (name of the child) ever been vaccinated?

IMMUNIZATION	Freq.	Percentage	Cum.
YES	244	81.6%	81.6%
NO	55	18.4%	100.0%
Total	299	100.0%	

22. At what age should (name of the child) receive measles vaccine?

Knowledge on EPI: At what age should a child receive the measles vaccine.

Percentage of mothers who know that the measles vaccine should be administered at the age of nine months.

KNOWLEDGE	Freq.	Percentage	Cum.
DOESN'T KNOW	82	27.4%	27.4%
OTHERS	112	37.5%	64.9%
KNOWS	105	35.1%	100.0%
Total	299	100.0%	

23. How many doses of tetanus toxoid should a pregnant woman receive to protect the new born?

TT DOSES	Freq.	Percentage
ONE	6	2.0%
TWO	66	22.1%
MORE THAN 2	145	48.5%
NONE	16	5.4%
DOES NOT KNOW	66	22.1%
Total	299	100.0%

Maternal Health

24. Do you have a Woman's Health Card (maternal immunization record)?

HAS CARD	Freq.	Percentage
YES	145	48.5%
NO	50	16.7%
LOST IT	104	34.8%
Total	299	100.0%

25. Review the Women's Health Card and register the number of TT vaccines in the corresponding space.

TT DOSES	Freq.	Percentage	Cum.
NONE	5	3.4%	3.4%
ONE	8	5.5%	9.0%
TWO OR MORE	132	91.0%	100.0%
Total	145	100.0%	

26. Register the number of prenatal check-ups done while the woman was expecting (name of the child).

PRENATAL VISIT	Freq.	Percentage	Cum.
ONE OR TWO	38	26.6%	26.6%
THREE OR MORE	18	12.6%	39.2%
NONE	87	60.8%	100.0%
Total	143	100.0%	

27. Are you pregnant?

PREGNANCY	Freq.	Percentage	Cum.
+	21	7.0%	7.0%
-	278	93.0%	100.0%
Total	299	100.0%	

28. Would you like to have another child within the next two years?

ANOTHER CHILD	Freq.	Percentage	Cum.
YES	13	4.7%	4.7%
NO	245	91.4%	96.0%
DOESN'T KNOW	11	4.0%	100.0%
Total	278	100.0%	

29. Are you using any method to avoid or to delay the next pregnancy?

FP METHOD	Freq.	Percentage	Cum.
YES	42	15.8%	15.8%
NO	223	84.2%	100.0%
Total	265	100.0%	

30. What method do you or your husband use to avoid pregnancy?

FP METHOD	Freq.	Percentage
PILLS	1	2.4%
IUD	11	26.2%
CONDOM	1	2.4%
VAGINAL FOAM	2	4.8%
BREASTFEEDING	3	7.1%
RHYTHM	19	45.2%
ABSTINENCE	1	2.4%
INTERR COITUS	1	2.4%
OTHERS	3	7.1%
Total	42	100.0%

31. While you were expecting (name of the baby), did you go to a health post (clinic or hospital) for prenatal check-ups?

PRENATAL CONT	Freq.	Percentage	Cum.
YES	127	42.5%	42.5%
NO	172	57.5%	100.0%
Total	299	100.0%	

32. During this pregnancy, did you receive ferrous sulfate tablets?

FERRSULFATE	Freq.	Percentage	Cum.
YES	126	42.1%	42.1%
NO	173	57.9%	100.0%
Total	299	100.0%	

33. Did you take the tablets you were given?

TOOK TABLETS	Freq.	Percentage	Cum.
YES, ALL	82	65.1%	65.1%
SOME OF THEM	39	31.0%	96.0%
DIDN'T TAKE	5	4.0%	100.0%
Total	126	100.0%	

34. After the delivery, did you receive (take) a capsule of Vitamin A?

VITAMIN A	Freq.	Percentage	Cum.
YES	55	18.4%	18.4%
NO	242	80.9%	99.3%
DOESN'T KNOW	2	0.7%	100.0%
Total	299	100.0%	

35. When (name of the child) was born, who cut and tied the umbilical cord?

CUT/TIED CORD	Freq.	Percentage	Cum.
WOMAN HERSELF	1	0.3%	0.3%
RELATIVE	189	63.4%	63.8%
MIDWIFE	59	19.8%	83.6%
HEALTH PROFESS	30	10.1%	93.6%
PROMOTER	4	1.3%	95.0%
OTHER	13	4.4%	99.3%
DOES NOT KNOW	2	0.7%	100.0%
Total	298	100.0%	

RELATIVE WHO ATTENDED THE DELIVERY	NUMBER	PERCENTAGE
HUSBAND	95	50%
MOTHER	50	26%
MOTHER-IN-LAW	23	12%
SISTER-IN-LAW	8	5%
AUNT	6	3%
OTHER RELATIVE	7	4%
TOTAL	189	100%

IV. DISCUSSION AND CONCLUSIONS

Since the main objective of the survey was to evaluate the project's achievements comparing them to the goals mentioned in the objectives, a part of the discussion will be devoted to compare the results obtained with the proposed objectives. In this section, relations between the different results are also discussed as well as their implications for the future of the project.

The discussion and conclusions are presented by groups in the following clusters:

- EPI
- Diarrheal Diseases
- Growth Monitoring
- Breastfeeding/Nutrition
- Vitamin A
- Maternal Health
- Respiratory Infections
- Family Planning

Expanded Program of Immunizations (EPI)

CS 5 OBJECTIVES	RESULTS
70% of children 12 to 23 months with complete series of BCG, DPT3, OPV3 and measles	* Coverage of the EPI measured by: OPV3 = 59% to 73% (see table 2) MEASLES = 56% to 69% (see table 3)
80% of children 12 to 59 months with complete series of BCG, DPT3, OPV3 and measles	* Was not measured by this survey since the sample included only women with children under two years of age
70% of women between 15 and 49 years of age will receive at least two doses of tetanus toxoid	* Coverage: TT2 = 44% to 68%

* This table of results shows two coverages; both numbers were obtained from the Road to Health Card. The first denominator is formed by the total number of mothers interviewed (299); however, this denominator prejudices the results since 17% of mothers said their children had health cards but these were not available when they were interviewed (they left them somewhere or kept them at home, etc.); we assume that those children whose health cards were not presented during the interviews did not have a complete chart of immunizations. For this reason we found it necessary to estimate the coverage in a more realistic way; this result is reflected in the second denominator of the table.

HAD CARD	Freq.	Percentage
YES	197	65.9%
NO	51	17.1%
DIDN'T SHOW IT	51	17.1%
	299	100.0%

For this denominator, only those children whose mothers showed their health cards and those who never had one were taken into account; children who did not show their health cards were excluded.

104 out of the 248 (197 + 51) corresponded to the age of 12 and 23 months.

These results are compared in the following tables.

Table 1

Coverage of Immunizations: Access to the EPI
Percentage of children between 12-23 months who received the First Dose of DPT

Age Group	First Dose of DPT	
12 - 23 months	Based on total number of children between 12-23 months	Excluding children who did not show their road to health card
	68.0%	**83.6%**

According to definitions of the Johns Hopkins University, the first dose of DPT constitutes a good indicator for measuring the access of families to the EPI; in fact, it means there has been contact between families and the EPI; this indicator is also used (together with DPT3) to estimate the rate of desertion.

Table 2

Coverage of Immunizations: Coverage of the EPI
Percentage of Children Between 12-23 Months Who Receive the Third Dose of OPV

Age Group	Third Dose of OPV	
12 - 23 months	Based on total number of children between 12 - 23 months	Excluding children who did not show their road to health card
	59.4%	**73.1%**

Table 3

Coverage of Immunizations: Coverage of Measles Vaccines
Percentage of Children Between 12-23 Months Who received Measles Vaccine

Age Group	Measles Vaccine	
12 - 23 months	Based on total number of children between 12 - 23 months	Excluding children who did not show their road to health card
	56.3%	**69.2%**

Observing the level of coverage reached, in general, one can say that the goals established have been achieved. This statement is reinforced if one considers the change of strategy from that of going house-to-house to look for children, to that of integrated development fairs where families should take their children; this change was done in order to maintain the sustainability of the interventions. Nevertheless, it is necessary to observe that the access to the EPI (estimated by the coverage of DPT1 = 68%) is still insufficient. The National Secretariat of Health promotes for the most isolated areas a level of access of at least 80%.

Another aspect to be taken into account, is the high percentage of children who do not have a Road to Health Card (17%) or who, due to reasons unknown to us, did not want to show it; in any case this observation should be subject to qualitative research. While registering data during the interviews, we had evidence of some deficiencies (for example, the dates of OPV1 y DPT1 did not coincide; there were some dates of vaccination previous to the date of birth; the growth curve had not been filled in, etc.)

Observing the standard indicators, one can see that the rate of desertion is still high (BCG-Measles = 16%); it would be an important goal to reach a rate < 10%.

Regarding maternal knowledge about the EPI, only 35% of mothers know at what age their children should receive the measles vaccine. To increase knowledge about the EPI could improve the demand of immunizations.

Acute Diarrheal Diseases

CS 5 OBJECTIVES	RESULTS
60% of families with children under 5 years of age, will be able to prove their knowledge on oral rehydration therapy/salts and how to prepare and administer them; they will know how to feed a child who is having an episode of diarrhea and how to follow-up; they will also be able to identify 3 signs of dehydration (little or no urine, sunken eyes and no reaction to pinching) and will be able to take adequate actions (referral and treatment).	* 41% of interviewed mothers (123/299) identified three signs of dehydration. * 72% of children suffering diarrhea within the last two weeks received the same quantity of, or more, breast milk. * 63% of those children receiving other fluids, received the same quantity or more fluids. * 52% of those children receiving other foods, received the same quantity or more solid or semi-solid food. * 69% of children with diarrhea received ORT (ORS, homemade serum, thick maize or quinua soup, and infusions). * 35% of mothers of children with severe diarrhea asked for help or referred their children to health staff or trained personnel.

Although one can observe that the percentage of mothers who identify signs of dehydration is still low compared to the goal established, it is interesting to highlight the high percentage of mothers who practice adequate behaviors regarding the child's feeding even exceeding the proposed goals.

As to taking action for seeking help or referring their children, although the percentage is low (35%), it can be interpreted in different ways considering that feeding practices, use of ORS and homemade serum are very frequent. It is possible that, in most cases, there was no need to refer patients.

In this survey we did not measure the ability for adequately preparing ORS or homemade serum.

Growth Monitoring

CS 5 OBJECTIVES	RESULTS
60% of children under 5 years will have attended, at least, 3 weighing sessions/year.	* 58% of children had been weighed within the last four months. (Note: What was measured does not correspond to the objective).
60% of mothers will be able to interpret the growth curve adequately using strings of different colors (green=adequate growth; yellow=slow growth; red=deficient growth), and will take actions accordingly.	* 72% of mothers with children under 24 months knew the meaning of a red string on the child's card. It was not possible to evaluate in this survey actions taken in case signs of risk arose.
68 communities will have the instruments needed for carrying out growth monitoring activities.	* This objective was not evaluated by this survey.

Goals relative to children involved in a growth monitoring program were achieved. There is an important number of mothers who can interpret adequately the different colors of strings. We did not find out what actions a mother takes according to the interpretation of her child's growth curve.

The survey did not measure the existence of weighing instruments in the communities.

Breatfeeding/Nutrition

CS 5 OBJECTIVES	RESULTS
30% of registered puerperal women will administer colostrum to their children within the first 24 hours of life.	* 74% of mothers breastfed their children within the first 24 hours of life
80% of mothers will practice breastfeeding during two years.	* 47% of mothers continued breastfeeding their children - in addition to other foods - for two years.
40% of mothers will start introducing adequate complementary food in their children's diet at the age of four months.	* 41% of mothers introduced complementary food in their children's diet between the first 4-6 months.
	* 77% of children received adequate complementary food between the first 4-6 months of life.
80% of families within the impact area will be consuming iodized salt.	* 90% of mothers use iodized salt in their food.

According to the results obtained in the evaluation, we can say that colostrum administration reaches a percentage of 74% which exceeds the proposed goal. This practice is positive for child nutrition. However, the percentage of continuance of breastfeeding for 24 months is only 47%; it does not reach the proposed goal. As to complementary feeding, one can observe that mothers know at what age they should start it but, in practice, they introduce complementary food in their children's diet much earlier. Iodized salt consumption exceeded the proposed goal; there is another 4% of women who use both iodized salt and cooking salt, they alternate both types of salt due to the low cost of cooking salt.

Nevertheless, 32% of children between 1 and 3 months also received other food besides breast milk (children under 3 months receive mainly water or anise infusion; the latter is a very deeply rooted practice in Bolivia). If we apply strictly the definition of exclusive breastfeeding, only 27% of mothers with children between 1 and 6 months started an adequate feeding compared to the goal. That is to say that only 27 children under 6 months out of 100 received adequate feeding.

Vitamin A

CS 5 OBJECTIVES	RESULTS
60% of children between 1-5 years of age will receive yearly megadoses of Vitamin A.	* 5% of children under 24 months received two doses of Vitamin A.
60% of families will be including vegetables rich in Vitamin A in their diet.	* 42% of interviewed mothers know that Vitamin A protects their children's sight.
	* 78% of interviewed mothers know which foods contain Vitamin A; most of them (71%) mentioned carrot and (43%) green vegetables.
	* 77% of mothers include carrot and pumpkin in their children's food.

The low coverage of Vitamin A is related to the failure of the National Secretariat of Health in regularly supplying this input ; to the fact that once children have a complete series of immunizations, mothers attend only sporadically to regular weighing visits and, finally, the proposed goal included children under 5 years of age while the evaluation was done based only on children under two years; within this age group the coverage of Vitamin A is simply lower.

However, thinking of the sustainability of the project in long-term, it is encouraging to observe that the level of knowledge and the frequency of practices related to Vitamin A consumption are high.

Since we do not have quantitative data, we can only do an observation: it is interesting to emphasize that 7 years ago, when SC/Bolivia started its activities in Inquisivi, there was practically no vegetable consumption within the area.

Maternal Health

CS 5 OBJECTIVES	RESULTS
75% of pregnancies will be registered on the Women's Roster.	* This data were not measured by the survey.
30% of pregnancies will be attended by trained individuals (midwife, husband, health staff, SC/Bolivia field staff).	* 30% of pregnancies were attended by trained staff (health staff and midwives). OBSERVATION: Husbands trained by the project and SC/Bolivia staff are not included; if they were included the result would surely be higher.
100% of registered pregnant women will receive iodized oil, preferably during the first trimester of pregnancy.	* There were no interventions within this area due to the lack of provision from the Secretariat of Health.
100% of registered pregnant women will receive ferrous sulfate beginning with the second trimester of pregnancy.	* 42% of mothers received ferrous sulfate during the pregnancy. (SEE OBSERVATIONS BELOW THE TABLE.)
40% of puerperal women will receive megadoses of Vitamin A	* 18% of puerperal women received one megadose of Vitamin A.
50% of registered pregnant women will have at least three prenatal control visits.	* 6% of mothers had 3 or more prenatal control visits. (* 9% after eliminating those mothers who did not show their health cards or had lost them.) OBSERVATION: Percentages were obtained from the total number of interviewed women; the survey did not select those registered pregnant women.

Even considering that data were obtained based on the total number of interviewed women disregarding whether they were registered or not, the coverage levels of Vitamin A, ferrous sulfate and prenatal check-ups, are low.

Birth attendance by trained staff reached 30%, in other words, the objective was achieved. The coverage would have been higher if we included husbands (many of them were trained by the project) and the SC/Bolivia field staff in the definition of "trained staff". In spite of the fact that trained husbands and SC/B staff were included in the objectives, nevertheless, due to operational definitions of the survey, only those deliveries attended by health staff and midwives were considered.

Among other problems found we must emphasize that, since only 6 months ago the project started distributing the Women's Health Card, many women did not have a Health Card; this had a negative influence in the registration of prenatal control visits since, on one hand, the period of time between the distribution of health cards and the evaluation was too short, and, on the other hand, because the survey was exclusively based on the number of prenatal control visits registered on health cards. We could also observe problems with the different cards distributed within the area by the National Secretariat of Health and SC/Bolivia as well as with TT vaccination cards; these findings had a negative influence in the actual registration of pregnant women who had prenatal control. (One must mention that the distribution of a maternal health card was not an objective of the project.)

Acute Respiratory Infections (ARI)

CS 5 OBJECTIVES	RESULTS
30% of mothers will know preventive actions (immunization, prevention of undernourishment, prevention of polluted atmosphere.)	* The survey did not measure preventive knowledge.
30% of parents will identify ARI signs of risk and they will also know where to go for treatment and follow-up.	* 35% of mothers with children under 24 months identified ARI signs of risk: respiratory frequency growth or tense interrib space. * 24% of mothers with children under 24 months who had respiratory difficulties, sought medical treatment or health personnel.

It was very difficult to measure the level of identification of signs of risk related to Respiratory Infections; questions prepared for identifying children who had suffered pneumonia are not very specific. However, even considering this observation, data obtained provide an orientation regarding the behavior of mothers who were in such situation. The percentage of mothers who look for help when their children have respiratory infections is still low.

As to objectives proposed for tuberculosis, no activities were carried out in this area.

Family Planning

The Child Survival 5 Project did not propose interventions in this field, but, since SC/Bolivia is currently implementing family planning projects as a response to the demand of these services within the Impact Area, we were interested in obtaining some information related to this subject. (Should you require more information, please refer to the Warmi Project Final Evaluation Report, June, 1993.)

It is interesting the potential demand of contraceptive methods, since 89% of women said they did not want to have another child within the next two years. Less than 2 years ago, SC/Bolivia contracted the services of a local NGO, AYUFAM, and later a contract was signed with the San Gabriel Foundation for providing assistance in family planning. If one considers the characteristics of this rural area of Bolivia, where cultural and educational factors besides the lack of access are truly complicated, 6% of women using some modern method should be considered as a significant achievement.

7% of women were pregnant at the moment of the survey, which means there is birth spacing.

Recommendations

A series of recommendations developed through discussions with evaluators and staff on each intervention was given to the qualitative teams and the field office for their use and follow-up.

ANNEX 1

SURVEY QUESTIONNAIRE WITH CONSENT STATEMENT

SCF/Bolivia

CUESTIONARIO SOBRE CONOCIMIENTOS PRACTICAS Y COBERTURA EN SUPERVIVENCIA INFANTIL

PRESENTACIÓN

Buenos días señora. Mi nombre es _____. y soy trabajador(a) de salud. Si Usted me permite, quisiera visitarla un momentito.

Estoy haciendo una visita a las madres que tienen hijos menores de dos años de edad. ¿Usted tiene un hijo menor de 2 años?

SI CONTESTA "SI", continua con la presentación.

SI CONTESTA "NO", agradecerla y despedirla.

Quisiera hacerle algunas preguntas sobre la salud de Usted y su hijo, y todo lo que me diga lo anotaré en éste formulario.

Esto servirá sólo para los trabajadores de salud para que podamos mejorar la atención a las madres y los chicos. Las respuestas que de son completamente confidenciales y no se dara la información a nadie.

Usted es libre de decidir si me recibe o no, y si contesta las preguntas.

¿Nos quiere ayudar?

SCF/BOLIVIA IDNUM _____

CUESTIONARIO SOBRE CONOCIMIENTOS. PRACTICAS Y COBERTURA EN SUPERVIVENCIA INFANTIL. INQUISIVI. FEBRERO/1994

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

Fecha entrevista _ _/_ _/1994 (día/mes) **Re-entrevista** _ _/_ _/1994 (día/mes)

Nombre entrevistador: _____

Supervisor: _____

Comunidad: _____

1 Nombre de la madre _____ Edad (años)_____

2. Nombre del niño menor de 2 años_____. y

fecha de nacimiento _ _/_ _/_ _ (día/mes/año)

entre Febrero de 1992 hasta el presente

Lactancia Materna/Nutrición

3. ¿Está dando de mamar a (nombre del niño)
¿(NOMBRE DEL NIÑO) ÑUÑUYASKTATI?
1. sí [ ] -----> **PASE A LA 5**
2. no [ ]

4. ¿Le ha dado alguna vez de mamar a (nombre del niño)
¿(NOMBRE DEL NIÑO) AVIS RATU ÑUÑ CHURIRITATI?
1. sí [ ]
2. no [ ] -----> **PASE A LA 6**

5. Después del parto, ¿cuándo le dió de mamar por primera vez a (nombre del niño)?
(NOMBRE DEL NIÑO) USUSKTA UKJAJJ CUNASAS ÑUÑ CHURAÑ QALLTA?
1. durante la primera hora después del parto [ ]
2. durante las primeras 8 horas [ ]
3. durante las primeras 24 horas después del parto [ ]
4. más de 24 horas después del parto [ ]
5. no se acuerda [ ]

6. Le está dando a (nombre del niño)
¿(NOMBRE DEL NIÑO) CHURASKTATI?

Lea cada opción a la madre y llene todas las respuestas

	SI	NO
a. Leche de vaca o en polvo ?	[ ]	[ ]
b. Agua, mates, tés ?	[ ]	[ ]
c. Allpi de trigo, quinua o maiz ?	[ ]	[ ]
d. Frutas o jugos ?	[ ]	[ ]
e. Zanahoria,zapallo,mangos o papaya ?	[ ]	[ ]
f. Verduras verdes como la acelga o espinaca ?	[ ]	[ ]
g. Carne ? (vaca, pollo,cordero) (Aycha) ?	[ ]	[ ]
h. Poroto, lentejas, tarwi, kañawa, millmi ?	[ ]	[ ]
i. Huevos ? (K'awna) ?	[ ]	[ ]

7. Prepara la comida de (nombre del niño) con....
.(NOMBRE DEL NIÑO) MANKHAP WAKICHASKTATI?

	SI	NO
a. Azúcar o chancaca ?	[ ]	[ ]
b. Aceite. manteca o cebo?	[ ]	[ ]

8. Que tipo de sal le pone a sus comidas ?
CUNA CAST JAYUMPIS USCUSKTAJ MANQ'AMARUJA? _____

9. ¿A qué edad deberia empezar a dar otros alimentos a su niño?
KAUQJA PHAJSITS YAQHA MANQ'AÑA CHURAÑASPAJA WAWASARUJA?

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

10. ¿Qué vitamina protege la vista?
KUNA VITAMINAS NAIRATJ JARKHEJA?

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

11. ¿Qué alimentos contienen vitamina "A" ?
KUNA ALIMENTONAKANS VITAMINA A UTJIJJA?

puede marcar más de una respuesta

a. no sabe u otros [ ]
b. verduras verdes [ ]
c. zanahorias, zapallo, o frutas de color amarillo intenso [ ]
d. higado de vaca, pollo, cordero [ ]
e. lactancia materna [ ]
f. la yema del huevo [ ]

Control del crecimiento

12. ¿Tiene (nombre del niño) su carnet de salud infantil? (o gráfica)
(NOMBRE DEL NIÑO) CARNET DE SALUD UKA UTJITI?

1. sí [ ](¡PIDA QUE SE LO MUESTRE!)
2. no [ ] -----> PASE A LA 16
3. perdió el carnet (o no lo mostró) [ ] -----> PASE A LA 16

13. Mire el cuadro de controles y registre la siguiente información: ¿ha sido pesado el niño en los últimos 4 meses (ENTRE NOVIEMBRE DE 93 Y FEBRERO DE 94?

1. si [ ]
2. no [ ]

14. Anote ahora las fechas en que le dieron cápsulas de vitamina "A" al niño, en el espacio correspondiente.

	(dia/mes/año)		(dia/mes/año)
1ra	_ _/_ _/_ _	3ra	_ _/_ _/_ _
2da	_ _/_ _/_ _	4ta	_ _/_ _/_ _

BUSQUE AHORA LA SECCION DE VACUNAS

15. Mire el carnet de vacunación y registre las fechas de las inmunizaciones en el espacio correspondiente:

		(dia/mes/año)
BCG		_ _/_ _/_ _
ANTIPOLIO	1	_ _/_ _/_ _
	1a	_ _/_ _/_ _
	2a	_ _/_ _/_ _
	3a	_ _/_ _/_ _
DPT (TRIPLE)	1a	_ _/_ _/_ _
	2a	_ _/_ _/_ _
	3a	_ _/_ _/_ _
ANTISARAMPION		_ _/_ _/_ _

16. ¿Qué significa la lana roja que se le amarra al carnet?
WAWAN CARNETEPARUJJA USCUPJIWA MA COLOR LANA JUMAJJ YATTATY CUN SAÑSA MUNI WILA COLORAJA ?

1. Que el niño está bien (aumenta de peso) [ ]
2. Que el niño no aumenta de peso [ ]
3. Que el niño está mal (bajó de peso) [ ]
4. No sabe [ ]
5. Otros (especifique)_____ [ ]

Enfermedades Diarreicas

17. ¿Ha tenido (nombre del niño) diarrea en las dos últimas semanas?
AKA PASIR PAYA SEMANANAKAN WAWAJJ DIARREANINTI (WICH'U-USU)?

1. si [ ]
2. no [ ] -----> PASE A LA 24
3. no sabe [ ] -----> PASE A LA 24

18. Cuando (nombre del niño) tenía diarrea, ¿le dió de mamar
(NOMBRE DEL NIÑO) DIARREANIPANJJA UKAJJ ÑUÑUYASKAYATATI?

lea las opciones a la madre

1. más ? [ ]
   JUK'AMPTI?
2. igual ? [ ]
   PACHPAKI?
3. poco ? [ ]
   JUK'AQUI?
4. dejó de darle ? [ ]
   JANIT KUNS CHURJTAJJ?
5. ya no recibía pecho ? [ ]
   ÑUÑUKTI?

19. Cuando (nombre del niño) tenía diarrea, ¿le dió otros líquidos, además del pecho ?.
(NOMBRE DEL NIÑO) DIARREANIPANJJA YAQHA UMANAK CHURAYATATI?

lea las opciones a la madre

1. más ? [ ]
   JUK'AMPTI?
2. igual ? [ ]
   PACHPAKI?
3. poco ? [ ]
   JUK'AQUI?
4. dejó de darle ? [ ]
   JANIT KUNS CHURJTAJJ?
5. ya no recibía pecho ? [ ]
   ÑUÑUKTI?

20. Cuando (nombre del niño) tenía diarrea, ¿le dió alimentos blandos (sopas o papillas) ?
DIARREANIPANJJA QHATHI ÑIT'ITANAKJJ WAWAR CHURTATI JANUCAJJ CALDITONAKCHA?

lea las opciones a la madre

1. más ? [ ]
   JUK'AMPTI?
2. igual ? [ ]
   PACHPAKI?
3. poco ? [ ]
   JUK'AQUI?
4. dejó de darle ? [ ]
   JANIT KUNS CHURJTAJJ?
5. ya no recibía pecho ? [ ]
   ÑUÑUKTI?

21. Cuando (nombre del niño) tenía diarrea, ¿Con qué lo ha curado?
(NOMBRE DEL NIÑO) DIARREANIPANJJA KUNJAMS QULLTAJA?

puede marcar más de una respuesta

a. nada [ ]
b. sobre de rehidratación oral [ ]
c. Suero casero (solución de azúcar y sal) [ ]
d. allpi o api [ ]
e. líquidos, tés o mates [ ]
f. medicinas antidiarreicas o antibióticos [ ]
g. otro (especifique) _____ [ ]

22. Cuando (nombre del niño) tenía diarrea, ¿ha pedido ayuda o consejo?
KUNAPACHATEJJ (NOMBRE DEL NIÑO) DIARREANIPANJJA JUMAJJ AMUYT'AWINAKA YANAPT'AWINAKA MAYTATI?

1. si [ ]
2. no [ ] -----> PASE A LA 24

23. ¿A quién pidió consejo o ayuda?
KHITIRUS CONSEJONAKA, YANAPAAWINAKA MAYTAJA, (NOMBRE DEL NIÑO)?

puede marcar más de una respuesta

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

24. ¿Cómo se daría cuenta que su hijo está grave cuando tiene diarrea ?
CUNJAMATS JUMAJJ AMUYASTAJJ WAWAN WALI USUNTATA DIARREAMPI UKAJA?

puede marcar más de una respuesta

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

Infecciones Respiratorias Agudas

25. ¿Ha estado (nombre del niño) enfermo con tos o problemas respiratorios en las dos últimas semanas?
AKA PASIR PAYA SEMANANJ (NOMBRE DEL NIÑO) UJUNINTI JAN UKAJJ CALORAM PINCHA?
1. sí [ ]
2. no [ ] -----> PASE A LA 29

26. ¿Ha estado (nombre del niño) con respiración rápida o respiraba como cansado cuando se enfermó ?
(NOMBRE DEL NIÑO) RATUKIK SAMSUNJJA JAN UCAJJ JARITJAMACHA SAMANJJA?
1. sí [ ]
2. no [ ] -----> PASE A LA 29
3. no sabe [ ] -----> PASE A LA 29

27. ¿Ha pedido ayuda o consejo cuando (nombre del niño) estuvo enfermo ?
JUMAJJ (NOMBRE DEL NIÑO) USUTAKAN UKAJJ MAYTATI AMUYT'AWINAKJJA?
1. sí [ ]
2. no [ ] -----> PASE A LA 29

28. ¿A quién pidió ayuda o consejo para (nombre del niño)?
KHITIUS CONSEJONAKA YANAPAWINAKA MAYTAJJA?

puede marcar más de una respuesta

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

29. ¿Cómo se daría cuenta que su hijo está grave con una enfermedad respiratoria?
CUNJAMATS AMUYASMAJJ WALI CALURAMPIPNAJJA?

puede marcar más de una respuesta

a. no sabe [ ]
b. respiración rápida y agitada [ ]
c. retracciones inter-costales [ ]
d. pérdida de apetito [ ]
e. fiebre [ ]
f. tos [ ]
g. otro (especifique) _____ [ ]

Inmunizaciones

30. ¿(nombre del niño) ha sido vacunado alguna vez?
(NOMBRE DEL NIÑO) VACUNAYRITATI?
1. sí [ ]
2. no [ ]
3. no sabe [ ]

31. ¿A qué edad (nombre del niño) debe recibir la vacuna contra el saramoión ?
QAWQHA PHAJJSIRUS WAWAJJ SARÁMPION USUTAKEJJ VACUN KATOQAÑAPAJJA?
1. Especifique en meses [__/__]
2. No sabe u otros [ ]

32. ¿Cuántas vacunas contra el tétanos debe recibir una mujer embarazada para proteger al recién nacido?
QAWQHA KUTIS MÄ USUR WARMEJJ TETANO USU CONTRAJJ VAKUNANAK KATOQAÑAPAJJ, ASHU WAWAR USUNAKAT JARK'ÑATAKI?
1. una [ ]
2. dos [ ]
3. más de dos [ ]
4. ninguna [ ]
5. no sabe [ ]

Salud Materna

33. ¿Tiene Ud. su carnet de la mujer ? (vacunación materna?)
JUMAJJ CARNETINITATI (SALUD MATERNATA)?
1. sí [ ] (¡PIDA QUE SE LO MUESTRE!)
2. no [ ] -----> PASE A LA 36
3. perdió el carnet [ ] -----> PASE A LA 36
(o no lo mostró)

34. Mire el Carnet de la Mujer y registre el número de vacunas TT en el espacio correspondiente:

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

35. Registre el número de visitas prenatales del embarazo de (nombre del niño)

1. Una o dos [ ]
2. Tres o más [ ]
3. Ninguna [ ]

36. ¿Está Ud. embarazada ?
JICHHAJJ JUMAJJ USURITATI?)
1. si [ ] -----> PASE A LA 40
2. no . [ ]

37. ¿Quisiera Ud. tener otro hijo en los próximos dos años?
JUMAJJ JUTIR PÄ MARANAKANJJA YAQHA WAWANIÑ MUNTATI?
1. si [ ] -----> PASE A LA 40
2. no [ ]
3. no sabe [ ]

38. ¿Está Ud. usando algún método para no embarazarse o retrasar el próximo embarazo?
JAN WAWANIÑATAKEJJ KUNJAMAS CUIDASISKTAJJA?
1. si [ ]
2. no [ ] -----> PASE A LA 40

39. ¿Qué método principal usa Ud. o su esposo para no embarazarse?
JUMAMP CHACHAMAMPEJJ KUNJAMS CUIDASISTKA JAN WAWANIÑATAKEJJA?
1. ligadura de trompas [ ]
2. Norplant [ ]
3. inyecciones [ ]
4. pastillas anticonceptivas (píldoras/tabletas orales) [ ]
5. "T" de cobre o espiral [ ]
6. diafragma [ ]
7. condones [ ]
8. tabletas vaginales [ ]
9. lactancia materna exclusiva [ ]
10. método del ritmo - calendario [ ]
11. abstinencia [ ]
12. coito interrumpido [ ]
13. otros (especifique) _____ [ ]

40. Cuando Ud. estaba embarazada de (nombre del niño), ¿visitó algún centro de salud (clínica u hospital) para el control de su embarazo?
KUNAPACHATEJJ JUMAJJ (NOMBRE DEL NIÑO) USURIKAYATAJJA UKJAJJ HOSPITALAR, CENTRO DE SALUD SARIRIYATATI CONTROLAYASIÑATAKI?
1. si [ ]
2. no [ ]

41. Durante su embarazo, recibió tabletas de Sulfato Ferroso ?
USURIKAYATA UKAJA CATUKAYATATI PASTILLAS SULFATO FERROSO?

Muestre la tableta

1. Si [ ]
2. No [ ] -----> PASE A LA 43

42. Tomó las tabletas que le dieron ?
UMAYATATI UKA PASTILLANAKA?
1. Si, todas [ ]
2. Si, algunas [ ]
3. No, ninguna [ ]

43. Después de su parto, recibió (tomó) usted una cápsula de Vitamina A ?
USUSJTA UKAJJA VITAMINA "A" CATUQTATI?

Muestre la cápsula

1. Si [ ]
2. No [ ]
3. No sabe [ ]

44. Cuando nació (nombre del niño), quien amarró y cortó el cordón?
(NOMBRE DEL NIÑO) YURKAN UKAJJ KHITHIS KURURUP CHINT'I, KUCHOQE?

1. Ud. misma [ ]
2. un miembro de la familia (especifique) _____ [ ]
3. partera [ ]
4. profesional de salud (médico, enfermera) [ ]
5. promotor o RPS. [ ]
6. otro(especifique) _____ [ ]
7. no sabe [ ]

ANNEX 2

TRAINING PROGRAM

PROGRAMA DE CAPACITACIÓN PARA EL ESTUDIO SOBRE CONOCIMIENTOS Y PRACTICAS SCF/Bolivia

Este programa es para se aplicado como una guía de capacitación para supervisores y entrevistadores del estudio sobre conocimientos y practicas en Supervivencia Infantil. El objetivo general de la capacitación de supervisores y entrevistadores es hallar un consenso en los diferentes aspectos de la ejecución del estudio.

COMPROMISO Y TIEMPO DE LOS SUPERVISORES.

a. Los supervisores están obligados a trabajar todos los dias con cada uno de los entrevistadores que le fueron asignados. Durante todos los dias del estudio, los supervisores deben observar por lo menos una entrevista completa por cada uno de los entrevistadores. Los supervisores **no deben interferir** durante las entrevistas tampoco avergonzar a los entrevistadores o madres entrevistadas con comentarios o preguntas. La tarea principal del supervisor es mas bien guiar y apoyar a los entrevistadores (después que la entrevista ha concluido), ya sea en la forma en que las preguntas están hechas a la madre, la forma en que se están presentando a la familia, o finalmente como conseguir la información requerida sin guiar o variar las respuestas. Esto ayudará a mantener un enfoque objetivo de las encuestas uniformidad en todos los entrevistadores. El supervisor puede ser presentado a la familia como un miembro mas del equipo y no como el supervisor o el jefe, esto con el fin de no influir en las respuestas de la madre entrevistada. Si los supervisores deben entrevistar ellos mismos, también deben ser supervisados por una entrevista completa por dia al igual que los entrevistadores, esto puede ser hecho por otro supervisor o por algún otro miembro del equipo (si esto es aceptable).

b. Los supervisores deben revisar cada uno de los cuestionarios por día para verificar si estos están completos. Si el cuestionario esta con todas las preguntas completas, deberá poner la fecha y firmarlo. El/ella deberán mantener los cuestionario en archivos separados por cada entrevistador. Los entrevistadores no pueden irse del lugar de reunión si su supervisor no ha concluido con la revisión de todos los cuestionario, y haya decidido que acción debe tomar para corregir o agregar información que falta. Si es posible, el entrevistador deberá completar la información que falta en el mismo día. Si no, la re-encuesta será la primera actividad de la mañana antes de empezar las actividades del dia.

c. Los supervisores deben manejar cualquier problema práctico que se presente con las personas que esta supervisando. Si un entrevistador no puede realizar sus actividades debido a enfermedad u otra emergencia, el supervisor debe hallar un

reemplazo entre los entrevistadores ya entrenados. Si no hay un entrevistador apropiado, el supervisor debe realizar las encuestas por su cuenta.

PROGRAMA

1. Introducción (30 minutos)

- Establecer el propósito y objetivos del estudio: porque se esta haciendo el estudio?; que es lo que queremos conseguir del presente estudio?.

- Presentar el tiempo de trabajo para cumplir con las actividades de: capacitación, aplicación de las encuestas a nivel de la familia, análisis y tiempo para el análisis, y presentación de un informe borrador. El tiempo que los entrevistadores y supervisores deben dedicar para el estudio debe ser claro y en forma comprensible.

2. Arreglos administrativos (30 minutos aproximadamente):

- Discutir problemas como:
  salarios;
  tiempo extra de trabajo;
  trasporte;
  comunicación oportuna a las comunidades:
  distribución de zonas de acuerdo a la estructura de logistica y materiales

Si otros problemas y arreglos necesitan ser discutidos, estos deben ser tocados después de la sesión de capacitación.

3. Metodologia para escoger la población (45 minutos aproximadamente):

- Describir el estudio sobre Conocimientos y practicas (C&P) en supervivencia Infantil.

- Explicar los calculos para la selección de la muestra y la lógica de estos.

- Discutir la selección de las casa a entrevistar de acuerdo a la técnica por conglomerado y para tomar todo el universo.

- Establecer claramente que la asignación de areas o zonas para cada entrevistador no se dará conocer sino hasta el mismo dia del estudio, de manera que no haya contaminación o influencia a otras casas o comunidades.

4. El cuestionario (90 minutos):

- Ver el cuestionario, pregunta por pregunta y explicar el significado de cada una de las preguntas (porque estamos preguntando estas preguntas y que es lo que queremos conseguir con estas). A este momento, no habrán discusiones de como se deben presentar las preguntas a la madre.

- Codificación del cuestionario: ver otra vez todas las preguntas para explicar como se deben llenar las respuestas en el cuestionario. Las respuestas múltiples deben ser muy bien entendidas por los entrevistadores.

5. Técnicas para la entrevista (30 minutos):

- Ver todas las preguntas nuevamente y discutir revisando el lenguaje y la forma en que cada pregunta debe ser presentada a la madre.

6. Simulación del llenado del cuestionario (2 horas):

- Llenar el cuestionario, primero con uno de los supervisores, jugando el papel de un entrevistador y una madre, muestre como se hace una pregunta en forma correcta y como evitar los sesgos (error sistemático)en las respuestas de la madre.

- Dos juegos mas con los supervisores: primero, como hacer una entrevista en forma correcta, luego como hacer una mala entrevista.

- Luego, toda le gente estará involucrada en las entrevistas: cada persona tendrá la oportunidad de jugar el papel de una madre y de un entrevistador por lo menos una vez. Después, una discusión general escogiendo situaciones especiales que se van a encontrar.

7. Análisis de datos (30 minutos aproximadamente):

Las personas designadas para la tabulación de datos y análisis deberán participar en toda la sesión de entrenamiento, incluyendo la prueba piloto (pre-test). Si esto no es posible, uno o dos de los supervisores deberán meter los datos porque esta es una parte esencial para los buenos resultados del estudio. Es muy importante asegurarse que las personas que van a tabular los datos e introducirlos en la computadora estén involucrados en el estudio desde el principio.

Todos los entrevistadores deben entender como los datos van a ser tabulados. Cada una de las personas involucradas en el estudio tendrán la oportunidad de ver las tablas y entender la importancia de tener cuestionarios bien llenados y sin errores, para una buena tabulación de datos. Lo mas importante es que los entrevistadores vean el efecto que tienen los datos provenientes de una buena información de base para la buena panificación del proyecto ahora

y en el futuro inmediato.

En resumen, el propósito de este ejercicio es:

- Aclarar como van a ser tabulados y analizados los datos

- Entender que el tiempo para el análisis de los resultados es de solo dos días.

- Entender que el tiempo para la elaboración de tablas es de solo un dia.

- Conocimientos para una buena presentación de los resultados en forma resumida (como punto final):
Los participantes deben estar prevenidos de que la información obtenida en el estudio, será presentada en reuniones de la directiva de SCF/Bolivia y otras instituciones interesadas, después que la capacitación y estudio de campo hayan concluido. Todos tendrán acceso a un informa escrito (borrador) de la metodologia y de los resultados. Las discusiones se basarán como el mejor uso de los resultados obtenidos: por ejemplo, las implicaciones para las decisiones futuras administrativas para mejorar el proyecto en guayape estarán basadas en este u otros estudios de campo.

9. Dia del pretest o prueba piloto

Al final de las sesiones de entrenamiento, se anunciara acerca de las actividades del siguiente dia; esto incluirá:

- la conducción de una prueba de campo con los formularios ya finalizados. cada persona llenara personalmente por lo menos tres cuestionarios completamente en un area fuera de guayape, esta actividad tomara por lo menos medio dia.

- almuerzo

- revisión de los cuestionarios.

Se deberá llegar a un consenso de como se reaccionara con preguntas difíciles y manejar situaciones complicadas y; entender la importancia de una supervisión estrecha durante los dias de las entrevistas. Esta última actividad tomara por lo menos una tarde.

LISTA DE SUPERVISIÓN
SCF/Bolivia

- Lo primero al llegar a la comunidad es la selección de la primera casa a entrevistar.
- Asista a una entrevista completa de cada uno de los entrevistadores a su cargo, y observe lo siguiente:
  - como se presenta el entrevistador a la madre;
  - ¿le explica la razón de su visita y le pide permiso para realizar el cuestionario?
  - ¿le lee las preguntas exactamente como están en el cuestionario?
  - observe si al hacèr las preguntas no guia las respuestas, el error mas común al realizar un cuestionario
  - también observe si cuando la madre no entiende, el entrevistador le aclara la pregunta pero sin darle las respuestas
  - observe también que el entrevistador no haga ningún comentario ante las respuestas de la madre

  Mientras el entrevistador realiza la entrevista, por favor no intervenga ni haga su presencia muy notoria para no intimidar a la madre. Sin embargo, anote también las respuestas de la madre para luego comparar con las del entrevistador y verificar si las respuestas se llenaron correctamente.
- Si hay errores, hable con el entrevistador para aclarar sus dudas y si déle mas explicaciones si las necesita.
- Luego que termine la entrevista vaya a observar al otro entrevistador y haga lo mismo.
- Al terminar el dia, junte los cuestionarios y reviselos cuidadosamente buscando errores o falta de información, si es asi, vea la mejor forma de llenar esa información antes de volver a Villamontes. Si todo está sin errores, firme el cuestionario y guárdelo con cuidado para llevarlo a Villamontes.
- Buena suerte en el trabajo !!!!!

SCF/Bolivia

COMPROMISO Y TIEMPO DE LOS SUPERVISORES.

A. Los supervisores están obligados a trabajar todos los dias con cada uno de los entrevistadores que le fueron asignados. Durante todos los dias del estudio, los supervisores deben observar por lo menos una entrevista completa por cada uno de los entrevistadores. Los supervisores **no deben interferir** durante las entrevistas tampoco avergonzar a los entrevistadores o madres entrevistadas con comentarios o preguntas. La tarea principal del supervisor es mas bien guiar y apoyar a los entrevistadores (después que la entrevista ha concluido), ya sea en la forma en que las preguntas están hechas a la madre, la forma en que se están presentando a la familia, o finalmente como conseguir la información requerida sin guiar o variar las respuestas. Esto ayudará a mantener un enfoque objetivo de las encuestas uniformidad en todos los entrevistadores. El supervisor puede ser presentado a la familia como un miembrp mas del equipo y no como el supervisor o el jefe, esto con el fin de no influir en laa respuestas de la madre entrevistada. Si los supervisores deben entrevistar ellos mismos, también deben ser supervisados por una entrevista completa por dia al igual que los entrevistadores, esto puede ser hecho por otro supervisor o por algún otro miembro del equipo (si esto es aceptable).

B. Los supervisores deben revisar cada uno de los cuestionarios por dia para verificar si estos están completos. Si el cuestionario esta con todas las preguntas completas, deberá poner la fecha y firmarlo. El/ella deberán mantener los cuestionario en archivos separados por cada entrevistador. Los entrevistadores no pueden irse del lugar de reunión si su supervisor no ha concluido con la revisión de todos los cuestionario, y haya decidido que acción debe tomar para corregir o agregar información que falta. Si es posible, el entrevistador deberá completar la información que falta en el mismo dia. Si no, la re-encuesta será la primera actividad de la mañana antes de empezar las actividades del dia.

C. Los supervisores deben manejar cualquier problema práctico que se presente con las personas que esta supervisando. Si un entrevistador no puede realizar sus actividades debido a enfermedad u otra emergencia, el supervisor debe hallar un reemplazo entre los entrevistadores ya entrenados. Si no hay un entrevistador apropiado, el supervisor debe realizar las encuestas por su cuenta.

ANNEX 3

COMMUNITY SELECTION LIST

SAVE THE CHILDREN BOLIVIA

COMUNIDADES COMPRENDIDAS EN EL PROGRAMA CS-5

FECHA: 30 de Septiembre de 1993

COMUNIDADES	POBLACION TOTAL	MUJERES	VARONES		NIÑOS < 5 AÑOS	MEF	TOTAL POBLAC.	POBLAC. ACUMULADO
INQUISIVI								
INQUISIVI	302	146	156		39	63	302	302
TUPUYO **	150						150	452
TAUCARASI	267	146	121		30	64	267	719
MICAYANI	153	79	74		22	40	153	872
YAMORA	262	124	138		40	52	262	1134
MACHACAMARCA	140	70	70		20	28	140	1274
IGUSANI	94	45	49		10	19	94	1368
TITIPACHA	173	83	90		27	32	173	1541
ACUTANI	167	77	90		22	27	167	1708
CORACHAPI	193	100	93		37	41	193	1901
CHIJI	313	151	162		53	57	313	2214
ACOTA	285	139	146		46	52	285	2499
CAPIÑATA	74	36	38		13	12	74	2573
QUINCU SUYO	532	244	288		85	96	532	3105
CHULLPANI	85	42	43		15	13	85	3190
ISPALLUTA	110	53	57		18	20	110	3300
UPUÑA	181	82	99		26	33	181	3481
JASA	82	38	44		13	14	82	3563
CAICHANI	181	93	88		30	32	181	3744
CHOROCONA	304	154	150		39	61	304	4048
SITA	479	229	250		72	97	479	4527
VILACOTA	131	64	67		18	28	131	4658
CANQUI CHICO	386	176	210		54	61	386	5044
TIA CANQUI	108	59	49		18	20	108	5152
CANQUI GRANDE	127	63	64		13	31	127	5279
LACA LACA	135	78	57		26	28	135	5414
ESCOLA	17	4	13		4	2	17	5431
OJO DE AGUA	182	91	91		21	38	182	5613
CHUALLANI	128	62	66		15	27	128	5741
TOTABA	110	49	61		22	23	110	5851
MACHACAMARCA	109	56	53		17	22	109	5960
LOCOTANI	205	102	103		39	37	205	6165
VENTILLA	215	97	118		38	41	215	6380
FRUTILLANI	132	63	69		21	34	132	6512
CHALLVIRI	154	72	82		21	37	154	6666
CHILCANI	351	159	192		60	64	351	7017
SUBTOTAL INQUISIVI	7017	3326	3541		1044	1346	7017	

SAVE THE CHILDREN BOLIVIA

COMUNIDADES COMPRENDIDAS EN EL PROGRAMA CS-5

FECHA: 30 de Septiembre de 1993

COMUNIDADES	POBLACION TOTAL	MUJERES	VARONES		NIÑOS <5 AÑOS	MEF	TOTAL POBLAC.	POBLAC. ACUMULADO
LICOMA								
PULCHIRI	213	110	103		30	40	213	7230
CHARAPAXI	236	111	125		44	41	236	7466
HUARITOLO	473	230	243		66	100	473	7939
SOJETACA-RR-PKLQUE	238	117	121		43	46	238	8177
BELLA VISTA **	100						100	8277
LACAYOTINI	84	40	44		18	16	84	8361
PENCALOMA	146	64	82		27	22	146	8507
KULUYO	101	47	54		13	17	101	8608
LICOMA	784	392	392		84	168	784	9392
KHARA	144	73	71		14	37	144	9536
TIRCO 1	72	29	43		8	17	72	9608
SANTA ROSA	108	48	60		17	19	108	9716
PALOMANI	91	36	55		14	19	91	9807
CHECA	166	80	86		29	28	166	9973
ALFAGIANI	123	52	71		17	20	123	10096
CHOJLLARA	97	44	53		21	18	97	10193
SURI	204	100	104		25	41	204	10397
CHAJNA	193	81	112		27	32	193	10590
PARPATA	112	54	58		24	20	112	10702
MOXACOCA	170	88	82		35	37	170	10872
ESPIGA PAMPA	195	92	103		31	45	195	11067
SUBTOTAL LICOMA	4050	1888	2062		593	783	4050	

SAVE THE CHILDREN BOLIVIA

COMUNIDADES COMPRENDIDAS EN EL PROGRAMA CS-5

FECHA: 30 de Septiembre de 1993

COMUNIDADES	POBLACION TOTAL	MUJERES	VARONES		NIÑOS < 5 AÑOS	MEF	TOTAL POBLAC.	POBLAC. ACUMULADO
CIRCUATA								
POLEA	193	91	102		22	46	193	11260
AGUA RICA	245	117	128		35	60	245	11505
LOMA LINDA	273	146	127		46	69	273	11778
TURCULI	271	130	141		36	62	271	12049
SAN JOSE	182	85	97		27	37	182	12231
CIRCUATA	777	367	410		116	161	777	13008
AMACHINA	39	19	20		4	10	39	13047
CAJUATA	504	236	268		73	125	504	13551
SIQUIMIRANI	412	182	230		51	96	412	13963
PUENTE ALEGRE	206	108	98		24	52	206	14169
CAÑAMINA	544	282	262		81	119	544	14713
VILLA BARRIENTOS	377	177	200		51	81	377	15090
VILLA KHORA	564	272	292		76	123	564	15654
LIMON VADO	134	63	71		19	25	134	15788
VILLA ANGELICA	77	34	43		7	17	77	15865
PLAYA VERDE	90	49	41		13	20	90	15955
LUJMANI	139	66	73		19	32	139	16094
MIGUILLAS	635	314	321		91	146	635	16729
SUBTOTAL CIRCUATA	5662	2738	2924		791	1281	5662	
TOTALES CS-5	16729	7952	8527		2430	3410	16729	

NTE: Datos actualizados del PROMIS.

** Comunidades donde no se realizó el censo de población.

$\frac{16,729}{30} = 557$ intervol

62

ANNEX 4

ROAD TO HEALTH AND MATERNAL HEALTH CARDS

ANTECEDENTES GINECO OBSTETRICOS

Número de embarazos: _____
Número de abortos: _____
Número de nacidos vivos: _____
Número de nacidos muertos: ___
Vivos actuales: _____

PARTOS ANTERIORES

Número de Parto	Fecha del Parto

Sexo	Problema

Número de Parto	Fecha del Parto

Sexo	Problema

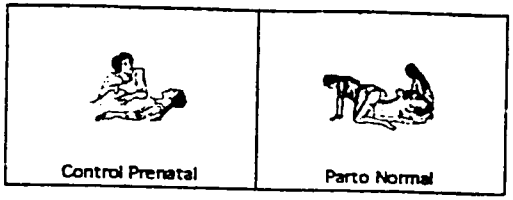
Número de Parto	Fecha del Parto

Sexo	Problema

VACUNA TT

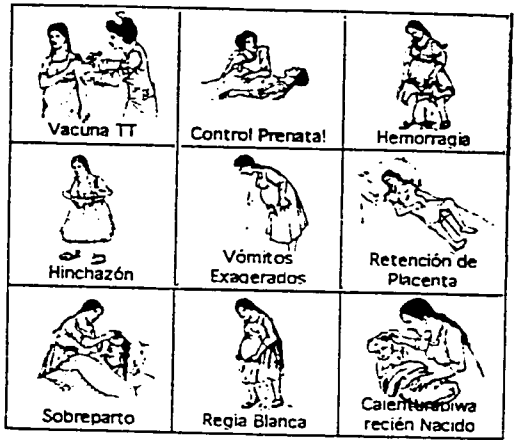
	1	2	3	4	5
FECHA					

PARTERA



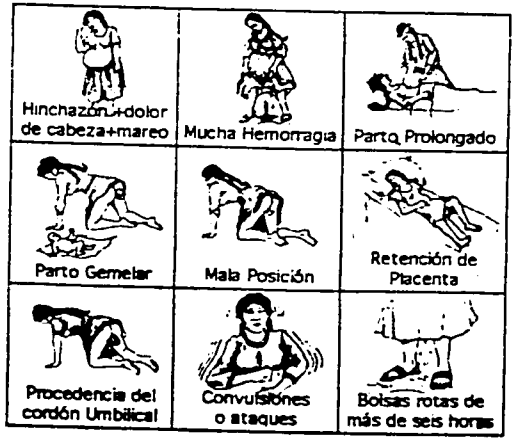
Debe ir al puesto sanitario en caso de:

PUESTO SANITARIO



Debe ir al hospital en caso de:

HOSPITAL



MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA

Desarrollo Juvenil Comunitario

CARNET DE LA MUJER

Nombre: _____

Fecha de Nacimiento: _____

Dirección: _____

Número de casa: _____

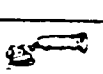
Comunidad: _____

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 Nº 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

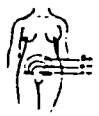
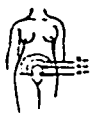
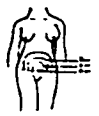
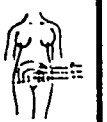
CALENDARIO DE LA MUJER

Código de Métodos de Planificación Familiar

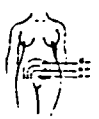
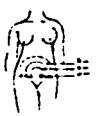
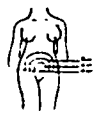
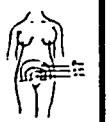
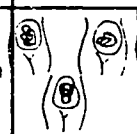
E=Embarazo  D=Diú  P=Pastilla  N=Natural/Ritmo  A=Abstinencia  C=Condón  L=Lactancia 

	AÑO 19___		AÑO 19___		AÑO 19___		AÑO 19___		AÑO 19___	
	Menstruación	Método	Menstruación	Método	Menstruación	Método	Menstruación	Método	Menstruación	Método
ENERO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
FEBRERO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
MARZO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
ABRIL	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
MAYO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
JUNIO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
JULIO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
AGOSTO	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
SEPTIEMBRE	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
OCTUBRE	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
NOVIEMBRE	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	
DICIEMBRE	Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___		Sí No Día___	

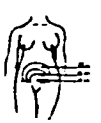
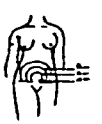
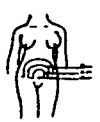
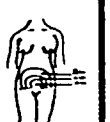
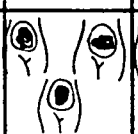
EMBARAZO N° [redacted]

Número de control	1	2	3	4
Fecha parto				
Fecha control				
Edad de embarazo				
Presión arterial				
Peso				
Altura uterina Jacha usurikiwa Jisk's usurikiwa				
Presentación				
Movimiento fetal	Sí No	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Sí No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción: 		
Edema Phusuntata		Sí No Fecha: / / Acción: 		
Vómitos Wakaguiskiwa Kutiaskiwa		Sí No Fecha: / / Acción: 		
Embarazo Gemelar		Sí No Fecha: / / Acción: 		

EMBARAZO N° [redacted]

Número de control	1	2	3	4
Fecha parto				
Fecha control				
Edad de embarazo				
Presión arterial				
Peso				
Altura uterina Jacha usurikiwa Jisk's usurikiwa				
Presentación				
Movimiento fetal	Sí No	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Si No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción: 		
Edema Phusuntata		Sí No Fecha: / / Acción: 		
Vómitos Wakaguiskiwa Kutiaskiwa		Sí No Fecha: / / Acción: 		
Embarazo Gemelar		Sí No Fecha: / / Acción: 		

EMBARAZO N° [redacted]

Número de control	1	2	3	4
Fecha parto				
Fecha contro				
Edad de embarazo				
Presión arterial				
Peso				
Altura uterina Jacha usurikiwa Jisk's usurikiwa				
Presentación				
Movimiento fetal	Sí No	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Sí No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción:		
Edema Phusuntata		Sí No Fecha: / / Acción:		
Vómitos Wakaguiskiwa Kutiaskiwa		Sí No Fecha: / / Acción:		
Embarazo Gemelar		Sí No Fecha: / / Acción:		

PARTO

Lugar, fecha y Quién atendió	/
Retención de placenta	Sí No Acción:
Mala posición Ladunquiwa	Sí No Acción:
Prolongado Jayawas t'alaya	Sí No Acción:
Hemorragia Wila apiri	Sí No Acción:

DESPUES DEL PARTO

Disminución del tamaño del útero	Normal ☐ Anormal ☐
Regla Blanca	Sí No Acción:
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	Sí No Fecha: / / Acción:
Hemorragia Wila apiri	Sí No Fecha: Acción:

RECIEN NACIDO

Nacido	Vivo ☐ Muerto ☐
Sexo	Niño ☐ Niña ☐
Peso	_____ Gramos
Calostro	1ra. Hora ☐ 1er. Día ☐ No ☐
Problema	Fecha: / / Acción:

PARTO

Lugar, fecha y Quién atendió	/
Retención de placenta	Sí No Acción:
Mala posición Ladunquiwa	Sí No Acción:
Prolongado Jayawas t'alaya	Sí No Acción:
Hemorragia Wila apiri	Sí No Acción:

DESPUES DEL PARTO

Disminución del tamaño del útero	Normal ☐ Anormal ☐
Regla Blanca	Sí No Acción:
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	Sí No Fecha: / / Acción:
Hemorragia Wila apiri	Sí No Fecha: Acción:

RECIEN NACIDO

Nacido	Vivo ☐ Muerto ☐
Sexo	Niño ☐ Niña ☐
Peso	_____ Gramos
Calostro	1ra. Hora ☐ 1er. Día ☐ No ☐
Problema	Fecha: / / Acción:

PARTO

Lugar, fecha y Quién atendió	/
Retención de placenta	Sí No Acción:
Mala posición Ladunquiwa	Sí No Acción:
Prolongado Jayawas t'alaya	Sí No Acción:
Hemorragia Wila apiri	Sí No Acción:

DESPUES DEL PARTO

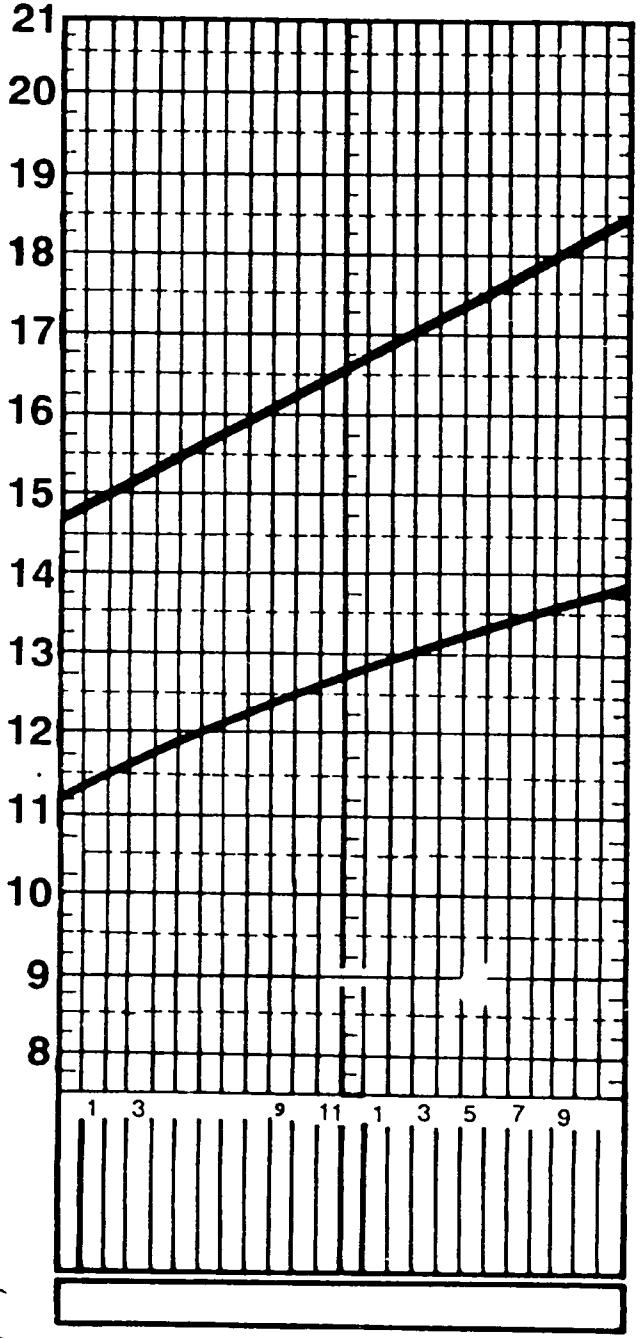
Disminución del tamaño del útero	Normal ☐ Anormal ☐
Regla Blanca	Sí No Acción:
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	Sí No Fecha: / / Acción:
Hemorragia Wila apiri	Sí No Fecha: Acción:

RECIEN NACIDO

Nacido	Vivo ☐ Muerto ☐
Sexo	Niño ☐ Niña ☐
Peso	_____ Gramos
Calostro	1ra. Hora ☐ 1er. Día ☐ No ☐
Problema	Fecha: / / Acción:

3 años 4 a 5 a

PESO EN KILOGRAMOS



CONTROLES

FECHA	EDAD Años	meses	PESO	TALLA

REPUBLICA DE BOLIVIA
Ministerio de Previsión Social y Salud Públic

CARNET DE SALUD INFANTIL

CENTRO DE SALUD	No. de Carnet
	SEXO F M

NOMBRE DEL NIÑO

FECHA DE NACIMIENTO año mes día

NOMBRE DE LA MADRE

NOMBRE DEL PADRE

FECHA DE LA PRIMERA VISITA año mes día

DONDE VIVE LA FAMILIA (DOMICILIO)

Dirección Nacional de Epidemiología

VACUNAS

Anotar la fecha de vacunación

BCG		
ANTI POLIO	i	
	1ª	
	2ª	
	3ª	
DPT (TRIPLE)	1ª	
	2ª	
	3ª	
ANTISARAMPION		

O.P.S./O.M.S. UNICEF

NOMBRE

PESO AL NACER GRS.

Nacimiento **Meses** **1año** **2 años** **3 a**

Intérvalo entre niños

PESO EN KILOGRAMOS

Kg 15 14 13 12 11 10 9 8 7 6 5 4 3 2

1 2 3 4 5 6 7 8 9 10 11

meses de edad

TRIPLE

SARAMPION

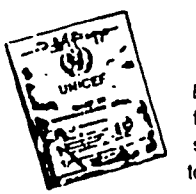
POLIO

BCG

Observe la dirección de la línea del crecimiento del niño

bueno **en riesgo** **malo**

Para ayudar al crecimiento del niño se recomienda a la madre darle comida suplementaria con más frecuencia.



REHIDRATACION ORAL
(En caso de diarrea)

En un litro de agua limpia y fría mezclar un sobre de suero oral y darle al niño todo lo que acepte y pida durante todo el día.

Lea más indicaciones en el sobre SRO.

PART II

FINAL EVALUATION
SUSTAINABILITY QUESTIONNAIRE
PIPELINE ANALYSIS

SAVE THE CHILDREN
BOLIVIA

SAVE THE CHILDREN
BOLIVIA FIELD OFFICE
CHILD SURVIVAL 5
FINAL EVALUATION SUSTAINABILITY QUESTIONNAIRE
PIPELINE ANALYSIS

Agency for International Development
Grant # AID-OTR-0500-A-00-9149-00
June 1994

Save the Children
54 Wilton Road
Westport, CT 06880

(203) 221-4000

77

TABLE OF CONTENTS

Final Evaluation Sustainability Questionnaire Pipeline Analysis

BOLIVIA CHILD SURVIVAL 5 PROJECT FINAL EVALUATION

SUSTAINABILITY QUESTIONAIRRE

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

A. Sustainability Status

A.1 At what point does A.I.D. funding for child survival project activities end?

A.I.D. financing of this project ends March 31, 1994.

A.2 At what point does the organization plan to cease child survival project activities?

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

A.3 How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

The project has been and will continue working with the VHWs (community level health promoters within the National Secretariat of Health system) and midwives to strengthen their capacity to train families in protective health behaviors and to assist with vaccination campaigns. Health data collected by the project is shared with the "Tres Cruces" Health District for inclusion in their district wide collection and analysis of health data. The National Secretariat of Health is also responsible for the distribution of ORT packets to the promoters. SC/B will continue to coordinate activities with the personnel of the Tres Cruces District and to work with the local unions and women's clubs, to provide support to strengthen the women's agrarian union and the local midwives' union. SC/B will continue vaccination campaigns coordinated with the National Secretariat of Health three times per year in approximately 50 communities of the remote Arcopongo zone and approximately 20 communities of the Siguas/Luruta zone, and to continue child survival and maternal health activities in the project area, working closely with the National Secretariat of Health in developing fairs and handing over continuously more responsibilities to the National Secretariat of Health. For example, the National Secretariat of Health health posts and hospital will assume responsibility for counselling in birth control methods and insertion of IUDs within the next few months.

B. Estimated Recurrent Costs and Projected Revenues

B.1 Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

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

B.2 What expenditures will continue to be needed (i.e., recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

SC/B will need to continue to provide SC/B personnel costs, transport, and access to external assistance. A budget is guaranteed through 12/95 for the communities of Quime (CS3 project area) as well as the communities of Inquisivi, Licoma and Circuata (CS5 project area) through funds committed by PROCOSI, a local Bolivia NGO. Funds donated by a private donor (the Agostino Foundation) will support vaccination and health education campaigns in the Arcopongo and Siguas/Luruta zones through 9/95.

B.3 What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after SC funding ends?

SC/B will receive $225,000 from PROCOSI for the time period January 1993 through December 1995 to finance child survival and maternal health activities in Quime, Inquisivi, Licoma, and Circuata zones. Since the National Secretariat of Health has shown increasing willingness to assume responsibilities in preventative health, project benefits should continue after the PROCOSI grant ends (12/95) with no additional PVO costs and with continued National Secretariat of Health participation. It is unlikely at this time that the National Secretariat of Health could continue the vaccination and health education activities in Arcopongo and siguas/Luruta given the logistical difficulties involved.

B.4 Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

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

B.5 What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?

The PROCOSI grant will finance activities in the project area from 1/1/93 to 12/31/95 with a $225,000 grant.

B.6 Identify costs which are not likely to be sustainable.

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

B.7 Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

Sustainability in the long term depends on a high level of community involvement and participation and responsibility. Projects which devote initial time for community organization and inclusion of indigenous community groups in the project including time for the community to understand their health problems and discuss their possible solutions have a greater chance on changing long-term health behaviors than projects which strive to reach high objectives in a tight timeframe. Initial costs and timeframe might be greater, in the long term they will lead to more sustainable work. While difficulties and delays may arise from coordinating activities with the National Secretariat of Health and other local institutions, it is absolutely essential that projects support and increase the capacity of these institutions so that activities can continue after the project ends. As a specific example, SC/B discontinued house-to-house vaccination visits in order to get community members accustomed to taking responsibility for taking their children to joint SC/B-NSH "integrated development fairs" or to National Secretariat of Health health posts for their vaccinations. Although this strategy meant a lower percentage of children vaccinated than would have been possible through house-to-house campaigns, it will more likely be more sustainable after SC/B withdraws from the project area.

C. Sustainability Plan

C.1 Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

Interviews: Lisa Howard-Grabman, Co-Director, SC/B
(Planning meeting)
Bob Grabman, Co-Director, SC/B (Planning meeting)
Fernando Gonzalez, Health Advisor, SC/B
(Planning meeting and field work)
Carlos Loayza, I.A. Manager, SC/B
Wilson Rivero, I.A. Administrator, SC/B
Field Staff (12 supervisors from Quime,
Inquisivi, Licoma and Circuata)

Since the mid-term evaluation, project implementation and monitoring/evaluation was conducted in quarterly planning and evaluation sessions. All staff worked as a team to evaluate their work, analyze data and develop plans for the next three months. Plans for community level activities were shared with

the promoters during community visits. Monitoring information on progress in child survival interventions is shared with the communities on a regular basis.

C.2 Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.

The strategy of sustainability of the project, as laid out in the DIP, includes the following activities:

a) The project's staff has the skills needed to carry out participatory research and diagnosis.

b) The project 's work relies on VHWs and traditional midwives training, involving the community as a whole.

c) The project returns the information obtained to the community for them to use it and make decisions.

d) The project has worked closely with the Regional Health Secretariat and has, therefore, done a good work of institutional strengthening in the District.

e) SC/B has implemented small projects oriented to income generation in the community and is currently executing credit projects in 35 communities.

f) The auto-sustainability plan is based on a two-tiered focus; on one hand, it strengthens the action of the Regional Secretariat of Health and, on the other hand, intends to strengthen the community demand through VHWs and traditional midwives.

C.3 Describe what sustainability-promotion activities were actually carried out by the PVO over the lifetime of the project.

Perhaps the most important aspect related to sustainability executed by the project, has to do with the effort of institutionalization. This implies the strengthening of the different areas' Health Posts within the project zone, which report to the Regional Secretariat of Health (Tres Cruces District).

In addition, SC/B's activities oriented to empower the communities through credit and an integrated vision of the problem and its solution are also oriented to the sustainability of health interventions.

C.4 Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

It is necessary to state that, although actions for rescuing traditional techniques were not included in the DIP, the project implemented such activities encouraging work with traditional midwives.

It is worth noting that the proposal for sustainability based on the VHW's role has demonstrated in general terms not to be the most appropriate due to the weakness of this local resource for executing health actions in their communities. Consequently, there is dissatisfaction both among local leaders and among the community members as to their work. Similarly, also the project and the institution have perceived this deficiency.

On the other hand, it is necessary to state that, although actions for rescuing traditional technics were not included in the DIP, the project implemented such activities encouraging work with traditional midwives.

C.5 Did any counterpart institutions (MOH, development agencies, local NGOs, etc) during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

The National Secretariat of Health provides vaccines, Road to Health Cards and ORS packets throughout the life of the project as originally promised. No other financial commitment were made.

C.6 What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

Success can be attributed to the increased coordination with the National Secretariat of Health since the mid-term evaluation and the fact that the National Secretariat of Health receives vaccines free from UNICEF.

D. Monitoring and Evaluation of Sustainability

D.1 List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes

The project tracks EPI coverage rates and weight trends of children by community and also the number of community members who have been trained by the project. The project also tracks vital events, i.e., births and deaths by community.

D.2 Do these indicators show any accomplishments in sustainability?

See pages 35-39 of this report.

D.3 What qualitative data does the PVO have indicating a change in the potential sustainability of project benefits?

See pages 35-39 of this report.

D.4 Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the mid-term evaluation and this final evaluation.

)SI, SC/Nicaragua
During the mid-term
cretariat of Health,

D.5 Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and the DIP? Did the PVO carry out those recommendations? If not, why not?

No feedback received.

D.6 Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

The mid-term evaluation recommended that SC/B improve its relationship with the National Secretariat of Health in the "Tres Cruces Health District, consider providing incentives for the promoters, and involve local community organizations in health activities. SC/B has increased the coordination and sharing of information with the National Secretariat of Health, for example through data sharing at the monthly information analysis (CAI) meetings. SC/B works with the men's agrarian union and is working to strengthen women's groups, the women's agrarian unions, and the midwives; union in order that these groups will play a greater role in the health of the communities. SC/B feels that incentives for promoters were not sustainable, and would therefore be counter-productive in the context of the project area. As mentioned previously, the shift to working in integrated development fairs was done with the goal of increasing possibilities for sustainability.

E. Community Participation

E.1 Please identify community leaders interviewed and indicate which group(s) they represent

Those interviewed were: Agrarian Unions' Leaders from Corachapi, Caichani, Canqui Chico, Acutani, Jasa, Locotani, Wilacota, Yamora, Tiacanqui, Titipacha, Micayani, Chorocona, Ventilla, Ispalluta, Challwiri and Taucarasi, in the Inquisivi zone;

- Leader of the Licoma Agrarian Central (6th Section) and agrarian union's leaders form Alfagiani, Lacayotini, Cheka, Sojetaca, Sikimirani y Pencaloma, in the Licoma zone;

- Union's leaders from Cañamina (Sub-Central), Circuata, Playa Verde, Villa Barrientos, Villa Khora and Polea, in the Circuata zone.

E.2 Which child survival activities do community leaders perceive as being effective at meeting current health needs?

84

The authorities stated that in general all the actions of the project were very important for their communities. However, they feel the activities of food promotion (vegetable gardens production) was one of the most noticeable.

E.3 What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

Promoters were trained on basic health messages and information collection, supervised as they made household visits and were accompanied by National Secretariat of Health and SC/B supervisors during immunization campaigns. Increasingly the emphasis has shifted to training groups of community members (unions, women's groups, etc.) to increase chances of sustainability and assure greater participation. Through the AID-funded MotherCare contract, under which SC was a subcontractor to John Snow Inc., women's groups in 50 communities learned to identify and prioritize community health problems, especially those related to maternal and reproductive health, and to seek locally appropriate solutions to these problems. This methodology is now being expanded to the entire impact area.

E.4 How did communities participate in the design, implementation and/or evaluation of child survival activities?

The project has facilitated the organization of women's groups who participated actively in the diagnosis of their own health needs, many of them also participated in the development of educational materials and, during the mid-term and final evaluations, they participated providing information, critic and suggestions for future interventions. On the other hand, the community participated in evaluations through its formal authorities who provided additional information.

E.5 What is the number of functioning health committees in the project area? How often has each met during the past six months? Comment on whether committee members seem representative of their communities.

The project did not form health committees but worked with local groups such as the agrarian union and women's groups. Each community has its own plan for community meetings ranging from monthly meetings to none.

E.6 What are the most significant issues currently being addressed by these health committees?

Community health issues addressed by women's groups and general community include: family planning, access to services (financial, transport), nutrition, water, safe birth, EPI, etc.

E.7 What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

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

E.8 What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

The communities have few resources to contribute except for their time and energy.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F.1 Identify persons interviewed and indicate their organization and relationship to the child survival project.

People interviewed were: health staff of the Regional Secretariat of Health; health personal from the Tres Cruces District residing in Inquisivi, Licoma and Circuata.

F.2 What links exist between the child survival project and the activities of key health development agencies (local/ municipal/district/provincial/state level)? Do these links involve any financial exchange?

There is no financial exchange but there is coordination of activities and exchange of information with the local health posts, the Tres Cruces Health District and the National Secretariat of Health-Regional Secretariat of Health in La Paz. The San Gabriel Foundation works under contract to SC/B to provide reproductive health services and training to National Secretariat of Health personnel. This activity is now in its final stage and is being phased over to the National Secretariat of Health. SC/B is currently negotiating with the National Secretariat of Health to carry out a model project in community based distribution of barrier method contraceptives. SC/B also supports some activities of both men's and women's agrarian unions.

F.3 What are the key local institutions the PVO expects to take part in sustaining project activities?

The key local institutions include the men's and women's agrarian unions, the midwives' union, women's groups, the National Secretariat of Health and the promoters. Bolivia has recently shifted to a decentralized system of government in which municipalities will take a much greater role in guiding health activities, but it is still too early to know how this will work out.

F.4 Which child survival project activities do MOH personnel another staff in key local institutions perceive as being effective?

The activities considered as important by the Regional Secretariat of Health are include: joint planning (Regional Secretariat of Health and the project) during integrated development fairs; joined activities such as planning and coordination both during the quality circles and during the CAIs. Likewise, they emphasized that they regularly receive accurate information from SC/B.

F.5 What did the PVO do to build skills of local MOH personnel of staff of key counterpart NGOs? Did they teach them to train VHWs or manage child survival activities once A.I.D. funding terminates?

The National Secretariat of Health has participated in some of the training events of SC/B and SC/B has participated in National Secretariat of Health training events too. Training of National Secretariat of Health personnel on reproductive health (including counselling and IUD insertion) will be held in April - June 1994.

F.6 What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

PROCOSI has provided financial support to continue child survival activities in the project's communities. It is also possible to get additional resources through the Social Investment Fund (FIS). The National Secretariat of Health is not in the situation to provide funds directly.

F.7 Are there any project activities that counterpart organizations perceive as effective?

See paragraph F.4.

G. Project Expenses

G.1 Attached is a pipeline analysis of project expenses

Please refer to Appendix 3 for a pipeline analysis.

G.2 Compare the budget for planned expenses identified in the DIP with actual expenses at the end of the project. Were some categories of expenses much higher or lower than originally planned?

No.

G.3 Does the project handle the finances in a competent manner?

Yes.

G.4 Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

No. Continued budget monitoring and careful planning are critical to proper budget management.

H. Attempts to Increase Efficiency

H.1 What strategies did the PVO implement to reduce costs, increase productivity or make the project more efficient?

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

H.2 What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

The impossibility to reduce costs is directly related to the lack of access to many of the project's communities; this necessarily increases costs of transport and communications. Several communities are very dispersed and, therefore, in order to provide a systematical and individual attention it is necessary to count on sizeable staff.

H.3 Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

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

Projects should develop long-term plans for both the development of the institutions in the community as well as for an increase in individual knowledge and practices.

I. Cost Recovery Attempts

I.1 What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

None.

I.2 Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

Not applicable.

I.3 What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

Not applicable.

I.4 What are the reasons for the success or failure of the household income generating activities of this project?

Not applicable.

I.5 Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

Preventive health projects should be linked to income generating or credit projects for families so that they have financial resources to contribute to the provision on their own health needs.

J. Household Income Generation

J.1 Did the project implement any household income-generating activities?

Not as part of the CS 5 project, but see J.4 below.

J.2 Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.

Not applicable.

J.3 Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

Not applicable.

J.4 Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

Income generating projects and/or credit was a felt need of the community, much more than preventive health. In response to this, SC/B has initiated a group guaranteed lending project, focused on the already formed women's groups.

K. Summary

K.1 Description of Project Accomplishments, Competence and Lessons Learned

Please refer to qualitative and quantitative reports included in this document.

K.2 Members of the Final Evaluation Team

KPC Survey:

Dr. Marcelo Castrillo	Johns Hopkins University
Oscar Borda	PROCOSI
Aracely Revuelta	Regional Secretariat of Health
Dr. Ruth Calderón	Regional Secretariat of Health
Karen LeBan	Save the Children/Westport
Rosemary Rivas	CARITAS
Dr. Fernando González	Health Advisor, Save the Children/Bolivia
Dr. Adolfo Martínez	Quime and Inquisivi Coordinator, Save the Children/Bolivia
Elsa Ramos	Licoma and Circuata Coordinator, Save the Children/Bolivia

Qualitative evaluation:

Erick Roth	Consultant, Team Leader
Dr. Delina de Mendoza	Regional Secretariat of Health
Dr. Luis Fernández	Director, Tres Cruces Health District
Dr. Fernando González	Health Advisor, Save the Children/Bolivia
Dr. Adolfo Martínez	Quime and Inquisivi Coordinator, Save the Chilldren/Bolivia
Elsa Ramos	Licoma and Circuata Coordinator, Save the Children/Bolivia
Joan Maria Jennings	Observer, Save the Children/Nicaragua

COOPERATIVE AGREEMENT OTR-0500-A-9149

CHILD SURVIVAL V BOLIVIA

26-Apr-94

BUDGET VS ACTUALS FOR YEAR 5 AND TOTAL EXPENSES TO DATE VS TOTAL GRANT *

Procurement	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES YEAR 3	EXPENSES YEAR 4	YEAR 5: EXPENSES VS. PLANNED BUDGET * EXPENSES 02/28/94	PLANNED BUDGET**	BALANCE	% SPENT	LIFE OF GRANT: CUM TOTAL VS. TOTAL GRANT * CUMULATIVE ACTUALS	TOTAL BUDGET***	BALANCE	% SPENT
Supplies***	3,428 00	5,877 98	2,739.05	5,236 93	1,144.41	1,777.04	632.63	64 4%	18,426.37	19,059.00	632.63	96.7%
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	2,000.18	2,000.18	0 0%	1,757.82	3,758.00	2,000.18	46.8%
Sub-Total:	3,428.00	6,635.80	3,739.05	5,236.93	1,144.41	3,777.22	2,632.81	30 3%	20,184.19	22,817.00	2,632.81	88.5%
Evaluation	0.00	911.30	1,742.84	0 00	1,129.08	1,999.86	870.78	56 5%	3,783.22	4,654.00	870.78	81.3%
Other Program Costs												
Personnel	67,843.54	86,061.48	82,829.05	77,932.16	35,998.11	43,474.77	7,476.66	82.8%	350,664.34	358,141.00	7,476.66	97.9%
Travel	4,535.66	3,684.44	417.86	3,119.38	1,657.79	1,442.66	(215.13)	114.9%	13,415.13	13,200.00	(215.13)	101.6%
Other	4,705.87	14,763.91	10,491.23	12,794.49	2,837.36	1,851.50	(985.86)	153.2%	45,592.86	44,607.00	(985.86)	102.2%
Sub-Total:	77,085.07	104,509.83	93,738.14	93,846.03	40,493.26	46,768.93	6,275.67	86.6%	409,672.33	415,948.00	6,275.67	98.5%
TOTAL	80,513.07	112,056.93	99,220.03	99,082.96	42,766.75	52,546.01	9,779.26	81.4%	433,639.74	443,419.00	9,779.26	97.8%

*Final Year 3 expenses; Year 4 expenses through: 02/28/94
** 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 PROJECT ENDS 3/31/94

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

PART III

FINAL EVALUATION
QUALITATIVE STUDY REPORT

SAVE THE CHILDREN
BOLIVIA

SAVE THE CHILDREN
BOLIVIA FIELD OFFICE
CHILD SURVIVAL 5
FINAL EVALUATION QUALITATIVE REPORT

Agency for International Development
Grant # AID-OTR-0500-A-00-9149-00
June 1994

Save the Children
54 Wilton Road
Westport, CT 06880

(203) 221-4000

2

SAVE THE CHILDREN/BOLIVIA

CHILD SURVIVAL 5 PROJECT
USAID Cooperative Agreement OTR-0500-A-00-9149

FINAL EVALUATION REPORT

(Translated from original Spanish documents)

Evaluation Team - Qualitative Study (includes Sustainability Questionairre):

Erick Roth	Consultant, Team leader
Dr. Delina de Mendoza	Regional Secretariat of Health
Dr. Luis Fernández	Director, Tres Cruces Health District
Dr. Fernando González	Health Advisor, Save the Children/Bolivia
Dr. Adolfo Martínez	Quime and Inquisivi Coordinator, Save the Children/Bolivia
Elsa Ramos	Licoma and Circuata Coordinator, Save the Children/Bolivia
Joan Maria Jennings	Observer, Save the Children/Nicaragua

Evaluation Team - Quantitative Study (KPC Survey):

Dr. Marcelo Castrillo	Johns Hopkins University, Team Leader
Karen LeBan	Health Unit, Save the Children/Westport
Dr. Fernando Gonzales	Health Advisor, Save the Children/Bolivia
Oscar Borda	Project Advisor, PROCOSI
Sister Aracely Revuelta	Supervisor, Regional Secretariat of Health
Dr. Ruth Calderón	Women, Child Health and Nutrition Division, Nat. Secretariat of Health
Rosmery de Rivas	CARITAS/Bolivia
Dr. Adolfo Martínez	Quime and Inquisivi Coordinator, Save the Children/Bolivia
Elsa Ramos	Licoma and Circuata Coordinator, Save the Children/Bolivia

LA PAZ, BOLIVIA
March, 1994

TABLE OF CONTENTS

Final Evaluation Qualitative Report

I. EXECUTIVE SUMMARY

The Child Survival 5 project was implemented by Save the Children/Bolivia (Desarrollo Juvenil Comunitario, DJC) from September 1989 to March 1994 and financed by USAID/W; a total of $499,849 was awarded. The project area serving 15,850 people in Inquisivi Province, Department of La Paz, includes three zones: Inquisivi, Licoma and Circuata.

The objectives of the project were to reduce child morbidity and mortality rates within the project area covering the following interventions: to increase the coverage of immunizations (EPI); to decrease the incidence of diarrheal diseases; to promote growth monitoring, nutrition and breast-feeding; to increase Vitamin A consumption; to reduce the incidence of acute respiratory infections; and to improve maternal health through prenatal visits, safe birth practices and supplementary Vitamin A, ferrous sulfate and iodine intake.

Project strategies included women's groups' organization and active community participation in all activities. Currently, integrated development fairs have become a new strategic option which offers an important perspective for community mobilization.

At the end of the project's activities two final evaluations were carried out; a quantitative evaluation and a qualitative one. The first evaluation was done utilizing a rapid assessment of Knowledge, Practice and Coverage following the methodology and using indicators developed by the Johns Hopkins University (please refer to Final Evaluation Report Part I for the complete survey report) The qualitative evaluation emphasized opinions, expectations and attitudes of the beneficiaries through focus groups and individual interviews with women's groups, community authorities and project staff (please refer to Final Evaluation Report Part II for the required sustainability questionnaire and pipeline analysis).

The main findings of the quantitative evaluation can be summarized as follows: the goals established for polio3 and TT2; management of diarrheal diseases (use of ORT, adequate feeding with breast milk and fluids); identification of ARI signs; knowledge and practice of growth monitoring; colostrum administration within the first hour postpartum; adequate weaning practices, consumption of iodized salt and food rich in Vitamin A; and deliveries attended by trained staff were reached and/or exceeded.

Results were low related to maternal identification of signs of dehydration and knowledge about when to receive treatment during a diarrheal episode (although practice was adequate) and ARI episodes; exclusive and prolonged breast-feeding; distribution of capsules of Vitamin A (although there was a high level of Vitamin A rich vegetable consumption); and prenatal control.

The qualitative evaluation emphasized the following important findings. In the field of institutional and human resources development SC/B achieved an organization that allowed efficient coordination of the various institutional activities. Adjustments were made to overcome those staff problems observed during the mid term evaluation.

Regarding the strategy, one can say that the implementation of integrated development fairs is a success; however, the possibility of diversifying this strategy in the future in order to avoid supersaturating the population must be considered. Likewise, methodological alternatives must be emphasized to make training more active and more responsive to the target population's characteristics (adult education).

Appraisals made by women's groups and community authorities regarding the project's programs coincide, in general, with the quantitative evaluation's findings. People are satisfied with achievements of EPI, diarrheal diseases management and, especially, with the production of food rich in Vitamin A (vegetable gardens). The results achieved regarding growth monitoring and iodized salt consumption were also confirmed and criteria about the interruption of breast-feeding before the age of two and obstacles to prenatal control were collected.

The community authorities emphasized problems related to health promoters or VHWs and suggested that an alternative strategy for community outreach should be found. It was made clear that VHWs are not sustainable resources since they are resisted within their own communities.

In relation to the health information system, we can say that the methodology used for returning the information to the community has proved to be extremely useful since it increased motivation within the communities. However, we could perceive that the VHW was not motivated to participate in data collection any longer.

On the other hand -- regarding management of information -- we could see that SC/B is duplicating activities carried out by the National Secretariat of Health. In the future, there should be better coordination to overcome this deficiency.

Regarding administrative fund management the budget assigned has been spent almost in its totality and it will be fully spent at the conclusion of the project. The flow of information between La Paz and Inquisivi has generally been regular and efficient as well as that between Inquisivi and the other zones.

The most important counterpart of the project has been the Regional Secretariat of Health through the Tres Cruces District. Several obstacles were found in the mid-term evaluation to smooth working relationships between SC/B and the project and the District Director due in part to personal factors. Currently, those relations have greatly improved and both SC/B and the Regional Secretariat of Health are very open and collaborative.

As to the project's sustainability we can say that the project (and therefore SC/B) played an important role influencing decisions at the policy level. Formal community authorities -- such as general secretaries of agrarian unions -- became part of the project. SC/B has also been working on a continuous basis in order to institutionalize the project's key components by strengthening the capacity of the Regional Secretariat of Health in its different areas. Another noticeable achievement of SC/B that affects the overall sustainability of the project is its integrated activities that responds to community needs. This is evidenced by the coordinated activities that exist between the Child Survival 5 Project and other projects that meet additional local needs such as education, economic opportunities and agricultural production.

Project efforts in health promotion and education based on cultural respect also contributed to the sustainability of health actions. The project used local resources in decision making, implementation of and support of all activities involving change, thereby increasing the possibility of successful adoption of new behaviors. Finally, SC/B is working to empower communities economically through other systematic actions. This is helping to improve the economic basis of the communities in order to support desired social change.

II. BACKGROUND AND PROJECT DESCRIPTION

A. Background

The Save the Children/Bolivia's (SC/B) Child Survival 5 Project in Inquisivi Province, financed by USAID/Washington, started in September 1989.

The Inquisivi Province is located in the South-East part of the Department of La Paz. The extension of the province is 5430 Km2 and includes regions of different altitudes and characteristics; the Altiplano (highlands) at an altitude of 3900 m. above sea level; valleys, at 2500 m. and the subtropical regions at 1000 m. Therefore, agricultural production is varied and includes potato and other tuberous crops in the highlands; wheat and maize in the intermediate areas; and citrus, coffee and coca leaves in the lowlands.

The Province is about 5 hours by car south-east of La Paz. The population are mostly Aymaras in the highlands and Quechua migrants in the low valleys; the total population is 22,055 distributed in dispersed rural villages.

Roads are deficient and means of transport scarce; one can reach many of those communities only after long walks. Most families are geographically, culturally and socially isolated.

A retrospective case-control study conducted by Save the Children/Bolivia in 1991 showed that the mortality rates were extremely high: over a study period of two years the perinatal mortality rate was estimated at 103/1000 births and maternal mortality was 140/10,000 births.

Health services in the province are provided by the Regional Secretariat of Health (S.R.S.) All three zones of the project (Inquisivi, Licoma and Circuata) are served by health posts; two of them are attended by a doctor who is completing his one-year obligatory service in a rural area. The other 3 posts are attended by auxiliary nurses. The equipment and supplies of the posts are very poor. The Quime referral hospital is attended by two doctors, a nurse, and a dentist; the hospital does not fill the requirements established by the WHO for a referral center and there is always new staff since changes are frequent.

SC/B implemented the CS 5 Project within this context. Its goals and objectives were the following:

B. Objectives of the Child Survival 5 Project

The purpose of this project was to reach a sustainable reduction of infant mortality and morbidity.

The specific objectives of the project to be achieved by the end of March 1994 were:

Expanded Program of Immunization (EPI)

* 70% of children between 12-23 months will have completed their immunization: BCG, DPT3, OPV3, measles

* 80% of children between 0-59 months will have completed their immunization: BCG, DPT3, OPV3, measles

* 70% of women between 15-49 years will have received at least two doses of Tetanus Toxoid

Acute Diarrheal Diseases

* 60% of families with children under 5 years will be able to demonstrate their knowledge about Oral Rehydration Therapy and the preparation and administration of ORS, child's feeding and follow-up as well as identification of three signs of dehydration (little or no urine, sunken eyes, no reaction to pinching) and they will also be able to take actions (reference and treatment)

Growth Monitoring

* 60% of children under 5 will have at least 3 weight controls/yea·

* 60% of mothers will be able to interpret the growthcurve through different colors of wool (green=adequate growth; yellow=slow growth; red=deficient growth) and will be able to act adequately in each case

* 68 communities will have all instruments needed to carry out growth monitoring

Breastfeeding/Nutrition

* 30% of registered puerperal women will administer colostrum to their children within the first hour postpartum

* 80% of registered puerperal women will continue breast-feeding their children until the age of two years

* 40% of mothers will start giving their children supplementary foods at the age of 4 months

* 80% of families within the impact area will be consuming iodized salt

Vitamin A

* 60% of children between 1-5 years will receive two megadoses of Vitamin A per year

* 60% of families will include in their daily diet vegetables rich in vitamin A

Maternal Health

* 75% of pregnancies will be registered in the women's roster

* 50% of registered women will receive at least 3 prenatal control visits

* 30% of deliveries will be attended by trained persons (midwife, husband, health staff)

* 100% of registered pregnant women will be given iodized oil preferably during the first three months of pregnancy

* 100% of registered pregnant women will receive ferrous sulfate starting during the second quarter of pregnancy

* 40% of puerperal women will receive a megadose of Vitamin A

Acute Respiratory Infections (ARI)

* 30% of mothers will know about preventive actions (immunization, prevention of malnutrition, prevention of polluted atmosphere)

* 30% of parents will identify ARI signs and will know where to go for treatment and follow-up

Tuberculosis

* 30% of families will know preventive actions, signs and symptoms of TB and will also know where to go for diagnosis and treatment

C. Strategies of the Project

The strategies of the project were always linked to the analysis of sustainability. The main strategy was to work with community organizations, especially with women's groups. Respect for and acknowledgment of agrarian unions and their authorities were the means that made it possible to carry out the activities of the project.

After the mid-term evaluation and based on the recommendations of its report, the work strategy was changed to that of "Integrated Development Fairs" instead of that of going house-to-house in order to get the desired coverage level and organizing groups for training sessions.The new strategy implemented from October 1991 under the name of "integrated development fairs" allowed the SC/B team to coordinate with local leaders the date for the realization of the fairs during which the team promotes health, trains and teaches about preventive actions (vaccines, Vitamin A, etc.) in that specific community, besides other activities related to other projects such as economic opportunities, sustainable agriculture and education. The fundamental difference between the previous strategy and the current one is that the staff of SC/B used to reach the community members and now - since the implementation of the new strategy - the community members will demand the services of a center established in their communities; in the long-term and once SC/B has completed its interventions within the project area, families will look for assistance in the health posts of the Regional Secretariat of Health. The main objective of this new strategy is to promote awareness about the community's self health care so that the demand for services within the area will increase.

III. METHODOLOGY OF THE EVALUATION

The project final evaluation included two phases; in February 1994 a quantitative evaluation was carried out which provided data about coverage, practices and knowledge. For detailed information on the methodology used and results obtained, please refer to Annex 4.

In March 1994 the qualitative evaluation was carried out and data collections was done through individual interviews, focus groups, direct observation, and detailed analysis of the health information system. Information was provided by the women's groups' representatives, midwives, authorities of agrarian unions, community representatives, and staff of the Regional Secretariat of Health and SC/B in each one of the project's zones (Inquisivi, Licoma and Circuata); approximately 80 people provided information.

Guides for interviews and focus groups developed included the following subjects:

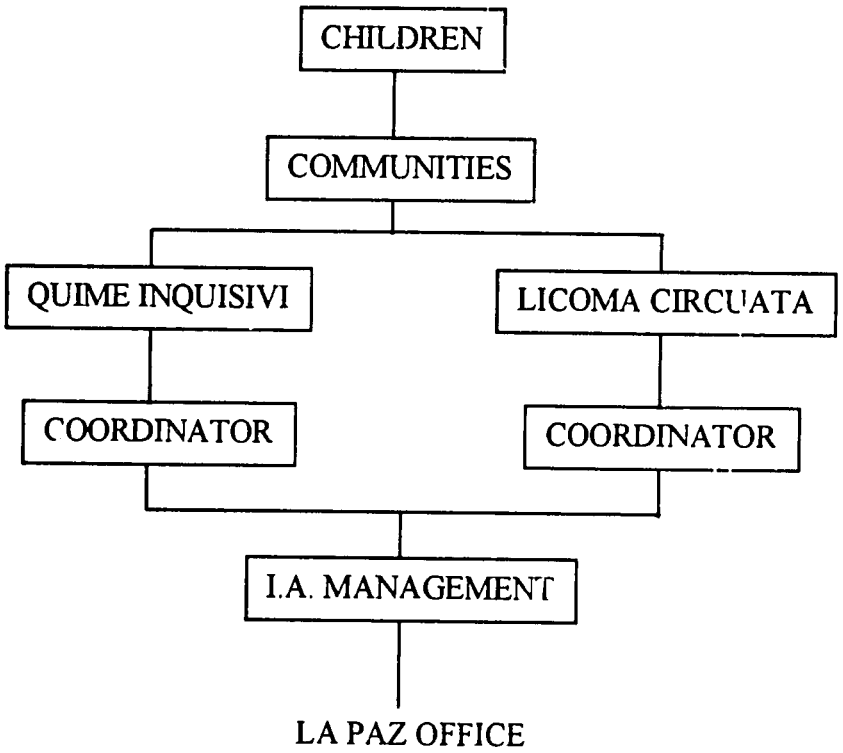
- Programs (Child Survival and Maternal Health)
- Strategies
- Information System
- Interinstutional and Intra-sectoral Coordination
- Sustainability
- Health Education and Training
- Human Resources

IV. FINDINGS OF THE QUALITATIVE EVALUATION

1. Structure of the Project

The project has been structured on two different teams in order to accomplish its purpose; one team works in the area of Quime-Inquisivi and the other one in the Licoma-Circuata area. Both teams are formed by one coordinator and six field supervisors.

The Child Survival team is continuously and systematically supported by the Impact Area Manager and the Impact Area Administrator, both of them based in Inquisivi. Likewise, the team receives inputs from the Health Information System which also works in the capital of the province. The general structure of the project can be graphically represented as follows:



It is important to note that this structure, which was developed to give functionality to the project's activities, is linked with another structure which functions directly - but not exclusively - in La Paz which in turn links the Health Advisor with the coordinators and through the Health Advisor the coordinators are linked with the Co-Directors of SC/B.

It is worth noting that this structure is the basis of the Quality Circles. These groups allow for discussion and decision making at different levels. Thus, a Quality Circle can include only the Inquisivi team and integrate within itself those individuals responsible for that zone's decision making; but it could also incorporate all the field teams. In other words, the outreach of the decisions and of the persons participating depends on the dimension of the quality circle.

The different actions executed by the project are generally supported by adjacent structures developed to carry out other institutional projects as well; many of them are implemented in the same communities of the impact area.

The presence of other projects in the institutional environment, tends to complement the existing structure of Child Survival 5 and to facilitate its functions. That is presently the case of literacy, credit, potable water and micro-irrigation programs, as well as the "Warmi" reproductive health project, which although now concluded, will be continued within the Child Survival/Maternal Health Project financed by PROCOSI.

> LESSON LEARNED: The project structure facilitates the coordination between the different projects of the institution and leads to the integration of actions. It also facilitates the impact on the quality of life.

2. Human Resources

The team coordinators have several years working in the institution, this has allowed them to know widely the sociocultural dynamics of the area. One of the members of the team had been coordinator of the project since the project started and another one is working in the project for two years now. This aspect has given the project certain stability and continuity. That is not the case of the supervisors' team working in the Licoma-Circuata zone which has suffered a recent series of changes both as to the staff and coordination; these aspects could have destabilized the rhythm of work. Certainly, this problem has not been unnoticed for the beneficiary population who have suggested the institution to adopt more stable policies related to the staff working in that zone. However, the Co-Directors of SC/B feel that personnel changes and adjustments provide more dynamism to the teams' activities and means new experiences for the staff.

The change of the field supervisors could affect the continuity of their actions in several ways. First, it interrupts a type of work which is a sort of characteristic of each technician; this discontinues the rhythm of progress of the beneficiaries who must be adjusting themselves to new styles and focuses. Secondly, the changes of personnel seem to have a negative impact on links and affective relationships created between the supervisors and the target population and it discourages them when they feel these relationships could be interrupted.

Finally, when there are changes of staff with or without a rationalization and these reasons are not known by the interested persons in advance, the situation can create labor uneasiness and a deep dissatisfaction among the team members. Once again, these kind of situations affect the project's progress.

It is necessary to note that during the mid-term evaluation it was recommended to apply precise regulations for personnel management in order to avoid conflicts originated by arbitrary decisions on this subject.

LESSON LEARNED: The stability of the team is generally translated into positive results for the target population. On the contrary, if the staff management does not correspond to the population's expectations it can lead to labor uneasiness and can gradually reduce the motivation needed to execute a work which demands a lot of dedication and personal sacrifice.

RECOMMENDATION: It is recommended to avoid in the future changes of personnel unless a change justifies its own social and human cost.

RECOMMENDATION: Since, on one hand we could identify a sort of dissatisfaction regarding personnel rotation (both from the point of view of the staff and that of the community itself), and, on the other hand SC/B acts under justifiable reasons when personnel changes occur systematically, it is recommended that the Co-Directors of the institution make clear those reasons on which changes are based and to propose a plan of personnel rotation and adjustments.

3. Team Integration and Coordination

A structure of the project should be created for facilitating work integration and coordination. These functions are currently being met in **Quality Circles**. Theses circles consist of meetings systematically carried out (regularly every month and every three months together with staff from La Paz with the purpose of evaluating and planning activities), in which the team participates as well as its coordinators and advisors from La Paz. The objective of these meetings is the joint planning, evaluation and follow-up carried out through the analysis of the goals achieved during a trimester. Regularly, the staff of the Regional Secretariat of Health from the Tres Cruces District also participate in these meetings.

According to the interviewed staff, this is the most important event of coordination and integration offered by the project and, although it fulfills the requirements of the project's life, it is not enough to satisfy other requirements of internal relations. For example, regarding the exchange of experiences and professionalism both teams have few opportunities to regularly share successes and failures of their daily work. Also, there is little communication with the Impact Area Manager regarding subjects related to the professional empowerment of the teams. However, the Co-Directors also informed that the Impact Area Manager had offered great openness to both teams for them to exchange as much information as they wanted. It seems that there are still some communication problems which must be solved.

Nevertheless, the Co-Directors' criterion is that the Quality Circles are the place and space where and when proposals and suggestions related to any aspect of the institutional work must be presented since it is during the Quality Circles' meetings when decisions will be made.

LESSON LEARNED: As we could appreciate, the quality circles could have met the project's planning needs according to the Detailed implementation Plan (DIP). However, the staff does not utilize this event as a space and place to facilitate other type of exchanges required by the personnel in order to coordinate their activities.

RECOMMENDATION: Since it seems there is a problem of communication that leads to avoidance of decision making during the Quality Circles meetings, it is advisable to look for an adequate mechanism to clarify the rights and obligations of the staff regarding their participation in those meetings.

RECOMMENDATION: It is recommended that the field personnel get to know the Manual of Politics and Procedures of the institution. This will facilitate the communication of general norms.

RECOMMENDATION: As to the Circuata team, the evaluation team could perceive feelings of project delays and abandonment by the project. It seems, therefore, that the project and the institution should attend their concerns and should pay attention to their requirements.

It is important to note that during the mid-term evaluation a lack of definition about obligations and responsibilities of the team members was found; the final evaluation has shown the problem has been solved.

4. Work Strategy of the Project

During the mid-term evaluation a change of strategy was recommended. At that time, the strategy consisted of promotion and education actions in the context of one-day visits to the communities. It was argued that one day was generally insufficient for achieving the education/training established goals.

Since then, the project adopted a new strategy which obliged the supervisor to visit each community during two or three days. The implementation of continuous educational activities during several days originated - according to information provided by the supervisors - a new problem. The community didn't have enough time for a **collective** attendance to the supervisor during his/her visit. Therefore, it was found that two or three days are too much time to stay in the same community. Nevertheless, during the mid-term evaluation it was never said that **all** the activities of the supervisor should be **collective**. Three days could allow a much more individual work of the project addressed to meet particular requirements of every family involved.

Subsequently, the project during this last year has adopted a new strategic mode: the integrated development fairs. These fairs constitute real community holidays in which all resident families are expected to participate. In that opportunity different health activities are planned, such as vaccinations, weight control sessions for children under five years, demonstrations, talks and group activities in which women participate. During the fair other projects of the institution participate too involving specific actions according to their interest. An integrated development fair is therefore, an answer to the different interests existing among the population.

This new strategy has been well received by the field supervisors who found in it something new to be added to their regular activities which are somewhat monotonous. On the other hand, this novelty has also given new energy to the community response which was diminished by the routine. Finally, this strategy has served to awaken men's interest since they are always reticent to participate in health actions.

Nevertheless, it is also necessary to say that there are some problems related to the implementation of the strategy mainly based on the integrated development fairs. First, the supervisors are agreed that many activities are planned and some of them are carried out at the same time. This has sometimes led the strategy conductors to make mistakes and to commit omissions.

Actually, this statement shows quite clearly that supervisors are facing some difficulties when planning and organizing fairs. One should not leave out the fact that the implementation of this strategy demands a great coordination effort to make staff availability, timetables and logistics coincide at the same time in the same community.

Secondly, the experience has demonstrated that the population, who at the beginning received the strategy with enthusiasm, has started to show signs of apathy and after some experiences the most participative groups are always the same ones: women who form the project's working groups.

The project has established that field supervisors must devoted approximately 75% their time to plan and implement integrated development fairs. One must assume then, that almost the whole intervention should be subordinated to this strategy which could create an excessive importance of the fair and, therefore, a possible saturation of this new activity.

One should not forget that the novelty of a community work awakens a transitory enthusiasm among the beneficiaries, but if the activity does not vary or change, the target population will get tired of it.

LESSON LEARNED: The integrated development fair constitutes an interesting perspective to encourage the service demand since they stimulate an active search of the benefit. It is contrary to those more passive procedures through which families are reached in order to offer them a service almost "forcing them" to accept it.

LESSON LEARNED: To organize an integrated development fair is complex enough to authorize more resources (time and energy) in planning and organization.

RECOMMENDATION: Perhaps the integrated development fair should be thought of in terms of another activity (and not necessarily as the most important) becoming a part of the whole work strategy. This will contribute to reduce the possibility of saturation and will diminish the difficulties emerging from high requirements of interinstitutional coordination and from the important demand of work for the supervisor.

LESSON LEARNED: In spite of the existence of information that evidences that integrated development fairs are mostly planned with the consent and agreement of the

community's leader, opinions have been collected from the unions' sector saying that these activities are sometimes carried out without consulting local leaders.

> RECOMMENDATION: Because of respect to local authorities and with the purpose of capitalizing the support of local leaders, in order to guarantee the consent of the population, it is recommended not to leave out the role of the union authorities when planning and executing integrated development fairs.

Certainly, the activities of the staff are not limited to the integrated development fairs, there are also meetings with groups of women who are interested, training activities are regularly carried out and so are home visits to follow-up children at risk. Among all these activities, those of training deserve a special consideration in a separate point.

5. Education and Training

One of the most important roles a Field Supervisor plays - if not the most important - is that of promotion, education and training of the beneficiary population. According to the DIP, almost all the components include in one or other way activities of transfer of knowledges and practices to the target groups including: VHWs, midwives, women's groups, and school teachers. Circumstantially, local leaders and community authorities are also included.

The importance of education lays on the fact that the project has considered it as the most important tool to improve the population's health conditions being favorable for increasing the demand of existing services (particularly activities of EPI and prenatal control.)

The project (at least originally) assumed that one of the pivots of training activities would be the community promoter or VHW. It was assumed that once this resource was trained it would intermediate educational activities in his/her community multiplying the effort of the project. During the mid-term evaluation some doubts had already arisen about the effectiveness and initiative of the promoters and these deficiencies were attributed to the lack of training. However, the problem seemed to be more complex now, since it is related to the credibility of the promoter, his/her capacity to convoke meetings, his/her voluntary work, and the little support received from his/her community leaders.

In fact, the present evaluation has shown a noticeable decrease of the promoter's work attributable to the gradual loss of interest in his/her work due to the scarce reply obtained from his/her own community. In part, the problem emerges because this resource does not meet the expectations of his/her people who, in general, ask for activities that are not important according to the vision of the program; and, in part, it is also due to the realization of a work which can be hard and has no benefit for him/her. We could also perceive among the different community sectors we interviewed, certain dissatisfaction with the promoters' performance; they are accused of acquiring knowledges only for their own benefit.

> LESSON LEARNED: We conclude saying that a health promoter is not - and will never be - a key piece for extending training coverages in his/her community. A health promoter

could only be a sort of link, a facilitator or an interlocutor between the project and the community during the project's life, but one must not expect much more from his/her role especially as for training.

RECOMMENDATION: Maybe it is worthy to continue questioning an alternative pattern for the project's outreach to the community, which does not consider health promoters as key pieces.

Women's groups have been a valuable resource for the project. Some of these groups used to be mothers' clubs or centers organized by CARITAS based on food donations but there are also many groups that have been organized by SC/B. Certainly, the number of participants decreased noticeably when food donations from CARITAS stopped and, although the number decreased, the quality improved since those women who currently are members of the groups are an elite the project can utilize to extend its range of action among women.

Training given to these women has proven to be very fertile and the level of motivation and interest the project has awaken in them can be considered as a very positive achievement.

The areas covered by training events were the following:

Child Survival:

* Acute Diarrheal Diseases
* Respiratory Infections and Pneumonia
* Needs of child and maternal vaccination
* Growth monitoring
* Nutrition, Vitamin A and iodized salt

Maternal Health:

* Importance of prenatal control
* The need of safe birth
* Ferrous sulfate, Vitamin A and iodized salt
* Women's vaccines

Regarding the procedures regularly used by field supervisors to conduct training activities, we must say the following. First, for most of them training is subordinated to the implementation of integrated development fairs. In other words, during the fair, additionally to vaccination, weight control sessions, sport activities, etc., educational activities are carried out as well. Nevertheless, due to the lack of time and to the limited availability of human resources for executing a fair, educational actions are often reduced to the minimum: not well structured talks, exhortations, suggestions and other procedures which are not always effective for achieving an efficient transfer of knowledge and generation of alternative practices. Very rarely demonstrations, working groups, structured workshops. and other methodologies of long technical-pedagogical reach, were mentioned as a regular exercise.

"Talks" have been an educational resource widely spread among the staff of institutions that provide community health services, but they have demonstrated not to be enough to affect the target population's behavior. However, they are still used since they demand nothing in terms of planning and execution and very little in terms of didactic support. The lack of effectiveness of this procedure has also been disguised due to the nature of training indicators which are generally summarized in the number of training actions or number of trained individuals and very rarely changes in routine practices or habits are highlighted.

> LESSON LEARNED: Educational activities based exclusively on procedures of exhortation, diffusion of knowledge, etc., not only have bored the beneficiaries, but they have also shown to be methodologically weak in order to reach the desired results.

> LESSON LEARNED: We must mention that SC/B introduced the "Community Action Cycle" methodology which consists of joint planning, action and planning and is currently being implemented in more than 50 communities where the Child Survival 5 Project was also implemented.

> > RECOMMENDATION: Therefore, it is recommended to reduce as much as possible training activities based exclusively on talks or exhortation and to use procedures such as the Community Action Cycle which, in spite of having a higher cost and being more complex, respond to adults' education requirements and allow more important changes in terms of the population's practices.

As for didactical support the project counts on some materials produced by SC/B for systematic utilization by field supervisors, such as flipcharts, booklets and manuals. Among them it is worthy to emphasize the Reproductive Health Manual for Midwives and its corresponding booklets which have been very well received by women participating in the project.

6. Perception, Opinion and Satisfaction of the Beneficiary Population

A relevant aspect of the qualitative evaluation had to do with the realization of a series of sessions of focus groups (FG) carried out with participation of women's groups and authorities of some of the communities participating in the project. The FG were conducted based on a previously prepared Agenda including a few subject suggested by the quantitative evaluation. The beneficiary population's observations, comments and suggestions include:

Women's Groups: The basic subject discussed by women's groups were the project's programs; Child Survival (diarrheal diseases, pneumonia, growth monitoring, nutrition and breast-feeding, Vitamin A, iodized salt consumption), and Maternal Health (prenatal control, safe birth, supplementary Vitamin A, ferrous sulfate and iodine). The subject of training was also discussed as well as its future expectations.

Acute Diarrheal Diseases: Women agreed that in general, there are no problems related to rehydration salts supply and these are always available thanks to the project's supervisor work. It is important to note that the active participation of the supervisor as an intermediate agent of ORS distribution could be an adverse factor to the sustainable supply. For this reason, some groups suggested to create community rehydration centers (UROS).

Women reported an increasing use of ORS in spite of traditional practices which are still largely practiced but now they are done based on rehydration therapy. It was reported that in some cases it is difficult to learn about signs of dehydration; nevertheless, there is a perception (verified during the quantitative evaluation) that the lack of identification of signs of dehydration does not affect the use of oral rehydration practices during an episode of diarrhea.

ARI and Pneumonia: In the case of the ARIs which do not involve Pneumonia, women reported that the practice of fluids administration and humidifying the environment are widely spread. However, the management of pneumonia is particularly complex since the only recommendation is to refer the patient. To accomplish this recommendation is, therefore, subordinated to real possibilities to refer the patient to the closest health center.

Growth monitoring: The interviewed women state that the Child Health Card, known as the road to health card, is a valuable instrument for monitoring their children's health. The road to health card is, doubtlessly, the most widely known instrument - although they also have the Women's Health Card, promoted by SC/B as well through another project - and so is the women's vaccines card which is used to monitor the number of tetanus toxoid doses received (the latter is promoted by the Regional Secretariat of Health).

For many women the road to health card is not as important as it should be and they may lose or spoil them because of negligence, but this behavior is a characteristic of those women who do not participate in the project. Likewise, we were informed that occasionally, some women do not show the road to health card when it is required by someone they do not know. It generally is because they are ashamed of evidencing the situation of disadvantage their children are in. It is worth to note that this problem arose during the quantitative evaluation.

Nutrition and Vitamin A: Regarding this point we must present two comments. First, the distribution of Vitamin A megadoses was restricted since these were given out exclusively through women participating (organized in groups). Additionally, we noted that in the past there were difficulties with the timely distribution by the government of capsules. Secondly, we could evidence that when women talk about Vitamin A they are referring to the activity of vegetable production and food preparation.

In fact, the project has particularly emphasized the promotion of family gardens as a means to improve nutrition and to induce the consumption of food rich in Vitamin A. In general, it seems logical to argue that the implementation of practices of food production will be more sustainable in terms of nutrition status, than the mere distribution of Vitamin A capsules. The latter generally depends on an adequate system of distribution to guarantee supply, while the promotion of family gardens seeks to lower the demand for capsules.

Regarding the concern about the policy of giving seeds for vegetable gardens twice only per family having a negative effect on the sustainability and in many cases (examples were given) this provision led to the habit of buying seeds in local shops as well as in La Paz. However, in other cases, when the donation stopped the practice of growing vegetables stopped.

Breast-feeding: Women agreed with the statement that breast-feeding is a common practice - fortunately an obliged one due to their economic conditions. They also said breast-feeding is interrupted in most cases before the child is two years and generally it coincides with a new pregnancy. They presented two types of justifications: this decision seems to be related to the belief that breast-feeding a baby when the mother is pregnant can provoke diarrhea. Another more rational argument is that breast-feeding is interrupted because the mother wants to protect her health since they know by evidence that both pregnancy and breast-feeding implicate maternal weakening.On the other hand, as women said, immediate breast-feeding is currently increasing and its acceptance contrasts noticeably to the practice only few years ago. The belief that children who are breast-fed immediately after the birth would become greedy is giving way to criteria definitely favorable for immediate breast-feeding. Something similar occurs with exclusive breast-feeding; there are more and more women who practice exclusive breast-feeding through the first four or five months.

Iodized salt: Since the regularization of the mechanisms to supply iodized salt to rural areas, its consumption seem to be consolidated. Women said there has been a great progress in this field during the last years.

Prenatal control: According to women's statements, this project - besides being promoted through training activities - facilitated the preparation of safe birth kits containing the most important items needed for attending a birth safely. At the beginning, the safe birth kits were a donation of the project for midwives so that they could organize a rotating fund to guarantee access to safe birth; this fund should function with incomes generated by the sale of kits to community women. However, midwives said they found difficulties for selling safe birth kits because women assumed these were given by the institution and, therefore, there was no reason to pay for it. As a result, the safe birth kit is tending to slowly disappear.

Husbands are still the most important resource for home delivery attendance and trained midwives have not yet demonstrated to be able to replace them - not because of lack of knowledge, but because of cultural resistance. This implicates that the quality of the process still depends on the quality of attention given by husbands. This resulted in training of 300 husbands through the Warmi project.

Ferrous sulfate, Iodine, and Vitamin A: As to Vitamin A and Iodine (iodized salt) opinions are similar to those above-mentioned. Ferrous sulfate has regularly been distributed to pregnant women and, occasionally, there is evidence of its consumption but it is also known that many women do not take it. It could be because they fear side-effects or because they are not used to take pills regularly.

> LESSON LEARNED: In the focus groups conducted with the beneficiaries we could perceive that the different programs of Child Survival and Maternal Health had been carried out extensively and profoundly. Nevertheless, it seems that training on subjects such as identification of signs of dehydration or respiratory infections do not show the

expected results. However, if the degree of information or knowledge that the beneficiaries have on these aspects does not greatly affect the practice of the treatment administered by the mother, then perhaps it is the concepts that are not sustainable.

RECOMMENDATION: Therefore, the convenience or inconvenience of transfer of certain concepts should be the object of a critical analysis in the light of the quantitative and qualitative results obtained.

LESSON LEARNED: The project's supervisors are doing a good work distributing and supplying ORS and other inputs, which is positively reflected in community availability.

RECOMMENDATION: However, since any supply made through non-permanent agents of the community can influence on those actions' permanence, it is recommended to prevent in the future the institutionalization of medical inputs supply.

RECOMMENDATION: It is also recommended that SC/B supports the constitution of Community Rehydration Centers in the most isolated villages.

LESSON LEARNED: It is evident that in all the project's communities there are individuals who resist the adoption of new practices. That is particularly true as for immunizations, management of the road to health card and prenatal control.

RECOMMENDATION: The institution should deepen its actions in the field of education and training addressed to those groups identified as resistants.

LESSON LEARNED: Regarding safe birth, we have seen that the midwife's role is still secondary compared to the husband's role. In most communities husbands are still the most frequently used birth attendants.

RECOMMENDATION: Although it is necessary to strengthen the image and skills of midwives, it seems recommendable to continue to incorporate husbands in actions of training on safe birth.

LESSON LEARNED: It was evident the existence of difficulties related to the distribution of Vitamin A megadoses but it was also evident that women were receptive as to the initiative of the implementation of vegetable gardens for production of food rich in Vitamin A. Results achieved in this field are noticeable.

RECOMMENDATION: The beneficiary population has recommended to re-initiate training actions on food preparation. Likewise, it seems recommendable that the institution carries out a careful evaluation of the

impact of seeds donations on the permanence of vegetable gardens implementation.

Authorities

The evaluation was extended to obtain opinions, observations and suggestions from community authorities. Subjects considered include relations with the project, the promoter's role and sponsorships.

Relations with the project: Since in rural communities at the beginning of year agrarian unions' authorities are always changed, those authorities interviewed by the evaluation team were all new. Nevertheless, they showed to be well informed about the project, its advantages for the community and its problems.

All of them agreed in requiring respect for formal mechanisms of community decision making represented by the General Secretary of the Agrarian Union. Their request should be understood in terms of consulting and informing local authorities about actions to be implemented by the project. Integrated development fairs they said should not be the exception. They recognized that SC/B works in that direction and appreciated that they convoked to a meeting with local authorities to explain to them the outreach and characteristics of the project.

They stated they are aware of their responsibility in health care and that is why they emphasized the importance of their assistance in the context of the project. Likewise, they highlighted the effort made by the institution to maintain an information system which is used by them to make political decisions about child health in their communities.

The Promoter's role: As to this subject, the authorities appeared to be skeptic. According to their experience, they considered that the promoter did not contribute as much as the community expected and that he did not share his knowledge. For this reason, they suggested to look for another alternative to replace promoters. Some of them stated that the role of an intermediary before the project, is a task that must be performed by the union authorities from their corresponding posts.

LESSON LEARNED: The receptivity of several authorities showed that when they are taken into account, they become a very valuable support to facilitate the project's actions.

RECOMMENDATION: The institution must keep and should even deepen the methodology of working directly with community authorities (particularly the General Secretary and the Secretary of the Sub-Central). Their role as organizers of integrated development fairs could be of great help.

RECOMMENDATION: It should also be considered to include the authority (Secretary of the Sub-Central) in the quality circles so that he takes part in the decisions made for his community. This, besides being

favorable for political decisions, will allow to strengthen the work of the authorities especially when faced with the new law of popular participation.

LESSON LEARNED: The discussion held with community authorities proved there is a crisis related to the role of the health promoter, evidenced by the incapacity of the promoter to act as an interlocutor between the community and the project/institution.

RECOMMENDATION: A new concept should be found as an alternative to promoters for future intermediacy of actions with the community. The new figure proposed by the law of popular participation can provide new ideas to make decisions towards this direction.

V. HEALTH INFORMATION SYSTEM

1. Purpose and Description of the Health Information System

As in other Child Survival Projects, Save the Children's Child Survival V Project includes a manual health information system to monitor project inputs, outputs and selected outcomes. The system is based on registration of the total population, use of personal records, and consolidation of information for decision making by project managers and all project participants.

The health information system uses the following instruments:

a) Family Registration Card
b) Child's Health Roster (children under-five: immunizations, growth monitoring, vitamin A administration, episodes and treatment of diarrhea or respiratory infections)
c) Road to Health Card (personal record for children under the age of five)
d) Women's Health Roster (women of childbearing age 15 to 49: tetanus toxoid, pregnancy detection and risk assessment, prenatal control, birth attendance, postnatal control)
e) Women's Health Card (personal record of reproductive health)
f) Cause of Death Report for Children Under the Age of Five

Family Registration:

Registration of the entire impact area population was accomplished early in the life of the project. Save the Children updates this information every six months. In and out migration have been extremely time-consuming to monitor, with almost all migration occurring in student age groups and little migration among women of childbearing age or children under the age of five. Vital events are continuously updated with project management estimating eighty percent capture of vital events within the project area.

Child's Health Roster and Road to Health Card:

Both instruments have been extremely useful to all project participants. The ability to consolidate information from the Child's Health Roster for project planning and evaluation is greatly appreciated by all team members. As this information is copied from one instrument to the other, problems do occur where one document is different from or more complete than the other. As the roster is used for planning and evaluation, Health Supervisors may give more attention to this instrument, while project surveys gather information from the Road to Health Card.

The Road to Health Card is the instrument chosen by the National Secretariat of Health to be the personal health record for children under the age of five. Thus, the same instrument serves both the project and the national health system. Other immunization cards for children are not presently in use in the project impact area, with immunization information recorded only on the Road to Health Card. Duplication of efforts by field staff occurs when reports are consolidated -- monthly for the National Secretariat of Health and quarterly for project planning. The National Secretariat of Health is in the process of reviewing all formats used within their health information system. It will be worthwhile for Save the Children to continue their present collaboration with the National Secretariat of Health in the development of instruments to supply the health information system.

Women's Health Roster and Women's Health Card:

The Women's Reproductive Health Roster has recently been revised to make this an efficient instrument for planning, monitoring and evaluation. The Women's Reproductive Health Card in use was designed jointly with women community members, with their interpretations and suggestions actively incorporated to produce an instrument validated by the users. It was produced through the WARMI Project which operated jointly in the Save the Children Child Survival V Project area from 1990 to 1993.

The National Secretariat of Health uses the Centro Latinoamericano de Perinatología (CLAP) Historia Clínica Perinatal for prenatal control and follow-up, and does also distribute small personal cards for women of childbearing age for the notation of tetanus toxoid immunizations, resulting in some duplication or discrepancy in records as this immunization is also recorded in the Women's Reproductive Health Roster and the Women's Reproductive Health Card.

The project is in the process of distributing the Women's Reproductive Health Card throughout the impact area. Reports from Health Supervisors and members of Women's Groups describe the instrument as valued and understood by users. Special mention is made of the reproductive health calendar segment which has aided women to take control of their fertility behavior. Save the Children/Bolivia is presently coordinating with the National Secretariat of Health for possible national replication of the Women's Reproductive Health Card. The card is being reviewed and tested in the different regions of Bolivia for validation and/or adaptation.

Vital events:

The health information system is continuously updated for new births by linking childbirth information form the Women's Health Roster to the computerized Family Register. The project created an instrument for reporting Cause of Death in Children Under the Age of Five.

2. Management of the Health Information System

The system was conceived to be managed by volunteer community health workers. Save the Children's Child Survival 5 Project was unable to obtain reliable and up-to-date information when the system was managed by community volunteers. Though training efforts decreased limitations of error, the greater difficulty was that the volunteers saw this activity as requiring compensation and were therefore not motivated to maintain the health information. Until the communities are willing to tangibly support their volunteer health workers, maintenance of a manual health information system at the community level will be problematic.

At present the manual health information system is maintained by project Health Supervisors. Those few community health volunteers who remain active continue to assist the Health Supervisors in updating information within their community. It is worth noting that these active community health volunteers expressed a desire to have copies of the health information and requested that when the project ends the rosters are given to the communities so that they can continue to monitor the health situation within their communities.

The health information gathered is housed in a computer and managed with a community population based program which can generate such files as rosters of immunization of children under five and impact statistics such as infant mortality within the project impact area. One of Save the Children's Working Principles is the importance of an integrated approach to community development. As other projects have been linked to the Child Survival Project communities, the limitations of the present computerized program to permit analysis of the relation between these additional projects (such as women's credit) and community health indicators have become apparent.

3. Use of Health Information

Child Survival projects typically use the information generated by health information systems to serve a variety of needs: a) the need for donors to be able to monitor projects and measure results; b) the need for coordinating bodies, such as the National Secretariat of Health to be able to monitor projects and consolidate information for regional and national planning needs; c) the need within the project itself to be able to monitor project results and plan effectively; and, d) the need for health information to be used for community empowerment to make decisions affecting their own health situation.

The manual and computerized health information system responds to present donor needs. However, it is worth noting that the quantitative evaluators did not use the HIS for the purposes of their evaluation, relying instead on a survey. This calls into the question the usefulness of the HIS as an evaluative tool for

donors. As noted previously, the inability to link inputs, outputs and outcomes from other projects integrated within the Child Survival V impact area to health outcomes is a serious limitation to the demonstration of the results of Save the Children's Working Principles to possible donors.

To respond to the needs of the National Secretariat of Health, SC/B personnel have had to duplicate reporting efforts in some areas. The high level of coordination between Save the Children/Bolivia and the National Secretariat of Health, coupled with the present review of the instruments used within the National Health Information System should help to eliminate duplication between the national and project health information systems, increasing the possibility of susceptibility of the health information system.

The Child Survival V Project has been greatly strengthened through follow-up of the mid-term evaluation recommendation that SC/B systematize the analysis of supervisors worksheets and reports and conduct regular meetings with Health Coordinators to review this information.

The project has focussed efforts on the use of the manual health information system for project planning and monitoring, and on the feedback to communities of this information. This is accomplished through Quarterly Planning and Evaluation Meetings, with quarterly consolidation of data on various indicators, such as the number of children under five completely immunized.

The entire integrated SC team of personnel (including literacy supervisors, nutrition supervisors) meet at the subdistrict level to evaluate the team's accomplishments during the previous quarter and to plan for the next quarter. In group interviews conducted with staff during the evaluation, the project Health Supervisors and Health Coordinators were very enthusiastic about the benefits of such use of the health information gathered by the project. They see the manual health information system as a valuable planning tool which enables them to concentrate their efforts to best achieve project goals.

The mid-term evaluation also recommended that the health information system be used to recognize staff achievements in an objective manner. This is done as part of the Quarterly Planning and Evaluation meetings. The evaluation process contains a section for discussion of difficulties encountered during the past quarter's activities and discussion by the team of suggestions to overcome these difficulties. The staff stated that this permitted their work to be evaluated justly and not in a black-and-white fashion based on numbers alone. Staff also mentioned to evaluators their appreciation on the interaction of all project management levels during these quarterly meetings.

Though the compilation of information for these Quarterly Planning and Evaluation meetings is time-consuming, staff recognize the difficulty of any further decrease in the information monitored without compromising planning and evaluation abilities.

Another important and useful recommendation from the mid-term evaluation was to use the health information system to increase coordination withy local authorities and promote community participation.

Following this recommendation, Save the Children developed and trained staff in a process to feed back health information to the communities within the project impact area. This process is called "Return of Information to the Community." A staff workshop was conducted with field personnel creatively designing non-formal participative methods to discuss with community members the health information

gathered. One of the most popular methods with staff and communities is the use of an imitation of the flag of Bolivia (turned sideways so as not to misuse the national flag in any way) with individual drawings of children and women pinned on it to represent consolidated health information. For example, if thirty children in that community are completely immunized while ten lack one immunization and another two lack two or more immunizations, thirty drawings of children would be pinned in the green section of the flag, representing good health, and ten and two drawings would be pinned in the yellow or red sections respectively, with yellow representing some danger to health and red as serious danger to the health of children.

Both staff and community beneficiaries expressed a very positive perception of the benefits of Save the Children's focus on the feedback of data from the health information system to the communities. Project staff report that this return of information to the community has empowered the communities to monitor their own health situation, with community authorities and mothers within the community taking an active role in encouraging the mothers of children lacking immunizations or growth monitoring to participate in these health activities. It is also generating demand for a community based health information system.

Data gathering and presentation can be a delicate matter in small and socially closed communities. At first, the health information was presented without using individual names due to concerns for the reaction of those families with children in the "red" danger zone. However, communities demanded to know the identity of those community members lacking health care in order to follow-up on this information. With careful explanation before the presentation of health information, the Health Supervisors feel any negative effects of the use of individual names have been avoided. And participation has increased as parents can be given a drawing to represent their own child's health history, to place in the category most appropriate. Staff also mentioned that his process has decreased or even eliminated community suspicion regarding project data gathering activities.

In group meetings with project beneficiaries during the evaluation, no negative opinions were expressed in regards to the health information system, but rather several women demonstrated awareness of their community's health situation by proudly mentioning that their community had obtained complete immunization of children and women or that their community only had two members lacking complete immunization.

Staff did express difficulties in finding methods appropriate to all community members, especially in the case of large communities where there is a greater range of abilities to interpret and analyze data within the community. The information may need to be presented more than once to different groups (community authorities in one group, with mothers of children at risk in another perhaps) to reach and motivate all community members.

LESSON LEARNED: The computer program presently used by Save the Children/Bolivia to manage its health information system does not meet all of the organization's needs. Save the Children's Working Principle of an integrated approach to development necessitates the ability to link other intervention outcomes to health impact.

RECOMMENDATION: Continue investigation of possible ways to meet organizational project development needs.

LESSON LEARNED: The methodology used for feeding back health information to the communities has had extremely positive results, generating greater community interest in and responsibility for their health situation and increasing the involvement of all community members, especially local leaders.

LESSON LEARNED: Volunteer community health workers are not readily motivated to maintain a reliable and up-to-date community health information system.

> RECOMMENDATION: Continue to stimulate the generation of a community demand for health information through the present methodology for feedback of health information to the community, while continuing to support volunteer community health workers involvement in the health information system. Respond to the request of those few active volunteer community health workers that health rosters be left in the community when the project ends.

LESSON LEARNED: Though time-consuming, consolidation of health information for use in Quarterly Planning and Evaluation meetings is a very beneficial planning and monitoring tool for Health Supervisors. It also contributes to development of staff skills in basic statistics.

> RECOMMENDATION: Continue Quarterly Planning and Evaluation meetings as presently conducted. Investigate possibilities for decreasing the Health Supervisors burden of information consolidation, such as rotating computer support for part of the consolidation of information or support from other members of the integrated field team.

> RECOMMENDATION: Continue with the process for feedback of health information to communities and support staff in the definition of the next steps to be taken once all communities have participated in this activity. As the new Government's process of "Popular Participation" is enacted, this feedback can assist the empowerment of communities, especially at the municipal level.

LESSON LEARNED: There is duplication of efforts by SC/B Health Supervisors to compile data on health as different instruments are used by SC/B and the National Secretariat of Health.

> RECOMMENDATION: Continue to coordinate with the National Secretariat of Health in the development of health information system instruments which meet the needs of both groups. The consideration for national replication of the SC/B Women's Fertility Card demonstrates SC/Bolivia's strength for assisting the present review process of instruments used in the national health information system.

VI. ADMINISTRATION AND BUDGET

A pipeline analysis is included as Annex 3. Field office project expenses followed the budget established in the DIP. The F.O. budget for this grant will be fully spent. Standardized monthly financial reports were used by the project. These were prepared by two part-time accountants and reviewed by the Co-Director, prior to submission to the home office.

Personnel expenses were made on the basis of percentage of time worked on the project. Summary time sheets were sent to the home office for review of percentage of actual time worked vs. percentage of time charged to the grant.

Requests for materials were made according to the standard office procedures, which can be found in the Field Office Policies and Procedures Manual. Requests were approved after a programmatic and administrative check of reasonableness by senior staff.

Overall field office charges totalled $443,419 to work with approximately 16,340 beneficiaries in the project area over four and one-half years for a cost/beneficiary ratio of $6.03 per person per year. The direct beneficiary ratio (including approximately 3,375 women of fertile age and 2,415 children under five years old for a total of 5,790 direct beneficiaries) was $17.02/person/year. These costs seem reasonable in light of the dispersed and isolated nature of the communities, and the fact that few other basic services exist.

VII. INTERINSTITUTIONAL COORDINATION

Coordination with the main counterpart of the project, The Regional Secretariat of Health (RSH), has improved substantially.

Currently, actions are being carried out together in the programmatic area as well as in the implementation of activities. Both institutions' staff meet monthly during the quality circles in each project zone. During these meetings they analyze the information produced during the last month and, jointly, they discuss problems and plan activities for the next month.

This change of attitude has produced more interest in coordinated work and is probably related to the designation of a new District Director who is openly supporting coordination activities. Changes of personnel in the District's areas (there are three recently designated Doctors) has also influenced this situation. In terms of sustainability it is worrisome since it shows that coordination depends on individual attitudes and not on an institutional policy of the National Secretariat of Health

Among the strengths the following can be mentioned:

Staff of the Regional Secretariat of Health participate in the integrated development fairs and they do joined and complementary work

- The activities of planning and analysis of difficulties are coordinated both during the quality circle meetings and during the Secretariat of Health's "Information Analysis Committees" (CAI) carried out in the area

- There is regular supply of insumes from the Regional Secretariat of Health to SC/B

- The Regional Secretariat of Health receives monthly information from SC/B

- Both institutions' activities complement each other; SC/B is working principally in preventive health and the Regional Secretariat of Health provides services although it also participates in activities of promotion and prevention.

Among weaknesses identified in regard to interinstitutional coordination, the following must be mentioned:

- Since staff from SC/B must provide information both to the project and to the Regional Secretariat of Health, there are too many forms to be filled every month

- Staff from the Regional Secretariat of Health have observed that some of the procedures and knowledge of the SC/B staff about health programs are not correct or are not up-to-date.

- The Regional Secretariat of Health is not returning information to the area; as a result the staff have no motivation because they receive no feedback on the information they produce.

As for intra-zonal coordination, it is evident that SC/B has great capacity to convoke at the level of the community and the agrarian union; formal authorities of larger towns within the impact area are also informed about the activities carried out by SC/B.

It is necessary to continue working hard in order to involve community authorities in sustainability.

LESSON LEARNED: It is evident that the quality of the staff of the Regional Secretariat of Health is a very important condition for coordination within the areas.

LESSON LEARNED: The coordination of health activities within the impact area have reached a satisfactory level compared to the level found at the beginning of the project.

RECOMMENDATION: Since the requirements of the Regional Secretariat of Health as to information are high, a mechanism should be created to facilitate the task of filling in forms.

RECOMMENDATION: SC/B should ask the Regional Secretariat of Health to carry out sessions for updating the staff about norms. This will facilitate even more to coordinate with the District.

VIII. SUSTAINABILITY

It is indispensable to incorporate in the planning phase of any health project the concept of **sustainability** of its actions. By sustainability we mean a process oriented to seek a permanence in time, stability and expansion of the different actions of a project.

It is well known that the most significant problems faced by short-term projects have to do with the gradual suspension of the implementation of activities, responsibility that was intended to be transferred to the target population. This frequently occurs some time after the project is physically discontinued and when financial support stops.

To solve this problem it would be useful to consider those variables indicated by experience which are related to the persistence of innovations implemented, including:

* Political support
* Institutionalization
* Quality of transfer
* Integration of actions
* Economic empowerment
* Rational use of resources
* Respect for the local culture

Political Support: As we understand it, it is the need for a project to be formally recognized by local and legally established authorities. Any action on the fringes of formal local political power could be resisted by the target population and its sustainability would be obstructed. Political support is closely linked to community participation as a strategy for the project's development.

In this sense, the Child Survival V Project has given an important step incorporating the different community authorities and encouraging them to actively consider the project's actions. It is interesting to note that early this year SC/B encouraged a meeting with local leaders during which they were informed about the characteristics and achievements of the project.

We have already recommended that some authorities should be invited to participate in the quality circles as a mean to include them in the dynamic of the institution's decision making. That would be an important progress.

Institutionalization: The project, during its execution, should seek to institutionalize its actions. This would implicate to establish close working links with community resources while empowering and enabling them for self-sufficiency. One must not forget that at the conclusion of the project these local resources will have to sustain actions introduced by the project.

This was a weakness of the project during the first phase, since SC/B could not establish positive or long-lasting links with the Tres Cruces District health staff. Nevertheless, since changes of staff occurred in the District, relations between the project and the District have experienced an important progress and currently they look like they will continue in that way.

Presently, the staff of the Regional Secretariat of Health and of SC/B share the quality circle meetings and the CAIs and they also participate in making programmatic health decisions which will affect the District. There are several aspects to be improved but, in general, the project is adequately transferring many of its practices to the Secretariat personnel in the area.

On the other hand, the CS V project worked and the institution will continue working with rural schools which represents a good perspective for the institutionalization of its activities.

Quality of transfer: Many of the actions promoted by the project demand from the target population knowledges and skills they do not always have. It is necessary, therefore, to support sustainable actions through a carefully planned process of transfer in which the quality of the methodology will play an important role. In this sense, we must keep in mind that there is a big difference between implementing slight knowledge or concepts and developing skills; they both demand different methodological proposals. Likewise, the target population's characteristics should in turn allow to differentiate training procedures.

This is still a weak aspect in the project. The general strategy of the project has varied during its implementation and, consequently, the types of transfer have also changed. This evaluation has found some difficulties related to the efficient management of the training methodological mechanisms and the institution must gradually improve them. For example, while at level of direction of the institution efforts are made to eliminate exhortative procedures as means of training, these persist in the supervisors' daily work. Naturally, this affects the quality of transfer and reduces the possibilities of acquiring long-lasting knowledges that can be assimilated for the patterns of behavior of the population. SC/B should do an additional effort to consolidate its methodology already used by the Warmi project.

Likewise, a deep analysis should be done of certain contents which do not seem to be sustainable, such as signs of dehydration and respiratory diseases.

Integration of actions: Since the problems of rural communities respond to an integrated vision of their reality, it is necessary that the project adopts a general conception of the proposed solutions. This implicates to emphasize intra- and interinstitutional coordination for global management of health and sanitation actions.

This has been found to be a strength of the project. The existence of several projects covering different fields such as education, credit for agricultural production, micro-irrigation, potable water systems, etc., allow the Child Survival V project to achieve a multisectoral status or, at least, to take advantage of the results obtained by the other projects. In this way, credit for women has motivated the implementation of

vegetable gardens, and so has the micro-irrigation project; this contributes to the sustainability of the nutritional initiatives of the health project.

Economic empowerment: Experience has shown that those communities which are likely to sustain innovations implemented by any project can also be considered economically stronger and diversified, with presence of more solid institutions and a higher level of social cohesion. This suggests that the actions of the project should consider the economic empowerment of the communities where they are implemented. One should not separate economic empowerment from health promotion.

The multisectoral focus that SC/B intends to give to its work with communities, has been favorable for the concept of economic empowerment; the existence of programs of economic opportunities (credit for women's groups or for potato seeds) indicate systematic actions oriented to strengthen the economic structure of the communities where the project was operating. This presents a perspective of sustainability.

Rational Use of Resources: In the search of efficiency of the project, it is necessary to recognize there is a need of optimizing the expenses/achieved goals ratio prioritizing only those activities addressed to reach the sustainability of the project.

According to the administrative information, the costs of the project indicate an efficient management of resources. In other words, the project spent only 17 dollars for each direct beneficiary per year in order to achieve the goals established on the DIP.

Respect for the local culture: The culture of the target groups of the project is expressed through patterns of behavior and types of health conservation and recuperation which respond to very deeply rooted beliefs and practices, attitudes, principles and rites. A project that pays no attention to these expressions or that overwhelms them will have no long-lasting support from the population it is addressed to.

The sustainability of an innovation is more likely to occur when this is compatible with the local culture. As long as the members of these cultures do not feel concepts and practices as theirs, the project will be resisted by the community.

By definition, change disturbs the integrity of a culture since it implicates a confrontation of attitudes, practices and principles between two cultures. It is therefore necessary to be aware that solely the presence of a project is a disturbing factor in the community's daily life.

The evaluation has collected sufficient evidence of respect for the local cultural patterns and norms. The management of local traditional resources, such as midwives, is a proof of it. Similarly, the project staff have expressed their interest in receiving training on the concept of traditional curative practices with the purpose of improving the communication with rural communities.

Sustainability of the HIS: Save the Children has done much to try to create a sustainable health information system through its Child Survival V project. Coordination for integration of the health information system with the government health body has been ongoing. The system has undergone a process of streamlining both the data gathered and the process for gathering and analyzing this data. The methodology of feedback of this health information to the community is beginning to generate a community demand for health information and for possible community based management of a health information system.

If the National Secretariat of Health is to have complete responsibility for the health care of the area when the project ends, there are questions as to the sustainability of the health information system as a whole. Due to coordination between SC/B and the National Secretariat of Health, parts of the system are already sustainable, such as the choice of instruments for personal health records for children and women of childbearing age. However, the National Secretariat of Health sees a population based health information system as unsustainable by them within the foreseeable future.

LESSON LEARNED: According to this analysis, the project (or more properly SC/B) has given important steps in terms of political decision, institutionalization, integration, cultural respect and economic empowerment.

RECOMMENDATION: However, to continue deepening the sustainability of its actions, SC/B should qualify even more consolidating educational experiences learned through other projects, the technical transfer to the communities and their most important figures.

ANNEX 1

Guide for Focus Groups' Conduction

GUIDE FOR FOCUS GROUPS' DISCUSSION

BENEFICIARIES (Mothers, midwives, VHWs)

1. Why some mothers do not have the Road to Health Card (they have lost it). If they believe it is useful and why is it useful (or why is it useless).

2. What other cards do women have. Which one is most useful and why.

3. What can they say about the Women's Card. Do you think women are using it? Why or why not?

4. It seems that families are not consuming enough food rich in Vitamin A. Why are they not consuming them? What could be done to solve this situation?

5. It seems that mothers can identify an undernourished child, but what does a woman do when her child is skinny? (Growth monitoring)

6. It seems that pregnant women are not having prenatal control as it should be done. Why don't they go to the health center or to see a midwife? What can be done to encourage women?

7. What is the best way to have every child completely immunized? What should health workers do? What should the authorities do? and What should mothers do?

8. It seems that many people don't attend anymore to the project's activities. Is it true? Why don't they attend? What should be done to make more people be interested in the activities?

9. We have seen that mothers stop breast-feeding their babies before they are two years old. Why do they do it so? What should be done to encourage women to breast-feed their children for a longer period?

10. The project has collaborated with family planning. What do you think about this? Is that good or is that bad? What should be done from now on?

11. How was the training events you attended? What was lacking? What other things should they teach to the community about health?

12. How were the classes? What did the supervisors do? How did they do it?

13. Did you have educational materials? What materials did you have? Were those materials good?

14. What educational messages should the community receive for understanding more about diarrhea, ARI and vaccination?

HEALTH PERSONNEL (Project and Regional Secretariat of Health)

1. Training requirements (EPI, management of cold chain).

2. Coordination between National Secretariat of Health and the project.

3. Coverage of the ROAD TO HEALTH CARD. Problems perceived. Suggested solutions.

4. Breast-feeding. Strategies to prolong it. Problems perceived, suggested solutions.

5. Perceived obstacles to institutional delivery and prenatal control. Suggested or foreseen solutions.

6. Acceptance of the reproductive and family planning program. Suggestions for the future.

7. To analyze low results obtained by the Vitamin A program. Causes of low distribution of capsules. Suggested solutions.

8. Characteristics of educational actions. Accomplishment of protocols, methodology used, etc. Training subjects. Subjects required.

9. Procedures of work in the community. Routine of work. Perception of problems and difficulties. Suggested solutions.

10. Requirements for updating the staff and training on subjects such as Diarrheal Diseases/ARI/EPI/Reproductive Health, Others.

AUTHORITIES

1. How do authorities find the execution of the health project?
2. What kind of relation have they established with SC/B?
3. What information and knowledge do they have about the project?
4. What should the authorities do to help to improve the communities' health?
5. Is there any community structure to work health together with the project?
6. Which are the most important health problems in the communities?
7. What would you recommend to SC/B?

ANNEX 2

Clarification by the Co-Directors of Save the Children/Bolivia on some points raised in the final evaluation

Clarifications by the Co-Directors of Save the Children/Bolivia on some points raised in the final evaluation of the Child Survival 5 grant

Due to the tight time line in the preparation of the reports, it was not possible for SC/B senior staff to review with the evaluators more than the initial draft before the evaluation reports were finalized. The final version was not completely clear in the few cases mentioned below.

Section IV. 2. Regarding rotation of staff, it should be noted that the evaluation took place just as a rotation took place. The reader may have been given the impression that there is general dissatisfaction among staff because of this rotation. Had the evaluation taken place two weeks later, once the field supervisors had started to settle down in their new communities, we believe this dissatisfaction would not have been found. The implication of constant rotation is not accurate - some of the staff who were recently rotated had been working in the same communities for three years. The recommendations regarding stability of personnel are appreciated; nonetheless, we will continue to rotate staff in the future to maintain a cross-fertilization of ideas, to avoid boredom and burn-out, to take advantage of particular staff skills (language for example), and to avoid a dependency on the part of the community on any one particular field supervisor.

The recommendation regarding the need for better communication regarding staff rotation is valid and accepted.

IV.3. Regarding "feelings of delay and abandonment" by the Circuata team, it should be noted that although Circuata received the full attention of the CS 5 project, this zone does not fall into the "core area" for interventions and so by definition will continue to receive less attention than the other three zones.

IV.4. Regarding integrated development fairs, all of the stated recommendations can take place within the existing fairs. A fair is nothing more than a team of SC/B staff being present for a series of activities in a community for 2-3 days. The fairs can and should be different each time. We see no need at this time to change the integrated fair methodology. The need to provide more variety within the fairs is noted.

IV.5. "For most of the (field supervisors) training is subordinated to the implementation of the integrated development fairs." See above comment. Integrated fairs should not replace training; rather training should take place within the development fairs. The need to strengthen training is accepted, because as in all aspects of SC/B's programs, there are always improvements which can be made.

IV.6. Regarding the "crisis" in the work of promoters and the recommendation to find a new concept as an alternative, it should be noted that SC/B has indicated this same point in various annual reports and is already seeking these alternatives. One example is working through the more than 80 women's groups now in operation.

Quantitative study:

It is important to emphasize what is noted in annex 4, that some of the results were evaluated using a different standard than that proposed in the DIP. For example, the DIP proposed that 40% of births would be attended by "trained individuals," defined as midwives, husbands, GOB health staff, and SC/B field staff. The evaluators chose to consider only midwives and GOB health staff as "trained individuals," thus understating the actual accomplishment. As noted in section IV.6 of the qualitative evaluation, husbands traditionally attend births. Though this longstanding cultural practice has begun to change, it is important to continue to train husbands. (The project achieved the stated goal even using the strict definition adopted by the evaluators.)

The discussion of the women's health card in Annex 4 may have caused some confusion. As noted, the production and use of SC/B's card was not even an objective of this project. The SC/B women's health card is for use by the individual women and is not in competition with the CLAP card, which is a clinical monitoring instrument. The fact that SC/B and the GOB are currently negotiating the distribution of the SC/B card nation-wide shows demonstrates that these cards are not in competition.