PD-ABP-879
95822

DETAILED IMPLEMENTATION PLAN

Child Survival XI

(Project #FAO-0500-A-00-5025-00)

Colonial Nueva Suyapa,
San Francisco and Flor del Campo
Tegucigalpa, Honduras
1995-1999

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United States Agency for International Development
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EPI - OK

CDD - Demphasis to more prevention from DCM.

Recommends BASICS Research on approaches.

Bonnie Stanton's Studies in homes in Dacca.

weighed is not a good indicator

Followup kids who dont come @ home

Combine CDD + ARI

Interview by health staff of Mothers leaving

* ① Vit A objectives

② Linkage c̄ SED

③ ? Identify abuse

④ Δ CDD focus to prevention

.1'

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Acronyms

ADRA	Adventist Development & Relief Agency
AHLACMA	Local NGO
AIDS	Acquired Immune Deficiency Syndrome
ALRI	Acute Lower Respiratory Infection
ASOMPLAFA	Local NGO
BEOC	Basic Emergency Obstetric Care
BP	Blood Pressure
CMD	Case Management of Diarrhea
CESAMO	Local Community Health Center
CHC	Community Health Committee
CHV	Community Health Volunteer
CMB	Community Medicine Bank
CEOC	Comprehensive Emergency Obstetric Care
CS	Child Survival
CSSP	Child Survival Support Program
DCM	Diarrheal Case Management
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus (triple vaccine)
EOP	End of Project
EPI	Expanded Program on Immunization
FANIA	Familia de Ninos Adelantados
FdC	Flor del Campo
FP	Family Planning
GM	Growth Monitoring
GOH	Government of Honduras
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IEC	Information, Education, Communication
IEF	International Eye Foundation
IUD	Intra Uterine Device
IV	Intra-Venus
JHU	Johns Hopkins University
KPC	Knowledge, Practice, and Coverage
Lp	Lempira
LBW	Low Birth Weight
MCH	Mother and Child Health
MCI	Ministerio Comunitario Integral
MD	Medical Doctor
MOH	Ministry of Health
MPH	Masters in Public Health (degree)
NG	Naso Gastric
NGO	Non Governmental Organization
NS	Nueva Suyapa
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PIE	Planning, Implementation, and Evaluation
PVO	Private Voluntary Organization
QA	Quality Assurance
RN	Registered Nurse
RR	Respiration Rate
RTH	Road to Health
SCM	Standard Case Management
SD	Standard Deviation
SED	Small Enterprise Development
SF	San Francisco
SM	Safe Motherhood
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UNISA	Local NGO
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
WCBA	Women of Child Bearing Age
WHO	World Health Organization

Section A - Field Project Summary

DIP Table A: Field Project Summary

PVO/Country: ADRA/Honduras
Cooperative Agreement No.: FAO-0500-A-00-5025-00
Project Duration (mm/dd/yy):
Start Date September 30, 1995
Estimated Completion Date September 29, 1999

1. Percent of Total USAID Contribution by Intervention

Percentages must add to 100%.

Intervention	Percent of Total Project Effort (%)	Percent of Total USAID Funds in US $
Immunization	5%	$32,233
Diarrhea Case Management	20%	$128,932
Nutrition	20%	$128,932
Micronutrients/Vitamin A	5%	$32,233
Pneumonia Case Management	20%	$128,932
Maternal Care	30%	$193,398
Family Planning		$0
Malaria Prevention & Management		$0
HIV/AIDS Prevention		$0
Other (specify)		$0
TOTAL	**100%**	**$644,660**

2. Size of the Potential Beneficiary Population

Note: Potential beneficiaries are the individuals eligible to receive services under Child Survival funding to whom you will provide services. Females (ages 15 - 49) should only be included as direct beneficiaries of services (i.e., TT immunizations or family planning services), and not for educational interventions (i.e., education on proper use of ORT).

Current Population within Each Age Group	Number of Potential Beneficiaries
Infants, 0 - 11 months	1,532
Children, 12 - 23 months	2,955
Children, 24 - 59 months	8,135
Children, 60 - 71 months (If vitamin A component)	1,802
Females, 15 - 49 years	8,655
Total Potential Beneficiaries Per Year	**23,079**

Important note: It is unlikely that there would be 2,955 children in the 12-23 months category and 8,135 children in the 24-59 months age group **if** only 1,532 children are born per year. ADRA double checked the accuracy of these figures and was given the same numbers with the explanation that recent population migration from the rural areas of Honduras in to the poor/slum suburbs of Tegucigalpa has dramatically increased the 12-59 months old population. Assuming that the rational given is true, ADRA will work with this population data.

Section B - Project Goals and Objectives

DIP Table B: Project Goals and Objectives

Project Goals:

1. To improve the health status of WCBA in the project area
2. To improve the health and nutrition status of children less than two years of age in the project area

(*) = The measurement method for the indicators/objectives listed in the table below is the rapid KPC survey.

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
EPI - 5.0%				
1.0) Increase the % of fully immunized children 12-23 months from 80.6% to 90.0% in SF/FdC and from 65.0% to 80.0% in NS.	1.0) % of children 12-23 months who received DPT1 1.1) % of children 12-23 months who received OPV3 1.2) % of children 12-23 months who received measles vaccine 1.3) % of children 12-23 months fully immunized 1.4) % of children 12-23 months who dropped out between DPT1 and DPT3	1.0) TOT training on EPI 1.1) Community selection of CHV 1.2) Initial and refresher training of CHVs on IEC/EPI 1.3) EPI promotion and key messages by CHVs 1.4) Follow-up of drop-outs/home visits 1.5) Yearly EPI mass campaigns 1.6) Radio/TV EPI ads 1.7) Training CESAMO staff on EPI promotion	1.0) 15 ADRA facilitators trained 1.1) 150 CHVs in NS and 31 CHVs in SF/FdC recruited 1.2) 360 existing and new CHVs trained in EPI/IEC 1.3) 8,655 WCBA receive key EPI messages/promotions and 7,000 households visited 1.4) Homes of drop,outs visited 1.5) 2 big and 3 small EPI mass campaigns held/year 1.6) 12 TV/radio ads on EPI run/year 1.7) 12 CESAMO vaccinators trained on EPI/IEC	1.0) Training report 1.1) CHC monthly report 1.2) Training report 1.3, 1.4) CHV monthly report 1.5) CESAMO EPI registry 1.6) Mass media records 1.7) Training report
2.0) Increase TT coverage of WCBA from 32.3% to 65.0% in NS and from 37.6% to 75.0% in SF/FdC.	2.0) % of WCBA who received at least 2 TT doses	2.0) TOT training on EPI 2.1) Community selection of CHVs 2.2) Initial and refresher training of CHVs on IEC/EPI 2.3) EPI promotion and key messages by CHVs 2.4 Follow-up of drop-outs/home visits 2.5) Yearly EPI mass campaigns 2.6) Radio/TV EPI ads 2.7) Training CESAMO staff on EPI promotion	2.0) 15 ADRA facilitators trained 2.1) 150 CHVs in NS and 31 CHVs in SF/FdC recruited 2.2) 360 existing and new CHVs trained in EPI/IEC 2.3) 8,655 WCBA receive key EPI messages/promotions and 7,000 households visited 2.4) Homes of drop-outs visited 2.5) 2 big and 3 small EPI mass campaigns held/year 2.6) 12 TV/radio ads on EPI run/year 2.7) 12 CESAMO vaccinators trained on EPI/IEC	2.0) TBA/midwife monthly report 2.1) CHC monthly report 2.2) Training report 2.3, 2.4) CHV monthly report 2.5) CESAMO EPI registry 2.6) Mass media records 2.7) Training report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
Nutrition and GM - 20% 1.0) Increase the % of children: 1.1) < 6 months exclusively breast feeding in NS and SF/FdC from 46.3% to 75.0% and from 53.6% to 80.0% respectively. 1.2) Between 6-10 months in NS and SF/FdC who are being given solid/semi-solid foods from 92.0% to 100.0% and from 88.9% to 96.0% respectively 1.3) between 20-24 months in NS and SF/FdC who are still breast feeding from 50.0% to 75.0% and from 32.5% to 65.0% respectively.	1.0) % of infants < 24 months who were breast-fed within the first 8 hours. 1hour 1.1) % of infants < 6 months who are given only breast milk 1.2) % of infants between 6-10 months who are given solid/semi solid foods + Breastmilk 1.3) % of infants between 20-24 months still breast feeding	1.0) TOT training on nutrition/GM 1.1) Training CESAMO staff on nutrition/GM 1.2) Community selection of CHVs 1.3) Training CHVs on nutrition and GM IEC	1.0) 15 ADRA facilitators trained on nutrition/GM 1.1) 12 CESAMO trained on nutrition/GM/IEC 1.2) 150 CHVs in NS and 31 CHVs in SF/FdC recruited 1.3) 360 existing and new CHVs trained in nutrition/GM/IEC 1.4) 8,655 WCBA receive key nut messages/promotions and 7,000 households visited 1.5) 360 CHVs self monitor with checklists	1.0) Training report 1.1) Training report 1.2) CHC monthly report 1.3) Training report 1.4) CHV monthly report 1.5) CHV monthly report
2.0) Increase the % of children < 2 years with GM card and weighed in the past 4 months in NS and SF/FdC from 67.1% to 85.0% and from 91.2% to 98.0% respectively.	2.0) % of children 0-23 months weighed in the past 4 months	2.0) Monthly weighing at CESAMO 2.1) Monthly weighing at the CHV's home 2.2) Replace weighing scales as needed	2.0) 3 CESAMOs conduct monthly GM and counseling 2.1) 360 CHVs conduct monthly GM at their homes 2.2) 100 new salter scales given to CHVs (old once replaced as necessary)	2.0) Monthly CESAMO report 2.1) Monthly CHV report 2.2) Inventory report
3.0) Improve the nutritional status of children < 2 years who attend GM sessions by at least 10% in NS and SF/FdC as recorded and monitored on the GM card.	3.0) % of children < 24 months whose nutrition status improved (monthly CESAMO GM reports)	3.0) Continued promotion of GM and follow-up of growth defaulters by CHV/home visits and referral	3.0) 8,655 WCBA receive key nutrition messages/promotions and 7,000 households visited 3.1) Growth faltering children referred for supplementary feeding and medical care	3.0) CHV monthly report 3.1) CHV monthly report 3.2) Monthly CESAMO report 3.3) Nursing care monthly report
4.0) Increase the % of mothers with < 2 year old children who ate more than a usual amount of food during their last pregnancy from 59.3% to 75.0% in NS and from 69.3% to 85.0% in SF/FdC.	4.0) % of mothers reporting eating more than usual during last pregnancy	4.0) Key messages check list for nutrition and GM activities	4.0) 8,655 WCBA receive key nutrition messages/promotions and 7,000 households visited 4.1) 360 CHVs self monitor with checklists	4.0, 4.1) CHV monthly report
5.0) Increase the % of mothers with < 2 year old children who know that a woman should gain at least 8-10 kilos during pregnancy from 15.0% to 50.0% in SF/FdC and from 4.0% to 40.0% in NS.	5.0) % of mothers who know that a woman should gain at least 8 - 10 kilos during pregnancy	5.0) Key messages check list for nutrition and GM activities	5.0) 8,655 WCBA receive key nutrition messages/promotions and 7,000 households visited	5.0) CHV monthly report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
Vitamin A - 5%				
1.0) Increase the % of children < 2 years in SF/FdC who received their first and second doses of vitamin A capsules from 57.0% and 17.0% to 75.0% and 45.0% respectively.	1.0) % of children < 2 years who received the first and second doses of vitamin A in SF/FdC	1.0) Training CHVs on vitamin A education and distribution 1.1) Obtain vitamin A capsules from the CESAMO/IEF	1.0) 360 CHVs trained on vitamin A promotion/education 1.1) 360 CHVs distribute vitamin A capsules 1.2) 360 CHVs self monitor with a checklist	1.0) Training report 1.1) Inventory report 1.2) Monthly CHV report
2.0) Increase the % of children < 2 years in NS who received their first and second doses of vitamin A capsules from 45.5% and 10.0% to 70.0% and 40.0% respectively.	2.0) % of children < 2 years who received the first and second doses of vitamin A in NS	2.0) Training CHVs on vitamin A education and distribution 2.1) Obtain vitamin A capsules from the CESAMO/IEF	2.0) 360 CHVs trained on vitamin A promotion/education 2.1) 360 CHVs distribute vitamin A capsules 2.2) 360 CHVs self monitor with a checklist	2.0) Training report 2.1) Inventory report 2.2) Monthly CHV report
Diarrhea Case Management - 20%				
1.0) Increase the % of mothers who continue to: 1.1) Give foods to their children < 2 years during diarrheal episodes from 45.5% to 70.0% in NS and from 56.6% to 75.0% in SF/FdC. 1.2) Treat their children < 2 years with ORT during diarrheal episodes from 47.4% to 70.0% in NS and from 57.6% to 80.0% in SF/FdC. 1.3) Breast feed their children < 2 years old during diarrheal episodes from 61.4% to 80.0% in NS and from 80.9% to 95.0% in SF/FdC. 1.4) Give fluids to their children < 2 years during diarrheal episodes from 79.1% to 95.0% in NS and from 86.2% to 98.0% in SF/FdC.	1.0) % of children < 2 years with diarrhea in the past two weeks who were given: -same/more amount of food -treated with ORT -same/more amount of breast milk -same/more amount of fluids	1.0) TOT and refresher training on DCM 1.1) Selection/recruitment of CHVs 1.2) Initial and refresher training of CHVs on DCM IEC: sanitary waste disposal, clean water supply, hand washing after toilet and before handling food 1.3) Education of mothers 1.4) Key messages check list for CHVs 1.5) Strengthen ORT posts at CHV homes 1.6) Organize community sanitation campaigns 1.7) Distribute ORS during home visits 1.8) Establish a referral protocol	1.0) 15 ADRA facilitators and 12 CESAMO staff trained in DCM 1.1) 150 new CHVs selected in NS and 31 new CHVs selected in SF/FdC 1.2) 360 CHVs trained in SCM and IEC skills 1.3) 7,000 households/monthly visits receive key messages 1.4) Key messages checklist used by 360 CHVs 1.5) 70% of the CHVs establish ORT corner at home 1.6) 3-4 community sanitation campaigns held/year 1.7) Total # of ORS distributed 1.8) 3 CESAMOs provide care for referred cases	1.0) Training report 1.1) CHC monthly report 1.2) Training report 1.3) CHV monthly report 1.4) CHV monthly report 1.5) Observation 1.6) CHC monthly report 1.7) CHV monthly report, inventory report 1.8) CESAMO monthly report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
2.0) Reduce the % of children < 2 years experiencing diarrhea in the past 2 weeks from 19.7% to 12.0% in SF/FdC and from 25.3% to 15.0% in NS.	2.0) % of children < 2 years who had a diarrheal episode in the past two weeks prior to the survey 2.1) % of mothers with children < 2 years who know two or more correct dehydration symptoms indicating the need to seek professional help	2.0) Education of mothers on sanitary waste disposal, use of clean water supply, hand washing after toilet and before handling food 2.1) Strengthen ORT posts at CHV homes 2.2) Distribute ORS during home visits	2.0) 7,000 households/monthly visits receive key messages 2.1) 70% of the CHVs establish ORT corner at home 2.2) Total # of ORS distributed	2.0) CHV monthly report 2.1) Observation 2.2) CHV monthly report, inventory report
Pneumonia Case Management - 20% 1.0) Increase the % of mothers who sought medical treatment from a health facility for infants < 2 years with cough and rapid, difficult breathing in the past two weeks from 58.0% to 80.0% in NS and from 71.1% to 88.0% in SF/FdC.	1.0) % of all ALRI visits to a health facility where SCM is appropriately applied by a trained provider who has antibiotic 1.1) % of mothers who sought medical treatment for infants < 24 months with cough and rapid, difficult breathing in the past two weeks 1.2) % of infants who died from ALRI related cause in the project area (MOH annual IMR report for Tegucigalpa/project area by cause of death)	1.0) Education of caretakers by CHVs and CESAMO staff 1.1) Supervision and monitoring of CHVs 1.2) Introduction of SCM quality assurance checklist at the CESAMOs	1.0) 360 CHVs trained in ALRI and IEC skills 1.1) 7,000 households visited monthly and receive key messages in ALRI 1.2) 3 CESAMO use SCM QA checklist	1.0) Training report 1.1) CHV monthly report 1.2) CESAMO QA report
2.0) Increase the % of mothers of children aged 0-23 months who know three alarm signs in cases of cough that would cause them to seek medical care (see section 4e.3c for percentage measurements).	2.0) % of mothers who know the warning signs of ALRI and when to refer	2.0) Education of caretakers by CHVs/CESAMO staff 2.1) Supervision and monitoring of CHVs 2.2) Key ALRI messages checklist for CHVs 2.3) CHV training and refresher courses on ALRI 2.4) TOT training on ALRI	2.0) 15 facilitators trained on ALRI 2.1) 150 new CHVs in NS and 31 new CHVs in SF/FdC recruited 2.2) 360 CHVs trained in ALRI and IEC skills 2.3) 7,000 households visited monthly and receive key messages in ALRI	2.0) Training report 2.1) CHC monthly report 2.2) Training report 2.3) CHV monthly report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
3.0) Increase the % of pneumonia cases receiving SCM at health facilities by at least 100% (measured by clinic records). Note: This objective will be revised later depending on the number of pneumonia cases currently seen at each CESAMO. (The adjusted objective will be reported in the first Annual Report to USAID.)	3.0) # of ALRI cases referred to the CESAMO by CHVs @ 3.1) # of ALRI cases referred to the hospital by the CESAMO, followed up by CHVs at home (counter referral) @ @ = CHV monthly report, clinic records	3.0) CESAMOs and CHVs with ALRI treatment chart on the wall 3.1) Provision of timers for CESAMOs and CHVs without watches to count respirations 3.2) Supplementation with antibiotics for CESAMOs 3.3) CESAMO staff training on ALRI	3.0) 12 CESAMO staff trained on ALRI/SCM 3.1) 3 CESAMOs provide SCM for referred cases 3.2) Monthly meetings held between the CHVs and CESAMO/ADRA 3.3) SCM providers use checklist for quality assurance 3.4) SCM providers use ALRI treatment charts/local terms 3.5) Antibiotics used by the CESAMO care providers only in cases of pneumonia, strep throat, and otitis 3.6) Adequate number of timers given to SCM providers and CHVs	3.0) Training report 3.1) CESAMO clinic records 3.2) CESAMO and ADRA monthly meeting minutes 3.3) Quarterly QA checklist summary report, interviews 3.4) Observation 3.5) CESAMO clinic records, drug inventory records 3.6) Equipment inventory
Maternal and Newborn Care/FP - 30% Note: See under nutrition and EPI sections for other maternal related interventions/objectives. 1.0) Increase the % of mothers with a maternal card for the birth of the youngest child < 2 years from 39.0% to 80.0% in SF/FdC and from 36.0% to 75.0% in NS (i.e., TT coverage).	1.0) % of mothers with a maternal card	1.0) TOT refresher training on MCH/FP 1.1) Initial/refresher training for CHVs on IEC MCH/FP 1.2) Education of mothers on key MCH/FP messages 1.3) Key messages checklist for CHVs	1.0) 15 facilitators trained on MCH/FP 1.1) 12 CESAMO midwife and nurses trained on MCH/FP 1.2) 150 new CHVs selected in NS and 31 new CHVs selected in SF/FdC 1.3) 360 CHVs trained in MCH/FP IEC and use checklist for education 1.4) 8,655 WCBA receive key MCH messages	1.0) Training report 1.1) Training report 1.2) CHC monthly report 1.3) CHV monthly report, training report 1.4) CHV monthly report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
2.0) Increase the % of mothers of children < 2 years of age who wish to delay their next pregnancy by two years who use a modern birth control method from 50.0% to 75.0% in SF/FdC and from 53.0% to 75.0% in NS.	2.0) % of mothers who desire no more children in the next two years, or are not sure and are using modern contraceptive method	2.0) FP devices obtained 2.1) TOT refresher training on MCH/FP 2.2) Initial/refresher training for CHVs on IEC MCH/FP 2.3) Education of mothers on key MCH/FP messages 2.4) Key messages checklist for CHVs	2.0) # of FP devices distributed, dependable supply 2.1) 15 facilitators trained on MCH/FP 2.2) 12 CESAMO midwife and nurses trained on MCH/FP 2.3) 150 new CHVs selected in NS and 31 new CHVs selected in SF/FdC 2.4) 360 CHVs trained in MCH/FP IEC and use checklist for education 2.5) 8,655 WCBA receive key MCH messages	2.0) FP devices inventory 2.1) Training report 2.2) Training report 2.3) CHC monthly report 2.4) CHV monthly report, training report 2.5) CHV monthly report
3.0) Increase the % of pregnant women with children < 2 years old screened and treated for STDs in NS from 20.7% to 50% and from 33.9% to 75% respectively.	3.0) % of pregnant women attending prenatal care who are diagnosed and treated for STDs	3.0) Initial/refresher training for CHVs on IEC MCH/FP 3.1) Education of mothers on MCH/FP 3.2) Training TBAs on STD referral protocols	3.0) 30 TBAs trained on STD referral protocols 3.1) # of pregnant women referred to a health facility	3.0) Training record 3.1) TBA training curriculum 3.2) TBA monthly report
4.0) Increase the % of pregnant women with children < 2 years old screened and treated for STDs in SF/FdC from 21.7% to 50% and from 52.3% to 85.0% respectively.	4.0) % of pregnant women attending prenatal care who are diagnosed and treated for STDs	4.0) Initial/refresher training for CHVs on IEC MCH/FP 4.1) Education of mothers on MCH/FP 4.2) Training TBAs on STD referral protocols	4.0) 30 TBAs trained on STD referral protocols 4.1) # of pregnant women referred to a health facility	4.0) Training record 4.1) TBA monthly report
5.0) Increase the % of mothers with children < 2 years old who had at least one prenatal visit prior to the birth of the last child from 28.3% to 60.0% in NS and from 32.6% to 75.0% in SF/FdC.	5.0) % of mothers who had at least one prenatal visit prior to the birth of the last child 6.0) % of pregnant women delivering by a health professional	5.0) Training TBAs and midwives on antenatal care, recognition of danger signs, and referral protocols	5.0) 30 TBAs trained on prenatal referral protocols 5.1) # of pregnant women referred to a health facility for prenatal care	5.0) Training record, TBA training curriculum 5.1) TBA monthly report, prenatal clinic records

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
6.0) Maintain current high level of women delivering by health professionals such as physicians, RNs, and trained midwives (91% in SF/FdC and 86.7% in NS).	6.0) % of women whose babies were delivered by health professionals	6.0) Refresher training of CESAMO midwives in BEOC, referral. and CEOC 6.1) Service quality monitoring 6.2) Referral protocol for mothers	6.0) 3 CESAMOs give BEOC and CEOC 6.1) Quarterly facility QA survey conducted by CESAMO director 6.2) 80% of pregnant women have emergency transport plan in place (taxi, other community transport means)	6.0) CESAMO clinic records 6.1) Facility services inventory report 6.2) TBA/CHV monthly report

Important Note: Listed below are the manuals ADRA/Honduras, in cooperation with the MOH, developed on each of the six Child Survival interventions planned. (The complete manual can be available for referral on request). These manuals, to be used by CHVs during home visits, contain key health messages with pictorial illustration. (See Appendix S for cover pages.)

1. Manual Para Personal Voluntario: *Lactancia Materna.* Proyecto De Supervivencia Infantil/CS-VII, ADRA/Honduras, MSPH, 1994.
2. Manual Para Personal Voluntario: *Proyecto De Supervivencia Infantil/CS-VII.* ADRA/Honduras, MSPH, 1994.
3. Manual Para Personal Voluntario: *Salud Reproductiva Y Planificacion Familiar.* Proyecto De Supervivencia Infantil/CS-VII, ADRA/Honduras, MSPH, 1994.
4. Manual Para Personal Voluntario: *Inmunizaciones.* Proyecto De Supervivencia Infantil/CS-VII, ADRA/Honduras, MSPH, 1994.
5. Manual Para Personal Voluntario: *Manejo De Diarreas Y Uroc.* Proyecto De Supervivencia Infantil/CS-VII, ADRA/Honduras, MSPH, 1994.
6. Manual Para Personal Voluntario: *Proyecto De Supervivencia Infantil/CS-VII.* ADRA/Honduras, MSPH, 1994.

Section C - Project Location

C.1 Location Maps (See Appendix A for maps indicating project location.)

C.2 Location Description There are three project impact areas, San Francisco (SF), Flor del Campo (FdC) and Nueva Suyapa (NS), located in the marginal urban communities of Tegucigalpa Metropolitan Region, Honduras. San Francisco is located southeast of the city. The project covers two (Solidad, 5,412 pop., and San Francisco, 2,294 pop.) of SF's 23 communities. Flor del Campo lies adjacent to San Francisco. The project operates in six (Flor del Campo, 13,682 pop.; Henry Mariam, 826 pop.; Olmos, 418 pop.; Rodus Alverado, 1,534 pop.; Los Torres, 5,946 pop.; La Rosa, 2,388 pop.) of the eleven communities in Flor del Campo. Nueva Suyapa, the third project impact area, is newly added. Nueva Suyapa is located in the western part of Tegucigalpa city. The project operates in nine (Villa Neuva Suyapa, 7,045 pop.; Universidad, 4,425 pop.; Guillermo Matute, 545 pop.; Fettcollil, 425 pop.; La Libertad, 1,135 pop.; Brisas de Suyapa, 1,080 pop.; 17 de Septiembre, 1,105 pop.; Flores de Oriente, 1,940 pop.; Alda de Soyapa, 1,348 pop.) of the ten communities composing Neuva Suyapa.

The populations in all three project impact areas represent the poor in Tegucigalpa city. The female literacy rate in the project area is good, with 83.3 percent in NS, and 88.8 percent in SF/FdC (project KPC survey, 1995), compared to 71 percent nationally (1). Unemployment rates range from 40 percent to 60 percent, with women being the most affected. Single motherhood is prevalent. The predominant religion is Catholicism. Ethnically, the population is mostly Mestizo (a mix of white, black, and indigenous Indians).

There is a lack of perception by the community of the seriousness of the existing health problems in the project area. Although the female illiteracy rate is low, most mothers are not educated beyond elementary level. Violence, especially against women, is prevalent. The status of women is low. Women are not involved in the decision making process. Men make the decisions, even though these decisions affect women. For example, men receive more food, eat first, and dominate every aspect of life in the family and community. Due to poor economic conditions, the migration rate of population from rural areas to these marginal project areas of Tegucigalpa is high. The unskilled nature of these migrants inflates unemployment and crime/violence rates. As a result, women and their children become vulnerable and husbands cannot support their families. The community health centers (CESAMOs) are accessible to the population in the project area, except in Nueva Suyapa, where poor terrain creates logistics problems. Lack of running water in the house and inadequate latrine facilities also lead to poor sanitation and diseases, which directly impact on CS activities. According to the State of the World's Children, UNICEF, 1996, IMR in Honduras is 41/1,000 live births. Nationally, respiratory infections and diarrhea cause nearly 50.0 percent of infant deaths (*La situacion de la salud en Honduras: Retos Para la Decada, UNICEF, 1990*). Twenty percent of infant deaths are related to perinatal complications. Accidents and violence cause 3.1 percent of infant deaths, followed by malnutrition problems at 2.1 percent as the major causes of mortality (*ibid, 1990). (*See Section 4g.1 for MMR and the leading causes of maternal mortality.)

Within the targeted impact areas, primary causes of infant and child mortality for FdC and SF are acute respiratory disease. The FdC CESAMO reports no mortality in under-fives as a result of diarrheal disease during the last year. In NS, the primary causes of mortality are acute respiratory infections, malnutriton, intestinal parasites, and dermatitis (2). Recent survey data from IEF has shown that although Honduras has a wide availability of fresh foods and mothers know foods that are high in vitamin A, mothers do not understand the relationship between vitamin A and night blindness. According to this study, 54.0 percent of children had results between 10-20 ug/dl, which falls within the PAHO standards for Public Health significance.

In FdC, approximately 35 percent of the children < five were reported to be malnourished (3). According to 1995 data, 35 percent of mortality among those < 1 in NS was ALRI related and 42 percent was delinquency/violence related (4). Nearly 20 percent of the mortality rate for WCBA in NS was maternity related (5).

In San Francisco, there is one CESAMO with 77 staff including five MD's, two RNs, 13 auxiliary nurses, one dentist, one auxiliary dentist, one lab technician, one social worker, three sanitation workers, four pest controllers, one health administrator and 45 CHVs. This CESAMO infrastructure includes a pharmacy and a laboratory providing basic urine, stool and hematology tests. Flor del Campo has one CESAMO facility staffed by six MDs, two RNs, nine auxiliary nurses, five pest controllers, one dentist, two sanitation workers and 134 CHVs. This infrastructure includes a lab unit, five consultation rooms, a pre-medical assessment area, an injection room, a pharmacy and dental care unit. Nueva Suyapa also has one CESAMO with three Mds, two RNs, ten auxiliary nurses, one dentist, one auxiliary dentist, one lab technician, one social worker, two sanitarians, four pest controllers, one health educator, one administrator, 15 CHVs and 11 TBA/midwives. This CESAMO

infrastructure incorporates a pharmacy, a laboratory, a dental clinic, three consultation rooms, a social worker room, a community-based drug store space, an archive unit, and a pest control room. Except for the CHVs and other TBAs who also work with this project on a volunteer basis, all health care workers are paid by the MOH. (See Section 4e.1b for other private health facilities in the project area.)

Section D - Project Design

D.1 Summary of Overall Project Design

This project is designed to primarily support existing services through the CESAMOs, rather than directly providing services. Vitamin A and contraceptives distribution are the exceptions, as the project will monitor CHVs, who will be distributors. The project focuses on mothers as the primary care giver for the family. Mothers are given training and support in maintaining health by the project's trained CHVs/TBAs. These volunteers will provide education and services on an individual basis during home visits and work through existing community organizations such as mothers' groups. The CHVs will be supervised by ADRA facilitators, who work closely with the CESAMO/MOH staff. Each ADRA facilitator will work with about 25 CHVs and each CHV will work with 20-30
households. This linkage with the CESAMO/MOH and the women of the community will promote project sustainability.

As the project is an extension of CS VIII, it will continue emphases in the interventions of Nutrition/GM, MCH/FP, CMD, ALRI, vit. A, and EPI. As a direct service, CHVs will weigh infants and children regularly, focusing on under two years at growth monitoring sessions and at mothers' clubs, with results plotted on growth charts that are kept by mothers. Infants, children less than 24 months, and children 24-60 months who are not gaining weight will be weighed every month in conjunction with counseling to mothers on appropriate nutritional/health care responses. The project will supply CHVs with scales. High risk or growth faltering children will be referred to the CESAMO for further attention. The GM event, coordinated by CHVs and facilitators provides a regular opportunity for food demonstrations and nutrition instruction, especially early breast feeding and exclusive breast feeding until six months of age, and appropriate introduction of an adequate, balanced diet thereafter. The special nutritional needs of pregnant and lactating women are also being emphasized during these educational sessions, which provide opportunity for promoting TT immunizations for pregnant mothers and EPI for under-ones.

The CESAMO staff will continue to receive refresher training in SCM of ALRI. In addition, ADRA will work with the CESAMO to establish quality assurance in ALRI case management targeting children under two years. Access to antibiotics is through the CESAMOs. Accordingly, the project will support existing public services through training CHVs in appropriate home care and recognition of signs of acute respiratory infections, with consequent referral to CESAMO when appropriate. CHVs will give messages to mothers during monthly home visits and through monthly mothers' club meetings.

The project will achieve its objectives for SM/FP by supporting the CESAMOs' provision of direct services and by developing and upgrading the skills of community TBAs. The project will support existing TBAs and midwives through initial training and skills upgrading in the provision of antenatal and postnatal care, safe birthing practices, recognition of high risk and danger signs, and immediate referral. Midwives at CESAMO level will have skills upgrading in dealing with obstetric emergencies. Training will be coordinated through and conform with the MOH protocols/curriculum. CHVs will be trained to detect and refer problems and begin education of mothers and weighing of babies during the postnatal home visit. CHVs will promote TT shots for WCBA, particularly pregnant women during home visits and at mothers' club meetings. Family planning will be promoted during home visits, postnatal visits, and at mothers' club meetings, through TBAs, midwives, and CHVs who will receive training in FP messages, including the need for birth spacing and the use of contraceptives. CHVs and TBAs will be supplied through the CESAMOs, with a small supply of condoms and other MOH approved FP commodities. The project will also include FP communication targeted to males through specially trained male CHVs and husbands of TBAs.

The project will provide direct services through initial training and several refresher training sessions for CHVs in CMD messages to be given to mothers. These messages will include increased breast feeding, other foods and fluids, and use of ORS/Litrosol during diarrheal episodes, as well as early referral in cases of severe dehydration of under two year olds. CHVs will also be trained to give sanitation and hygiene messages to mothers. Training for CHVs will be organized by the ADRA training coordinator and will involve the CESAMO staff.

The project will provide direct services through training of CHVs in key messages on the need for EPI. CHVs will promote immunizations primarily at the monthly GM sessions as they note EPI coverage and encourage immunizations for those who have not completed according to age. Children under one year old will be

targeted for EPI. CHVs will be expected to record and follow-up defaulters. Special attention will be given to NS where EPI rates are not as high. The project will focus on areas of particular need for EPI mass campaigns in conjunction with the CESAMOs.

The project will provide direct services in support of the CESAMOs with distribution of vitamin A mega-doses by CHVs at GM sessions. Children between age six months and five years old will be targeted. Supplies of vitamin A capsules will be provided by the CESAMOs/IEF. Appropriate educational messages will also be given by CHVs during home visits and weighing sessions.

Because it is an ongoing project, relationships have already been developed and sustainability strategies are being adopted with the targeted communities in FdC and SF. This is the rationale for choosing the above project design. Thus, the community involvement was greatly facilitated and was an important part of the project development process. The CS VIII project initiated a sustainability committee with representatives from the local Patronatos or local government committees and CESAMOs as well as community members in both FdC and SF. These sustainability committees will work with the health committees in instituting the sustainability recommendations (see Section 4b.2f). NS representatives will form their own committees during CS XI following lessons learned from CS VIII project.

D.2 Collaboration and Formal Agreements

The project involves collaboration among the community, the CESAMO, MOH, UNICEF, local and international NGOs, and the Patronatos. Currently, the CESAMO and the community jointly select CHVs. ADRA participates through promotion and facilitation of the processes. ADRA also trains these CHVs.

Criterion for selecting the CHVs includes the following: being between ages 18 to 50; acceptance by the community; public relations ability; availability of time to spend in the community; willingness and motivation to work with the community; residence in the community; and literacy. CHVs meet monthly at the CESAMO facility. ADRA provides logistics and stationary, and participates in these meetings. However, no financial transaction takes place between ADRA and the CHVs or the CESAMO. ADRA will continue to facilitate the formation of more small CHV committees in the community who will report to the CESAMO in their respective project areas.

An arrangement has been made between ADRA/Honduras and the Patronatos (powerful local governing organizations that look after the welfare of the community) that requires the Patronatos to recognize CHVs who have served. Recognition by Patronatos is considered to be prestigious and everyone in the community desires it. The patronato has a health wing called "committee de salud" represented at the CESAMO to facilitate these activities.

UNICEF Honduras will continue to provide scales, bags for weighing, and educational materials. In addition, arrangements have been made where UNICEF will provide a TV/VCR set and furniture through ADRA to the two CESAMO centers ADRA uses to train CHVs and CESAMO staff.

Among the local NGOs who will collaborate with ADRA in providing training, information, and educational materials are the following: Leaga de Lactancia Materna, AHLACMA, and UNISA. ADRA has reached an agreement with UNISA to enroll interested CHVs for training and provision of small capital for income generation activities such as starting basic community drug stores. UNICEF provides UNISA with the drugs. ASOMPLAFA, an indigenous NGO that specializes in family planning, will serve as a referral center for tubaligation procedures for those who desire it.

The IEF will continue to provide the CESAMO with vitamin A to be distributed by CHVs. Each CHV has an identifying sign at his/her home. If clients do not show up to collect their vitamin capsules, the CHV, who has a record of all the homes under his/her assignment, visits the home. There is no financial exchange planned between ADRA and any of the above collaborating agencies. No other organization is subcontracted to help implement this project.

In-country organizations, with which the project collaborated during the development of this DIP, include representatives from each of the CS XI project areas, including the CESAMOs, community leaders, a consultant with good knowledge of the Honduran health care system, ADRA/Honduras project manager and technical staff, CHVs, MOH, social workers, and community nurses.

D.3 Technical Assistance

The project plans to obtain technical assistance in the intervention areas of ALRI, nutrition, DCM, and HIS from various local sources. Private consultants would be contracted to review the existing project HIS system and strengthen them by introducing a comprehensive "community friendly" data collection system. Ethnographic studies will also be conducted to identify cultural factors associated with food intake during pregnancy. Focus group studies would also be held on DCM and nutrition by the third quarter of 1996. Results of these studies would be used to design persuasive health messages that are culturally appropriate.

Focused Ethnographic Study on ALRI was already conducted by Lisa Lynch, MS. Jerald Whitehouse, MPH, DrPH, served as the primary consultant on this project. Additional technical help in the areas of ALRI and sustainability will be sought from the PVO CSSP at JHU. This assistance is planned for the second or third quarter of the second implementation year.

References

1. *The State of the World's Children*, UNICEF, 1995.2.
Metropolitan Sanitation Regional Team: Evaluation of Health Activities for SF CESAMO, MOH Tegucigalpa, Honduras, 1994.
3. Ibid, FdC CESAMO, 1995.
4. Ibid, NS CESAMO, 1995.
5. Ibid, NS CESAMO, 1995.

D.4 Detailed Plans by Intervention

D4.a Immunizations (5%)

4a.1 Incidence and Outbreaks According to Dr. Medina, Director of the CESAMO for SF, the MOH conducts weekly and monthly surveillance and monitoring of vaccine preventable diseases. MOH reports indicate that in the past five years in FdC and SF, there has not been an outbreak of vaccine preventable diseases.

4a.2 Baseline Coverage Estimates DPT1, OPV3, and measles coverage rates for SF/FdC are 84.3 percent, 82.1 percent, and 80.0 percent respectively. Coverage rates for DPT1, OPV3, and measles for NS are 72.8 percent, 68.8 percent, and 66.9 percent respectively. The drop-out rate for DPT in SF/FdC is 2.65 percent. The dropout rate for NS is 4.55 percent. The percentage of children 12-23 months who are completely immunized in SF/FdC, is 80.6 percent, and 65.0 percent for NS. The estimated percentage of births that are fully protected by TT immunizations in SF/FdC is 37.6 percent and 32.3 percent in NS. The national EPI coverage rates for children 12-23 months old, for BCG, DPT, OPV, and measles are 95 percent, 95 percent, 95 percent, and 94 percent respectively. The coverage rate for TT is 88.0 percent (1).

4a.3 MOH Policies The Honduran MOH immunization policies do not differ from that of WHO/UNICEF guidelines. The immunization schedule followed is identical to the WHO recommended schedule. (See Appendix W.)

4a.4 Knowledge and Practice Knowledge of mothers regarding timeliness of measles and immunizations for their children, and knowledge of TT vaccine protection against tetanus in SF/FdC are 66.6 percent and 47.5 percent respectively. The rate of mothers with knowledge in NS of the timeliness of measles and immunizations for their children is 48.0 percent and is 37.6 percent for mothers with knowledge of TT vaccine protection. The project needs to emphasize health messages in EPI to raise awareness of the importance and timeliness in maintaining the EPI schedule.

4a.5 Immunization Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase the % of 12-23 month olds fully immunized	NS	65	80
	SF/FdC	80.6	90
2. Increase TT coverage of WCBA	NS	32.3	65
	SF/FdC	37.6	75

4a.6 Approach The overall quality of immunization service in Honduras is reportedly good. Honduras has the highest EPI coverage rate for children less than two years, in Central America. The drop-out rate in SF/FdC, according to the Baseline Survey, was only 2.65 percent, and 4.55 percent in NS. However, some barriers exist, including problems associated with logistics,and the CESAMO running out of vaccines at times. Furthermore, the CESAMOs are closed on weekends and in the evenings. ADRA plans to play a supportive role for the CESAMO in the immunization activities. This includes training of CHVs and educating mothers, promotion of EPI during home visits and at monthly women's meetings. CHVs will also refer children and mothers to the CESAMO and other immunization campaign sites (usually there are two big and three small community EPI campaigns per year). ADRA provides logistics/vehicle for this activity. CHVs and CESAMO staff advertise the community EPI dates. Since these are national EPI campaign dates, the radio and TV will be used to promote announcements. The CESAMO/MOH role includes communication of EPI dates and sites utilizing the radio and TV, education through mass media and CHVs, vaccine and cold chain equipment provision, monitoring and supervision, administration, and community mobilization. EPI activities are already functional in both project areas. EPI services will be provided year round from a fixed facility at the CESAMO and during mass campaigns, through mobile units, at the community level. The vaccinators and CHVs have a list with addresses of all the children in the community. Those who missed the EPI campaign will be followed up by the mobile EPI crew. The search will not stop until they are found and vaccinated. CHVs, during monthly home visits and GM sessions, will examine the child's card to determine their EPI status and refer if

needed. Linking the EPI intervention to the GM component should improve the follow-up of defaulters.

ADRA will not participate in training of staff on vaccination administration. The supply of vaccines is adequate although infrequent shortage is reported. Vaccines are obtained from UNICEF and channeled to the CESAMOs through the Central MOH vaccine supply in Tegucigalpa.

4a.7 Individual Documentation (See Appendix C for MOH immunization card.) The MOH card will be used by the project for recording vaccinations. If the card is lost, mothers will be referred to the CESAMO and a new one is issued for 1 Lp (less than a dime). The vaccination information from the CESAMO EPI registry will be transferred to the new card, for those children who live in the area served by the CESAMO. During mass campaigns, the child's vaccination status will be recorded on their card; a copy is filed on the CESAMO registry. The mothers are taught to bring the child's card for each session. Cards are issued freely the first time. Women's TT vaccinations will be recorded on their antenatal card. Mothers are instructed to keep this card and bring it every time they visit the CESAMO. Records are kept at the CESAMO in case the card is lost. Appropriate retention of the antenatal cards by mothers will be promoted through education.

4a.8 & 4a.9 Drop-out - Children and Women The major causes of drop-out for children and women include the following: mothers working outside the home; no one taking the baby to the CESAMO for immunizations; and occasional shortage of vaccines at the CESAMO, which creates a barrier to compliance with EPI schedule. (See section 4a.6 for strategies for reducing missed vaccination opportunities.) These strategies have one primary purpose: to increase effective vaccination coverage; that is, giving the right dose at the right time, and giving all doses before the first birthday. Mass campaigns, social marketing, and social mobilization are all solutions to perceived gaps in families knowledge and acceptance of vaccinations. The strategy for increasing the demand for TT immunization includes the following: education/motivation of mothers by CHVs to comply with TT schedules; assuring that the MOH policy of showing the proof of TT immunization for single mothers who receive a welfare bonus of 30 Lp per month for the nutrition of their children is complied with; and using the monthly women's meetings for promoting the importance of immunizations.

4a.10 Population The project will target both WCBA and pregnant women for TT immunizations. While the MOH policy target group for primary immunization is 0-24 months, priority will be given to children 0-11 months. Beneficiary/target population breakdown includes: 4,547 children under two years old and 8,655 WCBA. The estimated number of children born in the project area per year is 1,532. The number of visits required to achieve full coverage for children less than 12 months is five, including BCG, 3 DPT/OPV, and measles visits (100% coverage - 1,532 x 5 visits = 7,660).

4a.11 Cold Chain Support According to the directors of each CESAMO in the project area, there is no significant problem with the cold chain system. This project does not intend to be involved in the monitoring or maintenance of the MOH cold chain links.

4a.12 Surveillance The project plans to have no direct EPI disease surveillance activities. However, the MOH/CESAMOs keep track of measles, neo-natal tetanus, and polio cases which will be used to indicate impact.

Reference Materials

1. *The State of the World's Children*, UNICEF, 1996.
2. *EPI Essentials: A Guide for Program Officers*. John Snow, Inc. 2nd Ed., August 1989.
3. Negerie M., G. Ormsby and M. McHenry. Child Survival XI Baseline Survey Data (KPC survey for NS and SF/FdC project areas), ADRA/Honduras, 1995.
4. *The State of the World's Children*, UNICEF, 1995.
5.Training for Mid-Level Mangers (MLM.) Published by WHO, 1991.

D4.b Nutritional Improvement/GM (20%)

4b.1 Nutritional Improvement for Infants and Children

4b.1a Baseline Nationally, 21.1 percent of less than five year olds, suffer from moderate and severe underweight problems. These estimates are based on below -2 SD from median weight for age of the reference population for moderate malnutrition, and below -3 SD from median weight for age of the reference population for severe malnutrition (1).

The project will use a multi-line weight chart (using Gomez classification) at the CESAMO level to determine degree of malnutrition (mild, moderate, and severe). A master chart showing weight levels at ten percent intervals for use in collecting information from mothers attending the CESAMOs will be introduced. This is simplified using reference (100 percent), -2 SD (approximately 80 percent), -3 SD (approximately 70 percent), and -4 SD (approximately 60 percent). (See Appendix V for Growth Monitoring Master Chart.)

Nationally, there seems to be adequate total quantity and variety of food available and no particular seasonal shortages are noted. The primary contributing factors to malnutrition in the target area seem to be economic constraints and selection of food, as well as the lack of knowledge of appropriate mother/child feeding practices. Community food stores have inflated prices, due in part to high cost of credit (up to 12 percent monthly) for the store owners. Knowledge of which foods are the most cost-effective and nutrient-dense is low, and family income is marginal. In addition, the prevalence of infectious diseases, including intestinal parasites, and low-frequency of feedings per day all contribute toward increasing infant and child morbidity/mortality.

An increase in malnutrition is correlated with diarrhea episodes that occur mainly during the rainy season (May-November). According to the CESAMO physicians, there is no age or sex difference in malnutrition rates seen at the CESAMOs.

The project is located in a mountainous slum area of Tegucigalpa where home gardens are difficult to grow. Currently, less than five percent of the families in the project area grow home gardens. Food for consumption is almost always purchased. There is occasional lack of food security and availability in the project area (2).

4b.1b Current Knowledge and Practice In SF and FdC, 80.6 percent of mothers initiate breast feeding within the first hour. The rate is 81.4 percent for NS. In SF and FdC, 87.3 percent of the mothers breast feed within the first eight hours. The rate is 88.4 percent for NS. 88.8 percent of the mothers in SF and FdC give their infants of 6-10 months of age complimentary foods, while 92.0 percent do the same in NS. Persistence of breast feeding up to 23 months in SF and FdC is at 32.5 percent and 50.0 percent for NS.

Most of the babies are delivered by trained health professionals (91 percent in SF and FdC, and 86.7 percent in NS). Most mothers give the infant the colostrum within the first hour. TBAs will teach the same message. Mothers feed their children from their plate, using a spoon or fingers. The frequency of feeding is less, because it coincides with the number of times the mother eats/day (two to three times). The child does not get a variety of foods and sometimes exists on low nutritional junk food, such as salty Doritos, Coca-Cola, and sweets. Mothers do not always supervise their children, so children may ingest anything they find on the floor when they are hungry.

Poor distribution of food within the family often means the child receives very little food and is a common cultural practice with a major impact on the child's health. Males usually eat the "best" foods, and leave leftovers for children. When the child is ill, most mothers withhold breast feeding or feed the child beans (the staple food) and fruits. Another cultural practice that impacts the child's health is known as "empacho". Empacho is a belief that the food becomes stuck in the stomach and causes diarrhea. As a cure, children are sent to a "curandero" or a traditional healer, who will massage the stomach of the baby and introduce laxatives including chicken oil extracted by frying the skin of the chicken. The oral feeding oil sometimes misses the trachea and lodges in the lungs and causes respiratory problems including pneumonia and sometimes death. The traditional healers also recommend no feeding for the child until the diarrhea stops. Sometimes Canada Dry is recommended because of beliefs that it has medicinal value.

4b.1c Nutrition Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase in the % of children < 6 months exclusively breast feeding	NS	46.3	75
	SF/FdC	53.6	80
2. Increase the % of children between 6-10 months who are being given solid, semi-solid foods	NS	92	100
	SF/FdC	88.9	96
3. Increase the % of children between 20 and 24 months who are still breast-feeding	NS	50	75
	SF/FdC	32.5	65

4b.1d Approach Currently, auxiliary and registered nurses in SF and FdC CESAMOs provide nutrition counseling for mothers during pre and postnatal visits. CHVs in this project area also provide nutrition education to mothers during home visits. The government also provides 30 Lp to single mothers with children less than two years old to assist with purchasing of nutritious foods.

In SF and FdC current nutrition awareness programs will be strengthened through cooperation with CESAMO staff. Nutrition activities will be introduced in NS. These activities will include training of CHVs on counseling techniques, with an emphasis on initiation, continuation, and persistence of breast feeding, and the introduction of semisolid foods at six months of age. These practices will be encouraged during illness and catch-up feeding. Food cooking demonstrations will be conducted by trained CHVs for mothers during community women's monthly meetings. The project will phase in nutrition activities in

NS by October 1996. (See Table C for Schedule of Activities.)

Constraints to improving the child's nutritional status include economic problems, inadequate food distribution in the family, the "empacho", and sanitation problems (dirty water, over crowding, and animals in the house). The project will attempt to reduce these constraints by: a) teaching mothers to budget for food as the first priority; b) discouraging spending of limited funds on junk foods (soda pop, Doritos, sweets, etc); c) encouraging the use of the 30 Lp given to single mothers by the MOH to strictly spend on food for the child; d) encouraging the feeding of children adequately, meaning children first and adults last; e) encouragement to increase the frequency of feeding children; f) educating mothers on the harmful effects of the beliefs related to "empacho"; and g) educating mothers on the importance of sanitation in handling of foods, drinking water/milk, and housing. This strategy should be successful, because in CS VIII, the same approach had a positive impact in improving the child's nutritional status, according to CSXI Baseline Survey Results (see CS XI Baseline Survey Results).

Ethnographic study on nutrition will be conducted in the first year of the project to identify harmful cultural practices and beliefs that adversely affect the child's health, and to aid the development of appropriate health messages and educational materials. Among the questions asked would be the following: what foods women introduce to their breast feeding infants before six months of age; why they introduce these foods; what the culturally suggested foods for women during pregnancy and lactation are; and the beliefs about foods that limit a woman's acceptance of the variety and quantity of foods that the project is advocating. ADRA will obtain assistance from La Leche League and AHLACMA for educational and training materials for CHVs engaged in exclusive breast feeding promotion.

The quality of project activities will be monitored through monthly CHV reports, CHV biweekly meetings, supervision of CHVs by ADRA and CESAMO staff, provision of training to CHVs, and introduction of checklists for CHVs to assure that the key messages are delivered. HIS should be practical. There will be feedback of reports with mothers, CESAMOs, and other CHVs during their respective monthly meetings to determine if performance has been effective.

4b.1e Low Birth Weight Babies The project will address LBW problems by encouraging exclusive breast feeding through CHVs and TBAs. Bimonthly weighing sessions for LBW children will be promoted to monitor progress. CHVs will refer LBW babies to the CESAMO for care, including treatment of neonatal infections. If the problem is beyond the CESAMOs technical capability and the child keeps faltering in weight, he/she will be referred to Escuela Hospital in Tegucigalpa for specialized care. A system for weighing newborns will be established. The CHVs will be given weighing scales. Currently, a newborn is weighed and given a card at Hospital Escuela and referred to the CESAMO to appear within ten days. The child is then weighed at the CESAMO on a monthly basis. One constraint is that children are stolen from mothers, and sold in Honduras and abroad to those who cannot have children. This is an increasing problem and is scaring mothers from bringing their children for monthly growth monitoring sessions at the CESAMO. The practice of weighing babies through CHVs during home visits may serve as an acceptable alternative. Currently, TBAs do not weigh babies. The project will encourage and train TBAs to refer newborns to either the CESAMOs or CHVs for GM.

The provision of home care will be encouraged. This includes prolonged breast feeding practices, keeping the baby warm and clean, and providing "kangaroo" care. A referral system for infants needing additional services at the CESAMO, especially for treating infections, deworming, treating ALRI, and dysentery, will be established. (See section 4b.3 for Nutrition Related Intervention to Prevent LBW Babies.)

4b.2 Growth Monitoring

4b.2a Baseline 91.2 percent of children under two years in SF/FdC, and 67.5 percent in NS attended growth monitoring sessions in the past four months. Children are weighed on a monthly basis at the CESAMO or at the CHVs home. The program attempts to reach the population at risk (children less than two years old), through CHVs during their home visits and CESAMOs during postpartum GM sessions.

4b.2b Knowledge and Practices Currently mothers are encouraged to bring their children once a month to the CHVs home or the CESAMO for GM. CHVs reinforce this message during their home visits. The CHVs give the mothers feedback in how their children are growing and educate them in how to interpret the GM chart. Not all mothers are motivated to attend GM sessions. However, according to CSXI baseline data, the trend of maternal GM seeking behavior is improving and this is due mainly to CHVs' encouragement. Mothers believe there is a direct relationship between "good" food and growth of the child, but their definition of "good" food is the problem. "Good" food includes meat/chicken which is expensive to purchase. Junk foods such as sweets, sodas, and Doritos are also classified as "good"

foods. As an infant's teeth appear, mothers force feed them with meat and junk foods. In many cases, vegetables are not considered "good" since they are comparatively cheaper than meat. Some mothers do not consider the traditional foods such as beans and rice as good for the child, especially when the child is ill and the practices surrounding "empacho" are initiated. (Source: CESAMO directors/physicians in each of the project area.)

4b.2c Growth Monitoring Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase the % of children < 2 years old who have GM cards and weighed in the past 4 months	NS	67.1	85
	SF/FdC	91.2	98
2. Improve the nutritional status of children < 2 years old who attend GM sessions by at least 10% in NS and SF/FdC as recorded and monitored on the GM card/CESAMO GM registry (10% fewer in the sever/moderate malnutrition categories using the classification described under section 4b.1a)			

4b.2d MOH Protocol and Practices The MOH recommends twelve GM visits per year for under five excess children that are normal or healthy. If the child is ill or under weight, the number of visits will be increased to twice per month for closer monitoring. A standard UNICEF provided "Salter" scale is used for weighing children. A weighing bag is attached to the scale. The CESAMO conducts GM and counseling activities every month during weighing sessions, but the quality of service providers is sub-standard. Poor attitudes and motivation of CESAMO staff affect job output. Although the problems stem from dissatisfaction related to poor remuneration and working conditions, quality control measures are said to be introduced by the CESAMO management to solve the problem.

4b.2e Individual Documentation (See Appendix D for the MOH Growth Monitoring Card.) If the GM card is lost, a new one will be issued. The information on the original record is kept at the CESAMO and will be transferred to the new card. The first GM cards and forms are given free to mothers, but if the mother loses her card, she will have to pay 1 Lp for a new card. All educational materials produced by the MOH and used for teaching mothers are free. Emphasis will be placed on the importance of keeping cards safe. UNICEF supplied plastic pockets will be provided by the CESAMOs to protect the card. Experience shows that most mothers keep their GM cards secure to avoid paying for a replacement. The card has space for recording vitamin A doses. It also has advice/instructions on breast feeding practices, weaning, ALRI, CMD, EPI, sanitation, GM, and nutrition. The card is complete with illustrations and important dates.

4b.2f Approach Training in GM will be provided for both CHVs and CESAMO staff to strengthen their GM skills and overcome attitude problems common at both professional and auxiliary levels. The GM system established by the MOH uses weight for age, and will be the method used for measuring the nutrition status of beneficiaries, and for the education of mothers in appropriate interventions. The CESAMO staff will be given additional training on how to use the "master chart" shown in Appendix V to help determine the degree of malnutrition. The role of CHVs, however, will be to refer (to the CESAMO) all children falling below the normal curve of the standard RTH.

Mothers will be encouraged to adopt traditional "anthropometric" prompters such as the fit of bead strings or cloths which could provide valuable early warning signs of malnutrition. This approach will actively involve mothers in monitoring their children's growth, and this process will make it a home based/community centered activity, with far reaching potential where mothers can give growth related advice/support to neighbors. At the community level, the mother would receive nutrition advice and follow-up during home visits by the CHV. Where problems persist, the referred child would receive further attention including assessment/treatment for infections and deworming at the CESAMO. The CHV will re-visit the baby in two weeks and evaluate the situation. If the weight still does not improve, the social worker will send the child to a nursing care center. Fifty percent of the cost at the nursing care center is paid by the MOH and 50 percent by the family (usually 10 Lp per month or $1.00.) The baby will be given supplementary feeding and medical attention until he recovers. If the child does not recover, he will be referred to Escuela Hospital where specialized care is provided.

Growth monitoring activities are ongoing at SF and FdC. The project will continue to strengthen these activities. However, both nutrition and GM activities will be phased in NS project area by the fourth quarter of 1996. (See Table C for Project Activity Chart.) At the community level, the CHVs are responsible for weighing the child, interpreting their growth card, and providing nutrition counseling to mothers. At the CESAMO level the registered and auxiliary nurses will also counsel mothers. Supervision and training activities will be jointly conducted by CESAMO/MOH and ADRA staff. The MOH GM training module will be followed. (See Document D for CHV training curriculum.) Joint

CESAMO/ADRA staff meetings will be conducted to share reports and project progress.

Among the constraints to weighing children is lack of motivation of CESAMO staff, CHV attrition rate, and the types of scales used for weighing. The standard UNICEF "Salter" scale is good and ADRA will obtain them. ADRA has made arrangements to obtain 80-100 new weighing scales from UNICEF. The locally made scale is occasionally inaccurate and is damaged easily. The lack of motivation among CESAMO staff could be solved through the measures discussed earlier. The CHV attrition rate can be reduced by providing incentives, including free medical care to CHV families, recognition by Patronatos, and creating training opportunities. As the project expands, the CESAMO is willing to hire or recommend CHVs to train as auxiliary nurses. These career ladder rewards will be available based on performance. Some CHVs have already become auxiliary nurses, and the opportunity is competitive and attractive to many. The quality of GM and follow-up activities will be monitored through joint ADRA/CESAMO supervision, monthly reports and meetings, feedback sessions with community womens' groups, quality assurance check lists, and periodic training of CHV and CESAMO staff who deliver these services.

4b.2g Follow-up on Children The project will track children who do not gain weight in the last three months by monitoring the records kept by the CHVs made during their home visits, and using the CESAMOs GM registry. The child's GM card will be the primary source of information for monitoring malnutrition status. The project HIS Coordinator will monitor monthly GM reports and will instruct CHVs to follow-up on growth faltering children (see section 4b.2f for follow up on growth faltering children). The counseling provided to mothers with growth faltering children will include continued breast feeding, provision of a variety of food, regular growth monitoring, and referral if indicated. (See Appendix G for key nutritional messages for mothers.) The nutrition education will underscore the importance of weight gain, rather than nutritional status, and accurate plotting and interpretation of the growth chart.

4b.2h Population 4,547 children under two years old will be targeted for monthly GM in the project area. If each of these children are weighed monthly a total of 54,564 visits would be required. However, children 24 - 59 months (8,135 pop.) will also qualify for GM which means an additional 97,620 visits would be needed. All in all, 152,184 visits are required to reach full coverage for all eligible children in a year. Each CHV has the addresses of 25-30 homes assigned to her/him. Eligible children in those homes will be enrolled during monthly CHV visits and targeted for GM and nutrition intervention.

4b.3 Nutrition Improvement for Pregnant and Lactating Women

4b.3a Baseline Major causes of nutritional problems that contribute to maternal and child illness and death include premature cessation of breast feeding, poor weaning practices, lack of iron resulting in anemia, eating inadequately during pregnancy, and poor economic situation associated with over-work and inadequate caloric intake. Low birth weight babies and very short stature among women are two rough indicators of maternal nutrition but no data on the prevalence of these was available.

4b.3b Knowledge and Practices 69.3 percent of pregnant women in SF and FdC report eating more than usual during pregnancy. The rate is 59.3 percent in NS. The percent of women who know that a pregnant woman should eat foods rich in iron during pregnancy in SF and FdC is 49.0 percent, and 30.0 percent said they eat leafy green vegetables. The rate is 32.0 percent and 21.6 percent respectively for NS. Only 6.33 percent in SF/FdC and 4.33 percent in NS believe, incorrectly, that during pregnancy a woman should gain only the same amount of weight as the baby will weigh at birth. Among the cultural practices that influence the diets of pregnant and lactating women are the beliefs that when the baby is born, the mother should eat a lot of cheese, chicken, and tortillas for the first 40 days to prevent from getting sick. Beans, green vegetables, avocados, and fruits are also avoided during that time. During pregnancy, where they can afford it, mothers drink a lot of sodas, Coca-Cola, and junk foods. Some mothers drink "Litrosol" (ORS), thinking it enhances lactation. The majority of the mothers know that their health status affects their ability to breast feed successfully, but they do not understand how to stay healthy. Most mothers belong to the lower socioeconomic class and do not have the economic luxury to refrain from hard labor during pregnancy or lactation. Most of the mothers only seek advice from the CESAMO and/or TBAs late during pregnancy. Little advice is sought during lactation. Most mothers receive iron supplements during pregnancy, and vitamin A at birth, if they visit the CESAMO.

4b.3c Nutritional Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase the percentage of mothers with < 2 year old children who ate more than the usual amount of food during their last pregnancy	NS	59.3	75
	FdC	69.3	85
2. Increase the percentage of mothers with < 2 year old children who know that a woman should gain at least 8-10 kilos during pregnancy	NS	4	40
	FdC	15	50

4b.3d Approach CHVs will be assigned 20-30 homes each in their neighborhood. They will register every woman's name and address assigned to them and visit on a monthly basis. This way, both pregnant and lactating women will be identified, enrolled, and followed up for education, counseling, and promotion of antenatal/postnatal care. Mothers who need urgent antenatal care will be referred to the CESAMO for a checkup. TBAs will make home visits for similar educational and referral purposes. Women will also be reached/identified by CHVs and CESAMO staff during monthly women's club meetings. As described earlier, the main constraints to improving maternal nutritional status are related to economic problems, cultural practices, and lack of awareness. These constraints will be partially overcome through education, training on budgeting, cooking demonstrations, nutritional advice, and counseling. The project anticipates reaching high risk groups through monthly women's club meetings and home visits.

4b.4 Supplementary Foods The project will not provide supplementary foods.

4b.5 Health Messages (See Appendix G for key health messages given to mothers to improve their nutritional status and promote healthy development of their children.) Ethnographic studies focusing on nutrition will be conducted to identify harmful traditional practices detrimental to the health/nutritional status of the mother and child. The educational methods used for mothers will include lectures, videos, flip charts, posters, pictures, stories, slogans, participatory dialogue, and cooking demonstrations. Lectures and participatory dialogue will occur during women's monthly meetings where mothers will be involved in the message design. One-on-one counseling will take place during CHV home visitations, at the CESAMO, and at the CHV homes. Here, counseling cards and action posters that provide advice for specific nutrition conditions and age levels will be used. Videos will be shown during scheduled women's monthly meetings, and followed by mother-to-mother exchange of ideas. The project will train CHVs on IEC skills to facilitate this process. Pregnant mothers will also receive messages on the importance of early and exclusive breast feeding.

Reference Materials

1. *The State of the World's Children*, UNICEF, 1995.
2. Ibid, 1995.
3.Analysis de Situacion dela INFANCIA, MUJER. Y JUVENTUD, Honduras, Unicef, 1995.
4.Growth Monitoring and Promotion: Behavioral Issues in Child Survival Programs, USAIS, Ref. # PNABG 752.
5. Negerie, M. G. Ormsby, M. McHenry. Child Survival XI Baseline Survey Report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial Nueva Suyapa, Tegucigalpa, Honduras, December 1995.
6. Negerie, M. G. Ormsby; M. McHenry. Child Survival XI Baseline Survey Report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial San Francisco and Flor del Campo, Tegucigalpa, Honduras, December 1995.

D4.c - Control of Vitamin A (5%)

4c.1 Baseline Night blindness is not prevalent in this project area. According to Drs. Medina and Torres (Directors of SF and FdC CESAMOs respectively), there were less than five cases of Xerophthalmia or other vitamin A deficiency related diseases in the past year in the project area. This is attributed to the good distribution of vitamin A capsules to children less than five years old (the high risk group targeted) and to mothers during postpartum visits. This project will not address other micronutrient deficiencies.

4c.2 Knowledge and Practice The percent of children 12-23 months of age who have received at least one vitamin A capsule as documented on the home based card in SF and FdC is 57 percent and 45.5 percent in NS. The percent of children six to 23 months of age receiving foods rich in vitamin A in SF and FdC is 51.3 percent, and 40.7 percent in NS. Mothers do not have to add iodized salt to the child's meals because all nationally manufactured salt is iodized. Knowledge among mothers about vitamin A preventing night blindness is relatively low, with only 37.7 percent in SF and FdC, and 13.4 percent in NS responding correctly to the survey question on this association.

Foods that are rich in vitamin A, such as papaya and carrots, are seasonally available in the market. Green leafy vegetables are also available but not easily accessible due to location of the markets and economic conditions which do not allow the purchase of these food items during off seasons. These foods are not pursued as a source of micronutrient by families in the project area. Among the obstacles to children eating foods that are rich in vitamin A are high costs and a lack of awareness about the food's nutritional value.

4c.3 Vitamin A Objectives

Objective	Doses	Baseline (%)	EOP (%)
1. Increase the percentage of children < 2 years in SF/FdC who have received their first and second doses of vitamin A capsules	1st	57	75
	2nd	17	45
2. Increase the percentage of children < 2 years in NS who have received their first and second doses of vitamin A capsules	1st	45.5	70
	2nd	10.4	40

4c.4 MOH Protocol and Practices The government protocol for supplementation of vitamin A to mothers is only within thirty days after delivery. Iron is given to pregnant/lactating mothers only by CESAMO staff and recorded on their charts at the CESAMO.

Vitamin A is distributed only for the prevention of night blindness. Mothers receive 200,000 IU once during the first month after pregnancy. Children receive the first dose of half capsule (100,000 IU) at six months of age, the second dose at year one (one capsule equals to 200,000 IU), and one capsule every six months after that until five years of age.

4c.5 Individual Documentation (See Appendix D for MOH card used for recording vitamin A capsules.) The regular child's GM card has a space for recording vitamin A distribution. A space for recording iron supplementation for mothers is available on the maternal card that remains in the CESAMO files. This project will use the same MOH GM card for recording vitamin A distribution for children less than five years of age.

If the child's card is lost, the mother will receive a new card following the same procedure described earlier. During mass campaigns, vitamin A will be recorded on the child's regular GM card. This project does not participate in the distribution of iron capsules to pregnant mothers.

4c.6 Approach This project will educate mothers about the importance of vitamin A in preventing night blindness through CHVs. The purpose of vitamin A supplementation is to prevent vitamin A deficiency/night blindness. (See Section 4c.4 for vitamin A distribution schedule.)

The source of vitamin A capsules will be the CESAMO who obtains the supplement from the IEF/MOH. So far, no irregularities have been reported in supply. ADRA facilitators will monitor vitamin A distribution through the CHVs, who distribute them to children and mothers during home visits. The vitamin A distribution activities adapted by the CHV/CESAMO and the MOH are similar with the protocol followed by IEF in non-ADRA project areas. As part of a long-term strategy the project will educate mothers about the importance of consuming dark green leafy vegetables, and other locally available fruits as sources of vitamin A. (See previous section on availability of vitamin A rich foods in the project area.) The hilly/rocky nature of most of the project area will make home gardening difficult. For iron and folate capsules, pregnant and lactating women will be referred to the CESAMO.

4c.7 Population Children six months to five years old, numbering approximately 10,782, will be targeted in both project areas. This project's protocol for vitamin A supplementation will be the same as the MOH protocol described in section 4c.4. Assuming that a child will need ten visits (every six months between the ages of six to 60 months), 107,820 visits will be required each year to reach full coverage of target groups. CHVs will examine the child's GM card during monthly home visits to determine eligibility for vitamin A supplementation. Subsequent doses will be given during follow-up visits by the CHVs.

Note: GM visits will coincide with vitamin A distribution and other CHV activities to reduce the need for excessive number of visits.

Reference Materials

1. The State of the World's Children, UNICEF, 1995.
2. Ibid, 1995.

D4.d - Diarrhea Case Management (20%)

4d.1 Baseline On the average, in the project area, a child gets three diarrheal episodes per year. The figure increases to four or five during the rainy seasons of May to November (1). In SF and FdC, two to five percent of all diarrheal cases among children under two years is dysenteric. The rate is five percent in NS. About 16 percent of the diarrheal cases are persistent and the remaining 80 percent, acute (2). Unlike morbidity, mortality from diarrhea is low, with less than one percent in each of the project areas (3). If it occurs, it is usually due to acute diarrhea associated with cholera. Dysentery resistance to antibiotics is not reportedly a major problem. Generally, patients respond well to deworming drugs and antibiotics in the project area.

4d.2 Knowledge and Practice When the flavor of ORS is resisted by children, mothers do not force feed them. Often when mothers do not see an immediate cure for diarrhea with the use of ORT, they lose confidence and revert to other forms of treatment including anti-diarrheal medications and antibiotic (teramycin being the drug of choice), or any injection they can obtain from the local private clinics and pharmacies at cost. The Baseline Survey indicated that 50 percent of mothers in NS and 52.5 percent in SF and FdC sought medications/antibiotics for diarrhea. According to the Baseline Survey, in NS, 61.4 percent of the mothers provided the same amount or more breast milk than usual during the child's diarrhea. The figure was 80.9 percent for SF and FdC. In NS, 79.1 percent of the mothers provided the same amount or more fluids (other than breast milk) than usual during the child's diarrhea. The rate was 86.2 percent for SF and FdC. The percentage of mothers who provided the same amount or more food (other than breast milk) than usual during the child's diarrhea in NS, was 45.5 percent. The rate for SF and FdC was 56.6 percent.

4d.3 Case Management of Diarrheal Diseases Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase the percentage of mothers who continue to give foods to their children < 2 years during diarrheal episodes	NS	45.5	70
	SF/FdC	56.6	75
2. Increase the percentage of mothers who treat their children < 2 years with ORT during diarrheal episodes	NS	47.4	70
	SF/FdC	57.6	80
3. Increase the percentage of mothers who continue to breast feed their children < 2 years of age during diarrheal episodes	NS	61.4	80
	SF/FdC	80.9	95
4. Increase the percentage of mothers who continue to give fluids to their children < 2 years during diarrheal episodes	NS	79.1	95
	SF/FdC	86.2	98
5. Reduce the % of children < 2 years experiencing diarrhea in the past 2 weeks	NS	25.3	15
	SF/FdC	19.7	12

4d.4 MOH Protocols and Practices (See Appendix H for MOH protocol for case management of diarrheal disease.) The first choice recommended by MOH is to use ORS during diarrhea. Second choice, in the absence of ORS, is feeding camomile tea, rice water, juca juice, or other home available fluids. The recipe for making cereal base home fluids (to be promoted in the absence of ORS) is as follows:

-Take one fistful of dry rice grain or other cereal/starch food.
-Soak in some water until soft.
-Grind the soaked rice in pestle and mortar (or any grinder) until it becomes paste.
-Put two and a quarter glasses of water (about 600 ml) in a cooling utensil and mix with the paste.
-Stir well and bring the mixture to boil until the first bubbles appear. Take the pan off the fire and allow to cool.
-Add one "three finger" (up to the first crease finger) pinch of salt to the mixture and stir well.

Note: The solution should be kept in a cool and clean place. The solution once prepared should be used within six to eight hours, after which it should be discarded. Mothers will be told that this mix is *not* a food.

name term CMD correctly?

4d.5 Approach The project intends to do the following: 1) Train CHVs to identify, recognize, and treat dehydrated children due to diarrhea using the MOH standard protocol (See Appendix H); 2) Train CHVs on CMD IEC skills (See CHV training module in Document D); 3) Educate mothers on CMD through CHVs with emphasis on sanitary waste disposal, clean water supply, and hand washing after toilet use and before handling foods; 4) Strengthen the ORT posts in SF and FdC, and establish new ORT posts (at the CHVs' home) in NS. ORS will also be distributed from CHVs' posts/homes; 5) Participate in the periodic community sanitation campaigns through CHVs who will help organize the event along with the CESAMOs, Patronatos, and the army.

Following the MOH CMD protocol, CHVs or mothers will manage all plan A cases. For plan B, CHVs will send patients to ORT stations in the community for rehydration and further evaluation. If there is progress within two hours, the baby is sent home. If not, he/she is referred to the CESAMO. The CESAMO will assess the situation and provide plan B treatment. If the baby shows no progress in two to four hours, he/she will be referred to Escuela Hospital. Based on the results of diagnosis, for dysentery and persistent diarrhea, medication will be given at the CESAMO/hospital. Antibiotics are used for bloody diarrhea/cholera and deworming drugs for parasites. Project CMD activities will be phased in in NS by the second quarter of 1997. (See Table C for project activities chart.)

The project will reach high risk populations through CHVs who will be assigned 20 - 30 homes in their neighborhood. All the children under two years of age within the 20 - 30 homes will be registered by the CHV responsible. The target children will be reached during home visits for CMD education and ORT distribution. The CHV will make the necessary follow up visits, in case ORS is needed. The home of the CHV will also serve as an ORT post for the 20 - 30 homes. The quality of the case management of dysentery at the CESAMO and hospital referral levels is hampered by the following: 1) Scheduling problems (the CESAMO is closed at night and weekends); 2) Long waiting time in emergency cases. Some cases may even be rejected; 3) Insufficiency of supplies (IV, NG tubes, antibiotics, and deworming drugs); 4) Poor attitudes of CESAMO care givers due to lack of motivation associated with low pay; and 5) overcrowded working conditions. ADRA has discussed these problems with the CESAMO doctors and as a result, a quality control program will be gradually introduced, including the following: 1) Monthly evaluation of the chart of the child who received ORT to determine the effectiveness of the diagnosis and treatment given by the health care providers; 2) Accepting complaints from mothers and following up on them with the care giver; 3) Providing sensitization training on patient care to the CESAMO care givers by the MOH; 4) Conducting monthly meetings to discuss ways of improving patient satisfaction. Due to a shortage of drugs, the patients will obtain free consultancy from the referral facility and then purchase drugs at a low cost from the community drug stores, which are being organized, or private pharmacies for those who can afford it.

4d.6 ORS The ORS distribution system, at least in Tegucigalpa, is satisfactory. The chain of distribution follows from UNICEF/PAHO to MOH to Metropolitan Health Regional Office to CESAMO to ADRA/CHV to CHV to mother and finally the child. So far there have been no ORS shortage problems experienced by the project. ORS is also available at the CESAMO, CHVs home, community ORT posts, and the hospitals. It is MOH policy to make ORS available to mothers at no cost. The quality control system of monitoring mothers' skills in ORS preparation and use includes explanation before distribution of the ORS by the CHV on how ORS is prepared, and watching how the mother administers it. If there is a mistake, it will be corrected during the consultation. Also, during ORS use at the CHVs' home/community ORT post, mothers will be asked to administer the ORT with the CHVs' supervision.

4d.7 Home Available Fluids The project does not promote use of home-based ORT unless there is no other alternative. This in harmony with the MOH policy. However, the project will promote cereal-based ORS. The MOH developed this working policy due to lack of adherence to correct measurement practices, unsanitary conditions, and availability of ORS. (See Section 4d.4 "MOH Protocols and Practices" for the two most cereal-based home solutions, and their content.)

4d.8 Health Education (See Appendix I for key CMD messages given to mothers on ORS administration and when to refer children to the hospital.)

The educational methods used to communicate with mothers will include one on one dialogue with CHVs during their home visits, group presentations, and informal discussions during women's clubs meetings. Periodic focus group discussion with women groups during monthly women's meetings and other special educational sessions will be arranged by the CHV and CESAMO/ADRA staff. In addition, videos and films available at UNICEF and ADRA, will be used to teach CMD concepts occasionally. These educational sessions would be organized by the CHVs during their home visits. To remind women of the upcoming monthly meeting, the CHV will send an invitation card (see Appendix J for the

card) which will be carried by a child from the neighborhood to each home reminding the mother of the time, date, and place of the meeting.

The quality of health education will be evaluated through unannounced home visits by ADRA staff and the CESAMO social worker who will ask the mother what the CHV taught and assess the mothers' knowledge of the information. The CHV will receive feedback on these evaluations during the monthly meeting. Careful analysis of the monthly CHV report and discussion with the CHVs during the monthly meeting will provide an opportunity to address quality assurance issues. This will be followed by CHV refresher training to improve skills on case management of diarrhea. ADRA facilitators and the CESAMO social worker will also observe the CHVs as they present health education messages. The project has and will continue to develop educational materials for mothers. The materials, already tested, developed, approved, and endorsed by the MOH and local USAID mission include key messages on CMD in the form of posters, leaflets, flip charts, and a complete manual.

4d.9 Prevention The project will teach caretakers ways to prevent diarrhea. This will include education on breast feeding and improved weaning practices and sanitation principles (washing hands before and after toilet use, cleanliness in handling foods, appropriate disposal of garbage, community sanitation campaigns). CHV efectiveness in teaching sanitation principles will be evaluated in the same way as for ORT messages, which were described earlier.

4d.10 Population The beneficiary population of 0-23 months is estimated to be 4,487. Assuming that approximately three visits by a CHV to a mother will be sufficient to cover ORT knowledge and use, the total number of home visits/mother contacts needed for full coverage is 13,461 (4487x3).

Reference Materials

1. Drs. Hippolito, Torres, and Medina. Directors of NS, SF, and FdC CESAMOs, Tegucigalpa, Honduras.
2. Negerie, M. Ormsby, G., McHenry, M.; Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial Nueva Suyapa, Tegucigalpa, Honduras, December 1995.
3. Negerie, M. Ormsby, G., McHenry, M.; Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial San Francisco and Flor del Campo, Tegucigalpa, Honduras, December 1995.
4. Statistical Information of the Annual Operational Plan of the MOH for the Metropolitan Health Area, Tegucigalpa, Honduras, 1994.

D4.e - Pneumonia Case Management (20%)

4e.1 - Providers Effectively Trained and Supervised in SCM and Supplied with Adequate Quantities of Appropriate Antibiotics

4e.1a MOH Policies The Honduran MOH allows only public/private physicians, pharmacists, trained CMBs, and RNs to prescribe antibiotics. However, antibiotics are sold everywhere without prescription, and those found selling them illegally are not prosecuted. The MOH has pneumonia training programs and materials for every level of health workers from CHVs to physicians. The MOH protocol for assessment and treatment of children with acute ALRI is consistent with the WHO protocols except that CHVs are not permitted to administer antibiotics.

4e.1b Current Situation The facilities/practitioners currently providing some form of ALRI care in the project area include the following: six private clinics, one CESAMO, one health post, and 16 TBAs in NS; seven private clinics, one CESAMO, one health post, two pharmacies, six CMBs, and five TBAs in FdC; two private clinics, one CESAMO, one health post, one CMB, and four TBAs in SF. It seems CMBs are more aware of the dangers of antibiotic abuse than pharmacies. Pharmacies are willing to sell partial prescriptions. CHVs are trained to detect ALRI cases and refer to CESAMOs for treatment where physicians and registered nurses are authorized to prescribe antibiotics. According to the CESAMO directors, in the CS project areas, all MDs and RNs are trained in pneumonia case management. The ALRI case management protocols at the CESAMOs are consistent with those of the WHO and MOH. However, shortage of antibiotic supply at the CESAMO hampers the effectiveness of the program. On the other hand, antibiotic use/abuse in the community is rampant. Private physicians and pharmacists tend to over-prescribe antibiotics since they are more concerned with client satisfaction than safe and effective treatment. If the mother gets what she asks for, lots of injections and pills, she is more likely to return. Some pharmacies give antibiotics for common colds. One private physician interviewed said she likes to give two or more kinds of antibiotics (some injectable and others oral) to make sure the child recovers. Although, according to the Baseline Survey, maternal recognition of ALRI cases is reasonably good, timely care seeking and adherence to SCM, adequacy of antibiotic supplies at the CESAMO, referral/counter referral systems, and adequate supervision of CHVs are issues needing attention.

4e.1c Plans for Current Providers An ethnographic study using focus groups on the management of ALRI in the project area by service providers was done. Results show that at the CESAMO level, although supervision and program strengthening is needed, staff get sufficient training from the MOH. For quality assurance, the CESAMO facility will be surveyed to evaluate the needs for improving SCM. The case management practices of providers will be observed, and progress towards objectives will be assessed using clinic records and questionnaires. However, the project staff will not assess provider knowledge about pneumonia case management or practices and/or monitor antibiotic supplies at the private clinic or hospitals. At the community level, further training and supervision is needed to upgrade skills in ALRI management for CHVs. Project staff will assess the CHVs knowledge of pneumonia case management through observation and check lists. Per MOH policy, CHVs are not allowed to manage a case with antibiotics. Cost and sustainability issues also make it difficult to allow CHVs to handle antibiotics. CHVs can however, detect, advise and refer ALRI cases at any time of day or night to the hospital or private clinic. The "mothers' home care advice box" will be given to CHVs, local pharmacies, drug dealers, health centers, and hospitals to serve as an education tool for mothers as well as health practitioners.

4e.1d Involvement of Workers not Currently Treating Pneumonia The project plans to provide pneumonia-related training to CHVs who do not currently treat a child with pneumonia. The responsibility of these workers regarding pneumonia case management will include provision of education and detection of symptoms and referral to the CESAMO. The role the CHV plays in the management of ALRI cases will be effective and credible without antibiotic treatment because it involves education of caretakers in prevention, early detection, and referral of cases. (See Appendix Lp for modified home care advice box CHVs will follow for education of mothers on ALRI case management.) At the CESAMO, antibiotic treatment is cheap (approximately 1Lp for the whole course of antibiotics). The community would rather pay 1Lp at the CESAMO at this early stage of ALRI, versus dealing with the problem at a later stage. The project will monitor and improve the quality of services provided by CHVs through training, supervision, review of monthly reports and check lists, referral analysis through clinic records (if the right cases are being referred to the CESAMO), and weekly meetings with CHVs/CESAMOs to share information about project activities.

4e.1e Training Program The ALRI training methods and materials used include didactic (lecture, dialogue, discussions, audio visuals); practical, (observation of cases at the CESAMO and practical demonstration, counting RR of children under five in the field, exercises on classification of treatment using hypothetical cases); evaluation (interviewing key informants, classification and treatment of hypothetical cases, simulated situations, orally testing the knowledge of the CHVs); and empirical techniques (asking and answering questions, personalized messages, demonstrations, giving feedback, reinforcing, and use of printed materials). The director for training at the CESAMO coordinates the training for the CESAMO staff. Trainers include experienced MDs, RNs, auxiliary nurses, and social workers from the CESAMO who have had daily patient contact. The training course lasts 15-20 hours for CHVs, and a five hour refresher course is provided every other month. A total of four hours will be devoted to practicing assessment and treatment of children (one hour communication with mothers, one hour for role plays with trainees, and two hours for clinical sessions with sick children). The training will include the use of a timer to enable the CESAMO staff to take an accurate one minute reading without forcing them to look away from the child's chest. The training will emphasize that the focus of the health provider's attention should be on the breathing of a child rather than on the severity of the cough or the presence of fever. There is no written exam. However, oral tests will be given on a one-on-one basis. Each trainee will be observed in her/his assessment and case management. The project plans to introduce a pre- and post-test to evaluate the effectiveness of the training.

4e.1d Assessment The CHV will refer all infants under two years of age for antibiotic treatment if the following symptoms are present: irritability; increase of respiratory frequency greater than 50 minutes; lack of appetite or no breast feeding; pus secretion through ears; and fever. For older infants the following symptoms would lead to referral and antibiotic treatment: increased respiratory frequency; lack of appetite; fever; chest in-drawing; cough; respiratory difficulty; wheezing signs; flaring nose; and pneumonia. If the pneumonia is severe, an IV is given by the CESAMO staff. The indications for antibiotics for children 12-59 months include the above symptoms and tonsillitis. (See Appendix Y for protocol used to assess and manage ALRI cases.) The respiratory cut-off for fast breathing for infants under two months of age is 60 breaths/minute or more, as assessed through direct observation. For older infants (two to 12 months), the cut-off rate is 50 breaths/minute or more, and for children 13-59 months of age it is 40 breaths/minute or more. The respiratory rates will be measured through direct observation of the chest and counting per minute using timers. CHVs will be trained to recognize chest in-drawing through observation--the space between the ribs will be increased and a depression is easily seen. Non-

pneumonia groups can be distinguished through observing wheezing disorders, chronic cough and simple coughs, and colds.

4e.1e Malaria Malaria treatment will not be part of this project's activities as the area is not malaria endemic.

4e.1f Antibiotic Treatment After assessment, CHVs will refer to the CESAMO all children of all age groups needing medical attention. The MDs and RNs are already trained to treat ALRI cases.

For children less than two months, the drug of choice for uncomplicated ALRI is procaine penicillin. Infants older than two months receive bacterin. Children 12-59 months old get either procaine penicillin or bacterin. Tylenol is given to treat fever for each age group. If the pneumonia case is complicated, the CESAMO refers children to Escuela Hospital. The project has no control over providers of antibiotics. Even the government has failed to control the use and abuse of antibiotics in the communities. However, MDs at the CESAMOs will be encouraged to follow appropriate prescription guidelines.

The project will monitor the effectiveness of the program as a whole by evaluating mortality rates of children under five in the project area. Mortality rate is determined by the "National Registry of Mortality", an MOH program that covers the project area. CHVs will also send monthly reports of mortality in the households of their assignment live to the CESAMO. The success or failure of each treatment provided will be assessed through follow-up appointment of each patient. When the child returns to the CESAMO for follow-up, the doctor will assess if he has responded to the antibiotics favorably. If the child has not responded well, a different antibiotic drug will be tried. If the child does not respond to the second drug, he/she will be referred to Escuela Hospital. The project will monitor the percentage of cases referred to the hospital by recording rejected cases who normally return to the CESAMO. About five to ten percent of referred cases by the CESAMO to the hospital are currently rejected. In these cases, the CESAMO refers them to another hospital (a lung institute for such cases), or a private clinic. Also, the CHV's who originally referred the child will make follow up visits at home to evaluate compliance with referral protocols and adherence to SCM.

The project does not plan to monitor pneumonia treatment rates by age group or by provider. However, a checklist will be introduced for use by the CESAMO staff, to improve the quality of service delivery for ALRI. (See Appendix X for the service quality checklist on ALRI for the CESAMO.) During the monthly meetings between ADRA and CESAMO directors, these QA checklists will be evaluated for compliance and recommendations to care providers. ADRA will encourage the CESAMO directors to follow-up with the recommendations made.

At the CESAMOs, despite type and dosage, antibiotics are sold to parents for only 1 Lp per course. At private clinics, one course of antibiotics costs at least 50 Lp plus a consultation fee. Using a matching fund, the project will assist in supplementing antibiotics to assure continued supply at the CESAMO. Community drug stores are currently being organized by other community groups where antibiotics will be sold more cheaply. This project is supported by UNICEF as a revolving fund. Once these community drug stores are in place (in two years time according to current plans), ADRA will encourage the establishment of linkages between the CESAMO and the drug stores where mothers would be referred for antibiotics in case of supply shortage at the CESAMO.

4e.2 Sufficient Access of the Target Population to SCM

4e.2a Current Access (See Section 4e.1b for types of pneumonia care providers in the project area.) Two-way traveling costs for residents of the project area to obtain antibiotics at the CESAMO are approximately 80 centavos by bus. On average, the CESAMO is five minutes walking distance from the closest residents and 40 minutes for the furthest residents. Waiting time at the CESAMO is 15-30 minutes if the patient has been referred by the CHV, which a little faster than usual. The hourly rate in Honduras is 3 Lp, so up to 1.5 Lp will be wasted during this waiting time. For those referred to Escuela Hospital, it takes on average 1.5 hours by bus from the project site. If patients are referred by a CHV or the CESAMO, the waiting time at the hospital is only one hour. If they are not referred by CHVs or the CESAMO, the wait could range between two to four hours.

There are no staff shortages at the CESAMOs. Weather situations may affect utilization of services because mothers avoid taking their children with ALRI to the CESAMO when it rains due to beliefs that rain and cold will further complicate the illness (called the "hot and cold belief").

4e.2b Sufficient Access Apart from the times they are closed, access to the CESAMOs for ALRI SCM is good. A partial solution to this problem is to train CHVs to detect and manage ALRI uncomplicated cases at home. For complicated cases, the CHV may give Tylenol and refer the patient to the CESAMO or to Escuela Hospital. Tylenol is relatively cheap and widely available in community shops. During nights, ALRI cases could be seen at ORT centers (home of the CHV), which provide

service 24 hours a day. If the community developed the habit of early care seeking from the CHVs, the problem would be partially solved. The spouses of CHVs know that their house is like a "health center" and expect to be called on any time of the day. In fact, some of the CHVs have devoted a room/section in the home for counseling and provision of health care, and have posters outsidethe home indicating the services available. There is one CHV for every 20-25 homes. Considering this scenario, there will be 100 percent access for ALRI care at the CHVs' homes. However, year-round availability of antibiotics for SCM at the CESAMOs is questionable. To assure year-round availability of antibiotics, ADRA is planning to supplement the CESAMOs supply of antibiotics for ALRI SCM purposes only. The CESAMOs will account for the use of these antibiotics on a monthly basis to ADRA.

4e.2c Increasing Access (See Section 4e.2b for what the project would do to increase the level of access for ALRI case management.) The project will not increase the number of SCM providers at the CESAMO level. At the CESAMO level, the focus will be on improving the quality of SCM, improving year-round antibiotic availability, and strengthening the referral system. It will be necessary to make a facility assessment using the number of trained providers; number of outpatient visits; pneumonia related deaths; records kept; antibiotics used; availability of timers; and case management. At the community level, the focus will be on training the CHVs on parental education for prompt recognition and care seeking, referral of mothers for SCM, and monitoring/improving parental compliance with SCM. Considering the recruitment and training of additional CHVs, the level of access and opportunity for parental education, promotion, detection, referral, and counter referral of ALRI will be increased.

4e.3 Prompt Recognition of Pneumonia Symptoms by Caretakers, and Prompt Seeking of, and Compliance with SCM

4e.3a Methods A focused ethnographic study on ALRI was conducted in the project area to identify information about local beliefs, practices, vocabulary related to symptom recognition, care-seeking, and compliance with treatment. (See document C.) The results of this study will be used to develop appropriate educational materials and messages. There are no additional plans for further investigation in ALRI. In addition, a baseline study was administered using the PVO CS rapid KPC survey on ALRI.

4e.3b Findings 46.3 percent of the mothers in SF/FdC, and 54.3 percent in NS, said their child has been ill with a cough or difficult breathing in the 2 weeks prior to the survey. Of these children with cough/difficult breathing, 37.4 percent in SF/FdC, and 38.3 percent in NS experienced rapid/difficult breathing (dyspnea) when ill. 80.0 percent of the mothers in SF/FdC and 66.1 percent in NS sought treatment. Of those who sought treatment in SF/FdC, 18.2 percent went to a hospital, 45.4 percent to a health post, 22.7 percent to a private clinic/doctor, and 6.8 percent to a pharmacy/chemist. In NS, 20 percent went to the hospital, 44.4 percent to a health center/health post, 24.4 percent to a private clinic, and 11.1 percent saw a relative/friend. The following table lists maternal recognition signs/symptoms of ALRI.

Symptoms	NS %	SF/FdC %
Fast or difficult breathing	60.3	80
Chest in-drawing	12	19
Loss of appetite	3.3	5.6
Fever	15	11.6
Cough	23.3	21.2
Does not know	10.7	5
Others	17.7	17.6

Local terms for fast breathing, difficult breathing, and chest-in-drawing have been identified though FES. (See Appendix M for glossary of local ALRI related terms identified.) The project will train CHVs to use these terms in their education of mothers. Mothers/care takers consider fever, cough, and "drowning" as the most dangerous signs that would lead them to seek help from a trained health professional. Mothers frequently use old medicine left over from the last household illness and administer it to children before seeking care outside the home. Self-medicating delays their care seeking behavior for several days. If mothers have the money, they bypass the health center altogether and buy drugs from pharmacies without prescription. Sometimes traditional healers, TBAs, and relatives are contacted for help. In general, mothers decide when and from whom to seek outside care.

Barriers to recognition of ALRI, prompt care seeking, and compliance to treatment include: 1) Mother's beliefs and practices related to homemade expectorants and chest rubs for ALRI treatment (a chest balm of grease and gasoline is often used to open up airways); 2) Shortage of antibiotics at the CESAMOs; 3) Self-medication which contributes to diminished effectiveness since mothers do not complete the entire course of antibiotics; 4) Mothers quitting medication when the child shows signs of improvement and keeping the remaining antibiotic regimen for future use; 5) Mothers lack of knowledge of prompt recognition and care seeking for ALRI.

4e.3c Communications Strategy

Objective	Location	Baseline (%)	EOP (%)
1. Increase the percent of mothers who sought medical treatment from a health facility for infants < 2 years with cough and rapid, difficult breathing in the previous two weeks	NS	58	80
	SF/FdC	71.1	88
2. Increase the percent of mothers of children aged 0-23 months who know three alarm signs in cases of cough that would cause them to seek medical care	NS	See the table below for percentage measurements	
	SF/FdC		
3. Increase the percent of pneumonia cases receiving SCM at health facilities by at least 100% (measured by clinic records)	NS	Measured by clinic records	
	SF/FdC		

(See table below for measurement of objective #2 above.)

Signs and Symptoms	Nueva Suyapa		San Francisco and Flor del Campo	
	Current Knowledge Level (percent)	Proposed Objective (percent)	Current Knowledge Level (percent)	Proposed Objective (percent)
Fast/difficult breathing	60.3	80	80	94
Chest in-drawing	12	50	19	60
Fever	15	50	11.6	60
Cough	23.3	60	21.2	60
Loss of appetite	3.3	25	5.6	40

The key components in this project are recognition of cough and difficulty in breathing by mothers as signs that should lead to seeking care; establishment of appropriate referral to health facilities by CHVs for SCM; appropriate case management at the CESAMO; and establishing a counter referral system for follow-up of cases in the community. The priority age group for MOH ALRI intervention includes infants less than two months of age, infants greater than two months of age, and children 12-59 months old. This project will focus on children less than two months of age as they constitute the highest group at risk of death from pneumonia. However, the project will also target mothers of children less than five years for education, early detection, and care seeking for ALRI. The key messages to be emphasized will include those already developed by the MOH and are available in the local language. (See brochure and key ALRI massages in Appendix N.) An ALRI manual with key messages and pictorial illustration has been developed by ADRA/MOH.

CHVs will be trained to communicate key ALRI messages to mothers. ADRA will facilitate this training and the CESAMO staff will conduct the actual training. Mothers will be educated by the CESAMO staff during SCM and by CHVs during monthly home visits and womens' group meetings. The quality of these communication efforts will be monitored through the monthly CHV reports and checklists, the CESAMO monthly reports, and on-site observation of CHVs during on-the-job supervision by ADRA facilitators. Mothers will be encouraged to bring back the child two days after treatment to see if the child has improved. This is a standard CESAMO procedure. Assessment will be made during this follow-up and a decision will be made to continue treatment or change antibiotic. Another follow-up will be scheduled within seven to ten days. However, mothers usually do not comply with the consecutive appointments. The assumption is that the child got better. Compliance to treatment will be monitored through CHV follow-up home visits. During these visits, messages emphasizing continued breast feeding, increased semisolid foods (as applicable), increased fluids, and catch-up feedings will be recommended. Tylenol is used to reduce fever and the mother is encouraged to complete the antibiotic course even if the child gets better.

Reference Materials

1. Acute respiratory Infections In Children: Case Management In Small Hospitals In developing countries. A Manual for Doctors and Others Senior Health Workers, WHO.

2. Lynch, L., Esquival Raina. Focused Ethnographic Study on Acute respiratory Infection. ADRA CS Project, Tegucigalpa, Honduras, 1995.
3. Negerie, M. Ormsby, G., McHenry, M. Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial Nueva Suyapa, Tegucigalpa, Honduras, December 1995.
4. Negerie, M. Ormsby, G., McHenry, M. Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial San Francisco and Flor del Campo, Tegucigalpa, Honduras, December 1995.
5. Primary Health Care Management Advancement Programme, Modules 5 and 6. Aga Khan Foundation, USA, 1993.

D4.f - Malaria Control Not planned.

D4.g - Maternal and Newborn Care (30%)

4g.1 Baseline The maternal mortality rate in Honduras is 221/100,000 live births (1). 83 percent of the maternal mortality cases are due to obstetric causes of which pregnancy and interpartum hemorrhages, post partum infection, hypertensive problems, and dystocic deliveries are ranked in descending order of importance (2). In San Francisco and Flor del Campo area, 39 percent (117/300) of the mothers had maternal cards indicating 37.6 percent (113/300) TT coverage, and 32.6 percent (98/300) antenatal visits prior to the birth of the last child. In Nueva Suyapa, 36.7 percent (110/300) of the mothers had maternal cards showing 32.3 percent (97/300) TT coverage and 28.3 percent (85/300) antenatal visits prior to the birth of the last child among mothers who had maternal cards.

In the best case scenario, the TBAs' friend or relative of the woman with an obstetric emergency will be contacted to provide transportation to the CESAMO or a taxi may be hired. During weekends or nights when the CESAMO is closed, mothers will have to go to Escuela Hospital, the government delivery facility about 30 minutes away by taxi or 1.5 hours by bus from the project area. In the worst case scenario, someone from the family will call the untrained or poorly trained TBA for delivery. If compilations occur during delivery, the TBA will contact the CESAMO, often when it is too late. The mother is carried to the CESAMO which is accessible by foot (about an average of ten minutes walking), but closed at nights and weekends. At the CESAMO, only emergency cases are seen. If the emergency is at night or the weekend, a bus will be taken to the hospital.

4g.2 Maternal Care Objectives

Objective	Location/ STD Status	Baseline (%)	EOP (%)
1. Increase the percent of mothers with a maternal card of the birth of the youngest child less than 24 months of age	NS	36	75
	SF/FdC	39	80
2. Increase the percent of pregnant women (with children < 2 years old) screened and treated for STDs in NS	Screened	20.7	50
	Treated	33.9	75
3. Increase the percent of pregnant women (with children < 2 years old) screened and treated for STDs in SF/FdC	Screened	21.7	50
	Treated	52.3	85
4. Increase the % of mothers with children < 2 years old who had at least one pre-natal visit prior to the birth of the last child	NS	28.3	60
	SF/FdC	32.6	75
5. Maintain current high level of women delivering by health professionals such as physicians, RNs, and trained midwives	NS	86.7	Same or better
	SF/FdC	91	Same or better

4g.3 Prenatal Care In each of the three project areas, there is one CESAMO providing prenatal care. On the average, one physician, two RNs and two auxiliary nurses are assigned to each of these prenatal care units. In addition, there are three private outpatient clinics in SF and FdC project areas, with a physician providing prenatal care services at high costs. NS has two such private clinics. The following prenatal care services are available in the CESAMOs: vitamin A and iron supplementation, TT, weight monitoring, BP monitoring, detection and

treatment of STDs and UTIs, identification of problem pregnancies, detection of danger signs in pregnancy, and referral systems which includes the Hospital Escuela.

4g.4 Delivery/Emergency Care Each of the CESAMOs in the project area have limited intrapartum delivery care facilities which are used only during emergencies by a physician and RNs. The quality of the CESAMO facility is poor because of the inadequacy of supplies and inaccessibility of services for non-emergency cases and closure during weekends and nights. Nearly 90 percent of mothers are referred by the CESAMOs to the hospital outside the project area. About eight to 13 percent of the deliveries are performed by TBAs in each of the project areas, and less than two percent by CESAMOs. Private clinics in the project areas do not provide deliveries. There is a total of 13 TBAs in the project area (three in SF, four in FdC and six in NS), who deliver babies at the mother's home. Although some of the TBAs are given basic training by the MOH, the quality of their services are hampered by lack of refresher courses, unhygienic practices, and efforts to manage complicated cases. As a result of the above limitations, the essential elements of obstetric services at each level of care are obstructed. All emergency deliveries referred to Escuela Hospital are provided with a slip indicating the priority service needed by the mother.

There are six ambulances from the fire department and Red Cross serving the whole city. It takes one to two hours before an ambulance arrives. If the ambulance does arrive, it takes an additional ten minutes from SF, 20 minutes from FdC, and 30 minutes from NS to reach the hospital. The mother may die while waiting, unless she is rich enough to hire a taxi or has a relative who can provide private transportation. On the average, it takes five minutes from the closest area and 40 minutes from the furthest home to reach the CESAMO by foot. It takes about ten minutes from the furthest home to the CESAMO if the mother is transported by a car.

4g.5 Postpartum Care Mothers are referred back to their respective CESAMOs for postpartum care by Escuela Hospital within ten days after delivery. CHVs and TBAs are also trained to refer mothers. Postpartum counseling includes the following: nutrition advice, detection and treatment of postpartum infections, breast feeding/
procedure difficulties, and FP services. In addition, the child is immunized and mothers receive a pap smear test to detect uterine cancer. Postpartum care is given by a physician and a RN, with a maximum of 20 minutes to a two hour session spent with each mother. Unless there is an infection, in which case the mother will be seen again in 72 hours, a follow-up session will be scheduled in two months.

4g.6. Constraints Postpartum referrals from CHVs and TBAs are poor. Training on the importance of postnatal care and supervision of TBAs and CHVs may help overcome this constraint. In some cases, illiteracy of mothers and lack of awareness as to where to seek maternity care can be the problem. Education of women will help. Developing a system where the CHVs and TBAs are given more training opportunities, recognized by Patronatos, given free medical care at the CESAMO, and recommendation of civil service by the local government authorities may be motivating to CHVs. A major problem is the difficulty in organizing emergency referrals to hospitals. However, by providing good prenatal care and improving maternal prenatal care seeking behavior, the chances for emergency obstetric transportation can be reduced.

4g.7 Population A total of 8,655 WBCA will benefit.

4g.8 Approach

4g.8a Maternal Care Providers and Birth Attendants In the project areas of FdC, SF, and NS, there are four, three, and six TBAs respectively. Only half of these TBAs were trained numerous years ago. In SF and FdC, 91 percent of the births were attended by trained medical professionals (MD and RN). Eight percent were attended by TBAs and less than one percent by a family member. No mothers reported delivering their own baby. In NS, 86.7 percent of the births were attended by trained medical personnel while TBAs delivered about 13 percent of the babies. No mothers nor their family members reported delivering the baby. (See Section 4g.8c for description on TBA training.)

According to the baseline data, family members of mothers do not significantly participate in delivery, so training them will be limited to education on the importance of pre- and postnatal care via visits by CHVs and TBAs. ADRA will collaborate with UNISA, a national PVO specializing on TBA training, and the CESAMO to train TBAs.

The TBAs will be monitored through their monthly reports, monthly meetings with the CESAMO, and community health committees they are required to attend. In addition, the TBAs will be given on-the-job supervision by the CESAMO trainer during delivery for the first three to four births and irregular follow-up visits. A standard form will be developed to include the number of deliveries, obstetric complications referred, and other pre-,

intra- and postpartum activities TBAs perform. To keep TBAs motivated, the CESAMO will provide them with free medical care. Cotton, soap, and clean razor blades will also be available from the CESAMO to be released at the time the TBA returns her report.

4g.8b Prenatal Care This project will limit its activities to training TBAs/CHVs, promoting attendance of mothers for pre- and postnatal care, and educating pregnant/lactating women and their family members via home visits and womens group meetings. Prenatal care will be provided at each of the CESAMOs. The CESAMO physicians, UNISA, and MOH experts will train the CESAMO staff. Pregnant women will be instructed to make a minimum of three prenatal visits (once per quarter) to the CESAMO. In cases of high risk pregnancy, as determined by the CESAMO physician, the mother will be advised to visit every month. At the CESAMO, the prenatal care will include the following: nutrition advice, detection of risk and correction, weight control, BP check up, STD screening, FP counseling, and pap smear for cancer detection. A TT vaccination is also given by the CESAMO staff at the CESAMO facility.

Each pregnant woman will be weighed to determine weight status. If her weight is excessive, further examination will be conducted to determine the risk factors associated with excessive weight such as edema, cardiac problems, renal problems, pre-eclampsia, etc. The information on BP will help determine if she has high blood pressure and pre-eclampsia. Such cases will be referred to Escuela Hospital since they are high risk pregnancies. If mother's weight is low, malnutrition may be indicated. The mother will be given nutrition counseling to reduce the problem of low birth weight/premature birth. In addition, she will be taught to recognize danger signs in pregnancy, their implications, and what to do. Danger signs include the following: vaginal bleeding anytime during pregnancy, excessive tiredness and or paleness which may signify severe anemia, swelling of the hands and face as warning signs for pre-eclampsia, and fever that may be associated with the breakage of water. Each of these conditions should alert the woman to seek care before the emergency situation arises. If the mother realizes these complications early on, timely transport and referral could be planned, access to the health care facility improved, and possibly lives saved. The gestational age will be determined using the following formula: date of the last menstruation period plus seven days minus three months plus one year = date of birth. This information will be used to determine the normalness of the growth of the baby and fetus presentation. If the prenatal care providers (RNs) who will be trained to determine fetal presentation detect breech or transverse lie, they will refer the case to the CESAMO doctor who will perform further investigation and refer the case to Hospital Esquela for surgery. Breech or transverse cases so far have been about five percent of all prenatal cases seen at the CESAMO (3). Although it is not completely complied with, it is mandatory MOH policy to screen all pregnant women for STDs and UTI. Those having STDs or UTI will be given antibiotics for treatment. There is an adequate supply of antibiotics provided by the MOH for these cases. Condilomatosis and vaginal fungus are two of the most prevalent conditions among pregnant women. The CESAMO only prescribes medication as they do not have drugs for them. The same principle applies for chlamydia and trichomoniasis. The CESAMO keeps a record (mothers name, number of visits, prenatal services given by type, STD status and treatment given, counseling session, vaccination, iron/folate distributed, etc.) documenting all treatment and prenatal consultations made at the center.

The pregnancy risk factors to be identified are: multi-parity (less than four children), maternal age (<18 or >35), child spacing (less than two years). For multi-parity problems, FP services will be provided. For maternal age, education, exclusive breast feeding until age six months (according to MOH policy) and prenatal care will be given. For child spacing, FP services, GM, and counseling will be provided. If followed, such actions will benefit mothers by improving their own health and the chances for delivering a healthy child. The child will also have increased immunity to fight infections. Early detection and reduction of high risk pregnancy may translate to better economic status for mothers. Mothers will be informed of these risk conditions that require her to seek care from a health care provider for evaluation. Thirty to 60 capsules of Iron and Folate are provided free of charge to pregnant women during each consultancy period. Malaria prophylaxis is not provided, since it is not an endemic area for malaria. The project will use several promotional means including puppets, informal discussions, lectures, and one on one counseling to educate mothers and members of their families. The Seventh-day Adventist radio station in Tegucigalpa, "La Voz Adventista", will be used for promotion of maternal health programs. Mothers will be given the schedule of broadcasting. Radios are widely available in homes in Tegucigalpa. TBAs and CHVs will receive their training through lectures and audiovisual resources.

(See Appendix P for key messages women will be given to promote prenatal care; the risk or danger conditions that mothers will be taught and what they will have to do if these conditions occur; and screening procedure health workers will follow to identify women with problems.)

When problems are identified, CHVs or TBAs will refer mothers to the CESAMO. During nights or weekends

when the CESAMO is closed, emergency cases will be referred to Esquela Hospital.

4g.8 Delivery/Emergency/Newborn Care

The project will use the standard MOH curriculum for training TBAs. The curriculum will, however, be modified to assure the inclusion of principles in the "Gold Standards in Maternal Care Curricula" developed by PVO CSSP JHU, 1995. (See Document E for MOH TBA training protocol for obstetric first aid procedures, and Appendix Z for "Gold Standards in Maternal Care Curricula".)

The TBA will be trained on referral procedures to the CESAMO for all complicated or emergency cases. She/he will accompany the mother to the referral facility and provide support such as holding the head of the baby if required. The identification of complications and danger signs (when vaginal bleeding is significant, when convulsions have occurred, when she has passed uncontrollable fluid that is not urine, signs of pre-clampsia, etc.) during the antepartum period is an important component of this TBA training. The training will focus on early contact with pregnant mothers, recognition of danger signs, planning for emergencies, linking with a referral facility, and ensuring that a transport system is available if complications arise. (See earlier sections for the chain of referral and communication systems during emergency.) Women would be taught that premature contractions may be a sign of premature labor, putting the fetus at risk for early delivery, in which case women should palpate contractions and increase fluid intake during contractions until a health care provider is seen. Hard labor that has lasted for longer than 12 hours and pushing for more than two hours may also indicate a problem that requires the assistance of trained personnel. ADRA has a good working relationship with the CESAMOs in the project area. There will be monthly meetings with the CESAMO directors to review reports and a discussion of problems affecting the referral program. All TBAs and mothers will be given an ID card which will be shown to the referral facility personnel to allow recognition and swift care. The project will make prior arrangements with each referral facility to accept women with obstetric emergencies as priority cases. Women that cannot afford to pay the 70 Lp for normal delivery will receive free service at the CESAMO/hospital. The social worker in the area will arrange this with the referral facility where an understanding has already been reached with these referral facilities. (See Section 4g.8d for immediate care of the newborn.)

The TBAs will be monitored/supervised through the monthly report they submit to the CESAMO and ADRA and weekly/monthly meetings with the CESAMO staff and ADRA during community health committees. An on-the-job supervision plan of up to three births after training and irregularly after that is planned. The date of birth of the women is determined during prenatal care. The facilitator will use that information to provide spot-checks when the TBA delivers babies in the community.

(See Section 4g.8b for key advice/messages that mothers/family members will be given on delivery and emergency care; the danger signs; and the actions needed to be taken.)

4g.8d Postpartum Care Educational messages about the care of the newborn are a key component of this project. The CESAMO staff, TBAs, mothers and family members/birth attendants will all be taught to clear the airway of the newborn and stimulate breathing and crying. The baby should be dried off immediately, kept warm, and the umbilical cord cared for properly. Breast-feeding should be initiated within the first hour of birth. This action causes the release of pitocin that will stimulate uterine contractions and potentially reduces the risk of post-partum hemorrhage. The newborn will be examined for congenital defects, size, and weight and referred if required.

The project intends to educate and promote mothers to attend postpartum care provided by the CESAMOs. The postpartum care provided by the CESAMO is divided into immediate and later postpartum periods which lasts up to six weeks after delivery. The services include: counseling on nutrition, detection and treatment of infection (UTI), bleeding and retained placenta, care of the nipples (nipple massage), physical exam of the uterus, and continuation of TT vaccinations until the women gets five doses following the MOH schedule. (See Appendix W for MOH TT vaccination schedule.) Postpartum education to women will be provided through CHVs/TBAs during their home to home visits (the first one within 72 hours after delivery), and during monthly womens' group meetings. All postpartum mothers are encouraged to visit the CESAMO within ten days after delivery. The CESAMO will set up subsequent visits, usually within 30 days, and then make FP visits unless there is complication in which case she will be referred. Asamplafa, a local NGO, also supplies both ADRA and CESAMO with contraceptives.

4g.9 Documentation (See Appendix Q for the copy of CESAMO/ADRA mothers' cards and other maternal care record keeping documents. How lost cards are replaced is discussed earlier.)

References

1. A Review of Maternal Care Messages and Curricula Used in PVO Child Survival Projects. JHU, 1995.
2. Country Situation Analysis, Honduras, UNICEF, 1995.

3. Dr. Alberto Medina, director, Flor del Campo CESAMO, Tegucigalpa, Honduras
4. Morrow, H.; and Anderson, F. Gold standards in Maternal Care Curricula for use by PVO CSSP, JHU, 1995.
5. Negerie, M. Ormsby, G., McHenry, M. Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial Nueva Suyapa, Tegucigalpa, Honduras, December 1995.
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D4.h - Family Planning

4h.1 Baseline According to the baseline data, in SF/FdC project areas, modern contraceptive usage rate is 50 percent and 53.5 percent in NS. National estimates for contraceptive prevalence is 47 percent (1).

4h.2 Family Planning Objectives

Objective	Location	Baseline (%)	EOP (%)
1. Increase the % of mothers of children < 2 years of age who wish to delay their next pregnancy by two years who use a modern birth control method	NS	53	75
	SF/FdC	50	75

4h.3 Current Family Planning Services and Constraints

Each of the three CESAMOs in the project area provide family planning services to women who come for postpartum care. The contraceptive commodities available from the CESAMOs are condoms, IUDs, and pills. Women can obtain contraceptives from two other sources: The TBAs/CHVs who distribute condoms during their home visits and the two ASOMPLAFA FP posts located in FdC. ASOMPLAFA also provides referral services for vasectomies at its own FP center in Tegucigalpa for about 40 Lp ($4.00). The MOH is the source of contraceptives. The supply level is good and accessibility is satisfactory. However, promotion and education are needed to increase usage. As Honduras is a predominantly Catholic nation, there is a considerable level of resistance to contraceptive use. Talking with the religious leaders and community groups individually may help reduce the effect of this constraint. In addition, the "machismo" culture of not ceasing procreation until males are born to the family is another constraint. If husbands know their wives are using contraceptives, they may cause trouble.

4h.4. Population: A total of 8,655 WCBA (3,940 in NS and 4,715 in SF/FdC) will benefit.

4h.5 Approach This project will be involved in promoting FP activities in the communities through CHV/TBA home to home educational visits, monthly womens' group meetings, and during EPI mass campaigns. (See Appendix R for key promotional/educational messages on FP.) The CHVs and TBAs will be trained in FP communication skills. The CHVs and TBAs will also refer mothers who wish to have tubaligation to ASOMPLAFA and those needing contraceptives other than condoms to the CESAMO. Mothers will be told where FP devises can be obtained (CESAMO, CHVs/TBAs, hospitals, pharmacies, and even shops for condoms). The CHVs/TBAs will receive condoms from the CESAMO, who in turn receive them directly from the MOH and distribute them during their home visits. Mothers and fathers can also obtain condoms from the CHVs/TBAs home any time to guarantee an uninterrupted supply of condoms over time. During their monthly report to the CESAMO/ADRA, CHVs/TBAs will give an inventory of their contraceptive stock, at which time it will be decided if replenishment is necessary. This will help maintain a constant supply of FP commodities.

The quality of FP services will be monitored and improved through the monthly reports of CHVs/TBAs. Key indicators to be monitored in the report will be trends in the number of mothers using contraceptives, FP drop-off rates, maintaining constant supplies of contraceptives, permanence of services, and referrals made for vasectomy. Using male CHVs and also targeting men for education during home visits and community gatherings may help reduce the problem. The project will include as many men as possible in promoting FP usage. The project will train male CHVs as promoters of FP, in particular, the husbands of the village birth attendants. FP classes for both genders will be given as a whole family and separately during CHV home visits. The approach to FP services promoted by the community based workers and CESAMO based practitioners is similar in promotion/education. The only difference is that CHVs are limited to distribution of condoms and refer to the CESAMO for other FP services. This project's FP intervention is in harmony with MOH policies for promoting contraceptives. Couples will be told of the pros and cons of using contraceptives during counseling sessions and the final decision to use it or not will be theirs. There will be no imposition on them.

4h.6 Health Education Messages (See Document D for CHV FP training curricula.) (See Appendix R for key messages on family planning.)

4h.7 Documentation (See Appendix U for the project HIS forms family planning documentation.)

References

1. The State of the World's Children, UNICEF, 1995.
2. Negerie, M. Ormsby, G., McHenry M. Child Survival XI Baseline Survey report. PVO Child Survival Rapid Knowledge, Practice and Coverage (KPC). Colonial Nueva Suyapa, Tegucigalpa, Honduras, December 1995
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D.5 Schedule of Field Project Activities

DIP Table C: Field Schedule of Activities

	Year 1				Year 2				Year 3				Year 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position																
a. Project Manager	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
b. Technical/Health Coordinator	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
c. Health Information System Manager	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
d. Community/Village Health Workers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
e. Training Coordinator	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
f. Facilitators	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
2. Baseline Survey																
a. Design/Preparation	x								x							x
b. Data Collection and Analysis	x								x							x
c. Feedback to Community		x								x						x
3. Health Information System																
a. Consultants/Contracts to Design HIS		x														
b. Develop and Test HIS			x													
c. Implementation				x	x	x	x	x	x	x	x	x	x	x	x	x
d. Feedback to Community				x	x	x	x	x	x	x	x	x	x	x	x	x
4. Training																
a. Design		x				x				x				x		
b. Training of Trainers		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
c. Training Sessions		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
d. Evaluation of Knowledge of Skills		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
5. Procurement																
a. Supplies	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
- Other																
b. Equipment	x	x	x			x				x				x		
6. Service Delivery to be Initialed																
a. Area 1: SF, FdC - List Interventions:																
I) MCH/FP	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ii) Nutrition/Vitamin A/GM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
iii) CMD	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
iv) ALRI	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
b. Area 2: NS - List Interventions:																
I) MCH/FP				x	x	x	x	x	x	x	x	x	x	x	x	x
ii) Nutrition/Vitamin A/GM					x	x	x	x	x	x	x	x	x	x	x	x
iii) CMD						x	x	x	x	x	x	x	x	x	x	x
iv) ALRI							x	x	x	x	x	x	x	x	x	x
7. Technical Assistance																
a. Headquarters	x		x	x		x		x		x		x		x		x
b. Consultants	x	x				x			x	x						x
8. Progress Reports																
a. Annual Reports					x								x			
b. Mid-Term Evaluation									x							
c. Final Evaluation																x

Section E - Human Resources

E.1. Organizational Plan

See Appendix T for an organizational chart of the ADRA/Honduras CS project

E.2. Training and Supervision Summary

DIP Table D: Training and Supervision Summary

Trainer Job Title	Course Title	No. of Hours		Facilitator	Contacts Per Month	Interventions
		Initial	In Service			
ADRA and CESAMO technical staff	MOH/PHC modules 1 and 2 for CHVs	40	5	Esther Argueta, ADRA HIS, and the training coordinator	4	All project interventions and HIS (See document D for CHV training curriculum)
CESAMO MD and RN/midwife	TBA training curriculum for TBAs	@	@	CESAMO training coordinator	4	Prenatal care, safe delivery, postnatal care, IEC skills, HIS, and referral protocols
CESAMO social worker	Community leaders orientation (CHC and Patronatos)	4	0	CESAMO training coordinator	2	Leadership, HIS, and supervision skills
CESAMO MD and RN	SCM for CESAMO staff	20	5	CESAMO training coordinator	4	ALRI SCM
MOH and NGO consultants, ADRA HQ staff	TOT for facilitators	30	5	Nelson Tabares, Project Director	4	All project interventions, HIS, supervision, and monitoring

@ = See Honduras MOH TBA Training Manual (Document E)

E.3 Training and Supervision Plan

The overall training design focuses on three groups: First, basic training on key messages, HIS, and specific skills for CHVs will be provided by the CESAMO and ADRA facilitators using the traditional MOH/PHC training modules. (See Document C for CHV training modules, and Appendix E for recruitment and training schedule of CHVs.) TBAs will also be trained following the MOH curriculum by the CESAMO personnel (MDs, RNs and midwives.) Second, TOT training and refresher courses for ADRA and CESAMO staff will be held with outside technical help (MOH experts, NGO experts, and ADRA HQ technical staff.) The CESAMO staff will be trained on SCM of ALRI by the CESAMO physician and RNs. Third, orientation will be provided to the Patronatos and CHCs on management and supervision skills by the CESAMO and project staff. (See the following table for description of training and supervision plan.) ADRA's role will mainly be to facilitate and help coordinate these training activities.

Training and Supervision Plan

Type of Trainees and Training Objectives	Number of Trainees	Ratio of ADRA Facilitators to CHVs	Number of Facilitators	Evaluation *
CHVs: To train CHVs on basic IEC skills on all interventions and HIS	181 new 179 old (refresher course)	1:23-25	15 (ADRA)	-Pre- and post-test -Observation -Interview
TBAs: To train TBAs on prenatal care, safe delivery, postnatal care, and referral protocols	13 old 17 new	Approx. 1:2	15	-Observation -Interview -Pre- and postest

Type of Trainees and Training Objectives	Number of Trainees	Ratio of ADRA Facilitators to CHVs	Number of Facilitators	Evaluation *
TOT: To train field facilitators and trainers in all interventions and supervision skills	15 ADRA staff 12 CESAMO staff	NA	15 ADRA 12 CESAMO	-Pre- and post test -Written exam
CESAMO Staff: To train the CESAMO staff on SCM of ALRI	12	NA	2 CESAMO sup.	-Pre- and post test -Observation -Interview
Community Leaders: To orient the Patronatos and CHCs on the roles that they play in support of the CS project	-13 old groups -6 new groups	NA	NA	-None

* See Appendix K for a generic training report form.

Major Training Concepts For CHVs, TBAs, and Community Groups		
Trainees	**Interventions**	**Key Concepts/Skills**
CHVs	GM/EPI	Correct method of weighing; checking accuracy of recording date of birth; plotting weight by age and connecting point to last point charted; interaction with the mother (educational, informative, sensitive, motivational); distinguishing problem cases and prompt referral for medical attention and /or nutritional rehabilitation; asking/answering questions giving appropriate counseling explanations and recommendations; significance of the six immunizable diseases; consequences, benefits of vaccination; key messages for parents and community; identification of high risk children and referral for vaccination at the CESAMO or mass EPI campaigns and follow up of defaulters.
	Nutrition and Vitamin A	Signs of malnutrition and specific deficiencies (marasmus, kwashiorkor, night blindness, anemia, etc.); key messages and cooking demonstrations teaching balance, variety, a sufficient amount in each meal, especially for children and pregnant/lactating mothers; positive, respectful, interaction with families and community, listening skills; building on what people know, since food beliefs and thinking are deeply rooted and difficult to change; sources of vitamin A and their inclusion in each meal; the importance of timely breast feeding, exclusive breast feeding, introduction of foods, and persistence of breast feeding.
	CMD	Understand the spread of gastrointestinal microbes (fecal-oral route) and prevention; key messages on diarrhea prevention, treatment, and rehabilitation; promotion of ORS packets; promotion of ORT corners; know and teach on the danger signs which mean child needs immediate medical attention; referral of severely dehydrated children or those with dysentery.
	FP/MCH	The essentials of male and female reproductive systems; the purpose and importance of FP; answers to commonly asked questions and potential conflicts; listening and observation skills; key messages (content and presentation); positive non-inflammatory interaction with couples/ community; basic types of contraceptives available and easily accessible in the project area; knowledge of correct use; possible difficulties (and solutions); side effects and actions to be taken; general health education targeting pregnant women (nutrition, rest, good hygiene, danger sings which require immediate medical attention, etc.); promote early TT vaccination and refer to the nearest CESAMO; emphasize the critical need for timely and appropriate prenatal care, provided either by a TBA or at the CESAMO; educate the community on the importance of maternal health and involve community leaders committees in ensuring the health of mothers; arranging a system for transporting obstetric emergencies; key messages delivered to all WCBA and community; CHV should be a resource person for all mothers with questions or concerns.
	ALRI	Key messages on ALRI; management of a child with a cough or difficult breathing; recognition, assessment of ALRI cases; signs and classification and referral protocols for ALRI cases; home care; management of the child with an ear problem or sore throat; referral and counter referral protocols; follow-up to assure compliance with treatment/antibiotics prescribed by an authorized health professional.

Trainees	Interventions	Key Concepts/Skills
TBAs	Prenatal care, safe delivery, and postpartum care	Present key messages (timely and appropriate prenatal care, TT immunizations); physical assessment of pregnant women; take an obstetric/medical history; identifying high-risk mothers and referring; education and counseling on proper nutrition (iron rich feeds, adequate weight gain)and other pregnancy related issues; education on danger signs/possible complications and when to access medical help immediately; preparation of the women for labor and delivery; maintenance of a safe-birth kit; normal deliveries performed cleanly and safely/management of appropriate first aid if needed; arranging for a quick response system (transportation) in the event of an obstetric or neonatal emergency; care of the newborn and immediate initiation of breast feeding; counseling mother on child care, EPI, exclusive breast feeding; counsel and educate parents on FP (see Appendix Z).
TOTs	All interventions	IEC skills in every area of intervention; HIS skills; monitoring and supervision skills; facilitation skills; key messages for each intervention and public relations skills.
Commun-ity groups	General orientation	The importance of each intervention to the community; support for CHVs and TBAs; motivational efforts to raise awareness of the existence of these services; sensitivity training; supervision and monitoring skills; key messages on the importance of early prenatal care; promotion of the trained CHVs in the community; obstetric emergency plan of action for the community; key messages on ORS/ORT corners; good hygiene; mass EPI activities.

E.4 Community Health Workers A total of 360 (150 in NS, 60 in SF and 150 in FdC) CHWs will take part in this project. A breakdown of those already trained and active from CS VIII versus those to be recruited by CS XI, is given in the table below.

CHVs To Be Trained or Recruited

Location	Trained & Active (CHW)	To Be Recruited	Total
Nueva Suyapa	0	150	150
San Francisco	45	15	60
Flor del Campo	134	16	150
Total	179	181	360

Although the CHVs are jointly monitored by ADRA field facilitators and the CESAMO staff, they are mainly community women who do not work for any organization for a salary. The ratio of CHVs to the number of families in the community is approximately 1:20 - 30. The supervision plan for CHVs includes review of CHV monthly report by ADRA/CESAMO and feed-back during CHVs monthly meeting. The ADRA/CESAMO facilitators will also do spot-checks both with and without the CHV to determine if the CHV had visited that home and mothers have received education. The CHV attrition rate is estimated to be about 12 percent/year. Reasons for this attrition rate include lack of motivation, employment, and relocation to other communities. Plans for minimizing the rate of replacement include: provision of free consultation and treatment for the CHW and the entire family at the CESAMO (this arrangement is already made with the CESAMO/MOH), priority care for CHVs at Escuela Hospital, recognition and provision of recommendation letter from the Patronatos (local civic government), creation of training opportunities, and a career ladder to become an auxiliary nurse/TBA.

E. 5 Community Committees and Groups

The project will work with various health committees and community groups. ADRA has a facilitator for each of the three project impact areas who along with a facilitator will meet with these community groups and serve as the liaison person. The table below shows the types of groups, frequency of contact, meetings/year, and their responsibilities in each of the three project locations.

Community Committees

Committees	Location	#OC	TBO	PC/M	M/Y	Purpose/Responsibility of the Committees
Patronatos	FdC	5	0	2	12	Local government, recognition, approval and endorsement of CHWs
	SF	2	0	2	12	
	NS	4	0	2	12	
Community Health Committees	FdC	2	1	1	12	Planning community health activities, support Patronato and CESAMO activities, support cleaning/EPI mass campaign
	SF	0	1	1	12	
	NS	0	4	1	12	
Organized Women's Groups/ Mothers' Clubs	FdC	4	0	1	24	Teaching, sewing, cooking, income generation activities, support CESAMO and Patronato activities
	SF	1	1	1	24	
	NS	0	5	1	24	
Inter-institutional Committee	FdC	1	0	1	12	Coordinate all NGO activities in the project area
	SF	1	0	1	12	
	NS	1	0	1	12	

#OC=# of organized committees; TBO=# committees to be organized; PC/M=# of project contact/month; M/Y=# of meetings/year

E.6 Role of Country Nationals The project is fully staffed and managed by qualified nationals. (See Appendix F for resumes of key CS XI staff.) Short-term plans for project staff skill enhancement include the following training activities. In addition, the project CS staff will be encouraged to attend short term skills enhancement training workshops conducted locally by other NGOs, MOH, and UNICEF periodically during the life of the project.

Staff Training

Area of Skills	Trainer	Trainee	Length	Venue for Training	Planned Date
MCH/CS (PIE)	ADRA HQ staff consultants	Project director/ health coordin.	15 days	Nairobi, Kenya	Nov. '95
Same	Same	Same/train./health coords.	15 days	TBA	Nov. '97, '99
Formative Research	Lisa Lynch (consultant)	Same	15 days (theory & practice)	Tegucigalpa	Nov. '95
Management (Financial and Personnel)	ADRA HQ staff	Country/CS project directors	15 days	Silver Spring, MD	March '97,'98, '99
Administration	HADER (local agency)	CS management staff	3 days	Tegucigalpa	March '96
Computer Use	Isaac Coello (local consultant)	HIS and CS proj. coord.	3 days	Tegucigalpa	April '96
Personnel Management	Jair Guarim (local consultant)	Key CS personnel	4 days	Tegucigalpa	January '97, '98

Area of Skills	Trainer	Trainee	Length	Venue for Training	Planned Date
Computer Use (FOX PRO SW)	Juan Burgos (consultant)	Same	15 days	Managua, Nicaragua	February '96

HADER - Honduran Center for Training of Human Resources Development

E.7 Role of Headquarters Staff Milton McHenry (Senior Administrator at ADRA/I) will provide administrative backstopping for this project. Dr. Mike Negerie (Associate Director of Health) will provide technical backstopping from ADRA/I. The following table describes the names and individuals from the PVO/Regional and HQ offices who are responsible for technical and managerial backstopping of the project. (See Appendix B for the resumes of staff backstopping this project at the HQ level.)

Headquarters/Regional Staff Visits

Name	Office	Visit/year	Days/visit	Purpose
Gail Ormsby	HQ	Once	Up to 10	Technical
Dr. Mike Negerie	HQ	Once	Up to 10	Technical
Dr. Solomon Wako	HQ	0.5	Up to 21	Evaluation
Milton McHenry	HQ	Twice	Up to 5	Administration/ Financial Compliance
Walter Britton	Regional office	Twice	Up to 7	Management
Wally Amundson	Regional office	Once	Up to 5	Management

Section F - Project Monitoring Health Information System

F.1 HIS Plan ADRA has identified a full time HIS coordinator who is computer literate to organize and monitor the project health information system. Esther Argeta is a college graduate with training in Economics and has extensive experience in management, training, information gathering, and statistical analysis with Child Survival activities in Honduras. The focus of the HIS will be to create a simple and community friendly data collection system. The project will monitor activities and services provided to beneficiaries at different levels. (See Section F.2 for description of the levels and data collection systems.)

F.2 Data Variables Data will be collected for every intervention to monitor project progress. Four levels of information flow are identified. The first level falls at the household/CHV level. The CHV collects pertinent data (i.e., number of women visited per month, number of key messages given to mothers using a check list, number of follow-ups made, number of children/mothers referred, number of children weighed, number of FP devices distributed, etc.) according to the information from mothers after each house visit, or encounters with the mothers' clubs. The information is compiled and summarized in a simple report by the CHV and submitted to the ADRA and CESAMO facilitators on a monthly basis. The ADRA and CESAMO staff will review the information gathered and determine if any action needs to be taken to augment work strategies or correct errors in data collection and reporting. A feedback activity will take place during the CHV monthly meeting. The ADRA and CESAMO facilitators are responsible for ensuring that the CHVs are adequately and accurately collecting the information at the community level. Copies of the summary reports will be filed at the CESAMO and ADRA office. A feedback session will be arranged every month with the community through the community health committees representing the Patronatoes. The ADRA HIS facilitator will coordinate these activities and report to the director of the CS project every month.

F.3 Data Analysis and Use Data gathered will be analyzed and used to support decision making at appropriate levels of project functions. Results of intervention monitoring/evaluation will be shared at the level they were generated. Summaries of the monthly reports submitted by each CHV/TBA to ADRA/CESAMO will be compiled and results will be disseminated to project staff (by the HIS coordinator), MOH authorities (by the CESAMO director/ADRA project director), the community committees (by the CESAMO social worker), CHVs/TBAs (by the CESAMO/ADRA facilitators), womens' groups (by the CHVs/TBAs), and Patronatos (by

the CESAMO and CHC representative) during their respective monthly and quarterly meetings. By observing trends, data collected on specific variables will be used to improve coverage rates or quality of specific interventions. This also allows the assessment and evaluation of intervention activities implemented in the field (i.e., coverage rates, drop off rates, maternal attendance rates, CHV attrition rates, etc.). The PVO home office and donors will receive copies of all quarterly reports and annual reports, and results of mid-term and final evaluations and the final project report. Collaborating organizations will also receive feed-back on project progress.

The MOH keeps track of annual maternal and child mortality rates in the project area through local vital events registries. Using CESAMO records, morbidity trends for diarrhea, ALRI, measles, polio, and neonatal tetanus will be monitored. These indicators will be used to measure impact. The major effect measurement tool is the mandated KPC 30 cluster sample survey which has been conducted as a baseline and will be repeated at the end of the project. (See accompanying Baseline Survey document for further information.) The following report forms will be used to monitor project progress.

Report Forms - Monitoring

Report Type	Reporting Frequency	Responsible Entity
Training report on: CHVs, TBAs, TOT, ADRA staff, CESAMO staff, community orientation	Per training activity	-ADRA training coordinator -CESAMO training coordinator
Community Health Committee minutes	Monthly	-ADRA training coordinator -Patronato committee -CESAMO social worker
CHV report/checklist	Monthly	-ADRA facilitator -CESAMO supervisor
TBA report	Monthly	-ADRA facilitator -CESAMO midwife/RN
CESAMO EPI report	Monthly	-CESAMO head vaccinator
CESAMO clinic records	Monthly	-CESAMO statistician
CESAMO/ADRA/CHV meeting minutes	Monthly	-ADRA facilitators -CESAMO social worker
CHV/mothers' clubs meetings report	Monthly	-ADRA facilitator -CESAMO social worker
CESAMO antibiotic inventory report	Monthly	-CESAMO pharmacist
Project report	Quarterly	-ADRA project director, HQ
Project financial statement	Monthly	-ADRA project/country director, HQ

Health Information Data Movement Route

Health workers and community groups at each level are expected to report their activities periodically. Below is the health information/monthly reports movement route. Origin, destination, bearer of the report, supervisor, and report type are given.

Origin/Destination	Bearer	Management	Report Type
1. Community Health Volunteers			
Household to CHV	CHV	CESAMO/ADRA staff	CHV monthly report/checklists
CHV to CESAMO/ADRA	CHV	Same	CHV monthly report/checklists
CESAMO to CHC	CESAMO soc.w.	CHC committee	CHV monthly report
CHC to Patronato	CHC chairman	Patronato committee	CHC monthly report/minutes
2. Traditional Birth Attendants			
Household to TBA	TBA	CESAMO/ADRA staff	TBA monthly report/checklists
TBA to CESAMO/ADRA	TBA	Same	TBA monthly report/checklists
CESAMO to CHC	CESAMO soc.w.	CHC committee	TBA monthly report
CHC to Patronato	CHC chairman	Patronato committee	CHC monthly report/minutes
3. Community Committees			
(See CHC and Patronato groups above.)			
4. Training and Orientation Information			
CHV to ADRA	ADRA training coord.	ADRA/Honduras	CHV training report
TBA to ADRA	Same	Same	TBA training report
CHC to ADRA	CESAMO/ADRA	CESAMO/ADRA/H	CHC orientation report
Patronato to ADRA	Same	Same	Patronato orientation report
ADRA/H to ADRA/HQ	Project Director	ADRA country director	CS XI project report
ADRA/HQ to USAID	Senior Administrator	ADCOM	CS XI project report (quarterly/annual/final)

F.4 Other HIS Issues Confidentiality of personal health data will be maintained since the summary of activities will not include names of mothers or any other form or identification. Information is gathered and summarized only on activities and behaviors of mothers. The materials and equipment used for HIS include a project computer with a hard disk and printer, a photocopy machine, calculators, stationary, and forms. (See Appendix U for HIS forms/charts used.) Technical assistance for HIS will be provided as necessary, which includes hiring a local computer expert to provide further training on relevant computer programs to the HIS coordinator and project director. The HIS coordinator will also make a trip to Nicaragua for computer training in the development, reviewing, analyzing, and evaluating of HIS materials. Further technical help will be obtained locally in the third quarter of 1996. The project HIS will be fully operational by January 1997 in NS, and by October 1996 in SF/FdC.

Section G - Budget The following four pages show the working budget for the CS XI project. The first two pages indicate the part of the budget that is allocated to HQ and those costs that will be handled at HQ for reasons of currency and Point of Payment. The second two pages, Honduras field costs, are the actual expenses to be incurred in the field.

ADRA HONDURAS CHILD SURVIVAL XI

Headquarters budget

	First Year		Second Year		Third Year		Fourth Year		All Years	
3 % Inflation rate	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
A. Personnel										
1 Direct Backstopping										
a Grant Manager	2,750	917	2,833	944	2,917	972	3,005	1,002	11,505	3,835
b Health Advisor	2,500	833	2,575	858	2,652	884	2,732	911	10,459	3,486
c Financial Compliance										
Subtotal direct backstopping	5,250	1,750	5,408	1,803	5,570	1,857	5,737	1,912	21,964	7,321
2 Technical support										
a Evaluation	800	267		275	899	283	926	291	2,625	1,116
b Accounting	800	267	824	275	849	283	874	291	3,347	1,116
c Support staff	650	217	670	223	690	230	710	237	2,719	906
Subtotal technical support	2,250	750	1,494	773	2,437	796	2,510	820	8,691	3,138
Subtotal Personnel	7,500	2,500	6,901	2,575	8,007	2,652	8,247	2,732	30,655	10,459
B. Other HQ costs										
1 Communication										
a. Telephone	400	133	412	137	424	141	437	146	1,673	558
b Fax	270	90	278	93	286	95	295	98	1,130	377
c Mail/express	141	47	145	48	150	50	151	51	587	197
Subtotal Communication	811	270	835	278	860	287	883	295	3,390	1,131
2 Report Preparation	350	117	361	120	371	124	382	127	1,464	488
Subtotal other HQ costs	1,161	387	1,196	399	1,232	411	1,266	423	4,854	1,619
Total HQ.	8,661	2,887	8,097	2,974	9,239	3,063	9,513	3,155	35,509	12,078
Total HQ Field Costs	14,250	16,833	7,856	4,669	14,067	4,809	15,059	4,954	51,231	31,266
Total Field Costs	111,597	35,020	110,428	39,088	113,491	37,957	110,520	28,027	446,036	140,092
21 % Indirect Costs	28,247	11,495	26,540	9,814	28,727	9,624	28,369	7,588	111,883	38,522
6 % Unrecovered IdC		8,070		7,583		8,208		8,105		31,967
TOTAL PROGRAM	**162,755**	**74,306**	**152,921**	**64,128**	**165,524**	**63,661**	**163,461**	**51,829**	**644,660**	**253,924**

ADRA HONDURAS FIELD EXTERNAL COSTS

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
C. HQ field costs										
1 Consultants										
a. Health	1,600	533	1,648	549	1,697	566	1,748	583	6,694	2,231
b Management	1,600	533	1,648	549	1,697	566	1,748	583	6,694	2,231
c Financial										
d Training										
e Evaluation					5,250		5,408		10,658	
f HIS			1,500						1,500	
g A-133 Auditor		1,000		1,030		1,061		1,093		4,184
Subtotal Consultants	3,200	2,067	4,796	2,129	8,645	2,193	8,904	2,258	25,545	8,646
2 International travel/per diems										
a Health	1,000	333	1,030	343	1,061	354	1,093	364	4,184	1,395
b Management	1,000	333	1,030	343	1,061	354	1,093	364	4,184	1,395
c Financial										
d Evaluation					2,300		2,369		4,669	
e HIS			1,000						1,000	
f. DIP wkshp	1,200	400							1,200	400
g Baseline	2,400	800		824	1,000	849	1,000	874	4,400	3,347
h Auditing		1,000		1,030		1,061		1,093		4,184
Subtotal travel/perdeims	5,600	2,867	3,060	2,541	5,422	2,617	5,554	2,695	19,636	10,720
Subtotal Consultants+Travel	8,800	4,933	7,856	4,669	14,067	4,809	14,459	4,954	45,181	19,366
3 Procurement										
a. Computer		8,200								8,200
b. Printer		1,300								1,300
c. Copier										
Subtotal Procurement		9,500								9,500
4 Other costs										
a. Baseline surveys	5,000	2,400					600		5,600	2,400
b. DIP orientation	450								450	
Subtotal other costs	5,450	2,400					600		6,050	2,400
Total HQ Field costs	14,250	16,833	7,856	4,669	14,067	4,809	15,059	4,954	51,231	31,266

ADRA HONDURAS CHILD SURVIVAL XI FIELD COSTS

1 % infl.	YEAR 1		YEAR 2		YEAR 3		YEAR 4		ALL YEARS		
ITEM	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	NARRATIVE
A. Salaries											
1 Administrative											
a Regional Director		4,420		4,464		4,509		4,554		17,947	1 pm/yr @ 3750/mo + $670 expat allowance w/6% ann
b Country Director		2,400		2,424		2,448		2,473		9,745	4 pm/yr @ 600/mo w/6% annual inflation
c CS Project Director	8,400		8,484		8,569		8,655		34,107		12pm/yr @ 700/mo w/6% annual inflation
d Health Coordinator	5,400		5,454		5,509		5,564		21,926		12pm/yr @ 450/mo w/6% annual inflation
Subtotal Administrative	13,800	6,820	13,938	6,888	14,077	6,957	14,218	7,027	56,034	27,692	
2 Technical											
a Accountant	3,840		3,878		3,917		3,956		15,592		12pm/yr @ 320/mo w/ annual inflation
b Field Facilitators	15,540		15,695		15,852		16,011		63,099		7x12pm/yr @$185/m w/ annual interest
c HIS Coordinator	3,840		3,878		3,917		3,956		15,592		12pm/yr @ $320/mo w/ annual inflation
d Training Coordinator	3,600		3,636		3,672		3,709		14,617		12pm/yr @ $300/mo w/ annual inflation
Subtotal Technical	26,820		27,088		27,359		27,633		108,900		
3 Support											
a Secretary	6,000		6,060		6,121		6,182		24,362		2 x 12pm/yr @ 173 + 314/mo w annual inflation
b Messenger	1,620		1,636		1,653		1,669		6,578		12pm/yr @ 135/mo w/ annual inflation
c Driver	3,480		3,515		3,550		3,585		14,130		2x12pm/yr @ $145/mo w/ annual inflation
Subtotal support	11,100		11,211		11,323		11,436		45,070		
Subtotal Salaries	51,720	6,820	52,237	6,888	52,760	6,957	53,287	7,027	210,004	27,692	
B Fringes											
1 Separation pay reserve	9,431		9,525		9,621		9,717		38,294		Required by law
2 Vacation pay	2,109		2,130		2,151		2,173		8,563		Required by law
3 Contractee benefits	6,000		6,060		6,121		6,182		24,362		Required by law
4 Salaried benefits	3,980		4,020		4,060		4,101		16,160		Non contract workers
5 Bonus months pay	8,437		8,521		8,607		8,693		34,258		Required by law
Subtotal fringes	29,957		30,257		30,559		30,865		121,637		
Total Personnel	81,677	6,820	82,494	6,888	83,319	6,957	84,152	7,027	331,641	27,692	
C TRAVEL											
1 Domestic Training travel	600		606		612		618		2,436		Mainly for training workshops
Subtotal Domestic	600		606		612		618		2,436		
2 International											
a CS Lessons Learned		2,000								2,000	Regional exchange of lessons
b Conferences			800	1,200	600				1,400	1,200	Administrative travel to CS conferences
Subtotal International		2,000	800	1,200	600				1,400	3,200	
Subtotal Travel	600	2,000	1,406	1,200	1,212		618		3,836	3,200	

1 % infl.	YEAR 1		YEAR 2		YEAR 3		YEAR 4		ALL YEARS		
ITEM	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	NARRATIVE
D Equipment											
a Vehicle		20,500								20,500	Heavy-duty van
b Radio System		4,700								4,700	1 base system, 2 mobile units
c Desk, Table and Chairs	600				300				900		
Subtotal equipment	600	25,200			300				900	25,200	
E. Supplies											
a Office Supplies	2,500		2,500		2,599		2,500		10,099		Routine Office Supplies, paper, etc.
b Nutrition Supplies	200		200		200		200		800		Nutritional teaching supplies
c Project Identification	1,350		1,364		1,800		1,190		5,704		Notebooks, pencils carry bags
d. ALRI timers	1,000		1,000						2,000		Digital timers/watches, 400@$5
e Medicines		1,000		1,000		1,000		1,000		4,000	Incidental antiparasitic/antibiotic
Subtotal supplies	5,050	1,000	5,064	1,000	4,599	1,000	3,890	1,000	18,603	4,000	
F Contractual											
1 Consultants, HIS	300				300				600		Local help
2 Consultants, Focus groups	300				300				600		Local help
3 Consultants, CMD/Nutrition	300				300				600		Local help
Subtotal contractual	900				900				1,800		
G. Other Direct Costs											
1 Communications	1,800		1,800		1,800		1,800		7,200		Telephone, fax, express mail
2 Facilities											
a Office Rental	1,800		1,818		1,836		1,855		7,309		Office at $133/m
b Building/equipment insure.	480		485		490		495		1,949		Fire/theft
c Equipment repair	350		354		357		361		1,421		Office equipment repair
d Utilities	240		242		245		247		974		Water, Electricity
Subtotal Facilities	2,870		2,899		2,928		2,957		11,653		
3 Training workshops	7,800		7,878		7,957		8,036		31,671		Training of TOTs, CHVs
Subtotal Training	7,800		7,878		7,957		8,036		31,671		
4 a Printing	800		808		816		824		3,248		Volunteer training manuals
b Sanitation Component				15,000		15,000		10,000		40,000	Water and septic
c Income Generation Project				15,000		15,000		10,000		40,000	Small Enterprise Projects
d Shipping/Clearing	1,500				1,500				3,000		Import paperwork, costs
e Vehicle fuel/oil	3,600		3,636		3,672		3,709		14,617		For two vehicles
f Vehicle Maintenance	2,000		2,020		2,040		2,061		8,121		For two vehicles
g Vehicle Insurance	2,400		2,424		2,448		2,473		9,745		For two vehicles
Subtotal other	10,300		8,888	30,000	10,477	30,000	9,067	20,000	38,732	80,000	
Subtotal Other Direct Costs	22,770		21,465	30,000	23,161	30,000	21,860	20,000	89,256	80,000	
TOTAL FIELD COSTS	111,597	35,020	110,428	39,088	113,491	37,957	110,520	28,027	446,036	140,092	

Section H - Sustainability Strategy

H.1 Sustainability Goals, Objectives, and Activities

DIP Table E: Sustainability Goals, Objectives, and Activities

Sustainability Goals	Objectives	Activities Required
-Establish functioning community health committees (CHC)	-100 percent (8) of the CHCs provide support to the CHVs	-6 new CHCs organized, oriented -Follow-up supervision of CHCs by Patronato to institutionalize the support -CHCs supervise CHVs, review CHV reports, recognize CHVs, and replace CHV dropouts -Obtain monthly reports from CHCs -CESAMOs provide technical support to CHVs -CHC chairmanships rotated yearly -CHC reps attend CESAMO/ADRA and CHV monthly meetings
-Establish functioning community womens' groups/clubs	-100 percent (11) of the mothers clubs will be organized	-6 new mothers' clubs formed, oriented, and trained -5 old mothers' clubs retrained -Periodic follow up/supervision of all mothers' clubs by CHVs, CESAMO staff, and ADRA -Monthly meetings of mothers' clubs -Educational activities held
-Strengthen local Patronato committees	-100 percent (11) Patronato committees oriented and given oversight reponsibiity of CHCs	-Monitor monthly CHC reports -Reps attend CESAMO/ADRA and CHC monthly meetings -Organize community health events (EPI mass campaigns, cleaning)
-Each community/CESAMO assumes responsibility for running its own CS activities	-100 percent (360) of the CHVs will be active -CHVs are not salaried but supported by community -100 percent of CHCs will collaborate with CESAMO to supervise CHVs -A financial system for the up-keep of CS activities/purchase of supplies will be designed -TOT for CESAMO staff on management -Integrate community CS activities with the CESAMO/MOH PHC plan of action	-181 new CHVs recruited/trained -179 old CHVs retained/retrained -CHVs recognized by Patronato publicly -30 TBAs trained -Monthly CHV meeting held -Fee for services/supplies introduced as decided by the community -Community and CESAMO staff trained on supervision of CHVs/TBAs -Coordination of existing community organizations -Involvement of CHVs in PIE of CS project
-Improve linkage between CESAMO/MOH and the community groups	-Open communication between community groups and CESAMO/MOH -Demonstrate sensitivity to community needs as voiced by CHC and Patronatoes	-Regular meeting between CESAMO/MOH and Patronato/CHC -MOH representatives attend monthly CHC committees and vice versa -Sharing information and feedback on monthly reports -Referral and communication protocols established with the CESAMO/Hospital Esquela
-Empower mothers as primary health givers	-Recruit and train 360 CHVs to educate mothers -Recruit/train 30 TBAs to educate mothers	-CHVs and TBAs educate mothers on each CS intervention during monthly home visits and womens' club meetings -CHVs/TBAs monitored and supervised

H.2 Sustainability Plan At the conclusion of this program, the Child Survival project expects to leave in place the following: 1) 360 trained CHVs and 30 TBAs; 2) Eight functioning community health committees; 3) groups from the community that are supportive of the CS activities including 11 Patronato bodies and 11 womens' clubs; and 4) CESAMO staff trained in CS interventions and management. The local institutions and organizations that will continue to finance and provide support after CS funding is over include Ministerio Comunitario Integral (MCI). MCI will provide medical assistance and primary schooling for children, and *Familia de Niños Adelantados* (FANIA), a Canadian supported local NGO, will introduce micro enterprise development activities. The CESAMO/MOH is committed to continue with the CS activities in the project area. While the CS project does not directly address economic issues, the small micro enterprise development program associated with this project will impact on the mothers' economic status.

H.3 Community Involvement Plans for community involvement and sustainability include the active participation of key community institutional committees such as the Patronato. The project will build a community network with key persons from the civic and non-civic leaders. Meetings will be held for generation of ideas and creation of proposals for solutions to the barriers to CS sustainability. Patronatos will be continuously informed of the CS needs, and will present them to higher government authorities, a common method used to solve community needs. The CS interventions will be implemented mainly through mothers' clubs and health committees at the Patronato level. (See Appendix V for the relationship of community groups with ADRA administration.) The authority for maintaining community committees rests on established Patronatoes, with supervision from the CESAMO, which should assure continued participation and sustainability.

Community priorities are diarrheal diseases, ALRI as a major cause of morbidity of children less than two, intestinal parasites, dermatological infections, and family planning. There is a high incidence of teenage pregnancy, gynecological, and maternal complications.

The fact that CHVs have been utilized effectively in CS VIII shows that the community is interested in CS services. The Baseline Survey has also shown improvement in every intervention since the CS project began in 1992, serving as evidence that the community wants and is responding to the provision of CS services. Continued public involvement will be encouraged through social marketing. All the community groups and CHVs discussed so far will keep motivating the public through education which would increase awareness as to the importance and availability of CS services in the project area.

H.4 Phase-over Plan The ownership of the CS project would be the CESAMOs and the community at the end. At present, the CESAMO in SF and FdC are already responsible for 40 percent of the program. It is planned to increase 15 percent ownership of the program every year during the four years of the project life so that at the end, 100 percent ownership would be theirs. In NS there is currently 20 percent ownership of CS interventions by the CESAMO. The first two years there will be 15 percent transfer of responsibilities and 25 percent per year during the last two years of the program. This will be achieved through training and developing the linkage between the CESAMO and community health functions. (See Section H.1 and H.3 for details on sustainability of activities.)

H.5 Cost Recovery In line with the MOH policy, ADRA will not participate in any cost-recovery activities (i.e., sale of condoms, drugs, charts). However, the MOH guidelines stipulate that the community costs are based on what the CESAMO charges. These charges are minimal and heavily subsidized by the MOH. Although ADRA is not involved with cost recovery, its companion SED project (matching funds) does seek to improve the economy of the community.

Section I - ADRA's Matching Fund - the SED Project During the initial funding cycle, a trial SED project was funded through the GOH that gave loans to some of the health workers as an incentive to continue their volunteer activities. Although there were some problems with the design and administration of the SED project, the results from the beneficiaries' standpoint were very encouraging. Anecdotal reports said that those who benefited from the program were better able to attend their volunteer duties.

ADRA/Honduras will seek funding again to provide a similar loan program for selected health workers during this project cycle.

The program will be organized so that those health workers who want to participate can apply to ADRA for the funds. The actual loan management will be done by ADRA facilitators of the community under the control of a staff member who will be funded by the SED project. Fifty to $300 dollar loans will be lent for periods of three to four months. About 80 loans will be maintained by the second year of the project, 100 more loans will be added the third year, and 40 would be added the final year, for a total to 220 rotating loans. Interest levels would be such as to be able to cover the administrative costs (coordinator salary, transportation needs) of the project, as well as to

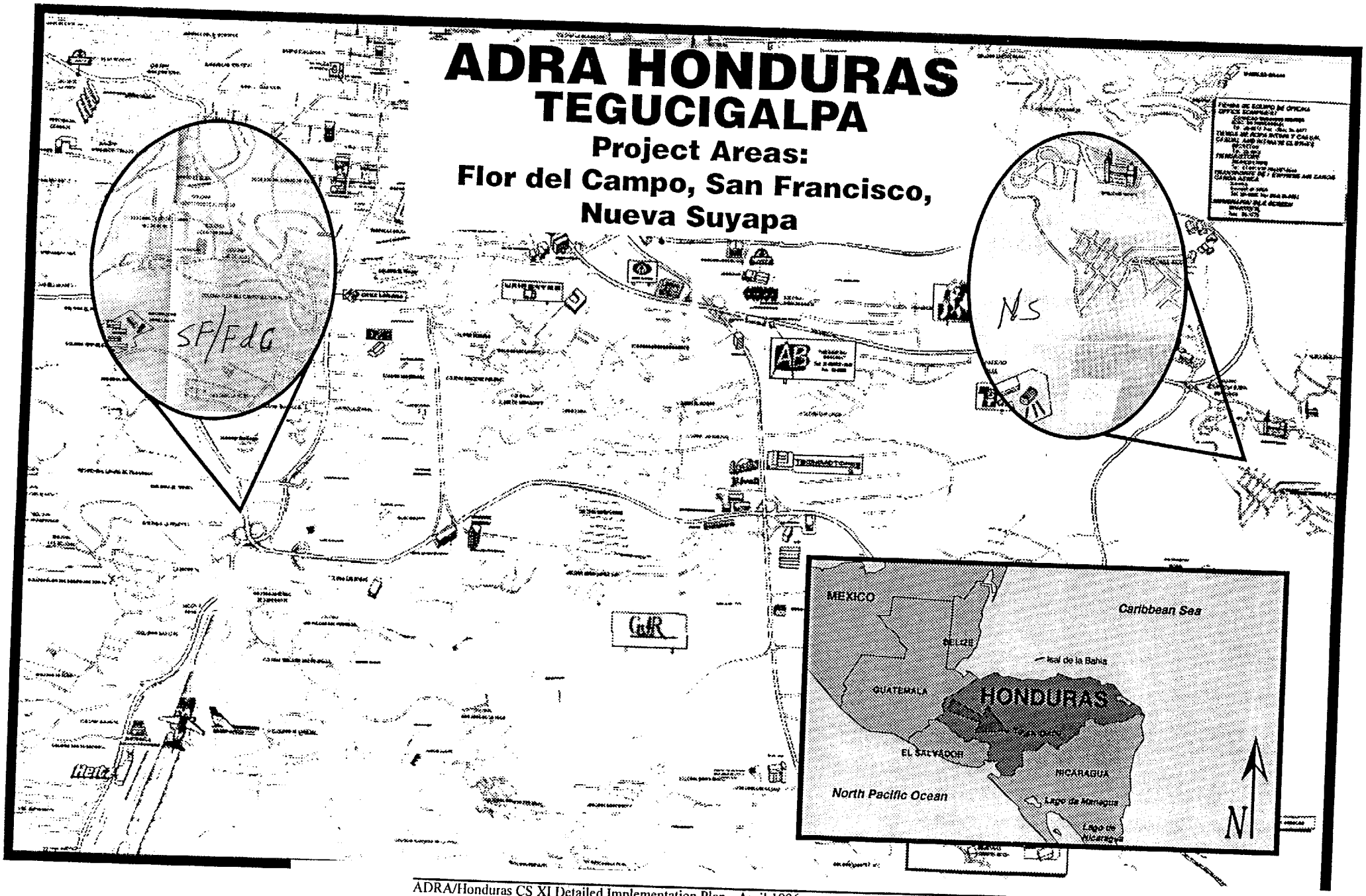
protect the value of the loan fund. The SED project should be self-financing at the end of the CS project and will be set up to continue on in a sustained fashion.

Section J - Sanitation Component In support of the CMD intervention, ADRA/Honduras will also seek to fund a water distribution project in the area of ADRAs interventions. Whereas the GOH has installed potable water to areas near the project area, it is still not accessible to most of the population in these areas. ADRA will work with the Patronatos of the barrios and with the municipal infrastructure engineers to extend the piping of the water to make it more readily available to the beneficiaries in the project area. In the NS area, some latrines will be constructed.

Appendix A

Map of Project Location

ADRA HONDURAS
TEGUCIGALPA
Project Areas:
Flor del Campo, San Francisco, Nueva Suyapa



Appendix B

ADRA Headquarters Staff Resumes

Milton D. McHenry
12309 Treetop Drive, #13
Silver Spring, MD 20904
(301) 680-5129

Education:

1968-1972	Bachelor of Science, Industrial Technology Pacific Union College, CA

Experience:

1993-present	Senior Manager Adventist Development & Relief Agency International, Silver Spring, MD
1992-1993	Assistant Director, Community Development, Contracts Manager ADRA/International, Silver Spring, MD
1990-1992	Owner/Operator McServices Construction, Paradise, CA
1986-1990	Crew Supervisor Paradisewood Development, Paradise, CA
1984-1986	Country Director ADRA/Bolivia
1980-1984	Business Manager Lake Titicaca Training School, Juliaca, PERU
1975-1980	Maintenance Manager/Construction Supervisor Bolivian Educational Center, Cochabamba, BOLIVIA

Gail Ormsby
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301-680-6383

Education

1985	Bachelor of Education Avondale College, NSW, Australia
1977	Diploma of Secondary Education (Applied Arts) Avondale College, NSW, Australia
1982	Master of Public Health (Nutrition) Loma Linda University School of Public Health, Loma Linda, CA, USA

Work Experience

Dec 1995 - Present	Director of Health, ADRA International Silver Spring, MD
1993-Nov. 1995	Senior Manager, ADRA International Silver Spring, MD
1990-Oct. 1993	Director, Human Resource Development, ADRA International Silver Spring, MD
1987-1990	Director, Nutritional Education Service, Sanitarium Health Food Company, Sydney, NSW, Australia
1985-1987	Associate Director, Adventist Health Department, South Pacific Division Sydney, NSW, Australia
1983-1985	Director of Health & Temperance Department, North New South Wales Conference of SDA, Hamilton, NSW, Australia
1983 Feb-Jul	Nutrition Consultant, Nutrition Project with Government St Lucia, Inter American Division, FL, USA
1982 Oct-Jan	Assistant to Program Planning & Evaluation, Seventh-day Adventist World Service (predecessor to ADRA), Takoma Park, MD, USA
1981-1982	Field Practicum, Bandung Adventist University, Indonesia
1975-1980	Teacher, Avondale SDA High School, Cooranbong, NSW, Australia Teacher, Mt Gravatt SDA High School, Brisbane, QLD, Australia Teacher, Strathfield SDA High School, Sydney, NSW, Australia Teacher, Mt Gravatt SDA High School, Brisbane, QLD, Australia

Professional Membership

American Dietetic Association

Mekebeb Negerie
12501 Old Columbia Pike
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301-680-5138

Education

1990-1994	DrPH Loma Linda University, School of Public Health, Loma Linda, CA
1985	Graduate Study for six months University of the Philippines, Philippines
1983-1985	MPH Philippine Union College, Philippines
1980-1983	BSc, Agriculture University of Eastern Africa, Kenya

Work Experience

Aug 1995 - Present	Associate Director of Health, ADRA International Silver Spring, MD
1991-1994	Refletron Lab Technician and Counselor, Center for Health Promotion Loma Linda University, Loma Linda, CA (part-time)
1990-1994	Circulation Desk Technician, Loma Linda University Library Loma Linda, CA (part-time)
1987-1989	Project Director for ADRA/Southern Sudan
1987	Mother and Child Health Project Consultant, Egypt (part-time)
1986	Mother and Child Health Coordinator, ADRA/Sudan
1985	Conducted Smoking Cessation Program for Military Personnel Philippine Union College
1983	Farm Shop Supervisor, Kenya
1980-1982	Painting, Construction, Gardening, Kenya
1979-1980	Music Instructor and Choir Director, Ethiopia

Consultancies (Primary Health Care and Child Survival)

1987-1995	Egypt, Sudan, Uganda, Eritrea, Honduras, Kenya

Languages

English, Amharic, Oromo, Arabic, Swahili

Solomon Wako
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301-680-5118

Education

1984	Doctor of Philosophy, Sociology Western Michigan University, Kalamazoo, MI, USA
1979	Master of Social Work Western Michigan University, Kalamazoo, MI, USA
1977	Master of Divinity Andrews University, Berrien Springs, MI, USA
1975	Master of Arts, Systematic Christian Theology Andrews University, Berrien Springs, MI, USA
1973	Bachelor of Arts, Major in Religion, Minor in History Newbold College, Bracknell, Berkshire, ENGLAND

Positions

1992 - Present	Director of Evaluation Adventist Development and Relief Agency International, Silver Spring, MD
1988-1990	Coordinator of MSW Program Indiana University at Fort Wayne, Fort Wayne, IN, USA
1987-1988	Assistant Professor of Social Work and Sociology Nebraska Wesleyan University, Lincoln, NE, USA
1984-1987	Assistant Professor of Social Work and Sociology Kearney State College, Kearney, NE, USA
1979-1982	Medical Social Worker Michigan Department of Social Services, USA

Professional Membership

National Association of Social Workers (NASW)
Academy of Certified Social Workers (ACSW)
African Studies Association
Midwest Sociological Society
American Sociological Association (ASA)

Lars Gustavsson
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301-680-6381

Education

1990	Masters Degree in Business Administration Andrews University, Berrien Springs, MI, USA
1980	Graduate studies in Business Administration University of Tennessee, Chattanooga, TN, USA
1979	Bachelor of Science in Business Administration Southern College, Collegedale, TN, USA
1979	Associate of Science in Industrial Arts Southern College, Collegedale, TN, USA
1976	French Language studies French Language Institute, Seminaire Adventiste, Collonges-sous-Saleve, France

Employment

1993 - Present	Senior Administrator, Adventist Development and Relief Agency International (ADRA), Silver Spring, MD, USA
1991 - 1993	Director for the Office of Food Supported Development, ADRA International Silver Spring, MD, USA
1990 - 1991	Assistant Director for Community Development Programs, ADRA International Silver Spring, MD, USA
1989 - 1990	Full-time study program--completing MBA
1987 - 1989	Country Director and Chief of Party for ADRA in Rwanda Kigali, Rwanda, East Africa
1987 - 1989	Director for the Adventist Health Systems for Rwanda Kigali, Rwanda, East Africa
1982 - 1987	Assistant Business Manager, Adventist University of Central Africa Gisenyi, Rwanda, East Africa
1980 - 1982	Telephone Technician, Ooltewah-Collegedale Telephone Company Collegedale, TN, USA
1979 - 1980	Architectural design and delivery of European high-end market specialty business and home furnishings, Luminaire, Miami, FL, USA

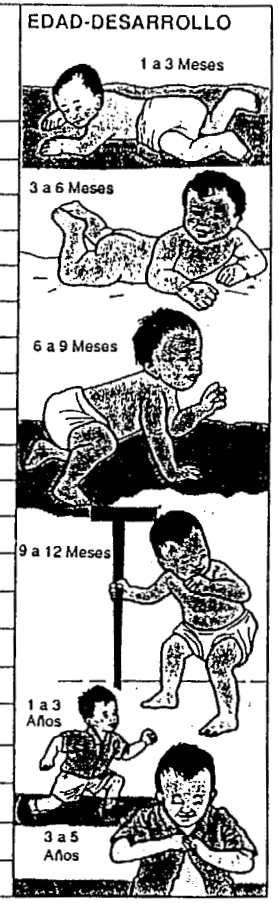
Languages

English, Swedish, French, Pigeon - excellent; Norwegian, Danish - good
Spanish, Dutch, German - some

Appendix C\D

MOH EPI Card/Growth Monitoring Card

FECHA	PESO	SUBIO PESO	MAN-TUVO PESO	BAJO PESO	INFECCION RESPIRATORIA	DIARREA	ALIMEN-TACION L. M.	OTROS



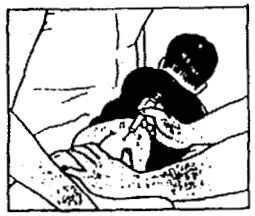
TARJETA DEL NIÑO

IDENTIDAD _____ EDAD _____
FECHA DE NACIMIENTO _____
DIRECCION _____
RESPONSABLE _____
ESTABLECIMIENTO _____

MINISTERIO DE SALUD PUBLICA
REPUBLICA DE HONDURAS

ANTIPOLIOMIELITIS(Cuatro dosis)

- ◯ Recien nacido ___ ___ ___
- ◯ 1ra DOSIS ___ ___ ___
- ◯ 2da DOSIS ___ ___ ___
- ◯ 3ra DOSIS ___ ___ ___
- ◯ OTRAS ___ ___ ___



DIFTERIA, TOSFERINA, TETANOS (D.P.T.) Tres dosis

- ◯ 1ra DOSIS ___ ___ ___
- ◯ 2da DOSIS ___ ___ ___
- ◯ 3ra DOSIS ___ ___ ___

ANTISARAMPION (Una dosis)

- ◯ 1ra DOSIS ___ ___ ___

ANTITUBERCULOSIS (B C G) (Tres dosis)

- ◯ 1ra DOSIS ___ ___ ___ R.N.
- ◯ 2da DOSIS ___ ___ ___ 7 AÑOS
- ◯ 3ra DOSIS ___ ___ ___ 12 AÑOS

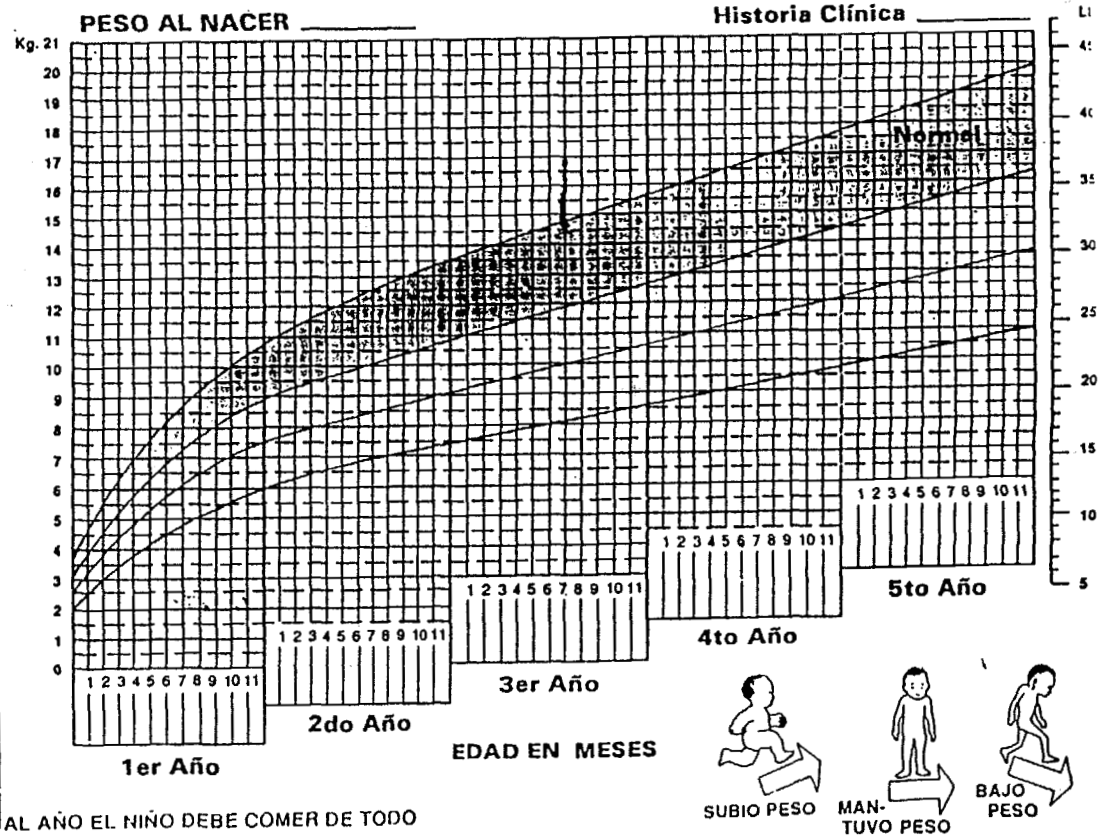
Alimentación DEL NIÑO

AL AÑO EL NIÑO DEBE COMER DE TODO

GRAFICA DE PESO PARA EDAD

Vitamina A ___ ___ ___ ___ ___ ___

PESO AL NACER _____ Historia Clínica _____



Appendix E

Recruitment and Training Plan for CHVs

Recruitment and Training of Volunteers

Nueva Suyapa
1996

January 18-February 29	Volunteers recruitment and contact with leaders of organized groups
March 11 -15	Training--CESAMO and ADRA staff
March 25 - 29	Training (first module)-50% of volunteers recruited in Flores de Oriente and sector Universidad
April 15 - 19	Training(first module) - the next 50% of volunteers recruited in Flores de Oriente and Sector Universidad
April 20 on	During this period we will organize the groups of volunteers (the whole group)
May 6 - 10	Training (second module) first group of volunteers
May 27 - 31	Training (second module) second group of volunteers
	June and July will be used to supervise, monitor and refresher training of the 45 volunteers of Flores de Oriente and Sector Universidad trained in the two modules. This includes monthly meetings with the CESAMO field staff, report submittance and weekly meetings with volunteers.

San Francisco
1996

August 12 - 16	Training - TOT - interventions in which the staff needs reinforcement
August and September	Recruitment of community leaders and volunteers for the area of Nueva Suyapa (45 volunteers)
October 7 - 11	Training on the first module for the first group of volunteers
October 28 - November 1	Training on the second module for the second group of volunteers
November and December	Refresher trainings, follow-up and monitoring of all the activities carried on by the volunteers

San Francisco and Flor del Campo

1996

February 19 - 23	To train 36 volunteers - 6 of them are midwives
September 9 - 14	Training on the second module in San Francisco and Flor del Campo

1997

January 13 - 17	Training on the first module for volunteers (25) in San Francisco and Flor del Campo
August 25 - 29	Training on the second module - 25 volunteers

Nueva Suyapa

1997

January 20 - 24	Training on the second module for the first group of volunteers
	The last week of January and first week of February, will be used for refresher training in a continual bases of knowledge in the second module and logistic support to volunteers
January 10 - 14	Training on the second module for the second group of volunteers
	The two last weeks of February and the month of March will be for supervision, monitoring and refresher of the 90 volunteers recruited and trained.
Third week of March	Training of ADRA-CESAMO and PVO staff
April	Recruitment of volunteers in Brisas de Suyapa (7) La Libertad (8)
May 5 - 9	Training on the first module to volunteers - Brisas de Suyapa and La Libertad
July, August, September	Refresher, follow-up, and monitoring with all the volunteers that have been trained and are active
November 17 - Dec 12	Recruitment of leaders and volunteers of Aldea Nueva Suyapa

1998

January 12 - 16	Training on the first module for volunteers of Aldea Nueva Suyapa
February 16 - 20	Training on the second module of volunteers of Aldea Nueva Suyapa
April 20 - May 20	Recruitment of volunteers in the area of FECHOVILI and Guillermo Matute
June 8 - 12	Training on the first module - 21 volunteers
August 3 - 7	Training on the second module of the areas FECHOVIL and Guillermo Matute

Appendix F

Resumes of Key CS XI Staff

Blanca Esther Hidalgo Carias
ADRA/Honduras, Colonia 15 de Setiembre
Tegucigalpa, HONDURAS

Education

1984 - 1992	MD in General Medicine and Surgery National Independent University of Honduras
1982 - 1983	Bachelor of Science

Work Experience

1995	Honduras Public Health Ministry, Roatan, Bahia Islands. Control and Prevention of Cholera.
1993-1994	Valle de Angeles Adventist Hospital. General Medicine.
1991-1992	Santa Teresa Departmental Hospital, Comuyagua. General Medicine.

Citizenship

Honduras

Esther Elizabeth Rodriguez de Argueta
ADRA/Honduras, Colonia 15 de Setiembre
Tegucigalpa, HONDURAS

Education

1991	Economical Science Degree (Economist) Honduras National University
1986	Economical Sciences Central American University, José Simeón Canas, El Salvador
1981	Secondary School, Central American Adventist Institute, Alajuela, Costa Rica

Post-Graduate

Small Enterprise Management - PROPEMI, San Salvador

Small Enterprise Accounting - national Associate of Private Companies

Pedagogical Training
Central American Post Graduate Course in Economics and Development planning - Tegucigalpa, M.D.C.

Maximization of Health Volunteers Work Course
International Eye Foundation, HOPE/Honduras OH/Honduras

Work Experience

1994	HIS Coordinator, Child Survival, Project ADRA Honduras
1993	Project Design "Mother's Enterprises" Tegucigalpa, ADRA/Honduras
1992	Project Design, Child Survival, Valle de Angeles, F.M.
1990	Consultant Assistant to Susan Fleck for "Survey over Boarding Women"Omoa Cortes for UNIFEM

Nationality Salvadoran

Ana Gloria Ortiz Lainez
ADRA/Honduras, Colonia 15 de Setiembre
Tegucigalpa, HONDURAS

Education

1963	Bachelor Degree - Nutritionist
1976	Secondary: Adventist Educational Center, Pena Blanca, Honduras

Work Experience

1984	Nutritionist at the Valle de Angeles Hospital, Honduras, C.A. Talks and Seminars Diests Coordinator - Valley de Angeles Hospital, Honduras, C.A.
1993	Training Coordinator, Child Survival Project XI, ADRA/Honduras

Nationality Honduran

Nelson Tabares Rodriguez
ADRA/Honduras, Colonia 15 de Setiembre
Tegucigalpa, HONDURAS

Education

1971	B.A. (Adventist Theological faculty, Adventist University Cooperation, Medellin, Colombia) Major in Theology Minor in Education and administration
1967	Secondary Diploma Colombo-Venezolano Institute, Medellin

Work Experience

1993 - Present	Director, Child Survival Project, ADRA/Honduras
1989 - 1992	Director, National Committee for Social Well-Being, Center for Attention of Minors of Tegucigalpa Director for Community Center of Juticalpa and Gracias Lempira
1987 - 1989	Program Department Director, Save the Children, Honduras
1985 - 1987	Assistant Director for National Education Extension Program, Consuplane
1984	Field Delegate, Red Cross, Honduras

Appendix G

Key Nutrition/Health Messages for Mothers

Breastfeeding Prime Messages

1 Breastmilk alone is the best possible food and drink for a baby. No other food or drink is needed for about the first six months of life.

2 Babies should start to breastfeed as soon as possible after birth. Virtually every mother can breastfeed her baby.

3 Breastfeeding causes more milk to be produced. A baby needs to suck frequently at the breast so that enough breastmilk is produced to meet the baby's needs.

4 Breastfeeding helps to protect babies and young children against dangerous diseases. Bottle-feeding can lead to serious illness and death.

5 A variety of additional foods is necessary when a child is about six months old, but breastfeeding should continue well into the second year of a child's life and for longer if possible.

6 Breastfeeding gives a mother 98% protection against pregnancy for six months after giving birth - *if* her baby breastfeeds frequently, day and night, *if* the baby is not regularly given other food and drink, and *if* the mother's periods have not returned.

Breastfeeding Supporting Information

1

Breastmilk alone is the best possible food and drink for a baby. No other food or drink is needed for about the first six months of life.

O From the moment of birth up to the age of about six months, breastmilk is all the food and drink a baby needs. It is the best food a child will ever have. All substitutes, including cow's milk, infant formula, milk-powder solutions, and cereal gruels, are inferior.

O Even in hot, dry climates, breastmilk contains sufficient water for a young baby's needs. Additional water or sugary drinks are not needed to quench the baby's thirst. They can also be harmful. If the baby is also given water, or drinks made with water, then the risk of getting diarrhoea and other illnesses increases.

O Other foods and drinks are necessary when a baby reaches the age of about six months. If monthly weighing shows that a child under six months of age is not growing well, then the child may need more frequent breastfeeding. If the child is already being breastfed frequently, then lack of weight gain shows either that the child has an illness or that other foods, in addition to breastmilk, are now necessary.

O Until the age of nine or ten months, the baby should be breastfed before other foods are given. Breastfeeding should continue well into the second year of life - and for longer if possible.

2

Babies should start to breastfeed as soon as possible after birth. Virtually every mother can breastfeed her baby.

O Mothers and newborn babies should not be in different rooms. The baby should be allowed to suck at the breast as often as he or she wants.

O If a mother gives birth in a maternity unit, then she has a right to expect that her newborn baby will be kept near her in the same room, 24 hours a day, and that no other food or drink will be given to her bab except breastmilk.

O Starting to breastfeed immediately after birth stimulates the production of breastmilk. Breastfeeding should begin not later than o hour after the delivery of the baby.

O The thick yellowish milk (called colostrum) that the mother produ in the first few days after birth is good for babies. It is nutritious and he to protect them against common infections. The baby does not need a other food or drink while waiting for the mother's milk to 'come in'. In some countries, mothers are advised not to feed this colostrum to thei babies. This advice is wrong.

O Many mothers need help when they begin to breastfeed, especiall the baby is their first. An experienced and sympathetic adviser, such a woman who has successfully breastfed, can help a mother avoid or so many common problems.

O The position of the baby on the breast is very important. A bad suc position is the cause of problems such as:

- sore or cracked nipples
- not enough milk
- refusal to feed.

O Signs that the baby is in a good position for breastfeeding are:

- the baby's whole body is turned towards the mother
- the baby takes long, deep sucks
- the baby is relaxed and happy
- the mother does not feel nipple pain.

O Almost all mothers can produce enough milk if:

- the baby takes the breast into his or her mouth in a good position
- the baby sucks as often, and for as long, as he or she wants, includ during the night.

O Crying is not a sign that a baby needs artificial feeds. It normally means that the baby needs to be held and cuddled more. Some babie need to suck the breast simply for comfort. If the baby is hungry, mor sucking will produce more breastmilk.

O Mothers who are not confident that they have enough breastmilk give their babies other food or drink in the first few months of life. Bu means that the baby sucks at the breast less often. So less breastmilk produced. To stop this happening, mothers need to be reassured that they can feed their young babies properly with *breastmilk alone.* They need the encouragement and practical support of their families, the cl father, neighbours, friends, health workers and women's organizatio

O Mothers employed outside the home need adequate maternity leave, breastfeeding breaks during the working day, and crèches where their babies can be looked after at the workplace. So employers and trade unions also have a part to play in supporting breastfeeding.

O Husbands, families, and communities can help to protect the health of both mothers and babies by making sure that the mother has enough food and by helping with her many tiring tasks.

O Breastfeeding can be an opportunity for a mother to take a few minutes of much-needed rest. Husbands or other family members can help by encouraging the mother to lie down, in peace and quiet, while she breastfeeds her baby.

3

Breastfeeding causes more milk to be produced. A baby needs to suck frequently at the breast so that enough breastmilk is produced to meet the baby's needs.

O From birth, the baby should breastfeed whenever he or she wants to - often indicated by crying. Frequent sucking at the breast is necessary to stimulate the production of more breastmilk.

O Frequent sucking helps to stop the breasts from becoming swollen and painful.

O 'Topping up' breastmilk feeds with milk-powder solutions, infant formulas, cow's milk, water, or other drinks, reduces the amount of milk the baby takes from the breast. This leads to less breastmilk being produced. The use of a bottle to give other drinks can cause the baby to stop breastfeeding completely. It can also confuse the baby because the sucking action of bottle-feeding is very different from sucking at the breast. Babies who are confused between sucking at the breast and sucking at the bottle may drink less breastmilk. This will cause less breastmilk to be produced.

4

Breastfeeding helps to protect babies and young children against dangerous diseases. Bottle-feeding can lead to serious illness and death.

O Breastmilk is the baby's first 'immunization'. It helps to protect the baby against diarrhoea, coughs and colds, and other common illnesses. The protection is greatest when breastmilk alone is given to the baby for about the first six months.

O Cow's milk, infant formulas, milk-powder solutions, maize gruel and other infant foods do not give babies any special protection against diarrhoea, coughs and colds, and other diseases.

O Bottle-feeding can cause illnesses such as diarrhoea unless the water is boiled and the bottle and teats are sterilized in boiling water before each feed. The more often a child is ill, the more likely it is that he or she will become malnourished. That is why, in a community without clean drinking water, a bottle-fed baby is many times more likely to die of diarrhoea than a baby fed exclusively on breastmilk for about the first six months.

O Mothers should be helped to breastfeed their babies. If for any reason a mother does not breastfeed, then she should be helped in other ways to give her baby good nutrition and protection against disease.

O The best food for a baby who, for whatever reason, cannot be breastfed, is milk squeezed from the mother's breast. It should be given in a cup that has been very well cleaned. Cups are safer than bottles and teats because they are easier to keep clean.

O The best food for any baby whose own mother's milk is not available is the breastmilk of another mother.

O If non-human milk has to be used, it should be given from a clean cup rather than a bottle. Milk-powder solutions should be prepared using water that has been boiled and then cooled.

O Cow's milk, infant formula, or milk-powder solutions can cause poor growth if too much water is added in order to make them go further.

O Cow's milk and milk-powder solutions go bad if left to stand at room temperature for a few hours. Breastmilk can be stored for at least eight hours at room temperature without going bad.

O In low-income communities, the cost of cow's milk or powdered milk plus bottles, teats, and the fuel for boiling water, can be as much as 25-50 of a family's income.

5

A variety of additional foods is necessary when a child is about six months old, but breastfeeding should continue well into the second year of a child's life and for longer if possible.

O Although children need additional foods after about the first six months of life, breastmilk is still an important source of energy and protein, and other nutrients such as vitamin A, and helps to protect against disease during the child's second year of life.

○ A mother can continue to breastfeed her child for as long as she wishes, but it is best for her own and her children's health if she avoids becoming pregnant again until her youngest child has reached the age of two years. Most methods of avoiding pregnancy - including condoms, IUDs, and voluntary sterilization - do not affect breastfeeding. 'Minipills' and injectable contraceptives also have no effect on breastmilk providing that they contain no oestrogen. But conventional contraceptive pills can reduce the amount of breastmilk.

○ Babies get ill frequently as they learn to crawl, walk, and play. A child who is ill needs breastmilk. It provides a nutritious, easily digestible food when the child loses appetite for other foods.

○ Between the ages of one and two, a baby benefits from breastmilk as well as needing family foods. Breastfeeding is good for the child as part of a meal, or between meals, or whenever the child feels hungry. But at this time, all children need other foods. In the second year of life, breastfeeding should be an addition to, not a substitute for, normal meals.

○ Breastfeeding also comforts a child when he or she is frightened, hurt, angry, or tearful.

6

Breastfeeding gives a mother 98% protection against pregnancy for six months after giving birth - *if* her baby breastfeeds frequently, day and night, *if* the baby is not regularly given other food and drink, and *if* the mother's periods have not returned.

○ It is now known that the sucking of the baby on the mother's breast causes a delay in the return of the mother's fertility. For some women, breastfeeding delays the return of menstrual periods for up to 12 months - or even longer. For other mothers, menstrual periods return only three or four months after giving birth.

○ How often the baby sucks at the mother's breast is the most important fact in deciding how long it will be before the mother's periods return.

If a baby sucks very frequently at the breast (whenever the baby wants to, including at night) then the return of the mother's periods will be delayed for much longer. But if breastfeeding is restricted to a regular routine, then the mother's periods will return much more quickly. Or if a mother gives other food or drink to a baby who is less than six months old, then the baby may suck less often at the breast and the mother's periods are likely to return much sooner.

○ The return of menstrual periods lets the mother know that she can become pregnant again.

○ It is possible for a mother to become pregnant again before her monthly period returns. This becomes more likely when six months have passed since the birth of the baby. A woman who wants to be protected against another pregnancy should choose another method of family planning if *any* of the following apply:

- her baby has reached the age of six months
- her monthly periods have returned
- the baby is starting to take other food and drink in addition to breastmilk.

○ Whether or not a mother intends to breastfeed a newborn child, parents should be provided with advice on family planning at the maternity unit or hospital where their child has been born. If the child is born at home, trained birth attendants can also give advice on family planning.

Child Growth Prime Messages

1 Children from birth to the age of three years should be weighed every month. If there is no weight gain for two months, something is wrong.

2 Breastmilk alone is the best possible food for about the first six months of a child's life.

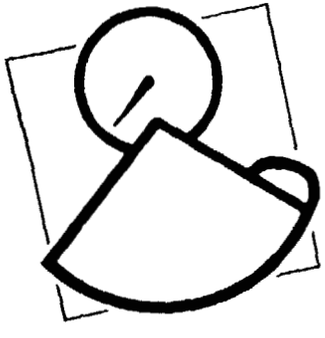
3 By the age of about six months, the child needs other foods in addition to breastmilk.

4 A child under three years of age needs food five or six times a day.

5 A child under three years of age needs a small amount of extra fat or oil added to the family's ordinary food.

6 All children need foods rich in vitamin A – breastmilk, green leafy vegetables, and orange-coloured fruits and vegetables.

7 After an illness, a child needs one extra meal every day for at least a week.



Child Growth Supporting Information

1

Children from birth to the age of three years should be weighed every month. If there is no weight gain for two months, something is wrong.

O Regular monthly weight gain is the most important sign of a child's overall health and development. It is the child's own weight gain which is important, not how the child compares in weight to other children.

O It is therefore important to weigh young children every month. If a child does not gain weight over a two-month period, then parents and health workers should act. The child is being held back either by illness, or poor food, or lack of attention. The following paragraphs cover the most likely causes of poor growth, and the most important actions parents can take to keep a child growing well.

O Breastfeeding helps protect a baby from common illnesses and ensure its growth for the first few months of life. A full course of immunizations in the first year of life is also essential - it protects against diseases which cause undernutrition.

O When additional foods are given, the risk of infection increases. From now on, it is specially important to check that the child is putting on weight regularly from one month to the next. If a child under the age of three is not gaining weight, and if the child has good food, these are the 10 most important questions to ask:

- is the child eating frequently enough? (a child should eat five or six times a day)
- do the child's meals have too little energy in them? (small amounts of oil or fats should be added)
- is the child frequently ill? (needs medical attention)
- has the child been refusing to eat when ill? (needs tempting to eat when ill and extra meals to catch up afterwards)
- is the child getting enough vitamin A? (needs dark green vegetables every day)
- is the child being bottle-fed? (bottle and water may not be clean, sugary drinks may be being used instead of milk)
- are food and water being kept clean? (if not, child will often be ill)
- are faeces being put into a latrine or buried? (if not, child will often be ill)
- does the child have worms? (needs deworming medicine from heal centre)
- is the child alone too much? (needs more stimulation and attention)

Recording the child's weight with a dot on the child's 'growth chart' an joining up the dots after each monthly weighing gives a line which enables a mother to see her child's growth. An upward line means the child is doing well. A flat line is a cause for concern. A downward line is sure sign that all is not well with the child. A child who is given only breastmilk will almost always grow well in the first few months of life. Seeing this good progress on a growth chart helps give the mother confidence.

2

Breastmilk alone is the best possible food for about the first six months of a child's life.

O From the moment of birth up to the age of about six months, breastmilk is all the food and drink a baby needs to grow well. In these early months, when a baby is most at risk, breastmilk helps to protect against diarrhoea and other common infections.

O Breastmilk is the best food a child will ever have. If possible, breastfeeding should continue well into the second year of life and for longer if possible.

3

By the age of about six months, the child needs other foods in addition to breastmilk.

O At the age of about six months, most infants need other foods in addition to breastmilk. Before the age of six months, an infant who is n gaining enough weight may need more frequent breastfeeding.

○ If the child is already being breastfed frequently, then failure to gain weight shows that other foods in addition to breastmilk are now necessary.

○ For an infant who continues to grow well, additional food may not be necessary until seven or even eight months. After that, all children need other foods in addition to breastmilk.

○ The baby should be breastfed *before* being given other foods so that the mother will have more breastmilk for a longer period.

○ Boiled, peeled and mashed vegetables should be added to a young child's gruel or other weaning food at least once each day.

○ The greater the variety of foods the child eats, the better.

4

A child under three years of age needs food five or six times a day.

○ A child's stomach is smaller than an adult's, so a child cannot eat as much as an adult at one meal. But its energy needs, for its size, are greater. So the problem is how to get enough 'energy food' into the child. The answer is:

○ feed the child frequently - five or six times a day

○ enrich the child's gruel or porridge with mashed vegetables and a little oil or fat.

○ A child's food should not be left standing for hours. Germs can grow in it which may make the child ill. As it is usually not possible to cook fresh food for a child five or six times a day, dried foods or snacks should be given in between meals - fruits, bread, patties, biscuits, nuts, coconut, bananas or whatever clean food is easily available. Breastmilk is also an ideal 'snack' and is always clean and free from germs.

5

A child under three years of age needs a small amount of extra fat or oil added to the family's ordinary food.

○ The family's normal food needs to be enriched to meet the special energy needs of the child. This means adding mashed vegetables and small amounts of fats or oils - butter, ghee, vegetable oil, soya oil, coconut oil, corn oil, groundnut oil, or crushed nuts.

○ Breastmilk also enriches a child's diet, and breastfeeding should continue, if possible, until well into the second year of a child's life.

6

All children need foods rich in vitamin A - breastmilk, green leaf vegetables, and orange-coloured fruits and vegetables.

○ Over 200,000 children go blind each year because they do not have enough vitamin A in their bodies. Vitamin A may also protect children against other illnesses such as diarrhoea. It should therefore be a part of every child's daily diet.

○ Vitamin A comes from breastmilk, dark green leafy vegetables, and from orange or yellow fruits and vegetables such as carrots, papayas, a mangoes.

○ If a child has had diarrhoea or measles, vitamin A will be lost from t child's body. It can be replaced by breastfeeding more often, and by feeding the child more fruit and vegetables.

7

After an illness, a child needs one extra meal every day for at le a week.

○ One of the most important skills of a parent is the skill of stopping illnesses from holding back a child's growth. In times of illness, and especially if the illness is diarrhoea or measles, the appetite falls and le of the food that is eaten is absorbed into the body. If this happens seve times a year, the child's growth will be held back.

○ So it is essential to encourage a child who is ill to eat and drink. Thi be difficult if the child does not want to eat, so it is important to keep offering food the child likes, usually soft, sweet foods, a little at a time a as often as possible. Breastfeeding is especially important.

○ When the illness is over, extra meals should be given so that the ch catches up on the growth lost. A good rule is to give a child an extra m every day for at least a week after the illness is over. The child is not fu recovered from an illness until he or she is at least the same weight as when the illness began.

○ If illness and poor appetite persist for more than a few days, the chil should be taken to a health worker.

○ It is also important to protect a child's growth by preventing illness:

○ give a child breastmilk alone for about the first six months of life. Then introduce other foods, and continue to breastfeed

○ make sure your child is fully immunized before the age of one year

○ always use latrines and keep hands, food, and kitchens clean.

Appendix H

MOH Protocol for Case Management of Diarrhea

PLAN B
PARA TRATAR DESHIDRATACION POR VIA ORAL

CANTIDAD APROXIMADA DE SUERO ORAL PARA LAS PRIMERAS 4 HORAS SI CONOCE EL PESO (50 - 100ml/kg) TANTO PARA NIÑOS COMO PARA ADULTOS

Se calcula multiplicando el peso en kg por 50-100 ml según intensidad de deshidratación. Los casos más deshidratados sin shock pueden recibir hasta 150 ml/kg.

Ejemplos

PESO (kg)	VOLUMEN (ml) (50 - 100 ml/kg)	PESO (kg)	VOLUMEN (ml) (50 - 100 ml/kg)
3	150 - 300	18	900 - 1800
5	250 - 500	25	1250 - 2500
8	400 - 800	30	1500 - 3000
10	500 - 1000	40	2000 - 4000
15	750 - 1500	60	3000 - 6000

Si no conoce el peso:
Dar suero oral continuamente con vaso o cuchara hasta que el paciente no desee más.

OBSERVAR AL PACIENTE CONTINUAMENTE DURANTE LA REHIDRATACION Y AYUDAR AL FAMILIAR A DAR EL SUERO ORAL

DESPUES DE CADA 4 HORAS, EVALUAR AL PACIENTE USANDO CUADRO DE EVALUACION, LUEGO SELECCIONAR PLAN PARA CONTINUAR TRATAMIENTO

- Si no hay signos de deshidratación, usar Plan A
- Si continúa **alguna deshidratación**, repita Plan B por 2 horas y reevalue al paciente
- Si cambió a **deshidratación con shock**, cambie a Plan C

SI LA MADRE O FAMILIAR DEBE IRSE ANTES DE COMPLETAR TRATAMIENTO

- Si después de 2 horas el paciente está recibiendo bien el suero oral, no está vomitando, y muestra señales de recuperación, indique al familiar como continuar el tratamiento en el hogar (Plan A)

PLAN C
TRATAMIENTO RAPIDO DE LA DESHIDRATACION CON SHOCK

¿Puede administrar líquidos EV inmediatamente?

- Comience E.V. inmediatamente. Administrar Lacto Ringer. Intente administrar suero oral mientras se consigue iniciar E.V.

PRIMERA HORA	SEGUNDA HORA	TERCERA HORA
50 ml/kg	25 ml/kg	25 ml/kg

- Evalúe al paciente continuamente. Si no está mejorando aumente la velocidad de infusión.
- Al poder beber (usualmente en 2-3 horas), pruebe tolerancia al suero oral, mientras continúa E.V.
- Al completar E.V., evalúe al paciente para seleccionar Plan A, B o repetir Plan C

¿Puede referir lugar cerca? (30 minutos de distancia)

- Refiera inmediatamente.
- Prepare suero oral y enseñe como darlo con jeringa o taza en el camino.

¿Sabe usar sonda nasogástrica?

- Comience suero oral por la sonda, 20-30 ml/kg/hora hasta total de 120 ml/kg.
- Evalúe al paciente continuamente
  - Si muestra señales de recuperación continue el tratamiento.
  - Si vomita, o presenta distención abdominal, dele 5-20 ml/kg/hora
  - Si no mejora después de 2 horas, enseñele a administrar el suero durante el camino y refiérelo para tratamiento E.V.
  - Después de 4 horas, evalúe al paciente y seleccione Plan A, B o C.

Urgente: Refiera para E.V. ó sonda nasogástrica.

Prepare suero oral y enseñe como darlo con jeringa o taza durante el camino.

En los casos de rehidratación sin shock en que la sonda no utilizar, a veces muchos se pueden administrar 5 ml/kg/hora E.V. hasta que desaparezca la condición que motivó el uso de la vía endovenosa.

NOTA

Es mejor observar al paciente durante 2 horas, por lo menos, después de completar hidratación y asegurarse que la madre o familiar puedan mantenerlo hidratado con suero oral y puedan alimentarlo.

1994

MANEJO DEL PACIENTE CON DIARREA

Use este cuadro para evaluar pacientes con:
- Diarrea líquida
- Disentería

BEST AVAILABLE COPY

ORGANIZACION PANAMERICANA DE LA SALUD

ORGANIZACION MUNDIAL DE LA SALUD

Programa ampliado control de enfermedades diarréicas / cólera

Ministerio de Salud Pública, Honduras

BEST AVAILABLE COPY

PRIMERO EVALUE EL ESTADO DE HIDRATACION DE SU PACIENTE

1. OBSERVE: CONDICION OJOS LAGRIMAS BOCA Y LENGUA SED	BIEN ALERTA Normales Con lágrimas Húmedas Bebe normal	INTRANQUILO, IRRITANTE Hundidos Ausentes Secas SEDIENTO, BEBE RAPIDO Y AVIDAMENTE.	COMATOSO O HIPOTONICO Muy hundidos Muy secas NO ES CAPAZ DE BEBER
2. EXPLORE: SIGNO DEL PLIEGUE	DESAPARECE RAPIDAMENTE	DESAPARECE LENTAMENTE	DESAPARECE MUY LENTAMENTE
3. DECIDA:	NO TIENE SIGNOS DE DESHIDRATACION	Si presenta dos o más signos, TIENE DESHIDRATACION.	Si presenta dos o más signos, indicando deshidratación grave, TIENE DESHIDRATACION GRAVE. ESTADO CONLATOSO INDICA SHOCK
4. TRATE:	Use Plan A	Use Plan B Pese al paciente, si es posible.	Use Plan C ¡Pese al niño!

Pulso radial ausente o muy débil y/o presión sanguínea baja, indica shock. Estos se miden mejor en adultos y niños mayores.

LUEGO, IDENTIFIQUE OTROS PROBLEMAS

PREGUNTE SI TIENE SANGRE EN LAS HECES	**EN CASO POSITIVO:** • Trátelo por 10 días con el antibiótico recomendado para Shigella E. Coli o G. Lamblia • Enseñe a la madre a administrar líquidos y a alimentar al niño, como se describe en el Plan A • Controle al paciente 2 días después • Si aún hay sangre en las heces, después de 2 días de tratamiento, cambie a un segundo antibiótico recomendado según las normas
PREGUNTE CUANDO COMENZO LA DIARREA	**SI LLEVA POR LO MENOS 14 DIAS DE EVOLUCION:** 1) Refiérelo al hospital: • Si presenta deshidratación, hidrátelo primero y remítalo al hospital. 2) Enseñe a la madre cómo administrar líquidos y alimentar al niño según Plan A • asegure ingesta calórica alta, dando 6 comidas al día. 3) Cite al niño 5 días después: • Si la diarrea continúa, refiera al hospital • Si la diarrea paró, indique a la madre: • continuar los alimentos de dieta regular y • dar 1 comida extra al día hasta que el niño alcance el peso adecuado.
OBSERVE SI TIENE DESNUTRICION GRAVE	**SI TIENE DESNUTRICION GRAVE:** • Inicie hidratación oral y refiérelo a un hospital. • Entregue a la madre suficiente suero oral, e indíquele darlo continuamente durante el viaje
PREGUNTE POR FIEBRE Y TOME LA TEMPERATURA	**SI TEMPERATURA ES 39°C O MAS** • Busque otros problemas

USO DE MEDICAMENTOS EN NIÑOS CON DIARREA

- **ANTIBIOTICOS** deben usarse sólo para disentería y cólera.
- **ANTIPARASITARIOS** deben usarse sólo para:
  - **Amebiasis**, después que el tratamiento de disentería por **Shigella** ha fracasado, o en casos en que se identifiquen en los trofozoitos de **E. histolytica** conteniendo glóbulos rojos en su interior.
  - **Giardiasis**, cuando la diarrea tarda 14 días o más y se identifican quistes o trofozoitos en heces, o aspirado intestinal
- "**ANTIDIARREICOS**" Y **ANTIMETICOS**, no deben usarse nunca.

PLAN A: PARA TRATAR LA DIARREA EN EL HOGAR

USE ESTE PLAN PARA ENSEÑAR A LA FAMILIA A:

- Continuar tratamiento en el hogar del episodio actual de diarrea.
- Iniciar tratamiento precoz en futuros episodios de diarrea.

CUATRO REGLAS PARA TRATAR DIARREA EN EL HOGAR

Aumentar la ingesta de líquidos disponibles.
- Usar líquidos caseros recomendados.
- Ofrecer sales de rehidratación oral a libre demanda.

Continuar la alimentación habitual, si es adecuada:
- Continuar lactancia Materna.
- Si no mama, continuar con la leche habitual.
- En mayores de 6 meses que reciben alimentos sólidos y en adultos, dar la dieta corriente.
- Incrementar 1 ración de comida por dos semanas.

Reconocer signos de empeoramiento:
- Aumento de vómitos.
- Aumento de las evacuaciones intestinales.
- Sangre visible en heces.
- Fiebre.
- Deshidratación.
- Sed intensa.
- Signo de pliegue
- Alteración del estado de conciencia.

Enseñar la prevención de las diarreas:
- Agua segura.
- Lavado de manos.
- Vacunación contra el sarampión.
- Lactancia materna.
- Comer alimentos recién preparados.

SI EL PACIENTE VA A RECIBIR SUERO ORAL EN EL HOGAR, MOSTRAR A LA FAMILIA COMO ADMINISTRARLO DESPUES DE CADA EVACUACION Y DARLE SUFICIENTES SOBRES PARA DOS DIAS:

Edad	Cantidad de suero oral para dar después de cada evacuación	Cantidad de SRO para utilizar en el hogar
< 12 meses	50 - 100 ml	1 sobre por día
1 - 10 años	100 - 200 ml	1 sobre por día
> 10 años	todo lo que desee	4 sobres por día

Appendix I

Key Messages on Case Management of Diarrhea

Diarrhoea Prime Messages

1 Diarrhoea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhoea plenty of liquids to drink.

2 A child with diarrhoea needs food.

3 When a breastfed child has diarrhoea, it is important to continue breastfeeding.

4 A child who is recovering from diarrhoea needs an extra meal every day for at least two weeks.

5 Trained help is needed if diarrhoea is more serious than usual, if it persists for more than two weeks, or if there is blood in the stool.

6 Medicines other than ORS should not be used for diarrhoea, except on medical advice.

7 Diarrhoea can be prevented by breastfeeding, by immunizing all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching food.

Diarrhoea Supporting Information

1

Diarrhoea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhoea plenty of liquids to drink.

O Diarrhoea is dangerous. Roughly one in every two hundred children who get diarrhoea will die from it.

O Most often, diarrhoea kills by dehydration. This means that too much liquid has been drained out of the child's body. So as soon as diarrhoea starts, it is essential to give the child extra drinks to replace the liquid being lost.

O Suitable drinks to prevent a child from losing too much liquid during diarrhoea are:

- breastmilk
- gruels (mixtures of cooked cereals and water)
- soups
- rice water
- fresh fruit juices
- weak teas
- green coconut water
- water from the cleanest possible source (if possible, brought to the boil and then cooled)
- oral rehydration salts solution.

O In almost all countries, special drinks for children with diarrhoea are available in pharmacies, shops, or health centres. Usually, these come in the form of packets of oral rehydration salts (ORS) to be mixed with the recommended amount of clean water (*see box*). Although ORS is especially made for the treatment of dehydration, it can also be used to prevent dehydration.

Do not add ORS to liquids such as milk, soup, fruit juice or soft drinks.

O *If ORS is not available, dehydration can be treated by giving the child* drink made from four level teaspoons of sugar and half a level teaspoon of salt dissolved in one litre of clean water.

This is less salt and less sugar than recommended in the first edition of *Facts for Life*. In practice, too much salt and sugar have sometimes been used because spoon sizes differ and because parents sometimes add more salt and sugar in the belief that this will make the treatment more effective. But too much sugar can make the diarrhoea worse and too much salt can be harmful to the child. Therefore a more dilute formula is now recommended. If the mixture is made a little too dilute, no harm can be done, and there is very little loss of effectiveness.

O To replace the liquid being lost from the child's body, one of these drinks should be given to the child every time a watery stool is passed:

- between a quarter and a half of a large cup for a child under the age of two
- between a half and a whole large cup for older children.

O The drink should be given directly from a cup or by a teaspoon - not from a feeding bottle. If the child vomits, wait for 10 minutes and then begin again, giving the drink to the child slowly, small sips at a time.

O Extra liquids should be given until the diarrhoea has stopped. This will usually take between three and five days.

ORS - a special drink

A special drink for diarrhoea can be made by using a packet of oral rehydration salts (ORS). This drink is used by doctors and health workers to treat dehydrated children. But it can also be used in the home to prevent dehydration.

- Dissolve the contents of the packet in the amount of water indicated on the packet. If you use too little water, the drink could make the diarrhoea worse. If you use too much water, the drink will be less effective.
- Stir well, and give to the child to drink in a cup or feed with a spoon

2

A child with diarrhoea needs food.

O It is often said that a child with diarrhoea should not be given any food or drink while the diarrhoea lasts. This advice is wrong. Food can help to stop the diarrhoea. Also, diarrhoea can lead to serious malnutrition unless parents make a special effort to keep feeding the child during and after the illness.

O A child with diarrhoea usually has less appetite, so feeding may be difficult at first. But the child should be tempted to eat - as frequently as possible - by offering small amounts of his or her favourite foods.

O After the age of about six months, all children need extra food in addition to breastmilk. They should be given soft, well-mashed mixes of cereal and beans, or cereal and well-cooked meat or fish. Add one or two teaspoonfuls of oil to cereal and vegetable mixes if possible. Also good for the child are yoghurt and fruits. Foods should be freshly prepared and given to the child five or six times a day. This diet should be continued if the child has diarrhoea.

3

When a breastfed child has diarrhoea, it is important to continue breastfeeding.

O Mothers are sometimes advised to give less breastmilk if a child has diarrhoea. This is wrong advice. Breastfeeding should continue - and if possible the child should be fed more often.

O If the child is being fed on milk-powder solutions or cow's milk, then feeding should continue as usual.

4

A child who is recovering from diarrhoea needs an extra meal every day for at least two weeks.

O Extra feeding after the diarrhoea stops is vital for a full recovery. At this time, the child has more appetite and can eat an extra meal a day for at least a week. This will help the child to catch up on the food 'lost' while the child was ill and the appetite was low. A child is not fully recovered from diarrhoea until he or she is at least the same weight as when the illness began.

O Breastfeeding more frequently than usual also helps to speed up recovery.

5

Trained help is needed if diarrhoea is more serious than usual, i it persists for more than two weeks, or if there is blood in the st

O Parents should seek help from a health worker without delay if the child:

- has a fever
- is extremely thirsty
- will not eat or drink normally
- vomits frequently
- passes several watery stools in one or two hours
- passes blood in the stool (a sign of dysentery)
- if the diarrhoea persists for more than two weeks.

O If a child has any of these signs, qualified medical help is needed quickly. The doctor or health worker will give the child a drink made w special oral rehydration salts (*see box*). In the meantime, keep trying to make the child drink liquids.

6

Medicines other than ORS should not be used for diarrhoea, except on medical advice.

O Most medicines for diarrhoea are either useless or harmful. The diarrhoea will usually cure itself in a few days. The real danger is usuall not the diarrhoea but malnutrition and the loss of liquids from the child body.

O Do not give a child tablets or other medicines for diarrhoea unless these have been prescribed by a trained health worker.

O Antibiotics should be given - after seeking medical advice - if a child diarrhoea with blood in the stool. Other drugs should not be used.

7

Diarrhoea can be prevented by breastfeeding, by immunizing all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching food.

O Diarrhoea is caused by germs from faeces entering the mouth. These germs can be spread in water, in food, on hands, on eating and drinking utensils, by flies, and by dirt under fingernails. To prevent diarrhoea, the germs must be stopped from entering the child's mouth.

O Poverty and lack of basic services such as clean drinking water mean that many families find it difficult to prevent diarrhoea. But the most effective ways are to:

o give breastmilk alone for about the first six months of a baby's life (breastmilk helps to protect babies against diarrhoea and other illnesses)

o at the age of about six months, introduce clean, nutritious, well-mashed, semi-solid foods and continue to breastfeed

o if a milk-powder solution or cow's milk has to be used, give it to the child from a cup rather than a bottle

o use the cleanest water available for drinking (water from wells, springs or rivers should be brought to the boil and cooled before use)

o always use latrines to dispose of faeces, and be sure to put children's faeces in a latrine immediately(or bury them). (Children's faeces are even more dangerous to health than those of adults)

o wash hands with soap and water immediately after using the latrine and before preparing or eating food

o cover food and drinking water to protect it from germs

o if possible, food should be thoroughly cooked, and prepared just before eating. It should not be left standing, or it will collect germs

o bury or burn all refuse to stop flies spreading disease.

O Measles frequently results in serious diarrhoea. Immunization against measles therefore also protects a child against this cause of diarrhoea. There is no vaccine to prevent ordinary diarrhoea.

Hygiene Prime Messages

1 Illnesses can be prevented by washing hands with soap and water after contact with faeces and before handling food.

2 Illnesses can be prevented by using latrines.

3 Illnesses can be prevented by using clean water.

4 Illnesses can be prevented by boiling drinking water if it is not from a safe piped supply.

5 Raw food is often dangerous. It should be washed or cooked. Cooked food should be eaten straight away - not left to stand. Warmed-up food should be thoroughly reheated.

6 Illnesses can be prevented by keeping food clean.

7 Illnesses can be prevented by burning or burying household refuse.

Appendix J

Community Women's Monthly Meeting Reminder

I N V I T A C I O N

Estimada Compañera:

Por este medio, te estamos invitando para que acudas al Centro de Pesaje el día _____ a las _____ en casa de _____.

NOTA: Si Usted no trae su niño a pesar, no tendrá derecho a reclamar su BONO y a inscribir a los que aún no lo tienen.

FIRMA ADRA FIRMA VOLUNTARIA

Appendix K

Generic Project Training Report Form

GENERIC PROJECT TRAINING REPORT FORM
ADRA/CESAMO CHILD SURVIVAL PROJECT
TEGUCIGALPA, HONDURAS

Date: **Venue:** **Training #:**

1. Type of training held/for whom _____, _____

2. Number of health workers trained _____

3. Number of hours of training on (fill as applicable)
   - EPI _____
   - CMD _____
   - Nutrition/GM _____
   - SM/FP _____
   - ALRI _____
   - Vit. A _____
   - Supervision/training skills/HIS _____

   Total # of hours _____

4. Names and qualifications of trainers _____

5. Average score of post-test evaluation _____

   Average score of pretest evaluation _____

   Total score percentage difference _____

6. Number of field trips made, if any _____
   Site/s _____, _____

7. Total budget used in US $ _____

8. Type/s of resource materials used _____

9. Reported by:_____

   Job title:_____
   Date: _____

Appendix L

Modified Home Care Advice Box for ALRI

MODIFIED HOME CARE ADVICE BOX

(See Appendix E for Spanish version of Home Care recommendations.)

Modified Home Care Box	
If your child has a: Cough Runny Nose Teary Eyes He/She probably has a COLD **Care for him/her at home with:** • Herb Tea • Steam vapors with herb • Keep the nose clean	DANGEROUS BELIEFS • Never put oil with gas on childs chest • Never give Vick's orally • Never give animal grease orally to rid child of phlegm ALL OF THESE PRACTICES WILL MAKE THE CHILD WORSE

If you child has: Fever Cough Runny Nose Rapid Breathing Loss of Appetit He may have PNEUMONIA or ASTHMA **Care for the child:**	**Do Not Self-Medicate** • Using old medication only wastes time while the child gets sicker • Finish all prescriptions that the doctor recommends Go to the Health Center or Hospital

If you child has: Loss of Appetit Rapid Breathing Chest In-drawing Wheezing Sleepy Fever Purple Lips or Nails Drowning He probably has PNEUMONIA	**Do Not Self-Medicate** • Using old medication only wastes time while the child gets sicker • **Finish all prescriptions that the doctor recommends** Go to the Health Center or Hospital

Appendix M

Glossary of ALRI Related Local Terms

GLOSSARY OF ARI RELATED SIGNS AND SYMPTOMS
(List used for matching illness to signs and symptoms game during FES interviews)

SIGNS AND SYMPTOMS

SPANISH	ENGLISH
Fiebre/Calenture	Fever
Ojos Rojos	Pink Eye
Ojos Mojados/LLorosos	Teary Eyes
Tos	Cough
Escalofrío	Chills
Nariz Tapada/Mocos	Blocked or Runny Nose
Mal/dolor de Cabeza	Head Ache
Cansancio	Tired/Fast breathing
Respiración Rápida/Agitado	Fast Breathing
Pérdida del Apetito	Lose of appetite
Dolor de Oído	Ear Ache
Gir-gir	Wheezing
Sibilancia/Estridor	Wheezing/Stridor
Tiraje	Chest indrawing
Se le mete/hunde las costillas	Chest indrawing
Hervor en el Pecho	Wheezing
Ataques/Convulsiones	Convulsions
Piel Pálida	Pale
Labios y Uñas Morados/Cianosis	Purple Lips and Nails/Cyanosis
Tos Seca	Dry Cough
Tos de Perro	Deep Whooping Cough
Gargajo/Flema	Flem
Aleteo Nasal	Flaring Nose
Oído Reventada	Fluid in the Ear
Labios Secos	Dry Lips
Desganado/Débil/Decaído	Rundown
Se Pone Triste	Sad/Energyless
Pecho de Gato	Wheezing
Llonroncito/Irritable	Won't stop crying/Irritable
Mal de Pecho	Chest Cold
Moquera	Runny nose
Somnolencia	Sleepy
Se ahoga	Drowning/ARI
Vómitos	Vomiting
Desesperado	Desperate/ARI
Ronquera/Mal de Garganta	Sore Throat
Respiración Ruidosa	Dyspnea/Wheezing

Appendix N

Key ALRI Messages for Mothers

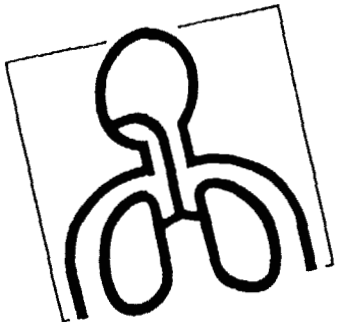
Coughs and Colds
Prime Messages

1 If a child with a cough is breathing much more rapidly than normal, then the child is at risk. It is essential to get the child to a clinic quickly.

2 Families can help prevent pneumonia by making sure that babies are breastfed for at least the first six months of life and that all children are well nourished and fully immunized.

3 A child with a cough or cold should be helped to eat and to drink plenty of liquids.

4 A child with a cough or cold should be kept warm but not hot, and should breathe clean, non-smoky air.



Coughs and Colds

Supporting Information

1

If a child with a cough is breathing much more rapidly than normal, then the child is at risk. It is essential to get the child to a clinic quickly.

○ Most coughs and colds, sore throats and runny noses, will get better by themselves. But sometimes pneumonia develops and threatens the child's life. Millions of child deaths from pneumonia could be avoided if:

○ parents know when a cough or cold is becoming a serious infection that needs medical attention

○ medical help and low-cost drugs are available.

○ Parents of a child with a cough should know that it is essential to get the child to a clinic or a trained health worker quickly if:

○ the child is breathing much more rapidly than normal (over 50 times a minute).

○ the lower part of the child's chest (the area between the two halves of the child's ribcage) goes in as the child breathes in instead of expanding outwards as normal

○ the child is unable to drink anything.

○ If a child is breathing normally, coughs and colds and runny noses can be treated at home without drugs. Most medicines sold for coughs and colds are useless or harmful.

2

Families can help prevent pneumonia by making sure that babies are breastfed for at least the first six months of life and that all children are well nourished and fully immunized.

○ **Breastfeeding**

Breastmilk helps to protect against infections. On average, babies who are bottle-fed have twice as many bouts of pneumonia as babies who are breastfed. It is particularly important to give breastmilk alone for about the first six months of a baby's life.

○ **Feeding**

At any age, a child who is well fed is less likely to become seriously ill or to die because of pneumonia.

○ **Vitamin A**

Vitamin A, from orange or yellow fruits and dark-green leafy vegetables also helps to protect against pneumonia.

○ **Immunization**

Immunization should be completed before the child is one year old. The child will then be protected against some of the most common causes of serious respiratory infections, including whooping cough, tuberculosis and measles.

○ **Crowding**

Overcrowding helps the spread of coughs and colds. At night, infants who are breastfed can sleep with the mother. But older children should be encouraged to sleep on their own.

3

A child with a cough or cold should be helped to eat and to drink plenty of liquids.

○ Important things to remember when treating a child at home are to:

○ **Continue feeding**

A breastfed child with a cough or cold may be difficult to feed. But feeding helps both to fight the infection and to protect the child's growth So it is important to persist in frequent attempts to give breastmilk. Clearing the child's blocked nose will help the child to suck. If a child cannot suck, it is best to squeeze out the breastmilk and feed the child from a clean cup.

Children who are not being breastfed should be coaxed into eating frequent small amounts. Periods of 'starvation' caused by illness and lost appetite are a major reason for poor growth. When the illness is over, a child should be fed an extra meal each day for a week. Recovery is not complete until the child is at least the same weight as when the illness began.

○ **Give plenty of fluids**

All children with coughs and colds need to drink plenty of liquids.

4

A child with a cough or cold should be kept warm but not hot, and should breathe clean, non-smoky air.

○ **Keep warm not hot**

Babies and very young children lose their heat easily, so it is important to keep them covered and warm, but not too hot or too tightly wrapped.

Fever is not always a sign of severe illness. But if a child has a fever, paracetamol (or other temperature-reducing medicine) can be given.

○ **Help in breathing**

A child's nose should be frequently cleared, especially before breastfeeding or when being put to sleep. A moist atmosphere can help to ease breathing. It can also help if the child inhales water vapour from a bowl of hot but not boiling water.

The air in the child's room should be kept fresh by opening a door or window two or three times a day. But a child with a cough or cold should be kept away from draughts.

○ **Clean air**

Children who live and sleep in smoky surroundings, either because of cooking fires or tobacco smoking, are more likely to get pneumonia. Tobacco smoke in the air that a child breathes can cause long-term damage to the child's health.

Spitting and sneezing by other people close to children also increases the risk. People with coughs and colds should be kept away from young babies.

COMUNICACION EDUCATIVA PARA EL CONTROL DE LAS IRA INFANTILES

Las divisiones de Educación para la Salud y Materno Infantil del Ministerio de Salud han elaborado una estrategia educativa para lograr un apropiado tratamiento del resfriado en casa y una oportuna llegada al Centro de Salud en caso de neumonía. Tanto los promotores de Saneamiento como Evaluadores de Vectores participarán activamente en los procesos educativos y de referencia oportuna.

MENSAJE PRINCIPAL

Puesto que a la población en general no se le puede hablar de la taxonomía de las IRA, hemos desarrollado los siguientes mensajes, que serán repetidos de distinta manera a través de los diversos materiales gráficos, la capacitación del personal y los medios de comunicación colectiva.

1.- Si su niño tiene tos y mocoqueza, dele tratamiento en casa. Este comportamiento disminuye la molestia que ocasiona la enfermedad y, en algunos casos, previene que se agrave.

2.- Trátelo en casa de esta forma:
- límpiele la nariz
- aplíquele dos gotas de agua de manzanilla en la nariz
- baíele la fiebre con paños tibios
- déle abundantes líquidos (tés, atoles, jugos)
- continúe dándole el pecho
- continúe con la alimentación acostumbrada
- humedezca el ambiente

El tratamiento oportuno permite desarrollar las defensas orgánicas con intervenciones naturales que no comprometen el sistema inmunológico ni al sistema nervioso central. Cuando sólo hay tos y secreción nasal, no se indican supresores de la tos, expectorantes, ni antibióticos que, en estos casos, no tienen efecto beneficioso. Al contrario, pueden ser perjudiciales. Si la tos es persistente se puede recomendar una mezcla de agua, miel y limón, además de los tesitos.

La continuidad del pecho materno y la alimentación acostumbrada son elementos claves para la recuperación y para mantener el crecimiento. La limpieza de la nariz mejora la respiración y facilita la lactancia, disminuyendo el riesgo de un destete precoz.

3.- Reconozca estas señales de peligro de muerte:
a) Respiración rápida (taquipnea)
b) Hundimiento en las costillas (tiraje)
c) Labios y dedos morados (cianosis)
d) Dificultad para tragar

¡Ante cualquiera de estas señales acuda rápido al Centro de Salud!

4.- Otras señales de peligro:
a) Pus y dolor en los oídos
b) Secas (adenopatía submaxilar)
c) Fiebre alta

Hemos seleccionado estas manifestaciones (artículo #3) para que la madre identifique a tiempo las señales de peligro. Así tendremos una oportuna referencia al establecimiento de Salud para que se inicie oportunamente el tratamiento que, en estos casos, amerita un antibiótico. Debe evitarse el uso de antitusivos y expectorantes.

5.- Si se agrava, es decir, si presenta algunas de estas señales, debe llevarlo rápido al Centro de Salud o al médico particular.

Además de estos mensajes esenciales también se informará a la comunidad sobre las medidas requeridas para evitar las Infecciones Respiratorias Agudas. Las principales son las siguientes:

Cómo Prevenir las IRA:

- lactancia materna exclusiva hasta los 6 meses de edad.
- alimentación adecuada según la edad.
- vacunación según esquema.
- ambiente limpio y libre de humo y polvo.

ESTRATEGIA CREATIVA

Con [illegible] a las ma[illegible] el Centro de [illegible] ofrecerles [illegible] acerca del ma[illegible] IRA en el hog[illegible] organizadoras [illegible] promocional [illegible]

EL PREMIO IRA

Esta actividad consiste en que las señoras de la [illegible] dad contestan preguntas relacionadas con el mensaje [illegible] y reciben, como premio, nuevos materiales educativos [illegible] bien en esa sesión practican algunas destrezas como [illegible] ción de agua de manzanilla, limpieza de la nariz y [illegible] lactancia. Luego reciben un certificado que las acre[illegible] "mamás dedicadas" y su nombre es colocado frente al C[illegible] Salud junto al nombre de las otras mujeres que, como e[illegible] neron a la sesión educativa.

Pero la mejor recompensa será, sin duda, la [illegible] ción, y recuperación cuando la ha perdido, de la sa[illegible] tiemo.

LOS MATERIALES GRAFICOS

El folleto IRA para madres presenta el mensaje esencial [illegible] gráfica y sencilla.

- El rotafolio IRA para el Centro de Salud da una expl[illegible] detalle y sirve como apoyo a las actividades educativa[illegible]
- El pañuelo IRA le recuerda a la mamá que es necesario [illegible] la nariz para que pueda mamar y comer con facilidad[illegible]
- El certificado IRA acredita que cada señora ha apren[illegible] manejo de IRA en casa y el reconocimiento de las señ[illegible] peligro.

LA RADIO

Se han producido varios spots para la radio y en cada uno de ellos se presenta la característica musical que dice:

"Si su niño tiene gripe
con moquera y poca tos,
déle tratamiento en casa
no lo debe descuidar...
Y si ve que no mejora
de la fiebre y de la tos,
llévelo enseguidita a su
centro de salud..."

Esta característica musical ha sido producida en varios ritmos para mantener la variedad. Los spots insisten en el tratamiento en casa y la identificación oportuna de los signos de peligro.

LA CAPACITACION

El personal de Atención Primaria de Salud será capacitado en los contenidos y en el manejo de la estrategia educativa a nivel de establecimiento. De esta manera se lograrán los siguientes objetivos:

1.- Que los mensajes emitidos a través de los medios de comunicación colectiva, especialmente la radio, sean los mismos que maneja el personal de salud.

2.- Que el personal de salud desarrolle actividades educativas de carácter participatorio con la comunidad.

3.- Que los contenidos de IRA sean tratados de manera integrada con los demás componentes del Programa Atención al Niño, en particular Enfermedades Diarréicas, Inmunizaciones y Nutrición Infantil.

4.- Que se viabilice una estrategia de medicina preventiva con énfasis en los procesos de comunicación y educación.

MINISTERIO DE SALUD PUBLICA:
DIRECCION GENERAL DE SALUD (DGS);
DIRECCION DE ALIMENTACION Y NUTRICION (DAN);
DIVISION DE EDUCACION PARA LA SALUD (DES);
DIVISION DE SALUD MATERNO INFANTIL (DSMI);
DIVISION DE SANEAMIENTO BASICO (DSB);
DIVISION ENFERMEDADES TRANSMITIDAS POR VECTORES (DETV);
DIVISION DE DESARROLLO DE LOS RECURSOS HUMANOS (DDRH);
HONDURAS, C.A.

AUNQUE SU NIÑO TENGA GRIPE
SIGA DANDOLE EL PECHO...

MINISTERIO DE SALUD PUBLICA

LAS INFECCIONES RESPIRATORIAS AGUDAS EN LOS NIÑOS

LAS INFECCIONES RESPIRATORIAS AGUDAS (IRA) EN LOS NIÑOS

Junto con las enfermedades diarréicas, las IRA en los niños son las principales causas de muertes prevenibles en Honduras. El problema es más crítico entre los niños menores de 5 años y, en particular, los menores de un año, quienes, por factores anatómicos y fisiológicos, constituyen el grupo de mayor riesgo. Asimismo, las deplorables condiciones de vida de la mayor parte de la población y la escasa educación son factores que contribuyen a las altas tasas de mortalidad por IRA entre los infantes.

La multicausalidad de las IRA, la diversidad de agentes etiológicos y la variedad de síntomas y signos han provocado distintas percepciones y prácticas de tratamientos caseros y automedicación que, en algunos casos, pueden ser muy peligrosos.

¿QUIENES ESTAN EN MAYOR RIESGO?

La incidencia de IRA es similar en países desarrollados y subdesarrollados. La diferencia se manifiesta en las tasas de mortalidad, que son entre 10 y 70 veces mayores en los países del Tercer Mundo. En Honduras se ha establecido que los más susceptibles son los menores de un año y que los factores de riesgo, en cuanto a incremento de incidencia y mortalidad, son los siguientes:

Factores que influyen en el incremento de Incidencia y de Mortalidad:

- Niños desnutridos (deficiencia de vitamina A y bajo peso al nacer).
- Destete prematuro.
- Hacinamiento.
- Falta de educación materna.
- Ambiente contaminado (humo y polvo).
- Falta de vacunación.
- Difícil acceso y concurrencia tardía a los servicios de salud.

Estos factores de riesgo se encuentran en el segmento poblacional de menores ingresos. Por lo tanto, podemos inferir que están en mayor peligro de enfermar y morir por IRA los niños de las familias más pobres de Honduras.

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Appendix O

CESAMO/MOH Support Letters for CS XI Project

Junta Pro-Mejoramiento Comunal Colonia Flor del Campo

Fundada el 5 de Diciembre de 1979

TELEFONO:.....

Afiliada FEDIPTENH - CGT - CCT - CLAT - CMT
Personería Jurídica Nº 57
Comayagüela, D. C., Honduras, C. A.

Tegucigalpa M.D.C.
7 de Diciembre de 1995

Licenciado
Nelson Tabares
Director Proyecto ADRA

Muy Distinguido amigo:

El patronato de la colonia Flor del Campo, le patentiza a un afectuoso saludo deseandole éxitos en las labores que humanamente desempeña.

Nuestra nota lleva para usted como Institución el más cincero agradecimiento y las bendiciones del todopoderoso por el beneficio, que ha recibido esta comunidad en el proyecto supervivencia infantil.

y al mismo tiempo solicitarle que nos den oportunidad a que este continue, para bien de aquellos que tanto lo necesitan.

Nosotros como patronato se lo suplicamos ofreciendoles acambio nuestro apoyo incondicional a ustedes y a todos los organismos que integramos el comite de Emergencía.

Muchas gracias y que Dios les Bendiga.

Atentamente

JUNTA PRO-MEJORAMIENTO COMUNAL
PRESIDENCIA
Personería Jurídica No. 57
Col. Flor del Campo

Donila Carranza
Presidenta

Ubence Aguirre
Secretario

Tegucigalpa M.D.C.
19 de Diciembre de 1995

Licenciado
Nelson Tabare
Coordinador del
Proyecto ADRA
Presente

Estimado Licenciado Tabare:

Es para nosotros de sumo placer que el proyecto que usted tan acertadamente coordina se de la oportunidad de prolongarse a 4 años más.

Ya que esto a servido para fortalecer las dos areas prioritarias como ser la atención al menor de 5 años y la atención a la mujer. Nos sentimos más aún satisfechos por el hecho de haber podido participar en la planificación de esta ampliación habiendo trabajado durante 4 días en esta actividad lo que nos permite conocer mejor el proyecto y orientarlo hacia nuestras necesidades.

Con esta ampliación se esta logrando la consolidación de todas las actividades ya iniciadas y podremos madurar y ejecutar el proceso de sostenibilidad a todas las actividades implementadas en nombre del Cesamo Flor del Campo

Le empreso mi más alto agradecimiento por el apoyo brindado y esperando continuemos desarrollando coordinaciones interinstitucionales por el fomento del bienestar de las areas postergadas.

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a los cuales nos debemos.

Le reitero mi más alta consideración y estima.

Atentamente

Doctor [illegible] Alberto Medina
Director [illegible]tro de Salud Flor
del Campo

CENTRO COLONIA FLOR DEL CAMPO
SALUD PUBLICA
DIRECCION
Honduras C.A.

cc: Dirección Regional
cc: Jefatura Area Nº 1
cc: archivo.

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Appendix P

Key Messages on Maternal and Newborn Care/EPI

Safe Motherhood Prime Messages

1 The risks of childbirth can be drastically reduced by going to the nearest health worker for regular check-ups during pregnancy.

2 A trained person should assist at every birth.

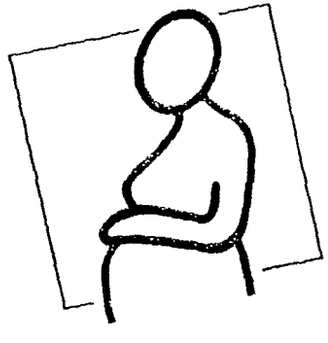
3 To reduce the dangers of pregnancy and childbirth, all families should know the warning signs.

4 All woman need more food during pregnancy. All pregnant women need more rest.

5 Spacing pregnancies at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35, drastically reduces the dangers of child-bearing.

6 Girls who are healthy and well fed during their own childhood and teenage years have fewer problems in pregnancy and childbirth.

7 If a woman who is pregnant smokes, or takes alcohol or drugs, her child may be damaged in the womb.



Safe Motherhood Supporting Information

1

The risks of childbirth can be drastically reduced by going to the nearest health worker for regular check-ups during pregnancy.

○ Many of the dangers of pregnancy and childbirth can be avoided if the mother-to-be goes to a health centre as soon as she believes she is pregnant. A health worker will help ensure a safe birth and a healthy baby by:

- checking the progress of the pregnancy so that if problems are likely the woman can be moved to a hospital for the birth
- checking for high blood pressure, which is a danger to both mother and child
- giving tablets to prevent anaemia ('thin blood')
- giving the two injections which will protect the mother and her newborn baby against tetanus
- checking that the baby is growing properly
- giving anti-malarial tablets where necessary
- preparing the mother for the experience of childbirth and giving advice on breastfeeding and care of the newborn
- advising on where to go or how to get help if problems arise during childbirth
- advising on ways of delaying the next pregnancy.

2

A trained person should assist at every birth.

○ A trained birth attendant will know:

- when labour has gone on for too long (more than 12 hours) and a move to hospital is necessary
- how to keep the birth clean and reduce the risk of infection
- how to cut the cord cleanly and safely
- what to do if the baby is being born in the wrong position
- what to do if too much blood is being lost
- what to do if the baby does not begin breathing straight away
- how to help the mother to start breastfeeding immediately after the birth
- how to dry and keep the baby warm after delivery
- how to help the mother prevent or postpone another birth.

○ If serious problems arise during childbirth, a trained birth attendant will know when medical help is needed and how to get it.

3

To reduce the dangers of pregnancy and childbirth, all families should know the warning signs.

○ With any pregnancy, it is important to ask the advice of a health worker about where the baby should be born and who should attend the birth. If a family knows that a birth is likely to be difficult or risky, it may be possible to have the baby in a hospital or maternity clinic. Or it may be possible to move, temporarily, closer to a clinic or hospital so that the mother is within reach of medical help.

○ So it is important for pregnant women, their husbands, and other family members to know the signs which indicate that extra care, and regular visits to a health worker, are needed.

Warning signs before pregnancy begins:

- an interval of less than two years since the last birth
- mother-to-be is less than 18 or more than 35 years old
- mother-to-be has had four or more previous children
- mother-to-be has had a previous baby weighing less than 2 kilograms at birth
- mother-to-be has had a previous difficult or Caesarian birth
- mother-to-be has had a previous premature birth
- mother-to-be has had a previous miscarriage, abortion or stillbirth
- mother-to-be weighs less than 38 kilograms before pregnancy
- mother-to-be is less than 145 cm in height.

Warning signs developing during pregnancy:

- failure to gain weight (at least 6 kilos should be gained in pregnancy)
- paleness of inside eyelids (should be red or pink)
- unusual swelling of legs, arms, or face.

Four signs which mean get help immediately:

- bleeding from the vagina during pregnancy
- severe headaches (sign of high blood pressure)
- severe vomiting
- high fever.

O Dangerous problems can arise during the process of giving birth. In at least half of all cases, there are no warning signs in pregnancy. Therefore all couples should know - *in advance* - where the nearest hospital or maternity unit is to be found and how to get there. In case problems arise during labour, the father-to-be should make advance arrangements for moving the mother-to-be to the nearest hospital or maternity unit. In particular, transport should be arranged in case it is needed.

4

All women need more food during pregnancy. All pregnant women need more rest.

O The husband and family of a pregnant woman should ensure that she has a variety of extra foods every day - starting as soon as pregnancy is confirmed. She should also have more rest than usual during the daytime, especially in the three months before the birth.

O A pregnant woman needs a variety of the best foods available to the family: milk, fruit, vegetables, meat, fish, eggs, pulses, and grains. There is no reason to avoid any of these foods during pregnancy.

O If possible, a woman should be weighed as soon as she knows that she is pregnant. It is important to gain weight every month during pregnancy, and to try to gain a total of 8-10 kilos before the baby is born.

5

Spacing pregnancies at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35, drastica reduces the dangers of child-bearing.

O One of the most effective ways of reducing the dangers of pregnanc and childbirth - for both mother and child - is to plan the timing of birth The risks of child-bearing are greatest when the mother-to-be is under or over 35, or has had four or more previous pregnancies, or when thei is a gap of less than two years since the last birth.

O Avoiding births by having an unsafe abortion can be very dangerou Illegal abortions carried out by untrained persons kill between 100,00(and 200,000 women every year.

6

Girls who are healthy and well fed during their own childhood a teenage years have fewer problems in pregnancy and childbirth.

O Safe and successful childbearing depends most of all on the health a readiness of the mother-to-be. So special attention should be paid to th health, feeding, and education of adolescent girls. The first pregnancy should wait until at least the age of 18.

7

If a woman who is pregnant smokes, or takes alcohol or drugs, h child may be damaged in the womb.

O A pregnant woman can damage her unborn child by smoking tobac drinking alcohol, and using narcotic drugs. It is particularly important r to take medicines during pregnancy unless they are absolutely necess and prescribed by a trained health worker.

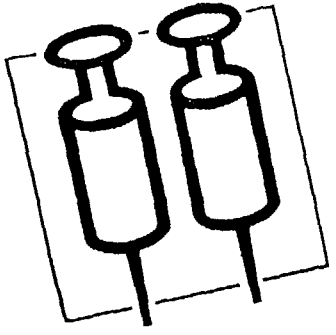
Immunization Prime Messages

1 Immunization protects against several dangerous diseases. A child who is not immunized is more likely to become undernourished, to become disabled, and to die.

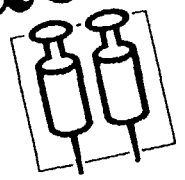
2 Immunization is urgent. All immunizations should be completed in the first year of the child's life.

3 It is safe to immunize a sick child.

4 Every woman between the ages of 15 and 44 should be fully immunized against tetanus.



Immunization Supporting Information



1

Immunization protects against several dangerous diseases. A child who is not immunized is more likely to become undernourished, to become disabled, and to die.

O Immunization protects children against some of the most dangerous diseases of childhood. A child is immunized by vaccines which are injected or given by mouth. The vaccines work by building up the child's defences. If the disease strikes before a child is immunized, immunization is too late.

O A child who is not immunized is very likely to get measles and whooping cough. These diseases can kill. But even children who survive these diseases are weakened by them. They may not grow well. And they may die later from malnutrition or other illnesses.

O Measles is also an important cause of malnutrition, poor mental growth, and blindness.

O An unimmunized child will almost certainly be infected with the polio virus. And for every 200 children who are infected, one will be crippled for life.

O Tetanus germs grow in dirty cuts and kill most of the people who become infected - if they are not immunized.

O Breastfeeding is a kind of natural immunization against several diseases. Some of the mother's resistance to disease is passed to the child in her breastmilk, and especially in the thick yellow milk (called colostrum) which is produced during the first few days after the birth.

2

Immunization is urgent. All immunizations should be completed i the first year of the child's life.

O It is vital to immunize children early in life. Half of all deaths from whooping cough, one third of all cases of polio, and a quarter of all deatl from measles, occur before the age of one year.

O It is vital for infants to complete the full course of immunizations, otherwise the vaccines may not work. Some vaccines need to be given only once. Others have to be given three times, with a gap of at least fou weeks between each dose.

O The important thing for parents to know is that a child should be tak for immunization five times in the first year of the child's life:

- at birth, or as soon as possible afterwards, babies should be immunized against tuberculosis
- in countries where polio is still a problem, newborn babies can also b given a dose of polio vaccine. This is in addition to the three doses giver at the ages of 6, 10 and 14 weeks
- at the age of 6 weeks, parents should bring their babies for a first immunization against diphtheria, whooping cough, and tetanus. These three vaccines are given together in a single injection called DPT. The first of three doses of polio vaccine should also be given at this time
- at the ages of 10 and 14 weeks, parents should return for their infant to complete the full course of DPT and polio vaccines
- as soon as possible after the age of nine months, parents should brin their babies for immunization against measles.

O Measles is one of the most dangerous of all childhood diseases. For the first few months of life, the child has some natural protection against measles. This natural protection is inherited from the child's mother. It may prevent measles vaccination from doing its job. But after about nine months, natural protection comes to an end. The child is now at risk fro measles and can and should be immunized. So it is vital to take a child fc measles vaccination as soon as possible after the age of nine months.

O If for any reason a child has not been fully immunized in the first yea of life, it is vital to have the child immunized as soon as possible.

	Immunization schedule for infants*
AGE	DISEASE TO BE IMMUNIZED AGAINST
Birth	Tuberculosis (and polio in some countries)
6 weeks	Diphtheria, whooping cough, tetanus, polio
10 weeks	Diphtheria, whooping cough, tetanus, polio
14 weeks	Diphtheria, whooping cough, tetanus, polio
9 months	Measles (12-15 months in industrialized countries and polio in some countries)
	*National immunization schedules may differ slightly from country to country.

3

○ One of the main reasons why parents do not bring their children for immunization is that the child has a fever, a cough, a cold, diarrhoea, or some other mild illness on the day the child is to be immunized. Even if the child with a case of mild illness or malnutrition is brought for immunization, health workers may advise against giving the injections. This is wrong advice. It is now known that it is safe to immunize a child who is suffering from a minor illness or malnutrition.

○ After an injection the child may cry, develop a fever, a rash, or a small sore. As with any illness, a child should be given plenty of food and liquids. Breastfeeding is especially helpful. If the problem seems serious or lasts more than three days, the child should be taken to a health centre.

4

Every woman between the ages of 15 and 44 should be fully immunized against tetanus.

○ In many parts of the world, mothers give birth in unhygienic conditions. This puts both mother and child at risk from tetanus, a major killer of the newborn. If the mother is not immunized against tetanus, then one baby in every 100 will die from the disease.

○ Tetanus germs grow in dirty cuts. This can happen, for example, if an unclean knife is used to cut the umbilical cord or if anything unclean is put on the stump of the cord. (Anything used to cut the cord should first be cleaned and then boiled or heated in a flame and allowed to cool.)

If the tetanus germs enter the mother's body, and if she is not immuni: against tetanus, then her life will also be at risk.

○ All women of child-bearing age should be immunized against tetan All women who become pregnant should check to make sure they hav been immunized against tetanus. In this way, both mothers and their new-born babies will be protected.

○ If a woman is not already immunized, a first dose of tetanus vaccine should be given as soon as she becomes pregnant. The second dose c be given four weeks after the first. This second dose should be given *before* the last two weeks of the pregnancy.

A third dose should be given 6 to 12 months after the second dose, or during the next pregnancy.

These three tetanus vaccinations protect the mother, and her newbor baby, for five years. All infants should be immunized against tetanus during the first year of life.

○ If a girl or a woman has been vaccinated five times against tetanus, then she is protected against the disease throughout her years of child-bearing. Any children she may then have will also be protected f the first few weeks of life.

Appendix Q

CESAMO/MOH Maternal Card

PROYECTO SOBREVIVENCIA INFANTIL VIII
ADRA
CONTROL PRENATAL

NOMBRE._____ FECHA DE NACIMIENTO:_____
DIRECCION:_____
ESTADO CIVIL: _____

TOXOIDE TETANICO

1 DOSIS	2 DOSIS	3 DOSIS	Remitida

CONTROL PRENATAL

1	2	3	Remitida

CRITERIOS DE RIESGO	REMISION POR SER EMBARAZO DE RIES(
1 - SANGRADO VAGINAL	
2.- MUJER DE BAJO PESO	
3.- NO GANA PESO	
4 - HINCHAZON	
5.- INFECCION URINARIA	
6.- FIEBRE	
7.- EMBARAZO ANTES DE 18 AÑOS	
8.- EMBARAZO DESPUES DE 35 AÑOS	
9.- LE HA NACIDO NIÑO PREMATURO	
10.- VOMITO	
11.- ANEMIA	
12.- DOLORES DE CABEZA	
13 -VISION BORROSA	
14.- SUMBIDO DE OIDOS	
15.- DISMINUCION O AUSENCIA DE MOVIMIENTOS FETALES	

MUJERES EN EDAD FERTIL

NOMBRE	EDAD	TOXOIDE TETANICO DOSIS					REMITIDA	METODO ANTICONC.
		1era.	2da.	3era.	4ta.	5ta.		

REMITIDA POR: CITOLOGIA , TOXOIDE, PLANIFICACION FAMILIAR

Appendix R

Key Messages on Family Planning

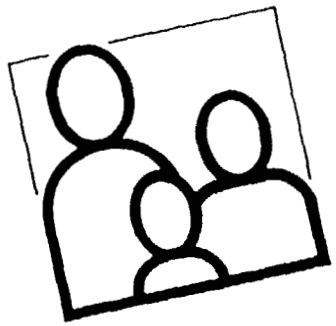
Timing Births
Prime Messages

1 Becoming pregnant before the age of 18, or after the age of 35, increases the health risks for both mother and child.

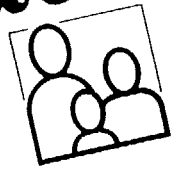
2 The risk of death for young children is increased by up to about 50% if the space between births is less than two years.

3 Having more than four children increases the health risks of pregnancy and childbirth.

4 There are many safe and acceptable ways of avoiding pregnancy. Family planning services can give couples the knowledge and the means to plan when to begin having children, how far apart to have them, and when to stop.



Timing Births Supporting Information



1

Becoming pregnant before the age of 18, or after the age of 35, increases the health risks for both mother and child.

○ Every year over half a million women die from problems linked to pregnancy and childbirth, leaving behind over 1 million motherless children. Most of these deaths could be prevented by acting on today's knowledge about the importance of planning pregnancies.

All girls should be allowed the time to become women before becoming mothers. In societies where many girls marry at an early age, couples should delay the first pregnancy until at least the age of 18.

○ For health reasons alone, no girl should become pregnant before the age of 18. A woman is not physically ready to begin bearing children until she is about 18 years of age. Babies born to women younger than 18 are more likely to be born too early and to weigh too little at birth. The birth itself is likely to be more difficult. Babies born to mothers who are too young are also much more likely to die in the first year of life. The risks to the mother's own health are also greater.

○ After the age of 35, the health risks of pregnancy and childbirth begin to increase again. If a woman is over the age of 35, and has had four or more previous pregnancies, then another pregnancy is a serious risk to her own health and that of her unborn child.

2

The risk of death for young children is increased by about 50% if the space between births is less than two years.

○ For the health of both mothers and children, parents should wait until their youngest child is at least two years old before having another baby.

○ Children born too close together do not usually develop as well, physically or mentally, as children born at least two years apart.

○ One of the greatest threats to the health and growth of a child unde: the age of two is the birth of a new baby. Breastfeeding stops too suddenly, and the mother has less time to prepare the special foods a young child needs. Also, she may not be able to give the older child the care and attention he or she needs, especially during illness. As a resul the child often fails to grow and develop properly.

○ A mother's body needs two years to recover fully from pregnancy a childbirth. The risk to the mother's health is therefore greater if the ne birth follows too closely upon the last. The mother needs to give herse time to get her strength and energy back before she becomes pregnan again.

○ If a woman becomes pregnant before she is fully recovered from bearing a previous child, there is a higher chance that her new baby wi be born too early and too light in weight. Low-birth-weight babies are l likely to grow well, more likely to fall ill, and four times more likely to d in the first year of life than babies of normal weight.

3

Having more than four children increases the health risks of pregnancy and childbirth.

○ After a woman has had four children, further pregnancies bring greater risks to the life and health of both mother and child.

Especially if the previous births have not been spaced more than two years apart, a woman's body can easily become exhausted by repeated pregnancy, childbirth, breastfeeding, and looking after small children. Further pregnancies usually mean that her own health begins to suffer

○ After four pregnancies, there is an increased risk of serious health problems such as anaemia ('thin blood') and haemorrhage (heavy loss blood). The risk of giving birth to babies with disabilities, or with low birth weight, also increases after four pregnancies and after the mothe reaches the age of 35.

4

There are many safe and acceptable ways of avoiding pregnancy Family planning services can give couples the knowledge and th means to plan when to begin having children, how far apart to h them, and when to stop.

○ Most health clinics can offer different methods of family planning s that all couples can choose a method which is acceptable, safe,

convenient, and effective. Couples should ask advice about the most suitable means of family planning from the nearest trained health worker or family planning clinic.

Some methods of family planning, such as condoms and contraceptive pills, may also be available from pharmacies and other shops.

○ Family planning is the responsibility of men as well as women. All men should be aware of the health benefits of family planning - and of the different methods now available.

Appendix S

Cover Pages of ADRA/Honduras CS Key Health Messages Manual

MANUAL

PARA PERSONAL VOLUNTARIO

LACTANCIA MATERNA

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

USAID

ADRA / HONDURAS

MANUAL

PARA PERSONAL VOLUNTARIO

INFECCIONES RESPIRATORIAS AGUDAS

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

USAID

ADRA / HONDURAS

MANUAL

PARA PERSONAL VOLUNTARIO

SALUD REPRODUCTIVA
Y
PLANIFICACION FAMILIAR

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

USAID

ADRA / HONDURAS

MANUAL

PARA PERSONAL VOLUNTARIO

INMUNIZACIONES

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

USAID

ADRA / HONDURAS

MANUAL

PARA PERSONAL VOLUNTARIO

MANEJO DE DIARREAS Y UROC

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

USAID

ADRA / HONDURAS

MANUAL

PARA PERSONAL VOLUNTARIO

NUTRICION

PROYECTO DE SUPERVIVENCIA INFANTIL / CS-VIII

MSPH

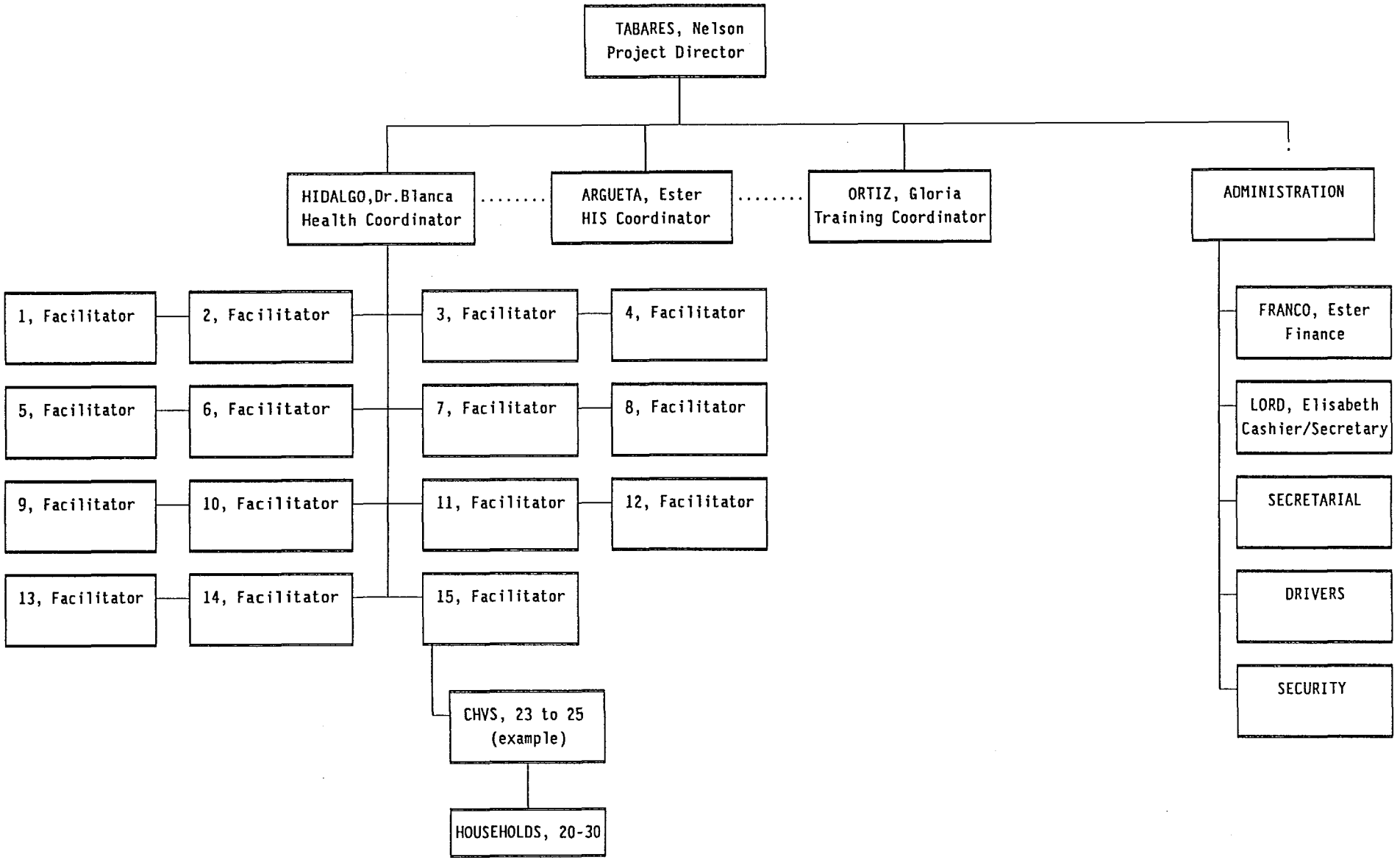
USAID

ADRA / HONDURAS

Appendix T

ADRA/Honduras CS XI Project Organizational Chart

ADRA HONDURAS CS XI PROJECT
ORGANIZATIONAL CHART



Appendix U

Project HIS Forms/Charts

CALENDARIO DE PESAJE VOLUNARIO DE SALUD

Nº	NOMBRE VOLUNTARIO																							OBSERVACIONES

MOVIMIENTO DE LAS BASCULAS DURANTE EL MES

	NOMBRE	SECTOR/MANZANA	1er.SEMINARIO	2do.SEMINARIO	3er.SEMINARIO	4to. SEMIN.

ADRA-HONDURAS
PROYECTO SOBREVIVENCIA INFANTIL
RESUMEN MENSUAL DE ACTIVIDADES

Voluntaria:---------- *Trimestre:*-------/-------

Supervisora:---------- *Area:*----------

ACTIVIDAD	1	2	3	TOTAL
Supervisoras				
Número de familias				
NUTRICION				
Lactancia Materna				
Número de niños menores de 4 meses				
Niños con Lactancia Materna Exclusiva 4 meses				
Niños con Lactancia Materna hasta 2 años				
Charlas y Orientaciones				
Demostraciones				
Remisiones				
DESTETE				
Charlas y Orientaciones				
Número de madres incluidas				
Demostraciones				
Remisiones				
CONTROL Y CRECIMIENTO				
Número de niños pesados				
Número de niños de 0-23 meses				
Niños de 24-59 meses				
Niños normales				
Niños sobre peso				
Niños grado I				
Niños grado II				
Niños grado III				
Centros de pesaje				
Supervisiones de pesaje				
Huertos familiares				
Huertos comunales				
Charlas y orientaciones				
Demostraciones				
Remisiones				
VITAMINA "A"				
Número de niños de 12-59 meses				
Niños de 12-59 meses con Vitamina "A"				
Niños de 12-59 meses sin Vitamina "A"				
Puérperas con Vitamina "A"				
Vitamina "A" distribuida				
Charlas y Orientaciones				
Remisiones				
INMUNIZACIONES				
Niños de 0-23 meses esquema completo				
Niños de 0-23 meses esquema incompleto				
Niños de 24-59 meses completo				
Niños de 24-59 meses incompleto				
Campañas				
Charlas y Orientaciones				
Remisiones				

ACTIVIDAD	1	2	3	TOTAL
CUIDADOS MATERNALES				
Mujeres en Edad Fértil				
Mujeres Embarazadas				
Mujeres en Control de Embarazo				
Mujeres con Toxoide Tetánico				
Mujeres Planificación Familiar				
Condones Distribuidos				
Nacimientos Reportados				
Charlas y Orientaciones				
Remisiones				
CONTROL DE DIARREA				
Niños con diarrea reportados				
Niños con diarrea tratados con Litrosol				
Litrosol distribuido				
Número de UROCS				
Atenciones en UROCS				
Charlas y Orientaciones				
Demostraciones				
Remisiones				
IRAS				
Niños con IRA reportados				
Madres que reconocen 2 signos de Neumonía				
Charlas y Orientaciones				
Demostraciones				
Remisiones				
GENERACION DE INGRESOS				
Bancos y Microempresas				
Reuniones de Bancos y Microempresas				
Supervisiones a Bancos y Microempresas				
Número de beneficiarias				
Capacitaciones				
INFORMACION GENERAL				
Voluntario				
Entrenamiento y capacitación a Voluntario				
Visita supervisora a voluntario				
Educación supervisora a voluntario				
Visita supervisora a familia				
Visita voluntaria a familia				
Educación Voluntaria a familia				
Capacitación				
Reunión mensual voluntaria				
Reunión coordinación con personal CESAMOS				
Reunión con líderes comunitarios				
Total de remisiones				
Muertes reportadas				
Causas de muerte				

PROGRAMA SUPERVIVENCIA INFANTIL VIII

REPORTE SEMANAL

SUPERVISORA: ----------DEL ----------A----------DE----------DE 199---

FECHA	ACTIVIDAD	PROGRAMADO	REALIZADO	DIFERENCIA	OBSERVACIONES

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA METROPOLITANA
INFORME DE VISITA DOMICILIARIA

NOMBRE DEL JEFE DE FAMILIA _____

DIRECCION DE LA VIVIENDA _____

NOMBRE DEL VOLUNTARIO DE SALUD _____ COMUNIDAD _____

CESAMO: _____ FECHA _____

INTERVENCION	QUE HACER EN LA INTERVENCION					
DIARREA NOMBRE(S)	PREGUNTE DESDE CUANDO TIENE DIARREA	ESTA DESHIDRATADO SI NO	TOTAI SOBRES DE LITROSOL ENTREGADOS	ENSEÑE A LA MADRE LA PREPARACION DEL LITROSOL	REFIERA AL NIÑO SI ES NECESARIO	REGRESE A VISITAR AL NIÑO
_____ EDAD ____	_____	___ ___	_____	_____	_____	_____
_____ EDAD: ____	_____	___ ___	_____	_____	_____	_____
_____ EDAD: ____	_____	___ ___	_____	_____	_____	_____
I R A	DESDE CUANDO TIENE IRA EL NIÑO	LA RESPIRACION DEL NIÑO ES NORMA RAPIDA	INDIQUE TRO Y LIQUIDOS _____ PUEDE BEBER NIÑO SI NO	TOTAL SOBRES DE LITROSOL ENTREGADOS _____ DEMUESTRE COMO MANTENER LIMPIA LA NARIZ E INDIQUE GOTAS DE MANZANILLA	DIGALE A LA MADRE CUALES SON LAS SEÑALES DE NEUMONIA	REFIERA AL NIÑO SI ES NECESARIO REGRESE A VISITARLO
NOMBRES(S) _____ EDAD ____	_____	___ ___	___ ___		_____	_____
_____ EDAD: ____	_____	___ ___	___ ___		_____	_____
NUTRICION NOMBRE(S)	P E S O	ENSEÑE E INDIQUE EL GRADO NUTRICIONAL	DE EDUCACION SOBRE ALIMENTACION DEL NIÑO	DE VITAMINA "A" SI ESTA INDICADO DOSIS DADA	REFIERA AL NIÑO SI ES NECESARIO SI NO	REGRESE A EVALUAR AL AL NIÑO
_____ EDAD ____	_____	_____		_____	___ ___	
_____ EDAD ____	_____	_____		_____	___ ___	
_____ EDAD ____	_____	_____		_____	___ ___	
VACUNAS NOMBRE DEL NIÑO(S)	PIDA EL CARNET Y REVISELO	DOSIS PENDIENTE	BRINDE EDUCACION EN PAI	REFIERALO AL CENTRO DE SALUD O PUESTO DE VACUNACION	REGRESE A COMPROBAR LA APLICACION DE LA VACUNA	
_____ EDAD ____		_____		_____		
_____ EDAD ____		_____		_____		
_____ EDAD ____		_____		_____		

EMBARAZADAS	ESTA EN CONTROL		ORIENTE SOBRE LA IMPORTANCIA DEL CONTROL PRENATAL	DETECTE Y REFIERA LA EMBARAZADA CON RIESGO	REVISE EL CARNET DE VACUNACION Y REFIERA SI TIENE DOSIS PENDIENTE	REGRESE A COMPROBAR EL CONTROL DE EMBARAZO Y LA APLICACION DE LA VACUNA	EDUQUE SOBRE EL CONTROL A LOS 10 DIAS DESPUES DEL PARTO Y LACTANCIA MATERNA
NOMBRE DE LA EMBARAZADA	SI	NO					
EDAD							
EDAD							
EDAD							

RIESGO REPRODUCTIVO Y PLANIFICACION FAMILIAR		No. DE HIJOS			ENFERMEDAD CRONICA DE LA CUAL PADECE				TIENE VACUNA TOXOIDE PENDIENTE		USA ALGUN METODO DE PLANIFICACION	No. DE CONDONES DISTRIBUIDOS
NOMBRE DE LA MUJER EN RIESGO REPRODUCTIVO		VIVOS	MUERTOS	ABORTOS	PRESION ALTA	DIABETES	PROBLEMAS DE: VENAS	CORAZON	SI	NO	CUAL:	
NOMBRE	EDAD											DIO EDUCACION
												REFIRIO
												SI NO

SINTOM. RESP. (TOSEDORES)		TIENE GARGAJO		DIO EL VASO PARA MUESTRA		EDUCACION	REFERENCIA	REGRESE A VERIFICAR SI LLEVO LA MUESTRA
NOMBRE	EDAD	SI	NO	SI	NO			

OTRAS ATENCIONES		MOTIVO DE REFERENCIA
NOMBRE	EDAD	

NACIMIENTOS	FECHA			SEXO		QUIEN ATENDIO PARTO		TIPO DE PARTO		TIPO DE NACIMIENTO		AMAMANTADO		INSCRITO EN EL RNP	
NOMBRE RECIEN NACIDO	DIA	MES	AÑO	M	F	MEDICO	PARTERA	NORMAL	CESAREA	ANTES DE 9 M.	DESPUES	SI	NO	SI	NO

NOMBRE MADRE DEL R.N.

MUERTES		SEXO		FECHA MUERTE	CAUSA DE LA MUERTE	LUGAR DE MUERTE	REPORTADO EN RNP	
NOMBRE	EDAD	M	F	DIA MES AÑO			SI	NO

OTRAS ACTIVIDADES REALIZADAS

ACTIVIDADES DE SANEAMIENTO

BEST AVAILABLE COPY

REGISTRO DE ATENCIONES POR PERSONAL COMUNITARIO

NOMBRE DEL VOLUNTARIO | MANZANA | LOCALIDAD | ESTABLEC COM 1 | MES | AÑO

NOMBRE DE LA PERSONA	SEXO		EDAD			SINTOMAS				PLANIFICACION FAMILIAR		ATENCION RECIBIDA	REFERENCIAS ENVIADAS	No. SOBRES DE LITROSOL ENTREGADOS
	M	F	< 5	5-14	+ 15	DIARREA	CATARRO	TOSEDOR	OTROS	CONDON	TAB.VAG			
SUB TOTAL														

UNIC - RSM - DEPTO EST

PLANIFICACION FAMILIAR

Píldora _____

Div _____

Ritmo _____

Inyección _____

Jaleas _____

EXISTENCIA Y ENTREGA DE SUMINISTROS

	ENTREGA	EXISTENCIA
LITROSOL		
CONDONES		
TAB. VAGINAL		

136

CODIGO	NOMBRE	PESO	NIV.	BCG	DPT 1-2-3	POLIO/RN 1-2-3	SARAMP 1-2-3	VISIT DOMIC	VIT "A"

EMBARAZADA

CODIGO	NOMBRE	PESO	NIV	REVIS. CAUSA	TOXOIDE 1-2-3-4-5	TIPO DE CHARLA
						1.
						2.
						DEMOSTRACIONES
						1. ( )
						2. ( )
						VISITA DOMICILIARIAS

MINISTERIO DE SALUD PUBLICA - CESAMO
CONTROL DE REHIDRATACION ORAL
UROCS

Nombre del niño:_____ Fecha Nac:_____Edad ____
Nombre de la madre:_____Dirección_____
Fecha inicio diarrea:_____Características: cantidad_____consistencia_____
moco:_____sangre_____ Vómitos: Sí____ No_____ Nº veces al día_____

Fecha y hora de ingreso_____

EVALUACION DEL PACIENTE			
SIGNOS Y SINTOMAS	PLAN "A"	PLAN "B"	PLAN "C"
Observe:			
CONDICION	Bien alerta	Intranquilo	Comatoso
		Irritable	Hipotonico
OJOS	Normales	Hundidos	Muy hundidos y secos
LAGRIMAS	Presentes	Ausentes	AUSENTES
BOCA Y LENGUA	Húmedas	Secas	Muy secas
SED	Bebe normal	Sediento,rápido	Bebe mal o no es ca-
		y avidamente	paz de beber
EXPLORE :			
SIGNO DEL PLIEGUE	Desaparece	Desaparece	Desaparece muy len-
	rápidamente	lentamente	tamente por más de 2
			segundos
DECIDA	No tiene signos de deshidratación sólo un signo de plan "B"	Presenta dos o más signos del plan "B"	Presenta 2 ó más signos del plan "C"

EVOLUCION Y MANEJO				
TIEMPO LIQUIDOS	NUMERO VOMITOS	NUMERO EVACUACION	ORINA	ALIMENTOS
1 HORA				
2 HORAS				
3 HORAS				
4 HORAS				
REEVALUACION				
5 HORAS				
6 HORAS				

Indicaciones: Alta con plan "A"_____ continua con plan "B"_____ se refirió_____

Fecha y hora de egreso_____Nombre de la persona que atendió al niño_____

PROYECTO DE SOBREVIVENCIA INFANTIL VIII
ADRA

NIÑO: _____ DIRECION: _____
MADRE: _____ SEXO: F M / FECHA NAC._____
PADRE: _____ FECHA INCORPORACION:_____
FECHA SALIDA: _____

	1993			1994			1995			Lactanc.	Aliment.
MES	PESO	NIVEL	CURVA	PESO	NIVEL	CURVA	PESO	NIVEL	CURVA	Exclusiv.	complem
Enero											
Febrero											
Marzo											
il											
Mayo											
Junio											
Julio											
Agosto											
Septiem											
Octubre											
Noviem.											
Diciemb											

	1 dosis	2 dosis	3 dosis	4 dosis	5 dosis	6 dosis	7 dosis	8 dosis	9 dosis	10 dosis
VIT "A"										

VACUNA	primera	segunda	tercera	REFUERZOS
BCG				
DPT				
POLIO				
SARAMP.				

FECHA	Sin deshi-dratación	Con deshi dratacion	Trat. con Litrosol	Remitido

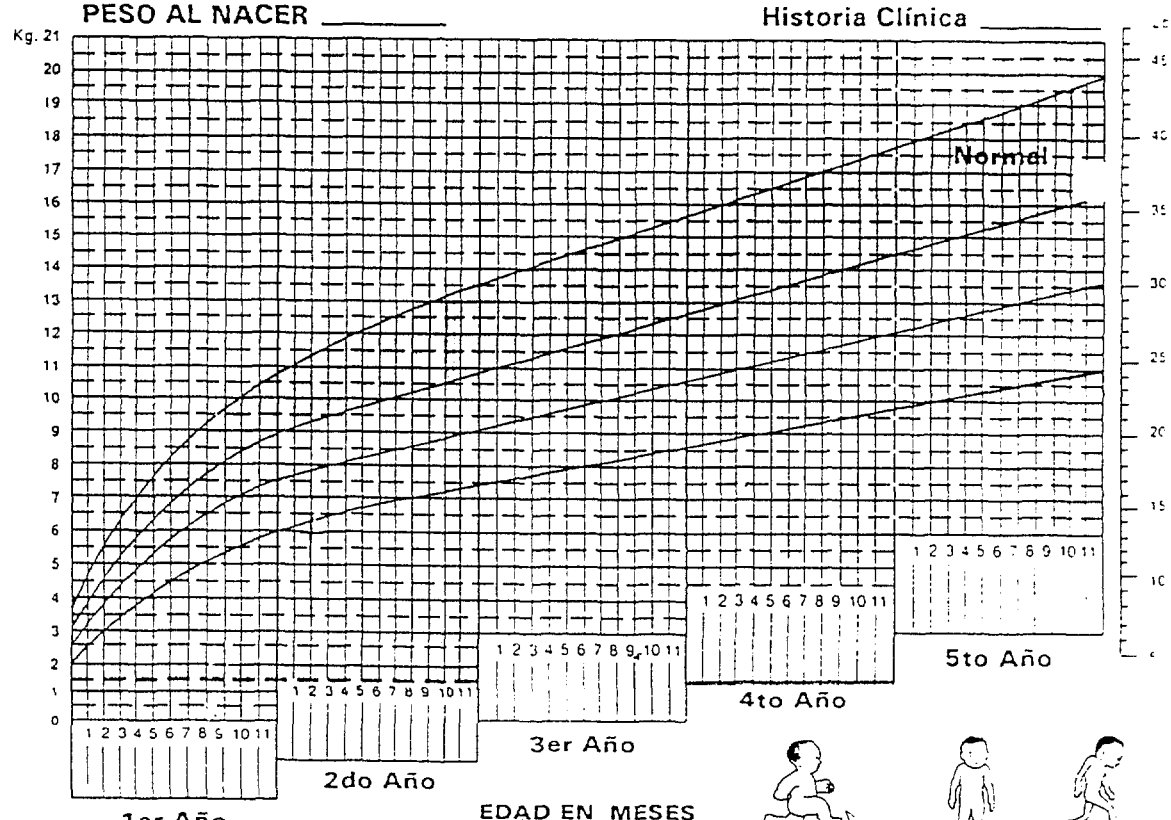
	FECHA	Tos o Gripe	Neumo-nía	Trat. con Litrosol	Tratam. Casero	Remitido
Enero						
Febrero						
Marzo						
Abril						
Mayo						
Junio						
Julio						
Agosto						
Septiemb.						
Octubre						
Noviemb.						
Diciemb.						

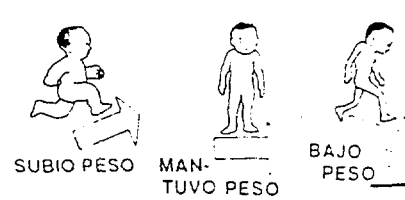
Alimentación DEL NIÑO

GRAFICA DE PESO PARA EDAD

Vitamina A _____

PESO AL NACER _____ Historia Clínica _____





AL AÑO EL NIÑO DEBE COMER DE TODO

-140-

REGION SANITARIA
METROPOLITANA
COPIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

REGION SANITARIA
METROPOLITANA
REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

Diarrea | Ira | Vacuna | Enferm. Inmun. | Desnutridos

Recién Nacido | Control Embar. | Planif. Familiar | Sinto Respir. | Otras

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

REGION SANITARIA
METROPOLITANA
CONTRA-REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA CONTRA-REFERENCIA

COMUNIDAD:

VOLUNTARIO DE SALUD

ESTABLECIMIENTO

NOMBRE DEL REMITENTE

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
COPIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

Diarrea | Ira | Vacuna | Enferm. Inmun. | Desnutridos

Recién Nacido | Control Embar. | Planif. Familiar | Sinto Respir. | Otras

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
CONTRA-REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA CONTRA-REFERENCIA

COMUNIDAD:

VOLUNTARIO DE SALUD

ESTABLECIMIENTO

NOMBRE DEL REMITENTE

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
COPIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA REFERENCIA:

Diarrea | Ira | Vacuna | Enferm. Inmun. | Desnutridos

Recién Nacido | Control Embar. | Planif. Familiar | Sinto Respir. | Otras

OTRO ESPECIFIQUE

ESTABLECIMIENTO AL CUAL REFIERE

COMUNIDAD

VOLUNTARIO DE SALUD

FECHA

MINISTERIO DE SALUD PUBLICA
REGION SANITARIA
METROPOLITANA
CONTRA-REFERENCIA # 0001

NOMBRE:

EDAD:

MOTIVO DE LA CONTRA-REFERENCIA

COMUNIDAD:

VOLUNTARIO DE SALUD

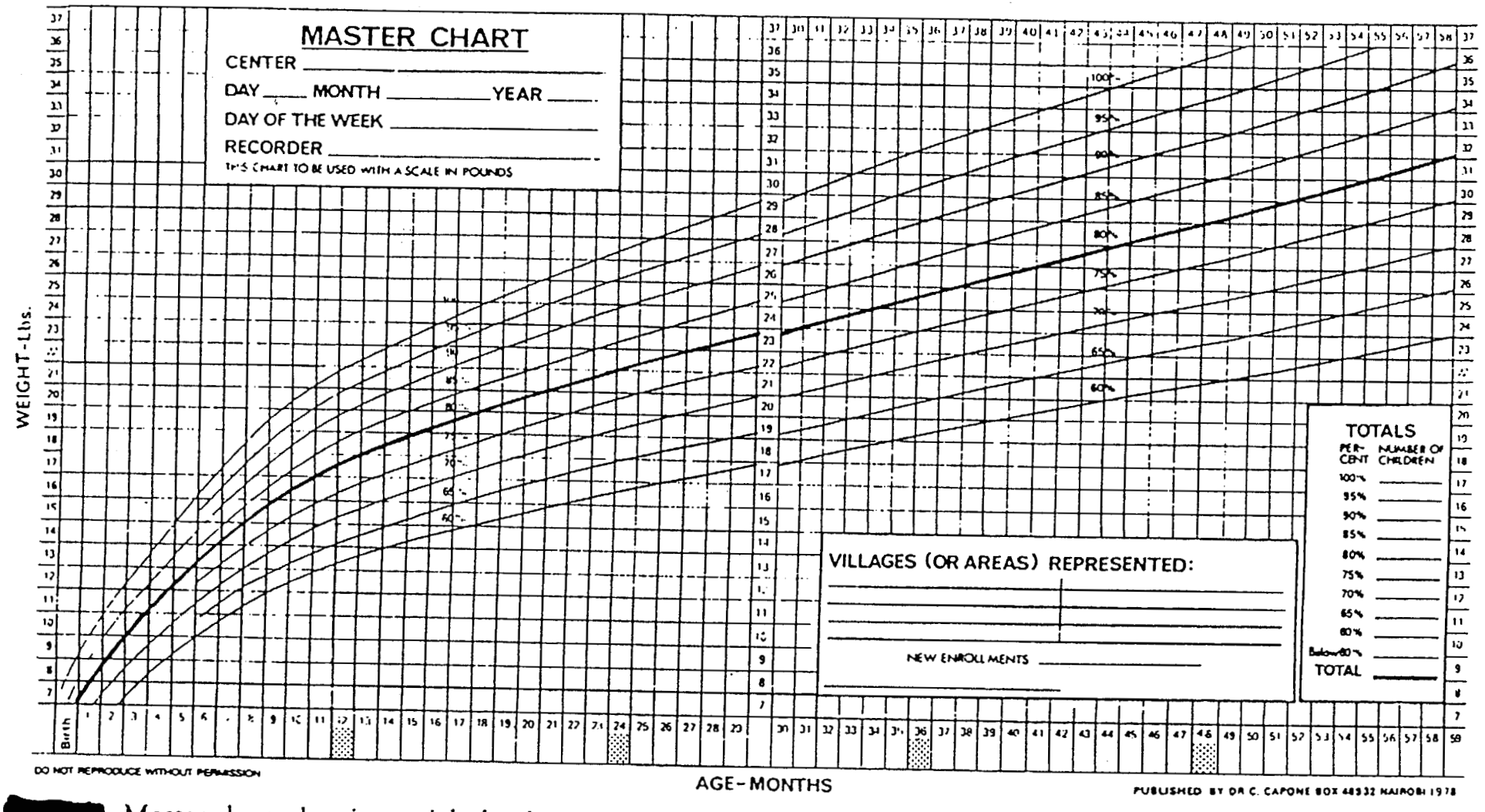
ESTABLECIMIENTO

NOMBRE DEL REMITENTE

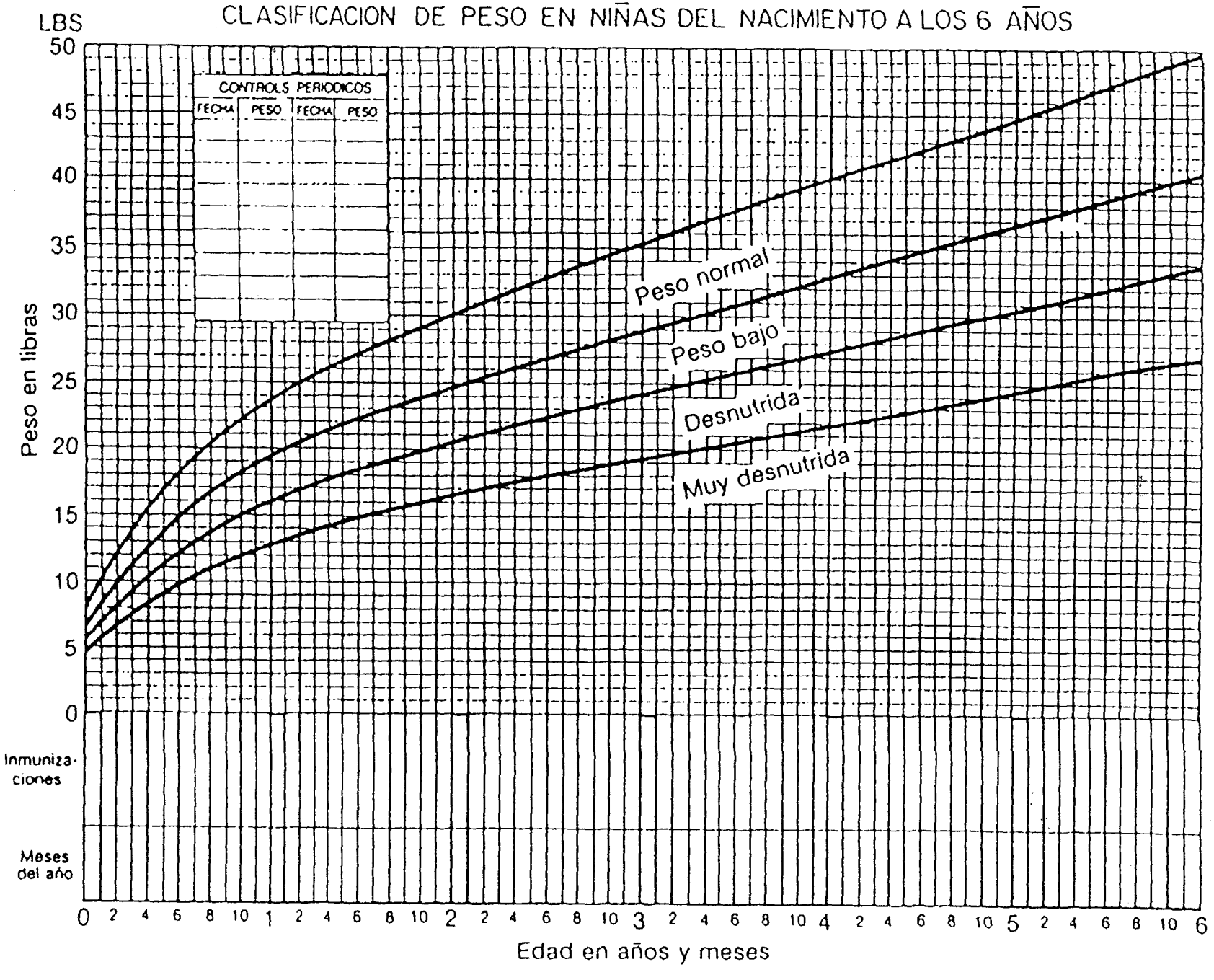
FECHA

Appendix V

Growth Monitoring Master Chart



[redacted] Master chart, showing weight levels at 10 per cent intervals for use in collecting information from mothers attending clinic(s) or in an area. This could be simplified using reference (100 per cent), −2 SD (approximately 80 per cent), −3 SD (approximately 70 per cent), and −4 SD (approximately 60 per cent). (Courtesy of Dr C. Capone, Catholic Relief, Nairobi, Kenya.)



Multi-line chart using the Gómez classification with added descriptive labels (*peso bajo* = low weight, etc.)

Appendix W

WHO Immunization Schedule

Vaccination Schedules

1. Schedule recommended by WHO to assure protection at an early age is as follows:

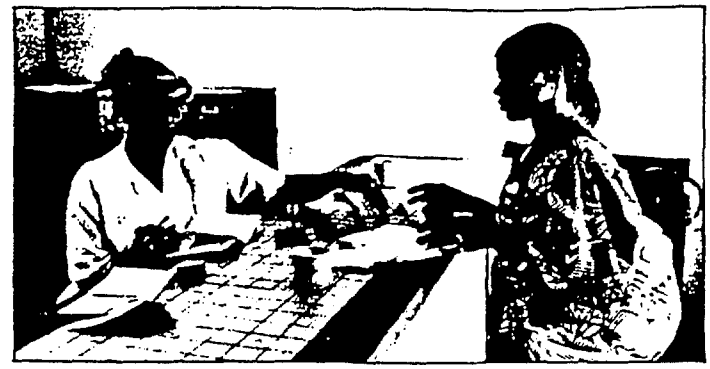
AGE	VACCINE	REASON
Birth	BCG, OPV_0^*	BCG given at the earliest possible age protects against the possibility of infection from other family members. The extent of protection against polio is increased the earlier the OPV is given.
6 weeks	DPT_1, OPV_1	An early start with DPT reduces the chances of severe pertussis.
10 weeks 14 weeks	DPT_2, OPV_2 DPT_3, OPV_3	Four week intervals between doses give effective protection, and reduce the time a child is exposed without protection, particularly to pertussis.
9 months	Measles	At least 80% of measles in children in the third world can be prevented by vaccination at this age.

*OPV: Oral Poliovirus Vaccine (dose at birth is *in addition* to the standard schedule of 3 doses)

2. WHO sample schedule for contacts at intervals from four weeks to four months:

AGE	VACCINE	REASON
Less than 6 weeks	BCG, OPV_0	This schedule is useful where populations are dispersed and accessible mostly to outreach services; protection is not optimal
Above 6 weeks	BCG (if not already given) OPV_1, OPV_2, OPV_3, DPT_1, DPT_2, DPT_3,	
Above 9 months	Measles	

Continued



VERONIQUE LEGER

Careful screening is essential if women and children are to receive every vaccine they are eligible for when they visit a clinic.

3. WHO sample schedule for contacts every six months:

AGE	VACCINE	REASON
Less than 3 years	OPV as often as contacted; DPT up to three doses; BCG once	Semi-annual schedules inadequately protect against pertussis, polio, and measles. These schedules should only be used in the most remote areas where it is infeasible to vaccinate more often.
From 6 months to 3 years	Measles, two doses if the first is given below 9 months, otherwise one dose	

4. Semi-annual single day "pulse" campaigns (as used in Brazil):

AGE	VACCINE	REASON
All children 0-59 months old	OPV (up to 10 doses)	After mass vaccination with OPV, the vaccine virus replaces the naturally occurring disease-causing virus in the environment.
All children 9-23 months old	measles (up to 2 doses)	Giving a second dose of measles vaccine increases effective coverage.
All children 2-11 months old	DPT (2 doses)	Third DPT through regular primary health care services in clinics; 2 doses of DPT are partially effective (50-60%) against pertussis.

Continued

5. Special vaccination for women against tetanus with tetanus toxoid:

AGE	VACCINE	REASON
Puberty or as early in any pregnancy as possible.	TT_1	Begin as close to childbearing age as possible (no protection against neonatal tetanus with one dose unless DPT previously given in childhood)
At least four weeks later	TT_2	Gives 3 years protection
At least six months later, or in next pregnancy	TT_3	Gives 5 years protection
At least one year later, or in the next pregnancy	TT_4	Gives 10 years protection
At least one year later, or in the next pregnancy	TT_5	Expected to protect all infants born to that mother

Tetanus toxoid schedules for women are more flexible than childhood vaccination schedules. Women should be vaccinated at least twice with tetanus toxoid before the first birth, or anytime during pregnancy. Note that the first dose can be given as soon as early puberty when girls may still be in school. A woman who received three doses of DPT in childhood and/or two doses of DT at school age may need only one TT booster when she reaches childbearing age.

Vaccination Session Records

All vaccination sessions need a record of vaccinations performed by vaccine and age group. The easiest way to maintain records is to keep a simple tally, as shown in the form at the right. Tally records should also show the number of vials of vaccine used. In addition to recording vaccine stocks, the record allows vaccinators to compare the number of doses used to the number of children vaccinated. This gives an estimate of wastage which is used to estimate future vaccine orders.

Appendix X

Service Quality Checklist for ALRI

PHC service quality checklist
Acute respiratory infection

This checklist is intended for use in the observation of service delivery for acute respiratory infection. Before using it, the national treatment protocol should be reviewed in order to adapt the tool to the local situation if necessary. It is also recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. _____ Health facility
2. _____ Service provider
3. _____ Observer/supervisor
4. _____ Date

Medical history

Did the service provider:

5. YES_____NO_____ Ask about presence/level of fever?
6. YES_____NO_____ Ask about duration of cough?
7. YES_____NO_____ Ask about activity level?
8. YES_____NO_____ Ask about ability to drink?
9. YES_____NO_____ Ask about presence of sore throat?
10. YES_____NO_____ Ask about presence of earache?
11. YES_____NO_____ Ask about any past history of respiratory problems (e.g. asthma)?
12. YES_____NO_____ Ask about family history of TB or other respiratory illness?
13. YES_____NO_____ Ask about any treatment administered?

Physical examination

Did the service provider:

14. YES_____NO_____ Assess general status (alertness, muscle tone)?
15. YES_____NO_____ Count respiratory rate?
16. YES_____NO_____ Take temperature?
17. YES_____NO_____ Observe breathing for chest indrawing?
18. YES_____NO_____ Listen for stridor, wheeze, and/or hoarseness?
19. YES_____NO_____ Auscultate chest?
20. YES_____NO_____ Examine throat for discharge, enlarged tonsils, or inflamed pharynx?
21. YES_____NO_____ Examine neck for tender glands?
22. YES_____NO_____ Examine ears?
23. YES_____NO_____ Observe colour of lips, ears, face, and nail beds?

Classification, treatment and referral

Did the service provider:

24. YES_____NO_____ Classify child by severity of illness (cold, pneumonia, severe pneumonia)?
25. YES_____NO_____ Administer/prescribe antibiotics for pneumonia, strep or otitis (per local policy)?
26. YES_____NO_____ Refrain from using antibiotics for colds?
27. YES_____NO_____ Administer or prescribe drug for fever (per local polic
28. YES_____NO_____ Administer or prescribe cough mixture (per local poli
29. YES_____NO_____ Refer children with severe pneumonia or cough lastir than 30 days?

ARI education

Did the service provider:

30. YES_____NO_____ Explain how to administer antibiotics?
31. YES_____NO_____ Explain the importance of completing entire treatme course?
32. YES_____NO_____ Explain how to administer cough mixture (how much often, how long)?
33. YES_____NO_____ Explain how to drain child's nose (especially if mothe breast feeding)?
34. YES_____NO_____ Tell mother to give extra fluids, continue feeding/bre ing during illness?
35. YES_____NO_____ Tell mother to maintain a neutral temperature for th
36. YES_____NO_____ Tell mother about at least three of the signs/symptor moderate/severe ARI?[1]
37. YES_____NO_____ Tell mother to return for further consultation if the cl condition worsens or does not improve?
38. YES_____NO_____ Verify that mother understands key messages?
39. YES_____NO_____ Ask mother if she has any questions?

Essential supplies for ARI treatment

Ask the service provider about the following supplies:

40. YES_____NO_____ Do you have a watch with a second hand or other tin to assess respiratory rate?
41. YES_____NO_____ Were antibiotic supplies adequate during the last mor
42. YES_____NO_____ Do you have a thermometer to measure the patient's ature?

Interview with mother

Mark "yes" if the respondent answers correctly:

43. YES_____NO_____ How will you treat your child at home?[2]
44. YES_____NO_____ What danger signs indicate that you should bring chil health centre?[1]
45. YES_____NO_____ If antibiotics were prescribed: How will you administ medicine?
46. YES_____NO_____ If antibiotics were prescribed: When will you stop giv medicine to your child?

1 Danger signs include stridor, chest indrawing/rapid breathing, inability to drink, cyanosis, a weakness or lethargy.

2 Supportive home treatment includes extra fluids, continued feeding, maintaining a neutral te clearing the nose, and using cough medicine or antihistamine (per local policy).

Interview with health worker

Mark "yes" if the respondent answers correctly:

47. YES_____NO_____ What are the signs and symptoms of pneumonia?[1]
48. YES_____NO_____ How can you differentiate a cold from pneumonia?
49. YES_____NO_____ How can you differentiate pneumonia from severe pneumonia?[1]
50. YES_____NO_____ When do you prescribe antibiotics?
51. YES_____NO_____ What home treatments do you recommend for colds and pneumonia?[2]
52. YES_____NO_____ When should you refer a child to the health centre/hospital?

1 Severe pneumonia is defined as cases with respiratory rates over 50 for children from 2 months to 5 years old (over 60 for children under 2 months), and with danger signs such as severe chest indrawing, inability to drink, or stridor.

2 Supportive home treatment includes extra fluids, continued feeding, maintaining a neutral temperature, clearning the nose, and using cough medicine or antihistamine (per local policy).

Rapid quality assessment
Acute respiratory infection

This checklist is intended for rapid assessment of service quality in the observation of service delivery for acute respiratory infection. To use the checklist, mark "yes" if the service provider carries out the task during service delivery. For interviews, mark "yes" if the respondent answers correctly. If you would like to assess this service in more detail, please refer to the appropriate service quality checklist. The checklist item numbers below correspond to that list.

1. _____ Health facility
3. _____ *Observer/supervisor*
4. _____ Date

Did the service provider:

5-12. YES___NO_____ Ask at least two medical history questions?
13. YES___NO_____ Ask about any treatment administered?
15. YES___NO_____ Count respiratory rate?
24. YES___NO_____ Classify child by severity of illness?
25. YES___NO_____ Give antibiotics for pneumonia, strep throat or otitis?
26. YES___NO_____ Refrain from using antibiotics for colds?
36. YES___NO_____ Tell mother about at least three signs of pneumonia?[1]

Ask mother:
(If antibiotics were prescribed):

45-46. YES___NO_____ How will you administer the medicine (how much, how often, for how long)?

1 Signs include stridor, chest indrawing/rapid breathing, inability to drink, cyanosis, anxiety and weakness or lethargy.

Appendix Y

Assessment/Management Protocol for ALRI Cases

MANAGEMENT OF THE CHILD WITH COUGH OR DIFFICULT BREATHING

ASSESS

ASK:

- How old is the child?
- Is the child coughing? For how long?
- Age 2 months up to 5 years: Is the child able to drink?
  Age less than 2 months: Has the young infant stopped feeding well?
- Has the child had fever? For how long?
- Has the child had convulsions?

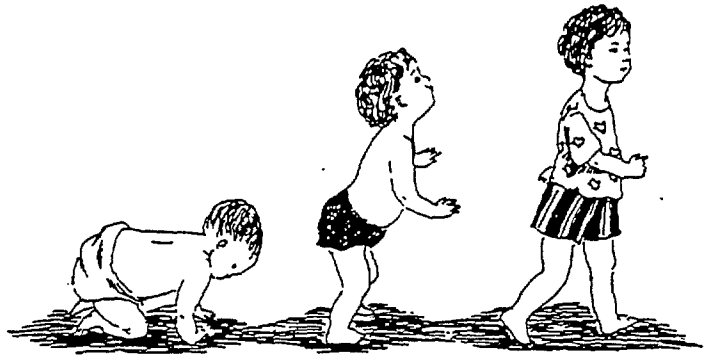
LOOK, LISTEN:

(Child must be calm)

- Count the breaths in one minute.
- Look for chest indrawing.
- Look and listen for stridor.
- Look and listen for wheeze. Is it recurrent?
- See if the child is abnormally sleepy, or difficult to wake.
- Feel for fever or low body temperature (or measure temperature).
- Look for severe malnutrition.

THE CHILD
AGE 2 MONTHS UP TO 5 YEARS

SIGNS:	• Not able to drink, • Convulsions, • Abnormally sleepy or difficult to wake, • Stridor in calm child, or • Severe malnutrition.
CLASSIFY AS:	VERY SEVERE DISEASE
TREATMENT:	► Refer URGENTLY to hospital. ► Give first dose of an antibiotic. ► Treat fever, if present. ► Treat wheezing, if present. ► If cerebral malaria is possible, give an antimalarial.



SIGNS:	• Chest indrawing. [If also recurrent wheezing, go directly to ► *Treat Wheezing*]	• No chest indrawing, and • Fast breathing (50 per minute or more if child 2 months up to 12 months; 40 per minute or more if child 12 months up to 5 years).	• No chest indrawing, and • No fast breathing (Less than 50 per minute if child 2 months up to 12 months; Less than 40 per minute if child 12 months up to 5 years).
CLASSIFY AS:	SEVERE PNEUMONIA	PNEUMONIA	NO PNEUMONIA: COUGH OR COLD
TREATMENT:	► Refer URGENTLY to hospital. ► Give first dose of an antibiotic. ► Treat fever, if present. ► Treat wheezing, if present. (If referral is not feasible, treat with an antibiotic and follow closely.)	► Advise mother to give home care. ► Give an antibiotic. ► Treat fever, if present. ► Treat wheezing, if present. ► Advise mother to return with child in 2 days for reassessment, or earlier if the child is getting worse.	► If coughing more than 30 days, refer for assessment. ► Assess and treat ear problem or sore throat, if present (see chart). ► Assess and treat other problems. ► Advise mother to give home care. ► Treat fever, if present. ► Treat wheezing, if present.

	Reassess in 2 days a child who is taking an antibiotic for pneumonia:		
SIGNS:	WORSE • Not able to drink. • Has chest indrawing. • Has other danger signs.	THE SAME	IMPROVING • Breathing slower. • Less fever. • Eating better.
TREATMENT:	► Refer URGENTLY to hospital.	► Change antibiotic or Refer.	► Finish 5 days of antibiotic.

THE YOUNG INFANT (AGE LESS THAN 2 MONTHS)

SIGNS:	• Stopped feeding well, • Convulsions, • Abnormally sleepy or difficult to wake, • Stridor in calm child, • Wheezing, or • Fever or low body temperature.
CLASSIFY AS:	VERY SEVERE DISEASE
TREATMENT:	► Refer URGENTLY to hospital. ► Keep young infant warm. ► Give first dose of an antibiotic.

SIGNS:	• Severe chest indrawing, or • Fast breathing (60 per minute or MORE).	• No severe chest indrawing, and • No fast breathing (LESS than 60 per minute).
CLASSIFY AS:	SEVERE PNEUMONIA	NO PNEUMONIA: COUGH OR COLD
TREATMENT:	► Refer URGENTLY to hospital. ► Keep young infant warm. ► Give first dose of an antibiotic. (If referral is not feasible, treat with an antibiotic and follow closely.)	► Advise mother to give the following home care: ► Keep young infant warm. ► Breast-feed frequently. ► Clear nose if it interferes with feeding. ► Return quickly if: ► Breathing becomes difficult. ► Breathing becomes fast. ► Feeding becomes a problem. ► The young infant becomes sicker.

▶ Give an Antibiotic

- Give first dose of antibiotic in clinic.
- Instruct mother on how to give the antibiotic for five days at home (or to return to clinic for daily procaine penicillin injection).

AGE or WEIGHT	COTRIMOXAZOLE trimethoprim + sulphamethoxazole ▸ Two times daily for 5 days			AMOXYCILLIN ▸ Three times daily for 5 days.		AMPICILLIN ▸ Four times daily for 5 days.		PROCAINE PENICILLIN ▸ Once daily for 5 days.
	Adult Tablet single strength (80 mg trimethoprim + 400 mg sulphamethoxazole)	Pediatric Tablet (20 mg trimethoprim + 100 mg sulphamethoxazole)	Syrup (40 mg trimethoprim + 200 mg sulphamethoxazole per 5ml)	Tablet 250 mg	Syrup 125 mg in 5 ml	Tablet 250 mg	Syrup 250 mg in 5 ml	Intramuscular Injection
Less than 2 months (< 5 kg)✦	1/4*	1*	2.5 ml*	1/4*	2.5 ml	1/2	2.5 ml	200,000 units
2 months up to 12 months (6-9 kg)	1/2	2	5 ml	1/2	5 ml	1	5 ml	400,000 units
12 months up to 5 years (10-19 kg)	1	3	7.5 ml	1	10 ml	1	5 ml	800,000 units

✦ Give oral antibiotic for 5 days at home only if referral is not feasible.

* If the child is less than 1 month old, give 1/2 pediatric tablet or 1.25 ml syrup twice daily. Avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced.

▶ Advise Mother to Give Home Care *(For the child age 2 months up to 5 years)**

▶ **Feed the child.**
- Feed the child during illness.
- Increase feeding after illness.
- Clear the nose if it interferes with feeding.

▶ **Increase fluids.**
- Offer the child extra to drink.
- Increase breast-feeding.

▶ **Soothe the throat and relieve the cough with a safe remedy.**

▶ **Most important: In the child classified as having No Pneumonia: Cough or Cold, watch for the following signs and return quickly if they occur:**
- Breathing becomes difficult.
- Breathing becomes fast.
- Child is not able to drink.
- Child becomes sicker.

} **This child may have pneumonia.**

* *See section on young infant for home care instructions for that age group.*

▶ Treat Fever

• Fever is high (≥ 39 °C).	• Fever is not high (38-39 °C).	In a falciparum malarious area: • Any fever, or • History of fever.	• Fever for more than five days.
▸ Give paracetamol.	▸ Advise mother to give more fluids.	▸ Give an antimalarial (or treat according to your malaria programme recommendations).	▸ Refer for assessment.

PARACETAMOL doses:

→ Every six hours

Age or Weight	100 mg tablet	500 mg tablet
2 months up to 12 months 6-9 kg	1	1/4
12 months up to 3 years 10-14 kg	1	1/4
3 years up to 5 years 15-19 kg	1 1/2	1/2

FEVER ALONE IS NOT A REASON TO GIVE AN ANTIBIOTIC EXCEPT IN A YOUNG INFANT (AGE LESS THAN 2 MONTHS).

GIVE FIRST DOSE OF AN ANTIBIOTIC AND REFER URGENTLY TO HOSPITAL.

▶ Treat Wheezing

Children with First Episode of Wheezing

If in respiratory distress ——→ Give a rapid-acting bronchodilator and refer.

If not in respiratory distress ——→ Give oral salbutamol.

Children with Recurrent Wheezing (Asthma)

- Give a rapid acting brochodilator
- Assess the child's condition 30 minutes later:

IF: THEN:

RESPIRATORY DISTRESS OR ANY DANGER SIGN ——→ Treat for SEVERE PNEUMONIA or VERY SEVERE DISEASE (Refer).

NO RESPIRATORY DISTRESS AND:

FAST BREATHING ——→ Treat for PNEUMONIA. Give oral salbutamol.

NO FAST BREATHING ——→ Treat for NO PNEUMONIA: COUGH OR COLD. Give oral salbutamol.

RAPID ACTING BRONCHODILATOR	
Nebulized Salbutamol (5 mg/ml)	0.5 ml Salbutamol plus 2.0 ml sterile water
Subcutaneous Epinephrine (adrenaline) (1 : 1000 = 0.1%)	0.01 ml per kg body weight

ORAL SALBUTAMOL • Three times daily for five days		
AGE or WEIGHT	2 mg tablet	4mg tablet
2 months up to 12 months (< 10 kg)	1/2	1/4
12 months up to 5 years (10-19 kg)	1	1/2

BEST AVAILABLE COPY

MANAGEMENT OF THE CHILD WITH AN EAR PROBLEM OR SORE THROAT

EAR PROBLEM

ASSESS

ASK:

- Does the child have ear pain?
- Does the child have pus draining from the ear? For how long?

LOOK, FEEL:

- Look for pus draining from the ear or red, immobile ear drum (by otoscopy).
- Feel for tender swelling behind the ear.

CLASSIFY THE ILLNESS

SIGNS:	• Tender swelling behind the ear.	• Pus draining from the ear LESS than two weeks, or • Ear pain, or • Red, immobile ear drum (by otoscopy).	• Pus draining from the ear two weeks or MORE.
CLASSIFY AS:	MASTOIDITIS	ACUTE EAR INFECTION	CHRONIC EAR INFECTION
TREATMENT:	▸ Refer URGENTLY to hospital. ▸ Give first dose of an antibiotic. ▸ Treat fever, if present. ▸ Give paracetamol for pain.	▸ Give an oral antibiotic. ▸ Dry the ear by wicking. ▸ Reassess in five days. ▸ Treat fever, if present. ▸ Give paracetamol for pain.	▸ Dry the ear by wicking. ▸ Treat fever, if present. ▸ Give paracetamol for pain.

SORE THROAT

ASSESS

ASK:

- Is the child able to drink?

LOOK, FEEL:

- Feel the front of the neck for nodes.
- Look for exudate on the throat.

CLASSIFY THE ILLNESS

SIGNS:	• Not able to drink.	• Tender, enlarged lymph node on neck and • White exudate on throat.
CLASSIFY AS:	THROAT ABSCESS	STREPTOCOCCAL SORE THROAT
TREATMENT:	▸ Refer to hospital. ▸ Give benzathine penicillin (as for streptococcal sore throat). ▸ Treat fever, if present. ▸ Give paracetamol for pain.	▸ Give an antibiotic for streptococcal sore throat. ▸ Give safe, soothing remedy for sore throat. ▸ Treat fever, if present. ▸ Give paracetamol for pain.

TREATMENT INSTRUCTIONS

▶ Give an Oral Antibiotic for an Ear Infection

- Give first dose of antibiotic in clinic.
- Instruct mother on how to give the antibiotic for five days at home.

AGE or WEIGHT	COTRIMOXAZOLE trimethoprim + sulphamethoxazole ▸ Two times daily for 5 days: Adult Tablet single strength (80 mg trimethoprim + 400 mg sulphamethoxazole)	Pediatric Tablet (20 mg trimethoprim + 100 mg sulphamethoxazole)	Syrup (40 mg trimethoprim + 200 mg sulphamethoxazole per 5ml)	AMOXYCILLIN ▸ Three times daily for 5 days: Tablet 250 mg	Syrup 125 mg in 5 ml	AMPICILLIN ▸ Four times daily for 5 days: Tablet 250 mg	Syrup 250 mg in 5 ml
Less than 2 months (< 5 kg)*	1/4*	1*	2.5 ml*	1/4	2.5 ml	1/2	2.5 ml
2 months up to 12 months (5-9 kg)	1/2	2	5 ml	1/2	5 ml	1	5 ml
12 months up to 5 years (10-19 kg)	1	3	7.5 ml	1	10 ml	1	5 ml

- Give oral antibiotic for 5 days at home only if referral is not feasible.
- If the child is less than 1 month old, give 1/2 pediatric tablet or 1.25 ml syrup twice daily. Avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced.

▶ Dry the Ear by Wicking

- Dry the ear at least 3 times a day:
  - Roll clean, absorbent cloth into a wick.
  - Place the wick in the child's ear.
  - Remove the wick when wet.
  - Replace the wick with a clean one until the ear is dry.

▶ Treat Fever

• Fever is high (≥ 39 °C).	• Fever is not high (36-38 °C).	In a falciparum malarious area: • Any fever, or • History of fever	• Fever for more than five days.
▸ Give paracetamol.	▸ Advise mother to give more fluids.	▸ Give an antimalarial (or treat according to your malaria programme recommendations).	▸ Refer for assessment.

PARACETAMOL dosage:

→ Every six hours

Age or Weight	100 mg tablet	500 mg tablet
2 months up to 12 months 5-9 kg	1	1/4
12 months up to 3 years 10-14 kg	1	1/2
3 years up to 5 years 15-19 kg	1 1/2	1/2

FEVER ALONE IS NOT A REASON TO GIVE AN ANTIBIOTIC EXCEPT IN A YOUNG INFANT (AGE LESS THAN 2 MONTHS).

GIVE FIRST DOSE OF AN ANTIBIOTIC AND REFER URGENTLY TO HOSPITAL.

▶ Give an Antibiotic for Streptococcal Sore Throat

▶ *Give Benzathine Penicillin*

BENZATHINE PENICILLIN IM
A single injection

< 5 years	600,000 units
≥ 5 years	1,200,000 units

OR

▶ *Give amoxycillin, ampicillin, or penicillin V for ten days.*

▶ *Soothe the throat with a safe remedy.*

▶ *Give paracetamol for pain or high fever.*

Appendix Z

Gold Standards
in
Maternal Care Curricula
PVO Child Survival Support Projects, 1995

GOLD STANDARDS

IN

MATERNAL CARE CURRICULA

For Use by Child Survival Projects

Helga Morrow and Frank Anderson
Johns Hopkins University School of Hygiene and Public Health
PVO Child Survival Support Program

1. EDUCATING MOTHERS

2. CONTENT FOR TRAINING TBAS

3. CONTENT FOR TRAINING NURSE-MIDWIVES

Revised October 1995

GOLD STANDARDS

Educating Mothers

A. Antenatal care

1. Contacting health provider early in pregnancy
2. Nutritional advice:
   Adequate weight gain and eating Iron-rich foods
3. Taking prophylactic medications as needed:
   Iron and folic acid
   Anti-malarials
4. Receiving tetanus toxoid immunization
5. Recognizing danger signs:
   vaginal bleeding
   excessive redness or paleness
   swollen hands, face
   fever
   passing fluids other than urine
   labor pains longer than 12 hours without progress
6. Planning for possible emergencies, including arranging for transport to health facility

B. Labor and Delivery

1. Seeking care promptly or referral based on danger signs
2. Delivering with a trained attendant
3. Delivering under hygienic conditions

C. Care of the Newborn

1. Breastfeeding the baby immediately after the birth or least within the first hour
2. Immediate warming, drying and stimulation of crying
3. Ensuring that the baby's airway is clear
4. Appropriate cutting and caring for the cord

D. Postnatal Care

1. Breastfeeding exclusively for six months
2. Recognizing and seeking care and referral for post-partum complications:
   infection,
   bleeding,
   severe abdominal pain
3. Ensuring adequate rest
4. Practicing good nutrition
5. Seeking post-partum check-up with trained provider

E. Family Planning

1. Planning future pregnancies
2. Procuring contraceptives
3. Learning about timing, spacing and other factors that impact on reproductive health

GOLD STANDARDS

Content for Training TBAs

A. Antenatal Care

1. Identifying pregnancy
2. Counseling pregnant women on:
   - appropriate and timely prenatal care
   - immunizations
   - nutrition
3. Identifying common pregnancy discomforts and how to relieve discomforts
4. Identifying/detecting complications or danger signs:
   - vaginal bleeding with or without pain
   - convulsions/severe headache/blurred vision
   - passing fluids other than urine
   - fever and chills
   - swollen hands, face and feet
   - paleness and other signs of anemia
5. Risk Analysis: All pregnant women are at risk for maternal mortality. Screening, identification and, if indicated, referral of pregnant women with "risk conditions" can occur only in areas with good health infrastructure capable of concretely addressing these conditions. ("risk conditions" are often based on local or national MOH guidelines that put women at increased risk for low birthweight or poor newborn outcome)
   - 1st pregnancy at < 15 years or > 35 years
   - > 5 pregnancies
   - preexisting medical conditions, such as
     - diabetes, heart disease, hypertension
   - short stature < 150 cm
   - previous poor obstetric history or previous C-section
   - pregnancy spaced < 2 years apart
6. Assessing nutritional status and referring undernourished women
7. Providing:
   - iron and folic acid prophylaxis
   - malaria prophylaxis (if appropriate)
8. Linking with a referral health care center and establishing procedures for referral
9. Assessing traditional practices
10. Maintaining and using a safe-birth kit

B. Labor and Delivery

1. Using hygienic practices during labor and delivery
2. Managing uncomplicated labor and delivery
3. Identifying complications during labor and delivery:
   - excessive bleeding
   - convulsions
   - fever and chills
   - no progress during 12 hours

4. Managing first aid during labor and delivery:
(These are possible options and depend on the local conditions, regulations and supervision for TBAs)
    - nipple stimulation
    - oxytocic drugs
    - sedatives
    - massage abdomen (fundus)
    - external bimanual compression - uterus
    - manual removal of the placenta
    - antibiotics
    - oral rehydration fluids
5. Referring women with complications and securing transport

C. Care of the Newborn

1. Establishing airway and stimulation of immediate crying
2. Appropriate cutting and caring for the cord
3. Immediate drying and warming
4. Putting the baby to breast immediately or within the first hour
5. Examining the newborn for congenital defects, size and weight and referring

D. Postnatal Care

1. Counseling mothers on:
    - breastfeeding
    - nutrition
    - cord care
    - hygiene
    - post-partum check-up
    - family planning
2. Identifying post-partum complications:
    - infection,
    - severe abdominal pain,
    - hemorrhage
3. Referring women with post-partum complications

E. Family Planning

1. Counseling mothers on pregnancy spacing and methods of contraception
2. Referring mothers to health unit for counseling and contraceptive usage
3. Replenishing non-clinical contraceptive supplies
4. Counseling on unsafe abortions and referral for abortion complications

GOLD STANDARDS

Content for Training Nurse-Midwives

A. Antenatal Care

1. Taking history, conducting physical examination and diagnosing condition
2. Risk Analysis: All pregnant women are at risk for maternal mortality. Screening, identification and, if indicated, referral of pregnant women with "risk conditions" can occur only in areas with good health infrastructure capable of concretely addressing these conditions. ("risk conditions" are often based on local or national MOH guidelines that put women at increased risk for low birthweight or poor newborn outcome)
    - 1st pregnancy at < 15 years or > 35 years
    - > 5 pregnancies
    - preexisting medical conditions, such as
        - diabetes, heart disease, hypertension
    - short stature < 150 cm
    - previous poor obstetric history or previous C-section
    - pregnancy spaced < 2 years apart
3. Counseling and promotion of healthful life styles:
    - nutrition: adequate weight gain, iron rich foods
    - compliance with iron and folic acid supplementation
    - compliance with malaria prophylaxis (if appropriate)
    - early breast feeding
    - child spacing
    - safe delivery techniques
    - benefits of trained attendant
    - recognition of danger signs:
        - vaginal bleeding
        - excessive tiredness
        - swollen hands, face and feet
        - fever
        - passing fluid other than urine
        - labor pains longer than 12 hours without progress
4. Identifying common pregnancy discomforts and how to relieve discomforts
5. Providing tetanus toxoid immunizations
6. Providing iron and folic acid supplementation and malaria prophylaxis
7. Assessing nutritional status and targeting supplemental feeding
    - adequate weight gain
8. Detecting, managing and referring for complications:
    - hemoglobin status to detect anemia
    - bleeding with or without pain
    - blood pressure and check for proteinuria to detect preeclampsia
    - fever indicating reproductive tract infection or malaria
    - rupture of the membranes without labor > 12 hours
9. Supporting and training community maternal health workers and TBAs
10. Managing health clinics or maternity waiting homes

B. Labor and Delivery

1. Managing labor and delivery
2. Using partograph
3. Identifying complications during labor and delivery:
   - excessive bleeding
   - convulsions
   - fever and chills
   - no progress during 12 hours
4. Providing obstetric first aid
   - nipple stimulation
   - oxytocic drugs
   - sedatives
   - massage abdomen (fundus)
   - external bimanual compression - uterus
   - manual removal of the placenta
   - antibiotics
   - oral rehydration fluids
5. Managing complications (based on the local and national regulations)
   - blood transfusions
   - Caesarean section
6. Referral and transport to referral hospital

C. Care of the Newborn

1. Establishing airway and stimulation of immediate crying
2. Caring for the cord
3. Immediate drying and warming
4. Immediate breastfeeding or within the first hour
5. Examining the newborn for congenital defects, size and weight and referring

D. Postnatal Care

1. Counseling mothers on:
   - breastfeeding
   - nutrition
   - cord care
   - hygiene
   - post-partum check-up
   - family planning
2. Identifying post-partum complications:
   - infection, severe abdominal pain, hemorrhage
3. Referring women with post-partum complications

E. Family Planning

1. Counseling mothers on pregnancy spacing and methods of contraception
2. Providing family planning services
3. Replenishing contraceptive supplies
4. Counseling on unsafe abortions and managing abortion complications

Document A

Response to Proposal Review Comments

Response to Proposal Review Comments

The following is a narrative explanation of how the DIP responded to each "concern" submitted to ADRA as a result of the project proposal's technical review committee.

Immunization

Please look under sections 4a.6, 4a.8 and 4a.9 for details on how the community health volunteers will identify and follow-up defaulters. What the vaccinators/EPI crew and CHVs will do with defaulters, when, where and how often immunization activities will occur is also described under this section of the DIP.

Nutrition

For nutrition component, the project will measure the percent of children who are faltering using the assessment method described in section 4b.1a. Read sections 4b.2f and 4b. 2g for follow up and referral of children identified as having growth faltering.

This project will obtain technical assistance in the area of nutrition (ethnographic study on nutrition) in the first year of the project to identify harmful cultural practices and beliefs that adversely affect the child's health, and aid the development of appropriate health messages and educational materials.

Promotion of breast feeding will be an integral part of the TBA/CHV educational effort during home visits. Read the "approach" sections under nutrition and MCH/FP interventions. ADRA will also obtain assistance from La Leche League and AHLACMA for educational and training materials for CHVs engaged in exclusive breast-feeding promotion (read section D.2.)

Pneumonia Control

Technical assistance was obtained to conduct a focused ethnographic study to identify what the main problems related to ALRI are (see document C for full report on the ethnographic study). Read section 4e.1b for current problems related to ALRI in the ADRA project area.

See sections 4e.1e, 4e.1f, 4e.2c and 4e.3c for what will be done to address the needs related to ALRI problems.

As described in section 4e.1a of the DIP, CHVs are not allowed by the MOH to prescribe antibiotics. The CHVs role in pneumonia control intervention will be limited to provision of education to care takers, detection, referral to a health facility for SCM and follow up of ALRI cases.

The project has included "the proportion of all ALRI visits to a health facility where SCM is appropriately applied by a trained worker who has antibiotics available" as an indicator. Please look at "Table B" (Pneumonia case management) for a complete list of objectives, indicators, planned inputs, outputs and measurement methods for outputs.

The key components of the ALRI intervention addressed in the DIP are: Recognition of cough and difficulty breathing as signs that should lead to seeking care from the appropriate health facility; prompt referral by CHVs to a health facility; development of a counter-referral system; correct SCM at the CESAMOs; and community follow-up by CHVs. CHVs will be trained to enhance their ALRI IEC skills. Read sections 4e.2b and 4e.2c for issues related to increasing accessibility to SCM. Supervision and monitoring of CHVs at the community level and the CESAMO staff at the CESAMO level will be provided. See section 4e.1f for a description of SCM quality assurance plans to be introduced at the CESAMO level.

Human Resources

To deal with the overall issue of CHV motivation and reduce CHV attrition rate, the project has devised numerous plans including:

-making an arrangement with each CESAMO and Esquela Hospital for provision of free medical care for the CHV and her/his family
-Provision of a special ID card to allow CHVs to have easy access to the CESAMOs/Esqela Hospital
-Recognition by patronatos
-Recommendation by patronatos for further training and employment opportunities in the community
-Creating training opportunities and career lader rewards based on performance
-As the project expands, the CESAMO is willing to hire or recommend CHVs to train as auxiliary nurses (some CHVs have already been employed as auxiliary nurses.)

So far, CHV attrition rate has been kept as low as 10%-12%, and future problems are not anticipated.

Health Information System

Please see Table B for indicators by intervention and how these indicators will be evaluated. Also, see under "Baseline Information" for each intervention in the DIP. Both project area and national statistics are quoted. Sections F.2 and F.3 address issues related to data variables collection and use.

The performance of the CHVs in relation to weighing and counseling mothers, on advising care givers on ALRI and FP and other interventions will be monitored through joint ADRA/CESAMO supervision, TBA monthly reports, monthly CHV reports and meetings, feedback sessions with community womens' groups and quality assurance check lists.

Budget

The 4.7% of the budget that is spent purely on evaluation is as high a percentage as for any intervention or other activity. Adding to that, the percentage of the time that the administration and technical staff that are not directly involved with evaluation, spend with evaluation issues, and the total expenditure would be a much higher percentage of the total. It is expected that the key staff will be spending as high as 10% of their time on HIS/evaluation monitoring, or issues.

Sustainability

The kind of support that the community health committees will provide to the CHVs is not technical. The community health committees, in conjunction with the CESAMOs will provide CHV supervision, recognition and replace the dropouts. Some of these supervisory activities are already being performed by both the CESAMO and the community health committees. Technical support to the CHVs is given by the CESAMOs. Read section H.4 for how much of the project responsibility is already in the hands of the CESAMO in Flor del Campo and San Francisco areas. This section also describes the plan for phasing out ADRA supervisors and turning over CHV technical support to the CESAMOs. By taking over these responsibilities, the CESAMO will not incur additional costs. The CHVs are volunteers. Read section H.1 for the sustainability goals, objectives and activities planed. As recommended by the review committee, the midterm evaluation of this project will focus on how well the sustainability plans are proceeding and further adjustments will be made based on lessons learned.

The local institutions and organizations (CESAMO/MOH/Patronato) are committed to continue to finance and provide support to this project after CS funding is over. There is ample evidence to demonstrate that including willingness to support CHVs, organization of community health events, joint supervision and monitoring of CHV activities, sharing information and holding periodic joint meetings. A strong linkage between the CESAMO/MOH

and the community groups is in the process of being formed. Financial commitment from the CESAMO comes in the form of salary for its outreach workers devoted to this project (social workers in each CESAMO, the EPI mobile team, the CESAMO staff who will jointly supervise CHVs with ADRA facilitators.)

The micro lending program that was initiated in the first project was based on a GOH model that was not efficient. Since the start of that program, the project director and key staff have had experiences with more refined and appropriate models, that approach self sustainability. If funding is received for this segment, the target of 300 families reached should not be difficult using ADRA's Jump Start technology.

Document B

Baseline Survey Report
(for SF/FdC and NS)

Separate Document

Document C

Focused Ethnographic Study on ALRI

FOCUSED ETHNOGRAPHIC STUDY ON ACUTE RESPIRATORY INFECTION

Adventist Development and Relief Agency
Child Survival XII
Tegucigalpa, Honduras
Oct/Nov 1995

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ABSTRACT

This paper reports results from an 18 day focused ethnographic study (FES) on acute respiratory infection (ARI) conducted in October and November of 1995 in Tegucigalpa, Honduras with the help of the Adventist Development and Relief Agency (ADRA) Child Survival project staff.

Using the World Health Organization (WHO) FES protocol, the research team gathered data using the following methods:

1) Interviews with key informants (ADRA staff).
2) Fourteen semi-structured home-based interviews with mothers and traditional bir th attendants.
3) Ten semi-structured facility-based interviews of mothers seeking care for children with ARI at the health clinics and hospitals.
4) Seven semi-structured interviews at health clinics, private clinics and hospitals with doctors who are responsible for the diagnosis and treatment of children with ARI.
5) Fourteen hypothetical childhood ARI illness scenarios with nurses, pharmacists and community drug suppliers.

The main objectives of the study were:

- Document signs and symptoms and identify terms by which mothers recognize illness that correspond in whole, or in part, to clinically diagnosed pneumonia.
- Identify factors that facilitate or deter seeking prompt care from a trained health provider.
- Identify relevant maternal expectations concerning antibiotics and other drug therapy, and anticipate compliance problems.
- Identify relevant cultural characteristics and conditions that are likely to strongly influence community response to program activities.
- Improve didactic materials used at the community level to include local terminology, perceptions and practices.
- Develop effective home care advice and other recommendations for appropriate communication with caretakers of young children. (WHO ARI program planning 1992)

The study found that child mortality from ARI is low but morbidity is very high. Mothers often call fast breathing *cansancio* (tiredness), *agitado* (irritable), *ahogando* (drowning) and *desesperado* (desperate). Mothers refer to chest in-drawing as *se le mete o hunde las costillas* (the ribs sink in) but this was not mentioned as a reason mothers would seek care for a child sick with an ARI. Mothers recognize fast breathing but do not distinguish between moderately fast or very fast nor do they count breaths per minute. Mothers consider fever, cough and drowning as the most dangerous signs that would force her to seek help from a trained health professional.

Although mothers use the term asthma when referring to pneumonia and give almost identical descriptions of their signs and symptoms, they seem to realize the two illnesses are not one in the same and that pneumonia can be more severe.

Mothers frequently use old medicine left over from the last household illness and administer it to children before seeking care outside the home for children with ARI. **Self-medicating greatly contributes to the delay in care seeking for children with ARI.** Mothers may waste two or three days using expired medicine when they should be seeking care from a trained health professional.

In addition to the use of old medicine in the home, mothers have several traditional remedies for ARI treatment. Some are harmless, some are beneficial and some are dangerous. Mothers almost always give the child a tea infused with local herbs to soothe the throat and honey with lemon juice to soothe a cough. Mothers are aware that children with an ARI should be kept warm and dry. The beliefs that could be dangerous are those related to homemade expectorants and chest rubs. A chest balm of grease and gasoline is often used to open up airways. As an expectorant, mother's mix animal grease with Vick's vapor rub and give it orally to the child. **Traditional birth attendants (TBAs) were the most common source of dangerous ARI home treatment practices.**

Homemade ARI treatment and the use of old medicine are popular among mothers who would otherwise be unable to buy prescribed treatment. Government run health clinics rarely have an adequate stock of medicine and patients are often given a prescription that they must buy from a private pharmacy. If mothers have the funds to buy modern medicine they often bypass the health clinic altogether and go directly to the pharmacy to purchase the medicine that was used for the previous ARI. Pharmacies commonly sell medicine without a doctor's prescription.

Self-medicating contributes to diminished medication effectiveness since mothers rarely give an entire course of treatment and are impatient with the recommended time expected before the medication will provide an effect. Mothers commonly expect medicine to take affect the same day it was administered and generally suspend treatment as soon as the child shows signs of improvement. Mothers need to be taught the appropriate use of antibiotics; when they are and are not necessary and the importance of finishing the recommended dosage.

Communication activities should focus on encouraging mothers to seek care from a trained provider as soon as fast breathing appears, even when no fever or cough is present. It is important to emphasize the use of safe home treatment before seeking help and the appropriate use of medication.

Doctors, nurses and community health workers should unify their language and treatment of ARI. They need to be conscious of explaining ARI treatment to mothers at a level in which she can understand. At this point, there is very little standardized ARI protocol and everyone seems to recommend what in their opinion is the best treatment. This contributes to mothers' confusion and ineffectiveness in ARI home care.

INTRODUCTION

In 1990 acute respiratory infections (ARIs) were responsible for 4.3 million deaths of children under five in developing countries, an estimated one-third of infant and child mortality in those countries (WHO 1992). Bacterial pneumonia, which can be controlled by antibiotics, is the principal cause of ARI related mortality (UNICEF).

In Honduras, ARIs, specifically pneumonia, are the principal cause of morbidity and mortality in children under five years of age. (Epidemiology and Family Health Survey/EFHS 1991-92) 38% of the children in Tegucigalpa and San Pedro Sula had ARI in the 15 days prior to the Epidemiology and Family Health Survey conducted in 1991-92. The Adventist Development and Relief Agency (ADRA) report 61% prevalence of ARI in the Child Survival (CS) project area of Nueva Suyapa (KAP survey 1995). Statistics gathered from the CESAMO in the project area report that ARI comprised 30% of all doctors' consultations during the months of March, April and May 1995. In San Francisco, a barrio in the project area with a population of 6,440, there had been two reported deaths from pneumonia. In Nueva Suyapa, a barrio in the project area with a population of 19,048, there were two unofficial reports of ARI related infant death (report given by traditional healer/midwife). The health center in San Francisco claims to have a 25% increase in ARI related consultations from 1994 to 1995. (MOH annual report 1995)

ARIs are of two basic types: Acute Upper Respiratory Infection (AURI), which includes colds, rhinitis, tonsillitis and ear infections, and Acute Lower Respiratory Infection (ALRI), which is primarily pneumonia. Effective treatment of children with ALRI involves early detection of ALRI related symptoms (cough, fever and rapid breathing) and appropriate use of antibiotics prescribed by a health provider.

Caretakers of young children at home have a strategic role in assuring early diagnosis and appropriate treatment of ARIs. They detect symptoms that warrent health facility treatment, and decide how prescribed medications will be used at home. Thus it is key to ARI program development that we identify what mothers know, how they refer to ARI, how they treat ARI and how health workers can best communicate information about ARI to caretakers of young children in a language that is most familiar to them.

A focused ethnographic study (FES) is designed to help national ARI programs do the following:

- Document signs and symptoms and identify terms by which mothers recognize illness that correspond in whole, or in part, to clinically diagnosed pneumonia.

- Identify factors that facilitate or deter seeking prompt care from a trained health provider.

- Identify relevant maternal expectations concerning antibiotics and other drug therapy, and anticipate problems affecting compliance with treatment.

- Identify relevant cultural characteristics and conditions that are likely to strongly influence community response to program activities.

- Improve didactic materials used at the community level to include local terminology, perceptions and practices.

- Develop effective home care advice and other recommendations for appropriate communication with caretakers of young children. (WHO ARI program planning 1992)

A key output of FES research is a series of suggestions for home care messages that health workers can discuss with mothers, including advice on when children with an ARI should be taken for care. The FES research in Tegucigalpa, Honduras was conducted in October and November of 1995. This paper reports the key results of research.

Research Setting

The research was carried out in three peri-urban barrios of Tegucigalpa, Honduras where the ADRA Child Survival project has been working. The barrios are San Francisco, Flor del Campo and Nueva Suyapa with a collective population of approximately 40,000 people. The population of Tegucigalpa is 800,000 and growing by an approximate rate of 2.8% annually. Rural to urban immigration is a common phenomenon. Such immigration creates an increased demand on already scarce housing. Immigrants typically live in makeshift houses built from scrap material. Potable water is a continual problem. People in the barrios are forced to purchase their rations of daily water because the few rivers that intersect the city are contaminated. The area is situated on steep hills accessed by clay surfaced roads that alternate between dust and mud, whose ruts are often channels for liquid waste runoff. Hygiene and sanitation are a challenge with limited and expensive fresh water supplies.

Tegucigalpa is a hilly city at 2000 feet above sea level. The climate is cooler than in the coastal lowlands and has a distinct wet and dry season. The dry season runs from October to April, roughly. The wet season runs from May to September.

METHODS

Research Design

The FES research was designed to be conducted in a fairly short time period, (3 to 6 weeks), using in-country research staff familiar with community-based social structure. To implement the study, the core research group consisted of one external consultant as the principal investigator (PI) and nine Honduran ADRA CS personnel as the research assistants (RAs). Though a smaller research team could have been used, all ADRA staff was involved in the FES research to insure that the entire project could benefit from the learning process. The study was designed to encourage ADRA staff participation in creating and conducting an ethnographic survey. The staff collected and processed the data to help refine their Child Survival project interventions and interactions with mothers.

The ADRA CS staff were well versed in conducting surveys at the community level, thus little training was needed. FES objectives were reinforced to insure qualitative rather than quantitative research techniques were understood. It was important to clarify that the interviews would be very open-ended and that there were no right or wrong answers.

The ADRA staff assisted in the planning and translation of the interview questions. (See appendix A, B & D) The methods used for FES data collection were: Unstructured interviews, hypothetical case scenarios, recall of past ARI episodes and a matching of illnesses to signs and symptoms card game. Data collection procedures were decided upon collectively by the research team to instill a sense of ownership in the research design. The cards used for paired comparison of illness to signs and symptoms (Appendix A & B), which were designed and cut out by the ADRA research staff, proved to be a successful method to ascertain local beliefs about the names and characteristics of different illnesses in the context of playing a game. This method was used with mothers, traditional healers (TBAs) and drug sellers/community medicine banks (CMBs).

The FES Manual suggests five different groups should be interviewed: mothers at home, mothers at the health facility, health providers, traditional healers and drug providers (See appendix D)

The number of respondents for each type of data collection procedure is as follows:

RESPONDENT	QUANTITY	TYPE OF INTERVIEW
Traditional Birth Attendant	3	Open-ended exploration with matching and severity rating of illness, signs and symptoms.
Mothers at Home	11	Open-ended exploration with matching and severity rating of illness, signs and symptoms.
Mothers at Health Facility	10	Open-ended exploration with matching and severity rating of illness, signs and symptoms.
Doctors	7	Unstructured interview.
Nurses	6	Hypothetical illness scenario.
Drug Sellers (CMB)	5	Hypothetical illness scenario.
Pharmacy	3	Presentation of staged illness.

The study was conducted over a two and a half week period in October and November of 1995. The research staff rotated responsibility by having three teams of three RAs. The PI was present for all interviews. Questioning and conversation duties were shared between the PI and one RA while the other two RAs took notes. Notes and observations were consolidated at the end of each day to insure fresh analysis.

Also relevant to this study are the quantitative results gathered during the previous baseline survey. An ARI annex was added to the KAP survey conducted in August of 1995. Information was gathered pertaining to medication usage, ARI related terminology, home treatment of ARI, ARI prevention and nutrition during ARI.

RESULTS

Principal Investigator's Questions and Answers

Global questions:

- What is the overall severity of ARI in the target area?
- Are significant numbers of children actually dying of pneumonia?
- How do cultural beliefs and customs help or hinder the prevention and treatment of ARI?

Specific questions:

1. Recognition and interpretation of ARI signs and symptoms.

Do mothers recognize fast breathing, can they describe it in beats per minute?

33% (7/21) mothers recognized fast breathing as an ARI sign with one mother of the 21 interviewed knowing what number of beats per minute constituted fast breathing. Mothers often define fast breathing as *cansancio* (tiredness), *agitado* (agitated or irritable), *ahogando* (drowning) or *desesperado* (desperate). Chest in-drawing is often referred to as *se le hunde/mete las costillas* (the chest sinks in). None of the mothers interviewed mentioned chest in-drawing as an ARI symptom but 4 of 21 (33%) mentioned chest in-drawing when asked to define rapid breathing.

Do mothers consider fast or difficult breathing to be a serious sign and indication to seek help?

Mothers are aware of rapid breathing, 67% (14/21) mentioned *cansancio* (rapid breathing) as a serious ARI sign that would force her to seek help. However, there is no distinction between fast and very fast breathing nor do mothers know how to count breaths per minute.

What other signs do mothers consider serious?

Mothers mentioned *fibre o calentura* (fever), *tos* (cough) and *se ahogo* (drowning) as serious signs that would force them to seek help. Mothers commonly refer to wheezing as *hervor en el pecho* but do not appear to consider it a sign of danger. Four mothers (19%) mentioned chest indrawing (*se le mete o hunde las costillas*) as

a danger sign. Overall tiredness or weakness (*debil/desganado/desesperado/triste)* are general terms that mother uses to explain dangerous ARI symptomology.

Although asthma is often used to refer to ARI rather than pneumonia, most mothers realize that pneumonia is more dangerous (14 out of 24 - 58%). Interestingly, 100% of doctors interviewed said mothers could not define pneumonia. Many mothers confused illness names with signs or symptoms names, for example, when asked the name of the sickness that the child had, the mother might respond with *moquera* (runny nose) or *tos* (cough). (See appendix A & B for a list of local terminology of illness, signs and symptoms.)

Are mothers aware of how rapidly young infants can become sick and die from respiratory infection?

It would seem that mothers are aware that a child can die rapidly from an ARI since they are less likely to wait a long time if the child is presenting signs of pneumonia. Five out of nine sought help the same day when presented with a case of pneumonia, as opposed to one mother who would have sought help for a child sick with the common cold.
Although ARI morbidity is high in Honduras, the mortality rate is low. Of the 44 people interviewed only two mentioned knowledge of infant death due to ARI, and those were unofficial reports from mothers and traditional birth attendants.

2. ARI household management practices

Who takes care of the child?

Mothers or grandmothers are most commonly sited as caretakers with an occasional mention of an older sibling or other family member.

Do mothers change the amount of food or liquids given to the child when sick?

Mothers predominantly provide less food (86%) and less fluids (52%) to a child sick with ARI. Mothers explained that the child had no appetite and refuses to eat. Interestingly, of the six mothers who did say that they give their child more fluids during an ARI episode, four of those were mothers at home and only two were mothers in the health center. Mothers at home seem to be keeping their children more adequately hydrated than mothers in the health center.

Do mothers use homemade remedies to treat cough and fever?

Mothers most predominantly use an herb tea infusion with camomile, eucalyptus, mint, oregano or cinnamon for children with a cough or cold. They also use drops of camomile tea to clean a runny or stuffed up nose. Vick's vapor rub is routinely used for congestion or steam vapors from boiling water. Some mothers have been told to give the child spoonfuls of animal grease and Vick's to get rid of phlegm and others use a combination of animal grease and gasoline as a chest rub for congestion. Lemon with honey is a commonly used cough syrup. For a fever, mothers are more likely to buy an aspirin or acetaminophen tablet than use a luke warm bath.

Are these remedies unsafe?

The use of animal grease as a laxative or animal grease with gas or Vick's as a chest rub is very dangerous. Any one of these combinations could cause chemical aspiration pneumonia, skin irritation and severe stomach upset. Mothers need to be taught the dangers of these practices!

What over-the-counter or prescribed medicines do mothers generally use and what are their dangers?

Mothers often use antibiotics, decongestants, bronchodilators, antipyretics and expectorants. Used according to the doctors orders, there should not be a large health risk. Unfortunately, all of these medicines are readily available without a prescription. There is one type of bronchodilator, *Theophylline*, that is particularly dangerous if not administered correctly. Due to its long lasting effect, the mother can chemically intoxicate a child if she gives too much of this drug or couples it with other medications. *Salbutamol*, another bronchodilator, is a safer choice since it does not last as long. *Salbutamol*, is often used in nebulization as well as syrup form.

Some doctors mentioned their dissatisfaction with expectorants in small children since an infant is unable to spit. The expectorant produces phlegm expulsion and the infant ends up swallowing the excess phlegm. The overuse and self-medicating with antibiotics is a continual community health problem. Antibiotics are used for anything from the common cold to acute pneumonia. The general preference is the injectable form rather than oral due to the perceived immediate effects. Mothers rarely finish an entire course of antibiotics because they want to save the medicine for the next bout of ARI or other sickness, thus creating a vicious cycle of drug dependance and reduced effectiveness.

What are mothers being told by drug sellers /pharmacists about drug treatment of ARI?

Two types of pharmacies were contacted, one which was a community based medicine bank (CMB) with donated supplies by UNICEF and the other which was a privately owned pharmacy. The former gave far better attention than the latter.

The community based drug sellers have a basic supply of medicine (See appendix C) and have been well trained by UNICEF as to the appropriate use and potential abuse of medications. The CMBs are run by community health volunteers. When asked what treatment one CMB would give to a child with a common cold, her response was:

"The mothers pressure me to give them antibiotics for everything and they only want to buy a little bit. I won't sell them anything other than the full dose and only if the child needs it. Then I refer them to the health center. "

This is in stark contrast to the pharmacy. None of the three pharmacies visited gave instructions on how to use the suggested medication and all were willing to sell any quantity of antibiotics without a prescription. The only additional question they asked regarding the child was its age. No referral for follow-up care was mentioned.

3. Patterns of care seeking

Who decides when a sick child needs treatment outside of the home and who takes the child for care?

Mothers or grandmothers are the decision makers for ARI care. An older family member or neighbor are often consulted for advice before taking the child to a health practitioner. Mothers are almost invariably the ones who bring the child to the health center. If the child is severely ill with ALRI, the father is more likely to accompany the mother. (Three of five mothers interviewed at the emergency room in the hospital were accompanied by their husbands, none at the health center were accompanied.)

Is there practitioner preference among mothers? What is the sequence and timing of care-seeking and how does it depend on perceived severity?

Practitioner preference depends on the severity of the illness. If a child had a common cold, the mother would be more likely to look for help from a community health volunteer or drug seller/CAB. With signs of pneumonia, mother would go to the health center (or hospital if the health center was closed). 14 out of 21 mothers preferred the health center over a private clinic or CHV. The main reasons were economic; consults and medicine are largely free. Close, easy access to the health center was also mentioned as well as less waiting than in the hospital, with the exception of hospital emergency room (ER) service. If mother did choose a private clinic over the health center it was because the clinic had a larger medicine

supply and gave service 24 hours a day. Mothers generally felt satisfied with the quality of care they received although one mothers said,

"You have to know someone at the health center to get good service, otherwise you just wait in line like all the rest. At the hospital they treat you right away." That mother had visited the ER.

In should be mentioned that not one mother mentioned seeking help from a community health volunteer or CAB. This should be improved.

What are the common causes of delay in care-seeking that could be modified or improved upon?

There are both modifiable and nonmodifiable causes for delay in care-seeking. The nonmodifiable is socio-economic. Mothers save medicine from previous ARI episodes for future occurrences. This way they don't have to buy the same medication twice. Two of the three TBAs visited also save medicine to give to their clients when necessary. One TBA held up an old bottle of Trimetropin Sulfa (antibiotic) and said,

"I save this for the neighbors when they come in with a fever or cough. I give them a spoonful and send them to the health center if they need a doctor."

Fortunately, she said she sends her clients to a doctor if they need it. Unfortunately, the old medicine has often lost its effectiveness and mothers waste time with useless home treatments when they should be going to the health center. Mothers also wait until the child is very ill rather than seeking help for a common cold because they know the health center has very little medicine and they will most likely receive a prescription for something that must be bought at the local pharmacy. We need to teach mothers the importance of finishing all medication and that old medicine is often useless. TBAs should always be involved in the health education workshops since they are the source of much home treatment advice and the main culprits for recommending dangerous practices. Mothers could also benefit from some reinforcement in the recognition of fast breathing and the importance of prompt care seeking. The socio-economic obstacle will be difficult to overcome.

Concerning infants less than 2 months of age:

What is the sequence and timing of care-seeking, are they taken out of the home for care at a health facility?

Both mothers interviewed who had children less than two months of age were at the health facility and said they gave no home treatment before seeking help and that they went immediately to the health facility since young children can get sick so quickly. One mother mentioned rapid breathing and the other mentioned inability

to cough as the reason for seeking help. Economic reasons for delay seem to be more applicable for older children, but when they are under two months, mothers seek medical attention very rapidly.

4. Maternal expectations concerning ARI treatment/compliance

What do mothers expect when they seek care from a health worker for a child sick with ARI?

Mothers expect to receive medicine. They are not overly concerned with a thorough examination nor explanation of how to use the medication or prevent further complications. To a mother, a good doctor is one who sends her on her way with a bottle of medicine.

What do mothers expect medications to do and how quickly do they expect these effects to occur?

Few mothers realize antibiotics are only useful for bacterial infection. Most mothers expect drugs to take effect the same day (nine out of 21). One physician mentioned the use of corticosteroids for airway obstruction due to an asthma attack or ARI. Corticosteroids give an immediate anti-inflammatory effect and should only be used for extreme cases. Unfortunately some mothers have seen the immediate effect of this type of drug and demand it from the doctor not realizing it has an additive toxicity effect if used long term in addition to immune system suppression, osteoporosis and Cushing's disease. Both doctors and mothers abuse corticosteroids because of the immediate effects. This also skews mothers perception of how quickly other types of medications should take effect.

When do mothers consider a medication has failed and another treatment is needed?

Eight of 21 mothers said if the child had not shown signs of improvement in 24 hours she would seek help from another doctor or health care provider that would prescribe a good medicine.

Do mothers complete a course of medication or stop when the child is better? What other factors affect medication compliance?

17% (4/24) of mothers and TBAs say they finish the full course of prescribed medicine. Most suspend treatment when the child appears to be better. As previously mentioned, mothers tend to save medicine for reuse. Medicine is expensive and they cannot afford to buy it every time a child gets sick. Also, the fact

that pharmacies are willing to sell small doses of antibiotics affects medication compliance.

Why would a mother be likely to return to the health center?

Because the doctor gave her free medicine or it is the closest health facility to her home.

5. Practitioner information/perspectives on maternal recognition and care-seeking

Who are the practitioners providing care for children with ARI?

Nueva Suyapa:	Flor del Campo:	San Francisco:
6 Private clinics	7 Private clinics	2 Private clinics
1 Health Center	1 Health Center	1 Health Center
1 Health Post	1 Health Post	1 Health Post
16 TBAs	2 Pharmacies	1 Pharmacy
	6 CMB	1 CMB
	5 TBAs	4 TBAs

Which health workers are authorized to provide antibiotics? Who else provides antibiotics?

Private and public physicians and pharmacists are authorized to provide antibiotics. CMBs also provide antibiotics and have been well trained by UNICEF. It seems that CMBs are more aware of the dangers of antibiotic abuse than pharmacies. Pharmacies are very willing to sell partial prescriptions.

Private physicians tend to over prescribe antibiotics more than public physicians since they are more concerned with client satisfaction. If they give a mother what she asks for, lots of injections and pills, she is more likely to return. The one private physician interviewed said she likes to give two or more kinds of antibiotics, some injectable others oral, to make sure the child responds. She even mentioned the use of antibiotics for a common cold. The other six physicians interviewed did not recommend antibiotics for the common cold but all would prescribe antibiotics for pneumonia type symptoms.

Do health workers think there is a delay in mothers care seeking and why?

Five of seven (71%) doctors interviewed said mother does not bring the child to a health professional on time. Most feel that the mother doesn't know any better and doesn't realize how serious ARI can be. The doctors at the health center said the mother most likely sought help at a private clinic before coming to the health center since she is guaranteed medicine there.

What do health workers say are the signs and symptoms that mothers pay attention to? Are there other terms that they feel mothers should know and are these terms concurrent with mothers' language?

Four of seven doctors interviewed said mothers recognize rapid breathing and cough as ARI danger signs, three mentioned fever. Doctors said the most important sign to recognize is *cansancio* (tiredness or rapid breathing). Cyanosis was also mentioned as well as *decaimiento* (energy less or loss of appetit). One doctor thought it was important for mothers to be able to distinguish between intercostal chest in-drawing and subcostal chest in-drawing. Since only four of 21 mothers mentioned it as a danger sign, recognition of either form would be an improvement.

6. Communication with mothers

In general, doctors realize the importance of speaking to mothers in a language that they understand but few practice what they preach. Most doctors said ARI morbidity could be reduced with continued education for mothers but there was little consensus on who should be responsible for providing that education. It was discovered that doctors are not aware of the work that CHVs do. Not one of the doctors interviewed mentioned CHVs as a viable place for mothers to seek help before coming to the health center.

It should be mentioned here that the Honduran MOH is in the process of reclassifying bronchitis. There was a lot of conflicting information on the treatment and classification of bronchitis. It was very confusing and must have an effect on the success of home treatment and prevention. There was also a lot of conflicting ARI treatment advice between doctors and nurses. If mothers receive a different suggestion from every health practitioner they'll probably give up and do nothing or resort to old dangerous habits suggested to by the traditional healers. Unification of practitioner terminology and treatment would help with the success of ARI treatment in general.

V. MODIFIED HOME CARE ADVICE BOX

(See Appendix E for Spanish version of Home Care recommendations.)

Modified Home Care Box	
If your child has a: Cough Runny Nose Teary Eyes He/She probably has a COLD **Care for him/her at home with:** • Herb Tea • Steam vapors with herb • Keep the nose clean	DANGEROUS BELIEFS • Never put oil with gas on childs chest • Never give Vick's orally • Never give animal grease orally to rid child of phlegm ALL OF THESE PRACTICES WILL MAKE THE CHILD WORSE

If you child has: Fever Cough Runny Nose Rapid Breathing Loss of Appetit He may have **PNEUMONIA** or **ASTHMA** **Care for the child:**	**Do Not Self-Medicate** • Using old medication only wastes time while the child gets sicker • Finish all prescriptions that the doctor recommends Go to the Health Center or Hospital

If you child has: Loss of Appetit Rapid Breathing Chest In-drawing Wheezing Sleepy Fever Purple Lips or Nails Drowning He probably has **PNEUMONIA**	**Do Not Self-Medicate** • Using old medication only wastes time while the child gets sicker • **Finish all prescriptions that the doctor recommends** Go to the Health Center or Hospital

VI. RECOMMENDATIONS

The following recommendations, in addition to those in the Home Care Box on page 18, are intended for ARI program planning:

1. The MOH personnel have little unification in their terminology and treatment of ARI. Though it would be difficult to change this on a national level, we can make an effort to include doctors and nurses from the health centers in the project area, in not only the workshops given to CHVs but also in the training we receive at the administrative level.

2. The mother's Home Care Advice Box should be posted in not only in the CHVs home, but should also be given to TBAs, local pharmacies, drug sellers, health centers and hospitals. This would serve as an education tool for mothers as well as health practitioners.

3. There are some good beliefs and some bad beliefs regarding home ARI treatment. ARI program planning should attempt to incorporated the good beliefs while teaching the dangers of bad beliefs. For example, mothers think bathing a child who has a cold is dangerous because the child is more likely to get chilled. Though mothers should keep the child clean, it is good that she recognizes the importance of keeping the child warm and dry.

Some of the more dangerous beliefs are mentioned in the Home Care Advice Box. TBAs are the predominant teachers of dangerous ARI home treatment. For example, one TBA explained in detail how to prepare a chest rub of lard and kerosene which helps to open-up the childs airways. Spoonfuls of Vick's mentholatum with grease is also mentioned as a method of getting rid of the child's phlegm. Needless to say, TBAs need to be more involved in ARI education. The percentage of mothers using TBAs rather than doctors as a birth attendant is rising (6% used a TBA in the 1993 ADRA/JHU KAP survey, 15% in 1995). TBAs are much more affordable than the local hospitals. In recognition of that fact, CS programing should include TBAs when choosing CHVs.

4. It was discovered in the course of the interviews that the local drug suppliers (CMBs) were a good source of ARI information as well as medication. The public pharmacies were far worse in their abuse of antibiotics and haphazard way of checking into the childs illness than the CMBs. Most CMBs are run by volunteers that have been trained by UNISA/UNICEF. Several of the CMBs volunteers are also ADRA CHVs. It would be worthwhile to continue to include CMBs in ADRA activities. They are a great example of how mothers at the community level are capable of understanding and teaching appropriate ARI treatment.

5. Mothers need to be taught to finish the full course of medication, specifically antibiotics, as prescribed by the doctor. Only 10 out of 24 mothers said they finish a

full course of medicine. Most mothers save medicine for the next illness not realizing it will have expired. This habit of self-medicating with old medicine contributes to the delay in care seeking. Mothers might waste days home treating a child with useless medicine when they should be seeking professional help.

Mothers also need reinforcement in the recognition of fast or difficult breathing. Mothers realize when a child is not breathing normally but do not know how to count breaths per minute nor check for chest in-drawing.

Mothers generally don't ask the health provider to explain what their child is sick with when visiting the health center or hospital nor do they ask for an explanation of medicine usage. Not only should doctors and nurses be trained to give more basic information to mothers, but mothers should be taught that it is their right to ask questions about their childs health. If a mother is able to demand antibiotics from the health professionals as she often does, she should be able to demand basic explanations of treatment as well. This is another reason why MOH staff should always be involved in ADRA training.

6. Lastly, a general note about household hygiene. The level of filth in the home directly relates to the likelihood of infection. If a child has a runny nose and is left shoeless and undressed to eat, play and sleep with other children, the other children will surely contract the same cold. Personal and household hygiene needs to be emphasized when discussing ARI prevention with mothers. This may seem like a socio-economic topic, but it does not have to be viewed as such. Poor mothers are capable of wiping their childs nose and washing its face, even if water is scarce.

7. The ADRA staff requests an ethnographic study to look at nutritional habits of mothers in the project area. The reasoning is similar to that for the ARI FES. Although mothers have received vast quantities of nutritional training and education, malnutrition continues to be a problem in peri-urban Tegucigalpa. In addition to a nutrition FES, I would suggest some research be done in the area of HIV/AIDS prevention. The CSXI project proposal mentions both of these as potential concerns.

APPENDIX A

GLOSSARY OF ARI RELATED TERMS
OBTAINED DURING FOCUSED GROUP INTERVIEWS

(List used for matching illness to signs and symptoms game during FES interviews)

ILLNESSES	
SPANISH	ENGLISH
Asma	Asthma
Neumonía	Pneumonia
Malaria	Malaria
Chiflona/Tosferina	Whooping Cough
Gripe	Flu
Catarro	Cold
Mal de Garganta	Sore Throat
Tonsilitis	Tonsilitis
Tuberculosis	TB
Alergia	Allergy
Bronquitis	Bronchitis
Laringitis	Laryngitis
Mal de Ojo/Conjunctivitis	Pink Eye
Amigdalitis	Tonsilitis
Dolor de Oído/Otitis	Ear Infection
Dengue	Dengue
Mal de Pecho	ARI/Chest cold
Faringitis	Tonsilitis
Sarampión	Measles

APPENDIX B

GLOSSARY OF ARI RELATED SIGNS AND SYMPTOMS
(List used for matching illness to signs and symptoms game during FES interviews)

SIGNS AND SYMPTOMS

SPANISH	ENGLISH
Fiebre/Calenture	Fever
Ojos Rojos	Pink Eye
Ojos Mojados/LLorosos	Teary Eyes
Tos	Cough
Escalofrío	Chills
Nariz Tapada/Mocos	Blocked or Runny Nose
Mal/dolor de Cabeza	Head Ache
Cansancio	Tired/Fast breathing
Respiración Rápida/Agitado	Fast Breathing
Pérdida del Apetito	Lose of appetite
Dolor de Oído	Ear Ache
Gir-gir	Wheezing
Sibilancia/Estridor	Wheezing/Stridor
Tiraje	Chest indrawing
Se le mete/hunde las costillas	Chest indrawing
Hervor en el Pecho	Wheezing
Ataques/Convulsiones	Convulsions
Piel Pálida	Pale
Labios y Uñas Morados/Cianosis	Purple Lips and Nails/Cyanosis
Tos Seca	Dry Cough
Tos de Perro	Deep Whooping Cough
Gargajo/Flema	Flem
Aleteo Nasal	Flaring Nose
Oído Reventada	Fluid in the Ear
Labios Secos	Dry Lips
Desganado/Débil/Decaído	Rundown
Se Pone Triste	Sad/Energyless
Pecho de Gato	Wheezing
Llonroncito/Irritable	Won't stop crying/Irritable
Mal de Pecho	Chest Cold
Moquera	Runny nose
Somnolencia	Sleepy
Se ahoga	Drowning/ARI
Vómitos	Vomiting
Desesperado	Desperate/ARI
Ronquera/Mal de Garganta	Sore Throat
Respiración Ruidosa	Dyspnea/Wheezing

APPENDIX C

GUIDE USED FOR COMMUNITY MEDICATIONS

Salbutamol (bronchodilator)
Usage: Deep cough, asthma, cough due to change in climate.
Presentation: Syrup 2 mg x 5 cc orally
Tablets - orally

Acetaminophen
Usage: For pain or fever
Presentation: Tablets or capsules 500 mg and 100 mg orally
Syrup 100 mg x 5 cc
Suppository 300 mg rectal

No Cotrimoxazole

Ampicillin (antibiotic)
Usage: ARI, skin infections, urinary tract infections
Dosage: 500 mg and 250 mg capsules orally.

Trimetropine Sulfa (antibiotic)
Usage: For penicillin resistance, due to allergy, urinary tract infection, bacterial respiratory infections, ear infections. oral
Presentation: Tablets 80 mg
Syrup 40 mg

Amoxicillan (antibiotic)
Usage: Moderate respiratory infections, skin infections, urinary tract infections, tonsillitis with pus. oral
Presentation: tablets or capsules 250 mg and 500 mg envelopes.
Usage: 250 mg orally

COMMON MEDICATIONS AVAILABLE TO THE COMMUNITY

- Acetaminophen - tablets or syrup
- Folic acid
- Allergil - Capsules and serape
- Amoxicillan - tablet and liquid
- Ampicillin - tablet and liquid
- Antispasm
- Aluminum hydroxide
- Mebendazol - tablets and liquid
- Metronidazole- syrup, vaginal suppositories
- Neomycin
- Nystatin cream suppositories
- Salbutamol - syrup (decongestant)
- Ferrous sulphate
- Tetracycline
- Gentian violet - vitamins, syrup and capsules

APPENDIX D

Interview with Doctors

1. How frequently do people bring infants or small children to you for treatment of ARI each day?

2. What kind of healer or facility do people usually use when seeking care for their small children with ARI problems?

3. What are the types of respiratory infection you see most often?

4. In this community, which of these are the cause of death among small children and infants?

5. What are the main signs and symptoms that mothers pay attention to? Which do they consider serious?

6. Do you think mothers know what pneumonia is?

7. Are there other names or terms that you hear for pneumonia or ARI?

8. Are there signs and symptoms of possible pneumonia that mothers should recognize, but don't seem to notice or pay attention to?

9. What local terms do mothers use for signs and symptoms in comparison to the more scientific terms used by the medical community for pneumonia?

10. Do you think mothers bring their kids in for ARI care on time or too late? If not, what are the reasons?

11. What recommendations would you give to mother regarding home care of ARI?

12. In general terms, who do you usually treat the following ARI cases:

    A child with a pneumonia?
    A child with a cough?
    A child with bronchitis?

13. What do you think could be done to reduce the numbers of deaths from pneumonia and other ARI?

14. Who should take responsibility for these actions?

Interview with Nurses

Q: I would like to read to you two hypothetical cases, and ask you to tell me what you think the mothers in the community would be likely to do in each situation.

Scenario A: A six month old child with cough and runny nose.

Scenario B: A six month old child with cough, runny nose, rapid breathing, fever and chest indrawing.

1. What would mothers call their illness? Which signs and symptoms are most alarming to mother which would force her to seek help?

2. What home remedies would she use?

3. How many days would she wait to seek care, and where would she go first?

Scenario Presented at the Pharmacy

Scenario A: Six month old child with cough and runny nose.

Scenario B: Six month old child with cough, runny nose, rapid breathing, fever, chest indrawing.

Things to look for...

1. Antibiotic prescribed?
2. Other medications?
3. Recommendation to seek help?
4. Referral of where mother might look for additional help?
5. Additional questions asked about the case?
6. Other options for cheaper medication?
7. Explanation of usage and dosage of medicine?

Interview with Traditional Healers

1. Name

2. Community

3. Number of years working as traditional healer, midwife.

4. Do you attend children with respiratory illness? (Or have you at some point taken care of a child with respiratory illness?)

5. What signs and symptoms are most important to mother, what gets her attention to compel her to seek advice for a sick child?

6. What type of counsel or suggestions do you give to a mother with a child who has ARI? (Referral and treatment)

7. Do you give follow-up care?

8. When do mothers think medicine will start to have an effect?

9. Do mothers finish the entire course of medicine prescribed or do they stop administering medicine when the child shows signs of improvement?

10. Why do you think some mothers wait to seek help for a sick child?

11. Do you know of any children in this community that have died from an ARI related illness?

Interview with Mothers at Home

1. Name and community?

2. Age of the child?

3. Who watches the child while mother is away?

4. Has your child been ill with ARI ?

5. What was the illness called?

6. What were the signs and symptoms, how did the child look when sick?

7. What did you do at home to treat the sick child? (home remedy, beliefs, costumes)

8. What signs or symptoms do you consider dangerous and make you seek help for a child sick with ARI?

9. Who did you seek advice from and why? (preference, good service, etc.)

10. If you didn't look for help, why not? (Who decided when the child should be brought to a health provider; mother, husband, grandparents?)

11. When your child became sick, how long did you wait before looking for help?

12. Was the help of use?

13. How long does it take for the medicine to take effect? (Did you finish all the medicine or stop when the child got better?)

14. How long before the medicine makes the child well again?

15. When your child was sick, what was the quantity of food and drink you gave them and why?

16. Have you or any one you know had a child die from ARI?

17. Card game with signs and symptoms...

Interview with Mothers at the Health Center

1. Name and community?
2. Age of the child?
3. Who watches the child while mother is away?
4. Has your child been ill with ARI ?
5. What was the illness called?
6. What were the signs and symptoms, how did the child look when sick?
7. What did you do at home to treat the sick child? (home remedy, beliefs, customs)
8. What signs or symptoms do you consider dangerous and make you seek help for a child sick with ARI?
9. Who did you seek advice from and why? (preference, good service, etc.)
10. Where did you seek help before coming the health center/hospital? (note preference, other options, where she is most comfortable...)
11. When your child became sick, how long did you wait before looking for help?
12. Was the help of use?
13. How long does it take for the medicine to take effect? (Did you finish all the medicine or stop when the child got better?)
14. How long before the medicine makes the child well again?
15. When your child was sick, what was the quantity of food and drink you gave them and why?
16. Have you or any one you know had a child die from ARI?
17. Card game with signs and symptoms...

Interview with Community Medicine Banks

Q: I would like to read to you two hypothetical cases, and ask you to tell me what you think the mothers in the community would be likely to do in each situation.

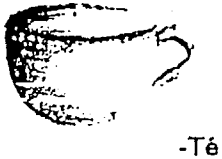
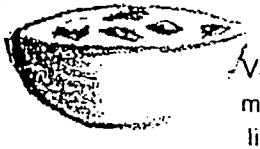
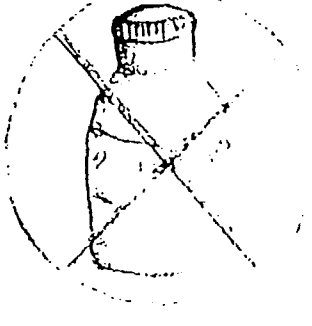
Scenario A: A six month old child with cough and runny nose.

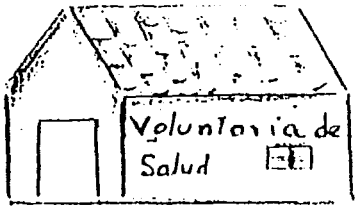
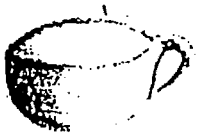
Scenario B: A six month old child with cough, runny nose, rapid breathing, fever and chest indrawing.

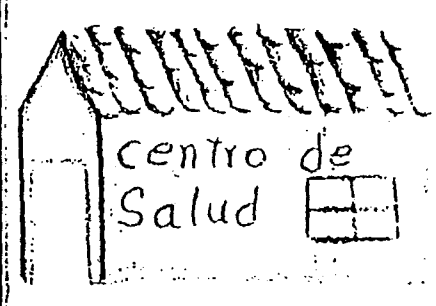
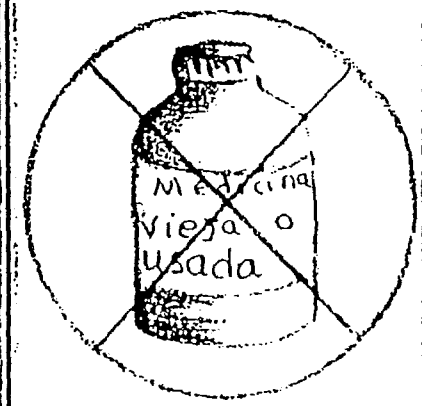
1. What would mothers call this illness? Which signs and symptoms are most alarming to mother which would force her to seek help?
2. What home remedies would she use?
3. How many days would she wait to seek care, and where would she go first?
4. When does mother think the medicine will take effect?
5. Does mother finish a full course of medication? If no, why not?
6. What recommendations do you have for mother?
   (Follow-up care or referral to other clinic?)

APPENDIX L
Home Health care box in Spanish

ENFERMEDADES RESPIRATORIAS

Si su niño se pone con...	Entonces tiene (enfermedad)	Tratamiento	Prácticas Peligrosas
 Tos Moquera (rinorrea) Irritadito (febricula) Ojos llorosos (lagrimeo) Lloroncito (irritable)	Gripe o catarro (resfriado común)	Cuídelo en casa con:  -Té de manzanilla, eucalipto, hierba buena, litrosol, limón con miel  -Vaporizaciones de manzanilla, eucalipto. - Limpiar la nariz con gotitas de agua de manzanilla. - Baje la fiebre con paños de agua tibia.	NUNCA! - Nunca ponga manteca con gas en el pechito. - Nunca frote con alcohol - Nunca le dé a comer vick o mentolina. - Nunca le dé aceites como ser de gallina, zorrillo, mono o de cualquier tipo. - Todas éstas costumbres son peligrosas el niño puede empeorar o morir. *EL NIÑO NO NECESITA ANTIBIOTICOS. 

Si su niño se pone con...	Entonces tiene (enfermedad)	Tratamiento	Prácticas Peligrosas
 Tos Calentura (fiebre) Moquera Lloroncito Cansado (respiración rápida) No quiere comer (falto de apetito).	Puede tener Neumonía ó puede tener Asma.	 - Llevelo al Voluntario de Salud o al Centro de Salud. - Mientras tanto dé abundantes líquidos o tés de Manzanilla o eucalipto.  ¡Atención! - Termine todo el tratamiento como el médico lo indica - Baje fiebre con paños de agua fria o de acetaminofen. 	NO SE AUTOMEDIQUE CON MEDICINA VIEJA O USADA, PUEDE SER MORTAL. (La medicina vieja pierde su efectividad y el niño puede empeorar).

Si su niño se pone con...	Entonces tiene (enfermedad)	Tratamiento	Prácticas Peligrosas
 -Desganado (sin apetito) Muy cansado (respiración rápida) Decaído Se le hunden las costillas (tiraje) Tiene hervor en el pecho, girgir (sibilancia/estridor) Adormitado (somnolencia) Calentura (fiebre) Uñas y labios morados (cianosis) Piel pálida Ahogo	MUY PROBABLEMENTE TIENE NEUMONIA O MUY PROBABLEMENTE TIENE ASMA.	 - Llevelo inmediatamente al Centro de Salud. ó al hospital. Madre !Cuidado! si su hijo padece de asma, también pudiera tener Neumonía. ¡Atención! -Termine todo el tratamiento como el médico lo indica.	NO SE AUTOMEDIQUE CON MEDICINA VIEJA O USADA, PUEDE SER MORTAL. (La medicina vieja pierde su efectividad y el niño puede empeorar). 

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Document D

MOH Honduras CHV Training Module/Curriculum

Document E

MOH Honduras TBA Training Manual

MANUAL

PARA LA CAPACITACION

DE PARTERAS TRADICIONALES

EN HONDURAS

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MANUAL PARA LA CAPACITACION DE PARTERAS TRADICIONALES EN HONDURAS

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I.- INTRODUCCION

El presente manual intenta abordar la capacitación de las parteras tradicionales en Honduras a través de metodologías no convencionales. El proposito fundamental es mejorar la capacidad de las mismas para identificar en mujeres en edad fértil embarazadas y no embarazadas los "factores de riesgo reproductivo" que cuando están presentes incrementan la probabilidad de muerte que ella y su producto tendrían al ocurrir un embarazo, parto o puerperio. Así mismo las parteras mejorarían su capacidad para atender el Parto limpio y el alumbramiento seguro.

Actualmente la partera tradicional se ha capacitado para atender partos, no obstante, no se le ha concientizado sobre los partos que no debe atender y de igual forma los embarazos que son riesgosos.

Se pretende garantizar una mejor atención a la población, reforzar la aplicación del enfoque de riesgo reproductivo y simultáneamente aumentar la cobertura del parto. Paralelamente se desarrollarán los mecanismos para fortalecer el sistema de referencia, donde la comunidad tendrá un rol protagónico en la aplicación de alternativas para resolver el problema.

El proceso de capacitación contenido de este manual se orienta a mejorar la calidad de atención a la Mujer en los diferentes momentos de su vida reproductiva y en su desarrollo hace énfasis en la búsqueda, detección y captación de mujeres en edad fértil no embarazadas con factores de riesgo reproductivo, para orientarlas sobre la prevención de embarazos de alto riesgo y temprana identificación, captación, manejo o referencia de embarazadas, según su grado de riesgo.

En la atención directa del parto se refuerzan las acciones que garanticen la atención del parto limpio y el alumbramiento seguro, como respuesta a las dos principales causas de muerte materna en Honduras. Además se incluyen contenidos sobre el manejo adecuado del puerperio, la lactancia materna y el uso de metodología anticonceptiva en función de la prevención de las muertes maternas y perinatales.

Dado que este proceso es diferente al desarrollado previamente y ha probado que *SI* induce cambios tanto en las parteras como en el personal supervisor, el Ministerio de Salud pretende que el 100% de las personas que atienden partos (parteras Activas) en el país sean capacitadas bajo esta nueva metodología, independientemente de quien realice y quien financie las actividades de capacitación.

Los autores esperan que la contribucion que este manual aporte al proceso de capacitación de Parteras Tradicionales y su relación con toda la red de servicios produzca realmente un impacto positivo en la reducción de las muertes de madres y niños y dedican la obra al Pueblo Hondureño.

II.- ANTECEDENTES

Aunque la existencia de la Partera Tradicional se remonta a tiempos inmemoriales fué hasta en la década de los cincuenta que el Ministerio de Salud Pública de Honduras dió los primeros pasos para participar de alguna forma en su orientación. En los años sesenta se iniciaron los primeros cursos de capacitación y se logró el reconocimiento de la "PARTERA EMPIRICA" por el Colegio Médico.

En los años setenta la capacitación de las parteras tradicionales se organizó y sistematizó. El proceso se sustentó en documentos como programas, proyectos y manuales. La metodología era predominantemente escolástica y aún continúa en la misma forma hasta la fecha en las localidades en que aún no son atendidas con el nuevo proceso.

El análisis de la situación Materno Infantil especialmente la estructura y características de la mortalidad materna e infantil condujo a los técnicos nacionales a concluir que la capacitación de parteras no estaba produciendo los resultados que se esperaba de ella, y que por lo tanto se hacía necesario revisar el proceso.

Se estableció entonces que la metodología escolástica tradicional y la falta de supervisión son las responsables de que la capacitación no sea efectiva y no logre producir cambios en las actitudes y prácticas de la partera y por ende en los indicadores de salud.

Como respuesta se planteó reorientar el proceso para lo cual a inicio de los años noventa se elaboró, en la Región Sanitaria No. 4, una primera propuesta metodológica para la capacitación de parteras tradicionales la cual fue probada e implementada en la Región Sanitaria No. 8 (La Mosquitia).

Con las experiencias vividas en la Mosquitia y en otros talleres con las Regiones de Salud # 2 y # 5 se hizo una serie de ajustes que permitieron obtener una propuesta metodológica que sirvió de base para la ejecución a nivel nacional de un proyecto con la participación directa de organizaciones privadas de desarrollo, la supervisión del Ministerio de Salud Pública, la asesoría técnica de OPS/INCAP y el financiamiento del Banco

Mundial a través del Fondo Hondureño de Inversión Social. Uno de los productos de este proyecto es la incorporación de las modificaciones a la temática y al diseño metodologico así como de las técnicas participativas y motivacionales que han surgido en el transcurso de ocho meses de aplicación del proceso para capacitar aproximadamente tres mil parteras.

III.- DEFINICIONES OPERATIVAS

1.- FACILITADOR: Recurso capacitado que induce al grupo a la reflexión y análisis, modera y conduce con metodologias participativas el desarrollo de actividades en el proceso de capacitación.

2.- PARTERA (o): persona que atiende partos.

3.- PARTERA TRADICIONAL CAPACITADA: Persona que atiende partos y participa en los procesos educativos.

4.- PARTERA (o) ACTIVA: Toda persona que atiende partos, excepto la que atiende un parto circunstancialmente.

5.- PARTERA VINCULADA: Toda persona que atiende partos y establece relaciones con el Ministerio de Salud a traves de reuniones, informes etc.

NOTA: **En todas las definiciones de "PARTERA" se debe considerar que historicamente la comunidad le asigna personalmente otras funciones relacionadas con los diferentes momentos de la vida reproductiva de la mujer.**

6.- SUPERVISOR: Recurso capacitado que ha desarrollado un proceso de capacitación inicial y que guia, orienta y apoya a la partera en el desarrollo de sus actividades.

7.- MUJER EN EDAD FERTIL: toda persona de sexo femenino con edad comprendida entre los doce y los cuarenta y nueve años.

8.- SEXO: es la caracteristica biológicamente determinada que define a la persona como masculino o femenino.

9.- GENERO: es el rol socialmente asignado a las personas que las define como mujer u hombre

10.- ATENCION INTEGRAL A LA MUJER: acción de salud que debe considerar a la mujer como una persona que tiene un problema condicionado no solamente por una causa biológica (enfermedad) sino también por su entorno socioeconómico-cultural.

11.- ENFOQUE DE RIESGO REPRODUCTIVO: es la estrategia que permite el abordaje integral de las causas que condicionan la enfermedad y la muerte relacionadas con el proceso de la reproducción humana.

12.- ENFOQUE DE RIESGO REPRODUCTIVO NO OBSTETRICO (PRECONCEPCIONAL): es la estrategia que permite la identificación de mujeres con FACTORES DE RIESGO REPRODUCTIVO y su captación para la prevención de embarazos de alto riesgo mediante la utilización de METODOLOGIA ANTICONCEPTIVA.

13.- ENFOQUE DE RIESGO REPRODUCTIVO OBSTETRICO (CONCEPCIONAL): es la estrategia que permite la utilización de la capacidad instalada para dar respuesta a la atención del embarazo y el parto en un nivel de complejidad adecuado a su grado de riesgo.

14.- FACTORES DE RIESGO REPRODUCTIVO: son aquellas condiciones, biológicas o socio-culturales, que cuando están presentes en la mujer aumentan la probabilidad de que ella o su producto potencial en caso de embarazarse puedan enfermar o morir.

Se consideran factores de riesgo reproductivo los siguientes:

a) SOCIALES:
- vivienda rural o urbano marginal,
- bajo ingreso económico (desempleo o subempleo),
- baja o ninguna escolaridad,
- soltera.

b) BIOLOGICOS:
- edades extremas (menor de 18 o mayor de 35 años),
- paridad mayor de cuatro hijos,

- espacio intergenésico menor de 12 meses,
- antecedente o presencia de enfermedades crónicas (diabetes, hipertension arterial,cardiopatia y nefropatia),
- antecedentes patológicos obstetricos (aborto,hemorragia post-parto, cesárea, recién nacidos de bajo peso).

15.- METODOLOGIA ANTICONCEPTIVA: es la serie de acciones, articulos o sustancias que mediante su uso permiten en forma natural o artificial prevenir los embarazos.

16.- EMBARAZO: estado fisiologico de la mujer producido por la concepcion, nidacion, formacion y desarrollo de un nuevo ser humano.

EMBARAZO DE BAJO RIESGO: aquel embarazo que ocurre en una mujer que no tiene factores de riesgo reproductivo y que transcurre unicamente con los cambios habituales de ese estado y por lo tanto no compromete la salud de la madre y/o su producto.

18.- EMBARAZO DE ALTO RIESGO: es aquel que ocurre en una mujer que tiene factores de riesgo reproductivo y/o durante el cual se presenta alguna patologia que lo complica.

Los signos y sintomas que pueden indicar presencia de patologias importantes durante el embarazo son:

- sangrado en cualquier trimestre del embarazo,
- aumento de la presión arterial,
- edemas, sobre todo si son matutinos y generalizados,
- disminución, estabilización o aumento exagerado de peso,
- disminución o ausencia de movimientos fetales,
- alteraciones del crecimiento uterino,
- cefaleas intensas,
- hemoglobina menor de 10 g. o palidez mucocutanea
- V.D.R.L. positivo,
- dolor lumbar y/o fiebre,
- violencia contra la mujer en todas sus formas.

19.- CONTROL PRENATAL: es la atención periódica y sistemática que permita la valoración clínica integral de la condición de la salud de la mujer y su producto con el fin de detectar y tratar las complicaciones.

20.- PARTO: comprende la serie de procesos mediante los cuales la madre expulsa los productos de la concepción a término o pretérmino a través del canal del parto.

Para fines estadísticos se define el parto cuando el embarazo finaliza después de las 20 semanas de gestación o el producto pesa 500 g. o más. Si la finalización del embarazo se produce antes de cumplir esas condiciones entonces se denomina ABORTO.

21.- PARTO DE BAJO RIESGO: es aquel en el cual los procesos fisiológicos ocurren espontáneamente y termina con una madre y un niño(a) en buen estado.

22.- PARTO DE ALTO RIESGO: el de las mujeres con embarazos de alto riesgo y/o en el que, en el trancurso de cualquiera de sus periodos se suscitan hechos que amenazan la salud de la madre y/o el niño(a).

Los signos y síntomas que pueden indicar PELIGRO durante el parto son:

- duración mayor de 15 horas en las primiparas o mayor de 10 horas en las demás mujeres,
- ruptura prematura de las menbranas ovulares,
- fiebre,
- sangrado abundante con o sin contracciones,
- variaciones de la frecuencia cardiaca fetal por arriba de 160 o por abajo de 120 latidos por minuto,
- tiempo corporal (tiempo transcurrido desde el nacimiento del niño-a hasta la expulsión de la placenta) mayor de 30 minutos,
- prolapso o procúbito del cordón umbilical,
- procedencia de una extremidad superior,
- Presentación fetal de diferente a la cefálica.
- diagnóstico previo o presente de enfermedades concomitantes(pre-eclampsia, eclampsia,hipertensión arterial cronica, diabetes y otras).

23.- **PUERPERIO:** es el periodo que se inicia despues del alumbramiento(expulsion de la placenta) y se extiende hasta el momento en que el organismo de la mujer recupera las condiciones anatómicas y funcionales que presentaba antes del embarazo. Dura aproximadamente seis semanas.

24.- **PUERPERIO DE ALTO RIESGO**: es aquel en el cual ocurren hechos relacionados con el parto que comprometen la salud de la mujer.

Los signos y sintomas que indican complicaciones puerperales son.

- sangrado uterino abundante.

Generalmente es producto de atencion inadecuada del parto, puede ser secundaria a retencion total o parcial de la placenta o las membranas. Es la causa mas frecuente de muerte materna en Honduras y puede prevenirse con una adecuada atencion del alumbramiento. Puede deberse también a otras causas como ruptura uterina, desgarros cervicales, vaginales o perineales y otras.

- Fiebre con o sin fetidez de los loquios.

Son signos de infeccion puerperal, generalmente secundaria a atencion NO LIMPIA O NO ASEPTICA del parto, en menor frecuencia a ruptura prematura de menbranas. Es la segunda causa de muerte en Honduras, podria prevenirse con atencion del parto limpio.

25.- CONTROL PUERPERAL: es la atencion que permite la valoracion integral de toda mujer puerpera y que se debe brindar de preferencia en los primeros 10 dias del puerperio, con el fin de detectar complicaciones, ya que es en este periodo donde ocurre el mayor numero de muertes puerperales.

26.- **LACTANCIA MATERNA**: todas las acciones que permiten garantizar que todo niño(a) hondureño(a) reciba el alimento del pecho materno durante sus primeros años de vida. Ello le previene problemas inmunológicos y nutricionales, fortalece los vinculos familiares y contribuye a la economía familiar. Se incluyen en el concepto las actividades que durante la etapa prenatal preparan a la mujer para la lactancia, las que la apoyan durante el parto y el puerperio, el manejo de las complicaciones y el proceso de destete.

27.- **LACTANCIA MATERNA EXCLUSIVA**: es al amamantamiento al pecho materno durante los primeros seis meses de vida del niño, durante los cuales no se le debe suministrar ninguna otra sustancia que no sea la LECHE MATERNA.

28.- **APEGO PRECOZ:** es la interacción entre la madre y el recién nacido en la primera hora post-parto. Puede o no haber amamantamiento en este periodo; lo más importante es el contacto físico piel a piel.

29.- **ALOJAMIENTO CONJUNTO**: significa que toda madre que tuvo un parto con recién nacido sano debe compartir su mismo lecho con el o ella durante toda su estancia en el lugar de ocurrencia del parto.

30.- **PLANIFICACION FAMILIAR:** aunque en realidad es un concepto más amplio, para efectos de comparaciones inter-institucioinales e internacionales se define como la aplicación y uso de metodologías anticonceptivas y todos los procedimientos administrativos necesarios para garantizar las atenciones y el suministro de los métodos en buen estado.

31.- **USUARIA DE PLANIFICACION FAMILIAR**: toda mujer adecuadamente informada que voluntariamiente decide utilizar un método anticonceptivo natural o artificial, temporal o permanente.

32.- **USUARIA DE PRIMERA VEZ EN EL PROGRAMA**: toda usuaria que NUNCA ANTES habia utilizado los servicios de planificación familiar del Ministerio de Salud en ninguna parte del pais.

33.- **USUARIA DE PRIMERA VEZ EN EL AÑO**: toda usuaria que en el año en curso acude por primera vez

a obtener servicios de planificacion familiar en alguna U.P.S. del Ministerio de Salud.

34.- **USUARIA DE CONTROL**: toda usuaria que en el año en curso ya recibió por lo menos una atención en planificación familiar en alguna U.P.S. del Ministerio de Salud.

35.- **LISTADOS DE MUJERES EN EDAD FERTIL**: es el instrumento institucional y comunitario que permite detectar a todas las mujeres de cada espacio población determinado y conocer sus condiciones socio-económicas y su situación de riesgo en salud materna y perinatal.

36.- **LISTADOS DE LAS MUJERES EMBARAZADAS**. es el instrumento institucional y comunitario que permite la detección y captación de toda mujer embarazada de cada espacio-población así como el análisis y seguimiento de su embarazo.

37.- **Mortalidad Perinatal**: es la muerte de fetos mayores de 28 semanas de edad gestacional o de niños durante el primer mes de vida.

38.- **Mortalidad Materna**: Se refiere a mujeres que mueren por cualquier causa durante un embarazo, un aborto, un parto o durante los primeros 42 días del puerperio.

IV.1 OBJETIVOS GENERALES:

1. Contribuir a disminuir la mortalidad y la morbilidad materna y perinatal mediante la capacitación de las Parteras Tradicionales.
2.- Integrar a la Partera Tradicional al funcionamiento de la Red de Servicios de Salud, en un proceso que garantice el acceso a la atención en salud materno-perinatal.
3.- Inducir un cambio real en las actitudes y prácticas de la partera tradicional, mediante el uso de una metodología de capacitación analítica, reflexiva, participativa y vivencial.
4.- Integrar al personal institucional al proceso de capacitación y seguimiento de la partera tradicional para garantizar el funcionamiento adecuado de la red de servicios en función de la solución de la problemática materno infantil.
5.- Fortalecer la organización comunitaria y la participación social en la solución de su problemática de salud materno infantil utilizando en el proceso de capacitación el enfoque de Sistemas Locales de Salud.

IV.2 OBJETIVOS ESPECIFICOS:

1.- Capacitar al 100% de las parteras a nivel nacional en atención materno infantil, enfoque de riesgo reproductivo, atención del parto limpio y alumbramiento seguro, utilizando la metodología descrita en este documento.
2.- Capacitar a la Partera en la identificación y manejo de los factores de Riesgo Reproductivo en forma oportuna y adecuada para incrementar el acceso a la atención integral de la mujer en edad fértil, esté o no embarazada.
3.- Capacitar a la Partera Tradicional para que identifique y reconozca a las embarazadas de BAJO RIESGO a las que ella ***SI*** puede atender, con una mejor calidad, garantizandoles un PARTO LIMPIO y un ALUMBRAMIENTO SEGURO.

4.- Concientizar a la Partera Tradicional y a la comunidad sobre la importancia de referir EFECTIVAMENTE y de acuerdo al grado de riesgo, a las mujeres con Factores de Riesgo Reproductivo o síntomas y signos de ALTO RIESGO a las UPS de mayor complejidad, de esta manera se contribuirá a disminuir las complicaciones y las muertes en el nivel comunitario.
5.- Capacitar a la Partera Tradicional en la prevención del tétanos neonatal mediante la aplicación de Toxoide Tetánico, por ella misma o por referencia a la UPS.
6.- Capacitar a la Partera Tradicional en el uso adecuado y distribución de métodos anticonceptivos naturales y de barrera y en la referencia para uso de otros métodos a las diferentes UPS de mayor complejidad a fin de reforzar la aplicación de la estrategia de Enfoque de Riesgo Reproductivo.
7.- Capacitar al 100% del personal institucional de los diferentes niveles de atención en salud en la aplicación del proceso de capacitación y seguimiento de la partera tradicional.

V.- DESCRIPCION GENERAL DE LA METODOLOGIA

El Proceso de capacitación de parteras está dirigido a inducir cambios, en las actitudes y prácticas de la Partera Tradicional, orientados al reconocimiento de su papel como parte de un sistema integrado de atención en salud que tiene como objetivo fundamental disminuir el número de muertes de madres y niños en su comunidad.

Para lograrlo, la estrategia de capacitación de Parteras Tradicionales, debe garantizar que el proceso:

1._ formará parte de la respuesta integral de la comunidad a su problema de muerte materna y perinatal,
2.- se desarrollará aplicando la metodología participativa, reflexiva, analítica y vivencial en su ambiente de trabajo. (En la reflexión y análisis se debe considerar el Enfoque de Género),
3._ incluirá contenidos educativos que respondan a la implementación del enfoque de riesgo reproductivo, obstetrico y neonatal,
4.- se desencadenará a partir del conocimiento de la realidad local,
5.- garantice la utilización de técnicas participativas para facilitar el proceso de APRENDER HACIENDO,
6.- garantice que el personal institucional identifique su rol como parte integral de la respuesta a la problemática materna y perinatal.

El proceso contempla dos momentos importantes que se complementan entre si: el primero un taller inicial de concentración y el segundo una etapa de seguimiento.

V.1.- TALLER INICIAL

El taller inicial se debe desarrollar considerando los siguientes elementos:

Participantes: - En la composición del grupo de personas participantes en un taller existen dos aspectos importantes:

El número total de participantes no debe de exceder de 13 y la relación de partera/personal institucional no debe de exceder de 3/1 respectivamente.

- Entre 8 y 10 parteras las que serán seleccionadas del grupo de personas que atienden parto en las áreas de influencia y sede de la unidad productora de servicios de salud (UPS).
- La auxiliar de enfermería de la UPS a la que las parteras pertenecen.
- El facilitador(a).
- La supervisora de área o sector al que la UPS pertenece (cuando sea necesario).
- Un futuro(a) facilitador(a) que no esté capacitado(a) en la metodología.
- Mujeres de la comunidad, de cualquier edad, embarazadas y no embarazadas.

- El ambiente principal a utilizar para las reuniones de discusión de preferencia debe ser la casa de una de las parteras participantes, pudiéndose usar también, escuelas, centros comunales, etc. y en último caso un salón del Centro de Salud.
- Las casas de mujeres embarazadas para las atenciones vivenciales en prenatal, parto y puerperio.
- Los consultorios de los CESAR y CESAMOS para presenciar las atenciones institucionales.
- Los hospitales y clínicas materno infantiles (cuando estén accesibles a lugar de la capacitación), para observar las instalaciones y si es posible la atención institucional del parto.
- Casos comunales, alcaldías, escuelas iglesias, etc. para realizar las reuniones comunitarias.

Rol del facilitador:

- Discutir previo al inicio del taller la metodología con el personal institucional.
- Identificar técnicas participativas que se adecúen al tema que se está desarrollando.
- Inducir a todos los participantes a la discusión sobre el tema en desarrollo.
- Inducir en los participantes la apropiación de conceptos a través del método deductivo.
- Propiciar la identificación de prácticas inocuas, beneficiosas y perjudiciales, su discusión e intercambio de experiencias.
- Promover durante el desarrollo de todo el proceso la disminución de barreras entre "facilitadores" y "participantes", eliminando la utilización de títulos y estimulando el trato de personas por su nombre.
- Utilizar técnicas participativas para mantener la motivación del grupo participante.
- Apoyar al personal institucional en la dirección de la reunión comunitaria.

Rol de Participantes Institucionales:

- Recordar que el personal institucional NO SOLAMENTE ES UN OBSERVADOR sino un participante más.
- En cualquier momento puede asumir el rol de Facilitador.
- Debe utilizar en forma permanente la metodología participativa, evitando intervenciones que influyan negativamente como ser:
  - actitudes que evidencien la relación maestro alumno.

- actitudes que evidencien una relación jerárquica.
- Dado el liderazgo que debe tener en su comunidad deberá conducir las reuniones comunitarias.

Reunión comunitaria.

Para garantizar la permanencia del proceso es necesario incluir en el desarrollo del mismo a las fuerzas vivas de la comunidad, para ello se deben realizar reuniones con amplia participación de la comunidad, en las que se expongan y discutan la situación de mortalidad y morbilidad materno-perinatal de la localidad y propongan las alternativas de solución.

Se aprovechan los ratos libres o las reuniones ya programadas por la Comunidad durante la semana de la reunión inicial para llevar a cabo esta actividad. Es conveniente que previo a la reunión las parteras hayan interiorizado el concepto de riesgo.

Duración: Los talleres iniciales tendrán una duración de cinco días. Se ha probado que reuniones con más duración interferieren en el interés de las participantes con la actividad, probablemente por el abandono prolongado de sus hogares.

Distribución de los Participantes:

Durante el desarrollo del taller, se deben distribuir los participantes y facilitadores siempre en círculos, se debe evitar la disposición con mesas principales o estrados de maestros. Asimismo se debe de asegurar que el vocabulario utilizado sea el que los participantes entiendan y no el lenguaje técnico institucional.

Cobertura de Contenidos:

El grupo institucional y principalmente el facilitador deben tener claridad que no siempre en el ***taller inicial*** se cubrirán todas las actividades. Sin embargo, lo más importante no es desarrollar todos los temas en el taller inicial, sino garantizar que cada tema que se aborde sea aprendido por la partera, en las visitas de seguimiento y en reuniones posteriores se debe completar el desarrollo de todos los temas faltantes.

V.2.- SEGUIMIENTO

El seguimiento es el elemento del proceso de capacitación que facilita a la partera la interiorización de los conocimientos y que experimente cambios reales en sus actitudes y prácticas.

Por otro lado permitirá a los facilitadores y supervisores dar continuidad a las actividades realizadas, evaluar el grado de avance del proceso de cambio de actitudes y prácticas y reforzar los conceptos necesarios para ello.

El seguimiento se realizará tomando en cuenta los siguientes elementos:

VISITAS A LA COMUNIDAD: El facilitador analizará con la partera la situación materno infantil de su población.

VISITAS A LAS EMBARAZADAS CON FACTORES DE RIESGO: El facilitador y la partera visitarán a las embarazadas que están en control con esta ultima, a fin de analizar la aplicación de los conocimientos adquiridos durante la capacitación.

EVISION DEL MATERIAL: El facilitador revisará el Maletín de la partera.

VISITA A LA UPS: El facilitador visitará la UPS a la que pertenece la partera a fin de analizar coberturas, referencias y aplicación del Enfoque de Riesgo Reproductivo.

REUNION CON LA COMUNIDAD: Se organiza una reunión con la comunidad a fin de evaluar el proceso de aplicación del Enfoque de Riesgo Reproductivo.

REUNIONES DE SEGUIMIENTO: Periódicamente se realizará en la UPS reuniones con el personal institucional y las parteras para evaluar el grado de avance del proceso y reforzamiento de conocimientos de acuerdo a necesidades identificados.

Se debe revisar la disponibilidad de materiales, equipo y se prepararán los paquetes estériles.

NOTA: Cuando el seguimiento sea realizado con personas ajenas a la UPS se debe elaborar un informe de la actividad.

V.3.- EVALUACION

Hay diferentes formas de evaluar el proceso:

Evaluaciones en el taller inicial:

a) Durante el desarrollo del taller inicial al final de cada día o cada tema, el grupo institucional se reunirá para analizar las actividades realizadas. Permanentemente el grupo debe evaluar el grado de captación o asimilación de los temas en discusión. No se podrá iniciar un tema mientras el anterior no haya sido asimilado por la mayoría (80%) de los participantes. La evaluación de cada actividad se hará a través de preguntas verbales para valorar el logro de cada objetivo.

b) Periodicamente se realizará evaluación con todo el grupo participante a fin de conocer el estado motivacional y de asimilación de los conocimientos en discusión.

c) Se realizará evaluación al final del taller inicial para analizar el desarrollo de las actividades, el grado de asimilación de conocimientos, la aplicación de la metodología y los elementos indispensables en el desarrollo del taller inicial (participantes, rol del facilitador, rol del personal institucional, local, limitantes y facilitantes etc.)

Evaluación durante el seguimiento:

d) Durante el seguimiento se evaluará el grado de asimilación de conocimientos, cambio de actitudes y prácticas de la partera; cobertura de atención por la partera y el nivel institucional y revisión de existencia de insumos.

Evaluación de Impacto:

e) La evaluación de impacto del proceso se hará a través de la medición de indicadores tales como:

- referencias
- morbilidad y mortalidad materno perinatal por sector o área.
- participación social.

VI.- CONTENIDO DEL PLAN EDUCATIVO

La capacitación inicial debe desarollarse en módulos que permitan al capacitado la interiorización de la importancia del enfoque de riesgo reproductivo en atención materna y perinatal. Debe también asegurarse que la mayor parte de los participantes hayan comprendido el tema en discusión antes de continuar al tema siguiente. Como ya se ha dicho anteriormente, la metodología debe ser participativa, reflexiva, analítica y vivencial; se evitarán las exposiciones magistrales y se promoverá el uso de técnicas participativas que permitan el aprendizaje mediante la acción y la deducción. También se utilizarán técnicas motivacionales cuando sea necesario, se evitará el uso excesivo de ellas.(ver anexo 1).

El plan educativo contiene las siguientes actividades:

Presentación de los participantes, concepto de riesgo conceptualización del Enfoque de Riesgo Reproductivo, identificación de Factores Riesgo Reproductivo, Atención prenatal y embarazo de alto riesgo, atención de parto limpio y alumbramiento seguro, atención inmediata del recién nacido, atención puerperal, atención en planificación familiar y sistema de información.

VI.1.- CONTENIDOS DEL TALLER INICIAL

ACTIVIDAD 1

PRESENTACION DE PARTICIPANTES

A. OBJETIVOS

.- Romper el hielo entre los participantes.
.- Establecer un clima de confianza mediante la identificación de cada participante por su nombre.

B. METODOLOGIA

La presentación de los participantes debe hacerse a través de técnicas participativas tales como: El baile de presentación, la presentación por parejas el complemento de mi corazón, imitación de varios animales y otros.

C. TECNICAS PARTICIPATIVAS

C.1

NOMBRE LAS FIGURITAS EN PAREJA

PARTICIPANTES: Se puede aplicar a grupos pequeños y grandes, de preferencia que los participantes en total formen un número par.

No importa si son o no alfabetas. En caso de no tener las figuras se pueden utilizar nombres de animales. (En tal caso el grupo debe tener instrucción mínima).

MATERIALES:
- Cartulina
- Figuras repetidas de animales y objetos
- Pegamento
- Marcadores.

PREPARACION: En un pedazo de cartulina se dibujan varios circulos, se recortan, se remarcan y luego se van pegando figuritas en pareja. (Hasta elaborar 10 parejas como minimo).

DESARROLLO: Se coloca un grupo en circulo, y se les reparte una tarjeta con una figurita a cada participante. Luego se les dice que busquen su pareja y en caso de que no hayan figuritas se les pone nombres repetidos de animales. Cada persona encontratrá su pareja imitando las voces de los animales que aparecen en su tarjeta.

Una vez que se han formado las parejas, se busca un lugar apropiado para dialogar sobre sus datos generales tales como: nombre, lugar de procedencia, cuantos hijos tiene, etc. Se les asignan unos minutos y después se reúne nuevamente al grupo y cada participante presenta a su compañera (o) narrando lo que éste le contó.

REFLEXION Y ANALISIS: Con esta dinámica se pretende presentar a todas las participantes, se conocen sus nombres, de donde vienen cada una de ellas y sirve para romper el hielo en todo el grupo.

C.2

NOMBRE: LA DELICADEZA

PARTICIPANTES: Un grupo de 10 a 12 parteras con instrucción mínima, que viven en una zona geográfica cercana

MATERIALES: Una flor Natural.

PREPARACION: NINGUNA.

DESARROLLO: Los participantes se colocan en circulo, si alguno se conoce con el del lado se cambia de sitio, un(a) compañero(a) entrega una flor al otro del lado izquierdo, llamandole por el nombre y diciendo que la envia el del lado derecho, del cual también mencionará su nombre y así pasan sucesivamente la flor. A la persona que se le olvide los nombres de sus compañeros se les cambiará su nombre propio por el de un animal, el juego concluye al declinar al interés del grupo.

REFLEXION Y ANALISIS: Las parteras muestran interés en recordar el nombre de la compañera que le da la flor y si se le olvida se vuelve y le pregunta el nombre, aunque ya habrá entregado la flor a la compañera del lado izquierdo. Ayuda a presentarse.

Cuando cambien el nombre de ellas por el de un animal se desaniman y pierden interés por la dinámica por lo que se recomienda darle varias oportunidades para acordarse del nombre de sus compañeras.

C.3.

NOMBRE: **EL BAILE DE PRESENTACION**

PARTICIPANTES: No importa el número ni el nivel de instruccion.

MATERIALES: Grabadora, casete con musica ranchera o típica.

PREPARACION: Se instruye a los participantes sobre la actividad.

DESARROLLO: Se pone la música y se arman las parejas, mientras bailan platican sobre temas personales, nombre de cada quien, datos sobre la familia, estado civil, actividad que más le gusta hacer, etc. Luego en pequeños grupos (6 personas)

se intercambia la información de la compañera.

REFLEXION Y ANALISIS: Las participantes comenzarán a conocerse entre sí y a entrar en confianza.

ACTIVIDAD No. 2

CONCEPTO DE ENFOQUE DE RIESGO

A. OBJETIVOS

Que los participantes comprendan que hay grupos poblacionales que tienen mayor probabilidad de experimentar un problema que otros.

B. METODOLOGIA

El grupo debe reflexionar que en una población puede ocurrir cualquiera de las siguientes situaciones.

1.- Hay un grupo de personas que están mas expuestos a sufrir un daño que otros.

2.- En el grupo de los que estan mas expuestos no todas sufrirán el daño.

3.- En el grupo de las menos expuestas, algunas también sufren el daño.

4.- Es imposible predecir de las que están expuestas quienes van a sufrir el daño.

C. TECNICAS PARTICIPATIVAS

C.1

NOMBRE: TECNICA DEL ARBOL DE PELIGRO

PARTICIPANTES: Puede utilizarse en un grupo no mayor de 15 personas, no es relevante el nivel de instrucción.

MATERIALES: Puede hacerse con un árbol o rama que se consigue en la comunidad.

PREPARACION: Se puede utilizar cualquier objeto que represente individuos.

DESARROLLO: Se colocan los objetos que representan individuos, algunos de ellos fijos en el arbol otros desprendibles del árbol y otro grupo de ellos debajo del árbol.

Se mueve o se sopla el árbol para observar que sucede con los objetos.

REFLEXION Y ANALISIS: Se induce al grupo a la reflexion de lo ocurrido; tratando de diferenciar que los individuos que estaban debajo del árbol no tenian ninguna posibilidad de caer, mientras que los que estaban ubicados en el árbol todos tenian la posibilidad de caer, sin embargo, solo algunos de ellos cayeron. Era imposible predecir cuales caerian.

NOTA:

> Esta técnica se puede adecuar para utilizar ejemplos como un bus, (Las personas que se transportan dentro de de un bus que va por la carretera tienen posibilidades de golpearse o morir, si este tuviera un accidente. No a todos les pasará algo. las que no estén en el bus no tienen probabilidad de acccidentarse en ese bus).

ACTIVIDAD No. 3:

CONCEPTUALIZACION DEL ENFOQUE DE RIESGO REPRODUCTIVO

A OBJETIVOS

Que los participantes estén en capacidad de identificar que existe un grupo de mujeres en edad fértil que tienen mayor probabilidad de que ella o su probable hijo puedan enfermar o morir en caso de que ocurra un embarazo.

B. METODOLOGIA

El grupo reconocerá que en todas las poblaciones existen mujeres en edad fértil con diferentes características (edad, estado civil, nivel socio-económico, paridad) algunas de las cuales condicionan un mayor peligro si ocurre un embarazo.

Se reflexionará sobre el hecho de que NO TODOS LOS EMBARAZOS SON IGUALES", pueden existir diferencias entre varias mujeres embarazadas, o entre varios embarazos de la misma mujer.

Recordar que dos terceras partes de las muertes maternas perinatales ocurren en mujeres con factores de riesgo reproductivo y que solo una tercera parte ocurre en mujeres que no tienen riesgo.

C. TECNICAS PARTICIPATIVAS

C.1

NOMBRE: LAS FLORES QUE CAEN AL AGUA

PARTICIPANTES: Grupos de 15 personas cuyo nivel de instrucción no es relevante.

MATERIALES: Papel higiénico, hilo, cartulina, maskin tape, palangana con agua.

PREPARACION: Se elaboran flores de papel, unas grandes que representan a las madres y otras pequeñas que representan a los hijos. Se atan a una flor grande 3 flores pequeñas que representan mujer sin riesgo o bajo riesgo y a otras flores grandes se le atan 5 y 6 flores representando alto riesgo por paridad. Se pega un pedazo de cartulina alrededor de una palangana sobre el cual se colocan fijamente varios grupos de flores de riesgo y otros grupos no se fijan. La palangana se coloca en una mesa sobre la cual se distribuyen grupos de flores de bajo riesgo.

DESARROLLO: El grupo de participantes se distribuye alrededor de la mesa, y una de ellas produce movimiento a la cartulina que está pegada a la palangana, las flores que no están pegadas caerán al agua. El grupo reflexionará sobre lo ocurrido.

REFLEXION Y ANALISIS: Con esta actividad se pretende que los participantes comprendan el ENFOQUE DE RIESGO REPRODUCTIVO. Hay mujeres con bajo riesgo (flores que están sobre la mesa) y mujeres con alto riesgo (flores que están en el borde de la palangana), de estas últimas no todas caen cuando se mueve la cartulina.

C.2

NOMBRE: EL TUTIFRUTI

PARTICIPANTES: Grupo de hasta 15 participantes cuyo nivel de instrucción no es de importancia.

MATERIALES: Repollos, frutas de la temporada, cuchillo, tabla, palangana, vasos, cucharón y cuchara.

PREPARACION: Se divide el grupo en 3 conformado por cantidades diferentes, unos más grandes que otros. Se pretende que cada grupo

trabaje con el material y equipo que se le asigna.

DESARROLLO:

Al primer grupo se le pide que haga un picado de repollo y se le da todo lo que necesita, (una cabeza de repollo, un cuchillo, una tabla y una palangana) y trabajan 2 personas.

Al segundo grupo se le pide que elabore un tutifruti y que además lo preparen para comer (listo para servir) se le dan solamente 2 o 3 frutas, un cuchillo, una tabla, una palangana (no se le dan vasos, ni cucharas) y trabajan 3 ó 4 personas

Al tercer grupo se le pide lo mismo y se dan las mismas frutas que al grupo anterior y todas las que se puedan, ademas se les da 3 cuchillos, 2 tablas, 1 palangana, vasos y cucharas y un cucharon para servirlo y hay varias personas preparandolo.

REFLEXION Y ANALISIS:

Con esta actividad se pretende que los participantes identifiquen la atención por niveles de complejidad, que comprendan que cada nivel tiene cierta CAPACIDAD RESOLUTIVA y que existen limitantes cuando no se cuenta con todos los elementos necesarios para realizar una actividad.

La primera actividad, en la que se da al subgrupo equipo y material mínimo para realizar una actividad NO COMPLICADA, puede compararse con el trabajo que hace la partera en la atención del parto de bajo riesgo. La segunda, sirve para hacer comprender la necesidad de que cuando se realiza una actividad compleja, se necesita contar con todos los materiales y equipos necesarios. Se evidencia el hecho de que hay un grupo que tiene que elaborar y servir EL TUTI-FRUTI pero no tiene los materiales y equipos necesarios; este sería el caso de médicos, enfermeras y parteras, que atienden en el domicilio, CESAR, CESAMO o CLINICAS MATERNO INFANTILES frente a un embarazo o parto de alto riesgo. Los hospitales se compararían con el grupo que tiene todos los materiales y los ingredientes y pudieron hacer y servir el tutifruti.

C.3

NOMBRE: **LA MANTA DE COCINA**

PARTICIPANTES: Grupo de hasta 15 personas cuyo nivel de preparación no es relevante.

MATERIALES: 3 pedazos de tela de manta corriente, madejas de hilo de varios colores, 3 agujas.

PREPARACION: Se divide el grupo en tres sub grupos de cantidades diferentes, unos más grandes que otros. Se pretende que cada grupo trabaje con los materiales que se le asignan.

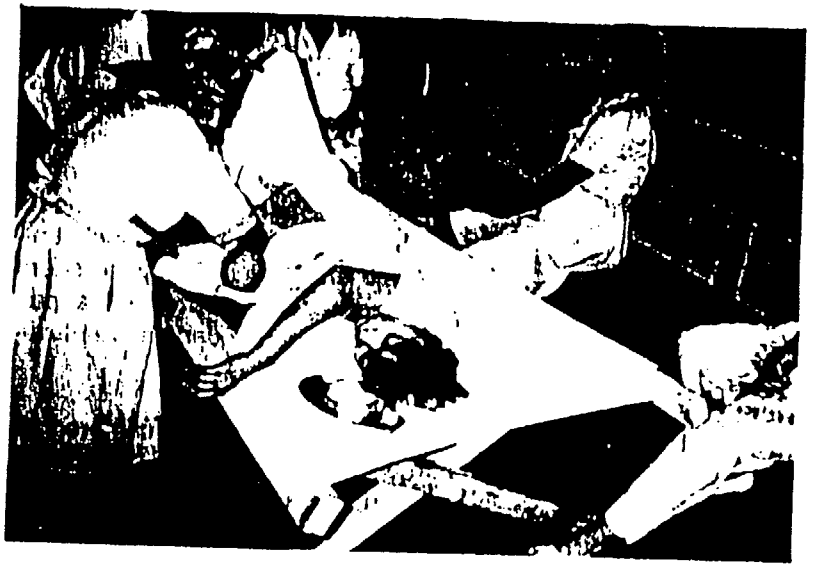
DESARROLLO: Al primer grupo se le pide que borde un dibujo que previamente se ha hecho en un trozo de manta (se le limita en lo que necesita a la manta unicamente).

Al segundo grupo se le pide que borde elmismo dibujo que el grupo anterior en otro trozo de manta (se les provee aguja y manta únicamente).

Al tercer grupo se le pide lo mismo y se le proporciona otro trozo de manta y todo lo necesario para bordarla (madejas de hilo de colores y aguja).

REFLEXION Y ANALISIS: Después que cada grupo realiza su trabajo se reflexiona y analiza lo ocurrido con todo el grupo se observa que las parteras se identifican con el primer grupo, además identifican la importancia de la atención por niveles.

NOMBRE: **SOCIODRAMA DE LOS GRADOS DE RIESGO EN LA ATENCION DEL PARTO.**



PARTICIPANTES: Grupos de hasta 25 personas no es relevante el nivel de preparación.

MATERIALES: Petate o catre, sábana, muñeco, líquido rojo (refresco de fresa o uva), agua, bolsas plásticas, lazos delgados que simulen venoclisis o venoclisis reales, esparadrapo.

PREPARACION: Se instruye a los participantes que actuarán en el sociodrama, se preparan las bolsas plásticas como si fuera una pinta de sangre y un bote de suero.

DESARROLLO: Se pide al grupo que dramaticen tres situaciones diferentes que se presentan al momento del parto.

1.- Embarazo y parto sin riesgo.
2.- Embarazo de alto riesgo con paridad de 5 hijos y mayor de 35 años, con parto complicado por retención de placenta que la lleva a la muerte.
3.- Embarazo de alto riesgo que NO es atendido por la partera, ésta la lleva al hospital donde el médico le atiende su parto. Se le retiene la placenta y se le extrae manualmente bajo anestasia, se le pone suero y sangre por hemorragia. La paciente no muere, queda hospitalizada.

REFLEXION Y ANALISIS: El grupo debe ser capaz de comprender el enfoque de riesgo y la importancia de la atención en salud por niveles.

ACTIVIDAD No. 4:

IDENTIFICACION DE LOS FACTORES DE RIESGO REPRODUCTIVO

A. OBJETIVOS

Que los participantes puedan identificar los factores de Riesgo Reproductivo presente en las mujeres en edad fértil.

B. METODOLOGIA

Que el grupo reflexione sobre el hecho de que en la mayoria de las mujeres que han muerto o que han tenido muertes perinatales o complicaciones del embarazo, parto o puerperio en su comunidad, existen algunas CARACTERISTICAS COMUNES (los factores de riesgo reproductivo).

La discusión se hará en base a las experiencias conocidas por las participantes sin que necesariamente se refieran a casos atendidos por ellas mismas. El facilitador(a) debe asegurar que en la búsqueda de las CARACTERISTICAS COMUNES se identifiquen y discutan los factores de riesgo biológico y social tales como edad, paridad, condiciones socioeconómicas, culturales, marginación y otras.

C. TECNICAS PARTICIPATIVAS

Se pueden utilizar las siguientes técnicas participativas de reflexión y análisis: El naufragio, las señales de peligro (El soldadito versión embarazadas, la muerte acecha, rompe cabezas.

C.1

NOMBRE: **ROMPE CABEZAS**

PARTICIPANTES: Se puede aplicar a grupos con instrucción mínima, con experiencias conocidas por ellas por práctica o referencias de otras compañeras y propias. Los grupos se limitarán por el número de piezas del rompecabezas, como máximo 6 participantes.

MATERIALES: Un rompecabezas de cartón con la figura de una mujer embarazada, con algún factor de riesgo.

REPARACION: El dibujo de una mujer con factores de riesgo se pega sobre una cartulina, se colorea para hacer mas apreciable el dibujo, se corta en varias piezas, 6 por cada rompecabezas

DESARROLLO: Las piezas del rompecabezas se distribuyen entre los participantes y se les indica que van a armar un rompecabezas, deben comenzar a armarlo, se les da un tiempo determinado para realizar la tarea.

Cuando terminen de armar un rompecabezas se les pide que interpreten el significado del dibujo que están observando.

REFLEXION Y ANALISIS: Ayuda a que las parteras se unan entre sí y sientan lo importante de cooperar entre ellas.

También hace que ellas identifiquen los factores de riesgo, al principio las parteras se sienten desorientadas al no identificar las piezas como un dibujo completo, existen pequeños roces al momento en que alguien intenta colocar una pieza en un sitio que parece no encajar, pero se olvidan de todas las diferencias cuando completan el rompecabezas y empiezan a identificar si el didujo representa un peligro o no. La solución que ellas pueden presentar es referir a un nivel de atención superior.

Lo que se quiere es que las parteras refuercen los peligros en mujeres embarazadas y la importancia de organizarse como grupo individual de parteras (junta directiva o asociación).

C.2

NOMBRE: LA MUERTE ACECHA

PARTICIPANTES: Se puede aplicar a un grupo con instrucción mínima, utilizando las experiencias adquiridas durante su aprendizaje del taller inicial o por experiencias ocurridas durante el desempeño de sus labores diarias (partos). El grupo no esta limitado por numero y se ubican en circulo.

MATERIALES: NINGUNO

PREPARACION: NINGUNA

DESARROLLO: Los participantes forman un circulo cerrado, representando una barrera entre la muerte y la embarazada de riesgo, luego se escogen dos de las participantes para que una represente una embarazada de riesgo (los riesgos deben ser seleccionados por las parteras, de acuerdo a sus experiencias) y la otra represente a la muerte.

La embarazada de riesgo permanecerá en el centro del circulo y la muerte fuera del circulo.

Las parteras protegerán a la embarazada para evitarle el paso a la muerte. Ellas se encuentran tomadas de la mano y al momento que la muerte intente entrar, ellas hacen un muro con sus cuerpos, acercándose mutuamente.

REFLEXION Y ANALISIS:

Reflexionar sobre la actividad de la partera en la identificacion de los factores de riesgo reproductivo que ya deben ser por ella conocidos.

Ellas pueden ser un elemento para evitar la muerte de las mujeres con factores de riesgo ya que conociendo los peligros los deben evitar.

Todos participan activamente obstruyendo el paso de la compañera que representa la muerte porque saben que si muere la mujer es responsabilidad de ellas y hay que evitarlo como les sea posible a ellas.

C.3

NOMBRE: LAS SEÑALES DE PELIGRO (EL SOLDADITO VERSION EMBARAZADAS)

PARTICIPANTES: Se puede aplicar a grupos con un mínimo de aprendizaje utilizando las experiencias vividas por el grupo. El número de participantes no debe exceder al de los peligros identificados por las parteras.

MATERIALES: NINGUNO

PREPARACION: NINGUNA

DESARROLLO: Cada participante del grupo se nombrará con una de las señales de peligro de todas las aprendidas durante las sesiones de trabajo.

La facilitadora recitara lo siguiente.

Al ir caminando por las calles de _____ (nombre de la localidad en la que se esta desarrollando el taller) me encontre con una mujer embarazada que tenia _____ (una de las señales de peligro que las participantes seleccionaron al inicio de la dinamica).

La persona que haya escogido la señal de peligro mencionada deberá contestar:

_____(la señal mencionada) no tenia, lo que tenia era _____ (nombrara otra señal de peligro).

Asi responde la aludida, sucesivamente alternando todas las señales de peligro con el resto del grupo.

Ejemplo:

facilitadora: Al ir caminando por las calles "Chinacla" me encontré con una mujer embarazada que tenia mas de cuatro hijos.

la aludida: mas de cuatro hijos no tenia, lo que tenia era más de treinta y cinco años.

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la nueva aludida: mas de treinta y cinco años no tenía, lo que tenia era hijos muy seguidos.

asi suscesivamente.

REFLEXION Y ANALISIS: Lo que se quiere con esta dinámica es reforzar los conocimientos adquiridos por el grupo e identificados por ellas mismas, que los repitan con un juego en los cuales recordarán el de la misma persona y el de los demás.

Las parteras deben identificar estas señales como peligros que han de ser encontrados en cualquier mujer que ellas encuentren, no necesariamente las controladas por la partera o la UPS, el estado de ánimo es de espectación para los que llaman por la señal que representan y alegría al reconocer otra y utilizarla para cambiar de persona.

C.4

NOMBRE: EL NAUFRAGIO

PARTICIPANTES: Se puede aplicar a grupos con instrucción minima, utilizando las experiencias adquiridas por ellos durante su tiempo de trabajo en la comunidad, que sepan expresar sus conocimientos aplicándolos a la dinámica. Se pueden ubicar en circulo sin importar el número de participantes.

MATERIALES: Cajas de papel de tres distintos tamanos, piedras de varios tamanos, una palangana grande, llena con agua.

PREPARACION: Entre las cajas que son de varios tamanos, se escoge la mas grande y se le hace una pequena abertura en la parte de abajo y se coloca en el centro del circulo de participantes de modo que todos aprecien el desarrollo de la dinamica

DESARROLLO: Las cajas se ubican enfrente de los participantes y se colocan en la paila.

En cada caja (que son de distintos tamaños) se colocan diferentes cantidades de piedras, sin exceder a la caja de tamaño mediano de mas de 4 piedras. En la de mayor tamaño se colocan las piedras necesarias hasta que la caja se hunda dentro de la paila, en la pequeña se coloca una piedra, hay que observar todas las cajas por varios minutos.

RELFEXION Y ANALISIS: Las parteras al analizar que puede representar cada caja de distintos tamaños: dan a entender que son las mujeres con edad en peligro, la caja pequeña son las mujeres de 18 a 35 anos que pueden no tener peligro y la caja grande es la mujer con mas de 35 años.

A cada capa se le coloca el número de piedras que puede ser el número de hijos de cada mujer, a la grande se le coloca el mayor número de piedras posible antes de hundirse, a la mediana solo las 4 con lo cual no se hunde y a la pequeña solo una.

ACTIVIDAD Nº 5

ATENCION PRENATAL Y EMBARAZO DE ALTO RIESGO

A OBJETIVOS

Los participantes deberán ser capaces de:

1.- Realizar un Control Prenatal oportuno y adecuado que permita, mediante la realización de un mínimo de actividades necesarias, evaluar la evolución del embarazo a fin de clasificar según grado de riesgo y decidir el nivel de atención.
2.- Detectar embarazadas de alto riesgo y referirlas al nivel de atención que corresponda.
3.- Establecer diferencias de la atención prenatal por niveles.
4.- Comprender la importancia de la referencia.

B. METODOLOGIA

La actividad se puede realizar mediante sociodramas en los cuales los participantes actúan espontáneamente lo que permite detectar las prácticas utilizadas por las parteras en la atención prenatal.

Es necesario que durante esta actividad se atiendan mujeres embarazadas individualmente y en grupo, en la sede del taller o en la casa de las embarazadas. Se observará como la partera que atiende a su embarazada realiza el interrogatorio y el examen físico, al final de la atención se discutirá la actividad y se establecerá cuales deben ser las preguntas indispensables en el interrogatorio y las actividades mínimas del examen físico que son: edad, paridad, antecedentes obstétricos, patológicos, presencia de movimientos fetales para el interrogatorio y revisión de conjuntivas, mamas, cambio de tamaño del útero y situación y presentación fetal, abdomen y extremidades inferiores para el examen físico.

Es conveniente que el grupo observe, la atención prenatal institucional que en la UPS se realiza, a fin de identificar cuales actividades pueden ser realizadas por la partera y cuales no. De esta manera se establecerán las diferencias de la atención por niveles y se promoverá el entendimiento de la importancia de la referencia.

Se debe garantizar que la Partera Tradicional Capacitada sea capaz de:

- Detectar al 100% las embarazadas de la comunidad.
- Identificar los factores de riesgo en la embarazada.
- Revisar signos de anemia (conjuntivas, mucosa oral, echos ungueales o reflujo capilar).
- Detectar presencia de edema.
- Diagnosticar situación y presentación del producto (más recomendado en el último trimestre).
- Evaluar el estado nutricional de la embarazada y hacer las recomendaciones necesarias.
- Preparar a la embarazada para una lactancia materna exitosa.
- Conocer la importancia de la aplicación Toxoide Tetánico. Analizar la posibilidad de aplicación por la partera o por la UPS.
- Decidir sobre el lugar donde se debe atender el parto.
- Evaluar actitud de la embarazada y la familia y sus posibilidades económicas, geográficas y culturales para traslado en caso de referencia.
- Discutir sobre las técnicas del sobado, utilidad, práctica, perjuicio o inocuidad.
- Practicar técnicas de evaluación del tamaño del utero (cinta obstétrica).
- Otras que espontaneamente surjan del grupo.

ACTIVIDAD 6

ATENCION DE PARTO LIMPIO Y ALUMBRAMIENTO SEGURO

A. OBJETIVOS

1.- Reflexionar sobre la importancia de la atención del parto limpio y alumbramiento seguro.
2.- Garantizar la atención del parto limpio y del alumbramiento seguro.

B. METODOLOGIA

Se procurará una atención conjunta de partos que ocurran durante la semana del taller inicial, si esto no es posible debe realizarse en las visitas de seguimiento.

Independientemente de lo anterior durante el desarrollo del taller se dramatizara la atención de partos simulando diferentes situaciones de embarazadas. Se dejará a la partera que simule la tecnica que ella utiliza para la atención del parto en su comunidad se hace reflexión y analisis después de cada situación presentada en la dramatización.

Si hay un hospital o clínica Materno Infantil cercanos a la sede del taller, se visitarán las áreas de maternidad y quirófanos para establecer las diferencias de niveles de atención y fortalecer la importancia de la referencia.

El grupo debe reflexionar sobre la importancia de la atención del parto limpio y el alumbramiento seguro, así como también la utilización de maniobras perjudiciales como las que aumentan la presión intra-abdominal (Kristeler), colgado de vigas, amarrados, etc.

Actividades mínimas para garantizar la atención del parto Limpio:

- Diagnóstico de riesgo
- Situación del feto
- Movimientos fetales, presencia de meconio
- Ruptura prematura de membranas
- Duración del trabajo de parto
- Estado general
- Ingesta del alcohol
- Occitocicos inyectables (efecto sobre el feto, produce muerte y ruptura uterina)
- Posición vertical de la madre: parada, sentada, incada o en cuclillas (favorece para la salida del niño)
- Apego precoz.
- Disposición de ropa limpia para la atención del parto, para la madre y el recién nacido.
- Aseo personal de la partera, baño diario, uñas cortas y limpias
- Lavado de las manos (y de cualquier otro miembro utilizado por la partera para protección del periné) con agua y jabón.
- Que la parturienta se bañe y se lave el periné con agua y jabón.
- Que el ambiente donde se atienda el parto esté limpio.

PAQUETE ESTERIL

Para garantizar el parto limpio es conveniente reflexionar sobre la importancia, elaboración y uso del paquete esteril, el cual deberá llevar los siguientes materiales que deben ubicarse de acuerdo al orden en que se utilizará:

1.- 1 gasa para eliminación de flemas
2.- Cinta umbilical (3 pedazos o cañamo o hilo)
3.- 1/2 Hoja de afeitar nueva para cortar el cordón umbilical
4.- 2 gasas para la protección del muñón umbilical (1 entera y 1 cortada).
5.- 4 torundas de algodón para limpieza ojos recién nacido
6.- 2 gasas para la revisión de la placenta
7.- Papel para hacer el paquete
8.- Bolsa plástica para guardar el paquete

Este paquete se hace y se esteriliza en la UPS durante el taller inicial y se coloca en una bolsa plástica para evitar que se moje y así garantizar su calidad.

Se elaborara y esterilizará con la partera un stock de paquetes equivalentes a la cantidad máxima de partos que atiende en un mes, se restituyen el número que haya gastado en el mes anterior.

Hay que recalcar que todo el contenido del paquete esteril es desechable, se debe colocar de nuevo todo el material en la bolsa plástica y tirar a la basura. En caso que se use tijera para el corte del cordón siempre debe ser **"HERVIDA"**, no se debe utilizar sucia, ni limpiada con antisépticos ni flameada.

RECORDAR QUE LO MAS IMPORTANTE ES QUE EL MATERIAL Y EQUIPO PARA LA ATENCION DE PARTO DEBE ESTAR ESTERIL O POR LO MENOS LIMPIO.

Alumbramiento seguro:

Se debe recordar en todo momento que el mecanismo de desprendimiento de la placenta **SIEMPRE** depende de **CONTRACCIONES UTERINAS** y en el parto normal es **ESPONTANEO**, por lo tanto **NO SE DEBE** halar el cordón ni utilizar maniobras perjudiciales.

Actividades minimas:

- No empujar el utero
- Reconocimiento de los signos de desprendimiento placentario

  . Alargamiento del cordón
  . Sangrado
  . Cambios en la forma y consistencia del útero

- Apego precoz durante el periodo de alumbramiento
- Maniobras beneficiosas durante la expulsión

  . Soplar la botella
  . Toser
  . Masaje suave en el fondo del útero

- Duracion del periodo del alumbramiento (no mayor de 30 minutos).

C. TECNICAS PARTICIPATIVAS

C.1

NOMBRE: **SOCIODRAMA DE ATENCION DE PARTOS**

cuales debe haber personas que hayan atendido partos y madres.

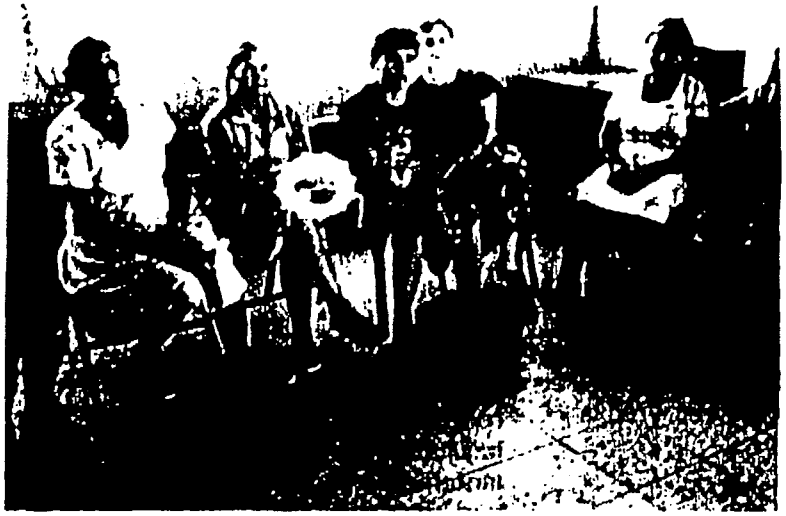
MATERIALES: Un muñeco, una placenta o cordón, un catre o cama, algo que simule un fogón y maletín de parteras.

PREPARACION: Una participante que hará de paciente se coloca el muñeco y la placenta bajo la ropa.

DESARROLLO: Una partera simula la atención de parto, se explica a las parteras que debe atender el parto tal como lo haría realmente, se observan las actividades mínimas, colocación del equipo, lavado de manos, protección del periné, corte del cordón, atención del recién nacido, etc. Se repite con varias parteras y parturientas.

REFLEXION Y ANALISIS: Se pretende que el grupo revise y practique las actividades mínimas para atención de parto limpio y alumbramiento seguro.

NOMBRE: **DINAMICA DEL SOMBRERO**



PARTICIPANTES: Grupo de hasta 15 participantes; no es relevante el nivel de preparación.

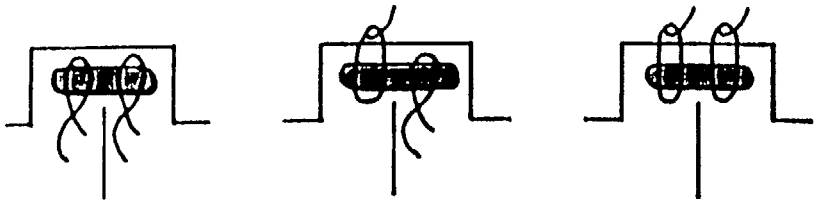
MATERIALES: 3 Sombreros de junco, tela roja, hilo, cañamo, algodón, gaza.

PREPARACION: Se utiliza la copa de 3 sombreros de junco, plástico o cualquier material firme y flexible para representar el cuerpo del útero.

Se preparan 3 placentas con una capa de algodón, por un lado descubierta y por el otro forrada con tela roja.

Una de las placentas, el algodón está completamente adherida a la tela, otra placenta se adhiere parte del algo-

dón a la tela y un fragmento a la capa del sombrero y la tercera placenta, la tela y el algodón se adhieren a la capa del sombrero según el siguiente dibujo:



DESARROLLO:

1.- Primero se simula el mecanismo normal de desprendimiento. La placenta (1) se coloca en el fondo del sombrero, el facilitador presiona desde afuera constantemente la capa del sombrero hasta que esta placenta se desprende sin halarla.

2.- Una partera tira del cordón de la placenta (2), el pedazo de algodón que está costurado a la copa del cordón se quedará en el fondo del sombrero y el resto saldrá. Esto simulará la retención parcial de la placenta.

3.- Otra partera tira del cordón de la placenta (3), mientras otra participante sostiene los extremos de la capa del sombrero, como la placenta está adherida al fondo de la capa, está se invertirá demostrando el mecanismo de la inversión uterina.

REFLEXION Y ANALISIS: Con estas tres actividades las participantes comprenderán que el mecanismo de desprendimiento de la placenta son las contracciones uterinas y que cuando se hala el cordón puede haber retenciones placentarias de diverso grado o inversión uterina.

C.3

NOMBRE: **LA BOMBA**

PARTICIPANTES: Se puede aplicar a grupos pequeños y grandes, que hayan tenido experiencias vividas en la atención de partos a mujeres mayores de 35 años y que tengan más de 5 hijos.

MATERIALES: Un condón

Un muñequito

PREPARACION: Dentro del condón se introduce el muñequito simulando que el condón es el útero y que el muñequito es el producto.

DESARROLLO: Se explica a los participantes que se inflará el condón con el producto adentro por varias veces tomando en cuenta la primera gestación y con un número determinado de embarazos de 8 a 9 en total.

REFLEXION Y ANALISIS: Con esta dinámica pretendemos que la partera analice la contextura y la flacidez que ocurre en el útero con cada embarazo, además el grupo evidencia que la

dinámica se asocia con algunas experiencias como por ejemplo: la hemorragia, retención de placenta, niños de bajo peso y prolapso uterino a causa del mucho estira y encoge del útero de la madre.

ACTIVIDAD 7

ATENCION INMEDIATA DEL RECIEN NACIDO

A. OBJETIVOS

- Garantizar que las participantes pueden brindar una adecuada atención inmediata al recién nacido.

B. METODOLOGIA

Siempre que sea posible se atenderá a recién nacidos, si no se hace en el taller inicial se debe hacer en las visitas de seguimiento, se debe garantizar la realización de las actividades siguientes:

- El recién nacido **NUNCA** se debe sostener de los pies y colgarlo con la cabeza hacia abajo (esto puede producir hemorragias intracraneales), debe sostenerse siempre en posición horizontal.

- El recién nacido no puede controlar su temperatura, el frío y la humedad lo hacen consumir excesos de energía que lo pueden conducir hasta la muerte; por lo tanto **EL RECIEN NACIDO NUNCA SE BAÑA**. En cuanto nace debe secarse y abrigarse con ropa limpia y seca.

- Aunque en el parto **NORMAL** no es necesario **ASPIRAR LAS FLEMAS**, se recomienda eliminar el exceso de ellas con gasas del paquete esteril.

- El cordón umbilical se corta cuando éste deja de pulsar.

- De ser posible se pueden utilizar sustancias antisépticas para hacer la profilaxis oftálmica, evitando el uso de productos cuya fecha de vencimiento ha caducado.

- Hay que medir el perímetro cefálico y braquial con la **CINTA NEONATAL** a fin de determinar si el recién nacido es de bajo peso o no. Si lo es debe referirse al hospital más cercano inmediatamente, garantizando que vaya bien abrigado.

- El recién nacido necesita alimentarse únicamente con pecho materno, practicar APEGO PRECOZ y comentar sobre la necesidad de no usar chupones.

C. TECNICAS PARTICIPATIVAS

C.1

SOCIODRAMA: El tema se incluye en el Sociodrama de Atencion del Parto.

ACTIVIDAD No. 8

ATENCION PUERPERAL

A. OBJETIVOS

Los participantes serán capaces de:

1.- Identificar factores de riesgo durante el puerperio
2.- Referir las puérperas con problemas al nivel de atención en salud que corresponda.

B. METODOLOGIA

La atención puerperal se debe realizar con puerperas de la comunidad siempre que esto sea posible, se realizarán visitas domiciliarias si no hay puerperas en la comunidad se discutirá en

grupo las actividades a realizar para la identificación de los signos normales y anormales.

El grupo reflexionará sobre el hecho de que la mayor parte de las muertes maternas y neonatales ocurre en los primeros siete días después del parto y principalmente en las primeras 24 horas, por lo que es importante identificar la presencia de factores de riesgo durante el puerperio.

Se hará enfasis en los signos y síntomas para detectar las principales complicaciones:

- Hemorragia: Hipotonía uterina, retención total o parcial de placenta (Palidez, sudoración, desmayo, hipotermia).
- Infección (fiebres, fetidez de loquios).

Actividades mínimas a realizar:

- Interrogar sobre funciones orgánicas generales, fiebre, características de los loquios, cefalea, otros.
- Examinar mucosas, conjuntivas abdomen, globo de seguridad de Pinard (útero contraído), características de loquios.
- Dar recomendaciones sobre lactancia materna exclusiva hasta los seis meses de vida.
- El grupo analizará la importancia de referir las puérperas con problemas en forma oportuna al nivel de atención en salud que corresponda.

C. TÉCNICAS PARTICIPATIVAS

DISCUSIONES GRUPALES

ACTIVIDAD 9

ATENCION EN PLANIFICACION FAMILIAR

A. OBJETIVOS

Los participantes serán capaces de:

1.- Reflexionar sobre las actividades necesarias y factibles para la prevención de embarazos en mujeres con factores de Riesgo Reproductivo No embarazadas.
2.- Referir a la Unidad Productora de Salud las mujeres en edad fértil que libre y expontáneamente hayan decidido utilizar un método de Planificación Familiar.

B. METODOLOGIA

- Discusión de grupo, retomar nuevamente lo que se discutió sobre Riesgo Reproductivo en las actividades 2 y 3 y que el grupo reflexione sobre las actividades necesarias y factibles para la prevención de embarazos en mujeres con factores de Riesgo Reproductivo **NO** embarazadas (Enfoque de Riesgo Reproductivo no obstétrico), ya que éstos pueden conducir a la muerte materna y perinatal.

- Discusión sobre metodología anticonceptiva y capacitación en uso de métodos naturales y distribución de métodos de barrera.

- El grupo reflexionará sobre la posibilidad que tienen las familias de su comunidad de espaciar los embarazos así, como la existencia de creencias, mitos, tradiciones que evitan el uso de métodos anticonceptivos artificiales.

Se analizara ademas la posibilidad de orientar a las parejas sobre todo aquellas en que la mujer tenga factores de riesgo reproductivo.

C. TECNICAS PARTICIPATIVAS

DISCUSIONES GRUPALES

ACTIVIDAD No. 10

SISTEMA DE INFORMACION

A. OBJETIVOS

1.- Registro y analisis sistemático de la información de las atenciones brindadas por las parteras en la Unidad Productora de Servicios.

B. METODOLOGIA

1.- Se realizarán discusiones de grupo para conocer y analizar los formularios COM-P4 y COM-P5, asi como los formularios para la referencia.

2.- El grupo analizará la información brindada por la partera y la comparará con la existente en la UPS para: confirmar coberturas y analizar las referencias de las embarazadas con factores de riesgo.

C. TECNICAS PARTICIPATIVAS

Analisis de Formularios

VI.2.- CONTENIDOS DEL SEGUIMIENTO

ACTIVIDAD 1

VISITA DE INDUCCION A LA UPS.

A. OBJETIVOS

1 - Dar a conocer el objetivo de la actividad de seguimiento (este objetivo se cumplirá en caso de que el seguimiento sea apoyado o realizado por otra persona).
2 - Planificar la realización del seguimiento en forma conjunta con el personal de la UPS.

B. METODOLOGIA

1 - Reunion previa a la actividad en el establecimiento de salud con el personal institucional donde se analizará la factibilidad de realizar el seguimiento y se planificará.

2 - Planificar el seguimiento de acuerdo a prioridades: (parteras que durante el taller inicial interiorizaron menos los conocimientos, parteras que atienden más partos, parteras de las comunidades donde presentan problemas de morbi-mortalidad materna perinatal.

ACTIVIDAD 2

VISITA A LA PARTERA EN LA COMUNIDAD

A. OBJETIVOS

1.- Investigar el total de mujeres embarazadas que existen en la comunidad.
2.- Investigar el número de mujeres embarazadas que están en control prenatal con la partera.
3.- Revisar si la partera identifica factores de riesgo en las embarazadas que tiene en control (aplicación del enfoque de riesgo reproductivo).

B. METODOLOGIA

El facilitador y/o supervisor visitarán a cada partera de la localidad en su casa para observar las actividades siguientes:

- Referencias de embarazadas con factores de riesgo
- Número de embarazadas que están vacunadas con toxoide tetánico.
- Los partos atendidos en el período y los problemas presentados durante los mismos.
- Número de muertes maternas y perinatales ocurridas en el período.
- Revisar lugar de atención de parto en caso de que exista.

ACTIVIDAD 3

VISITA A LAS EMBARAZADAS CON LA PARTERA

A. OBJETIVOS

Observar las atenciones que brinda la partera a sus embarazadas y otras actividades relacionadas con la misma.

B. METODOLOGIA

Se hará a través de la visita a la embarazada para:

- Realizar control prenatal.
- Identificación de factores de riesgo.
- Conversar con la embarazada y su familia sobre sus hallazgos.
- Decisión sobre el nivel que se ha recomendado para la atención del parto.
- Si hay posibilidad de realizar atención del parto con la partera debe hacerse.
- Observar la realización de otras actividades como atención en planificación familiar, puerperio y recién nacido.

ACTIVIDAD 4

REVISION DEL MATERIAL DE LA PARTERA

A. OBJETIVOS

Verificar las existencias y condiciones del material y equipo con que cuenta la partera para atención del parto.

B. METODOLOGIA

Se hará a través de:

- Revisión del maletín o del material y equipo
- Verificar la existencia y limpieza de insumos
- Enfatizar en el uso y manejo del paquete esteril
- Elaboración y esterilización del paquete cuando sea necesario

- Reorientar sobre el contenido del maletín (no guardar otro material que no sea para atención de parto)
- Reforzar técnicas domiciliarias para esterilización de material y equipo (hervido de la tijera, baño maría del paquete estéril, otros).

ACTIVIDAD 5

VISITA DE ANALISIS A LA U.P.S.

A. OBJETIVOS

Analizar coberturas, referencias y aplicación del enfoque de riesgo reproductivo.

B. METODOLOGIA

Esta actividad se realizará mediante la ejecución de las siguientes actividades:

1.- Revisión de referencias enviadas por la PTC.
2.- Revisión de LISEM de la UPS para observar si las mujeres atendidas y referidas por la partera están incluidas en el mismo.
3.- Revisar agendas de reuniones mensuales para verificar si se han incluido contenidos relacionados con la problemática materno infantil.
4.- Reflexionar sobre la situación identificada y búsqueda de alternativas de solución a la problemática materno-perinatal.

ACTIVIDAD 6

REUNIONES DE SEGUIMIENTO

A. OBJETIVOS

Dar seguimiento a la aplicación del proceso de enfoque de riesgo reproductivo.

B. METODOLOGIA

Se harán 3 tipos de reuniones:

a.- **Reuniones Mensuales de Personal Comunitario:**

Son las ya establecidas actualmente.- Se debe reorientar la metodología, además de recibir información se debe discutir sobre la aplicación del Enfoque de Riesgo Reproductivo, dificultades que las parteras tengan en su trabajo y situaciones especiales. Además se debe elaborar y esterilizar los "paquetes estériles".

b.- **Reunión con las Parteras:**

Son reuniones específicas con Parteras Tradicionales Capacidadas, solicitadas por ellas mismas; en las que se reflexionará sobre la aplicación del enfoque de riesgo reproductivo, refrescamiento de conceptos, cambios de actitud y prácticas de la partera.

c.- **Reunión con la comunidad:**

Se organizará durante la visita de seguimiento una reunión comunitaria en la que se reflexionará sobre:

- La problemática materno perinatal

- Papel de la partera y la comunidad frente a esa problemática.
- Búsqueda de alternativas de solución a la problemática materno perinatal.
- Casas comunitarias para atención de partos.
- Hogares maternos.
- Fondos comunales para traslado de pacientes.

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A N E X O No. 1

TECNICAS PARTICIPATIVAS

DE MOTIVACION

NOMBRE: EL FUTBOL
PARTICIPANTES: GRUPOS CON MINIMA INSTRUCCION
MATERIALES: DOS OBJETOS PEQUEÑOS
PREPARACION: NINGUNA
DESARROLLO:

Se pide al conjunto de participantes que formen un círculo y se numeran del 1 al 2.

Los número 1 representan un equipo y los número 2 al otro; se nombra un capitán por cada equipo. Los capitanes quedan uno al lado del otro y se les da a cada uno un objeto que puede diferenciarse, de distinta forma o por su color.

Al dar una señal el grupo uno pasa el objeto de mano en mano hacia la izquierda y los compañeros del grupo dos hacia la derecha hasta llegar nuevamente donde el capitán y cuando esto sucede, se anota un punto al equipo, ganando el grupo que acumule más puntos.

REFLEXION Y ANALISIS:

Al aplicar la dinámica las parteras se entusiasmas y rien cuando alguna compañera se confunde al momento de entregar el objeto.

Ayuda cuando las parteras tengan cansancio o estén aburridas.

También ayuda a que las parteras sepan coordinar y organizarse en grupos.

NOMBRE: BESO AL MUÑECO
PARTICIPANTES: ADAPTABLE A GRUPOS DE DIFERENTES TAMAÑOS Y NO TIENE RELEVANCIA EL NIVEL DE INSTRUCCION.
MATERIALES: UN MUÑECO PEQUEÑO.
PREPARACION: NINGUNA.
DESARROLLO:

El grupo se coloca en círculo y el muñeco pasará de mano en mano, cada participante debe en su oportunidad hacer lo que desee al muñeco: besarlo, abrazarlo, pellizcarlo, pegarle, etc.

Cuando el muñeco ha sido pasado por todos los miembros del grupo, se vuelve a empezar, pero esta vez las "caricias"

que el muñeco recibió deben ser repetidas pero con el compañero de al lado.

De esta forma los integrantes del grupo se besan, se abrazan, se pellizcan, se pegan... etc.

REFLEXION Y ANALISIS:

Esta técnica provoca la hilaridad del grupo por lo que es ideal utilizarla para motivar y despejar al grupo.

NOMBRE: EL PAN DULCE Y LAS FRUTAS.
PARTICIPANTES: SE PUEDE APLICAR A GRUPOS PEQUEÑOS Y GRANDES TOMANDO EN CUENTA EL ESTADO DE ANIMO DE CADA UNO DE LOS MIEMBROS.
MATERIALES: NINGUNO
PREPARACION: NINGUNA
DESARROLLO:

Esta dinámica se puede utilizar en 2 ocaciones si se desea, cuando se va a utilizar nombre de frutas se le dice a los participantes que se cambien, su nombre verdadero por el de una fruta, sin que se repita con el de otra persona.

Si se va a utilizar nombres de pan dulce, pues se les dice lo mismo que se cambien el nombre verdadero por el de un pan dulce.

Una vez que los participantes tienen su nombre cambiado por el de una fruta o un pan, se les dice que formen un círculó y que uno por uno en orden deberán decir la siguiente frase:

"Todas las mañanas al levantarme, lo primero que hago es lavarme la ...? y la persona menciona la fruta que dijo o el nombre del pan dulce que escogió.

REFLEXION Y ANALISIS:

Esta dinámica provoca alegría y entretenimiento en el grupo pues les motiva y además los relaja de muchas tensiones.

NOMBRE: LOS ANIMALES QUE VUELAN.
PARTICIPANTES: EL NUMERO VARIA SEGUN EL GRUPO Y SE PUEDE APLICAR A PERSONAS CON UN NIVEL MINIMO DE INSTRUCCION.
MATERIALES: NINGUNO.
PREPARACION: NINGUNA.
DESARROLLO:

Se forma un círculo con los participantes y la persona que dirige la dinámica mencionará una serie de animales que vuelan y los participantes iran simulando el vuelo de las aves, pero de vez en cuando se mencionará un animal que no vuela. Ejemplo: El pato vuela, el burro vuela, el zorzal vuela, más de algún participante se equivocará y simulará volar.

REFLEXION Y ANALISIS:

Con ésta dinámica se logra la motivación además de observar el grado de atención en el grupo.

NOMBRE: LA TEMPESTAD.
PARTICIPANTES: NO HAY LIMITE EN EL NUMERO DE PARTICIPANTES, CON UN GRADO DE INSTRUCCION MINIMO.
MATERIALES: NINGUNO
PREPARACION: NINGUNA
DESARROLLO:

Los participantes, sentados en círculo, el coordinador parado al centro y explica que las olas del mar se mueven a la derecha o a la izquierda pero cuando hay una tempestad estas se mueven sin orden.

Al decir el coordinador: "las olas se mueven a la izquierda", los participantes se deben mover y sentarse en un puesto de la izquierda de donde se encuentren, pero si dicen "las olas se mueven a la derecha" deben hacer lo contrario; cuando se pronuncia "hay tempestad" cambian de puesto, en desorden y se ubican en cualquier lugar que se encuentre vacío, el coordinador aprovecha y se sienta, dejando a otro participante para que de las órdenes.

REFLEXION Y ANALISIS:

Ayuda a que las parteras se concentren en posibles órdenes recibidas, ayuda en momentos de aburrimiento o después de algún tema y se desea que las parteras se relajen.

NOMBRE: HORNO CALIENTE.

PARTICIPANTES: DIRIGIDA A UN GRUPO DE PARTERAS DISTRIBUIDAS EN CIRCULO SIN IMPORTAR EL NUMERO.

MATERIALES: NINGUNO.

PREPARACION: NINGUNA.

DESARROLLO:

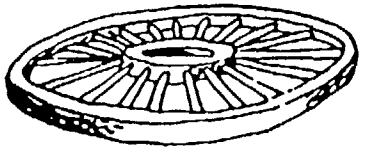
Se escoge un voluntario que se aleje del grupo. Se le explica que él deberá buscar un horno caliente tocando la cabeza de los integrantes del grupo.

Previamente a los demás miembros se les advierte que uno de ellos deberá ser el horno caliente y que cuando el voluntario toque la cabeza del elegido, todos deberán gritar y tocarle la espalda, tratando de asustarlo, es conveniente utilizarla al inicio de una sesión de trabajo, utilizando 1 o 3 voluntarios.

REFLEXION Y ANALISIS:

Con esta dinámica además de romper hielo, se pretende tratar que las parteras sepan tomar iniciativa, cuando la compañera toque a la voluntaria se levanten, griten y palpen a la compañera, todas al mismo tiempo y les sirva de análisis para que interpreten que todas unidas pueden encontrar solución a un problema o llamar la atención de otra compañera cuando esta no actúe de acuerdo al **comportamiento aprendido durante las sesiones de trabajo.**

la doble rueda



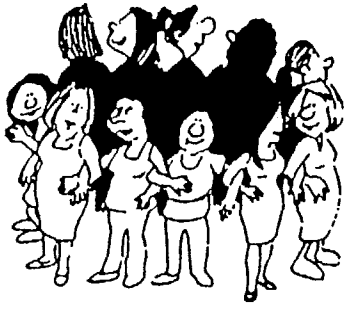
I. OBJETIVO:
ANIMACION

II. MATERIALES:
- Un lugar amplio.
- Número ilimitado de participantes.
- Un radio potente o algún material que haga ruido

III. DESARROLLO:

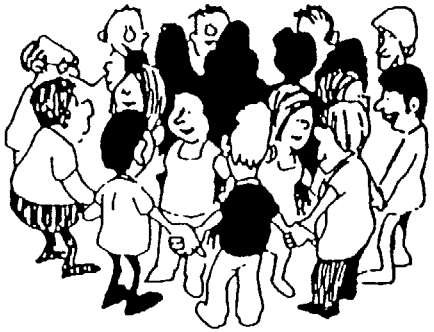
Se divide a los participantes en dos grupos iguales, (si un grupo puede ser de mujeres y otro de hombres, mejor).

Se coloca a un grupo formando un círculo tomados de los brazos, mirando hacia afuera del círculo.



Se coloca al otro grupo a su alrededor, formando un círculo, tomados de las manos, mirando hacia adentro.

Se les pide que cada miembro de la rueda exterior se coloque delante de uno de la rueda interior, que será su pareja y que se fijen bien, en quién es pareja de cada quien.



Una vez identificadas las parejas, se les pide que se vuelvan de espaldas y queden nuevamente tomados de las manos unos y de los brazos otros.

Se indica que se va a hacer sonar una música (o el ruido de algún instrumento) y que mientras suena deberán moverse los círculos hacia su izquierda. (Así cada rueda girará en sentido contrario a la otra), y que cuando pare la música (o el ruido) deberán buscar su pareja, tomarse de las manos y sentarse en el suelo; la última pareja en hacerlo pierde y sale de la rueda. (El coordinador puede interrumpir la música en cualquier momento).

Las parejas que salen van formando luego el jurado que determinará qué pareja pierde cada vez.

La dinámica continúa sucesivamente hasta que queda una pareja sola al centro, que es la ganadora.

IV. RECOMENDACIONES:

Esta oportunidad de girar a la derecha e izquierda simultáneamente marea a las señoras por su edad.

Se puede utilizar también como dinámica de presentación, añadiéndole los elementos de la presentación por pareja y subjetiva.

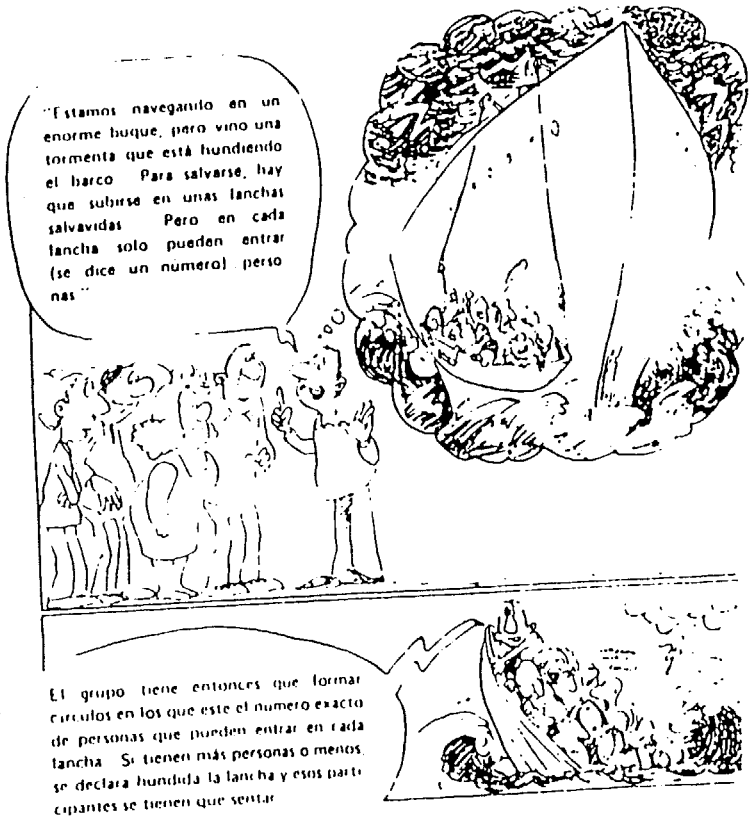
las lanchas

(El número de participantes es indefinido: se recomienda un mínimo de 15)

I. OBJETIVO: ANIMACION

II. DESARROLLO:

Todos los participantes se ponen de pie. El coordinador entonces, cuentala siguiente historia:



Inmediatamente, se cambia el número de personas que pueden entrar en cada lancha, se van eliminando a los "ahogados" y así se prosigue hasta que quede un pequeño grupo que serán los sobrevivientes del naufragio.

RECOMENDACIONES:

- Debe darse unos cinco segundos para que se formen las lanchas, antes de declarar los hundidos.
- Como en toda dinámica de animación, deben darse las órdenes rápidamente para hacerla ágil y sorpresiva.

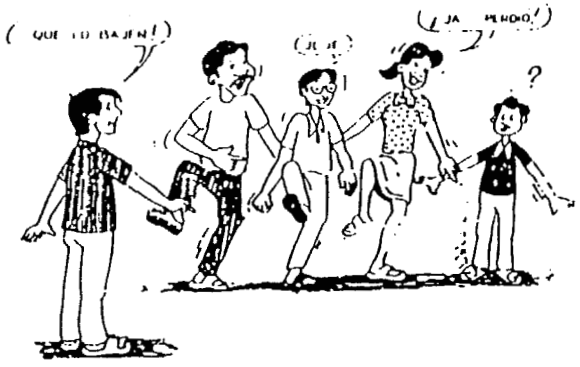
II. ¿COMO SE HACE LA TECNICA?

El coordinador explica que va a dar diferentes órdenes, que para ser cumplidas él tiene que haber dicho antes la siguiente consigna: "EL PUEBLO MANDA".

Por ejemplo: "El pueblo manda que se pongan de pie". Sólo cuando se diga la consigna, la orden que se dice debe realizarse. Se pierde si no se cumple la orden o cuando NO se diga la consigna exactamente.

Por ejemplo: "El pueblo dice que se sienten", los que obedecen pierden, ya que la consigna es: "el pueblo manda".

Las órdenes deben darse lo más rápidamente posible para que el juego sea ágil.



Los que se equivocan salen del juego.

El juego acaba cuando queda poca gente y se siguen sin problema las órdenes correctas y las falsas.

III. SE RECOMIENDA...

Para hacer perder a los participantes, es bueno repetir varias órdenes correctas rápido y luego decir una falsa:

* El pueblo manda que se rasquen la cabeza.

* El pueblo manda que saquen la lengua.
* El pueblo manda que se rasquen la panza con la otra mano.
* El pueblo manda que se rasquen más fuerte.
* ¡Qué griten!

Es conveniente poner a dirigir esta dinámica a personas que la conocen bien, para que no pierda agilidad.

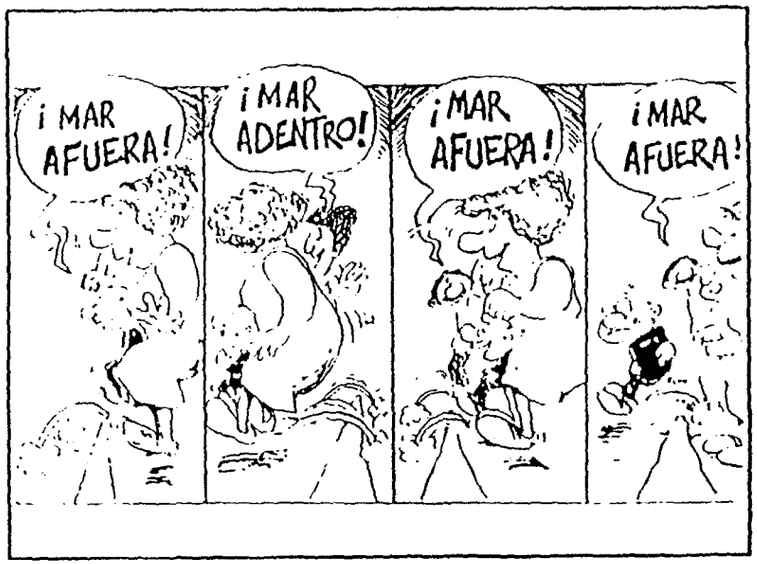
mar adentro - mar afuera

I. OBJETIVO: ANIMACION

II. DESARROLLO:

Todos los participantes se ponen de pie. Puede ser un círculo o en una fila, según el espacio que se tenga y el número de participantes. Se marca la línea que representa la orilla del mar, los participantes se ponen detrás de la línea.

Cuando el coordinador de la voz de mar adentro, todos dan un salto hacia adelante sobre la raya. A la voz de mar afuera todos dan un salto hacia atrás de la raya. Debe hacerse de forma rápida, los que se equivocan salen del juego.



el alambre pelado

I. OBJETIVO; ANIMACION

II. DESARROLLO:

Se le pide a un compañero que salga del salón. El resto de compañeros se forman en un círculo de pie y tomados del brazo y se les explica que el círculo es un circuito eléctrico, dentro del cual hay un alambre que está pelado, que se le pedirá al compañero que está afuera que lo descubra tocando las cabezas de los que están en el círculo. Se ponen todos de acuerdo que cuando toque la cabeza del sexto compañero (que es el que representa el alambre pelado), todos al mismo tiempo y con toda la fuerza pegarán un grito.

Se llama al compañero que esta fuera, se le explica sólo lo referente al circuito eléctrico y se le pide que se concentre pra que descubra el cable pelado.

Esta dinámica es muy simple pero muy impactante; debe hacerse un clima de concentración de parte de todos.

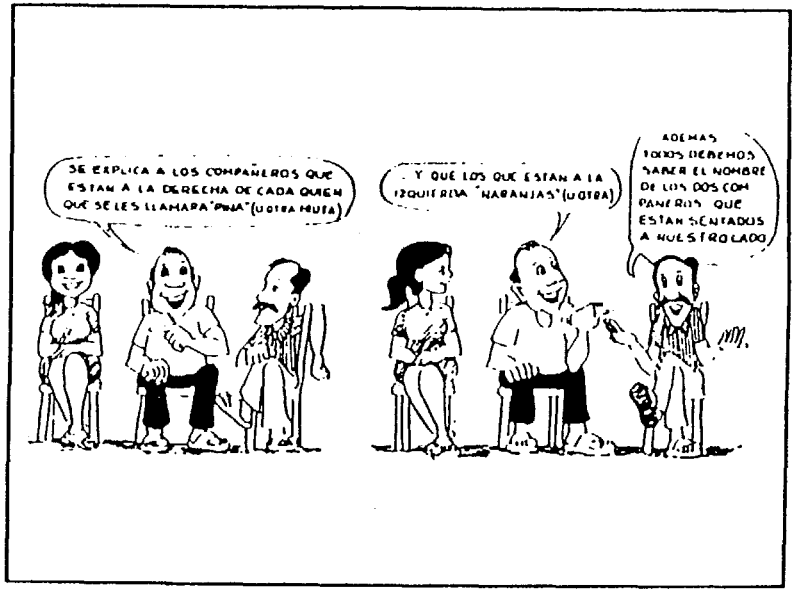
CANASTA REVUELTA

I. ¿PARA QUE SE HACE ESTA TECNICA?

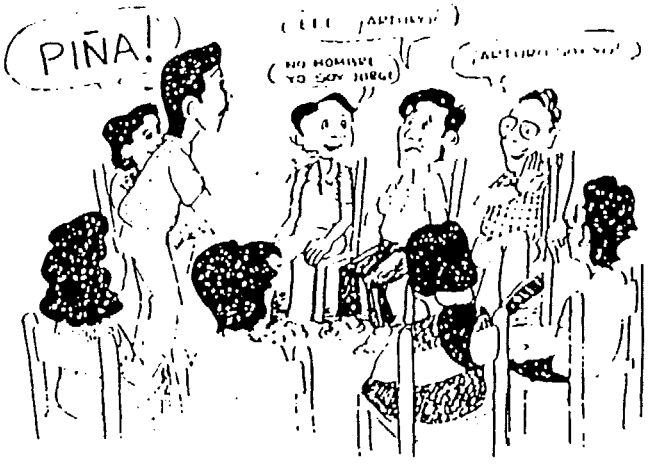
Para conocerse entre todos y animar al grupo.

II. ¿COMO SE HACE?

Todos los participantes se sientan en un círculo. El coordinador queda en el centro, de pie. Si hay mucha gente, se puede formar más de un coordinador de pie en cada uno.



En el momento en que el coordinador señale a cualquiera diciéndole ¡Piña!, éste debe responder el nombre del compañero que esté a su derecha. Si le dice ¡Naranja!, debe decir el nombre del que tiene a su izquierda. Si se equivoca o tarda más de 3 segundos en responder pasa al centro y el coordinador ocupa su puesto.



LA PANTOMIMA

I. ¿QUE ES LA PANTOMIMA?

II. ¿PARA QUE SE HACE LA PANTOMIMA

La pantomima permite representar situaciones y analizar las reacciones que frente a ellas se tiene.

La pantomima se caracteriza por representar las reacciones de las personas frente a diferentes situaciones o hechos de nuestra vida real.

III. SE RECOMIENDA:

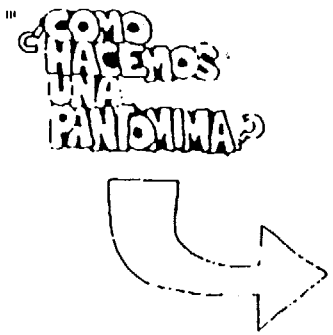
Esta dinámica debe hacerse rápidamente, para que mantenga el interés, porque cada vez que se diga **"canasta revuelta"**, las personas al lado de uno cambian.

Esta dinámica se utiliza para reforzar el conocimiento de los nombres de los participantes en un curso o taller, pero no es la más adecuada para iniciar una presentación.

Generalmente se aplica al segundo día o en la segunda reunión, después de haber realizado otra dinámica de presentación.

EJEMPLOS:

III.



Sabemos que la pantomima va a tratar de las condiciones que describen los factores de riesgo reproductivo o los problemas de las embarazadas que podrían sufrir una preeclampsia. Ya hemos conversado mucho sobre el tema.

En este paso los grupos deben poner cuidado en escoger las actitudes o reacciones que puedan trasmitir mejor el mensaje. Luego, deben ensayar un poco y utilizar expresiones conocidas por todos para hacer más claro lo que quieren decir. Es bueno exagerar algunos gestos o movimientos.

• Reirse para expresar alegría

• Temblar para expresar frío

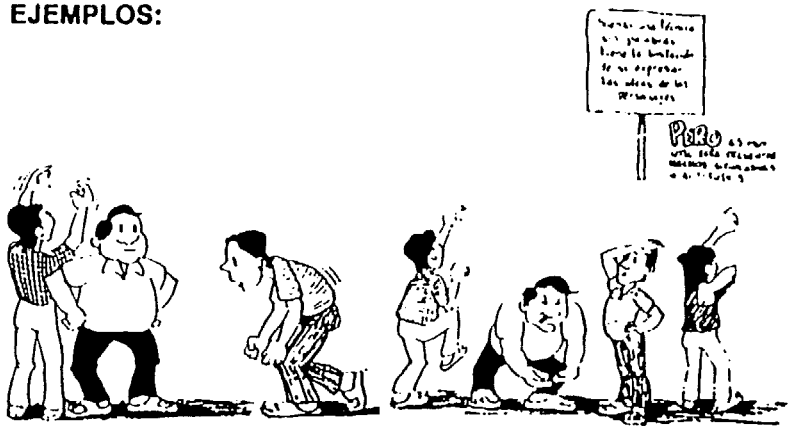
• Abanicarse para expresar calor

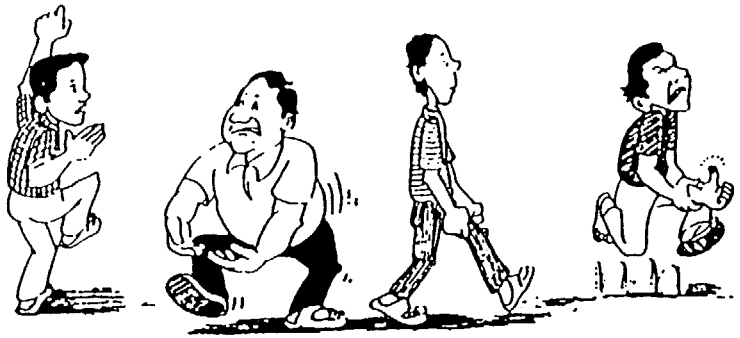
IV. ¿CUANDO SE PUEDE UTILIZAR LA PANTOMIMA?

Se puede usar la pantomima:

* para empezar a estudiar un tema (diagnóstico)
* para ver una parte de un tema
* al terminar de estudiar un tema (como conclusión o síntesis)

EJEMPLOS:





V. SE RECOMIENDA...

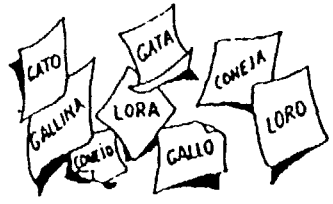
Es conveniente usar la pantomima cuando hay mucho ruido y es difícil que las voces sean escuchadas por todos. La pantomima, por ser muda, va a exigir que el público se concentre más en la actuación.

Es útil para personas que nunca han hecho pantomima, hacer como ejercicio algunos juegos antes, como la técnica "Cuerpos expresivos", ver la página 100.

CUERPOS EXPRESIVOS

I. ¿PARA QUE SE HACE LA TECNICA?

Se hace la técnica para animar al grupo antes de empezar la reunión.



II. ¿CON QUE SE HACE LA TECNICA?

Se necesitan papeles pequeños.

III. ¿COMO SE HACE?

Se escriben en los papelitos de animales (macho y hembra), ejemplo: León en un papelito, en otro Leona (tantos papeles como participantes.

Se distribuyen los papelitos y se dice que, durante 5 minutos, sin hacer sonidos deben actuar como el animal que les tocó y buscar a su pareja. Cuando creen que la han encontrado, se toman del brazo y se quedan en **silencio** alrededor del grupo; no se puede decir a su pareja que animal es.

ADRA INTERNATIONAL CHILD SURVIVAL XI

Multi-Country Budget Summary

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
A. Salaries										
1 Direct Backstopping										
a Grant Manager	9,876	3,291	7,475	3,461	7,838	3,641	8,221	3,830	33,409	14,223
b Health Advisor	11,375	1,916	7,217	2,006	7,573	2,101	7,948	2,200	34,112	8,224
c Financial Compliance	7,126	812	2,436	861	2,582	913	2,737	967	14,881	3,553
Subtotal direct backstopping	28,376	6,020	17,128	6,329	17,993	6,654	18,905	6,998	82,402	26,000
2 Technical support										
a Evaluation	1,550	517	2,850	840	2,699	564	3,976	926	11,075	2,846
b Accounting	2,725	908	2,224	842	2,333	884	2,447	928	9,729	3,562
c Support staff	2,675	892	2,220	826	2,333	868	2,452	914	9,679	3,499
Subtotal technical support	6,950	2,317	7,294	2,507	7,364	2,316	8,875	2,768	30,483	9,908
Subtotal Personnel	35,326	8,336	24,421	8,835	25,357	8,970	27,780	9,766	112,885	35,908
B. Other direct HQ costs										
1 Communication										
a. Telephone	1,180	250	1,260	261	1,323	273	1,390	285	5,153	1,070
b Fax	920	223	967	234	1,017	245	1,069	257	3,973	960
c Mail/express	2,041	414	2,159	437	622	462	623	488	5,445	1,801
Subtotal Communication	4,141	887	4,386	932	2,961	980	3,082	1,030	14,570	3,830
2 Report Preparation	1,200	267	1,262	279	1,326	292	1,395	306	5,183	1,144
Subtotal other HQ costs	5,341	1,154	5,648	1,212	4,288	1,272	4,477	1,336	19,753	4,974
Total HQ.	40,667	9,490	30,069	10,047	29,645	10,243	32,257	11,102	132,638	40,883
HQ field costs										
F. Contractual										
1 Health	6,025	1,058	5,166	1,106	5,427	1,156	5,701	1,208	22,319	4,528
2 Management	6,025	1,033	5,166	1,079	5,427	1,128	5,701	1,178	22,319	4,419
3 Financial	4,425	306	3,518	324	3,729	343	3,953	364	15,625	1,336
4 Training										
5 Evaluation			18,500		5,250		26,108		49,858	
6 HIS	2,500		4,150		2,809				9,459	
7 A-133 Auditor	4,400	1,000	4,664	1,030	4,944	1,061	5,240	1,093	19,248	4,184
Subtotal Consultants	23,375	3,397	41,164	3,539	27,585	3,687	46,703	3,843	138,827	14,467

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
B International travel/per diem										
1 Health	6,600	333	6,754	343	7,128	354	7,524	364	28,007	1,395
2 Management	8,800	333	6,754	343	7,128	354	7,524	364	30,207	1,395
3 Financial	5,600		5,724		6,067		6,431		23,823	
4 Evaluation			11,792		2,300		15,939		30,031	
5 HIS	2,400		3,544		2,697				8,641	
6 DIP wkshp	6,600	400							6,600	400
7 Baseline	4,800	800		824	1,000	849	1,700	874	7,500	3,347
8 Auditing	5,280	2,767	5,597	2,903	5,933	3,046	6,313	3,197	23,122	11,912
Subtotal travel/perdeims	40,080	4,633	40,165	4,413	32,253	4,602	45,432	4,800	157,930	18,448
Subtotal Consultants + Travel	63,455	8,031	81,329	7,952	59,838	8,289	92,135	8,642	296,757	32,915
C. Equipment										
1 Computers		14,600								14,600
2 Printer	900	1,300							900	1,300
3 Copier	1,300								1,300	
4 UPS	480								480	
5 Fax Machine	1,200								1,200	
6 Radio systems	2,500								2,500	
7 Typewriter	600					200			600	200
Subtotal Procurement	6,980	15,900				200			6,980	16,100
G. Other costs										
a. Baseline surveys	5,000	2,400					600		5,600	2,400
b. DIP orientation	450								450	
Subtotal other costs	5,450	2,400					600		6,050	2,400
Total HQ Field costs	75,885	26,331	81,329	7,952	59,838	8,489	92,735	8,642	309,787	51,415
Country Programs								8,642		
Honduras Country Costs	111,597	35,020	110,428	39,088	113,491	37,957	110,520	28,027	446,036	140,092
Yemen Country Costs	120,459	100,140	163,820	44,257	143,126	22,798	140,521	24,166	567,926	191,361
Zambia Country Costs	143,404	87,360	142,725	49,676	130,989	49,736	118,130	50,450	535,247	237,222
Total Field Costs	375,460	222,520	416,973	133,021	387,606	110,491	369,171	102,643	1,549,209	568,675
TOTAL DIRECT COSTS	492,012	258,341	528,370	151,021	477,089	129,223	494,163	122,388	1,991,634	660,972
21.00 % Indirect Costs	104,299	54,078	110,630	31,773	100,068	27,633	103,335	26,171	418,332	139,655
6.00 % Unrecovered IdC		28,544		32,030		28,746		30,089		119,409
TOTAL PROGRAM	**596,311**	**340,964**	**639,000**	**214,824**	**577,157**	**185,602**	**597,498**	**178,647**	**2,409,966**	**920,036**
							Match		27.63%	