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Enlace PROJECT

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Health Sector Manager

Dr Luis Tam

Project Coordinator

Dr Luis Espejo

Head Technical Assistant

Narcisa Lopez

Technical Assistants

Jenny Milla

Silvia Valderrama

Rosario Vargas

Luz Elena Mendoza

Administrative Assistant

Sandra Sanchez

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INTRODUCTION

The Enlace Project is implemented in more than 360 communities in the provinces of Otuzco and Julcan, in the jurisdiction of Territorial Health Unit (UTES) No 8 of La Libertad Regional Health Office. Project activities are carried out in close coordination with local UTES No 8 staff. The project seeks to strengthen the training and supervision of community health promoters.

To assure the sustainability of project activities in the communities, the Enlace Project has helped promoters to consolidate the Community Health Agents Network through the institutional strengthening of the Health Promoters' Associations (APROMSAs), linked to the Ministry of Health (MOH) Service Network and to local governments. Twenty-five Health Promoter Committees (COPROMSAs), with representatives to five APROMSAs, have been formed. The project also has started educating women leaders of community-based organizations and traditional birth attendants. This work began with the training of 55 women leaders and/or traditional birth attendants in the Julcan Micro-network. This strategy is designed to contribute to promoting sustainable change in the health practices of mothers and their families.

The goal of training health promoters and women leaders is to encourage the use of preventive and treatment services among mothers of children under the age of two, to improve the primary health status of vulnerable communities, and to reduce maternal-child morbidity-mortality rates.

This report presents the achievements made in the project after the mid-term review. Progress toward meeting each of the specific objectives, constraints and efforts to overcome them, activities implemented in response to mid-term review recommendations, and the most important project achievement are detailed in this report.

a PROGRESS TOWARDS ACHIEVING OBJECTIVES

OBJECTIVES	Y/N	COMMENTS
Objective 1 - primary health services at community level - improved family health practices - community surveillance system	Yes No Yes	Sustainability potential through APROMSA, MOH support Change of IEC strategy now will accelerate desired behavior changes Effective and appears sustainable
Objective 2 -APROMSAS formed and strengthened	Yes	Effective and self-sustainable
Objective 3 -Improved MCH services through MOH	Yes	Enlace's efforts were enhanced by the existence of two other bi-lateral projects for a synergistic effect

Objective 1

Strengthen the delivery and sustainability of primary health care services at the community level and improve family health practices through IEC, health promoter training and the creation of a community health surveillance system

Progress

The project has trained volunteer health promoters to provide first-line primary care in 360 communities. The promoters distinguish cases of diarrhea, dehydration, and respiratory infections which can be treated in the community from those requiring referrals for medical care. A very functional referral-counterreferral system is in place, which is highly valued by the MOH. The MOH staff have stated that the promoter's ability in diagnosing the causes for referral is highly accurate.

The project identified and trained 76 women leaders so far to educate other community members to improve family health practices, particularly demand for pre-natal care and recognition of problems in pregnancy and delivery which require medical attention. The women leaders have been trained in maternal health, gender, breastfeeding promotion and leadership.

Their efforts complement the IEC work of the health promoters, who are primarily using popular education methods such as street theater, murals, songs, poetry, and games to transmit health messages related to diarrhea, pneumonia, and maternal health. As a means of evaluating the impact of the community education, CARE conducted a rapid assessment in August, 1999. A complete report of the assessment is included in Annex A. The chart that

follows the report compares results to the baseline survey for specific indicators

The community surveillance system has been completely operational for over a year and a half, with virtually no inputs or supervision by CARE staff, which bodes well for its sustainability by the MOH and community health promoters. The system includes continual up-dating of vital statistics, census, monitoring of morbidity, and the referral-counterreferral system.

Results of Enlace Project	Current	Baseline	Target
% of mothers who know the correct age to introduce foods	67	-	-
% of mothers who give equal or more liquids	68	63	75
% of mothers who give antibiotics for diarrhea	23	30	15
% of mothers who identify 2 or more signs of dehydration	23	25	60
% of mothers who identify 2 or more signs of severe diarrhea	20	-	-
% of mothers who identify 2 or more signs of pneumonia	14	17	70
% of women seeking prenatal care per card	53	38	60
% of women who know to get at least 1 prenatal visit	59	38	60
% of women who know 2 or more danger signs of pregnancy	36	5	60
% of mothers who know to give more liquids or liquids more frequently when child has diarrhea	50	63	75
% of mothers who know that giving foods in greater quantity or more frequently is important when a child has diarrhea	11	49	65

Objective 2

Promote the institutional strengthening of the APROMSAs (and their COPROMSA sub-divisions) through training in management and leadership

Progress

Twenty-six COPROMSAs and five APROMSAs are covering the entire project area. The health promoter members have received training, experience and support in developing the systems, administration and management skills, and leadership to make these sustainable effective institutions for providing supervisory and financial support to health promoter activities, and creating

viable links between the MOH, local governments and the communities More information is found in Section f

Work in partnership with the MOH to improve maternal-child health through the provision of technical assistance, equipment and systems development

Project Enlace has worked with MOH to improve information systems, community outreach, supervision of volunteers, emergency care, and now, the implementation of the CLAS This is a new national initiative to turn administration of health services over to local committees Maternal-child health services in the project area have improved significantly due to the synergism between this project and two large projects, Basic Health for All which is funded by the Interamerican Development Bank, and the USAID-funded Project 2000

CREATION OF CAPACITY AND SUSTAINABILITY

GOALS	OBJECTIVES	IS IT BEING MET?	COMMENTS/NECESSARY STEPS
A) The APROMSAs become effective agents of change	The APROMSAs reorganize join forces and articulate the vision of the health promoters in the communities The APROMSAs establish a system of credentials for the health promoters	Yes	a Five APROMSAs have been organized and trained in administration supervision and evaluation b APROMSA supervision of Committees and health promoters has been strengthened c APROMSAs have been linked with local governments (municipalities) d Signing of Cooperation Agreements between the Agallpampa APROMSA and four local municipalities e APROMSA leaders are members of the Local Health Service Administration Committees (CLAS)

Sustainability and Capacity cont

GOALS	OBJECTIVES	IS IT BEING MET?	COMMENTS/NECESSARY STEPS
B) Health promoters raise community awareness to encourage community members to seek quality health services	1) Community health promoters organize a community health surveillance system 2) Community health promoters teach mothers to recognize danger signs and encourage better practices for themselves and their children under two years of	Yes	Activities to supervise promoters have been incorporated into MOH operating plans Regular feedback of results with communities through the promoters has begun This has already been established at the level of the COPROMSAs and APROMSAs

	age		<p>Agreements have been made through multisectoral meetings and an agreement was signed with a CLAS and local authorities. The CLAS has earmarked funds for the community health surveillance system.</p> <p>Promoter training in maternal health and the promotion of breastfeeding is still pending in third-year communities.</p> <p>Meetings are taking place to reinforce promoter skills in the use of adult education methodologies.</p>
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GOALS	OBJECTIVES	IS IT BEING MET?	COMMENTS/NECESSARY STEPS
C) Community leaders respond to local needs	<ol style="list-style-type: none"> 1) Leaders manage the community health surveillance system detecting and informing authorities about cases in a timely manner 2) Leaders establish a system of community referral and emergency evacuation 	Yes	<p>(See categories B and C above Community health surveillance system)</p> <ol style="list-style-type: none"> a) Canvas was distributed and the community supplied the wood for the construction of stretchers. Many have been modified for better patient transport. b) In each community there is an emergency evacuation team composed of local leaders and authorities. c) Only promoter training in birth plans is pending in third-year communities. d) To date 760 family health emergency savings banks have been installed by the APROMSAs in 152 communities.
D) The MOH addresses issues of the quality and equity of health service delivery	<ol style="list-style-type: none"> 1) The MOH implements norms and rewards staff for compliance 2) The MOH monitors service quality and guarantees the supply of all essential medicines and materials 	Yes	<ol style="list-style-type: none"> a) With the new health service administration modality (CLAS) agreements are being made to assure continuity in the implementation of procedures for the supply of medicines and materials.

b FACTORS THAT HAVE HINDERED PROGRESS AND ACTIONS THAT ARE BEING TAKEN TO OVERCOME CONSTRAINTS

Lack of commitment of MOH staff to supervise and monitor promoters

Staff view these activities as extra work and often lack transportation. The supervision of promoters has been assumed only through monthly meetings.

Promoter performance evaluations are based on the reports promoters deliver at meetings. The MOH had no appropriate supervision tools.

To overcome this difficulty, the project has trained MOH staff, APROMSA leaders and Health Promoter Committees (COPROMSAs) in supportive supervision. Instruments were also designed to carry out supervision activities, some for MOH workers and others for COPROMSA and APROMSA members (Annex 2).

The COPROMSAs and APROMSAs were the first groups to undertake their own supervision. This year, MOH health facilities have included health promoter monitoring and supervision activities in their programming (1999). To date, these activities have been jointly fulfilled by the MOH and the APROMSAs, in accordance with operating plans.

Change of MOH staff

A year ago, a new director was hired at UTES No. 8 (Otuzco-Julcan), the project intervention area. This change impeded many of the processes underway at UTES No. 8, especially with regard to staff relationships, the progress in the adaptation of health services to improve quality and the organization of services in terms of their treatment capacity.

This situation indirectly affected the project. It did not, however, influence the more operative levels of the UTES. At these levels, the processes implemented by the project were incorporated and assumed by staff. To prevent situations that could put the project at risk, technical measures were taken. The project promoted the work with promoters at all levels and strengthened the relationship with the MOH at the level of the Regional Health Office. Another important element is the empowerment of the APROMSAs and their links with the micro-networks¹ and local governments.

In addition, the constant changes and rotation of some lower-level MOH staff have caused some activities to be discontinued. This constraint is being overcome by involving all health establishment staff in project activities and incorporating these activities in local operating plans.

Transition of Health Facilities to the New Administrative Form

Currently, important changes in the administration of UTES No. 8 health facilities are taking place. The centralized administration at the level of the UTES has been changed to a decentralized system. This new administrative system works through the legally established CLAS². Community members hold all posts on the CLAS and the head physician of the health facility serves as the manager. In this new

¹ A micro-network is part of a Health Services Network. It brings together a set of health facilities whose communities have permanent commercial and socio-cultural exchange. This strategy favors access to health services.

² A new form of health service administration, with community participation in the framework of the MOH reform.

administrative form, the CLAS has the capacity to administer all resources, including personnel

Implementation of this process affected project development since many lead promoters were appointed to important posts on the CLAS, causing an imbalance in the organization of the APROMSAs and in the health facilities

Because the system prioritizes service supply over demand and community work, the project involved the CLAS in the community work it is implementing. The APROMSA leaders serving on the CLAS incorporate project activities in their operating plans. Some have already financed the implementation of the community health surveillance system. The project is also participating in CLAS events organized by the MOH to learn about progress made and contribute its experience.

Rainy season

Due to El Niño Phenomenon, the rainy season in the highlands (December-March) was more intense than usual. Roads became impassable, making access to communities difficult.

This situation delayed project activities since the promoters could not travel to households to carry out educational activities. Additionally, the excess rains made field supervision difficult. During this season, activities planned for the health facilities were prioritized.

To avoid delaying educational activities during these months, health messages on radio broadcasts were intensified. The project also took advantage of the time to train promoters or reinforce their knowledge when it was possible to bring them together.

c PROJECT AREAS NEEDING TECHNICAL SUPPORT

The areas needing technical support include the processes of systematizing experiences and improving the adult education methodology. A Harvard public health student has begun to document the experience of the APROMSAs. Technical assistance is being sought to conduct additional training in participatory adult education.

d IMPORTANT CHANGES TO THE PROGRAM DESCRIPTION AND TO THE DIP THAT WILL REQUIRE MODIFICATIONS IN THE COOPERATION AGREEMENT

No important changes were implemented in the program description or in the DIP.

MID-TERM REVIEW RECOMMENDATIONS

a Multiply and prioritize plans to strengthen community health promoters in educating the target populations

Health promoter training workshops in educational methodology were held. These prioritize the role of health promoters as educators in community health. To date, 60 percent of health promoters have multisectoral programming plans for education in their communities. Likewise, promoters are organizing Maternal Health, ADD and ARI Fairs in their communities. At these fairs, mothers participate in educational games and receive symbolic prizes. To promote breastfeeding, there are contests for crafts containing breastfeeding messages. Textiles are the best crafts for this activity since they permit greater versatility in design and can also be sold.

The Art in Health strategy also is being implemented with much success. For this strategy, promoters compose songs with clear messages on ARI, ADD, maternal health, nutrition and family planning. The winning songs are recorded on cassettes. These are then played on five local radio stations. The radio programs are hosted by community health promoters. The programs have contests with prizes, sociodramas, debates, games and songs to educate listeners.

The COPROMSAs have obtained support from local businesses for the prizes awarded during the municipal and/or community fairs.

The project has identified and trained women leaders and traditional birth attendants in maternal health and breastfeeding. This strategy is already producing positive results: there is an increase in the number of pregnant women who go to a health facility for pre-natal check-ups, delivery assistance, puerperium control and family planning.

Flipcharts on ADD, ARI and maternal health were distributed to the community volunteers. The ADD flipcharts have an illustrated users manual. Thirty sets of blankets with breastfeeding messages were also distributed. Additionally, the project produced and distributed a calendar with key maternal health messages and a poster promoting breastfeeding. There was much community demand for the calendar.

To evaluate the impact of the health education efforts to date, the project conducted a limited KPC survey of ___ mothers selected by cluster sampling in the project area. The complete report of this survey is found in Appendix A. The report indicates that there is need to increase education through direct contact with mothers, while it is apparent that the radio messages are reaching fathers.

b Increase project human resources

Two technical assistants were hired to work with two health facilities, resulting in more intensive field activities. Each assistant is responsible for a micro-network with an average of five health facilities and 60 communities, one APROMSA, and between 4 and 6 COPROMSAS.

The administrative assistant now also spends 40 percent of her time carrying out field activities. For this reason, a typist has been hired to input information in the project monitoring system.

f MOST SUCCESSFUL STRATEGY

Consolidation of the Network of Community Health Agents through the institutional strengthening of the APROMSAs, linked to the MOH Service Network and local governments

The project strengthened APROMSA organization to create the means to promote empowerment of these community-based organizations and their sustainable democratic participation in civil society and local government.

This achievement was made possible through definition of the APROMSAs function and organizational structure. At all levels, they are linked to the Health Services Network of UTES No. 8 and to local governments.

This participation originates in the community. Local authorities³, leaders of community-based organizations⁴, teachers, promoters and traditional birth attendants serve on Community Health or Multisectoral Committees and Emergency Evacuation Committees. These committees support education and promotion efforts with Community Health Agents⁵ in their communities.

The next level of participation takes place through the COPROMSAs and the Committees of Women Leaders and Traditional Birth Attendants, which are formed by their respective leaders.

The COPROMSA is linked to the health facility (health center or post) and to the local government in its jurisdiction. This articulation takes place through the incorporation of annual operating plans in the programming of the health facility and that of local governments for specific activities. The plans include the activities programmed by community health agents in their communities.

³ *Municipal agent, lieutenant governor*

⁴ *Glass of Milk, Mothers' Club, Parent-teachers' Associations, Community Water Committee*

⁵ *Community health agents, Promoters, traditional birth attendants and women leaders*

Twenty-six COPROMSAs and five Women's Committees were formed in the project intervention zones. As their role is more operative, each COPROMSA management committee is responsible for a specific number of nearby communities (three or four) whose promoters it supervises. This distribution of communities coincides with the areas the health facility assigns to different health staff.⁶

The highest level of participation takes place through the APROMSAs. These are formed by representatives of the COPROMSAs of a health micro-network. They have a leadership role within the institutions and management at the level of the micro-network with the public and private district and/or provincial institutions.

The APROMSAs consolidate in their annual operating plans the activities planned by the COPROMSAs and add activities corresponding to their level. Approximately 70 percent of members participate in this process.

As a result of their ability to negotiate, they have obtained borrowed office space and furniture, used their own funds to purchase equipment for the locale, and convinced the municipality to donate property to two APROMSAs. Likewise, they use their own funds or arrange for the municipalities to cover the costs of fuel and maintenance of the motorcycles they use to supervise members. They have also persuaded a CLAS to fund the implementation of community health surveillance systems and an incentive system for health promoters.

Monitoring and supervision are the most important elements for establishing a connection among the different levels of this organizational and functional structure. These activities are included in the annual operating plans of the COPROMSAs and APROMSAs.

Mr Modesto Rodríguez (director of the Barro Negro COPROMSA) was charged with supervising a member. He and his brother, who is also a promoter, left Los Andes community very early to travel to Las Mercedes. He wasn't aware how far Las Mercedes was. He thought he would return soon. His brother told him 'we should turn back.' But Mr Rodríguez wanted to fulfill his supervision duty. After almost six hours of walking, he arrived to his destination and was able to supervise his co-worker. For Mr Rodríguez, it was an unforgettable experience. He has promised to visit that community often.

Monitoring and supervision take place at three organizational levels from the COPROMSAs to health promoters, among COPROMSAs and among APROMSAs. COPROMSA and APROMSA monitoring and supervision activities are crossed. For each level, there are guides and checklists (Annex 1).

⁶ MOH strategy through which the total number of communities in the area of influence of the health establishment is divided by the number of health care workers. Each worker assumes responsibility for a group of communities in terms of service coverage, referral and counter-referral, as well as preventive-promotional activities.

Promoters perceive monitoring and supervision as part of their work and as a support before their authorities. They build promoter self-esteem and raise their status in the community.

With the development of this organizational structure, members have improved their individual leadership skills. Several members of the five APROMSAs serve on the CLAS. One member of the COPROMSA of Barro Negro was elected councilman of his community. A health promoter was chosen as a literacy agent (and therefore can combine his health and education work). Twenty promoters work as radio announcers on local programs in Barro Negro, Usquil, Cuyuchugo, Julcan and Otuzco.

Mr Policiano Quispe, Barro Negro promoter, said:

"I used to be one of many; I didn't even know how to talk. Now I'm a councilman. I was at a very important meeting with the president of the micro-region and the president of the regional government."

The organization continues its growth process. An example of this is the recent election of the APROMSA boards of the Otuzco, Usquil and Julcan APROMSAs. The leaders oversaw all steps of this "electoral process," as stipulated in the statutes. All procedures were followed, from the formation of the electoral committee to the swearing in of those on the winning ballot.

The project promoted women's participation in this process. Women leaders of community-based organizations (Mothers' Clubs and Glass of Milk Committees) and traditional birth attendants have become involved. They have shown confidence in their skills. They make up 35 percent of promoters, hold management positions in 89 percent of COPROMSAs and in all APROMSAs. In the Julcan Micro-network, the project is strengthening the leadership and management skills of this group. Health promoters and women leaders have a healthy attitude of mutual cooperation.

This achievement has been recognized as a sustainable strategy for community health work. Within CARE-Peru, it has been applied in the community work strategy of the Niños Project (PL 480) and the OSSAN Project (CARE-Peru consultancy to the MOH Basic Health and Nutrition Project). Project sites were visited by Child Survival staff of Esperanza and Hope Project, the APRISABAC and VIGIA projects, and the Maternal-Perinatal Health Program. These visitors expressed an interest in the experiences and lessons learned regarding this achievement and gathered inputs for their projects.

VII ANNEXES

- Annex 1 Instruments for the monitoring of the Community Health Agents Network*
- Annex 2 Instruments for the supervision of the Community Health Agents Network*
- Annex 3 Other instruments used by the Community Health Agents*
- Annex 4 Rapid Assessment of Mother's Knowledge and Focus Groups with Fathers*

Anexo 1 : Instrumentos de Monitoreo de la Red de Agentes Comunitarios de Salud.

Anexo 2 : Instrumentos de Supervisión de la Red de Agentes Comunitarios de Salud.

FICHA DE SUPERVISION AL PROMOTOR DE SALUD

Nombre del promotor _____ Fecha _____
Comunidad _____ CS/PS _____
Nombre del supervisor _____
Cargo _____
APROMSA (_____) Comité de Promsas (_____)

I Objetivo de la supervisión

II Documentos/instrumentos revisados

Censo () Croquis () Registros de atención ()
Boletas de referencias () Notificación de nacimientos ()
Notificación de fallecimientos () Programación mensual ()
Registro de Salud Materna () Acta de reuniones ()

III

AVANCES

DIFICULTADES

IV RECOMENDACIONES Y ACUERDOS

Firma del supervisor

Firma del promotor

FICHA DE SUPERVISION AL COMITE DE PROMSAS

Comité _____ Fecha _____
Nombres y cargo de los supervisados

APROMSA _____
Nombres y cargo de los supervisores

I Objetivo de la supervisión

II Documentos/instrumentos revisados

Padron de socios () Plan operativo () Estatutos ()
Libro de caja () Libro de actas ()
Informes de PROMSAs () Informes de supervision()

III

AVANCES

DIFICULTADES

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IV RECOMENDACIONES Y ACUERDOS

Firma de los supervisores

Firma de los supervisados

FICHA DE SUPERVISION A LA APROMSA

APROMSA _____ Fecha _____
Nombres y cargo de los supervisados

Comisión de Supervisión

I Objetivo de la supervisión

II Documentos/instrumentos revisados

Padron de socios () Plan operativo () Estatutos ()
Libro de caja () Libro de actas () Libro de compras ()
Informes de PROMSAs() Plan de Supervision ()
Informes de supervision()

III

AVANCES

DIFICULTADES

<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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IV RECOMENDACIONES Y ACUERDOS

Firma de los supervisores

Firma de los supervisados

LISTA DE CHEQUEO DE APROMSA

APROMSA _____ FECHA _____

ACTIVIDADES		CUMPLEN	
		SI	NO
I	ORGANIZACIÓN Cuenta con personeria juridica ? Cuenta con organigrama de la institucion ? Cuenta con padron de socios actualizado ? Realizan asambleas con sus socios ? Tiene Plan operativo ? Sus integrantes conocen sus funciones segun estatutos y reglamentos ?		
II	MANEJO ADMINISTRATIVO Cuenta con libro de actas al dia ? El libro de caja esta correctamente llenado ? El libro de compras esta correctamente llenado ? Los fondos de la institucion se encuentran seguros y disponibles ? Los aportes de los socios estan al dia ?		
III	SUPERVISION Cuentan con un Plan de Supervision ? Estan realizando supervision periodica a los Comites ? Estan realizando supervision periodica a los promsas ? Tienen los informes de las supervisiones realizadas ? Cuentan con consolidado de los informes de los promsas ? Cuentan con listado de materiales y equipos entregados a promsas ? Velan el buen uso de los materiales y equipos entregados a promsas ?		
IV	GESTION Estan realizando gestiones para conseguir apoyo para sus actividades ? Estan realizando actividades para conseguir fondos economicos ? Buscan e implementan incentivos para los promsas ?		
V	TRABAJO CONJUNTO CON MINSA Coordinan sus actividades con el MINSA ? Realizan planes de trabajo conjunto con el MINSA ? Organizan y participan en actividades de IEC con el MINSA ? Evaluan planes de trabajo con el MINSA ? Realizan supervision conjunta con el MINSA ?		
VI	RELACIONES INTERINSTITUCIONALES Participan en mesas de concertacion provincial ? Tienen coordinaciones con otras instituciones ? Participan en actividades civicas provinciales o distritales ? Realizan difusion de sus actividades ?		

FIRMA DE LA PERSONA QUE APLICA LA FICHA _____

LISTA DE CHEQUEO DE COMITES

COMITE _____ FECHA _____

ACTIVIDADES		CUMPLEN	
		SI	NO
I ORGANIZACION	Todas las comunidades cuentan con promotor ? Cuenta con padron de socios actualizado ? Realizan reuniones mensuales con sus socios ? Tiene Plan operativo ? Conocen estatutos y reglamentos de su institucion ? Los integrantes del comite conocen sus funciones ? Participan en asambleas de su APROMSA ?		
II MANEJO ADMINISTRATIVO	Cuenta con libro de actas al dia ? El libro de caja esta correctamente llenado ? El libro de compras esta correctamente llenado ? Los fondos de la institucion se encuentran disponibles ? Los aportes de los socios estan al dia ?		
III SUPERVISION	Cuentan con un Plan de Supervision ? Estan realizando supervision periodica a los promsas ? Tienen los informes de las supervisiones realizadas ? Cuentan con copia de los informes de los promsas ? Velan por el buen uso de los materiales y equipos entregados a promsas ?		
IV GESTION	Estan realizando actividades para conseguir fondos economicos ? Buscan e implementan incentivos para los promsas ? Realizan aportes para la capacitacion de los promsas ?		
V TRABAJO CONJUNTO CON MINSA	Coordinan sus actividades con el MINSA ? Realizan planes de trabajo conjunto con el MINSA ? Organizan y participan en actividades de IEC con el MINSA ? Participa en la organizacion de los talleres de capacitacion para promsas ? Evaluan planes de trabajo con el MINSA ? Realizan supervision conjunta con el MINSA ?		
VI RELACIONES INTERINSTITUCIONALES	Coordinan actividades con otras instituciones y organizaciones de base ? Participan en actividades civicas provinciales o distritales ? Realizan difusion de sus actividades ?		

FIRMA DE LA PERSONA QUE APLICA LA FICHA _____

FICHA DE SEGUIMIENTO A ASISTENTES

Nombre del supervisado _____
Cargo _____ Lugar _____
Fecha de la supervision _____
Nombre del supervisor _____ Cargo _____

I Metodología utilizada

II Instrumentos utilizados

III

AVANCES

DIFICULTADES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV RECOMENDACIONES Y ACUERDOS

Firma del supervisor

Firma del supervisado

Anexo 3 : Otros instrumentos manejados por los Agentes Comunitarios de Salud.

REGISTRO DE LA GESTANTE LADO A



REGISTRO DE LA MADRE GESTANTE EN LA COMUNIDAD



NOMBRES Y APELLIDOS _____ EDAD _____
 COMUNIDAD _____ SECTOR _____ N° DE CASA _____

CONTROL DEL EMBARAZO									
FECHA DE ÚLTIMA MESTRUACION	DIA	MES	AÑO	N DE EMB ANTER	MESES DE EMBARAZADA	N° DE CONTROLES DEL EMBARAZO	VAC ANTITETAN	FECHA DE REFERENCIA	
FECHA PROBABLE DEL PARTO					1 A 3 MESES 4 A 6 MESES 7 A 9 MESES	① ② ③ ④ ⑤ ⑥			DIA MES AÑO _____
SI TIENE SEÑALES DE PELIGRO DURANTE EL EMBARAZO, REFERIRLA									
								SEGUIMIENTO	
AUSENCIA DE MOVIMIENTOS FETALES	SANGRADO VAGINAL	PERDIDA DE LIQUIDO POR VAGINA	DOLOR DE CABEZA	OPILADO	FLIBRE	VOMITOS EXARACOS		1er Trim	2do Trim

ATENCION DEL PARTO					¿Quién atendió el Parto?					FECHA DE REFERENCIA		
FECHA DEL PARTO	DIA	MES	AÑO						DIA MES AÑO _____			
DURACION DEL TRABAJO PARTO				SI TIENE SEÑALES DE PELIGRO EN EL PARTO REFERIRLA					SEGUIMIENTO			
1er Dia												
2do Dia				PERDIDA DE LIQUIDO POR MAS DE 6 HORAS	PRESENTACION D NALGAS	PRESENTACION TRANSVERSA	PRESENTACION OF JEJAR	SANGRADO VAGINA ABUNDANT				
3er Dia												
✓ Si es tu primer hijo esperar hasta 12 hrs ✓ A partir de tu segundo hijo esperar hasta 8 hrs				SALIDA POR VAGINA DE L CORDON	SALIDA POR VAGINA DE LA MANO	SALIDA POR VAGINA DE L PI	RETENCION DE LACENTA	1	2	3		

DESPUES DEL PARTO		SI TIENE SEÑALES DE PELIGRO DESPUES DEL PARTO REFERIRLA			
1er Dia		SI	NO		
2do Dia		SI	NO	H.MORRAGIA VAGINAL	S.LGRES ON VAGINAL MAL OL ENTE
3er Dia		SI	NO		
				PIEBRE	HENCHAZON Y DOLOR DE MAMAS
<input type="checkbox"/> ENVELO URGENTE AL ESTABLECIMIENTO DE SALUD MARQUE LA SENAL DE PELIGRO QUE PRESENTA					
PLANIFICACION FAMILIAR					
OBSERVACIONES					

RECEN NACIDO					
RECEN NACIDO			SI EL NIÑO AL NACER TIENE ESTAS SEÑALES REFERIRLO		
SANO	A.OSTRO	MUERTO	FLACIDO	MORADO	BAJO O PESO
Del 1er Dia al 7mo Dia		8vo a 28 DIAS		FECHA DE REFERENCIA	
				DIA MES AÑO _____	
SANO	SANO	FLACIDO	FLACIDO		
REFERIRLO	REFERIRLO	NOTIFIQUE	NOTIFIQUE		
				SEGUIMIENTO	
MUERTO	MUERTO	MUERTO	MUERTO	1	2

REGISTRO DE LA GESTANTE LADO B

PLAN DE PARTO

CUIDADO DE LA FAMILIA

Una semana antes y una despues de la fecha probable de tu parto
¿Estará tu esposo?

SI NO

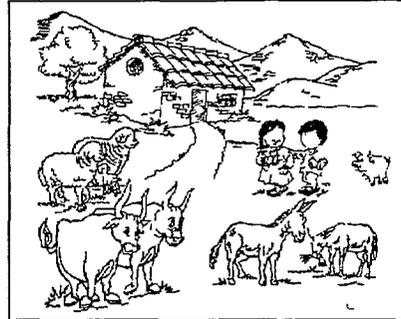
Para que estes tranquila, es necesario que dejes a alguien al cuidado de tu familia, casa y animales

Si tu esposo NO va a estar entonces

¿Quien te acompañará?

¿Quien cuidara a tus hijos?

¿Quien cuidara tu casa y animales?



ATENCION DE SU PARTO

¿Donde te vas atender tu parto?

¿Quien te va atender tu parto?

¿Cuanto te va a costar la atención de tu parto?

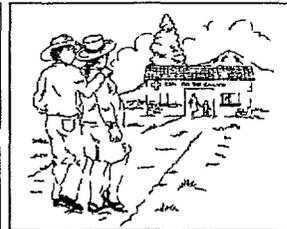
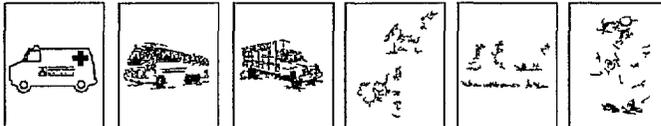
¿Como piensas juntar ese dinero?

La familia debe ahorrar un monto de dinero para el momento del parto y otro monto adicional para cualquier emergencia



TRANSPORTE PARA LA ATENCION DEL PARTO Y/O EMERGENCIAS

Si se te presenta algun problema o emergencia ¿Cómo vas a trasladarte?



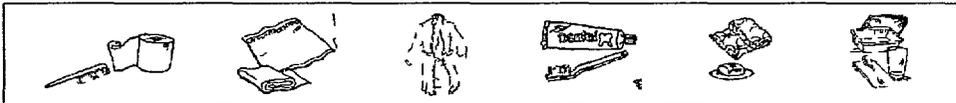
¿En tu comunidad existe una litera para trasladarte en caso de emergencia?

SI NO

MATERIALES NECESARIOS PARA LA ATENCION DEL NIÑO Y LA MADRE



MATERIALES QUE NECESITA LA MADRE SI SU PARTO ES EN EL ESTABLEC DE SALUD



BOLETA DE REFERENCIA PARA EL PROMOTOR						
N° DE REFERENCIA						
COMUNIDAD			N° CASA			
EST DE SALUD			SECTOR			
PROMOTOR						
FECHA						
NOMBRE						
EDAD						SEXO
						HOMBRE <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUJER <input type="checkbox"/>
< 6m	6m<1a	1a 2a	2a 4a	Escolar	Adulto	
MOTIVO DE LA REFERENCIA						
Vacunacion	CRED	Diarrea	No Neumonia	Neumonia		
Control del Embarazo	Atención de P.rio	Control después del Parto	Mujer con Señales de Peligro	Planificación Familiar		
TRATAMIENTO INDICADO						
LM	Líquido	SRO	Cotrimoxazol			
Otro (Especifique)						

Firma del PROMOTOR

BOLETA DE REFERENCIA PARA EL ESTABLECIMIENTO DE SALUD						
N° DE REFERENCIA						
COMUNIDAD			N° CASA			
EST DE SALUD			SECTOR			
PROMOTOR						
FECHA						
NOMBRE						
EDAD						SEXO
						HOMBRE <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUJER <input type="checkbox"/>
< 6m	6m<1a	1a 2a	2a 4a	Escolar	Adulto	
MOTIVO DE LA REFERENCIA						
Vacunacion	CRED	Diarrea	No Neumonia	Neumonia		
Cont. del Embarazo	Atención de P.rio	Control después del Parto	Mujer con Señales de Peligro	Planificación Familiar		
TRATAMIENTO INDICADO						
LM	Líquido	SRO	Cotrimoxazol			
Otro (Especifique)						

Firma de QUIEN ATENDIO EN EL ESTABLECIMIENTO DE SALUD

BOLETA DE CONTRARREFERENCIA PARA EL PROMOTOR						
N° DE REFERENCIA						
COMUNIDAD			N° CASA			
EST DE SALUD			SECTOR			
PROMOTOR						
FECHA						
NOMBRE						
EDAD						SEXO
						HOMBRE <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUJER <input type="checkbox"/>
< 6m	6m<1a	1a 2a	2a 4a	Escolar	Adulto	
FECHA DE ATENCION						
ATENDIDO POR (CARGO Y NOMBRE)						
DIAGNOSTICO O ACTIVIDAD REALIZADA						
RECOMENDACIONES PARA EL SEGUIMIENTO						
FECHA QUE RECIBE LA CONTRARREFERENCIA						

NOTIFICACION DE NACIMIENTO

 MADRE CON NIÑO RECIEN NACIDO	LOCALIDAD DEL NACIMIENTO	<input style="width: 100%;" type="text"/>	
	FECHA DEL NACIMIENTO	<input style="width: 100%;" type="text"/>	
	SEXO DEL RECIEN NACIDO	HOMBRE	<input type="checkbox"/>
		MUJER	<input type="checkbox"/>
DONDE NACIO EL NIÑO			
	 ESTABLECIMIENTO DE SALUD	 EN SU CASA / COMUNIDAD	
SI NACIO EN SU CASA / COMUNIDAD QUIEN ATENDIO EL PARTO	PARTERA <input type="checkbox"/>	PROMOTOR <input type="checkbox"/>	FAMILIAR <input type="checkbox"/>
	OTRO <input type="checkbox"/>	ESPECIFIQUE <input style="width: 100%;" type="text"/>	

NOMBRE DEL PADRE	<input style="width: 100%;" type="text"/>
NOMBRE DE LA MADRE	<input style="width: 100%;" type="text"/>
NOMBRE DEL PROMOTOR	<input style="width: 100%;" type="text"/>
FECHA DE NOTIFICACION	<input style="width: 100%;" type="text"/>
	<div style="border: 1px solid black; width: 150px; height: 40px; margin: 0 auto;"></div> FIRMA

NOTIFICACION DE FALLECIMIENTO

FECHA DE LA MUERTE	<input style="width: 100%;" type="text"/>	LOCALIDAD DONDE OCURRIO LA MUERTE	<input style="width: 100%;" type="text"/>
NOMBRE Y APELLIDOS DEL MUERTO	<input style="width: 100%;" type="text"/>		
CAUSA DE LA MUERTE	<input style="width: 100%;" type="text"/>		
NOMBRE DEL PROMOTOR	<input style="width: 100%;" type="text"/>		
LOCALIDAD	<input style="width: 100%;" type="text"/>		

 NACIDO MUERTO 	 MUERTE DEL RECIEN NACIDO 	 MUERTE DE NIÑO ENTRE 6 Y MENOR 1 AÑO 	 MUERTE DE NIÑO ENTRE 2 Y 4 AÑOS 	 OTRA MUERTE ESPECIFIQUE EN NOTA
 MUERTE DE MADRE GESTANTE 	 MUERTE DE MADRE DANDO A LUZ 	 MUERTE DE MADRE DESPUES DEL PARTO 	NOTA <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/>	
				<div style="border: 1px solid black; width: 150px; height: 30px; margin: 0 auto;"></div> FIRMA

**Anexo 4: Rapid Assessment of Mothers' Knowledge and
Focus Groups with Fathers**

**Rapid Assessment of Mothers' Knowledge
and Focus Groups with Fathers**

CARE/Project *Enlace*

La Libertad, Peru

August, 1999

Rachael McClennen

MPH Student, Harvard School of Public Health

Rapid Assessment of Mothers' Knowledge

Abstract

This report describes the implementation and results of a rapid assessment instrument used to measure mothers' knowledge in communities covered by Project *Enlace*, a child survival project. Project staff should use these results to improve certain aspects of the project in the fourth and final year of implementation.

Introduction

Project *Enlace* is a three year old child survival project in the region of La Libertad, Peru. The project aims to improve health behaviors in the areas of diarrheal diseases, respiratory infections, maternal health, and breast-feeding in 367 communities. With the project's imminent completion, project staff are interested in identifying strengths and areas that need improvement with regard to community education. The rapid assessment survey (see Annex 1) described here attempts to measure the project's work to date with regard to mothers' knowledge and practices related to project interventions. Project staff hope that with greater knowledge of the healthy behaviors, health practices will improve, in turn lowering infant, child, and maternal mortality and morbidity rates.

Methods

The rapid assessment was administered in 26 communities in the project area where project interventions began in the first or second year of the project. The figure 26 was chosen because it was equivalent to approximately 10% of the total number of communities involved during the first or second years of the project (approximately 260). Random selection determined the communities used for rapid assessment, thereby reducing selection bias. This guaranteed sufficient representation of the actual set of communities, with regard to accessibility to health facilities and urban areas, presence or absence of a health promoter, etc.

The rapid assessment was administered orally to almost all mothers in the project communities who had children less than 24 months old. The total number of mothers interviewed was 227. The interviewers who administered the rapid assessment were instructed to interview all mothers in the community with children less than 2 years old, with a maximum number of 15 surveys. If the mother was not home or could not be located in the community on the day of the interview, then she was not interviewed. This could lead to bias because it is possible that those mothers missed may be more frequently away from home, therefore receiving less communication with health promoters, mothers' groups, radio programs, or Ministry of Health (MOH) staff. Bias also may have been present if there were more than 15 mothers in each community. The mothers whose houses were easiest to reach or closest to the main road would have been

more likely to be interviewed than those more inaccessible. This might lead to bias because the less accessible women could be less likely to have less communication with those individuals who can educate her about the project's health indicators. This bias is not very likely, however, because there were very few communities (three or four) that had more than 15 mothers.

Project health promoters were selected to administer the rapid assessment instrument in the 26 communities. The interviewers were selected based on their high level of knowledge of the project's indicators and their leadership skills. The interviewers were assigned to communities that were not near their own, to prevent bias. The interviewers were instructed to find the health promoter in the community to be assessed, so that he/she could lead the interviewer to each house that had a mother with children less than 24 months old. The promoter from the community was instructed to stay outside of the house, so as to make the mother feel less uncomfortable if she answered a question incorrectly. This was a way to reduce response bias.

All of the interviewers attended a 7-hour training workshop the day before they traveled to the community where they were to administer the rapid assessment. The workshop included instructions on what to do upon arriving in the community, how to present the survey to the mothers, how to ask and answer each question, role-playing of how to administer the survey, and a practice survey exercise with mothers in the town where the workshop was held. During the workshop, the interviewers also gave ideas and suggestions of how to change the wording of the questions so that they would most easily be understood by the mothers. This insured the most culturally-appropriate wording, so as to increase accuracy of the results.

Results (also see Annex 2)

Breast-Feeding

The majority of mothers (67%) correctly answered the question that asked at what age a child should begin receiving foods other than exclusive breast milk. The second most common response was between 7 and 12 months (17.6%). The third most common response was between 4 and 5 months (7.5%).

Mothers' most common response (44.1%) to the question that asked where they learned what they know about breast-feeding was from MOH staff. The second most common response was a health promoter (40.5%). 14.1% of mothers learned what they know from other women. 5.7% of mothers reported hearing breast-feeding messages on the radio, and 23.8% of mothers had not heard any such health messages. No mothers reported hearing messages regarding breast-feeding from health fair games or health skits. When examining mothers' responses in the space allowed for "other" answers, the most

common answers were pamphlets and CARE trainings¹ Four (1 8%) mothers identified CARE trainings as sources for their knowledge about breast-feeding, and three (1 3%) identified pamphlets as their source of knowledge

Diarrhea

Two questions were designed to find out if children who are breast-fed are given breast milk when they have diarrhea One indicated that 23 9% of mothers continue breast milk when the child has diarrhea, however this result was not cross-tabulated with mothers still breastfeeding at the time of the survey Another indicated that 27 3% of mothers knew the importance of continuing to give breast milk when her child has diarrhea, but this does did not insure that the mother is raising her child with that health practice

Sixty-eight percent (68 3%) of mothers reported that they give their child with diarrhea equal or more liquids than when they are healthy This was a small increase from the 63% measured in the baseline survey Twenty-three percent (23 3%) of mothers indicated that they give antibiotics to their children when they have diarrhea This is also an improvement from the baseline, where 30% of mothers reported the use of antibiotics to treat diarrhea When examining the answers given under “other”, ten (4 4%) mothers said that they would take their child to a health center, and many others (6 2%) said that they would give their child some sort of traditional remedy, such as tea made from avocado pit, chamomile tea, lemon rind tea, or oregano tea, all of which would increase liquids

A small proportion of mothers (18 5%) could identify two or more important things to do when her child has diarrhea Forty-nine percent (49 3%) of mothers knew the importance of giving equal or more liquids to a child who has diarrhea, a decrease from 63% measured in the baseline survey Under eleven percent (10 6%) of mothers noted the importance of giving the child equal or more food, a decrease from the 49% measured in the baseline survey More than a quarter (26 4%) of mothers did not know any important things to do when her child has diarrhea Interviewers noted other responses that mothers gave as well For example, thirty-seven (16 3%) mothers stated the importance of cleanliness of the child or of the house when a child has diarrhea Seventeen (7 5%) said that giving home remedies was an important thing to do, seven (3 1%) said that going to the health center was an important action to take, and four (1 8%) said that it was important to visit the health promoter, both of which would be acceptable responses

Twenty-three percent (23 3%) of mothers identified two or more signs of dehydration in children with diarrhea This was an increase from the baseline survey, where only 2 5% of mothers who could identify two or more signs A fairly large portion of mothers (39 2%) could not identify even one sign of dehydration In the space entitled “other”,

¹ Most probably these respondents are women leaders who have participated in training events as CARE does not provide direct education to mothers in the communities

many interviewers noted other responses that mothers stated. For example, nineteen (8.4%) said that being underweight or malnourished was a sign of dehydration. Seven (3.1%) said that a child with diarrhea who can not eat or breast-feed is dehydrated. Five (2.2%) mothers noted that a child was dehydrated if he/she is thirsty, an appropriate response, but not one of the messages taught by the project.

Few mothers (19.8%) could identify two or more signs of grave diarrhea in children. A fairly large portion of mothers (30.8%) could not identify even one sign of grave diarrhea. Interviewers noted that six (2.6%) mothers said that dehydration was a sign of grave diarrhea, and they noted that four (1.8%) mothers thought that sunken eyes was a sign of grave diarrhea.

Health promoters were the most frequent source (41.0%) of mothers' knowledge about diarrhea. The next highest reported source of health messages were MOH staff (38.8%). Approximately eleven percent (10.6%) of women reported learning about diarrhea from other women, 5.7% learned through the radio, and 27.3% had not heard any health messages regarding diarrhea. No mothers reported hearing messages regarding diarrhea from health fair games or health kits. Other common responses that mothers gave included family members (1.8%), CARE workshops (1.3%), and pamphlets (1.3%).

Respiratory Infections

Almost fourteen percent (13.7%) of mothers were able to identify two or more danger signs of respiratory infections in children. This was a decrease from the 17% measured in the baseline survey. Almost half of mothers (49.3%) identified rapid breathing as one of the warning signs during respiratory infections. Almost twenty-one percent (20.7%) of mothers identified in-drawing of the ribs as one of the warning signs during respiratory infections. A large number of mothers noted other warning signs of respiratory infections. Twenty-seven (12.0%) said that a cough was a danger sign, and twenty-six (11.5%) said that a fever was a danger sign.

Mothers identified health promoters as the most common source for learning about respiratory infections (40.5%). The second most common source was MOH staff (35.2%). Eleven percent (11%) recognized health messages from the radio, and 4.8% from other women. Almost thirty-two percent (31.7%) of women had not heard any health message regarding respiratory infections. No mothers reported hearing messages about respiratory infections from health fair games or health kits. Two (0.1%) mothers said that they learned what they know through pamphlets, two (0.1%) through CARE trainings, and one (1) through a mural.

Maternal Health

More than half of mothers interviewed (52.7%) reported going to the health center for prenatal visits for the birth of their last child. This was an increase from the 38% measured in the baseline survey. Fifty-four percent (54.1%) of those women reported

orally, or by showing her prenatal card to the interviewer, that she went to 4 or more prenatal visits, which is the MOH policy

Fifty-nine percent (59%) of all mothers interviewed knew that they should go to at least one prenatal visit during pregnancy. Of the mothers who knew that they should go to at least one control, 49.3% of them actually did go to one control. One must question these results however, because some women simply reported the number of times they went to their prenatal controls, while others actually proved that they went by showing their prenatal card.

Almost thirty-six percent (35.7%) of mothers knew at least two signs of danger that needs medical attention during pregnancy. This showed an increase from the 5% measured in the baseline survey. Thirty-eight percent (38.3%) could not identify any signs of danger. Thirteen (5.7%) mothers said that a bellyache was a danger sign during pregnancy. Others responded to this question with answers such as having the fetus in a bad position, having fallen or gotten hit, or being pregnant for the first time, valid responses but not those being taught through the project.

MOH staff was the most frequently identified source of information about maternal health by mothers (41%). Thirty-four percent (33.9%) identified health promoters as where they learned about maternal health, 7.5% learned from the radio, 5.7% learned from other women, and 33.9% had not heard any messages. One mother said that she learned what she knew about maternal health through a health fair competition. No mothers reported hearing messages from health skits. Three (1.3%) mothers said that they learned what they know about maternal health from pamphlets, and two (0.1%) said that they learned these health messages from television.

Discussion

Breast-Feeding

The results to the question regarding the best age to begin introducing foods other than exclusive breast milk indicates that most mothers (67%) are introducing solid foods at the right age. Of some concern, however are the 17.6% of mothers who introduce foods between 7 and 12 months. This is of concern because those children who are exclusively breast-fed until one year of age are likely to be malnourished because they are not getting the necessary nutrients normally acquired through solid foods. Of similar concern are the mothers who begin introducing foods before their children are 6 months old. These children do not get the maximum benefit of breast milk, thereby also potentially causing undernourishment and putting them at risk for future disease.

Diarrhea

Only a small percentage of mothers (23.9% or 27.3%, depending on the question used) reported continuing to give breast milk when her child has diarrhea or noted the importance of continuing breast milk when her child has diarrhea. However, since the survey did not ask if the mother is actually breastfeeding, there was no way to tabulate this for those who are breastfeeding. It does appear that the message of continued and more frequent breastfeeding during diarrhea needs to be reinforced.

One of Project *Enlace*'s goals is to increase the number of children who receive equal or more liquids when they have diarrhea from 63%, measured in the baseline survey, to 75%, by the end of the project. This rapid assessment found that 68.3% of children received equal or more liquids, demonstrating improvement in mothers' knowledge, and presumably practice, since the initiation of the project. One must be concerned about the number of mothers (4.4%) who still think that it is necessary to bring a child with diarrhea to a health center. If the child does not have grave diarrhea or serious dehydration, it is better that he/she is treated in the home so as to avoid having to travel to the health center.

Other project goals were to increase the percentage of women who know the importance of giving their child more liquids and more foods when he/she has diarrhea. In the case of more liquids, the project hopes to increase from 63% to 75%. The rapid assessment found that the percentage of mothers who know to give more liquids or liquids more frequently is only 49.3%. This health message needs to be strengthened in the last year of the project.

In addition, only 10.6% of mothers knew that giving foods in greater quantity or more frequently is important when a child has diarrhea. The project hoped to improve this behavior from 49% to 65%. It is possible that this question was asked differently in the baseline survey as compared to this rapid assessment, however such a small percentage of mothers who noted the importance of giving food and liquids during diarrhea indicates the great need for improvement in the next year of the project. It is also concerning that the 26.4% of mothers reported not knowing any important action to take when her child has diarrhea. Also of concern is the large number of mothers (16.3%) who think that cleaning the child or the house will help to treat diarrhea, although they may have interpreted the questions to be asking about prevention.

Another one of the project's goals is to reduce the use of antibiotics from 30% to 15%. The survey found that currently, 23.3% of mothers report using antibiotics to treat their child with diarrhea, so some advances with this indicator have been made during the project. The question in the final survey will be re-worded to take out those mothers using antibiotics prescribed by health personnel.

Project *Enlace* also hopes that the percentage of mothers who know at least two signs of dehydration increases from 2.5% to 60%. Through this rapid assessment, it was found that 23.3% of mothers identified two or more signs of dehydration, so there have been improvements in this area as well. Also, it seems that some mothers (8.4%) have a

misconception that a child who looks malnourished is dehydrated. Thirty-nine percent (39.2%) of mothers reported not knowing any signs of dehydration in a child with diarrhea. If a mother can not identify when a child is dehydrated, she is not apt to treat the child in her home.

Thirty-one percent (30.8%) of mothers could not identify even one sign of grave diarrhea, so mothers' knowledge needs to be greatly improved in this area. In addition, some mothers had misconceptions about dehydration (2.6%) and sunken eyes (1.8%) being danger signs in a child with diarrhea, indicating there is confusion between danger signs of severe diarrhea and those of dehydration. The concern is that if she does not recognize danger signs, she may not be apt to take a child with grave diarrhea to a health facility to get proper care.

Respiratory Infections

The project hopes to increase the number of mothers who can identify the two principal warning signs of respiratory infections from 17% to 70%. This rapid assessment instrument found that only 13.7% of mothers could identify both signals of alarm. This may be due to the interviewer not waiting long enough before moving on to the next question. It is interesting to note, however, that the percentage of each sign separately has increased dramatically since the baseline survey. In the case of rapid breathing, 16.8% of mothers identified it as a sign in the baseline survey, whereas in the rapid assessment, 49.3% identified it as a sign. In the case of indrawing of the ribs, 0.6% of mothers identified it as a sign in the baseline survey, whereas in the rapid assessment, 20.7% identified it as a sign. So some improvements have been made in the case of each message separately, but both messages need to be reinforced in a cohesive health message that incorporates all of the warning signs of respiratory infections in children. As with other health messages, mothers seem to have some misconceptions about danger signs of respiratory infections. For example, twenty-seven (12.0%) thought that a cough was a danger sign, and twenty-six (11.5%) thought that a fever was a danger sign. This is of concern because such mothers may treat their child with a simple cold with unnecessary antibiotics.

Maternal Health

One of the goals of the project is to increase the percentage of mothers who access prenatal care in a health facility from 38% to 60%. This rapid assessment indicated that 52.7% of women reported going to a health facility during their last pregnancy. This figure indicates the project's successful advance in this area.

The project also hopes to increase the percentage of mothers who believe they should go to one or more prenatal visits. The rapid assessment found that 59% of mothers know that they should go to one or more prenatal visits.

In addition, the project hopes to increase the percentage of women who can identify two danger signs during pregnancy from 5% to 60%. The rapid assessment found a level of 35.7%, so although there is more work to be done in this area, some improvements have been made with regard to mothers' knowledge. Some mothers however, do have some misconceptions about danger signs during pregnancy. For example, thirteen (5.7%) said that a bellyache was a danger sign.

Sources of Mothers' Knowledge

Health promoters and MOH personnel were the most frequent source of health messages for mothers surveyed in this rapid assessment. This seems to indicate that the Project's health promoters actively relay health messages to the mothers. It could also be possible that mothers inflated the number of responses of health promoters' influence because they were biased by being interviewed by health promoters. In addition, other women and the radio proved to be fairly important sources for health messages. When given the opportunity to note other sources of mothers' knowledge, interviewers noted the importance of both pamphlets and CARE workshops. It seems that mothers are referring to pamphlets given out in health facilities, such as health centers and hospitals, so it may be helpful to examine their use in the future. In addition, given that CARE workshops were identified to be a source of knowledge, it is clear that the project has had a fair amount of influence on women leaders in the project communities.

It is interesting to note that health fair competitions were chosen only once, and health skits were never identified by the mothers as a source of knowledge for any of the indicators. Despite the low level of recognition of these two sources, this does not mean that the project should not utilize these means of education, however it appears that the energy the health promoter put into disseminating messages directly in the communities is more effective. It is possible that health fair and skits activities with the community may have other benefits. One possibility is that it helps to increase the trust in the health promoters and MOH personnel. Qualitative research needs to be done to determine if these activities affect project goals in ways other than promoting behavior change.

Conclusion

There have been various significant accomplishments that the project has made since the baseline survey. For example, there have been great improvements in the number of mothers who know two or more signs of dehydration in a child with diarrhea, and fewer mothers are likely to give antibiotics to their child with diarrhea. In addition, the number of mothers who attend pre-natal visits in the health establishments has increased. A far greater number of mothers also have more knowledge about danger signs during pregnancy. Improvements in the project need to be made so that mothers improve the practices of giving more liquids and food to children with diarrhea. Messages about the danger signs of respiratory infections also need to be strengthened in the last year of the project.

Because this rapid assessment indicated that health promoters were one of the important sources of mothers' knowledge, it seems that they are being quite successful in disseminating messages. In addition, MOH personnel and radio messages were identified to be an important source of knowledge, so they should continue to be utilized in the last year of the project. Because the health fair competitions and the health skits did not seem to have much impact with regard to mothers' knowledge, the project should consider what benefits, if any, they might have.

Focus Groups with Fathers

Introduction

During the implementation of a rapid assessment to measure mothers' knowledge of certain Project *Enlace* health messages, project staff members implemented focus groups with fathers in communities. The purpose of the focus groups was to gain qualitative data about beliefs that fathers had concerning breast-feeding, diarrheal diseases, respiratory infections, and maternal health. By examining what fathers know, and from the source of their health knowledge, project staff can best adjust certain aspects of the project to target fathers most effectively in the last year of implementation.

Methods

For a description of how communities were selected for the rapid assessment, please see the previous report entitled, "Rapid Assessment of Mothers' Knowledge." Project staff members held a focus group with fathers in a total of five (5) communities. They invited a small group of fathers (between 4 and 8) to talk with her about what they knew about certain health behaviors. They asked them about various themes such as diarrhea, respiratory infections, maternal health, and breast-feeding, given an outline of questions. They recorded the responses in their own words. Following the data collection, the responses were examined in order to be able to learn more about fathers' knowledge and to compare the results with those of the rapid assessment of mothers' knowledge.

Results

Breast-Feeding

Like mothers in the communities where the rapid assessment was administered, fathers had a fair amount of knowledge about breast-feeding. They noted its ability to sufficiently nourish children, and to allow them to grow and gain weight. One commented that breast milk is a way to prevent dehydration (presumably during diarrhea), and some even noted the importance of colostrum. They stated that one of the advantages of breast milk is its low cost, ease in preparation, ability to protect from illness, and that it is much cleaner than a bottle. Some fathers did have some misconceptions about its processes, for example, one thought that after one year of breast-feeding, milk converts itself to blood.

Most fathers also knew a fair amount about when a mother should introduce foods other than breast milk. The majority knew that at 6 months of age, a child can begin to eat solid foods. Like some mothers, some fathers had misconceptions about when to introduce foods, and responses ranged from as early as 3 months to as late as 8 months.

The majority of fathers said that they had learned what they know about breast-feeding from radio programs. A few noted the importance of health messages received from health promoters, some learned from being fathers, and one noted the efforts of the PIRKA Project in 1998.

Diarrhea

When fathers were asked what they give their children who have diarrhea, many responded that they give tea made from avocado pits. Many also noted the importance of oral rehydration therapy (ORT), homemade ORT, breast milk, antibiotic pills, and other natural teas, such as sugar tea, oregano tea, chamomile tea, or lima bean tea. No fathers said to give children with diarrhea more food.

When project staff asked fathers what were the important things to do when a child has diarrhea, some said to go to a health center, others said to give antibiotic medicines, and others said to give ORT, homemade ORT, teas, and breast milk. So, like the mothers interviewed for the rapid assessment, fathers tended to note the importance of more liquids but not the importance of more foods.

When asked what were the signs of dehydration in children with diarrhea, fathers clearly identified the correct answers: sunken eyes, sad child, dry mouth, etc. Some were also able to correctly identify the signs of grave diarrhea, such as high fever and abundant diarrhea.

The majority of fathers identified the radio as the source for their knowledge about diarrheal diseases. A few said that the health promoter was responsible for their knowledge.

Respiratory Infections

Many fathers were able to identify one or both of the signs of alarm of a respiratory infection in a child. Some did have some misconceptions about danger signs, however. For example, one said that folding (*pliegue*) of the skin was one danger sign, and others said that fever and cough were danger signs.

Most fathers noted that they learned what they knew about respiratory infections through the health promoters. Others learned from radio programs, others through conversations with neighbors and their wives. One said that he learned from a water project recently operating in his community.

Maternal Health

Many fathers said that a pregnant woman should visit the health center monthly for her prenatal visits. Others said that after the fifth or sixth month, monthly prenatal visits were necessary. Another said that three times during the pregnancy was sufficient, and

one did not know. So, it seems that fathers responded somewhat like their wives in this regard, but one must question how many times, if at all, their wives would visit the health center for her prenatal visit.

Like mothers, fathers seemed to have a fair amount of knowledge of danger signs during pregnancy. Many said swelling of the extremities, others said heavy bleeding, and others said headaches or nausea. One incorrectly stated buzzing in the ears, and another said lack of appetite.

The majority of fathers have learned what they know about maternal health from health promoters. Some also noted that they learned things from radio programs, and another noted Project PIRKA.

Conclusion

It seems that the majority of fathers have about the same level of knowledge that the mothers do. Quantitative research would need to be done with fathers to examine the degree to which they know the health messages in comparison to the mothers. The most interesting finding in these focus groups was the importance of the radio. In some cases, the radio seemed to be the most frequently stated source for knowledge. It is possible that fathers more than mothers are apt to listen to the radio and therefore gather information about health through that means. The next common response was health promoters, so it is clear that these two aspects of the project are very successful in disseminating health messages.

Annex 1

APROMSA MINSA CARE

Encuesta Rápida

Agosto, 1999

ID # _____
Nombre de Encuestador(a) _____

Nombre de Comunidad _____

Nombre de Establecimiento de Salud _____

Nombre de Micro Red _____

LAS SIGUIENTES PREGUNTAS SON PARA LAS MADRES DE NIÑOS MENORES DE DOS AÑOS (24 MESES) VERIFICA PRIMERO QUE LA FAMILIA DE LA VIVIENDA VISITADA TIENE UN NIÑO O NIÑA MENOR DE DOS AÑOS (NACIDO DESPUES DEL 24 DE AGOSTO DE 1997) SALUDA A LA MADRE CORDIALMENTE E IDENTIFICATE A NOMBRE DE APROMSA MINSA Y CARE SOLICITA EL CONSENTIMIENTO INFORMADO DE LA MADRE AVISANDOLA QUE NO ESTA BAJO NINGUNA OBLIGACION DE CONTESTAR INCLUSO PUEDE NEGAR A CONTESTAR CUALQUIER PREGUNTA DESPUES DE PERMITIR LA ENTREVISTA LO QUE DIGA NO LE AFECTARA EN CUANTO A LOS SERVICIOS DE SALUD QUE RECIBE DEL MINSA Y DEL PROMOTOR

1 Nombre y edad de la madre

Nombre _____

Edad (años) _____

2 Nombre y edad del ultimo niño menor de 2 años

Nombre _____

Edad (meses) _____ Fecha de Nacimiento _____

VERIFICA LA EDAD CON SU CARNET DE VACUNACION O PAPELETA DE NACIMIENTO

LACTANCIA MATERNA

3 ¿Esta dando de mamar a (nombre del niño)?

a Si [] → PASA A LA PREGUNTA 5

b No []

1 ¿Le ha dado alguna vez de mamar a (nombre del niño)?

- a Si []
- b No []

1 ¿A qué edad empieza Ud a dar otros alimentos además de la lactancia materna?

- a No sabe []
- b Antes de los 4 meses []
- c Entre los 4 y 5 meses []
- d Alrededor de los 6 meses []
- e Entre los 7 y 12 meses []
- f Después de los 12 meses []

1 ¿Como aprendio Ud lo que sabe sobre la lactancia materna?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No ha escuchado ningun mensaje []
- b Promotor de salud []
- c Personal de salud []
- d La radio []
- e Arte en salud []
- f Tómbola []
- g Otras mujeres []
- h Otros (ESPECIFICA) _____ []

DIARREA

1 Cuando (*nombre del niño*) tiene diarrea, ¿qué le da?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a Nada []
- b Leche del pecho []
- c Sales de rehidratación oral []
- d Solución de agua y sal (suero casero) []
- e Panetelas []
- f Líquidos aguitas, infusiones o calditos []
- g Medicinas anti-diarreicas o antibióticos []
- h Otros (ESPECIFICA) _____ []

1 ¿Cómo sabe Ud que su niño con diarrea está deshidratado?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No sabe []
- b Boca seca []
- c Ojos hundidos []
- d Mollera hundida []
- e Orina poco []
- f Pliegue de la piel []
- g Débil, deprimido, o desganado []
- h Otros (ESPECIFICA) _____ []

1 ¿Sabe que señales de gravedad haría que Ud lleve a su hijo con diarrea a un establecimiento de salud?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No sabe []
- b Vomitos []
- c Fiebre []
- d Diarrea por mas de 14 días []
- e Sangre en las heces []
- f No come, no mama []
- g Otros (ESPECIFICA) _____ []

1 ¿Sabe que cosas importantes debe hacer una madre en su casa cuando su niño tiene diarrea?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No sabe []
- b Continuar con la lactancia materna []
- c Iniciar con liquidos lo mas pronto posible []
- d Dar al niño mas liquidos de los usual []
- e Dar alimentos con mas frecuencia y menor cantidad []
- f Preparar y administrar suero correctamente []
- g Alimentar mas al niño despues de la diarrea,
de manera que recupere el peso []
- a Otros (ESPECIFICA) _____ []

1 ¿Como aprendio Ud lo que sabe sobre la diarrea?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No ha escuchado ningun mensaje []
- b Promotor de salud []
- c Personal de salud []
- d La radio []
- e Arte en salud []
- f Tómbola []
- g Otras mujeres []
- h Otros (ESPECIFICA) _____ []

INFECCIONES RESPIRATORIAS

1 ¿Conoce Ud algunas señales de peligro de una enfermedad respiratoria en un niño?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No sabe []
- b Respiracion rapida y agitada []
- c Hundimiento de piel debajo de las costillas []
- d Otros (ESPECIFICA) _____ []

1 ¿Cómo aprendió Ud lo que sabe sobre las infecciones respiratorias?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No ha escuchado ningun mensaje []
- b Promotor de salud []
- c Personal de salud []
- d La radio []
- e Arte en salud []
- f Tómbola []
- g Otras mujeres []
- h Otros (ESPECIFICA) _____ []

SALUD MATERNA

1 En su ultimo embarazo, ¿se controló Ud en un establecimiento de salud?

- a Si [] → PIDE QUE TE MUESTRE EL CARNET PERINATAL
- b No [] → PASA A LA PREGUNTA 16

1 VERIFICA EN SU CARNET DE CONTROL DE EMBARAZO SI LA MADRE ACUDIO A SUS
CONTROLES PRENATALES SI HA PERDIDO SU CARENET ANOTALO

- a Ninguno []
- b Uno []
- c Dos a tres []
- d Cuatro o mas []

1 ¿Sabe Ud cuantas veces debe controlar su embarazo una mujer?

- a No sabe []
- b Ninguno []
- c Uno []
- d Dos a tres []
- e Cuatro o más []

1 ¿Sabe Ud cuáles son las señales de peligro que obliga a una mujer buscar ayuda en un establecimiento
de salud durante su embarazo?

(PUEDES MARCAR MAS DE UNA RESPUESTA)

- a No sabe []
- b Hemorragia vaginal (sangrado) []
- c Pérdida de liquido de la vagina []
- d Fiebre []
- e Dolor de cabeza intenso []
- f Vómitos exagerados []
- g El niño no se mueve []
- h Hinchazón u opilacion en las extremidades []
- i Otros (ESPECIFICA) _____ []

1 ¿Como aprendio Ud lo que sabe sobre la salud materna?
(PUEDES MARCAR MAS DE UNA RESPUESTA)

- | | | |
|---|--------------------------------|-----|
| a | No ha escuchado ningun mensaje | [] |
| b | Promotor de salud | [] |
| c | Personal de salud | [] |
| d | La radio | [] |
| e | Arte en salud | [] |
| f | Tombola | [] |
| g | Otras mujeres | [] |
| h | Otros (ESPECIFICA) _____ | [] |

CHEQUEA QUE TODAS LAS RESPUESTAS ESTEN COMPLETAS TERMINA LA ENTREVISTA
CON LA MADRE AGRADECE Y DESPIDETE CORTESMENTE

UNA VEZ FUERA DE LA CASA ESCRIBE TU NOMBRE EN LETRAS MAYUSCULAS Y FIRMA EN
LA LINEA INDICADA

¡GRACIAS! ☺

YO HE COMPLETADO LA ENTREVISTA BAJO LOS PROCEDIMIENTOS APROBADOS Y HE
REGISTRADO CORRECTAMENTE Y FIELMENTE LAS RESPUESTAS DE LA MADRE LO MEJOR
POSIBLE

Nombre Encuestador(a) (letras de molde)

Firma Encuestador(a)

Annex 2

	Esperado	Total	Julcan	Agallpampa	R Castilla	Usquil
Lactancia Materna						
Freq de la edad de ablactancia						
*6 meses		67%	72 60%	71 80%	62 10%	61 20%
*Entre 4 y 5 meses		8%				
*Entre 7 y 12 meses		18%				
Freq de fuentes de los mensajes sobre LM						
*no ha escuchado		23 80%	30 10%	10 30%	16 70%	34 70%
*promotor		40 50%	43 80%	66 70%	30 30%	28 60%
*personal de salud		44 10%	41 10%	69 20%	36 40%	38 80%
*la radio		5 70%	1 40%	10 30%	7 60%	6 10%
*arte en salud		0%	0%	0%	0%	0%
*tombola		0%	0%	0%	0%	0%
*otras mujeres		14 10%	6 80%	5 10%	21 20%	22 40%
Diarrea						
Freq de niños que reciben leche cuando EDA		23 90%				
Freq de madres que saben imp de dar leche		27 30%				
Freq de niños que reciben igual o mas liq	63% 75%	68 30%	79 50%	79 50%	63 60%	50 00%
Freq de niños que reciben igual o mas liq						
*leche del pecho		22 50%	24 70%	28 20%	21 20%	16 30%
*sales de rehidratacion		19 80%	37 00%	28 20%	7 60%	4 10%
*suero casero		15 90%	19 20%	25 60%	12 10%	8 20%
*panetelas		7 50%	9 60%	23 10%	1 50%	0%
*liquidos		31 30%	31 50%	23 10%	37 90%	28 60%
Freq de madres que dan medicinas antibioticas	30% 15%	23 30%	8 20%	12 80%	28 80%	46 90%
Freq de madres que saben 2 o + cosas imp		18 50%	20 50%	30 80%	15 20%	10 20%
Freq de madres que saben dar mas liquidos	63%-75%	49 30%	47 90%	64 10%	53 00%	34 70%
*continuar con lactancia		25 10%	31 50%	41%	19 70%	10 20%
*iniciar liquidos pronto		17 60%	13 70%	23 10%	24 20%	10 20%
*dar al niño mas liquidos		10 60%	8 20%	17 90%	10 60%	8 20%
Freq de madres que saben dar mas alimentos	49% 65%	10 60%	4 10%	10 30%	16 70%	12 20%
*alimentar con mas frecuencia		8 40%	5 50%	10 30%	9 10%	10 20%
*dar mas alimentacion		5 70%	2 70%	10 30%	7 60%	4 10%
Freq de madres que saben cosas imp						
*continuar con lactancia		25 10%	31 50%	41%	19 70%	10 20%
*iniciar liquidos pronto		17 60%	13 70%	23 10%	24 20%	10 20%
*dar al niño mas liquidos		10 60%	8 20%	17 90%	10 60%	8 20%
*alimentar con mas frecuencia		5 70%	2 70%	10 30%	7 60%	4 10%
*administrar suero		8 40%	9 60%	10 30%	6 10%	8 20%
*alimentar para recuperar peso		8 40%	5 50%	10 30%	9 10%	10 20%
Freq de madres que no saben cosas imp		26 40%	21 90%	15 40%	28 80%	38 80%
Freq de madres que saben 2 o mas sig de desh	2 5% 60%	23 30%	23 30%	46 10%	12 10%	20 40%

Freq de madres que saben signos de desh						
*boca seca		19 40%	17 80%	43 60%	13 60%	10 20%
*ojos hundidos		24 20%	30 10%	46 20%	10 60%	16 30%
*mollera hundida		2 20%	5 50%	2 60%	0%	0%
*orina poco		4 80%	9 60%	5 10%	1 50%	2%
*pliegue de la piel		7 90%	9 60%	17 90%	3 00%	4 10%
*debil deprimido		23 80%	9 60%	23 10%	31 80%	34 70%
Freq de madres que no saben signos de desh		39 20%	37 00%	20 50%	42 40%	53 10%
Freq de madr que saben 2 o mas sig de EDA gr		19 80%	12 30%	41 00%	19 70%	14 30%
Freq de madres que saben signos de EDA gr						
*vomitos		15 90%	15 10%	28 20%	10 60%	14 30%
*fiebre		20 30%	17 80%	30 80%	21 20%	14 30%
*diarrea prolongada		11 50%	4 10%	25 60%	15 20%	6 10%
*sangre en la heces		10 10%	6 80%	17 90%	7 60%	12 20%
Freq de madres que no saben sig de EDA grave		30 80%	28 80%	23 10%	27 30%	44 90%
Freq de las fuentes de mensajes sobre EDAs						
*no ha escuchado		27 30%	23 30%	10 30%	27 30%	46 90%
*promotor		41 00%	47 90%	71 80%	28 80%	22 40%
*personal de salud		38 80%	32 90%	64 10%	36 40%	30 60%
*la radio		5 70%	1 40%	5 10%	13 60%	2%
*arte en salud		0%	0%	0%	0%	0%
*tombola		0%	0%	0%	0%	0%
*otras mujeres		10 60%	11 00%	7 70%	6 10%	18 40%
Infecciones Respiratorias						
Freq de madres que saben 2 senales de IRAs	17% 70%	13 70%	19 20%	25 60%	7 60%	4 10%
Freq de madres que saben senales de IRAs						
*respiracion rapida		49 30%	49 30%	71 80%	34 80%	51%
*hundimiento de la piel		20 70%	27 40%	30 80%	18 20%	6 10%
Freq de madres que no saben senales de IRAs		32 60%	31 50%	12 80%	45 50%	32 70%
Freq de las fuentes de los mensajes de IRAs						
*no ha escuchado		31 70%	26 00%	7 70%	43 90%	42 90%
*promotor		40 50%	46 60%	69 20%	25 80%	28 60%
*personal de salud		35 20%	35 60%	64 10%	28 80%	20 40%
*la radio		11 00%	6 80%	17 90%	10 60%	12 20%
*arte en salud		0%	0%	0%	0%	0%
*tombola		0%	0%	0%	0%	0%
*otras mujeres		4 80%	4 10%	0%	6 10%	8 20%
Salud Materna						
Freq de madres que se controlaron en P/S	38% 60%	52 70%	52 10%	68 40%	54 50%	38 80%
Freq de madres que fueron a 1 o mas contr		97 60%				
Freq de madres que fueron a controles						
*ninguno		2 40%	0%	10 50%	0%	0%
*uno		17 60%	16 70%	10 50%	14 30%	33 30%
*dos a tres		25 90%	23 30%	15 80%	38 10%	26 70%
*cuatro o mas		54 10%	60%	63 20%	47 60%	40%

Freq de madres que creen que deben de ir a 1 o +	38% 60%	59 00%				
Freq de madres que creen que deben de ir a P/S						
*no sabe		41 00%	38 40%	10 30%	47%	61 20%
*uno		0 90%	0%	5 10%	0%	0%
*dos a tres		7 00%	8 20%	10 30%	3%	8 20%
*cuatro o mas		51 10%	53 40%	74 40%	50%	30 60%
Freq de madres que saben y tambien fueron		49 30%				
Freq de madres que saben 2 o mas sen de pel	5% 60%	35 70%	35 60%	64 10%	28 80%	22 50%
Freq de madres que saben senales de peligro						
*hemorragia		28 60%	30 10%	38 50%	28 80%	18 40%
*perdida de liquido		14 10%	19 20%	23 10%	6 10%	10 20%
*fiebre		8 80%	11 00%	12 80%	7 60%	4 10%
*dolor de cabeza		26 00%	28 80%	43 60%	19 70%	16 30%
*vomitos exagerados		22 00%	27 40%	38 50%	9 10%	18 40%
*nino no se mueve		6 20%	2 70%	12 80%	7 60%	4 10%
*hinchazon		18 90%	21 90%	33 30%	16 70%	6 10%
*no sabe		38 30%	37 00%	12 80%	39 40%	59 20%
Freq de las fuentes de mensajes sobre SM						
*no ha escuchado		33 90%	28 80%	15 40%	30 30%	61 20%
*promotor		33 90%	38 40%	61 50%	24 20%	18 40%
*personal de salud		41 00%	41 10%	66 70%	37 90%	24 50%
*la radio		7 50%	2 70%	7 70%	13 60%	6 10%
*arte en salud		0%	0%	0%	0%	0%
*tombola		0%	0%	2 60%	0%	0%
*otras mujeres		5 70%	4 10%	10 30%	3%	8 20%

Annex 3

Mothers' responses to Rapid Assessment of Knowledge and Practices			
	Current	Baseline	Target
% of mothers who know the correct age to introduce foods	67	-	-
% of mothers who give equal or more liquids	68	63	75
% of mothers who give antibiotics for diarrhea	23	30	15
% of mothers who identify 2 or more signs of dehydration	23	25	60
% of mothers who identify 2 or more signs of severe diarrhea	20	-	-
% of mothers who identify 2 or more signs of pneumonia	14	17	70
% of women seeking prenatal care per card	53	38	60
% of women who know to get at least 1 prenatal visit	59	38	60
% of women who know 2 or more danger signs of pregnancy	36	5	60
% of mothers who know to give more liquids or liquids more frequently when child has diarrhea	50	63	75
% of mothers who know that giving foods in greater quantity or more frequently is important when a child has diarrhea	11	49	65