PN-ABC-011

PARTICIPATION IN PVO CHILD SURVIVAL COUNTRY WORKSHOP

USAID/La Paz

September 9 - 19,1987

Resources for Child Health Project

REACH

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AID Contract No.: DPE-5927-C-00-5068-00

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ACKNOWLEDGEMENTS

The writer expresses his appreciation first and foremost to the Workshop participants, and to the national and international resource persons with whom a mutually beneficial two-way dialogue was established. Credit for establishing an effective learning environment goes to Dr. Dory Storms, PVO Child Survival Support Program Coordinator, with able logistic assistance from Ms. Beverly Tucker, Workshop Course Coordinator, and Planning Assistance (Bolivia). Mr. Paul Hartenberger, Deputy Director, Health and Human Services, USAID/Bolivia, was especially helpful and considerate in facilitating this consultancy.

ACRONYMS

CS	Child Survival
EPI	Expanded Program on Immunization
FVA/PVC	Food For Peace and Voluntary Assistance/Private Voluntary Cooperation
MPSSP	Ministerio De Prevision Social and Salud Publica
PVO	Private Voluntary Organization
SOW	Scope of Work

I. EXECUTIVE SUMMARY

FVA/PVC through S&T/H requested REACH technical assistance for a PVO Child Survival Bolivia Country Workshop, hosted by USAID with the cooperation of Planning Assistance (Bolivia), September 15-18 at Lake Titicaca. The purpose of the consultancy was to serve as a resource person at the Workshop for the plenary and special interest sessions on monitoring and evaluation of immunization activities at the community level. In addition to planning and presenting some six hours of technical discussions, the writer also participated in pre-Workshop planning and lesson preparation in La Paz from September 10-14 and post-Workshop evaluation on September 19 in La Paz. This trip report provides background information and the output of the writer's involvement at the Workshop.

Key Findings:

1. The Workshop was a success due to careful planning and to the hard work of the participants/resource persons/ organizers alike.

2. PVO CS project staff are thirsty for technical knowledge of practical use and have identified topics within the field of immunization in which they require further technical assistance.

3. The collection and analysis of data for action, monitoring and evaluation must be a routine part of effective program management.

4. AID'S Tier I reporting requirements are the basic minimum and do not substitute for each project's own daily routine monitoring and periodic evaluation for improving program management and implementation.

5. The needs and resources of PVOs vary considerably from one to another and frequently differ, as well, from those of the MPSSP.

6. Possibly as a result of Workshop discussions, key individuals within the MPSSP have expressed an interest in conducting a neonatal tetanus survey and have already begun planning for the first time to conduct extensive coverage evaluation surveys in late October after the next urban immunization campaign.

Key Recommendations

1. FVA/PVC, together with the Missions, should consider replicating such Workshops in other individual countries with large numbers of CS grants. REACH is ready to assist in providing technical assistance, as required.

2. PVOs with CS grants expressed an interest in further technical assistance. The Mission in collaboration with a newly-formed rotating PVO Executive Committee may wish to access technical assistance through appropriate funding mechanisms. Again, REACH is prepared to provide technical assistance, as required.

3. Various key individuals within the MPSSP (including the Director General of Health and the National Director of Epidemiology) have expressed an interest in conducting a neonatal tetanus survey in April 1988 and in coverage evaluation surveys, now scheduled for the end of October after the next urban immunization campaign. The Mission should pursue these worthwhile initiatives with funds and, in the case of the neonatal tetanus mortality survey, with technical assistance. REACH can assist, if requested.

4. Workshop organizers should collaborate well in advance of the Workshop as closely as possible, given the constraints, with the designated resource people in the formulation of resource materials to be used at the Workshop.

5. As much as possible, resource persons should use local data, forms, and procedures during presentations and should keep presentations field-oriented and practical.

II. PURPOSE OF VISIT

The SOW for the consultancy, excerpted and summarized from a memorandum dated July 31, 1987 from FVA/PVC to S&T/H, was as follows:

- collaborate in pre-Workshop planning and post-Workshop evaluation and assist in preparing brief report of lessons learned and recommendations for future Workshops for submission to FVA/PVC;

- organize Workshop session on monitoring and evaluation of immunization activities at Bolivian community level;

- review with PVO staff current and suggested recording, monitoring and evaluation methods;

- assist PVO staff to evaluate and strengthen cold chain practices and delivery strategies;

- assist PVOs to identify actions which could strengthen MOH/EPI ability to conduct regularly scheduled as well as pulse immunization services.

This particular SOW fit into the overall objectives of the Bolivia CS Project Monitoring and Evaluation Workshop. The themes, objectives, and expected outcomes of the Workshop appear in Appendix I.

III. BACKGROUND

Cooperation between the Johns Hopkins University and S&T/H, who had deputed REACH consult nt Dr. Mary Carnell, led to the development in early 1987 of general workshop guidelines based on an assessment of PVO CS project needs. The framework of the current Bolivia Workshop flows from this earlier work and follows similar workshops conducted in Africa.

The eight PVOs in Bolivia with 1985, 1986, and 1987 CS grants had specifically requested that this workshop focus on monitoring an evaluation. The Workshop was to serve as a forum for field staff from

different PVOs with different years of funding (CSI, CSII, CSIII) to exchange ideas and experiences.

Most of the PVOs include immunization to under-fives as part of their CS interventions. A majority deliver childhood immunizations themselves, as well as assisting the MPSSP to do so. Few of the PVOs deliver TT immunization to either pregnant or fertile-aged women. Some additionally delivery yellow fever vaccination. According to a questionnaire filled in at the Workshop, approximately 60,000 under-fives reside in the EPI-operational areas of the PVOs, constituting approximately 5% of the estimated 1.1 million under-fives in the country.

Vaccines are exclusively obtained from the MPSSP. Some PVOs provide immunizations all year round, while others are active only during the periodic campaigns. Many of the PVOs have estimated coverage levels based on tally data. DPT3 coverage ranges from 50% to 90%. Coverage surveys have not been done by the PVOs nor by the MPSSP.

All the PVOs engage in EPI training of various cadres, including nurses, nutrition and nursing auxiliaries, supervisors, and both paid promotors and voluntary community workers. A variety of methods and forums are employed for providing health education and information. These include: flipcharts, AV media, demonstrations, market places, mothers groups, house to house visits, training of trainers, socio-drama, puppets, games, adolescent groups, etc.

EPI target disease data are collected and analyzed by a few of the PVOs.

IV. TRIP ACTIVITIES

The writer participated in La Paz and Lake Titicaca at pre-planning sessions for the Workshop. At the Workshop itself, he prepared and presented in plenary the lesson on Monitoring Immunization Activities and Determining Coverage. He also served as the resource person in small group special sessions on "Monitoring the EPI Cold Chain, and AIDS" and "EPI Evaluation Methods, Including Coverage Surveys and Epidemiological Surveillance". He was also consulted by individual PVOs on specific areas of concern, including cold chain, delivery strategies, monitoring and evaluating routine data, surveys, epidemiological appropriateness of immunization schedules, etc.

V. METHODS

The writer reviewed the plethora of resource documents on immunization which the Workshop organizers had brought and locally made photocopies of the more appropriate materials he had brought himself. He prepared a short list (Appendix II) for future Workshops of the most appropriate materials for distribution concerning monitoring and evaluation of immunization activities.

The plenary session on "Monitoring Immunization Activities and Determining Coverage" lasted two and one half hours on day number two of the Workshop. Its objective was to present information on:

- Which information do we need?
- How to use routine data and surveys for program management and action?
- Data recording and techniques of monitoring and evaluation.

Responding to the expressed needs of the participants at the close of day number one, the presentation focused on practical and simple methods of monitoring and evaluation, using concrete field-oriented examples. One approach worked particularly well to demonstrate the potential value of information routinely collected at the immunization sessions. A sample filled-in immunization register page was distributed and participants in small groups, playing the role of supervisors, were asked to review the register. Many missed immunization opportunities, including possible unfamiliarity with or failure to follow sound Government policies, were illustrated. Areas for needed action were then identified.

Other sample MPSSP and WHO prototype forms, cards, and graphs were also distributed, as were recently-revised MPSSP immunization schedules. The outline of this plenary presentation appears on Appendix III.

A complete set of the six hand-outs used during the presentation appears in Appendix IV. In addition, flipcharts were prepared in advance, one of which appears as Appendix V.

An optional reading assignment for the participants in preparation for this plenary session included:

- Foster, Stan, "The Epidemiology of Non-Immunization", EPI Newsletter, PAHO, October 1986. (2 pages) (available in Spanish and English)

- Modulo V: Evaluacion del P.A.I., from Taller sobre Planificacion, Administracion, y Evaluacion, PAHO/WHO. (pages 1-15, available in Spanish only)

The module Evaluate Vaccination Coverage from the WHO EPI Mid-Level Managers Course was distributed to each PVO.

The teaching method used in the two small group special sessions, each of one and three quarters hours duration on day number three, was to present brief explanations about when and how to use certain monitoring and evaluation techniques. Most of the sessions were then devoted to questions and answers so as to meet the concerns of individual participants. No hand-outs were circulated at these small sessions. The discussion points were listed on flipcharts and shared with the larger group in plenary sessions.

VI. RESULTS/CONCLUSIONS

The previous section on methods explained how the objectives and tasks given in the SOW were carried out.

Monitoring and evaluation must be a routine part of program management to improve implementation and guide future action. An information system is needed to measure whether program objectives and targets are being met. The information thus generated should be of practical use locally to enhance staff motivation and to encourage its continued collection.

The plenary session on "Monitoring Immunization Activities and Determining Coverage" filled a very real need and expressed desire for practical techniques using concrete examples.

The needs and resources of PVOs vary considerably from one to another and frequently may differ, as well, from those of the MPSSP. Some PVOs are able to track children in limited service delivery areas by means of computerized MIS. The MPSSP has a continuing need to receive regular statistical reports from PVOs in the proscribed MPSSP format.

The participants freely exchanged their experiences. The session benefited also from inputs from representatives of the MPSSP, UNICEF, and PAHO. Discussion was animated and enjoyable.

It is clear that AID's reporting requirements are the basic minimum and cannot substitute for daily routine monitoring and periodic evaluation for improved program management and implementation.

The Workshop in general was a success due to the hard work and interest of the participants and resource persons/organizers.

Many of the PVOs expressed a need for continuing technical assistance in areas of planning/administration, monitoring/evaluation, cold chain, and particularly in health care financing. Individual short sessions were arranged at the Workshop itself and also during this writer's stay during the following week.

Possibly as a result of the Workshop, there is an interest on the part of key individuals in the MPSSP to conduct a neonatal tetanus mortality survey and coverage evaluation surveys, none of which have been done before. Evaluation of the impact of neonatal tetanus in the Americas was recommended by the Fourth Meeting of the EPI Technical Advisory Group on Eradication of Poliomyelitis in the Americas, in April 1987. The coverage evaluation surveys will be done in MPSSP administrative areas to permit a comparison between reported and surveyed data. Although routine health services statistics are incomplete, the National Director of Epidemiology reports that, according to civil registries, five percent of all perinatal mortality is due to neonatal tetanus and that this figure rises to twenty percent in some areas.

The only short-term measurement possible of this writer's role as a resource person (apart form the new-found MPSSP interest in conducting surveys) is the feedback obtained at the Workshop's conclusion. Each participant filled an evaluation form and rated the various sessions on a scale of 0 (worst) to 10 (best). The average scores for the three sessions presented by the writer were:

		score
- plenary:	Monitoring Immunization Activities and Determining Coverage	8.9
- special session:	Monitoring the EPI Cold Chain, and AIDS	10.0
- special session:	EPI Evaluation Methods, Including Coverage Surveys and Epidemiological Surveillance	8.7

VII. FOLLOW-UP ACTION REQUIRED

1. Ensure that funds are identified to support the MPSSP in their plan to conduct coverage evaluation surveys for the first time.

2. Identify funds and technical assistance to support the MPSSP in conducting a crucial neonatal tetanus survey in April 1988 in the eastern area of Bolivia.

VIII. RECOMMENDATIONS

1. FVA/PVC, together with the Missions, should consider replicating such Workshops in other individual countries with large numbers of CS grants. REACH is ready to assist in providing technical assistance, as required.

2. PVOs with CS grants expressed an interest in further technical assistance. The Mission in collaboration with a newly-formed rotating PVO Executive Committee may wish to access technical assistance through appropriate funding mechanisms. Again, REACH is prepared to provide technical assistance, as required.

3. Various key individuals within MPSSP (including the Director General of Health and the National Director of Epidemiology) have expressed an interest in conducting a neonatal tetanus survey in April 1988 and in coverage evaluation surveys, now scheduled for the end of October after the next urban immunization campaign. The Mission should pursue these worthwhile initiatives with funds and, in the case of the neonatal tetanus mortality survey, with technical assistance. REACH can assist, if requested.

4. Workshop organizers should collaborate well in advance of the Workshop as closely as possible, given the constraints, with the designated resource people in the formulation of resource materials to be used at the Workshop.

5. As much as possible, resource persons should use local data, forms, and procedures during presentations and should keep presentations field-oriented and practical.

APPENDIX 1

BOLIVIA CHILD SURVIVAL PROJECT MONITORING AND EVALUATION WORKSHOP

September 15-18, 1987

WORKSHOP THEMES, OBJECTIVES, AND EXPECTED OUTCOMES

THEMES:

- To provide PVO field staff with useful techniques for monitoring, reporting, and evaluating Child Survival interventions in Bolivia.

- To facilitate collaboration among PVOs, Government health authorities, and other bi-lateral and multi-lateral agencies working in Child Survival in Bolivia.

OBJECTIVES:

A. To discuss uses of health information in management decision making.

B. To provide the opportunity for participants to discuss the design of their respective project Health Information Systems (HIS) and to share strategies to achieve a smooth functioning HIS.

C. To provide the opportunity for participants to share some pragmatic lessons learned in conducting baseline surveys, monitoring project implementation, and mid-term evaluation of process and effectiveness.

D. To present participants with current methodological standards for assessing coverage and effectiveness of the key child survival program components: immunization and oral rehydration therapy.

   Information will be presented on how to carry out nutrition surveillance, and growth monitoring.

   Approaches to assessing interventions directed towards Vitamin A deficiency and acute respiratory infections will also be covered.

E. To clarify AID's revised CS Reporting Schedule and other reporting requirements.

F. To present resources to participants for other components integral to the health of mothers and children, e.g. birth-spacing, potable water systems.

EXPECTED OUTCOMES:

A. To identify concrete actions to be taken in next 90 days by each PVO project to improve project monitoring and evaluation.

B. To develop a consensus on follow up activities to be taken at the country level to increase effectiveness of CS interventions, e.g.

- Subsequent workshops
- Special monitoring and evaluation activities
- Collaboration with key Government and multilateral health agencies
- Technical Assistance follow up

APPENDIX II

RESOURCE MATERIALS ON EPI MONITORING AND EVALUATION

The following documents are the most appropriate concerning monitoring and evaluating immunization programs:

a) Module: "Evaluate Vaccination Coverage" from WHO EPI Mid-Level Managers Course, Geneva. (available in English and French)

b) Document from WHO used in Indonesia (EPI/I8/445/3) available from WHO South-East Asia Regional Office, New Delhi, in English only. (Note: a very good similar type document combining EPI and CDD surveys is also available from SEARO). These documents provide operational instructions for conducting coverage evaluation surveys.

c) Evaluation and Monitoring of National Immunization Programmes, WHO, Geneva. (available in English and French)

d) Modulo V: Evaluacion del P.A.I., Taller sobre Planificacion, Administracion, y Evaluacion, PAHO, Washington. (available in Spanish only).

e) Foster, Stan, "The Epidemiology of Non-Vaccination", EPI Newsletter, PAHO, October 1986. (available in Spanish and English).

f) Foster, Stan, "Evaluation of Immunization Services", EPI Newsletter, PAHO, October 1984. (available in Spanish and English).

APPENDIX III (a)

IMMUNIZATION PRESENTATION OUTLINE

SESSION:

Monitoring Immunization Activities and Determining Coverage.
(presented by Mr. Robert Steinglass)

THEMES:

- What information do we need?
- How do we use routine survey data for program management and action?
- Data recording and monitoring/evaluation techniques.

I. Some differences between the medical/curative model and the public health preventive model concerning evaluation.

- Recovery or death of the individual
- Impact frequently unknown for the community.

II. Importance of EPI.

- Relevance - the number of deaths in unimmunized populations.
- Progress - coverage in Bolivia.
- Impact - Reduction of incidence in Bolivia.

III. Monitoring and Evaluation.

- Collection and analysis of information for action.
- Must be a part of routine management for program improvement.
- An information system is necessary to measure progress towards objectives and targets.

IV. Uses of data routinely collected at immunization sessions.

(Needs and resources of Ministry of Health and PVO's may differ.

a) Monitoring/Supervision for action

- all required immunizations given appropriate to age?
- missed measles immunization opportunities?
- too many older children versus infants?
- intervals too long between visits?

b) Service Delivery

- tracing defaulters.
- documentation in case card lost.

c) Management

- calculating vaccine required on next visit or session.

d) Monitoring/Evaluation for action

- access: $\frac{\text{annual no. BCG in infants}}{\text{eligible infant population (= no. newborn)}}$

- completion: $\frac{\text{annual no. DPT 3 in infants}}{\text{eligible infant population (newborns)}}$

- drop-out: $\frac{\text{annual no. of DPT 1-DPT 3 in infants}}{\text{annual no. of DPT 1 in infants}}$

- Progress: every quarter, compare no. of infant DPT 3, BCG, measles (and TT 2 for women) against annual no. of eligibles.

(Local consolidation and analysis of data encourages continuous accurate data collection and enhances staff motivation).

V. Special considerations for data recording during campaigns.

- continue using routine records to permit later follow-up.
- community members to assist.

VI. Frequent Areas of Confusion in Data Collection, Reporting, and Analysis.

- age not broken down (0-11, 12-23, 24+ months)
- percent of target achieved is reported. Should be percent of eligible population.
- DPT, Polio, TT not reported by dose.
- infant eligible population for measles immunization considered to be 1/4 of that for DPT/Polio/BCG. Should be same as for DPT.

VII. Limitations of routine data for evaluation of impact.

- absent, incomplete, doubtful data.
- output (no. of immunizations) does not predict impact (reduced incidence)
- cold chain problems?
- inappropriate dose and age of immunization?
- vaccine efficacy?
- child already had the disease?

VIII. Other Evaluation Techniques (to be fully discussed in later session)

a) Immunization Coverage Evaluation Surveys

1) - 7 children 12-23 mos. old in 30 clusters
   - 2 weeks for 2 teams
   - gives percent fully immunized
   - gives information about why the child was not fully immunized
   - questions on other subjects can be asked at same time

2) - children 12-23 months old in 100 houses nearest health center

b) Analysis of health center's records for missed measles immunization opportunities.

- 2 hours
- especially useful if measles incidence in infants is high
- example of data from Bhutan

c) Cold chain monitoring and evaluation

- 6 months using indicators
- identify chronically weak links in cold chain

d) Knowledge, attitude, practice survey of mothers leaving immunization session

- 30 minutes (example in Appendix V)
- do if coverage is low or drop-out rate is high

e) Disease surveillance

- routine or sentinel
- measures incidence trends, seasonality

APPENDIX III(b)

SEMINARIO DE CONTROL Y EVALUACION DE PROYECTOS DE "CHILD SURVIVAL"

BOLIVIA, 15 - 18 DE SEPTIEMBRE DE 1987

Sesión: CONTROL DE LAS ACTIVIDADES DE INMUNIZACION Y DETERMINACION DE LA COBERTURA

(Presentado por Sr. Robert Steinglass, REACH)

TEMAS:

1. Qué información necesitamos
2. Cómo utilizar datos rutinarios y de encuestas para manejo y acción del programa.
3. Registro de datos y técnicas de monitoreo y evaluación

I. Algunas diferencias entre el modelo médico/curativo y el de la salud pública/preventiva, respecto a la evaluación:

- recuperación o muerte del individuo
- impacto frecuentemente desconocido por la comunidad.

II. La importancia del P.A.I.

- Relevancia - el número de muertes en poblaciones sin inmunización
- Progreso - cobertura en Bolivia
- Impacto - reducción de incidencia en Bolivia

III. Monitoreo y Evaluación

- Recolección y análisis de información para tomar acción.
- Deben ser una parte del manejo rutinario para mejorar el programa
- Un sistema de información es necesario para medir los objetivos y metas, y ver si éstos están siendo alcanzados.

IV. Uso de los datos recolectados rutinariamente en sesiones de inmunización.
(Las necesidades y recursos del Ministerio de Previsión Social y Salud Pública, y de los PVOs podrían ser diferentes).

a) Monitoreo/Supervisión para Acción

- todas las inmunizaciones requeridas fueron dadas apropiadamente de acuerdo a la edad?
- perdieron la oportunidad de recibir inmunización contra Sarampión?
- demasiados niños mayores en relación con bebés?
- intervalos demasiado largos entre visitas?

b) Provisión de servicios

- seguimiento a los niños que no volvieron
- documentación en caso de que el carnet se pierda

c) Manejo

- Estimar el número de vacunas requeridas para la próxima visita o sesión.

d) Monitoreo y Evaluación para Acción

- Acceso: $\frac{\text{Número Anual de BCG para Bebés}}{\text{El universo de la población infantil (no recién nacidos)}}$
- Terminación: $\frac{\text{Número Anual de Bebés que recibieron DPT-3}}{\text{El universo de la población infantil (recién nacidos)}}$
- Abandono: $\frac{(\text{Número Anual de DPT 1 para bebés})-(\text{DPT 3 para bebés})}{\text{Número anual de DPT-1 en bebés)}}$
- Progreso: Cada trimestre; comparar el número de bebés con DPT-3, BCG, Sarampion, contra el universo de la población infantil

La consolidación y el análisis de información local incentiva la contínua recolección de datos precisos y aumenta la motivación del personal

V. Consideraciones Especiales para el Registro de Datos durante campañas.

- Uso contínuo de Registros Rutinarios que permiten el subsiguiente seguimiento.
- Asistencia de miembros de la comunidad.

VI. Areas Frecuentes de Confusión en la Recolección de Datos, Informes y Análisis.

- No subdivisión de edades (debería ser: 0-11; 12-23; 24 ó + meses)
- Los informes son de porcentajes de metas logradas. Debería ser: porcentaje del universo de la población infantil
- DPT, Polio, TT no informados por dosis. Debería ser por Dosis
- Se considera la población infantil como el universo para la vacuna contra el Sarampion, 1/4 de la población para DPT/Polio/BCG.
  Debería ser: la misma que para DPT/Polio/BCG

VII. Limitaciones en la evaluación del impacto en los Datos Rutinarios.

- Datos omitidos, incompletos, dudosos?
- El número de vacunas no pronostica el impacto (disminuye la incidencia)
- Problemas en la cadena de frio?
- Dosis y edad inapropiados para la vacunación?
- Eficacia de las vacunas.
- El niño ya tuvo la enfermedad?

VIII. Otras técnicas de evaluación

A) Encuestas de Evaluación sobre la Cobertura de Vacunación

1 - Muestreo de grupos de 7 niños de 12-23 meses de edad. Completar 30 grupos

- Tomar dos semanas con 2 equipos.
- Dá el porcentaje del universo protegido
- Dá información sobre los motivos por los cuales el niño no recibió todas las vacunas.
- Preguntas que sobre otros temas pueden hacerse al mismo tiempo.

2 - Niños de 12-23 meses de edad en 100 viviendas cercanas al centro de salud

B) Análisis de los registros en los centros de salud de las oportunidades perdidas de vacunación contra el Sarampión.

- Toma dos horas de análisis
- Especialmente útil si la incidencia en bebés es alta.

C) Monitoreo y Evaluación de la Cadena de Frio

- Toma 6 meses de uso rutinario
- Identificar lazos crónicamente débiles en la cadena de frio.

D) Encuestas a madres que salen de las sesiones de vacunación sobre conocimientos, actitudes, y prácticas.

- Toma 30 minutos
- Hacerlo si la cobertura es baja, ó si la tasa de abandono es alta

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E) Vigilancia Epidemiológica

- Rutinaria o centinela
- Según la estación, la incidencia en edades varía, y las tendencias pueden medirse.

APPENDIX IV (HAND-OUT no. 1)

Seminario de Control y Evaluacion de Proyectos de "Child Survival"; Bolivia, September 15-18, 1987

Session: Control de las Actividades de Inmunizacion y Determinacion de la Cobertura

(presentado por Sr. Robert Steinglass, REACH)

Temas:
- Que informacion necesitamos.
- Como utilizar datos rutinarios y de encuestas para manejo y accion del programa.
- Registro de datos y tecnicas de monitoreo y evaluacion.

1. La importancia del PAI

   - Relevancia
   - Progresso en Bolivia
   - Impacto en Bolivia

2. Monitoreo y Evaluacion

   - algunos puntos

3. La Utilizacion de los Datos Recopilados de Manera Rutinaria durante Sesiones de Vacunacion

   - Monitoreo y Supervision para accion
   - Entrega de Servicios
   - Manejo
   - Monitoreo y Evaluacion para accion

4. Algunas Consideraciones especiales para la Recopilacion de Datos durante las Campanas

5. Areas de Confusion Frecuente en la Recoleccion, Reportaje, y Analisis de Datos

6. Limataciones de los Datos Rutinarios para la Evaluacion de Impacto

7. Otras Tecnicas de Evaluacion

APPENDIX IV (Hand-out no. 2)

MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA
DIRECCION NACIONAL DE EDIDEMIOLOGIA

CIRCULAR NORMATIVA N 1/87

VISTOS Y CONSIDERANDO:

Que el manual Tecnico del Programa Ampliado de Inmunizaciones editado en diciembre de 1979, establece un esquema de Vacunacion que no corresponde al estado actual de los conocimientos y a las rcomendaciones recientes de la (Organizacion Panamericana de Salud / Organizacion Mundial de la Salud) OPS/OMS.

SE RESUELVE:

ARTICULO 1ro.

Modificar el esquema Nacional de Vacunacion de acuerdo al siguiente detalle:

Recien Nacidos:	Polio dois inicial B.C.G. dosis unica	(Administracion simultanea)
A los dos meses:	Polio primera dosis D.P.T. primera dosis	(Administracion simultanea)
A los cuatro meses:	Polio segunda dosis D.P.T. segunda dosis	(Administracion simultanea)
A los seis meses:	Polio tercera dosis D.P.T. tercera dosis	(Administracion simultanea)
A los nueve meses:	Sarampion dosis unica	
Primer curso basico:	Revacunacion B.C.G.	(Sin tuberculina previa) (6 a 7 anos)

EMBARAZADAS:

Qunito mes: T.T. segunda dosis
Septimo mes: T.T. segunda dosis

ARTICULO 2do.

El grupo etareo en que se administran las vacunas es el siguiente:

Polio:	Recien nacidos hasta menores de 3 anos (en situacion de brote Epidemico se amplia el grupo etareo)
B.C.G.:	Primo vacunacion recien nacidos hasta menores de 3 anos. Revacunacion 1er curso basico.
D.P.T.	2 meses hasta menores de 3 anos (no se administra por ninguna razon a mayores de 5 anos)

Sarampion:	9 meses a menores de 3 anos (en brotes Epidemicos se amplia el grupo etareo)
Antiamarilica:	Mayores de 1 ano excepto embarazadas (en brotes epidemicos con grave riesgo se puede vacunar a mayores de 6 meses y embarazadas con mas de 3 meses de gestacion).
T.T.:	Mayores de 3 anos (se recomienda Emplearen embarazadas)
D.T.:	Mayores de 3 anos (se debe emplear en mujeres en edad fertil y conscriptos).

ARTICULO 3ro.

El intervalo minimo para vacunas de mas de una dosis es de 1 mes entre dosis, no existe intervalo maximo.

ARTICULO 4to.

Se establece la obligatoriedad de la entrega del carnet de vacunacion enforma gratuita como medio de control y educacion.

Las vacunas aplicadas se registran en el formulario PAI-7, mensualmente se consolsidara estos datos en el formulario PAI-8 debiendo enviarse el original a Epidemiologia de la Unidad Sanitaria, una copia a la cabecera del distrito y otra copia debe quedar en el establecimiento de salud.

ARTICULO 5to.

Los establecimientos de Salud que cuentan con refirgeradores, termometros y otros elementos de cadena de frio tienen la obligacion de mantener un puesto vacunatorio permanente, la periodicidad con que se brinden las vacunas dependera del tamano de la poblacion que demanda los servicios.

ARTICULO 6to.

Es obligatoria la vacunacion a los recien nacidos en Maternidades o Servicios de Salud con BCG y Polio, los ninos que recibieron vacuna contra la Polio al nacer necesitan 3 dosis adicionales a partir de los 2 meses de edad, se recomienda revacunar con BCG a los escolares en el primer ano basico en campana de vacunacion.

ARTICULO 7mo.

Las Movilizaciones Sociales de Vacunacion cumplen una funcion epidemiologica de elevar las coberturas de Vacunacion, para alcanzar coberturas utiles que garantizan immunidad de grupo, por tanto en estas ocasiones se recomienda que todos los ninos reciban su vacuna aunque hubieran sido vacunados con anterioridad.

Con vacuna Polio se cumple otro objectivo adicional que es multiplicar y difundir extensamente el virus vacunal par que compita en el ambiente con el virus salvaje que es patogeno.

ARTICULO 8vo.

Es obligatorio desechar todas las jeringas descartables una vez utilizadas con el fin de evitar riesgos a la poblacion.

La Paz Marzo 13 de 1987

Lic. Enrique Lavandez
JEFE NAL. PROGRAMA PAI

Dr. Jorge Flores R.
JEFE DETO CONTROL DE ENFERMEDADES

Dr. Jorge Mariscal P.
DIRECTOR NAL.DE EPIDEMIOLOGIA

NOTE: This was handed out without the answers or the key as Hand-out No. 4 and with the answers and key after the exercise.

REGISTRO DE VACUNACION

Pueblo/Ciudad

Sector

Area

Unidad Sanitaria

Carner N°	Nombre del niño o de la mujer	Nombre de la Madre y/o del Padre	Fecha de Nacimiento	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Saramp	TT 1	TT 2	TT R
180	Pedro Lopez Choque	María de López	G 1 Mar 84	1 May 85	1 May 85			15 May 85 B						–
181	Pablo Arispe Mamani	Juana de Mamani	G 10 Abr 84	1 May 85	1 May 85	15 May85 E		15 May 85 B			15 May 85 ABC			
182	Tomás Lopez Torres	Luisa de López	G 5 Jul 84	1 May 85	1 May85	15 May 85 E	1De85	15 May85 BD	1 Dec85		1 May 85			
183	Andrés Arias Suárez	Ana de Arias	Julio 84	1 May 85	B			BD						
184	Juan Castedo Solíz	José Castedo	5 Jun 85	1 Dec85	1 Dec 85			1 Dec 85			F 1 Dec 85 CH			
185	Teresa Pacheco		1961									1 Dec85		
186	Simón Perez Antelo	Elena de Perez	15 Mar 85	1 May 85	1 May 85			BD						
187	Jesús Salas Condori	Luis Salas	6 May 85	15 May 85	1 Dec 85			1 Dec 85			1 Dec 85			
188	Martha de Suárez		1949									1 Nov84	15May85	
189	Javier Lozada Arce	Sonia de Lozada	1 Oct 84	15 May 85	1 Dec 85 B			1Dec'85			1 Dec 85			
190	Anicato Arce Quispe	Carlos Arce	J											

KEY: A. Simulaaneous administration with all vaccines to eligible child? B. All required immunizations given appropriate to age? C. Missed measles immunization opportunities as soon as possible after 9 months age? D. All vaccines in use during each session? E. Minimum 4 weeks interval between multi-dose series? F. Immunization given too early for age? G. Too many older children versus infants? H. Too many children incorrectly denied some vaccinations due possibly to illness or undocumented claim of prior disease/ immunizatin (e.g., measles)? I. Newly eligible babies and children immunized at each session? J. No visits from 15 May to 1 December!

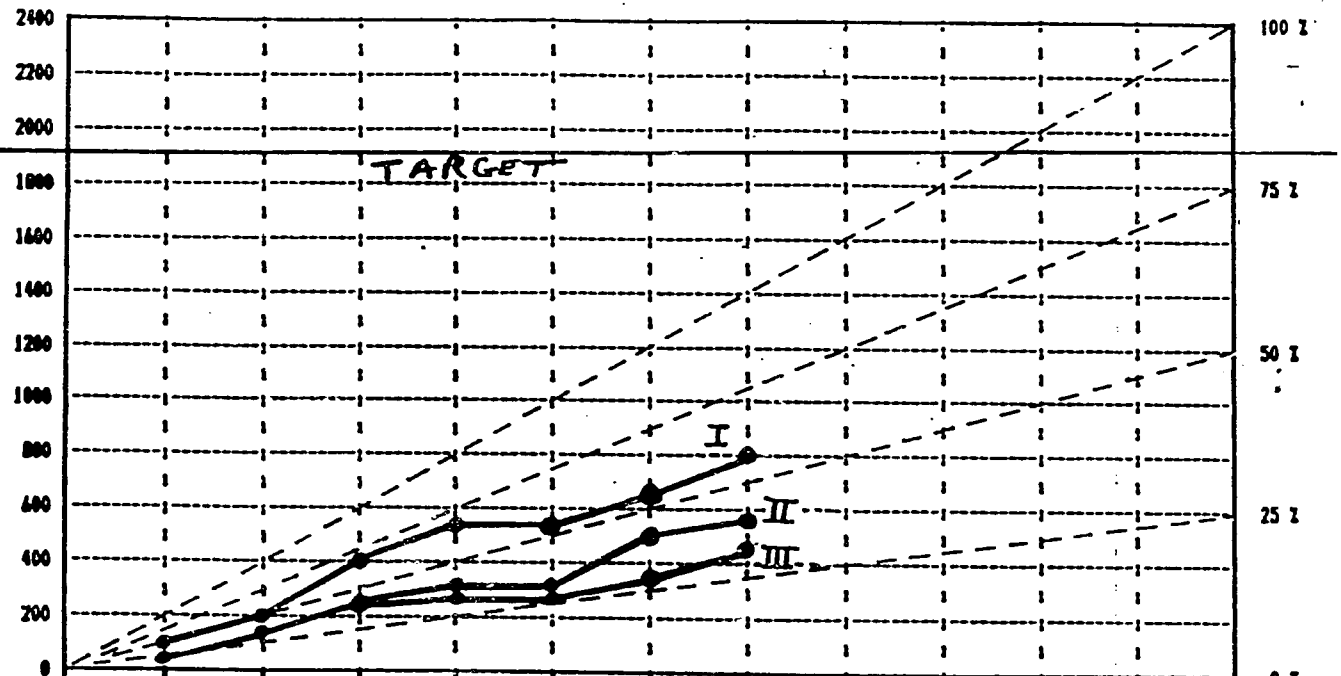
APPENDIX IV (Hand-out no. 4)

APPENDIX IV (Hand-out no. 5)

Figure 2. Immunization monitor

Health Centre: Valla Year: 1984

ELIGIBLE ~~Target~~ population: 2400 Vaccine: DPT 1,2,3



	Jan.	Feb.	March	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	
DPT 1	100	100	200	150	0	100	150						No.immunized in month
	100	200	400	550	550	650	800						Cumulative total for year
DPT 2	50	90	100	70	0	150	100						No.immunized in month
	50	140	240	310	310	460	560						Cumulative total for year
DPT 3	60	70	100	50	0	100	70						No.immunized in month
	60	130	230	280	280	380	450						Cumulative total for year

MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA
DIRECCION NACIONAL DE EPIDEMIOLOGIA
BOLIVIA

FORMULARIO P.A.I. 7

PLANILLA DIARIA DE VACUNACIONES

UNIDAD SANITARIA _____

DISTRITO _____

AREA _____

SECTOR _____

NOMBRE ESTABLECIMIENTO _____

Actividad realizada durante:

P.A.I. REGULAR ☐ 1

BRIGADA VACUNADORES ☐ 2

MOVILIZACION: PRIMERA ☐ 3

SEGUNDA ☐ 4

TERCERA ☐ 5

DEPARTAMENTO _____

PROVINCIA _____

LOCALIDAD _____

MES _____

AÑO _____

FECHA	No. ORDEN	NOMBRE Y APELLIDOS	SEXO		EDAD EN AÑOS			DOMICILIO	TIPO DE VACUNA																
									POLIO				D.P.T.				SARAMPION	B.C.G.		T.T.		D.T.		FIEBRE AMARILL
			M	F	MENORES DE 1 AÑO	1 Y 2 AÑOS	3 Y MAS AÑOS		1a	2a	3a	R	1a	2a	3a	R		1a	R	1a	2a	1a	2a	

APPENDIX IV (Hand-out no. 6)

APPENDIX V

AN EXAMPLE OF SIMPLE MONITORING AT THE IMMUNIZATION SITE

Ask 10 mothers one by one as they leave the immunization site:

	Mother answers:	
	correctly	incorrectly
a) Can you tell me why we give immunization?	_____[ ]	_____[ ]
b) Can you name three diseases that can be prevented by immunization?	_____[ ]	_____[ ]
c) Does your child need any more immunizations?	_____[ ]	_____[ ]
d) Where and when can your child receive his next immunizations?	_____[ ]	_____[ ]