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PROJECT APPRAISAL REPORT (PAR)

102

20p

1. PROJECT NO. 513-15-560-271	2. PERIOD FOR WHICH PAR IS TO BE PREPARED 3/25/75 - 5/15/76	3. COUNTRY Chile	4. PAR SERIAL NO. T.Q.-3
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CHILD NUTRITION - TARGETED MALNOURISHED CHILD PROGRAM (OPG)

6. PROJECT DURATION: Begin FY 75 Ends FY 76	7. DATE LATEST PROJ. REPORT None	8. DATE LATEST PIP ---	9. DATE PRIOR PAR ---
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10. U.S. FUNDING	a. Cumulative Obligation thru Prior FY: \$240,000	b. Current FY Estimated Budget: \$---	c. Estimated Budget to completion After Current FY: \$---
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11. KEY ACTION AGENTS (Contractor, Participating Agency or Voluntary Agency)

a. NAME Seventh Day Adventist World Service/Obra Filantrópica de Asistencia Social Adventista	b. CONTRACT, PASA OR VOL. AG. NO. Grant N°513-75-011
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1. NEW ACTIONS PROPOSED AND REQUESTED AS A RESULT OF THIS EVALUATION

A. ACTION		B. LIST OF ACTIONS	C. PROPOSED ACTION COMPLETION DATE
USAID	SAWS		
	x	1. That a qualified assistant to the SAWS representative be hired.	To be on-board 10/76.
	x	2. That additional nutritionists be hired to bring field staff up to four.	Completed
	x	3. That quarterly up-to-date beneficiary and clinic lists be furnished to USAID along with narrative progress reports and analyses made during the period and steps taken toward developing an educational program.	First complete list- 10/76 Educ. Program -11/76
x	x	4. That discrepancies in consumption reports in for 1975 and 1976 be reconciled, and that special attention be paid to the reports on the Malnourished Program.	Completed
	x	5. That the final INUAL report breakout the 0-6 months old group of infants, and the number of under-ones in third degree malnutrition that transfer to recuperation centers, as distinct from hospitals, be reported when they occur where the SAWS program is operating.	10/76
x		6. That a designated USAID official work closely with SAWS during current negotiations on an operating agreement with SNS to begin Calendar Year 1977, and to discuss other problems on a regular basis.	10/76
	x	7. That urgent emphasis be given to getting an educational program going. Plan to be prepared.	11/76

D. RECLASSIFICATION	REVISION OR NEW	<input type="checkbox"/> PROP	<input type="checkbox"/> PIP	<input type="checkbox"/> PRO AG	<input type="checkbox"/> PIP T	<input type="checkbox"/> PIP C	<input type="checkbox"/> PIP P	E. DATE OF MISSION REVIEW 9/8/76
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PROJECT MANAGER: TYPED NAME, SIGNED INITIALS AND DATE Charles D. Matthias, 9/8/76	MISSION DIRECTOR: TYPED NAME, SIGNED INITIALS AND DATE James L. Roush, 9/10/76
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CHILE

PAR N° TQ-3

Project N° 513-15-560-271

2.

Child Nutrition - Targeted Malnourished Child Program (OPG)

A. ACTION

**C. Proposed Action
Completion Date**

USAID AID/W SAWS

B. List of Actions:

8. That some testing with control groups be carried out by INUAL to determine:

a) the effect of adding more food, particularly to the 6 months through 23 months groups, even with presently available high protein foods;

b) the effect of adding calories to the present rations and to the SNS rations (which cover more than 100% of the protein requirements in age groups 0-23 months).

10/76

EVALUATION
OF
SAWS/OFASA
PROGRAM FOR MALNOURISHED CHILDREN

March 1975 - May 1976

Prepared by: Joyce King, Consultant
USAID/Santiago.

INITIALS, ACRONYMS, DEFINITIONS

Organizations

CONPAN	Consejo Nacional para la Alimentacion y Nutricion, National Nutrition Planning Council.
INUAL	Ingenieria en Nutricion y Alimentos, Nutrition and Food Engineering.
OFASA	Obras Filantropicas y Asistencia Social Adventista
SAWS	Seventh-Day Adventist World Service
SNS	Servicio Nacional de Salud, Public Health Service.

Foods

CSB	Corn - Soya Blend.
WSB	Wheat - Soya Blend.

Malnourished

1st degree - 10-25% below standard weight
2nd degree - 26-49% " " " "
3rd degree - 50% or below " "

Iowa Standard One month - 4300 grams; two months-5000 grams;
three months - 5700 grams; four months-6300 grams;
five months - 6900 grams; six months-7400 grams.

Sempé Standard 3-4% less demanding than above.

NARRATIVE

I. SPECIAL CHARACTERISTICS OF THE PROGRAM

A. Beneficiary Profile

Tags that characterize the majority of the families of the malnourished children in the program are: poorest of the poor; chronically unemployed; low literacy rate; high degree of alcoholism; large family size; inadequate housing; and lack of potable water. Without integrated programs to change these conditions, the chances for permanent rehabilitation of children through supplemental feeding are not high. And modifying mother behavior is more difficult than in programs where traditional educational methods and materials can be used effectively. Yet the Chilean Government recognizes the need to assist these beneficiaries pending longer term solutions, and does so at a cost above \$100 million annually for a vast milk and special food distribution program for the vulnerable groups, and for school feeding and unemployment programs. Thus the GOC particularly needs to know the costs of public service programs and the real benefits they bring to the impoverished.

B. Voluntary Agency Profile

And because of humanitarian concern for the underprivileged, private agencies often participate in getting the job done, notably in bringing in "title II" foods. In Chile, the "malnourished program" (meaning infants and children through five classified in first, second or third degree malnutrition in the clinic network) was initiated by SAWS, with the idea of adding more food, education and concern to the substantial GOC milk inputs. SAWS relies entirely on its counterpart agency, OFASA, to carry out operations. SAWS had the job of weaning the counterpart agency from its narrower, church activities for the old, the handicapped, and the orphans and young as well, which the agency had been carrying over many years in Chile. SAWS moved the agency from small projects for its own, through the period of enforced consideration of food priorities resulting in the phasing out of old programs, up to the present administration of a large scale intervention program in which accuracy of data and meeting stated deadlines decide efficacy. Pressure for greater efficiency in the agency's operations has had to be tempered with concern for the continued identity of the agency. Thus, the pace of program development is not always as quick as planners might prefer. But, on the other side of the coin, it is hoped that an OFASA presence will be a special ingredient toward the success of the program.

II. STATUS OF THE PROGRAM

The program described in the PROP did not get under way until August of 1975, due mainly to the absence of the SAWS Representative from Chile, difficulties in getting a sacking plant in operation, and lack of preparedness for the scope of the program. Thus it started about six months behind the planned schedule.

Even so, the program was reaching some 20,000 malnourished children by January of this year, against the planned 25,000 and 27,000 to this date against some 30,000 planned. Quality has suffered in reaching these quantitative targets. Until the SNS is an active participant in a nationwide program, present numbers should not be exceeded if the program as conceived and approved is to have a chance of being developed.

Getting the information needed for analysis is vital to the success of the program. Maintaining up-to-date central lists of clinics and beneficiaries, and of food consumed, have been deficient, severely handicapping the analyses that are being attempted.

A self-analysis of management and operational deficiencies has been made by INUAL, a food engineering firm based in Santiago, with whom SAWS/OFASA sub-contracted essentially for carrying out studies and data analyses but also to improve the voluntary agency's operations. The principal recommendations made by INUAL to bring the agency to adequate efficiency were: to hire additional staff and train existing staff and define lines of responsibility; to develop an adequate reporting, controlling and inspection system. INUAL developed new forms for consolidating information at the different levels and a data gathering system in the clinics that would produce the raw data needed for analyses. Along the way INUAL was obliged to train staff and forge far information that should have been available. All of this led to loss of time devoted to the purposes intended by the sub-contract and its subsequent amendment to increase man hours.

In response to the INUAL recommendations, the agency has hired three more half-time nutritionists and a program coordinator and has fleshed out its statistics division. Lacking is someone who can replace the SAWS Representative in his absence and act as full-time program coordinator. The person already added does not carry out this role at present and he is on the OFASA side of operations.

To fulfill minimum requirements of an education program, there needs to be a full-time nutritionist in each of the regions, responsible to OFASA and brought in for extra training if necessary. These suggestions are based on present program size. The expansion foreseen under the original PROP would be adding to the burden of over-stretched resources, and SAWS agrees that it is at its maximum capacity with the present program. There might, however, be dire need for SAWS/OFASA to assist with a much larger program if economic conditions so merit, and it might, on an ordering and inspection basis only, want to respond to GOC requests with USAID approval.

Scope

Units of operation, which include not only the polyclinicos (out-patient clinics) mentioned in the PROP but also hospital centers, number 175 with a concentration of units in the south (and of beneficiaries in the Central and South). They extend as far north as Arica and south to Puerto Montt. Shown below are the clinic locations and numbers of beneficiaries, as of May 1, 1976:

	<u>No. of clinics</u>	<u>Beneficiaries, 0 through 5</u>
Central	61	11,141
North	26	3,526
South	88	12,437
Total	175	27,104

Endlessly-long Chile presents special problems of proper coverage which the agency does not need. And SAWS/OFASA is thinking about concentrating its program in urban areas, where according to ECEN, 60-70% of the malnourished live. To be considered in seeking manageable range is the fact that 30% of the population is in Santiago. The present widely scattered program has come about because of admirable priority placement on the most severely malnourished and the youngest, more vulnerable, age groups. The planned expansion of recuperation centers for the severely malnourished will also affect these considerations.

Method of Operation

The clinics submit applications to join the program. (Clinics refer to the 126 permanent health units which also service an additional 300 small posts, according to current information.)

Then, based on the priorities noted above, the central office of SAWS/OFASA, or the zonal chief, decides on the ones to be included. In principle, a SAWS/OFASA nutritionist then visits the selected clinic along with the zonal chief, and meets with the SNS staff to describe the program goals, the hygienic preparation of the new Title II foods, and the data keeping required. The food is then sent and the nutritionist returns to demonstrate the handling and preparation to an initial number of mothers of malnourished children while the SNS "manager" of the program watches. The SNS team then carry out demonstrations with the rest of the mothers in the program. In fact, the nutritionists have sometimes had to content themselves with imparting the information at the area level, from which it is then passed on to the clinic with resulting loss of content and impact.

With additional staff on board and a cessation of expansion efforts, the quality of existing programs could be improved through more thorough visits, on a more regular basis, by the nutritionists.

Title II Foods

The clinics in the program receive directly from SAWS/OFASA one kilo packages of specially named foods directed to the malnourished child, labelled "for the recuperation of your child". These are Vigorin (CSB), Robustin (WSB) and Avena (rolled oats). So far, there has been no measure of the amounts that actually are consumed by the child, but one of INUAL's tasks is to determine what is a amount of food for a degree of cure.

Rations. The ration levels under the original PROP have been reduced on the whole, based on subsequent agreements between SAWS/OFASA and SNS. Table A shows the current amounts compared with planned amounts. This alteration increased protein for all but the 2-5 group, increased calories for the 0-6 months, and decreased calories in all other groups.

Instead of being locked into any ration level, it is strongly recommended that some testing with control groups be carried out by INUAL to determine: a) the effect of adding more food, particularly to the 6 months through 23 months groups even with presently available high protein foods; and b) the effect of adding calories to the present rations and to the SNS rations (which cover more than 100% of the protein requirements in age groups 0-23 months). Oatmeal only

or cornmeal borrowed from another program ought to be tried. Potato flakes should be ordered and tested, since this combination is a likely future direction in a national program supported exclusively by ODA. These ideas and others should be explored with the SNS and CONIFAN. They might be willing to contribute locally available calories for tryout purposes.

The Malnourished program, with its data gathering system and measuring devices, provides an excellent opportunity that should not be missed in finding a way to move out of the present protein on top of protein input.

Consumption Reports

Discrepancies in consumption reports vis-a-vis numbers of beneficiaries have been discussed with EFP and SAWS/OFASA. With the present ration levels, the reported consumption figures do not reconcile. In FY 75, 58 MTs of WSP, CSB and oats were reportedly used for an average 4125 beneficiaries. Using the most favorable use of food per age spread (assumption that program reaches 10% of infants up to six months and 90% of those six months to five years), it was found the amount required was 84 MTs (1.7 kilo average per child per month x 12 x 4125). And in the first half of FY 76, the 14,780 beneficiaries in the first quarter and the 20,560 beneficiaries in the second, would require 180 MTs rather than the 245 MTs shown on the SAWS/OFASA consumption report.

It is of utmost importance in this particular program to know exactly how much food is made available to beneficiaries; else our goals will be defeated.

The PROP estimated that 840 MTs of the three commodities would cover 23,000 children for 12 months. With the altered ration, needs are 528 MTs.

Education of Mothers

The most serious defect in the program is lack of the planned education input. Unless there is other magic in the program, it will be impossible to show lasting effects of the food inputs until there are efforts to change behavior of the mothers. Minimal amounts of the funds intended for this purpose have been used. 200 special tools for teaching called rotafolios (a combination flannelograph, blackboard and projector screen) were ordered for the clinics to be used by the nutritionists. But, lacking close coordination with the SNS and

It should be known that Dr. Monckeberg does not agree that Chilean children get too much protein, as witnessed by their smaller stature. But, the evaluator adds, will that picture not change now that, a recent study shows, consumption of milk by children has increased from 25 to 85%.

therefore, the necessary accord and coordination for the development and printing of any materials used in the clinics. SAWS/OFASA concentrated its energies on building up the program, with education to come later. As noted above, the SNS did not officially recognize the Malnourished program and, while in no way hindering SAWS/OFASA work with the SNS clinics, gave no support whatsoever to the program. Sometimes things worked well (and, progressively more unofficial support has been given), and the SNS Zonal, Area or the individual clinic provided good support (e.g. see Report on Visit to Concepcion prepared by Manuel Jaime dated May 3, 1976). There, with the effective coordination of a part-time OFASA regional nutritionist, the clinic personnel, SNS officialdom and the University have come up with a training program to orient nutritionists to the special problems of the malnourished which is beyond the caliber and depth envisaged for this program. In other clinics and areas, and especially early in the program, no such dynamic cooperation existed.

In addition to the teaching materials and programs for clinic personnel, didactic materials for the mother were to be designed and printed. INFAL's first forays into the milieu of families of malnourished children convinced them and SAWS/OFASA that traditional materials were unlikely to be effective, and that to find the right kind of motivational material, they would have first to learn more about the targeted mothers. A socio-psychological study is planned if and when the man hours in the INFAL contract are increased, by virtue of the amendment mentioned above. In the meantime, the clinic work with mothers can be broadened beyond the lessons in Title II food preparation with or without full SNS support, as the SAWS/OFASA corps of nutritionists expands and as time spent on opening new clinics decreases.

SAWS/OFASA has now been asked to support SNS planned regional workshops for other nutritionists. (There are about 600 in the country and they are in charge of the malnourished program in about 80% of the clinics.) Worthy of support too might be the dissemination of a brochure with current information on malnourished children to all of the clinics; this could also encourage program identity toward common goals. Results of the socio-psychological study and other CONPAN data should be put together with educational technology to develop a motivational product for reaching mothers. SNS said they thought Johanna Dwyer of Harvard might be of great assistance at that stage. SAWS/OFASA might wish to offer technical assistance for this purpose and, if so, should try for the U.S. summer months.

These activities could go forward whether the operating guidelines have been sent to the field or not, now that SNS-SAWS are prepared to sign an agreement of cooperation to the end of CY 76.

SAWS/OFASA also plans to explore with the SNS the possibility of using a Chilean-adjusted graphic nutritional status "report card" for high-risk mothers, on a test basis at first, since the SNS and CONPAN are still dissatisfied with standards currently being used (Iowa and Sempe, see discussion under Measurements, below). Such a chart belongs to the mother. The clinic plots her child's weight on it against the desired standard weight line, giving the mothers a visual understanding of her child's nutritional status. It has been used with considerable success in other countries as the principal teaching tool.

Home Consumption Studies.

Behind schedule is the first home consumption study. Efforts in Temuco with the School of Social Workers came to naught, and a first study in Santiago is now planned for August 1976 with assistance from the University of Chile. Six students will be assigned for the study.

INUAL

Work Scope

A one-year sub-contract with INUAL runs from October 15, 1975 to October 1976. Initially for \$25,000, the amendment would bring the total to some \$34,000. The contract calls for work and quarterly reports as follows:

- January 15, 1976 - Evaluation of programs in progress or scheduled to begin.
- April 15, 1976 - Presentation of revised program operation design and design of experimental procedures.
- July 15, 1976 - Evaluation and analysis of the operation of the revised program design.
- Oct. 15, 1976 - Final report and evaluation.

Professional man hours include the time of: a psychologist, an engineer in food and engineering, an economist, a systems analyst, a doctor, a communications expert and assistants.

The January 15th report only was available during the evaluator's visit. However, ongoing and future work were discussed with the contractor. The evaluator's first observation was that the report which includes preliminary findings on the degree of success in the program had either not been read or not been read carefully. Inasmuch as considerable other related work is being done by CONPAN, and SNS must be a partner in implementing the designs proposed, the evaluator strongly recommends that closer coordination be maintained with these two bodies and that their participation in detailed and revised design for subsequent periods be sought at each stage of the reporting. It is planned that INUAL will include a last section in its quarterly reports which lists points for discussion.

The first report was called an evaluation but is in fact an analysis of preliminary data and of the agency's operations; and it is very well done, containing not only recommendations but proposed solutions in the finest detail.

The contract appears flexible enough for the needs--it allows for taking up new variables and unexpected problems (e. g. the high dropout rate encountered; slipperiness of baseline data in the clinics; wide extent of agency management shortcomings).

Among ongoing work is: a detailed study of 40 clinics to determine effects of unemployment and other economic factors on beneficiary health improvement; study of 500 cases from birth (drawn from clinic records) to learn pattern of food input in relation to nutritional status; study of six clinics to determine effects of clinic attitude toward malnutrition and the malnourished based on observations of fatality. Also being studied is the normal movement within the clinic without an OFASA program--i. e. what is the probability of children becoming malnourished, and what is the probability of recovering without an input.

Need for Computerization. In order to maintain up-to-date information on children by age group and in different degrees of malnutrition vis-a-vis food provided, it will be essential for SAWS/OFAA to buy computer time. In the meantime, SAWS is exploring with the USAID possibilities for utilizing the voluntary agency computer system.

Problems in Measurement:

"Malnourished" classification. INUAL has found that there is an overall 10% error in calculating whether a child is in a malnourished state - i.e. first, second or third, and that it is 30% in the first and second degrees. The data gathering system used by INUAL/SAWS is not affected by these calculation errors since it takes raw data from the clinics, but it does affect analyses made against clinic records. This means that the clinic classifications have first to be converted to raw data on weight. There was also found to be a 5-10% error in copying figures.

PROP Goal. The project proposed that success would mean "permanent cure for six months after recovery to health status". This measure will not be known for too long a time when repeater rate patterns have been determined. As a temporary measuring device, INUAL is letting up health results after six months in the program. Shortly enough will be known about movement within the degrees of malnutrition so that a more meaningful target can be established.

Standard Weight Charts. The weight-for-age charts used in the clinics vary. Some are using the Iowa standard, while others use the new less-demanding Sempe chart. There is a 3-4% difference in the two charts, which may account for the statistical drop in malnutrition in 0 through five years old over the past year shown in Table B. The problem is that those who have been malnourished may be shorter than other children in their age group but be in normal health, but they show up on a weight-for-age basis as malnourished. Attempts are being made to relate height to weight, but the measure is difficult to take on infants because of the minuteness of height increases per month. And there is the problem of providing accurate scales to take these measurements in many of the clinics. At the moment it is planned to use a Colombia chart, but then again, a new chart specifically for Chilean averages between elite and lowest strata children might be developed.

PRELIMINARY RESULTS

As will be seen from Table C, analyses of six months performance on a global basis of 2480 children in 15 clinics, and on an in-depth basis of two and three clinics with a maximum of 447 children, show especially promising early recovery. Depending on the "turn" achieved and how dropouts are to be counted, the range was 21% to 70% recovery.

During the current period for which data are not shown here, the recovery rates are running about 30% in the first three months and 60% over six months.

Caution is invited in looking at these statistics, however. We have calculated a repeater rate of 50% with an ongoing nutrition program; it might be higher without one. But the "concern" factor plus the new foods might constitute an educational input.

Until all seasonal considerations are known--diarrhea in the summer, bronchial diseases in the winter, vacations in February, unqualified results can not be stated.

Reporting of SAWS/OFASA

The only substantive report available was made in January 1976 and did not quantify progress but was rather a summary of the problems encountered and future plans. The INUAL report necessarily provided the background of knowledge from which verifications in the present report were made.

SAWS/OFASA should submit quarterly reports to the USAID for distribution to SNS and CONPAN which refer to the findings of INUAL and bring up to date statistics on numbers of beneficiaries, location of clinics, food used, and the extent to which the education program has been launched.

Because of the paucity of information on the program, the evaluator included highly detailed comments on all aspects in the hope that they will be useful to the USAID.

Cost-Benefits

Costs were computed on the basis of six months' treatment, which preliminary studies show to be an adequate length of time for "curing" most cases of malnutrition when complicating medical problems are absent.

Without educational inputs, costs were as follows:

Food . . .	\$4.40	(40%)
Handling		
and Distrib. . .	1.65	(15%)
OFASA		
Pers. & Adm. . .	1.81	(16.5%)
SNS		
Personnel. . . .	3.14	(28.5%)
	<hr/>	
	\$11.00	

Seen in the perspective of an add-on program between ongoing prevention programs and intensive care programs, the picture is the following:

(Monthly Cost added on at each stage)

Prevention Program in Effect	
SNS food and education.	\$6.00
OFASA/SNS - (Personnel for Spec. program for malnourished)	2.00
Recuperation Center.	52.00
Hospital.	400.00

III. FUTURE

SAWS/OFASA is scheduled to sign an operating agreement with SNS on May 25, 1976. This agreement will be helpful in the local programs as it validates the program from the national level. What are more important are: the transmission from SNS of the Operational Guidelines to the clinics which will constitute the order to give attention to the Malnourished Program; and the new agreement between SNS and SAWS-OFASA for Calendar Year 1977. This agreement should be negotiated before or during budget time, July or August 1976, and the USAID should assist with these negotiations and obtain CONPAN concurrence. SNS expect to decentralize operations and it may be that the Zonal Chiefs (see eq. 11) important in the negotiating stage, if indeed they are to get allocations for regional programs.

SAWS/OFASA to ensure that INIAL can make its in-depth study with accuracy may feel that equipment in the clinics is of great importance in the 40 clinics where height measurements will be taken. UNICEF or other sources who supply equipment should be explored by SAWS and the USAID before using any of the budgeted funds for this purpose.

SAWS/OFASA will continue to require technical assistance for its data analysis, and will plan to go out for bid again to assure continuation of the data-gathering system beyond October 1976. The ideal solution would seem to be to have the INIAL group continue because of their knowledge of the agency's operations, but the requirements would be drastically reduced from present needs.

GOC Recuperation Centers.

The Recuperation Centers springing up around the country under the personal inspiration of Dr. Monckeberg, complement the Malnourished program and in no way, overlap. 75% of the infants taken into these centers are hospitalized cases. These centers depend on municipal support and volunteers from upper social strata. They are staffed with professionals--doctors, nurses, social workers and specialists in psycho-motor stimulation.

From Table B, it can be seen that the number of severely malnourished is small, and most of them are in the 0-2 year old group with a majority in the 0-6 months age group. The manage-

USAID Comment: No action required since SAWS determined that equipment within the clinics was available and was being maintained properly.

able size (plus 5,000) makes it possible to do a fairly thorough job of rehabilitating the family; and this is part of the program: to find the mother who may have deserted her baby in the hospital by giving a false name; to help the father find a job, getting him cured of alcoholism, etc.

The mortality rate for these children under hospital care has been above 30%; thus it was realized that medical care alone was not adequate. And it was very evident that without modifying the home situation, the infants were back in hospitals within a short time. (Survivors of severe malnutrition are in and out of hospitals for an average 155 days of the year; costs for caring for the malnourished run to some \$6 million annually; 28% of the beds in pediatric wards are taken up by these cases.)

It is estimated that about 62 centers will be needed to meet the needs. If these children could all be brought back to health, the mortality figures would be down to 42%.

What was added to medical care in this program were love and psycho-motor stimulation. The results are exciting. Of the 79 released so far, only two have not kept up their nutritional status. A psychological factor important to continued health was that the mothers who were returned a healthy attractive baby in place of the diarrhetic, disease-racked bawling infant she had psychologically deserted, if not physically, were motivated to love it properly and learn what was necessary to keep it healthy.

Dr. Monckeberg, contrary to current belief, is convinced that mental retardation caused by nutritional deficiency is not irreversible, based on the results his clinics have shown in improved psycho-motor development. He adds that the psycho-motor stimuli in the program have not been tested on normal children so that it is not yet known to what extent improvement of psycho-motor development in normal children might be raised.

In the final report, INEAL is requested to determine, at least the numbers of malnourished who move out of the SAWS/OFASA program in the areas where the two programs are in effect, and if possible, effect on the percentage of cure rate.

TABLE A

VALUE OF RATION LEVELS

PLANNED & ACTUAL

I. Title II Supplements

<u>Age Group</u>	<u>Planned</u>	<u>Actual</u>
0-6 months	1 kg WSB	1 1/2 kg WSB
6-12 months	3 kg WSB, CSB and Oats	1 1/2 kg WSB, CSB & Oats
1 thru 5 years	3 kg " " "	2 kg " " "

II. Combined with GOC 26% milk or enriched food, the food delivered, by age group, is:

(in kilos per month)

	<u>0-5</u>	<u>6-11</u>	<u>12-23</u>	<u>2-5</u>
Milk or Enriched Fd	3 (M)	2 (M)	2 (M)	1.5 (EF)
WSB	1	1	1	0
CSB	.5	.5	.5	0
Rolled Oats	0	0	.5	1
Total	<u>4.5</u>	<u>3.5</u>	<u>4</u>	<u>3.5</u>

III. The above meet % of requirements in:

Proteins.....	311	212	197	137+
Calories.....	103	53	42	28+

+ averaged out for convenience.

TABLE C
 PRELIMINARY FINDINGS ON RECOVERY RATE
 (ANUAL, 1/15/76)

First, Second and Third Degree Malnutrition* Attain Health
 (These figures take into consideration 30% dropouts.)

Global**Study 21%

In-Depth, 2 clinics*** 20% and 30%

Second and Third Degree Malnourished Attain First Degree or Health
 (These figures consider only those who remained in the program six months)

Global Study From Second to First or Health

Central 63% ----- 41%
 North 25%

From Third to First or Health

Central 70% ----- 66%
 North 56%

In Depth, 3
 clinics***

From Second and Third to First or Health

41%, 44% and 49% ----- 45%

If we subtract 30% dropout rate, the figures become
 29% instead of 41%, 46.2% instead of 66%; and 31.5% instead of 45%.

* see page i.

** 2480 cases in 15 clinics in the North and Central.

*** In-depth study of 447 cases.

