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FINAL EVALUATION REPORT
CHILD SURVIVAL PROJECT

CATHOLIC RELIEF SERVICES
&
CARITAS BOLIVIANA

OCTOBER 23 - NOVEMBER 10, 1989

LA PAZ, BOLIVIA

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LIST OF ACRONYMS

CSP:	Child Survival Program
ORT:	Oral Rehydration Therapy
CHC:	Child Health Card
MCC:	Mother Child Center
MB:	Maternal Breastfeeding
ARI:	Acute Respiratory Infection
GPS:	Growth Promotion and Surveillance
USAID:	United States Agency for International Development
PRITECH:	Primary Health Care Technologies
MPSSP:	Ministry of Social Welfare and Public Health
DS:	Diocesan Supervisor
FC:	Field Coordinator
NC:	National Coordinating
CS:	Child Survival
NGO:	Non-governmental Organization
DO:	Diocesan Office (of the Child Survival Program)
DD:	Diocesan Direction (Caritas Diocesan Office)
CRS:	Catholic Relief Services
UNICEF:	United Nations Children's Fund

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I. EXECUTIVE SUMMARY

From October 23 to November 10, a team made up of external consultants, Catholic Relief Services/CARITAS and field personnel, carried out a final evaluation of the Child Survival Project performed by CARITAS/Bolivia with financing from the United States Agency for International Development and PL-480. Primary Health Care Technology offered technical assistance to the Child Survival Project until September 1988.

The original concept of the Child Survival Project was to use CARITAS's Mother Child Center's as a means to introduce knowledge of Child Survival such as: Oral Rehydration Therapy, Growth Promotion Surveillance/nutrition and Acute Respiratory Infection control. Included in this idea is the selection, training and support to the voluntary promotor of the Mother Child Center.

The Child Survival Project began work in July 1986, with Oral Rehydration Therapy and Growth Promotion Surveillance, in the areas of the Altiplano and Valleys of Bolivia. In 1989, the component of Acute Respiratory Infection was added, and activities in the plains were initiated.

In 1989, the Child Survival Project benefitted 65,418 children below the age of five (16% of which are below one year of age) and 26,167 mothers, all members of the Mother Child Center/s of CARITAS. In 1988, 32% of the Mother Child Center of CARITAS were beneficiaries of the Child Survival Project. Not all the Mother Child Center's have responded with the same enthusiasm to the knowledge of the Child Survival Project; there are features which permit prediction of a better acceptance of this knowledge from within. Besides, the Child Survival Project has conceived the Mother Child Center isolated from its community, with the latter being a decisive factor for the perpetuation of a demand for new knowledge.

Food distribution has both facilitated and limited access to knowledge about the Child Survival Project. Food acts as a subsidy which allows the mother, busy with daily chores, to participate in the information offered by the Mother Child Center's. Food, however, acts as a limiting factor, because mothers have to pay a quota for it, which limits mothers' access to the Mother Child Center (and therefore to the Child Survival Project).

The present organization of the Child Survival Project (National Coordinating Office and the Diocesan Offices) satisfies the present needs of the Child Survival Project only partially. There are problems with technical support and

supervision from the National Coordinating to the Diocesan Offices, in the coordination of the National Coordinating Office with the diocesan directors, and with the flow and management of information gathered. The National Coordinating Office is not organized to attend to technical support requests from the Diocesan Offices, and the DO's are not prepared to assume the responsibilities of a decentralized program without support from the central office. At the DO's, the personal and technical quality of the Diocesan Supervisor, and the support offered by the diocesan offices have been the determining factors for progress made in the dioceses.

The promoters of the Mother Child Center's know their work and do it well. The annual drop-out rate, however, is high, between 15% and 45% annual. The reason is that the role and work of promoters has not been analyzed in relation to the efforts demanded of them and to the incentives (from the Child Survival Project and/or from the Mother Child Center) necessary to compensate these efforts. Moreover, the Child Survival Project is not providing supervision and/or supplies in a regular manner to the promoters, which generates repercussions in their morale and performance. In those dioceses where extra food rations were given to promoters, the drop-out rate is less.

Training of project personnel and promoters has been "step by step", and has included subjects such as how to program and offer training courses. It has been very useful to transmit knowledge to different groups, but lacked a feedback mechanism: experiences generated by training the different audiences are not collected by the National Coordinating Office for program improvement.

There have been two types of educational material used: for interpersonal communications and for mass communication. Both were carefully designed based on the characteristics of the audiences.

In Oral Rehydration Therapy, this evaluation has estimated that 42% of the cases of diarrhea among beneficiary children in the Child Survival Project were well managed, whether by the promotor or the mother, which is above the 30% goal established at the Reformulation Workshop of the Child Survival Project (February 1988). In addition, beneficiary mothers had adequate understanding of the causes of diarrhea and dehydration, and the importance of Oral Rehydration Therapy.

In Growth Promotion and Surveillance, every beneficiary child of the Child Survival Project has an average of 2.2 weighings/year, which is below the recommended standard of 4 per year. No significant differences were found between the nutritional status of beneficiary children of the Child Survival Project, as compared to non-beneficiary children. Beneficiary

mothers, however, understood the importance of periodic weight control, in relation to their children's proper growth.

The control of Acute Respiratory Infection showed that 42% of cases among children below the age of five were well handled, either by the promotor or the mother. The most significant change of conduct, was the replacement of traditional medicines and commercial placebos, with an adequate treatment (continued feeding, lowering fever, giving liquids), access to a promoter, and the use of antibiotics. There are problems, however, which must be resolved, with the educational material used, with the level of knowledge of the promotor and with the supply of medications.

The information system of the Child Survival Project is rudimentary: information collected from the promoter is channelled to the National Coordinating Office, where it is tabulated. It is not used to make decisions nor as feedback. There are no alternate means used to collect information (e.g.: rapid field studies).

Financial analysis shows the low recurring costs, per beneficiary and per result, obtained during 1988-1989: $2.89 per beneficiary (mother or child below age 5), $0.48 for cases of diarrhea, $0.77 for cases of Acute Respiratory Infection, and $0.92 for weighing of children below age 5. The reason for theses low costs is economies of scale (it is a nationwide coverage project), relatively low salaries, and the non-inclusion of voluntary work.

To conclude, the Child Survival Project has marked a difference in its area of influence. Knowledge, attitudes and practices of mothers with regards to child care, have been favorably modified do to the Child Survival Project activities. The joint effort of promoters Child Survival Project and CARITAS personnel, and technical assistance have been generally relevant. This evaluation, however, found some problems in the organization and implementation of the project, which must be resolved to achieve greater impact on the population.

The Child Survival Project was designed without a strategy for sustainability, either institutional (CARITAS), communal or from other institutions. This strategy must be taken into account for the future. CARITAS is not an institution of limited duration. National coverage and the importance of CARITAS (linked to the standing of the Catholic Church) allow the Child Survival Project to become a means which will permanently affect the life and health of thousands or Bolivian children.

Recommendations of the evaluation team are found in Chapter XV.

II. EVALUATION APPROACH AND METHODOLOGY

A. FOCUS OF THE EVALUATION

EFFICIENCY AND IMPACT OF THE PROJECT

1. What are the strength and weaknesses of the training scheme of the Child Survival Project? Are promoters capable of grasping the basic concepts of Child Survival? Are they capable of efficiently transmitting these concepts to the mothers at their Mother Child Center's?

2. Are educational materials designed by the Child Survival Project, efficient?. Is there a noticeable difference per subject in Child Survival or per region?

3. Is the information system useful and appropriate?
   - collection methods
   - information analysis and processing
   - use of information gathered

4. What have been the means of coordination between public and private services?

5. In management of the Child Survival Project adequate, particularly in terms of centralization vs. decentralization of functions? Has National Coordinating Office provides effective technical assistance and supervision for local implementation?

6. What impact was obtained in terms of the goals of the Child Survival Project? Is there a marked difference in infant mortality or in the rates of morbidity in participating communities? In the nutritional status.

7. What has been the cost per beneficiary of the Child Survival Project? How do these costs compare with other initiatives if Child Survival in Bolivia? In Latin America?

SUSTAINMENT OF THE CHILD SURVIVAL PROJECT

1. Which components of the methodology are more cost-effective? What elements should be included in a continuation package at a reasonable and effective cost?

2. How can coordination with other health services improve feasibility and efficiency of those activities already carried out, when external financing comes to an end.

3. What resources does CARITAS have to sustain the basic activities of Child Survival? Internal funds? Community contributions?

B. EVALUATION METHODOLOGY

1. Revision of Child Survival Project documents, at local and diocesan levels.

2. Interviews with members of institutions related with the Child Survival Project: Ministry of Social Welfare & Public Health, United States Agency for International Development/Bolivia, PL-480, CRS, UNICEF, etc.

3. Visits to 6 dioceses working with the Child Survival Project in areas I and II. Evaluators were divided into three teams, each visiting 2 dioceses.

   - Team I: Dioceses of Corocoro and Cochabamba
   - Team II: Dioceses of Coroico and La Paz
   - Team III: Dioceses of Sucre and Potosi.

   During these visits the following activities were carried out:

   a. Interviews with a total of 57 health promoters in 6 dioceses.

   b. Interviews with local authorities of the Ministry of Social Services & Public Health or Non-Governmental Organizations who work with Child Survival. A total 15 persons in 6 dioceses were interviewed.

   c. Visits to a total of 17 Mother Child Center's 6 beneficiaries of the CARITAS food program (but not of the Child Survival Project). In both types of Mother Child Center's beneficiaries of the Child Survival Project (Mother Child Center PROJECT) and non-beneficiaries (Mother Child Center CONTROL), plus 11 beneficiaries of the Child Survival Project. The following was performed:

      - interviews with mothers of 351 children below age 5, attempting to identify their practices of managing diarrhea, Acute Respiratory Infection and Growth Promotion & Surveillance/nutrition.

- focal groups of family mothers: 15 focal groups were formed with a total participation of 145 mothers: their purpose was to investigate their knowledge and attitudes regarding diarrhea, Oral Rehydration Therapy and Growth Promotion & Surveillance.

- focal groups of family fathers and communal authorities: ten focal groups were formed with a total participation of 70 members.

Age, length of membership in the Mother Child Center and the number of children presently alive were not significantly difference between mothers of the Child Survival PROJECT and those of the Child Survival Project CONTROL (3.62 years vs. 1.73 years, average 0.05). Therefore, all results between both types of communities had to analyzed in a stratified manner, taking into account the educational level of the mother for difference.

d. Interviews with the diocesan personnel of the Child Survival Project, who were also requested to fill in a written confidential survey regarding their functions, successes, problems and expectations of the Child Survival Project.

4. Interview of National Coordinating Office personnel of the Child Survival Project, who were also regulated fill in a written confidential survey on their functions, successes, problems and expectations of the Child Survival Project.

5. During the visits to the dioceses, CARITAS personnel had a relevant participation (national and diocesan levels) who accompanied external evaluators. Their enthusiasm, drove and motivated for a minute search of the truth, to obtain a future improvement of the Child Survival Project, which is palpable proof of the vigor and faith of personnel in this project.

DATA PROCESSING AND ANALYSIS:

1. Quantitative analysis of data coming from interviews with mothers (351) and promoters (57) was carried out with the EPI-INFO program (CDC, Atlanta, USA).

2. For qualitative data processing (focal groups and interviews) summary sheets were used (for Mother Child Center in each dioceses), whose purpose was to seek out differences and similarities among answers given by Mother Infant Centers PROJECT and CONTROL.

FORMULATION OF REPORT:

Formulation of the report was the responsibility of Dr. Tam. However, the following evaluators prepared some of the Chapters:

- Dr. Joel Kuritsky: Information Systems
- Lic. Nancy Ventiades: Personnel & Promoters Training
- Dr. Carmen Daroca: Sustainability
- Lic. Susana Martinez: Educational Materials

III. HISTORICAL BACKGROUND OF THE PROJECT

The Child Survival Project (CSP) was conceived in 1985, as a strategy to take advantage of the infrastructure of Mother's Centers organized by CARITAS Bolivia for food distribution in the rural areas for over 30 years. Its purpose was to introduce training activities aimed at promoting prevention and control of acute diarrhea, specially Oral Rehydration Therapy (ORT) and periodic growth surveillance among children, with the use of a Child Health Card designed by the MInistry of Health.

The strategy was broadly justified, not only as a potentially effective means to promote control of one of the illnesses that causes the greatest morbidity and mortality among children in Bolivia, and one of its conditioning factors (malnutrition), but as a mechanism to diversify activities at the Mothers' Centers.

This motivated CARITAS Bolivia to become interested in the Project, aside from the possibility of obtaining financial support from United States Agency for International Development. The strategy coincides with a longstanding concern of CARITAS to transform its Mother & Child Centers (MCC) into true agents of change and promotion for sustainability and community development. CARITAS was, in fact, already performing different integral activities of social promotion in the majority of the Mother Child Center's which included non-systematized activities of Growth Promotion and Surveillance (GPS).

The project was originally designed by a team of international consultants hired by USAID/Bolivia and Primary Health Care Technology (PRITECH), who at the beginning of 1985 issued a basic document proposing a strategy to promote and disseminate the control of diarrhea and Oral Rehydration Therapy. Later on, the component of Growth Promotion & Surveillance was added by suggestion of CRS. On the basis of said report, representatives of USAID/Bolivia, PRITECH and CARITAS drafted a programming document which served as a basis for negotiations among institutions. Unfortunately, these negotiations took place without the participation of technical counterparts of CARITAS. In addition, financing from USAID/Bolivia was conditioned to the imposition of PRITECH as a technical group and CRS as financial intermediary. The latter, due to the difficulty of PRITECH receiving the funds, since it surpassed the financial limit which it was allowed to manage. These special conditions under which interinstitutional agreements were made, had negative repercussions in the performance of the project, by generating institutional conflicts which were slowly resolved on the basis of good interpersonal relations.

The coverage of the Child Survival Project was planned by phases in three areas:

Area I Altiplano (July 1986-December 1989). Dioceses of La Paz, Oruro, Corocoro, and Coroico).

Area II Valleys (July 1987 - December 1989). Dioceses of Cochabamba, Chuquisaca, Aiquile and Potosi.

Area III Plains (as of 1989; Departments of Tarija, Santa Cruz, Beni and Pando.

The total budget of the Child Survival Project was $1,830,000, from the following sources:

- OPG from USAID/Bolivia to Catholic Relief Services for $1,136,000 (USG No. 511-0590),
- Technical Assistance worth $310,000, through PRITECH.
- Funds from PL-480 Title III, worth $392,000 disbursed directly to CARITAS.

In the middle of 1987, the evaluation team of the Child Survival Project found a series of structural, managerial, coordination and implementation problems.

On the basis of the findings of this evaluation, a reformulation workshop was carried out in February, 1988. During the workshop, modifications of the objectives, strategies and organization of the Child Survival Project were proposed, many of which have not been carried out to date.

At the beginning of 1989, the Child Survival Project began to execute the Acute Respiratory Infection component. During this year, the Child Survival Project also initiated activities in area III (Plains).

In December 1989, the present agreement for external cooperation will cease. This is why CRS and CARITAS have considered a final evaluation useful.

IV. ORGANIZATION AND PROJECT PERSONNEL

A. PROJECT ORGANIZATION

NATIONAL COORDINATING OFFICE

The functions of the National Coordinator were reformulated during the workshop in 1988. It is the opinion of this team that many of these functions are not being executed at present, specially technical/administrative assistance, monitoring and evaluation and the processing and flow of information.

Also, many Child Survival Project workers mentioned that during the past year, the administrative capacity of the National Coordinating Office had improved (eg. disbursements are more timely), but the technical aspects had had ups and downs. Possible reasons for these problems:

- Although the NCO has 15 workers, only 4 (the Coordinator, the Doctor, the Social Communicator and the Nutritionist) have technical functions; the rest is administrative personnel. Half the technical personnel has not visited areas I and II since they entered the Child Survival Project.

- The NCO is not organized to respond to the technical needs of the diocesan offices; for example there is only one social communicator to respond to training and communal education needs in the whole country. By contrast there are three workers in the computer department.

- The autonomy of Diocesan Offices has influenced the flow of communications between the NCO and the diocesan Offices and the Child Survival Project. However, the NCO has not carried out significant steps to improve this communication. The diocesan directors are conscious of the impact that the Child Survival Project has had within its CARITAS, and a greater technical role could be negotiated for the NCO in local Child Survival Project affairs.

DIOCESAN OFFICES OF THE CHILD SURVIVAL PROJECT

Each Diocesan Office (DO) of the Child Survival Project is directed by a person responsible as Diocesan Supervisor (DS), and made up of a managerial-accounting secretary, and 4-7 Field Coordinators. This personnel is paid for by the dioceses, using funds periodically transferred by the Child Survival Project. Supervision of this personnel is also a function of the dioceses, and not of the Child Survival Project.

The main activity of the Diocesan Office is to execute Child Survival Project activities, according to programming approved by CARITAS Diocesan Direction. The role of the National Coordinating Office is approved by CARITAS Diocesan Direction. The role of the National Coordinating Office in approving these programs and in the supervision of this personnel is not very clear; in some dioceses the National Coordinating Office reviews the programs before the Diocesan Direction, in other dioceses, the revision follows after, and in others there is not revision by the National Coordinating Office. The National Coordinating Office can propose a salary level for Child Survival Project personnel, but the dioceses has the right to establish the definite salary.

It is surprising that the Diocesan Offices perform their work within the possibilities and limitations of their personnel; they generally lack, however, ability and knowledge to analyze local experiences and modify strategies according to their findings, to know the effect of their actions (monitoring and evaluation), and to have greater comprehension of their human and social surroundings (promoters, Mother Child Center's, diocesan personnel). Upon talking with members of the DOs, their motivation and faith in the project is notable, but their disappointment due to the lack of incentives and support from the National Coordinating Office and/or diocesan offices, is also very clear.

One of the team's observations has been the positive correlation in the degree of coordination between the diocesan office and the Diocesan direction and the results obtained. Where good relations and dialogue have prevailed between the Diocesan Offices and the diocesan direction, effective work was achieved.

RELATIONS BETWEEN THE NATIONAL COORDINATING OFFICE, DIOCESAN OFFICES AND DIOCESAN DIRECTORS

According to CARITAS, the National Coordinating Office lacks hierarchical authority with the Diocesan Directions of CARITAS regarding technical-administrative matters of the Child Survival Project at the diocese level. However, the majority of the dioceses were eager to have greater contact with the National Coordinating Office: the problem, according to them, was that the National Coordinating Office did not visit them. It is our impression that the National Coordinating Office has not used all of its negotiation and persuasion capacity in order to achieve a greater role in the execution and assistance of the Child Survival Project's activities in the dioceses.

B. PROJECT PERSONNEL

GENERAL CHARACTERISTICS

CSP personnel at a national and diocesan levels were requested to fill in a confidential questionnaire. At the diocesan level 21 field coordinators and 6 diocesan supervisors answered the questionnaire. At a national level, 8 members (CARITAS and Child Survival Project) also responded to this questionnaire.

DIOCESAN PERSONNEL

The 21 FCs interviewed had a average time of work of 23 months (range 9-39 months). The 7 DS interviewed had an average time of work of 26 months (range 2-40 months).

The 7 Diocesan Supervisors and the 21 Field Coordinators had received and average of 1.4 training courses recently. The majority were offered by the Child Survival Project, but there was attendance at courses organized by similar public and private entities.

On the question: which are the objectives of the Child Survival Project, 6 out of the 7 Diocesan Supervisors interviewed were able to quote an objective similar to those mentioned in the Project Document. However, only 15 out of 21 Field Coordinators's were able to do the same. These responses suggest an intrinsic weakness in the basic question of the Project: What do we want to achieve?

FUNCTIONS OF THE DIOCESAN PERSONNEL

On the question: Which are your functions? all 7 Diocesan Supervisors answered in the following manner:

70% training, including planning and/or implementation
100% personnel supervision
43% administrative work, including report preparation
30% planning of activities
14% inter-institutional coordination.

The qualitative analysis of those answers suggests that there is no uniform perception regarding the functions of the diocesan supervisor. Some answers are also vague and suggest that there are functions that are not clearly defined among this personnel.

When this question was presented to the 21 Field Coordinators's, the answers were:

71% training of promoters
75% follow-up and supervision of promoters and/or Mother Child Centers
20% administrative work (gather data and/or prepare reports)
10% administer supplies to promoters.

Qualitative analysis of the answers suggests a lack of clear and uniform perception of functions among a significant percentage of coordinators.

The Diocesan Supervisors have perception of their functions than the Field Coordina n comparing in each dioceses,however, we reach the conc the clarity of DS functions is positively correlated with the clarity of functions among its coordinators. Another correlation is that the clearer the functions in the diocese, the greater the participation of personnel in training courses (offered by CARITAS, or other institutions like the Ministry of Social Services & Public Health, UNICEF, etc.).

C. STRENGTHS AND WEAKNESSES OF THE CHILD SURVIVAL PROJECT

On the question: which are the successes of the Child Survival Project? the Field Coordinators's and the Diocesan Supervisors responded:

- To have reached the neediest communities with a social impact program.

- The adequate selection of child survival (CSP) interventions used (Oral Rehydration Therapy, Acute Respiratory Infection, Growth Promotion & Surveillance).

- The use of the Mother Child Centers as a means of disseminating Child Survival Project's interventions.

- Training of the promoter and her use as knowledge transmitter.

- The use of alternative means of communication (radio, festivals, etc.) to broadcast health messages to beneficiaries.

On the question: which are the problems encountered by the Child Survival Project during its implementation? the Field Coordinators's and the Diocesan Supervisors responded:

- The Child Survival Project has no influence in the community, because it has been limited to working with the Mother Child Centers.

- Insufficient supervisory visits, due to lack of transportation, per-diem, local regulations, etc.

- Inadequate relationships with Diocesan Directions and the National Coordinator.

- Due to the unstable nature of their work conditions (they sign annual contracts) and the requirements of their work, salaries and incentives are considered insufficient.

- Lack of organization in the Mother Child Centers.

- Turnover of promoters at the Mother Child Centers.

- Absence of supplies such as medications for Acute Respiratory Infection.

- Delays in financial disbursements, which delays salary payments and,

- The absence of communication of the Child Survival Project (at the diocesan level) with the local church and with authorities of the Ministry of Social Welfare & Public Health.

At a national level (CARITAS and Child Survival Project), the answers to this second question were:

- Lack of technical professional personnel in some dioceses,

- Bureaucracy (at a national & diocesan levels),

- Lack of continuous supervision of the National Coordinator of the activities in each dioceses, and

- Inappropriate relationships between the Coordinator and the Diocesan Directions.

CONCLUSIONS

1. The present organization of the Child Survival Project is barely covering the needs of the institution. There are problems of coordination and technical support among the central and peripheral levels of the Project, which are difficult to solve with the present structure.

On the one hand, the Diocesan Offices are not technically nor administratively prepared to manage a decentralized program, without the support of the National Office. On the other hand, the National Office is not organized to respond efficiently to the requests of support of the diocese.

2. At present the National Coordinating Office has little capacity of negotiation with the diocesan directions of CARITAS, specially in programming and supervising activities, and personnel policies of the Child Survival Project (specially, selection and wage scale). Both parties are responsible for this situation: the National Coordinating Office has not shown interest in the subject, and the Diocesan Directions are zealous of their autonomy. There is room, however, for improving relations between both parties.

3. The diocesan personnel of the Child Survival Project (Field Coordinators and 4 Diocesan Supervisors) impressed the evaluation team as capable and motivated workers. They have the following problems, however:

   - Some of them do not know the objectives of the Child Survival Project, nor the functions of their posts (effect of autonomy?).

   - Salaries are perceived as insufficient, because their contracts are fixed time-limit and demands on their time are above the average for CARITAS workers.

   - Their educational level is heterogeneous, which hinders the achievement of a uniform level of knowledge among the team.

   - lack and/or inexistent observation of professional profiles has allowed some personnel members to carry out inadequate functions and/or responsibilities in relation to their educational training and/or previous experience.

4. The successes and problems identified by Child Survival Project and CARITAS personnel, have been verified for the most part by the evaluating team. They can be resolved with greater organization and a better strategy of the Child Survival Project.

V. BENEFICIARY POPULATION

INITIAL GOAL

According to the initial proposal of the Child Survival Project, beneficiary population for this initiative of Child Survival, would be 250,000 children who are beneficiaries of the CARITAS/Catholic Relief Services food distribution program among the 1800 Mothers' Clubs in all of Bolivia. At no point in this proposal, is the Mother Child Center perceived as part of the community; let's remember that the Mother Child Center is a foreign institution regarding local traditions, and that the true social group is the community. It is important to consider the relation between the Mother Child Center and the Community in order to perpetuate a demand for innovation within a social group.

This proposal did not include as beneficiaries the members of the Mother Child Centers, whose change of behavior in favor of Child Survival is basic to this Program.

PROGRAM COVERAGE

The number of Mother Child Centers, children below age of 5 and members covered by the Child Survival Project during the 1987-89 period is shown below:

Year	No. of MCC with the CSP	No. Children under 5 With the CSP	No. of members in the CSP
1987	1280	76223	20489
1988	1152	69055	27622
1989	1113	65418	26167

During 1987, the Child Survival Project covered 41% of participation of Mother Child Centers in the food donation program of CARITAS; during 1988 this coverage was 32%. The reason for the drop in coverage was due to a drop in the number of participating Mother Child Centers in the Child Survival Project, and at the same time due to an extension of coverage of the food donation program.

About 51% of children who benefited from the food program also participated in the Child Survival Project during 1987. In 1988, this percentage was 44%. The reasons for this drop are the same as above.

During 1988-89, only 16% of children under 5, registered at the Child Survival Project were below age 1. In an average population, over 20% of children below age 5 are infants. Therefore, there are difficulties within the Child Survival Project to enroll this age group, which is of high risk.

It was possible to estimate among the 104 rural communities of Oruro, Cochabamba, Potosi, and Sucre, the percentage of community population influenced by the MCC's. In order to obtain this percentage, each member was multiplied by 5 (average family size) and the result was divided by the estimated community population. An average of 40% of the community population is influenced by the Mother Child Center (range 15%-95%). As is logical to assume, smaller communities have a greater percentage of members influenced by the Mother Child Center. See Graph #1. This concept in important to select communities with greater probabilities of sustaining a demand for innovation of the Child Survival Project: among small communities (below 400-500 inhabitants), the possibilities of rapidly obtaining a "critical mass" (and therefore, selfsustaining innovation) are greater than in the larger communities.

A concept of balance: access to health services is much more restricted in the rural areas than in the suburban ones. The Child Survival Project has shown efficiency in both instances. Therefore, if the Child Survival Project would focus its actions specifically towards the rural dweller, it could extend services to a population with no access to other public or private entities.

BENEFICIARY POPULATION IN FACE OF AN INNOVATION

In the majority of cases it is the mother who carries innovations proposed by the Child Survival Project, (e.g. Oral Rehydration Therapy) to the home; she tries it out successfully with here loved ones, and later makes it part of her family life.

But what factors work in the adoption of this innovation? Dr. Llobet, professor of the University of Sucre, gave us some clues during an interview:

- The prestige of the person proposing an innovation. Three prestige factors are important: sex, profession and age. A male, middle aged doctor will have more social prestige (in the eyes of the mother) than an illiterate young woman,

- Besides, if the innovation fails in the home, and the husband recriminates her, the wife can transfer guilt to the person who proposed the innovation. The more prestigious this person is for the father, the more secure the mother will feel in transferring her guilt, and therefore she can try the innovation at home.

- Women's social role: women manage most of the domestic decisions, but she responds to the husband (including physical aggression) if something goes wrong. Women who have obtained a better role with regards to the husband (e.g. with higher formal education) can take important decisions with greater liberty.

MOTHER'S CLUBS & THE CHILD SURVIVAL PROJECT

The Child Survival Project started its activities with one basic assumption: all the Mother Child Centers would accept and internalize the activities of the Child Survival Project equally. Evidence to date shows that this assumption was false.

The Mother Child Centers have responded in a diverse manner to the Child Survival Project; some have made the CSP an integral part of their activities, but other have rejected it not openly (by lowering the attendance to meetings). Other Mother Child Centers have accepted these activities, encouraged by their desire to continue receiving food donations: attendance to meetings (and to the Child Survival Project activities) is a requisite to receive them.

During 1989, OFINAL, a public institution, has begun to distribute commodities to families in the rural and peripheral areas. Some Mother Child Centers have resigned to CARITAS in order to enter into OFINAL. OFINAL only requires a nominal enrolment of the family to a Mother Child Center or to a similar communal institution as a requisite for delivery of commodities. The following chart compares savings in Bolivian currency, among commodities distributed by CARITAS and OFINAL for a family with two children below age 6, for a period of three months:

	Nominal Paid Value (Bs)	Market Value (Bs)	Savings (Bs)
CARITAS	6-36	36-54	0-48
OFINAL	40-50	50-90	0-50

To interpret the Chart, we must establish an assumption; that the population knows market prices and takes rational decisions. If this is so, the Chart shows that the decision to change to OFINAL doesn't represent monetary savings: in both situations a similar amount is saved. The advantage may be a savings in time: OFINAL doesn't require attendance to the Mother Child Centers as a requisite for distribution. Therefore the Mother Child Centers which have switched to OFINAL have intrinsically decided that their time may be better used in other activities instead of the Mother Child Center (and the Child Survival Project).

Many Field Coordinators were asked about the factors which most influenced the acceptance of the Child Survival Project within a Mother Child Center. Their main answers were:

- organization of the Mother Child Center, above all leadership and spirit of cooperation among its members. For example, frictions between members of the Mother Child Center due to the amount of food that each one receives are signs of poor cohesion within the Mother Child Center.

- Greater literacy levels among members favors acceptance of the Child Survival Project. However, the Mother Child Centers with unequal literacy among their members tend towards lack of cohesion.

- Greater abandonment of the Mother Child Center (and the community) for public and private benefit/development services, favors the acceptance of the CSP within the Mother Child Center. For example, the Child Survival Project is better accepted in the rural than in the urban and suburban areas.

THE ROLE OF FOOD DISTRIBUTION IN THE CHILD SURVIVAL PROJECT

This evaluation touches on two aspects of the relation of food distribution and the activities of the Child Survival Project:

a. food distribution as a limiting factor for access to the CSP: CARITAS doesn't donate food; it distributes it to the members of the CSP at a symbolic monetary price, but it may be an obstacle for the poorest of the poor.

   We spoke with a number of FCs and DSs regarding the economic status of the members of the MCC; the majority coincided that the average population were members of the

MCCs: the poorer ones lacked money to pay the monthly quota, and the wealthier ones had other alternatives for subsistence. This situation is important for coverage of the CSP. Oral Rehydration Therapy is offered to all members of the community, but GPS and the management of ARI is reserved only for members of the MCC.

b. Food distribution as facilitator of innovations: the material needs among the beneficiary population of CARITAS is imperative, in some areas more than in others.

The MCCs that have rejected food distribution don't live in the worst situations: they have a reasonable source of subsistence and/or are attempting additional forms of income (ie. weaving). In communities such as these, to continue food distribution is to create dependency: an opportunity to improve is replaced by a temporary solution.

In the poorer areas (specially rural), the time women have is very limited, due to the daily subsistence struggle. On the other hand, many of CSP's interventions (such as nutrition) require time to be internalized through talks, demonstrations and games. Also, in many cases, husbands disapprove of their wives meeting at the MCCs and "doing nothing".

Therefore, under theses conditions, food donations act as a logical and appropriate subsidy so that the mother may have access to Child Survival Project information, without provoking stress in the family economy. Internalization of this knowledge will depend on the strategy of the Child Survival Project and the intrinsic interest of the mother; yet, food distribution has played an important role: it has allowed a greater number of potential users to have access to interventions proposed by the Child Survival Project.

CONCLUSIONS

1. Present coverage (among children below age 5) of the Child Survival Project is only 25% of that established in the Initial Proposal. Moreover, the population below age 1 is not adequately covered. The Child Survival Project, however, has reached the limit of its coverage, according to the resources and strategies it manages.

2. During the permanence of the Child Survival Project, the range of behavior of the MCCs has been outstanding with regards to the interventions proposed. This leads us to observe that there are features within the MCCs which can help us select those communities with better possibilities of success on a short term basis.

The number of communities managed by each FC must be diminished in order to allow better work with each MCC. Selecting communities with a greater success potential and working with them is vital for the successful continuation of the Child Survival Project.

Possible selection criteria:

- rural community: This is a criteria of equity because it is more difficult for health services from public and private institutions to reach them:

- small community (below 400 inhabitants); because it is easier to establish a "critical mass" in the community due to the influence of the MCC in the family circle.

- adequate organization of the MCC, specially leadership and spirit of cooperation of its members.

- greater literacy among its members favors the acceptance of the Child Survival Project. Those MCCs with unequal literacy tend towards lack cohesion among their members.

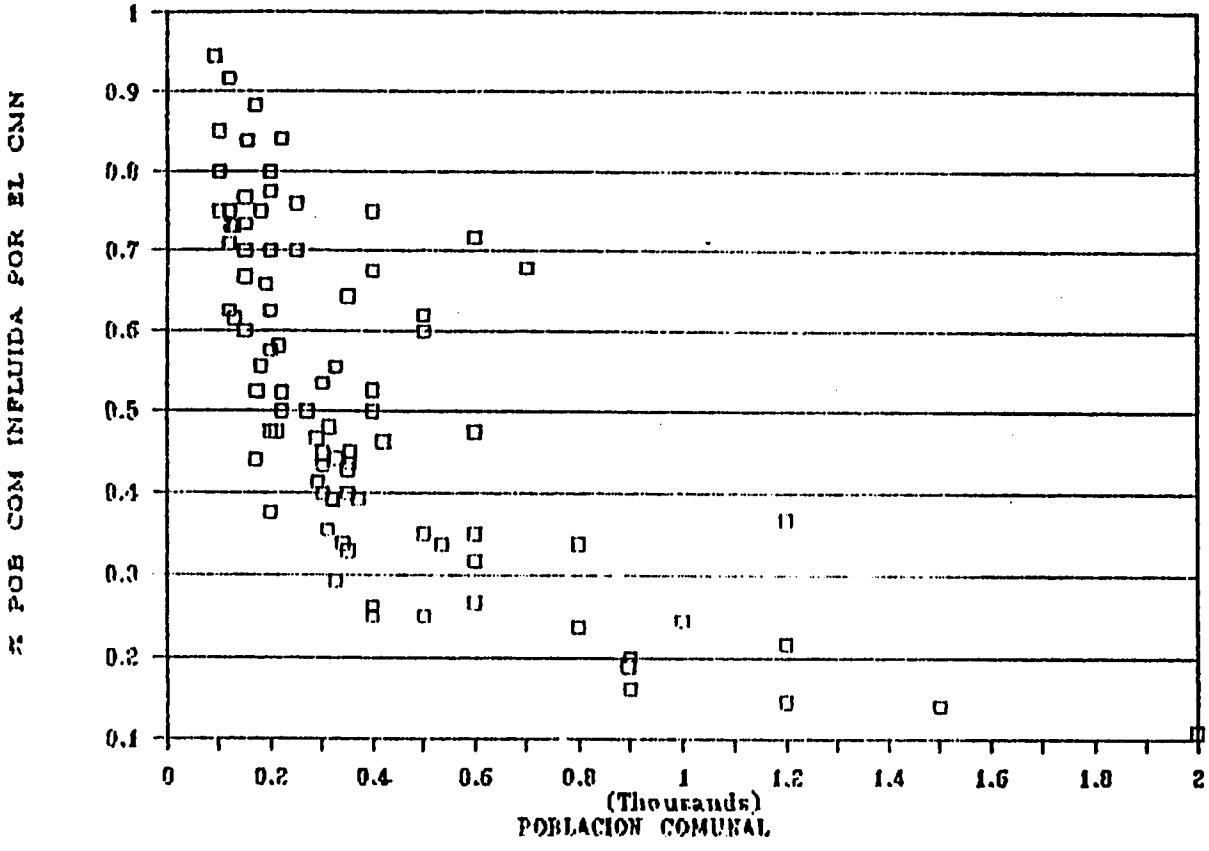
- greater abandonment of the MCC (and of the community) from public and private benefit and/or development services, favors the acceptance of the Child Survival Project within the MCC.

3. Food distribution plays an ambivalent role in the Child Survival Project: it is limiting and facilitating. It is limiting because quotas prevent access to the non-members (including the poorest) to the services of the Child Survival Project. It is facilitating because it allows a greater number of potential users to have the opportunity of participating in the activities of the Child Survival Project without causing stress in their family and their economic lives.

   Food donations should be directed to the population under extreme poverty conditions, where opportunities for progress on their own are minimal on a short terms basis. In populations with greater economic possibilities and/or potential for progress, CARITAS may replace food donations with other alternatives which will increase the productivity of the local dweller: agricultural and animal raising, craftsmanship, etc. In this latter situation, offering these alternatives to the community may be "tied" to the people's participation in Child Survival Project's activities.

RELACION ENTRE LA POBLACION COMUNAL

Y SU % INFLUENCIADA POR EL CMN



VI PROMOTERS

INITIAL GOALS

The initial proposal of the Child Survival Project suggests the use of voluntary MCC member promoters, to transmit CSP knowledge to the members. However, details to how to implement and support this network of promoters are not included. During the Child Survival Project mid-term evaluation (1987) and the reformulation workshop (1988), any deep analysis was made of the situation or role of the promoters. According to the Child Survival Project, promoters have been selected to nothing more than to receive training and to transmit it to the members of the MCC.

GENERAL CHARACTERISTICS

Fifty seven health promoters from 6 dioceses were interviewed. An implicit feature in this group was their greater access to the regular services of the Child Survival Project, which allowed them to be easily called to the diocesan offices of CARITAS for an interview. We may also infer, that their performance was above average. This situation should be considered when analyzing the data shown ahead.

The average age range among promoters was 28 years (range 15-46), with an average of 2 children (range 0-9), and an average formal education of 6 years (range 1-14).

FUNCTIONS OF THE PROMOTERS

Most promoters interviewed (over 75%), mentioned that their main tasks were: educating MCC members on child care, providing Oral Rehydration Therapy and managing ARI, plus a periodic weight control of children. Few promoters (below 50%) mentioned data gathering and report preparations. Very few (less than 30%) included home visits as one of their tasks.

The target population for these promoters are the MCC members, and not the community. However, they provide Oral Rehydration Therapy to those who need it. Due to limitations in the distribution of medication the ARI program as well as the GPS, is restricted to members.

The actual work of promoters demand between 6 to 14 hours a month, being the main activity their participation in the weekly meetings of the Mothers' Clubs.

PROMOTERS SELECTION

To choose their promoters the MCCs have used a series of mechanisms; from majority vote to a volunteer, to group pressure for task acceptance.

The average of Promoters' time of work within the surveyed group was of 17 months (range 2-36 months).

TRAINING

The promoters interviewed received an average of 3.7 of training courses (range 0-8), and their last training 2.2 months ago also as an average (range 0-9 months). For more details, see Chapter "PROJECT PERSONNEL AND PROMOTERS TRAINING".

SUPERVISION

The promoters interviewed mentioned that the last CARITAS personnel supervision took place two months ago (range 1-17 months). During these last visit, the supervisor carried out the following activities, measured in number of promoters answers:

- the 70% (40/57) answered that training was given on a new or known subject.
- the 60% (39/57) that the promoters registered were reviewed.
- the 85% (48-57) that coordination with Club authorities was made.
- the 25% (14/57) that coordination with communal authorities was made.
- the 77% (44/57) that a talk was given to members.

The 27 Field Coordinators and Diocesan Responsibles interviewed answered that their last supervisory visit was carried out 13 days average ago (range 2-30 days), and lasted an average of 3 hours (range 20 minutes-6 hours). Actually each coordinator has direct responsibility over an average of 40 centers (range 17-48), being capable to ordinally visit one center every two to three months. According to them, the optimum number of centers to manage would be 15 to 25 (depending of geography dispersion), and the optimum frequency of visits per MCC would be 1 to 2 times a month.

FACTORS FOR A GOOD PROMOTER PERFORMANCE

According to the survey results, we attempted to identify the factors which helped a better promoter performance. Three positive behaviors were identified: appropriate treatment of the last case of diarrhea detected by the promoter, appropriate treatment of last ARI episode detected by the promoter, and appropriated knowledge of actions to be taken according to the tendency of the growth curb in the Child Health Card. On the other hand, the following factors were chosen as potentially conditioned to the promoter: age, number of children, degree of formal education, time of work as promoter, number of courses attended, time passed since the last training course, time passed since the last supervision.

Analysis of both groups of variables showed that age, time of work as promoter, the number of children and the degree of formal education had no influence in conduction a positive approach. On the other hand, a greater number of courses attended, and recent training did have significant influence in the appropriate execution of the three conducts chosen (p less than 0.05). These behaviors were also influenced by a recent supervision but in a lesser degree (p less than 0.1).

The analysis also pointed out that the promoter who managed ARI well, also had proper management of Oral Rehydration Therapy (p less than 0.1).

RATES OF DROPPING OUT AND LINKED REASONS

The promoter annual drop out rate during the 1988-89 period varies in the different dioceses with a range between 15% and 45%. This desertion is greater in those dioceses which do not donate commodities to the promoters as an incentive to their voluntary work.

All 57 promoters interviewed were asked which were the main impediments for an efficient job. In order of importance their responses were: lack of participation of the members of the MCCs in activities called for by the promoter, the promoter lacks sufficient training for the post, and project personnel do not visit her. The 21 FC and Diocesan Responsibles who were asked the same question coincided with these answers, and added that the lack of community compensation was also a limiting factor for the promoter's work.

CARITAS's rules within MCC are however, another reason for dropping out: a promoter-mother whose children are above age 6, ceases to receive her corresponding commodity quota, and therefore, in many cases, upon lack of an appropriate incentive, she drops-out her job and the MCC.

Promoters were also asked the type of support they expected from their MCCs and the Child Survival Project. They expected of their MCCs greater participation in programmed activities and a material incentive (in kind or in work). From the Child Survival Project, promoters requested greater training (including First Aid), more supervisory visits and more supplies and materials. A significant minority mentioned its expectation of material incentives from the CSP, specially in kind. Surprisingly, FCs and DSs had similar responses to these questions, but they also emphasized that the project should provide material incentives to promoters.

When asked what would be their attitude if the Project stopped working in their MCC, the response among 80% of those interviewed was: "We will continue working as far as we can". CARITAS field staff was divided in its answers to this question: 60% opined that the promoters would work to the limit of their capacity and motivation, 30% responded that they would leave immediately, and the rest was of the opinion that they would move to another institution.

CONCLUSIONS

1. Promoters have proved to be useful for transmitting knowledge of the CSP to the MCC members. The promoters activities to be implemented in order to meet the goals of the Child Survival Project are well defined.

   However, the Child Survival Project has not given deep thought to the double role of the promoter: as a voluntary health personnel, with responsibilities and obligations established by the Child Survival Project; and as a family mother, with personal and family expectations and needs. The Child Survival Project has only perceived the first role of the promoter, and that is why it has loaded tasks after task on her shoulders without considering the time and effort that her compliance demands, nor on the incentives that the Child Survival Project (and the MCC) should give her to obtain a greater personal and family satisfaction. To make the situation more difficult, the system of supervision and material supplies has faults, which have repercussions in the morale of promoters.

   This lack of perception of the dullness of the promoter-family mother role explains the high percentage of drop-outs in this group. It is difficult, if not impossible, to be a volunteer under critical conditions, such as the rural areas of Bolivia. Under these conditions time is very valuable and it necessarily has a price. This situation is even more difficult, if the promoter does not find the

incentives and/or adequate support from the Child Survival Project and/or the MCC.

2. The rules which prevent a promoter from receiving food if she stopped having eligibility criteria in the MCC are an example of the inexistence in the Child Survival Project of a strategy for promoters. Under this situation, the promoter is practically forced to leave the MCC.

VII. ORAL REHYDRATION THERAPY

IMPORTANCE OF THE PROBLEM

In the community studies, the mothers of 351 children below age 5, were asked about the existence of diarrhea episodes during the last 15 days and during the day of the survey. From the first question, we were able to calculate the prevalence of diarrhea during the period (period prevalence) which was 31.6%. This prevalence is similar to that found in diverse parts of the country by the MPSSP and NGOs working with Child Survival.

From the second question, it was calculated that the punctual prevalence of diarrhea (point prevalence) was 14%. Using the formula: PUNCTUAL PREVALENCE = (INCIDENCE) * (EPISODE DURATION) and assuming that each episode lasts 4 days, annual incidence of diarrhea among the population below age 5 is 12.78 episodes per child below age 5, which is above the average of 9-11 cases reported by public and private institutions in Bolivia.

On the other hand, during 1989, the population below the age of 5 treated by the Child Survival Project was 65,418. Therefore, we can estimate that 836,042 diarrheic episodes occurred in this population during 1989.

COMPONENT GOALS

The original component goals were:

a. Ensure that 50% of the project's mothers correctly identify three signs of dehydration.

b. Ensure that 50% of mothers participating in the project appropriately prepare the ORS as well as the homemade solution.

These goals were reformulated in February 1988, during the Follow-up and Reviewal Workshop in the following way:

a. Ensure that 60% of the participants correctly understand how to treat an episode of acute diarrhea within one year.

b. Ensure that 30% of the participants correctly carry out treatment of acute diarrhea within two years.

Positive evolution is clear in the formulation of goals from those based purely on knowledge to those based on practice. The 30% goal of correct practice, however, is a not very ambitious one for a project that has previously established a system to provide services, such as promoters and MCCs.

STRATEGY EMPLOYED

The Oral Rehydration Therapy was one of the initial components of the Child Survival Project, starting implementation in July 1986.

The Child Survival Project has trained health promoters in the use and promotion of Oral Rehydration Therapy during courses carried out in each dioceses. Material produced by CARITAS/PRITECH has been of invaluable help for efficiently training promoters and for the transmission to members of the MCCs.

Promoters use MCC meetings to train members of the MCCs. They also treat cases in their communities, using the sachet as initial treatment, and the homemade solution (sugar, salt and water) if the first in unavailable. Part of this strategy also consists of the continuation of feeding, breast feeding and supply of additional liquids.

SUPPLIES

The oral rehydration sachets are donated by USAID/UNICEF to the National Coordinator of the Child Survival Project, who in turn distributes them directly to the participating dioceses.

At the beginning of the Child Survival Project, the coordinators used to distribute three sachets to every participating mother in the MCC. However, when they noticed that the sachets were misused in the home, it was decided that only patients should receive them, through the promoters. At present, the promoters periodically receive boxes containing 50 sachets from the field coordinators.

Educational material (posters, flip-charts, health games) on Oral Rehydration Therapy is distributed to each promoter, upon completion of the corresponding course.

The survey conducted among 57 health promoters (see METHODOLOGY) has pointed out that:

- at the time of the survey, the number of sachets per promoter was 31.6. There were 14 promoters (25%) who lacked sachets at that time.

- 19 promoters (33%) pointed out that they were out of sachets at some point during the past year.

- 11 promoters (19%) completely lacked educational material on diarrhea.

- Failures in ORS packet distribution are at the dioceses-promoter levels because it was observed that the dioceses stock an adequate amount of sachets. There is no significant correlation (less than 0.05) between the supply of sachets and the supply of children's aspirin and cotrimoxazole, in other words the absence or presence of sachets is not related to the absence or presence of these medications with the same promoter. One of reasons is that the ARI program has supply problems at another level: National Coordinator-dioceses.

KNOWLEDGE AND PRACTICE OF PROMOTERS

The survey among promoters has also explored their knowledge and practices with Oral Rehydration Therapy. The basic results are:

- 50 promoters (88%) affirm that Oral Rehydration Therapy prevents dehydration in diarrhea. However, 34 promoters (60%) also mention that Oral Rehydration Therapy cures diarrhea.

- When asked about the diagnosis of dehydration performed during the last episode of diarrhea treated, 82% of promoters were coherent in their diagnosis and the signs/symptoms presented by the patient.

- When asked about the treatment of the last episode seen by the promoters, 82% (37/45) of them were coherent regarding the treatment and degree of dehydration.

- 19 promoters (33%) did not register the sachet handed out to their patients, and 25 promoters (44%) did not register patients attended.

- A review of registry sheets in one of the dioceses showed that 1-5% of cases treated by the promoter got worse and/or died. In similar programs, this proportion has been 1%.

The last talk on Oral Rehydration Therapy was offered to the MCCs approximately 4 weeks before, as indicated by the half the number of 57 promoters interviewed.

RESULTS OF THE STUDY OF THE MCC

Fifteen focal groups from the same number of MCCs were set up in relation to knowledge and attitudes towards Oral Rehydration Therapy among mothers of children below age 5; 10 of the MCCs were beneficiaries of the Child Survival Project (PROJECT MCCs) and 5 non-beneficiaries groups (CONTROL MCCs).

Some similarities and differences found upon comparing both groups were:

1. Both groups perceive diarrhea as a debilitating and mortal illness.

2. In the majority of the PROJECT MCCs, diarrhea is attributed to a lack of hygiene and food preparation, filth, flies and contaminated water. In the CONTROL MCCs, diarrhea is attributed equally to: lack of hygiene, strong winds, colds, carelessness of the mother, bad smells. In other words, the PROJECT MCC women have a clearer idea of the causes of diarrhea.

3. Both groups know certain signals of dehydration (weight loss, sunken cheeks). No differences are perceived between both groups.

4. Among the majority of PROJECT MCCs, the sachet is clearly recognized as an element to treat dehydration, together with complementary feeding and reference to health personnel (in moderate to severe cases). In the CONTROL MCCs additional medicines are used (herb teas, soaked bread, etc.) and some patients are referred to health personnel. In the CONTROL MCCs, the sachets are not used, although some mothers were of the opinion that they were good for diarrhea.

There were also 10 focal groups established in relation to diverse subjects (including knowledge and attitudes on diarrhea and ORT), among family fathers from an equal number of MCCs: 6 from the MCC beneficiaries of the Child Survival Project (MCC PROJECT) and 4 from non-beneficiary MCCs (MCC CONTROL). The answers obtained were similar to those of the mothers but less specific and ample.

In the interviews of mothers of 351 children below age 5,they were asked about the symptoms which appeared and the treatment of the last episode of diarrhea (if it had occurred within the last 15 days). In the MCC PROJECT, 68% (54/80) of cases had been adequately managed, whereas in the MCC CONTROL this rate was only 24% (11/45). These differences are statistically significant (to less than 0.01), even after stratification by maternal education. The greatest changes observed were the replacement of traditional medicines for ORT (including complementary feeding, use of Breast Milk, and use of homemade solution).

Assuming that the MCCs PROJECT visited are among the top range of the sphere, and that the data of the MCCs CONTROL could be compared with the MCC PROJECT on the lowest range of the sphere, the average number of properly managed cases of diarrhea

among the homes of CSP beneficiaries is 45% (average 68% and 24%). This average result is above the 30% goal established by the Child Survival Project in 1988.

The differences between the average obtained and the result in MCC CONTROL constitutes an estimate of the percentage of cases which were well managed in the home and that could be attributed to an influence of the CSP. If the estimated number of cases in the target population is 836,042, the number of cases properly managed at home due to the influence of the CSP and during the past year is 183,929.

CONCLUSIONS

1. The CSP has marked a difference in knowledge, attitudes and practices of its target population with regards to diarrhea and ORT. It has also surpassed its goal proposed in March 1988: 30% use of ORT during home treatment of diarrhea.

2. The main causes for the success of this component are:

   - diarrhea is identified by the population as a weakening and mortal illness. The introduction of ORT represented an adequate alternative in the face of this important necessity.

   - emphasis of the CSP (and of technical assistance) on this component. ORT was the essence of the CSP since its original design in 1985-86.

   - the educational materials (posters, flip-charts, etc.) and mass communication (radio) employed, were praised by CSP personnel, promoters and members of the MCC's visited because they were well adapted to the socio-cultural conditions of the population.

   - personnel and promoter training in this component was adequate, in spite of some limitations found. See chapter on "Personnel and Promoters Training".

3. This evaluation, however, has identified the following problems:

   - educational materials need renewal. Some promoters and personnel interviewed noticed boredom among members of the MCCs due to repetitive use of the material. Innovative alternative mass media, such as the health festivals observed in Sucre, should be identified and analyzed by the National Coordinator to be used by all the CSP.

- there is inadequate sachet distribution among at least 25% of promoters. Apparently the reason is the infrequent visits by the FC and his MCC (when the redistribution of sachets takes place), since there is no distribution problem among the dioceses and at the National Coordination level.

- the information system has failures at the promoter level: between 33% and 44% of promoters do not register patients treated and/or sachets distributed. Causes for this problem are: illiteracy of the promotor, forms are not adequate to her level of literacy, and/or there are failures in the distribution of forms.

- mortality rate after ORT (1%-5%) observed in some areas of the CSP is high, and deserves separate research. The greatest possibility is failure in gathering and/or processing information.

VIII GROWTH PROMOTION AND SURVEILLANCE

In taking weight and age of 299 children below age 5, during this evaluation, it was observed that 16% (49/299) had a weight/age average below the 2 standard deviations (using the NCHS table for reference), and this is a definition of malnutrition. Age average among malnourished children is not significantly different from the average of those not malnourished.

COMPONENT GOALS

The initial goals of this component were:

a. to see that 50% of MCC's correctly use the Child Health Card (CHC) in a period of 4 years.

b. to see that 60% of the MCCs have correct notions of: maternal feeding, feeding infants below age 1, feeding during other stages of life, personal and food hygiene, adequate preparation of donated foods.

These goals were reformulated in March 1988, during the Workshop on Evaluation, Follow-up and Revision of the Project, in the following way:

a. to achieve 60% knowledge and use of the CHC in a period of one year by participating mothers.

b. to achieve 30% of correct use of the CHC in a period of two years by participating mothers.

c. to achieve 60% knowledge and practice of maternal nutrition and infant feeding, with emphasis on maternal breast feeding by participating mothers.

Present goals are better focused for the target population than the initial ones. However, these present goals are difficult to evaluate, because terms like "know", "utilize", "practice", "use correctly", are not defined in a measurable manner.

STRATEGY USED

Growth Promotion and Surveillance (GPS) was one of the initial components of the CSP, starting implementation at the end of 1986.

The strategy has had two main themes:

a. promotion of infant feeding and nutrition in the MCCs with emphasis on adequate feeding during weaning, hygiene in food preparation and promotion of breast feeding. This promotion is carried out by means of talks offered by the promoter at the MCC, using teaching material prepared by CARITAS/PRITECH. Another means of dissemination (not used much) has been demonstrations of food preparation using local and donated foods.

b. growth surveillance and promotion, with periodic weighing (a minimum of 4 weighings a year) during the MCC meetings. The official model of the Infant Health Chart (CHC) of the MPSSP is used to register data: the original CHC remains with the mother and a copy with the promoter.

SUPPLIES

Each promoter is given a Salter scale, flip-charts and posters on the subject. In addition, the FC's periodically give them CHCs.

The scales have been purchased by the CSP. The CHCs have been provided by the MPSSP or printed by the CSP using the official blueprint. These CHCs have suffered a series of modifications during these last three years by the MPSSP, which has made understanding difficult by promoters.

During the interview of 57 promoters, 33% (19/57) mentioned that they lacked the CHC at least once during the past 12 months. At the time of the survey, the average of CHC's reserved by each promoter was 5.62, and 41% (24/57) declared they had two or less reserved. 23% (13/57) of the promoters interviewed stated they lacked at least one poster or flip-chart on the subject.

KNOWLEDGE OF THE PROMOTER

All 57 promoters were interrogated regarding the significance and reason for the three lines sketched in model CHC. 86% (49/57) were able to interpret the significance of two or more lines and suggest coherent management. This included reference of the malnourished (red thread) to a health center, and the use of oil as food supplement.

About 77% (13/57) of promoters registered weights obtained in the Charts that they managed.

The last talk on weight control offered to the MCC was approximately 3 weeks before given by half of the 57 promoters interviewed.

RESULTS OF THE STUDY OF MCC

Fifteen focal groups were established regarding knowledge and attitudes towards GPS, among mothers of children below age 5 from an equal number of MCCs: 10 MCCs were beneficiaries of the CSP (MCC PROJECT) and 5 were not (MCC CONTROL). Some differences and similarities found in comparing both groups are:

1. Among the MCC PROJECT, it is understood that the CHC is used to register weight and vaccines of children.

   Among the MCC CONTROL, some mothers know that the Chart is useful to register this data (children are weighed during the inoculation campaigns of MPSSP), but others ignore their existence and use.

2. Both groups recognize periodic weighing as a way to control growth of children. Yet, answers are more ample and precise among the MCC PROJECT mothers. For example, the MCC PROJECT mothers specifically mention the relation between weight and growth, whereas the MCC CONTROL mothers relate weighing with a general state of health.

3. In the MCC PROJECT, it is recognized that the CHC is useful for diagnosis through the color of the thread. At the MCC CONTROL, malnutrition is recognized through a change in the general state of health of the child.

   In addition, 10 focal groups were formed on different subjects (including knowledge and attitudes on the periodic control of weight) among family fathers from an equal number of MCCs: 6 MCC beneficiaries of the CSP (MCC PROJECT) and 4 non- beneficiaries (MCC CONTROL). Responses obtained are similar to those of the mothers, both with less specificity and amplitude.

   Due to the lack of precision in the goals proposed, the following indicators were used to evaluate results of that activity among children below age 5:

PROCESS INDICATORS

a. PROCESSION OF A CHC FOR CHILDREN BELOW AGE 2: defined as the % of children below age 2 at the MCC CONTROL and MCC project, who had their CHC at the time of the survey or the promoter showed the copy that she had. In the MCC CONTROL,

14% (8/57) of children below age 2 had a CHC, in the MCC PROJECT the proportion was 61% (66/109). The difference observed was statistically significant, including after stratification according to educational level of the mother (p less than 0.01).

b. AVERAGE NUMBER OF WEIGHINGS IN THE LAST 12 MONTHS: In the MCC CONTROL, the average number of weighings per child with a CHC was 0.75/year, while in the MCC PROJECT it was 3.62/year. This difference is statistically significant ($p<0.01$) even after stratification by maternal educational level.

Assuming that the MCC PROJECT visited make up the top range of the spectrum, and that the data of the MCC CONTROL could be compared with the MCC PROJECT in the extreme lower part of the spectrum, the average weighing per year of each child of the beneficiary MCC's (of the CSP) is 2.2 (average of 3.62 and 0.75).

The difference between the average obtained and the result in the MCC CONTROL is the estimate of the number of weighing/child/year which may be attributed to the actions of the CSP. Thus, 1.45 weighings (difference between 2.2 and 0.75) per child/year could be attributed to the influence of CSP. If the target population is 65.418, the number of weighings carried out by the CSP during the past year was 94.856.

c. THE PROPORTION OF CHILDREN WHO WERE FIRST WEIGHED BEFORE THE AGE OF SIX MONTHS: at the MCC CONTROL, 11% (9/83) of children with a CHC had first been weighed before the age of six months, whereas at the MCC PROJECT that proportion was 44% (72/163). The difference seen is statistically significant ($p<0.05$), including after stratification according to the mothers' educational level.

IMPACT INDICATORS

a. PROPORTION OF CHILDREN BELOW AGE 5 WITH WEIGHT/AGE BELOW TWO STANDARD DEVIATIONS (DEFINITION OF MALNUTRITION): in the MCC PROJECT, 13.5% (25/185) of children were malnourished, whereas in the MCC CONTROL, this proportion was 22%. The difference is statistically significant ($p<0.07$), but it looses significance when the results are stratified according to maternal education.

b. EARLY WEANING: defined as the use of complementary feeding (any food or drink other than breastmilk) before 4 months of age. At the MCC CONTROL no infant below age 4 months (0/10) was receiving complementary feeding, whereas at the

MCC PROJECT, this proportion was 22% (4/18). The difference found is not statistically significant.

c. PROPORTION OF CHILDREN BETWEEN AGES 4 and 6 MONTHS WITH ADEQUATE NOURISHMENT: which is defined as simultaneous administration of BF and complementary feeding. In the MCC CONTROL, 60% (3/5) of children in this age span were receiving BF and complementary feeding, while in the MCC PROJECT, this proportion was 66% (11/17). The difference found is not statistically significant.

CONCLUSIONS

1. The observations performed suggest that the Child Survival Project has marked a difference in knowledge, attitudes and practices related to the periodic weight control of children. Results in process indicators (possession of CHC, and the percentage of children who began to be weighed before age 6 months, plus the number of average weighings in the last 12 months), indicate that the MCC PROJECT have managed surprising advances compared to MCC CONTROL.

   The effect of the CSP, however, could not be verified with the impact indicators, such as the percentage of malnourished children, and the presence (or absence) of appropriate infant feeding habits. Different reasons for these results are: the small size of sample used, the actions of the CSP have not yet had effect on these indicators (results will be seen in the long run), or the strategy chosen is not appropriate and will not definitely influence these indicators.

   Process indicators, which have shown favorable changes are more influenced by food donations that impact indicators, which have remained without variation. The relation between food donation and the execution of the behavior pointed out by these indicators, could suggest if the strategy used may effect a change in the "hard" indicators: if attendance to the sessions of the GPS is related solely to the expectation of receiving food donation, we can expect little impact on the "hard" indicators, since these depend on the internalization of certain behavioral patterns.

2. The strong points of this component are:

   a. The educational material used. Comments are similar to those for the ORT Chapter.

   b. Training of promoters is adequate.

3. The weak points of this components are:

   a. There is no place to transfer patients with malnutrition (red thread). Some promoters transfer them to the sites of the MPSSP for nutritional rehabilitation, but they are turned down because of the inexistence of this activity.

   b. about 23% of promoters lack a copy of the CHC of their children, making data collection difficult for the information system, The reasons are similar to those mentioned in the preceding chapter.

IX. CONTROL OF ACUTE RESPIRATORY INFECTIONS

IMPORTANCE OF THE PROBLEM

In the community studies, mothers of 351 children below age 5, were asked about the existence of ARI episodes (coughing, nasal secretion and/or agitated ·breathing) during the past 15 days, and the existence of such episodes on the day of the survey. From the first question, the prevalence of IRA was calculated during the period prevalence, which was 52.4%. This prevalence is similar to that found in diverse parts of the country by the MPSSP and by NGOs that work with child survival.

From the second question, it was calculated that the punctual prevalence of diarrheic episodes (point prevalence) was 31.6% Using the formula: POINT PREVALENCE = (INCIDENCE) * (DURATION OF THE EPISODE) and assuming that each episode lasts 5 days, the annual incidence of ARI among the population below age 5 is 23.1 episodes/child below age 5 per year, which is above the average of 11-13 cases/child/year reported by public and private institutions in Bolivia. It is important to stress that the majority of these cases (above 95%) are cases of mild ARI, a self limiting illness featured by coughs and/or nasal secretion.

On the other hand, population below age 5 attended by the CSP during 1989 was 65,418. Therefore, we can estimate that 15,111,156 episodes of ARI occurred in that population during 1989.

COMPONENT GOALS

This component was not included as an initial part of the CSP, and its goals were established during the Evaluation, Follow-up and Reviewal Workshop of the Project (February 1988).

a. To achieve in a period of one year, that 60% of participating mothers correctly know the treatment of mild ARI.

b. To achieve in a period of two years, that 50% of participating mothers correctly perform treatment of mild ARI.

These goals separate from what is established for similar programs: a drop in mortality due to acute infection of the lower respiratory tracts (moderate-severe ARI), by means of diagnosis and early treatment. During the implementation of this component, these initial goals were surpassed, since the

component has included the treatment of mild-severe ARI, with goals which were not established.

STRATEGY USED

The component began to be implemented by the CSP as of January 1989.

The strategy used is the official one of the MPSSP: support treatment for mild ARI, use of oral antibiotics (cotrimoxazole in tablet form) for moderate cases, and reference to health centers for severe cases.

The expected behavior is that the mother may provide support treatment adequately in mild cases and refer the moderate ones to the promotor. The promotor manages mild cases with antibiotics and will refer severe cases to the nearest health center.

The last talk on ARI control was offered to the MCC approximately 2 weeks before, as was confirmed by half of all 57 promoters surveyed.

MEDICATIONS SUPPLY

Promoters are provided with educational material (posters, calendars, flip-charts) and medications (children aspirin, contrimoxazole in pediatric tablets) to treat this component at the level of the MCC.

The educational material has been created by CARITAS and the use of the text is difficult for promoters and members of the MCC to understand. At the time of the survey, 30% (17/57) of the promoters lacked this educational material.

Medications are provided by the Mother-Infant Health Office of the MPSSP to the National Coordinator of the CSP, who distributes it to the participating dioceses. During the interview of 57 promoters, 63% (36/57) mentioned lack of medications (children's aspirin or cotrimoxazole) at least once since the beginning of the program (less than a year ago). At the time of the survey, the average reserve of medications per promotor was 7 aspirins and 18 cotrimoxazole tablets. Also, 58% (33/57) of the promoters said they lacked aspirins at the time of the survey. Approximately, 39% (22/57) of promoters also lacked cotrimoxazole at the time of the survey.

Failures in the supply of medications are at the level of National Coordinator - Dioceses, because it has been observed that the Dioceses have an inadequate stock or absence of these

medications. There is no significant correlation ($p < 0.05$) between the supply of packets and that of aspirins and cotrimoxazole. In other words, the absence (or presence) of packets is not related to the absence (or presence) of these medications with the same promoter. One reason is that the ORT program has supply problems at another level: dioceses-promotor. The supply of aspirins, however, is very related ($p < 0.01$) with the supply of cotrimoxazole, because both medications are distributed jointly at all levels.

PROMOTERS PRACTICE

The survey among promoters has also explored their practices in the treatment of ARI. The basic results are:

- questions on the diagnosis of the severity of ARI performed during the last episode treated; among 68% (30/44) of promoters there was coherence in the diagnosis and the signs/symptoms presented by the patient.

- asked about ARI treatment performed during the last episode seen by the promoters, 68% (30/44) of promoters were coherent about the type of treatment and the degree of severity of the ARI. The survey didn't measure deossification and length of medicated treatment.

- 60% (35/57) of promoters said they had a register of patients attended and medicines handed out.

A common error observed among the promoters interviewed is to administer cotrimoxazole to cases, which in retrospect could be qualified as mild ARI. This is a fault observed in other projects of Child Survival, when community personnel with little training and/or experience had to take difficult decisions (moderate or mild ARI?) with a patient who might be a relative or neighbor, generally they took the most secure decision.

The promoters' registrations in the Dioceses of Cochabamba and Oruro (322 cases, May - August 1989) reveal that 4% of patients with ARI seen by promoters had to be referred to the hospital. This figure is above the 1% found in the ARI Program of PLAN/Sucre during 1989. The differences suggest that: CARITAS patients go to the promoter for more severe cases of ARI, or that the treatment of CARITAS promoters is more deficient (due to lack of medications or failures in training).

The data from Cochabamba and Oruro also suggest an inadequate pattern in the administration of cotrimoxazole, shown in the following chart (compared with the norms of the MPSSP):

AMOUNT OF COTRIMOXAZOLE TAB. DELIVERED BY THE PROMOTER IN CASES OF MODERATE ARI, PER AGES

AGE	COTRIMOXAZOLE TABLETS (PER PATIENT) DELIVERED BY THE PROMOTER		
	ORURO	COCHABAMBA	MPSSP
Less than 1 year	10		10
1 "	20		20
2 years	20	10	20
3 "	30	15	30
4 "	30	15	30
5 "	15	15	30

Possible reasons for under-deossification in Oruro and Cochabamba are: scarcity of cotrimoxazole forces to rationalize spending, failures in promoters' training, or perception in the FC or the promoter that "it's too many tablets for a small child". These patterns of under-deossification may hamper treatment of patients, which could partially explain the 4% of patients with ARI referred to hospitals.

RESULTS OF THE STUDY OF THE MCC

In interviews with mothers of 351 children below age 5, they were questioned on symptoms presented as well as treatment the last ARI episode (if it had occurred in the last 15 days). In the MCC PROJECT, 57% (71/125) of cases had been adequately treated, whereas in the MCC CONTROL this proportion was only 27% (17/64). These differences are statistically significant ($p < 0.01$), even after stratification of maternal education. The most important change observed among both groups was the replacement of traditional medicines and others (Eno, Alka Seltzer), for support treatment, access to the promoter and use of antibiotics.

Assuming that the MCC PROJECT visited make up the extreme top range of the spectrum, and that data from MCC CONTROL could be compared with MCC PROJECT but at the lower range of the spectrum, the average percentage of cases of ARI well managed at the home among MCC beneficiaries of the CSP is 42% (average of 57% and 27%). This result can not be evaluated due to the lack of measurable initial goals.

The difference between the average obtained and the results among the MCC CONTROL make up an estimate of the percentage of cases which were well managed at home and that could be attributed to the actions of the CSP. Thus, 15% (difference between 42% and 27%) of cases were well managed at home due to the influence of the CSP. If the estimated number of cases in the target population during 6 months (the average duration of this component) is 755,578, the estimated number of cases well managed at home due to the influence of the CSP and during the length of the component was 113,336.

CONCLUSIONS

1. The Child Survival Project has marked a difference in knowledge, attitudes and practices that the target population had with respect to ARI, in spite of the short time working in this component (less than 1 year). The most important change observed between the MCC CONTROL and MCC PROJECT was replacement of traditional medicines and others (ENO, Alka Seltzer), due to access to the promoter and use of antibiotics.

2. The reasons for the success of this component were:

   a. treatment of ARI is a strongly felt need among the target population (first cause of mortality among children below age 5 at a national level). Besides, the treatment proposed by the CSP (including antibiotics) is compatible with the perception that this population has of "modern" medicine. This last factor has accelerated the acceptance of this component in the population.

   b. the selection of medications and manner of deossification, according to the norms of the MPSSP, has been adequate. The preference for cotrimoxazole instead of penicillin is correct, due to a greater facility of administrating the former.

3. The following problems have been identified, however:

   a. training of promoters is inadequate: one third of them were unable to make a proper diagnosis and/or treatment with their last ARI patient.

   b. there are serious problems with medication supplies, specially at the National Coordinator-Dioceses level. Apparently, no one has taken into account the minimum periodic needs for medications in this program.

c. both of the points above favor an inadequate deossification for patients who evolve more unfavorably than in other projects with similar characteristics.

d. educational materials (posters, flip-charts, calendars), due to text use, are difficult for mothers and promoters to understand. They require modifications in order to be relevant.

e. the information system at the promoter level requires improvement: 40% of promoters interviewed said they did not have a registration of patients attended and/or medicines handed out.

X. TRAINING OF PROJECT PERSONNEL AND PROMOTERS

BACKGROUND, OBJECTIVES AND GOALS

The Child Survival Project executes actions since 1986, with CRS/Bolivia as an intermediary for the management of funds coming from USAID/B.

The main purpose, according to initial agreements, is to reduce infant mortality, introducing a training component in health at the MCCs depending on CARITAS.

The strategy designed shows the educational component as a central factor of the CSP, effecting mothers as direct participants of the MCC.

To carry out the CSP, the organizational structure of CARITAS was respected: a central level and diocesan levels, all dependant on the Promotion Department. The selection of FC and DS follows criteria established in each area. There are functions manuals for hiring and they establish responsibilities, but they lack position profiles (professional level, experience, etc). This failure permits the existence of heterogeneous teams.

The general and specific objectives of the Child Survival Project, related to the educational component, have not undergone substantial variation. Modifications carried out in February 1988 are on the basis of specific criteria: they only mention formal change.

In the educational field they intend to: "establish a system of continuous training in the different aspects related to health improvement in the MCC". This objective holds direct relation to the general objective of the Child Survival Project.

The goals established lack quantifiable and temporal elements that could be measured, and which could be used as evaluation criteria.

DESCRIPTION OF THE COMPONENT

In order to meet the objectives, a training system has been developed with technical assistance from PRITECH. The strategy is an escalated series of courses called "step by step" training, which covers the central level, influences the diocesan teams and reaches the mothers to obtain an important role in the attention of their children below age 5.

The central subjects are: ORT, GPS (including nutrition) and ARI. Training is completed with a supervision mechanism and medications supply and educational material, besides a system of information which gathers basic data on the activities of the CSP.

In areas I and II, there were 244 courses given, where 1,300 promoters were trained between 1987 and 1989. Data corresponds to the dioceses of La Paz, Oruro, Coroico, Aiquile, Cochabamba, Corocoro, Potosi and Sucre.

THE ROLE OF TECHNICAL ASSISTANCE

Technical assistance given by PRITECH influenced 3 aspects:

A. ORGANIZATION

Three areas for progressive expansion were established (Altiplano, Valleys and Plains); a system of replication was established for training at 3 levels: diocesan personnel, promoters and mothers.

Criteria for the selection of promoters were suggested at the courses for diocesan personnel: the levels for operational action were also designed.

B. TRAINING EXECUTION

Courses were given to diocesan personnel on the central themes of the CSP, whose preparation and design corresponds to:

- duly processed theoretical framework. This was carried out through thematic research in the MCCs to adapt content and prepare adequate educational material.

- design of courses, differentiated by subject, which include: gathering of participants' experiences (success and difficulties during practices), initial and final evaluations, theoretical-practical development of subjects with the use of participatory techniques (theatre, socio-drama, puppets, group work, etc.).

- additional contents during training are the planning and programming of courses, teaching methods, application of educational material and evaluation systems.

C. FORMULATION OF EDUCATIONAL MATERIAL

Educational material was formulated using the following stages: selection of frames of reference, surveys, validation tests of pilot samples, readjustments and production.

Technical assistance was also oriented to the use of mass media and techniques applicable to radio systems.

THEORETICAL-METHODOLOGICAL OBSERVATIONS

The "step by step" training method, applied in the execution of the Child Survival Project, is unidirectional because its actions are directed from the central level to the MCC level, without any feedback capacity.

This model presents a fracture at the level of FC and DS (national courses) due to little or no control that is exercised from the central level in regional applications. Another problem is the inadequate communication from the central level with the Diocesan Directions, which prevents a return of the monitoring and follow-up tools which could become a feedback mechanism in the educational process.

The analysis of national courses suggests that deossification of topic contents is not related to the intrinsic capacity of the participants, which make up a heterogeneous group due to their different levels of education. During these courses, emphasis is given to the transmission of contents at the expense of methodological aspects. This emphasis in knowledge and lack of methodologies is also observed in courses given by the diocesan personnel to the promoters.

The national courses also provided the participants with some elements for planning and programming, but a review of training activities in the dioceses shows that this knowledge has not been applied.

Finally, the execution of these courses do not show any difference according to levels of responsibility. The FCs and DSs participated in the national courses, and their different roles should have had specific attention.

The courses carried out by the FC's reveal homogeneity in their design. The sequence is as follows: presentation of objectives, identification of difficulties, initial and final evaluations, review of previous subjects, development of the central subject, execution of techniques and information systems (with their corresponding report forms). There is a difference, however, between the deossification of contents and the socio-

cultural situation of the participants. There is emphasis in developing memory capacity for concepts. The design of courses does not indicate spaces destined for partial conclusions for each stage. In the educational work with rural sectors, with low educational levels, the repetitive feature of the process plays an important role in consolidating learning. The time established for each activity seems to be insufficient. The theoretical elements also seem to be insufficient for the execution of participative techniques.

A weak aspect of this educational model is follow-up. National courses provide the participants with tools for execution, but the experiences resulting from this training do not return to the central level to be processed.

Another weak point are the promoters, due to the high drop-out level, specially in places where voluntary work is promoted. It is to be assumed that due to the national economic crisis, payment for hours worked is a deeply felt need for family subsistence. This situation affects the continuation and efficiency of the program. Interviews with the promoters show a good concept management of the objectives and contents of the Child Survival Project. It is necessary, however, to reinforce their training, specially in methodological aspects.

In relation to the MCCs, there are conditioning factors which must be taken into account in the conceptualization of the educational process: high rates of illiteracy, their socioeconomic conditions, their role in the community, their situation as women with capacity to influence the family sphere. These factors should be considered during the courses to detect educational needs and to develop a critical spirit, which should contribute effectively to their training process. It is evident that the mothers have learned the basic concepts of the Child Survival Project; the influence of these concepts is less evident in detecting a change of behavior compatible with their cultural values and which may have influence on their surroundings. These changes of behavior should be verified and quantified through follow up.

EDUCATIONAL MATERIALS

Educational materials play an important role in the learning process. A careful process is observed in their formulation. Due to their graphic features they are better able to transmit messages among the sectors where the CSP works. The response to this stimulus is very valuable (except material for ARI). Sequence in its application is homogeneous. These features suggest that training at central levels has motivated and guided the use of such material with precision.

The teaching process starts with observation, followed by comparison with the immediate reality. Then follows complementary analysis and information. This format, where the process of reflection is important, indicates that actions are directed towards a process that combines the informative with the formative. This process, however, must be complemented with the recuperation of cultural values, daily practices and openness towards the community. In this manner, an eminently formative process would be generated.

Materials are of two categories: interpersonal means (flip-charts, games) and mass media (radio, posters, festivals, contests, etc.). In the former, the methodology of use should be emphasized, to avoid mechanical work of the promoter and boredom of the audience.

A special mention should be given to the use of radio, specially in radio contests, which enable an opening of the CSP towards the community. Due to the favorable response obtained, shown by the amount of participants in the radio contests, this should be reinforced continually. Another aspect to be reinforced are the regional festivals, which are alternate means of educational communication. These events strengthen collective work of the MCCs and rescue their cultural values.

LIMITATIONS IN EDUCATIONAL WORK

The interviews performed indicate little precision in the knowledge of the functions of the DSs and FCs. Another limiting aspect is the poorly defined relationship of the CSP with the diocesan promotion departments, which prevents the execution of coordinated actions that help the work of the MCC.

The allocation of the number of MCCs for each FC, does not seem to be adequate. The MCCs assisted by each FC range between 30 and 45, preventing proper supervision. The monitoring and supervision forms do not return to the national coordinator for processing and analysis.

Restrictions to the FCs in their field visits also limit the execution of a follow-up process.

CONCLUSIONS

1. Technical assistance (PRITECH) allowed the Child Survival Project an adequate implementation, by means of the training offered and the preparation of educational materials. PRITECH, however, did not generate capacity within CARITAS so that, after technical assistance terminated, the CSP would be able to initiate a self sufficient process in the

educational aspect. Why wasn't this vision of the future included during planning of the Child Survival Project? Many reasons can be given: the absence of a technical counterpart in CARITAS during the initial stage of negotiations between USAID and PRITECH, the inadequate interpersonal relations between CARITAS personnel and PRITECH during a good part of the existence of the CSP, and finally, the lack of this emphasis (establishment of institutional capacity) in PRITECH's Scope of Work.

2. The step by step training model has weak points starting from its unidirectional conceptualization, specially when applied to sectors with low educational levels. The model also lacks instruments to recapture local cultural values and experiences of the application of the training model according to geographical areas. The influence of the local team is concentrates and ends in the training at diocesan levels (FC and DSs), creating a rupture in the replication of the course with the promoters and mothers.

3. National courses (for FC and DSs) lack their own instruments to be efficiently reproduced at lower levels. The FCs do not have the elements -specially methodological- to reproduce and replicate the experience. This deficiency is also noted in the courses for promoters.

   The training of promoters, DS and FCs, therefore, should emphasize methodological aspects and the complete educational process in order to allow an integral vision.

4. National courses do not establish role differentiation. The DSs should receive adequate training to perform their functions. The subjects of this training should be decided with the DSs, but could include: managerial programming, local monitoring and evaluation, basic statistics, rural and community development, planning and programming, etc.

XI. THE EDUCATIONAL COMMUNICATION SYSTEM

The Educational Communication Systems in the Child Survival Project is conceived as a facilitating mechanism for the process of exchanging information, knowledge and practices in which a series of messages directed towards the target population organized in MCCs are related. It rests on a harmonic group of educational multimedia and multitechniques to obtain its objectives and goals in the CSP.

The two large components of these systems are made up of:

* The process of producing educational materials

* The levels of replication of human resources training (technicians, field personnel, promoters and mothers)

Both interact and have the community as a starting point. In order to put the system to work, one begins by gathering qualitative information coming from the community which serves as an input for the design of support educational material. Once formulated, these are put to the consideration of the diocesan technical personnel who contribute while they are trained in educational methodologies to teach management at the promoters level. Then the material is printed on a large scale, it is distributed and used in all of the activities foreseen in the step by step model.

The system includes an information flow from bottom up and supervision designed to feedback and observe advances and difficulties in the Child Survival Project.

MEANS USED AND THEIR PURPOSE

From the information gathered through a series of Field Reports, four systematization reports of the experience in Areas I and II, documents of the initial stage of the Child Survival Project, and information given by technical personnel in materials, files and others, we can determine that the mass media used has played an important mediating role in the process developed, in both areas covered.

Each one of them was used with different intentions, according to the type of interaction which was intended in the target population of the CSP. It is possible, therefore, to classify them as interpersonal, personalized and massive directed towards the mothers and others directed to various audiences.

INTERPERSONAL MEDIA

Interpersonal means in the form of flip-charts and educational games, have the purpose of supporting training of promoters and, through them, the mothers participating in the Child Survival Project; they were designed to interact with them during the educational meetings of the mothers' groups. They are large poster and half poster size. The first flip-charts were printed in two colors and it was later observed that colors motivate the attention. of the mothers and facilitate understanding of visual messages.

a. MATERIALS DESIGN

The formulation process was carefully planned taking into account the following methodological steps:

* review of existing material
* definition of scientific concepts on the corresponding subject.
* qualitative research of cultural practices and mothers' knowledge on the particular subject.
* preliminary design of material.
* field tests in the area where material will be used
* adjustments made to material design
* in case of doubts, new tests of materials
* edition, distribution and use of material.

These steps were taken with the participation of the entire technical team of the Child Survival Project and technically assisted by PRITECH.

The time it took to follow all of the steps listed was approximately three to four months for each subject. What allowed them to do it was a proper time planning, the use of spaces between subject and subject, the existence of field personnel for field work. The constraint was to make time compatible between subject and subject and supervision actions that technical personnel had to perform from the central to the diocesan levels.

b. CENTRAL PRODUCTION MECHANISM

The production of all of the materials, following the centralized structure of CARITAS, was done centrally, with the participation of base groups of the dioceses in each area; once the decentralized system of Caritas/Bolivia is strengthened, however, be it by zones or groups of dioceses according to socio-cultural identity criteria, it is possible to advance one step in this form of producing decentralized materials. . It is recommended to transfer methodologies of production of educational materials to the diocesan teams, these teams with experience accompanied by timely technical assistance will be able to grow by themselves.

It has been demonstrated that in order to develop educational health actions it is necessary to be constantly motivating the target population and that material produced at the central level is not always satisfactory.

c. IMPACT OF THE USE OF INTERPERSONAL MATERIALS

The use of illustrations, on the basis of technical criteria such a proportionality, realistic drawings, representation of messages, elements of the socio-cultural environment and others, have allowed an improvement in the use of language for the image directed to populations who are mostly illiterate.

Proof of this is that particularly in the flip-charts, the use of scenes representing the environment, be it Altiplano or Valleys, has allowed a greater identification of the mothers with the illustrated messages.

The material has been well received in the field. At the time of this evaluation it was observed that both promoters and mothers kept them, even if they had been mistreated with time.

With the use of this material, we were able to observe saturation and boredom of the mothers. This permits us to see that all materials suffer from excessive use and the technical field personnel should have the capacity of an alternative response before this situation arises. The fact that material may become old from use is no guarantee of learning; this means that the same messages have to be collected and reworked in with other material as motivating as the former, be it for promoters or mothers, putting special emphasis on those messages that are difficult to understand.

Educational Games were designed with the purpose of awakening interest and reviewing knowledge acquired by promoters and mothers. These instruments have accomplished their objectives, with the exception of one (the game of diarrhea and dehydration) which, due to the amount of texts, was difficult to manage in illiterate communities. The game called Altipanaku has had great acceptance, specially because the drawings have been taken from previously produced material and the mothers are happy to recognize them.

d. THE CRITERIA TO DESIGN ILLUSTRATED MATERIAL

From the systematized experience of the Child Survival Project, CSP was able to establish criteria for illustrated material: some of it is the introduction of the socio-cultural elements featuring the environment to which the message is directed, the proportions, complete images, simplification of features, use of visible comparisons, and others.

TYPES OF PERSONALIZED MEANS

This material serves as instruments for the diocesan personnel whose function it is to train promotion personnel. This material is designed thinking of the level of promotion in which it will be used to manage flip-charts and games. It is characterized by individual use and interaction with the facilitator who orients training. It has been used in the training courses of promoters and has indications on the use of interpersonal material.

a. SUPPORT TO TRAINING ACTIVITIES

Regarding the use of GUIDES for flip-chart handling, there is significant improvement in the evolution of the Child Survival Project. In Area I, though there is a process of reflection, in Area II it is more structured as far as the recommended methodological sequence, which advises to go from the more descriptive and general to the more explicative and particular.

There is no doubt that in training diocesan personnel, observed in the written training programs, much importance was given to the conscious reflexive process through the technique of managing questions and answers. The weakness of step by step training, however, is in the feedback to promoters by means of continuous supervision, so that this process may be qualitatively effective for mothers.

Observations made during educational talks given by promoters show progress in the descriptive aspects, rescue of experiences, transmission of educational messages and review; however, identification of cultural resistance factors which block the understanding of messages, are not delved into in depth. In this aspect, supervision with recycling in handling teaching techniques for the promoters, will improve their performance and will reach mothers more successfully.

Without a doubt, the training of the promoter by means of courses, with the aid of flip-charts, guides and other materials, has allowed advancement in acquiring new knowledge for the mother. This evaluation was not able to observe the practices of this knowledge under concrete circumstances. In the face of this operative limitation, efficient indirect indicators to observe impact levels are: mothers' motivations with the Child Survival Project by attending talks, knowing other health subjects, consulting the promoter when their child is ill and their willingness to consult health services.

b. DIALOGUE WITH THE MOTHER

In Area II, particularly in Nutritional Surveillance, we observed much importance assigned to dialogue the with mothers, to give her timely advice, after weighing her child. This component, which includes the use of the Child Health Chart, facilitates the convergence of other programs (ADD, feeding, breast feeding, ARI, inoculations) and it is important to strengthen it much more, specially in Area I, where it holds second place among subjects.

c. AN EFFORT TO INTEGRATE PROGRAMS

In the design of the GUIDE to handle flip-charts on growth monitoring (GM), an effort is seen to teach this aspect of programmatic concentration which tends to unify to the CSP. In Area I, although GM worked with subject concentration, there was no depth given to specific messages as done in Area II, which introduced already known charts in previous flip-charts regarding Food Education and Food and Nutrition, adding illustrated pages with messages on breast feeding, vaccines, feeding by mothers and pregnancy. Undoubtedly each one of these complementary subjects deserve separate treatment with materials and guides: their value lies in not having fragmented aspects which makes sanitary education of the mother more integral.

The effectiveness of the use of personalized media, is recommended, not only for training of promoters but should also be taken into account with the mothers. In other words, brief materials should be produced, attractive, in colors, with practical advice so that mothers may take them home and use them as aids in their every day lives; they would also be effective for children needing home treatment like ARI, vaccination, feeding frequency, etc. Due to her many responsibilities, mothers tend to forget easily, and that is why it is recommended that this educational resource be strengthened so that what is learned from the talks may be extended to the home.

d. EDUCATIONAL MESSAGES

A progressive technical handling in the design of educational messages is observed in the Child Survival Project, regarding language, deossification and adaptation. From the experience, the technical team systematized technical criteria for the design of educational health messages. Some of these are: simplicity of language, use of local words, that it be demonstrable and feasible in practice, motivation to action pointing out the benefits or disadvantages for the child's health, the importance of reiteration, etc.

It is recommended that for future experiences homologous to the CSP, that these guidelines be taken into consideration, contrary to that observed in ARI flip-charts. It would seem that lessons regarding methodological steps for the production of materials were not heard, such as previous field research, criteria for making illustrations and the design of educational messages.

This material has been criticized by mothers, promoters and field personnel regarding the distortion in the proportion of drawings, the introduction of texts and even mistakes in visual messages.

MASSIVE EDUCATIONAL MEANS

The Child Survival Project saw this as a support action to personalized education and training in general. It is clear that this means, in radio or printed format, is not enough in itself, but it helps to remind and to make legitimize those educational messages taught through other media and techniques,

a. RADIO AND FORMATS EMPLOYED

Regarding radio, there is a variety of proven formats, such as radio mini-dramas, produced in spanish, quechua and aymara; radio-novels in quechua; songs and poems with old native music; short and long radio programs in which socio-dramas and interviews to mothers and promoters were transmitted.

The impact of the Child Survival Project can be measured by the contests with radio support which permitted mobilization of thousands of mothers, who responded to the contest by answering questions related to the educational messages taught through the educational action of promoters, or by composing songs, singing and dancing songs allusive to Child Survival Project subjects. in Cochabamba, for example, one of the contests gathered nearly 5,000 mothers among which there were members and non-members.

It should be pointed out that for the production of radio-dramas, novels, traditional songs and programs the CSP hired native radio people of great prestige. This permitted giving the productions a genuine national cultural image. Proof of this is the acceptance these transmissions had in the most listened to stations in the rural areas (radio San Gabriel, Radio San Rafael, Esperanza, Mendez, Bahai).

b. CONTINUITY AND SUSTAINABILITY

The disadvantage of this audible media are production and transmission costs. The costs of space rentals are high for social investment projects such as these; in spite of the fact that all stations contracted, are characterized by their community service, because of their self sustaining policies, it is impossible for them to give up minimum charges.

Because of this, one of the limitations that the Child Survival Project had to face was lack of continuity on the air. A challenge for the future is to invent or create self sustaining, funded mechanisms, "commercial support", or similar mechanisms for health education programs on radio. This situation has interfered with the permanence of programs in diverse forms. No doubt that the repetition of messages, during prolonged periods of time, through different means, leading to one same target population guarantees greater assimilation and learning.

c. POSTERS AND CALENDARS

Regarding Posters and Calendars, during visits made to different mothers' clubs, we were able to observe that this material is in great demand, even more so in the rural areas where the population has little access to printed material: posters and calendars were glued to walls, together with others from the Ministry of Health and commercial company calendars.

Aside from the activities of the promotor and radio support, this type of massive printed materials support educational actions from another angle, visually familiarizing and impacting the eye with mural messages fixed for a long period of time. After a while, however, there is saturation of the eye and the reader becomes insensitive to the messages. At that time, it is important to renew the material, repeating key educational messages.

To counteract costs of these materials, we recommend exploring among commercial firms related to food industry, fertilizers, construction materials, etc, who print yearly calendars in order to negotiate with them support of illustrated health messages while being careful with ethical questions.

It is recommended to try out and diversify a variety of resources rescued from social marketing to maintain the target population of the Child Survival Project in a motivational tension. There are posters and calendars with participatory variations. One way to promote the participation of mothers and their family group, is by handing out "incomplete" material, so that the family can drawn paint, hang, glue or mark according to the message that is to be stressed. For example, health care for the child: frequency of meals per day, number of times weighed, amount of liquid given while with diarrhea, vaccines given, state of child growth according to growth chart, etc.

d. SYSTEM OF COMPENSATION

It is also important to mount a system of retribution and stimulus for mothers, fathers, siblings and grandparents regarding care of infants and mothers' health, for example: colored ribbons with marks, stamps, food dishes, spoons with initials, etc., so that the family may hold feelings of self esteem due to health care.

MASSIVE MEANS OF MOBILIZATION AND INFORMATION

During the past year Caritas Boliviana gave great importance to the dissemination of the Child Survival Project. the creation of bulletins, magazines, triptychs, videos, etc., presentation-fairs and interdiocesan sports encounters have created a spirit of unity and identification with the CSP at a national level. The activation of this series of resources has allowed the Child Survival Project to crate its own personality among Child Survival Programs, headed by the NGOs in the country, many times becoming a reference. We discourage to continue to conceive it as a Program separate from the Promotion Department of Caritas.

THE MATERIALS OF THE CHILD SURVIVAL PROJECT AND OTHERS NGOs

Consulting with technical personnel of some NGOs (MFM, PSRA, SAVE, CARE, PLAN INTERNATIONAL), regarding the use of educational material produced by CSP it was seen that many of them have been used with their promoters and community leaders; in other cases it has served as reference material to create their own materials. A repetitive comment presented, was criticism due to the prices they had to pay for them.

UNICEF/Bolivia is of the opinion that the material is good and useful for programs it supports with the Ministry of Health, because they have been tested in the field.

This is why their agency is willing to reproduce some flip-charts and educational games of the Child Survival Project, if and when the decision is supported by the National Committee for Training and Production of Educational Materials as support to Child Survival and Maternal Health Programs -established a few months ago- made up of three Offices of the MPSSP, NGOs, PVOs and UNICEF.

THE IMPORTANCE OF RESEARCH AS A GUIDE TO ACTION

Projects such as these, because of their nature, tend to fall into mechanical empiricism and activism. The importance given to operational research as a guide to new actions, helps programs to advance and to provide a support quota to the theories of the different sciences which combine to promote Primary Health Care (anthropology, sociology, communications, education, social psychology, and others related to human behavior).

For this reason it is recommended to encourage short operational research, well focused, of low cost employing the same

field personnel, under the guidance of some experienced technician.

It is possible to investigate interferences in adult learning, clues for child rearing, social value of children, alternate communications mechanisms, natural learning systems in the communities, difficult assimilation messages, etc. are possible subjects for recycling and reformulating the strategies of community participation, educational communication, primary health care and others.

DESCRIPTIVE CHART ON TYPES COMMUNICATIONS MEDIA AND THE PRODUCTION OF SUPPORT MATERIAL USED BY THE CHILD SURVIVAL PROJECT OF CARITAS / BOLIVIA

INTERPERSONAL MEANS

FORMAT	TOPIC	AREA	AMOUNT	EDITION
Flip-chart	ADD	I	1,000	Printed
Flip-chart	ADD	II	1,000	"
Flip-chart	F&N	I	1,000	"
Flip-chart	F&N	II	800	"
Flip-chart	GM	I	800	"
Flip-chart	GM	II	1,000	"
Flip-chart	ARI	I-II	2,000	"
Educational Games Shepherd	ADD	I	882	Mimeo
Educational Games Shepherd	ADD	II	800	"
Educational Games Story of Juanita	F&N	I-II	1,600	"
Educational Games Snakes & Escalators	GM	I-II	5,000	Printed
Games on Diarrhea & Dehydration	ADD	I-II	5,000	"
Game of the Road to Health	GM	I-Ii	5,000	"
Game of the Road to Health	ADD	I-II	5,000	"
ATIPANAKU game	GM	II	800	"
Broadened Health Chart	GM	I-II	1,800	"

PERSONALIZED TYPE MEDIA

FORMAT	TOPIC	AREA	AMOUNT	EDITION
Guides for Flip-chart Handling	ADD	I-II	1,800	Mimeo
Guides for Flip-chart Handling	F&N	I	1,105	"
Guides for Flip-chart Handling	F&N	II	CBB 200 Aiquile 200 Potosi 200 Sucre 200	"
Guides for Flip-chart Handling	GM	I	662	"
Guides for Flip-chart Handling	GM	II	1,000	Printed
Guides for Flip-chart Handling	ARI	I-II	2,000	Printed
Instructions for Games	INCLUDED IN THE GUIDES FOR FLIP-CHART HANDLING			
Sheets to work on Clinical Chart	ADD	I-Ii	1,200	Mimeo
Flyers on Treatment Plans	ADD	I-II	1,200	"
Set of Photographs	ADD	I-II	50	"

EDUCATIONAL MASS MEDIA

FORMAT	TOPICS	AREA	AMOUNT	EDITION
*** Printed**				
Posters	ORS-ADD	I	20,000	Print
Poster	ORS-ADD	II	30,117	"
Poster	HOMEMADE SOLUTION	I	19,996	"
Poster	" "	II	30,179	"
Calendar	ORS	I	17,404	"
Calendar	ORS-GM	II	20,000	"
Posters	NJ	I	14,000	"
Poster	NJ	II	35,502	"
*** Radio**				
Radiograms	ADD-F&N-SEN-ARIs	I-II	83	Illustration
Soap-opera		II	16	"
Short Programs	ADD-F&N-SEN	I	48	"
Long Programs	ALL	I	50	"
*** Contests**				
At national level	ALL	I-II	5	
Carried out in Cochabamba, Coroico, Oruro, Sucre, Potosi, Aiquile	ALL	I-II	8	"
Typical music	ALL			
Songs	Idem	I	6	"

MASS MEDIA TO INFORM, DISSEMINATE AND MOBILIZE

FORMAT	SUBJECT	AREA	AMOUNT	EDITION
Exposition Fairs Cochabamba, Oruro Tarija, Ministry	All	I-II	5	Performed
Folklore Festivals Oruro, Sucre	All		2	"
Sports Encounters Coro-coro & Sucre			1	"
Mural Newspapers	All	I-II	A Series	"
Videos	ADD-NJ-AIP	I-II	3	"
Kitchen Recipes Potosi, Sucre, Oruro	F&N		3	"
Bulletin	Informative	Caritas Bolivia		
Magazine	"	"	"	
Video	"	"	"	

OTHER MEANS OF SUPPORT

CSP Identification logotypes

Certificates recognizing course attendance.

XII. INFORMATION SYSTEM

GOALS OF THE CHILD SURVIVAL PROJECT

During the reformulation Workshop of the CSP (February 1988), the following goals were established for the information system:

a. systematize data obtained and feedback the information to the participating centers at least every six months, for programming of activities.

b. to achieve that 50% of forms which make up the information system be filled correctly and on time at least twice a year.

There are the following problems with these goals:

- processing and information analysis is not decentralized; the dioceses would only collect data to be forwarded to the NCO.

- in the best of cases, the dioceses would expect, the return of their information every six months, which is late for timely correction measures.

COMMENTS ON THE FORMS

1. Evaluation test for FCs and DSs (ARI Program - Area II). This form is used for the courses where data is gathered. In my opinion it is relatively useless to have a pre-test, then a course, with a second test a few days later. I would suggest a follow-up test 6 months after the course.

2. Evaluation test (Area I). This form requires to be evaluated by an expert in communications. But it seems reasonable for understanding diarrhea.

3. Evaluation text (Area II), Subject: diarrhea, it is a perfected version of the previous one and seems to be an improved method to evaluate the knowledge of members. These evaluations need to be performed frequently, for example, monthly, if we want them to be of any value for members and the community.

4. Registration of promoters. Redundant data should be eliminated. This data could be included in another form.

5. Supervision. This form can only be useful if it is fed back to the FC, it could be used as a teaching tool for

coordinators.

6. Follow-up form. This form is very important. The way it is used is not very clear. Since data is not fed back to the DOs. It is not clear how they regulate ORS packets distribution and other supplies. The way it is used now, to count cases at the NCO, is not very managerial.

7. Nutritional Surveillance. This possibly necessary form, seems to be very complicated to be filled in by the promoter. Again, this information needs to be fed back to the FCs.

8. Monthly report of ARI cases. This form has to be joined with the one for diarrhea, and be filled in routinely.

DEMOGRAPHIC INFORMATION

The DOs update their beneficiary population (mothers and children below age 5) in the MCCs, every three months and, through, polls among members.

INFORMATION ANALYSIS AND PROCESSING

The majority of DOs send the data gathered by the promoter to the NC, without any previous processing or analysis. A commendable exception is the dioceses of Sucre, whose personnel has designed a system of processing and analyzing field data, which includes impact and process indicators. At this DO, personnel hold monthly and quarterly meetings for evaluation, using the information as a source for decision taking.

At the NCO, the data is tabulated and presented in form of Charts. No indicators are used (process or impact), nor graphs to facilitate the interpretation or the results.

DECISION MAKING

It is our impression that very few decisions are taken at the central and diocesan levels on the basis of data collected and tabulated. This is not surprising, because their presentation is unfavorable for managerial use.

INFORMATION FEEDBACK

Feedback of information sent to the NCO is absolutely absent for the DOs and the MCCs. This topic was mentioned during the workshop in February 1988, without any results.

CONCLUSIONS

1. The Child Survival Project has a rudimentary information system, which collects data mainly from promoters and processes it in a centralized manner. There is no feedback nor taking of decisions based on this system.

   It is the impression that the CSP has not defined objectives for its information system, nor its uses and potential users. The lack of indicators and ways to present information (e.g. graphs) in a managerial way, is symptomatic of a lack of objectives in the system. When there is no knowledge of important data, there is a tendency to present all data in the most complete possible way (for example a Table of 15 * 6 entries).

2. There is no feedback of information from the central level from La Paz to the dioceses. This lack of feedback presents problems in motivation and in the desire to complete required forms.

3. Promoters have to fill in too many forms. Forms are needed to verify entry data fed by promoters.

4. At least in Cochabamba, there is no exchange of data between the CSP and the Sanitary Unit of the Ministry of Health.

XII. FINANCIAL ANALYSIS

COSTS OF THE CHILD SURVIVAL PROJECT

The total budget of the CSP was $1,838,000, coming from the following sources:

- a grant from USAID/Bolivia to Catholic Relief Services for $1,136,000 (USG No. 511-0590).
- technical assistance worth $310,000, through PRITECH, and
- funds from PL-480 Title III, worth $392,000 and directly disbursed to CARITAS

Chart No. 1 shows Child Survival Project costs, during the three operational years (July 1986 - June 1989). For 1989, only the first 6 months were included. The evaluation team was able to justify expenses for $1,152,537 which makes up over 60% of the total budget of the CSP. A great deal of the balance is unused funds, coming from PL-480 or CRS.

In the following analysis, we have not included as expenses the value of supplies (ORS packets, ARI medications) donated, or the opportunity costs of health promoters. Nor have we included any type of voluntary work. Expenses for training and educational materials have been considered capital expenses up to June 1988, to be later considered as recurrent costs.

Capital expenditures make up 50% of costs of the CSP, the highest expense being technical assistance of PRITECH 27% of the total expenses of CSP, followed by field team (9%) and office team (5%). Graph No. 2 shows the evolution of these capital expenses during the time of CSP existence.

Recurrent expenditures make up 50% of CSP's costs, the highest expenses are in salaries and social benefits (20% of the total expenditures of the CSP), followed by per-diem and training expenses financed by PL-480 (17%), and other training expenses (9%). Graph #2 shows the evolution of these recurring expenditures during the existence of the CSP.

During the past 12 months (July 1988 - June 1989) recurrent expenditures have been $264,267.

The coefficient "r" is defined as recurrent expenditures incurred in one year, divided between the total capital expenditure of the project. It is an indicator of necessary expense to maintain the operation of the project, after

implementation has ended. According to Graph #3, coefficient "r" has progressively increased during the existence of the CSP, it is 39% in 1989. This means that in less than three years the CSP will require recurrent expenses equivalent to the total capital expenses of the project. This is typical of social type projects, where training expenses, salaries and operation costs (spare-parts, materials, supplies, etc.) are high and constant.

RESULTS OF THE CHILD SURVIVAL PROJECT

COVERAGE

The average number of children benefitted per year of operations (1987-89) of the CSP has been 70,232 and the average number of members benefitted has been 28,092. If we consider both groups as beneficiaries, the average annual coverage has been 98,324.

During 1989, coverage of the CSP was 65,418 children below age 5, and 26,167 family mothers. If we consider both groups as beneficiaries, then coverage was 91,585.

RESULTS

The results of this evaluation, have estimated the following for the last year of operations:

- 183,929 cases of diarrhea have been well managed at the home or with the promoter, due to the influence of the CSP.
- 113,366 cases of ARI have been well managed at the home with the promoter, due to the influence of the CSP.
- 94,856 child weighing took place among children below 5, due to the influence of the CSP.

COST EFFICIENCY ANALYSIS

Two types of cost efficiency analysis were made: beneficiary and per activity.

PER BENEFICIARY

Since 98,324 was the average number of beneficiaries per operational year of the CSP, and $ 1,152,537 were total expenses of the CSP during three years of operations (July 1986-June 1989), the cost has been $3.91/beneficiary/year.

During 1989, 91,585 mothers and children were benefitted, and the CSP has had recurrent expenses of $264,967, therefore the recurrent expense per beneficiary during the past 12 months has been $ 2.89. This figure is the closest estimate of what it would cost the CSP to continue operations without altering coverage and without incurring in capital expenditures.

PER ACTIVITY

It has been observed that the three interventions of the CSP have equal priority: GPS, ORT and ARI. The question is: what is the execution cost of each one of these activities?

We have an estimate of the results of these activities during the past year, and we also have recurrent costs carried out during this period. Therefore, we can estimate the recurring costs per unitary result. This would be an indicator of the cost that CARITAS would have to cover per result obtained, without coverage variation and not incurring in capital expenses.

a. Oral Rehydration Therapy

- 183,929 cases of diarrhea have been well managed at the home or with the promoter, due to the influence of the CSP.

- to obtain this result, the CSP has invested 0,33 * $264,967= $87,439 in recurring costs.

- therefore, each case of diarrhea well managed has cost $0.48 to the CSP in recurrent costs.

b. Acute Respiratory Infection

- 113,366 cases of ARI have been well managed in the home or with the promoter, due to the influence of the CSP.

- to obtain this result, the CSP has invested 0.33 * $264,967 = $87,439 in recurring costs.

- therefore, each case of well managed ARI has cost $0.77 to the CSP in recurrent costs.

c. Growth Promotion and Surveillance

- 94,856 children below age 5 have been weighed, due to the influence of the CSP.

- to obtain this result, the CSP has invested 0.33 * $264,967 = $87,439 in recurring costs.

- therefore, each child weighing has cost $0.92 to the CSP in recurring costs.

CONCLUSIONS

1. This analysis demonstrates low costs, per beneficiary and result obtained in the project. It is the lowest found by the author among the NGOs working with Child Survival in Bolivia.

   The reasons for these low costs have been:

   - economies of scale: it is a national dimension project, where economies can be made by hiring technical assistance, purchase of equipment, etc.

   - the analysis has not considered the value of supplies donated by international finances and the MPSSP.

   - personnel perceives low salaries as related to the responsibilities of the post (e.g 1 FC is in charge of 35-45 MCCs). Therefore, the nominal productivity of each Boliviano invested in salaries is high.

2. However, this analysis allows us to estimate the cost (recurrent) that CARITAS would have to invest to continue program operations, without coverage or capital expense changes. This evaluation did not ask if CARITAS has the necessary funds to continue with these expenses, because the decision of whether or not the CSP will continue does not only depend on economic feasibility.

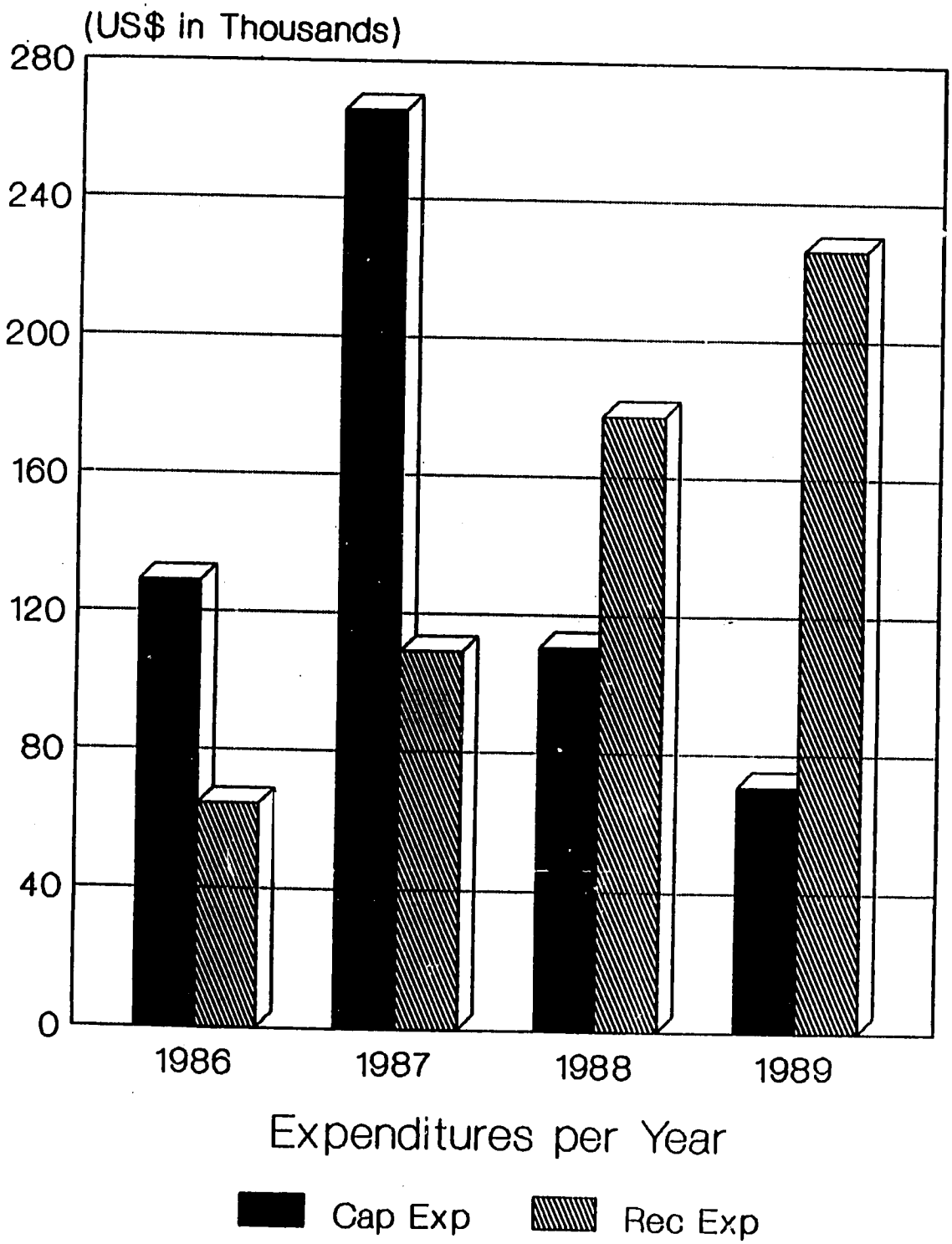
GASTOS DEL PROGRAMA DE MEJORAMIENTO INFANTIL

COSTS FOR CS/CRS

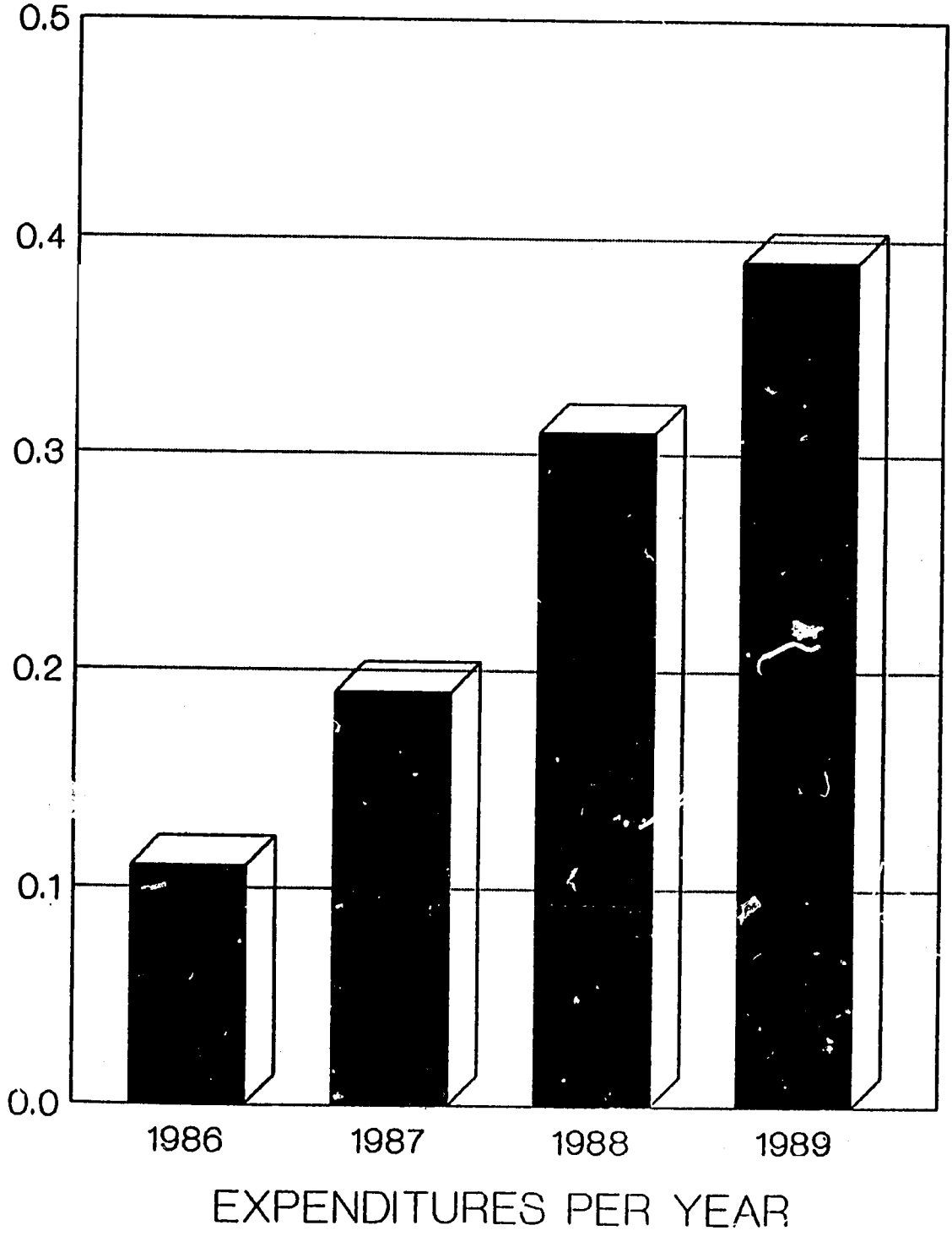
	TOT ITEM EXP	%TOT EXP	EXP 1986	EXP 1987	EXP 1988	EXP 1989
CAPITAL COSTS						
PRITECH TA	310000.00	0.27	103000.00	138000.00	69000.00	0.00
CS EQUIPMENT	106149.00	0.09	0.00	69349.00	3420.00	33380.00
VEHICLES	12600.00	0.01	12600.00	0.00	0.00	0.00
EVALUAT/RESEARCH	9878.00	0.01	0.00	6898.00	2980.00	0.00
TRAINING	26353.00	0.02	6800.00	17653.00	1900.00	0.00
MEDIA PRODUCT	36717.00	0.03	5000.00	17717.00	14000.00	0.00
OFFICE EQUIPMENT	52335.00	0.05	1400.00	16000.00	0.00	34935.00
OTHERS	21442.00	0.02	0.00	0.00	19154.00	2288.00
TOTAL CAPITAL COST	575474.00	0.50	128800.00	265617.00	110454.00	70603.00
RECURRENT COSTS						
SALARIES NAT	51554.00	0.04	4000.00	12281.00	17199.00	18074.00
SALARIES REG	149594.00	0.13	4500.00	31041.00	63650.00	50403.00
FRINGE BENEF	33099.00	0.03	1500.00	6479.00	11712.00	13408.00
REPLENISH STOCKS	490.00	0.00	0.00	0.00	490.00	0.00
OFFICE SUPPLIES	11530.00	0.01	2400.00	4290.00	2040.00	2800.00
OMA VEHICLES	9992.00	0.01	1360.00	2057.00	3635.00	2940.00
PL480 DONATION	200000.00	0.17	50000.00	50000.00	50000.00	50000.00
TRAINING	102021.00	0.09		0.00	13844.00	88177.00
MEDIA PRODUCTION	11030.00	0.01	0.00	0.00	11000.00	30.00
CARITAS ADM	7753.00	0.01	500.00	2953.00	3900.00	400.00
TOTAL RECURR. COSTS	577063.00	0.50	64260.00	109101.00	177470.00	226232.00
TOTAL COSTS	1152537.00	1.00	193060.00	374718.00	287924.00	296835.00
RECURRENT/CAPITAL	1.00					
ANNUAL "R" COEFF			0.11	0.19	0.31	0.39
%TOT EXPEND BY QTR	1.21					
TOTAL SALARIES	234247.00	0.20	10000.00	49801.00	92561.00	81885.00

FUENTE: CRS FINANCIAL REPORTS

CAPITAL AND RECURRENT



ANNUAL "R" COEFFICIENT



XIV SUSTAINABILITY

PRESENTATION OF THE PROBLEM

When we speak of sustainability of a project, a series of ideas come up.

- The institution executing the project should be capable of institutionalizing it, which is to say to convert it from a project into a regular program of the institution.
- the beneficiaries of the project should develop the capacity to cover its costs.
- the institution and the beneficiaries share the responsibility of financing.

The initial design of the CSP, as well as in the different amendments and in the reformulation of February 1988, no self-sustaining strategy is proposed; this concern appears as a recommendation in some of the semester reports of the CSP formulated by CRS. However, there is no concrete response to focus on the subject.

AT THE LEVEL OF CARITAS

At this level, the Child Survival Project has revitalized the MCCs, and has awakened a great interest to transform it into a continuing activity. At the national as well as the diocesan level, however, CARITAS has not designed a specific strategy for institutionalization. Those leaders of CARITAS who were interviewed also expressed their concern that self-financing of the CSP in the institution is not possible, and that they relied on interinstitutional cooperation and coordination to continue totally or partially with the CSP.

AT COMMUNITY LEVEL

At the community level, the CSP has generated demand for child survival interventions, specially among rural communities and those lacking basic health services. The demand is very strong for the ARI program, the ORT is a second priority in the communities, and GPR in the third. This order of priorities is in accordance with the situation of morbi-mortality in the areas worked by the CSP.

The promoters, family mothers, and communal leaders who were interviewed, showed great interest for the CSP to remain.

The majority of promoters mentioned that they would continue even after the CSP left. The community leaders said it would be a disaster for their communities if the CSP would cease to render services. They also said they would not cease to render services. They also said they wouldn't know what to do if the CSP disappeared.

It is our impression that some communities, where the economic situation is not critical could pay for some services considered as priority by them, for example: medications of ARI, and ORT packets. In fact, even among the poorest communities visited, the mothers were using commercial medications to cure their children's diarrhea and ARI.

INTERINSTITUTIONAL COORDINATION

This is another important factor to reduce costs and improve the quality of interventions. The CSP has developed this mechanism with a number of governmental and non-governmental institutions.

The CSP has kept good relations with the MPSSP, at the central and regional levels, which has helped the project's interventions. These good relations have been kept in many occasions, due to the good relations between personnel of both institutions, and not so much because of formal mechanisms. The experience of Sucre deserves to be pointed out, where interns of the Pediatrics Section of the local university support the activities of the CSP at the nearby MCCs in the city of Sucre.

Coordination with NGOs has taken place at regional and local levels and it has mostly consisted of agreements of non-interference in work. No agreements were reached to join efforts towards common goals.

FACTORS WHICH FAVOR SUSTAINABILITY OF THE PROJECT

1. The present governmental health policy: the MPSSP has given priority to a National Plan for Child Survival and Maternal Health, which represents an increase of resources in activities similar to those of the CSP, another aspect is the emphasis given to regionalization and decentralization which allows the establishment of more precise levels and specific strategies for coordination.

2. The organization and power of appeal that CARITAS has in the rural areas: CARITAS is the most important NGO to reach the rural population of Bolivia with health programs. An important factor is the importance that CARITAS puts in its Social Promotion Program.

3. The demand created among beneficiaries of the CSP.

4. The excellent disposition of international cooperation agencies to finance projects that will benefit children, as well as institutional coordination mechanisms. This helps continuity and cost control.

LIMITING FACTORS OF SELF-FINANCING

1. Limited financial availability of CARITAS according to personnel interviewed.

2. The present management and organization of the CSP, which should improve to guarantee better technical and managerial administration.

3. The critical economic situation of beneficiary communities together with high illiteracy, require complementary action from CARITAS.

CONCLUSIONS

1. The strategy of sustainability was not presented during the execution of the CSP. At this time, CARITAS is not prepared to assume self-financing of the CSP.

2. The possibilities and communal self-financing mechanisms are not very clear. There is potential in some communities to assume costs, specially medications.

3. Interinstitutional coordination (specially with the MPSSP) is an efficient mechanism to reduce costs and improve the quality of interventions. There are very positive regional experiences in this aspect.

4. International cooperation will continue to be the main form of financing for the Child Survival Project, but should not be the only one.

XV. RECOMMENDATIONS

A. GENERAL RECOMMENDATION

This is a very important time for the Child Survival Project and CARITAS. Through the promoters and the MCCs, CARITAS has been able to generate among it's beneficiary population an efficient demand for the activities of CS, specially for ORT and treatment of ARI. Its national coverage and institutional standing (linked to the existence of the Catholic Church) make CARITAS a potential means to permanently influence the lives and health of thousands of bolivian children.

CARITAS faces two questions at this time:

1. How should the CSP be organized to become more efficient in giving services? This evaluation has proven that the present organization, at the central and diocesan levels, have faults which limit the actions of the project.

2. What steps should be taken to sustain the CSP using institutional and/or communal resources? The subject of selfsustainment has not been touched seriously during the time that CSP is working, therefore, its present possibilities are minimal.

This evaluating team recommends the continuation of external financing, if and when CARITAS may be able to make modifications within the CSP to attempt to respond to these two questions.

<u>HOW CAN THE NCO OF THE CSP ORGANIZE TO BE MORE EFFICIENT IN RENDERING SERVICES?</u>

The NCO should be reorganized to efficiently comply with the functions designated at the workshop (February 1988) for project reformulation. It is important to remember that CARITAS is not a finite duration project, but rather an institution where capacity can be constructed to offer an efficient health program permanently.

In the future, the NCO should put emphasis on the following points:

- How to adapt its training system and educational materials to experiences gained and the evolution of the project?

- How to define and implement its information system, so that it may be decentralized instrument in decision making and feedback to the MCCs, promoters, DOs and NCO?

- How to offer effective technical assistance to the DOs, specially in the areas of training, educational materials. program management, monitoring systems and evaluation?

- How to improve technical and managerial aspects of the interventions (e.g. supplies)?

- How to influence the diocesan management of the CSP, such as activity programming and supervision, and personnel policies? How can criteria for personnel selection be improved and equalized?

- How can cooperation with other public and private entities be improved?

- What is the possibility and desire of beneficiaries to self-finance health services of the CSP?

To respond to these questions, the following organizational scheme of the NCO is proposed:

a. National Coordinator: his functions would be to manage the CSP, relations with the diocesan and national levels of CARITAS, interinstitutional relations. His hierarchy should be at least equivalent to a Diocesan Director, to obtain equal communications at this level.

b. Technical Coordinator: his functions would be the technical management of the CSP and supervision of DOs. He should be a health professional, with broad experience and training in child survival programs and sanitary management.

c. Department of Education and Information: Made up of a health professional (to direct it), a social communicator and social scientist. One of the goals of the Department of Education would be to redesign the training model with a return process, allowing knowledge, attitudes and practices emerging from the process to be rescued to benefit the department.

The functions of this Department would be to:

1. Establish a continuing training strategy, in accordance with the functions and responsibilities of trainer personnel.

2. Design the contents of training courses, according to

what is mentioned in the preceding paragraph.

3. Design, validate and produce educational materials. At this point CARITAS can and should maintain contact with other institutions that perform similar efforts, without forgetting that CARITAS is not an interminable project, but rather an institution which will possibly last until the end of the Catholic Church in Bolivia. Therefore, establish capacity within CARITAS to manage this educational component as a goal towards the future.

4. Design and execute an research strategy on the impact and collateral effect of the educational process. Reformulate the training strategy according to research performed.

d. Monitoring, Evaluation and Research Department Managed by a health professional, and made up a bio-statistician and a social scientist. The objective of this department is not to put data into a computer, but rather to covert data into useful information for decision making and feedback to the CSP.

Its basic functions would be:

a. design and execute a decentralized system of information to satisfy the managerial needs of the CSP at all levels (community, dioceses, national). Design and carry out an adequate feedback system.

The information system may be enriched with the use of the alternative media (such as, sentinel posts, rapid field studies, sampling surveys), whose data is of managerial importance, but can not be collected through the regular system, such as: what is the quality of ARI treatment offered by the promoters? what is the perception of mothers regarding ORT?

b. Train and supervise diocesan personnel in managing information at the DO level.

c. Perform operational research studies, to satisfy the managerial needs of the CSP. For example, this Department could research: Which should be the functions and incentives of the health promoter? which criteria predict a better acceptance of the CSP within the MCC?

e. Administration and Support Department, in sufficient quantity and quality to satisfy the other instances.

HOW CAN THE DOs OF THE CSP ORGANIZE TO BE MORE EFFICIENT IN RENDERING SERVICES?

The following points are important at the diocesan level:

a. The Diocesan Directions should be fully informed of the progress of the CSP at a national level and in their working area, whether it be through the DO and/or the NCO. This constant communication may improve dialogue between the NCO, the DO and the Diocesan Directions.

b. The DSs should have technical training and/or the necessary previous experience to manage a DO. To establish and apply a professional profile in this post is very urgent. The NCO must participate in selecting the DS, since it is a highly important technical post. Preferably the DSs should be health professionals, with experience in sanitary administration and/or public health in similar projects.

c. Professional profiles should be established for the FCs. The minimum criteria could be: previous experience in similar projects, adequate educational level and approval of an aptitude test. It is recommended that the NCO should participate in the selection of the FC, due to the specialized nature of his work.

d. The DOs should receive assistance from the NCO in planning and programming of activities, sanitary administration, rural development, work with promoters and communities, educational and communications methodology, etc. The DOs should also be provided with training and supervision for the decentralized management of its information system.

e. Diocesan personnel should be provided with the necessary stimulus to perform an adequate task. For example, a salary scale according to his qualifications, experience and work demands, timely payment of per-diem, transportation, field equipment, and supplies.

f. Communications between the DOs and the NCO should be increased through visits of the NC to the dioceses, and periodic execution meetings between a series of DOs and the NCO. It is also important to improve the flow of supplies from the NCO to the DOs, specially medications for the ARI program.

g. The number of MCCs per FC should be diminished to improve the quality of their work in each MCC. The optimum number of MCCs per FC should be from 15 to 25 (depending on geographical dispersion), with a variable frequency in visits, depending on the MCC (See recommendations on "Selection of MCC and Opening Towards the Community).

Diminishing of MCCs per FC can be done in two ways:

- increasing the number of FC in each DO

- working only in the MCCs with a criteria predicting acceptance of the CSP on a short term basis. This evaluation has suggested some criteria; others need research.

B. SPECIFIC RECOMMENDATIONS

THE ROLE OF TECHNICAL ASSISTANCE

It is obvious that the CSP will require technical assistance to respond better to present and future needs of the institution.

In our opinion, technical assistance to be given should have three characteristics:

- be directed to create institutional capacity to manage the problem in a satisfactory way;

- it should be subcontracted on a short term basis;

- it should be liked by attending personnel

SELECTION OF THE MCC AND OPENNESS TO THE COMMUNITY

The Child Survival Project should conceive the MCC as part of the community, and that perpetuation of an innovation in the MCC (e.g. ORT) will depend on the perpetuation of this innovation within the community. Popular health festivals, seen in Sucre, are a form of opening to the community which deserves to be analyzed carefully.

In order to manage more efficient work with the MCCs (and with the community), the following steps are recommended

a. Using adequate criteria (for research), select the MCCs in three categories:

I. With high acceptance potential: gathers characteristics which predict a rapid and efficient education of the CSP, at the MCC as well as dissemination of the message to the community.

II. Intermediate acceptance potential: these are the "frontier" cases.

III. Low acceptance potential: its characteristics do not predict a rapid and/or efficient educational task, at the level of the MCC or in the community.

b. At the beginning, the FCs would work with 15-20 MCCs, making visits every 2 to 4 weeks to each MCC.

c. When the DO perceives that an MCC has internalized an innovation and that a "critical mass" has been formed in the community, this MCC would pass on to become a second priority: it will be visited by the FC every 4 to 8 weeks, to reinforce knowledge, resupply promoters and introduce a package of "secondary" knowledge (first aid, chagas, etc.). Thus, the FC could accept another MCC, to work intensively to obtain internalization and critical mass. When all of the type I MCCs have been covered, the FCs can start working with the MCCs type II and III.

d. The proposed Department of Monitoring and Evaluation could assist the DOs in the selection and follow-up of the MCCs.

The services of CS, as well as ORT and ARI management, should be offered to all community dwellers.

THE HEALTH PROMOTER

The health promoter should be seen as a human being, with personal and family needs and expectations. To ask volunteer work from her, is something we would not ask of ourselves under similar circumstances. The Child Survival Project should create incentives to support her permanence as a promoter. The type and scope of these incentives should be explored by the CSP. One which has given good results, are extra food rations given for services rendered.

Also, the CSP should be careful upon allocating responsibilities to the promoters; if they perceive that these tasks will hinder their family routine, they will abandon their posts as promoters.

TRAINING OF CSP PERSONNEL AND PROMOTERS

1. Preparation and production of educational material should encourage opportunities for regional creativity, prior to training in the process of formulating this material. An alternative would be for the Department of Education to offer the dioceses techniques and guides for the preparation and/or adaptation of educational material previously revised at the national level.

2. The FCs, DSs and promoters should have the opportunity of receiving continuous training; their roles and expectation will vary with time, and the Education Department of the Child Survival Project should be capable of responding to these changes. Special attention should be given to the training of DSs, who have to satisfy the needs of their posts, without it constraining their participation in courses given to the FCs.

3. Establish a strategy to collect regional experiences, which are the result of the application of an educational strategy in the different areas of the CSP. After they are analyzed at a national level, these experiences could be converted (if pertinent) to a part of the educational component of the CSP.

THE STRATEGY OF EDUCATIONAL COMMUNICATION

Recommendations are included in the corresponding chapter.

INFORMATION SYSTEM

1. Define the objectives and methods of the information system: what does it want to measure?, why does it want to measure it?, what decisions will be taken with the data?, who is going to take the decisions?, what indicators will be used?, who will be provided with feedback and how?, etc.

   Within the strategy of the system, the DOs should have the technical and managerial capacity to process data collected and use the information to take decisions. The Diocese of Sucre is an example of the importance of this proposal. In this manner, the DOs would only send relevant processed data to the NCO.

2. Develop a bulletin which could feedback information to the dioceses at least 6 times a year.

3. Develop a mechanism so that information system specialists at the NCO could travel to the DOs twice or three times a year to exchange information with its counterparts.

4. Simplify the forms to be filled in by promoters. Bring together the ARI and diarrhea forms.

5. Provide promoters with incentives and motivation as well as all personnel who fill in the forms.

SUSTAINABILITY

1. Institutional as well as interinstitutional discussions should be promoted, at national and diocesan levels, regarding possible selfsustaining mechanisms. The self-financing strategy should deserve special treatment in the operations plan for 1990.

2. The possibilities and mechanisms for communal self-financing deserve to be researched.

3. CARITAS should seek self-financing of the CSP. But, for the time being, external financing is necessary to continue with the project's operations.

4. Mechanisms of cooperation and coordination should be specified with the MPSSP and other NGOs, which will help to diminish costs and improve results.

ACKNOWLEDGEMENTS

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LIST OF PERSONS INTERVIEWED

Diocese of Coroico - San Silverio Community
Mothers of 21 children under age 5

Diocese of Coroico - San Antonio Community
Mothers of 13 children under age 5

Diocese of La Paz - Vilacota Community
Mothers of 11 children under age 5

Diocese of Sucre - Villa Margarita Community
Mothers of 25 children under age 5

Diocese of Cochabamba - Mollepampa Community
Mothers of 7 children under age 5

Diocese of Potosí - Florida Community
Mothers of 53 children under age 5

PROJECT - MOTHER CHILD CENTERS

Diocese of Coroico - Viluyo Community
Mothers of 19 children under age 5

Diocese of Coroico - Villarroel Community
Mothers of 22 children under age 5

Diocese of La Paz - Chacoma Community
Mothers of 11 children under age 5

Diocese of Sucre - San José de Toca Community
Mothers of 26 children under age 5

Diocese of Sucre - Zudañaz Community
Mothers of 37 children under age 5

Diocese of Corocoro - Llallagua Community
Mothers of 7 children under age 5

Diocese of Corocoro - Capillunia Community
Mothers of 4 children under age 5

Diocese of Corocoro - Equillaga Community
Mothers of 6 children under age 5

Diocese of Cochabamba - Carraje Rosario Community

Mothers of 10 children under age 5

Diocese of Cochabamba - Guadalupe Community
Mothers of 7 children under age 5

FOCUS GROUPS

145 mothers participated in 17 focus groups in each of the Mother Child Centers visited.

70 fathers heads of families and communal authorities participates in 10 focus groups.

HEALTH PROMOTERS

57 health promoters from the Dioceses of Corocoro, Cochabamba, Sucre, Potosí, La Paz and Coroico were interviewed.

CARITAS PERSONNEL (NATIONAL OFFICE AND CHILD SURVIVAL)

Lic. Oscar Borda
Caritas Boliviana Executive Secretary

Mr. Enrique Lavadenz
Child Survival National Coordinator

Mr. Cornelio Ballesteros
Child Survival Social Communicator

Lic. Rossemery de Rivas
Child Survival Nutritionist

4 persons from the Child Survival National Coordinating Administration and Computer Department.

6 Diocesan Supervisors from the Dioceses of Corocoro, Cochabamba, Sucre, Potosí, Oruro, La Paz and Coroico.

6 Diocesan Directors from the Dioceses of Corocoro, Cochabamba, Sucre, Potosí, La Paz and Coroico.

21 Field Coordinators from the Dioceses of Corocoro, Cochabamba, Sucre, Potosí, Oruro, La Paz and Coroico.

MINISTRY OF HEALTH AUTHORITIES

Dr. Mario Pomier
Maternal Child Health Department Director

Dr. Martha Mejía
DDC (Diarrhea Disease Control) Program National Chief

Dr. Yucra
Maternal Child Health Regional Director - La Paz Sanitary Unit

Dr. Llobet
Professor from the University of Sucre

Chief Doctor from the Caranavi Region

Chief Doctor from the Yocalla Region

Sanitary from the Villarroel Community

OTHER INSTITUTIONS REPRESENTATIVES

Mr. Paul Hartenberger
Mr. Charles Llewellyn III
Mr. Salvatore Pinzino
USAID/Bolivia

Dr. Rene Zumarán
PL-480

Dr. Hugo Alarcón
Child Survival Coordinator - Plan International - Sucre

Radio San Gabriel Director

Ms. Magaly de Yale
UNICEF/La Paz

MATERIAL USED
DURING THE CARITAS BOLIVIANA
CHILD SURVIVAL PROGRAM
FINAL EVALUATION

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CARITAS BOLIVIANA
PROYECTO DE MEJORAMIENTO INFANTIL

CUESTIONARIO A LOS NINOS MENORES DE 5 ANOS

IMPORTANTE:

A) SOLO SE ENTREVISTARAN A LOS NINOS NACIDOS DESPUES DEL 26 DE OCTUBRE DE 1984. LA MADRE SERA LA INFORMANTE EN TODOS LOS CASOS.

B) SI SE DESCONOCE UNA RESPUESTA ("No sabe cuantos anos de educacion tiene"). DEJAR EN BLANCO EL CASILLERO. SI LA RESPUESTA ES 0 ("No tiene ningun ano de educacion"), COLOCAR 0.

c) NO CORRIJA A LA MADRE EN NINGUNA RESPUESTA.

1. Nombre de la comunidad: 1) _____

2. Diocesis a la que pertenece: 2) _____

3. Es la comunidad beneficiaria del proyecto de Mejoramiento Infantil? 3) NO SI

4. Si la respuesta a la pregunta 3) es "SI", PREGUNTA: En que ano se nombro a la primera promotora del Club de madres? 4) _____

"SENORA, DESEAMOS CONVERSAR CON UD. SOBRE COMO CUIDA A SUS HIJOS. SUS VECINAS NOS HAN DICHO QUE UD. CONOCE BASTANTE SOBRE EL BUEN CUIDADO DE LOS NINOS EN SU COMUNIDAD."

5. Edad de la madre (anos) 5) _____

6. Numero de hijos actualmente vivos 6) _____

7. Duracion de educacion formal (anos) 7) _____

8. Desde cuando pertenece al club de madres? (mes/ano de ingreso: _____) Antiguedad(meses): 8) _____

REVISE EL Carnet DE SALUD INFANTIL DEL NINO. VERIFIQUE:

9. Tiene Carnet de Salud Infantil? 9) NO SI

Nombre completo: _____

10. Fecha de nacimiento (mes/ano): _____ Edad(meses): 10) _____

11. Tiene por lo menos una pesada correctamente registrada en su carnet? 11) NO SI

SI LA RESPUESTA A LA PREGUNTA 11 ES "NO", CONTINUE DIRECTAMENTE CON LA PREGUNTA 14.

12. Tuvo su primer control de peso antes de los 6 meses de edad? 12) NO SI

13. Cuantas veces se ha pesado en los ultimos 12 meses? 13) _____

14. Sexo del nino (M/F) 14) _____

15. Edad actual (meses) _____
Peso desnudo (en kg. y decimas de kg)_____

Es su peso igual o mayor al peso de la TABLA PESO/EDAD)? 15) NO SI

PREGUNTE A LA MADRE:

16. Tuvo su hijo diarrea (mas de 3 deposiciones sueltas al dia) EN LAS ULTIMAS DOS SEMANAS? 16) NO SI

17. Tiene diarrea HOY? 17) NO SI

18. Si la respuesta a cualquiera de las dos preguntas anteriores (14 o 15) es "SI", pregunte:

Tuvo su hijo alguna de las siguientes molestias?
(MENCIONE UNA POR UNA Y MARQUE)
Mollera hundida ( ) Llora con pocas o sin lagrimas ( )
Orina poco ( ) Ojos hundidos ( )

Cual fue el tratamiento de este episodio de diarrea?
(MARQUE TODAS LAS RESPUESTAS ESPONTANEAS DE LA MADRE)
EN TODOS LOS CASOS:
a) darle mas liquidos
g) continuar alimentacion
h) continuar lactancia materna
c) sobres en forma correcta
b) suero casero en forma correcta
EN CASOS MODERADOS-GRAVES:
i) llevado a la promotora
j) lo ha derivado a un Puesto/Centro de Salud
SIEMPRE INCORRECTO:
f) pastillas, jarabes o inyectables.
c) sobres en forma incorrecta
d) suero casero en forma incorrecta
k) Otro (incluyendo remedios tradicionales):
_____

En base a las respuestas dadas, fue apropiado el tratamiento para este tipo de diarrea? 18) NO SI

19. Tuvo su hijo alguna de las siguientes molestias
EN LAS ULTIMAS DOS SEMANAS?
(MENCIONE UNA POR UNA Y MARQUE)

a)	Tos	19) NO	SI
b)	Secrecion nasal	19) NO	SI
c)	Respiracion agitada	19) NO	SI

20. Tiene su hijo alguna de las siguientes molestias
EL DIA DE HOY?
(MENCIONE UNA POR UNA Y MARQUE)

a)	Tos	20) NO	SI
b)	Secrecion nasal	20) NO	SI
c)	Respiracion agitada	20) NO	SI

21. Si la respuesta a cualquiera de las dos preguntas anteriores (17 o 18) es "SI", pregunte:
Que tratamiento ha usado para esta enfermedad?
(MARQUE TODAS LAS RESPUESTAS <u>ESPONTANEAS</u> DE LA MADRE)
EN TODOS LOS CASOS:
a) darle mas liquidos
b) continuar alimentacion
c) continuar lactancia materna
d) limpieza fosas nasales
e) medicamento contra la fiebre: _____
EN CASOS MODERADOS-SEVEROS:
h) llevado a la promotora
i) llevado al Puesto/Centro de Salud
j) OTROS (incluye remedios tradicionales):
_____

En base a las respuestas dadas,
fue apropiado el tratamiento para el tipo de IRA? 21) NO SI

22. Actualmente, le da pecho a su hijo? 22) NO SI

23. Actualmente, le da otras comidas o bebidas aparte de pecho? 23) NO SI

MEJORAMIENTO INFANTIL
CARITAS DE BOLIVIA

ENTREVISTA A LAS PROMOTORAS

COMUNIDAD: FECHA:
NOMBRE: CARGO:

"SENORA Promotora, HEMOS ACUDIDO A UD. PORQUE SABEMOS DE SU CONOMICIENTO E INTERES EN LA SALUD DE SU COMUNIDAD. QUEREMOS QUE UD. NOS AYUDE A MEJORAR LAS ACTIVIDADES DE SALUD QUE SE ESTAN REALIZANDO, Y POR ELLO LE SOLICITAMOS SU COLABORACION PARA RESPONDER LAS SIGUIENTES PREGUNTAS."
(EN LAS SIGUIENTES 8 PREGUNTAS. NO MENCIONAR LAS ALTERNATIVAS DE RESPUESTA. SOLO RECOGER LAS RESPUESTAS DADAS ESPONTANEAMENTE.)

Labor del Promotora

1. Que hace Ud. como Promotora?
   - _____ Trata a los ninos con diarrea
   - _____ Trata a los ninos con IRA
   - _____ Aconsejado a las madres sobre el cuidado de sus hijos
   - _____ Control del peso a los ninos
   - _____ Cura enfermedades (diferentes a la diarrea e IRA)
   - _____ Orienta a las miembros del Club de Madres en las discusiones sobre temas de salud
   - _____ Sirve de comunicacion entre CARITAS y la Comunidad
   - _____ Prepara informes y recoge datos para el proyecto.
   - _____ Hacer visitas domiciliarias
   - _____ Otro (mencione): _____

2. Por que el CARITAS esta trabajando en su comunidad?

   _____

   _____

   _____

3. Que va a hacer Ud. cuando el proyecto termine?

   _____

   _____

   _____

"SENORA Promotora, ESTAMOS MUY PREOCUPADOS PORQUE ESTAMOS OBSERVANDO QUE MUCHAS DE SUS COMPANERAS ESTAN PREOCUPADAS POR SU FUTURO COMO PromotoraS. QUISIERA QUE UD. NOS AYUDARA A CONOCER ALGUNAS RAZONES DE ESTA PREOCUPACIONES, Y ASI PODER APOYARLAS MEJOR."

6. En su opinion, cuales son los principales problemas que tienen las Promotoras para seguir trabajando?
   _____ No hay participacion de la comunidad en las actividades
   _____ La comunidad no compensa a la Promotora a cambio de su trabajo
   _____ No tiene suficiente capacitacion para enfrentar los problemas de su comunidad
   _____ No hay materiales para trabajar
   _____ El personal CARITAS no lo visita
   _____ CARITAS no compensa a la Promotora a cambio de su trabajo
   _____ Otro. Mencione: _____

7. Que tipo de apoyo pueden dar las comunidades a las Promotoras para que continuen con sus actividades?
   _____ Incentivo economico al Promotora
   _____ Incentivo en especies a la Promotora
   _____ Incentivo en trabajo a la Promotora
   _____ Mas participacion en las actividades promovidas por las Promotoras
   _____ Otro (mencione): _____

8. Que tipo de apoyo puede dar CARITAS a las Promotoras para que continuen con sus actividades?
   _____ Incentivo economico a la Promotora
   _____ Incentivo en especies a la Promotora
   _____ Incentivo en trabajo a la Promotora
   _____ Mas capacitacion
   _____ Mas visitas de supervision
   _____ Mas equipos y materiales
   _____ Otro (mencione): _____

"SENORA Promotora, NOS GUSTARIA MUCHO HACERLE LAS SIGUIENTES PREGUNTAS PARA SABER QUE CONOCIMIENTOS NECESITA UD. REFORZAR EN FUTUROS CURSOS DE CAPACITACION. ESTO NO ES UN EXAMEN. SOLAMENTE QUEREMOS SABER QUE LES PODEMOS ENSENAR A UDS. EN FUTURAS CAPACITACIONES."

IMPORTANTE:

A) SI SE DESCONOCE UNA RESPUESTA ("No sabe cuantos anos de educacion tiene"), DEJAR EN BLANCO EL CASILLERO. SI LA RESPUESTA ES 0 ("No tiene ningun ano de educacion"), COLOCAR 0.
B) NO CORRIJA A LA PROMOTORA EN NINGUNA RESPUESTA.

Datos basicos

01. Edad de la promotora (anos) 01) _____

02. Cuantos hijos tiene? 02) _____

03. Cuantos anos de educacion formal tiene? 03) _____

04. Desde cuando fue elegida promotora?
(mes/ano de ingreso: _____)' Antiguedad (meses): 04) _____

Capacitacion y supervision

05. Cuantos cursos de capacitacion ha recibido? 05) _____

06. Hace cuantos meses fue su ultima capacitacion? 06) _____

07. Hace cuantos meses fue supervisada por el personal de Caritas por ultima vez? 07) _____

Durante esta ultima visita de supervision:

08. Se le dio capacitacion? 08) NO SI

09. Se revisaron los cuadernos de registro? 09) NO SI

10. Se coordino con los miembros del club de madres? 10) NO SI

11. Se coordino con las autoridades locales? 11) NO SI

12. Se dio charla sobre algun tema de mejoramiento infantil? 12) NO SI

13. Se vieron los pacientes tratados por la promotora? 13) NO SI

Control de la diarrea

14. El suero oral cura la diarrea? 14) NO SI

15. El suero oral evita que el nino se seque? 15) NO SI

16. Cuando ha tratado la promotora su ultimo paciente con diarrea? Hace:_____ dias 16) _____

17. Que signos y sintomas tuvo ese paciente?
(MENCIONE UNA POR UNA Y MARQUE)
Fontanela hundida ( )
Pliegue ( ) Orina poco ( ) Ojos hundidos ( )

Cual fue el diagnostico de deshidratacion de la promotora?
leve ( ) moderado-grave ( )

Es el diagnostico de la promotora compatible con los signos y sintomas de la paciente? 17) NO SI

18. **Cual fue el tratamiento de este episodio de diarrea?**
Verifique preparacion y administracion. (MARQUE TODAS LAS RESPUESTAS ESPONTANEAS DADAS POR LA PROMOTORA).

EN TODOS LOS CASOS:
a) darle mas liquidos
g) continuar alimentacion
h) continuar lactancia materna
c) sobres en forma correcta
b) suero casero en forma correcta
EN CASOS MODERADOS-GRAVES:
j) lo ha derivado a un Puesto/Centro de Salud
SIEMPRE INCORRECTO:
f) pastillas, jarabes o inyectables.
c) sobres en forma incorrecta
d) suero casero en forma incorrecta
OTROS (incluyendo remedios tradicionales):
_____

En base a las respuestas dadas, fue apropiado el tratamiento para este tipo de diarrea? 18) NO SI

19. En alguna oportunidad le ha faltado SRO durante el ultimo ano? 19) NO SI

20. Cuando fue la ultima vez que explico a las madres del club sobre la diarrea? Hace _____ semanas 20) _____

21. Tiene un registro de los casos de diarrea atendidos 21) NO SI

22. Tiene materiales educativos en exhibicion 22) NO SI

35. Que signos y sintomas tuvo ese paciente?
(MENCIONE UNA POR UNA Y MARQUE)
Secrecion nasal ( ) Tos ( )
Respiracion rapida ( )
Otro (mencione): _____

Cual fue el diagnostico de infeccion respiratoria aguda de la promotora?
leve ( ) moderado-grave ( )

Es el diagnostico de la promotora compatible con los signos y sintomas de la paciente? 35) NO SI

36. **Cual fue el tratamiento de este episodio de IRA?**
(MARQUE TODAS LAS RESPUESTAS ESPONTANEAS DADAS POR LA PROMOTORA).
EN TODOS LOS CASOS:
a) darle mas liquidos
b) continuar alimentacion
c) continuar lactancia materna
d) limpieza fosas nasales
e) medicamento contra la fiebre: _____
dosis diaria: _____ duracion tto: _____
EN CASOS MODERADO-GRAVES:
f) antibioticos: _____
dosis diaria: _____ duracion tto: _____
h) transferirlo al Puesto/Centro de salud
OTROS:
i) Otro (incluye remedios tradicionales):
_____

En base a las respuestas dadas, fue apropiado el tratamiento para este tipo de infeccion respiratoria aguda? 36) NO SI

37. Cuando fue la ultima vez que explico a las madres del club sobre la infeccion respiratoria aguda?
Hace _____ semanas 37) _____

38. Le han faltado medicinas durante el ultimo ano? 38) NO SI

39. Tiene un registro de los casos de infeccion respiratoria aguda atendidos? 39) NO SI

40. Tiene un registro de las medicinas entregadas 40) NO SI

41. Tiene materiales educativos en exhibicion? 41) NO SI

Cantidad de medicinas en stock:

42. Aspirinetas 42) _____
43. Cotrimoxazole tabletas 43) _____
44. Otro (mencione): _____ 44) _____

PREGUNTAS PARA LOS GRUPOS FOCALES A

AUTORIDADES COMUNALES

1. Cuales son las principales preocupaciones (en general) que tiene su comunidad actualmente? Enumerar de mayor a menor importancia.

2. Que se esta haciendo para resolver estas preocupaciones? Con ayuda de quien?

3. Cuales son los principales problemas de salud en su comunidad? Enumerar de mayor a menor importancia.

4. Que se esta haciendo para resolver estas preocupaciones de salud? Con ayuda de quien?

5. Que actividades especificas esta haciendo CARITAS en su comunidad?
   Que opinan Uds?

6. Que cosas buenas ha escuchado sobre el sobre en su comunidad?
   Que opinan Uds?

7. Que cosas malas ha escuchado sobre el sobre en su comunidad?que opinan Uds.?

8. Que cosas buenas ha escuchado sobre el pesado continuo de los ninos en su comunidad? que opinan Uds.?

9. Que cosas malas ha escuchado sobre el pesado continuo de los ninos en su comunidad? que opinan Uds.?

10. Que actividades hace la promotora de salud? Que actividades de la promotora le gustan mas? Que actividades le gustan menos? Por que?

11. Que va a suceder con las actividades de salud que CARITAS esta apoyando actualmente, cuando CARITAS deje de trabajar en su comunidad?

PREGUNTAS PARA LOS GRUPOS FOCALES

A MADRES DE FAMILIA

TERAPIA DE REHIDRATACION ORAL

1. Que es la diarrea?
2. Cuales son las causas de la diarrea?
3. Que es la deshidratacion?
4. Que harian Uds. si su hijo tuviera diarrea?
5. Que cosas buenas han escuchado sobre el sobre en su CMN?
6. Que cosas malas han escuchado sobre el sobre en su CMN?

VIGILANCIA Y PROMOCION DEL CRECIMIENTO

1. Para que se pesan los ninos en el CMN?
2. Que es el CSI? Para que sirve?
3. Que cosas buenas han escuchado sobre el pesado de los ninos en el CMN? Que opinan Uds?
4. Que cosas malas han escuchado sobre el pesado de los ninos en el CMN? Que opinan Uds?
5. Como saben Uds. que un nino esta creciendo sanito? Sirve el CSI para darse cuenta? Como? Que hacen Uds. en este caso?
6. Como saben Uds. que un nino no esta creciendo sanito? Sirve el CSI para darse cuenta? Como? Que hacen Uds. en este caso?

PREGUNTAS PARA LAS AUTORIDADES

LOCALES DEL MINISTERIO DE SALUD

Nombre:

Lugar:

Cargo:

1. Cuales son los objetivos de CARITAS en su area de trabajo?

_____

_____

2. Para ejecutar esos objetivos, que actividades esta realizando?

_____

_____

3. Ha podido CARITAS apoyar actividades propias del Ministerio de Salud en esta zona? Que actividades? Cuando? Como? (Describa)

_____

_____

4. Ha podido su institucion apoyar actividades propias de CARITAS en esta zona? Que actividades? Cuando? Como? (Describa)

_____

_____

5. Han podido su institucion y CARITAS realizar actividades

23. Tiene un registro de las SRO entregadas 23) NO SI

24. Cantidad de SRO en el Puesto 24) _____

25. Cantidad de medidas para SRO (jarro/cuchara) 25) _____

Control de crecimiento

26. Use el carnet modelo y pregunte:
Curva #1: como esta yendo su estado de nutricion?
Curva #2: como esta yendo su estado de nutricion?
Curva #3: como esta yendo su estado de nutricion?

La promotora ha fallado en el significado de 2 o 3 curvas? 26) NO SI

27. Use el carnet modelo y pregunte:
Curva #1: cuales son sus recomendaciones y acciones
Curva #2: cuales son sus recomendaciones y acciones
Curva #3: cuales son sus recomendaciones y acciones

La promotora ha fallado en las recomendaciones y acciones de 2 o 3 curvas? 27) NO SI

28. En alguna oportunidad le han faltado carnets durante el ultimo ano? 28) NO SI

29. Cuando fue la ultima vez que explico a las madres del club sobre el control de peso? Hace _____ sem 29) _____

30. Tiene un registro de los controles realizados 30) NO SI

31. Tiene materiales educativos en exhibicion 31) NO SI

32. Cantidad de carnets en el puesto 32) _____

33. Esta la balanza operativa y calibrada? 33) NO SI

Infeccion Respiratoria Aguda

34. Cuando ha tratado la promotora su ultimo paciente con IRA? Hace:_____ dias 34) _____

conjuntas en esta zona? Que actividades? Cuando? Como? (Describa)

_____

_____

6. Que actividades realizan los clubes de madres que CARITAS esta promoviendo en su area de trabajo? Que actividades de los clubes le gustan mas? Que actividades le gustan menos? Por que?

_____

_____

7. Que actividades hace la promotora de salud? Que actividades de la promotora le gustan mas? Que actividades le gustan menos? Por que?

_____

_____

8. Que va a suceder con las actividades de salud que CARITAS esta apoyando actualmente en las comunidades. cuando CARITAS deje de trabajar en su zona?

_____

_____

9. Que recomendaciones daria su institucion a CARITAS para que mejore sus actividades en su zona?

_____

_____