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MID-TERM EVALUATION

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT (PROSAMI)

Project Number 519-0367

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LIST OF ABBREVIATIONS AND ACRONYMS

ADD	Acute Diarrheal Diseases
ADEMUSA	Asociación de Mujeres Salvadoreñas
ADHU	Asociación para el Desarrollo Humano
ADS	Asociación Demografica Salvadoreña (Salvadoran Demographic Association)
AGAPE	Asociación AGAPE de El Salvador
AMCS	Asociación de Mujeres Campesinas Salvadoreñas
AMS	Asociación para la Autodeterminación y Desarrollo de Mujeres Salvadoreñas.
APSISA	Health System Support Proyect
ARI	Acute Respiratory Infection
ASADEH	Asociación Salvadoreña para el Desarrollo Humano
ASALDI	Asociación Salvadoreña para el Desarrollo Integral
ASAPROSAR	Asociación Salvadoreña PRO-SALUD Rural
ASEI	Asociación Salvadoreña de Extensionistas Empresariales Egresados del INCAE
ASPS	Asociación Salvadoreña Promotora de Salud
CALMA	Centro de Apoyo de Lactancia Materna
CHP	Community Health Promoter
CIPHES	Coordination Council for Private Institutions in Human Promotion in Salvador
CIRES	Comite de integración y Reconstrucción para El Salvador
CISI	Comittee for Child Survival
CODECA	Coordinadora para el Desarrollo de las Comunidades del Cacahuatique
CODECOSTA	Coordinadora comunidades y Cooperativas para el Desarrollo Integral de la Costa
CODECUS	Consejo para el Desarrollo Comunal de Usulutan
CODELUN	Coordinación para el Desarrollo Comunal de la Unión
COMAFAC	Comite de Madres y Familiares Cristianos para la Promoción y Defensa de los Derechos Humanos "Padre Octavio Ortiz y Hna. Silvia".
COMUS	Comunidades Unidas de Usulutan
CONAMUS	Coordinadora Nacional de la Mujer Salvadoreña
COP	Community Organization and Participation
COSDECSAM	Comite de Solaridad para el Desarrollo de las Comunidades
CRS	Community Health Specialist
CRT	Community Health Trainer
DIOCESIS	Diocesis de Zacatecoluca
EOP	End of Proyect
EPI	Expanded Program of Immunizations
FASTRAS	Fundación para la Autogestión y Solidaridad de los Trabajadores
FMLN	National Liberation Front Farabundo Marti

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F

FUMA	Fundación Maquilishuat
FUNDAC	Fundación Cuscatlan "Manuel Franco"
FUNDEPRENS	Fundación de Enseñanza de El Salvador
FUNDEMUN	Fundación Salvadoreña para el Desarrollo de la Mujer
FUNDESO	Fundación de Desarrollo Social
GMD	Growth Monitoring and Development
IDB	Inter-American Development Bank
IDEA	Iniciativa para el Desarrollo Alternativo
ISSS	Salvadora Social Security Institute
IUD	Intra-Uterine Device
GOES	Government of El Salvador
LOP	Life of Project
MCH	Maternal Child Health
MHCS	Maternal Health and Child Survival
MOH	Ministry of Health
MRH	Maternal and Reproductive Health
MSCI	Medical Services Corporation International
NGO	Non-Governamental Organization
NPH	Neonatal and Perinatal Health
OIC/MOH	Office of International Cooperation/Ministry of Health
OEF	Asociación para la Organización y la Educación Empresarial Femenina.
ORMUSA	Organización de Mujeres Salvadoreñas
ORS	Oral Rehydration Salts.
ORT	Oral Rehydration Therapy
OPRODE	Organización Profesional de Desarrollo
PAC	Project Advisory Committee
PADECOMSM	Patronato para el Desarrollo de las Comunidades de Morazan y San Miguel
PAHO	Pan American Health Organization
PROCADES	Asociación Salvadoreña de Promoción, Capacitación y Desarrollo
PROGRESO	Promogestora de Repoblaciones Solidarias
PROSAMI	Maternal Health and Child Survival Project
PVO	Private Voluntary Organizatión
TBA	Traditional Birth Attendent
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development
USG	United States Government

I. EXECUTIVE SUMMARY

1. NAME OF MISSION

USAID/EL SALVADOR
Mid-term Evaluation, Maternal Health and Child Survival Project (PROSAMI)
September--November, 1994

2. PURPOSE OF ACTIVITIES EVALUATED

The PROSAMI Project was designed to extend coverage of basic Maternal Child Health services into rural communities lacking access to these services due to the impact of the past armed conflict and/or geographic isolation. The Project goal is to improve the health of rural population by increasing the percentage of this population which has access to adequate basic health services. The purpose of the Project is to expand community based MHCS services to those areas of El Salvador where such services have been weak or nonexistent.

3. PURPOSE OF THE EVALUATION AND METHODOLOGY USED

The purpose of this Mid-term Evaluation is to assess the appropriateness of the Project design, and determine the progress and impact to date by the Project. The Evaluation Team used three methods to determine the effectiveness and efficiency of the extent to which services are reaching the intended beneficiaries of the Project: 1) interviewing key informants, 2) reading primary source materials, and 3) field observations.

4. FINDINGS AND CONCLUSIONS

The major findings in the area of maternal health and child survival are the following: PROSAMI is successfully fulfilling its objectives in relation to organizing a network of NGOs to provide a uniform system of maternal health and child survival services. The system appears to be very effective in reducing morbidity and mortality. With appropriate training and supervision, community personnel with little formal education can successfully provide fairly complex primary health care services. Also, a community based health delivery system consisting of a basal census, active case detection, simplified case management, immediate referrals of high risk patients, and health education and counseling, can effectively reduce morbidity and mortality rates.

With regard to the planning systems for technical and financial control, the PROSAMI Project has developed very detailed innovative and appropriate reporting, monitoring and feedback systems to move information around the communities, the NGO's, and the central staff of PROSAMI. These systems are important to express how management wants organizations to work and to make important changes. The conclusion is, therefore, that the overall system has led to organizational clarity and control by independent NGO's, as opposed to central control by advisors.

The major findings in the health finance area are the following: The total cost of the PROSAMI health care promoter program is comparatively high in absolute terms, particularly when the home and field office costs are added to the NGO costs. The promoter cost per attention provided is competitive when compared to the MOH or other organizations. Cost recovery from monies provided from other NGO activities has considerably more potential than patient fee money. The cost recovery from client based fees and the management of these funds is just at the "launch" stage. The percentage of patients that pay so far is very low.

5. RECOMMENDATIONS

The PROSAMI network of NGOs and community-based maternal health/child survival primary health care system has proved to be highly effective in reducing morbidity and mortality in rural communities of El Salvador. This should serve as a model for projects in other areas.

The presence of a central supervisory, training and normative organization is essential for the continued success of PROSAMI network and system. Therefore, we recommend that CONSALUD be developed and supported by USAID, MSCI and other agencies/donors to assume these roles and functions. This support should be manifested by providing access to sufficient financial resources and technical assistance to allow CONSALUD to achieve self-sufficiency and assure its sustainability.

6. LESSONS LEARNED

The various NGO's had a wide variety of management styles and structures as well as a wide variety of individual capabilities and capacities. It is important not to place undue restrictions, nor to force diverse NGO's into one model of organizational design, but instead, a flexible system of good administration, planning and finance should be provided, and then the NGOs should be permitted to adapt these systems to their own organization and management styles as they see fit. The transition from dependence to independence is an important step in the process of developing the sustainability of the PROSAMI program by the NGOs which comprise the network. This is facilitated by developing plans for individual and collective action by each organization on program sustainability, institutional permanence and financial self-sufficiency. To assist and shorten the time line to independence, the NGO's have formed a network organization (CONSALUD) to centralize administrative functions, technical training and standardization of services, and to coordinate activities.

PROSAMI has demonstrated that a relatively diverse group of indigenous NGOs can be successfully organized into a coherent and collaborative network to effectively provide specific technical services (e.g., maternal health and child survival services). PROSAMI has shown that community personnel with relatively little formal education can successfully deliver a relatively complex package of primary health care services when they receive adequate basic training, with complementary, regular supervision and continuing education. Active case detection and simplified case management can be effective in reducing morbidity and mortality. A community based health service system can significantly impact and improve community health. Primary preventive services (education, promotion and protective measures to prevent health problems) are more effective if associated with and delivered as complements to secondary preventive services (diagnosis and treatment of existing health problems).

Many of the NGOs working with PROSAMI have highly sophisticated and creative ways of generating funds that help to pay the administrative costs of other programs that need subsidies. They are good examples of how to set up small business enterprises, small factories, training programs, consulting assistance, agriculture ventures, and similar enterprises. PROSAMI and the associated NGOs have implemented a number of advanced systems in accounting, inventory, payroll, accounts receivables, and purchasing. These systems could be compared and then combined into one system that utilizes the best of each individual program.

II. BACKGROUND

1. DESCRIPTION

Because of the past internal conflict in El Salvador, severe budgetary strain has been placed upon the public sector, especially in the social services sector. The MOH has achieved some improvement in health indicators with assistance from other donors and its own limited budget. There are still large areas where populations lack access to basic health care. The Maternal Health Child Survival Project has been designed to help address the gap in basic services delivery. The Project will widen the scope and improve efficiency/effectiveness of health care programs. Existing Salvadoran private voluntary organizations will help to reach some of the rural poor not now attended by public health programs.

2. GOAL

The goal of the Maternal Health Child Survival Project is to improve the health status of the rural population by increasing the percentage of this population which has access to adequate basic health services.

3. PURPOSE

This purpose is to expand community based maternal health/child survival (MHCS) services to those areas of El Salvador where such services have been weak and non-existent.

4. PROJECT NUMBER

519 - 0367

III. SCOPE OF WORK

A brief summary of the Scope of Work (SOW) follows. The complete version of the SOW is in Annex E.

The overall objective of the mid-Term Evaluation is to assess the appropriateness of the Project design and determine the programs and impact to date by the Project. The Evaluation will be conceptualized on four levels to include:

a) Measurement of Efficiency
b) Measurement of Effectiveness
c) Measures of impact
d) Measures of sustainability

A three person technical evaluation team will review and assess these four levels as follows:

a) Points related to efficiency:

1. Appropriateness of Project Objectives
2. Viability of methodology for service delivery
3. Quantity and quality for inputs to NGO's
4. Efficacy of methodologies

b) Points related to effectiveness:

1. Technical and administrative capacity
2. Project progress to date
3. Coverage
4. Quality of services
5. Cost Effectiveness
6. Benefit-Cost Analysis
7. Coordination

c) Impact

1. Impact achieved by the Project

d) Points related to sustainability

1. NGO's program sustainability
2. Projects contributions to strategic USAID objectives
3. Legal Status

Draft final report in English and Spanish will be submitted prior to Evaluation Team departure from country, and final report not later than four weeks after receipt of USAID review of final draft report.

IV. EVALUATION TEAM

Brief summaries of the three evaluation team members are presented below. See Annex F. for the complete résumés of each team member.

Lewis H. Thornton

Lewis Thornton, MS, Organizational Management specialist and Team Leader for the Mid-term Evaluation of the El Salvador Maternal Health and Child Survival Project (PROSAMI) has had over twenty-five years of development experience, primarily in Latin America. Mr. Thornton has specialized in organizational development, project management planning, monitoring, evaluation and training in rural development, education, agriculture, and recently in health evaluation. He has worked in the public and private sectors and with NGO's.

His primary responsibilities in the PROSAMI Project covered the evaluation of NGO technical and administrative capacity, project progress to date, inter- and intra-institutional coordination and project sustainability section. Mr. Thornton's team leader responsibilities included ensuring that the evaluation objectives were met and for incorporating the team member contributions into the USAID/El Salvador Scope of Work referenced in Section III.

Peter H. Boddy

Dr. Peter Boddy, MD, MPH, Maternal Health and Child Survival Specialist has worked in primary health care in Latin America for over 15 years. He is currently Country Director of Esperanza Bolivia and Program Director, Human Resource Development Matching Grant, and supervises an USAID funded child survival project in Bolivia. He has worked as resident advisor and consultant in Honduras where he provided technical assistance and administrative support to the Ministry of Public Health for the USAID funded Nutritional Communication Project.

Dr. Boddy was responsible for evaluating the PROSAMI health care delivery system and the maternal health and child survival activities. In particular, he examined the following areas related to the efficiency of PROSAMI: The appropriateness of project objectives, viability of service delivery, inputs and outputs, and the training, supervising, monitoring and evaluation methodologies used by PROSAMI. In the area of effectiveness, Dr. Boddy reviewed the coverages achieved by medical service components and the quality of services. Finally, he also evaluated the impact of PROSAMI NGO activities on morbidity and mortality in the communities where they are working.

M. Roy Brooks, Jr.

Roy Brooks, MBA, MPH, Health Financial & Cost Analysis Specialist, has spent the last twenty years working in the health sector primarily in the USA, Asia and Latin America, specializing

in international health care in the areas of health finance of country-wide health care programs, hospitals, and ambulatory centers, as well as management and organizational development of the same. Mr. Brook's responsibilities under the PROSAMI Project included cost-effectiveness analysis which compared the NGO quality of care and costs with those of the public sector and among the NGO's. He also focused his evaluation on the benefit-cost analysis which compared the benefits of community-level preventive services (deaths and incidence of morbidity averted through increased coverage and savings to society) and their cost with the benefit-cost of curative care.

V. Methodology

INTRODUCTION

The Evaluation Team consulted together and designed a general evaluation strategy and methodology to obtain the information necessary for the PROSAMI MTE (mid-term evaluation). Three basic methods were employed to determine the efficiency, effectiveness, impact and sustainablilty of the PROSAMI health care system and NGO network, and the extent to which services are reaching and improving the lives of the intended beneficiaries of the Project. These three methods were the following:

1) interviewing key informants,
2) reading primary source materials, and
3) field observations.

Each evaluator designed, organized and coordinated with the others a specific evaluation work plan based on the three methods mentioned above. The specific evaluation work plans developed and implemented by the evaluators are described in the sections which follow. A brief description of the elements of the evaluation work plans is presented below.

Each evaluator reviewed pertinent documents, and conducted interviews with individuals or organizations related to his area of responsibility. Each evaluator designed one or more questionnaire guides to cover his area of responsibility for the evaluations. Samples of the questionnaires and evaluation instruments are in Annex D.

Field visits were made to NGOs following the selection criteria explained in the sections that follow. A total of 16 different NGOs were visited by the three evaluators during a total of 2 joint and 21 separate visits. Table 1 presents a summary of the NGOs visited by the Evaluation Team members. A total of 26 communities were visited by the evaluators, representing a range of geographical areas in El Salvador, including a high proportion of areas from the former conflictive zones.

The insights and understanding of the PROSAMI Project obtained through the implementation of the three basic evaluation methodologies provided the Evaluation Team with adequate information and consistent results to be able to draw valid conclusions and recommendations.

Table 1.
NGOs Visited by Evaluation Team Members
PROSAMI Mid-Term Evaluation, El Salvador, 1994

No.	NGOs VISITED	ROUND	NRP	Visited by the Following Evaluators:		
				Lewis Thornton	Roy Brooks	Peter Boddy
1	AGAPE	First	No		Yes	
2	ASALDI	First	No	Yes	Yes	Yes
3	ASAPROSAR	First	No			Yes
4	FUNDEMUN	First	Yes		Yes	Yes
5	OEF	First	Yes	Yes		
6	OPRODE	First	No		Yes	
7	PROCADES	First	Yes	Yes	Yes	Yes
8	ASADEH	Second	Yes	Yes		
9	CONAMUS	Second	Yes		Yes	Yes
10	FUMA	Second	Yes	Yes		
11	FUNDESO	Second	No		Yes	Yes
12	KNAPP	Second	Yes	Yes		
13	COSDECSAM	Third	Yes		Yes	
14	FUNDEPRENS	Third	Yes			Yes
15	IDEA	Third	Yes	Yes		
16	PADECOMSM	Third	Yes	Yes		
	TOTAL			8	8	7

ORGANIZATIONAL AND MANAGEMENT EVALUATION METHODOLOGY

1. GENERAL

As mentioned in the Introduction of the Methodology Section, the Organizational Management Evaluation Specialist used three methods to determine the effectiveness of the extent to which services are reaching the intended beneficiaries; specifically, the technical and administrative capacity of the NGO's to implement the Project. Additionally, program sustainability was evaluated. These three methods were:

1) interviewing key informants (see list of persons interviewed in Annex C-1).
2) reading primary source materials (see list of documents reviewed in Annex C-1).
3) field observation (see instruments in Annex D-1).

In determining the site selection criteria, the NGOs were stratified according to their average monthly technical ratings, which were prepared by the PROSAMI technical staff based upon NGO monthly and quarterly reports. Ratings included measures of progress implementation and coverage achieved and ranged from A to D, which were quantified as a 4.0 to 1.0. In addition to the MSCI ratings, institutional characteristics and geographical distribution were considered in the selection of NGOs to be visited. The Organizational Management Specialist, using the questionnaire guide developed by him, then met with the MSCI Technical Coordinator prior to the visit with each NGO. Meetings were then held with members of the board of each NGO, executive directors, administrator, project technical coordinator and two or more supervisors. Accompanied by the MSCI technical coordinator, the evaluator visited regional offices of the NGO's, and finally, accompanied by the community supervisor visited approximately 15 communities meeting with promoters, community health committee members and community volunteer workers.

The eight NGO's visited by the Organizational Management Specialist were:

ASADEH
ASALDI
FUMA
IDEA
KNAPP
OEF
PRODECOMSM
PROCADES

2. SUSTAINABILITY METHODOLOGY

The methodology used to evaluate factors influencing sustainability in the PROSAMI Project was based on the USAID CDIE Study of U.S. foreign assistance health programs in a six country study. One third (12) of the executive directors of the NGO's, and ten professionals from the

MSCI PROSAMI technical and administrative staff were selected to answer the sustainability questionnaire. These persons met as two groups (NGO executive directors and PROSAMI staff) where the instructions were explained for completing the questionnaires, and once the questions were understood, the questionnaires were filled-out. The results provided insights and understanding into the various factors found to influence the sustainability.

MATERNAL HEALTH AND CHILD SURVIVAL EVALUATION METHODOLOGY

The maternal health and child survival (MHCS) specialist evaluated specific medical and health care delivery aspects of PROSAMI ("Proyecto de Salud Materno y Supervivencia Infantil" or "Maternal Health and Child Survival Project"). The methodology used to obtain information and data for evaluation purposes consisted of three principal actions: 1. Review of documents; 2. Interviews and discussions with key persons; and, 3. Visits to NGO project sites and communities. These are explained in further detail below.

1. REVIEW OF DOCUMENTS

The MHCS specialist reviewed documents relating to PROSAMI, the way PROSAMI operates, and PROSAMI's goal area (maternal and child health in El Salvador). Pertinent documents were identified through discussions with PROSAMI staff, USAID/El Salvador Mission personnel, and others. The documents reviewed were national survey reports, and PROSAMI documents, including monthly and quarterly evaluation reports, training materials, evaluation and monitoring documents, technical assistance reports, and technical component coverage reports. A list of the documents reviewed is in Annex C-2.

2. INTERVIEWS, DISCUSSIONS AND MEETINGS

The MHCS specialist conducted interviews and discussions with PROSAMI staff, personnel of participating NGOs, and members of the target population. Meetings were held with USAID/El Salvador Mission personnel, PROSAMI staff, the NGO evaluation committee, and MOH staff. A list of persons interviewed and meetings attended is included in Annex C-2.

3. SITE VISITS

Fifteen NGOs were selected for one-day visits (see site selection criteria below). The site visits were conducted by one of three evaluation teams formed by the evaluator. One team was composed of the evaluator (MHCS specialist) accompanied by two members of the PROSAMI technical advisory staff. Seven of the selected sites were visited by this team (see Table 2 for sites visited).

The second team was composed of three members of the PROSAMI technical advisory staff and visited four NGOs. The third team was formed by two of the PROSAMI technical advisors, and also visited four NGOs. A debriefing meeting was held with the participating PROSAMI technical advisors to discuss the evaluation process and their experiences. Completed survey

forms were reviewed by the evaluator. The results of the PROSAMI technical advisors were found to be of good quality, with no significant errors, and were consistent with the results of the evaluator

The participation of PROSAMI technical advisors in the collection of data and information for the technical evaluation permitted the inclusion of more sites, and also served as a learning experience for the technical advisors, who heretofore had not conducted this type of evaluation of project activities. It is expected that the PROSAMI technical advisors will incorporate these new evaluation skills in their continuing monitoring and supervisory efforts.

Three main activities were carried out during the site visits: 1. Interviews, 2. Observation of service delivery, and, 3. Completion of survey instruments. The two PROSAMI technical advisor teams principally conducted the third activity. The first activity was interviews of NGO project personnel, including technical coordinators, supervisors, and promoters; volunteer community participants; and, members of the client population.

The evaluator interviewed the following persons at the seven sites he visited: 6 technical coordinators were interviewed at the sites (an additional 17 completed survey instruments at a meeting). A total of 23 supervisors were interviewed individually or in small groups (with other supervisors). A total of 76 promoters were interviewed in 7 groups ranging in size from 6 to 17 persons. Eight promoters were interviewed individually in their communities, and were observed providing care to 11 clients. The latter were interviewed alone (without the promotor or supervisor present) by the evaluator after the consult by the promotor was finished.

The second activity was to observe service delivery in the communities. This was done by interviewing a promotor in her/his community; discussing how she/he would treat patients with specific problems; examining her/his dispensary, patient records, and program reports; reviewing the risk map and its use; and, accompanying the promotor on a visit to a household with a pregnant woman for a prenatal visit and another household for a growth monitoring visit. The evaluator accompanied 8 promoters on visits to 11 clients. Also, 4 supervisors were observed supervising the promoters during patient visits.

The third activity was to apply a series of nine survey instruments to seven groups of people. The surveys included a combination of qualitative and quantitative questions. The persons surveyed included the following: NGO directors, technical coordinators, technical supervisors, promoters, traditional birth attendants (TBAs), community health committees, and members of the target population. The survey instruments were completed during the site visits with the exception of the NGO executive directors and the majority of the NGO technical coordinators, who filled out the surveys during meetings.

The surveys were completed by individual self-report, individual interviews and focus groups. Table 2 indicates the persons surveyed, the number surveyed, and the method of survey completion, for each of the survey instruments. Examples of the survey instruments and consolidated results are in Annexes D-2 and G-1.

Table 2. Persons Surveyed and Completion of Survey Instruments PROSAMI MTE, El Salvador, 1994			
INSTRUMENTS	SUBJECTS	NUMBER SURVEYED	METHOD OF COMPLETION
1	NGO Directors	25	Individual self-completion
2	Technical Coordinators	25	Individual self-completion
3	Technical Supervisors	34	Individual self-completion
4A	Promoters	129 persons in 15 groups, ranging in size from 3 to 17 (mean=9.4)	Focus groups
4B	Promoters	129	Individual self-completion
4C	Promoters	Same as for 4A, above	Focus groups
5	TBAs	21 TBAs in 3 groups (mean=7 per group) and 11 individual interviews	Focus groups or individual interview
6	Community Health Committees	172 members in 18 groups (mean=9.5 per group)	Focus groups
7	Members of the client population	58	Individual interview

NGOs were selected for site visits on the basis of five criteria:

1. Funding Rounds: The sites were distributed among the NGOs funded in each of the three PROSAMI Funding Rounds, with a predominance in the first two rounds.
   6 (40%) of the sites visited were from the first round.
   7 (47%) of the sites visited were from the second round.
   2 (13%) of the sites visited were from the third round.

2. NRP area: There were representative sites from the area of National Reconstruction Program (NRP). Of the 15 sites visited , 11 (73%) were in the NRP area.

3. Technical ratings: Sites were selected on the basis of their annual average of monthly (process) and quarterly (coverage) technical ratings, which are prepared by the PROSAMI technical staff based on NGO monthly and quarterly reports. The ratings include measures of process implementation and coverage achieved. Ratings range from A to D, which are quantified as 4.0 to 1.0. Of the 35 NGOs in the PROSAMI network, 4 (11%) have combined monthly and quarterly technical ratings of 3.5 to

4.0, 25 (71%) have combined ratings between 2.5 to 3.0, and 6 (17%) have ratings of 2.0. In the selected sample of 15 NGOs, the corresponding distribution was 2 (13%), 11 (73%), and 2 (13%).

4. Recommendations of the PROSAMI technical staff, who commented on special characteristics or qualities of NGO project implementation.

5. Relative accessibility in terms of distance, road conditions, and weather.

The NGOs selected through these criteria are listed in Table 3.

Table 3.
Selected NGOs and some Characteristics
PROSAMI MTE, El Salvador, 1994

No.	NGO	FUNDING CYCLE	COMBINED TECHNICAL RATINGS	NRP AREA	VISITING EVALUATION TEAM
1	ADHU	First	3.0	No	PROSAMI Team
2	ASALDI	First	3.5	No	Dr. Boddy
3	ASAPROSAR	First	3.0	No	Dr. Boddy
4	FUNDEMUN	First	2.0	Yes	Dr. Boddy
5	OEF	First	3.0	Yes	PROSAMI Team
6	PROCADES	First	2.5	Yes	Dr. Boddy
7	ASADEH	Second	3.0	Yes	PROSAMI Team
8	ASPS	Second	2.0	Yes	PROSAMI Team
9	CIRES	Second	3.0	Yes	PROSAMI Team
10	CONAMUS	Second	2.5	Yes	Dr. Boddy
11	FUMA	Second	3.0	Yes	PROSAMI Team
12	FUNDESO	Second	4.0	No	Dr. Boddy
13	KNAPP	Second	3.0	Yes	PROSAMI Team
14	FUNDEPRENS	Third	3.0	Yes	Dr. Boddy
15	IDEA	Third	2.5	Yes	PROSAMI Team

HEALTH FINANCE EVALUATION METHODOLOGY

A. COST EFFECTIVENESS ANALYSIS

Total cost of PROSAMI project, and comparison with cost of other services (MOH and one non-USAID NGO).

METHODOLOGY

Several discussions were held with personnel of PROSAMI, USAID, as well as a review of the available data (see annex for list of names and activities). Following this initial activity, information was collected from on-site visits to NGOs, as well as from questionnaires sent to the central level and NGO level.

1. Site visits -

Step 1: In order to collect on-site information for overall financial management, financial sustainability, and conduct a comparative cost analysis, eight NGOs were selected for site visits. They were selected by first applying the following criteria:

a. Six-month average of the classification of the financial monitor report conducted by the central level office. Each NGO is classified in accordance to how well and timely the produce financial reports from A to D. A, is the highest rating, and was assigned a value 4, and the others respectively assigned to D with a value of 1.

b. The percentage of counterpart funding for 1993 was used with ratings as follows:

I)	A=4	Counterpart funding 90% or more
ii)	B=3	Counterpart funding 75% to 89%
iii)	C=2	Counterpart funding 50% to 74%
iv)	D=1	Counterpart funding less than 50%

c. 1993 Audit reports using A=4 to D=1.

Using the above three criteria, a weighted average of the three was determined for each of the 35 NGOs, and then the NGOs were sorted from highest to lowest. Category "a", monthly financial reports, was assigned a weight of 2, and the other two categories of counterpart funding and audit reports were assigned a weight of one. The monthly financial reports are tabulated by the PROSAMI financial department and consider seven factors such as correctness of vouchers, timeliness of accounts, etc. The classification assigned to these reports was averaged over a six month period. Given the number of factors considered in these financial reports as well as the time period, the weighted factor of 2 was applied. Table 4, "Classification of NGOs for the Financial Evaluation," on the following page illustrates the rank order of the NGOs.

Table 4. Classification of NGOs for the Financial Evaluation							
NGO	R	WORK AREA/"DEPARTAMENTO"	%	MON	CON	AUD	AVE
OPRODE	1	LA LIBERTAD - CUSCATLAN	34.1	8	4	2	14
AGAPE	1	AHUACHAPAN -SONSONATE	NO	8	4	2	14
FUNDESO	2	AHUACHAPAN - SONSONATE	NO	8	4	2	14
ASADEH	2	SAN MIGUEL - LA UNIÓN	NO	6	4	3	13
CIRES	2	SAN MIGUEL	100	6	4	3	13
FASTRAS	3	USULUTAN . SAN MIGUEL	100	6	4	2	12
FUNDEPRENS	3	SAN MIGUEL	100	6	4	2	12
ASALDI	1	LA LIBERTAD - SAN SALVADOR	86.5	6	4	2	12
DIÓCESIS	1	LA PAZ	41.7	6	3	2	11
PADECOMSM	3	MORAZAN	100	6	3	2	11
AMCS	2	AHUACHAPAN	NO	4	4	2	10
ADHU	1	SONSONATE	NO	4	4	2	10
OEF	1	CHALATENANGO - CABAÑAS)	59.2	4	4	2	10
ASIPES	3	CUSCATLAN	23	4	4	2	10
ORMUSA	3	SONSONATE	100	6	2	2	10
PROGRESO	3	CUSCATLAN - CABAÑAS	100	4	4	2	10
CODECA	3	SAN MIGUEL - MORAZAN	100	4	4	2	10
CODELUM	3	MORAZAN - LA UNIÓN	100	6	1	2	9
COMUS	3	USULUIAN	67	4	2	3	9
FUNDEMUN	1	USULUIAN - SAN MIGUEL	24.4	4	4	1	9
PROCADES	1	LA LIBERTAD -SAN SALVADOR - SAN MIGUEL	56.3	2	4	2	8
FUMA	2	LA LIBERTAD - SAN MIGUEL	NO	2	4	2	8
ASAPROSAR	1	SANTA ANA	25.4	2	4	2	8
CODECOSTA	3	USULUIAN	100	2	4	2	8
ASPS	2	USULUIAN	100	2	4	2	8
FUNDAC	2	CUSCATLAN	80.9	2	4	2	8
IDEA	3	MORAZAN	100	4	1	2	7
ASEI	3	SAN VICENTE	100	2	3	2	7
ADEMUSA	3	SAN SALVADOR	92.2	2	1	4	7
KNAPP	2	SANTA ANA - CHALATENANGO	59.1	2	4	1	7
CAIMA	3	SAN SALVADOR	NO	2	3	2	7
CODECUS	3	USULUIAN	91	2	3	2	7
CONAMUS	2	CHALATENANGO - SAN SALVADOR	84.1	2	2	2	6
COSDECSAM	3	USULUIAN - SAN MIGUEL	100	2	1	2	5
AMS	3	MORAZAN	100	2	1	2	5
Key	R = Round. MON = Monthly financial monitoring reports, 6 months average. CON = Counterpart funding. AUD = Audit reports of 1993. AVE = weight average.						

Once the NGOs were rank ordered by these three categories, a sample of the NGOs with the highest total points (14), the lowest total points (5-6), and those in the middle range (8-9) were selected (ASALDI was also included since all of the team made this visit before this sort was taken in order to get an initial picture of the NGOs). The second level sort provided an array from strongest to weakest using the three criteria.

The third level sort then consisted of applying the following criteria:

a. At least 4 of the NGOs visited would be at the highest level, and two would be at the lowest level, with the remaining in between.
b. A maximum of NGOs from "Round 3" (those NGOs recently admitted into the PROSAMI program) would be included, since they were too new to draw many conclusions about their financial operations and sustainability. .
c. At least 2 NGOs would work in the National Reconstruction Program areas.
d. There would be a wide geographic distribution among the NGOs selected.
e. The first two NGOs visited would be within a close-proximity to PROSAMI in order to pilot-test the survey instrument as well as learn about the operations of the NGOs at the community and regional level.

The NGOs that fulfilled the above criteria and remained after the three sorting process were:

1. OPRODE
2. AGAPE
3. FUNDESO
4. ASALDI
5. FUNDEMUN
6. PROCADES
7. CONAMUS
8. COSDECSAM

Taking the amount of time allowed to conduct visits, if was decided that it would be possible to make 8 site visits.

Step 2: A questionnaire was then designed to collect the data during the site visits. As agreed at the initial USAID meeting, the survey instrument for financial analysis included some of the questions used in a prior NGO assessment tool developed by PATHFINDER and MSH . This instrument not only included the majority of indicators in the CDIE study, but also considered several other financial issues. It was tested at the first two site visits, slightly modified, and then applied at the subsequent 6 site visits. See Appendix in Section II.5 for an example of one of the questionnaires and answers.

2. Information collection -

PROSAMI Information:

Step 1: A meeting was held with the central level technical supervisors, and a consensus was arrived as to what basic information should be collected from all of the NGO to observe trends in target population, number of communities served, administrative and technical staff (including health care promoters), number of promoter attentions (visits) provided for acute respiratory infections (IRA), diarrheal illness (EDA), prenatal visits (SR), post-natal visits (RN), and child growth and development (CYD). In addition, the number of educational sessions provided was also counted.

This information also provided preliminary unit cost per visit information, which served to illustrate unit cost range among the NGOs and to identify areas in financial efficiency needing further exploration. The ranges among the NGOs of per capita cost per population served, administrative cost per population served, and NGO cost per promoter were also derived from this information. Lastly annual trends in the per capita costs were observed over time. Administrative costs were divided into three categories: (1) Those costs that were incurred at the "home office". In the case of PROSAMI, this is MSCI operations in Virginia, USA. In the case of the MOH, it is the administrative overhead costs of central departments such as Finance, Maintenance, etc. (2) Costs incurred at the "local or field office" which is the PROSAMI operations at the central level that manages the project. And, (3) those costs incurred at the NGO level called "program administrative costs" (non-personnel administrative costs such as insurance, transportation, office supplies etc.) as well as "administrative staff".

Step 2: A meeting was held with the central level financial advisors and director and a consensus was arrived as to what basic revenue and expense information should be collected from the 35 NGOs. A form was developed along with a set of instructions. This form was used for the 8 NGOs visited on site, and then sent to the remaining 27 NGOs to fill out. It should be noted that although a large part of this information was available in some form or another at the central level, the intent was not only to collect this information but to compile it in a usable manner for the objectives of this evaluation as well as *test* the NGOs to see if they were able to collect the information requested in a timely and accurate fashion. The information collected from this sample was focused on (1) calculating the total costs which included counterpart donations either in kind or in the form of direct payments; and (2) measuring the overall size of the NGO operation in financial terms as well as the array of different projects undertaken. In other words, some NGOs rely 100% on PROSAMI project funds, whereas others manage several other projects and therefore have a larger and probably more stable infrastructure than those only operating with a single funding source that will end in two years.

Step 3: A meeting was held with the Director, Deputy Director of PROSAMI, and Vice President of MSCI to collect information concerning the budgets and expenditures at both the field office and home office in order to complete the information necessary to compute the total PROSAMI costs of delivering services at the central, "regional NGO", and community levels. The "regional NGO" is defined as the NGO structure and budget that will operate after the PROSAMI project, and therefore does not include either PROSAMI field office or home office costs.

Step 4: The Director of PROSAMI was asked to invite five NGO directors and their accountants in addition to the original sample of 8 in order to have a discussion with the USAID finance evaluator to discuss other ways to be financially sustainable besides generating client fees. The NGOs were chosen by the PROSAMI Director on the basis of unique accomplishments that they have performed that might be replicable for other NGOs in either PROSAMI or elsewhere. This meeting also assisted in assessing potential options for financial sustainability.

Step 5: Meetings at the Ministry of Health and FUSAL were conducted.

A visit with the Minister of Health, the Director of Finance, and the Director, Administrator, and Head of Training for the Community Health Department was held. Information concerning

finance and productivity was collected to compare with PROSAMI.

A meeting was held with the Executive Director and Finance Director of FUSAL, which was chosen by USAID as an alternative health promoter program to compare with PROSAMI.

2. COST ANALYSIS FOR PROSAMI NETWORK AND COMPARATIVE ANALYSIS WITH OTHER SERVICES

METHODOLOGY

As mentioned, meetings were held with USAID health staff, PROSAMI administrative and finance staff, USAID economist, the Minister of Health, the Ministry of Health Department of Community Health, and a non-USAID organization, FUSAL. It was decided with USAID that comparing PROSAMI with the Social Security Insurance (ISSS) health care program would not be appropriate in this case since they did not have a specific health care program. FUSAL was requested by USAID to be used as the non-USAID group most likely to have comparative aspects for use with this evaluation, although it should be mentioned that it was not directly comparable due to significant program differences.

PROSAMI was then asked to provide a summary for total costs incurred (not budgeted) by year, since the inception of the project in 1990. This was done in conjunction with both the field office and the MSCI home office. This information was also corroborated by data collected directly from the 8 NGOs visited, by information collected from all 35 NGOs from a questionnaire, and by information provided by the PROSAMI field office finance department. Throughout this process, the methodology and preliminary results were discussed with the PROSAMI Chief of Party.

The Department of Community Health then provided financial information as well as patient statistics for this evaluation. MOH rates such as salaries as well as the estimate for MOH administrative overhead were provided from the MOH Director of Finance. Lastly, these figures provided by the MOH were corroborated by APSISA, the USAID organization providing technical assistance to the MOH.

FUSAL data was provided from the Executive Director as well as the Director of Finance. Additional data was provided through discussions with the FUSAL Medical Director.

The total cost of each health care promoter program was first calculated. The cost is important since it reflects the cost of a promoter to provide all services including curative, preventive, educational, and community work. In the case of the Ministry of Health, the 1994 budget was the most useful to calculate Community Health costs, but administrative overhead was calculated as a percent of the administrative and renovation 1993 costs since this was what was provided by the MOH for total costs. The overhead percentage was 23% for 1993, and assumed to have not changed significantly for 1994, but it should be mentioned that this is probably on the high side since it includes administration for the hospitals which is always require more resources. However, this probably balances out since central level department support such as Epidemiology, Health Education, etc. were not added into the cost since information was not

provided or available at this detail. Only 25% of the renovation costs were included as attributable to the primary care programs.

In the case of PROSAMI, the 1993 budget as well as 1993 patient care statistics were used. It was agreed that using 1994 budgets and/or patient statistics would skew the data in a negative fashion since 17 of the 35 NGOs were still in training and had not yet begun field level implementation. 90% of the central warehouse supplies and 70% of the audit costs were applied to the NGOs. Although all medicines provided by PROSAMI are donated, the value of these medicines was determined based on: (1) the actual cost of these medications; and, (2) the market value of these same medications if they were to be purchased directly in El Salvador. Using the MSH report by David Lee and James Bates, the market value was estimated at 20% the USA cost. In addition, counterpart donations such as additional volunteer and paid staff and office space were not included. It is estimated that including counterpart funds could increase the PROSAMI costs by up to 19%, and this percentage contribution could be included into the total cost calculation at a later time. However, it is clear that the larger the NGO, the greater the ability it had to "contribute" other resources to the program. It is therefore highly probable that either these counterpart contributions or existing PROSAMI funded costs at the NGO level would continue at their current rates.

In the case of FUSAL, the comparison was not as direct as between PROSAMI and the MOH since their program includes health care promoters, but they are not the only health care providers. With PROSAMI and the MOH Community Health Department, the programs are set up with the promoters as the principal health care providers. Although the physicians and supervisors provide some direct patient care, their job responsibilities are mainly for the purpose of providing training and supervision to the promoters. FUSAL uses almost all of their staff for provision of services directly to the community. A much smaller percentage of their time is spent on training and supervision of the promoters, and the promoters themselves are volunteers who work for FUSAL an average of 15 hours a week. For this reason, in the case of FUSAL, the cost per provider versus promoter was considered.

In all of the above cases, the cost per target population was also analyzed, and in the case of the MOH and PROSAMI, a look at the cost per certain activities was also reviewed.

It should also be mentioned that this analysis addresses quantitative inputs as well as cost efficiencies, but does not make qualitative judgements on the care delivered. The quality of care issues are addressed in the service delivery section of this paper.

3. COST EFFICIENCY AND EFFECTIVENESS ANALYSIS OF THE 35 NGOs COMPARED TO ONE ANOTHER

METHODOLOGY

Following discussions with USAID and PROSAMI, it was clear that there was a high level of interest in how the 35 NGOs receiving money from the PROSAMI project were performing in comparison to one another. For this reason, two questionnaires were distributed as described in the original methodology section. The questionnaires solicited information from all 35 NGOs, the technical advisors, and the financial department of PROSAMI.

VI. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. EFFICIENCY

1. APPROPRIATENESS OF OBJECTIVES

El Salvador is a Central American country with 5,047,925 inhabitants, according to the 1992 census. Its population pyramid is typical of a developing country, with a predominance of children and people in the younger age groups. 39.2% of the population is under the age of 15 years.[1] There is a surplus of women, especially between the ages of 20-34 years (the fertile age group), of approximately 103,500. The maternal-child group (women between the ages of 15 and 44 years, and children under the age of 5 years) makes up 37.4% of the total population. Approximately 54% of the population lives in rural areas or communities with less than 2,000 inhabitants. The country is recovering from an armed conflict, that particularly affected northern and eastern regions. The country still has relatively high rates of child mortality, fertility, malnutrition, and intestinal parasitism.[2]

Deficiencies in child health care are particularly evident in the principal causes of mortality in children. These are listed in Table 5, for three age groups. According to FESAL-93, 57.3% of neonatal deaths were from perinatal causes. In postneonatal children (older than 28 days and under one year), 68.3% of deaths were a result of acute diarrheal diseases and dehydration (ADD), and acute respiratory infections including pneumonia (ARI), with the former constituting the first cause of death. In children between the ages of one and four years, 51.9% of the deaths resulted from ADD and ARI, and 13% were attributed to measles. In this age group, ARI are the first cause of death. Measles, an infectious diseases that can be prevented through inexpensive immunizations, is the third cause of death in children between one and four years of age.[3]

According to ANSAL-94, the Analysis of the Health Sector study completed this year, and the recently completed evaluation of the APSISA Project, maternal care is deficient in several areas, again accentuated in the rural areas. A large number of women who delivered in hospitals did not receive any prenatal care. While 80% of urban women delivered in hospitals, only 30% of rural women did so. In addition, 51% of births were attended in hospitals by trained personnel, 36.4% were attended by TBAs (who, if trained, generally received one training course, with no follow-up training nor supervision), and 12.6% were delivered by untrained personnel or the mother herself. Births attended by untrained personnel, and high-risk

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[1] ANSAL-94: La Reforma de Salud: Hacia su Equidad y Eficiencia, page 8.

[2] ANSAL-94. Perfil Epidemiológico, pages ix, x, 1, 3, 5.

[3] FESAL-93, page 127.

pregnancies are associated with increased maternal mortality. The principal causes of maternal mortality are hemorrhage, eclampsia and sepsis. Women under the age of 20 years have accounted for 30% of pregnancies.[4]

Table 5.
Causes of Child Mortality en El Salvador[5]

NEONATAL (0-28 days)		POSTNEONATAL (>28 days and <1 year)		CHILDREN 1-4 years	
CAUSES OF DEATH	%	CAUSES OF DEATH	%	CAUSES OF DEATH	%
Low birth weight & prematurity	34.2	Diarrheal diseases & dehydration	35.6	Acute respiratory infections & pneumonia	27.8
Birth trauma & asphyxia.	17.9	Acute respiratory infections & pneumonia	32.7	Diarrheal diseases & dehydration	24.1
Congenital abnormalities	14.5	Sepsis/multiple organ failure	10.6	Measles	13.0
Respiratory Distress Syndrome	10.3	Congenital abnormalities	7.7	Accidents	11.1
Sepsis/multiple organ failure	7.7	Malnutrition	3.8	Meningitis	3.7
Diarrheal diseases & dehydration	4.3	Meningitis	1.0	Sepsis/multiple organ failure	1.9
Other perinatal complications	4.3			Congenital abnormalities	1.9
Acute respiratory infections & pneumonia	1.7			Malnutrition	1.9
Neonatal tetanus	0.9				
Others	4.3	Others	8.6	Others	14.8
Total	100		100		100

Another maternal problem is short intervals between pregnancies, again especially accentuated in rural areas. As mentioned previously, there is a 25% surplus of women of fertile age (between the ages of 20-34), with more younger women entering the group than older women leaving. Also, the national fertility rate has declined from 4.6 in 1988, to 3.8 in 1993, though it continues to be higher in rural areas at 5.0.[6]

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[4] ANSAL-94. Situación Materno-Infantil, pages 6, 20.

[5] FESAL-93, page 127.

[6] ANSAL-94. Perfil Epidemiológico, page 3, & Situación Materno-Infantil, page 25.

HIV/AIDS is becoming a serious heterosexual problem, having changed from a male/female ratio of 15/1 in 1988, to 3.3/1 in 1993. The groups most affected are those of fertile age, which implies an increase in HIV infected babies.[7] One of the contributors to the dissemination of HIV is the return visits of infected Salvadoran men from the US, who come to El Salvador for temporary visits, and then return to the US. The surplus of women of fertile age provides fertile ground for high-risk sexual behavior. Most of these women believe that they are not at risk for HIV[8], STDs, or unwanted pregnancies. What is alarming is the number of cases of HIV/AIDS appearing in the rural areas. We saw one case of a young mother who had recently been diagnosed HIV seropositive, whose husband was considered to be actively promiscuous and reportedly showed symptoms of AIDS.

There are many factors which contribute to inadequate maternal and child health care, but primary contributors include lack of accessibility to primary care services, failure to recognize danger signs by parents, lack of basic water and sanitation services, relative ignorance about health and health care, and poverty. These are particularly accentuated in rural areas, where both curative and preventive services are usually not available or deficient in comparison with urban areas.

Accessibility to health care services is restricted geographically, economically and culturally. Most rural communities do not have health care facilities. The nearest facilities require one to various hours of travel on foot, or long waits for vehicles which pass their communities once or twice a day, if at all. In addition to distance, frequent rains make many roads impassable. Costs involved in paying for transportation, a medical consult at an MOH health unit, laboratory tests and prescribed medicines tend to be significantly expensive and daunting to many community people. Many community residents believe that going to MOH or private health facilities will be expensive, and are reluctant to do so. Cultural barriers to health care include a preference for traditional medicine by many community members, usually because they view it as more amenable and less expensive. Many dislike the discourteous and disrespectful treatment they report receiving at MOH and private health facilities. Most of these barriers can be surmounted by establishing health services in the communities.[9]

Efficiency refers to the provision of high-quality, effective health services for the most people at the lowest cost. Increasing efficiency reduces costs. NGOs tend to be more efficient than government providers. According to ANSAL-94, 68% of NGOs in El Salvador have a high level of efficiency[10]. NGO health service providers are willing to work in areas where the MOH has not been able to provide services. Taking into account the lack of resources of the MOH, which limits their ability to extend services, and the emphasis on decentralization currently underway within the MOH, it is unlikely that the MOH will provide additional community level maternal

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[7] ANSAL-94, Situación Materno-Intantil, page 20.

[8] FESAL-93, page 292.

[9] Kolodin, ANSAL: Demanda de Servicios de Salud, Enero, 1994.

[10] Prieto y Carrizosa, ANSAL: Sistemas de Servicios de Salud, Enero, 1994.

health and child survival (MHCS) services in the near or immediate future. Considering the better efficiency of NGOs and their willingness to work in adverse conditions, NGOs are seen as a good alternative to providing needed MHCS services in underserved communities.[11]

In response to the needs described above, PROSAMI has organized a network of indigenous Salvadoran NGOs which have been strengthened and trained to provide appropriate MHCS services, which respond to the principal health problems of mothers and children. The MHCS services provided include the following:

1. The control of acute diarrheal diseases and dehydration in children under the age of 5 years.
2. The control of acute respiratory infections/pneumonia in children under the age of 5 years.
3. Maternal and reproductive health, including prenatal, birth and puerperal care, and birth spacing and family planning counseling and care.
4. Expanded program of immunizations in children under the age of 5 years.
5. Neonatal and perinatal health.
6. Growth monitoring, development and nutrition in children under the age of 5 years.
7. Community organization and participation.

There are currently 35 NGOs participating in the PROSAMI MHCS/primary care service network, working in 433 "cantones" (community areas) throughout the country. Approximately 57% of the cantones are in areas affected by the recently terminated armed conflict. The NGOs serve an estimated total population of 439,882 persons, of which 74,780 are children under the age of 5 years, and 104,331 are women between the ages of 15 and 44 years.[12]

CONCLUSIONS AND RECOMMENDATIONS

1. The health problems of mothers and children are among the most critical health issues in El Salvador. Many of these problems can be resolved by increasing access to appropriate and adequate health services, in particular low-technology primary care and preventive services, combined with opportune community based treatment and referrals of cases with signs of serious, life-threatening conditions. The objectives of the Maternal Health and Child Survival Project (PROSAMI) are designed to respond to the principal health problems affecting mothers and children in El Salvador. As stated in the Project Paper, the goal of PROSAMI is to improve the health of rural populations by providing access to community based maternal and child health services in those areas where such services have been weak or nonexistent. PROSAMI objectives are a most appropriate response to the maternal and child survival problems, and primary health care needs in underserved populations in El Salvador.

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[11] ANSAL: La Reforma de Salud: Hacia Su Equidad y Eficiencia. Mayo, 1994.

[12] Information from "1POP51994, DATA FOR THE YEAR 1994: TOTAL." Department of Health, Population and Nutrition, USAID/El Salvador.

The PROSAMI design provides the solutions recommended[13] for the principal problems of children under the age of 5 years and women of childbearing age. These include the following:

- A focus providing basic preventive, educational and case management services.
- Easy access to health services, especially in rural areas.
- An integral health system with provision for effective referral of high risk cases.
- Increase of potable water and comprehensive protection of the environment.

Recommendation: Continue to provide the services as designed.

2. PROSAMI fulfills recommendations of ANSAL-94, and offers practical solutions to some of the major health problems in El Salvador[14].

Recommendation: Present the project design and results to the MOH as a demonstration of what can be done to rectify the current deficient health situation in El Salvador.

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[13] ANSAL: La Reforma de Salud: Hacia Su Equidad y Eficiencia, page 21.

[14] ANSAL: La Reforma de Salud: Hacia Su Equidad y Eficiencia, pages xvi, xv, 21, 48-50, 81, 83, 89, 120 and 137.

VI. B. EFFICIENCY

2. VIABILITY OF NGO SERVICE DELIVERY SYSTEM

Viability refers to feasibility and vitality, particularly in the sense of being "practically workable". The viability of the PROSAMI service delivery system depends on the capabilities of community promoters and NGOs. There are four levels of functioning of the health service system: PROSAMI → NGOs → community promoter → referral center. Thus, for the system to be viable, it must be transferrable to NGOs and community promoters. The latter are usually persons with relatively little educational background, but must be able to implement the system. And finally, after passing through the NGOs and the promoter, the services must reach the target/client population in such a way as to measurably improve maternal and child health.

In the PROSAMI network, indigenous Salvadoran NGOs have been strengthened and trained to provide appropriate maternal health and child survival services (MHCS) at the community level. The health services focus on specific preventive measures and case management. In reality, all of the measures are basically preventive in nature. The health services include promotional/educational and protective activities, early detection and diagnosis, case management and basic immediate treatment, and referrals to limit the damage from pathological processes. These actions constitute primary and secondary prevention.[15]

The NGOs provide the same basic services, beginning with essentially the same training, following the same standards and protocols, and using the same system of health care delivery. Achieving this uniformity of services with a group of disparate NGOs is in itself a significant achievement. This permits comparing the achievements by the PROSAMI NGO network with other systems, such as the MOH, as well as demonstrating the efficacy of the delivery system in different environments.

The NGO network has grown in three stages, beginning with 9 NGOs in 1991, followed by an additional 10 in 1992, and finally 16 that began last year. The great majority have successfully initiated and are maintaining implementation of the system. A few NGOs are experiencing some difficulties, but, in general, are working hard to surmount them. This shows that indigenous NGOs can join together and effectively adopt and implement a standardized health care delivery system.

The specific MHCS services are provided by community promoters recruited, trained and supervised by NGOs. NGO technical coordinators and supervisors are trained and supervised by PROSAMI. PROSAMI technical advisors provide technical assistance and backstopping to the NGO. PROSAMI also provides the NGOs funding for operating expenses, personnel, and

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[15] Leavell, HR, & Clark, EG: Preventive Medicine for the Doctor in His Community: An Epidemiologic Approach. Third Edition. McGraw-Hill Book Co. New York, 1958. Pages 19-27.

necessary materials and supplies, including medicines and diagnostic equipment required by the promoters. Primary care procedures and protocols have also been established and defined by the PROSAMI technical staff, and all of the NGO subprojects are implementing the same MHCS services and protocols. The PROSAMI norms and protocols either conform to or include the corresponding MOH norms and protocols. In some cases, the PROSAMI norms and protocols are more extensive than the MOH counterparts.

The specific MHCS services provided by PROSAMI and associated NGOs are organized into seven technical components:

1. The control of acute diarrheal diseases and dehydration (ADD).
2. The control of acute respiratory infections/pneumonia (ARI).
3. Maternal and reproductive health, including prenatal care, clean births, puerperal care, and family planning and birth spacing (MRH).
4. Expanded program of immunizations (EPI).
5. Neonatal and perinatal health (NPH).
6. Growth monitoring, development and nutrition (GMD).
7. Community organization and participation (COP).

The way in which health services are offered will of course affect the success of the system. The MOH establishes health units which essentially wait for beneficiaries to come to them. This means that the beneficiary population must first recognize the need for health care, and then go to the nearest health unit for the required services. The MOH trains community health promoters to encourage their target population to go to the health units. The MOH health promoters are primarily educators. They educate the communities as to their health needs and what constitutes good health behavior, and refer persons with danger signs to MOH health units. They generally do not provide curative services or therapy, with the exception of the distribution of ORS (oral rehydration salts) and mebendazole for parasitism (intestinal worms-nematodes and cestodes).

The NGO promoters do the same thing that the MOH promoters do, and more. Thus, the PROSAMI-NGO promoters educate their target populations and promote the adoption of health behaviors which favor better health, and they refer persons with danger signs to MOH health units or to private physicians. In addition, they provide active case detection and active case management. The case management includes basic preventive measures, such as prenatal care, postnatal care of women and newborns, family planning, growth monitoring, nutrition counseling, etc. It also includes simplified management of conditions that are potentially life threatening, such as administering ORS to prevent dehydration in cases of acute diarrheal diseases in children under the age of 5 years, and administering antibiotics to children with incipient pneumonia to prevent more severe complications or death due to severe pneumonia.

The NGO promoter strategy is to take the services to the beneficiary population. The NGO promoter identifies all potential beneficiaries of her/his services in the community, rates them in terms of risk, and prioritizes their need for services. Then the promoter goes to their homes to provide the services they need.

The PROSAMI NGO health delivery system is based on the community promoters, who, as described above, attend patients in their homes or in community dispensaries. They are

complemented by supervisors, who as part of their supervision examine patients with problems which are difficult to resolve for the promotor, review diagnoses and treatment plans, answer questions, clarify doubtful cases, and reinforce and continue training in the technical areas.

CONCLUSIONS AND RECOMMENDATIONS

1. The PROSAMI-NGO system is an excellent model for the delivery of community based primary health care using community personnel with very little formal training as the principal service providers, who identify and refer cases which require the attention of highly trained (and expensive) health professionals. The promoters serve to identify cases which otherwise would not seek care from physicians or nurses necessary to prevent death or debilitating (individually, economically and socially) morbidity.

   Recommendation: Maintain the PROSAMI-NGO service model and expand it to other communities.

2. The health promoters serve as a filter for higher level (and more costly) health services, reducing the number of persons with mild or incipient cases who can be easily treated with low technology in the community, thus reducing the load of unnecessary cases which need to be seen by high cost personnel such as physicians and nurses. They also act early to interrupt disease processes to prevent potentially worse and more costly (in human and economic terms) conditions. Thus the NGO promoters help to conserve financial and human resources for the health system in El Salvador. They contribute to making the health system in general and the use of MOH resources in particular, more efficient. Perhaps most important, they are saving lives and improving health in previously underserved rural areas.

   Recommendation: Encourage the MOH to adopt the PROSAMI-NGO model of community health promoter functions and primary health care delivery, and to establish an effective training-supervisory system implemented by health professionals (e.g., physicians, nurses, maternal-child health technicians) with experience in community health.

VI. B. EFFICIENCY

3. INPUTS/OUTPUTS

PROSAMI had three major outputs (see Table 6), which have been successfully fulfilled or are on the way to being completed. The first was to extend and expand maternal health and child survival (MHCS) services in high risk communities. This was accomplished by improving or establishing new MHCS services in 433 communities, surpassing the goal of 350. The MHCS services were provided by community health promoters supported by health committees. Associated with the MHCS services, 25 new water systems were to be established.

Table 6.
PROSAMI Output Goals and Achievements
El Salvador, March 31, 1994.[16]

OUTPUT DESCRIPTION	INDICATORS	GOALS	ACHIEVE-MENTS	DEGREE ACCOM-PLISHED
1. Maternal health and child survival (MHCS) services extended and expanded in high risk communities.	Communities receiving new or improved MHCS services	350	433	124%
	Health promoters providing services	410	537	131%
	Community committees formed and functioning	350	739	211%
	New water systems established and maintained by communities	25	14	56%
2. A network of NGOs strengthened and trained to provide MHCS services.	Number of NGOs with improved or expanded MHCS services	35	35	100%
	New clinics established or abandoned MOH facilities reopened with NGO/community/MOH collaboration	10	172	1720%
	Personnel trained where necessary	480	662	138%
3. Enhanced inter-agency coordination and information dissemination.	Functioning project advisory committee	14	6	43%
	NGO coordinating body activities	NA	11	Fulfilled
	OIC/MOH activities	NA	2933	Fulfilled
	Newsletter disseminated	24	13	54%
	National conferences/seminars	10	9	90%

[16] PROSAMI Project Paper, Annex A, and Project Status Reports.

The second major output goal was to organize and strengthen a network of NGO's to provide the MHCS services. 35 NGOs added to, improved or expanded their capacity to deliver MHCS services. The NGOs, communities and the MOH have collaborated in establishing, opening or reopening 172 new dispensaries, clinics or abandoned MOH facilities. The personnel required to provide the MHCS services were trained.

The third major output was to enhance inter-agency coordination and information dissemination. The accomplishment of this goal was achieved by instituting a functioning project advisory committee, and establishing a NGO coordinating body. An intersectoral coordinating committee including the MOH was strengthened. Information dissemination was accomplished by producing and distributing a newsletter and conducting national conferences and seminars.

The inputs provided to the NGOs by PROSAMI to accomplish the output goals included:

- training,
- technical assistance,
- supplies, and
- financing.

A survey questionnaire (see Annexes D-2 and G-1, Cuestionario 1) was completed by the executive directors of 25 of the 35 NGOs. In their opinion, the principal inputs their NGOs received from PROSAMI are indicated in Table 7. It is interesting to note that they rate technical assistance and training as important as funding. They also considered Institutional strengthening and administrative assistance as significant as receiving equipment and supplies.

Table 7.
PROSAMI Support of NGOs: Inputs Recognized by NGO Executive Directors
El Salvador, 1994

No.	INPUTS/SUPPORT RECEIVED	Number of Responses
1	Technical assistance, technical supervision, and standardization of technical criteria	16
2	Training (systematic and continuous training of personnel)	15
3	Funding and financial resources	15
4	Institutional strengthening, development and support; and, approval of legal incorporation	8
5	Administrative assistance	7
6	Equipment, supplies and medicines	6
7	Integrally, financially, technically, and in agreement with the established plan	2
8	A space where NGOs could learn about each other and coordinate activities	1
9	Implementation of the project allowed the NGO to extend the area of its influence	1
10	Fulfillment of the established agreement	1

Several executive directors indicated that they felt the institutional strengthening and development given to the NGOs, particularly in regards to organizing and implementing a technically appropriate health service project, was of great value. While many felt initially that PROSAMI was excessively demanding in regards to the implementation of the technical components, financial management and commodities control, they now feel that such experience has enhanced their institutional capacity to deliver health and other development services.

When asked to rate the degree of support their NGO received from PROSAMI on a scale of 1 to 10 (see Table 8), the average rating was 8.8. This high rating indicates that the executive directors felt that the inputs from PROSAMI had corresponded very well with the outputs their NGOs were expected to produce.

Table 8.
Degree of Support NGOs Received from PROSAMI
El Salvador, October, 1994

RATING SCALE: (Useless) 1 2 3 4 5 6 7 8 9 10 (Excellent/Ideal)

RATERS	NUMBER	AVERAGE RATING	LOWEST RATING	HIGHEST RATING
NGO Executive Directors	25	8.8	6	10

PROSAMI has organized a total of 71 training events between 1991 and the present, including workshops, conferences, lectures, seminars and short courses for the technical and administrative personnel concerned with the project (see list of training events in Annex G-2). The total cumulative sum of the attendance of all the training events was 4,426 persons (see Annex G-2). The events included training for technical coordinators and supervisors, basic courses for promoters and TBAs, education for finance and commodity administration, and sessions for executive directors.

The purpose of the training was to facilitate the completion of project goals and objectives by project staff. The degree to which the training events contributed to the successful completion of the NGOs' work is best expressed by the personnel who participated in the events and who subsequently did the work. NGO Executive Directors, technical coordinators, technical supervisors, community health promoters, TBAs, and members of community health committees, answered this question on separate questionnaires by rating the degree to which the PROSAMI training events contributed to fulfilling the work of their NGO on a scale of 1 (useless) to 10 (excellent/ideal). See Table 9. The average rating of the effectiveness of the PROSAMI training activities for the accomplishment of the work of these six groups was 8.50. These high ratings indicate that, based on the experience of the project personnel in doing the required work, the training was a valuable contribution to "getting the work done".

Table 9. Degree to which PROSAMI Training Activities Facilitated NGO Efforts El Salvador, October, 1994				
RATING SCALE: (Useless) 1 2 3 4 5 6 7 8 9 10 (Excellent/Ideal)				
RATERS	NUMBER	AVERAGE RATING	LOWEST RATING	HIGHEST RATING
NGO Executive Directors	25	8.40	4	10
NGO Technical Coordinators	26	7.08	4	10
NGO Technical Supervisors	34	8.44	6	10
Community Health Promoters	129	9.00	5	10
TBAs	32	9.50	5	10
Community Health Committees	141	9.28	5	10
TOTAL	387	8.93	4	10

Technical assistance (TA) was provided to the NGOs primarily by the PROSAMI technical advisory personnel , and the finance and commodities administrative staff. TA is offered through three modalities. The first is through group coordinating meetings, where needs are identified through consultation and consensus. For example, general meetings with the NGOs are held monthly at PROSAMI with the NGO executive directors and NGO technical coordinators. At these meetings, deficiencies, incapacities and problems facing the NGOs are identified and discussed. Seminars, conferences or workshops for the network, and individualized TA, where indicated, are organized to respond to these needs.

The second is regular supervision and monitoring, which identifies deficiencies or problems in the implementation of the MHCS components, and the financial and commodities management. The technical, financial and commodities advisory staff identifies the specific needs (deficiencies, incapacities and problems) of each NGO, and provides the TA necessary to satisfy them. A member of the technical advisory staff visits each NGO at least once a month to observe MHCS service activities, and schedules repeat visits in accord with the observed needs of the NGOs.

The technical staff meets with the NGO technical coordinators and supervisors, and observes supervisors and promoters while they work. Problems or deficiencies are noted and addressed immediately. Through the review of monthly and quarterly reports, needs can be identified and TA is provided through the supervisory visits. The supervisory and monitoring methodologies are briefly described in the next section.

Third, the NGOs request specific TA, and, if feasible, the technical staff responds with what they need.

The PROSAMI training and technical coordinating staff has also organized five national conferences, for all Salvadoran NGOs. The conferences dealt with the following themes:

1. The Importance of Intersectoral Coordination, 2. Cholera, 3. Follow-up Conference on Cholera, 4. Maternal and Perinatal Health, and, 5. Acute Respiratory Infections.

A newsletter entitled, "Maternal Health and Child Survival," is published quarterly and sent to over 200 organizations in El Salvador and internationally, including the 35 NGOs in the PROSAMI network, other NGOs which work in the area of MHCS, the MOH, international agencies such as PAHO and UNICEF, and other. Thirteen newsletters have been produced so far. Each newsletter has 8 to 10 pages, and is dedicated to a specific theme corresponding to one of the MHCS technical components. The newsletter contains articles relating to the theme, news about the PROSAMI NGOs, information concerning MHCS services in general, etc. See Table 10, for a list of bulletin themes.

Table 10.
Themes of PROSAMI Newsletter: "Maternal Health and Child Survival"
El Salvador, 1991-1994

YEAR	NUMBER	THEME
1991	1	Uniting Efforts and Improving Communication
	2	Acute Respiratory Infections
1992	1	Maternal and Perinatal Mortality
	2	Acute Diarrheal Diseases
	3	Acute Respiratory Infections
	4	Maternal Health
1993	1	The Importance of Management
	2	Acute Diarrheal Diseases
	3	Acute Respiratory Infections
	4	Reproductive Health
1994	1	Newborns
	2	Immunizations
	3	Growth and Development

PROSAMI provides all of the supplies required by the NGOs to provide the MHCS services in the communities. Eleven categories of supplies are provided. A list of the items included in each category is in Annex G-3. The categories of supplies are the following: 1. Office supplies, 2. office equipment, 3. training supplies and materials, 4. training equipment, 5. medical supplies, 6. medical equipment, 7. medicines, 8. water and sanitation equipment, 9. construction materials, 10. motorcycles and helmets, and 11. others, such as mules, horses, bicycles, etc.

Each NGO requests the supplies it needs in relation to its budget and project activity requirements. The quality of the supplies is appropriate and adequate to fulfill the project goals

and objectives. The NGOs are receiving the supplies they need to initiate and maintain the MHCS service network in the 433 cantones they are serving throughout El Salvador.

In general, all supplies are remitted to the NGOs in a timely fashion. One notable exception which has presented this year is in regard to the provision of some medicines. All medicines are purchased annually in bulk in the US by USAID/El Salvador to supply all medical/health projects currently being implemented in the country (e.g., PROSAMI, APSIS, and SDA). This year there has not been any mebendazole, the medicine used to treat parasitic nematode and helminth infections in children, which is part of the ADD control program. There also have not been any vitamins for pregnant women, given as part of prenatal care, nor vitamin A, given to children as part of GMD, and an important adjunct to the control of ARI/pneumonia and other infectious diseases.

Most of the inputs have been mentioned directly or by implication. Nevertheless, there are some intangibles that have not been specifically stated. The executive directors of the NGOs indicated some of these when they described what they liked about PROSAMI on the questionnaire they completed (see Table 11). These included focussing on the area of maternal and child health, providing a climate of help, the health service methodology, developing a multidisciplinary team, standardizing health service protocols and norms, constantly monitoring the implementation of the methodology and the completion of work plans, the integrity of PROSAMI, and the information system and organization. The intangibles reinforced institutional development and served as models for organizational functioning.

CONCLUSIONS AND RECOMMENDATIONS

1. The inputs PROSAMI has provided to the NGOs to achieve the three major outputs have been instrumental in fulfilling most of the output goals by the time of the midterm evaluation. The training, technical assistance, institutional strengthening and administrative support, supplies and funding have facilitated and stimulated the initiation and continuation of the activities designed to produce the outputs. The needs for technical assistance, training and institutional strengthening will continue to be important for the continuation of project activities after PROSAMI terminates.

   Recommendation: The inputs provided by PROSAMI to the NGOs should continue.

   Recommendation: Alternative sources and mechanisms to provide these services need to be identified for the NGOs, at both individual and collective levels. A good option would be to develop the capacity to provide technical assistance and training through CONSALUD, the organization being formed by the NGOs to maintain the organization of the NGO network after PROSAMI terminates.

   Recommendation: PROSAMI and the NGO network should work with the MOH to develop its capacity to provide inputs similar to PROSAMI's for MOH promoters and community primary health care programs. This would assist the MOH in replicating the successes of the PROSAMI NGOs and in providing better primary health care services to rural and other communities in El Salvador.

Table 11. Benefits of PROSAMI Indicated by NGO Executive Directors El Salvador, 1994	
No.	BENEFITS
1	Financial and technical support
2	The project goal focusing on the area of maternal and child health.
3	The impact achieved.
4	The climate of help.
5	The methodology.
6	Permitting a NGO to develop their work with financial assistance.
7	Multidisciplinary team.
8	Standardization.
9	Constant monitoring.
10	Integrity.
11.00	Information system.
12	Organization.

2. Purchasing medicines and other supplies in the US for use in El Salvador has resulted in some shortages, and is detrimental to the process of self-sufficiency and private enterprise. This is particularly important for sustainability, as the NGOs will have to obtain their supplies themselves when PROSAMI terminates. Maintaining a medical supply system requires a number of abilities and skills. PROSAMI has helped many NGOs obtain the knowledge and skills necessary to evaluate needs, store and distribute medical supplies. It seems to leave a "hole" not to include procurement and purchasing as part of the process. Also, many medicines can be purchased in El Salvador less expensively and more reliably so as to avoid shortages.

   Recommendation: Medicines should be purchased locally and by the NGOs, either individually or collectively.

VI. A. EFFICIENCY

4. EFFICIENCY OF METHODS

The efficiency of the methodologies utilized in the training, supervising, monitoring and evaluation of the NGOs has particular significance for the maternal health and child survival (MHCS) service delivery system. This is the heart and soul of PROSAMI: the services that reach community inhabitants and improve their health. While there are other aspects of PROSAMI, such as NGO institutional organization and functioning, finances, logistics, etc., which are important, their importance depends on the degree to which they facilitate and support the MHCS services. Consequently, the following comments will focus on the methodologies concerned with MHCS service delivery.

The current PROSAMI MHCS service delivery system consists of four levels:

1. PROSAMI technical advisors.
2. NGO technical coordinators and supervisors.
3. Community promoters and TBAs.
4. Referral centers.

PROSAMI has a technical advisory staff and a training coordinator. The PROSAMI technical advisory staff is composed of eight health professionals: seven physicians and one nurse. Each was selected on the basis of experience in primary health care and work with NGOs, technical expertise, and skills commensurate with the PROSAMI methodologies. One physician is the technical coordinator who supervises the collective efforts of the department. Seven of the staff members coordinate each of the seven technical components, and are responsible for supervising and monitoring five NGOs each (see Annex G-5 for list). In addition to supervising, monitoring and evaluating the MHCS services of the NGOs, the technical staff is responsible for technical assistance and training provided to the NGOs in support of the MHCS services each should provide to its target population.

The PROSAMI training coordinator is a registered nurse and a specialist in higher education. The training unit organizes and coordinates technical training, programs and schedules training events, reviews training methodologies, produces materials, and monitors and evaluates training events. The NGO staff training is conducted by PROSAMI technical, financial and commodities control staff and consultants. NGO promoters and TBAs are trained by the NGO technical staff and the MOH.

Each NGO has a technical coordinator, technical supervisors, and community promoters (see Table 12) for distribution of health care personnel). In accord with PROSAMI methodology, for every five promoters there should be one supervisor. There are currently a total of 459 promoters (63.4% females) working for the 35 NGOs. There are a total of 98 technical supervisors distributed among the 35 NGOs. The technical coordinators, one per NGO, supervise and monitor the activities of the technical supervisors, ensure that the promoters and supervisors have the supplies and equipment necessary to provide the MHCS services, and

prepare reports on the progress of their subproject for the PROSAMI technical staff. The technical supervisors oversee and monitor the activities of the community promoters and TBAs and give them continuing education and guidance.

Table 12.
Number of Health Care Staff Members of the 35 NGOs of the PROSAMI Maternal Health and Child Survival Service Network
El Salvador, 1994

No.	PERSONNEL	RANGE		AVERAGE NUMBER	TOTAL
		MINIMUM	MAXIMUM		
1	Technical Coordinators	1	1	1.0	35
2	Technical Supervisors	2	7	2.8	98
3	Community Health Promoters	8	34	13.1	459
	TOTAL	11	42	16.9	592

TRAINING

Training and educational activities are designed and developed by the PROSAMI technical advisory staff and the training coordinator to respond to initial or basic training needs as well as to provide for continuing education. Training events provide education for the technical/medical components, administrative requirements, and institutional strengthening. See Annex G-2 for lists of training activities, training subjects, and NGO staff members trained.

The PROSAMI training coordinator is responsible for coordinating, programming and contributing to the methodological efficiency and effectiveness of all training activities. The training sessions use a participative methodology based on principles of adult education, with small group sessions, work groups, role playing, round table discussions, etc. In effect, the sessions are designed to teach participants to teach themselves. Participants also form commissions within the sessions to conduct administrative and logistical task associated with their session. The training program, not only uses innovative and efficient instructional technology to improve learning, but through the participatory techniques and activities also enhances coordination, collaboration and standardization among the NGOs. Thus, by learning together, NGO personnel also learn to work together.

PROSAMI organizes seminars, workshops and courses for the NGOs, including the executive directors, technical coordinators and supervisors, administrators, promoters and TBAs. The NGOs organize training for the promoters and TBAs. All these activities are evaluated in regards to qualitative and quantitative indicators. These evaluations have shown that the participants have grasped the purpose and content a particular session, and in general that the session satisfied their expectations. (See graph of sample qualitative evaluation in Annex G-2.)

There are three basic training modalities: classroom training, on-the-job training, and

evaluation/feedback sessions. Generally, all NGO technical staff members begin with a basic classroom course, which is reinforced and supplemented by on-the-job training, constructive supervisory visits, and regular staff meetings, which include feedback and continuing education sessions.

Since medical professionals in El Salvador have little formal training in public health, the NGO technical staff (coordinators and supervisors) receive a 36 day basic training course which reviews the seven technical components of the MHCS services, emphasizing basic knowledge, MOH standards, and the norms established by PROSAMI (which are in accord with PAHO and MOH standards and protocols). Additionally, they study health education practices, primary health care, personnel management and supervision, health information systems, and needs assessment. An important achievement of the basic course is that NGO technical staff learn to standardize their expectations, activities and goals. Consequently, all 35 of the NGOs in the network have the same service delivery system, work methodology, protocols, norms and objectives.

Once they start to work, technical supervisors receive reinforcement and further training in relation to individualized needs from their technical coordinator and the PROSAMI technical advisors through regular supervisory visits, and through weekly meetings of the NGO technical staff, where specific problems are discussed and clarified.

Of 33 supervisors interviewed, the average length of service (time of work) was 12.7 months, with a low of 1 month and a high of 39 months. The supervisors attended an average of 7.4 training each, with a low of 1 and a high of 25. When asked to rate on scale of 1 to 10 (with 1 being "useless", and 10 "excellent/of maximum use"), the degree to which PROSAMI training assisted them in doing their jobs, 33 NGO technical supervisors gave an average rating of 8.4, with a low score of 6 and a high score of 10. This relative high rating indicates that the PROSAMI training activities were valuable and useful to the supervisors, and effectively contributed to helping them to perform their duties.

The supervisors said that the training they received have contributed to their job performance first by enabling them to unify criteria within the technical components in regards to procedures and protocols for diagnosis, treatment (including referrals), and education. It clarified the standards for each of the technical components. Secondly, the training provided orientation on supervisory techniques and the use of supervisory instruments. Third, the training enabled the supervisors to improve their job performance, particularly for work in rural communities.

The health promoters receive a 60 day basic course, composed of 12 modules, covering the 7 technical components, the health-sickness process, health information systems, first aid, basic sanitation (elimination of sewage and solid wastes, potable water, etc.), and simplified patient care. It is approximately 42% theory and 58% practice. Initially, the course used materials prepared by the MOH for the training of its promoters, and MOH instructors taught the course.

The inclusion of NGO promoters in the MOH training program was a key accomplishment of PROSAMI at the beginning of the project. It represented a ground breaking effort to coordinate and collaborate with the MOH, which had previously never recognized promoters who worked outside of the MOH. It also meant that the diplomas issued for successful completion of the

basic promoter course were signed by the MOH as well as PROSAMI. This greatly facilitated the subsequent relations of NGO promoters with MOH health establishments, which is a vital element in the PROSAMI NGO health delivery system, especially for referrals.

In 1992, the PROSAMI NGOs expanded upon the themes taught to conform to the reality of what their promoters were doing. More materials were added, content was standardized with that of the MOH, and the MOH continued to provide instructors. Some of the practice sessions were conducted in the MOH health establishments. In 1993 and 1994, PROSAMI prepared its own modules to respond to the specific needs of the NGOs, based on the materials of the MOH promoter training and NGO promoter experience. The diplomas of the promoters who completed the course were signed by the Minister of Health, which constitutes another groundbreaking achievement by PROSAMI. The validation and recognition of the NGO promoters is important not only for NGO acknowledgment, but for the individual promoters who received a nationally recognized diploma.

The NGO participants in the promoter basic course have performed well on pre/post knowledge tests (see graph in annexes). Perhaps more important is that when asked to rate the degree to which the training they receive contribute to their job performance, on a scale of 1 (useless) to 10 (excellent/maximum benefit), 127 promoters gave an average rating of 9.0.

Each NGO gives complementary/continuing education to its promoters. This is accomplished through two mechanisms. One is through the regular supervision. The technical supervisors visit the promoters in their communities, observe their service delivery and correct their mistakes, and provide education to improve their performance in relation to observed needs. They also clarify doubts and answer questions the promoters may have. The second mechanism is monthly meetings of all the community promoters with the NGO technical staff, where they receive feedback on their performance, and training on common problems and or needs.

Currently 64 TBAs have been trained to collaborate with the NGOs, though only 20 are given a small stipend by one NGO with PROSAMI funds. An additional 450 TBAs trained by the MOH collaborate with the PROSAMI NGOs as volunteers. The NGO TBAs were trained either by MOH personnel or NGO personnel trained and authorized by the MOH. The training, standardized by the MOH, lasts three weeks, two of which are dedicated to theory, and one to practice, including attending 3 to 5 births. The training focuses on the normal birth and hygiene which should be used during the birth.

SUPERVISION

The PROSAMI philosophy of supervision is that it should be positive and "empowering" (or enabling). It has three main purposes. First, it is seen as a means of reinforcing, complementing and supplementing the basic training, and as a means of continuing education. Supervisory instruments have been developed by the PROSAMI technical staff to identify specific deficiencies that need help to improve. Based on the results of the instrument, the supervisor can provide exactly the assistance the supervisee needs to do a better job. Second, it contributes to the quality control of the MHCS services, including the fulfillment of norms and protocols. And, third, it ensures the completion of the work plans and achievement of project goals.

There are three levels of MHCS service supervision. The first consists of the PROSAMI technical advisors who supervise the NGO technical staff (coordinators and supervisors), and promoters. The second is the supervision of the technical supervisors and community promoters by the NGO technical coordinators. The third is the supervision of the community promoters by the NGO technical supervisors. Each level uses specific supervisory instruments to guide the supervision. Examples of the supervisory instruments are in Annexes G-6 and G-7 (technical coordinators use the same instruments used by the advisors and supervisors).

The PROSAMI technical advisors visit each NGO on an average of once or twice a month to conduct supervision. The frequency of supervisory visits depends on the needs and demonstrated skills of the NGOs. The purpose of the supervision is to guide and focus technical assistance to the areas indicated by the supervision. The advisors also supervise promoters as a check and example for the supervisors. Again, the supervision is based on the supervisory instruments (see Annex G-6), and the specific needs and deficiencies expressed and observed by both supervisors and supervisees. In general, the NGO technical supervisors indicated that they were very pleased with the supervision performed by PROSAMI, and wanted more. When asked to rate the assistance their NGO received from PROSAMI, including in particular the technical assistance, on a scale from 1 (useless) to 10 (excellent/ideal), the NGOs supervisors gave an average rating of 8.2, with a low of 6 and a high of 10.

The supervision of the NGO technical supervisors by NGO technical coordinators is more varied, and ranges from infrequent to very active. Of 34 supervisors interviewed, 10 (29%) said that the coordinator visited them in the field (i.e., in communities with promoters) 1 to 3 times a week; and another 11 (32%) said that they were visited between 1 to 3 times a month. Those who indicated that their coordinator visited them infrequently or irregularly (7/34, 21%) said the following: The coordinator visited them only when it was necessary, when it was needed, only when the PROSAMI advisor came, once every 2-3 months, or was new.

In accord with the PROSAMI methodology, the NGO technical supervisors should visit their assigned promoters in their communities 3 to 4 times per month (approximately once a week or once in eight days) and conduct a constructive, "enabling" supervision of their activities (see supervisory instruments in Annex G-7). During the supervisory visit, the supervisors review recent activities of the promoter, examine patient records (these include an individual record form [diagnosis/treatment record, in the case of ARI or ADD, or prenatal control form, or immunization record, etc.]; a family history; daily control sheet of persons attended) and other forms, assess stocks of supplies, answer questions the promoter might have and accompany the promoter on patient visits (observing service delivery).

The promoter supervision is perhaps the most critical activity in the PROSAMI methodology for ensuring the efficiency and effectiveness of the MHCS services in the community, and is of critical importance for the continuing education of the promoters. All of the promoters surveyed indicated that they benefitted from their supervisor visits, and either wanted more frequent visits or at least wanted the visits to continue at the same frequency. A total of 122 promoters said that they had been visited in their communities by their supervisors an average of 2.1 times per month. Of the 122 total, 75 promoters (61%) were visited 2-4 times per month, 37 (30%) were visited 1-2 times a month, one (1%) was visited once in two months, and 9 (9%) were not visited regularly and had not been visited in the last four months. One promoter adduced that

the lack of visits was due to a change in the coordinator within the past three months.

MONITORING AND EVALUATION

Monitoring is primarily conducted through a system of monthly and quarterly reports prepared by the NGOs and remitted to PROSAMI (see monthly and quarterly report forms in Annexes G-10 and G-11). The community promoter fills out a summary report form which is revised and consolidated by the technical supervisors. The latter is given to the technical coordinators who prepare monthly technical reports of the results of the MHCS service processes and procedures, and quarterly technical reports of coverage. These are then sent to the corresponding PROSAMI technical advisors, who grade the consolidated report results in comparison to established standards and assign each NGO a letter grade of A (ideal), B, C, or D. The ratings from the two technical reports (monthly process and quarterly coverage data), are added to monthly ratings in finance management and monthly ratings in the management of commodities to produce NGO overall monthly ratings. (See examples in Annex G-4.)

The monthly technical reports require 6 forms which cover the follow technical areas (see copies in Annex G-10):

1. Monthly evaluation of cases of ADD (acute diarrheal diseases).
2. Monthly evaluation of cases of ARI (acute respiratory infections).
3. Monthly evaluation of reproductive health (including prenatal, birth and postnatal care, and family planning and birth spacing).
4. Monthly evaluation of newborn health.
5. Monthly evaluation of GMD (growth monitoring and development).
6. Monthly evaluation of community education activities.

The area of EPI (expanded program of immunizations) is reported in quarterly reports. Immunizations are offered continuously and are administered during periodic campaigns performed in collaboration with the nearest MOH health unit. Information concerning activities or actions performed in relation to births (monitoring of TBAs) is included in the quarterly evaluations of reproductive health. The use of antibiotics by promoters to treat certain cases of ADD and ARI is monitored quantitatively but not qualitatively. For example, the number of children under the age of 5 years who receive antibiotics for cases of diarrhea or pneumonia are recorded, but there is no provision for reporting the adequacy of the use of antibiotics (this is monitored by the supervisors individually as part of quality control, but is not reported).

The quarterly report forms are based on indicators for coverage. There are eight forms of indicators (see examples in Annex G-11), for the following technical areas: ADD (8 indicators), ARI (8 indicators), 2 forms for reproductive health (15 indicators), perinatal and neonatal health (8 indicators), EPI (7 indicators), GMD (7 indicators), and community participation (4 indicators).

In general the monitoring is fairly thorough, and uses indicators which are appropriate and sufficient, with the exception of TBAs and births, and the use of medicines (see Annexes G-10 and G-11 for copies of the monthly and quarterly report forms with indicators, and Annex G-4 for examples of ratings). On the one hand, the ratings provide a easy and rapid way of

summarizing how a NGO is performing in regards to its goals. On the other hand, since the ratings are summary scores, it is easy to gloss over problems, or to miss specific problems unless one reviews the monthly reports carefully. The rating system has been effective in calling the attention of NGOs to areas they need to improve.

PROSAMI has developed a well coordinated training, supervisory and monitoring system which functions at the three basic levels of community, NGO and PROSAMI itself. The training process is initiated by PROSAMI and continued by the NGOs, in an expanding cascade: PROSAMI trains NGO personnel who train the community promoters who educate the community population. The supervisory and monitoring systems function in similar fashions: PROSAMI technical advisors supervise and monitor the NGO technical staff, who then supervise and monitor the community promoters.

CONCLUSIONS AND RECOMMENDATIONS

1. The training, supervisory and monitoring methodologies used to initiate, implement and evaluate the MHCS service delivery system are essential, effective and appropriate.

   Recommendation: Continue and expand the training, supervisory and monitoring methodologies currently being used. This could be accomplished by developing the NGOs which have demonstrated capabilities and skillful implementation of the methodologies in their subprojects.

   Recommendation: Develop the NGO network organization, CONSALUD, to facilitate and coordinate training, supervision and monitoring, both within the NGO network and also as services for non-network organizations.

   Recommendation: Organize a relatively short follow-up basic training course for promoters after they have worked for 3 to 4 months. In lieu of a course, organize a series of workshops to reinforce the protocols, norms and procedures corresponding to each technical component. Repeating the material of their basic training would help to consolidate the understanding of the promoters of fundamental concepts, and more importantly to understand the norms and protocols they are expected to implement.

   Recommendation: Organize brief annual retraining (e.g., of a week's duration) of promoters to assist in achieving greater uniformity in fulfilling norms and protocols and increasing coverage.

2. Clean births are an important element for improving reproductive health and reducing maternal mortality. This area seems to be somewhat weak within the PROSAMI NGO service delivery system. TBAs should be trained more consistently, and should receive better supervision. Since the TBAs would like to receive some supplies from the NGOs, and have also expressed the desire to receive more training, these could be made conditional upon the acceptance of supervision.

Recommendation: Organize more frequent training and retraining activities for TBAs. At least one TBA should be trained or retrained in each community served by the PROSAMI NGO MHCS services.

Recommendation: Train TBAs and promoters to collaborate and work together with more consistency. Both should share responsibilities of providing prenatal, birth and postnatal maternal care. Investigate mechanisms for including the more active participation of the TBAs in the MH services (e.g., examine means for remunerating TBA efforts in providing preventive services). If the TBAs assume more responsibilities for MH, the promoters would have more time for other MHCS services, including community organization.

Recommendation: Expand the supervisory and monitoring forms to better cover the activities of TBAs and births, and supervise TBAs more consistently and regularly, including observations of how they attend births. .

3. Among the aims of the PROSAMI NGO MHCS service delivery system is that the responsibility for supporting the community health promoters will eventually devolve upon the communities. This is a laudable goal, and has great potential for achieving an important degree of self-sufficiency of health services as well as insuring the continuity of the services. The success of this objective depends on community participation and acceptance of this responsibility. In general, program efforts to develop the potential of community participation and support are inadequate.

Recommendation: Concentrate more efforts on developing community participation and ownership of the MHCS services. Include community organizations (e.g., the "directivas", health committees, mothers clubs, volunteers, etc.) in the planning of MHCS services, establishing priorities, collecting and analyzing information, deciding how much to pay the promoters and TBAs, determining how to pay the promoters and TBAs, formulating and carrying out monthly and weekly work plans, planning and executing special campaigns and projects, supervising personnel, monitoring program results, evaluating the impact of services, etc.

Recommendation: Train and give the community health committees responsibilities to supervise some of the health promoter and TBA activities, in particular in regards to coverage. This would help to increase community participation and ownership of the services, and assure the responsiveness of the promoters and TBAs to community needs and desires.

Recommendation: Develop more regular mechanisms for the feedback of information and program results. There is a good flow of information from bottom to top (i.e., from the community to the NGO to PROSAMI), but there does not seem to be the same flow from top to bottom. In particular, the promoters and the community do not seem to receive feedback and reports on how the communities are doing in regards to services offered and delivered, and coverage achieved.

VI. B. EFFECTIVENESS

1. NGO Technical and Administrative Capacities

PROSAMI BACKGROUND AND OBJECTIVES

When the PROSAMI Project started to provide institutional support to the NGOs in mid-1990, the areas identified covered 433 cantons with a total population of almost 440,000. Some of these NGOs had never worked in the health field before, while others had worked in health areas other than maternal and child survival services. The NGOs working in these geographical areas were not well coordinated, not well integrated, nor uniform in providing services. Those working in health were also predominantly vertical in their organizational structure (conducting single disease programs) as well as in their delivery services.

The primary objectives of the PROSAMI Project are:

1) Betterment of the state of health in rural populations by increasing access to basic maternal-child health services,
2) Strengthening of non-governmental institutions (NGO), and
3) Improving coordination, and the development of policies and research.

Under these initial conditions, the PROSAMI Project began to build an integral and more uniform permanent delivery service capability among Salvadoran NGO's. Key to this integrated transition of delivering services was the institutional strengthening component which focused upon improving: (1) planning [17] - development of integrated management information systems in finances, administration, and technical health areas, annual, monthly, weekly, and daily reporting with corresponding action plans which break down and identify steps and establish milestones; (2) administration [18] - the day-to-day management processes, the systems which move information around the organization to help make decision and implement change; (3) financial control functions[19] for efficient project development which serves as a guide in the transition from dependence to independence of NGO's in the PROSAMI Project and in the preparation of financial information such as the budgets, general ledgers, and account journals; (4) monitoring[20] - supervision of inventory records of NGO's including reports, Kardex systems, requisition orders, warehouse storage, physical inventories, warehouse medicine stock and

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[17] Manual de Operación del Sistema de Logros, PROSAMI

[18] Manual de Procedimientos Administrativos y Control, PROSAMI

[19] Manual Financiero Contable, and Job Cost General Ledger, CERTIFLEX, MSCI

[20] Scope of work, Monitor Supervisor for Inventory Control System Supervision to PVOs PROSAMI.

tracking flow of goods out of NGO warehouses into field; (5) Evaluation - as used by PROSAMI is information gathering for decision making in two basic areas; a) rating of 35 NGO's on a monthly index system of the seven components of the Project for finances, commodities and technical process (management, administration and execution of the 7 components), and b) on a quarterly basis with 57 indicators (7 of which are used as sentinel indicators) of the coverage of the technical components of the Project. Then an evaluation is made of all NGO's producing an overall technical score, which is used to make cost efficient comparisons.

PROFILE OF PROSAMI NGOs

According to the PROSAMI NGO database of June 1994, there are a total of 216 NGOs in El Salvador, of which 135 work in health and nutrition. Of the 135 NGOs working in health, 78 work through health promoters, who may or may not have medical dispensaries. 35 of 78, or 45% are in the PROSAMI network[21]. These NGOs are providing a wide range of services including health education, training volunteers, promoters, and TBAs, and providing hospital attention. These NGOs are highly integrated into communities in high risk areas providing programs in basic curative methods, 71% of the NGOs, with 62% focusing upon preventive care.

In August 1994 there were approximately 700 paid employees working in the 35 NGOs as members of the PROSAMI Project; 459 were promoters, 133 technical personnel, 98 administrative staff, and 66 trained TBAs. An additional 393 TBAs have been incorporated on a volunteer basis. (SAR Sept., 1994).

Most NGOs in PROSAMI are structured hierarchically with board of directors or associates at the top providing policy direction, financial assistance and leadership with budgetary control. A general director or executive director manages the organization on a day-to-day basis and generally was one of the founders or key motivators in the start-up of the NGO. Most (70%) have legal status with the Government of El Salvador[22] which permits them to operate as a non-profit establishment with legal status given by the Ministry of the Interior. If multiple programs or projects are undertaken, divisions or separate units to manage and implement each project are found at the operational hierarchical level with either a centralized administrative and accounting unit, or individual project administrators and accountants formed as administrative staff for each program or project. Below the divisional or project level one finds the implementing or project staff. In the case of PROSAMI NGOs this consists of a technical coordinator, technical supervisors, promoters, community health committees, and volunteers.

A typical large NGO in PROSAMI is presented graphically in Chart 1, on the next page. Chart 2, is representant of a small typical NGO.

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[21] PROSAMI: NGO Database 6/94. The number of NGOs in El Salvador according to the Ministry of Health surpasses 300. The figure of 216 is from the documented Database of PROSAMI and is the figure used in this report.

[22] 25 of the 35 have officially received legal status as of October 14, 1994.

Generally the health technical coordinator has the overall day-to-day management responsibility for the PROSAMI Project for each NGO. At the technical supervisor level and below, each supervisor, who is either a medical doctor or health practitioner, has supervisory responsibility for five promoters, and sometimes one TBA for each community. Each promoter, who is paid by the PROSAMI Project but is selected by the community based upon selection criteria provided by PROSAMI, works in one canton with caserios made up of an average between 50 and 150 houses, sometimes more. The promoters visit each house of women in fertile age and children under 5 years of age with prescribed duties related to the seven technical components of the PROSAMI Project.

Each community has a health committee with from five to ten volunteers who work directly under the guidance of the health promoter. At times, there are additional volunteers, separate from the committee, who are identified by the promoter to work on specific tasks, such as fund raising activities, promotional campaigns, or general community-wide vaccination campaigns, and latrine construction. One or two health committee members are also members of the community directory board (Junta Directiva). Each promoter receives three months of basic training initially upon selection by the community. In 1991 and 1992, PROSAMI contracted the Ministry of Health to carry out this training, and supplemented with additional materials from PAHO (Pan-American Health Organization), UNICEF and PROSAMI itself. This was a very important achievement of the Project, as it was the first time that the MOH had agreed to train NGO promoter personnel. In 1993, PROSAMI organized groups of NGOs to work together in training their health promoters. This training was unified with the MOH, and the diplomas were issued jointly with the signature of the Minister and PROSAMI. Supervisors in the NGOs provide on-going training and consultations to the promoters, visiting each promoter in his community once a week on the average. NGO supervisors are given their guidance and backstopping support directly by the NGO Technical Project Coordinator. Technical advisors of PROSAMI (MSCI) also assist these supervisors and technical coordinators of each NGO by visiting them on the average of at least once per month, and sometimes twice.

FIGURE A: TYPICAL LARGE NGO IN PROSAMI PROJECT

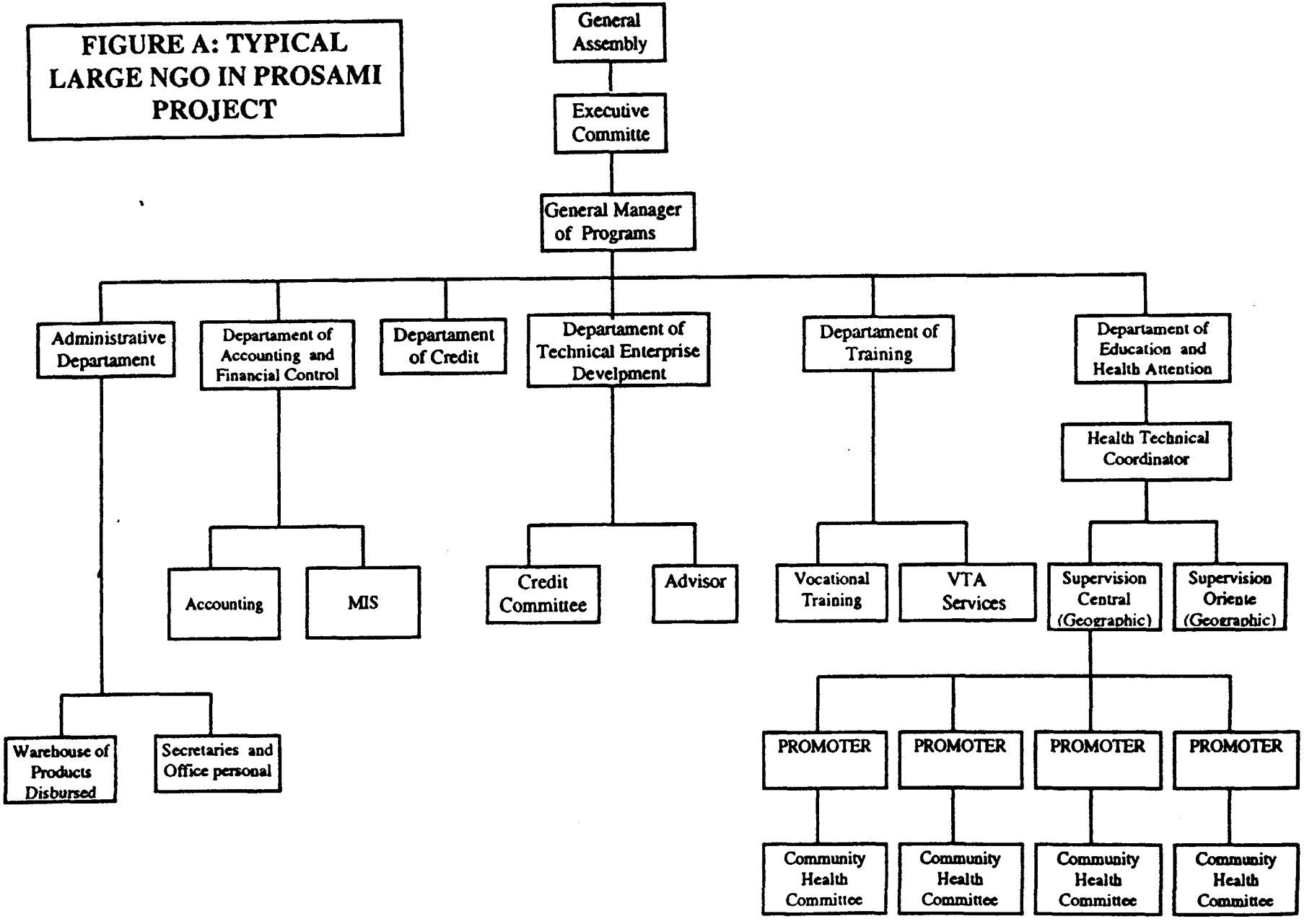
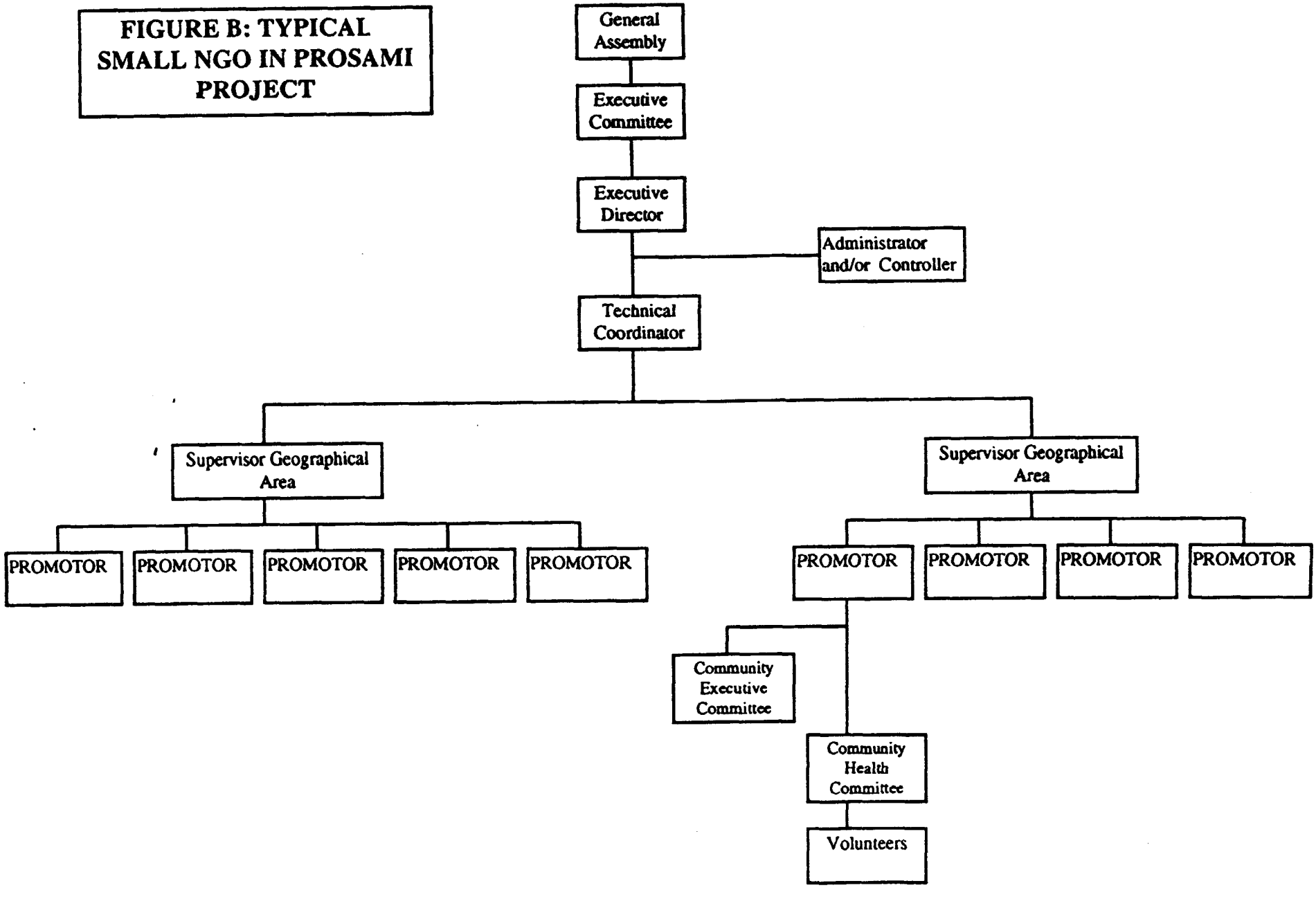


FIGURE B: TYPICAL SMALL NGO IN PROSAMI PROJECT



FINDINGS

Regarding the systems of planning for technical and financial control, PROSAMI (MSCI) has developed very detailed innovative and appropriate reporting, monitoring and feedback systems designed to move information around the communities, the NGOs, and around the PROSAMI Project and inter-organizational reporting requirements e.g., with the Ministry of Health and USAID. These systems are important in expressing how management wants organizations to work and to make important decisions and implement changes. This overall system has led to organizational clarity and control by independent NGOs with strong beneficiary orientation in most cases, and away from central control by advisors. To promote intra-NGO cooperation, NGOs have formed special topic (functional) committees and NGO director and technical coordinator meetings on a monthly basis.

Another innovation in the project is the formation by the NGOs in the PROSAMI network of the new CONSALUD corporation which brings together the 35 NGOs as members under a single entity and could assume some of the more centralized financial, purchasing, accounting and warehouse controls, training and MIS functions. It also could serve the function of sharing information through meetings, routines, and determining how conflict is handled and how decisions will be made.

The administrative, technical, and financial processes are how the PROSAMI Project works: the vital arteries, the routine processes, and mundane details. These are powerful. They are the systems that communicate down the line what senior managers want, and back up with information on what is happening. Feeding the information system consumes a lot of time; it directly determines how personnel time is spent and focuses energies. The planning and financial systems together give coherence and direction to the nation-wide network of NGOs and communities. A description of the planning and financial systems follows.

PLANNING

Briefly, planning begins the year before the planning year under consideration. Promoters in the communities ask the health committee volunteers, Junta Directivas (directive boards), and volunteers to identify health problems in the communities. These requests are passed through the health supervisors to the technical coordinator of each NGO. Then with the executive director, board members in some cases, and the administrator/accountant and technical coordinator, the maternal health and child survival targets for care in technical areas, e.g., diarrhea and parasites, acute respiratory infections, pneumonia, maternal health, pre-natal problems, etc., are detailed for each community. Month by month projections for all communities are developed with annual and monthly projections of goods distributions, personnel salaries and operating costs, training, visits to communities, etc., estimated for each NGO.

Parallel to this community and NGO planning, PROSAMI (MSCI) has estimated annual budget projections for the seven-year period based upon the original financial plan for the Project, which serves as the basic justification for Project activities and funding. Against these benchmarks project implementation is planned. Based upon Project goals, plans are subdivided into specific project areas of activities; training, technical assistance, commodities, program administration, audits, contingencies, and inflation.

The NGO, once it has been certified and the pre-award assessment is carried out by MSCI, must submit for the first year an annual plan and first year budget. Each subsequent year the NGO submits for approval an annual plan and budget at least one month before the beginning of that year. The plan describes the details of accomplishments to date, goals to be achieved during the next year, the methods to be used to carry out activities, dates during the year when goals are to be achieved and schedules of funds disbursement to achieve the plan. The planning processes, therefore establish the targets for performance, which can then be measured over the year.

FINANCE

The budget year for each NGO is the calendar year. On blank forms provided by MSCI[23] the NGO must submit its annual budget. The process is carried out in close coordination with MSCI technical and financial staff [24]. Working meetings and field visits are scheduled for this purpose to give technical assistance to the NGO. Monthly budget statements are prepared by both the NGO and MSCI according to a format prepared by the PROSAMI Project. Reporting codes are provided to the NGOs, which are also used by MSCI. MSCI uses a computerized Network Manager Accounting System called CERTIFLEX. MSCI has developed a simplified financial system for each NGO which has been provided to the NGO's in binder form with the name of the NGO printed on the cover. The binder manuals include two sections: (1) Manual of Financial Accounting, and (2) Manual for Administrative Procedures and Control. The first annual budget plan and subsequent years approval process was explained above under Planning.

According to the Financial Manual the NGO is required to establish the recommended internal controls and obtain certification by the audit firm contracted for this purpose before funds disbursement and commodity donations can begin, with the exception for funding of technical and administrative personnel. NGOs must submit monthly financial reports to PROSAMI, which include check registry report, funds request, bank reconciliation, trial balance, and in-kind and cash contributions.

Monitoring is carried out by MSCI advisors through visits to NGOs on at least a monthly basis by financial unit monitors, of which there are three; one per each 11-12 NGOs. Monitoring activities by the three technicians have been detailed in the Financial Manual in the section under Monitoring NGO Activities - Finance.

MANAGEMENT INFORMATION SYSTEMS

The technical, financial and commodities Management Information Systems (MIS), report on 21 key indicators of performance on a monthly basis. Management then flags discrepancies to take action. MIS, however, is only one of a number of activities that create an environment of knowledge. Others include monthly reports, peer reviews, meetings, technical coordination, etc. The principle criteria of efficient management is the ability to stay on target and fulfill plans.

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[23] These form are found in PROSAMI Financial Manual, February 1993.

[24] See Annex I-1 for PROSAMI, Interphase MSCI/PROSAMI-NGO's Flow or Financial Process, October, 1994.

We found a large appetite for information in PROSAMI. The number of reports confirm this. Technicians, right down to the community health promoters, are all talking numbers and showing charts, maps, graphs and backpacks (in the case of promoters) full of their reports. People are talking numbers, not just passing reports around. We also found the PROSAMI/MSCI staff were out in the field, asking questions, probing, trouble shooting and staying on top of NGOs who were not getting their supervisors out into the communities, visiting promoters and visiting houses as often as they should. The prime motivator of these activities was the desire to get to the problem and fix it. This was especially true of the MSCI medical technical staff under the direction of a very capable technical coordinator, who are all physicians or nurses.

The warehouse, business office, commodities advisor and MIS[25] manager, under the direction of the MSCI Deputy Director are well trained, skillful professionals who have been given clear direction as to the responsibilities and tasks and are carrying out their roles with knowledge of where their activities fit into the global perspective of the PROSAMI project. This is because they are informed through divisional and senior management level working meetings, routines and networks, as well as reports and computers printouts of the MIS.

MSCI warehouse control and disbursement procedures have been extremely well designed and implemented under one of the finest control systems we have seen. The person in charge has 20 years or more of experience and the system shows this. Losses are practically non-existent within this systems. Commodities training to NGOs has been good and is reflected in the individual NGO warehouses for which there are 50. Control in the communities is more difficult because there are small medicine dispensaries in each of the approximately 433 communities in the PROSAMI project. However, the monitoring and control by the MSCI monitor of goods in visits 25 of the 50 NGO warehouse each month, and he visits to communities where the dispensaries are located on a planned bases.

TRAINING

The training component of MSCI PROSAMI has been central to the quality programs that have been presented to the NGOs during the past three years. The training specialist is a registered nurse as well as being a licensed teacher and holding a university degree in education. She has been very active within and without the PROSAMI project. The dynamism of this individual is contagious and she has transferred her knowledge and experience not only by doing, but also by teaching others how to train. MSCI staff have become trainers themselves. Each Division of MSCI develops their own training plans, and then carries them out with the support and backing of this excellent training coordinator.

It is unfortunate that no budget funds were made available by USAID for further training of MSCI/PROSAMI El Salvador staff. A number of good opportunities have been lost where MSCI Salvador staff could have been trained in new innovations, especially in the use of self-instructional materials. This was a poor decision, not to approve training cost for this staff.

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[25] See flow chart for MIS program, Annex I-2

Continuing training is needed for the NGOs in administration, finances, auditing, budget preparation, accounting and all levels of management. Elsewhere in this Report, observations were made on focusing training on the community level specifically on aspect of the project cycle, and on the general management levels. Built into all training should be the upgrading of basic educational skills, in which rural and peri-urban residents are deficient. Self-instructional materials for community members, as well as multi-media materials should be the norm for all training at the community levels.

CONCLUSIONS AND PRIORITIZED RECOMMENDATIONS

NGO CONCLUSIONS AND RECOMMENDATIONS

1. The basic focus of this Section of the Report has been the effectiveness of the NGO's technical and administrative capacity to provide services that reach beneficiaries in the communities. The conclusion is that these services are reaching the beneficiaries, and in an effective and efficient way. The systems are working well. Not all NGOs are at the same levels of efficiency and effectiveness, for example, those in the first round of selection are more experienced and have had more time to work out the problems. The second round NGOs more experienced than the third round. Not all NGOs started equally in their capacity to administer projects, and some have learned more quickly than others. There are weak NGOs and there are strong NGOs, and a large range in between.

   Recommendation: Those NGOs which are weak must identify their own weaknesses, with the help of MSCI, and develop plans to strengthen the management, financial and accounting systems, planning and information system, board of directors role, or leadership. In their own self-analysis the plan should be realistic, focus on problem solving and use the resources available in PROSAMI to correct the organizational deficiencies.

   Recommendation: Those NGOs which are stronger must begin to move toward quality improvement in their systems and outputs. Again, an organizational plan must be carefully developed to lead to the changes required in the organization. The literature on organizational development and its focus upon quality control, excellence in managing organization, reengineering corporations, etc., is replete with examples, how-to-do-it advice, and straight forward ways to better what the organization is already doing. There is no reason why most NGOs in the PROSAMI Project cannot become excellent organizations which manage well the resources available.

   Recommendation: Management training of the NGO staff should be a high priority. Short courses designed specifically for NGO staff at all levels, i.e., board of directors, executive directors, technical coordinators, and supervisors, could be designed and carried out by the PROSAMI NGOs which have training facilities and instructors.

MSCI CONCLUSIONS AND RECOMMENDATIONS

1. This component of the PROSAMI Project has been designed very well to provide the assistance and direction of the overall Project, which has focused upon the provision of efficient and effective services through organization and the establishment of incentives to reach the beneficiaries. The high quality and level of professionals that have been brought into the MSCI unit is impressive. They are also motivated and committed to the goals and objectives of the Project and have been given clear direction and leadership, but at the same time, have been given the latitude to expand, grow and learn, which has benefitted the Project immeasurably. It is one of the principal reasons why the overall PROSAMI Project has been such a success.

   Recommendation: MSCI should evaluate the existing staff of MSCI to identify personnel knowledgeable and with a minimum of five years experience working in the communities in the development of community participation and organization. A new unit should be designed, staffed and financed within MSCI to coordinate this activity with the NGOs and directly with the communities. Training should be a major function of this new unit.

2. The systems of planning, finance and technology that have been designed have been professionally of high quality, but at the same time tailored and adapted to the reality of the environmental conditions in which the Project is working. The systems have been designed to meet the organizational needs of a wide variety of style and structure as well as a wide variety of capability and capacity of individual and independent NGOs. This has been another principal reason why the project has been successful. It has not attempted to place restrictions, nor fit diverse NGOs into one model of organizational design, but instead, has provided a system of good administration, structure, planning and finance, and then let the NGOs fit these systems into their own management style. The NGOs generally have done this themselves, and quite well.

   Recommendation: MSCI should also contract an individual with management training experience to help the NGOs design and carry out the first courses until a cadre of instructors and training coordinators exist within the PROSAMI/NGO's network. The NGOs could then take over the training with guidance from the MSCI training personnel.

COMMUNITY CONCLUSIONS AND RECOMMENDATIONS

1. This has been a most important aspect that is still evolving, but most recently at an accelerating rate. The PROSAMI Project is attempting to find the right model in an ever changing environment in which the role of the community in the PROSAMI Project will find its own place that permits the optimum use of this important resource of potential strength to solve problems and set program priorities in the health sector. This is a big challenge facing the PROSAMI Project over the next two to three years. What will the role of the community be in the PROSAMI Project by the end of the Project? This is what must now be debated and decided. The question, however, is not only being raised in the PROSAMI Project, it is also an issue which is being debated, or will shortly be

debated, on a national level and its effect will be felt in many sectors. The specific problem of the community role in the health sector turns on the role of the promoters in the PROSAMI Project, which are the providers of services to the community. Who will control and provide supervision and resources to these promoters? As it exists today, supervision, salary payments, and the provision of resources is being provided by MSCI through the NGO network of the Project. However, there is some indication that the communities not only want a role in the provision of resources to the promoters, but they are beginning to want to have more say in the activities of the promoters and in raising resources in the communities for the promoters.

Recommendation: Training of community health committees and volunteers in assuming more responsibility in the management of health projects. Training should include aspects of the project cycle, coordination and negotiation with municipal government entities for the design of infrastructure and the development of financial resources, how to work with the decentralized MOH units responsible for allocation resources and identifying community technical health priorities, and interventions and in allocating resources to the service providers, which are the health promoters. This is a major new activity for MSCI to undertake over the next three years.

2. The communities have shown, on an increasing basis, their willingness to allocate the time of a substantial number of community volunteers to help the promoters in ways that had not been envisioned at the outset of the Project. The communities are also finding new innovative ways in which the human resources of the communities can be brought to bear on health problems, e.g., fund raising, generating income from fees and charges, taking over some of the routine activities of the promoters, explaining the health program and activities to the whole community. The community is just beginning to discover their role and to explore new areas of activity. This debate and challenge over the role of the communities in the PROSAMI Project should be encouraged and accelerated by planned activities which assure that all participants, including the communities, are present in the debate.

MINISTRY OF HEALTH CONCLUSIONS AND RECOMMENDATIONS

1. The Ministry of Health is in its own process of change which will affect the health sector and the PROSAMI Project. It is not clear at this point just how this Ministry reorganization will finally evolve, and what its basic role in health will be. In the analysis section of this Report, it was mentioned that the Ministry unit of Community Health is beginning to see its role more in the area of supervision of health services, with the promoters again in a key role. The Community Health unit would supervise, provide training, pay salaries, and provide project development resources through the new departmental structure, and then through the local levels to the promoters. If this truly evolves, and depending upon the increase in resources to this Ministry, the Community Health unit would have an increasingly important role in the decisions which impact on the communities through the control of promoters, their training and the resources made available through these promoters to the communities.

Recommendation: The inter-institutional coordination between PROSAMI and the MOH is good, and the willingness to better this relationship is evident on both sides. The MOH would welcome assistance and guidance in regards to decentralization. Specifically there is a need to identify functions, tasks and organizational resources to carry out health activities at the regional and community levels. The NGO network is seen by the MOH as a delivery system which is operational and close to the communities.

PROSAMI NGOs and the MSCI should begin to facilitate, perhaps through the CONSALUD corporation, a dialogue through working groups (MOH and CONSALUD) to address the design and operational issues of decentralization.

CONSALUD CONCLUSIONS AND RECOMMENDATIONS

1. This is another component of the PROSAMI Project which is just now coming into its own and which is presently being encouraged by the MSCI, USAID, and the NGOs. Only the communities do not have a role in the development of this corporation and its functions. The principal benefit of the CONSALUD network of PROSAMI NGOs could be that of channeling resources, primarily financial, but certainly not limited to this function, to the network. The debate in the evolution of this institution should also be as widespread as possible. A principal and determining factor will be that of financial self-sufficiency, and will CONSALUD be able to generate project funds from international donor organizations? This is not as simple a question as it may first appear, in that much depends upon the ability and capacity of each individual NGO to restructure its own organization to the point that quality programs with equity and economically viable projects are being developed by the PROSAMI NGOs.

   Recommendation: A new NGO standing committee should be formed within CONSALUD to discuss the role, structure, functions, and relationships between the NGO's, municipalities and communities, and the MOH in the new decentralized structure of the health sector. This new committee should lead a national discussion on these topics through national conferences, radio and TV debates and talk shows, publication of articles and news releases, and bring into El Salvador international authorities with experience in decentralization.

2. The design of functions for CONSALUD is a critical next step. There is still some concern and unresolved questions as to the long-term viability of NGOs in the health sector. Is their role one limited to working closely with the communities, where their past experience has been positive? Or is their role a broader one, whereby they identify outside funding and help channel and control, supervise and evaluate funding to the communities. If it includes the latter, then aspects such as the possible endowment from USAID financial assistance from the MOH, other GOES organizations, the multilateral donors (World Bank, BID, UNESCO, PAHO), etc. are critical to CONSALUD.

   Recommendation: USAID, PROSAMI and the MOH should give more active support and guidance to consolidating CONSALUD as an effective NGO network. This should include providing or identifying a financial base to initiate and sustain CONSALUD as

an organization; leadership and organizational training; training in locating, securing and managing financing; as well as how to maintain network unity and stability. The PROCOSI network in Bolivia is a good model.

3. NGOs have been given a major role in preparing communities for decentralization in many other countries in Latin America. Bolivia is a good example. In the case of Bolivia, the communities themselves have the authority and resources to choose which organization will help them prepare for the tasks of presenting projects to funding organizations, implementation, and especially training the communities to manage their own affairs. A major shift in national resources in Bolivia, primarily funds from the national treasury, are being reallocated directly to communities to provide the funding for the development of small projects that the communities themselves have identified.

   Recommendation: As a start, in El Salvador, the MOH could channel funds through CONSALUD to implement decentralized health projects at the community level, thus taking advantage of the strengthened NGOs in the PROSAMI network.

VI. B. EFFECTIVENESS

2. PROGRESS TO DATE

Project progress to date in meeting established goals has been good. The established goal taken from the Mission Project Paper states, "To improve the health of rural and marginal urban population by increasing the percentage of this population which has access to adequate basic health services". This can be shown in a number of ways in which the PROSAMI Project has built an NGO network into high risk areas of El Salvador unserved by the MOH where rural people have had limited access to health care.

The first round selection of nine NGOs in March, 1991 covered a total population of 148,000. The second round selection in 1992 added eleven new NGOs and another 121,882 persons. The third round in 1993 added 170,000 persons, with 16 new organization in June, 1993. See Table 13.

TABLE 13.
PROSAMI NGOs and Population Covered
PROSAMI MTE, 1994

DATE	NEW NGOs	NEW POPULATION	ACCUMULATIVE TOTALS
March 1991	9	148,000	148,000
January 1992	10	121,882	269,882
June 1993	16	170,000	439,882

This total of 439,882, Project population is located in high risk areas in which limited access to maternal health and child survival services were available in communities which are over 5 KM. from health services.

Furthermore, the Mission's Project Status Report of April 1, 1994, through September 30, 1994, shows the PROSAMI Project to have had major impact upon increasing access of this population to basic health services in the program areas. For example, maternal health and child survival (MHCS) services extended or expanded in high risk communities by the PROSAMI Project are shown in Table 14.

Finally, infant and child mortality rates in the rural areas served, which are verifiable indicators of the basic PROSAMI goal stated above, can be compared to both baseline date of 1992-1993, and to the country-wide FESAL (RURAL) data (see Table 15).

TABLE 14. Access to Maternal Health and Child Survival Services PROSAMI MTE, 1994			
SERVICES	LOP GOAL	ACCOMPLISHED TO DATE	%
Beneficiary Communities *	350	433	124%
Beneficiaries (in 1,000's)	350	440	126%
Health Promoters Trained	410	583	142%
Traditional Birth Attendants Incorporated	141	413	293%
Clinics Functioning	10	182	182%
Community Committees Formed	350	739	211%
Water Systems Installed	25	14	56%

- Cantons Only; SAR September, 1994

TABLE 15, Comparative Infant and Child Mortality Rates PROSAMI, 1994			
PROSAMI			COUNTRY-WIDE FESAL - (Rural) 1988 - 1993
	BASELINE* 1992-1993	1994**	
Infant Mortality	41	16.5	44
Neonatal	--	10.1	23
Postnatal	--	6.4	22
Child Mortality (1-4 Years)	--	6.5	14
TOTAL (0 - 4 Years)	--	23	58
Number of Live Births	--	7,536	4287

- Household census data for 156,360 population, 58% of the NGO population total (first and second round NGOs)
- ** Annual Rate based on 6 month of field data (first and second Round NGO's).

VI. B. EFFECTIVENESS

3. COVERAGE

Coverage refers to how well health services reach the target population. It is the measure of how well health services get to those who need them and those who want them. Coverage depends on accessibility and demand. To increase health coverage, the corresponding health services have to be readily available to the target population; and, the target population has to recognize their need, and seek or at least accept the services when indicated. In the case of the PROSAMI NGOs, the major goal was to provide MHCS services to communities which either did not have such services or where they were deficient. A complementary goal was to provide the health services which would satisfy community demands and would have an impact on reducing morbidity and mortality in women and children.

Accessibility and coverage of the PROSAMI NGO health delivery system is based on the community promoters, who, as described previously, are located in underserved and often remote communities and attend patients in their homes or at community dispensaries. At the end of 1993, PROSAMI NGO promoters were serving in 433 cantones distributed throughout the five regions of the country. A "canton" is the second smallest Salvadoran geopolitical unit (the smallest is a "caserio", which is a small village) and is the principal means of identifying locations in the rural areas. A canton usually contains one or more communities. This is compared with the coverage of MOH health promoters in Table 16. Together the PROSAMI NGOs and the MOH cover 77% of the cantones in the country. All of the cantones served by the PROSAMI NGOs are in the rural areas.

Table 16.
National Coverage of Cantones by Health Promoters
El Salvador, December 1993

	NUMBER	PERCENTAGE
TOTAL CANTONES	2,564	100%
MOH	1,352	52.7%
PROSAMI NGOs	433	16.9%
BOTH	180	7.0%

Two mechanisms help to assure coverage: one is a community census and associated risk map. The NGO promoters initiate their activities by conducting a census of the community or communities that will be their responsibility. First they draw a map of the community, indicating the location of each house and major geographical features (roads, streams, canyons, etc.) and social structures (dispensary, churches, schools, meeting halls, football fields, etc.). Each house is assigned a number on their map. Then they visit every house in the community, and register the number of inhabitants of each, noting in particular women of fertile age and children under the age of 5 years. Information is gathered from each house relating to the MHCS to be provided.

Each house is then rated for maternal and child health risk presented: Children under the age of 5 (those with diarrhea or ARI, those who have not completed the schedule of immunizations, those who should receive GMD visits, etc.), newborns and puerperal women, pregnant women, women of fertile age, etc. The houses on the map are marked with colored pins or colored pieces of paper as high, medium or low risk. This is their risk map. The promotor then makes a monthly or weekly work plan which takes into account the risks indicated on her/his map, and plans visits to high and medium risk houses accordingly. Forming a new work plan regularly (i.e., weekly or monthly) permits the incorporation of persons whose risk status changes and new members of the community population.

Coverage is affected by reception of services. Health promoters visit all high risk households, but not all of the households desire or accept their services. Some persons reject promoter services for political reasons, associating the promoters and NGOs with conflicting parties of the recent civil strife. Others prefer to seek health care from private practitioners in towns nearby. Others do not recognize the importance or need for services. The last relates to the essential preventive nature of the promoter services. The promoter services emphasize education, counseling, protection, early detection, and early treatment. As in many places, Salvadorans usually do not recognize the importance of prevention.

The NGO promoters work to prevent the occurrence of serious, life-threatening health problems, but when these are detected they immediately refer the cases to physicians or hospitals. Many people in the Salvadoran rural areas tend to wait until a serious problem occurs before seeking assistance, when they need to consult a physician directly. As people see friends and neighbors benefit from promoter services, begin to enjoy better health through their preventive services, and avoid life-threatening conditions, those previously resistant to promoter services become more receptive, and demand increases.

The second mechanism is the promotion of promoter services to stimulate demand. This is accomplished by the promoter her/himself, who offers her/his services to potential clients, and by word-of-mouth recommendations by satisfied clients. Along with this, coverage is also augmented by the cooperation of individual volunteers and volunteer health committees, who assist the promotor in identifying changes in risk: women who become pregnant, children who become ill, new persons who enter the community, etc. They inform the promotor of new cases that require treatment or control visits, and also encourage the affected persons to seek attention from the promotor.

The use of a basal census, risk map, case detection and monthly planning assist in extending coverage of basic MHCS services to those most in need. This contributes to improved health throughout the community. Improved impact as a result of better coverage of health services is described in the section on Impact. The specific coverage achieved in the MHCS areas implemented by the PROSAMI NGO promoters are presented in Tables 17-23, below, along with some comparable data pertaining to MOH promoters. A review of the little data available for MOH promoters indicates that the coverage achieved by the PROSAMI NGO promoters are better or equivalent.

ADD: See Table 17. In general, in 1993, the NGO promoters attended 4.3 time more children with acute diarrheal diseases (ADD) than did MOH promoters. NGO promoters gave oral rehydration salts to 83% of cases attended, and followed up with an average of 3.5 visits. The objective of

treating children with ADD is to prevent death due to dehydration. Approximately 14% of the cases of ADD were accompanied by dehydration in the NGO areas. A total of 41% of the cases of ADD with dehydration were referred to MOH health units for further treatment. The other 59% of the cases with dehydration were managed in the communities with oral rehydration.

Table 17.
Coverage of the Control of Diarrheal Diseases and Dehydration
El Salvador, 1993

No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Incidence (per 1,000 children under 5 years of age)	251/1,000	185.6/1,000
2	Number of cases of diarrhea attended by promotor	168.1	68.4
3	Cases with dehydration	14%	
4	Number of follow-up visits per case of dehydration	3.5	
5	Cases treated with oral rehydration salts (ORS)	83%	100%
6	Cases with dehydration referred	41%	
7	Cases with diarrhea referred	6.0%	5.2%
8	Cases accompanied by individual education	89%	
9	Educational sessions to groups	25	426
10	Number of potable water sources constructed or improved, by promotor	22.2	4.7
11	Number of latrines constructed or improved, by promotor	18.5	16.8

* PROSAMI, Quarterly Field Reports, 1993.
** MOH, Annual Report, Division of Community Health, 1993.

ARI: See Table 18. The NGO promoters attended a total of 57,328 children with ARI during 1993. They attended an average of 312.7 cases of ARI per year, which is 5 times the 63.8 seen by MOH promoters. Of the cases of ARI, 12% were accompanied by pneumonia and 2% were accompanied by severe pneumonia. There was an average of 2.4 follow-up visits for each case of pneumonia, and all cases of severe pneumonia were referred to MOH health units for further evaluation and treatment. Each promoter also gave individual education to 41% of the ARI cases, and delivered 14 educational sessions on ARI to community groups.

Table 18. Coverage of the Control of Acute Respiratory Infections/Pneumonia El Salvador, 1993			
No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Incidence (per 1,000 children under 5 years of age)	476	
2	Number of cases of ARI attended per year per promotor	312.7	110.9
3	Cases with pneumonia	12%	
4	Cases with severe pneumonia or severe disease	2%	
5	Number of follow-up visits per case of pneumonia	2.4	
6	Cases of severe pneumonia referred	99%	
7	Cases of ARI referred per promotor	2.0%	4.8%
8	Cases accompanied by individual education	41%	
9	Number of educational sessions to groups per promotor	14	65.7

* PROSAMI, Quarterly Field Reports, 1993.
** MOH, Annual Report, Division of Community Health, 1993.

MRH: See Table 19. The NGO promoters made an average of 5 prenatal care visits to pregnant women equivalent to 27.8% of expected births, which is 3.8 times that of MOH promoters. The calculation of expected births was made by calculating 5% of the community's total population, in accord with MOH norms. According to FESAL-93, the current total fertility rate (TFR) in El Salvador is 3.8.[26] The ANSAL-94 study has recommended that coverage rates be determined with this figure (3.8) as the continued use of 5.0 (the figure used currently) artificially increases the estimate of pregnancies by 20%.[27] If this recommendation is followed, the actual NGO prenatal coverage rate would be approximately 36.8%.

Danger signs were seen in 13% of the prenatal cases. The danger signs included hemorrhage, hypertension, edematous hands or face, headaches with bright spots or stars in the visual field, pain or irritation when urinating, fever or chills, abdominal pain, etc. The coverage of puerperal women with a minimum of two visits was 28.9%, which is 2.3 times that of the MOH promoters. Again, this was calculated with a TFR of 5.0, which produces an artificially lower amount. Danger signs, such as hemorrhage, infection, etc., were seen in 12% of the postpartum cases. A total of 66% of the prenatal and postpartum cases were referred to MOH health units. In 84% of the prenatal and postpartum cases, individualized education was given, and an average of 14 group education sessions were presented per promoter. The MOH promoters provide some care, but are not trained to make pre- or postnatal care visits.

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[26] FESAL-93, page 27.

[27] Becerra: ANSAL-94, Situación Materno Infantil, El Salvador. Page 13.

Table 19. Coverage of Maternal and Reproductive Health by Promoters El Salvador, 1993			
No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Prenatal care (minimum of 5 visits per pregnancy)	27.9%	7.4%
2	Prenatal cases with danger signs (hemorrhage, hypertension, or infection, etc.)	13%	
3	Postpartum care (minimum of 2 visits per puerperal woman)	28.9%	12.8%
4	Postpartum cases with danger signs (hemorrhage, infection, etc.)	12%	
5	Prenatal and postpartum cases referred	66%	32%
6	Prenatal and postpartum cases accompanied by individual education	84%	
7	Number of group educational sessions per promotor	14	50
8	Women of fertile age receiving oral contraceptives (13 cycles)	1.4%	0.4%
9	Couple coverage (100 condoms)	0.5%	0.2%

* PROSAMI, Quarterly Field Reports, 1993.
** MOH, Annual Report, Division of Community Health, 1993.

PNH: See Table 20. The NGO promoters visited 61% of the newborns at least once. Danger signs, including infected umbilical stumps, fever or hypothermia, irritability with weakness or constant crying, rapid respiratory rate or retractions, convulsions, has difficulty breast-feeding, etc., were found in 10% of the cases seen, and 20% of the cases were referred to MOH health units for further evaluation. All mothers of newborns received individual education, including breast-feeding promotion. An average of 7 educational group sessions were given per promoter. No data on newborn care was available from the MOH.

EPI: See Table 21. The immunization coverage is achieved in collaboration with the MOH health units. Some NGOs provide continuous immunizations, on demand, and others provide immunizations during sporadic to monthly campaigns. In many cases, MOH personnel participate in the campaigns along with the NGO promoter. Consequently, EPI coverage is measured as an extension of MOH coverage. As such, the NGO promoters extended the coverage of DPT3, Polio3 and measles to 26%, 22% and 15% of children under the age of 1 year, respectively, and to 5%, 5% and 4% of children between the ages of 1 and 4 years, respectively. The combined MOH-NGO coverage in the communities served by the PROSAMI NGOs (by the end of 1993) averaged 76% for DPT3 and 71% for measles. They also extended the coverage of 2 doses of tetanus toxoid to 10% of pregnant women.

Table 20. Coverage of Neonatal and Perinatal Health El Salvador, 1993			
No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Newborns visited (minimum 1 visit)	61%	
2	Newborns with danger signs (infected umbilical stumps, general infection, etc.)	10%	
3	Newborns referred	20%	
4	Number of return visits per newborn	0.6	
5	Cases of newborns where individual education was given	100%	
6	Number of group educational sessions per promotor	7	

* PROSAMI, Quarterly Field Reports, 1993.
** Data not available

Table 21. Immunization Coverage El Salvador, 1993			
No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Extension of DPT3 coverage: - Children under the age of 1 year - Children between 1-4 years	 26% 5%	 34% 7%
2	Extension of Polio3 coverage: - Children under the age of 1 year - Children between 1-4 years	 22% 5%	 34% 7%
3	Extension of measles coverage: - Children under the age of 1 year - Children between 1-4 years	 15% 4%	 39% 13%
4	Extension of TT2 coverage in pregnant women	10%	24%

* PROSAMI, Quarterly Field Reports, 1993.
** MOH, Annual Report, Division of Community Health, 1993.

GMD: See Table 22. The NGO promoters made an average total of 226.1 growth monitoring visits each, which was 7.8 times that of MOH promoters. The coverage of at least 3 GMD visits per child was 64% of the children under the age of 5 years. In comparison, the MOH indicated that the national coverage rates in 1992 for El Salvador were 44% for children under the age of 1, 28% for children between the ages of 1 and 2 years, and 14.4% for children between the ages of 2 and 4 years. The NGO promoters found that 24% of the cases presented moderate to severe malnutrition, and 93% of the cases of severe malnutrition were referred to the MOH health units.

Two doses of vitamin A were given to 45% of the children under the age of 5 years, and 5 doses of iron were given to 10%. Individual education was given in 60% of the GMD visits, and an average of 15 group educational sessions were presented per promoter.

Table 22.
Coverage of Growth Monitoring, Development and Nutrition (GMD)
El Salvador, 1993

No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Children under the ages of 5 years who received at least 3 GMD visits	64.0%	13.8%
2	Number of GMD visits per promotor	226.1	29.3
3	Cases with moderate to severe malnutrition	24%	
4	Cases of severe malnutrition referred	93%	
5	Children between the ages of 0-4 years who received at least 2 doses of Vitamin A	45%	
6	Children between the ages of 0-4 years who received at least 5 doses of Iron	10%	
7	GMD visits accompanied by individual education	60%	
8	Number of group educational sessions per promotor	15	84.8

* PROSAMI, Quarterly Field Reports, 1993.
** MOH, Annual Report, Division of Community Health, 1993.

Table 23.
Coverage of Community Organization and Participation
El Salvador, 1993

No.	DESCRIPTION	PROSAMI NGOs*	MOH**
1	Number of community meetings	9	
2	Number of volunteers per quarter	29	
3	Number of health campaigns	8	
4	Number of community dispensaries or health centers donated	25	

* PROSAMI, Quarterly Field Reports, 1993.
** Data not available.

COP: See Table 23. The NGO promoters contributed to community organization and participation through several activities in addition their to health education actions. Each NGO promoter helped to organize and participated in an average of 9 community assemblies. Each promoter is supported

by a community formed volunteer health committee. There was an average of 29 community volunteers who assisted the promoter in various activities, ranging from informing and inviting their neighbors to participate in meetings and campaigns, to actively assisting the promoter to weigh children, administer immunizations, give first aid, run community oral rehydration centers and community ARI treatment centers, etc. There was an average of 8 health campaigns per promoter, and a total of 25 communities established and donated health centers/dispensaries to be used by the communities.

CONCLUSIONS AND RECOMMENDATIONS

1. The coverage achieved by the PROSAMI NGO promoters are impressive, considering their relatively little formal training, and is a tribute to their dedication and enthusiasm. The health delivery system designed by PROSAMI and implemented by the NGOs facilitates the success of the promoters' activities. The community based census, formulation of the risk map and regular (weekly and monthly) prioritized work plans, active case detection, simplified case management, referral of all cases which present danger signs, or which are doubtful, to a physician or registered nurse (usually an MOH health unit or hospital), individual and community health education, and community organization and participation, all contribute to increasing accessibility, and satisfying needs and demand. And these achieve good coverage. As the NGO network grows in experience, and perhaps expands, there is great potential for achieving even better coverage through this model.

   Recommendation: Continue the community based health promoter primary care service delivery model, and expand to other communities as opportunities and resources permit. More resources should be allocated to expand the NGO service delivery system. This is a very worthwhile and cost-effective investment.

   Recommendation: Obtain funds to establish a self-sustaining, self-directed NGO organization, such as CONSALUD, to continue the PROSAMI NGO network and primary health care delivery system. An adequate endowment would facilitate self-sufficiency, and should not only permit continuation of the network, but also expedite expansion and extension of the services.

   Recommendation: Offer the PROSAMI NGO MHCS health service model to the MOH as a means of increasing primary health care coverage in the rural areas of El Salvador. PROSAMI could assist the MOH in redesigning the functions and procedures of their promoters to replicate what the NGO promoter accomplishments.

2. The calculation of coverage by NGOs is done in accord with MOH standard practice, which conforms to current PAHO recommendations. These calculations tend to produce an average of services per unit of population rather than a proportion of population which receives services. This is somewhat misleading in terms of the objectives of health service coverage, particularly in regards to evaluating the efficacy of NGO health services.

   For example, the current MOH norm for prenatal care is a minimum of 5 visits. This means that each pregnant woman should have a minimum of 5 prenatal visits. When we evaluate

prenatal care coverage, we want to know two things: the proportion of all pregnant women who receive prenatal care, and the proportion of pregnant women who receive 5 or more visits. NGO prenatal care rates are calculated in two steps. First, the total number of prenatal care visits is divided by 5 to determine the number of "protected pregnancies" (PP). Second, the PP is divided by the estimated number of pregnancies per unit of time (e.g., a trimester or quarter), which produces the prenatal care coverage rate.

In actuality, this prenatal care rate does not tell us how many pregnant women received prenatal care, nor how many received 5 or more prenatal care visits. Further, the calculation is based on two deceptive numbers. First, summing together all of the prenatal visits performed during a specific unit of time, and dividing this by 5, to produce the number of protected pregnancies is misleading. For example, suppose a particular community of 1000 inhabitants has a total of 10 pregnant women at a given time. The women should receive a minimum of 5 visits during their pregnancies, at intervals of once a month, if the pregnancies are normal. Consequently, during a trimester (3 months), each pregnant woman should receive at most 3 visits. So if all 10 women receive 3 visits during the trimester, that would give a total of 30 visits. If 30 is divided by 5, the result would be 6, meaning that 6 pregnancies are protected, even though all of the women received prenatal care. If we calculate the prenatal care rate, dividing the PP by the estimate of pregnancies in the population (which is calculated at 5% of the population)[28] which in this case would be 20, the rate would be .30 or 30%, rather than 100%.

Suppose that a community of 1000 total population had a total of 20 pregnant women during a year. If 5 women received 8 visits, 5 women received 2 visits, and 10 women received 0 visits during the year, the total number of visits would be 50. If this is divided by 5, the number of protected pregnancies would be 10. In reality, only 5 pregnancies are protected by the minimum of 5 prenatal care visits. The prenatal care coverage rate would be (10/20) x 100 = 50%.

Recommendation: Calculate coverage rates with real data, and not with estimates or fictitious variables. Since each community initiates services with a census, real data can be used, and more accurate and useful coverage information will result. Using real data will also make more sense to the promoters and will enhance their ability to apply the data they collect.

Recommendation: Base all coverage calculations on the community census, and not on national estimates. For example, instead of using the estimated number of pregnancies to calculate prenatal care coverage, the real number of pregnancies should be used. This will provide accurate coverage information for the communities served and will facilitate better planning and prioritization of services. Adequately maintained census and risk map data should make this possible.

3. The community census, the formulation of risk maps, and the monitoring of coverage rates are important elements for planning health service activities.

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[28] PROSAMI, Indicadores de Evaluación 1994, page 3.

Recommendation: Update the community census at least once a year. This should be done with the participation of the community health committee, community "directiva" (the community "council"), community volunteers, and other interested community members. This data should be used to prepare a new risk map and annual work plan, again with community participation. Community members and organizations should be involved in planning to achieve 100% coverage in all MHCS areas in their community.

Recommendation: Involve the community health committee in monitoring the achievement of coverage in the NGO areas. The community as a whole should be regularly informed as to the degree of coverage that have been achieved, so as to stimulate community support and collaboration.

4. Some members of the populations of the communities served by the PROSAMI NGOs receive services from other sources. Even though the NGO promoters do not provide services to these persons, they are being covered by other providers and should be included in the coverage statistics.

   Recommendation: Include information about those persons who receive comparable care from other sources. For example, women who receive prenatal care from MOH or private providers should be included in the community statistics, though in separate categories. The data could be obtained with the help of community volunteers. This will improve the accuracy of the coverage of the primary health care services offered by the PROSAMI NGO promoters, which will assist in formulating more effective work plans and in establishing appropriate priorities.

5. Some members of the communities do not initially accept nor seek PROSAMI NGO promoter primary health care services. Nor do they seek similar services from other services. Since the promoters tend to become very occupied with serving those who willingly cooperate with them, they tend to forget the persons who initially do not respond to them.

   Recommendation: The promoters and health committees should make more of an effort to reach nonparticipants. The community health committees and volunteers could take on the task of searching out women and children who are not receiving or participating in the services provided by the promoter, and make arrangements for their participation.

VI. B. EFFECTIVENESS

4. QUALITY OF CARE

The quality of care is one of the determinants of whether or not PROSAMI's efforts will achieve its goals of improving health and reducing MHCS morbidity and mortality. The quality of health care depends on several factors. One is the degree to which the medical technology used is appropriate and adequate to the needs of the target population; and, whether it is "state-of- the-art" for the context of the client population. A second factor is the degree to which the services conform to accepted standards and norms. A third factor is the personnel who deliver the services: whether the personnel are sufficiently trained and competent. A fourth factor is whether the materials and supplies are appropriate and adequate for the level of medical technology. A fifth factor is consistency in service delivery in terms of accessibility and fulfillment of standards and treatment protocols with each client. A sixth factor is ethics and equity.

The seven technical components were designed to respond to six major areas of maternal health and child survival, and community organization as a means of sustaining the health measures. They correspond to the principal causes of maternal and child mortality and debilitating morbidity in El Salvador. The seven areas were described previously, and are listed briefly again:

1. The control of acute diarrheal diseases and dehydration (ADD).
2. The control of acute respiratory infections/pneumonia (ARI).
3. Maternal and reproductive health, including prenatal care, clean births, puerperal care, and family planning and birth spacing (MRH).
4. Expanded program of immunizations (EPI).
5. Neonatal and perinatal health (NPH).
6. Growth monitoring, development and nutrition (GMD).
7. Community organization and participation (COP).

The component designs were based on internationally recognized recommendations and standards as defined and promoted by the Pan American Health Organization (PAHO, representing the World Health Organization), and recommendations of UNICEF. The basic purpose of the components is to decrease maternal and child morbidity and mortality through community based actions. The same standards have been incorporated in the national health norms for the component areas and consequently are the same standards promulgated by the MOH.

Each component has protocols for the diagnosis or performance of control procedures (such as prenatal care, GMD, etc.), treatment, referral and education/prevention of the corresponding MHCS health conditions and pathologies. Each health promoter has been given a set of protocols printed on plasticized paper which is to be used when patients are visited. Thus, the promoter is not dependent on her/his memory. She/he has the important points available for immediate use for diagnosis or procedures, both provider (promoter) and home (parents) treatment, danger signs which should be searched for and noted, and educational messages which should be delivered to clients.

These protocols are an important contribution to quality control and to assuring consistency in treatment, and are an excellent aide for the promoters. In practice, all of the promoters observed (8) used the protocols with every patient. When asked whether or not they used the plasticized protocols, others replied that they did so as to be sure that they did not forget anything important, and they considered them to be important parts of their equipment. See Annex G-9 for copies of these promoter guides/protocols.

The quality of care of depends on how well the promoter completes and applies the protocols for each component. Promoter ability depends on her/his knowledge and skills. The promoter quality of care is monitored regularly through the supervisory visits (described previously). In addition to ensuring that the promoter is following the protocols adequately, the supervisors also provide continuing education so as to enhance promoter knowledge and skills. The supervisor also serves as a higher level of expertise and can resolve difficult questions or problems, and clarify doubtful diagnoses and treatment plans.

Another essential element in achieving good quality care is the referral process. Perhaps one of the most important responsibilities of the promoters is to identify health risks and danger signs, and refer the persons that present them to appropriate medical personnel. This means referring their clients to physicians at MOH health units, health posts, health centers, hospitals, physicians in private practice, or other health care providers. Thus, when the promoter encounters a mother or child with a potentially life-threatening condition, or with a condition that requires physician care, they immediately refer the person. In many cases, they personally take the person at risk to the nearest MOH health unit/post/center or hospital. In addition, if they have doubts about a case, they refer the patient.

As explained previously, this increases the efficiency of the MOH health providers by sending them people with high-risk conditions: patients they really need to see, such as cases of pneumonia or dehydration, and not mild cases, such as people with colds or headaches or incipient diarrhea. The promoter then awaits the results of her/his referral, as this feedback is a valuable complement to their training. When a promoter refers a patient, she/he fills out a referral form, which explains why the person is being referred. The referral form also has a space for the attending physician or nurse to fill in the results of the referral, which is then sent back to the promoter.

Some observers have commented that they feel that the PROSAMI NGO promoters are attempting to replace physicians in the communities. Actually, the system is designed to complement physicians, and make more efficient use of physician time. It is essential that the PROSAMI NGO promoters be able to refer cases with signs of alarm, or more than simple health problems, to physicians. The PROSAMI NGO promoters perform routine, simplified procedures, offer simplified case management, provide health promotion and education, and detect those cases in a community which merit and require physician attention. It is also important to recall that the PROSAMI NGO promoters work under the supervision of a physician or other health professional (such as a maternal child health technician, nurse, etc.).

Another issue is accessibility. The PROSAMI NGOs work in small, rural, relatively remote communities where there are no physicians, and where it is highly unlikely that a physician will ever decide to reside. Since the promoters are community residents, they are always available. In particular they are available for emergencies and life threatening situations, which paradoxically

rarely seem to occur when a physician or nurse happens to be in the community. Promoters also know where to go to find clients and patients, especially high-risk persons who are reluctant to seek health care. This is important in sometimes disperse rural communities.

A model of sporadic physician visits to communities, such as once or twice a week, has been suggested as an option to PROSAMI and PROSAMI NGO promoters. While physicians can provide more comprehensive and competent health care, by only being in a community for relative brief lengths of time they clearly cannot be available at all the times when their services are essential. Consequently, sporadic visits by physicians alone is not a good solution to the problems of coverage and accessibility currently affecting rural Salvadoran communities.

Promoters can help to increase the efficiency of physician visits by programming patients to be seen. A physician's time can be taken advantage of to a greater degree by reducing the number of routine and mild cases she/he needs to see. This is the model being used by the PROSAMI NGOs: The promoters screen patients at their homes or in community dispensaries, treat the mild cases, and refer serious or unsure cases to physicians. The the technical supervisors visit communities to supervise and monitor the promoters, and, as part of the visit they see cases which are difficult for the promoter.

Credibility is also an important factor. A promoter who only promotes and educates, while performing a valuable community service, does not fulfill popular expectations concerning health personnel. When people generally think of health personnel, they tend to think of someone who helps them to get well when sick. The words of a person who heals has more credibility and more impact. The NGO promoters not only talk about health: they also provide specific services to individuals. This has given them greater credibility in the communities in regards to matters which concern health.

DESCRIPTION OF THE TECHNICAL COMPONENTS
(See copies of the promoter protocol guidelines in Annex G-9.)

ADD: The ADD component has two primary focuses: First, to prevent diarrhea, and second, to prevent deaths due to dehydration and shock in children who present ADD. The first is accomplished through individual and group education, hygiene campaigns, and assuring sources of potable water and basic sanitation. The second is accomplished by the promoter through two basic actions: 1. The early detection and adequate management of dehydration in cases of diarrhea in children under the age of 5 years. And, 2. Education of mothers and other caretakers, on preventive measures and home management of cases of diarrhea. The promoter must examine a child and determine the duration of the episode of diarrhea, check to see if blood is evident in the stool, classify the ADD, evaluate the signs of dehydration, choose the appropriate treatment plan, plan the appropriate follow-up, and distribute sufficient packets of ORS. Education is given about the preparation and administration of the ORS, diet during the diarrhea, danger signs, and hygiene and sanitation measures. Treatment is also given for intestinal parasites. For this purpose, the promoter administers mebendazole and, under the direction of the technical supervisor, metronidazole. The former is given for nemathelminth and cestode infections (worms), and the latter is given for amoebic infections.

Promoters also assist in the establishment of CUORT (URO-C): Community Units for Oral

Rehydration Therapy. These are small centers established in the houses of volunteers who have been trained by the community promoter and NGO technical supervisor to treat ADD with ORT (oral rehydration therapy). They have a supply of ORS (oral rehydration salts) packets which they distribute to parents of children with diarrhea. They also help parents to recognize danger signs, and teach them how to prepare the ORS solutions and administer them. This extends the accessibility to ORS/ORT to different points in the community, facilitating the opportune treatment of children with ADD, thereby contributing to the control of mortality. The units are also part of the community participation program.

In the promoter protocol-guidelines, each promoter has a plasticized copy of a pamphlet published by PAHO (1994) entitled: "Management of a Patient with Diarrhea." This contains guidelines for the evaluation of the state of hydration, the evaluation of other problems (bloody stool, duration of more than 14 days, severe malnutrition, and fever of 39° C or more), the use of medicines in children with diarrhea, and the three treatment plans: Plan A, for home treatment; Plan B, for oral rehydration therapy, and Plan C, for rapid treatment of dehydration and shock.

ARI: While some preventive measures, such as the control of residential smoke and improved ventilation, are implemented by the NGOs in the communities, the main focus of the ARI component is to prevent deaths due to pneumonia in children under the age of 5 years. The two basic actions are: 1. The early detection and standardized management of ARI cases. And, 2. The education of mothers and other persons responsible for the care of children to recognize the warning signs of pneumonia. There are five objectives of the ARI component: 1. Reduce the morbi-mortality of ARI, especially of pneumonia, in children under the age of 5 years. 2. Administer standardized antibiotic treatment of all cases of pneumonia diagnosed by the promoter. 3. Expand the capacity of families to recognize the danger signs of pneumonia so that they seek treatment opportunely. 4. Reduce the inappropriate use of antibiotics and other medications in the treatment of ARI in children under the age of 5 years. And, 5. Reduce the complications of ARI, such as otitis, amygdalitis, and pharyngitis, through early diagnosis and appropriate treatment.

Promoters assist in the establishment of Community Units for ARI Care (UAIRAC), to facilitate the opportune detection and treatment of pneumonia. The UAIRACs are small centers in volunteers' homes. The volunteers are trained to recognize the danger signs of ARI. They help parents measure the respiratory rate of a child, and if pneumonia is suspected, they send the child to the promoter, or to an MOH health establishment for further evaluation. This unit extends accessibility for the early diagnosis pneumonia, thereby contributing to the control of morbidity and mortality from ARI. The units are also one of the areas of community participation.

To assist in the control of ARI and pneumonia, promoters encourage the completion of the standardized immunization schedule (EPI), especially immunizations for measles and DPT (diphtheria, pertussis or whooping cough, and tetanus) in children under the age of 5 years. Adequate levels of vitamin A contribute to proper immunological functioning, especially in regards to ARI. So, a megadosis of vitamin A is administered every 6 months, in particular to malnourished children (under the age of 5 years). Families are taught to recognize the danger signs for pneumonia: rapid respiratory rate, respiratory difficulty, chest noises such as wheezing, etc. Complementary preventive measures are also promoted, including such measures as the elimination of sources of smoke, dust and other atmospheric contaminants; the promotion of breast feeding, prenatal care, and good nutrition.

The promoter protocol-guidelines have 7 pages for ARI. These include diagnostic signs for children with ARI to diagnose severe pneumonia, pneumonia, and ARI without pneumonia. Another page gives guidelines for treating severe pneumonia, pneumonia, and ARI without pneumonia. Three other pages give guidelines for the standardized management of ARI cases. One deals with home treatment of children with ARI, giving indications for children under 2 months and children between 2 months and 5 years. The second deals with the management of children under 2 months of age with coughing and/or respiratory difficulty. And, the third deals with the management of children between 2 months and 5 years of age with coughing and/or respiratory difficulty.

The protocols contain instructions on the use of cotrimoxazole (trimethoprim-sulphametoxazole). The last two ARI pages are therapy instructions. These have instructions on the use of cotrimoxazole, and acetaminophen, which the promoters may prescribe, under close professional supervision. Other medications which may be recommended for special situations are described, but these are generally not handled by the promoters, and should be prescribed by better trained personnel, such as the technical supervisors. The importance and indications for referrals are described on several sheets.

MRH: The maternal and reproductive health component includes prenatal care in the community, clean births attended by trained personnel, postpartum (puerperal) care, birth spacing and family planning, the prevention of STDs (sexually transmitted diseases), and education in reproductive health.

The promoters fill-out a pregnancy monitoring form for each pregnant woman, which contains data relevant to reproductive health. The mother is given a maternal registry card which replicates the information. The monitoring form was designed by CLAP (Centro Latinoamericano de Atención Perinatal - Latin American Center for Perinatal Care), has danger signs marked in red, and has space for up to 9 prenatal care visits. Filling out this card also helps the promoter to maintain consistency in the care given.

The promoter has the goal of providing a minimum of 5 prenatal care visits to all pregnant women in the community, and a minimum of 4 postpartum visits (which can be combined with neonatal care visits). Vitamin supplements are distributed during both periods (prenatal and puerperal). Birth spacing and family planning information and counseling are offered during prenatal and postnatal care visits, and to women who present risks factors. Oral contraceptives and condoms are distributed by the promoters. Sterilization and IUDs are given by the appropriate professionals through referrals. When a women solicits oral contraceptives, the promoter reviews a list of 14 questions to determine whether or not there may be a risk present.

During prenatal visits, the promoters calculate the probable delivery date, take the pregnant woman's blood pressure, measure uterine height, measure the woman's weight and write it on a standardized graph (see "Carnet Materna" in Annex G-9) to see whether or not there is excess or insufficient weight gain, and search for other danger signs. The promoter also gives the pregnant woman education on maternal nutrition, personal hygiene, preparation for breast feeding, danger signs during pregnancy, and birth-spacing counseling.

The promoter protocol-guidelines contain five pages related to maternal and reproductive health. One page concerns 12 maternal risk factors before beginning pregnancy. Two pages deal with the

signs of maternal risk, including the danger signs during the prenatal, birth and postpartum periods, and the danger signs of toxemia. It is indicated that all of the signs are medical emergencies requiring immediate referral to a hospital. The third page deals with the classification and management of pregnancy in the community, with the indication of 21 danger signs which require referral to a hospital or health unit. The fourth page deals with the management of puerperas in the community. This sheet includes a list of 7 danger signs which require referral to a hospital or health unit.

PNH: The peri/neonatal health component has three principal objectives: 1. Reduce the morbimortality from newborn infections and low-birth weight. 2. Early detection of newborns and opportune neonatal care. A minimum of 4 neonatal visits should be given to each newborn. And, 3. educate pregnant women and TBAs in regards to the danger signs that might present in newborns, and how to care for a newborn at home. Newborns with infections, low birth weight with complications, or the observation of congenital anomalies are all referred to a hospital.

The promoter protocol-guidelines have three pages dealing with peri/neonatal health. One page contains danger signs in newborns, and reviews 5 danger signs for which immediate referral to a hospital or health unit is indicated if observed. A second page deals with the evaluation, classification and treatment of a low-birth weight newborn. It lists four danger signs which indicate urgent referral if observed. The third page deals with the evaluation and treatment of newborns with an infection. It lists six danger signs, which if observed are medical emergencies required immediate referral.

EPI: The immunization component seeks to achieve 100% coverage of children under the age of 5 years for BCG (immunization against TB), DPT, anti-polio, anti-measles, and tetanus toxoid in pregnant women and women of fertile age (15-49 years).

The promoter protocol-guidelines have four pages relating to immunizations. One deals with the normal schedule of immunizations for children, including BCG, anti-polio, DPT, and anti-measles. The second page presents the schedule for children not immunized in conformity with the normal schedule. The third presents contraindications for immunizations, and possible adverse reactions. The fourth page presents the immunization schedule for tetanus toxoid for pregnant women and women of fertile age.

GMD: The growth monitoring and development component includes nutrition. Children should be weighed and their height measured at least once every two months during the first year of life, and children 1 to 4 years of age, should have 2 to 4 GMD visits per year. The promoter fills out the growth chart on the "Carnet del Niño" and discusses it with the mother (see Annex G-9). She/he also fill out copies for their own records. The "Carnet del Niño" also has space to record immunizations, and has a series of drawings to stimulate development of the child. The latter show in graphic form some of the actions a child should be able to perform at different ages, and simple activities mothers and caretakers can perform with children to stimulate psychomotor development.

COP: The community organization and participation component attempts to include the community in the processes of needs assessment and problem definition, planning, implementation, and evaluation. The specific objectives of this component are: 1. Introduce and integrate the NGO into the community environment. 2. Foment a critical appreciation of the situation of health in the

community. And, 3. Organize the community to participate in the project and to develop the capacity of self-determination in solving its problems and satisfying its needs and interests.

To accomplish this, the promoter assists the community in holding community assemblies to discuss the community health situation, progress in the project, and community needs. The following community work groups are organized: health committees, community councils, mothers' clubs, UROC (community oral rehydration units) and UAIRAC (community ARI care units), etc. The promoter also recruits individuals to function as health volunteers. These volunteers assist the promoter in various activities, which range from assisting in providing patient care, helping to staff the dispensaries, aiding in education and promotion, organizing fund raising, etc. The number of volunteers varies considerably among the communities and among the NGOs.

Another important area of community participation are group educational sessions, classes and talks on health subjects for the community. Along with this specific health campaigns are also organized. The health campaigns parallel campaigns organized by the MOH, or deal with particular problems of the communities.

QUALITY CONTROL

Quality control is an important aspect of modern medical care at all levels. It refers to the actions taken to make sure that the best possible services reach the client population in the most efficient and effective way feasible. For the PROSAMI NGO network, this means making sure that the services provided by the promoter adhere to the established standards, norms and protocols; and that services are provided opportunely, appropriately, and correctly. The mechanisms for quality control are the supervisory visits and monitoring reports. The supervision, as described previously, is performed by the PROSAMI technical advisors (who supervise the NGO technical staff and promoters) and the NGO technical staff (coordinators and supervisors who supervise the promoters). The monitoring reports include the promoter reports of community activities and persons attended, and NGO monthly and quarterly reports.

As stated previously, perhaps the most critical element of quality control is the supervision of the community promoters by the NGO technical supervisors. Close supervision (frequent visits) is important in this system where the primary providers have little formal training, and in many cases, little formal education in general. Well educated supervisors (such as physicians, nurses, maternal-child technicians, etc.) can compensate somewhat for the lack of educational depth in the promoters; and, it should be noted that constant constructive supervision is itself educational and contributes to developing the professional competence of the promoters.

It is important that the supervisory visits be regular and constant. The goal is approximately once a week, which many of the NGOs are fulfilling through an average of 3 to 4 individual promoter visits per month (once every 8 days), and one group session per month. All of the promoters asked indicated that they attended at least one group meeting per month with the rest of the NGO's promoters and the coordinator and supervisors. When asked how often their supervisor visited them per month, 122 promoters stated the following:

40.2% (45/122) visited them 3 to 4 times per month;
51.6% (63/122) visited them 1 to 2 times per month;

8.2% (10/122) visited them less than 1 time in 2 months.

The monthly group meetings are important for the promoters as it is a good opportunity to discuss successes and difficulties in common, and is a good forum for motivating them. Nevertheless, it should not be seen as a substitute for the community supervisory visits. It appears that a few of the NGOs believe that the purpose of the supervision is simply to gather information on the activities of the promoters. Therefore, they think that the group meetings accomplish essentially the same things as do the supervisory visits. This replicates the practice of the MOH, where the promoter supervisors are simply experienced promoters, and where the average frequency of visits is once in two months. As stated previously, the field supervisory visits are very important for quality control, and for the continuing education of the promoter, promoter motivation, and promoter credibility. Without doubt, this active and generally regular field supervision by well trained health professionals is one of the factors which contributes to the success achieved by the project in improving health in the rural communities they serve.

MEDICINES/MEDICATIONS

Another of the innovations introduced by PROSAMI was to train the community promoters to dispense certain medicines for specific maternal-child health situations. The pharmacopeia used by the promoters is limited, and the situations for which they are instructed to administer medicines is also limited and clearly defined. Medicines are used to treat "urgent" or serious problems, or the possible initiation of such problems. In general, medicines are used to control morbidities which commonly become mortalities. All medications are used under professional supervision.

The list of medicines provided to the promoters includes 23 items. All of the items are sold over-the-counter in El Salvador. In the US, 13 of the items are sold over-the-counter, and include vitamins and minerals (iron, prenatal vitamins, vitamin A), a topical antibiotic (bacitracin), an analgesic (acetaminophen) and 2 other symptomatics (aluminum acetate and chlorpheniramine-an antihistamine), ORS, antimycotic preparations (tolnoftate and two vaginal antimicotic creams), and condoms. The remaining 10 items are sold by prescription only in the US, and include 2 oral antibiotics (cotrimoxazole and amoxacillin), 1 ophthalmic antibiotic unguent (tetracycline), 2 bronchodilators (albuterol and salbuterol), 3 antiparasitic preparations (lindane lotion-against scabiosis, mebendazole-against intestinal worms, and metronidazole-against amoebas), and an oral contraceptive.

The PROSAMI NGO community health promoters do not abuse the use of medicines. Rather, their training and supervision by the NGOs, contribute to reducing abuse. It is widely recognized that there is widespread abuse of medicines and medications at all levels of society by health and non-health personnel. Self medication is rampant. Pharmacists and pharmacy clerks sell whatever is solicited, and recommend whatever medicine seems to be the "best-seller" at the moment. Neighborhood stores often sell medicines I did not observe the abuse of medicines by community promoters, nevertheless I did observe a tendency on the part of some promoters to do what virtually everyone else in this society does (including physicians): fulfill client expectations and prescribe a pill for whatever ailment presents.

Some of the remarkable results achieved by the PROSAMI NGOs in reducing infant mortality and ameliorating life-threatening morbidity is attributable to the strategies of active case detection and

simplified case management, including the utilization of antibiotics in certain situations. This is particularly true in regards to the treatment of suspected pneumonia. Incipient pneumonia is treated with cotrimoxazole or amoxicillin, and observed. Severe pneumonia or severe respiratory disease cases are given a dose of one of these antibiotics and immediately referred to a hospital or physician.

Becerra, in ANSAL-94 commented that this strategy was "very favorable showing that trained promoters are able to diagnose and distribute antibiotics correctly." He also stated: "We believe that integrated case management (prevention, early detection and case management) of this disease [ARI] by promoters has positive effects and can quickly reduce mortality."[29]

Becerra also indicated that the MOH presented two objections to this strategy: 1. It is not part of their current standards nor promoter training. And, 2. the MOH does not have the resources for frequent operational supervision of promoters and therefore cannot control possible excessive promoter prescription. Both of these objections have been successfully resolved by the PROSAMI NGOs: The community promoters receive training in the appropriate use of a few selected critical medicines and antibiotics; and, the promoters receive effective supervision by health professionals which includes the use of the medications mentioned.

Bossio, in a report on the PROSAMI ARI treatment strategy, said the following: "The ARI control activities carried out under the coordination of PROSAMI have contributed to the reduction in the mortality due to pneumonia in children under five years of age in the areas covered by the health promoters... The health promoters' early identification and treatment with antibiotics of many cases with signs of pneumonia resulted in many patients progressing well. An undetermined percentage of these cases were true pneumonia cases that, without the intervention of the health promoters, would have become more serious and even resulted in death, if treatment [antibiotic] had not been provided, or even if delayed treatment had been provided."[30]

CONCLUSIONS AND RECOMMENDATIONS

1. The PROSAMI NGO system of MHCS care is effective and efficient. The combination of training, positive supervision and frequent monitoring, coupled with community based health care delivered by promoters consisting active case detection, simplified case management, referrals, and preventive education and counseling are important elements in achieving good quality health care.

   Recommendation: Continue the current system within the PROSAMI network of NGOs. Promote the use of the PROSAMI NGO methodology by the MOH and other NGOs.

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29 Becerra: ANSAL-94: Situación Materno-Infantil, El Salvador. Pages 50-51.

30 Bossio: Evaluation of Activities to Control Acute Respiratory Diseases in Children under Five Years of Age in El Salvador. Page 1.

Expand the system to the rest of the rural cantones in El Salvador.

2. The supervision of the community promoters is an essential element of the health service delivery system. Most of the NGOs appear to be fulfilling the goal of providing supervision at least once every 8 days. Unfortunately, some NGOs are not. Before reducing the frequency of supervisory visits, the NGOs need to define minimal levels of capacity for promoter self-sufficiency.

   Recommendation: Enact measures to more actively enforce the regularity of frequent NGO supervision. Discuss the measures to be enacted with the NGOs at an assembly. The NGOs and the PROSAMI staff could offer suggestions, and the NGOs should arrive at a consensus on the measures to be enacted. One possibility might be to withhold funding provided to pay the technical coordinator and supervisors if they do not comply with the scheduled visits.

3 The PROSAMI NGO promoter protocol-guidelines are an excellent contribution to quality control and consistency of service delivery. The current guidelines are printed on plasticized sheets. As stated, this is a good instrument; but, like all good things, can be improved.

   Recommendation: Redesign and rewrite the promoter protocol-guidelines into a more readable format (e.g., using small and capital letters, not all capital; more colored letters and areas for emphasis and clarity, better layout, etc.). The guidelines should be organized into sections for each technical component.

4. While the promoters do not handle many medications, and studies have shown that the NGO promoters do not abuse the prescription of medicines, there is still much room for improving the use of medicines by promoters.

   Recommendation: Design and produce a brief, "pocket" manual for the use of medicines by the promoters, similar to the protocol-guidelines. The PROSAMI technical advisory staff and NGO technical staff members could work together to produce this. The manual should review the purpose of the medication, when to prescribe, dosage recommendations, and simplified instructions for patients.

   Recommendation: Design a review workshop for NGO technical staff and promoters on medication: what medicines do, when they should be used, complications and secondary effects, how to determine the correct dosage, the use of traditional or "natural" medicines, review of protocols, etc.

5. Health education is an important part of the PROSAMI health care system. Nevertheless, it has not received sufficient emphasis to date due to the immediate need to focus on survival issues pertaining to mothers and children. Now that the health care system is well established, more attention can be dedicated to health education. To assist in the health education efforts of the promoters, campaigns emphasizing one theme would also lend impetus and stimulation to promoter activities. Such a campaign could be organized in league with the MOH to be implemented throughout the country.

Recommendation: Organize health education campaigns focusing on one major theme and a minor theme, of two to three months duration each, with radio spots to complement promoter talks, classes and individual efforts. The campaigns could be timed to precede the epidemiological peaks of community health problems. They could be launched every two to three months with special workshops to teach basic messages and supporting information. The workshops could be taught by the NGO technical team after the latter receives a training from PROSAMI.

VI. B. EFFECTIVENESS

5. COST EFFECTIVENESS ANALYSIS

Total cost of PROSAMI project, and comparison with cost of other services (MOH and one non-USAID NGO).

FINDINGS

Table 24, "Total Cost Comparison and Cost per Attention: MOH, PROSAMI, and FUSAL, 1993," is a summary of the total costs for Ministry of Health, PROSAMI, and FUSAL. A more detailed table as well as an explanation of how calculations were derived is found in Annex H-1.

Per capita allocation per target population. First it is useful to look at the amount of money assigned per target group - the per capita allocation per target population (see Table 25). In this case, the per capita allocations per target group by PROSAMI appears to be more than both the MOH and FUSAL. There can be many reasons for this. It may be that the respective populations served need more care because they are just starting, or the mortality and morbidity rates are higher. It may be that the amount of medical attention provided is more extensive. Or it may be that one organization is providing care in a more effective and efficient manner. It is most likely that it is a combination of all these factors. Also, the array of services provided by PROSAMI and FUSAL are greater than those provided by the MOH. In addition, FUSAL and some PROSAMI NGOs are providing both adult and maternal and child care as well as working on other programs such as ecology improvements. Even when these factors are taken into account, the differences of money budgeted per capita among the three organizations appears to be significant - ¢ 53.82 for the MOH, ¢ 69.41 for PROSAMI, and ¢ 41.74 for FUSAL (see Table 25). Hence PROSAMI is allocating 22% more per capita target population than the MOH, and nearly 40% more than FUSAL.

Cost per health care promoter. In the case of the MOH and PROSAMI, the promoters are the ones providing direct patient care. It is relatively easy to measure their productivity when only considering number of attentions they provide, but this does not take into account all the other activities in preventive care and community relations. For example, in addition to attending children and mothers for pre- and post-natal care, diarrheal illness, respiratory infections, and growth and development, they are also giving classes in health education, building latrines, organizing community groups, participating in vaccine campaigns, and a host of other activities. The MOH and PROSAMI do not have a rigidly established standard that says the health care promoters have to distribute their time to each type of activity. There are productivity targets, but these may differ between each community. Therefore, if one wants to take into account the cost of all of these activities, it is useful to look at the cost per promoter.

TABLA 24
COMPARACION DE COSTO TOTAL Y COSTO POR ATENCION
MSPAS, PROSAMI Y FUSAL 1993

	MSPAS		PROSAMI		FUSAL	
	NUM.	COSTO	NUM.	COSTO	NUM.	COSTO
MSPAS Regiones de la División de Salud Comunitaria / ONG's						
Médico / Ejecutivo (20%MSPAS/30%ONG)	1		35		1	
Enfermera (20% MSPAS)	1				1	
Trabajadores Sociales	0		1		1	
Coordinador Técnico / Supervisor	9		42		1	
Administrador	0		24			
Supervisores	180		89			
Contadores	12		40			
Nutricionista			3			
Ingreso de Datos	7					
Promotores	1442		460		10	
Mecánicos	6					
Personal Pagado por Contrapartida				4,727,471		
Sub Total Personal	1,658	52,531,824	694	20,510,975	14	171,600
Provisiones y Equipo		4,045,912		7,125,121		80,875
Costos Administrativos(Of. Central)						30,000
Otros no-personal		2,251,108		3,943,496		134,974
MSPAS División de Salud comunitaria Nivel Central.						
Costos Administrativos		17,935,390				
Personal de la Central	19	702,975				
MSPAS Apoyo Central		19,413,519				
Sub total MSPAS/ ONG	1,677	96,880,728	694	31,579,565	14	417,449
Costos Externos TA						
Costos Administrativos MSCI				819,372		
Personal de la Central MSCI			35	7,249,036		
Costos Central No-Personal MSCI				1,890,881		
Asistencia Técnica APSISA		455,500				
TOTAL COSTOS	1,677	97,336,228	729	41,538,855	14	471,449
Desgloce de Costos Unitarios						
Costo Total por Promotor		67,501		90,302		41,745
MSPAS/ONG Costo por Promotor		67,185		68,651		41,745
Número de Atenciones 1993				**		
(IRA, EDA, SR, CYD, Adultos)		513,615		344,013		NA
Costo Total Por Atención		190		121		NA
Población Objetivo	1,800,000		454,985		10,000	
Costo Regional MSPAS/ONG por Población Objetivo		53.82		69.41		41.74
MSPAS/ONG Costo por Atención		189		92*		NA

* Este promedio incluye 17 ONG's de la Ronda 3 que están iniciando implementación del programa.
El Costo/Atención promedio para las ONG's de las Rondas 1 y 2 , incluyendo la donación de contraparte es aproximadamente 59.8

**292 Promotores quienes prestan atenciones del programa (de las ONG's de las rondas 1 y 2).
163 Promotores en capacitación, quienes prestan atenciones limitadas (de las ONG's de la Ronda 3).

Table 25. COST PER POPULATION, PROMOTER, AND PROMOTER VISITS (Amounts indicated in ¢, "colones")			
UNIT	MINISTRY OF HEALTH	PROSAMI	FUSAL
Target Population per Promoter	1,248	909	1000
Per capita allocation per Target Population	53.82	69.41	41.74
Regional/NGO Cost per Promoter	67,185	68,651	41,749
Regional/ NGO Cost per Promoter Visit	152	92	NA

In Table 25, the cost per MOH promoter includes the direct cost of the promoter, the cost of the Community Health Department, and 33% added to this for overhead (maintenance, housekeeping, payroll and finance, central level technical support such as epidemiology and family planning, etc). The PROSAMI NGO cost includes all costs at the NGO level including both PROSAMI and counterpart funds (PROSAMI field and home office costs are not included. This MOH and PROSAMI cost per promoter is in effect the cost of what it takes to run and operate a health care promoter program if it were not assisted by USAID (APSISA central office and PROSAMI home and field office funds respectively).

Hence, if APSISA or PROSAMI projects were ended, and the MOH and NGOs continued the health care program, the cost per promoter would be ¢ 67,186 for the MOH, ¢ 68,651 for PROSAMI, and ¢ 41,749 for FUSAL. The MOH is nearly the same as the cost of the PROSAMI promoter, while FUSAL is 61% of the PROSAMI cost. Again, one should consider the services provided and accessibility when considering cost effectiveness.

Cost per promoter visit: Of equal importance is to look at the cost per "service delivery unit", or cost per promoter attention. The final output is not the service population or number of promoters, but the number of promoter attentions (visits) received by the target population. This does not include other preventive and community activities. When comparing the MOH and PROSAMI, the data was fairly straightforward. The total "attentions" provided by the promoters included acute respiratory infections (IRA), diarrheal illness (EDA), reproductive health (SR), perinatal and neonatal health (PNH), and growth and development (CYD) as well as miscellaneous adult visits. When one looks at the NGO cost of the PROSAMI promoter in comparison to the regional cost of the MOH promoter, PROSAMI is delivering the most inexpensive output at ¢92.00 per promoter attention versus ¢189.00 for the MOH. The PROSAMI cost per promoter attention is 49% of the MOH cost per attention. In 1993, the first and second round NGOs of PROSAMI were fully operational in terms of implementing the primary health care/promoter program while the third round NGOs were not, as they were still in training. Thus, when one only looks at the first and second round NGOs of PROSAMI, the cost per promoter visit is even lower. The cost is

31% of the MOH cost or approximately ¢59.80 per attention. PROSAMI expects to have the cost of this service delivery even further decreased for some of the round one NGOs, but in any case it is appreciably lower than the MOH, and probably lower than FUSAL since their promoters are only working part time and are voluntary.

It is important to note that without the number of attentions provided by FUSAL, it is not possible to make any conclusions about their particular cost effectiveness at this time. It is clear from the above data that FUSAL has less per capita money to allocate to the target population, and the cost per provider is proportionately less as a result. However, the question of how effective is the use of volunteer providers needs to be assessed once productivity figures are attained. PROSAMI, for example, had one NGO that was using volunteers, but it had the lowest productivity of any of the NGOs within its round (ASAPROSAR was averaging 411 visits per year per promoter, half the average of round one which was 960.78 visits per year). With the encouragement of PROSAMI technical assistance, ASAPROSAR agreed to pay the volunteers on a trial basis, and their annual productivity increased five-fold to 2,206 visits per promoter for the first six months of 1994 - twice the average of the same NGOs in round one.

Other PROSAMI costs: Other issues to examine are the cost of the project inputs: technical assistance, training and supplies, and financial support. This helps to further explain the PROSAMI costs per promoter and cost per capita target population. Concerning technical assistance relative to both home office and field officer support, this cost has been decreasing significantly since the inception of this project. Table 26 on the following page illustrates how each year a significantly higher proportion of money goes directly to the NGOs, and less is spent at the field and home office level.

The cost of technical and administrative support can be analyzed as a percentage of total personnel costs. The number of administrative and technical support staff per promoter at the NGO level is significantly high. The Table in Annex H-1, titled "NGO Cost Efficiency Analysis" illustrates that administrative and technical personnel account for an average of no less than 79% of the total personnel costs. Or, there are approximately 1 technical and administrative persons for every 2 promoters (each PROSAMI technical supervisor oversees five promoters). From a technical standpoint this may be justifiable as NGOs are just starting out, but in the long run this will prove unsustainable financially. Ways in which the efficiencies among the NGOs might be improved will be discussed in the final section which compares the 35 NGO efficiencies.

In summary, PROSAMI is allocating more money per capita target population, and providing a significantly higher number of attentions per promoter which accounts for the lower cost per promoter attention. As previously mentioned, the cost per attention for the MOH at the regional and NGO level is 152 colones for the MOH and only 86 colones for PROSAMI. It is therefore important to note that although the cost per promoter of PROSAMI is higher, the actual cost per service delivery as defined as cost per attention is significantly less.

Table 26 PROSAMI Home and Field Office Expenses: Cost and Trend Analysis PROSAMI MTE 1994					
ITEM	1990	1991	1992	1993	1994
MSCI HOME EXPENSES	$61926	$101141	$91541	$100661	$201322
MSCI FIELD OFFICE					
Training	7406	111789	239156	417691	835382
Technical Assistance	177683	421070	487598	635595	1271190
Commodities	0	186194	167720	69222	138444
Less 90% for NGO	0	-167575	-150948	-62300	-124600
Personnel	22124	89754	171680	254952	509904
Program Administration	73093	125632	118879	118603	237206
Audit	0	25370	52491	113693	227386
Less 70% for NGO	0	-17759	-36744	-79585	-159170
TOTAL MSCI HOME/FIELD OFFICE	342232	875616	1141373	1568532	3137064
NGO EXPENSES	0	15235	1287488	2990588	5981176
Commodities / Warehouse	0	167575	150948	62300	124600
NGO Audits	0	17759	36744	70585	159170
TOTAL NGO EXPENSES	0	200569	1475180	3132473	6264946
TOTAL PROSAMI	342232	1076185	2616553	4701005	9402010
HOME + FIELD / TOTAL	100%	81%	44%	33%	33%
	8.03	10.95	8.14	9.23	9.11

CONCLUSIONS AND RECOMMENDATIONS

PROSAMI was initially designed to provide urgently needed primary care to areas of high mortality, morbidity, marginalization, and high conflict. The areas that are served also have some of the highest levels of illiteracy in the country. Starting a program of even basic primary care requires more resources than normal - particularly at the training and supervisory levels. In addition to having to start many projects in areas with absolutely no infrastructure, basic administrative system such as a set of accounting books often had to be started for the first time. Both the technical and administrative systems have evolved in a remarkably short time to a level that will undoubtedly be sustainable in the long term.

The PROSAMI costs appear higher than the MOH per capita, but are approximately the same per promoter; and, in actuality, are lower in terms of productivity and services provided. Just the same, PROSAMI is still exploring ways to provide services with even greater efficiency, and this evaluation is therefore particularly opportune in the sense that PROSAMI is now at the juncture where it has no less than 35 NGOs on board, and can begin to devote more emphasis on quality of care, sustainability, and greater affordability.

Specific recommendations concerning costs include the following (not in order of importance):

a. As a result of project strengthening nearly half of the NGOs visited have evolved from a hand written set of accounting books into a sophisticated computerized accounting system. These systems were independently developed through the contracting of private computer programmers with expertise in accounting. Each NGO appears to have a different accounting system. Although all the NGOs are using the same policy and procedure manual for the PROSAMI project, It is recommended that PROSAMI establish a working group of NGOs to develop one standard computerized accounting system that can be applied to all project NGOs. The practicality of implementing the system in regards to the relative institutional development of each NGO also needs to be studied and taken into account.

More important, PROSAMI should consider having the NGOs develop any number of management programs that could not only serve the consortium of NGOs, but also provide another potential revenue source to develop a financial reserve for the NGO consortium.

b. The evolution of management systems such as computerized accounting, inventory, and patient statistics systems, should serve to reduce the time necessary to complete certain management tasks. It is therefore recommended that the current administrative and technical staff be reviewed at both the field office and NGO levels to see if job descriptions and responsibilities maximally utilize the current availability of employee time.

c. It was found that PROSAMI did not have an annual administrative budget at the field office level. It is recommended that an administrative budget be established no later than calendar year 1995, and monitored by both the PROSAMI Chief of Party and Deputy Director.

d. There appears to be a wealth of financial and technical information available at the field office, but it would be more useful to better integrate these two sources of information. The major part of the information obtained for this report was available in one form or another, but some of it took weeks to aggregate in a form that looked at the financial aspects of technical operations. For example, the financial advisors write reports that are not shared with the technical advisors and vice versa. Both technical and financial advisors need to become better "managers" and work with both technical and financial data. The technical advisors can say whether or not a particular NGO is on track as far as projected activities, but do not know specifically if the NGO is over or under budget in accomplishing these activities. The technical advisors in particular should take an increasing role in monitoring the financial status of each NGO under their responsibility. This will help all the technical staff to understand better how to become more sustainable through a combination of actions which continually maintain high standards of quality of care while providing services in the most economically viable manner.

e. The management policies and procedures for the NGOs have been well developed by PROSAMI. Some of these policies have been modified during the course of the project, however, and this has caused some problems at the NGO level. There may not be the need for enacting any more policies that require procedural changes, but if there are, they should be implemented in a prospective manner and not require retroactive changes of more than a couple of months.

f. The Project currently implements monthly financial, technical, and commodities control systems, which grades the NGOs on a set of indicators from A-D. This financial classification of the NGOs

is an excellent lesson learned as to how to keep track of individual NGO performance and compare NGOs on a regular basis. This system should continue to be used throughout the life of the PROSAMI project, and it should be shared with both the technical and NGO staff. Although the NGOs receive a monthly notice as to how they have financially performed, they do not receive the letter classification from "A to D" which tangibly grades their financial performance. It is recommended that this classification of "A to D" not only be shared with the NGOs, but also "among the NGOs" themselves. This form of peer review can be quite effective in inducing the NGOs to attain a minimum standard of productivity.

g. The training resources in the NGO budgets are for promoter training and community level education. Each NGO determines how much to budget for each area. Resources for community education should continue at similar levels and probably should increase from one year to another. The first round NGOs may be at the stage where they require less training of the promoters from the technical staff, and could perhaps require a lower percentage of training resources than the round two and three NGOs for promoter training. These funds should be applied to community education needs. However, a number of NGOs interviewed expressed a desire to provide "incentive programs" to those first and second round NGOs who can continually meet high classification standards in patient care delivery and promoter training which would enable them to use some of the training funds for either more direct patient care activities or financially generating activities.

FINDINGS RELATED TO FINANCIAL SUSTAINABILITY : Cost Recovery, Other Sources of Income, and Community Participation and Management of Funds

Using some of the indicators of sustainability included in the CDIE scale as well as the Management Development Assessment Tool developed by Management Sciences for Health and Pathfinder International, the findings include not only the assessment of cost recovery, but also indicate: (a) what the NGOs are either planning or currently doing to become more financially sustainable; and (b) how the NGO Boards of Directors (BOD) and community boards serve to help long-term financial sustainability. Findings are based on the 8 on-site interviews as well as interviews with five additional NGO Executive Directors and Accountants.

A.1 Current cost recovery situation: client based fees

The following data collected on cost recovery from client based fees is based on the site visits of the 8 NGOs.

From the perspective of cost recovery based only on patient charges, the NGOs in general are experiencing a weak potential for financial sustainability. Of the 8 NGOs visited, 6 charged for services, but only three could estimate what percent of the patients were paying for services, and only two could estimate how much the communities were collecting from patient charges. Although some of the NGOs said that the supervisors of the promoters knew what was being collected, the information was not readily available at the NGO level - in other words they did not know for sure. The three NGOs that could estimate what the patients were charging indicated that the percent of patients that paid varied from a low of 5-10% to a high of 80%. As previously mentioned, the charge per patient ranged from 3 colones to 10 colones, with some NGOs charging an additional amount for the direct purchase cost of medicines.

Of interest to note is that the NGO visited that charged the most, also had one of the highest percentage rates of patients paying. FUNDESO indicated that they charged 3 to 10 colones for a visit or consult, and the cost or partial cost of medicines. They had an explicit written policy for charging patients, and also budgeted a target of 40,000 colones that each community had to reach by 1996.

As previously mentioned, in addition to the 8 site visits, a focal group was held with executive directors and accountants of five other NGOs participating in the PROSAMI project. During this interview with five other NGOs, one of the other NGOs, ASAPROSAR, mentioned that they have established four rural health posts where they are succeeding in charging for services. They insist that all patients pay for services, whether they are in cash, or "in kind". For example, patients who can not pay cash must agree to some other form of payment. It can be in the form of a donation of supplies to the center, or in the form of donated time. Unless it is an emergency, the patient will only be seen if they agree to some form of payment. One innovative idea of this NGO is that they own land where they cultivate soya and other products. One form of an in-kind payment is for the individual to work an agreed number of hours in this field. They did not mention how many patients were turned away for not paying in one form or another, but they did not think the number was significant.

After the 8 site visits and interview with five other NGOs, it is clear that the maximum charge at this time is 10 colones plus some charge for the purchase cost of medicines. When both the community members, health care promoters, and NGO staff were asked what the maximum potential is that could be charged, almost no one said it could be more than 15 colones. The maximum fee obviously depends on the level of income of the particular area, yet this is probably a good estimate for the majority of NGOS since it is higher that the MOH physician fee of 3 colones, and lower than the private physician fee of between 25-60 colones (this private physician fee was what was reported by the NGOs when asked what was the charge of the nearest physician to their community post).

It seems clear that if community people want good and adequate health services, they will have to make efforts to establish and sustain them. It probably will not be financially feasible for needy populations to pay all of the costs involved, but they should accept the responsibility to pay or compensate a significant portion of the costs. The government, the civil sector, or private business could subsidize part of the costs, and probably would be willing to do so if the beneficiary population assumed responsibility for a significant portion of the costs in accord with real possibilities to pay or compensate (money, species or labor). Ultimately, the community, with the assistance of other socially conscientious institutions and organizations, should take charge of fulfilling its needs and achieving its own socioeconomic development.

A.2 Analysis of Financial Sustainability.

In order to analyze the potential financial sustainability of an NGO after the PROSAMI project, it is useful to calculate the expenses of a typical NGO model that is now being operated, and then determine the "break even number" of patients that would be necessary to support the model. For this exercise, the fee will be set at 10 colones, the maximum average that the NGOs felt could be charged without losing a significant number of patients. This model will be one that uses 10 promoters (the average is 13) and the costs will be as follows:

Table 27. HYPOTHETICAL MODEL NGO PROSAMI MTE, 1994	
Item/Position*	**Annual Cost (colones)**
Executive Director (30%)	30,000
Administrator	57.600
Accountant	43,200
Promoters (10)	129,300
Program Administration	22000
Training	307,600
Counterpart paid Staff	30,000
TOTAL	620,000

*Many of the executive directors also are running other projects, so the average annual amount paid by PROSAMI was used with the assumption that the director only is charging for 30% of his/her time. Program administration includes non-personnel costs such as insurance, office supplies, etc. Training includes both the cost of the PROSAMI training personnel as well as costs of training programs such as viaticos, supplies, rental of conference rooms, etc. Counterpart paid staff are those individuals such as secretaries and warehouse personnel who support the project but are paid from funds other than from PROSAMI.

At 10 colones per attention, this model would require 62,000 paid attentions a year. If one uses an NGO from the first round with 10 promoters, the average estimate of attentions per year is 14000 for 10 promoters. This would indicate a financial sustainability level from client based cost recovery or fee for service of 22.5% (140000 colones collected divided by the total NGO cost of 620,000).

Another way of looking at this is to compare this with the annual goals established for the promoters. It assumes that each promoter will see 4000 attentions per year. If this were the case, the number of visits for the 10 promoters would be 40,000. Not all the patients would be able to pay the 10 colones, so for the purpose of this exercise, it will be assumed that 75% of the patients pay an average of 10 colones. The revenue generated for 40,000 attentions with 75% paying would therefore be c. 300,000. This would mean that this hypothetical NGO would be 65% financially sustainable from patient charges.

Unfortunately, after interviews with both PROSAMI and NGO staff, it is clear that although 4000 visits per year is a national standard, it is not realistic when distances to travel as well as other work responsibilities are taken into account. A more realistic productivity expectation is probably around 2,500 visits per year, with 75% of the patients paying an average of 10 colones. This would translate to a revenue projection for 10 promoters of c. 187,500 per year, or 30% sustainability. Another way of looking at it is to take this number of annual visits (25,000) and ask what would have to be charged In order to break even from patient charges. In this example,

the fee would have to be 24.8 or 25 colones per attention (620,000 divided by 25,000 attentions) - clearly more than most rural poor could afford.

It is important to realize, however, that there virtually is no health organization in any country that is 100% sustainable from patient care (client based) fees. Health organizations throughout the world are subsidized either through third party insurance (medical insurance), taxes (government subsidies), private donations, social insurance, company contributions, or a combination of all of these methods. A typical hospital in the United States, for example, relies on average from third party private insurance (sometimes 40%), government subsidation in the form of Medicaid and Medicare (sometimes 45%), bad debts (10%), and only 5% from actual patient payments. This of course varies considerably for each hospital, but the point is that few if any hospitals in any country survive on patient fees - the majority rely on some form of government subsidation and/or private third-party insurance.

RECOMMENDATIONS

1. Improve Cost Recovery

Although it is not likely that current NGO costs are able to be sustainable solely through patient care fees in a significant manner, the current support from patients can and should be improved. Lessons can be learned from the three (and probably more) of the 8 NGOs visited that have a strong and well defined cost recovery program. Some of the requisites for a sound cost recovery program include:

> Start with the community and explain to them that the PROSAMI project funding is not indefinite, and ask the community if they feel it is important enough to them for the promoter to continue in their community. The first step is to establish a community understanding and then translate this into a commitment to sustain the program or a portion of the program in their community.
>
> Continue to let the community become the "owners" of the program. Unless the community feels that they have some control into the direction of the project, they will always feel it is "someone else's" problem.
>
> Work with the promoters and the community to determine a minimum charge. This charge needs to be balanced against the needs of the community, but the reality is that if the NGO health programs are to continue after USAID funding, then the communities which demonstrate a commitment may be the only ones who will eventually receive the promoter services in the long run. As already pointed out by a couple of the NGOs, community commitment does not have to mean a cash payment, but it does have to be translated into something that truly supports the sustainability of the program.
>
> Set financial goals for the health care promoters. The health care promoters also have to share in the responsibility of their sustainability. This begins with delivering a satisfactory "product" to the community members. An incentive or personnel evaluation system that makes the promoter realize that a significant portion of their salary depends on patient fees

is important. The incentive system should be carefully thought out so that a standard proportion of preventive versus curative care is maintained, medications are not included, and ceilings on number of patients visited are set.

The patient fees are not something that should be considered as an increase to their salary unless it is a calculated portion of their salary. Starting the next year by telling them that their raise will be from patient fees, having them pay for their uniforms, viaticos, or transportation are some ways to do this. There are a number of such employee incentive programs that are used throughout the world. The PROSALUD program in Bolivia, for example, utilizes an incentive system that takes into account number of curative and preventive visits to be provided, and rewards all staff, not just the providers, for increasing patient revenues while maintaining high quality care.

A written policy on how much the patients will be charged, for what type of services, how it will be collected and accounted, and then how it will be used is critical. This policy should be established jointly with the community members, the NGO staff, and eventually approved by the NGO board of directors. This policy, combined with a budget projection of expenses and revenues, needs to be shared with all committed members at least on a quarterly basis.

Equally important, this community budget should also include revenue projections from other community donations in cash or in kind. If the program is going to be financially sustainable in any significant manner, one has to address the dichotomy of meeting patient "demand" versus patient "need". The fact is that there are more communities which need health care attention than programs such as PROSAMI and the Ministry of Health can provide assistance. Therefore, hard decisions have to be made when resources can not meet all the health care needs of a country. Communities which demonstrate a willingness to support programs such as PROSAMI and share in the responsibility of the program may have to be chosen over communities who are not willing or ready to actively participate.

2. Review current project costs, "mix" of services provided, and job descriptions.

Although PROSAMI services are more cost efficient than the MOH, it is clear that costs and expenses are still an important issue, especially in terms of sustainability and accessibility. The current organizational structure and associated expenses were considered necessary at the initiation of the project since the key objective was to get health care services out to the communities as quickly as possible. Now that the project has been underway for over two and a half years for some NGOs, it is probably timely to concentrate simultaneously on revenue increases and cost decreases that do not affect the quality of care. ***These cost decreases should be reviewed at both the PROSAMI field office level as well as the NGO level. After two and a half years of operation, technical assistance from the field office should become refocussed on cost recovery, community participation, prevention and the maintenance of quality care.***

In the case of the NGOs, the average number of administrative and technical staff per promoter is approximately 1 administrative/technical person to every two promoters. This is high no matter how you evaluate it. It is recommended that the staff number and mix take into account the

following questions in order to reduce costs and achieve continued high productivity of supervisory, administrative, and provider staff. It is understood that staff reductions may not be appropriate for implementation as soon as 1995, however, it is appropriate to consider changing some of the staff responsibilities at this time. Some of the questions to assist with this review include:

Are administrative and management personnel used efficiently? Have NGOs analyzed the real time their personnel dedicate to the primary health care program and promoters? Have the NGOs analyzed the question of employee turnover? How does turnover affect program efficiency and effectiveness? Is it necessary to have an executive director, administrator, and coordinator running the program and promoters? After two years of operation, can it be done with fewer people?

Is it necessary to have a full time accountant and administrator for the administrative and accounting details? Several NGOs are already operating with either one person or are hiring a private company to manage their accounts.

For NGOs that are from the first and second round, does it still make sense for the supervisors and medical staff at both the NGO as well as the field office level to provide only training and supervision? If the fact is that many PROSAMI physicians and nurses are already informally providing patient attentions, should they not consider formalizing this by having scheduled patient consults and charging for them? If financial sustainability is truly important for this project, this will eventually be a requisite if the number of supervisors and medical staff are to be supported after 1996. Also, continuity of care versus referring patients to other facilities is usually preferable, and more marketable, to patients willing to pay.

Would a mix of trained TBAs and promoters generating fees merit consideration from both a medical and financial standpoint? A number of NGOs already indicated how they are working more closely with TBAs. The average TBA charges between 50 and 90 colones for each delivery. Should they be considered to be part of the NGO staff?

The use of nurses or maternal-child health technicians to provide backup to the promoters as well as provide patient visits was also mentioned as a long-term alternative for financial viability by a few of the NGOs.

Given the importance of community support, do PROSAMI field office and NGO staff have specific financial targets to improve community support? For example, a number of the community boards visited appeared to be involved with the project, but not financially committed to the project. Even though several community boards were not willing to personally contribute to the health care promoter program, all of the community boards agreed with charging for patient visits - so why is the charge system not implemented? Is one or more of the NGO PROSAMI staff specifically assigned with addressing and improving this situation? The PROSAMI field office technical and financial staff should now be at the stage where they can devote an increasing level of technical assistance to community and program sustainability.

Can the number of monitoring and administrative forms be decreased so that the NGO administrative and supervisory time can also be reduced or reallocated?

B. Other Sources of Income

When specifically asked about whether or not they have any activities or plans for financial sustainability once the PROSAMI support ends, it was clear that a number of the NGOs had very definite and excellent plans for what they were going to do once PROSAMI funding ended, and several had already undertaken activities in order to reduce their financial dependence upon PROSAMI funding. The recommendations/activities presented by the NGOs are divided in two categories. Category 1 reflects activities and plans which are considered highly sustainable over the long run or are considered innovative ideas that merit further exploration and testing; and Category 2 represents activities which are not considered sustainable in the long run or may possibly result in a "negative sustainability" over the long run. "Negative sustainability" is here defined as any activity or plan which may either lead to an increased dependence on USAID/PROSAMI funding, or may serve as a deterrent for exploring more viable and long-term alternatives to becoming financially sustainable.

Category 1:

1. Cost recovery from services provided. As previously mentioned, some of the NGOs visited are currently changing a fee for service, and this needs to be further developed for all of the NGOs. FUNDEMUN, ASAPROSAR, and FUNDESO are examples of NGOs that illustrate how to generate and manage funds generated at the community levels.

2. Reduce current PROSAMI expenses at the NGO level. Only four of the eight NGOs felt that they would continue with the existing number of PROSAMI staff once the project ended. The majority felt that they would have to either change the composition of the staff, reduce the staff, or both. The site visits and interviews therefore reinforced the need to look at staff numbers, mix and job descriptions at this time. PROCADES has other health care projects where lessons could be learned as to how to efficiently use limited staff resources.

3. Solicit government or other donor funding subsidies for the percentage of cost not covered from client fees. Many NGOs are currently receiving funding from both national and international companies. Agape and Knapp are examples of large, multi-funded projects. Concerning international funding, the NGOs believe that:

- there will be more competition for international funds.
- those NGOs that are most efficient and/or have a demonstrated track record in developing sustainable projects will have the greatest chance of competing for these funds.
- many new funds will be using the government as an intermediary (IDB, World Bank)

Some NGOs felt that national funding (FIS) might be increasing since it appeared that government decentralization was making more money available at the municipality level. In addition, national monies are still available for construction such as health centers.

4. Start mini-companies or small businesses. A number of the NGOs interviewed such as OEF, Knapp and Agape are either teaching women and families how to start their own business, or they are running a business themselves to provide a source of income to cover administrative costs of other projects which need subsidizing. A "*micro-empresa*" is a family or one-person enterprise where people normally work at home and sell their products on a contract basis. For example, articles of clothing might be contracted out by a larger company to these *micro empresas* . One of the NGOs, is considering using the *micro-empresa* as a means of starting a *micro-empresa* with a small amount of capital, and then growing to a larger company over time.

Two of the NGOs interviewed, Agape and Knapp, are actually running one or more businesses and factories. These businesses and factories usually started with some donation at least ten years ago, and include clothing factories, machine factories, a large restaurant, and a radio station. The radio station also has had the added advantage of being able to provide health care education such as announcing vaccination campaigns. The amount of surplus funds generated by these businesses was not made available, but it is clear that enough is generated that it can at least help to subsidize other programs by paying for supplies, medications, and administrative support.

5. Agriculture production. At least four of the NGOs have invested or received donated land, and are growing products such as soya and coffee. Knapp, which started with a donation the equivalent of $10,000 25 years ago, now has over 300 acres of coffee plantations.

6. Pre-payment or insurance. ADHU is starting a pre-paid model for providing care to its target population of 10,000 people. Their hope is to enroll 3000 families, and provide basic care which includes primary care visits and medications with the health care promoter, health education and home visits, and a limited life insurance policy. They are also hoping to receive some national funding as well as from the International Development Bank (IDB) to build small clinics to be made available to the subscribers.

7. Provide consulting expertise. At least two of the NGOs interviewed, OEF and ASAPROSAR, are providing consulting help in the form of paid classes and individual consulting. The classes they are teaching include formation of *micro-empresas* and development of community boards of directors. Both appear to be active in providing consulting work involving capital enterprise. As the NGOs continue to grow, this may be an increasing source of income, both nationally and internationally.

8. Sell technical products. Two of the NGOs interviewed, mentioned the fact that they paid to have an accounting, inventory, and payroll system designed, and are considering printing a manual and selling the system. It basically is another form of consulting for "lessons learned" and expertise gained through their NGO and PROSAMI activities.

Category 2:

1. Wait for the Ministry of Health to absorb the health care promoters. Although one of the plans is for the Ministry of Health to incorporate some of the NGO health care promoters into their program once the PROSAMI project ends, it appears risky to count on this as the only means of

potential income for sustainability. Counting on this as the sole source of potential income also tends to lower NGO motivation to search for other options for sustainability.

2. Provide added income to the health care promoters through patient care cost recovery. Two of the NGOs interviewed, ASALDI and FUNDEMUN, have provided individual bank accounts to their health care promoters, and allowed them to keep the money generated from patient charges as an additional source of income when the project ends. This will be discussed further in the cost recovery section. However, it should be mentioned that this incentive system can potentially provide a disincentive to the promoter since it potentially abrogates them from other responsibilities of providing health to their community. FUNDEMUN found this to be the case, and dropped this form of payment to the promoters.

RECOMMENDATIONS

In preparing and competing for donor or government funding, the NGO should keep in mind that efficient and sustainable operations will probably increase their chances for receiving funds. The size of the operating budget will probably not be as important as the ability to demonstrate results that fully utilize the NGO resources in an efficient and effective manner. In addition, to receive funding, it is usually a requirement that an NGO be constituted as a legal entity. MSCI/PROSAMI should continue to assist the NGOs with this.

Starting a business can be risky, and should be well thought out. Before investing money, the creation of a "business plan" is critical. One must assess what the potential demand (quantity and market price) of the service to be provided might be, what is the competition, what will the total production costs be, what is the minimum level of sales necessary to generate a surplus, and what amount of start up capital is required. The time factor is also important. Some of the ventures considered did not project any operating surplus for at least five years or more, whereas others required several million colones to start.

Several of the NGOs appeared to have considerable experience in starting a business. Those that had this experience, also said that one other key ingredient to successfully generating a profit is that one has to take a "hard view" of the operations, and only undertake endeavors that have the greatest probability of making money sufficient enough to support other deficit operating programs.

Pre-payment or health insurance. This must be considered analogous to starting a new business. There is risk involved, and a business plan is equally important for this activity. Assessing the demand and associated costs can be more difficult, since it involves probabilities of both morbidity and mortality. In addition to a business plan, start-up capital is required to: (1) provide sufficient marketing and promotion to reach the minimum break-even number of subscribers; (2) perform the necessary actuarial calculations to assess demand for services offered; (3) pay for the health care, administrative, and billing staff; (4) educating new members what services will and will not be provided; and last but not least, (5) provide a sufficient "buffer" for worse case probabilities of demand for services.

In addition to the above criteria for a successful pre-paid or insurance plan, the following considerations are suggested to increase the chances of success:

- Consider co-insuring or sharing risk with an establish insurance company. This is particularly useful for "catastrophic illnesses". There may be some insurance companies who are willing to provide coverage for certain more costly services for an annual fee.
- Consider using deductibles or co-payments. This is particularly important for groups of people of lower education. It is difficult to understand that a subscription does not mean that they are entitled to unlimited services. The easiest way to control this is through co-payments such as a minimum fee payable for receiving any service, or a deductible such as payment of a certain percentage for medications.
- Consider subscribing established groups such as cooperatives or companies.
- Consider providing services to a mix of groups so not all of the subscribers belong to low-income sectors.

Provide money for trial programs in financial sustainability. Some of the NGOs working with the PROSAMI project have a demonstrated track record in developing means for providing various sources of income. This experience needs to be expanded not only within the same NGOs that are well established, but also to those NGOs that have not had much experience in receiving funds other than those from the PROSAMI project. It is therefore recommended that PROSAMI and the NGOs work with USAID to explore a mechanism that could "dedicate" a certain portion of the funds of the current project (or possibly from another USAID source such as the public initiative project) and provide start-up money or venture capital for NGOs that wish to experiment with well thought out funding projects. For example, providing an NGO with funds to start up a pharmacy with a rotating fund, or conducting a marketing analysis for starting a pre-paid program might be two examples. Perhaps the NGOs could "bid" for this money using certain established selection criteria based on both the NGOs business proposal and their need to create other funding sources. This type of "operations research" would have the dual advantage of both providing the NGO with another potential income source once the PROSAMI project is completed as well as providing a means to test the feasibility of certain funding sources whose lessons learned could be used by other NGOs.

C. Use of NGO Boards of Directors and Community Boards to assist with financial management and sustainability.

The following information was collected from the 8 site visits.

The composition of the Boards of Directors (BOD) varied considerably among the 8 NGOs visited. Six of the eight NGOs had a BOD that consisted only of community professionals, and did not include the Executive Director of the NGO or any NGO employees (with a voting status). The majority the NGOs had boards that truly reflected both community representation as wel. as a professional composition that provided a valuable service to the NGO. For example, six NGOs had members from professions that included legal, medical, architectural, leadership, business administration, and nursing expertise.

On the other hand, two of the NGOs included the NGO Executive Director as a voting member of the BOD, and one NGO not only had the Executive Director as President of the BOD, but all the

BOD members were employees that reported to the Executive Director/President. This latter BOD did not appear to have any community representation or support, nor did it have a check and balance for decisions taken by the Executive Director.

The number of meetings ranged from 4 to a minimum of 18 per year. Six of the eight said that the BOD met at least once a month, and at additional times when they needed to be called for extraordinary reasons. However, it should be noted that two of the eight NGOs could not produce minutes of the meetings. Both said that the minutes were kept at the home of the secretary.

The role of the BOD also varied significantly, although the majority appeared to serve in a leadership, versus advisory capacity. Nearly all of the NGOs said that they annually approved the NGO budget. However, when their role as directors was explored further in terms of their knowledge of the NGO budget and the NGO policy on cost recovery, three of the NGO BODs either could not provide any estimate as to what the annual NGO or PROSAMI budget was, and two thought that the NGO was not charging for services even though the Executive Director said that they were charging for services.

Three community board of directors were also visited. In each case, they appeared to be advisory in nature, and did not have much information or knowledge concerning the budgetary status of the NGO or health care promoter. Two expressed some trepidation about actually having the responsibility of running a medical program, and did not feel comfortable about telling the NGOs what to do. On the other hand, they both indicated active participation in the selection of the health care promoter, and one recounted how they asked to have one promoter changed the previous year.

None of the three community boards had written policies on how promoter money was spent. In one case, the promoters had personal bank accounts and were allowed to keep the money in reserve, in another other case the money went to the supervisor to pay for medications.

CONCLUSIONS AND RECOMMENDATIONS

The majority of NGO Board of Directors are extremely well organized, professional, and representative of the community. The community board of directors are also representative of the community, and provide s significant support to the health care promoters.

The management of promoter funds and financial participation of the community members is not well organized at this time for at least the three community boards that were visited. This may not be the case for other community boards, but it does appear that continued work will have to be done to get the communities to really feel that they are the owners of the program, and are therefore responsible in part for the operations. It has already been recommended in the cost recovery section that they become more participatory in the charges and management of the patient care funds. All NGOs should have a written policy that is approved at the community, NGO, and PROSAMI field office level. FUNDEMUN and FUNDESO have good examples of written policies that should be reviewed by other NGOs. The written policy has to indicate the fees to be charged, how to handle patients who say they can not pay, and how the money will be spent. Last but not least, as mentioned in the cost recovery section, this policy should be accompanied with a budget

for expected revenues, and personally monitored on a quarterly basis with the community and NGO boards, health care promoters, and NGO administration.

VI. B. EFFECTIVENESS

6. COST-BENEFIT ANALYSIS

POTENTIAL BENEFITS OF COMMUNITY-LEVEL PREVENTIVE SERVICES IN TERMS OF DEATHS AND INCIDENCE OF MORBIDITY AVERTED

PROSAMI has designed a system for monitoring and evaluating the NGOs in regards to finance management, commodities management, and technical program implementation and coverage. Within this system, NGO cost-efficiency is evaluated. Nevertheless, the financial specialist of the midterm evaluation team felt that there was a lack of appropriate data to actually conduct a cost-benefit analysis as expressed in the terms of reference of the evaluation. Consequently, it was only possible to construct a potential model to collect and use data for the future.

Several sources of data were first explored. The FESAL data is survey data available for 1988 and just recently for 1993. This has the usual mortality and morbidity statistics, but it is understandably organized by government defined regions such as states and municipalities. There is obvious overlap with the geographically defined target areas of the PROSAMI project, but the PROSAMI target areas are not defined in exactly the same manner as the FESAL geographic divisions.

Secondly, PROSAMI was able to provide what appears to be a thorough collection of data of not only increased coverage levels, but also mortality and morbidity data. This data was based on an initial, usually one-time, census conducted by each NGO in their geographic work area, or based on estimates derived from the census data. However, for cost-benefit evaluations and comparisons, effectiveness of coverage, accessibility and quality of care issues, future morbidity and mortality data cannot simply be based on the individuals served, but needs to include the entire target population. A meeting with the finance and health care evaluation team members, and the PROSAMI Executive Director, arrived at the conclusion that "census" data would need to be collected in order to measure the impact of this program in a meaningful manner. The various options for conducting such a census is described in the impact section of this paper.

What is of interest, however, is to look at some of the initial comparisons that PROSAMI has done concerning mortality rates which were based on the household census conducted by each PROSAMI NGOs in their work areas. See Tables 30 and 31, Section C, Impact. On the basis of this information, it is reasonable to conclude that PROSAMI areas are performing significantly better than other rural areas without PROSAMI services.

Constructing analyses for the future should be related to the four goals of health impact of the USAID plan of action; any other indicators added would be the responsibility of PROSAMI and the NGOs. Therefore the four indicators that should be used are: infant mortality, child mortality, number of women with tetanus vaccine, and number of women receiving at least four pre-natal visits. Two are impact indicators, and two are provider coverage indicators. As previously mentioned, all of the four indicators should be collected through some form of census data.

Working with the Ministry of Health to see if it is possible to collaborate in collecting this data might be one option.

Once this data is collected, cost-benefit analysis usually looks at the monetary value of benefits in three different ways. One is to measure the value of potential deaths averted, another is to look at potential healthy life days (HLDs) saved in terms of a value such as income generated, and another is to measure the value of number of work days saved (from reduced morbidity). Given the age group of this population, number of work days saved is not a particularly useful option. It should also be mentioned that any type of cost benefit analysis usually requires very large population samples or a significant length of time to measure the impact, or both. Typically, three to five years is a minimum length of time to measure reductions in morbidity patterns. In addition, control groups are often necessary to analyze the impact. This would mean selecting areas which are to receive treatment, and others which will not receive treatment. Control groups for programs such as rural primary health care are obviously not feasible.

Therefore the model with probably the most potential is one that compares the effectiveness between programs over time, in this case the Ministry of Health, PROSAMI, and any other type of rural primary health care programs. This should not be limited to simply health care promoter programs as was done for the purpose of this evaluation (which had a specific time limit as well as several other important objectives). In the long run, it is advisable to compare the promoter program with primary care programs that have different approaches such as those that use physicians and nurses as direct care providers. At the moment, it is assumed that promoters are a less expensive means of delivering care to the rural community, but if transportation, availability, and access to health care services increase over time, other forms of primary care may be equally or more cost-effective.

Also, a cost-effective, versus cost-benefit analysis is probably more useful and less problematic to conduct. The difference is that cost-effective analysis does not attempt to assign monetary values to health outcomes as cost-benefit analysis does. Cost-effective analysis expresses gains in simpler terms such as number of deaths averted or years of life gained, but does not attempt to put a monetary value on these benefits.

RECOMMENDATION

To construct a cost-effective model over time, the following activities need to be undertaken[31]:

1. Define the program. Determine exactly what problems will be analyzed (who, what, why, when, and how).

2. Compute the net costs. Agree upon the program components in number 1, and then cost them.

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[31] Shepard, Donald, and Thompsin, Mark. "Cost-Effectiveness Analysis in Health: First Principles", Public Health Reports, November-December 1979.

3. Determine the health effects that will be measured, and how the data will be collected. In this case it will be the two health effects and two provisions of care mentioned earlier. Then determine the effect in terms of additional years with full health.

4. Compare the programs by looking at the net cost divided by the number of life years gained. The lower the number, the more effective the program.

The time and resources to undertake this exercise should not be underestimated. It will require a well-thought out plan as well as negotiations with other parties such as the MOH. A budget will also need to be determined. Survey instruments, data collection, and computer programs and equipment will need to be assessed. Then the available resources need to be identified and quantified, and the needs for additional resources, if any, will need to be determined. Last, but not least, the amount and availability of additional funding will have to be determined before starting out with this analysis.

PROSAMI currently does cost-effectiveness analysis in terms of the efficiency of NGO in implementing the primary care/promoter program components, and achieving program effectiveness and coverage. This is a good system for monitoring, evaluating and comparing the PROSAMI NGOs in regards to the fulfillment of goals and institutional functioning within PROSAMI. The cost-effective model described above is suggested as a means of obtaining data that can be compared with primary health care programs and organizations outside of PROSAMI, such as the MOH, FUSAL, social security system, private providers, etc.

VI. B. EFFECTIVENESS

7. COST EFFICIENCY AND EFFECTIVENESS OF THE NGOs

ANALYSIS OF THE 35 NGOs COMPARED TO ONE ANOTHER

METHODOLOGY

Following discussions with USAID and PROSAMI, it was clear that there was a high level of interest in how the 35 NGOs receiving money from the PROSAMI project were performing in comparison to one another. For this reason, two questionnaires were distributed as described in the original methodology section. The questionnaires solicited information from all 35 NGOs, the technical advisors, and the financial department of PROSAMI.

FINDINGS

The table titled "NGO Cost Efficiency Analysis" can be found in Annex H-1. This table is used as a reference for discussion in this section.

First the NGOs were analyzed in reference to success in generating counterpart contributions. The counterpart funding is basically divided into the following categories, and reported on a quarterly basis to the field office:

> Paid personnel - those individuals paid by other NGO funds that were providing assistance to the PROSAMI health promoter program. For example, a number of NGOs provided part time secretarial, maintenance, and procurement staff to assist with the program, but these staff were not charged to the PROSAMI project.
>
> Physical office space and equipment maintenance - the value of the rent and equipment maintenance was included as a counterpart contribution.
>
> Other Donor funding - non-USAID funds that paid for utilities, gas, and other items.
>
> Cash funding - any cash contributions from the NGOs
>
> Volunteer help - the value of hours contributed from volunteer workers from the communities.

The first four categories of NGO paid personnel, office space, and other funding (non-USAID and cash) were used for this analysis. The volunteer help was sometimes significant for NGOs but it had a great deal of variety and was therefore difficult to measure. Also, it was sometimes double counting of

existing resources such as one NGO who put for volunteer time extra hours worked by the same staff who were paid on the project. The majority of NGOs, however, had a long list of volunteers who were usually used on specific projects such as vaccination campaigns.

The breakdown of average contributions is shown in Table 28, as follows:

Table 28.
COUNTERPART FUND DISTRIBUTION
PROSAMI MTE 1994

ITEM	AVERAGE DONATION	PERCENT
Paid Personnel	5438	8%
Physical Space	28813	4%
Other Funding	34663	5%
Cash Donations	10037	2%

When counterpart sources were counted for all the NGOs, it was found that the average NGO received ¢.681,950 from PROSAMI, and contributed an extra 18%. making the average NGO budget ¢. 782,298. This, when included with the volunteer time, usually amounts to the 25% counterpart requirement by the PROSAMI agreement. Perhaps the most tangible counterpart funding was the donation of office space and other NGO paid staff. The NGOs frequently contributed personnel time such as a warehouse specialist, maintenance worker, or other administrative personnel. This appeared to be real time provided by the NGO, and needs to be included in the cost projections necessary to run the NGOs.

It can be seen from the table in the appendix entitled NGO Cost Efficiency Analysis that the different sources of contributions, as well as the mix of counterpart contributions, vary considerably among the NGOs. There appears to be some relationship with the overall size of the NGO and its ability to provide counterpart contributions as expected - those NGOs with the highest percent of their total budget derived from PROSAMI have to rely the most on volunteer help for counterpart funding.

The staff mix and cost among NGOs was then analyzed. The average number of promoters per NGO was 13, and the average number of technical and administrative staff was 7 (usually two to three are administrators). The number of administrative staff usually did not vary considerably in relation to the promoters, and the technical staff was always an average of 5 promoters to every supervisor. The average number of other paid personnel by the NGO was 6, but this was number of people, and not full-time equivalents. As previously mentioned, the number of administrative and technical staff and the associated cost is high, an average of 79% of the total PROSAMI personnel costs. The promoters are therefore receiving a lot of technical support, but this may not be financially sustainable one the project ends.

The other table, "NGO" in the appendix then looks at comparative cost figures in relation to productivity and services delivered. It also looks at the difference between years 1993 and 1994 as well as the differences between those NGOs who started initially (first round) and those who started

subsequently (second and third round). It should be noted that these costs only include the PROSAMI costs, and do not include counterpart contributions.

The budgets assigned to the NGOs are in relation to the target population (children under 5, and mothers and women of fertile age). This figure therefore does not vary significantly among the NGOs or between rounds, and is an average for all three of ¢ 138.56. What is of interest is that the range of per capita NGO cost per target population does not vary much in the first round, but does vary for round two and three NGOs. The range is ¢ 86.73 to ¢ 206.23. Part of this is due to the fact that the NGOs are still "stabilizing" as they develop, and part of it is due to the fact that some areas were war torn areas and therefore required more resources per capita.

The cost per promoter among the NGOs was then analyzed, and the average was almost identical for the first and second round groups, ¢ 54,381 and ¢ 54,885 respectively. The third round was appreciably higher at ¢ 68,681. The range was also considerable within the individual rounds. In the first round, the least expensive NGO was ¢ 28.931 and the most expensive was ¢ 66,971, a difference of 232%, and in the second round it was ¢ 674 and ¢ 45,562 for the two lowest and ¢ 82,685 for the highest. This difference of promoter cost is useful if the program is going to consider continuing as a health care promoter program after the project ends. It is obviously going to be more difficult for the more costly NGOs to survive.

The cost per promoter for the third round NGOs was higher than the average for the first two rounds at ¢ 68,681. As previously mentioned, this is primarily due to the infusion of additional resources in war torn areas.

Perhaps the most important statistic when looking at relative NGO efficiency as well as number of service units (attentions) provided is the cost per attention and the number of attentions provided by promoters. Since the first and second rounds have all been operating for nearly two years or more, it can be seen that their average is similar in both cases. For example, the cost per attention of round one and two is ¢ 49.69 and ¢ 45.91 respectively. The number of attentions per promoters is c. 1,039 for the first round, and c. 1,221 for the second round in 1994.

The first thing to note is that the number of attentions increased from 1993 to 1994 for the first round, and the range of promoter productivity among the first round NGOs decreased. That is to say, there were some NGOs with a comparatively low productivity of the promoters in relation to number of provider visits, two were less than half of the average at 411 and 440 visits per promoter. The PROSAMI technical advisors worked with these groups, and the promoter productivity was increased substantially in 1994 to 2,206 and 667 for the same two NGOs. Nonetheless, the range of promoter productivity is still between 967 and 2206 attentions per promoter. That is to say, there are some NGOs within the first round that are providing nearly three times the number of attentions per promoter than their counterparts. Although some of this difference can either be attributed to differences in distances traveled by the promoters or the percentage of time they spend on other activities such as community and health education, it is still too great a range to consider acceptable between NGOs. This was discussed with the PROSAMI Executive Director, who mentioned that they have been actively working towards establishing a more uniform level of productivity among the NGOs.

The difference in productivity is even more significant for the second round NGOs. Here the range is from 337 visits to promoter to 2,461! Three of the ten NGOs were less or close to only half the

average productivity of the round two NGOs. In addition, the average productivity decreased somewhat between 1993 and 1994 for this round. The cost per attention follows the same pattern as expected.

The third round productivity is almost too premature to assess since these NGOs are primarily at the census taking stage, and the emphasis for promoter visits is just beginning to take place. Just the same, the range of productivity is greatest for this group, with one NGO actually reporting the highest number of visits per promoter than all of the other 34 NGOs, with ASEI reporting 2,531 visits per promoter. The lowest is 119 visits per promoter, and is in one of the areas where the conflict of the war was the highest.

In summary, although there is a wide range among the NGOs, the amount of efficiency on average has been significantly progressive during the past three years. Table 29, on the following page summarizes this progress (it does not include the estimated 25% counterpart funds or cost of medications).

As can be seen from this table, the first round NGOs have progressed from an average cost per promoter attention from ¢153.75 to ¢49.69. If one includes the counterpart funding of 25% this would be approximately ¢ 62 plus medications or USD $7, with the average number of attentions at 1,038 per year. The annual cost per promoter with counter part funding would be ¢ 67,976 or $7,725.

CONCLUSIONS AND RECOMMENDATIONS:

Recommendation 1 - First and foremost, information that ties productivity with costs and compares each NGO within the "round" that it started should be collected and shared with the technical and financial advisors, and most importantly, with the NGOs. It should be provided in an aggregated fashion as presented in the "NGO" table in the appendix, so that the NGOs clearly know how they compare to both their peers in their round, as well as to all the other NGOs. This quarterly report alone will help to raise the minimum standard of productivity as well as reduce the difference among the NGOs.

Recommendation 2 - It is now opportune to set levels of productivity in comparison to other NGOs, and **not based on past performance.** NGOs with levels of productivity at less than 800 visits per promoter and with a cost per visit of c. 60 or higher will not be able to compete in any sustainable fashion. It is recommended that in the sustainability workshop or during the 1995 budgeting process, and the NGOs and technical advisors come to an agreement what is an acceptable **minimal** level of productivity, and this be established for 1995 and then 1996. Those

Table 29. Cost and Efficiency Comparison by Year of Field Implementation by NGO Funding Round, 1994			
	YEAR 1	YEAR 2	YEAR 3
First Round NGOs (9)			
Cost / Target population	170.88	135.45	127.95
Cost / Attention	153.75	60.68	49.69
Cost / Promoter	55,900.82	54,695.61	54,381.12
Attentions / Promoter	529.42	960.78	1,038.84
Second Round NGOs (9)			
Cost / Target population	141.37	142.52	---
Cost / Attention	105.58	45.91	---
Cost / Promoter	58,328.40	54,885.71	---
Attentions / Promoter	1,330.35	1,220.76	---
Third Round NGOs (9)			
Cost / Target population	179.96	---	---
Cost / Attention	170.24	---	---
Cost / Promoter	68,681.44	---	---
Attentions / Promoter	713.35	---	---

NGOs that do not obtain the minimal level should not be encouraged to think they will be able to compete either in the open market, or for future donor funding.

The main point is that there has to be a clear standard set for future continuation within the project. This is also important if one is going to be fair to those NGOs who are clearly demonstrating a very high level of productivity, and should be rewarded for this. These minimum standards should not be thought of just in the negative sense, but also used as a means to recognize those NGOs with the highest performance, and to consider giving them more responsibilities and associated funding.

Recommendation 3 - These increased productivity figures should be used in tandem with the cost recovery programs that must be established for all the NGOs in 1995. And equally important, the number of supervisory staff and as well as the amount of other training costs need to be reviewed with a long term strategy that arrives at an "acceptable and viable level" of resources that will be

turned over to the NGOs by 1996. The NGOs cannot wait until 1996 when the project ends to plan to significantly dismantle their project and/or increase patient charges.

In summary, preparation for financially sustainability when the project ends begins now. This means:

a. Establish a well defined cost recovery program (from client fees and other sources)

b. Determine the best level and use of staff

c. Agree upon acceptable and more uniform levels of productivity

VI. B. EFFECTIVENESS

8. COORDINATION

Inter-institutional coordination between the PROSAMI Project (MSCI, NGOs and the communities) and other non-project organizations can be characterized as good. Intra-institutional coordination and cooperation has from the beginning been a concern of MSCI. The NGOs have realized the importance of this issue. The NGOs have all become quite active instituting formal coordination mechanisms, for several reasons, discussed below. Coordination and communication in general is at the heart of survival and growth of the PROSAMI Project. Coordination is the linchpin upon which sustainability will become a reality.

Intra-institutional Environment

CONSALUD is the most recent and important activity in coordination to be put forward by the NGOs. Although not fully formalized, the constitution has just been approved, this corporation is an absolute requirement for the sustainability of the programs of PROSAMI and for the strengthening and permanence of the NGOs. Financial self-sufficiency of the Maternal Health and Child Survival Project is dependent upon institutionalizing CONSALUD. A general assembly has met on a number of occasions, as has the Executive Committee. The Executive Committee has a President, Vice-President and Treasurer who have been elected by the Assembly and the Executive Committee, which meet weekly. The Committee has presented work plans for other working committees.

These working committees have been hard at work in the following areas: Executive Director's group. coordination, programs and projects, administration, communications and public relations. There are five to ten NGOs in most of these committees.

At present the 25 NGOs that have received their legal status are members of CONSALUD. The other 10 NGOs are waiting for their legal status approval and are attending meetings of the CONSALUD corporation, waiting to enter formally to take their place as founding members. Terms of reference for hiring an executive director has been written and a campaign to recruit such a person will begin soon. The formal structure of the corporation is presently under discussion in one of the committees.

The two principal issues which have helped to motivate NGOs to work together are, 1) The union of forces to obtain legal status for each member, and 2) the issues of sustainability and financial self-sufficiency.

It is evident to almost all NGOs that a unified approach to their problems and future activities will provide a much better chance for success by working together. Much of this change has come about over the past three years as the NGOs have worked together in a unified way providing coverage in the service delivery system, in reaching the goals of the project, and in using a methodology that has proven successful, including a strategy of popular participation that is presently coming into the picture as a real source of support and strength to the overall Project.

Specific activities that are being planned by CONSALUD committees are: contacts with other health cooperating agencies, the publishing of a bulletin, educational campaign on health issues, radio and TV spots, possible membership dues and fees, fund raising campaign, and the like. CONSALUD has asked for financial help in contracting a study which will diagnose and analyze the global health efforts which the NGOs have undertaken and accomplished over the years, as the basis for the development of new projects in the sector.

The PROSAMI Project standing Coordinating Committees that have been formalized over the past three years have been an important mechanism for providing cooperation and communication between NGOs and the MSCI staff. Standing committees are: Evaluation Training, Gender, Financial Sustainability, CONSALUD, Community Education and Participation, Retaining Personnel. These committees have met frequently and the tasks which have evolved have brought together members which have worked closely and shared resources to reach common goals.

Inter-institutional Environment

One of the primary contacts for the PROSAMI Project is the Ministry of Health. Coordination, information sharing, training, health technology transfer, NGO coordination, setting of norms, are the principal activities that are coordinated on a continuing basis between PROSAMI and the Ministry.

The units of Health Education and Community Health of the Ministry in 1991 developed and carried out the training of promoters providing materials, setting norms, methodology of training, and evaluation. By 1992, PROSAMI had a clearer idea of what was needed in their own training activities and training content was tailored to PROSAMI needs, but still followed the basic Ministry norms. By 1993 PROSAMI began doing most of its own training with the MOH providing norms and signing training certificates. By 1994 PROSAMI had completed its own model of training and began giving courses with MOH approval, using their own model.

The current situation in the Ministry is changing. Much of the coordination between PROSAMI and the MOH takes place with the unit of Community Health. The new focus of this unit, according to its personnel, is the supervision of health throughout the nation. The structure of the unit consists of the Chief Technical Officer and her staff, with divisions of Research and Information, Training (primarily promoters in community health), Computer and Information, and Administration.

An important change is in the regional offices of the Ministry, which will be changed shortly to departmental offices with health teams for supervising and communication. Supervision is at the departmental (region) level with local (sector) specific supervision providing technical support to promoters. Promoter function is primarily preventive medicine, but curative as well. Identification, referral, control of child growth and administrative system are the priority area. The MOH promoter's range of health activities will be more open now than in the past, we were told. Multidisciplinary teams will be based in local (sector) level hospitals, and made up of health professionals; nurses, doctors and sanitation experts. These professionals will have responsibility for training promoters and developing the health projects in each area, e.g., vaccination campaigns, cholera, and the like.

Training courses and continuing education will be carried out at the regional level also. The training department is in the MOH in San Salvador, but training personnel in the regions will supervise and control the local levels.

Coordination with the PROSAMI Project and the Health Community unit was characterized as good. This unit stated they have a study of all health indicators in each community of women of fertile age as well as data on children. This study is updated yearly and includes water, transportation and the like. It also includes resources available in high risk areas and reconstruction areas.

Finally, the Offices of International Cooperation, and Coordination of NGOs of the MOH characterized their coordination with the PROSAMI Project as generally good but with some NGOs reticent to give information and cooperate completely with the MOH. This, to the MOH, seemed to be a natural state of things due to the recent trauma that this country has just passed through. There is still a certain amount of concern on the part of some NGOs as to what the Government and its various ministerial units really want. This did not seem to be a major preoccupation of the Ministry and the opinion was expressed that with time and working together this will change for the positive. Presently there are NGOs which do not respond to the MOH requests, but these were not included in the PROSAMI Project. The office of NGO Cooperation stated there are presently 137 NGOs which have projects that are principally concerned with health programs, and 227 more which work in health areas, but it is not their principal activity.

What is needed to work more closely with NGOs, as seen by these two offices, is more meetings and dialogue. The mechanisms now in existence are adequate.

It was emphasized in our meeting that NGOs know the communities and this is important. The norm of the MOH is not fiscalization of these NGOs. The Ministry must move to the municipal levels, it was emphasized. NGOs that are well organized will survive, it was stated, almost all are capable of continuing on. It is a combination of the selection of NGOs, and strengthening them. The communities identify with the NGOs, it was stressed.

International Cooperation is presently carried out with the Governments of the U.S., Spain, Switzerland, Germany, Japan and Holland. With the exception of the U.S., this now consist primarily of training and infrastructure building. Also cooperation is underway with the following multilateral donors; UNICEF, OPS, World Bank and the European Economic Community, where training, child survival, rehabilitation, technical assistance, and SILO support are being supported by these international organizations.

Non-Governmental Organization Cooperation

CIPROS

Another important organization for PROSAMI in the inter-institutional coordination area is that of CIPROS, International Committee for the Promotion of Health, an organization made up of ten different institutions. PROSAMI is one member of CIPROS and a very active institution.

General Objective

To coordinate inter-institutional actions for the promotion of health, increasing coverage, contributing to improvement of the quality of life of the Salvadoran population.

Specific Objectives

1) Strengthening inter-institutional relations between the Government of El Salvador, NGOs, and other institutions carrying out health care activities.

2) Promoting and dissemination, application, and feedback of educational norms which apply to health.

3) Unify criteria on concepts and update strategies in health promotion.

4) To obtain, through trained personnel, the promotion and strengthening of the social participation of the communities, with emphasis on high-risk municipalities.

There are various other coordinating organizations, but PROSAMI's involvement with them is minimal. For example, CISA, (Comisión International de Supervivencia Infantil), CIMR, (Inter-institutional Commission on Alternative Medicine), CODEPROSE (Cooperation for the Development of Social Promotion).

VI. C. IMPACT

1. IMPACT ON MORBIDITY AND MORTALITY

Impact is an indication of the effectiveness of the project methodology and activities in actually improving the health of mothers and children. If the project functions as planned, and MHCS services are delivered adequately and appropriately, health should improve and morbidity and mortality rates should decrease in the project areas. Impact implies a change, and while, as mentioned, we expect changes in the health of mothers and children, the project also seeks other changes. These include establishing a network of NGOs capable of providing good quality primary health care services for women and children, and changing attitudes and practices in communities to facilitate and favor the establishment and maintenance of good health.

Mortality data was not collected systematically, and infant and child mortality rates were not calculated, by the PROSAMI NGO network until recently. The quarterly collection of mortality data was initiated in January, 1994. Heretofore, the NGOs only collected data on promoter services and their own activities. Many are still learning the process of organizing and conducting community wide data collection. Thus, not all of the NGOs are collecting mortality data consistently yet. This is a normal part of the institutional learning process.

Currently, the mortality data is reported on two forms: One is the Quarterly Summary Report of Health Promoter Activities Form (see Annexes G-8, G-10 and G-11), wherein quarterly data is recorded which reports on the deaths of children under the age of 5 years attributed to ADD (and dehydration) and ARI (including pneumonia), newborn deaths (i.e., deaths of children between 0 and 28 days of age), and maternal deaths (deaths during pregnancy, birth or puerperia). The second form is the Quarterly Tabulator of Mortality per NGO, wherein all deaths in the target population during a specific quarter are recorded. One problem that has occurred is that there have been incongruencies between the two forms. Again, this is probably due to lack of experience in maintaining data collection systems, as has been observed in relation to the community censuses, and with time should be rectified. The result of this inexperience, is that we do not have mortality data that we can consider to be reliable. With this caveat in mind, we can make some interesting observations.

A retrospective analysis of census data collected by the first and second round NGOs, based on a population of 156,360 persons, permitted the calculation of the baseline infant mortality rate (IMR) for 1992-1993 of 41/1000 LB (live births) at the beginning of health service activities. This is comparable to the national IMR for rural areas for 1988-1993 determined by FESAL-93[32] (see Table 30). Mortality rates for 1994 in Table 1 were calculated by using the total number of newborns who received a first time visit from a promoter as equivalent to the number of live births (2724). This is probably an underestimate of the total number of live births. FESAL-93 found that there was a ratio of 0.133 live births per woman of fertile age per year. Using this to calculate the estimated number of live births in the community population indicates that there should be more than 3,750 (for 6 months). On the other hand, casual observation of the number of pregnancies in

[32] FESAL-93, page 119.

the communities served by the PROSAMI NGOs indicate that the observed numbers are less than the estimated figures.

Table 30.
Mortality Rates, FESAL-93 and PROSAMI-94, El Salvador, 1994

MORTALITY RATES per 1000 live births	FESAL-93, RURAL	PROSAMI NGOs	
	1988-1993	1992-1993	1994*
Infant mortality rate (IMR)	44	41	25.7
Neonatal mortality (0-28 days)	23		16.9
Postneonatal mortality (29-364 days)	22		8.8
Child mortality (1-4 years) (CMR)	14		8.8
Total mortality (0-4 years) (TCMR)	58		34.5
Number of live births	4,287		2,724

* Based on data from the first 6 months of 1994, from 19 first and second round NGOs.

As can be seen in Table 30, the IMR for the first six months of 1994 reported by 19 NGOs, shows a significant improvement in relation to the base line IMR: 25.7 compared to 41 (both per 1,000 live births). It is also a significant improvement when compared to the national figures of 44/1,000 LB. The child mortality rate (CMR) also shows notable improvement when compared to the FESAL-93 rural CMR: 8.8 to 14 ‰ The total child mortality rate (TCMR) was 34.5 ‰ for PROSAMI-94, which again is a very significant improvement when compared to the FESAL-93 (rural) TCMR of 58 ‰. These are very impressive results.

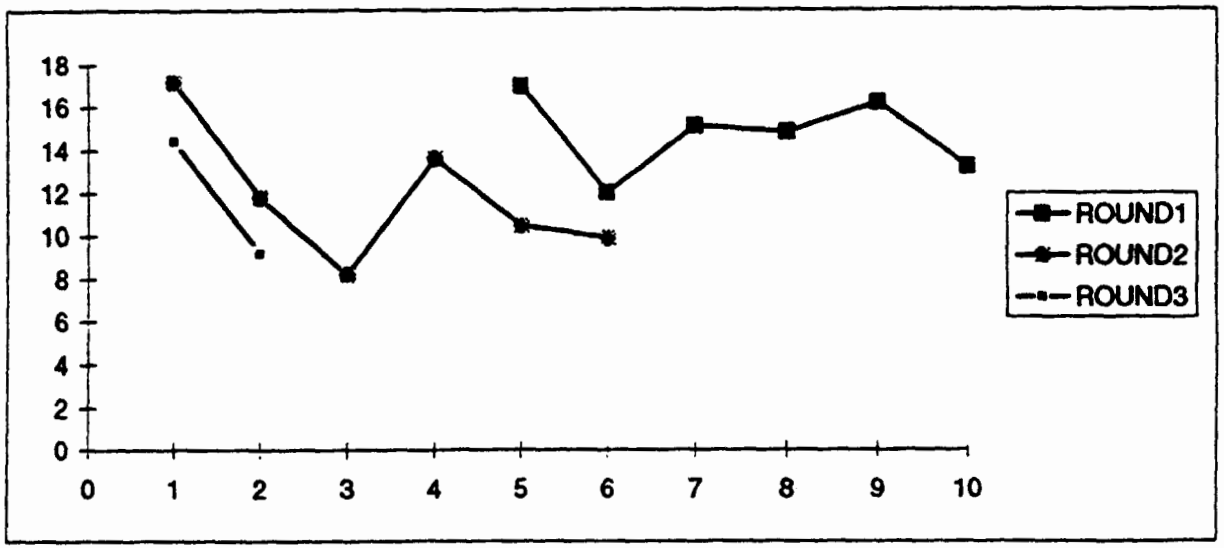
Table 31 shows a comparison of the causes of infant, child, and total child mortality. The relationship of causes is virtually the same in both FESAL-93 and PROSAMI-94 for the TCMR. There are some variations in the IMR and CMR. It is notable that decreases in proportional mortality have occurred in ADD among infants, and in ARI among children 1-4 years. As indicated above, the overall mortality has decreased in the PROSAMI NGO project areas. The differences in the causes requires further study and elucidation, and should be taken into account when formulating action plans. The morbidity and mortality results in regards to the technical components are discussed in the following paragraphs.

Table 31. Causes of Child Mortality in El Salvador Comparison of FESAL-93[33] and PROSAMI-94						
CAUSES OF DEATH	INFANT (0-1 year)		CHILDREN (1-4 years)		TOTAL CHILDREN (0-4 years)	
	FESAL-93	PRO-SAMI	FESAL-93	PRO-SAMI	FESAL-93	PRO-SAMI
Diarrheal diseases & dehydration	19.0	8.7	24.1	58.6	20.0	20.7
Acute respiratory infections & pneumonia	16.3	18.5	27.8	10.3	18.6	16.5
Low birth weight & prematurity	18.1	19.5	0	0	14.6	14.9
Congenital abnormalities	11.3	15.2	1.9	0	9.5	11.6
Birth trauma & asphyxia.	9.5	13.0	0	0	7.6	9.9
Sepsis/multiple organ failure	9	5.4	1.9	3.4	7.6	4.9
Respiratory Distress Syndrome	5.4	2.2	0	0	4.4	1.7
Measles	0	0	13	0	2.6	0
Accidents	0	1.1	11.1	6.9	2.2	2.5
Other perinatal complications	2.3	8.7	0	0	1.8	6.6
Malnutrition	1.8	2.2	1.9	6.9	1.8	3.3
Meningitis	0.9	1.1	3.7	0	1.5	0
Neonatal tetanus	0.5	3.3	0	0	0.4	2.5
Others	1.8	1.1	7.4	13.8	2.9	4.1
Not indicated	4.1	0	7.4	0	4.7	0
Total	100	100	100.2	99.9	100.2	99.2

ADD: Graph 1 shows the decreasing trends of the presentation of dehydration with ADD. Other graphs in the indexes relating to the first two quarters of 1994 show the following results. The incidence of ADD increased slightly during the first two quarters of 1994, and at the same time, the proportion of cases accompanied by dehydration decreased slightly from a high of 16.2% to a low of 9.2%, as compared with the expected 15%. The ADD cases accompanied by dehydration and shock decreased among the NGOs of the first round and increased among those of the second and third rounds. Notwithstanding the increasing/ decreasing trends of cases, the proportion of cases accompanied by dehydration and shock was still below 1.0% in all three

[33] FESAL-93, page 127.

GRAPH No. 1
'1994
TREND ANALISYS
DIARRHEAL DISEASE
PERCENT OF CASES WITH DEHYDRATION
BY QUARTER OF FIELD IMPLEMENTATION AND BY PVO FUNDING ROUND



	QUARTERS										
ROUND	0	1	2	3	4	5	6	7	8	9	10
ROUND1						17.00%	12.00%	15.10%	14.80%	16.2%	13.2%
ROUND2	0.00%	17.20%	11.80%	8.20%	13.60%	10.50%	9.90%				
ROUND3	0.00%	14.40%	9.20%								

Round 1 : Data no available from 1st. to 4th quarter

rounds, as compared with the expected 5.0%. Concurrently, the second and third round NGOs increased the average number of follow-up visits from an low of 2.3 per case to a high of 6.8.

Almost all cases of ADD (95%) were referred. The mortality rate in children under the age of 5 years due to ADD decreased, as did the rate of cases of ADD that ended in death. These results indicate that the overall rates of ADD cases which were accompanied by dehydration, and dehydration and shock, and the proportion of ADD cases that end in death have decreased in the communities attended by the PROSAMI NGOs.

ARI: As can be seen in Graph 2, there is a decreasing trend for the presentation of pneumonia with ARI over the life of the project to date. A review of results for the first two quarters of 1994 (see Annex G-12) show an overall increased incidence rate of ARI cases detected and attended. What is important was the decreasing trend in mortality over the same period. The proportion of cases of ARI in children under the age of 5 years that ended in death showed a decreasing trend from an average of .08% to .01%. The proportion of deaths in children under the age of 5 years attributable to ARI also decreased from an average of 9.8% in the first quarter to an average of 2.5% in the second. Recalling that the national proportion indicated by FESAL-93 for this age group is 18.6%, these results again are impressive.

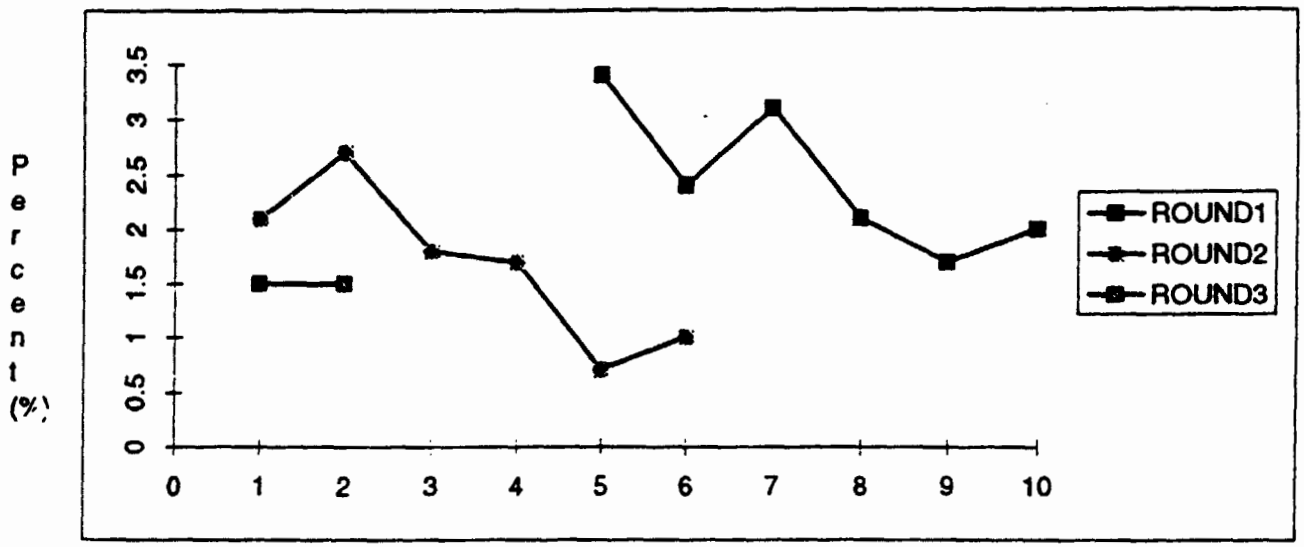
MRH: Graphs 3 and 4, show increasing trends for the proportion of pregnant women who receive at least 5 prenatal care visits. The overall baseline proportion was 19% (pregnant women receiving 4 or more visits). By 1994, the PROSAMI NGOs had increased this to 40.5%.

PNH: Graph 5 shows that the proportion of newborns that received 4 visits during the first 28 days of life increased from 0 to an average of 32.5% per NGO round. Graphs and tables in Annex G-12 present more results from the first and second quarters of 1994, in regards to neonatal health. In general, in addition to increased coverage, they show decreasing trends in the number of newborns who present low birth weight or infection. The proportion of deaths of children under the age of 5 occurring in the neonatal period showed a decreasing trend in the second and third round NGOs (46.8% to 27.9%), while first round NGOs showed an increasing trend (23.7% to 69.4%).

EPI: EPI coverage increased in regards to all immunizations. In Graph 6, it is shown that DPT3 coverage increased from an average of 15.9% in the PROSAMI NGO communities to 126%, according to data from the MOH Division of Epidemiology. The figure "126%" is calculated in accord with MOH standard operating procedure, by dividing the total number of immunizations administered by the estimated number of children in the area vaccinated. This means that if more children are vaccinated than was estimated, the rate will be greater than 100%. Since all children that are encountered during campaigns are vaccinated, whether or not they live in a given community, and since the checks against revaccination (vaccinating children that have already be vaccinated) are virtually nonexistent, there is ample room for arriving at a number of vaccinations which exceeds the estimate.

In general. the EPI coverage rates compare very well to the national coverage of 59.2% reported by FESAL-93. More immunization data is presented in graphs and tables in Annex G-12.

GRAPH No. 2
'1994
TREND ANALISYS
RESPIRATORY INFECTIONS
PERCENT OF CASES WITH ACUTE PNEUMONIA/RESP. INFECT.
BY QUARTER OF FIELD IMPLEMENTATION AND BY PVO FUNDING ROUND



	QUARTERS										
ROUND	0	1	2	3	4	5	6	7	8	9	10
ROUND1						3.40%	2.40%	3.10%	2.10%	1.70%	2%
ROUND2	0.00%	2.10%	2.70%	1.80%	1.70%	0.70%	1.00%				
ROUND3	0.00%	1.50%	1.50%								

Round 1 : Data no available from 1st. to 4th quarter

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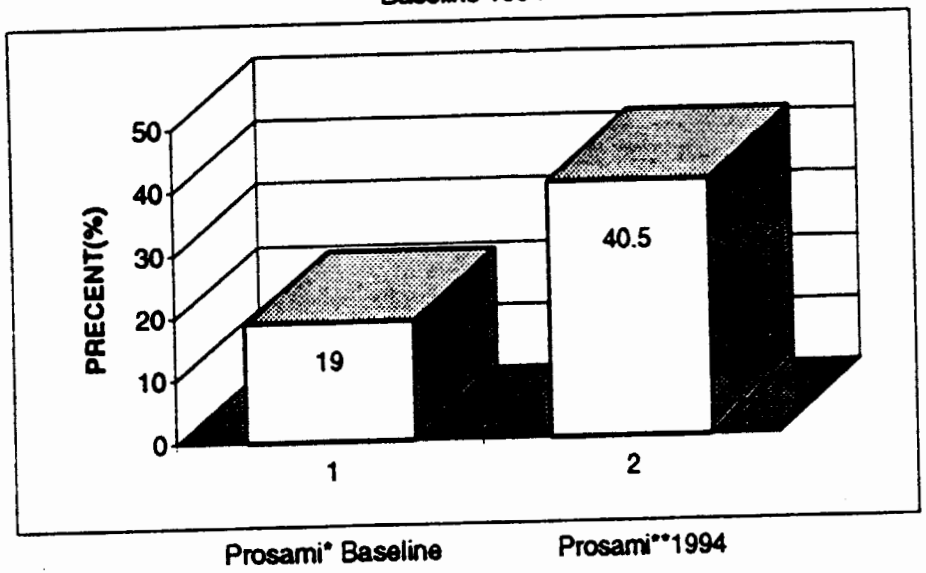
GRAPH No. 3
PROSAMI
INCREASE IN PRENATAL CARE COVERAGES
(Percent of Pregnant Women with 4 or more Prenatal Visits)
Baseline 1994



* Based on busehold census baseline data for 120,000 population (48,29% of the PVO populations in the first and second funding rounds) conducted in 1992 and the first quarter of 1993.

** Preliminary annual rate based on 6 months of 1994 fuld data reports, PVOS's first and second round. Excludes women covered in the same population by the MOH.

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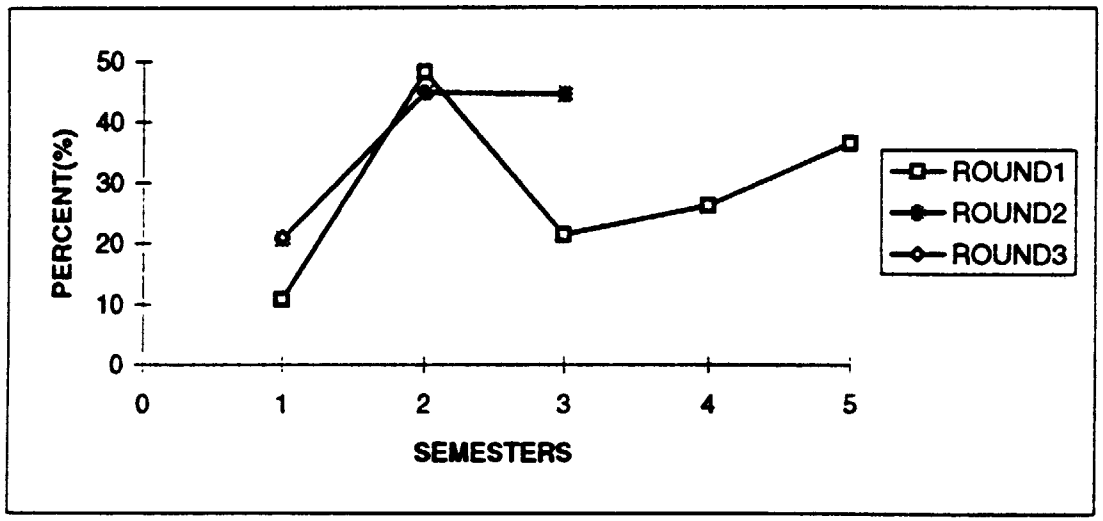
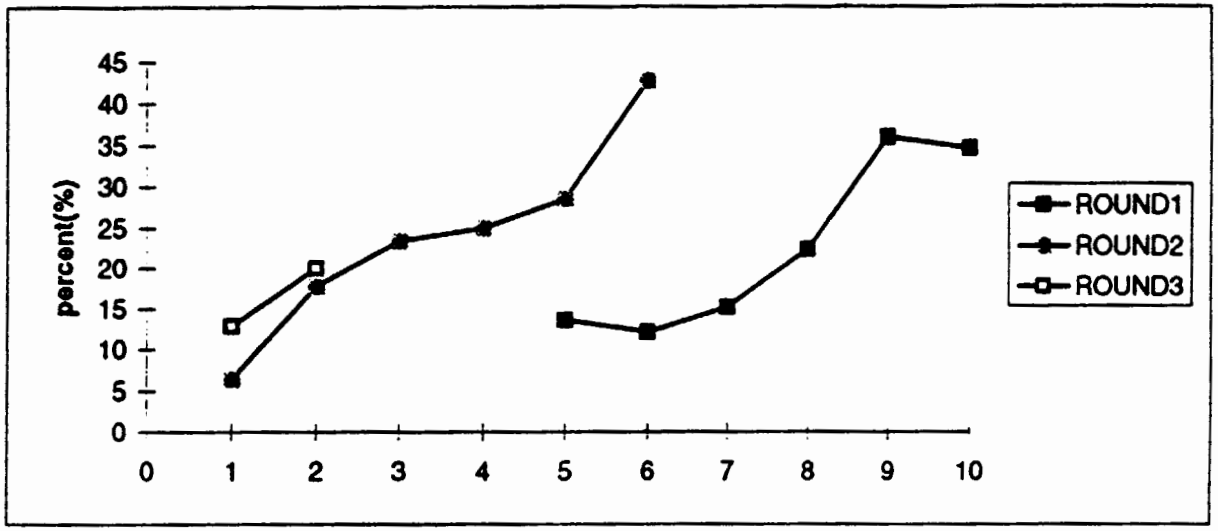
GRAPH No. 4
1994
TREND ANALYSIS
MATERNAL HEALTH
PRENATAL CARE COVERAGES* BY SEMESTER
OF FIELD IMPLEMENTATION, BY PVO FUNDING ROUND



* (5 VISITS/PREG. WOMAN)

ROUND	0	1	2	3	4	5
ROUND 1	0	10.80%	48.20%	21.40%	26.20%	36.40%
ROUND 2	0	20.80%	44.80%	44.60%		
ROUND 3	0	21.00%				

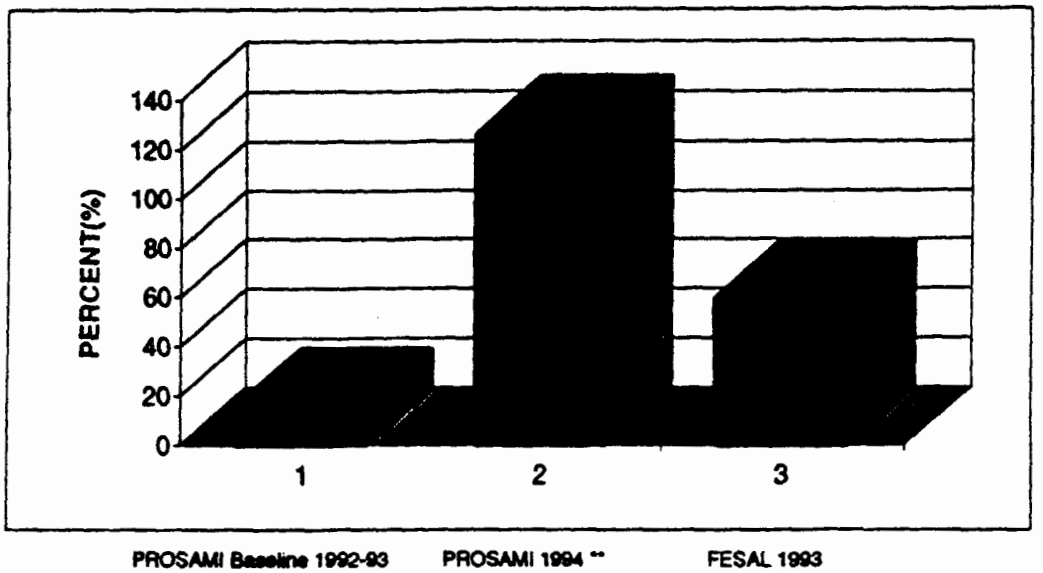
GRAPH No. 5
'1994
TREND ANALYSIS
NEWBORN COVERAGE (4 VISITS/NEWBORN)*
BY QUARTER OF FIELD IMPLEMENTATION AND BY PVO FUNDING ROUND



	QUARTERS										
ROUND	0	1	2	3	4	5	6	7	8	9	10
ROUND1						13.60%	12.10%	15.20%	22.40%	36.00%	34.70%
ROUND2	0.00%	6.40%	17.80%	23.40%	25.00%	28.50%	42.70%				
ROUND3	0.00%	12.90%	20.00%								

Round 1 : Data no available from 1st. to 4th quarter
* Expected No. Newborns = 80% of espected pregnancies.

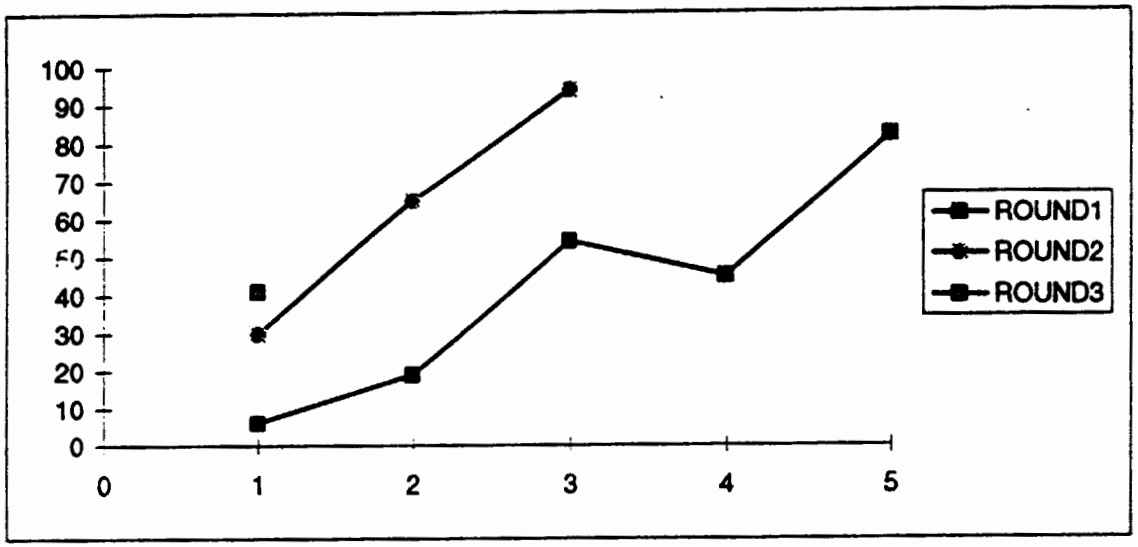
GRAPH No. 6
PROSAMI
Increases in DPT3 coverages, Children under 1 year of age in geographical areas attended by first and second round PVO's and the MOH



* Based on husehold census baseline data for 77,000 population (58% of the PVO population in the first and second funding rounds conducted in 1992 and the first quarter of 1993.

** Analysis based on coverage by municipality, data from MOH , 1994, Division of Epidemiology.

GRAPH No. 7
1994
TREND ANALYSIS
GROWTH AND DEVELOPMENT
GROWTH MONITORING COVERAGE*, CHILDREN 0-5, BY SEMESTER OF FIELD IMPLEMENTATION AND PVO FUNDING ROUND



* (Based on an average norm for children 0-5 years 3 controls/child/yr.)

ROUND	0	1	2	3	4	5
ROUND 1	0	6.00%	19.00%	54.00%	45.00%	82.00%
ROUND 2	0	30.00%	65.00%	94.00%		
ROUND 3	0	41%				

GMD: Graph 7 shows increasing trends in the extension of coverage of at least 3 GMD visits per child under the age of 5 years throughout the NGO network. Round 1 NGOs increased from 0 to an average coverage of 82%; Round 2 NGOs increased to an average of 94%; and, Round 3 NGOs increased to an average of 41%. Concurrently with the increase in GMD, as shown in Graph 8, the proportion of children under the age of 5 years with moderate to severe malnutrition decreased from 22.6% at the beginning of PROSAMI NGO activities, to 5.7% currently (based of data from the first two quarters of 1994). This can be compared to the national rate of 14.1% indicated by FESAL-93. The increase in GMD coverage and concomitant decrease in moderate to severe malnutrition are notable improvements achieved by the PROSAMI NGOs. More data concerning nutrition is presented in graphs and tables in Annex G-12.

COMMUNITY PARTICIPATION: Graph 9 shows trends for increasing the number of health education group sessions per promoter per semester and NGO round. Further data, from the first two quarters of 1994 (see graphs and tables in Annex G-12) show that the average number of community health committees per promoter was more than 1: 1.5 among Round 1 and 2 NGOs, and 0.87 among Round 3 NGOs, for an average of 1.3 committees per promoter overall. The average number of community volunteers per health promoter was 18.2 among Round 1 and 2 NGOs, and 3.5 among Round 3 NGOs. The average number of community general assemblies increased from an average of 1.3 to 2.7 per promoter per quarter among all of the NGOs. These results indicate very good levels of community participation.

The results of the PROSAMI NGO activities reviewed here indicate very good impact in terms of decreasing morbidity and mortality in the rural communities where they are working. Infant, neonatal, and child mortality rates have all decreased. The number of deaths due to ADD and ARI have decreased. Moderate to severe malnutrition in children under the age of 5 years has decreased. Prenatal care, puerperal care, neonatal care and GMD visits have all increased. The coverage of immunizations has also increased. These are impressive results attributable not only to the efforts of the NGOs and their promoters, but also to the service delivery system developed and implemented by PROSAMI.

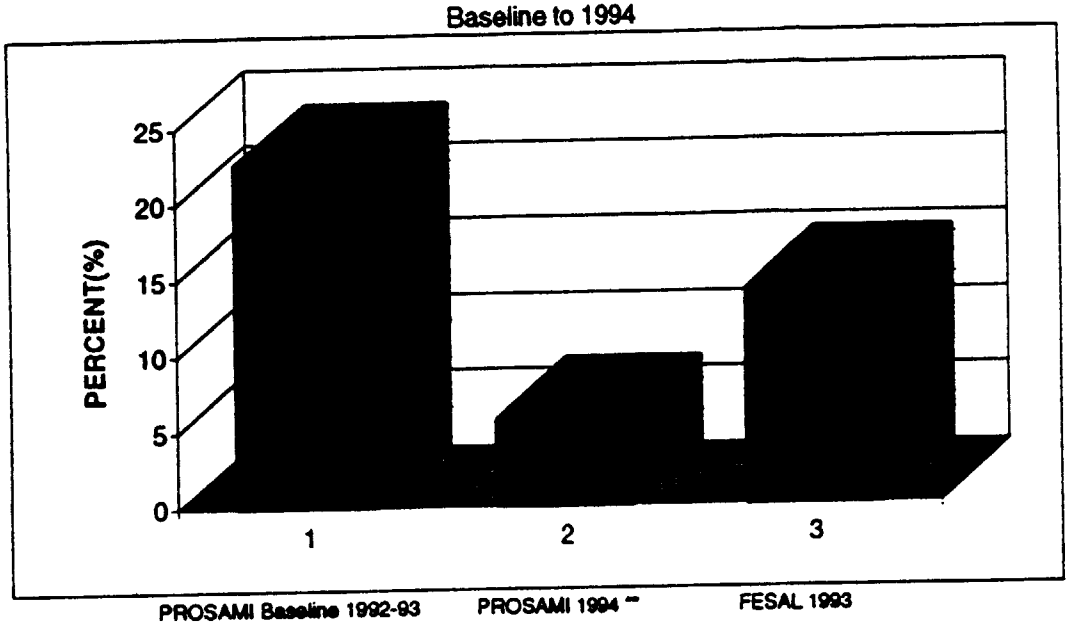
CONCLUSIONS AND RECOMMENDATIONS

1. While a community census was conducted at the beginning of NGO service activities in all of the areas served, the main purpose of the census was to identify persons at risk for maternal/child morbidity and mortality. Once completed, the census is not updated and the promoters generally only collect and remit information concerning their clients (i.e., those persons who directly receive curative or preventive services from the promoter).

   Recommendation: Update the census in all communities annually. Health information concerning all members of the community population should be collected, and not just information from clients.

   All births and deaths should be noted, all cases of ARI and ADD in children, all GMD controls, etc., so that accurate statistics for the entire community population can be maintained. If this is done, the exact morbidity, mortality, fertility, etc., rates of the

GRAPH No. 8
PROSAMI
(Percent of Children under 5 with Severe or Moderate Malnutrition, wt/age)
in the PROSAMI Area Compared with Rural El Salvador Overall)
Baseline to 1994

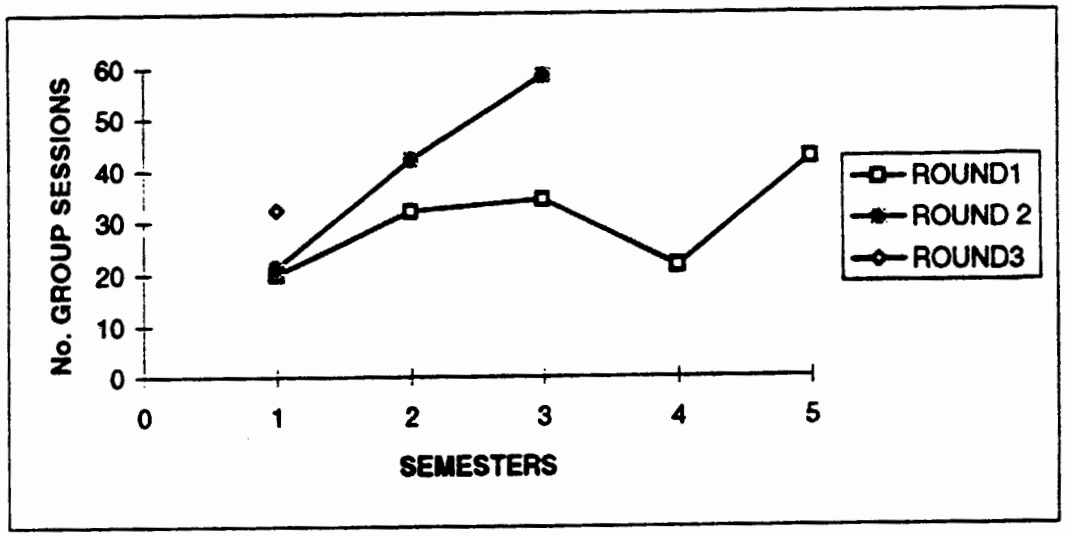


* Based on husehold census baseline data for 156,360 population (58% of the PVO population first and second round PVO's)

** Projected Annual Rate field data based on 6 months of growth monitoring, first and second round PVO's.

PROSAMI Baseline (No. 26,581)
PROSAMI 1994 (No. 42,042)
FESAL (No. 1,824)

GRAPH No. 9
1994
TREND ANALYSIS
HEALTH EDUCATION
COMMUNITY EDUCATIVE GROUPS SESSIONS FOR HEALTH PROMOTORS, OF SERVICE IMPLEMENTATION ABD ROUND FINANCY OF PVO'S



ROUNDS	0	1	2	3	4	5
ROUND 1	0	20.00%	32.00%	34.30%	21.60%	42.40%
ROUND 2	0	21.30%	42.10%	58.50%		
ROUND 3	0	32.30%				

community can be calculated, and the community's health can be monitored more accurately. This will also contribute to formulating better annual work plans, better prioritization of curative services, and better programming of educational activities.

Recommendation: Make the community health committees and community volunteers responsible for updating and maintaining the community census and community database of health information. This will not only facilitate the collection of data, but will also involve community members in the first stage of needs assessment and planning. It also follows that the community health committees and volunteers, together with the promoter, should formulate the annual health plan for the community. This will contribute to greater community participation in and support of health activities.

2. A better understanding of the purposes and importance of maintaining a good health information system (HIS) and its place in planning, supervision, and monitoring would help to increase compliance and implementation of the HIS.

   Recommendation: Design and organize more training sessions on the collection of morbidity and mortality data, and the calculation of impact indicators for the NGO executive directors, NGO technical staff, community promoters and TBAs, and members of the community health committees.

VI. D. SUSTAINABILITY

1. NGO LEVEL

The value of self-sufficient organizations as a stable and capable way of sustaining health services and programs is appreciated by the NGOs in the PROSAMI Project. Self-sufficiency is in the best interest of the organizations, and there constituency; it is in the organizations self-interest to become financially self sufficient.

PROSAMI NGOs should be in control of their own goals and activities. Diversification of income base, inter-institutional collaboration and quality programs are just a few of the ways that can help move NGOs away from their dependence upon international donors.

Each organization should be examined by looking at its many activities and programs to determine which are focusing specifically on PROSAMI goals and objectives. Look at their delivery services, planning and financial systems to see whether the institution has the mechanism for implementing program activities.

NGOs in the PROSAMI Project are not alike. Their mission, structure, style, constituency size are quite different, as they should be. This independence, uniqueness, the presence of highly motivated professionals, their ability to work with and penetrate into high risk area where communities have been under great stress during the conflict period is impressive. Some organizations are going to take longer than others to make the transition from dependance to self sufficiency. Some believe that if the economy is reactivated, more resources will be made available through GOES programs. This may or may not be the case.

Many of the NGOs are involved in purely social programs and are highly unlikely to generate any significant amount of funds for cost recovery. Developing a diversified donor base may be difficult for these NGOs. Most will always be in need of budget support from outside sources. On the other hand, there are some NGOs already providing 30% of their total costs through income producing activities. Others feel secure for the time being with income from outside private donor groups. However, the long-term view of international donor funds has these organizations concerned.

There will be considerable demand for these funds. When NGOs were asked of the probability of their self-sufficiency, they either did not known or were doubtful, but felt it was possible. See finance section for more details.

VI. D. SUSTAINABILITY

2. PROJECT SUSTAINABILITY

PROSAMI must be able, over the next three years, to look carefully at the various programs, activities, structure and internal procedures of each NGO to determine what is necessary for each organization to be able to move ahead independently developing a program to strengthen the sustainability of each institution. Detailed sustainability plans must be developed for each NGO, with a strategy to bring their delivery system up to a level which is more effective and efficient and at the same time cost recovery becomes a realistic alternative for part of their activities. With fewer funds directed to personnel costs, as well as administrative operating costs, their programs will be more attractive to donor organizations. Optimizing funds directly to maternal and infant care programs via a system of effective and efficient delivery is appealing to potential donors and for fund raising activities. An NGO with this image is more apt to succeed than one with high operating costs and salary levels which reach 30 to 40 percent of total costs.

To begin to look at the future of each organization it is important to make clear the definitions which are now being used interchangeable by PROSAMI NGOs. Program sustainability, institutional permanence and financial self-sufficiency are not the same things. Each should be clear in the minds of the NGOs so that a plan of action can focus upon the needs of the organizations on each of these levels. In the transition from dependance to independence, each of these concepts means a different objective for the NGO and a better understanding of what is involved in organizational change. When one or two of these concepts are working well in the organization, priorities can be set, ranking the prospects of obtaining funds to concentrate on the weak links and constraints to program sustainability or institutional permanence. Strategies and plans can then be developed for each organization to achieve program sustainability, institutional permanence or financial self-sufficiency. One of the important aspects for providing resources to NGOs through the transition period is its ability to develop planning in an effective way to carry the NGO through the next three years and into sustainability. Another criteria is the ability of the NGO to write proposals. MSCI has an important role here to support training and identify resource persons for assistance in this activity.

Substantial assistance by PROSAMI will continue to be required by many of the NGOs in finance and accounting, project development and marketing research, communications and human resource development[34]. An internal analysis of the NGO's environment is critical and should include a mission statement, organizational structure, staff, delivery services, administrative systems and procedures. Leadership, management and staff development over the long run should be a high priority. Organizational image is very important and the building of collaboration efforts among NGOs for the design and initiative of fund raising activities is important. An understanding of the market for fund raising will probably entail outside assistance for the NGO, together with building

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[34] An internal evaluation grading system for each NGO has been developed by the MSCI unit for PROSAMI, over the last three years. This grading system, together with the interviews and visits to the eight NGO's have been used to help make the evaluation of organizational strengths and weaknesses. See Annex H1 for the list of the NGO's visited and Annex G-4 for NGO ratings.

into the organization these capabilities. A good fund raiser can pay for his or her salary many times over during the period of a year.

A sustainability plan which incorporates all of these activities will take three to five years to carry out and should focus upon cost constraints, recovery of costs and increasing the income base through fund raising, endowments, raising fees, community donations, and private sector tax-right-offs for property tax deductions, which are permissible under El Salvador Law.

VI. D. SUSTAINABILITY

3. COMMUNITY LEVEL

Decentralization seems to be an interest of the present GOES. Identifying functions at the municipal level and providing resources to implementing organizations (NGOs) to carry out these functions could have an important impact on a communities ability to manage and finance its own educational, health and productive activities. More project emphasis over the next three years should be placed upon the communities active participation in helping to design, determine feasibility, manage and implement, maintain and evaluate PROSAMI NGO health projects. Over the first three years of the PROSAMI Project the technical aspects have been emphasized, because results were important, and successes had to be visible. Now that this has been accomplished it is time to refocus the project upon activities designed to: train community members to accept more responsibility in the management and active participation in the NGO health projects. This is time consuming and costly, however, to obtain a sense of ownership by community members it is critical if the Project is to be sustainable. If it is to be expected that financial self-sufficiency is to be reached with a part of the funds coming from the communities through increased fees, dues, community activities, then popular participation must be forthcoming.

An important aspect of the PROSAMI Project is the community local health committees. These committees together with other volunteers of the community, are involved in activities such as; fund raising, constructing infrastructure (latrines, water systems, garbage disposal, chlorination of water, etc.) communicating health, household visits assisting the promoters in diagnosis of the community, helping with client visits, assisting promoters where there are a large number of houses, or where promoters have responsibilities in more than one community.

The community health committees are being developed at the local level and NGOs need to strengthen the capacity and abilities of community volunteers to assume more responsibility. Training of these volunteers should increase the range of activities they carry out in the communities, decrease the workload of existing promoters, increase the supply of potential future promoters, reduce costs by taking over part of the workload of promoters and of course, increase the committee's role in generating revenue by training to volunteers in fund raising campaigns.

Low levels of literacy will prove troublesome in some activities for community volunteers, but on the other hand, the ideas communicated by these groups will add to improving participation in upgrading the quality of the Project.

The current institutionalizing and expanding of community health committees is a positive factor in sustaining the PROSAMI Project. Its horizontal organizational contribution makes it harder to shut down operations at the end of the Project because it has extended its activities over a broader base with more constituents.

VI. D. SUSTAINABILITY

4. CDIE STUDY OF FACTORS INFLUENCING SUSTAINABILITY

The sustainability ratings of PROSAMI according to the USAID/CDIE (Center for Development, Information, and Evaluation) sustainability scale have proven to be an important exercise and should be continued by PROSAMI on an annual basis through the remaining years of the Project. This tool serves as an important reference to attitudinal change, especially within the NGO organizations. The CDIE scale consists of ten factors which were considered to be important indicators of the sustainability of U.S. foreign assistance programs in health. These factors were applied to the Maternal Health and Child Survival Project in El Salvador. The factors were as follows[35]: 1) Project Effectiveness, 2) Institutional Organization and Management, 3) Economic Context, 4) Political Context, 5) Financing, 6) Project Content, 7) Project Negotiation Process, 8) Implementing Institution, 9) National Commitment, and 10) Community Participation. Respondents were asked to rate each factor on a scale of 0 to 5, with 5 being the highest and best score.

The NGOs rated 6 out of the 10 indicators as positive factors in the sustainability of PROSAMI efforts over the long run, while MSCI staff rated 9 out of the 10 as positive. Both groups agreed that positive factors included project effectiveness, organization, project content, negotiation process, institutional organization, national commitment, and community participation. Factors considered to be primarily negative or problematic for sustainability by both NGOs and MSCI included financing, and the economic and political contexts.

The methodology used was to distribute a questionnaire with the ten indicators to one third (12) of the executive directors of the NGOs, and ten professionals from the MSCI staff. The questionnaires results were discussed in focus groups formed with the respondents. The focus groups were used to provide insights and understanding of the data. Furthermore, the two focus groups provided a basis upon which the data could be compared between groups and validated.

Table 33 below, with its corresponding graphic representation in Graph 10, shows the results of the data tabulation for the responses of NGO executive directors, Part 1, and for the response of PROSAMI technical advisory staff, Part 2. Part 3 is a summation of the combined NGO and PROSAMI responses.

Factors which influenced the sustainability of PROSAMI, such as the project's reputation (01), institutional organization and management (02), Project content (06), implementing institution (08), national commitment (09), and community participation (10), received positive ratings, high priority, favorable consensus, strong commitment with positive effect. This can be seen in the NGO responses whose percentages cluster around the 3, 4, and 5 upper end of the scale.

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35 See Annex I.3 for the definition of the factors and the CDIE questionnaire that were used with both the NGO's and the PROSAMI MSCI professional staff.

It is also interesting to note that the NGOs believe the Project stimulates community participation (10) as can be seen from 92% of the Executive Directors answers clustered around the upper scale of 3, 4, and 5. This means they believe the Project is now stimulating community participation and responds to community-defined requests. The MSCI professionals are a bit less optimistic on this factor as their answers group more around the 2, 3, and 4 or middle of the scale.

This factor measures the degree of consensus among interest groups and decision makers ratings show a high positive response by both NGOs and MSCI professionals that (09) national commitment, shows that 73% of the Executive Directors, and 82% of MSCI professionals grouped their answers in the high end of the scale, 3, 4, & 5, indicating that general consensus favored the goals, and saw signs of favorable consensus among leadership, and that the Project represents a high priority of the country.

Institutional organization and management (02) addressed the issue of whether the Project was designed and implemented as a vertically run separate hierarchy (single-disease program or campaign) or integrated into existing institutional hierarchy (full service package of interventions). According to the CDIE study in the six countries, integrated services proved to be more sustainable than vertical services. 100% of the NGO Executive Directors answered this question in the high 3 and 4 categories, while the MSCI professionals, 100%, answered in the 3, 4, and 5 upper range, or felt the Project was essentially one of integrated services, with one professional stating it was totally integrated.

Furthermore, 100% of MSCI respondents, and 100% of Executive Directors of the NGOs answered the Project effectiveness factor in the upper end of the rating, 3 and 4, believing that the Project basically is accomplishing most of its objectives, has a positive reputation in terms of effectiveness and was heading toward a success in reaching its objectives.

One of the more interesting results is the insight into the thinking of the NGO Executive Directors with regard to the three factors concerned with Economic (03) and Political Context (04) and Financing (05), which are closely related. That is, NGO's perception of a strong and growing economy, national political stability and a source of financial support turned out to have a more negative or unfavorable, almost pessimistic effect on the NGO Executive Directors opinion regarding the sustainability of the project. The large percentage of answers regarding these three factors of the directors are grouped around the lower end of the scale 1, 2 & 3, which implies lack of confidence, weak sectors, is a serious constraint, questionable whether post-project financial needs will be taken care of. [36]

Likewise, the MSCI professionals were also somewhat pessimistic and troubled by these three factors 03, 04, & 05, but not as pessimistic as the NGO Executive Directors. Their MSCI scores clustered around 2, 3, & 4, which represented a more questionable attitude The 3.21 average sustainable score response by the NGO directors, and the 3.17 response by the MSCI staff indicates

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[36] This should be a major concern to the Project because the Evaluation Team has made a strong case that financial factors such as cost recovery , government and donor commitment and other sources of income are critical factors in sustainability of the Maternal Health and Child Survival Project.

that these two groups are not far apart, both consider the PROSAMI Project to be moderately sustainable in its present form.

Below, in Tables 32 and 33, we have taken the responses and added them up and averaged them to provide an overall "sustainability score" for each factor in the Maternal Health and Child Survival initiative.

Table 32.
Averaged Results from NGO and MSCI Raters of Sustainability Study
PROSAMI MTE, 1994

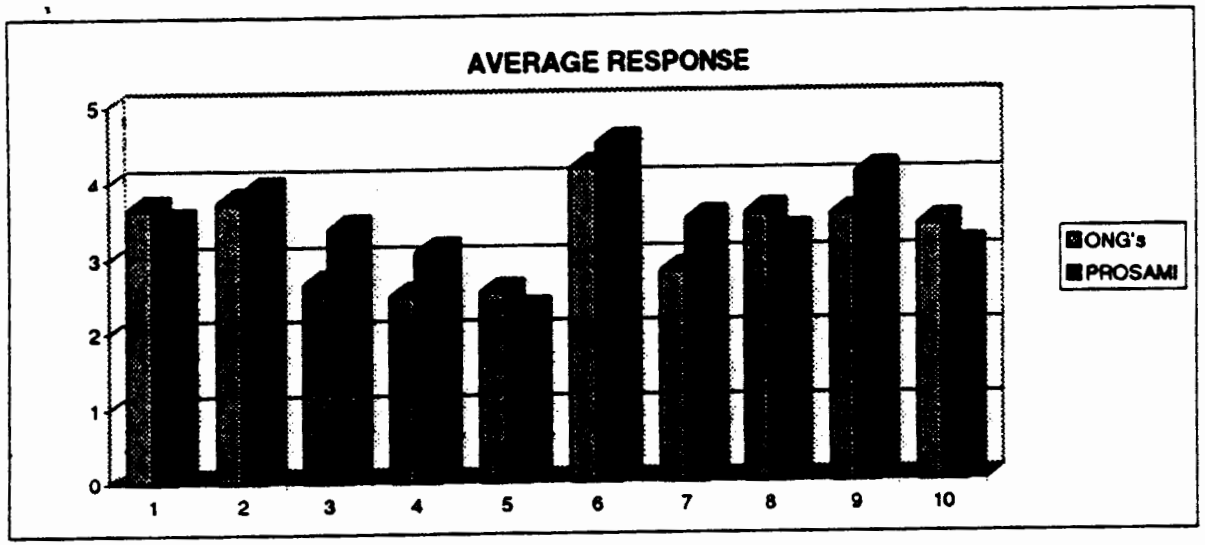
FACTORS	NGO	MSCI	NGO+MSCI
1. Effectiveness	3.67	3.5	3.59
2. Organization	3.75	3.9	3.89
3. Economic Context	2.67	3.4	2.95
4. Political Context	2.5	3.1	2.59
5. Financing	2.55	2.3	2.43
6. Project Content	4.17	4.5	4.32
7. Negotiation Process	2.28	3.5	3.14
8. Institution	3.58	3.3	3.45
9. National Commitment	3.55	4.1	3.67
10. Community Participation	3.42	3.1	3.27
AVERAGES	3.21	3.17	3.32

Table 33.
Responses to Sustainability Study
PROSAMI Mid-Term Evaluation, El Salvador, 1994

	CRITERIA	RATINGS												TOTAL RES-PON-DENTS	AVER-AGE RAT-ING
		0		1		2		3		4		5			
		No.	Tot.	No.	Tot.	No.	Tot.	No.	Tot.	No.	Tot,	No.	Tot.		
	RESPONSES OF NGO EXECUTIVE DIRECTORS														
01	Effectiveness	0	0	0	0	0	0	4	12	8	32	0	0	12	3.67
02	Organization	0	0	0	0	0	0	3	9	9	36	0	0	12	3.75
03	Economic Context	0	0	1	1	7	14	0	0	4	16	0	0	12	2.58
04	Political Context	0	0	4	4	4	8	2	6	2	8	0	0	12	2.17
05	Financing	0	0	0	0	6	12	4	12	1	4	0	0	11	2.55
06	Project Content	0	0	0	0	0	0	1	3	8	32	3	15	12	4.17
07	Negotiation Process	2	0	0	0	1	2	3	9	5	20	0	0	11	2.82
08	Institution	0	0	0	0	0	0	6	18	5	20	1	5	12	3.58
09	National Commitment	0	0	3	3	0	0	2	6	3	12	3	15	11	3.27
10	Participation	0	0	0	0	1	2	6	18	4	16	1	5	12	3.42
	RESPONSES OF PROSAMI STAFF														
01	Effectiveness	0	0	0	0	0	0	5	15	5	20	0	0	10	3.5
02	Organization	0	0	0	0	0	0	2	6	7	28	1	5	10	3.9
03	Economic Context	0	0	0	0	3	6	0	0	7	28	0	0	10	3.4
04	Political Context	0	0	1	1	2	4	2	6	5	20	0	0	10	3.1
05	Financing	1	0	0	0	6	12	1	3	2	8	0	0	10	2.3
06	Project Content	0	0	0	0	0	0	0	0	5	20	5	25	10	4.5
07	Negotiation Process	0	0	0	0	0	0	6	18	3	12	1	5	10	3.5
08	Institution	0	0	0	0	2	4	5	15	1	4	2	10	10	3.3
09	National Commitment	0	0	0	0	0	0	4	12	1	4	5	25	10	4.1
10	Participation	0	0	0	0	3	6	3	9	4	16	0	0	10	3.1
	AVERAGE OF NGO EXECUTIVE DIRECTORS AND PROSAMI STAFF														
01	Effectiveness	0	0	0	0	0	0	9	27	13	52	0	0	22	3.59
02	Organization	0	0	0	0	0	0	5	15	16	64	1	5	22	3.82
03	Economic Context	0	0	1	1	10	20	0	0	11	44	0	0	22	2.95
04	Political Context	0	0	5	5	6	12	4	12	7	28	0	0	22	2.59
05	Financing	1	0	0	0	12	24	5	15	3	12	0	0	21	2.43
06	Project Content	0	0	0	0	0	0	1	3	13	52	8	40	22	4.32
07	Negotiation Process	2	0	0	0	1	2	9	27	8	32	1	5	21	3.14
08	Institution	0	0	0	0	2	4	11	33	6	24	3	15	22	3.45
09	National Commitment	0	0	3	3	0	0	6	18	4	16	8	40	21	3.67
10	Participation	0	0	0	0	4	8	9	27	8	32	1	5	22	3.27

GRAPH No.10

FACTORS TO KEEP THE PROSAMI PROJECT



CRITERIES
1.Efectiviti
2.Organization
3.Economic Context
4.Politic Context
5.Financing
6.Project Context
7.Process of negotiation
8.Institution
9. National Compromise
10.Participation

ONG'S	3.67	3.75	2.67	2.5	2.55	4.17	2.82	3.58	3.55	3.42
PROSAMI	3.5	3.9	3.4	3.1	2.3	4.5	3.5	3.3	4.1	3.1

VI. D. SUSTAINABILITY

5. CONTRIBUTION TO USAID MISSION STRATEGIC OBJECTIVES

Improved quality with equity in health and education is the fourth Strategic Objective of the Mission. The Maternal Health and Child Survival Project has contributed to this Strategic Objective by providing access to essential primary health care services that were not available in 433 rural high risk communities before the PROSAMI Project began. Also, the Project has established a three tier quality control system; (1) PROSAMI technical advisors, (2) NGO technical coordinators, and (3) NGO supervisor of the service provider, which are the community promoters.

The contribution of the Project to equity has been the incorporation of the total population of 440,000 persons in rural high risk areas who heretofore did not have these services.

Finally, there are seven technical components of the Project which also contribute to the Strategic Objective of improved quality by grouping various services, such as children under five are vaccinated (complete series), women vaccinated with complete tetanus series, and pregnant women receive a minimum of five prenatal visits.

VI. D. SUSTAINABILITY

6. LEGAL STATUS

Without legal status no Government funds including FIS, (Fondo de Inversión Social), can be obtained by the NGOs. Their ability to raise funds from most other sources will also be restricted without this status. An NGO can not become a full member of the CONSALUD network of NGOs, which is presently being formed within PROSAMI. It is a critical issue for ten of the NGOs presently in the Project, who have not been able to obtain their legal status.

USAID and MSCI have been actively assisting in the task of obtaining legal status assuring that all documentation is correctly prepared and presented to the proper authorities. MSCI has contracted an attorney to assist in the process, and who is helping each individual NGO to obtain their legal status. Six NGOs have recently obtained their status through the help of this attorney, however, the remaining NGOs have presented their documents to the proper authorities, and are waiting.

For various reasons the remaining ten NGOs have had significant delays, for example, their past political affiliations, as well as bureaucratic delays. Personnel in the project are quite optimistic, however, that all hurtles will be overcome and approval will be received soon. One NGO received its status from the El Salvador Government after a US Senator visited their organization and communities and used his good offices to speed-up the process.

At official levels, USAID/El Salvador should help facilitate and speed-up the process here in San Salvador for the remaining ten PROSAMI NGOs.

VII. LESSONS LEARNED

MANAGEMENT AND ORGANIZATIONAL LESSONS

1. The planning systems for technical and financial control were designed as a detailed, innovative reporting, monitoring and feedback system to move information around the communities, the 35 NGO's, and around the PROSAMI Project itself, as well as for interinstitutional reporting. These systems were important in expressing how management wanted the organization to work and to make important decisions and implement change. They were the systems that communicated down the line what managers wanted, and back up with information on what was happening, to make a significant contribution to the success of the Project.

2. The various NGO's had a wide variety of management styles and structures as well as a wide variety of individual capabilities and capacities. It is important not to place undue restrictions, nor to force diverse NGO's into one model of organizational design, but instead, a flexible system of good administration, planning and finance should be provided, and then the NGOs should be permitted to adapt these systems to their own organization and management styles as they see fit.

3. The transition from dependence to independence is an important step in the process of developing the sustainability of the PROSAMI program by the NGOs which comprise the network. This is facilitated by developing plans for individual and collective action by each organization on program sustainability, institutional permanence and financial self-sufficiency. To assist and shorten the time line to independence, the NGOs have formed a network organization (CONSALUD) to centralize administrative functions, technical training and standardization of services, and to coordinate activities.

MATERNAL HEALTH AND CHILD SURVIVAL LESSONS

1. PROSAMI has demonstrated that a relatively diverse group of indigenous NGOs can be successfully organized into a coherent and collaborative network to effectively provide specific technical services (e.g., maternal health and child survival services).

   The PROSAMI network has united NGOs which in some cases had been political antagonists, feminist associations, religious organizations, social service groups, new NGOs and well established NGOs. Prior to their association under the aegis of PROSAMI, many of the NGOs did not associate with each other. Many of the NGOs did not have a strong background in health care. Within the context of a common social service project; sharing the same goals and implementing the same primary health care services, and fulfilling the same standards and norms, the members of the PROSAMI

network of NGOs have learned to work together to benefit a much larger population than any one organization could have accomplished.

2. PROSAMI has shown that community personnel with relatively little formal education can successfully deliver a relatively complex package of specifically adapted technical services when they receive adequate basic training, with complementary, regular supervision and continuing education.

The PROSAMI community health promoters were trained to deliver some health care services which had been previously only been delivered by physicians and nurses. In El Salvador, as in many other countries, this was the case. Consequently, where there were no doctors or nurses, these services were not available. This situation was especially acute in rural areas. PROSAMI technical staff simplified and adapted the case management of selected maternal health and child survival interventions so that the promoters could identify high risk situations and send them to physicians or nurses. Case detection and simplified case management were taught to the promoters in a three-month basic training course, which was significantly complemented and supplemented by "on-the-job" training by technical supervisors. The supervisors were physicians, nurses or maternal-child health technicians.

In sum, there were three important steps. 1) Simplified and focused technical procedures. In PROSAMI, the case management of MHCS services was simplified to recognize and refer high-risks or possible high-risks, combined with the treatment of mild cases and surveillance. 2) Basic training. The simplified procedures were taught to the selected community personnel in a basic course. And 3) Regular supportive supervision. Supervisor ensure that the simplified procedures are implemented correctly and provide continuing education.

3. Active case detection and simplified case management can be effective in reducing morbidity and mortality.

A large proportion of morbidity and mortality in developing countries, and particularly in the rural areas of these countries, results from health conditions that can be easily prevented if detected and treated opportunely. This can be accomplished by actively searching for and identifying cases of morbidity that have the risk of leading to mortality, and providing opportune treatment to avoid the risk of death, or by referring the person to a physician or nurse.

4. A community based health service system can significantly impact and improve community health.

A health service system which includes primary preventive services (health promotion and protection), and secondary preventive services (early detection and opportune treatment), and which is permanently located in the community can improve community health and

reduce mortality. Such a system can respond to community needs both in terms of resolving specific problems and in terms of access.

5. Primary preventive services (education, promotion and protective measures to prevent health problems) are more effective if associated with and delivered as complements to secondary preventive services (diagnosis and treatment of existing health problems).

HEALTH FINANCE LESSONS

1. In a comparatively short time, PROSAMI and the associated NGOs have implemented a number of advanced systems in accounting, inventory, payroll, accounts receivables, and purchasing. A number of NGOs hired computer programmers and accountants to design systems that met the financial requirements of general accounting principles as well as the project requirements. These systems could be compared and then combined into one system that utilizes the best of each individual program.

2. PROSAMI has developed a good system of accounting and purchasing policies and procedures that could serve as a guide for other cooperative agencies managing NGOs.

3. Many of the NGOs working with PROSAMI have highly sophisticated and creative ways of generating funds that help to pay the administrative costs of other programs that need subsidies. They are good examples of how to set up small business enterprises, small factories, training programs, consulting assistance, agriculture ventures, and similar enterprises. Almost all of the successful NGOs in this endeavor have only recently started enterprises that can generate a surplus sufficient enough to subsidize other programs, such as rural primary care.

4. Two of the NGOs have developed a very good system for monitoring cash collecting from patient charges. It is always a challenge to establish a system that can account for all money charged for services for any rural health program of wide geographic distribution, and these systems should be applied to other health care promoter programs.

5. Many of the NGOs have very influential and professional Boards of Directors. They operate in a very sophisticated manner, and could be models for other NGOs.

ANNEXES

MID-TERM EVALUATION

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT

PROSAMI

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ANNEX A.

LIST OF NGOs IN THE PROSAMI NETWORK

LIST OF NGOs IN THE PROSAMI NETWORK

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AMCS — **Asociación de Mujeres Campesinas Salvadoreñas**
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Ahuachapan, El Salvador
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Fax: 43-0537

AMS — **Asociación para la Autodeterminación y Desarrollo de Mujeres Salvadoreñas.**
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ASADEH — **Asociación Salvadoreña para el Desarrollo Humano**
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ASALDI — **Asociación Salvadoreña para el Desarrollo Integral**

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ASAPROSAR — **Asociación Salvadoreña Pro-Salud Rural**

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ASPS — **Asociación Salvadoreña Promotora de Salud**

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CALMA — **Centro de Apoyo de Lactancia Materna**

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Antigua Ruta Militar
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COMUS — **Comunidades Unidas de Usulutan**

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San Francisco Javier (Frente a ANTEL), Usulután
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CONAMUS — **Coordinadora Nacional de la Mujer Salvadoreña**

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Municipio de Villa El Rosario USULUTAN
o,
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FASTRAS — **Fundación para la Autogestión y Solidaridad de los Trabajadores**

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San Salvador
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FUMA — **Fundación Maquilishuat**

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FUNDAC — **Fundación Cuscatlan "Manuel Franco"**

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FUNDEMUN — **Fundación Salvadoreña para el Desarrollo de la Mujer**

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FUNDEPRENS — **Fundación de Enseñanza de El Salvador**

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FUNDESO — **Fundación de Desarrollo Social**

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KNAPP — **Fundación Knapp**

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OEF — **Asociación para la Organización y la Educación Empresarial Femenina**

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ORMUSA — **Organización de Mujeres Salvadoreñas**

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PADECOMSM — **Patronato para el Desarrollo de las Comunidades de Morazan y San Miguel**

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PROCADES — **Asociación Salvadoreña de Promoción, Capacitación y Desarrollo**

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PROGRESO — **Promogestora de Repoblaciones Solidarias**

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ANNEX B.

LIST OF TABLES, CHARTS Y GRAPHS IN THE TEXT

LIST OF TABLES, CHARTS AND GRAPHS IN TEXT

TABLES

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Table 10. Themes of PROSAMI Newsletter: "Maternal Health and Child Survival"
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Table 17. Coverage of the Control of Diarrheal Diseases and Dehydration
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Table 19. Coverage of Maternal and Rreproductive Health by Promoters
Table 20. Coverage of Neonatal and Perinatal Health
Table 21. Immunization Coverage
Table 22. Coverage of Growth Monitoring, Development and Nutrition (GMD)
Table 23. Coverage of Community Organization and Participation
Table 24. Total Cost Comparison and Cost per Attention: MOH, PROSAMI, and FUSAL, 1993
Table 25. Cost per Population, Promoter, and Promoter Visits
Table 26. PROSAMI Field and Home Office Expenses: Cost and Trend Analysis
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Graph 2. 1994 Trend Analysis; Respiratory Infections: Percent of Cases with Acute Pneumonia/Respiratory Infection, by Quarter of Field Implementation by PVO Funding Round.
Graph 3. PROSAMI: Increase in Prenatal Care Coverage; Baseline/1994.
Graph 4. 1994 Trend Analysis; Maternal Health: Prenatal Care Coverage by Semester of Field Implementation, by PVO Funding Round.
Graph 5. 1994 Trend Analysis; Newborn Coverage (4 Visits/Newborn): Percent of Cases with Dehydration, by Quarter of Field Implementation and by PVO Funding Round.
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Graph 7. 1994 Trend Analysis; Growth and Development: Growth Monitoring Coverage, Children 0-5, by Semester of Field Implementation and by PVO Funding Round.
Graph 8. PROSAMI: Percent of Children under 5 with Severe or Moderate Malnutrition (wt/age) in the PROSAMI Area Compared with Rural El Salvador Overall. Baseline to 1994.
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ANNEX C.

DOCUMENTS REVIEWED, & PEOPLE & ORGANIZATIONS VISITED

ANNEX C-1.

Organizational Management Specialist

C-1. Organizational Management Specialist

Principle Documents Reviewed

USAID/El Salvador Action Plan FY 1995-1996
AID/LAC/P-618: El Salvador Project Paper, PVO, Maternal Health, Child Survival. 1994
ANSAL; Infrastructura Del Sector Salud, Informe Tecnico, Enero, 1994
Workshop On Sustainability and Self-sufficiency, The InterAmericas Group,1993
Finance Manual, MSCI, PROSAMI. February, 1993
Taller Sobre: Sistema de Logros, PROSAMI. Abril, 1993
Manual De Procedimientos Administrativos Y De Control, AMS Aguirre, Paredes y Asociados, Junio, 1993
Manual De Operacion Del Sistem de Logros, PROSAMI, MSCI Junio de 1994
Resumen Mensual De Calificacion De 36 ONG's, Julio, 1994, PROSAMI,1994
Unidad De Capacitacion y Asesoria Tecnica: Reporte De Capacitaciones Desarrollades en 1993. PROSAMI, 1994
Manual De Operacion Del Sistema De Activo Fijo, PROSAMI, MSCI. 1994 Manual De Operacion de Bodega, PROSAMI, MSCI, Febrero, 1993
Guia De Operacion Del Sistema De Inventario-Certiflex, PROSAMI, MSCI/AID, 1992
Manual De Operacion De Bodega, PROSAMI, MSCI/ AID, Marcos Valdes, Febrero, 1993
"Evaluation of AID Child Survival Program", Child Survival In Bolivia. AID Technical Report No. 5. 1992
Normas De Educacion Para La Salud, Ministerio de Salud Publica y Asistencia Social. San Salvador, 1993
La Participacion Social En Los Sistemas Locales De Salud, Ministerio De Salud Publica Y Asistencia Social, Unidad De Educacion Para La Salud. Agosto, 1993
Analisis del Sector Salud en El Salvador (ANSAL), Final Report; USAID, OPS/OMS, Banco Mundial, Banco Interamericano de Desarrollo. Mayo, 1994

Interviews and Meetings

Non-Governmental Organizations

Site Visits

1. ASADEH; Asociacion Salvadorena Para El Desarrollo Humano, Second Round

2. ASALDI; Asociacion Salvadorena Para El Desarrollo Integral, First Round

3. FUMA; Fundacion Maquilishuat, Second Round

4. IDEA; Iniciativa Para El Desarrollo Alternativo, Third Round

5. KNAPP; Fundacion KNAPP, Second Round

6. O.E. F.; Asociacion Para La Organizacion Y Educacion Empresarial Femenina, First Round

7. PADECOMSM; Patronato Para El Desarrollo De Las De Comunidades De Morazan Y San Miguel, Third Round

8. PROCADES; Asociacion Salvadorena De Promocion, Capacitacion Y Desarrollo, First Round

Key informants of NGO's are listed below, however, numerous community volunteers, community health committee members, promotors,technical personnel, office administrator/accountants and technical coordinators from the NGO's were visited but are not included in this list.

NGO Executive Directors, site visits:
Lic. Denorah de Sanchez, O.E.F.
Lic. Claudia Caceres, PROCADES
Lic. Carlos Adams Zamora, ASALDI
Lic. Modesto Rebollo, ASADEH
Dr. Santiago Orellana Armador, KNAPP
Sra. Martha Elena Rauda, FUMA
Sr. Leandro Uzquiano, IDEA
Sra America Vaqueran, PADECOMSM

PROSAMI NGO Evaluation Committee, Executive Directors:
Lic. Sara del Carmen Ventura, FUNDEMUN
Lic. Claudis Caceres, PROCADES
Dra. Ana Cecilia Melendez, OPRODE
Lic. Dinorah de Sanchez, O.E.F.
Lic. Luis Palma Lopez, OPRODE

PROSAMI MSCI Principle Staff

Dra Elizabeth Burleigh, Project Director
Dr. Manuel Beza, Technical Coordinator
Lic. Jose Landaverd, Financial Manager
Lic Rosa Maria Valiente, Business Office Manager
Li . Flor de Maria Ramirez, Training Coordinator
Mr Lloyd Welter , Assistant Director
Li . Rene Osorio, Mangt. Information Systems
Sr Marcos Valdés, Warehouse Manager

Ministry of Public Health and Social Assistance

Dr. Eduardo Interiano, Minister of Health
Dr. Rendones, Director General of Health
Dra Sonia de Melchor, Director, Health Education
Lic. Gicela Cenela de Garrero,Community Health Department
Dra. Sonia Mairazin de Machoa, Community Health Department
Dra. Patricia de Quinteros Sub-Director Community Health Dept.
Lic. Angela de Larin, International Cooperation
Lic. Monroy, Coordinator, NGO's in Health

United States Agency For International Development, USAID El Salvador

Ms. Brenda Doe, Director, HPN
Ms. Karen Freeman, Evaluation Officer
Mr. Cris Edwards, Programming and Planning Office
Dr. Raul Tolido, Acting Project Officer
Ms. Margereta de Lobos, Project Officer

ANNEX C-2.

Maternal Health & Child Survival Specialist

C-2. Maternal Health and Child Survival Specialist

Documents Reviewed

1. ADS, CDC, MSPAS, MPCDES, DGEC, ISSS, USAID: FESAL-93, NATIONAL FAMILY HEALTH SURVEY. April 1994.

2. AID/LAC/P-618: EL SALVADOR PROJECT PAPER, PVO MATERNAL HEALTH, CHILD SURVIVAL. Project Number 519-0367. 1990.

3. ANSAL: INFRAESTRUCTURA DEL SECTOR SALUD, INFORME TECNICO, Borrador Avanzado. Enero, 1994.

4. ANSAL: LA REFORMA DE SALUD: HACIA SU EQUIDAD Y EFICIENCIA. ANALISIS DEL SECTOR SALUD DE EL SALVADOR (ANSAL). USAID, BM, OPS/OMS, BID. Mayo, 1994.

5. Ayalde, J: PERFIL EPIDEMIOLOGICO, EL SALVADOR. ANALISIS DEL SECTOR SALUD DE EL SALVADOR (ANSAL). USAID, BM, OPS/OMS, BID. Mayo, 1994.

6. Becerra, F: SITUACION MATERNO INFANTIL, EL SALVADOR. ANALISIS DEL SECTOR SALUD DE EL SALVADOR (ANSAL). USAID, BM, OPS/OMS, BID. Mayo, 1994.

7. Beza, JM: DESCRIPCION DEL COMPONENTE INFECCIONES RESPIRATORIAS AGUDAS, TALLER DE UNIFICACION DE CRITERIOS, 1993. PROSAMI, Agosto de 1993.

8. Bossio, JC: EVALUATION OF ACTIVITIES TO CONTROL ACUTE RESPIRATORY DISEASES IN CHILDREN UNDER FIVE YEARS OF AGE IN EL SALVADOR-PROSAMI. JSI/REACH, May-June, 1993.

9. Godoy Bolaños, JM: COMPONENTE CRECIMIENTO Y DESARROLLO. PROSAMI, 1994.

10. González Portillo, R: COMPONENTE SALUD DEL RECIEN NACIDO. PROSAMI, San Salvador, Julio de 1994.

11. Kolodin, S: ANSAL: DEMANDA DE SERVICIOS DE SALUD, INFORME TECNICO, Borrador Avanzado. Enero, 1994.

12. Linares, MA: DESCRIPCION DEL COMPONENTE ENFERMEDAD DIARREICA AGUDA, ENFERMEDADES PARASITARIAS Y TERAPIA DE REHIDRATACION ORAL. PROSAMI, MSCI, San Salvador, Agosto de 1994.

13. Martínez, E: ANSAL: RECURSOS HUMANOS EN SALUD, INFORME TECNICO, Borrador Avanzado. Enero, 1994.

14. Morales Velado, MA: DESCRIPCION DEL COMPONENTE DE SALUD REPRODUCTIVA. PROSAMI, San Salvador, 1994.

15. Prieto, C, y Carrizosa, A: ANSAL: SISTEMAS DE SERVICIOS DE SALUD, INFORME TECNICO, Borrador Avanzado. Enero, 1994.

16. PROSAMI, RESUMEN MENSUAL DE CALIFICACIONES DE 36 ONG'S, JULIO, 1994. San Salvador, 20 de Agosto de 1994.

17. PROSAMI, RESUMEN MENSUAL DE CALIFICACIONES DE 36 ONG'S, AGOSTO, 1994. San Salvador, 20 de Septiembre de 1994.

18. PROSAMI, UNIDAD DE CAPACITACION Y ASESORIA TECNICA: (11) MODULOS DIRIGIDOS A PROMOTORES DE SALUD. 1993 y 1994.

19. PROSAMI, UNIDAD DE CAPACITACION Y ASESORIA TECNICA: REPORTE DE CAPACITACIONES DESARROLLADAS EN 1993. Diciembre de 1993.

20. Ramírez, FM: COMPONENTE: ENFERMEDADES PREVENIBLES CON VACUNAS. PROSAMI, San Salvador, 30 de Abril de 1994.

21. USAID/EL SALVADOR ACTION PLAN, FY 1995-1996.

22. USAID/EL SALVADOR PROJECT PAPER, PVO MATERNAL HEALTH/CHILD SURVIVAL. AID/LAC/P-618, Project Number: 519-0367.

Interviews and Meetings

1. Dr. Elizabeth Burleigh, PROSAMI Project Director
2. USAID/El Salvador:
   - Ms. Brenda Doe, HPN Director
   - Ms. Karen Freeman, Evaluation Officer
   - Ms. Ana Cristina Mejia, Project Backstop in Project Office
   - Mr. Chris Edwards, Programming and Planning Office
   - Dr. Raúl Toledo, Interim Project Officer
3. PVO technical staff training session.
4. PROSAMI-Technical Staff, orientation to technical activities:
   - Dr. Manuel Beza, Technical Coordinator
   - Dr. Miguel Angel Linares
   - Dr. Aníbal Quijano
   - Lic. Miriam Bernal
5. Lic. For de María de Ramírez, PROSAMI Training Coordinator

6. PROSAMI Technical Staff, presentation of seven technical components, followed by discussions with individuals at various times:
   - Dr. Manuel Beza, Technical Coordinator
   - Dr. Miguel Angel Linares
   - Dr. Aníbal Quijano
   - Lic. Miriam Bernal
   - Dra. Marina Silva
   - Dr. Ricardo Gonzales
   - Dr. Manuel Godoy
   - Dr. Mario Morales
7. PROSAMI PVO Evaluation Committee:
   - Lic. Sara del Carmen Ventura, Executive Director of FUNDEMUN
   - Lic. Claudia Cáceres, Executive Director of PROCADES
   - Dra. Ana Cecilia Meléndez, Executive Director of OPRODE
   - Luis, OPRODE
   - Enma, OEF
8. Site visit to ASALDI, and the community of San Isidro Lempa.
9. Meeting of 25 Technical Coordinators of PVOs.
10. Ministry of Public Health and Social Assistance (MOH):
    - Dr. Eduardo Interiano, Minister of Health
    - Dr. Rendones, Director General of Health
    - Ms. Brenda Doe, USAID/El Salvador, Director of HPN
    - Dr. Elizabeth Burleigh, PROSAMI Project Director
    - Evaluation Team
11. Site visit to PROCADES, and the community of Las Delicias.
12. Site visit to FUNDESO, and the community of Quebracho.
13. Ministry of Public Health and Social Assistance (MOH):
    - Dra. Delmi Zelaya de Hernández, Chief, Division of Preventive Medicine
    - Dra. Evangelina de Ventura, Medical Supervisor
    - Dra. Sonia de Melchor, Director, Health Education Department
    - Lic. Gicela Cente de Gamero, Community Health Department
    - Dr. Gustavo Domínguez Grimaldi, Director, Reproductive Health Dept.
    - Dr. Alfonso Alvarez, Reproductive Health Department
14. Meeting with 25 Executive Directors of PVOs.
15. Site visit to ASAPROSAR in Santa Ana, and the community of El Jícaro.
16. Site visit to CONAMUS in Nueva Concepción, and the communities of El Bado and El Sitio de las Flores.
17. Site visit to FUNDEPRENS in Chinameca, and the community of Cruz Primera.
18. Site visit to FUNDEMUN in Usulután, and the community of El Cerrito.
19. PROSAMI PVO Evaluation Committee:
    - Lic. Sara del Carmen Ventura, Executive Director of FUNDEMUN
    - Lic. Claudia Cáceres, Executive Director of PROCADES
    - Dra. Ana Cecilia Meléndez, Executive Director of OPRODE
    - Lic. Luis Palma Lopez, OPRODE
    - Lic. Dinorah de Sanchez, OEF

ANNEX C-3.

Health Finances Specialist

ANNEX D.

INSTRUMENTS

ANNEX D-1.

Instruments Used by the Organizational Management Specialist

ORGANIZATIONAL MANAGEMENT SPECIALIST
Lewis Thorton
Questionnaire Guidelines
for interviews with staff from:
PROSAMI
PVO's
Communities

I. METHODOLOGY FOR INTERVIEWS*

Key informants from each institution interviewed will be selected in consultation with staff of PROSAMI, with confirmation from PVO's. This questionnaire to be used as a guideline in interviews, however, interviewees will be given time to raise issues and provide information not contemplated in this questionnaire.

II. KEY INFORMANTS

A. PROSAMI

Divisional Directors: Project Director, Technical Coordinator, Training Specialist, Finance Manager -- pre-campo meeting, first group, four hours; Project Deputy Director, MIS Manager, Commodities Advisor, Warehouse Manager, Business Office Manager. Second group, four hours pre-campo. First meeting focuses upon divisional functions, planning and budgeting systems to determine how information is moved around the organization and how decisions are made. We wish to identify the characteristic features of the policy-making and problem solving process. Hard copy systems; reports and computer printouts will be compared with other systems; meetings, routines, and networks.

Post-campo meetings with the same individuals in the two groups will be used to validate information and impressions, and to dig deeper. We wish to learn whether some PVO's and technologies have a special vocation for inducing learning, attitude change and institutional reform.

B. PROSAMI Questions:

1. Explain your divisional functions.
2. Explain the overall planning process in your division, frequency of reporting (monthly, quarterly, annually, etc.) and how this is communicated down the line and back-up the line. Explain targets. What is your most important submission.

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* Methodology of mid-term evaluation includes key informant interviews, primary source document review, site visits to PVO's and communities.

3. Explain the overall financial control system and accounting for your division. Most important and significant submission. When variances occur how are they corrected?
4. Do operational plans identify steps; are milestones concrete and mensurable? Show these on your Plan Anual, Plan Operativo, Plan Trimestral.
5. A planning system must be very detailed and pragmatic - very carefully done. Rate yours on a scale of 1 to 5 (5 = excellent).
6. The MIS reports on a number of key indicators of divisional, PVO, and community performance. Does management flag discrepancies to take prompt action? How often? What action is taken and how? Where is this noted? (Which report). Is this discussed in meetings or only in charts and tables? Explain.
7. Divisional performance reviews are carried out when? Frequency? Where do operational plans go once completed? On the less qualitative side of systems, explain how you keep the division on track, i.e., ability to stay on plans.
8. Are plans and peer reviews carried out in front of all division heads? How are division heads graded by top management? How is poor performance graded?
9. Do divisional heads get out into the field? Show me schedules.
10. Is everyone being trained at the divisional level in PROSAMI? Budget for this? What is training criteria for divisional staff, including heads of divisions. Is there a personal career path developed for each employee? Show this.

C. <u>PVO Questions</u>
1. Board of Directors
2. Executive Director
3. Administrator and/or Accountant
4. Technical Coordinator
5. Supervisor Promotor
6. Promotor

1. <u>Executive Directors/Administrator/Accountant</u>
Give me a brief profile of your PVO, including structural characteristics.

a) Explain the planning process and number of plans (annual, operational, quarterly, etc.). Walk through the total process showing steps, forms, meetings, and communication process down the line and back up. Who do you send reports to in PROSAMI.

b) Explain MIS reports and process. Who, in the organization works directly with this report, filling out the forms, gathering information, identifying discrepancies, and taking prompt action.
c) Explain the financial control system. Who is directly responsible in your PVO for complying with financial control.
d) Discuss human resource strengths and weaknesses and how training is, or is not, helping. Explain staff training and discuss evaluation reports of this training.
e) Discuss project problems and what you are doing to overcome these problems.
f) What services are you providing the communities, especially those services related to strengthening community ability to help sustain projects in these communities.
g) What is your professional formal training including university. What specific training have you received during the PROSAMI project.

2. <u>Technical Coordinator/Supervisor/Promotor</u>
<u>Coordinator and Supervisor</u>
a) Discuss your work schedules and calendar of visits to communities.
b) Explain forms and questionnaires you fill out after each visit.
c) What is your individual professional background and training.
d) List the basic and specific training you have been given during your PROSAMI tenure.
e) What routine meetings do you attend before or after community visits. What is a typical agenda and what subjects are covered in these meetings.

<u>Promotors</u>
f) Describe your community; i.e., number of families, number of families, number of persons per family, absenteeism in the family, principal illnesses usually encountered, mortality, morbidity, economic level (minimum wage received), father's occupation, mother's occupation, number of chilldren working, is the family able to save.
g) What possibilities do you see for a typical family beginning to pay for health treatment and medicines in the near or distant future in either money or kind?
h) Describe the three most important benefits to the communities you see from the PROSAMI maternal health and child survival project. Elaborate on these.

i) Describe the three most critical problems the communities confront with the PROSAMI project. Elaborate.
j) Explain your understanding of the concept of sustainability.
k) Relate this concept to the communities possibility of helping to sustain the services now provided by the PROSAMI project.

Communities: Health Committee and Directorio

a) Describe the health problems that presently exist in your community. The health problems of women and young children.
b) How long has your community participated in the PROSAMI project. Describe your community; number of families, number of houses, work the men do, and work the women do.
c) What is the PROSAMI project? Describe its activities. What is its objective? Who visits your community and how many times per month do they come? What do they do when they are in your community? Do they visit each house or is there a community building available? Do doctors come? Do they talk with everyone waiting who has medical problems? Can anyone talk to the promotor or doctor about any medical problem they have? If not, what medical problems do they talk about?
d) Are there always enough medicines available when the technical supervisors come. Do you have to buy medicines yourself? Are they expensive? Where do you buy them?
e) List the three most important benefits of the PROSAMI project.
f) List three problems with the PROSAMI project you think could be corrected to help make the project more effective for your community.
g) What would you do for medical assistance for your wives and children if the PROSAMI project was unable to continue?
h) If you could get better services, more visits, and have most medicines available, would you be willing to pay a fixed monthly amount of money for better services?

(Second Draft)
ELBA5

ANNEX D-2.

Instruments Used by the Maternal Health & Child Survival Specialist

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 1. DIRECTOR/GERENCIA

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
ENTREVISTADO	**ONG y Lugar:**	
Nombre:		**Cargo:**
Profesión:		**Tiempo en cargo:**

1.1 ¿ Cómo ha apoyado PROSAMI a su ONG ?

1.2 Califica su impresión del apoyo de PROSAMI para su ONG en una escala de 1 a 10:

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

1.3 ¿ Cómo les ha ayudado PROSAMI para responder a los problemas de salud en las comunidades ?

1.4 ¿ Qué le gusta del proyecto PROSAMI ?

1.5 Califica su impresión de las capacitaciones de PROSAMI para su ONG en una escala de 1 a 10:

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

1.6 ¿ Qué le gustaría que se mejorará ?

1.7 ¿ Algún comentario ? (Responder al dorso)

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 2. COORDINADORES TECNICOS

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
ENTREVISTADO	**ONG y Lugar:**	
Nombre:		**Cargo:**
Profesión:		**Tiempo en cargo:**

2.1 ¿ Cuáles son las necesidades de salud de su población ?

2.2 ¿ Qué servicios prestan a las comunidades en su poyecto ?

2.3 Califica su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

2.4 ¿ Cuáles son sus principales responsabilidades ?

2.5 ¿ Cómo le ha ayudado las capacitaciones de PROSAMI a cumplir sus responsibilidades ?

2.6 ¿ A cuántas capacitaciones de PROSAMI asistió Ud. ? _____

2.7 **Califica su impresión de como las capacitaciones de PROSAMI le ha ayudado a realizar su trabajo (en una escala de 1 a 10):**

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

2.8 **¿ Cómo contribuye usted para asegurar la calidad del servicio ?**
¿ Cómo sabe usted si los promotores y las parteras están dando servicios apropiados ? (Descripción de la supervisión)

2.9 **¿ Cuál ha sido su más grande éxito o logro ?**

2.10 **¿ Cuál ha sido su problema más difícil o fracaso ?**

2.11 **¿ Qué sugerencias tiene para PROSAMI o para su ONG ?**

2.12 **Califica su impresión del apoyo de PROSAMI para su ONG en una escala de 1 a 10:**

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

2.13 **¿ Algún comentario ?**

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 3. SUPERVISORES TECNICOS

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
ENTREVISTADO	**ONG y Lugar:**	
Nombre:	**Cargo:**	
Profesión:	**Tiempo en cargo:**	

3.1 ¿Qué tipo de servicios le prestan a las comunidades en su proyecto?

3.2 ¿Cómo calificaría su impresión (en una escala de 1 a 10) sobre la respuesta que su ONG y los servicios prestados a la comunidad han dado a las necesidades de la Comunidad y en qué grado han satisfecho dichas necesidades?:

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

3.3 ¿Cuáles son sus principales responsabilidades dentro del Proyecto?

3.4 ¿ A cuántas capacitaciones de PROSAMI ha asistido Ud. ? _____

3.5 ¿Cómo han contribuido las capacitaciones de PROSAMI para que Ud. cumpla con sus responsabilidades como Supervisor técnico?

3.6 ¿Cómo calificaría su impresión (en una escala de 1 a 10) sobre la contribución de las capacitaciones de PROSAMI para desarrollar su trabajo :

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

3.7 ¿En qué forma le ayuda la supervisión del Coordinador a hacer mejor su trabajo?

3.8 ¿Cada cuánto tiempo lo acompaña el Coordinador a las visitas de campo?

3.9 ¿Cómo contribuye usted para asegurar la calidad del servicio?
¿Cómo sabe usted si los promotores y las parteras están dando servicios apropiados? (Descripción de la supervisión)

3.10 ¿Cuál ha sido su más grande éxito o logro?

3.11 ¿Cuál ha sido su problema más difícil o fracaso?

3.13 ¿Cómo calificaría su impresión (en una escala de 1 a 10) el apoyo de PROSAMI para su ONG?:

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

3.12 ¿Qué sugerencias tiene para PROSAMI o para su ONG?

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 4.A. PROMOTORES

ENTREVISTADOR	Nombre:	
Fecha:		Nro.:
ENTREVISTADO	ONG y Lugar:	
Nombre:		Cargo:
Profesión:		Tiempo en cargo:

4.01 ¿Cómo responde Ud. a los problemas de salud de la comunidad?
¿Cuáles son los servicios que presta Ud. a la comunidad?

4.02 ¿En qué forma le han ayudado las capacitaciones de PROSAMI para cumplir con sus responsibilidades como Promotor de Salud?

4.03 ¿Cuál ha sido su más grande logro/satisfacción como Promotor en la Comunidad?

4.04 ¿Cuál ha sido el problema más difícil con que se ha enfrentado?

4.05 ¿Qué sugerencias tiene para PROSAMI o para su ONG?

4.06 ¿Algún otro comentario?

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 4.B. PROMOTORES

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
NOMBRE ENTREVISTADO		
ONG y Lugar:	**Cargo:**	
FECHA:	**Tiempo en cargo:**	

4.01 **¿A cuántas capacitaciones de PROSAMI ha asistido Ud., incluyendo el Curso Básico de Promotores?** _____

4.02 **¿Cómo calificaría su impresión acerca de que si las capacitaciones de PROSAMI le han ayudado a realizar su trabajo (en una escala de 1 a 10) ?**

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

IRA

4.03 **¿Cuáles son los signos de peligro que Ud. debe buscar en un niño con IRA?**

4.04 **¿Cuáles son los signos de neumonía y cómo la trata?**

4.05 **¿Cuando es que usted refiere o manda a un niño con IRA al hospital?**

EDA

4.06 **¿Cuáles son los signos de deshidratación que usted conoce?**

4.07 **¿Cuándo observa los signos de deshidratación, qué hace Ud.?**

4.08 ¿Qué recomendaciones da a la madre para tratar al niño con EDA en el hogar?

SALUD REPRODUCTIVA/MATERNA

4.09 ¿Cuáles son las causas por las cuales Ud. debe referir a una mujer embarazada?

4.10 ¿Cuántas veces da control prenatal durante el embarazo ?

4.11 ¿ Qué recomendaciones da a la embarazada durante el control prenatal ? (Alimentación, inmunización, preparación del pezón para la lactancia materna, higiene y vestimenta)

4.12 ¿Cuáles son las causas por las cuales Ud. debe referir a una mujer en el post parto?

CONTROL DE CRECIMIENTO Y DESARROLLO/NUTRICIÓN

4.13 ¿Cuáles son las actividades que Ud. realiza durante un control de crecimiento del niño?

4.14 ¿Cuándo es que usted refiere a un niño desnutrido al hospital?

4.15 ¿Qué es lá lactancia materna exclusiva y hasta cuándo la recomienda?

INMUNIZACIONES

4.16 ¿Cuál es el esquema regular de vacunación del niño menor de 5 años?

4.17 ¿Cuál es el esquema de vacunación de la mujer en edad fértil?

SALUD PERINATAL/NEONATAL

4.18 ¿ Qué hace usted antes de comenzar a examinar o manipular al recién nacido ?

4.19 ¿Cuáles son las causas por las cuales Ud. debe referir a un recién nacido?

4.20 ¿Cuántas veces realiza control del recién nacido?

4.21 ¿ Cuándo considera usted que un recién nacido tiene bajo peso al nacer ?

PARTICIPACIÓN COMUNITARIA

4.22 ¿ Cuál es el apoyo que reciben por parte de la comunidad en su trabajo de salud?

4.23 ¿ Cómo organizan los comités de salud ?

4.24 ¿En qué medida la ONG ha satisfecho las necesidades de salud de su Comunidad, indicándolo en una escala de 1 a 10)?:

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 4.C. PROMOTORES

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
NOMBRE ENTREVISTADO		
ONG y Lugar:	**Cargo:**	
FECHA:	**Tiempo en cargo:**	

Describir los MENSAJES EDUCATIVOS para las siguientes componentes técnicos (es decir, ¿qué deben saber las madres acerca de ...?):

4.01 IRA (Signos de peligro, tratamiento casero)

4.02 EDA (Signos de deshidratación, tratamiento casero)

4.03 Salud Reproductiva/Materna

4.04 Control de Crecimiento y Desarrollo/Nutrición:

4.05 Inmunizaciones:

4.06 Salud Perinatal/Neonatal (Recien Nacido):

4.07 ¿Cómo calificaría su impresión sobre el apoyo que PROSAMI le da a su ONG (en una escala de 1 a 10:

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

ROSAMI MTE/AREA TECNI A
CUESTIONARIO 5. PARTERAS

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
ENTREVISTADO	**ONG y Lugar:**	
Nombre:		**Cargo:**
Profesión:		**Tiempo en cargo:**

5.01 **¿Cómo le ha ayudado PROSAMI y la ONG a mejorar la salud en su comunidad?**

5.02 **Califica su impresión de la respuesta de la ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):**

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

5.03 **¿Cuáles son los servicios que presta Ud. a la comunidad?**

5.04 **¿A cuántas capacitaciones de PROSAMI (y el MSPAS) asistió Ud.?** _____

5.05 **¿Cómo le ha ayudado cumplir sus responsibilidades las capacitaciones de PROSAMI (y el MSPAS)?**

5.06 **Califica su impresión de como las capacitaciones de PROSAMI le ha ayudado a realizar su trabajo (en una escala de 1 a 10):**

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

5.07 **¿Cuántos partos ha atendido?** _____

5.08 ¿Cuántos partos atendia al mes? _____

5.09 ¿Cómo se prepara para la atención de un parto?

5.10 ¿Cuándo debe referir a una embarazada al hospital?

5.11 ¿Qué debe hacer inmeditamente después que el niño nace?

5.12 ¿Cuál ha sido su principal satisfacción?

5.13 ¿Cual fue su problema, decepción o fracaso más notable?

5.14 ¿Tiene sugerencias para PROSAMI o su ONG?

5.15 ¿Tiene comentarios?

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 6. COMITE DE SALUD

ENTREVISTADOR	Nombre:	
Fecha:		Nro.:
ENTREVISTADO	ONG y Lugar:	
Nombre:		Cargo:
Profesión:		Tiempo en cargo:

6.01 ¿Cómo le ha ayudado PROSAMI y la ONG a mejorar la salud en su comunidad?

6.02 Califica su impresión de la respuesta de la ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

6.03 ¿Qué hace el comité de salud?

6.04 ¿Cómo se conformó el Comité de Salud?

6.05 ¿Cómo llegó Ud. a integrar el Comité de Salud?

6.06 ¿A cuántas capacitaciones de PROSAMI, la ONG y el promotor ha asistido Ud.?

_____

6.07 ¿Cómo le ha ayudado cumplir sus responsibilidades las capacitaciones de PROSAMI, la ONG y el promotor?

6.08 Califica su impresión de como las capacitaciones de PROSAMI, la ONG y el promotor le ha ayudado a realizar su trabajo (en una escala de 1 a 10):

1 2 3 4 5 6 7 8 9 10

Inútil Excelente/acertado

DESCRIBIR LOS MENSAJES que se debe dar en cuanto a los siguientes componentes:

6.09 IRA (neumonia):

6.10 EDA

6.11 Salud Reproductiva/Salud Materna

6.12 Nutrición/Crecimiento y Desarrollo del niño.

6.13 Inmunizaciones

6.14 Salud Perinatal/Neonatal

6.15 ¿Cuál ha sido su principal satisfacción?

6.16 ¿Cual fue su problema, decepción o fracaso más notable?

6.17 ¿Tiene sugerencias para PROSAMI o la ONG o el promotor?

6.18 ¿Tiene comentarios?

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 7. POBLACION

ENTREVISTADOR	**Nombre:**	
Fecha:		**Nro.:**
ENTREVISTADO	**ONG y Lugar:**	
Nombre:		**Cargo:**
Profesión:		**Tiempo en cargo:**

7.01 ¿Cuáles son los servicios que presta la ONG y el promotor en su comunidad?

7.02 ¿Está satisfecho con los servicios de salud prestados? ¿Por qué sí o no?

7.03 ¿Cómo calificaría su impresión (en una escala de 1 a 10) acerca de los servicios que el Promotor de Salud le ha prestado?:

1 2 3 4 5 6 7 8 9 10

Inútil **Excelente/acertado**

7.04 ¿Seguirá usando los servicios en el futuro, o buscará la atención de otros servicios de salud ?

7.05 ¿Cómo PROSAMI y la ONG a ayudado a mejorar la salud en su comunidad?

7.06 ¿Cómo calificaría su impresión (en una escala de 1 a 10) sobre los servicios prestados a la comunidad y el grado en que han satisfecho sus necesidades básicas de salud?:

1 2 3 4 5 6 7 8 9 10

Inútiles **Excelentes/acertados**

7.07 **Qué recuerda usted sobre los siguientes temas: (por ejemplo, ¿Cuáles son los signos de peligro más importantes, y que haría usted si los observara?)**

7.08 **IRA**

7.09 **EDA**

7.10 **Salud Reproductiva/Salud Materna**

7.11 **Nutrición/Crecimiento y Desarrollo del niño.**

7.12 **Inmunizaciones**

7.13 **Salud Perinatal/Neonatal**

7.14 **¿Están pagando actualmente al Promotor por los servicios prestados?**

7.15 **Si fuera necesario, ¿estaría dispuesto a pagar por los servicios prestados por el Promotor?**

7.16 **¿Hasta cuánto estaría dispuesto a pagar por la atención?**

7.17 **¿Tiene sugerencias para PROSAMI o la ONG o el promotor?**

ANNEX D-3.

Instruments Used by the Health Finances Specialist

GUIA PARA COMPLETAR INFORMACION DE LOS FORMULARIOS F1 Y F2

FORMULARIO F1

Está formado por los cuadros siguientes :

CUADRO A - Ingresos del proyecto PROSAMI año 1993.
CUADRO B - Ingresos del proyecto PROSAMI (Enero a Junio de 1994)
CUADRO C - Personal actual pagado con fondos del proyecto PROSAMI.

CUADRO A
Mostrar los ingresos totales del año 1993, aplicables al proyecto PROSAMI.

Linea 1. PROSAMI.
Indicar el valor de los ingresos en efectivo y especie recibidos para el proyecto PROSAMI.

Linea 2. Ingresos por servicios prestados en la comunidad (En efectivo).
Mostrar el valor percibido en concepto de servicios prestados en la comunidad (consultas,medicamentos,...).

Linea 3. CONTRAPARTIDA.
Mostrar el valor reportado como aportes de contrapartida, desglosado en los diferentes rubros que ahi se muestran. Además, estos rubros deberán detallarse en el formato "Informe de Contrapartida", adjunto al presente.
Linea 4. TOTAL INGRESOS
Indicar el total de las lineas 1 a 3.

CUADRO B.
Mostrar los ingresos totales aplicables al proyecto PROSAMI durante el periodo comprendido de Enero a Junio de 1994.
Los datos de este cuadro deberán completarse siguiendo las mismas instrucciones para llenar el cuadro A.

CUADRO C.
Mostrar las diferentes plazas que a la fecha son financiadas por el proyecto PROSAMI, indicando el número de personas por posición y el total de los salarios mensuales pagados.

FORMULARIO F2

Este formato deberá mostrar el presupuesto total de la CMG para el año 1994, detallando todas las fuentes de financiamiento, incluido PROSAMI.
Las diferentes columnas de este formulario se llenan de la siguiente manera :

Nombre del Donante.
Indicar el nombre de la fuente de financiamiento, Ejemplo : World Relief, FIS, PROSAMI,etc..

Costos Directos del Proyecto.
Mostrar el valor presupuestado para costos directos del proyecto, que no incluyan gastos administrativos.

Costos de Operación
Indicar el valor presupuestado para costos administrativos, ejemplo: sueldo de contador, administrador, alquiler oficina central,etc...

Total Presupuesto
Totalizar los Costos Directos del Proyecto más los Costos de Operación.

Vencimiento de la Donación
Indicar el mes y año en que vence el convenio de donación.

ANNEX E.

COMPLETE SCOPE OF WORK

DELIVERY ORDER STATEMENT OF WORK

BACKGROUND:

PROSAMI was designed to extend coverage of basic Maternal Child Health services into rural and marginal urban communities lacking access to these services due to the impact of the past armed conflict and/or geographical isolation. The Project's goal is to improve the health status of 350,000 persons through grants to some 35 PVOs. The project is comprised of three inter-related categories: 1) Maternal Health & Child Survival Service Delivery, 2) Institutional Strengthening of PVOs and 3) Coordination, Policy Development and Research. The proposed contractor will be required to determine whether or not the project is reaching its intended objectives and to evaluate the project from all sides as to projects strengths, weaknesses and accomplishments.

Article I Title

Project: Maternal Health and Child Survival Number: 519-0367

Article II Objective

The overall objective of this Mid-Term Evaluation is to assess the appropriateness of the Project design, and determine the progress and impact to date by the project. Evaluation will be conceptualized on four levels to include:

a) **Measures of efficiency:** the evaluation of inputs, systems, and methodologies utilized by the Project in support of the PVOs, and outputs to date.

b) **Measures of effectiveness:** an evaluation of PVO institutional strengthening (e.g. changes in knowledge, attitudes and practices among PVO personnel (KAP), the PVOs achievement of stated goals, coverage achieved to include exconflictive areas and any special needs, quality of care, and an analysis of cost-effectiveness and/or cost-benefit.

c) **Measures of impact:** an evaluation of KAP changes on the community level, as well as changes in child survival indicators such as mortality and morbidity and their attribution to the Project.

d) **Measures of sustainability:** an evaluation of both PVO and community-level program sustainability.

Article III Statement of Work

A three person technical evaluation team will review and assess the following:

POINTS RELATED TO EFFICIENCY:

1) The appropriateness of the Project's objectives corresponding to the most important maternal and child survival problems in El Salvador (1990 to the present).

2) The viability of the methodology for service delivery utilized by the Project through a network of local PVOs.

3) The quantity and quality of the inputs provided to the PVOs (i.e. technical assistance, training, supplies, and financial support) related to the outputs.

4) The efficacy of the methodologies utilized in the training, supervising, monitoring and evaluation of the PVOs.

POINTS RELATED TO EFFECTIVENESS:

1) The technical and administrative capacity of the PVOs to implement the Project (e.g. comparing abilities before and after efforts at institutional strengthening).

2) Project progress to date in meeting established goals.

3) Coverages achieved in all technical components, degree of service coverage extended nationally over MOH coverage. Comparison of PVO and MOH coverage rates for the most important causes of infant morbidity and mortality.

4) Quality of services provided to the community in all technical components (i.e. Family Planning, ARI, Sustainability), degree of community participation achieved.

5) Cost-effectiveness analysis which compares PVO quality of care and costs with those of the public sector if available and among PVO's.

6) Benefit-cost analysis which compares the benefits of community-level preventive services (deaths and incidence of morbidity averted through increased coverage, savings to society) and their cost with the benefit-cost of curative care.

7) The degree of intra-Project and inter-institutional coordination achieved (MSCI-PVOs, PROSAMI-MOH and others).

POINTS RELATED TO COMMUNITY LEVEL IMPACT:

1) The impact achieved by the Project on morbidity, mortality, and KAP changes in community members.

POINTS RELATED TO PROGRAM SUSTAINABILITY:

1) Rating of each PVO's program sustainability according to the CDIE sustainability scale, project sustainability with and without an endowment, community-level program sustainability.

2) Clearly, the project is a major contributor to USAID/El Salvador's Strategic Objective Nr. 4, "Improve Quality with Equity in Health and Education". Evaluators will comment on the project's contributions both at the strategic objective and program output level. In addition, evaluators will comment on the project's contributions to other strategic objectives in the Mission's framework.

3) Attainment of legal status (personeria juridica) has been, for various reasons, difficult. Evaluators should assess major impedaments to receiving personeria juridica and impact of not having such status.

Article III - Statement of Work (continued)

The team will conduct the Evaluation in a manner which assures the most participation with PVOs as is possible. The following methods are suggested for evaluation of each of the points identified above: These are only some of the many possible methods available to the team.

1) Review of documents from the MOH and USAID including national surveys (i.e. ANSAL, FESAL, ESANES, Hogares Multiples, Nutrition), and comparison with the Project design.

2) Interviews with PVOs, MOH, USAID and the community members served.

Analysis of the results of the evaluation itself based on a definition of internal and external factors and indicators of administrative, and technical viability.

3) Review of the inputs provided to the PVOs by MSCI including educational materials, goods, and the financial system.

Interviews with PVO health promoters and technical personnel and administrative/financial personnel.

4) Review of Project reports (training evaluations, MIS, supervision methods, field monitoring reports).

Interviews with PVO personnel.

5) Review of documents (audit reports, technical and administrative reports, field monitoring reports).

Interviews with PVO and MSCI staff.

Focal groups with health promoters to determine changes in KAP.

6) Review of documents (PVO and MSCI annual reports and plans).

7) Review of Project coverage data (in technical areas and geographically), comparison with MOH reported coverages.

8) Review of Project quality of care data in each technical component, data on community level participation.

Focal group interviews with community members and PVO staff.

9) Review of Project data on costs and quality of care.

Interviews with community members and clinical observations to determine quality of care.

10) Review of Project data on costs.

Analysis of impact data to determine benefits.

11) Review of documents (correspondence, training agreements, PVO quarterly reports, annual reports).

Interviews with MSCI, PVO, MOH and community personnel.

12) KAP like evaluation based on:

Review of PVO quarterly reports.

Focus groups with community members.

Sample surveys on project's effectiveness in the community.

Community level changes according to PVO interviews.

Evaluation of changes in morbidity based on:

Changes in household Risk Status in target communities.

Case studies: interviews with health promoters and the community.

Evaluation of impact on mortality based on:

PVO coverage achieved for major illnesses: Comparison of morbidity estimates with cases attended.

Comparison of number of deaths expected in a given community with PVO mortality data.

Case studies: interviews with health promoters and review of field documents related to the results of community level treatment and the adequacy of referrals.

13) Evaluation of PVO program/sustainability based on Project and PVO data using the CDIE scale. (See Attachment B).

Evaluation of program sustainability with and without an endowment based on PVO and Project data.

Evaluation of community-level program sustainability based on funds generated and community participation information from PVOs, and community perception based on interviews.

Article IV - Reports

The contractor shall provide USAID with the following reports:

DRAFT REPORT OUTLINE AND WORK PLAN

Within a day after arrival, the team will conduct a team planning meeting. From the outcome of this meeting the team will submit for USAID approval a working outline of the evaluation and a detailed work plan to include a list of proposed PVO visits for Mission approval. These will be reviewed with the contractor at an entry interview with the Mission Evaluation committee.

DRAFT REPORT

At least 7 working days before departure, the Team Leader will provide USAID with 10 copies of the draft report in English and 37 copies of a Spanish translation of an executive summary and recommendations following the outline agreed upon at the beginning of the consultancy.

The Contractor will participate in reviews of this draft with designated USAID officials. Project Managers and PVO participation, with a USAID staff review to be held three days after the date of submission of the draft. The contractor will be responsible for incorporating written and oral comments received in this meeting into the final draft. Immediately before departure, the Team Leader will deliver 10 copies in English and 40 copies in Spanish in a final draft report. USAID will have 10 working days to review this final draft before returning it to the contractor.

FINAL REPORT

Not later than 4 weeks after receipt of the final draft from USAID, the contractor will submit a final evaluation report (10 English copies and 37 Spanish copies) to USAID/HPN, incorporating clarifications and/or additions requested by the Mission. The evaluation report will include the following sections.

1) Executive Summary. Including purpose of the evaluation, methodology used, findings, conclusions and recommendations. It will also include comments on development impact and lessons learned. It should be complete enough so that the reader can understand the evaluation without having to read the entire document. The summary should be a self-contained document.

2) Scope of Work and Methodology. A copy of the initial scope of work and a detailed outline of methodology used will be included. Any deviation from the scope will be explained.

3) Evaluation Team. A complete list of evaluation team members including host country personnel, their field of expertise and the role they played on the team.

4) Evaluation Findings, Conclusions and Recommendations. In a separate section of the report if possible.

Recommendations should be prioritized actions that can be taken by the USAID and implementing entities and put into action.

5) Previous Evaluations should be discussed, if existing. This will include a brief description of conclusions and recommendations made in earlier reports. The evaluator will discuss briefly what use was made of the previous evaluation in their review of the project.

6) List of Tables and Charts. As appropriate to the evaluation to make the report and findings more meaningful.

7) List of abbreviation and acronyms used in the report.

8) List of all people and organizations contacted.

9) Lessons Learned. These should describe the causal relationship factors that proved critical to project success or failure, including necessary political, policy, economic, social and bureaucratic preconditions within the host country and AID. These should also include a discussion of the techniques or approaches which proved most effective or had to be changed and why. Lessons relating to replicability and sustainability will also be discussed.

10) Paginated Table of Contents.

11) A.I.D. Evaluation Summary. Mission will provide forms and appropriate guidance for the submission of a draft of this formal summary which is subject to Mission approval.

Article V - Relationship and Responsibilities

The team will work under the technical guidance of Margarita de Lobo, PROSAMI Project Manager, Office of Health, Population and Nutrition, USAID El Salvador. All coordination with the institutional contractor (Medical Services Corporation International - MSCI) will be coordinated through the A.I.D. technical office.

Article VI

The proposed period of performance for the mid project review is to be determined on availability of the Contractor.

Article VII

Position	Work Days
Team Leader/Organizational Management Specialist	41
Health Financial/Cost Analysis Specialist	36
Maternal Health/Child Survival Specialist	36
Secretary	36

Article VIII - AID Illustrative Budget

See Attachment A

Article IX - Special Provisions

A. **Duty Post** - San Salvador, El Salvador with site visits outside City of San Salvador.

B. **Language Requirements and Required Team Member Qualifications**

1. **Team Leader/Organizational Management Specialist:**
   Masters in organization management or equivalent degree with extensive experience in Latin America in the design, evaluation and organizational sustainability of rural projects, particularly PVOs working under a PVO umbrella organization. Fluent Spanish FS3 or equivalent. Sensitivity to the Salvadoran context. Significant inter-personal skills.

2. **Health Financial/Cost Analysis Specialist:**
   At least a Masters in Health Financing. At least five years experience in Latin America in evaluation and cost benefit analysis of health project financial plans in the public and/or NGO/PVO sector. Fluent Spanish (FS-3 or equivalent). Field level experience in the application of health financial/cost analysis. Sensitivity to the Latin context. Significant inter-personal skills.

3. **Maternal Health/Child Survival Specialist:**
   Masters in Public Health with extensive experience in Latin America in the design, evaluation and implementation of rural public health projects. Fluent Spanish (FS3 or equivalent). Sensitivity to the Latin context. Significant inter-personal skills. Field level experience in rural MCH and experience with PVO's.

C. **Access to classified information**

Contractor shall not have access to any government classified material.

D. **Logistic Support**

See Par 21, of PIO/T

E. **Work Week**

A six day work week is authorized.

Scope of Work

Financial Analyst/Cost Specialist
PROSAMI Evaluation

Objective of Assignment: To evaluate the efficiency, effectiveness, equity and sustainability of the PROSAMI Project in terms of key financial factors affecting project implementation.

Background: PROSAMI offers services through 35 PVOs, which operate in 122 municipalities and in 433 cantones, serving a population of approximately 439,882 people. They have a total of 433 health promoters and 773 traditional midwives, health committees and volunteers. The principal beneficiaries are women of fertile age and children under five years of age.

Staffing of PROSAMI includes a total of 422 health promoters. Each health promoter has a "Dispensario," i.e., a small clinic. Each has a staff of 35 professionals and support persons.

Issues to Examine:

1) The Cost Specialist shall examine the costs of representative services and for the PROSAMI network overall, including the costs of services delivered and the costs of project inputs: technical assistance, training supplies and financial support. What are the costs of services provided under PROSAMI and how do they relate to similar services under PVOs outside of PROSAMI? Are the inputs provided to the PVOs improving the efficiency of services? Are there ways in which the efficiency of Maternal Health and Child Survival Services could be further improved?

2) The Cost Specialist shall examine the financial sustainability of PROSAMI PVO activities, including: determining the levels of cost recovery by analyzing facility income and expenditures, analyzing cost recovery success or failure, and assessing the equity of the financing arrangements, including examining available information on socio-economic characteristics of clients and fee waiver arrangements. These sustainability issues should be looked at with and without an endowment. The CDIE sustainability scale, appended to this scope, should be utilized as a measurement tool if possible.

3) The Cost Specialist shall examine the overall financial management arrangement for use of funds generated under the cost recovery arrangement, including community participation in decision making over the use of those funds.

4) The Cost Specialist shall prepare an analysis which compares PROSAMI-assisted PVO costs with those of the public sector for comparable quality of services. These include Ministry of Health, the Salvadorian Institute of Social Security and other non-USAID funded NGOs.

5) The Cost Specialist shall prepare an analysis which addresses the relationship of benefits and costs for PROSAMI-assisted services compared to benefits and costs of government-provided curative care. Recognizing the relative lack of available data, the Cost Specialist shall construct this analysis to identify the potential benefits of community-level preventive services, defined in terms of deaths and incidence of morbidity averted through increased coverage, and savings to society and their cost with the benefits and costs of curative care in comparable populations.

6) If possible, the Cost Specialist shall prepare a cost-effectiveness analysis of the 35 PVOs compared to one another.

ANNEX F.

RÉSUMÉS OF THE EVALUATION TEAM MEMBERS

RESUME

LEWIS H. THORNTON
Casilla No. 12123
Tel: (2) 323354
La Paz, Bolivia

A combination of practical skills and academic background in management, planning, evaluation, organizational development, and training are brought together to bear on international development activities in program and project development, education and manpower development, urban and rural project development in the private and public sectors.

EXPERIENCES

USAID/BOLIVIA, AGRICULTURAL AND RURAL DEVELOPMENT OFFICE, LA PAZ

For USAID/Bolivia PL-480, Title II Program provided technical services by conducting a review of annual progress reports, multi-year operating plans, and technical evaluation reports of four PL-480 cooperating sponsors (PVOs) responsible for implementing Title II development programs, 1993.

Conducted a detailed institutional analysis and evaluation of the Santa Cruz, Bolivia Municipal Infrastructure Program for USAID/Bolivia, PL-480 Title II Food for Work Program. Evaluation included analysis and recommendations for refocusing the program to better utilize Food for Work to enhance the financial system, reorganize the organizational structure and improve program operations, 1992 - 1993.

For USAID/Bolivia, PL-480 Titles I and III Programs evaluated the administrative and institutional strengths and weaknesses of the health projects implemented by the Executive Secretariat and many of the implementing agencies, governmental and non-governmental, 1992.

FOOD FOR THE HUNGRY INTERNATIONAL, BOLIVIA

Evaluated the School Feeding Program over the past nine years, visiting three Departments which were currently receiving USAID/Bolivia Title II Food Assistance and developed a two year global operational plan for FHI/Bolivia and the Ministry of Education and Culture, 1992.

Under separate contract for FHI/Bolivia wrote a proposal for the PL-480, Title II, Institutional Support Grant for FY 1992, which was submitted to the Office of Food for Peace, Washington, D.C., 1992.

League for the Defense of the Environment (LIDEMA), Bolivia

Developed a strategy for institutional strengthening of LIDEMA, which included 13 member organizations. Analyzed the functions of the organization LIDEMA and interviewed member institutions together with their principal funding organizations. Developed an extensive institutional diagnosis and an institutional strategy for future organizational change, financial system alternatives, management and operational recommendations, 1991 - 1993.

Save the Children, Bolivia

As one member of a five person team which wrote a two year "Monetization Proposal" to be submitted to USAID/Bolivia, major responsibilities were the design of four projects: Micro-irrigation Systems, Agriculture Ecology and Marketing Study; Rural Credit Revolving Fund; Potable Water systems. Also, responsible for designing an institutional linkage system, a monitoring and evaluation system, and a sustainable project concept, 1991.

Agro-Industria Boliviana Ltda., Sucre, Bolivia

Owner and General Manager of an agro-business primarily devoted to cut flower production and export, import of bulbs, seeds and plants, 1985 - 1991.

Designed, directed and participated as one of five instructors in multimedia training courses for engineers and technical personnel responsible for the designer projects in water supply, sanitation and irrigation. Various NGO and public sector organizations sent their personnel to these courses, 1990 - 1991.

Plan Internacional, Sucre and La Paz, Bolivia, and Cuenca, Ecuador

Organizational development, functional and task analysis, leading to restructuring, training of personnel, and program analysis. Managerial analysis with recommendations leading to staffing changes and new task responsibilities. Assessment of staffing patterns and program implementation and evaluation, 1986, 1989, 1990.

United States Agency for International Development - Bolivia

As Management Training Advisor to USAID, assisted in the initial design and in the implementation of a management training institute to provide short-term management training courses and services to private sector industry throughout Bolivia, 1985 - 1986.

United States Agency for International Development, Panamá

Human Resources Development Advisor and principal designer of a nationwide workforce training project to upgrade skills of workers, on-the-job, in the private sector of Panamá. Coordinated a small enterprise development project which provided technical assistance, management, training, economic evaluation and financial analysis to small firms. Coordinated a project to provide administrative and technical support to governmental agencies which had responsibility to provide services to the private sector. Assisted the Ministry of Labor in statistical analysis and information development for private industry. Coordinated a women in private industry development project, 1983 - 1984.

Action Programs International, Southern Africa

Advisor to the Southern African Development Confederation Conference. Assessed the post-secondary technical education needs of four countries: Malawi, Botswana, Lesotho and Swaziland. Developed a report recommending regional technical training institutions for the nine SADCC countries, 1983.

For AID Washington, wrote a background paper entitled, "Occupational and Vocational Training Systems: Planning, Finance and Administration", which identifies issues, concepts and country examples of alternative approaches to the subject, 1983.

Action Program International, Africa

In Somalia, examined the existing human resource data base and the management and technical training and education programs of the country. Assessed the constraints of existing management and technical training institutions and developed estimates of manpower needs and expected supply in both the public and private sectors. Developed a primary source document with program recommendations for USAID, 1982.

National Association of Schools of Public Affairs and Administration, Pakistan

In Pakistan developed a support training program for the public and private sectors to upgrade managerial and technical training and educational institutions. Based upon development plans and manpower needs a training program was developed for private business and public administration in all sectors of the economy, 1982.

United States Agency for International Development, Jamaica

Prepared a comprehensive report on the establishment of an improved occupational skills training system for the public and private sectors. Assisted in the design of a four-year project to upgrade and expand non-formal occupational skills training for apprenticeship, on-the-job and industrial development enterprises to strengthen skills training for individuals and industries in the private and public sectors, 1982.

Academy for Education Development, Washington, D.C.

Designed and assisted in the implementation of a seminar for the Singapore government for employers, professional trainers and training directors to introduce self-paced competency-based vocational and technical skills training into the industrial setting. In Bolivia assisted in and coordinated the implementation of a rural educational teacher program to develop curricula, teaching materials, administration and planning programs, teacher training and school construction. In Washington, D.C., assisted in the design of a project management and implementation project for AID worldwide staff. Also assisted in the curriculum and program evaluation of two U.S. universities, 1981 - 1982.

United States Department of Agriculture, Office of International Cooperation and Development - International Training Division, Washington, D.C.

Developed a study with recommendations for international training and educational activities for Latin American, 1980.

University of Connecticut, Institute of Public Service

Invited lecturer in project management, 1980.

New TransCentury Foundation

Developed a feasibility study of a regional planning program in Bolivia. Assisted private voluntary organizations in Alabama, Connecticut, Washington, Jamaica and Ohio in management development services, 1978 - 1979.

Compañia Minera del Sur

A diversified Bolivian mining company in mineral extraction, construction, agriculture, and machinery imports. Special studies in organization and management, salary and wage analysis, training needs assessment, recruitment and transportation projects, 1977 - 1978.

Ministry of Farmer Affairs and Agriculture, National Community Development Program, Bolivia

Personal services contract with USAID. Project consultant to small farmer credit program for agriculture production and infrastructure, 1976 - 1977.

California State University Foundation, San José

As Chief of Party, directed the technical assistance contract to reorganize the Ministry of Education and Culture, Bolivia into a single national and regional level administrative system to service both rural and urban education. Internal administrative and managerial procedural recommendations were made, implementation begun, including training of personnel, 1972 - 1974.

Peace Corps, Irán

Assisted in the development of a five-year Peace Corps Program, which included obtaining program ideas from the Government of Irán, 1970.

PROFESSIONAL EXPERIENCE: 1985 - 1975

International Development Institute, Indiana University

As Research Associate developed a case study on organizational change and technical assistance. Assisted in institution building activities with the Midwest Universities Consortium for International Activities, 1974 - 1975.

International Bank for Reconstruction and Development

Loan Officer for Mexico. Responsible for guiding and coordinating the work of the various departments concerned with the operations between the Bank and Mexico, 1971.

University of Wisconsin, Milwaukee

Special Assistant to the Vice Chancellor of Academic Affairs. Assisted the Vice Chancellor on policy and administration of the University functions in academic affairs and related program development, 1969 - 1970.

Governmental Affairs Institute

As Administrative Assistant to the Chairman of the Board and President responsibilities included both administrative support to the seven divisions and coordinating the activities with universities, government organizations and private foundations. Assisted in the design and implementation of a population orientation course for USAID personnel from around the world, 1967 - 1969.

Peace Corps, Bolivia

Community Development Education Specialist. As Peace Corps volunteer initiated the first vocational technical school for Bolivia constructions workers, which led to the establishment of similar institutions throughout Bolivia, 1965 - 1967.

EDUCATION AND TRAINING

Graduate courses in Industrial Education, University of Maryland, 1983 - 1984.

Master of Science in Education, with concentration in organizational change, diffusion and adoption of innovation, evaluation and training. Indiana University, 1975.

Bachelor of Arts in Economics and Political Science. California State University, San Diego. Awarded AFL-CIO Scholarship; National Center for Education in Politics Grant, 1965.

LANGUAGE AND TRAVEL

Fluency in Spanish, extensive travel and living experience in Latin America: some knowledge and work experience in Asia and Africa.

Peter Boddy, MD, MPH

Casilla 4577
Santa Cruz, Bolivia
Telephone: 591 3 338625 (Office)/321020 (Home)
Fax: 591 3 338625

RÉSUMÉ

CURRENT POSITION

COUNTRY DIRECTOR OF ESPERANZA BOLIVIA AND PROGRAM DIRECTOR, HUMAN RESOURCE DEVELOPMENT MATCHING GRANT

Direct and supervise national activities of Esperanza Bolivia, US-based health PVO, with USAID financed Child Survival (CSV and CSIX), Radio Education, VITAL-Gardens and health human resource development Matching Grant projects in Southern and Eastern Bolivia. Responsible for project planning, implementation and evaluation.

Direct and coordinate the development of a health human resource education and training program designed to train local healthcare personnel to improve capacities to plan, manage, and evaluate public health programs and projects. The program includes graduate level public health seminars and courses, an MPH degree program in Health Systems Management at a Bolivian university, and seminars in NGO/PVO institutional development and program management.

PREVIOUS PROFESSIONAL EXPERIENCE

RESIDENT ADVISOR, ACADEMY FOR EDUCATIONAL DEVELOPMENT, HONDURAS

Provided technical assistance and administrative support to the Ministry of Public Health for the AID funded Nutrition Communication Project in Honduras. Supervised the development of a communication/education program designed to increase and improve breastfeeding, and the initial development of communication/education programs in growth monitoring, infant feeding, maternal and child nutrition, and related child survival programs.

CONSULTANT, ACADEMY FOR EDUCATIONAL DEVELOPMENT, HONDURAS

Consultant to the Honduran Ministry of Public Health for the AED HealthCom Project in the areas of behavior modification and behavior analysis, infectious disease control, and maternal and child health programs. Particularly concerned with ARI control programs, and other child survival programs such as diarrheal disease control and ORT, EPI, growth monitoring, etc.

PROGRAM DIRECTOR AND PROJECT DEVELOPMENT, LOGAN HEIGHTS FAMILY HEALTH CENTER, SAN DIEGO, CALIFORNIA

Directed California state funded community education program, and assisted in the establishment and development of the Health Promotion Department at a community health center. Developed clinic-centered and community-based education programs. Designed educational materials and curricula for the general public and health care provider staff. Hispanic representative to the San Diego County Task Force on AIDS. Designed, developed and implemented AIDS prevention education programs for Hispanics and other minorities. Developed behavioral skills training and peer educator curricula. Developed and wrote grant and project proposals.

RESEARCH AND PROGRAM CONSULTANT, PERU

Radio Bahá'í of Lake Titicaca, Chucuito, Puno, Perú. Consultant in educational programing, public health, audience and program evaluation, and station management and administration.

EDUCATION

MASTER OF PUBLIC HEALTH (MPH) - San Diego State University, San Diego, California. Completed double concentrations of health promotion/health education, and maternal and child health.

MD ("MEDICO-CIRUJANO") - San Agustin National University, Arequipa, Peru. General medicine.

BACHELOR OF ARTS - University of California, Davis, California. Completed degree programs for both anthropology and psychology.

LANGUAGE ABILITY

ENGLISH - Native speaker.

SPANISH - Understand, read, speak and write fluently. Able to translate (Spanish/English, English/Spanish) general and medical language.

AFFILIATIONS

American Public Health Association
Bahá'í International Health Society
Phi Kappa Phi National Honor Society.

M. ROY BROOKS, JR.

2126 Connecticut Avenue
Washington, D.C. 20008
Phone: (202) 265-2133

PROFESSIONAL EXPERIENCE

February 1994 to Present

Health Finance and Management, Inc.
2126 Connecticut Avenue
Suite 31
Washington, D.C. 20008

President, International health care consulting primarily in the areas of health finance of country-wide health care programs, hospitals, and ambulatory centers, as well as management and organizational development of same.

November 1987 to February 1994

Management Sciences for Health
165 Allandale Road
Boston, Massachusetts

Principal Program Associate. Worked in the Health Financing Program as well as the Development Department and consulted in various countries in South America and Asia. In addition to participating in the development of several competitive bids for MSH, provided consulting expertise in the areas of logistics of pharmaceuticals, management information systems, organizational development, financing and purchasing health care, and conducting management analyses of several organizations.

Also worked in the following capacities while at MSH:

Chief of Party, Ecuador Health Care Financing and Child Survival Project. Director of a 12 million dollar project with the objective of improving the health care management systems of the Ministry of Health.

Senior Management and Planning Specialist, USAID Health Financing and Sustainability (HFS) Project. Provided assistance on financial sustainability to projects in Belize and Ecuador, and served as co-team leader for Cost Recovery project in Egypt.

Chief of Party, Bolivia Self-Financing Primary Health Care Project. Based in Santa Cruz, Bolivia, directed and managed all project activities in conjunction with the on-site PROSALUD staff. Responsible for the management of human resources and financial management of the project, as well as oversaw and reviewed all project strategies, objectives and work plans. Technical assistance focused on the successful design and implementation of private revenue-generating health care systems which provided care to middle and low income groups.

January 1987 to November 1987

770 Boylston Street
Boston, Massachusetts

Investment Manager. Managed over one million dollars in stock and joint ventures in real estate. Established over $750,000 in real estate trusts within a five-month period. Oversaw all management and legal issues, and conducted computer analyses for financial decisions and budgetary projections.

February 1986 to January 1987 — Western Europe

Sabbatical. Upon completion of three annual contracts in Saudi Arabia, spent one year traveling in Europe and studying Spanish in Madrid.

January 1983 to January 1986 — Al-Mouwasat Medical Services, Jubail, Saudi Arabia

Executive Director. Responsible for the dispensary, 12 clinics, 8 emergency ambulance stations, and several public health activities in Jubail Industrial City, a city of 40,000 inhabitants. The Medical Chief of Service and the Directors of Clinical Services, Nursing, Accounting, Personnel and the Assistant Director reported to the Executive Director. Also served on the planning committee for the Mouwasat Medical Services, which coordinated the construction of their private 250 bed hospital in Damman. In addition, wrote and/or coordinated the submissions of over eight different government and private contract bids, including management of four industrial clinics, one maternity hospital, and other public health services for Jubail.

January 1979 to January 1983 — Children's Hospital Medical Center, Boston, Massachusetts

Associate Director. Responsible for management of the Medical Services and associated laboratories, the profit section - Commercial Properties, Ambulatory Services, and the Montrath Pediatric Nursing Home. This management also included the Departments of Psychiatry, Neurology, Dentistry, Cardiology, the community health center, Wrentham State School medical clinics for the retarded, and the Emergency Ward. The Commercial Properties consisted of the Inn at Children's, Sterling Restaurant, 400 apartments, and other medical rental properties. These responsibilities consisted of a total operating budget of approximately $40 million and 842 full time positions.

July 1975 to January 1979 — Massachusetts General Hospital, Boston, Massachusetts

Group Business Manager. Managed the M.G.H. neighborhood health centers, the emergency Ward, Dermatology and Pediatric Group Practices, and the Case Management Grant to enroll the Medicaid population. Coordinated the activities of the Ambulatory Care Division Business Managers. Combined clinical services with the private out-patient services, while initiated a physician incentive system to promote more efficient care while reducing the deficit. Reorganized the health centers into the hospital management structure and coordinated the transfer of their billing to the hospital computerized billing system. Under the direction of the Associate General Director, wrote the Determination of Need as well as coordinated the acquisition of the Chelsea memorial Hospital. Once the Chelsea hospital was acquired, directed the hospital on a temporary start-up basis.

January 1974

Rochester Regional Medical Program
Rochester, New York

Research and Evaluation Coordinator. Worked on a project part-time while analyzing the utilization of nurse practitioners in primary care in rural areas of Western New York while attending graduate school.

EDUCATION

MBA University of Rochester, 1975. Emphasis on economics of the non-profit Sector.

MPH University of Rochester, 1974. Completed first phase of a combined masters program, with emphasis on community health planning and preventive medicine. Awarded a full scholarship from the national Institute of Health as well as a scholarship from the Fogarty Institute to be co-author of a book.

BA University of Rochester, 1971. Psychology.

PUBLICATIONS

Berg, Robert, Brooks, M. Roy, Savicevic, Miomir. Health Care in Yugoslavia and the United States. Fogarty International Center, 1976.

Other related articles to APHA and MCIH on establishment of self-financing primary health care systems, and employee incentive systems.

ANNEX G.

MATERNAL HEALTH & CHILD SURVIVAL SPECIALIST SUPLEMENTAL ANNEXES

ANNEX G-1.

Survey Results

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 1. DIRECTORES DE LAS ONGS

Número de Cuestionarios: 25

ONG DE LA PRIMERA RONDA	ADHU (1) ASALDI (1) AGAPE (1)	DIOCESIS (1) FUNDEMUN (1) OEF (1)	OPRODE (1) PROCADES (1)
ONG DE LA SEGUNDA RONDA	ASADEH (1) AMCS (1) CALMA (1)	CONAMUS (1) FUMA (1) FUNDESO (1)	CIRES (1)
ONG DE LA TERCERA RONDA	ADEMUSA (1) ASEI (1) ASIPES (1)	CODECUS (1) FASTRAS (1) FUNDEPRENS (1)	IDEA (1) ORMUSA (1) PADECOMSM (1)
NO ESPECIFICADO	(1)		

PROFESION	No.	TIEMPO EN CARGO EN MESES (m)	MEDIA
PRIMERA RONDA			
Médico	2	30 m, 24 m,	27m
Ing. Agrónomo	1	36 m.	36m
Admdor Empresas	2	72 m, 60 m	66m
Abogada	1	60 m	60m
Trabajador Social	1	42 m	42m
No Especifica	1	120 m	120m
TOTAL	8	MEDIA PRIMERA RONDA	55.5 m
SEGUNDA RONDA			
Bachiller	1	96 m	96m
Politólogo	1	48 m	48m
Lic. en Enfermeria	1	?m	?m

Trab. Social	2	216m, 64m	140m
Antropóloga	1	28m	28m
Profesora	1	48 m	48m
TOTAL	7	MEDIA SEGUNDA RONDA (no incluye Enfermera)	83.33m
TERCERA RONDA			
Trab. Social	3	18m, 48m, ?m (incluye solamente dos)	11m
"Organizadora"	1	24 m	24m
Médico	2	17m, 36m	26.5m
Agricultor	1	18m	18m
Auditor	1	5m	5m
Sicóloga	1	21m	21m
Economista	1	24m	24m
TOTAL	10	MEDIA TERERA RONDA (incluye 9 solamente)	23.44m
TOTAL GLOBAL			
Médico	4	30m, 24 m, 17 m, 36 m	26.75m
Agrónomo	2	36m, 18m	27m
Admdor de Empresas	2	72 m, 60 m	66 m
Abogada	1	60 m	60 m
Trabajador Social	6	42m, 216m, 64m, 18m, 48m, ?m (El promedio incluye 5 trabajadores sociales)	77.6 m
Bachiller	1	96 m	96 m

Politólogo	1	48 m	48 m
Lic. en Enfermería	1	? m (no incluido en promedio)	?.0 m
Antropólogo	1	28 m	28 m
Profesora	1	48 m	48 m
Organizadora	1	24m	24 m
Auditor	1	5 m	5 m
Sicóloga	1	21 m	21 m
Economista	1	24 m	24 m
No Especificado	1	120 m	120m
TOTAL	25	MEDIA GLOBAL	325.7m

1.1 ¿Cómo ha apoyado PROSAMI a su ONG?

ITEM No.	MANERAS	NUMERO
1	En forma integral, financiera y técnicamente, de acuerdo al plan establecido.	2
2	Capacitación (capacitaciones sistemáticas y permanentes de los recursos)	15
3	Asesoría técnica, Sistematización de criterios técnicos, Monitoreo técnico	16
4	Recursos financieros y económicamente	15
5	Bienes (equipo, materiales, medicinas)	6
6	Administrativamente, apoyo administrativo	7
7	Desarrollo, fortalecimiento y apoyo institucional, la gestión, promover la aprobación de la personería jurídica	8
8	En base al convenio establecido	1
9	Con la implementación del proyecto se amplió el área de influencia	1
10	Un espacio para el conocimiento mutuo y coordinación	1

1.2 Califique su impresión del apoyo de PROSAMI para su ONG en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	5	50
9	8	72
8	9	72
7	2	14
6	1	6
TOTAL	25	214
PROMEDIO		8.84

1.3 ¿Cómo les ha ayudado PROSAMI para responder a los problemas de salud en las comunidades?

No. de cuestionarios: 25

No.	PRINCIPALES AREAS DE AYUDA INDICADAS POR LOS ENTREVISTADOS	NUMERO
1	Bien en área materno-infantil, pero hay áreas descubiertas como: saneamiento ambiental, nutrición y otras.	1
2	Con lineamientos, métodos, equipo y medicinas.	17
3	Con financiamiento y asesoría de monitores.	12
4	Normatividad en Salud Pública.	1
5	Apoyo en supervisión y control.	10
6	Fortalecimiento en la comunidad.	5
7	Ha apoyado nuestras ideas de manera pragmática.	1
8	Siendo metodológicamente más accesibles para conocer la problemática de la comunidad.	2
9	Asistencialismo está obsoleto para tiempos de paz. Se necesita responsabilizar a la comunidad sobre el cuido de su salud.	1
10	Capacitación.	13

1.4 ¿Qué le gusta del proyecto PROSAMI?

ITEM No.	PRINCIPALES AREAS DE AGRADO INDICADAS POR LOS ENTREVISTADOS	NUMERO
1	Apoyo financiero y técnico.	10
2	Objetivo: materno-infantil.	7
3	Impacto logrado.	6
4	Integridad.	3
5	Permite a OVI's desarrollar su trabajo con apoyo financiero.	3
6	Equipo multidisciplinario.	3
7	Normatividad.	2
8	Monitoreo constante.	3
9	Clima de apoyo.	4
10	TODO.	1
11	Sistema informativo.	3
12	Organización.	2
13	Metodología.	4

1.5 Califique su impresión de las capacitaciones de PROSAMI para su ONG en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	4	40
9.5	1	9.5
9	11	99
8	4	32
7	3	21
6	1	6
5	0	0
4	1	4
TOTAL	25	211.5
PROMEDIO		8.46

1.6 ¿Qué le gustaría que se mejorara?

ITEM No.	MEJORIAS INDICADAS POR LOS ENTREVISTADOS	NUMERO
1	Apoyo financiero a Administración.	3
2	Fomento autogestión comunitaria y ONG.	3
3	Prolongar duración del proyecto	4
4	Más eficiente coordinación de actividades organizativas.	10
5	Apoyo administrativo a ONG.	2
6	Agilizar aprovisionamiento de las medicinas.	3
7	NADA. Siempre tenemos espacio para sugerencias.	2
8	Incluir desarrollo psico-social del niño y la madre en el programa.	2
9	Incluir adultos en el programa.	1
10	Incluir desarrollo económico.	1
11	Cambios de reglas en el camino, especialmente en aspecto financiero.	1
12	Sistematización de impacto del proyecto.	2
13	Equilibrar formación técnica.	4
14	Estimular procesos investigativos y vigilancia epidemiológica.	1

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 2. COORDINADORES TECNICOS

RESULTADOS

Número de Cuestionarios: 26

ONGs ENTREVISTADAS	
ONG DE LA PRIMERA RONDA	ADHU (1) DIOCESIS (1) PROCADES (1) ASALDI (1) FUNDEMUN (1) ASAPROSAR (1) OEF (1)
ONG DE LA SEGUNDA RONDA	ASADEH (1) CONAMUS (1) KNAPP (1) ASPS (1) FUMA (1) CIRES (1) FUNDAC (1)
ONG DE LA TERCERA RONDA	ADEMUSA (1) CODECOSTA (1) FASTRAS (1) AMS (1) CODECUS (1) FUNDEPRENS (1) ASIPES (1) COMUS (1) IDEA (1) CODECA (1) COSDECSAM (1) ORMUSA (1)

DATOS DE LOS COORDINADORES TECNICOS			
PROFESION DE LOS SUPERVISORES	No.	TIEMPO EN CARGO EN MESES (m)	Media (m)
PRIMERA RONDA			
Médico	3	36 m, 9 m, N/R	22.5 m
Enfermera	2	6 m, 5 m	5.5 m
Ed. de Salud/MPH	1	22 m	22.0 m
Ing. Agronomo	1	36 m	36.0 m
TOTAL	7	MEDIA PRIMERA RONDA	16.3 m
SEGUNDA RONDA			
Médico	6	24 m, 24 m, 24 m, 16 m, 12 m, 3m	17.2 m
Enfermera	1	27 m	27.0 m
TOTAL	7	MEDIA SEGUNDA RONDA	18.1 m

TERCERA RONDA			
Médico	9	24 m, 18 m x 6, 7 m, 4 m	15.9 m
Enfermera	1	17 m	17.0 m
Psicologa	2	23 m, 16 m	19.5
TOTAL	4	MEDIA TERCERA RONDA	16.6 m
TOTAL GLOBAL			
Médico	18	36 m, 24 m x 4, 18 x 6, 16 m, 12 m, 9 m, 7 m, 4 m, 3 m, N/R	17.1 m
Enfermera	4	27 m, 17 m, 6 m, 5 m	13.8 m
Ed. de Salud/MPH	1	22 m	22.0 m
Psicologa	2	23 m, 16 m	19.5 m
Ing. Agronomo	1	36 m	36.0 m
TOTAL	26	MEDIA GLOBAL	17.7 m

2.1 ¿ Cuáles son las necesidades de salud de su población ?

2.1 Nesecidades	NUMERO
Educación	2.00
Asistencia General	1.00
Salud Mental	1.00
Salud Oral	1.00
Saneamiento Ambiental	4.00
Completar Vacunación en niños menores de cinco años	2.00
Educación en Salud	4.00
Mejorar las condiciones de vida	2.00
Todas las Atenciones de todo nivel	1.00
Espacios Físicos e implementos	1.00
Agua y Saneamiento Básico	1.00
Carreteras, Vivienda, Escuelas, Tierras	4.00
Enfermedades Comunes	4.00
Organización Comunitaria	2.00
Atención de Mortabilidad	1.00
Multiples, necesidad de mayores recursos	3.00
Programas de atención preventiva y curativa	1.00
Infraestructura, Equipo, y Recursos Humanos	1.00
Desnutrición	2.00

2.2 ¿ Qué servicios prestan a las comunidades en su proyecto ?

2.2 Servicios	NUMERO
Atención a toda la población	2.00
Atención en Salud	4.00
Atención Curativa	3.00
Controles de IRA'S, EDAS, Salud Materno Infantil, vacunación	1.00
Coordoinación	1.00
Saulud Oral, Saneamiento Ambiental coordinado con SMI	2.00
Contrarestar la Mortabilidad	2.00
Salud	1.00
Educación	0.00
Capacitación	2.00
Créditos Agricolas	2.00
Atención Preventiva	2.00
Servicios de Educación	2.00

2.3 Califica su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	0	0
9	4	36
8	6	48
7	4	28
6	6	36
5.5	1	5.5
5	4	20
4	1	4
3	0	0
TOTAL	26	177.5
PROMEDIO		6.83

2.2 ¿ Qué servicios prestan a las comunidades en su proyecto ?

2.2 Servicios	NUMERO
Atención a toda la población	2.00
Atención en Salud	4.00
Atención Curativa	3.00
Controles de IRA'S, EDAS, Salud Materno Infantil, vacunación	1.00
Coordinación	1.00
Salud Oral, Saneamiento Ambiental coordinado con SMI	2.00
Contrarestar la Mortabilidad	2.00
Salud	1.00
Educación	0.00
Capacitación	2.00
Créditos Agricolas	2.00
Atención Preventiva	2.00
Servicios de Educación	2.00

2.3 Califica su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	0	0
9	4	36
8	6	48
7	4	28
6	6	36
5.5	1	5.5
5	4	20
4	1	4
3	0	0
TOTAL	26	177.5
PROMEDIO		6.83

2.4 ¿ Cuáles son sus principales responsabilidades ?

No. de cuestionarios:

ITEM No.	PRINCIPALES RESPONSIBILIDADES INDICADAS POR LOS COORDINADORES	NUMERO
1	Coordinar Otras Instituciones	7
2	Supervisar y evaluar el trabajo de campo	4
3	Administrar	5
4	Proveer de Material necesario a los supervisores y promotores	3
5	Atención Medica	7
6	Informes	2
7	Planificación	3
8	Conducción personal	3
9	Coordinar las Acciones del proyecto PROSAMI	5
10	Gerencia del proyecto	1
11	Vigilancia Epidemiológica	3
12	Coordinación de proyectos	7
13	Supervición del programa	3
14	Evaluación Sistemática	3
15	Supervisar Actividades	2
16	Planificar y Evaluar	2
17	Elaborar Reformas a PROSAMI	3
18	Garantizar el cumplimiento de las normas del proyecto	2
19	Apoyo y asesoria a los promotores y supervisores del poryecto	
20	Consolidar resultados trimestralmente del proyecto	
21	Supervisar a promotores y coordinadores	
22		
23		
24		
25		

2.5 ¿ Cómo le ha ayudado las capacitaciones de PROSAMI a cumplir sus responsibilidades ?

- Orientar las actividades deacuerdo a los lineamientos dados por la institución
- Coordinación del proyecto PROSAMI en la zona
- Atención medica
- En forma excelente
- Ordenar y definir objetivos
- Bastante porque provee elementos básicos de administración de gerencia y planificación
- Actualización técnica de programas

- Apoyo técnico mínimo
- Se han recibido capacitaciones
- Solo se han recibido unificación de criterios para cumplir metas
- Para la ejecución y la evaluación del desempeño

2.6 ¿ A cuántas capacitaciones de PROSAMI asistió Ud. ?

- Todas las de la primera ronda
- Todas las de la segunda ronda
- Todas las de la tercera ronda
- 100% (5)
- Aproximadamente 13
- Siete (3)
- Diez (2)
- Ocho (2)
- Cuatro (1)

2.7 Califica su impresión de las capacitaciones de PROSAMI para su trabajo en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	1	10
9	3	27
8	3	24
7	11	77
6	3	18
5	2	10
4	1	4
NO INDICADO	2	
TOTAL	26	170.00
PROMEDIO		7.08

2.8 ¿ Cómo contribuye usted para asegurar la calidad del servicio ?
¿ Cómo sabe usted si los promotores y las parteras están dando servicios apropiados ? (Descripción de la supervisión)

- A través de la visita de campo
- Por medio de informes en el sistema de logros
- Por medio de la observación de la visita domiciliar
- Supervisión permanente (8)
- Visitas Domiciliarias
- Capacitaciones a promotores y voluntarios (4)
- Apoyo y monitoreo
- Evaluación (3)
- Se promueve la participación si la supervisión se hace de acuerdo a las circunstancias.

2.9 ¿ Cuál ha sido su más grande éxito o logro ?
- Mantener el equipo técnico y promotores desde el inicio del proyecto
- Formación junto a otras ONG's de Escuela de Capacitación Comunitaria (3)

- Elaborar diagnostico Situacional en coordinación de otras ONG's
- Vacunación
- Reducción de casos de IRA o EDA graves
- Reducción de mortabilidad
- Supervisar el trabajo (3)
- Realizar el diagnostico comunitario
- Escuela de capacitación Dr. Julio Castro
- Tenemos una escuela de Capacitación
- Capacitar en el sistema gerencial a promotores en salud
- Se ha comenzado a asistir a las actividades organizadas por la comunidad

2.10 ¿ Cuál ha sido su problema más difícil o fracaso ?
- Pocos recursos materiales y financieros
- No logramos subir significativamente las coberturas
- Falta de Equipo
- Poca participación de la comunidad (3)
- Elebar Coberturas
- Conciliar la parte administrativa con la técnica
- El tiempo que requiere para cumplir metas
- Educación
- Organización
- Desmotivación

2.11 ¿ Qué sugerencias tiene para PROSAMI o para su ONG ?
- Que PROSAMI tome en cuenta el área geográfica de la zona
- Reorientar estrategicamente el proyecto en areas de desarrollo de la organización comunitaria
- Educación en Salud
- Agilizar la entrega de medicamentos y equipo
- Simplificar el trabajo de los promotores
- Mayor apoyo
- Mejorar la comunión entre directores, coordinadores (2)
- Que la capacitación se haga tomando en cuenta las necesidades
- Se estan viendo resultados

2.12 Califica su impresión del apoyo de PROSAMI para su ONG en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	1	10
9	6	54
8	13	104
7	2	14
6	2	12
5	2	10
TOTAL	26	204
PROMEDIO		7.85

2.1.3 ¿ Algún comentario ?

- Las comunidades necesitan planificación de actividades
- Tomar en cuenta las necesidades para gestionar el apoyo
- Ninguno (5)
- Desde hace diez meses no se ha hecho devoluciones de experiencia
- Evaluar los problemas del personal técnico al interior de PROSAMI
- El apoyo de PROSAMI es exelente

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 3. SUPERVISORES TECNICOS
RESULTADOS

Número de Cuestionarios: 34

ONGs ENTREVISTADAS	
ONG DE LA PRIMERA RONDA	ADHU (1) FUNDEMUN (4) ASALDI (1) OEF (2) ASAPROSAR (7) PROCADES ( )
ONG DE LA SEGUNDA RONDA	ASADEH (2) CONAMUS (2) KNAPP (3) ASPS (3) FUMA (1) CIRES (2) FUNDESO (2)
ONG DE LA TERCERA RONDA	FUNDEPRENS (2) IDEA (2)

DATOS DE LOS SUPERVISORES TECNICOS

PROFESION DE LOS SUPERVISORES	No.	TIEMPO EN CARGO EN MESES (m)	Media (m)
PRIMERA RONDA			
Médico	5	12 m, 11 m, 6 m, 4 m, 1 m	6.8 m
Enfermera	3	39 m, 31 m, 21 m	30.3 m
Tec. Materno Infantil	2	18 m, 8 m	13.0 m
Psicologa	1	3½ m	3.5 m
Trabajador Social	4	19 m, 18 m, 9 m, 3 m	12.2 m
TOTAL	15	MEDIA PRIMERA RONDA	13.6 m
SEGUNDA RONDA			
Médico	6	24 m, 12 m, 10 m, 8 m, 6 m, 6 m	11.0 m
Enfermera	1	24 m	24.0 m
Tec. Materno Infantil	4	28 m, 24 m, 17 m, 15 m	21.0 m

Técnico Médico en Anestesiología	1	1 m	1.0 m
Educador en Salud	1	4 m	4.0 m
Bachiller en Salud	1	6 m	6.0 m
No Especificado	1	No Indicado	
TOTAL	15	MEDIA SEGUNDA RONDA	14.2 m
TERCERA RONDA			
Médico	1	6 m	6.0 m
Enfermera	3	10 m, 10 m, 9 m	9.7 m
TOTAL	4	MEDIA TERCERA RONDA	8.8 m
TOTAL GLOBAL			
Médico	12	24 m, 12 m, 12 m, 11 m, 10 m, 8 m, 6 m, 6 m, 6 m, 6 m, 4 m, 1 m	8.8 m
Enfermera	7	39 m, 31 m, 24 m, 21 m, 10 m, 10 m, 9 m	20.1 m
Tec. Materno Infantil	6	28 m, 24 m, 18 m, 17 m, 15 m, 8 m	18.3 m
Psicologa	1	3.5 m	3.5 m
Trabajador Social	4	19 m, 18 m, 9 m, 3 m	12.2 m
Técnico Médico en Anestesiología	1	1 m	1.0 m
Educador en Salud	1	4 m	4.0 m
Bachiller en Salud	1	6 m	6.0 m
No Especificado	1	No Indicado	
TOTAL	34	PROMEDIO GLOBAL	12.7 m

3.1 ¿ Qué servicios prestan a las comunidades en su proyecto ?
- Consultas dadas por los promotores capacitados
- Campañas de vacunación
- Capacitación
- Agua (5)
- Letrinas
- Servicios de salud permanentes (9)
- Desnutrición en niños
- IRAS y EDAS
- Atención en salud materno infantil (10)
- Educación en salud (5)
- Servicios educativos
- Atención a embarazadas
- Proyectos de autogestión de agua y saneamiento
- Preventivos en un 90%
- Curativos en un 10%
- Saneamiento y agua (3)
- Consultas (2)
- Atenciónm primaria en salud (13)
- Salud preventiva (7)
- Organización comunitaria

3.2 Califica su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	2	20
9.5		0
9	9	81
8.5	1	8.5
8	18	144
7.5		0
7	3	21
6.5		0
6	1	6
5.5		0
5		0
NO INDICADO		0
TOTAL	34	280.5
PROMEDIO		8.25

3.3 ¿ Cuáles son sus principales responsabilidades ?

No. de cuestionarios: 34

ITEM No.	PRINCIPALES RESPONSIBILIDADES INDICADAS POR LOS SUPERVISORES	NUMERO
1	Planificar las actividades para el año, mes y semana, fijar prioridades, evaluar metas del proyecto.	3
2	Evaluación de los servicios que se prestan a las comunidades.	1
3	Retroalimentación de las fallas encontradas y seguimiento; resolver dudas de promotores y voluntarios. Proveer educación continua y actualización del promotor.	18
4	Supervisión de promotores.	31
5	Facilitar, dar y participar en capacitaciones al personal.	5
6	Identificar necesidades de la comunidad y contribuir a las soluciones de las comunidades; desarrollo comunitario.	4
7	Brindar consulta médica para contribuir a la autogestión de la ONG, y atender necesidades de la población en apoyo al promotor.	3
8	Evaluar posibilidades de nuevos proyectos que generan ingresos que permitan la autosostenibilidad de la ONG. Contribuir a la realización y ejecución de los proyectos citados, en su evaluación y gestión de nuevos.	2
9	Participación en proyectos de FIS y de SEMA.	1
10	Fabricar y validar material educativo y técnico.	2
11	Manejar el vehículo.	2
12	Manejo de equipo de oficina; trabajo de oficina.	3
13	Preparar el informe mensual.	4
14	Controlar la recepción y entrega de medicamentos; asegurar el abastecimiento. Responsable de la bodega. Asegura la distribuición de los insumos.	3
15	Coordinar (con el promotor) relaciones y actividades con otras instituciones, ONGs y el Gobierno (MSPAS).	5
16	Evaluar cumplimiento de metas y objetivos del proyecto.	3
17	Ayudar la organización de la comunidad, incluyendo el comité de salud, directiva y otros grupos.	3
18	Recopilar datos y elaborar gráficos de coberturas; consolidación de la información y análisis.	2
19	Preparación de informe diario de actividades al coordinador.	1
20	Coordinar la instalación de UROC's	1
21	Coordinar la capacitación nutricional y producción de alimentos	1

3.1 ¿ Qué servicios prestan a las comunidades en su proyecto ?
- Consultas dadas por los promotores capacitados
- Campañas de vacunación
- Capacitación
- Agua (5)
- Letrinas
- Servicios de salud permanentes (9)
- Desnutrición en niños
- IRAS y EDAS
- Atención en salud materno infantil (10)
- Educación en salud (5)
- Servicios educativos
- Atención a embarazadas
- Proyectos de autogestión de agua y saneamiento
- Preventivos en un 90%
- Curativos en un 10%
- Saneamiento y agua (3)
- Consultas (2)
- Atención primaria en salud (13)
- Salud preventiva (7)
- Organización comunitaria

3.2 Califica su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	2	20
9.5		0
9	9	81
8.5	1	8.5
8	18	144
7.5		0
7	3	21
6.5		0
6	1	6
5.5		0
5		0
NO INDICADO		0
TOTAL	34	280.5
PROMEDIO		8.25

3.3 ¿ Cuáles son sus principales responsabilidades ?

No. de cuestionarios: 34

ITEM No.	PRINCIPALES RESPONSIBILIDADES INDICADAS POR LOS SUPERVISORES	NUMERO
1	Planificar las actividades para el año, mes y semana, fijar prioridades, evaluar metas del proyecto.	3
2	Evaluación de los servicios que se prestan a las comunidades.	1
3	Retroalimentación de las fallas encontradas y seguimiento; resolver dudas de promotores y voluntarios. Proveer educación continua y actualización del promotor.	18
4	Supervisión de promotores.	31
5	Facilitar, dar y participar en capacitaciones al personal.	5
6	Identificar necesidades de la comunidad y contribuir a las soluciones de las comunidades; desarrollo comunitario.	4
7	Brindar consulta médica para contribuir a la autogestión de la ONG, y atender necesidades de la población en apoyo al promotor.	3
8	Evaluar posibilidades de nuevos proyectos que generan ingresos que permitan la autosostenibilidad de la ONG. Contribuir a la realización y ejecución de los proyectos citados, en su evaluación y gestión de nuevos.	2
9	Participación en proyectos de FIS y de SEMA.	1
10	Fabricar y validar material educativo y técnico.	2
11	Manejar el vehículo.	2
12	Manejo de equipo de oficina; trabajo de oficina.	3
13	Preparar el informe mensual.	4
14	Controlar la recepción y entrega de medicamentos; asegurar el abastecimiento. Responsable de la bodega. Asegura la distribución de los insumos.	3
15	Coordinar (con el promotor) relaciones y actividades con otras instituciones, ONGs y el Gobierno (MSPAS).	5
16	Evaluar cumplimiento de metas y objetivos del proyecto.	3
17	Ayudar la organización de la comunidad, incluyendo el comité de salud, directiva y otros grupos.	3
18	Recopilar datos y elaborar gráficos de coberturas; consolidación de la información y análisis.	2
19	Preparación de informe diario de actividades al coordinador.	1
20	Coordinar la instalación de UROCs	1
21	Coordinar la capacitación nutricional y producción de alimentos	1

22	Brindar asistencia psicológica y retroalimentar, capacitar y educar a la población sobre ésta tema.	1
23	Identificar recusros.	1
24	Promoción	1
25	Coordinar con otros proyectos.	1

3.4 ¿ A cuántas capacitaciones de PROSAMI asistió Ud. ? _____
- A una (5)
- A dos (3)
- Promedio de cinco
- A doce
- A trece
- A tres (3)
- A todas
- A seis (4)
- A siete (3)
- A diez (10)
- A la mayoria
- A 25

3.5 ¿ Cómo ha contribuido PROSAMI en su capacitación para mejorar la salud ?
- Abasteciendo a las capacitaciones de cada componete (3)
- Ayuda a unificar criterios (9)
- Capacitan (7)
- Se aprende bastante (5)
- No ha recibido ninguna (5)
- Se adquieren más conocimientos (6)
- Ayudan a a clarar dudas (4)
- Normas y orientación (3)
- Orientan (7)
- Me ha ayudado a unificar criterios (6)
- De manera sastisfactoria ya que se han unificado criterios (6)
- De manera exelente

3.6 Califica su impresión de las capacitaciones de PROSAMI para su trabajo en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	7	70
9	9	81
8	9	72
7	5	35
6	2	12
5		0
NO INDICADO	1	
TOTAL	34	278.50
PROMEDIO		8.44

3.7 ¿ Cómo contribuye usted para asegurar la calidad del servicio ?
¿ Cómo sabe usted si los promotores y las parteras están dando servicios apropiados ? (Descripción de la supervisión)
- En señalar o decir las deficiencias que se tienen en cuanto a la capacitación
- Cuando hay dudas de algun problema se le pide apoyo
- Ayudan a facilitar el trabajo (3)
- Dan apoyo técnico y logístico (2)
- Esto nos sirve para facilitar el trabajo (4)
- Supervisión de promotores
- En hacer observaciones necesias y oportunas para el buen desarrollo del trabajo
- Asistiendo el coordinador en forma personal a las comunidades
- Por medio de la supervición y coordinación
- De apoyo pues compartimos la toma de decisiones, los problemas encontrados
- Apoya actividades del equipo y permite coordinación adecuada del mismo
- En unificar criterios
- Retroalimentando areas débiles
- A organizar el plan de trabajo en base a recursos y necesidades
- Ayuda a coregir errores

3.8 ¿ Cada cuánto tiempo lo acompaña el Coordinador a las visitas de campo ?

ITEM No.	VECES POR MES EL COORDINADOR VISITA AL SUPERVISOR EN LA COMUNIDAD	NUMERO	CALCULO
1	12 veces por mes	1	12
2	8 veces por mes	4	32
3	6 veces por mes	1	1
4	4 veces por mes	4	16
5	3 veces por mes	1	3
6	1.5 veces por mes	2	3
7	1 veces por mes	8	8
8	0.5 veces por mes	1	0.5
9	0.4 veces por mes	1	0.4
10	Frecuente, pero no especificado	1	
11	Según las necesidades	2	
12	Pocas veces, cuando se amérita	1	
13	No es regular por ser nuevo	1	
14	Sólo cuando viene el asesor de PROSAMI	1	
15	Sin respuesta	5	
	TOTAL	34	75.9
	PROMEDIO (77.4/23)		3.30

3.9 ¿ Cuál ha sido su más grande éxito o logro ?
- Por observación directa de las actividades (3)
- Monitoriar con la comunidad atendida, así como tambien con los promotores (2)
- Contamos con hojas de supervición de cada componente el cual se utiliza en cada visita domiciliaria (4)
- Revesando los diferentes registros (4)
- Supervbición directa en el campo a través de seguimiento decasos (2)
- Visitas domiciliarias (4)
- Por observación directa de actividades de la promotora (2)
- Se acompaña al promotor a la visita domiciliaria (5)
- Se realizan visitas a cada una de las comunidades (6)
- En la visita domiciliar aplicando técnicos de observación

3.10 ¿ Cuál ha sido su problema más difícil o fracaso ?
- Capacitación de promotores en control de crecimiento y desarrollo
- Hasta hoy no tengo problemas ni fracasos
- Se han detectado cambios de actitudes en los beneficiarios
- Aumentar cobertura en vacunación
- Lograr que la mayoria de promotores de mi responsabilidad realicen un trabajo eficiente
- Completar el número de promotores
- Capacitación de promotores en control de crecimiento y desarrollo
- Poder de alguna forma ayudar a las comunidades pobres
- La aceptación por parte de la comunidad y los promotores
- El integrarme al trabajo real de cada promotor y su comunidad

3.11 ¿ Qué sugerencias tiene para PROSAMI o para su ONG ?
- La idiocineracia de la población en lo referente a corregir habitos y costumbres
- Que muchas veces no son aceptadas sugerencias para realizar el trabajo
- No se practica la democracia
- Tener que integrar nuevos promotores en las comunidades
- Trabajar con saneamiento ambiental
- El creer que el cambio de la comunidad es rápido
- La despreocupación de algunas personas
- Fracaso no, dificil al principio
- El no tener equipo necesario de trabajo, en el tiempo ni en el momento oportuno

3.12 Califica su impresión del apoyo de PROSAMI para su ONG en una escala de 1 a 10:

CALIFICACION	NUMERO	CALCULO
10	4	40
9.5	1	9.5
9	10	90
8	10	80
7	4	28
6	5	30
TOTAL	34	277.5
PROMEDIO		8.16

3.13 ¿ Algún comentario ?

- Que las visitas de supervición de prosami sean programadas con anticipación
- Que sean flexibles en lo posible de acuerdo a situaciones surgidas dentro de la comunidad
- Que PROSAMI realice una encuesta comunitaria
- Tratar de aumentar en lo posible el presupuesto (3)
- Que se de en PROSAMI la papelería necesaria a los promotores
- Para las ONG's que las gerencias no sean verticales
- Que nivele salarios (2)
- Mejores prestaciones para el personal (3)
- Mas comprensión al promotor de bajo nivel educativo (2)
- Unificar critérios (3)
- Disminuir la papelería para consignar actividades (8)
- Que no se olviden de lo más importante del trabajo comunitario
- Que se incremente el salario a promotores y parteras (2)
- Para PROSAMI es dar importancia real al componente de la participación comunitaria
- Para ADHU, la selección de personal técnico, administrativo.

ROSAMI MTE/AREA TECNICA
CUESTIONARIO 4.A. PROMOTORES
RESULTADOS

RONDA	ONG	NUMERO DE PRO-MOTORES	TIEMPO EN EL CARGO	CAL-CULO	MEDIA
PRIMERA	ADHU	10	(2)36m, 35m, 32m, (2)31m, (3) 9m, 7m	235	23.5m
	ASALDI	13	(6)36m, (3)24m, 12m, (2)6m	312	24.0m
	ASAPROSAR	16	30m, (7)29m, 28m, (4)20m, (2)18m, 17m	394	24.6m
	FUNDEMUN	17	33m, 24m, 19m, 18m, 17m, 16m, 11m, (2)10m, 6m, 4m, (2)3m, 2m, (3)n/r	176	12.6m
	OEF	10	(3)35m, 34m, 24m, (2)21m, 20m, 18m, 9m	252	25.2m
	PROCADES	6	(2)36m, (2)21m, 8m, 2m	124	20.7m
	SUBTOTAL	72		1493	17.74
SEGUNDA	ASADEH	6	(4)24m, 18m, 7m	121	20.2m
	ASI'S	10	(4)24m, 20m, 12m, (2)10m, 6m, 1m	155	15.5m
	CIRES	3	25m, 24m, 12m	61	20.3m
	CONAMUS	6	(2)36m, (3)7m, 5m	98	16.3m
	FUMIA	6	(6)24m	144	24.0m
	FUNDESO	8	(6) 24m, 6m, 3m	153	19.1m
	KNAFP	11	(6)24m, 17m, (2)16m, 15m, (2)12m, 9m	241	21.9m
	SUBTOTAL	50		973	19.46
TERCERA	FUNDEPRENS	10	(9) 15m, 1m	136	13.6m
	IDEA	9	(3) 17m, (3) 12m, 4m, 3m, n/r	94	11.8m
	SUBTOTAL	19		230	12.78
TOTAL		141		2696	19.68
MEDIA					19.68m

4.01 ¿Cómo responde Ud. a los problemas de salud de la comunidad?
¿Cuáles son los servicios que presta Ud. a la comunidad?
- Educación a la madre (9)
- Control MEF
- Dar pecho/LMEx
- Alimentos bien condicionados
- Vacunación (7)
- Control de embarazo (5)
- Dando atención a las mujeres y niños menores de cinco años
- Visitando los hogares para conocer las necesidades
- Dar capacitación (2)
- Dar atención (3)
- Organizar proyectos de agua y letrinas
- Educación a madres y familias (7)
- Salud preventiva (5)
- Mejoramiento de condiciones de la comunidad (3)
- Visitas domiciliares (6)
- Actividades de autogestión
- Dando la primera atención
- Transmitir conocimientos
- Atenciones de consulta
- Dar medicinas
- Orientar y educar en saneamiento y desnutrición
- Servicios a personas necesitadas
- Atención a niños
- Educación comunitaria en casos de IRAS, diarreas, parasitos

4.02 ¿En qué forma le han ayudado las capacitaciones de PROSAMI para cumplir con sus responsibilidades como Promotor de Salud?
- En mucho ha ayudado
- Le facilita todo lo que saben hacer
- Convivencia y experiencia
- Reconocer y curar enfermedades
- Organización en la comunidad
- A prevenir enfermedades dando orientación a la comunidad
- Han ayudado bastante
- Ha sido determinante para poder realizar sus tareas
- Le ha orientado y le permite hacer el trabajo
- Le estimula
- Ha aprendido a ayudar a la comunidad
- A hacer el trabajo de la comunidad
- A aclarar
- Retroalimentación
- Ayudan mucho a desarrollar habilidades

4.03 ¿En qué forma le ayuda la supervisión del Técnico de la ONG a hacer mejor su trabajo en la Comunidad?

#	COMO AYUDA EL SUPERVISOR	NUMERO
1	A resolver dudas y aclarar conceptos; orientación sobre problemas; resolver casos deficiles	4+3+6+6+16+10+10+10+17
2	Le ayuda a corregir/rectificar errores o fallas en la atención; mejorar el trabajo; apoyar las atenciones	10+4+6+3+10+13
3	Ayuda a aprender más y mejor; aclarar conceptos	8+6+10+16+10
4	Le sirva de apoyo para el trabajo en la comunidad; le da confianza para la participación del promotor; apoyo moral	3+6+16+10
5	A conocer el nivel de preparación de cada promotor para ayudarle más; le evalua el trabajo; da retroalimentación	4+6+17
6	Le acompaña en visitas	8+3+10
7	Ayuda establecer credibilidad en la comunidad, que el promotor es respaldado por un medico o enfermera	10+13
8	Ayuda a educar a la comunidad	10+6
9	Ayuda en casos que no se conoce bien	8+17
10	Apoya a la coordinación y organización de la comunidad	13+10
11	Orientación al trabajo; como hacer las cosas	10+17
12	Orientación al uso del material y al trabajo en la comunidad	16
13	Orientación al uso del papelería	10

4.04 ¿Cada cuánto tiempo le visita su Supervisor Técnico?

#	VECES POR MES EL SUPERVISOR VISITA AL PROMOTOR EN LA COMUNIDAD	CALC.	NUMERO
	0 ///// ////	0	9
	0.5 /	.5	1
	1 ///// ///// ///// ///// ///// ////	29	29
	1.5 ///// ///	12	8
	2 ///// ///// ///// ///// ///// /	52	26
	3 ///// ///// ///// ///// ///// ////	87	29
	4 ///// ///// ///// /////	80	20
	TOTAL	260.5	122
	MEDIA	2.14	

4.05 ¿Cuál ha sido su más grande logro/satisfacción como Promotor en la Comunidad?

- Ayudan los que necesitan
- Control de embarazo
- Han disminuido enfermedades en la comunidad
- Facilitar otros proyectos para la comunidad (agua, letrinas, etc.)
- Menos niños enfermos
- Comprobar que puede aprender mucho
- Poder tratar a gente en su propia comunidad
- La aceptación que han tenido en las comunidades
- Haber participado en la solución de los problemas
- La confianza que han ganado
- Haber sido aceptado por la comunidad
- Conocer promotores de otras zonas (1)
- Ayudarle a poder trabajar con la comunidad más necesitada
- Darse a conocer con la comunidad (4)
- Obtener más conocimiento
- Enseñar lo aprendido
- Que la comunidad haya comprendido la necesidad de recibir la educación en salud
- La confianza y participación activa con la gente
- La forma de grupos y organización para salud
- Atender a la comunidad (8)
- Aceptación por la comunidad (5)
- Atender a los niños y madres
- Compartir con otros y la comunidad (4)
- Nuevos conocimientos y enseñar a la comunidad (4)
- Conocer la comunidad (2)

4.06 ¿Cuál ha sido el problema más difícil con que se ha enfrentado?

#	PROBLEMA MAS DIFICIL	NUMERO
	El niño murio	1
	A veces no le hacen caso a referencias en la Unidad de Salud	2
	Cierta rivalidad en promotores y MSP llegan después	5
	El no poder ayudar a alguien por la distancia	3
	No tener la medicina adecuada para poder ayudar)	3
	El no poder atender a todo el que lo necesita sino solo a población materno/infantil (6)	2
	La aceptación en algunas comunidades	5
	La desconfianza de la gente por el trabajo que realizamos	2
	Que la gente acepte el control de niños y embarazadas	4
	No tener transporte	1
	Bajo salario	4
	Los hombres no son aceptados en control de embarazo	1
	Las referencias no son aceptadas	3
	Resistencia de la comunidad en la organización y participación	2
	Dificultad de coordinar con el establecimiento de salud oral	2
	Poca participación de la comunidad	2
	No aprobar un proyecto de agua potable lo cual desanimo a la comunidad	2
	Mucha población a atender	3
	La ignorancia	3
	Encontrarse con personas negetivas	1
	Poder concientizar a las personas	2
	Críticas de la comunidad	4
	Falta de colaboración de comunidad	3
	La situación de la planificación familiar	2
	Embarazos en adolecentes	1
	No dan viáticos cuando salen acapacitaciones	1

4.07 ¿Qué sugerencias tiene para PROSAMI o para su ONG?

#	SUGERENCIAS	NUMERO
	Dar capacitación en partos	
	Dar capacitación para suturar heridas	
	Ayudar a tener víveres para niños desnutridos	
	Un caballo o bicicleta para transportarse (4)	
	Que aumenten las medicinas para ayudar a los adultos (3)	
	A veces la distancia impide que lleguen las vacunas	
	Que el proyecto continue (2)	
	Que se utilice menos papelería	
	Actividades que se han planificado no se llevan a cabo porque el equipo técnico tienen reuniones con PROSAMI	
	Dar el material necesario (equipo y material educativo porque ninguno lo tiene completo)	
	Mejorar los salarios	
	Dar uniformes, zapatos	
	Mayor recurso humano en cantones	
	Que PROSAMI de los recursos para potabilizar el agua	

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" IRA "	PREGUNTA No.	4.03

#	RESPUESTAS	NUMERO
1	Signo del Pliegue	3
2	Estridor	50
3	Tiraje	75
4	Respiración Rápida	83
5	Somnolencia	45
6	No puede beber ó alimentarse	50
7	Convulciones	37
8	Sibilancias	43
9	Desnutrición severa	18
10	Fiebre	30
11	Fiebre ó hipotermia si es menor de dos meses	1

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" IRA "	PREGUNTA No.	4.04

#	RESPUESTAS	NUMERO
1	Fiebre	33
2	Sibilancia	23
3	Acetaminofén	30
4	Albuterol	16
5	Respiración Rápida	87
6	Trimetropim – Sulfa	49
7	Eritromicina	9
8	Estridor	22
9	Tiraje	26
10	Referirlo	5
11	Antibiótico	35
12	Cuidados en el hogar	19
13	Seguimiento a las 48 horas	24

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" IRA "	PREGUNTA No.	4.05

#	RESPUESTAS	NUMERO
1	No mama ó no come	27
2	Respiración rápida	21
3	Tiraje	36
4	Sibilancia	8
5	Estridor	18
6	Neumonía Grave	48
7	Enfermedad muy grave	45
8	Somnoliento (anormalmente)	15
9	Convulsiones	20
10	Si no hay nada en el Dispensario	1
11	Fiebre ó hipotermia	9
12	Infección de Oído y Garganta	2
13	Deshidratación	2

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" EDA "	PREGUNTA No.	4.07

#	RESPUESTAS	NUMERO
1	Dar SRO por 4 horas. Si no mejora, referir y si mejora usar Plan "A"	19
2	Dar SRO y referir	18
3	Referir inmediatamente	6
4	Referir cuando haya shock	6
5	Dar abundantes líquidos	17
6	Dar SRO (sin referir)	18
7	Otras respuestas	

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" EDA "	PREGUNTA No.	4.06
#	RESPUESTAS		NUMERO
1	Ojos hundidos		35
2	Fontanela (mollera) hundida		65
3	Signo del pliegue		68
4	Ojor hundidos y secos		33
5	Boca seca		51
6	Somnoliento		8
7	Boca y lengua secas		30
8	Llenado capilar		5
9	Ausencia de lágrimas		27
10	Sed (avidez para beber)		28
11	Orina poco o nada		13
12	Piel y huesos		2

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" EDA "	PREGUNTA No.	4.08
#	RESPUESTAS		NUMERO
1	Aumentar líquidos		61
2	Seguir alimentación		54
3	Seguir amamantando		37
4	Enseñar signos de peligro		24
5	Indicar volver si hay alguno de ellos		
6	Recomendaciones sobre prevención		25
7	Que le dén SRO		36

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	SALUD REPRODUCTIVA	PREGUNTA No.	4.09

#	RESPUESTAS	NUMERO
1	Hemorragia o sangramiento	92
2	Salida de líquido por vagina (líquido omniótico)	36
3	Signos de Toxemia (cefalea intensa TA elevada edema de cara y manos convulsiones).	95
4	Sospecha de infección de vías urinarias (dolor en rabadilla)	22
5	Abortos previos	8
6	Cesárea aterior	8
7	Dolores de parto antes de las 38 semanas	44
8	Palidéz marcada (anemia)	2
9	Fiebre alta	18
10	No movientos fetales	12
11	Cualquier otra enfermedad junto con el embarazo	4
12	Primigestas	9
13	Presentación no cefálica	4
14	Multíparas (más de 4 partos)	15
15	Ultimo parto prematuro	1
16	Menor de 18 años	7
17	Aumentó demasiado de peso	5
18	Desnutrición	4
19	Que sea mayor de 45 años	1
20	Partos Generales	1
21	Partos Prematuros	1
22	Mayor de 35 años	9
23	Menor de 15 años	6
24	Altura uterina anormal	3
25	No contesta nada adecuado	4

PROSAMI MTE
CUESTIONARIO 4.B PROMOTO..ES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	SALUD REPRODUCTIVA	PREGUNTA No.	4.12
#	RESPUESTAS		NUMERO
1	Hemorragia vaginal (sangramiento mayor que la regla)		95
2	Loquios fétidos		41
3	Temperatura a fiebre de 38 ó mas		75
4	Tensión arterial baja (abajo de 60 latidos)		8
5	Tensión arterial alta (arriba de 140/90)		19
6	Pulso elevado sin fiebre (arriba de 100/min)		9
7	Dolor y rubor en senos		10
8	Convulsiones, dolor de cabeza, visión borrosa		5
9	Cuando noo pueda nacer la placenta		4
10	Dolor en la matríz		9
11	Retención de placenta o restos placentarios		6
12	No plantea nada adecuada		10

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	'CRECIMIENTO Y DESARROLLO'	PREGUNTA No.	4.13
#	RESPUESTAS		NUMERO
1	Pesar al Niño		122
2	Medir (Tallar) al Niño		109
3	Graficarlo		60
4	Medir Perímetro Afílico		51
5	Evaluar Estado Nutricional		51
6	Educación sobre Alimentación		51
7	Ver si faltan Vacunas		10
8	Educación a la Madre sobre Higiene		9
9	Educación a la Madre sobre Inmunización		8
10	Episodios de IRA y EDA		6
11	Cómo está el Desarrollo y la Alimentación		5
12	Educación sobre Estimulación para el Desarrollo		4
13	Otros		16

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	*"CRECIMIENTO Y DESARROLLO"*	PREGUNTA No.	4.14
#	RESPUESTAS		NUMERO
1	Desnutrición Severa / Grave		60
2	Desnutrición Severa y Otra Enfermedad		22
3	Desnutrición Moderada o Severa		13
4	Además de la Desnutrición tiene complicación de enfermedades (IRA – EDA)		9
5	Desnutrido Severo o Moderado con algún tipo de Infección		5
6	Cuando tiene una enfermedad muy grave		2
7	Está desnutrido, No aumenta de peso		1

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	"CRECIMIENTO Y DESARROLLO"	PREGUNTA No.	4.15
#	RESPUESTAS		NUMERO
1	Solamente seno materno, ni otro tipo de alimento por 6 meses		62
2	Dar pecho, no otro alimento por 4 a 6 meses		25
3	Lactancia Exclusiva sin otro alimento hasta 4 meses		20
4	Lactancia materna durante 2 años		4
5	Más apropiado, protege de enfermedades y les dá defensas		6
6	Lactancia materna hasta 1 1/2 años.		2

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	* INMUNIZACIONES *	PREGUNTA No.	4.16

#	RESPUESTAS	NUMERO
1	Esquema completo	89
2	Esquema incompleto	22
3	Esquema muy incompleto	18
4	Sin Respuesta	1

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	'INMUNIZACIONES'	PREGUNTA No.	4.17
#	RESPUESTAS		NUMERO
1	Esquema completo		48
2	Esquema incompleto		20
3	Esquema deficiente		35
4	Esquema muy deficiente		22
5	Sin Respuesta		5

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" SALUD DEL RECIEN NACIDO "	PREGUNTA No.	4.18

#	RESPUESTAS	NUMERO
1	Lavarse las manos	124
2	Qué edad tiene	1
3	Preguntar la edad a la madre	1
4	Interrogar a la madre	2
5	Resarlo	1

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	" SALUD DEL RECIEN NACIDO "	PREGUNTA No.	4.19
#	RESPUESTAS		NUMERO
1	Hipotermia		43
2	Muñón umbilical infectado		72
3	Signos de infección		31
4	Pesa menos de 2,500 gramos		16
5	Fiebre alta		43
6	No mama		47
7	Quejumbroso		25
8	Malformación congénita		30
9	Somnoliento		4
10	Bajo pesp grave		9
11	Si tiene temperatura		1
12	Cianosis		35
13	Palidez		11
14	Combulsiones		10
15	Enfermedad muy grave		4
16	De bajo peso		50
17	Tétanos neonatal		2
18	Problemas respiratorios		2
19	Prematuro		22

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	"PARTICIPACION COMUNITARIA"	PREGUNTA No.	4.23
#	RESPUESTAS		NUMERO
1	En Asambleas con la Comunidad		67
2	Elegidos por Votación		22
3	Celebrando reuniones con grupos		26
4	Seleccionando a líderes y voluntarios		17
5	Formando Directivas por cada Comunidad		19

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 4.C. PROMOTORES

No de Cuestionarios: 15

4.01 IRA (Signos de peligro, Tratamiento casero)
- Ha dejado de mamar
- Convulsiones (5)
- Fiebres
- Respiración rápida (5)
- No dejar de darle pecho
- Continuar la alimentación acostumbrada
- Limpiar la nariz (3)
- Dar acetaminofen (7)
- Vacunarlo contra el sarampión
- Si tiene temperatura
- Contar respiraciones
- Higiene
- Signos de peligro
- Respiración lenta (2)
- Dar líquidos (7)
- Que lo siga alimentando suficiente
- Consejos sobre saneamiento ambiental (humo) (4)
- Dificultad al respirar (3)
- Neumonia
- Dar te de Manzanilla/Eucaliptó

4.02 EDA (Signos de deshidratación, tratamiento casero)
- Si llora sin lagrimas
- Boca seca (10)
- Cuando hay Bomito
- Presencia de Sangre
- Dar abundantes líquidos (7)
- Medidas de higiene
- Agua
- Asear letrina
- Piel arrugada
- Ojos Hundidos (9)
- Dificultad para respirar
- No dar antibioticos
- Deshidratación
- Mama con dificultad
- Suero oral
- Orina poco
- Hervir agua

4.03 Salud Reproductiva/Materna
- Hacer controles (6)
- Vacunas durante el embarazo (13)
- Fecha de probable parto
- Alimentación (6)
- Higiene (4)
- Sangramiento (4)
- Transtornos urinario (mal de orin) (3)
- Planificación familiar
- Cefalea (3)

PROSAMI MTE
CUESTIONARIO 4.B PROMOTORES
COMPONENTES TECNICOS: TABULACION DE RESPUESTAS

COMPONENTE	*"PARTICIPACION COMUNITARIA"*	PREGUNTA No.	4.23
#	RESPUESTAS		NUMERO
1	En Asambleas con la Comunidad		67
2	Elegidos por Votación		22
3	Celebrando reuniones con grupos		26
4	Seleccionando a líderes y voluntarios		17
5	Formando Directivas por cada Comunidad		19

- Hemorragias vaginal (7)
- Hinchazon en mie[illegible]ros de la cara (2)
- Vacuna Tetano
- Hinchazon en las manos y cara (2)
- Mareos, nauseas, mal de ojos
- Espaciamientos en los embarazos (2)
- Que este atenta a la expulsión de liquidos (1)
- No usar ropa ajustada
- Evitar consumo de bebidas alcoholicas y tabaco

4.04 Control Crecimiento Desarrollo y Nutrición
- Clasificación de estados de desnutrición según gráfico de crecimiento
- Importancia de la lactancia materna exclusivamente hasta los seis meses
- Higiene del niño (4)
- Lavar bien los alimentos
- Hervir o clorar el agua
- Dieta balanceada
- Lactancia materna
- Educación
- Alimentación (3)
- Revisar tarjeta de vacunas
- Crecimiento y abilidades del niñó
- Si gana o pierde peso
- Tiene que cuidar al niño
- Detectar enfermedades
- Importancia del control
- Identificación de la desnutrición
- Importancia de alimentación
- Desarrollo psicomotor
- Nutrición (2)
- Control de peso
- Control CD
-

4.05 Inmunizaciones:
- Protección sobre enfermedades (2)
- Nesecidad de tener completo el esquema de vacunación (3)
- Mas vale prevenir que lamentar (1)
- La vacuna no afecta (3)
- Es importante la vacunación
- Para que sirven las vacunas
- Orientación sobre alimentación
- Poner la DPT y Polio a los 1 1/2 años y 4 años
- Explica las dosis de vacunas 2m, 4m y 6m
- BCG, 2m DPT y Polio

4.06 Salud Perinatal/Neonatal (Recien Nacido)
- Aseo en general, particularmente en el muñon umbilical (6)
- En caso de niños de bajo peso se recomienda el método de madre canguro
- Lactancia materna a libre demanda
- Importancia de iniciar esquema de vacunación
- Baño diario
- Higiene
- Alimentación (2)
- Dar pecho (4)
- Control de vacunas (4)
- Que este pendiente que el niño no presente ningun signo de peligro
- Abrigarlo
- Limpiar la nariz
- Bañarlo
- Ombligo infestado

- Lavar el pecho
- Exámenes
- Dar pecho

4.07 ¿Como clasificaría su impresión sobre el apoyo que PROSAMI le da a su ONG? (en una escala de uno al diez)

ROSAMI MTE/AREA TECNI A
CUESTIONARIO 5. PARTERAS

Número de Cuestionarios: 14 Personas entrevistadas: 32

ONG DE LA PRIMERA RONDA	OEF (2) PROCADES (1)
ONG DE LA SEGUNDA RONDA	ASADEH (1) CONAMUS (1) ASUS (1) FUMA (1) FUNDESO (1)
ONG DE LA TERCERA RONDA	FUNDEPRENS (1) IDEA (2)
NO ESPECIFICA	(3)

5.01 ¿Cómo le ha ayudado PROSAMI y la ONG a mejorar la salud en su comunidad?

- Le da medicinas (5)
- Enfermedades de los niños
- Atiende a las embarazadas
- No le han dado mucho
- Le proporciona: guantes, alcohol, gasa, cintas.
- Orientan en el parto
- Ayuda bastante con medicinas
- Dan mucho beneficio
- Hasta hace poco ha tenido contacto con el promotor
- Visitar enfermos
- Dar consejos
- Con medicinas a embarazadas (3)
- Vigilando a las mujeres después del parto y a los niños
- Los niños se enferman menos
- Capacitan parteras (2)
- Hay muchas cosas que no sabía y el promotor las enseña (2)
- No ha recibido capacitación (2)

3.02 Califique su impresión de la respuesta de su ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	24	240.00
9.5		0.00
9	2	18.00
8.5		0.00
8	2	16.00
7.5		0.00
7	7	49.00
6.5		0.00
6	1	6.00
5.5		0.00
5		0.00
NO INDICADO		0.00
TOTAL	36	329
PROMEDIO		9.14

5.03 ¿Cuáles son los servicios que presta Ud. a la comunidad?
- Atención a embarazadas (5)
- Estudia medicina natural
- Visita a embarazadas
- Atiende partos (10)
- Cura al niño
- Vigilancia del puerperio (4)
- Vigilancia del recien nacido (2)
- Prenatal y control (3)
- Asistencal del parto
- No hace control prenatal
- Hace visitas a los niños (2)
- Educación a las mujeres
- Capacitación (5)

5.04 ¿A cuántas capacitaciones de PROSAMI (y el MSPAS) asistió Ud.? _____
- A una (7)
- A dos (2)
- A tres
- De dos a cuatro (4)
- A ninguna

5.05 ¿Cómo le ha ayudado a cumplir sus responsabilidades las capacitaciones de PROSAMI (y el MSPAS)?
- No ha tenido ninguna
- Mando las primerizas al hospital
- Con las enseñanzas de preparar suero y el aseo

- Le ha ayudado ha prev[illegible] complicaciones
- La muerte de mujeres relacionadas con el parto
- Les ha enseñado a hacer los procedimientos de higiene
- Signos de peligro
- Es bastante la ayuda, se ha mejorado la atención de partos
- Falta renovaciones
- Le han atendido muy bien
- Mucho porque toma bien las ideas en las capacitaciones
- Le gusta asistir a capacitación
- Refresca la mente
- Peligros de embarazadas
- Le gustaría asistir a capacitación
- Aprendió a lavarse las manos
- Aprendió como atender mejor el parto

5.06 Califique su impresión de cómo las capacitaciones de PROSAMI le han ayudado a realizar su trabajo (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	19	190
9.5		0
9		0
8.5		0
8	1	8
7.5		0
7		0
6.5		0
6	1	6
5.5		0
5	1	5
NO INDICADO	8	
TOTAL	30	209
PROMEDIO		9.50

5.07 ¿Cuántos partos ha atendido? _____
- No recuerda (3)
- mas de 1000
- Diez
- Ciento cuatro
- Siete
- Treinta y tres
- Veinte y siete
- Veinte
- Muchos
- Cuatro

- Uno
- Tres

5.08 ¿Cuántos partos atiende al mes?

PARTOS/MES	NUMERO	CALCULO
0.05	1	0.05
1	1	1.00
2	3	6.00
3	2	6.00
4	3	12.00
5.5	2	11.00
NINGUNO	3	0.00
TOTAL GLOBAL	15	36.05
PROMEDIO		2.40

5.09 ¿Cómo se prepara para la atención de un parto?

ITEM No.	PREPARACION PARA ATENDER UN PARTO	NUMERO
1	Preparar gorro, gabacha, proteger cama, tijera,....	9
2	Esterilizar los materiales necesarios.	7
3	Poner cinta a usarse en el ombligo en alguna sustancia para su esterilización.	3
4	Lavarse las manos.	6
5	Papel periódico.	2

5.10 ¿Cuándo debe referir a una embarazada al hospital?

No.	CUANDO UN PARTO SE REFIERE AL HOSPITAL	NUMERO
1	Cuando la parturienta es primigesta.	7
2	Primigestas, segundos partos y superiores a quintos partos.	2
3	Cuando la parturienta está sufriendo fiebre, refolea, complicaciones.	5
4	Hemorragia.	6
5	Cuando el bebé tiene una presentación anormal, posición difícil.	9
6	Cuando la parturienta está sufriendo "hinchazón."	4
7	Cuando la primigesta se tarda más de seis horas en parir o se atrasan demasiado para entrar en trabajo de parto.	3
8	Cuando el parto presenta dificultades.	3
9	Cuando el bebé no presenta movimiento.	1
10	Cuando la placenta está siendo retenida.	6
11	Cuando la placenta está en posición previa.	2
12	Cuando la parturienta no tiene suficientes fuerzas para llevar a cabo el parto.	1
13	Cuando así se le refiere la paciente, como paciente que necesita ser enviada a un hospital.	1

5.11 ¿Qué debe hacer inmediatamente después que el niño nace?

ITEM No.	QUE HACE DESPUES QUE HA NACIDO EL BEBE	NUMERO
1	Amarrar el cordón.	8
2	Limpiar al bebé.	10
3	Revisar bebé para decidir si se vé normal.	5
4	Curar el ombligo.	9
5	Envolver al bebé.	3
6	Aspirar al bebé que se ven "moradito."	4
7	Estimular al bebé para que comience a respirar.	3
8	No se le saca la flema.	1
9	Sin comentarios.	1

5.12 ¿Cuál ha sido su principal satisfacción?
- Atender partos
- El apoyo de la gente
- Cuando una mujer sale bien ligerito sale bien el niño (3)

- La alegria de haber atendido un parto y que todo ha salido bien
- No haber tenido ninguna muerte
- Que la gente le hace caso a los consejos
- Atendió a una primeriza porque no le dió tiempo deir al hospital
- Entender mejor lo que uno hace
- Atender partos complicados que nohan tenido tiempo de ir al hospital
- Servir a la comunidad
- Dar vida a los niños
- Haber salvado la vida a os niños en situaciones difíciles para la madre
- Ver niños sanos
- Ver mujeres sanas y sin hemorragia
- Servir a quien necesita
- Sentir valor y fe

5.13 ¿Cuál fue su problema, decepción o fracaso más notable?

ITEM No.	DESCRIPCION DE PROBLEMAS DE PARTE DE LAS PARTERAS	NUMERO
1	Ninguno.	6
2	Desmayo.	1
3	La parturienta no ayuda, está nerviosa.	2
4	Se presenta sangramiento, hemorragia.	1
5	No se tiene el equipo adecuado.	1
6	La parturienta está desnutrida.	1
7	Sin comentarios.	1
8	Partera ya no atiende más partos.	1
9	La placenta se retrasó.	1

5.14 ¿Tiene sugerencias par PROSAMI o su ONG?
- Ninguna (4)
- Materiales
- Maletin
- Botiquin
- Rotulo de partera
- Báscula
- Olhas, lámpara
- No (3)
- Que promuevan reuniones entre las parteras y la comunidad
- Continuar trabajando con el promotor
- Que la capaciten porque cree que le falta y teine miedo de atender
- Hacer capacitaciones

5.15 ¿Tiene comentarios?
- No (6)
- Necesitamos promotor en el canton
- Hay otra partera pero esta de mucha edad, necesitamos otra
- Todo esta bien nos ayuda mucho

PROSAMI MTE/AREA TECNICA
CUESTIONARIO 6. COMITES DE SALUD

Número de Cuestionarios: 18 Número de Entrevistados: 172

ONG DE LA PRIMERA RONDA	ADHU (1) ASALDI (1) ASAPROSAR (1)	FUNDEMUN (1) OEF (1) PROCADES (1)	
ONG DE LA SEGUNDA RONDA	ASADEH (1) ASPS (2) CIRES (1)	CONAMUS (2) FUMA (1) FUNDESO (1)	KNAPP (1)
ONG DE LA TERCERA RONDA			
NO ESPECIFICA	3		

6.1 ¿Cómo le ha ayudado PROSAMI y la ONG a mejorar la salud en su comunidad?

- Hay menos enfermedades y muertes (1)
- Han mejorado fuentes de agua (2)
- Charlas educativas de tipo preventivo (1)
- Nos dan medicinas (2)
- Nos dan charlas para cuidar la salud (2)
- Tenemos clínicas (1)
- Nos capacitan para luego compartir con otros (1)
- Visitas domiciliarias (1)
- Atención médica, eso implica menos enfermedades en los niños
- Ayuda a gestionar otro tipo de proyectos
- Han sido de mucha ayuda (3)
- Mayor accesibilidad a la atención de salud
- Han disminuido los casos de tos y resfriado
- hay un mejor control de la población materno infantil
- Asistencia a niños
- Uso de medicamentos
- Ve a mujeres embarazadas
- Da charlas educativas en salud
- Atiende a domicilio (3)
- Da un gran servicio
- Se enferman menos los niños
- Dan medicina (4)
- Regalan Vitaminas, lentes y medicinas.

- Que no falten medicinas
- Que les da la oportunidad de asistir a un curso
- Que les den medicinas como necesitaríen
- Les gustaría que el material para la atención del parto estuviera en una sola bolsita
- Algunas no tienen básculas
- Quieren seguir practicando y aprender más
- Piden equipo, uniforme, ropa
- Ayuda para terminar la clínica
- Pisaceitas cambiar al hospital

6.2 **Califique su impresión de la respuesta de la ONG y los servicios prestados a la comunidad y el grado que satisface las necesidades de salud (en una escala de 1 a 10):**

CALIFICACION	NUMERO	CALCULO
10	61	610
9.5		0
9	14	126
8.5		
8	5	40
7.5		0
7	1	7
6.5		0
6		0
5.5		0
5		0
NO INDICADO		0
TOTAL	81	783
PROMEDIO		9.6

6.3 ¿Qué hace el comité de salud? Entrevistados 172 en 18 cuestionarios.

ITEM No.	QUE HACE EL COMITE DE SALUD	NUMERO
1	Ayudar en campañas.	8
2	Referir casos.	6
3	Visitar hogares.	7
4	Higiene, limpieza pública.	4
5	Educación, capacitación.	6
6	Capacitarse.	3
7	Monitoreo y apoyo en actividades de peso y talla.	5
8	Recaudar fondos.	7
9	Vacunas.	7
10	Organiza reuniones semanales, mensuales y talleres.	3
11	Atender casos.	3
12	Ayudar en aspectos administrativos.	2
13	Planificación.	2

6.4 ¿Cómo se conformó el Comité de Salud?
- Elección en asamblea (3)
- El Promotor nos dijó (6)
- En la comunidad fue electa una asamblea general
- A través de la asamblea general (4)
- Algunas instituciones
- Las promotoras (2)
- La directiva comunal nos dijo
- El comite nos informo
- Reunión de la comunidad (2)
- Funciona desde antes

6.5 ¿Cómo llegó Ud. a integrar el Comité de Salud?
- Todas fueron propuestas por la asamblea comunal (2)
- Por voluntad (5)
- No contesto (2)
- Por invitación de la promotora (3)
- Invitado porque se renueva al año
- Reunión a llamado de la promotora
- En asamblea general de la comunidad, se formo el comite con voluntarios
- Invitados por el doctor y promotores (3)
- Porque la comunidfad los elije
- Porque le pidio personalmente la ONG

6.6 ¿A cuántas capacitaciones de PROSAMI, la ONG y el promotor ha asistido Ud.?
- Capacitación más o menos cada 2 meses (2)
- Se reunen cada ocho días (1)
- Sesiones educativas cada 8 ó 15 días (2)
- A 10 (3)
- 1 cada mes (2)
- A siete
- A cuatro por mes (2)
- 20 en promedio

6.07 ¿Cómo le ha ayudado a cumplir sus responsabilidades las capacitaciones de PROSAMI, la ONG y el promotor?
- Se han concientizado de su labor (1)
- Han aprendido a manejarse como directiva (1)
- Han aprendido a manejar los fondos (1)
- Han permitido su desarrollo como Comité de Salud (1)
- Mejora los conocimientos para enseñar a otros (1)
- Le ayuda en la atención
- Para reconocer signos de enfermedad y remitirlo al promotor (1)
- Les ha ayudado mucho
- Desarrollar la mente
- Ha ayudado con sus propios hijos
- Les gusta capacitaciones
- No les han explicado cuales son sus responsabilidades
- Lo que la promotora he enseñado
- Si porque las charlas le ayudan a llevar más cuidado
- Aprender cosas que no sabia
- Ha conocer las enfermedades para dar asistencia
- Detecta casos de EDA/IRA
- A concientizarse más

6.08 **Califique su impresión de cómo las capacitaciones de PROSAMI, la ONG y el promotor le han ayudado a realizar su trabajo (en una escala de 1 a 10):**

CALIFICACION	NUMERO	CALCULO
10	79	790
9	32	288
8	16	128
7	3	21
6	5	30
5	1	5
NO INDICADO	5	
TOTAL	141	1257
PROMEDIO		9.28

DESCRIBIR LOS MENSAJES que se debe dar en cuanto a los siguientes componentes:

6.09 **IRA (neumonia)**
- Excelente concepto de clasificación de IRA's. TX casero (3)
- Evitar el polvo regando (1)
- Tener la cocina afuera (1)
- Trapos mojados para la fiebre (1)
- Referirlo al Promotor (2)
- No mantenerlo desnudo (1)
- Dandole agua con miel (2)
- Cuando hechan moquitos verde limpiarlos (2)
- Referirlo al hospital (1)
- Sensación-cuenta respiraciones-si no normal-ir al hospital
- Llevar al hospital
- Medidas preventivas
- Cansancio

6.10 **EDA**
- Reconocer los signos de deshidratación. TX Casero (2)
- Dar suero oral (3)
- Clorar el agua (1)
- Entrar la basura (1)
- Mantener alimentos tapados (1)
- Uso de calzado (1)
- Mantener aseada la casa (1)
- Medidas preventivas (1)
- Liquidos para evitar deshidratación
- Alimentos
- Diarrea
- Darle suero

6.11 Salud Reproductiva/Salud Materna.
- Reconocer signos de peligro (2)
- Referirla con el Promotor (1)
- Aplicarse vacunas (1)
- Alimentarse lo mejor posible (1)
- No recuerdan (1)
- No ha recibido capacitación (1)
- Hacer control en primeros meses
- Comer de todo
-

6.12 Nutrición/Crecimiento y Desarrollo del Niño.
- Sirve para mantener a los niños sanos (1)
- Referirlo para vacunas (1)
- Alimentar mejor a los niños (1)
- Estimulación temprana (1)
- Lactancia materna (1)
- No recuerda (1)
- Previenen algunas enfermedades (2)
- Alimentación
- Control medir y pesar
- Consejo y orientación
- Gráfica
- Control de peso (3)

6.13 Inmunizaciones
- BCG: Al nacer (1)
- DPT y OPV: 2 - 4 - meses + Refuerzos (2)
- Antisarampion: 9 meses (1)
- Aconsejar a la madre para acudir al Promotor (1)
- Evitar el Sarampion, tosferina, difteria, tétano (2)
- No ha recibido capacitación (1)
- Medidas preventivas (1)
- Prevención
- Poner todas las vacunas

6.14 Salud Perinatal/Neonatal.
- Reconocen: Importancia de control del RN para evitar complicaciones, para referencia en caso de problemas (2)
- Curación del ombligo (1)
- Lactancia materna exclusiva (1)
- Baño diario (1)
- Signos de enfermedad (1)
- No recuerdan (2)
- No ha recibido capacitación (1)
- Asco
- Recetas
- BCG desde el primer mes
- Control

6.15 ¿Cuál ha sido su principal satisfacción?
- Ayudar a los que necesitan de atención o indicaciones (1)
- Darle comida y asear al niño (1)
- El apoyo de la comunidad (1)
- Ser utiles a la comunidad
- Agregarse y orientarse
- Sigan Colaborando
- Ayudar a la comunidad
- La promotora capacita
- Aprende mucho
-

6.16 ¿Cuál fue su problema, decepción o fracaso más notable?
- Ninguno (4)
- La actitud de algunos habitantes que no están de acuerdo con el trabajo del comité (1)
- A veces no atienden otra gente
- Nada (5)

6.17 ¿Tiene sugerencias para PROSAMI o la ONG o el promotor?

ITEM No.	SUGERENCIAS	NUMERO
1	Aumentar Número de Promotores.	1
2	Ofrecer más capacitación.	5
3	Prolongar duración del proyecto.	5
4	Construir instalaciones (letrinas, dispensarios, etc.)	3
5	Introducir agua.	2
6	Mantener constante reabastecimiento de medicinas.	4
7	Agregar personal capacitado (médico, promotor de salud, etc.)	6
8	Ayudar o conseguir financiamiento para instalaciones.	2
9	Agregar promotor permanente.	1
10	Ninguna.	5

6.18 ¿Tiene comentarios?
- Ninguno (3)
- No cobra atención
- Paga una cantidad voluntaria para las medicinas
- Buena atención
- Tienen una profesora que pagan 1/2 hora los padres y 1/2 hora la alcaldía
- Comunidad tendría que reunir para ver como se puede sostener la promotora
- Piensan que es posible
- Que venga el médico cada 15 días de San Salvador que viene de PROCADES

PROS/ MI MTE/AREA TECNICA
FORMULARIO No. 7, LA POBLACION

RESULTADOS

Número de Cuestionarios: 58 Número de Entrevistados: 58

NUMERO DE PERSONAS ENTREVISTADOS POR PVOs VISITADO		
ONG DE LA PRIMERA RONDA	ADHU (2) ASALDI (1) ASAPROSAR (8)	FUNDEMUN (1) OEF (6) PROCADES (2)
ONG DE LA SEGUNDA RONDA	ASADEH (4) ASPS (3) FUNDESO (12)	CONAMUS (3) FUMA (4) KNAPP (5)
ONG DE LA TERCERA RONDA	FUNDEPRENS (4) IDEA (2)	
NO ESPECIFICA	(1)	

7.01 ¿Cuáles son los servicios que presta la ONG y el promotor en su comunidad?

- Agua, casa, control de enfermedades para niños, capacitaciones.
- Capacitación.
- Atención de mortabilidad, crecimiento y desarrollo.
- Medicinas y curaciones.
- Consultas.

7.02 ¿Ha usado los servicios de salud de la ONG y el promotor? ¿Cómo?

- Si (41), No (4); en salud, atención prenatal, atención de niños.

7.03 ¿Está satisfecho con los servicios de salud prestados? ¿Por qué si o no?

	NUMERO	PORCENTAJE
SI	48	97.96%
NO	1	2.04%
NO RESPONDE	0	0.00%
TOTAL	49	100.00%

7.04 ¿Cuál ha sido su principal satisfacción en relación al promotor?

	NUMERO	PORCENTAJE
SI ES FAVORABLE	45	97.83%
NO ES FAVORABLE	1	2.17%
NO RESPONDE	0	0.00%
TOTAL	46	100.00%

7.05 ¿Cuál ha sido su decepción o desagrado más notable en cuanto al promotor?

No	DETALLE
8	No responden
2	No ha invitado a charlas educativas
3	A veces no hay medicina
2	No avisa cuando vacuna
5	No atiende a cualquier hora

7.06 Califica su impresión de los servicios que el promotor le ha prestado (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	28	0
9	4	0
8	10	0
7	5	0
6	2	12
5.5	1	0
TOTAL		
PROMEDIO		??

7.07 ¿Seguirá usando los servicios en el futuro, o buscará la atención de otros servicios de salud ?

	NUMERO	PORCENTAJE
SI	36	97.30%
NO	1	2.70%
NO RESPONDE	0	0.00%
TOTAL	37	100.00%

7.08 ¿Cómo PROSAMI y la ONG a ayudado a mejorar la salud en su comunidad?

No	DETALLE	TOTAL
1	EDUCACION	3
2	SERVICIOS	3
3	SALUD	6
4	MEDICINA	5

7.09 Califica su impresión de los servicios prestados a la comunidad y el grado que satisface sus necesidades de salud (en una escala de 1 a 10):

CALIFICACION	NUMERO	CALCULO
10	38	380
9	2	18
8	1	8
7		0
6		0
5	3	15
TOTAL	44	421
PROMEDIO		9.57

7.10 Qué recuerda Ud. sobre los siguientes temas. P.ej: Cuales son los signos de peligro más importantes, y que hacía usted si los observara?

No.	7.11 IRA	NUMERO
1	No recuerda	3
2	Nada	1
3	Consejos	1
4	Charlas	1
5	La medicina esta cerca	1
6	No se pierder tiempo	1
7	Darles medicina para la calentura	1
8	Cuando siente que es ahoga el niño	1
9	Si esta cansado ir a la consulta	1

7.12 EDA

No.	7.12 EDA	NUMERO
1	Ojos hundidos	1
2	Lavar las manos	1
3	Proteger al niño	1
4	para la diarrea usar suero oral	5
5	No recuerda	3
6	Llevarlos a la consulta	4

7.13 Salud Reproductiva/Salud Materna

No.	7.13 Salud Reproductiva/Salud Materna	NUMERO
1	Buena alimentación durante el embarazo	2
2	Tomar vitaminas	3
3	Hay que poner en control	1
4	No recuerda	3
5	Nada	4

7.14 Nutrición/Crecimiento y Desarrollo del niño.

No.	7.14 Nutrición/Crecimiento y Desarrollo del niño	NUMERO
1	Mejorar alimentación	4
2	Higiene	1
3	Tomar vitaminas	3
4	Visitar al medico	2
5	Lactancia materna	1
6	Aseo	2
7	Nada	3

7.15 Inmunizaciones

No.	7.15 Inmunizaciones	NUMERO
1	Poner vacunas	8
2	Nada	3

7.16 Salud Perinatal/Neonatal

No.	7.16 Salud Perinatal/Neonatal	NUMERO
1	Ir al Centro de Salud	1
2	Avisar al Promotor	1
3	No recuerda	3
4	Nada	3

7.17 ¿Tiene sugerencias para PROSAMI o la ONG o el promotor?

No.	7.17 Sugerencias	NUMERO
1	Atender a los adultos y no solo a niños y embarazadas	1
2	Construir una clinica	1
3	No usa este servicio	1
4	Mantener aqui la clinica	1
5	Nada	4
6	Que mejore la atención al niño	1
7	Que continue el proyecto	1

7.18 ¿Tiene comentarios?

No.	7.18 Comentarios	NUMERO
1	Ninguno	3
2	Nada	1
3	Ayudan mucho	1
4	Que siga el servicio	1
5	Dar medicina a todos	1
6	La consulta y la medicina cuesta cinco colones	2
7	Mas acercamiento de los ONG's y los promotores	2
8	La atención no se paga, la medicina es barata	1
9	Esta dispuesto a pagar un poco	1

ANNEX G-2.

PROSAMI Training Events Organized between 1991-1994

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
P R O S A M I

UNIDAD DE CAPACITACION

CAPACITACIONES DESARROLLADAS POR EL PROYECTO CON LAS ONG'S

AÑO	NUMERO DE EVENTOS	ASESORES	MEDICO Y TMI	ENFERMERAS	OTROS	TOTAL	ADMINISTRATIVO	PROMOTORES	PARTERAS
1991	9		201	141	488	830	0	70	0
1992	18		295	123	288	706	59	201	9
1993	28		626	213	286	1125	72	208	50
1994	16	12	392	170	157	731	234	124	7
TOTAL	71	12	1514	647	1219	3392	365	603	66
GRAN TOTAL									4426

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
	1992					
Seminario Taller sobre Contabilidad y Presupuestos			X	X		
Seminario Taller para formular un diagnóstico situacional de las comunidades	X	X				
Reuniones de trabajo sobre aspectos financieros en la planificación			X	X		
Taller para la implementación de la prueba piloto del sistema de logros	X	X				
Taller de la validación del sistema de logros	X	X				
Taller sobre el Sistema de logros	X	X				X
Taller de desarrollo de propuestas a gremios	X		X	X		
Talleres de Unificación de Criterios Técnicos	X	X				
Conferencia para ONG's sobre Salud Materna, Perinatal y Neonatal	X	X	X		X	X
Taller sobre Planificación estratégica y cálculo de medicamentos	X	X				
Charla sobre presentación de formularios de reporte/ONG's			X	X		

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
	1991					
Talleres sobre submición de Propuestas			X	X		
Jornadas sobre la situación del Cólera	X	X	X			
Seminario Taller sobre la Nuevas Normas de Atención Materno Infantil	X	X				
Convivio con las 9 ONG's Seleccionadas	X		X			
Sesiones de trabajo con ONG's seleccionadas						
Taller de Seguimiento del Cólera	X	X	X			
Jornadas sobe Infecciones Respiratorias Agudas	X	X	X			
Cursos Básicos para Promotores de Salud						X
Curso Básico para Promotores de Salud						
Talleres sobre Sistemas Financieros			X	X		
SUB –TOTAL	5	4	6	3		1

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
Taller sobre la estructura y el contenido de avance de procedimientos adminis-trativos y financieros			x	x		
Taller sobre técnicas educativas y par-ticipativa	x	x				
Taller informativo sobre el manejo y control del sistema de inventarios				x		
Seminario Taller sobre H_>lidades de Supervisión	x	x				
SUB TOTAL	10	9	6	6	1	1

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
CAPACITACIONES CORTO PLAZO	1993					
A. EDUCACION CONTINUA A PERSONAL TECNICO						
Metodologia Participativa	X	X				
Seminario Taller Rehidratación oral comunitaria y saneamiento (UROCS) y unidades de atención de infecciones respiratorias agudas (UAIRAC)	X	X				
Salud Reproductiva. (Enero 1993)	X	X				
Salud Perinatal y Neonatal (Enero 1993)	X	X				
Crecimiento, Desarrollo y Nutrición (enero, 1993)	X	X				
Lineamientos para la Jornada Nacional de Vacunación	X					
Lineamientos para la elaboración del Plan Anual y Cálculo de medicamentos para el Segundo año, 2da. Ronda	X	X				
Elboración del Diagnóstico situacional de las comunidades técnicos/Asaprosar	X	X				
Elaboración del Diagnóstico Comunal	X	X				
Formularios y Reportes de PROSAMI			X	X		

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
Lineamientos para la elaboración del Plan Anual y Cálculo de Medicamentos para el Primer Año, 3ra. Ronda	X	X				
B. CURSO BASICO DE PARTERAS						
Región Paracentral de Salud MSPAS					X	
Región Occidental de Salud MSPAS					X	
C. ASESORIAS TECNICO ADMINISTRATIVAS INDIVIDUALIZADAS SOBRE PLANIFICACION.						
Tercera Ronda, Primer Año	X	X	X	X		
36 ONG's, 1994	X	X	X	X		
CAPACITACIONES DE LARGO PLAZO						
A. CURSO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL						
Sistema de Logros, Abril 1993	X	X				
Atención Primaria de Salud	X	X				
Diagnóstico de Salud y Mapa de Riesgo	X	X				
Participación Comunitaria/Desarrollo Comunal	X	X				
Educación para la Salud	X	X				

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
CAPACITACIONES CORTO PLAZO	PRIMER SEMESTRE – 1994					
A. EDUCACION CONTINUA A PERSONAL TECNICO						
Seminario Taller sobre el cólera	X	X				
Seminario Taller Auditoria, Documentos de Costos y Contrapartida			X	X		
Seminario Taller sobre Supervivencia:						
Dirigido a Asesores Técnicos de PROSAMI						X
Dirigido a Coordinadores y Supervisores	X	X				
Talleres de Unidicación de Criterios sobre:						
Participación Comunitaria	X	X				
Salud Reproductiva	X	X				
Salud Perinatal/Neonatal	X	X				
Crecimiento y Desarrollo	X	X				
I R A	X	X				
EDA	X	X				
INMUNIZACIONES	X	X				
Finanzas y Contabilidad del Proyecto de las ONG's			X	X		
Rol de la Junta Directiva			X	X		
Monitores de Bienes				X		

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

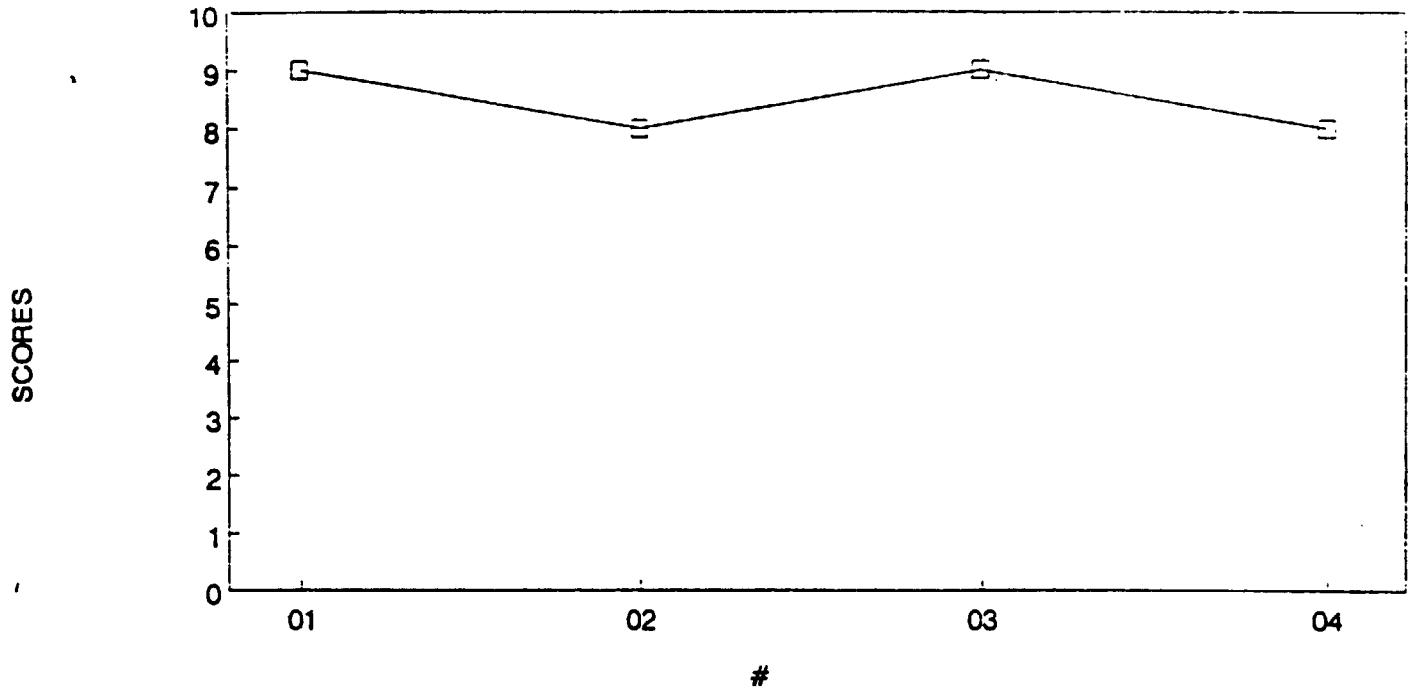
NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
Inmunizaciones	X	X				
Enfermedades Diarreicas Agudas	X	X				
Infecciones Respiratorias Agudas	X	X				
Crecimiento, Desarrollo y Nutrición, AGosto, 93	X	X				
Salud Reproductiva, Sept. 1993	X	X				
Salud Perinatal y Neonatal, Agosto, 1993	X	X				
B. CURSO BASICO DE PROMOTORES DE SALUD						
Primera y Segunda Ronda de ONG's						X
Tercera Ronda						X
SUB TOTAL	23	22	3	3	2	2

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

CAPACITACIONES REALIZADAS 1991 – 1994

NOMBRE DEL EVENTO	ASISTENCIA					
	COORDINADORES	SUPERVISORES	DIRECTORES EJECUTIVOS	PERSONAL ADMINISTRATIVO	PARTERAS	PROMOTORES DE SALUD
B. CURSO BASICO DE PARTERAS					X	
CAPACITACIONES A LARGO PLAZO Curso Básico de Promotores de Salud ONG's 1ra., 2da. y 3ra. Ronda						X
SUB TOTAL	9	9	3	4	1	1
GRAN TOTAL	47	44	18	16	4	5

TABLE IX
AVERAGE SCORES FOR BASIC TRAINING 49 PVO HEALTH PROMOTERS AND 7 TRADITIONAL BIRTH ATTENDANTS.
JAN – JUNE, 1994



• NATIONAL NORM : SCORE REQUIRED FOR GRADUATION

#		SCORE
01	1st. PROM	9.00
02	2nd. PROM	8.00
03	3nd. PROM	9.00
04	1st. TBA	8.00

ANNEX G-3.

List of Supplies Given to NGOs

2. BIENES

2.1 SUMINISTROS / MATERIALES DE OFICINA – 5553H1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Clips Medida Regular	03030003	cja/100	¢0.70		
2	Liquido corrector blanco	03030004	c/u	¢4.06		
3	Dispensador para colocar tape	03030007	c/u	¢37.95		
4	Fastener para papel 1"	03030009	cja/50	¢8.01		
5	Engrapadoras	03030010	c/u	¢29.36		
6	Perforador de dos orificios	03030014	c/u	¢67.75		
7	Reglas métricas de metal de 30 cm.	03030015	c/u	¢14.88		
8	Sacapuntas de escritorio	03030016	c/u	¢196.47		
9	Rollos de tirro 1 x 60 yds	03030017	c/u	¢4.44		
10	Papel Carbon tamaño carta	03030020	cja/100	¢23.45		
11	Tijeras de 8"	03030035	pk/100	¢6.35		
12	Libretas rayadas tam.carta 50 hojas	03030030	c/u	¢4.17		
13	Lapiceros punto mediano color negro	03030032	cja/12	¢7.76		
15	Grapas medida estandar	03030037	cja/5000	¢3.48		
16	Folder Manila tamaño carta	03030039	cja/100	¢27.47		
17	Papel bond 8 1/2" x 11" (carta) B-20	03030040	res/500	¢18.57		
18	Lápices No. 2	03030046	cja/12	¢14.95		
19	Cuadernos rayados	03030055	pk/50	¢146.53		
20	Cinta adhesiva transparente	03030058	rollo	¢8.46		
21	Papel para computadora 8 1/2 x 11"	03030070	cja	¢219.55		
22	Papel para Fax	03030083	Caja	¢193.12		

TOTAL (2.1) – 5553H1 . . . . . [ ]

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2.2 EQUIPO DE OFICINA - 53H1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Calculadora de Bolsillo	03030008	c/u	¢33.85		
2	Fotocopiadoras pequeñas	03030012	c/u	¢14,965.59		
3	Computadora, Reg/ Voltaje/Impresora	03030022	c/u	¢11,417.29		
4	Estantes Metálicos	03030023	cuerpo	¢1,334.36		
5	Ventiladores (16")	03030025	c/u	¢204.59		
6	Fax	03030028	c/u	¢2,480.11		
7	Sillas Secretariales	03030047	c/u	¢392.89		
8	Archivo 4 gavetas	03030050	c/u	¢1,309.72		
9	Escritorio cátedra (secretarial)	03030052	c/u	¢668.79		
10	Mesas Mecanográficas	03030054	c/u	¢349.44		
11	Sillas Metálicas Plegables	03030061	c/u	¢104.54		
12	Mesas plegables de metal	03030065	c/u	¢238.71		
13	Máquinas de escribir electricas	03030066	c/u	¢1,823.92		

TOTAL (2.2) – 5553H1 . . . . .

2.3 SUMINISTROS / PAPELERIA Y UTILES PARA CAPACITACIONES – 5553J1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Cartulina 22 x 34	03040001	c/u	¢1.42		
2	Borrador de Pizarra	03040003	c/u	¢3.65		
3	Yeso blanco	03040009	cja/12	¢3.12		
4	Marcadores tam. regular negro	03040010	cja/12	¢17.56		
5	Marcadores tam. regular azul	03040011	cja/12	¢17.85		
6	Marcadores tam. regular rojo	03040012	cja/12	¢17.59		
7	Marcadores tam. regular verde	03040013	cja/12	¢17.57		
8	Marcadores tam. regular amarillo	03040014	cja/12	¢17.84		
9	Acetatos para Transparencias	03040017	cja/100	¢123.72		
10	Rotaf. "Crecimiento y Desarrollo"	03040018	c/u	¢123.50		
11	Rotaf. "Reproducción Humana"	03040019	c/u	¢437.62		
12	Rotaf. "Saneamiento B/Hig. Personal"	03040020	c/u	170.73		
13	Rotaf. "Parasitismo Intestinal"	03040021	c/u	¢123.58		
14	Rotaf. "Las Vacunas"	03040022	c/u	¢196.95		
15	Rotaf. "Supervivencia Infantil"	03040024	c/u	¢196.73		
16	Rotaf. "Control Diarrea/Rehid. Oral"	03040025	c/u	¢124.90		

2.3 SUMINISTROS / PAPELERIA Y UTILES PARA CAPACITACIONES – 5553J1 (Continuación)

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
17	Rotaf. "Alimentación del Niño"	03040027	c/u	¢128.79		
18	Rotaf. "Infecciones Resp.Agudas"	03040028	c/u	¢163.06		
19	Form. Pre-Tab. Mens Vacunación	03040029	c/u	¢0.11		
20	Form. Inf. Mens de Actividades/ONG	03040031	c/u	¢0.11		
21	Form. Inf Trimes. de Actividades/ONG	03040032	c/u	¢0.11		
22	Form. Registro de Defunción	03040033	c/u	¢0.11		
23	Form Inf. Trim. De Act. del Trab/Salud	03040034	c/u	¢0.11		
24	Libro "Aprend. a Promover la Salud"	03040035	c/u	¢0.11		
25	Form. Pre-Tab Diario de Trab/Salud	03040036	c/u	¢0.11		
26	Form. Tab. Diario P/Inf.Mens.T.Salud	03040037	c/u	¢0.34		
27	Form. Tab. Trimes. de Mortalidad	03040038	c/u	¢0.17		
28	Poster Manejo del Paciente con Diarrea	03040039	c/u	¢14.59		
29	Libro Donde No Hay Doctor	03040040	c/u	¢96.09		
30	Fichas Familiares	03040042	c/u	¢0.17		
31	Rotaf. "Juntos Contra el Cólera"	03040045	c/u	¢3.80		
32	Afiches Att.Niño Tos/Dif. Para Respirar	03040046	c/u	¢6.00		
33	Afiches Att. Niño Prob.Oldo/Garganta	03040047	c/u	¢3.57		
34	Hoja de Crecimiento Niños	03040048	c/u	¢0.12		
35	Hoja de Crecimiento Niñas	03040049	c/u	¢0.12		
36	Manuales Para Parteras	03040051	c/u	¢237.52		
37	Rotaf. Riesgo Reproductivo	03040052	c/u	¢175.10		
38	Rotaf. Prev.Las Enferm. Sexuales	03040053	c/u	¢216.51		
39	Rof.Factores de Riesgo Reproduct.	03040054	c/u	¢123.50		
40	Libro "Prog.Nac.Integ.Salud Matema"	03040056	c/u	¢16.97		
41	Rotaf. "SIDA"	03040057	c/u	¢197.13		
42	Libro "Técnicas Particip. p/Educ.Pop."	03040058	c/u	¢28.67		
43	Afiche "Esquema de Vacunación	03040059	c/u	¢33.92		
44	Folleto "Porque es mejor Lac.Mater."	03040061	c/u	¢3.10		
45	Folleto "Supervivencia Infantil"	03040062	c/u	¢2.20		
46	Folleto "Las vac. evitan enfermedad."	03040063	c/u	¢0.44		
47	Libro "Buscando Remedio"	03040065	c/u	¢70.00		
48	Folleto "Cuide su embarazo"	03040066	c/u	¢0.44		
49	Folleto "Estamos er control Infantil"	03040068	c/u	¢0.44		
50	Folleto "Como evitar los parasitos"	03040070	c/u	¢0.44		

2.3 SUMINISTROS / PAPELERIA Y UTILES PARA CAPACITACIONES – 5553J1 (Continuación)

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
52	Folleto "Cuidados A.y D del parto"	03040080	c/u	¢2.10		
53	Folleto "Mama, lo que tu niño desea"	03040085	c/u	¢0.44		
54	Folleto "Como prev y trat deshidrat."	03040090	c/u	¢0.44		
55	Folleto "Así evitamos las efermedad."	03040095	c/u	¢0.44		
56	Folleto "La higiene personal"	03040100	c/u	¢0.44		
57	Folleto "Una vivienda limpia"	03040105	c/u	¢0.44		
58	Tabla Con Clip	03040109	c/u	¢11.67		
59	Libreta/Papelografos P/	03040116	c/u	¢47.60		
60	Papel Bond Pliegos	03040121	c/u	¢0.60		
61	Form. Registro de Referencias	03040125	c/u	¢0.11		
62	Hoja de Evaluación Trimestral 1995	03040127	c/u	2.05		
63	Carnet de la Embarazada	03040128	c/u	¢0.83		
64	Carnet del Niño	03040129	c/u	¢1.10		
65	Cuadros de Evaluación de Componentes*	03040130	Juegos (6)	¢1.20		
66	Form.Hoja de Vigilancia Embarazada*	03040132	c/u	¢0.38		
67	Form.Tab.Trimest. de Referencias*	03040134	c/u	¢0.11		
68	Hoja de Parto, Post – Parto – RN	03040135	c/u	¢0.15		
69	Laminario de Materno – Infantil	03040137	c/u	¢11.33		
70	Libro de Atención/Emb/Parto/Bajo R.	03040138	c/u	¢65.31		
71	Gráficas de Cobertura de Vacunación *	03040139	c/u	47.24		
72	Formulario de Vigilancia Epidemiológica *	03040140	c/u	0.20		
73	Hoja de Registro de Atenciones *	03040141	c/u	0.20		
74	Censo de Atenciones *	03040142	c/u	0.30		
75	Hipótesis y Activ. a Supervisar con Prior. *	03040143	c/u	0.20		
76	Necesidades Medidas a Adoptar *	03040144	c/u	0.20		
77	Tarjetas Integradas Materno–Infantil *	03040145	c/u	0.15		
78	Tarjetas Vacunación *	03040146	c/u	0.10		
79	Laminas (17) Lactancia Materna *	03040147	Juego	14.71		
80	Afiches Lactancia Materna *	03040148	Juego	7.00		
81	Folleto (18) Lactancia Materna *	03040149	Juego	17.50		
82	Libro "1 – 6 años de Vida" *	03040150	c/u	95.00		
83	Afiche "Salud Prenatal" *	03040151	c/u	6.00		
84	Guia Lactancia Materna Prob./Madre *	03040152	c/u	2.53		
85	Afiche Consejos Prácticas Lac. Materna *	03040153	c/u	6.52		
86	Talonario Referencias/Alcaldías *	03040154	c/u	20.00		
87	Talonario Tarjetas de Referenc.(Parter.)*	03040155	c/u	20.00		
88	Manual del Vacunador *	03040156	c/u	15.00		

TOTAL (2.3) – 5553J1 . . . . .

* Precios Sujetos a Revisión

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2.4 EQUIPO DE CAPACITACION Y MATERIAL EDUCATIVO – 5553J1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Megáfonos	03040002	c/u	¢378.30		
2	Proyector de Slides	03040026	c/u	¢2,870.68		
3	Mochilas	03040030	c/u	¢99.82		
4	Pizarra p/yeso (1.20 x 80)	03040041	c/u	¢299.40		
5	Retroproyector	03040055	c/u	¢1,604.83		
6	Uniformes	03040106	c/u	¢200.00		
7	Zapatos	03040111	Par	¢160.00		
8	Cronómetros	03040113	c/u	¢195.00		
9	Rótulos Para Promotores	03040114	c/u	¢140.00		
10	Cartapacios 1 ½"	03040115	c/u	¢21.96		
11	Tripoide Para Papelógrafo	03040119	c/u	¢308.07		

TOTAL (2.4) – 5553J1 . . . . . ERR

2.5 SUMINISTROS MEDICOS – 5553L1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Jeringas Desechables 3 cc/1"	03060001	cja/100	¢41.99		
2	Jeringas de Tub., (1cc,26g x 3/8")	03060002	cja/100	¢39.81		
3	Depresor de Lengua Infantil	03060005	cja/100	¢27.73		
4	Jeringas Desechables (3cc/1.5")	03060006	cja/100	¢41.82		
5	Hisopos 6"	03060007	cja/100	¢32.13		
6	Cinta Métrica p/infantes 2 mts.	03060012	c/u	¢2.99		
7	Cinta Umbilical, 25 yds. por jarra	03060013	rollo	¢42.20		
8	Jabón Líquido antiséptico (verde)	03060016	gal.	¢52.21		
9	Agodón estéril 1lb. 12"x10 ples	03060017	rollo	¢52.39		
10	Gaza rollo (9" x 10yds)	03060018	rollo	¢42.49		
11	Banda adhesiva, 1 " x 3" (curitas)	03060020	Cja/100	¢22.20		
12	Bandas Elásticas (3" x 5yds)	03060022	rollo	¢11.57		
13	Vaselina Blanca	03060029	Bts/15 oz	¢12.63		
14	Guantes Desechables (medianos)	03060031	cja/100	¢82.41		
15	Alcohol, Isopropyl	03060032	gal.	¢70.19		
16	Esponja Gaza Estéril (4"x4")	03060041	cja/25	¢26.04		
17	Esparadrapos (1" x 10yds.)	03060047	rollo	¢16.14		
18	Capas para lluvia	03060050	c/u	¢94.66		
19	Toallas	03060051	c/u	¢9.73		

TOTAL (2.5) – 5553L1 . . . . .

2.6 EQUIPO MEDICO – 5553L1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Balanza clínica métrica	03060003	c/u	¢1,293.19		
2	Balanzas Colgante Pediatrica	03060004	c/u	¢287.07		
3	Tijeras de vendas (7.5")	03060008	c/u	¢136.19		
4	Tensiómetro manual	03060009	c/u	¢118.17		
5	Estetoscopios dbl cabeza neg.	03060010	c/u	¢46.48		
6	Termómetro/Oral (°C)	03060014	c/u	¢6.16		
7	Termómetro/Rectal (°C)	03060015	c/u	¢7.87		
8	Bombillo de Succión (perilla)	03060030	c/u	¢10.51		
9	Termos para vacuna item #3504/38	03060034	c/u	¢123.12		
10	Pinguinos	03060035	c/u	¢11.67		
11	Baterias p/Lanternas	03060038	c/u	¢2.94		
12	Linternas de mano modelo 20/4	03060039	c/u	¢12.44		
13	Tallímetros	03060040	c/u	¢149.70		
14	Balanza/parteras	03060044	c/u	¢74.62		
15	Básculas para baño	03060046	c/u	¢86.24		
16	Cocinas de gas c/tambo	03060053	c/u	¢603.78		
17	Sábanas	03060055	c/u	¢34.61		
18	Frigorifico para vacunas (4 pies)	03060056	c/u	¢2,207.55		
19	Juego de Atención Perinatal	03060123	c/u	¢56.59		
20	Tijera para cordón umbilical *	03060126	c/u	¢160.00		
21	Olla de 2 litros *	03060127	c/u	¢50.00		
22	Huacal de Aluminio P/Lavar Manos *	03060128	c/u	¢14.00		
23	Mascarla Atención Parto *	03060129	c/u	¢3.00		

TOTAL (2.6) – 5553L1 . . . . .

*** Precios Sujetos a Revisión**

2.7 MEDICAMENTOS

	DESCRIPCION	CODIGO ARTICULO	UNIDAD DE MEDIDA	TOTAL
1	Sulfato Ferroso liquido 125 mg/ml	03050003	Bt x 50 ml	
2	Vitaminas Prenatales tabletas	03050004	Bt x 100	
3	Acetaminofen Jarabe (160mg/5ml)	03050005	Bt x 118 ml	
4	Sulfato Albuterol Jarabe 2 mg/5 ml	03050009	Bt x 473 ml	
5	Sales de Rehidratación Oral, 27.9 gms	03050010	c/u	
6	Trimetroprin Sulfa (Jarabe)	03050011	Bt x 100 ml	
7	Lo–Femenal	03050014	cja/100	
8	Acetaminofen Tabletas (500 mg)	03050015	cja/100	

2.7 MEDICAMENTOS (Continuación)

	DESCRIPCION	CODIGO ARTICULO	UNIDAD DE MEDIDA	TOTAL
9	Bacitracin 500 un/gr.	03050017	Tubo x 14.17 gr.	
10	Loción Lindane 1%	03050018	Bt x 59 ml	
11	Amoxicilin Jarabe 250 mg/5ml	03050020	Bt/150ml	
12	Tolnoftato Solución	03050021	Bt x 10 ml	
13	Condones	03050022	Cja/100	
14	Crema vaginal Triple Sulfa	03050023	Tubo x 78 gr.	
15	Salbutamol inhaladores	03050024	c/u	
16	Tetraciclina Ungüento Oftálmica 1%	03050025	Tubo x 5 gr	
17	Amoxicilina (500mgs/cápsulas)	03050026	cja/100	
18	Crema Vag. Fung. Clotrimazole	03050027	tubo/45 grms	
19	Acetato de Aluminio (Domeboro)	03050028	Cja de 100 tabletas	
20	Mebendazole suspensión (100 mg ml)	03050029	Bt 30 ML	
21	Metronidazole suspensión 125 mg/ 5 ml	03050031	Bt 100 ML	
22	Vitamina "A", Capsulas 60 mg 200.000 U.I.	03050035	Bt x 100 cap	
23	Clorfeniramina Maleate 2mg/5ml	03050045	Bt x 118 ml	

2.8 EQUIPO DE AGUA Y SANEAMIENTO – 5553M1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1				¢		
2				¢		
3				¢		
4				¢		
5				¢		
6				¢		

TOTAL (2.8) – 5553M1 . . . . . [ ]

2.9 MATERIALES DE CONSTRUCCION – 5553N1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1				¢		
2				¢		
3				¢		
4				¢		
5				¢		

TOTAL (2.9) – 5553N1 . . . . . [ ]

3.2 GASTOS DE VIAJE/TRANSPORTE PERSONAL ADMINISTRATIVO PERMANENTE – 5614D1

	PERSONAL	NUMERO PERS.	TRANSP. POR DIA	DIAS POR PERIODO	TOTAL
1			¢		
2			¢		
3			¢		
4			¢		
5			¢		

TOTAL (3.2) – 5614D1 . . . . . .

3.3 PAGO DE VIATICOS PERSONAL ADMINISTRATIVO PERMANENTE – 5634D1

	PERSONAL	NUMERO PERS.	VIATICOS POR DIA	DIAS POR PERIODO	TOTAL
1			¢		
2			¢		
3			¢		
4			¢		
5			¢		

TOTAL (3.3) – 5634D1 . . . . .

TOTAL COMPONENTE 3 – PERS. ADMINISTRATIVO. . . . .

(Sumatoria Totales desde 3.1 hasta 3.3)

4. ADMINISTRACION

4.1 Administración

	DESCRIPCION	CODIGO REPORTE	TOT. ANUA BRUTO	% PROSAMI	
1	Alquiler *	5195P1	¢880.00		
2	Seguro de Vehiculos *	5275F1	¢10,614.89		
3	Seguro de Motocicletas *	5275G1	¢1,139.05		

TOTAL (4.1) . . . . .

* Precios Sujetos a Revisión

TOTAL COMPONENTE 4 – ADMINISTRACION . . . . .

(Sumatoria Total 4.1)

2.10 MOTOCICLETAS Y CASCOS - 5553G1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Cascos Motocicletas 7 1/2"	03020002	c/u	¢757.28		
2	Cascos Motocicletas 6 7/8"	03020004	c/u	¢756.72		
3	Cascos Motocicletas 7 1/4"	03020005	c/u	¢757.24		

ANUAL (2.10) – 5553G1 . . . . . [ ]

2.11 OTROS BIENES – 5553Y1

	DESCRIPCION	CODIGO ARTICULO	UNIDAD	PRECIO UNITARIO	CANT.	TOTAL
1	Mulas	03010002	c/u	¢3,000.00		
2	Bicicletas	03020010	c/u	¢949.25		
5				¢		

ANUAL (2.11) – 5553Y1 . . . . . [ ]

TOTAL COMPONENTE 2 – BIENES . . . . . [ ]

(Sumatoria Totales desde 2.1 hasta 2.11)

3 PERSONAL ADMINISTRATIVO

3.1 SALARIOS PERSONAL ADMINISTRATIVO PERMANENTE – 5014D1

	PERSONAL	SALARIO MENSUAL	ANUAL BRUTO	% PROSAMI	TOTAL
1					
2					
3					
4					
5					

SUB–TOTAL . . . . . [ ]

PRESTACIONES LABORALES . . . . . [ ]

TOTAL (3.1) – 5014D1 . . . . . [ ]

ANNEX G-4.

NGO Ratings

MATERN[illegible] HEALTH AND CHILD SURVIV[illegible] PROJECT
JULY 1994
COMPARISION OF IMPACT AND PROCESS RATINGS IN TECHNICAL AREA

ROUND	PVO	Process Rating		Qtr. Rating Impact **	
FIRST	ADHU	B	3	B	3
	AGAPE	A	4	B	3
	ASALDI	A	4	B	3
	ASAPROSAR	C	2	B	3
	DIOCESIS	B	3	C	2
	FUNDEMUN	C	2	C	2
	OEF	B	3	B	3
	OPRODE	B	3	C	2
	PROCADES	B	3	C	2
AVERAGE:		B	3	B	3
SECOND	AMCS	B	3	B	3
	ASADEH	B	3	B	3
	ASPS	D	0	B	3
	CALMA	B	3	B	3
	CIRES	A	4	B	3
	CONAMUS	C	2	C	2
	FUMA	D	1	B	3
	FUNDAC	B	3	C	2
	FUNDESO	A	4	B	3
	KNAPP	B	3	C	2
AVERAGE:		B	3	B	3
THIRD	ADEMUSA	C	2	C	2
	AMS	C	2	C	2
	ASEI	B	3	B	3
	ASIPES	A	4	C	2
	CODECA	B	3	C	2
	CODECOSTA	B	3	C	2
	CODECUS	B	3	C	2
	CODELUM	C	2	C	2
	COMUS	C	2	C	2
	COSDECSAM	C	2	B	3
	FASTRAS	B	3	C	2
	FUNDEPRENS	A	4	C	2
	IDEA	C	2	C	2
	ORMUSA	B	3	C	2
	PADECOMSM	C	2	C	2
	PROGRESO	C	2	B	3
AVERAGE:		B	2	C	2
MONTH AVERAGE		B	3	B	3
No. IN D		3		0	
% IN D		9%		0%	
No. IN C		11		21	
% IN C		31%		58%	

**Data based on rating from first quarter

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RESULTADOS DE EVALUACION TRIMESTRAL DE ONGs

UNIDAD: TECNICA — 1er. Trimestre, 1994 — MES: ABRIL/94

No.	ONGs	COMPONENTES																PROMEDIO	
		EDA		IRA		SALUD REPRODUC.		S. PERINATAL Y NEONATAL		CREC. Y DESAR.		PARTICIP. COMUNIT.		EDUCACION COMUNITARIA					
	1A. RONDA																		
1	AGAPE	A	4	B	3	C	2	C	2	A	4	C	2	B	3	B	3		
2	ADRU	D	1	A	4	C	2	B	3	B	3	C	2	A	4	B	3		
3	O.E.F.	B	3	B	3	C	2	C	2	B	3	D	1	A	4	B	3		
4	PROCADES	A	4	B	3	C	2	C	2	C	2	D	1	C	2	C	2		
5	ASALDI	A	4	C	2	B	3	B	3	A	4	C	2	A	4	B	3		
6	ASAPROSAR'	B	3	C	2	B	3	B	3	B	3	D	1	A	4	B	3		
7	DIOCESIS DE ZACATEC.	D	1	D	1	C	2	B	3	C	2	D	1	A	4	C	2		
8	FUNDEMUN	C	2	B	3	B	3	C	2	D	1	C	2	A	4	C	2		
9	OPRODE	C	2	D	1	C	2	C	2	B	3	B	3	A	4	C	2		
	PROMEDIO PRIMERA RONDA	B	3	C	2	C	2	C	2	B	3	C	2	A	4	B	3		
	2DA. RONDA																		
10	AMCS	B	3	D	1	B	3	B	3	A	4	A	4	A	4	B	3		
11	ASADEH	A	4	B	3	B	3	C	2	A	4	C	2	B	3	B	3		
12	ASPS	B	3	B	3	B	3	C	2	C	2	B	3	A	4	B	3		
13	CALMA	B	3	B	3	B	3	B	3	C	2	A	4	B	3	B	3		
14	CONAMUS	D	1	B	3	C	2	D	1	B	3	D	1	A	4	C	2		
15	CIRES	A	4	B	3	C	2	D	1	B	3	C	2	B	3	B	3		
16	FUNDAC	A	4	A	4	D	1	D	1	D	1	D	1	A	4	C	2		
17	FUNDESO	A	4	B	3	B	3	A	4	B	3	B	3	A	4	B	3		
18	FUNDACION KNAPP	C	2	C	2	B	3	D	1	D	1	D	1	C	2	C	2		
19	FUMA	A	4	C	2	B	3	C	2	B	3	A	4	C	2	B	3		
	PROMEDIO SEGUNDA RONDA	B	3	B	3	B	3	C	2	B	3	B	3	B	3	B	3		
	3A. RONDA																		
20	ADEMUSA	D	1	C	2	C	2	C	2	D	1	D	1	A	4	C	2		
21	AMS	C	2	C	2	C	2	D	1	D	1	B	3	A	4	C	2		
22	ASEI	A	4	B	3	B	3	B	3	A	4	D	1	A	4	B	3		
23	ASIPES	B	3	B	3	B	3	C	2	B	3	D	1	D	1	C	2		
24	COMAFAC	B	3	D	1	B	3	C	2	D	1	D	1	C	2	C	2		
25	COSDECSAM	A	4	A	4	C	2	D	1	D	1	A	4	A	4	B	3		
26	CODECUS	C	2	B	3	D	1	D	1	D	1	C	2	A	4	C	2		
27	COMUS	C	2	D	1	D	1	D	1	D	1	C	2	A	4	C	2		
28	FASTRAS	B	3	B	3	C	2	D	1	D	1	D	1	C	2	C	2		
29	CODELUM	B	3	D	1	D	1	D	1	D	1	D	1	A	4	C	2		
30	CODECOSTA	B	3	A	4	D	1	D	1	D	1	D	1	B	3	C	2		
31	CODECA	B	3	C	2	C	2	D	1	D	1	D	1	A	4	C	2		
32	FUNDEPRENS	D	1	D	1	C	2	C	2	D	1	D	1	A	4	C	2		
33	IDEA	B	3	B	3	B	3	C	2	D	1	D	1	C	2	C	2		
34	ORMUSA	B	3	B	3	C	2	D	1	B	3	D	1	B	3	C	2		
35	PADECOMSM	B	3	A	4	D	1	D	1	D	1	C	2	A	4	C	2		
36	PROGRESO	A	4	A	4	D	1	D	1	C	2	C	2	A	4	B	3		
	PROMEDIO TERCERA RONDA	B	3	B	3	C	2	D	1	D	1	C	2	B	3	C	2		
	PROMEDIO PROSAMI	B	3	B	3	C	2	C	2	C	2	C	2	B	3	B	3		

C:\EVAONGS4

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MES: SEPTIEMBRE/94

ONG	Vist. Prog	Vist. Real	AREAS EVALUADAS														Eval. Gral.
1a RONDA			1	2	3	4	5	6	7	8	9	10	11	12	13	14	
ADIIU	1	1	C 1	B 2	D 0	D 0	D 0	D 0	C 1	D 0	B 2	A 3	B 2	B 2	A 3	A 3	C 1
AGAPE	2	2	B 2	B 2	A 3	D 0	A 3	D 0	B 2	D 0	A 3	A 3	A 3	A 3	A 3	A 3	B 2
ASALDI	1	0	C 1	C 1	B 2	A 3	D 0	D 0	A 3	D 0	A 3	A 3	D 0	A 3	A 3	A 3	B 2
ASAPROSAR	1	0	C 1	D 0	B 2	A 3	C 1	D 0	A 3	D 0	B 2	A 3	A 3	A 3	A 3	B 2	B 2
DIOCESIS	1	1	C 1	B 2	B 2	B 2	A 3	D 0	B 2	D 0	A 3	A 3	B 2	A 3	A 3	A 3	B 2
FUNDEMUN	1	0	D 0	D 0	D 0	D 0	A 3	D 0	D 0	D 0	C 1	A 3	D 0	A 3	A 3	C 1	C 1
OEF	1	0	A 3	A 3	A 3	A 3	D 0	D 0	C 1	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3
OPRODE	1	1	B 2	B 2	A 3	C 1	D 0	D 0	B 2	A 3	A 3	C 1	B 2	A 3	A 3	B 2	B 2
PROCADES	1	0	A 3	A 3	B 2	B 2	A 3	A 3	B 2	B 2	B 2	D 0	B 2	A 3	B 2	B 2	B 2
PROM. RONDA	10	5	C 1	C 1	B 2	C 1	D 0	D 0	C 1	C 1	B 2	B 2	C 1	A 3	B 2	B 2	B 2
2a. RONDA																	
AMCS	1	1	A 3	B 2	B 2	A 3	A 3	D 0	C 1	A 3	C 1	A 3	C 1	A 3	A 3	A 3	B 2
ASADEI	1	1	B 2	B 2	A 3	B 2	A 3	D 0	B 2	B 2	B 2	D 0	B 2	B 2	B 2	A 3	B 2
ASPS	2	2	A 3	C 1	B 2	B 2	A 3	A 3	A 3	B 2	C 1	D 0	B 2	A 3	B 2	D 0	B 2
CALMA	2	2	A 3	A 3	A 3	B 2	A 3	B 2	A 3	D 0	B 2	A 3	B 2	A 3	A 3	A 3	A 3
CIRES	1	1	A 3	A 3	B 2	B 2	A 3	D 0	C 1	C 1	A 3	D 0	B 2	A 3	A 3	A 3	B 2
CONAMUS	2	1	D 0	D 0	D 0	D 0	D 0	D 0	A 3	C 1	A 3	A 3	A 3	A 3	A 3	A 3	B 2
FUMA	2	2	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3
FUNDAC	1	1	B 2	D 0	C 1	C 1	C 1	C 1	D 0	D 0	C 1	A 3	C 1	A 3	B 2	A 3	C 1
FUNDESO	2	2	A 3	B 2	A 3	A 3	A 3	A 3	A 3	A 3	B 2	A 3	B 2	A 3	A 3	A 3	A 3
KNAPP	2	1	A 3	A 3	A 3	D 0	A 3	B 2	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3
PROM. RONDA	16	14	B 2	C 1	B 2	D 0	C 1	D 0	C 1	D 0	B 2	C 1	C 1	B 2	B 2	B 2	C 1
3a. RONDA																	
ADEMUSA	1	1	B 2	B 2	B 2	C 1	C 1	C 1	A 3	B 2	A 3	A 3	B 2	A 3	A 3	A 3	B 2
AMS	1	1	A 3	A 3	A 3	D 0	D 0	D 0	D 0	A 3	A 3	A 3	A 3	A 3	A 3	A 3	B 2
ASEI	1	1	C 1	B 2	B 2	C 1	D 0	D 0	D 0	C 1	C 1	A 3	C 1	A 3	A 3	A 3	B 2
ASIPES	1	1	A 3	A 3	A 3	B 2	A 3	A 3	A 3	C 1	A 3	A 3	A 3	A 3	A 3	A 3	A 3
CODECA	1	0	A 3	A 3	A 3	A 3	C 1	D 0	D 0	B 2	B 2	A 3	C 1	A 3	A 3	A 3	B 2
CODECOSTA	1	1	B 2	C 1	C 1	C 1	D 0	C 1	C 1	C 1	B 2	A 3	B 2	A 3	A 3	B 2	B 2
CODECUS	2	2	A 3	A 3	B 2	C 1	A 3	B 2	A 3	A 3	A 3	D 0	A 3	A 3	A 3	A 3	A 3
CODELUM	1	1	A 3	A 3	A 3	D 0	D 0	D 0	D 0	C 1	A 3	A 3	D 0	A 3	A 3	A 3	B 2
COMUS	1	1	B 2	C 1	B 2	C 1	B 2	C 1	C 1	C 1	C 1	D 0	B 2	C 1	B 2	D 0	C 1
COSUDECSAM	1	1	D 0	A 3	B 2	D 0	A 3	D 0	D 0	D 0	C 1	A 3	C 1	A 3	A 3	A 3	B 2
FASTRAS	1	0	A 3	A 3	A 3	D 0	D 0	D 0	D 0	A 3	B 2	A 3	B 2	A 3	B 2	C 1	B 2
FUNDEPRENS	1	1	A 3	A 3	A 3	A 3	A 3	A 3	A 3	A 3	C 1	A 3	A 3	A 3	B 2	B 2	A 3
IDEA	1	1	C 1	C 1	D 0	C 1	D 0	D 0	D 0	C 1	B 2	D 0	C 1	B 2	A 3	A 3	C 1
OTMUSA	2	2	A 3	B 2	B 2	D 0	B 2	B 2	C 1	C 1	A 3	A 3	A 3	A 3	B 2	B 2	B 2
PADECOMSM	1	1	D 0	B 2	B 2	C 1	D 0	D 0	D 0	C 1	A 3	A 3	A 3	A 3	A 3	A 3	B 2
PROGRESO	1	1	B 2	B 2	A 3	C 1	A 3	D 0	B 2	C 1	A 3	A 3	B 2	A 3	A 3	C 1	B 2
PROM. RONDA	18	16	C 1	C 1	C 1	D 0	D 0	D 0	D 0	C 1	C 1	C 1	C 1	B 2	B 2	B 2	C 1
PROM. RONDAS	44	35	C 1	C 1	C 1	C 1	D 0	D 0	D 0	D 0	C 1	C 1	C 1	B 2	B 2	B 2	B 1.3

3(A) Califica los 3 ámbitos, 2(B) = aplican solo 2 ámbitos, 1(C) aplica solo 1 ámbito y 0(D) ninguno.

1. Planea sus actividades de acuerdo a un diagnostico situacional
2. Cumple con las metas segun lo planeado en su ONG
3. Las actividades de supervision cumplen con los criterios tecnicos correspondientes (planeacion, ejecucion, seguimiento).
4. Se realizan evaluaciones tecnicas de rendimiento/componente
5. Se tiene grafica actualizada de indices de EDA e IRA
6. Se tiene grafica actualizada de coberturas de vacunacion
7. Se tiene archivo de control materno infantil actualizado
8. Se utiliza un mapa de riesgo actualizado para la programacion de las actividades y la visita domiciliar.
9. Hay disponibilidad y buen uso de equipo y suministros en el nivel comunitario.
10. Hay disponibilidad de transporte para el equipo supervisor
11. Se cumple con las acciones basicas de cada componente
12. Se realiza coordinacion con otras instituciones
13. Todos los promotores son diplomados del curso basico
14. Todos los técnicos son diplomados por PROSAMI.

Visitas canceladas por ONG

FUNDEMUN	1
O.E.F.	1
	2

Canceladas por Evaluación Externa

ASALDI	1	KNAPP	1
ASAPROSAR	1	CODECA	1
PROCADES	1	FASTRAS	1
CONAMUS	1		3
	4		

Total visitas canceladas = 9

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
1994
PVO MONTHLY RATINGS OVERALL

ROUND	PVO	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG. YR.
FIRST	ADHU	C 2	B 3	B 3	C 2	C 2	C 2	B 3	B 3					B 3
	AGAPE	A 4	A 4	A 4	B 3	B 3	A 4	A 4	A 4					A 4
	ASALDI	B 3	B 3	A 4	B 3	A 4	B 3	C 2	B 3					B 3
	ASAPROSAR	C 2	C 2	C 2	C 2	B 3	B 3	C 2	C 2					C 2
	DIOCESIS	B 3	C 2	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	FUNDEMUN	B 3	B 3	B 3	C 2	B 3	C 2	C 2	C 2					B 3
	OEF	B 3	C 2	C 2	C 2	C 2	C 2	C 2	B 3					C 2
	OPRODE	B 3	A 4	A 4	B 3	B 3	B 3	B 3	B 3					B 3
	PROCADES	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
AVERAGE		B 3	B 3	B 3	C 2	B 3	B 3	B 3	B 3					B 3
SECOND	AMCS	B 3	B 3	B 3	B 3	A 4	B 3	B 3	B 3					B 3
	ASADEH	A 4	C 2	B 3	A 4	A 4	B 3	B 3	A 4					B 3
	ASPS	C 2	C 2	C 2	C 2	C 2	C 2	D 1	C 2					C 2
	CALMA	B 3	C 2	C 2	C 2	C 2	C 2	C 2	B 3					C 2
	CIRES	B 3	B 3	A 4	B 3	B 3	B 3	B 3	B 3					B 3
	CONAMUS	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
	FUMA	C 7	B 3	B 3	B 3	B 3	B 3	C 2	B 3					B 3
	FUNDAC	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
	FUNDESO	A 4	A 4	A 4	B 3	A 4	A 4	A 4	A 4					A 4
	KNAPP	B 3	B 3	B 3	C 2	C 2	C 2	C 2	B 3					B 3
AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	C 2	B 3					B 3
THIRD	ADEMUSA	B 3	B 3	B 3	C 2	C 2	C 2	C 2	B 3					B 3
	AMS	B 3	B 3	B 3	C 2	C 2	C 2	C 2	C 2					C 2
	ASEI	B 3	B 3	B 3	C 2	C 2	C 2	C 2	C 2					C 2
	ASIPES	B 3	B 3	B 3	C 2	B 3	A 4	B 3	B 3					B 3
	CODECA	C 2	C 2	A 4	B 3	B 3	C 2	B 3	B 3					B 3
	CODECOSTA	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
	CODECUS	C 2	C 2	C 2	C 2	C 2	C 2	C 2	B 3					C 2
	CODELUM	B 3	B 3	B 3	B 3	B 3	B 3	B 3	A 4					B 3
	COMUS	C 2	C 2	C 2	B 3	B 3	B 3	C 2	C 2					C 2
	COSDECSAM	B 3	B 3	C 2	C 2	B 3	C 2	C 2	C 2					C 2
	FASTRAS	B 3	A 4	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	FUNDEPRENS	A 4	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	IDEA	C 2	C 2	B 3	C 2	C 2	C 2	C 2	B 3					C 2
	ORMUSA	A 4	A 4	A 4	C 2	C 2	B 3	B 3	B 3					B 3
	PADECOMSM	C 2	B 3	B 3	B 3	B 3	B 3	B 3	C 2					B 3
	PROGRESO	B 3	C 2	C 2	C 2	C 2	B 3	B 3	B 3					B 3
AVERAGE		B 3	B 3	B 3	C 2	C 2	B 3	C 2	B 3					B 3
MONTH AVERAGE		B 3	B 3	B 3	C 2	B 3	B 3	C 2	B 3					B 3
No. IN D		0	0	0	0	0	0	2	0					0
% IN D		0%	0%	0%	0%	0%	0%	6%	0%					0%
No. IN C		13	15	12	21	17	18	18	12					14
% IN C		36%	42%	33%	58%	47%	50%	50%	34%					40%

MATERNAL HEA[illegible] FAMILY CHILD CO[illegible]

1994

PVO MONTHLY RATINGS IN TECHNICAL AREAS

ROUND	PVO	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG. YR.
FIRST	ADHU	C 2	B 3	B 3					B 3
	AGAPE	B 3	A 4	A 4					A 4
	ASALDI	A 4	A 4	B 3					A 4
	ASAPROSAR	A 4	C 2	B 3					B 3
	DIOCESIS	B 3	B 3	B 3					B 3
	FUNDEMUN	C 2	C 2	C 2					C 2
	OEF	B 3	B 3	A 4					B 3
	OPRODE	C 2	B 3	B 3					B 3
	PROCADES	B 3	B 3	B 3					B 3
AVERAGE		B 3	B 3	B 3					B 3
SECOND	AMCS	C 2	B 3	B 3					B 3
	ASADEH	B 3	B 3	B 3					B 3
	ASPS	C 2	D 0	C 2					D 1
	CALMA	B 3	B 3	A 4					B 3
	CIRES	B 3	A 4	B 3					B 3
	CONAMUS	C 2	C 2	C 2					C 2
	FUMA	B 3	D 1	A 4					B 3
	FUNDAC	B 3	B 3	B 3					B 3
	FUNDESO	B 3	A 4	A 4					A 4
	KNAPP	B 3	B 3	A 4					B 3
AVERAGE		B 3	B 3	B 3					B 3
THIRD	ADEMUSA	C 2	C 2	B 3					C 2
	AMS	C 2	C 2	B 3					C 2
	ASEI	B 3	B 3	B 3					B 3
	ASIPES	A 4	A 4	A 4					A 4
	CODECA	C 2	B 3	B 3					B 3
	CODECOSTA	C 2	B 3	B 3					B 3
	CODECUS	B 3	B 3	A 4					B 3
	CODELUM	C 2	C 2	B 3					C 2
	COMUS	C 2	C 2	C 2					C 2
	COSDECSAM	C 2	C 2	B 3					C 2
	FASTRAS	C 2	B 3	B 3					B 3
	FUNDEPRENS	C 2	A 4	A 4					B 3
	IDEA	C 2	C 2	B 3					C 2
	ORMUSA	B 3	B 3	B 3					B 3
	PADECOMSM	C 2	C 2	C 2					C 2
	PROGRESO	C 2	C 2	C 2					C 2
AVERAGE		C 2	B 3	B 3					B 3
MONTH AVERAGE		B 3	B 3	B 3					B 3
No. IN D		0	3	0					1
% IN D		0%	14%	0%					3%
No. IN C		19	12	6					10
% IN C		53%	33%	17%					29%

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
1993 – 1994
PVO QUARTERLY RATINGS IN TECHNICAL AREA

ROUND	PVO	1993 1st.	1993 2nd.	1993 3td.	1993 4th.	AVG YR.	1994 1st.	1994 2nd.	1994 3td.	1994 4th.	AVG YEAR
FIRST	ADHU	B 3	B 3	B 3	A 4	B 3	B 3	C 2			B 3
	AGAPE	B 3	B 3	B 3	B 3	B 3	B 3	B 3			B 3
	ASALDI	A 4	B 3	B 3	B 3	B 3	B 3	B 3			B 3
	ASAPROSAR	B 3	B 3	B 3	B 3	B 3	B 3	B 3			B 3
	DIOCESIS	B 3	B 3	B 3	B 3	B 3	C 2	B 3			B 3
	FUNDEMUN	B 3	A 4	A 4	A 4	A 4	C 2	C 2			C 2
	OEF	A 4	A 4	B 3	B 3	A 4	B 3	B 3			B 3
	OPRODE	A 4	A 4	A 4	A 4	A 4	C 2	C 2			C 2
	PROCADES	B 3	B 3	B 3	B 3	B 3	C 2	C 2			C 2
AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	B 3			B 3
SECOND	AMCS	B 3	A 4	A 4	A 4	A 4	B 3	B 3			B 3
	ASADEH	B 3	A 4	A 4	B 3	A 4	B 3	B 3			B 3
	ASPS	B 3	A 4	A 4	B 3	A 4	B 3	B 3			B 3
	CALMA	B 3	A 4	B 3	B 3	B 3	B 3	B 3			B 3
	CIRES	C 2	C 2	B 3	B 3	B 3	B 3	B 3			B 3
	CONAMUS	C 2	A 4	B 3	B 3	B 3	C 2	B 3			B 3
	FUMA	B 3	A 4	A 4	A 4	A 4	B 3	B 3			B 3
	FUNDAC	C 2	C 2	C 2	C 2	C 2	C 2	C 2			C 2
	FUNDESO	C 2	A 4	A 4	A 4	A 4	B 3	A 4			A 4
	KNAPP	B 3	B 3	A 4	A 4	A 4	C 2	B 3			B 3
AVERAGE		B 3	A 4	A 4	B 3	B 3	B 3	B 3			B 3
THIRD	ADEMUSA				A 4	A 4	C 2	B 3			B 3
	AMS				A 4	A 4	C 2	C 2			C 2
	ASEI				A 4	A 4	B 3	A 4			A 4
	ASIPES				A 4	A 4	C 2	C 2			C 2
	CODECA				A 4	A 4	C 2	C 2			C 2
	CODECOSTA				A 4	A 4	C 2	C 2			C 2
	CODECUS				A 4	A 4	C 2	B 3			B 3
	CODELUM				A 4	A 4	C 2	C 2			C 2
	COMUS				A 4	A 4	C 2	C 2			C 2
	COSDECSAM				A 4	A 4	B 3	C 2			B 3
	FASTRAS				A 4	A 4	C 2	C 2			C 2
	FUNDEPRENS				A 4	A 4	C 2	B 3			B 3
	IDEA				A 4	A 4	C 2	B 3			B 3
	ORMUSA				A 4	A 4	C 2	B 3			B 3
	PADECOMSM				A 4	A 4	C 2	C 2			C 2
	PROGRESO				A 4	A 4	B 3	B 3			B 3
AVERAGE					A 4	A 4	C 2	B 3			B 3
MONTH AVERAGE		B 3	B 3	B 3	A 4	A 4	B 3	B 3			B 3
No. IN D		0	0	0	0	0	0	0			0
% IN D		0%	0%	0%	0%	0%	0%	0%			0%
No. IN C		4	2	1	1	1	21	14			12
% IN C		21%	11%	5%	5% 5%	5%	58%	40%			34%

MATE AL HEALTH AND CHILD SURVI . PROJECT
1994
PVO MONTHLY RATINGS IN FINANCE

ROUND	PVO	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG. YR.
FIRST	ADHU	D 1	D 1	B 2	D 1	D 1	D 1	C 2	A 4					C 2
	AGAPE	A 4	A 4	A 4	A 4	A 4	A 4	A 4	A 4					A 4
	ASALDI	A 4	B 3	A 4	B 3	A 4	C 2	D 1	B 3					B 3
	ASAPROSAR	D 1	D 1	D 1	D 1	C 2	D 1	D 1	D 1					D 1
	DIOCESIS	D 1	D 1	A 4	A 4	A 4	A 4	B 3	B 3					B 3
	FUNDEMUN	C 2	B 3	D 1	D 1	B 3	D 1	D 1	D 1					C 2
	OEF	B 3	C 2	C 2	D 1	D 1	D 1	D 1	D 1					C 2
	OPRODE	A 4	A 4	A 4	A 4	A 4	A 4	B 3	B 3					A 4
	PROCADES	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
AVERAGE		C 2	C 2	B 3	C 2	B 3	C 2	C 2	C 2					C 2
SECOND	AMCS	D 1	D 1	C 2	C 2	A 4	B 3	B 3	B 3					C 2
	ASADEH	B 3	D 1	C 2	A 4	A 4	B 3	B 3	A 4					B 3
	ASPS	D 1	D 1	D 1	D 1	C 1	D 1	D 1	D 1					D 1
	CALMA	D 1	D 1	D 1	D 1	C 1	C 2	C 2	C 2					D 1
	CIRES	B 3	B 3	A 4	B 3	B 3	C 2	D 1	D 1					B 3
	CONAMUS	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	FUMA	D 1	D 1	D 1	C 2	C 2	D 1	D 1	D 1					D 1
	FUNDAC	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	FUNDESO	B 3	A 4	A 4	B 3	A 4	A 4	A 4	B 3					A 4
	KNAPP	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
AVERAGE		C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
THIRD	ADEMUSA	D 1	D 1	D 1	D 1	B 3	D 1	D 1	C 2					D 1
	AMS	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	ASEI	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	ASIPES	D 1	D 1	C 2	D 1	B 3	B 3	C 2	D 1					C 2
	CODECA	D 1	D 1	A 4	B 3	C 2	D 1	D 1	C 2					C 2
	CODECOSTA	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	CODECUS	D 1	D 1	D 1	D 1	D 1	D 1	D 1	D 1					D 1
	CODELUM	B 3	C 2	C 2	A 4	A 4	A 4	A 4	A 4					B 3
	COMUS	D 1	D 1	D 1	B 3	B 3	B 3	D 1	C 2					C 2
	COSDECSAM	D 1	D 1	D 1	D 1	B 3	C 2	D 1	D 1					D 1
	FASTRAS	B 3	A 4	B 3	A 4	A 4	B 3	B 3	C 2					B 3
	FUNDEPRENS	A 4	C 2	A 4	A 4	B 3	A 4	C 2	B 3					B 3
	IDEA	D 1	D 1	D 1	D 1	B 3	C 2	C 2	B 3					C 2
	ORMUSA	A 4	A 4	A 4	C 2	D 1	B 3	B 3	C 2					B 3
	PADECOMSM	D 1	D 1	B 3	B 3	B 3	A 4	B 3	C 2					B 3
	PROGRESO	D 1	D 1	D 1	D 1	D 1	B 3	B 3	C 2					C 2
AVERAGE		C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
MONTH AVERAGE		C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
No. IN D		23	24	18	20	13	17	20	16					14
% IN D		64%	67%	50%	56%	36%	47%	55%	46%					40%
No. IN C		1	4	5	3	5	5	5	8					9
% IN C		3%	11%	14%	8%	14%	14%	14%	23%					26%

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
1994
PVO MONTHLY RATINGS IN COMMODITIES

ROUND	PVO	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG. YR.
FIRST	ADIIU	C 2	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	AGAPE	A 4	A 4	A 4	B 3	B 3	A 4	A 4	A 4					A 4
	ASALDI	B 3	A 4	A 4	A 4	A 4	A 4	C 2	C 2					B 3
	ASAPROSAR	B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	DIOCESIS	A 4	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	FUNDEMUN	B 3	B 3	B 3	B 3	B 3	C 2	B 3	B 3					B 3
	OEF	C 2	C 2	C 2	B 3	B 3	B 3	B 3	A 4					B 3
	OPRODE	C 2	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	PROCADES	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2					C 2
AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
SECOND	AMCS	A 4	A 4	A 4	A 4	A 4	A 4	A 4	A 4					A 4
	ASADEH	A 4	B 3	B 3	A 4	A 4	A 4	A 4	A 4					A 4
	ASPS	C 2	C 2	C 2	B 3	B 3	B 3	B 3	A 4					B 3
	CALMA	A 4	B 3	B 3	C 2	C 2	C 2	C 2	C 2					B 3
	CIRES	A 4	A 4	A 4	A 4	A 4	A 4	A 4	A 4					A 4
	CONAMUS	B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	FUMA	C 2	B 3	B 3	B 3	B 3	A 4	A 4	A 4					B 3
	FUNDAC	C 2	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	FUNDESO	A 4	B 3	B 3	A 4	A 4	A 4	A 4	A 4					A 4
	KNAPP	B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 4					B 3
THIRD	ADEMUSA	B 3	B 3	B 3	B 3	C 2	C 2	C 2	B 3					B 3
	AMS	B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	ASEI	A 4	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	ASIPES	A 4	B 3	B 3	A 4	A 4	A 4	A 4	A 4					A 4
	CODECA	C 2	C 2	A 4	A 4	A 4	A 4	A 4	A 4					A 4
	CODECOSTA	C 2	C 2	C 2	C 2	C 2	C 2	C 2	D 1					C 2
	CODECUS	C 2	C 2	C 2	C 2	C 2	C 2	C 2	B 3					C 2
	CODELUM	B 3	A 4	A 4	A 4	A 4	A 4	A 4	A 4					A 4
	COMUS	C 2	C 2	C 2	B 3	B 3	B 3	B 3	B 3					B 3
	COSDECSAM	A 4	A 4	C 2	C 2	C 2	B 3	C 2	B 3					B 3
	FASTRAS	B 3	B 3	B 3	B 3	A 4	A 4	A 4	A 4					A 4
	FUNDEPRENS	A 4	B 3	B 3	A 4	A 4	B 3	A 4	A 4					A 4
	IDEA	C 2	C 2	A 4	C 2	C 2	C 2	C 2	B 3					C 2
	ORMUSA	B 3	B 3	B 3	B 3	B 3	B 3	A 4	A 4					B 3
	PADECOMSM	C 2	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
	PROGRESO	B 3	C 2	C 2	C 2	B 3	B 3	A 4	A 4					B 3
AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
MONTH AVERAGE		B 3	B 3	B 3	B 3	B 3	B 3	B 3	B 3					B 3
No. IN D		0	0	0	0	0	0	0	1					0
% IN D		0%	0%	0%	0%	0%	0%	0%	3%					0%
No. IN C		13	9	8	7	8	8	9	3					4
% IN C		36%	25%	22%	19%	22%	22%	25%	9%					11%

ANNEX G-5.

Distribution of NGOs to PROSAMI Technical Advisors

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

DISTRIBUCION DE ONG's Y COMPONENTES TECNICOS POR ASESOR EN LA DIVISION TECNICA

Dr. Ricardo González	Ronda	Dr. Juan Manuel Godoy	Ronda	Dr. Miguel Angel Linares	Ronda
COSDECSAM	3	CODELUM	3	ASAPROSAR	1
CIRES	2	PADECOMSM	3	KNAPP	2
FASTRAS	3	A.M.S.	3	CONAMUS	2
PROCADES	1	IDEA	3	ASALDI	1
CODECUS	3	CODECA	3	O.E.F.	1
Salud Perinatal	C.T.	Crecimiento y Desarrollo	C.T.	E.D.A.	C.T.

Dr. Anibal Quijano	Ronda	Dr. Mario Morales	Ronda	Dra. Marina de Silva	Ronda
FUMA	2	PROGRESO	3	CALMA	2
FUNDEMUN	1	ASIPES	3	ASPS	2
FUNDEPRENS	3	DIOCESIS	1	ASADEH	2
ADEMUSA	3	ASEI	3	CODECOSTA	3
FUNDAC	2	OPRODE	1	COMUS	3
Participación Comunitaria	C.T.	Salud Materna		Inmunizaciones	C.T.

Lic. Miriam Henríquez	Ronda
A.M.C.S.	2
ADHU	1
AGAPE	1
FUNDESO	2
ORMUSA	3
I.R.A.	C.T.

ANNEX G-6.

Supervisory Instrument Used by PROSAMI Technical Advisors

PARA RESPONDER UTILICE X

D

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL. PROSAMI. 1994.
CONTROL DE ACCIONES BASICAS DE LA ONG PARA EL REPORTE DE VISITA DE CAMPO DE LA DIVISION TECNICA

ONG: FECHA(S):

LUGAR(ES) VISITADO(S):

ASESOR TECNICO: TECNICO(S) ONG:

ASPECTOS A SUPERVISAR	3=	2=	1=	0=	CRITERIOS DE PONDERACION
Planea sus actividades de acuerdo a un diagnóstico situacional					Aplican 3 ámbitos= 3; 2= 2; 1= 1; ninguno= 0
Cumple con las metas según lo planeado en su ONG					Aplican 3 ámbitos= 3; 2= 2; 1= 1; ninguno=
Las actividades de supervisión cumplen con los criterios					
técnicos correspondientes (planeacion, ejecución, seguimiento)					Aplican 3 ámbitos= 3; 2= 2; 1= 1; ninguno= 0
Se realizan evaluaciones técnicas de rendimiento/componente					5-6 comp.= 3; 3-4 comp.= 2; 1-2 comp.= 1; 0=
Se tiene gráfica actualizada de índices de EDA e IRA					Aplican 3 ámbitos= 3; 2= 2; 1= 1; ninguno= 0
Se tiene gráfica actualizada de coberturas de vacunación					Aplican 3 ámbitos= 3; 2= 2; 1= 1; ninguno= 0
Se tiene archivo de control materno infantil actualizado					Embarazadas + Crecim. y Des. + Inmunizac.= 3
Se utiliza un mapa de riesgo actualizado para la programación					
de las actividades y la visita domiciliar.					Embarazadas + Crecim. y Des. + Inmunizac.=
Hay disponibilidad y buen uso de equipo y suministros en el					
nivel comunitario.					Medicamentos + Equipo + Papelería= 3
Hay disponibilidad de transporte para el equipo supervisor					Tiene = 3. No tiene= 0
Se cumple con las acciones básicas para cada componente					5-6 comp.= 3; 3-4 comp.= 2; 1-2 comp.= 1; 0= 0
Se realiza coordinación con otras instituciones					Se realiza = 3. No se realiza = 0
Todos los promotores son diplomados del curso básico					Todos = 3; la mayoría = 2; la minoría = 1
Todos los técnicos son diplomados por PROSAMI.					Todos = 3; la mayoría = 2; la minoría = 1

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ANNEX G-7.

Supervisory Instruments Used by the NGO Supervisors for Promoters

PARA RESPONDER UTILICE X

D

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL. PROSAMI. 1994.
INSTRUMENTO DE SUPERVISION No. _____
LISTAS DE CONTROL DE ACCIONES BASICAS DEL PROMOTOR
ONG: MUNICIPIO: CANTON:
SUPERVISOR: SUPERVISADO:

Salud Reproductiva	SI	NO	OBSERVACION, COMENTARIO
Utiliza adecuadamente la Hoja de Vigilancia del Embarazo			
Calcula correctamente la FPP			
Toma T.A. correctamente			
Usa la gráfica de Altura Uterina			
Usa la gráfica de ganancia de peso			
Clasifica correctamente el riesgo durante el embarazo			
Da orientaciones sobre:			
– Alimentación y embarazo			
– Higiene personal			
– Preparación para la lactancia			
– Signos de peligro del embarazo			
Convoca al siguiente control			
Utiliza adecuadamente la Hoja de Vigilancia del Puerperio/RN			
Da orientaciones sobre:			
– Lactancia Materna			
– Higiene y protección del periné			
– Alimentación y puerperio			
– Signos de peligro del puerperio			
– Espaciamiento del siguiente embarazo y cuidados del RN			
Salud Perinatal	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Se lava las manos antes de manipular al recién nacido (RN)			
Pesa correctamente al RN			
Llenó correctamente la hoja de registro del recién nacido			
Tomó la temperatura axilar al RN			

Observa correctamente al RN en busca de cianosis o palidez			
Exploró correctamente el muñón umbilical.			
Utiliza correctamente los laminarios sobre Bajo Peso e Infección del RN			
Exploró al RN en búsqueda de anomalías congénitas			
Dio orientaciones sobre:			
– Cuidados del recién nacido			
– Lactancia Materna			
– Referencia al establecimiento de salud y alcaldía			
Crecimiento y Desarrollo	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Pesa y talla correctamente al niño			
Usa correctamente el gráfico de crecimiento físico del niño			
Convoca a control de seguimiento			
Clasifica correctamente el estado nutricional del niño.			
Indica seguimiento según normas			
Da orientaciones sobre:			
– Alimentación del niño según la edad.			
– Inmunización del niño			
– Desarrollo y estimulación temprana del niño.			
Inmunizaciones	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Revisa correctamente el carnet del niño.			

en el niño con tos			
Utiliza correctamente los gráficos de tratamiento del niño con tos			
Da orientación sobre:			
– Los cuidados en el hogar (F–A–L–T–A–N)			
– Como administrar el medicamento en el hogar			
– Referencia			
Convoca al seguimiento según norma.			
Enfermedad Diarréica Aguda	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Pregunta el tiempo de evolución			
Pregunta por sangre en las heces			
Usa correctamente el gráfico para clasificación y tratamiento de EDA			
Explora correctamente los signos de deshidratación del niño			
Clasifica correctamente la EDA			
Selecciona correctamente los Planes de Tratamiento			
Plantea el seguimiento correcto para cada caso.			
Entrega suficientes SRO			
Da orientación sobre:			
– Como preparar y dar TRO			
– Alimentación durante la diarrea			
– Signos de peligro y referencia			
– Higiene y saneamiento			

Participación Comunitaria	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Informa regularmente a la comunidad sobre los problemas y logros en salud que se tienen			

Indica correctamente la dosis a cumplir según la norma.			
Usa correctamente la cadena de frío según normas.			
Manipula correctamente el biológico y las jeringas.			
Anota vacunas aplicadas y la que sigue según norma en el Carnet del Niño o mujer vacunada			
Indica y programa siguiente dosis			
Da orientaciones sobre: – Las enfermedades prevenibles por vacunas aplicadas. – Tratamiento de los efectos secundarios en el niño.			

Infec. Respiratorias Agudas	SI	NO	OBSERVACION, COMENTARIO
Elige correctamente el gráfico según la edad del niño con tos			
Pregunta si puede beber o comer el niño según la edad y la norma			
Pregunta si ha habido convulsión			
Cuenta la frecuencia respiratoria			
Aplica la técnica correcta para el conteo de la frecuencia respiratoria			
Reconoce la respiración rápida según la edad del niño con tos			
Observa correctamente al niño para ver si tiene tiraje			
Clasifica correctamente la IRA			

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL. PROSAMI. 1994.
INSTRUMENTO DE SUPERVISION No. _____
LISTAS DE CONTROL DE ACCIONES BASICAS DEL PROMOTOR

ONG: MUNICIPIO: CANTON:

SUPERVISOR: SUPERVISADO:

Salud Reproductiva	SI	NO	OBSERVACION, COMENTARIO
Utiliza adecuadamente la Hoja de Vigilancia del Embarazo			
Calcula correctamente la FPP			
Toma T.A. correctamente			
Usa la gráfica de Altura Uterina			
Usa la gráfica de ganancia de peso			
Clasifica correctamente el riesgo durante el embarazo			
Da orientaciones sobre: – Alimentación y embarazo – Higiene personal – Preparación para la lactancia – Signos de peligro del embarazo			
Convoca al siguiente control			
Utiliza adecuadamente la Hoja de Vigilancia del Puerperio/RN			
Da orientaciones sobre: – Lactancia Materna – Higiene y protección del periné – Alimentación y puerperio – Signos de peligro del puerperio – Espaciamiento del siguiente embarazo y cuidados del RN			

Salud Perinatal	SI	NO	OBSERVACION, COMENTARIO
Se lava las manos antes de manipular al recién nacido (RN)			
Pesa correctamente al RN			
Llenó correctamente la hoja de registro del recién nacido			
Tomó la temperatura axilar al RN			
Observa correctamente al RN en busca de cianosis o palidez			
Exploró correctamente el muñón umbilical.			
Utiliza correctamente los laminarios sobre Bajo Peso e Infección del RN			
Exploró al RN en búsqueda de anomalías congénitas			
Dio orientaciones sobre: – Cuidados del recién nacido – Lactancia Materna – Referencia al establecimiento de salud y alcaldía			

Motiva a la comunidad para la prevención de las enfermedades			
Promueve la participación de la comunidad en la detección de NIP, planteamiento y ejecución de alternativas de solución, y evaluación de las actividades			
Facilita la organización de comités de apoyo en la comunidad.			
Aplica el enfoque de riesgo para la promoción de la salud.			
Trabaja más de 4 horas al día en la prestación de servicios por visita domiciliar			
Utiliza el método de Acción–Reflexión–Acción en su trabajo diario con la comunidad			

B:\sprvsn04

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA IN[illegible] REPRODUCT. 1994.

LISTA DE COMPROBACIÓN SOBRE ACCIONES BASICAS DE SALUD REPRODUCTIVA

ONG: MUNICIPIO: CANTON:

SUPERVISOR: SUPERVISADO:

VIGILANCIA DE EMBARAZADA	SI	NO	OBSERVACION, COMENTARIO
Detecta todas las embarazadas de su área.			
Cumple con Número de atenciones según normas.			
Usa Hoja de Vigilancia de Embarazada.			
Calcula correctamente la FPP.			
Calcula correctamente amenorrea.			
Toma T.A. correctamente.			
Toma Altura Uterina correctamente.			
Usa la gráfica de Altura Uterina.			
Usa la gráfica de ganancia de peso.			
Investiga signos de peligro en Embarazada.			
Clasifica correctamente el peligro durante el embarazo.			
Da orientaciones sobre:			
– Alimentación			
– Higiene.			
– Lactancia.			
– Signos de peligro del embarazo.			
Verifica la comprensión de las orientaciones por parte de la madre.			
Hace referencia oportuna.			
Entrega vitaminas, explicando su uso.			
Señala fecha del siguiente control.			
Registra atención en sistema información.			
Establece una relación de mutuo respeto con quien recibe su atención.			

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL. PROSAMI. 1994.
INSTRUMENTO DE SUPERVISION No. _____
LISTAS DE CONTROL DE ACCIONES BASICAS DEL PROMOTOR
ONG: MUNICIPIO: CANTON:
SUPERVISOR: SUPERVISADO:

Infec. Respiratorias Agudas	SI	NO	OBSERVACION, COMENTARIO
Elige correctamente el gráfico según la edad del niño con tos			
Pregunta si puede beber o comer el niño según la edad y la norma			
Pregunta si ha habido convulsión			
Cuenta la frecuencia respiratoria			
Aplica la técnica correcta para el conteo de la frecuencia respiratoria			
Reconoce la respiración rápida según la edad del niño con tos			
Observa correctamente al niño para ver si tiene tiraje			
Clasifica correctamente la IRA en el niño con tos			
Utiliza correctamente los gráficos de tratamiento del niño con tos			
Da orientación sobre: – Los cuidados en el hogar (F–A–L–T–A–N) – Como administrar el medicamento en el hogar – Referencia			
Convoca al seguimiento según norma.			
Enfermedad Diarréica Aguda	**SI**	**NO**	**OBSERVACION, COMENTARIO**
Pregunta el tiempo de evolución			
Pregunta por sangre en las heces			
Usa correctamente el gráfico para clasificación y tratamiento de EDA			
Explora correctamente los signos de deshidratación del niño			
Clasifica correctamente la EDA			
Selecciona correctamente los Planes de Tratamiento			
Plantea el seguimiento correcto para cada caso.			
Entrega suficientes SRO Da orientación sobre: – Como preparar y dar TRO – Alimentación durante la diarrea – Signos de peligro y referencia – Higiene y saneamiento			

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

INSTRUMENTO DE SUPERVISION No._____

LISTAS DE CONTROL DE ACCIONES BASICAS DEL PROMOTOR

ONG:_____ MUNICIPIO:_____ CANTON:_____

PARTICIPACION COMUNITARIA	SI	NO	OBSERVACION, COMENTARIO
Promueve la organización de comités o grupos de apoyo en la comunidad.			
Tiene al menos 5 voluntarios activos por comunidad.			
Tiene censados los recursos humanos y materiales de la comunidad.			
Promueve la participación de la comunidad en la elaboración y manejo del Mapa de Riesgo.			
Cumple con las capacitaciones para la prevención y manejo de casos de riesgo en la madre del niño.			
Actualiza el Mapa de Riesgo junto al comité o miembros del voluntariado.			
Planifica como mínimo 2 asambleas al año con la comunidad.			
Organiza un sistema de apoyo para el traslado de enfermos en estado grave.			
LLeva a cabo la participación activa de la comunidad en la elaboración del Diagnóstico Situacional de Salud.			
Promueve y concretiza el aporte de locales comunitarios para el desarrollo de las actividades del proyecto.			
Ejecuta las actividades del plan con la participación activa del voluntariado y otros agentes de salud comunitarios.			
Proporciona apoyo a las actividades del voluntariado.			
Planifica con los voluntarios las actividades a realizar.			
Promueve la autogestión de la comunidad.			
Registra información en sistema de logros.			
Coordina con otros actores sociales (MSPAS, ONG, Iglesia, etc.), otras actividades pro-mejoramiento comunitario.			

PROYECTO DE SALUD M[illegible] Y SU ENVIVENCIA IN[illegible]TIL. PROGRAM[illegible]

LISTA DE COMPROBACION SOBRE ACCIONES BASICAS DE SALUD REPRODUCTIVA

ONG: MUNICIPIO: CANTON:

SUPERVISOR: SUPERVISADO:

VIGILANCIA SOBRE PARTO	SI	NO	OBSERVACION, COMENTARIO
Coordina con parteras			
Investiga si hay signos de peligro			
LLena hoja de información de parto			
VIGILANCIA DE PUERPERA			
Usa Hoja de Vigilancia de Puérpera			
Cumple con Número de atenciones según normas.			
Investiga signos de peligro en Puérpera.			
Clasifica correctamente el peligro durante el puerperio			
Da orientaciones sobre: – Alimentación y Lactancia – Higiene y protección del periné – Signos de peligro del puerperio – Espaciamiento de embarazos.			
Verifica la comprensión de las orientaciones por parte de la madre.			
Hace referencia oportuna			
Entrega Vitaminas			
Señala fecha del siguiente control.			
Registra atención en sistema información.			
ESPACIAMIENTO EMBARAZOS			
Entrega Preservativos			
Explica forma de usar preservativos.			
Asegura comprensión para uso de preservativos.			
Entrega Anticonceptivos orales ACO			
Explica forma de usar Anticonceptivos orales:			
Asegura comprensión para uso de anticonceptivos orales.			
Registra atención en sistema información.			
Establece relación de respeto			
Tiene equipo/material para atención			

ANNEX G-8.

Patient Record & Monitoring Forms Filled-Out by the Promoters

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI
CALENDARIO MENSUAL DE ACTIVIDADES POR ASESOR

NOMBRE: _____ DIVISION: _____

MES: _____

LUNES	MARTES	MIERCOLES	JUEVES	VIERNES
LUNES	MARTES	MIERCOLES	JUEVES	VIERNES
LUNES	MARTES	MIERCOLES	JUEVES	VIERNES
LUNES	MARTES	MIERCOLES	JUEVES	VIERNES
LUNES	MARTES	MIERCOLES	JUEVES	VIERNES

HOJA DE ATENCION DEL TRABAJADOR DE SALUD

ONG: _____ Municipio: _____ Cantón: _____

Caserío: _____ Fecha: _____

Nombre del usuario: _____

Edad: Años: _____ Meses: _____ días: _____(si es de 0 a 4 años)

Peso (kg): _____ Presión Arterial: _____/_____ Respiraciones por minuto: _____

Desnutrición: Leve _____ Moderada: _____ Severa: _____

Consulta por:(Anote el motivo por el que solicita atención):

SIGNOS DE ENFERMEDAD	SI	NO	SIGNOS DE ENFERMEDAD	SI	NO
Infección Respiratoria Aguda			**Enfermedad Diarréica Aguda**		
Menos de 15 días de evolución			Menos de 15 días de evolución		
Puede beber			ojos hundidos		
Ha dejado de comer bien			lágrimas		
fiebre			boca seca		
está helado			signo de pliegue		
convulsiones			puede beber		
(1) tiraje			casi inconciente/inconciente		
respiración rápida			Pupú con sangre		
(2) estridor			fiebre		
(3) sibilancia			"moyera" hundida		
ganglios del cuello alterados					
oidos con pus					
ruidos en el pecho					
Recién Nacido					
Fiebre					
(4) Hipotermia					
Dificultad para mamar					
LLanto débil o quejumbroso					
(5) Onfalitis					
convulsiones					
(6) Cianosis					
Palidez					
Respiración rápida y/o tiraje					

Glosario de palabras técnicas
(1) Hundimiento por debajo de la última costilla al respirar.
(2) Ruido en el pecho que se produce durante la inspiración
(3) Ruido en el pecho que se produce durante la espiración
(4) Piel fría o helada
(5) Ombligo inflamado con pus y maloliente
(6) Piel morada

Otras (especifique):

Clasificación de la enfermedad: _____

Tratamiento (especifique): _____

Referencia: Si _____ No _____ Lugar de referencia: _____

Responsable: _____

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UNIDAD DE ESTADISTICA DE SALUD

MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL

REGISTRO DE VACUNACION

FORMULARIO Nº ____ DE ____

AREA GEOGRAFICA
1= URBANO
2= RURAL

ESTRATEGIA VACUNACION:
1 CAMPAÑA
2 REGULAR
3 BARRIDO
4 PRECAMPAÑA

MUNICIPIO ____ NOMBRE ESTABLECIMIENTO ____ CODIGO ESTAB. ____ COD. PUESTO VAC. ____ COD. PROFESION VACUNADOR ____ COD. PERSONA ____ SEMANA ____ DIA ____ MES ____ AÑO ____

NOMBRE (1)	FECHA DIA (2)	EDAD AÑOS (3)	EDAD MESES (4)	MENORES DE 1 AÑO: DPT (DOSIS Nº) (5) 1	2	3	AMA	ANTIPOLIO (DOSIS Nº) (6) 1	2	3	R	SARAMPION (7) P	R	BCG (8)	DE 1 A 4 AÑOS: DPT (DOSIS Nº) (9) 1	2	3	R	ANTIPOLIO (DOSIS Nº) (10) 1	2	3	R	R	SARAMPION (11) P	R	BCG (12)	DE 5 A 14 AÑOS: DT (DOSIS Nº) (13) 1	2	R	ANTIPOLIO (DOSIS Nº) (14) 1	2	3	R	R	SARAMPION (15) P	R	BCG (16) P	R	TOXOIDE TETANICO: EMBARAZADAS (DOSIS Nº) (17) 1	2	R	OTRAS MUJERES (DOSIS Nº) (18) 1	2	R	POSIBLES (DOSIS Nº) (19) 1	2	R	TQ	ANTIRRABICA (21)
TOTAL																																																	

TOTAL POR GRUPOS DE EDAD					
TOTAL VACUNA ANTIRRABICA	1º ____	2º ____	3º ____	4º ____	5º ____

PROCEDIMIENTO DE REGISTRO

- Una línea por persona vacunada
- Por cada dosis aplicada marque un chaque (✓) en la columna correspondiente (excepto en antirrábica)
- Utilice códigos especiales para edad, area U-R y vacuna antirrábica.

EDAD

(3) Años:

Para los de 1 año y mas anote años

(4) Meses:

Para los menores de 1 año anote Nº de meses, para los menores de 1 mes anote "0"

(21) ANTIRRABICA

- Inicia vacunación = 1
- Continua vacunación = 2
- Termina vacunación = 3
- Interrumpe vacunación por orden médica = 4
- Interrumpe vacunación sin orden medica = 5

CODIGO DE PROFESION

- Medico = 1
- T. M. I. = 2
- Enfermera = 3
- Auxiliar de enfermería = 4
- Odontólogo = 5
- Promotor de Salud = 6
- Inspector de Saneamiento = 7
- Otros = 8

NOMBRE DEL REGISTRADOR ____ FIRMA ____ NOMBRE DEL VACUNADOR ____ FIRMA ____

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UNIDAD DE ESTADISTICA DE SALUD

MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL

REGISTRO DE VACUNACION

FORMULARIO Nº ____ DE ____

AREA GEOGRAFICA
1 = URBANO
2 = RURAL

ESTRATEGIA VACUNACION:
1 CAMPAÑA
2 REGULAR
3 BARRIDO
4 PRECAMPAÑA

MUNICIPIO ____ NOMBRE ESTABLECIMIENTO ____ CODIGO ESTAB. ____ COD. PUESTO VAC. ____ COD. PROFESION VACUNADOR ____ COD. PERSONA ____ SEMANA ____ DIA ____ MES ____ AÑO ____

NOMBRE (1)	FECHA DIA (2)	EDAD AÑOS (3)	EDAD MESES (4)	MENORES DE 1 AÑO: DPT (DOSIS Nº) (6) 1	2	3	ANTIPOLIO (DOSIS Nº) (6) 1	2	3	B	SARAMPION (7) P	R	BCG (8)	DE 1 A 4 AÑOS: DPT (DOSIS Nº) (9) 1	2	3	R	ANTIPOLIO (DOSIS Nº) (10) 1	2	3	R	B	SARAMPION (11) P	R	BCG (12)	DE 5 A 14 AÑOS: DT (DOSIS Nº) (13) 1	2	R	ANTIPOLIO (DOSIS Nº) (14) 1	2	3	R	B	SARAMPION (15) P	R	BCG (16) P	R	TOXOIDE TETANICO: EMBARAZADAS (DOSIS Nº) (17) 1	2	R	OTRAS MUJ. (DOSIS Nº) (18) 1	2	R	OTROS GRUPOS (DOSIS Nº) (19) 1	2	R	TB (20)	ANTIRRABICA (21)
TOTAL																																																	
TOTAL POR GRUPOS DE EDAD																																																	

TOTAL VACUNAS ANTIRRABICAS 1º____ 2º____ 3º____ 4º____ 5º____

PROCEDIMIENTO DE REGISTRO

- Una línea por persona vacunada
- Por cada dosis aplicada marque un chequo (✓) en la columna correspondiente (excepto en antirrábicas)
- Utilice códigos específicos para edad, área U-R y vacuna antirrábica.

EDAD

(3) Años:

Para los de 1 año y más coloque años

(4) Meses:

Para los menores de 1 año coloque Nº de meses, para los menores de 1 mes coloque "0"

(21) ANTIRRABICA

- Inicia vacunación = 1
- Continua vacunación = 2
- Termina vacunación = 3
- Interrumpe vacunación por orden médica = 4
- Interrumpe vacunación sin orden médica = 5

CODIGO DE PROFESION

- Medico = 1
- T.M.I. = 2
- Enfermera = 3
- Auxiliar de enfermería = 4
- Odontólogo = 5
- Promotor de Salud = 6
- Inspector de Saneamiento = 7
- Otros = 8

NOMBRE DEL REGISTRADOR ____ FIRMA ____ NOMBRE DEL VACUNADOR ____ FIRMA ____

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ONG _____
No. DE FICHA _____
VIVIENDA No. _____
HOGAR No. _____

FICHA FAMILIAR PROSAMI / ONG

CARACTERISTICAS DE LOS MIEMBROS DEL HOGAR

FECHA: _____
RESPONSABLE _____

REGION: _____
DEPARTAMENTO _____
MUNICIPIO _____
CANTON _____
CASERIO _____

No. Corr.	1. NOMBRE	2. SEXO		3. FECHA DE NACIMIENTO	4. EDAD	5. LUGAR DE NACIMIENTO DE MENORES DE 5 AÑOS	6. ALFAB.		DEFUNCION			
		M	F				SI	NO	7. FECHA DEFUNCION	8. EDAD	9. CAUSA POSIBLE	10. LUGAR
01												
02												
03												
04												
05												
06												
07												
08												
09												
10												
11												
12												

SINTESIS DEL HOGAR

11. POBLACION DE MENORES DE 1 AÑO	12. POBLACION DE 1 A 4 AÑOS	13. POBL. MUJERES DE 15 - 44 AÑOS	14. POBLACION DE OTRAS EDADES	15. POBLACION TOTAL

16. TOTAL DE MADRES	17. No. MADRES QUE SABEN LEER	18. JEFE DE FAMILIA	HOMBRE	MUJER	19. TOTAL ALFABETOS

MUJERES DE 15 A 44 AÑOS

No. Corr.	CITOLOGIA ULTIMO AÑO		PLANIFICA		EMBARAZADA				CONTROL PRENATAL						TOXOIDE						ATEN. PARTO			NAC. VIVO		C. POST PARTO		C. RECIEN NAC.				
	SI	NO	SI	NO	SI	NO	FUR	FPP	0	1	2	3	4	5	0	1	2	3	4	5	DOM	INS	PAR	SI	NO	SI	NO	0	1	2	3	4

Cod. Defunc.
1 Diarrea
2 IRA
3 Accid.
4 Parto
5 Otras

Cod. Lugar
1 Casa
2 Hospt.
3 Otro

MENORES DE 5 AÑOS

IDENTIFICACION	No. CORRELATIVO:				No. CORRELATIVO:				No. CORRELATIVO:				No. CORRELATIVO:			
VACUNACION	FECHA				FECHA				FECHA				FECHA			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1 BCG																
2 DPT 1a DOSIS																
2a DOSIS																
3a DOSIS																
REFUERZO 1																
REFUERZO 2																
3. ANTIPOLIO 1a. DOSIS																
2a. DOSIS																
3a. DOSIS																
REFUERZO 1																
REFUERZO 2																
4. ANTISARAMPIONOSA 1a.																
REFUERZO																
5. ESQUEMA COMPLETO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
CONTROL DE DIARREA																
6. TIENE DIARREA HOY?	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
7. DIARREA HACE 15 DIAS?	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
INF RESPIRATORIAS AG.																
8. TIENE IRA HOY?	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
9 IRA HACE 15 DIAS?	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
CRECIMIENTO-DESARROLLO																
10. ESTA EN CONTROL?	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO
11. ESTADO NUTRI. EN NIÑO																
1. NORMAL																
2. DESNUTRIDO LEVE																
3. DESNUTRIDO MODERADO																
4. DESNUTRIDO SEVERO																
12. L. M./EXCLUSIVA 4-6 M	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO	SI NO

INDICADORES SOCIO-ECONOMICOS

19 ___ 19 ___ 19 ___ 19 ___	CATEGORIA 1	CATEGORIA 2	CATEGORIA 3
VIVIENDA	PRESTADA COLONO	ALQUILADA	PROPIA
PARED	CARTON VARA RIPIO	ADOBE MADERA BAHAREQUE	LADRILLO BLOQUE
PISO	TIERRA	CEMENTO	LADRILLO
TECHO	PAJA CARTON	LATA	TEJA LAMINA DURALITA
No. DE DORMITORIOS	NO HAY	UNO	DOS O MAS
FUERZA DE TRABAJO	UN MIEMBRO DE LA FAMILIA	MAS DE UN MIEMBRO DE LA FAMILIA	CONTRATA MANO DE OBRA
MEDIOS DE INFORMACION	NO HAY	RADIO	T. V. PERIODICOS OTROS
ANIMALES DOMESTICOS	NINGUNO PERRO GATO	AVES CERDOS CABRAS	GANADO CABALLOS MULAS
IMPLEMENTOS AGRICOLAS	MANUALES	ARRENDA CARRETA ARADO	PROPIETARIO DE: CARRETA, ARADO ANIMALES DE TIRO
ILUMINACION	CANDIL CANDELA	LAMPARA DE GAS	ELECTRICIDAD
AGUA LIMPIA	RIO, POZO AGUAS LLUVIAS NACIMIENTO	AGUA DE CAÑERIA DOMICILIAR COLECTIVA	HERVIDA CLORADA
DEPOSITO DE BASURA	SE ACUMULA CERCA DE LA CASA	SE ACUMULA LEJOS DE LA CASA	ES QUEMA ENTERRA ABONERAS
DEPOSITO DE EXCRETAS	AL AIRE LIBRE	LETRINA	SERVICIO SANITARIO
COMERCIO	NO TIENE	PEQUEÑO NEGOCIO	MICROEMPRESA COOPERATIVA
TRANSPORTE	A PIE	COLECTIVO BICICLETA ANIMALES	VEHICULO MOTORIZADO PROPIO ANIMAL DE CARGA
	TOTALES		

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL

HOJA DE VIGILANCIA DE LA EMBARAZADA

Este color significa peligro y referencia

Este color significa alerta

REPUBLICA DE EL SALVADOR O. N. G. — RESPONSABLE

NOMBRE _____

DOMICILIO _____

LOCALIDAD _____ TEL.: _____

EDAD años — menor de 15 — mayor de 35

ALFABETA: SI / NO

ESTUDIOS: ninguno, sec., años aprob., prim., univ.

ESTADO CIVIL: casada, acompañada, soltera, otra

ANTECEDENTES FAMILIARES (NO / SI): diabetes, tuberculosis, hipertensión, gemelares, otros

ANTECEDENTES PERSONALES (NO / SI): tuberculosis, diabetes, hipertensión crónica, cirugía pélvico-uterina, infertilidad, otros _____

ANTECEDENTES SOBRE EMBARAZOS

NUMERO DE EMBARAZOS ANTERIORES — abortos — partos — vaginales — cesáreas — nacidos vivos — nacidos muertos — viven — muertos 1a. semana — después 1a. semana

ninguno o más de tres partos — algún RN menor de 2500 g — gemelares

fin de anterior embarazo: MES / AÑO

RN con mayor peso: ____ g

EMBARAZO ACTUAL

PESO ANTERIOR ____ Kg — TALLA (cm) 1 ___

	día	mes	año
FUM			
FPP			

DUDAS: NO / SI

VACUNA ANTITETANICA: previa si / no — actual 1a. / 2a./R — mes de emb.

TIPO DE SANGRE: GRUPO — Rh + / −

FUMA: NO / SI — cigarrillos por día

HOSPITALIZACION: no / si

CAUSA DE LA HOSPITALIZACION _____

FECHA DE CONSULTA	1	2	3	4	5	6	7	8	9
Semanas de amenorrea									
Peso (Kg)									
• Tensión Arterial máxima/mínima									
Altura Uterina (cms.)									
Movimientos Fetales SI/NO									
Presentación Cefálica SI/NO									
Frecuencia Cardíaca Fetal (120-160)/m									
SIGNOS DE PELIGRO									
Sangrado genital SI/NO									
Salida de líquido por Vagina SI/NO									
Dolor de Cabeza Intenso SI/NO									
Hinchazón de Cara y Manos SI/NO									
Mal de orín (ardor al orinar) SI/NO									
Dolores de Parto antes 38 sem. SI/NO									
Temperatura arriba de 38ºC SI/NO									
Otros signos de PELIGRO SI/NO									
¿Tiene signos de PELIGRO? SI/NO									
REFERENCIA SI/NO									
Entrega de Vitaminas SI/NO									

• Si la tensión arterial está arriba de 140 la Máxima y arriba de 90 la Mínima, significa Peligro.

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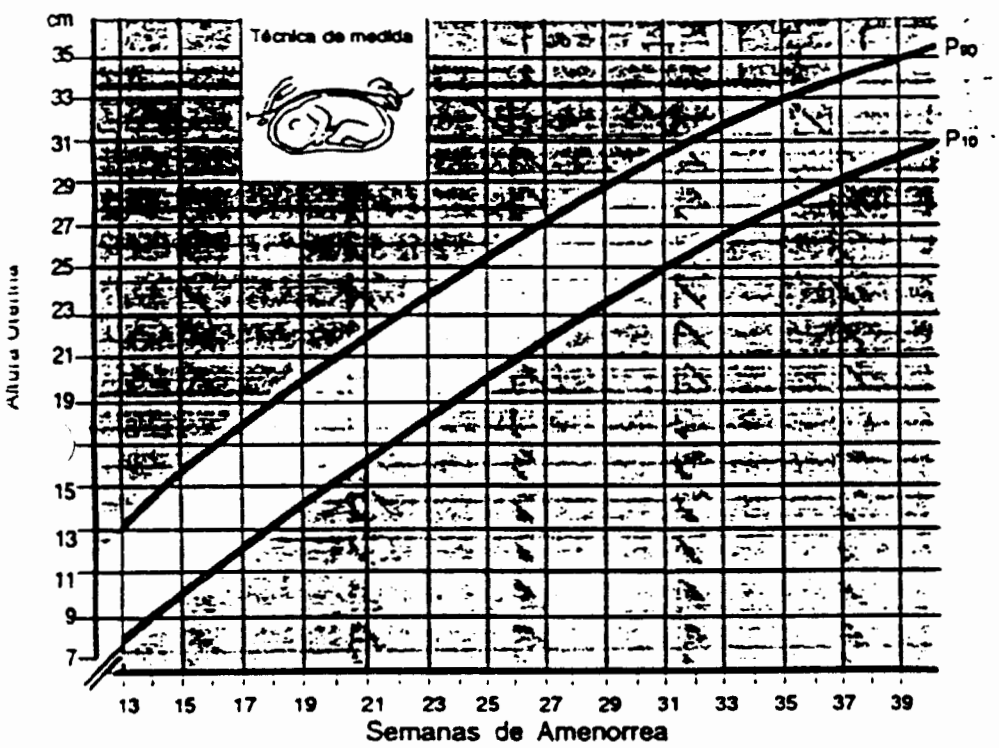
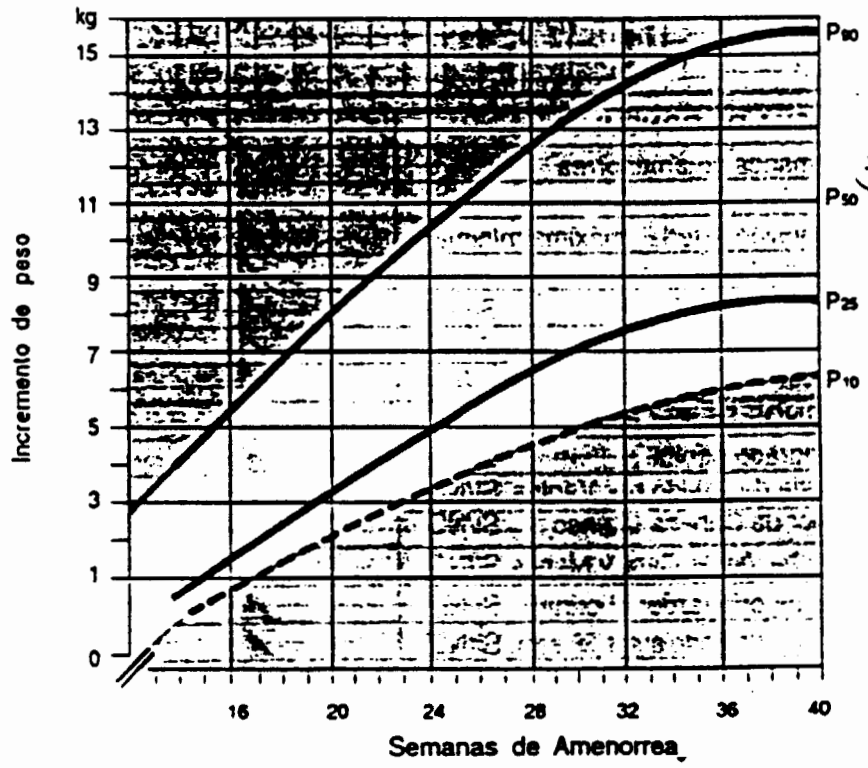
Límites mínimos aceptables de peso previo al embarazo para intervalos de talla

Talla en centímetros	Peso mínimo previo al embarazo
140 - 145	40 Kg = 88 libras
146 - 150	43 Kg = 94.6 libras
151 - 155	46 Kg = 101.2 libras
156 - 160	48 Kg = 105.6 libras
161 - 165	51 Kg = 112.2 libras
166 - 170	53 Kg = 116.6 libras

CURVA DE INCREMENTO DE ALTURA UTERINA



CURVA DE INCREMENTO DE PESO MATERNO



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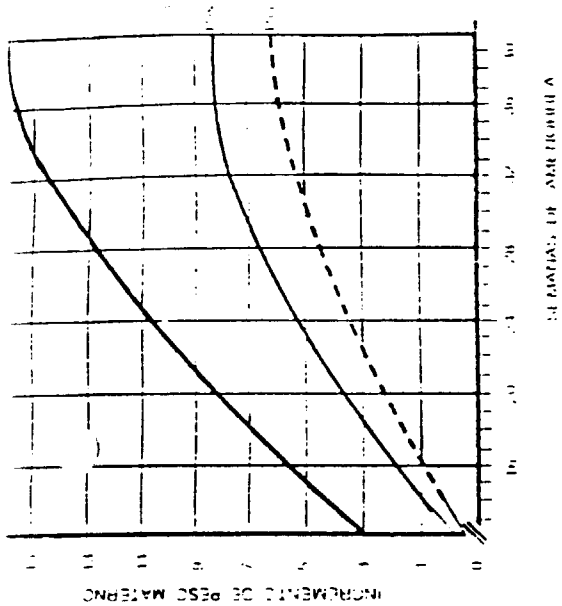

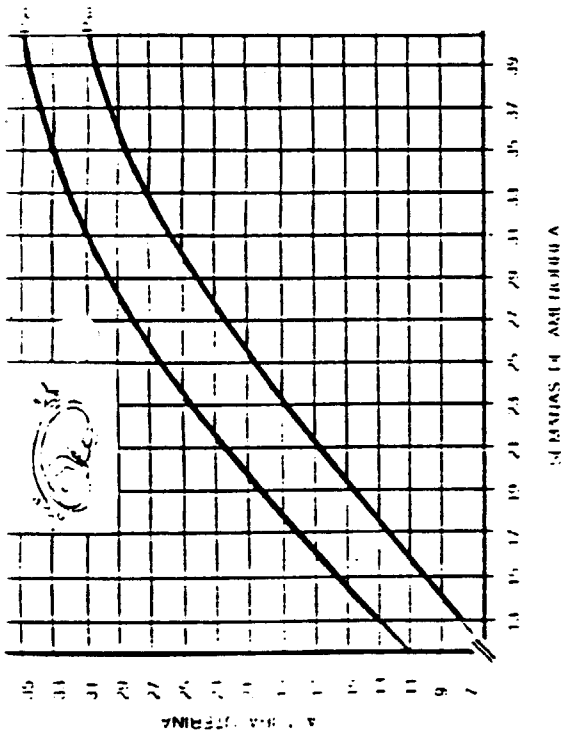

DEPARTAMENTO MATERNO INFANTIL
1992

MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL
PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
P R O S A M I

C A R N E T M A T E R N O

_____
PRIMER APELLIDO SEGUNDO APELLIDO

NOMBRES _____

ONG _____

No. DE EXPEDIENTE _____

EDAD _____ AÑOS, ESTADO CIVIL _____

PROFESION U OFICIO _____

DIRECCION _____

_____

LLEVE SIEMPRE ESTE CARNET A SUS CONTROLES Y A DONDE ATENDERAN SU PARTO

SI ESTE CUADRO _____ APARECE PINTADO COLOR ROJO INDICA QUE SU PARTO NO PUEDE SER ATENDIDO EN CASA

DEBERA IR _____

_____

* NO OLVIDAR SU CARNET EN SU PROXIMA CITA

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL

HOJA DE VIGILANCIA DE LA EMBARAZADA

Este cobri significa peligro y referencia

Este cobri significa alerta

REPUBLICA DE EL SALVADOR O. N. G. — RESPONSABLE

NOMBRE _____

DOMICILIO _____

LOCALIDAD _____ TEL.: _____

EDAD años — menor de 15 / mayor de 35

ALFABETA SI / NO

ESTUDIOS: ninguno, sec., años aprob. / primaria, univ.

ESTADO CIVIL: casada, unión cansada, otra, ninguna

ANTECEDENTES FAMILIARES (NO / SI): diabetes, tuberculosis, hipertensión, gemelares, otros

ANTECEDENTES PERSONALES (NO / SI): tuberculosis, diabetes, hipertensión crónica, cirugía pelvico-uterina, infertilidad, otros _____

ANTECEDENTES SOBRE EMBARAZOS

NUMERO DE EMBARAZOS ANTERIORES — abortos — vacunas — nacidos vivos — viven

ninguno o más de tres partos — alguna RN menor de 2500 g — gemelares — partos — cesareas — nacidos muertos — muertos 1a. semana — después 1a. semana

fin de anterior embarazo: MES / AÑO

RN con mayor de ____ g

EMBARAZO ACTUAL

PESO ANTERIOR ____ Kg — TALLA (cm) 1 ___

	día	mes	año
FUM			
FPP			

DUDAS NO / SI

VACUNA ANTITETANICA: previa SI / NO — actual 1a. / 2a. R — mes de emb.

TIPO DE SANGRE: GRUPO ____ Rh + / −

FUMA NO / SI — cigarrillos por día

HOSPITALIZACION no / si

CAUSA DE LA HOSPITALIZACION _____

FECHA DE CONSULTA	1	2	3	4	5	6	7	8	9
Semanas de amenorrea									
Peso (Kg)									
• Tensión Arterial máxima/mínima									
Altura Uterina (cms.)									
Movimientos Fetales SI/NO									
Presentación Cefálica SI/NO									
Frecuencia Cardiaca Fetal (120-160)/m									
SIGNOS DE PELIGRO									
Sangrado genital SI/NO									
Salida de líquido por Vagina SI/NO									
Dolor de Cabeza Intenso SI/NO									
Hinchazón de Cara y Manos SI/NO									
Mal de orín (ardor al orinar) SI/NO									
Dolores de Parto antes 38 sem. SI/NO									
Temperatura arriba de 38ºC SI/NO									
Otros signos de PELIGRO SI/NO									
¿Tiene signos de PELIGRO? SI/NO									
REFERENCIA SI/NO									
Entrega de Vitaminas SI/NO									

Si la presión arterial está arriba de 140 la Máxima y arriba de 90 la Mínima, significa Peligro

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

REGISTRO DE CONTROLES A EMBARAZADAS

ONG:_____ COMUNIDAD:_____ PROMOTOR:_____

No. VDA	NOMBRE	EDAD	FUR	FPP	MESES											
					ENE	FEB	MAR	ABR	MAY	JUN	JUL	AGO	SEP	OCT	NOV	DIC

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

ONG: _____

COMUNIDAD: _____ PROMOTOR _____

REGISTRO DE CONTROL DE PUERPERAS

No. Vda.	NOMBRE	EDAD	FECHA DE PARTO	ATENCIONES BRINDADAS					POR:
				1	2	3	4	Otras	

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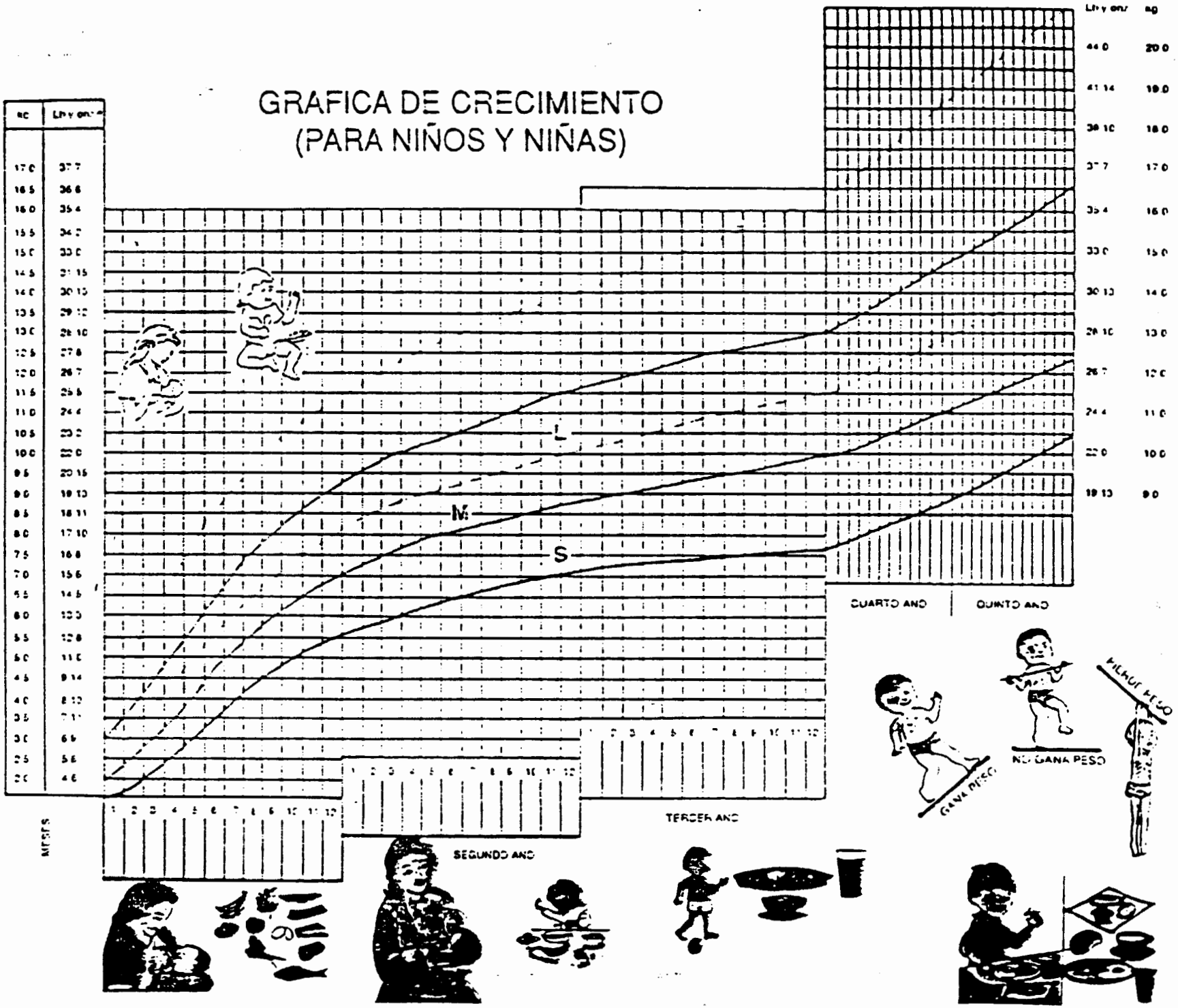
GRAFICA DE CRECIMIENTO
(PARA NIÑOS Y NIÑAS)



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DESARROLLO NORMAL

ESTIMULACION DEL DESARROLLO

	AREA MOTORA	AREA COORDINACION	AREA SOCIAL - AFECTIVA	AREA LENGUAJE
MESES 0 - 3	SOSTIENE FIRME LA CABEZA.	BUSCA SONIDOS CON LA MIRADA. DIN DIN	SONRIE.	EMITE SONIDOS
MESES 3 - 6	PERMANECE SENTADO CON APOYO.	SIGUE CON LA MIRADA OBJETOS QUE SE MUEVEN.	ATIENDE AL ESCUCHAR SU NOMBRE. CARLITOS	BALBUCEA
MESES 6 - 9	TRATA DE PARARSE APOYADO	BUSCA OBJETOS ESCONDIDOS.	MURANO ANTE EXTRAÑOS	COMBINA SILABAS TATA MAMÁ
MESES 9 - 12	CAMINA SOSTENIDO DE LA MANO	METE Y SACA OBJETOS DE UNA CAJA DE ZAPATOS	RECONOCE A LOS DE SU FAMILIA	3 A 5 PALABRAS PAPÁ MAMÁ
AÑOS 1 - 2	CAMINA SIN AYUDA	COLOCA OBJETOS UNO SOBRE OTRO	JUEGA CON OTROS NIÑOS.	HABLA CON FRASES CORTAS

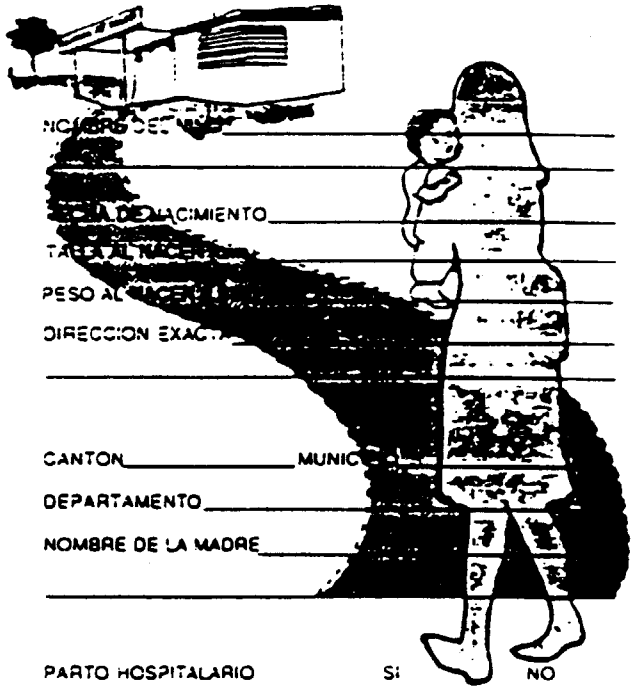
	DOSIS			REFUERZO	
VACUNAS	1ª	2	3ª	1ª	2ª
B C G					
ANTIPOLIO					
D P T					
ANTISARAMPION					
D T					
OTRAS					

EL SALVADOR, C.A. 1994

ESTABLECIMIENTO _____

Nº EXPEDIENTE _____

CARNET DEL NIÑO



NOMBRE DEL NIÑO _____

FECHA DE NACIMIENTO _____

TALLA AL NACER _____

PESO AL NACER _____

DIRECCION EXACTA _____

CANTON _____ MUNICIPIO _____

DEPARTAMENTO _____

NOMBRE DE LA MADRE _____

PARTO HOSPITALARIO SI NO

PARTO NORMAL SI NO

CITAS PARA CONTROL DE CRECIMIENTO DESARROLLO				
FECHA	HORA	MEDICO	ENFER	ENTREGA DE ALIMENTOS
				1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12

GRAFICA DE CRECIMIENTO PESO/EDAD

NIÑOS MENORES DE 5 AÑOS

Nombre: _____

Fecha de nacimiento: _____

No. de Expediente: _____ Peso al nacer: _____

Lb y onz	Kg
37. 7	17.0
36. 6	16.5
35. 4	16.0
34. 2	15.5
33. 0	15.0
31.15	14.5
30.13	14.0
29.12	13.5
28.10	13.0
27. 8	12.5
26. 7	12.0
25. 5	11.5
24. 4	11.0
23. 2	10.5
22. 0	10.0
20.15	9.5
19.13	9.0
18.11	8.5
17.10	8.0
16. 8	7.5
15. 6	7.0
14. 5	6.5
13. 3	6.0
12. 2	5.5
11. 0	5.0
9.14	4.5
8.13	4.0
7.11	3.5
6. 9	3.0
5. 8	2.5
4. 6	2.0

LACTANCIA MATERNA

N

L

M

S

Kg	Lb y onz
20.0	44. 0
19.0	41.14
18.0	39.10
17.0	37. 7
16.0	35. 4
15.0	33. 0
14.0	30.13
13.0	28.10
12.0	26. 7
11.0	24. 4
10.0	22. 0
9.0	19.13

MESES

PRIMER AÑO

SEGUNDO AÑO

TERCER AÑO

CUARTO AÑO | QUINTO AÑO

CLASIFICACION DEL ESTADO NUTRICIONAL

N - NIÑO CON ESTADO NUTRICIONAL NORMAL
L - NIÑO CON DESNUTRICION LEVE
M - NIÑO CON DESNUTRICION MODERADA
S - NIÑO CON DESNUTRICION SEVERA

LACTANCIA MATERNA	INFECCIONES ASOCIADAS
E = EXCLUSIVA	D = DIARREAS
M = MIXTA	IR = INFECCIONES RESPIRATORIAS
O = SIN LACTANCIA	O = OTRAS ENFERMEDADES

Ministerio de Salud Pública y Asistencia Social

Departamento de Nutricion y alimentacion

1993

PROSAMI

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL

SERVICIO MEDICO INTERNACIONAL

U.S.A.I.D.

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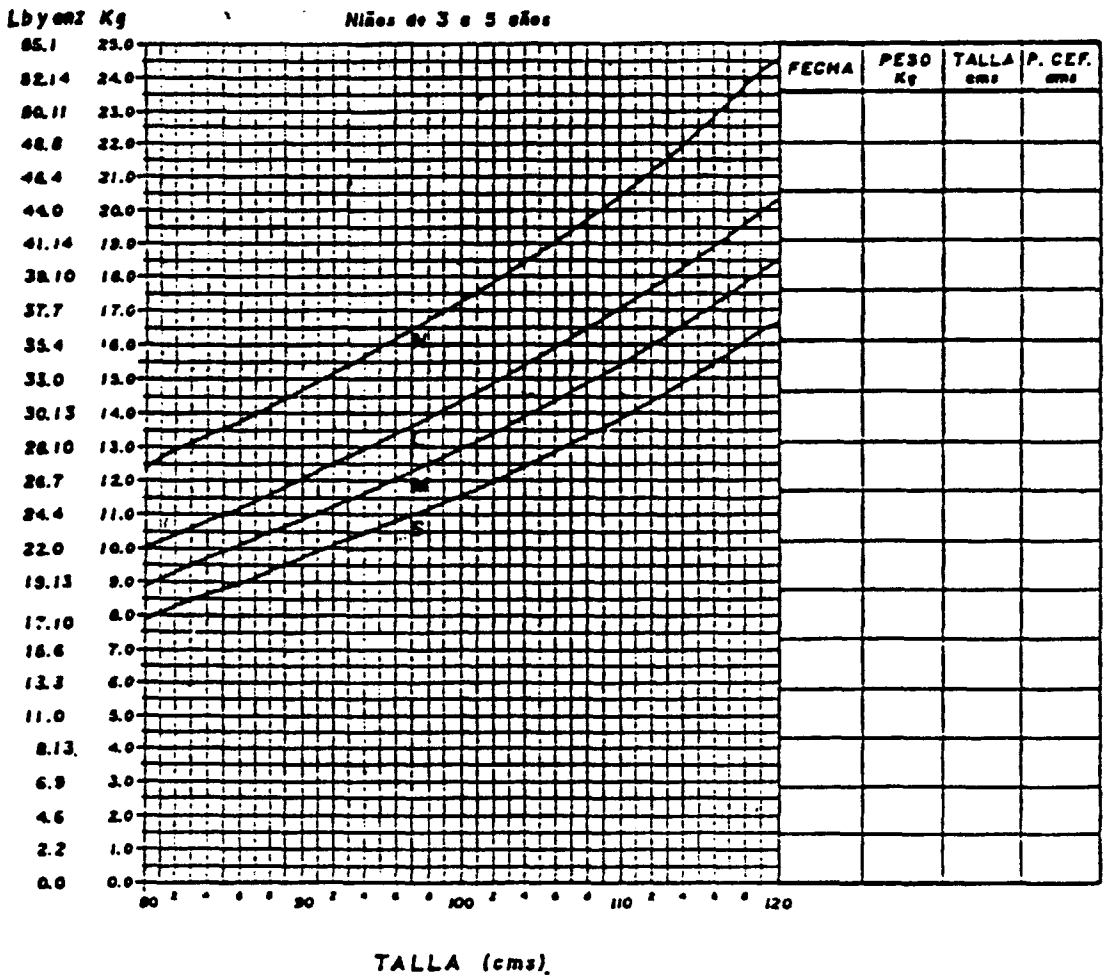
♂ NIÑOS

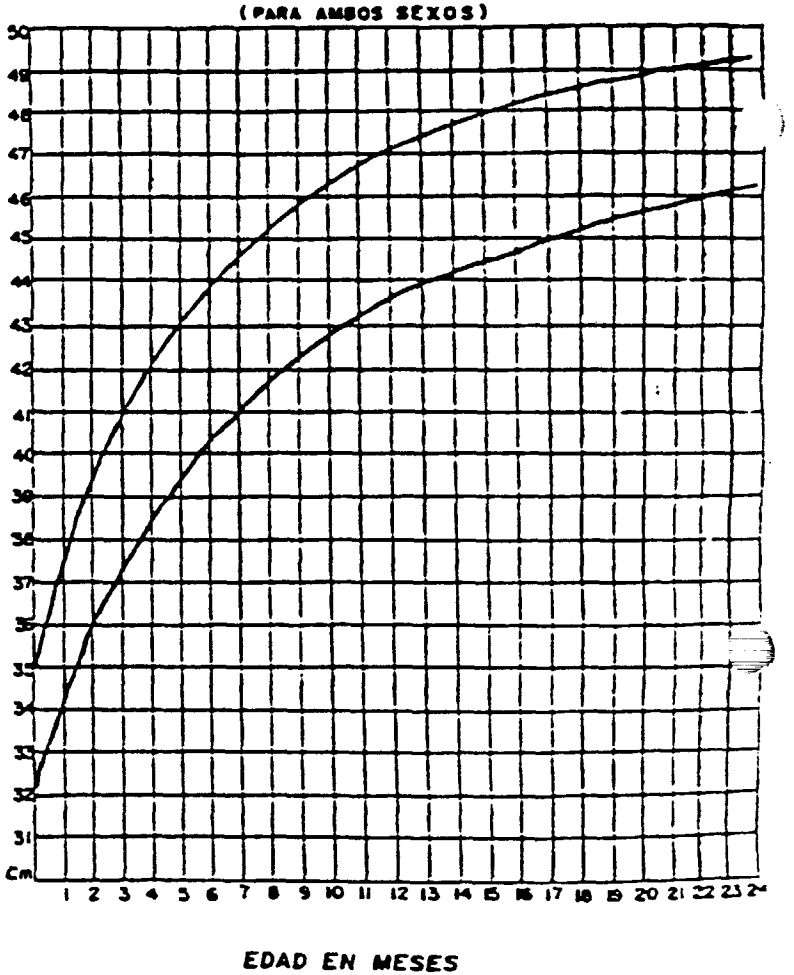
GRAFICA DE CRECIMIENTO
PESO/TALLA

Niños de 3 a 5 años



FECHA	PESO Kg	TALLA cms	P. CEF. cms

GRAFICO PERIMETRO CEFALICO
(PARA AMBOS SEXOS)



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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
HOJA PARA INFORMACION SOBRE PARTO Y VIGILANCIA DEL PUERPERIO Y DEL RECIEN NACIDO

ONG _____ FECHA _____

TERMINACION DEL EMBARAZO

CONTROL O VIGILANCIA PRENATAL SI [ ] NO [ ] RESPONSABLE _____

ABORTO [ ] PARTO VAGINAL [ ] CESAREA [ ]

EDAD GESTACIONAL [ ]

DESGARRO EN CANAL DEL PARTO SI [ ] NO [ ] PLACENTA COMPLETA SI [ ] NO [ ]

PARTO DOMICILIAR [ ] PARTO INSTITUCIONAL [ ] PARTO EN OTRO LUGAR [ ]

PARTO ATENDIDO POR

PERSONAL CAPACITADO (MEDICO, ENFERMERA, TECNICO M. I.) [ ] PARTERA CAPACITADA [ ]

OTRO [ ] QUIEN _____

DATOS DEL RECIEN NACIDO

NACIO VIVO [ ] NACIO MUERTO [ ]

PESO [ ] TALLA [ ]

VIGILANCIA DEL PUERPERIO

No. de Visita	1	2	3	4	5
Fecha					
Días Postparto					
Temperatura					
Pulso					
Presión Arterial					
Sangrado Vaginal (cantidad)					
Loquidos					
Molestias y otros...describir...					
Referencia					
RECIEN NACIDO					
Edad					
Peso					
Muñón umbilical sano					
Muñón umbilical infectado					
Signos de peligro de infección					
Signos de peligro de bajo peso					
Otras enfermedades					
Lactancia materna					
Referencias					

D:\123R3\FILES\INFORMAR.WK1 MM/CEG

PROMOTOR _____

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI

NOMINA DE MUJERES CON TOXOIDE TETANICO

ONG:_____

No. VIVIENDA	NOMBRE	EDAD	MUJERES TOXOIDE				
			TT-1	TT-2	TT-3	TT-4	TT-5

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI/MSCI/USAID

Pretabulador Diario de Actividades del Trabajador(a) en Salud – 1994

ONG: _____

MUNICIPIO (S): _____ CANTON: _____ CASERIO: _____

RESPONSABLE: _____ FECHA: _____

ACTIVIDADES		////// NUMERO //////	TOTAL
V.1. Crecimiento y Desarrollo del niño menor de 1 año	Total de atenciones de crecimiento y desarrollo (A+B)		
	A – Primera atención		
	B – Seguimiento		
	C – No. con peso normal		
	D – No. con Desnutrición Leve		
	E. – No. con Desnutrición Moderada y Severa		
V.2. Crecimiento y Desarrollo del niño de 1 a 4 años	Total de atenciones de crecimiento y desarrollo (A+B)		
	A – Primera atención		
	B – Seguimiento		
	C – No. con peso normal		
	D – No. con Desnutrición Leve		
	E – No. con Desnutrición Moderada y Severa		
VI. Otras atenciones en niños de 0 a 4 años	No. de Atendidos		
	No. de Referencias		
VII. No. de Visitas Domiciliarias realizadas			

******** RECUERDE **********

En el Tabulador Diario Para Informe Mensual de Actividades del Trabajador(a) en Salud 1994 se registraran los siguientes datos que no aparecen consignados en este pretabulador:
No. de muertes por diarrea aguda
No. de muertes por IRA
Total de partos en la comunidad (A+B)
No. de muertes en el embarazo, parto y puerperio
No. de muertes de recién nacidos
VIII. Participación Comunitaria
IX. Educación Comunitaria

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI/MSCI/USAID

Pretabulador Diario de Actividades del Trabajador(a) en Salud – 1994

ONG:

MUNICIPIO (S): **CANTON:** **CASERIO:**

RESPONSABLE: **FECHA:**

	ACTIVIDADES	////// NUMERO //////	TOTAL
I. Enfermedad Diarreica Aguda en niños de 0 a 4 años	Total de Casos nuevos Atendidos por diarrea (A+B+C)		
	A – Diarrea sin deshidratación		
	B – Diarrea con deshidratación		
	C – Diarrea con deshidratación con shock		
	No. de Atenciones de seguimiento		
	No. de Referencias		
II. Infecciones Respiratorias Agudas en niños de 0 a 4 años	Total de Casos nuevos atendidos por IRA (A+B+C+D+E+F)		
	A – Casos con enfermedad muy grave		
	B – Casos con Neumonía Grave		
	C – Casos con neumonía		
	D – Casos con Tos o resfriado		
	E – Casos con problema de oidos		
	F – Casos con dolor de garganta		
	No. de Atenciones de seguimiento		
	No. de referencias		
III. Salud Reproductiva	Total de atenciones prenatales (A+B)		
	A – De primera vez		
	B – Seguimiento		
	C – Con signos de peligro		
	Total de atenciones a puérperas (A+B)		
	A – De primera vez		
	B – Seguimiento		
	C – Con signos de peligro		
	Total atenciones para espaciamiento de nacimientos (A+B)		
	A – De primera vez		
	B – Seguimiento		
	C – No. de ciclos de anticonceptivos orales entregados		
	D – No. de condones entregados		
	Total de referencias por signos de peligro		
IV. Salud del Recién Nacido (0–28 días)	Total de Atenciones a recién nacidos (A+B)		
	A – De primera vez		
	B – Seguimientos		
	No. de niños con signos de peligro de infección		
	No. de niños con menos de 2500 grs. de peso		
	No. de Referencias por signos de peligro		

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI) MSCI/USAID
Tabulador Diario Para Informe Mensual de Actividades del Trabajador(a) en Salud 1994

ONG: _____ RESPONSABLE: _____ MES: _____ AÑO: _____

MUNICIPIO: _____ CANTON: _____ CASERIO: _____

	ACTIVIDADES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
I. Enfermedad Diarreica Aguda en niños de 0 a 4 años	Total de casos nuevos atendidos por diarrea (A+B+C)																																
	A- Diarrea con deshidratación																																
	B- Diarrea con deshidratación																																
	C- Diarrea con deshidratación con shock																																
	No. de Atenciones de seguimiento																																
	No. de Referencias																																
	No. de muertes por diarrea aguda																																
II. Infecciones Respiratorias Agudas en niños de 0 a 4 años	Total de casos nuevos atendidos por IRA (A+B+C+D+E+F)																																
	A- Casos con enfermedad muy grave																																
	B- Casos con neumonía grave																																
	C- Casos con neumonía																																
	D- Casos con Tos o resfriado																																
	E- Casos con problema de oído																																
	F- Casos con dolor de garganta																																
	No. de Atenciones de seguimiento																																
	No. de referencias																																
	No. de muertes por IRA																																
III. Salud Reproductiva	Total de Atenciones Prenatales (A+B)																																
	A- De primera vez																																
	B- Seguimiento																																
	C- Con signos de peligro																																
	Total de partos en la comunidad (A+B)																																
	A- Atendidos por personal capacitado																																
	B- Por otros																																
	Total de atenciones a puérperas (A+B)																																
	A- De primera vez																																
	B- Seguimiento																																
	C- Con signos de peligro																																
	Total atenciones para espaciamiento de nacimientos (A+B)																																
	A- De primera vez																																
	B- Seguimientos																																
	C- No. de ciclos anticonceptivos orales entregados																																
	D- No. de condones entregados																																
	Total de referencias por signos de peligro																																
	No. de muertes en el embarazo, parto y puerperio																																
IV. Salud del Recién Nacido: (0 a 28 días)	Total de atenciones a recién nacidos (A+B)																																
	A- De primera vez																																
	B- Seguimientos																																
	No. de niños con signos de peligro de infección																																
	No. con menos de 2500 grs. de peso																																
	No. de referencias por signos de peligro																																
	No. de muertes de recién nacidos																																

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI) MSCI/USAID
Tabulador Diario Para Informe Mensual de Actividades del Trabajador(a) en Salud 1994

ONG: _____ RESPONSABLE: _____ MES: _____ AÑO: _____

MUNICIPIO: _____ CANTON: _____ CASERIO: _____

	ACTIVIDADES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
V.1. Crecimiento y Desarrollo del niño menor de 1 año	Total de atenciones de crecimiento y desarrollo (A+B)																																
	A- Primera atención																																
	B- Seguimiento																																
	C- No. con peso normal																																
	D- No. con desnutrición leve																																
	E- No. con desnutrición moderada y severa																																
V.2. Crecimiento y Desarrollo del niño de 1 a 4 años	Total de atenciones de crecimiento y desarrollo (A+B)																																
	A- Primera atención																																
	B- Seguimiento																																
	C- No. con peso normal																																
	D- No. con desnutrición leve																																
	E- No. con desnutrición moderada y severa																																
VI. Otras Atenciones en niños de 0 a 4 años	No. de Atendidos																																
	No de Referencias																																
VII No. de visitas domiciliarias realizadas																																	
VIII. Participación Comunitaria	No. de comités de salud activos																																
	No. de otros grupos organizados																																
	No. de voluntarios activos																																
	No. de hombres dados por la comunidad (perm. y trans.)																																
	No. de proyectos en gestión																																
	No. de campañas																																
	No. de asambleas																																
	No. de reuniones con comité de salud																																
IX. Educación Comunitaria	Total de Sesiones a grupos : (mas que 5 personas)																																
	No. sobre diarrea, parásitos y saneamiento																																
	No. sobre IRA																																
	No. sobre Salud Materna/Repr. Humana																																
	No. sobre Salud Perinatal/Neonatal																																
	No. sobre Inmunizaciones																																
	No. sobre Nutrición, Crec. y Desarrollo																																
	No. sobre Participación Comunitaria																																

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REGISTRO MENSUAL DE ATENCIONES POR TRABAJADOR DE :

CANTON: _____ POBLACION TOTAL: _____ MES: _____ AÑO: 19____

Nombre del usuario	Fecha	Edad	Peso (kg)	Consulta por:	Signos de Enfermedad	Clasificación de la Enfermedad	Tratamiento

ANNEX G-9.

Promoter Protocols & Guide Sheets

PLAN B
PARA TRATAR DESHIDRATACION POR VIA ORAL

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

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

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

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

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

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

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

SI LA MADRE O FAMILIAR DEBE IRSE ANTES DE COMPLETAR TRATAMIENTO

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

PLAN C
TRATAMIENTO RAPIDO DE LA DESHIDRATACION CON SHOCK

¿Puede administrar líquidos EV inmediatamente?

SI →

- Comience EV inmediatamente. Intente administrar suero oral mientras se consigue iniciar EV.

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

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

NO ↓

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

SI →

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

NO ↓

¿Sabe usar sonda nasogástrica?

SI →

- Comience suero oral por la sonda -20 - 30 ml/kg/hora, hasta total de 120 ml/kg.
- Evalúe al paciente continuamente.
  - Si muestra señales de recuperación, continue el tratamiento.
  - Si vomita, o presenta distención abdominal, dele 5 - 20 ml/kg/hora.
  - Si no mejora después de 2 horas, enséñele a administrar el suero durante el camino y refiérelo para tratamiento EV.

NO ↓

Urgente: Refiera para EV ó sonda nasogástrica

SI →

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

En los casos de deshidratación sin shock en que es necesario utilizar la vía endovenosa, puede administrarse 25 ml/kg/hora EV hasta que desaparezca la condición que motivó el uso de la vía endovenosa.

NOTA:
- Es mejor observar al paciente durante 6 horas, por lo menos, después de completar hidratación, y asegurarse que la madre o familiar pueden mantenerlo hidratado con suero oral y pueden alimentarlo.

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MANEJO DEL PACIENTE CON DIARREA

Use este cuadro para evaluar pacientes con:
- **Diarrea líquida**
- **disentería**

PROSAMI
PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
SERVICIO MEDICO INTERNACIONAL
U.S.A.I.D

ORGANIZACION PANAMERICANA DE LA SALUD
Oficina Sanitaria Panamericana
Oficina Regional de la
ORGANIZACION MUNDIAL DE LA SALUD

CONTROL DE LAS ENFERMEDADES DIARREICAS

Cuidados en el Hogar para un Niño con IRA

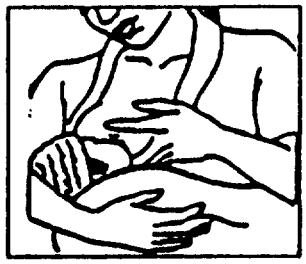
Menor de 2 Meses

Signos más importantes: **Vigile los siguientes signos o señales de peligro y si aparecen busque ayuda inmediatamente.**

- La respiración se dificulta aún más.
- La respiración se vuelve más rápida.
- La alimentación se dificulta.
- El estado general del niño empeora.

Mantenga al niño abrigado.

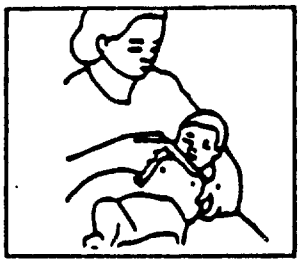
Déle de mamar frecuentemente.



Límpiele la nariz si es obstruida y eso dificulta la alimentación.

De 2 Meses a 5 Años

Signos más importantes: **Vigile los siguientes signos y si aparecen busque ayuda inmediatamente.**

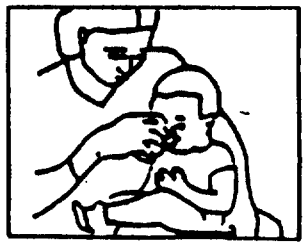


- La respiración se hace más difícil.
- La respiración se vuelve más rápida.
- El niño no puede beber.
- El estado general del niño empeora.

Estos son signos de Neumonía.

Alimente al niño.
Alimente al niño durante la enfermedad.
Aumente las comidas del niño después de la enfermedad.
Limpie la nariz si eso le dificulta la alimentación.

Aumente los líquidos.
Ofrezca más líquidos al niño.
Aumente la lactancia materna.



Suavice la garganta.
Déle al niño agua y miel.

INSTRUCCIONES PARA EL TRATAMIENTO

» *Recete un antibiótico oral para la neumonía*

. Dé la primera dosis de antibiótico en la clínica o dispensario.
. Enseñe a la madre cómo administrar el antibiótico durante siete días en la casa.

EDAD O PESO	COTRIMOXAZOL »Trimetoprim + Sulfametoxazol Dos veces al día por 7 días	AMOXICILINA »Tres veces al día durante 7 días	*Para la Infección Aguda del oído*
	Jarabe (40 mg trimetoprim + 200 mg Sulfametoxazol por cucharadita) (5 ml)	Suspensión 250 mg en una cucharadita (5 ml)	***Seque el oído con mechas*** . Enrolle en forma de mecha una tela limpia y absorbente. . Coloque la mecha en el oído del niño. . Retire la mecha cuando esté mojada. . Reemplace la mecha con otra limpia hasta que el oído quede seco.
Menor de 2 meses (<5 Kg) debe ser referido urgentemente al hospital.			
De 2 a 6 meses (5–7 Kg)	1/2 cucharadita	1/4 de cucharadita (1.25 ml)	
De 6 a 11 meses (7–9 Kg)	1 cucharadita	1/2 cucharadita (2.5 ml)	
De 1 a 4 años (10 – 19 Kg)	1 y media a 2 cucharaditas	3/4 a 1 cucharadita (3.75 a 5 ml)	

» *Enseñe a la madre a cuidar el niño en la casa*

- Alimente al niño
  - Aliméntelo durante la enfermedad
  - Aumente los alimentos después de la enfermedad
- Aumente los líquidos
  - Ofrézcale al niño más líquidos que de costumbre
  - Aumente la lactancia materna
- Límpiele la nariz
- Alivie la tos con remedios caseros
- Vigile si muestra las siguientes señales de peligro y regrese rápidamente si ocurren:
  - »Respira con dificultad
  - »Respira rápidamente
  - »No puede beber
  - »La salud del niño empeora

Este niño puede tener neumonía

» *Trate la fiebre y/o dolor*

.Fiebre alta. Mayor o igual a 38.5° (axilar)	La fiebre no es alta. (38–38.5°C) (axilar)
» Dele acetaminofén	» Dígale a la madre que le dé más líquidos

. Fiebre por mas de 5 días
»Remítalo para una evaluación

ACETAMINOFEN cada 6 horas 15 mg/kg/dosis	
EDAD	JARABE 160 mg/por cucharadita 5 ml
Niños entre	
2 y 3 meses	1/2 cucharadita = (2.5 ml)
4 y 10 meses	3/4 de cucharadita = (3.75 ml)
11 y 24 meses	1 cucharadita = (5 ml)
25 y 36 meses	1.5 de cucharadita = (7.5 ml)
37 y 60 meses	2 cucharaditas = (10 ml)

. Si solo tiene fiebre, no se justifica dar antibiótico.

. Un lactante pequeño (menor de 2 meses) con fiebre refiéralo urgentemente al hospital.

»*Dé un antibiótico para infección estreptocócica de la garganta*

De penicilina benzatina Dosis por Kg de peso 50.000 U/Kg/dosis. Una sola inyección.

1a. – 5 años 600.000 unidades

6a. – 9 años 900.000 unidades

Mayor de 9 años 1,200.000 unidades

O dé amoxicilina durante 10 días.

Dé acetaminofén para el dolor y la fiebre.

»*TRATE LA SIBILANCIA*

(Ruido respiratorio al espirar)

Niños con el primer episodio de sibilancia

Si tiene "urgencia respiratoria"* refiéralo

Si no tiene "urgencia respiratoria" dele jarabe de salbutamol

Niños con sibilancia a repetición (asma)

Si:	Entonces:
Tiene "urgencia respiratoria" o cualquier señal de peligro	Trate como NEUMONIA grave o como ENFERMEDAD muy grave. Refiéralo
No tiene "urgencia Respiratoria" y: Respira rápido	Trate como NEUMONIA y dele jarabe de Salbutamol.
No respira rápido	Trate como NO ES NEUMONIA: TOS O REFRIADO y dele jarabe de Salbutamol.

*URGENCIA RESPIRATORIA: Incomodidad o inquietud producida por no entrar aire suficiente a los pulmones debido al estrechamiento de los bronquios.

• JARABE DE SALBUTAMOL 3 veces al día durante 7 días	
Edad o Peso	Jarabe 2 mg en 5 ml
de 2 a 11 meses (menos de 10 kg)	2.5 ml (1/2 cucharadita)
de 1 a 4 años (10 a 19 kg)	5 ml (1 cucharadita)

TARJETA PARA PROMOTORES PARA TRATAMIENTO DE NIÑOS CON INFECCIONES RESPIRATORIAS AGUDAS

NEUMONIA GRAVE	NEUMONIA	NO NELMONIA TOS O CATARRO
Refieralo urgentemente al hospital	Dele un antibiótico apropiado	Explíque cuidados en casa
Dele la 1ª dósis de antibiótico	Dele acetaminofén si hay fiebre	Desobstruir la nariz con gotas
Dele salbutamol si hay sibilancia	Dele salbutamol si hay sibilancia	Dele acetaminofén si hay fiebre
	Explíque cuidados en casa y pida un control en 2 dias	Dele salbutamol si hay sibilancia

Cuadro para la Clasificación y Manejo de un Niño Menor de 2 Meses con Tos y/o Dificultad para Respirar

Verifique si el niño es menor de 2 meses y si tiene tos o dificultad para respirar.

Cuente las respiraciones en un minuto. Repita la cuenta si la respiración es rápida (60 o más).

¿Hay algún signo de peligro?

- Se alimenta menos de lo normal.
- Convulsiones.
- Difícil de despertar.
- Fiebre o temperatura baja.

SI → **Enfermedad Muy Grave**

- Refiera urgentemente al hospital.
- Mantenga abrigado al niño.
- Administre la primera dosis de Cotrimoxazole.

NO → **¿Hay tiraje severo o respiración rápida? (60 o más en 2 conteos)**

SI → **Neumonía Grave**

- Refiera urgentemente al hospital.
- Mantenga abrigado al niño.
- Administre la primera dosis de Cotrimoxazole.

NO → **Tos o Resfriado (No Neumonía)**

- Enseñe a la familia los cuidados en el hogar.

Si la referencia no es posible,

- Enseñe a la familia cómo dar el Cotrimoxazole.
- Enseñe a la familia cómo dar cuidados en el hogar.
- Dele seguimiento diario al niño.
- Si la salud del niño empeora durante el seguimiento, refiéralo urgentemente.
- Si el niño no mejora en dos días, refiéralo urgentemente.

Uso del Cotrimoxazole suspensión (40/200/5 ml)

- Dosis: de 0 a 1 mes de edad, 1/4 cdita. (=1.25 ml; 25 gotas); de 1 a 2 meses de edad, 1/2 cdita. (=2.5 ml, 50 gotas).
- Administre la primera dosis al referir al niño.
- Si la referencia no es posible, administre la dosis 2 veces al día por 7 días.
- Repita la dosis si el niño vomita en los 30 minutos siguientes a la ingestión de la dosis.

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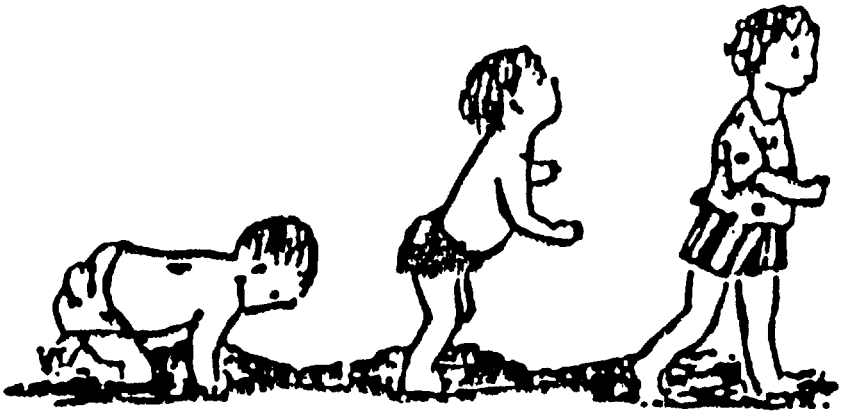
Cuadro para la Clasificación y Tratamiento de un Niño de 2 Meses a 5 Años con Tos o Dificultad para Respirar

Pregunte si el niño tiene de 2 meses a 5 años de edad y si tiene tos o dificultad para respirar.

Cuente las respiraciones en un minuto. Repita la cuenta si la respiración es rápida:
40 o más (1 a 4 años).
50 o más (2 a 11 meses).



¿Hay algún signo de peligro?

- No puede beber.
- Convulsiones.
- Difícil de despertar.
- Desnutrición severa.

SI → **Enfermedad Muy Grave**
- Refiera urgentemente al hospital.
- Administre la primera dosis de Cotrimoxazole.
- Si la referencia no es posible, trátelo como neumonía.

NO → **¿Hay tiraje?**

SI → **Neumonía Grave**
- Refiera urgentemente al hospital.
- Administre la primera dosis de Cotrimoxazole.
- Si la referencia no es posible, trátelo como neumonía.

NO → **¿Hay respiración rápida?**
- 40 o más (1 a 4 años)
- 50 o más (2 a 11 meses)

SI → **Neumonía**
- Enseñe cómo dar el Cotrimoxazole.
- Enseñe cómo cuidar al niño en el hogar.
- Dé seguimiento cada 1 ó 2 días al niño.

NO → **Tos o Resfriado (No Neumonía)**
- Trate la fiebre.
- Si la tos es de más de 30 días de duración, refiéralo.
- Enseñe los cuidados en el hogar.

Uso del Cotrimoxazole Suspensión de 40/200/5 ml.

- Dosis. De 2 meses a 1 año: 1 cdita.
  de 1 a 5 años: 1 y media cdita.
- Dé 2 veces al día, por 7 días.
- Repita la dosis si el niño la vomita en los 30 minutos siguientes a la ingestión.

En cada visita:

- Asegúrese de que el paciente esté recibiendo el Cotrimoxazole y los cuidados en el hogar.
- Verifique si hay signos de peligro, tiraje o respiracón rápida.
- Refiéralo urgentemente si:
  - hay signos de peligro.
  - aparece el tiraje.
  - la respiración se hace más rápida.
- Refiérase si no mejora en 2 días de tratamiento.

ESQUEMA REGULAR DE VACUNACION

VACUNA	PROTECCION CONTRA	EDAD DE APLICACION	DOSIS Y VIA DE ADMINISTRACION
B.C.G.	FORMAS GRAVES DE TUBERCULOSIS	AL NACER.	0.1 CC INTRADERMICA
ANTI POLIOMIELITICA	POLIOMIELITIS (PARALISIS INFANTIL)	AL NACER DOS MESES CUATRO MESES SEIS MESES 1 AÑO 6 MESES 4 AÑOS 6 MES.	DOS GOTAS VIA ORAL BLOQUEO 1a. DOSIS 2a. DOSIS 3a. DOSIS 1º REFUERZO 2º REFUERZO
D.P.T.	DIFTERIA TOSFERINA TETANOS	2 MESES 4 MESES 6 MESES 1 AÑO 6 MESES 4 AÑOS 6 MESES	0.5 CC INTRAMUSCULAR 1a. DOSIS 2a. DOSIS 3A. DOSIS 1º REFUERZO 2º REFUERZO
ANTI SARAMPIONOSA	SARAMPION	9 MESES	0.5 CC SUBCUTANEA DOSIS UNICA

A TODO NIÑO QUE NO PUEDA PRESENTAR SU CARNET DE VACUNACION SE LE CONSIDERARA COMO NO VACUNADO Y SE INICIARA EL ESQUEMA. EL PONER MAS VACUNAS DE LAS QUE SE PONEN NORMALMENTE, NO REPRESENTA PELIGRO PARA EL NIÑO SINO PROTECCION.

RECUERDE QUE LA FIEBRE, LA TOS, LA DIARREA, LOS VOMITOS, INFECCIONES PEQUEÑAS DE LA PIEL Y LA DESNUTRICION NO SON IMPEDIMENTO PARA QUE EL NIÑO SE VACUNE.

PRIMERO EVALUE EL ESTADO DE HIDRATACION DE SU PACIENTE

1. OBSERVE CONDICION OJOS LAGRIMAS BOCA Y LENGUA SED	BIEN ALERTA Normal	INTRANQUILO, IRRITANTE Hundidos Ausentes Secas SEDIENTO, BEBE RAPIDO Y AVIDAMENTE	"COMATOSO"; "HIPOTONICO" Muy hundidos y secos Ausentes Muy secas "BEBE MAL O NO ES CAPAZ DE BEBER"
2. EXPLORE SIGNO DEL PLIEGUE		DESAPARECE LENTAMENTE	"DESAPARECE MUY LENTAMENTE" (>2 segundos)
3. DECIDA:		Si presenta dos o más signos, TIENE DESHIDRATACION	Si presenta dos o mas signos incluyendo por lo menos un "signo" llene DESHIDRATACION GRAVE. ESTADO COMATOSO INDICA SHOCK.
4. TRATE:	Use Plan A Pase al niño.	Use Plan B Pase al niño, si es posible.	Use Plan C Pase al niño.

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

LUEGO IDENTIFIQUE OTROS PROBLEMAS

PREGUNTE SI TIENE SANGRE EN LAS HECES	**EN CASO POSITIVO** • Trátelo por cinco días con el antibiótico recomendado para Shigella en su área. • Enseñe a la madre a administrar líquidos y a alimentar al niño, como se describe en el Plan A. • Controle al niño 2 días después. • Si aún hay sangre en las heces, después de 2 días de tratamiento, cambie a un segundo antibiótic recomendado para Shigella. Dele por 5 días. Si persiste sangre inicie Metronidazol.
PREGUNTE CUANDO COMENZO LA DIARREA	**SI LLEVA POR LO MENOS 14 DIAS DE EVOLUCION:** • Refiérelo al hospital: – si es menor de seis meses – si presenta deshidratación, hidrátelo primero y remítalo al hospital • Si no lo refiere, enseñe a la madre cómo administrar líquidos y alimentar al niño según Plan A. – asegure ingesta calórica alta, dando 6 comidas al día – cite al niño cinco días después: si la diarrea continúa, refiera al hospital; Si la diarrea paró, indique a la madre: • Continuar los alimentos de dieta regular y • dar 1 comida extra al día hasta que el niño alcance el peso adecuado.
OBSERVE SI TIENE DESNUTRICION GRAVE	**SI TIENE DESNUTRICION GRAVE:** • Inicie hidratación oral y refiérelo a un hospital • Entregue a la madre suficiente suero oral, e indíquele darlo continuamente durante el viaje.
PREGUNTE POR FIEBRE Y TOME LA TEMPERATURA	**SI LA TEMPERATURA ES 39° C O MAS:** • busque otros problemas – en ausencia de otros síntomas y si hay malaria por: P. falciparum en su área, administre un antimalárico (de acuerdo con el programa contra malaria).

USO DE MEDICAMENTOS EN NIÑOS CON DIARREA

- **ANTIBIOTICOS** deben usarse sólo para disenteria y cólera. En otras condiciones son ineficaces y no deben prescribirse.
- **ANTIPARASITARIOS** deben usarse sólo para:
  - **Amebiasis**, después que el tratamiento de disenteria por Shigella ha fracasado, o en casos en que identifican en las trofozoitos de E. histolytica conteniendo glóbulos rojos en su interior.
  - **Giardiasis**, cuando diarrea tarda 14 días o más y se identifican quistes o trofozoitos en heces, o esprúe intestinal.
- **"ANTIDIARREICOS" Y ANTIEMETICOS**, no deben usarse nunca.

USE ESTE PLAN PARA ENSEÑAR A LA FAMILIA A:

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

EXPLIQUE LAS TRES REGLAS PARA TRATAR DIARREA EN EL HOGAR

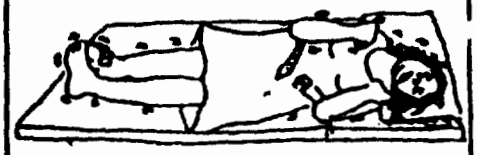
1. **DAR MAS LIQUIDOS DE LO USUAL PARA PREVENIR DESHIDRATACION**
   - Usar líquidos caseros recomendados, o suero oral después de cada evacuación.
2. **DAR SUFICIENTE ALIMENTOS PARA PREVENIR DESNUTRICION**
   - Continuar: lactancia materna.
   - Si no mama, continuar la leche usual.
   - En mayores de 4 meses, que reciben alimentos sólidos, y en adultos, dar la dieta corriente.
3. **LLEVAR AL PACIENTE AL TRABAJADOR DE SALUD, SI NO PARECE MEJORAR DESPUES DE 2 DIAS, O SI PRESENTA CUALQUIERA DE LOS SIGUIENTES SIGNOS:**
   - Muchas evacuaciones intestinales líquidas
   - Vomitos o repetición
   - Sed intensa
   - Come o bebe poco
   - Fiebre
   - Sangre en las heces

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

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Conocer los Signos de Peligro de Toxemia Durante el Período Prenatal, Parto y Post-parto

LA TOXEMIA: La toxemia es la primera causa de la muerte materna en nuestro país. Es una condición que se marca por señas de alta presión e hinchazón y que puede causar convulsiones (ataques) si no se da un tratamiento rápido. Los signos de la toxemia son los siguientes:

SIGNOS	OBSERVAR Y PREGUNTAR	QUE HACER
Hinchazón de la Cara y Manos	Están hinchadas la cara y las manos.	CUALQUIERA DE ESTOS SIGNOS ES UNA EMERGENCIA MEDICA. HAY QUE LLEVAR A LA MUJER INMEDIATAMENTE A UNA CLINICA O AL HOSPITAL.
Dolor de Cabeza con Estrellitas o Manchas en la Visión	El dolor viene con estrellitas o manchas de la visión.	
Dolor en el Abdomen	Tiene dolor en el vientre, en la parte arriba de la derecha.	
Aumento Rápido de Peso	Aumenta de peso en una forma rápida.	
Ataques/Convulsiones 	Tiene ataques o convulsiones.	

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Factores de Riesgo para la Mujer Antes del Inicio del Embarazo

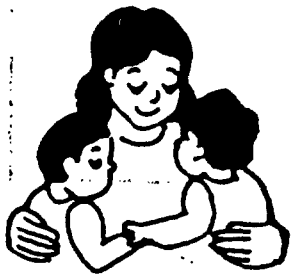
Un factor de riesgo es algo que pone en peligro la salud o la vida de la persona. Ciertamente hay factores de riesgo que pueden determinarse. Cualquiera de ellos hace que el embarazo sea más peligroso para la madre y para el niño. La mujer y su familia lo deben de conocer antes del embarazo para actuar oportunamente y buscar atencion médica.

Riesgo No 1: Mujeres menores de 18 años o mayores de 35.

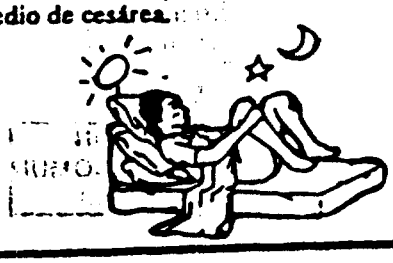
Riesgo No 2: Haber tenido cuatro o más hijos.
Riesgo No 3: Intervalo menor de dos años desde el último parto.

Riesgo No 4: Haber presentado una fuerte hemorragia en el último parto.
Riesgo No 5: Haber tenido anteriormente un aborto espontaneo o provocado o que el último niño nacio muerto o que muriera a las pocas horas del parto.

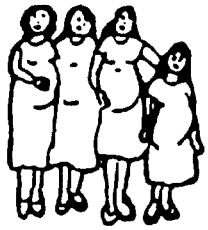
Riesgo No 6: Haber tenido gemelos o embarazo múltiples.



Riesgo No 7: El último parto fuerolongado o por medio de cesárea.



Riesgo No 8: Estatura inferior a 145 cm.



Riesgo No 9: Peso menor de 90 libras o mayor de 176libras.
Riesgo No 10: Tener anemia o desnutrición.

Riesgo No 11: Haber tenido parto prematuro o que el niño pesara menos de 5.5 libras.

Riesgo No 12: Tener alguna enfermedad crónica o degenerativa

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Preventing Maternal Deaths WHO Geneva 1988
Interventions to Improve Maternal and Neonatal Health WHO Geneva 1987

EVALUACION, CLASIFICACION Y MANEJO DE LA EMBARAZADA EN LA COMUNIDAD

EN TODA EMBARAZADA DETECTADA LLENAR HOJA DE VIGILANCIA PARA EVALUAR:

ANTECEDENTES
DATOS DE EMBARAZO ACTUAL
SIGNOS DE PELIGRO

SIGNOS DE PELIGRO:

- CESAREA ANTERIOR
- RECIEN NACIDO MUERTO EN EMBARAZOS ANTERIORES
- TIPO DE SANGRE RH NEGATIVO EN MADRE CON RH POSITIVO EN PADRE
- INCREMENTO DE PESO ANORMAL EN EMBARAZO ACTUAL
- TENSION ARTERIAL ARRIBA DE 140 LA MAXIMA Y ARRIBA DE 90 LA MINIMA
- ALTURA UTERINA ANORMAL
- FALTA DE MOVIMIENTOS FETALES
- PRESENTACION NO CEFALICA
- FRECUENCIA CARDIACA FETAL ANORMAL (V.N.=120-160/M)
- SANGRADO GENITAL
- SALIDA LIQUIDO POR VAGINA, CON OLOR A LEGIA (RUPTURA DE FUENTE)
- DOLOR DE CABEZA INTENSO
- EDEMA (HINCHAZON DE CARA Y MANOS)
- MAL DE ORIN (ARDOR AL ORINAR)
- DOLORES DE PARTO ANTES DE 38 SEMANAS
- TEMPERATURA ARRIBA DE 38 GRADOS
- OTROS: PALIDEZ MARCADA (ANEMIA)
  EMBARAZADA CON ENFERMEDAD, QUE LA PONE EN PELIGRO
  EMBARAZOS MULTIPLES YA DETECTADOS
  *PRIMIGESTAS O SEA MUJERES CON PRIMER EMBARAZO
  *MULTIPARAS CON CUATRO PARTOS O MAS

*EN ESTOS CASOS LA REFERENCIA ES AL FINAL PARA LA ATENCION DE PARTO SI NO TIENEN OTRO PELIGRO PREVIO.

CLASIFICACION

SI HAY SIGNOS DE PELIGRO → REFERENCIA A HOSPITAL O CENTRO DE SALUD

NO HAY SIGNOS DE PELIGRO → CONTINUAR CON VIGILANCIA EN LA COMUN SEGUN NORMAS

TARJETA PARA PROMOTORES PARA DIAGNOSTICO DE NIÑOS CON INFECCIONES RESPIRATORIAS AGUDAS

NEUMONIA GRAVE	NEUMONIA	NO NEUMONIA TOS O CATARRO
Tiraje (grave para menos de 2 meses) Respiración rápida: 60 ó más/menor de 2 meses 50 ó más/de 2 a 11 meses 40 ó más/de 1 a 4 años	No Tiraje Respiración rápida: 50 ó más/de 2 a 11 meses 40 ó más/de 1 a 4 años	No Tiraje No respiración rápida

Cuestionario Para la Prescripcion de Anticonceptivos Orales por Distribuidores Comunitarios

Compruebe lo siguiente antes de proporcionar anticonceptivos orales:

		SI	NO
1-	Más de 40 años	___	___
2-	Más de 35 años y muy fumadora	___	___
3-	Ataques de epilepsia	___	___
4-	Fuertes dolores en pantorrillas o muslos	___	___
5-	Varicosidades sintomáticas en las piernas	___	___
6-	Dolores fuertes en el pecho	___	___
7-	Jadeo inhabitual después de un esfuerzo	___	___
8-	Dolores fuertes de cabeza y/o trastornos de la vista	___	___
9-	Si está lactando (sobre todo menos de 6 meses) . . .	___	___
10-	Hemorragias entre las reglas o después de tener relaciones sexuales	___	___
11-	Falta de regla	___	___
12-	Presión sanguínea de 140/90 (si es posible tomarla)	___	___
13-	Durezas o tumores en los senos	___	___
14-	Piernas hinchadas	___	___

INSTRUCCIONES:

- Si todas las respuestas son negativas, se puede prescribir a la mujer anticonceptivos orales.

- Si alguna es afirmativa, es menester que consulte antes al establecimiento.

Conocer los Signos de Peligro de Infección en el Recién Nacido

INFECCION: Los recién nacidos no pueden defenderse bien contra las infecciones y por eso todos debemos de conocer las señas de infección. Cuando un recién nacido tiene una infección, la detección y tratamiento inmediato con antibióticos le pueden salvar la vida. El antibiótico puede estar dado por un médico, enfermera o por un promotor capacitado de su comunidad.

SIGNOS	OBSERVAR Y PREGUNTAR	QUE HACER
Fiebre o Frío	- Tiene fiebre (más de 39C) o está helado (menos de 35C).	CUALQUIERA DE ESTOS SINTOMAS ES UNA EMERGENCIA MEDICA. HAY QUE LLEVAR AL NIÑO INMEDIATAMENTE AL HOSPITAL O CLINICA. También: • Darle de mamar. • Darle suero. • Abrigar al bebé y llevarlo en brazos de la madre.
Ataques/Convulsiones	- Tiene ataques(convulsiones)	
Respiración Rápida con Tiraje	- Tiene la respiración rápida y agitada, y se le hunde la piel debajo de las costillas (tiraje).	
Triste y Dormido o Llorón y Agitado	- El niño está muy triste, débil y dormido o - Está muy agitado y llora mucho.	
No Puede Mamar	- El bebé no tiene fuerza para mamar o deja de mamar durante más de 4 horas, especialmente cuando el bebé también se ve medio dormido o enfermo o si llora y se mueve diferente de lo normal.	

Agradecemos al Colectivo de Mujeres de Matagalpa, Nicaragua por sus dibujos en este boletín.

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Conocer los Signos de Peligro Durante el Período Prenatal, Parto y Post-parto

SIGNOS	OBSERVAR Y PREGUNTAR	QUE HACER
Hemorragia Prenatal	Le empieza a salir sangre durante el embarazo aunque no hay dolor.	EMERGENCIA MEDICA. HAY QUE LLEVARLA INMEDIATAMENTE AL HOSPITAL.
Infección	Tiene fiebre o mucho frío. Siente dolor en el vientre. Manifiesta pulso rápido. Tiene dolor al orinar. Presenta flujo con mal olor.	Hay que dar la primera dosis de antibiótico (ampicilina, 500 mg. oral). CUALQUIERA DE ESTOS SINTOMAS ES UNA EMERGENCIA MEDICA. HAY QUE LLEVARLA INMEDIATAMENTE AL HOSPITAL.
Hemorragia Post-Parto	Sale mucha sangre durante o después del parto y: - La mujer se siente mareada. - Tiene el pulso rápido y débil. - Se siente débil. - Está pálida.	Hacer lo siguiente: 1. Para que salga la placenta, • Hacer masaje del útero (no hacer examen vaginal). • Hacer que la madre orine. 2. Poner al recién nacido a mamar inmediatamente. 3. Dar tratamiento médico (oxitocina, 10 unidades intra-muscular). EMERGENCIA MEDICA. HA QUE LLEVARLA INMEDIATAMEI TE AL HOSPITAL.
Parto Prolongado	Se rompe la fuente de agua y no nace el niño durante un día. La mujer está empujando más de 3 o 4 horas. El parto activo dura más de 12 horas.	Hay que: • Parar el uso de oxitocígenos. • Parar el empuje. CUALQUIERA DE ESTOS SINT MAS ES UNA EMERGENCIA M DICA. HAY QUE LLEVARLA INM DIATAMENTE AL HOSPITAL.

EVALUACION, CLASIFICACION Y TRATAMIENTO DEL RECIEN NACIDO CON INFECCION

EN TODO RECIEN NACIDO DETECTADO
EVALUAR

SIGNOS DE PELIGRO

- FIEBRE O HIPOTERMIA
- DIFICULTAD PARA MAMAR
- LLANTO CONSTANTE, DEBIL O QUEJUMBROSO
- RESPIRACION RAPIDA Y/O TIRAJE
- ONFALITIS
- CONVULSIONES

SI

NO

CLASIFIQUELO COMO

RECIEN NACIDO CON INFECCION

TRATAMIENTO

1. REFIERALO URGENTEMENTE AL HOSPITAL
2. MANTENERLO ABRIGADO

RECIEN NACIDO SIN INFECCION

TRATAMIENTO

1. SEGUIMIENTO SEGUN NORMA
2. MANTENERLO COMODO Y CUBIERTO
3. LACTANCIA MATERNA

EVALUACION, CLASIFICACION Y TRATAMIENTO DEL RECIEN NACIDO DE BAJO PESO

ANTE TODO RECIEN NACIDO DETECTADO

ACCION A TOMAR: → PESARLO

↓

PESA MENOS DE 2500 GRS

↓

RECIEN NACIDO DE BAJO PESO

↓

SIGNOS DE PELIGRO →

- NO TOMA EL PECHO
- HIPOTERMIA
- CIANOSIS O PALIDEZ
- QUEJUMBROSO

SI → **Recién Nacido de Bajo Peso Grave**

NO → **Recién Nacido de Bajo Peso Estable**

Clasifíquelo así:

↓

TRATAMIENTO

1. Refiéralo Urgentemente al hospital
2. Mantenerlo abrigado
3. Trasladarlo, cargándolo tipo canguro

↓

TRATAMIENTO

1. Observación diaria
2. Mantenerlo abrigado
3. Utilizar el método "Madre Canguro"
4. Iniciar pronto lactancia materna
5. Si desmejora, trátelo como recién nacido de Bajo Peso Grave

EVALUACION, CLASIFICACION Y MANEJO DE LA PUERPERA EN LA COMUNIDAD

EN TODA PUERPERA DETECTADA LLENAR HOJA DE VIGILANCIA PARA EVALUAR:

TERMINACION DEL EMBARAZO
DATOS DEL RECIEN NACIDO Y DEL PUERPERIO
SIGNOS DE PELIGRO

SIGNOS DE PELIGRO EN EL PUERPERIO:

- TEMPERATURA DE 38 GRADOS O MAS
- PULSO AUMENTADO SIN FIEBRE (DE 100 O MAS POR MINUTO)
- PRESION ARTERIAL ANORMAL DE 140/90 O MAS, O MENOS DE 95/55
- SANGRAMIENTO VAGINAL MAYOR QUE UNA REGLA
- LOQUIOS FETIDOS
- DOLOR, CALOR Y RUBOR EN SENOS
- OTROS, QUE PONGAN EN PELIGRO EL ESTADO DE LA MUJER

CLASIFICACION

SI HAY SIGNOS DE PELIGRO → REFERENCIA A HOSPITAL O CENTRO DE SALUD

NO HAY SIGNOS DE PELIGRO → CONTINUAR CON VIGILANCIA EN LA COMUN SEGUN NORMAS

ESQUEMA DE VACUNACION PARA NIÑOS NO VACUNADOS DENTRO DEL ESQUEMA REGULAR

EL ESQUEMA PARA NIÑOS QUE NO INICIARON SU VACUNACION EN EL TIEMPO QUE DICE EL ESQUEMA REGULAR ES EL SIGUIENTE:

INTERVALO DE TIEMPO	1 A 5 AÑOS	NIÑOS DE 6 AÑOS O MAS
PRIMERA VISITA	DPT ANTIPOLIOMIELITICA ANTISARAMPIONOSA	Td ANTIPOLIOMIELITICA BCG.
1 MES O 4 SEMANAS DESPUES	DPT, BCG ANTIPOLIOMIELITICA (2ª DOSIS)	ANTISARAMPIONOSA
1 MES O 4 SEMANAS DESPUES DE 2ª DOSIS	DPT, ANTIPOLIOMIE-LITICA (3ª DOSIS)	Td, ANTIPOLIOMIE-LITICA (2ª DOSIS)
1 AÑO MAS TARDE DESPUES DE LA 3ª DOSIS	DPT, ANTIPOLIOMIELITICA (REFUERZO)	Td, ANTIPOLIOMIE-LITICA (REFUERZO)
14 A 16 AÑOS	Td	Td

DEBEMOS FIJARNOS QUE CUANDO AL NIÑO MAYOR DE 5 ANOS SE LE VA A VACUNAR, NO SE USA LA "DPT" SINO OTRA VACUNA QUE SE LLAMA "Td" Y QUE SOLO PROTEGE CONTRA EL TETANOS Y LA DIFTERIA PORQUE LA "DPT" PUEDE HACE DAÑO A ESTA EDAD. LA "Td" SE APLICA USANDO LA MISMA DOSIS Y TECNICA QUE LA "DPT".
NO OLVIDEMOS QUE TODOS LOS MENORES DE 15 AÑOS Y LAS MUJERES EN EDAD FERTIL (ENTRE 15 Y 45 AÑOS) DEBEN ESTAR VACUNADOS.

A LOS NIÑOS QUE SE LES HAYA INICIADO ESQUEMA DE VACUNACION (Y QUE CONSTE EN EL CARNET) Y LO HAYAN SUSPENDIDO POR ALGUNA RAZON, SE LES CONTINUARA A PARTIR DE DONDE LO INTERRUMPIERON.

CONTRAINDICACIONES Y POSIBLES REACCIONES DE LAS VACUNAS

VACUNA	NO VACUNAR A	POSIBLES REACCIONES	PARA ALIVIAR LAS REACCIONES
B.C.G.	*RECIEN NACIDO CON PESO MENOR DE 5 1/2 Lb. (2.5 Kg) *NIÑOS CON QUEMADURAS Y ENFERMEDADES GRAVES DE LA PIEL. *NIÑOS CON ENFERMEDADES GRAVES(INCLUYENDO EL SIDA).	*DESPUES DE ALGUNOS DIAS APARECE EN EL LUGAR DE LA VACUNA UNA PEQUEÑA ULCERA QUE DESPUES FORMA UNA COSTRA Y DESAPARECE.	*NO SE NECESITA NINGUN CUIDADO ESPECIAL.
D.P.T.	NIÑOS QUE HAN PRESENTADO REACCIONES GRAVES A DOSIS ANTERIORES DE DPT, TALES COMO: 1.CONVULSIONES 2.ALERGIA INMEDIATA.	*ENROJECIMIENTO, CALOR, DOLOR EN EL SITIO DE LA INYECCUIB. *FIEBRE.	*APLICAR LIENZOS DE AGUA TIBIA EN EL LUGAR DE LA VACUNA.. *DAR ACETAMINOFEN PARA LA FIEBRE Y EL DOLOR.
ANTI POLIOMIELITICA	NIÑOS EN TRATAMIENTO POR CANCER.	NINGUNA	-
ANTI SARAMPIONOSA	*NIÑOS CON CANCER. *APLICACION RECIENTE DE INMUNOGLOBULINAS (MENOS DE 3 MESES).	*FIEBRE ENTRE 1º y 2º DIAS DESPUES DE LA VACUNA. *MANCHAS ROSADAS ESCASAS EN EL CUERPO.	*DAR ACETAMINOFEN PARA BAJAR LA FIEBRE.

RECUERDE QUE SI NO MEJORAN LAS MOLESTIAS EN DOS DIAS DEBE RECOMENDARLE A LOS PADRES DEL NIÑO QUE ACUDAN AL ESTABLECIMIENTO DE SALUD MAS CERCANO.

ESQUEMA DE VACUNACION PARA MUJERES EMBARAZADAS Y EN EDAD FERTIL

VACUNA: TOXOIDE TETANICO (TT)	CUANDO APLICAR LA VACUNA
TT-1	LO ANTES POSIBLE A LA EMBARAZADA Y A LAS MUJERES EN EDAD FERTIL.
TT-2	4 SEMANAS DESPUES DE TT-1 (DESPUES DE LA 1ª DOSIS)
TT-3	6 MESES DESPUES DE TT-2 (DESPUES DE LA 2ª DOSIS)
TT-4	1 AÑO DESPUES DE TT-3 (DESPUES DE LA 3ª DOSIS)
TT-5	1 AÑO DESPUES DE TT-4 (DESPUES DE LA 4ª DOSIS)

ESTE ES EL NUEVO ESQUEMA DE VACUNACION PARA MUJERES EN EDAD FERTIL Y EMBARAZADAS PERO PUEDE USARSE TAMBIEN EN HOMBRES.

ANNEX G-10.

Monthly Technical Report Forms Sent by NGO to PROSAMI

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL

PROSAMI, MSCI.

CUADRO DE EVALUACION MENSUAL DE CASOS DE IRA.

ONG: MES:

NOMBRE DEL PROMOTOR																					
No. de casos de IRA / Porcentaje		%		%		%		%		%		%		%		%		%		%	
1 Enfermedad muy grave	(1/11)																				
2 Neumonia Grave	(2/11)																				
3 Neumonia	(3/11)																				
4 No Neumonia	(4/11)																				
5 Problema de oidos	(5/11)																				
6 Dolor de garganta	(6/11)																				
7 Seguimiento	(7/1+2+3)																				
8 Referidos	(8/1+2)																				
9 Tratado con antibiótico	(9/11)																				
10 Muertes por IRA																					
11 Total de casos de IRA																					

MARCO DE ANALISIS	OBJETIVO DE ANALISIS
Clasificación diagnóstica de los casos de IRA atendidos por el trabajador de salud Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre el comportamiento de las diferencias en la presentación de los datos	Detectar problemas en la calidad de la detección y necesidades de refuerzo en la capacitación sobre el uso de gráficos para la clasificación de casos de IRA.
El Uso Adecuado de los Antibióticos Es importante reflexionar y verificar el registro de uso de los antibióticos en el tratamiento estandarizado para los casos de IRA.	Detectar problemas de abuso en el manejo de los antibióticos y necesidades de capacitaciones de refuerzo sobre el manejo estandarizado de casos de IRA.
Referencias Los referidos deben analizarse según los siguientes criterios: 1. Si la referencia fue cumplida por el usuario y recibió tratamiento hospitalario. 2. Si la referencia no fue cumplida y se curó con tratamiento estandarizado en la comunidad Verificar las referencias por Enfermedad Muy Grave y Neumonía Grave y el resultado de las mismas.	Determinar el funcionamiento del sistema de referencia y contrarreferencia y detectar problemas de clasificación de los casos referidos para fortalecer oportunamente la capacitación y mejorar el sistema de referencia para los casos que necesitan manejo hospitalario.
Mortalidad por IRA Las muertes deben analizarse según los siguientes criterios: 1. Si la muerte ocurrió sin haber recibido atención por ningún trabajador de salud. 2. Si la muerte ocurrió por atención tardía o por no cumplir con la referencia. 3. Si la muerte ocurrió por manejo inadecuado del caso. La revisión de las muertes deben incluir la ubicación en el mapa de riesgo y la determinación de los factores de riesgo biológicos, ambientales y socioeconómicos o estructurales que condicionaron la muerte.	Detectar problemas de acceso al servicio para proporcionar tratamiento estandarizado en el área de responsabilidad del trabajador de salud (antibióticos, referencia, etc.) y retomar el Enfoque de Riesgo como método de reflexión y tambien como Estrategia para atacar las causas de morbimortalidad en el siguiente período de Ejecución del Plan de acción.

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI, MSCI.
CUADRO DE EVALUACION MENSUAL DE CASOS DE EDA.

ONG: MES:

NOMBRE DEL PROMOTOR																					
No. de casos / Porcentaje			%		%		%		%		%		%		%		%		%		%
1	Diarrea sin deshidratación (1/8)																				
2	Diarrea con deshidratación (2/8)																				
3	Diarrea con deshidrat. y shock (3/8)																				
4	Seguimiento (4/2+3)																				
5	Referidos (5/2+3)																				
6	Tratado con antibiótico (6/8)																				
7	Muertes por EDA																				
8	Total de casos de EDA																				

MARCO DE ANALISIS	OBJETIVO DE ANALISIS
Clasificación diagnóstica de los casos de EDA vistos por el trabajador de salud	
Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre el comportamiento de las diferencias en la presentación de los datos.	Detectar problemas en la calidad de la detección y necesidades de refuerzo en la capacitación sobre el uso de gráficos para la clasificación de casos de EDA.
El Uso Adecuado de los Antibióticos	
Es importante reflexionar y verificar el registro de uso de los antibióticos en el tratamiento antibacteriano para los casos de EDA.	Detectar problemas de abuso en el manejo de los antibióticos y necesidades de capacitaciones de refuerzo sobre el manejo de casos de EDA.
Referencias	
Los referidos deben analizarse según los siguientes criterios: 1. Si la referencia fue cumplida por el usuario y recibió tratamiento hospitalario. 2. Si la referencia no fue cumplida y se curó con rehidratación oral en la comunidad Verificar las referencias por Diarrea con deshidratación y shock y el resultado de las mismas.	Determinar el funcionamiento del sistema de referencia y contrareferencia y detectar problemas de clasificación de los casos referidos para fortalecer la capacitación oportunamente y mejorar el sistema de referencia para los casos que necesitan manejo hospitalario.
Mortalidad por EDA	
Las muertes deben analizarse según los siguientes criterios: 1. Si la muerte ocurrió sin haber recibido atención por ningún trabajador de salud. 2. Si la muerte ocurrió por atención tardía o por no cumplir con la referencia. 3. Si la muerte ocurrió por manejo inadecuado del caso. La revisión de las muertes deben incluir la ubicación en el mapa de riesgo y la determinación de los factores de riesgo biológicos (estado nutricional), ambientales y socio – económicos estructurales que condicionaron la muerte.	Detectar problemas de acceso al servicio para proporcionar atención y tratamiento en el área de responsabilidad del trabajador de salud (TRO, antibióticos, referencia, etc.) y retomar el Enfoque de Riesgo como método de reflexión y tambien como Estrategia para atacar las causas de morbimortalidad en el siguiente período de Ejecución del Plan de Acción.

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI, MSCI.
CUADRO DE EVALUACION MENSUAL DEL COMPONENTE DE SALUD REPRODUCTIVA.

ONG: MES:

NOMBRE DE LOS PROMOTORES																		
Embarazadas esperadas																		
ATENCIONES PRENATALES	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.
1 Primeras atenciones																		
2 Seguimientos																		
3 Embarazo con signos de peligro (3/1)																		
4 Partos en la comunidad																		
5 Total de atenciones prenatales																		
ATENCIONES A PUERPERAS	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.
6 Primeras atenciones																		
7 Seguimientos																		
8 Puérperas con signos de peligro (8/6)																		
9 Total de atenciones a puérperas																		
10 Referencias (10/3+8)																		
11 Muertes maternas																		

MARCO DE ANALISIS

Detección y cobertura de Embarazadas por el trabajador de salud.

Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre el comportamiento de las diferencias en la presentación de los datos probablemente hayan dificultades en el control de las fechas probables de parto.

El Uso Adecuado de los Intrumentos de Clasificación

Es importante reflexionar y verificar el uso adecuado del gestograma, cinta obstétrica, la báscula y los formularios o cuadros para la clasificación del peligro en el embarazo, parto y puerperio.

Referencias por signos de peligro

Los referidos deben analizarse según los siguientes criterios:

1. Si la referencia fue cumplida por el usuario y recibió tratamiento hospitalario.
2. Si la referencia no fue cumplida y la mujer fue atendido en comunidad sin ningún problema. Verificar las referencias por signos de peligro y la evolución de los casos.

Mortalidad por embarazo parto y puerperio

Las muertes deben analizarse según los siguientes criterios:

1. Si la muerte ocurrió sin haber recibido atención por ningún trabajador de salud.
2. Si la muerte ocurrió por atención tardía o por no cumplir con la referencia.
3. Si la muerte ocurrió por manejo inadecuado del caso. La revisión de las muertes deben incluir la ubicación en el mapa de riesgo y la determinación de los factores de riesgo biológicos, ambientales y socioeconómicos o estructurales que condicionaron la muerte.

OBJETIVO DE ANALISIS

Detectar problemas en la calidad del control del embarazo, parto y puerperio y la necesidad de diseñar estrategias para mejorar la atención de la mujer en su comunidad. (En el mapa de riesgo)

Detectar problemas en el manejo de los instrumentos para la clasificación del peligro en la embarazada, y así detectar oportunamente la necesidad de reforzamiento en la capacitación al trabajador de salud.

Determinar el funcionamiento del sistema de referencia y contrareferencia y detectar problemas de clasificación de peligro de los casos referidos para mejorar el sistema de referencia – contrareferencia para la atención de la embarazada de alto riesgo.

Detectar problemas de acceso al servicio para proporcionar una vigilancia adecuada del embarazo, atención adecuada del parto y el puerperio; y retomar el Enfoque de Riesgo como método de reflexión y tambien como Estrategia para atacar las causas de morbimortalidad en el siguiente

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI, MSCI.
CUADRO DE EVALUACION MENSUAL DEL COMPONENTE DE SALUD DEL RECIEN NACIDO.

ONG: MES:

NOMBRE DEL PROMOTOR																		
ATENCIONES AL RECIEN NACIDO	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.
1 Primeras atenciones																		
2 Seguimientos																		
3 RN con signos de peligro de infección (3/1)																		
4 RN con bajo peso (< de 2500 gr.) (3/1)																		
5 Referencias (5/3+4)																		
6 Muertes de Recién Nacidos																		
7 Total de Atenciones a Recién Nacidos																		

MARCO DE ANALISIS	OBJETIVO DE ANALISIS
Detección y cobertura de Recién Nacidos por el trabajador de salud. Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre el comportamiento de las diferencias en la presentación de los datos probablemente hayan dificultades en el control de las fechas probables de parto.	Detectar problemas en la calidad del control del Recién Nacido y la necesidad de diseñar estrategias para mejorar la detección temprana del R. N. en la comunidad.
El Uso Adecuado de los Intrumentos de Clasificación Es importante reflexionar y verificar el uso adecuado del paquete neonatal, la báscula y los formularios o cuadros para la clasificación del peligro de signos de infección y bajo peso en el Recién Nacido.	Detectar problemas en el manejo de los instrumentos para la clasificación del peligro en el recién nacido, y asi detectar oportunamente la necesidad de reforzamiento en la capacitación al trabajador de salud.
Referencias por signos de peligro Los referidos deben analizarse según los siguientes criterios: 1. Si la referencia fue cumplida por el usuario y recibió tratamiento hospitalario. 2. Si la referencia no fue cumplida y el Recién Nacido fue atendido en comunidad sin ningún problema. Verificar las referencias por signos de peligro y la evolución de los casos.	Determinar el funcionamiento del sistema de referencia y contrareferencia y detectar problemas de clasificación de peligro de los casos referidos para mejorar el sistema de referencia – contrareferencia para la atención del recién nacido con infección o bajo peso – inestable.
Mortalidad por embarazo parto y puerperio Las muertes deben analizarse según los siguientes criterios: 1. Si la muerte ocurrió sin haber recibido atención por ningún trabajador de salud. 2. Si la muerte ocurrió por atención tardía o por no cumplir con la referencia. 3. Si la muerte ocurrió por manejo inadecuado del caso. La revisión de las muertes deben incluir la ubicación en el mapa de riesgo y la determinación de los factores de riesgo biológicos, ambientales y socioeconómicos o estructurales que condicionaron la muerte.	Detectar problemas de acceso al servicio para proporcionar una vigilancia adecuada del Recién Nacido, y retomar el Enfoque de Riesgo como método de reflexión y tambien como Estrategia para atacar las causas de morbimortalidad en el siguiente período de ejecución del Plan de Acción.

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI, MSCI.
CUADRO DE EVALUACION MENSUAL DEL COMPONENTE DE CRECIMIENTO Y DESARROLLO.

ONG: MES:

NOMBRE DE LOS PROMOTORES															
Población menor de 1 año															
Población de 1 a 4 años															
ATENCIONES A NIÑOS MENORES DE 1 AÑO	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl
1 Primeras atenciones															
2 Seguimientos															
3 Total de atenciones programadas.															
4 Atenciones a niños con Desnutrición Leve (4/3)															
5 Atenciones a niños c/ D. Moderada y Severa (5/3)															
ATENCIONES A NIÑOS DE 1 A 4 AÑOS	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl
6 Primeras atenciones															
7 Seguimientos															
8 Total de atenciones programadas.															
9 Atenciones a niños con Desnutrición Leve (9/8)															
10 Atenciones a niños c/ D. Moderada y Severa (10/8)															

MARCO DE ANALISIS	OBJETIVO DE ANALISIS
Detección y cobertura del crecimiento físico del niño de 0 a 4 años.	
Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre el comportamiento de las diferencias en la presentación de los datos. Verificar si las atenciones equivalen al No. de niños en la comunidad.	Detectar problemas en la estrategia para la detección y vigilancia del crecimiento físico del niño y retroalimentar el proceso de atención para mejorar el acceso al servicio en la comunidad (Mapa de Riesgo)
El Uso Adecuado de los Intrumentos de Clasificación	
Es importante reflexionar y verificar sobre el uso adecuado de los gráficos de crecimiento físico del niño, básculas, tallímetros y el instructivo de las acciones básicas a tomar para cada niño con algún grado de Desnutrición.	Detectar problemas en el llenado correcto del gráfico de crecimiento físico, y el manejo adecuado de la báscula, el tallímetro y la aplicación de las normas de atención, para retroalimentar oportunamente.
Referencias por desnutrición con complicaciones.	
Los referidos deben analizarse según los siguientes criterios: 1. Si la referencia fue cumplida por el usuario y recibió tratamiento hospitalario. 2. Si la referencia no fue cumplida y el niño fue atendido en comunidad sin ningún problema. Verificar las referencias por desnutrición con complicación y la evolución de los casos.	Determinar el funcionamiento del sistema de referencia y contrareferencia y detectar problemas de clasificación de los desnutridos con complicaciones.

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
PROSAMI, MSCI.
CUADRO DE EVALUACION MENSUAL DE ACTIVIDADES SOBRE EDUCACION COMUNITARIA

ONG: MES:

NOMBRE DEL PROMOTOR																		
SESIONES EDUCATIVAS	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.	Progr.	Realiz.	Cumpl.
1 Enfermedad Diarréica Aguda																		
2 Infecciones Respiratorias Agudas																		
3 Salud Reproductiva																		
4 Salud del Recién Nacido																		
5 Nutrición, Crecimiento y Desarrollo																		
6 Inmunizaciones																		
7 Participación Comunitaria																		
8 Total de sesiones educativas																		

MARCO DE ANALISIS

Detección y cobertura de necesidades educativas según problema de salud más sentido.

Iniciar con un análisis comparativo de los datos tabulados por cada promotor o comunidad. Reflexionar sobre la concordancia que debe haber entre los resultados de cada componente y las sesiónes educativas a desarrollar en cada período (mes o trimestre).

OBJETIVO DE ANALISIS

Jerarquizar las sesiones educativas de acuerdo a la morbimortalidad predominante y a las bajas coberturas del conrtrol del crecimiento físico, vigilancia del embarazo, inmunizaciones, etc.

OBSERVACIONES, COMENTARIOS:

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ANNEX G-11.

Quarterly Technical Report Forms Sent by NGO to PROSAMI

(PROSAMI) MSCI/USAID

INFORME TRIMESTRAL DE ACTIVIDADES DE LA ONG

ONG: _____

TRIMESTRE: _____ AÑO: _____

A C T I V I D A D E S	ESTE TRIMESTRE	
I. COBERTURA		
a. No. de clinicas nuevas o rehabilitadas		
b. No. total de Centros establecidos		
1. No. de UROCs		
2. No. de UAIRACs		
3. No. de Centros Nutricionales		
4. No. de Estim. Temp.		
5. Otros		
c. No. de Promotores de Salud Comunitaria trabajando con el proyecto		
d. No. de Parteras Empiricas trabajando con el Proyecto		
e. No. de Letrinas construidas o mejoradas		
f. No de pozos artesanales con sistema de bombeo construidos o mejorados		
g. No. de Planes de Autogestión desarrollados		
h. No. de Fondos de Salud Establecidos con las Comunidades		
II. COORDINACION E INVESTIGACION		
. No. de actividades coordinadas con el Ministerio de Salud Pública y Asistencia Social (Reuniones, campañas, etc.)		
. No. de actividades coordinadas con otros grupos (ONGs, etc.)		
. No. de investigaciones realizadas (Evaluaciones, etc.)		
III. CAPACITACION	DURACION	
	MENOS DE UN MES	MAS DE UN MES
a. Personas de la ONG que recibieron capacitación para el Proyecto		
1. No. de personal técnico		
2. No. de personal administrativo		
3. No. de promotores y voluntarios comunitarios		
4. No. de parteras empiricas u otros trabajadores tradicionales en salud		
5. No. de otros		
b. No. de sesiones de Educación permanente con personal de la ONG		
1. No. Componente Diarrea		
2. No. Componente IRA		
3. No. Componente Crec. y Desarrollo		
4. No. Componente Inmunización		
5. No. Componente Salud Materna		
6. No. Componente Salud Perinatal		
7. No. Componente Participación Comunitaria		

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PROSAM/MSCI/USAID

Informe Trimestral y Acumulado de Actividades del Trabajador(a) en Salud – 1994

ONG: Pob. < de 1 año: Pob. de 1 a 4 años: No. Embarazadas

MUNICIPIO (S): CANTON: CASERIO:

RESPONSABLE: FECHA:

	ACTIVIDADES	ESTE TRIMESTRE	AÑO A LA FECHA
I. Enfermedad Diarreica Aguda en niños de 0 a 4 años	Total de Casos nuevos Atendidos por diarrea (A+B+C)		
	A– Casos sin deshidratación		
	B– Casos con deshidratación		
	C– Casos con deshidratación con shock		
	No. de Atenciones de seguimiento		
	No. de Referencias		
	No. de muertes por diarrea aguda		
II. Infecciones Respiratorias Agudas en niños de 0 a 4 años	Total de Casos nuevos atendidos por IRA (A+B+C+D+E+F)		
	A– Casos con enfermedad muy grave		
	B– Casos con neumonía grave		
	C– Casos con neumonía		
	D– Casos con tos o resfriado		
	E– Casos con problema de oidos		
	F– Casos con dolor de garganta		
	No. de Atenciones de seguimiento		
	No. de referencias		
	No. de muertes por IRA		
III. Salud Reproductiva	Total de atenciones Prenatales (A+B)		
	A– De primera vez		
	B– Seguimiento		
	C– Con signos de peligro		
	Total de partos en la comunidad (A+B)		
	A– Atendidos por personal capacitado		
	B– Por otros		
	Total de atenciones a puérperas (A+B)		
	A– De primera vez		
	B– Seguimiento		
	C– Con signos de peligro		
	Total atenciones para espaciamiento de nacimientos (A+B)		
	A– De primera vez		
	B– Seguimiento		
	C– No. de ciclos de anticonceptivos orales entregados		
	D– No. de condones entregados		
	Total de referencias por signos de peligro		
	No. de muertes en el embarazo, parto y puerperio		
IV. Salud del Recién Nacido (0 a 28 días)	Total de atenciones a recién nacidos (A+B)		
	A– De primera vez		
	B– Seguimientos		
	No. de niños con signos de peligro de infección		
	No. de niños con menos de 2500 grs. de peso		
	No. de Referencias por signos de peligro		
	No. de muertes de recién nacidos		

(PROSAMI) MSCI/USAID

INFORME TRIMESTRAL DE ACTIVIDADES DE LA ONG

ONG: _____

TRIMESTRE: _____ AÑO: _____

ACTIVIDADES	ESTE TRIMESTRE	
IV. INMUNIZACIONES – NO. DE DOSIS APLICADAS	0 – 12 Meses	1 – 5 Años
BCG		
DPT3		
REFUERZO		
Polio 3		
REFUERZO		
Sarampión		
No. de Mujeres vacunadas con Toxoide Tetanico	EMBARAZADAS	EDAD FERTIL
SEGUNDA DOSIS		

V. MEDIDAS DE AUTOGESTION EN LA COMUNIDAD

a. ¿Cuales son los esfuerzos de las Comunidades para mejorar la autogestión financiera del Proyecto a largo plazo? (Pago de servicios, ferias, fondos rotativos, etc.)

b. Dar ejemplos especificos de cambios en comportamiento o cambios de actitud o conocimiento en las comunidades que han resultado de su Proyecto:

VI. MEDIDAS DE AUTOGESTION FINANCIERA DE LA ONG

a. ¿Cuales son los esfuerzos especificos que ha realizado para mejorar la autogestión financiera de su institución?

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PROSAMI/MSCI/USAID

Informe Trimestral y Acumulado de Actividades del Trabajador(a) en Salud – 1994

ONG: Pob. < de 1 año: Pob. de 1 a 4 años: No. Embarazadas

MUNICIPIO (S): CANTON: CASERIO:

RESPONSABLE: FECHA:

	ACTIVIDADES	ESTE TRIMESTRE	AÑO A LA FECHA
V.1. Crecimiento y Desarrollo del niño menor de 1 año	Total de atenciones de crecimiento y desarrollo (A+B)		
	A– Primera atención		
	B– Seguimiento		
	C– No. con peso normal		
	D– No. con Desnutrición Leve		
	E– No. con Desnutrición Moderada y Severa		
V.2. Crecimiento y Desarrollo del niño de 1 a 4 años	Total de atenciones de crecimiento y desarrollo (A+B)		
	A– Primera atención		
	B– Seguimiento		
	C– No. con peso normal		
	D– No. con Desnutrición Leve		
	E– No. con Desnutrición Moderada y Severa		
VI. Otras atenciones en niños de 0 a 4 años	No. de Atendidos		
	No. de Referencias		
VII. No. de Visitas Domiciliarias realizadas			
VIII. Participación Comunitaria	No. de comités de salud activos		
	No. de otros grupos organizados		
	No. de Voluntarios Activos		
Denominadores:	No. de Locales dados por la comunidad (perm. y trans.)		
Promotores: _____	No. de proyectos en gestión		
	No. de campañas		
Cantones: _____	No. de asambleas		
	No. de reuniones con comité de salud		
IX. Educación Comunitaria	Total de Sesiones a grupos : (más que 5 personas)		
	No. sobre diarrea,parásitos y saneamiento.		
	No. sobre IRA		
Denominadores:	No. sobre Salud Materna/Reproducción Humana		
Promotores: _____	No. sobre Salud Perinatal/Neonatal		
	No. sobre Inmunización		
Cantones: _____	No. sobre Nutrición,Crecimiento y Desarrollo		
	No. sobre Participación Comunitaria		

PROYECTO DE SALUD MATERNA Y SUPERVIVECIA INFANTIL
PROSAMI

EVALUACION TRIMESTRAL POR INDICE TECNICO
1994

COMPONENTE	INDICADOR	A	B	C	D
EDA	% de casos de diarrea en niños menores de 5 años con deshidratación ***	0 – 7.9%	8 – 15.9%	16 – 23.9%	> 23.9%
IRA	% de casos de IRA en niños menores de 5 años con neumonía grave **	0	0.1 – .99%	1.0 – 1.9%	> 1.9%
SALUD REPRODUC.	Cobertura de atención prenatal •	>19.9%	8 – 19.9%	2.5 – 7.9%	0 – 2.4%
SALUD R.N.	Cobertura de atención al Recien Nacido •	>19.9%	8 – 19.9%	4 – 7.9%	0 – 3.9%
INMUNIZ.	Cobertura de vacunación con DPT3 en niños menores de 1 año •	>19.9%	15 – 19.9%	7 – 14.9%	0 – 6.9%
CREC. Y DESAR.	Cobertura de control de crecimiento en niños menores de 1 año •	>19.9%	11 – 19.9%	5 – 10.9%	0 – 4.9%
PART. COMUN.	Número de Asambleas Comunales por promotor de salud (1o., 2o., 3er. Trim.)	> .99%	.66 – .99%	.33 – .65%	0 – .32%
	Número de Asambleas Comunales por promotor de salud (4o. Trim.)	> 1	–	1	0

NOTAS: "A" es equivalente a lo ideal (por ej.: Cobertura útil)
• = La división entre calificación B y C, es equivalente a la cobertura promedio nacional trimestral
▬ = La división entre calificación C y D, es equivalente al logro promedio de 19 ONG's en 1993 (IRA = 2 casos)
▬ = La división entre calificación C y D es equivalente al promedio de casos esperados (15%)

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)

MSCI/USAID

INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	PROMOTORES	SESIONES

COMPONENTE: ENFERMEDADES DIARREICAS Y PARASITARIAS EN NIÑOS DE CERO A CUATRO AÑOS.

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
INCIDENCIA DE DIARREA EN NIÑOS DE 0 A 4 AÑOS	No. DE CASOS NUEVOS DE DIARREA ÷ POBLACION DE 0 A 4 AÑOS X 1000 =			
*PORCENTAJE DE CASOS DE DIARREA CON DESHIDRATACION EN NIÑOS DE 0 A 4 AÑOS	No. DE CASOS DE DIARREA CON DESHIDRATACION ÷ No. DE CASOS NUEVOS DE DIARREA X 100 =		15%	
PORCENTAJE DE CASOS DE DIARREA CON DESHIDRATACION Y SHOCK.	No. DE CASOS DE DIARREA CON DESHIDRATACION Y SHOCK ÷ No. DE CASOS NUEVOS DE DIARREA X 100 =		5 %	
NUMERO DE ATENCIONES DE SEGUIMIENTO A NIÑOS DE 0 A 4 AÑOS QUE PRESENTARON DESHIDRATACION	No. DE ATENCIONES DE SEGUIMIENTO ÷ No. DE CASOS NUEVOS DE DIARREA CON DESHIDRATACION =		1	
PORCENTAJE DE NIÑOS DE 0 A 4 AÑOS REFERIDOS POR DIARREA CON DESHIDRATACION Y SHOCK.	No. DE CASOS REFERIDOS POR DIARREA ÷ No. DE CASOS NUEVOS DE DIARREA CON DESHIDRATACION Y SHOCK X 100 =		100%	
PORCENTAJE DE MUERTES POR ENFERMEDAD DIARREICA AGUDA EN NIÑOS DE 0 A 4 AÑOS.	No. DE MUERTES POR EDA EN NIÑOS DE 0 A 4 AÑOS ÷ No. TOTAL DE MUERTES EN NIÑOS DE 0 A 4 AÑOS. X 100 =			
TASA DE LETALIDAD POR EDA EN NIÑOS DE 0 A 4 AÑOS	No. DE MUERTES POR EDA EN NIÑOS DE 0 A 4 AÑOS ÷ No. DE CASOS NUEVOS DE EDA EN NIÑOS DE 0 A 4 AÑOS. X 100 =			
NUMERO DE SESIONES EDUCATIVAS SOBRE DIARREA A MAS DE 5 PERSONAS POR PROMOTOR DE SALUD	No. DE SESIONES EDUCATIVAS SOBRE DIARREA A MAS DE 5 PERSONAS ÷ No. DE PROMOTORES DE SALUD =		1	

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: INFECCIONES RESPIRATORIAS AGUDAS EN NIÑOS DE 0 A 4 AÑOS

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
INCIDENCIA DE IRA EN NINOS DE 0 A 4 AÑOS.	NUMERO DE CASOS NUEVOS DE IRA ÷ POBLACION DE 0 A 4 AÑOS X 1000 =			
PORCENTAJE DE CASOS DE NEUMONIA GRAVE	No.DE CASOS NUEVOS DE NEUMONIA GRAVE ÷ No. DE CASOS NUEVOS DE IRA X 100 =			
PORCENTAJE DE CASOS DE NEUMONIA. EN NIÑOS DE 0 A 4 AÑOS.	NUMERO DE CASOS DE NEUMONIA ÷ No. DE CASOS NUEVOS DE IRA X 100 =		10%	
PORCENTAJE DE CASOS DE NEUMONIA GRAVE Y ENFERMEDAD MUY GRAVE, REFERIDOS.	NUMERO DE REFERENCIAS POR IRA ÷ No.DE CASOS DE NEUMONIA GRAVE Y ENFERMEDAD MUY GRAVE X 100 =		100%	
NUMERO DE ATENCIONES DE SEGUIMIENTO POR CASO DE NEUMONIA.	NUMERO DE VISITAS DE SEGUIMIENTO ÷ No.DE CASOS DE NEUMONIA =		1	
PORCENTAJE DE MUERTES POR IRA EN NIÑOS DE 0 A 4 AÑOS.	NUMERO DE MUERTES POR IRA EN NIÑOS DE 0 A 4 AÑOS ÷ NUMERO TOTAL DE MUERTES EN NIÑOS DE 0 A 4 AÑOS X 100 =			
TASA DE LETALIDAD DE LAS IRA EN NIÑOS DE 0 A 4 AÑOS.	NUMERO DE MUERTES POR IRA EN NIÑOS DE 0 A 4 AÑOS ÷ NUMERO DE CASOS NUEVOS DE IRA X 100 =			
NUMERO DE SESIONES EDUCATIVAS A MAS DE 5 PERSONAS	NUMERO DE SESIONES EDUCATIVAS SOBRE IRA A MAS DE 5 PERSONAS ÷ NUMERO DE PROMOTORES DE SALUD =		1	

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: SALUD REPRODUCTIVA

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
NUMERO DE EMBARAZADAS PROTEGIDAS	TOTAL DE ATENCIONES PRENATALES (DE PRIMERA VEZ + SEGUIMIENTO) / 5 No. MINIMO DE ATENCIONES PRENATALES POR EMBARAZADA, SEGUN NORMAS	=		
COBERTURA DE ATENCION PRENATAL	No.DE EMBARAZADAS PROTEGIDAS / No.DE EMBARAZADAS ESPERADAS EN TRIM. (5% DE LA POBLACION TOTAL) X 100 =		20%	
PORCENTAJE DE ATENCIONES PRENATALES CON SIGNOS DE PELIGRO	No. DE ATENCIONES PRENATALES CON SIGNOS DE PELIGRO / TOTAL DE ATENCIONES PRENATALES X 100 =		Hasta un 20% A 30%	
COBERTURA DE ATENCION DE PARTOS EN LA COMUNIDAD ATENDIDOS POR PERSONAL CAPACITADO	No. DE PARTOS ATENDIDOS POR PERSONAL CAPACITADO / TOTAL DE PARTOS ESPERADOS (EQUIVALE A 80% DE EMB. ESPERADAS) X 100 =		12.5 %	
NUMERO DE PUERPERAS PROTEGIDAS	TOTAL DE ATENCIONES A PUERPERAS (DE PRIMERA VEZ + SEGUIMIENTO) / 2 No. MINIMO DE ATENCIONES POR PUERPERA SEGUN NORMA (PROMEDIO)	=		
COBERTURA DE ATENCION A PUERPERAS	No.DE PUERPERAS PROTEGIDAS / TOTAL DE PUERPERAS (EQUIVALE A TOTAL DE PARTOS ESPERADOS) X 100 =		20%	
PORCENTAJE DE ATENCIONES A PUERPERAS CON SIGNOS DE PELIGRO	No. DE ATENCIONES A PUERPERAS CON SIGNOS DE PELIGRO / TOTAL DE ATENCIONES A PUERPERAS X 100 =		Hasta un 20%	

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

DWG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: SALUD REPRODUCTIVA

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
NUMERO DE EMBARAZADAS PROTEGIDAS	5 / TOTAL DE ATENCIONES PRENATALES (DE PRIMERA VEZ + SEGUIMIENTO) — No. MINIMO DE ATENCIONES PRENATALES POR EMBARAZADA, SEGUN NORMAS	=		
COBERTURA DE ATENCION PRENATAL	No.DE EMBARAZADAS PROTEGIDAS / No.DE EMBARAZADAS ESPERADAS EN TRIM. (5% DE LA POBLACION TOTAL) X 100 =		20%	
PORCENTAJE DE ATENCIONES PRENATALES CON SIGNOS DE PELIGRO	No. DE ATENCIONES PRENATALES CON SIGNOS DE PELIGRO / TOTAL DE ATENCIONES PRENATALES X 100 =		Hasta un 20% A 30%	
COBERTURA DE ATENCION DE PARTOS EN LA COMUNIDAD ATENDIDOS POR PERSONAL CAPACITADO	No. DE PARTOS ATENDIDOS POR PERSONAL CAPACITADO / TOTAL DE PARTOS ESPERADOS (EQUIVALE A 80% DE EMB. ESPERADAS) X 100 =		12.5 %	
NUMERO DE PUERPERAS PROTEGIDAS	2 / TOTAL DE ATENCIONES A PUERPERAS (DE PRIMERA VEZ + SEGUIMIENTO) — No. MINIMO DE ATENCIONES POR PUERPERA SEGUN NORMA (PROMEDIO)	=		
COBERTURA DE ATENCION A PUERPERAS	No.DE PUERPERAS PROTEGIDAS / TOTAL DE PUERPERAS (EQUIVALE A TOTAL DE PARTOS ESPERADOS) X 100 =		20%	
PORCENTAJE DE ATENCIONES A PUERPERAS CON SIGNOS DE PELIGRO	No. DE ATENCIONES A PUERPERAS CON SIGNOS DE PELIGRO / TOTAL DE ATENCIONES A PUERPERAS X 100 =		Hasta un 20%	

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: SALUD REPRODUCTIVA

INDICADOR	FORMULA Y APLICACION			LOGROS	STANDARD	COMENTARIOS
COBERTURA DE ATENCION PARA ESPACIAMIENTO DE EMBARAZOS	No. DE ATENCIONES PARA ESPACIAMIENTO DE EMBARAZOS DE PRIMERA VEZ	÷	POBLACION DE MUJERES EN EDAD FERTIL DEL AREA (20% de su población total)	X 100 =		
NUMERO DE MUJERES PROTEGIDAS POR CICLO DE ANTICONCEPTIVOS ORALES (ACO)	NUMERO DE CICLOS ENTREGADOS	÷	3.25 NUMERO DE CICLOS POR MUJER SEGUN NORMA	=		
COBERTURA DE ESPACIAMIENTO DE EMBARAZOS CON ANTICONCEPTIVOS ORALES	NUMERO DE MUJERES PROTEGIDAS CON ANTICONCEPTIVOS ORALES	÷	MUJERES EN EDAD FERTIL (20% DE LA POBLACION TOTAL)	X 100 =	7.7 %	
NUMERO DE PAREJAS PROTEGIDAS POR CONDONES	NUMERO DE CONDONES ENTREGADOS	÷	25 NUMERO DE CONDONES POR PAREJA SEGUN NORMA	=		
COBERTURA DE ESPACIAMIENTO DE EMBARAZOS POR CONDONES	NUMERO DE PAREJAS PROTEGIDAS POR CONDONES	÷	MUJERES EN EDAD FERTIL (20% DE LA POBLACION TOTAL)	X 100 =	2.1 %	
PORCENTAJE DE REFERENCIAS POR SIGNOS DE PELIGRO	TOTAL DE REFERENCIAS POR SIGNOS DE PELIGRO	÷	No.DE ATEN. PREN. CON SIGN.DE PELIGRO + No.ATEN.A PUERP.CON SIGN.DE PELIGRO	X 100 =	100%	
NUMERO DE SESIONES EDUCATIVAS A GRUPOS SOBRE SALUD REPRODUCTIVA	No DE SESIONES EDUCATIVAS SOBRE SALUD REPRODUCTIVA A GRUPOS	÷	NUMERO DE PROMOTORES	X =	1	
TASA DE MORTALIDAD MATERNA	No DE MUERTES MATERNAS	÷	TOTAL DE NACIDOS VIVOS	X 10000 =		

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: SALUD PERINATAL Y NEONATAL

INDICADOR	FORMULA Y APLICACION			LOGROS	STANDARD	COMENTARIOS
NUMERO DE RECIEN NACIDOS PROTEGIDOS	No. DE ATENCIONES DE PRIMERA VEZ + SEGUIMIENTOS	+	No DE ATENCIONES MINIMAS AL RECIEN NACIDO, SEGUN NORMA	=		
COBERTURA DE ATENCION AL RECIEN NACIDO	No. DE RECIEN NACIDOS PROTEGIDOS		No DE RECIEN NACIDOS ESPERADOS (80% DE EMBARAZADAS ESPERADAS)	X 100 =	20%	
PORCENTAJE DE RECIEN NACIDOS CON INFECCION	No. DE RECIEN NACIDOS CON INFECCION		NUMERO DE RECIEN NACIDOS ATENDIDOS DE PRIMERA VEZ	X 100 =	20%	
PORCENTAJE DE RECIEN NACIDOS CON BAJO PESO AL NACER	NUMERO DE RECIEN NACIDOS CON BAJO PESO		NUMERO DE RECIEN NACIDOS ATENDIDOS DE PRIMERA VEZ	X 100 =	10%	
PORCENTAJE DE RECIEN NACIDOS REFERIDOS	NUMERO DE RECIEN NACIDOS REFERIDOS		NUMERO DE RECIEN NACIDOS CON INFECC. + RECIEN NACIDOS DE BAJO PESO	X 100 =	100%	
NUMERO DE SESIONES EDUCATIVAS A GRUPOS SOBRE SALUD PERINATAL Y NEONATAL	No. DE SESIONES EDUCATIVAS A GRUPOS SOBRE SALUD PERINATAL Y NEONATAL		NUMERO DE PROMOTORES	=	1	
TASA DE MORTALIDAD NEONATAL	NUMERO DE MUERTES NEONATALES		TOTAL DE RECIEN NACIDOS VIVOS	X 1000 =	29/MIL N.V.	
PORCENTAJE DE MUERTES NEONATALES EN RELACION AL TOTAL DE MUERTES EN MENORES DE 5 AÑOS	NUMERO DE MUERTES NEONATALES		TOTAL DE MUERTES EN MENORES DE 5 AÑOS	X 100 =		

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PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: CRECIMIENTO Y DESARROLLO

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
No DE NIÑOS MENORES DE 1 AÑO PROTEGIDOS	No. DE PRIMERAS ATENCIONES + SEGUIMIENTOS A NIÑOS MENORES DE 1 AÑO + 6 No. DE ATENCIONES AL MENOR DE 1 AÑO SEGUN NORMAS. =			
*COBERTURA DEL NIÑO MENOR DE 1 AÑO.	No. DE NIÑOS MENORES DE 1 AÑO PROTEGIDOS + TOTAL DE NIÑOS MENORES DE 1 AÑO (3.5 % DE LA POBLACION) X 100 =		25 %	
No DE NIÑOS DE 1 A 4 AÑOS PROTEGIDOS.	No. DE PRIMERAS ATENCIONES + SEGUIMIENTOS A NIÑOS DE 1 A 4 AÑOS + 2 No. DE ATENCIONES AL NIÑO DE 1 A 4 AÑOS SEGUN NORMAS =			
COBERTURA DEL NIÑO DE 1 A 4 AÑOS	No. DE NIÑOS DE 1 A 4 AÑOS PROTEGIDOS + TOTAL DE NIÑOS DE 1 A 4 AÑOS (13.5 % DE LA POBLACION) X 100 =		12.5%	
NUMERO DE SESIONES EDUCATIVAS SOBRE NUTRICION CRECIMIENTO Y DESARROLLO A MAS QUE 5 PERSONAS POR PROMOTOR	No.DE SES. EDUC.DE MAS DE 5 PERS. SOBRE NUTRICION, CREC. Y DESARR. + NUMERO DE PROMOTORES =		1	
% DE CONTROLES DE NIÑOS MENORES DE 1 AÑO CON DESNUTRICION MODERADA Y SEVERA	NIÑOS MENORES DE 1 AÑO CON DESNUTRICION MODERADA Y SEVERA + No. DE PRIMERAS ATENCIONES + SEGUIMIENTOS A NIÑOS MENORES DE 1 AÑO X 100 =			
% DE CONTROLES DE NIÑOS DE 1 A 4 AÑOS CON DESNUTRICION MODERADA Y SEVERA	NIÑOS DE 1 A 4 AÑOS CON DESNUTRICION MODERADA Y SEVERA + No. DE PRIMERAS ATENCIONES + SEGUIMIENTOS A NIÑOS DE 1 A 4 AÑOS X 100 =			

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES / NO CANTONES

COMPONENTE: ENFERMEDADES PREVENIBLES POR VACUNA

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
COBERTURA DE VACUNACION CON BCG EN NIÑOS MENORES DE 1 AÑO	TOTAL DE NINOS MENORES DE 1 AÑO VACUNADOS CON BCG ÷ TOTAL DE NINOS MENORES DE 1 AÑO (3.5 % DE LA POBLACION TOTAL) X 100 =		25%	
COBERTURA DE VACUNACION CON DPT3 EN NINOS MENORES DE 1 AÑO	TOTAL DE NINOS MENORES DE 1 AÑO VACUNADOS CON 3a. DOSIS DE DPT ÷ TOTAL DE NINOS MENORES DE 1 AÑO (3.5 % DE LA POBLACION TOTAL) X 100 =		25%	
COBERTURA DE VACUNACION CON ANTIPOLIO3 EN NIÑOS MENORES DE 1 AÑO.	TOTAL DE NINOS MENORES DE 1 AÑO VACUNADOS CON 3a. DOSIS DE ANTIPOLIO ÷ TOTAL DE NINOS MENORES DE 1 AÑO (3.5 % DE LA POBLACION TOTAL) X 100 =		25 %	
COBERTURA DE INMUNIZACION CON ANTISARAMPIONOSA EN EL NIÑO MENOR DE 1 AÑO.	TOTAL DE NINOS MENORES DE 1 AÑO VACUNADOS CON ANTISARAMPIONOSA ÷ TOTAL DE NIÑOS MENORES DE 1 AÑO. (3.5 % DE LA POBLACION TOTAL) X 100 =		25%	
COBERTURA DE INMUNIZACION CON ANTISARAMPIONOSA EN NIÑOS DE 1 A 4 AÑOS DE EDAD.	TOTAL DE NINOS DE 1 A 4 AÑOS DE EDAD VACUNADOS CON ANTISARAMPIONOSA ÷ TOTAL DE NINOS DE 1 A 4 AÑOS (13.5 % DE LA POBLACION TOTAL) X 100 =		20%	
COBERTURA DE INMUNIZACION CON TOXOIDE TETANICO2 EN LA MUJER EMBARAZADA	TOTAL DE EMBARAZADAS VACUNADAS CON 2a. DOSIS DE TOXOIDE TETANICO ÷ TOTAL DE EMBARAZADAS (5 % DE LA POBLACION TOTAL) X 100 =		25%	
COBERTURA DE INMUNIZACION CON TOXOIDE TETANICO2 EN LA MUJER 15 A 44 AÑOS DE EDAD.	TOTAL DE MUJERES DE 15 A 44 AÑOS VACUNADAS CON 2a. DOSIS DE TOXOIDE TETANICO. ÷ TOTAL DE MUJERES DE 15 A 44 AÑOS. (20 % DEL TOTAL DE LA POBLACION) X 100 =		15 %	

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL (PROSAMI)
MSCI/USAID
INDICADORES DE EVALUACION 1994

ONG : _____ PERIODO DE EVALUACION : _____

POBLACION TOTAL	NIÑOS MENORES DE 5 AÑOS	MUJERES EN EDAD FERTIL	HOGARES	No. PROMOTORES	NO CANTONES

COMPONENTE: PARTICIPACION COMUNITARIA Y DESARROLLO COMUNAL

INDICADOR	FORMULA Y APLICACION	LOGROS	STANDARD	COMENTARIOS
No DE COMITES ACTIVOS POR PROMOTOR	No DE COMITES DE SALUD ACTIVOS ÷ No. DE PROMOTORES =		1/año	
No. DE VOLUNTARIOS ACTIVOS POR PROMOTOR	No DE VOLUNTARIOS ÷ No. DE PROMOTORES =		5/año	
*No DE ASAMBLEAS COMUNALES POR PROMOTOR	No. DE ASAMBLEAS COMUNALES ACUMULADAS EN EL AÑO ÷ No. DE PROMOTORES X =		2/año	
No DE PROYECTOS EN GESTION O EJECUCION POR PROMOTOR	No DE PROYECTOS EN GESTION O EN EJECUCION ÷ No. DE PROMOTORES X =		2/año	

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ANNEX G-12.

Graphs & Tables Indicating the Results of the PROSAMI Technical Components for 1994

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
PROSAMI

EVALUATION TABLES 1994

DIARRHEAL DISEASE

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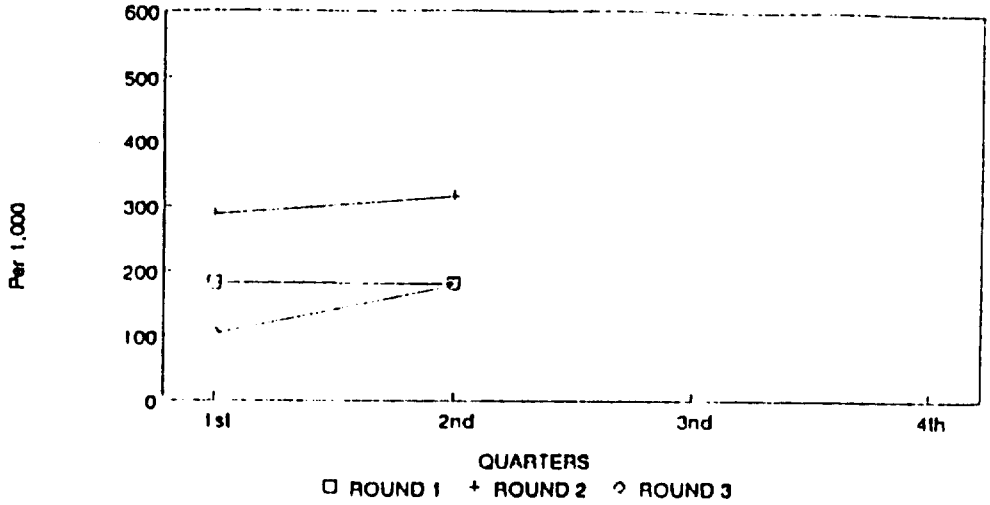
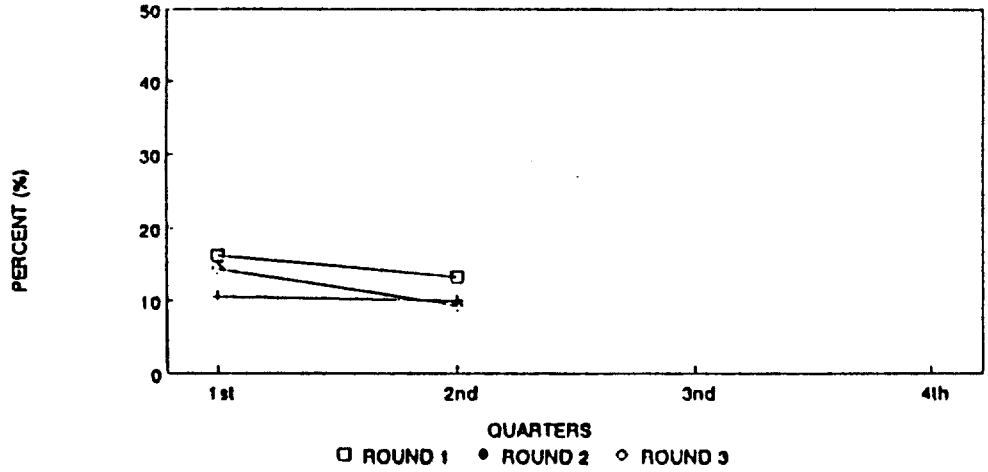
TABLE I
DIARRHEA INCIDENCE RATES
(Per 1000 CHILDREN UNDER 5*)
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	182.40	288.00	103.70
2nd	181.72	316.85	179.20
3nd			
4th			

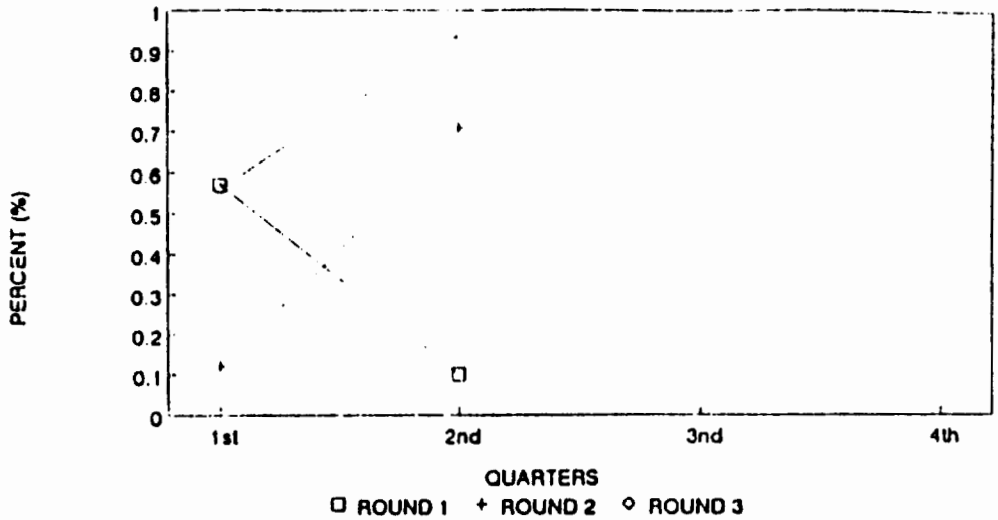
TABLE II
PERCENT OF CASES OF DIARRHEA WHICH PRESENTED DEHYDRATION*



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	16.20	10.50	14.40
2nd	13.23	9.94	9.22
3nd			
4th			

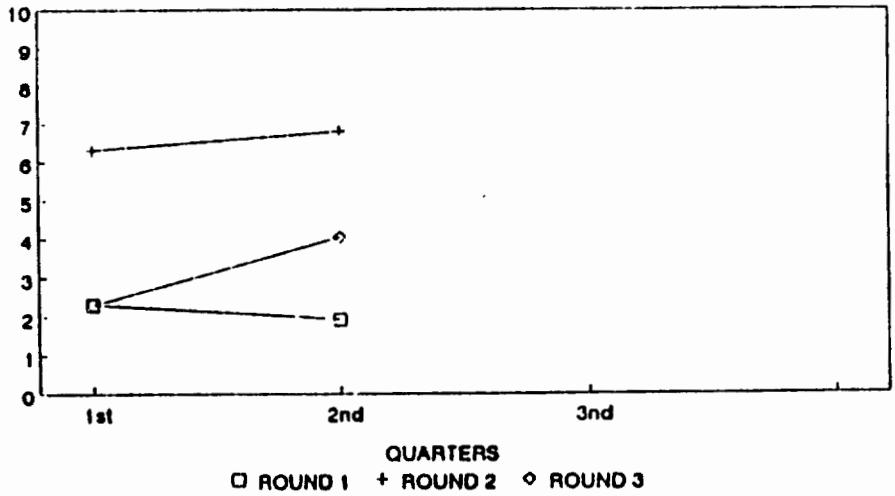
* 15% OF CASES EXPECTED

TABLE III
PERCENT OF CASES OF DIARRHEA WHICH PRESENTED DEHYDRATION AND SHOCK*
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	0.57	0.12	0.56
2nd	0.10	0.71	0.94
3nd			
4th			

TABLE IV
AVERAGE NUMBER OF FOLLOW-UP VISITS FOR EACH CASE OF DEHYDRATION DETECTED AMONG CHILDREN UNDER 5
1994
(GOAL OF ONE PER CASE)



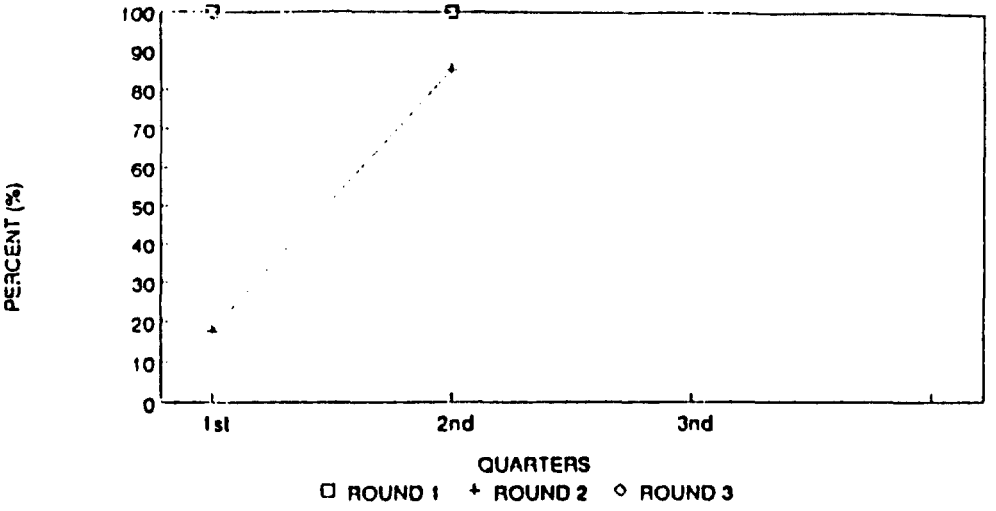
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	2.30	6.30	2.30
2nd	1.92	6.80	4.04
3nd			
4th			

TABLE V

PERCENT OF CASES OF DIARRHEA WITH DEHYDRATION AND SHOCK DETECTED IN CHILDREN UNDER 5 WHICH WERE REFERRED. *

1994

(GOAL OF 100%)

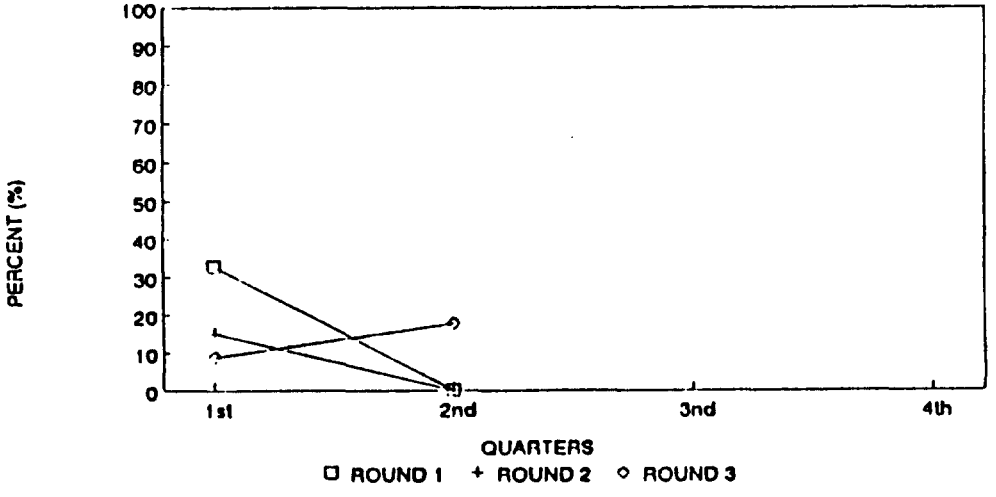


QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	100.00	17.50	100.00
2nd	100.00	85.32	100.00
3nd			
4th			

TABLE VI

PERCENT OF DEATH AMONG CHILDREN UNDER 5 YEAR OF AGE DUE TO DIARRHEAL DISEASE.

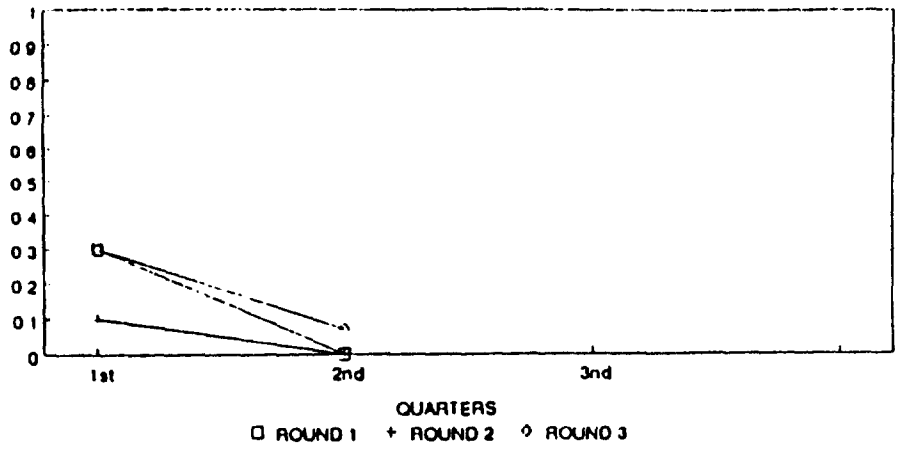
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	32.80	15.00	8.80
2nd	0.00	0.00	17.65
3nd			
4th			

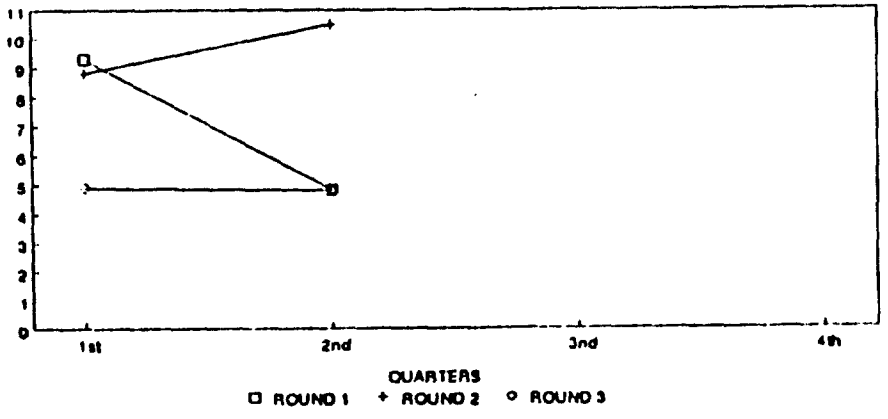
TABLE VII
PERCENT OF DIARRHEA CASES AMONG CHILDREN UNDER 5 THAT ENDED IN DEATH

1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	0.30	0.10	0.30
2nd	0.00	0.00	0.07
3nd			
4th			

TABLE VIII
AVERAGE NUMBER OF COMMUNITY GROUP EDUCATION SESSIONS PER HEALTH PROMOTER ON THE SUBJECT OF DIARRHEA
1994
(GOAL OF ONE/PROMOTER/QUARTER)



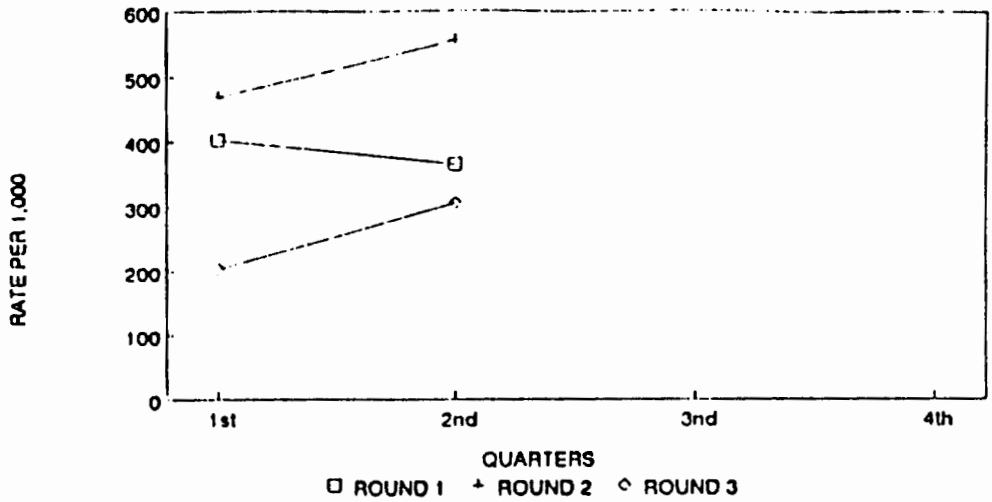
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	9.30	8.80	4.90
2nd	4.83	10.49	4.82
3nd			
4th			

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
PROSAMI

EVALUATION TABLES 1994

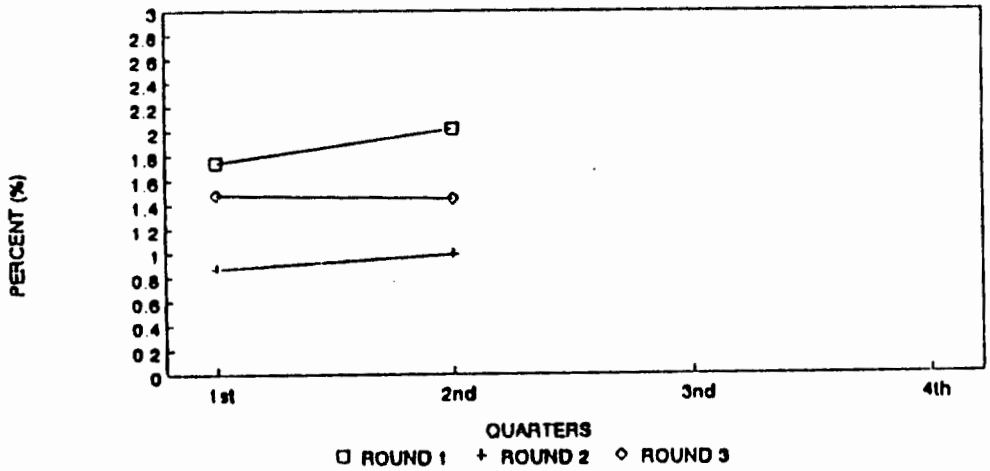
ACUTE RESPIRATORY INFECTIONS (ARI)

TABLE I
ARI INCIDENCE RATE (Per 1,000 Children under 5)
DETECTED AND ATTENDED
1994



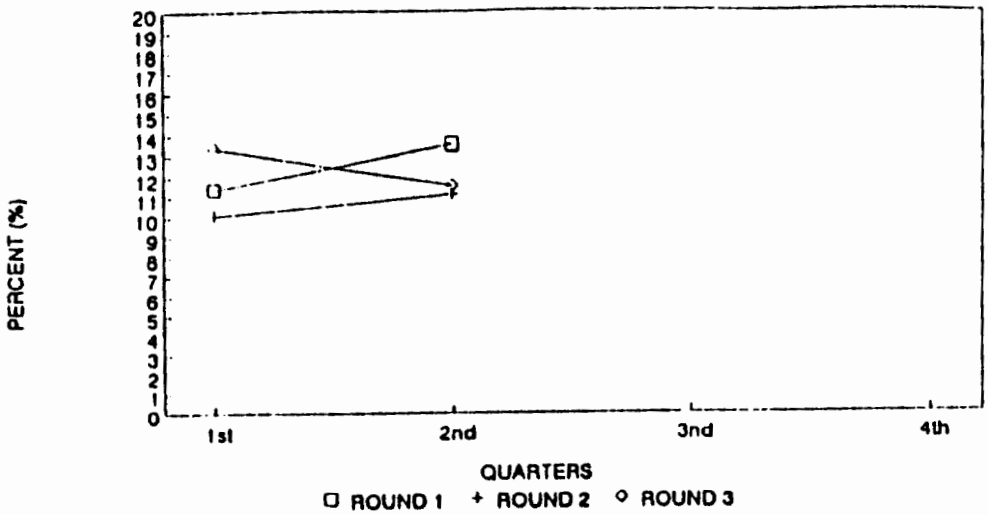
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	402.60	469.25	203.46
2nd	367.18	555.76	307.72
3nd			
4th			

TABLE II
PERCENT OF ARI CASES AMONG CHILDREN
UNDER 5 THAT PRESENTED SEVERE NEUMONIA
1994



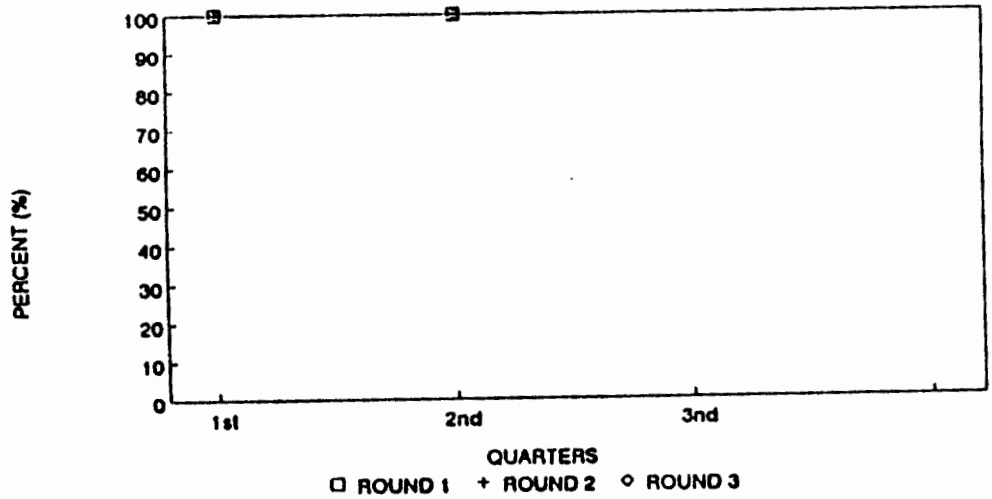
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	1.74	0.87	1.48
2nd	2.02	0.99	1.45
3nd			
4th			

TABLE III
PERCENT OF ARI CASES AMONG CHILDREN UNDER 5 THAT PRESENTED NEUMONIA
1994



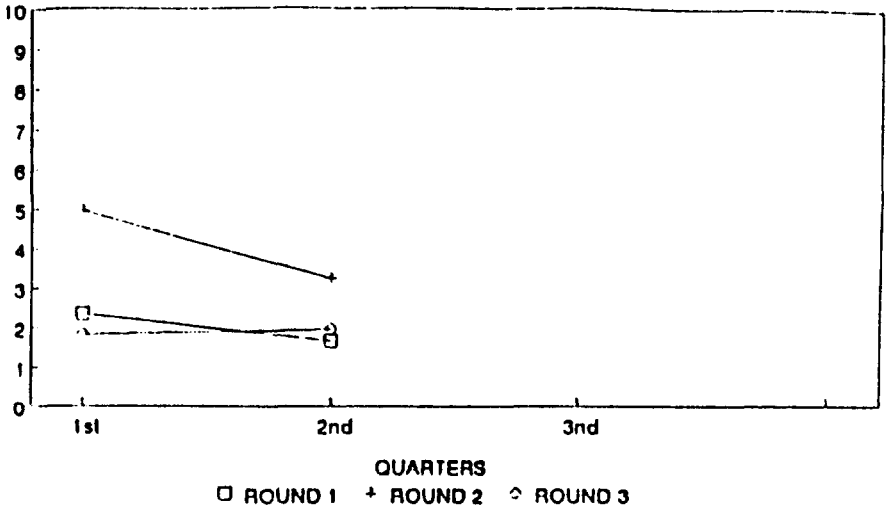
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	11.42	10.09	13.38
2nd	13.58	11.17	11.61
3nd			
4th			

TABLE IV
PERCENT OF CASES OF SEVERE ARI AND SEVERE NEUMONIA DETECTED IN CHILDREN UNDER 5 WHICH WERE REFERED
1994
(GOAL OF 100%)



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	100.00	100.00	100.00
2nd	100.00	100.00	100.00
3nd			
4th			

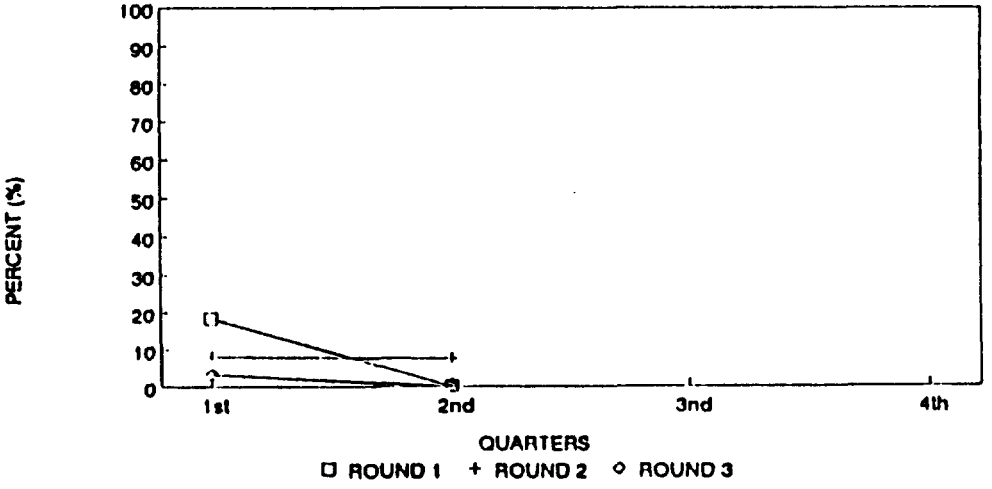
TABLE V
AVERAGE NUMBER OF FOLLOW – UP VISITS FOR EACH CASE
OF NEUMONIA DETECTED AMONG CHILDREN UNDER 5
1994
(GOAL OF ONE PER CASE)



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	2.34	4.95	1.82
2nd	1.65	3.24	1.95
3nd			
4th			

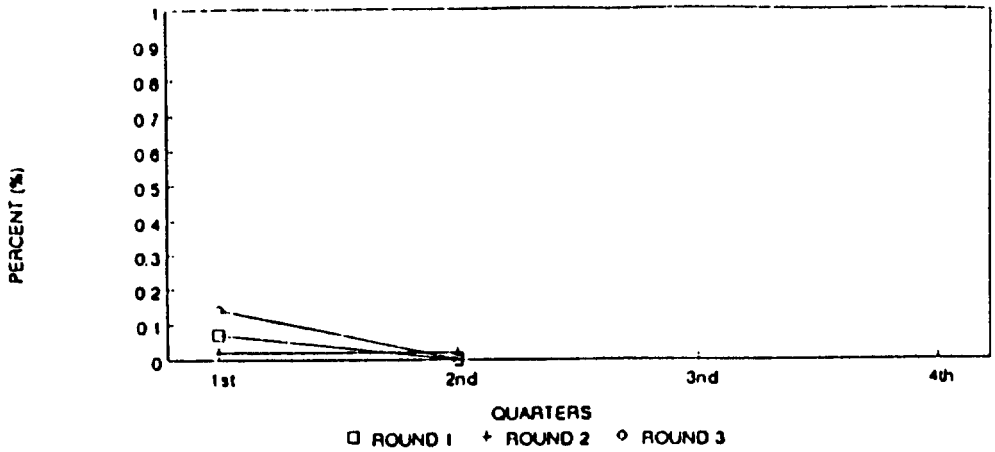
TABLE VI
PERCENT OF DEATHS AMONG CHILDREN UNDER 5 YEARS AGE DUE TO ARI

1994



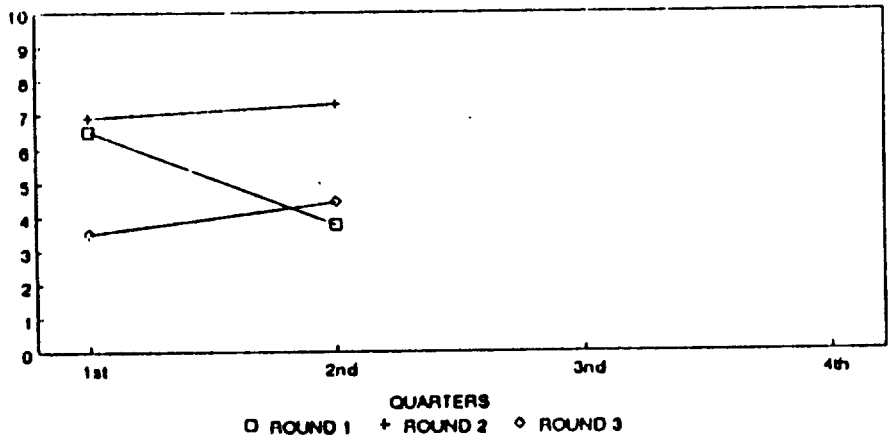
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	18.33	7.92	3.14
2nd	0.00	7.50	0.00
3nd			
4th			

TABLE VII
PERCENT OF ARI CASES AMONG CHILDREN UNDER 5 THAT ENDED IN DEATH
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	0.07	0.02	0.14
2nd	0.00	0.02	0.00
3nd			
4th			

TABLE VIII
AVERAGE NUMBER OF GROUP EDUCATION SESSIONS PER HEALTH PROMOTER ON THE SUBJECT OF ARI
1994
(GOAL OF ONE/PROMOTER/QUARTER)



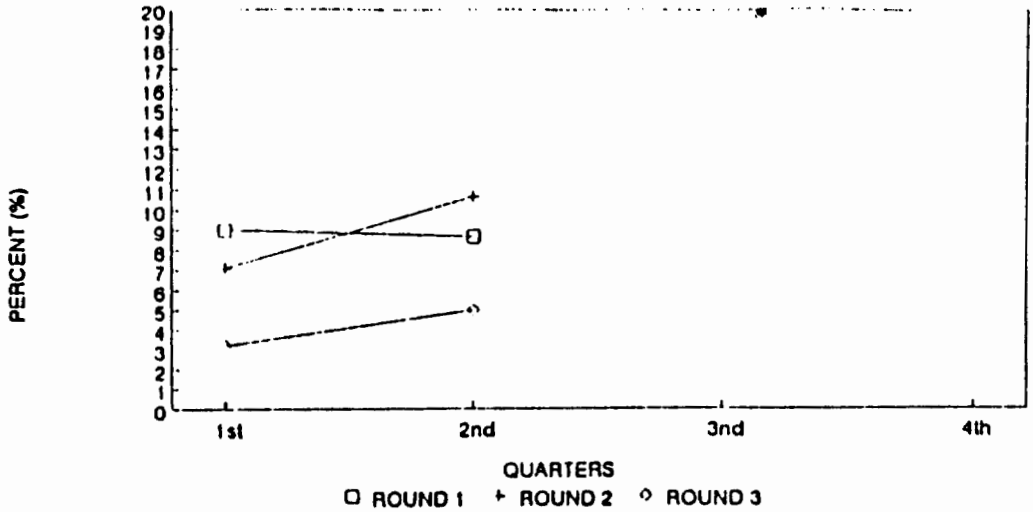
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	6.51	6.91	3.53
2nd	3.79	7.30	4.46
3nd			
4th			

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
PROSAMI

EVALUATION TABLES 1994

NEONATAL HEALTH

TABLE I
QUARTERLY NEWBORN CARE COVERAGE
1994
(GOAL OF 20% PER QUARTER,80% PER YEAR)

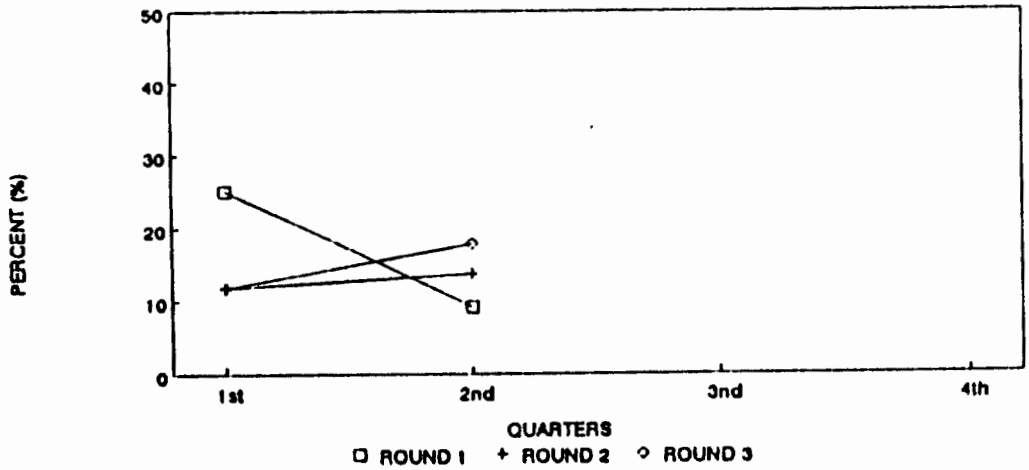


QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	9.00	7.12	3.22
2nd	8.68	10.64	5.00
3nd			
4th			
	35.4	35.6	32.2

* NEWBORNS : 80 % OF EXPECTED PREGNANCIES

* ANNUAL COVERAGE 80%; QUARTERLY 20%

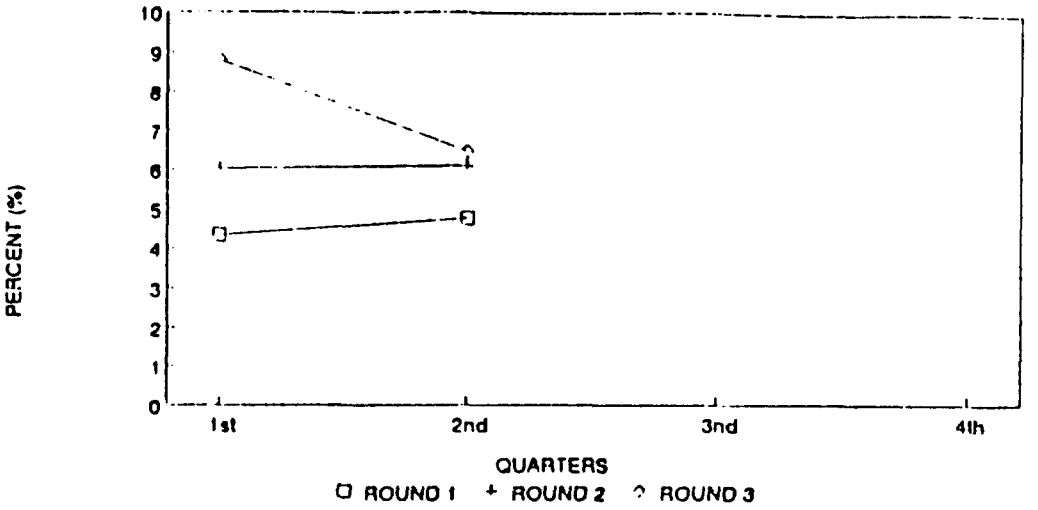
TABLE II
PERCENT OF NEWBORN VISITS WHICH PRESENTED DANGER SIGNS RELATED TO INFECTION *
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	25.14	11.80	11.75
2nd	9.13	13.70	17.76
3nd			
4th			

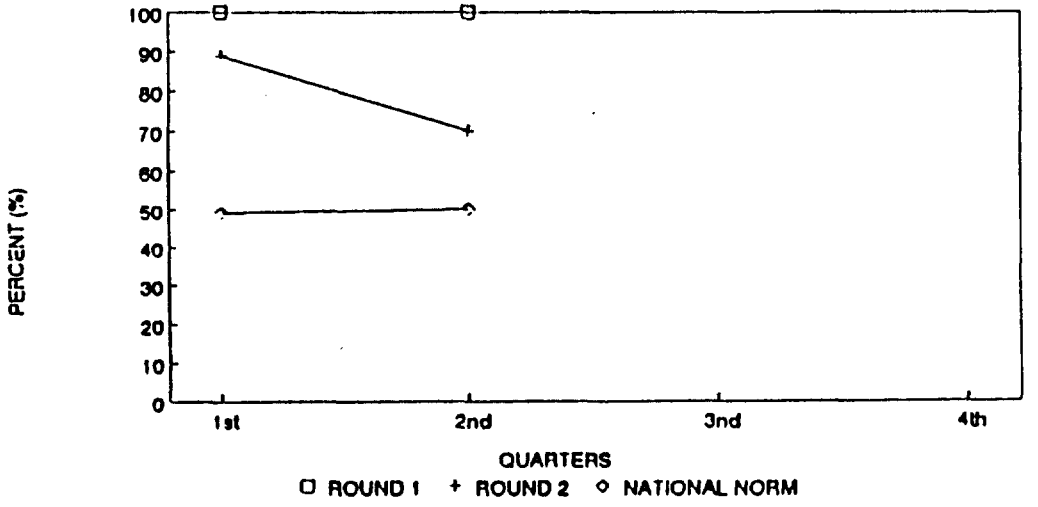
* 20 % PERCENT EXPECTED TO PRESENT DANGER SIGNS

TABLE III
PERCENT OF NEWBORN VISITS WHICH PRESENTED LOW BIRTH WEIGHT
1994



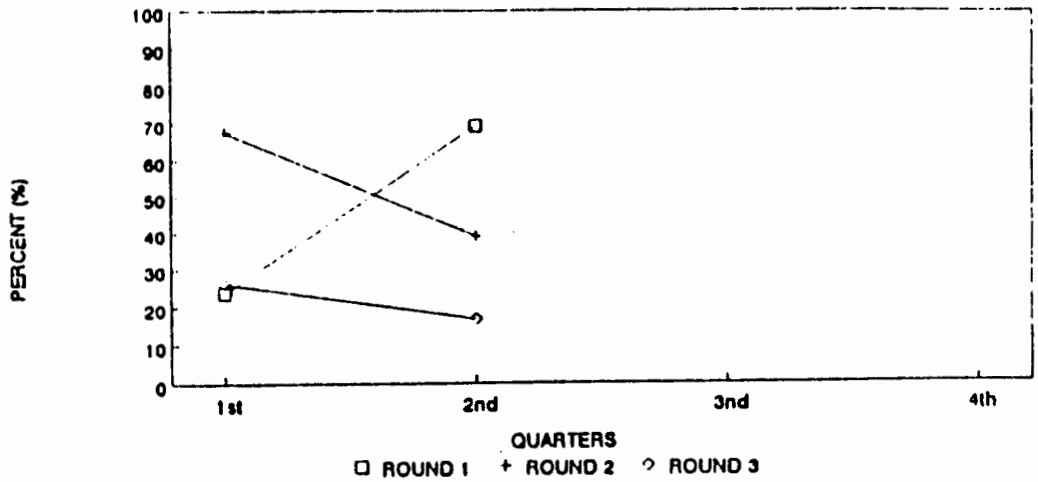
QUARTERS	ROUND 1*	ROUND 2	ROUND 3
1st	4.34	6.04	8.80
2nd	4.79	6.11	6.47
3nd			
4th			

TABLE IV
PERCENT OF NEWBORNS WITH INFECTION OR LOW BIRTH WEIGHT WHICH WERE REFERRED
1994
(GOAL OF 100%)



QUARTERS	ROUND 1*	ROUND 2	ROUND 3
1st	100.00	88.89	49.06
2nd	100.00	69.98	50.00
3nd			
4th			

TABLE VII
PERCENT OF DEATHS AMONG CHILDREN UNDER 5 OCCURING
IN THE NEONATAL PERIOD
1994



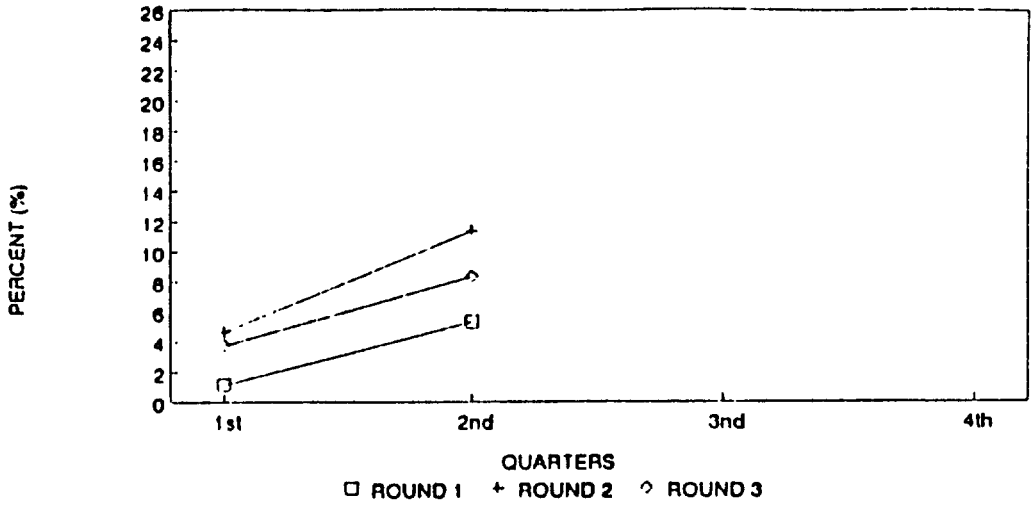
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	23.70	67.50	26.08
2nd	69.44	39.17	16.67
3nd			
4th			

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
PROSAMI

EVALUATION TABLES 1994

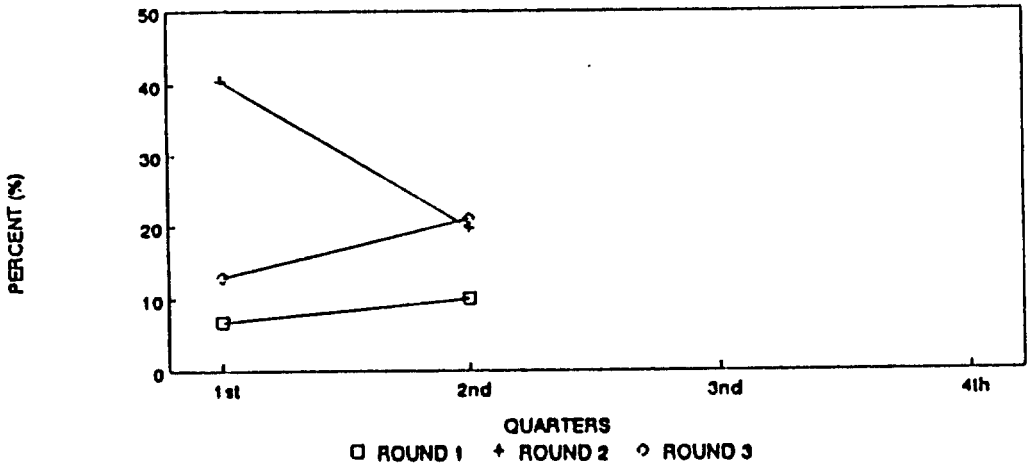
IMNUNIZATION

TABLE I
PERCENT OF CHILDREN UNDER ONE YEAR OF AGE WHO WERE VACCINATED WITH BCG
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



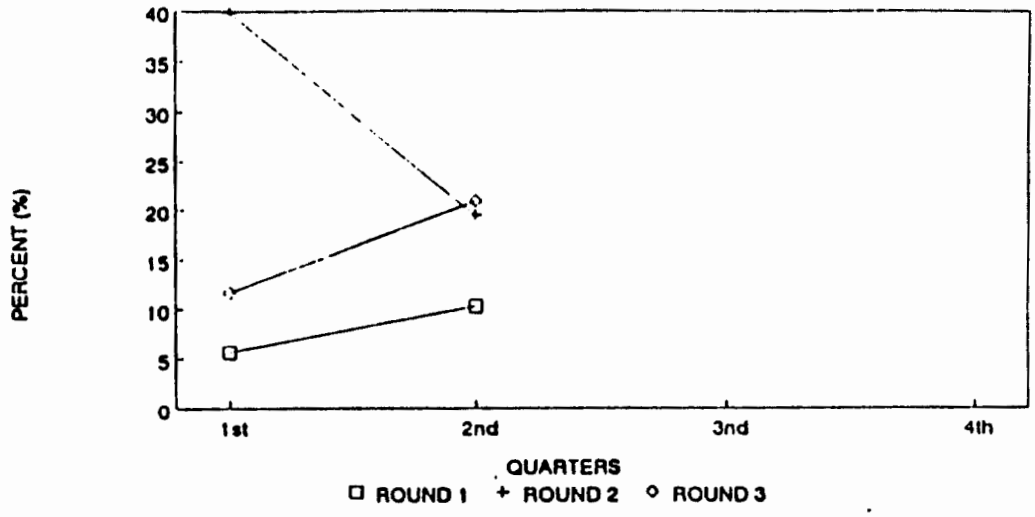
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	1.16	4.66	3.76
2nd	5.32	11.43	8.37
3nd			
4th			

TABLE II
PERCENT OF CHILDREN UNDER ONE YEAR OF AGE WHO WERE VACCINATED WITH DPT 3
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



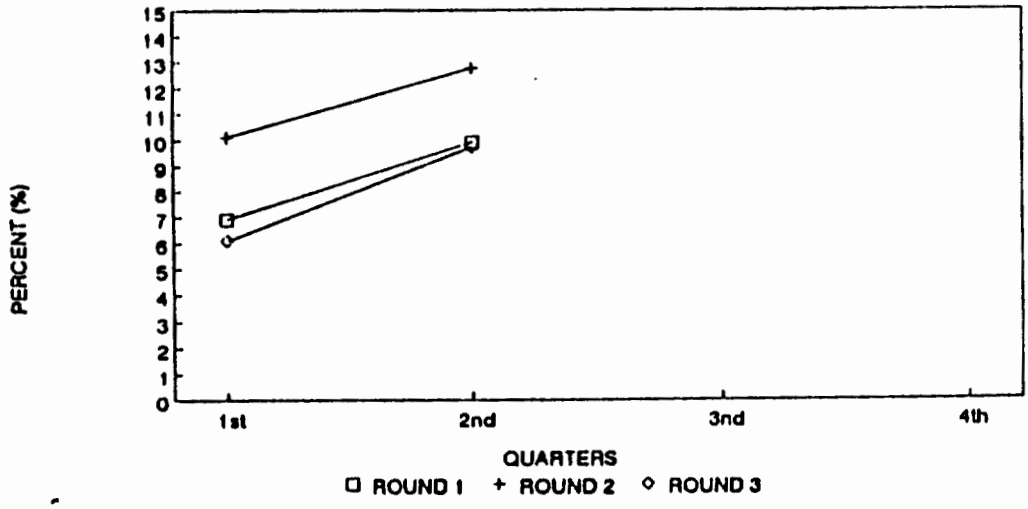
ROUND 1	ROUND 2	ROUND 2	ROUND 3
1st	6.79	40.50	12.96
2nd	10.02	19.73	21.03
3nd			
4th			
	34%	100%	68%

TABLE III
PERCENT OF CHILDREN UNDER ONE YEAR OF AGE WHO WERE VACCINATED WITH POLIO 3
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



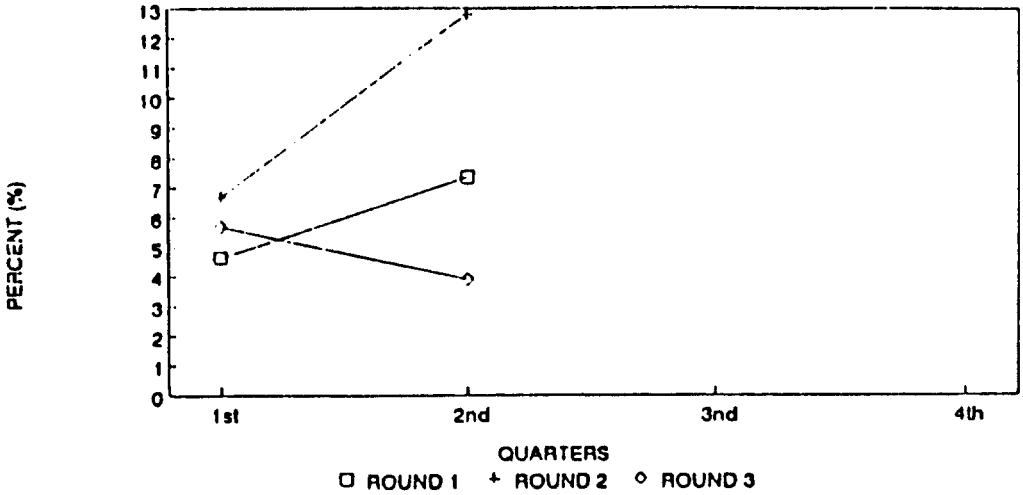
QUARTERS	ROUND 1*	ROUND 2	ROUND 2
1st	5.65	39.84	11.65
2nd	10.32	19.58	21.01
3nd			
4th			

TABLE IV
PERCENT OF CHILDREN UNDER ONE YEAR OF AGE WHO WERE VACCINATED AGAINST MEASLES *
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



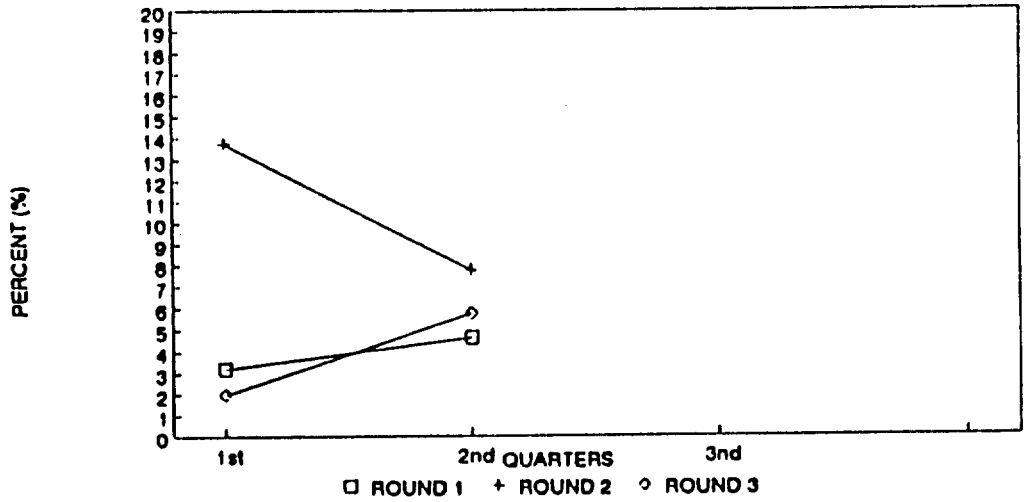
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	6.92	10.12	6.10
2nd	9.92	12.75	9.73
3nd			
4th			

TABLE V
PERCENT OF CHILDREN 1-4 YEARS OF AGE WHO WERE VACCINATED AGAINST MEASLES *
1994
(GOAL OF 20% PER QUARTER, 100% PER YEAR)



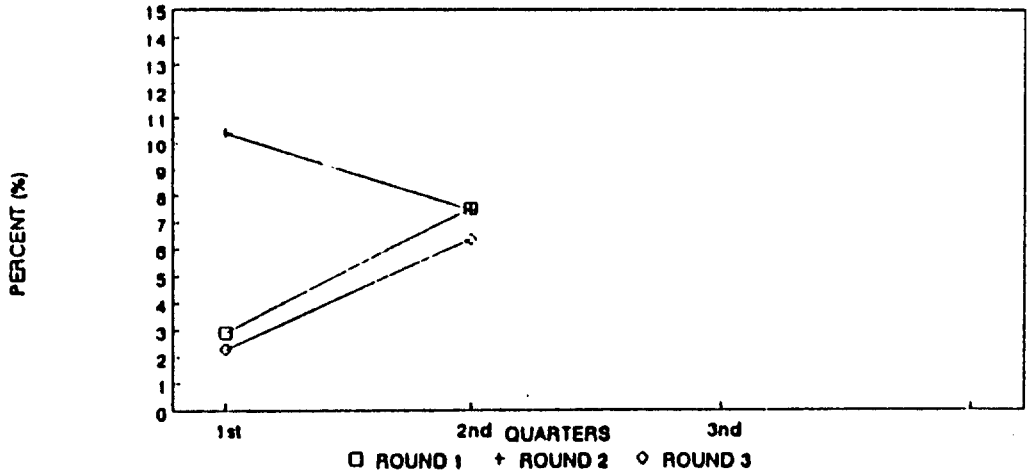
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	4.63	6.70	5.69
2nd	7.37	12.79	3.90
3nd			
4th			

TABLE VI
PERCENT OF PREGNANT WOMEN EXPECTED IN THE POPULATION THAT WERE VACCINATED WITH TETANUS TOXOID II
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	3.21	13.73	1.98
2nd	4.65	7.76	5.76
3nd			
4th			
	15.7%	43%	15.5%

TABLE VII
PERCENT OF WOMEN IN FERTILE AGE EXPECTED IN THE POPULATION THAT WERE VACCINATED WITH TETANUS TOXOID II
1994
(GOAL OF 15% PER QUARTER, 60% PER YEAR)



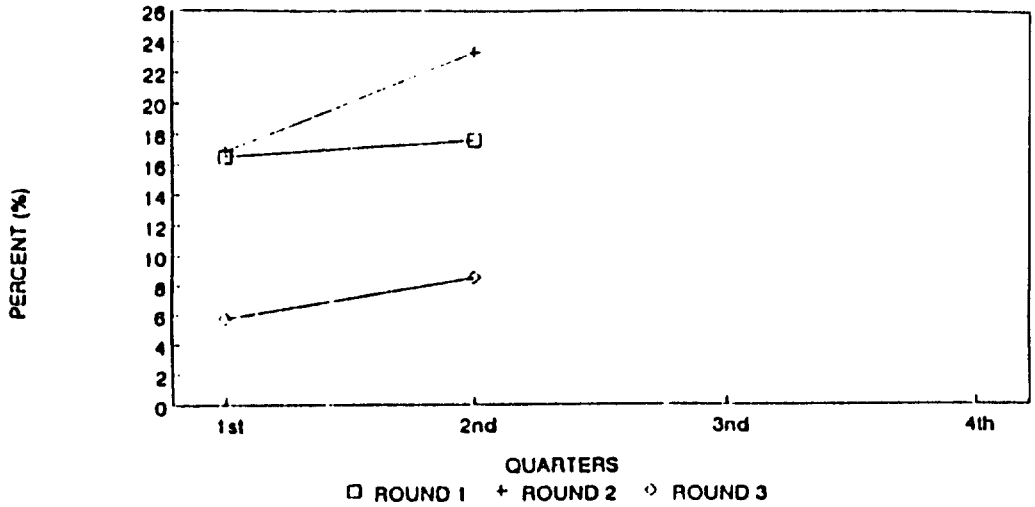
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	2.91	10.40	2.29
2nd	7.52	7.46	6.37
3nd			
4th			

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
PROSAMI

EVALUATION TABLES 1994

NUTRITION

TABLE I
QUARTERLY GROWTH MONITORING COVERAGE, CHILDREN UNDER 1 YEAR OF AGE
1994
(GOAL OF 25% PER QUARTER, 100% PER YEAR)



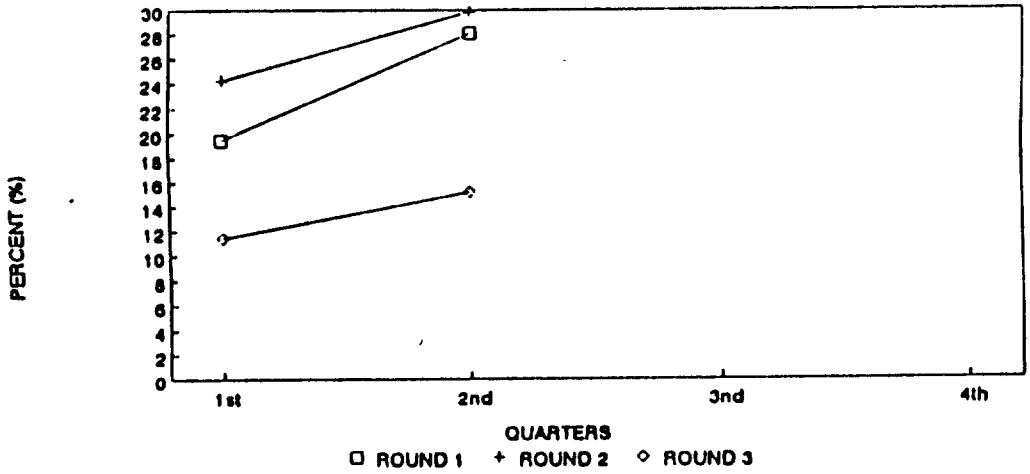
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	16.49	16.82	5.75
2nd	17.55	23.28	8.57
3nd			
4th			

60%

* NATIONAL NORM OF 6/YEAR; 100% COVERAGE/YEAR; 25% COVERAGE/QTER.

68.1 80.2 28.6

TABLE II
QUARTERLY GROWTH MONITORING COVERAGE, CHILDREN UNDER 1 – 4 YEARS OF AGE
1994
(GOAL OF 12.5% PER QUARTER, 50% PER YEAR)



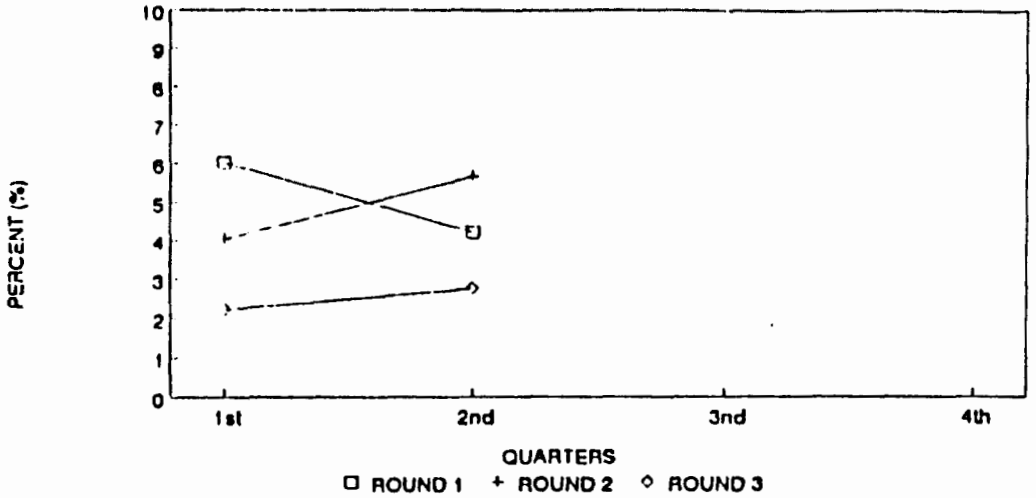
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	19.45	24.26	11.41
2nd	28.09	29.84	15.20
3nd			
4th			

85%

95.08 106.2 53.2

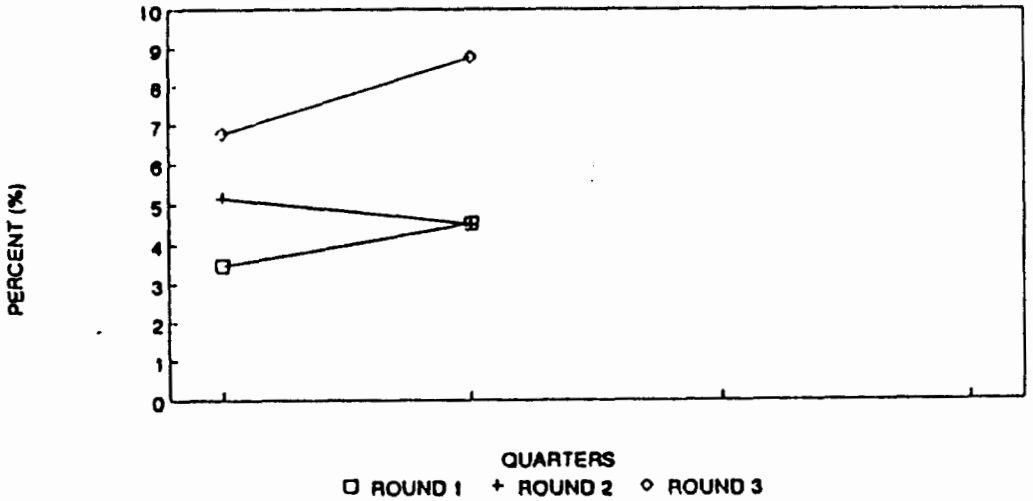
435

TABLE III
AVERAGE NUMBER OF GROUP EDUCATION SESSIONS PER HEALTH PROMOTER ON THE SUBJECT OF NUTRITION, GROWTH AND DEVELOPMENT.
1994
(GOAL OF ONE/PROMOTER/QUARTER)



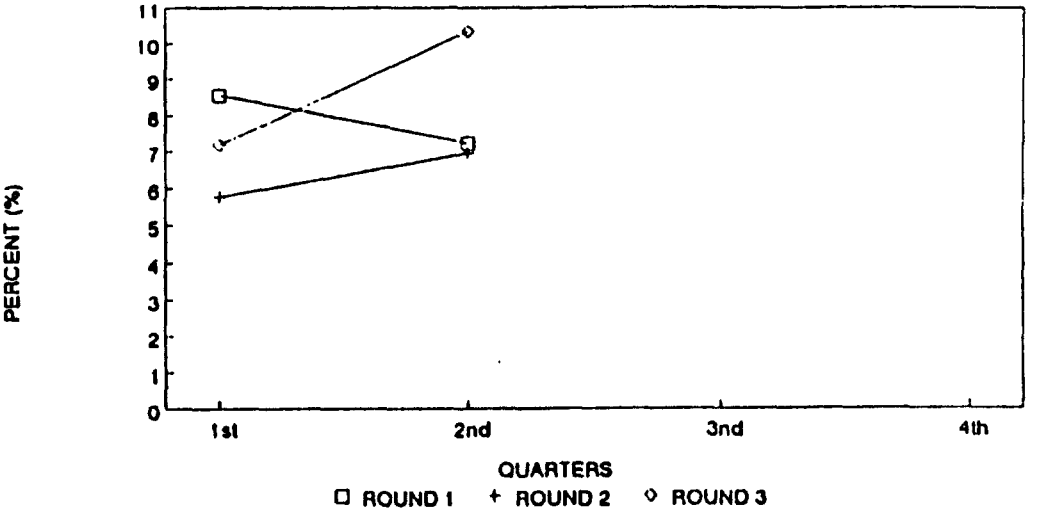
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	6.02	4.05	2.21
2nd	4.22	5.68	2.76
3nd			
4th			

TABLE IV
PERCENT OF GROWTH MONITORING SESSIONS AMONG CHILDREN UNDER 1 YEAR OF AGE THAT PRESENTED SEVERE OR MODERATE UNDERNUTRITION (WT/AGE)
1994



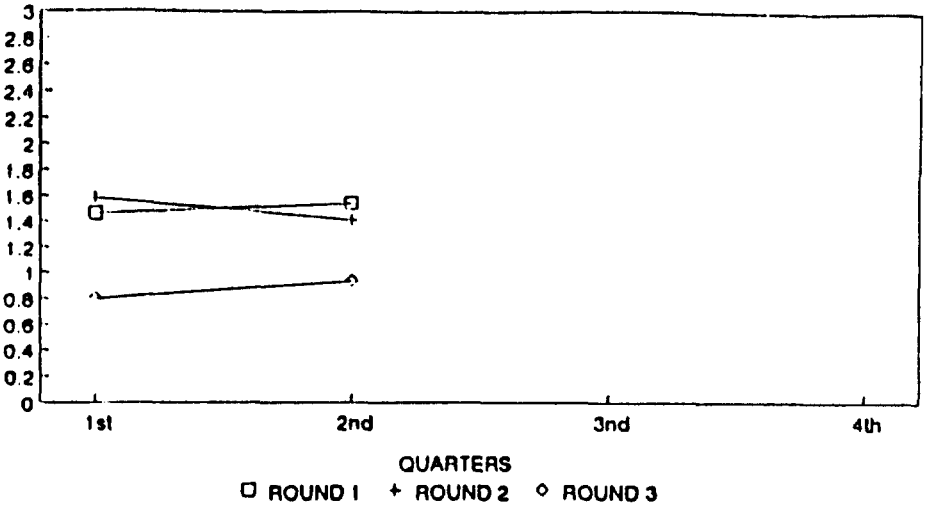
QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	3.47	5.15	6.77
2nd	4.53	4.51	8.75
3nd			
4th			

TABLE V
PERCENT OF GROWTH MONITORING SESSIONS AMONG CHILDREN 1 – 4 YEAR OF AGE THAT PRESENTED SEVERE OR MODERATE UNDERNUTRITION (WT/AGE)
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	8.55	5.76	7.18
2nd	7.24	6.98	10.34
3nd			
4th			

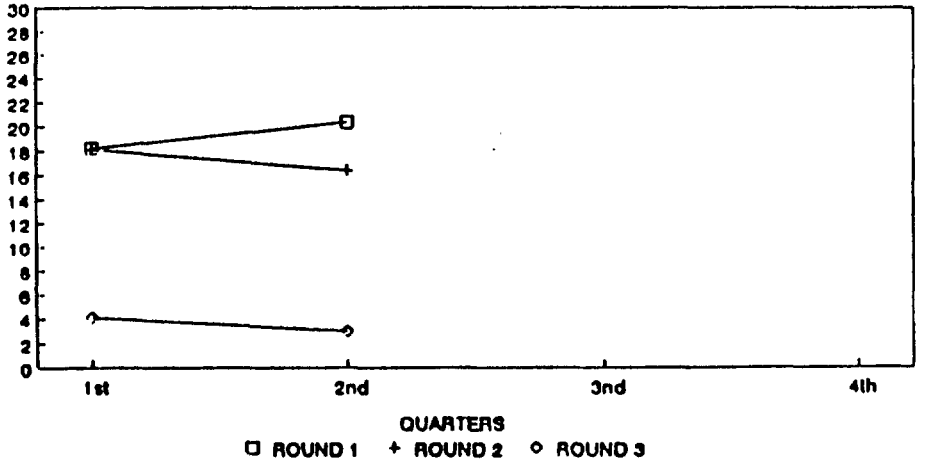
TABLE I
AVERAGE NUMBER OF ACTIVE HEALTH COMMITTEES PER HEALTH PROMOTER
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	1.46	1.58	0.80
2nd	1.54	1.41	0.94
3nd			
4th			

* PROJECT NORM 1 PER PROMOTER MINIMUM

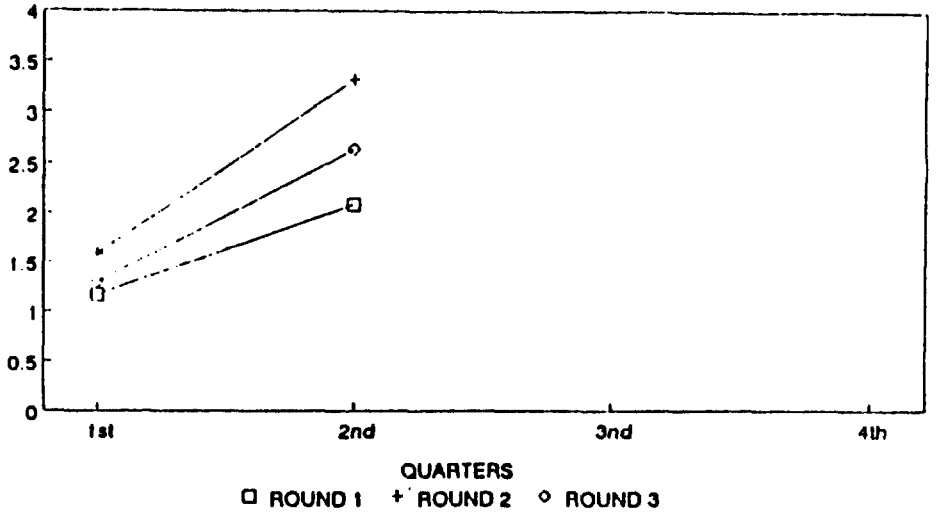
TABLE II
AVERAGE NUMBER OF ACTIVE VOLUNTEERS DEDICATING TIME TO THE PROJECT PER HEALTH PROMOTER*
1994



QUARTERS	ROUND 1	ROUND 2	ROUND 3
1st	18.19	18.11	4.12
2nd	20.33	16.35	2.99
3nd			
4th			

* PROJECT NORM OF 5/YEAR

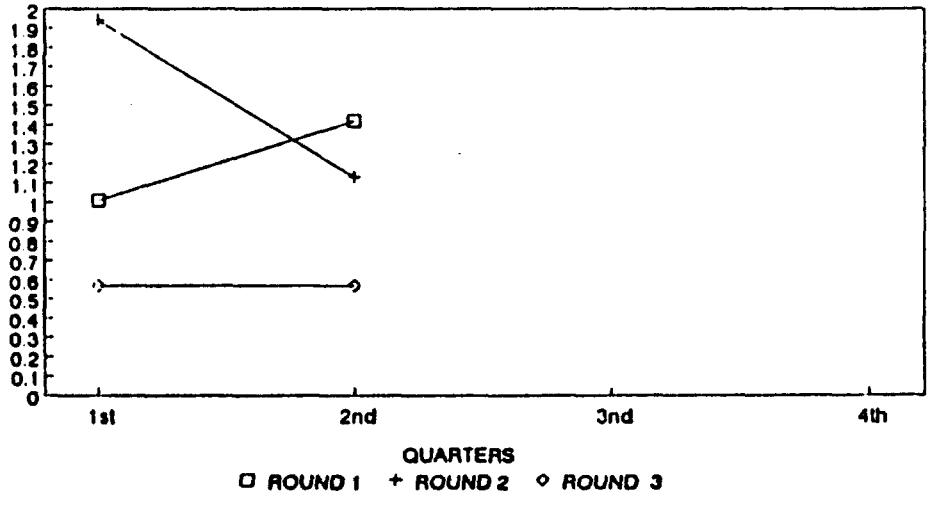
TABLE III
AVERAGE NUMBER OF COMMUNITY GENERAL ASSEMBLIES HELD PER HEALTH PROMOTER
1994



QUARTERS	ROUND 1*	ROUND 2	ROUND 3
1st	1.16	1.58	1.29
2nd	2.09	3.32	2.64
3nd			
4th			

* PROJECT NORM OF 2 PER YEAR

TABLE IV
AVERAGE NUMBER OF COMPLEMENTARY PROJECTS BEING IMPLEMENTED OR PROPOSED IN THE COMMUNITY PER HEALTH PROMOTER*
1993



QUARTERS	ROUND 1*	ROUND 2*	ROUND 3
1st	1.01	1.94	0.57
2nd	1.42	1.13	0.57
3nd			
4th			

* PROJECT NORM OF 2/PROMOTER/YEAR

ANNEX H.

HEALTH FINANCE SUPLEMENTAL ANNEXES

ANNEX H-1.

Cost-Efficiency Analysis

TOTAL COST COMPARISON AND COST PER ATTENTION
MOH,PROSAMI AND FUSAL 1993

		MOH		PROSAMI		FUSAL	
		NUMBER	COST ¢	NUMBER	COST ¢	NUMBER	COST ¢
1	MOH Community Health Div.Regions/NGO Level						
2							
3	Medical/Executive (20%MOH/30%NGO)	MOH		PROSAMI		FUSAL	
4	Nurse (20% MOH)	MOH				FUSAL	
5	Trabajadoras Sociales	MOH		PROSAMI		FUSAL	
6	Technical Coordinator/Supervisor	MOH		PROSAMI		FUSAL	
7	Administrator	MOH		PROSAMI			
8	Supervisors	MOH		PROSAMI			
9	Accountants	MOH		PROSAMI			
10	Health Educator			PROSAMI			
11	Data Entry	MOH					
12	Promoters	MOH		PROSAMI		FUSAL	
13	Mechanics	MOH					
14	Personnel Paid by Counterparts				19%X 24,881,424		
15	Sub total Personnel	SUM 3 to 14	MOH	SUM 3 to 14	FINANCE DEPT+14	SUM 3 to 14	FUSAL
16	Supplies and Equipment		MOH		+ Total PVO Commodities		FUSAL – 1,000,000
					+ Commodities warehouse		
17	Administrative Costs						FUSAL
18	Other non-personnel		MOH		+ Total PVO training		FUSAL
					+ Total PVO personnel		
					+ Total PVO program admin		
					–15		
19	MOH Community Health Div. Central Level						
20	Administrative Costs		MOH				
21	Personnel	MOH	MOH				
22	MOH Central Level Support		(15+16+18)*0.33				
23	Sub total MOH /NGO	SUM 15+21	SUM 15 TO 22	SUM 15+21	SUM 15 TO 22	SUM 15–21	SUM 15 TO 22
24							
25	External TA Costs						
26	Administrative Costs MSCI				Total MSCI office/Program Admin		
27	Central Personnel MSCI			PROSAMI	+ Technical Assitance		
					+ Personnel		
28	Central Non-Personnel Costs MSCI				+ Program Administration		
					+ Audit		
29	Technical Assistance APSISA		MOH				
30	Total Costs	SUM 15+21	SUM 23 TO 29	SUM 23+27	SUM 23 TO 29	SUM 15–21	SUM 23 TO 29
31							
32	Unit Cost Break Down						
33	Total Cost Per Promoter		÷ 30/12		÷ 30/12		÷ 30/12
34							
35	MOH/NGO Cost per Promoter		÷23/12		÷23/12		÷23/12
36							
37	Number of Attentions 1993				**		
38	(IRA,EDA,SR,RN,CYD,Adult)		MOH		PROSAMI		NA
39	Total Cost per Attention		÷30/38		÷30/38		NA
40	Target Population	MOH		PROSAMI		FUSAL	
41	MOH/NGO Cost Per Target Population		÷23/40		÷23/40		÷23/40
42	MOH/NGO Cost per Attention		÷23/38	*	÷23/38		NA

* This average includes 17 third round PVO's missing field implementation

Average Cost/Attention for PVO's in round one and two including counterpart donation is approximately 59.8

** 292 Promoters providing attentions (round 1 and round 2 PVO's) 163 in training, providing limited attentions (Round 3 PVO's)

Rel. Rene/NCTES2.WK1
09-NOV-94

NGO COST EFFICIENCY ANALYSIS

ITEM	Formula	ADHU	OEF	AMCS	ASAPROSAR	DIOCESIS	ASADEH	ASPS
Income PROSAMI	A.#1. F1	563,881	710,602	626,607	1,394,428	717,147	652,164	544,274
Compensation	(none)							
Pay Personnel	A.#3. F1	103,337	27,176	55,238	126,223	17,032	18,500	105,77[illegible]
Physical Space	A.#3. F1	16,400	23,870	600	48,620	15,000	106,000	34,719
Other Funding	A.#3. F1	35,381	47,603	14,926	54,317	2,992	38,652	30,712
Cash Funding	A.#3. F1	40,700	6,378	0	0	0	918	0
Total Cost of PVO	Sum. B3:B8	759,699	815,629	697,371	1,623,588	752,171	816,234	715,484
PVO Training Cost		350,177	454,352	439,114	1,044,338	423,005	445,855	391,873
% Training Cost Total	C19/C17	46	56	63	64	56	55	55
# Promoters	F1.C	8	20	10	34	18	10	10
# Admin+Tech PROSAMI	F1.C.	6	7	5	30	6	6	6
# Other pay Personnel	1993. A. Append	2	4	4	13	3	11	4
All Project Personnel	Sum B13:B15	16	31	19	77	27	27	2[illegible]
% # Promoters/All Personnel	B13/B16	50	65	53	44	67	37	50
Promoter Cost	F1. C. promot	9,850	21,600	14,000	34,422	18,000	14,500	16,500
Costo Admin +Tech	todo F1.C – B21	22,495	24,260	23,050	35,955	25,700	25,900	25,586
Cost pay Personnel	F1.A.#3 1993	103,337	27,176	55,238	126,223	17,032	18,500	105,779
Total Cost of Personnel	Sum B21:B23	135,682	73,036	92,288	196,600	60,732	58,900	147,865
% Cost Admin+Tech/								
Total Cost of Personnel	(B22+B23)/B24	93	70	85	82	70	75	89

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NGO COST EFFICIENCY ANALYSIS

ITEM	CALMA	CIRES	FUNDAC	FUMA	KNAPP	ADEMUSA	AMS	ASEI
Income PROSAMI	705,531	701,416	431,623	844,327	1,275,671	347,726	471,366	637,629
Compensation								
Pay Personnel	28,578	109,623	68,945	60,154	148,683	2,476	21,094	19,750
Physical Space	19,520	26,446	11,998	151,800	78,300	7,475	11,120	13,000
Other Funding	15,355	7,293	10,049	59,893	120,000	14,234	11,076	35,206
Cash Funding	0	26,684	0	9,510	0	0	45	4,430
Total Cost of PVO	768,984	871,462	522,615	1,125,684	1,622,654	371,911	514,701	710,015
PVO Training Cost	513,947	378,842	307,546	650,381	824,305	220,570	305,877	271,466
% Training Cost Total	67	43	59	58	51	59	59	38
# Prómoters	16	12	8	21	23	10	10	10
# Admin+Tech PROSAMI	9	6	7	7	12	6	6	6
# Other pay Personnel	4	19	4	9	9	2	4	3
All Project Personnel	29	37	19	37	44	18	20	19
% # Promoters/All Personnel	55	32	42	57	52	56	50	53
Promoter Cost	13,600	14,200	11,100	23,200	31,050	13,250	13,500	14,000
Costo Admin +Tech	34,700	23,625	20,745	26,000	44,625	23,190	25,700	24,960
Cost pay Personnel	28,578	109,623	68,945	60,154	148,683	2,476	21,094	19,750
Total Cost of Personnel	76,878	147,448	100,790	109,354	224,358	38,916	60,294	58,710
% Cost Admin+Tech/								
Total Cost of Personnel	82	90	89	79	86	66	78	76

4441

NGO GOST EFFICIENCY ANALYSIS

ITEM	ASIPES	CODECA	CODECOSTA	CODECUS	CODELUM	COMUS	FUNDEPRENS
Income PROSAMI	544,761	699,459	680,000	655,803	416,969	444,540	680,669
Compensation							
Pay Personnel	40,805	71,400	43,800	55,159	5,895	20,043	46,799
Physical Space	13,049	7,100	47,100	10,520	5,895	2,485	7,250
Other Funding	20,477	2,655	21,219	20,890	9,200	23,049	60,542
Cash Funding	4,449	47,665	35,096	58,000	19,735	16,926	0
Total Cost of PVO	623,541	828,279	827,215	800,372	457,694	507,043	795,260
PVO Training Cost	231,148	376,139	345,794	331,111	295,050	349,565	332,282
% Training Cost Total	37	45	42	41	64	69	42
# Promoters	10	10	10	10	10	10	10
# Admin+Tech PROSAMI	5	6	6	5	5	6	6
# Other pay Personnel	7	14	5	6	3	6	2
All Project Personnel	22	30	21	21	18	22	18
% # Promoters/All Personnel	45	33	48	48	56	45	56
Promoter Cost	16,500	15,900	13,500	13,500	13,500	13,500	13,236
Costo Admin +Tech	17,375	22,300	25,850	20,700	21,900	26,800	24,700
Cost pay Personnel	40,805	71,400	43,800	55,159	5,895	20,043	46,799
Total Cost of Personnel	74,680	109,600	83,150	89,359	41,295	60,343	84,735
% Cost Admin+Tech/							
Total Cost of Personnel	78	85	84	85	67	78	84

NGO COST EFFICIENCY ANALYSIS

ITEM	IDEA	ORMUSA	PADECOMSM	FASTRAS	PROGRESO	COSDECSAM	FUNDEMUN
Income PROSAMI	672,789	641,776	559,493	643,622	381,094	385,107	1,498,964
Compensation							
Pay Personnel	31,694	37,870	15,450	90,685	0	8,548	59,143
Physical Space	15,587	11,325	15,300	1,760	2,500	4,200	62,600
Other Funding	15,720	24,317	2,100	4,025	7,295	6,737	114,695
Cash Funding	0	4,580	0	29,273	0	0	0
Total Cost of PVO	735,790	719,868	592,343	769,365	390,889	404,592	1,735,402
PVO Training Cost	341,698	306,874	302,846	321,757	249,058	243,786	770,461
% Training Cost Total	46	43	51	42	64	60	44
# Promoters	10	20	10	10	13	10	18
# Admin+Tech PROSAMI	6	11	6	6	5	6	8
# Cther pay Personnel	7	5	2	14	0	2	10
All Project Personnel	23	36	18	30	18	18	36
% # Promoters/All Personnel	43	56	56	33	72	56	50
Promoter Cost	13,500	28,340	16,500	15,900	21,450	13,500	19,300
Costo Admin +Tech	23,850	48,225	49,200	24,283	16,846	26,500	30,800
Cost pay Personnel	31,694	37,870	15,450	90,685	0	8,548	59,143
Total Cost of Personnel	69,044	114,435	81,150	130,868	38,296	48,548	109,243
% Cost Admin+Tech/							
Total Cost of Personnel	80	75	80	88	44	72	82

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NGO - COST EFFICIENCY ANALYSIS

ITEM	FUNDESO	CONAMUS	OPRODE	ASALDI	PROCADES	AGAPE	AVERAGE
Income PROSAMI	579,989	566,910	608,878	581,720	1,351,129	650,169	681,950
Compensation							0
Pay Personnel	34,845	765	40,845	8,523	271,019	107,427	54,380
Physical Space	40,550	29,750	77,381	13,000	65,710	10,515	28,813
Other Funding	98,307	27,456	39,486	60,921	56,616	99,824	34,663
Cash Funding	0	0	0	0	0	46,915	10,037
							0
Total Cost of PVO	753,691	624,881	766,590	664,164	780,416	914,850	782,298
PVO Training Cost	352,582	382,328	428,086	452,032	989,075	370,360	422,677
% Training Cost Total	47	61	56	68	127	40	54
							0
# Promoters	8	10	4	12	18	17	13
# Admin+Tech PROSAMI	7	6	7	5	8	7	7
# Other pay Personnel	4	3	3	3	10	25	6
All Project Personnel	19	19	14	20	26	49	26
							0
% # Promoters/All Personnel	42	53	29	60	49	35	49
							0
							0
Promoter Cost	10,330	12,300	13,300	18,800	25,125	23,150	16,969
Costo Admin +Tech	18,605	17,575	20,175	20,400	32,900	20,500	26,171
Cost pay Personnel	34,845	765	40,845	8,523	271,019	107,427	54,380
Total Cost of Personnel	63,780	30,640	74,320	47,723	329,044	151,077	97,519
% Cost Admin+Tech/							
Total Cost of Personnel	84	60	82	61	92	85	79

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ANNEX H-2.

Other Suplementary Annexes

NGO TRENDS OF EFFICIENCY AND EFFECTIVENES

N G O	COST (¢) PER TARGET POPULATION		COST (¢) PER PROMOTER ATTENTION		COST (¢) PER PROMOTER		No. OF ATENTIONS PER PROMOTERS	
	1993	1994	1993	1994	1993	1994	1993	1994
FIRST ROUND								
AGAPE	109.35	138.01	46.24	46.41	40,635.54	48,270.26	879	1,040.[illegible]
ADHU	151.13	166.74	42.29	77.26	80,554.46	62,210.60	1,905	805.20
O.E.F.	128.04	122.79	53.61	41.51	29,608.41	28,931.75	552	696.92
PROCADES	140.45	125.72	78.65	52.53	90,075.26	67,189.33	1,145	1,279.00
ASALDI	142.93	73.06	65.15	53.67	48,476.68	66,971.83	744	1,247.83
ASAPROSAR	134.60	127.87	67.93	23.36	27,888.57	51,550.08	411	2,206.40
DIOCESIS	122.66	150.43	82.49	68.03	36,306.82	45,370.60	440	666.90
FUNDEMUN	163.07	128.14	63.42	41.44	72,748.91	57,164.78	1,147	689.67
OPRODE	126.83	118.76	46.33	43.04	65,965.89	61,770.89	1,424	717.56
Average First Round	135.45	127.95	60.68	49.69	54,695.61	54,381.12	960.78	1,038.84
SECOND ROUND								
AMCS	96.66	102.13	48.07	26.65	62,056.87	65,567.80	1,291	2,460.[illegible]
ASADEH	150.30	134.87	34.12	26.79	65,216.46	58,518.60	1,912	1,092.30
ASPS	113.06	139.33	25.37	46.43	54,427.43	67,074.80	2,146	1,444.80
CALMA	158.90	117.60	43.55	31.12	44,095.70	46,157.75	1,012	1,483.00
CONAMUS	206.23	245.82	107.85	111.30	69,369.06	82,685.09	643	371.45
CIRES	153.38	150.38	130.30	38.51	58,451.36	57,312.50	449	744.08
FUNDAC	116.66	88.94	519.40	66.80	53,952.99	674.25	104	337.13
FUNDESO	139.25	111.12	17.76	14.88	72,894.84	58,169.75	4,105	1,954.50
KNAPP	143.01	180.63	77.47	55.96	53,152.97	67,134.42	686	1,199.67
FUMA	136.25	154.40	51.91	40.68	49,666.30	45,562.19	957	1,120.10
Average Second Round	141.37	142.52	105.58	45.91	58,328.40	54,885.71	1,330.35	1,220.76

NGO TRENDS OF EFFICIENCY AND EFFECTIVENES

NGO	COST (¢) PER TARGET POPULATION		COST (¢) PER PROMOTER ATTENTION		COST (¢) PER PROMOTER		No. OF ATENTIONS PER PROMOTERS	
	1993	1994	1993	1994	1993	1994	1993	1994
THIRD ROUND								
ADEMUSA	93.98	235.53	N/D	89.34	N/D	87,145.20	N/D	487.70
AMS	127.40	247.45	N/D	213.03	N/D	91,558.20	N/D	429.80
ASEI	172.33	163.14	N/D	23.85	N/D	60,360.60	N/D	2,531.20
ASIPES	129.71	114.46	N/D	28.79	N/D	48,071.60	N/D	1,670.00
COSDECSAM	106.11	232.65	N/D	321.43	N/D	86,060.00	N/D	267.80
CODECUS	156.14	136.82	N/D	64.80	N/D	57,466.40	N/D	886.80
COMUS	120.15	245.68	N/D	194.74	N/D	90,902.20	N/D	466.80
FASTRAS	176.13	160.07	N/D	147.70	N/D	59,227.00	N/D	401.00
CODELUM	99.47	259.43	N/D	438.43	N/D	96,015.20	N/D	219.00
CODECOSTA	180.88	163.23	N/D	247.11	N/D	60,394.60	N/D	244.40
CODECA	166.54	108.21	N/D	118.34	N/D	59,547.20	N/D	503.20
FUNDEPRENS	182.58	166.82	N/D	66.54	N/D	62,189.80	N/D	934.60
IDEA	181.83	178.91	N/D	82.28	N/D	66,196.60	N/D	804.[illegible]
ORMUSA	86.73	86.80	N/D	71.01	N/D	64,231.80	N/D	904.60
PADECOMSM	151.21	170.00	N/D	530.90	N/D	63,071.00	N/D	118.80
PROGRESO	90.74	210.11	N/D	85.53	N/D	46,445.58	N/D	543.05
Average Third Round	138.87	179.96		170.24		68,681.44		713.35
AVERAGE ROUNDS	138.56	150.14	55.42	88.62	37,674.67	59,316.09	763.71	990.98

PROYECTO BAHIA DE JIQUILI O

PRESUPUESTO PARA UN PERIODO DE 12 MESES

1- Salario Personal Técnico más beneficios	¢	745,860.00
2 Médicos 1 Enfermera 3 Trabajadoras Sociales 1 Tecnóloga Materno Infantil 1 Nutricionista 1 Ecotécnologo 1 Agrónomo 1 Educador para la salud		
2- Salario del Personal Administrativo	¢	108,000.00
3- Asistencia Técnica	¢	360,000.00
4- Apoyo Logístico Papelería y Utiles Material Didáctico Insumos y suministros Uniformes Transporte Combustible Comunicaciones Aseo y Limpieza	¢	858,319.00
5- Bienes Mobiloiario y Equipo (Inversión Inicial)	¢	220,300.00
6- Medicinas y Equipo Médico	¢	648,000.00
	¢	2,940,479.00
APORTE DE LA COMUNIDAD	¢	56,635.20
TOTAL DEL PROYECTO	¢	2,997,114.20

PROYECTO SAN JULIAN

PRESUPUESTO PARA UN PERIODO DE 12 MESES

1- Salario Personalo Técnico más beneficios	¢	257,400.00
1 Médico 1 Enfermera 1 Trabajadora Social 1 Tecnóloga Materno Infantil		
2- Porcentaje de Salario del Personal Admtvo.	¢	79,200.00
3- Capacitaciones a Promotores	¢	150,000.00
4- Materiales y suministros Material Didáctico Insumos y suministros	¢	101,400.00
5- Transporte	¢	120,000.00
6- Medicinas y Equipo Médico	¢	888,000.00
	¢	1,596,000.00
APORTE DE LA COMUNIDAD	¢	77,611.20
TOTAL DEL PROYECTO	¢	1,673,611.20

36 10 horas/da

3) PRESUPUESTO POR PROGRAMAS

	Fc. General	Fr. Bx	Total
1.01 Administración Central de los Servicios de Salud	196.967.840		196.967.840
1.02 Servicios Técnicos Normativos	10.791.990		10.791.990
1.03 Servicios de Salud, Región Occidental	48.466.320		48.466.320
1.04 Servicios de Salud, Región Central	37.163.260		37.163.260
1.05 Servicios de Salud, Región Metropolitana	53.436.470		53.436.470
1.06 Servicios de Salud, Región Paracentral	50.499.930		50.499.930
1.07 Servicios de Salud, Región Oriental	83.823.090		83.823.090
2.01 Financiamiento para Gastos de Funcionamiento de las Instituciones Autónomas y Otras Entidades	371.616.840		371.616.840
3.01 Ampliación de la Red de los Servicios de Salud		169.170	169.170
3.02 Construcción, Ampliación y Mejoras de Edificios del Ramo	20.840.160		20.840.160
3.03 Saneamiento Básico Rural	8.167.920		8.167.920
Totales	881.735.820	169.170	881.906.990

4) CLASES GENERALES DE GASTO POR PROGRAMAS

	0-0	0-0	0	0	0	0	0	0	Total
1.01	90.[illegible].070	8.170.700	3.796.000	[illegible].220	2.388.190		11.200		196.967.840
1.02	8.015.290	1.394.000	96.000	513.000			3.600		10.791.990
1.03	40.000.270	9.300.000	615.040	9.730.000			1.050	100.000	48.466.320
1.04	30.[illegible].000	5.162.220	300.710	4.556.000			1.230	100.000	37.163.260
1.05	30.[illegible].220	7.103.270	677.140	11.300.420			1.390	100.000	53.436.470
1.06	30.[illegible].210	11.133.000	630.200	9.233.270			1.050	100.000	50.499.930
1.07	30.[illegible].600	15.020.000	734.050	13.311.000			1.100	100.000	83.823.090
2.01							371.616.840		371.616.840
3.01						169.170			169.170
3.02						20.840.160			20.840.160
3.03		7.790.270	300.050	100.000			10.000		8.167.920
Totales	191.000.000	60.000.000	6.000.000	110.000.000	2.388.190	11.000.330	371.660.910	500.000	881.906.990

5) CLASIFICACION ECONOMICA-SECTORIAL

	Desarrollo Social
CASTOS CORRIENTES	850.359.550
Castos de Consumo	478.718.640
Remuneraciones	254.810.930
Compra de Bienes y Servicios	223.907.710
Transferencias	371.640.910
Al Sector Privado	969.070
Al Sector Público	370.671.840
CASTOS DE CAPITAL	31.545.440
Inversión Real	31.545.440
Equipo	2.388.190
Obras y Construcciones	29.157.250
Total	881.906.990

CARGO	SUELDO	APORTACIONES	VIATICOS	TOTAL
PROMOTOR	2,187.90	244.61	400	2,832.51
SUPERVISOR ESPECIFICO	2,659.80	297.37	400	3,357.17
MEDICO SUPERVISOR REGIONAL	5,534.10	618.71	--	6,152.81
ENFERMERA SUPERVISORA LOCAL	3,903.90	436.46	400	4,470.36

SEGURO DE VIDA ¢ 30,000.oo

DIVISION FINANCIERO CONTABLE
SAN SALVADOR
EL SALVADOR, C. A.

MSCI/PROSAMI
EXPENSES INCURRED BY PVO's
FROM JUL 90 TO JUL 94
EXPRESED IN COLONES

		01/01/91 Through 12/31/91	01/01/92 Through 12/31/92	01/01/93 Through 12/31/93	01/01/94 Through 06/30/94	Grand Total
115 AGAPE	Training	47,710.93	232,473.97	370,360.44	245,770.03	896,315.37
	Commodities	0.00	423,130.46	96,352.46	101,117.89	620,600.81
	Personnel	390.00	22,252.59	74,667.75	53,960.25	151,270.59
	Program Admin	0.00	23,175.24	108,787.96	9,449.00	141,412.20
TOTAL AGAPE		48,100.93	701,032.26	650,168.61	410,297.17	1,809,598.97
120 ADHU	Training	39,434.39	213,176.40	350,177.25	214,477.71	817,265.75
	Commodities	53.60	309,265.59	67,377.39	25,517.12	402,213.70
	Personnel	3,598.00	105,413.86	134,547.87	60,203.61	303,763.34
	Program Admin	0.00	14,027.87	11,778.68	10,854.83	36,661.38
TOTAL ADHU		43,085.99	641,883.72	563,881.19	311,053.27	1,559,904.17
125 OEF	Training	59,823.06	326,643.53	454,352.53	235,952.51	1,076,771.63
	Commodities	0.00	515,797.00	105,092.28	37,276.79	658,166.07
	Personnel	1,256.81	48,349.92	122,331.63	59,817.08	231,755.44
	Program Admin	0.00	28,050.94	28,825.32	14,134.89	71,011.15
TOTAL OEF		61,079.87	918,841.39	710,601.76	347,181.27	2,037,704.29
130 PROCADES	Training	100,808.00	975,463.26	989,075.38	418,466.09	2,483,812.73
	Commodities	0.00	643,577.56	152,563.76	89,823.38	885,964.70
	Personnel	5,000.00	116,601.46	170,049.41	58,585.79	350,236.66
	Program Admin	0.00	35,750.14	39,440.40	37,829.17	113,019.71
TOTAL PROCADES		105,808.00	1,771,392.42	1,351,128.95	604,704.43	3,833,033.80
135 ASALDI	Training	84,738.02	350,274.98	452,032.07	276,546.17	1,163,591.24
	Commodities	0.00	311,602.31	38,556.60	74,858.81	425,017.72
	Personnel	7,404.50	66,057.35	77,704.20	39,811.67	190,977.72
	Program Admin	0.00	14,729.23	13,427.25	10,614.89	38,771.37
TOTAL ASALDI		92,142.52	742,663.87	581,720.12	401,831.54	1,818,358.05
140 ASAPROSAR	Training	0.00	544,094.79	1,044,338.09	488,192.00	2,076,624.88
	Commodities	0.00	600,273.91	201,089.23	67,723.58	869,086.72
	Personnel	0.00	77,642.78	114,493.17	58,161.72	250,297.67
	Program Admin	0.00	36,129.61	34,507.86	30,299.05	100,936.52
TOTAL ASAPROSAR		0.00	1,258,141.09	1,394,428.35	644,376.35	3,296,945.79
145 DIOCESIS	Training	6,960.00	260,495.90	423,004.81	274,433.15	964,893.86
	Commodities	0.00	262,831.06	134,217.71	85,199.76	482,248.53
	Personnel	7,020.00	102,614.88	141,143.16	73,643.86	324,421.90
	Program Admin	0.00	11,716.27	27,770.67	20,430.20	59,917.14
TOTAL DIOCESIS		13,980.00	637,658.11	726,136.35	453,706.97	1,831,481.43
150 FUNDEMUN	Training	78,702.45	577,744.65	770,461.09	327,056.85	1,753,965.04
	Commodities	4,166.35	634,299.16	325,624.11	65,564.99	1,029,674.61
	Personnel	0.00	106,535.98	171,359.76	94,385.20	372,280.94
	Program Admin	0.00	37,895.74	42,035.40	27,476.58	107,407.72
TOTAL FUNDEMUN		82,868.80	1,356,475.53	1,309,480.36	514,483.62	3,263,328.31
155 OPRODE	Training	57,910.00	376,356.14	428,086.27	200,895.63	1,063,248.04
	Commodities	0.00	236,015.89	78,252.57	27,248.74	341,517.20
	Personnel	2,150.00	78,739.15	75,575.46	37,167.31	193,631.92
	Program Admin	0.00	14,027.87	11,778.68	12,657.97	38,464.52
TOTAL OPRODE		60,060.00	705,139.05	593,692.98	277,969.65	1,636,861.68
205 AMCS	Training		262,272.52	439,114.29	204,083.22	905,470.03
	Commodities		232,477.41	48,469.60	62,279.53	343,226.54
	Personnel		43,851.54	115,669.94	57,076.96	216,598.44
	Program Admin		13,404.67	17,314.89	4,400.00	35,119.56
TOTAL AMCS		0.00	552,006.14	620,568.72	327,839.71	1,500,414.57

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MSCI/PROSAMI
EXPENSES INCURRED BY F[illegible]'s
FROM JUL 90 TO JUN 94
EXPRESED IN COLONES

			01/01/91 Through 12/31/91	01/01/92 Through 12/31/92	01/01/93 Through 12/31/93	01/01/94 Through 06/30/94	Grand Total
210	ASADEH	Training		237,133.77	445,855.39	212,311.39	895,300.55
		Commodities		241,169.73	52,556.78	2,358.29	296,084.80
		Personnel		40,866.74	130,747.55	72,644.00	244,258.29
		Program Admin		19,197.70	23,004.85	5,280.00	47,482.55
	TOTAL ASADEH		0.00	538,367.94	652,164.57	292,593.68	1,483,126.19
215	ASPS	Training		163,322.83	391,873.51	283,458.82	838,655.16
		Commodities		224,002.84	52,165.32	6,385.12	282,553.28
		Personnel		36,789.27	80,020.57	40,250.38	157,060.22
		Program Admin		14,604.67	19,414.89	5,280.00	39,299.56
	TOTAL ASPS		0.00	438,719.61	544,274.29	335,374.32	1,318,368.22
220	CALMA	Training		179,123.45	513,947.47	257,092.71	950,163.63
		Commodities		217,330.65	60,364.33	34,835.02	312,530.00
		Personnel		40,439.58	113,304.53	71,834.29	225,578.40
		Program Admin		14,204.67	17,914.89	5,500.00	37,619.56
	TOTAL CALMA		0.00	451,098.35	705,531.22	369,262.02	1,525,891.59
225	CIRES	Training		126,182.92	378,842.35	204,968.26	709,993.53
		Commodities		230,108.25	131,176.69	66,524.51	427,809.45
		Personnel		19,381.96	147,615.08	71,606.46	238,603.50
		Program Admin		17,982.99	43,782.17	776.00	62,541.16
	TOTAL CIRES		0.00	393,656.12	701,416.29	343,875.23	1,438,947.64
230	CONAMUS	Training		174,943.56	382,328.18	208,162.02	765,433.76
		Commodities		44,251.30	241,264.15	187,038.56	472,554.01
		Personnel		25,321.47	77,195.05	58,025.39	160,541.91
		Program Admin		3,200.00	62,272.27	1,542.62	67,014.89
	TOTAL CONAMUS		0.00	247,716.33	763,059.65	454,768.59	1,465,544.57
235	FUNDAC	Training		195,384.93	307,546.06	136,689.13	639,620.12
		Commodities		215,412.73	36,780.84	14,454.40	266,647.97
		Personnel		38,402.26	66,682.13	20,298.01	125,382.40
		Program Admin		16,767.71	20,614.89	8,716.00	46,098.60
	TOTAL FUNDAC		0.00	465,967.63	431,623.92	180,157.54	1,077,749.09
240	FUMA	Training		321,751.50	650,380.68	353,841.65	1,325,973.83
		Commodities		442,207.30	73,314.22	72,041.01	587,562.53
		Personnel		35,046.10	87,416.74	47,241.26	169,704.10
		Program Admin		26,808.70	33,215.40	5,280.00	65,304.10
	TOTAL FUMA		0.00	825,813.60	844,327.04	478,403.92	2,148,544.56
245	FUNDAMAV	Training		223,868.61	147,842.69		371,[illegible]11.30
		Commodities		174,418.17	(177,194.85)		(2,776.68)
		Personnel		47,937.47	26,876.39		74,813.86
		Program Admin		16,204.67	4,200.00		20,404.67
	TOTAL FUNDAMAV		0.00	462,428.92	1,724.23	0.00	464,153.15
250	FUNDESO	Training		188,757.52	352,581.59	141,238.42	682,577.53
		Commodities		267,937.62	156,870.00	57,078.47	481,886.09
		Personnel		33,312.31	55,092.20	26,363.08	114,767.59
		Program Admin		17,804.67	18,614.89	8,000.00	44,419.56
	TOTAL FUNDESO		0.00	507,812.12	583,158.68	232,679.97	1,323,650.77
255	KNAPP	Training		219,849.59	824,305.20	519,522.52	1,563,677.31
		Commodities		208,750.86	266,752.08	136,541.47	612,044.41
		Personnel		39,151.29	98,184.17	50,971.22	188,306.68
		Program Admin		14,604.67	86,429.78	98,578.10	199,612.55
	TOTAL KNAPP		0.00	482,356.41	1,275,671.25	805,613.31	2,563,640.95

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MSCI/PROSAMI
EXPENSES INCURRED [illegible] PVO's
FROM JUL 90 TO JUN 94
EXPRESED IN COLONES

			01/01/91 Through 12/31/91	01/01/92 Through 12/31/92	01/01/93 Through 12/31/93	01/01/94 Through 06/30/94	Grand Total
305	ADEMUSA	Training			220,570.12	144,252.12	364,822.24
		Commodities			67,073.15	224,983.26	292,056.41
		Personnel			60,082.76	55,876.20	115,958.96
		Program Admin			0.00	10,614.89	10,614.89
	TOTAL ADEMUSA		0.00	0.00	347,726.03	435,726.47	783,452.50
310	AMS	Training			305,876.68	208,634.70	514,511.38
		Commodities			76,572.94	171,332.35	247,905.29
		Personnel			56,917.03	62,409.84	119,326.87
		Program Admin			32,000.00	15,414.89	47,414.89
	TOTAL AMS		0.00	0.00	471,366.65	457,791.78	929,158.43
315	ASEI	Training			271,466.42	188,759.76	460,226.18
		Commodities			247,325.70	37,326.03	284,651.73
		Personnel			103,422.20	69,557.67	172,979.87
		Program Admin			15,414.90	6,160.00	21,574.90
	TOTAL ASEI		0.00	0.00	637,629.22	301,803.46	939,432.68
320	ASIPES	Training			231,148.27	156,624.11	387,772.38
		Commodities			244,778.37	46,033.14	290,811.51
		Personnel			53,431.22	32,101.11	85,532.33
		Program Admin			15,403.89	5,600.00	21,003.89
	TOTAL ASIPES		0.00	0.00	544,761.75	240,358.36	785,120.11
325	CODECA	Training			376,138.61	210,907.15	587,045.76
		Commodities			215,596.41	37,183.67	252,780.08
		Personnel			70,109.61	44,845.38	114,954.99
		Program Admin			37,614.89	4,800.00	42,414.89
	TOTAL CODECA		0.00	0.00	699,459.52	297,736.20	997,195.72
330	CODECOSTA	Training			345,794.34	187,622.84	533,417.18
		Commodities			194,409.90	47,161.22	241,571.12
		Personnel			93,532.59	67,189.48	160,722.07
		Program Admin			35,527.89	0.00	35,527.89
	TOTAL CODECOSTA		0.00	0.00	669,264.72	301,973.54	971,238.26
335	CODECUS	Training			331,110.58	187,403.22	518,513.80
		Commodities			220,052.65	26,170.62	246,223.27
		Personnel			62,174.40	32,958.34	95,132.74
		Program Admin			42,464.89	40,800.00	83,264.89
	TOTAL CODECUS		0.00	0.00	655,802.52	287,332.18	943,134.70
340	CODELUM	Training			295,050.17	209,001.40	504,051.57
		Commodities			44,516.49	213,346.55	257,863.04
		Personnel			60,602.67	40,694.31	101,296.98
		Program Admin			16,800.00	17,033.94	33,833.94
	TOTAL CODELUM		0.00	0.00	416,969.33	480,076.20	897,045.53
345	COMAFAC	Training			323,895.22	147,639.05	471,534.27
		Commodities			30,390.63	11,847.91	42,238.54
		Personnel			80,646.79	36,621.50	117,268.29
		Program Admin			10,614.89	0.00	10,614.89
	TOTAL COMAFAC		0.00	0.00	445,547.53	196,108.46	641,655.99
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]
		Personnel			56,789.48	38,153.25	94,942.73
		Program Admin			0.00	10,500.00	10,500.00
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

NOMBRE DE LA ONG: _____

F1

A– INGRESOS DEL PROYECTO PROSAMI (1993)

CONCEPTO	VALOR
1. PROSAMI (Ingresos según sub–convenio)	¢
2. INGRESOS POR SERVICIOS PRESTADOS EN LA COMUNIDAD (EN EFECTIVO)	¢
3. CONTRAPARTIDA	¢
Personal Pagado	¢
Personal Voluntario	¢
Espacio Físico	¢
Bienes Prestados	¢
Bienes Donados	¢
Otras Aportaciones en Especie	¢
Aportaciones en Efectivo	¢
4. TOTAL INGRESOS	¢

B– INGRESOS DEL PROYECTO PROSAMI (ENERO A JUNIO DE 1994)

CONCEPTO	VALOR
1. PROSAMI (Ingresos según sub–convenio)	¢
2. INGRESOS POR SERVICIOS PRESTADOS EN LA COMUNIDAD (EN EFECTIVO)	¢
3. CONTRAPARTIDA	¢
Personal Pagado	¢
Personal Voluntario	¢
Espacio Físico	¢
Bienes Prestados	¢
Bienes Donados	¢
Otras Aportaciones en Especie	¢
Aportaciones en Efectivo	¢
4. TOTAL INGRESOS	¢

C. PERSONAL ACTUAL PAGADO CON FONDOS DEL PROYECTO PROSAMI

POSICION	PERSONAS POR POSICION	SALARIO TOTALES POR MES
		¢
		¢
		¢
		¢
		¢
		¢
		¢
		¢
		¢
		¢
		¢

NOMBRE DE LA ONG: _____

F2

PRESUPUESTO TOTAL DE LA ONG PARA EL AÑO 1994

NOMBRE DEL DONANTE	COSTOS DIRECTOS DEL PROYECTO	COSTOS DE OPERACION	TOTAL PRESUPUESTO	VENCIMIENTO DE LA DONACION
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
	¢	¢	¢	
TOTALES	¢	¢	¢	

NOTA : ADJUNTAR BALANCE GENERAL DE TODA LA ORGANIZACION AL 31 DE DICIEMBRE DE 1993

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

Organización _____ AÑO 1993

Nombre y Título del Representante _____ Firma del Representante _____

A. PERSONAL PAGADO

	CONCEPTO	No. de Personas	Salario por Hora	Total Anual Hrs. por Persona	VALOR TOTAL
1			¢		¢
2			¢		¢
3			¢		¢
4			¢		¢
5			¢		¢
6			¢		¢
7			¢		¢
8			¢		¢
9			¢		¢
10			¢		¢

A. Total Personal Pagado . . . . . ¢ _____

B. PERSONAL VOLUNTARIO

	CONCEPTO	No. de Personas	Salario por Hora	Total Anual Hrs. por Persona	VALOR TOTAL
1			¢		¢
2			¢		¢
3			¢		¢
4			¢		¢
5			¢		¢
6			¢		¢
7			¢		¢
8			¢		¢
9			¢		¢
10			¢		¢

B. Total Personal Voluntario . . . . . ¢ _____

E:\LOTUS\FINANCE\CONTRA

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

C. VALOR DE ESPACIO FISICO

	Tipo de Edificio (Oficina, Clínica, Centro Comunal, Casa, etc.)	Valor Total Anual	% PROSAMI	TOTAL PROSAMI
1		¢	%	¢
2		¢	%	¢
3		¢	%	¢
4		¢	%	¢
5		¢	%	¢
6		¢	%	¢

C. Total Valor Espacio Físico . . . . . ¢ _____

D. VALOR DE BIENES PRESTADOS

	BIENES PRESTADOS (Vehículo, Calculadora, Equipo Médico, etc.)	Valor Total Anual	% PROSAMI	TOTAL PROSAMI
1		¢	%	¢
2		¢	%	¢
3		¢	%	¢
4		¢	%	¢
5		¢	%	¢
6		¢	%	¢

D. Total Bienes Prestados . . . . . ¢ _____

E. VALOR DE BIENES DONADOS

	BIENES DONADOS (Medicamentos, Equipos y Materiales Médicos, Educativos, de Oficina, etc.)	VALOR TOTAL (Aproximado)
1		¢
2		¢
3		¢
4		¢
5		¢
6		¢
7		¢

E. Total Bienes Donados . . . . . ¢ _____

E:\STUDFINANCE\CONTRA

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

F. OTRAS CONTRIBUCIONES EN ESPECIE

	TIPO DE CONTRIBUCION EN ESPECIE (Gastos de Vehiculos, Luz electrica, Agua, Teléfoino, Viáticos, Correo, Fotocopias, etc.)	VALOR TOTAL
1		¢
2		¢
3		¢
4		¢
5		¢
6		¢
7		¢
8		¢
9		¢
10		¢
11		¢
12		¢
13		¢
14		¢
15		¢

F. Total Otras Contribuciones en Especie . . . . . ¢ _____

G. APORTACIONES EN EFECTIVO

	CONCEPTO	VALOR TOTAL
1		¢
2		¢
3		¢
4		¢
5		¢

G. Total Aportaciones en Efectivo . . . . . ¢ _____

GRAN TOTAL DE CONTRIBUCIONES EN ESPECIE Y EN EFECTIVO DE 1993 . . . . . _____

(SUMAR A – G)

E:\LOTUS\FINANCE\CONTRA

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

AÑO 1994
(Enero a Junio)

Organización

Nombre y Título del Representante

Firma del Representante

A. PERSONAL PAGADO

	CONCEPTO	No. de Personas	Salario por Hora	Total Anual Hrs. por Persona	VALOR TOTAL
1			¢		¢
2			¢		¢
3			¢		¢
4			¢		¢
5			¢		¢
6			¢		¢
7			¢		¢
8			¢		¢
9			¢		¢
10			¢		¢

A. Total Personal Pagado . . . . . ¢

B. PERSONAL VOLUNTARIO

	CONCEPTO	No. de Personas	Salario por Hora	Total Anual Hrs. por Persona	VALOR TOTAL
1			¢		¢
2			¢		¢
3			¢		¢
4			¢		¢
5			¢		¢
6			¢		¢
7			¢		¢
8			¢		¢
9			¢		¢
10			¢		¢

B. Total Personal Voluntario . . . . . ¢

B:\LOTUS\FINANCE\CONTRA

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

C. VALOR DE ESPACIO FISICO

	Tipo de Edificio (Oficina, Clínica, Centro Comunal, Casa, etc.)	Valor Total Anual	% PROSAMI	TOTAL PROSAMI
1		¢	%	¢
2		¢	%	¢
3		¢	%	¢
4		¢	%	¢
5		¢	%	¢
6		¢	%	¢

C. Total Valor Espacio Físico . . . . . ¢ _____

D. VALOR DE BIENES PRESTADOS

	BIENES PRESTADOS (Vehículo, Calculadora, Equipo Médico, etc.)	Valor Total Anual	% PROSAMI	TOTAL PROSAMI
1		¢	%	¢
2		¢	%	¢
3		¢	%	¢
4		¢	%	¢
5		¢	%	¢
6		¢	%	¢

D. Total Bienes Prestados . . . . . ¢ _____

E. VALOR DE BIENES DONADOS

	BIENES DONADOS (Medicamentos, Equipos y Materiales Médicos, Educativos, de Oficina, e	VALOR TOTAL (Aproximado)
1		¢
2		¢
3		¢
4		¢
5		¢
6		¢
7		¢

E. Total Bienes Donados . . . . . ¢ _____

PROYECTO DE SALUD MATERNA Y SUPERVIVENCIA INFANTIL
INFORME DE CONTRAPARTIDA
(EN EFECTIVO Y EN ESPECIE)

NOTA: Use hojas adicionales, si es necesario.

F. OTRAS CONTRIBUCIONES EN ESPECIE

	TIPO DE CONTRIBUCION EN ESPECIE (Gastos de Vehículos, Luz electrica, Agua, Teléfoino, Viáticos, Correo, Fotocopias, etc.)	VALOR TOTAL
1		¢
2		¢
3		¢
4		¢
5		¢
6		¢
7		¢
8		¢
9		¢
10		¢
11		¢
12		¢
13		¢
14		¢
15		¢

F. Total Otras Contribuciones en Especie . . . . . ¢

G. APORTACIONES EN EFECTIVO

	CONCEPTO	VALOR TOTAL
1		¢
2		¢
3		¢
4		¢
5		¢

G. Total Aportaciones en Efectivo . . . . . ¢

GRAN TOTAL DE CONTRIBUCIONES EN ESPECIE Y EN EFECTIVO DE ENERO A JUNIO DE 1994 . . . . . .

(SUMAR A – (

B:\LOTUS\FINANCE\CONTRA

NOTAS

1. *Monitoreo Financiero Promedio*

   La base fue la evaluación acumulada de monitoreo financiero que aparece en el reporte de "Calificaciones mensuales de ONG's en Finanzas" enero-agosto de 1994, de acuerdo con el procedimiento para evaluación mensual por categorías y que establece las clasificaciones A, B, C y D. Se le dio un peso de dos veces el puntaje.

2. *Presupuesto 1993*

   a) *Ninguna de las ONG's - participantes tuvo exceso de gastos sobre el presupuesto aprobado al inicio del año.*

   b) *Hubo un total de 57 transferencias entre rubros solicitados por las ONG's y aprobadas por un total de ¢1,436,526 (5% del presupuesto total).*

3. *Contrapartida 1993/1994*

   a) *1993:*

      - *Nivel más alto:*
        ¢1,986,610, 279.6% con respecto a lo gastado por la ONG.

      - *Nivel más bajo:*
        ¢19,478, 5.0% con respecto a lo gastado por la ONG.

   b) *1994 hasta agosto:*

      - *Nivel más alto:*
        ¢668,378, 151.0% con respecto al gasto.

      - *Nivel más bajo:*
        ¢10,849, 3.1.% con respecto al gasto

   c) *En la hoja de clasificación, el nivel de contrapartida, corresponde a 1993 y se representa así:*

A = 4	*Aportación del 90% o más*
B = 3	*Más de 75% y menos de 90%*
C = 2	*Más del 50% y menos de 75%*
D = 1	*Menos del 50%*

4. *Auditoría:*

La fuente para este puntaje es el reporte de "Clasificación de Informes de Auditoría Externa de 1993" en donde A, B, C y D tienen el equivalente de 4, 3, 2 y 1 respectivamente.

5. *Puntaje:*

Representa la suma de los datos que aparecen en cada una de las columnas predecentes.

Septiembre, 1994

ANNEX I.

ORGANIZATIONAL MANAGEMENT SUPLEMENTAL ANNEXES

ANNEX I-1.

PROSAMI/MSCI/NGO Financial Process Flow Chart

CONCEPTO	MSCI / PROSAMI	ONG
A. ANNUAL PLAN AND BUDGET	Prepare policies, guidelines, budget assignation, and work meeting with NGO's	Set up policies for the NGO aplicable to the Project
	Reviews with NGO and appoves	Prepares and submits plans and Budget.
B. GRANT SUB-AGREEMENT	Prepare Grant Sub-Agreement or amends same	Approval process and signature by parties
C. MANAGEMENT OF FUNDS 1. Funds Request	Validate and approves advance of funds	Prepares and submits first request for funds
	Deposits funds into NGO bank account for the Project	Available Bank Funds
	Enters fund advances in the Books	Enters in the Books amount's funds received.
2. Check Payments		Authorizes expenses and disbursement. Issues Checks.

1

CONCEPTO	MSCI / PROSAMI	ONG
		Accounting of payments effected.
3. Monthly Settlement of Payments	Reviews and accepts or invalidates disbursements.	Prepare and submits a check payment report.
	Enters settlemen of expenses in Books	
	Prepare reconciliations and statements of Advancements	Prepare and submits a monthly Bank Reconciliation
4. Funds Advances and subsequent settlement	Same as Steps 1 to 3	Same as Steps 1 to 3
D. DIRECT TRANSACTION FROM MSCI		
1. Ex-PROSAMI Warehouse Commodities	Warehouse processes requisi-tion or issues local procurement order within preestablished limits	Requests commodities approved in its Budget.
	Forwards commodities or delivers local procurement order	Procurement reception or authorization
	2	2

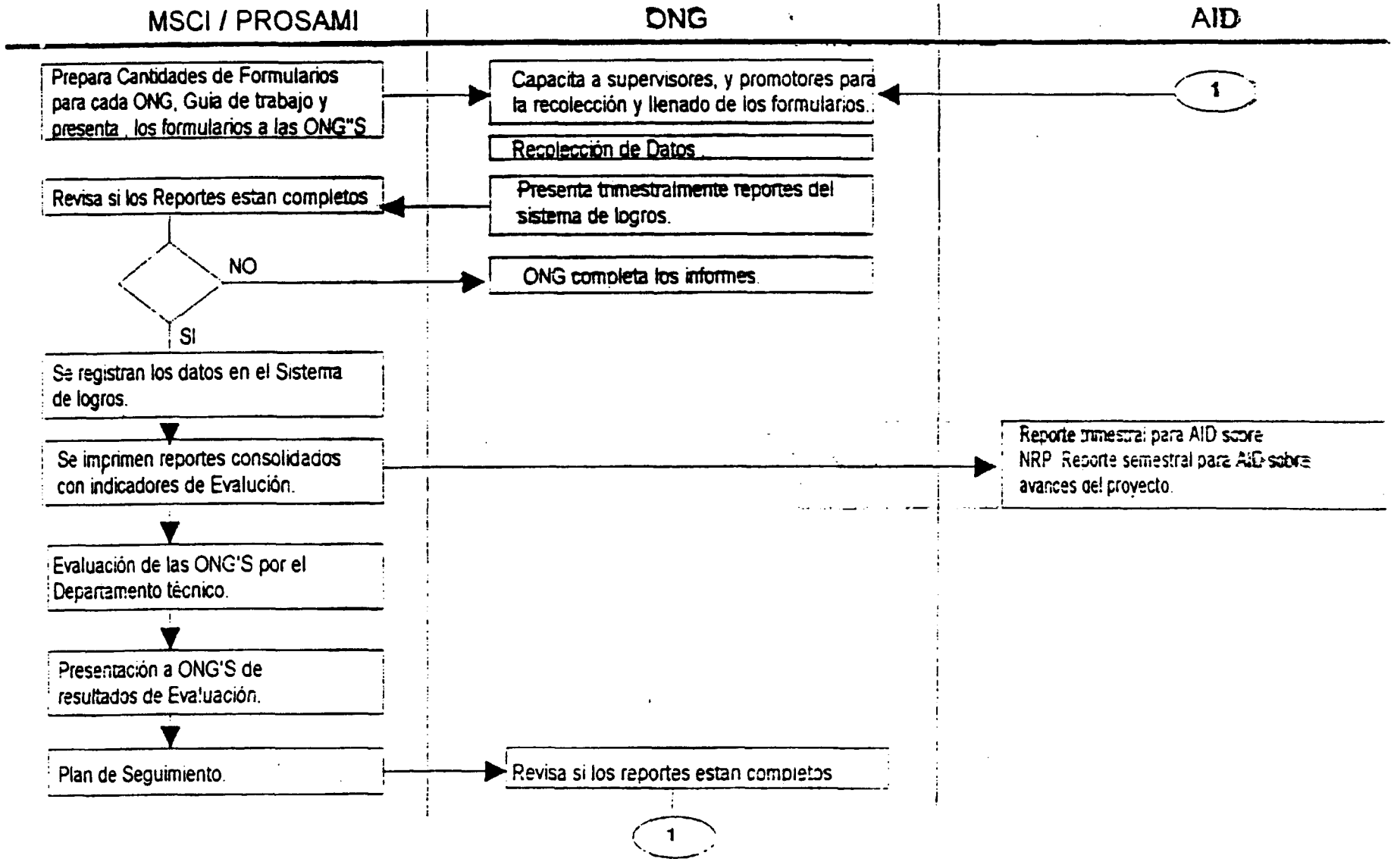
CONCEPTO	MSCI / PROSAMI	ONG
	(2) Registers withdrawals of units to control stocks	(2) Registers entry of units in stock control
	Sends copies of forwarding notes to accounting Department.	
	Registers into inventory system (CERTIFLEX) units and values (Except medicines values)	
	Accounting Department prepares monthly detail of deliveries in units and values, with copy to NGO's (Excepto medicine values)	Enters in books the value of commodities received (except medicines)
	Stocks are reconciled monthly between balances in Warehouse and balances in Accounting Dept. every quarter according to physical inventories.	The policies for operation of inventories and fixed capital assets include in Chapters VIII and IX of the Financial Administrative Manual.
2. Payments for NGO's Accounts	Direct payments are made in exceptional cases, charging NGO's bubgets (Training, etc.) ONG's (Capacitaciones, etc.)	
	Accounting Dept. registers transactions and forward debit notes to NGO's	Enters charges and deducts them from his budget.

CONCEPTO	MSCI / PROSAMI	ONG
E. FINANCIAL REPORTS	– Enters in books the Counterpart – Prepares local financial information for MSCI/ Arlington – Effects the necessary accounts reconciliations	Prepare and submits: – Counterpart report – Bank Reconciliation – Trial Balance – General Balance – Statement of Accounts – Budgetery Statement – Details of Fixed Capital Assets
F. CLOSING OF ACCOUNTING PERIOD	All budgets expire on December 31. Required adjustments are made and budgets are closed.	Closes his accounting period and budget. (Auditoria Anual del Proyecto)

ANNEX I-2.

Management Information System Flow Chart

FLUJOGRAMA DEL SISTEMA DE LOGROS



ANNEX I-3.

CDIE Study: "Factors Influencing the Sustainability of U.S. Foreign Assistance Programs in Health"

Attachment B

SUSTAINABILITY FACTORS
BOLIVIA CHILD SURVIVAL ASSESSMENT

In the CDIE study, "Factors Influencing the Sustainability of U.S. Foreign Assistance Programs in Health, 1942-1989: A Six Country Synthesis" (December 1990), 10 factors were found to generally influence the long-term sustainability prospects of A.I.D.-supported health projects.

We are going to try to apply the factors developed in the CDIE paper to the Child Survival [illegible] We will define the factors as follows:

1. Project Effectiveness

The most important factor is the project's *reputation* for effectiveness among key informants. Let's rate the projects as follows:

0 - Project has a reputation as a complete failure; viewed as totally ineffective.
1 - Project has a reputation as a qualified failure, an overall failure in terms of its objectives but it did a few things right and had minor impact.
2 - Project has a reputation as somewhat disappointing, although it did have some significant positive effects.
3 - Project has a neutral reputation in terms of effectiveness; it accomplished most but not all of its objectives and is considered a qualified success.
4 - Project has a positive reputation in terms of effectiveness; it accomplished all of its objectives and achieved the anticipated impact.
5 - Project has a reputation as a spectacular success; it exceeded its objectives and had more impact than anticipated.

2. Institutional Organization and Management

The important element here is whether projects were designed and implemented as vertically run separate hierarchies (single-disease programs, campaigns) or integrated into existing institutional hierarchies ("full-service" packages of interventions). Integrated services proved to be more sustainable than vertical services in the CDIE study. Rate the projects as follows:

0 - perfectly vertical service; no functional relationship at all with any other health service or unit
1 - essentially vertical service with only minimal relationship with other services or units
2 - vertical services packaged together somewhat, but not constituting an integrated program
3 - a mix of vertical and integrated services

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4 - essentially integrated services, but with a few "special" services such as vaccination campaigns
5 - totally integrated services

3. Economic Context

A strong and/or growing national economy was found to be a favorable factor with regard to project sustainability. Rate the economy of Bolivia as follows:

0 - chaotic and collapsing
1 - troubled; not growing, high uncertainty, lack of confidence
2 - stagnant; some sectors improving slightly, other sectors weak
3 - indifferent; not performing as well as it could, but not collapsing
4 - improving slowly
5 - improving rapidly

4. Political Context

This factor seems to have several dimensions: national political stability, priority given to national health programs, and a well-established and well-run public sector health establishment. Based on these three criteria, rate the political environment of Bolivia as follows:

0 - extremely negative and unfavorable; health sector projects virtually impossible
1 - somewhat negative, enough to seriously constrain health sector projects
2 - slightly negative, minimally constraining health sector projects
3 - indifferent; political environment neither favors nor constrains health sector projects
4 - generally positive; political context overall supports health sector projects
5 - extremely positive; political environment provides strong positive incentives for rapid progress with health sector projects

5. Financing

This factor measures whether a source of financial support was developed during the project to provide continuing funding support after the A.I.D. project ends. Let's rate projects as follows:

0 - no anticipation at all of postproject financial requirements
1 - only vague, unclear account taken of postproject financial needs
2 - postproject financial requirements taken into consideration, but not clearly and strongly provided for
3 - postproject financial needs apparently provided for, but it is questionable whether they will really be adequately covered
4 - postproject financial needs apparently covered adequately, although it will be a constant problem for the implementing organization

5 - strong, convincing provision of financing for postproject activities and additional, new activities assured

6. Project Content

This factor seems mainly concerned with the degree to which the project provided training so that project staff could continue project activities by itself. Let's rate projects as follows:

0 - no training, no attention at all to creating a permanent staff
1 - practically no training
2 - some training, but the local staff will be shaky when project ends
3 - barely adequate training; local staff will be ill prepared, but will carry on
4 - adequate training; local staff will be strong at end of project
5 - superior quality and quantity of training; local staff will be able to sustain project activities and launch new initiatives on their own

7. Project Negotiation Process

A mutually respectful negotiation process favors long-term sustainability, according to the CDIE study. Rate projects as follows:

0 - project exclusively an A.I.D. initiative; no consultation at all
1 - only minimal consultation and negotiation after A.I.D. develops the project
2 - a little host country participation in project development, followed by a negotiation process
3 - some active host country participation throughout project development, but still an A.I.D. initiative
4 joint, collaborative A.I.D. host country project development
5 - project essentially a host country initiative which is negotiated with A.I.D.

8. Implementing Institution

Negative institutional factors include rapid turnover of staff and executives, centralization, political patronage, internal conflict, and low skill levels. This multidimensional factor will be rated as follows:

0 - extremely deficient implementing institution capability
1 - weak institution, very low capability
2 - moderately weak institution
3 - fair institutional capability, strengths balance weaknesses
4 - moderately strong institution, strengths outweigh weaknesses
5 - very strong institution

9. National Commitment

This factor measures the degree of consensus among important interest groups and decision-makers that project goals and objectives are a national priority.

0 - lack of national consensus on project goals, including some strong opposition
1 - lack of consensus, but only weak opposition
2 - official indifference; neither support nor opposition
3 - some signs of a general consensus favoring project goals, but not a high priority
4 - firm, generalized consensus among leadership favoring project objectives
5 - project objectives represent a major national initiative with highest priority on the part of the host country

10. Community Participation

This factor measures the degree to which the project stimulates community participation and responds to community-defined requests. Rate projects as follows:

0 - no community involvement, participation, or initiative whatsoever
1 - very minimal, token community participation
2 - some community participation, but not very much
3 - moderate community participation
4 - strong elements of community participation, active participation a requirement for success at the community level
5 - activities based on strong community initiative; community designs and implements project activities at the local level

AGENCY FOR INTERNATIONAL DEVELOPMENT
UNITED STATES A.I.D. MISSION
TO EL SALVADOR

A.I.D. Unit 3110
A.P.O. AA 34023
Tel: (503)98-1666
Telex:20648 USAID SAL
Fax: (503)98-0885

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REMARKS:

Linda, attached are the final comments on the PROSAMI Evaluation. The e-mail with the attached comments was returned as "undeliverable" last week. Therefore, I'm faxing them to you. Please call me if you have questions (503-298-1401)

Cleared by: CW Edwards RELEASE APPROVAL: [signature]
Office Director

USAID/SS-006 (7/91)

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To: Christopher Edwards@PPD@SAN SALVADOR
Cc: Brenda Doe@HPN@San Salvador
Bcc:
From: Margarita Lobo@HPN@San Salvador
Subject: PROSAMI evaluation comments
Date: Monday, January 16, 1995 9:55:06 GMT
Attach:
Certify: N
Forwarded by:

On page 18, in the last paragraph they mention that FUSAL does not get any funding from USAID. This is not correct since they have a small health project in the Bahia de Jiquilisco under Nation Reconstruction.

On page 26 they state that the services are preventive and curative. But basically to my understanding all the measures preventive in nature. The word curative is not considere part of primary care. It would be better to substitue the word curative for secondary prevention.

On page 28 in conclusion No. 2 please have them clarify who "THEY" refers to in the begining of the paragaph.

On page 41 in paragraph 4 it is not true that their is "no provisions for monitoring the adecuacy of the use of the antibiotics". This information is reproted and supervised at the community level in their records and it is part of the supervisors duty to review the charts and supervise this.

On page 60 in paragraph 2, they state that a canton is the smallest unit. This is not correct a "Caserio " is the smallest unit.

On page 77 in the last paragraph is confusing. Are you saying that they found PROSAMI is abusing medications or are you refering to the fact the the society abusues medications? Please clear this paragraph.

On page 83 in the second paragraph the correct word is APSISA not ABSISA.

On page 85, table 26 there are no dates at the top.

On page 95, paragraph 1 To my understanding the MOH is planning to subcontatct NGO's to provide primary health care in the rural area not just absorb the health promotors.

On page 99 , in the second paragraph the corect name of the national survey is FESAL not FUSAL, they need to correct this throughout

COMMENTS ON THE FINAL DRAFT OF THE
PROSAMI
MIDTERM EVALUATION

TO: LEW THORNTON, CHIEF OF PARTY, EVALUATION TEAM

FROM: PROSAMI STAFF (DIRECCION, TECNICO, FINANZAS Y BIENES)

What follows are the comments from me (Elly) and the rest of the staff (Lloyd, Beza and the technical crew, Jose Angel and the finance guys, and Armando and Roberto) on the final draft of the evaluation. The PVO comments are presented seperately.

Our sincere thanks to you and Peter for your hard work in bringing this final draft together. Hope the comments are of help!

I. Executive Summary

Pg.1: third and fourth paragraphs - Reverse the order of these to emphasize the technical findings rather than systems. Also, on pg. 2 you mention under recommendations that the system appears to be highly effective in reducing morbidity and mortality. This is an important finding that should be included under Findings and Conclusions.

Pg.2: first paragraph - review changes in the health finance section below and modify as necessary.

General: there are some recommendations under lessons learned. Make sure findings are under findings, recommendations under recommendations, etc.

II. Background

Brief but no comment

III. Scope of Work

No comment

IV. Evaluation Team

No comment

V. Methodology

Organizational and Management Evaluation Methodology:

pg.10: paragraph 2 - this is the first time that the MSCI rating system is mentioned, so it needs to be explained briefly.

Health Finance Evaluation Methodology:

pg.17: last paragraph - there is a problem with the way in which MOH and PROSAMI data were compared in the table presented in the financial section of the report as well as the conclusions. Please see the changes in the presentation of the financial results, below, and adjust this paragraph accordingly.

Pg.18: last two paragraphs - the paragraph mentioning the MOH does not fit under Step 5 as it refers to the MOH and not FUSAL. In the last paragraph you mention that FUSAL was chosen as a PVO that does not receive USAID funding. This is incorrect as FUSAL is funded by USAID but was identified by the MOH and USAID for comparison anyway.

Pg. 20 first paragraph - 17 of the 35 (rather than "25") NGOs had not yet begun field level implementation and were still in training (rather than "not reached optimal productivity levels at this time"). Make it clear here that all PROSAMI costs, personnel and population include the 35 PVOs and just the "attentions" do not include the third round (as per the redone financial table).

second paragraph - if you count all FUSAL personnel (project coordinator, supervisors and promoters) as providers, but you only count PROSAMI promoters as providers (even though the coordinators and supervisors also provide some attentions) it is clear that PROSAMI's cost per provider will be higher than that of FUSAL. It is our opinion that the differences cited between the design of the FUSAL and PROSAMI projects are not as great as stated as we know that FUSAL's project was designed using the PROSAMI model since the beginning (and with the assistance of one of the PROSAMI PVOs, ASAPROSAR).

VI. Findings, Conclusions and Recommendations

A. Efficiency

1. Appropriateness of Objectives

pg 25: first • - this says that the focus is ... "basically curative". I think this was a typo. Maybe you meant "provides simplified curative interventions"?

2. Viability of NGO Service Delivery System

pg. 26: paragraph 2 - better explain what you mean by "services are both preventive and curative ... all of the measures are basically preventive in nature". Remember that the use of the term "curative" in this country tends to mean something that

people don't consider to be a part of primary care (and is therefore controversial when used to refer to PROSAMI). For instance, ORS is not primary prevention but secondary prevention (of dehydration), nevertheless people refer to it as a primary care measure and don't consider it to be curative. To us, the PAHO protocol for the treatment of pneumonia and prevention of acute pneumonia is secondary prevention and not "curative" care, just as the treatment of dehydration and prevention of acute dehydration with ORS is considered to be prevention and not "curative" care. We prefer the term "secondary prevention" or "case management" to the word "curative" for these reasons (for example see pg.27 paragraph three). Also, AID requested an analysis of the percentage of time the Project spends on primary and secondary level prevention. Please include the table I sent to you on this.

pg.28: conclusion no. 2 - clarify who "they" (promoters?) are in the beginning of this paragraph.

3. Inputs/Outputs

pg.31: third paragraph - use only one term to refer to the TBAs throughout the document, instead of the 3 cited in the parenthesis (search the others and replace with the one you select).

pg.33: paragraph 2 - please mention that the newsletter is 8-10 pages. Best not to refer to it as a "bulletin" as this is much smaller than a newsletter (in English). The newsletter is mailed to over 200 organizations in El Salvador and internationally.

4. Efficiency of Methods

pg. 36: paragraph 4 - please mention that the PVO staff training is conducted by PROSAMI technical, financial and commodities control staff and by consultants, while PVO promoters and TBAs are trained by PVO technical staff and the MOH (or put on pg. 37).

Also, remember that AID wanted a presentation of the training data by person-day, subject,etc. Please refer to the table we sent to you on this.

pg.41: paragraph 4 - many PVOs provide vaccines as a part of their routine care and not just in campaigns. I checked this with the advisor (Marina Silva). Also, it is not strictly true that their is "no provision for measuring or monitoring the adequalcy of the use of antibiotics". This info is not reported to PROSAMI on the central level, but it is available from community level records and is part of the supervisors duty when reviewing promoter records in the community.

B. Effectiveness

1. NGO Technical and Administrative Capacities

pg.45: paragraph 1 - Omit from this discussion "Health services were not available prior to the arrival of the PROSAMI in mid-1990. These areas cover 433 cantons with a total population of almost 440,000." The second sentence doesn't seem to fit with the rest of the discussion, while the first is not true.

pg.46: paragraph 1 - under Evaluation b) all 57 indicators are used quarterly to determine progress. 7 of these are key indicators used to construct a summary Index which summarizes the efficiency overall of each PVO. Thus is is misleading to say that "7 out of the 57 are actually used" and sounds as if we collect but don't use the other 50. It might be a good idea to rewrite this paragraph for more clarity.

pg.54: last recommendation - does this refer to management training such as the recommendation at the top of the page? repetitive?

pg.56: last recommendation - rather than debate the role, structure and functions of the MOH, maybe it would be better to say "debate and define the relationships between the MOH, NGOs, municipalities, and communities in the new decentralized structure of the health sector". Some of the PVOs in CONSALUD feel that it is important for the PVOs to define their position rather than wait for the government to decide. Other PVOs think that we should wait and comment on the government design rather than develop a PVO position. Your opinion?

general: Could we recommend that USAID encourage the MOH to implement it's pilot projects in decentralization through the PVOs that have been strengthened through PROSAMI and are members of CONSALUD? It seems nuts that the MOH is not subcontracting these PVOs for the pilot projects but rather is subcontracting others that have not been strengthened. Logically, the strengthened PVOs would be phased out of PROSAMI funding and simultaneously phased into MOH subcontracting with government funds. This would achieve not only the unification and extension of the health sector and the improvement of coverages, but would also solve the problem of PVO sustainability as they would receive subsidies from the government for those costs not covered by fees for service (just as is done in the US), as well as make the best use of USAID's investment in PVO strengthening through PROSAMI.

2. Progress to Date

Pg.59: Table 15 - the asterisks are placed wrong: the asterisk* refers to the Baseline; the double asterisk** refers to the 1994 data. The Country-wide data from the FESAL doesn't have an asterisk*.

3. Coverage

pg.60: paragraph 2 - a canton is the second smallest unit, not the smallest. When we say "community" we mean canton. The caserio is the smallest unit. We have generally referred to caserios as "hamlets". Also, all cantones are in rural areas whether they are PROSAMI or the MOH.

pgs 61 - 69: Please cite the sources of data for PROSAMI (quarterly field reports, 1993) and for the MOH (Annual Report, Division de Salud Comunitaria, 1993). This is really important as after you left CONSALUD had a conference with the MOH and presented the data and the MOH said the numbers were "subjective" and made up by the PVOs. Make sure it is emphasized and stands out so they can't discredit the report later. Thanks.

pg.62: paragraph 1 - Add: The 59% of cases of dehydration not referred were managed on the community level with oral rehydration.

pg.67-68: last paragraph and first two on next page - after you left we met with Materno-infantil to analyze MOH-PROSAMI achievements in maternal health through the 3rd quarter of 1994. FYI they have changed their indicators and are now using two: 1) the percentage of expected pregnant women (still using 5%) who received at least 1 prenatal care visit, and 2) the average number of visits for each of the women attended (no. of visits total divided by no of women attended). The MOH as a whole (hospitals and all) came up with an average number of prenatal attentions per women of 3.5, while ours was 3.0. We will adjust our analysis in 1995 to fit theirs with the exception that we will use real nos. of pregnant women rather than the 5% estimate. I told them about the need to reduce the estimated pregnancies down from 5% but I don't think they are convinced.

4. Quality of Care

pg.72: last paragraph - the ADD component has two focuses: the primary prevention of diarrhea and the secondary prevention of deaths from dehydration and shock. The prevention of diarrhea itself is through group and individualized education, cleanup and other compaigns, water and sanitation. The rest is secondary prevention.

pg.73: third paragraph - the ARI component has two focuses: the primary prevention of respiratory infections and the

secondary prevention of deaths from acute pneumonia. The prevention of respiratory infections is more difficult that ADD but PVOs work in group and individual education and improvements of the household through lorena stoves and improved ventilation. The rest is secondary prevention, as you say.

fourth paragraph - Did you see volunteers in UAIRAC's using antibiotics? The MOH says they do so indiscriminately (someone told the Minister OPRODE was doing so). They are supposed to identify pneumonia and refer to the promoter for treatment or the the MOH if severe.

pg.77: last paragraph - this paragraph is unclear and a bit alarming the way it is written. It sounds as if you are saying that there is "widespread abuse of medicines and medications at all levels of PROSAMI by health and non-health personnel". I don't think that is what you mean. Are you talking about a society-wide tendency or the Project. Please rewrite and be careful here as the MOH could take this out of context and use it as a major arm against the PVOs. For instance, I can hear it now "the PROSAMI evaluation found widespread abuse, etc.".

pg.78: last paragraph - this is an interesting analysis of the medicines used by the project. It might be better placed, however, just prior to the earlier discussion regarding promoter use of medicines as it leaves the reader in doubt about which type of provider can use which kind of medicine and if there is abuse of antibiotics or not.

pg.80: last recommendation - what do you think about timing these campaigns to preceed epidemiological peaks?

5. Cost Effectiveness Analysis

general: search and replace all NGO with PVO.

pg.81: second paragraph - Annex H-1 is missing in the Annexes.

pg. 81-82: Table 24 - as much of the discussion in this section is based on this table, we thought it important to start our comments with the table itself. Firstly, the table you present in the final draft does not correspond to the text. Roy's final draft table is coded MOHPR12e.WK1, not MOHPRO10.WK1. Attached you will find a copy of the correct table with my writing all over it.

In any case, the table Roy constructed is basically divided into 3 parts: Currently, the first part includes data on the regional costs of the MOH salud comunitaria program (not central costs), PROSAMI NGO level costs (central and field offices), and FUSAL field office costs (not central costs). The second part includes data on the MOH salud comunitaria central level costs and APSISA field office costs, MSCI field office costs, and FUSAL central office costs. The third section is a

Rey's Final Draft Table 24

TOTAL COST COMPARISON AND COST PER ATTENTION
MOH, PROSAMI AND FUSAL 1993

	MOH		PROSAMI		FUSAL	
	NUMBER	COST ¢	NUMBER	COST ¢	NUMBER	COST ¢
MOH ~~Regional~~/NGO Level						
~~Central~~ Municipal/NGO						
Medical/Executive (20%MOH/30%NGO)	1		35		1	
Nurse (20% MOH)	1				1	
Social Workers	0		1		1	
Technical Coordinator/Supervisor	9		42		1	
Administrator	0		24			
Supervisors	180		89			
Accountants	12		40			
Nutritionist						
Ecologist						
Agriculturist						
Health Educator			3			
Data Entry	7		460 ~~429~~ ~~415~~	~~445~~		
Promoters	1442				10	
Mechanics	6					
Personnel Paid by Counterparts				4,727,471		
Sub total Personnel	1,658	52,531,824	649	20,510,975	14	171,600
Supplies and Equipment		4,045,912		7,125,121		80,875
Other non-personnel		2,251,108		3,943,469		134,974
Sub total ~~Regional~~/NGO	1,658	~~78,242,363~~	649	31,579,564	14	~~387,449~~
MOH						
~~Central (Field) Level Plus Administrative Costs~~						
Administrative Costs (~~Home Office~~) Central MOH		17,935,390		819,372		30,000
~~Central~~ Personnel (~~field office personnel~~) Central MOH	19	702,975	35	7,249,036	TA	
Central Non-Personnel Costs		NA		1,890,881		no TA
Technical Assistance APSISA		455,500 TA				
TOTAL COSTS	1,677	97,336,228	684	41,538,854	14	417,449
				302 OK		
Unit Cost Break Down				90,~~899~~		
Total Cost Per Promoter		67,501 OK		~~100,094~~		41,745 OK
MOH ~~Regional~~/NGO Cost per Promoter		~~54,260~~		~~76,095~~		~~38,745~~
		67,185		68,~~581~~ OK		41,745
Number of Attentions 1993 (IRA,EDA,SR,RN,CYD,Adult)		513,615 OK		344,013 OK		NA
Total Cost per Attention		1900	~~439,882~~	121		NA
Target Population	1,800,000	53.82	~~260,832~~	71.80	10,000	41.74
MOH ~~Regional~~/NGO Cost Per Target Population		~~43.47~~	454,985	~~117.03~~		~~38.74~~
MOH ~~Regional~~/NGO Cost per Attention		~~152~~		69 ~~82~~		NA
		~~188~~ 189		OK		OK

* This average includes 17 third round PVO's initiating field implementation.
Average Cost Attention for PVO's in round one and two including counterpart donation is approximately 59.8

Ref. Rep MOHPRIS.WK1
20-OCT-94

* 292 promoters providing attentions (~~15~~ round one and round two PVO's). ~~163 in b~~ 163 in training, providing limited attentions (third round PVO's).

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Final Table 24

TOTAL COST COMPARISON AND COST PER ATTENTION
MOH,PROSAMI AND FUSAL 1993

	MOH		PROSAMI		FUSAL	
	NUMBER	COST ¢	NUMBER	COST ¢	NUMBER	COST ¢
MOH Community Health Div.Regions/NGO Level						
Medical/Executive (20%MOH/30%NGO)	1		35		1	
Nurse (20% MOH)	1				1	
Trabajadoras Sociales	0		1		1	
Technical Coordinator/Supervisor	9		42		1	
Administrator	0		24			
Supervisors	180		89			
Accountants	12		40			
Health Educator			3			
Data Entry	7					
Promoters	1442		460		10	
Mechanics	6					
Personnel Paid by Counterparts				4,727,471		
Sub total Personnel	1,658	52,531,824	694	20,510,975	14	171,600
Supplies and Equipment		4,045,912		7,125,121		80,875
Administrative Costs						30,000
Other non-personnel		2,251,108		3,943,469		134,974
MOH Community Health Div. Central Level						
Administrative Costs		17,935,390				
Personnel	19	702,975				
MOH Central Level Support		19,413,519				
Sub total MOH /NGO	1,677	96,880,728	694	31,579,565	14	417,449
External TA Costs						
Administrative Costs MSCI				819,372		
Central Personnel MSCI			35	7,249,036		
Central Non-Personnel Costs MSCI				1,890,881		
Technical Assistance APSISA		455,500				
Total Costs	1,677	97,336,228	729	41,538,855	14	417,449
Unit Cost Break Down						
Total Cost Per Promoter		67,501		90,302		41,745
MOH/NGO Cost per Promoter		67,185		68,651		~~41,745~~ 38,745
Number of Attentions 1993 (IRA,EDA,SR,RN,CYD,Adult)		513,615		** 344,013		NA
Total Cost per Attention		190		121		NA
Target Population	1,800,000		454,985		10,000	
MOH/NGO Cost Per Target Population		53.82		69.41		41.74
MOH/NGO Cost per Attention		**189**	*	**92**		**NA**

* This average includes 17 third round PVO's initiating field implementation.
Average Cost/Attention for PVO's in round one and two including counterpart donation is appoximatily 59.8

** 292 Promoters providing attentions (round 1 and round 2 PVO's). 163 in training, providing limited attentions (Round 3 PVO's).

Ref. Rene MOHPROI2e.WK1
09-NOV-94

TOTAL COST COMPARISON AND COST PER ATTENTION
MOH,PROSAMI AND FUSAL 1993

		MOH		PROSAMI		FUSAL	
		NUMBER	COST ¢	NUMBER	COST ¢	NUMBER	COST ¢
1	**MOH Community Health Div.Regions/NGO Level**						
2							
3	Medical/Executive (20%MOH/30%NGO)	MOH		PROSAMI		FUSAL	
4	Nurse (20% MOH)	MOH				FUSAL	
5	Trabajadoras Sociales	MOH		PROSAMI		FUSAL	
6	Technical Coordinator/Supervisor	MOH		PROSAMI		FUSAL	
7	Administrator	MOH		PROSAMI			
8	Supervisors	MOH		PROSAMI			
9	Accountants	MOH		PROSAMI			
10	Health Educator			PROSAMI			
11	Data Entry	MOH					
12	Promoters	MOH		PROSAMI		FUSAL	
13	Mechanics	MOH					
14	Personnel Paid by Counterparts				19%X 24,881,424		
15	**Sub total Personnel**	SUM 3 to 14	MOH	SUM 3 to 1	FINANCE DEPT + 14	SUM 3 to 14	FUSAL
16	Supplies and Equipment		MOH		+ Total PVO Commodities + Commodities warehouse		FUSAL - 1,000,00
17							
18	Other non-personnel		MOH		+ Total PVO trainig + Total PVO personnel + Total PVO program admin -15		FUSAL
19	**MOH Community Health Div. Central Level**						
20	Administrative Costs		MOH				
21	Personnel	MOH	MOH				
22	**MOH Central Level Support**		(15 + 16 + 18)*0.33				
23	**Sub total MOH /NGO**	SUM 15+21	SUM 15 TO 22	SUM 15 + 2	SUM 15 TO 22	SUM 15 + 21	SUM 15 TO 22
24							
25	**External TA Costs**						
26	Administrative Costs MSCI				Total MSCI office/Program Admin		
27	Central Personnel MSCI			PROSAMI	+ Technical Assitance + Personnel		
28	Central Non Personnel Costs MSCI				+ Program Administration + Audit		
29	Technical Assistance APSISA		MOH				
30	**Total Costs**	SUM 15+21	SUM 23 TO 29	SUM 23 + 2	SUM 23 TO 29	SUM 15 + 21	SUM 23 TO 29
31							
32	**Unit Cost Break Down**						
33	**Total Cost Per Promoter**		+ 30/12		+ 30/12		+ 30/12
34							
35	**MOH/NGO Cost per Promoter**		+23/12		+23/12		+23/12
36							
37	Number of Attentions 1993				**		
38	(IRA,EDA,SR,RN,CYD,Adult)		MOH		PROSAMI		NA
39	Total Cost per Attention		+30/38		+30/38		NA
40	Target Population	MOH		PROSAMI		FUSAL	
41	MOH/NGO Cost Per Target Population		+23/40		+23/40		+23/40
42	**MOH/NGO Cost per Attention**		**+23/38**	*	**+23/38**		**NA**

* [illegible]

Average Cost/Attention for PROSAMI in round one and two including counterpart distribution is approximately [illegible]

** [illegible] (round 1 and round 2 PVO's) 182 in training, providing limited services (round 2 PVO's)

Annex H-1

Final

Table 25.
COST PER POPULATION, PROMOTER, AND PROMOTER VISITS
(Amounts indicated in ¢, "colones")

UNIT	MINISTRY OF HEALTH	PROSAMI	FUSAL
Target Population per Promoter	1,248	909	1000
Per capita allocation per Target Population	~~43.47~~ 53.82	~~109.73~~ 69.41	38.74
Regional/NGO Cost per Promoter	~~54,260~~ 67,185	~~71,345~~ 68,651	38,745
Regional /NGO Cost per Promoter Visit	~~153~~ 189	92	NA

comparative analysis of the preceeding data (cost per attention, etc.).

As discussed and agreed with USAID in a previous meeting with Roy, the order of the presentation of the table as it stands mixes apples with oranges. Furthermore, some of the PROSAMI numbers (no. of promoters, total population) need to be updated as they only include the first 2 PVO rounds, while the cost figures for the same period include the cost of all 3 PVO rounds.

Attached is a new table (modification of the correct table, MOHPR12e.WK1) with the necessary changes (and the annex table explaining the worksheet manipulations - Annex H-1). The first section of the table has been modified to now include all of the MOH costs of running salud comunitaria (regional and central levels), PROSAMI NGO total costs (NGO regional and central levels), and FUSAL total costs (regional and central levels). These are the costs of sustaining each type of program once external assistance ends. The second section of the table now only includes the cost of the external assistance to the MOH (APSISA) and the NGOs (MSCI)(FUSAL does not have external TA). The third section still includes the same comparative analysis of the preceeding data (cost per attention, etc.). In the new table not only the cost but also the total no. of promoters and population now include the third round. Although PROSAMI still comes out as more expensive than the MOH in cost per population, and the NGO cost per attention does not change, we and AID still consider this to be a more straightforward and clearer comparison and presentation of the data.

The text that refers to this table needs to be re-done as follows:

pg.81 second paragraph - "the MOH has allocated 78% of the amount of percapita expenditures than has PROSAMI and 1.3 times that of FUSAL." (rewrite the conclusions in the paragraph to fit - even according to the original table FUSAL is not allocating more than the MOH). Remember that the difference in the PROSAMI-MOH allocations is not because of the increased need of the NGO communities, but because the MOH has placed little emphasis on support to primary care, while most expenditures are going towards the tertiary level and personnel (see ANSAL). The MOH also assigns a higher population to each promoter than does PROSAMI. Differences between PROSAMI and FUSAL are at least partly due to the fact that PROSAMI has salaried promoters while FUSAL's promoters are volunteers. "The percapita difference is now c53.82 for the MOH, c69.41 for PROSAMI, and c41.74 for FUSAL. PROSAMI is allocating 1.3 times more percapita than the MOH, and 1.7 times more than FUSAL."

pg83: Again, Table 25 does not match with the text. Also, it should be modified to reflect the new table 24 summary. The text refering to Table 25 should also be modified as follows:

second paragraph - APSISA, not ABSISA. " ... the cost per promoter would be c67,186 for the MOH, c68,051 for PROSAMI,

and c38,745 for FUSAL. The MOH is nearly the same as the cost of the PROSAMI promoter, while FUSAL is 56% of that cost."

third paragraph - PROSAMI supervisors and coordinators also provide direct care on an as-needed basis (Roy needs to talk to Peter about this). Again, we don't feel that there is as much difference between what PROSAMI does and FUSAL does as Roy seems to think. We also feel that he should be using only the 10 promoters as his divisor for FUSAL, or he should add in PROSAMI supervisors as providers for PROSAMI to make the comparison fair.

pg.84: first paragraph - please modify as per the new table to read "When one looks at the NGO cost of the PROSAMI promoter in comparison to the MOH promoter, PROSAMI is delivering the most inexpensive output at c92 per promoter attention versus c189 for the MOH. The PROSAMI cost per promoter attention is 49% of the MOH cost per attention. When one only looks at the first and second round NGOs of PROSAMI in full field implementation (in 1993 the third round PVOs were still in training), the cost per promoter visit is even lower: the cost is at least 31% of the MOH cost or approximately c59.8 per attention." the rest of the paragraph is OK.

pg.85: Table 26 is missing the dates at the top. They should range from 1990 to 1994.

pg.86: third paragraph - this should also be modified to say "The PROSAMI costs are higher than the MOH percapita, but the same as the MOH in cost per promoter and lower in terms of productivity and services provided."

pg.87: paragraph 2 - it is not strictly true that the "technical advisors ... do not know if the NGO is over or under budget...". The technical advisors approve all NGO budgets at the beginning of the year and then pre-approve any changes in these budgets during the year. Therefore, an NGO cannot be "over budget" without technical approval at any time. In general, however, I think the recommendation is good and we will see what more information should be shared between the divisions.

paragraph 3 - I don't know of any policies or procedures "implemented retroactively". Some policies were changed in the course of the project (the PVO manuals were improved), especially in the first few years and the project matured but these changes didn't imply "retroactive" measures. Please clarify.

paragraph 5 - training resources in NGO budgets are not just for promoter training, but also for community level eduation (maybe we didn't make that clear to Roy). Therefore, if you see a lot of training budgeted for each PVO it doesn't mean promoter training only. Also, it is each PVO and not us who decides how much money each one puts under training. The only training a promoter is expected to receive is the basic course (when they are new) and some continuing refreshers during the year. Maybe

what the PVOs want is less money in their budgets (they tend to put extra money under training) and a cash incentive (reward) instead at the end of the year if they do a good job?

pg.89-90: Excellent discussion

pg.92: We agree with an increased focus on increasing revenue and decreasing cost, however some of the recommendations in this section contradict the analysis in others. In particular: 1) the need to reduce supervisory technical staff on MSCI and PVO levels, and 2) that the medical staff begin to provide care to reduce referrals and increase income. Peter and Roy need to come to an agreement on this section and at least mention the technical concerns here, too.

pg.94: second paragraph - FIS, not FIZ.

fourth paragraph - a restaurant is not a factory. Perhaps you mean large businesses and not factories. Another example is PADECOMS, which has a restaurant in Perquin.

pg.95: 1. The MOH is considering subcontracting NGOs to provide primary health care in rural areas, not just absorb health promoters. We agree that this should not be counted on as the only means of income.

last paragraph: In order to receive virtually any funding, it is also very important that the NGOs are legally constituted in the eyes of the government. MSCI will continue to assist the NGOs with this.

general: FUNDEMUN, not FUNDAMEN.

pg.96: last paragraph - trial programs, not trail programs.

6. Cost Benefit Analysis

general: Did <u>Peter</u> write this? If not, he needs to work on it as some of it is wrong and does not match with his section on impact starting on pg. 112.

pg.99: first paragraph - as you know, we have a complete system for evaluating cost/efficiency by PVO. Please mention this in this paragraph as the way it is stated "lack of available data to actually conduct a cost benefit analyis" sounds like we don't do any analysis of this type. Please clarify what you mean. We also have morbidity incidence data for 1992 - 1994, and mortality data for 1994.

second paragraph - FESAL, not FUSAL. FUSAL is an NGO, not the name of the national survey. Change throughout this section.

third paragraph - We agree with the recommendation that we collect household based information annually, but what do you mean by "on a prospective basis"? Quarterly coverages, morbidity and mortality are current data and not prospective figures. Also, mortality data refers to the entire population and not only persons attended by the project.

fourth paragraph - The mortality rates in Tables 30 and 31 are based on information reported by all 35 PVOs in the first 6 months of 1994, not 58% of the population as stated here. Please rewrite.

fifth paragraph - it is not true that PROSAMI has no baseline. Table 30 itself includes a PROSAMI baseline rate for infant mortality which is based on 58% of the first and second round population total (see Table 30, PROSAMI NGOs, 1992-1993, rate of 41 IMR). This shows that PROSAMI areas were not better off than the rest of the country when the project began. (Peter mentions this on pg.112) Please rewrite.

pg.100: third, fourth and fifth paragraphs - these say the cost-benefit analysis is probably not feasible and the best model is probably cost-effectiveness analysis. This is confusing as the preceeding pages imply that PROSAMI should be conducting a cost-benefit analysis. Please clarify your recommendation.

pg.100-101: PROSAMI currently does a cost-effectiveness analysis which compares the actual cost of each PVOs effort each year with the effectiveness (based on 7 key indicators of coverage and mortality). This gives us: a projected cost-effectiveness for each PVO for each year, and quarterly cost-effectiveness measures to see how each is doing. How does this differ from what you recommend? Please keep in mind that we need to follow the KISS principle here and not mount a complex and costly survey. Please clarify.

7. Cost Efficiency and Effectiveness of the NGOs

pg. 103: third paragraph - what is the range? Mention here.

7. Coordination (this should be no. 8)

no comments

C. Impact

1. Impact on Morbidity and Mortality

excellent section

D. Sustainability

1. NGO Level

pg. 127: what do you mean by "judgmental"? critical? negative? I don't think this sentence is necessary.

2. Project Sustainability

no comments

3. Community Level

no comments

4. CDIE Study of Factors Influencing Sustainability

pg.131: the discussion of this section is a little confusing. It might be clearer if you start off the discussion with a summary paragraph saying something like "NGOs rated 6 out of the 10 indicators as positive factors in the sustainability of PROSAMI efforts over the long run, while MSCI staff rated 9 out of the 10 as positive. Both groups agreed that positive factors included project effectiveness, organization, project content, negotiation process, institutional organization, national committment, and community participation. Factors considered to be primarily negative or problematic for sustainability by both NGOs and MSCI included financing, and the economic and political contexts."

pg.132: fifth paragraph - what do you mean by "indifferent and questionable attitude"? don't you mean "more optimistic"? Indifferent sounds as if they (the technical team) doesn't care.

last paragraph - what does the average sustainbility score of 3.32 tell us? That the NGOS and MSCI staff consider the project to be moderately sustainable. Please finish this paragraph.

5. Contribution to USAID Mission Strategic Objectives

6. Legal Status

no comments, just thanks for stressing this.

VII. Lessons Learned

no comments

To: Christopher Edwards@PPD@SAN SALVADOR
Cc:
Bcc:
From: Linda Sanei@R+D.H@AIDW
Subject: re: PROSAMI Comments
Date: Tuesday, February 7, 1995 15:58:35 GMT
Attach:
Certify: Y
Forwarded by:

My fax number is (703) 516-9188. Thanks and look forward to receiving feedback.

To: Christopher Edwards@PPD@SAN SALVADOR
Cc:
Bcc:
From: Linda Sanei@R+D.H@AIDW
Subject: re: PROSAMI Comments
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Attach:
Certify: Y
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My fax number is (703) 516-9188. Thanks and look forward to receiving feedback.

September 21, 1994

Doctor
Raul Toledo
Acting Project Manager
Health, Population and Nutrition
USAID/El Salvador

Dear Dr. Toledo:

The attached revised Draft Outline and Work Plan incorporates changes made this morning in the Mid-Term Evaluation meeting.

Your early approval will be appreciated.

Cordially,

Lewis H. Thornton
Team Leader
Maternal Health and Child Survival Project
Med-Term Evaluation
Health Technical Services

LHT/merc

Enclosures: Revised Draft Outline and Work Plan

cc: Ms. Brenda Doe, Director Health, Population & Nutrition
Ms. Karen Freeman, USAID Evaluation Officer

500

September 21, 1994

REVISED DRAFT OUTLINE
MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
MID-TERM EVALUATION

I. **Executive Summary**

II. **Background**
   - A. **Description, Goals and Purposes, Project Number**

III. **Scope of Work (Summary plus Full in Annex)**

IV. **Evaluation Team (Summary plus Full in Annex)**

V. **Findings, Conclusions and Recommendations**
   - A. Efficiency
     - 1. Methodology and Findings
       - a. Appropriateness of Objectives
       - b. Viability of Methodology
       - c. Analysis of Inputs and outputs
       - d. Efficiency of Methods
     - 2. Conclusions and Prioritized Recommendations
   - B. Effectiveness
     - 1. Methodology and Findings
       - a. PVO technical and administrative capacities
       - b. Progress to date
       - c. Coverages
       - d. Quality of care
       - e. Cost-effectiveness
       - f. Cost-benefit analysis
       - g. Coordination
     - 2. Conclusions and Prioitized Recommendations
   - C. Impact
     - 1. Methodology and Findings
       - a. Morbidity
       - b. Mortality
       - c. Changes in knowledge, attitude and behavior change
       - d. Contribution in accordance to USAID mission strategy
     - 2. Conclusions and Prioitized Recommendations

September 21, 1994

REVISED DRAFT OUTLINE
MATERNAL HEALTH AND CHILD SURVIVAL PROJECT
MID-TERM EVALUATION

D. Sustainability
   1. Methodology and Findings
      a. PVO level
      b. Project sustainability
      c. Community level
      d. Contribution to Mission Strategic Objectives
      e. Legal Status

   2. Conclusions and Recommendations

VI. Lessons Learned

<u>Annexes</u>

VI. Lists of Tables and Charts and Instruments Used

VII. List of Abbreviations and Acronyms

VIII. People and Organizations Contacted

IX. AID Evaluation Summary

PROPOSED DETAILED WORK PLAN

I. Activities to date, September 20, 1994

A. Introductory Meeting with PROSAMI Director
B. Introductory meeting with USAID officials
C. Introductory meeting with 35 NGO representatives
D. Initial review of available data
E. Team process meeting

II. Daily Operations

The Evaluation Team members initially have their office at MSCI. As soon as possible, the team will establish an office at the Camino Real with necessary computer equipment, rented car, and support staff consisting a full-time translator and a secretary. In addition, PROSAMI has made available one of two conference rooms at all times during the six weeks. The team will emphasize working closely with PROSAMI and PVO staff, and spend the majority of time accordingly. For communications purposes, the secretary at the Camino Real office will always have a contact number for each of the team members.

III. Activities involving PVO's

Following initial review of information currently available, the evaluation team has identified basic information needed from the PVO's, and proposes the following strategy:

A. The team members will see between 12 and 15 PVOs. Each team member will stratify the PVOs they are going to see according to the four highest rated in his particular area of responsibility (e.g. health care delivery, institutional development, or financial stability), the four "middle" category, and the four PVOs that are the lowest rated or are considered for possible separation from the project. In addition, the PVOs will be stratified according to geographic distribution, National Reconstruction Project (NPRs), and date of entry into the PROSAMI organization (*rondas).* The team members will carry out the following respective activities at the PVO site visits:

1. Organizational Management Specialist- will meet with the MSCI technical advisor responsible for the PVO before the site visit. In the PVO, he will meet with the central office staff consisting of the executive director, the project coordinator, and two or more of the supervisors. In the community, he will meet with representatives of the health committee, the community *directiva,* and the health promoters.

2. Maternal Health/Child Survival Specialist - will hold meetings with the MSCI technical advisor responsible for the PVO, the PVO project coordinator and the supervisors. In the community he will hold two focal groups - one with the community members and one with health promoters, and also observe service delivery.

3. Health Financial/Cost Analysis Specialist - will meet with the MSCI financial and commodities advisors responsible for the PVO. At the PVO level, he will meet with the executive director, the administrator, accountant, and with one or two community *directiva* members as well as members of the health committees and health promoters.

B. Although it is theoretically possible to choose the PVOs to be visited from existing MSCI data, the evaluation team proposes to first make two initial visits as a group to determine the following:

1. Data available at PVO regional and community level
2. Typical staffing pattern at the PVO and community levels
3. Average time needed to collect data

These two initial sites will be relatively close in proximity to PROSAMI, and one will be an advanced PVO, and the other will be a PVO that is encountering difficulties.

Following these two visits, the evaluation team and PROSAMI will meet to determine the exact PVOs that will be visited and by whom. Although it is assumed that there will be some overlap in the PVOs chosen by each of the team members according to the aforementioned

criteria, some that excel or have problems in one area (e.g. institutional management) may not be the same who excel or have problems in other areas (such as finance or health care delivery). Consequently, some PVOs will be visited by the whole team, and some will be visited by only one or two team members as appropriate.

The list of the PVOs to be visited will be presented to both PROSAMI and USAID for their review.

C. Additional PVO input - Both technical and financial representatives of the 35 PVOs will be invited to meet the week of September 26 and at least every other week thereafter. The purpose of these meetings will be to collect certain data, hold interviews with some of the PVOs not visited, and collectively discuss evaluation advances and solicit feedback and recommendations.

D. Meet first week with the PVO evaluation committee, and periodically thereafter.

IV. Activities involving project and other organizations

A. Meet with USAID every other week for two hours to discuss progress and receive feedback.
B. Meet every other week with PROSAMI management committee.
C. Work closely with PROSAMI chief of party.
D. Other activities and collection of information will be undertaken by each of the individual evaluation team members (see attachments).
E. Conduct team meetings twice a week to analyze data and monitor progress.
F. Meet with vice-minister of MOH

V. Other Scheduled Deliverables

October 12-14 - Turn in all required work for first draft to team leader and secretaries

October 17 - 10 English copies of the first draft of the report as well as 35 copies in Spanish will be distributed to USAID and PROSAMI, and the PVOs.

October 20 - USAID staff review

October 21 - One day meeting with PVO representatives

October 25 - presentation of 10 copies in English and 40 copies in Spanish in final draft report

By November 7, USAID and PVOs will review final draft and USAID will return it to the contractor.

No later than December 5, contractor will submit final evaluation report (10 English copies and 37 Spanish copies).

ATTACHMENT

Additional activities in San Salvador: L. Thornton
Organizational Management Specialists

PROSAMI

Additional interviews with directors will include:

- MIS Manager
- Business Office Manager
- Commodities Advisor
- Project Director/Deputy Director
- Finance Manager

MINISTRY OF HEALTH

Dra. Sonia de Melchor - Salud Comunitaria y Educacion de Salud
MSP Materno Infantil
Sra. Margarita de Monroy - International Cooperation (Data Base)
Vice-ministro de MOH

PVO

Central Office

- Executive Director
- Administrative or Accountant
- Project Coordinator

USAID

Evaluation Committee Members

- Licda. Margarita de Lobo/Project Manager

ATTACHMENT

Activities, interviews and meetings scheduled by Peter Boddy:

I. GENERAL

1. Review and assessment of evaluation points: Maternal and child survival (MCS) responsibilities

2. Review project and related documents, survey reports, monthly and quarterly evaluation reports (PROSAMI), training materials, evaluation and monitoring documents, technical assistance reports, technical component coverage reports, etc.

2. INTERVIEWS, MEETINGS & VISITS

1. USAID/EL SALVADOR

- Evaluation committee, once every two weeks

2. PROSAMI

- Dr. Manual Beza, Technical Coordinator
- Technical component advisors
- Lic. Flor de Maria Ramirez, Training coordinator,
- Coordination/director, twice a week

3. MOH

- Dr. Cruz Gonzales, División de Materno-Infantil
- Dra. Sonia de Melchor, División de Salud Comunitaria

4. GROUPS

- PROSAMI/PVO evaluation committee, (periodically)
- PVO directors/representatives, weekly

5. Site visits: personnel

- PVO director/management
- PVO technical advisor(s)/personnel
- Community promoters
- Target population

6. Interantional Agencies

- PAHO
- UNICEF

7. Others: Open

3. EVALUATION TEAM MEETINGS

4. ANALYSIS OF FINDINGS

5. PREPARATION OF REPORT SECTIONS: METHODOLOGY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS.

Attachment

Additional activities in San Salvador: Roy Brooks

Examination of Project and NGO Costs an d Comparative Analysis

Visit Accounting People
Send mini-survey to other NGO's
Look at overhead percentages (specifically training, TA, and financial support)
Analyze Data, conclusions and recommendations

Examination of Financial Sustainability

Concurrent with above
Meet with USAID for reports on cost recovery and socio-economic factors
Use Financial stability scale published at NCIH for NGO's for 35 NGOs
Analyze data, conclusions, and recommendations

Overall Financial Management

Review available reports at local, project, and USAID level
Review minutes of community board meetings with NGO (random solicitation of this information, and validation with discussion during the 6 NGO visits
Review audits conducted
Review trends in performance (% of vouchers rejected, audit trends, variance report analyses, balance sheets over time, etc..), evolution of systems development
Analyze data, conclusions and recommendations
Note lessons learned and potential replicability

Comparison of PROSAMI assisted PVO costs with MOH, ISSS, and non-USAID funded NGO's

Meet with ISSS and MOH officials and review budget and unit cost data
Meet with USAID to get revenue/cost data of USAID funded NGO's

To: Christopher Edwards@PPD@SAN SALVADOR
Margarita Lobo@HPN@San Salvador
Cc:
Bcc:
From: Brenda Doe@OHE@San Salvador
Subject: re: PROSAMI Evaluation
Date: Wednesday, December 28, 1994 15:16:15 GMT
Attach:
Certify: N
Forwarded by:

Chrish - What is the AES? I won't have a chance to read the PROSAMI evaluation until I return on 1/12 and I hope we don't make final comments without mine - they were very late in getting it to us as you know. Can you hold off until 1/13 COB for my comments? BAD

To: Margarita Lobo@OHE@San Salvador
Cc: Brenda Doe@OHE@San Salvador
Bcc:
From: Christopher Edwards@PPD@SAN SALVADOR
Subject: PROSAMI Evaluation
Date: Wednesday, December 28, 1994 11:35:23 GMT
Attach:
Certify: N
Forwarded by:

Margarita, have there been any comments from the final draft of the PROSAMI evaluation? If not, I would like to finish the AES and have the final distributed. Thank you? Chris