Save the Children

Wawa Sana
Mobilizing Communities and Health Services
for Community-Based IMCI:
Testing Innovative Approaches for Rural Bolivia

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September 30, 2000 – September 29, 2004
In Partnership with APROSAR and the
Ministry of Health Districts of Challapata, Eucaliptus, & Huanuni

Report of the Bolivia CS-16 Midterm Evaluation

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ANNEXES

Lograr que las comunidades sean actores de sus propias actividades a través de una capacitación adecuada.

The Wawa Sana project assists communities to become the principal actors in their own lives, through adequate training.

Vision of the Evaluation Team
Midterm Evaluation
Wawa Sana Project, Oruro, Bolivia
September 2002

ACRONYMS AND ABBREVIATIONS

APROSAR Association of Rural Health Promoters (*Asociación de Promotores de Salud del Area Rural*)
ARI Acute Respiratory Infection
BASICS Basic Support for Institutionalizing Child Survival (USAID Project)
BCC Behavior Change Communication
CAI Committee for Analysis of Information or **TAI**
CB-IMCI Community-Based Integrated Management of Childhood Illnesses
CDD Control of Diarrheal Disease
CORE Child Survival Collaborative and Resource Group
CS Child Survival
CSSP Child Survival Support Project, Johns Hopkins University
CSTS Child Survival Technical Support Project, Macro International
DCM Diarrheal Case Management
DIP Detailed Implementation Plan
DJC *Desarrollo Juvenil Comunitario* (Save the Children/Bolivia)
EPI Expanded Program of Immunizations
HQ Headquarters
H/PD Hearth Model of Positive Deviance
HPN Health, Population, and Nutrition sector of Save the Children/US
IEC Information, Education, Communication
JHU Johns Hopkins University
IMCI Integrated Management of Childhood Illness
IR Intermediate Result
KPC Knowledge, Practices and Coverage Survey
MOH Ministry of Health
MTE Mid Term Evaluation
NGO Non-Governmental Organization
OH Office of Health at SC/US
ORS Oral Rehydration Solution
PAHO Pan American Health Organization
PCM Pneumonia Case Management
PCS4 Population Communications Services 4 Project Johns Hopkins University
PLG Program Learning Group of Save the Children's HPN sector
PROCOSI PVO/NGO Network in Bolivia (Programa de Coordinación en Salud Integral
PVO USAID Registered, Private Voluntary Organization
RHD Rural Health District
SECI Integrated Community Epidemiology Surveillance System(*Sistéma Epidemiológico Comunitario Integral*)
SEDES Ministry of Health departmental level in Oruro
SC/B Save the Children in Bolivia
SC/HQ Save the Children/US Headquarters
SNIS National MOH Information System (*Sistema Nacional de Información en Salud*)
TA Technical Assistance
USAID United States Agency for International Development
Wawa Sana "Healthy Child." *Sana* is Spanish for "healthy." Wawa is Aymara and Quechua for "child."
WHO World Health Organization

A. Summary

The Bolivia Child Survival-16 Project, called Wawa Sana, is funded from September 30, 2000 through September 29, 2004 through a $1 million "New Program" grant from USAID/BHR/PVC, and a $1 million match from Save the Children. The project is located in three Ministry of Health Rural Health Districts in the Department of Oruro, Bolivia. The project is being implemented jointly with APROSAR (Association of Rural Health Promoters) and the three MOH Rural Health Districts.

The project will benefit an estimated 13,500 children under five. The project interventions include: nutrition and micronutrients, pneumonia case management, control of diarrheal disease, and immunization. The main strategies of the project are: Community Based Integrated Management of Childhood Illnesses (CB-IMCI), the Hearth Model using a Positive Deviance approach (H/PD), and the Community Epidemiology Surveillance System (SECI). CS-16 Goals include: a sustained improvement in nutrition status of children in Hearth/PD communities; a sustained reduction in under-five mortality in the three health districts; and innovative approaches inform policy and improve programming in Bolivia.

To assess the process and progress made in CS-16, a midterm evaluation was carried out in September 2002. The MTE revealed the Wawa Sana project showed good potential for meeting all project objectives.

Approximately 167 Promoters have been trained in CB-IMCI by the project. Data from SECI showed 1,052 children had been treated for respiratory infections during the first 6 months of 2002. This represents a 43% increase from those treated in all of 2001. Data for Huanuni revealed, during the first six months of 2002, five times as many children with diarrhea were treated by Promoters or health facilities than in 2001.

The SECI strategy, which promotes the joint collection, analysis, and use of health information/data by MOH staff and communities to address local health problems, has been very effective. Motivated by the discussion of data on their own illnesses and health care utilization, communities have increased health care utilization, taken communal action such as construction of a health post, and demanded information on health topics. Often health service providers respond immediately, even during the very same meeting.

H/PD has been implemented in 13 communities. The strategy continues to be adapted to meet local needs. The documentation of this process will be used to inform future projects.

SC/B feels that "sustaining important innovative approaches on a larger scale through "uptake" by other organizations may be more meaningful than a concept of sustainability which focuses mainly on the project site." (DIP 2000) Of the three strategies, IMCI is already a national program and shows good potential for

sustainability due to support by the government, donors, and other NGOs. SECI has the potential to be scaled up to a national level strategy and there is a lot of interest in replicating the strategy in other areas. H/PD will probably never have the same potential for sustainability due to the intensive investment in time. But the strategy has enormous potential for being expanded with outside funding from other NGOs.

There are two basic flaws in the original design of this project which form two important lessons learned: (1) Implementation of CB-IMCI is premature until clinical IMCI is well established; and (2) Creating a demand for services in health facilities, without a parallel effort to improve the quality of services at those facilities, provides an incomplete package of services.

Areas Needing Further Improvement:

1. Formation of a Wawa Sana team which includes SC/B, APROSAR and MOH: there is too much of a focus within the project of "belonging" to SC/B
2. Development of a monitoring and supervision system for all aspects of the project.
3. The lack of an adequate instrument for measuring institution capacity, and the subsequent lack of an agreed upon plan with the major partner, APROSAR, has lessened the potential impact of this project in the vital area of institutional strengthening.

Key Recommendations:

1. Modify the objective of H/PD from a curative focus of recuperating malnourished children to one of changing household level practices to prevent malnutrition.
2. A documentation plan should be developed for all three strategies now so appropriate information can be collected during the next two years.
3. Develop a concrete plan to improve the retention of Promoters. A mechanism should be developed to strengthen sector and area CAIs. This could greatly increase understanding of health issues and local decision making ability.
4. A one-day annual conference to present project advances and the next year's plan would help to keep all stakeholders informed.
5. SC/B staff needs technical assistance in tools available for assessing institutional capacity and the development and monitoring of capacity building plans for partners.
6. M&E plan should be simplified and re-translated so that project indicators and means of verification can be easily identified by Wawa Sana team and other stakeholders.
7. An annual plan for the next two years needs to be made by the Wawa Sana team; a combined planning process will improve project ownership for partners and develop the tools necessary for monitoring project indicators. This plan should include the expansion of the three strategies into new communities within the three RHD.
8. Direct field supervision of SC/B project staff needs to be improved, and supervision tools developed for tracking improvement and problem solving.

B. Progress Made Toward Achievement of Objectives

1. Technical Approach

a. Overview of the project

This four-year Child Survival Project is based on two contributions which Save the Children Bolivia (SC/B) feels it can make towards improving child survival in Bolivia which are: (1) documenting the feasibility of replications by other organizations and results of implementing innovative approaches to improving community capacity to identify and effectively address priority child health needs, which have excellent potential for "uptake" by other organizations and improving child survival programming in other areas of Bolivia, and; (2) partnering with the MOH and NGOs at the district-level to improve their capacity to support community activities and to implement innovative culturally acceptable approaches to child survival. (DIP 2001)

The Bolivia Child Survival (CS)-16 Project called Wawa Sana is funded from September 30, 2000 through September 29, 2004 through a $1 million "New Program" grant from USAID/BHR/PVC, and a $1 million match from Save the Children.

The project is located in three Ministry of Health (MOH) Rural Health Districts (RHD) in the Department of Oruro, Bolivia: Challapata, Eucaliptus, and Huanuni. The project is being implemented jointly with APROSAR (Association of Rural Health Promoters *Asociación de Promotores de Salud del Area Rural*) and the three RHDs.

The project will benefit an estimated 13,500 children under five. The project interventions and their corresponding level of effort include: Nutrition and Micronutrients (30%), Pneumonia Case Management (30%), Control of Diarrheal Disease (20%), and Immunization (20%).

Main strategies of the Wawa Sana Project:

Community Based Integrated Management of Childhood Illnesses (CB-IMCI)
Focuses on training and supporting Promoters to provide CS services for children in an integrated manner in their communities, and supporting the concurrent MOH implementation of clinical IMCI.

Hearth Model using a Positive Deviance approach (H/PD)
To rehabilitate malnourished children at the community level and have a sustainable influence on preventing malnutrition by identifying positive practices of mothers of well nourished children utilizing local resources and sharing these with mothers of malnourished children in communal education/cooking sessions.

Community Epidemiology Surveillance System (SECI)
Promotes the joint collection, analysis and use of health information by MOH staff and communities to address local health problems.

H/PD and SECI were both pilot tested in the Eucaliptus District during a previous USAID mission funded CS Project. The Wawa Sana project represents a scaling up of these two strategies and the introduction of the national level MOH program of CB-IMCI.

Main components: Training, Coordination, Transportation, Information, Education and Communication (IEC), Access to Basic Supplies, and Referral.

Geographical changes since the DIP include moving from the Huari area to the Qaqachaca area in March 2002. The project found that due to the disperse population of communities, low population density, and lack of interest by communities in Huari, their work was not productive. Some activities are still carried out in the zone, but major project effort has shifted to Qaqachaca. This area was mentioned in the DIP as being unstable due to internal conflict. Peace has been restored in the area and this was one of the areas visited during the Mid -Term (MTE).

In the DIP the focus was on working in communities with a minimum population of 120 people. It was found that there were not enough communities that fit this criterion and the project is now working with a minimum of 80 people. (See Attachment F for suggested modifications to project indicators)

This document presents the results of a participatory midterm evaluation (MTE) which was held September 2-13, 2002. The evaluation team included representatives from SC/B, APROSAR, MOH, BASICS and an external consultant, principal author of this document. See Attachments B, C, & D for more information on the evaluation methodology. Specific recommendations are underlined throughout the document and summarized in the final section. A summary of the MTE team results is included in Attachment E, including detailed conclusions and recommendations.

b. Progress report by intervention area

1. Nutrition and Micronutrients

The nutrition intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. Indicators for this intervention include:

1. 85% of 12-23 month olds with cards received 1/more vitamin A capsules in last year. (Baseline 64%)
2. 30% decrease in 6-35 month olds in Hearth/PD communities below -2Z weight-for-age (pre-/post-).
3. 30% decrease in 6-35 month olds in Hearth/ PD communities below -3Z weight-for-age (pre-/post-)
4. 50% of the nutrition status impact on % of all 6-35 month olds below -2Z WFA is sustained 1 year after the end of Hearth sessions

5. 50% of the nutrition status impact on % of all 6-35 month olds below -3Z WFA is sustained one year after the end of Hearth sessions

Suggested changes to these indicators are included in Attachment F. The most important change to these indicators is a modification in the objective of the H/PD strategy from a curative focus of recuperating malnourished children to one of changing household level practices to prevent malnutrition. This is discussed further in Section B.1.c.3 New Approaches-H/PD. It is also recommended that indicators 3 and 5 be omitted due to the low prevalence of severe malnutrition (0.5-1%), any resulting changes in the indicator would not be significant.

The principal activities for this intervention are:

Training for SC/B, APROSAR, and MOH staff, and Promoters
Coordination with Municipal and local authorities, MOH and other NGOs
Access to services via transportation and to supplies i.e. Vitamin A
Community education for improved knowledge and practices
Integration with the IMCI framework

Training:
SC/B has been able to access technical support from LINKAGES through their involvement in PROCOSI as part of a national effort to improve breastfeeding and complementary feeding practices. SC/B and LINKAGES have a signed agreement outlining technical assistance. A 2-day LINKAGE's training was received by 12 SC/B and three APROSAR staff. This training, on breastfeeding, introduction of foods, negotiation skills, and home visits, was replicated in a series of 3-day training courses for 98 Promoters, 11 MOH staff, and 8 people from other NGOs. Training has been provided, but the process lacks follow-up to insure quality implementation. An excellent quality manual and educational materials have been supplied to Promoters on all the training topics.

A course on anthropometric measurement, with an accompanying manual was given by La Paz SC/B staff to 15 SC/B Wawa Sana staff. SC/B and partner staff also received training on nutritive value of foods, IMCI, and the H/PD strategy. Approximately 48 Promoters and 50 representatives from other NGOs have been trained in H/PD. The three SC/B District Coordinators received extensive training with Jerry Sternin (15 days) on positive deviance inquiry.

Supply of Vitamin A:
Results from the baseline KPC showed 64% of children with cards had received 1 or more doses of Vitamin A as verified by vaccine card. Staff reports that this is probably an underestimation as many times Vitamin A is given and not recorded on the card. The supply of vitamin A has apparently been unstable. MOH data presented during the MTE, using their information system SNIS, showed Vitamin A supplementation has declined by 65% during the last three years (comparing 1999 to 2001). There seems to be a lack of clarity as to who should pay for the supplies. The

MTE data shows that 13% (2/16) of Promoters had capsules as did 88% (7/8) of auxiliary nurses and 100% of area doctors (7/7). Also 100% of auxiliary nurses and doctors visited during the MTE had ferrous sulfate pills and syrup. The role of the Promoter in distributing vitamin A and Iron is not clearly defined. Municipal funds are available in some areas to purchase vitamin A. This issue requires further investigation by the project to eliminate the bottleneck of vitamin A supply.

Use of the term "malnutrition" by project staff, without defining what is meant is very confusing. Project staff uses the term 1st, 2nd, and 3rd degree malnutrition, meaning usually weight/age of greater than -1SD, -2 SD, -3 SD. Project indicator and the VEN system of the MOH classify moderate malnutrition as >-2SD and severe malnutrition is considered >-3 SD (or z scores). Sometimes malnutrition is defined as Ht/Age, without distinguishing from Wt/Age.

Community Education:
During interviews with Promoters and community groups all groups mentioned at least some of the signs of malnutrition. There is general agreement about the importance of weighing children to see if they are malnourished.

In talking with women during the MTE it seems a misconception has arisen as to the relative value of adding vitamins to the diet (through increased vegetables and fruits) and adding calories (through calorie dense foods such as oil and sugar). Teaching women to resolve problems of malnutrition by adding vegetables to the diet of a child will only lead to frustration for the mother and lack of impact for the project. More of an emphasis needs to be given to increasing caloric density through the addition of oil to common foods.

A more detailed discussion on the progress in this area can be found in section B.1.c.3 New Approaches-H/PD.

2. Pneumonia Case Management

The PCM (Pneumonia Case Management) intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. The indicators for this intervention include:
1. 90% of APROSAR Promoters have adequate supply of cotrimoxazole
2. 23% annual increase in total <5 pneumonia cases treated by CS-16 facilities & Promoters.
3. 80% of CS-16 ARI-trained Promoters pass pneumonia knowledge & skills test
4. 80% of caretakers of children recently treated by CS-16 facilities/ Promoters report correct dose & course of cotrimoxazole for pneumonia.
5. 75% of mothers of children under 2 years report that help should be sought if their child has "fast and agitated breathing." (KPC Baseline17%)
6. 50% of mothers of children under 2 years report that help should be sought if their child's "thorax is sunken" (chest indrawing) (KPC Baseline 2%)

Suggested changes to these indicators are included in Attachment F. The most important change being recommended is due to the ambiguity of current MOH policy on use of cotrimoxazole by Promoters. It is recommended that this indicator be used to measure access to basic IMCI supplies by measuring Promoters with Oral Rehydration Solution (ORS). Additionally, the percent of change for the indicators for mother's knowledge of danger signs is very high and the project should consider lowering them.

Data from SECI showed 737 children treated with respiratory infections during 2001 and 1,052 during the first 6 months of 2002. This represents a 43% increase. With the suggested modifications to indicators, there is good reason to believe that the project will be able to reach all objectives for PCM.

The principal activities for this intervention are:

Training for SC/B, APROSAR, and MOH staff, and Promoters
Coordination with Municipal and local authorities, MOH and other NGOs
Access to services via transportation and to supplies i.e. Cotrimoxazole
Community education for improved knowledge and practices
Integration with the IMCI framework

Four of the 18 Promoters interviewed during the MTE had Cotrimoxazole, as did 100% of the auxiliary nurses and area doctors. Further discussion of IMCI can be found in section B.1.c.1 New Approaches-CB-IMCI.

3. Control of Diarrheal Disease (20%)

The CDD (Control of Diarrheal Disease) intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. Indicators for this intervention include:

1. 75% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD. (24%)
2. 80% of CS-16 CDD-trained Promoters pass CDD knowledge & skills test
3. 80% of caretakers recently counseled on DD by CS-16 facilities/ Promoters report following three DD home care rules

Suggested changes to these indicators are included in Attachment F. The most important change being recommended is to omit the indicator for measuring caretaker's practices due to the difficulty of conducting exit interviews on patients of Promoters and at most health centers. The percent of change for the indicator for mother's practice in increasing fluids is very high and the project should consider lowering it. With the suggested modifications to indicators, there is good reason to believe that the project will be able to reach all objectives for CDD.

The principal activities for this intervention are:

Training for SC/B, APROSAR, and MOH staff, and Promoters
Coordination with Municipal and local authorities, MOH and other NGOs

Access to services via transportation and to supplies i.e. ORS
Community education for improved knowledge and practices
Integration with the IMCI framework

Training:
All IMCI trained promoters (about 167 according to the IMCI section) have had a session on diarrhea, which takes about 4 hours.

Access to ORS:
Of great concern is the lack of availability of ORS via Promoters. During the MTE, only 1 of 16 Promoters (6%) interviewed had ORS. All of the auxiliary nurses and area doctors had a supply of ORS. This points out a serious access issue, if one of the simplest, least expensive, and best documented CS activities is not being implemented. The solution to this problem should be a top priority of Wawa Sana.

SECI showed an increase from 12 cases of children with diarrhea being treated by Promoters or health facilities in 2001 to 69 cases during the first six months of 2002 in Huanuni.

Community education:
In interviews with community members and Promoters, during the MTE, there appears to be a good level of knowledge of danger signs of diarrhea (two or more signs of dehydration; sunken eyes, pliegue, agitated/ crying, thirsty, diarrhea for more than 14 days, and blood in the stool), with the exception of duration of chronic diarrhea.

4. Immunization (20%)

The Immunization intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. Indicators for this intervention include:
1. 80% or more DPT3 coverage of infants in all CS-16 municipalities (KPC 32%)
2. 60% of 12-23 month olds have maternal history or card for measles immunization. (KPC 27%)

Suggested changes to these indicators are included in Attachment F. The most important change being recommended is to follow standardized CS indicators for immunizations, including measuring immunizations in children 12-23 months and the use of a vaccination card for verification. (Only 48% of children in the KPC had a card.) It may be difficult to reach the levels set in these indicators unless a serious effort is made to ensure all children have vaccination/growth card. It is understood that the DPT3 indicator is meant to coincide with the MOH indicator, but information could be collected in both formats-one for the MOH and a standardized CS indicator as measurement of progress in the Wawa Sana project.

Main activities include:

* Use of SC/B vehicle for transportation of MOH staff to isolated communities to provide immunization and other health services
* Creation of demand for services through education, follow-up of child immunization status and community health meetings using SECI
* Integration within the IMCI framework

It was found during the MTE that 100% of health centers and post visited had basic supplies for immunization activities; vaccines, thermoses, syringes, etc
Details regarding SECI activities and progress can be found in section B.1.c.2 New Approaches-SECI.

Each of the three districts has been provided with a vehicle, a driver and fuel. They average approximately 18 community visits with "multiprogramatic activities" per month. The visiting team includes a nurse from the District provides vaccinations and does growth monitoring, a doctor to treat sick children and adults, a nurse from SCB to do group education or SECI and sometimes the District dentist.

c. New Approaches

The Wawa Sana project is using three innovative approaches for the implementation of CS activities. These three strategies form the main structure of the project within which the CS interventions are implemented. The three strategies are:

Community Based IMCI (CB-IMCI)
Community Epidemiology Surveillance System (SECI)
Hearth/Positive Deviance (H/PD)

SC/B recently received funding for a USAID Food For Peace Title II development project in the Department of La Paz. CB-IMCI, SECI, and Hearth/PD will be a focus of the Title II project's health component, and experience gained through implementation of CB-IMCI, SECI, and H/PD in Wawa Sana will be used by SC/B to inform implementation and improve performance in the Title II site.

SC/B has shown good use of lessons learned from previous experiences, including the use of the Warmi methodology for decision making developed by SC/B 1990 to 1993. SC/B provided TA to MOH and other agencies on the WARMI methodology expanding it to national level. CS-16 is a scaling up of activities from a PROCOSI/USAID funded CS project in the RHD of Eucaliptus.

1. <u>CB-IMCI</u>

Planning for the implementation of clinical IMCI by the MOH in Oruro was started in 1999, with a training team being formed and functioning in 2000. The implementation of IMCI was slower than expected and much work still remains to be done,

particularly in monitoring and supervision. The MOH training team was instrumental in training SC/B staff but a number of the MOH staff has never been trained. SC/B facilitated training of MOH staff in both clinical and CB-IMCI.

Based on a study conducted nation wide (UNAP/PAHO/BASICS, 2002) it was found that 70% of the appropriate MOH health staff had been trained in clinical IMCI (189/270) in the department of Oruro, with a 61% implementation rate. The study also found in Challapata 87% of the personnel had been trained with 50% applying IMCI and in Eucaliptus 70% of staff was trained but only 29% were implementing the strategy. One of the main problems noted was the lack of follow-up after training. A majority of RHDs visited during the study (including Challapata and Eucaliptus) had not had any monitoring visits. This was confirmed during the MTE during interviews with doctors and auxiliary nurses, the majority had not received monitoring visits for clinical IMCI.

One of the important lessons learned from this project is that clinical IMCI needs to be functioning well first before CB-IMCI can be introduced. The introduction of CB-IMCI was perhaps premature, until IMCI was being adequately used on a clinical basis.

SC/B coordinates with PROCOSI and BASICS as a member of an IMCI working group, along with UNICEF, PAHO and other NGOs. With funding from CORE Group they have been able to continue coordinating with the MOH for the quality implementation of IMCI including field testing and improving instruments. SC/B and Plan International are the only two PROCOSI members who are members of this working group, due to their field experience in implementing CB-IMCI.

The MOH has materials for CB-IMCI, which have been adapted with the help of BASICS. This includes a manual for training Health Promoters and a Procedure Manual (which 16 of the 18 Promoters interviewed during the MTE had) and registration sheets (which 17 of the 18 Promoters interviewed had), for use in evaluating children under 5. Seventeen of the18 Promoters also had an IMCI flipchart for use in educating families. BASICS has also developed checklists, interview and focus group guides for monitoring CB-IMCI. One of these checklists was used during the MTE for monitoring IMCI home visits by Promoters. It was noted during the MTE that some of the materials are hard for the Promoters to use. New materials are being developed and piloted by BASICS.

CB-IMCI can improve coordination with health facilities, improve relationships with communities, and provide Promoters with a valuable tool for viewing child health from a more holistic point of view. The problems in implementing the strategy include:

- High turnover in MOH staff and Promoters
- Materials are expensive and still being tested
- Some Promoters (and MOH staff) feel it takes too much time

- The MOH official IMCI course is very short which limits the amount of supervised practice that students receive
- The role of the Promoter in IMCI is somewhat different than the role of APROSAR Promoters who have used rotating drug funds for years. Official policy is for Promoters to refer patients to health facilities for most problems and usually are not supplied with ORS or parecetamol. This was evident during the MTE when it was found that only 1 out of 16 (6%) of Promoters has ORS and 5 out of 17 (29%) had parecetamol, two essential supplies for IMCI. On the other hand APROSAR Promoters are better supplied and manage cotrimoxazole and other drugs, which provides them with a small income. It is contradictory to tell them that now they cannot treat illnesses which they have been treating for years.
- Promoters lack essential equipment such as scales and chronometers

Notwithstanding these barriers, IMCI is the official child health strategy in Bolivia. Approximately 167 Promoters have been trained in CB-IMCI by the project. The implementation of clinical IMCI needs time to be absorbed by MOH staff and a continued effort is needed to strengthen the link between MOH staff and the Promoters. An exchange visit for Wawa Sana staff is planned to visit IMCI projects in Tarija and Chuquisaca. SC/B will continue efforts via the IMCI working group to advocate for policy changes that will enhance the implementation of CB-IMCI.

2. SECI

Of the three new approaches, SECI is definitely seen as the most successful. The system is very effective in rapidly returning information to the communities in a manner that helps them to use the information to analyze the health of the community and take positive actions to improve health. At first some health staff felt it was stirring up a hornet's nest, trying to revolutionize rural communities, but as people have become more knowledgeable about the strategy, there is a greater level of acceptance. The strategy also supports the Bolivian government's Popular Participation reform. SECI gives communities a more proactive role in their own development.

One of the motivations for health personnel to work with SECI is because it improves their coverage by increasing demand for services such as immunizations and prenatal care. A number of anecdotal examples were given of the success of SECI community action plans; for example to build a health post, give vaccines in a community which before had rejected all immunizations on religious grounds, coordinate with municipal authorities, etc.

One issue is that many people see that knowledge of the situation is enough (and this is definitely a step in the right direction) but more of a focus on actions is needed. A newsletter twice a year on what decisions communities are making with the information might stimulate ideas. Many times communities simply do not know what to do. This is a first experience for many of them of making decisions based on health data and they need to be helped to see possible actions. This can be a very

empowering experience for communities, but sometimes they need help in visualizing potential activities.

The SECI strategy appears to be having a very positive impact in rural communities where a great deal of autonomy in decision-making exists. The strategy has been less successful however in urban areas. Many of the urban groups meet, not based on geographical area but on mutual interests. This means that the political decision-making ability of the group is greatly limited. SC/B has developed several alternative approaches to working with urban populations:

- In Caracollo working with 20 students of the adult learning center "Cetha" and intermediate level students
- University medical students in Oruro
- Military personnel in Challapata

These three pilot projects use the same concepts of dividing the urban area into manageable sectors, using volunteers to collect information on health conditions, then applying a feedback mechanism to the general population, occasionally via television. **SC/B will need to continue trying new approaches to SECI in urban environments and documenting these experiences.**

There are a total of 575 communities in the project area, those defined as eligible for implementation for SECI are shown below. There was an effort made to combine several small communities into one for purposes of data collection, but in general this was unsuccessful. Active communities are defined as presenting consolidated information monthly. Some communities only collect data bi-monthly.

	Huanuni	Challapata	Eucaliptus	Total
Comm > 80	54	38	64	156
Comm w/ SECI	24	21	42	90
Defined as Active	2	6	30	38

Some suggestions and observations made during the MTE to improve SECI are:

- SECI has a good focus on ensuring anonymity and confidentiality in the collection of health information
- Take the cloth flipchart apart into it's 3 components and display them on a wall at the same time. When you flip over from one to the other and cover the information on preceding pages, the relationship gets lost. There would be greater understanding if people could see how one page of information relates to the next.
- Look for ways to compare month to month, or community to community, as the information is not put into a comparative context.
- In one of the action plan observed during the MTE, the steps were very vague-"vaccinate children" and the responsible person was the "nurse". These actions need to be broken down into "How?" steps-the first step would be to take the child to the health center and the responsible party would be the parents. Another step might be to have the child's vaccination card. Health

staff needs to be seen as a resource or support. The parents/community are responsible for making sure everyone is vaccinated not the health staff. Another example was; a cause of malnutrition was listed as lack of vitamins, the solution was to get vitamins from health personnel, while no mention was made of giving foods that contain vitamins.

- In the action plans developed by the communities, there appears to be little follow-up on whether any of the actions are taken. Some action plans seen during the MTE were many months old, with no follow-up on whether the activities were completed
- The words and numbers on the bandera are too small to read in a group
- The spaces on the forms are too small, people with limited literacy skills tend to write larger than people with more advanced skills
- The consolidation form should indicate what information the Promoter will provide and what information comes from the MOH, to avoid confusion
- The SECI manual for volunteers is very complex and needs to be simplified to make it easier for the Promoter to understand
- The form for reporting community planning was modified by APROSAR-so that it includes a copy of the Action Plan developed by the community. This change might make it easier to monitor the completion of planned activities.

The computer system that was developed to complement the community collection of data is very easy to use and flexible in terms of modifying which indicators are monitored. The software includes a short video on how the integrated system works and a tutorial for learning the software.

The SECI specialist has provided training to the statisticians and other staff in the three RHDs and makes approximately three follow-up visits to each RHD per year. In three municipalities the SECI software has also been installed and they are using information from the SECI system in writing their annual development plans. The municipalities have also named someone to be in charge of the SECI system.

A number of other organizations have expresses interest in the SECI strategy and some have received the software and training from SC/B, including PLAN International in Tarija, Project Concern International in Cochabamba, and Nur University in Cocabamba. Training in SECI has also been held for SC/B CS staff, APROSAR, and a computer specialist for the newly funded SC/B/USAID Title II project, which will also be using the SECI strategy.

SECI information is presented in the MOH analysis meetings (CAI) by SC/B, not yet by MOH staff which is an objective of the project, A monitoring plan is needed for SECI to ensure the quality of the data being used.

APROSAR wants to add some additional indicators in the SECI system, such as pneumonia, other risk signs during pregnancy, etc. If technical assistance is required, SC/B should provide guidance to APROSAR on modifying the software. It should be

kept in mind that the beauty of SECI is its simplicity, tracking too many indicators would make the system burdensome.

3. H/PD

The positive deviance model is a step in the right direction to focus more on who is doing things right rather than identifying only those people with problems. It can be very empowering as communities discover their own solutions and it has been shown to maintain improved levels of nutrition even after the program ended because the changes are based on solutions which were developed locally. H/PD is a good way to mobilize the community, provide leadership opportunities to women, encourage the use of local foods and resources, and aid in the self-discovery of beneficial practices.

H/PD is currently in 2 communities in Challapata, 5 in Eucaliptus and 6 in Huanuni for a total of 13. In the first Annual Report the project proposed working in 30% of the communities with a population over 120, approximately 35 communities. It is doubtful that that many communities could be successfully implemented.

In the pilot project during the previous USAID mission funded CS there was a greater level of energy expended in H/PD but now that more communities are using the strategy, the amount of time spent on each one is less. H/PD requires intensive work to implement and monitor.

Some of the issues that are currently impeding implementation are:

- Can be frustrating if it doesn't work; a number of examples were given when even after following all of the steps, the child did not improve (this is partially attributed to the long distances some children travel to participate in the communal kitchen),
- Does not take into consideration the work load of women nor the agricultural cycle, participation in the program takes not only a lot of staff time, but mother's time as well
- H/PD is based on practices, resources, needs of every individual community, the strategy needs to be specific to each community so it is hard to use on larger scale
- Population density is very important; it does not appear to work in small or disperse communities and may be more successful in urban areas
- Some of the areas where H/PD is now being implemented are mining and urban areas, where people do not produce their own food, so it is more difficult for them to contribute to a communal kitchen
- Men do not like the women using their household food to share with others
- The strategy of providing one additional meal is not working, the meal prepared in the group merely replaces the family lunch
- Mothers who can't bring food simply don't come, eliminating the poorest families
- Leaders become unmotivated because the women do not attend.
- The social stigma of being identified as a "negative" family is obvious. A change in terminology is needed to identify "model mothers" without subsequently saying

that the other mothers are “bad”. The same applies to classifying families as rich and poor. This causes friction among community members.
- The project has not really been able to identify key practices which differ between positive and negative deviants

The original structure of H/PD was for 10-20 children under five and their caretakers to attend a communal kitchen 14 days per month for 8 months, 2-3 hours per day, to prepare food together, in addition to normal meals, which contains 600-800 calories and 25-27 grams protein. Each woman contributes part of the food based on a pre-determined schedule. This has not worked for most communities for reasons previously listed.

Some alternatives have been tried, with mixed success:
- Intersperse months to better adapt to agricultural and work calendar
- Meet for 3-4 days with a break of 2 days, then repeat
- Three time a week for 5 weeks
- Meeting on weekends only
- Instead of having all (10-15) mothers cook each time-rotate responsibilities with 3-4 mothers cooking and the rest only bring their children to eat

The Wawa Sana Project should modify the objective of the H/PD strategy from a curative focus of recuperating malnourished children to one of changing household level practices to prevent malnutrition. If the intense period of feeding is not included, the rapid recuperation of children will not function. Don’t give up the idea of recuperating children completely but be honest with mothers-if you come 14 days in a row you will probably see a quicker change than if you come 14 days spread out over 3 months-but give them more flexibility in how the strategy is implemented. The basic outline of H/PD should include some minimal criteria: identifying model mothers, forming groups to employ improved nutritional practices, meeting at least once per week, identifying positive practices, and following up on malnourished children. Then let communities make their own decisions on the details of how to implement. **One of the main goals of the Wawa Sana project is the documentation of the implementation experience. A documentation plan should be developed for all three strategies now so appropriate information can be collected during the next two years.**

Other Suggestions for Improvement:
- Needs better monitoring tools and clearer steps for implementation.
- Continued effort is needed to identify what practices differentiate between well nourished and malnourished children by looking at family environment, morbidity, and frequency of disease
- Need Implementation Manual
- Recipes need to be improved to be shared with mothers. SC/B recipes only have ingredients with no amounts or steps to preparation. APROSAR gives out too much info on nutritional content i.e. grams of protein and carbohydrates and needs to include steps to prepare the recipe.

- Need more involvement of men
- Child feeding centers (PAN) exist in many of the same communities as Wawa Sana. **Investigate ways the H/PD strategy can integrate activities with the PAN centers to improve nutritional status of children.**
- The H/PD sessions were adding oil reinforced with vitamins A & E that was available from the health posts free. This supply is ending, but the message should be stated much more strongly that calories are needed to prevent and cure malnutrition.

Increasing the flexibility of the implementation strategy will probably lead to better acceptance of H/PD but will probably mean that Wawa Sana will not be able to show significant improvement (30% decrease) in nutritional status. The nutrition indicators will be hard to reach. The SECI Specialist is currently starting a monthly database on nutritional status (name/wt/ht/age/sex) in H/PD communities in EXCEL, which will be later transferred to EPI-NUT for analysis. **It is recommended that the project continue to monitor both weight/age and height/age in order to see if a significant impact is seen in either one. The SECI specialist needs technical assistance in use of EPI-NUT.**

2. Cross-cutting approaches

a. Community Mobilization

The effect of SECI in community mobilization has been very impressive, as was discussed previously. There are many anecdotal accounts of communities being able to effect change both within the community and through advocacy at other levels to improve health conditions. Other community mobilization activities revolve around the selection, training and retention of a Promoter in the majority of communities with a population over 80 people and in establishing a link between Promoter, community, MOH, and municipal authorities.

Promoter

Information from SECI for 2002 shows a total of 242 Promoters, 144 active and 98 inactive. This represents a 40% desertion rate. This is very high and brings into question the sustainability of the Wawa Sana strategies. This issue really needs to be further studied. There is a proposed ratio of 25-30 families that each Promoter should be responsible for. There are currently 167 SECI promoters and 164 IMCI promoters- but most times these are the same people. The workload of the Promoter needs to be taken into consideration, especially if they are working in two or more labor-intensive activities such as CB-IMCI and SECI. **During the MTE workshop many ideas for motivating Promoters were discussed, these ideas need to be formalized by the Wawa Sana team and a concrete plan developed to improve the retention of Promoters by the project and to clarify what the project will accomplish in terms of training new Promoters for expansion into additional communities during the next two years.**

In some area the Promoters have been recognized as part of the MOH health team, some receive free medical care, and others, municipal support. Communities are reported to be much more supportive of the work the Promoters do now, compared with when the Wawa Sana project first started. A number of communities have modified the traditional work exchange system, relieving Promoters of community work activities due to their volunteer health work and working in the Promoter's fields as compensation for his/her work. These positive first steps need to be supported and disseminated so other areas can begin taking concrete steps to support the work of these valuable community resources. **Wawa Sana should encourage the formation of Promoter organizations that will exert a level of internal control/self-governance and support of the Promoters. The project should also foment the exchange of experiences and use of sector CAIs as an opportunity for Promoters to share experiences**. l

CAI or TAI Meeting

Bolivia has an excellent national system for the analysis of health information called CAI (Committee for Analysis of Information) or TAI (Workshop for Analysis of Information). The system is designed to function at all levels of data collection; community, health post (sector), municipality (area) and district. At the sector, area and district levels there are supposed to be regular meetings to look at the information collected through the MOH information system (SNIS) and to use it for decision making. The system is quite successful in some areas but needs to be strengthened in the 3 RHDs where Wawa Sana works. Area meetings are usually every 2 months, and District meetings every 3 months (but as infrequent as every 6).

The direct supervisory visits by MOH staff to the Promoters have been limited. A direct supervisory system by the MOH after CS funding ends may not be sustainable. An excellent opportunity exists for indirect supervision of all Promoters, with a system for prioritizing those Promoters who need a direct visit, through the already established sector CAI meeting. The CAI at the sector level is a missed opportunity to provide sustainable, low cost, continuous support to the Promoters and should be strengthened. A guide for conducting CAIs needs to be developed with the MOH so that the CAI meeting is a forum for:

1. consolidating reports and analyzing information,
2. resupplying the Promoter, i.e. ORS packets,
3. an exchange of experiences and a problem solving session for Promoters,
4. monthly refresher training in an area identified by MOH staff or the Promoters as a weakness.

A mechanism should be developed to strengthen sector and area CAIs. This could greatly increase understanding of health issues and local decision making ability.

Formalizing Community/Municipal relations

With the Popular Participation Law of decentralization, funds are available at the municipal level for social services and development activities. A set percentage of the municipal budget is dedicated to health. This requires constant pressure to make sure that what is supposed to be for health is used for health. Fund disbursement is behind schedule from municipal authorities in paying the national Basic Insurance.

Both SC/B and APROSAR have been active in advocacy at the municipal level to include funds for health in the annual budget, plus inclusion of money to support the Promoters, i.e. funds for travel to training courses, perdiem, purchase of basic materials, etc. The project needs to continue with this proactive position in working with communities and municipalities to define responsibilities for a sustainable future. During MTE interviews there was openness on the part of community leaders towards supporting the Promoters through helping with their agricultural work, paying for transportation to training course and general support, but this needs to be formalized at the municipal and community level to ensure adequate support.

Wawa Sana needs to improve communication with RHDs, Municipalities, and other stakeholders about project objectives, activities and advances. **A one-day annual conference to present project advances and the next year's plan would help to keep all stakeholders informed.**

SC/B has been involved in the strengthening of municipal structures through the creation of a Mancomunidad in Challapata. This structure includes various municipalities, plus NGOs: SC/B, APROSAR and ABRIR Salud who pool resources to effect a regional area. The main focus is on increasing services and IEC in health. The annual budget is approximately $8,000, half of which has been pledged by the mayor of Challapata. The NGOs mainly provide technical assistance. The formation of another Mancomunidad is planned in Eucaliptus. This is an excellent example of municipal coordination to enhance sustainability. Links with municipalities is the key to sustainability for the Promoter. **Promoters should be trained in how to develop and present small projects for funding**.

b. Communication for Behavior Change

The Wawa Sana project is implementing several excellent Behavior Change Communication (BCC) strategies; Positive Deviance within H/PD and "dialogue of knowledge" within SECI. Both of these strategies are effective in helping communities to identify their health issues and take positive steps towards improving their own health. The CB-IMCI uses a methodology of home visits which incorporates ORPA (Observe, Reflect, Personalize, Take Action) and the identification and prioritization of problems.

SC/B and some APROSAR and MOH staff have been trained in negotiation by LINKAGES, but the use of this methodology is limited. Some Wawa Sana staff received a course on interactive learning which was presented by CEPRA, but the

focus was mainly on the transmission of messages. A second course will be presented by CEPRA to assist SC/B in the elaboration of mass media materials, mainly for local radio stations.

The project also has an IEC focus, mainly through the use of mass media for the transmission of messages. The main IEC activities are:

- APROSAR has been particularly active in radio, both through regularly scheduled health programs and health message "spots"
- Weekly radio program with Radio Bahai, which has national coverage, in coordination with the Carrocollo hospital
- Coordination with the mancomunidad in Challapata for strengthening IEC
- Use of television in some areas, but this need strengthening as the project still lacks materials and expertise.

Wawa Sana staff has little understanding of BCC theory even though they have received training in specific BCC methodologies such as Positive Deviance, dialogue of knowledge, and negotiation. The term IEC is used interchangeably with BCC, with mainly a focus on the transmission of messages. One of the main weaknesses of this component is the lack of measurement of the impact BCC and IEC approaches are having on changes in knowledge and practices.

The Wawa Sana team should receive technical assistance in general theory of BCC (vs. IEC) and techniques for monitoring changes in knowledge and practices. Several of the indicators for the project depend on measuring changes in skill level of partner staff, Promoters and community members. See Attachment F for more detailed information on the need to develop tools for monitoring indicators.

c. Capacity Building Approach

(i) Strengthening the PVO Organization

Save the Children/HQ

SC/HQ completed an Institutional Strengthening Assessment (ISA) in March 2002 with assistance from CSTS utilizing the following methodology:

- Completion of an organizational profile by SC's CS Team.
- A self-assessment participation of three members of the Office of Health (OH) CS Team, staff from Human Resources, Finance, and International Programs; and written input from the OH Manager and Regional Health Advisors.
- Field input from six field respondents from current USAID-supported CS projects.
- Data analysis involved the following methods:
  - Scores were calculated by capacity area.
  - The range of scores identified where there was agreement and for identifying 'critical questions.'

- Within each capacity area areas of strength and areas for improvement or further assessment were identified.
- Quantitative and qualitative input was utilized

- A self-assessment results-sharing and prioritization meeting was held to developed criteria for establishing priority: feasibility and highest impact.

Findings

- SC/OH, working within an established agency of formidable experience, is a strongly performing PVO unit.
- SC/OH has a strong sense of self-efficacy demonstrated by the homogeneity of scores in all six areas of capacity
- Technical skills and knowledge, management and governance, organizational learning and human resources management are the strongest areas
- Administrative procedures and structures, and financial management, are the two weakest

Initial Recommendations from the CSTS/ISA Team to SC/OH

1. The area needing most attention is financial management; timely access to cost information, including financial management and analysis training of CS staff
2. Enhance focus on quality assurance to ensure project success and long-term sustainability.
3. Other areas for improvement: conduct organizational capacity assessments with local field partners, design and implementation of sustainability strategies, and behavior change communication (BCC) interventions.
4. Develop a more systematic approach to building management, leadership, crosscutting, and technical skills for field staff through training, mentoring, visits.
5. Continue focus on including communities in all aspects of project design, implementation, and evaluation, and ensure that lessons learned are systematically shared.
6. More country-specific managerial support to the field may be indicated, as well as more frequent management training for field staff.
7. Institutionalize periodic review of staffing needs for OH and the field against program requirements and funding levels.
8. Explore increasing the translation of selected programmatic documents into local languages.

Concrete steps which have been taken with OH as a result of the ISA exercise include:

1. Field training/clarification regarding budget line-item flexibility; and training for program managers in Ethiopia and are planned 11/02 & 5/03 for SC Middle-East/Eurasia and Africa area staff.

2. Further develop BCC support capacity by adding a Behavior Change Communication Specialist Karin Lapping on a part-time basis.
3. Diversify donor base & increase resource mobilization to support OH MCH-related initiatives.
4. Train field staff in & implement capacity assessments at field level in Guinea, Tajikistan, and Viet Nam.
5. Further development and implementation of a Quality Assurance program.
6. Build field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge.

Save the Children/Bolivia

SC/B has undergone a rapid expansion, growing from 40 staff to 120 in a few years time. This has lead to some growing pains administratively. SC/HQ has developed a Quality Management Guide: A Save the Children Management Toolbox which was used by SC/B for an administrative assessment. A study was also made by SC/B of staff on their motivation in completing their job and general satisfaction. Results from these two studies have led to the following administrative steps being taken:

- Updating of policies and procedures which have become out-of-date
- Development of a staff training plan and budget for strengthening technical and managerial abilities
- A salary scale study is being conducted to adjust salaries as needed.

Other steps, which have been taken to strengthen the organization are:

- SC/B staff have been involved in a continuous learning process calles Living University; which includes exchange visits from CEPAC in Santa Cruz, Comision Técnica de Belgica Santa Cruz, ADRA in Chuquisaca, Food for the Hungry in Cochabamba, the PUENTES project, and a delegation from the MOH in Puno, Peru. SC/B and partner staff will be making exchange visits in the future to Puno, Chuquisaca, and Tarija.
- Focus on opened leadership, shared responsibility, and team building
- Training for management in Meyers-Briggs personality types to appreciate and complement different learning and leadership styles
- Quality circles-monthly meetings at all levels of the organization which provide a forum for sharing experiences and problem solving
- Active involvement in PROCOSI which has offered the opportunity to share experiences with other organizations working in health in Bolivia. SC/B is one of the founding members of PROCOSI and has been active in all phases of its development.

(ii) Strengthening Local Partner Organizations

A complete listing of capacity building indicators is included in Attachment F.

A baseline capacity building assessment was conducted with APROSAR, 4 hospitals and three MOH District offices. The SC/B staff had very limited understanding of what an institutional diagnosis should include and the instrument used for this diagnosis

was inadequate. No capacity building plan was developed with partners after the diagnosis was conducted. It is difficult to use the same tool for an independent local NGO and a government office. A great deal of work has been done in the last several years on institutional strengthening within the CS context, for example by the CORE group. **SC/B staff needs technical assistance in tools available for assessing institutional capacity and the development and monitoring of capacity building plans for partners.**

APROSAR Capacity Building

APROSAR has conducted their own needs assessment as part of the development of a 5 year strategic plan and re-engineering of their organizational structure. The tool they used was a self-diagnosis using the SWOT technique (strengthen, weaknesses, opportunities, threats). They also solicited input from external sources, such as municipal authorities. APROSAR staff feels their reputation as an organization has been enhanced through participation in Wawa Sana, they have been able to improve community mobilization with SECI, and improve the technical abilities of their staff. They identified a number of areas which require strengthening including:

- Development of a training plan
- Development of a plan for institutional marketing
- Strengthening the area of IEC
- Forum for sharing experiences with other NGOs
- Follow-up and supervision of field staff
- High turnover of Promoters
- Broaden donor base

SC/B and APROSAR need to work together to develop a comprehensive institutional strengthening plan for the next two years, based on felt needs of APROSAR and abilities of SC/B.

The current SC/B supervisory structure of APROSAR is inadequate. APROSAR is made up of a competent group of professions and a full time staff liaison is not necessary. **It is recommended that the current structure of supervision of APROSAR be modified.** The current SC/B staff position could be better utilized to develop a comprehensive monitoring and supervision plan. Support for APROSAR can be accomplished through monthly meetings at managerial level, plus monthly exchange between Trainers of SC/B and Trainers of APROSAR to look at technical and operational experiences. This project is to test strategies, so open exchange is needed on alternatives. There is a richness and creativity within both organizations that needs to be exploited further.

Additional coordination with APROSAR is needed to jointly develop instruments for monitoring various project initiatives, i.e. change in skill levels of partner staff and Promoters, impact of BCC and IEC activities, and other project indicators. These tools need to be developed with partners and tested with partners in order to have tools that are both functional and effective.

MOH Capacity Building

Coordination with the MOH is on three levels; at the Departmental level by SC/B CS Coordinator, at the three MOH Districts which work closely with the SC/B District Coordinators, and at the area and sector levels with the SC/B Trainers. At the District level coordination is enhanced by having SC/B staff housed at the MOH facility.

The main steps taken so far in building capacity with the MOH has been through technical training in IMCI, both clinical and community, and in the strategies of Wawa Sana; H/PD and SECI. Five of the eight auxiliary nurses and six of the seven area doctors interviewed during the MTE reported receiving training during the last year, the majority in SECI, IMCI and H/PD.

SC/B also finances transportation for MOH staff to increase access to basic health services, and transportation and supplies for the CAI/TAI meetings.

One of the capacity building indicators is to see an improvement in facilitation skills of MOH staff, yet no plan for accomplishing this has been formalized. Formal courses are not necessarily required, but would be one way of enhancing facilitation skills. Mentoring by SC/B staff is a very valid methodology, but the steps in this mentoring process need to be clearly outlined and monitored.

It was stated in the DIP that "The organizational assessment indicated that all districts believed that their capacity to support cultural sustainability, by ensuring that the work of their institutions is consistent with values, beliefs and practices of the communities, was unsatisfactory." One of the major weaknesses in the design of this CS project is the lack of a focus on improving the quality of services in health facilities parallel to creating a demand for those services. One step towards improving patient relations would be to follow-up on this statement from the DIP and develop training for MOH staff to overcome the problem of cultural understanding. In the district of Challapata the NGO ABRIR Salud has already done a lot of work in this area, and could perhaps serve as a resource for developing a curriculum for use in the other two RHDs. PROCOSI could also serve as a valuable resource.

SC/B should provide additional training as part of the capacity building effort for MOH staff through the strengthening of facilitation skills and cultural sensitivity.

(iii) Health Facilities Strengthening

Health facility strengthening was also previously discussed in the section on Capacity Building for the MOH.

Referral System

One of the principal mechanisms for linking the health facilities with the communities is through a referral system. It was found during the MTE that 11/18 of the Promoters had referral slips, but only 50% of the auxiliary nurses had referral slips. At both

levels the system is working moderately well, but at neither level does the counter-referral aspect work. According to a study on IMCI implementation in Bolivia (UNAP/PAHO/BASICS, 2002) 83% of the health facilities in Oruro have problems with the referral system but this has not been identified as a priority by the Oruro MOH.

SC/B uses a referral slip which does not have a designated counter-referral function. APROSAR uses another type of slip which is more graphic for use by Promoters, it also does not have a specific tear-off section for returning information from the health facility to the Promoter. **The referral system should be modified to better serve the needs of the Promoter and Health Facility, and include a clearly stated tear-off section for counter-referral.**

Access to Services

Wawa Sana has improved access to services through providing transportation to MOH staff for immunization and other services on a monthly basis and by creating an increased demand for services. One of the project indicators is: 75% of CS-16 population is within a 1 hour walk of facility or IMCI-trained promoter. This indicator is already met in Huanuni and Challapata due to the distance from MOH facilities. Additional effort will be needed in Eucaliptus through training additional Promoters.

Percentage of Population with Access to Services

Eucaliptus	30% <1 hr	26%>1 hr w/ Promoter	44% > 1hr w/out Promoter
Huanuni	82% <1 hr	5% >1hr w/ Promoter	11% >1hr w/out Promoter
Challapata	78% <1hr	8% > 1hr w/ Promoter	14% >1hr w/out Promoter

Problems with population estimate figures continue to plague the project, estimates from the national census and Institute of National Statistics are high as migration figures are misrepresented due to people from the rural area returning to be counted at their traditional home, even though they have migrated to other areas.

Quality of Services

One of the Intermediate Results is to improve the quality of services in the RHDs but this was a weakness in the original project design, as very little was planned in this area, even though it was clearly stated that it is one of the main reasons people do not seek care. In Challapata a DIFD project, ABRIR Salud is working with improving quality of care at MOH health facilities. In the other two RHDs, an effort should be made to incorporate at least minimal training for health staff on improving patient relations. Training materials and curriculum are available from other NGOs working in Bolivia.

(iv) Strengthening Health Worker Performance

The main activities for strengthening health worker performance are:

Training (discussed in next section)
Coordination
Provision of transportation to improve access to services (discussed in previous section)

The coordination between MOH and SC/B is generally positive. SC/B staff is well known in the area and meet regularly with MOH staff to schedule use of the vehicle and other activities. There is a certain level of lack of motivation on the part of MOH staff; many see the project as only adding additional work for them, with very little results. The increased pressure to implement IMCI has also added some resistance. Greater effort is needed to form a partnership among SC/B, MOH and APROSAR, to form a united Wawa Sana team, not to have the project identified as "belonging" to SC/B.

A health services study was completed as part of the baseline, but the results were incomplete and inconclusive. No other tools have been used to assess worker performance. No tools are available to monitor change in worker performance.

(i) Training

The training strategy is a cascade approach; SC/B and partner staff receiving training, then replicated the topics for Promoters, then the Promoter has the responsibility for transmitting topics to community members. Some variation is seen with SC/B or partner staff helping Promoters to provide community education. SC/B staff received some topics and they replicated the training for partner staff. At the beginning of the project all training for Promoters was being done exclusively by SC/B and APROSAR, but now there is greater involvement of the MOH.

A very good facilitation guide is used for training Promoters in IMCI. Facilitation guides were not available for all topics. It is difficult to comment on the effectiveness of training as no monitoring tools are being used. During interviews with MOH staff, Promoters and community members, there appears to be a high level of knowledge of CS topics.

Training of Promoters has followed the DIP plan with the additional of training in breastfeeding, complementary feeding and negotiation skills through replicating training received from Linkages. The training plan from the DIP included the training of 120 Promoters; Wawa Sana needs to take into consideration the high turnover rate of Promoters and plan for additional training during the second half of the project for new Promoters.

The training plan presented in the DIP has been completed as planned, with the exception of courses in MOH regulations and facilitation skills. The course on MOH regulations should be completed after the next set of rules for Seguro Basico de

Salud are realized (supposed to be later this year) as there are many questions about how IMCI fit with the Basic Insurance. **Training in facilitation skills for MOH staff still needs to be completed, plus a tool for monitoring the use of these skills.**

d. Sustainability Strategy

The sustainability objectives for this project are:
1. 50% of the nutrition status impact on % of all 6-35 month olds < -2Z WFA is sustained 1 year after the end of Hearth sessions
2. 50% of the nutrition status impact on % of all 6-35 month olds < -3Z WFA is sustained one year after the end of Hearth sessions
3. MOH or other PVO/NGO has written plans for implementation of SECI and/or Hearth/PD in two other health districts

It is a recommendation of the MTE to omit the second objective because the prevalence of severe malnutrition is so low that any change would not be significant. The first sustainability objectives will be difficult, but not impossible to meet. The problem with this indicator is that it will be measured a year after the end of the H/PD sessions, a date which has not yet been reached for any community at the time of the MTE, and with changes in the H/PD, as previously outlined in this report, may not be able to be measured prior to the final evaluation of this project. This indicator is tied to the indicator for change in nutritional status, that is a 30% decline in malnutrition rates. If this nutrition change indicator is not met (and it will be difficult to improve by 30%) then obviously the lesser percent change will be easier to maintain.

SC/B feels that "sustaining important innovative approaches on a larger scale through "uptake" by other organizations may be more meaningful than a concept of sustainability which focuses mainly on the project site." (DIP 2000) The third sustainability indicator has probably already been met; by having other NGOs present written plans for including SECI in two other areas of Bolivia. CEPAC, PLAN International Tarija and Nur University have all made plans to incorporate SECI in their CS activities. CEPAC will use SECI in implementing a subgrant from SC/B for a neonatal project in Potosi with Gates Foundation funding.

The sustainability of health activities at the community level will be attained through having competent, well trained community volunteers, a strong supportive community structure, and a strong linkage between the community and MOH services. Wawa Sana is moving towards impacting each of these three aspects.

Of the three strategies, IMCI is already a national program and shows good potential for sustainability due to support by the government, donors, and other NGOs. SECI also has the potential to be scaled up to a national level strategy and there is a lot of interest in replicating the strategy in other areas. H/PD will probably never have the same potential for sustainability due to the intensive investment in time. It would be surprising for H/PD to be replicated by the MOH alone. But the strategy has

enormous potential for being expanded with outside funding from other NGOs. The concept of Positive Deviance also has great potential for being applied to other health problems, besides nutrition of children.

During the MTE, communities and local authorities were asked about sustaining activities, they suggested a closer link with municipal government as an alternative source of funding, they also suggested increased support of the Promoters and linkages with the MOH.

While advocacy was not a direct part of the sustainability plan, its effect can certainly lead to more sustainable programming. Both SC/B and APROSAR have taken steps in advocating change in policy which will effect health programs. They both actively work with municipalities to motivate the inclusion of a budgeted amount for Promoter activities, such as training, transportation and some supplies. **Additional needs for effecting policy include advocating for increased stability of trained MOH staff and for supplying Promoters with ORS and paracetamol.** Carol Miller, SC/HQ's Associate Vice President for Public Policy & Advocacy has been working on a draft advocacy plan for health with senior health staff.

C. Program Management

1. Planning

There has been limited involvement of partners and field staff in the planning process. People at all levels understand the basic goals of decreasing mortality and morbidity and improving the health of children, but specific objectives are not clearly understood.

The DIP was never completely translated and the translation which was made was of poor quality as to make it of limited use for CS staff and partners. The objectives and indicators were presented during the start-up workshop, but again the poor translation has limited their use. In the sub-contract with APROSAR, different indicators are used which do no coincide with DIP indicators. There is little tracking of the indicators, making use of the indicators during the MTE a challenge. The M&E plan which was included in the DIP is perhaps useful to SC/HQ staff, but is extremely complex and not understandable to CS or Partner staff. **The M&E plan should be simplified and re-translated so that project indicators and means of verification can be easily identified by Wawa Sana staff and other stakeholders.**

There are monthly meetings called quality circles within SC/B at each level of project management; district level, Oruro office, and La Paz SC/B, These meetings have both a planning and a problem solving function and are used for developing a monthly calendar for use of the vehicles and programmed activities. These calendars should be developed with the initial input of partners.

There is a good quarterly evaluation and planning process (including La Paz staff and APROSAR), held one day every three months jointly with child sponsorship, health, education and teen programs. Activities monitored during these meetings include: community planning activities, training for communities, promoters and staff, new communities SECI, follow-up on use of SECI software, community EDP activities, supervision of promoters, population with access to services, monthly staff meetings, coordination efforts and CAI meetings. **Results from these quarterly evaluations should be shared with partners and other stakeholders to improve an understanding of what Wawa Sana is doing.**

There is no annual planning process for defining activities or monitoring change. The only annual tool currently being used is the original four-year plan included in the DIP, which is not sufficiently detailed to be a stand-alone instrument. The DIP work plan has been followed but more detailed planning is needed. As was previously mentioned in this report, there is a lack of a monitoring plan to be used in improving implementation through a continuous planning process. **An annual plan for the next two years needs to be made by the Wawa Sana team, a combined planning process will improve project ownership for partners and develop the tools necessary for monitoring project indicators. This plan should include the expansion of the three strategies into new communities in the three Districts.**

2. Staff Training

SC/B staff have been well trained, with an adequate budget for training, Courses received include:
Linkages: Breastfeeding, complementary feeding, negotiation, home visits
SECI, H/PD, IMCI Clinical and CB by MOH
Anthropometric measurement and nutritive value of foods
Interactive Methodologies for Training & IEC-development and transmission of messages CEPRA, Rapid Food Security Assessment, Cultural Sensitivity, etc.

There is no system for assessing and monitoring staff competencies or for ensuring that new knowledge is put into practice. As part of the capacity building plan for SC/B a staff training plan and budget are being developed for strengthening technical and managerial abilities.

3. Supervision of Program Staff

There is a good system of indirect supervision through monthly meetings or Quality Circles. There was a need identified by all levels of field staff for improving the direct supervision in the field, with a particular emphasis on problem solving through supportive supervision. There is no supervision format or schedule. **Direct field supervision of SC/B project staff needs to be improved and supervision tools developed for tracking improvement and solutions to identified problems**.

4. Human Resources and Staff Management

SC/B has a well organized personnel system, including clear policies for recruiting, orienting and evaluating staff. A written personnel manual outlining organizational policies is available to all staff and there are current job descriptions for all positions. Staff benefits include health insurance, life insurance and other benefits as required by law. Staff turnover in the CS project has been low; most of the staff has been with the project since it began and a great many worked on the previous mission funded CS project. Two of seven trainers left the CS project within the last 2 years to work on the Title II project, to be nearer their families in La Paz. They have subsequently been replaced; one of the new trainers was a previous APROSAR employee. The SC/B team works as a cohesive unit, morale seems high and collaboration is evident

All staff that completes 2 years in their position becomes permanent staff by Bolivian law. SC/B adheres to all local labor laws, including the payment of one additional monthly salary per year and for permanent staff, the payment of three months salary if they leave the organization. SC/B sees their staff as an investment and a valuable resource and whenever possible try to retain staff when one project ends until additional financing can be obtained.

5. Financial Management

SC has good experience in managing CS projects in the past and has several levels of USAID compatible financial control systems with regular internal and external audits. SC has a computerized accounting system which is approved by USAID.

Financial reporting on a quarterly basis to USAID is carried out without problems and good financial support is received from CS/HQ.

The budget shows approximately 60% has been spent of USAID funds and 50% of SC/B match funds. A vehicle valued at $45,000 was budgeted for during YR2 with match funds, but these funds have not been expended. **Review the budget for the next two years and make adjustments as needed within USAID guidelines. There are funds available in some line items which could be internally transferred to cover additional supplies i.e. minimal equipment for IMCI (scales for growth monitoring) and a large amount of funds are available for additional training i.e. training for MOH staff in educational methodologies or improved patient relations.**

A recent change in financial management has been made so that Oruro now has it's own bank account. This is a very positive change as the flow of funds was very cumbersome using only a petty cash system. CS-16 financial reports are sent to the CS Coordinator, but not on a regular basis. It is vital that the CS Coordinator receives a monthly print-out of the budget, with year to date figures, and if possible life-of-the-project figures also. **The CS Coordinator should receive a complete orientation to the budget and monthly budget reports so that he can more adequately manage the CS project.**

PROCOSI facilitated external audits for all of its principal members in March of 2002, resulting in only minor observations. The last external audit from SC/HQ was in 1995. There is an internal auditor within SC/B who audits program documents on a rotating basis. The subcontract with APROSAR has not presented any financial difficulties. APROSAR presents monthly financial reports and receives disbursements of funds every three months. The head of accounting for SC/B is planning a visit to APROSAR in October of this year to review APROSAR's financial system and documentation.

6. Logistics

Logistics and procurement have not been major limitations during the implementation of this project. These aspects are well planned and managed and should present no challenges to staff during the remainder of the project.

7. Information Management

The information system of Wawa Sana has four main components:

- KPC survey which is one of the main instrument for measuring indicators
- SECI community epidemiological surveillance system
- SNIS national MOH information analysis system
- Other qualitative studies (Focus groups, Institutional Assessment)

KPC

The KPC was conducted at baseline and will be repeated at final. The KPC was conducted for two age groups; mothers with children <2 and mothers with children 2-4 years. A total of 659 women were surveyed. Results from the KPC show a high rate

of incomplete interviews, this problem is mainly a result of not using the standard KPC CSSP/CSTS methodology for supervising numerators in the field. Improvement in the KPC can be made by clarifying information through the following suggestions:

- Use standard indicators when reporting data i.e. 12-23m for vaccination coverage, food intake from 6-9 months (not 6-23m), use of card to verify vaccines, prolonged breastfeeding should be measured as 20-23months.
- "n" for vaccines and Vitamin A should be all children 12-23 m, not just those with cards
- The response for home treatment of diarrhea is somewhat confusing as the answer "homemade medicines" should be separated between homemade liquids-teas, etc, and other homemade remedies to have a better idea of intake of fluids.
- The indicators presented by APROSAR do not coincide with the Wawa Sana indicators and some of these additional indicators will need to be included in the final KPC.

It is recommended that future KPCs follow the CSSP/CSTS methodology for the collection of field data and description of indicators.

The project has 31 indicators (this report is suggesting the elimination of six of those). A number of the indicators will be measured through the KPC survey as part of the final evaluation or through SECI, but a great many have no monitoring tool available. A chart is included in Attachment F on suggested changes for the indicators and indicating which indicators still require the development of a monitoring tool. A priority area for the next two years needs to be the development of a monitoring and supervision system for all aspects of the project.

SECI

A complete discussion of the SECI strategy is included in Section B.1.c.2 New Approaches-SECI. The project indicators, which will be measured via SECI, with some modifications, are outlined in Attachment F.

SNIS

The main use of the SNIS system is to analyze MOH indicators during regularly scheduled CAI/TAI meetings. These CAI meetings also provide an opportunity to share results from the SECI system. The SECI system supports the SNIS system; there is no duplication of effort as SNIS focuses on facility services and SECI on community activities.

Other Studies

Basic information was collected from each community, as well as a census and community map. This information is included in the SECI to provide valuable information about each community.

Focus groups were conducted with women at baseline for use in defining project content. These focus groups were very well conducted and documented, and provided valuable information for the project on cultural beliefs and practices.

The institutional Assessment and Health Services Staff Survey were both used at baseline, but were both of questionable quality. The results were inconclusive and no apparent actions were taken as a result of these surveys. Both methodologies could provide valuable input into project design, if improved instruments were used.

8. Technical and Administrative Support

SC/HQ's CS Specialist, Dr. Eric Starbuck, is budgeted at 15% time for the Wawa Sana project in Year 1, and at 10% in Years 2 through 4. The Health Office Manager, Carmen Weder is budgeted at 12% time in Year 1, and at 10% in Years 2 through 4. The CS Advisor, Dr. David Marsh is budgeted at 3% time in Years 1 through 4.

SC/HQ staff support for Wawa Sana has focused on the initial CS-16 design work, application, baseline assessments, and DIP. Since the last visit for the development of the DIP support has been in the form of e-mails and review/revision of the first annual report. Ms. Carmen Weder, Manager, OH, provides financial and administrative backstopping for the project. Most of her support was also for the initial application budgeting, and negotiating the award/budget with USAID. She also works with field office staff on sub-agreements, regular monitoring of expenditures and grant compliance, reporting of budget pipelines to AID and SC field office counterparts, and responds to questions from field offices.

SC/B program and administrative staff feel that the level of support they receive from SC/HQ is adequate and timely. SC/B staff in Oruro is also satisfied with the support they receive from the La Paz office.

The National Health Coordinator, Ccoya Sejas traveled to Washington D.C. for the DIP defense and attend the 2001 Health Program Learning Group to share project advances with worldwide SC health staff. The National Health Advisor, Caroline Hilari attended the 2002 SC's Health Program Learning Group. The cross-fertilization of CS programs that occurs through these visits strengthens SC's overall ability to manage CS programs regionally and worldwide. This is an opportunity to review and analyze the project, and to make strategic decisions about necessary project modifications and adjustments.

Other technical assistance received:

H/PD specialist Jerry Sternin

Training through Linkages and other local organizations has already been described under staff training

Technical assistance needs for the future include:

- Budgeting information for the CS Coordinator
- Capacity Building Assessments and Planning
- Behavior Change Communication and monitoring change

D. Conclusions and Recommendations

The Wawa Sana project is an exciting project because it is pioneering new ground with very innovative strategies, particularly H/PD and SECI. There is a great deal of learning taking place about how, and when, to use these strategies. The project shows good potential for meeting all project objectives (with the modifications suggested in this document), with the exception of the nutritional indicators. Some of the strengths of this project include:

- A focus on strengthening the Promoter as a principal actor in implementing and sustaining health activities;
- Use of local languages at the community level to encourage greater participation and sharing;
- Involvement of Municipalities to improve coordination and as part of the sustainability strategy;
- Empowerment of communities and women; all three strategies contain elements of finding solutions within the community and contributing to the development of organizational and leadership skills;
- Formation of strong team within SC/B, but this concept needs to be extended to include the greater team of Wawa Sana; and
- Good technical approaches.

<u>Areas Needing Further Improvement:</u>

1. Formation of a Wawa Sana Team which includes SC/B, APROSAR and MOH: there is too much focus on this project as "belonging" to SC/B. Partners should be involved in all aspects of the project, including a decision making role.

2. Based on comments in the DIP review, in the first Annual Report it was stated that checklist for monitoring field staff and quality assurance would be in place by January 2002. This has not been done and continues to represent one of the major weaknesses of the project. A priority area for the next two years needs to be the development of a monitoring and supervision system for all aspects of the project.

3. Capacity building for partners is a current weakness of the project. The lack of an adequate instrument for measuring institution capacity, and the subsequent lack of an agreed upon plan with the major partner, APROSAR, has lessened the potential impact of this project in the vital area of institutional strengthening.

There are two basic flaws in the original design of this project which form two important lessons learned: (1) Implementation of CB-IMCI is premature until clinical IMCI is well established; and (2) Creating a demand for services in health facilities, without a parallel effort to improve the quality of services at those facilities provides an incomplete package of services.

Wawa Sana needs to improve communication with RHDs, municipalities, and other stakeholders about project objectives, activities and advances. A one-day annual conference to present project advances and the next year's plan would help to keep all stakeholders informed.

Recommendations:

1. One of the main goals of the Wawa Sana project is the documentation of the implementation experience. A documentation plan should be developed for all three strategies now so appropriate information can be collected during the next two years.

2. SC/B will need to continue trying new approaches to SECI in urban environments and documenting these experiences.

3. The Wawa Sana Project should modify the objective of the H/PD strategy from a curative focus of rehabilitating malnourished children to one of changing household level practices to prevent malnutrition.

4. The SECI specialist needs technical assistance in use of EPI-NUT.

5. The Wawa Sana team should receive technical assistance in general theory of BCC (vs. IEC) and techniques for monitoring changes in knowledge and practices.

6. SC/B staff needs technical assistance in tools available for assessing institutional capacity and the development and monitoring of capacity building plans for partners.

7. It is recommended that future KPCs follow the CSSP/CSTS methodology for the collection of field data and description of indicators.

8. A one-day annual conference to present project advances and the next year's plan would help to keep all stakeholders informed.

9. The M&E plan should be simplified and re-translated so that project indicators and means of verification can be easily identified by Wawa Sana staff and stakeholders.

10. Results from quarterly evaluations should be shared with partners and other stakeholders to improve an understanding of what Wawa Sana is doing.

11. An annual plan for the next two years needs to be made by the Wawa Sana team; a combined planning process will improve project ownership for partners and develop the tools necessary for monitoring project indicators. This plan should

include the expansion of the three strategies into new communities in the three Districts.

12. Investigate ways the H/PD strategy can integrate activities with the PAN centers to improve nutritional status of children.

13. It is recommended that the project continue to monitor both weight/age and height/age in order to see if a significant impact is seen in either one.

14. Ideas for motivating Promoters need to be formalized by the Wawa Sana team and a concrete plan developed to improve the retention of Promoters by the project and to clarify what the project will accomplish in terms of training new Promoters for expansion into additional communities during the next two years.

15. Wawa Sana should encourage the formation of Promoter organizations that will exert a level of internal control/self-governance and support of the Promoters.

16. A mechanism should be developed to strengthen sector and area CAIs. This could greatly increase understanding of health issues and local decision-making ability.

17. The project should also foment the exchange of experiences and use of sector CAIs as an opportunity for Promoters to share experiences.

18. Promoters should be trained in how to develop and present small projects for funding.

19. SC/B and APROSAR need to work together to develop a comprehensive institutional strengthening plan for the next two years, based on felt needs of APROSAR and abilities of SC/B.

20. It is recommended that the current structure of supervision of APROSAR be modified.

21. SC/B should provide additional training as part of the capacity building effort for MOH staff through the strengthening of facilitation skills and cultural sensitivity.

22. The referral system should be modified to better serve the needs of the Promoter and health facility, and include a clearly stated tear-off section for counter-referral.

23. Training in facilitation skills for MOH staff still needs to be completed, plus a tool for monitoring the use of these facilitation skills.

24. Additional needs for effecting policy include advocating for increased stability of trained MOH staff and for supplying Promoters with ORS and paracetamol.

25. Direct field supervision of SC/B project staff needs to be improved and supervision tools developed for tracking improvement and solutions to identified problems.

26. Review the budget for the next two years and make adjustments as needed within USAID guidelines. There are funds available in some line items which could be internally transferred to cover additional supplies i.e. minimal equipment for IMCI (scales for growth monitoring) and a large amount of funds are available for additional training, i.e. training for MOH staff in educational methodologies or improved patient relations.

27. The CS Coordinator should receive a complete orientation to the budget and monthly budget reports so that he can more adequately manage the CS project.

E. Results Highlight

The SECI (Community Epidemiology Surveillance System) Methodology

SECI promotes the joint collection, analysis, and use of health information/data by MOH staff and communities to address local health problems. During community gatherings, local health care providers and community promoters present health data to the community members using colorful, easy-to-understand SECI tools, analysis, and planning guides. Using culturally appropriate materials suitable for adults without literacy or numeric skills, a space above each indicator (represented by a colorful picture) is filled with small images of women, boys, or girls to represent the number of cases recorded in the CB-HIS. The corresponding denominator is attached to a space at the top corner of each banner. Red, yellow, and green color-coding on individual health cards and presentation banners categorizes three levels of risk (dangerous, at risk, healthy). The SECI strategy has been very effective:

1. Families have increased their use of health care services. Compared to controls, more households in the intervention communities reported:

    - Complete child immunization (OR = 4.78, 11.2% versus 2.6%, $p<.05$),
    - Vitamin A supplementation (OR = 1.96, 58.6% versus 41.9%, $p<0.05$),
    - Possession of a health card (OR = 2.12, 44.9% versus 27.7%, $p<.05$),
    - Early postpartum breast-feeding (OR = 2.62, 25.7% versus 11.7%, $p<.05$), and
    - Oil supplementation for young children (OR = 1.95, 67.5% versus 51.6%, $p<.05$).

2. Communities have changed their meeting agendas. Health used to be the last topic in their meetings, long after political issues, boundary conflicts with neighboring territories, road maintenance and other community works, and issues related to schools. With the introduction of SECI, health is now discussed first on the agenda.

3. Motivated by the discussion of data on their own illnesses and health care utilization, communities have demanded information on health topics. Frequent demands on information have included topics such as appropriate child feeding, diarrhea and cough management, as well as antenatal care and management of labor and delivery. Usually, health service providers respond immediately, during the very same meeting.

4. Local authorities used their power to convince families to increase their use of health care services, specifically immunizations.

5. Local community representatives have been mobilized to demand leveraging of funds from the local governments to address specific health needs.

F. The Action Plan

The Wawa Sana team (SC, APROSAR, MOH and Promoters) will have a one-day workshop during October to develop a plan of action for implementing the recommendations from the MTE after the final version of the MTE evaluation document is received and translated into Spanish. Additional stakeholders will be invited to this process, including municipal and community authorities, MOH management staff, and other NGOs .As the evaluation team developed the recommendations included in this document, they will be able to move forward on implementing the recommendations immediately. The process of involving the MOH in the evaluation has served to strengthen their commitment to improving the project over the next two years.

Attachments

ATTACHMENT A

A. Baseline information from the DIP

No significant changes were made since the DIP, expect as noted in the body of this document.

1. Executive Summary:

Estimated Program Effort and USAID Funding by Intervention

Intervention	% Effort	USAID Funds (a)
Micronutrients	30%	$300,000
Pneumonia Case Management	30%	$300,000
Control of Diarrheal Disease	20%	$200,000
Immunization	20%	$200,000

(a) Estimated amount of USAID funding (excluding PVO match funds) the program will devote to each intervention to be implemented

Target Beneficiaries:

Type	Number
0-59 month old children:	13,500

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
27%	73%

2. Program Goals and Objectives:

CS-16 Goals, Results, Intermediate Results, and Selected End of Program Objectives

Goal 1: Sustained improvement in **nutrition status** of 6-35 month olds in Hearth/PD communities.

Goal 2: Sustained reduction in under-five **mortality** in the 3 health districts.

Goal 3: Innovative CS-16 approaches inform **policy** and improve CS **programming** in other areas of Bolivia.

R-1: Improved **capacity of APROSAR & 3 RHDs** to support community activities & implement innovative culturally acceptable CS approaches.

- 3 RHDs have incorporated SECI data, discussion, & planning in district information analysis meetings.
- 90% of APROSAR Promoters receive regular support and supervisory visits from APROSAR staff.

R-2: Improved **capacity of communities** in the 3 health districts to identify & effectively address priority health needs of children <5.

- 75% of SECI communities have action plans with service providers to address CS needs.
- 75% of communities with action plans revise plans based on analysis of SECI/SNIS data.

R-3: Increased **use** of key CS services and improved CS **practices** at household level in the 3 health districts.

- 23% annual increase in # of <5 pneumonia cases treated by CS-16 facilities & Promoters.
- 80% DPT3 coverage in infants in all CS-16 municipalities.
- 85% of 12-23 month olds with cards got 1/more vitamin A capsules in last year.

R-4: Uptake of successful innovative CS-16 approaches by MOH or by other organizations.

- MOH or other PVO/NGO has written plans for implementation of SECI and/or Hearth/PD in two other health districts.

IR-1: Increased **availability** of selected child survival services in the 3 health districts.

- 60% of communities with pop. over 120 have CB-IMCI-trained Promoter or MOH facility.
- 75% of CS-16 population is within a 1-hour walk of facility or ARI-trained Promoter with cotrim. stock.

IR-2: Improved **quality** of selected child survival services in the 3 health districts.

- 80% of PCM-trained Promoters pass pneumonia knowledge & skills test.
- 80% of caretakers recently counseled on DD by CS-16 facilities & Promoters report following 3 home care rules.

IR-3: Increased caretaker **knowledge**/ **awareness** in 3 health districts of selected CS issues.

- 75% of mothers of <2's report that help should be sought if child has "fast and agitated breathing."
- 50% of mothers of <2's report that help should be sought if child's "thorax is sunken."

IR-4: Documented results and feasibility of implementing **innovative CS-16 approaches**.

Documented results & marginal cost of human resources & supplies for service delivery & support to implement:

- CB-IMCI;
- Hearth/Positive Deviance; and
- SECI.

IR-5: Demonstrated **SC/B capacity** in CB-IMCI, SECI, & H/PD capacity building of CS-16 partners & advocacy.

- 75% of CS-16 partners & community capacity building objectives achieved.
- SC/B advocates for implementation of effective & innovative approaches to child health at public and NGO levels.

CS-16 Nutrition Status and Sustainability Goals, Results, Objectives, and Means of Verification

Goal or Result	End of Program Objectives	Means of Verification
Goal 1: Sustained improvement in **nutrition status** of 6-35 month olds in Hearth/PD communities.	• Nutrition Status: 30% decrease in 6-35 month olds in Hearth/PD communities < -2Z weight-for-age (pre-/post-). • Nutrition status: 30% decrease in 6-35 month olds in Hearth/ PD communities < -3Z weight-for-age (pre-/post-). • Sustainability: 50% of the nutrition status impact on % of all 6-35 month olds < -2Z WFA is sustained 1 year after the end of Hearth sessions. ***** • Sustainability: 50% of the nutrition status impact on % of all 6-35 month olds < -3Z WFA is sustained one year after the end of Hearth sessions.	Nutrition Status: Hearth/PD community-wide pre- and post-Hearth growth monitoring records. Sustainability: Hearth/PD community-wide post- and one-year post-intervention growth monitoring records.
Result 4: Uptake of successful innovative CS-16 approaches by MOH or by other organizations.	• Sustainability: MOH or other PVO/NGO has written plans for implementation of SECI and/or Hearth/PD in two other health districts.	PROCOSI, MOH, and/or donor reports and interview information.

***** An example of these objectives being met would be a mean pre-intervention Hearth/PD community-wide rate of 30% underweight in 6-35 month old children, reduced by the end of Hearth sessions to a mean of 20%, and one year after the end of Hearth sessions to a mean of 24%.

CS-16 Capacity Building Results, Objectives, and Means of Verification

Result or IR	End of Program Objectives	Means of Verification
R-1: RHDs' capacities to support community activities & implement innovative culturally acceptable CS approaches improved.	• SECI Data: 3 RHDs incorporate SECI data, discussion, & plans into district info. analysis (CAI) meetings. • SECI Facilitation: 60% of permanent Auxiliary Nurses demonstrate good skills in co-facilitating SECI meetings. • H/PD Training: 80% of permanent MOH staff demonstrate good skills in co-facilitating H/PD training.	• CS-16 reports and CAI meeting minutes. • Facilitation methods & skills checklist during observation of Auxiliary Nurses at SECI meetings. • Training methods & skills checklist during observation of training.
R-1: APROSAR's capacity to support community activities & implement innovative culturally acceptable CS approaches improved.	• Training: All APROSAR trainers demonstrate competency in CB-IMCI, SECI, & H/PD training of Promoters. • Support: 90% of APROSAR Promoters receive support/ supervisory visit from APROSAR staff in the previous 3 months. • Supply: 90% of APROSAR Promoters have adequate supply of cotrimoxazole.	• Training methods & skills checklist during observation of training. • Checklists from SC visits to APROSAR Promoters. • Checklists from SC visits to APROSAR Promoters.
R-2: Communities' capacities in the 3 RHDs to identify & effectively address priority health needs of children under 5 improved. *****	• CB-IMCI: 60% of communities with pop. over 120 have CB-IMCI-trained Promoter or MOH facility. • SECI: 75% of SECI communities have action plans with service providers to address CS needs. • SECI: 75% of communities with action plans revise plans based on analysis of SECI/SNIS data. • Women: 40% participants in CS-16-related community meetings women.	• CS-16 reports. SECI meeting records, SECI Joint Planning and Meeting Monitoring forms, joint action plans, attendance lists, and other CS-16 reports (for last 3 indicators).
IR-5: SC/B capacity demonstrated in CB-IMCI, SECI, & H/PD capacity building of CS-16 partners and advocacy.	• Capacity Building: 75% of partner & community capacity building objectives achieved. • Support: 100% of CS-16 APROSAR & permanent MOH staff receive support/ monitoring visit from SC staff in last 6 months. • Advocacy: SC/B advocates for implementation of effective & innovative approaches to child health at public and NGO levels.	• Review of capacity building achievements during final evaluation. • CS-16 records, MTE & final evaluation interviews with APROSAR & MOH staff. • Review of CS-16 advocacy plan and activities during final evaluation.

***** See table below for family/individual prevention & care-seeking objectives (related to Result 3).

Use/Practice, Availability, Quality, & Knowledge: Results & Objectives (Baseline Values)

Result or IR	End of Program Objectives	Means of Verification
R-3: Increased **use** of key CS services & improved CS **practices** at household level in the 3 RHDs.	• EPI: 60% of 12-23 month olds have maternal history or card for measles immunization. (27%) • EPI: 80% or more DPT3 coverage in infants in all CS-16 municipalities. ***** • Vit. A: 85% of 12-23 month olds with cards received 1/more capsules in last year. (64%) • CDD: 75% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD. (24%) • ARI: 23% annual increase in total <5 pneumonia cases treated by CS-16 facilities & Promoters.*****[1]	• KPC survey • DHO EPI records, estimated <1 pop. • KPC survey • KPC survey • DHO, facility & Promoter records.
IR-1: Increased **availability** of selected CS services in the 3 RHDs.	• ARI: 75% of CS-16 population is within a 1-hour walk of facility or ARI-trained Promoter with cotrim. stock. • 60% of communities with pop. over 120 have CB-IMCI-trained Promoter or MOH facility.	Checklists from SC-APROSAR-facility staff supervisory visits, and review of CS-16 site map.
IR-2: Improved **quality** of selected CS services in the 3 RHDs.	• ARI: 80% of CS-16 ARI-trained Promoters pass pneumonia knowledge & skills test. • CDD: 80% of CS-16 CDD-trained Promoters pass CDD knowledge & skills test. • ARI: 80% of caretakers of children recently treated by CS-16 facilities/ Promoters report correct dose & course of cotrim. fed for pneumonia. • CDD: 80% of caretakers recently counseled on DD by CS-16 facilities/ Promoters report following 3 DD home care rules.	• Refresher training needs assessment of Promoters previously trained by CS-16. • SC-APROSAR-facility staff interviews with caretakers of children recently treated by CS-16 facilities/ Promoters.
IR-3: Increased caretaker **knowledge & awareness** of selected CS issues.	• ARI: 75% of mothers of children under 2 years report that help should be sought if their child has "fast and agitated breathing." (17%) • ARI: 50% of mothers of children under 2 years report that help should be sought if their child's "thorax is sunken" (chest indrawing) (2%)	KPC survey

***** CS-16 objective and indicator corresponds to MOH HIPC objective and indicator.

[1] The actual incidence of WHO algorithm positive pneumonia is very difficult to measure accurately, and is likely to vary between sites. The Global Burden of Disease and Injury Series (Murray CJL, Lopez AD. Volume II, Global Health Statistics, Harvard University Press, 1996, Table 105) estimates an average incidence of "lower respiratory infection" of 0.45 episodes per infant/child under five years of age per year in developing countries. The actual incidence of WHO algorithm positive pneumonia in children in Bolivia is unknown. Thus, SC decided to use the MOH indicator relating to the annual increase in the number of children treated for pneumonia, instead of an indicator relating to a rate of treatment. However, SC also believes that an effective facility- and CB-IMCI program in rural Oruro, a high mortality setting, should achieve combined rates of treatment between 0.2 and 0.5, and thus will also monitor the rate of treatment. MOH data for January through December 2000 indicate that all MOH facilities in the CS-16 site treated under-fives for pneumonia at a rate of approximately 0.08 cases per child per year (or approximately 18% of the expected incidence of 0.45 episodes per child per year).

End of Program Objectives, Indicators, and Means of Verification for IR-4:
Documented Feasibility and Results of Implementing Innovative CS-16 Approaches

Objectives	Indicators	Means of Verification
Documented feasibility and results of implementing CB-IMCI. **	• Feasibility: Estimated marginal cost of human resources & supplies for service delivery & support for implementation of approach.***	• SC/B & CS-16 records.
	• PCM/Use: Annual increase in # of <5 pneumonia cases treated by CS-16 facilities-Promoters. *	• DHO-facility & Promoter records.
	• PCM/Quality: % of PCM-trained Promoters passing pneumonia knowledge & skills test.	• CS-16 Promoter refresher training needs assessment tests.
	• CDD/Quality: % of caretakers recently counseled on DD by CS-16 Promoters who report following 3 home rules.	• Follow-up of recently counseled DD cases by SC-APROSAR-DHO staff.
	• PCM/Availability: % of CS-16 population within a 1-hour walk of facility or trained Promoter with adequate cotrim. stock.	• Checklists from SC-APROSAR-DHO supervisory visits & review of site map.
Documented feasibility and results of implementing Hearth/PD. **	• Feasibility: Estimated marginal cost of human resources & supplies for service delivery & support for implementation of approach. ***	• SC/B & CS-16 records.
	• Nutrition status/sustainability: % of all 6-35 month olds in Hearth/ PD communities < -2Z weight-for-age.	Hearth/PD community-wide pre- vs. post-H/PD intervention (status), & post- vs. one-year post-intervention (sustain.) growth monitoring records (for both indicators).
	• Nutrition status/sustainability: % of all 6-35 month olds in Hearth/ PD communities < -3Z weight-for-age.	
Documented feasibility and results of implementing SECI. **	• Feasibility: Estimated marginal cost of human resources & supplies for service delivery & support for implementation of approach. ***	• SC/B & CS-16 records.
	• Community Capacity: % of SECI communities having action plans with service providers to address CS needs.	• SECI meeting records, JPMM form, joint action plans, other CS-16 reports.
	• RHD Capacity: % of RHDs in which SECI data is incorporated in quarterly district information analysis meetings.	• Records of the 3 DHOs quarterly information analysis meetings.
	• EPI/Use: % of 12-23 month olds have maternal history or card for measles immunization. (27%)	• KPC survey
	• EPI/Use: % or more DPT3 coverage in infants in all CS-16 municipalities. *	• DHO EPI records, estimated <1 populations.

***** CS-16 indicator corresponds to MOH HIPC indicator.

****** With regard to these three strategies, the end of program objectives are to document the feasibility and results of implementing the strategy. However, all indicators, except those for feasibility, also have numeric end of program objectives described in the tables above on capacity building, sustainability, and/or CS-16 interventions.

******* This is intended to estimate the additional cost to another organization of implementing this approach over a four-year period in an area where the organization already has ongoing development activities.

3. Program Location:

The CS-16 Site and Population

Bolivia is divided into three geographical zones: the *Altiplano* (high plains), the valleys, and the sub-tropical zone; and administratively into nine Departments. Oruro Department is located on the Altiplano, south of La Paz. The Department covers an area of 53,588 square kilometers, has an estimated total population of 394,000,[2] and is administratively divided into one urban and six Rural Health Districts (RHDs). The urban health district, which includes Oruro City, has a total population of 241,000.

The CS-16 site includes two entire Rural Health Districts and most of a third RHD.[3] Each district is divided into "areas" (most of which have one hospital), and each area is divided into "sectors" (most of which have one health center). (Please see map, next page):

- District I, Huanuni (in the east of Oruro Department),
- District III, Challapata (in the southeast of Oruro Department, excluding the area of Cacachaca in the east of the RHD, and the municipality of Salinas[4] in the west, where CS-16 will provide limited indirect support to selected MOH child health activities and include MOH staff from these areas in CS-16-supported training activities),[5] and
- District V, Eucaliptus (in the north of Oruro Department), where SC has been working since 1997.

The site includes approximately 450 communities,[6] with a total population of approximately 104,500, and 13,500 children under age five.[7] The MOH estimates that there will be approximately 13,600 live births in the site over the four-year life of the project.[8]

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[2] According to the 1992 national population census, Oruro Department had 340,114 inhabitants. The National Statistics Institute estimates that Oruro had a total population of 393,991 in the year 2000.

[3] The site includes a total of 9 provinces and 12 municipalities.

[4] Precise definition of the municipality of Salinas: Excluded from CS-16 will be the province of Ladislau Cabrera (Health Service Areas of: S. Garci Mendoza, Luca, Puqui, San Martin, and Ucamasi), except for the municipality and Health Service Area of Pampa Aullagas, which is included in CS-16.

[5] These areas (containing a total population of approximately 8,000, and 1,000 children under 5) are excluded from CS-16 because a complex local vendetta has led to increasing violence, including approximately 50 deaths during the first six months of 2000, and substantial out-migration. Salinas in the west of the RHD is also excluded because of its isolation and sparse population. (See: "Bolivia's deadly West Side Story," in *The Economist*, July 22nd, 2000, page 37.)

[6] The 450 CS-16 communities range in population from 3 to 9,800, with a mean of only 230 people (30 children under five) per community in this mostly rural area with low population density. For the purposes of the CS-16 survey of communities, any settlement ½ hour or more walk from the nearest neighboring community was considered a "community" in its own right.

[7] Total and under-five population estimates for the CS-16 site are for 2001 from the central MOH. These are based on the estimate that children under five are 12.93% of the total population in this area.

[8] This is based on the MOH estimate that there will be 3.24 live births per 100 total population in this area, a CBR of 32.4. This estimate is clearly not consistent with the MOH estimate that infants make up 2.59% of the total population, nor with MOH estimate of the <5 population in the site (unless mortality were several times higher than

Though most of the people of the CS-16 site are Roman Catholics, rural Oruro, as the rest of Bolivia, is culturally heterogeneous. Most of the population speaks Spanish, though Aymara or Quechua is the first language of many.

Languages Spoken in the Three RHDs of the CS-16 Site[9]

Speak Spanish	Don't Speak Spanish
Spanish only: 20%	Aymara only: 8%
Spanish & Aymara: 28%	Quechua only: 3%
Spanish & Quechua: 35%	Aymara & Quechua: 6%
Total: 83%	Total: 17%

Agriculture is a primary occupation, but production is limited in this area due to the poor soil quality and harsh environmental conditions, with Oruro suffering from a process of desertification due to prolonged draughts over the last few decades. Agricultural products include potato, oca, barley, and quinoa. Animal husbandry is practiced on a small scale as well, and primarily includes raising llamas, alpacas, and sheep. The area's poverty results from low incomes due to the weak position of traditional farming systems in the agricultural economy, limited non-farm job opportunities, and low wages in the rural sector. Income from the sale of farm products by rural households is impeded by market imperfections such as the poor quality of access roads and resulting high transaction costs, and physical and financial barriers to retailing in urban markets (fees and fines). Income from working in the mines, once a significant industry, has been decreasing as prices have dropped and the cost of extracting ore is increasing. The production of traditional arts and crafts generates little income as well in a market that appears to be quite saturated and controlled by intermediaries.

The household food economy in rural Oruro is definitely determined by the combination of limited agricultural production, low income, and unfavorable terms of trade. Many rural residents are net purchasers of food, with the average number of months that households are self-sufficient in food ranging from five to seven months. Access to food is further constrained by relatively high prices for food items not produced locally, such as rice, bread, pastas, fruits, vegetables, salt, and sugar. The decline of the farm economy with resulting unfavorable terms of trade for small-scale farmers, has forced more and more of them to seek income-generating opportunities outside of their home communities. For that reason, seasonal and permanent out-migration is high from this area.

The Altiplano and rural areas of Bolivia have the worst health and social indicators in the country. The rate of illiteracy in people over age 15 is 15% nationwide, 9% in urban zones, and 28% in the rural areas. In Oruro Department as a whole (which is 70% urban), 6% of men and 24% of women over age 15 are illiterate, while in the three rural health districts of the CS-16 site, 11% of men and 38% of women are illiterate.[10]

MOH Child Health Services in the CS-16 Site

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reported, or there is substantial out-migration of infants soon after birth). SC believes that it is possible that the under-five population is being under-counted/estimated and the number of expected live births over-estimated.

[9] Atlas Estadístico de Municipalities, INE, MDSP, COSUDE, 1999.

[10] Atlas Estadístico de Municipalities, INE, MDSP, COSUDE, 1999.

Government hospitals and health centers are the principal providers of formal health services for the population of the CS-16 site. However, in Oruro Department, 70% of MOH staff are working in Oruro City.[11] MOH health facilities in the three Rural Health Districts of the CS-16 site include nine hospitals and 38 Health Centers.

Health Facilities in the Three Rural Health Districts of the CS-16 Site

Level	Facility	Huanuni	Challapata	Eucaliptus	Total
District	District Offices	1	1	1	3
Area	Hospitals	2	3	4	9
Sector	Health Centers	9	18	11	38

Hospitals in the three RHDs have basic essential drugs and equipment, and professional staff including physicians in place, but do not conduct surgery and do not provide comprehensive emergency obstetric care. Approximately 11 Health Centers in the CS-16 site have between two to eight beds, and staff that usually includes a doctor and a nurse. Small Health Centers (formerly called Health Posts) are staffed by an Auxiliary Nurse, are equipped with basic medicines, and do not have the capacity to admit inpatients.

MOH Staff in the Three Rural Health Districts of the CS-16 Site[12]

District	Service Unit	Personnel				
		Doctors	Admin. Staff	Nurses	Aux. Nurses	Others
Eucaliptus	Dist. Office	1	2	1	0	
	Hospitals	6	7	3	10	
	H. Centers	1	0	0	11	
Challapata	Dist. Office	1	2	1	0	2
	Hospitals	7	8	5	9	6
	H. Centers	5	5	6	22	0
Huanuni	Dist. Office	1	2	1	0	1
	Hospitals	8	5	4	7	3
	H. Centers	4	2	11	4	2

Government hospitals and health centers offer the following services for children under five: management of diarrheal diseases and of acute respiratory infections; growth monitoring and nutrition counseling; vitamin A supplementation; in-patient management of malnutrition; and, immunizations. Maternal health services include: prenatal care, delivery, postpartum care, iron supplementation for pregnant women, and family planning. From a supply-side perspective, the Expanded Program on Immunization (EPI) is one of the strongest MOH interventions in the CS-16 site. In the three Rural Health Districts, a cold chain is well established, EPI vaccines and supplies are available at health facilities, and EPI-related technical knowledge and skills of staff are good.

The Bolivian government introduced reforms in recent years to make public services more responsive to communities. In 1994, the Law of Popular Participation mandated grassroots

[11] Reported to SC staff by Dr. Martha Mejia, Child Survival Consultant, PAHO/Bolivia, 11/4/99.

[12] Servicio Departamental de Salud, MOH, 2001

representation on district health and social sector councils. In 1995, Administrative Decentralization transferred economic and political decision-making for key public services and resources, including the health system, to regional departments, municipalities, local citizens' councils, peasants' unions and ethnic groups. In 1998, the Ministry of Health and Social Welfare instituted universal access to primary care that covered basic MCH services, paid for through funds distributed to municipalities.

The Basic Health Insurance law now regulates the services offered by the MOH. According to this law, primary health care services for women of reproductive age and for children under five are provided free of cost. The costs of these services are supposed to be reimbursed by the municipal government through payments to the health district on a per visit/per service basis. The law states that Mayors must reserve at least 6.4% of their municipal budget to pay for these basic health insurance costs. The law is relatively new, and there are still many problems implementing the scheme, with some municipalities accumulating over a year's worth of debts, while others are unable to spend their health budgets.

Other Child Health Services in the CS-16 Site

A Bolivian NGO and CS-16 partner, APROSAR, The Association of Rural Health Promoters (Asociación de Promotores de Salud del area Rural), has been training and working with Promoters over the last 17 years in Oruro. Promoters are volunteers who carry out health education and promotion activities and provide basic curative care in rural areas to communities that do not have easy access to formal health services. APROSAR currently has 87 Promoters in the three rural health districts of the CS-16 site, each elected in community meetings. APROSAR's selection criteria for Promoters include: sense of public service, honesty, willingness to be responsible for the health of families and the community, leadership abilities, and respect in their communities. Current services provided by Promoters include: ORT and referral for diarrhea when appropriate, detection and referral of children with ARI in need of further assessment (and treatment of pneumonia with cotrimoxazole by some Promoters), clean delivery and recognition of maternal danger signs, growth monitoring, nutrition and breastfeeding counseling, detection of epidemics, family planning, providing immunization with DHO support, first aid, prenatal and postnatal care visits, home visits, and health education in community meetings. Promoters receive 30 days of training, including training in participatory methods and inter-sectoral coordination. Medicines are sold to clients, with Promoters retaining a 10% profit, and re-supplied to Promoters through regular supervisory visits by APROSAR nurses. APROSAR provides Promoters with food during their training, reimburses them for travel costs to and from the training site, and provides some non-monetary incentives, such as books, jackets, and bicycles when funds are sufficient.

SC/Bolivia (SC/B) estimates that approximately 10-15% of the under-five population of the CS-16 site currently receive small food supplements through programs in Eucaliptus and Huanuni RHDs supported by the World Bank and the European Union. Other organizations supporting child survival-related activities in the CS-16 site include GTZ, which supports MOH institution strengthening and reproductive health in District III (Challapata), and DFID, which is initiating a family health project in the same district, though activities will be concentrated in Challapata's urban area. A Bolivian NGO, Reform, is supporting the construction and staffing of health centers and is initiating some community health activities in District III with World Bank support. Food for the Hungry has recently phased out its support for health-related activities in Challapata RHD, which included food supplements. While there is much development activity

going on in Challapata, very little is being done to mobilize rural communities around basic health issues, nor are mechanisms being provided to the district health office to respond to prioritized community needs. In meetings with SC, local authorities and the District Director have explained their intention of working via a unified community health vision ("perspectiva de mancomunidad"), by coordinating with the other projects that work in Challapata.

Traditional health providers, called "Yatiris," "Jampiries," "Laris," "Kallawayas," "Tataquitos" (men), or "Mamaquitas" (women), are recognized by some for their powerful knowledge and effectiveness in treating illnesses.[13] These traditional providers are respected and feared because they can use their powers against the people, provoking severe illnesses. They use herbs, flowers, fruits, seeds, wood, tobacco, animal feces, honey, oil, parts of different animals, minerals, urine, and petrol, among other things, to cure illness caused by bad wind, loss of soul, or lightening, and to make offerings to offending gods and goddesses. Huari in Challapata RHD is an important center for the purchase of herbs and supplies for rituals. Mothers participating in CS-16 focus group discussions did not cite supernatural causes of childhood illnesses frequently. Use of traditional healers was mentioned in three of the twelve focus group discussions, and was much less commonly cited than was use of home and traditional remedies, neighbors, drug shops, Promoters, and health facilities. In the CS-16 KPC Survey, less than three percent of mothers reported seeking advice from healers for childhood diarrhea or for serious respiratory illness.

Some private providers, including doctors, nurses, and pharmacies, also provide CS-related services in the larger towns of the CS-16 site (please see table below). In the CS-16 baseline KPC Survey, only three percent of mothers reported seeking advice from drug stores for childhood diarrhea or respiratory infections.

Private Health Providers in the Three Rural Health Districts of the CS-16 Site

	Huanuni	Challapata	Eucaliptus	Total
Doctors	0	1	0	1
Dentists	1	2	0	3
Nurses	2	0	0	2
Laboratories	0	0	0	0
Pharmacies	3	3	0	6
Traditional Providers *	5	1	1	7

* This data is only for the urban areas of each district. SC estimates that each district has 20 to 30 traditional health providers.

[13] Alba Fernandez Juan, *Between life and death, campesinos' health providers*, 1996.

4. Program Design:

Broad Program Approach

SC will work with the site's three MOH Rural Health Districts and the NGO APROSAR to implement four child survival interventions: Nutrition and Micronutrients, Pneumonia Case Management, Control of Diarrheal Disease, and Immunization. SC will document the feasibility and results of implementing these four interventions through three innovative approaches to child survival in Bolivia: (1) Community-Based-IMCI (CB-IMCI), focussed on training and supporting volunteer Rural Health Promoters to provide selected child survival services in their communities, based on the PAHO CB-IMCI materials adapted for Bolivia, while supporting concurrent MOH implementation of IMCI at health facilities; (2) The Hearth model using a Positive Deviance approach (Hearth/PD) to sustainable community-based rehabilitation of malnourished children and prevention of malnutrition, building on SC's recent experience piloting Hearth/PD for the first time in Bolivia and building on SC's success with this approach in other countries. If successful and cost-effective in CS-16, Hearth/PD has good potential for "uptake" by other organizations and reducing childhood malnutrition in other areas of Bolivia, and; (3) The Community Epidemiology Surveillance System (SECI), recently developed by SC/Bolivia to promote joint collection, analysis, and use of health information by health providers and communities to address local health needs, will be scaled-up through CS-16 based on SC's initial success in ten communities of rural Oruro. SECI has great potential for improving utilization of health services on a large scale in Bolivia, if the approach continues to be successful and feasible following implementation throughout the CS-16 site.

CS-16 Goals and Results

CS-16 Goals include:

- A sustained improvement in nutrition status of 6 to 35 month old children in Hearth/PD communities (which will be documented through CS-16);
- A sustained reduction in under-five mortality in the three health districts; and
- Innovative CS-16 approaches inform policy and improve programming in other areas of Bolivia.

These goals will be achieved through the CS-16 Results of:

- Improved capacity of APROSAR and the three health districts to support community activities and implement innovative, culturally-acceptable child survival approaches;
- Improved capacity of communities in the three health districts to identify and effectively address priority health needs of children under five;
- Increased use of key health services and improved child survival practices at household level in the three health districts; and
- Uptake of successful innovative approaches by the MOH or by other organizations in Bolivia.

These Results will be achieved through the CS-16 Intermediate Results of:

- Demonstrated SC/Bolivia capacity in CB-IMCI, SECI, and H/PD capacity building of CS-16 partners and advocacy;
- Documented feasibility and results of implementing innovative CS-16 approaches;
- Increased availability of selected child survival services in the three health districts;
- Improved quality of selected CS services in the Program site; and

- Increased caretaker knowledge and awareness in the three health districts of selected child survival issues.

The following three sections describe the analytical basis and methodologies for combinations of CS-16 strategies and interventions to address key CS-related needs of rural Oruro in an integrated way, and increase equitable access to and use of key CS services.

(1) Implementation of PCM, CDD, and EPI Activities through the CB-IMCI Approach

The Bolivian MOH has made IMCI its most important strategy to reduce child mortality in the country. Community-Based-IMCI is being developed to address community and family practices related to child survival, and to address poor access to health facilities, especially in isolated rural communities. PAHO has developed three training packages for CB-IMCI: a basic CB-IMCI training course for community health workers, a module on "Talking with Mothers," and a course for planning IMCI at the community level. The MOH, together with PAHO, BASICS and an inter-institutional team (of which SC/B is a member), has recently completed the adaptation of the generic PAHO CB-IMCI materials for use in Bolivia. The Bolivian MOH CB-IMCI approach is based on training and supporting Rural Health Promoters to provide appropriate CS services, including health education, in their communities.

Because of the very high under-five mortality in rural Oruro, poor geographic access of much of the population to health facilities, and the low utilization of health services, CB-IMCI is particularly important in this setting. The CDD and PCM interventions address two of the leading causes of under-five deaths in Bolivia. The immunization intervention will address low immunization coverage in the project site. All three are key IMCI, and particularly CB-IMCI, interventions. SC has had substantial experience and success working with Promoters and implementing of CDD, PCM, and immunization activities at the community level in Eucalyptus Health District through the recently completed Mission/PROCOSI [14] -funded child survival project.

SC/Bolivia, in coordination with the MOH and PAHO, will implement CB-IMCI on a pilot basis through CS-16, while supporting concurrent MOH implementation of IMCI at health facilities in the project site. The CS-16 CB-IMCI approach is based on training and supporting Rural Health Promoters to provide appropriate child survival services in their communities, including promotion of key CS practices at the household-level and utilization of key CS services, and case management of childhood illness in communities with poor access to health facilities. Promoters, working out of their own homes, will provide diarrhea and pneumonia case management services for ill children, assess immunization and nutrition status and refer children for immunization and nutrition rehabilitation (at Hearths or health facilities). They will provide health education services from their homes when seeing ill children, during home visits (when SECI information is collected, see below), and during community-level group activities, including community/SECI meetings, using SC, MOH, and PAHO CB-IMCI materials adapted for Bolivia, and interactive methods, including SECI information analysis and discussion.

[14] "PROCOSI is a network of nonprofit Bolivian organizations who contribute to the improved health of the population through activities to strengthen the health and development programs of its members and to influence public opinion." (PROCOSI's mission statement). SC was one of the three PVOs which developed and submitted the original proposal for PROCOSI to USAID in 1987, and has continued to play a leading role in the organization.

CS-16 will conduct a field test of the PAHO CB-IMCI materials adapted for use in Bolivia and of the entire CB-IMCI strategy, testing different methodologies and approaches. CS-16 will help define and describe a CB-IMCI model for rural Bolivia, including definition of roles of Rural Health Promoters, service providers, communities, and NGOs in CB-IMCI; revise draft CB-IMCI materials adapted for Bolivia, if required; develop a revised Promoter job description; determine and meet needs for CB-IMCI BCC materials; define content and methodology of training courses; conduct CB-IMCI training and follow-up activities, including meetings to assess progress, in-service TA and supervision, and refresher training.

CS-16 will establish links between CB-IMCI, facility-based IMCI, and other organizations. Links with facility-based IMCI will be promoted through the establishment of a two-way referral system for ill children between Promoters and health facilities, and through joint training, monitoring, exchange of information, and joint CS activities at the community level. Links with other organizations will be promoted through inter-institutional participation in training and follow-up of Promoters, joint design of educational materials, and advocacy with the MOH to approve policies that facilitate the work of Promoters. PAHO and the MOH in Bolivia support SC's proposed introduction of CB-IMCI, and are committed to providing assistance to the project.

(2) Improving Child Nutrition through the Hearth Model Using a Positive Deviance Approach

The Hearth/PD approach seeks affordable, sustainable, community-based nutritional rehabilitation and prevention of childhood malnutrition. The approach is based on "positive deviance" (PD), the observation that most poor communities include impoverished families with *well-nourished* children. These poor "Positive Deviant Families" who have well-nourished "Positive Deviant Children" are the living proof that it is possible for poor families to have well-nourished children, before economic improvements occur or clean water and sanitation are accessible to all. The positive deviance method identifies these families, catalogues the unique behaviors (including healthy breastfeeding and complementary feeding practices, among others), which have enabled them to raise healthy children, and then disseminates these behaviors among neighbors through Hearth sessions, leading to new community norms for child feeding and caring.

Building on work by other PVOs in Haiti and Bangladesh, SC has demonstrated and brought to scale a measurable, replicable, community-based approach to sustainably alleviate childhood malnutrition in Vietnam.[15,16,17] The Hearth/PD approach has only recently been introduced in Bolivia for the first time by SC on a small scale through the recently completed Mission/PROCOSI-funded child survival project in Eucaliptus. CS-16 will build on initial SC experience with Hearth/PD to further refine the approach, and document impact on nutritional status of children and feasibility of implementation. Because of the lower population density and

[15] Sternin M, Sternin J, Marsh D, Scaling Up A Poverty Alleviation and Nutrition Program in Viet Nam, for Marchione T, *Scaling Up, Scaling Down: Capacities for Overcoming Malnutrition in Developing Countries,* in press, Gordon and Breach.

[16] Sternin M, Sternin J, Marsh D, Rapid, Sustained Childhood Malnutrition Alleviation Through a "Positive Deviance" Approach in Rural Vietnam: Preliminary Findings" in Keeley E, Burkhalter BR, Wollinka O, Bashir N (eds) The Health Nutrition Model: Applications in Haiti, Vietnam, and Bangladesh, Report of a Technical Meeting at World Relief Corporation, Wheaton, IL, June 19-21, 1996, Arlington: BASICS, 1997.

[17] Larimer T, Nghia T, Vietnam's Deadly Puzzle, Time, 152(1), July 13, 1998.

lower rates of childhood malnutrition in rural Oruro than in Vietnam, the marginal costs of Hearth/PD implementation in relation to nutrition status outcomes will be an important issue to be documented by CS-16. If successful and cost-effective, Hearth/PD could be implemented as a component of CB-IMCI through other organizations, and make an important contribution to reducing childhood malnutrition in other areas of Bolivia.

CS-16 will gradually phase-in Hearth/PD activities in eligible communities throughout the project site based on the SC Hearth/PD Field Guide[18] and CORE Group/CSTS Field Cookbook.[19] Hearth/PD eligible communities will be identified based on the following criteria: (a) Twenty or more underweight (< -2Z weight-for-age) 6 to 35 month-old children identified in the community through the H/PD nutrition status survey; (b) Availability of affordable local foods; and (c) Mothers willing to work as Hearth Volunteers. Following the selection of communities, local human resources for support of Hearth/PD will be identified and oriented, including: community health committees, health volunteers, and formal and non-formal health workers. This will be followed with a situational analysis of malnutrition in children, including a baseline nutrition survey, focus group discussions, and then a joint CS-16/community definition of Hearth/PD program goals. Then, through the Positive Deviance Inquiry (PDI), villagers and program staff will identify the PD families' special and demonstrably successful current feeding, child care, and health-seeking practices which enable them to "out perform" their neighbors whose children are malnourished but who share the same resource base. For example, in the initial PDI in six communities of Eucaliptus Health District in June-July 1999, quinoa, eggs, llama meat, carrot juice, and papaya were identified as PD foods; and feeding the child a mid-morning snack, using games and songs to convince children to eat, and active feeding, were identified as a PD feeding practices.[20]

Based on the PDI findings, the villagers and the program staff plan a "Nutrition Education and Rehabilitation Program" (NERP) to sustainably rehabilitate malnourished children and prevent malnutrition in young children in the community through the promotion of current successful child feeding, caring, and health-seeking behaviors. The NERP plan includes Hearth menus and messages, identification of household PD food contributions as the price of admission to the Hearth sessions, Hearth health and nutrition education protocols, and plans for support of and integration of other existing nutrition-related programs into NERP, particularly the MOH vitamin A supplementation program. Each month, over a two-week period, caretakers of malnourished children identified through regular growth monitoring are invited to participate in daily Hearth sessions to rehabilitate their children with the help of neighborhood volunteer mothers. These Hearth Volunteers supervise caretakers preparing a calorie-dense meal and feeding it to their malnourished children.

(3) Mobilizing Communities and Health Services through SECI, the Community Epidemiology Surveillance System

[18] Sternin M, Sternin J, Marsh D. Designing a Community-Based Nutrition Program Using the Hearth Model and the Positive Deviance Approach – A Field Guide. Save the Children, December 1998.

[19] The Field Cookbook for the HEARTH Nutritional Model Using the Positive Deviance Approach, First Draft, Sponsored by the CORE Group and CSTS, Written and compiled by Donna Sillan, MPH, September 2000.

[20] The Results and Application of a Positive Deviance Inquiry on the Bolivian Altiplano. Melissa Cribben, Rollins School of Public Health, and Save the Children/Bolivia.

Two important lessons were learned through the *Warmi* Project that have helped to guide the design of *SECI*: (1) Communities need to have access to relevant information on their health status, and on what has and has not worked in other similar settings, to make informed decisions about priorities, to develop appropriate strategies, and to be able to monitor their progress toward their objectives; and (2) A development approach to health where external organizations work in parallel is not ideal. Some organizations work almost exclusively with service providers to build capacity for service delivery while others almost exclusively work with communities to increase demand for services and improve health behaviors, without paying attention to how these groups relate. This can result in services that are not responsive to clients' needs, and can lead to client expectations that may not be realistic. While there are important and valid reasons to provide assistance to communities and service providers separately, this paradigm does not allow for the possibility of sharing responsibility for health by establishing common objectives and building on the joint resources and commitment of service providers and communities.

SC/B's experience in Bolivia has also shown that disseminating key messages from a biomedical perspective through health talks and other means, has limited impact on the adoption of these practices by rural families. Health service providers and others who work with communities, such as those in rural Bolivia where traditional beliefs and practices are strong, need to recognize the importance of both kinds of knowledge: the scientific technical and the popular traditional knowledge. Establishing a respectful dialogue between the two can lead to innovative and effective "new and improved practices" and a broader understanding of the rationale behind existing and recommended actions. SC/B applied this approach successfully in its work with the *Warmi* project, and will adapt these methods to incorporate a "dialogue of knowledge" between service providers and communities around priority child health topics at general community meetings at which SECI is implemented.

SECI, recently developed and introduced on a small-scale by SC in Eucaliptus RHD through the JHU PCS4 grant, attempts to address these concerns by adopting a partnership and team-building approach, so that respectful dialogue and analysis can take place, leading to joint action based upon common goals and objectives. SECI consolidates primary health care data collected by health service providers and community health Promoters using simple forms and community maps. SECI facilitates increased communication between communities and health service providers, first by bringing Promoters and service providers together to consolidate the data. They then present the data in easy to understand graphics to the community so that together, they can obtain and analyze new information about community health problems and articulate health priorities that reflect community priorities. Communities and service providers acting together have also been able to leverage increased financial resources for health services from municipal health budgets, and SECI meetings have stimulated joint community and service provider action that has led to several improvements in local health services. (Please see examples in DIP Section I.I. on the CS-16 Devolution Strategy.)

An evaluation of the SECI pilot was conducted in June 1999, in collaboration with Emory University, and showed promising results. The evaluation assessed the experiences of villagers and health personnel who participated in SECI for one year, and compared health practices and use of MCH services in intervention and control communities. SC staff kept project-related records for all ten intervention communities and supervised an ethnographic study involving fifty key informants and nine focus groups in three of the intervention communities. Local interviewers conducted a cross-

sectional survey in seven intervention and seven control communities, randomly sampling 218 households and 344 children. The evaluation found that SECI enabled communities to assess their health, plan, and act as partners in the local health system. Intervention communities promoted local health, demanded more responsive and accountable health services, and built positive working relationships with participating health personnel. Intervention communities were more likely to use several types of child health services and practice healthier behaviors. More intervention than control households reported: complete child immunization (11% vs. 3%, $p<.05$); vitamin A supplementation (59% vs. 42%, $p<.05$); health card possession (45% vs. 28%, $p<.05$); early breastfeeding (26% vs. 12%, $p<.05$); and adding oil to complementary foods for young children (67% vs. 52%, $p<.05$).[21] However, caregivers' recognition and home care of child illness, and caregivers' knowledge of contraceptive methods did not appear to be influenced by participation in the project, and participation in the project did not appear to influence use of services for child illness or reproductive health (including antenatal care and tetanus-toxoid immunization).

In the ten pilot communities, a total of 2,334 people participated in regular monthly community meetings into which SECI has been incorporated to analyze health data and plan solutions together with service providers. Evaluation "participants reported that community members and leaders were more concerned about maternal and child health than they had been before." Meeting records and key informants indicated that community members were adopting new health behaviors to "protect" maternal, infant and child health in order to prevent illness and death "so they would not feel sorry later."

"The results of this study support the hypothesis that SECI mobilized community members to use health information to improve maternal and child health. SECI has provided a new way for communities to organize around health issues. Qualitative data indicated that SECI was successful in bringing community members, health professionals, and community authorities together to discuss maternal and child health problems and issues related to health services." Based on these initial encouraging results and on MOH interest in SECI, CS-16 will phase-in SECI throughout the three health districts of the project site, following the SC/Bolivia SECI manual. A "dialogue of knowledge" will be incorporated into general community meetings at which SECI is implemented. The dialogue begins with an in-depth exploration of existing attitudes, beliefs, and practices, based on a series of questions that a facilitator will pose to community participants. The dialogue begins with a general discussion about children and what children mean to a family and the community, what it means to a family when a child is born and when a child dies, when a child is sick and when a child is healthy. The discussion will then focus on priority health problems as identified by the community through analysis of SECI data. Communities will share their experience with these priority health problems, discussing what the problem is called locally, what people believe causes the problem, how it is treated, and what happens when it is not treated or treatment is not effective. At this point, there are no correct or incorrect answers and the service providers' role is to listen, ask questions, and learn. Service providers then have the opportunity to share what the current "state-of-the-art" medical practice is in terms that community members can understand. A discussion then ensues between all

[21] Cynthia P. Willis, Dirk G. Schroeder, Lisa Howard-Grabman, David Marsh, and Fernando Gonzales. Strengthening partnerships in local Bolivian health systems with community-based health information, Draft, February 14, 2001.

participants to explore what is feasible, what is currently working well, and which practices are harmful. At this point, positive deviance approaches may be used to discuss healthy/PD practices of community members with the healthiest children. Based on these discussions, the participants negotiate "new" and/or "improved" practices. They then monitor the results of adopting these new practices, and revise practices if necessary.

SC and the MOH believe that SECI has the potential to make an important contribution to improving the utilization of health services on a large scale in Bolivia if the approach continues to be successful and feasible following implementation throughout the CS-16 site.

5. Partnerships:

Selection, Description, and Roles of CS-16 Partners

The selection of the CS-16 site, covering Rural Health Districts I and III, in addition to District V, Eucaliptus, where SC has been working since 1997, was based on detailed discussions with the NGO APROSAR and the Directors and staff of all three RHDs, and their enthusiasm for jointly implementing CS-16 with SC. These three districts are the three most populous Rural Health Districts of Oruro Department. CS-16 partnerships build on SC/Bolivia's relationships with the Eucaliptus MOH Rural Health District and with APROSAR to implement "Child Survival in Oruro"[22] from February 1998 through January 2001, and "Community Mobilization" (SECI)[23] from July 1997 through June 2000. APROSAR had a sub-contract with SC to support these child survival activities in Eucaliptus, including SECI and Hearth/PD, through APROSAR Promoters.

APROSAR was born out of grassroots organizing of Rural Health Promoters with initial assistance from Project Concern International from 1980 through 1989. Since its inception, APROSAR's Promoters have been working with communities on child survival and other primary care activities in Oruro and Northern Potosí. In 1992, APROSAR was legally registered as a non-governmental organization in Bolivia. APROSAR's mission is to preserve and promote health in communities with scarce resources, respecting their customs and culture, emphasizing self-care in health to contribute to community development. APROSAR has worked in partnership with several institutions including Freedom from Hunger, CIES, CARITAS, the MOH in selected districts, and municipal governments and local health districts. In the CS-16 site, APROSAR is currently implementing a reproductive health project funded by PROCOSI and an adolescent reproductive and sexual health project funded by Population Concern, both in Huanuni RHD.

Most CS-16 activities, with the exception of financial management and reporting, will be conducted jointly with APROSAR and the three District Health Offices. SC will: Develop detailed action plans with CS-16 partners; Coordinate and organize project activities with partners; Train partners in CB-IMCI, Hearth/PD, and SECI; Provide technical assistance to CS-16 partners in the use of SECI and SNIS health information systems, management, logistics,

[22] Funded through PROCOSI/USAID.

[23] Funded through Johns Hopkins University PCS4/USAID.

human resource management, strategic planning, and financial management; Supervise the subcontract with APROSAR and ensure the fulfillment of commitments; Support, supervise, and evaluate Program activities; Monitor CS-16 progress; Identify and resolve technical and organizational problems; Implement baseline assessments and mid term and final evaluations; Promote the organizational development of the partners; Document and disseminate results; Encourage the MOH to establish policies favorable to CB-IMCI and Promoters; Adapt, test, and revise new CB-IMCI materials with partners, and; Prepare and submit program and financial reports for SC and BHR/PVC.

The three MOH Rural Health Districts will: Participate in the training of Promoters and Auxiliary Nurses in CB-IMCI, SECI, and Hearth/PD; Jointly supervise and support Promoters and Auxiliary Nurses; Implement CB-IMCI community activities; Facilitate SECI sessions and help develop community health plans; Help design and implement baseline assessments and evaluations; Maintain SECI information in the district SECI database, incorporate SECI data into SNIS, and use this information in the Information Analysis Committees (CAI's); Establish a two-way referral system with Promoters; Develop annual operations plans which include CS-16 activities, and; Participate in the quality circles, as part of quarterly evaluation and planning meetings. All MOH health facilities in the three RHDs are under the jurisdiction of the District Health Offices. The roles of these facilities in CS-16 includes: Treatment of ill children, provision of immunization services in the facility and in outreach sites, and contribution of one member of their staff for regular participation in SECI meetings.

In Huanuni RHD and Totora Municipality of Eucaliptus RHD, APROSAR will: Develop a work plan for CS-16 activities; Participate in the training of its Promoters in CB-IMCI, SECI, and Hearth/PD; Ensure completion of CS-16 work plan activities; Support, monitor, and evaluate implementation and quality of the work of Promoters; Evaluate the completion of the quarterly results and propose modifications to the quarterly plan, and; Participate in the midterm and final evaluations.

PAHO will: Provide technical assistance for the adaptation, testing, and revision of CB-IMCI materials; Provide technical assistance for evaluation of the CB-IMCI strategy; Participate in the evaluations, and; Promote change in policies to facilitate CB-IMCI and work of Promoters.

SC/B also has agreements which support CS-16 activities, or which relate to CS-16 activities, with the following organizations in Bolivia: the MOH at central level in La Paz and departmental level in Oruro, PROCOSI, and the World Bank.

6. Health Information System:

F.2. Program Monitoring and Evaluation Plan

SC/B's Organizational Approach to M&E: As noted in Section II.A., above, CS-16 will be managed, and program performance monitored, through the Quality Circle management structure currently used by SC in Bolivia, which has proven effective in rural project management. This structure provides for an appropriate delegation of authority to promote efficient decision making. The CS-16 field staff will have monthly quality circle meetings to plan for the next month, as well as to discuss and propose solutions to immediate problems. Senior project management from Oruro and La Paz, APROSAR, and MOH district staff will participate in the

monthly quality circle meetings. APROSAR & MOH STAFF DO NOT PARTICIPATE IN MONTHLY MEETINGS

Quarterly project evaluations also take place as part of the normal implementation process. All SC/B program staff are familiar with the monthly quality circles and quarterly evaluation structures, and participate actively in the collection and presentation of quarterly information for their programs. Quarterly evaluations document activities from the last quarter, assess progress toward achieving results and objectives, and serve as a basis for planning activities for the upcoming quarter. As currently implemented by SC, senior management from La Paz will participate in the quarterly evaluations. Feedback is provided by the entire office, not just from health staff. Senior and key staff review the information for accuracy and make appropriate strategic management decisions to improve program quality. A quarterly plan is then created and agreed upon by the participants. A quarterly report is produced, documenting results, plans, and decisions made. This information will be used for CS-16 reports to partners and collaborating organizations in Bolivia, to SC's Home Office, and contribute to annual reports and mid-term and final evaluations.

CS-16 Approach to M&E, Relationship to Community and Facility Data, and Tools Used: SECI and the MOH SNIS (described in DIP Section I.F.3) form the core of the CS-16 approach to monitoring. Evaluation of program performance will be based on measuring achievement of the CS-16 objectives using the means listed in the tables above, and based on midterm and final evaluations following BHR/PVC guidelines.

SECI consolidates primary health care data collected by health service providers and community health Promoters using simple forms and community maps. SECI also contributes more complete reporting of health information from communities to the RHDs. Currently the following information is collected by Promoters during home visits every two months, and included in SECI data analysis and presentations/discussions in community meetings every two months:[24] number of live births, stillbirths, children <5 with diarrhea in last month, <5s with rash and fever in last month, <5 deaths, signs prior to death in infants and in 1-4 year olds, number of pregnancies, deliveries with the help of trained personnel, deliveries without trained personnel, maternal deaths, signs prior to maternal deaths, and observations/remarks. Communities may decide to collect information on additional variables. Health facility staff currently contribute the following information to SECI: The same variables as reported by Promoters (above), but for cases seen at health facilities, pregnancies with anemia, pre-natal visits, nutrition status data from growth monitoring sessions (through Hearth/PD in some communities), immunization coverage, and pneumonia treatment. This set of variables also varies over time and between communities as variables are added and dropped by community members and health workers in SECI meetings.

After SECI is initially introduced in a community and Promoters trained in data collection, Promoters start collecting information during home visits together with SC staff. SC staff also conduct periodic home visits without Promoters to ensure validity of data collected by the Promoters, and check Promoter and RHD/health facility data for errors.

SECI facilitates increased communication between communities and health service providers, first by bringing Promoters and service providers together to consolidate the data. They then

[24] Mortality data is presented and discussed every six months.

present the data in easy to understand graphics to the community so that together, they can obtain and analyze new information about community health problems and articulate health priorities that reflect community priorities. The methodology builds in a series of analysis questions and ways to present the data so that community members and service providers can compare trends over time, monitor progress, and determine where alternative strategies are needed. As changes are implemented, the health information system will continue to help the communities and health staffers work together to monitor progress toward achievement of agreed upon objectives and to make decisions on municipal and community resource allocation. Communities and service providers acting together have been able to leverage increased financial resources for health services from municipal health budgets, and SECI meetings have stimulated joint community and service provider action that has led to several improvements in local health services. (Please see examples in DIP Section I.I. on the CS-16 Devolution Strategy.)

SECI tools include a manual,[25] problem picture cards, pictorial ways of presenting quantitative information to literate and illiterate community members (for example, using the national flag with red, yellow, and green bands to represent high, medium, and low risk), and an optional software package to consolidate community-level data from health Promoters with SNIS national health information system service-based data, and translate this more complete epidemiological picture into graphics that can be used with communities. CS-16 will use the SECI software to computerize all basic/uniform data from Promoters and health services on the variables listed above. CS-16 SECI implementation will include an operational assessment of how the SNIS national health information system is functioning; training of DHO staff in the use of the SECI software package and SNIS; monitoring and supervising trainees in the flow of SECI and SNIS information, and use of this information in the District Health Information Analysis Committees; and providing technical assistance to the Area and District Health Information Analysis Committees.

SECI and SNIS are essentially complementary systems. The SNIS focuses on collecting data from health facilities on services provided, while SECI focuses on data from households on events in the households. SNIS data is analyzed and presented at the RHD, departmental (Oruro) and national levels, while SECI data is analyzed and presented at the community level. CS-16 seeks to develop RHD capacity to effectively collect and use both SECI and SNIS data. CS-16 does not seek to integrate SECI data into the SNIS, an important issue raised in the USAID Bolivia Mission review of the CS-16 application.

CS-16 staff will also monitor the quality of CS-16-related services, and obtain feedback on which program approaches are working well and which need to be improved, through participatory reviews of CS-16 progress with health workers and community members during the community-wide SECI meetings. Other sources of information for monitoring CS-16 progress and performance include: Assessments of health worker performance and availability of essential supplies through supervisory visits; Assessments of health worker knowledge and skills during refresher training needs assessments, and; the DHO reporting system for data on use of health services, including pneumonia and diarrhea case management and EPI coverage.

Information from the DHO, SECI, and APROSAR/Promoter reporting system will be analyzed on a quarterly basis by CS-16 staff. Reasons for comparatively very high or very low rates of

[25] Save the Children/Bolivia, Johns Hopkins University. Manual SECI, "Sistema Epidemiologico Comunitario Integral." September, 1999.

service provision in any community or by any facility or health worker, will be investigated, and actions taken to improve performance if indicated. Meetings at the RHD-level with DHO, facility, APROSAR, and SC staff will be used to review progress, activities, and achievements, and to identify and solve problems.

Monitoring and Improving Performance of Health Workers: Quality CS services will be achieved through: Basing health worker training and behavior change messages on good and current curricula and materials, and on participatory SECI meeting results regarding beliefs, practices, and satisfaction with services; Competency-based training involving clinical and counseling practice with small groups of trainees and ill children and their mothers; Using standards of practice during health worker training and supervision; Providing refresher training to address identified problems; Regular supportive supervision and provision of essential supplies, and; Through regular meetings to discuss activities and achievements, and identify and solve problems. Supervisory visits will include reviews of health worker's records and stocks of essential supplies, and discussions about activities, problems, and solutions.

Tools Used by CS-16 to Promote Quality of Service: In addition to the SECI tools described above, other important tools to promote quality of service in CS-16 include the PAHO CB-IMCI materials adapted for Bolivia and Hearth/PD materials. Although the CB-IMCI materials contain several mistakes, the national IMCI committee has decided that this year all the organizations that are implementing IMCI should use this material, and after one year, this same committee will make a revision with inputs from other organizations. SC/B plans to contribute suggestions based on experience with the materials gained through implementation of CS-16 and the DAP. Hearth/PD materials adapted for Bolivia, are not yet available, but will be developed through CS-16 and the DAP, based on the SC Field Guide, materials from SC/Vietnam, and the draft CORE cookbook. The Hearth/PD materials will be complemented by nutrition materials produced in Bolivia by the LINKAGES Project in cooperation with the MOH and PROCOSI members. Training curricula, supervisory checklists, and job descriptions of MOH staff, CS-16 staff, and Promoters in CS-16 are being developed by the project. Tools to be used to promote quality of service currently being designed with all CS-16 partners include: checklists to be used on a quarterly basis to assess performance of Promoters, MOH staff, and CS-16 staff, based on CB-IMCI guidelines, the draft PD cookbook, training messages and curricula. THESE HAVE NOT BEEN DEVELOPED

Aspects of the M&E System which May Be Sustained by the Community: SC hopes that joint implementation of SECI through CS-16 will allow the three Rural Health Districts, APROSAR, Promoters, municipalities, and communities to reach sound decisions about which of the program's approaches and activities they wish to and can sustain following the end of the project. SECI data collection through home visits by promoters may not be very sustainable. During the last year, the frequency of home visits has been reduced from once a month to once every two months. Other possibilities for more time efficient methods of SECI community data collection include collection of information at market days or through women's and other groups, or more Promoters could be used to reduce the data collection burden on each Promoter.

Attachment B

Team members and their titles

Name	Position	Institution
Albina Chacolla	District Coordinator Eucaliptus	SAVE
Nelson Tola	Health Trainer Totora	APROSAR
Carmelo Churo	Promoter Sacari	
Felix Condori	Statistician Challapata	MOH
Carola Cossio	Health Trainer Challapata	SAVE
Jaime Leon	Health Trainer Huayllamarca	SAVE
Juan Laime	Health Trainer Qaqachaca	SAVE
Marcelino Brañez	District Coordinator I Huanuni	SAVE
Delia Flores	Trainer Health Poopo	APROSAR
Raul Salinas	Director Hospital Caracollo	MOH
Silverio Padilla	Trainer Health Pampa Aullagas	SAVE
Edgar Callahuara	Promoter	
Jorge Viricochea	District Director Challapata	MOH
Julia Lipiri	Nurse Pampa Aullagas	MOH
German Viscarra	Health Trainer Caracollo	SAVE
Ruth Perez	District Coordinator Challapata	SAVE
Alfredo Juaniquina	District Coordinator Huanuni	APROSAR
Carolina Reynaga	Health Trainer Eucaliptus	SAVE
Zenon Caceres	Promoter Eucaliptos	
Jaime Salinas	Statistician Eucaliptos	MOH
Alberto Tenorio	IMCI	BASIC
Romelia Antonio	Trainer Health Challapata	SAVE
Renee Charleston	Team Leader	Consultant
Gonzalo Arevalo	CS Coordinator	SAVE
Ccoya Sejas	National Health Coordinator	SAVE

Other participants in Planning and Analysis Workshops

Jovana Centeno	Health Trainer Pazña	APROSAR
Reyna Arteaga	Health Trainer Huanuni	APROSAR
Caroline Hilari	National Health Advisor	SAVE
Dr. Lesmes Muñoz	Departmental Planner	MOH
Teresa Peleaz	Departmental CB- IMCI	MOH
Iber Tapia	MIS/SECI Specialist	SAVE
Wilge Arandia	Health Sector Coordinator	APROSAR
Anastasio Choque	Director	APROSAR

Attachment C

Assessment methodology

PARTICIPATORY EVALUATION PROCESS

I. OBJECTIVES OF THE EVALUATION

The purpose of the Midterm Evaluation was to;

1. Assess progress in implementing the DIP;
2. Assess progress towards achievement of objectives or yearly benchmarks;
3. Assess if interventions are sufficient to reach desired outcomes,
4. Identify barriers to achievement of objectives, and
5. Provide recommended actions to guide the program staff through the last half of the program.

The evaluation was carried out in accordance with USAID/BHR/PVC MTE guidelines and the evaluation report follows the suggested format.

The objectives of the evaluation are:

- Identify the principal achievements of the project, focusing on which strategies were most effective and the barriers which were overcome during the implementation.
- Develop recommendations for improving project strategies in order to achieve greater impact during the next two years.
- Develop recommendations on how to improve sustainability.

II. COMPOSITION OF EVALUATION TEAM

The team was composed of SC Project staff and SC Bolivia staff, MOH staff, APROSAR staff, Community Health Promoters, and a representative from BASICS, plus an external consultant who served as team leader. The team leader was responsible for coordinating all evaluation activities, supervision of the team, meeting all specified objectives, collaborating with SC, APROSAR and MOH, and submitting a draft and a final report according to the defined timeline. Three SC Project staff functioned as the coordinators of the teams for field data collection, including overall coordination, planning and logistical support of the team.

III. METHODOLOGY

Using both a participatory approach and participatory methodologies, a multi-disciplinary term of key project stakeholders examined the implementation of CS activities using a variety of qualitative methodologies. Field visits allowed project participants and community volunteers to provide their inputs and suggestions to the evaluation process. The evaluation focused on the process of activities including; capacity building, planning, information system, community participation, coordination with MOH and APROSAR, and sustainability. The methodologies to obtain information for the evaluation included:

Document Review
Key Informant Interviews
Group Interviews

Observations

IV. EVALUATION PLAN
The evaluation was divided into four phases:
Phase I Planning

- Preplanning (Formation of team, logistics, document review, selection of communities)
- Planning Workshop (Content, methodologies, design of instruments)

Phase II Data Collection

- Field Work visits
- Other interviews
- Document review

Phase III Data Analysis

- Summarize data
- Analysis of data by the evaluation team (2 day Analysis Workshop)

Phase IV Presentation

- Written report
- Formal presentation to be scheduled after report is finalized

A two-day Planning Workshop was held for all team members plus additional collaborators, to define the objectives of the evaluation, the content of the evaluation and to develop instruments for obtaining information during field visits.

The evaluation team was divided into 3 small groups to collect information from the field. Each team consisted of 7-8 people. The teams were in the field for 3 days to visit 12 communities previously selected by SAVE staff for visits. Visits were also made to Municipalities, Area MOH hospitals, and a training session for CHWs. A fourth team made up of the team leader, CS Coordinator and National Health Advisor traveled with each of the three teams on a rotating basis as indicated in the following table.

7 of SEPT. SATURDAY		8 of SEPT. SUNDAY	9 of SEPT. MONDAY
District	Huanuni	Eucaliptus	Challapata
GROUP 1			
Albina* Nelson Carmelo Felix Carola Jaime L. Juan	Totoral Antequera **(IMCI)** **Hospital**	Eucaliptus **(IMCI)** Quemalla **(H/PD)** Hospital	Qacachaca **(SECI)** △ **Municipality** **Hospital**
GROUP 2			

Marcelino* Delia Raul Silverio Edgar Jorge Julia German	Casa Lopez **(H/PD)** △ COMUSA	Huayllamarca Chillcani **(SECI)** **Municipality**	Sacari Challapata **(IMCI)** Hospital **Municipality**
GROUP 3			
Ruth * Alfredo Carolina Zenon Jaime S Alberto Romelia	Callipampa (**SECI)** **Municipality**	Caracollo **(IMCI)** △ Hospital	Totorani **(H/PD)**

* Team Coordinator

△ Observers: Renee, Ccoya, Gonzalo visited: Group 2 Saturday
Group 3 Sunday
Group 1 Monday

Each team visited at least one community or peri-urban area with an activity in each of the 3 interventions.

Completed Activities-

Interviews with:

- 6 MOH Area Doctors
- 8 MOH Auxiliary Nurses
- 19 Health Promoters
- 6 H/PD Leaders
- 11 Meeting with Municipal Authorities (including a meeting with COMUSA, a municipal health committee)
- 8 Meetings with 18 community leaders
- 9 Community meetings, including 34 men and 130 women

Observations of:

- 5 H/PD Sessions
- 14 IMCI Home Visits
- 3 SECI Sessions

A two-day Analysis Workshop was held for all team members, plus additional collaborators, to review the results of the field work and other information

collected during the evaluation, and to formulate recommendations for improving the quality of implementation during the second half of the project.

V. EVALUATION SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				August30 Preparation	31 Document Review	Sept 1 Travel
2 Evaluation Planning	3 Workshop for Evaluation Team	4 Workshop for Evaluation Team	5 Interviews Document Review	6 Preparation of evaluation tools	7 Community Visits	8 Community Visits
9 Community Visits	10 Interviews	11 Preparation of information	12 Evaluation Workshop	13 Evaluation Workshop	14 Wrap-up and de-briefing	15 Travel
16 Interviews	17 Write Report	18 Write Report	19 Write Report	20 Write Report	21 Submit draft report	22
23	24	25 Project returns comments	26Re-write Submit Final	27	28	29

TALLER DE PLANIFICACION
Evaluación de Medio Termino
Wawa Sana

3 de Septiembre

9:00-9:30	Bienvenida	Gonzalo
	Introducción de participantes	Romelia
9:30-10:30	Evaluación Participativa	Renee
10:30-11:00	Refrigerio	
11:00-1:00	Presentación del Proyecto –SAVE	Bolivia
1:00-2:00	Almuerzo	
2:00-2:30	Presentación del Proyecto-Distritos de Salud	
2:30-5:00	Trabajo de Grupos-Situación Ideal	
3:30-4:00	Refrigerio	

4 de Septiembre

8:30-10:00	Plenaria	
10:00-10:30	Contenido de la evaluación	Renee

10:30-11:00	Refrigerio	
11:00-1:00	Trabajo de Grupos:	
	Desarrollo de Instrumentos Para la Recolección de Información	
1:00-2:00	Almuerzo	
2:00-3:00	Como hacer entrevistas	Caroline,
		Carolina. Juan
3:00-4:30	Formación de equipos	Coordinadores
4:30-5:00	Próximos Pasos	Renee
5:00	Refrigerio	

TALLER DE ANALISIS

12 de Septiembre, Jueves

8:30-9:00	Experiencias en el campo	Gonzalo
9:00-9:30	Revisión de información colectada	
9:30-12:00	Trabajo de Grupos-	
	Análisis por Intervención - Situación Actual	
11:00-11:30	Refrigerio	
12:00-1:30	Trabajo de Grupos-	
	Análisis por Intervención- Recomendaciones	
1:30-2300	Almuerzo	
2:00-5:00	Plenaria	
5:00-5:30	Refrigerio	

13 de Septiembre, Viernes

8:00-10:30	Trabajo de Grupos- Temas Transversales	Ccoya
10:30-11:00	Refrigerio	
11:00-12:00	Plenaria- Temas Transversales	
12:00-12:30	Priorización de Acciones	
12:30-1:30	Almuerzo	
1:30-2:00	Recomendaciones Adicionales	Renee
	Cinco Estrellas	
2:00-2:30	Evaluación del Proceso	
	Clausura	Varios

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Manual de Procedimientos, AIEPI, Seguro Básico de Salud, MSPS, 12/00, Bolivia

Manual SECI Sistema Epidemiológico Comunitario Integral, Save the Children Bolivia, Centro de Programas de Comunicación de Johns Hopkins en Bolivia

Prevención y Rehabilitación Comunitaria de la Desnutrición Infantil Mediante el Enfoque de Desviación Positiva, Manual de Implementación, Save the Children, DJC, 10/02.

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Quality Management Guide: A Save the Children Management Toolbox, prepared for LAC Regional Meeting 4/02, El Salvador.

Qualitative Study on Health and Nutrition Practices Using Focus Groups: Districts of Eucaliptus, Huanuni, and Challapata.

Study on Knowledge, Practices, and Coverage (KPC) in the Districts of Eucaliptus, Huanuni, and Challapata.

Wagonhurst, P. El Sistems Epidemiologico Comunitario Integral (SECI) Process Monitoring and Formative Evaluation. 1/00, La Paz, Bolivia.

Willis, C, D. Schroeder, L. Howard-Grabman, D. Marsh, The Integrated Epidemiological System (SECI): Local Participation in Community Health Assessment and Planning in Rural Bolivia. Summary of Preliminary Findings 11/99.

Evaluation of the Process

Thirty-four team members and resource persons completed an evaluation of the MTE process, during the Analysis Workshop. The results from the questionnaires were:

- 17/34 (50%) of participants felt that the process used was very effective, and 17/34 (50)% that it was effective.
- 38% of the respondents felt that the participation of municipal and local authorities was lacking from the process, making this the principal recommendation for improving evaluations in the future.
- What people liked most about the evaluation (59%) was the team participation of SC, APROSAR, MOH, BASICS and Promoters. While there was a strong positive feeling that the MOH participation improved the MTE, some thought this should have been strengthened even more. Other positive aspects were the visits to the communities, the participatory methodology used and developing their own recommendations.
- Four people said what they liked least was that field visits were made on the weekend when health personal and authorities were unavailable, in some cases.
- 21/34 (62%) felt the content of the evaluation was very adequate for developing strategies for guiding the project in the future, 13/34 (38%) said the content was adequate.
- The main suggestion for improving the process in the future was to have more prior information on the development of the evaluation team and the selection of communities, as changes had to be made during the planning process.

ATTACHMENT D
Persons Interviewed And Contacted

SAVE THE CHILDREN
Gonzalo Arevalo, CS Coordinator
Iber Tapia, MIS/SECI Specialist
Ccoya Sejas, National Health Coordinator
Caroline Hilari, National Health Advisor
Beatriz Gorritti, Human Resources Director
Daisy Beltran, Accounting
Hugo Paniagua, Accounting
Agusto Costas, Oruro Regional Manager
Ruth Perez, District Coordinator
Marcelino Brañez, District Coordinator
Albina Chacolla, District Coordinator
Carolina Reynaga, Health Trainer
Romelia Antonio, Health Trainer
Silverio Padilla, Health Trainer
German Viscarra, Health Trainer
Carola Cossio, Health Trainer
Jaime Leon, Health Trainer
Juan Laime, Health Trainer

APROSAR
Delia Flores, Health Trainer
Jovana Centeno, Health Trainer
Reyna Arteaga, Health Trainer
Wilge Arandia, Health Sector Coordinator
Anastasio Choque, Director
Marcos Herbas, Technical Manager
Alfredo Juaniquina, District Coordinator

MOH
Dr. Lesmes Muñoz, Departmental Planner
Dr. Roberto Núñez, Departmental IMCI in Oruro
Dr. Jorge Viricochea, District Director
Teresa Peleaz, Departmental CB-IMCI

Other Interviews
Alberto Tenorio, BASICS
Dilberth Cordero, BASICS
Walter Agreda, PROCOSI
Jose Ignacio Carreño, PROCOSI
Jorge Velasco, USAID
Julia Costas, Director CETHA

ATTACHMENT E

Results of the Evaluation

EVALUACION MEDIO TERMINO
PROYECTO WAWA SANA
SAVE/DJC/APROSAR/MSPS

19 PROMOTOR

1. **Cuánto tiempo estas como Promotor?**

   5 = < 1 año 7 = 1 – 5 años 7 = > 5 años

2. **Conoces cuales son los objetivos del proyecto WAWA SANA?**

   Evitar la mortalidad infantil.

   Desminuir la desnutrición de las Wawas.

   Mejorar la salud de las Wawas. desde Recién Nacido hasta los 5 años.

   Orientación capacitación en SECI – AIEPI Y EDP.

3. **Has recibido capacitación en este último año? 19 SI En que?**

   19 AIEPI Comunitario 17 SECI 5 EDP

   Otros : Lactancia Materna , SBS, Salud Reproductiva .

4. **Que sugerencias tienes para mejorar las capacitaciones?**

   Apoyo constante y reforzamiento.

   Apoyo continuo de DJC – APROSAR.

   Capacitación en manejo de medicamento.

   Folletos de capacitación para uso en grupo.

   Apoyo con trasporte.

5. **Crees que necesitas mas capacitación?** *10 Si* **En que?**

   6 en AIEPI 8 en SECI 7 EDP Otros : 2

   OTROS: capacitación continúo en los programas de salud.

   Capacitación en tejidos y telares,

   Capacitación SBS , Nutrición.

   Capacitación en como organizar a las comunidades.

6. **Cada cuanto te vista el personal del centro de salud y que actividades realizan con ellos?**

   Mensualmente 12 , 2 veces al mes, no visita 3.

   Visita al centro de madres para realizar control de peso y vacunas.

   Controles prenatales y charlas educativas en los programas de salud.

7. **Sabes cuantas familias hay con niños menores de 5 años en tu comunidad?**

   < 5 familias respondieron 4. de 5 – 10 familias 3 10 – 20 familias 7
   20 – 50 familias 2 >50 familias 3

Cuando visitas a las familias con niños menores a 5 años?

Cada mes 9 Cada semana 4 En reuniones 3

8. **Que haces en tus visitas domiciliarias?**

Buscamos signos de peligro.

Hace educación a la comunidad.

Identifican niños con problemas de salud y comunica por radio .

Control de peso y recolecta información para SECI.

9. **Que opinan las familias en tu comunidad sobre tus visitas domiciliarías?**

Le tienen confianza, piden apoyo del promotor y quieren más visitas continuas para saber más sobre salud.

Quieren atención gratuita.

Les gusta las capacitaciones y charlas que se realizan en la comunidad.

10. **Cómo reconoces a un niño desnutrido?**

Realizando el control de crecimiento y desarrollo, utilizando la hoja de AIEPI, nos damos cuenta que está con: Bajo peso, cabello amarillo, flaco, estomago crecido, pantalón caído, pies hinchados, palidez palmar, deja de comer, esta desganado, anemia, piel sin grasa y deja de comer.

11. **Cómo te das cuenta cuando un niño está con diarrea grave? Que haces en este caso?**

Diarrea con sangre, ojos hundidos, signo del pliegue, tiene mucha sed, no quiere comer ni lactar, pálido, llora mucho, niño deshidratado, ojos asustados, vomita, no juega y se utiliza la hoja de referencia.

12. **Cómo te das cuenta cuando un niño está con tos grave? Que haces en este caso?**

Respiración rápida, estridor o ruidos raros, tiraje, tos másde21 días, fiebre, ojos boca morada, no lacta, agitación, le duele la garganta, tos fuerte y seguido.

13. **Estás realizando seguimiento a los niños enfermos? Como lo haces?**

Si

Mediante las visita domiciliaria

Para capacitar

Mediante el registro

Para realizar seguimiento

14. **Has recibido visitas de supervisión?** *Si* **De quien?**

Con que propósito?

DJC APROSAR Centro de Salud Autoridad

No reciben

15. **Recibes apoyo de tus autoridades?** *Si* **Que tipo de apoyo recibes?**

Apoyo moral

Reúne a la comunidad

Apoyo de padres de familia

Apoyo en capacitación

16. **En algunas comunidades, después de algún tiempo los**

Promotores dejan de trabajar, cómo se puede evitar el abandono de Promotores?

Mas capacitaciones por otras instituciones

Buscar apoyo económico de otras instituciones

Elegir un promotor responsable

Que viva permanente en la comunidad

SECI

1. **Conoces el SECI?** *Si*

   Si la mayoría

2. **De que forma te ayuda el SECI en tu trabajo y a tu comunidad?**

   Identifica necesidades de por ejemplo en vacunas

   Niños con algunas enfermedades

   Embarazadas

   Conocer el numero de niños desnutridos

   Priorizar algunas enfermedades

   Valorar el trabajo del promotor

   Analizar

   Reúne a la comunidad

3. **Que decisiones ha tomado la comunidad con la información del SECI**.

   Llevar al centro de salud a los niños desnutridos

   Reflexión sobre la salud de la comunidad

   Mejorar la desnutrición de la mala alimentación

   Controles prenatales en las mujeres embarazadas

   Capacitar en temas de priorizadas en la comunidad

   Buscar en otros ONGs que trabajan con apoyo y equipamiento

   Participan las autoridades

4. **Que logros ha conseguido tu comunidad con el SECI?**

   Asistir a los controles prenatales

   Capacitación y concientizacion sobre diferentes temas de salud

   Alimentación de las wawas

   Coberturas de vacunas

   Participan las autoridades en SECI

   Sabré de las enfermedades de los niños

5. **Te dan espacio en las reuniones de la comunidad para poder hablar y discutir de salud con tu comunidad?**

   12 si 8 no

   Raras veces me dan tiempo

6. **Con que materiales cuentas para trabajar con el SECI? Crees que es suficiente?**
   Registros de SECI y libro de actas
   Bandera de salud y munecos
   Manual de SECI y rotafolio
7. **Te es difícil el llenado de los formularios?** *Si 7* *No 18* **Porque?**
   Consolidado no es claro
   No tiene suficiente material

EDP

1. **En tu comunidad se está realizando el EDP?**
   No 12 Si 6
2. **En que consiste el EDP?**
   Preparar alimentos para niños desnutridos
   Usar alimentos locales para mejorar los niños desnutridos
   Dar cariño y afecto
   Control de peso y talla
   Capacitación en grupos de mujeres
3. **Que tareas cumples en el EDP?**
   Ninguno 11
   Distribución de grupos y enseñando los valores nutritivos de cada producto
   Apoyar en la participación de las madres
4. **Quiénes participan en los talleres hogareños? Que hacen?**
   Las mujeres algunos hombres
   Cocinamos para nuestras wawas
   Participan las mamas y niños menores de 5 años
   Personal de salud
5. **Recuerdas sobre el caso de algún niño desnutrido? Que hiciste?**
   12 niños pero mejoraron con los talleres hogareños
   Algunos no recuerdan

8 Entrevistas con 18 Autoridades Comunitarios

1. **Ud. conocen que actividades realiza el proyecto WAWA SANA?**

Capacitación a las mamas sobre salud.
Capacitación a los promotores.
Organización de talleres de salud y evaluación.

2. **Que beneficios ha recibido la comunidad a través del proyecto WAWA SANA?**

Orientación a la comunidad para mejorar la salud.

Apoyo de movilidad al personal de salud, mensual.

Capacitación al personal de salud, para mejorar niños desnutridos.

Apoyo con menaje de cocina.

3. **Tienen promotores capacitados en la comunidad?**

Si 8 promotores.

4. **Que actividades realiza el promotor de salud en su comunidad?**

Realiza visitas domiciliaras.

Realiza capacitación en salud.

Coordina con autoridades y personal de salud.

5. **Es importante el trabajo del promotor de salud en su comunidad?** *Si*

Realiza reuniones en la comunidad.

Apoya al personal de salud.

Da charlas de orientación en salud.

Atiende a niños enfermos.

Otros: Que maneje medicamentos de SBS.

6. **¿Como pueden apoyar Uds. al Promotor?**

Dar apoyo mancomunada en agricultura (faina, cosecha).

Apoyo con transporte para que asista al taller.

Coordinar entre la autoridad y el promotor.

7. **Viene el personal de salud a la comunidad?**

7 SI 1 NO.

8. **Cómo Coordinan los promotores con el personal de salud?**

Consolidando la información en salud.

Coordinan entre el Promotor y personal de salud para visitas a comunidad.

Otros :Mencionan que no hay buena coordinación con el centro de salud..

9. **Cree usted que el hablar de salud en las reuniones es importante?**

7 SI 1 NO **Porque?**

Hay muchas necesidades, para dar solución a los problemas de enfermedades.

Conocer sobre Seguro Básico de Salud.

Para que las wawa estén sanos y fuertes.

10. **Que hace Ud. como autoridad para mejorar la salud de las wawas de su comunidad?**

Apoyar a reunir hombres y mujeres para que se capaciten.

Pedir mas capacitación al servicio de salud.

Reunirse con el centro de salud para campañas de vacunación.

11. **Cuando termine el proyecto de WAWA SANA, como pueden Uds. continuar con las actividades que hace el proyecto WAWA SANA?**

Continuar reuniéndonos a la cabeza del promotor.

Continuaremos con las actividades juntamente con el hospital

Continuaremos con las reuniones cocinando con las mamas

Buscar financiamiento

SECI

1. **Conoce el SECI?**

Si 2 *No 6*

2. **Conoce la bandera de salud? Cómo es la bandera?**

Si 4 *No 4*

Tiene 3 colores rojo amarillo verde

3. **Para que les sirve esta bandera?**

Nos sirve para saber analizar si nuestra wawa esta bien o mal

Sirve para demostrar sobre la gravedad de salud en la comunidad

Algunos no saben sobre la bandera de salud

4. **Participa en las reuniones de su comunidad? Con que frecuencia? Para qué sirven estas reuniones?**

Si 8 No 0

Cada mes se reúnen para hablar de salud

Sirve para dar solución a los problemas de salud

Sirve para orientar y educar en salud a la comunidad

5. **Sabe que es un TAI? Participa en los TAI o CAI?**

Si 6 *No 2*

Alguna vez participamos en los TAI de área, mas participan los promotores

EDP

1. **Han escuchado hablar del EDP? Saben para que sirve el EDP?**

No 6 *Si 1* *1 no respondió*

Conocen EDP como Taller hogareño
Sirve para ayudar a los niños desnutridos donde las mamas alimentan a sus niños y mejoren de peso

2. **Que actividades se realizan para mejorar la nutrición de los niños(as)?**

Alimentan a los niños

Cocinan con las mamas

No sabe

Traen alimentos

Mejoran los platos

Capacitan y charlan

3. **Las señoras de su comunidad participan en los Talleres hogares para mejorar la alimentación?**

Participan la mayoría

No saben

Todas las mamas con wawitas

Las inscritas mamas

4. Cree Ud. que las practicas grupales de cocina mejoría la nutrición de las wawas?

Si 6

Es importante la higiene de niños y preparación de alimentos

No sabe 2

Mejora la nutrición cuando están juntas comen y acostumbran a comer

Preparan alimentos sólidos y combinan sus costumbres

Es bueno practicar

Las señoras preparan alimentos en grupos pequeños y queremos mas grupos

8 AUXILIAR DE SALUD

1. **Hace cuánto tiempo trabaja en este Centro/Puesto de Salud?**

3 = < 1 año 2 = 2 – 3 años 1 = > 10 años.

2. Sabe cuáles son los objetivos del Proyecto WAWA SANA?

Desminuir la desnutrición.

Mejorar la salud integral del niño.

3. En su opinión, cuales han sido los logros mas importantes del Programa WAWA SANA hasta ahora?

Comunidades concientizadas.

Capacitación, seguimiento en EDP y visitas domiciliaras.

Implementación de SECI de manda de servicio.

4. Cuál ha sido el efecto de las actividades del proyecto en su trabajo?

Seguridad de reunión en las comunidades.

Facilita la recolección de información.

Otras: en reunir a las mamas para las charlas educativas.

5. Ha recibido capacitación en este último año? 5 si - 1 no En que?

3 AIEPI-Clinico 3 AIEPI-Comunitario 1 IEC

4 SECI 3 EDP 3 Otro *Lactancia Materna y Crecimiento y desarrollo*

6. Que sugerencias tiene para mejorar las capacitaciones?

Capacitar a todo el personal de salud.

No cambiar cronograma del taller

7. Esta aplicando el AIEPI clínico? *4 si* **El AIEPI comunitario?** *No*

De que manera esta aplicándolos?

Utilizando los formularios para buen control de niño.

Otros : a medias por falta de tiempo.

8. **En su opinión, el trabajo en WAWA SANA ha podido cambiar practicas de salud en las comunidades? Puede dar algún ejemplo?**

Mas participación al servicio de salud.

Las señoras conocen los signos.

Otros : Mas interés de las mamas en las capacitaciones

9. **Tiene en el centro de salud los formularios del AIEPI?**

De que manera afecta en su trabajo el uso de estos formularios?

No tiene.

Se tarda, cuando hay mucho usuario no se puede

10. **Ha recibido vistas de supervisión post capacitación? Nos puede comentar como fueron? Que sugerencias tiene para mejorar estas supervisiones?**

No .

Otros: manejo de SBS, de cardex,

11. **Que ventajas y desventajas identifican al AIEPI?**

Nos permite evaluar en su integridad al niño.

Desventaja :

Seguro Básico no cubre todo.

No se cuenta con suficiente medicamento.

12. **Cuantos promotores tiene en su sector?** *4 sabe 2 no*
13. **Cuantos están capacitados en AIEPI?** *3 sabe 3 no*
14. **Cuantos están capacitados en SECI?** *4 sabe 2 no*
15. **Cuantos están capacitados en EDP?** *1 sabe 5 no*
16. **Participa en las capacitaciones del promotor?** *Si*
17. **De que manera apoyo a los promotores?**

Consulta gratuita.

Atendiendo pacientes referidos.

Dotando paracetamol.

Orientando sobre programas de salud.

18. **Que opinión tiene sobre el trabajo de los promotores de su sector?**

Colaboran bastante.

Nos refiere pacientes

Reúne a la comunidad y a las autoridades.

19. **Sabe si los promotores de su sector realizan visitas domiciliarias? Cuándo las realizan?**

Si en las mañanas, algunos días de la semana.

Mensualmente se consolida la información.

20. Conoce los materiales que usa el promotor en el AIEPI-Comunitario? Cuales son? Cuales aplica?

Hojas de registro.

Hojas de referencia.

Rotafolio.

Cuaderno de registro

Otros : solo 1 no sabia.

21. Que actividades relacionadas con el AIEPI realizan con los promotores?

Visitas domiciliaras.

Como evaluar a los niños

22. Realiza seguimiento del trabajo del promotor en su sector? Que instrumento usa?

No se tiene un instrumento.

Acompañamiento en visitas mensuales.

23. El promotor esta refiriendo niños con problemas de salud a Ud.? Si

Está usando boletas de referencia y contra referencia?

Con boletas , Algunos sin boletas de referencias
Otros: Lo que no funciona es contra referencia

24. Como esta funcionando el sistema de referencia?

No, la contra referencia

Los promotores usan cuaderno de registro

25. Cuenta con algún plan de IEC para capacitar en la comunidad?

No tiene

26. **¿Cuando el proyecto WAWA SANA termine, va a poder seguir con todas las actividades?**

Si **Como ?**

Se dará seguimiento.

Juntamente con Autoridades Municipales.

*Autoridades comunales y Promotores***.**

27. Tiene sugerencias de como puede mejorar el trabajo del proyecto WAWA SANA?

Implementación de medicamentos, la gente no cuenta con recursos.

Apoyo material didáctico

SECI

1. Que opinión tiene de la bandera de salud?

Se capta mejor la realidad de la comunidad.

Es un instrumento que podemos usar con facilidad.

2. Cómo consolidan la información con el promotor?

Haciendo una comparación con el personal de salud y promotor.

Con que frecuencia?

Mensualmente en el centro de salud

3. **Cómo utiliza la información del SECI en su área?**

Para devolver la información a la comunidad.

Sirve para el SNIS.

Buscamos soluciones.

4. **Participa usted en las planificaciones conjuntas?**

Todas participan.

EDP

1. **Sabe que quiere decir EDP o de que se trata?**

2 Si 4 No.

2. **Que opinión tiene de esta estrategia?**

Es bueno para mejorar la alimentación del niño.

3 No respondieron

3. **Ha participado en capacitaciones de EDP? Como?**

1 Si

Apoyando al facilitador durante el taller.

5 No participo

4. **Ha participado en un taller hogareño?** *Si*

De que manera?

Pesando los alimentos.

Reuniendo a las señoras para charla educativos.

8 COMUNIDADES

NUMERO DE MUJERES: *130* **NUMERO DE HOMBRES**: *34*

1. **Cuantos niños menores de 5 años existen en su comunidad?**
   159 niños menores de 5 años
2. **Hay promotor en su comunidad?**
   Si
3. **Han recibido visitas del promotor?**
   Si
4. **Con que frecuencia les visita el promotor?**
   7 cada mes
   2 alguna vez al mes.
   Otros 2 veces al mes
5. **Que atenciones recibieron del promotor? Nos puede contar?**
   Nos da charla sobre temas de salud:
   - *Alimentación*
   - *Diarrea*
   - *Higiene Personal y aseo*
   - *Planificación familiar*
   - *Lactancia materna*
   - *Como cuidar a los niños*
   - *Cuando acudir al centro de salud*
6. **Que capacitación han recibido del promotor del salud y que recomendación les ha dado?**

- *Lactancia materna*
- *Cuidado del niño*
- *Alimentación complementaria*
- *Higiene*
- *Vacunas*

7. **Cuales de estas recomendaciones han podido poner en practica en su casa?**

   Lactancia materna inmediata

   Grupos de alimentos

   Como preparar alimentos

   Higiene

   Planificación familiar.

8. **Como pueden ayudar al promotor para que mejore su trabajo**?

   Obedeciendo

   Asistiendo a las reuniones

   Que reciba mas capacitaciones

   Que cuente con medicamentos del seguro básico de salud

   Buscar apoyo de otras instituciones para apoyo al promotor

   Trabajar un día en su chacra

9. **Viene el personal de salud a la comunidad?**

   Si cada mes.

10. **Que beneficios les ha traido la visitas a la comunidad del personal de djc, aprosar y del centro de salud?**

- *Capacitaciones sobre como criar a nuestras wawas*
- *Alimentar y grupos de alimentos*
- *Embarazo*
- *Como mejorar la salud de los niños*

11. **Que hacen cuando su wawa esta enferma? Porque?**

    Llevamos al promotor

    Curamos con medicamentos caseros

    Llevamos al centro de salud

    Cuando esta grave

12. **Como se dan cuenta cuando un niño esta con diarrea grave?. Que hacen en este caso?**

    ojos undidos

    signo de pliegue

    Llora mucho

    Tiene sed

    No lacta

Hace caca como agua

Le damos sales de rehidratación oral

Llevamos al centro de salud

13. Como se dan cuenta cuando un niño esta con tos grave. Que hacen en este caso?

Tiene temperatura

Respiración rápida

Ruidos raros

Tiraje intercostal

Dan mates caseros

Otros llevan al centro de salud

14. Cuanto tardan en llegar al centro de salud o puesto de salud?

1 hora, 2 horas, 5 horas

15. **El centro de salud que medicamentos les da en forma gratuita?**

Aceite vitaminado, ferrosol, paracetamol, sales de rehidratación oral, vitamina A medicamento para la diarrea

16. **Conoce el carnet de salud infantil?** *Si.*

Algunos no tienen

Han hecho perder

17. **Recibe orientación en los servicios de salud sobre la manera de alimentar y cuidar a sus wawas?** *Si*

Si de DJC

Vacunas CSI

Alimentación

Lactancia materna

18. Como reconocen a un niño desnutrido?

Flaco	*Desganado*
No come	*Hinchado*
Bajo peso	*no es sano*
Esta amarillo	*mediante el color de la lana*
Pálido	*Comparando*

19. Han escuchado mensajes por radio o televisión sobre salud de los niños. De que temas? *Si*

Radio PIO XII

Lactancia materna

Alimentación

Planificación familiar

Como cuidar a los niños

Radio Bahai

Alimentación complementaria, Lactancia exclusiva

20. **Cuando ya no venga los de djc y aprosar como van a poder seguir con las actividades de salud?**

Reuniendonos con el promotor

Continuar con lo que se ha aprendido

Pidiendo ayuda al centro de salud

SECI:

1. **Conoce el seci**

Si conocen.

Otros no conocen el significado

2. **Participa de las reuniones SECI de su comunidad? Con que frecuencia y porque?**

Participamos de las reuniones del SECI una vez al mes. Porque queremos aprender.

Participamos de las reuniones del SECI cada dos meses

3. **Conoce la bandera de salud?**

Si. 7

Otros no 1

4. **Para que sirve la bandera?**

Para saber sobre las vacunas

Enfermedades

Embarazadas

Control prenatal

5. **Que significan los colores de la bandera?**

Rojo: Malo, esta enfermo y puede morir.

Amarillo: regular

Verde: buena salud

Algunos no conocen.

EDP:

1. **Han escuchado hablar del EDP?**

Si 2 No 4

Otros no saben la sigla pero conocen las actividades

2. **Saben para que sirve el EDP?**

Para mejorar la alimentación de las wawas

Aprendemos a cocinar otras cosas

Para que los niños no estén desnutridos

Cocinamos para nuestras wawas

3. **Participa de grupos en los que se realiza practicas alimentarías para mejorar la nutrición de sus wawas? Que piensa de estos grupos?**

En grupos

Aprendemos sobre los grupos de alimentos

Mejorar la alimentación

Todos participamos

4. **Que actividades hacen para realizar la nutrición de los niños?**

    Cocinamos con los alimentos de nuestra comunidad

    Hacer comer de rato en rato

    Combinamos verduras

8 Auxiliares de Enfermería

Item	Si	No	Comentarios
Manual de AIEPI	7	1	
Rotafolio AIEPI	8		
Hojas de registro	5	3	
Formularios clínicos	4	4	
Balanza	7	1	
Tallimetro	5	2	
Boletas de referencia	4	4	
Paracetamol	8		
Cotrimoxazol	8		
Sulfato ferrosos tabletas	8		
Vitamina A	7	1	
Aceite vitaminado	7	1	
Mebendazol	7	1	
Penicilina Procaina	8		
Sales de rehidratación	8		
Ferrosol	8		
Vacunas	8		
Carnet de salud infantile	8		Algunos solo tienen pocos
Equipo de URO Institucional	5	3	
Termos de vacunas	8		
Insumos PAI (Jeringas, agujas, etc.)	8		
Bandera y muñecos	4	4	
Croquis	8		
Censo	5	3	
Moto u otro vehículo	7	1	
SECI			
Formulario consolidado	4	4	
Manual de SECI	5	3	
Software de SECI instalado	0	8	Solo en el Distrito
Guías de SECI	5	3	
EDP			
Tablas peso y talla	3	3	No todos manejan el EDP
Protocolo o fotocopias manual	0	6	
Formularios de seguimiento	2	4	
Folletos volantes	1	5	
Material educativo	1	5	

6 Médicos de Area

Item	Si	No	Comentarios
Manual de AIEPI	3	3	
Rotafolio AIEPI	2	4	
Hojas de registro	4	2	
Formularios clínicos	4	2	
Balanza	4	2	
Tallimetro	4	2	Solo cinta métrica
Boletas de referencia	5	1	
Paracetamol	6		
Cotrimoxazol	6		
Sulfato ferrosos tabletas	6		
Vitamina A	6		
Aceite vitaminado	5	1	

Mebendazol	6		
Penicilina Procaina	6		
Sales de rehidratación	6		
Ferrosol	6		
Vacunas	6		
Carnet de salud infantil	6		
Equipo de URO Institucional	3	3	
Termos de vacunas	6		
Insumos PAI (Jeringas, agujas, etc.)	6		
Bandera y muñecos	3	3	
Croquis	6		
Censo	4	2	
Moto u otro vehículo	6		
SECI			
Formulario consolidado		5	Solo 5 respondieron
Manual de SECI		5	
Software de SECI instalado	2	3	
Guías de SECI		5	
EDP			
Tablas peso y talla	1	4	
Protocolo o fotocopias manual	1	4	
Formularios de seguimiento		5	
Folletos volantes	1	4	
Material educativo		5	

18 PROMOTORES

Item	Si	No	Comentarios
Hoja de registro AIEPI (2)	17	1	
Rotafolio de AIEPI	17	1	
Manual de procedimientos	16	2	
Cuaderno de seguimiento	14	4	
Balanza	5	11	Algunos prestan del pers. de salud
Tallimetro	2	14	Solo Tienen cinta métrica
Boleta de referencia	11	7	
Croquis	15	3	
Censo	12	5	
SRO	1	15	
Vitamina A	2	14	
Paracetamol	5	12	Algunos compran de APROSAR
Cotrimoxizol	4	12	Algunos compran de APROSAR
Sulfato ferroso	3	14	
SECI			
Manual de SECI	15	2	Un Promotor no trabaja con SECI
Formulario de consolidación	12	5	
Formulario del Promotor	16	1	
Bandera	7	10	
Muñecos	7	10	
EDP			
Laminas de alimentos	2	3	Solo 5 Promotores trabajan con EDP
Formularios de seguimiento	2	3	
Rotafolio	1	4	
Folletos y Volantes	2	3	

7 MÉDICOS DE ÁREA

1. **Hace cuánto tiempo trabaja en este Servicio de Salud?**

2 < 1 año *5 = 1 – 5 años*

2. **Conoce Ud. los objetivos del Proyecto WAWA SANA?**

2 tienen conocimiento sobre las tres estrategias

2 no conocen las estrategias.

Otros: mejoramiento del estado de salud, recuperar a todos los niños desnutridos, Capacitar a las madres en temas de salud reproductiva,

Reconocer casos de EDA - IRA

3. **Ha recibido capacitación en este último año ? 6 SI 1 No**

En que ?

3 - AIEPI-Clínico 3 - AIEPI-Comunitario 2 - IEC

5 - SECI 2 - EDP 1 - Otros Manejo de alimentos

.Como pueden mejorar las capacitaciones?

- *Capacitar al medico de planta.*
- *Aplicar y practicar con la comunidad*
- Mas capacitación al personal

4. **Utiliza los formularios de AIEPI? Como funcionan?**
   - *Aplica los formularios clínicos un 50 %*
   - *Un 50% no utiliza por que no cuenta con formularios.*
5. **Recibe seguimiento del programa de AIEPI?**

Como ve Ud. este seguimiento?

   - *3 médicos han recibido seguimiento.*
   - *4 médicos no recibieron.*

   Otros mencionan que el seguimiento es mal. Por cambio constante del personal.

6. **Se reúnen con los promotores de salud? En estas reuniones que hacen?**
   - 4 se reúnen y 3 no .
   - *En las reuniones se Coordina y realizan cronogramas*
   - *Planifican capacitación.*
   - *Socializan de los temas aprendidos.*

   Otros mencionan que no es su función delegan a las licencias y auxiliares.

7. **Sabe si los promotores de su sector realizan visitas domiciliarias? Cuándo las realizan?**
   - 3 Si 2 No 1 No sabe.
8. **De que manera apoya a los promotores?**
   - Apoya en valoración en AIEPI.

- *El personal de salud le da su lugar al promotor por son lideres.*
- *La información del promotor es incluida en el libro de consulta.*

9. Que opinión tiene sobre el trabajo de los promotores de su sector?

- El trabajo del promotor es bueno, por que facilita el contacto con la comunidad.
- Uno menciona que el trabajo es relativo con sus actividades .

Otros no conocen el trabajo de los promotores

10. El promotor esta refiriendo niños servicio de salud?

6 Si 1 No.

Otros: mencionan el trabajo del promotor es bueno y facilita el contacto con la comunidad.

11. Está usando boletas de referencia y contra referencia?

5 Si 2 No.

12. Esta funcionando el sistema de referencia?

7 Si

La contra referencia no se esta utizando

13. Cuando tiene niños con desnutrición, que acciones se ha tomado con estos niños?

2 en forma adecuada

4 en forma regula y 1 tiene dificultad.

14. **Cuenta con algún plan de IEC para capacitar en la comunidad**

_ Prestación de SBS con micro nutrientes

_ Dar orientación ,Educación y Capacitación a grupos de mujeres.

- Clasificación de alimentos.

15. Cuando termine el proyecto WAWA SANA de que forma continuaran las actividades que realizaba en el proyecto?

4 No 1 Si

Otros : Plan interinstitucional para las capacitaciones.

- Seguir con orientación a la comunidad.
- *Hay personal con capacidad para dar continuidad SECI, AIEPI.*
- *Buscar apoyo de otras ONGs y municipio.*

SECI

1. Conoce la estrategia SECI ?

5 Si 2 No

2. Utiliza la información del SECI en sus TAIs de área?

3 Si 4 No

3. Que utilidad le da la información del SECI?

Hace conocer la información para el área y Distrito, *Para ver el avance de las coberturas.*

4. Conoce la bandera de salud? Cuál es su opinión de la bandera de salud?

Todos conocen.

Otros: Es útil para diferenciar problemas y fácil de entender para la comunidad.

5. Sabe que son las planificaciones conjuntas? Participa usted en las planificaciones conjuntas?

6 Si 1 No

Otros: Reunión comunitaria para resolver problemas.

EDP

1. Sabe que quiere decir EDP o de que se trata?

5 Si 2 No

2. Que opinión tiene de esta estrategia?

Es bueno pero no hay un buen seguimiento.

Mejora la alimentación y conoce el valor nutritivo.

3. Ha participado en capacitaciones de EDP? De que manera?

4 Si 3 no

4. Sabe que es un taller hogareño? Ha participado en estos talleres?

4 Si 3 No

Otros : Donde la comunidad participa en preparación de alimentos.

5. Tiene sugerencias como puede mejorar el trabajo del proyecto WAWA SANA?

Que se realiza una buena socialización del proyecto.

Mayor seguimiento a promotores.

Capacitación al personal de salud.

Apoyo logístico.

11 ENTREVISTAS CON 17 AUTORIDADES MUNICIPALES

1. Que organizaciones de salud trabajan en su municipio?

DJC
APROSAR
HOSPITAL
OTROS: PAN - CRECER - ABRIR SALUD – CAEP – ONDI

2. Sabe con que programas y proyectos están trabajando?

Programas de capacitación y cursillos
Mejorando la nutrición y crecimiento de los niños
Dotación de medicamentos (ONDI)
Prestamos a las mujeres (CRECER)
Otros Control niño sano, diarreas, vacunas, prevención de la mujer y el niño, y dotación de material de escritorio y equipos

3. De que manera toman en cuenta actividades de salud en su POA?

Porcentajes previstos por ley
Según requerimientos seguro básico
Otros no conoce y HIPIG

4. De que manera incluyen al promotor y sus actividades en sus POAS?

No incluyen
A través de la mancomunidad
Otros con viáticos y alimentación

5. Se ha ejecutado el presupuesto de salud el año pasado?

Si en un 70 a 80 %
No conozco
No se

6. Tiene usted algún plan de cómo mejorar la salud de los niños en las comunidades?

Proyectando a las comunidades al personal de salud
Educando a las comunidades
No sabe como
Mayor apoyo con recursos económicos
Otros gestionar recursos humanos ante SEDES
Pedir mas puestos de salud a las autoridades
A través de la Mancomunidad Azanaque
Dando vitamina A

7. Cuando termine el proyecto Wawa Sana, como Uds. continuar con sus actividades en salud que esta apoyando el proyecto?

Buscar otras organizaciones que estén apoyando a los promotores
Incluir el tema de salud en el POA municipal
Coordinar mas estrechamente con el personal de salud de los hospitales
Que los promotores deben continuar con la coordinación interinstitucional

8. Tiene sugerencia de cómo puede mejorar el proyecto Wawa Sana?

Seguir capacitando a los promotores
IEC Información Educación y Comunicación
Incentivar la participación de la comunidad
Socializar los objetivos del proyecto
Interactuar con otros proyectos
Otros apoyo de las autoridades. No sabe
Visitas mas largas, continuas y oportunas

6 MADRES LÍDERES POSITIVAS

1. **Le gusta ser líder?**

5 Si

1 No porque las señoras no escuchan

2. El ser líder ha cambiado su vida? De que forma?

5 Si

1 No

He podido mejorar el hogar (aseo)

Otros: Era nerviosa, pero ahora ya no; Ahora toma mas conciencia

3. Ha recibido alguna capacitación?

6 SI

4. Que le han enseñado? Te sirve, lo estás practicando?

EDP, Aseo, Cocina, Nutrición

4 mencionaron que están poniendo en practica

Otros: es de beneficios de las compañeras, ayuda a mi familia

5. Que mas necesitarías aprender para poder trabajar mejor?

Mas sobre salud y nutrición; Cocina

Otro: Intercambio de experiencia con otras comunidades

6. Está de acuerdo con el tiempo que se usa en los talleres hogareños?

4 están de acuerdo

2 no están de acuerdo

Por los cosechas y siembra no es adecuada

Que seria una vez al mes
Otros: Hay que ver la posibilidad de las señoras

7. Vale la pena el tiempo que invierte con sus compañeras?

1 No porque no tiene quien ayudar

5 Si

Porque estamos aprendiendo mucho y estamos mejores

8. Mamas están conformes con lo que cocinan y las actividades del taller?

5 Si

1 No, no están de acuerdo cada día, solo una vez a la semana

9. Recibes apoyo de tus compañeras y comunidad? De que forma?

6 Si, reciben apoyo de las compañeras

Con la organización del grupo, Con la cocina

Otro: Se ponen de acuerdo con el aporte

10.Se siente apoyada por el capacitador o el auxiliar de enfermería?

Todas ha dicho que Si

De que manera?

Capacitándonos en salud; Con recetas mejoradas

11.Como se puede mejorar las actividades de EDP?

Visitas seguidas

Recetario

Reforzando los conocimientos

Otros: Carpa solar, visitas a las casas

Inventario de Materiales y Equipo

Ítem	Si	No	Comentarios
Menajes de cocina (Platos)	3	3	Casi todas falta algunas cosas, algunas prestan ollas
Espacio para cocinar	6		Algunas en aire libre
Combustible	5	1	Ellas traen leña, un grupo compra gas
Material desarrollo infantil	1	5	
Receta mejoradas y menú	6		Falta procedimiento o preparación
Lista de asistencia de niños participantes	4	1	

Observación de 3 Sesiones SECI

	SI	NO	Comentarios
Llenado correcto de			

Formulario del Promotor	3		
Llenado correcto de Formulario de consolidación del SECI	3		Consolidación bimensual Con ayuda del facilitador y personal de salud
Realiza el proceso de Planificación Conjunta correctamente	3		2-con participación Promotor, 2-sin participación del Promotor
Participación activa del grupo	2	1	Participación de hombres y mujeres
Usa materiales adecuados para la Planificación conjunta	3		Números, letras y muñecos son muy pequeños para diferenciar
Existe presencia de autoridades	3		Subcentral, Comité de Agua, Corregidor
Llegaron a una toma de decisiones a quienes involucra	3		Seria bueno hacer un plan de acción para cada concepto
Participación de personas claves en el proceso	3		

Número de participantes: __25____ Hombres ___64____ Mujeres

Observación de 5 Sesiones EDP

	SI	NO	Comentarios
CARPETA:			
Información básica con croquis	4	1	
Estudio EDP	5		
Lista de niños	5		
Peso/talla inicial	5		
Peso/talla Seguimiento	5		
Tasa de participación en el taller hogareño	4	1	Algunas mujeres ya no vinieron
Tasa de abandono en talleres hogareños	4	1	
Ordenamiento y claridad	4	1	
TALLER HOGAREÑO:			
Presencia de la líder	5		
Presencia del promotor	4	1	
Presencia del auxiliar	2	3	
Actitud positiva de los facilitadores	5		Trabajan en equipo
Participación activa de la			

comunidad	5		
Ambiente limpio	3	2	Cocina en el patio
Agua limpia disponible	5		
Lava las manos antes de cocinar	5		Cada niño tiene su toalla
Lava las manos antes de comer	5		
Usa recetas mejoradas Y apropiadas	5		Usa productos locales
Da respuestas a las preguntas de las mamas	4	1	

Número de participantes: ___12_ Hombres ___65__ Mujeres

OBSERVACION DE 13 VISITAS DOMICILARIAS

ASPECTO OBSERVADO	CORRECTO		COMENTARIOS
	SI	NO	
Se presenta y genera un ambiente de confianza	13		
Búsqueda de las 4 señales de peligro de muerte	6	7	
Búsqueda y evaluación de tos, diarrea, fiebre y problema de oído	7	6	Olvido del oído
Búsqueda y evaluación de desnutrición y anemia	5	8	No hizo le evaluación directa en el niño
Búsqueda y evaluación de otros problemas	3	9	
Revisión de vacunas empleando el Carnet de Salud Infantil	9	4	
Evaluación del afecto y cariño	6	7	Menciono la importancia del cariño
Evaluación de la alimentación	10	3	Tiene dudas en como responder a las preguntas de la madre
Evaluación de medidas preventivas en el hogar	8	4	No hubo oportunidad, no estaba en casa
Según los problemas identificados "Decide que Hacer"	11	2	
Da recomendaciones según la priorización de los problemas Encontrados	12	1	Muchos mensajes
Uso del rotafolio con el ORPA	8	5	Falta seguridad en usarlo
Uso de la hoja de registro	8	5	Uso la hoja, pero no correctamente
Realiza preguntas de verificación	8	5	
Felicita a la madre	10	2	
Acuerda próxima visita	9	2	

EVALUACIÓN de MEDIO TERMINO

SECI (Sistema Epidemiológico comunitario Integral)

Situación Ideal	Situación Actual	Recomendaciones
Suministros Esenciales • Banderas • Material por niveles • Muñecos por colores, sexo, gestación • Registros del promotor y el consolidado • Libros de actas • Croquis • Hoja de planificación conjunta • Material de escritorio • Material de capacitación – guías • Equipo de computación (software) • Material de apoyo del promotor o SRO o Balanza o Tallimetro o Bicicleta o Cotrimoxasol o Paracetamol o Sello	• Existe parcialmente y algunos sucios • Solo para el personal de salud • Incompletos(faltan mujeres gestantes y niños) • Existe 18 y 7 completar dificultad de manejo • En algunas comunidades • Falta y disposición inadecuada • No verificado(manejado implementado, capacitador y no por el promotor) • Cuentan pero insuficiente • Tienen rota folio de AIEPI, LINKAJES • Verificado en un área con software de SECI o Ninguno o Pocos o Ninguno o Propios del promotor o Si = 4 No =12 o No , propios o Ninguno	• Dotar de rota folio SECI a cada sector y área (Muñecos diferentes por enfermedades) • Talleres de reforzamiento sobre manejo de registros de diseño • Croquis poner en lugares visibles de reuniones con la comunidad • Socializar la hoja de planificación conjunta en SEDES, distrito y promotores • Material de escritorio dotar según sus necesidades • Optimizar equipo de computación área y tener visitas mensuales del técnico DJC • Material de capacitación catalizar y optimizar el uso del AIEPI • Material de apoyo al promotor • Niveles de coordinación distritos • Desarrollo de una estrategia con el MSPS para dotar SRO y paracetamol • Balanza a analizar RREE • Dotar sellos como incentivo • socializar SMIA equipo wawa sana
Recursos Humanos Capacitados • Comunidad • Distrito • Autoridades • Escuelas Juntas Escolares Profesores • Implementadores	• No se a capacitado • Al 100 % estadísticos, por cambios falta algunos directores • Al 50 % • No • 100 % • 50 %	• Uso de información SECI en toma de decisiones TAIs • Uso de software que se utilice a nivel de distrito y que haya mas capacitación a distrito para reciclar a áreas • Nombrar responsable del personal de salud para la recolección y consolidación Áreas y sectores

Situación Ideal	Situación Actual	Recomendaciones
• Auxiliares enfermería • Otras instituciones • Municipio • Lideres • Promotores	• Parcialmente • Escaso • Se realizo • La mayoría	• Socializar las capacitaciones • Incorporación del promotor en TAI de sector y área como: o Invitación escrita del director de área o Fortalecer la incorporación del promotor en TAI comunidad, sector, área o Coordinación con distrito o Dotar de credenciales al promotor
Sistemas Funcionando • Uso del Software CAI- TAI • Recolección continuo de datos • Reporte mensual • Reporte mensual de informes a l centro de salud • Que exista una persona responsable para recoger y consolidar la información • Red de información funcionando • Capacitación continua a todo nivel • Incorporación del promotor en los TAI • Motivación del promotor de distrito, municipio • Planificación conjunta que genere plan de acción comunitario • Planificación adecuada de trabajo (promotor – distrito - ONG) • Reunión mensual o bimensual de planificación conjunta • Respetar liderazgo y jerarquía del promotor • Organización interna de promotores	• A Nivel Distrital 2 utilizan de 3 • Regular • Continuo • Si • Algunos sectores • A mejorar • Incompleta • Mínima • Existe consenso pero no se realiza • Parcial, poca participación del personal de salud • Poca coordinación • Si • Si la comunidad y no así el personal de salud • En algunos sectores	• Motivación al promotor o Distrito y municipio o Incluirlos en el POA 1. Plan adecuado 2. Compartir las recomendaciones de este taller 3. Facilitar la organización del promotor para tener control interno 4. Incentivos positivos de parte del personal de salud
Actividades completadas • Visitas domiciliarias por promotor mensual • Planificación conjunta mensual, bimensual • Análisis y uso de información por distrito y a todo nivel • Participación del personal de salud en el proceso • Plan de capacitación cumplido • Promotores realizando viajes de intercambio de experiencias • Actividades multiprograma ticas en comunidad • Sistema de monitoreo y evaluación multisectorial semestral al promotor capacitación	• Si • Si • Mejorar • Mejorar • Mejorable, ajustar completar • Escaso • Si	5. Promoción de intercambio de experiencia 6. Premio al mejor promotor 7. Realizar encuentros culturales y deportivos 8. Compartir experiencias en el desarrollo del sistema de monitoreo y evaluación APROSAR, DJC y MSP 9. Incorporación a personal MSPS en proceso de monitoreo y supervisión

Situación Ideal	Situación Actual	Recomendaciones
nultisectorial semestral al promotor capacitación **AIEPI (Atención Integral de las Enfermedades Prevalentes de la Infancia)** **Suministros Esenciales** **Comunidad** • Laminas para la comunidad • Rota folio, grupo de madres organizados **Promotor** • Hojas de registro de AIEPI – Comunitario • Rota folio de AIEPI Comunitario • Laminas • Material de escritorio • Balanza, tallimetro • Botiquín (paracetamol y cotrimoxasol, vitamina A y SRO) • Boletas de referencia • Croquis, Censo actualizado • Cuaderno de seguimiento • Equipo de URO – comunitario • Una mochila • Una chamarra o ropa de agua • Una bicicleta • Plan de actividades Personal de Salud **1.** Manual de AIEPI **2.** Rota folio, hojas de registro **3.** Balanza taquímetros **4.** Boleta de referencia y contra referencia	• Falta instrumentos • No tienen (laminas, rotafolios) • Tienen • Tienen • Dotación en capacitaciones • La mayoría no tiene o se presta del promotor de APROSAR no tienen • 95 % no cuenta con medicamentos • 11 tienen 7 no tienen • tiene la mayoría • tienen • no tienen • no se pregunto pero tienen algunos • tienen solo los de APROSAR • promotores antiguos de APROSAR	**Promotores** 1. Dotación de material de escritorio semestral (cuadernos, lápices, papelografos, etc.) 2. Inventario de balanzas en los servicios de salud 3. Dotar de balanzas salter a los promotores que están sin acceso a servicio 4. Hacer gestiones a través del SBS que todos los promotores cuenten con (SRO, paracetamol) estableciendo un sistema de control 5. Diseño de un sistema de contrarreferencia 6. Gestiones con la alcaldía para que incluyan en el POA, la implementación suministros (URO) estimulo para los promotores (equipos de trabajo)

Situación Ideal	Situación Actual	Recomendaciones
5. Plan de seguimiento a cada promotor **6.** Contar con medicamentos esenciales 7. Croquis encuesta/ comunidad 8. Funcionando URO institucional 9. Formulario de AIEPI clínico 10. Carnet salud infantil 11. Vacunas 12. Balón de oxigeno 13. Mochila 14. Apoyo logística 15. Atención adecuada 16. Capacitación en AIEPI comunitario preventivo 17. Talleres de gestión de AIEPI comunitario 18. Buenas relaciones humanas 19. Calidad de atención **Sistemas Funcionando** **1.** Flujo de información **a.** atención del niño (hoja de registro) – comunidad **b.** registro de atenciones (cuaderno del SECI) – promotor **c.** informe al centro de salud (consolidado en libro de consulta externa) – personal de salud – planificación conjunta 2. Referencia contra referencia a. Referencia de niño con señales de peligro (promotor) –Centro de Salud mas cercano – contra referencia - referencia a nivel superior	• La mayoría del personal cuenta con el personal de AIEPI • La mayoría de Aux. de enfermería cuenta con el Rota folio AIEPI Comunitario • La mayoría del personal de salud cuentan con balanzas y tallimetros • La mayoría del personal de salud cuenta con la hoja de registro • El 50 % de estos tienen URO institucional • Todos los servicios de salud cuentan con croquis • La mayoría tienen CENSO • La mayoría de los servicios de salud cuentan con medio de transporte (motos o ambulancia) • solo la mitad utilizan los instrumentos del AIEPI • la información que genera el promotor de salud es incluida en el libro de consulta interna exterior y SNIS del servicio de salud	**Sistemas funcionando** • Promover los POA, a niveles de sector área distrito, con la participación de todo los actores sociales

Situación Ideal	Situación Actual	Recomendaciones
Actividades completadas • Visitas domiciliarias • Referencia contrarreferencia • Talleres AIEPI: promotores – Recursos humanos – servicios de salud • Sistema de monitoreo • Sistema seguimiento AIEPI (clínico comunitario) **Recursos Humanos** Comunidad • Grupo de madres capacitados en AIEPI < 5 años • Familias capacitadas • Comunidad autoridades Promotor o Líder • Capacitado en: • Manejo de suministros • Manejo de instrumentos o Hojas registro o Plan registro o Plan mensual o Carnet seguro infantil o Técnicas participativas o Peso talla Personal de Salud • Capacitados en AIEPI comunitario y clínico • Capacitado reforzamiento del componente promoción prevención	• Solo el sistema de referencia del promotor funciona al servicio de salud pero no funciona la contra referencia • Más de la mitad de los promotores realizan visitas domiciliarias y además saben el objetivo de esta actividad • La comunidad satisfecha • Saben generar ambiente de confianza toman decisiones • Recomiendan priorizando el tema • La mitad busca señales de peligro • 7 de 13 hacen búsqueda de evaluación de tos, diarrea y fiebre • el personal de salud recibieron menos de la mitad capacitación en AIEPI • seguimiento de monitoreo reciben menos de la mitad • el promotor recibió supervisión mas de DJC y APROSAR poco del servicio de salud • grupos de madres capacitados en AIEPI con niños menores 5 años como reconocer las señales de peligro de muerte • las familias se dan cuenta para identificar algún signo de SEÑAL DE PELIGRO PROMOTOR/ LIDER • La mayoría de los promotores han sido capacitados en el AIEPI comunitario; SECI lactancia materna, SSR y algunos en EDP	**Recursos Humanos** 1. Reforzar con talleres de capacitación todos los grupos de madres de la comunidad para que aprendan a identificar señales de peligro 2. Completar y reforzar la capacitación al promotor en el manejo y aplicación de los instrumentos del AIEPI complotar y reforzar 3. Capacitación en la gestión de AIEPI comunitario para su involucramiento y seguimiento a los promotores 4. Mejorar el nivel de coordinación entre el personal de salud y el promotor para que la información sea incluidas en el SNIS, retroalimentación a la comunidad 5. adecuar al sistema de referencia y contrarreferencia, con intervención de servicio de salud, promotor y comunidad **Otras Actividades** **1.** SI fortalecer las actividades del promotor, mediante los procesos de capacitación y

Situación Ideal	Situación Actual	Recomendaciones
• ID Prom. **EDP Estudio Desviación Positiva** **Suministros esenciales** • Balanzas y tallimetros en comunidad (a cargo del promotor) • Carnet de seguro infantil • Tablas de peso y talla por edad / sexo • Banderas mas muñecos • Espacio para pesaje / reunión • Cocina / fogón • Mensajes de cocina /platos • Productos • Espacio donde cocinar • Combustible • Platos • Vitamina A, Hierro • Mebendazol • Material de desarrollo infantil • Material educativo: rota folio, laminas de alimentos • Papel y marcadores • Protocolo o manual • Formularios de investigación de seguimiento • Transporte para capacitadores • Recetas mejoradas	PERSONAL DE SALUD • Menos de la mitad recibieron capacitación en AIEPI clínico y algunos en el comunitario • Mas del 50 % entre promotores y lideres no cuentan con balanzas y tallimetros • Cuentan con banderas y muñecos • No cuentan con espacio adecuado para pesar talleres hogareños • No existe material educativo para talleres hogareños • Recetas mejoradas en los talleres hogareños	monitoreo **2.** El personal de salud realice el seguimiento y monitoreo, para su sostenibilidad (acompañado en visitas domiciliarias y revisando el registro) **Suministros** **1.** Implementación de 10 balanzas con comunidades EDP **2.** Elaborar una guía de implementación incluyendo información técnico **3.** Ir preparando Manual EDP • Mantener capacitaciones en comunidades

Situación Ideal	Situación Actual	Recomendaciones
Recursos humanos capacitados • Mujeres lideres capacitados madres (positivas, negativas y caso estudio) • Promotores • Auxiliares de enfermería • Médicos de área y sector • Autoridades de la comunidad informados motivados • Otras ONGs. • Personal de monitoreo • Personal con experiencia en nutrición	• Buena 77% • Promotores 26 % • Auxiliares 38 % • Médicos 29 % • Autoridades informadas y motivadas • ONGs, personal de monitoreo, personal con experiencia en nutrición NO EXISTE	• Reforzar en los próximos 2 años capacitación promotores auxiliares, médicos y autoridades comunales • Fortalecer el monitoreo dentro del personal existente • Capacitación al personal existente en nutrición y coordinación con instituciones socias que tienen nutricionistas
Sistema funcionando • Referencia para desnutridos • Exámenes de laboratorio	PROMOTORES • Reconocen signos de desnutrición • refieren al Aux. no todos con boleta • No reciben contrarreferencia AUXILIAR • Refiere Con boleta • No recibe contrarreferencia MEDICO • Manejo de casos desnutridos regular • Refieren a niveles superiores ? • No reciben contrarreferencia	**Sistemas funcionando** • Sensibilizar al personal de SEDES sobre el sistema de referencia y contrarreferencia • Lograr una nota de apoyo de la SEDES para que el personal acepte el personal las referencias y contrarreferencias • Mejorar las instrucciones de referencia y contrarreferencia
• Programa de IEC o Difusión de mensajes claves folletos, radio, ferias audiovisuales	• Hay actividad en radio o Productores : LINKAJES o Financiadores: APROSAR o Difusores: Pió XII, Bahai • Hubo feria y video pero no se menciono en entrevistas • No hay folletos o material impreso • No hay plan general monitoreo y evaluación	• Elaborar un plan de estrategia de IEC para su implementación que seria anual, por sectores y niveles
Actividades completadas • Pesaje del 100 % de niños • Proceso de información • Clasificación de familias	• 100% comunidades EDP cuenta con estudio • personal de salud, promotor no conocen la estrategia • se utilizan recetas mejoradas pero no cuentan	**Actividades completadas** • Adecuar el EDP serán según necesidades de la comunidad • Visitas domiciliarias con conserjería nutricional • Feria de nutrición

Situación Ideal	Situación Actual	Recomendaciones
• Grupos focales visitas domiciliarias • Devolución de información y análisis de información • Capacitación a mujeres lideres, promotores y personal de salud • Reunión con las mujeres para realizar los menús e identificar e incluirlos en los menús • Taller hogareño (14 días) • Administración de micronutrientes y desparacitación a niños participantes crecimiento y desarrollo • Seguimiento • 8 meses	con cantidades y de modo de preparación • no se cumple con los 14 días esperados por la escasa disponibilidad de tiempo (solo se llevo a cabo un taller hogareño en cada comunidad) • No se están haciendo ciclos de 8 meses/14 días) • Existe administración de micronutrientes a los niños no así la desparasitación • Existe seguimiento antropométrico mensual y un parcial seguimiento en desarrollo	• Sistematización y socialización de la información de EDP

MONITOREO Y SUPERVISIÓN

ASPECTOS POSITIVOS

1. MONITOREO A TRAVEZ:

    - Libros de actas
    - Formularios de desarrollo y crecimiento
    - Formulario de planificación conjunta
    - Cuadernillo de consolidación de información
    - Formulario de monitoreo comunitario
    - Software SECI
    - Circulos de calidad mensual y trimestral

2. SUPERVISIÓN

    - Informes Mensuales
    - Informes trimestrales

ASPECTOS NEGATIVOS

- Sistema de monitoreo no funciona en todos los niveles del proyecto proyecto
- No existe un modelo de monitoreo del avance de actividades
- No existe una programación anual operativo
- Que el circulo de calidad y evaluación trimestral implementado es sectorial y no como programa Wawa Sana
- No existe instrumento de supervisión en todos los niveles

RECOMENDACIONES

- Implementar instrumentos de supervisión y monitoreo, socializando y adecuando instrumentos de otras instituciones (APROSAR, SEDES y/o otros programas)
- Elaboración del POA Wawa Sana en todo los niveles
- Círculos de calidad transversales ampliado del proyecto Wawa Sana cada 3 meses donde participen del gerente al promotor.

COORDINACIÓN
ASPECTOS POSITIVOS

COMUNIDAD

- Coordinación con autoridades, madres, padres y lideres
- Promotor elegido por su comunidad

SECTOR

- Fácil coordinación con los auxiliares de enfermería

ÁREA

- Buena coordinación cuando el director es motivado y permanente

DISTRITO

- Tiene conocimiento de los programas del proyecto
- Convenios firmados
- Buena predisposición del equipo

ASPECTOS NEGATIVOS

COMUNIDAD
- Falta de información y motivación de las autoridades
- Falta de liderazgo de los promotores

SECTOR
- Confusión en el equipo de información entre el promotor SS – DJC

ÁREA
- Cambios frecuentes de recursos Humanos
- Actividad negativa de algunos Recursos humanos

DISTRITO
- Poca permanencia por actividades administrativas

RECOMENDACIONES

ONGs
- Formalizar y revisar convenios
- Reuniones periódicas de intercambio de experiencias planificación programación

SEDES ORURO DIRECCIÓN DEPARTAMENTO DE PLANIFICACION
- Informe y reuniones de coordinación semestralmente programadas
- Participación en los CAI regionales

MUNICIPIOS
- Formalizar convenios
- Informes reuniones de coordinación programadas
- Incorporación al COMUSA

OTRAS ORGANIZACIONES
- Formalizar convenios
- Informes reuniones de coordinación programadas
- Incorporación al COMUSA
- PAN coordinar con promotor
- Ejercito
- Educación Informal
- Radios
- CETHA

COMUNIDAD
- Informar a las autoridades por lo menos anualmente con reuniones programadas
- Fortalecer capacidad resolutiva del promotor (Sello, credencial, SRO y paracetamol) gestionando con los municipios y distritos

SECTOR
- Establecer un flujo de informaciones de los promotores que debe ser entregado a un Auxiliar de enfermería con copia para ONGs.

ÁREA

- Reglamentar por instrumentos que si no se cumple las actividades programadas con el proyecto, acudir a la dirección Distrital, para tomar acciones

DISTRITO

- Gestionar ante SEDES, permanencia y estabilidad de los recursos humanos

SOSTENIBILIDAD
ASPECTOS POSITIVOS

- Las tres estrategias están diseñados para manejo comunitario
- Existe respuesta de las Autoridades
- Promotores dispuestos y capacitados
- Autoridades comunitarias dispuestas a apoyar
- Personal capacitado a todo nivel
- Madres y mujeres motivadas y organizadas

ASPECTOS NEGATIVOS

- Personal de sedes no comprometido
- Autoridades municipales no comprometido
- Falta de un balance en la capacitación entre nivel comunitario y personal de salud
- Constante cambio del personal de salud
- Poco apoyo de las autoridades hacia sus comunidades
- Trabajo individualizado de parte DJC

RECOMENDACIONES

- Involucrar planificar continuamente con las autoridades municipales comunitario para generar compromiso
- Incorporar al personal del SEDES en la elaboración e implementación de las capacitaciones
- Reforzar las capacitaciones de las tres estrategias en los diferentes niveles
- Empoderamiento de las tres estrategias por los promotores para que lleven adelante solos
- Lograr que las comunidades sean actores de sus propias actividades a trabes de una capacitación adecuada
- Que los promotores sean protagonistas en las capacitaciones de sus comunidades u otras
- Promotores capacitados en gestión de proyectos

Attachment F

Suggested Changes to Indicators

CS-16 Wawa Sana Project Indicators

Current Indicator	Suggested Change	Measure	Comments
1. 3 RHDs incorporate SECI data, discussion, & plans into district info. analysis (CAI) meetings *		Interview during Final Evaluation	
2. 60% of permanent Auxiliary Nurses demonstrate good skills in co-facilitating SECI meetings *	60% of Promoters and Auxiliaries demonstrate good skills in co-facilitating SECI meetings *	Need to develop tool to monitor this indicator	It is important that Promoter also acquire these skills
3. 80% of permanent MOH staff demonstrate good skills in co-facilitating H/PD training *	60% of permanent MOH staff demonstrate good skills in co-facilitating IMCI training *	Need to develop tool to monitor this indicator	Few MOH staff would have the opportunity to assist with H/PD training, most could with IMCI
4. All APROSAR trainers demonstrate competency in CB-IMCI, SECI, & H/PD training of Promoters		Need to develop tool to monitor this indicator	
5. 90% of APROSAR Promoters receive support/ supervisory visit from APROSAR staff in the previous 3 months*	Omit		This indicator was probably met before the project started. Supervision is one of APROSAR's strengths. Capacity building indicators should be developed with APROSAR based on their need to improve
6. 90% of APROSAR Promoters have adequate supply of cotrimoxazole *	80% of Promoters have adequate supply of ORS *	Need to develop tool to monitor indicator	Due to MOH policy a focus on supply of ORS is more appropriate

Current Indicator	Suggested Change	Measure	Comments
7. 75% of SECI communities have action plans with service providers to address CS needs *		Need to develop tool to monitor this indicator	Need to clarify that action plans can be what is written in the "libro de actas"
8. 75% of communities with action plans revise plans based on analysis of SECI/SNIS data *	75% of communities with action plans have implemented the plan *	Need to develop tool to monitor this indicator	Need to clarify that action plans can be what is written in the "libro de actas"
9. 40% participants in CS-16-related community meetings are women *		SECI	
10. 75% of partner & community capacity building objectives achieved *	Omit		This objective is redundant as all capacity building objectives are already included in this M&E plan
11. 100% of CS-16 APROSAR & permanent MOH staff receive support/ monitoring visit from SC staff in last 6m *	100 % of APROSAR and MOH staff in CS 16 have coordinated activities with SC staff in the last 6 months	Need to develop tool to monitor this indicator	The focus should be on coordination, not a monitoring function
12. SC/B advocates for implementation of effective/innovative approaches to child health at public and NGO levels *	SC/B advocates for effective implementation of child health at public and NGO levels *	Interview during Final Evaluation	Advocacy should include more than just implementing SCB approaches, but should influence policy at all levels
13. 60% of 12-23 month olds have maternal history or card for measles immunization. (27%)	60% of 12-23 month olds have measles immunization measured by vaccine card	KPC	Use of vaccine card for verification is recommended
14. 80% or more DPT3 coverage in infants in all CS-16 municipalities (32%)	60% coverage of DPT3 or Pentavalent 3 in children 12-23 m measured by vaccine card in all CS-16 municipalities	KPC	Should measure 12-23m only for vaccines, use of card for verification is recommended but will lower percentage of change

Current Indicator	Suggested Change	Measure	Comments
15. 85% of 12-23 month olds with cards received 1/more capsules in last year. (64%)	50% of 12-23 month olds received 1/more Vitamin A capsules in last year as verified by with card (64%)	KPC	The denominator should be children 12-23 m, not just children with card Verification with card makes 85% too high
16. 75% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD. (24%)	50% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD. (24%)	KPC	Percentage of change originally set too high
17. 23% annual increase in total <5 pneumonia cases treated by CS-16 facilities & Promoters.	23% annual increase in total <5 respiratory infection cases treated by CS-16 facilities & Promoters.	SECI	SECI collects respiratory infections, not necessarily a diagnosis of pneumonia
18. 75% of CS-16 population is within a 1-hour walk of facility or ARI-trained Promoter with cotrim. stock.	75% of CS-16 population is within a 1 hour walk of facility or IMCI-trained promoter.	SECI	Currently tracking population with trained Promoter, not Promoter with Cotrimoxizole
19. 60% of communities with pop. over 120 have CB-IMCI-trained Promoter or MOH facility *	80% of communities with pop. over 80 have CB-IMCI-trained Promoter or MOH facility	SECI	With cutoff at 120 insufficient # of communities, changed to cutoff of 80
20. 80% of CS-16 ARI-trained Promoters pass PCM knowledge & skills test.		Need to develop tool for this indicator	
21. 80% of CS-16 CDD-trained Promoters pass CDD knowledge & skills test.		Need to develop tool for this indicator	

Current Indicator	Suggested Change	Measure	Comments
22. 80% of caretakers of children recently treated by CS-16 facilities/ Promoters report correct dose & course of cotrim. fed for pneumonia	Omit		This indicator will be very difficult to measure as exit interviews for mothers with pneumonia will be difficult to conduct due to frequency of pneumonia
23. 80% of caretakers recently counseled on DD by CS-16 facilities/ Promoters report following 3 DD home care rules	Omit		This indicator will be very difficult to measure as exit interviews for mothers with diarrhea will be difficult to conduct after counseling
24. 75% of mothers of children under 2 years report that help should be sought if their child has “fast and agitated breathing.” (17%)	40% of mothers of children under 2 years report that help should be sought if their child has “fast and agitated breathing.” (17%)	KPC	Percentage of change originally set too high
25. 50% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing) (2%)	25% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing) (2%)	KPC	Percentage of change originally set too high
26. Estimated marginal cost of human resources & supplies for service delivery & support for implementation of approach		Feasibility report completed	Need to develop plan for documenting strategies now
27. 30% decrease in 6-35 month olds in H/PD communities below -2Z weight-for-age (pre-/post-).		SECI	This indicator still under study and a decision on how to modify it will be included in the 3rd Annual Report

Current Indicator	Suggested Change	Measure	Comments
28. 50% of the nutrition status impact on % of all 6-35 month olds below -2Z WFA is sustained 1 year after the end of Hearth sessions ☾		SECI	This indicator still under study and a decision on how to modify it will be included in the 3rd Annual Report
29. 50% of the nutrition status impact on % of all 6-35 month olds < -3Z WFA is sustained one year after the end of Hearth sessions ☾	Omit		The prevalence of severe malnutrition is minimal (0.5-1%), so changes will not be significant.
30. MOH or other PVO/NGO has written plans for implementation of SECI and/or Hearth/PD in two other RHDs ☾		Interview during Final Evaluation	

* Capacity Building Indicator
☾ Sustainability Indicator