CARE INTERNATIONAL/ USA

CARE BOLIVIA FIELD OFFICE

CHILD SURVIVAL XIII

FINAL EVALUATION REPORT

Location: El Alto, Bolivia

Cooperative Agreement No: FAO-0500-A-00-6040-00

September 30, 1997 - September 29, 2002

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August, 2002

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ACKNOWLEDGEMENTS

The principal authors of this report would like to thank the staff of CARE/ Bolivia's Field Office for its support and patience during the period of this final evaluation. They would also like to acknowledge the CIES project staff's guidance, hard work and dedication throughout the evaluation. They gave freely of their time despite their very busy schedules and responsibilities. It is also important to recognize the high level of dedication and professionalism that they all bring to their work. This is evident in the quality of the programs that CARE and CIES manage in Bolivia.

The efforts and support of the CARE (USA) headquarters office must also be acknowledged for their guidance before, during and after the evaluation. In addition, the USAID Bolivia Health Office deserves special recognition for its continuing interest and support of the CSXIII activities in El Alto. They have enthusiastically supported the WARMI groups and recommended to BHR/PVC that the project be given a one-year no-cost extension. Finally, the authors acknowledge the consistent and on-going technical guidance and financial support from the USAID BHR/PVC Office, without which this project's achievements and success would not have been possible.

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ACRONYMS

ARI:	Acute Respiratory Infection
CBD:	Community Based Distribution
CDC:	Centers for Disease Control and Prevention
CDD:	Control of Diarrhea Disease
CIES:	Center for Research, Education and Services
CS:	Child Survival
DHS:	Demographic Health Survey
DIP:	Detailed Implementation Plan
FHI:	Family Health International
HIS:	Health Information System
HQ:	Headquarters
IEC:	Information, Education and Communication
INE:	Bolivian National Statistics Institute
INLASA:	Bolivian National Laboratory Institute
IUD:	Intrauterine Device
KPC:	Knowledge, Practice and Coverage Survey
LAM:	Lactation Amenorrhea Method
MOH:	Ministry of Health
NGO:	Non-Governmental Organization
ORS:	Oral Rehydration Solution
ORT:	Oral Rehydration Therapy
PAHO:	Pan-American Health Organization
PROCOSI:	Coordination Program for Integrated Health
PSI:	Population Services International
SNIS:	Bolivian National Health Information System
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
TA:	Technical Assistance
UNICEF:	United National Children’s Fund
URO-P:	Popular rehydration centers
USAID:	United States Agency for International Development
WHO:	World Health Organization
WRA:	Women of Reproductive Age

INTRODUCTION

The Bolivia CSXIII final evaluation fieldwork was conducted between August 1 to August 15, 2002 in the cities of La Paz and El Alto Bolivia. The team consisted of Sandra Wilcox, team leader, and Judy Canahuati, the CARE headquarters representative. In addition, the project staff participated in the evaluation, assisting with field interviews, organizing schedules and logistics and reviewing findings. The staff from CARE and CIES who participated include: Dr. Irma Carrazana, Dr. Jenny Romero, Dr. Carmen Monasterios, Matilde Sanchez, Adela Paredes, Celia Pacari, Norma Mariaca, Jonny Mendoza, Jose Mamani and Carman Mamani. The CIES clinic staff, under the direction of Dr. A. Machicao, also assisted the team.

The schedule followed by the team consisted of spending the first two days in La Paz at the CARE office receiving a briefing from the project team, reviewing documents and interviewing CARE field office staff. The team also reviewed and revised evaluation tools during this time. The team then spent the next twelve days interviewing field staff, visiting sites in the El Alto project area, and interviewing agencies involved in project activities, in La Paz and El Alto.

The evaluation team spent the last three days writing up preliminary findings for the report and conducting both internal and external debriefings of findings to CARE /CIES, USAID/ Bolivia and to other interested agencies.

A. Summary

The goal of the CS XIII project has been to improve the maternal and child health among 50,000 women of reproductive age and 23,300 children under age five in El Alto, Bolivia. CARE intended to achieve this goal through strengthening the capacity of its NGO partner, CIES and by expanding a community network with other local institutions in order to provide improved, community-based MCH services. Project activities include diarrhea disease case management (30%), community education regarding maternal health with emphasis on how to prevent and recognize high-risk pregnancies and neonatal complications (30%), STD/HIV/AIDS prevention (20%) and birth spacing (20%). The objectives, evaluation methods, inputs, outputs, and monitoring methods are listed in the annex. This is a follow-on project to the CS X project, which was configured the same way, but focused primarily on diarrhea disease control, family planning and STD/HIV/AIDS prevention.

The project has been very successful in creating a network of health service providers between the CIES clinic in El Alto and the 150 -195 community-based health promoters operating in three districts delivering basic services, education and promotion about each of the four intervention areas. During this project the network has expanded to include community physicians who are associated with the CIES clinic, pharmacies and some MOH health centers. The expanded network is functioning well, with each service provider referring clients to the other members of the network for additional services.

As can be seen from the results of the final KPC survey in the next section, the project has exceeded all of its proposed objectives. Some of the accomplishments are dramatic, such as the increase in contraceptive prevalence among mothers who do not desire children within the next two years, from 22 percent to 84 percent. There were also substantial increases in behaviors associated with home diarrhea management, such as mothers giving the same or increased amounts of food and liquids (93% from 76% and 95% from 70% respectively). Some additional key accomplishments of this project are:

- There continues to be strong evidence of excellent teamwork in the project. This is demonstrated by the strong working relationship between CARE and CIES, the high level of integration of the project within the CIES El Alto clinic and the strong team of supervisors.

- The supervisors have been able to greatly expand their reach through the recruitment and training of "star promoters" from among existing promoters. These "stars" are recruiting new promoters and supervising their own groups of promoters, thus extending the network of volunteer promoters through a self-sustaining system.

- The project staff was able to make several modifications on the simplified WARMI method adapting it to the peri-urban environment of El Alto. CARE in Potosi developed the simplified method from the original WARMI methodology developed by Save the Children in Inquisivi.

- This adaptation of the WARMI method, which was applied to an urban environment and required the formation of separate men's and women's groups in different locales and timeframes, demonstrates the methodology's flexibility and capability of being applied outside rural environments.

- One of the biggest achievements in the area of sustainability is the spontaneous development among WARMI groups of looking for new projects and outside funding to continue their development process. The groups' initiative together with their creativity allowed them to not only consolidate their own community funds for obstetric emergencies but to also go after funds available for development from the municipality. Sometimes these are rotating funds, some are loans for emergencies and in other cases they are direct grants. But in each case, this process resulted in a sense of community empowerment and confidence where previously only a sense of fatalism existed.

- Many leaders and civil society representatives have been birthed out of the WARMI and KHARI groups. For example:

  - Presidents of the zonal school committees;
  - Presidents and vice-presidents of the neighborhood governing boards;
  - Members of the Mayoral Health Surveillance Committees;
  - Leaders and organizers in factories or other places of employment where the WARMI/ KHARI groups have formed;

- Representatives for the MOH and municipal health watch systems.

In each instance, the WARMI method has not only focused on maternal health issues but also has been used as a springboard from which to generate a sense of social awareness and community empowerment.

- There was a high level of retention of promoters (70%). This is most likely due to the high quality of training and the strong supervision system. In addition, the support of the "star promoters" is allowing the supervisors to extend their reach.

- At the end of the project, there are between 50 and 195 active promoters. In accord with the final CSX and mid-term CSXIII recommendations, the project had reduced the number of promoters to 80, a number that was manageable for the 6 project supervisors. However, with the advent of the thirty-five star promoters, the project decided that it could recruit more than 80 volunteer promoters.

- High quality training is evident in the work of the promoters, WARMI and KHARI groups and project staff through knowledge, skills and feedback. There is also evidence that the project is constantly trying to improve their training through the contracting of consultants and advisors.

- Volunteer promoters are being offered other community roles, such as being "health defenders" (MOH), "manzaneras" (municipality health representative), members of the neighborhood governing boards, and boards of education, because of the high quality of training and supervision that the volunteer promoters are receiving. This is a good example of how the promoters' work will be sustained after the project ends.

- The pharmacy and associated doctors network has grown. There's much enthusiasm among members for their continuing work and referral system.

- The pharmacist and associated doctor network formed a board of directors, providing further evidence that this association will be sustained after the project ends.

- The network of pharmacists, community doctors and "star promoters" are also promoting reproductive and child health at local markets. This is further evidence that these activities will be sustained once the project ends, since it is no longer only the supervisors that are doing these promotions.

- The project is producing high quality IEC materials including posters, flyers, pamphlets, flipcharts, referral cards, etc, which reinforce the program's key messages in all the intervention areas.

- The quantity of IEC materials available for distribution by volunteer promoters improved since the mid-term evaluation. At the end of the project, all the promoters interviewed

had materials for distribution. The pharmacies visited were also well stocked with CIES's informative materials.

- The project seems to be reaching a significant number of men through educational activities conducted with the KHARI groups, factories and the police in El Alto. The talks emphasize prevention of STIs and family planning.

- Since the mid-term evaluation, the project improved its quarterly reporting on volunteer promoter activities. These activities include: WARMI/KHARI group educational activities; referrals to the CIES clinic; referrals to community physicians, CBD sales, market promotions etc.

- The birth-spacing education provided by the promoters was more comprehensive than it was at the mid-term evaluation. In addition to talking about modern methods, the promoters also educate women about LAM and calendar methods.

- According to project reports, the incidence of childhood diarrhea has decreased markedly. Project staff believe this is because many neighborhoods have been able to access and install potable water systems. Indirectly, this is the result of the work of the WARMI and KHARI groups, which have conducted education about diarrhea and organized requests to the municipalities for water systems.

- One of the project's greatest achievements is its promoter training methodology which includes an on-going system of supportive supervision whereby promoters continue receive job training. Another strength of the training program is the way that promoters and community leaders have been included in staff training programs. There is also a good exchange of training experiences between CARE and CIES in which members of one organization are invited to participate in trainings given by the other organization.

Some of the issues that the CSXIII project faces as it closes include:

- CARE, CIES and USAID have all made a substantial investment in this project in terms of capital and human resource development. Now they are seeing a return on this investment in terms of the increased awareness and empowerment of people in El Alto and the increased number of people seeking services from CIES and other providers such as the Ministry of Health.

- Some of the WARMI and KHARI (42) groups are now capable of independently continuing their own community development activities after the project ends. Other groups (11) have still not completed enough training cycles to be able to function independently.

- The volunteer promoters interviewed said they do not have a problem being volunteers. They state that their work gives them a certain amount of credibility in their communities. They have become important people in their neighborhoods and feel a

certain responsibility to educate and help the people around them. When asked what they would like to help them with their work, they inevitably ask for more training and education. This is because this education has helped these promoters become important resources in their communities. They are concerned about how they will continue to learn new things. Many of them are also MOH or municipality representatives, but they don't receive the same level of training from these jobs as they have from the project.

- The pharmacists and associated doctors are organizing themselves and forming a board of directors in order to continue their activities, but this is a recent effort and they will continue to need support and guidance from CIES for a while longer.

Some of the key recommendations made by the evaluation team for the remaining project period and immediately afterwards include:

- CIES and CARE need to develop a joint strategy to preserve the gains that they've made with this project. They've made a huge investment in the formation of a well-trained and capable team. In addition, the CIES El Alto clinic has gained significantly from the increased referrals from the groups, the pharmacies and the promoters. It is recommended that this project serve as a model for achieving community participation and that CARE and CIES look for further funding to continue developing and implementing this model.

- Before the project ends, the staff need to work with the WARMI and KHARI groups to suggest on where they can go to gain more support for their group activities, such as other NGOs that teach community groups. Many of the groups are contacting with organizations that teach literacy or provide credit for loans. The project plans to contact and compile a list of organizations in El Alto that are interested in working with organized community groups and make the list available to all the WARMI and KHARI groups.

- It is recommended that CARE and CIES document lessons learned about health and community participation. This information can then be presented to other branches of CARE; at national meetings; or at international meetings, such as the American Public Health Association and the Global Health Council.

- It is recommended that when the project staff develop survey instruments, that they use questionnaires that have been developed in accordance with international standards. This way it will be easier to compare results with other surveys made in the same area of study.

- The MOH health centers in the project area recognize the impact of the CS project and the demand for CS services. This is important in keeping the MOH support for CIES and CARE projects.

- The CSXIII project is preparing a manual, which will contain all educational information

developed by the project. In order to share this information with other organizations, it will be necessary to provide training on these techniques and methodologies.

- The project staff from CARE and CIES have been working together on a proposal for adolescent reproductive health. The objective was to work with adolescents in the families involved in the WARMI and KHARI groups. At this point, it is uncertain as to when the project will be funded and in which department it will be located within CARE and CIES. If the adolescent project staff are going to work with the WARMI groups, they should coordinate with the project staff and, hopefully, involve them in the project.

B. Assessment of Results and Impact of the Program

B.1. Results Summary Chart

Objectives	Baseline	Goals	Final
DIARRHEA (Among mothers of children under 5 years) 1. Increase from…..the number of mothers who recognize the signs of dehydration.	25%	35%	87.6%
2. Increase from …. the number of women who recognize at least 3 or more symptoms of diarrhea.	31%	40%	74.5%
3. Increase from….. the number of women who know that ORS prevents dehydration from diarrhea.	54%	65%	89.6%
4.Increase from …..the number of women who use CLARO solution to purify drinking water.	0%	10%	24%
(Of mothers whose children are under 5 years of age and who had episodes of diarrhea during the 2 weeks previous to the survey.) 1.Increase from… the number of mothers who gave the same amount or more liquids during diarrhea episodes to children who were not exclusively breastfed.	70%	80%	94.9%
2. Maintain or increase the number of women who gave the same amount or more of breastmilk to exclusively breastfeeding children.	87%	-	87.4%
3.Increase from …. the number of mothers who gave the same amount or more food to their children during diarrhea episodes occurring during the 2 weeks previous to the survey.	76%	80%	93.2%
4. Increase from …. the average number of monthly diarrhea cases treated by volunteer promoters in the communities.	126	250	335
MATERNAL HEALTH (Of women 15 to 49 years) 1. Increase from …. The number of women who recognize 4 or more danger signs that can occur during pregnancy.	4%	15%	37.6%
2. Increase from… the number of women who recognize three or more signs related to pregnancy and delivery that indicate the need to seek immediate medical attention.	19%	25%	56.4%
3.Increase from… the number of women who recognize 2 or more signs and symptoms of post-partum complications requiring immediate medical attention.	19%	30%	42%
TWELVE GROUPS WITH EOC PLANS			
STI, HIV/AIDS 1. Increase from…the number of WRAs who recognize at least 2 symptoms of STIs in women.	22%	30%	45%
2. Increase from…. The number of men aged 15 – 49 years who know at least 2 STI symptoms in men.	38%	46%	77%
3. Increase from… the number of WRAs who know 3 methods for preventing STIs.	6%	15%	42.3%
4. Increase from ….the number of men 15 years or older who know 3 methods for preventing STIs.	9%	18%	56%
CHILD SPACING 1. Among non-pregnant women who do not wish to become pregnant during the next 2 years, increase the number who are using modern methods of contraception from …	22%	35%	84.4%

B.2. Results: Technical Approach

B.2.a. Overview

Goals and Objectives of CS XIII

The goal of the CS XIII project is to improve the maternal and child health among 50,000 women of reproductive age and 23,300 children under age five in El Alto. CARE's intention for achieving this goal was to strengthen the capacity of its NGO partner, CIES and to expand a community network with local pharmacies and doctors in order to provide improved, community-based MCH services. Project activities include diarrhea disease case management (30%), community education on maternal health with emphasis on how to prevent and recognize high-risk pregnancies and neonatal complications (30%), STD/HIV/AIDS prevention (20%) and birth spacing (20%). The objectives, evaluation methods, inputs, outputs, and monitoring methods are listed in the attached chart (see Annex I). KPC results are listed above in section B.1. of this report. Of special note is the fact that due to the technical and financial efficiency of this project which allowed several unanticipated cost savings, CARE and CIES were able to extend the life of this project for an additional year at no cost.

CS XIII was built upon the interventions established in the previous project, CS X, which were developed to improve maternal and child health. The existing health network of community promoters was expanded to include pharmacists and community physicians. The purpose for including pharmacies was to strengthen the STD prevention component of the project. Safe pregnancy and improved birthing practices have been promoted along with post-partum contraception. Men were targeted for messages and counseling regarding birth spacing, STD prevention, and maternal health promotion. Community education about diarrhea case management has continued as well as referral to the CIES clinic for IUD insertion, Depo-Provera, first time pill use, and treatment of STDs and acute diarrhea.

Program Location

Market Networks for Health II is being implemented in Districts III, IV, V, and VI of the city of El Alto, a large urban center adjacent to La Paz, the capital of Bolivia. The district configuration has changed several times during the life of the project due to population growth and government re-districting. El Alto is located at 13,000 feet above sea level on the cold, barren high plains region called the Altiplano. The city has become a center for rural-urban migration and is currently the fastest growing city in Bolivia. The population was 705,492 during the 1998 National Census update and has a current annual growth rate of 9.2%. El Alto is also expanding through the incorporation of new neighborhoods, both within the project area and on the edge of the city of El Alto. Market Networks for Community Health II has focused on these newly incorporated neighborhoods while still maintaining services in the rest of the project area.

The target population of the project is 50,000 women of reproductive age and 23,300 children less than 5 years of age. Additional beneficiaries are 45,000 men 15 years and older.

Most of the target population are first generation rural migrants of Aymara and Quechua origin with limited knowledge, practice and access to maternal and child health services and

information. The KPC survey performed in July of 1997 at the initiation of the project, found that 78% of women and 79.9% of men speak Aymara and 4% of women and 10.4% of men speak Quechua. Most of this population also speaks Spanish, but is more comfortable speaking their native language. A total of 44% of women and 39.5% men have lived in El Alto 9 years or less. Half the population surveyed was born in rural areas (50.3% of women and 50.8% of men).

The majority of the population works in the informal sector or is employed in factories. Many work in La Paz as domestics or as day laborers. According to CARE's KPC survey conducted in 1997, only 23.7% of reproductive age women (15-49 years) and 27.4% of men 15 years and older had attended high school. A total of 82.6% of women interviewed work to earn a living. Commonly these women work as artisans, street vendors, agricultural product sellers or own a small store. Small children often accompany women who work in the informal sector. Women and children in El Alto face difficult health situations as reflected by elevated statistics of infant and maternal mortality. According to the 1994 DHS (Demographic Health Survey), infant mortality for the Altiplano region where El Alto is located, is 96 per 1,000, child mortality (under five years of age) is 142 per 1,000 and maternal mortality was measured to be 591 per 100,000 live births.

Neighborhoods in the project area lack basic services, particularly electricity, potable water and sanitation systems. Houses are crowded together and often shelter more than one extended family plus domestic animals such as dogs, guinea pigs (raised for food), and poultry. However, throughout the project period, various poverty reduction strategies being implemented through the municipality and other avenues have allowed active El Alto neighborhoods to access a larger number of services. More and more streets are being paved with stones to minimize mud and dust. There is an extensive public transportation network, which includes buses, mini-buses, and different levels of taxis. There are an increasing number of large and small markets (some of which have been stimulated by the project volunteers), either open-air or enclosed, throughout the city, most of which operate on specified days of the week.

El Alto is serviced by different health facilities, both governmental, NGO, private sector and religiously-affiliated. The MOH of El Alto is responsible for six health districts. However, public sector facilities do not have sufficient funds, personnel, supplies or management support systems to deliver maternal and child health services to all neighborhoods. Many of the private health facilities do not place a high priority on maternal and child health, nor do they provide community based services and education.

In El Alto the MOH operates two district hospitals "12 de Octubre" and "Los Andes" which are referral hospitals for CIES and the project. The hospitals offer referral services in obstetrics, pediatrics, and general medicine. In addition the MOH operates small health centers, usually staffed by one or two physicians and two nurse auxiliaries. The El Alto MOH has a total of 206 staff, including 53 physicians, 8 licensed nurses, and 52 nurse auxiliaries.

The current MOH is in the process of developing its specific health strategy and plan following the "Plan Vida" (Life Plan) developed under the MNR government whose term ended in 1997. (This government has just recently been re-elected during the 2002 elections and is expected to further this process). "Plan Vida" states as its goals the reduction of maternal and infant (less

than 1 year) mortality each by 50%. " Plan Vida" proposes to accomplish this by establishing local systems with referral sites that provide obstetrical, perinatal and pediatric services, which can handle complications. The previous government established a national maternal-child health insurance system (Seguro Básico) for government facilities with the aim of providing free services to the population. This insurance system has had difficulty covering all the population in the country but it has gradually been able to incorporate non-government health centers once they can be accredited by the GOB. For example, the new CIES clinic in El Alto will be able to meet the MOH requirements for inclusion as a Seguro Básico service provider and will then be reimbursed for its services. The MOH sponsors vaccination campaigns, treatment of pneumonia and Diarrhea disease, growth monitoring, and reproductive health care (pre- and post-natal care, deliveries, and some family planning), however budget and staff concerns limit the MOH in delivering these services to all of the population.

Several NGOs, including CIES, provide health services or health education in El Alto. CIES operates out of a single clinic and provides both outreach and clinical services in maternal and reproductive health and is the major provider of birth spacing services in the project area. Other services are available in El Alto, such as PROSALUD, which operates low cost primary care clinics in El Alto. Other organizations that address women's health issues through education include PROMUJER, CIDEM and Gregoria Apaza. The municipality of El Alto sponsors four health centers. There are four church supported clinics, four private clinics plus an undetermined number of physicians in private practice. As one of its objectives, this project assessed the services provided by these entities and identified those who were interested in becoming part of the network. By the end of the project, there were a large number of local physicians who had become part of the CIES affiliated doctor's program. In addition, several pharmacies (12) joined the network. Also, some of the doctors from the MOH health centers receiving referrals from project volunteers have joined the network and are being included in the training and other project sponsored activities.

Public transportation is available to health centers at a cost of approximately US$ 0.25 each way for buses. Accessibility to transportation varies depending on the neighborhood. In outlying neighborhoods, the population may need to walk half an hour to reach public transportation. Night service is not always available and sometimes it is necessary to take more than one bus. Radio taxis are available in some parts of El Alto and cost approximately US$ 2.50/trip. Although the public transportation system is variable, the population can reach health facilities from their homes.

B.2.b. Progress Report by Intervention Area

Diarrhea Case Management (30%)

The 1994 Bolivian DHS found that diarrhea was the single most important cause of death in children under three, accounting for 20% of all deaths for this age group. The same study found that nationally, 30% of children under three had diarrhea in the two weeks prior to the survey. A baseline KPC survey in July 1997 (Bolivian winter) found that 43% (129/300 children under two years of age had diarrhea during the two weeks prior to the survey. In 1998, Bolivia had a

cholera epidemic, with 32 cases reported in El Alto and La Paz during January and February of that year.[1] Thirty-three percent of the children under three years of age in the Dept. of El Alto, had an episode of diarrhea in the two weeks prior to the survey, according to the DHS of 1998,[2] quite similar to the prevalence in 1994.

At the beginning of project implementation, the policy of the Bolivian Ministry of Health (MOH) promoted evaluation of the level of dehydration; use of ORT; referral of severe cases of dehydration or prolonged diarrhea (14 days) to health centers; and continuation of breastfeeding and food during diarrhea episodes.[3] During the course of project implementation, Bolivia MOH began adapting, adopting and implementing IMCI at an institutional level. Community IMCI has been initiated by CARE/CIES during the course of the CS XIII project (beginning in 2000).

During the Child Survival X project, an anthropological study was performed that indicated diverse beliefs about diarrhea including infectious or hygienic causes. However, people also believed in emotional causes in the child or the mother while breastfeeding. The population, as do many populations in different parts of the world, classifies diarrhea into the type that needs to be treated and the type that doesn't need treatment. The study found that the population associates diarrhea with different breastfeeding conditions, such as mother having a cold or being pregnant. However, breastfeeding usually continues throughout the episode. Breastfeeding is suspended when the woman is pregnant because the milk is considered harmful for the nursing child.[4]

The study found that the population distinguished well between severe and not-severe diarrhea. Not-severe diarrhea is generally managed by home remedies many of which, like rice water and cornstarch gruel, correspond to modern practices. However, severe diarrhea can be treated by traditional or modern treatments or some combination of both. Although dehydration is recognized, the need for increasing liquids and food was seldom practiced. Most people had heard of ORS packets, but only 30% of the mothers interviewed had ever used them. Only 27.3% of the mothers of children with diarrhea in the two weeks prior to the survey gave their children more liquid during the episode and only 19.4% had given ORS. Although the population recognized severe symptoms, they did not understand that they should seek help. Only 27.4% could indicate dehydration symptoms, 13% recognized blood in the stools and 31% diarrhea that continued for more than 14 days.

BASELINE OF CSXIII: FINAL EVALUATION OF CS X KPC JULY 1997

The 1997 KPC study, complementing the anthropological study found that although 85% of mothers had heard of ORS, only 51.3% had every used it. 54.3% of mothers believed that ORS prevents dehydration and 50% thought that it cured diarrhea[5].

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[1] CARE Bolivia: Detailed Implementation Plan Child Survival XIII, *Market Networks for Community Health II*, El Alto, Bolivia. September 30,1997 – September 30, 2001 (extended to September 30, 2002). USAID Cooperative Agreement No. FAO-A-00-97-00060-00. Submitted March 31, 1998.
[2] INE, DHS, Encuesta Nacional de Demografía y Salud. 1998.
[3] Ibid, p. 32
[4] Ibid, p. 33.
[5] CARE, 1998. *Detailed Implementation Plan Child Survival XIII MARKET NETWORKS FOR COMMUNITY HEALTH II.* , El Alto, Bolivia. CA No. FAO-A-97-00060-00.

The Anthropological Study Carried out in 1996[6] had the following findings:

- Two explanations for the origin of diarrhea:
  1. Natural causes: infection, eating dirty food or change of milk in baby
  2. Supernatural causes (affective scare, complaints while breastfeeding)

  People can simultaneously believe one or both of these causes.
- Two categories of diarrhea:
  1. Illness: should be treated, may be treated medically
  2. Not illness: "aika" does not require treatment, part of child's development, such as learning to walk
- Treatment will be applied according to symptoms. Light diarrhea receives home remedy and serious diarrhea receives both traditional and modern treatments or modern only. (Symptoms of serious diarrhea: pallor, frequent stools, watery stools with or without blood, sunken eyes, wasting, vomiting, temperature, less appetite.)
- Homemade remedies include rice water or cooked maize flour. Mothers know more about homemade remedies than fathers.
- The majority of people knew about ORS, but most think it cures diarrhea. When that doesn't happen, they doubt efficacy and discontinue use. Mothers may use it when children are seriously ill which causes the children to vomit.
- Breastfeeding conditions are associated with diarrhea. If mother is angry (complains) or has a cold, this can produce diarrhea. In general, breastfeeding is not interrupted during diarrhea. Breastfeeding is interrupted if mother is pregnant because it is believed that milk is not good.

FOCUS OF THE CSXIII PROJECT:

Regarding diarrhea, the CS XIII has emphasized prevention, home and community management of diarrhea and referral to health centers for complicated cases. The target population is children under five years of age and educational efforts were directed to the mothers of these children. The current project focuses on recognizing bloody and persistent diarrhea as indicators for seeking medical treatment. CIES clinic took information about antibiotic resistance (from a study carried out in Bolivia in 1994-5) into account when prescribing treatment.

The Objectives of the project were built on the information of the final evaluation of the CS X project. The KPC took place in July 1997. In this KPC, 300 mothers of children under 24 months of age were interviewed.

CDD OBJECTIVES FOR CS XIII:

- Increase from 52.2% to 65% the quantity of mothers who have used ORT.

[6] Castro, MD and Huanca, J. 1995. *Knowledge, Attitudes and Practices of Family Planning, Sexually Transmitted Diseases and Childhood Diarrhea in the City of El Alto (Districts I and II)* summarized in DIP for CS XIII. Annex V.???

- Increase from 27.7% to 40% the number of mothers who know that ORT is used to prevent dehydration.
- Increase from 51% to 64% the quantity of mothers who know how to prepare ORS packets correctly.
- Increase from 19.7% to 30% the numbers of caregivers who know that it is necessary to give more fluids than normal when a child has diarrhea.
- Increase from 36% to 50% the numbers of caregivers who can recognize the signs of dehydration as an indicator for seeking health care.
- Increase from 46.7% to 55% the numbers of caregivers who know its necessary to give a child more food than normal when a child is recovering from an episode of diarrhea.
- Maintain at 84.2% or increase the percentage of mothers who breastfed the same or more frequently during an episode of diarrhea.
- Increase from 62.7% the percent of children not exclusively breastfed who were given the same quantity or more liquids (not including breastmilk) during a diarrhea episode.
- Maintain at 67.6% or increase the % of children who were given the same quantity or more food during a diarrhea episode.

Prevention efforts have centered around the promotion of hand-washing and water treatment. The project has promoted a point-of-use disinfectant known as "Claro", a mixed oxidant disinfectant developed through a project with the Centers for Disease Control.

CARE/CIES obtained additional funds via a small grant from Emerging Markets Charity for Children (EMCC) to be used during the first year of CSXIII to enhance activities. ORS packets, supplies for demonstrating ORS preparation and use, supplies for demonstrating proper hand washing and an initial supply of CLARO were purchased. The grant also supported publication of educational materials and radio spots.

This add-on project concentrated on two zones within the CS XIII project areas (Cosmos 79 and German Busch/Ingavi/Mercurio). Volunteers were recruited from those active in CS X and they served as information reference points for proper management of diarrhea cases and suppliers of ORS packets and CLARO. They made home visits to detect diarrhea cases in children <5 years of age, assist mothers in proper case management, including ORS use and referral if the child does not recover.

The staff used interactive educational cassettes developed by BASICS. National policy at the time was to sell ORS packets, which were to be bought through the EMCC grant. There was to be a rotating fund system to ensure a continuing supply of packets. Mothers were encouraged to increase giving any kind of liquids including home remedies such as rice water.

IEC strategies were developed to reinforce educational messages about prevention, home management and medical attention for complicated cases. Materials used included:

Diarrhea manual produced under CS X
Pamphlets (developed or adapted EMCC funds)
Flip chart (EMCC funds)
Educational panels with information to be used in markets.

Interactive learning cassettes adapted from material already developed in Bolivia.

Key messages continued from CS X were:
Diarrhea is the main cause of infant mortality
When the child has diarrhea s/he loses a lot of water, dries up and can die. Loss of liquid is called dehydration.

All children can become ill with diarrhea when:
- They drink unboiled water
- Hands are not washed before eating and after "performing necessities"
- Food is not protected from flies

In order for the child to recover liquid lost from diarrhea, we must do the following:
- Give a lot of liquid such as rice water, water with cinnamon, soups or ORS
- Continue to breastfeed if the child is still breastfeeding and continue to feed the child
  ORS solution is prepared by adding one packet to one liter of boiled and then cooled water. Packets are available from CIES or from volunteers.
- The signs of dehydration are: dry mouth, sunken eyes, crying without tears, no urine or less urine. If these signs exist, a child should be taken quickly to a health center.
- All children should be breastfed exclusively from birth to six months.
- All people should wash hands before eating, before preparing food and after using the bathroom or doing "one's necessities"
- We should wash and store food away from flies in order to prevent food from being covered with dust and flies.

A mother can prevent diarrhea by the following:
- Breastfeeding
- Growth monitoring
- Proper weaning
- Immunizations
- Adequate nutrition
- Hand washing before eating and after "doing one's necessities"
- Drinking boiled water
- Eating cooked food and avoiding raw food.

The following messages used in CS X were to be adjusted to emphasize the following:
- Increased use of any liquid including ORS when the child has diarrhea
- ORS prevents dehydration, which can kill the child. ORS does not cure diarrhea.
- An Emergency plan developed before child is ill is important.
- Recognizing danger signs and seeking medical attention is important.
- CLARO should be available to treat water.

At the time of the DIP for the CSXIII project, water supplies in El Alto were still very irregular and people used public taps and water from contaminated streams that flow through the city. It was considered essential to disinfect water used in the home.[7]

STUDY OF WATER AND CENSUS IN 1998.

In November 1998, CARE supported a baseline study on Water in El Alto. 556 parents of children 60 months and under were interviewed. The average number of children under five years was 1.6. 500 families or 90% did not have a bathroom or a latrine in the home. 35% had water inside the home, 44% used a public spigot and 21% had a well. 56% drank untreated water and 44% boiled water.[8]

CDD STUDY APRIL 2000.

Between 1999 and 2000, with the help of a special grant from *Emerging Markets Charity for Children* (EMCC), CARE/CIES carried out a short-term project focusing specifically on control of diarrhea diseases in the 4 zones in the areas of intervention of the CS XIII project (Geman Busch, Mercurio, Ingavi and Cosmos 79), with 14% of the population of the total of 29 zones in the areas of influence of the CS project. These zones were identified as priority because of the relative recent influx of migrants into El Alto.[9] 278 or 48.7% of the under fives surveyed were under two years of age.

During the period between 1998 and 2000, potable water systems were connected in the intervention districts in El Alto. This seems to be related to a dramatic decrease of diarrhea incidence, which dropped from 43% in 1997 to 32% in 2000 and to 23.6% in July, 2002 at the same time as intra-domicile water increased from 34.5% in 1998 to 90.9% in 2000 and to 98% in the 2002 survey.

FINAL KPC AND QUALITATIVE EVALUATION: JULY 2002

The project had initially contemplated more individual, house-to-house promotion. However, the WARMI and KHARI groups seem to have mobilized communities to press for improvements, such as water systems and sewage systems that are currently being installed in the intervention communities. The interplay between group members who have also become politically active (members of the neighborhood governing boards [Juntas Vecinales]) and have been able to submit successful proposals for community improvement has no doubt played a role in the decrease in diarrhea during CS XIII. In addition, the group members have become successful word-of-mouth transmitters of improved behaviors, along with providing a peer group to both model and promote improved behaviors related to both prevention and treatment of diarrhea.

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[7] CARE, DIP, p.38.

[8] CARE/CIES, 1999. *Redes Comerciales para la Salud, CSXIII, Informe de Actividades de 22 Meses de Ejecución*, 30/9/1997-30/7/1999.

[9] Iglesias, I. 2000, *Estudio Encuesta Muestreo sobre actitudes prácticas y conocimientos de Enfermedad Diarreíca Aguda en la ciudad de El Alto*. CARE/CIES

In addition to the effectiveness of the WARMI and KHARI groups in promoting a series of behaviors that led to improved prevention and care practices in relation to diarrhea, the project introduced additional improvements in practices that may have contributed to prevention, the development of support groups and improvements in counseling methodology related to breastfeeding practices.

Although improved breastfeeding practices and complementary feeding practices were not an explicit goal of either CS X or CS XIII, there seem to have been important shifts in behaviors in the intervention communities. These behavior changes, such as increases in exclusive breastfeeding in infants under six months of age, reinforce the diarrhea prevention and treatment messages and no doubt have contributed to the over-all decline in diarrhea incidence during CS XIII. Unfortunately, in the baseline survey for CSXIII, there was no question about the incidence of breastfeeding among children under two years of age or about the incidence of exclusive breastfeeding for those under six months of age.

During the final evaluation, project managers decided to collect information on the incidence of breastfeeding and exclusive breastfeeding, as it had become an important part of the project interventions. At the same time, the population surveyed had changed. At baseline in 1997, the population surveyed was the population of children under two years of age. As a result of the special intervention on diarrhea disease prevention and treatment, the project managers decided to broaden the population surveyed to include all children less than five years of age.

60% (151/250) of the mothers of children under five years of age reported having exclusively breastfed their children to six months. The rest reported breastfeeding exclusively to four months (5.6%) or to 5 months (34%). In the final evaluation, 32 children, or 12.8%, were under six months old at the time of the survey. 71.8% of the mothers of these children reported that they were using LAM as a birth spacing method. In the discussions with members of WARMI and KHARI groups, all respondents who mentioned LAM, indicated that one of the criteria was exclusive breastfeeding. In addition, all of the women interviewed by the evaluators, both mothers of children less than six months of age, or women who have had children in the last two years indicated that they exclusively breastfed for six months.

In a recall question for mothers of children less than five years of age at follow-up, 45.2% of the mothers (113/250) reported that they had breastfed for more than two years and only 7.6% (19/250) indicated that they had stopped breastfeeding before one year of age. 84% (210/250) of the mothers reported that they had introduced complementary foods from six months on.

While these questions do not correspond completely to the set of questions in the Rapid-Catch survey, nor were there corresponding baseline questions, the response does suggest that knowledge has improved and that it is possible that practices have improved during CS XIII. Our qualitative interviews certainly suggest increase in knowledge and a feeling of empowerment among the women who have begun to understand the importance of breastfeeding for their children. Men interviewed in the KHARI groups often indicated that breastfeeding had been one of the most important topics in their discussions and that they had not understood how important it was prior to becoming members of the group.

At follow-up, mothers were asked to list advantages of breastmilk for their children and for themselves, with the following results:

Advantages of Breastfeeding for mother and child. Final survey, CS XIII. (n=250)

Advantage	Frequency	%
For the child		
Vitamins A, B, C	213	85.2
Minerals, Phosphorus and Calcium	159	63.6
Fatty acids	148	59.2
Sugars	183	73.2
Proteins	57	22.8
DR/DK	12	4.8
For the mother		
Helps expel placenta	187	74.8
Uterus contracts to normal size	174	69.6
Decreased risk of breast cancer	122	48.8
Others	38	14.9
DR/DK	26	10.1

Maternal Health (30%)

Objectives (Among women 15 - 49 years):

- Increase the number of women who know at least 4 pregnancy danger signs from 4% to 15%.
- Increase from 19% to 25%, the number of women who recognize three danger signs during delivery.
- Increase from 19% to 30% the number of women who recognize 2 signs of complications during the post-partum period.

As noted in the KPC results, the project has surpassed these objectives. The percentage of women surveyed that recognizes at least four pregnancy related danger signs is 37.6 percent. 56.4 percent of women recognize three or more delivery related danger signs that require immediate medical attention; and 42 percent of women recognize two or more post-partum danger signs requiring immediate attention.

This maternal health intervention began in the CSXIII project and was not part of the previous CSX activities. The high levels of increased knowledge surprised the evaluators, given that this is a recent intervention. The project staff attribute the high level of success to the WARMI strategy, whose participative methodology allowed for increased internalization of project messages.

The project trained its staff (5 educators, 1 coordinator and 2 others) in the WARMI methodology. "WARMI" means "woman" in Aymara and Quechua. This popular and participative community mobilization technique was originally developed by Save the Children

Bolivia in 1991 for educating rural populations about pregnancy related danger signs and helping them develop strategies to address obstetric complications in a timely manner. This methodology was adapted and used by CARE Bolivia for many years. In this project, the strategy has been implemented in 23 groups of women and 4 groups of men in KHARI groups (KHARI means "man" in Aymara).

The WARMI technique mobilized women to join groups organized in order to identify maternal health problems and solutions for the community, and to train the group participants in several key maternal-child health areas. "Joint planning" is used to prioritize problems and needs, in which volunteer promoters play a key role in creating and maintaining ties between the WARMI groups, the communities and authorities. WARMI and KHARI group participants have learned to identify, prioritize and search for solutions to the most pressing health problems in their areas. The volunteer promoters and staff facilitate the group meetings. The objective is to train the women to be self-motivated in seeking solutions for their health, the health of their children and families, and their community's general health situation. During the initial cycle of training and group formation, the staff and volunteers used the WARMI methodology by empowering male and female community groups to seek services for maternal health and pregnancy care. This process involves assisting community members in the early detection of obstetrical complications and helping them develop emergency plans for getting complicated deliveries to appropriate health services in a timely manner. The group often goes on to address other development issues besides health after the group has passed through the first few cycles of group diagnosis (problem identification), joint planning for resolving identified problems, implementation of proposed solutions, participative evaluation and planning for a new cycle of problem solving. The groups were initially formed to deal with maternal health issues, however, the methodology allowed and encouraged awareness of general community issues, not just health concerns (see section on cross-cutting issues for more discussion).

During the initial project development stage, the project conducted an assessment to identify all the referral centers in the project area. The project met with Juntas Vecinales (neighborhood governing boards) from 92 neighborhoods and discovered that:

Of the 92 neighborhoods, only 24 have health centers (26%).
Of the 24 health centers, 7 have an obstetrician-gynecologist, 2 have pediatricians and 11 offer dental service.
Of the 24 health centers, 21 have at least one doctor, 18 have pharmacies with basic supplies, 4 have laboratory services and 2 have X-ray services.
Of the 24 health centers, 8 have maternity beds, 6 of which are well equipped. Of the 8 centers, 4 have a surgical room.
The study identified 11 health centers that have both general doctors and gynecologists. All offer good quality services.

Since this study helped the project identify and qualify the interventions offered by the health centers, it has been useful for developing the referral network between the health promoters and leaders, associated doctors, clinics and pharmacies. Formation and strengthening of this network is one of the key project activities. This network is not only useful for obstetric emergency plans but for any health referral purpose. The project evaluators noted that promoters were aware of

and referred to the health centers and associated doctors in their areas as well as the CIES clinic.

In addition to training the staff, the project formed 27 community WARMI (women's) groups (out of 18 projected by EOP) and 11 KHARI (men's) groups (out of 12 projected EOP). Also, the project staff has surpassed all objectives in the provision of community education sessions. Each of the WARMI groups had developed birth-planning strategies for group members. These plans included knowledge by group members of what constituted an obstetric emergency and exactly what steps to follow in order to get to health services in a timely manner. These groups had also established emergency funds for transport to services.

At the time of the mid-term evaluation, the evaluators noted that project staff was not completely following the standard WARMI methodology. As a result, the communities were not being effectively developing solutions for community problems nor learning how to apply the process in solving other problems. However, at the final evaluation, the project had corrected this situation. In general, the sessions were very active with good participation by the community members and promoters or other community leaders led most of the groups. The numbers of groups had increased and each had made substantial progress in health and other development areas. The groups had gone far beyond health in their community development efforts once they passed through the first WARMI training cycle. The fact that the project staff speaks Aymara and relate well to the community populations has been a great asset to the project. In fact, the staff's community organization skills have grown dramatically since the mid-term evaluation.

STI and HIV/AIDS Prevention (20%)

Objectives:

- Increase the ability of women of reproductive age to identify at least 2 STI symptoms from 22% to 30%.
- Increase the ability of men between the ages of 15 to 49 to identify 2 STI symptoms.
- Increase the ability of women of reproductive ages to identify 3 methods for preventing transmission of STIs from 6% to 15%.
- Increase the ability of men between the ages of 15 to 49 to identify 3 methods for preventing transmission of STIs from 9% to 18%.

As can be seen from the KPC results, the project has surpassed its STI objectives. Among women of reproductive age, the percentage who recognize at least 2 STI symptoms increased from 22 percent at baseline to 45 percent. The percent who know 3 methods for preventing STIs went from 6 percent at baseline to 42.3 percent. Among men 15 – 49, the percentage who recognize 2 STI symptoms increased from 38 to 77 percent, and the percent who know three methods for preventing STIs increased from 9 to 56 percent.

In order to reach these objectives, the project has conducted several training sessions concerning prevention of STIs (see annex for list of training activities). The project has focused on key messages and syndromic management of STIs. According to annual and quarterly reports, 20

percent of the educational activities have been in the area of STI prevention.

During the first 22 months, the project activity provided refresher training to 10 staff, 80 volunteer promoters and 56 others, including adolescents. All staff and volunteers passed the course posttests with scores averaging 95%. In addition, the project conducted STD syndromic diagnosis and treatment training for associated doctors and pharmacists (who collaborate with CIES in El Alto) as well as 9 staff. This training constituted one of the initial steps in activating the network between the project promoters, the CIES clinic, associated physicians and pharmacists who have been referring to each other for services. In addition, the supervisors and promoters have worked with the pharmacies to develop educational panels placed in the front of the pharmacies. Each associated doctor and pharmacist distributes educational materials related to project intervention areas that are supplied by the project. The project has also worked with 12 different factories and police units and has educated approximately 3000 of these men in the areas of STIs, family planning, cancer prevention and others. The evaluators had the opportunity to observe a session at the police training center and interview officials afterwards. The directors of the station were very pleased with the training and offered to provide any assistance needed, including payment of instructors, to keep the training going. This is an important audience, not only because they are young men who are exposed to sexually transmitted diseases but also because they are in influential positions in society. The sessions are obviously having an impact as evidenced by the fact that the day after the session, the evaluators noticed police cadets attending the CIES clinic.

These educational efforts with the network and the WARMI and factory groups seem to be generating a substantial number of referrals to the CIES clinic. Throughout the project period, there have been close to 4000 referrals for STIs from project-related activities.

Birth Spacing (20%)

Objectives:

- Increase use of modern family planning methods among women who do not wish to have more children during the next two years from 22 percent to 35 percent.
- Increase to 100% the number of project personnel who can explain LAM (lactation amenorrhea method).

As can be seen from the KPC results, the project has gone well beyond its projected objective in terms of use of modern methods. At the final evaluation it was found that 84.4 percent of women who did not wish to become pregnant during the next two years were using a modern method of contraception.

Annual and quarterly reports document that all fixed clinic staff and 80 volunteer promoters and star promoters have been trained in the LAM methodology and are able to successfully train women and couples about how to use it. However, project reports noted the need to provide regular refresher training on this subject. The evaluators noted that all promoters interviewed

could explain the LAM method. In addition, a large number of WARMI group members mentioned using LAM after their children's births.

Corresponding to these objectives, all project staff and 150-190 volunteer promoters have been trained in family planning promotion and education. The promoters are all provided with condoms and pills by the project to sell at a small profit. Evaluators observed that promoters had a good understanding of birth spacing methods and their use, informed choice, and sexual and human rights. They also had and distributed informational materials to new users. During the project, promoters provided 1708 referrals for IUDs, 3327 referrals for new pill users and 1658 referrals for new users of Depo-Provera. The project reported steadily increasing sales of Depo-Provera with 369 in the second project year, 1212 in year three, 1840 in year four and 948 by the middle of the fifth year. According to clinic staff, Depo-Provera is becoming more widespread and the use of IUDs is decreasing.

Use of Depo-Provera in El Alto has dramatically increased since the mid-term evaluation. At that time, CIES was just beginning to participate in a Family Health International (FHI) sponsored operations research study on Depo-Provera in order to expand the menu of long-term temporary methods available in Bolivia. The study focused on Depo-Provera use delivered by volunteer auxiliary nurses living in the intervention areas. The research was funded by USAID through FHI. Volunteer auxiliary nurse promoters were trained in the administration of Depo-Provera through an agreement between FHI, CIES and CARE. This parallel activity to the child survival project expanded birth spacing options for couples in El Alto. The study results were used to advocate for a policy change that encouraged the MOH and other PROCOSI NGO members to consider using trained and well supervised community personnel in the administration of Depo-Provera, particularly in under-served areas. One of the interesting findings was that the women in El Alto weren't particularly bothered by amenorrhea.

Condom sales have only improved slightly since the time of the mid-term evaluation and have not reached the high level of sales that were achieved during the first two years of the project, when CIES, as a PSI partner, participated in condom promotional efforts. During the first year, CIES sold 4,498 condoms and sold 3,150 during the second year. Then the amount of sales dropped during the next three years to 1549, 1793 and 1700 respectively. As part of their agreement with USAID, CIES has only been selling Pantera condoms and these condoms may be too expensive for their customers. CIES is not a commercial distributor for Pantera and does not participate in marketing incentives and sales propaganda distribution. There also appears to be wide availability of cheaper condoms from other sources. Current condom promotional efforts now stress birth spacing and its importance in preventing STDs. At the time of the mid-term, the STD prevention aspect was not as heavily promoted. Many other organizations in El Alto are also selling Pantera condoms. Recently, CIES was given permission by USAID to sell other brands of condoms besides Pantera, and is currently researching the best products and options. During the final evaluation, some of the pharmacists commented that many of their clients in El Alto thought that condoms were the only birth spacing method available. The pharmacists thought this was because condoms were the only method being promoted recently through national level media campaigns. They asked that more national level media attention be given to the other methods. The evaluators also noted that condoms were the main methods being sold by project promoters.

As noted above, project volunteers are making referrals to the CIES clinic. However, CIES is still having difficulty documenting when referrals come from the promoters. Although the intake form has a space for notation of a volunteer promoter as a referral source, it is believed by project staff that community members may not identify them as promoters but rather as a "friend." In order to clarify this situation, the evaluators suggested that the intake interviewer ask for the name of the friend and note it on the form for later reference.

When the evaluators asked the KHARI or men's groups about what they'd learned, most of them talked about the importance of birth spacing and how important it had been for them to learn about being able to control the number of children they have. Many talked about not being able to have normal sexual relations with their wives for fear of having more unwanted pregnancies prior to learning about contraception. They also spoke about how the training and group interaction had helped them improve their communication with their wives and families. Most of the work is in marginal neighborhoods composed of new residents to El Alto who still maintain close contact with their communities of origin and many of these men were interested in bringing information back to their communities. They requested that CARE and CIES facilitate this process. In fact, several of them asked that the project train them as promoters so they could do this work themselves. This presents a great opportunity for expansion and multiplication of the methodology into rural areas.

Another thing the evaluators observed was how much of an impact membership in WARMI groups had on women's decisions about using contraception. Studies have demonstrated that women's fertility tends to drop as they increase their level of education. However, the evaluators noticed in speaking with the WARMI groups that most women began practicing birth spacing when they joined the groups, regardless of their educational backgrounds. This tendency may be influenced by the fact that these are rural women are coming into an urban environment who are looking for work outside the home. It is interesting that child spacing is a priority concerns for the groups.

B.2.c. New Tools or Approaches

Some studies conducted during this project addressed the Depo-Provera operations research. The successful implementation of this project not only allowed CIES to provide Depo-Provera on an expanded scale in the project area but also allowed the results to feed into country data that permitted the MOH to approve use of Depo-Provera as one of the official contraceptives provided by the government.

Of course, the most novel activity conducted by the project is WARMI methodology (see sections 2 and 3 of this report for more details). Several case studies have been conducted concerning this activity, some partially supported by the CS project. One study conducted by Ann Davenport in 2001[10], compared the original WARMI methodology developed by Save the Children in Inquisivi, Bolivia to the simplified method adapted by CARE in rural Potosi, Bolivia

[10] Davenport, Ann, "Evaluación de la Metodología Warmi (Simplificada)." La Paz. 2001. CARE, Save the Children, CIES.

and to the later adaptations made to the peri-urban environment of El Alto. Another case study, conducted by Tess Aldrich, an MPH student at Harvard[11] in February 2001 documented how the WARMI groups in El Alto were formed, the backgrounds of the participants, a description of how the groups function and their achievements, discussion of the roles and achievements of the "star promoters", and how the promoter's and group members' have been transformed through participation in the groups.

One of the recommendations of Ann Davenport's study, "Evaluación de la Metodología WARMI (Simplificado)", was that CARE and CIES write up the methodology used for the El Alto CS project. As a result of this recommendation, the CS project has contracted Yolanda Zeballos to write up a systematized analysis of the methodology used in the CS project.[12] The evaluators were able to review a draft of the document and made some suggestions to the project director regarding inclusion of more specific data about particular steps and adaptations made by the project from the simplified WARMI method used in Potosi.

B.3. Results: Crosscutting Approaches

B.3.a. Community Mobilization

Some of the cross cutting strategies involving community mobilization include the following**:**

- One of the major cross cutting strategies that has always been part of this project as well as the previous project is the **use of volunteer promoters** to educate and motivate the communities in the project area to practice better preventive health in the areas of diarrhea disease control, maternal health, family planning and prevention of sexually transmitted diseases. At the time of the mid-term evaluation the project was working with 80 volunteer promoters. During the previous project the number has been as high as 200. However, the project staff discovered that if they wanted to sustain quality services in this area, it is better to work with a manageable number of promoters that they could train and adequately supervise. There are finite number of supervisors (6) and the project staff found 80 volunteers to be a manageable number to work with. There is a high level of retention of volunteers (more than 70%) and the evaluators observed that they are well-supervised with 2 or 3 supervision visits a month.

  After the mid-term, the project staff discovered how to work more efficiently with "star promoters". These are volunteer promoters who have demonstrated certain leadership abilities to project staff by their ability to lead groups, superior educational knowledge and training, or organizing skills. As a result of a recommendation from the final CSX evaluation, the project staff began recruiting and training "star promoters". These stars have come to fill two important roles in the project: 1) 35 of the 80 volunteer promoters

[11] Aldrich, Tess. "Estudio Cualitativo sobre las Areas de Cambio en las Participantes de los Grupos Warmi." Feb. 2001. La Paz, Bolivia. Market Networks for Community Health II Project: USAID, CARE, CIES.
[12] Zeballos, Y. & Molina, M., "Proceso Operativo de Sistematización de la Experiencia Desarrollada en la Implementación de la Metodología Warmi/Khari.". Market Networks for Community Health II Project. October, 2001.

became "stars," and they could take over much of the volunteer promoter recruitment and supervision roles previously conducted by the supervisors. With this large number of "extra supervisors" available, the staff found that they could indeed recruit and supervise more community-based distributor (CBD) volunteer promoters. The number of active volunteers has grown to between 150 and 200. This group is also sustainable. Although they do request regular training from the project, the system runs itself on a volunteer basis. The PVs do receive a regular supply of contraceptives to sell, which CIES will have to maintain after the project ends but the activities and organization is well established. 2) A second role filled by the "stars" is that they of the main leaders of the WARMI and KHARI groups once the groups have passed through one complete cycle of activity. This is also self-sustaining because it demonstrates that the groups are capable of maintaining the development methodology and of seeking out other organizations to help them with activities they wish to pursue like literacy, credit, income generation etc.

A number of the VPs are members of the Juntas Vecinales, school boards, parents committees, manzaneras (municipality health workers), defensorías de salud (MOH community workers), to name a few. These multiple roles occupied by promoters also point to the important community roles they now play as well as the sustainability of their work after the project ends.

- **Associated doctors and pharmacists.** The project has developed a network of doctors associated with CIES (CIES provides the training, IEC materials and contraceptive supplies – and in exchange receives referrals and increased sales of contraceptives), local pharmacies, volunteer promoters and the CIES clinic. The project has provided several training events on syndromic management of STDs, contraceptive updates, correct application of Depo-Provera, when and where to refer patients for services, etc. to pharmacists and associated doctors.

  The doctors and pharmacists interviewed for the evaluation were very enthusiastic about this network. They were pleased about working with the promoters and serving as referral sources for community members. The pharmacists were pleased to have reliable sources when patients asked them where they should go for medical attention or if they realized the individual needed to consult a doctor. The general practitioner doctors also expressed that they were pleased to know about specialists they could refer to who were part of the network or worked with the CIES clinic. They were also glad to know about pharmacies in their area that charged reasonable rates. Over the project period, these groups have begun to work together and regularly refer to each other. El Alto is still a new and rapidly growing per-urban city, many of the practitioners are not well established and not yet part of this referral network.

  The network of associated pharmacists and doctors has recently formed a board of directors. This board will plan regular promotional events, such as education and promotional events at local markets. They are also forming a buying network among participating pharmacies that will allow them to keep their prices down and maintain a supply of medicines. Presently, the smaller pharmacies are having difficulty maintaining drug supplies amid the growing demands of the constantly expanding El Alto population.

This is an activity that the CIES clinic could easily coordinate with its own pharmacy activities.

- One of the new community mobilization strategies adopted in this project is the **WARMI methodology**, is a community-based strategy for improving maternal and neonatal health in areas with poor access to health services. Save the Children in Inquisivi, Bolivia originally developed this methodology. It was then simplified by CARE in rural Potosi and has been adapted again for use in El Alto by the CS project. This methodology allows participants to recognize and analyze their problems, prioritize them and then, through a structured process, design and implement their own solutions as a community. An evaluation and next steps planning stage then follow these phases. This is the first time that this methodology has been applied in an urban setting.

  As a first step in initiating this process, the project trained the staff in the simplified WARMI method developed by CARE Potosi. Next they contacted numerous neighborhood governing boards (Juntas Vecinales) and other organized community groups. Later, they selected and approached organized community women's groups and invited them to participate in the program. During the last two years the project began to work with men's groups in the community in an effort to educate and mobilize them around issues of maternal and newborn health. These groups are called KHARI (Aymara for men).

  At first it was difficult to convene the groups. The project began working with a few groups and more people from neighboring areas began to approach the staff and ask them to participate. At the mid-term, there were 11 WARMI groups and 3 KHARI groups. By the end of the project there were 24 WARMI groups and 11 KHARI groups.

  The community leaders are usually surface during the group-planning phase. The groups tend to take on an organized direction and structure. For example, many of the groups form governing bodies that include a treasurer who collects dues from the rest and establishes a fund to be accessed by the group whenever emergencies occur. The majority of the WARMI groups had established emergency funds with rules for the use of the funds.

  At the mid-term, the WARMI process seemed to be generating community participation, but there needed to be more refinement of the methodology. The process as it was being practiced tended to impose solutions on the community groups rather than guide them to discovering their own solutions for problems. In some instances the steps were out of order, with solutions being promoted by staff before the problems had been identified. This situation was improved after the mid-term with further training and supervision of use of the methodology by CARE Potosi staff.

  One of the adaptations made in El Alto was the establishment of separate women's and men's groups. This was done initially for convenience because the men could not attend meetings until after working hours and the women could not attend at night because of household duties. So the groups met separately and this proved to be very successful. One of the by-products of this decision was that the participants in the women's groups

seemed to find a way to express themselves more easily than if there had been men in the groups. In Potosi, for example, the men tended to dominate the mixed group meetings. Since there were men's and women's groups occurring simultaneously, growth was taking place on an equal basis. When evaluators asked participants about what they'd gained from the groups, most responded that there had been improved communication and understanding with their spouses and families.

According to the studies done on the WARMI process (see section 2.b. of this report on the maternal health intervention) and the evaluators' findings, the women who participated in the WARMI groups stated that they enjoyed tremendous individual and group satisfaction because they experience personal growth, empowerment and group transformations. Their family lives, attitudes and behaviors that are not always directly related to health issues, also improve. As Ann Davenport notes in her report: "The attitudes of participants have changed and they have new perspectives on their ability to make positive changes, both on the personal and community levels. They are more aware of their identities, and their sexual and reproductive rights, and their rights and the rights of their communities to health care. They have learned to be more "responsible" for their health, to use health services, and to demand higher quality services. They enjoy a greater sense of belonging to the community, and are self motivated to implement the WARMI methodology. They are eager to learn and to share their knowledge with others. They are clear about the WARMI methodology objectives and on how to apply their training in a practical manner."[13]

The work of the groups has been recognized within their surrounding communities and this has inspired other communities to request that WARMI groups are formed in their areas. The evaluators also observed that among the men's groups, there was an overriding concern about being able to expand the KHARI group work to their rural communities of origin.

The most significant benefit of this WARMI education process is that beyond increasing awareness and improving practices in the area of maternal and child health, the methodology has been applied to other areas of community concern. Many communities, after using problem identification and planning to address community-wide problems, have gone to the Municipality and other government bodies to ascertain electricity, potable water and sewage systems for their communities. One group managed to dam up a river of contaminated water flowing through their community, and close a factory that was spewing noxious gas substances into their area. All these achievements have strengthened the sense of community empowerment and an ability to solve life problems, which go well beyond the goals of the CS project. This kind of consciousness raising process has often been demonstrated in work with literacy, education and credit programs. This project provides a good example of how awareness and community development can also be stimulated through health education activities.

- **Education of community leaders**. As a key strategy, the project identified community

[13] Davenport, A. "Evaluación de la Metodología Warmi (Simplificada)," 2001. USAID (CARE, CIES, Save the Children).

leaders such as members of the Juntas Vecinales (neighborhood governing boards) as necessary supporters for the mobilization of the project. For this reason, the project spent time educating and interacting with these leaders (for example, during the health facility assessment study) so that they would understand the importance of the project activities for their community members. During this consciousness raising process, the leaders were motivated to make requests for some of the project education activities such as formation of WARMI groups, informal talks, education sessions, and others. As these groups have evolved and leaders have been formed within them, many have become members of the Juntas Vecinales and other governing bodies in their communities.

- Through its promotion activities, the project has also been working with **organized groups** such as factory unions, military units and the police. In fact the project discovered that male promoters were very effective in working with these largely male groups particularly in the area of STD prevention and family planning. The project has added two male supervisors and several male promoters to organize and expand these efforts. The evaluators attended an education session being conducted with police recruits and found that the students and the authorities were very enthusiastic about the program. They even offered to continue paying for the educator's time after the project ends.

B.3.b. Communication for Behavior Change

As shown in the final KPC study, there appears to be significant change in the knowledge and behaviors practiced by the target population in El Alto. At the time of the mid-term evaluation there was some evidence that the behavior change strategies were successful from the results of a water and diarrhea census conducted in four of the project neighborhoods. 72% of mothers interviewed knew about oral rehydration salts and 77% of these knew how to prepare it correctly. 82% of these had given ORS salts to children during diarrhea episodes. 44% of the families interviewed were drinking boiled water. At the time of the final KPC it was evident that knowledge levels had increased dramatically with 87 percent of mothers with children under 5 years able to identify signs of dehydration; 75 percent recognized 3 or more symptoms of diarrhea and; 90 percent knew that ORS salts prevented dehydration. Likewise 38 percent of women recognized 4 or more danger signs during pregnancy and 57 percent of women knew 3 or more reasons for seeking medical attention during pregnancy. Likewise knowledge about STDs increased among women and men of reproductive ages. The KPC noted that 45 percent of women and 77 percent of men could identify at least 2 symptoms of STIs and 42 percent of women and 56 percent of men knew at least 3 methods for preventing STIs.

The KPC also demonstrates that there has been significant behavior change in the intervention areas as a result of project activity. 24 percent of mothers began using CLARO water purification bottles for their drinking water. 88 percent of exclusively breastfeeding mothers gave either the same amount or more breastmilk to their children when they had diarrhea. 95 percent of non- exclusive breastfeeding mothers gave the same amount or more liquids to children with diarrhea and 93 percent of mothers gave the same amount or more food to their children during diarrhea episodes. As a result of project activity, it was found that all of the WARMI and KHARI groups had developed Emergency Obstetric Complications birth plans and

had established emergency funds. One of the biggest changes in the area of behavior was the increase in use of modern contraceptive methods from 22 percent at baseline to 84 percent, among women who did not wish to have more children during the following 2 years.

The educational activities conducted by the staff in the three districts or 31 neighborhoods of the project area include messages and skills directed at changing behavior. Through July of 2002, 62,368 women and 19,351 men participated in educational activities. Also during the project, 6,611 educational talks a total of 81,721 participants. The educational sessions are directed at encouraging behavior change by increasing use of family planning methods, preventing STD transmission, preventing and treating diarrhea disease and encouraging women to seek preventive medical care during pregnancy and recognize danger signs. In addition, CIES has also sponsored several radio campaigns encouraging the preventive health behaviors mentioned above.

The project used the results of the water and diarrhea census study to promote better hygiene, encourage drinking of purified water, and educate mothers on the recognition of dehydration. The large number of project communities that now have potable water has greatly reduced diarrhea incidence in the project area. The WARMI and KHARI groups have worked hard to motivate and organize communities to acquire potable water systems.

According to CIES's data, there has been a steady increase in the use of Depo-Provera as a method of family planning (more than 100 percent of CIES's projected goals). Project volunteers make regular referrals for IUDs, Depo-Provera, and pills. An increasing number of people are referred for STD diagnosis and treatment.[14]

Much of the project's educational activities, particularly since the mid-term, have been delivered through the community WARMI group meetings. These activities encourage participants to develop behavior change strategies that will improve pregnancy and other health outcomes among women of reproductive age. These include seeking prenatal care, being aware of danger signs and developing plans for dealing with obstetrical emergencies, prevention of STIs and child spacing. To date the project has worked with 24 WARMI groups and 11 KHARI groups.

B.3.c. Capacity Building Approach

B.3.c. (i) Strengthening of the PVO and local Partner Organizations[15]

The CARE-CIES partnership has been a new and exciting arrangement for both institutions. CARE has a global policy directed at enhancing its work through partnerships with other organizations and CIES was interested in strengthening its own institutional capabilities through work with CARE. At the time the partnership was proposed (during CS X), it was thought that CIES would become a stronger organization and gain experience in working in diarrhea disease control; and CARE would gain experience working in urban areas, in reproductive health, and in

[14] Monasterios and Carrazana. "Autoevaluación del Proyecto Bol 026." La Paz. 2002. CIES/CARE.
[15] Because institutional strengthening of the PVO and the NGO partner are interrelated, the authors chose to discuss them together rather than separately.

learning the advantages and disadvantages of implementing projects through partnerships.

At the time of the final Evaluation of CS X, an effective working relationship seemed to have been established between the two organizations and this has strengthened through the current project. The first project saw many administrative adjustments and negotiations required in making the partnership work. The major issues centered around the internal interests and autonomy of the two organizations, and meeting CARE's contractual obligations with AID.

One of the issues in implementing this project and the previous project through a sub-agreement arrangement is that the CARE project manager (the only full-time CARE staff person) is responsible and accountable to CARE for all project resources and results, but has no direct authority over CIES's project staff nor its management of resources. The CARE project manager has a legitimate role in overseeing, monitoring and contributing to project implementation. Thus, CARE's influence resides in the precision and clarity of the subcontract, obtaining agreement to strategic objectives, operational plans, clarity and respect for roles and responsibilities, and ultimately on the strength of human relations, good will, and mutual respect of the individuals involved. The current CARE project manager has excellent relationships with the CIES staff and is appreciated for her support and dedication to the partnership and project functioning. In fact the CIES staff consider her very much a member of their own team. Unfortunately, since she is the only CARE staff member involved in the project (the previous health officer involved in the project recently left), CARE's direct involvement at project operational levels and integration of CIES staff into CARE is not as evident.

Both institutions have considerable experience in implementing health projects and in managing finances and program agreements from diverse donors. CIES staff has considerable experience in family planning and reproductive health. CIES provides these services through 10 regional centers in the major cities of Bolivia. CIES field staff is experienced in working with volunteers and community groups and have always promoted reproductive and sexual rights.

Early in the previous project (CS X) there were two project management areas that needed attention. The first was the inadequate financial management capabilities of both the CARE project manager and the CIES deputy project manager. The second was the inadequate structure, leadership and operational planning capabilities of the field coordinators and supervisors in El Alto. Most of these problems had been resolved by the end of the project. The members of the CS XIII final evaluation team found that both the CARE project manager and the CIES deputy project manager were jointly working with the financial offices of both institutions to facilitate any financial management issues. In addition, CARE decided during CSXIII to treat CIES as a financial subcontractor and turn all responsibility for subcontractor financial transactions over to them. CARE maintained its management role through regular project audits and review of reports. Thus, CARE was not responsible for regular financial monitoring of activities, which greatly facilitated project administration. Through this arrangement, the project budget is well-monitored and there do not appear to be any problems with expenditures. As a result of this careful management and cost savings measures, CARE and CIES were able to save enough funding to permit an additional year's extension of project activity. Also, as noted in other sections of this report, the supervisors and the promoter coordinator are very well organized and have regular planning sessions to assure compliance with project objectives. The coordinator of

the CBD activities has taken on a very strong leadership role with the supervisor team and has been a real inspiration in motivating and directing them in their activities and in interfacing with the CIES deputy project coordinator and the CARE project director. There appears to be a very strong spirit of cooperation and collaboration among all parties involved in this project.

During the first project, part of CARE's role was to assure that CIES "as an institution will be strengthened through improved monitoring, evaluation and supervision systems for the CBD program.".[16] The CARE-CIES sub-agreement went further by stipulating that CARE would strengthen CIES by improving its information and supervision systems, training project staff in the development of the information and supervision systems, training staff in documentation of (CBD) activities, and providing technical assistance to improve financial management and reporting. In practice, the institutional strengthening has gone both ways, with CARE learning a great deal about working in partnership and about urban programming.

Significant progress has been achieved in developing the project information system (see Section IV.B of 1996 Mid-Term Evaluation) and in financial management capabilities (see Section 3.3 of final evaluation). As noted above there has also been significant and progressive improvement in the CBD supervision system, with expansion of the "star promoter's" role as promoter supervisors and recruiters. This has allowed an exponential expansion of the number of community-based health promoters that are now active in the project area. One of the areas that the project has strengthened for CIES, that was not anticipated, is the experience base from which to consolidate and expand its CBD program nation-wide through its other clinics. In another area, the child survival project has also allowed CIES to link the diarrhea disease control and maternal health promotion (WARMI) activities with family planning and reproductive health.

Some ways that CARE has contributed to CIES's institutional capacity include: articulating and systematizing program procedures and practices; improving the organizational structure regarding the CBD program; proposal development for PROCOSI financing and follow-on funding for similar projects; quantitative techniques for baseline survey, KPC and evaluation studies; providing models and training for detailed implementation planning (DIP). CIES was already working on many of these areas but this project has allowed them to be strengthened and expanded. As anticipated, at the end of this project CARE and CIES are leaving behind functioning systems for referrals, information exchange, supervision and logistics (contraceptives, ORS packets and Claro for water disinfection). CIES will be assuming the continuation of these policies, increased financial resources, and trained personnel to manage them.

B.3.c. (ii) Health Facilities Strengthening

CIES recently opened a new clinic in El Alto. This is a much larger clinic than the previous one with specialty services including gynecology, pediatrics, dental, ultrasound, x-ray and many others. It has expanded to include 10 beds for in-patient delivery services. Because of the

[16] Detailed Implementation Plan. 1995. P. 23

expansion, CIES is eligible and in the process of becoming a provider for the Seguro Básico government services and will be reimbursed accordingly. The CIES's clinic in El Alto provides services in maternal health, child spacing, STI treatment and pediatrics. Laboratory services include diarrhea and STI diagnosis, pregnancy tests and PAP tests, among numerous other services. The clinic performs pre-natal care and offers low cost sonogram services. Pediatric services include, well-baby check ups, vaccines and attention of severe diarrhea cases (see section 2.b. Detailed Plans by Intervention: Diarrhea Control for further details). CIES performs assisted births including cesareans and has a surgical room where tubal ligation is performed. CIES can also provide vasectomies. CIES refers complicated maternal and pediatric cases to government hospitals, "Los Andes" and "20 de Octubre" in El Alto and the Children's Hospital and the Women's Hospital in La Paz. The hospitals offer referral services in obstetrics, pediatrics, and general medicine.

CIES has agreements with the Bolivian Ministry of Health and the Mayor's office in El Alto. CIES provides health information to the national health information system and participates in local and national health information committees where problems are discussed and activities coordinated.

Other important partners in this project are NGOs such as ProMujer (Women's credit programs) and Gregoria Apaza (promotes women's issues) who work in El Alto and whose groups of women receive education from the project and the El Alto Regional Ministry of Health. CIES also has a good relationship with other NGOs, such as CRECER, CIMCA, USFA and UDSEA. These organizations work with women's groups in credit and other development areas and CIES provides these women's groups with education and services about reproductive health. In addition, the project supervisors and promoters are working with a number of factories in the area, such as the Kristi factory, in the provision of reproductive health information and services. One of the outgrowths of this project is that CIES and four other organizations operating in El Alto successfully competed for funds from PROCOSI to develop the "Collaborative Project." The goal of this project has been to use the CS project as a model and strengthen the referral networks among themselves and the market networks developed by the project.

As noted in the previous section, the project and CARE have contributed significantly to strengthening the CIES clinic in El Alto. Specific areas that have been strengthened include: improving its information and supervision systems, training project staff in the development of the information and supervision systems, training staff in documenting (CBD) activities, and providing technical assistance to improve financial management and reporting. The evaluators were able to observe the CBD team plans that are developed regularly during monthly and weekly meetings. These plans are followed up at the next team meeting and adjusted accordingly. The supervision system appears to be particularly strong.

Early in the CS XIII project, the staff conducted a study to identify all the referral centers in the project area. The project met with Juntas Vecinales from 92 neighborhoods and discovered that there were 24 adequately staffed health centers in the area and many of these were from the MOH. Since then and through the "Collaborative Project" the CS project has developed relationships with other MOH and municipal services. The project has actively sought to include these services in the referral and "market network" of services available to community members.

The evaluators verified that the project promoters were referring patients to these health centers when it was not convenient or necessary for patients them to go to the CIES clinic.

One of the purposes of the project is to build and to leave in place a network of volunteer promoters, community physicians, pharmacists and cooperating health services which will continue to provide education, information and supplies to project beneficiaries. In addition to the incentives of profits, fees and customers, these health personnel will benefit from officially belonging to the CIES health network and the system of cross referrals within the network. It is expected that they will continue to serve their community, with on-going coordination from CIES. As mentioned above, this network of pharmacists, promoters and associated doctors has now formed a board of directors, which will oversee joint community promotional events as well as address pertinent issues of joint concern.

B.3.c. (iii) Strengthening Health Worker Performance

One of the tools that the project has used to improve performance of supervisors and health promoters is the job description document entitled "Manual de Desempeño". The document has been revised several times and serves an important function in clarifying roles and responsibilities and as a supervision tool for annual evaluations for all project staff. The staff developed a form based on one of CARE's documents, then CARE and CIES evaluated the staff together, to make joint decisions regarding how to strengthen the work of the employee, support them in undertaking a necessary activity or in the worst case, terminate an employee.

The evaluators observed that all staff and volunteer promoters had copies of their job descriptions and that they were satisfied with the supervision they received. They appreciated the supportive supervision and attention they received from project staff in the performance of their job functions. Whenever a problem is detected during the monthly supervisory sessions with the promoters, then the supervisor addresses the problem, correcting it and making sure that the volunteer has all the necessary tools for fulfilling the task appropriately. The supervisor then follows up during the month to make sure the problem is resolved. If the supervisor has a problem she can not solve in the community or if she has another problem in her work, then the field coordinator works with this person by accompanying them in their work, observing the problem and offering solutions as appropriate. In general, most of these problems are resolved with more education or training.

The supervisors and the coordinator have formed a very close-knit team. They meet weekly to plan activities and schedule events. They also meet monthly with the promoters and conduct review sessions. They work individually, in pairs or smaller teams depending upon the demands of the job. Their job responsibilities have evolved, especially since the mid-term evaluation. Now, in addition to supervising their own groups of promoters, the supervisors also manage the work of the "star promoters" who are also recruiting and supervising their own promoters. In addition to overseeing CBD activities, these "star promoters" also lead most of the WARMI and KHARI groups. Also as noted in the document in the ANNEX, these promoters are fulfilling multiple leadership roles in their communities. So in general, all the health workers roles have been strengthened by the project.

B.3.c. (iv) Training

Training of project personnel and CBD promoters is the main strategy being implemented by the project to reach its objectives. The project developed a training plan at the beginning of the project and at the time of the mid-term evaluation, was reasonably on-target with this plan (see Annexes).

Initially the Supervisors and Coordinators and other project personnel are trained in a new area. Then, the trained staff offers courses to the CBD promoters. The purpose of training all the staff is to assure that everyone uses the same language, standard concepts, the same kinds of teaching tools and to assure that they provide refresher training using the same methodologies with promoters and communities.

As a strategy for strengthening project training activities, each of the initial (TOT) workshops included a field-based activity that was conducted in each of the supervisor's project areas. This allowed the supervisor/trainer an opportunity to receive individual feedback on site. Then training was provided to the promoters by the supervisor/ trainers under the guidance of the training consultant in each of the different intervention areas of the project. Thus, the training consultant and supervisor/trainers worked together in workshop preparation and in providing and receiving feedback. In addition, for each training workshop there were pre- and post-test results from each of the participants, which gave an indication of training effectiveness.

Overall, the training conducted by the project has been strengthened by:

- The contracting of a training specialist who oversaw the training process from the planning stages to the evaluation and follow-up activities.
- Coordination with the LINKAGES project to provide updated training on LAM, breastfeeding and complementary feeding.
- The assistance of the La Leche League in selected training activities.
- The training of personnel in the IMCI system to strengthen training skills.
- Follow-up training in the WARMI methodology.
- Participation of project personnel in some of CARE's related internal training courses.

To date, the project has conducted training for staff and volunteers in the following areas:

- WARMI methodology training.
- Training Skills
- How to Effectively Use IEC Materials
- LAM Training (Lactation Amenorrhea Method)
- Maternal Health
- Using Standard Key Messages for Infectious Disease, family planning and STDs
- Marketing Techniques
- Syndromic Diagnosis of STDs
- IMCI Workshop for MDs

- IMCI Workshop for Educators
- Monitoring and Supervision
- Referral System Networking (M.D.s)
- Referral System Networking (Pharmacies)
- Treatment of STIs (for associated MDs and pharmacists)
- LAM, Breastfeeding and Complementary Feeding
- Effective Group Education
- Community IMCI
- Dealing with Menopause
- Masculinity Workshop
- Human Relations and Teamwork
- Counseling and Orientation
- Moral Leadership and Political Effectiveness
- Solar Method for Disinfecting Water

Although the evaluators did not directly observe a training course, the staff and volunteers generally appeared knowledgeable and confident about the intervention areas.

Given that one of the major strategies of the project is to strengthen the referral network between the CIES clinic, the community promoters, the associated doctors and pharmacies, it is noteworthy that the project continuously provided training activities for the participating pharmacies and doctors. It is anticipated that CIES will continue to provide training activities like these in order to strengthen the "network," which is coordinating with the clinic and providing regular referrals. The evaluators noticed that there were a number of referrals from pharmacies in a quick survey that they conducted among waiting patients during the final evaluation.

Training strategies in the project have evolved over the course of the five years. In the fourth and fifth years of the project, the role of the star promoters has become particularly noteworthy. They began to not only participate heavily in community and promoter training activities but to also co-facilitate the training. Their skills were monitored and strengthened by the supervisors as well as the use of training guides along with the development of "Key Messages" guides, which have been developed by the training consultant and produced by the project.

At the time of the DIP, the plan was to reduce the number of training activities for volunteer promoters by the fourth year because most would have completed all the training by then. However, given the development of "star promoters" and their expanded activity of recruiting new promoters, the project found that it needed to continue with promoter training. The difference is that the "star promoters" are now conducting much of this training.

Another interesting event that has occurred as a result of close coordination between CIES and CARE, is that now each organization sends members of its staff to training events sponsored by the other organization. There is a mix in levels of staff at training events – i.e. supervisors and promoters may often attend the same training events and then together reproduce the training for community groups. Through this process, the staff has become more relaxed and flexible in their

training strategies.

B.3.d. Sustainability Strategy

The Detailed Implementation Plan emphasizes the following key points in its sustainability strategy:

The project will achieve lasting changes on three levels:

1. By the end of the project, the community will have incorporated a variety of health seeking behaviors related to diarrhea case management, maternal and newborn care, STD/HIV/AIDS prevention and birth spacing. These behaviors will maintain the demand for services, which the service network will have established through this project.

2. The project will leave in place a network of volunteer promoters, community physicians, pharmacists and cooperating health services, which will continue to provide education, information and supplies to project beneficiaries. In addition to the incentives of profits, fees and customers, these health personnel will benefit from officially belonging to the CIES health network and the system of cross referrals within the network. It is expected that they will continue to serve their community, with on-going supervision from CIES.

3. The third level of sustainability is a strengthened local health outreach system operated by CIES. This system will have increased CIES's capacity to provide periodic supervision, training and supplies in support of the market distribution network. CARE will leave behind strengthened systems for referrals, information exchange, supervision and logistics (contraceptives, ORS packets and Claro for water disinfection). CIES will assume the continuation of these policies, increased financial resources, and trained personnel to manage them.

This strategy was developed with CIES during the development of the proposal.

According to observations made by evaluators, the project has made progress in all three areas. From the final KPC study, there is strong evidence that the health seeking behaviors of the project population have improved steadily from the beginning of the original CS X project (1994-1997) through to the end of CSXIII (1997-2002). Additional studies conducted during the project such as the Water Use Census, the 2000 Iglesias Diarrhea study[17], and the two studies conducted on the WARMI methodology[18],[19] as well as the data from the project's monitoring system indicate that

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[17] Iglesias, I. 2000. *Estudio Encuesta Muestreo sobre prácticas y conocimientos de Enfermedad Diarreíca Aguda en la Ciudad de El Alto.* CARE/CIES

[18] Davenport, A. 2001. *Evaluación de la Metodología Warmi (Simplificada).* CARE/CIES Save the Children.

[19] Aldrich, T. 2001. *Estudio Cualitativo sobre las Areas de Cambio en las Participantes de los Grupos Warmi.* CARE/CIES

people in the project area are increasing their health seeking behaviors (see section 2.b.of this report).

As mentioned in the previous section, the project has made progress in the establishment of its network of service providers in the El Alto area. The network includes the CIES clinic, volunteer promoters, community physicians, pharmacists and cooperating health service providers. The number of MOH service providers has increased since the mid-term evaluation, especially with the cross-referral system brought about through the new "Collaborative Project" funded by PROCOSI. CARE and CIES spearheaded the development of this project (along with 3 other NGOs), which is modeled after the market networks concept in CSX and CSXIII. By the end of the last project the CIES clinic and the health promoters had a strong presence in El Alto. In the CSXIII project, the staff has worked on enhancing the relationship with the community physicians through the CIES Associated Doctors program, and on building relationships with pharmacists through training programs and coordination meetings. The evaluators were impressed by the enthusiasm of the pharmacists and doctors about the network and their interest in coordinating with CIES. As mentioned in other sections of this report, the pharmacies and doctors have formed a board of directors and are now planning joint promotional events. This provides good evidence that their activities will be sustained after the project ends. There is also evidence that the project has continued to build relationships with the 24 health facilities in the project area that were identified by the health facilities survey. These relationships have been strengthened through the "Collaborative Project," which will be continue a while longer in El Alto.

CIES is continuing to build its capacity and has the ability to provide periodic supervision, training and supplies in support of a market distribution network. CIES's management of its associated doctors program demonstrates this ability and local doctors that want to be affiliated with them are provided with training, supplies and periodic visits by the program coordinator. The market networks approach was built on this associated doctors program by adding pharmacies and coordinating with the community promoters. CIES already has systems in place for referrals, information exchange, supervision and logistics (contraceptives, ORS packets and Claro for disinfecting water). During the final evaluation, the evaluators conducted a brief survey of waiting patients and found that a number of them had been referred by the network pharmacies, so the system is clearly benefiting CIES. It will be of obvious benefit for CIES to continue strengthening this network through training and regular contact.

In addition to these factors, CIES and CARE have continued exploring mechanisms to sustain the project after the project ends. It is assumed that CIES' cost recovery mechanisms will help support supervisory staff needed to maintain the service network after the CS XIII project ends. In addition, CIES is expanding CBD networks in its clinics in other areas of Bolivia and some CSXIII staff members have already taken jobs in these areas. CARE and CIES have already acquired one project (the Collaborative Project) that supports and expands the project efforts, and staff members are also actively searching for additional projects that can be built on the CSXIII activities in El Alto. This network is cost effectiveness because a limited number of volunteers who are able to reach a large segment of the El Alto population. This is enhanced by the project's easy access to the target neighborhoods. Cost effectiveness is also fostered through the

incorporation of community physicians, pharmacies and cooperating health services that charge fees for their services and therefore will not have to be paid from other sources.

Since community outreach activities began under the CS X project, demand for services in CIES' clinic has risen. In 1994, CIES attended 6,000 consultations. In 1995 the number reached 10,500 and climbed to 12,000 as of September 1996. The CS X project doubled the demand for services in the CIES clinic. Clinic attendance continues to be high during the CS XIII project. Community outreach through the child survival projects is helping to ensure the financial sustainability of the El Alto clinic.

One of the significant innovations developed in CSXIII and greatly enhanced since the mid-term is the strengthening of the "star promoter" role (see section 3.a. for details). These "star promoters" are now leading WARMI groups and recruiting and supervising their own promoters and co-training the promoters with the project supervisors. This enhancement of the "star promoter" role has allowed the project to greatly increase the number of active CBD promoters beyond the projected 80. It is now between 150 and 195. In addition this has been done at very low cost to the project because these "stars" are volunteers. The project has provided incentives and training only. This system is self-sustaining because the stars can continue to operate in their communities maintaining and coordinating the promoters with a minimum of support from CIES.

The project has now formed 24 WARMI groups and 11 KHARI groups. The majority of the groups have completed at least two cycles of diagnosis, planning, implementation and evaluation and moved from just addressing health concerns to other development issues. These groups now have their own leaders, many of whom are star promoters, and set their own agendas. Many of these groups are functioning independently now and will be able to continue developing activities after the project ends. However, there are groups that formed more recently that are now completing their first cycle or beginning their second one and these groups will need support to continue functioning. Many of these are men's groups since the project was not able to start men's groups until well into the fourth year. Hopefully, CIES and CARE will be able to find a way to continue working with these groups since they effectively motivating their communities in health and development.

The project staff has continued to work on strategies for presenting project proposals to potential donors for part of the existing project, a related project or an expansion of the project into some other regions. T he results of the final evaluation will be presented to an audience of potential donors by CIES and CARE during the fall of 2002. There appears to be significant interest in continuing project activities after the child survival funding ends in September 2002.

C. Program Management

C.1. Planning

At the beginning of the CS XIII project, the staff developed a detailed implementation plan (DIP) and the planning process involved all project staff. Involving the staff made the process slower, but it assured their understanding and commitment to the process. In addition, each staff member is involved in development of the CIES annual operational plan. Each staff member develops his or her own monthly plan of activity in keeping with the overall operational plan.

Each staff member has a copy of the program objectives as well as a summary of the detailed implementation plan. The staff are expected to have an understanding of the project plans so that they can be prepared for the monitoring activities conducted at weekly and bimonthly El Alto staff meetings between the Clinic Director, other project staff and CBD project staff.

The CBD coordinator and the supervisors also meet on a regular monthly basis to review progress. The promoters also attend these meetings.

The evaluators reviewed the work plan with the staff and the project has been on schedule with the bulk of its planned activities. When an activity is not occurring as planned, then the coordinator sorts out the reasons for it and either reschedules or changes the activity so it can be completed appropriately.

C. 2. Staff Training

As noted in section 3.C. (v) of this document, training is the one of the key strategies employed by the project in order to reach its objectives. All the project staff and volunteer promoters have received basic training in all project intervention areas. As noted above most staff members appear knowledgeable and confident about the intervention areas. The training specialist and the CBD coordinator continually monitor the quality of the training. In addition, all courses include pre- and post-tests and evaluations and the supervisors make follow-up visits to volunteer promoters in the field to address any misconceptions.

Presently, it appears that the resources allotted for training are more than adequate. In fact, the project was able to stretch training funds to cover more training activities than originally planned. This was because the project staff found less expensive venues for to hold the training and split the training with other institutions and share costs.

Some of the overall lessons from building capacity of the staff include the fact that the staff members have learned to delegate their functions to capable community volunteer promoters. During the first project and the first part of the second project, the supervisor staff felt that they needed to do all the supervising, recruitment and training of volunteers.

The "star promoters" do all these activities now in addition to leading the WARMI groups.

Another lesson is that the project has learned to include different levels of staff in the training being offered by CARE and CIES. Project coordinators, supervisors and sometimes promoters may be invited to attend national training programs. These individuals are then expected to replicate the training for others back in El Alto. This strategy has been successful in building confidence and skills among all levels of staff.

C. 3. Supervision of Program Staff

As previously noted (see section 2B(iv), health worker performance) the project supervision system is one of the strongest areas of the project. The project managers, coordinators and supervisors understand that guidance and support are key to motivating volunteers and other staff. It also motivates staff to provide high quality service.

During the first year of the project, CIES staff received supervision training from CARE and also from Management Sciences for Health (who adapted some of CARE's training curriculum). The project staff then validated the training curriculum used.

Because the project decided to limit the number of promoters to 80 and because the staff use "star promoters" [20] to assist with supervisory responsibilities, there appears to be adequate supervision for the volunteer promoters. As a result of the work with the "star promoters" the number of promoters was increased to 150 - 195, since the "stars" could provide additional supervision. All of the promoters interviewed indicated they were satisfied with the supervision they were receiving.

C.4. Human Resources and Staff Management

As noted above each staff person and each volunteer promoter has a written job description. CIES also has a policies and procedures manual that the staff has copies of. Although the program tends to conduct informal supervision of promoters and staff during field visits, each employee's work is formally reviewed on an annual basis and recommendations are made for salary increases at this time. In addition, there is a personnel file with pertinent information for each project employee.

In general the morale of the staff is quite high. Even though the supervisors carry a heavy load, the expanded role of "star promoters" is easing the administrative requirements (staff are now reimbursed for transportation expenses and have resolved the 'mid-day time clock' requirement, which were issues during the mid-term) have all contributed to improved work satisfaction. In the past the field staff has worked well

[20] A recommendation of the CS X final evaluation was that the supervisors consider delegating some of their supervisory tasks to motivated and capable promoters or "star promoters". The project began working with these star promoters during CSXIII and the evaluation interviews indicated that they were highly motivated to do this work and were comfortable with the responsibility even though they were not paid. Each of those interviewed was responsible for between 2 and 8 promoters. Some lead WARMI groups and many of them conducted PV training.

together but now the clinic staff and field staff have formed a strong team. The clinic staff recognized the important contribution that field staff (supervisors and promoters) makes in bringing patients to CIES. During the last two years, the clinic personnel (clinic director (DTA), Lab Technician and nurses) have been actively involved in field activities, particularly the WARMI events. The clinic staff has also conducted several Pap smear campaigns in the local communities. Also the supervisors take turns greeting patients and seeing that they are attended appropriately at the clinic. In the past the clinic receptionist did this, but she often did not have time to deal with the patients suitably as she was also responsible for the accounts. In addition the CBD program coordinator has taken on a much more proactive role than she had in the previous project. She has learned how to provide leadership and direction as well as maintain good human relations with her staff. All of these factors have contributed to a high morale among the project staff and clinic staff. The clinic director has also played a strong role in motivating employees. He was not as involved during CSX but he has come to recognize the importance of the community work and collaboration in this work is.

In general there is good retention of staff. Most staff members have only left because of illness or because the project is ending. The level of retention of volunteer promoters is also higher than it has been in the past, with a rate of 70%. Reasons for this high retention are quality training and a strong supervision system. When staff and promoters were asked what suggestions they had to improve the project, many responded that they would like to receive more training. Thus, training appears to be a major incentive and motivating factor.

If CIES is able to maintain the field staff and the current level of supervision as well as the training, then the transition after the program will be straightforward. The major cost will be staff salaries and the added income from the increased number of patients may be enough to cover this cost. They are really getting a tremendous system for very little cost. The five supervisors and one coordinator are able to supervise enough “star promoters” to maintain a system of almost 200 CBD promoters as well as a referral network of 50 associated doctors and pharmacists. In addition, CARE and CIES are actively soliciting funds from other donors to offset the costs of the project (see Sustainability Strategy section of this report). CARE is very strong on job descriptions and has made sure that appropriate job descriptions have been developed for all project staff and are in place in CIES and at CARE, respectively.

C.5. Financial Management

As discussed in the capacity building section of this report, the financial management of this project has undergone successive improvements since the mid-term evaluation of the first project, CS X. At that time there were several difficulties in the administration of funds for the project. The funds were dispersed from USAID to CARE who then subcontracted funds to CIES. In addition, both the CARE project manager and the CIES deputy project manager needed more training to adequately manage the budget aspects of the project. However, by the end of the project these difficulties had been corrected and the project ended right on track with its projected budget.

The CS XIII project has been on target with its expenditures. Some of the training activities cost less than anticipated. The project was able to take advantage of these savings and other efficiencies to extend the activities an extra year. There have been some improvements in the financial management of the new project at CIES involving buying procedures, accounting adjustments, processing of checks in a more timely manner and other administrative modifications. The other big change in financial management of CSXIII was that CARE decided to treat CIES as an independent sub-contractor. CARE believed they had adequately trained CIES in the required financial management procedures during CSX, so that they could independently manage the financial aspects of the project. This has allowed much less management time to be spent on monitoring financial records etc. Instead CARE depends on regular audits and properly executed reports from CIES. In fact this model has served CIES well since they now have financial responsibility for the management of the "Collaborative Project."[21] The CARE financial manager for the project has a good working relationship with the CIES accounting office and the two teams are usually able to resolve most difficulties.

At the time of the mid-term the CIES administrators were able to allow for project personnel to be reimbursed for travel in the El Alto area, which has facilitated their work. The project also worked out an arrangement with the El Alto office so the supervisors were no longer required to punch in at a time clock at the CIES office at mid-day. This requirement may be normal for clinic personnel but it created difficulties for field personnel who often have to leave meetings early in order to reach the clinic in time to do this and then rush back in order to complete their work. Solving these problems did wonders for morale!

There was a recommendation in the final evaluation of CS X that suggested that the CIES assistant project coordinator should charge the actual amount of time she was spending on the project to the project rather than 80% of her time. At the time they thought it was about 20 to 30% of her time. To assure that adequate oversight continues, it was suggested that the clinic programs officer spend more of her time managing the project and charge this time appropriately. The intent of this suggestion was to assure that the budget realistically reflect actual project activity. Another purpose for this was to facilitate better coordination between the clinic and the CBD project, which was operating in isolation from the other projects at the El Alto clinic.

This issue was raised during a meeting the evaluators had with the CIES financial office during the mid-term evaluation. The director of programs had left El Alto and no one replaced her management role with the project. The CBD coordinator was named to the position but decided after working in that role for a while that she preferred her job as the CBD coordinator. As a result, the assistant program manager has assumed more management responsibilities in El Alto and is working beyond the 20% time budgeted in the project. The CARE project manager has also been spending a lot of time in El Alto so between the two managers and the CBD coordinator, the project has more than

[21] This project is funded by PROCOSI and its purpose is to develop referral networks between 5 NGOs and the Ministry of Health. The NGOs are CARE, CIES, SERVIR, Promujer, and Prosalud.

adequate coverage. In addition, coordination between the project and the clinic has improved tremendously so the there was not an obvious need for a clinic programs coordinator.

The one issue raised by the CIES financial office at the time of the final evaluation concerned the project automobile. According to the original CSX contract, CARE was supposed to provide CIES with a vehicle for the CS project. After the mid-term of CSX, an older vehicle was given to the project even though CARE did purchase a new vehicle, ostensibly for this purpose. CIES wondered why it was never given the newer vehicle. When the evaluators asked the care financial officer about this she explained that while the contract did require that CIES be given a vehicle, it did not stipulate for it to be a new vehicle. This is unfortunate since this older vehicle is the only one available to the clinic, is constantly used and regularly needs to be repaired.

C.6. Logistics

In general the project has not had difficulties in acquiring the logistical supplies needed. CIES acquires the contraceptives, ORS packets and other items distributed by the promoters. No vehicles or other major equipment items were budgeted for the CSXIII project.

At the mid-term the evaluators identified a need to acquire more IEC materials for distribution by staff and volunteer promoters in information dissemination and education activities. This has been done and the final evaluators noted that there were materials available at all the promotional and educational events visited.

C.7. Information Management

CIES has a good information management system both for the clinic activities and for the project. The health information system (HIS) for the CS XIII project is based on the system developed for the CS X project. The HIS provides information, which allows staff and service network participants to monitor activities and detect problems in order to ensure efficient project implementation. The system also provides evaluation information. The assistant project manager is responsible for managing the HIS.

Volunteers collect the following information: cases of diarrhea attended; number of ORS packets, Claro and contraceptives sold; contraceptive users and referrals to the service network. Field supervisors report on educational activities in the community, volunteer activities, supplies distributed to volunteers, WARMI and KHARI sessions and activities in the diarrhea focus project. The project counselor collects information on number of counseling sessions performed and on distribution of supplies. Community physicians provide information on number of patients attending, contraceptives distributed and number of referrals made. Pharmacies report on number of clients attending for project components. This information is consolidated into monthly reports by the field coordinator who adds information on training activities. This information is passed to CIES's central office where it is reviewed and checked for consistency of information by

the assistant project manager. She ensures that problems in the information reported are corrected and then sends this information to the project manager on a quarterly basis and internally to CIES's national information system on a monthly basis. The project manager analyzes the information and writes quarterly reports, which are sent to CARE-USA.

At each level, information is used for decision-making. Volunteers use the information that they collect to track their own activities and follow up on diarrhea cases and contraceptive users and ask for supplies. Field supervisors review this information with volunteers and identify and discuss problems.

The visiting physician coordinator reviews information with community-associated physicians and discussed problems and solutions. The supervisor in charge of pharmacies reviews information collected from pharmacies and also discusses problems and solutions.

Field staff meet with the supervisor coordinator and assistant project manager to review consolidated reports and monitor progress toward project objectives, determine supply needs, identify problems and plan follow-up activities as needed.

The project manager reviews monitoring information on a quarterly basis. Results of this analysis are discussed during project coordination meetings and activities are prioritized to address problems encountered.

Information for project evaluation is obtained through a KPC survey performed before project activities begin and repeated at the end of the project in order to measure change at the community level. Mid-term and final evaluations are performed by outside evaluators who review monitoring information and results of KPC surveys, who interview staff and members of the service network and who observe educational activities.

Information from the KPC surveys and the monthly monitoring system is being incorporated in community education activities to provide feedback to the community. Information is also being disseminated to the following groups and partners:

- Project staff during monthly meetings
- Volunteers during quarterly meetings
- The regional MOH via information committee meetings
- Other CARE Bolivia projects and development agencies in Bolivia through reports, workshops and conferences
- CARE-USA via quarterly reports and field visits of HQ staff during annual reviews and evaluations
- CIES through reports and meetings

The project tries to assure that staff and members of the service network retain essential knowledge, skills and practice through a variety of activities. Pre- and post-tests are being performed for participants in each training session (see training sections of this report). Supervisory visits are used to strengthen knowledge, skills and practice. Refresher courses are programmed to concentrate on weak areas detected during these visits.

Quality of service in the CIES' clinic is being measured using CIES' system of exit interviews, review of information obtained and actions taken based on this review.

C.8. Technical and Administrative Support

So far the project has received short-term technical assistance from several sources. One major activity has been the hiring of a training consultant who reviewed the training needs of staff and volunteers in their field sites and then developed the training program appropriately from the assessment. After the training was completed, she followed up with the staff in their field sites to be sure that needs have been met and addresses any concerns. The supervisors also follow-up with their individual promoters.

The project staff members have also received some technical assistance from Management Sciences for Health in the area of supervision training. Apparently the MSH curriculum used CARE course materials that were given to the previous CARE project manager and clinic coordinator, both of whom attended the CARE supervision training program (international CARE workshop for CS held in Nicaragua in May, 1998).

During the first half of CSXIII, the project received training from the Bolivian chapter of La Leche League International in LAM and promotion of exclusive breastfeeding. This was replicated for the volunteers. However at the mid-term LAM was not well understood, so CARE arranged for its LINKAGES regional coordinator to provide an updated training on LAM as well as breastfeeding to the staff. This training was later replicated to other staff at CIES and to community personnel.

Project staff also received training from CARE Potosi staff in the modified WARMI methodology. This methodology has been used in developing community awareness regarding maternal and neonatal care. As noted in section 2.B., this methodology has been adapted to peri-urban audiences and has been very effective in generating community awareness about health and in improving maternal and neonatal health. Although the mid-term evaluation noted that the staff had not completely grasped all the steps in the WARMI community empowerment process, the final evaluators found that this situation had been corrected. The groups were operating very effectively at the time of the evaluation.

CARE headquarters has made two visits per year to Bolivia to offer technical assistance. Also, CARE Bolivia has a new Reproductive Health sector coordinator who provides continual oversight of the project. In addition, the Regional Technical Advisor, based in

Guatemala, periodically visits Bolivia to provide staff training and technical assistance on pertinent topics such as improving the implementation of the WARMI methodology.

C.9. Management Lessons Learned

Some of the management lessons mentioned in other sections of this report include:

- The importance, in a community-based distribution and market networks project such as this, of the field staff having the support of the clinic staff and director. This partnership allows the field staff and clinic to mutually support promotion of clinic services and facilitates expansion of services into the community.

- If you have the right profile for community volunteer promoters and provide them with good quality training and regular supportive supervision, then you will be able to maintain a sustainable system with very little volunteer turnover.

- Once a system of volunteer promoters is established, it is possible to train a segment of them who are highly motivated and skilled leaders (star promoters), to recruit and supervise other volunteers.

- Once "star promoters" are trained by the project, they often begin to function as community leaders through WARMI groups, Juntas Vecinales, school boards, defensorías de salud, manzaneras and other leadership roles. In this way, the project is has a sustainable impact on development in El Alto.

- Because El Alto is a rapidly growing area, many of the local service providers are not familiar with each other, so a referral network of pharmacies and doctors is necessary. Training and network opportunities have been attractive to participants.

D. CONCLUSIONS AND RECOMMENDATIONS

Achievements

- There continues to be strong evidence of excellent teamwork in the project. This is demonstrated by the strong working relationship between CARE and CIES, the high level of integration of the project within the CIES El Alto clinic and the strong team of supervisors.

- The supervisors have been able to greatly expand their reach through the recruitment and training of "star promoters" from among existing promoters. These "stars" are recruiting and supervising their own groups of promoters, thus extending the network of volunteer promoters through a self-sustaining system.

- The project staff made several modifications on the simplified WARMI method adapting it to the peri-urban environment of El Alto. CARE in Potosi developed the simplified method from the original WARMI methodology developed by Save the Children in Inquisivi.

- This new adaptation of the simplified WARMI method that was applied to an urban environment and required the formation of separate men's and women's groups in different locales and timeframes, demonstrates the methodology's flexibility and capability of being applied outside rural environments.

- One of the biggest achievements in the area of sustainability is the spontaneous development among WARMI groups of looking for new projects and outside funding to continue their development process. The groups' initiative together with their creativity has allowed them to not only consolidate their own community funds for obstetric emergencies but to also go after funds available for development from the municipality. Sometimes these are rotating funds, some are loans for emergencies and in other cases they are direct grants. But in each case, this process resulted in a sense of community empowerment and confidence where previously there existed only a sense of fatalism.

- Many leaders and civil society representatives have been birthed out of the WARMI and KHARI groups. For example:

  - Presidents of the zonal school committees;
  - Presidents and vice-presidents of the neighborhood governing boards;
  - Membership in the Mayoral Health Surveillance Committees;
  - Leaders and organizers in factories or other places of employment where the WARMI/ KHARI groups have formed;
  - Group members have become representatives for the MOH and municipal health watch systems.

  In each instance, the WARMI method has not only focused on maternal health issues but also has been used as a springboard from which to generate a sense of social awareness and community empowerment.

- Evidence of a high level of retention of promoters (70%). This is most likely due to the high quality of training and the strong supervision system. In addition the support of the star promoters is allowing the supervisors to extend their reach.

- In accord with the final CSX and mid-term CSXIII recommendations, the project reduced the number of promoters to 80, a number that was manageable for the 6 project supervisors. However, with the advent of the thirty-five star promoters, the project decided that it could recruit more than 80 volunteer promoters. So now at the end of the project there are between 50 and 195 active promoters.

- Evidence of high quality training is provided by feedback from promoters, WARMI and KHARI groups and project staff through knowledge, skills and feedback. There is also evidence that the project is constantly trying to improve their training through the contracting of consultants and advisors.

- Because of the high quality of training and supervision that the volunteer promoters are receiving, they are being offered other community roles, such as being "health defenders" (MOH), "manzaneras" (municipality health representative), members of the neighborhood governing boards, and boards of education. These provide good examples of how the promoters' work will be sustained after the project ends.

- There is evidence that the pharmacy and associated doctors network has grown. There's much enthusiasm among members for their continuing work and referral system.

- The pharmacist and associated doctor network has formed a board of directors, providing further evidence that this association will be sustained after the project ends.

- The network of pharmacists, community doctors and star promoters are also doing a lot of promotion of reproductive and child health at local markets. This is further evidence of how these activities will be sustained once the project ends, since it is no longer only the supervisors that are doing these promotions.

- The project is producing high quality IEC materials including posters, flyers, pamphlets, flipcharts, referral cards etc. There is also evidence that the materials reinforce the program's key messages in all the intervention areas.

- There's evidence that the quantity of IEC materials available for distribution by volunteer promoters has improved since the mid-term. All the promoters interviewed had materials for distribution. The pharmacies visited were also well stocked with CIES's informative materials.

- The project seems to be reaching a significant number of men through educational activities conducted with the KHARI groups, factories and the police in El Alto. The talks emphasize prevention of STIs and family planning.

- Since the mid-term evaluation, the project has improved its quarterly reporting on volunteer promoter activities. These activities include: WARMI/KHARI group educational activities; referrals to the CIES clinic; referrals to community physicians, CBD sales, market promotions etc.

- The evaluators noted that the birth spacing education provided by the promoters is more comprehensive than it was at the mid-term evaluation. In addition to talking

about modern methods, they also educate women about LAM and calendar methods.

- According to project reports, the incidence of childhood diarrhea has decreased markedly. Project staff believe this is because many neighborhoods have been able to access and install potable water systems. Indirectly, this is the result of the work of the WARMI and KHARI groups, which have conducted education about diarrhea and organized requests to the municipalities for water systems.

- One of the project's greatest achievements is its promoter training methodology which includes an on-going system of supportive supervision whereby promoters continue receive job training. Another strength of the training program is the way that promoters and community leaders have been included in staff training programs. There is also a good exchange of training experiences between CARE and CIES in which members of one organization are invited to participate in trainings given by the other organization.

Issues

- CARE, CIES and USAID have all made a substantial investment in this project in terms of capital and human resource development. Now they are seeing a return on this investment in terms of the increased awareness and empowerment of people in El Alto and the increased number of people seeking services from CIES and other providers such as the Ministry of Health.

- Some of the WARMI and KHARI (42) groups are now capable of independently continuing their own community development activities after the project ends. Other groups (11) have still not completed enough training cycles to be able to function independently.

- The volunteer promoters interviewed said they do not have a problem being volunteers. They state that their work gives them a certain amount of credibility in their communities. They have become important people in their neighborhoods and feel a certain responsibility to educate and help the people around them. When asked what they would like to help them with their work, they inevitably ask for more training and education. This is because it is through this education that these promoters have become important resources in their communities that people look up to. They are concerned about how they will continue to learn new things and train themselves. Even though many of them are also MOH or municipality representatives, they don't receive the same level of training from these jobs as they have from the project.

- Although the pharmacists and associated doctors are organizing themselves and forming a board of directors in order to continue their activities, this has all

happened very recently and they will continue to need support and guidance from CIES for a while longer.

Recommendations

- CIES and CARE need to develop a joint strategy to preserve the gains that they've made with this project. They've made a huge investment in the formation of a well-trained and capable team. In addition the CIES El Alto clinic has gained significantly from the increased referrals from the groups, the pharmacies and the promoters. It is recommended that this project be presented as a model for achieving community participation and that CARE and CIES look for further funding to continue developing and implementing this model.

- Before the project ends, the staff need to work with the WARMI and KHARI groups to give them suggestions on where they can go to get more support for their group activities, such as other NGOs that teach community groups. Many of the groups are getting in contact with organizations that teach literacy or provide credit for loans. It is recommended that the project contact organizations in El Alto that have something to offer and are interested in working with organized community groups and then make the list available to all the WARMI and KHARI groups.

- It is recommended that CARE and CIES document lessons learned about health and community participation. This information can then be presented to other branches of their own organizations or at national meetings. It would also be useful to present this experience at international meetings such as the American Public Health Association and the Global Health Council.

- It is recommended that when the project staff develop survey instruments, that they use questionnaires that have been developed in accordance with international standards. This way it will be easier to compare results with other surveys made in the same area of study.

- The MOH health centers in the project area recognize the impact of the work that the CS project is having in their areas because so many people are seeking services from them. It would be important to make this project's activities known to other MOH centers that are interested in improving their services. Because although the MOH by themselves would not be able to do all the community work needed to motivate people to use MOH services, they could do it in association with CIES and CARE.

- The CSXIII project is preparing a manual, which will contain all the educational information developed by the project. It will be important to share this information with other organization, but to do this it will also be necessary to

provide training on how to use the materials and what techniques and methodologies need to be utilized.

- The project staff from CARE and CIES have been working together on a proposal for adolescent reproductive health. The objective was to work with adolescents associated with the families in the WARMI and KHARI groups. At this point it is uncertain as to when the project will be funded and which department it will be located in within CARE and CIES. If the adolescent project staff are going to work with the WARMI groups, they should coordinate with the project staff and, hopefully, involve them in the project.