CARE PERU

MIDTERM EVALUATION: CHILD SURVIVAL PROJECT XVI

FAO-A-00-00-00036-00; October 1, FY2000 -- September 30, FY2004

PROJECT REDESS: "HEALTH AND SOCIAL NETWORKS"

Consultant: Joan M. Jennings, MPH

CARE HQ Contact:
Dr. Elena McEwan
Technical Specialist, Children's Health
Health Unit
CARE USA
151 Ellis St. NE
Atlanta, GA 30303
Tel: 404-979-9413
Email: emcewan@care.org

CARE Peru Contact:
Carlos Cardenas
Country Director
CARE Peru
Aparto 11-0628
Lima 11, Peru
Tel: 51-14-317430
Email: cardenas@care.org.pe

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PROJECT REDESS

MIDTERM EVALUATION, AUGUST 2002

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ATTACHMENTS

ACRONYMS

BCC	Behavioral Change Communication
CDD	Control of Diarrheal Disease
CHA	Community Health Agent
CHP	Community Health Promoter
COACS	Community Health Agent Committees
CODECO	Community Development Committee
CS	Child Survival
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
FY	Fiscal Year
GIACS	Mothers' Interchange Groups
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
JFSC	Juan Faustino Sanchez Carrion Province
KPC	Knowledge, Practices and Coverage
LAC	Latin America and Caribbean
LQA	Lot Quality Assessment
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PCM	Pneumonia Case Management
PVO	Private Voluntary Organization
SISCAPI	Project Partners' Training Plan
SIVICS	Community-based Health Information Surveillance System
TBA	Traditional Birth Attendant
TIPS	Trials in Improved Practices
TOT	Training of Trainers
TT	Tetanus Toxoid
UPAO	Private University Antenor Orrego

CARE PERU CHILD SURVIVAL XVI: PROJECT *REDESS*
MIDTERM EVALUATION, AUGUST 2002

A. EXECUTIVE SUMMARY

A1. DESCRIPTION OF PROJECT *REDESS* AND PROGRAM OBJECTIVES

The CARE PERU *REDESS* (*Health and Social Networks*) Child Survival Project is located in the northern Andean highlands in two contiguous Departments, **La Libertad and Cajamarca**, which are regional divisions for the national Ministry of Health (MOH). Each department consists of several provinces and each province consists of multiple districts and their communities. The *REDESS* Project covers the entire province of J.F.Sanchez Carrion Province (JFSC) in La Libertad Department and one MOH Area (or about half of the 4 Districts) in Cajabamba Province of Cajamarca Department.

As per the project Detailed Implementation Plan, the project is serving **382 rural communities** with an estimated population of 160,169. Project beneficiaries number approximately 67,116, consisting of **22,659 children under age five and 44,457 women of reproductive age** (Attachment A). The project contributes to the goal of reducing maternal-child morbi-mortality through interventions focused on:

a) **maternal care** (40%), especially improvements to prenatal and post-natal care, along with promotion of institutionally-based or linked safe childbirth;

b) **nutrition promotion** (30%) of appropriate complementary feeding practices and the importance of breastfeeding;

c) community-based management/referral of **child pneumonia** cases (PCM, 15%);

d) community-based **control of diarrheal disease** (CDD, 15%).

The project goal and expected intermediate results are the following:

GOAL: By the year 2004, to have improved the health of children under age five and women of reproductive age, with a focus on decreasing maternal, peri-natal and infant morbidity and mortality, in 382 rural communities in J.F.Sanchez Carrion and Cajabamba Provinces.			
Intermediate Result 1 Improved coverage & quality of services by local health networks in PCM, CDD, maternal health and nutrition.	**Intermediate Result 2** Increased care-taker knowledge and practices in PCM, CDD, maternal health and nutrition.	**Intermediate Result 3** Improved quality & coverage of care by Community Health Agents in PCM, CDD, maternal health and nutrition.	**Intermediate Result 4** Strengthened re-lations between health promoter associations & local government and civil society.

The project is most advanced in the province of **J.F.Sanchez Carrion,** where the full complement of activities initiated in early FY2001, with initiation in Cajabamba Province in November 2001. Midterm Evaluation activities (Attachments B,C) were primarily conducted in J.F.Sanchez Carrion Province and all comments, unless otherwise noted, refer to the project area of J.F.Sanchez Carrion Province (JFSC).

A2. KEY ACCOMPLISHMENTS TO-DATE

- **All project participants displayed an excellent awareness of the project goals, objectives and strategies.**

Although the JFSC Network[1] is an area of high rotation of personnel, all 27 MOH personnel interviewed in 6 health units, including personnel with less than 6 months in the area, were very clear about the project's goals and objectives. Similarly in other interviews, all Community Health Agents and other actors within the social networks also displayed a clear understanding of the project.

- **MOH personnel in all 16 Health Units and the JFSC Network have prepared and conducted quality training of CHAs in the topic of maternal care.**

The project has provided technical assistance and training-of-trainer activities for MOH personnel in support of capacity-building of MOH community outreach. The training of Community Health Agents by MOH personnel is considered by the Midterm Evaluation Team to be of high quality based on: the use of **adult education techniques** to teach key messages based upon **up-to-date MOH norms** and the incorporation of methods to strengthen CHA **technical competencies**, including a pre and post-test during training, with monthly meetings as an opportunity for continuous improvement.

- **A community-based health surveillance system has been established in all communities with active CHAs (roughly 80%) and linked with 100% of the 16 Health Units and the Hospital/Network center.**

The community-based health surveillance system (*SIVICS*) includes: a community census; community mapping of at-risk women of childbearing age and children under age one (*CROQUIS*); community organization of emergency evacuation systems; and a referral system to refer cases to local health units and receive counter-referral information for follow-up by CHAs. From January to July of 2002, there have been over **1,000 community referrals to local health units**. This element of the project is likely to have the **greatest immediate impact** on reducing maternal-child morbi-mortality.

- **Community Health Agents are organized into CHA Committees at each of the Health Unit level and demonstrate organizational and leadership skills.**

[1] The Health Network is responsible for all health units at the provincial level and is housed within the provincial hospital. The JFSC Network includes a management team responsible for the network of 4 district capital Health Centers and 12 Health Posts within sub-districts), and for outreach to rural communities within the district of Huamachuco.

During Midterm Evaluation, interviews were held with 6 of 8 CHA Committees (*COACS*) formed at the district level. Committees have clearly defined roles and responsibilities for leadership, skills in basic financial management and an **annual operating plan** that is clearly a product of their participation and a "living" committee management tool.

- **Appropriate health education community outreach materials and a long-term plan for sustainable training-of-trainers have been developed jointly with JFSC Network personnel.**

Project REDESS has adapted child health education materials to include a focus on Integrated Management of Childhood Illness (IMCI) and has developed maternal health materials in a joint process with MOH personnel from all levels, including local, regional and national MOH offices. Draft materials were validated by project staff in multiple community settings. Midterm Evaluation review of the materials found the health education messages based upon internationally recognized norms, limited to key messages of importance and appropriate for a rural population with low literacy levels.

A long-term training plan (*SISCAPI*) for MOH personnel has been developed through Project REDESS in a highly participatory manner, involving MOH personnel from health posts, the provincial Health Network and the La Libertad regional office and based upon a participatory needs assessment.

A3. PROGRESS IN ACHIEVING PROGRAM OBJECTIVES

The project has made good progress in achieving the project **Intermediate Result No.1**, "improved coverage and quality of services provided by local health networks" and **Intermediate Result No.3**, "improved quality and coverage of care provided by Community Health Agents" for the technical interventions related to maternal health, including prenatal care, safe delivery, and post-natal care. Midterm Evaluation shows recent signs of progress in achieving **Intermediate Result No.2**, "increased caretaker knowledge and practices", in the technical component of maternal health.

It is likely that the project will be able to achieve Intermediate Results Nos. 1, 2 and 3 in all technical components by 2004 in the J.F.Sanchez Carrion target area, based upon project implementation to-date and future work plans; however, project staff note that they were overly ambitious in setting targets for a few project indicators (for example, "increase from 11.8% to 70% children age 6-23 months who receive 5 feedings/day").

Midterm Evaluation found the project to have established a sustainable base to build upon for achieving **Intermediate Result No.4**, "strengthened relationships between health promoter associations and local municipal and civil society". The link between health promoters and local health institutions has been reactivated and greatly strengthened. The link between health promoters and community development committees has also been strengthened. At present the link between health promoters and civil society at the municipal level is through MOH representatives.

A4. AREAS NEEDING FURTHER ATTENTION AND KEY CONSTRAINTS

Given the up-front investment in strengthening MOH capacities, it is appropriate to **shift this balance** towards assuring the capacity of Community Health Agents in technical competencies-- as community-based service providers, as community health educators, and as civil society participants at the district level through their representative committees. Similarly, in activities related to strengthening Health Information Systems, the project should focus on **strengthening the link** between the health unit and the communities, such as a periodic review of referrals and counter-referrals. Efforts should be directed towards promoting the institutionalization and sustainability of these HIS elements at the regional level. The key **constraints** to the project are not within the powers of the project to easily change. These include: high rotation of MOH personnel; high attrition of community members due to the opportunity costs involved in an area of high economic need; increasing crime and insecurity in the area; and increasing operational costs in the local area.

A5. CAPACITY-BUILDING EFFORTS

The project directly contributes to strengthening the capacities of the local MOH through several strategies: all activities are developed in a participatory manner; training-of-trainers is coordinated with MOH personnel so that they can then train and supervise CHAs; and all health education materials were developed through a participatory process involving the MOH at all levels, from local to national.

A6. SUSTAINABILITY

The widespread use of the community-based health surveillance system (*SIVICS*) and its direct contribution to MOH goals supports the sustainability of this strategy. MOH participation in developing a comprehensive training plan is another factor favorable to sustainability of project activities. The provincial level JFSC Network has supported project activities through a variety of mechanisms, including the participation of a wide range and large number of personnel in all training activities and through investment in computers in the Network office. However, sustainable support for project activities demonstrated by the regional level to-date has been limited to the participation of 1-2 regional training unit personnel in project training activities. At present it is difficult to gauge the prospects for sustainability due to recent changes in management.

A7. PRIORITY RECOMMENDATIONS

The key recommendations after Midterm Evaluation are primarily focused on details related to the overall suggestion that the balance of efforts switch from MOH institutional capacity-building to strengthening the competencies of CHAs to be effective social agents of change for their communities (section E. Conclusions & Recommendations). It is also recommended that project management and supervision carefully plan a detailed use of the remaining budget for Years 3 and 4 of the project, looking for ways in which to improve cost-efficiencies while addressing the operational needs of the project. The project should re-think plans to replicate all strategies in the Cajabamba Province target area and perhaps focus on a limited set of high-impact strategies, such as the *SIVICS* system, for the remaining two years life-of-project.

B. ASSESSMENT OF PROGRESS

B1. TECHNICAL APPROACH

B1a. OVERVIEW: The *REDESS* (*Health and Social Networks*) Child Survival Project of CARE PERU is located in the northern Andean highlands in two contiguous Departments, **LA LIBERTAD AND CAJAMARCA**. The Department capitals are the regional centers for the national Ministry of Health. Each Department consists of several provinces and each province consists of several districts and their communities. The *REDESS* Project covers the entire province of J.F.Sanchez Carrion Province in La Libertad Department and about half of the 4 Districts in Cajabamba Province of Cajamarca Department (health is organized into 3 Areas in Cajabamba Province, which are split between 4 government districts).

According to the project Detailed Implementation Plan, the project is directly serving 269 rural communities in JFSC Province (70%) and has established a solid base for serving an additional 113 rural communities in Cajabamba Province (30%), for a total estimated population of 160,169. Project beneficiaries number approximately 67,116, consisting of **22,659 CHILDREN UNDER AGE FIVE AND 44,457 WOMEN OF REPRODUCTIVE AGE**. These figures are based upon projections from the last national census conducted in 1993. Project *REDESS* has supported the Ministry of Health in project areas to conduct a community census. The results of this census are roughly three-quarters complete at present and generally appear to match overall area projections, though with a greater than projected internal migration from rural communities to the semi-urban provincial capitals.

The project employs several **STRATEGIES** to achieve project objectives:

a) The project seeks to strengthen the demand for and use of available local integrated maternal-child health services by reducing cultural constraints to care-seeking behavior.

b) The project actively promotes the training and coordination of Community Health Agents by local health personnel and seeks to link the health sector to a participatory local government environment involving all local actors, including rural community representatives.

c) Additionally, the project works to strengthen the quality of available health services at the health center and health post level, through support for training of staff in integrated management of maternal-child illness.

The project expects to contribute to reducing maternal-child morbi-mortality through **INTERVENTIONS** focused on:

a) improving **maternal care (40%)**, especially improvements to pre-natal and post-natal care, along with increases in institutionally-based safe childbirth;

b) **nutrition promotion (30%)**, including recommended appropriate complementary feeding practices and general promotion of the importance of breastfeeding;

c) community-based management and referral of **child pneumonia cases (15%)**;

d) community-based **control of diarrheal disease (15%)**.

Specific program objectives can be found in Attachment A. The project goal and expected results and intermediate results are the following:

GOAL: By the year 2004, to have improved the health of children under age five and women of reproductive age, with a focus on decreasing maternal, perinatal and infant morbidity and mortality, in 382 rural communities in J.F.Sanchez Carrion and Cajabamba provinces.			
Result 1 Improved MOH capacity for community outreach.	**Result 2** Increased community responsibility for improved personal health.	**Result 3** Sustained provision of front line services by Community Health Agents.	**Result 4** Sustained participation of local governments in health management.
Intermediate Result 1 Improved coverage and quality of services provided by local health networks in PCM, CDD, maternal health and nutrition.	**Intermediate Result 2** Increased caretaker knowledge and practice regarding PCM, CDD, maternal health and nutrition.	**Intermediate Result 3** Improved quality and coverage of care provided by Community Health Agents in PCM, CDD, maternal health and nutrition.	**Intermediate Result 4** Strengthened relationships between health promoter associations and local municipal and civil society.

B1b. PROGRESS BY INTERVENTION AREA: The project is most advanced in the Province of J.F.Sanchez Carrion, since early FY2001,with on-the-ground implementation of activities in Cajabamba Province initiated in November 2001. A meeting was held with representatives of all project participant groups in Cajabamba Province during the Midterm Evaluation; more detailed Midterm Evaluation activities were conducted in J.F.Sanchez Carrion Province and all comments, unless otherwise noted, refer to the project area of J.F.Sanchez Carrion (JFSC) Province.

The project has invested a sizeable amount of effort in strengthening the **QUALITY OF SERVICES** available from all 17 health units in JFSC (this includes the portion of the Leoncio Prado Hospital which also functions as a health center with outreach to all rural communities in Huamachuco District), both in assisting the local health units to organize as a Network and Micro-Network, in providing management training, in organizing the

training of health personnel in the norms and protocols for the integrated management of maternal and child health and in establishing a local MOH health information system linked to a community-based system.

Communities have been supported in electing **COMMUNITY HEALTH PROMOTERS** and in organizing existing or non-existing groups into **COMMUNITY DEVELOPMENT COMMITTEES** (70% of communities).

The community-based health information system (***SIVICS* - SYSTEM FOR COMMUNITY HEALTH VIGILANCE**) includes a community-census (75% complete), a community map of high-risk groups (100% complete), and use of a Community Health Agent referral system (100% in communities with active CHAs) with counter-referral by local health personnel to the CHA. Midterm Evaluation review in 10 communities of CHA referral and counter-referral documentation found roughly half of referrals to receive a counter-referral. From January to July of 2002, there have been over **1,000 COMMUNITY REFERRALS TO LOCAL HEALTH UNITS**. Midterm Evaluation review of CHA referrals in 10 communities found roughly 70% to be for prenatal care, 20% for common childhood illness, 5% for family planning and 5% for other community health needs.

> The *SIVICS* structure and use of the referral system is one of the elements of this project having the **greatest and most immediate impact** on reducing maternal-child morbi-mortality.

Community Health Agents have also organized **COMMUNITY EMERGENCY EVACUATION COMMITTEES** with an emergency evacuation plan for each community. The project supplied CHAs with an easy-to-clean material to construct the bed of a litter, while communities supplied the wood for the carrying poles. Midterm Evaluation review of emergency evacuations reported since January 2002 found most for complicated childbirth. However, emergency evacuation of at-risk children have also occurred, and health personnel interviewed in the health unit of Sarin, Curgos, JFSC Province described their greatest emergency evacuation achievement as related to a recent case of pneumonia in a six month old (see section F. Results Highlight).

TRAINING-OF-TRAINERS activities have been coordinated for MINSA personnel in the use of Adult Education Techniques and all 17 (100%) local health units have prepared and conducted training of Community Health Agents (including **COMMUNITY HEALTH PROMOTERS AND TRADITIONAL BIRTH ATTENDANTS** formerly trained and recognized by the health system) in the key messages for maternal and newborn care with limited direct involvement by CARE project staff. The training of Community Health Agents by MOH personnel is considered by the Midterm Evaluation Team to be of high quality based on several aspects:

a) **ADULT EDUCATION TECHNIQUES** are incorporated to provide training to adults in a rural area with low literacy levels;

b) training information is based upon **UP-TO-DATE MOH NORMS** and protocols and limited to the key messages of importance, such as the most frequent danger signs that occur during pregnancy, childbirth and/or the post-natal period;

c) a pre and post-test is used during training of CHAs, while monthly meetings with CHA and future plans for community outreach visits by MOH personnel provide opportunities for continuous improvement of **CHA TECHNICAL COMPETENCIES**.

Although the project proposal originally planned for the immediate reproduction of health education materials developed through the CARE PERU CSXII project, Project REDESS found a need to adapt the materials to fully include an IMCI focus, and to further develop maternal-newborn care messages. The development of the **HEALTH EDUCATION MATERIALS** was conducted as a joint process with MOH personnel from all levels, including local, regional and national MOH offices. Project staff **VALIDATED** draft materials in multiple community settings, based upon the following criteria: attractiveness to client, comprehension, acceptability, identification with the situation portrayed, and persuasiveness of the message. As Spanish is spoken by all of the population in the target area, local language translation was not an issue.

It should be noted that KPC Baseline Survey found 53.0% of randomly selected mothers of children under age two to be between the ages of 20-29, with 41.6% of all mothers having attended primary school and able to read. Health education materials developed by the project are appropriate for both a **NON-LITERATE AND LITERATE** target population alike (validated drawings with text support materials).

Project REDESS has coordinated the participatory development, along with MOH personnel and input from the Private University of Antenor Orrego (UPAO), of a **BEHAVIORAL CHANGE COMMUNICATION CAMPAIGN PLAN** that incorporates multiple strategies to reach project beneficiaries through a variety of methods and fora. These include: radio spots disseminated to all rural communities[2]; "popular education" activities, such as games, songs, etc., in centralized locations where rural community members naturally group along socio-economic corridors; inter-personal methods of communica-tion between CHAs and community members, such as individual counseling and community support groups; and community-based activities, such as painting murals.

Project staff have provided technical assistance to **SOCIAL NETWORKS** through both the Provincial Coordination Roundtable (*Mesa de Concertacion*) in JFSC Province and Cajabamba Province, and with all District Coordination Roundtables in JFSC Province, in support of including a focus on health activities within planning activities (see section B2. Cross-cutting approaches).

[2] Qualitative investigation by students from the Communications Sciences Department of the Private University of Antenor Orrego found that almost all rural families listen to radio programs during the mid-day lunch break, especially radio *Los Andes*. Roughly half of men stated they completely trust in the information they hear on the radio, as compared to 100% of women.

B1b1. MATERNAL AND NEWBORN CARE (40%): As noted in the Detailed Implementation Plan, the 1996 DHS Report estimated maternal mortality at 379 per 100,000 live births in the Andean highlands of Peru. Per regional MOH data for the regions targeted for this project, **MATERNAL MORTALITY** has continued to rise, although some of this apparent increase is likely due to improved information systems and/or increases in the number of institutional births. The key causes of maternal mortality are hemorrhage, eclampsia, and sepsis.

Results from the **BASELINE KPC SURVEY** revealed the following for maternal health:

- Only 37.6% of mothers of children under age two had documentation of 2 or more doses of tetanus toxoid.

- Among the roughly 30% of mothers with a prenatal care card, greater than 90% had obtained at least two or more prenatal health care visits, with more than 50% of these obtaining 4 or more visits; 68.1% of mothers, with or without a prenatal care card, claimed to have utilized available prenatal care services, with more than 85% of these reporting 2 or more visits.

- Roughly 40% of all mothers of children under age two reported having taken iron supplements during their last pregnancy.

- Only 19.7% of mothers of children under age two could identify 2 or more danger signs of an obstetric emergency.

- About 82% of mothers of children under age two had given birth at home, while only 23.7% had a health professional cut the umbilical cord at home or at a health unit.

There have been no changes to the detailed plans for this intervention from that noted in the DIP. The project is most advanced in the technical intervention for maternal and newborn care and has provided support for capacity-building activities for MOH personnel, training of Community Health Agents, and dissemination of key maternal care messages by CHAs to their community through group events and one-to-one counseling with provision of appropriate health education materials. The **KEY MESSAGES** promoted by the project are: danger signs during pregnancy, importance of good nutrition during pregnancy, importance of prenatal care check-ups, danger signs during childbirth, promotion of childbirth attendance by a health care professional, danger signs for newborns.

For improved communication during emergency evacuation of complicated childbirth from local health units to the Network Hospital, **14 RADIO TRANSMITTERS** (2-way) were provided to 10 local health units in JFSC Province and 4 in Cajabamba Province. The *SIVICS* referral system and community-based evacuation committees and plans were established early in the implementation of this intervention. It should be noted that many of the **30 EMERGENCY EVACUATIONS** reported by communities to-date were for complicated childbirths.

MOH personnel in every participating health unit have conducted **TRAINING FOR A TOTAL OF 401 CHAs**, including 308 Community Health Promoters and 93 registered traditional midwives, in maternal and newborn care. Midterm Evaluation found the training of CHAs in maternal care messages, including newborn care, to be of good technical quality, based on the criteria noted above and on results of interviews with health personnel, CHAs and beneficiaries (mothers).

CLOTH FLIPCHARTS ON MATERNAL AND NEWBORN CARE HAVE BEEN DISTRIBUTED, one per community, to over 70% of communities. Midterm Evaluation review of the materials found the health education messages to be based upon internationally recognized norms, limited to key messages of importance and appropriate for a rural population with low levels of literacy.

MTE encountered a few comments regarding the conservative nature of communities in relation to the first few panels, which address human sexuality. However, all CHPs interviewed and even some of the oldest traditional midwives stated that communities need this information and that they could address the issue by providing the proper context. Project opportunities for continued strengthening of CHA abilities to transmit health education can stress both the options for CHAs to choose which panels to use and in which order, along with stressing that the entire flipchart should never be covered in any one event.

A book-size **LAMINATED FLIPCHART OF DRAWINGS WITH KEY MESSAGES** for maternal care noted on the back will shortly be distributed. The responsibility of CHAs to disseminate information to their communities was emphasized in the initial selection of CHAs and training events, and a monthly form for reporting these activities has been instituted this year. As of July 2002, over **370 COMMUNITY EDUCATION ACTIVITIES** to promote maternal and newborn care have been conducted by CHAs in 269 communities.

The MOH protocol at present is to promote **"SECURE CHILDBIRTH"** as opposed to previous efforts directed towards "Safe Childbirth". The difference is a focus on recommending that all births be attended by trained MOH personnel in either the local health unit or the home, as opposed to previous efforts to train traditional midwives in sterile childbirth techniques. Traditional midwives are encouraged to participate in the process, but the lead actor is the health unit obstetric technician.

Peru has strongly invested in the training of obstetric technicians and each of the 16 local health units in JFSC Province has an obstetric technician as a part-time staff member (doctors or nurses can also attend a birth if the obstetric technician is unavailable). Baseline KPC Survey did reveal a trend towards institutional childbirth, with only 7.2% of births during the second-last pregnancy reported by mothers as having occurred in an institutional setting, while 17.4% (more than double) reported for the last pregnancy.

Midterm Evaluation interviews with all health unit personnel, and especially the obstetric technicians, noted a strong and positive trend towards increased **SENSITIVITY AND ACCEPTANCE OF LOCAL (NON-HARMFUL) CULTURAL PREFERENCES** for childbirth. This is supported both within the MOH system and by Project REDESS and is likely to be a key factor in overcoming local resistance to institutional childbirth.

> The obstetric technicians and nurses within the Curgos health sector demonstrated several techniques they use to respond to local cultural preferences: a traditional sheepskin was obtained and covered with plastic and is placed below women who prefer to give birth from a squatting position; IV solutions are warmed up enough to take the "chill" off, due to local beliefs related to hot and cold systems; and local color preferences and styles are taken into account in the bonnets and booties provided to newborns.

This area of project implementation, maternal and newborn care, is quickly growing to the proportions desired. **FUTURE PROJECT ACTIVITIES** to orient and promote CHA participation in Mothers Mutual Support Group activities in natural forums in socio-economic corridors and Mothers Group Learning Activities in communities will provide immediate strengthening in this area in early FY2003. As part of this process, the introductory concepts managed by CHAs to assist mothers to develop a Birth Plan will be formalized through support materials. Implementation of the mass media campaign, planned for the 1st quarter of FY2003, will also focus on the promotion of maternal-newborn care messages initially.

B1b2. NUTRITION (30%): Several positive practices in nutrition were identified in the KPC Baseline Survey:

- More than 90% of mothers of children under age two were presently breastfeeding at time of survey.
- Approximately 75% of mothers provided breast milk within the first 3 days after childbirth.
- More than 90% of mothers of children age 6 months or older give dark orange vegetables or fruits high in Vitamin A to children.

Several indicators revealed positive trends with room for improvement that could positively impact upon child morbi-mortality:

- About 60% of mothers give children 6-23 months dark green leafy vegetables.
- About 60% of mothers add fats or oils to weaning foods of children age 6-23 months

However, baseline results also revealed several key areas in which recommended feeding practices are limited:

- Only 44% of mothers initiated breastfeeding within one hour after childbirth

- Only 41.7% of mothers of children 0-5 months practice exclusive breastfeeding

- Only 11.8% of children age 6-23 months are fed solid or semi-solid food at least 5 times per day (though 85.5% are fed at least 3 times per day)

The project will support positive nutrition practices while encouraging the adoption of other important child feeding behaviors. There are three changes to the nutrition intervention as outlined in the **DETAILED IMPLEMENTATION PLAN**: 1) community-based growth monitoring will not be undertaken based on two factors: the low level of education of CHAs and the MOH protocol for promoting growth monitoring as a key element of integrated child health services available at local health units; 2) the HEARTH model for community-based nutritional recuperation of malnourished children will not be implemented in a limited number of pilot communities, due to the low levels of acute malnutrition (less than 1.0%) as compared to high levels of chronic malnutrition (41.4%) found in children under age two; 3) therefore, the nutrition intervention will not be limited to a small number of pilot communities, but rather recommended feeding practices will be promoted in **ALL TARGET COMMUNITIES**.

The ***SIVICS* REFERRAL SYSTEM**, already in place in communities, will support CHA referral of children for growth monitoring. To-date, Project REDESS has finalized the development of supporting educational materials but has not yet entered into the training phase for implementation of this intervention. For health and nutrition education materials, similar to those developed for maternal and newborn care, a combination of cloth flipchart and laminated charts have been finalized for the integrated modules related to **WELL-CHILD HEALTH CARE** and **SICK CHILD HEALTH CARE** -- encompassing the topics of complementary feeding practices, pneumonia case management, diarrheal disease control and prevention, and promotion of breastfeeding -- within a framework for the Integrated Management of Childhood Illness (IMCI).

Health education materials will be available to support CHAs in the dissemination of messages regarding well-child health and sick-child health care during the next round of **CHA TRAINING ACTIVITIES**. Training activities for training-of-trainers of MOH personnel and training of CHAs by MOH personnel will be implemented as two separate integrated modules -- the Well-Child module and a Sick-Child module, including the abovementioned topics of nutrition and common childhood diseases -- and will initiate in early FY2003.

As noted in the Detailed Implementation Plan, CARE HQ has been developing conceptual and practical materials related to the steps necessary to analyze, promote and achieve behavioral change, especially in regards to complementary feeding practices. A CARE consultant knowledgeable in **BCC METHODOLOGY** based upon the TIPS technique (Trials in Improved Practices) will facilitate the adaptation of key basic complementary feeding messages to local practices, beliefs and food availability in early FY2003. This will be incorporated into the on-going process by project personnel, MOH counterparts and UPAO Communications students to implement a

broad and multi-level communications campaign for behavioral change. Backstopping TA provided by CARE HQ will also focus on these techniques in FY2003 (see section B2b. BCC and C2. Staff Training for additional information.)

A **CARE PERU TITLE II PROJECT** will enter roughly a fifth of Project REDESS target communities in FY2003, and will directly collaborate with Project REDESS personnel and counterparts in the promotion of good nutrition through improved maternal-child health practices. Personnel from both projects have had two meetings in preparation for their collaboration and have shared strategies, techniques and materials in the area of health, hygiene and nutrition. In addition, the Title II project (*REDESA*) will also assist families to sustainably increase income generation activities, primarily agriculture related, and to appreciate the importance of investing disposable income in improvements to household nutrition. The two projects plan to continue to meet at least quarterly to discuss ways to collaborate and achieve increased efficiencies.

B1b3. PNEUMONIA CARE MANAGEMENT (PCM 15%): KPC Baseline Survey revealed very poor knowledge and practices in this area of technical intervention:

- Only 5.7% of mothers recognize at least 2 signs of acute respiratory infection (pneumonia), while 64.4% do not recognize even one sign.

- Only half of mothers seek treatment when their child shows signs of acute respiratory infection.

Implementation of this technical intervention will begin in early FY2003. To-date, appropriate **PCM MESSAGES**, including local terms for signs of pneumonia, have been incorporated into the Well-Child and Sick-Child health materials and modules developed to-date. Similarly, the established community health information system (*SIVICS*) also supports the **REFERRAL** and counter-referral of child pneumonia cases.

Midterm Evaluation review identified **TWO POTENTIAL CONSTRAINTS** to this intervention: 1) an occasional delay of up to 2 months of shipments of essential medicines to the local health units, and 2) a lack of support by all MOH personnel for the identification of selected CHAs to be supplied with antibiotics. The first constraint has been somewhat addressed through project efforts to provide capacity-building activities for key Network MOH personnel in management and administration issues. At this point, **ADVOCACY AT THE LOCAL, REGIONAL AND NATIONAL LEVELS** is indicated to increase support for broadening the role of Community Health Agents to include first-dose treatment and referral of cases of pneumonia, especially in remote rural areas such as this target area.

FUTURE PLANS for the implementation of this intervention do not vary from that described in the DIP: 1) support for improved MOH capacity for community outreach; 2) provision of front-line services by CHAs; 3) community health information system and referral/counter-referral system; and 4) capacity-building of CHA committees and associations; and 5) community health education activities. For selected CHAs (criteria

including distance of community to nearest health unit and individual CHA demonstrated technical capacities), the MOH will provide them with sufficient *cotrimoxazole* antibiotic for administration of an initial dose to children with pneumonia, along with immediate referral and/or evacuation to the nearest health unit.

B1b4. CONTROL OF DIARRHEAL DISEASE (CDD 15 %): KPC Baseline Survey identified a lack of knowledge and/or appropriate practices for CDD:

- Less than 5% (only 2.3%) of mothers of children under age two could identify 2 signs of dehydration along with the key sign of dysentery (blood in stools).
- Only 5% of mothers provided Oral Rehydration Therapy to children when they had diarrhea.

However, per KPC results, several CDD messages appear to have been incorporated into maternal-child health practices in the area:

- Less than 20% of mothers stop or reduce breastfeeding during diarrheal episodes.

Implementation of this technical intervention will begin in early FY2003. To-date, appropriate **CDD MESSAGES**, including local terms for diarrhea and/or dehydration, have been incorporated into the Well-Child and Sick-Child health materials and modules developed to-date. Similarly, the established community health information system (*SIVICS*) also supports the **REFERRAL** and counter-referral of child dehydration cases. In addition, the project will build upon the experiences and materials developed by previous Project Title II activities to promote improved **SANITATION AND HYGIENE**.

No potential **CONSTRAINTS** to implementation of this intervention were identified during Midterm Evaluation; rather, a few CHAs were encountered during Midterm Evaluation who were continuing to receive supplies of ORS based on community outreach activities which had occurred more than 5 years ago. This link is most likely even stronger in Cajabamba Province, where several other organizations and CHA support interventions have been active in the recent past.

B2. CROSS-CUTTING APPROACHES

The key cross-cutting approaches of Project REDESS include a focus on community mobilization and linkage of communities to local government to increase civil society participation by rural community members. In addition, local government entities are encouraged to coordinate and plan with other institutions and district or provincial level civil society representatives. CARE HQ technical assistance is also focused on support for strengthening capacities in behavioral change communication techniques. As for other CARE PERU projects, a cross-cutting focus on promoting gender equity is also included in Project REDESS. This has specific relevance in the context of maternal care issues. Last but not least, the central effect sought by the project is to individually build the capacities of the local MOH network and the community health volunteers, and to strengthen their linkage through a community outreach system.

B2a. COMMUNITY MOBILIZATION: Midterm Evaluation found that the project has been able to build upon the **LOCAL GOVERNMENT STRENGTHENING** efforts of a previous CARE PERU private funds project, *FOGEL*, in which municipalities developed long-term strategic plans that incorporate a focus on health needs, among other basic needs. Project REDESS has both supported and facilitated provincial and district roundtable coordination meetings during the two years of project implementation. The greatest impact of this effort to-date found at MTE is the direct contribution by roughly half of municipal governments in support of the Community Health Agent representative Committees - primarily through the provision of office space/supplies.

Several **CHALLENGES** in the area of local government/civil society strengthening were identified during Midterm Evaluation. There are two almost parallel government channels in existence, with appointed provincial and municipal governor positions that have somewhat similar functions as the municipal mayor positions, which will soon become a democratically elected position (end of 2002). Local institutions have almost no or very limited budgetary discretion and therefore the "response" to civil society participation is limited. Yet, in spite of these constraints, representatives of local government-civil society interviewed during Midterm Evaluation were uniformly **SUPPORTIVE OF THE GOALS** of Project REDESS and local health care institutions.

As the CARE PERU **TITLE II PROJECT** will also be collaborating within the same two provinces and several of the same districts as Project REDESS, past and future quarterly meetings between the two projects' staff include a strong focus on coordinating local government strengthening activities and developing an efficient strategy to build upon the strengths of each project.

At the community level, the project has supported communities in organizing **COMMUNITY DEVELOPMENT COMMITTEES** (CODECOs) in 65% of communities. Midterm Evaluation review found these committees to be highly supportive of their Community Health Agents. This was cited by CHAs as a strong motivation factor for this voluntary position. Midterm Evaluation review encountered both CODECOs in which the CHA was only one of several strong community leaders, and CODECOs in which the CHA was the leading force. The project has reached the phase where additional strategies will be defined regarding how to best achieve civil society participation at the municipal level by representatives of rural community groups.

B2b. BEHAVIORAL CHANGE COMMUNICATION: To-date, as described further in section B1b. Progress by Intervention Area, Project REDESS has developed a Communications Campaign Plan for behavioral change, with technical assistance from the private University of Antenor Orrego. This campaign plan ranges from mass media radio spots to one-on-one counseling techniques. In support of BCC, the project has developed appropriate health education materials in a participatory fashion with project partners, and all materials were validated in multiple field settings.

Also, CARE HQ has chosen a focus of strengthening field office capacities for developing locally appropriate behavioral change communication strategies. Project

REDESS management participated in an HQ-sponsored workshop on adult education methodologies in FY2001. CARE HQ has a follow-on workshop planned for January in FY2003 which will range from methodologies for adult education to strategies for rapid qualitative assessment of beliefs and practices in relation to recommended health education messages, specifically complementary child feeding messages. Qualitative assessment of beliefs and practices will thereby be incorporated as an element within any health education teaching strategy, along with the incorporation of individual responsibility and "negotiation techniques" for one-on-one counseling. This workshop will be immediately followed up by a field visit from HQ to provide supportive assessment of the use of these new techniques and incorporation into project activities.

B2c. GENDER: Project REDESS has included several strategies to-date to promote gender equity within communities:

- by encouraging CHAs to elect women also among their representatives on the district-level CHA Committees (**COACS**)

During Midterm Evaluation, the evaluation teams met with 6 different Community Health Agent Committees within the 8 districts of JFSC Province. Each of these had at least one woman in a significant position, such as President, Vice-President or Treasurer. Interviews with the COACS as a group revealed the women to be self-confident and demonstrate a strong degree of participation. (Also see section B2d. Capacity-building.)

- by encouraging communities to consider women leaders equal to male leaders when electing **COMMUNITY HEALTH PROMOTERS**

Midterm Evaluation found that, at present, approximately 25% of Community Health Promoters are female. As any CHP chooses to drop from active participation in project activities, the project considers this an opportunity to promote the incorporation of more women as CHPs, as a number of women leaders have already received technical training and are therefore appropriate replacement candidates (see below).

- by including **TRADITIONAL BIRTH ATTENDANTS** (TBAs) in training activities for technical interventions

Traditional birth attendants (TBAs), with prior training and official recognition by the MOH system, have been incorporated into project technical training activities as TBAs are another significant community group that influences household decisions. Midterm Evaluation found that attrition rates average 20% for project participation by the 122 traditional birth attendants registered in JFSC Province. This rate, acceptable in such a remote rural region and in a project with so few incentives for participation, suggests that the project has been successful in developing training activities and materials appropriate for this group.

- by including training activities on technical intervention for other **WOMEN LEADERS** (such as the President of the "Glass of Milk" program, for example)

Women leaders have received training as another strategy to strengthen women's capacities to participate in civil society-local government activities. Midterm Evaluation found most women leaders now desire to participate even more fully, as CHPs. As part of project support for community outreach practicum experience by the nursing students of the National University of Trujillo, students conducted one study of the motivation for active women leaders in rural communities. Results showed that women were most frequently motivated by a desire to "work for the benefit of their community"[3].

- presenting an active and caring role for **HUSBANDS AND FATHERS** in project-developed health education materials

Midterm Evaluation review of the project health education messages and materials found they portray and promote an active role for husbands and fathers, along with the role of the mother, to attain improvements in maternal and child health.

B2d. CAPACITY BUILDING OF PARTNERS

Capacity-building of partners is a key strategy for Project REDESS. In **SUMMARY,** Midterm Evaluation review finds this to be one of the key strengths of the project, with the project generally advancing well and according to plan in the area of capacity-building for local partners.

Capacity-building Objective No.1: *Improve and strengthen the capacities of CHA Association members and other community leaders to provide leadership and to plan, manage and evaluate their organizations.*

The project seeks to strengthen the organizational and leadership capabilities of Community Health Agents, both within their individual communities and as collective representatives participating at the district-level. One of the key findings of MTE was that CHAs have been organized into **COMMITTEES OF COMMUNITY HEALTH AGENTS (COACS)** within each health unit and these committees can demonstrate organizational and leadership capacities.

[3] *The Experiences of Women Leaders in Serving Their Communities;* Dept. of Family and Community Health, School of Nursing, National University of Trujillo; 2002.

During Midterm Evaluation, 6 COACS were interviewed. Each group had at least 3 to 5 active members equally capable of describing the process of developing their annual operating plan, the present status of planned activities, the goals and objectives of the organization and the individual responsibilities of each position. All have carried out at least one fundraising activity this year, with one-time profits ranging from US$70 to US$100. Several have obtained in-kind support from local municipal governments, such as office space and/or furniture and supplies. Thanks to advocacy efforts by one COACS in the Curgos Health Micro-Network, CARE will collaborate in support of a project by the local Catholic Church Diocese to provide emergency first aid kits and training to CHAs in that district.

The most frequent **REQUEST** for the final years of project implementation expressed by COACS (and CHAs) during Midterm Evaluation was for further training, in both technical health topics and in organizational skills. COACS cited the organizational/leadership training they had received, along with the technical assistance and follow-up provided by both project personnel and MOH partners, as the key to their acquisition of skills.

Midterm Evaluation of specific **CAPACITY-BUILDING INDICATORS** found that indicator C1.1 has been achieved to-date, as measured among the 6 COACS interviewed. C1.2 has been partially achieved, as women are participating in a greater-than-planned number as leaders within the COACS groups, but no COACS yet has direct representation on local government roundtable coordination meetings.

Capacity-building Indicators for Objective No.1:

C1.1 8 associations of CHAs have been organized and are complying with 80% of their annual operating plan.
C1.2 More than 50% (90) of community representation groups (COACS) have women leaders participating and acting as representatives to local government.

The project will implement activities to address the final two capacity-building indicators in early FY2003. The project is in the process of finalizing the participatory adaptation of supervision reports, previously used in CSXII, for use by COACS to provide supportive supervision and feedback. COACS members have participated in organizational and leadership training workshops to develop their skills as future social actors with the local government.

C1.3 80% of CHAs receive supervisory and feedback visits from COACS members.
C1.4 50% of COACS have representatives participating in local government coordination roundtable meetings.

Capacity-building Objective No.2: *Improve and strengthen local health unit personnel capacities in the training and management of CHAs.*

A positive assessment of local health unit capacities for training CHAs was one of the key findings of the Midterm Evaluation. As noted previously, 100% of health units have conducted training and this training was assessed as being of good quality, based on

the use of adult education techniques to transmit up-to-date norms and protocols for maternal and newborn care, and the incorporation of methods to assess CHA capacities and provide for continuous improvement.

The project has supported the strengthening of **MOH CAPACITIES** in several key areas: management and supervision skills, organization as a network with sub-network groupings, incorporation of MOH protocols for Integrated Management of Childhood Illness and/or Maternal Health within day-to-day activities, and improved community outreach structures and capacities. MOH personnel interviewed during Midterm Evaluation stated that the present-day strengths of the MOH system are: a) the emphasis on democratic procedures to disseminate information and involve local governments and civil society in health activities, and b) a focus on problem analyses of health care issues.

Interviewees stated that the greatest contributions of Project REDESS to-date are:

a) a focus on creating **SYSTEMATICALLY STRUCTURED MODELS**, procedures and planning to address training issues for both MOH personnel and CHAs;
b) strategies to strengthen extra-mural **COMMUNITY OUTREACH** by health units;
c) **TRAINING OPPORTUNITIES** to strengthen the capacities of MOH personnel in adult education techniques, development of a communications plan for behavioral change, and management of obstetric emergencies.

Activities to achieve the following two indicators, C2.1 and C2.2, of MOH capacities will be implemented in early FY2003. Preparatory activities, such as participatory development of a monitoring report to guide MOH supervisory visits and feedback to CHAs, have been developed and on-the-ground implementation will start next quarter:

Capacity-building Indicators for Objective No.2:

C2.1 80% of CHAs will receive sufficient supplies of oral rehydration salts (and *cotrimoxasole* for selected CHAs).
C2.2 80% of CHAs will receive supervisory and feedback visits on a quarterly basis from MOH personnel.

Capacity-building Objective No.3: *Improve CHAs leadership and organizational abilities for community development actions.*

This objective refers specifically to CHAs abilities within their own communities, which has been a specific focus of Year 2 of the project. The training and materials received by CHAs in the topic of maternal-newborn care have supported their initial activities to disseminate key messages. They are active participants in Community Development Committees. The project is well on the way to achieving the first capacity-building indicator, C3.1, with almost 100% of CHAs conducting educational activities, though not yet on a monthly basis. In regards to C3.2, although not all Community Development Plans were reviewed during Midterm Evaluation, those that were reviewed (approx. 10)

each contained a planned health activity. However, most of these are planned for implementation in the final quarter of calendar year 2002.

Capacity-building Indicators for Objective No.3:

C3.1 80% of CHAs will conduct monthly health education activities and home visits.
C3.2 50% of communities execute at least one health development project/year.

Capacity-building Objective No.4: *Assist local government-civil society groups to analyze community health problems and develop effective action plans.*

As noted in section B2a. Community Mobilization, Project REDESS is at a point where it is building upon the capacities established with local governments through the CARE PERU *FOGEL* Project and planning for coordination with the future CARE PERU Title II Project, *REDESA*, in all aspects of local government-civil society strengthening. Midterm Evaluation review found most local governments to be coordinating with civil society to some degree, while all have strategic plans involving a health component, primarily due to collaboration with the *FOGEL* Project. Whether or not these include an annual action plan for health is very individualized, based on the strength, interest and budget availability of local government leaders.

At present, communities and community needs are represented indirectly through the local health unit participation in local government roundtable coordination groups. Local health unit staff are aware of community needs through their linkage with CHA representatives (COACS).

Capacity-building Indicators for Objective No.4:

C4.1 50% of local government -civil society groups develop annual action plans for community health.
C4.2 50% of communities have representatives providing health advocacy to local government.

Capacity-building Objective No.5: *Improve management and technical skills in child survival programs for REDESS Project staff.*

Five of the six field staff for Project REDESS were on the staff for implementation of the previous Child Survival XII Project, ENLACE, and therefore brought significant strengths in management and technical implementation to this project. To-date the project has achieved two of the indicators for this objective, C5.1 and 5.2:

Capacity-building Indicators for Objective No.5:

C5.1 100% of REDESS staff facilitate TOT workshops in CS technical interventions.
C5.2 100% of REDESS staff assess capacity-building needs of partners and design activities for continuing improvement.

The project has made some advances in the following objective, having organized the planning and design of a Communications Campaign for Behavioral Change, but further

technical assistance from both CARE HQ and a consultant specialist in Behavioral Change Communication are planned for FY2003 (section B2b) to achieve C5.3:

C5.3 100% of REDESS staff design and train partners in innovative BCC strategy implementation.

At present, the project has not yet identified a source for technical assistance in the topic measured by the final indicator, C5.4:

C5.4 100% of REDESS staff demonstrate mediation skills in conflict resolution with MOH, CHA groups and local governments.

B2e. SUSTAINABILITY

Sustainability Objective No.1: *Assist CHAs, within an institutionalized structure, to become active health change agents that create demand for and access to quality health care by at-risk groups within their communities.*

Midterm Evaluation interviews with MOH personnel found a perception that project activities, especially the community-based health information and referral system, had increased the use of available prenatal care services. The end-of-year review of 2002 activities typically conducted by the MOH at the beginning of the next calendar year will provide documentation of the use of services. However, Midterm Evaluation review of project monitoring data found that the following sustainability indicators have been, or are very close to being, reached to-date.

Sustainability Indicators for Objective No.1:

S1.1 6 health micro-networks (all 5 in JFSC, early FY2003 in Cajabamba) institutionalize the community health information system (*SIVICS*).
S1.2 80% of CHAs (100% of active CHAs) refer women of reproductive age and children age 0-59 months to local health unit services.
S1.3 80% of referrals (approximately 50% at Midterm Evaluation review) receive counter-referrals by MOH to the CHA.

The project has not yet entered into the issue of CHA certification, to achieve the final sustainability indicator, S1.4, for this objective.

S1.4 80% of CHAs certified by MOH.

In regards to "access to quality health care", all MOH personnel interviewed during Midterm Evaluation revealed a working knowledge of up-to-date norms and protocols for providing **QUALITY PRIMARY HEALTH CARE**. The project has provided laminated copies of flowcharts of these protocols to all 17 health units. Furthermore, MOH personnel cited various strategies to address **CLIENT SATISFACTION**. For example, in one health post clients are given a piece of paper with a face with a smile and a face

with a frown. Clients are asked to confidentially mark one or the other to express their satisfaction and place these in a bag near the exit.

The factors most likely to contribute to long-term sustainability of project activities and strategies within the **MOH SYSTEM** include:

- national MOH norms and protocols in support of community outreach activities;
- national government trends in support of democratic participation by civil society and decentralization to the provincial and municipal levels;
- the low cost-per-beneficiary of project activities and limited use of incentives;
- the participatory fashion in which project strategies have been developed with project partners;
- the direct contribution of project activities to MOH goals and objectives, such as the community-based health information system; and
- the distribution to partners of the documentation of strategies and of health education materials. (See Attachment E for a list of project documents distributed.)

The provincial health network of JFSC has provided concrete contributions to the sustainability of project efforts. For example, several computers were recently purchased and dedicated to the processing of information from the community-based health information system. The regional-level MOH structure has recently undergone a change in leadership and has been in a process of re-organization. The project will increase advocacy efforts at the regional and national level to promote the sustainability of project strategies.

The project has encountered high attrition rates of **COMMUNITY HEALTH AGENTS**, of up to 35% in some districts. Project investigation, supported by findings from the Midterm Evaluation, has determined that many CHAs initially participated due to unrealistic expectations of potential benefits based on confusion with other models of community outreach previously supported by other institutions. At present, the project has approximately 1.5 active CHAs per community. It is likely that these CHAs will sustain their activities throughout and beyond the life-of-the-project as they have received few incentives to-date. Interviews with CHAs revealed them to be primarily motivated by a desire to help the people of their community.

Sustainability Objective No.2: *Assist CHA Associations and other community leaders in becoming effective agents of community health advocacy for health administration.*

To-date, the project has not organized CHA Committees (COACS) into larger Associations, as was done in the previous Child Survival project and anticipated for this project. At this time, it is suggested that this may not be the best strategy at present,

due to the on-going and fluid definition of the exact mechanisms and roles for participation by social networks. The project has attained significant achievement in the following three indicators at the committee or municipal level, and it is suggested the project focus on sustainably strengthening and involving the COACS at the municipal level during the remaining life-of-the-project.

Midterm Evaluation found anecdotal confirmation by MOH personnel of the S2.1 indicator, while visits to 6 of 8 COACS confirmed S2.2 and S2.3. S2.3 was indirectly achieved by municipal government contributions to support the COACS.

Sustainability Indicators for Objective No.2:

S2.1 80% of CHAs are incorporated as members in CHA committees and/or associations.
S2.2 6 CHA Associations (*8 CHA Committees at the district level*) have defined sustainability strategies in annual plans.
S2.3 50% of local governments assign funds to community health activities.

The project has initiated activities with women's organizations separate from the promotion of women's participation as CHAs and in COACS. However, program strategies to link these women to CHA Associations and/or municipal roundtables for coordination, will be further defined in early FY2003. It would seem more useful to the project to promote an active role for women's organizations that already have a presence on municipal coordination roundtables (*mesas de concertacion*), while promoting a similar role for COACS, including the women leaders within their present committees. If so, the indicator S2.4 should be altered from "CHA Associations" to "municipal coordination roundtables".

S2.4 50% of communities have active women's organizations within CHA Associations.

C. PROGRAM MANAGEMENT

C1. PLANNING

Project REDESS has actively involved local MOH counterparts in the **PLANNING PROCESS** since the original design phase of this project. Each individual intervention activity or strategy, such as training of Community Health Agents, is planned jointly by project staff and members of the Network Health Management Committee, Regional Health Human Resources staff, and MOH personnel representative of the 17 local health units within the network.

This level of collaboration was reflected in the Midterm Evaluation, which found an excellent awareness displayed by all project partners/participants of the goals, objectives and strategies of the project. Although the JFSC MOH Network is an area of high rotation of personnel, all 27 MOH personnel interviewed in 6 Health Units, including

personnel with less than 6 months in the area, were very clear about the project's goals and objectives. Almost all suggestions given for the final period of project implementation fell within the range of activities provided for within the project Detailed Implementation Plan. This demonstrates: a) the effectiveness of the way in which CARE PERU Project REDESS personnel involve participants, b) the high level of participation throughout the 16 Health Units and the JFSC Health Network management team, and c) the positive orientation of new personnel within the MOH system towards strengthening community outreach. Similarly, all Community Health Agents and other actors within the social networks also displayed a clear understanding of the project. Midterm Evaluation found the most frequent requests from CHAs to be for increased training and/or incentives limited to a few items directly useful in their community activities, such as a rain cape or flashlight for night-time emergency evacuations of high-risk births.

Internally, Project REDESS submits annual **WORK PLANS** to both the central CARE PERU office in Lima and to the CARE HQ backstopping Child Health Unit in Atlanta. Detailed work plans are developed jointly with MOH partners. The annual work plan for calendar year 2002 was reviewed during Midterm Evaluation and found to be satisfactory if some of the project efforts are redistributed from MOH capacity-building and local government/civil society capacity-building towards Community Health Agent capacity-building activities.

The project is generally on-track with the work plan submitted in the DIP, for the area of JFSC Province, which comprises roughly 70% of the targeted population. Technical interventions are behind schedule, with only maternal-newborn care fully implemented to-date; however, nutrition, control of diarrheal disease and pneumonia care management will begin simultaneously in the next few months through activities based on support for the Integrated Management of Childhood Illness. Conversely, establishment of the community-based health information system is ahead of schedule and clearly having a direct impact on maternal-child morbi-mortality. In addition, MTE found that the initial investment in extensive participatory planning with partners has most likely contributed to the enthusiasm displayed by partners for the project's goals, objectives and strategies and will be an important contributing factor to sustainability.

The initiation of the REDESS Project in Cajabamba Province, 30% of the project target population, was scheduled to "cascade" behind implementation in JFSC Province, by roughly six months. This was delayed a further six months for multiple reasons, including changes in MOH partner positions in Cajabamba; a greater than anticipated need for up-front organizational support to establish networks, micro-networks and sectoralized community outreach by health units in JFSC Province; and a realization by the project that another field technician was needed in order to achieve coverage of this remote target area with very poor access in some zones. Another field technician position was added in November 2001 to address the strengthening of implementation specifically in Cajabamba Province.

The project maintains an internal **MONITORING SYSTEM** and also directly supports the design and implementation of useful monitoring information by MOH partners in the area of community outreach, such as monthly reports by CHAs, the referral/counter-referral system, etc. All project staff review internal monitoring data on a regular basis, as part of their development of plans for follow-up of health units, CHAs, and/or communities that may need additional technical assistance beyond that normally planned for all areas.

C2. STAFF TRAINING

All of the project staff have previous experience in either the CARE PERU CS XII Project, other CARE PERU health projects, or the regional MOH system. CARE provides for continuous technical education of Child Survival project staff through participation in international events, regional workshops and national fora. To-date, Project REDESS personnel have rotated participation in the following events:

- Annual Child Survival Workshop, 2001 in India (2 staff)
- Annual Child Survival Workshop, 2002 in Kenya (1 staff)
- CARE HQ Workshop on Maternal and Peri-natal Health, Atlanta GA 2001 (1 staff)
- CARE LAC Regional Health Workshop, Trujillo Peru 2001 (7 staff)
- Peru National NGO Forum for Health, Lima Peru 2002 (1 staff)
- International Conference on Women's Health (*IGAM*), 2002 in Lima (1 staff)

Participation in future training workshops is planned:

- CARE HQ Workshop on Maternal and Peri-natal Health, Atlanta GA 2002 (1 staff)
- Annual Child Survival Workshops, 2003 and 2004 (at least 1 staff each)
- CARE LAC Regional Health Workshop on BCC, January 2003 (at least 2 staff)

CARE PERU also forms regional working groups to investigate and share information towards the development of CARE PERU strategies and materials in cross-cutting issues, such as gender equity and/or local government - civil society strengthening. Individual Project REDESS field staff are members of several of these working groups.

C3. HUMAN RESOURCES

The CARE regional long-range strategic plan for Latin America and the Caribbean calls for a transition to a new role for field offices, with a greater emphasis on the provision of technical assistance to project counterparts while decreasing the PVOs role in direct implementation at the community level. This transitional strategy influenced both the design of the CARE PERU CS XII project and the present CS XVI project.

At preparation of the Detailed Implementation Plan, provisions were made to include as paid **PROJECT PERSONNEL**: a Child Survival Coordinator (100%); a Field Team Leader (100%); 4 Field Technical Assistants; and 1 Administrative Assistant. However, after one year of project implementation it was determined that another Field Technical Assistant position was needed to achieve coverage in such an under-developed rural area as J.F.Sanchez Carrion and Cajabamba Provinces represent. The Field Team

Leader and 4 Field Technical Assistants are based in Huamachuco, the capital of JFSC Province, while the 5th Technical Assistant, added in November 2001, was placed in the capital of Cajabamba Province. The Child Survival Coordinator and Administrative Assistant are based in the CARE PERU regional office in Cajamarca.

For the remaining life-of-the-project, project management is considering the elimination of the Field Team Leader position. The staff member in this position will leave at the end of FY2002 to pursue an opportunity for obtaining a master's degree. The project is presently conducting a detailed analysis of the budget, both USAID funding and counterpart contributions, to assess the feasibility of adding a **SIXTH TECHNICAL ASSISTANT** position to further strengthen project implementation, follow-up and coverage. Project management is also considering increasing the percentage of Project Coordinator's time spent on direct project supervision. Both ideas are endorsed by the Midterm Evaluation external consultant. The Project REDESS plan for Human Resources will be submitted, along with the Action Plan in response to Midterm Evaluation recommendations, within one month of submission of this Midterm Evaluation report.

MOH COUNTERPARTS at the Network level in JFSC Province have fully complied with their expected role in providing human resources in support of project implementation. Project REDESS staff in JFSC Province partner with a minimum of 17 doctors, 18 registered nurses, 17 obstetric technicians (professionally trained midwives), 26 auxiliary nurses and 16 health technicians. In addition, at least 4 members of the JFSC Health Network Management Team directly support project activities. These 100 MOH professionals, not paid by the project, contribute a minimum of 10% of their time directly to project activities in support of MOH community outreach goals.

At present, 308 fully-active Community Health Promoters (CHPs) and 93 traditional birth attendants (TBAs), for a total of 401 **COMMUNITY HEALTH AGENTS** (CHAs), are voluntarily supporting project activities at a minimum of approximately 15% of their time per quarter (this includes participation in 2-3 day training events). The overwhelming majority of TBAs, though not all, are female; approximately 25% of active CHPs are female. An additional 185 CHAs support project activities at varying levels of intensity.

C4. SUPERVISION AND STAFF MANAGEMENT

As an international private voluntary organization actively assisting Peru for more than 20 years, CARE PERU has well-defined **PERSONNEL POLICIES AND PROCEDURES**, including detailed job descriptions for each position within this project. Annual performance evaluations, based on CARE's human resource management system, are conducted. The Project Coordinator reports to the CARE PERU Regional Director in Cajamarca, who reports to the Assistant Country Director for Programming.

CARE HQ, CARE PERU, and project management endorse the concept of "supportive supervision", in which staff are active partners in assessing project progress. Project REDESS **FIELD STAFF** are a tight-knit group that actively support one another in work

planning, project implementation and problem-solving. Five of the six field staff positions are filled by staff that participated in the CARE PERU CSXII project. The Project Coordinator, with support from the Field Team Leader who dedicates 25% of the time to project co-coordination and 75% to direct implementation in the Huamachuco municipal micro-network, provides leadership in all project planning activities and regular supervision to project field personnel. In addition, the Project Coordinator functions as a representative of the project in all provincial-level organizational meetings and in coordination with regional MOH representatives. (See section C3. Human Resources, for potential changes in project organizational structure.)

C5. FINANCIAL MANAGEMENT

CARE PERU uses the **FINANCIAL MANAGEMENT SYSTEM**, *SCALA*, developed by CARE USA headquarters, with monitoring of the system by CARE HQ finance. The program budget is managed by the program manager (Project Coordinator), with accounting support from the project Administrative Assistant. Accounting reports are submitted to the CARE PERU financial administration unit. Costs are tracked quarterly and financial reports are formulated in accordance with the approved budget line items and headings. The CARE PERU financial administration unit submits financial reports to CARE HQ for review by the Child Health Unit and by the Financial Officer.

Financial planning for **SUSTAINABILITY** is based on the human resource structure of this project, which includes a minimal number of paid project personnel but a high level of MOH counterpart and voluntary community contribution of time (1 to 14 and 1 to 60, respectively). Additional project costs are for training events and health education materials, primarily, with limited provision of necessary equipment to MOH units, such as two-way radio transmitters.

The project has provided little direct support, other than training, for the municipal-level CHA representative Committees **(COACS)**. Midterm Evaluation found each of 6 COACS interviewed to have conducted at least one fundraising activity, at a profit of US$75-US$100, and to have future plans for quarterly fundraising. In addition, at least half of the COACS interviewed during Midterm Evaluation have obtained direct or in-kind financial support from municipal government, such as the provision of office space, furniture or funds for purchase of daily supplies.

C6. LOGISTICS

There have been no logistic obstacles to project implementation to-date; however, local costs of services in the JFSC provincial capital of Huamachuco are increasing. This is attributed to a dramatic change in private investment in the area in the mining sector. Although costs for office rental, supplies, fuel, etc. remain within the project operational budget at present, the possibility exists that these costs might become a constraint by Year 4 of the project.

C7. INFORMATION MANAGEMENT

As noted in section C8, the project received technical assistance from the National Coordinator of the CARE PERU Monitoring Unit for development of the project's internal monitoring system. The **TYPE OF DATA** collected by the project includes: numbers and types of participants at all project training events; number and sex of CHAs, CHA implementation of the community-based health information system (such as the census and community risk mapping), along with monthly reports of educational activities and home visits, community-based health care provision (such as that for CDD or PCM), referrals to local health units, and/or emergency evacuations.

The project obtains information on monthly CHA activities from the information gathered through the manual **MOH HEALTH UNIT COMMUNITY-BASED INFORMATION SYSTEM**, established with the assistance of the project. The project provides technical assistance to the provincial health network in tabulating this information and the project will begin activities focused on the analysis of this information for community outreach planning and "supportive supervision" and feedback of CHAs in early FY2003.

Project REDESS also includes a focus on **INVESTIGATIONAL STUDY** to inform project design. The project coordinated with the (private) University of Antenor Orrego for an assessment of community preferences in media and fora for behavioral change communication. These results were disseminated to project partners and formed the basis of participatory planning for a Communications Campaign for Behavioral Change. In addition, the project supported nursing students from the National University of Trujillo in conducting an assessment of experiences among local women leaders, as part of their community fieldwork. These results have also been shared with MOH partners and participants in local government and are social networks, to further the discussion of the role of women in civil society participation.

The project may obtain technical assistance in **LOT QUALITY ASSESSMENT** techniques in FY2003 and hopes to use this tool to assess progress in changing attitudes and practices among project beneficiaries, as an interim step between baseline and final KPC Survey evaluation.

C8. TECHNICAL AND ADMINISTRATIVE SUPPORT

Technical support is provided to the project by the **CARE PERU HEALTH ADVISOR**, who coordinates information-sharing on strategies, materials and lessons learned by all CARE PERU projects in the health sector and other PVOs/NGOs in the region and participates in bi-annual internal assessment of project progress. In addition, the project received technical support in Year 1 from the National Coordinator of the CARE PERU Monitoring Unit for development of the project's internal monitoring system.

CARE HQ provides back-stop support to the project through a variety of mechanisms, such as the review of all project plans and budgets, regular technical information up-dates, design of over-arching health strategies and materials, etc. In addition, members

of the CARE HQ Child Health Unit staff visit the project at least annually to review project implementation. In two years of project implementation, CARE HQ staff have visited the project three times, along with previous participation by HQ staff in the design of the project. In addition, CARE HQ staff network with project management at the annual Child Survival Workshop. CARE HQ also coordinates and participates in annual regional technical workshops (see section C2. Staff Training).

For Years 3 and 4 of the project, Project REDESS will obtain external technical assistance for the following topics:

- Update of Adult Education Methodologies
- Qualitative assessment of child nutritional practices, including techniques to assess positive deviation and incorporate assessment into plans for behavioral change communication
- Use of Lot Quality Assessment tools for monitoring and evaluation
- Strategies for strengthening local government - civil society linkages

D. OTHER ISSUES

No other issues were identified during Midterm Evaluation.

E. CONCLUSIONS AND RECOMMENDATIONS

The analysis of Midterm Evaluation results and development of recommendations and suggestions was a participatory process between the external consultant, Project REDESS staff, MOH counterparts, and the CARE HQ health unit representative. The final day of Midterm Evaluation was devoted to small group analysis and discussion of Midterm Evaluation results (Attachment E) as the first step in developing recommendations.

Recommendations are focused more on the balance of project efforts, with the key suggestion being that the project shift into a balance that is directed slightly more towards the capacity-building of CHAs and community outreach capacities of MOH personnel, and less towards strengthening the quality of services available in local health units. The recommendations noted below are generally additional suggestions for the strategies already planned by the project for implementation in FY2003 and FY2004.

E1. STRENGTHENING COMMUNITY HEALTH AGENT CAPACITIES

Training of Community Health Agents is the core strategy of Project REDESS and Midterm Evaluation found the strategy used to-date (that of providing considerable support to MOH personnel in the design of training and materials, and limited technical assistance during the training of CHAs) to be an excellent strategy for multiplying project outputs while establishing a basis for future sustainability.

It is recommended that Project REDESS maintain and expand plans to focus on multiple mechanisms to strengthen and document CHA technical capacities during follow-up, both to ensure the quality of community-based services and as part of CARE PERU advocacy for the role and capacities of community volunteers in health. Project REDESS has plans for intensive training of CHAs in Year 3 in technical topics related to the Integrated Management of Childhood Illness. If the preferred plan for selecting training centers and tutors from among local health units is not yet established at the start of FY2003, MOH personnel who are recommended to be tutors could be included as additional members within one or more different local MOH training teams, with the support of Project REDESS. This would provide for further modeling of tutor behavior by other MOH personnel and strengthening in their skills as trainers.

The Incorporation of selected CHAs, most likely COACS leaders, in a limited role as other additional members of the MOH training teams to train CHAs, would also strengthen another link for follow-up and sustainability of CHA capacities.

Project REDESS, in participation with MOH partners, has developed a supervision form and guidelines for sectoral supervisory visits to communities by MOH personnel. The project plans to provide further guidance and support in strengthening this community outreach system. In addition, Project REDESS is presently assisting COACS leaders to establish their own plans and mechanisms for conducting community visits to CHA members, to provide support, supervision and feedback.

It is recommended that Project REDESS field staff establish a plan to accompany individual MOH personnel on a (limited) rotating basis during sectoral community visits, to provide technical assistance and guidance to MOH personnel in the assessment of CHA technical capacities and provision of feedback. Selected COACS leaders could be included in these visits and Project REDESS staff could strengthen their supervisory capacities at the same time. A case study of randomly selected referrals and/or community-based treatment by a student intern would be very useful in providing documented support for advocacy at the national and international level in regards to community health volunteer capacities.

E2. ACHIEVING BEHAVIORAL CHANGE AT THE COMMUNITY LEVEL

In participation with MOH partners, Project REDESS has developed a Communications Plan for Behavioral Change. This plan contains strategies for disseminating health messages at multiple levels and through various methods, from mass media radio spots to one-on-one counseling. In order to achieve the greatest amount of positive behavioral change in the life-of-the-project, it is suggested that the project increase the focus on strategies for popular education at the mid-level -- specifically, group activities at locations and events that are natural socio-economic corridors for project beneficiaries (Mutual Support Group,*Grupos de Apoyo Mutuo*). Through further definition and adaptation of the organization of these events, several goals can be attained: strengthening the link between MOH personnel and community members,

increasing leadership for community health by CHAs, and positive and supportive exchanges of experiences among project beneficiaries.

In regards to planned strategies to develop Mothers' Interchange Groups (*GIACS*) at the individual community level (in addition to larger community health education activities and home visits for one-on-one counseling), it is recommended that the project consider a Training-of-Trainers model for use in developing the facilitation skills of select CHAs. These CHAs can then function as assistant trainers in the replication of these groups from community to community (and will most likely further increase their leadership skills if they are representatives in COACS).

The strongest, or "star", Mothers' Interchange Groups (*GIACS*) can also be a forum for the planned period of practical application of techniques for assessing nutritional practices and beliefs, after the FY2003 CARE staff workshop on this topic, for the addition of appropriate detailed suggestions for mothers' practice of general complementary feeding recommendations.

In regards to the mass media campaign for local radio spots, as discussed with MOH counterparts who participated in the Midterm Evaluation process, the project will review and re-consolidate the plans developed to-date to ensure that the types of messages and period in which they are disseminated do not saturate the listening market. It would also be useful for the planned technical assistance from UPAO Communications Science students to also include incorporation of Lot Quality Assessment techniques to evaluate the effectiveness of mass media messages.

For the target area within Cajabamba Province, which is implemented in a cascade fashion after establishing strategies and activities in JFSC Province, the project needs to re-think or streamline these strategies so that the greatest impact can be achieved in this zone during the remaining life-of-the-project. The project should also plan to select a stratified sample for administration of the final evaluation KPC Survey, increasing the size of the sample in JFSC Province so that the impact of the lengthiest implementation of the most complete package of project interventions can be measured.

E3. CIVIL SOCIETY PARTICIPATION IN LOCAL GOVERNMENT

It is recommended that the project consider devoting efforts in the area of local government - civil society strengthening to achieving a place for COACS representatives within the municipal coordination roundtables. These efforts would be in place of forming COACS into Association Groups, and then assisting Associations to represent ACS and communities within local government structures. This is suggested because Midterm Evaluation seemed to detect a greater opportunity for a positive and more immediate response to community representatives, and their potential requests, at the municipal level, based on the support they've provided to COACS groups to-date.

This could be initiated through a process as simple as having COACS representatives regularly (quarterly?) give presentations on CHAs roles, activities and impact within their communities to the municipal coordination roundtable members. COACS could also

become the representatives and advocates for the health proposals of the many local community development committees (CODECOs) before municipal government and other institutions.

F. RESULTS HIGHLIGHT

Preventing child mortality

It took a great deal of persuasion by the volunteer Community Health Promoter to convince the parents of a six-month-old baby girl that she needed immediate medical treatment for pneumonia. However, the CHP succeeded and the community evacuation committee, organized with support from the CARE PERU Child Survival Project REDESS, assisted in carrying the child 1-1/2 hours to the nearest road where they were met by the doctor and ambulance driver of Sarin Health Post.

The baby's situation was determined to be so serious that the doctor decided upon her direct transfer to the J.F. Sanchez Carrion Hospital. With oxygen support and antibiotic treatment, the infant was cured and returned home within a week, where she continues to do well. The parents and other community members, along with the Community Health Promoter and the medical staff involved in this emergency, are happy that a potential infant death was averted.

Preventing maternal mortality

In Markahuamachuco, the obstetric technician at the local health center has high praise for the efforts of Community Health Agents. During Midterm Evaluation, she cited three instances this year so far (2002) in which their actions made a significant contribution to the prevention of maternal mortality.

Each of three different community health agents in three different communities have at one point or another identified a potential childbirth emergency in time to notify the obstetric technician and bring her to the home of the mother in labor. In each case, the obstetric technician was able to assist the mother in childbirth such that a dangerous emergency childbirth situation was avoided.

G. ACTION PLAN

Please see attachment G for Project REDESS' action plan in response to the recommendations of this Midterm Evaluation. A detailed review of the budget was conducted, along with a review of staffing and logistics issues. The goal of this review was to maintain or increase project momentum while increasing budget efficiencies. As noted above, all Midterm Evaluation recommendations have been thoroughly discussed with the Project Coordinator and CARE PERU Health Advisor, and they are in agreement with all suggestions.