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EVALUATION

FINAL EVALUATION REPORT ON “HEALTH IN THE HANDS OF WOMEN: A TEST OF TEACHING METHODS” PROJECT IN PERU: 2010-2014

December 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared by Laura C. Altobelli, Peru Country Director, Future Generations, Jose Cabrejos-Pita, Project Manager, Future Generations, and Sandra Wilcox, External Consultant.

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Cover photo: Women Leader teaching mother using the project flipchart “Pregnancy” in a rural community of Huánuco, Peru. Photo by: Lurdes Cabello.

FINAL EVALUATION OF “HEALTH IN HANDS OF WOMEN: A TEST OF TEACHING METHODS”:

**STRENGTHENING PRIMARY HEALTH CARE SYSTEMS TO LINK WITH
LOCAL GOVERNMENT AND COMMUNITIES FOR COLLABORATIVE
MANAGEMENT OF HEALTH PROMOTION FOCUSED ON MOTHERS,
NEWBORNS, AND CHILDREN IN COMMUNITIES**

December, 2014

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

AOP	Annual operating plan
ARI	Acute respiratory infection
BCC	Behavior change communications
CCL	Local Coordination Committee (Comité de Coordinación Local)
CENAN	National Center for Food and Nutrition (Centro Nacional de Alimentación y Nutrición)
CF	Community Facilitator
CHA	Community health agent
CHA-A	Community health agent association
CRED	Growth and Development Program (Crecimiento y Desarrollo)
CLAS	Local Health Administration Community Association (Comunidad Local de Administración de Salud)
CND	National Commission on Decentralization (Comision Nacional de Descentralización)
CODECO	Community Development Committee (Comité de Desarrollo Comunal)
CSHGP	Child Survival and Health Grants Program
DGPS	General Directorate of Health Promotion (Dirección General de Promoción de la Salud)
DGSP	General Directorate of Personal Health (Dirección General de Salud de las Personas)
DHS	Demographic and Health Surveys
DIGEMID	General Directorate of Medicines, Supplies, and Drugs (Dirección General de Medicinas, Insumos y Drogas)
DIRESA	Regional Health Directorate (Dirección Regional de Salud)
ENC	Emergency neonatal care
EOC	Emergency obstetric care
EOP	End of project
EBF	Exclusive breast feeding
FE	Final Evaluation
FG	Future Generations
FGP	Futuras Generaciones/Perú (Future Generations/Peru)
HF _s	Health Facilities
HIS	Health Information System
HW	Health Worker
IMCI	Integrated Management of Childhood Illness
JASS	Sanitation Service Administration Committees (Juntas Administradoras de Servicios de Saneamiento)

ACRONYMS (continued)

KPC	Knowledge, practice and coverage
LAM	Lactational amenorrhea method
MAM	Health in the Hands of Women (Salud en Manos de Mujeres)
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
MTE	Mid-term evaluation

NBI	Unsatisfied basic needs (Necesidades básicas insatisfechas)
NGO	Non-governmental organization
NMR	Neonatal mortality rate
ORT	Oral rehydration therapy
PAAG	Program for Administration of Management Agreements (Programa de Administración de Acuerdos de Gestión)
PAC	Shared Administration Program (Programa de Administración Compartida)
PEI	Infant and Child Emergency Plan (Plan de Emergencia Infantil)
PDC	Municipal Development Plan (Plan de Desarrollo Municipal Concertado)
PHC	Primary health care
PMR	Perinatal mortality rate
PP	Participatory Budget (Presupuesto Participativo)
PSL	Local Health Plan (Plan de Salud Local)
PRA	Participatory Rapid Appraisal
PVO	Private voluntary organization
RGC	Regional Government of Cusco
SCALE-One	Successful Change As Learning Experiences
SCALE-Squared	Self-help Centers for Action Learning and Experimentation
SCALE-Cubed	Systems for Collaboration, Active Learning, and Extension
SEED-SCALE	Self-Evaluation for Effective Decision-making – System for Communities to Adapt Learning and Expand
SICOS	Community Co-Managed Health System (Sistema Co-Gestionado de Salud Comunitaria)
SIS	Integrated Health Insurance (Seguro Integral de Salud)
SIVICO	Community Surveillance System (Sistema de Vigilancia Comunal)
TBA	Traditional Birth Attendant
WFA	Women of Fertile Age
WL	Women Leader



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FINAL EVALUATION EXECUTIVE SUMMARY

Final Evaluation of “Health in Hands of Women: A Test of Teaching Methods” - Executive Summary

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

December, 2014

Evaluation, Purpose, and Evaluation Questions

The USAID CSHGP-funded Project “Health in Hands of Women” (MAM), was implemented by Future Generations (FG) in four districts of the Huánuco region in Peru from 2010 to 2014. The final evaluation was to determine how the MAM project met its goal to “contribute to sustainable improvements in maternal and child health in three micro-networks of primary health care in Huánuco, which can later be scaled up to the region and nationally.” This was a performance evaluation to be accessed by various audiences including the MOH. Findings were meant to contribute evidence relevant to global initiatives in health. Key questions were: 1) To what extent were original project goals accomplished? 2) What were key strategies and factors that contributed to what worked or did not work? 3) What elements are likely to be sustained or expanded?

Project Background

The project design centered on two main key over-arching strategies. First, the SEED-SCALE strategy developed by FG was used in MAM to strengthen sustainability and replication of successful interventions. This approach emphasizes building on successes, three-way partnerships, and using local data to make local action plans. Second was the Sectorization Strategy, which guides the reorganization of primary health services to focus on communities and is expected to be sustained and expanded by the regional MOH: a component of this strategy was the *Modular Program for Training Women Leaders in Maternal, Neonatal and Child Health*.



*Women Leader teaches a mother with a flipchart.
Photo: Lurdes Cabello.*

Key Findings:

- **Home visits and education of mothers by female community health workers were highly associated with reduction in stunting in poor rural children.**
- **Strengthening rural primary care services and linking them with local government and communities is essential for health promotion in communities.**

Evaluation Questions, Design, Methods, and Limitations

The final evaluation team consisted of an external evaluator and five FG project staff. The evaluation methodology consisted of a mixed-methods approach using both quantitative and qualitative data. The approach comprised both a desk review of secondary data sources and the collection of qualitative data to complement existing data. Evaluation questions were provided in the external consultant's scope of work, which had previously been reviewed by a special team providing technical assistance on final evaluations. The written design of the evaluation was finalized by the external evaluator and the evaluation team (e.g., number of key informant interviews, focus groups discussions, observations, and locations) and shared with project stakeholders and implementing partners.

Findings and Conclusions

Major findings showed major improvements in mothers' knowledge and behaviors for maternal, neonatal and child health and nutrition, largely related to successful implementation of a behavior change strategy that introduced innovations in the Peruvian health sector for CHW trainers (Tutors), CHW supervisors and supporters (Community Facilitators), a role for older community women as CHW (Women Leaders), teaching and training materials (flipcharts and facilitator manuals), and CHW teaching methodology ("Sharing Histories"). The MAM project built on the new CLAS law that includes co-management of health facilities (HFs) with citizen participation, and set into place the "Sectorization" strategy to strengthen linkages between community, HFs and municipalities in Huánuco. This included incorporation of community priorities in a participatory budgeting process and coordination with institutions, particularly municipal governments, to fund Community Facilitators who were introduced in this project as a new cadre of human resources from communities who served as the link with primary health services for supervision of female community health worker (CHW) known as Women Leaders.

MAM worked to improve the quality of care in HFs by changing staff attitudes about community health outreach. FG's Sectorization strategy was introduced at community and HF levels to strengthen services and focus on prevention. The strategy for reorienting health services to work in communities was presented in the Methodological Guide to Sectorization for Health Promotion in Co-management with the Community, which was approved by the Huánuco Diresa and published by Future Generations in September 2012. A Directorial Resolution issued by Diresa declares the Sectorization Strategy as an official policy for the Huánuco region, to be scaled up to every primary health care facility in the region (about 400). At the community level, MAM provided training and support to *Women Leaders* (WLs) and *Community Facilitators* (CFs) through the training of *Tutors* and development of training modules and materials. MAM also provided tools to the WLs for monitoring target groups and reporting to the HFs and municipalities.

A key project activity was the implementation and testing of an innovative teaching method for community health workers, called "Sharing Histories" that empower mothers by sharing their own experiences, hearing other's experiences, and learning best practices by analyzing what was done correctly or incorrectly in the past. Women leaders gained self-confidence to speak in front of others, took ownership of their own experiences, and became more effective in their home visits to other women teach them better health practices. The MAM project tested the effect of the "Sharing Histories" teaching method as an embedded operations research project using a cluster-randomized controlled trial.

Some of the key accomplishments of MAM include:

- Significant increases in knowledge of pregnancy, post-partum and newborn danger signs by an average of 16 to 48 percentage points.
- Significant increase in newborns that are wrapped and dried immediately at birth (76% to 98%)
- Significant increases in all hygiene and sanitation indicators including hand washing, disposal of feces and water treatment.
- Significant increase in the percentage of HF managed by CLAS Associations (43% to 70%).
- Development of a new cadre of human resources for community health called Community Facilitators, and all 47 are now contracted directly by the municipalities.
- Community Facilitators and Women Leaders are recognized by health workers (sectoristas) as being key components for the HF community strategy.

- CF and WLs are recognized by community authorities and municipalities as playing a critical role in improving community health.
- The Huánuco Regional MOH established a permanent “*Center for Development of Competencies in Health Promotion*” in the Acomayo Health Center to sustain the new approach to community health promotion by guaranteeing the on-going training of Tutors to continue the training and support for CFs and WLs on a wider scale.
- Municipalities are increasing support to HFs by funding the CF stipends, and financing ML and FC training costs as well as contracting health personnel, constructing and remodeling infrastructure, providing equipment, implementing services (laboratory, maternity waiting homes), and providing fuel for motorcycles or bus fare for health personnel supervision to communities.
- Municipalities are improving the participatory budgeting process by organizing their districts into 4-5 zones and having each zone focus on 1-2 projects that will benefit all communities in each zone.

Although the project achieved most of its goals and put many new systems in place, there are still questions regarding whether the changes will remain as now established. While the project has been successful in developing strategies to overcome many obstacles (distances, high staff turnover, migrating populations) there are still uncertainties. The WLs are functioning and have community support but since they are volunteers, there is turnover and more incentives would help. The CFs are now fully funded by municipal budgets but the contracts are renewed yearly and will require that there is regular lobbying with the local governments if it is to continue. There could be a possibility of the strategy being expanded nationwide if the Ministry of Economics and Finance decides to promote CF financing as part of the Program to Modernize Municipal Management. With the recent establishment of the regional “*Center for Development of Competencies in Health Promotion*” training center in the Acomayo Health Center, it suggests that the role of the Tutors will be expanded to other HF in the region, allowing the Behavior Change Strategy to be expanded through continued monthly CF and WL training meetings in a wider number of health facilities in the Huánuco region. Again, the budget to support the monthly meetings at HFs is being provided by the local governments and in cases where CLAS (that control HF discretionary budgets) has not assumed the cost, this will need attention. Ideally CLAS or the general MOH budget process would take over all CF and WL training costs.

Sectorization and its strategy of regular outreach to the project area communities is in place but it requires that staff participate. They currently have no legal obligation to do so, therefore not all staff are on board with it. Given the levels of staff rotation, and the reduced motivation and working hours for staff who gain contracts on the public payroll, the project estimates that only about half of the sectorists are functioning in the communities as expected. Four years is a relatively short time when one hopes to make changes in a local, regional and national health system. So far, FG Peru has been able to continue acquiring funding for projects so that they can keep assisting the MOH to decentralize and improve its health services, through its SEED SCALE approaches and other technical assistance.

One of the lessons learned by FG in this and previous projects is that if you want to impact changes to the health system at higher levels, it is necessary to document your experience and present them to the stakeholders. FG did this in its previous projects by working with both the MOH and the national Congress on a new law and regulations on CLAS with its presentations to national MOH regarding its changes to regional CLAS. FG is doing this with the MAM project by officializing its sectorization strategy in the Regional Health Office of Huánuco (DIRESA). It is also presenting and advocating for this strategy to be accepted at the national MOH in Lima. If sectorization goes the way of the CLAS modifications that became national law, it is likely that it will be approved at the national level as well.

Key Recommendations:

Recommend that donors in Peru work with the MOH to continue support for activities initiated and systems put in place by the “MAM project” in the Huánuco Region. Should also consider expanding the model to other regions and nationalize the sectorization strategy.

To strengthen community partnerships and engagement in the future, recommend more time for project implementation to assure that the new systems set in place by the project, the MOH and the municipalities actually take hold and become institutionalized, and lead to expanded impact.

The project “Health in the Hands of Women” in the Huánuco Region of Peru was supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The project “Health in the Hands of Women” was managed by Future Generations under Cooperative Agreement No. AID-OAA-A-10-00048. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information on the project “Health in the Hands of Women”, visit: www.future.org

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of the USAID Child Survival and Health Grant Program (CSHGP) support to Future Generations in Huánuco Peru was to contribute the health system strengthening goals of the Ministry of Health (MOH) of achieving sustainable improvements in maternal and child survival and health outcomes in three micro-networks of primary health care services, with a model that can be scaled up to the region and nationally in Peru. The USAID-CSHGP cooperative agreement offered FG an opportunity to demonstrate the links between specific delivery strategies and measured outcomes. The final evaluation (FE) was a performance evaluation to be accessed by various audiences including Ministries of Health (MOHs), and findings were meant to contribute evidence relevant to global initiatives in health.

The FE process provided an opportunity for project stakeholders to take stock of accomplishments and listen to the beneficiaries at all levels, including mothers and caregivers, other community members and opinion leaders, health workers, health system administrators, local partners, other organizations, and donors. Project staff indicated that the FE Report will be reviewed by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

- In-country partners at national, regional, and local levels (e.g., MOH and other relevant ministries, district health team, local organizations, communities in project areas).
- USAID (CSHGP, Global Health Bureau, USAID Missions), and other CSHGP grantees.
- The international global health community.

The FE report will be posted for public use at <http://www.mchipngo.net> and the USAID Development Experience Clearinghouse at <https://dec.usaid.gov>.

The external evaluator was selected by the project and hired with project funds. To assure independence of the review, USAID approved the evaluator and reviewed the Scope of Work. A debriefing of initial findings was presented to the Regional Health Directorate (DIRESA) and partners in Huánuco, and the MOH and USAID in Lima by the FE team. The final report was submitted to USAID simultaneously at the time it was provided to the grantee.

Evaluation Questions

The external evaluator and the evaluation team used existing data collected or compiled during the life of the project, as well as additional data collected during the final evaluation (FE) to answer the questions below. Please see the Annex (SOW) for more details regarding probes for the specific questions.

General Overview Question

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the DIP?

Questions on Community Engagement and Strengthening Health Service and Local Government Involvement with the Community

2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

Specific questions on Community Engagement

- a. What community structures and partners have been especially important for improving MNCH outcomes? In what ways have they contributed to improved MNCH outcomes?
- b. What specific strategies have been most effective in engaging and mobilizing community partners for improving MNCH outcomes? Why, or in what ways, are they most effective?
- c. What are you or your institution/organization doing differently in the area of MNCH as a result of the MAM project? What are you doing differently than you were before?
- d. In what ways can community partnerships and engagement be strengthened to best support MNCH outcomes?
- e. What is the evidence of change in the level of women's empowerment as a result of the MAM project?

Specific questions on Strengthening Health Service and Local Government Involvement with Communities

- a. To what extent and in what ways has the MAM Project been able to increase access to MNCH services for the most vulnerable groups in [your] community?
- b. To what extent and in what ways has the MAM Project improved the quality of MNCH services at the household and community level?
- c. To what extent and in what ways has the MAM Project improved the quality of MNCH services and counseling provided by health personnel in the clinical setting in health facilities?
- d. What management and governance structures were established to ensure delivery of quality services? How effective were they? What were the challenges?
- e. In what ways can health services and local government partnerships be strengthened to best support MNCH outcomes?

Sustainability and Scale-Up

3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?

Specific questions on Sustainability and Scale-Up:

- a. What exit strategies or processes are in place to maximize the likelihood that program elements will be sustained and scaled-up after the end of the current program? What in your opinion would be the most important strategies for sustaining the MAM Project innovations?

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- b. What elements of the MAM Project are most likely to be sustained after the end of the current program? Why are these most likely to be sustained?
 - c. To what extent have components of the CSHGP program been integrated or institutionalized in the formal health system and local government at this time?
 - d. How have the results and learning been shared with decision makers at district, sub-national and national level to influence scale up of CSHGP approaches?

PROJECT BACKGROUND

Future Generations (FG) received funding from USAID as a New Partner for the implementation of a four year Child Survival Project in Huánuco, Peru. The project title is “Health in the Hands of Women: A Test of Teaching Methods” and is also referred to as “MAM.” Funding was provided from October 2010 until September 2014. The project had three interventions: maternal and newborn care with 40% level of effort; infant and young child feeding with 30% level of effort and; control of diarrheal disease with 30% level of effort. Five program elements were applied to each of the program technical areas: increasing knowledge and demand; strengthening community leadership and participation in health to improve access, assuring quality services and; developing a supportive policy environment through advocacy. The project was implemented in 4 districts in the Andean Huancayo Region, Sta Maria del Valle, Umari, Chinchao, Churubamba. The population is 90% rural and distances to health facilities range from 30 minutes to 8 hours.

Table 1. Beneficiary Population by age and sex

Population Beneficiaries	District				TOTAL 1 yr.	TOTAL 4 yrs.
	Chinchao	Churubamba	Santa María del Valle	Umari		
Neonates	50	55	42	39	186	744
0-11 months (infants)	567	623	466	433	2,089	8,356
Children aged <5 Years	2,822	3,104	2,321	2,160	10,407	16,641
Women 15 – 49 years	5,974	6,572	4,914	4,570	22,030	23,974
Total Beneficiaries	8,796	9,676	7,235	6,730	32,437	40,615
Total Population	23,642	26,005	19,443	18,084	87,174	93,441

Source: Direction of Informatics and Statistics – DIRESA Huánuco, 2010.

Each of 24 geopolitical regions of Peru is governed by a Regional Government, which has a Regional Health Directorate (DIRESA). Regional health services are organized into networks and micro networks, each with a management center. In the Huánuco Region there are three health service networks (Huánuco, Marañón and Leoncio Prado) and 25 micro networks (districts). At the beginning, the project area covered three micro networks (Santa María del Valle, Quera and Acomayo) within the Huánuco health service network. In the three micro networks there were **22 PHC facilities**, of which four were health centers and 18 were peripheral health posts. Early in 2011, two peripheral health posts in Churubamba district, built by the municipality, were officially recognized as health facilities, extending the intervention to **24 HF**. By the end of the project, two new micronetworks, Umari and Churubamba, were created by sub-dividing Santa Maria del Valle and removing Quera; and achieving one Micronetwork per district as established through recent decentralization policies. Also, three additional PHC facilities were built (two in Umari and one in Santa María del Valle in all cases with municipal or regional government financing) for a total of **27 PHC facilities**. At the beginning of the project, there were 219 health workers within the project area including 18

doctors, 53 nurses, and 47 midwives. After four years of intervention the number of health workers increased 16% (to a total of 255 health workers; including 23 doctors, 56 nurses and 56 midwives).

The project was implemented by Future Generations (FG) in collaboration with ten government partners (from regional to local levels): the Regional Government of Huánuco; the Regional Health Office of Huánuco (DIRESA); the Huánuco health service management network; three micro-networks in four districts; and four district municipalities (local government). See table 2.

Table 2. Community and Government Beneficiaries

	District				TOTAL
	Chinchao	Churubamba	Sta María del Valle	Umari	
Women Leaders (CHWs) (now)	188	140	181	130	639
Community Facilitators	10	9	12	10	41
Health Personnel	86	67	110	72	335
Health Facilities	6	6	10	4	26
Hospitals	0	0	0	0	0
Health Centers (I-3)	2	1	2	1	6
Health Posts (I-2) with doctor	3	3	8	1	15
Health Posts (I-1) no doctor	1	2	0	2	5
Community-Based Structures – JVC or CODECO	48	45	66	22	181

MAM Project Results Framework

The MAM *Project Goal* was to “contribute to sustainable improvements in maternal and child health in three micro-networks of primary health care in Huánuco, which can later be scaled up to the region and nationally in Peru.”

The *Strategic Objective* was “To improve maternal-neonatal-child health and reduce chronic child malnutrition.” The key *Overarching Strategies* are the SEED-SCALE Methodology and Sectorization Strategy.

The *Desired Results* were:

Result 1 - Mothers and families change behaviors and achieve best practices for MNCH and nutrition

Result 2 - Communities have strengthened capacities to lead and monitor the protection of MNCH and nutrition

Result 3 - Health system has strengthened capacities for financing, managing, and implementing improved quality of primary health care oriented to communities to resolve key needs for MNCH and nutrition.

Result 4 - Local governments increase their management and financial contributions to community health oriented to MNCH and nutrition

Result 5 - Public policies promote processes for scaling-up community-oriented PHC services of the Ministry of Health (MOH).

The abbreviated *Results Framework* is found on the following page:

ABBREVIATED RESULTS FRAMEWORK – “HEALTH IN THE HANDS OF WOMEN” PROJECT¹

Strategic Objective SO1: Increase use of best practices for MNCH and nutrition by mothers and families.	SO2: Strengthen communities’ capacities to monitor and lead the protection of MNCH and nutrition	SO3: Strengthen health system capacities for financing and managing the quality of primary health care oriented to communities to resolve key needs for MNCH and nutrition.	SO4: Increase capacity of Local governments in management and financing of community-oriented MNCH and nutrition activities.	SO5: Improve public policies at the national, regional, and local levels that promote processes for scaling-up community oriented PHC
Results/Outcomes: <ul style="list-style-type: none"> • Improved knowledge & practice for MNCH by mothers /families • Increased care seeking by pregnant women and mothers 	Results/Outcomes: <ul style="list-style-type: none"> • Strengthened community organization structures • Increased MNCH behaviors of women 	Results/Outcomes: <ul style="list-style-type: none"> • Improved HW technical capacity in obstetrical and neonatal emergencies, nutrition counseling, CDD • Improved HS organization for work w/ communities 	Results/Outcomes: <ul style="list-style-type: none"> • Increased capacity of CLAS and Local Municipalities • Increased management and planning capacity of DIRESA, Networks 	Results/Outcomes: <ul style="list-style-type: none"> • Improved capacity of national, regional MOH to scale-up community-oriented PHC. • Strengthened policies for community MNCH.
Strategies: <ul style="list-style-type: none"> • Home Visits • BCC 	Strategies: <ul style="list-style-type: none"> • Create: Community Emergency evacuation committees; community workplans; community birth plans; Care Groups, CF to support WL; • OR study to test “Sharing Histories” Methodology 	Strategies: introduce <ul style="list-style-type: none"> • Sectorization strategy • Develop “Tutors” at HFs to train WL & CF • “Situation Rooms” in health facilities, • Support Maternity Waiting Homes 	Strategies: <ul style="list-style-type: none"> • Build the capacity of CLAS and Local Municipalities • Support the process of micronetworks accreditation through implementation of a Quality Assurance System 	Strategies: <ul style="list-style-type: none"> • Advocate for scaling up project strategies • Promote new child health policies with civil society organizations, local, regional, and national government
Activities: <ul style="list-style-type: none"> ▪ Print, distribute: Flip charts, facilitator manuals, birth plans, referral and reporting forms. ▪ Train WL and CFs to educate mothers, pregnant women on MNCH-nutrition 	Activities: <ul style="list-style-type: none"> ▪ Train community leaders on MNCH, emergency evac. Committees, work plans ▪ Train WL for home visits, Care Groups, BF support groups 	Activities: <ul style="list-style-type: none"> ▪ Train HWs as Tutors to use Facilitator Manuals, ▪ Train HWs on improved OB/NB emergency care, nutrition, CDD, EBF, Sectorization, ▪ Train HWs on plans,budget 	Activities: <ul style="list-style-type: none"> ▪ Orient local governments on financing mechanisms and planning for MNCH ▪ Provide T.A. to Health Network, Micronetworks and other partners to improve CLAS mgmt and operations 	Activities: <ul style="list-style-type: none"> ▪ Develop: model training center; performance competencies for HWs in communities; ▪ Advocacy w/ GOP for scale-up of project strategies

¹See Annex for the more detailed Results Framework

Project design

There were no significant changes to the project design since the original Detailed Implementation Plan (DIP) submitted by FG in the first project year.

Cross Cutting Element of Project Design: SEED-SCALE Methodology

A key strategy of the project design is its employment of the Seed-Scale methodology.¹ This approach builds on successes, partnership, and local decision making based on data to develop action plans. The approach as applied in the MAM project includes elements of self-evaluation, continuous learning, collection and use of data for decision making, local action planning and the exchange of information and positive experiences. The approach contributes to: (1) scaling-up, (2) increased governance capacity in local institutions and communities, (3) greater equity, and (4) sustainability. A key design element is the project's focus on sustainability, which is one of the main tenets of the SEED-SCALE approach. Project implementation from the beginning is based on a principle of not providing direct services in the communities, but instead relying on all services to be provided by HF staff with support from the MAM project. Usually change in government structure is needed for true sustainability, but often existing government strategies are underused or never implemented. FG attempts to effect change by providing advocacy and technical assistance at the national MOH and congressional level. The MAM project also implemented and improved on government strategies at local levels that are often not developed or implemented.

This philosophy and thinking has guided implementation of the four technical interventions described above. Progress was documented through the project's monitoring system and work plans. The project used the four SEED-SCALE principles of starting from success, three-way partnerships, decisions based on local data and local planning to build empowerment. For example, communities were asked to select WLs for the Care Groups. In order to gain their support for MNCH, community leaders were also oriented to the work of WLs including community health promotion as well as home visits for monitoring pregnant women and children under two. Municipalities and HW were asked to assist with selection of a special new cadre of human resources called Community Facilitators (CFs) to work part-time as WL supervisors, who received a stipend initially from the MAM project that was gradually taken over for funding by the municipality, as planned in the DIP.

Cross Cutting Element of Project Design: Sectorization Strategy

The Sectorization strategy is another key program design element. Sectorization was a non-detailed strategy briefly described by the MOH in the guidelines for its Community and Family-Based Integral Health Care Model. This consisted in giving each health worker the responsibility of attending health needs in one or several communities within the HF jurisdiction. MOH guidelines stated that sectorists (HWs) were to deliver interventions to the target population in

¹ Taylor D and Taylor CE (2002). *Just and Lasting Change: When Communities Own Their Futures*. Baltimore: Johns Hopkins University Press in collaboration with Future Generations. See DIP for more details about the Seed-Scale method.

their sectors or communities; however, there was no description of what specific interventions were to be implemented or how to organize and accomplish that responsibility. Building on this idea over the past ten years, , Future Generations developed well-defined roles and functions to strengthen linkages between community, HFs and municipalities within the project area. The MAM project demonstrated that co-management of health facilities (HF) through CLAS Associations could catalyse an effective sectorization. CLAS includes incorporation of community priorities and decision-making in a participatory process for administration of public funds for primary health care services, and coordination with institutions, particularly municipal governments, to fund community health workers and community work plans. FG's sectorization strategy approach has been introduced at community and HF levels to strengthen services and focus on prevention. This sectorization approach was officially institutionalized by the Regional Health Office at the end of the second project year with the intent that it be implemented in all HFs in Huánuco. In addition, the Sectorization Guide manual developed by the project and validated by the regional MOH has been published and is being promoted as a national guide for Sectorization. Although the MAM project has pushed hard for the DIRESA to implement sectorization, it has not been easy to change the system.

Additional Cross Cutting Strategies

Capacity building of local partners for implementing BCC strategies

Modular training in key technical and methodological topics as listed in the training matrix (Annex VII) was provided by project staff to self-selected health personnel teams of "Tutors for Promotion of MNCH and Nutrition" in every project area health facility (HF). Modular training was then provided by Tutors to Community Facilitators (CF) and Woman Leaders (WL) in the key technical and methodological topics as listed in the DIP training plan in monthly meetings at the health facilities. The WL were organized using the Care Group methodology. Based on FG's experience with their previous CSHGP-funded NEXOS project in the Cusco region of Peru, the traditional Care Group structure was adapted to suit rural conditions and integrate them into the government health system. For example, due to the large distances, instead of having the CFs meet with groups of 10-15 WL, the CFs chose to meet with smaller groups of 4-9 and consequently, hold more meetings each month. For the same reasons, each CF is responsible for about 20 WLs and dedicates approximately half a work week to completing her tasks. In the traditional Care Groups, the promoter does the training, whereas the MAM project has the HW Tutors conduct training and education of WLs and CFs in monthly HF workshops. Then the CFs follow-up with smaller groups of the WLs in the villages, reinforcing the messages. CFs also made individual visits to WLs and accompanied them on home visits to demonstrate home visiting, teaching of mothers using the flipchart, and use of the home-monitoring checklists. Another role of the CFs was to convene her WLs for the monthly HF training workshops and make sure her WLs attended. CFs were a new addition to the traditional Care Group model. Supervision visits to communities by health personnel (sectorists) to support CFs and WLs were occasionally planned and conducted jointly between health personnel and project staff, but in general, sectorists were responsible for making the community visits on their own several times per month.

Behavior Change Communication

The BCC strategy builds on the experience of the previous CSHGP-funded FG “NEXOS” project in Peru (FY2005-2009). The strategy has three broad behavior change goals that correspond with the project’s three technical health objectives described above. It promotes a three phase methodology for adult learning: (1) motivation based on prior experience and/or knowledge; (2) participatory behavioral analysis and; (3) reflection and commitment to change to a better practice. The project Strategy for behavior change (as part of the Sectorization strategy) was based in the implementation of four innovations in this project which together form the *Modular Program for Training Women Leaders in Maternal, Neonatal and Child Health*:

1. Community Facilitators: A new category of human resources for Health Promotion. They represent a new asset in health and the link between health services and the community, with the involvement of local government financing their stipends.
2. Tutors for Promotion of Maternal Neonatal and Child Health and Nutrition: A new role for trained and certified health personnel to conduct the process of capacity building for Community Facilitators and Women Leaders (female CHW).
3. Materials, manuals, and formats for training, education, and home monitoring: This is a set consisting of: seven (07) Flipcharts for education of mothers at home or in health facilities; eight (08) facilitator manuals to guide the training of CF and WL (CHW) by Tutors; and a tool set of forms and checklists for household level monitoring and supervision of behavior change, identification of danger signs, and case referrals to the health facility.
4. Innovative training methodology: "Sharing Histories" is a new training method for WLs and CFs that is oriented to enhancing their level of learning and self-esteem, and facilitates their ability to educate and change the health care practices of mothers in their community. Sharing their MCH experiences builds bonds between the WL, empowers them to own their past behavior and learn new ones, reduces shyness and increases self-esteem. WL who are empowered through this type of training are more effective in changing maternal behavior in the home.

Women Leaders (WL) as female community health workers (CHW) was a fifth innovative strategy in that most health promoter programs in Peru rely on males to serve as volunteer CHW. The reliance on male CHWs is due to the tendency of community leaders to choose other men when asked to select CHW, as well as the assumption that women are more likely to be illiterate and have more difficulty attending training away from their villages. The MAM project insisted on female CHWs on the assumption that women can best teach other women to change behaviors on practices related to MNCH.

The CFs and WL education by the Tutors was done in two groups with different methodologies. Health facility areas were randomly assigned to intervention or control groups. The two groups of WL received monthly training at HFs from the Tutors. One WL group received training using the “Sharing Histories” methodology (intervention group). The second WL group received training on the same topics, but using the standard teaching method (control group). With the intervention group, the WLs shared their experiences with facilitation and feedback from the tutors and the CFs also used the method to generate discussion with the WLs in their Care Groups.

Key communication channels used by the MAM included Home Visits. Each WL made monthly home visits to each pregnant woman and mother of child under 2 in her sector, providing face-to-face education, with key messages using flipcharts or monitoring guides, observed the mother and/or child for danger signs, and made referrals to the HF for preventive visits or curative care. Another channel was the Community Assembly, where the WL with support from health personnel (sectoristas) took advantage of the meetings to offer key health messages to both men and women.

Partnerships / Collaboration

Future Generations worked closely with the Regional Government of Huánuco and their Regional Directorate of Health (DIRESA), especially with its Office of Health Promotion. At the subregional level, the Project worked with the Huánuco Health Network Management Center; 4 micro-Networks (districts); and 27 primary health care facilities. Other major partners included the 4 District Municipalities in the project area. Future Generations collaborated closely with several local NGOs working in the area including Islas de Paz, a Belgian NGO, in Maria del Valle district and Caritas in Chinchao district.

The Project encouraged local partners to strengthen their alliances. The four project area municipalities contracted more HWs, achieving greater HF collaboration. This resulted in municipalities being able to meet the 2012 and 2013 goals of the Plan for Municipal Incentives for Improving Municipal Management. The goals included the development of *Community Centers for Promotion and Surveillance of Integrated Care for the Mother and the Child*, which coincided with the MAM Project goal of developing community based growth promotion pilot centers. During the final project year, the municipality was also able to better implement the *Project for Closing Gaps on Prioritized Products of the Articulated Nutrition Program*, that sought civil society participation in monitoring of child nutrition services. This included joint supervision of health services by the municipality and health services micronetwork in each district. Caritas and the FONDAM Project (Fund for the Americas) were more able to intervene satisfactorily in the districts of Chinchao and Churubamba, building on the strengthened relationships between communities and health services established by the MAM Project.

Advocacy with the central Ministry of Health (MOH) was a constant project activity throughout the four year project period. The FE team debriefed MOH officials in Lima during the evaluation discussing sustainability of activities at project end and extension of project materials.

Mission Collaboration

FG has had a long-standing and productive relationship with the USAID Mission based on previous project work in Peru. Copies of the DIP, Mid-Term Evaluation, and Annual Reports were shared with the Mission throughout the MAM project. Although it had not been possible to meet with USAID Mission personnel during the MTE, in the following months a meeting was held in the Mission with the Office of Health and Education to debrief them on the MTE findings.

In the third project year, a new USAID Health Officer, Jo Jean Elenes, was posted to Peru. Future Generations held a series of meetings with Ms. Elenes to first present the MAM Project and then keep her updated on the project. A debriefing meeting was arranged at the time of the FE and the external evaluator, the Project Coordinator and the FG director met with the Office Chief of Health and Education, the Health Officer, Ms. Elenes, and the Office Chief for the Regional Program Office. The evaluation team debriefed the officials on FE preliminary findings and discussed possible collaborations in the future. Unfortunately, the Mission is closing its Health Office and suggested the likelihood that there will be no further support available from them but they indicated that the Food for Peace Program will still be active in health.

EVALUATION METHODS AND LIMITATIONS

During September 2014, a final evaluation (FE) was conducted by a multidisciplinary team of six members (see Annex 8 for team members). The team used a participatory methodology (See Annex 9 for summary of MTE methodology) to derive conclusions and recommendations. Additional interviews were conducted by an external evaluator, and principal author of this report. (See Annex 10 for a list of people interviewed). The evaluation methodology consists of a mixed-methods approach using both quantitative and qualitative data. The approach comprised both a desk review of secondary data sources and the collection of qualitative data to complement existing data. Evaluation questions were provided in the external consultant's scope of work, which had previously been reviewed by a special team providing technical assistance on final evaluations for MAMs. The written design of the evaluation was finalized by the external evaluator and the evaluation team (e.g., number of key informant interviews, focus groups discussions, observations, and locations) and shared with project stakeholders and implementing partners for comment.

Secondary Data Review

The external evaluator reviewed project reports, including: Detailed Implementation Plan; annual reports; Mid Term Evaluation; KPC knowledge, practice, and coverage surveys at baseline, midterm and endline; quarterly field reports; and numerous qualitative studies done at baseline and endline. The evaluation team's task was to assess the quality of quantitative and qualitative data and make assessments of project results in relation to the project design and targets set.

The external evaluator also reviewed key U.S. Government/USAID strategic documents at the global and national levels relevant to the content of project. Relevant MOH policies and guidelines were also reviewed. In addition, the evaluator reviewed a series of qualitative interview studies conducted during July-August of 2014 by the project staff of key stakeholders including WLs, CFs, CLAS Associations, municipal government staff and regional/ local health personnel.

Qualitative Data Collection

The team met during the first two days of the 10 day FE field visit to review KPC findings and comparisons with the baseline and MTE findings and discuss relevant issues. Based on these, the team developed interview guides to further explore findings among selected target groups. Prior to the external evaluator's arrival, the team had arranged the field visit schedule, which was also reviewed and finalized. The communities and eight implementation areas (health facilities, local government, regional government) were randomly selected. The external

evaluator asked that the HFs to be visited be balanced among high performing and lower performing facilities. These were selected from a list provided by Future Generations. The team conducted in-depth qualitative interviews or focus group discussions with stakeholders as key informants, including the following groups:

- project staff
- a regional MOH official (DIRESA) (one who had recently left his post in charge of the Office of Health Promotion who had been a strong supporter of the MAM project)
- municipal officials
- network and micro-network health management teams
- facility-based health workers including Sectorists and Tutors for Promotion of MNCH and Nutrition
- Women Leaders
- Community Facilitators
- community members and community leaders
- national Ministry of Health officials.

A total of 76 individuals were interviewed (See Annex X for a list and location of persons interviewed) The assessment also included observations of activities supported by the project. In general the team divided and conducted individual or focus group interviews at each site, with the external evaluator as a team member. When sensitive information pertaining to project or staff performance was required of an interviewee (usually government official), the external consultant conducted the interview alone.

There were no substantial changes in the MAM since approval of the DIP that required modification of the Cooperative Agreement. There were few limitations in conducting the assessment encountered during the FE process. Only normal ones such as individuals experienced with project activities were not always available and consequently, evaluators had to interview individuals with less exposure to program objectives and methods. Also there has been substantial staff turnover at health facilities due to government hiring practices, and this meant that often interviewees had limited time in post and experience with the project inputs.

Data Quality and Use

The MAM project has developed several systems for Monitoring and Evaluation (M&E) that are effective in measuring progress toward project objectives. There are two sets of indicators that the project is using to track its progress. One is the M&E plan as presented in the DIP and the other is the work plan. Also the MAM project used a modified DHS questionnaire with selected questions added from the standardized Knowledge, Practice and Coverage (KPC) survey tool at baseline, midterm and final for evaluation.

The KPC study with anthropometric assessment was subcontracted by the project to the Institute of Nutrition Research (IIN). A survey using 30-cluster sampling was conducted at baseline, midterm and the final evaluations. The survey samples were based on two groups of health facilities that had been randomized after matching them according to complexity and population characteristics. The sample size included 606 households (at baseline and final, 620

at midterm) with children under two years in communities served by 22 project area health facilities. Twenty communities that were five or more hours walking distance from the health facilities were excluded, as were four urban population centers since the project focuses on changes in rural communities. Further details of the methodology are located in the KPC baseline, MTE and FE reports. The FE KPC results were reviewed carefully by the team to note progress and identify areas where there are still challenges. Although the team had a few questions about the FE findings (which were reviewed after the field visits), in general they thought that the KPC questions and survey findings were consistent and valid. Most KPC questions are the same standard questions that are usually based on the DHS and/or CSHGP proposed indicators, the findings usually compare well with those of the DHS and internationally. One indicator that was questioned had to do with the reported (97%) high level of institutional births. The team did not believe that the actual level was that high. Given that there is some government coercion involved, it is unlikely that women will admit to home births.

The CS project implemented a multi-level monitoring and information system. The intent was to have HFs adopt community monitoring of MCH, though this was only partially achieved for reasons discussed below. The tools for this system were developed, tested and validated by Future Generation's previous projects in Peru.² The community level tools were further validated in a format for non-literate WL workers using pictorial icons that were used in the previous MAM . The instruments include:

- Individual home monitoring sheet for each child under 2 for use by WLs to observe and teach preventive behaviors, danger signs recognition for referrals and, preventive health referrals
- Individual home monitoring sheet for each woman of fertile age and each pregnant woman for use by WLs to observe and teach preventive behaviors, danger sign recognition referrals and preventive health referrals;
- Monthly reporting form used by WLs
- Notebook to register all home visits and community activities for use by WLs;
- Notification form for all births for use by WLs;
- Notification forms for deaths for use by WLs
- Referral forms used by WLs
- Community Birth Plan forms (complementary to the standard Birth Plan filled out on all pregnant women at HFs) distributed by WLs and CFs to pregnant women and their families to promote institutional birth, ensure availability of materials for the mother and newborn, prepare the family and community for the possibility of an obstetrical emergency. On the reverse side of the birth plan are icon drawings of danger signs in pregnancy, birth, postpartum, and in the newborn as an additional learning and information recall instrument kept in the home.
- Summary form of WL activities for use by FCs and health personnel.
- A community workplan (CWP) form developed by FG International, used globally, and tested and used in its previous CSHGP project in Peru.

² A CSHGP project in Cuzco 2005-2009 and the Future Generations pilot CLAS Las Moras project in Huánuco (2003-2006).

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

FINDINGS

Summary Tables of Inputs, Activities, and Outputs that Contributed to Key Outcomes

Result #1: Mothers and families change knowledge and behaviors and achieve best practices for MNCH and nutrition.

Project Inputs	Activities	Outputs	Outcomes
<p>Training.</p> <ul style="list-style-type: none"> * Monitoring and supervision. * Human resources FG, MOH, municipalities, and other partners. * Developing educational materials and innovative BCC strategies. * Methodologies and strategies for community empowerment in health. * Community information system and tools. 	<ul style="list-style-type: none"> * Design, validation and distribution of educational materials. * Implementation of cyclical modular training to tutors (TOT), women leaders and community facilitators. * Door-to-door visits and educational sessions in the community. * Educational sessions for womens groups. * Participatory learning activities. * Mass media radio dissemination of MNCH & nutrition messages. 	<ul style="list-style-type: none"> • 779 women leaders and 42 Community Facilitators trained to educate, monitor, & refer MN%C. • 2700 mothers trained in 270 demonstration sessions on infant food prep. with local products. • 5 Community health fairs and events for health learning • 6 local radio stations broadcasted multiple pretested radio spots in Spanish and Quechua language. <p>Produced, printed and distributed:</p> <ul style="list-style-type: none"> • 866 Pregnancy flipcharts. • 866 Birth & Postpartum flipcharts. • 821 Newborn Care flipcharts. • 818 Breastfeeding flipcharts. • 820 Child Growth flipcharts. • 815 Diarrhea flipcharts. • 180 Pneumonia flipcharts. • 7 Facilitator manuals on six training topics plus introductory produced & distributed to 90 Tutors • Sets of the six flipcharts distributed to WL, CF and health personnel in 27 health facilities (HF). • 25 sets of amplified posters of each flip-chart image (of 6 flipcharts) distributed to each HF for use by Tutors to teach CF&WL. 	<ul style="list-style-type: none"> • Increase in percentage of children 6-23 months consuming iron rich foods (BL- 54% FE-94%) • Increase in mothers taking iron and folic acid supplements min. 120 days in preg. & lactation (BL-40% FE-52%). • Significant improvements in child feeding practices: <i>Minimum acceptable diet</i> (BL-54% FE-85%) <i>Minimum frequency of feeding</i> (BL-69% FE-92%) <i>Minimum dietary diversity</i> (BL 57% FE 77%) • Increases in maternal knowledge 2 or + danger signs in: <i>Pregnancy</i> (BL-41% FE-74%) <i>Birth</i> (BL-43% FE-56%) <i>Postpartum</i> (BL-22% FE-38%) <i>Newborn</i> (BL-21%FE-69%) • Increase in children with diarrhea given fluids for care (BL-31% FE-57%)

Result #2: Communities have strengthened capacities to lead and monitor the protection of MNCH and nutrition.

Project Inputs	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> * Training. * Monitoring and supervision. * Human resources FG, MOH, municipalities, and other partners. * Methodology and format for community work plans. * Methodology for teaching WL using "Sharing Histories" 	<ul style="list-style-type: none"> * Training, supervision and support to community leaders * Training on leadership in MNCH for community leaders. * Support to community leaders for the development of community work plans. * Observational learning visits to successful families and communities were organized. 	<ul style="list-style-type: none"> • 779 Women Leaders (WL) selected by communities and trained in HF. • WLs completed three training rounds in seven module topics (the first six and Pneumonia in Chinchao and Umari). • 42 CF selected and trained in HF. All receive stipend from municipalities up to December 2014. • 42 CFs trained in all 6 project topics. • Trained 26 (half) of 55 tutors and 17 (half) of 42 CFs in experimental teaching methodology • 158 Care Groups of WL organized; 82% meeting monthly during the previous three months, led by CF. • 385 community leaders from 77 communities trained in leadership and planning for MNCH. • 70 communities developed community work plans. • 41 communities formed <i>Committees for Evacuation of Obstetric and Neonatal Emergencies</i>. • 3 observational learning visits with participation of health staff, community leaders and local government representatives 	<ul style="list-style-type: none"> • Home visits* by ML and CF to teach and monitor pregnant women and mothers of children 0-23 months of age on preventive behaviors and danger signs in: <ul style="list-style-type: none"> Pregnancy (4,346 visits) Postpartum (2,380 visits) Newborn (2,180 visits) Breastfeeding (4,552 visits) Child nutrition (4,660 visits) Diarrhea & hygiene (5,178 visits). • Increased utilization of health services by community members. • 2,049 referrals made by WL for mothers to obtain curative or preventive care in a health facility.. • 41 communities organized and equipped for OB/NB emergency evacuations.

*N° of home visits listed are only those made by WL accompanied by CF. Additional visits by WL by herself
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Result #3: Health system has strengthened capacities for financing, managing, and implementing improved quality of primary health care oriented to communities to resolve key needs for MNCH and nutrition.

Project Inputs	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> * Training. * Monitoring and supervision. * Human resources FG, MOH, municipalities, other partners. * Developed educational materials and BCC strategies. * Methodologies for community empowerment in health. 	<ul style="list-style-type: none"> * Design, validation and distribution of Facilitator Manuals for each of 7 flipcharts. * Implementation of modular training to Tutors (TOT) * Development of HW competencies for health promotion.. * Quality improvement projects in HF. 	<ul style="list-style-type: none"> • 283 health workers (HW) were trained in Sectorization Strategy. • 24 health facilities (HF) reorganized according to the Sectorization Strategy • 22 HF re-organized clinical records in family folders by community. • HW were trained in four clinical areas (103 HWs on OB/NB community emergency management, 42 in nutrition assessment & counselling, 42 on clinical management of diarrhea, and 196 on BF). • 30 HW in 10 HF were trained for operation of 17 community centers for child growth monitoring • 96 HW were trained and recognized by the DIRESA as “<i>Tutors for Promotion of MNCH</i>”. • <u>Methodologic Guide to Implementation of the Sectorization Strategy for Promotion of MNCH in Co-Management with the Community</u> was approved by the DIRESA for application in all 400 PHC facilities in the Huánuco Region. • 1500 copies of the <u>Guide to Sectorization</u> were published and distributed to health facilities and local partners in Huánuco and nationwide. • Three existing CLAS were strengthened and one new CLAS was established: strengthening links between HF, municipalities and communities. 	<ul style="list-style-type: none"> • 27 HF are better organized to implement community-oriented health promotion. • 96 HWs in 27 HF have appropriate skills and materials to successfully train WL and CF in promotion of MNCH. • 27 HF are actively training and supervising WLs and CFs in promotion of MNCH. • 4 HF heads of the Micronetworks have initiated monthly meetings with CF and WL to collect, process and analyze community information (from CF and WL) to include in monthly reports to local governments. • Increase in mothers who receive a visit in the first two days after birth by a trained health provider (BL-15% FE-56%)

Result #4: Local governments increase their management and financial contributions to community health oriented to MNCH and nutrition.

Project Inputs	Activities	Outputs	Outcomes
<p>* Training. * Monitoring and supervision. * Human resources FG, MOH, municipalities, and other partners. * Technical assistance to CLAS Associations to strengthen community participation in co-management of PHC services.</p>	<p>* Coordination with DIRESA, CLAS, health facilities, health service mgt network and micronetworks, NGOs and other authorities. * Training provided to: -CLAS members, -micronetwork chiefs, -heads of HF, -community leaders, -municipal officials.</p>	<p>* Three existing CLAS Associations strengthened and 1 new CLAS Association established (CLAS Churubamba). * 10 additional health facilities incorporated into CLAS Associations so that now 19 of 27 HF (70%) are administered by CLAS. * 48 CLAS Board of Directors members and managers trained in their legal functions according to the new law on CLAS and its regulations. * 141 heads of Micronetworks and HF, community leaders and municipalities' functionaries trained in Participatory Budgeting in 3 workshops conducted by the regional MEF consultant. * Four tripartite agreements were signed by four municipalities with their respective CLAS or health facility, and Future Generations, in which the municipality committed to financing stipends of the CF in their district, and also funding incentives for WL. * 42 CF receive stipends funded by municipalities. * 675 WL receive incentives from municipalities. * 4 municipalities achieved goals of MEF Program for Municipal Incentives</p>	<ul style="list-style-type: none"> ● Significantly increased municipal investment in health infrastructure and equipment, health personnel contracts, and stipend support for community facilitators. ● During the project (2010-2014), four municipalities and other partners have invested S/. 28'221,535.77 (USD \$10,079,119) on health, WASH and nutrition leveraged by the MAM project in the project area.

Result #5: Public policies promote processes for scaling-up community-oriented PHC services at the national, regional, and local levels.

Project Inputs	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> * Training. * Monitoring and supervision. * Human resources FG, MOH, municipalities, and other partners. 	<ul style="list-style-type: none"> * Policy advocacy at the local, regional and national level. * Participation as civil society member of the National Committee for Health Services, of the National Health Council of Peru. * Participation on a commission to advise the MOH on the new Health Reform policy document. * Participation on two civil society/government ombudsman groups to monitor and make policy recommendations on the national Maternal-Neonatal Health and Articulated Nutrition Programs. * Participation on a consortium of 17 civil society and donor agencies for national monitoring of child nutrition and government advocacy for child nutrition policy (called the <i>Initiative Against Child Malnutrition</i>). 	<ul style="list-style-type: none"> * <u>Methodological Guide to Implementation of the Sectorization Strategy for Health Promotion in Co-management with the Community</u> was approved by the DIRESA for application in all PHC facilities in the Huánuco Region. * Development of criteria for certification of <i>Centers for Development of Competencies in Health Promotion</i> (as an observational training center) (DIRESA – FG - MOH): Acomayo * <i>"Tutors for Promotion of MNCH"</i> as a new category for health worker specialization are in process of evaluation and formal accreditation. * Observational visits to the project made by high level officials from: the national MOH; national MEF; Regional DIRESAs of Ayacucho (2 groups) & San Martin; UNICEF Peru. * A major public event for project dissemination was held in Lima in 2013 with 55 attendees. * Four awards on quality were won from the central MOH and as "Best Practice in Public Management" (including diffusion of a video on national public TV). * Local government ordinances that recognize WL & CF and sustain the behavior change strategy. 	<ul style="list-style-type: none"> * Influence national law and policy on community participation in the co-management of health. In particular, the Health Reform policy document of the MOH includes terminology on "Co-Management" as a form of community participation in health, signifying support to the CLAS model of health services management and financing. * Influence national norms for health promotion and strategies for working with community health workers. * Influence national norms for organizing primary health care services to implement health promotion.

Findings - Contextual Factors

The project initiation in October 2010 coincided with the election of new regional and municipal authorities in Peru. The newly elected regional president (akin to State governor in the U.S.) and district mayors in Huánuco took office in January 2011 and served throughout the four project years. This permitted project strategy and activity implementation without political interference of an electoral process, which is what occurred in the second project year of the previous Future Generations NEXOS project in Cusco. Nevertheless according to project staff, the Regional President of Huánuco interfered with the leadership of the Regional Health Directorate and the Health Service Network Management Units. He also instituted permanent rotation of contracted health personnel in primary health care services. These changes were the result of a manipulation of public budgets, and created significant operational problems for the project. Thus, the main contextual factor influencing the project's implementation was the unnecessary constant rotation of personnel at all levels of the regional and health network systems. The regional president regularly replaced the Regional Health Director at 3 month intervals. This was frustrating for the project because as the regional directors change, so do many of the top level posts in the regional health system. The project had a difficult time maintaining sufficient numbers of committed sectorists and trained tutors due to: the constant renewal of HW contracts by the Huánuco regional government; there was continual transfer of contracted staff into tenured positions on the government payroll in other areas (causing loss of regular work on community health efforts); wages are low and health staff are generally not anxious to do extra work beyond their required time.

In municipalities, the mayor remains stable for four years, but he/she changes the municipal leadership staff frequently for political or technical reasons. At the end of this year there will be municipal elections and people are concerned about continuing municipal support for the community structures (especially in regard to municipal-funded stipends for CFs) put in place by the project.

Another factor influencing project efficiency is the rainy season between December and March. Due to landslides and other problems, it is difficult for project staff to visit communities and it is difficult for CFs and WLs to go to Care Group meetings since the dirt roads are often impassable.

The dispersion of the target population and the difficulties of operating a project in a low density rural area also affected implementation. In addition, a significant part of the population migrates to the jungle for seasonal work. The project has made adjustments for this but it has created some inefficiencies.

Evaluation Question #1. *To what extent did the project accomplish and/or contribute to the results stated in the DIP?*

The bulk of project efforts were targeted at changing mother's behavior so as to improve child health and reduce stunting. Achievements in Result 1 ("Mothers and families change behaviors and achieve best practices for MNCH and nutrition") above demonstrate accomplishment of DIP targets.

During the first project year, the KPC survey and 6 qualitative baseline studies were completed, 53 of 180 communities were oriented to the project with community selection of 280 Women Leaders (of the total to be selected), all 187 health personnel were trained as "Sectorists" and all 22 health services implemented the Sectorization Strategy, all 55 "Tutors for Promotion of Maternal, Neonatal and Child Health" were selected and trained in two 3-day workshops in adult learning theory and teaching methodologies, four municipalities were oriented to the project's purpose, three CLAS signed project agreements with their respective municipalities and Future Generations, and the first two of six flipcharts (Pregnancy and Birth & Postpartum) were fully adapted and printed, with one more flipchart (Newborn) in progress. This was achieved in the first year, despite challenges to project implementation that included: three changes in the Regional Director of Health in Huánuco and two changes in Health Network Management leadership, requiring repeated orientations and partnership building with key partners; and a prolonged DIP review process with multiple revisions to the results framework at CSHGP request.

During Year 2, selection and training was completed for 42 Community Facilitators (CF) and a total of 779 Women Leaders (WL) * on six training module topics, while the project staff continued the adaptation and printing of the remaining four flipcharts and facilitator manuals. Training for CFs and WLs by Tutors was implemented on a monthly basis in all 24 (later 27) health facilities during years 2-4. This was done in three rounds of training workshops for all CFs and WLs including new ones who replaced dropouts. Health personnel "Sectorists", CFs and WLs began conducting home visits together in communities providing education, orientation, monitoring of key behaviors and danger signs, and referral of pregnant, women, postpartum women and children under two. In order to improve quality of care in health facilities, clinical update training for health personnel was provided in four areas: emergency OB-newborn management, breastfeeding management, nutrition evaluation and counseling, and updated clinical management of diarrheal diseases.

Results of impact on child growth and reduction of chronic child malnutrition (stunting) were not clear when assessed globally. After a significant decline in stunting at the midline evaluation in the OR intervention group (BL 34.1%, MT 27.9%), there was a slight increase in stunting at the endline evaluation (EL 30.3%) to give an overall difference of 5.1 percentage points in stunting between the intervention and control groups. This is not a statistically significant result.

* During year 2, all 180 project communities were oriented and 599 more WLs selected.

Results in chronic child malnutrition (height-for-age less than -2 sd)

	Baseline KPC		Midterm KPC		Endline KPC	
	Control %, n, c.i.	Interven %, n, c.i.	Control %, n, c.i.	Interven %, n, c.i.	Control %, n, c.i.	Interven %, n, c.i.
Percentage of children 0-23 months of age with chronic malnutrition						
All study children	35.3% 104/295 29.8, 40.7	34.4% 105/305 29.1, 39.8	34.6% 104/301 29.2, 40.0	27.9%* 56/201 21.7, 34.1	35.4% 104/294 29.9,40.8	30.3% 88/290 25.1,35.6
Percentage of children 0-23 months of age with chronic malnutrition, by educational level of their mother						
Illiterate (cannot read)	43.6% 41/94	45.3% 43/95	49.3% 35/71	49.0% 25/51	42.9% 27/63	47.2% 34/72
Any primary education (can read)	36.3% 45/124	33.6% 47/140	35.2% 51/145	29.1% 25/86	35.3% 48/136	28.0% 33/118
Any secondary education or higher	24.7% 18/73	19.4% 13/67	21.2% 18/85	9.4%* 6/64	30.5% 29/95	21.0%* 21/100

*p<.10 due to small n size

However, more disaggregated analyses showed that compared with the control group, there were 11 and 8.5 percentage point differences in stunting in the intervention group among mothers with primary education or greater at midterm and endline, respectively. There were also 6 to 7 percentage point differences in children whose mothers had any primary education, both at midterm and endline. Meanwhile, the group of illiterate mothers had no differences in stunting between study groups throughout the project.

Evaluation Question #2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

Regarding SO 1: Mothers and families change behaviors and achieve best practices for MNCH and nutrition.

The main project intervention associated with maternal behavior change and knowledge improvements was the *Modular Program for Training Women Leaders in Promotion of Maternal, Neonatal and Child Health*, which was comprised of 7 flipcharts and 8 facilitator manuals that were developed and validated by Future Generations Peru. Once trained with these materials using appropriate teaching methodologies (including the innovative teaching method “Sharing Histories” in half of the project area), the WLs used flipcharts to educate mothers during home visits when they also observed mothers, newborns and children for danger signs for referral.

As noted in the results tables above, the KPC found many indicators related to women’s knowledge and practices during pregnancy, postpartum and newborn periods had significant improvement by the time of the FE. Some additional positive findings include:

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- Where positive increases over baseline findings occurred, usually the advances were higher for the intervention (over control) groups that used the “Sharing Pregnancy Histories” methodology. This was also evident with the pre-post test results for WL on each training module.
 - Increase in the percentage of children 0-23 months who received a postnatal visit within two days after birth by a CHA or other health provider (BL 3% - MT 58% - FE 48%).
 - Increase in the percent of mothers who receive a visit in the first two days after birth by a CHA or other health provider (BL 15% - MT 18% - FE 56%)
 - Increase in percentage of newborns that are wrapped and dried with a warm cloth immediately after birth (BL 76% - MT 88% - FE 98%)
 - Increase in percentage of children 0-5 months given only BF in last 24 hours (BL 78% - MT 88% - FE 89%)
 - Increase in percentage of children 6-23 months consuming iron rich foods in past 24 hours (BL 54% - MTE 63% - FE 94%)
 - Increase in the percentage of children 6-23 months given iron sulfate or multi-micro-nutrient supplements in the past 24 hours (BL 24% - MT 28% - FE 55%)
 - Increase in the percent of children with diarrhea who were given ORS or any type of home liquids for home treatment of diarrhea (BL 31% - MT 34% - FE 47%).
 - Prevalence of diarrhea in the previous two-week period increased then declined (BL 19% - MT 23% - FE 17%). Greater reduction in diarrhea prevalence occurred in the intervention group: control group (BL 18% - MT 25% - FE 19%) vs. intervention group (BL 21% - MT 21% - 16%)
 - FE team found that flipcharts and facilitator manuals were considered high quality, culturally appropriate and necessary tools for educating mothers by health workers, Tutors, CFs and WLs.

Discussion of challenges and other findings

During discussions with the FE team and interviews with health personnel the consensus is that maternal nutrition is a key problem. This was also true of the previous FGNEXOS project in Cusco. The MAM KPC results showed that the percentage of women who increased food consumption during pregnancy did not change (BL 17.6%, - EL17.7%) and remained low. Women eat less during pregnancy because they believe that if they eat more they will have big babies and as a result will have more problems with their deliveries. Although women have heard from HWs and WLs that they need to eat more, there are obviously socio-cultural beliefs and attitudes that prevent women from practicing that behavior during pregnancy. Eating more by mothers during lactation is less of a problem, but there also was not a significant change from baseline (BL 44% - MT 43% - FE 52%).

Regarding the diarrhea training and education component of the project that began immediately after the MTE, KPC indicators suggest a problem at health facilities that impedes access to treatment. Project staff believe that the public health insurance program – SIS - is responsible because only a limited number of clinic visits per year

per child are reimbursed by the insurance program, and is not enough to cover all the diarrhea episodes. HWs turn away sick children who have had their “quota” of medical consultations. In addition, the baseline HFA showed that the HF staff do not manage diarrhea properly. As a planned intervention, early in the project the MAM project brought pediatric specialists from the major medical school in Lima to provide training on diarrheal disease management to 39 HWs (one or two from each of 24 health facilities). The HWs admitted that they did not properly manage diarrhea in that they treat with antibiotics and don’t counsel mothers about fluids, ORT and nutrition during illness. Treatment of diarrhea with medicines was found in the KPC survey to be frequent (BL 59% - MT 62% - FE 55%), and was highly correlated with seeking care from a health facility when the child had diarrhea. The seemingly high turnover of HWs could have resulted in the loss of HWs who had received the diarrhea clinical management training early in the project. However, consistent with the finding that knowledge of diarrhea prevention and control was high among CFs and WLs (see Results Table 1), there was a significant improvement in the percentage of mothers giving any type of liquids to their child to “treat” an episode of diarrhea (BL 31% - MT 34% - FE 47%). On the other hand, the KPC did show that there was little change in the amount of fluids (BL 39% - FE 41%) or food (BL 53% - FE 53%) offered to the children during a diarrhea episode. This is confusing and the project staff believe that it could be an issue of the ordering of questions or in how the questions were asked in the KPC questionnaire.

Concerning the finding that there is no change (in fact there is a drop) in the percentage of mothers who breast feed (BF) within an hour of birth, project staff believe this is due to the system of care at the HFs and new MOH norms on care of the newborn. Midwives (*obstetras*) take care of the mothers during pregnancy and birth. Then their care is transferred to the neonatal nurse who takes care of the neonatal activity. While nurses are trained in the importance of BF and exclusive breast feeding (EBF), project and MOH staff believe that there is a delay in BF due to the increased number of activities required of newborn nurses immediately after childbirth. The project thinks that this will be corrected shortly as several of the facilities are attempting to acquire “baby-friendly health facility” status and since early skin-to-skin contact and breastfeeding in the first hour after birth are key components, they think the MOH staff will pay attention to this.

At the time of the MTE there was a slight improvement in iron and folic acid (FA) supplementation among pregnant women but only in Intervention Group (BL-40.9%, MTE-44.8%), and by the FE the percentage raised in both groups from 39.7% to 51.6%. Acceptability of iron and FA supplementation for pregnant women is a major challenge in rural areas because of adverse effects of tablets (constipation, gastrointestinal discomfort and the belief that the baby will be too big, complicating the delivery). As in previous projects, FG found that when CHW or WL receive training and education on iron and FA, then the mothers go to the HFs asking for supplements. Also, when WLs visit and educate pregnant women, there is a greater acceptability of iron and FA tablets despite adverse effects. The picture was more confusing for children’s iron supplements that were linked to the well child visits. Apparently children receive the vitamin and mineral supplements during the first year when they come for monthly well child and immunization

visits but dropped off after that possibly because mothers were no longer brought them so frequently to the HFs. Furthermore, at the beginning of the project, MOH policy on micronutrient supplementation changed from Vitamin A (softgel) plus ferrous sulfate (suspension) to multi-micronutrient powder (Sprinkles); however, acceptability of Sprinkles was a challenge. To address this the project introduced Sprinkles during the infant food preparation demonstration sessions as a strategy to improve mothers' compliance (acceptance increased from (BL.4% MT 36.7% at MT to FE 49%).

The flipcharts that FG adapted to the Huánuco region from its previous project in the Cusco area have been well received by WL, FCs and Tutors. The WL interviewed during the FE explained that since most of them are not literate, the pictures serve as reminders for the messages they are supposed to convey. On the back of the flipcharts, the messages are written in Spanish but since many of the WL do not read, this is often not used by them but are used by the CFs and literate WLs, also by health personnel who frequently use the flipcharts for counseling of mothers during consultations at the HF. The forms used to tabulate WL and CF visits and record numbers of education sessions have pictorial depictions (same as the flipcharts) of the messages to be conveyed, particularly about preventive actions and danger signs. During the MTE, the WL had recently received the forms and were confused about how to fill them out. Some illiterate WLs were being helped by the FC or their own children to fill out the forms; otherwise, they reported verbally to the FC who consolidated the data and reported it to health facility and municipality for the payment of their stipends. However, the project provided more training and assistance with the forms in the second half of the project. During the FE, the evaluation team found most of the forms were filled in correctly: while some WL still had problems, most were able to fill them out.

One of the major concerns that the national government is trying to address is the level of chronic malnutrition among young children. The national trend was a steady decline in the prevalence of chronic child malnutrition from 2007 to 2011 in rural areas, after which there were several years of flattened rates and a recent increase in chronic malnutrition in the past two years. The KPC indicates that rates in the project area did not change significantly during the project period (BL-35%, MT 32%, and FE 33%). On the other hand, the HF personnel interviewed think children are better nourished as mothers come to facilities for treatment and attend the maternity waiting homes. D,. Furthermore, the final KPC showed a significant improvement in good feeding practices (based on WHO-defined indicators), an increase in exclusive breastfeeding, and a decline in prevalence of diarrhea. The project staff hypothesizes that the chronic malnutrition rate among young children could be related to the large number of low birth weight and premature neonates who are now surviving due to increased rates of institutional births, but are not thriving. They speculate that these LBW infants do not catch-up in growth and are contributing to the numbers of chronically malnourished.

In regard to child feeding practices, significant gains were made in the percentages of children 6 - 23 months that were receiving a "minimally acceptable diet" (BL 54% - FE 85%), "minimum frequency of feedings" (BL 69% - FE 92%) and "minimum dietary

diversity” (BL 57% - FE 77%) (WHO-defined indicators). These gains can be attributed to the substantial attention devoted to child nutrition in the second half of the project by CFs and WLs. (The nutrition module had not been taught until after the MTE). Another result is the increase of children who consume iron-rich foods (including fortified with iron) in the previous 24 hours (BL 54% - FE 94%).

The project printed and encouraged use of community birthing plans. The KPC asked whether the mother had had a birthing plan during her last pregnancy, without distinguishing between the health facility birth plan kept in the mother’s clinical history file, and the project community birth plan. Results suggested that there was not much change between BL and EL regarding use of the plans (BL 68% - MTE 78% - FE 66%), though the FE team observed and was told that most mothers had the plans on their walls and understood the steps to prepare for births.

The project also introduced the community referral/ counter-referral forms that are being used by WLs. However patient referral really depends on the organization and management of health facilities and therefore, use of the forms was more successful in Umari District, where FG has worked for seven years.

Regarding SO 2: *Communities strengthened capacities to lead and monitor the protection of MNCH and nutrition.*

The MAM Project has also made progress in *Community Engagement and Strengthening Health Service and Local Involvement with the Community*. As indicated in the Results tables above, during the project:

- 779 women leaders (WL) were selected and trained. All of these were trained in danger signs, key health behaviors, preventive care visits for pregnancy, birth, postpartum, newborn, breastfeeding, child growth and nutrition, and diarrhea. In addition, the Umari WL were trained in pneumonia. Initially the project calculated that they would need 934 WL to meet the population needs, based on the most recent government census projections, using the criteria of one WL for every 30 families. However, the actual population is smaller than estimated so the project recalculated the required number of 779 WL as sufficient to monitor risk groups, using the same criteria of number of families per WL.
- 42 Community Facilitators (target 36) were selected and trained in all 6 project topics. These CF provided supervision and training support to WLs as Care Group leaders. As evidence of their success, Umari municipality is contracting 5 additional CFs to work on a BF activity.
- 158 Care Groups (C-G) of WL were formed of which 129 groups are active surpassing the EOP target of 93 groups. The reason for a greater number of Care Groups is because the C-G method requires 10-15 women per group but due to the dispersed populations in the project area, FG decided to have a larger number of groups with fewer women. This also resulted in a need for more CFs than originally planned.

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- 26 (half) of 55 tutors and 17 CFs were trained in the intervention communities were trained in the innovative CHW teaching method. Control group Tutors and CF were trained in a standard CHW teaching method.
 - 231 community leaders were oriented in community organization and leadership for MNCH nutrition.
 - 62 communities were trained to form Community Committees for Evacuation for Obstetric and Neonatal Emergencies.
 - 41 (22%) of the 62 communities trained actually formed the committees, surpassing the EOP goal of 20%.

There are a number of community structures and partners that have contributed to improved MNCH outcomes. These include the WLs and CFs as well as the community leaders and committees. The following are some of the findings related to project community engagement strategies.

Women Leaders: The MAM project strategy was based on a gender-specific strategy of women peers working with women. Previously the health promoters mainly conducted coordination activities between the Health facilities and communities, or participated in the identification, follow-up and referral of patients. However, they never worked in community education and tended to be men who were not trained or able to reach women as effectively. To the degree that communities understand the importance of selecting a WL and do so, this change in the role of health promoters constitutes an effective community mobilization strategy for maternal, neonatal, and child health. In the qualitative studies conducted by the project to assess their experience with the project, it was found that the successful WLs and CFs, not only possessed leadership abilities and previous health experience but tended to be older and no longer had small children in the home. For these reasons, they are more likely to be respected and able to fulfill a social function within the community.

The project designers understood that women leaders could reach community women more easily than men or health workers who were not known in the community. The WLs made the sectorists' job easier as they organized the women before the sectorists visits and provided an on-going link between them and the community. The FE found that WLs are appreciated by the community leaders and their work is seen as important. Some leaders who were interested in health, stated that the WLs should be members of the community board (*Junta Directiva*) and that they should also be members of the community emergency committees. Most of the membership of these committees is composed of men. Though the WLs and CFs are beginning to achieve some recognition on the community boards, since the boards tend to be dominated by men, they do not tend to focus on maternal and child health. During interviews, WLs and CFs noted that some men were very supportive of their work but that in general men needed to be educated and brought up to speed regarding MCH.

The main task of the WL tasks was to conduct **home visits** to educate mothers on key knowledge and practices and monitor them and children for danger signs and needed preventive services for referral to the HF. Here each WL was urged to make monthly

home visits to each pregnant woman and mother of child under 2 in her sector. When the WL visits she offers face-to-face education, presenting or reinforcing key messages to mothers using flipcharts and monitoring guides. This has proven to be an effective way of engaging and educating women who might not have been reached before in these hard to reach areas

Community Facilitators: This is an innovative new category of health worker introduced by the MAM project as a coordinating link and extra support between the HF field staff and the WLs as well as a community mobilization promoter. Because of the highly dispersed rural population, the CFs were a key link between health facilities and the community. This is a modification of the Care Group strategy, adapted to the Peruvian health system. The role of CFs is very appreciated by the HF staff as they support the WLs to educate and follow up with mothers. (See sections above for more explanation of the CF role). In an effort to establish greater sustainability of the role and function of the CF, the MAM project worked closely with the municipalities and health facilities to form a panel of judges that interviewed applicants in an open hiring competition to select the CFs based on selection criteria especially regarding previous training and experience as a CHW (5 or more years preferably) or as a health technician or auxiliary nurse. The CF had to be a female. By the time of the FE, all four municipalities had assumed financial responsibility for paying part-time stipends of the 42 CFs. The problem with this arrangement is that the funding has to be renewed every year (annual budget) and there will be municipal elections this year so there is some question as to how long the individuals will be maintained in these roles. Being a new role, not everyone either in the municipalities or the health system, is aware of the importance of their work.

During the third year of the project, FG also trained HWs, CFs and WLs to do infant food preparation demonstrations as part of the Child Growth module. Before, as required by the MOH, the HWs demonstrated using plates of pre-prepared dishes. But since the project started, they demonstrate how to prepare food for young children to women's groups in HFs, showing them how to mash it and make it edible as a weaning food using locally available ingredients. They also provide demonstrations in *Community Centers for Promotion and Surveillance for the Integrated Care of Mothers and Children* (CPVC). Due to the high prevalence of anemia and the new MOH program for Sprinkles distribution through HF, the Project introduced training on how to use Sprinkles (multi-micronutrients) during feeding demonstration sessions as a strategy for improving the acceptability of the powder among rural mothers.

In Umari district there are a larger number of CFs. This is because the municipality was so pleased with the CF strategy that they requested an extra five CFs be selected and trained, in addition to the five planned existing CFs. All of them are paid through municipal stipends. In response to a new MOH norm calling for **breastfeeding support groups**, the Umari district asked the CFs to organize and facilitate these monthly support groups. FG helped with the training in breastfeeding promotion and management for the groups that are composed of pregnant and lactating women.

During the third and fourth years the project began conducting participatory MNCH-related learning activities at **health fairs** to coincide with community festivals. The project also took advantage of MOH commemorative dates (Nutrition Week, Breastfeeding Week, Safe Motherhood Week, Community Health Agent Day, etc.) to organize participatory learning activities. Some of the health fairs were not only attended by health workers and community members, but also officials from the Regional DIRESA and health networks along with workers from other local governments from outside the project area. Many of the events were covered by regional mass media including television and newspapers. Starting in the third year the project began distributing **radio** spots with MNCH messages in both Spanish and Quechua to local radio stations in several districts of the Huánuco Region. The radio spots had been developed by a World Bank funded project.[†] The MAM project obtained the radio spots then copied and distributed them on CDs to all the local radio stations, which agreed to play them frequently on free air time. In addition, the CFs and health personnel participated in local radio programs broadcasting the health messages from the project flip charts. (See communication section above for discussion of the flip charts and facilitator manuals developed by the project).

Regarding **women's empowerment**, according to the qualitative studies of WLs and CFs conducted by the project^{‡ § **} and the FE interviews, some of the major findings the project has strengthened these women's knowledge, skills and attitudes. For example the WLs stated that the work has been important in increasing their knowledge of health not only to improve conditions in the community but also for themselves and their families. In terms of personal growth the most frequent response cited by the WLs was the adoption of healthy behaviors in their homes. Over half said that they were happy and satisfied with their roles in the community. Regarding the Community Facilitators, the most frequently identified skill is to be able to speak and teach in public. A third of them said they had gained improved skills for making household decisions as well as the ability to listen to and respect diverse people and opinions. These findings indicate that the project has helped these women mature and feel empowered.

FE interviews with HF staff indicated that WLs and CFs greatly enhanced the work of HF staff in communities. The WL and CF facilitated their work by organizing women and children for outreach visits, following up on missed appointments, building relationships

[†] Project "Implementation of participatory intervention models to improve child nutrition" conducted by the Nutrition Research Institute and Kallpa. 2013.

[‡] Future Generations Peru. Report: Survey of Women Leaders. Project "Health in Hands of Women." Huánuco. August 2014.

[§] Future Generations Peru. Report: Survey of Community Facilitators. Project "Health in Hands of Women." Huánuco. August 2014.

^{**} Future Generations Peru. Report: Qualitative study on "Sharing Histories" teaching methodology. Project "Health in Hands of Women. Huánuco. December, 2014.

and trust between sectorists and community members. Evidence of this is demonstrated by the 2049 referrals made by WLs during the second half of the project.

Regarding SO 3 Result: *Strengthening the local health system capacity for managing PHC for communities to resolve MNCH/ nutrition needs.* According to the HFA and staff reports, the MAM project also met its goals for this objective.

The project conducted training to improve the organization and management of PHC services (see above table 3 and project work plan in Annex):

- 283 health facility staff were trained in the Sectorization Strategy (EOP target 206).
- All 27 HFs (100%) created an organizational unit to take charge of community-based work (EOP target 68%).
- All HF (100%) implemented the Sectorization Strategy according to criteria proposed by the project (EOP target 50%).
- An estimated 3,060 community visits were conducted by health staff in the previous three months (EOP target 3,000).
- 9 of the larger HF completed a self-assessment and 4 of those completed a quality improvement plan based on the assessment (EOP target 22 HF).
- 41 HWs from all 22 HFs were trained as leaders of the “Self-evaluation teams” for formal accreditation of HF based on MOH standards (EOP target 27 HW).
- All 27 HFs are actively training and supervising WL and CFs in MNCH.
- All HF heads (100%) were trained in Results-Based Budgeting (EOP target 100%).
- All HF heads (100%) now have access to information on the amount of RBB funds that are allocated to their facility for MNCH and nutrition (EOP target 100%).

The project conducted several training courses to improve the quality of health care delivery:

- 103 health workers (HW) were trained in community management of obstetrical and newborn emergencies (EOP target 112).
- 42 HWs were trained in nutritional assessment and counseling (EOP target 40)
- 30 HWs were trained on nutritional assessment for community-based growth promotion (EOP target 112).
- 196 HWs were trained in BF (EOP target 40). These include 162 HW who were trained in BF in 2014 for development of MOH Baby-Friendly Health Facility Initiative in the 4 districts.
- 42 HWs were trained in updated clinical management of diarrhea (EOP target 40).
- 96 HWs were trained as “Tutors” in all 6 modules as well as adult education methods. (EOP target 60). All “Tutors” were officially recognized by the DIRESA.
- The project conducted legal training for CLAS managers and members with an update on the new CLAS law and regulations.

Improvements in health care access

The **most vulnerable groups served by the MAM project are pregnant women and children under 2**. The KPC findings have shown that access has been improved (see Results Table 1 and discussion above). The Rapid Catch indicators also show that access has been improved: the percentage of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of the youngest child raised from 84%-BL to 90.9%-EF; percentage of children aged 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider increased from 88.2% to 93.4%. During FE interviews, HWs noted that since MAM activities began, mothers regularly take children for their well-baby checks, vaccines, value health more, attend educational talks, demonstrations, follow preventive methods (hand washing, drink purified water, practice hygiene at home). They also believe that MCH nutrition is better. They believe that with the collaboration of CFs and WLs, their sector work is more organized and that they are better able to connect with the communities. “They speak their language.” “The communities accept us better.” “The facilitators are always coming to the facilities, we coordinate regularly.” “Sometimes we make visits together and with the WLs.” Most indicated that they found no drawbacks in working with the CFs and WLs.

There are two main strategies that the project employed for **increasing access**. These were sectorization and establishing the health facility/ community training strategy for Tutors, CFs, WLs (see above and section Project Background for discussion). A key activity related to these strategies was the home visits conducted by WLs who educated and encouraged women to take themselves and their children for regular HF visits. Also, when a pregnant woman or a child needed any preventive, recuperative or even emergency intervention, WLs used referral forms to send the mother to seek appropriate attention at the HFs. Previously there had been low demand for many of the preventive services. The project worked to improve quality and helped organize the services. For example, before, the well-child visit procedure was that all children were told to come on a certain date and all at the same time and there was no counseling or education. Now each of the visits is organized for a specific time for each mother so they don't have to wait as long. Also the project trained HW in counseling and community education, and provided HWs with flipcharts to use for counseling and educating mothers during ambulatory visits. As a result the HWs are now more interested in quality of services, and because they're working with the WLs who educate women and assure that people come at the right time, the system works better. During the FE, HWs interviewed noted that now more people are coming to appointments on time and more regularly.

Despite these improvements though, there are still **challenges with access**. As noted in other sections of this report, staff turnover among Tutors but especially among all HW is a major issue for the project. The staff turnover makes it difficult to build and maintain provider-client relationships with families and communities. The turnover is not voluntary. Project staff and HWs interviewed stated that the regional government has incentives to continue transferring staff as it receives money through staff rotation (each new worker's first salary is taken by the regional government). A second challenge is getting health

workers to internalize the Sectorization strategy and feel motivated to work with communities. The project estimates that only half of the HWs are actively involved in the community services. The other challenge is the amount of time that HWs spend at their job. Previously only the tenured government workers worked 6 hours a day and the employees contracted through CLAS or CAS worked 8-10 hours per day. Now everyone only works 6 hours and this limits HWs availability and willingness to go to communities. Another challenge is the lack of an organized referral and counter referral system at the health facility level. The Tambillo Health Center (previously part of an FG project in Umari district) which has more committed personnel was able to implement a more effective system but this system is deficient in other facilities.

There are several ways that the **MAM has improved the quality of MNCH services at household and community level**. The most important one is that before this MAM project, there was no existing strategy to deliver educational interventions to risk groups (pregnant women and mothers of children under age two) at household and community levels. Some counseling was delivered to mothers during their well-child or prenatal visits at the HFs. But the effectiveness of this education was limited due to cultural barriers, health facility barriers, or simply lack of educational materials. Another improvement is that since the MTE the WL have learned how to fill out the pictorial referral forms and recognize when a woman or child needs to go for services. Usually the woman will not go alone, so the WL either asks the sectorist to visit the mother when she comes to the community or the WL accompanies the woman to the HF.

Another project contribution to better organized health services, relates to the implementation of the Sectorization strategy. At baseline, only 62% of health facilities had simple geographical maps of their jurisdictions. During the FE, it was found that 86% of health facilities now have maps of their jurisdictions by sectors, which thanks to the introduction of community census-taking in all project area HF, are updated with information identifying locations of risk groups. In this way pregnant women and children under 2 can easily be identified and followed-up with by sectorists.

Other improvements include the activities noted above such as training and empowering of the CFs and WLs, training the Tutors who continue meeting monthly with the WLs and CFs, provision of training materials (flipcharts, facilitator manuals), provision of monitoring materials (reporting and referral forms), improved linkages and referrals between communities and HFs.

Management and governance structures established to ensure quality services:

The overall management of health services improved considerably during the MAM. Significant differences were found between the HFA at BL and FE with respect to management instruments and organizational structures. At BL, 14% of HF had management committees (see more below), while at FE this was 57%. Similarly, the percentage of HF that had a Manual of Organization and Functions went from BL-19% to FE-43%; HF with a functional organigram from BL- 29% to FE-67%; HF with a Local

Health Plan from BL-19% to FE-38%; and HF with updated information on SIS health insurance reimbursements from BL-10% to FE-52%.

During the third year of the project a lengthy process was completed to establish management teams in each of the three Health Management Micronetworks in the MAM project areas. The process began in the first two project years with an analysis by each health facility of their level of organization and management for working in communities as well as an assessment of the quality of their health services. This information was used to subsequently develop quality improvement plans. This process increased motivation for working in the communities in their catchment areas. Through this project-led process, the management teams improved their problem-solving capacity and improved their management of CLAS.

As part of this methodology the HF management teams began the reorganization of their clinical history files into family folders ordered by community and flagged by level of risk, in accord with the Sectorization strategy. One of the major delays in seeing patients was that patient files were alphabetized by last name, meaning that children were filed separately from their mothers, often the files were placed haphazardly on the clinic shelves, and the clinic staff had a hard time locating them, this delaying services or treating them without the chart for reference. The reorganization of files was a boon to decreasing clinic waiting times for patients.

In addition, management committees were established in the facilities. At baseline there were only 3 HF management committees but by the time of the FE most facilities had them. Generally the larger facilities have them because they have large teams of health workers who need to compare notes and develop strategies. But the smaller facilities (Health posts) tend to have small staffs handling multiple areas and the teams don't meet as regularly. Most teams now meet monthly.

Also there are local health technical teams in the district municipal offices. Before the project these teams existed but did not meet. Now they meet regularly with the regional health system, the education system, social programs, NGOs etc. The municipalities have taken leadership roles in convening meetings with the various sectors. They have convening authority as the local government. But they have a special link to the health sector due to their role as one of three signatories on the Co-Management Agreement between the CLAS Association, the DIRESA, and the district municipality. This legal arrangement for three-way local co-management of PHC services has caused municipal governments to feel more commitment to the health sector. The municipal government's participation in health programming with MAM, has opened the door for the municipalities to put funding into human development in the districts by funding the CF. The project goals and role of the CFs fit in well with their objectives and it is a low budget activity that will hopefully be sustained in municipal budgets.

Regarding SO 4: *Increasing local governments' ability to manage and finance community MNCH and nutrition activities.* The HFA and staff reports indicate that:

- Now 70% (BL 41%) of project area facilities are managed by CLAS (EOP target 68%).
- 48 CLAS members, health personnel, municipal officials were trained in their legal functions according to the new law on CLAS (EOP target 33).
- All 42 CFs are now contracted by the municipalities (EOP target 36).
- 141 municipal officials, micro-network managers, and community leaders were trained on participatory budgeting (EOP target 30).
- During the project period (2010-2014) 4 municipalities spent S/.28,221,535.77 (USD \$10,079,119.00) on health, WASH and nutrition leveraged by the MAM project (EOP target USD \$250,000).
- Twelve (12) HF in the project area have health personnel contracted with municipal resources (4 HF at baseline) (EOP target 22).

CLAS – Local Community Health Administration Committees (*Comunidades Locales de Administración de Salud*)

The MAM project has worked to strengthen CLAS in the project area. At the beginning of MAM only 10 of 22 HFs were managed by CLAS associations, at the FE that number increased to 19 out of 27 facilities or 70%. In addition, 48 CLAS Board of Directors members and managers, HWs, local officials were trained in the new CLAS law and regulations. The 4 CLAS Associations in the project area now report annually to its communities on the status of its programmatic and financial plans. During FE interviews with heads of HFs/ CLAS managers, the team learned that the facility heads think they have better links with their communities through the CLAS members. They also felt they had more control over their budgets due to decentralized financing that is permitted only through CLAS.

Municipalities

A mark of the project's progress is its work to involve municipal authorities in health prevention and promotion. As part of the decentralization process, municipal authorities are often untrained to assume new management responsibilities. They tend to gravitate to the most visible types of projects that will provide political capital such as infrastructure and place less of an emphasis on social programs. However, the MAM project, as part of its work to orient local governments to financing mechanisms and increase contributions in health in their districts, has had success in generating support from the municipalities. As mentioned above, the municipalities are now supporting all 47 CFs. All four municipalities have Co-Management Agreements signed with CLAS and DIRESA (none existed when the project began). Another interesting finding is that during the project period municipalities have invested the equivalent of USD \$10,079,771 (S/. 28,221,535.77 Peruvian soles) in health in the past four project years.

The development of a **participatory municipal budget** is an opportunity for the health sector and local government to work with the community and collaboratively decide how to allocate funding for projects. The budget is developed through an analysis of community priorities, which are supposed to become incorporated into municipal budgets through a participatory process. In this and the previous MAM project FG influenced the Local Health Planning (PSL) process so that community health promotion activities would be included. In total, the MAM project supported training sessions in participatory budgeting for 141 municipal officials, micro-network managers, and community leaders. According to project staff and health workers interviewed, the process for deciding on which community projects to fund is still very complicated and in trying to correct the difficulties, the process has become more cumbersome requiring several justifications, extensive background information, etc. As a result, the awards process is often circumvented and the Mayor makes the decision on which projects to fund without going through a detailed process.

As noted above, links for co-management in health have been strengthened between health facilities, municipalities, and communities. Aside from the formal CLAS Co-Management Agreements, the four municipalities signed four tripartite agreements with their respective CLAS health facility, and Future Generations, in which the municipality committed to financing stipends for the CFs in their districts and also funded incentives for the WL. At the end of the project these agreements precipitated Municipal Resolutions and Ordinances to continue funding the CF stipends.

Regarding SO 5: Improve public policies at the national, regional, and local levels that promote processes for scaling-up community-oriented PHC services. The HFA and staff reports indicate that:

- A model-training center was established in a major facility of the project area, Acomayo Health Center, which was officially designated by the DIRESA as a *Center for Development of Competencies (CdC) in Health Promotion* which will serve for scaling-up the project model.
- A modular training package for teaching in the model Training Center was developed (EOP target - 1)
- 60 health personnel, CHW, and community leaders were trained as facilitators in the new *CdC in Health Promotion* (EOP target - 12).
- 20 high-level MOH and MEF officials from other regions and from the capital city visited the *CdC in Health Promotion*.
- An estimated 100 or more advocacy meetings were held by FG project staff with local partners during the life of the project at national, regional, and local levels to promote scaling-up of project strategies (EOP target - 10).
- 6 or more new health policies or strategies were adopted by local and regional partners based on advocacy on project strategies.

Evaluation Question #3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?

Areas of the project likely to be sustained or expanded

FE interviews indicated that local government officials, health officials and communities believed that community level changes and activities were likely to be sustained after the project ends. This includes the work of the WL and CFs and the Care Groups. It also includes the community work plans and community health committees for emergency evacuations. Those interviewed stated that even though some individuals will be lost in the communities due to the volunteer nature of the work and family commitments, that as long as the CFs and HF personnel continued to work with the communities the work would probably continue.

FE interviews with government authorities indicated that the Tutors and their training role would probably continue as well. This was confirmed during the FE when the project was informed that a Directorial Resolution had been signed by the DIRESA that establishes a Regional Training Center for Development of Competencies in Health Promotion, which will be located in Acomayo (*Centro de Desarrollo de Competencias en la Promoción de la Salud*). This is the first of its kind in Peru. The Tutors will play a key role in running the Center. This resolution confirms that the regional government assures there will be ongoing training for FCs and WLs as well as Tutors. At the project's instigation, CLAS and district municipalities have assumed responsibility for payment of transport and snacks for all WL/FC monthly meetings with the Tutors at HFs.

There have also been a regular series of annual mayoral resolutions that guarantee the payment of stipends for the facilitators (*Resoluciones del Alcaldía annual*). The project has been able to secure local government directives (*ordenanzas*) that recognize the work of the WLs and CFs including longer term payment of CFs in 3 of the 4 districts. The fourth one does not have a directive but it does continue to pay the CFs through annual government resolutions. From FE interviews it is believed that CF support will continue because the health workers and the facilitators will advocate with whoever takes over in the next local government elections. However there is no official decree that permanently integrates them into the health system and this could be a challenge.

In addition the Sectorization process will continue. The methodological strategy to achieve the reorientation of health services to work in communities has been laid out in the Methodological Guide to Sectorization for the Promotion of Health in Co-management with the Community, which was published by Future Generations in September 2012 and has been approved by the Huánuco DIRESA. A Directorial Resolution issued by DIRESA declares the Sectorization strategy as an official policy for the Huánuco region, to be scaled up to every primary health care facility in the region (about 400). FG has worked with DIRESA to win four achievement awards and other kinds of recognition for its work during the MAM project. (See Annex II). FG made a presentation to 200 MOH officials at

the MOH/Lima on the Sectorization strategy at the “National and International Conference on Quality of Care” and showed a 7-minute video on the project (produced for FG by Inti Films). Through this and other presentations and dissemination of the video on the www.future.org website, FG worked to get the strategy made official at the national level. The project staff thought that the Sectorization process was becoming institutionalized through the Directorial Resolution and would continue in the region particularly at the larger facilities where there are a number of staff who have received the Sectorization training. At the time of the FE, the MAM project staff was told that a Regional Ordinance on the Sectorization strategy was being prepared, which is more permanent, for scaling-up the strategy.

As a result of the participation of a large number of local government officials from the Huánuco region at “Health Municipality” competition events held in Chinchao and Churubamba Districts, the nearby municipality of Hermilio Valdizan requested (and received) 50 full sets of the series of 6 flipcharts developed by the project. In addition the Huánuco DIRESA and FG have received requests from other municipalities to extend the entire MAM project into their areas. Teams of health officials and professionals have come to visit the project from other regions such as the DIRESA of San Martín (USAID-funded ABT/Futures Group project) and the DIRESA of Ayacucho to see how they can apply the MAM model. The director of health sector liaison office at the Ministry of Economy and Finance (MEF) visited and liked the work of the CFs, wanting to expand their role throughout the country through mandates to municipalities. During the FE debriefing at the MOH in Lima, the Director of Health Promotion expressed a clear desire to sustain the activities and systems instituted by MAM and requested a follow-up meeting to discuss this, specifically mentioning a desire to expand use of the flipcharts and other communication materials. Much of this will depend on future funding but clearly there is interest in scaling up the MAM project and/or its activities.

As a result of the MAM (and FGs other work), evidence of sustainability within Peru is in process through a new pilot effort by the MOH of Peru for a program focused on newborns, called “Plan Welcome to Life” (*Plan Bienvenidos a la Vida*). The program is built around distribution of a “newborn kit” consisting of a box that can serve as a newborn cradle at home for the purpose of maintaining warmth and protection of the newborn. The box comes filled with blankets, clothing, diapers, and basic supplies for the newborn. The plan is to distribute these boxes free of charge to mothers who deliver at MOH health facilities. Future Generations initially suggested the idea to distribute newborn kits in Peru, building on a program in Finland. Furthermore, Future Generations suggested to the MOH the need to also train community health workers to do home visiting of newborns to monitor for danger signs, reinforce education of the mother on exclusive breastfeeding and home care of the newborn, as well as monitor correct use of the newborn kit and its contents. For purposes of this MOH pilot project, Future Generations donated to the MOH: 30 flipcharts of each of three flipcharts on the topics: Birth & Postpartum, The Newborn, and Breastfeeding; 6 copies of each of the accompanying Facilitator Manuals for each flipchart; icon-based check-lists for monitoring

of newborns at 1, 3, 5, 7, 15, 21, 28 days. This MOH pilot program was just started in September, 2014.

What are local institutions doing differently now as a result of the project?

Learning from the Project has been shared at local, regional and national levels. As noted above other projects and government departments have visited the MAM project and are interested in replicating parts of it. In addition to the conference presentation on quality of care, the project has won four national achievement awards including:

- (1) In September, 2012, the MAM project was one of two projects selected in a national MOH competition as a “Successful Experience in Management of Quality in Health”. As a result, the project was invited to make a presentation at the National and International Conference on Quality in Health organized by the MOH.
- (2) In December 2012, the MAM project was selected for presentation at the "National and International Forum on Health Promotion as a Tool for Social Inclusion and Sustainable Human Development" organized by the MOH with 400 attendees from all parts of Peru. FG developed a 7-minute video on the MAM project that was shown at this event. The video is available on the FG website for viewing.
- (3) In July 2013, the MAM project was selected for the First-Place prize for experiences judged as *Good Practices in Public Management* in the category of Maternal-Infant Nutrition in the annual national competition run by a local organization in collaboration with a team of judges formed of local politicians, university professors, donor agency representatives, the leading daily newspaper in Lima, and other local intellectuals with financing from the Japanese Cooperation Agency (JICA). The title of our winning experience based on the MAM project was: “Implementation of an Innovative Strategy for Community Education for Promotion of Maternal, Neonatal & Infant Health and Nutrition Based in the Community and in Collaborative Management with Local Government.” Following receipt of the award, a video production company created a 15-minute video of the MAM project that was broadcast on national public television in September 2013 as part of the JICA strategy to disseminate effective government strategies. This video is available via Dropbox.
- (4) In September 2013, one of the four districts in the MAM project, Chinchao District, won second-place prize in the annual national MOH competition for "Quality Improvement in Health Services" in the category of Primary Health Care Services. The experience was presented at a national meeting of experiences of quality improvement in health organized by the MOH with 200 participants from all regions of Peru.

Other venues for sharing results and lessons learned from the MAM project include Future Generations participation in the following:

- Through MAM, Future Generations participates in monthly meetings of the Initiative Against Child Malnutrition (IDI), a coalition of 17 international technical assistance agencies and NGOs, that provide guidance and advocacy for government programs for reduction of chronic malnutrition and anemia in children.

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- FG also participates actively in monthly meetings of two groups of Oversight of the National Maternal-Neonatal Program and for the Articulated Nutrition Program, both of which are organized by the National Roundtable for Poverty Reduction in collaboration with civil society.
 - FG was appointed to a civil society commission to draft recommendations to the MOH on its Health Reform proposals.
 - In the third year of the project, FG held a public event in Lima to present the results of the MTE to the MOH, NGOs and international cooperation agencies.

In summary, the MAM project successes have already received recognition by the MOH and other local partners in numerous instances, and key project strategies have been institutionalized by the Huánuco Diresa. Future Generations' intent is to position the MAM project strategies and materials for expansion to sustainable national level policies and guidelines. Although the project is ending, FG is continuing its advocacy efforts with the health reform process and direct advocacy with MOH departments. For this reason it is significant that the Director of Health Promotion has arranged follow-up meetings with the project directors to discuss sustaining MAM activities.

Evaluation Question #4. Operations Research on Sharing Histories Methodology for Teaching Women Leaders

A separate report was prepared on the operations research project on the "Sharing Histories" Methodology for Teaching Women Leaders. This is found in Annex VIII of this report.

CONCLUSIONS

Some of the key accomplishments include:

- Significant increases in knowledge of pregnancy, post-partum and newborn danger signs by an average of 16 to 48 percentage points.
- Significant increase in newborns that are wrapped and dried immediately at birth (76% to 98%)
- Significant increases in all hygiene and sanitation indicators including hand washing, disposal of feces and water treatment.
- Significant increase in the percentage of HF managed by CLAS Associations (43% to 70%).
- All 47 Community Facilitators are now contracted directly by the municipalities.

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- Community Facilitators and Women Leaders are recognized by health workers (sectoristas) as being a key components for the HF community strategy.
 - WLs are recognized by community authorities and municipalities as playing a critical role in improving community health.
 - Municipalities are increasing support to HFs by contracting health personnel, constructing and remodeling infrastructure, providing equipment, implementing services (laboratory, maternity waiting homes), providing fuel, funding the CF stipends, and financing ML and FC training costs.
 - Municipalities are improving the participatory budgeting process by organizing their districts into 4-5 zones and having each zone focus on 1-2 projects that will benefit all communities in each zone.

Conclusions

The project has much to contribute to the child survival knowledge base. The project has worked on change at all levels of government services. One of the most notable is the project's continuing work focusing on advocacy and technical assistance at the national level that resulted in the passage of the new CLAS law and co-management of HFs. Another success is DIRESA's acceptance of the sectorization strategy and plans to implement it in all HFs in the region (400). FG is also advocating for its acceptance at the national level. Strengthened linkages are being established between the community, HFs and municipalities including the incorporation of community work plan priorities as part of the participative budgeting process. Sectorization is being introduced at community and HF levels to strengthen community health services and focus on prevention and health promotion. At the community level MAM is contributing to training and support of WLs and CFs through the development of training materials for use by HFs, WLs and CFs as well as tools for monitoring of target groups, contributing to improved health behaviors and practices.

There are a number of factors within and outside the project that are contributing to the positive changes occurring in the region and noted in the KPC. Peru is working to improve institutional birth rates and other MCH indicators through implementation of several national programs including: SIS (Integrated Health Insurance), which provides free health services to low income families; JUNTOS a conditional cash transfer program where poor women receive cash monthly (about US\$35 equivalent) on the condition that they access certain health and education services; and PIN provides food donations if the woman attends prenatal care. Other factors impacting the indicators are MAM project interventions to develop an improved referral system, improve quality of care at the HFs, and improve community education and outreach services by WLs, CFs and health facility staff. So, given the presence of all of these programs, it is not completely possible to attribute all the positive changes to the MAM

project alone. However, the FE team can say that the MAM project with its staff presence on the ground, has done a good job of coordinating all of these activities and pushing for improved community education and use of HF services. MAM is also working to improve effectiveness of these initiatives by systemizing and supporting the implementation process through the health system and improving clinic administration and organizing clinic records.

Despite the many evident gains and improvements in knowledge and behavior among women and children in the project areas, there are still some behaviors that are lagging such as no evident change in the percentage of women who increase food consumption during pregnancy, little change in the percent of children who are chronically malnourished and little change in the percentages of children with diarrhea who are not offered more fluids or food during diarrhea episodes. These challenges have persisted in both CSHGP projects despite efforts to improve them. As noted above, these behaviors point to deep seated cultural values and practices, which may take substantial effort to change.

The SEED-SCALE strategy used by FG projects and now by MAM to strengthen sustainability and replication of successful interventions has been key. Some of the strategies that may be sustained and expanded include: Sectorization (including the situational analysis of each community and self-assessment of each health facility), HF training modules and accompanying flipcharts and posters with facilitator manuals, methods for strengthening community work planning, and participatory budgeting. As noted above, the work of the WLs is well received by communities but the distances between HFs and communities have been a problem and the WLs don't always attend the group training sessions. The CFs try to follow-up with women who miss sessions and provide them the flipcharts and recent training but the learning is not as comprehensive. In an effort to rectify this, some tutors are arranging to hold more than one session per month and a few of them in locales closer to WLs in some of the remote communities. However, the cost of transport remains an issue. There is also an issue of turnover and a consensus that the WLs need more incentives to encourage their work.

The MAM project has successfully developed two important cadres of workers to strengthen its community education activities. These are the Tutors and the community facilitators. Both of these are recognized as playing important roles in improving community outreach and access to services. However, being new their positions initially were not fully integrated into the health system. Yet by the FE, the Tutors have received a Directorial Resolution that officially establishes the role of Tutors and recognizes them each by name. The project strategy was to have the municipalities assume the contracting and support of the CFs and this is proving successful. At the time of the MTE 20 of the 42 CFs were supported by municipalities and by the FE all of them were supported. The concern is that the CFs contracts have to be renewed annually and there may be some politics involved in assuring their continuity, particularly since there will be municipal elections this year.

Although the project has achieved most of its goals and put many new systems in place, there are still concerns regarding whether the changes will remain as now established. The project began having to address many obstacles. It is a rural area with a dispersed and hard-to-reach population, the population regularly migrates to the jungle to harvest coca, and the HWs regularly turnover their positions. While the project has been successful in developing strategies to overcome them, there are still uncertainties. As noted above, the WLs are functioning and have community support but since they are volunteers, there is turnover and more incentives would help. The FCs are now fully funded by municipal budgets but the contracts are renewed yearly and will require that there is regular lobbying with the local governments for it to continue. It looks like with the establishment of the training center in the Acomayo Health Center (Chinchao District) that the role of the Tutors will continue and they will continue with the monthly training meetings with CFs and WLs but again, the budget to support the meetings is being provided by the local governments in cases where CLAS has not assumed the cost, so this will need attention. Ideally CLAS would take over all CF and ML training costs. , the new national MOH health promotor strategy, has the same funding issue regarding support for local training costs. If that is resolved in the MOH budget process, the MAM sectorization strategy and *Modular Program for Training Women Leaders in Maternal, Neonatal and Child Health* will be available for immediate scale-up.

Sectorization and regular outreach to the communities is in place and the regional government supports it but it requires that staff participate and not all staff is on board with it. Given the levels of staff rotation, lack of motivation and the reduced staff hours, the project estimates that only about half of the sectorists are functioning in the communities as expected. This is despite all the support being provided in the communities for the Sectorists. Four years is a relatively short time when one hopes to make changes in a local, regional and national health system. So far FG – Peru has been able to continue acquiring funding for projects so that they can keep assisting the MOH to decentralize and improve its health services, through its SEED SCALE approaches and other technical assistance. It is hoped that FG will be successful in acquiring additional support from donors and government to continue this needed technical and training support.

As evidenced above, one of the lessons learned by FG in this and previous projects is that if you want to impact changes to the health system at higher levels, it is necessary to document your experience and present them to the stakeholders. FG did this in its previous projects with its presentations to the national MOH regarding its changes to regional CLAS. FG is doing this with the MAM project by officializing its Sectorization strategy in the Regional Health Office of Huánuco (DIRESA). As noted above it is also presenting and advocating for this strategy to be accepted at the national MOH in Lima. If Sectorization goes the way of the CLAS modifications, it is likely that it will be approved at the national level as well.

RECOMMENDATIONS

Although the MAM project has ended, the following recommendations might be considered for partners that are continuing the activities in the Huánuco region.

Recommend that donors in Peru work with the MOH to continue support for activities initiated and systems put in place by “MAM” in Huánuco Region. Should also consider expanding the model to other regions and nationalize the Sectorization strategy.

To strengthen community partnerships and engagement in the future, recommend more time for project implementation to assure that the new systems set in place by the project, the MOH and the municipalities actually take hold and become institutionalized, and lead to expanded impact.

Some specific recommendations for future efforts:

- MOH/ DIRESA should continue community education efforts. New knowledge needs continued reinforcement if it is to lead to consistent changes in practice.
- If the WL data collection forms are reprinted by DIRESA, NGOs, recommend that they print the pictorial boxes in color to be more consistent with flipcharts
- Recommend that future work in nutrition during pregnancy among rural Andean women include a more in depth barrier analysis to understand cultural beliefs and identify acceptable practices and messages for increasing food intake during pregnancy.
- Recommend that DIRESA focus on correct diarrhea management at facility and community levels, including training HWs on reduction of pharmaceutical use and increasing fluids and nutrition during diarrhea episodes. Explore methods for changing HW and community attitudes and behaviors about diarrhea treatment and teaching mothers about fluid and nutrition management.
- It is recommended that the finding that babies are not routinely breastfed during the first hour after birth, be brought to the attention of the MOH so that they can review neonatal BF practices.
- Recommend that future NGO/ local gov't projects work with men in the communities to encourage support for the WL's work and bring more attention to health in the community committee meetings.
- Recommend that the CF role be instituted as part of multi-year local government plan. They should also be officially included in the Sectorization strategy.
- Project communication materials (flipcharts, reporting forms, manuals) have been appreciated and favorably commented upon throughout the FE. The Central level MOH and the Huánuco DIRESA have expressed interest in continuing their use. It is important that Future Generations do whatever possible to promote the materials expanded use and set up convenient structures for reprinting.

ANNEXES

- I. Program Learning Brief(s): Evidence Building
- II. List of Publications and Presentations Related to the Project
- III. Project Management Evaluation
- IV. Monitoring & Evaluation Table
- V. Work Plan Table
- VI. Rapid CATCH Table
- VII. Final KPC Report
- VIII. CHW Training Matrix
- IX. Evaluation Scope of Work
- X. Evaluation Methods and Limitations
- XI. Data Collection Instruments
- XII. Information Sources
- XIII. Disclosure of Any Conflicts of Interest
- XIV. Evaluation Team Members, Roles, and Their Titles
- XV. Final Operations Research Report
- XVI. Operations Research Brief
- XVII. Stakeholder Debrief PowerPoint Presentation
- XVIII. Project Data Form
- XIX. Optional Annexes

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

1300 Pennsylvania Avenue NW

Washington, DC 20523