

INMED PARTNERSHIPS FOR CHILDREN

Healthy Babies Project

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INMED Partnerships for Children
Creating Opportunities, Transforming Communities

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ACRONYM LIST

BCC	Behavior change communication
BF	Breast feeding
CATCH	Core Assessment Tool on Child Health (as in Rapid CATCH survey)
CHW	Community Health Worker (also, health promoter, community agent)
CRECER	Peruvian national campaign against poverty and child malnutrition
CSSA	Child Survival Sustainability Assessment
DIP	Detailed implementation plan
DIRESA	Dirección Regional de Salud (Regional Health Direction), highest local health authority in Ucayali, reports to Ministry of Health
HBLSS	Home Based Life Saving Skills
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
INMED	INMED Partnerships for Children, a U.S.-based international non-profit organization
INMED Andes	INMED registration in Peru
IR	Intermediate result
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practices and Coverage
M&E	Monitoring and evaluation
MAMAN	Minimum Activities for Mothers and Newborns
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTE	Mid-term evaluation
PD	Project Director
PIN	Programa Integral de Nutrición, a program that grants food staples to participating mothers at health centers and health posts each month
PRISMA	Asociación Benéfica PRISMA, operating non-governmental organization in Peru
PVL	Proyecto Vaso de Leche (“Glass of Milk Project”), a government sponsored, community-level mothers’ group that provides a daily glass of milk or an alternative nutritious food item for participating children
RENIEC	Registro Nacional de Identificación y Estado Civil (National Register of Identity and Civil Status)
SIS	Seguro Integral de Salud, the social health insurance for children, pregnant women and indigent people offered by the Peruvian state and administered through Ministry of Health facilities
TA	Technical assistance

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Healthy Babies Project 2008-2009 Annual Report

A. PROJECT ACCOMPLISHMENTS

The Healthy Babies project continued to make steady progress in its third year of operation, and substantial momentum is gaining behind efforts to improve child and maternal health in Peru. The positive MTE results were analyzed and used to inform project adaptations at all levels. The project work plan was amended to reflect the evaluation team's recommendations, and the new version was accepted by USAID in March 2009. In the field, INMED and PRISMA have continued to place emphasis on maternal and neonatal care training for MOH health workers and community-based health worker volunteers. As of September 30, 2009, a total of 238 health professionals from 77 health establishments had received training, in addition to 624 volunteer community health workers. Health education materials, including health professional training manuals and low-literacy information cards and calendars with maternal health messages, have been validated, produced and distributed to mothers, CHWs and health professionals at the health centers and health outposts, as well as local and regional government agencies and universities. Spanish-language radio spots have been produced and are on the air in Pucallpa and Aguaytia. The radio messages have also been translated into the Shipibo Conibo language so that they can reach remote, vulnerable indigenous populations. INMED continued to conduct supervisory visits, provide technical assistance and training, and identify service gaps at 117 health care facilities across the project area. In addition, the PD remains an active participant in ongoing policy debates at all levels from local municipalities to the national stage.

A.1 Discussion of Key Results by Outcome (See Annex 2 for full discussion of M&E results)

IR1. Increased knowledge and practice of maternal and newborn care seeking behavior: Participants made strong gains in knowledge and put their new understanding into practice where their activities were not severely constrained by lack of resources or access. Dramatic gains were made in the percentage of women who recognize three danger signs in pregnant women and newborns, the percentage of women who breastfeed within one hour of birth, and the percentage of women with a complete birth plan. The percentages of women and newborns having six or more prenatal appointments, an institutional delivery and postnatal care in the first week were virtually unchanged or have declined slightly from the baseline.

At least three factors may be affecting the apparent lack of forward progress on perinatal care and institutional births: 1) better information management (During the MTE, a number of senior health officials remarked that they were surprised by the number of pregnant women in the community, suggesting that the project has been successful in identifying a group of women who were not previously receiving services and not counted at baseline.); 2) different sampling methodology between baseline and monitoring protocol (urban women are more likely to have more convenient access to perinatal care, and compared to the Rapid CATCH survey conducted at baseline, the supervision protocol, which expanded to the more rural areas over time, disproportionately represents rural women; and 3) the disconnect between understanding the importance of both perinatal care and an institutional birth and their accessibility, especially for the more rural populations.

IR2. Increased quality of maternal and newborn care services in health facilities and the community: The project has improved the quality of care in the community by greatly increasing the percentage of CHWs demonstrating competence in basic IMCI skills. It has improved the quality and consistency of care provided in health establishments by codifying MOH guidelines into a basic checklist and greatly increasing the percentage of establishments that follow those guidelines.

IR3. Increased availability/access to maternal and newborn services in health facilities and the community: The project has been less successful at increasing the percentage of health facilities that have supplies such as ferrous sulfate and those for birthing and maternal and neonatal emergencies. The Healthy Babies team has reported service gaps identified during supervisory visits. However, the ultimate responsibility rests with DIRESA to ensure that health facilities receive the supplies they need. Significantly, this year the Ministry of Economy asked the DRESAs nationwide to identify their needs, and plans to develop a computer-based procurement system to streamline the process.

The Healthy Babies project is working to increase access to emergency care in several ways, such as building support for *casas de espera* (maternity waiting homes), with the first house under construction and plans in place for five more; working with local mayors on emergency transportation plans, with plans in place in Campo Verde, Aguaytia and Irazola; and helping to initiate and coordinate a Navy-led training course for health professionals on how to handle boats on the river during an emergency evacuation.

IR4. Improved policy environment for maternal and newborn care: Recently, maternal and child health issues have been gaining prominence at the national level, and large investments are being made in Peru's public health infrastructure. Thanks in part to the tireless campaigning of the PD, both DIRESA and MOH have made commitments to address sexual and reproductive health in the Ucayali Health District, and the Regional Health Committee of Ucayali has formally prioritized the following issues addressed by the Healthy Babies project: anemia, basic sanitation and maternal death. These issues have also been gaining prominence at the municipal level, especially in Campo Verde, Aguaytia and Irazola. At the level of the family and individual, the project has been remarkably successful in increasing the percentage of women and children who are enrolled in SIS and the number of children who have a birth certificate.

A.2 Factors Contributing to Success

One of the most important factors contributing to the success of the Healthy Babies project is a strong sense of local ownership of the project fostered by 1) intensive involvement of local partners in Ucayali in all phases, from the preparation and implementation of the baseline study through all subsequent activities, and 2) close alignment of goals and coordination of services with the local and regional health departments as well as with other local and national organizations such as MCLCP, a national coalition combating poverty and CEPREN, the Peruvian network for breastfeeding promotion. This synergy has enabled the project to jointly produce material with these organizations, thereby reaching a wider audience. The support of the Ucayali Regional Health Department has also been instrumental in achieving project objectives. Finally, the project is benefiting from—and contributing to—the growing momentum to adopt policy changes that promise to improve maternal and child health outcomes.

B. ACTIVITY STATUS BY PROJECT OBJECTIVE AND TECHNICAL INTERVENTION AREA

Maternal and newborn care represents 65% of the life of the project and breastfeeding represents 35%.

Table 1: Activity Status by Project Objective

Key Activities (as outlined in the DIP)	Status	Comments
<i>IR1. Increased knowledge and practice of maternal and newborn care seeking behavior</i>		
1. Conduct BCC strategy. Develop radio messages, posters, picture cards and CHW dramas (practice with stakeholders) with consistent messages for: (i) comprehensive birth plans (birth plans that include transportation and emergency)	CHW training: on track Radio: on track	A total of 624 CHWs have received training to date. Spanish-language radio messages have been produced, translated into in Shipibo Conibo; 4,000 radio messages have been on the air in Pucallpa, Padre Abad, Neshuya and Irazola.

Key Activities (as outlined in the DIP)	Status	Comments
(ii) messages to encourage women to breastfeed within one hour of birth (iii) pregnant women and mothers of infants wash their hands routinely to prevent the spread of disease (iv) Recognizing danger signs during pregnancy (v) Recognizing danger signs in the newborn (vi) Taking iron supplementation (vii) Exclusive breastfeeding (viii) Prenatal care visits (ix) Institutional delivery	Posters: on track Printed materials: on track Handwashing: on track	Posters for each of the 9 health messages have been produced, with a total of 9,000 distributed to all health posts in the region. Materials on all 9 topics distributed to health workers at each training. 900 calendars, 300 flipcharts, and 900 coloring books to reinforce the messages among children have been produced and distributed to health centers, CHWs, mothers, and public institutions. Ongoing training of health workers to reinforce handwashing messages. Strengthened by a donation of antibacterial hand soap from Johnson & Johnson.
2. Air messages on radio, publish and distribute posters and cards.	On track	See above.
3. Review messages based on mid-term evaluation results.	Completed	Validated and standardized messages with DIRESA
4. Insert consistent messages into CHW and HW training programs (including dramas).	Completed in prior year	Refer to IR1.1.
5. Supervisory visits and observation to ensure that health personnel and health promoters are appropriately promoting the BCC strategy.	On track	Technical assistance and supervision of staff of 117 health facilities to improve the processes of maternal and neonatal health care.
6. Review data from supervisory visits and observation. Compare to mid-term results and make necessary changes to the checklist.	Completed	
7. Develop support groups for breastfeeding in each micro-network.	Delayed	2 support groups have been created to date.
8. Train pregnant women and mothers at PVL groups and MOH nutrition program meetings.	On track	A total of 6 trainings have been conducted at MOH Nutrition program meetings occurring at Tupac Amaru, 2 May and New Magdalena, attended by a total of 195 mothers.
9. Training of support groups for breastfeeding.	Delayed	2 trainings have been conducted for 12 health personnel. 2 trainings have been conducted for 5 mothers.
<i>IR2. Increased quality of maternal and newborn care services in health facilities and the community</i>		
1. Preparation of HBLSS and neonatal IMCI training materials in Spanish and pilot testing.	HBLSS: Deleted IMCI: Prior year	HBLSS materials were adapted for the Peruvian setting and translated, as originally planned. See Section D for discussion. IMCI pilot testing complete.
2. Training of trainers in HBLSS.	Deleted	See above.
3. Training of trainers in IMCI.	On track	
4. Training of health workers in IMCI.	On track	238 health workers at 77 health care facilities have been trained.
5. Refresher courses in IMCI (10 locations).	On track	83 health workers and 158 CHWs have received refresher trainings.
6. Training of CHWs in IMCI.	On track	
7. CHWs conduct ongoing census, visits to home births and education of pregnant women in their communities and refer them to health posts and health centers. BCC dramas conducted. Calendar of prenatal care visits made for each woman.	On track	CHWs conducted 302 home visits to pregnant women, postpartum women and children under 1 month.
8. CHWs and health workers draw up birth, transportation and emergency plans with women and their families.	Delayed	Delayed while we continue to work with municipal leaders to establish emergency transportation plans in their communities.
9. Develop and review the Comprehensive Health Worker Checklist appropriate for prenatal, labor and postpartum periods.	Prior year	

Key Activities (as outlined in the DIP)	Status	Comments
10. Supervise health worker use of checklist, using interviews and observation compared to mid-term results.*	On track	To date, 117 health facilities have been inspected and observed in operation. Due to the number of communities and health posts and health centers, supervisory visits are performed in continual rounds.
IR3. Increased availability/access to maternal and newborn services in health facilities and the community		
1. Meetings with municipalities and community leaders to help them form community boards and develop transportation and emergency transportation plans.	Delayed and extended	Meetings held throughout year. Activity extended through the end of the project. This area is a major focus of the PD (see discussion below).
2. Visit maternity waiting homes (<i>casas de espera</i>) in other regions to assess feasibility and a model for Ucayali.	Prior year	Project staff visited an operational <i>casa de espera</i> in Huánuco Region.
3. Identification of deficiencies and improvement of birthing facilities, equipment and supplies at the health post level, using as a baseline the analysis of the maternal and child-focused Rapid Health Survey. Verification of improvements during supervisory visits.	On track	Deficiencies identified and reports made to DIRESA.
4. Develop plan with partners for maternity waiting homes. Current options under discussion include:	Gaining momentum	See discussion below.
a. Construction of homes if sustainability is assured.	In progress	Construction has begun on a casa at Monte de los Olivos (Mt. Olive).
b. Volunteers living close to the hospital who offer use of a room in their home.	Not pursued	
5. Evaluate the chosen strategy for maternity waiting homes and provide recommendations.	Upcoming	
IR4. Improved policy environment for maternal and newborn care		
1. Workshop with regional and central level MOH and PAHO to incorporate neonatal component into existing IMCI approach. Improve Community IMCI manual with more maternal and neonatal content.	Added Completed	Because previous workshops had been so successful, the Health Department in Ucayali requested that we conduct another workshop.
2. MOH incorporates HBLSS into policy for rural areas.	Deleted	See IR2.1 for explanation.
3. Distribution of MOH policy manuals. Refresher workshops in health posts and health centers and updates.	On track	Policy manuals distributed. Refresher workshops conducted and more planned.
4. Technical assistance to municipalities to adopt emergency transportation plans.	On track	Pilot in three municipalities: Campo Verde, Aguaytia and Mirasol.
5. (New) Meet with National Register of Identity (RENIEC) to provide information to help it comply with new regulations to facilitate enrollment of mothers and children.	On track	Workgroup established including representatives of RENIEC, local governments and DIRESA See discussion below.
6. (New) Assist municipalities in adopting policies for maternal and neonatal health, birth registration and breastfeeding, through ordinances and regulations.	On track	Provide TA to municipalities to develop policies that support maternal health.
Cross-Cutting Activities		
1. Share baseline KPC findings with Lima-based NGO and local USAID Mission stakeholders.	Prior year	
2. Complete Rapid Health Assessment in Iparia and Masisea.	Prior year	
3. Conduct CSSA with MOH.	Prior year	

Key Activities (as outlined in the DIP)	Status	Comments
4. Complete focus groups and in-depth interviews in Masisea and Iparia.	Prior year	
5. Conduct organizational assessment with INMED Andes and PRISMA.	Prior year	
6. Future Generations project report for Cuzco analyzed.	Completed	
7. Anti-helminthic medicine distributed to women of reproductive age and families with children.	On track	270,000 high-risk individuals annually have received doses of mebendazole.
8. KPC, Rapid Health Assessment, focus groups and in-depth interviews conducted at mid-term.	Prior year	
9. Capacity building activities for INMED, PRISMA and partners to strengthen monitoring and evaluation.	On track	See Section J.
10. Ongoing monitoring by INMED and PRISMA utilizing checklists, meetings with Committee on Maternal Death to review/monitor data.	On track	In process of integrating activities into an existing committee structure. See Section E.
11. Management Information System implementation for data entry and analysis of data from supervisory visits.	On track	MIS in place; manual data tracking system developed and implemented. Checklists to monitor data quality created. Regular reports to the Committee on Maternal Death.
12. Mid-term and final evaluations.	On track	Mid-term evaluation completed; final evaluation upcoming.
13. Completion of the Sustainability Plan.	Upcoming	
14. KPC Rapid Health Assessment focus groups and in-depth interviews at final evaluation.	Upcoming	See Section F for discussion.

Breastfeeding support groups have been established, trained and are ongoing in the two largest micro-networks. Several of the original 15 micro-networks represent very small numbers of people in extremely remote areas, and DIRESA is re-evaluating the number and composition of these groups. These micro-networks also are used to introduce other child development and feeding programs such as CRECER and Vaso de Leche, so women in the area have a number of activities competing for their attention. INMED is working closely to coordinate efforts with these vital community mainstays, often conducting trainings in conjunction with the other programs. Breastfeeding support groups are a new activity in the project area, and it will take time to build widespread support for and participation in them.

The Healthy Babies project continued working with community leaders on raising awareness of maternal health issues, developing transportation plans and identifying community resources that can be mobilized in the event of an emergency, focusing on three communities: Campo Verde, Aguaytia and Irazola. The PD has made significant progress by working closely and collaboratively with the town mayors to sign working agreements, recognize the work of the CHWs, and provide infrastructure. Recently, the mayor of Aguaytia offered the project an office in the municipality.

DIRESA is very interested in the *casa de espera* strategy. Preliminary sites were identified in Campo Verde, Manantay and on the hospital grounds in Yarinacocha. Widespread construction of the *casas* was put on hold due to mixed reports about the efficacy of the model in other regions of Peru and concerns about the long-term sustainability of the project. It was essential to make additional assessments, such as the meeting with Future Generations staff about the model it used in the Andean highlands, before moving forward with this intervention. In the meantime, however, the *casas de espera* have proved to be a catalyst for planning on the more fundamental issues of communication, information management and transportation.

Construction has begun on a smaller *casa de espera* with all the necessary commitments for sustainability at the Mt. Olive Health Post/Delivery Center in the Irazola district of Ucayali's Padre Abad province. Mt. Olive's municipal government has donated land and labor, and has agreed to provide ongoing oversight and maintenance. The shell of the house has been completed, and INMED recently secured additional funds from the Dominion Woman's Club of Virginia to finish and equip the interior, adding a floor, four bunk beds with room dividers, and a small kitchen. An outdoor latrine is separate. The Club has also committed to provide infant clothing and blankets for the women guests and their new babies. INMED is currently pursuing several potential avenues of additional funding, and has received a request for a full proposal from Ronald McDonald House Charities to support further development of the *casas*, including parenting and health education classes and stimulating and useful activities such as vegetable gardening.

Three major deworming campaigns and numerous DIRESA-led smaller deworming events have been held throughout the region, even beyond the project area. The fourth major campaign is planned for November 2009. Johnson & Johnson/Janssen-Cilag have donated deworming medication (mebendazole) to the project since its inception, and over the life of the project have contributed more than 743,000 single dose (500mg) mebendazole tablets. All women of reproductive age who are not pregnant and children from 2-14 years of age are treated semiannually. In areas with extremely poor sanitation, other family members are also treated. A copy of a banner promoting the deworming campaign and a brochure for prevention with an emphasis on handwashing that was distributed to the population are included in Annex 4. INMED recently secured a donation of antibacterial soap from Johnson & Johnson, which will be distributed in association with hygiene and sanitation education during the November 2009 deworming campaign.

The project team continued to maintain an active role in regional and local committees and to support other organizations' efforts to improve maternal and child health by: 1) Coordinating with the standing Committee of Sexual and Reproductive Health to create a standardized system of record keeping for medical records to track prenatal, neonatal and child growth and development outcomes; 2) Working with MOH to incorporate a neonatal component into the national CRECER campaign and with the standing Committee on Nutrition to insert messages into its materials; 3) Supporting MOH breastfeeding awareness campaigns by providing communication materials (see Annex 4, banner from 2008 World Breastfeeding Week); 4) Participating in the joint Community Surveillance System with local government in Padre Abad; 5) Disseminating news of project activities and new messages through Radio Progreso, Radio Super and Radio Felicidad, and in Padre Abad, through the Municipal Channel; and 6) Ran a booth at a CRECER health fair in Nueva Requena, distributing calendar coloring books and discussing maternal and neonatal health with fair attendees.

C. IMPEDIMENTS TO SUCCESS

In addition to frequent turnover of DIRESA directors and health personnel in the MOH health centers and health posts, especially during the first two years of the project, as well as strikes and recent uprisings in the region, other impediments merit further discussion:

Financial Constraints. Progress on the project work plan has been limited somewhat by financial constraints brought on by 1) the economic crisis; 2) the sharp decrease in the value of the dollar in 2007-2009; 3) the general increase in cost of local salaries, goods and transportation; 4) higher than anticipated costs associated with transportation; and 5) a temporary reduction in Year 2 funding from USAID. While USAID restored the project funding to full levels in the third year, some activities were not begun or ramped up until later than originally planned. INMED responded to the economic challenges by intensifying its efforts to raise counterpart funds, and has been successful in securing some matching funding and

excellent in-kind donations from the private sector for such things as development of radio messages by the Peruvian branch of an international marketing company, free shipping of supplies to Pucallpa by DHL, donated medicines and supplies, professional design assistance for posters and calendars and flipcharts, funding for development and printing of materials, and initial funding for a *casa de espera*. INMED continues to seek matching funding, and considerable momentum has developed as the project has produced tangible results and the economy is beginning to improve. INMED is taking additional cost-saving measures in the final year, such as renting an office with bedroom space in the project area to reduce per diem costs for the PD, and adding a highly qualified volunteer nurse practitioner/certified nurse-midwife to the project staff.

High number of health facilities proposed and the distance, difficulty and cost of transportation to rural/river communities. The project originally proposed to work in 150 health facilities in the area. However, given the vast distances between them and the expense and difficulty of travel in the region—with river access routes often impassable between April and November—we were compelled to focus our limited resources where they would have the greatest impact, outward from the population centers of Pucallpa and Aguaytia. The project has continued to work in the more distant rural and river communities, but the progress of work plan activities has been slower in those areas.

Negative perceptions of the quality of the health system and cultural barriers. During the MTE, health staff and CHWs alike identified motivating behavior change in the community as the largest challenge to their work with the Healthy Babies project thus far. The project has made considerable progress in overcoming negative perceptions of the quality of the health system by integrating seamlessly into the health system and improving the quality of care. It is also working to bridge the cultural divide by recruiting bilingual CHWs, producing health education materials in indigenous languages, and using radio spots in indigenous languages to reach remote populations.

D. TECHNICAL ASSISTANCE REQUIREMENTS

INMED will contract with an experienced, independent evaluation team to conduct the final evaluation, as it did for the mid-term evaluation.

E. SUBSTANTIAL CHANGES AND MONITORING PLAN PROGRESS

The project work plan was amended to reflect the evaluation team's recommendations, and the new version was accepted by USAID in March 2009. Adjustments to the work plan included the following:

Elimination of HBLSS activities and related outcomes: The HBLSS materials are designed for rural areas and focus on home births using trained midwives, whereas MOH is promoting institutional births. Therefore, pushing for approval of the HBLSS materials would jeopardize progress in other areas. Instead, we chose to focus on the neonatal IMCI materials and supplementary IEC/BCC materials that have been developed and approved by DIRESA.

Re-evaluation of the timeline for Community Board implementation: INMED has been working with community leaders to establish formal community boards. Developing the local ownership of this process, which will be the key to its sustainability, has proven to be a lengthy process. We have achieved momentum, especially in Campo Verde, Aguaytia, and Irazola, around the issues of transportation. Originally planned for completion in the first quarter of Year 4, the timeline for this activity has been extended through the end of the project and will represent a major focus for the PD. He will continue to work actively with DIRESA to explore alternative existing structures that might be adapted to serve this

purpose. We hope to have a working model in three communities by September 30, 2010 that could then be replicated in communities across the region.

Re-evaluation of the Data Quality Committee: INMED had planned to form a committee made up of representatives from INMED, PRISMA and MOH to monitor on a quarterly basis the data collected from supervisory visits and CHWs about pregnant women and newborn babies in their communities, to review data from focus groups and surveys conducted during the mid-term and final evaluations, and to make recommendations. However, since INMED and PRISMA are already both active in the DIRESA-led Committee on Maternal Death, it is more efficient to support and expand this existing committee rather than create a new group. While working with the existing committee is at times cumbersome because of its political nature, it currently has the best long-term potential for sustaining this activity. We regularly report on the outcomes of the Healthy Babies project at committee meetings, and are working to make data quality monitoring an official role of the committee.

Reassessment of the *casa de espera* strategy: INMED remains committed to the *casa de espera* strategy and has been working intensively with DIRESA and local municipal leaders to resolve the issues around long-term sustainability. Efforts will focus on making the pilot project at Mt. Olive a success, with a solid evaluation of the results. We have plans for two additional *casas de espera* in place, but anticipate that they will not be operational before the end of the current project period.

Addition of workshop on neonatal components of IMCI and two new activities under IR4 related to the National Register of Identity: These additional activities will contribute to the long-term sustainability of the project by increasing understanding of, and building support for, efforts to improve maternal and child health on a broader level.

Reassessment of the management information system strategy: A manual management information system was developed and implemented for this project. While we had hoped to implement a computer-based system, and are currently in discussions with DIRESA and the information management company Voxiva, it is unlikely that we will be able to develop and implement this activity before September 30, 2010. DIRESA is interested, but currently lacks funding for this activity. The focus during this planning stage is on finding the most feasible and sustainable solution.

F. SUSTAINABILITY ISSUES

While great strides toward sustainability have been made and will continue throughout the fourth year of the project, there is a strong belief among all partners that the Healthy Babies project should be extended and expanded over the next three years with a renewed commitment from the USAID Child Survival Program. Continued investment is necessary to 1) allow time to build on current momentum and cultivate additional supportive relationships with private sector companies, both local and multinationals with operations in Peru; 2) fully implement and evaluate the *casa de espera* strategy; 3) develop and roll out a centralized, computer-based maternal and child health management information system and communications strategy for the Ucayali Region; 4) expand the existing curriculum to include nutrition education messages focused on the weaning period and conduct a mass marketing campaign to promote exclusive breastfeeding and improve weaning practices; 5) strengthen community capacity to sustain the positive changes already achieved by continuing to develop the political will by engaging local leaders in child and maternal health issues and by developing an updated and comprehensive Sustainability Framework; and 6) reaching out further into Ucayali's remote rural areas to build on the indigenous-language efforts that have been initiated in the third year of the project.

From the inception of the Healthy Babies project, a participatory process built a sense of ownership—recognized and commended by the independent evaluation team—that will be the key to long-term sustainability. A training cascade approach has been employed since the inception: staff/consultant → master trainers → trainers (health personnel) → guides (CHWs, technical personnel), which has strengthened the capacity of the District Health Department to provide trainings in the future. INMED and the project team are also working closely with DIRESA on supervisory visits to health care facilities to ensure that it will have the capacity to monitor the quality of care available in health centers and health posts. Currently, MOH staff accompany the Healthy Babies team on visits whenever possible, and they have begun to move more from a shadowing role to a lead role. This element of the project is well positioned to create lasting change and serve as a model for other regions.

Continuing the project would give the team time to develop a full Sustainability Framework and institutionalize a monitoring process, allowing for the development of a system of mutual accountability that would also help partners recognize strengths, weaknesses, opportunities and threats in a timely manner, building on the common vision articulated in 2007 during a CSSA workshop conducted with a broad range of stakeholders.

While we have worked hard to cultivate supportive partnerships with the private sector throughout the life of the project—with several notable successes discussed throughout this report—these relationships take time to build, especially with a new project, a poor economy and unrest in the jungle regions of Peru. However, now having solid results and more stability within DIRESA and the region, we are building on many new relationships with companies in the energy, food, health and technology industries, as well as women's clubs in the USA, that are interested in contributing to the sustainability of the project.

The establishment of a *casa de espera* in Mt. Olive will allow us to begin to move this vital strategy forward, but a year is not long enough to ensure its success and long-term sustainability. The PD will need more time to rally corporate and community support for supplies and donations for the *casas*, to finalize all relevant agreements with local municipalities, to ensure that partners are familiar and comfortable with their respective roles, and to evaluate the success of the initial *casas*.

The desire for more information and more training—particularly around issues of nutrition—was a recurring theme at focus groups conducted during the mid-term evaluation. Participants of those groups wanted to learn more about the nutritional needs of pregnant women and young children, especially during the weaning period. The need for better nutrition is clear from the results of the 2004 Demographic and Health Survey: more than one in three children (34%) in the Ucayali Region are affected by nutritional stunting caused by chronic malnutrition. The Healthy Babies project would provide an ideal platform from which to develop and launch an expanded maternal and child health curriculum, including a strong nutrition component to promote the introduction of adequate complementary, locally available foods at six months with continued breastfeeding up to, or beyond, two years. INMED is planning to partner with Grey Communications to develop and implement a communication and marketing strategy that will use sophisticated blend of commercial and social marketing techniques to reach this project population living outside of the cash economy.

There is a clear and pressing need for improved health communication and data management systems in Ucayali. Such improvements would support better management of patient care and day-to-day operations of health care facilities, strengthen the referral system, foster better coordination of care of patients moving

between facilities, and allow the MOH to monitor and evaluate the impact of public health programs at the regional level. In collaboration with Voxiva, which has a wealth of experience working in the health care sector in cooperation with all levels of the Peruvian government, we have assessed the situation and developed a concrete proposal for a centralized computer-based data management system. As previously mentioned, DIRESA is very interested, but currently lacks the funding to support this endeavor. With additional time and funding from USAID, we believe we could secure additional support from the private sector that could bring this vital project to fruition.

G. RESPONSE TO MID-TERM EVALUATION RECOMMENDATIONS

INMED has responded positively and proactively to the recommendations of the independent evaluation team, ramping up highlighted activities, updating the workplan, and engaging actively in policy and sustainability issues.

H. PROJECT YEAR SPECIFIC INFORMATION

We are entering the final year of the project, and have included relevant discussion in Section F.

I. UPDATES TO THE PROJECT MANAGEMENT SYSTEM

Dr. Fernando Perez succeeded Dr. Marilú Chiang as Project Director on January 1, 2009. He has proven to be an exceptionally strong program director with innovative ideas for expanding the project and strengthening opportunities for sustainability, and a talent for building strong relationships. In addition, the USAID Backstop was changed from Ms. Jo Gilman to Dr. Thad Jackson. The transitions were smooth and there was no negative impact on project operations. Both changes were reviewed and accepted by USAID during 2009.

J. LOCAL PARTNER ORGANIZATION COLLABORATION AND CAPACITY BUILDING

Both INMED and PRISMA are highly experienced in M&E, and the inclusion of a KAP consultant at the outset of the project and during the MTE further developed this capacity. The PD directly oversees the project team in Ucayali and fosters their continued development. As noted above, INMED is currently working with Voxiva to introduce electronic data collection and monitoring to the region.

K. MISSION COLLABORATION

The Healthy Babies project responds to the USAID Peru Field Mission Strategic Objective of Improved Health for Peruvians at High Risk by addressing the quality and accessibility of services, while encouraging the adoption of healthy behaviors. The project plays an important role in contributing to overall mission health objectives. The PD meets and communicates monthly with USAID Mission contacts in Peru, and also is actively working with the Calidad en Salud group established by USAID Peru.

ANNEX 1: Monitoring and Evaluation – Healthy Babies Project in Ucayali Peru, 2008-2009

Monitoring information is being used to measure progress toward the Healthy Babies project objectives: IR1) Increased knowledge and practice of maternal and newborn care seeking behavior, IR2) Increased quality of maternal and newborn care services in health facilities and the community, IR3) Increased availability/access to maternal and newborn services in health facilities and the community, and IR4) Improved policy environment for maternal and newborn care. Data is collected from project training records and health center and health post records and is cross-referenced with data gathered from pregnant women and about newborn babies in their communities. Information is tabulated and analyzed at quarterly intervals.

I. Community Health Workers

A total of 624 Community Health Workers (CHWs)—584 health promoters and 40 traditional birth attendants—have received training through the Healthy Babies project on Integrated Management of Neonatal and Childhood Illness (IMNCI), a strategy that integrates all available measures for prevention of diseases and health problems during childhood, for early detection and effective treatment and to promote healthy lifestyles in the community. CHWs complete questionnaires testing their knowledge of health topics covered in the IMNCI training. In 2008, 19% of CHWs demonstrated competence in IMNCI. In 2009, 63% of CHWs demonstrated competence in IMNCI. Of the CHWs who had received training, 38% made home visits (a 10 percentage point gain over 2008); 32% referred pregnant women or new mothers to a health facility (a 2 percentage point gain over 2008); and 16% referred newborns (a 2 percentage point gain over 2008).

II. Supervisory Visit Information Collection

The following information is collected once per year for each health establishment: 1) the availability of equipment and medicine to treat pregnant and postpartum women and their newborns; 2) prenatal care received; 3) care received during labor and delivery (only for facilities that regularly attend births); and 4) postpartum care received. In each visit, field staff interview the health personnel responsible for maternal and child programs, review two clinical histories of postpartum mothers and two clinical histories of children under six months, and conduct two home visits to administer questionnaires to mothers of children under 1 year old selected at random from health records.

Monitoring Results

In 2009, the Healthy Babies team conducted supervisory visits at 117 health establishments, completing 117 monitoring forms, reviewing the clinic histories of 225 women and collecting surveys from 193 women. Thirty-one establishments were not monitored. Typical reasons for exclusion included some combination of the following: dispersed and/or small population (fewer than 20 families), limited—or no—hours of operation attended by health personnel, no work conducted with CHWs, limited accessibility, high cost of transit, length of time required to make the trip, language barriers among native populations, resistant population, or violence in the area.

Table 1. Overview of Supervisory Visit Activity by Micro-Network

Micro-network	# of establishments monitored	# of establishments not monitored
Aguaytía	14	0
San Alejandro	5	2
Campo Verde	19	0
Nueva Requena	6	1
Neshuya Curimaná	14	0
9 de Octubre	9	2
San José de Yarinacocha	10	5
San Fernando	5	0
Nuevo San Juan	7	4
Nuevo Paraiso	6	0
Tashitea	7	2
Iparía	8	8
Masisea	7	7
Total	117	31

Table 2. Detailed Reasons for Exclusion for Individual Health Posts

Micro-network	Name of Health Establishment (health post)	Reason for Exclusion	Travel Time	COST (soles)	
				Public Transit	Private Transit
9 de Octubre	2 de Mayo	Fewer than 20 families; limited hours of operation; no work with CHWs	2 hrs. by car	30	180
	Santa Teresita	Fewer than 20 families; limited hours of operation; accessible only in summer	1 day to go, 1 day to return	80	300
San Alejandro	Sinchi Roca	Accessible only in summer; flooding; indigenous population; resistant population	1 day to go, 1 day to return	40	400
	Puerto Nuevo	Same as above	1 day to go, 1 day to return	50	400
Nueva Requena	Shambo Porvenir	Fewer than 20 families; long travel time; high cost	2 days to go, 2 days to return		400
Nuevo San Juan	Betania	Dispersed population; accessible only in summer; high cost	1 day to go, 1 day to return	150	1200
	Puerto Betel	Fewer than 20 families; dispersed population; accessible only in summer; high cost	1.5 day to go, 1.5 day to return	150	1200

Micro-network	Name of Health Establishment (health post)	Reason for Exclusion	Travel Time	COST (soles)	
				Public Transit	Private Transit
	Masaray	Same as above	1.5 day to go, 1.5 day to return	180	1200
	Santa Ana	Same as above	1.5 day to go, 1.5 day to return	180	1200
San Jose de Yarinacocha	Esperanza de Panaillo	Fewer than 20 families; dispersed population; accessible only in summer; limited hours of operation	1 day to go, 1 day to return		200
	Huitococha	Same as above	1 day to go, 1 day to return		200
	Nueva Alejandria	Same as above	1 day to go, 1 day to return		150
	Señor de los Milagros	Same as above; plus no public transportation	6 hrs. to go, 6 hrs. to return	N/A	150
	Union Zapotillo	Same as above; plus no public transportation	8 hrs to go 8 hrs to return	N/A	200
Tashitea	Santa Sofia	Fewer than 20 families; dispersed population; accessible only in summer; high cost; violence in area; only accessible by river	1 day to go, 1 day to return	70	500
	Utuquinia	Same as above; plus indigenous population	1 day to go, 1 day to return	70	500
Iparia	Amaquiria	Fewer than 20 families; dispersed population; accessible only in summer; high cost; violence in area; only accessible by river; border crossing necessary; Portuguese speaking population	1.5 day to go, 1.5 day to return	300	2000
	Cuariaca del Caco	Same as above	1.5 day to go, 1.5 day to return	250	2000

Micro-network	Name of Health Establishment (health post)	Reason for Exclusion	Travel Time	COST (soles)	
				Public Transit	Private Transit
	Coloni Adel Caco	Same as above	1.5 day to go, 1.5 day to return	250	
	Caco Macaya	Same as above	1.5 day to go, 1.5 day to return	250	
	Nueva Nazaret	Same as above	1.5 day to go, 1.5 day to return	250	
	Pueblo del Caco	Same as above	1.5 day to go, 1.5 day to return	250	
	Runuya	Same as above	1.5 day to go, 1.5 day to return	250	
	Santa Rosa de Sheshea	Same as above	1.5 day to go, 1.5 day to return	250	
	Masisea	Abujau	Same as above	1.5 day to go, 1.5 day to return	250	2000
Nohaya		Same as above	1.5 day to go, 1.5 day to return	150	2000
Putaya		Same as above	1.5 day to go, 1.5 day to return	150	2000
Santa Fe de Inamatuya		Same as above	1.5 day to go, 1.5 day to return	150	2000
San Pedro de Inamapuya		Same as above	1.5 day to go, 1.5 day to return	150	2000
Nuevo Horizonte		Same as above	1.5 day to go, 1.5 day to return	150	2000
Santa Rosa de Abujau		Same as above	1.5 day to go, 1.5 day to return	150	2000

Summary Table of Progress on Indicators

Table 3. Monitoring Indicators Compared to Baseline Information

Intermediate Result	Indicator	Baseline (%)	2009 Monitoring Data (%)	EOP target (%)
IR1. Increased knowledge and practice of maternal and newborn care seeking behavior	% of pregnant women who know 3 danger signs in pregnancy	45	59	75
	% of women who recognize 3 newborn danger signs	2	20	45
	% of women who breastfeed within one hour of birth	52	91	70
	% of women who have a complete birth plan	21	41	60
	% of women with adequate handwashing practice	10	No data*	50
	% of women who have at least 6 prenatal visits	63	61	75
	% of micro-networks that have a breastfeeding support group	0	13	70
IR2. Increased quality of maternal and newborn care services in health facilities and the community	% of institutional births (total)	N/a	72	N/a
	% of institutional births(urban)	78	No data	88
	% of institutional births (rural)	55	No data	70
	% of women who have separate mother and baby follow-up visits within 3 days of birth	No data	26	75
	% of women who have post-partum control in the first week	38	31	72
	% of newborns who have post-partum control in the first week	54	44	60
	% of women who receive iron/folate supplementation during pregnancy and for 3 months afterwards	56	36	80
	% of health establishments that have midwives, nurses and technical nurses trained in community based IMNCI	0	51	75
	% of rural health establishments that have midwives, nurses and technical nurses trained in HBLSS	Activity deleted	Activity deleted	Activity deleted
	% of health establishments that correctly follow Ministry of Health (MOH) policy and	No data	66	80

Intermediate Result	Indicator	Baseline (%)	2009 Monitoring Data (%)	EOP target (%)
	guidelines			
IR3. Increased availability/access to maternal and newborn services in health facilities and the community	% of district municipalities who have an emergency transportation system in place and functioning for women with an emergency	0	0	80
	% of health establishments with complete equipment and material for maternal and newborn attention	13	26	60
	Number of maternity waiting homes (<i>casas de espera</i>)	0	1	3
IR4. Improved policy environment for maternal and newborn care	% of district municipalities with policies that support maternal and neonatal health	10	No data	80
	% of community boards with members trained in IMCI or HBLSS	0	0	80
	% of children with a birth certificate	42	61	80
	% of women registered in the government health insurance system (SIS)	87	95	85
	% of newborns covered by health insurance (SIS)	65	90	85

*According to the definition provided in the Detailed Implementation Plan, handwashing practice is said to be “adequate” when a woman washes her hands on at least two appropriate occasions. However, the Healthy Babies team changed the way this data was tracked to provide a much more detailed analysis. Unfortunately, it is not currently possible to aggregate the data for the summary measure (see next section).

III. Brief Discussion of Outcomes by Intermediate Result and Indicator

IR1. Increased knowledge and practice of maternal and newborn care seeking behavior

Recognition of danger signs in pregnant women and newborns: Participants continued to show strong gains in knowledge, with a 15-point gain in the percentage recognizing danger signs in pregnant women and an 18-point gain in the percentage recognizing danger signs in newborns.

The most commonly recognized signs in pregnancy include bleeding (67%), headaches (46%) and edema (36%). The least often recognized signs include convulsions (2%), foul-smelling discharge (6%) and vomiting (21%). The most commonly recognized signs in the newborn include fever (27%) and inflamed cord (27%). The least often recognized signs include pus in the eyes (1%), jaundice (4%) and convulsions (4%).

Breastfeeding within one hour of birth and exclusive breastfeeding: There has been a 40-point gain in percentage of women initiating breastfeeding within one hour of birth. The project also encourages women to exclusively breastfeed for up to six months. However, data for this indicator is only recorded during the Knowledge, Practices and Coverage (KPC) Survey and will not be documented again until 2010.

Birth, transportation and emergency plans: Over the life of the project, the percentage of women with a complete birth plan has nearly doubled, from 21% at baseline to 41% in 2009. Birth plans include basic preparations such as packing clothes, preparing the house for the baby, putting aside some money, deciding where the birth will occur, identifying who will accompany the woman and arranging transportation, and planning what to do in the event of an emergency. To be considered complete, a birth plan must include some arrangement for location, transportation, if necessary, and emergency planning. However, these plans are often constrained by the lack of community resources. The Healthy Babies project continues to work with municipalities to prioritize maternal health issues and identify resources that can be allocated to improving transportation and emergency assistance options.

Handwashing: Encouraged by the significant percentage increase of women adopting appropriate handwashing practices, the project has intensified efforts to further promote better hygiene. INMED recently secured a donation of antibacterial soap from Johnson & Johnson, which will be distributed in association with hygiene and sanitation education during the next major deworming campaign scheduled for November 2009.

Table 4. Percentage of Women Washing Hands Before or After Key Activities

Activity	2008 (%)	2009 (%)
After changing a diaper	27	49
Before breastfeeding	36	69
After going to the bathroom	23	47
Before eating or preparing food	28	46
Other	1	4

Prenatal visits: According to 2008 MOH statistics (2009 figures are not yet available), the total number of prenatal appointments completed in the region in 2008 increased by a total of 545 appointments over 2007; a total of 69% of health establishments achieved their targets for the number of pregnant women they projected that they would attend, but only but only 18% met their target for total number of prenatal appointments. The Healthy Babies project will continue to train CHWs to educate women about the importance of prenatal care.

According to surveys of mothers, almost all of the mothers interviewed (95%) referred to having had prenatal visits; 61% reported having six or more visits, with that percentage remaining virtually unchanged from baseline.

During the mid-term evaluation, a number of senior health officials remarked that they were surprised by the number of pregnant women in the community. This suggests that the project has been successful in identifying a group of women who were not previously receiving services. In other words, the apparent lack of forward progress on this objective may in fact reflect better information management.

In addition, it may be constructive to consider other, potentially more sensitive, measures of the project's impact. While six prenatal visits is the official MOH policy, it may be an unrealistic goal, especially for women who live in the more remote areas; rather, it may be informative to consider the average number of prenatal appointments or to break out the data by percent of women receiving each number of appointments: 1, 2, 3, 4, 5 and 6 or more. Also the project may have the additional benefit of encouraging women to initiate prenatal care earlier in their pregnancy. According to the clinical histories, a higher percentage of women initiated their prenatal care earlier in their pregnancies, with a 5-point increase in percent of women initiating care in the first trimester, and a 2-point gain in care seeking beginning in the second trimester rather than in the third.

Micro-networks that have a breastfeeding support group: Breastfeeding support groups have been established, trained and are ongoing in two of the 15 micro-networks. Initially planned for each micro-network, INMED has reevaluated the feasibility of such broad coverage, and will instead seek to establish groups in half of those communities. The reality is that with a number of child development and feeding programs such as CRECER and Vaso de Leche, among others, women in the project area have a number of activities competing for their attention. INMED is working closely to coordinate efforts with these vital community mainstays, often conducting trainings in conjunction with the other programs. Breastfeeding support groups are a new activity in the project area, and it will take time to build widespread support for and participation in them.

IR2 Increased quality of maternal and newborn care services in health facilities and the community

Institutional birth (changed from "Delivery by skilled attendant" to reflect the current MOH position and priorities): According to MOH statistics for 2008, overall, 83% of births occurred in institutions, 4% occurred in homes attended by health professionals, and the remaining 13% of home births were assisted by a traditional birth attendant or a family member. However, among

women interviewed during home visits conducted during health establishment supervisions, only 72% had institutional births. This discrepancy most likely reflects our sampling methodology, which disproportionately represents rural women, by selecting two clinical histories and two women to interview regardless of the size of the population served by the facility. While data are not available to break out results by urbanicity, the proportion of births occurring in health care facilities has typically been much higher in urban and peri-urban areas. Birth location data—home versus institution—classified by urban or rural locale was available through a Rapid CATCH assessment that was conducted at project baseline in 2006 and will be repeated at the end of 2010.

Over the life of the project, there has been an apparent decrease of 6 percent in institutional births. Again, however, lack of forward progress on this outcome may reflect both better information management and a disconnect between understanding the importance of an institutional birth and its accessibility. INMED is working to address the accessibility issue through its *casa de espera* strategy.

Activities registered in clinical histories for the immediate postpartum period were blood pressure control (40%), uterine involution care (32%) and discharge care (34%). Activities registered in clinical histories for immediate newborn care are listed in the table below.

Table 5. Activities for Immediate Newborn Care

Activity	Clinical Histories 2009 (%)
Body measurements	83
Temperature	70
Physical exam	62
Immediate breastfeeding	61
APGAR @ 1 minute	70
APGAR @ 5 minutes	67
Ophthalmic prophylaxis	72
Umbilical prophylaxis	69
Vitamin K administration	69

Activities registered in clinical histories for follow-up newborn care were BCG vaccine (45%) and Hepatitis B vaccine (42%).

The person responsible for the assistance was a nurse (39% of cases), obstetrician (10%), physician (6%), or technician (40%). The responsible person was not recorded in 5% of cases, representing a dramatic improvement in record keeping with a reduction from the baseline figure of 17% not recorded.

Iron supplementation: A high proportion of women (81%) received ferrous sulfate (iron) at some point in their pregnancy. Administration of ferrous sulfate for three or more months was recorded in only 36% of women surveyed.

Responsibility for providing iron supplementation ultimately rests with DIRESA (Dirección Regional de Salud), the highest local health authority in Ucayali. While the Healthy Babies project can educate the women about the importance of iron and folate for a healthy pregnancy, unless supplies are available, the women cannot act on their knowledge. In 2009, the health department faced a severe shortage of iron supplements

Postpartum Care: Over the life of the project, there have been apparent decreases of 7 and 10 percentage points in women and newborns, respectively, receiving a postpartum check-up within the first week after birth. Again, however, lack of forward progress on these outcomes may reflect both better information management and a disconnect between understanding the importance of postpartum care and its accessibility. INMED is working to address the accessibility issue by training CHWs to conduct home visits in order to make obtaining this care more convenient.

Also, it is important to note that while there has been an apparent decrease overall of women receiving a postpartum check-up at any time, there have been increases in the percentage of newborns receiving a first postnatal appointment (7 points), and in the percentage of newborns receiving a second postnatal appointment (10 points).

Health establishments that correctly follow MOH policy and guidelines: The Minimum Activities for Mothers and Newborns (MAMAN) checklist is an instrument developed to provide a global view of what is happening in the health establishments regarding these minimum activities. A supervisory visit was conducted at 117 facilities in 2009, compared to 78 that were observed in 2008. Births are regularly attended at 65 of these facilities. The table below compares the monitoring results from 2008 and 2009. In 2007, only 12 health facilities were visited, all of them in peri-urban areas, so the results were not reflective of what was occurring more broadly across the region, particularly in the more rural settings.

Some of the following information was registered from the clinical histories, but other activities are not registered, so the questions were directly asked of the health personnel.

Only one (2%) of the health establishments observed practiced all of the MAMAN minimum activities. The activities least practiced in the health establishments are birth preparedness (30%) and partograph (32%). For newborn resuscitation, none of the health establishments reported using an Ambu bag, saying that they did not need to use it.

Table 6. Heath Establishments Following MOH Guidelines for MAMAN Activities

ACTIVITY	# Health Establishments 2008		# Health Establishments 2009	
	#	%	#	%
1. Birth preparedness	20	26	34	30
2. Tetanus vaccine	26	33	45	39
3. Infection prevention	22	28	60*	92
4. Emergency referral	6	50	62*	95
5. Partograph	7	28	21*	32
6. Active management of third stage of labor	36	46	31*	48
7. Use of Ambu bag	22	28	27	42
8. Cord care	62	79	106	92
9. Thermal care	76	97	62*	95
10. Breastfeeding in the first hour	12	100	100	87
11. Referral of infections	75	96	113	98

* Activities occur only in EESS where births are regularly attended.

Table 7. Number of MAMAN Activities Conducted

Number of Activities	2008		2009	
	# Health Establishments 2008	%	# Health Establishments 2009	%
Health establishments where births are NOT regularly attended				
From 0 to 3 activities	.....	.....	14	28.0
From 4 to 5 activities	.....	.....	30	60.0
6 activities	.....	.....	6	12.0
Health establishments where births are regularly attended				
From 0 to 6 activities	43	55.1	21	32.3
From 7 to 10 activities	33	42.3	43	66.2
11 activities	0	0	1	1.5

IR3 Increased availability/access to maternal and newborn services in health facilities and the community

District municipalities that have an emergency transportation system in place and functioning for women with an emergency: The Healthy Babies project continued working with community leaders on raising awareness of maternal health issues, developing transportation plans and identifying community resources that can be mobilized in the event of an emergency, focusing on three communities: Campo Verde, Aguaytia and Mirasol. The Project Director (PD) has made significant progress by working closely and collaboratively with the town mayors to sign

working agreements, recognize the work of the CHWs, and provide infrastructure. Recently, the mayor of Aguaytia offered the project an office in the municipality.

Health establishments with complete equipment and material for maternal and newborn attention: In general, health establishments did not have a complete range of equipment and material for adequate maternal and neonatal care. The three most common pieces of equipment are obstetrical measuring tape (97%), Pinard Horn fetoscope (93%) and thermometers (91%); the two least common are clock with a second hand (32%), and Ambu bags (39%). The four largest changes between the 2008 and 2009 monitoring cycles were 1) 23-point increase in availability of umbilical clamps, 2) 11-point increase availability of educational materials, 3) 10-point increase in availability of clocks with second hands, and 4) 7-point decrease in the availability of blood pressure monitors.

The most commonly available drugs are oxytocin (93%) and gentomycin (87%). The proportion of facilities having vaccines increased for ATT (by 3 percentage points) and HVB (by 8 percentage points) and decreased for BCG (by 4 percentage points). Only 79% had ferrous sulfate on hand.

Only 40% had printed MOH formats for the partograph. The two largest changes between the 2008 and 2009 monitoring cycles were 1) 14-point increase in use of birth plans, and 2) 14-point increase in CHW referrals.

Number of maternity waiting homes (casas de espera): DIRESA is very interested in the *casa de espera* strategy. Preliminary sites were identified in Campo Verde, Manantay and on the hospital grounds in Yarinacocha. Widespread construction of the *casas* was put on hold due to mixed reports about the efficacy of the model in other regions of Peru and concerns about the long-term sustainability of the project. It was essential to make additional assessments, such as the meeting with Future Generations staff about the model it used in the Andean highlands, before moving forward with this intervention. In the meantime, however, the *casas de espera* have proved to be a catalyst for planning on the more fundamental issues of communication, information management and transportation.

Construction has begun on a smaller *casa de espera* with all the necessary commitments for sustainability at the Monte de los Olivos (Mt. Olive) Health Post/Delivery Center in the Aguaytia district of Ucayali. Mt. Olive's municipal government has donated land and labor, and has agreed to provide ongoing oversight and maintenance. The shell of the house has been completed, and INMED recently secured additional funds from the Dominion Woman's Club of Virginia to finish and equip the interior, adding a floor, four bunk beds with room dividers, and a small kitchen. An outdoor latrine is separate. The Club has also committed to provide infant clothing and blankets for the women guests and their new babies. INMED is currently pursuing several potential avenues of additional funding and has received a request for a full proposal from Ronald McDonald House Charities to support further development of the *casas*, including parenting and health education classes and stimulating and useful activities such as vegetable gardening.

IR4 Improved policy environment for maternal and newborn care

District municipalities with policies that support maternal and neonatal health: Data was not collected for this indicator in Year 3. A full report on municipal-level policies supporting maternal and neonatal health will be included in the final report for this grant cycle.

Community boards with members trained in IMCI: While the PD continues to work with community leaders and a broad spectrum of stakeholders from each community, no formal community boards have yet been established. As with the emergency transportation plans, efforts are focused on developing working models in the three communities of Campo Verde, Aguaytia and Irazola.

Women and children with proper identification and enrolled in SIS: In Peru, obtaining a national identity card (DNI) is a multi-step process that includes obtaining certificates from multiple agencies. The first step is to obtain a Certificate of Live Birth from the health post (79% of our sample had received this document); the next step is to obtain a registered birth certificate; and the final step is to obtaining the DNI from a third agency (61% had done so—an improvement of 19 percentage points over baseline).

ANNEX 2: Work Plan
Healthy Babies Project – Ucayali, Peru, 2009-2010

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
IR1: Increased knowledge and practice of maternal and newborn care seeking behavior														
1.	Conduct BCC strategy - Develop radio messages, posters, picture cards and CHW dramas (practice with stakeholders) with consistent messages for: (i) comprehensive birth plans (birth plans that include transportation and emergency) (ii) messages to encourage women to breast feed within one hour of birth (iii) pregnant women and mothers of infants wash their hand routinely to prevent the spread of disease (iv) Recognizing danger signs during pregnancy (v) Recognizing danger signs in the newborn (vi) Taking iron supplementation (vii) Exclusive breastfeeding (viii) Prenatal care visits (ix) Institutional delivery	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH Health Workers and CHWs
2.	Air messages on radio, publish posters and cards and distribute.	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH
3.	Review messages based on mid-term evaluation results.													INMED, PRISMA, MOH, community stakeholders Completed
4.	Insert consistent messages into CHW and HW training programs (including dramas) for: (i) comprehensive birth plans (birth plans that include transportation and emergency) (ii) messages to encourage women to breast feed within one hour of birth – and the establishment of a breast feeding advocacy support group.													INMED, PRISMA MOH Completed

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
	(iii) pregnant women and mothers of infants wash their hand routinely to prevent the spread of disease. (iv) Recognizing danger signs during pregnancy (v) Recognizing danger signs in the newborn, (vi) Taking iron supplementation, (vii) Exclusive breastfeeding (viii) Prenatal care visits (ix) Institutional delivery													
5.	Supervisory visits and observation to ensure that health personnel and health promoters are appropriately promoting: (i) comprehensive birth plans (birth plans that include transportation and emergency) (ii) messages to encourage women to breast feed within one hour of birth – and the availability of an advocacy support group in health centers and health posts for pregnant and post-partum women. (iii) pregnant women and mothers of infants wash their hand routinely to prevent the spread of disease (iv) Recognizing danger signs during pregnancy (v) Recognizing danger signs in the newborn, (vi) Taking iron supplementation, (vii) Exclusive breastfeeding (viii) Prenatal care visits (ix) Institutional delivery	X	X	X	X	X	X	X	X	X	X	X	X	INMED, PRISMA Supervisors with MOH Health Workers
6.	Review data from supervisory visits and observation compare to mid-term results and make necessary changes to the checklist.													INMED, PRISMA MOH Completed
7.	Develop support groups for breastfeeding in each micro-network.	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
8.	Training of support groups for breastfeeding	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH
IR2: Increased quality of maternal and newborn care services in health facilities and the community														
1.	Preparation of HBLSS and neonatal IMCI training materials in Spanish and pilot testing. (HBLSS activities deleted)													INMED, PRISMA, PAHO Completed
2.	Training of trainers for IMCI													INMED, PRISMA MOH, PAHO Completed
3.	IMCI training of health workers (10 locations)													INMED, PRISMA, MOH Completed
4.	Refresher courses in IMCI (10 locations)													INMED, PRISMA, MOH Completed
5.	Training of CHWs in IMCI	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH
6.	CHWs conduct ongoing census, visits to home births and education of pregnant women in their communities and refer them to health posts and health centers. BCC dramas conducted. Calendar for prenatal care visits made for each woman.	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH Health Workers, CHWs
7.	CHWs and health workers draw up birth, transportation and emergency plans with women and their families.	X	X	X	X	X	X	X	X	X				INMED, PRISMA, MOH Health Workers, CHWs
8.	Develop and review the Comprehensive Health Worker Checklist – appropriate for prenatal, labor and post partum.	X	X	X	X	X								INMED, PRISMA, MOH
9.	Supervise health worker use of checklist – using interviews and observation compare to results of mid-term results. <i>Note: Due to the number of communities and health posts and health centers supervisory visits will be performed in continual rounds.</i>	X	X	X	X	X	X	X	X	X	X	X	X	INMED, PRISMA, MOH

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
IR3: Increased availability/access to maternal and newborn services in health facilities and the community														
1.	Meetings with municipalities and community leaders to help them form community boards and develop transportation and emergency transportation plans.	X	X	X	X	X	X	X	X	X				INMED, MOH, municipalities, community leaders, MOH Health Workers
2.	Visit maternity waiting homes in other regions to assess feasibility and model for Ucayali.													INMED Completed
3.	Identification of deficiencies and improvement of birthing facilities, equipment and supplies at the health post level through the Committee on Maternal Death coordinated by DIRESA, using as a baseline the analysis of the maternal and child-focused Rapid Health Survey, with verification of improvements during supervisory visits.	X	X	X	X	X	X	X	X	X	X	X	X	INMED, PRISMA, MOH
4.	Develop plan with partners for a maternity waiting home, depending on feasibility plan.	X	X	X	X	X	X							INMED, MOH
5.	Secure donation for construction and supplies for maternity waiting homes, if that is the preferred method according to feasibility and model chosen.	X	X	X	X	X	X							INMED
6.	Secure volunteers who offer use of a room of their home, close to the hospital, for maternity waiting home clients.													INMED, PRISMA, MOH Not being pursued
7.	Evaluate the maternity waiting home strategy and provide recommendations for the future.								X	X				INMED, PRISMA, MOH
IR4: Improved policy environment for maternal and newborn care														
1.	Workshop with regional and central level MOH and PAHO to incorporate neonatal component into IMCI. Improvement of Community IMCI manual with more maternal and neonatal content.													INMED, PRISMA, MOH, PAHO Completed

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
2.	Distribution of MOH policy manuals. Refresher workshops and updates in health posts and health centers.	X	X	X										INMED, PRISMA, MOH
3.	Technical assistance to municipalities to adopt emergency transportation plans				X	X	X							INMED, PRISMA, MOH, municipalities and community leaders
4.	Meet with National Registry of Identity (RENIEC) to provide information and promote compliance with new regulations to facilitate enrollment of mothers and children.													Completed
5.	Assist municipalities to adopt policies for maternal and neonatal health, child identity and breastfeeding through ordinances and regulations.	X	X	X				X	X	X				INMED
Cross Cutting Activities														
1.	Share baseline KPC findings with Lima-based NGO and local mission stakeholders.													INMED, PRISMA, MOH Completed
2.	Complete Rapid Health Assessment with Iparia and Masisea.													INMED, PRISMA, MOH Completed
3.	Conduct CSSA with MOH.													INMED, PRISMA, MOH Completed
4.	Complete focus groups and in depth interviews in Masisea and Iparia.													INMED, PRISMA, MOH Completed
5.	Conduct organizational assessments for INMED Andes (Peru) and PRISMA.													INMED, PRISMA, MOH Completed
6.	Analyze Future Generations project report for Cuzco.													INMED Completed
7.	Anti-helminthic medicine distributed to all women of reproductive age and families with children over two years of age. [determined w/MOH]		X								X			INMED, PRISMA, MOH, Johnson & Johnson

IR	Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Responsible/Status
8.	KPC, Rapid Health Assessment, focus groups and in-depth interviews at mid-term evaluation.													INMED, PRISMA, MOH Completed
9.	Presentations of mid-term and final results to all project stakeholders.												X	INMED
10.	KPC, Rapid Health Assessment, focus groups and in-depth interviews at final evaluation.							X	X	X				INMED, PRISMA, MOH
11.	Capacity building INMED, PRISMA and partners for M&E.							X	X	X				INMED, PRISMA, MOH
12.	Ongoing monitoring by INMED and PRISMA, utilizing checklists and meetings with Committee on Maternal Death to review/monitor data.	X	X	X	X	X	X	X	X	X	X	X	X	INMED, PRISMA, MOH
13.	Management Information System implementation for data entry and analysis of data from supervisory visits (System is currently all manual. INMED is working with DIRESA on a plan to automate/computerize).	X	X	X	X	X	X	X	X	X	X	X	X	INMED, PRISMA, MOH
14.	Mid-term and final evaluations							X	X	X				External Evaluator, INMED, PRISMA, MOH
15.	Completion of the Sustainability Plan				X	X	X	X	X	X	X	X	X	INMED and partners
17.	Annual Report												X	INMED

ANNEX 4: INMED Healthy Babies Project, Ucayali, Peru, 2008-2009 – List of Papers, and Presentations

Chiang, Marilú and Josephine Gilman (2008) “Situación de salud infantil en niños menores de dos años en dos provincias de Ucayali. Línea de base proyecto “Bebés Sanitos” Investigaciones Operativas en Salud y Nutrición de la niñez en el Perú, Organización Panamericana de la Salud pp. 73-76

Aguila, H Del, “ONG dona 300 mil antiparasitarios: Disa iniciará segunda campaña de deparasitación en Ucayali” Ahora Ucayali 5, 1 Oct. 2009

ANNEX 5: Healthy Babies Project Results Highlight

To reduce maternal and neonatal mortality in Ucayali, Peru, INMED Partnerships for Children (INMED) launched the Healthy Babies project in 2006 to 1) increase the knowledge and care seeking behavior of pregnant women and new mothers, 2) increase access and improve quality at the local health care provider level, and 3) improve the policy environment for maternal and neonatal health. INMED has introduced a number of successful strategies across nine of the 14 districts of the Ucayali Region to strengthen the District Health System and increase its capacity to carry out health care best practices such as Integrated Management of Childhood Illness (IMCI) and Minimum Actions to Save Mothers and Newborns (MAMAN) at scale. In addition, the Healthy Babies team, in collaboration with the Ministry of Health (MOH), has developed and implemented a Regional Health Information Management System that will greatly contribute to the long-term sustainability of the project.

The Healthy Babies project provides training for community health workers and MOH staff in IMCI and MAMAN, management training for health professionals and technical assistance to health facilities in the form of improved supervisory system visits, identifying gaps in service quality by observation, client interviews and review of clinical history forms. The pre-existing MOH supervisory system was weak. Quality assurance visits were sporadic, and there were no information system or data collection guidelines for the monitoring activities. Since the launch of the Healthy Babies project, however, changes at the health post level have been radical. Health service delivery is now guided by the use of a checklist developed by the Healthy Babies team in partnership with the MOH, using the MOH policy standards as a guideline.

The results have been impressive. To date, 238 health professionals from 77 health establishments have received training in life-saving health care best practices, in addition to 624 volunteer community health workers. Supervisory visits have been conducted at 117 health care facilities. Although baseline data is unavailable for the number of health care facilities that adhered to MOH guidelines, anecdotal evidence suggests that few—if any—followed them. In 2008, the first supervisory visits conducted at a representative sample of health establishments found that only 42% regularly employed more than half of the MAMAN activities and no facility followed all of them. In 2009, 70% of facilities followed more than half, and one facility employed all 11 of the activities covered in the survey.

In Ucayali, health statistics from some of the area health posts and health centers had been non-existent, so the Healthy Babies project helped design and implement a region-wide information management system. INMED and PRISMA, which partner closely with the provincial health department to implement the Healthy Babies project, participate in the Committee on Maternal Death, led by the Dirección Regional de Salud (DIRESA), Ucayali's highest health authority. Efforts are currently underway to encourage the Committee to augment its focus by assuming full responsibility for monitoring data from the supervisory visits to inform and improve clinical decision-making. By fully integrating the Healthy Babies project strategies into the existing health care system, the project will make long-term, sustainable as well as scalable, improvements to the District Health System.

Thanks in large part to the Healthy Babies project, maternal and child health issues have been gaining prominence at the national level; large investments are being made in Peru's public health infrastructure. The Ministry of Economy asked the DIRESAs nationwide to identify their needs, and plans to develop a computer-based system to streamline the procurement process, both DIRESA and MOH have made commitments to address sexual and reproductive health in the Ucayali Health District; and the Regional Health Committee of Ucayali has formally prioritized a number of maternal and neonatal health issues.

