

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

**Bolivia CS-16
Final Evaluation**

Cooperative Agreement No.: FAO-A-00-00-00010-00
September 30, 2000 – September 30, 2004

Submitted to
USAID/GH/HIDN/NUT/CSHGP
December 31, 2004

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Glossary of Acronyms

APROSAR	The Association of Rural Health Promoters (CS-16 partner NGO) (<i>Asociación de Promotores de Salud del area Rural</i>)
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival (USAID Project)
BCC	Behavior Change Communication
BHR/PVC	USAID's Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation
CAI/TAI	Information Analysis Committee (<i>Comite de Analisis de Informaci3n/Taller de Analisis de Informaci3n</i>)
CB-IMCI	Community-Based Integrated Management of Childhood Illnesses
CDD	Control of Diarrheal Disease
CORE	The Child Survival Collaborations and Resources Group
CS	Child Survival
CS-16	Child Survival-16 (SC's <i>Wawa Sana</i> project described in this FE, supported through the 16 th cycle BHR/PVC CS funding)
CSTS	Child Survival Technical Support Project, Macro International
DD	Diarrheal Disease
DHS	Demographic and Health Survey
DILOS	<i>Directorio Local de Salud</i>
DIP	Detailed Implementation Plan
DPT3	Diphtheria-Pertussis-Tetanus immunization, 3 rd dose
EPI	Expanded Program on Immunization
FE	Final Evaluation
FO	Field Office (country office of Save the Children/US)
H/PD	The Hearth model using the Positive Deviance approach
HIPC	World Bank indicators for "Heavily Indebted Poor Countries" used by the Bolivian MOH
IMCI	Integrated Management of Childhood Illnesses
IR	Intermediate Result
ISA	Institutional Strengths Assessment

KPC	Knowledge, Practice, and Coverage survey
LAC	Latin America/Caribbean Region
LINKAGES	USAID initiative for improving breastfeeding
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-Governmental Organization
OH	Office of Health of Save the Children
ORS	Oral Rehydration Solution
PAHO	Pan American Health Organization
PCM	Pneumonia Case Management
PD	Positive Deviance/Positive Deviant
PDQ	Partnership Defined Quality
PLAN	PLAN International
POA	<i>Plan Operativo Anual</i> (Annual Operational Plan)
PROCOSI	PVO Integrated Health Network (in Bolivia) (<i>Programa de Coordinación de Salud Integral</i>)
PVO	Private Voluntary Organization
RHD	Rural Health District
SC	Save the Children/US
SC/B	Save the Children/US Bolivia Field Office
SC/HQ	Save the Children/US Headquarters
SECI	Community Epidemiology Surveillance System/Integrated Community Epidemiological System (<i>Sistema Epidemiologico Comunitario Integral</i>)
SEDES	Ministry of Health departmental level in Oruro
SNIS	National Health Information System (of the Bolivian MOH) (<i>Sistema Nacional de Información en Salud</i>)
SUMI	New financial assistance basic care package providing free coverage in Bolivia
TA	Technical Assistance
<i>Wawa Sana</i>	“Healthy Child.” <i>Sana</i> is Spanish for “healthy.” <i>Wawa</i> is Aymara and Quechua for “child.”
WHO	World health Organization

I. Executive Summary

The “*Wawa Sana*” (healthy child) Project, a four-year Child Survival-16 Program to mobilize communities and health services for Community-Based Integrated Management of Childhood Illness (CB-IMCI) by testing innovative approaches to improve child health in rural Bolivia, was funded from September 30, 2000 through September 30, 2004 through a \$1 million “New Program” grant from USAID/BHR/PVC, and matched by a \$1 million cost-share from Save the Children. The *Wawa Sana* Project aimed to: (1) document the feasibility and results of implementing innovative approaches to strengthen community capacity to identify and effectively address priority child health needs, and; (2) partner with the Ministry of Health (MOH) and non-governmental organizations (NGOs) at the district-level to strengthen their capacity to support community activities and to implement innovative culturally acceptable approaches to child survival.

The CS-16 site covered 445 communities with a total population of 104,500, including 13,500 children under five, in three Rural Health Districts¹ of Oruro Department on Bolivia’s Altiplano. The Program addressed high under-five mortality in this site, estimated at 109 deaths per 1,000 live births, associated with pneumonia, diarrhea, malnutrition, and immunizable diseases; in a population with low use of health services and health information, and health services which did not meet the needs of the population.

SC worked with the site’s three MOH Rural Health Districts (RHDs), a Bolivian NGO, APROSAR, local governments, and communities to implement four child survival interventions:

- 1) Nutrition and micronutrients (30% of estimated intervention-specific project effort);
- 2) Pneumonia case management (30%),
- 3) Control of diarrheal disease (20%), and,
- 4) Immunization (20%).

SC implemented these four interventions through three innovative approaches to child survival in Bolivia:

- Community-Based-IMCI (CB-IMCI), focused on training and supporting volunteer Rural Health Promoters to provide selected child survival services in their communities, utilizing PAHO CB-IMCI materials recently adapted for Bolivia, while supporting concurrent MOH implementation of clinical integrated management of childhood illness (IMCI) at health facilities;
- The Hearth model using a Positive Deviance approach (H/PD) to sustainable community-based rehabilitation and prevention of malnutrition in children under five;
- Expansion of the Community Epidemiology Surveillance System (SECI), developed and pilot-tested by SC/Bolivia in 1997-98 to promote joint collection, analysis, and use of health information by health providers and communities to address local health needs.

¹ During the course of CS-16, Bolivia changed the health administrative structure in the project area from three districts (District I: Huanuni, District III: Challapata, and District V: Eucaliptus, to two “Networks” (*Redes*). They are called *Red Azanake* and *Red Norte*. SC/B staff worked in former districts III and V, while APROSAR’s work was concentrated in District I.

Wawa Sana Project Goals included:

- A sustained improvement in nutrition status of 6 to 35 month old children in H/PD communities;
- A sustained reduction in under-five mortality in the three health districts; and,
- Innovative CS-16 approaches to inform policy and improve programming in other areas of Bolivia.

Wawa Sana aimed to achieve the following results:

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

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

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

Accomplishments

Over the last four years, in the midst of a rapidly changing, complex sociopolitical and cultural context, the *Wawa Sana* project was highly successful, having achieved or surpassed nearly all of its objectives. Key accomplishments include:

- Pentavalent-3 vaccine coverage increased from 32% to 85% in infants.²
- The number of acute respiratory infections treated by health services and Promoters increased 224% from 2001 through 2003 in CS-16 intervention areas.³
- Families increased their children's fluid intake during diarrheal diseases from 21% at the start of the program to 54% at final evaluation.⁴
- Most CS-16 communities now place health at or near the top of their agenda in sharp contrast to prior to *Wawa Sana* when health was low or absent completely from public community dialogue.

² KPC Surveys, baseline (2000) and final (2004), based on verified registration on child health card.

³ Bolivia National Health Information System data (SNIS).

⁴ KPC Surveys, baseline (2000) and final (2004).

- Municipalities, communities, and health service providers learned to share and analyze community health information to set priorities, plan, act, and evaluate progress resulting in stronger working relationships.
- APROSAR, a major local NGO partner, strengthened its technical capacity to provide CB-IMCI and to apply, document, and expand SECI and H/PD strategies to communities outside the *Wawa Sana* project area. APROSAR also strengthened its capacity to implement other communication strategies (materials development, improved educational methods, and use of radio programming). Finally, APROSAR increased and diversified its funding sources from nearly total dependence on USAID funding at the start of CS-16 to only 25% today.
- At least 15 other NGOs and government health services have adopted and adapted *Wawa Sana's* SECI and H/PD strategies throughout Bolivia.

Priority conclusions:

- In spite of the constant change of national and local government staff and policies, health personnel, community authorities, and volunteer health Promoters, *Wawa Sana* achieved or surpassed nearly all of its health and capacity strengthening objectives. Many of these achievements (improved family health and nutrition knowledge and practice, access to trained Promoters, community/provider coordination, use of health information to set priorities, plan, take action, and monitor progress, improved organizational capacity of APROSAR and MOH services and others) are likely to continue after the project ends, although some decrease in intensity and quality is likely to occur in some communities and health facilities given the constant rotation of personnel at all levels and the highly political nature of the current environment.
- SECI is a powerful, effective, and feasible methodology to mobilize communities for health that increases community awareness of and interest in health problems, builds community and service provider capacity in collecting and using health information in accessible ways to set priorities, plan, act, and monitor progress. SECI effectively put into practice the Bolivian “Law of Popular Participation” and has had important direct impact on health status as well as possibly more important indirect positive impact through its ability to change the system of local government decision-making and planning that could also be applied to other sectors. The spread of SECI to other organizations in various parts of the country demonstrates that others outside of the project value and use the methodology.
- H/PD should be further developed and studied in rural Bolivia before it can be recommended for expansion. H/PD was successful in some, but not all *Wawa Sana* communities. Geographic, population migration, climate, and many other challenges contributed to less significant changes in nutritional status than expected. Many communities enjoy the Hearth meetings where they share and prepare improved recipes, and families have learned improved child care attitudes and practices that contribute to healthier, happier children. *Wawa Sana* partners have begun to apply a PD approach to other aspects of their work which provides a broader perspective of possible options that build on what is already working.

II. Assessment of Results and Impact of the Program

Presented below is a summary chart of the results of *Wawa Sana*. The chart is based on the program objectives and indicators presented in the project's Detailed Implementation Plan (DIP) with several modifications that were approved by USAID based on recommendations from the Midterm Evaluation.

II.A. Results Summary Chart

Result	Objective	Final Evaluation Results	Comments
R-1: Improved capacity of APROSAR and three RHDs to support community activities and implement innovative culturally acceptable CS approaches.	Three RHDs incorporate SECI data, discussion, and plans into district info. analysis (CAI) meetings	<p>Yes. All health personnel interviewed expressed appreciation for the manner in which health information is presented through SECI, making it easier to understand and use for decision-making.</p> <p>The information from the Promoter is not incorporated into the SNIS now, but is used in the CAIs for local analysis and decision-making. The SNIS requires daily reporting which is impossible for the Promoter to provide. Promoters provide information only monthly.</p>	SECI data is community based surveillance data, which is different from service production data. The latter is required by the MOH to report in the national health information system. As long as surveillance data are not required as part of the national system, motivation to incorporate them will be sporadic. SC requires greater advocacy efforts to reach this goal.
	60% of Promoters and Auxiliaries demonstrate good skills in co-facilitating SECI meetings	Yes, partially (Carpetas)	Instability of staff (high levels of rotation) and Promoters make it difficult to ensure that all Promoters and auxiliaries demonstrate good skills.
	60% of permanent MOH staff demonstrate good skills in co-facilitating IMCI training	Yes	
R-1: APROSAR's capacity to support	All APROSAR trainers demonstrate competency in CB-IMCI, SECI, and H/PD training of Promoters	Achieved.	

Result	Objective	Final Evaluation Results	Comments
support community activities and implement innovative culturally acceptable CS approaches improved.	80% of Promoters have adequate supply of ORS	No.	Packets are no longer provided to Bolivia free of charge and even though the universal health insurance covers the cost for the child under five, confusion about payment schemes and policies that prohibit Promoters from distributing basic medicines limit Promoter access to the packets. (See page _ for more discussion.)
R-2: Communities' capacities in the 3 RHDs to identify and effectively address priority health needs of children under 5 improved.	75% of SECI communities have action plans with service providers to address CS needs	Achieved. Nearly all SECI communities have action plans although not all are formally written.	
	75% of communities with action plans have implemented the plan	Achieved.	All communities have had at least one action plan implemented during the year. About 70% of these plans are related to a training or information session with MOH health staff. 20% are related to communal action, mainly building some very simple facility for receiving MOH staff visits for growth monitoring and consultation in the village. 10% are related to advocacy activities for leveraging funds for their village.

Result	Objective	Final Evaluation Results	Comments
	40% participants in CS-16-related community meetings are women	Achieved. In fact, over time, women's participation has increased so much that it has overtaken men's participation. Staff began to concentrate on ensuring men's participation for decision-making, so that women's and children's health issues are not considered "women's business" only. To address this development, some communities now schedule two SECI sessions, one at the general community assembly at which men are the main actors, but at which women are often present, and one meeting primarily for the women so that they have a greater role in the information sharing, planning and decision-making process.	
IR-5: SC/B capacity demonstrated in CB-IMCI, SECI,	100 % of APROSAR and MOH staff in CS-16 have coordinated activities with SC staff in the last 6 months	Yes.	Verified through monthly and quarterly meeting minutes and plans.

Result	Objective	Final Evaluation Results	Comments
CB-IMCI, SECI, and H/PD capacity building of CS-16 partners and advocacy.	SC/B advocates for effective implementation of child health at public and NGO levels	Yes. With all NGOs that are using Title II funding, SC has advocated for effective implementation of child health in their programs based on its experience with Wawa Sana. SC was the leader in the development of the new community IMCI materials. In Colombia, Ccoya Sejas presented the Wawa Sana experience to health professionals by invitation from PAHO. Caroline de Hilari is one of the leaders of the CORE group in child health. Within SC, Wawa Sana's experience with SECI was incorporated into the Saving Newborn Lives project, Title II and Environmental Health and Hygiene projects.	SC is an active partner at the national MOH level, participating in the strategic plan for child health and as national consultant for the new version of IMCI materials.
R-3: Increased use of key CS services and improved CS practices at household level in the 3 RHDs	60% of 12-23 month olds have measles immunization measured by vaccine card	Achieved at 65%.	KPC survey, 2004.
	60% coverage of DPT3 or Pentavalent 3 in children 12-23 mos. measured by vaccine card in all CS-16 municipalities ⁵	Achieved at 85%.	KPC survey, 2004.

⁵ This indicator was originally stated in the DIP as “80% or more DPT3 coverage of infants in all CS-16 municipalities” but was changed after the MTE. *Wawa Sana* achieved this original objective with 90% of infants under one year in participating municipalities receiving DPT3 (SNIS data).

Result	Objective	Final Evaluation Results	Comments
	50% of 12-23 month olds received one or more Vitamin A capsules in last year as verified by card	Achieved at 84.5% (KPC, 2004)	During the last year there appears to have been a problem with registering Vitamin A and other services (vaccination) on child health cards so the KPC is lower than what is reflected in the services' records.
	50% of mothers of 6-23 month olds with DD in last two weeks report feeding increased fluids during DD.	Achieved, 54% increased fluids with DD. (KPC)	This indicator has improved notably since baseline. (Information was also confirmed reviewing CB-IMCI records of Promoters.)
	23% <u>annual</u> increase in total <5 respiratory infection cases treated by CS-16 facilities and Promoters.	Achieved. National Health Information System data reported an 80% increase from 2002 to 2003 in suspected pneumonia/ respiratory infections seen by health services and Promoters. (From 2001 to 2003, the increase was 224%.)	
	75% of CS-16 population is within a one-hour walk of facility or IMCI-trained Promoter.	Yes.	
	80% of communities with pop. over 80 have CB-IMCI-trained Promoter or MOH facility	Yes.	
IR-2: Improved quality of selected CS services in the three RHDs.	80% of CS-16 ARI-trained Promoters pass PCM knowledge and skills test.	86% knew three or more danger signs for ARI, 46% knew what to do in case of severe ARI and 47% knew most, but not all, actions to take in case of severe ARI.	

Result	Objective	Final Evaluation Results	Comments
	80% of CS-16 CDD-trained Promoters pass CDD knowledge and skills test.	Achieved, 90% knew three or more danger signs for dehydration. 66% knew all actions to take, 28% knew some but not all actions to take.	
IR-3: Increased caretaker knowledge and awareness of selected CS issues.	40% of mothers of children under two years old report that help should be sought if their child has “fast and agitated breathing.” (17%)	Achieved, 62% reported that help should be sought if their child has “fast and agitated breathing.”	KPC survey, 2004
	25% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing) (2%)	Achieved, 47% reported that help should be sought if their child’s “thorax is sunken” (chest indrawing).	KPC survey, 2004.
Documented feasibility and results of implementing CB-IMCI**	Feasibility: Estimated marginal cost of human resources and supplies for service delivery and support for implementation of CB-IMCI approach.***	Estimated marginal cost for all CS-16 communities with CB-IMCI for three years at the time of the study was \$117,770, or \$1,682 per community.	Cost Study, S. Santosham. (2004).
	PCM/Use: 23% annual increase in # of <5 pneumonia cases treated by CS-16 facilities and Promoters.*	Achieved. National Health Information System data reported an 80% increase from 2002 to 2003 in suspected pneumonia/respiratory infections seen by health services and Promoters. (From 2001 to 2003, the increase was 224%.)	

Result	Objective	Final Evaluation Results	Comments
	PCM/Quality: % of PCM-trained Promoters passing pneumonia knowledge and skills test.	86% knew three or more danger signs for ARI. 46% knew what to do in case of severe ARI and 47% knew most but not all actions to take in case of severe ARI.	
	PCM/Availability: 75% of CS-16 population is within a 1-hour walk of facility or trained Promoter.		The original project indicator stated that the Promoters could treat with cotrimoxazole. APROSAR Promoters all have adequate stock of cotrimoxazole because of an institutional agreement they negotiated with the MOH. Most other CS-16 Promoters do not manage cotrimoxazole due to MOH policy restrictions that CS-16 was not able to change during the life of the project. Local CS-16 negotiations to allow Promoters to manage cotrimoxazole were successful in several cases where distance to the nearest health post was two hours or more.
Documented feasibility and results of implementing H/PD.**	Feasibility: Estimated marginal cost of human resources and supplies for service delivery and support for implementation of H/PD approach.***	Estimated marginal cost for all communities with H/PD at the time of the study was \$102,495 or \$6,833 per community.	Cost Study, S. Santosham, 2004.

Result	Objective	Final Evaluation Results	Comments
	Nutrition status/sustainability: 30% decrease in 6-35 month olds in H/PD communities <- 2Z weight-for-age (pre-post).	<p>Red Norte: “EF” status decreased from 9% to 5% of all children in H/PD communities. In control communities in this area, “EF” status increased from 9% to 10%.</p> <p>Red Azanake: “EF” status in H/PD communities decreased from 8% to 4%. In control communities in this area, “EF” status increased from 8% to 9%.</p> <p>While these results are somewhat encouraging, the numbers of children participating are small, the drop-out rate high and differences may not be significant.</p>	In Red Norte, the improved nutritional status was maintained and even continued to improve one year after the Hearth sessions had formally ended. This was not the case in the Red Azanake, where improvements reverted back to previous rates after one year.
Documented feasibility and results of implementing SECI.**	Feasibility: Estimated marginal cost of human resources and supplies for service delivery and support for implementation of SECI approach.***	Estimated marginal cost for all CS-16 communities with SECI over three years at time of the cost study was \$184,801 or \$1,945 per community.	Cost Study, S. Santosham, 2004.
	Community capacity: 75% of SECI communities have action plans with service providers to address CS needs.	Achieved. Nearly all SECI communities have action plans with service providers. Some are not written formally, but appear in meeting notes.	

Result	Objective	Final Evaluation Results	Comments
	RHD capacity: 3 RHDs incorporate SECI data, discussion, and plans into district information analysis (CAI) meetings.	Achieved. All three districts use SECI data and presentation/analysis methods regularly in their CAI meetings.	SECI data are not always incorporated in the national health information system reporting since there is no mandate to include this information. District and other health personnel have commented that SECI information is very important and helpful to them at the operational level. There are a number of systemic barriers to including community level data in the national system. This is discussed further on page 65 of this report.
	EPI/Use: 60% of 12-23 month olds have measles immunization measured by vaccine card (27%).	Achieved. 65% of 12-23 month olds have measles immunization measured by vaccine card.	KPC survey, 2004.
	EPI/Use: 80% or more DPT3 coverage in infants in all CS-16 municipalities.*	Achieved. 90% of infants completed the Pentavalent vaccine series in CS-16 municipalities.	SNIS data for 2003.
	MOH or other PVO/NGO has written plans for implementation of SECI and/or H/PD in two other RHDs.	Achieved. See map of expansion of SECI and H/PD in Bolivia for details (pages 32 & 37).	

* CS-16 indicator corresponds to MOH HIPC indicator.

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

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

II.B. Results: Technical Approach

II.B.1. Project Overview

This four-year Child Survival-16 Program, *Mobilizing Communities and Health Services for Community-Based IMCI: Testing Innovative Approaches for Rural Bolivia*, reflected the conviction that the two most important contributions which Save the Children (SC) can make towards improving child survival in Bolivia are: (1) Documenting the feasibility and results of implementing innovative approaches to improving community capacity to identify and effectively address priority child health needs, which have excellent potential for “uptake” by other organizations and improving child survival programming in other areas of Bolivia, and; (2) partnering with the MOH and NGOs at the district-level to improve their capacity to support community activities and to implement innovative culturally acceptable approaches to child survival. CS-16 staff decided to name this project *Wawa Sana*, reflecting the site’s cultural setting, “*sana*” meaning “healthy” in Spanish, and “*wawa*” “child” in both Aymara and Quechua. The CS-16 site covers 445 communities with a total population of 104,500, including 13,500 children under five, in three Rural Health Districts of Oruro Department on Bolivia’s Altiplano. The Program is designed to address high under-five mortality in this site, estimated at 109 deaths per 1,000 live births, associated with pneumonia, diarrhea, malnutrition, and immunizable diseases; in a population with low use of health services and health information, and current health services which do not meet the promotive, preventive, and curative health needs of the population. Because this situation applies to much of rural Bolivia beyond the Program site, SC will test solutions through CS-16, which if found feasible and successful, will be promoted for application in other areas of the country through SC’s partners and collaborating organizations. SC will work with four CS-16 partners, the site’s three MOH Rural Health Districts, and a Bolivian NGO, APROSAR, to implement four child survival interventions:

- Nutrition and Micronutrients (30% of intervention-specific effort),
- Pneumonia Case Management (30%),
- Control of Diarrheal Disease (20%), and
- Immunization (20%).

SC/B documented the feasibility and results of implementing these four interventions through three innovative approaches to child survival in Bolivia:

1. Community-Based-IMCI (CB-IMCI), focussed on training and supporting volunteer Rural Health Promoters to provide selected child survival services in their communities, based on the PAHO CB-IMCI materials recently adapted for Bolivia, while supporting concurrent MOH implementation of IMCI at health facilities;
2. The Hearth model using a Positive Deviance approach (H/PD) to sustainable community-based rehabilitation of malnourished children and prevention of malnutrition, building on SC’s recent experience piloting H/PD for the first time in Bolivia and building on SC’s success with this approach in other countries. If successful and cost-effective in CS-16, H/PD has good potential for “uptake” by other organizations and reducing childhood malnutrition in other areas of Bolivia.

3. The Community Epidemiology Surveillance System (SECI), recently developed by SC/Bolivia to promote joint collection, analysis, and use of health information by health providers and communities to address local health needs, will be scaled-up through CS-16 based on SC's initial success in ten communities of rural Oruro. SECI has great potential for improving utilization of health services on a large scale in Bolivia, if the approach continues to be successful and feasible following implementation throughout the CS-16 site.

The CS-16 design reflects SC/Bolivia experience and expertise with the community-level implementation of all four CS-16 interventions, builds on recent innovative SC work with H/PD and SECI in one of the health districts of the CS-16 site, responds to Bolivian MOH and PAHO interest in working with SC to begin implementation of CB-IMCI activities, and responds to community-defined priorities identified through SECI. The Program builds on recent SC/Bolivia partnerships with one of the MOH Rural Health Districts (RHDs) and with APROSAR, and reflects extensive discussions with the other two RHDs, and with the MOH and PAHO in La Paz. CS-16 Goals include:

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

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

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

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

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

The Bolivia CS-16 Program was funded from September 30, 2000 through September 29, 2004 through a \$1 million "New Program" grant from USAID/BHR/PVC, matched by a \$1 million cost-share from SC.

II.B.2 Progress report by intervention area

a. Nutrition and Micronutrients

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

1. 50% of 12-23 month olds received 1/more Vitamin A capsules in last year as verified by card⁶. This objective was achieved with 85% of 12-23 month olds having received at least one Vitamin A capsule as verified by the child health card. *Wawa Sana* team members indicated that during the last year they identified problems with registering Vitamin A distribution and vaccinations on the child health cards, so they estimate that coverage is actually even higher than 85%.
2. 30% decrease in 6-35 month olds in H/PD communities below $-2Z$ weight-for-age (pre-post). This objective was achieved. In the Red Norte, “EF” ($-2Z$) status decreased from 9% to 5% of all children in H/PD communities. In control communities in this area, “EF” status increased from 9% to 10%. In the Red Azanake, “EF” status in H/PD communities decreased from 8% to 4%. In control communities in this area, “EF” status increased from 8% to 9%. It is important to note that the number of children participating was relatively low and drop-out rates were high (see additional information below) so this achievement may not be significant. It is interesting, however, that nutritional status in control communities worsened slightly over the same time period.
3. 50% of the nutritional status impact on % of all 6-35 month olds below $-2Z$ WFA is sustained one year after the end of Hearth sessions. Improvements in children’s nutrition in participating communities in the Red Norte appeared to be sustained and even improved upon one year after termination of the Hearth sessions whereas improvements in children’s nutritional status in the Red Azanake appeared not to be sustained, but reverted back to a status similar to baseline. Children participating in Hearth sessions in Huanuni were not measured after one year. Again, it is important to note that the numbers of participating children were low and drop out rates, especially in Red Azanake, were high.

The MTE recommended that two additional indicators presented in the DIP relating to reduction in severe malnutrition be omitted because of the low prevalence (0.5-1%) of severely malnourished children in the project area. The focus of the intervention was shifted to improving household practices to prevent malnutrition.

The principal activities for this intervention were:

⁶ This indicator was originally presented in the DIP as “85% of 12-23 month olds with cards got 1/more Vitamin A capsules in last year”. It was changed at mid-term to “50% of 12-23 month olds received 1/more Vitamin A capsules in last year as verified with card.” The baseline of 64% did not verify using the child health card (only 48% of children in the baseline KPC had a child health card as compared to 95% for the final KPC) so results were higher than they would have been; thus the indicator was changed.

- Training for SC/B, APROSAR, and MOH staff, and Promoters in the Hearth/Positive Deviance methodology;
- Coordination with Municipal and local authorities, MOH and other NGOs;
- Access to services via transportation and to supplies i.e. Vitamin A;
- Community education for improved knowledge and practices through Hearth cooking sessions, Promoter home visits and community dialogue during SECI meetings; and
- Integration with the IMCI framework.

Training:

SC/B received technical support from LINKAGES through their involvement in PROCOSI as part of a national effort to improve breastfeeding and complementary feeding practices. LINKAGES provided a two-day training for 12 SC/B and three APROSAR staff. This training, on breastfeeding, introduction of foods, negotiation skills, and home visits, was replicated by Wawa Sana staff in a series of three-day training courses for 98 Promoters, 11 MOH staff, and eight people from other NGOs. Promoters received an excellent quality manual and materials on all training topics. [The process lacks follow-up to insure quality implementation.]

US-based and La Paz SC/B staff conducted a course on anthropometric measurement for 15 SC/B Wawa Sana staff. All participants received a manual outlining standard procedures. SC/B and partner staff also received training on the nutritive value of foods, IMCI, and the H/PD strategy. Approximately 48 Promoters and 50 representatives from other NGOs were trained in H/PD. The three SC/B District Coordinators received extensive training with Jerry Sternin (15 days) on PD inquiry.

Supply of Vitamin A:

The supply of Vitamin A continued to be unstable following the MTE due to several logistical and management factors including supplies remaining in the central warehouse for lack of transport and coordination with health services, confusion about who needs to pay for and distribute the supplies. For example, the role of the Promoter in distributing Vitamin A is still not well defined.

Community Education:

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

Successes, Lessons Learned and Recommendations

Mothers and project staff interviewed during the evaluation spoke about the importance of nutritious foods such as a variety of vegetables, as well as the importance of ensuring adequate calories, reflecting a change in content of community education resulting from the MTE recommendation that families focus on increasing calories as well as vitamin-rich foods. They also stated that learning new recipes, cooking and eating together stimulates children to eat more

and helps families learn to feed and take better care of their children. Mothers noted improvements in their children's energy level, appearance, ability to play and learn and interact with others. An important result of the Hearth sessions was that a number of mothers learned about the value of playing with and demonstrating affection to their children, stimulating their children's overall development and self-esteem. All communities interviewed said that they learned that their children can be well-nourished by eating local foods, when these foods are prepared in appropriate ways in sufficient quantities.

There were many challenges implementing the H/PD methodology in the isolated, sparsely populated areas of Oruro in Bolivia including: not identifying sufficient numbers of severely and moderately malnourished children within a reasonable geographic area to form a group which often led to including all community children in groups, distances that mothers and children had to walk to meet for the Hearth sessions, the significant amount of time needed to carry out the sessions, difficulties ensuring that all malnourished children actually had access to the same resources as "positive deviants", harsh climate and agricultural calendars that made it hard to meet during parts of the year, difficulties identifying positive deviant behaviors and practices when many families were doing similar things and when "positive deviants" may have been practicing "negative" behaviors and "negative deviants" may have been practicing "positive behaviors". These challenges and project responses are presented in the next section on "Cross-cutting Approaches".

b. Pneumonia Case Management

The PCM (Pneumonia Case Management) intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. The indicators for this intervention, baseline and final results follow with discussion related to each.

1. 90% of APROSAR Promoters have adequate supply of cotrimoxazole

This objective was achieved. Of the 23 Promoters interviewed, 14 non-APROSAR and 1 APROSAR Promoter for a total of 15 (65%) reported they did not have adequate stock of cotrimoxazole and six APROSAR and two non-APROSAR for a total of 8 (35%) reported that they did have adequate stock. APROSAR management staff reported that nearly all APROSAR Promoters have adequate stock of cotrimoxazole. However, most other *Wawa Sana* Promoters outside of APROSAR did not have access to cotrimoxazole due to MOH policies that do not permit Promoters (outside of those who have specific permission through formal agreements with the MOH, such as APROSAR's agreement), to administer even basic medicines. In a few cases where the distance from a community to the health facility was several hours away, and where health service staff was open to an enhanced role for Promoters, *Wawa Sana* staff was able to negotiate permission for Promoters to distribute cotrimoxazole when they identified pneumonia.

2. 23% annual increase in total <5 pneumonia cases treated by CS-16 facilities and Promoters.

Wawa Sana achieved and surpassed this objective with an annual increase of 80% from 2001 to 2002 and 2002 to 2003 for a total two-year increase of 224% in CS-16 municipalities based on

national health information system data. Interviews and focus group discussions indicated that families were aware of danger signs of ARI through their participation in SECI sessions, home visits with Promoters, and other community education efforts such as health fairs and radio programs. Additionally, the increased community contact and improved relations with health service providers through these activities and the presence of a trained Promoter in the community that served as a bridge to the formal health service improved referral and the number of families who sought treatment.

3. 80% of CS-16 ARI-trained Promoters pass pneumonia knowledge and skills test

86% of all Promoters knew three or more danger signs for ARI. 46% knew all actions to take as described in the CB-IMCI protocols and 47% knew most but not all actions to take in case of pneumonia.

4. 80% of caretakers of children recently treated by CS-16 facilities/ Promoters report correct dose and course of cotrimoxazole for pneumonia.

This indicator was dropped after the MTE found that it would be very difficult to measure.

5. 40% of mothers of children under 2 years report that help should be sought if their child has “fast and agitated breathing.” (The original objective in the DIP was set too high at 75% and was lowered to 40% after the MTE.)

This objective was achieved, with 62% of mothers in the KPC survey reporting that help should be sought if their child has “fast and agitated breathing” compared with 17% at baseline.

6. 25% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing). (The original DIP indicator was set too high at 50% and was decreased after the MTE.)

This objective was achieved, with 47% of mothers reporting that help should be sought if their child’s “thorax is sunken” (chest indrawing) compared to a baseline of 2%.

The principal activities for this intervention were:

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

Successes, Lessons Learned and Recommendations

The number of children with ARI treated by health service providers and Promoters clearly increased over the life of the project as families became more aware of danger signs, Promoters initiated their work with home visits, and health service providers developed relationships with and were more present in the communities, on average once a month.

At the national level, a decision was made to refer children for treatment when they have a “severe cough” rather than focusing on rapid breathing and chest indrawing. The CB-IMCI materials and information system reflect this decision and have created more emphasis on education and monitoring around a danger sign that is relatively subjective and not as indicative of pneumonia as rapid, agitated breathing and chest indrawing. This is unfortunate and may have contributed to over treatment of bad colds with cotrimoxazole. During this evaluation, we did not review treatments of specific cases but this is an area that may be explored in the future. *Wawa Sana*’s experience demonstrated that many families and Promoters can recognize fast, agitated breathing and chest indrawing. There is enough evidence in other countries of the world that community level volunteers can identify and appropriately treat pneumonia that WHO has issued a statement of support for community level intervention. We recommend that program and policy decision-makers reconsider the ARI/IMCI classification of “severe cough” in favor of “pneumonia,” and focus on “fast breathing” (locally used term in the CS-16 site is “fast and agitated breathing”) as the sign of pneumonia and “chest indrawing” as the sign of severe pneumonia. Additionally, we recommend community level access to trained Promoters of cotrimoxazole, particularly in communities that are more than one hour away from health service facilities.

Health service providers and mothers mentioned that the cotrimoxazole available through the MOH is in tablets and must be crushed and dissolved to give to children. The tablets are bitter and children often refuse to swallow the medicine. Cotrimoxazole syrup is available in Bolivia, but is too costly for the MOH to purchase and there are no plans to change the tablets to syrup in the near future. Providers should try to identify appropriate ways to make the tablets more palatable to children. There are likely a variety of solutions that parents have found and could be shared with others.

The most important lesson learned in other countries and in Bolivia as demonstrated by APROSAR regarding ARI treatment is that trained Promoters can effectively treat pneumonia with cotrimoxazole and that the MOH policy of not allowing Promoters access to cotrimoxazole (when in fact, anyone can go into a pharmacy and purchase cotrimoxazole without a prescription) is likely costing children in isolated areas their lives. We recommend that the MOH reconsider this policy, especially in communities where health facilities are more than an hour away, recognizing the importance of good training.

Finally, the referral system was improved when *Wawa Sana* introduced referral cards (SC developed one and APROSAR developed another, more pictorial version). However, counter-referral, in spite of having a counter-referral section on the referral card to send back to the Promoter, did not work. Health service providers often did not send the card back at all, or sent it late so that it really did not serve its intended purpose.

c. Control of Diarrheal Disease (20%)

The CDD (Control of Diarrheal Disease) intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. The indicators for this intervention, baseline and final results follow with discussion related to each.

1. *50% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD. (The original DIP indicator of 75% was reduced to 50% after the MTE indicated that it was too high.*

This objective was achieved with 54% of mothers of 6-23 month olds reporting having increased fluids with diarrheal diseases compared with 21% at baseline as assessed by the KPC survey. This indicator improved notably and was verified through review of CB-IMCI Promoter records.

2. *80% of CS-16 CDD-trained Promoters pass CDD knowledge and skills test*

90% of Promoters knew three or more danger signs for dehydration. 66% knew all actions to take and 28% knew some but not all actions to take based on the CB-IMCI protocols.

3. *80% of caretakers recently counseled on DD by CS-16 facilities/Promoters report following three DD home care rules*

This indicator was omitted after the MTE recommended that it be dropped because it would be very difficult to measure.

The principal activities for this intervention were:

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

Successes and Lessons Learned and Recommendations

Training:

All IMCI trained Promoters participated in a four-hour session on diarrhea.

Access to ORS:

Of continued concern since the MTE was the lack of availability of ORS via Promoters. During the MTE, only 1 of 16 Promoters (6%) interviewed had ORS. All of the auxiliary nurses and area doctors had a supply of ORS. During the final evaluation, 6 of 23 Promoters (26%) interviewed had ORS, an improvement since the mid-term, but still not adequate. The national policy recently changed so that now health services and Promoters must purchase the ORS packets. The minimum cost is now Bs 2 but can reach Bs 8 (approx. US \$1) in pharmacies. Children under five receive the packets free of charge only if they go to the formal health service so that it can be reported to the municipality through SUMI. This has limited Promoters' access to ORS packets. Most APROSAR Promoters still maintain their stock, but they are having difficulty selling the packets to be able to replenish their stock.

Community education:

In interviews with community members and Promoters, there appeared to be a good level of knowledge of danger signs of diarrhea.

During focus group discussions, some communities commented that they noticed a decrease in the numbers of children with diarrhea and they attributed this to better hygiene (washing hands, disposing of waste).

d. Immunization (20%)

The Immunization intervention was implemented in accordance with MOH and international standards and essentially as outlined in the DIP. The indicators for this intervention, baseline and final results follow with discussion related to each.

1. *60% coverage of DPT3 or Pentavalent 3 in children 12-23 months measured by vaccine card in all CS-16 municipalities. (This indicator was originally stated in the DIP as “80% or more DPT3 coverage of infants in all CS-16 municipalities” but was changed after the MTE.)*

This objective was achieved at 85% compared with a baseline of 32%. We also reviewed the SNIS data (see the below Table) that indicated an average Pentavalent 3rd Dose coverage of 90% in the CS-16 municipalities.

**SNIS Data on Pentavalent 3rd Dose given to infants
(MOH infant population estimates under one year ~ 2.2% of total population)**

Municipality	2001	2003
Antequera	69%	92%
Pazña	69%	94%
Poopó	76%	89%
Caracollo	85%	95%
Challapata	82%	100%
Santuario de Quillacas	81%	68%
Eucaliptus	82%	98%
Huanuni	74%	94%
Machacamarca	90%	94%
Huayllamarca	97%	93%
Pampa Aullagas	84%	80%
Santiago de Huari	77%	75%
Totora ⁷	110%	101%
Mean municipal coverage	83%	90%

2. *60% of 12-23 month olds have maternal history or card for measles immunization.*

⁷ SNIS population denominators are projections based on national census data. Due to the high migration in Oruro, SNIS coverage rates may appear to be impossibly high, as presented in Totora.

This objective was achieved; 65% of 12-23 month olds had measles immunization measured by vaccine card as compared to 27% at baseline.

Principal activities for immunization included:

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

All health centers and posts had basic supplies for immunization activities; vaccines, thermoses, syringes, etc.

Each of the three districts was provided with a vehicle, a driver and fuel. The visiting team includes a nurse from the District who provides vaccinations and does growth monitoring, a doctor to treat sick children and adults, a nurse from SC/B to facilitate group education or SECI, and sometimes the District dentist.

Successes, Lessons Learned and Recommendations

Health providers, Promoters and communities attribute the notable improvement in coverage to increased awareness of low coverage rates and the importance of vaccines to prevent illness and coordination with health services through SECI sessions (see “Cross-cutting Approaches” section for more details on SECI), home visits by Promoters to identify children in need of immunization and to encourage parents to take their children, and increased presence of health service providers in the communities due to better scheduling, and logistical support with transport and/or gasoline. In several focus groups with communities, community members commented that they now feel more comfortable going to health services since they know the providers better and know what to expect. One particularly impressive achievement was in a community that had almost no children vaccinated when *Wawa Sana* began because of religious beliefs. Through SECI presentations and discussion, the community realized that their children would be healthier if they were vaccinated and they ultimately completed vaccinations for all eligible children in the community.

II.C. Results: Cross-cutting approaches

1. Community Mobilization and Communication for Behavior Change: Wawa Sana’s three innovative approaches to improve child health

In its effort to improve child health, *Wawa Sana* tested three innovative approaches:

- **Community Integrated Management of Child Illness (CB-IMCI)** by community volunteer health Promoters;
- ***Sistema Epidemiologico Comunitario Integral (SECI)***, a community health information, planning and monitoring system; and

- **Hearth/Positive Deviance Inquiry** to improve the nutritional status of children.

Wawa Sana also employed other complementary cross-cutting approaches including:

- **Mass media** radio programs;
- **Training** at all levels of the project;
- **Partnerships** with the MOH, local authorities, communities, the local NGO APROSAR and other institutions; and
- **Advocacy.**

This section discusses *Wawa Sana's* progress implementing these approaches, lessons learned, and provides recommendations for the future. We have chosen not to separate “community mobilization” and “behavior change communication” as indicated by the Final Evaluation Guidelines because *Wawa Sana's* three innovative strategies integrated both. The map on the following page shows the communities that implemented *Wawa Sana's* three strategies.

a. **Community-Based Integrated Management of Childhood Illness (CB-IMCI)**

IMCI is the official child health strategy in Bolivia. The MOH in Oruro began planning for the implementation of clinical IMCI in 1999 with training initiated in 2000. Implementation went much more slowly than expected and is still in process, complicated even further by the rapid turnover of health staff, with some doctors and nurses staying as little as a few months in their positions. SC/B facilitated training of MOH staff in both clinical IMCI and CB-IMCI. In total, 316 *communities* were implementing CB-IMCI at the time of the evaluation. The MTE reported that monitoring and supervision at that time were not functioning well with the majority of health facilities having had no supervisory visits at all. Monitoring and supervision have improved since the mid-term since *Wawa Sana's* team arranged to conduct biannual supervisory visits to health facilities with the Health Network Directors and other regional level health staff. *Wawa Sana* provided the transportation for the visits.

SC/B has been a very active member of a national IMCI working group, along with UNICEF, PAHO, Plan International and other NGOs. With funding from the CORE Group, and in coordination with PROCOSI and BASICS, they have developed and tested attractive field materials and approaches to CB-IMCI. The materials for Promoters to use during their home visits were completed, printed, distributed and are in use now in the field. Most Promoters liked the materials including a training manual, a procedure manual and registration sheets, although Promoters found one of the algorithms (Sheet #4) complicated and difficult to use. Promoters who were interviewed also mentioned that the process was sometimes long and they would like to simplify it. *Wawa Sana* team members commented that it was unfortunate that the materials were not yet available when the CB-IMCI training for Promoters was held since there had been an unanticipated delay in printing. They recommend that in the future program planners ensure that all materials be ready before scheduling training.

CB-IMCI Steps

Wawa Sana implemented CB-IMCI using the following general steps:

- 1) SC/B La Paz staff **planned IMCI workshops.**
- 2) SC/B La Paz staff **prepared training materials.**
- 3) SC/B La Paz staff **trained SC/B Oruro facilitators** in [clinical] and CB-IMCI.
- 4) **Promoters were elected by their communities**, usually following an introductory orientation and discussion about child health and the role of a community volunteer health Promoter. Communities and project staff established criteria for selection of the Promoter including ability to read and write, ability to speak and understand the local language (Aymara or Quechua), interest in the position, time available to carry out the Promoter's responsibilities and others. Most Promoters were men, however, some areas selected women. Some larger communities selected more than one Promoter to lessen each person's workload. Some communities, especially those working with APROSAR, already had identified Promoters prior to *Wawa Sana*.
- 5) **Promoters were trained** in CB-IMCI two phases of three days each.
- 6) **Promoters implemented CB-IMCI** home visits, applying what they learned and using the materials.
- 7) *Wawa Sana* conducted formal **refresher training in CB-IMCI** on an annual basis and informally in the field during monitoring visits.
- 8) SC/B, APROSAR and health service providers **monitored Promoters** on their home visits and **collected Promoters' reports** every month.
- 9) SC/B **conducted a five-day training in clinical IMCI and CB-IMCI for health service providers.**
- 10) Health personnel co-facilitated **CB-IMCI workshops for new Promoters.**
- 11) **Supervision of Promoters using monitoring forms.**
- 12) **Promoters presented their monthly reports** to health services.
- 13) **Promoters educated families** in their communities.

Based on their experience, the *Wawa Sana* team recommended that future programs train health personnel first so that they can then co-facilitate training workshops for Promoters.

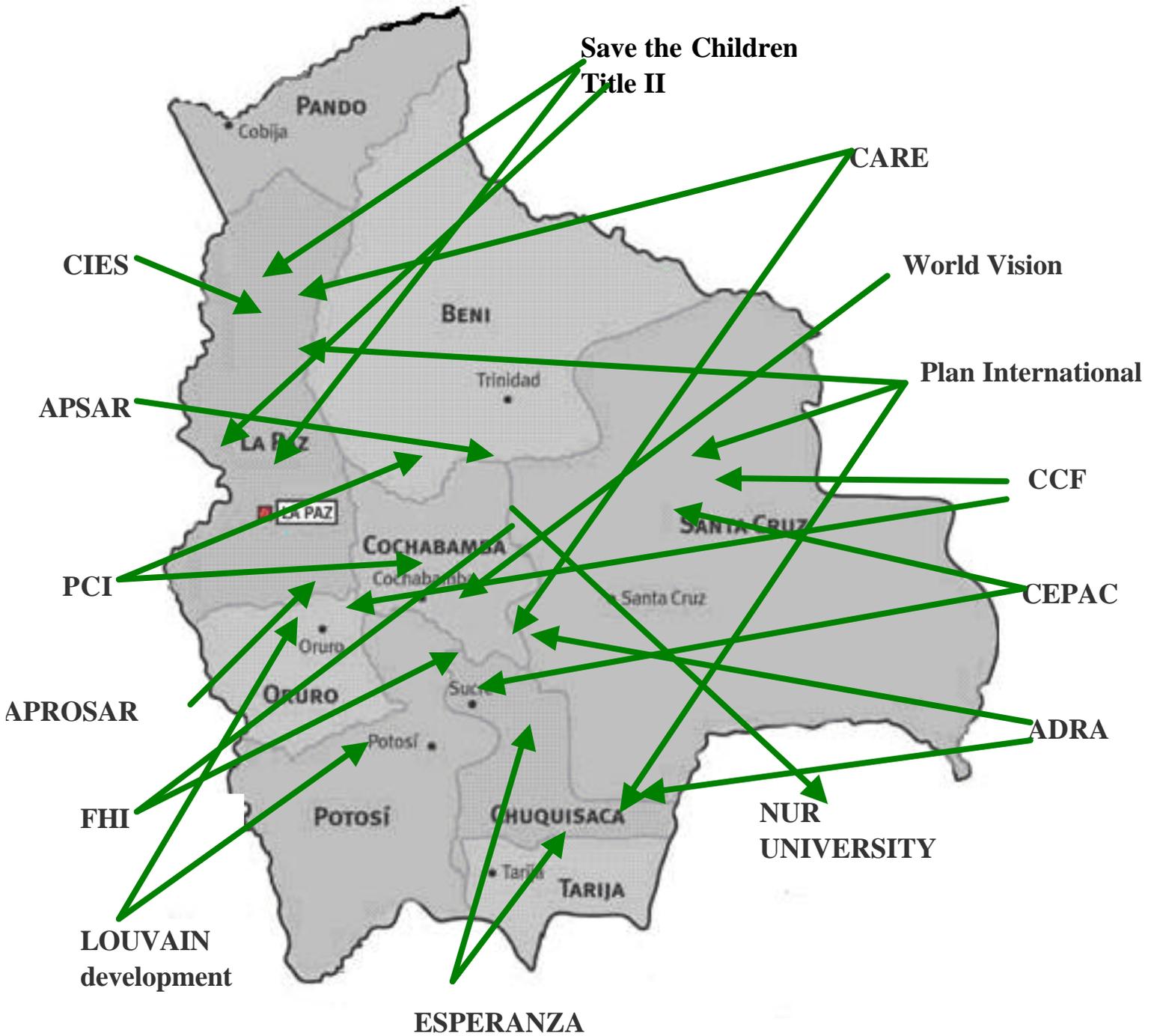
The MTE stated that a lesson learned was that “clinical IMCI needs to be functioning well first before CB-IMCI can be introduced.”⁸ This would be ideal, however, in the case of *Wawa Sana*, the national clinical IMCI training program was seriously delayed, health service staff turnover was, and continues to be very high, some of those trained are still having trouble grasping the holistic concepts of IMCI, and the overall socio-cultural and political context has been unstable, often negatively affecting the implementation of many government programs, at least in the short-term. If *Wawa Sana* had waited until clinical IMCI was functioning well, it would still be waiting to implement CB-IMCI today. As it turned out, much was done at the community level through CB-IMCI in spite of the less than optimal implementation of clinical IMCI. Even more could have been done had more Promoters had access to basic medicines. (See discussion in previous section above on cotrimoxazole and ORS.)

A cost study carried out by Shireen Santosham in 2004 estimated that *Wawa Sana's* marginal cost of implementing CB-IMCI was US \$1,682 per community. This estimate does not include basic organizational operating costs such as office, vehicle, international and other basic

⁸ Report of the CS-16 Midterm Evaluation, October, 2002, page 10.

expenses associated with having an office and operations in rural Bolivia. It does include the costs of training, materials, staff time, gasoline, vehicle maintenance, and other initial and recurring program costs.

EXTENSION OF CB-IMCI STRATEGY AT NATIONAL LEVEL



b. Sistema Epidemiológico Comunitario Integral (SECI)

The Bolivian National Health Information System (SNIS) was developed primarily to serve as a national and regional planning system and is similar to national health information systems in other countries in Latin America. The system was designed to capture information from health service sites (health posts, health centers and hospitals) at the “area” level (several communities served by a health facility). The information is then moved up a vertical path to districts, departments (states) and finally the national level. The SNIS was not designed to show the health problems and specific demands of each community. Health planning was normally done by providers who applied set formulas to population variables. These formulas do not differentiate communities, areas or districts; all districts plan in the same way using the same formulas. Although “Committees for Information Analysis” (CAIs) were instituted by the MOH as part of the Bolivian government’s policy to support popular participation at the district level, community participation in these committees was limited to one or two representatives. The CAIs are a positive step, but often community representatives did not understand the information presented and/or did not feed back this information to the broader community. Thus, prior to *Wawa Sana*, the community did not actively participate in health planning.

As mentioned above, the SNIS was designed to meet the needs of health service planners at the national and regional levels. Because of its facility-based orientation, the SNIS does not register events that happen in the community such as deaths, births, pregnancies and illness when patients do not seek care in a facility. To estimate prevalence rates, more complete community data are needed in addition to service-based data. A community health information system that complements the SNIS can help to develop a more complete picture of a community’s health. Health information belongs not only to health care providers, but also to the community members who generate this information. Community members’ participation in the interpretation and analysis of the information is critical. Service providers working with communities leads to better interpretation and understanding of the information which leads to better planning and greater community participation.

In 1997-98, prior to *Wawa Sana*, SC worked with local health service providers and communities to develop a community health information system that could provide health information to community members in a format in which they could analyze and use to help improve community health. Pilot testing of SECI began in 10 communities in Eucaliptus District of Oruro in September, 1998 and proved successful enough to merit further expansion through *Wawa Sana* beginning in 2000.

SECI aims to increase the utilization of health services and improve household behaviors to improve the health status of women and children in rural areas of Bolivia by increasing communication between participating communities and health service providers through the use of a community and facility-based health information system to contribute to improved health and by increasing participating communities’ and health service providers’ ability to analyze and use information to address community health problems.

SECI consolidates primary health care data collected by community health Promoters and health service providers using simple forms and community maps. The methodology facilitates

increased communication between communities and health service providers first by bringing Promoters and service providers together to consolidate the data. They then present the data in easy to understand graphics (a health flag that looks like the red, yellow and green Bolivian flag and two cloth pictorial charts to which paper dolls can be attached) to the community so that together, they can obtain and analyze new information about community health problems and articulate health priorities that reflect the community's perspective. The methodology builds in a series of analysis questions and ways to present the data so that community members and service providers can compare trends over time, monitor progress and determine where alternative strategies are needed. Community representatives share the consolidated information, plans and strategies that have been developed and other results of these community meetings at the district level CAI meetings. As changes are implemented, the health information system helps the communities and health staffs work together to monitor progress toward achievement of agreed upon objectives and to make decisions on municipal and community resource allocation.

In addition to the cloth flag and charts, SECI materials include a user's manual, a set of picture cards with maternal and child health problems and interventions, reporting forms and a software package that was designed to be used by health districts or, now, health networks. The software package consolidates community level data from health Promoters with national health information system service-based data and translates this more complete epidemiological picture into graphics that can be used with communities. Designed to be fun to use, the software package helps service providers at the district/network level analyze the data to help them plan program strategies.

Everyone interviewed during the evaluation viewed SECI as a powerful and effective way to mobilize communities to take action to improve maternal and child health. According to communities, local authorities, Promoters, health service providers, SC/B and APROSAR staff, SECI's methodology is easy to understand for everyone, regardless of his or her level of formal education. Gaining access to one's own community's health information sparks interest and raises awareness of health issues. Many people interviewed attributed increases in vaccination coverage, increases in care-seeking at formal health services and other health and organizational/management improvements in large part to SECI.

Wawa Sana implemented SECI in (156 communities (including urban "zones")). *Wawa Sana* actively tried to ensure at least 40% women's participation in SECI meetings. They were so successful that by the end of the project team members were concerned about ensuring an adequate level of men's participation. Several communities addressed gender equity in participation by holding two meetings each month, one at which primarily women would attend and another at the general monthly community meeting which is attended by more men, but women would also be present in some cases, although they often spoke less, if at all. Some communities had previously viewed health as primarily a concern of women, but SECI sessions helped to establish health as a priority on the formal community agenda. Mothers are still the primary caretakers of children's health, but men in the community are also involved in decision-making and in setting community priorities and have a vital role to play in the SECI process.

SECI tools and processes were also applied at the community level C.A.I.s, the "mancomunidad" (multiple communities served by a health facility) level information analysis workshops (T.A.I.s)

and at the district/network level information analysis meetings. While SECI data were not systematically incorporated into the SNIS, they were used for local and regional decision-making, planning and monitoring.

SECI Steps

Wawa Sana implemented SECI by taking the following steps:

1. SC/B Oruro **staff were trained in SECI.**
2. SC/B Oruro **staff trained health service providers in SECI.**
3. Local authorities and health service providers coordinated to organize community **elections of health Promoters.**
4. SC/B and health service providers **trained health Promoters in SECI** during a 3-day workshop.
5. Health Promoters and their communities determined how large the community population was for SECI through a **census** and development of a **community map.**
6. **Promoters collect information** on health events in the community every month during home visits, at market days and other community events.
7. Promoters and health service providers **consolidate their data** at the end of each month.
8. Promoters, communities and service providers **determine the date for the SECI “planning together” session.**
9. All actors **carry out the planning together session** at the appointed time.
10. Communities **develop Action Plans** with service providers and Promoters.
11. Communities and service providers **monitor progress on their Action Plans** (return to step 6).
12. Conduct two to three, two-day **refresher training courses**, once a year is recommended.

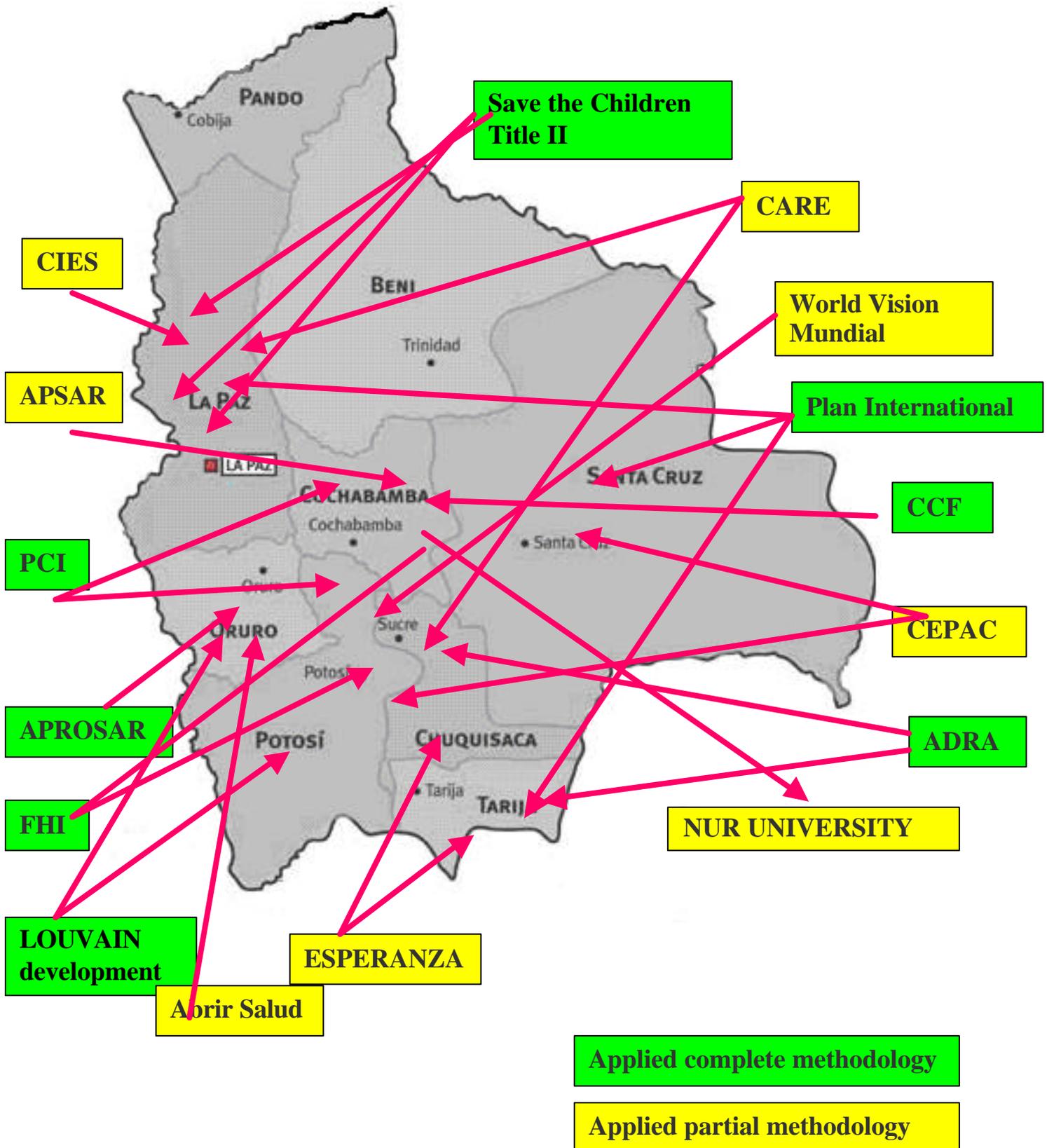
The 2004 Cost Study estimated that *Wawa Sana*'s marginal cost of implementing SECI was US \$1,945 per community. This estimate does not include basic organizational operating costs such as office, vehicle, international and other basic expenses associated with having an office and operations in rural Bolivia. It does include the costs of training, materials, staff time, gasoline, vehicle maintenance, and other initial and recurring program costs.

SECI's methodology and materials have been adopted in full or adapted in part by more than 15 organizations in Bolivia including APROSAR, part of the MOH Azanaque Network, CEPAC-Santa Cruz, Esperanza Bolivia in Tarija, and PCI in Cochabamba (see map below for the organizations and where they have implemented SECI).

Lessons Learned and Recommendations

- SECI is a powerful, effective and feasible methodology to mobilize communities for health. It effectively put into practice the Bolivian “Law of Popular Participation” and has had important direct as well as possibly more important indirect positive impact through its ability to change the system of local government decision-making and planning that could also be applied to other sectors.
- SECI was effective because it is specific, participatory, objective, educational and helps people analyze their own health situation.
- SECI doesn’t function well without the commitment and work of the Promoter and health service providers.
- In health sectors (facility centered) and in some areas (multiple facilities) they have adopted the SECI methodology to use in their CAIs.
- There is strong demand to continue using SECI. No formal measure of demand was taken, but interviewees mention that the best proof is in community members’ continued participation in the planning together meetings.
- SECI has been adopted and adapted by over 15 organizations throughout Bolivia. Some have adopted only the tools, while others have adopted the complete methodology. We were not able to learn about all of the experience of the other organizations implementing SECI but recommend that these experiences be shared, documented and used to strengthen community participation in health information collection, analysis, decision-making, planning and monitoring.
- The SECI software is relatively user-friendly and functions well but was only completely implemented in Challapata where the statistician was well-trained, had a keen interest in the program and understood how it could be used to help decision-making and planning at what was formerly a district level. However, the other former districts and current health networks have not used the software regularly, primarily because there is no formal mandate from the health system to do so and it is extra work for them since they must enter data into the SNIS now. Additionally, the relocation of staff trained in SECI software to new sites, leaves *Wawa Sana* facilities without trained personnel. The Challapata statistician stated that the SECI software is best suited to be used at the departmental and sub-departmental levels for planning and monitoring purposes, not higher up. He suggested some technical changes to improve the functioning of the software package including making the importation and exportation of the databases easier.

EXTENSION OF SECI STRATEGY AT NATIONAL LEVEL



c. Hearth/Positive Deviance

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

The original structure of H/PD was for 10-20 children under five and their caretakers, to attend a communal kitchen, 14 days per month for eight months for two to three hours per day. At these communal kitchens, they prepare food together (in addition to normal meals) which contains 600-800 calories and 25-27 grams of protein. Each woman contributes part of the food based on a pre-determined schedule. This has not worked for a number of reasons cited in the MTE and again during the final evaluation including:

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

As a result of many of the challenges stated above, in the majority of communities, participation in the Hearth sessions dropped off from initiation of the program to the final session. In the Red

Norte, of the 16 implementing communities, nine lost participants (56%), three maintained the same number of participants (19%) and four gained participants (25%), for an overall loss in participation of 7%. In the Red Azanake, of the 16 implementing communities, 14 lost participants (88%), one maintained the same number of participants (6%), and one gained participants (6%) for an overall loss of participants of 38%. Some *Wawa Sana* team members attribute the lesser drop-off in participation in the Red Norte to having worked longer in the communities (prior to *Wawa Sana*) allowing them to form better relationships with the communities.

As reported in the MTE, some alternatives have been tried, with mixed success:

- Intersperse months to better adapt to agricultural and work calendar;
- Meet for three to four days with a break of two days, then repeat;
- Meet three times a week for five weeks;
- Meet on weekends only; and
- Instead of having all (10-15) mothers cook each time, rotate responsibilities with 3-4 mothers cooking and the rest only bring their children to eat.

Hearth/Positive Deviance Steps

Wawa Sana implemented the H/PD strategy by taking the following general steps:

1. **Train health personnel** (and in some cases Promoters in the participating communities).
2. **Select a community** in coordination with local officials, health Promoters and health service providers.
3. **Weigh 100% of children** less than five years old.
4. **Determine children's nutritional status.**
5. **Classify families "positive" or "negative"** with the local officials and health Promoter
6. **Conduct home visits** to "positive" and "negative" families.
7. **Conduct focus groups** with the women of the community.
8. **Feed back information** on the results from the community.
9. **Make a decision** to use the H/PD strategy.
10. **Conduct a workshop** with mother leaders of "positive" children.
11. **Develop schedules and menus.**
12. **Conduct Hearth workshops** with key messages.
13. **Measure weight and height** at the beginning of the Hearth sessions. Continue to implement Hearth sessions every day in the first phase for eight to 12 days.
14. **Monitor weight** at the end of the eight days.
15. **Do follow-up monitoring of weight** each month.
16. **Measure height every three months.**

In spite of the challenges mentioned above, many participants including community members, authorities and Promoters, commented that they thought the cooking sessions were very positive, that they learned a lot about nutrition and child rearing and that they see positive physical, cognitive and emotional changes in their children. The results for nutritional status presented in the preceding section indicate that there was some improvement in the Red Norte, even one year after the Hearth sessions had ended (see summary of results charts below.) However, in the Red

Azanake, modest gains made at the end of the eight months of Hearth sessions reverted back to the nutritional status prior to Hearth one year after the Hearth sessions ended. SC/B staff commented that they observed during home visits that more than 50% of the participating families put into practice what they learn during the Hearth sessions. APROSAR's experience in Huanuni was that eight communities demonstrated improvement while six did not. APROSAR did not measure nutritional status one year after termination of the Hearth sessions so sustained nutritional status for these communities is not known.

The 2004 Cost Study estimated that the H/PD strategy cost approximately \$6,833 per community, significantly higher than the other two strategies, predominantly due to the much smaller number of communities in which it was implemented.

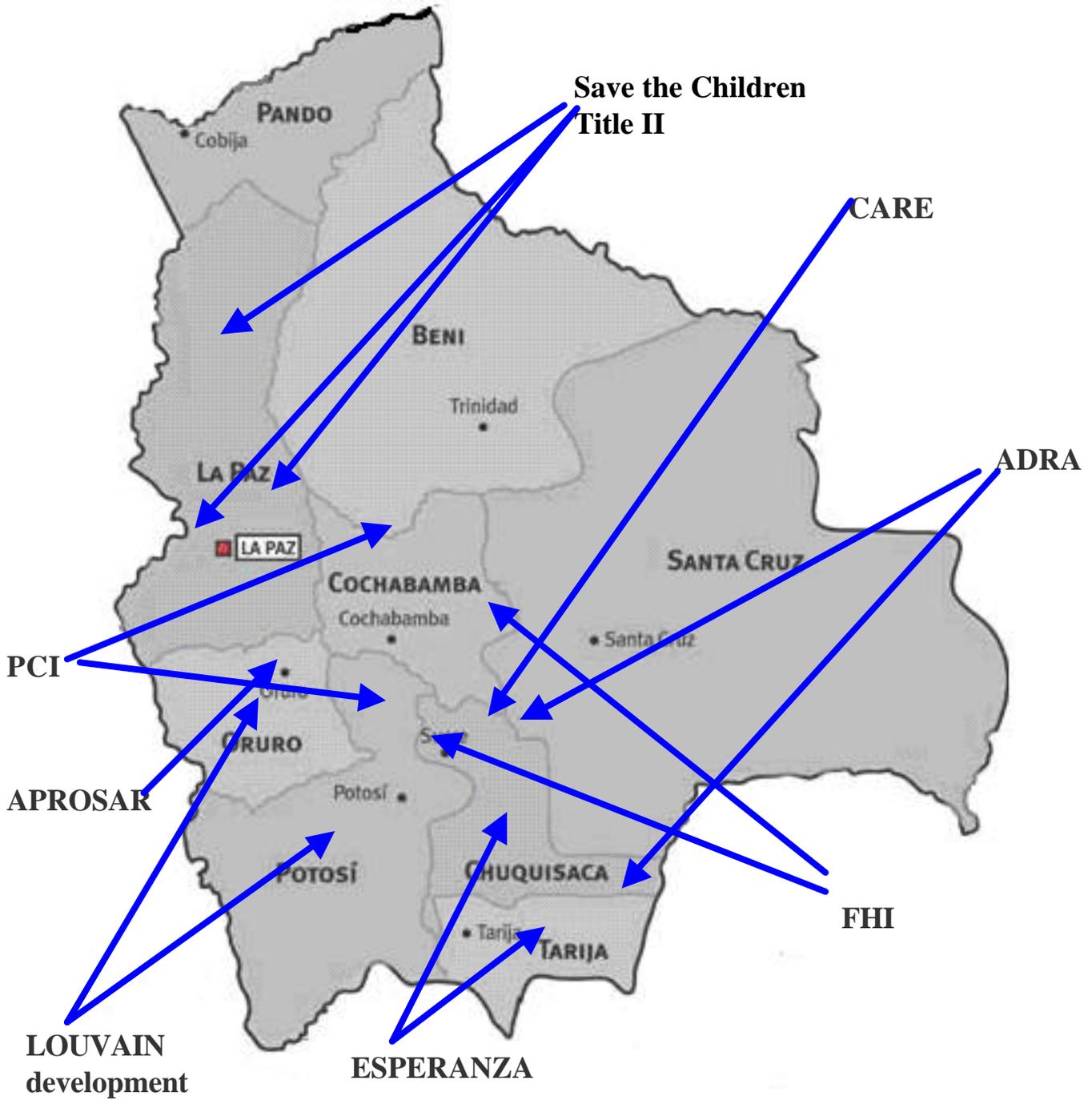
Toward Wawa Sana's objective of "uptake" by other institutions of Wawa Sana strategies, Wawa Sana coordinated with PROCOSI, a network of NGOs in Bolivia, to conduct a workshop for 50 NGO representatives on H/PD methodology. As a result of this workshop and ongoing dialogue between SC/B and other NGOs and government health services, H/PD has been used (and in some cases adapted) by World Vision in Qacachaka (Oruro), health services providers in Cañohuma, and APROSAR as well as others (see map below).

Lessons Learned and Recommendations

- Women's groups are very interested in practicing and learning lessons about nutrition and did demonstrate improved knowledge related to nutrition, complementary feeding and breastfeeding. H/PD sessions can result in communities gaining a new, or strengthened appreciation for local foods and local, beneficial practices.
- When mother and children share food in Hearth sessions it reinforced adequate habits for consuming their own foods (in various centers mothers indicated that their children weren't eating at home, but on seeing other children eat at the sessions, they were stimulated to eat as well.)
- H/PD methodology must be carefully adapted to new contexts, taking into account factors such as distance between houses in communities, climate and calendar constraints, size of population and level of malnutrition in the population. To adapt the methodology effectively, we recommend that future programs which choose to use this strategy start small and document very carefully how the methodology is applied, as well as the results. There were a variety of ways that H/PD was applied in *Wawa Sana* and very few, if any, examples of a direct replication of the original methodology from Vietnam. This is understandable and was necessary. However, it makes it difficult to draw strong conclusions about recommending the methodology for use in the rural Bolivian context, since methods (and results) varied, sometimes substantially, from one participating community to another.
- Applying the PD inquiry in some cases shed light on why some children were malnourished while others were not. However, *Wawa Sana* was sometimes challenged by not being able to identify differences in practices, behaviors and/or diets between the "positive" and "negative" groups.

- Suggestions to keep in mind when selecting communities include:
 - Don't wait for a high rate of malnutrition; when severe malnutrition is not as prevalent as recommended in the protocol, focus more on prevention.
 - Divide communities into sub-zones so that participants don't need to travel so far.
 - The municipality needs to contribute something to the process (pots/pans, space or other things).
 - The community needs to be interested in participating in the program.
 - Support from local officials.
 - Commitment of health service providers from the beginning.
- Monitoring of nutritional data was important as it allowed the *Wawa Sana* team to track the nutritional progress of each community and guided modifications in the process.
- Many mothers lacked the time recommended by the original protocol to participate in cooking sessions. The *Wawa Sana* team modified the schedule to accommodate more mothers.
- As H/PD had not yet been adapted for use in Bolivia, there was no systematized manual for the facilitator and Promoter to help with adequate planning with specific interventions suited to the rural Bolivian context. As a result, *Wawa Sana* staff implemented the methodology in a variety of ways, trying to find approaches that fit the rural Bolivian context. The *Wawa Sana* team recommended that SC/B, APROSAR and others implementing H/PD consolidate and systematize their experiences to create a Bolivia-specific H/PD manual that can help future implementers.
- Initially, *Wawa Sana* did not have adequate forms and a database that allowed for timely analysis of the data to monitor the study and make decisions about program implementation. Several monitoring forms and processes were developed throughout the life of the project but these are still a work in process. We recommend that future CS projects adapting H/PD develop appropriate monitoring forms at the beginning of the program, learning from *Wawa Sana's* experience.
- Some communities demonstrated that the improved nutritional status of children could be sustained even a year after ending Hearth sessions. However, many other communities were not able to sustain their improvements. We recommend that those communities that were successful in sustaining improvements be studied further and compared with other, unsuccessful communities to determine factors that may have contributed to the results. One of the factors that should be investigated more thoroughly is participation, since we noted less drop-out in communities that overall fared better than the others.
- Finally, it is clear that H/PD as implemented by *Wawa Sana* did not lead to a resounding success in nutritional status improvement, although certain children and their families did benefit from their participation. This methodology needs further development and study to determine whether it is feasible and effective in this setting.

EXTENSION OF THE HEARTH/PD STRATEGY AT THE NATIONAL LEVEL



d. Radio Programs

Wawa Sana worked with the Bahai radio station to present weekly health-centered radio programs on Saturday mornings during 2003. The radio programs presented information about maternal and child health and invited local community participants to share their experiences in caring for their children and with *Wawa Sana*. During the last year, the programs stopped because the person responsible for airing them on Bahai Radio returned to school to complete his studies and no one picked up the Saturday morning show after his departure. No formal monitoring or evaluation was done so it is not possible to report to what extent these radio programs contributed to *Wawa Sana*'s results. However, during the evaluation, many of the community members interviewed mentioned the radio programs in a positive light and hoped that they would start again in the future. Bahai Radio reaches a large audience throughout much of Bolivia and into Perú. During one interview, a health provider mentioned that when a team from Puno visited *Wawa Sana*, they talked about the radio program that apparently had a listening audience in Puno as well. In the future, if a program contains a radio component, we recommend that a more formal monitoring and evaluation system be included to determine the reach and effectiveness of the program.

e. Partnerships

The *Wawa Sana* project was implemented through a partnership between SC/Bolivia, the MOH in the Oruro Department, APROSAR, a local NGO Promoter association and local governments. Prior to the MTE, the members of the partnership did not perceive themselves as a team. Although representatives from all of the partners participated in the development of the original proposal and in the development of the DIP, and there was a workshop at the beginning of the project to orient everyone to the project goals, objectives and strategies, it was clear during the mid-term and final evaluations that during project start-up there was some confusion regarding project indicators, roles and responsibilities, and how the partners were going to work together. Beyond the lack of clear definition, *Wawa Sana*'s three strategies were new to most of the implementing team, SC/B was entering into new communities and the MOH and local authorities were in the process of decentralization and changes in policies and procedures. This context understandably contributed to a tendency toward a more internal organizational focus and led to less cohesive implementation during the first half of the project.

During the MTE, *Wawa Sana* team members realized that they were not working as a team and they agreed to begin to think of themselves as a team and develop mechanisms to help them better coordinate their actions such as monthly quality circle meetings and quarterly evaluation and planning meetings (see Program Management section for more details). SC/B and APROSAR needed to better define their relationship, which initially was more of a contractor and sub-contractor to a more equal partnership. APROSAR staff eloquently described the relationship during this evaluation as that of an older and younger brother. APROSAR felt at the beginning of the project as though SC/B was telling them what to do and how to do it and APROSAR, as a growing younger brother, rebelled and said they could do it themselves. After the mid-term, as APROSAR had grown more and had more experience, SC/B and APROSAR could sit down and discuss how they could have a more mutually beneficial relationship with both parties contributing. Financial arrangements were also discussed so that APROSAR had

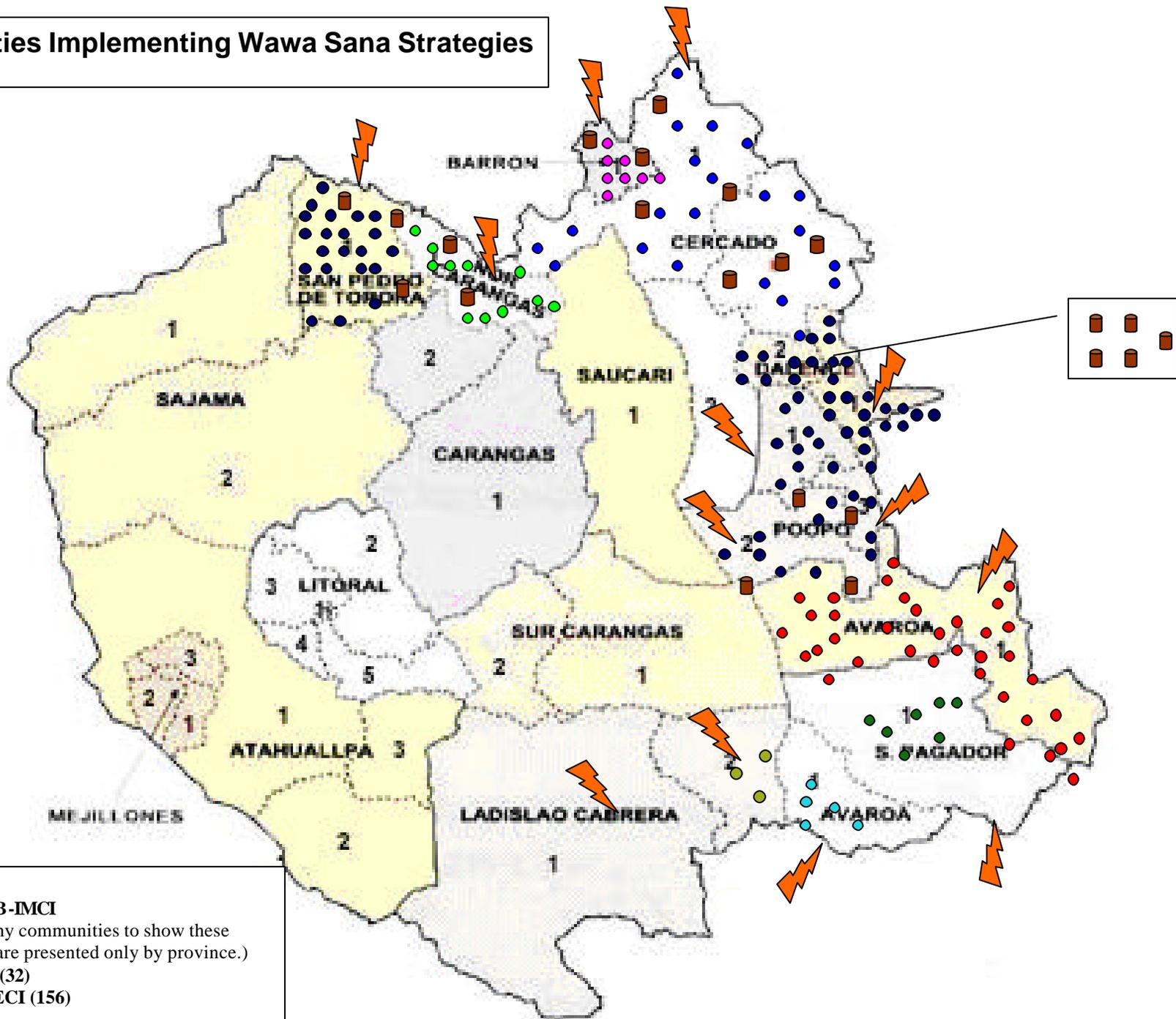
more control over its project funds. The better defined roles and responsibilities that more equally shared responsibilities, more clearly defined indicators, establishment of communication, monitoring and planning mechanisms and more financial autonomy all contributed to what is now a much more positive, mutually beneficial relationship.

Similarly, relationships and coordination with health service providers and municipal/community leaders improved when *Wawa Sana* implemented regular monthly and quarterly joint monitoring and planning meetings that involved all team members.

Wawa Sana's experience with partnership highlights some important lessons and recommendations for the future including:

- When representatives of all partners participate in the development of key initial project documents and indicators, don't assume that all project implementers are aware of and understand the goals, objectives, indicators and strategies of the new project. All members of the implementing project team should receive adequate orientation to the project and should receive a copy of the key project documents. Program Managers should make sure that all program team members read the document and have opportunities to ask questions, seek clarification and discuss doubts and concerns.
- Clearly define in writing all roles and responsibilities of each partner during the proposal process and then revisit roles and responsibilities clarification again at the beginning of the project. This is particularly important when new staff is hired or join the project at project initiation that haven't been involved in the initial proposal development phase. It is also important for all partners to brief new staff about roles and responsibilities of the partners and how the partners work together to avoid misunderstandings.
- Regular monthly and quarterly monitoring, evaluation and planning meetings and access to relevant and timely health data (through SECI) help team members stay focused on project goals and objectives, reinforce teamwork and lead to more efficient, and better coordinated implementation.

Communities Implementing Wawa Sana Strategies



II.C.2. Capacity Building Approach

a. Strengthening the PVO Organization

Save the Children/HQ

SC completed an Institutional Strengths Assessment (ISA) in February and March 2002 with assistance from CSTS using the CSTS ISA methods and tools. ISA inputs included:

- Completion of an organizational profile by SC's CS Team in Westport.
- A self-assessment conducted in Westport with in-person participation of all three members of the Office of Health CS Team, as well as SC/Westport staff from Human Resources, Finance, and International Programs; and written input from the OH Manager and the Regional Health Advisors for Asia and Africa.
- Field input: Eight field respondents were identified by SC/OH for this assessment, each of whom works closely with one of SC's eight current AID/DCHA/PVC-supported CS projects. These eight respondents are either CS field project managers or Field Office (country office) health program managers who support CS field projects. Responses were received by CSTS from six of these eight field respondents. The mode of response was "one individual completed the guide after reflecting on guiding questions" for three respondents and "multiple individuals participated in a group discussion and then scored" for three others. Reasons for non-response can, in one case, be linked to the newness of staff in key positions and thus difficulty in identifying an appropriate respondent.
- A self-assessment results-sharing and capacity improvement prioritization meeting conducted in Westport with in-person participation of all those who participated in person in the self-assessment, as well as participation by phone of the Regional Health Advisor for Asia.

Data analysis involved the following methods:

- Scores were calculated by capacity area.
- The range of scores provided information on where there was agreement and for identifying 'critical questions.'
- Within each capacity area:
 - Questions with highest scores were examined to identify areas of strength; and
 - Questions with lowest scores were examined to identify areas for improvement or further assessment.
- Quantitative data was supplemented by qualitative input from ISA participants through discussion and recommendations.
- According to the section of the ISA final report on findings, "General Trends and Overall Scores of SC/OH Capacity Areas:"⁹
- "The positive scores received both from the field and central office suggest that the SC/OH, working within an established agency of formidable experience, is a strongly performing PVO unit.

⁹ Institutional Strengths Assessment. *Final Report*. Save the Children. Office of Health / Child Survival. Westport, CT, 03/13/2002. ISA Facilitators: Lea Bethune, Consultant; Eric Sarriot, CSTS. Page 10.

- “The SC/OH has a strong sense of self-efficacy in all six areas of capacity, as demonstrated by the homogeneity of scores obtained across the board.
- “Field scores are – overall – strongly congruent with OH scores.
- “Technical skills and knowledge, Management and governance, Organizational Learning and Human resources management are assessed as the strongest areas of capacity, with high agreement between field and OH.
- “The last two capacity areas, Administrative procedures and structures, and Financial management, are the two weakest areas of the six, though both are performing at relatively strong levels.”

Based on findings from the analysis of ISA input from SC staff based in Westport and in the field, the two-member CSTS/ISA team made the following initial recommendations to the SC/OH team for discussion, clarification, amendments, and prioritization:

1. The systems needing most attention appear to be in the area of financial management. Timely access to cost information, not only by line item and grant category, but also by activity, is needed. In addition, financial management and analysis training of more CS staff in OH and the field appears to be a felt-need.
2. Enhance focus on quality assurance (QA) in all programs. The importance of QA to project success and long-term sustainability is paramount. However, QA was less of a perceived need among field-based ISA respondents.
3. Examine the balance of roles and responsibilities between Westport-based CS specialists and the OH Regional Health Advisors, to advance some of the suggestions and recommendations stemming from this assessment.
4. Other identified areas for improvement include: the conduct of organizational capacity assessments with local field partners, the design and implementation of sustainability strategies, and behavior change communication (BCC) interventions.
5. Develop a more systematic approach to building management, leadership, crosscutting, and technical skills for field staff through training, mentoring, site visits, and temporary duty/acting assignments.
6. Continue to focus on including target communities in all aspects of project design, implementation, and evaluation, and ensure that lessons learned about community engagement in one program are systematically shared. Developing standards and systems for their dissemination would support consistency in level and quality of community engagement efforts across projects.
7. More country-specific managerial support to the field may be indicated, as well as more frequent management training for field staff.
8. Institutionalize periodic review of staffing needs for OH and the field against program requirements and funding levels.
9. Explore increasing the translation of selected programmatic documents into local languages.

After a discussion of ISA findings and recommendations, participants in the ISA results sharing and capacity improvement prioritization meeting on March 7, 2002, developed two criteria for establishing priority among the issues: *feasibility* and *highest impact*. They reviewed each issue and assigned a value from 1 to 3 for each criterion and each issue. For example: “identifying costs by activity” was assigned a “1” for feasibility and a “2” for impact. Once the group applied the criteria to each issue and a value or score assigned for each criterion, the scores were totaled by issue. The final prioritization matrix follows:

ISA Final Prioritization Matrix

Type of Recommendation	Sub Category (Comments)	Feasibility 3 = easy	Impact 3 = high	Sum of Scores	RANK 1=HIGH
1. Costing activities and finance training	a. Field training/clarification regarding budget line-item flexibility	3	3	6	1
	b. Training and providing on- or off-the-books Activity Costing for program managers	1	2	3	
2. Diversify donor base and increase resource mobilization		2	3	5	3
3. Further development and implementation of a Quality Assurance program		1	3	4	
4. Number, roles and responsibilities of RHAs	c. Clarify roles and responsibilities of SC/OH, the RHAs, and CS team	3	1	4	
	d. Augment the CS team, and/or the number of RHAs	2	2	4	
5. Capacity assessment and sustainability	e. Train field staff in and implement capacity assessments at field level.	3	2	5	4
	f. Sustainability (developing a systematic approach)	1	2	2	
6. Further develop BCC support capacity by adding a Behavior Change Communication Specialist.		2	3	5	2
7. A more systematic approach to building field capacity in management, leadership, and technical and cross-cutting (M&E, research, training, etc.) skills and knowledge.	(A quality management review process is becoming an agency initiative, so it is not so hard to support this.)	2	2	4	
8. Explore “translations” / access to key documents in the field	g. Explore issue of translating documents into other languages	3	1	4	
	h. Respond	1	2	3	

Following the prioritization exercise, the resulting high priority issues were organized in three categories: Easy to achieve; Hard to achieve; and, On-going processes:

Easy and should do quickly:

- Field training/ clarification regarding budget line-item flexibility.
- Clarify roles and responsibilities among OH, the RHAs, and the CS Team.
- Train field staff in and implement capacity assessments at the field level.
- Explore issue of translating documents into local languages.

Hard:

- Further develop BCC support capacity by adding a Behavior Change Communication Specialist.
- Further development and implementation of a Quality Assurance program.
- Augment the CS team, i.e., the number of RHAs.

On-going within SC or OH, but needing more focus and/or OH attention:

- Diversify donor base and increase resource mobilization for CS.
- A more systematic approach to building field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge.

The following actions have been taken since the ISA to address the above priorities:

- During 2002, ISA findings were shared with other members of the OH staff, and with Westport and field-based staff who participated in the ISA. Results from the ISA were used by the CS Team to plan priority CS-related activities for SC's *Every Mother Every Child High Impact Initiative*. ISA findings also contributed to meetings regarding OH CS Team staffing needs, and were used to inform the continuing OH/CS strategic planning process.
- Field training/clarification regarding budget line-item flexibility; and training and providing on- or off-the-books activity costing for program managers: These activities have been conducted by SC Finance and Grants Management staff for SC field office-based finance staff in the Middle-East/Eurasia and Africa areas, and are planned for LAC and Asia area staff in 2005.
- Diversify donor base and increase resource mobilization: OH is seeking funding from sources other than USAID/GH/HIDN (which now houses the PVO Child Survival and Health Grants Program) to support OH MCH-related initiatives for immunization; community case management of childhood malaria, pneumonia, and diarrhea; safe motherhood; and newborn health.
- Train field staff in and implement capacity assessments at field level: This was done with regard to SC's three CS-18 grants in Guinea, Tajikistan, and Viet Nam.
- Further development and implementation of a Quality Assurance program:
 - SC's International Programs Management has recently instituted an approach to Minimum Operating Standards (MOS) to help improve field office (FO) performance and focus FO management attention on achieving greater efficiency, effectiveness and impact. Through a transparent process involving Home Office departments, Area Offices, and the Field Offices they are intended to quickly identify

areas needing improvement, what needs to be done in order to improve, and then allocate responsibility and accountability for that improvement.

- Partnership Defined Quality (PDQ) is a methodology to equitably involve community members (users and non-users of health services) and health providers in defining quality, identifying and prioritizing problems, and creating and implementing solutions to strengthen the quality, access, and use of services that improve health status for all. SC developed the methodology in 1996, and has since used the approach in several countries, including Haiti, Nepal, Pakistan, Uganda, Rwanda, Azerbaijan, the West Bank, Georgia, and Ethiopia. Lovich R, Rubardt M, Fagan D, Powers MB, *Partnership Defined Quality: A tool book for community and health provider collaboration for quality improvement*, was published by SC in January 2003. Efforts to scale-up PDQ implementation have included a recent workshop for Asia area staff from several PVOs.
- A more systematic approach to building field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge: OH has conducted week-long workshops in program planning, monitoring, and evaluation for senior SC health program managers in the Asia, Africa, and Middle-East/Eurasia areas.
- Augment the CS team: An additional Child Survival Specialist, Kathryn Bolles, joined the CS Team in September 2003.

Wawa Sana is only one of many child survival projects that SC has implemented over many years, so it is impossible to attribute SC's growth in capacity over the last four years in child survival programming to *Wawa Sana* alone. However, *Wawa Sana* has contributed to SC's development in some important ways as stated in the following quotes from CS Specialist [Eric Starbuck]:

"The main benefits [of CS-16 in Bolivia] have been to move SECI forward. We now have more experience with SECI in a larger area over a longer time. We've learned a lot. It exemplifies what I'd like to see CS grants used for—to strengthen a field office in a methodology and raise their credibility/visibility in country so that others come to them for assistance leading to larger scale."

"CS-16 helped to consolidate a vision within the health office to not try to do everything everywhere, but to focus on a specific area of expertise. It's a defined strategy in the CS team called, "Focused, country-specific programming at scale."

SC has adapted SECI in Bolivia for a Title II project and for the Saving Newborn Lives project and, through SC's participation in the Population Communication Services 4 project and the Health Communication Partnership, has adapted SECI for use in Ghana by the MOH, demonstrating that the methodology has potential to be applied in other country settings.

Wawa Sana's experience trying to adapt H/PD to fit the Bolivian context offers many valuable lessons for SC and these lessons should be shared within the Office of Health and more broadly with other sectors in the organization.

As SC continues to strengthen its capacity to develop, test, refine, consolidate and document defined strategies and methodologies that aim to be applied at larger scale, home office and field staff are learning how to transform ideas, concepts and theories into practical steps, and the importance of keen observation, clear description and documentation of methods.

SC/Bolivia Field Office

Since the MTE, SC/B changed Field Office Directors and continues to adjust to a much larger staff, primarily as a result of Title II funding received two years ago. The La Paz staff is changing with a new accountant, a new human resources manager and several others. The office continues to work on strengthening its management systems to support its new and existing programs.

Because of difficulties that Program Managers had implementing projects without knowledge of the project budgets, the La Paz office decided to decentralize financial management. To ensure that the *Wawa Sana* Project Manager, Dr. Gonzalo Araya could manage the finances, he was trained by the La Paz finance staff. This change was viewed as highly positive by field staff because decisions about expenses could be made relatively quickly based on weekly updates of the budget versus actual expense reports.

To strengthen SC/B field staff capacity to implement the *Wawa Sana* project, they participated in training workshops (see table below for summary of courses), “learned by doing” through practice in the field, some went on field visits as part of a “Living University” (to CEPAC in Santa Cruz, Comisión Belgica Santa Cruz, ADRA in Chuquisaca, Food for the Hungry in Cochabamba, Plan International in Tarija, and the *Puentes* project in Puno, Perú), they participated in monthly and quarterly quality circle meetings, and many participated in PROCOSI-sponsored training and experience sharing events including training by LINKAGES in breastfeeding. La Paz staff sent a representative each year to SC’s annual Program Learning Group where health staff from around the world gathers for a week to learn about new research and program approaches, and to share their experiences.

SC/B continues to be a very active member of PROCOSI and as mentioned above, has benefited from PROCOSI-sponsored events as well as contributed to these events by sharing its experience in the field and by sharing a TA visit by Jerry Sternin so that other NGOs could be trained in the H/PD methodology.

Additionally, SC/B staff participated in the development, testing and production of CB-IMCI materials as an active member of the national IMCI committee. This experience provided SC/B with the opportunity to enhance staff materials development, advocacy and networking skills.

Field staff mentioned that they would have benefited from more field visits by their supervisors and senior SC staff. They felt that they did not receive enough feedback based on direct observation of their work in the field. Some staff reported that they were never visited. They recommend that supervisors visit field workers early in the project to assess their skills and determine with them what they need to work on and how they will strengthen these skills. Once basic capacity is assessed, supervisors can monitor more closely those staff in greater need of

assistance. This is an important recommendation for future programs –it is not sufficient for supervisors to rely solely on reports and meetings to assess staff capacity and performance. Apparently, there were some constraints on gasoline prior to decentralizing financial management to Oruro that made it difficult to program supervisory visits, but this should have been rectified once the Program Manager was able to manage the budget. Perhaps the other lesson learned here relates to management of resources to ensure that supportive supervision is incorporated into scheduling.

b. Strengthening Local Partner Organizations

As mentioned in the MTE report, a baseline capacity building assessment was conducted with APROSAR, four hospitals and three MOH District offices, but due to SC/B's inexperience with this type of assessment, it was not that helpful in developing a capacity strengthening plan. SC/B has not yet received any type of TA in this area and **obtaining TA in how to conduct an organizational assessment and develop a capacity strengthening plan remains a recommendation** for them in the future. It is important to recognize also that, although there have been advances, this field is still very much evolving and capacity is almost always context specific, relating to specific goals and objectives.

APROSAR

APROSAR conducted its own institutional assessment and identified a number of areas in need of strengthening including: development of a training plan; development of a plan for institutional marketing; strengthening IEC; forum for sharing experiences with other NGOs; follow-up and supervision of field staff; dealing with the high turnover of Promoters; and broaden their donor base. APROSAR developed a plan to strengthen these areas and they have achieved many of their objectives (see table below).

APROSAR CAPACITY STRENGTHENING RESULTS

Desired Result	Status at beginning of Wawa Sana Project	Actions taken to achieve the Desired Result	Status	Future plans
Develop a training plan	None existed.	<ul style="list-style-type: none"> • Training plan developed. 	<ul style="list-style-type: none"> • In process. 	
Develop an institutional marketing plan	No formal plan existed.	<ul style="list-style-type: none"> • APROSAR needed to define an institutional image—conducted and analyzed interviews and surveys with clients (communities), members and donors • Networking and promotion • Develop plan 	<ul style="list-style-type: none"> • In process. 	
Strengthen IEC	Minimal experience with materials development; no formal training in IEC; Promoters did some interpersonal counseling during home visits.	<ul style="list-style-type: none"> • Developed an Almanac • Completed two brochures and are finishing the last one on danger signs. • Developing a coloring book. • Completed poster on the nine major services that universal health insurance doesn't cover. 	<ul style="list-style-type: none"> • APROSAR reports that their capacity has grown quite a bit in this area. 	<ul style="list-style-type: none"> • Production of a flipchart for community mobilization with Belgian and USAID funding.
Forum to share experiences with other NGOs	Member of PROCOSI.	<ul style="list-style-type: none"> • Joined with other PROCOSI members to form a regional technical committee. • Exchange visits with PLAN Int. in Sucre, <i>Puentes</i> Project in Puno Peru • Member of “Socios en Salud” 	<ul style="list-style-type: none"> • APROSAR is pleased with progress in this area. Would like to play a greater role in PROCOSI and Socios en Salud. 	<ul style="list-style-type: none"> • Will share experiences in Oct. 2004 at Socios en Salud conference. • Will share their strategic plan with more management oriented organizations • Plan to open learning forums at the community level. <p>Will share their SECI and CB-IMCI experience with World Vision.</p>
Follow-up and supervision of field workers	There wasn't much follow-up. No adequate instruments existed- those that did exist were too long and complicated.	<ul style="list-style-type: none"> • Shortened the supervision form so that it could meet the needs of field visits to better assess and strengthen skills. 	<ul style="list-style-type: none"> • APROSAR reports that the system is functioning much better. 	
Address the high drop-out rate of Promoters		<ul style="list-style-type: none"> • Work with health service providers to improve collaboration, support and supervision of Promoters. • Meetings with Extensa project. 	This is still a complex challenge. “Extensa”, a World Bank project entered the project area two years ago and	<ul style="list-style-type: none"> • Continue to advocate for Promoters at the national, departmental and municipal levels to improve technical,

Desired Result	Status at beginning of Wawa Sana Project	Actions taken to achieve the Desired Result	Status	Future plans
		<ul style="list-style-type: none"> • Negotiations with local municipal authorities. • Advocacy to Oruro Department and national MOH on the role of Promoters in the context of the new universal health insurance system. • Trained new Promoters to replace former Extensa Promoters who dropped out. 	contracted a number of APROSAR's Promoters, paying them a monthly salary. A year or so later, a new Director came and changed Extensa's policy of paying Promoters, thereby creating much disappointment and resulting in a number of trained Promoters who no longer wanted to volunteer their services. The new volunteer Promoters who were trained earlier this year are still all working, there is less desertion among these Promoters due to the support of health service providers.	improve technical, institutional and logistical support.
Diversify the donor base	All funding was from USAID.	<ul style="list-style-type: none"> • Developed marketing plan • Marketing through print materials, promotion, personal outreach • Design of website. 	Achieved over 75% funding from sources other than USAID including European donors, LOVIM, UTOPIA, MIVA, Dutch, French, Inter-American Foundation	
Growth of APROSAR to a national organization	APROSAR is present now in Oruro and a part of Potosí.	<ul style="list-style-type: none"> • Feasibility study in the eastern departments of Bolivia. • Enter other areas of northern Potosí. • Change several instruments/forms/processes to meet the needs of a national level program. 	<ul style="list-style-type: none"> • APROSAR presented a proposal to a prospective donor but it was rejected because the budget was too high. APROSAR is reformulating the proposal for resubmission. 	

c. Strengthening Local Government and Communities

Wawa Sana worked closely with local municipal government, community formal and traditional leaders and community members to strengthen their capacity in many areas of local governance and organizational development (management, leadership, use of information, communication, participation, etc.) as well as improving health specific knowledge and practice. Local mayors, council members and other leaders interviewed during the evaluation stated that they learned a lot from the quality circle, SECI and Information Committee Analysis (C.A.I./T.A.I.) meetings about how to plan more systematically using health information to set priorities and monitor progress. They learned through practice about how to coordinate with health services and Promoters. The new health structure introduced through the universal mother and child insurance scheme, “DILOS”(Directorio Local de Salud), is essentially a local health board composed of the municipal Mayor, the Technical Director of the Department Health Service (SEDES) and a representative of the Surveillance Committee elected by the public specifically to serve on the board. This new structure was not yet well understood nor utilized in the majority of municipalities in the project area and *Wawa Sana* tried to orient municipal leaders to the purpose and functions of this centrally mandated structure by doing training in groups and one-on-one.

A major challenge for some municipalities was a constant change in leadership with some municipalities electing a new mayor every year. In one case, a municipality had three mayors at one time resulting in a “freeze” of all municipal funds. Fortunately, the health services and universal health insurance money was not subject to the freeze. Rotation of leadership is not new in Bolivia with community leadership in the past traditionally changing every year in January. Every time a new leader was elected or appointed, *Wawa Sana* team members began anew to orient the new leader to the project. One of the most effective ways to educate authorities about the project was to invite them on supervisory visits to see the project in action themselves. For future projects that find themselves in similar contexts of constant rotation of leaders and implementers, it would be helpful to develop a short publication (brochure or leaflet) for local authorities and health service providers that describes the project goals, objectives, indicators, project strategies, participating organizations, length of project, source of funding and how implementers will coordinate their actions.

Community members who participated in *Wawa Sana* strengthened their capacity in: their awareness of their rights and responsibilities in health, gathering and using information that is presented in accessible ways (SECI methods/tools), planning skills (SECI, CAIs, some participation in the development of municipal Annual Operational Plans), presentation skills, coordination particularly with health services and NGOs, monitoring, management of resources, and technical knowledge and practice of improved maternal and child health care, particularly related to nutrition, ARI, CDD, immunization, prenatal care, and breastfeeding. Women’s participation steadily increased throughout the life of the project so much so that it became an issue to ensure an adequate level of men’s participation. All SECI communities developed action plans based on health information and over 75% of these communities carried out their plans: all communities implemented educational sessions on specific health topics; some constructed meeting places or health posts using their own resources; most elected health Promoters and some provided them with non-monetary incentives; some were able to advocate

for municipal support for transport, gasoline, equipment and materials for health services; clean up of their communities; construction of water sources and solar greenhouses and many other activities.

d. Health Facilities Strengthening

Ministry of Health

Wawa Sana's project design did not include a major focus on strengthening health facilities as other organizations in the country were responsible for supporting this component at the time the project was developed. A World Bank Project ("Reforma") began work in parts of the *Wawa Sana* project area (Challapata) in coordination with ABRIR Salud to strengthen health facilities, and the MOH was working with national clinical IMCI training of providers. To support project implementation, *Wawa Sana* purchased a small amount of basic equipment for health services and Promoters such as scales when none were available or working.

A health services assessment was conducted at the beginning of the project but the results were incomplete and inconclusive and it was therefore not used as a baseline for comparison for this evaluation.

Health service staff was trained in clinical IMCI and all three of *Wawa Sana's* strategies. In response to a MTE recommendation, SC/B trained health service staff in facilitation skills and observed them in the field as they facilitated sessions with communities. The MTE recommended that providers be trained in ways to improve patient relations.

Wawa Sana worked to strengthen coordination between health services and communities through SECI "planning together" meetings that used health information as a basis upon which to set priorities, plan activities and coordinate schedules, and monitor progress. The statisticians in the three former districts were trained to use the SECI software, but, as mentioned earlier, only the statistician in Challapata regularly entered data and issued reports. Additionally, SC/B trained MOH staff and other DILOS members in the new regulations, structures and processes outlined in the "SUMI" universal insurance scheme. There is still much to do to strengthen the operation of the DILOS. Although health staff is learning that they must have some basic management skills to function in the decentralized structure, many do not yet possess these basic skills. During the evaluation, a number of directors at various levels in the health system asked for more information and access to training in basic management skills such as budgeting, strategic and operational planning, and other topics. However, they acknowledged that they have learned a lot about how to more systematically manage information, plan and coordinate not only from the SECI meetings, but also from *Wawa Sana's* monthly and quarterly quality circle meetings.

Coordination between health services and communities improved notably through *Wawa Sana's* efforts due to several factors: 1) Promoters served as a bridge between communities and health services. Promoters could ensure that dates for activities were acceptable to communities and would remind community members of the visits before providers came to the communities, thereby avoiding wasted time. 2) Improved transportation to the communities increased the frequency of visits so communities and providers could get to know one another better. 3) SECI

planning together meetings increased dialogue and led to observable improvements in health which created a good base upon which to coordinate further. 4) Decentralization has created a real need to coordinate when municipal authorities have a defined role to play in supporting and monitoring health services. 5) Tools and techniques used by SECI, CAI/TAI meetings and quality circle meetings helped to make coordination easier, clearer and more formal.

Referral System

Based on a mid-term recommendation, a tear off counter-referral slip was added to the referral slip. However, the counter-referral slip did not improve counter-referral much. The good news was that referral appeared to be working relatively well. Given the bureaucratic and hierarchical nature of a health system that is relatively slow to change, it is possible that until Promoters are formally integrated into the system, procedures designed to incorporate them may continue to be ignored by some providers. A similar challenge relates to the incorporation of Promoter health data into the national health information system (see CB-IMCI section).

Access to Services

Wawa Sana continued to provide transportation and/or gasoline to health services so that they could reach the communities on average once a month. Additionally, the project improved access to services and trained Promoters in communities that did not have a health facility within an hour walking distance.

As mentioned in the MTE, population estimates based on the national census data were not at all accurate in a number of communities due to high migration and the fact that many families actually have several homes. Entire communities that appeared on the map may be deserted at certain times of the year.

e. Strengthening Health Worker Performance

This section will focus on community volunteer health workers, known as “Promoters” in the *Wawa Sana* project since we have discussed MOH service providers above in the previous section.

Promoters are members of the community who are elected by their communities to serve as a community health resource and a link to MOH services. When *Wawa Sana* began in 2000, there were Promoters already working in communities in the project area as a result of previous SC/B and APROSAR work. Over the four years of the project, the number of Promoters grew. At the time of the evaluation, 95 Promoters (81%) out of 118 were actively working in communities in the Red Norte and Red Azanake, nearly 70% of whom were men. In Huanuni areas supported by APROSAR, Promoters are permitted to treat basic health problems and have generally had more clinical training than the Promoters in the other areas. APROSAR has elected to call community volunteers who have been trained in CB-IMCI and often also SECI, “leaders” to distinguish them from the Promoters who manage medication and have had more clinical training. Of the eight Promoters in the area, five were active at the time of the evaluation. Of

the 42 leaders trained in SECI and CB-IMCI, 41 were still active, and of the 23 leaders who were trained only in CB-IMCI, all 23 were still active.

Project activities that helped to strengthen Promoter performance included:

- ? Training in CB-IMCI, SECI, and H/PD;
- ? Workshops on specific health topics including care of the newborn and reproductive and sexual health;
- ? In-service mentoring by SC/B and APROSAR staff;
- ? Supervisory visits with feedback on facilitation skills, home visit performance and record-keeping;
- ? “Learning by doing”; and
- ? Two-day refresher course each year.

The approach to strengthening Promoter performance appears to have been successful based on the very positive results achieved by the project, in large part due to the work of the Promoters in coordination with health service providers.

SC/B administered a post-test to the Promoters in August 2004 to assess their knowledge of child survival topics. Overall, 84% passed the exam, achieving the project’s capacity objectives for Promoters; 86% knew three or more danger signs for ARI, 46% knew all actions to take in case of severe ARI, and 47% knew most but not all actions to take in case of severe ARI. Ninety percent (90%) knew three or more danger signs for dehydration, 66% knew all actions to take in case of dehydration, 28% knew some but not all actions to take.

f. Training

Wawa Sana implemented the training plan and met its training objectives as presented in the DIP (see table below for a summary). In addition, the project did annual refresher training courses in the three strategies. Training was carried out at various levels in a cascade approach with La Paz staff usually training SC/B Oruro staff, SC/B Oruro staff training APROSAR and MOH staff, and then these groups trained or co-trained with SC/B Oruro more of their own staff and community level Promoters and others as appropriate. Some training was done by outside resources. For example, LINKAGES trained SC/B in breastfeeding and complementary feeding, an outside consultant trained *Wawa Sana* team members in intercultural relations and communication, and an outside consultant trained *Wawa Sana* team members and PROCOSI members in the Hearth/Positive Deviance methodology. Based on a mid-term recommendation, the *Wawa Sana* team monitored those service providers and Promoters trained in facilitation in the field and provided them with feedback on their facilitation skills.

At the community level, *Wawa Sana* team members, particularly Promoters and service providers, facilitated educational sessions of approximately one hour on maternal and child health based on community interest as topics arose in SECI and H/PD sessions and as the team determined appropriate.

The training component (as with all other aspects of the project) was affected by the rapid rotation of people in all levels, particularly service providers and Promoters. Those people who participated in the project for over two years were likely to be more confident facilitators and educators who could work more independently than newer Promoters and service providers who had less experience, some of whom still relied on SC/B trainers to help them with their sessions. This was less due to a problem with the training than due to the constant state of change in the area. At the time of this evaluation, SC/B and APROSAR staff reported that over 60% of health providers demonstrated adequate facilitation skills based on direct observation in the field.

It was clear that the training in the three strategies led to new practices and ways of working with communities. Each strategy provided a new set of tools and methods that implementers learned, applied and, in some cases, revised based on their own experience. One of the most important changes was in the improved communication and coordination between health services and local authorities and communities.

To sustain training activities, there is a sufficient number of people trained in the project area overall to continue to conduct annual refresher training and updates. IMCI training will likely continue since IMCI is a national strategy and resources come from the central and departmental level. We estimate that SECI and H/PD training is likely to be continued in approximately 50-60% of the project area since APROSAR is committed to continuing the strategies in the Huanuni area. A critical factor will be to what extent municipalities and DILOS will include training in their Annual Operating Plan budgets. Some have already introduced a line item to cover these costs, but the majority has not yet included training costs in their previous budgets. Health Promoters have made advocacy for funding of training costs one of their major priorities for this year.

WAWA SANA TRAINING

INSTITUTION	PARTICIPANTS	THEME	MÉTHOD	DURATION	Nº PARTIC.
S.C. - APROSAR	Wawa Sana Team	SECI	Workshop	5 days	18
S.C. - APROSAR	Wawa Sana Team	H/PD	Workshop	5 days	18
S.C.	Wawa Sana Team	Food Security Rapid Evaluation	Workshop	5 days	13
S.C. - APROSAR	Wawa Sana Team	Anthropometry	Workshop	3 days	18
S.C. - APROSAR	Wawa Sana Team	Breastfeeding and Complementary Feeding	Workshop	3 days	18
S.C. - APROSAR	Wawa Sana Team	Intercultural Training	Workshop	3 days	18
S.C. - APROSAR	Wawa Sana Team	Communication for health (development and transmission of messages)	Workshop	3 days	18
S.C. - APROSAR	Wawa Sana Team	Clinical IMCI	Workshop	6 days	18
S.C. - APROSAR	Wawa Sana Team	Days-Based IMCI	Workshop	6 days	18
S.C. - APROSAR	Wawa Sana Team	Nutritional Value of Foods	Workshop	3 days	18
S.C. - APROSAR	Wawa Sana Team	CB-IMCI (refresher course)	Workshop	6 days	18
S.C.	Wawa Sana Team	Essential care of newborns	Workshop	3 days	14
S.C.	W.S. Trainers	Neonatal IMCI	Workshop	3 days	3
S.C.	W.S. Trainers	L.Q.A.S.	Workshop	5 days	2
S.C.	W.S. Trainers	"SODI" Technique	Workshop	2 days	
S.C.	W.S. Trainers	Quality of Care-PUENTES Project	Field Visit	3 days	8
S.C.	W.S. Trainers	CB-IMCI	Field Visit	3 days	8
SEDES	Doctors	SECI-H/PD-IMCI	Workshop		
SEDES	Nurses	SECI-H/PD-IMCI	Workshop		
SEDES	Auxiliary Nurses	SECI-H/PD-IMCI	Workshop		
SEDES	Nurses and Auxiliary Nurses	Anthropometry	Workshop	2 days	3
SEDES	Auxiliary Nurses	Communication Techniques	Workshop	3 days	3
SEDES	Doctors, Nurses and Auxiliary Nurses	Quality of Care-Puentes project	Field Visit	3 days	6
COMMUNITY	Promoter	SECI	Workshop		

INSTITUTION	PARTICIPANTS	THEME	MÉTHOD	DURATION	Nº PARTIC.
COMMUNITY	Promoter	H/PD	Workshop		
COMMUNITY	Promoter	CB-IMCI	Workshop		
COMMUNITY	Promoter	Care of the Newborn	Workshop		
COMMUNITY	Promoter	Reproductive and Sexual Health	Workshop		
COMMUNITY	Promoter	CB-IMCI-Plan Int.	Field Visit		
COMMUNITY	Fathers and Mothers	<ul style="list-style-type: none"> • Breastfeeding • Complementary Feeding • Cough • Diarrhea • Immunizations • Malnutrition • Nutritional Value of Foods • Danger Signs of Pregnancy, Delivery, Post-Partum • Essential Care of the Newborn • Family Planning • Hygiene • Benefits of Vitamin A • Anemia • Fevers 	Educational talks	Approx. 1 Hr.	

II.C.3. Sustainability Strategy

The sustainability objectives for this project follow with results:

- 50% of the nutrition status impact on % of all 6-35 month olds <-2Z WFA is sustained one year after the end of Hearth sessions.

This objective was met, although the high drop-out rate in the Red Azanake and the small numbers of children in some of the communities make it difficult to draw any solid conclusions. In the Red Norte, improvements were sustained and even surpassed over a year following the end of Hearth sessions. In the Red Azanake, improvements were not sustained one year following Hearth sessions; they reverted back to baseline rates. In Huanuni, they did not have the data to analyze whether improvements were sustained one year after implementation of Hearth sessions. They did, however, show that nutritional status improved in eight out of fourteen communities in which H/PD was implemented (see *Results of cross-cutting approaches* section for more details).

APROSAR is committed to continuing to work on developing the H/PD methodology as they have seen improvements and believe that if they implement it in a manner more suitable to Bolivia, they could increase its impact. Still, H/PD remains, at least for now, the most intensive and expensive of the three approaches and for it to be a viable strategy to recommend for expansion, more fieldwork is needed to refine it and ensure that it can be effective in the challenging conditions in rural Bolivia. Positive deviance inquiry can be applied in many ways and in programs outside of the health sector, such as SC/B's work in Education looking at positive deviant schools. APROSAR has also recognized this potential and plans to continue to use the approach in some of its other programs.

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

Wawa Sana surpassed this objective with at least 15 organizations having already adopted and/or adapted SECI or H/PD throughout Bolivia (see maps on previous pages that indicate which organizations are now implementing all or part of the SECI and/or Hearth methodologies).

CB-IMCI is a national strategy that will continue beyond the *Wawa Sana* project as long as Promoters continue to work. Similarly, those Promoters who continue to work and who have been trained in and using SECI are likely to continue it (if health providers continue) because of high community demand. The evaluation team estimates that approximately 60% of Promoters will continue to work based on expressed interest and previous experience. However, whether they continue depends on the support they receive from the health providers and their communities and municipalities. Some encouraging signs include: 1) *Wawa Sana* instituted an accreditation program that provided those Promoters who successfully completed the training courses and who are actively working in their communities with formal ID cards that give them more credibility with health providers and their communities; 2) the Promoters have started to organize themselves into more formal bodies with elected presidents and other officers; 3) they have started to take steps to register formally with the government; 4) they are beginning to

approach municipalities and other institutions to ask for support; and, 5) some of the municipalities have included budget line items for training and material support to Promoters in their annual budgets.

SECI has the potential to be scaled up to a national level. There is already an organic expansion of the methodology through government health facilities and NGOs. For SECI to expand, the MOH at the central level and various donors would need to support it. It is recommended that the *Wawa Sana* team present the experience with SECI including its process and results to central level MOH decision-makers to determine their level of interest in pursuing further expansion of the methodology.

Phase-over plan

The phase-over plan was on schedule and should be completed by the end of the project.

Financial sustainability

Financial sustainability of project activities depends primarily on the municipalities and whether they include these expenses in their annual budgets. Some municipalities have done this but the majority of them have not. The annual planning and budgeting process is still new to municipalities in Bolivia, and has recently changed again with the addition of the “DILOS”. It will take some time before the DILOS are fully functional. Promoters and communities are aware that they need to do more proactive advocacy if funds are to be allocated to their priorities. However, funds are limited and they will need to persuasively make their case. Communities themselves have demonstrated that they will also use their own resources to achieve their objectives. For example, several communities constructed buildings in which Promoters could meet with communities with their own materials and labor. Others have donated their time to conduct community censuses, carry out health fairs and other educational activities, contributed food to the Hearth sessions and there are many other examples.

As mentioned previously, APROSAR clearly increased its funding and diversified its funding sources from 100% USAID at the beginning of *Wawa Sana* to 25% USAID and the remaining 75% from European donors.

Programmatic sustainability

When asked what project activities and results they thought would be sustained, community members stated that they:

- Will continue to practice what they have learned to prevent illness and to seek care when their children have danger signs;
- Want to continue with monthly community SECI “planning together” meetings;
- Need to support their Promoter. Some communities are now relieving Promoters of mandatory community service and intend to continue this practice;
- Intend to continue dialogue with community members who do not attend meetings and who need to vaccinate their children and learn how to better care for them;

- Will continue to call upon their local authorities to provide support to the activities;
- Will continue to insist that providers come regularly to meet with them and provide services in the community, especially those communities that are far from facilities; and
- Have a vision for the future that health will continue to improve due to their continued participation in health activities. (This was observed during an exercise in which community focus groups were asked to draw what health in their community was like before *Wawa Sana*, now, and what they believed it would look like in three years. All groups depicted a steady progression to better health over the time periods; many also showing improved coordination with health services, municipal authorities and Promoters and other sectors outside of health.)

Lessons Learned and Recommendations

- There is constant rotation of providers, authorities and Promoters. We recommend that communities, providers and authorities who are leaving their posts orient new people to the program providing them with current health data and an overview of the strategies. As the *Wawa Sana* team said, “an informed authority is a committed authority.” In the health service, at least one, but preferably two people who are likely to be more stable (auxiliary nurses tend to stay longer) should be designated as direct contacts for the Promoters. When Promoters leave their posts, community leaders need to ensure that the community elects a new Promoter to fill the gap and this new Promoter should be trained as soon as possible, initially by the Promoter who is leaving, if available, and/or by the designated health provider at the nearest facility. Alternatively, if there is an annual training scheduled within a short time, the Promoter could take advantage of that opportunity.
- For Promoters to continue their work they need three types of support: 1) moral: see that they are making a difference, be valued by the community and by health services; 2) technical: opportunities to learn and grow through training and supportive supervision; and, 3) some logistical (a bicycle, basic CB-IMCI, SECI and other educational materials, and ideally, basic medicines such as cotrimoxazole which would increase community access to services, increase community demand for their services and would provide a small income).
- Resources for health activities may come from municipal budgets, local or external institutions and donors, and the community itself. It is critical that Promoters be involved in the preparation of the Annual Operational Plan so that community-based health needs are identified and included in the budget. Promoters, communities and health services need to be proactive to seek funding opportunities from local and external institutions. APROSAR has been successful in this regard and can help Promoters identify opportunities and guide them in how to approach these organizations. Communities should be encouraged to continue to seek ways to support their Promoters and carry out their health activities using their own resources and solutions when possible and to advocate for municipal resources when necessary.
- CB-IMCI is a national strategy that has political will and financial support already in place so is likely to continue into the foreseeable future. In the communities in which SECI has been implemented, it is likely to be sustained due to community demand and the fact that it makes

analysis and decision-making easier for communities and service providers. SECI has the potential to be expanded to a national level, having proven that it is effective and relatively cost efficient but will also need political will and financial support if it is to realize the potential kind of impact. *Wawa Sana* should first meet with all other organizations that are currently implementing SECI and consolidate experiences. The group of organizations that have implemented SECI should present the results of their experience with SECI to central level decision-makers and other potential implementers to determine the level of interest in expanding SECI further. It is recommended that the group consider proposing the expansion of SECI not to all rural communities in the country, but to target expansion to priority health networks with communities with the poorest health indicators.

- H/PD needs to be studied further to determine under which conditions it is effective in sustaining nutritional improvements beyond one year after *Hearth* sessions have ended.
- Inter-institutional coordination and the development of a spirit of teamwork improved relations and the potential to sustain program activities. It is recommended that future projects nurture teamwork in all aspects of the project from program design through implementation. The establishment of coordination mechanisms, or better yet, the integration of new team members into existing mechanisms if they work well, is critical to smooth functioning of the project. A common information system built on common goals, objectives and desired results with a standard reporting format helps to unify team focus. *Wawa Sana* struggled to develop a unified reporting system and experienced difficulties when reporting formats were different (at times even within the same institution).
- Four years is too short a period in which to expect that everything that the project achieved will be sustained over time, particularly in a context such as rural Bolivia where seemingly contradictory forces are at work: rapid change in the national and political realm and relatively slow rate of cultural change both at the family and institutional levels. We anticipate that approximately 50-60% of communities and Promoters will continue with *Wawa Sana* strategies and activities, primarily those that have had at least two years experience with the project.

III. Program Management

III.A. Planning

The original project design process involved representation from SC/B, APROSAR, the MOH and municipal authorities. However, most of the *Wawa Sana* implementing team had not been hired yet and many of the original participants were no longer in their positions by the time the project began. The DIP was developed with limited involvement of partners and field staff. The MTE found that there was good general understanding of the project goals, but confusion about specific objectives. This finding was validated during the final evaluation.

There was a start-up workshop in which representatives of all partners participated, however, the DIP was never completely translated and the part that was translated was poorly translated so that it may have created more confusion. The mid-term recommended that the translation be

redone and the M&E plan simplified to make it easier for team members and communities to understand and monitor.

Monthly quality circle meetings at each level of the project (local areas, Red, Oruro and La Paz) and quarterly evaluation and planning meetings at the project level include all of the partners and are described in several other sections of this report. Many *Wawa Sana* team members mentioned these meetings as being essential to good planning and coordination. They also went a long way toward helping partners work more as a team.

Based on a recommendation by the MTE, the team developed annual plans to plan activities in more detail than presented in the DIP. The DIP was followed and provided good general direction for the annual planning process.

One area of activity that the DIP could not anticipate was the intensive level of support that *Wawa Sana* needed to provide to the MOH in response to the significant changes in the health system with the introduction of the SUMI insurance system and the new decision-making structures (e.g. DILOS) associated with this change. *Wawa Sana* responded to these changes by supporting the MOH on the local level in the implementation of the new policies, co-financing meetings and workshops with municipal authorities, and supporting information campaigns for the public to inform them about the new free care package.

At the community level, planning was an integral part of the SECI process and is described in several other sections in this report (see *Results of cross-cutting approaches*).

III.B. Staff Training

SC/B staff was well trained, with an adequate budget for training (see *Capacity Building, Training* section above for more details).

As mentioned above, supportive supervision to assess knowledge and skills in the field at trainers' sites could have been stronger. It is recommended that future projects ensure that there is an adequate system for assessing all field staff. (See the following section and the *Capacity Building, Strengthening the PVO* section for more details.)

III.C. Supervision of Program Staff

Internal institutional supervision improved notably in the second half of the project as supervision systems began to evolve to better suit the needs of the project and the institutions. For example, APROSAR simplified its supervision forms and process to make it less bureaucratic and more supportive of learning in the field. SC/B instituted annual performance reviews of its staff based on stated desired results and reviewed the progress of each trainer during monthly and quarterly quality circle meetings. The MOH benefited from the project vehicle and gasoline to make biannual supervisory visits to all health facilities. Additionally, to supervise field staff, SC/B and APROSAR supervisors reviewed a number of other project forms including workshop reports, "planning together" meeting and summary forms, training participant lists and monthly program reports. However, field staff mentioned that the recommendation from the MTE to provide more direct in-the-field supervision of their work was

still lacking; in several cases trainers were never visited (see *Capacity Building: Strengthening the PVO* for more details).

Supervision of Promoters was made more efficient when the project developed a “Guide to monthly evaluation of performance during home visits”. This is a checklist that the supervisor uses to ensure that the Promoter is covering the key topics effectively.

MOH directors appreciated the value of the biannual supervisory visits and expressed interest in continuing them after the project ends. Their main concern is budget for gasoline for which they are advocating from the municipalities for next year’s budget.

III.D. Human Resources and Staff Management

Personnel Policies and Procedures

SC/B has essential personnel policies and procedures in place but does not have follow-on funding to continue to work on the project, so has had to lay off trainers and the CS Coordinator. The remaining staff has been reassigned to other SC/B projects. The MOH and APROSAR have personnel policies and procedures in place that support continuation of *Wawa Sana* activities. Outside of APROSAR areas, Promoters have initiated the process of forming their own organizations and have elected their boards. They are now initiating development of a formal registration of their organizations. These are very new organizations and do not yet possess personnel policies and procedures. They can learn much from APROSAR about how to register and how to establish themselves as a formal organization. We recommend that Promoters who are starting these new organizations seek guidance from APROSAR. Additionally, these Promoters have begun to seek assistance from other institutions.

Working relationships of program personnel

Throughout the project, morale and working relationships within partner teams were generally good. Prior to the MTE, the partner organizations tended to work on their own and didn’t view all of the partners as a team. During the MTE, partners began to reflect on how they could work more effectively as a team and after the mid-term they took a number of important steps toward this goal.

- a. There were one-on-one meetings between SC/B and APROSAR to work out roles, relationships and coordination mechanisms. As mentioned earlier, APROSAR saw its relationship to SC/B as that of a younger brother in a family who wanted to do things independently. Over the second half of the project, APROSAR matured, as did the relationship into a more trustful and mutually beneficial relationship for both parties.
- b. The partners instituted monthly and quarterly quality circle meetings to review together what they had achieved during the last month/quarter and what they planned to do in the next month/quarter. (These meetings were formerly held only by SC/B staff.)

- c. SC/B developed formal agreements with municipal authorities to clarify goals and objectives of the project, roles, responsibilities, activities and timelines.
- d. All partners participated on the final evaluation team.

Level of Staff Turnover

As mentioned several times earlier in this report, staff turnover was a tremendous challenge for the project, especially in the MOH. It was not unusual for a doctor or nurse to stay in a facility for only three to six months before being moved to another facility, and sometimes to another area altogether. Municipal and community authorities also changed fairly frequently, the extreme case being a town that had four mayors in one year! This instability necessitated repeated training courses, many hours orienting new staff and new municipal and community authorities.

In the past, Bolivia instituted a one-year mandatory rural service for graduating doctors. This system did not work well because many of the new doctors did not want to be out in the rural areas and would leave their posts for long periods of time. The MOH ended this program last year and now finds itself in perhaps worse shape because now doctors are leaving after three or four months. Another factor that contributes to the high turnover is that communities essentially fire providers that they do not like or accept. MOH staff interviewed during the evaluation suggested that to lengthen providers' terms at a given facility, especially in rural areas, personnel should be given extra support and incentives such as better pay (although MOH staff received a pay increase the year before), a house to live in, better supervision and several consecutive days off each month so that they can go to see their families. The Philippines instituted a program along these lines that worked very well. Bolivia's resources are more limited and it may not be feasible to provide these benefits for everyone, but it is clear that something needs to be done.

Additionally, the World Bank "Extensa" Project's hired some of the project Promoters and then changed its policy and did not pay them, resulting in the loss of many disgruntled trained Promoters. These Promoters then needed to be replaced, with new training and follow-up supervision.

III.E. Financial Management

During the first half of the project, SC/B managed project finances from La Paz and Westport. This made it difficult for the program managers in Oruro to manage their budgets as they didn't know how much was budgeted and how much was actually spent against the various line items. This situation was rectified when the financial management of the project budget was decentralized to Oruro. Now, there is a system in place for program managers to review weekly updates of their budget versus actual expenses reports. This change has made it much easier for field staff to know where they stand and to plan accordingly. This shift has also contributed to staff being able to better budget in the future.

The project spending met the proposed budget, with no over or under-spending.

As for future expenses related to sustaining project activities, SC/B did not win follow-on funding and must end its support. Some of the recurring project costs have already been included in municipal budgets (for training and/or materials for Promoters as well as gasoline in some cases). However, not all municipalities have included these costs and this is a source of concern to all who intend to continue implementing activities. (See sustainability section that follows for more details.)

III.F. Logistics

Logistics were well-managed and did not present any limitations to the project. A majority of health service providers interviewed mentioned the helpful support that the project provided in transportation for supervisory visits and community activities. While this led to an increase in access during the life of the project, it is of some concern now that the project is ending and health services can no longer count on this support. Some of the municipalities have already begun to address the service provider's need for gasoline by including this in their budgets. However, the majority of municipalities have not yet incorporated project expenses. For future projects, it is important to plan well ahead how logistics costs will be covered when the project ends and begin to implement these solutions during the project, while phasing out project support over time. The reality is that the timeline for this project was relatively short given the major changes occurring in the country at the time and even had *Wawa Sana* started earlier to phase over costs of gasoline, it would have been difficult to fully integrate these costs into all municipal budgets.

III.G. Information Management

The health information system had five components including:

- KPC survey which is one of the main instruments for measuring indicators;
- SECI community epidemiology surveillance system;
- SNIS national MOH information analysis system (SNIS);
- Other qualitative studies (Focus groups, Institutional Assessment); and
- Community notebooks managed by *Wawa Sana* trainers.

The health information system was quite effective, particularly at the service and community levels. Health information was collected by health services using the national health information system (SNIS) forms and by Promoters using SECI, CB-IMCI and/or APROSAR forms that had been agreed upon between APROSAR and the MOH. At the end of the month, in the 156 SECI communities, Promoters and health services met to consolidate their information. They then presented this information to the community at a monthly SECI planning together meeting, where the information was analyzed, priorities were set and plans were made to address priority health concerns, as previously discussed. The information was also entered into the SECI computer database to provide an overall picture of project progress for the *Wawa Sana* team. In those communities that did not use SECI, health services and Promoters also collected information. Promoters shared their information with health services that then incorporated it into the information analysis committee meetings ("CAIs" or "TAIs"). Most Promoters and service providers feel confident that they can continue to collect information in the future when

the project ends. Promoters' information often was not included in the health services report for the SNIS and this was a point of some concern for Promoters. In the past, the form used to have a box for Promoter information. The current form does not have this box and many of the Promoters report that their information is now not included. We recommend that SC/B and APROSAR continue to advocate at the national level for a change in the form to reflect the work of the Promoters as their information provides a clearer picture of what is happening in communities than only what the service facility data provides.

The SECI database also houses information on community characteristics including how far the community is from a health service facility, whether a Promoter is working there, principal services available in the community, population based on community implemented census (which tends to be more reliable than projections that the MOH uses based on the national census data), a map of the community and other resources available there. As mentioned in the section on SECI, the database, although relatively easy and fun to use, was only used by the program management housed at SC/B and by Challapata, primarily because MOH staff were required to use the SNIS database and SECI was an additional task that was not mandated. Additionally, staff turnover and the extra training needed made it difficult to maintain the continuity of data entry.

At the program level, health information could have been used more effectively during quarterly evaluation and planning meetings. Team members said that this information was shared in monthly quality circle meetings, but it is not present in most of the quarterly meeting reports. More recently in 2004, some nutrition data were included, but the quarterly meetings could be more effective if they focus not only on activities completed and planned, but review progress on project objectives that can be measured on an ongoing basis. The Evaluation Team Leader recommends that the format of the quarterly presentation be modified to include a first column for "Desired results" that help to link the activities that are reported on to specific desired results as articulated in the project DIP. This will keep focus on the goals and objectives of the project. (See also *Sustainability, Lessons Learned and Recommendations* above for additional information on reporting formats.)

The KPC survey was conducted at baseline and at the end of the project. See Attachment E for a description of the methodology used during the final evaluation.

Special Assessments and New Approaches

Wawa Sana tested three new approaches that are described in detail in other parts of this report including:

- **SECI** to improve community participation in health information collection, analysis, decision-making and planning (this system has also been adapted for use in SC/B's newborn health project and Title II program);
- **PD** approach to improve nutritional status of children; and
- **CB-IMCI** which introduced new educational materials and forms to collect information on child health during home visits.

As mentioned earlier, SC/B carried out organizational assessments that were incomplete and inconclusive. The field office should continue to work on improving its capacity in this area.

III.H. Technical and Administrative Support

SC/HQ's CS Specialist, Dr. Eric Starbuck was budgeted at 15% time for the *Wawa Sana* project in Year 1 and at 10% in Years 2-4. He provided technical assistance in the development of the project design, the DIP, and for baseline assessments. He prepared for the MTE and reviewed the results and recommendations and provided ongoing email correspondence support from home office. Additionally, he participated in the final evaluation. Dr. Starbuck felt that one important limitation in his ability to support the project was his inability to speak Spanish. Several of the team members also spoke English so he was able to communicate well with the La Paz based staff. At the time CS-16 began, SC/HQ did not have CS staff who spoke Spanish. This year, SC hired a new CS Specialist who does speak Spanish thereby strengthening the team's language capability.

The Health Office Manager, Carmen Weder was budgeted at 12% time in Year 1 and at 10% in Years 2 through 4. She developed the initial project budget in coordination with the field office, monitored project expenses and match requirements and reported to AID and the field office on budget pipelines, worked with field staff on the development of sub-agreements with partners, and responded to administrative and financial questions from the field office.

The CS Advisor, Dr. David Marsh was budgeted at 3% time in Years 1 through 4. Dr. Marsh reviewed key project documents, supervised Dr. Starbuck's work on the project and served as a technical resource to the project.

Field staff was satisfied with the support that they received from SC/HQ and SC/B staff was satisfied with the support they received from La Paz. However, as mentioned earlier, field staff would have liked to have had more supportive supervisory visits at their sites by senior staff.

Other technical assistance received included:

- H/PD specialist Jerry Sternin;
- Training through LINKAGES and other local organizations (intercultural training, communication (BCC) and radio programs);
- Budgeting and expense monitoring for the CS Coordinator; and
- Cost study by SC volunteer Shireen Santosham.

As mentioned above, SC/B could still benefit from participating in training to assess institutional/organizational capacity.

III.I. Management Lessons Learned

- All key project documents should be available to all partners in clear, local language that can be understood by all.

- Roles and relationships should be negotiated ideally during the project design phase, and then reconfirmed in writing through formal agreements prior to writing the DIP so that these agreements enter as part of the DIP and are clear to all, keeping in mind *Wawa Sana*'s experience of developing teamwork, rather than individual roles and responsibilities.
- A start-up workshop is critical to help everyone, especially newly hired or recruited project implementers, understand the project's goals, objectives and desired results. However, a start-up workshop is not sufficient to ensure continuing understanding and focus as project team members change. Orientation is necessary every time new members enter and periodic review for existing members is important. Projects should build this function into their management plans from the beginning, with a process that is well described so that all new members receive adequate information about the project. Projects may want to consider developing a short brochure for municipal authorities and health service directors and providers that includes key information about the project goals, objectives, desired results, partners, roles and relationships, timeline, source of funding, requirements for participation (if inviting participation, for example, many people interviewed suggested that municipalities should be required to contribute its own funds and/or materials to participate).
- Supervisors need to assess field staff capacity at the beginning of the project, determine in which areas staff needs strengthening, develop a plan to strengthen these areas and follow-up to ensure that these plans are implemented and that they are producing the results desired. It is not sufficient to rely on indirect supervision through reports and meetings to assess skills.
- Monthly quality circles and quarterly evaluation and planning meetings in which all partners participate are valuable mechanisms through which projects can maintain focus on their goals, objectives and desired results and ensure better coordination, planning and problem solving among partners. However, these meetings must maintain focus on the goals, objectives and desired results of the project, not only on project activities (e.g. number of people to train, number of communities to visit) to maximize their effectiveness. Teams can help to ensure focus on goals and objectives by developing reporting formats that are based on the goals, objectives and desired results, not on activities.
- Decentralization of project finance monitoring improved project implementation.
- Logistic support to the MOH can increase access to services in communities but projects need to be aware of the longer-term implications when the project ends. It is recommended that projects try to establish local funding mechanisms for recurring costs such as gasoline as early in the project as possible. This recommendation complements several previous recommendations (establishing roles and responsibilities, and requiring a counterpart contribution from municipalities for participation).
- A health information system such as SECI that is accessible and easily understood by all actors in the project provides a good base upon which to set priorities, make decisions, plan actions, and monitor and evaluate progress. It also raises community awareness and mobilizes them to take action.

- Assessing institutional capacity was difficult for this team. Assessing institutional capacity should answer at least two important questions: 1) capacity to do what? and, 2) in what context?

IV. Conclusions and Recommendations

Wawa Sana was an exciting, successful project that pioneered innovative approaches to improve child health, particularly SECI and H/PD, and learned a lot about when and how to apply these approaches in rural Bolivia.

The project successfully met nearly all of its objectives and surpassed many, as presented in the Results Summary Table. Vaccination coverage increased dramatically, the numbers of acute respiratory infections seen by health services and Promoters increased by 224% from 2001 to 2003, nutritional status improved in the majority of children participating in the H/PD sessions and 54% of children with diarrheal diseases received more liquids, compared with a baseline of 21%. 85% of children received Vitamin A compared with the project objective of 50%¹⁰. In 2000, only 13% of children received a checkup at the health center within their first week of life. In 2004, 41% of children received a check up within their first week. Community members, health personnel, SC, and APROSAR attribute these achievements to several factors including:

- SECI planning together sessions raised awareness and knowledge about communities' health problems and status using simple-to-understand tools and processes so that community members, authorities, and health personnel understood the information and could discuss and plan ways to improve health status together.
- CB-IMCI increased community access to trained Promoters who helped families learn to identify danger signs and problems during home visits and community meetings and served as an important bridge to the formal health service. In some cases, Promoters provided basic health services (cotrimoxazole for ARI, ORS for diarrhea, paracetamol).
- Increased presence of health personnel in communities due to SECI sessions, better coordination with Promoters and communities and, at times, assistance with transport and/or gasoline from *Wawa Sana* for supervisory and program visits;
- The recently introduced universal health insurance ("SUMI") likely contributed to improved economic access by making health services free to children under five years old and pregnant women.
- Program management was notably strengthened since the MTE to focus more on team efforts to coordinate actions, decentralize financial monitoring, monitor progress during monthly (local) and quarterly (all project areas) quality circle meetings.

One objective that *Wawa Sana* did not meet, due to policy and cost structure constraints as previously described, was for 80% of Promoters to have had adequate supplies of ORS.

Health personnel, Promoters, community members, and SC and APROSAR staff all strengthened their technical, organizational, and management capacities to identify health problems, set priorities, work together to plan and take action to address these priorities, and monitor their

¹⁰ No reliable baseline data existed for comparison.

progress. The major challenge to capacity strengthening was the constant rotation of health service personnel (it was not uncommon for staff to stay a mere three to four months at a health center or health post), local authorities at the municipal and community levels, and to a lesser extent, Promoters. Decentralization of government functions and procedures begun in the late 1990s, and a totally new structure and new policies introduced by the most recent national government administration in 2002 and again last year, also presented important organizational, management, and relationship challenges to local capacity to implement health programs. More detail on capacity strengthening is presented on pages 41 to 56. Additionally, the project team was not able to effectively and systematically assess institutional capacity upon which to develop capacity strengthening plans which could have helped to guide and monitor this process.

Wawa Sana achieved and surpassed its objectives for “uptake” of its strategies by other organizations, not only in Oruro Department, but throughout Bolivia. At least 15 organizations adopted and adapted SECI and/or Hearth/Positive Deviance in the areas in which they work. (See maps on pages 32 and 37 for organizations and where they are applying these strategies.) A cost study of the three strategies as implemented in the *Wawa Sana* project area estimated that the marginal per community cost for implementing CB-IMCI was \$1,682, for SECI \$1,945 and for H/PD \$6,833.

At present, there are no follow-on funds to continue *Wawa Sana* after the CS-16 funding ended in September 2004. However, APROSAR intends to continue using the three *Wawa Sana* strategies in its ongoing projects using other donor funding. Communities, health service providers, and Promoters in the other project areas have expressed their desire to continue with the *Wawa Sana* activities to the best of their abilities and available resources, recognizing that municipal budget allocations are a major key to sustaining support for these activities. Based on their experience with *Wawa Sana*, those interviewed during the final evaluation who will continue with the activities after CS-16 funding has ended, intend to apply the following lessons learned:

- Teamwork is essential to success: continue inter-institutional coordination between communities, local authorities, health service providers, Promoters, and other relevant institutions.
- Learn to plan with change in mind: given the rapid rate of change of people, structures, policies, politics in Bolivia and the world in general, while it is tempting to try to stop the change and hold stable the forces that influence programs, it is more realistic to assume that change is liable to continue, and to develop implementation strategies accordingly.
- SECI is a powerful, effective, and feasible methodology to mobilize communities for health. It effectively put into practice the Bolivian “Law of Popular Participation” and has had important direct as well as possibly more important indirect positive impact through its ability to change the system of local government decision-making and planning that could also be applied to other sectors. Continue to use SECI methodology to inform communities, local authorities, and providers about health status and to monitor progress (“An informed authority is a committed authority” --a *Wawa Sana* team motto);
- Continue to develop and refine the H/PD methodology to fit local Bolivian conditions and document what works in a user-friendly manual with accompanying educational materials,

tools, and techniques. Families involved in the H/PD sessions learned that many local foods are nutritious and can be prepared in tasty recipes that they are sharing with their neighbors.

- Continue home visits by Promoters, modifying the process to simplify and shorten it. Revise the Promoters' didactic materials as necessary.
- If possible, continue the weekly radio program focusing on health issues and involving communities to share their challenges, successes, and what they are learning.
- Communities and Promoters need to participate in Information Analysis Committee meetings and in the development of annual operational plans to advocate strongly for budget support for health program activities.
- Promoters need to continue to develop their newly formed organizations, strengthening their technical, organizational, and political capacities by learning from organizations such as APROSAR that have invaluable experience.
- Families will continue improved health practices at home and plan to continue to share what they have learned with their neighbors.
- Promoters and service providers recognize the need for at least annual refresher training and to incorporate new people into training. They plan to identify new institutions working in the area to assist with training.

SC believes that the CS-16-related experiences and materials that are most relevant to the "broader development community" are those which relate to SECI. SC presented SECI to the broader development community at the CSTS/ CORE/ USAID workshop on Data For Action: Using Data to Improve Child Health, Silver Spring MD, September 9-11, 2002. (Please see the paper and presentation by Caroline de Hilari and Lisa Howard-Grabman. Does a Mayor Need Epidemiology? Data Use by Local Decision Makers. Save the Children, Bolivia, 2002. Paper: <http://www.childsurvival.com/documents/workshops/DataforAction/SaveBol.doc>, PowerPoint presentation: http://www.childsurvival.com/documents/workshops/DataforAction/ppt/Day_1/est_arbuck_save.ppt). The proposed Curamericas and SC CS-21 project focuses on taking SECI to scale through partner PVOs and NGOs in Bolivia, and beyond Bolivia, through a series of regional workshops in Guatemala and Honduras.

Recommendations

1. Logistic support to the MOH can increase access to services in communities but projects need to be aware of the longer-term implications when the project ends. It is recommended that projects try to establish local funding mechanisms for recurring costs such as gasoline as early in the project as possible.
2. Monthly quality circles and quarterly evaluation and planning meetings in which all partners participate are valuable mechanisms through which projects can maintain focus on their goals, objectives, and desired results, and ensure better coordination, planning, and problem solving among partners. However, these meetings must maintain focus on the goals, objectives, and desired results of the project, not only on project activities.

3. Roles and relationships should be negotiated, ideally during the project design phase, and then reconfirmed in writing through formal agreements prior to writing the DIP, so that these agreements enter as part of the DIP and are clear to all, keeping in mind *Wawa Sana's* experience of developing teamwork, rather than individual roles and responsibilities.
4. For Promoters to continue their work they need three types of support: 1) moral: see that they are making a difference, be valued by the community and by health services; 2) technical: opportunities to learn and grow through training and supportive supervision; and, 3) some logistical (a bicycle, basic CB-IMCI, SECI and other educational materials, and ideally, basic medicines such as cotrimoxazole which would increase community access to services, increase community demand for their services, and would provide a small income).
5. Initially, *Wawa Sana* did not have adequate forms and a database that allowed for timely analysis of the data to monitor the study and make decisions about program implementation. Several monitoring forms and processes were developed throughout the life of the project but these are still a work in process. We recommend that future CS projects adapting H/PD develop appropriate monitoring forms at the beginning of the program, learning from *Wawa Sana's* experience.
6. The MTE stated that a lesson learned was that “clinical IMCI needs to be functioning well first before CB-IMCI can be introduced.”¹¹ This would be ideal, however, in the case of *Wawa Sana*, the national clinical IMCI training program was seriously delayed, health service staff turnover was, and continues to be, very high, some of those trained are still having trouble grasping the holistic concepts of IMCI, and the overall socio-cultural and political context has been unstable, often negatively affecting the implementation of many government programs, at least in the short-term. If *Wawa Sana* had waited until clinical IMCI was functioning well, it would still be waiting to implement CB-IMCI today. As it turned out, much was done at the community level through CB-IMCI in spite of the less than optimal implementation of clinical IMCI. Even more could have been done had more Promoters had access to basic medicines.
7. SECI has the potential to be expanded to a national level, having proven that it is effective and relatively cost efficient, but will also need political will and financial support if it is to realize the potential kind of impact. *Wawa Sana* should first meet with all other organizations that are currently implementing SECI and consolidate experiences. The group of organizations that have implemented SECI should present the results of their experience with SECI to central level decision-makers and other potential implementers to determine the level of interest in expanding SECI further. It is recommended that the group consider proposing the expansion of SECI not to all rural communities in the country, but to target expansion to priority health networks with communities with the poorest health indicators.
8. Four years is too short a period in which to expect that everything that the project achieved will be sustained over time, particularly in a context such as rural Bolivia, where seemingly contradictory forces are at work: rapid change in the national and political realm, and relatively slow rate of cultural change, both at the family and institutional levels. We

¹¹ Report of the CS-16 Midterm Evaluation, October, 2002, page 10.

anticipate that approximately 50-60% of communities and Promoters will continue with *Wawa Sana* strategies and activities, primarily those that have had at least two years experience with the project. The Red Norte and parts of Huanuni are likely to sustain more of their activities because of more time and greater experience working with the strategies and with SC/B and APROSAR prior to *Wawa Sana*.

V. Results Highlight

The SECI (Community Epidemiology Surveillance System) Methodology

SECI is a powerful, mobilizing strategy that helps communities improve their health through a community and facility-based health information system. Using SECI methodology and tools, community health Promoters and health service providers consolidate primary health care data that they have collected using simple forms and community maps. These data are consolidated every month and then presented to the community in easy to understand graphics so that together, providers and communities can obtain and analyze new information about community health problems and articulate health priorities that reflect the community's perspective. Community representatives share the consolidated information, plans, and strategies that have been developed and other results of these community meetings at district level information analysis meetings. SECI helps communities and health staffers make decisions on resource allocation and monitor progress toward achievement of agreed upon objectives.

From 2000-2004, in the midst of a rapidly changing, complex sociopolitical and cultural context in rural Bolivia in three districts of Oruro (445 communities) reaching a total population estimated at 104,500, including 13,500 children under five, the *Wawa Sana* ("Healthy Child") project was highly successful, having achieved or surpassed nearly all of its objectives, in large part due to SECI's powerful ability to mobilize communities. Key accomplishments include:

- Pentavalent-3 vaccine coverage increased from 32% to 85% in infants.¹²
- Acute respiratory infections treated by health services and Promoters increased 224% from 2001 through 2003 in CS-16 intervention areas.¹³
- Families increased their children's fluid intake during diarrheal diseases from 21% at the start of the program to 54% at final evaluation.¹⁴
- Most CS-16 communities now place health at or near the top of their agenda in sharp contrast to prior to *Wawa Sana* when health was low or absent completely.
- Municipalities, communities, and health service providers learned to share and analyze community health information to set priorities, plan, act, and evaluate progress resulting in stronger working relationships.
- At least 15 other NGOs and government health services throughout Bolivia have adopted and adapted *Wawa Sana's* SECI methodology.

SECI is a powerful, effective, and feasible methodology to mobilize communities for health. It effectively put into practice the Bolivian "Law of Popular Participation" and has had important direct as well as possibly more important indirect positive impact through its ability to change the system of local government decision-making and planning that could also be applied to other sectors. SECI was effective because it is specific, participatory, objective, educational, and helps people analyze their own health situation while forming operational alliances with health providers to address priority health problems.

¹² KPC Surveys, baseline (2000) and final (2004), based on verified registration on child health card.

¹³ Bolivia National Health Information System (SNIS) data.

¹⁴ KPC Surveys, baseline (2000) and final (2004).

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1. KPC Report, 2004.....	156
2. Cost Study Report, 2004 by Shireen Santosham.....	167
3. List of Documents Reviewed.....	176
F. Project Data Sheet form – Updated Version.....	179

ATTACHMENT A
Evaluation Team Members and their titles

Name	Title	Contact Information
<u>Save the Children</u>		
Lic. Ccoya Sejas	Nat. Health Coordinator	Save the Children
Dr. Gonzales Arevalo	Reg. Health Coordinator	Bolivia Field Office
Albina Chacolla	District Responsible	csejas@savechildren.org.bo
Ruth Pérez	District Responsible	
Juan Copa Laime	Trainer	
German Viscarra	Trainer	
Sonia Hidalgo	Trainer	
Maclovio Mamani	Trainer	
Isaac Cordero	Trainer	
Silverio Padilla	Trainer	
Romelia Antonio	Trainer	
Lina Rodríguez	Trainer	
Delia Flores	Trainer	
<u>APROSAR</u>		
Alfredo Juaniquina	District Responsible	
Nelson Copa	Trainer	
Eliane Canqui A.	Trainer	
Giovanne Zenteno	Trainer	
<u>Ministry of Health –</u>		
<u>SEDES</u>		
Dr. Roberto Núñez	IMCI Reg. Responsible	
Lic. Teresa Pelaez	IMCI Reg. Trainer	
Dr. Victor Yucra	Area Director	
Lic. Felix Condori	Statistician	
Lic Aydee Montaña	Nurse	
Lic. Mirna Grandi	Nurse	
<u>Promoters</u>		
<u>Community members and</u>		
<u>Municipal authorities</u>		
<u>External Consultant</u>		
Lisa Howard-Grabman	Evaluation Team Leader	Tel: 506-289-7248 grabman@racsa.co.cr

ATTACHMENT B

Evaluation Assessment Methodology

The final evaluation team was composed of representatives from all the major actors in the project (see previous Attachment A) and was led by an external consultant. The evaluation was conducted in a highly participatory way with team members involved in, and contributing to, all stages. Knowledge, skills, attitudes, practices and supplies of health workers and facilities associated with the program included:

1. **KPC survey.** The purpose of this survey was to collect post-intervention data on health knowledge, practices, and coverage among mothers of infants less than 24 months old who resided within the catchment area of the *Wawa Sana* project in Oruro Department, Bolivia. A similar survey was conducted at baseline from October 13 to 18, 2000. See Attachment E.1. for the KPC survey report including the complete methodology.

2. **Health Promoter post-test**
Health Promoters completed a written exam similar to an exam to test knowledge and practices that they had taken at baseline. 114 Promoters completed the exam presented in this Attachment on pages 6 and 7.

3. **Review of project documents**
We reviewed SECI data, quarterly reports, project instruments and forms, community folders, financial reports, community and information analysis committee meeting minutes, national health information system data, and other relevant project documents.

4. **Interviews and focus group discussions**
During a two-day preparation workshop and one office workday, the evaluation team developed a set of questionnaires and group facilitation guides (see below for the workshop agenda and methodology and the following pages for examples of the questionnaires) based on their own questions and questions presented in the USAID Final Evaluation Guidelines. Team members administered the questionnaires and facilitation guides to the following groups:

Group	No. of Interviews	No. of Focus Groups
Community women	19	6
Community men	6	5
Munic. and local authorities	32	
Promoters	23	3
Health personnel	30	
Save the Children staff	17	1
APROSAR	10	1
USAID La Paz	1	
Central MOH- La Paz	2	
Others	1	

Team members reviewed the results from the interviews and the focus group discussions during a two-day analysis workshop following fieldwork. An agenda of this workshop is included on pages 8 - 13 and the tools used to assist participants in consolidating the information are also included along with their results on pages 14 to 57.

Lessons Learned from the Final Evaluation

- Over thirty “stakeholders” from the MOH, APROSAR, municipalities and communities, SC and an external consultant, participated as members of the final evaluation team. Most participants said that it was the most participatory evaluation they had ever been a part of. To manage such a large team with a wide range of experience, knowledge and skills, we developed a methodology that aimed to address AID’s questions as presented in the guidelines and also those questions of our participants. Relatively simple matrices helped to guide the process. Much of the evaluation preparation and analysis was done in small groups of 4 to 6 people each oriented around the various groups participating in the project (communities, authorities, Promoters, service providers, SC/B and APROSAR) and the main categories of interest (Health Results (Technical Approach), strategies, capacity building, sustainability and program management). This worked fairly well, although there was some confusion initially about what “technical approach” meant as this is a relatively abstract term.
- Do not schedule field visits on market days unless you wish to observe activities in the market itself. Many communities on these days were vacant and little interviewing could be done.
- This evaluation was highly participatory and could have benefited from more time (at least one more day) for preparation, and analysis (one or two more days). Because at least a third of the participants had never participated on an evaluation team before, they were also learning by doing and could have assimilated and digested more had they had more time.
- SC/B and APROSAR were noticeably working well as a team during the evaluation. An area that could have been improved internally within SC/B and between APROSAR and SC/B was the consolidation of information at a project level. Most information was available by geographic area, but the project level consolidation was an extra step that had not been taken prior to fieldwork in a number of cases and could have facilitated the analysis of evaluation results.
- The Chamber of Commerce building worked well for the evaluation workshops with the option of two spaces, one for presentations that was also used for small group work and the other for small group work and lunch.
- Ensure that several staff members have access to the database files and passwords so that information is always accessible to the team. The SC statistician had to leave during the evaluation for a course and we were not able to access the SECI databases during his absence. This could have been avoided by making sure that more staff know how to import and use the databases (passwords, file locations, etc.).

**TEST DE CONOCIMIENTO EN SALUD DEL MENOR DE 5 AÑOS-
PROMOTORES Y ACS**

NOMBRE: _____

COMUNIDAD: _____

MUNICIPIO: _____

TIEMPO DE TRABAJO: _____

1. ¿Cuales con las señales de peligro de muerte del niño o niña menor de 5 años?

1. _____

2. _____

3. _____

4. _____

2. ¿Cuales son las señales de peligro que se debe considerar si un niño o niña tiene tos grave y sea referido de inmediato?

1. _____

2. _____

3. _____

4. _____

3. Cuales son las señales de peligro cuando un niño o niña tiene diarrea y debe ser referirlo a un servicio de salud?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

4. Que cuidados recomendaría Usted a una mamá que tiene una wawa con diarrea?

5. ¿Cuales son las medidas de prevención de enfermedades que Usted recomienda para evitar enfermedades (hoja de revisión 4)?

6. ¿A partir de que edad se debe empezar a dar otras comidas a los y las niñas y ya no solo pecho?

Horario de la Evaluación Final de SI 16 en Oruro

30 de Agosto, Lunes

Planificación y revisión de documentos

Entrevistas con MINSA (AIEPI y SNIS)

31 de Agosto, Martes

Entrevistas y viaje a Oruro

PROCOSI

USAID

1 de Septiembre, Miércoles

Taller de evaluación preparatorio

09:00 Dinámica rompe hielo

Inscripción y presentación de participantes

¿Qué es una evaluación? (Lisa)

Presentación de los objetivos de la evaluación final:

- Apreciar si el programa logró sus metas y objetivos
- Apreciar la efectividad de las intervenciones y estrategias
- Desarrollar lecciones aprendidas que pueden servir a nosotros y otros interesados en el futuro
- Desarrollar una estrategia para comunicar nuestras lecciones aprendidas a todos los interesados.

Presentación de la agenda del Primer Día del Taller

09:30 Presentación de las metas, los objetivos de SI 16 (Gonzalo y Ccoya)

10:00 Rompe cabeza de los resultados hasta la fecha (tarjetas de todos los resultados recolectados por el CAP, resultados de los informes de promotores, etc. (1 hora total) (Participantes con facilitación por Ccoya)

10:30 Refrigerio

10:45 Preguntas de la evaluación final (Lisa)

Cada participante escribió 2 preguntas que ellos quieren saber de la evaluación en tarjetas. Colocamos las tarjetas en papel rotafolio de acuerdo con las categorías de AID/W de los lineamientos para la evaluación final. También, colocamos las preguntas de AID/W y las preguntas de personas entrevistadas en La Paz de USAID, el Ministerio de Salud y Deportes (SNIS y Atención a los menores de 5 años).

12:30 Almuerzo

14:00 Técnicas de recolección de datos, esp. Participativas
 Hicieron 8 laboratorios y los participantes asistieron a cada laboratorio durante 15 minutos para conocer las técnicas de: bandera de salud (su aplicación a la evaluación final), historias reales, diagramas Venn, Mapa, Bosillo Mágico, Dibujo, Sociodrama, puntaje/conteo. También los participantes mencionaron en plenaria: entrevistas, grupos focales, observación, visitas domiciliarias, censo, formularios, cuestionarios, revisión de documentos.

16:00 Refrigerio

16:20 Presentación de la primera tarea para equipos para elaborar instrumentos.

Relacionado a la Meta, Resultado y Resultado Intermedio...	Lo que queremos saber.....	Fuente de información	Técnica o método para recolectar la información

16:50 Organización de equipos de trabajo para elaboración de los instrumentos de la evaluación

	Ministerio	Comunidad	Save	APROSAR	Otros
EQUIPO 1: Enfoque Técnico	Felix Mirna Segundin	Judith Carmelo	Iver Ruth Ccoya Albina	Alfredo	
EQUIPO 2: Estrategias	Teresa Victor	Eziquel Edmundo	Romelia Isaac Gonzalo	Giovani	Pepe
EQUIPO 3: Fortalecimiento de capacidad	Aydee Raul	Lucía Milan	Sonia Maclovio Carolina	Eliana	Romberto
EQUIPO 4: Sostenibilidad	Roberto	María Julio	Silverio Lina Juan	Nelson	Bernardo
EQUIPO 5: Gestión del programa	Alfredo	Fortunato	German Dalia	Dalcy	Salustio

17:30 Cierre

2 de Septiembre, Jueves

Taller de evaluación preparatorio

09:00 Introducción y presentaciones

09:10 Presentación de Estudio de mortalidad de Cacachaka (Caroline)

10:15 Organización de equipos encuestadores para la visita al campo

10:30 Refrigerio

10:45 Trabajo de equipos para completar la matriz

11:30 Presentación de las matrices a la plenaria y observaciones

12:30 Almuerzo

14:00 Elaboración de instrumentos

16:00 Refrigerio

16:20 Práctica en el uso de los instrumentos y revisión (Trabajo en grupos)

17:00 Cierre (o 17:30)

- **Organización de equipos**

Participación compuesta por: promotor, miembros de la comunidad, SEDES, APROSAR

Se necesita un supervisor/coordinador de cada equipo.

3 distritos, 1 equipo por distrito de por lo menos 5 personas cada equipo

Visita a 2 comunidades cada día, a veces, por distancia, solamente una.

Tratar de organizar las visitas a comunidades con buenos resultados, resultados medianos y resultados no tan buenos para rescatar lecciones en cuanto a los “porqués”.

3 de Septiembre, Viernes, Oruro

Preparación de instrumentos de evaluación

4 de Septiembre, Sábado, Campo

Visita al campo

5 de Septiembre, Domingo, Campo

Visita al campo

6 de Septiembre, Lunes, Campo

Visita al campo

7 de Septiembre, Martes, Oruro

Consolidación de información de campo.

13:30 – 16:30 Entrevista al equipo de APROSAR

17:00 – 18:15 Entrevista con Director de SEDES

18:30 – 19:45 Entrevista al Gerente de Area de Oruro de Save the Children

8 de Septiembre, Miércoles, Oruro

9:00 – 12:30 Entrevista al equipo Wawa Sana de Save the Children

12:45 – 13:45 Entrevista al Director de AIEPI- Oruro

14:00 – 16:30 Continuación de entrevista con equipo Wawa Sana de Save the Children

9 de Septiembre, Jueves, Oruro

Taller de evaluación analítico

08:30 – 09:00 Inscripción de participantes

09:00 – 09:10 Dinámica de rompe hielo

09:10 – 09:30 Revisión de lo realizado

09:30 – 10:30 Trabajo en grupos para consolidar los resultados del trabajo de campo (participantes divididos en grupos de los entrevistados (comunidad/ municipio, personal de salud, promotores, Equipo Wawa Sana (Save the Children y APROSAR)

C. TRABAJO EN GRUPOS—ANÁLISIS 1

Trabajo en grupos para consolidar los resultados del trabajo de campo (participantes divididos en grupos de los entrevistados (comunidad/ municipio, personal de salud, promotores, APROSAR y Save the Children)

Revisar los resultados de las entrevistas y de los grupos focales y sistematizar la información de acuerdo con las categorías de la evaluación final: enfoque técnico, estrategias, capacidad, sostenibilidad y gerencia usando la tabla a continuación:

Tema: (ej.) Enfoque Técnico

Grupo entrevistado: _____

No. de entrevistas: _____ No. de grupos focales: _____

Otra información utilizada en el análisis:

Logros, Resultados y Hallazgos	Lecciones aprendidas	Recomendaciones	Otros comentarios/sugerencias

10:30 – 10:50 Refrigerio

10:50 – 11:30 Continuación trabajo en grupos

11:30 – 12:30 Presentación de resultados de trabajo en grupos

12:30 – 14:00 Almuerzo

14:00 – 15:00 Continuación de presentaciones de resultados de trabajo en grupos

15:00 – 17:30 Trabajo en grupos para consolidar información de acuerdo con las categorías de la evaluación final (enfoque técnico, estrategias, capacidad, sostenibilidad, gerencia)

A. TRABAJO EN GRUPOS: ANÁLISIS 2

Se dividirá los participantes en grupos por categoría de la evaluación final (Enfoque técnico, estrategias, capacidad, sostenibilidad, gerencia). Cada grupo recibirá los resultados correspondientes del trabajo de grupos que se realizó anteriormente. Ellos usarán la misma tabla como se usó en el análisis 1, pero ahora sistematizando la información de todos los actores involucrados en el proyecto enfocando en una de las categorías de la evaluación final. Cada grupo tiene que recordar las metas, los objetivos y los indicadores del proyecto para estar atento a información relacionada con estos objetivos y indicadores.

10 de Septiembre, Viernes, Oruro

Taller de evaluación analítico

09:00 – 10:00 Presentación de resultados del estudio de costos de Wawa Sana

10:00 – 10:30 Continuación de trabajo en grupo si necesario, o presentaciones de grupos

10:30 – 10:50 Refrigerio

10:50 – 12:30 Presentaciones de grupos

12:30 – 14:00 Almuerzo

14:00 – 15:00 Preparación del plan de difusión de resultados de la evaluación final y conclusiones

11 de Septiembre, Sábado, La Paz

Viaje de Lisa a La Paz y reunión con Gary Shaye

12 de Septiembre, Domingo

Viaje de Lisa a Costa Rica

TABLA DE RESUMEN: ENFOQUE TECNICO

Logros, Resultados y Hallazgos	Lecciones Aprendidas	Recomendaciones	Comentarios
Disminución de la desnutrición de los niños menores de 5 años, mediante la utilización y preparación de alimentos locales y accesibles	Prácticas de cocina Estimulan a que los niños coman más contribuyen a identificar mensajes saludables sobre nutrición	Seguimiento del personal de salud y promotores	Continuar con emisión de cuñas radiales
	Trabajo coordinado entre el equipo de salud, instituciones promotores, autoridades, comunidad	Continuar con capacitación a comunidad y promotores de salud.	
Disminución de la morbimortalidad de los niños menores de 5 años	Rol del promotor y personal de salud es indispensable para la disminución de la morbimortalidad en niños menores de 5 años	Continuar con trabajo conjunto. Centros de salud abastecidos con medicamentos e insumos	Continuar con la aplicación de la estrategia del SECI Continuar con la aplicación de la estrategia del AIEPI
98 % de niños vacunados y carnetizados	Madres reconocen la importancia del carné de salud y vacunas	Seguimiento y capacitación a comunidades	
Mujeres embarazadas acuden al centro de salud	Mujeres reconocen riesgos del embarazo parto y puerperio	Seguimiento y capacitación a comunidades Mejorar la calidad y calidez de atención en los servicios de salud	
		Promocionar el parto humanizado en los servicios de salud	
Mayor acceso a los servicios de salud con casos de IRAs y EDAs de niños < de 5 años	Trabajo de promotores mediante visitas domiciliarias contribuye a coberturas y acceso a servicios de salud	Personal de los servicios de salud que sigan coordinando	
		Incorporar en el SNIS las actividades realizadas por el promotor	

Logros, Resultados y Hallazgos	Lecciones Aprendidas	Recomendaciones	Comentarios
		Normar el uso de instrumentos de referencia y contrareferencia	

TEMA: ENFOQUE TECNICO
Grupo Entrevistado: Comunidad
Número de entrevistas: Mujeres: 19; Hombres: 6
Número de grupos focales: Mujeres: 6; Hombre: 5

Logros, Resultados, Hallazgos	Lecciones Aprendidas	Recomendaciones	Otros comentarios y sugerencias
Mujeres y hombres del área de impacto conocen las enfermedades que atacan a los niños menores de cinco años.	Las mujeres reconocen sus propias limitaciones para acceder al servicio de salud. Cuando el personal de salud trata mal ya no acudimos al centro de salud.	El niño menor de cinco años debe tener las vacunas completas.	
Se logró cambiar la conducta en la comunidad de la atención domiciliaria a atención en servicio (ej. Ellas exigen)	La gente acude al servicio de salud por su propia voluntad incluso controlan al personal de salud.	Continuar con las cuñas radiales y la importancia de la salud.	
Ya sabemos cuidar a nuestras wawas.	Debemos asistir a reuniones de salud. No debemos escaparnos del personal de salud. Nuestras wawas se enferman por culpa de nosotros porque con nuestros animales no le cuidamos bien en frío y lluvia.	Poner en práctica todo lo aprendido. El hospital dé preferencia a comunidades alejadas. Priorizar la salud de sus hijos que a sus animales.	
Incorporar la participación de hombres en las reuniones.	De principio no se tomaban en cuenta a los hombres en las reuniones.	Tomar en cuenta a la pareja y niños en las reuniones.	

TEMA: ENFOQUE TECNICO

Grupo Entrevistado: Autoridades

Nro. de entrevistas: 32

Nro. de grupos focales: 0

Otra información utilizada en el análisis: ninguno

Logros y resultados y Hallazgos	Lecciones aprendidas	Recomendaciones	Otros comentarios y sugerencias
Municipios facilitan materiales de trabajo y estos estan insertados en los POAs (Azanake)		Promotor de salud debe participar en la elaboración de POAs para insertar sus necesidades	
Direcciones locales de salud DILOS funcionan <i>a media maquina</i>	Autoridades no conocen el funcionamiento	Promover el funcionamiento	
Plan consensuado para la continuidad de trabajo, en unidades educativas			Apoyar iniciativas
Liberan de trabajos comunales a promotor para que siga con sus actividades	Autoridades motivados y sensibilizados		Apoyar iniciativas
Grupos organizados con deseo de seguir reuniones de salud	Se creó movilización comunitaria	Apoyo a grupos por parte del personal de salud para continuar actividades	
Apoyo del municipio con combustible para las visitas a comunidades	Seguimiento para exigir el cumplimiento a cronogramas de Personal de salud	Personal de salud debe continuar actividades	
Deseo de la comunidad de seguir realizando actividades de Salud			
Apoyo por parte de autoridades a promotores y lideres de salud		Promotores de salud deben continuar desarrollando las estrategias	

TEMA: ENFOQUE TECNICO
Grupo Entrevistado: Promotores
Número de entrevistas: 23
Número de grupos focales: 3

Logros, Resultados, Hallazgos	Lecciones Aprendidas	Recomendaciones	Otros comentarios y sugerencias
Promotores con la capacidad de resolver problemas de salud (desnutrición, diarrea, etc.)	Promotores aprendieron a identificar señales de peligro del niño menor de cinco años y la mujer embarazada.	Continuar con las capacitaciones a promotores y comunidad.	
Promotores involucrados en el seguimiento de los niños desnutridos en forma conjunta con el personal de salud (micronutrientes)	El trabajo coordinado entre personal de salud y promotores ayuda a mejorar el estado nutricional.	Continuar con el trabajo conjunto. Personal de salud cuente con un stock de micronutrientes.	
Promotores de salud comentaron que antes del proyecto no cumplían con esquema de vacunación. No tenían centro de salud. Mujeres embarazadas acudieron a parteras.	Ahora con el proyecto se concientizó y existe demanda hacia el servicio de salud ya los niños cumplen esquema de vacunación, tenencia de CS y embarazadas acuden al servicio.	Personal de salud de continuación a crear esta demanda al servicio de salud.	

TEMA: ENFOQUE TECNICO
Grupo Entrevistado: Personal de salud
Número de entrevistas: 30
Número de grupos focales:

Logros, Resultados, Hallazgos	Lecciones Aprendidas	Recomendaciones	Otros comentarios y sugerencias
<ul style="list-style-type: none"> - Detección, captación y seguimiento de Enfermedades Prevalentes de en niños < de 5 años - Evita la morbi mortalidad infantil 	<ul style="list-style-type: none"> - No existe un registro de información de mortalidad 	<ul style="list-style-type: none"> - Continuar con el seguimiento capacitante a los Promotores - Incorporar en el SNIS el trabajo de los Promotores 	<ul style="list-style-type: none"> - Detección, captación y seguimiento de Enfermedades Prevalentes de en niños < de 5 años - Evita la morbi mortalidad infantil
<ul style="list-style-type: none"> - Detección, captación y referencia de pacientes - La información generada por el Promotor es incorporada parcialmente 	<ul style="list-style-type: none"> - Incremento de coberturas en: Vis. Dom. IRAS EDAS, Emb., y otros - Algunos servicio de salud incorporan la información del Promotor y por lo tanto el Promotor se siente motivado 	<ul style="list-style-type: none"> - Normar el uso de instrumentos de ref. y contrareferencia - Incorporar en el SNIS las actividades realizadas por el Promotor - Generalizar y normatizar en los Servicios de Salud la incorporación de la información del Promotor 	
<ul style="list-style-type: none"> - El SECI identifica, analiza, compara, prioriza y toma decisiones - Con referencia a la Desnutrición Infantil existen porcentajes 	<ul style="list-style-type: none"> - Permite identificar problemas de salud por la comunidad 	<ul style="list-style-type: none"> - Continuar fortaleciendo el SECI en diferentes niveles - Es primordial la responsabilidad del Personal en el seguimiento a los niños 	

Logros, Resultados, Hallazgos	Lecciones Aprendidas	Recomendaciones	Otros comentarios y sugerencias
elevados en las distintas comunidades		Desnutridos - Implementar y dar continuidad a los talleres hogareños	

TEMA: ENFOQUE TECNICO
Grupo Entrevistado: Save the Children y APROSAR
Número de entrevistas: 14
Número de grupos focales: 2

Logros, Resultados, Hallazgos	Lecciones Aprendidas	Recomendaciones	Otros comentarios y sugerencias
98% de niños vacunados y carnetizados.	Familias comprometidas en la vacunación de los niños.	Seguimiento y continuidad del personal de salud con el apoyo de los promotores.	
Disminución de la desnutrición de los niños menores de cinco años.	La solución para desnutrición se encuentra en las comunidades.		
Disminución de casos de IRAs, EDAs de niños menores de cinco años.	El rol del promotor y del personal de salud es indispensable para la disminución de la morbimortalidad de los niños menores de cinco años.	Continuar con los sistemas de información, educación y comunicación a la comunidad. Mejorar la calidad y acceso de los servicios de salud.	
Mujeres embarazadas acuden al centro de salud.			
Hacer abogacía para la incorporación de la información generada por el promotor al SNIS.			
Sistema de referencia funcionando, contrarreferencia no funciona.			

TABLA DE RESUMEN: ESTRATEGIAS

Logros, Resultados y Hallazgos	Lecciones Aprendidas	Recomendaciones	Comentarios
Manejo y conocimiento de las 3 estrategias de la mayoría del personal de salud del proyecto.	Para lograr éxitos, es necesario involucrar al inicio del proyecto a todos los actores del proyecto.	Hacer abogacía al nivel nacional y regional, la implementación de un proyecto.	Jefes de SEDES. REDES deben bajar al campo para conocer las estrategias. Hacer un estudio de cuantas personas han salido del área que estaba apoyando al proyecto.
Recuperación y valoración de los alimentos locales para el mejoramiento nutricional (EDP)	Los talleres hogareños permite a las familias otorgar cuidados integrales y reales a la comunidad en niños menores de cinco años.	Escribir un manual y guía para aplicar el EDP al nivel local.	
Comunidades incluyen en su agenda el tema de salud en reuniones comunitarias.	Población que conoce su problemas y necesidades en salud buscará el cumplimiento de sus derechos.	Continuar trabajando en comunidad que aún no han incluido salud en sus agendas.	
Comunidades cuentan con promotores capacitados.	La capacitación a promotores debe ir paralelamente al mejoramiento de la calidad de los servicios.	La información y capacitación es más efectiva si se la realiza a la mayor parte de los actores.	
Se acortan distancias entre personal de salud y comunidad.			
El SECI se adapta al nivel urbano solo en grupos organizados.	Para aplicar SECI urbano, necesariamente se debe hacer en grupos ya organizados.		

B. Key Indicators by District

	Percentages					
	Euca- liptus	Cha- llapata	APROSAR Huanuni	Low Intensity	Euca- liptus	Ch- llapata
Health card and growth monitoring						
% children who have a health card in the home or in the health center	97	95	92	95	95	99
% children who visited health center within the first week of life	40	47	46	46	91	99
Average # of times weighed in the past year	4.58*	4.58*	3.32*	4.19*	92	99
Vaccination and Vitamin A						
% of children ages 12-23 months with complete vaccination	70	53	60	66	46	49
% of children ages 12-23 months who received Vitamin A at least once in the past year	93	86	89	92	45	49
Breastfeeding						
% of children ages 0-5.99 months exclusively breastfed yesterday	64	54	68	75	22	29
% of children ages 0-5.99 months who are fed with bottle	18	25	9	13	22	29
Of children who have stopped breastfeeding, % who stopped after 12 months	67	100	90	33	3	19
Complimentary Feeding						
% of children 6-11 months who received other liquids than breast milk yesterday	81	88	87	88	27	29
% of children 6-11 months who received other milk than breast milk yesterday	37	31	17	38	27	29
% of children 6-11 months who received food yesterday	96	100	100	100	27	29
% of children ages 20-23 months who are still breastfeeding	89	50	63	50	9	19
% of children ages 6-23 who are fed using a bottle	32	21	21	30	73	79
Diarrheal Disease						
% of children ages 0-23 months with diarrhea in the past two weeks	31	29	26	29	95	99
% of caregivers who gave more liquid than normal during diarrhea episodes	50	65	56	60	26	29
Pneumonia knowledge and service use						
% of caregivers who have asked for advise regarding cough	87	80	68	71	95	99
Of those who asked for advice, % who asked hospital staff	87	88	89	78	83	79
Of those who asked for advice, % who asked a health Promoter	19	8	22	11	83	79
% who mentioned fast breathing as a danger sign for Pneumonia	46	67	72	47	95	99
% who mentioned a sunken thorax as a danger sign for pneumonia	47	53	41	29	95	99
% who mentioned at least two valid danger signs for Pneumonia	57	74	81	50	95	99

*Number of times, rather than percentage

Discussion

Overall, the Wawa Sana program reached virtually all of the target coverage levels it set out to reach. The following table reports indicators set at baseline and their actual levels at follow up.

Key Indicators for the Wawa Sana program

Baseline target indicator	Revised target at Midterm	Baseline %	Follow up %	P- value
60% of 12-23 month olds have maternal history or card for measles immunization.	60% of 12-23 month olds have measles immunization measured by vaccine card	27%	65%	<. 0001
80% or more DPT3 coverage in infants in all CS-16 municipalities	60% coverage of DPT3 or Pentavalent3 in children 12-23 m measured by vaccine card in all CS-16 municipalities	32%	85%	<.0001
85% of 12-23 month olds with cards received 1/more Vitamin A capsules in last year.	50% of 12-23 month olds received 1/more Vitamin A capsules in last year as verified by card	64%	85%	<.0001
75% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD.	50% of mothers of 6-23 month olds with DD in last 2 weeks report feeding increased fluids during DD.	24%*	59%*	<.0001
75% of mothers of children under 2 years report that help should be sought if their child has “fast and agitated breathing.”	40% of mothers of children under 2 years report that help should be sought if their child has “fast and agitated breathing.”	17%	62%	<.0001
50% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing)	25% of mothers of children under 2 years report that help should be sought if their child’s “thorax is sunken” (chest indrawing)	2%	47%	<.0001

*Percentages reported in the diarrhea treatment table in the results section were for all children ages 0-23, rather than children ages 6-23.

Conclusion

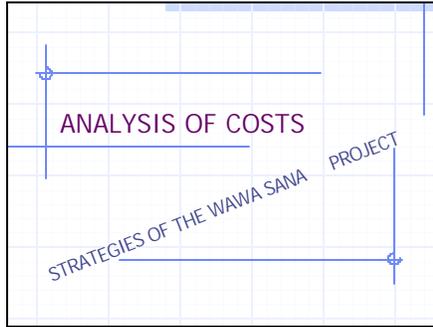
The Wawa Sana Project has achieved virtually all goals related to coverages of key child health services, maternal knowledge and home-based practices of childcare which formed part of its results framework. It can safely be assumed that these results will contribute to a better health status in children and to their survival.

Wawa Sana was built upon three strategic pillars: the community mobilization based on a community-based surveillance system (SECI), the CB-IMCI training of community health volunteers for both health promotion at the home or in public as well as early recognition and referral of child health problems and finally the Hearth model of nutrition intervention based on positive deviance inquiries.

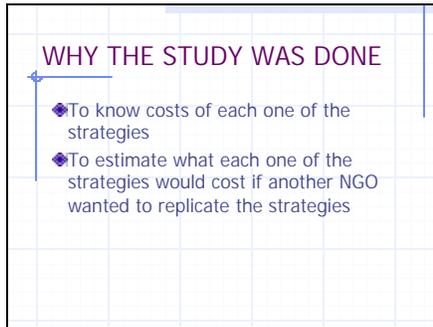
The qualitative evaluation work will have to pursue the finer distinction which of these strategies or the interaction between them was the most successful in contributing to the positive changes in the project area, and which of these changes might potentially be the most lasting ones.

ATTACHMENT E-2. Cost Study Presentation

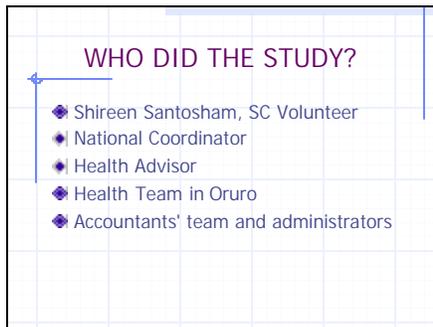
Slide 1



Slide 2



Slide 3



Slide 4

WHAT WAS TAKEN INTO ACCOUNT?

- ◆ Costs of implementation from October 2000 to October 2003
 - Personnel
 - Transport (motorcycles)
 - Materials + Mass Communication
 - Training + Group Communication
 - Of Save the Children staff
 - Of SEDES staff
 - Of promoters
 - Of mothers /fathers

Slide 5

THINGS THAT WEREN'T TAKEN INTO ACCOUNT

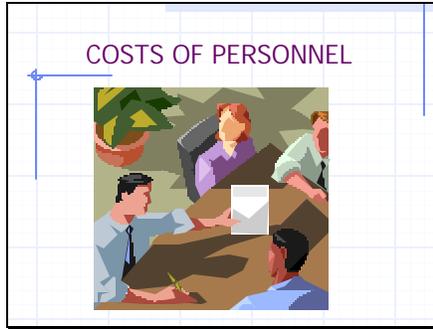
- ◆ International costs
- ◆ Costs of the La Paz office (except 50% of National Coordinator)
- ◆ Office costs (rent, electricity, office supplies, computers etc.)
- ◆ Transportation costs

Slide 6

PRESENTATION OF RESULTS

- ◆ IN \$US
- ◆ Rounded
- ◆ Total
- ◆ Per strategy

Slide 7



Slide 8

A slide titled "RESULT: ANNUAL PERSONNEL COSTS" with a list of bullet points and associated costs.

- Personnel for programs of any size ● 94.110
- Facilitators: depends on the size of the program: 1 per 10 communities, average 2.870 inhabitants ● 5.830 per facilitator
- Consultants: a single time, production of radio messages and analysis of nutritional data ● 1.650

Slide 9

A slide titled "Total costs of personnel for SC" with two bullet points.

- ◆ \$US 450.000 for 3 years
- ◆ \$US 150.000 per year

Slide 10

COST OF PERSONNEL PER STRATEGY

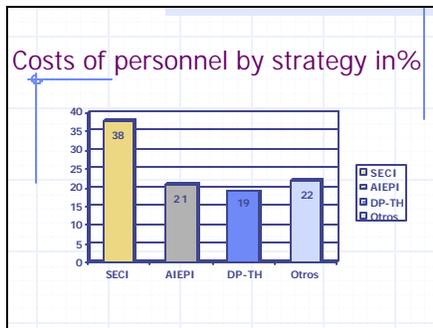
- Based on interviews, staff estimated the time they spent (days per month dedicated to one or another strategy)
- This method was not very valid, since people gave different estimates when asked again

Slide 11

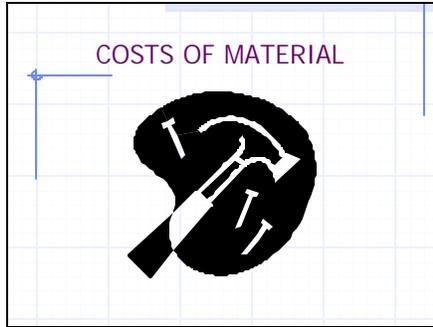
Costs of personnel by strategy

• SECI	• \$US 57.430
• Community IMCI	• \$US 30.310
• Radio Consultant	• \$US 1.220
• Positive Deviance-Hearth sessions	• \$US 27.720
• Nutrition data consultant	• \$US 430
• Other (activities , multi-program, SNL)	• \$US 33.390

Slide 12



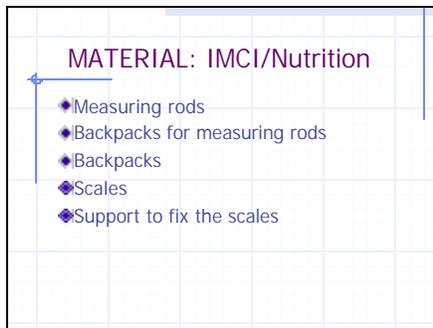
Slide 13



Slide 14



Slide 15



Slide 16

MATERIAL: PD/Hearth	
◆ Pots	
◆ Pans	
◆ Covers	
◆ Plates	
◆ Vitamin TO	
◆ Pictures of foods	

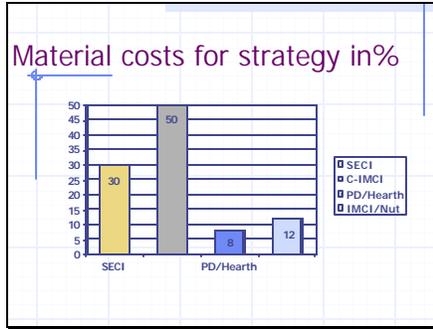
Slide 17

MATERIAL: SECI	
◆ Manuals	
◆ Flags with paper dolls	
◆ CD's	

Slide 18

RESULTS: COSTS OF MATERIALS	
◆ Community IMCI	↓ 10.270
◆ IMCI/Nutrition	↓ 2.560
◆ Positive Deviance/Hearth	↑ 1.560
◆ SECI	↓ 6.150
◆ Total	↓ 20.540

Slide 19



Slide 20



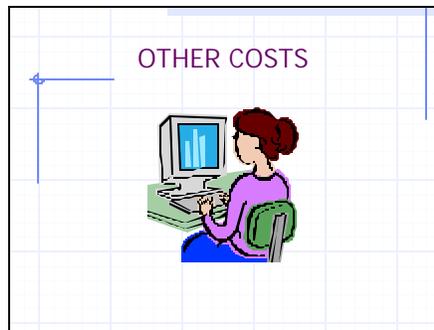
Slide 21

- ### Training costs
- ◆ Materials for workshops
 - ◆ External facilitators
 - ◆ Workshops
 - Food
 - Lodging
 - Transport or transport reimbursement

Slide 22



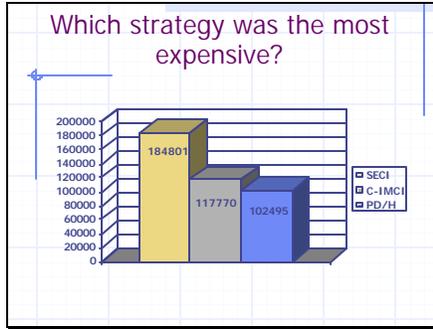
Slide 23



Slide 24

- ### OTHER COSTS
- ◆ 1 Computer =
 - \$US 1.530
 - ◆ Annual maintenance =
 - \$US 108
 - ◆ 1 Motorcycle per facilitator =
 - \$US 3.344
 - ◆ Gasoline, annual maintenance =
 - \$US 2.050

Slide 25



Slide 26



Slide 27



ATTACHMENT E-3.

List of Documents Reviewed

AIEPI Comunitario Componente del Hogar y la Comunidad: Manual del Voluntario de Salud. Bolivia- 2003. Ministerio de Salud y Deportes, Seguro Universal Materno Infantil, USAID y Save the Children.

Analysis of Costs of Wawa Sana Strategies. (Presentation by S. Santosham, 2004).

Baseline Institutional Study: Health Services Staff Survey Sedes/APROSAR. Save the Children/US, Bolivia Field Office. 2000.

Boletín Estadístico” Gestión 2003, Oruro Bolivia, Ministerio de Salud y Previsión Social, Servicio Departamental de Salud Oruro, Unidad de Planificación, Departamento Estadística.

Bolivia CS-16 Final Evaluation, KPC Survey. 2004.

Child Survival and Health Grants Program, USAID/GH/HIDN/NUT Final Evaluation Guidelines. August 2004.

Cost Analysis for Child Survival-16, Shireen Santosham, Intern SC/B, 2004.

Informes Trimestrales: Wawa Sana. Save the Children. 2001, 2002, 2003 y 2004.

“La información en el Sistema Epidemiológico Comunitario Integral (SECI)” por Ccoya Sejas and Carolina de Hilari in *J and G Revista de Epidemiología Comunitaria*. No. 21, Julio-Diciembre 2002.

Manual para Promotores de Salud: Lactancia Materna y Alimentación Complementaria en Menores de 2 años. PROCOSI y LINKAGES. Bolivia, 2003.

Memoria del Seminario “Conceptos, metodologías e instrumentos para el trabajo de salud en la comunidad”. Buena Vista, 12 al 14 de Junio, 2003.

Mobilizing Communities and Health Services for Community-Based IMCI: Testing Innovative Approaches for Rural Bolivia. Save the Children/US CS-16 Application to USAID/BHR/PVC. 1999.

Monitoreo Actividades Wawa Sana (Monitoreo y Seguimiento SECI, Planificaciones Conjuntas, Cobertura de Vacunaciones Pentavalente 3), 2001-2004.

Qualitative Study on Health and Nutrition Practices Using Focus Groups: Districts of Eucaliptus, Huanuni and Challapata. Save the Children/US, Bolivia Field Office?.2000.

Reglamento, Organización Funciones: DILOS. Ministerio de Salud y Previsión Social, Resolución Ministerial No 0446. 7 de Agosto de 2003.

Wawa Sana: Mobilizing Communities and Health Services for Community-Based IMCI: Testing Innovative Approaches for Rural Bolivia. Bolivia CS-16 Detailed Implementation Plan. April, 2001.

Wawa Sana: Mobilizing Communities and Health Services for Community-Based IMCI: Testing Innovative Approaches for Rural Bolivia. Report of the Bolivia CS-16 Midterm Evaluation prepared by Renée Charleston, 2002.

Instruments and Forms:

For Families:

Carnet de Salud para Niños Menores de 5 Años

For Promoters:

AIEPI Comunitario Componente en el Hogar y la Comunidad: Para el Niño o Niña Menor de 2 Meses y la Embarazada (Hoja de Revisión 1).

AIEPI Comunitario Componente en el Hogar y la Comunidad: Para el Niño o Niña de 2 Meses a Menor de 5 Años (Hoja de Revisión 2).

AIEPI Comunitario Componente en el Hogar y la Comunidad: Para el Desarrollo Físico y Mental del Niño o Niña Menor de 2 Años (Hoja de Revisión 3).

AIEPI Comunitario Componente en el Hogar y la Comunidad: Para la Prevención de Enfermedades, Accidentes y Maltrato (Hoja de Revisión 4).

Bandera de la Salud, Presentación de Indicadores de SECI en tela para niños menores de 5 años y mujeres embarazadas.

Hoja de Referencia y Contrareferencia AIEPI Comunitario Mayor de 2 Meses a 5 Años.

Promotor de Salud: Formulario de Monitoreo Comunitario
Consolidado Formulario de Monitoreo Comunitario

Test Promotores Wawa Sana, August 2004.

For Save the Children Staff:

Cronograma Mensual de Actividades.

Evaluación del Personal: Formulario de Evaluación del Personal.

Formulario de Planificación Conjunta Proyecto Wawa Sana.

Formulario de Informe Programático Mensual.

Guía para la Evaluación Mensual de Desempeño en Visitas Domiciliaria

Proyecto Wawa Sana: Informe Taller.

Resumen de Planificaciones Conjuntas Programa Wawa Sana: Sistema Epidemiológico Comunitario Integral.

Seguimiento en Capacitaciones a Personal de Salud, Promotores y Líderes.

ATTACHMENT F
Project Data Sheet Form – Updated Version

Child Survival Grants Program Project Summary
Final Evaluation Submission: Nov-02-2004, SC/Bolivia

Field Contact Information:

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Project Information:

Project Description:	<p>The CS-16 project involves four child survival interventions: Nutrition and Micronutrients (30% of intervention-specific effort), Pneumonia Case Management (30%), Control of Diarrheal Disease (20%), and Immunization (20%). SC will document the feasibility and results of implementing these four interventions through three innovative approaches to child survival in Bolivia: (1) Community-Based-IMCI (CB-IMCI), focused on training and supporting volunteer Rural Health Promoters to provide selected child survival services in their communities, based on the PAHO CB-IMCI materials recently adapted for Bolivia, while supporting concurrent MOH implementation of IMCI at health facilities; (2) The Hearth model using a Positive Deviance approach (H/PD) to sustainable community-based rehabilitation of malnourished children and prevention of malnutrition, building on SC's recent experience piloting H/PD for the first time in Bolivia and building on SC's success with this approach in other countries. If successful and cost-effective in CS-16, H/PD has good potential for "uptake" by other organizations and reducing childhood malnutrition in other areas of Bolivia. (3) The Community Epidemiology Surveillance System (SECI), recently developed by SC/Bolivia to promote joint collection, analysis, and use of health information by health providers and communities to address local health needs, will be scaled-up through CS-16 based on SC's initial success in ten communities of rural Oruro. SECI has great potential for improving utilization of health services on a large scale in Bolivia, if the approach continues to be successful and feasible following implementation throughout the CS-16 site.</p>
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Partners:	SC will work with four CS-16 partners: the site's three MOH Rural Health Districts, and a Bolivian NGO, APROSAR.
Project Location:	Oruro Department is located on the Altiplano, south of La Paz. The CS-16 site includes two entire Rural Health Districts and most of a third RHD: District I, Huanuni, District III, Challapata (excluding the area of Cacachaca in the east of the RHD, and the municipality of Salinas in the west), and District V, Eucaliptus.

Grant Funding Information:

USAID Funding:(US \$)	\$1,000,000	PVO match:(US \$)	\$1,000,000
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Target Beneficiaries:

Type	Number
0-59 month old children:	13,500
Women 15-49:	0

Beneficiary Residence:

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

General Strategies Planned:

Advocacy on Health Policy
 Strengthen Decentralized Health System
 Information System Technologies

M&E Assessment Strategies:

KPC Survey
 Organizational Capacity Assessment with Local Partners
 Organizational Capacity Assessment for your own PVO
 Lot Quality Assurance Sampling
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change and Communication (BCC) Strategies:

Mass Media
 Interpersonal Communication
 Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HO (CS)	Local NGO	(None)	Dist. Health	CHWs

unit) Field Office HQ CS Project Team		Selected)	System Health Facility Staff	
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Interventions:

Immunizations 20 %
Nutrition 30 %
Acute Respiratory Infection 30 %
Control of Diarrheal Diseases 20 %