

*Andean Rural Health Care*

*Follow-on of Census-Based Impact-Oriented Child  
Survival Services in Three Rural Areas of Bolivia*

*Annual Report*

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## **SUMMARY**

The third year of the ARHC Child Survival (CS) grant has been a busy one for ARHC and Consejo de Salud Rural Andino, CSRA, our partnering organization in Bolivia. In December 1999, ARHC/CSRA completed a Mid-term Evaluation of the project, with complimentary remarks of the progress being made, and an annual program evaluation in the each project site. In January 2000, CSRA wrote their annual operating plan for the year, including indicator goals to achieve by the end of calendar year 2000.

During the past year ARHC experienced some staff changes in the headquarters office. Sara Lewis Espada, the Bolivian Program Manager, left the organization in September to take a position with another international health institution, INTRAH. Craig Boynton joined ARHC in June as the International Program Director, and he has been backstopping the program with the departure of Sara. Since joining ARHC, Mr. Boynton has been to Bolivia and participated in the CSRA mid-year evaluations in July.

Dr. Javier Baldomar, former CSRA Project Director in Puerto Acosta, returned to Bolivia in May after completing a master's degree in public health in Mexico. He has been rehired by CSRA as the Technical Manager, and Dr. Maria Elena Ferrel remains as the CSRA Operations Manager. Dr. Ferrel also recently completed her coursework for a public health degree from the Bolivian university, Universidad Nur.

ARHC/CSRA continue to focus on sustainability of the program in the project sites. The local municipalities have budgeted to support the local health programs, and most of the monies have been disbursed. The one exception has been the municipal government of Ancoraimes. In October, CSRA and the Ancoraimes municipal government evaluated the health service activities in the municipality and reached a new agreement that calls for CSRA to continue to provide health care services in the area, and the local municipality will provide promised financial support. ARHC/CSRA will continue to monitor the progress of the new agreement and advocate for prompt and timely disbursements of the funds.

The Bolivian MOH continues to provide most of the health care workers in the project sites. Almost all of the community health workers and nurses receive their salary support from the MOH. However, the MOH has changed their system of providing medical doctors to the rural areas. Before, new medical graduates were assigned to rural areas for one year as residents, and this supplied most of the rural areas with medical doctors, albeit inexperienced medical doctors. The current system is to send new medical graduates to the rural areas for six months, and to hire another doctor as an Area Manager. The Area Manager is hired on a three-year contract and, in theory, has more experience than the recently, graduated residents.

Finally, ARHC/CSRA is working diligently to provide quality health care in the sites on the altiplano of Bolivia and to save the lives of the local people. Based on the mid-year evaluations in each site, and the most recent statistics from the CSRA health information system, the CS objectives are on track for most of the interventions. In December,

CSRA/ARHC will conduct the annual project evaluations and set program intervention objectives (based on the CS 13 DIP and recent achievements) for the upcoming calendar year.

### 1. Progress towards program objectives

<b>Objectives</b>	<b>Achieving Progress towards the objectives</b>	<b>Comments</b>
Increase % of children with all vaccinations: 12-23 months 12<= 15 months	Yes	
Maternal TT coverage (at least 2 doses) for all pregnant women	Yes	CSRA measures coverage rates for second doses of TT among women of childbearing age (15-49 years of age), thus the percentages are much lower than they would be among just pregnant women. However, among the two sites where TT coverage rates of pregnant women is measured (Puerto Acosta and Ancoraimes) the rates are in line with the third year goals of the DIP. In Carabuco the TT rates to women of childbearing age were very low in July (3.5%), but have since risen to 12% thanks to a concerted effort by the health workers to reach the women through home visits and community education.
Proportion of mothers who recognize at least one danger sign of dehydration (dry mouth, sunken eyes or fontanel, and decreased urine output)	Yes	
Proportion of mothers who: -have heard of ORT -understand use of ORT -can properly prepare ORT -used ORT recently	Yes	
Proportion of mothers who give equal/more liquids during diarrhea (excluding breastmilk)	Yes	
Increased maternal awareness of pneumonia danger signs (rapid/difficult breathing and/or chest indrawing)	Yes	
Increased proportion of mothers who seek care for ALRI symptoms from trained health personnel	Yes	

<b>Objectives</b>	<b>Achieving Progress towards the objectives</b>	<b>Comments</b>
Proportion of infants and children receiving appropriate schedule of controls (0-23 months = 6 times/year)	Yes	
Proportion of infants receiving first control before completing first month of life	Yes	
Increase proportion of infants and children with control card in home and/or clinic	Yes	
Provide intensive nutrition education and follow up to mothers/caretakers with children under two with moderate and severe malnutrition	Yes	
Increase proportion of malnourished children under two enrolled in "Hearth" nutrition rehabilitation sessions	No	We have found that the implementation of the "Hearth" methodology has not worked in our Altiplano sites. The caretakers did not want to participate in the rehabilitation sessions, and those that did wanted to be financially compensated for their participation which is against ARHC and CSRA's principles.
For malnourished children receiving "Hearth" nutrition rehabilitation sessions, measure % of children with an increase in weight for age Z score of 0.3 or larger	No	CSRA presently is preferentially selecting malnourished children less than 24 months of age and their caretakers to participate in a nutritional counseling program with the community health workers. In this intervention strategy, the caretakers and child receive home visits every 15 days from a community health worker who provides growth monitoring of the child and nutritional counseling to the caretaker.
Increase exclusive breastfeeding of infants through first six months of life	Yes	
Increase proportion of children beginning solid foods 6-10 months	Yes	
Provide Vitamin A supplements to children following MOH norms	Yes	
Increase proportion of women receiving Vitamin A after delivery	Yes	
Increase proportion of women receiving 3-month supply of iron sulfate tablets during pregnancy	Yes	

<b>Objectives</b>	<b>Achieving Progress towards the objectives</b>	<b>Comments</b>
Increase the proportion of pregnant women receiving at least one prenatal care visit	Yes	
Increase the proportion of pregnant women delivering in the presence of a trained person	Yes	
Increase proportion of follow-ups for high-risk obstetrical cases following MOH norms	Yes	On target in all the project areas except for Puerto Acosta, where it is low (56% in July 2000). Staff mentioned that follow-up is weak because neither MOH nor CSRA has a policy or norm for follow-up of high-risk pregnancies.
Monitor maternal deaths through verbal autopsy methodology	Yes	
Increase percentage of women using modern family planning methods (pill, IUD, injections, foams/gels, condoms)	Yes	In the rural, highland sites where this project is taking place, the local population has not accepted most methods of contraception for many cultural and religious reasons. However, with the introduction of Depo-Provera as a MOH endorsed method, contraceptive acceptance has increased and the number of users is increasing.
Increase percentage of women using natural methods of family planning (rhythm and LAM)	Yes	
Increase fee-for-services by 25%	Yes	CSRA believes that they have been successful at increasing income from fee-for-services activities, and that they are on target to achieve the objectives outlined in the DIP. However, Bolivia is currently experiencing a severe economic recession, and the ability to maintain increasing income from these services is in doubt.
Increase municipal funds of local health services from 3% to 20%	Yes	In most municipalities we have been very successful, although the disbursement of funds sometimes is delayed.
Increase regional government funds by 15% by year four	Yes	

**2. What factors have impeded progress towards achievement of objectives and what actions are being taken by the project to overcome these constraints?**

During the month of July, Craig Boynton, Andean Rural Health Care (ARHC) International Program Director, travelled to all the project sites and participated in the Consejo de Salud Rural Andino (CSRA) mid-year evaluations. In October 2000, Mr. Boynton returned to Bolivia and discussed CS XIII progress with the Project Site Directors, Dr. Maria Elena Ferrel, CSRA Operations Manager, and project staff.

Two times during the past year Bolivia has experienced major social conflicts that have made health work difficult. In April and September 2000, there were conflicts between the Bolivian people and the government throughout most of Bolivia, but particularly close to our project areas in La Paz. The rural Bolivians, “campesinos”, declared a national strike and road blockade in protest of various issues. Along the road from the city of La Paz to our project sites the campesinos were very active in establishing blockades that prevented access to the health centers and posts. In fact, in one municipality close to Ancoraimes there were major clashes between the civilians and Bolivian military and police that left civilians and Bolivian government forces dead. These protests and blockades drew many of our clients away from the area to join the protests, and/or prevented the health staff from visiting the dispersed communities and performing their scheduled activities.

Since the protests are directed at the Bolivian government and not our activities, ARHC or CSRA clearly can do nothing to resolve these matters. However, CSRA/ARHC has a strong relationship with the community leaders and members that minimize the tension that may be directed at the project staff. This allowed the health workers to reach clients in an emergency during the conflicts. Understanding that these conflicts and protests are likely to be repeated in the coming months, ARHC/CSRA continues to maintain strong relations with the community organizations and leaders to diminish the possibility of violence directed toward our workers.

In the last year there have been some problems working with the local health districts that are managed by Departmental Health Unit staff (SEDES). Previously, SEDES placed recently graduated medical students in the field to complete a twelve-month residency program. These were mostly inexperienced doctors who, for the most part, did not care to be placed in a distant and remote, rural area. This system has now been replaced. Its’ replacement system is to place a more experienced Area Manager (a MD, who may have just finished his obligatory residency requirements) in the field on a three year contract, and to place new resident doctors for a maximum of 6 months. Inherent in the system is a high turnover of MOH-assigned medical doctors to the areas, and difficulty in training them in the CSRA projects and Census-Based, Impact-Oriented methodology (CBIO) being implemented in the areas. A strategy to improve consistency of care in the areas has entailed hiring doctors that have completed their residency in our program sites as our program site directors. We also encourage the newly placed doctors to participate in CBIO methodology activities (verbal autopsies, home visits, and community analysis) and provide orientation to the methodology.

The Carabuco project has experienced some problems with the SEDES Area Manager. For example, verbal autopsies of children under 5 and women of childbearing age are part of the CBIO methodology that ARHC and CSRA use. During one verbal autopsy analysis, it was concluded that a woman died a preventable death from eclampsia because the SEDES MD misdiagnosed the symptoms. The staff, to try to improve training and diagnosis skills among the medical personnel to lower rates of preventable deaths in the future, had used this as a case study. However, the district health representative was

offended and declared that he was not responsible and did not incorrectly diagnosis the patient. At the time this caused great tension among the community health workers, who are employed by MOH or CSRA, and the MOH assigned doctors. The Carabuco Project Site Director has had to spend much of his time managing conflicts between the different parties, as well as administrating project activities.

In Puerto Acosta, we have had a better experience in the relationship with the district health office. CSRA Project Site Director, Dr. Ramiro Llanque, is a previous SEDES district representative in Chuquisaca Department and has been able to negotiate with SEDES to also represent them as the Area Manager, in addition to his role with CSRA. This has given CSRA more control over local personnel management in the area and direct responsibility to SEDES for our performance.

Bolivia is implementing the Seguro Basico de Salud, or Basic Health Insurance. The insurance covers maternal and child health, and some infectious disease control (tuberculosis and malaria are a couple of examples). The local health posts are required to report the services that they provide that are covered by the insurance, and they are reimbursed the costs by the local municipal government according to a set rate. However, the disbursements of monies are not always on time and CSRA staff spends a lot of their time trying to secure their disbursements. CSRA continues to maintain an open dialogue with the municipal leaders in each of the project sites in hopes of improving disbursement schedules of the funds.

In July, a municipality near Carabuco experienced an outbreak of measles and the SEDES representatives ordered the Carabuco community health workers (CHW) to the area to assist the local staff in vaccinating there. Although this was not a service area covered by CSRA, most of the CHW's are employed by SEDES/MOH and were sent to control the outbreak. These outbreaks and MOH priorities pull staff away from their established annual plans and activities, which may influence our coverage rates. CSRA project site directors have a strong relationship with the SEDES representatives and try to share the importance of the CSRA activities to reduce the amount of time that the health workers are pulled away from their scheduled activities. Yet, since the majority of workers are MOH/SEDES employees we do not have full control of their responsibilities.

ARHC/CSRA continue to have problems with the Ancoraimes municipal leaders, and the municipality has not been providing financial support to the project as expected and promised. Nathan Robison, CSRA Executive Director, and Dr. Franz Trujillo, Ancoraimes Project Site Director, are in continual negotiations with the municipal leaders to ensure their support and commitment. In October, they met again with the municipality to secure the funds from prior commitments and to assess the current relationships. According to Dr. Trujillo, the Ancoraimes municipal leaders have promised to disburse the funds. In light of the fact that this has been a repeated occurrence in Ancoraimes, CSRA/ARHC is evaluating the relationship and assessing the possibility of withdrawing from the municipality upon completion of the CS XIII project.

### **3. In what areas of the project is technical assistance required?**

Both CSRA and ARHC have identified as a priority the need for technical assistance in assessing local NGO organizational capacity. Currently, CSRA is going through a restructuring process including identifying their values and vision for a new long-term strategic plan. This is being carried out with the assistance of an ARHC Board Member, and a local, Bolivian management consultant. The process has been slow, but profound, for our counterpart.

There is strong concern from ARHC that CSRA may be administratively heavy (local administrators, accountants, logistics support), yet CSRA denies this. Technical assistance in conducting job function analysis and productivity analysis would be of importance to determine appropriate staffing needs and increase cost-effectiveness within CSRA. Assistance from USAID, CSTS, or an outside consultant are to be explored by ARHC.

### **4. Describe any substantial changes from the program description and DIP that will require a modification to the cooperative agreement. Discuss the reasons for these changes.**

Previously, CSRA hired a nutrition specialist to identify appropriate rehabilitation strategies in the field projects. The nutrition rehabilitation methodology that they tried was the “Hearth methodology”, described in the DIP. The strategy relied on peer training and positive deviance to affect behavioral changes among the participants. The nutritionist identified locally available and appropriate nutritious foods and worked with mothers who had malnourished children providing nutritional counseling and training on a regular basis through demonstrations. The nutritionist also worked with a community mother who had a child growing optimally and together they provided classes to the other selected mothers on preparing inexpensive, nutritious foods.

According to the health workers this approach wasn’t successful as it required too much of the mother’s time and took away from her other duties (such as tending animals, working in the fields, and taking care of the other household chores). The nutritionist said that there was no sense of “community” among the participants and that the mothers did not want to gather to do this. According to the nutritionist, the mothers thought it was a way for them to make money or to receive compensation for attending the training even though it was carefully explained that these were voluntary, unremunerated activities designed in the best interests of the malnourished child. Nevertheless, once sessions began, mothers frequently complained that they should be compensated financially to continue attending the training sessions. There is a local culture of “me das algo, te doy algo” (You give me something, I’ll give you something), which also influences maternal behaviors.

CSRA presently is preferentially selecting malnourished children less than 24 months of age and their caretakers to participate in a nutritional counseling program with the

community health workers. In this intervention strategy, the caretakers and child receive home visits every 15 days from a community health worker who provides growth monitoring of the child and nutritional counseling to the caretaker.

**5. For each of the recommendations made in the mid-term evaluation, please provide a thorough discussion describing the activities that are being undertaken to implement each recommendation.**

*a) Immunization coverage is very high in Carabuco/Ambana and Ancoraimes, but the proportion of children fully-covered needs to be increased in Puerto Acosta during the remainder of the project.*

The project-set immunization full-coverage projection for this calendar year in Puerto Acosta is 74.1% (based on past performance and trends over the last months), and at the end of September 56% of the children were fully covered. This is still lower than the other project areas but higher than the goals set out in the DIP (55% year 3). Puerto Acosta has increased community outreach and home visits to the villages by the health workers to further increase the coverage rates. In the communities that are censused, the CHW's visit the communities on a regular schedule. In the communities that aren't yet censused, CSRA has a mobile health team that visits the community every couple of months, which is less frequent than the censused communities, and actively promote the utilization of the health posts and centers. Also, during quarterly evaluations, CSRA/ARHC identify workers and health posts that have lower coverage rates and focus on improving their coverage. This is done through re-training and supervision of the workers, as needed.

*b) Growth monitoring has been very successful in terms of initiating early contact with health care providers and promoting regular contact where malnutrition as well as other problems can be addressed. Growth monitoring should be continued during the next two years of the project.*

The CSRA health workers continue to provide growth monitoring in an integrated fashion in the field and in clinic settings. Based on the CBIO methodology, ARHC/CSRA has records and maps of the children under 5 years of age in each community, and scheduled dates for their next growth monitoring. These frequent contacts with clients ensure that we monitor the nutritional status of children and identify other problems that may be present.

*c) The strategy for improving the nutritional status of malnourished children is not working as well in some areas as others and should be revisited, perhaps using focus group studies to involve the communities in developing an acceptable strategy or identifying barriers to the acceptability of the present strategy.*

The project sites have started a new strategy to improving nutrition in the program sites. Each health worker identifies two or three malnourished children and their families to participate in a intensive-counseling program. Follow-up is provided to the families and

the child on a routine basis of one home visit every two weeks. During these visits the health workers monitor the child's weight, provide appropriate nutritional counseling including recommended strategies to increase weight gain (i.e., adding oil to the child's food), and schedule follow-up visits with the family.

Also, last year an anthropologist, along with a Fulbright scholar from the US, conducted an ethnographic study on health practices in our altiplano sites. CSRA has contracted with the anthropologist to develop appropriate strategies, including improving nutritional practices of the local population, based on the results of the study.

*d) The pneumonia case management strategy is weak. Efforts should be increased to train volunteers and mothers in how to recognize danger signs and when to bring children to a health facility. Communities should be prioritized according to whether there is good detection of pneumonia cases and efforts intensified in those communities with poor detection or child deaths due to pneumonia.*

CSRA has developed a strategy to increase ALRI education towards families in each of the project areas. The CHW's and some health volunteers are focusing on providing more education to families during their home visits, and are using their health education folders that they carry with them during their community visits. The staff feels that the best way to reach the people with messages is through personal contact and visits. In addition, community education is being provided during meetings with local community groups such as women's clubs.

*e) Prenatal care and follow-up for pregnant women at-risk needs to be strengthened through such means as monthly reviews of the list of registered pregnant women, increased information sharing between clinics and the community-based program, community censuses, pregnancy testing at health posts, and comprehensive health education from the beginning of pregnancy. Criteria for high-risk should also be reviewed.*

CSRA has a set of criteria to identify high-risk pregnancies, based on MOH guidelines. However, follow-up of high-risk cases isn't defined either by the MOH or by the health workers and must be improved. In the project sites, the CHW's and other health workers have begun to improve their monthly revision of records of pregnant women and make home visits to the identified women of high-risk for follow-up monitoring and care.

*f) The information system needs to be modified to report contraceptive acceptance rates.*

CSRA uses the MOH SNIS monthly-information reporting system since they work directly with the MOH. The SNIS HIS has been computerized but does not take into account contraceptive acceptance rates. However, the SNIS reporting forms do measure the number of new users of modern contraception and this is what CSRA report on a monthly basis.

*g) Health education given to school-aged youth should be expanded.*

Over three days at the end of April, CSRA sponsored a workshop on implementing FP/RH among schools in the Altiplano service areas. Each project site sent two health workers to the workshop that was facilitated by Save the Children/Bolivia. The CSRA attendees learned about Save the Children's pedagogy techniques, which have been appropriately adapted to the Bolivian culture. Our Puerto Acosta project site has since implemented the program into their work with the Bolivia School of Iquipuni, and the other project sites have scheduled to increase their education presence among the local schools as well.

*h) Mothers forget messages that are not repeated. More repetition of health messages is needed in the communities.*

We have intensified the number of fairs in the communities where the health workers provide health education to the local populations. In addition, CSRA and CRECER have joined to provide microcredit and health education to community groups (mostly women, but some men). During the CRECER-sponsored microcredit meetings, a CHW will provide health education sessions to the participants using materials that CSRA and/or CRECER have developed. CSRA has also stepped up the number of educational sessions with local community groups such as women's clubs using flipchart and other educational tools. Most of the focus during the community education sessions has been on maternal and reproductive health.

*i) The project needs to clearly determine its strategy for working with volunteer health promoters and develop a consistent policy toward incentives across project areas.*

Nothing has been developed here to date as ARHC/CSRA continue to decide what is the best practice of using health volunteers. The matter has been deferred to CSRA to establish a consistent policy but without results. For various reasons CSRA has not been able to successfully maintain health volunteers using non-monetary incentives, and sees the current strategies as non-sustainable. Mr. Boynton will continue to promote the standardization of a health promoter policy among CSRA during routine telephone conversations and country visits, but does not foresee any progress in this area over the coming year.

*j) Communication needs to be improved, to the extent possible given the conditions, between the La Paz headquarters and the field offices as well as in the field between members of the facility-based health teams and the volunteers and communities.*

Based on the remoteness of the field offices, ARHC and CSRA do not see any affordable means to improve communications between La Paz and the field sites. Each main municipality has access to a telephone and the health centers have radio for contact with La Paz headquarters, yet these are not always reliable for a variety of reasons (i.e. power shortages, interference). Electronic mail still has not reached most rural communities in Bolivia, and is presently not available where we work.

Communication between the CHW's and the volunteers and communities has increased. The health workers have increased visits and contacts with the community volunteers (where they exist) and to community groups. In Puerto Acosta, mobile health teams visit non-censused communities on a regularly scheduled basis (usually once every two months) and provide basic PHC, child survival and health education.

CHW's and volunteer promoters frequently accompany each other during their routines and visits to communities and homes. This provides regular contact between the two and allows the CHW to observe the services offered by the health volunteer (and vice versa).

Finally, feedback is provided to the communities and leaders through monthly local meetings and quarterly evaluations. CSRA encourages the participation of local representatives in the monthly Information Analysis Committee (CAI, initials in Spanish) meetings when the health teams present activities and results from the last month. CSRA holds quarterly evaluations, and an annual evaluation in December, and encourages the participation of community leaders and representatives. It is at this time that the results of their work are analyzed and new strategies are developed.

*k) Although program management is strong, especially financial management, written manuals should be developed for policies and procedures.*

CSRA has developed an Internal Regulations manual. Included in the manual are CSRA's administrative and personnel policies and procedures. In addition, CSRA has recently developed a Health Information Systems manual that includes all of the MOH and CSRA reporting forms. Directions for completing the forms have also been developed. Currently, CSRA is in discussions with SEDES on adapting the manual and some of the CSRA complimentary forms among other SEDES districts.

*l) The logistics system is relatively weak, compared to other management systems. External technical assistance is needed to improve this system.*

Recently, the Bolivian MOH established a new logistics project that is being implemented in ARHC/CSRA program sites. This new project has established rotatory funds for each community health post, and the health worker is responsible for managing these funds to supply her post with the needed medical and pharmaceutical supplies. The project has taken us out of the logistical loop for securing the supplies in our area since the worker is responsible for purchasing her own supplies in La Paz. It is our belief that this is a positive development since each health worker is responsible for managing her own health post. However, there exists the possibility that these funds may be mismanaged. ARHC/CSRA will monitor the implementation of the project in their program site areas to ensure appropriate use and administration of the funds, and will try to identify any assistance that they may be able to offer the health workers to guarantee successful implementation.

*m) The census-based information system has produced reliable data. The project should continue to conduct censuses in willing communities.*

ARHC/CSRA continue to census the willing communities in all of our project sites. All of the communities in Carabuco have completed censuses and Ancoraimas will be finishing their communities by the end of November 2000. In Ambana, 19 of 36 communities have been censused and they have more communities scheduled for the rest of the year. And in the communities of Puerto Acosta, 19 of 113 communities have been censused to date. Here, the censuses have moved slower since they are working with a new model to census communities that is based on active community participation in the process and overall community development, including the formation of strong community leaders (discussed more in question 6). As it focuses strongly on overall community development and not just improving health care, the process is more profound and time-consuming for the workers and community members. ARHC and CSRA are planning to conduct an investigation next year on the impact of this methodology within the communities where it is being implemented.

*n) USAID should assist CSRA in identifying external technical assistance, perhaps through centrally funded projects, in order to improve the logistics system as well as to conduct special studies.*

There has been no progress made here with the local USAID mission directly. However, CSRA is a member of PROCOSI, and they actively participate in the workshops and technical assistance PROCOSI sponsors. Also, as mentioned above, the MOH has implemented a new, decentralized logistics procurement system in our program areas. CSRA is still trying to define their role in the new system to ensure that the health posts and centers are administered and stocked appropriately.

*o) The CSRA sustainability strategy is being successfully implemented. The strategy of increasing support from the municipalities and the regional MOH should continue while beginning to discuss a transferal plan of the project to the government in Carabuco Municipality. Discussions should begin early in 2000, as soon as the new municipal government is in place, to ensure a smooth transition at the end of the project.*

During 2001, CSRA plans to begin discussions with the Carabuco municipal leaders regarding the role and responsibility of the municipality in managing the local health system. Nathan Robison, CSRA Executive Director will be responsible for the activities, along with other key members of the CSRA staff. However, ARHC and CSRA believe that non-profit organizations such as ours can continue to play an important role in the management of the health systems, either as contracted health administrators or consultants to the local municipality.

*p) The present strategies for capacity building within the public sector have been very successful and should be continued. The planned courses in teamwork should be delivered in the field, with appropriate follow-up, to maintain the momentum of these successful efforts.*

Presently, CSRA is going through an organizational restructuring and strategic plan development. They have contracted with a local management consultant in Bolivia who has been working with the CSRA staff on their vision, values and mission for themselves and the organization. This has been a soul-searching experience for the organization as they identify where they want to go as an organization. At the heart of their values they identified teamwork within the organization. CSRA continues to emphasize teamwork within their work, and in the field they stress collaboration among health workers from different institutions, community volunteers and leaders to achieve results. Project directors and field supervisors will continue to stress the inclusion of all health personnel in planning activities and evaluations.

*q) CSRA should continue to explore areas of collaboration with other NGOs, such as PLAN International in its sponsored communities and with Intervida's school-based program.*

CSRA has established relations with PLAN International in Ancoraimés Municipality. In the communities where PLAN International is present, PLAN supports CSRA's work with donations of supplies and funds to purchase items such as safe birthing kits and educational materials. In addition, PLAN has financed training workshops for the health workers of the municipality. CSRA and PLAN will continue to work together and maintain ties of collaboration for future activities.

CSRA/ARHC has begun coordinating with CRECER and Freedom From Hunger, microcredit and development organizations, in Carabuco to offer joint microcredit and health services to local families. This project will expand to our other service areas this year through a recently approved USAID Matching Grant to ARHC.

In Puerto Acosta, Ambana and Carabuco, Intervida, a Spanish NGO, is providing a broad range of services to many of the same communities in which CSRA is providing services. One of the services that they offer is a nutrition program for the local population. In some communities they are donating foodstuff such as milk and fortified cookies for school children. However, the foodstuff do not reach what we consider to be the high risk child (9-24 months of age) since these children are not of school age. In other communities, Intervida has a "conejo" program (guinea pigs) to improve local protein intake. The CSRA Puerto Acosta staff reports that Intervida has a nutritionist in the office in Puerto Acosta. To date no services have been coordinated and the relationship between Intervida and CSRA is not strong. One of the self-proclaimed reasons for the strained relationship is that CSRA staff does not support the concept of food give away programs. However, CSRA remains open to the possibility of collaborating in order to improve the nutritional status of the population and the local project directors are in contact with their Intervida counterparts.

**6. Identify and provide an analysis of an important issue, success, new methodology, or new process that would be of interest to the greater development community.**

An important issue for both ARHC and CSRA is the Community Epidemiological Surveillance System (SIVIECO, in the Spanish acronym) currently being pilot-tested in the Puerto Acosta Municipality. This system compliments ARHC/CSRA and our CBIO methodology, but with a much stronger community participation component. It relies on full community acceptance and participation of the methodology. The main steps in the process are:

- a) Promotion of the CBIO methodology and signed agreement to work in the community
- b) Community, if interested, accepts (if not, CSRA continues to offer health services but with mobile health teams and without censuses)
- c) Community and CSRA send a request to begin services to the local health authorities
- d) Plan census activities
- e) Community census and health problems detected
- f) Results shared with the community
- g) Formation of community group that is responsible for analyzing:
  - i) Diagnosis and prioritization of the health (epidemiological) problems
  - ii) Joint planning to tackle the identified problems
  - iii) Execution of activities to solve the identified problems
  - iv) Progress of activities is evaluated
  - v) Repeat the process

SIVIECO is a continual process that identifies community problems, and attempts to solve the problems with full community participation. During the analysis process, natural leaders of the groups are identified by CSRA personnel and offered to receive training as community health volunteer promoters (or as we call them, health leaders), including training in leadership. The leaders are the community members responsible for community health education, referral of sick patients to health posts or the health center, vital event's registration and vigilance, and assist in identifying local health problems.

The communities that agree to participate in the program receive monthly visits from a mobile health team, and home visits from community health workers. Those local communities that don't participate still receive visits by the mobile health team but less frequently. They also don't have the presence of a trained community health leader, nor do they receive home visits from the CHW's.

Both CSRA and ARHC are interested in the results of this methodology and any impacts that it has had on the health status of the local populations. We are planning on conducting an evaluation of the program in August 2001, and sharing the results with the larger PVO community.