

**INMED Partnerships for Children
Asociación Benéfica PRISMA
INMED Andes
Ministry of Health - Ucayali Health Region**

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ACRONYM LIST

- AIEPI –Spanish acronym for IMCI (see below)
- BCC – Behavior change communication
- BF – Breast feeding
- CHW – Community Health Worker, Health Promoter, Community Agent
- DIP – Detailed implementation plan
- DIRESA – Dirección Regional de Salud (Regional Health Direction), highest local health authority in Ucayali, reports to Ministry of Health
- FONDAM – Fondo las Americas (“The Americas Fund”)
- HBLSS – Home Based Life Saving Skills
- IMCI – Integrated Management of Childhood Illnesses
- IMNCI - Integrated Management of Newborn and Childhood Illnesses
- INMED – INMED Partnerships for Children, US based international non-profit organization
- INMED Andes – INMED affiliate in Peru
- IR – Intermediate result
- MAMAN – Minimum Activities for Mothers and Newborns
- MOH – Ministry of Health
- MOU – Memorandums of understanding
- MTE – Midterm evaluation
- PIN – Programa Integral de Nutrición, a program that grants food staples each month at the health centers and health posts to participating mothers
- PRISMA – Asociación Benéfica PRISMA, operating non-governmental organization in Peru
- PVL – Proyecto Vaso de Leche (“Glass of Milk Project”), a government sponsored, community-level mother’s group that provides a daily glass of milk or an alternative, nutritional food item for all participating children
- SIS – Seguro Integral de Salud, the social health insurance for children, pregnant women and indigent people offered by the Peruvian state and administered through Ministry of Health health facilities
- TA – Technical Assistance

EXECUTIVE SUMMARY

The Healthy Babies Project, “Bebes Sanitos”, managed by a collaboration between INMED Partnership for Children, based in VA with its affiliate in Lima, INMED Andes, and the Asociación Benéfica PRISMA, with its main office in Lima and regional office in Pucallpa, in conjunction with the Ministry of Health (MOH), aims to improve the health status of mothers and newborns in the Ucayali region of Peru by increasing the use and quality of maternal and newborn care provided by the MOH, community health workers (CHWs), and traditional birth attendants. This is being carried out through four main intermediate results:

- IR1. Increased knowledge and practice of maternal and newborn care seeking behavior
- IR2. Increased quality of maternal and newborn care services in health facilities and the community
- IR3. Increased availability/access to maternal and newborn services in health facilities and the community
- IR4. Improved policy environment for maternal and newborn care

Despite significant obstacles associated with the project implementation, the progress and outcomes achieved are substantive and technically strong. Specifically, in the first 18-24 months of the project, the project team participated in the initial baseline data collection and presented the results to key players, as well as prioritized activities; 11 memorandums of agreement were written and signed by the Regional government, the Regional Health Direction (DIRESA, which reports to the MOH), and 9 municipalities; 14 training sessions on Minimum Activities for Mothers and Newborns (MAMAN) and 5 training sessions on Integrated Management of Childhood Illnesses (IMCI) have been conducted with health personnel, 8 trainings and 17 educational sessions have been done with community health workers (CHWs), and 16 educational sessions have been carried out with expecting/new mothers; training materials were translated and culturally validated or, in few instances, developed from scratch; health education materials were developed or are being finalized, with an appropriate materials development process; technical assistance has been provided to 102 facilities; and there have been numerous meetings, especially in Lima, to create an improved policy environment for maternal and newborn care.

Findings from the evaluation team regarding the impact of the project so far are very positive. The interviews and focus groups conducted with participants at all levels – from participating mothers to health personnel to health officials – reveal that people are very pleased with the project and the way it has been implemented. Namely, the project has used a very collaborative and participatory approach with all involved, from planning stages to conducting trainings. Health officials praised the project team describing that the Healthy Babies project has supported the health officials’ needs for training and priorities, and as a result, the health officials have been willing to support the efforts of the project. The health officials have also been so impressed with the quality of the training, that as they state themselves: “the training techniques used by the PRISMA team were an instrument in themselves. We would like them to teach us these methods so that we can apply them in our trainings.” One health official remarked that she was struck by the change in the organization of the medical charts in one of the health facilities following the technical assistance visit of one team member. It is a compliment to the project that the main complaint from the CHWs was that they want more trainings, on more topics, and want more health education materials (particularly the popular “laminated picture cards”). Most importantly, there is a

strong sense of ownership about the project, which will be key when focusing on efforts to make the project sustainable. Regarding policy, and as part of collaborative work the Project Director has been involved in (starting even before this project was funded), newborn health is now considered a national health priority.

The quantitative results associated with knowledge change are also strong, especially considering the short time frame of this project. When comparing pre- and post-test results for participants who attended trainings and educational sessions, we observe a statistically significant increase in knowledge on every item on the tests. It is important to mention that a Rapid Catch Survey was not conducted at mid-term, and though we estimated percentages for certain indicators measured at baseline using data from TA/supervision visits, the sampling design and population sampled is different. Hence, the percentages could not be compared statistically. Nonetheless, the data presented for the various indicators reveal potential tendencies and changes happening in these communities, pointing specifically to improvements in knowledge.

However, there have been significant challenges that have affected the project's ability to meet all its expected activities. Some challenges are inherent to the region: in 2008, there have been 3 DIRESA directors (the highest local health authority for the region); Pucallpa has been paralyzed for at least 34 days due to three strikes in this year (and is in the midst of a fourth one as this is written); during the non-rainy season, the river flow is very low, making it extremely difficult for the Healthy Babies team to reach the health facilities in the remote rural regions – a large proportion of the facilities.

The most significant obstacles relate to the funding; specifically, 1) the reduction in funding received from USAID in the second year, 2) the decision to utilize in-kind and line-item specific cash contributions as a way to support activities, and 3) the management of the funding. The Healthy Babies team had planned on incremental spending of funds, but the funding cut impacted them at a very critical time in this project: all materials and trainings were ready, but there was little money to roll out the trainings on a large scale. In the same time period, the value of the dollar decreased, coupled by an increase in fuel and local salary costs, impacting again on the level of activities they could implement, as detailed later in this report. In addition, the initial plan proposed matching the USAID funds with in-kind donations as well as cash donations. Though the team worked hard – writing to and visiting at least thirty potential donors – it is difficult to rely on projected in-kind and cash contributions to implement a project, especially in the early stages of the project. More than half of year one focused on preparing the DIP, translating materials, training staff, signing Ministry agreements, etc., so there were few tangible outcomes to present to potential donors in year two. The prospects for the next two years are much better: with good results to show, in-kind and cash contributions should be easier to obtain; and in this third year of the project, funding from USAID is for the full amount budgeted. However, the cut in funding during the second year of this project, when activities needed to be implemented fully, will likely impact the project's ability to reach its aims associated with health care access and use, since activities to address these have barely begun, and have focused so far on the improving quality of care (by training providers), but no work has been done on improving women's access to facilities nor on regional policies to develop feasible and sustainable strategies for this region. Finally, long term planning was impossible without information regarding the total annual distribution of funds that would be available for the various activities. Specifically, at the start of the second year, the Project Director had less money to rely on from USAID than had originally been approved in the DIP, and matching funds and in-kind contributions that had been obtained were inflexible and additional

match amounts and designations uncertain, making long term planning for project activities very difficult.

In summary, the evaluation reveals a project of excellent quality that is obtaining significant changes in the area of maternal and neonatal health, especially with regards to knowledge. But, as the project enters its last two years, recommendations are as follow:

- Discuss and update the project work plan to ensure that all specified project activities are still feasible and desirable. As the project has progressed, it is evident that some proposed activities may not be optimum strategies any more (such as the emergency transportation plans and the maternity waiting homes), but new strategies have emerged that should be discussed among project management, updated on the workplan and worked towards.
- Update grantee partner information now that INMED-Andes, the INMED affiliate in Peru, has obtained all licenses and registrations as a Peruvian NGO.
- Key personnel from all collaborating partners, INMED, its local affiliate INMED Andes, and PRISMA, should meet annually to discuss the exact funds received from USAID for the year, prioritize the activities to be accomplished based on the funding, and designate specific amounts of the budget for the different expenses (i.e., salaries, training, materials, transportation, etc) that will go to the different institutions for planning purposes. Any changes to the programmed amounts (i.e., new in-kind contributions) should be informed to key personnel involved. Knowing the full obligation for year 3 should facilitate this, but the uncertainty of how matching donors designate will designate their contributions is still a factor.
- The new Project Director (the former one has recently stepped down), working closely with the INMED financial director, should have a clear plan for managing the funding to be used on project activities for the year, including options for matching funds, which are less predictable..
- The Project Director and Project Management need to ensure that a large proportion of the budget is spent on operationalizing the project activities in Pucallpa now that all the materials and strategies have been approved by the government.
- Now that most activities associated with IR1 and IR2 are in progress and that a positive collaboration has been established with the community and its leaders, training activities should continue as initiated, but emphasis should be placed on regional policy work and strategies for long term sustainability of the project (IR3 and IR4).

Summary of Impact Model Elements

Inputs	Activities	Outputs	Outcome	Goal
BCC materials and radio spots development and production	Placement of BCC materials in health centers and community (via CHWs)	1 poster on birth plans distributed; 8 ready to be printed	Increased % of women who recognize 3 newborn danger signs, from 2% to 48.5%**	Improved health status of mothers and newborns in Ucayali
	Launch radio spots	9 radio spot messages developed, but not aired yet		
Training curriculum developed and implemented	Train health providers as trainers	416 health providers trained (including trainers)	Increased % of women who breastfeed within 1 hour of birth, from 52% to 79.5%**	
	Health providers train other providers and CHWs	289 CHWs trained		
Monitoring, supervision and TA to health facilities	Assessments of quality of care during TA visits to health facilities	494 mothers at educational sessions*	Increased births attended by skilled attendant (actually decreased from 78% to 69.4%)**	
	CHWs do census to identify & work with expecting/ pregnant women	Increased % of health providers that follow MOH policy guidelines, from 0% to 52.6%**		
Work with local government on policy friendly to maternal and neonatal health	Meetings and 11 MOUs signed with government	Increased % of pregnant women with birth plans (actually decreased from 21% to 17.5%)**	Increased institutional births (actually decreased from 79% to 63.8%)**	
	Formation of community boards to plan & implement emergency transportation systems	Increase access of women to health facilities through emergency transportation systems (no change actually observed: from 0% to 0%)		
		Distribution of MOH policy manuals at health facilities where lacking (not done yet)		

*This is the total number of participants at all educational sessions; some mothers may have attended more than one session and thus been counted more than once.

**Indicators not comparable statistically due to different sampling design at baseline and MTE.

ASSESSMENT OF PROGRESS TOWARD PROJECT OBJECTIVES

1. Results: Technical Approach

A. Brief Overview of the Project

The Healthy Babies project, managed and implemented by the partnership of INMED Partnerships for Children, its affiliate in Lima, INMED-Andes, and the Peruvian non-governmental organization (NGO), Asociación Benéfica PRISMA (PRISMA), in conjunction with the Ministry of Health (MOH), is currently taking place in 9 of the 14 districts of Ucayali, a Peruvian state in the Amazon region. The nine districts are Calleria, Campo Verde, Iparia, Masisea, Yarinacocha, Nueva Requena, Padre Abad, Irazola and Curimana. Within the project area, there are 150 MOH health centers and health posts and two hospitals serving approximately 388,067 people living in 567 communities. The goal of this community-based project is to improve the health status of mothers and newborns in the target area by increasing the use and quality of maternal and newborn care provided by the MOH personnel, community health workers, and traditional birth attendants. The project works with each of these actors to achieve the following 4 intermediate results (as stated in INMED DIP 2007):

- IR1. Increased knowledge and practice of maternal and newborn care seeking behavior
- IR2. Increased quality of maternal and newborn care services in health facilities and the community
- IR3. Increased availability/access to maternal and newborn services in health facilities and the community
- IR4. Improved policy environment for maternal and newborn care

The DIP outlines the strategies proposed to meet these intermediate results. For IR1, a behavior change strategy is in progress that focuses on the topics of maternal and neonatal care; preparation of birth, transportation and emergency birth plans; delivery by a skilled birth attendant; antenatal visits; recognizing danger signs during pregnancy and in the newborn; taking iron supplementation; breastfeeding within the first hour of birth; exclusive breastfeeding and hand washing. Implementation of this strategy proposed the use of radio spots, dramas, culturally appropriate picture cards and education from MOH personnel, CHWs, TBAs, strategic placement and distribution of health education and promotion materials, and the promotion of community advocacy groups for breastfeeding.

For IR2, training in Neonatal IMCI and HBLSS was proposed, and the IMCI trainings have been initiated, for MOH health personnel, CHWs and TBAs. A health personnel check list, using the MOH policy standards as a guideline, has been developed. Technical assistance is being provided to health facilities in the form of improved supervisory system visits. Gaps in service quality are being identified by observation, client interviews and review of clinical history forms. Breastfeeding support groups will be trained in breastfeeding techniques, solution of problems, and counseling skills.

For IR3, the project plans to promote the establishment of emergency transportation systems in the target communities. These systems will involve community support, improved birthing facilities, increased supplies and a maternity waiting home close to one of the hospitals in order to increase access to care.

For IR4, the project has been working, with the community’s involvement, to foster adequate implementation of existing MOH policies for maternal and newborn care and promote related policies. The project is also working on promoting policies at the local government level, and working at the national level to establish sound maternal and neonatal care policies.

B. Summary M&E Table

This table displays the most important results from the project to date (see Annex 4 for full table).

Objective	Indicators	Baseline Estimate	Midterm Estimate	Target	Explanation or Reference
IR1. Increased knowledge and practice of maternal and newborn care seeking behavior	% pregnant women know 3 danger signs in pregnancy	45%	56.7%	75%	KPC; Supervision Survey
	% women who recognize 3 newborn danger signs	2%	48.5%	45%	KPC; Supervision Survey
	% women who breastfeed within one hour of birth	52%	79.5%	70%	KPC; Supervision Survey
	% women who have a complete birth plan	21%	17.5%	60%	KPC; Supervision Survey
IR2. Increased quality of maternal and newborn care services in health facilities and the community	% of women who have a delivery with a skilled attendant	78%	69.4%	88%	KPC; Supervision Survey
	% women who receive iron/folate suppl during pregnancy and 3 months afterwards	56%	81.6%	80%	KPC Health center and health post records
	% health providers that correctly follow MOH policy guidelines	0%	52.6%	85%	Supervision survey: observation & checklist
IR3. Increased availability/access to maternal and newborn services in health facilities and the community	% of district municipalities with emergency transportation system in place	0%	0%	80%	Health center, Health post & Municipal records

	% health facilities that have supplies for birthing and maternal and neonatal emergencies	25%	39.2%	80%	Supervision Visits: Observation
IR4. Improved policy environment for maternal and newborn care	% children with birth certificate	42%	82.1%	80%	Municipal records, KPC, Supervision survey
	% women and children registered in the government health insurance system	65%	88.3% (children) 92.9% (pregnant women)	85%	Municipal records, KPC

*This was defined as the percentage of establishments that follow at 50% of the MAMAN policies. Out of the 11 possible points for MAMAN, those with 6 points were counted as following policy.

C. Workplan Activity Status Table

The following table is a representation of the project workplan activities and the status of those activities to date. The activities are organized by the objectives presented by each of the four Intermediate Results.

Objective:		Objective Met:
IR 1:	<i>Increased knowledge and practice of maternal and newborn care seeking behavior</i>	<i>In progress</i>
	Activities	Activity Status
1	Conduct BCC strategy: Develop radio messages, posters, picture cards and CHW dramas (practice with stakeholders) with consistent messages for: <ol style="list-style-type: none"> i. comprehensive birth plans (incl. transportation & emergency plans) ii. messages to encourage women to breastfeed within 1 hour of birth iii. pregnant women and mothers of infants wash hands routinely to prevent spread of disease iv. recognizing danger signs during pregnancy v. recognizing danger signs in the newborn vi. taking iron supplementation 	In progress: <ul style="list-style-type: none"> - Laminated picture cards have been developed, but are currently only available for training purposes. - Comprehensive birth plan poster has been developed, field tested and distributed at all 150 health centers and posts. - Posters for the remaining 8 messages are currently in draft form, having been validated in Ucayali. - Radio messages are currently under development, validation of the text of the messages is complete. - CHW dramas are done during the training sessions, and will be done as outlined for the mothers' trainings.

	vii. exclusive breastfeeding viii. pre-natal care visits ix. institutional delivery	- Flyers with selected messages have also been developed and distributed.
2	Air messages on radio, publish posters and cards and distribute	In progress: - Only the birth plan poster has been published and distributed to some health facilities, and in October, was distributed to CHWs for home visits. - The laminated picture cards have been distributed for training only (see item IR1- 1 above).
3	Review messages based on midterm results	In progress: Incorporation of recommendations from validation session into the messages is currently in progress.
4	Insert messages into CHW and HW trainings (including dramas) for: <i>List of i – ix, as numbered in activity 1 for this section.</i>	Complete: However, the need to further reinforce hand-washing messages has been identified by the project staff.
5	Supervisory visits and observation to ensure that health personnel and health promoters are appropriately promoting: <i>List of i – ix, as numbered in activity 1 for this section.</i>	In progress: Related to health personnel: Technical Assistance has been given to 102 (out of 150) health facilities to ensure MAMAN is being implemented by health personnel. Related to CHWs: Supervisory visits and observation carried out only in San Fernando
6	Review data from supervisory visits and observation compare to mid-term results and make necessary changes to the checklist.	Incomplete: Following results from mid-term evaluation
7	Develop support groups for breastfeeding in each micro-network	Incomplete: Support groups established in 2 health centers: San Fernando and Neshuya.
8	Educational sessions for pregnant women and mothers at PVL groups and MOH nutrition program meetings.	In progress: Educational materials have been developed. 16 educational sessions for PIN and PVL mothers have been held in 4 health centers: San Fernando, Neshuya, Aguaytia and Campo Verde. (Total participants at all sessions: 494, but some are repeated since they might have gone to session on different topics.)
	Objective:	Objective Met:
IR 2:	<i>Increased quality of maternal and newborn care services in health facilities and the community</i>	<i>In progress</i>
	Activities	Activity Status
1	Preparation of HBLSS and neonatal IMCI training materials in Spanish and pilot	Partially complete: Neonatal IMCI training materials have been

	testing	developed and validated. <i>Note: The three HBLSS manuals were translated into Spanish and one of them was adapted for this community. The team is in process of deciding a plan of action regarding HLBSS training and use.</i>
2	Training of Trainers for HBLSS	Incomplete: HBLSS training has not been implemented – <i>see note in activity 1 above.</i>
3	Training of Trainers for IMCI	Complete: Conducted in November 2007.
4	HBLSS and IMCI Training of Health workers (10 locations): HBLSS for rural locations IMCI for peri-urban locations	In progress: 5 IMCI training done with health personnel (55 participants); <i>re: HBLSS: see note in activity 1 above..</i>
5	Refresher courses in HBLSS and IMCI (10 locations)	In progress: Refresher courses conducted on IMCI topics that remained unclear in 2 locations: San Fernando and 9 de octubre.
6	Training of CHW's in IMCI or HBLSS (peri-urban vs. rural)	In progress: 8 IMCI training done with CHWs (total 180 participants) <i>HBLSS: see note in activity 1 above.</i>
7	Community Board Orientation (10 municipalities)	Incomplete: Community boards not yet formed; due to funding issues, work on this item will not begin until January 2009
8	CHW's conduct on-going census, visits to home births and education of pregnant women in communities and refer them to health facilities – BCC dramas conducted – calendar for visits made for each woman	In progress: Of the 289 CHWs that have been trained, about 30% have been supervised and are currently known to be doing home visits and census activities. Because team has not been able to supervise in other communities, they do not know if others have done census or home visits yet.
9	CHW's and health workers draw up birth, transportation and emergency plans with women and their families	Incomplete: - Health center personnel currently working with mothers on birth plans (observed during TA visits) - CHWs will start with mothers on birth plans in April 2009 - transportation and emergency plans might change due to feasibility
10	Develop and review the Comprehensive Health Worker Checklist – appropriate for pre-natal, labor and post-partum.	Complete: This checklist has been developed and is starting to be used in TA visits to health facilities.
11	Supervise health worker use of checklist – using interviews and observation compare to results of mid-term results. <i>Note: Due to the number of communities and health facilities, supervisory visits are performed in continual rounds.</i>	In progress: 102 health workers have been supervised using the checklist, and ongoing supervisions are expected.
	Objective:	Objective Met:
IR 3:	<i>Increased availability/access to maternal and newborn services in health facilities and the community</i>	<i>Very limited progress</i>

	Activities	Activity Status
1	Meetings with municipalities and community leaders to develop transportation and emergency plans <i>(Emergency meetings will be held where necessary if systems fail)</i>	Incomplete: Due to financial constraints this activity will not begin until January 2009. Also, unclear whether emergency transportation plans are feasible strategy.
2	Visit to Maternity Waiting Homes in other regions to assess feasibility and model for Ucayali	Incomplete: Maternity waiting home in Huanuco visited. Ongoing discussion regarding feasibility in region.
3	Identification of deficiencies and improvement of birthing facilities, equipment and supplies at the health post level – through the Data Quality Committee using as a baseline the analysis of the Maternal and Child focused Rapid Health Survey – with verification of improvements during supervisory visits	In progress: Data collected at 102 health facilities between October 2007 – September 2008, and follow up data has been gathered from supervisory visits. Data Quality Committee has not been formed yet because of personnel changes, but it is being coordinated with the DIRESA.
4	Develop plan with partners for a maternity waiting home – depending feasibility plan	Incomplete: Feasibility plan not yet complete. In addition, funding constraints impeded a proper assessment by PRISMA/INMED as to how much money they can offer for this process.
5	Secure donation for construction and supplies – if that is the preferred method according to the feasibility and model chosen.	Incomplete: Pending feasibility plan results, possibly reassess strategy. Pending proper assessment of project's ability for financial contribution.
6	Secure volunteers who offer use of a room of their home, close to the hospital, for maternity waiting home clients.	Incomplete: Pending feasibility plan results. Reassess strategy.
7	Evaluate the maternity waiting home strategy and provide recommendations for the future.	In progress: This item is in the planning phase; maternity home in Huanuco visited; contacts made with Pathfinder. Reassess strategy.
	Objective:	Objective Met:
IR 4:	<i>Improved policy environment for maternal and newborn care</i>	<i>Very limited progress</i>
	Activities	Activity Status
1	Workshop with regional and central level MOH and PAHO to incorporate neonatal IMCI into IMCI. Improvement of Community IMCI manual with more maternal and neonatal content	Complete: Workshop held in November 2007. Participation in neonatal health group work in Lima to improve policy environment for maternal and newborn care; contribution to develop a package of validated interventions in neonatal health that will be launched in Dec. 2008.
2	MOH incorporates HBLSS into policy for rural areas.	Incomplete: HBLSS training not implemented, but discussion needed to determine next steps related to HBLSS.

3	Distribution of MOH policy manuals – refresher workshops in health posts and health centers and updates	Incomplete: - Refresher workshops will begin in 1/09. - Printing and distribution of MOH policy manuals within Ucayali to start this fiscal year.
4	Municipalities adopt emergency transportation plan as their own – through community boards	Incomplete: Community boards not yet formed. Reassess strategy.

Cross-Cutting Activities Across Objectives:		
	Activities	Activity Status
1	Share baseline KPC findings with Lima based NGO and local mission stakeholders	Completed May 2007
2	Complete Rapid Health Assessment with Iparia and Masisea	Completed Sept 2007
3	Conduct CSSA with MOH	Held 1 planning meeting with local groups to take on project activities upon closure of “Health Babies”
4	Complete focus groups and in depth interviews in Masisea and Iparia.	Completed (baseline data collection April 2007)
5	Organizational Assessment – INMED Andes Peru and PRISMA	Completed in June 2007
6	Visit Future Generations project in Cuzco – Peru	Incomplete, though there were 2 meetings with FG in Lima
7	Anti-helminthic medicine distributed to all MEF and families with children under (2) 5 years of age.	Completed 2 campaigns: Sept 2007, May 2008.
8	KPC, Rapid Health Assessment, Focus groups and in-depth interviews at mid term.	KPC and rapid health assessment will not be conducted for midterm. Focus groups and in-depth interviews and quantitative data review for midterm evaluation complete.
9	Presentations of mid-term and final results to all project stakeholders	Pending finalizing the MTE report – in progress.
10	KPC, Rapid Health Assessment, Focus groups and in-depth interviews at final.	Pending end of project
11	Annual and final Reports due	Pending end of project
12	Capacity building in M&E for INMED and PRISMA	Incomplete: There has been no training
13	Formation and Meetings of the Data Quality Committee	Incomplete: No committees formed yet – but results were presented to DIRESA personnel and committee to be formed this Nov 2008
14	Management Information system implementation for data entry and analysis of data from supervisory visits in preparation for data Quality Committee meetings	Incomplete: no committee, so data currently being maintained by Pucallpa team
15	Mid-term and Final Evaluations	Pending

D. Progress by Intervention Area

The specific intervention areas for this project are maternal and neonatal care and breastfeeding. The interventions make use of the following key strategies:

- A behavior change strategy
- Training for community health workers and MOH health workers
- Community based strategies to improve access to quality services
- An improved policy environment.

The project’s progress is discussed below, and organized according to the main activities that correspond to each of the four IRs and key strategies.

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

Key Strategy: Behavior change

The activities towards the accomplishment of IR1 are in progress, and now that 1) most of the health education materials for behavior change have been drafted, validated and are ready for print, and 2) the training topics and materials for training expecting/new mothers and CHWs are developed and have been used, the project is in a good position to truly expand activities associated with IR1.

Despite the partial progress in implementing activities and the limited time frame to observe change (less than 2 years since some trainings have started), we observe increased percentages of women recognizing danger signs in pregnancy (from 45% to 56.7%) and newborns (from 2% to 48.5%), and a higher percentage of women breastfeeding within an hour of birth at midterm compared to baseline (52% to 79.5%) (see annex 4 for all indicators). Though it is important to point out that the sampling design and population sampled were different and percentages can not be compared statistically, among those sampled, some changes are striking, such as women’s recognition of danger signs among newborns. This dramatic change likely reflects the complete absence of health education available about newborns and their care previous to this project, and the fact that through this project, there has been increased awareness at the MOH about newborn health, and they have promoted this population’s health with other organizations as well. Small differences are impossible to interpret.

Main Activities 1 & 2: Preparation and distribution of health promotion material

The Healthy Babies work plan includes the creation of health promotion material for a behavior change campaign focused on nine target behaviors for maternal and neonatal health and breastfeeding. Proposed health promotion materials included posters, radio spots, picture cards and health dramas. The development of nine posters was planned to promote nine key health messages. To date, one poster on birth plan preparation was developed and distributed to all 150 health centers/posts in Ucayali region. Posters for the remaining 8 health messages have been drafted, validated in field, and are ready to be printed and distributed. The project also created a set of laminated “picture cards” illustrating key health promotion messages that are currently only being used for training purposes due to limited supply; hence, only health personnel have received these. These laminated cards, 8 ½ x 11 sheets, come in packages based on a theme: danger signs in the newborn, danger signs during pregnancy, birth plan, pregnancy care, and newborn care. They also depict two different scenarios for “Mariana”: one in which she uses family planning, goes to prenatal care when pregnant, and has a healthy and happy family; and one in which Mariana has many children, does not seek care while pregnant, and who starts bleeding during a pregnancy and

hemorrhages to death. Pamphlets for mothers promoting breastfeeding, danger signs at pregnancy, danger signs in newborns' first month, and newborn care were also developed and printed in Pucallpa. These pamphlets did not go through the rigorous development process – they were developed by the local project team, reviewed by the DIRESA maternal and child health director, and printed. These have been used and distributed by CHWs.

The behavior change strategy also includes the use of radio spots on each of the 9 health promotion messages. These are currently under development: the text to be used for the radio spots has been developed and validated in Pucallpa for content, and the next step is the voice recording. The completion of this activity has been slower than originally planned due to financial constraints; specifically, the radio spots are an in-kind contribution from a private company and its progress has been constrained by the company's timelines. However, this remains a priority for the project staff.

Preparation of most health education materials (with exception of the locally developed pamphlets), including the radio spots, has been appropriate: key messages were developed; the illustrations and text were drafted; these were validated with health professionals, CHW's and mothers in Pucallpa; and revisions were incorporated to the draft materials based on the validation.

The feedback obtained regarding the health education materials during the MTE was mostly positive. Urban and peri-urban health personnel mentioned that the poster illustrating the importance of a birth plan is “good because it is colorful” and the images are “helpful,” but they feel it should be bigger so that it is more visible from farther away. CHWs reacted to the birth plan poster positively as well, and suggested it be bigger and that the father accompany and help the mother more in the image. Beneficiary mothers who have seen the birth plan poster also commented that it should be larger and they would like to see it hung up in the community (in the streets, their homes). Health staff notice that the birth plan poster draws considerable attention from many women and incites comments and questions, but sometimes women are too shy to ask about the poster, or do not know who to ask. In all cases, health facility staff chose where to hang the birth plan poster, and most did so in the waiting area. They mentioned that some facilities have posters on newborn stimulation and breastfeeding, in addition to the birth plan. They are most likely referring to the posters donated by Johnson and Johnson to this project. In general, the staff would like to receive more posters.

Health staff working in areas being targeted for alternative development activities to reduce dependence on coca crops had different reactions to the birth plan poster, and to health promotion material in general. In Aguaytía, for example, the health staff expressed that there is great distrust in the community towards NGOs and USAID. Some parts of the population support NGOs, but others don't and consider those who do as betrayers. For this reason, the health center prefers that collaboration with these entities on health issues be “anonymous” or that the link between a project's activities and its source are minimized. Staff from health centers in these areas reported that they sometimes chose not to hang up posters with logos in the facilities. In the case of the birth plan posters, at one rural Aguaytía health center, staff chose to hang it in the exam room instead of the waiting area because of its prominent NGO and USAID logos. Despite this issue, health personnel participating in the focus groups expressed the desire to receive this poster, and others, at their various health facilities.

The laminated cards are very well-liked by all due to their clear visual representation on the topic. During MTE focus groups, the CHW expressed that these cards would be ideal for use during home visits to mothers, but there are not enough copies yet to give sets to all of the CHWs due to funding. Due to recent increased funding, these will be distributed to all CHWs as of FY09. At one urban health center, staff mentioned that they use the laminates every day with pregnant women, especially to explain breastfeeding and warning signs to go to the health center. A nurse at another

facility mentioned that she uses the laminated pictures as a rotfolio on her desk to show the patients. These laminated cards are also ideal in a setting with various native groups that do not speak Spanish.

The pamphlets developed were lower-budget and developed locally. These were developed out of necessity for a quick tool, but the process of development was not as thorough as the rest, and it is evident in the quality of the pamphlet: there is a lot of text and few images, as observed during MTE by the evaluation team, and stated by the CHWs and health staff.

In general, during the MTE interviews and focus groups, health personnel, CHWs and PVL leaders all asked for more materials. Specifically, health personnel and CHWs are anxious to receive sets of the laminated “picture cards”, which they insist will be very helpful during home visits and conversations with mothers to promote the target behaviors. Some health staff explained that in the absence of materials, they have been periodically lending the “picture cards” to some of the CHWs, but that this is not the ideal situation for the CHWs to conduct their community work in a regular manner.

During the MTE, interview and focus group participants made various suggestions for future health promotion material:

Content of future topics:

- Growth and development
- Basic hygiene
- Different types of foods to eat during pregnancy
- Adolescent pregnancy

Design issues for health materials:

- Larger posters, larger images

Media types for behavior change strategies:

- Audiovisual material to show mothers
- More pamphlets for mothers

Main Activity 3: Educational sessions held with mothers and CHWs

As part of the project, the PRISMA local team and trained facilitators hold educational sessions with CHWs and mothers to promote key components of maternal and neonatal care. To date, sessions with CHWs have mostly been conducted in the most accessible communities. In addition, talks with mothers have taken place within the context of the “Programa Integral de Nutrición” or PIN, a program working to improve nutrition for families by providing food packages to participating families, or the Programa Vaso de Leche (PVL). In both these cases, the project has taken advantage of having a captive audience of mothers to hold educational sessions (i.e., mothers coming to pick up food from program). The educational sessions last about 1 hour and cover one of the following specific topics:

- (i) Comprehensive birth plans (birth plans that include transportation and emergency plans)
- (ii) Breastfeeding within one hour of birth
- (iii) Pregnant women and mothers of infants routinely wash hands to prevent disease spread
- (iv) Recognizing danger signs during pregnancy
- (v) Recognizing danger signs in the newborn
- (vi) Taking iron supplementation
- (vii) Exclusive breastfeeding
- (viii) Pre-natal care visits

(ix) Institutional delivery

The following educational sessions have taken place:

Educational Sessions with CHWs and Expecting/New Mothers

Sector	# Sessions	# Communities	# Topics	Total participants
CHWs	17	8	7	289 participants*
PIN Mothers	11	1	7	208*
PVL leaders	5	3	3	286*

**Some participants may have attended more than once, so they may have been counted more than once, since they might have attended educational sessions on different topics.*

At the MTE, focus groups were held with attendees of the educational sessions (each group separately: CHWs, PIN mothers, PVL leaders). Overall, focus group participants were pleased with the content and delivery of the information. During focus groups with 6 urban and 2 rural PIN mothers, they reported that the information they had received was new to them. They talked about learning about the warnings signs in both pregnancy and the newborn. They appreciate that the topics they learn about help them avoid diseases and death and are important messages for the mother, baby and family. And, mothers mentioned changing certain behaviors, such as exclusively breastfeeding and preparing proper pap for the baby when it is ready to eat (“mashed potato mixed with liver or meat”).

Regarding the teaching methods used at the education sessions, mothers appreciated the exchange of information that occurs and that they are allowed to give their opinions. The talks make use of “health dramas” or role-plays (which are quite popular), and validated visual materials developed by the team. They suggest, however, that these sessions be conducted in rooms with more privacy to avoid distractions. One possibility discussed with the project management team in the presentation of MTE results was to use homes or school infrastructure for these sessions to reduce the distractions and interruptions. As for the educational materials, mothers would like to see videos (“something audiovisual”) and to receive more copies of the pamphlets so to distribute themselves in their communities. In general, participating mothers expressed they would like more materials for their homes to show their neighbors and husbands. This willingness to take initiative in the dissemination of information reflects well on the BCC methodology of the project. Moreover, this is important to consider because many women must convince their mothers or mothers-in-law that these new behaviors are appropriate: these materials may help them explain to others who influence what the mothers will actually do.

Urban participants of the educational sessions mentioned they would like to see the following topics included or discussed at greater detail:

- Cervical cancer prevention
- Breast cancer
- Vaccinations
- Breastfeeding
- Nutrition for babies after weaning, recipes
- Keeping one’s family healthy in general

Rural participants described interest in the following topics:

- Most common illnesses for babies < 1 year (prevention and when to go to the health center)
- Family planning after birth

PVL coordinators/leaders in some communities (another captive audience of mothers) also received educational sessions. These women also spoke positively about the content and delivery of the sessions. They described learning new, interesting and important topics. Specifically, they were unaware of the importance of prenatal visits and presence of skilled attendants at birth. This led to a discussion in one focus group of the recent death of a pregnant woman in her community, and one PVL leader emphasized “we should not have more maternal deaths.” Another important point that emerged at the MTE was that the PVL leaders, upon receiving a series of educational sessions from the project, have been inspired to disseminate this information themselves. They see it as their role to educate mothers about health topics, especially nutrition, and during a focus group discussed ways to incorporate information from Healthy Babies into the PVL routine. For example, they are considering having talks with mothers when milk is distributed. The project can leverage the PVL leaders’ initiative and social capital to further diffuse BCC messages in the future.

Currently, these educational sessions are only being conducted with mothers in the context of PIN (at the health center) and PVL (mostly leaders). With increased funding in the third year of this project, these sessions can be offered in more communities and on different topics to ensure that mothers and community members learn more on the subjects. It is evident that the quality of the sessions is good, but it is important to expand as planned in the work plan to allow more of the population to benefit.

In summary, this activity has progressed well since the start of the project, and it is hoped the educational sessions will continue to expand to reach a larger audience. Coordinators of the Healthy Babies project recognize that handwashing behavior has not been emphasized in these sessions as much as the other behaviors have been, and they plan on including more content on handwashing in the upcoming sessions.

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

Key Strategy: Training for community health workers and MOH health workers

The key strategy of IR2 is the training of CHWs and MOH health personnel. Training materials have been developed and trainings on MAMAN and IMCI are in progress, as described in more detail below. All data, qualitative and quantitative, associated with the trainings are positive: these were well liked, conducted with techniques that participants described as interactive and dynamic, and pre- and post-tests for training participants indicate statistically significant changes in all knowledge items, as presented later in this section.

Using data from project training records and the TA supervisory survey, findings regarding specific indicators for IR2 are presented in the annex 4. It is important to point out again that the sampling design and population are different for most of these indicators, so the percentages can not be compared statistically. However, the bias expected for the MTE would be for it to be higher than what might be estimated with a KPC because the supervision survey was conducted at facilities where activities have taken place. Though we observe that indicators associated with knowledge show a tendency to have increased, indicators associated with changing people’s health care seeking

behaviors have not increased (i.e., use of birth plans or institutional births) and are actually lower than expected (taking into account the expected bias). Changing people's care seeking behaviors takes time, and the funding cut at the initiation of this project was unfortunate timing, since it may diminish the project's ability to create this change in the four year time period.

Main Activity 1: Preparation of training materials for CHWs and MOH health staff

The project team has completed the preparation of training materials, which included the translation and cultural adaptation of existing manuals for training in neonatal IMCI, MAMAN and HBLSS. For the MAMAN training, slides for each of the 11 minimum activities were developed based on MOH norms and how it is being implemented in the Ucayali region. Specialists from the Regional Hospital of Ucayali participated in the process. All health personnel who acted as training facilitators received a CD with the powerpoint slides of this training. In addition to the training materials for the IMCI trainings with neonatal focus (IMNCI), stories depicting the key messages were developed, and innovative training materials to reinforce messages were produced, such as poster boards cut in half with half a message on one side and half on the other (i.e., "breastfeeding should be initiated... in the first hour of life"). Pre- and post-tests for both MAMAN and IMNCI were also developed. Regarding HLBSS, the three manuals were translated, and one of the three manuals was culturally validated, but the project needs to discuss how to proceed with its implementation.

These materials are already being used: project staff trained MOH facilitators to become trainers, and then project staff and MOH facilitators have trained MOH health personnel and CHWs to teach expecting/new mothers about maternal and neonatal health topics. The training materials seem to have been well-developed by the team, based on feedback from participants of the training sessions. At the MTE, focus group participants from each of these three sectors discussed their impressions of the training materials. In all cases, participants were very pleased with the materials, describing them as very interesting and easy to understand and adapt in subsequent trainings. In particular, they found the illustrations in the materials very clear and they liked that there were many illustrations. Health personnel noted very few difficulties in applying what they learned to train CHWs (see Main Activity 2: Implementation of Training Sessions & Workshops, below), but some did ask for a more ample bibliography and an updated manual (that was promised to some of them).

Main Activity 2: Implementation of Trainings and Educational Sessions; Refresher courses

With the materials ready, a series of training and educational sessions have been carried out with various sectors by the Health Babies project team. Two of the workshops focused on training trainers to conduct the rest of the workshops to health personnel on MAMAN and on IMCI with a neonatal focus (IMNCI). The trainers, with support from the Healthy Babies team, then conducted the MAMAN and IMNCI workshops with other health personnel throughout Ucayali, and conducted the IMNCI workshops with CHWs throughout the region. See table below for list of topics and participants.

Training Sessions with Health Personnel and CHWs

Sector	Number of Sessions	Number of Health Facilities	Topics	Total participants
Health personnel and DIRESA	1	All 13 “health micronetworks” represented	Training of trainers: MAMAN	42
Health personnel and DIRESA	1	All 13 “health micronetworks” represented	Training of trainers: IMCI (w/ neonatal)	33
Health personnel	14	13	MAMAN	319
Health personnel	4	4	IMNCI	22
CHWs	8	9	IMNCI	180

During the MTE, these trainings were discussed in interviews and focus groups with health personnel (in particular those who went on to become trainers) in urban, peri-urban and rural health facilities. All of the health staff that received training and participated in the MTE described the training as superb, specifically commenting on the innovative approaches to learning. They praised the participatory methodology, the comprehensiveness of the topics, and the clarity with which they were explained, and found the role plays very dynamic and interesting. One participant mentioned that the integration of maternal and child health topics (referring to IMCI with a neonatal focus) was a new but important way to look at the issues. Trainees were especially excited by the new information they learned in the trainings. They felt that this new information contributed to their professional development, and ability to provide proper services. Some examples of new information presented for the health staff were the *partogram*, the birth plan, and newborn stimulation. Participants found the sessions genuinely interesting, with comments such as “normally, long trainings are boring, but this one wasn’t” and that due to the “active participation, no one slept.” Everyone specifically commended the techniques used in the trainings, including DIRESA authorities. The Director of Health Promotion at the DIRESA mentioned that they would like to learn more on the training techniques: she considered the “training techniques used by the team were an instrument in themselves”.

Another key point raised by many trainees during the MTE was the significant emphasis placed on balancing both theory and practical application of the topics. Many reported that they had not really been trained previously on the practical application of topics they learn about, and much less on how to train CHWs on those topics. They appreciated these new skills. Others appreciated that the trainings brought together doctors, nurses and midwives. Finally, they liked doing a pre- and post-test to see their increase in knowledge, and on what topics, after receiving training.

The pre- and post-tests were conducted to assess change of knowledge among training participants to these workshops. Importantly, using Chi-square tests, statistically significant changes in knowledge on all items tested for are evident for training participants. See tables below for more details.

MAMAN: Change in knowledge by topic

Topic	Pre test (n=251)	Post test (n=234) ^a
	%	%
Knows when ferrous sulfate supplementation should start, end and the appropriate dose	10.4	54.3*
Can describe issues to consider during the preparation of a birth plan for a pregnant woman	3.6	22.6*
Knows of the delays or barriers to attendance at perinatal visits	1.6	45.9*
Understands the importance of using a partogram	16.4	57.9*
Can describe the three principal steps in active management of the third phase of labor	2.0	41.2*
Knows in which body part to initiate drying during immediate care to the just-born newborn	49.0	87.2*
Knows correct technique for successful breastfeeding	15.2	58.5*
Can identify the minimum activities for maternal and neonatal care	2.8	27.8*
Can describe the roles and duties of the CHWs in their community	23.5	52.1*
Knows of the appropriate birth spacing interval	13.5	64.7*

^a Numbers vary slightly because a few people left early or in a hurry. Sampling design allows for comparison between these groups.

*p<.05, using chi-square tests. Statistically significant change observed.

IMNCI : Change in knowledge by question

Question	Pre test (n=200)	Post test (n= 222) ^a
	%	%
Can describe key elements of pregnancy care that a mother must take	13.5	40.1*
Can describe the number of prenatal visits a pregnant woman should have	25.1	82.0*
Can describe the key elements of a birth plan	8.5	54.1*
Knows what measures to take for a pregnant woman in labor at home	10.0	34.2*
Knows two precautions that a woman must take after giving birth	2.5	27.6*
Knows precautions to take in newborn's first 28 days of life	10.5	36.5*
Can name two advantages of breastfeeding during the first hour of life	7.7	22.7*
Can identify two danger signs for women post delivery	23.5	59.5*
Can describe what a pregnant woman should consume to reinforce her food intake	24.0	54.5*
Can describe three advantages of exclusive breastfeeding	11.0	19.4*
Can describe the appropriate number and consistency of meals during complimentary feeding	26.5	35.7*
Can identify key moments for a mother to wash hands if she has a baby in the house	13.0	28.4*

^a Numbers vary slightly because a few people left early or in a hurry. Sampling design allows for comparison between these groups.

*p<.05, using chi-square tests. Statistically significant change observed.

Regarding the IMNCI training, participants were pleased with the following qualities:

- Practical training (involved going into the field)
- Participatory methodology
- Interesting (use of role plays and stories)

- First-time integration of neonatal and maternal health

Differentiating the MAMAN training from IMNCI, participants mentioned that in the former they also learned practical applications, but this training did not take them into the field. They appreciated learning how to improve clinical history taking and the registration of clinical activities.

During the MTE, trainees listed the following topics as confusing or needing more emphasis to participants:

- MAMAN specifics, especially growth and development, and infant massage/stimulation
- Vaccines
- Disease prevention

The following suggestions for improvement were offered, which happen to be a mixture of new topics which may or may not be relevant to this project, as well as recommendations for the trainings:

- Include STIs (given the adolescent sexual activity in communities)
- Devote longer times to each specific theme
- Teach emergency first aid
- Include food preparation after exclusive breastfeeding (“Many times mothers have the wrong idea of ‘papillas’ [pap].”)

At MTE, the facilitators discussed their experiences replicating their trainings with the CHWs. Overall, these experiences were positive, with many specifically citing the role plays as very effective. One aspect of this training that they appreciated very much was that unlike previous trainings that were very “professional” and used technical language that the CHWs would not understand, the Healthy Babies training taught the health staff how to “speak to the population,” and how to “assess if they are understanding.” They felt that, thanks to this training, they were really able to reach the people from the community, such as the CHWs. Another health provider explained that “facilitating was like a test to see how well we had learned the information... so it benefited the facilitators as well as the CHWs, and reinforced how to teach.”

In Aguaytia, a rural area, a member of the health staff commented that prior to the Healthy Babies training, the CHWs had been inactive for some time, but that this project has changed that. CHWs had not received any trainings in years, and many were beginning to abandon their work in the community. The Healthy Babies training session, however “brought them back in” and the CHWs are now more active than before and following up with newborns in the communities. He further commented that the content of this training was sorely needed; newborn care was new to all of the CHWs, and for some CHWs, the entire content of the trainings was new. Other topics that were new to the rural CHWs included:

- Nutrition for specific populations and specific periods in life
- Breastfeeding
- Immunizations

Finally, MOH health personnel mentioned encountering the following difficulties as training facilitators:

- The time allotted for CHW training was too short to cover all of the topics. Many trainers complained that what they learned in 4 days, they later had to replicate in only 2 days to the CHWs. This was the most common problem mentioned.

- In some cases (generally rural areas), some training materials were missing. Specifically, the laminated picture cards were not available for CHW training, which made training more challenging as CHWs respond better to illustrations.
- Lack of time to prepare their own materials (“it would be a great support to get (colored) materials to be able to use”).
- Motivating the CHWs to be engaged. Some say that the CHWs arrive late, leave early, or expect to receive small incentives like T-shirts or hats.
- For the river communities, distance is a limiting factor for CHW attendance, and some river-CHWs are disgruntled because they complain not receiving appropriate reimbursement for their travel expenses from the project.

Despite these difficulties, health staff feel that they have ample support from the project, reporting that coordination and communication is very frequent, and that “the project staff is very supportive and receptive to their needs.” In one focus group the health staff reported that the “promoters felt that for the first time, an NGO cared about them.” The MOH staff would like the project to continue and train more CHWs (“because they help us a lot”), as well as more health providers. During one focus group, health personnel suggested that the CHWs be trained every 3 months to keep them motivated and up to speed. They also expressed that the dynamic and participatory format should stay the same.

During three different focus groups, CHWs who received the training sessions explained that they have learned much information on many new topics. All of the CHWs participating in the focus groups learned something new, and for some newer CHWs, all of the information was new. They did not know the details of taking care of pregnant women and newborns, such as knowing that pregnant women need vitamins and care as of the first month, and hygiene of umbilical cords and nipples. CHWs report that almost all of the information has been applicable and that the trainings have had a positive impact on their behavior. They are applying their new knowledge and skills in their own homes and with other expecting/new mothers in their communities. During the focus groups for the MTE, the CHWs told several personal stories of how they have impacted maternal and neonatal health in their close environment: whereas previously they did not take pregnant women to health facilities, they now do, and they can counsel women on how to successfully breastfeed. Most CHWs feel that they are gaining community trust and they are seeing the beginnings of positive change in their communities. This perception was especially marked among urban CHWs.

The CHWs, like others, were highly pleased with the methodology of the training sessions. They found the dynamic and participatory nature of the trainings highly effective at keeping them interested and engaged. They enjoyed the group work, and found that the mix of theory and practice was crucial to information retention. The role-playing and drama made the topics easier to understand. In one focus group, participants mentioned that the topics of nutrition and growth were difficult to understand.

The problems CHWs have had in applying what they learned in the training sessions have to do with local barriers/situations encountered vs. lack of training. In the focus groups, it was frequently discussed that there is a perception that there is poor quality of care at health facilities, and as a result, it inhibits the care-seeking behavior in the community that this project promotes. The second issue that came up, though not as frequently, is that it is hard to issue birth certificates in the area because there are many men who do not recognize the child as their own, either because they are not married to the mother, do not want to take responsibility of the new baby, have left the relationship, or suspect infidelity. A recent law in Peru stating that mothers over the age of 14 can

name the father of the baby on the certificate may reduce this barrier, but for now, this issue is a barrier to the issuing of birth certificates in the region which in turn is a barrier to obtaining the SIS for the child.

In future trainings, CHWs would like to learn about the following topics, since they are asked about them or find themselves in those situations:

- Why babies get “susto” (“susto” means fear, and susto is often blamed for a baby who cries a lot. Though it is a local/cultural belief, teaching ways to deal with crying babies might address this issue.)
- What to do if they find a woman already giving birth and it is too late to go to the health facility
- What to do for a baby when it is born in the house
- Family planning
- Family violence/Child abandonment/Incest
- STIs

Although the CHWs were largely positive about the Healthy Babies project and the training sessions, some of the rural CHWs were bothered by logistical issues. Some described having to travel large distances (ie, two days in a row) to make it to trainings, and in some cases, they did not receive lunch and/or full reimbursement for their travel expenses. Those who live far away are inconvenienced by arriving home late at night and leaving very early the next morning for a 2-day training, and expect reimbursement and meals/snacks, and/or some sort of small incentive for their effort to be present.

Like the health personnel, the CHW reiterated the need for refresher trainings every 3 months. Refresher courses in IMNCI have been conducted by the Healthy Babies team, but not on the entirety of IMCI topics. Rather, the Healthy Babies team made an assessment of topics which remained unclear to trainees and conducted refresher courses on those specific IMCI topics. Those courses have taken place in 2 locations: San Fernando and 9 de Octubre. This task remains incomplete; refresher courses were to be conducted in 10 locations. During the MTE focus groups, trainees expressed the desire for refresher courses specifically in MAMAN and emergency procedures. This was supported by what one DIRESA authority mentioned: “though the trainings are excellent, no one remembers everything 100%, so it is important to provide the refresher workshops.”

Main Activity 3: CHWs conduct on-going census, visits to home births and education of pregnant women in their communities

As part of this activity, CHWs are expected to keep an updated list of the pregnant women and new mothers in their communities, making frequent home visits to them and referring them to health posts and health centers for birth. To do this, they start by conducting a census of their region and document all the expecting or new mothers in their region. One of the DIRESA leaders cited this as one of the most important accomplishments of the project: she learned the importance of conducting this census because many pregnant women/new mothers in the communities were completely unknown to them. This activity helped them identify women who had not been to health facilities, a very important population to have “discovered”. Then the CHWs carry out educational visits using the information that they learned in the training sessions, in particular the BCC socio-dramas. The CHWs are expected to keep a calendar for their visits to each woman.

At midterm, 289 CHWs have been trained in these methods; however, the project estimates that only about 30% conducted census activities and are making home visits (the exact number is unknown because the team has been unable to go to the communities to supervise their work). According to MOH health staff that work closely with the CHWs, and the CHWs themselves, this is because they believe they lack the materials they need to effectively communicate with people at the community level, where literacy and health knowledge are low. Specifically, they express the need for each CHW to have a set of laminated “picture cards” (see IR 1, Main Activity 2, above). These cards are described to be very effective in conveying the important messages of the project to mothers. During focus groups, health personnel specifically mentioned that it is the CHWs who most need these laminates for their educational sessions and follow-up with pregnant and post-pregnancy mothers.

In other cases, baseline census activities have not yet occurred, and this is another obstacle to the work of CHWs. (A census has been done in the urban areas, and is scheduled to begin in a peri-urban area in November.) In some focus groups, a minority of CHWs expressed lack of confidence in their ability to get community members to listen to them and change behaviors. Specifically, some feel they still have much to learn, or that they forget some of the information (for which laminates would help), or that they would benefit from having some sort of credential to show community members, such as identification cards (again, just owning training materials might help here as well).

Urban CHWs feel that they have plenty of support from both the project team and staff at their local health facility, although they would like more materials. Rural CHWs also feel positively about their relationship with the Healthy Babies team and staff at their local health facility, but are not happy with the infrequent communication and lack of support by way of provision of materials, site visits, and reimbursement of travel expenses for workshops and trainings. Those furthest away from the urban area wanted more project support (materials, visits by project team, etc) to carry out their community duties.

Main Activity 4: CHWs and health workers draw up birth, transportation and emergency plans with women and their families

This is a very important part of the Healthy Babies project, and is currently being implemented by health center personnel only. During focus groups at MTE, health personnel mentioned that making birth plans with mothers is a new activity for them; although some mention that though they had a birth plan format available to them previously, they had never actually done it. Now that the staff has attended Healthy Babies training sessions, they know and understand the importance of birth plans and are using them with pregnant mothers. They said they now view birth plans as “necessary” and take the time to ask expecting mothers about birth plans and inform them about what they need to think about in advance of the birth. Since the birth plans involve giving birth in a health facility, health staff say that the plans help them convince mothers of the importance of an institutional birth. However, MOH staff explained that institutional births are more difficult to promote in the river communities: health posts are closed at night, and it is unsafe to be on foot or boat at night in these regions. CHWs are scheduled to start working with expecting mothers on birth plans in January 2009. The postponement of this activity was due to financial constraints: before CHWs initiate this work, the project wants to ensure they can provide them with adequate support and supervision, and the census must have been conducted.

With regards to transportation and emergency plans, there has been discussion about the feasibility of transportation plans in this region based on the issue described by MOH staff and the project team: it is unsafe for women in some communities to be out at night. No work has been done

on either the transportation nor emergency plans, yet the feasibility (and safety) of accomplishing the transportation component has been discussed. It is recommended that the project management discuss whether this planned activity still makes sense, or whether new strategies need to be developed for women in this region, and update their workplan accordingly.

Main Activity 5: Technical assistance and supervisory visits to health facilities

The project has conducted TA visits to the 102 health facilities whose staff have participated in Healthy Babies training, making 1-2 visits to each to date. During these visits, they randomly select 2 clinical histories of births and review them for completeness. They also make note of types of supplies available, information about the health facility (institutional births), and then they proceed to select two mothers of newborns associated to that health facility randomly for survey questions with them.

During focus groups with staff from various health facilities that had received these TA and supervisory visits, participants expressed that the project team had visited their centers 1-2 times to check that all information is being documented in clinical histories. From their point of view, they admit that sometimes health personnel forget items, or for lack of time, they do not fully fill out registries, and that it helps to have someone make sure they are filling out forms correctly. However, they also feel that there should be “less judgment” and more “understanding of how much health personnel have to do.” Interestingly, these comments, coupled with what we learned from the project staff, help to also reveal another issue: providers are paid for each delivery attended. As medical charts were reviewed, the Healthy Babies team sometimes detected the report of an attended delivery with no other information in the chart. As it turns out, sometimes the providers claim to have attended a delivery for compensation, while not having actually been there. In other words, they were caught “cheating.” Some providers also felt that the review provides a limited perspective of reality by only examining 1-2 clinical histories, and would like a general review of more histories. They also requested more understanding: sometimes they do not have all of the materials they need to carry out activities properly, such as clinical history forms, certain medications, gloves, and water and soap for handwashing. They would like more follow-up for these missing supplies, rather than criticism, and even suggested that TA visits occur more frequently. Despite some negative feelings, representatives from at least 2 facilities mentioned that now they are being more careful about filling out registry forms and noting the entire birth process, from “when the water breaks” to birth. Finally, it is important to point out that health facilities are also monitored by the DIRESA, and that those visits may be confused with Healthy Babies team visits.

From a technical approach standpoint, the TA visits seem important for the project goals and the methodology adequate, given the large number of facilities that must be supervised (currently 102, and in the future 150). Perhaps not all of the health personnel understand that the purpose of the visits is to work with them to improve care and not to judge or blame anyone in particular. In addition, results of the visits are reported to the DIRESA. This year the project will provide the DIRESA support by giving them some materials they need to carry out activities.

Main Activity 6: Community Board Orientation (10 municipalities)

Due to funding issues, these community boards have not yet been formed, and the project team reports that they will begin this activity in January 2009. This important activity involves the formation of community boards, and holding subsequent orientation/educational sessions with the members to sensitize them to the importance of having transportation and emergency plans for the pregnant women of their communities. It is an essential component for the birth plan intervention to

function and to improve access to quality maternal and neonatal services. In addition, the formation of these boards, and subsequent involvement of the boards in the project will be crucial for program sustainability once the project activities have finalized. For these reasons, this is a technical approach that is central to the overall project that needs to be initiated as soon as possible.

Main Activity 7: Develop and review the Comprehensive Health Worker Checklist, and supervise health worker use of the checklist

The Comprehensive Check Lists are a crucial element ensuring quality of care, swiftly referring emergencies, and organizing the work of the health personnel. The Comprehensive Checklists have been applied at the 102 facilities, for which the 11 MAMAN activities are checked for. At the time of the TA visit, a laminated checklist is left at the health facilities as a reminder of the items being checked for and what they need to be documenting on health files of all their patients.

With exception to those who described feeling “judged” during the TA, the MOH health personnel have reacted very positively to the organization and fullness of the information that this checklist provides. They explained that prior to this, there was little organization of the documentation of their work: “Before there was no uniformity on how to take down this information,” or “there were documents before but no one used them.”

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

Key Strategy: Community based strategies to improve access to quality services

Progress towards IR3 at midterm is the most limited of all the IRs. Importantly, in the first two years of the project, it is clear that there are some activities which may not be feasible, so new strategies must be developed and discussed immediately, and the work plan must be updated to reflect the changes. Unfortunately, the activities associated with increasing availability and access are also going to take time to implement, and additional time will pass before people’s health care seeking practices also change. Hence, in the 2 years left, much work can and should be done in this area, but it may be difficult to observe a significant change in the indicators in this short period of time. That said, the project, having now worked in this community for 2 years, is in a great position to start working on policy and sustainability aspects of this project.

Main Activity 1: Meetings with municipalities and community leaders to develop transportation and emergency transportation plans

These meetings have not yet taken place due to the project’s financial constraints. However, in these two years, the Healthy Babies team has also identified specific challenges that will need to be addressed in this process: namely, that it is unsafe in many river communities to be out at night, and that this will have to be taken into account as these plans are developed. The team must meet, alone and with municipalities and community leaders, to determine which strategies make most sense for this region. At that point, the work plan should be updated.

Main Activity 2: Assessment of the feasibility of Maternity Waiting Homes in Ucayali and the planning

As a technical approach, again, this intervention may not be appropriate to reach the project's desired outcome, as the project team itself has found out, so in a sense, this activity is in progress. The feasibility assessment of this intervention was to be based on visits to Maternity Waiting Homes in other regions, and input from other stakeholders. A maternity home in Huanuco was visited. The project also learned that Pathfinder reported a poor experience opening Maternity Waiting Homes in the Ucayali region three years ago. Hence, additional assessments are needed before moving forward with this intervention. Specifically, the project needs to determine what is the best strategy for carrying out this activity. Meetings with key informants (such as Future Generations who has maternity waiting homes in Cusco, Pathfinder, and municipal leaders) are necessary during this evaluation period. Also, in this process, the project will need to assess issues of sustainability associated with these waiting homes. Then the project can develop a sustainable and realistic plan with local partners for this intervention.

Main Activity 3: Identification of deficiencies and improvement of birthing facilities, equipment and supplies at the health post level through the Data Quality Committee

This activity is in progress. Data has been collected at 102 health facilities between October 2007 – September 2008. Baseline data was established using the analysis of the Maternal and Child focused Rapid Health Survey, and subsequently verifications of improvement have been conducted during supervisory visits to 102 (out of 150) health facilities. With regards to supplies, these were split into three types of supplies at MTE: medical equipment (i.e., blood pressure monitor, surgical equipment, thermometers), forms and print materials (i.e., partogram, birth plan), and medications (i.e., vaccines, oxytocin). Though ideally all health facilities would be stocked on all the necessary medical equipment, medications and forms/print material, we learned during the MTE that the most deficient supply item was the forms/print material: only one facility (1%) had more than 7 of the necessary forms (out of 14). The database with specific information regarding which of the other supplies are in most need can be used by the project to inform others (municipalities, DIRESA) and prioritize activities and supply distribution. Finally, the Data Quality Committee has yet to be formed.

IR4: Improved policy environment for maternal and newborn care

Key Strategy: Foster an improved policy environment

Related to policy development to promote maternal and neonatal health, yet not outlined specifically in the workplan, a workgroup composed of PAHO, UNICEF, CARE and PRISMA/INMED was formed that has worked to develop and review a “neonatal package” of cost-effective neonatal health interventions. This package was presented and discussed with other topic experts and MOH leaders, and other organizations and institutions have since become involved. This package will be released in December 2008 by the MOH. Please see Annex 4 for estimates of indicators at baseline and midterm that are associated with IR4.

There has been work toward improving the policy environment, but most of this work so far has focused in Lima (see section 2E, for details) and is not outlined in the work plan. Hence, there will be no indicators to examine the result of this work. In addition, the project team realizes that several activities associated with IR4, such as municipalities adopting emergency transportation

plans, or MOH incorporating HLBSS into policy, may not be feasible. These activities need to be discussed now, a decision with regards to how to proceed should be made, and the work plan must be updated accordingly to reflect the work that is being done or that will be done. Overall, however, progress towards IR4 is very limited, and it is recommended that in these next two years, much effort is placed into regional policy development on maternal and newborn health.

Main Activity 1: Improvement of Community IMCI manual with more maternal and neonatal content in conjunction with MOH

This activity has been completed through the participation of the Project Director in a national workgroup with PAHO, UNICEF, CARE, MOH and other NGOs to improve the Community IMCI manual incorporating more maternal and neonatal content. The end product is a training manual that incorporated the desire of the MOH to place emphasis on neonatal care and the content has been updated (and going through the final revisions at the MOH). The project developed a shorter version of the IMNCI manual and this has been used in the Healthy Babies training sessions.

Main Activity 2: MOH incorporates HBLSS into policy for rural areas.

All three HLBSS manuals have been translated and one of the three manuals was culturally validated. However, the HLBSS activities were put on hold due to limited funding. The project team is discussing the next steps that need to be taken to provide HLBSS training and distribute the manuals, which may or may not include having the MOH incorporate the HLBSS into policy. Because of the content change in the manuals to be locally relevant and appropriate, the team needs to check with the American College of Nurse Midwives to ensure that they approve of the new content. Due to internal politics associated with institutional vs. home births in Peru's government currently, it is questionable whether this is the right moment to try to obtain MOH buy-in for the HLBSS. Once the project team decides on a strategy for this, the work plan associated with this activity should be updated accordingly.

Main Activity 3: Distribution of MOH policy manuals – refresher workshops in health posts and health centers and updates

This activity has not yet begun. Though the project intended to help print and distribute MOH policy manuals related to obstetric emergencies and clinical management of the newborn, the project's funding reduction limited this activity, but they intend to start printing and distributing these manuals immediately with the secured funding for this third year of the project. The project staff also estimates that refresher workshops will begin in January 2009.

Main Activity 4: Municipalities adopt Emergency Transportation Plan as their own – through community boards

Community boards need to be formed and Emergency Transportation Plans developed. The project team has also learned more about the feasibility of this activity and must reassess whether this is truly the best strategy in this location, and adapt their work plan accordingly.

E. New and Innovative Tools or Approaches

There are various innovative tools and approaches mentioned during the evaluation.

First, though IMCI, a strategy developed by the World Health Organisation's Division of Child Health and Development and UNICEF for integrated management of children's health, has been introduced in over 30 countries (WHO website), the focus has traditionally been on children under the age of 5. The IMCI with a neonatal focus is more innovative, though other countries, like India, have started focusing their IMCI strategies in the under-5 children most at risk: neonates. This project has been considered innovative due to its focus on a population that has not been on the MOH's radar: newborns. This has translated into policy discussions at the national level regarding health priority setting for this country: putting newborns on the national health agenda.

Second, everyone commended or wanted a set of the word-less, laminated picture cards. As a health education tool, it was an ideal choice for this population because: 1) in a low literacy population, the images are understood by all; 2) since there are various native ethnic groups, it is impossible to develop health education materials in all the languages, so these picture cards work for all; 3) these picture cards are bound by topics (ie, newborn danger signs, pregnancy danger signs), so one can focus on one set of cards per session. Some of the images were borrowed from the HLBSS, but adapted by a local illustrator to look like the people in that region, whereas many other images have been developed by the project team based on the IMNCI content and the project's BCC strategy. Those who had the picture cards spoke highly of them: they felt the messages got across to all. Those who did not have the laminated cards (the CHWs) wanted them for their home visits. Though the funding has limited the printing of this card, it should be prioritized as an innovative health education tool for this population.

Third, though interactive and dynamic training techniques are no longer considered "innovative" in the field of public health or adult education, these techniques were innovative for the population in Ucayali. Everyone who attended a training session or workshop commented on the excellent training techniques. The DIRESA authorities requested a training on how to use these techniques in training, and as presented earlier, one said that "the training techniques were an instrument in themselves".

Fourth, again, participatory methods are not novel in public health practice. However, the Healthy Babies project team in Pucallpa, along with the Project Director, Marilu Chiang, were specifically commended for the style of interaction with the community and community leaders. There was clear ownership by people outside of the project team to the activities being conducted by this group: DIRESA authorities contacting Healthy Babies team members when they were visiting rural sites (since they were aware of the funding limitations and could lower boat costs for all if they went in larger group to rural sites); PVL leaders who were taking on a new role in their communities, asking to work as CHWs, to promote specific health education messages after being trained themselves; etc. This ownership of the project speaks well of the interactions they have had within the team and with others, and will be key for sustainability efforts as well.

Finally, conducting a census to identify expecting and new mothers may not be novel to Child Survival projects, but the DIRESA authorities were impressed with the information that was obtained through it. The Health Promotion Director was surprised at how many women had "slipped through the cracks" and were unknown to them, and now wants to implement census activities of a similar nature in the entire region to ensure that the local health authorities are well informed about their population and its needs.

2. Results: Cross-cutting Approaches

A. Community Mobilization

The project's approach holds much potential for considerable and successful community engagement in maternal and neonatal health. In fact, the approach thus far has been very participatory, and through their involvement of people from all sectors and levels, there has been much community mobilization which has led to ownership of the project, and which lends itself to sustainability. Moreover, the work plan for the Healthy Babies project has a strong community mobilization component, including the involvement of community leadership in the creation of emergency transportation systems for women in labor and creating support groups for breastfeeding women, as well as the work of local community members as CHWs in the promotion of MAMAN and IMCI at the community level. Much progress has been made in the area of training the CHWs: 289 people have been trained to carry out the project activities at the community level. Although trainings were reportedly successful according to both the trainers and trainees, only about 30% of the trained CHWs have been able to engage in community activities and home visits. Leaders of PVL (often very active community members) have been inspired after participating in training sessions to become CHWs and promote the messages of the project, an example of people's feelings of ownership in this process.

However, there remains much to be done in the realm of community mobilization. Though there are plans to work with community leaders to develop options for transportation for mothers in labor, due to funding limitations and specific challenges (i.e., safety of women traveling at night), these efforts have not been initiated. Through key informant interviews with local MOH staff and focus groups with CHWs, it seems that the community has unrealistic expectations of the health centers and a general attitude of apathy, expecting the health centers to solve all their problems. They may also be misinformed about the cost of services and what services are provided. This makes them reluctant to go to health centers and to heed the advice of the CHWs. Thus, community mobilization efforts could start by disseminating information to community members regarding what to expect from the MOH facilities, from SIS (and other insurance schemes) and from this project.

In addition, a few regions (coca-producing regions where there have been strong alternative development interventions) are resistant to collaboration with the MOH, USAID, the Healthy Babies project and NGOs in general. It is critical to start changing community perspectives on NGOs and USAID and MOH. It is evident to the evaluation team that the project team has been very successful in positive engagement of the communities in more urban areas. Though the challenges of geography and distance will be difficult, this is an ideal team to start organizing, engaging with, and mobilizing communities in more difficult regions. In the long term, this will be key for any other health or development interventions in these regions. This could be a slow and challenging process, but it is very important. With high turnover of health personnel and difficult access to MOH infrastructure in more urban centers, the people living in these rural areas will need to depend on one another to take sustainable action to making improvements in their new mothers' and newborns' health.

B. Communication for Behavior Change

The BCC approach employed by Healthy Babies is quite strong. All messages and materials have been very carefully developed by the project staff and validated with the target population.

Illustrations created by a local illustrator, depicting people and situations that people identify with. As a result, the project has produced BCC materials and messages that truly resonate with the target audience and, most importantly, are completely understandable. However, only a minority of the planned materials have been published and distributed, and the radio spots are also still under development.

The materials that are in use (birth plan poster, laminated picture cards on various topics) have been very well-received by health personnel, CHWs, and beneficiary mothers, and quite effective in conveying the behavior change messages. They report that the designs and colors are very understandable and draw attention. In the case of the laminated picture cards, the CHWs and health staff find them very effective in the community because they do not intimidate the audience with text. These also work well with low literacy populations, and native groups who do not speak Spanish. The supply of sufficient picture cards to all CHWs is essential to their work in their communities. In general, all participants in the project (both trainers and trainees) would like to have more BCC materials to use as education tools and to distribute to the community: their request is a compliment to the project's materials, but these need to be made available for more effective interventions. For the BCC materials still under development, it will be important to ensure that the company making the materials fully takes into account the suggestions given during the validation tests for the illustrations and messages, as has been done thus far with other materials.

C. Capacity Building Approach

i. Local Partner Organizations

Throughout the project, Healthy Babies has worked very closely and cooperatively with DIRESA: to provide trainings, provide TA to health facilities, and integrating data obtained to development of policy. There is a strong sense of ownership of the project at all levels: from DIRESA to health personnel to CHWs. One project coordinator at an urban health facility spoke very favorably of the cooperative manner in which the project is implemented at all phases, describing the project staff as “our allies.” She worked closely with the project staff to develop the training materials, explaining that “the team does not impose its plan like other organizations; instead they accompany us step by step.” It is clear that the DIRESA and local MOH health personnel are learning new skills and techniques to promote health and improve the quality of services, and they are participating actively in the development and implementation of the project activities, while requesting training on training techniques that they can use for other health topics.

ii. Training

There is a strong training component to this project; MOH staff at all levels, community health workers, and mothers are the various recipients of training sessions thus far. Most importantly, with regards to capacity building, health personnel from the region have been trained to conduct the workshops themselves. Training objectives are on track to being met, and the training of community leaders/boards is scheduled to take place in the near future. The training sessions have been overwhelmingly well-received by all participants (see section 1D: Progress by Intervention Area – IR 2 – Main Activity 2, above). Of special interest is that many participants reported not only learning new information, but new skills as well. Specifically, several are keen on the training techniques that have been used in this project, described as dynamic, engaging, clear, and effective by people interviewed in the course of this evaluation. Urban as well as rural MOH health staff consulted during the MTE acknowledged the professional development resulting from attending

“Healthy Babies” trainings. Urban health staff mentioned: “every training is a benefit...to strengthen and improve knowledge,” and rural staff stated that they can now offer more health education and in greater depth to the population.

Trainees also appreciate that health personnel and CHWs are sometimes trained together since it is crucial that the two groups be in close communication to truly reach the community. Specifically, in facilities where CHWs have received the trainings and been most active, we have heard the aftermath: MOH staff members mentioning that CHWs “really help our work” and requesting that more CHWs be trained into the program.

Another important capacity building component of this project is that the Healthy Babies team trained CHWs to conduct a census of their communities, registering (among other data) all pregnant women and neonates. Those CHWs now have the ability to keep their census data updated on their own, which they pass on to their local health.

The training of various stakeholders is having a strong positive impact on the project and needs to be continued and expanded to increase the number of trainees. With the local health authorities so pleased with training activities, there is great potential for scaling up the project in the future to include more locations if these authorities take on training responsibilities as well. The sustainability plans are promising, as the DIRESA has expressed a strong interest in incorporating the training methodology into their policy and work (see section i. Local Partner Organizations, above).

D. Health Systems Strengthening

During focus groups and interviews with health staff and CHWs at MTE, several participants mentioned the positive impacts on the health system as a result of this project. Various aspects of the Healthy Babies project are contributing to health systems strengthening:

i. Training of health staff and CHWs

See section 1D – IR 2 – Main Activity 2 for a description of this training. The impact on the health system of training is clear. At midterm, both health staff and CHWs discussed several examples of new information and procedures that they have learned to apply thanks to the training they have received. The quantitative data reveals statistically significant changes in knowledge in the pre- and post-tests in all areas. For example, as a result of training efforts, health facilities that previously did not implement birth plans report that they now have begun to do so. CHWs report that prior to the project, they did not keep track of pregnant women in their communities, and now they have a system to do so.

ii. Efforts to organize the work of CHWs

See section 1D – IR 2 – Main Activity 7. CHWs in some project locations are now designated to work within a sector of their community, using a folder system to keep a file on all the pregnant women and neonates in their sectors. They use uniform registry forms for women they take to the health facility, and keep community census data constantly updated. The efforts to organize the work of CHWs are a large help to the health system, especially in reducing “missed cases” at the community level. In general, MOH staff appreciated that the CHWs have been given more resources to improve and strengthen their work.

iii. Constant collaboration with the DIRESA

For the DIRESA, collaboration with Healthy Babies is viewed as a strengthening of their health system because the project goals overlap (improvement of maternal and neonatal care) with current DIRESA health priorities. Staff members consulted at MTE appreciate working with a project that shares goals and that works with the same population. Project staff are described by DIRESA authorities as flexible and helpful in their joint collaborations. The two groups jointly developed the training materials, health education materials, and the census, and have worked together in offering the trainings; through this collaborative process, DIRESA personnel have acquired new methods and techniques that they can apply in future work.

iv. Sharing of all baseline (and other) data with local stakeholders

Data is crucial to adapting the project activities to the specific needs of the target population. Through this project, members of the health system have participated in the collection of baseline data, and the results have been shared with the local stakeholders. The information and the skills gained in its collection are invaluable to DIRESA and the health personnel. Staff members reported that they have learned much about their catchment population, and realized that there were many “missed cases.” They appreciate that the Healthy Babies project uses the same indicators as the DIRESA, which makes the application and integration of the data into their system very convenient. As the project progresses, the DIRESA will keep its own indicators updated, and if sustainability plans come to fruition, it will do so on its own accord.

However, there is more work that could be done on the issue of data. One project activity described in the DIP was to organize and strengthen the DIRESA data management systems, but little progress has been made in this area. Every time health personnel see data about their facility’s/region’s progress, improvements in indicators, etc, it is a powerful reminder of the key objectives of this project. This would be even more useful, and would make the project’s objectives more sustainable, if there were a system in place for regular monitoring – not simply at time of this project’s evaluations. There is software available that can be used for this, and the project should consider setting up a data system process for regular monitoring.

v. Supervisory visits and Technical Assistance to health facilities

See section 1D – IR 2 – Main Activity 5. The visits to health facilities by project staff are an ongoing health system strengthening component of the project. They have begun to have a positive impact on staff, as members have worked to improve their practice, especially to be more complete in the care of pregnant women and during labor and delivery, as reflected by the content of clinical histories.

Improvements achieved in health systems strengthening need to be solidified and scaled up to all project sites. To continue in this direction, the project plans to expand the conduction of a baseline census in several of the other project communities, again with CHWs.

E. Policy and Advocacy

“They started working on what they could see was coming...” were the words of the Pan American Health Organization (PAHO) Infant Health Assessor, Miguel Davila. From his perspective, at the national level, there is an increasing recognition of the fact that health priorities had seemed to “abandon” neonates, whereas now there is an increased dialogue on this topic and national priorities and strategies to address this very vulnerable population. As of the years 1999/2000, in response to the comment from various NGOs that “neonatal health in Peru was still

weak”, a team composed of PRISMA, Caritas, ADRA and CARE have been meeting with UNICEF and PAHO to improve neonatal and maternal health policies in Peru. In 2000, they started introducing the focus of neonatal health in the IMCI approach, and experienced some resistance in 2002 and 2003 to this. However, as people started using the IMCI, with its neonatal focus, there seemed to be a paradigm shift with regards to how to manage children’s health, and the response started becoming more positive because “it made sense” to the health providers working with children. Now the MOH is about to launch this national strategy for maternal/neonatal health, addressing the gaps in the current programs. Dr. Davila discussed the various activities associated with the three main components of this strategy associated with: 1) shifting clinical practice of health providers from focusing on a medical consult to integrated care for the child, 2) changing the way the health care delivery system is set up (which focuses on specific “health problems” vs. the integrated perspective), and 3) addressing the fact that integrated care does not end in a health facility: community level work must be complementary. He felt that Dr. Chiang, Project Director of the Healthy Babies project, had seen what was coming and has been instrumental in the changing national policies for almost a decade. With specific regards to the Healthy Babies project, due to their commitment to validate the IMCI (with neonatal focus) manual in the Ucayali region, they are making a great contribution to the MOH by starting to locally and culturally adapt the manual to the needs of rainforest populations in Peru. Moreover, the Healthy Babies project interventions are being implemented in the rainforest, and the results will guide the MOH in ways to implement similar interventions in other regions of the country, making the process more cost-effective.

Moreover, Healthy Babies project data are used in discussions at the national level work group meetings of the Mesa de Concertacion de la Lucha Contra la Pobreza (Work Group in the Fight Against Poverty), to which the PRISMA Director attends bi-monthly. This work group, that focuses its work in three main areas (health, focusing on nutrition and maternal/neonatal mortality; identification, helping people become officially registered to be able to access services; and education), is working both at a national level, and at the regional level through its regional affiliates, to reduce poverty.

Interviews with DIRESA authorities in Pucallpa revealed that the objectives of the project tie in very well with their regional health priorities. Some of these health priorities include items such as improvement of basic hygiene, which Healthy Babies’ focus on handwashing partially addresses. Moreover, the Peruvian MOH has been working towards decentralizing health efforts, which has been put into practice by the project by focusing on training people at one level (trainers/facilitators), who then go train other health personnel, who are then responsible for training the CHWs, who then promote health education and institutional deliveries among expecting or new mothers.

In addition, DIRESA authorities talked about how the presentation of the baseline findings impacted their work. As an example, one person mentioned that the percentage of women breastfeeding their babies was lower than they expected, and they are increasing efforts in breastfeeding promotion to ensure these numbers go up.

There is more work to be done in this area, however. Much of the policy work thus far has centered in Lima. After its first two years of project activities and building such positive cooperations, the project is in a good position to start developing regional policies that support maternal and neonatal health. Though the project has been involved with the DIRESA, much of the policy work needs to include municipal leaders at this point. Because of Peru’s policy to decentralize health management, municipalities have much power and have funding. They would be key partners to help sustain some of the activities associated with this project. In addition, many municipal leaders were formerly community leaders, who were formerly community volunteers,

including CHWs (not necessarily with this project). Thus, supporting and helping to fund activities associated with community development and CHWs may be viewed very positively by municipal leaders. Management Sciences for Health (MSH) has a strong positive relationship with the Healthy Babies project, and they work closely with the municipalities in the Ucayali region, so they may also be good conduits for future policy work with the municipalities.

F. Contribution to Scale/Scaling Up

One of the components of this project not directly associated with the results, but related to accomplishing them, is involving private sector partners and raising funds for the project activities. INMED US, with in-country help from its Peruvian affiliate, INMED-Andes, has taken the lead in this activity and has worked through various strategies to develop the most strategic way to obtain donations, which vary by institution, as might be expected. Internationally this has focused on corporate partners, netting cash and in-kind contributions from Johnson & Johnson/Janssen-Cilag and Grey Communications. Many foundations also were approached, but most of these are awaiting more information on project outcomes. One of their strategies within Peru focused on developing a summary of the project, and then creating slides depicting “products” that be could supported by donors for a specific amount of money. For US\$5K, one could support the making of a health education poster for distribution, for \$10K they could pay for a training and materials for 25 CHWs, and for \$25K, they could support the development of a “mother’s waiting home” (see annex 9). The largest donation that has been obtained to date was from Johnson & Johnson/Janssen-Cilag, for two large deworming campaigns (and a third one is scheduled for approximately March 2009).

More than 300,000 women of reproductive age, children and other high-risk family members participated in the deworming campaigns. Johnson & Johnson/Janssen-Cilag provided a donation to the project of 324,000 single dose (500mg) mebendazole tablets. Initial plans were to treat all pregnant women and other women of reproductive age, according to World Health Organization (WHO) recommendations. Due to the central-level MOH concern about side effects during pregnancy, a decision was made by the local Health Department and INMED not to treat pregnant women at this time, until the MOH has time to reformulate its policy. All women of reproductive age who were not pregnant and children from 2-14 years of age were treated. In areas with extremely poor sanitation, other family members were also treated. This was a high-profile activity, and prevention through handwashing was emphasized at this time as well. The issue of treating pregnant women will be revisited with the MOH. However, by treating all women of reproductive age and children from 2-14 years, household helminth burdens may be drastically reduced overall. Johnson & Johnson has agreed to donate mebendazole in similar quantities sufficient for two treatments per year. For future campaigns, the basic *Healthy Babies* messages will be promoted as part of the high profile activities. Finally, the results obtained in the MTE will provide the type of information that the project needs to go public and start scaling up. Specifically, it is evident that the project has had a very positive impact on the community, and this is something that can help them obtain future support.

G. Equity

With regards to equity, the project is working in some of the regions with lowest socio-economic indicators of the country, as well as with native communities. However, this has not been easy. The regions with lowest indicators are also some of the most remote regions – hardest and most expensive to reach – and yet the project has given some of these areas priority, despite its limitations in funding in the second year. If this project had approached its activities with regards to where it would be of most cost-benefit to it, it would have ignored these underserved areas, but to its credit, it did not do this. There are specific underserved regions – Coronel Portillo, Masisea, Iparia – whose link with the DIRESA has been strengthened due to this project’s work. Working with native communities also brings a share of new challenges, such as language barriers. The most commended health education material produced by this project, the laminated picture cards, are a great tool for working with communities that speak different languages.

Another important issue with regards to equity is being able to provide the most underserved people with ways to access the system. One of the activities of this project has been to help people with no identification (documento nacional de identidad, DNI) with ways to obtain this national identification card, which allows them to then access other services, such as the government health insurance plan (SIS).

H. Sustainability

Despite the large turnover rate, the participatory approach taken by the Healthy Babies team has been praised as one that has led to improved collaborations, a sense of team work and support in different health efforts, and one that remain as part of the community efforts even after the project is done. DIRESA Health Promotion Director discussed sustainability from her perspective: “in other projects, the teams do not involve health personnel and thus there is no sustainability of the project...” For example, she discussed the fact that the DIRESA is observing a higher level of CHW participation than in the recent past. CHWs have very different educational levels and experiences, but providing these trainings and materials has allowed to provide certain standard messages for the CHWs to use in their communities. Likewise, one health professional mentioned that “the CHWs are now a great support” and he is trying to figure out how to work closer with them and support them in their work. The CHWs are community members who are unlikely to leave their communities, so their knowledge remains in the community and can continue to be shared.

The project has been developing a sustainability plan in conjunction with local partners who may be able to take over some activities of the Healthy Babies work plan when the project ends. A first meeting took place with representatives from various groups from Ucayali, including: the local Mesa de Concertación para la Lucha Contra la Pobreza, Colegio de Obstetricas, Red de Promoción de la Mujer, Management Sciences for Health (MSH), Municipality of Nueva Requena, Municipality of Yarinacocha, Forosalud, ADRA, some CHWs, and units of DIRESA. Unfortunately, there has been no follow up to this meeting.

Nationwide policy work has been initiated and has been well advanced through project efforts, which has helped place newborn health on the national agenda. However, efforts in the next two years to emphasize policy efforts at the regional level will be key towards sustainability of specific components of the project. Moreover, now that the project has certain results to show, support from Peruvian institutions should be easier to attain.

CHANGES IN GRANTEE ORGANIZATION CAPACITY

As stated in the DIP, “INMED is interested in further organizational development, not only to improve its technical programming of health components in its ongoing projects, but also to increase the organizational capacity of its headquarters operations and field offices. In a preliminary self-assessment of its organizational needs, INMED has identified two areas for strengthening: (i) monitoring and evaluation and (ii) technical strengthening of its Peru office to include care of pregnant women and their newborn babies and the implementation of HBLSS in a rural area that has few resources available.” There are no specific indicators from the MTE that assessed improvements in these areas, there is clear evidence that INMED has strengthened its institutional capacity in Peru. Specifically, its local affiliate, INMED-Andes is now an officially registered NGO, which expands the activities they can manage locally, such as receiving donated good from overseas without paying taxes for them. The newly hired Project Director who will work out of the INMED-Andes office brings technical expertise to the Peru office in the care of the focus populations. Related to evaluation, during the organizational assessment using the CSTS’s Institutional Strengths Assessment (ISA) that was conducted as part of the baseline, INMED felt that their governance section was weaker than they would like it to be (despite all scores for both institutions coming out strong), and INMED’s President, Linda Pfeiffer, presented these scores to the Board of Directors. The board itself had never evaluated itself, and yet now, they carry out an annual evaluation of their work. However, one area that they could strengthen based on their stated objectives is to participate in M&E workshops in coordination with CSTS and the CORE, as described in the DIP.

The PRISMA team felt that they have gained from the opportunity to work in the area of neonatal health, an important and emerging topic in Peruvian national health policies. They feel this project has provided an opportunity to work with an institution they had not worked before, INMED. But the leaving Project Director regrets that she did not have the opportunity to get the child survival trainings at the Backstop Institute as they had agreed on, since it was a topic she wanted to expand her theoretical background in.

MISSION COLLABORATION

The Healthy Babies project responds to the USAID Peru Field Mission Strategic Objective: Improved Health for Peruvians at High Risk. USAID Peru’s interventions are focused around the following themes: “Transparent and Democratic Governance to limit corruption” and “Accountable social governance to reduce conflict”. The proposed project improves the health of Peruvians at risk in Ucayali and addresses the quality and accessibility of services, while encouraging people to adopt healthy behaviors. The project plays an important role in contributing to overall mission health objectives. The project sites were chosen in collaboration with the USAID Health Office and the office of Alternative Development, so as to respond to the specific social problems found in the coca growing areas. The USAID Mission in Peru recognizes that families living within areas that grow illicit drug crops, due to social unrest and insecurity, have limited access to services and a less secure living environment. It is evident in the MTE that these coca-growing areas are suspicious of USAID and NGOs, and this has affected the work in those areas, yet it also permits an opportunity to work with these communities in developing a different perception of USAID and NGOs in general.

The Project Director meets and communicates regularly, at least once per month, with the Mission contact Dr. Luis Seminario. Meetings also are requested and have taken place with the mission when senior staff and backstop visits from HQA. The presentation of the KPC results was

held on May 7th, 2007, with Mission, MOH officials and partner NGOs. Information from some of the rapid catch and baseline indicators for Ucayali will be utilized by the Mission in both health and alternative development. This MTE will also be shared with the Mission.

The Mission is not optimistic about future support for the project as health funds for Peru have been considerably reduced. The Mission is supportive of INMED working with international partners, located in Peru, to try to secure further funding. INMED has been in conversations with Pluspetrol, an Argentinian Oil company, to work in part of the 3rd Health Network in Ucayali in Sepahua. This is a negotiation process that depends also on the company's relationship to regional governments, the process is on going.

CONTEXTUAL FACTORS THAT HAVE INFLUENCED PROGRESS TO DATE

Several contextual factors that have impacted on the progress of the project to date, including:

Financial difficulties

Progress on the project work plan has been limited by the financial difficulties brought on by: 1) the reduction of project funds from USAID; 2) the sharp decrease in the value of the dollar in 2007-2008; and 3) the general increase in cost of local salaries, all goods and transportation. The reduction of project funds meant – among other limitations – that certain proposed activities are on hold or have been limited in scope. The Pucallpa project team mentioned that, after salaries and office rental expenses were taken into account, they had an operating budget of less than US\$400 in total for the months of January and February, one person's position was cut, and they were asked to take their paid vacations at that time. Though this extremely reduced budget was partly due to INMED and PRISMA's joint decision to implement trainings in September and October before activities in Pucallpa slowed down for the holiday season and beginning of the year resulting in higher-than-budgeted monthly field expenses in September and October) and the increase in local salaries, it affected morale. It is only fortunate that none of the other capable project team members left for another more "stable" position at that time (though as of writing this evaluation, someone else has resigned).

One of the few negative feelings voiced during the focus groups and interviews about the Healthy Babies project was from health staff and CHWs who attended training sessions held after the budget cuts who were not always provided with immediate travel reimbursements or with individual copies of all training and BCC materials because of limited supplies. For a project that has strived to create a participatory approach and ownership amongst participants, it is important that people feel appreciated for their work.

Frequent turnover of DIRESA directors

The DIRESA office is the highest level of health authority in the region, and yet there have been three directors of the DIRESA in the course of this year, 2008. The DIRESA Director of Human Health, Dr. Jose Mercedes Garay, has been very helpful and supportive of the project, but he turned in his resignation in the past month, so this will once again require that the Project Director meet with the new DIRESA leads to describe the project and promote collaborative work between institutions.

Frequent turnover of health personnel in the MOH health centers and health posts

The DIRESA Director of Integrated Health Services estimates that the turnover rate of health personnel is about 45% per year: meaning that trainings to health personnel in this region need to be repeated and ongoing. It also means that some health personnel are not committed to the region they are working in and do not want to assume new responsibilities, even if the skills and information to be gained from the Healthy Babies project could benefit their practice anywhere. In addition, the CHWs work closely with the health personnel at the local health facilities. The change of health personnel affects this relationship, both for better and worse. The CHWs at San Fernando health center, for example, mentioned that the new director in their health center values their work and meets with them regularly, and they feel that their work is important to the community, which inspires them to work harder. However, this frequent turnover is a challenge for this project and others.

Strikes

There have been three strikes that have paralyzed Pucallpa for at least 34 days in Pucallpa in 2008 that affected programmed work activities – and as this report is being written, another strike has begun. All labor activities were affected by these strikes.

Weather affecting access to remote regions

During summer months (April – October), the water in the river is so low that it is hard to reach the most rural communities. The project team tries to program activities so that TA and training at most rural communities takes place when there is better access, but inclement weather is still an issue.

Cost of transportation and access to trainings

Because access is difficult, travel in Ucayali is expensive. Organizing workshops involves costs beyond those normally considered: in Ucayali, it has meant paying for participants' transport to the workshops or educational sessions, since many health workers or mothers would otherwise be unable to afford the boat trip.

Extensive area and number of health facilities proposed

The project proposed to work in 150 health facilities in the area, yet due to staffing and access issues, it has been hard to reach all health facilities that they are committed to. It might have been more appropriate to focus on a select number of health facilities to start with, as a pilot, work through the challenges, and then increase the magnitude and outreach of the project. Though this would have limited the population served, it might have permitted the project to work through some of the local challenges and barriers before tackling the entire region.

Challenges to the Construction of Maternity Waiting Homes

The complexity of this issue has come up in interviews with key project staff. The team visited a maternity waiting home in Huanuco last year, but has not moved forward with the plan of constructing and implementing a maternity waiting home in Ucayali for 2 reasons:

1- The feasibility of successful maternity waiting homes in Ucayali is uncertain. This is due, in part, to gained knowledge about previous experiences by Pathfinder, which attempted to open 2 homes in the Ucayali region 3 years ago without success.

2- The decrease in project funding left the Healthy Babies project with no funds available to pledge to the construction of maternity waiting homes. Without a concrete funding pledge on behalf of the Healthy Babies project, the team cannot request matching donations from local government (ie, the municipality) or other donors.

The hospital of Yarinacocha has offered space for the construction of a maternity waiting home, however, until there are funds, construction will not commence. However, the delay in working towards this activity has resulted in the time that the team needed to re-assess the value of this strategy and discussions regarding the best strategy to take are in process.

Distance and difficulty of transportation to rural/river communities

In general, work has progressed more in the areas closest to the urban center of Pucallpa than in the rural and river communities. In these more distant communities, progress of workplan activities has been slower in part due to the challenges presented by large distances, river access routes and expensive transportation. For these reasons, project staff has not been able to visit the more distant health facilities very frequently, and more importantly, MOH staff and CHWs from these areas have had difficulty attending the training sessions held in the urban areas. They are deterred from making the long trip by the cost of travel (Healthy Babies project has not yet been able to reimburse all travel expenses) and the time commitment. To attend trainings, these participants have to leave their homes and families very early in the morning and return very late at night, only to do so again the following day (in the case of trainings over several days). During focus groups, training participants from the rural areas mentioned that they would appreciate (prompt) reimbursement of travel expenses, lunch included for all participants and some sort of incentive for their time in order to attend again in the future. This would motivate higher rural attendance.

The distance does not only affect attendance at urban training sessions. The rural health post staff also has difficulty reaching their more distant catchment population and keeping in good communication with those CHWs that are most far away and isolated. When rural health staff hold training sessions for the CHWs at their health post, it is also difficult to achieve representative attendance by volunteers from the most distant areas. Focus group participants mentioned they would like to see more training sessions and educational workshops held in the more distant and/or rural areas. In addition, rural catchment areas sometimes have less health staff or less CHWs willing to work. In one rural focus group, MOH staff explained that there are some CHWs that have to spread their efforts among 3,000 residents. This, combined with the large distances between communities and the high cost to mobilize between communities and to training sessions, makes the work of rural CHWs difficult.

In river communities, transportation relies on availability of boats and ability to pay for them. At MTE, rural focus group participants stated that this lack of transportation continues to hinder the ability of women in labor to reach a health facility, claiming that there was a maternal death in an indigenous community last year. In fact, project staff mentioned that they could promote institutional deliveries non-stop, but as long as it is unsafe to travel in those regions at night, women will continue to deliver at home, so new strategies must be developed.

Perceptions in Community about Quality of Care at Health Facilities

In a key-informant interview, the director of health promotion at one of the urban health centers discussed that negative attitudes towards the MOH health facilities and misperceptions of what services the MOH health centers can and cannot provide for the community are key obstacles to community health promotion. She states that community leaders and CHWs need to work to

change these perceptions, but that “authorities can be resistant” and the general lack of organization and mobilization of the communities in her catchment area inhibits the ability to gain full support from local leaders and the community as a whole on the issues related to the Healthy Babies project, such as supporting the work of CHWs, urging attendance at prenatal visits and institutional birth, and clarifying misperceptions. Similarly, the head of an urban health center explained in a key-informant interview that a challenge to moving the project forward is apathy among the catchment population. She further discussed that people choose not to go to the health center because they are “misinformed” about costs of services or quality of treatment. These are attitudes and perceptions that she hopes the project can help to change by engaging the community and its leaders.

This issue was brought up by women from the community as well. In both urban and rural areas, the quality of services provided at the health facilities are questioned due to rumors of poor treatment and doubts of the safety of vaccines for children. Leaders from PVL explained that many women choose not to go to the health facility when in labor, saying that “it’s better to just deal with the pain” because at the health facility they will come across mistreatment, lack of respect and long waiting times (unless they go in as an emergency). It seems that these perceptions maybe be largely based on anecdotal stories, such as those related to us: “One of their daughters was in labor but was turned away from health center because they said she wasn’t yet giving birth, so she went home and gave birth at home;” or “If you arrive 15 minutes late for your prenatal control, they won’t see you.”

Both PVL leaders and MOH health staff pinpointed that another important issue is that people do not know which services are free and which are not, or, in the case especially of pregnant women, may not realize that they qualify for health insurance that covers services such as prenatal visits and labor and delivery. This community-wide lack of information and perceptions about the health facilities, services and insurance need to be further explored and mitigated. If there is any truth to the perceptions of poor treatment in any of one of the health facilities within the project target area, it will be imperative to identify the problem area(s) and work to improve the situation there.

Lack of trust in NGOs and outside groups in certain regions

As discussed above, in some of the coca-growing areas in particular, there is general distrust of outside groups implementing projects with the MOH or the community. During MTE focus groups, local health staff explained that this distrust comes from false or poorly run projects in the past: “You have to give credit to NGOs that do good things, but there are some that deceive and then the community blames all of them.” This is an area of Peru that turns to coca farming during difficult economic times, and the current USAID programs to foster alternative crops have not been well-received by all. MOH staff at the local level are hesitant to hang up posters or distribute materials displaying NGO or USAID logos because they are poorly received by the community. Health staff working in these areas explained that there is a “cocalero” (coca-growing) zone that is strongly opposed to any workers bearing logos of any kind. This distrust needs to be taken into consideration for the project to succeed in the area and its sustainability ensured.

Cultural barriers to promoting project goals in the community

All involved in the project – project staff, MOH health personnel, CHWs – have had to overcome various cultural barriers to help keep the project moving towards its goals. During the MTE, health staff and CHWs alike identified motivating behavior change in the community as the largest challenge to their work with the Healthy Babies project thus far.

Some cultural/local barriers are specific to river communities. Some of these areas are home to indigenous groups whose native language is not Spanish, making it difficult for those involved in the project to communicate the key messages with them. Recruiting CHWs who are bilingual will help overcome this issue, as will the use of picture cards in the field for communicating the BCC messages since these employ illustrations and no text. Also, during rural focus groups, participants mentioned that they know of indigenous groups that live in difficult to reach areas where boats are not always available for transportation to a health facility.

These rural participants also described that behavior change is very difficult in their areas because people have become used to programs providing services, goods, and food for free, and do not have the habit of seeking out the services that they need (i.e., health services). Some stated there is strong opposition to family planning and some women even look to have more children in order to receive free food from various programs. In terms of child nutrition, there are misperceptions of what constitutes both a healthy baby/child and a healthy diet. Rural health staff state that people only perceive their child to be sick when he/she has diarrhea and they feed meals largely based on carbohydrates. They believe this is the cause of the many malnourished children in the area.

CONCLUSIONS AND RECOMMENDATIONS

This is a technically-sound, innovative program to address the health needs of an underserved region of a country, as well as the health needs of an underserved population: newborns. The BCC strategy is in progress and its quality is excellent: print and audio materials have been developed following proper materials development techniques. The laminated picture cards have been praised by all and the main complaint is that not everyone involved in training others has a full set. The trainings on IMNCI and MAMAN, as well as the educational sessions related to IMNCI topics, were well received by all of those who have attended: from health personnel to CHWs to expecting/new mothers. They are described as dynamic, interactive, participatory and interesting, both due to the topics covered, and the techniques used (with special mention to the role plays). Many people have complimented the way the project team has interacted with local authorities, community members, and each other. This favorable review has led to a feeling of ownership among those involved/participating, which will be important to tap into as plans to make this project sustainable are developed. At the policy level, the (former) Project Director has been working closely with colleagues, on bringing the topic of IMCI with a neonatal focus to the national health agenda, with success. Newborn health is now a national health priority, and the Healthy Babies project can be used as a trial of the implementation of the IMNCI in a rainforest site: results from this project will help guide national level strategies with regards to the IMNCI implementation at a national level.

Where the project is lacking has been in its scope of work: due mostly to funding issues, as well as various other contextual factors described in that section in detail, the project has only done a small number of the proposed trainings and only developed some of the materials. The good news is that the training materials and capacity is in place, and the materials are drafted and validated and ready to be printed, so the project is in a great position to implement its activities fully with the complete budget they received for Year Three. Moreover, policy work has been focused on the national level. The new Project Director will be based 50% of the time in Pucallpa, which will be key in full involvement in the work towards development of regional health policies that focus on maternal and newborn health improvements. In addition, as the project enters its last two years, it will be crucial to start working strongly towards its sustainability. It is clear that this work must be done in collaboration with the local municipalities. So again, the presence of a Project Director part-time in Pucallpa will be key for this collaborative work and the discussions that need to take place. One issue that will need to be considered during final evaluation, though, is whether the project, hampered by funding restraints in the initiation of this project's activities, will be able to attain a change in indicators associated to behavior change, such as seeking health care, since activities to changes these behaviors are really only going to fully start in the third year of this project, and this may not be sufficient time to observe significant changes.

With regards to specific recommendations, these can be summarized as:

Material Printing and Distribution: With the full budget for Year Three, there should be no stopping of the printing and distributing of health materials. Each CHW should have a full set of the laminated picture cards for their educational work. Posters have been validated; now they need to be printed and distributed.

Training: The number of sites that have benefitted from the trainings is limited. The syllabi and materials for the trainings and educational sessions have been used and are well-liked. These

trainings now need to be conducted in all sites, and refresher workshops need to be scheduled regularly, again, in all sites.

CHW Census and Work: One key activity that seems to have inspired more community involvement, especially on behalf of the CHWs, was the implementation of a community census done by the CHWs themselves by dividing the community into sectors and assigning a sector to each worker. This activity has been done in some communities, and has been highly appreciated by all stakeholders. It is recommended that a census with CHWs be conducted in the remaining project sites. In addition, CHWs play a key role in the sustainability of this project, as resources that will remain in their community long after the project has ended. It will be key to train all CHWs, and initiate supervision of all CHWs so that they can start their work and obtain feedback on it in the next two years.

Policy Issues and Sustainability: Continue the work at the national level, but start working towards developing regional policies for maternal/neonatal health improvements. The regional level work must also contain a strong emphasis on the sustainability of the project. Moreover, municipalities have a health budget, but may not have all the technical expertise with regards to how to prioritize health expenditures, so regional policy development must be linked with close work and collaboration with municipalities. Finally, related to sustainability and scaling up, with the results of this MTE, the project is in a good position to approach private institutions and corporations for donations towards the project and this population.

Crucial to achieving sustainability of the project is the level of community involvement that can be managed in the next two years. It is key for the project team to form community committees and hold meetings and orientation sessions with them and with community leaders. These activities are programmed for the next two years. It is recommended that they be fully supported financially to complete these tasks in all of the key municipalities, given that successfully involving the community is key to long-term sustainability.

Updated Workplan: There are various proposed activities, specifically the implementation of the HLBSS training, the development of emergency transportation plans, and the construction of a maternity waiting home, that need to be thoroughly reassessed by the project management. Based on a meeting with the project management team to present the results of this MTE, it is clear that all involved are aware of the issues associated with each of these three activities, and there is no clear decision with regards to how to proceed. The team must decide amongst themselves what the best strategies would be, and update the workplan accordingly. Moreover, there are various activities that they have been involved in, such as policy level work at the national level, which is only minimally described, if at all, in the workplan. It would be strategic for the Healthy Babies team to include these other activities which are focused on improving maternal and neonatal health within their workplan and discuss ways to evaluate how effective these activities were in obtaining their goal.

Training/Strengthening Opportunities for Grantee and Partner Organizations: If the Project Management team decides to move forward with HLBSS, and this should be decided soon, then both INMED and PRISMA expressed interest in technical assistance associated with implementing the HLBSS training, which was not attained partly due to the costs of bringing the HLBSS trainers to Peru. However, the teams recognize this may not be the best time to push the

Peruvian MOH towards a decision on supporting HLBSS due to the political discussions regarding institutional vs. home births. Moreover, INMED had stated interest in strengthening its monitoring and evaluation skills, and the former Project Director in obtaining more training on child survival. I recommend that all partners discuss how their training interests have evolved, if at all, how to meet these training needs in the next two years, within the scope of the existing two years of funding.

Funding: With two years left to go, and much to be accomplished, but a good track record for the initial portion of their work, this project should get full funding to finalize its workplan. Moreover, the project management team must continue to meet annually to discuss how to prioritize expenditures on specific activities to ensure that all partners involved have a clear picture of how the funding for the entire year will flow, and on what particular activities. A large portion of the funding must be allocated to the operationalizing of field activities, such as trainings and policy meetings, which are a lot more expensive than originally expected due to distances, access and expenses associated with these.

ACTION PLAN

The key findings of the MTE were presented by the lead evaluator, Valerie Paz Soldán, to INMED Partnership for Children President, Linda Pfeiffer, and CFO, Thad Jackson; PRISMA Executive Director, Delia Haustein; the former Project Director who will now play a role in TA for the project, Marilu Chiang; and INMED-Andes Vice-Director, Liesel Stahr. The USAID Mission contact, Luis Seminario, was invited, but was not available for meetings during the week-long visit of the INMED Partnership for Children team. There was a thorough discussion regarding the findings and the next steps to be taken by the project management. This action plan was written after the meeting took place, in order to capture the ideas discussed regarding how to proceed. Some of these are specified in the recommendations as well, since these were items that came up separately during the MTE. Here are some key items for the action plan:

Maternity Waiting Homes: As described in this report, there are genuine issues about feasibility of these Maternity Waiting Homes. On one hand, there are reasons to proceed with this activity. Specifically, the MOH and the World Bank, through the ParSalud program, are aiming to reduce maternal mortality, and in the second phase of their project, specifically outline the use of maternity waiting homes near hospitals for this goal. This activity would fit into a larger national-level vision of setting up more of these types of homes around the country. However, the project team talked to Pathfinder with regards to their feasibility assessment to set up 3 such homes in rural Ucayali region: Pathfinder found that this project was not sustainable and did not pursue it further. Thus, there are genuine questions regarding what would happen if such a home were to be built: how would it be maintained? Who would buy the food for people staying there? Would it be better to rent a room in someone's home (if this type of "free space" is available in homes in the area)? The project management should make a decision with regards to this strategy, and then update the workplan accordingly.

Emergency Transportation Plans: Again, as described in this report, the feasibility of this strategy is questionable. In addition to the issue of safety and security of women travelling at night, there is the issue of access (it is hard enough to obtain transportation during some seasons to the most remote areas) and sustainability (how would these emergency transportation plans be maintained considering their expense?). The project management should determine how to proceed with this activity, and update their workplan accordingly.

Regional Policy Work: Much of the work related to the BCC strategy, trainings, and national level policy work has been initiated and is set to go as the funding for this third year comes in. However, more work towards developing regional policies for improving maternal and neonatal health, and the sustainability of various activities associated with this project, needs to be initiated.

Setting Up a Monitoring System: Key partners recognize the benefit of setting up a regular monitoring system in place: it allows them to monitor their progress, but serves as a reminder to involved health personnel about proposed objectives associated with maternal/neonatal health. Project management team should discuss the direction they want to take in setting up such a monitoring system in the next two years, which would also be beneficial to the region once the project has ended. For sustainability purposes, if personnel (health or municipal) from the region are able to manage their own monitoring system, it will enable them to take over this function at the end of the project.

HLBSS: With the training materials translated and one of the three manuals validated, it seems that there are three main issues for the project management to discuss now: 1) discuss the changes with the American College of Nurse Midwives to obtain their approval to use the modified HLBSS with their support. If this is achieved, then a member of the project should attend one of the training sessions in order to train others on particular issues associated with conducting trainings on HLBSS; 2) discuss and decide whether or not this should be presented to the Peruvian MOH for their approval. There is much debate at the moment regarding the promotion of institutional births vs. home births, so this may not be the best time to try to obtain the approval of the MOH with regards to the HLBSS training. However, there are many other components to the HLBSS which could be promoted and supported by the MOH; 3) decide whether or not to implement the HLBSS trainings, with or without the support of the American College of Nurse Midwives and with or without the support of the MOH. Considering the investment of time and funds towards the translation and (partial) validation of the materials, the project should make a decision regarding how to proceed and update their workplan accordingly.

ANNEXES

1. Results Highlight of an Innovative Idea

One of the main objectives of this project is to educate expecting and new mothers on their own and their newborn's health. To accomplish this, health personnel and CHWs are being trained on health issues so that they, in turn, can reach out to mothers in various settings. Moreover, a behavior change campaign is in place to reinforce specific key messages.

One of the challenges faced by the Healthy Babies project is that the Ucayali population is spread out over a large area with difficult access to reaching them, and the population is diverse: there are various native ethnic groups that speak different languages. This project relies heavily on CHWs to access expecting and new mothers in all communities, including the most remote, and to encourage them to go to health facilities, as well as to provide basic health messages. However, most CHWs have minimal health backgrounds themselves and are often not highly educated. Thus, providing CHWs with the tools they need to reach out and educate people in their communities is a key issue for this project. The "laminated picture cards", described in detail in section 1D, IR1, Main Activity 1 & 2, as well as section 1E, are 8 ½ x 11 sheets, with whole-page illustrations of different health situations, which come in packages based on a theme: danger signs in the newborn, danger signs during pregnancy, birth plan, pregnancy care and newborn care. They also have depictions of "Mariana's story", a woman who can take two paths – one to life and one to death – based on the health choices she makes. (One story focuses on her path to life – using family planning, going to pre-natal care when pregnant, seeking help for problems, and having a healthy and happy family; and one story focuses on her path to death – she has lots of children, is pregnant again, and does not seek help in time when she starts bleeding, and hemorrhages to death.) These laminated sheets, bound by a ring based on theme, are word-less and depict, in a series of images, the message being conveyed. Many images were taken from the HLBSS and adapted by a local illustrator to depict people from the Ucayali region, including the type of clothes or background items one might see in this region; others were developed by the local illustrator based on the message to be depicted.

Though the effectiveness of these laminated cards has not been specifically evaluated, these seem well suited for the population and the objective of this project. First, in a region with various languages spoken by the native ethnic groups living there, it relies on the image to convey the message. Thus, it can be used CHWs throughout the region. Second, as with any low-literacy population, less words on the health education material are better. In this case, there are none. Thus, it is not intimidating: it simply gets across the message. Third, because it comes in packages by theme, it is an easy tool to use: one package can be used to provide a specific health message in one visit.

Everyone interviewed for the MTE had positive comments about the laminated picture cards. However, due to financial constraints, only enough laminated picture cards have been printed to be provided to health personnel working in the region. Thus, it is strongly recommended that these picture cards be printed out and distributed as health education tools for the CHWs to use. Moreover, since the picture cards have not been used by CHWs in the field yet, the project is in an ideal moment to evaluate the effectiveness of these picture cards by measuring change of knowledge amongst mothers with whom these would be used. There could be measures of knowledge change

that are taken right after the picture cards are used, as well as measures of long term retention of those specific messages taken over time.

2. Publications and/or Presentations

See article that follows:

Chiang, Marilú and Gilman, Josephine. 2008. “*Situación de salud infantil en niños menores de dos años en dos provincias de Ucayali. Línea de base proyecto ‘Bebés Sanitos’.*” (“Infant health situation among children under 2 years old in 2 provinces of Ucayali. Results of baseline of ‘Healthy Babies’ project.”) Published in “*Investigaciones Operativas en Salud y Nutrición de la Niñez en el Perú*” (“Operational Research in Child Health and Nutrition in Peru”): Ministry of Health of Peru, WHO and PAHO.

3. Project Management Evaluation

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4. Full M&E Table

Note: The following is the full M&E Table as presented in the DIP. For this reason, the format of this table differs slightly from that specified in the MTE guide and used in the Summary M&E Table.

Intermediate Result	Indicators	Source/ Measurement Method	Frequency	Base-line	EOP Target	Midterm^a
IR1. Increased knowledge and practice of maternal and newborn care seeking behavior	% pregnant women know 3 danger signs in pregnancy	KPC; Supervision Survey	Baseline, MTE, and Final	45%	75%	56.7%
	% women who recognize 3 newborn danger signs	KPC; Supervision Survey	Baseline, MTE, and Final	2%	45%	48.5%
	% women who breast feed within one hour of birth	KPC; Supervision Survey	Baseline, MTE, and Final	52%	70%	79.5%
	% women who have a complete birth plan	KPC; Supervision Survey	Baseline-Mid-term and Final	21%	60%	17.5%
	% women who have adequate hand washing practice	KPC; Supervision survey	Baseline, MTE, and Final	10%	50%	-- ^b
	% of women who have at least 6 antenatal visits	KPC; Supervision Survey	Baseline, MTE, and Final	63%	75%	56%
	% Micro-networks that have a breast-feeding support group	Supervision Survey; health establishment records	Bi-annually	0%	70%	15%

IR2. Increased quality of maternal and newborn care services in health facilities and the community	% of women who have a delivery with a <i>skilled attendant</i> ^c	KPC; supervision survey	Baseline, MTE, and Final	78%	88%	69.4%
	% of women who have an institutional birth	KPC; Supervision survey	Baseline, MTE, and Final	79%	--	63.8%
	% of women received follow-up visits within three days of birth from provider or CHW	Health facility records and Supervision Survey	Annually	NA	75%	23.5%
	% women who receive iron/folate suppl. during pregnancy and 3 months afterwards	KPC Health center and health post records	Baseline, MTE, and Final	56%	80%	81.6%
	% urban health facilities with midwives, nurses and technical nurses trained in community based IMNCI	Health facility records	Records updated after every training session	0%	75%	58.6%
	% rural health establishments that have midwives, nurses and technical nurses trained in HBLSS	Project training Records	Records updated after every training session	0%	70%	0%
	% health establishments workers that correctly follow MOH policy guidelines ^d	Supervision survey – observation and checklist		0%	85%	52.6%

IR3. Increased availability/access to maternal and newborn services in health facilities and the community	% of district municipalities with emergency transportation system in place for women with emergency	Health center, Health post and Municipalities records	Bi-annually	0%	80%	0%
	% health facilities that have supplies for birthing and maternal and neonatal emergencies	Supervision Visits – Observation	Bi-Annually	25% ^e	80%	39.2%
	Number of maternity waiting home	Supervision visits; MOH and municipal records	Bi-Annually	0	3	0
IR4. Improved policy environment for maternal and newborn care	% district municipalities with policies that support maternal and neonatal health	Municipal records	Annually	10%	80%	Not measured
	% community boards with members trained in IMCI or HBLSS	Training records	Bi-annually	0%	80%	0% (no community boards)
	% children with Birth Certificate	Municipal records; KPC; Supervision survey	Bi-annually	42%	80%	82.1%
	% women and children registered in the government health insurance system	Municipal records; KPC	Bi-annually	65% (children)	85%	88.3% (children), 92.9% (mother while pregnant)

^a Different sampling design and population: results are not statistically comparable.

^b This data was supposed to come from the supervision survey, but the way the question is asked and coded in the database, this indicator is impossible to estimate. The question has been rephrased in subsequent surveys, but the database is still formatted with the initial survey, and this should be updated to be useful at the final evaluation.

^c Skilled attendant was defined as a health provider who did the delivery, whether at a health facility or the woman' home.

^d This was defined as the percentage of facilities that follow at 50% of the MAMAN policies. Out of the 11 possible points for MAMAN, those with 6 points were counted as following policy.

5. Evaluation Team Members and their Titles

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Anamarie Brown, BA

Independent consultant

6. Evaluation Assessment Methodology

The MTE team utilized both quantitative and qualitative data to implement the evaluation.

Quantitative Component

Data for the quantitative component were already available, though the evaluation team re-entered data related to the pre- and post-tests given to participants at the workshops and educational sessions to obtain more detailed information about the change in knowledge in specific topics. Namely, all pre- and post-tests administered to participants in workshops/educational sessions were re-scored and a new database was created to be able to analyze change of knowledge for specific topic areas.

All these pre- and post-test data were analyzed in STATA 8.0. Percentages and frequencies were documented in tables. Chi-square tests were conducted to determine whether there were statistically significant changes in the pre- and post-test data for the training sessions, and to assess differences in the data from the baseline compared to that collected during TA visits.

Quantitative data associated to the indicators being measured was obtained from the Healthy Babies project information system that included a baseline KPC survey, as well as data from the technical assistance visits and interviews with mothers conducted by the Healthy Babies Pucallpa team. For 102 facilities, Healthy Babies team members had documented general information regarding the facility, the types of supplies available, and then 2 medical files of new mothers were randomly selected and reviewed. At these TA visits, 2 mothers from the community associated to that health facility were also recruited to answer some questions regarding their knowledge, attitudes and practices associated with specific topics (pregnancy care, newborn care, etc). Unfortunately, the sampling design and thus, population sampled, were different at MTE and baseline, and hence not comparable. It is expected that the bias in the population sampled at MTE would be upwards, considering that locations sampled were those who had received the trainings, whereas those left out of the supervision survey were those with least involvement in the project.

Qualitative Component

Three members of the evaluation team traveled to Ucayali to conduct qualitative research with the various sectors and stakeholders involved in the Healthy Babies project. Data consisted of a combination of key informant interviews and focus groups. Specifically, three focus groups with approximately 8 people in each were conducted with 1) health providers, 2) CHWs and 3) participating mothers in Pucallpa (urban), and three focus groups were conducted with the same three populations in Masisea (rural). Convenience sampling was used to recruit participants to the focus groups. In the focus groups held in Pucallpa, there was a selection of participants from urban, peri-urban and rural locations (but close to Pucallpa), and in Masisea, participants represented a variety of rural communities near Masisea. Key informant interviews were held with DIRESA authorities (3) most involved with this project, Healthy Babies PRISMA Pucallpa team (3), health providers (3; 2 who are Healthy Babies workshop facilitators), CHWs (2), and participating mothers (2). In addition, the evaluation team conducted observation of some of the health facilities, observing specifically for health education materials from the project and where these had been placed. Though these focus groups and interviews are not meant to be representative of the entire region, and there is a likely bias towards the health personnel, CHWs and participating mothers who have been most active in the Healthy Babies project, due to the extensive area and limited time and

funding for the qualitative evaluation, we tried to ensure representation from both rural, peri-urban and urban locations.

Various key informant interviews also took place in Lima, with Health Babies team members (PRISMA, INMED Andes, INMED Partnership for Children), as well as key informants regarding policy and direction of the program: Miguel Davila, Pan American Health Organization; and Luis Seminario, USAID Health Office in Peru.

Health education and promotion materials were reviewed by the Lead Evaluator, who has her Master’s degree in Health Education and substantive experience in health education materials development. All materials were reviewed, and she interviewed key informants regarding the process of developing these materials. Finally, documents associated with the Healthy Babies project were reviewed by the Lead Evaluator to understand the details and magnitude of the project.

All focus groups were audiotaped and detailed notes were also taken (details about the composition of the focus groups listed in table below). Detailed notes were also taken of all interviews (listed in the next section of this report, section 8). All notes were written up into a preliminary report at the end of each day. Observations were conducted in 5 health centers (2 in the city itself and 3 outside), and consisted of a systematic documentation of educational materials visible and available to the population related to maternal and child health. The team specifically looked for the presence of Healthy Babies project materials. Main findings from each of the focus groups and interviews were reported in the corresponding section of the evaluation structure. Quotes were included as appropriate. The 8 focus groups completed (FG1-8) are listed in the following table:

Health personnel	Position at Health Center	Function within Project	Number of participants	Participants’ place of work
FG 1	Nurses, nutritionists	Training facilitators	7	Urban, peri-urban and rural districts
FG 2	Nurse, midwives	Training facilitators	3	Rural
FG 3	Nurse technicians, midwives	Training facilitators	5	Rural
CHWs	Associated Health Center	Function within Project	Number of participants	Participants’ type of community
FG 4	CS 9 de Octubre	Community Health promoter	3	Urban
FG 5	CS San Fernando	Community Health promoter	8	Urban
FG 6	CS Campo Verde	Community Health promoter	5	Urban, peri-urban and rural districts
Beneficiary mothers	Association	Function within Project	Number of participants	Location of residence
FG 7	PIN Mothers	Final recipients of health information	6	Urban
FG8	PVL (directive or administrative roles)	Final recipients of health information & diffusers to mothers	10	Urban, peri-urban and rural districts

7. List of persons Interviewed and Contacted during Midterm Evaluation

Valerie Paz Soldan's interviews:

- Eduardo Arrarte – Director, INMED Andes
- Ursula Barrientos – Administrative assistant, INMED Andes
- Marilú Chiang – Director, Proyecto Bebes Sanitos (Healthy Babies Project)
- Miguel Davila – Infant Health Assessor, Pan American Health Organization
- Martha García – Maternal-Neonatal Coordinator, DIRESA (MOH)
- Josephine Gilman – former technical backstop for Healthy Babies, INMED Partnership for Children
- Delia Haustein – Director, Asociación Benéfica PRISMA
- Antonia Hinostroza – Director, Atención Integral de Salud, DIRESA (MOH)
- Nelly Mercado – Data manager, Proyecto Bebes Sanitos, PRISMA Pucallpa
- Linda Pfeiffer – President, INMED Partnership for Children
- Luz Ponce – Director, Promoción de la Salud, DIRESA (MOH)
- Luis Seminario – USAID Health Office
- Liesel Stahr – Vice-director, INMED Andes
- Maybee Terrones – Training coordinator, Healthy Babies Project, PRISMA Pucallpa
- Amanda Vasquez – Team manager of activities, Healthy Babies Project, PRISMA Pucallpa

Maziel Giron and Lauren Nussbaum's interviews:

- Dolith Ríos – Project Coordinator, 9 de Octubre Health Center, Pucallpa
- Mónica Zevallos – Chief, 9 de Octubre Health Center, Pucallpa
- Alejandro – Midwife, Masisea Health Center, Masisea
- 2 CHWs
- 2 participating mothers

8. Special reports

See attached example of a powerpoint presentation developed by Healthy Babies Project for seeking potential donors.

9. Project Data Form

-CSHGP Project Data Form:

Printed and updated from www.childsurvival.com/projects/dipform/login.cfm

10. Reference Documents used for Report

1. Detailed Implementation Plan (DIP) and response to USAID on DIP review, August 2000
2. KPC Survey 2007 – Health Babies
3. Annual Progress Report to USAID October 2007
4. Technical Support Project and the CORE monitoring and Evaluation Working Group
5. Program Narrative Field Reports Healthy Babies project Ucayali (in Spanish)
6. Training Materials – Healthy Babies Project
7. Letter and modified Work Plan received by USAID on April 4th 2008.
8. WHO Website:
http://www.who.int/child_adolescent_health/topics/prevention_care/child/imci/en/index.html