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MID-TERM ASSESSMENT OF USAID/PERU HEALTHY COMMUNITIES AND MUNICIPALITIES PROJECT
JULY 2006 – DECEMBER 2009

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EXECUTIVE SUMMARY

The USAID/Peru Office of Health contracted CAMRIS International to conduct a mid-term assessment of the Healthy Communities and Municipalities (HCM) activity, which is scheduled to end on September 30, 2010. The assessment examines and verifies programmatic results to date, provides a detailed account of the project strategies and interventions, identifies recommended improvements to the activity model, and determines to what extent HCM is coordinating with and contributing to overall USAID/Peru objectives and activities. In addition, the assessment provides USAID/Peru with an informed basis to consider options regarding the value and design of possible follow-on activities that would foster continued increases in healthy behaviors, basic-level health care services to communities, and organizational capacities and infrastructures required to sustain community-based health interventions and services.

Background

The HCM project was created to complement USAID/Peru’s Alternate Development Program (ADP) with a focus on improving maternal and child health through behavior change for developing healthy lifestyles. The ADP is a multisectoral effort designed to promote licit development in areas where coca cultivation and narco-trafficking are common. The ADP includes health, education, democracy and governance, and economic development activities. In 2002, USAID/Peru prioritized development activities in seven regions (Ayacucho, Cusco, Huánuco, Junín, Pasco, San Martín, and Ucayali) that are characterized by poor health indicators including childhood malnutrition. Drug trafficking—sometimes coupled with guerrilla activity—exacerbates the challenges posed by poverty. Due to these problems and the inherent instability of the situation, these areas had largely been abandoned both by the government and private investors. Through work with district-level authorities, HCM seeks to build the organizational capacity and infrastructure required to sustain community-based health interventions and services to communities participating in the ADP.

In July 2006, USAID/Peru engaged MSH through field support to the USAID Leadership, Management and Sustainability Program (LMS) to continue the implementation of HCM in 340 communities in 32 districts that had signed coca-eradication agreements. From July 2004 to June 2006, the HCM project was implemented by PRISMA, a Peruvian NGO subcontracted by Pathfinder through field support to the USAID/Washington Catalyst Project. The initial HCM project emphasis was on the community level. However, in 2007–2008 this emphasis began to increasingly shift to supporting the district and regional levels to adopt the program and assume responsibility; this included extending the HCM strategy to other communities.

Methodology

The information used in this assessment came from review of project documentation, key informant interviews and structured group discussions, and site visits. The assessment team worked with the Mission and the USAID/HCM project to review the sampling frame of districts, communities, and households and stratify according to key criteria. The whole team visited the
sites in Ucayali the week of February 15, and then two members each went to San Martín and Ayacucho the week of February 22. Upon returning to Lima, the team held follow-up meetings with key stakeholders, USAID, and HCM project staff to review and validate the findings and gather further information and clarifications. The team also held in-depth internal discussions on each of the six thematic areas in the SOW before writing the report so that the final report represents a consensus view of the different perspectives provided by each team member. A formal debriefing with USAID was held on March 17.

Findings

The HCM project, which has been extended on a year-by-year basis through the approval of annual work plans and budgets, never developed a PMP or an M&E plan. Instead, each year it presented a set of results and indicators, which varied slightly from year to year, in a logframe format. The project then tracked and reported annual results against the targets in that year’s plan. Many indicator results, but not all, built on the previous year’s targets (Appendix G).

The project has been successful at organizing and empowering more than 500 communities in zones of difficult access, particularly when one takes into account the challenges presented by the socio-political situation in the coca-producing region. The communities visited all perceive themselves as being better off as a result of the project. This perception is shared universally by personnel at the district, micro-network, and regional levels who believe that these communities have improved over time. These same informants also believe that these communities have improved relative to neighboring communities and are cleaner, better organized, and with improved practices and health outcomes such as reduced childhood morbidity and malnutrition. The assessment team noticed that in fact these communities appeared relatively clean and organized with little trash, few animals such as pigs and cows running loose, and ordered public spaces, often with ornamental plants.

HCM has done a laudatory job under difficult conditions of helping to organize the communities around health-related issues and strengthening their capacities to collect and report data and to set priorities and negotiate with the district governments as part of the participatory budget process through the effective functioning of the CC. Through its values-based leadership training, promotion of healthy lifestyles, and organization of the local communities, HCM contributes to the overall goals of the ADP program and provides a facilitating environment for other ADP activities. The improvements in the physical appearance, self-esteem, empowerment, and wellbeing of the communities are readily noticeable to outside observers. However, the external assessment team did not find hard data to determine if there had been improvements in health status of the target population, much less to attribute improvements to project efforts.

The assessment team also noted some concerns that require attention, including the need to:

- Reestablish the focus on the target population;
- Modify and simplify the community diagnostic data collection instrument while making it more relevant to other development programs (USAID and GOP);
- Structure and further strengthen coordination with other USAID projects to maximize the potential for synergies;
• Develop and implement an M&E plan; and
• Establish community-based growth monitoring for integrating MCH activities.

In terms of implementation of the model, health technologies and primary health care seem to have suffered at the expense of the community development and strengthening approach. The main weakness of the model as it is being applied is HCM’s loss of its focus on the target population, pregnant women and children under two years of age and their caretakers, especially those in the most vulnerable situations. When visiting communities, project staff first seek out the members of the CC and then the model families they are working with. Other community members are not excluded from group activities; however they do not receive the same level of attention. The assessment team observed that the model families tended to be better off and older, with few or no pregnant women or children under two in the household. Therefore, a disproportionate amount of project effort is going to the less needy. The team encountered some community members that felt alienated, that it was “a program for the rich.” The team also met some mothers of children under two years of age that expressed that they had been specifically excluded from the program.

The facilities-based growth monitoring is being carried out very poorly and is not applying lessons learned and best practices from Peru and Latin America.\(^1,2\) In the communities where there is no health center, poor mothers are not inclined to spend money on a moto-taxi to take an apparently well child for a growth monitoring visit, especially when there is a risk that the center will be closed. The team could not find examples of true community-based growth monitoring with active meaningful participation of the community and families.

There was an almost universally correct and sometimes enthusiastic response to the question “Do you know who (what agency) is supporting the project?” (“Our good friend USAID,” according to a Regional Vice-President). The only respondent that did not know was one CC that thought that the project had originated in Boston. A special appreciation was expressed in Ayacucho where HCM is currently the only USAID project with an active presence. The team believes that it can be said with a great deal of certainty that the HCM project has generated considerable good will towards USAID among Peruvians in the ADP program area.

In summary, the main achievement of the HCM project is its insertion into the national, regional and district government agendas, and its adoption as the implementation strategy for health promotion within the context of integrated development programs such as CRECER, and more recently with the MOH/Directorate for Health Promotion. There is now widespread political support for extending the model nationally. The question is how USAID can best support the GOP in this effort.

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\(^1\) World Bank, Promoción del Crecimiento para Disminuir la Desnutrición Crónica, Estrategias con Bases Comunitarias en Centro América.
Main lessons learned

- Projects should have a multi-year time frame with a PMP (optimally with a baseline study and follow up). The year-to-year HCM project renewal modality complicated efforts to evaluate project effects and also hindered the continuity of manpower development and training programs for project staff, beneficiaries, and local counterparts.

- Health promotion programs that take a community development and institutional strengthening approach need to ensure that they do not lose their focus on the target population, in this case pregnant women and children under two years of age, and vulnerable women of reproductive age such as adolescents. These groups need to be first and foremost in project activities.

- Key to success at the community level in improving maternal child health is the smooth functioning of the team of the CC, the auxiliary nurse, the health promoter, and, potentially, the school (Figure 1).

- Individual schools and the educational system have an important normative role, and institutionalization of the healthy schools approach can contribute to sustainability.

- The ability of the CC to effectively participate in the district planning and budgetary processes is of almost equal importance. These processes and functions, particularly in the area of data collection, analysis and use, still require an almost constant accompaniment as do the rest of the activities at family, community, district and even regional levels.

- True coordination across projects requires more than good intentions and occasional meetings to share information. A stipulation with measures of compliance (preferably contractual) that the projects working in the ADP zones mutually select districts for the design and implementation of integrated development plans based on the multisectoral CRECER strategy would enhance the development of synergies across projects.

- Singling out “Model Families” for attention appears to have been counterproductive and should be discontinued. However, the “Model Community” approach does appear to have value, particularly in terms of refining project instruments and for serving as locations for guided observational site visits. Providing competitive rewards at the family and community levels should be discontinued since there are not level playing fields and this strategy only highlights or even exacerbates pre-existing differences. Incentives are probably best left at the community level and should be based on level of execution of the commitments in their development plans that ideally have been negotiated and agreed upon with the districts.

- The health promotion model has provided local communities with improved organization, self-esteem, and quality of life. Coupled with HCM training and strengthening in areas such as value-based leadership and community management and healthy lifestyles, the model has facilitated the work of other programs, such as those promoting alternate means of production/income generation.

- The sexual/reproductive health education programs, largely provided through the school and health center settings, are insufficient to modify the risk of teen pregnancies given the social context (including delinquency, transactional sex, and drug use).3

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• There is limited potential for further extension of health services through the MOH/HE. Complementary strategies for empowering communities to resolve their own health problems are needed.

Recommendations

The transition of HCM from an implementation project to a primarily technical assistance project should be continued and accelerated. The HCM-follow on should concentrate on best practices and excellence and focus down geographically on a few model districts in the ADP zones in each region, to be selected according to need in collaboration with the GOP and other USAID projects. The focus in these districts should be on:

• Developing district-wide coverage of comprehensive development plans and programs;
• Refining tools and instruments such as the community diagnostics; and
• Using information at the community, district, and regional levels for developing and implementing plans and monitoring the health of the target population.

The solicitation document for a follow-on activity should stipulate that the applicant presents:

• A four-to-five-year proposal along with a detailed M&E plan including baseline and follow-up studies (possibly with comparison communities selected from the ENDES sample)
• How it proposes to coordinate with the other USAID projects in the ADP zone in the selection of model districts and the development and implementation of integrated development plans in those districts with specific project commitments. These plans will use as a reference the GOP multisectoral CRECER social development strategy framework. The initial work plan will have a timeline for a series of deliverables that will be the individual district development plans (each with its own implementation timeline).
• A detailed sustainability plan for passing responsibility for supporting community-level activities to the district and regional governments.
• A detailed human resources development strategy that includes passing the capacity for trainings suggested below to the host country and the development of non-monetary and other incentives for community-level personnel and committees.

The applicant should specify how it will develop integrated approaches for:

• Environmental management
• Community youth programs
• Human resource development
• A multi-pronged plan to develop national capacities for training key health promotion and development personnel on a continuing basis through
  - diploma-level courses
  - health promotion for district and regional government officials and sector staff
  - leadership training at the community, district, and regional levels
- paper-based self learning modules for nurse auxiliaries at the micro-network level

- Community-based growth monitoring programs
- Resource development
- Streamlining and improving the information system including refining the indicators and data collection instruments and procedures (including quality assurance)
- Behavior change
- Strengthening the capacity of the micro-networks to support the HE
- Developing non-competitive community-based incentives.
# ACRONYMS

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<th>Full Form</th>
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<tr>
<td>ADP</td>
<td>Alternate Development Program</td>
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<td>ASIS</td>
<td>Health Assessment Methodology (Análisis de Información en Salud)</td>
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<td>CC</td>
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<td>CQI</td>
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<td>DIGEPROM</td>
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I. INTRODUCTION

A. BACKGROUND AND PURPOSE OF ASSESSMENT

The USAID/Peru Office of Health contracted CAMRIS International to conduct a mid-term assessment of the Healthy Communities and Municipalities (HCM) activity, which is scheduled to end on September 30, 2010. The assessment examines and verifies programmatic results to date, provides a detailed account of the project strategies and interventions, identifies recommended improvements to the activity model, and determines to what extent HCM is coordinating with and contributing to overall USAID/Peru objectives and activities. In addition, the assessment provides USAID/Peru with an informed basis to consider options regarding the value and design of possible follow-on activities that would foster continued increases in healthy behaviors, basic-level health care services to communities, and organizational capacities and infrastructures required to sustain community-based health interventions and services.

The assessment covers issues and questions in the following six thematic areas:

- Development theory/conceptual model
- Interventions and activities
- Results to date
- Activity model
- Management, communication, and coordination
- Future directions

The HCM project was created to complement USAID/Peru’s Alternate Development Program (ADP) with a focus on improving maternal and child health through behavior change for developing healthy lifestyles. The ADP is a multisectoral effort designed to promote licit development in areas where coca cultivation and narco-trafficking are common. The ADP includes health, education, democracy and governance, and economic development activities. In 2002, USAID/Peru prioritized development activities in seven regions (Ayacucho, Cusco, Huánuco, Junín, Pasco, San Martín, and Ucayali) that are characterized by poor health indicators including childhood malnutrition. Drug trafficking—sometimes coupled with guerrilla activity—exacerbates the challenges posed by poverty. Due to these problems and the inherent instability of the situation, these areas had largely been abandoned both by the government and private investors.

In July 2006, USAID/Peru engaged MSH through field support to the USAID Leadership, Management and Sustainability Program (LMS) to continue the implementation of HCM, in 340 communities in 32 districts that had signed coca-eradication agreements. From July 2004 to June 2006, the HCM project was implemented by PRISMA, a Peruvian NGO subcontracted by Pathfinder through field support to the USAID/Washington Catalyst Project. As of December 2009, HCM was active in 515 communities in the original project zone, and is expanding to include an additional 1,249 communities in 63 districts. The project aims to foster behavior changes that will result in the improvement of social and maternal and child health indicators.
Through work with district-level authorities, HCM seeks to build the organizational capacity and infrastructure required to sustain community-based health interventions and services to communities participating in ADP. This assessment covers the period of performance from July 2006 through December 2009 and does not include the recent expansion. However, it also makes reference to predecessor activities that it builds on.

The HCM Project initiated by PRISMA in 2004 built upon previously existing interventions active in the ADP areas:

- Catalyst’s Healthy Municipality Strategy developed in the framework of the Improvement of the Health of the Poor in Seven Regions Project, which had standardized methodological guidelines and materials in health promotion for work at the district level. At that time, HCM was intended to complement and extend this intervention to the community level in 32 coca-producing districts in the ADP.

- PRISMA had been working in the PDA zone in the River Apurimac Valley (VRA) since 1996 to combat acute malnutrition in this coca growing region. Through its experience with the PL-480 Title II project, it had developed a health and nutrition intervention based on Communication for Social Change. The intervention was aimed at reducing chronic child malnutrition through working with local and regional political authorities, Ministry of Health (MOH) personnel, voluntary community health promoters (HP), and families with pregnant women and children under three years to promote preventive health practices and to insert the problem and its causes into the local political development agenda.

PRISMA had been working as a sub-contractor with the USAID ADP Project implemented by Chemonics. However, it was felt that their activities were more relevant to the health portfolio, and the decision was made to switch mechanisms to the USAID Catalyst/Pathfinder project in 2004. The resulting HCM project built on already established social networks so that the local government would adapt the Healthy Municipalities Strategy through a health promotion approach. Each district was to have a Local District Technical Team (LDTT), and each community a Communal Committee (CC). The LDTS’s and CC’s role was to establish the political and technical framework within which health promotion activities were developed, both at the communal and family levels. In addition, the project implemented the “Healthy Schools” concept in order to strengthen the community-level intervention and, through school children, the family-level intervention. All activities were aimed at promoting healthy lifestyles and environments. The project encouraged the participation of the Ministries of Health and Education in the LDTT and the CC.4

It is very much worth noting that at that time, in addition to the difficult socio-economic and political situation (including political violence and narco-trafficking), the population in the PDA zones was reserved, if not outright hostile, towards external cooperation agencies. These conditions provided a major challenge to the project during the start-up phase. This situation has improved significantly over time as the local communities have gained confidence in the project. However, there are still flare-ups of violence, strikes and unrest in a number of zones, such as the

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4 This section was adapted from the Pathfinder/PRISMA proposed work plan for July 2004 – June 2005.
VRA and parts of San Martín (Pólvora), Huánuco (Cholón) and Junín (River Ene region). Staff in those areas is on a constant state of alert, has had to postpone, limit or cancel activities, and sometimes takes protective measures for personal safety.\(^5\) HCM is the only USAID project that currently has a presence in VRA.

When HCM project implementation changed from PRISMA (through Catalyst/Pathfinder) to LMS/MSH, project staff transferred from PRISMA to MSH, thereby providing a nearly seamless transition in local project management. The project also changed its reporting period to correspond to the USAID fiscal year. Other health activities supported by USAID during the period included\(^6\):

- USAID/Promoting Alliances and Strategies (PRAES)
- USAID/Health Policy Initiative (HPI)
- USAID/Health Systems 20/20
- USAID/Quality Healthcare.

USAID is also implementing the Millennium Challenge Corporation (MCC) Threshold Program in Peru, which has components of corruption control and immunizations. In addition, USAID provided technical assistance from the MEASURE, POLICY, and DELIVER projects and funded other health activities through MaxSalud, ReproSalud, and Buen Inicio.

HS20/20 and HPI provided support for macro-structural reform through technical assistance for the overall design and implementation of the sector’s decentralization process, sector financing, sector-wide regulatory structures, and health insurance for the poor. They also supported the development of systems to strengthen human resources, pharmaceutical logistics and supply chain management, service delivery, and information systems. Although HPI and HS20/20 ended by November, 2009, many of their activities will be continued through the new USAID/Health Policy Reform (HPR) project. Quality and MCC are aimed at strengthening key health functions at the operational level, addressing problems related to poor implementation of existing technical procedures and practices, and focusing on technical capacity of providers. Quality will continue operating through 2013.

Finally, USAID/Peru is initiating a new, five-year Health Policy Reform project, with the goal of increasing capacities of the MOH and regional and local public entities to deliver quality health programs and services and improve and effectively use key health system inputs. HPR will focus on five components of the health sector: governance; financing; information; workforce; and medical products, vaccines and technologies. HPR will operate from 2010 to 2015. The USAID-supported Amazon Malaria Initiative (AMI) and South American Infectious Diseases Initiative (SAIDI) are also currently active in Peru.

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\(^5\) According to information provided by HCM project staff.

\(^6\) This section is adapted from the draft report “Assessment of Three USAID/Peru Health Projects Implemented by the Ministry of Health: VIGIA; Coverage with Quality; and Improved Health for Populations at High Risk, USAID/GH Tech Project, November 12, 2009.”
USAID/Peru’s Health Program also implemented a significant part of its work (1998–2008) by directly funding activities implemented by the Ministry of Health (MOH), under three separate bilateral agreements: Addressing the Threats of Emerging and Re-emerging Infectious Diseases (VIGIA) – Enfrentando las amenazas de las enfermedades infecciosas emergentes y remergentes; Coverage with Quality (CwQ) – Cobertura con Calidad; and Improved Health for Populations at High Risk (PAR) – Poblaciones en Alto Riesgo. VIGIA had national coverage, whereas CwQ and PAR focused their activities in seven health regions.

- VIGIA (1998–2008) aimed to increase local and national capacities to identify, control and prevent emerging and re-emerging infectious diseases.
- CwQ (1996–2007) worked to improve the quality of reproductive, maternal and perinatal health services.
- PAR (2003–2007) aimed to improve the health of high-risk populations through the development of health program campaigns and capacities in priority health areas.

Health Sector Reform

All health activities in Peru operate in the context of the ongoing process of health sector reform with decentralization. On April 1, 2003 President Toledo announced: “The future of Peru is beginning to change, political and economic centralism are being left behind and true decentralization is beginning.” That same year the GOP started to transfer resources and tools to regional and municipal governments (provincial and district) along with social development projects. The Organic Law of Regional Governments (Nov. 2002) defined 16 health sector functions to be transferred to the regional governments in the areas of organization, management and governance. 7

In summary, during 2003-2008 sector reform was replaced by a decentralization process that redefines the roles of national, regional, and local levels. The MOH was supposed to relinquish service delivery and take on a stewardship role of defining and enforcing standards and norms while regional governments appointed Social Development Directors to oversee regional health directorates or DIRESAs along with the other social programs under their purview. However, uncertainty still exists about which functions have been transferred and accepted, and there are also questions about the level and transparency of the necessary transfer of resources to carry out these functions, which affect the current capacity for effective financial management under this arrangement. 8

There is also an expectation that the regions will further devolve decentralization to lower operational and administrative levels as part of the health reform. This process should involve other sectors, including local governments and civil society, in the decision making and monitoring of health-related activities. Health sector reform including decentralization and a move towards universal health insurance is an emerging and evolving process that will have to be factored into all future project designs and implementation.

Other Relevant USAID/Peru Projects

In order to promote development in formerly coca-growing areas and sustain coca reduction achieved with eradication programs, USAID/Peru has been focusing its development efforts in these zones to achieve a voluntary self-eradication through the promotion of “licit” lifestyles. Due to the civil disorder that accompanies coca production, these areas had been largely neglected by both public services and private enterprise. Through the Alternate Development Program, USAID has been investing in infrastructure (schools, potable water systems, health clinics, community buildings, and bridges) as well as alternate sources of income through licit crop production (cacao, coffee, and oil palm) and increased access to credit markets. It also works to strengthen governance through training and technical assistance.9

The Decentralization and Active Schools (AprenDes) Program “focused on strengthening the management of multi-grade, primary schools in rural areas using an active schools approach that promoted the participation of students, parents, teachers, school principals, community members and school authorities in the learning process.”10 The recently ended project increased student learning and achieved a gender balance, with girls leading the majority of student councils.

USAID/Peru’s Office of Democratic Initiative has supported decentralization through national level policy reform while working directly with regional and municipal governments “…and leading civil society groups … to develop and institutionalize capabilities in strategic planning, participatory budgeting, and public accountability”.11

The Decentralization Program for More Effective and Responsible Sub-National Governments (PRODES) began in 2008 and will run for four years. Its aim is to further the decentralization process through strengthening the legislative framework for decentralization and the capacities of regional and local governments to govern more effectively. PRODES intervenes at the national level with the entities responsible for the policy and regulatory framework for decentralization and, at the sub-national level, with four provinces (Ayacucho, Junín, San Martín and Ucayali), 34 provincial- and 325 district-level local governments. PRODES provides technical assistance in project development in the areas of public investment, economic development, competitiveness, results-based budgeting, taxation, procurement, contracting, participation, and conflict management.

The Peruvian NGO CEDRO implements the USAID Project on Youth Development in Coca-Growing Areas. The purpose of this activity is to help the populations of these of narco-trafficking areas take on attitudes opposed to the illegal production of coca and drugs in favor of sustainable local development. The aim is to strengthen teams of young male and female promoters to function as agents of change for their communities. The activity has five strategic areas: the coordination between rural and urban labor, social marketing, civic education for change, leadership and community organization, and educational interventions for development. The project has two components: ‘Public Opinion in Urban Areas’ in the cities of Tarapoto,

Juanjui, Tocache Uchiza Aguaytía, Tingo Maria and Pucallpa; and ‘Promotion and Strengthening of Young Advocates in Rural Areas’ in 100 communities that have signed agreements for the voluntarily eradication of coca in San Martín and Ucayali.

**B. METHODOLOGY**

The team performed an intensive review of the documents provided by the USAID/HCM project and other documents and data encountered through searches, visits, and discussions with local counterparts (Appendix B). This was followed by a team planning meeting and initial briefings with USAID, implementing partners, stakeholders, and the Ministry of Health.

The team worked with the Mission and the project implementer to review the sampling frame of districts, communities, and households and stratify according to key criteria. The team visited three of the seven project regions, San Martín, Ucayali, and Ayacucho. A two-step randomized process was used to determine which sites were visited. First, three candidate sites were selected randomly from each region for each of the four community classification categories used by the project: Model, Advanced, Intermediate, and Basic. The “Model” communities were identified as such by the project staff, whereas the other three categories came from a scoring system based on points assigned to progress in implementing various project instruments. The three candidate sites for each stratum were then ranked randomly in order of preference. The sites were then reviewed in order of preference for feasibility according to logistics and security considerations. The final site selection is in Appendix C. The whole team visited sites in Ucayali and then split with two members each going to San Martín and Ayacucho.

The assessment team met with the project staff and Regional Governments and Health Directorates in each region as well as the ADP staff in Ucayali and San Martín. The team also visited selected district offices in each region and a number of health centers/posts. They had initial orientation meetings and exit meetings for clarification with the HCM project staff. The team applied a series of structured discussion guides at each level. They met with more than 300 key informants through this process, the great majority through guided group discussion.

Upon return to Lima, the team conducted additional interviews in person and by phone. Preliminary findings from the field were discussed and cross-validated. This process included a preliminary debriefing meeting with USAID, followed by a formal debriefing before the team leader’s departure.

The primary information came largely from key-informant and structured group discussions. The discussion guides were shared with USAID in Lima before modifying and taking to the field. The guides sought both spontaneous and prompted responses to the informant’s knowledge of the project and its activities. The team reviewed the implementer’s data collection procedures and compared the contents of the computerized reports generated by the HCM/Lima office with the actual data collection instruments in the field. They also conducted structured group discussions with selected groups of stakeholders and beneficiaries to elicit further qualitative information. Discussion guides, check lists and data collection tools were developed for the following informant groups and sites (Appendix D):
- Regional authorities
- District offices (Local District Technical Team and municipal officials)
- Community Committees
- Health centers
- Beneficiary focus groups
- Local HCM Project Team
- Schools and teachers
- Homes

The lists of potential contacts to be interviewed provided by USAID and implementing partners was the starting point for identifying interviewees. This list was enriched through discussions with local counterparts. Care was taken to include a cross-section of stakeholders and counterparts (Appendix C).

The team held follow-up meetings upon return to Lima with key stakeholders from the GOP, MOH, USAID, other partners, and USAID/HCM project staff to review and validate the findings and gather further information and clarification. The team also held in-depth internal discussions on each of the six thematic areas in the SOW before writing the report so that the final report represents a consensus view of the different perspectives provided by each team member.
II. FINDINGS

A. DEVELOPMENT THEORY/CONCEPTUAL MODEL

1. Underlying Development Theory, Overarching Project Design Strategies, and Assumptions

HCM was developed within the context of the USAID ADP and builds on health and nutrition activities that began in those zones in 1996. Part of the justification for the incorporation of health and other social and infrastructure activities into the ADP was the realization that an approach emphasizing the conversion to alternate crops was a hard sell given the relative profitability of the coca trade. The inclusion of health (and other benefits) seemed to further open the door for the productive component of ADP. In addition to the community-level primary health care (PHC) activities that PRISMA had been supporting, the new HCM project that initiated in July 2004 also incorporated the Healthy Municipalities Strategy that USAID/Catalyst had been developing.

In 2004, USAID/Catalyst/PRISMA proposed HCM activities within the context of the ADP. The project proposed that "within the context of the ADP in coordination with other projects it would improve ‘the quality of life of the local population by working at the family level, promoting healthy lifestyles especially among women and children, and at community, at schools and district municipality levels to place the idea of health promotion in their agenda’ and ‘that community ownership and participation is essential for sustained program effects.’" They envisioned a long-term, coordinated effort with a broad spectrum of local government and civil society partners that would form a social network to support the intervention after project completion.

The project subsequently has been renewed on an annual basis through the approval by USAID of one-year work plans and budgets (with a shift to MSH as the implementer through the USAID/Washington LMS Project in July 2006). This modality of annual work plan renewals has given the project a certain level of flexibility to adapt to changing situations and make adjustments as lessons learned are accumulated (including annual modifications to the results and indicators in the logframe). However, this year-to-year modality created some labor instability and a higher staff turnover rate than what might have occurred otherwise, as well as limited the ability to develop a long-term strategic vision.

Although there have been adjustments over time (including the introduction of leadership training, a territorial expansion, and an increased focus on sustainability and the role of the regional governments), the core project structure and emphasis on achieving improvements in maternal-child health through the health promotion model have not changed substantially. Table 1 provides a summary overview of how the project has evolved over time.

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12 Personal communication, Delia Haustein, PRISMA, 03/05/10.
13 Adapted from Healthy Municipalities and Communities in Alternate Development Areas, July 1, 2004 – June 30, 2005, Catalyst/Pathfinder-PRISMA.
HCM applies the health promotion model as stated in the 1986 Ottawa Charter and a series of subsequent international forums. According to the Ottawa Charter, “Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.”

This concept was ratified by the Peruvian MOH (Ministry of Health Law, Chapter X, article 27, Jan. 17, 2002) when it created the General Directorate for Health Promotion (DIGEPROM) followed by an accompanying set of guidelines. In this context, health promotion goes somewhat beyond the traditional primary health care approach focusing on the delivery of services to emphasize the community’s role to modify contextual factors that increase vulnerability on a sustainable basis. This approach is considered a best practice by WHO/PAHO, and is widely accepted internationally and substantiated by an extensive bibliography (Appendix B).

The HCM Project has presented at various times in text and graphic formats a complex mixture of conceptual models and schemes for achieving improvements in women’s reproductive health and child health and nutrition in the ADP areas through a health promotion strategy. Within the overall context of health promotion, the project subscribes to five cross-cutting core values: citizen participation/empowerment, promotion and implementation of health policies, healthy environments, healthy lifestyles and habits, and reorientation of social services (particularly health establishments) to emphasize promotion and prevention. The project has four phases in relation its implementation approach: awareness creation, planning, implementation, and self-evaluation. Beneficiary groups by program level include families, communities, schools, and municipalities. However, in order to achieve the desired goal of improved health in the target populations, HCM also strengthens regional and some national capacities. The 2008–2009 logframe structured results by four levels: community, district, regional, and national. Furthermore, the guidelines in the project toolkit identify five steps towards a healthy family, eight steps towards a healthy community, and 10 steps towards a healthy district/municipality. Four HCM support areas are communication, leadership and management, environmental management, and quality improvement.

The most recent work plan (2009–2010) also mentions three implementation stages: advocacy and organization of the social structure, strengthening, and institutionalization and sustainability. The same document also presents an intervention scheme (encouragement of healthy lifestyles + coordination of the health sector and district and community-level government = results) that does not relate directly to the other conceptual structures. The logframe for October 2009–July 2010 for these communities now has the results structured by three sub-headings: communities organized with families taking care of and monitoring their practices; health sector and local

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government representatives consolidating and sustaining the HCM model in the original PDA areas; and health sector and local government representatives strengthening the HCM strategy in the expansion areas in the seven regions outside the PDA. However, for its own reporting purposes, LMS uses a different results matrix for reporting to USAID/Washington.

In terms of organizational and operational purposes as well as for structuring the results in the logframes, the key elements of the HCM model identified by the external assessment team are:

- The structuring of results/outcomes by level: family, community (including the school), district, region, and national; and
- The four phases of the implementation process: awareness creation, planning, implementation, and self-evaluation.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Purpose</th>
<th>Focus and Modifications</th>
<th>Communities Districts (Funds US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. July 2004 – June 2006</td>
<td>Year 1: Improve the health of women and children living in coca-producing zones through a health promotion strategy in municipalities, districts, communities, schools, and families. Year 2: Improve maternal-infant health through the implementation of the municipality, community, family and school health promotion strategy in the coca-producing zones.</td>
<td>Implementation by Catalyst/PRISMA. Continuation of previous activities in the PDA zone by Catalyst (Healthy Municipalities Strategy) and PRISMA (Communication for Social Change focusing on families with pregnant women and children under three). Awareness creation of the communities through the general assemblies and formation of the JVC. Formation of LDTT and LDO. Validation of models and development of best practices with focus on behavior change to improve maternal-child health. Development and testing of MCH indicator and community diagnostic tools. Micro-projects financed by HCM with some counterpart.</td>
<td>370 in 32 Districts (reduced to 340 in 2nd year) ($2.364M)</td>
</tr>
<tr>
<td>II. July 2006 – June 2007</td>
<td>Improve the maternal-perinatal-infant health in communities that had signed an auto-eradication agreement through the implementation of the municipality, community, family, and school health promotion strategy in the coca-producing zones.</td>
<td>Change in implementation to LMS/MSH and project cycle to match USAID fiscal year calendar. Consideration that leadership and management are essential to sustain gains and continuous quality improvement (CQI) for health centers/posts strengthened. More emphasis on strengthening municipal governments/districts through LDTT and LDO. Implementation of annual Community Diagnosis and semi-annual Maternal-Child Indicator Tools. Initiation of Values-Based Community Leadership Development (CDL) and Management Training Program adapted from Nicaragua (190 CC/929 participants). Initiated “emphasis on active citizenship and self-governance through the development of community organizations with democratically elected officials. Micro-projects financed by HCM with some counterpart.</td>
<td>557 in 61 Districts ($3.288M)</td>
</tr>
<tr>
<td>July 2007 – Sept. 2008</td>
<td>Communities in the PDA zone improve their maternal infant health through efficient and sustainable local leadership and management.</td>
<td>Continued emphasis on strengthening districts. Implementation of SISMUNI and installation in Municipal Governments. Further training in Values-Based Leadership (272 CC/914 participants). Initiation of Managers Who Lead Program (442 participants).</td>
<td>557 in 61 Districts ($3.037M)</td>
</tr>
</tbody>
</table>
Baseline study of reproductive health in adolescents conducted and a manual on sexual and reproductive health developed and disseminated through TOT mechanism. No more micro-projects financed by HCM.

| III. Oct. 2008 – Sept. 2009 | San Martín, Ucayali, Huánuco, Ayacucho, Junín, Cusco, and PASCO regions improve their maternal-infant and reproductive health through empowerment of individuals, leadership, and synergy with the regional, district, and community authorities assuring: - Sustainability of achievements in the PDA zone - Expansion of the HCM strategy in these seven regions - The adoption of the strategy into the national social development plans and programs. | Beginning of a period of consolidation and “expansion and increased sustainability of the participatory management model for health and development... In this new phase the project has the end goal of improving maternal and child health and reproductive health ... through the empowerment of individuals, improved leadership and management, and synergy between regional local and community leaders.”

Expansion of Virtual leadership Development Program (13 teams/132 participants). Support for extension and use of SISMUNI. Continued collection of annual Community Diagnosis and semi-annual MCH indicators. Recognition of HCM by MOH and other government agencies and national programs such as CRECER as modality to reduce poverty and malnutrition. Production and dissemination of toolkits (print and electronic formats). Renewed concern on returning to communities to strengthen the CC. Increased support to role of Health Regions in adoption and extension of the HCM Project to other communities. | 532 in 58 Districts ($2.739M) |
| Oct. 2009 – Sept. 2010 | Improve maternal-infant and sexual-reproductive health in the intervention area through the HCM strategy. | Further expansion of HCM within and without the PDA zones such as those covered by the new Universal Health Insurance Program. Period of documentation and self-evaluation including an internal evaluation report and the results of a validation study of the semi-annual MCH indicators. | 515 in 58 Districts (+ 1,249 in 32 more Districts in zones identified for extension of program) |

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All of the other elements of the HCM health promotion model mentioned above, including the five cross-cutting core values (citizen participation/empowerment, promotion and implementation of health policies, healthy environments, healthy lifestyles and habits, and reorientation of social services), provide the theoretical basis and guidance as to how to achieve the desired program results.

The HCM implementation approach has been the promotion of model families, schools, communities, and districts/municipalities. At the community level, these families are selected from the participants in the original awareness-creating sessions and informative workshops (open to everyone), and who were willing to enter into an agreement to use the project tools to perform a self-assessment, vision, and plan. These “model” families, approximately ten per community, receive extra attention from project staff, although supposedly all community members are invited to participate in group information sessions and other activities. The assessment team observed that these families appear to have been older, better off, and less vulnerable than their neighbors. The attention paid by project staff to the communities appears to have been somewhat opportunistic; they seem to have paid more attention to the communities that were better organized and could move rapidly to the model stage. However, these model communities have played an important role as sites for observational visits where interested parties could see a positive example of the results (improved appearance, etc.) and process for a healthy community. The HCM project is still refining a certification process for recognizing model families, schools, communities, and districts, whereby each level is certified through a set of criteria to be applied by the next higher level.

2. Original Project Plan

Mandate and beneficiary population

The original project mandate was to complement and support USAID/Peru’s Alternate Development Program (ADP) by contributing to the improvement of maternal and child health through promoting behavior change for developing healthy lifestyles. The project intended to use a bottom-up health promotion model to empower the local families and communities to organize and resolve their health problems through performing their own community diagnosis and plans. These plans were to be used for internal purposes as well as for communicating and negotiating with the district authorities. This basic mandate has never changed, although there have been adjustments to the approach and focus, such as the introduction of leadership training, increasing attention to developing the district and regional capacities to assume more responsibility for the program, and geographical expansion of the model. The approved work plans and logframes have been structured around the community, district, and regional levels.

According to information provided by the HCM project, there are currently approximately 35,000 families, about 150,000 inhabitants and 5,891 children under two years of age in the project communities. Estimates of coverage of the total number of children under two by region are approximately 8-10% for San Martín and Ucayali, 4% in Huánuco, and less in the other regions. Project staff estimates that they only directly reach 13–20% of the families in those
communities with the full healthy families package. Furthermore, HCM over time has increasingly emphasized community support and strengthening of individuals and institutions (district and regional governments, community leaders, and health services) that in turn are expected to promote and induce healthy behaviors and environments. Therefore, much of the project effort is expected to have indirect benefits to the target population. The more recent emphasis on adoption and expansion of the HCM program by district, regional, and national programs means that benefits from project-developed strategies and tools now will extend even further beyond the project areas.

Objectives and sub-objectives

The purpose of the HCM project evolved slightly from year to year from 2004–2009 (Table 1) always with the goal of improving maternal child health in the project zones. However, over time there was a shift in the logframes towards emphasizing “sustainable local leadership and management” (2007–08); and “empowerment of individuals, leadership, and synergy with the regional, district, and community authorities” including sustainability, expansion, and “the adoption of the strategy into the national social development plans and programs (2008–2009 and again in 2009–2010).

The “results” (written more as processes than results) likewise changed over time (Table 2), beginning with six in 2006–07: LDO implementing a strategy to promote health and development at the district level at the district level; education committees implementing a comprehensive health promotion strategy through the schools; CC implementing a comprehensive health promotion strategy in the community; families adopting healthy lifestyles and behaviors; communities and districts coordinating with health establishments to reduce chronic malnutrition; and members of the LDO, LDTT, CC, and education committees improving their leadership and management capabilities. The 2006–07 work plan had three results: communities and districts effectively implementing HCM strategies for the practice of healthy behaviors; regional governments expanding and implementing the HCM strategy in coordination with the districts; and selected public and private institutions implementing the HCM strategy with project technical assistance. The 2008–2009 work plan had four results that do not correspond neatly to those from previous years: communities with empowered individuals practicing sustainable health practices to improve maternal-child and sexual-reproductive health; 58 districts implementing and expanding the HCM strategy in their area of jurisdiction; regional governments strengthened in leadership and health management in coordination with district governments; and public and private social development programs incorporating the strategy.
<table>
<thead>
<tr>
<th>Purpose:</th>
<th>Evolution of HCM Project Logframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;From: July '06 To: Sept. '07</td>
<td><strong>Year 4</strong>&lt;br&gt;From: Oct. '07 To: Sept. '08</td>
</tr>
<tr>
<td>Improve maternal, perinatal, and child health in communities that had signed a self-eradication agreement through the implementation of the municipality, community, family, and school health promotion strategy in the coca-producing zones.</td>
<td>Communities in the ADP zone improve their maternal and child health through efficient and sustainable local leadership and management.</td>
</tr>
<tr>
<td><strong>Result 1</strong>&lt;br&gt;Local Development Office (ODL) of the District Municipality implements a comprehensive strategy to promote health and development at the district level.</td>
<td>557 communities and 61 districts of six regions in the scope of the ADP implement effective strategies to practice healthy municipal and community behavior.</td>
</tr>
<tr>
<td><strong>Result 2</strong>&lt;br&gt;Institutional Educational Councils implement a comprehensive strategy to promote health and development in educational institutions.</td>
<td>Regional governments expand and implement the HCM strategy in collaboration with local governments.</td>
</tr>
<tr>
<td>Result 3</td>
<td>Community Committees (JVCs) implement a comprehensive strategy to promote health and development at the community level.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Result 4</td>
<td>Families incorporate healthy lifestyles, surroundings, and behavior.</td>
</tr>
<tr>
<td>Result 5</td>
<td>Communities and municipalities articulate with health facilities to strengthen quality improvement processes in order to diminish chronic child malnutrition.</td>
</tr>
<tr>
<td>Result 6</td>
<td>Members of LDTT, LDO, CC, and CONEI improve their capabilities and skills in management and leadership.</td>
</tr>
</tbody>
</table>
Proposed strategies and specific interventions

Figure 1 provides a graphic snapshot of the levels of the HCM project and the important actors at each level. Key to project functioning is the premise that there is a self-diagnosis made at the family, community, and district levels with commitments and plans made at each level based on that self-diagnosis. The HCM project has elaborated an extensive toolkit with detailed guides for a healthy family (46 pages), community (40 pages), and district/municipality (60 pages). There is also a 135-page guide for the CC for improving the water supply and community and family hygiene. Certain families were selected as model families according to the guide, after agreeing to a certain set of conditions including the development of a household plan. Likewise, communities that progressed rapidly were identified as model communities that have served as positive examples for site visits (pasantías).

As discussed previously, the initial HCM project emphasis was on the community level. However, in 2007–2008 this emphasis increasingly shifted towards supporting the district and regional levels to adopt and assume responsibility for the program, including the extension of the HCM strategy to other communities. At the national level the project has been successful in inserting itself into the national agenda, and the HCM health promotion approach has been adopted by CRECER, the national multisectoral development strategy, as its implementation model for reducing childhood chronic malnutrition and, more recently, with the MOH/DIGEPROM.

Effective project implementation depends on a productive relationship between the CC (an entity recognized in the Law of Municipalities), the voluntary health promoter who resides in the community, the school, and the health establishment (that often covers several communities). Also key to the success of the model is the technical assistance provided by the project, particularly in terms of leadership training and awareness creation in the beginning stages (as part of the first of the four implementation phases mentioned earlier). In order to improve maternal-child health indicators, these local actors need to coordinate in the promotion of healthy behaviors and the improvement of basic hygiene and sanitation at the household and community level. At this level, the nurse auxiliary, who usually resides in the community, plays a much more central role than the health professionals who generally rotate on an annual basis.

Another important element at the community level is the school, which through the “Healthy Schools” initiative reinforces positive behaviors and can be a force for extension of these concepts to families and communities. In spite of the fact that schools were closed for the holidays at the time of the site visits, the team managed to hold meetings with a number of students who demonstrated healthy habits (hand washing, the use of boiled water, and dental and personal hygiene). The team also visited schools where the teachers had created special areas for cleaning supplies (soap, towels, toothbrushes, potable water containers, first aid kits, and cleaning utensils) as recommended by the strategy. For their part, parents commented positively on the changes in the schools and the guidance received by teachers related to healthy behaviors.
The Parents' Association (APAFA) is important for monitoring school activities and maintaining the link between community, teachers, and school policy. It can promote healthy habits and reinforce the focus on a healthy community. On the other hand, the Institutional Education Council (CONEI) supports the comprehensive strategies that promote health and development in educational institutions. It has limited influence and depends on personal initiatives of the schoolteacher or community leader. In reality, meetings of the APAFA meet the goals set for the CONEI.

Currently the HCM Project has submitted a document to the Ministry of Health entitled "Technical Proposal: Municipalities, Communities, Healthy Families, and Educational Institutions" to be formalized and implemented at some later stage. This document incorporate a checklist for qualifying Educational Institutions that consists of twenty-six criteria grouped into concepts such as Organization and Empowerment, Healthy Public Policy, Improvement of Healthy Environments, Healthy Practices and Styles and Reorientation of Services. These criteria were collected and improved by the HCM technical teams and have been used to measure the level of progress of the communities.
The Ministry of Education (067-2009-ME-VMGP-DICA) emitted a directive for “Safe, Clean, and Healthy Schools” in October of 2009 that supports the activities proposed in the healthy schools initiative. However, there does not appear to be any real coordination between the two ministries (MOH and MINEDU) in implementation.

At the district level, the project works to institutionalize the support for the health promotion model through advocacy with the political level and two institutions that the project has aimed to establish: the Local Development Office (LDO) made up of district/municipal staff; and the Local District Technical Team (LDTT) that is made up of technical officers in health, agriculture, education, etc. The LDTT is supposed to help orient the LDO in the setting of priorities, plans, and development of projects. The LDTT and LDO are project constructs and do not have a basis in law. The establishment, formation, and functioning of these groups vary from district to district. The community-level health establishments receive technical support and backstopping from the MOH micro-networks whose coverage area does not currently correspond with the geographic jurisdiction of the district governments. The regional governments play a broader role in establishing policy, priorities, assigning resources, and in terms of certain sectors such as health, and providing technical support and supervision to the lower levels.

The team found that, within the scope of the HCM project, the Health Posts and Centers (HE) have limited problem-solving capacity, difficult access, and administrative difficulties. Health Post personnel include a recently graduated professional who stays for less than a year and technical personnel (a nurse auxiliary or a midwife). The Centers have a medical doctor, nurse, midwife, and technical personnel, with frequent staff rotation, small facilities, minimal equipment, and scarce supplies. User access to the HE is difficult due to the wide dispersion of the communities and costly transportation. Another problem is the lack of correspondence between the political-geographical and health jurisdictions. This means that the community-level health personnel go to one district for personal and legal matters, but have to go to a different one for health issues; i.e. there are no “one-stop” services.
Table 3

Health Centers/Posts within the Scope of the HCM Project by Location and Category

<table>
<thead>
<tr>
<th>REGION</th>
<th>CATEGORY OF THE HEALTH CENTER/POST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>H.P. I-1</td>
<td>H.P. I-2</td>
</tr>
<tr>
<td>San Martín</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>64</td>
<td>4</td>
</tr>
<tr>
<td>Huánuco</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>Ayacucho</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Cusco</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Junín</td>
<td>51</td>
<td>1</td>
</tr>
<tr>
<td>Ucayali</td>
<td>51</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>356</td>
<td>47</td>
</tr>
</tbody>
</table>


HCM has facilitated coordination between local health providers by having technical personnel from each HE work jointly with the health promoters (HP) from communities in their coverage area. They participate directly in the neighborhood committees and coordinate with the micro-networks. This coordination means there are a greater number of communities associated with HCM than there are affiliated directly with the project. As a result, HCM has extended its scope of influence to other communities that are not directly affiliated with the project.

The HCM project has conducted a large number of training sessions for HE and micro-network personnel, community members and leaders, and local authorities. These activities have strengthened knowledge and have helped to reorient the health services toward promoting changes in health behavior with an emphasis on safe water consumption, hand washing, latrines, solid waste disposal, animal husbandry, improved stoves, separate living spaces and household cleanliness, gardens, and environmental protection. Likewise, clinical services integrate more promotion themes into general care of children and women. Similarly, campaigns also are carried out to monitor weight, height, and vaccination status of children in remote communities.

Health personnel use the community diagnostic to prioritize their community-based activities in terms of the behaviors that they promote within and outside of the HE. The health personnel, mostly the nurse auxiliaries, orient and support the HP in their basic functions such as surveillance, referrals and, in some cases, first aid. In Ayacucho the team encountered the community health staff applying a series of guides and manuals for healthy families developed by the health region.

Health personnel interviewed felt that the HCM project had increased the demand for care, so in response they have conducted periodic health campaigns, in some cases accompanied by medical specialists from the micro-network. The leaders in some communities deemed these campaigns as insufficient to meet their needs, leading them to make efforts to improve the infrastructure and
equipment and have more staff. For example, in Campo Verde, Neshuya-Curimana, Nueva Requena, and San Francisco, the community carried out some basic improvements such as facility rehabilitation, painting, roof repair and general maintenance, and purchase of basic equipment such as a refrigerator. In Ucayali and Ayacucho, the districts extended the contracts of certain health professionals to enable them to stay longer at their posts. In Campo Verde and San Francisco the communities used their own funds to augment staff.

The project strengthened the HE through training in the technical norms, CQI, and certain emergency care actions. This support has increased outreach to the communities and contributed to improved health services (Figure 2). Better citizen oversight has helped improve user referral to micro-networks and hospitals, and, to a lesser degree, counter-referrals back to the HE of origin. The professional personnel who rotate frequently were less aware of continuous quality improvement than the technical staff. This finding can be associated with decreased numbers of HE reporting their quality indicators over time. However, there seems to be a slight trend in improvement in quality compliance indicators from those HE that have been reporting, although this could be due to a selection bias (only the more committed HE continued to report).

![Figure 2](image_url)

**Figure 2**
Children’s Health Service Quality Indicators FIP in Health Posts/Centers within the Scope of the HCM Project 2006–2009


The women who participated in the group interviews indicated that for those in communities with an HE, their access to services had improved, while things were little changed for those
women in communities without an HE because of the high cost of transport and the possibility of the center being closed when they arrive. They expressed a preference to be attended by a female for prenatal visits and births. In terms of the quality of the services, the women reported that they were well treated for simple problems. In one community in Ucayali there were complaints about the nurse-midwife who gave cursory exams with little communication.

The glue that is supposed to hold all of these project elements together is the HCM information system. The system is based on a comprehensive community annual diagnostic (with a 107-page guide) that covers the health, education, productive, and infrastructure sectors; and the semi-annual collection of certain MCH indicators. The CC is responsible for collecting this data and reporting it to the district, where it is entered into a computer as part of a municipal information system known as SISMUNI (discussed elsewhere in this report). This information is intended as the basis for the community plans and the development of projects for the participatory budget and social investment projects. The information also gets passed to the regional office with the intention of using it for the regional plans. Key actors at the regional level are the Director for Social Development, responsible for putting together the regional development plans and budgets; the Regional Health Directorate; the Regional Education Directorate; and, at the political level, the Regional President and Vice President.

The project works with these various GOP levels in a decentralized fashion through its regional offices. Initial emphasis (beginning in 2004) was on the community level and encompassed awareness creation, development and testing of tools and instruments, and development and implementation of communication plans and programs (individual and group contacts supported by mass media campaigns). Training in the health promotion strategy, community surveillance, continuous quality improvement, health communication and education, leadership, and the information system (SISMUNI) has been a major HCM project effort. At the time of the assessment, 27,217 person-trainings had been provided (14,522 male and 12,695 female participants, with some individuals receiving training in more than one thematic area—Appendix F). The leadership training seems to have made the most impact on the key informants. This consists of three distinct sub-components: values-based leadership and community management (1,843 community-level personnel trained); a virtual leadership development training program (138 regional and district personnel trained); and training for managers who lead (442 managers trained). The project has also invested in substantial training for its almost 100 current and approximately 20 past employees (who are still working in related areas) thereby, along with the training provided to beneficiaries, creating a critical mass of trained personnel that can continue to contribute to project-related efforts (Appendix F).

During the early years, HCM made heavy investments with considerable counterpart contribution (Table 4) in community infrastructure micro-projects in 470 communities including basic sanitation, water supply, improved kitchens, first aid stations, community improvement, school improvements, solid waste disposal, and snacks for community meetings. During the second year of the MSH implementation period, they phased out this type of support in favor of generating local cost-sharing, mostly in-kind, for project activities and events.
### Table 4
Cost-Sharing Activities of HCM Project 2004–2009

<table>
<thead>
<tr>
<th>Period</th>
<th>Activity Description</th>
<th>Contribution (in soles S/.)</th>
<th>USAID</th>
<th>Region</th>
<th>District</th>
<th>Community</th>
<th>Others</th>
<th>Sub-Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 04 – June 06</td>
<td>Community Projects/Initiatives</td>
<td>765,157</td>
<td>931,116</td>
<td></td>
<td>277,233</td>
<td>1,208,349</td>
<td></td>
<td>1,973,506</td>
<td></td>
</tr>
<tr>
<td>July 06 – Sept 07</td>
<td>Community Projects/Initiatives</td>
<td>263,729</td>
<td>12,847</td>
<td>280,224</td>
<td>24,859</td>
<td>317,931</td>
<td>581,660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct 08 – Sep09</td>
<td>Project Activities</td>
<td>79,283</td>
<td>4,983</td>
<td>45,976</td>
<td>6,740</td>
<td>31,851</td>
<td>89,550</td>
<td>168,833</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL S/</strong></td>
<td></td>
<td>1,342,498</td>
<td>4,983</td>
<td>159,956</td>
<td>1,246,172</td>
<td>361,250</td>
<td>1,772,362</td>
<td>3,114,860</td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td></td>
<td>43.1</td>
<td>0.2</td>
<td>5.1</td>
<td>40.0</td>
<td>11.6</td>
<td>56.9</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: MSH information system

Beginning in 2007–08, the strategy for developing support for social infrastructure projects shifted to assisting the community participation, through their plans, in the district participatory budget and the social investment program processes. As of September 2009, project technical assistance had contributed to the development and submission of projects for $2,231,725 from the regional governments’ Public Investment Projects (PIP) for strengthening and expansion of the HCM activities in Junín and Ayacucho, and $1,174,541 of district-level PIP mostly for the construction of maternal waiting houses in San Martín.

One strategy to promote the HCM project model for expansion to other areas within and without the project zone, and also to enhance adoption and sustainability, was a series of guided observational site visits to model communities and, within those communities, to model families from the district level to the community level, between neighboring communities, regional government to the district and community level, and, more recently, between regions and from national programs such as CRECER. HCM sponsored 146 such person visits from 2005–2009.

As discussed previously, the initial HCM project emphasis was on the community level. However, in 2007–2008 this emphasis began to increasingly shift to supporting the district and regional levels to adopt the program and assume responsibility including the incorporation of the extension of the HCM strategy to other communities. At the national level the project has been successful in inserting itself into the national agenda and the HCM health promotion strategy has been adopted by CRECER, the national multisectoral development strategy, as its
implementation model for reducing childhood chronic malnutrition. Formal endorsement of the HCM approach by the MOH/DIGEPROM for expansion nationwide is in process.\textsuperscript{17}

Model for behavior change

The HCM Project proposed a communication strategy that combines two models: communication for social change and communication for behavioral change.\textsuperscript{18,19} The first model is aimed at individual and collective decisions to change either individual behaviors or collective reforms. This model identifies goals and how to achieve them through an individual or communally determined agenda. It supports community strengthening and the local decision-making process. The second model identifies individual behaviors to be changed through targeted strategies.

The communication for social change model is based on the decisions of the person, i.e., individuals as the subjects of change, while the second model is based on change through persuasion that is directed at behavior, i.e., the subjects are the object of change. They are complementary models, because while communication for social change can lead to communities identifying the changes they want, communication for behavioral change can dig deeper in order to understand the behavior and prioritize the changes identified. The original project proposal document proposed the development of “information, education, and communication plans,” which has been surpassed by the communication for social change model. The 2005–2007 plan that was later cut back to one year, specified mass media and interpersonal strategies by level, e.g. district officials (LDO, LDTT) and with participation of community groups (CC, Education Committee).

Performance Management Plan (PMP)

The HCM project, which has been extended on a year-by-year basis through the approval of annual work plans and budgets, never developed a PMP or an M&E plan. Instead, each year it presented a set of results and indicators (that varied slightly every year) in a logframe format. The project then tracked and reported annual results against the targets in that year’s plan. Many indicator results, but not all, built on the previous year’s targets. Section II.A.2 above provides an overview of the year by year modifications to the purpose results with details of the evolution of the indicators in Appendix G. A more detailed discussion of the project M&E efforts and indicators is in Section II.C.1 below.

\textsuperscript{17} Personal communication with Edgar Medina, March 11, 2010.
\textsuperscript{19} UNICEF: Comunicación para el cambio social de comportamientos en la alimentación de la niña y el niño pequeño, Managua, 2010.
B. INTERVENTIONS AND ACTIVITIES

1. Evolution of Mandate and Design over Time

As mentioned above, the basic HCM project mandate never changed. However, there were some key adjustments to the strategy as to how to achieve the desired results as well as a shift over time towards an increased emphasis on individual and institutional strengthening and sustainability. There were some very minor editorial year-to-year changes to the logframe until 2007–2008 when leadership and management received a more prominent role in accordance with the LMS mandate20 (Appendix G). The following year the regions and the national level received an even higher profile in the logframe. However, the focus on improving MCH through implementation of the health promotion model never really varied. The difference is that in these latter years the HCM project tried to transfer more of the facilitation and support role that project staff had been playing to the national counterpart at the district and regional government levels with an eye towards furthering adoption and sustainability of the health promotion model. The HCM project also began to promote the adoption of the methodology and instruments by important national programs and plans such as CRECER, and more recently, the MOH/DIGEPROM.

Stakeholder involvement

In this context stakeholders are considered those entities with a shared interest in how the project is working and the role or capacity to partner and/or contribute towards common goals. In this case principal stakeholders would be the relevant GOP entities and programs such as the MOH, MINEDU, and CRECER at the central level, other USAID projects, other cooperation agencies such as UNICEF and regional governments and local district/municipal governments. Involvement has been varied. At the outset HCM focused on implementation at the community level and had some coordination with the ADP project. Its relationships with the other USAID projects have been largely cordial and based around information sharing with closer coordination at the regional level and occasional joint site visits and activities. In some cases the question of overlap, redundancy, and even activities in conflict (different directions in development of local plans and strengthening in governance) has arisen. Another project activity at the district level that was questioned was the need for certain project constructs such as the LDOs and LDTTs within the overall context of decentralization (Figure 1). As the project has evolved over time, HCM has done an excellent job of involving district and regional level counterparts and more recently at the national level with CRECER and the Health Promotion Directorate of the MOH. The topic of stakeholder coordination (including opportunities for further synergies) is dealt with in more detail in section II.E and Appendix I.

Compliance with mandate

20 Personal communication with Marguerite Farrell, USAID/Washington, LMS/CTO.
The HCM project has had its mandate renewed annually without significant modifications through the approval of its work plan and logframe, and it has implemented activities within that framework. When one reverts back to the previously mentioned definition of health promotion as: “the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment … health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being,” there is very little in the way of social, economic, and human capital development that would fall outside of this umbrella.  

However, the question has been raised if the project is sometimes encroaching upon, duplicating, and even at times conflicting with other USAID-supported activities in governance and agricultural production. The table in Appendix H identifies some instances where there were duplicative community plans with different focus and overlap in strengthening of district-level personnel in management and governance. These problems can be resolved through an integrated development approach at the district level (Section III).

2. Behavior Change Model and Its Applications

The communications model proposed by HCM combines the adaptations of the models of communications for social change and behavioral change to meet the different needs of the project. Whatever the model, four basic steps will be applied to assess the HCM behavioral change strategy: diagnosis, design of communications strategies, implementation, and evaluation.

At the family level, HCM aims to influence behavioral changes related to the health of mothers and children as follows:

- **Diagnosis:** HCM used two diagnoses prepared under the project related to water quality and child care and the 2005 Communications Plan. In the latter, general behaviors related to the HCM strategy are identified, but the way these behaviors were identified and their causes are not mentioned. The child care study and the communications plan fail to analyze the causes of behaviors (beliefs, customs, economic impediments, knowledge, etc.) to form the basis for the development of communications strategies. Another study concerns hand-
washing behavior, which was developed in urban and rural areas in San Martín and Ucayali, but it is unclear whether it is within the project zone. The project also carried out a study on knowledge and practices related to the sexual and reproductive health of schoolchildren in the intervention area, which served as the basis for the development of capacity building activities for teachers.

Most studies combine quantitative and qualitative techniques which yield valuable inputs for communications activities. Region-specific studies were not conducted, which is important given the cultural differences among the regions and the presence of migrant and native families. For example, the evaluation team encountered women from the highlands who maintained their custom of prenatal care and childbirth with midwives.

- Design of strategies: The desired behavioral changes in families are identified in the communications plan, but only in very general terms, i.e., the adoption of healthy practices, without mentioning which ones. Communications campaigns propose the adoption of behaviors, but do not propose differentiated strategies to develop, change, or maintain behaviors. Furthermore, the original materials developed, especially radio spots, remain in use without taking into account behaviors that have already been adopted, in which case strategies for the reinforcement or maintenance of those behaviors would be required. In addition, the studies do not necessarily directly apply to the design of the strategy. For example, the communications campaign on child care had seven foci, including obtaining a birth certificate and growth monitoring/immunization card, when the study noted the already extensive practice of these two behaviors. In San Martín, a radio spot that promoted growth monitoring included up to nine messages relating to child care.

HCM also conducted some communications campaigns without prior diagnostic studies, such as the campaigns on adolescent pregnancy, HIV/STD prevention, and trash collection. The primary and secondary audiences are identified in the HCM campaigns, although the families are not segmented, which is important due to the presence of migrants from the highlands in the intervention areas, including adolescent mothers.

- Implementation: To change family behaviors, HCM uses a mixture of communications media: mass (radio), community (home visits by health workers for CCs and health personnel), and interpersonal (demonstration sessions). Three campaigns (water quality, hand washing, and child care) were designed in Lima and adapted for each region.

HCM developed print materials (brochures, posters) targeted to families. The informants interviewed during the evaluation did not recall them. Many illiterate and semi-literate women live in the area, so materials should contain a minimum of text. Interpersonal communication included home visits by the CCs and demonstration sessions by health personnel. Many of the women who participated in focus groups said they had never received

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visits in their homes, and those who had received visits mentioned that they were conducted sporadically. They did not remember demonstration sessions.

- **Evaluation:** HCM did not perform an evaluation of the coverage or impact of the communications campaigns.

The HCM Project seeks two types of change at the **community level:** practices related to health, and the strengthening of community organization through application of the communications for social development model:

- **Diagnosis:** The 2005 communications plan proposed some community behaviors related to community organization, values, and participation. The document does not mention how this behavior was identified or its causes. HCM does not have an updated diagnosis of the behavior of community leaders.

- **Design and implementation of strategies:** The HCM intervention at this level is for the sensitization, capacity building and social mobilization activities. It promotes community organization – CCs - and the preparation of community development plans. It also provides training to members of the CCs in different areas such as communication for development.

HCM also promotes the selection of families that are models of healthy practices, seeking an imitation effect in other families. The family visits and focus groups with women suggest that the imitation effect has not happened as desired and may even be causing negative reactions by highlighting differences between families (in Ucayali, some women said that the model families that received the most attention were the “wealthy families”). Feelings of exclusion were also expressed on occasion (in Ucayali, some women said that they were not invited to participate in project activities because only certain families were convened).

- **Evaluation:** HCM has tools to monitor progress in the phases of community organization, but has not conducted an evaluation of the communication strategies.

At the **district level,** HCM directs the social change communications model at district authorities. HCM focused its intervention on achieving policy changes and sustainability as follows:

- **Diagnosis:** The behavior of the municipal authorities related to development and to the knowledge of health promotion and the HCM strategy is only mentioned in the communications plan. HCM does not have an updated diagnosis, which is important because progress in decentralization has changed the context, needs, and behavior of district authorities.

- **Design and implementation of strategies:** HCM chose an advocacy strategy but did not develop specific ones for each region. This strategy was supported through capacity building.

- **Evaluation:** HCM has not developed evaluations to measure the results of the strategies.
Identification of behaviors that must be changed and the desired behavior for each group of beneficiaries

As stated in the previous section, HCM identified behaviors to be changed for each level of intervention. Behavioral studies were used with respect to the water quality, hand washing, and health care for mothers and children. Behavioral studies were not conducted at the community and district levels, but there is a list of general behavioral goals without identifying specific behaviors in the 2005 Communications Plan.

A weakness in the design of the communications strategies is the absence of a breakdown of current, desired, and feasible behaviors, as well as the identification of behaviors to be promoted, changed, or maintained. The differentiation of behavior by intervention level is mentioned in general terms only in the Communications Plan (2005).

Interface with the beneficiary groups to achieve behavioral change

HCM intervened at three levels (family, community, and municipality), applying various strategies to achieve the objectives. Specifically for behavioral change, communications strategies were developed for each level, with families and district leaders and authorities being considered as beneficiaries. The assessment team did not encounter communications strategies that were differentiated for adolescents, teachers, and health personnel. Outside of some initial focus groups, the beneficiary population did not have an active role in the development of the communications materials and strategies.

Links between program activities and the objectives of behavioral change

The communications activities during the first years were aimed at sensitizing the general public for the implementation of the HCM strategy. In this sense, they were directly linked to other programmatic activities. But in respect to changes in the family behaviors, communications activities have had their own timetable as shown in Table 5 below. Only two topics were continuous throughout the time period: consumption of safe water and hand washing with soap, which complemented other programmatic activities (CC capacity building, for example).
Table 5
Timetable for HCM Communication Strategies

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCM Strategy</td>
<td>informational campaign on the Healthy Municipalities, Communities, Schools, and Families strategy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe water</td>
<td>Consumption of safe water</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hand washing</td>
<td>Hand washing with soap</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Identity</td>
<td>Identity birth certificate</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Healthy practices for the promotion of child nutrition</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healthy nutritional practices and development</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breastfeeding and complementary feeding</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complementary feeding</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care</td>
<td>Adequate care for boys and girls</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth</td>
<td>Institutional childbirth</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD and HIV</td>
<td>Struggle against HIV</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention of STD and HIV/AIDS</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention of STD</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent</td>
<td>Adolescent pregnancy</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal health</td>
<td>Maternal health</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prenatal care and institutional childbirth, feeding of pregnant woman and lactating mother</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Trash collection</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that many of the shortcomings referred to above could be due, to some extent, to the year-by-year project renewal modality that limited its ability to develop a strategic vision.

C. RESULTS TO DATE AND FINDINGS BASED ON EVIDENCE

1. Strengths and Weakness of the Project’s PMP, Indicators, Benchmarks and Targets, and Use of PMP or M&E Plan by Implementers

As discussed earlier, the project has no PMP or M&E plan. The HCM implementer proposed targets in its annual work plan approved by USAID according to an annual logframe and reports on progress quarterly. According to project reports, progress towards meeting goals in terms of programmed activities was very strong in 2006–2007 (98%) and 2008–2009 (101%).
Performance against meeting activity targets was less successful (76%) in 2007–2008, possibly due to a reorientation of the program towards expansion and sustainability.

Each year, the project made adjustments by adding or removing activities in order to achieve the modified indicators. For example, from June 2005 to September 2009 the project created seventy-three different indicators (Appendix G). Only one of them, “children under 24 months with a birth certificate,” has been measured continuously over the last four years. Two indicators: “pregnancies in women 10-19 years old” and “communities with the community referral system in operation” have been measured for three years. The other indicators were measured only twice: first, between July 2005 and September 2007; second, between October 2007 and September 2009 (Appendix G).

The work undertaken between 2006 and 2007 was measured by the MCH indicators (growth and development monitoring, breastfeeding, pregnant women, school attendance), progress in schools (creation of the community education committees, implementation of health standards, promotion of healthy lifestyles), the creation of the CC, and the evaluation of healthy practices by families.

In the last two years of the project, from late 2007 to late 2009, the focus of project activities shifted with greater importance given to strengthening district governments to support and expand HCM. District teams were trained to carry out monitoring activities and expand the implementation of SISMUNI, which, in turn, provides information in support of district investment projects. While it is difficult to directly measure the results of SISMUNI, the team found that authorities were interested in expanding the system coverage the rest of the communities in the district.

It should be noted that, to their credit, the HCM project staff has been well aware of the limitations of the current project framework for evaluating results and impact, as well as for attributing any possible changes to programmatic efforts. The HCM team has made a number of efforts to supplement the logframe information through special studies including:

A validation of ten of the MCH indicators

The HCM project performed a validation study of 10 of the semi-annual MCH indicators by comparing them to the results of an MCH census using the ENDES format in 19 communities. Any datum that was within 10 percentage points was considered acceptable. Six indicators met that criterion:
### Table 6

<table>
<thead>
<tr>
<th>HCM MCH Indicators Not Validated by Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of boys and girls 0–23 months with growth monitoring card current for vaccinations</td>
</tr>
<tr>
<td>% boys and girls 0–23 months with growth monitoring card current for vaccinations</td>
</tr>
<tr>
<td>% exclusively breastfed (children 0–5 months)</td>
</tr>
<tr>
<td>% consumption of safe water (children 6–23 months)</td>
</tr>
<tr>
<td>% of pregnant women who have pre-natal control at a health center</td>
</tr>
<tr>
<td>% of pregnant women who have a pre-natal control at a health center</td>
</tr>
<tr>
<td>Number of pregnant women (also validated was the subset of pregnant women 10–19 years of age)</td>
</tr>
<tr>
<td>Number of pregnant women (also validated was the subset of pregnant women 10–19 years of age)</td>
</tr>
<tr>
<td>% of women between 15 and 49 years of age who know a FP method (traditional or modern)</td>
</tr>
<tr>
<td>% of women between 15 and 49 years of age who know a FP method (traditional or modern)</td>
</tr>
<tr>
<td>% of boys and girls under 6 months delivered at home</td>
</tr>
<tr>
<td>% of boys and girls under 6 months delivered at home</td>
</tr>
<tr>
<td>% of boys and girls under 6 months delivered at home</td>
</tr>
<tr>
<td>% of boys and girls under 6 months delivered at home</td>
</tr>
</tbody>
</table>

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The HCM project attempted to evaluate the costs and benefits of the health promotion strategy through a special study. Two project intervention communities from their top-ranked stratum of communities were selected (one with and one without a health establishment) along with two control communities from different districts (to eliminate the “contamination effect”). Benefits measured through a cross-sectional survey, were differences in episodes of diarrheal disease, and prevalence of chronic malnutrition in children under 5 years of age. The study found significant differences between the two groups being compared in terms of diarrhea, respiratory infections, and malnutrition in the under-5 population, with the group being higher in the comparison community. However, there were also significant differences between the two groups in terms of key household variables (extreme poverty, crowding, access to safe water). Since there was no baseline study to compare with, it was impossible to determine if the differences were due to basic differences in the communities or to changes over time in the project communities. The HCM project assessed costs (direct and indirect) of their interventions in the comparison communities. Of those six indicators, one (births at home) is simply the inverse of the births delivered at a health facility. The family planning indicator is largely meaningless as asked, and the number of pregnant women is a denominator figure and not an indicator. Another “indicator” (really a denominator) number of women of reproductive age (15–49), was found to be heavily under-counted, possibly due to physical limitations in the reporting form (only 35 lines). The external assessment team’s observations on the MCH indicators are in Appendix H.

A cost-benefit analysis

The HCM staff attempted to evaluate the costs and benefits of the health promotion strategy. However, there were also significant differences between the two groups in terms of key household variables (extreme poverty, crowding, access to safe water). Since there was no baseline study to compare with, it was impossible to determine if the differences between the groups was due to basic differences in the communities or to changes over time in the project communities.
A retrospective comparison of health establishment data from project and non-project areas

In this study the HCM project hired a consultant to seek evidence to determine if it is having an impact on MCH by doing a retrospective longitudinal data analysis comparing trends of visits for prenatal check-ups, family planning, diarrheal diseases, respiratory infections, vaccinations, and growth monitoring in a sample of HE within, nearby, and outside of the project communities. The data for the study came from the MOH Health Information System (HIS) for the period 2002–2009. According to preliminary results, the only one of these health indicators that demonstrated change was an increase in growth monitoring visits, although it was not clear if the increase was significantly greater in project area HE than in non-project areas.

A comparison of internal progress indicators from community diagnostics with MCH healthy practices indicators

As part of the ongoing project management monitoring, HCM project staff performed a comparison of progress towards the four phases of implementation of the health promotion model according to a numerical scale score from the information in the community diagnostics entered into the SISMUNI. It ranked the communities as basic, intermediate, or advanced based on their compliance (self-reported) in completing certain project tasks and instruments. They then compared this ranking to healthy practices data collected in the semi-annual MCH indicator reports. The communities were also ranked high or low as to healthy practices based on certain MCH indicators (birth certificate for young children, consumption of safe water, and born in a health establishment), also self-reported. Communities with a higher healthy practices score tended to have an increased level of progress implementing the HCM phases (Table 7). However, this apparent trend could be due to confounding factors and it is not possible to attribute any putative effects to project efforts. However, it is also worth noting that nearly one third of the “advanced” communities ranked “low” in the healthy practices score.

<table>
<thead>
<tr>
<th>Healthy Practices</th>
<th>Basic</th>
<th>Intermediate</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>56</td>
<td>80</td>
<td>71</td>
</tr>
<tr>
<td>207</td>
<td>(53.8%)</td>
<td>(41.5%)</td>
<td>(32.6%)</td>
</tr>
<tr>
<td>High</td>
<td>48</td>
<td>113</td>
<td>147</td>
</tr>
<tr>
<td>308</td>
<td>(46.2%)</td>
<td>(58.55)</td>
<td>(67.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>193</td>
<td>218</td>
</tr>
<tr>
<td>515</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An internal project evaluation

A four-person team consisting of two external consultants and two MSH/Boston staff are completing an internal evaluation of the HCM project that began in December. The preliminary report was made available to the CAMRIS external assessment team on March 3, shortly after
the CAMRIS team had discussed its preliminary findings and recommendations with USAID.\footnote{LMS Perú-Proyecto Municipios y Comunidades Saludables, Evaluación Interna, Borrador, Velazquez, A; Colindres, H; Baker, D; y Díaz, Ricardo. Febrero, 2010.}

The report provides valuable documentation and insight into areas such as the evolution of the socio-political situation and context and the role of social programs in alternate development; the complexity of the HCM model as described in project documents (a shared concern); and the internal project leadership structure. There was a high degree of concurrence with the internal assessment and the preliminary findings, conclusions, and recommendations developed by the external assessment team. However, there are also some important areas not fully covered in the internal evaluation, such as the lack of appropriate targeting of the beneficiary population (most vulnerable women and children); the relative neglect of certain primary health care technologies (such as community-based growth monitoring) relative to the health promotion emphasis on community organization and work with model families; stakeholder analysis; cost-effectiveness; and a review of the specific behavior change approaches, materials, and campaigns. These issues are treated elsewhere in this external assessment report.

2. Coherence of Stated Programmatic Coverage and Achievements with Evidence Obtained During Field Visits

Much of the information in the project reports comes from the annual community diagnosis and the semi-annual collection of MCH indicators reported by the CC to the district governments where it is entered into a computerized database (SISMUNI) and then reported to the regions (in some cases) and to the project office in Lima. The assessment team brought to the field a print-out of the data generated from SISMUNI by the HCM project office in Lima for each community to be visited and found a near perfect correspondence between it and the hand-written records that the CCs maintained and had readily available. This finding is a remarkable achievement.

3. Main Results to Date

Achievement of objectives

The goals in the project’s logical framework changed each year and so, there were changes in the activities. A full list of the 73 project indicators and how they have evolved is in Appendix G. The percentage of compliance with planned activities was quite satisfactory during the implementation of activities from 2006 to 2009. Between July 2006 and September 2007 (the first period after the project went to MSH), 98% of the programmed activities were implemented. Then during the period between October 2007 and September 2008, the percentage of compliance activities decreased to 76%. This decline is explained by the reorientation of the project to expand the HCM strategy into new communities. This change caused the local advisors to redirect their time to the expansion and stop promoting certain programmed activities. However, compliance with planned activities rose to 101% during the period between October 2008 and September 2009.
Likelihood of reaching objectives by the end of the project

The final goal of the project, as noted in its 2009–2010 plan, indicates that in the areas of coverage, the project should “Improve their maternal, child and reproductive health through leadership and empowerment of individuals and synergy with the regional, district, and community authorities, assuring: Sustainability of achievements in the ADP zone; Expansion of the HCM strategy in these seven regions; The adoption of the strategy into the national social development plans and programs.” However, of the ten principal indicators in the logframe, five are MCH indicators found to be invalid in the previously mentioned study, and two have a target for slight improvement (diarrheal disease and use of family planning), but no baseline. Only three of the indicators are valid and have baselines (prenatal care, children born in a health center, and percentage of pregnancies in adolescents) and targets for improvement, 1%, 4% and 2% respectively. The percentage of prenatal consults and children born in a health center is already high, and the percentage of pregnancies in adolescents is not likely to decrease. This situation illustrates the shortcomings of the HCM M&E system.

As measured every six months from 2006 to 2009, the main indicators of child and maternal health increased, especially the consumption of safe water and five solid foods per day, which doubled their percentages. The indicator of pregnant adolescents (10 to 19 years of age) increased slightly from 26.1% to 29.1%, which is worrisome. Of the eight indicators presented in the figures below, five of them are now above 80%. However, as seen in more detail in section II.D and Appendix H, several of these MCH indicators could not be validated in comparison to survey data (consumption of safe water, breastfeeding, supplementary feeding and having vaccination cards up-to-date). Of the other indicators, some (such as the knowledge of at least one family planning method) have little practical meaning.

Improvements in health and adoption of healthy practices

Most women who participated in the focus groups knew about the treatment of water (chlorinated or boiled) for consumption. However, some women in Ucayali reported consuming rainwater without chlorination or boiling "because it is clean and comes from the sky." It should be noted that boiling or chlorination is practiced by most families when in the community, but not when they are on their farms, where they have very rustic houses (some mentioned carrying bottles of boiled water). Some adults also expressed their rejection of chlorinated or boiled water because the flavor was different. On household visits in all three regions, the assessment team found that most families have containers to store water, but they are not necessarily adequate. Complicating factors are: (i) the source since, in some cases, it is used as a trough for the animals, thus contaminating the water, and (ii) the variable knowledge of the quantities of chlorine per volume of water.

Most of the women from Ucayali and San Martín know when and how to wash their hands and it was generally not a problem to buy soap or detergent, although cost was a factor for a few respondents. In more than half the households, they wash their hands in a tank where the water sits, and not all households had soap or detergent. Inadequate waste disposal was encountered. Most households in Ucayali and San Martín have a simple latrine and do not know how to treat
waste or the time required before emptying. In a community of Ayacucho, the latrines were built too close to the houses, providing a source of infection.

A large proportion of the families of San Martín and Ucayali bury their trash in two types of holes: one for organic and another for inorganic waste. The assessment team only observed one community in Ucayali where families sell the plastic to a recycler. A small number of families throw their waste into the river or the countryside, or they burn it. Many families make their stoves out of a clay base and place a metal grill on top. They cook with wood and have an adapter so the smoke will leave the room. In some houses, animals are in the kitchen or enter the homes. The use of mosquito netting is widespread.

All pregnant women were aware of the need to go to health facilities and to eat well, as well as the need to deliver in a health facilities. However in Ucayali, some women from the highlands mentioned using midwives their childbirths, and the approval of the midwife (“accommodate the baby,” “estimate the time of birth”) before giving birth in health facilities. In Ayacucho and San Martín, some women delivered at home. Women participating in the focus groups know correct information about exclusive breastfeeding and the feeding of small children, but there was not extensive practice of these behaviors. While stating that they exclusively breastfed their children 0-5 months, they also give them an infusion of anise when they have stomach gas. Respondents also had a variety of opinions regarding the age to begin feeding boys and girls and the type of food suitable for children. Some said they began feeding with chapo (a thick drink made from bananas), others, either porridge or soup. Women also have economic difficulties in providing animal sources of protein to their children (or mistaken beliefs, such as that guinea pig is not good for young children, as was mentioned in a community in San Martín) or in preparing balanced foods with fruits and vegetables from the area.

Acceptance of family planning methods appeared to be nearly universal with the major problem being stock-outs at the HE, particularly of injectables. School and HE-based efforts to reduce adolescent pregnancies do not appear to be achieving the desired reduction and need to be supplemented.
Mid-term Assessment of USAID/Peru HCM Project

Figure 3
Trends in Child Indicators 2006-2009

Figure 4
Trends in Maternal Indicators: 2006-2009
4. Data Validity and Use for Decision Making

One of the project’s most important achievements is the creation of an information flow from the family to the community and district levels. The respondents recognized the importance of having and using data at these different levels as the basis for the planning process and to prepare and present projects for financing through the participatory budgeting process. The evaluation team discussed with the district and regional authorities the possibility of extending the coverage of the SISMUNI as an information management tool to non-project communities. However, there is ample room for improvement in the quality and relevance of the indicator and data collection tools (Appendix H).

Community-based statistics used to influence behaviors and make decisions

HCM has developed a wide range of tools for collecting information from families and consolidating it at the community, district, and regional levels. The purpose of the system is to analyze information for making informed decisions at all levels.

<table>
<thead>
<tr>
<th>Level</th>
<th>Tool</th>
<th>Usefulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>Healthy family guide</td>
<td>Shows the steps to follow to have a healthy family</td>
</tr>
<tr>
<td></td>
<td>Drawing board for the family vision</td>
<td>The family draws its dream or vision of a healthy family</td>
</tr>
<tr>
<td></td>
<td>Wall poster for a family diagnosis</td>
<td>Helps to analyze the behavior in the family for monitoring and self-evaluation</td>
</tr>
<tr>
<td></td>
<td>Wall poster of commitments</td>
<td>Makes notes of the commitments that the family will fulfill for its vision</td>
</tr>
<tr>
<td></td>
<td>Educational mural for the consumption of safe water and family hygiene</td>
<td>Shows the steps to follow to have and consume safe water and improve family hygiene</td>
</tr>
<tr>
<td>Community</td>
<td>Healthy community guide</td>
<td>Shows the steps to follow to have a healthy community</td>
</tr>
<tr>
<td></td>
<td>Diagnosis and plan of my community, neighborhood, or village</td>
<td>Instrument to assist in the process of health planning and community development. Feeds the SISMUNI. Annual use.</td>
</tr>
<tr>
<td></td>
<td>MCH indicator form</td>
<td>Gives guidelines for follow-up, monitoring, and self-assessment of mother and child health. Feeds the SISMUNI. Semi-annual use.</td>
</tr>
<tr>
<td></td>
<td>CD of rural technologies for healthy families</td>
<td>Shows the environmental impact of improved stoves, latrines, micro-landfills, and children’s parks</td>
</tr>
<tr>
<td></td>
<td>Drawing board of self-assessment of mother and child health</td>
<td>The community notes its progress in health practices</td>
</tr>
<tr>
<td></td>
<td>Facilitator’s guide to the promotion of the consumption of safe water</td>
<td>Tool to train families in the consumption of safe water and improved hygiene</td>
</tr>
<tr>
<td>Municipality</td>
<td>Healthy municipalities guide</td>
<td>Shows the steps to follow to have a healthy municipality</td>
</tr>
<tr>
<td></td>
<td>SISMUNI program</td>
<td>Computer program that processes data for the local management of health and development</td>
</tr>
<tr>
<td></td>
<td>Audio-visual tool box</td>
<td>Set of CDs with guides, communications materials, SISMUNI, etc.</td>
</tr>
<tr>
<td></td>
<td>Communications kit to promote the consumption of safe water</td>
<td>Materials to train community facilitators</td>
</tr>
</tbody>
</table>
The extensive list of tools above complicates monitoring of their use by the local project advisor. Their relative usefulness merits a detailed analysis before taking them to the next project stage.

Data use at all levels to improve programmatic activities

The team verified that the tools were known by the families, but with the exception of the wall poster for the family vision, few were well understood and used. Nevertheless, it was clear that the communities understood the usefulness of using safe water, hand washing, household cleaning and latrines.

The principal tools at the community level are the Community Diagnosis and the MCH indicators list, which are also the main data sources of the SISMUNI. The Community Diagnosis is a potentially very useful tool, but its main limitation is the very large amount of information on population, health, education, and economic-production data that are often difficult to obtain (e.g., the number of livestock in the population, economic productivity per hectare, etc.). This complexity affects the quality of the data, especially given the low educational level of the community residents collecting them. Given his daily tasks, the community leader makes an extra effort to comply with this task. However in some cases he merely sits down with other members of the CC to answer the questions together.

With some improvements, the MCH indicators could be an important tool for the analysis of community health. Like the Community Diagnosis, it is completed by the leader of the community with technical support from the nearest health facility. This relationship is very important for monitoring the community MCH indicators, and the HE uses the information to develop its plans.

Sharing with and use of programmatic data by local health authorities

The documents described above, the MCH indicators and the Community Diagnosis, are sent to the district level for entry into the SISMUNI. It is the only detailed information that the district government has with which to make decisions on these communities. However, use of the SISMUNI information is still limited despite the number of project training sessions in SISMUNI (427 in 2008 and 209 in 2009), as well as the support for the design and administration of municipal government web sites (32 in 2008). Some possible reasons are that the culture of using information is not yet widespread and officials in the municipalities change frequently. Nonetheless, during the visits to the district mayors and their technical team, they recognized the importance of SISMUNI. Some requested and others stated that they have plans to extend the coverage of the information to all communities in their districts so as to have a situational map, which is the ultimate objective for this tool.

Adequacy of information systems for program needs

The regional government in Ayacucho decided to adapt the CRECER strategy creating CRECER Wari (the name of the cultural group from that region). This strategy has permitted all public and private social sector activities in this region to adopt joint goals and work together. The HCM Project has made its tools available for revision. As a result of this activity the regional
government, through its Social Development Office, analyzed the Community Diagnosis document and adapted it, making a few changes, mainly in the number of questions, and naming the document “Llaqtanchik.” The regional government is currently promoting the use of this tool and, in a parallel fashion, is analyzing the SISMUNI to make the adjustments required to be able to use it as a data processing system. This example could be a model for adapting the information system to the needs of other regions and programs.

D. ACTIVITY MODEL (How well the model is working, in terms of results and resources invested, and what improvements may be needed)

1. Achievement of Desired Health Behaviors and Outcomes by Program Model

The communities visited all perceive themselves as being better off as a result of the project. This perception is shared universally by personal at the district, micro-network, and regional levels who believe that these communities have improved over time. These same informants also believe that these communities have improved relative to neighboring communities, and are cleaner, better organized, and with improved practices and health outcomes such as reduced childhood morbidity and malnutrition. The assessment team noticed that in fact these communities appeared relatively clean and organized, with little trash, few animals such as pigs and cows running loose, and ordered public spaces, often with ornamental plants.

The anecdotal evidence, project MCH indicators information system (Figures 3 and 4), and qualitative evidence all concur that there is an overall improvement in the project areas, both in terms of from where things were prior to the HCM project and relative to other non-project communities. Commonly cited areas of improvement by the informants were MCH outcomes (maternal mortality, incidence of childhood morbidities, and prevalence of malnutrition) and health behaviors (safe water, births in health centers, exclusive breastfeeding and other child feeding practices, use of latrines, hand washing and growth monitoring). However, as was mentioned above, there is no hard objective data to validate these assertions, much less to attribute the perceived changes and differences to project efforts.

The HCM internal semi-annual MCH indicator system shows almost continued improvement in most indicators. However, the assessment team was convinced that there was almost universal awareness in the communities as to what are the correct responses to these questions and that this knowledge could have biased the self-reported MCH indicator data collection and reporting process.

Strengths of the application of the model

The project has been successful at organizing and empowering over 500 communities in zones of difficult access, particularly when one takes into account the challenges presented by the socio-political situation in the coca-producing region. The communities are proud of what they perceive to be their achievements in organizing and cleaning their communities and households. The project approach, which seeks to improve maternal-child and reproductive-sexual health
through simultaneously reducing risk by promoting healthy behaviors and reducing vulnerability through improvement of societal and environmental factors, is both comprehensive and valid, with potential for leading to sustained impacts. A major achievement and strength of the model has been the development of a capacity for collecting and reporting community-level data as well as the support of a culture of information-based decision making.

The health promotion model has four clear implementation phases (awareness, planning, implementation, and self-evaluation) that are easy to implement. Coupled with the leadership training and other project strengthening such as in data collection and use, the model can lead to true empowerment of the beneficiary communities. The project appears to have strengthened the organization of the communities as well as their capacity for prioritizing and identifying and resolving problems. By facilitating effective relationships with other levels of government (districts and regions), the project further enhances the empowerment and self-esteem of the communities. This type of organization and effective use of resources through information-based planning and programming can lead to improvements in the quality of life of the families and individuals.

**Weaknesses and where the model can be improved**

In the implementation of the model, health technologies and primary health care seem to have suffered at the expense of the community development and strengthening approach. The main weakness of the model as it is being applied is that the HCM project has lost its focus on the target population: pregnant women and children under two years of age (and their caretakers), especially those in the most vulnerable situations. When visiting communities, project staff first seek out the members of the CC and then the model families they are working with. Other community members are not excluded from group activities; however they do not receive the same level of attention. The assessment team observed that the model families tended to be better off and older, with few to no pregnant women or children under two in the household. The implication of this observation is that a disproportionate amount of project effort is going to the less needy. The team encountered some community members that felt alienated, that it was “a program for the rich.” The team also met some poor and teenage mothers of children under two years of age (that exhibited some indications of growth faltering) that expressed that they had been specifically excluded from the program.

The growth monitoring is being very poorly carried out and is not applying lessons learned and best practices from Peru and Latin America.\(^{28,29}\) It is facility-based and there are long gaps between measurements on the growth monitoring cards (that to everyone’s credit all mothers were able to produce). Furthermore, the mothers had no idea as to what the dots and line connecting them (the dots were not always connected on the cards) meant. It appeared that the health staff was paying no attention to growth faltering if the dot was not in one of the malnutrition categories. In the communities where there is no health center, poor and disadvantaged mothers are not inclined to pay 7 – 15 soles for a moto-taxi to take an apparently

\(^{28}\) World Bank, promoción del Crecimiento para Disminuir la Desnutrición Crónica, Estrategias con Bases Comunitarias en Centro América.  
well child for a growth monitoring visit, especially when there is a risk that the center will be closed. The team could not find examples of true community-based growth monitoring with active meaningful participation of the community and families.

In general the approach, which appears to be supported by the health center staff, is that the primary role of the community health promotors is to refer patients. It appears that the communities are not being strengthened (with a few exceptions) to resolve their own problems, such as providing basic first aid (given current shortages of supplies, the health centers are not able to stock community first aid stations), diarrheal diseases and growth monitoring.

Home births still occur in some communities. This appears largely due to geographical access problems, although in some cases, quality of treatment and care by health center staff and cultural practices can be an issue. However, when births do happen at a health unit, it is sometimes at a health post without a qualified professional in attendance. The nurse auxiliaries are well aware that this is not their responsibility, but they cannot turn down a pregnant woman in active labor. These births still get recorded in the project semi-annual MCH indicator survey as an institutional birth. Some of the regions such as San Martín are moving aggressively to expand the network of waiting houses for pregnant women (*casas de espera*), which should help reduce this problem in the not-too-distant future.

The project has developed a tremendous engine and capacity for community-level data collection and reporting up the system based on an annual community diagnosis and semi-annual MCH indicator reports. However, the former is overly large, complicated, and under-utilized, and the latter has some serious indicator problems (Appendix H). These instruments could benefit from a serious overhaul. In summation, the basic HCM model based on community organization for health and social development is sound; it simply requires some adjustments in its direction and application.

### 2. Cost per Beneficiary of the Model and Efficiency in Terms of Results Achieved

Total HCM program costs from 2006–2009, including technical assistance, all indirect costs, and overhead for the 515 ADP zone communities, was approximately US$2.710 million/year or $5,094 per community (Table 9). Total population coverage was estimated at 35,000 families or 150,000 inhabitants, of whom 5,891 are under two years of age, according to the project information system. This comes to a gross cost of $18 per inhabitant.

However, a major portion of project efforts, especially during the later years, has gone towards strengthening the regional and local government capabilities and policy dialogue at the national level for incorporation of the MCS model into national, regional, and district plans and programs. These efforts have most likely contributed to indirect benefits in non-project areas and influenced national policies and programs. Likewise, the 445 health establishments that the project has worked with and supported also cover a large number of project communities and persons and those beneficiaries have not been counted in the costing exercise. These elements of the project’s benefits and effects are difficult to incorporate into a straight forward cost-effectiveness analysis.
The GOP has expressed a determination to adopt and scale up the HCM health promotion approach within the context of an integrated development strategy. The question has arisen as to what the cost would be for the host country to assume the support and accompaniment identified as necessary for the effective implementation of the HCM program. The CRECER model of having a local adviser in each district plus responsible parties at the regional government level would be a relevant model to cost out in response to this question. The assessment team worked with project staff to develop an estimate for the incremental direct costs (i.e. above and beyond what is already in regional and district level budgets for PHC activities) for successfully implementing the HCM health promotion methodology in a region with 50 districts, based on the assumptions that:

- Each region would have a three-person technical assistance team well versed in the health promotion strategy and instruments, particularly for data collection and information use;
- Each district would have a health promotion coordinator (as per the CRECER model);
- An average of 30 communities per district with an average of 50 families per community; and
- Costs of incremental salaries and implementation activities would come largely from regional and district PIP funds. External technical assistance for methodological development and special investigations would still be paid for by cooperating agency funds.

### Table 9
Costs of Implementing the HCM Project 2004 - 2006

<table>
<thead>
<tr>
<th>Item</th>
<th>Jul ’04-Jun ’05</th>
<th>Jul ’05-Jun ’06</th>
<th>Jul ’06-Sept ’07</th>
<th>Oct ’07-Sept ’08</th>
<th>Oct ’08-Sept ’09</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>1,105,481</td>
<td>1,259,108</td>
<td>3,193,306</td>
<td>2,984,603</td>
<td>2,709,855</td>
</tr>
<tr>
<td>Cost sharing</td>
<td>360,248.88</td>
<td>11,218.30</td>
<td>94,626.74</td>
<td>52,667.27</td>
<td>28,887.27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,465,730</strong></td>
<td><strong>1,270,326</strong></td>
<td><strong>3,287,933</strong></td>
<td><strong>3,037,271</strong></td>
<td><strong>2,738,743</strong></td>
</tr>
<tr>
<td>Nº of communities</td>
<td>340</td>
<td>340</td>
<td>557</td>
<td>557</td>
<td>532</td>
</tr>
<tr>
<td>Nº of Families</td>
<td>20,000</td>
<td>20,000</td>
<td>35,000</td>
<td>35,000</td>
<td>35,000</td>
</tr>
<tr>
<td><strong>USAID cost per community</strong></td>
<td><strong>3,251</strong></td>
<td><strong>3,703</strong></td>
<td><strong>5,733</strong></td>
<td><strong>5,358</strong></td>
<td><strong>5,094</strong></td>
</tr>
</tbody>
</table>

Source: HCM Management Information System
### Table 10
Incremental Annual Costs to Implement HCM Model

<table>
<thead>
<tr>
<th>Level</th>
<th>Item</th>
<th>Amount in USD (1 USD=2.85 Soles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>Coordinator salary</td>
<td>17,000</td>
</tr>
<tr>
<td></td>
<td>Coordinator community site visits for awareness (for new communities), training of CC and supervision of implementation</td>
<td>12,100</td>
</tr>
<tr>
<td></td>
<td>Materials, tool kits, etc.</td>
<td>7,500</td>
</tr>
<tr>
<td></td>
<td>Mass media</td>
<td>5,000</td>
</tr>
<tr>
<td></td>
<td>Training of health personnel</td>
<td>7,000</td>
</tr>
<tr>
<td></td>
<td>Supervisory site visits by LDTT</td>
<td>5,300</td>
</tr>
<tr>
<td></td>
<td>District advocacy work</td>
<td>200</td>
</tr>
<tr>
<td><strong>District Total</strong></td>
<td></td>
<td><strong>$54,100</strong></td>
</tr>
<tr>
<td><strong>Average annual cost per community</strong></td>
<td></td>
<td><strong>$1,803</strong></td>
</tr>
<tr>
<td>Region</td>
<td>Salaries for specialists in health promotion, behavior change, and information systems</td>
<td>51,000</td>
</tr>
<tr>
<td></td>
<td>Regional advocacy</td>
<td>350</td>
</tr>
<tr>
<td></td>
<td>Training of district coordinators</td>
<td>10,000</td>
</tr>
<tr>
<td></td>
<td>Site visits to districts</td>
<td>9,000</td>
</tr>
<tr>
<td></td>
<td>Mass media</td>
<td>10,500</td>
</tr>
<tr>
<td></td>
<td>M&amp;E and administrative meetings</td>
<td>7,000</td>
</tr>
<tr>
<td></td>
<td>Implementation of M&amp;E and information system</td>
<td>5,300</td>
</tr>
<tr>
<td></td>
<td>M&amp;E costs</td>
<td>21,000</td>
</tr>
<tr>
<td><strong>Regional Total</strong></td>
<td></td>
<td><strong>$114,150</strong></td>
</tr>
</tbody>
</table>

The costs in Table 10 are for the full geographical implementation of the model that will probably take several years while areas not previously covered are phased in. There could be some savings in salaries at the regional level if existing health region or other personnel could assume some of these functions. However, not having dedicated personnel would definitely limit program effectiveness. It is likely that the GOP will want to seek complementary sources of funding (external agencies and the private sector, for example the mining sector) to help defray the costs. However, these data are reasonable estimates of incremental costs that need to be considered for effective implementation and expansion of the model.

3. **Sustainability of the Model at the Family, Community (Including JCV and Local Health Authorities/Services), and Local/Regional/National Government Levels**

The HCM project has laid the groundwork for sustainability of the health promotion model through its acceptance and incorporation into plans and programs at the community, district,
regional and national levels by CRECER and the MOH/DIGEPROM. As per the original project proposal, HCM has achieved a high degree of the desired “community ownership and participation.” Individuals and institutions at all levels appear to be committed to its continuance. Furthermore, through the training it has provided both to beneficiaries and internal project staff, it has built up a mass of committed individuals knowledgeable of the health promotion methodology, and project instruments and procedures. An element for sustainability that needs to be further developed and strengthened is the role of the schools and the interest of MINEDU in maintaining the healthy schools initiative. Effectively strengthening their role can go a long way toward cementing community norms for promoting healthy lifestyles and behaviors.

However, the effective implementation of the model requires intensive supervision, and the main question is how well it will be carried out, especially with reduced or no project technical assistance. Successful transfer of responsibilities and functions will require extensive human resource strengthening (section III), and finding resources to cover the costs for maintaining staff and materials for optimal implementation is also of major concern (Table 10).

E. MANAGEMENT, COMMUNICATION, AND COORDINATION

1. **Key Stakeholder (USAID, MOH, Government Representatives, Implementing Partners, and Other USAID Projects) Awareness of HCM Goals and Objectives**

The assessment team found a high level of awareness and knowledge of the HCM project and its goals among a broad spectrum of stakeholders at different levels. It also found some examples of coordination, a few examples of duplication, and opportunities for further collaboration (see Appendix I for detailed information by stakeholder). The USAID partners meet periodically at the central level (at the insistence of USAID), and more importantly at the regional level, and are well-informed of each other’s activities. However, this communication needs to be structured and broadened into true coordination through the preparation and implementation of jointly constructed district-level development plans.

2. **Stakeholder, Beneficiary, and Local Government Awareness that HCM is Supported by USAID. Evidence that the Program is Generating Good Will among Peruvians Living in the Program Area**

There was an almost universally correct and sometimes enthusiastic response to the question “Do you know who (what agency) is supporting the project?” (“Our good friend USAID,” was a Regional Vice-President’s response). The only respondent that did not know was one CC that thought that the project had originated in Boston. A special appreciation was expressed in Ayacucho, where HCM is currently the only USAID project with an active presence. The team believes that it can be said with a great deal of certainty that the HCM project has generated considerable good will towards USAID among Peruvians in the ADP program area.
3. Opportunities to Improve Coordination among USAID-Supported and Other Projects as well as Local Governmental Authorities to Improve Synergies and Health Outcomes

Appendix I provides details about the history of coordination and suggestions for further areas of collaboration to create synergies between HCM and other USAID projects. Relations have been cordial and mutually respectful, and they occasionally combine on-site visits at the regional level. Although the HCM focus was at the community level, the other projects recognize the need for the involvement of district governments in the project. Other projects such as ADP have used the SISMUNI on occasion. However, the periodic meetings at the central and regional levels referred to in section III are mostly for information-sharing purposes, and there is potential for more synergies through true joint program coordination for comprehensive social development projects at the district level.

The principal overarching suggestion for improved coordination is that within the regions the projects should collaborate on identifying two model districts for preparing comprehensive district-wide development plans based on the information derived from a jointly developed and implemented community diagnostic tool. In the spirit of the Paris Declaration, the CRECER comprehensive multisectoral development strategy incorporating health, education, housing and sanitation, economic productivity, identity, and social protection could provide the framework for collaboration with regional and district level authorities in the development, implementation, and M&E of these plans. The CRECER Wari initiative in Ayacucho that has adapted the HCM methodology (including a baseline study) is a possible model for a regional approach in other areas. Another possible best practice of inter-USAID project coordination is currently ongoing in the Chazuta District of San Martín, where the USAID projects have been carrying out a joint planning exercise that they expect to evaluate and document at the end of March.

4. Relevance of HCM Program to the ADP

Since the inception of its predecessor activities in the mid-late 1990s, improved health and wellbeing have been essential elements of a strategy to wean communities from the illicit coca trade. The health program has been credited by some as having contributed to the overall acceptance of the ADP strategy and personnel from other projects have acknowledged the HCM contribution to promoting a licit lifestyle, particularly through its promotion of healthy lifestyles and values-based leadership training at the community level. The HCM project has generated considerable good will at the community, district, and regional levels, which is supportive of the overall USAID effort in these zones. Currently, it is the only USAID project with a continued presence in the high-conflict VRA area.

5. The Program’s Contribution to the National Agenda for Health

As can be seen in Table 11, the HCM project not only contributes to the national agenda for health, but it has also helped shape that agenda to a large extent. CRECER recently presented it as the implementation model for its national integrated development strategy at a recent launch
Revising and updating the existing MINSA MCS norms and instruments
Initial implementation in the approximately 1,200 CRECER priority districts
Subsequent extension nationwide after official MOH approval of the new norms.

However, there are certain areas in which HCM could better align itself with the national agenda:

- a clearer focus on the most vulnerable target populations;
- orientation of assistance to the districts/municipalities to assume the functions and competencies assigned to them under decentralization;
- and informing the target population about their rights and benefits under the new universal assurance plan. As mentioned elsewhere, the project data collection instruments are in need of a serious revision to be an effective part of an integrated development planning and implementation strategy.

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30 Personal communication from Edgar Medina/MSH, March 11, 2010.
III. CONCLUSIONS AND RECOMMENDATIONS

A. CORE COMPONENTS OF THE PROJECT THAT MERIT FUTURE SUPPORT

In summary, the main achievement of the HCM project is how it has inserted itself into the national, regional, and local government agendas and its adoption as the implementation strategy for health promotion within the context of integrated development programs such as CRECER, and more recently with the MOH/DIGEPROM. There is now widespread political support for extending the model. The question is how can USAID best support the GOP in this effort.

HCM has done a laudatory job under difficult conditions of helping to organize the communities around health-related issues. It can be commended for strengthening community capacities to collect and report data as well as to set priorities and negotiate with the district governments as part of the participatory budget process through the effective functioning of the CC. Through its values-based leadership training, promotion of healthy lifestyles, and organization of local communities, HCM contributes to the overall goals of the ADP program and provides a facilitating environment for other ADP activities. The improvements in the physical appearance, self-esteem, empowerment, and wellbeing of the communities are readily noticeable to outside observers. However, as noted previously, the external assessment team did not find hard data to determine if there had been improvements in health status of the target population, much less attribute improvements to project efforts.

The assessment team also noted some concerns that require attention including the need to:

- Reestablish the focus on the target population
- Modify and simplify the community diagnostic data collection instrument while making it more relevant to other development programs (USAID and GOP)
- Structure and further strengthen coordination with other USAID projects to maximize the potential for synergies
- Develop and implement an M&E plan
- Establish community-based growth monitoring for integrating MCH activities.

What components of the program are most likely to be sustained? What key components are needed to sustain behavior change?

The GOP has made the determination to adopt and scale up the HCM health promotion approach within the context of an integrated development strategy and has taken initial first steps through CRECER. Therefore, the main question is how to best assist them to do it effectively. The section on costs presents the incremental staffing and materials requirements for maintaining the same level of health promotion activities. Recommendations below discuss specific program components where USAID can contribute to making a full hand-off to the GOP.
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>HCM CONTRIBUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Policies in the National Accord</strong>(^{31}):</td>
<td>HCM contributes to the promotion of healthy lifestyles.</td>
</tr>
<tr>
<td>13th State Policy on Universal Access to Health Services and Social</td>
<td>HCM promotes the active participation of the members of the community and supports CQI.</td>
</tr>
<tr>
<td>Security: “We are committed to ensuring the conditions for free, continuous,</td>
<td>It does not focus on the most vulnerable.</td>
</tr>
<tr>
<td>timely and quality universal access to health services, with priority in</td>
<td></td>
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<tr>
<td>areas where the population is most impoverished and vulnerable. We also</td>
<td></td>
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<tr>
<td>pledge to promote citizen participation in the management and evaluation</td>
<td></td>
</tr>
<tr>
<td>of public health services ... promote healthy lifestyles.”</td>
<td></td>
</tr>
<tr>
<td>National Strategy CRECER places the districts as the center of these</td>
<td>HCM is fortifying the districts and regions to assume the role.</td>
</tr>
<tr>
<td>activities and has adopted the HCM methodology formally (for example in</td>
<td>HCM has initiated activities in coordination with the CRECER strategy, specifically in Ayacucho.</td>
</tr>
<tr>
<td>Ayacucho, CRECER Wari)(^{32}).</td>
<td></td>
</tr>
<tr>
<td>The Direction of Health Promotion has expressed its intent to take HCM</td>
<td>HCM is coordinating with and supporting the DIGEPROM In this effort.</td>
</tr>
<tr>
<td>to the national level.</td>
<td></td>
</tr>
<tr>
<td><strong>Health Sector Policy</strong>(^{33}):</td>
<td>The HCM empowers the communities to perform their own diagnosis, identify goals and take actions for the improvement of their wellbeing.</td>
</tr>
<tr>
<td>Policy Guidelines for Health Promotion 2002 – 2012. Seeks to achieve a</td>
<td></td>
</tr>
<tr>
<td>state of physical, mental and social wellbeing, in which individuals and</td>
<td></td>
</tr>
<tr>
<td>groups may be able to identify and achieve their goals, satisfy needs</td>
<td></td>
</tr>
<tr>
<td>and change or cope with their environment.</td>
<td></td>
</tr>
<tr>
<td><strong>Strategies for Health Promotion</strong>: National Strategic Plan for Reducing</td>
<td>HCM strengthens the role of the family and community and promotes incorporation of women into CC.</td>
</tr>
<tr>
<td>Maternal and Perinatal Mortality 2009 to 2015: “...the family and community</td>
<td></td>
</tr>
<tr>
<td>are vital elements of the social factors that influence maternal and</td>
<td></td>
</tr>
<tr>
<td>perinatal health ...” &quot;women’s health problems are a reflection of the</td>
<td></td>
</tr>
<tr>
<td>place assigned to them socially”</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th><strong>National Policy for Quality in Health.</strong> “Citizens exercise and monitor respect for their right to quality health care and share responsibility for their health care and that of their family and community with the support of health authorities”</th>
<th>HCM supports CQI and community surveillance.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Management Guidelines in MINSA</strong>[^1] 34: “We will not achieve the reduction of malnutrition nor maternal mortality, nor infant mortality … if we do not strengthen our capacity to act particularly at the first level of care.”</td>
<td>HCM supports CQI in HE coupled with community surveillance.</td>
</tr>
<tr>
<td><strong>Decentralization Process Organic Law of Municipalities:</strong> 2.5. Manage primary health care and build and equip HE in the population areas that need them, in coordination with district municipalities, towns and regional and national organizations.</td>
<td>In collaboration with the CC and municipalities, needs are being detected, and in some cases directly addressed, such as improvement in infrastructure and equipment, waiting house construction, and hiring of staff. This area requires a greater effort on the part of HCM to directly address the transfer of responsibilities contemplated within the municipality laws.</td>
</tr>
<tr>
<td>2.6. Preventive medicine campaigns, first aid, health education and local prevention.</td>
<td>Prevention campaigns are being carried out from the HE to the community.</td>
</tr>
</tbody>
</table>

B. MAIN LESSONS LEARNED

- Projects should have a multi-year time frame with a PMP (optimally with a baseline study and follow up). The year-to-year HCM project renewal modality complicated efforts to evaluate project effects and also hindered the continuity of manpower development and training programs for project staff, beneficiaries, and local counterparts.

- Health promotion programs that take a community development and institutional strengthening approach need to ensure that they do not lose their focus on the target population, in this case pregnant women and children under two years of age, and vulnerable women of reproductive age such as adolescents. These groups need to be of highest priority in project activities.

- Key to success at the community level in improving maternal and child health is the smooth functioning of the team of the CC, the auxiliary nurse, the health promoter, and, potentially, the school (Figure 1).

- The school and educational system has an important normative role, and institutionalization of the healthy schools approach can contribute to sustainability.

- The ability of the CC to effectively participate in the district planning and budgetary processes is of almost equal importance. These processes and functions, particularly in the area of data collection, analysis, and use, still require considerable accompaniment.

- True coordination across projects requires more than good intentions and occasional meetings to share information. A stipulation with measures of compliance (preferably contractual) that the projects working in the ADP zones should mutually select districts for the design and implementation of integrated development plans based on the multisectoral CRECER strategy would enhance the development of synergies across projects.

- Singling out “model families” for attention appears to have been counterproductive and should be discontinued. However, the “model community” approach does appear to have value, particularly in terms of refining project instruments and for serving as locations for guided observational site visits. Providing competitive rewards at the family and community levels should be discontinued, because there are not level playing fields and this strategy only highlights or even exacerbates pre-existing differences. Incentives are best left at the community level and should be based on level of execution of the commitments in their development plans that ideally have been negotiated and agreed upon with the districts.

- The health promotion model has provided local communities with improved organization, pride, and quality of life. Coupled with HCM training and strengthening in areas such as value-based leadership and community management and healthy lifestyles.
(including self-evaluations) facilitated the work of other programs such as those promoting alternate means of production/income generation.

- Effective functioning of the model requires continued accompaniment at family, community, district, and regional levels.

- The sexual/reproductive health education programs, largely provided through the school and health center settings, are insufficient to modify the risk of teen pregnancies given the social context (including delinquency, transactional sex, and drug use).³⁵

- There is limited potential for further extension of health services through the MOH/HE. Complementary strategies for empowering communities to resolve their own health problems are needed.

C. RECOMMENDATIONS FOR POSSIBLE FOLLOW-ON ACTIVITY

For any possible follow-on activity, the assessment team recommends that USAID consider:

1. Continue and accelerate the transition of HCM from an implementation project to a primarily technical assistance project. The HCM follow-on should concentrate on best practices and excellence and focus down geographically on a few model districts in the ADP zones in each region, to be selected according to need in collaboration with the GOP and other USAID projects. The focus in these districts should be on:
   - developing district-wide coverage of comprehensive development plans and programs
   - refining tools and instruments such as the community diagnostics
   - the use of information at the community, district, and regional levels for developing and implementing plans
   - monitoring the health of the target population

2. The solicitation document for a follow-on activity should stipulate that the applicant presents:
   - A four-year proposal with a detailed M&E plan that includes baseline and follow-up studies (possibly with comparison communities selected from the ENDES sample);
   - A plan to coordinate with the other USAID projects in the ADP zone in the selection of model districts, and to develop and implement integrated development plans in those districts with specific project commitments. In the spirit of the Paris Declaration, these plans will use as a reference the GOP multisectoral CRECER development strategy framework integrating health, education, housing and sanitation, the productive sector, identity, and social protection (see recommendations below for elements to be included in those plans). The initial work plan will include a

timeline for a series of deliverables that will be incorporated in the individual district
development plans (each with its own implementation timeline);

- A detailed sustainability plan to pass the responsibility for supporting activities at the
  community level to the district and regional governments; and
- A detailed human resources development strategy that will pass the capacity for
  providing the trainings suggested below to the host country and develop non-
  monetary and other incentives for community-level personnel and committees.

The applicant should specify how it will develop integrated approaches for:

- **Environmental management** including:
  - Improved water supply
  - Drainage
  - Garbage disposal/recycling
  - Composting of organic waste
  - Improved latrines
  - Improved kitchens
  - Home/community gardens and ornamental plants
  - Reforestation

- **Community-youth programs** incorporating:
  - Sports
  - Recreation
  - Gender
  - Entertainment
  - Life skills (including vocational training
  - Sexual/reproductive health

- **Human resource development**: A multi-pronged plan to develop national
capacities for training key health promotion and development personnel on a
continuing basis through:
  - Diploma-level courses (a combination of on-line and presence-based) at
    regional universities in health promotion for district and regional government
    officials and sector staff. A component of this diploma course (or even a
    separate course) should be on the collection, channeling, and use of community-
    level data for developing, implementing, and monitoring projects as part of the
    participatory budget process
  - Leadership training at the community, district, and regional levels
  - Paper-based self-learning modules for nurse auxiliaries at the micro-network
    level to be conducted on monthly basis as part of their monthly administrative
    meetings
• **Community-based growth monitoring programs** based on national and international best practices as an integrative force to focusing MCH/PHC services on the most vulnerable children and women

• **Resource development**: A plan for finding (including developing proposals) and executing the district and regional level national resources to fund the activities identified in Table 10 that are necessary for the effective functioning of the HCM approach

• **Information system**: A plan for streamlining and improving the system including refining the indicators and data collection instruments and procedures (including quality assurance)

• **Behavior change**: focusing on key child care issues and family planning/reproductive health

• **Strengthening the capacity of the micro-networks** to support the HE, including maintaining and strengthening continuous quality improvement

• **Development of non-competitive community-based incentives** based on completion of commitments made in their annual plans.

**D. MOST IMPORTANT INTERVENTIONS FOR SCALING UP**

Given that reduced USAID resources will be available for this activity and that the GOP has expressed its intention to scale up the HCM approach, these limited resources should not go to directly funding the extension of implementation activities. Rather, the USAID contribution in this context would most productively go to the further development of standards, capacities, tools, and best practices, including the selection of a limited number of model districts for district-level comprehensive development plans. These community plans would be based on information collected at the community level (using improved versions of the data collection instruments as described above) to be used for building district development plans through the participatory budgeting process.

Other areas where targeted USAID investment can make important contributions to national scale-up are development and documentation of best practices in community-based growth monitoring as the engine for extending primary health care; capacity strengthening through the development of national training programs for leadership, health promotion, and nurse auxiliaries; and comprehensive community-based youth programs.
APPENDICES (separate volume)

A. Assessment Scope of Work
B. Documents Reviewed
C. Team Composition, Methodology, and Key Informants
D. Data Collection Instruments
E. Power Point Presentation on Assessment Results
F. Training of HCM Staff and Beneficiaries
G. Evolution of Purpose-Level Indicators
H. Project MCH Indicators
I. Coordination between HCM and Other Projects/Programs
J. Proposed Results Framework in LMS Format