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Healthy Communities and Municipalities II Project:

A Case Study on Citizen Engagement and its Influence on Health Practices and Outcomes in Peru

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List of Acronyms

ADP	Alternative Development Program
CE	citizen engagement
CIAS	Comisión Interministerial de Asuntos Sociales-CRECER
CNC	Community Neighborhood Committee (a multi-stakeholder and multi sector committee)
DHS	Demographic and Health Survey
DEVIDA	National Commission on Development and Life without Drugs
DIRESA	Dirección Regional de Salud (Regional Health Directorate)
FP	family planning
GOP	Government of Peru
HCM I	Healthy Communities and Municipalities Project I
HCM II	Healthy Communities and Municipalities Project II
JUNTOS CCT	Programa Nacional de Apoyo Directo a los Más Pobres, Juntos Conditional Cash Transfer program
LMS	Leadership, Management and Sustainability Project
LG	Local Government (represented by the district Social Development Office)
LQAS	Lot Quality Assurance Sampling
LTT	Local Technical Team (includes representatives from the Social Development Office)
M&E	monitoring and evaluation
MCH	maternal-child health
MEF	Ministerio de Economía y Finanzas (Ministry of Economy and Finance)
MEP	monitoring and evaluation plan
MIDIS	Ministerio de Desarrollo e Inclusión Social (Ministry of Development and Social Inclusion)
MINSA	Ministerio de Salud (Ministry of Health)
MSH	Management Sciences for Health
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PAIMNI	Programa de Acciones Integrales para Mejorar la Nutrición Infantil
PpR	Presupuestación por Resultados (Results-based Budgeting)
PROMSA	Programa de Promoción de la Salud (Health Promotion Program of MINSA)
RFA	Request for Application
RH	reproductive health
SDO	Social Development Office
SIS	Seguro Integral de Salud
SISMUNI	Sistema de Información Municipal de Salud Comunal
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Executive Summary

The objective of this case study is to explore how health interventions and outcomes in the Healthy Communities and Municipalities II (HCM II) Project implemented by Management Sciences for Health in Peru were enhanced through the active engagement of the community. The original objective of the HCM II Project was to improve maternal and child health, family planning, and reproductive health through the promotion of a range of healthier community practices that targeted children under two years of age, pregnant women, and women of reproductive age in Lima and other select areas of Peru. The rationale for including some form of citizen engagement in development programs is based on the belief that giving citizens a voice in program implementation and design will help ensure that programs are tailored to their needs, build a greater sense of ownership, and make service delivery more accountable to users. The Project employed community committees as the main vehicle for citizen engagement. Although the unit of analysis is the first component of the HCM II Project, in-depth information on how the Project was implemented, as well as its successes and challenges, was obtained through a field visit to the region of San Martín.

The Project introduced a bottom-up health promotion model designed to empower families and communities to resolve their own health problems with support from local government. The HCM II model promoted citizen engagement through community neighborhood committees (CNCs), which diagnosed community health issues and planned, carried out, and evaluated community health solutions within their community. The health promotion model adopted was consistent with the World Health Organization's (WHO) approach, which is based on the notion of health as quality of life and addresses both individual behaviors and the underlying determinants of health. WHO defines health promotion as "the process of enabling people to increase control over and to improve their health It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions." The healthier community practices promoted by the Project included the adoption of healthier behaviors and the creation of healthy environments that would lead to improved MCH/FP/RH outcomes.. Communities became "Healthy Communities"— i.e. "empowered" — when they successfully completed the process of empowerment. Completion of the process ensured they would be able to work independently. Once they reached this empowered status, their oversight was transferred to local governments and the corresponding health post.

While the whole community benefitted from health promotion delivered by CNCs, families were encouraged to participate more actively and become designated Healthy Families. CNCs included local health and education staff, religious leaders, community representatives of local development services, and heads of other community organizations. Coordination with health staff (including both community and government providers) took place within the CNC. Coordination with local government was through the Local Technical Team (LTT), which was a multi-sector committee established specifically to implement the HCM model. Local governments/LTTs were considered Healthy Municipalities when they successfully completed the necessary steps to independently support and manage the HCM model. Healthy (Empowered) Municipalities were expected to eventually take on all support for CNCs currently provided by the Project, bringing sustainability to the model.

As data to measure health outcomes were not available, the analysis focused on how citizen engagement affected the various links in the chain of influence leading to key intermediate indicators. It was based on key informant interviews, project documents, and monitoring data. This analysis found that citizen engagement, through the actions of CNCs, was very effective in addressing community health in a multi-sectoral manner. However, it found that citizen engagement — through the actions of CNCs — was less effective in ensuring that health practices were prioritized. Although the reason for this was not assessed, this case study suggests that

specifying the role of health staff in Project documents and manuals, and clearly establishing the tasks for which local health officials would be responsible, would provide a clear roadmap and motivate staff to work more closely with CNCs encouraging a greater focus on health practices. CNCs can also place pressure on public services to be more accountable. Citizen engagement, through the actions of CNCs, was likely effective in improving local health service accountability. However, the effectiveness of its accountability efforts at the local government/LTT level appeared limited; this may be due to frequent staff turnover in the local government offices and because CNCs don't have enough of a voice at the local government/LTT level, as they are not represented in LTT meetings and planning processes related to their communities. The Project also postulated that the number of Healthy Families would increase over time through their own efforts to encourage other families to follow suit. However, this assessment did not find that to be the case. Overall, even when health practices were not prioritized, citizen engagement through CNCs did have an important influence on the type of health-related activities implemented and the accountability of local health services.

I. Introduction

Rationale for Citizen Engagement. The rationale for including some form of citizen engagement in development programs is based on a belief that giving citizens a voice in the design, implementation, and monitoring of such programs will ensure that they are tailored to their needs, will build a greater sense of ownership, and will make service delivery more accountable to users. Citizen engagement can be defined as the "the two–way interaction between citizens and governments or the private sector. . . . that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention" (World Bank 2014, p.8). Citizen engagement can range from the more limited kind of citizen involvement consisting of consultation, to a greater degree including participation, to the most engaging level, i.e., citizen-led mechanisms, where final decision-making is in the hands of citizens.

Citizen Engagement in Health. Citizen engagement in health has evolved considerably since the Alma Ata Declaration in 1978. Initially, programs encouraged community participation in health provision in order to cover geographic areas the health system could not reach due to staff shortages, difficulty of access, or cultural or language barriers. These initiatives provided preventive and very basic health services to the underserved and included community-based nutrition, reproductive health, and maternal and child health programs. Community health workers, such as community midwives and health promoters, were trained to provide this support, but they functioned essentially as extensions of the health system and were not given a voice in program design, implementation, or oversight. With time, the benefits to program effectiveness due to greater citizen engagement in programs became evident (Cornwall, et al, 2009; Rifkin, 2014). Citizens began to be included in participatory needs assessments to inform program design or in consultations on various aspects of service delivery to improve implementation. These initiatives, however, were supply-driven; they served the interests of providers. In the last two decades, citizens — either individually or through representative committees — have been involved to varying degrees, in program planning and coordination, decision-making, and oversight, opening up different opportunities to demand accountability to improve services.

Brief Project Overview and Theory of Change

Project Overview. The objective of the Healthy Communities and Municipalities II (HCM II) Project, as stated in the Management Sciences for Health (MSH) Technical Application,[1] is to improve maternal and child health, family planning, and reproductive health (MCH/FP/RH) through the promotion of a range of healthier community practices that target children under two years of age, pregnant women, and women of reproductive age in Project areas. The Project is funded through a United States Agency for International Development (USAID) Cooperative Agreement under the Leadership, Management and Sustainability (LMS) Project with MSH, implemented from December 2010 to December 2015, with an award ceiling of approximately US$11.9 million.

The Project introduced a bottom-up model of health promotion that empowers families and communities to resolve their own health problems with support from local government. The concept of health promotion adopted is consistent with WHO's approach, which is based on the notion of health as quality of life and addresses both individual behaviors and the underlying determinants of health. The healthier community practices promoted by the Project included the adoption of healthier behaviors and the creation of healthy environments that would lead to improved MCH/FP/RH. Healthier behaviors included adequate nutrition, proper use of mosquito nets, hand-washing, etc. The project also included environmental interventions to provide access to safe water, safe waste disposal, vegetable gardens, kitchens free of smoke, etc. Health

[1] Submitted in response to USAID's Request for Application (RFA) No. 527-10-000015.

promotion includes efforts to improve healthy practices as well as environmental interventions designed to facilitate healthy practices.

The HCM II model promoted citizen engagement through community neighborhood committees (CNCs), which diagnosed community health issues and planned, carried out, and evaluated community health solutions within their community. Communities were considered to be Healthy Communities when they carried out this process successfully. While the whole community benefitted from health promotion delivered by CNCs, families were specifically encouraged by the CNCs to participate more actively and become known as Healthy Families, i.e. families, deemed to be "empowered" to resolve their own health problems with the support from the CNC and local government. CNCs included community leaders, local health and education staff, religious leaders, community representatives of local development services, and heads of other community organizations. Coordination with health staff (including both community and government workers) took place within the CNC. Coordination with local government was through the Local Technical Team (LTT), which was a multi-sector committee established specifically to implement the HCM model. Local government/LTTs, together with local health staff, were expected to eventually take on all support to CNCs currently provided by the Project, enabling to continue functioning independently. Local governments/LTTs were considered Healthy Municipalities when they successfully completed the necessary steps to independently support and manage the HCM model.

Theory of Change. The HCM model included a health promotion approach that emphasized citizen engagement and empowerment to make health promotion more effective. The theory of change underpinning the Project posited that health practices and outcomes would be enhanced as a result of the active engagement of communities through their CNCs and Healthy Families.. Implicit in the model was that the involvement of an empowered CNC would ensure that services delivered would be more tailored to the community's needs, making them more effective. This would affect both health services delivered in the community and services provided at the local health facility. As engaged citizens, Healthy Families were expected to encourage other families to adopt the health practices advocated in the HCM model, both by demonstrating their benefits and communicating about them. The latter would constitute citizen engagement to the extent that Healthy Families were actively working to convince other families to follow their example —e.g., by making modifications to their homes, boiling drinking water, and having their children vaccinated. Health promotion would lead to an improvement in self-care and health-seeking behavior, increased utilization of health services, and, ultimately, improved outcomes. Empowered CNCs' influence on the appropriateness and quality of services would also lead to increased utilization and, in this way, influence health outcomes. The latter would occur through interactions within the CNC or with local government/LTTs.

The Objective of the Case Study

The main objective of the case study is to explore how health interventions and outcomes can be enhanced through the active engagement of the community. The study also seeks to identify mechanisms that may enhance the sustainability of the implementation of the model.[2] Specifically, the study examines the theory of change of the effects of citizen engagement implicit in the HCM model by examining the actual chain of influence on the ground, in light of its implementation experience. Outcomes are assessed and the chain of evidence leading to those outcomes is examined to determine the role citizen engagement may have played in their attainment. Parallel initiatives that may also be contributing to health outcomes are also examined. The study seeks to increase the evidence base on how citizen engagement influences health program

[2] MSH Request for Proposal-LMG-15-001. A request was made to provide insights into mechanisms enhancing the sustainability of the model during the review of the study's research plan.

implementation and outcomes, and provides recommendations for improved programming. The original scope of work is included in Appendix A.

Case Study Methodology and its Limitations

Methodology. Standard theoretical design and methodology for case study research, as described in *Case Study Research: Design and Method*s (Robert Yin, 2014, 5th edition), is employed to explore how citizen engagement has influenced health practices and outcomes. The unit of analysis is the HCM II Project, with a focus on its implementation in the region of San Martín. The focus of the analysis is on the implementation of the HCM model at the family, community, and local government level, and not on interventions designed to facilitate its expansion and institutionalization. Although the latter constitutes an important focus of the Project, activities consist primarily of support to the citizen engagement model implemented.

Sources of Information. The sources of information utilized in the analysis included: Project progress reports and available evaluations for both HCM I and HCM II; the Project's 2011 and 2014 Monitoring and Evaluation Plans; HCM instruments employed at family, community, and local government levels; monitoring data collected by the Project; Peru Demographic and Health Surveys (DHS) conducted annually[3]; documents and presentations shared by MSH/Peru staff; key documents related to the HCM II Project (posted on project and relevant government websites); and qualitative interviews and/or group discussions with key informants. Key informants included MSH staff in the US and Peru (Lima and Tarapoto, San Martín), USAID-Peru technical staff, and Project participants —i.e., families, CNCs, health staff posted in the community and at district and regional levels, and members of local government and LTTs as well as some regional officials. Literature on citizen engagement and participation was also reviewed, as were publications on Peru's health policies and system, and on Healthy Municipalities, Cities, and Communities programs in other countries in Latin America.

Field Visit. A two-week field visit was carried out, including one week in Lima and one week in the region of San Martín. San Martín was selected because of its strong commitment to HCM at the regional and district levels. MSH-Peru staff selected the communities based on the following criteria:

- They are classified as "advanced" in terms of their implementation of the HCM model;
- They are culturally homogeneous, so that they can be compared; and
- They are reachable within a 2-hour drive from Tarapoto, the main city in San Martín.

The communities selected were: Convento in the district of Pongo de Caynarachi (Huallaga province), and Chambira in the district of Saposoa (Lamas province). Both have been implementing the methodology since the HCM I Project. Convento does not have a health post.[4] MSH opted to include a highly successful expansion experience in the province of Moyobamba, Soritor district (Alto Peru). A CNC was interviewed in the community of Los Milagros and Soritor to be able to see a more representative experience in the expansion area. The expansion area is the focus of several USAID and United States government projects.[5]

[3] Peru is the first country to carry out annual DHS, and has been doing so since 2004. The surveys are carried out by the Instituto Nacional de Estadística e Informática and are financed by the Peruvian government.

[4] Most communities, because of their size, have only health posts, most of which have limited problem-solving capacity. They are staffed with a nurse technician, health technician or recent graduate technician, and sometimes two.

[5] USAID projects operating there include a Quality Healthcare Project and a Health Policy Reform Project. The United States government is financing a Millenium Challenge Corporation Threshold Program that includes corruption and immunization components. Together with HCM they are expected to address all aspects of health care provision for improved health outcomes.

Approach. A model reflecting the theory of change underpinning HCM II was constructed. It was based on a review of the available documentation, initial exchanges with Lima and US-based MSH staff, and feedback from key informants in the field. The model identifies the links/pathways through which citizen engagement is hypothesized to be influencing health practices and outcomes. Data gathered from the various sources were triangulated to assess how each of the observable links in the hypothesized chain of influence works in practice. The links between families, CNCs, health staff, and local government/LTTs were examined not only in the context of the HCM II Project inputs, but also with respect to other influences on health practices and outcomes; these influences included Peruvian health service provider inputs, and regional and national incentives to the health sector — i.e., grassroots organizations, local health officials, and providers — and local governments. The analysis also sought to identify missed opportunities to enhance effects in order to make recommendations for future programming. The opportunity to visit an expansion experience and that the communities visited in the direct intervention area had been working independently for six months provided some insights on the model's sustainability. A description of the research tools employed and sources used in the preparation of this study, including the bibliography and key informants, are in Appendices B and C, respectively.

Limitations of the Research. While case studies can provide in-depth information as to how and why certain effects may be occurring in a given context, they are not an appropriate or robust methodology for assessing the extent to which the observed effects resulted from the intervention. To assess whether Project inputs had the desired effect, one should rely on a comparison of baseline and endline evaluations of Project outcomes that also include non-Project areas for control of external factors. However, the baseline and endline studies were not set up ex-ante to isolate the effects of the Project from those of other actors because they were not meant to be impact evaluations. As such, attribution of outcomes to citizen engagement or the Project is not appropriate. Moreover, with the exception of the measurement of chronic malnutrition, Project indicators were intended to measure health practices rather than outcomes, and thus, little can be said about the effects of citizen engagement on health outcomes. While ample monitoring data have been collected, they were collected to inform program implementation decisions and are therefore not useful for the purposes of evaluation.

Other limitations have to do with the fact that the Project had been winding down activities, as it was closing on December 2, 2015. Thus, Project activities slowed down in April in areas where MSH was implementing HCM directly, and it ceased altogether in June 2015. Technical assistance for expansion in government-managed areas continued until October. At the time of the field visit for this case study, few staff members were still on board, particularly in the field, and thus important viewpoints could not be obtained, including those of the head of Monitoring and Evaluation in Lima and some field workers in San Martín. In Lima, Project-closing activities also limited access to some key informants (e.g., Project Directors). In San Martín, several CNC and local government/LTT members were unavailable, and most interviewed had only been on the job since January 2015 as a result of the 2014 elections, and thus had much less experience with Project implementation than the previous authorities. Efforts (some successful) were made to locate previous officials to interview them. The visit to Soritor coincided with school vacations, so many families were not available to be interviewed.

II. Detailed Project Description and Expected Theory of Change

Project Context and Evolution

Project Context. The HCM Project was developed to complement USAID/Peru's Alternative Development Program (ADP), which was implemented in coca-eradication areas. The ADP promoted self-eradication of coca cultivation through agreements with communities in exchange for access to alternative sources of income through the growth of legal crops including cocoa, coffee, and palm oil, and increased access to credit markets.

At the time, coca-growing areas were characterized by widespread violence due to drug trafficking and guerilla warfare activity, both of which drove away government services. Corruption was pervasive. These factors generated discontent with and distrust of government services and overall low social cohesion (Velásquez et al, 2010). As a result, social indicators — including health — were poor, and governance was an important challenge. ADP opted to incorporate basic infrastructure and social services to the Project when it became evident that the conversion to alternate crops alone would be insufficient to sustain change (CAMRIS, 2010, p.9). Adding a health service component was viewed both as an additional incentive to sustain self-eradication efforts and a way to directly address low health indicators.

Project Evolution. HCM builds on the experiences of nutrition and health activities carried out in eradication areas since the mid 1990s. Under a subcontract with ADP, PRISMA had been working to combat acute malnutrition in the area since 1996, employing a community-based approach focusing on communities and families. In 2004, PRISMA joined with Catalyst (under Pathfinder Fund with USAID financing), which had been working on a Healthy Municipalities model, and submitted a one-year proposal for a Healthy Communities and Municipalities (HCM) Project to USAID. The focus was on health promotion, community ownership, and participation. The general approach adopted was considered best practice by WHO/PAHO, and has been implemented in several countries in Latin America in different forms since the 1990s. The dire social conditions at the time provided a solid justification for the Project. PRISMA was to work with 370 communities that had signed coca eradication agreements.

HCM I: The Project was initially funded for a year, and was extended on an annual basis throughout HCM I. Project implementation shifted to MSH through USAID/Washington LMS Project financing in July 2006. Annual extensions had the benefit of allowing flexibility to make adjustments based on lessons learned. Given that the HCM model has been constructed incrementally, opportunities to adjust have been important. However, annual budgeting prevented long-term planning and caused high staff turnover. Moreover, the constant change of indicators made it difficult to track change over time (CAMRIS, 2010). HCM I closed on September 30, 2010.

Despite the difficulties of working in such an inhospitable and dangerous environment, HCM I managed to work in as many as 550 communities in ADP regions in Ayacucho, Cusco, Huánuco, Junín, Pasco, San Martín, and Ucayali. The need to work closely with local governments and strengthen their capacity to implement the model became evident, not just to ensure that local governments would be able to take on the technical support provided by the Project, but also to ensure that communities could implement their plans, as they needed some municipal services (e.g., access to water and sanitation) in order to implement their healthy practices. While there had been interest in expanding the HCM approach early on, the crucial impetus for expansion came in 2007 from the requirement by CRECER, a national multi-sector model to combat poverty, that a community-based approach be employed to implement it. This led to the inclusion of some non-ADP communities and to a significant expansion. The expansion centered in four regions: San Martín, Ucayali, Huánuco, and Ayacucho. Agreements were reached with regional and local governments for them to take the lead to expand HCM in their territory. The Project provided technical assistance and training to local governments and regional governments (RGs) to be able to gradually take over the technical support the Project was providing (Velásquez et al, 2010).

Relevance of the Approach

The relevance of the approach is evident given reforms introduced by the Peruvian government, particularly since its renewed emphasis, in 2002, on the decentralization of the state. The decentralization law of 2002 and

the laws outlining the responsibilities and governance of regions and municipalities promulgated in 2003[6] all recognize citizen participation as an inherent right and principle of regional and local governance (Cotlear, 2006). These laws provide the legal framework for citizen participation in government. The operating structure of HCM at the community level is based largely on the Municipal Law. Its more relevant provisions are included in Box 1.

Box 1
Municipal Law 27972, which in its Article VIII on the rights of participation and control of citizens, calls for the establishment of community committees. These committees are to be composed of representatives of the different grassroots organizations and of entities promoting local development efforts (Article No. 106); and they are responsible for providing oversight for: (1) the delivery of local public services; (2) compliance with municipal norms; and (3) the construction of public works (Article No. 116). These committees are entitled to a voice at municipal council meetings, and to participate in municipal economic development committees (Article No. 117). The same law also gives municipal governments — at the district and provincial levels — responsibility for providing primary health care and health promotion, as well as water, sanitation, and environmental health (Article No. 80). The law notes that the functions and organization of the community committees are to be approved by municipal councils, but it does not define them (Article 116).

While the Project has sought to align itself with government initiatives, the government has also adopted some of the methodologies developed by the Project. The Ministry of Health (Ministerio de Salud, MINSA) expressed its intention to operationalize the full HCM model to address health promotion. Different national government agencies, including MINSA, are adopting the manuals the Project developed to guide communities on how to apply for public financing for local projects through Public Investment Projects (PIPs). The Ministry of Women and Vulnerable Populations is adopting the component of the model that corresponds to families, and the National Commission on Development and Life without Drugs (DEVIDA) has adopted the model at the local and national level, and it has even begun co-financing the intervention in the area of Monzón.

HCM II Project Detailed Description

Design and Coverage. The design of HCM II incorporates feedback[7] from two evaluations of HCM I (CAMRIS, 2010; Velásquez et al, 2010). The HCM II Project continued to be implemented in San Martín, Ucayali, and Ayacucho, and incorporated Lima. It initially reduced the number of communities to 170 (from 550) for budgetary reasons, and they were again reduced to 107 in 2012 because USAID reduced the budget by 30 percent.[8] In 2013, USAID requested that 54 additional communities in post-eradication areas be incorporated, with funding from ADP (Monzón valley in Huánuco, and Huipoca in Ucayali). The latter are working in conjunction with DEVIDA and employ a slightly different approach.

[6] Ley de Bases de la Descentralización-27783, Ley Orgánica de Gobiernos Regionales-278867, and Ley Orgánica de Municipalidades 27972.

[7] Key modifications included: longer-term financing, a simplification of instruments, improvement of the community-based Municipal Information System (SISMUNI), and the introduction of an M&E Unit. The focus on expansion and sustainability was increased significantly, particularly with regard to the strengthening of local governments.

[8] USAID Peru stopped funding health projects at the end of FY 2012, as funding for bilateral health projects began to prioritize development activities in Africa. MSH was informed in February 2012.

Table 1. HCM II Results Framework in Place During Project Year One through Project Year Four*

USAID/Peru Office of Health Overriding Objective Health status of high-risk populations — including poor and marginalized groups — improved		
Strategic Objective Use of MCH and FP/RH practices and services increased in the Project target areas		
Component 1 Healthier community practices for improved MCH and FP/RH adopted (30% of funds)	**Component 2** HCM II approach adopted by public and private sector institutions (30% of funds)	**Component 3** Local capacity to replicate and/or expand the HCM II approach developed and institutionalized (40% of funds)
Activities		
1.1: Refine the HCM methodology and tools 1.2: Strengthen community organization and management of health 1.3: Support development of healthy practices and lifestyles 1.4: Increase community participation in community health management 1.5: Reorient health services away from a curative focus toward prevention and health promotion 1.6: Improve the quality of information from community self-evaluations	2.1: Raise public awareness of health problems and advocate for healthy practices in MCH and FP/RH 2.2: Build capacity to use the HCM model and tools 2.3: Provide technical assistance to strengthen institutions 2.4: Institutionalize the HCM model 2.5: Fortify existing public-private alliances and stimulate and establish new alliances	3.1: Develop and support partnerships between NGOs and civil society and the government for ongoing application of the HCM model 3.2: Create Regional Certification Units 3.3: Execute Public Investment Projects (PIPs) with local governments

*See Appendix E for revised framework now used by the Project.

Specific Objective and Components. The original Project Results Framework is shown in Table 1 above. The Project had three components, with 70 percent of funding being allocated to expansion and sustainability (Components 2 and 3). Component 1, MSH's direct implementation of the model, is the focus of this case study. Its intermediate result is defined as the improvement of community health practices related to MCH/FP/RH. Due to their similar focus on transition and sustainability of the HCM model, Components 2 and 3 were merged into one: "Public and private institutions institutionalize HCM in a sustainable manner" — which was based upon USAID recommendations in the final year of the Project, as indicated in the 2014 MEP and the 2014 annual progress report.[9]

The expected results under Component 1 are: (1) communities are organized and participating in strengthened community management practices to improve health, using the HCM tools and methods; and, (2) families practice self-care, adopt healthy practices, and implement other interventions in the model for Healthy Families, such as monitoring, and evaluation (M&E) of their MCH, FP, and RH practices and indicators. The updated 2014

[9] The overriding objective of the Project was modified in the final year of the Project, as were the objective and intermediate results. The overriding objective was changed to "management and quality of public services in the Amazon Basin in Peru, through increased citizen engagement in decision-making and oversight and through improved governance to provide quality services." The objective changed from "improvement of health practices" to "improvement of health outcomes", with "improvement in health practices" becoming the intermediate result. And, lower-level results included, under Component 1, the implementation of health promotion and healthy environments both at the community and family level, and the implementation of district healthy municipality plans. Because these changes were introduced in the final year of the Project, and because actual indicators were not modified, this study is employing the results framework included in initial Project documents. *The revised results framework is included in Appendix E.*

Monitoring and Evaluation Plan (MEP) rephrases the second expected result to include the adoption both of healthy practices and healthy environments. HCM II implements a health promotion approach that is based on the notion of health as quality of life and addresses not just individual behaviors but also the underlying determinants of health that are within the control of communities and families. This is in line with the model as implemented in other countries in Latin America (PAHO, 2012), and is more in line with the World Health Organization's (WHO) definition of health promotion.[10] Because the Project's RFA, Technical Application, and MEPs include only indicators related to MCH/FP/RH health practices and none for the adoption of healthier environments, the study implies that the adoption of health practices is the priority.

The description that follows focuses primarily on Component 1 and aspects of Component 2 that relate to support to CNCs by local governments and RGs. Most communities under Component 1 began working with the Project under HCM I; at the time, they were selected from a list of small villages provided by USAID/Peru. Of the 160 communities, 66 are communities selected specifically to showcase the model.

The HCM Model

The overall intention of the HCM model is to foster coordination at the community level through CNCs, and at the local government level, through LTTs, for a more efficient use of resources and to establish a harmonious framework for collective decisions and consensus building. The emphasis on a cooperative relationship among the parties involved permeates Project documents and public discourse by Project staff and government officials. Coordination between the different levels (CNC, local government) is encouraged through a process of bottom-up planning and the establishment of forums for coordination. It is believed that by becoming empowered, CNCs will become agents of change. The implementation of the model consists of the four phases described below:

(1) Sensitization and organization phase: Once selected, communities are approached and are sensitized — i.e., made aware of — to the benefits of the HCM model and about becoming Healthy Families. The community elects CNC members, including community representatives of local government and heads of other community organizations. They receive no remuneration. CNCs are trained to carry out community diagnoses, plan and coordinate the needed interventions, and monitor changes in community health practices. CNC engage with and support families within their communities. The training emphasizes leadership skills and uses a values-based approach that emphasizes non-discrimination and multicultural inclusion. Health staff and local government/LTT staff receive similar training. The Project developed a toolkit, including how-to manuals and materials focused mainly on how CNCs and local government/LTTs should fulfill their roles and responsibilities. The Project carries out the sensitization and training. The establishment of each CNC is legitimized through a resolution drafted by local governments.

(2) Planning phase: CNCs prepare a 28-page community diagnosis outlining demographic, social, and environmental aspects of the community. It also includes a summary of health practices at the family level; these health practices include: use of safe water; hand-washing; use of mosquito nets; proper disposal of solid waste; proper enclosing of animals; cleanliness; and aspects related to mental health such as alcoholism, sexual abuse, violence, etc. Detailed information on health practices of mothers and children is gathered through a separate instrument, an MCH monitoring form. The community discusses the results, proposes solutions, and includes them in communal plans. Plans include health promotion activities to be carried out by CNCs — which

[10] "Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions." (WHO) http://www.who.int/topics/health_promotion/en/

include health staff — and environmental improvements (provision of water, latrines, etc.) to be implemented by the community or through district-level services when relevant. At the family level, families interested in becoming Healthy Families are visited to help them carry out a similar process, diagnosing their household's health practices and environment, and preparing an improvement plan. Family-level improvement plans can include: making modifications to their homes to separate living spaces; updating kitchens to ensure a smoke-free environment; installing latrines; planting vegetable gardens; and making commitments to boil drinking water, ensure children are vaccinated, etc. These are contained in a 37-page Healthy Family Manual. The Project provides technical assistance in the preparation of community diagnoses and plans and visits families to help them fill out forms in the manual. They are also encouraged to sign a Healthy Family Commitment to verify their intention.

(3) Implementation phase: CNCs implement their plan and monitor changes in community health practices on a semi-annual basis (using the MCH/FP monitoring form). These data are consolidated and given to local government/LTTs to include in the SISMUNI database. They follow up with families committed to becoming Healthy Families and provide support to implement their commitments. Because health promotion activities are carried out by CNCs in public areas, including community assemblies, the whole community benefits. Thus, even when they fail to sign Healthy Family commitments, many families become knowledgeable about healthy practices. The Project provides technical support to CNCs in the implementation of their plans and visits to families committed to becoming Healthy Families. The Project carries out educational sessions and information campaigns in the community, including radio campaigns, community fairs, and caravans.

(4) Self-evaluation phase: CNCs carry out semi-annual self-evaluations of progress attained in their plans. CNCs that complete the four-step process adequately are considered to be empowered. The Project model is rooted in the idea that empowerment leads CNCs to become "agents of change," giving them the tools with which to take leadership roles in the management of community health. Likewise, families that complete the process satisfactorily are recognized as Healthy Families poised to influence others. Considerable importance is given to reaching Healthy-Family status, and signing the commitment form is an important step. There is an understanding that they will serve as positive role models, and that through their example and/or the peer pressure they apply, more families will become Healthy Families. The Project provides continuing technical assistance to CNCs on community management and their work with families.

The role of local health and LTT staff: The role of local health staff throughout this process is instrumental, as it will be the primary source of technical assistance for CNCs and families once the Project moves on. It is expected that as CNCs gain confidence and experience, they will carry out the Project activities on their own, with sporadic oversight by health staff. The Project trains health staff on the HCM model; health staff members then participate with the Project throughout the four stages. However, although Project documents portray their role as being confined to their work through the CNC and through their participation in LTTs, their specific tasks and responsibilities are not outlined. The participation of health organizations is not as seamless in a community that does not have its own local health post. In those cases, the nearest health post is responsible for the support coverage of that community; but the distance clearly limits access.

LTTs also have a critical role. LTTs were originally established by the Project to provide technical support to local governments in the management of HCM. Social Development Offices (SDOs) at the district level are the local government entity tasked with the implementation of HCM. SDOs were established in response to a requirement by the Municipal Law 27972 that a multi-sectoral coordinating body be established at the district level to reach agreements and prepare municipal development plans and budgets.[11] Despite the law, many

[11] Municipal Law 27972, Title VII, Articles Nos. 97 and 102.

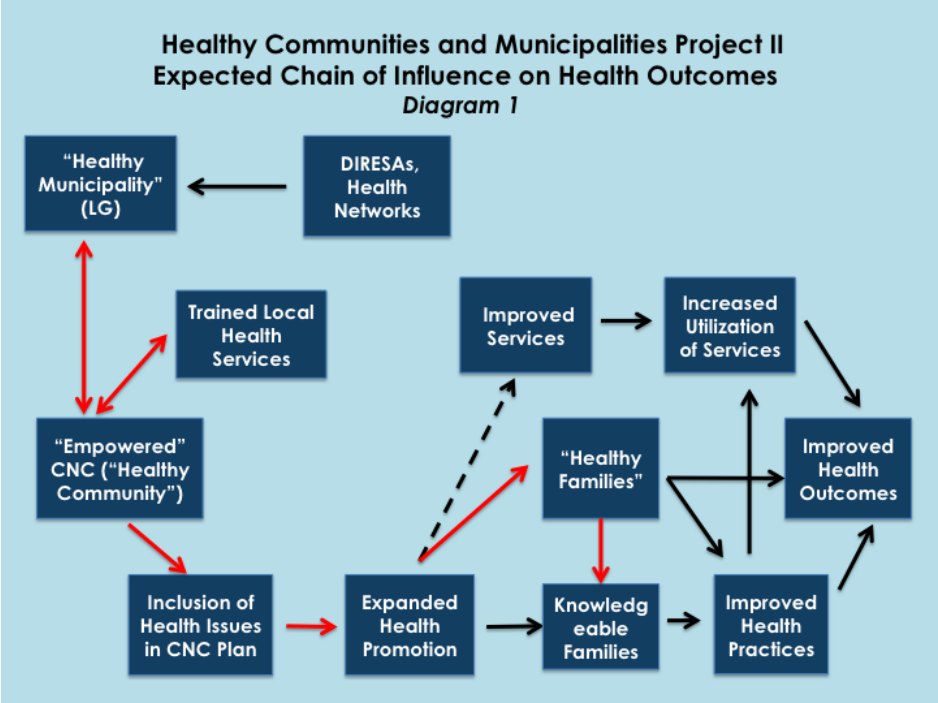
districts did not have a SDO, and thus SDOs had to be established to implement HCM. LTTs are headed by the chief of the district SDO. Some documents — including the Healthy Municipality Manual — note that the LTT should be composed of members of the various branches of government, including health, education, social development, environment, etc.; it should also include NGOs and religious and for-profit entities involved with social programs, with its composition mirroring that of CNCs at the community level. Other documents, however, specify only government staff.

LTTs are responsible for providing support to CNCs within their jurisdiction, and to gradually take over support currently provided by the Project. Specifically, they are tasked with providing support in the formation and strengthening of CNCs, the follow-up of CNCs every six months on the basis of SISMUNI data, and the provision of technical assistance and oversight to HCM implementation. LTTs prepare an annual District Plan based on a diagnosis of what districts need to become a Healthy Municipality, including the support they provide to CNCs. The Manual for a Healthy Municipality does not specify the role of health sector members within the LTT, which includes grassroots organizations, local health officials, and providers. It mentions only biannual meetings with the local health network to assess the health situation of the district.

The HCM II Project has made a sizeable effort to foster sustainability, training local government/LTTs and the health staff at the local, district, and regional levels to be able to roll out a further expansion of the model to other districts. Further, so that they can expand the program on their own, advocacy training, and technical assistance on the HCM model are provided to various levels of government and NGOs to nurture the necessary policy environment and strengthen entities.

HCM II Expected Theory of Change

The theory of change underpinning the HCM approach postulates that health practices (and healthy environments) and outcomes will be enhanced as a result of the active engagement of CNCs and families in the management of community health and the delivery of health promotion. Implicit in the model is that the involvement of an empowered CNC will ensure that services delivered will be more tailored to the community's needs, making them more effective and increasing demand for services. This would affect both health promotion delivered in the community and services at the health facility. Healthy Families are expected to encourage other families to adopt the HCM model The latter constitutes citizen engagement to the extent that they are actively working to convince other families. Thus, the main vehicle for citizen engagement is through empowered CNCs. Citizen engagement, through the actions of Healthy Families, plays a less important role.



Health outcomes can be enhanced through strengthened health promotion (the demand pathway to health outcomes) or through improved services (the supply pathway). Diagram 1 displays the links in the expected chain of influence, with arrows in red denoting where citizen engagement may be influencing outcomes. An implicit assumption in Project documents is that reorienting services away from curative care towards a greater focus on prevention will eventually lead to greater efficiency of services.[12] Because this would only occur in the long run, and improvement in services was not measured, this link is represented by a dashed line. The HCM model posits that empowered CNCs will include activities to improve community health practices in their annual plans, and will implement them.[13] And, because of their involvement, they would be more tailored to community needs. Health post staff is part of the CNC, and as such, provides support in preparing the plan and carrying out health promotion, gradually delegating health promotion activities to the rest of the CNC. They are key actors in the process of community health management.

Through CNC-implemented health promotion, families are expected to become more knowledgeable about the benefits of healthy life styles and practices; some will adopt healthy practices, improving health outcomes directly, by increasing preventive self-care and improving sanitation in their homes and the community, and indirectly, by increasing utilization of preventive and other health services at the health post/center. Even if families become more knowledgeable and even adopt some healthy practices, they do not all opt to sign Healthy Family commitments, which entail a higher level of adherence. By being the first to become Healthy Families, CNC members serve as role models for the community, in this way encouraging others to do the same. Peer pressure and demonstration of effects by existing Healthy Families are also expected to influence other

[12] Project documents make references to "improved services" but do not include specifics on how the Project will improve the quality of services other than in the long term by reorienting services away from curative care. Conversations with Project staff clarified that improved services refer to improved health promotion in the community through training of health staff and strengthened community health monitoring.

[13] Because HCM II only includes indicators related to health promotion, the adoption of healthier environments is not included in the model beyond their inclusion in CNC plans.

families to become Healthy Families. To the extent that Healthy Families are actively trying to convince their peers, one could surmise that citizen engagement, through citizen participation, is having an influence on improving health practices. The model implicitly assumes that becoming a Healthy Family results in greater adoption of healthy practices than is the case among families who simply become more knowledgeable. This was not assessed.

CNCs also have a role to play in the supply pathway to improved outcomes. Through the process of becoming empowered, CNCs are expected to become agents of change in their community and for their community. CNCs, by including representatives of all sectors working in the community, provide a forum to coordinate across sectors and ensure that services address local needs, and as such, provide a space to hold health services accountable. The Municipal Law stipulates that CNCs are to provide oversight in the delivery of public services in the community and compliance with Municipal law, so by law, CNCs are expected to require some accountability.

CNCs, however, do not consist of citizens alone. They also include representatives of the various government sectors working in the community,[14] many whom are viewed as community leaders. They are community multi-stakeholder committees, rather than committees representing only citizens. Communities can influence decisions made at the local government level through their CNCs. To the extent that government officials do not overpower decision-making and crowd out citizens, CNCs could be considered vehicles for citizen engagement with decision-making ability.

A second space to exert accountability lies in the link between CNCs and local governments through their LTTs. Communities can influence decisions made at the local government level through their CNCs, or they can go directly to local government and express their concerns. During LTT follow-up and support visits, CNCs are expected to have the opportunity to express their concerns to the health representative within the LTT. Citizen engagement in this case would be part consultative and part participative. There is one final link where the Project asserts that CNCs can use their "voice," and that is in the context of the "participative budgeting" process carried out annually at local, provincial, and regional levels to finance small investment projects. However, some processes were more participative than others; CNCs submit proposals, but may or may not be involved in the selection process.

III. Citizen Engagement and Project Outcomes

The following examines data available with which to assess Project outcomes; it is followed by an assessment of how citizen engagement may have influenced these outcomes based on information gathered in the field and Project documents.

Project Outcomes

Available Project Data on Outcomes. The Project planned for baseline, midterm, and end-of-Project evaluations. As of the writing of this case study, only the first two evaluations were available. Both evaluations utilized Lot Quality Assurance Sampling (LQAS) methodology. LQAS allows for an assessment of changes in indicators based on small samples. Both used the same instrument allowing an assessment of change over time. The baseline was completed in April 2011, and during the midterm at the end of 2014. The evaluations included

[14] According to Project staff, they generally include mainly health and education staff.

communities in Ayacucho, San Martín, and Ucayali. As the evaluations included only Project areas, the standard USAID design did not allow for a control of factors extraneous to Project interventions, so it was therefore not possible to separate Project effects from other effects on outcomes. Project indicators focused on MCH/FP health practices and process variables; the only health outcome measured was chronic child malnutrition. The Project was designed to measure changes in health practices and access to services, but not health outcomes. Data were intended to inform program decisions and to serve to empower communities with data on their situation with regards to health and its determinant. Data on morbidity or environmental improvements were not collected.

Baseline and Midterm Evaluation Results. The results of the evaluations give a mixed picture. Changes in chronic malnutrition between the two measurements were not significant (MSH, 2011; MSH, 2014). With respect to child health practices, there were significant increases in the proportion of mothers correctly introducing supplementary feeding for children under 24 months of age, but not with regards to exclusive breastfeeding in the first 6 months. Growth monitoring significantly increased, but there was no difference in the proportion of infants fully vaccinated or in the proportion drinking safe water. The proportion of children with a national identification document also increased significantly. There were, however, significant declines in access to nutrition services and children registered for health insurance.

With regards to maternal health, the picture is equally mixed. There were no significant differences related to reproductive health. There were significant increases in the proportion of mothers having six or more pre-natal visits and the proportion of deliveries carried out by trained birth attendants. Access to post-natal care and the proportion of mothers registering for health insurance declined significantly over the period.

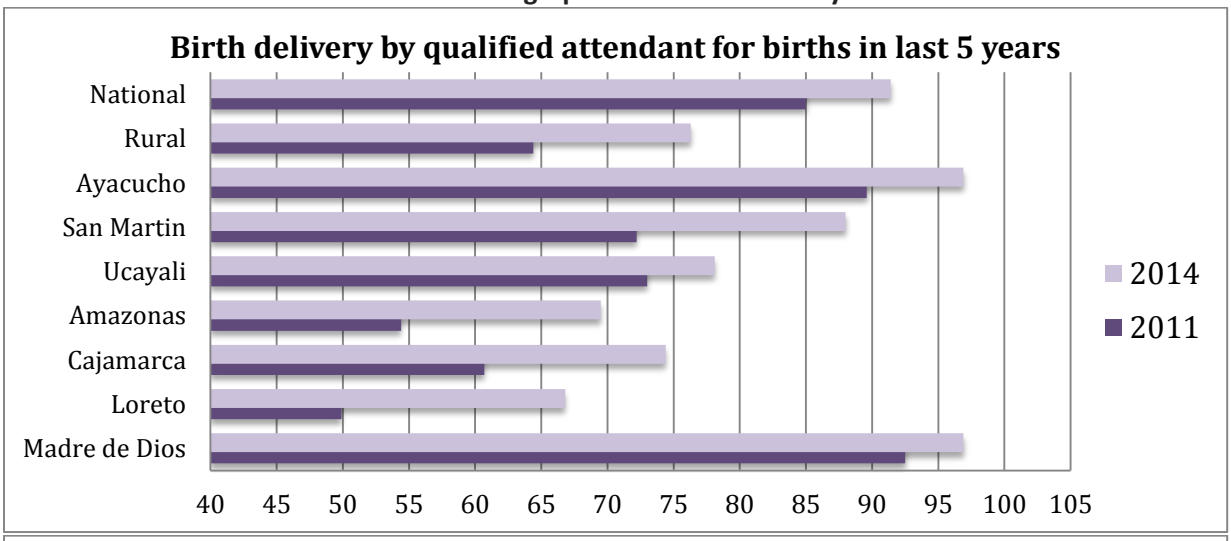
Although there were improvements in some key indicators, they can't be attributed to the Project, as there were improvements in these indicators nationwide. Table 2 includes comparable indicators from the 2011 and 2014 Demographic and Health Surveys (DHS), including values for national and rural areas, for the three Project regions (Ayacucho, San Martín, and Ucayali) and for three adjoining regions. Only maternal care data were included, as child health indicator breakdowns were not comparable for the two years compared. Please note that the data is available only by province, so local disparities within provinces are not shown. Although not available by region, chronic child malnutrition, the focus of the government's initiatives, declined from 15.2 to 10.7 percent nationally, and from 30 to 21.9 percent in rural areas, between 2011 and 2014. As Table 2 indicates, with the exception of prenatal care in Ucayali, there were demonstrable improvements in prenatal and delivery care everywhere. Further, all except two regions show increased utilization of postnatal care. Nonetheless, these are two of the three regions where HCM II is shown to be working. Given the limited coverage of the Project in these regions, it may be that the reasons for significant declines in post-natal care have to do with factors outside of the Project.

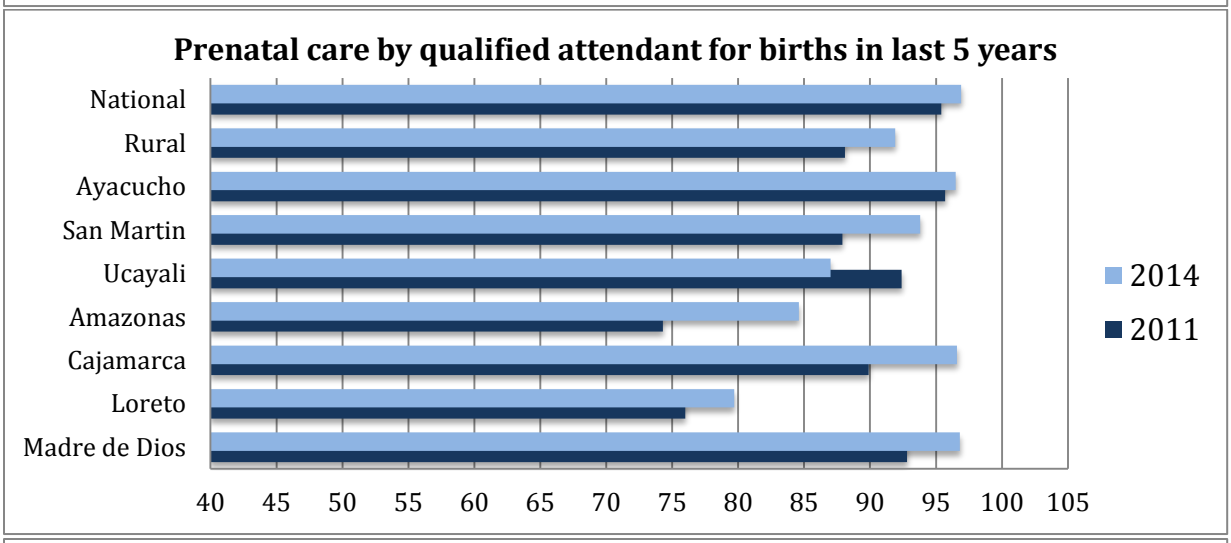
Other Factors Affecting Health Outcomes. The reason for the broad change nationwide has to do with reforms introduced by the government to address malnutrition and MCH over the last decade. Five initiatives have been instrumental in improvements in these indicators: (1) the establishment of the Integral Health Insurance system (Seguro Integral de Salud [SIS]); (2) the CRECER initiative currently under the Ministry of Development and Social Inclusion (Ministerio de Desarrollo e Inclusión Social [MIDIS]) and its regional versions[15]; (3) the Juntos conditional cash transfer (Juntos CCT) program under CRECER designed to complement SIS; (4) the Ministry of Economy and Finance's (MEF) results-based budgeting (Presupuesto por Resultados [PpR]) of the health sector; and (5) MEF's financing of municipal incentives. Any analysis of health outcomes would be incomplete without

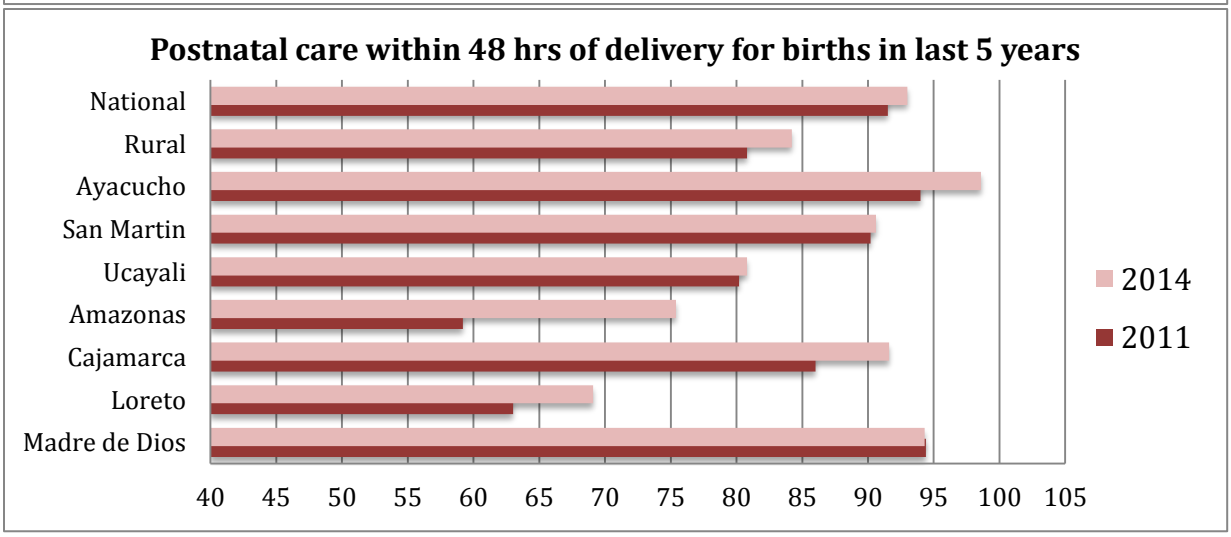
[15] For instance, in San Martin, CRECER is being implemented through a regional program called Programa de Acciones Integrales para Mejorar la Nutrición Infantil (PAIMNI).

an understanding of how these initiatives work and their coverage. It should be noted that their introduction has been gradual, and uptake has been uneven across regions. Together, these initiatives have significantly increased the demand and utilization of MCH/FP/RH services nationwide. Box 2 contains a description of these programs.

Table 2: Selected Maternal Care Indicators for Project Areas and Adjoining Regions From the Peru Demographic and Health Surveys for 2011 and 2014







Box 2

The Seguro Integral de Salud, (SIS) provides health insurance coverage to the uninsured, giving priority to the poor. It was established in 2001 by the merging of an existing health insurance for mothers and children (Seguro Materno-Infantil) and an insurance for school children (Seguro Escuela). Although initially focused on maternal and child care, since 2006, it substantially expanded its coverage to adults. Services are free for the very poor and are subsidized for the less poor. Beneficiaries must register for coverage at a primary care facility in order to obtain coverage. SIS has greatly increased access to health services to the poor.

Incluir para Crecer, the full name for CRECER, is a multi-sectoral program to combat poverty; it was initially established in 2007 by the Technical Secretariat of the Inter-ministerial Commission for Social Affairs (Comisión Interministerial de Asuntos Sociales [CIAS]) under the office of the President. It was transferred to the newly formed MIDIS in 2011. Under MIDIS, CRECER continues to report directly to the President. It employs a three-pronged poverty-reduction strategy that prioritizes malnutrition and MCH as part of its human development strengthening focus. The other two areas of intervention focus on productive aspects and social protection. The strategy relies on the vertical integration of government, beginning at the community level through community committees, for its implementation. Several regions are implementing their own versions of CRECER.

The Juntos CCT program was established by CRECER to generate incentives for the very poor to utilize basic health and nutrition services provided under SIS. Juntos gives mothers with children under 14 years in extremely poor households the equivalent of $30 per month to ensure the use of the required preventive services, comprehensive care, and nutrition by pregnant women in the household and children under five (Walker, 2011).

An equally important influence on health outcomes derives from MEF's introduction of PpR in 2008 (Walker, 2011). The PpR links public spending to development outcomes. Based on a logical framework, it identifies outcome variables that are linked to specific sectors. In health, the high-level goals are to reduce maternal and neonatal mortality and reduce malnutrition among children under five years of age. The Peru DHS has been carried out on an annual basis since 2004 to assess compliance with agreed goals. Funds go directly from MEF to the regions, which then allocate them to health networks and micro-networks. Failure to reach agreed goals leads to a reduced funding allocation in the following year.

Since 2010, MEF has also provided financial incentives to local governments through its Municipal Incentive (Incentivo Municipal) program to improve municipal management. Funds go directly from MEF to the local government. One of the four outcomes local governments are supposed to meet is the reduction of chronic malnutrition. Failure to meet the goals results in reduced funds, which then go to local governments that met more than 100 percent of their goals. To meet their nutrition goal, local governments need to establish health promotion centers in community health posts (Centros de promoción y vigilancia comunal de la salud integral madre-niño) and to prepare rosters (padrón nominal) of all children under six years of age.

Citizen Engagement: The Experience in San Martín.

San Martín and its communities. San Martín was selected for the field visit because of its commitment at both regional and local levels of government to address child malnutrition and adopt the HCM model to do so. In 2012, the government of San Martín introduced PAIMNI, a multi-sectoral program that is its version of the

CRECER program, to address chronic malnutrition for children under five years of age. It promotes most of the health practices included in HCM.

The region of San Martín in northern Peru is located in the lowlands just east of the Andean highlands and west of the Amazon. Classified geographically as jungle, it is characterized by rolling hills and large valleys. It used to be a major coca growing area and has been involved in a coca-eradication program for the last 20 years. Agriculture dominates the economy. Replacement crops include coffee, cocoa, and African palm. Rice and bananas are also important crops. As in other agricultural contexts, migration — much of it seasonal — is common, and security continues to be a problem in some areas.

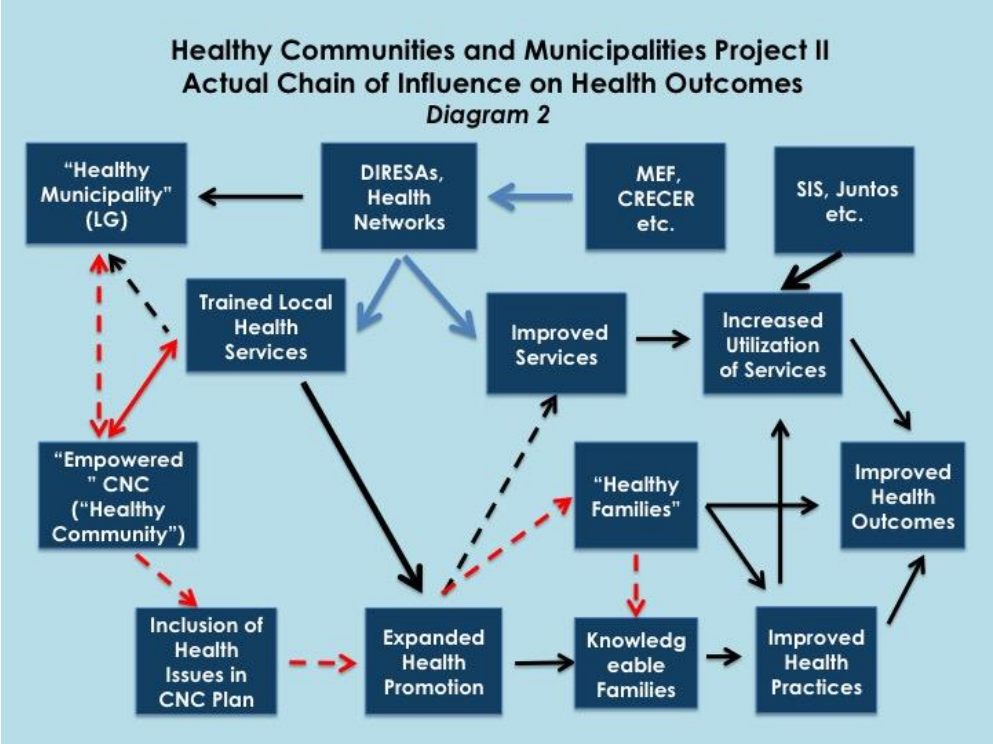
While Project data from San Martín cannot be used to measure outcomes, they can give a sense as to whether or not citizen engagement is playing a role in key links in the chain of influence. Table 3 provides a summary of some descriptive statistics on the 22 communities working in San Martín under HCM II's Component 1.[16] A more detailed table is included in Appendix D. All except two communities began implementation under HCM I (Barrio La Perla and Alto Shamboyacu). Nineteen of these communities are classified as model communities by the Project and are used to showcase the model. Community sizes vary considerably, ranging from 69 to close to 3000 inhabitants, with two-thirds having fewer than 250 inhabitants. The number of families increased by 10 percent during the four years of implementation. At the same time, the number of families with children under two years of age declined by 22 percent. Both of these changes primarily reflect the impact of migration.

Table 3: Summary description of 22 communities in San Martin.

				2011 or first year		2015 or latest			
Province	**No. of Communities**	**No. with Health Post**	**Population in 2015**	**No. of Families**	**Families with under 2s**	**No. of Families**	**Families with under 2s**	**No. Healthy Families**	**Empower-ed CNCs**
Huallaga	8	6	1642	453	76	493	58	56	5
Lamas	11	4	5800	1137	249	1294	215	85	8
Picota	3	0	854	224	42	198	28	15	1
Total	22	10	8296	1814	367	1985	301	156	14

Diagram 2 displays the chain of influence, as evidenced from interviews and data gathered during the field visit. The following discusses each of the links in the chain. Red lines indicate areas where citizen engagement may be influencing outcomes. Blue lines indicate where higher-level government is influencing outcomes. Dashed lines indicate where the links appear to be weak, based on the field visit and document review. The hypothesized influence in several of the links cannot be observed, but can sometimes be assumed from international evidence, such as the link between improved services — quality and quantity — and the increase in utilization of health services, and the latter's influence on health outcomes. Another assumption supported by international evidence is that improved health practices lead to improved health outcomes.

[16] There were originally 24, but two merged with other communities. The Project is also working with the regional government on an expansion area in Moyobamba and expansion to individual communities within the districts where the 24 communities are located. They are not included here, as they began implementing much later and some employ a modified approach.



CNC Empowerment and the Delivery of Health Promotion. How empowered are CNCs? Are they functioning as agents of change? The Project considers those communities that have successfully completed the four phases to ensure they are able to work independently — i.e. without Project inputs — to be empowered. When they reach this empowered status, their oversight is transferred to local governments and the corresponding health post. At the time of the field visit, two-thirds (14) of the 22 communities in San Martín were working independently. The other third were not fully empowered, some for temporary reasons — due to turnover in CNCs leadership — and others due to internal conflicts or lack of time and commitment. Maintaining CNCs in empowered status has proven difficult not only due to migration, but also because frequent turnover of health and local government officers leaves them unattended.

Empowered CNCs are expected to prepare communal plans that address community health needs, prioritizing health promotion. Communal plans from 2011 to 2015 were reviewed for the majority of the 22 communities. Entries were often not specific — e.g., improve health practices — so it was not always possible to know what the activity entailed. Moreover, there was great variability in what was included in the plans, even within the same CNC over time, so it was difficult to generalize. What is clear is that, while all plans contained environmental interventions — such as access to clean water, latrines, and waste disposal (i.e., interventions that facilitate healthy practices) — not all contain activities that promote individual healthy practices and behaviors. Plans for CNCs in the province of Lamas (including 11 CNCs) included the monitoring of health practices in their plans, but it was often the only healthy behavior-related item in the plan, with the major focus on environmental interventions. CNC plans in Huallaga and Picota provinces included a mixture of MCH health practice-related activities and environmental interventions. Plans often also contained community development activities that impact the ability to access health services, such as bridges, electrification, paved roads, and mobile phone coverage

Plans for the two communities that began implementation during HCM II were similar, and thus their contents did not appear to be related to program maturity.

While plans did appear to be generally linked to the needs identified in the community diagnoses, activities to improve individual health practices were not always a focus. The same was noted in the 2014 annual progress report (MSH, 2011-2014, p.35), which found that changing MCH practices continued to be a challenge, while at the same time noting that changes regarding physical aspects of homes — e.g., improved gardens; separation of living, cooking, and sleeping quarters; and kitchen improvements — were adopted much more easily.[17] To the extent that physical changes in homes and the community contributed to improved health, one can surmise that empowered CNCs were enhancing health outcomes. Nevertheless, the links in Diagram 2 between empowerment of CNCs and inclusion of health issues in the CNC plan are dashed rather than solid because plans and activities were more focused on environmental interventions than on improving MCH/FP health practices—the objective of the Project.

CNC Empowerment and Accountability of Services. There are several "spaces" offering potential opportunities for CNC's to hold local officials and health providers accountable for health services..

First, meetings of CNCs offer a space to hold health services accountable by providing a venue in which members can voice opinions and suggestions about the services provided in an environment where they can communicate as equals. There are several reasons why citizen engagement is expected to have an effect on health services. First, the Municipal Law gives CNCs the mandate to provide oversight to public services in the community. Second, because health post staff members receive financial incentives for expanding health promotion, and CNCs are expected to support them in this role, the health post staff is likely to be responsive to CNC concerns. In addition, CNCs can exert some accountability pressure at the health micro-network level through meetings with LTTs, as discussed below. Further, very empowered CNCs can go directly to district-level authorities to voice complaints. Factors limiting these effects would be associated with either the presence of uncommitted health staff or insufficient CNC empowerment. Thus, in Diagram 2 the link between CNCs and local health services in Diagram 2 is solid.

A second space in which CNCs can engender accountability is with local government through their LTTs during LTT's follow-up visits. These meetings provide an opportunity whereby the community, through the CNC, can coordinate and voice its requests with local government. However, this link is generally not strong for several reasons. Commitment by local government/LTTs has been a significant problem. While there have been some very committed local governments, the constant turnover of government officials has made it difficult to maintain a cadre of committed local governments. Moreover, the concept of LTT, as applied, has its limitations. Sectors often send different representatives to subsequent meetings, limiting continuity, and the people attending do not have decision-making power. In addition, local government/LTTs don't always have funds to supervise CNC plans. While they could use funds from the MEF's Incentivo Municipal program, which offers financial incentives to local governments for improved municipal management, they generally prioritize other uses for those funds, as they are not obliged to spend them on health. Another limitation is that interactions between community and district level staff may be unequal due to socioeconomic differences, making it more difficult to promote advocacy in that context.

An additional "space" in which CNCs can demand accountability at the local government level has to do with the process of district planning. These district plans contain the activities LTTs need to carry out to be a Healthy Municipality and include activities to support CNCs. Although they use data from SISMUNI to identify priorities, plans are prepared by LTTs without any participation or consultation with CNCs. Thus, the link between CNCs and local government is weak, as indicated by the dashed line between them in Diagram 2.

[17] All of these activities form part of what families are expected to carry out to become Healthy Families.

Healthy Families as Outcomes and as Facilitators.

From among the 160 communities in which the Project worked, 10,513 families were reached through Project activities, such as: training; communication campaigns; and visits for community monitoring of healthy practices — including improving the environment around the home — among families with children under 3 years of age, families with pregnant women, women of reproductive age, and families with pregnant teenagers. There were also demonstration sessions. Among these beneficiaries of the Project activities, 1,002 families volunteered to take on the extra challenge to become Healthy Families through completion of the Healthy Families process described in the HCM model. These families used Healthy Family materials to develop their family vision, family assessment, make commitments to one another, set norms for living together, and track their progress. Uptake of this commitment was much greater among families with children under two years of age, just over 50 percent. It is worth noting that the Project did not begin focusing on families until 2012, as it had been working at the community level prior to that. The low rate of Healthy Family commitments was noted in the 2013 and 2014 project progress reports (MSH 2013, p. 79; MSH 2014, p. 31). The reasons given were: the high turnover of health staff, insufficient leadership within the CNC, community migration, limited amount of time given to local health staff to follow up sufficiently, and limited support by local governments/LTTs, due both to high turnover and lack of commitment. These issues were all confirmed through interviews in the field.

Opportunities to reach families that have not committed to become a Healthy Family may have been missed. Project staff and LTTS are supposed to follow up with the committed families, and CNCs are supposed to follow up with the uncommitted families. But communication with CNCs indicated that they too focus on the Healthy Families, and that their only visits to the uncommitted occur during semi-annual health-practice monitoring. While this may not be the rule, it is likely not an isolated case.

Other factors that may have served as barriers to families to take on the challenge of becoming Healthy Families were expressed by the families themselves. First, the process is time-intensive, and families may not have that time available. The men are often away at their farms during the day, often accompanied by their spouses. Second, there was an impression expressed by several community members, including those who were not Healthy Families, that the program is just for families with young children. Third, use of the instruments requires advanced literacy skills that not all parents have. Families often have to rely on their children or health post staff to fill in forms. Not only does this reduce the usefulness of the instruments, but it also increases the time needed to work with them. Fourth, the process of participation can be intrusive. Families might be less averse to having health staff periodically walk in to their home to assess health and sanitation issues than to having other CNC members do so. One CNC president noted that this was a major problem due to the distrust that pervades communities, which is heightened by high in-migration and persistent security problems. Consistent with this was the fact that some men do not allow their wives to participate in Project activities while they are away. Finally, some families noted they did not have the money to participate. While Project instruments stress cleanliness and order — neither of which implies cost — they also emphasize separation of sleeping, eating, cooking, and living quarters, and the use of improved stoves to promote a smoke-free environment. The example pictured in the manual includes seven living spaces plus separate areas for animals. The poorer members of the community typically do not possess sufficient space to separate quarters, even with temporary materials.

The relatively limited uptake of Healthy Family commitments means the role model effects of Healthy Families may have also likely been equally limited and as this was the experience found in some of the interviews it may merit further investigation. And, while information on what these families are doing to attract others was not recorded, some families interviewed who had not joined as “Healthy Families” noted that they did not experience positive interactions with the families who did. .“The emphasis on “healthy” and “model” families

was viewed negatively by others in some communities. The divisive nature of the emphasis on these families was noted in the HCM I Mid-term assessment (p. 29), which recommended discontinuing its use. That review also noted that interviews with families suggested the purported demonstration effects were not occurring. Thus, it warrants further investigation to explore why these families felt excluded and did not experience the intended demonstration effects

The rest of the actual chain of influence depicted in Diagram 2 addresses links not discussed in Project documents but that link key players both inside and outside the model to improvements in health outcomes. It begins with the targets the Government of Peru agrees with — MEF and CRECER — and the productivity required to respond to the increase in users of the SIS insurance and Juntos CCT program. In addition, Regional Directorates of Health (DIRESAs) identify the needed productivity targets in the work plans of their health networks and micro-networks; and health staff, including the community's health post, provide whatever is in its work plan, whether or not a CNC is involved, because its funding depends on it.

IV. Conclusions and Recommendations for Future Programming

This section provides a synthesis of the strengths of citizen engagement in improving health outcomes in the HCM II model, some of its more important challenges, and recommendations to strengthen citizen engagement mechanisms employed in HCM for future programming. A final section includes some methodological considerations to improve the model's effectiveness.

Overall Strengths of the HCM II Approach

Project design was aligned with country health priorities. The focus of HCM II was on MCH and nutrition, both of which are development priorities for the Peruvian government. The results-based budgeting utilized by MEF to assess outlays for MINSA uses MCH and nutrition outcome measures. Further, CRECER, the MIDIS national multi-sectoral program to combat poverty — which reports directly to the office of the President — and the Juntos CCT also prioritize MCH and nutrition. At the time CRECER began to require regions to adopt a community-based approach to implement its program, it did not have a defined community-based strategy and tools. HCM II was able to provide both the strategy and tools, giving the project an opportunity to effectively assist the government in the implementation of its CRECER policy nationwide. The government's promotion of CRECER increased the commitment of regional governments to adopt HCM.

Project design was aligned with decentralized governance structures. The operating structure of HCM at the community level is based largely on the Municipal Law. Citizen participation, a basic component of regional and local governance in Peru, is central to the model. CNCs, as defined by law and as implemented in HCM, foster multi-sectoral coordination and collective decision-making at the community and local government level, which built ownership and likely improved effectiveness. The model also provided a forum for coordination between CNCs and local governments.

HCM addressed health as a development issue. The HCM II Project implemented a health promotion approach that is based on the notion of health as quality of life and addresses both individual behaviors and the underlying determinants of health. The model and approach were in line with the Healthy Municipalities and Communities initiative promoted by PAHO/WHO, which is considered best practice. By addressing health in a holistic manner and bringing all sectors together to discuss health priorities, HCM II placed health as a development issue on the table, and used this forum to "educate" other sectors about the interconnections

between the health of the community and the sectors they represented. Involving all sectors will likely increase the model's sustainability.

Overall Challenges of the HCM II Approach

Ensuring sustained commitment of regional and local authorities was difficult. Obtaining and maintaining the commitment of regional and local authorities to adopt the HCM approach was generally difficult. Changes in administration often resulted in programmatic adjustments, as incoming administrations often tried to change their predecessor's programs to distinguish their own administration from the previous one. In some cases, new administrations stopped the program altogether, and work with them had to start over from the beginning. Lack of sustained commitment at the regional level was probably the biggest obstacle to Project implementation.

High turnover of government officials limited program consolidation and expansion. The frequent turnover among staff in both local government and health providers required constant retraining of new staff and caused delays and reversals in the transfer of community support from the Project to the government.

Project requirements limited the participation of the poorest families. The participation of some families, particularly the poorest, was limited by a lack of the necessary literacy skills to independently use Project instruments and the lack of funds to implement some of the activities. Moreover, Project instruments were time-intensive, adding further difficulties to families that had to be away at work all day or for days at a time.

The community planning process did not sufficiently prioritize the improvement of community health practices. The broad approach adopted in community diagnoses, which focused on community development overall, not just health may have inadvertently led CNCs to focus more on broad development needs rather than on promoting health practices. The fact that CNCs had multi-sectoral membership may have also contributed.

Recommendations for Strengthening citizen engagement in HCM to Improve Health Outcomes.

Summary of Findings: CNCs were the main vehicle for citizen engagement. Overall, CNCs were very effective in addressing community health in a multi-sectoral manner, and they likely had positive effects on health outcomes. CNCs were also successful in placing pressure on local health staff to be more responsive to community needs. Factors limiting these effects were the presence of uncommitted health staff — often due to health staff turnover — or insufficient CNC empowerment. CNCs likely had limited effects on accountability at the local government/LTT level due both to frequent local government staff turnover and the inadequate voice of CNCs at the local government/LTT level. Healthy Families played a smaller role as vehicles for citizen engagement; they likely had a limited effect on health outcomes, given the insufficient uptake of Healthy Family commitments and the lack of evidence that they had demonstrated effects on other families.

Multi-stakeholder committees should be employed to work on multi-sectoral tasks such as developing healthy environments. While all CNC plans contained activities to address the improvement of healthy environments, not all included health-specific activities. Part of the reason for the inadequate focus on health-specific activities relative to other multi-sectoral activities had to do with the composition of CNCs. Committees with a multi-sectoral representation, whose purpose is to coordinate, plan, and oversee community development activities, will naturally seek to address issues in a multi-sectoral manner. When such committees are composed of

community leaders and government representatives, they may not have the time or inclination to take on additional health activities. As such, multi-stakeholder committees may not be the best vehicle for delivering health interventions.

Establish a separate subcommittee under the leadership of the health representative in the CNC to address health promotion specifically. Health promotion activities to address behaviors at the family level will be more easily prioritized if delivered by a dedicated group. The leadership and responsibility of the subcommittee should be in the hands of the health sector members of the CNC (i.e., grassroots organizations, local health officials, and health providers). CNCs should be the forum in which the community jointly defines which health issues to prioritize. The role of health staff is to make a case for health promotion within that forum.

The role of the health sector within the CNC and LTT needs to be made explicit. Project documents and manuals mention that the health sector (i.e. grassroots organizations, local health officials, and health providers) is an important player, and the toolkit includes a how-to manual for local government/LTTs to perform their roles and responsibilities. But, other than indicating that they are members of the CNC and LTT, they do not specify their role within the two committees. The health sector was the "invisible hand" in the model and sometimes the only hand. Health providers carried out health promotion whether or not the CNC was involved. Specifying their role will give health staff clear recognition of their place inside the CNC and LTT, and may increase their commitment, motivating them to work more closely with CNCs and thus increasing health promotion. In expansion areas in Soritor, their role was expanded and was made much more explicit (although not in the manuals) and successfully so. In this way, health providers were made responsible for the support and oversight to CNCs at the LTT level. Many more CNC plans in Soritor contained health promotion activities.

CNCs should be represented in LTT planning meetings and be given a voice regarding issues that affect their community. LTT district plans contained activities to support to CNCs, yet CNCs did not have a voice in their preparation. The Municipal Law appears to give more voice to CNCs than does HCM, as the law stipulates that community committees are entitled to a voice at municipal council meetings, and to participate in municipal economic development committees (Article No. 117). The model promoted by PAHO also includes joint planning between government and communities.

Project instruments should be designed and adapted to the target population. The Project's target population were the poor and marginalized groups, yet, because of the nature of the Healthy Family instrument and the modifications Healthy Families were expected to make in their homes, the Project inadvertently ended up excluding the poorest families. The instruments required good literacy skills and considerable time dedication, which the poorest families did not have. Moreover, modifications such as improved stoves and kitchens, divided living spaces, etc., implied expenditures they could not afford. The Healthy Family Manual needs to be further field-tested.

Methodological Considerations

Although HCM II did a laudable job in strengthening monitoring, and improving the SISMUNI, the results framework had several important weaknesses, as did the Project evaluations. As a result of both, key activities were not measured, making it difficult to interpret results and to measure the Project's full effects.

Results frameworks should be consistent with activities and Project emphasis on the ground and vice-versa. As noted on Page 7 there was an inconsistency in how the RFA, Technical Application, and the Project MEP interpreted the intermediate indicator "Healthier community practices for improved MCH and FP/RH adopted"

and the interpretation given to it on the ground. As a result, efforts to create Healthy Environments, the more important focus of CNCs, were not directly measured. Given the discussions in the literature about whether or not the effects of these environmental changes on health are equal or more important than those of health promotion are still ongoing, this was a noticeable shortcoming.

Results frameworks should include more than one outcome measure, and outcome measures selected should be indicators that change within the lifespan of the Project. Although the Project was not intended to measure health outcomes, Project results could be strengthened with the inclusion of additional outcome indicators. The only health outcome included in the results framework was chronic child malnutrition. A more relevant indicator might have been acute malnutrition, as chronic malnutrition only changes over the medium-term. Given the Project's focus on drinking safe water, hand-washing, smoke free environments, and separate sleeping spaces, the Project could have also measured the prevalence of diarrhea and upper respiratory tract infections, for instance.

USAID Project procurement documents might have considered including non-Project areas to control for extraneous factors affecting Project outcomes. That the evaluations were measuring outcomes that the government has also been targeting, including non-Project areas to control for non-Project factors, would have made it possible to determine the extent to which the effects detected were due to Project efforts and/or government efforts.

Appendix A: Original Scope of Work

Scope of Work
Two Case Studies on Successful Strategies for Engaging Citizens in Health Activities

Dates: May 1, 2015 – September 30, 2015

A. Overview

The USAID-funded Leadership, Management, and Governance (LMG) Project at Management Sciences for Health (MSH) seeks an applicant to explore how health interventions can be enhanced through the active engagement of community members using case study methodology. The objective of this discrete research activity is to document two examples of health projects that include citizen engagement interventions in the health project design to increase the evidence base on how citizen engagement influences health program implementation and outcomes — including lessons learned, best practices, and recommendations for future programming.

The applicant will investigate three pre-selected country case studies (in Peru, Haiti, and The Democratic Republic of the Congo) where citizen engagement was a key aspect of a USAID-funded MSH health project. Each of the three potential cases identified include citizen engagement interventions as part of a larger health project with a range of interrelated health interventions contributing to project results. This makes direct attribution of any project outcomes solely to the citizen engagement intervention not possible. Based on their initial screening of these three case studies, the applicant will **select two of the three examples** to examine how the citizen engagement elements of the activity contribute to project results. Their selection criteria will likely be based on data availability, estimated costs, and logistical considerations.

For the two selected case studies, the applicant will document the project activities and its results or (anticipated results) using qualitative case study methodology, which will include a targeted literature review of relevant citizen engagement interventions in the health sector, analysis of program monitoring data, and key informant interviews with community leaders, government officials, program managers, and patients. For research practices and methodologies guidance, the applicant should reference Robert K. Yin's *Case Study Research: Design and Methods* (Fourth Edition).

The final product will consist of a targeted literature review (10-15 pages), two case studies on the selected projects, and two abbreviated versions of the case studies intended as how-to guides to inform future programming. The two case studies should include theories of change, detailed implementation steps, challenges, best practices, and recommendations for future programming. For guidance on case study format, please reference the USAID-funded AIDSTAR I Case Study Series. (See link http://www.aidstar-one.com/resources/case_study_series.)

The intended audience for the proposed document will be public health stakeholders including policy makers, health program managers, community leaders, and technical advisers who can use the findings to inform the design and implementation of health activities that seek to engage community voices and leadership in project design, implementation, and monitoring to improve program outcomes. The applicant will explore whether relevant government bodies for each case study will grant permission to make public any relevant data so it could be accessed and used for additional analyses.

B. Statement of Work

The research activity will likely include the implementation steps below. Applicants are encouraged to put forward alternative approaches when accompanied by clear rationale for improved research quality and effectiveness.

Expected Level of Effort	Anticipated Implementation Steps
3-4 weeks	• Conduct introductory interview with client and agree on implementation approach. • Conduct initial briefings with case study points of contact to understand the context for the intervention, objectives, health activity design, and data available. Select two of three examples to examine how citizen engagement elements of intervention influenced project results, in coordination with the client. • Develop literature review to clarify term definitions (such as citizen engagement /community involvement) and provide an evidence base and context for each of the case studies.
3-4 weeks	• Draft and submit research design and plan, including: methodology, interview tools, draft interview schedule, and outline of case study reports. • Plan field visits and schedule interviews with key informants.
6 weeks	• Conduct field visits for the two selected case studies to conduct key informant interviews and beneficiary interviews, and collect and verify program-monitoring data.
4 weeks	• Analyze data and draft case studies for review.
2 weeks	• Incorporate feedback from client, finalize case studies, and draft 4-5 page briefers with main findings.

C. Deliverables:

(Note: Due dates are forthcoming.)

1. Proposed research design, including research question(s), key informant tools, theory of change for each case study, and report outline.
2. Targeted literature review on citizen engagement (10-15 pages).
3. Two case studies that are each approximately 15-20 pages with overview, visual graphics, general implementation steps, main findings, and recommendations for future programming. Interview questionnaires and other tools from field visits will be included as appendices.
4. Two abbreviated 4-5 page how-to guides for each case study designed for donor community and other relevant stakeholders, with a focus on future program design and implementation recommendations.

Appendix B: Areas of Inquiry: Questions Guiding Informant Interviews

Project Inputs:

- What were project inputs at the community level? Local government level?
- Did the inputs produce the desired response? Were they assessed?
- What were the inputs to health services, besides training?

CNCs (CNC Empowerment) and CNC's role

- Do CNC members have the needed skills to fulfill their role (diagnosis, planning, implementation, and monitoring)? Can they carry out the activities without assistance from the Project or the local health services? How many CNCs work independently? How many continue functioning after the Project closed?
- Do they themselves feel they have the needed skills? What could be improved?
- What issues are discussed in CNC meetings?
- Did they need assistance to carry out the community diagnosis? Who participated?
- Do CNCs feel local governments/local health services are receptive to their needs?
- Do they feel they have a voice and in what way? How have they used it?
- Is their voice free, or is there political interference, or social constraints? What has been the experience?
- It assumes the CNC will speak with a single voice. What are the dynamics within the CNC?
- Does being officially recognized by local government through a municipal ordinance give CNCs greater confidence/legitimacy? Does this translate to having a greater voice?
- Does "empowerment" bring commitment to improve health status/practices of their community? Do they prioritize health promotion in their plans?
- Do CNCs have time available to become empowered and carry out their work?
- How often do they hold assemblies? Who comes?
- Do they carry out home visits? To all families?
- Why don't all families become Healthy Families? How do they try to convince them?
- What support do they get from local government/LTTs? And from health staff?

Role of Local Government/LTT:

- What is the exact role of local governments — are they mainly the providers of oversight? Do they provide funds or other resources? Do they provide technical assistance to implement the model?
- Do local governments/LTT staff have the needed capacity/ability to provide the needed support? Is the support technical? Financial?
- Do they have the necessary funding to carry out their role?
- Do they have the time to carry out their role? How often do they meet with CNCs?
- What kind of coordination takes place? Is it to discuss joint activities? Is it to discuss how to move forward on the community plan? Is it to change how things are working?
- Do they engage in dialogue with CNCs as partners? Is there a two-way relationship?
- Are empowered CNCs perceived as "equals" by local government? Do CNCs feel free to express their needs?
- Is there political interference by local governments?
- Is there political will to adopt their role?
- Do changes in government lead to turnover of all or part of the staff? Is there political support for local government/LTT work?
- Do local government work plans prioritize CNC activities?
- How cooperative and committed are local governments?
- Where does local government's funding come from? How much is for health?

- What do they spend the Municipal Incentive on?
- What do they use SISMUNI data for?

Role of Local Health Services:

- What is the staffing at the health post? What services are provided?
- Do families also go directly to pharmacies, midwives, or other health workers?
- What did they learn through the training provided?
- What is the role of local health services overall? Do they participate in health promotion activities along with CNCs, or do they also participate in the process of empowering CNCs?
- What type of encounters did CNCs have with health staff? What is their exact relationship? Is it two-way? Are they more than training/health promotion education meetings?
- Who initiates requests for changes/meetings? Were they regular or ad hoc? Were they able to regularly meet with the head of the local services and the head of regional services? What issues were generally discussed? Do CNCs request changes to service delivery?
- What has been the response of health services? Are health services receptive to their needs?
- How does it work when the community has no health post?
- Do they feel a right to comment on quality of services provided at the health center? If they did, were any changes made?
- Do empowered CNCs know what improved quality services would look like in order to demand them?
- Does health staff change with changing administrations? How is their commitment maintained?

Relationship between Local Government/LTT and Local Health Services:

- What is the relationship between the LTT and local health services?
- What is the role, if any, of local government/LTTs in improving the provision of health services?
- Do their work plans include activities to improve health services, or are they just to promote healthy practices?
- Did some of the inputs from MSH come via local government/LTT? What were they?
- Are they in any way supervising the local health services to ensure they are delivering the HCM model?

Effectiveness of Health Promotion.

- What aspects of the communication strategies are implemented by CNCs/by the project team/health staff?
- If carried out by CNCs on their own, have they acquired the necessary leadership, communication, and advocacy skills. How was this assessed?
- Were the communication strategies evaluated? Was the CNC's work evaluated?
- Are CNCs more trusted communicators because they are part of the community? How does the community view the role of CNCs vis-à-vis the role of health staff in the provision of health education/promotion?

Healthy Families and what it means.

- How did they first hear of Healthy Families?
- Do you have your Guide? What was their experience in working with the Healthy Family Guide. Did they find it easy to work with? What was hard?
- What changes have they introduced in their lives?
- What is their relationship with local health services? Are they responsive? Do they treat them with respect? Is the nurse there when s/he is supposed to be?
- Do they try to convince friends to become Healthy Families? Does she know families that aren't Healthy Families? Why don't they participate?
- What health promotion activities has she attended? Is the doctor/nurse always there?

- Do they go to assemblies held by CNC?
- Questions to families that have not committed to being Healthy Families: Why are they not participating?

Questions to Regional authorities

- How does participative budgeting work?
- How are funds from the PpR reallocated?
- How does regional coordination/integration take place — i.e., how do they coordinate with districts?
- How do they propose to address problems caused by high staff turnover?
- What differences do they see between communities using HCM approach and those that don't? What differences are there when a community does and does not have a health center?
- Health sector specifically: What proportion of their funds comes from PpR? From SIS? From MINSA?
- What are the greatest challenges in the implementation of HCM?

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Key Informants

Name	Institution and Position
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Neptalí Santillán Ruiz	USAID Peru Consultant
San Martín Region Health	
Dr. Maria Linares Sandoval	Director of Collective Health, DIRESA
Sofia Velasquez	Previous Director of Social Development, San Martín
Pongo de Caynarachi District, Lamas	
Aureliano Chávez,	President of CNC, Convento
Members of CNC (7)	Convento CNC
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Dr. Victor Piña	Head of Caynarachi health micro-network
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Laura Orna	Nurse Technician
Marcelina del Castillo Barrera	Director of Promsa, Saposoa, and regent of Huallaga Province
Ulises Fernandez Aliaga	Head of Social Development of Huallaga Province and Saposoa District
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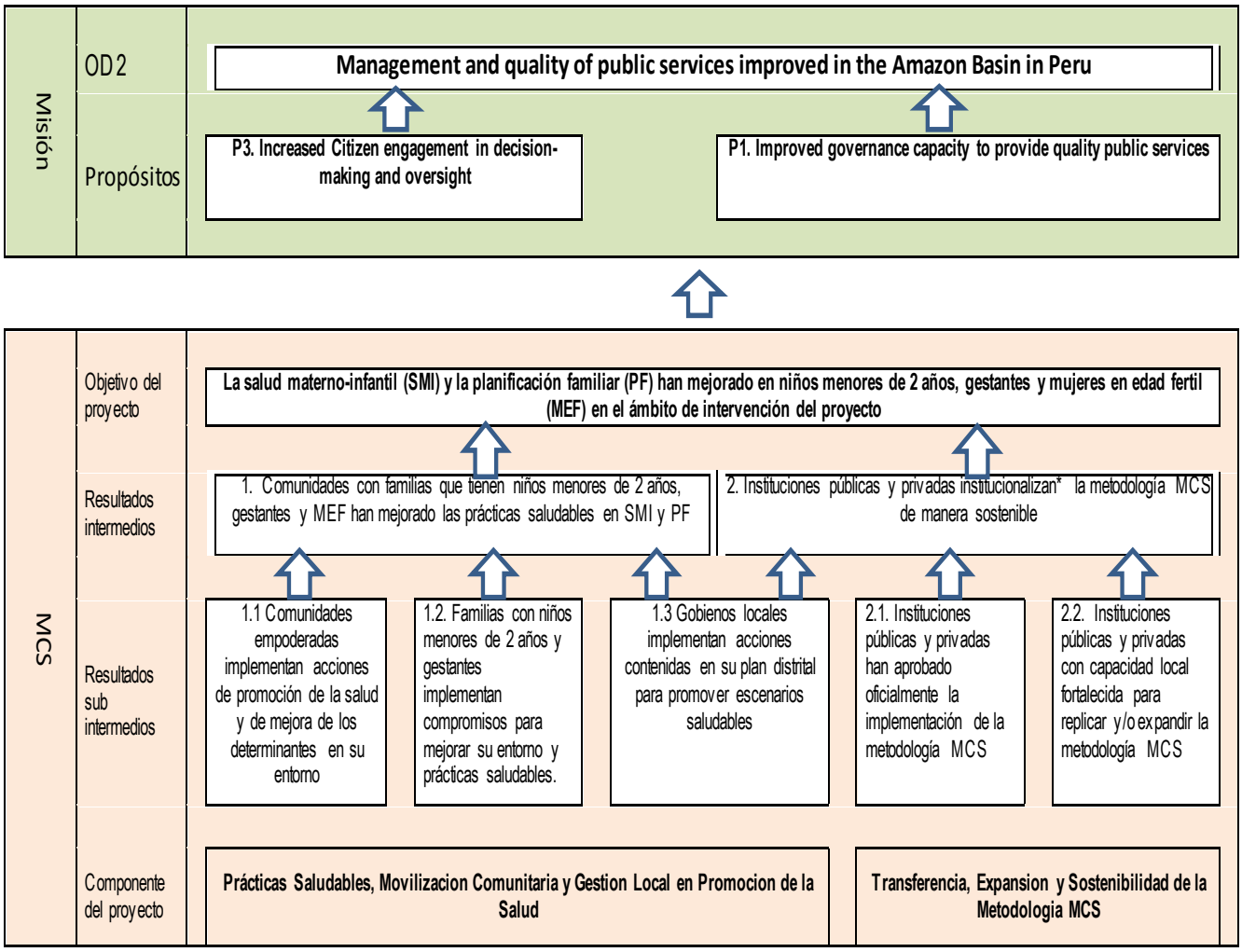
Dionisio Tocto Huamán	President CNC, Alto Peru
José Antonio Vergara Sánchez	Vice-President of CNC and Teniente Governador
Members of CNC (9)	Alto Peru CNC
Patricia González Pezo	Obstetrician, Alto Peru Health Post
Timoteo Cardoso	President CNC, Señor de los Milagros
Soralinda Quinde Morales	Vocal of CNC, Señor de los Milagros
Dr. Lenard Rengifo González	Head of Social Development of Soritor District
Elena Quispitongo Díaz	Teniente Gobernadora Soritor
Magally Marin Ríos	Teniente Alcalde y regidora, Soritor
Maria del Carmen León	Assistant, Social Development

Appendix D: Descriptive Statistics on the 22 Communities in San Martín.

					2011 or First Year		2015 or Latest			
Province	**District**	**Community**	**Has Health Post?**	**Population 2015**	**No. Families**	**Families w/ <2s**	**No. Families**	**Fams w/ <2s**	**No. Healthy Fams**	**CNC is Empowered?**
Huallaga	Saposoa	*Ahuihua*	yes	170	65	8	54	4	7	yes
		Almendras	yes	81	31	3	30	6	5	no
		Chambira	yes	110	30	6	38	5	4	no
		Nuevo San Andrés	yes	185	44	10	54	4	6	yes
		Paltaico	yes	237	35	5	46	2	5	no
		San Regis	yes	448	136	19	151	21	7	yes
		Shima	no	195	50	11	58	9	13	yes
		Tanger	no	216	62	14	62	7	9	yes
Lamas	Pongo de Caynarachi	*Barrio La Perla, Pongo*	no	514	190	13	134	20	7	no
		Bonilla	yes	432	86	72	96	28	10	yes
		Convento	no	69	21	8	24	4	8	yes
		Santa Rosa Davicillo	no	263	65	13	83	7	4	yes
		Yumbatos	yes	695	190	21	216	23	5	no
	Lamas	*Pampayacu*	no	106	40	2	38	2	7	no
	Barranquita	*Nueva Libertad*	no	84	35	11	18	3	7	yes
		San Juan de Pachicilla	no	117	20	4	27	12	11	yes
	San Roque de Cumbaza	*Alto Shamboyacu*	yes	532	109	32	144	18	13	yes
		Boca del Shambuyacu	no	73	21	5	17	3	4	yes
		Pamashto	yes	2915	360	68	497	95	9	yes
Picota	Tres Unidos	*San Juan*	no	440	109	25	70	18	4	no
		Bello Horizonte	no	214	63	0	73	1	5	yes
		Sapotillo	no	200	52	17	55	9	6	no
Total			**10**	**8296**	**1814**	**367**	**1985**	**301**	**156**	**14**

Model communities are in italics.

Appendix E: Updated HCM II Project Results Framework



* Institucionalización: implementación efectiva de los escenarios saludables a cargo de la organización que adopta la metodología.

**MEF: Mujeres en Edad Fértil.