

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office (ES#) <u>USAID/DR</u>		B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan? Yes <input type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input checked="" type="checkbox"/> Evaluation Plan Submission Date: FY <u>91</u> Q <u>2</u>		C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>	
D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
517-0239	Child Survival	09/29/87	06/30/93	5,652	4,652

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
1) Project Paper to be amended.	Mathia/Truitt	12/90
2) RFP issued for new T.A. Contractor. Statement of Work specifies priorities and tasks to be completed.	Reynolds/Truitt	1/91
3) New T.A. Contractor selected.	Reynolds	3/91
4) Save the Children Cooperative Agreement terminates.	Reynolds	5/91
5) Project Implementation Plan for new T.A. Contractor to be established with sequencing of activities and deliverables.	T.A. Contractor Truitt	6/91

(Attach extra sheet, if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) (Day) (Year)

G. Approvals of Evaluation Summary And Action Decisions:

Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
	TTruitt/JThomas	J. Rivas	T. Cornell	R.F. Rifenburg
Signature	<i>T. Truitt</i>	<i>J. Rivas</i>	<i>Thomas J. Cornell</i>	<i>R. F. Rifenburg</i>
Date	<i>2/26/91</i>	<i>2-28-91</i>	<i>3/2/91</i>	

Purpose

The purpose of the project is to strengthen the public and private sector service delivery capability for child survival interventions and to deliver those interventions directly to children most in need in three health regions. After two years of project operation under a Cooperative Agreement, the Mission, noting that project accomplishments lagged behind expectations, terminated the agreement. The work of the evaluation team was to focus on the redesign of the project for its remaining life. Key officials were interviewed, records were reviewed, and site visits were made to service delivery points. The principal recommendations follow:

Recommendations

1. The objectives of the project should be a) strengthening NGOs to provide greatly expanded services in the future; b) an increase in the coverage targets by 30 percent; and c) education and promotion of child survival practices through mass media.
2. Introduction of child survival interventions should be phased: first, diarrheal disease management, birth spacing, and support of national vaccination campaigns; second, breastfeeding; third growth monitoring and routine provision of vaccination; and fourth, management of acute lower respiratory infections and prevention of low birth weight.
3. Primary project attention to strengthening NGO capability should be directed at service delivery and supervision; training and logistics may be centralized in one or more NGOs; mass media and project monitoring should be sub-contracted out to relieve NGOs of these burdens; and financial control may require relatively little attention.
4. The project should be managed under a contract with a PVO, private for-profit company, or private non-profit company.
5. The contract should specify priorities, sequencing of activities, and deliverables.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Michael Bernhart	Univ. Research Corp.	25	24,516 for entire URC	Project funded
Sharon Erzinger	Univ. Research Corp.	20	Contract	
2. Mission/Office Professional Staff Person-Days (Estimate) <u>12</u>		3. Borrower/Grantee Professional Staff Person-Days (Estimate) <u>16</u>		

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:

USAID/DR

Date This Summary Prepared:

FEBRUARY 19, 1991

Title And Date Of Full Evaluation Report:

INTERIM EVALUATION AND PROJECT REDESIGN,
September 19, 1990I. Background

In 1988 USAID entered into a Cooperative Agreement with Save the Children Federation (SC) to implement USAID's child survival project in the Dominican Republic. The project was to provide seven child survival interventions to children under five and women 15 - 49 years:

management of diarrheal disease,
prevention of low birth weight,
promotion of breastfeeding,
management of acute lower respiratory infections,
growth monitoring and nutrition education,
promotion of birth spacing, and
immunization against six childhood diseases (the last two interventions were supported by other A.I.D. projects; resources for implementation of those were to be drawn from their respective projects).

The project was directed to the neediest populations in three health regions (of eight in the nation) and was to provide services through both non-governmental organizations (NGOs) and the Ministry of Health (SESPAS).

Project implementation encountered a series of obstacles. SESPAS was unable to disburse local currencies and did not participate fully in service delivery; SC had difficulty placing and retaining staff; and NGO field activities were not funded early in the project. The result of these and other problems was that the project failed to achieve anticipated service delivery coverage and project outputs lagged even further behind. Believing that decisive action was needed to restore project momentum, in July 1990 USAID terminated the agreement with SC and decided to assess the project design. The evaluation team was charged with proposing a redesign for the project.

II. Recommendations

The health conditions that prompted the initial project had not changed significantly by 1990 and the deteriorating economic situation augured for even greater health problems in the immediate future. In the absence of effective SESPAS participation, the burden of service delivery fell directly on the NGOs, many of whom were already receiving project support. The NGOs, however, lacked the resources, scope of operations, and experience in managing large health programs to be able to immediately extend their coverage to the large numbers of children and mothers in need. As a consequence of this situation, the

amended project should have three objectives:

- a) To develop the capacity of the NGOs to implement the revised child survival strategy and provide the basis for future expansion of coverage.
- b) To extend child survival services as far as project resources and the capabilities of the NGOs permit.
- c) To improve knowledge, attitudes, and practices related to child survival.

In recognition of the difficulties that arose in the original project when SC and the NGOs undertook a highly ambitious and broad program of activities, the revised project should sequence some activities, relieve the NGOs of the performance of selected tasks, and direct resources at strengthening NGO capabilities to perform other tasks.

The child survival interventions should be phased in as follows:

Phase I - Management of diarrheal disease, birth spacing, and support of the national vaccination campaigns.

Phase II - Promotion of breastfeeding.

Phase III - Direct delivery of vaccinations on a regular (non-campaign) basis, and growth monitoring.

Phase IV - Management of acute lower respiratory infection and prevention of low birth weight.

Implementation of the Phase IV interventions requires clinical backup which the NGOs do not possess and which SESPAS may not be able to provide; consequently these two interventions might not be introduced during the remaining life of the project.

Examination of the administrative tasks or systems required to implement the project suggests that project resources should be focussed on two principal systems: supervision and service delivery.

Two project tasks have been identified which should not be conducted by the NGOs: 1) promotion and education via electronic media, and 2) monitoring of project impact. The first would be supervised by the contractor and NGOs who would identify topic areas for education and promotion but the work would be sub-contracted to qualified media experts or firms. Impact monitoring would be performed via sub-contract by a research group, using A.I.D.'s core child survival indicators.

Of the remaining systems or project functions, one appears to require little immediate assistance: financial control is believed to be sound.

Two other systems should be centralized to reduce administrative burden and to take advantage of economies of scale. The participating NGOs may elect to centralize both logistics management and training in a few of their members. Some of the current and prospective NGOs have demonstrated sound training and logistics performance in the past and may be able to perform these tasks for the others economically and with minimum assistance.

Supervision should focus primarily on assuring the quality of health services. The project would provide resources to develop supervisory systems and to enable supervisors to maintain continuous contact with the volunteer promoters.

Service delivery is the major functions that would require attention. The NGOs have demonstrated their ability to deliver community health care but none of them are experienced at managing large programs or providing low-cost service. As these programs will have to grow rapidly to fill the vacuum left by the government program and will have to improve cost-effectiveness significantly, project efforts should be directed to assisting the NGOs in these two areas. As the NGOs are currently well managed, it is believed that they can best learn to handle the problems associated with growth by experiencing those problems during a period of paced expansion. Therefore the project should try to provide resources at a rate that demands continuous, but manageable, growth; technical assistance would be provided to assist NGOs in working through the discontinuities that such growth brings. To assist the NGOs to move toward sustainable programs, the project would disseminate information on cost-effective approaches to health care provision. The project would also provide support to innovative approaches to these issues.

The project should be managed by a US organization (private for profit, non-profit, or voluntary) via a contract with USAID.

III. Lessons Learned

- 1) Priorities should be set for the contractor. A.I.D. personnel, who designed the project and understand it should provide guidance for the contractor on how the activities of the project are to be phased.
- 2) Statement of clear objectives. As a corollary of the preceding, when a project has multiple objectives, as many do, A.I.D. should indicate which take precedence. It is acknowledged that this may often be difficult to do but it is, nonetheless, necessary. It is not appropriate for a contractor to make such decisions.
- 3) Statement of deliverables. Consistent with establishing priorities for a project is a statement of project deliverables. These state A.I.D. expectations in the clearest terms and provide task oriented goals and benchmarks that facilitate project management.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Interim Evaluation and Project Redesign

IQC Contract # PDC-1406-I-00-7113-00

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The "Recommendations" and the "Lessons Learned" reported in this Interim Evaluation provided useful information for redesigning Child Survival Project No. 517-0239 and amending the original Project Paper.

The Mission has proceeded to issue a RFP for a contracted technical assistance team which should arrive in-country before May 15, 1991.

YD-ABC-670-A
71072

**INTERIM EVALUATION
AND PROJECT REDESIGN**

**USAID/DOMINICAN REPUBLIC
CHILD SURVIVAL PROJECT
NO. 517-0239**

Evaluation team:

**Michael H. Bernhart
Sharon Erzinger**

Evaluation performed under PIO/T No. 517-0239-3-70236, USAID/DR

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I. SUMMARY

In 1988 USAID entered into a cooperative agreement with Save the Children Federation (SCF) to implement USAID's child survival project in the Dominican Republic. The project was to provide seven child survival interventions to children under five and women 15 - 49:

management of diarrhoeal disease,
prevention of low birth weight,
promotion of breast feeding,
management of acute lower respiratory infections,
growth monitoring and nutrition education,
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immunization against six childhood diseases (the last two interventions were supported by other A.I.D. projects; resources for implementation of those were to be drawn from their respective projects).

The project was directed to the neediest populations in three health regions (of eight in the nation) and was to provide services through both non-governmental organizations (NGOs) and the Ministry of Health (SESPAS).

Project implementation encountered a series of obstacles. SESPAS was unable to disburse local currencies and did not participate fully in service delivery; SCF had difficulty placing and retaining staff; and NGO field activities were not funded early in the project. The result of these and other problems was that the project failed to achieve anticipated service delivery coverage and project outputs lagged even further behind. Believing that decisive action was needed to restore project momentum, in July 1990 USAID terminated the agreement with SCF and redesigned the project. This report describes the proposed redesign.

The health conditions that prompted the initial project had not changed significantly by 1990 and the deteriorating economic situation augured for even greater health problems in the immediate future. In the absence of effective SESPAS participation, the burden of service delivery fell directly on the NGOs, many of whom were already receiving project support. The NGOs, however, lacked the resources, scope of operations, and experience in managing large health programs to be able to immediately extend their coverage to the large numbers of children and mothers in need. As a consequence of this situation, the amended project will have three objectives:

To develop the capacity of the NGOs to implement the revised child survival strategy and provide the basis for future expansion of coverage.

To extend child survival services as far as project resources and the capabilities of the NGOs permit.

To improve knowledge, attitudes, and practices related to child survival.

In recognition of the difficulties that arose in the original project when SCF and the NGOs undertook a highly ambitious and broad program of activities, the revised project will

sequence some activities, relieve the NGOs of the performance of selected tasks, and direct resources at strengthening NGO capabilities to perform other tasks.

The child survival interventions will be phased in as follows:

Phase I - management of diarrhoeal disease, birth spacing, and support of the national vaccination campaigns.

Phase II - Promotion of breast feeding.

Phase III - Direct delivery of vaccinations on a regular (non-campaign) basis, and growth monitoring.

Phase IV - Management of acute lower respiratory infection and prevention of low birth weight.

Implementation of the Phase IV interventions requires clinical backup which the NGOs do not possess and which SESPAS may not be able to provide; consequently these two interventions may not be introduced during the remaining life of the project.

Examination of the administrative tasks or systems required to implement the project suggests that project resources may be focussed on two: supervision and service delivery.

Two project tasks have been identified which will not be conducted by the NGOs: promotion and education via electronic media and monitoring of project impact. The first will be supervised by the contractor and NGOs who will identify topic areas for education and promotion but the work will be sub-contracted to qualified media experts or firms. Impact monitoring will be performed on sub-contract by a research group, using A.I.D.'s core child survival indicators.

Of the remaining systems or project functions, one appears to require little immediate assistance: financial control is believed to be sound.

Two other systems may be centralized to reduce administrative burden and to take advantage of economies of scale. The participating NGOs may elect to centralize both logistics management and training in a few of their members. Some of the current and prospective NGOs have demonstrated sound training and logistics performance in the past and may be able to perform these tasks for the others economically and with minimum assistance.

Supervision will focus primarily on assuring the quality of health services. The project will provide resources to develop supervisory systems and to enable supervisors to maintain continuous contact with the volunteer promoters.

Service delivery is the major function that will require attention. The NGOs have demonstrated their ability to deliver community health care but none of them are experienced at managing large programs or providing low-cost service. As these programs will have to grow rapidly to fill the vacuum left by the government program and will have to improve cost-effectiveness significantly, project efforts will be directed to assisting the NGOs in these two areas. As the NGOs are currently well managed, it is believed that they can best learn to handle the problems associated with growth by experiencing those problems during a period of paced expansion. Therefore the project will try to provide resources at a rate that demands continuous, but manageable, growth; technical assistance

will be provided to assist NGOs in working through the discontinuities that such growth brings. To assist the NGOs to move toward sustainable programs, the project will disseminate information on cost-effective approaches to health care provision. The project will also provide support to innovative approaches to these issues.

The project will be managed by a US organization (private for profit, non-profit, or voluntary) on a contract with USAID.

II. BACKGROUND

A. Health problem

Since 1987 when the present Child Survival Project was developed, there have been some encouraging indicators of improvements in child health, and some discouraging ones. On the positive side, official figures indicate a slight decline in the infant mortality rate to 67.7. On the negative side, there is accumulating evidence that fundamental child survival practices are not taking hold (these data should not be read as an indictment of the project as they were collected as project activities were being initiated). As examples:

- A recently released cohort study (1625 infants) of child survival practices conducted in the three regions where the A.I.D. supported project has been active reports that only 27 percent of the children suffering a recent attack of diarrhoea had received oral rehydration salts (ORS). Anti-diarrhoeals were administered in 31 percent of the cases, and antibiotics in 16 percent of the cases reported. Diarrhoea continues to be the leading cause of death and illness among children under five.
- The same study reported that an overwhelming number of mothers initiated breast feeding, 93 percent; however, 23 percent had abandoned the practice by three months and 46 percent by six months. The study documented the already familiar associations between illness and malnutrition with cessation of breast feeding.
- Fourteen percent of the children 12 months old were two standard deviations below average weight for their age.
- Vaccination coverage was found to be lower than anticipated. Although all of the sampled children had been born in hospitals, 14 percent had not been vaccinated against tuberculosis and less than a third had received OPV-zero. Forty-one percent of the children eligible had been vaccinated against measles (the study reported cases of measles in 2.2 percent of the sample) and half had received the full series of DPT vaccinations (0.5 percent of the sample reported pertussis).
- The Family Planning Unmet Needs Study put the national level of unmet demand for contraception at 11 percent of women aged 15 to 49. Higher levels of unmet need were found in rural areas, notably in region 6 which is served by the project where unmet demand stood at 16 percent. In absolute terms, the greatest concentration of couples whose demand for contraception is not being met is in the capital, 104,000 -- an area also served by the project.

In sum, there is little basis for hope that the health conditions the Child Survival Project sought to address in 1987 have improved markedly.

B. Economic situation

Severely complicating the health situation has been the steady deterioration of the national economy. Official estimates of inflation or decline in output are not cited here as it is widely believed that the deterioration has accelerated rapidly in recent months, outpacing efforts to document that deterioration. It may be instructive to note that in recent home visits to a small sample of homes served by the project, there was no food in two-third of the homes, no money to buy food in approximately one-half of the homes, no family member had eaten breakfast in one half of the homes, and one-half of the children seen showed signs of malnutrition.

This desperate situation is unlikely to improve immediately. A long history of subsidies for basic commodities has introduced market distortions which have worked against production. The government of the Dominican Republic (GODR) recognizes the pernicious effects of such distortions and is taking steps to remove subsidies. This cure, unfortunately, is worse than the disease for many consuming families. Prices for food stuffs have risen rapidly in recent weeks and more increases are expected. A poor family is finding that a budget that once provided a marginally adequate diet may no longer be sufficient to preserve the health and energy of income earners, let alone the children.

C. Child Survival Project

In response to conditions preceding, but similar to, those cited above, A.I.D. initiated a child survival project through Save the Children Federation in August of 1988. The key components of that project were the following:

1. Interventions

Seven child survival interventions were selected:

- management of diarrhoeal disease,
- support of the national vaccination campaigns,
- promotion of birth spacing and provision of contraceptives,
- prevention of low birth weight,
- promotion of breast feeding,
- management of acute lower respiratory infections, and
- growth monitoring and nutrition education.

Two of the listed interventions are supported by other USAID projects, family planning and vaccination; the child survival project was to complement those projects in three health regions of the country and draw upon them where appropriate.

The rationales for these interventions were two: 1) the proven impact the successful implementation these interventions have on childhood morbidity and mortality; and 2) the

public sector health program had adopted these interventions as the basis of its child survival program.

2. Mixed public/private participation

Support was provided to both public and private sector health providers. SESPAS (Secretary of State for Health and Social Welfare - the ministry of health) was to employ PL480 monies to support implementation of the child survival program. Direct financial grant support was channeled to non-governmental organizations (NGOs) for strengthening and expanding their health services. Coordinating committees were established at different hierarchical levels to reduce duplication and overlap while encouraging synergy, complementarity, and a common approach to training, service delivery, data reporting, and so on.

3. Responsibility for project execution

An international private voluntary organization (PVO), Save the Children Federation (SCF), entered into a cooperative agreement with A.I.D. to implement the project. An international PVO with extensive field experience in child survival was believed to possess the technical and managerial skills appropriate to the development of a strong child survival program in the Dominican Republic. SCF was charged with, among other things, developing training, information, financial, impact monitoring, communication, and research systems; identifying innovative and capable NGOs for funding of child survival activities; developing coordinating mechanisms among the collaborating organizations, both public and private; and managing project resources.

4. Limited geographic scope

The project provided services to children under five and women of reproductive age in three health regions (of eight in the nation), two on the western border with Haiti and the capital. These regions were chosen because of their high concentrations of the poorest segments of the population.

D. Implementation problems

As the project developed, a number of problems were encountered that combined to undermine seriously progress toward the project's objectives. Among those problems were the following:

1. **Staffing.** SCF had difficulty locating and retaining field staff.
2. **PL480 funds.** For the first two years of the project SESPAS was unable to obtain and disburse local currency.

3. Delayed funding of NGO field activities. Rapid response grants were given to three NGOs to establish field operations at the outset and to set the tone for the project. These were not quickly followed up with other grants to NGOs and the perception grew among NGOs that the project was largely directed to research and training materials development.

The net result of these and other problems was to produce results that, in some areas, were positive, but in many areas failed to meet the expectations of all parties involved. As examples of positive results achieved:

- The financial control systems of collaborating NGOs were strengthened and the integrity of those systems is widely regarded.
- Coordination was strengthened and tangible evidence of the same can be cited. As an example, the NGOs operating in region 6 re-allocated geographic responsibilities among themselves.
- Important and useful information on knowledge, attitudes, and practices were obtained in child survival areas.
- Child survival interventions have been provided to families in need of them. By mid-1990 a total of 572 health promoters, supported by the project, were working in their communities.

On the negative side of the ledger, however, the government's resources were never fully mobilized. As these were a major program component, their absence precluded achievement of project impact objectives. Another disappointment was the failure of the participating parties to adopt a common core of indicators in their health information systems. Further, training materials were not developed at a pace that kept up with the expansion of field activities. And, even though field operations were outstripping training capacity, coverage was expanding at a rate slower than anticipated.

E. USAID Response

USAID responded to these mounting problems by investing increased staff time in project monitoring and technical assistance. In July 1990, USAID, believing that only decisive action could change the fortunes of the project, made two decisions:

1. Termination of cooperative agreement. SCF was notified that the cooperative agreement was being terminated for convenience. SCF was asked to continue through May 1991 and complete specific activities while a new contractor was found.
2. Re-design of child survival program. Given the changes that had occurred since the project was designed and with the benefit of two years of experience with the Child Survival Project, the mission re-examined its design. This amendment is the product of that re-examination.

III. AMENDED PROJECT DESCRIPTION

A. Project Objectives

The amended project has three objectives. These do not represent radical departures from the original objectives but do narrow the focus of the project.

Objective 1. To strengthen the NGOs' capacity to implement the revised child survival strategy and provide the basis for expanded coverage in the future.

Rationale: Three factors combine to lend this objective special importance.

- a) The inability of SESPAS to participate as fully as anticipated in delivery of child survival services. Almost by default, the burden of child health care in many communities has fallen to the NGOs.
- b) The demonstrated enthusiasm and ability of NGOs to deliver services. The response of the NGOs has been gratifying. They have been innovative and hard-working. Their capacity to place services in the field has often out-stripped the project's ability to support that expansion.
- c) The limited size and geographic scope of the NGOs. Despite their enthusiasm and innovativeness, few of the NGOs are large and none of them are positioned to undertake service delivery on a national scale. This is an important limitation as the project has always contemplated eventual extension of child survival services beyond the three health regions now receiving project assistance.

These three factors combine to argue for increased attention to development of NGO capacity so that they may extend child survival services to a much expanded geographic area (if not national) in a succeeding project. The components requiring attention are listed under section E below. A common theme of the strengthening efforts is to develop institutional capacity only where such is important to the sustainability of NGO provided child survival services. Functions such as health service delivery, supervision, training, logistics, and financial control are deemed to be central to the continued provision of services by the NGOs. Functions that are not directly tied to health service provision such as impact monitoring and utilization of electronic media will be, in this amended project, performed outside of the collaborating NGOs.

Objective 2. To deliver child survival services in three health regions, principally through NGOs.

Rationale:

The over-arching purpose of this Project is to improve the health of those in greatest need. This objective is balanced by the first one which is to prepare the executing field organizations to serve a much larger population in the near future. The result is paced growth in coverage.

Given the difficulties SESPAS has encountered in mobilizing resources, the future success of the project cannot be held hostage to the resolution of these difficulties. In contrast, the

NGOs have proven themselves to be cost-effective service providers, largely through their ability to utilize volunteers as health promoters.

This is not to deny SESPAS a role in the project, however. It is recognized that SESPAS may resolve its long-standing problems and emerge as an effective vehicle. In that instance, the project would re-evaluate this position. Further, the project will tap into the undoubted strengths of the public sector program. There is already extensive collaboration at the field level where SESPAS clinics have provided backup and informal training to NGO promoters. Additionally, SESPAS officials have participated in training programs, design exercises, and materials development. Conversely, SESPAS may utilize project resources where that is appropriate. An obvious example would be participation of SESPAS personnel in project training activities where it is believed that such training would be utilized in pursuit of project objectives.

Objective 3. To improve knowledge, attitudes, and practices-related to child survival.

Rationale:

A just completed survey on knowledge, attitudes, and practices (KAP) in the project regions uncovered some erroneous beliefs that will need to be addressed if the project is to have a lasting effect on child health. As examples:

Seventy-six percent of the mothers interviewed would reduce the diet of children with diarrhoea.

Only 26 percent of the responding mothers stated that the purpose of ORS is rehydration (many expect it to stop the diarrhoea).

Twenty-four percent favor abrupt cessation of breast feeding when a child has diarrhoea.

And 85 percent believe that breast milk is sometimes "leche mala" which could kill a child or make him/her ill.

There are also some significant KAP-gaps that need to be addressed. Notably, despite widespread knowledge of ORS and its use, only 10 percent of the mothers stated they would first give their child ORS the next time s/he suffered from diarrhoea; 60 percent would take the child to a doctor where it appears the child often receives a non-ORS medicine. (These data are consistent with the cohort study findings cited earlier.)

B. Implementing Organizations

1. Project management

A US contractor will be sought through solicitation of proposals. The contractor may be a for-profit organization or a voluntary/non-profit organization.

Rationale:

At this stage of the project's development, program management skills are assuming increasing importance. Due to the demonstrated, and improving, capacity of NGOs to deliver child survival interventions, special technical and organizational skills involved in delivering child survival interventions are receding in importance in project implementation. In contrast, the NGOs lack the broad administrative and service delivery structure required for future growth. A primary task of the contractor will be to assist in the development of that structure.

2. Service Delivery and Support

No change from the original project is anticipated in this area. Service delivery will be provided through sub-contracts to NGOs. Support services -- media campaigns, materials development, research, etc. -- will be provided through sub-contracts with public and private organizations in the Dominican Republic.

C. Contract Duration

The PACD will be extended to 31 March 1993, an extension of 18 months.

This extension can be made without commitment of additional funds. Project funds were spent at a rate slower than anticipated during the first two years of the project.

D. Project Interventions

The seven child survival interventions will be introduced in four phases:

Phase I - Management of diarrhoeal diseases, birth spacing, and support of national EPI campaigns.

Phase II - Promotion of breast feeding.

Phase III - Direct delivery of vaccinations by promoters on a regular (non-campaign) basis, and growth monitoring.

Phase IV - Detection and management of acute lower respiratory infections (ALRI), and prevention of low birth weight.

Rationale:

A frequent complaint with the project to date has been the absence of priorities; implementers were concerned that all interventions had to be introduced, if not simultaneously, at least within a short period of time. The sequencing listed above was decided on the basis of need for the intervention, ease of implementation, contribution of the intervention to the credibility of the promoter, state of the economy, and availability of resources to the target population through other USAID projects (notably emergency nutrition assistance).

It is felt that the first phase interventions which should respond to urgent health needs of the target population, are relatively easy to implement (the interventions are not complex

and require brief training), and, by giving the promoter products which s/he can distribute, will enhance her or his credibility as a source of health services in the community.

Promotion of breast feeding will follow. It was not placed in the first phase, despite its great contribution to infant health, because it is felt that the promoters have little initial credibility to secure changes in established infant feeding practices. It should be recalled that the majority of the current promoters are mothers selected by the community. Their advantage in education and personal accomplishments over their peers is probably small; hence their credibility needs to be built before asking them to influence ingrained practices.

Direct provision of vaccinations is in the third phase because of the time and effort required to develop a reliable cold chain. Growth monitoring was also placed in this phase because of the dire condition of the economy. Given that many families have little control at this point over their diet – because of what is available at an affordable price or through donations – education in nutrition becomes, for many, almost a cruel joke. It is hoped that the economy will have emerged from the present difficult transition by the time this intervention is introduced.

It is doubtful that the project will progress to the point where phase IV interventions are introduced (ALRI and low birth weight); implementation may have to wait for a follow on project. ALRI is clearly an important threat to child health and is second only to diarrhoea in incidence; however, it requires clinical support which the NGOs do not have. The KAP study showed that mothers see the clinic as their first recourse for health services, not the promoter; hence, it is not expected that ALRI cases will be taken directly to clinics for attention and will not be brought to promoters. Future promoter activities in this area will focus on education to improve recognition of early danger signs associated with ALRI.

Prevention of low birth weight also depends, in part, upon clinical services (antenatal examinations and counseling). The cohort study conducted in the project regions found no association between antenatal care and birth weight; the researchers speculate that the quality of the care may be so low as to make no difference. Alternatively, the poor nutrition of the mothers may over-ride other efforts, a factor that is now difficult to influence. Given that two of the interventions commonly used to combat low birth weight (maternal nutrition and antenatal care) are presently outside of project control, this component was assigned to the last phase of the project. (Note that birth spacing, which also can affect birth weight, is in the first phase.)

E. Development of Delivery and Support Systems

The primary, although not exclusive, objective of the re-designed project is to strengthen key project components that will permit a rapid expansion of coverage of services later in this project and throughout a successor child survival project. The program components of interest are described below.

1. Service delivery system

Central to the success of the project is the strength of the delivery mechanisms. Two objectives address that need:

Objective 1. To expand the coverage of the target population, via NGOs, in the three project regions. As a numerical target, the project will reach 52,000 families by the date of the revised PACD; this figure represents a 30 percent increase over projected coverage for sub-grants currently approved or under review.

Rationale:

The problems concomitant with sustained and rapid growth are best understood by experiencing that growth. The aim here is to pace growth at a rate so that problems emerge but do not arrive in such abundance and with such rapidity as to overwhelm the organization. It is expected that the rate of program expansion proposed here will strike an appropriate balance that will permit program managers to learn to cope with the discontinuities that arise as old structures and systems are outgrown.

Implementation:

- i) Direct financial support will be provided to collaborating NGOs for personnel, some other recurring costs (fuel for supervisor's vehicles, training and promotional materials, office supplies, and purchase of birth spacing, immunization, and oral rehydration commodities where not available through other channels) and some direct costs associated with establishment of the supervisory system (e.g., motorbikes) and the cold chain (refrigerators and thermos bottles).
- ii) There is no predetermined number of collaborating NGOs. There may be as many as thirteen NGOs receiving project support at the time the redesigned project becomes effective. The contractor, with the approval of the Advisory Committee (on which USAID is represented) may expand that number or allow the support of some NGOs to lapse at the conclusion of their existing sub-grant. That decision will be based upon an assessment of current performance, potential for providing greatly expanded coverage in the future, and potential for developing innovative solutions to problems of coverage, cost-recovery, and institutional sustainability.

Objective 2. To undertake creative experimentation to improve the coverage and cost-effectiveness of service delivery.

Rationale:

National coverage, if current promoter to client ratios were used, would require a cadre of over 13,000 promoters; at present there are under 600 working with the project. Alternatives to the present delivery structure might include:

- increasing client load and reducing services,
- increasing client load by increasing incentives,
- providing some interventions through channels other than promoters (e.g., breast feeding promotion through electronic media),
- initiating cost-recovery programs to fund expansion,
- preparing families to "graduate" from the program,
- use of "multipliers", and
- redesign of services (e.g., reduce frequency of growth monitoring for children who have maintained satisfactory growth in the past).

The projected costs of providing services under current subgrants are not high, \$12 per beneficiary per year, but it is clear that A.I.D. cannot sustain that figure as the coverage of the project increases. To illustrate: A projected budget of \$10,000,000 was cited for a follow-on child survival project; if that amount, after project administration costs are taken out, were extended across the Dominican population in need of child survival interventions, there would be approximately 67 cents for each beneficiary for each year of a five year project. Again, it is evident that the project must address these issues of growth and sustainability.

Implementation:

- i) The contractor will disseminate information, perhaps through a seminar, on alternatives to promoter-based services.
- ii) The contractor will disseminate information, perhaps through a seminar, on approaches to serving a larger client group with existing promoter cadres. Current promoter to client ratios of 1:40 limit the reach of the NGOs.
- iii) The contractor will organize two seminars on institutional sustainability to include presentation of information on cost-recovery. Note that for the remainder of this project the emphasis will be on development of NGO capacity for expansion, not on recovery of recurrent costs. This information will be provided to prepare collaborating NGOs to better address this issue in the future. Regarding this and the preceding two dissemination activities, the contractor is encouraged to draw on centrally funded projects that have specialized expertise in these areas.
- iv) The contractor, with Advisory Committee approval, may fund NGO service delivery projects that attempt novel approaches to issues of cost-effectiveness and cost-recovery.

It is not expected that a single operations research project will cut this Gordian note of massive need and limited resources. Rather, increasingly cost-effective approaches may evolve as NGOs distill their own field experience and make incremental changes in the organization of service delivery. Insistence upon standardization of approach would be inimical to such incremental improvements.

2. Training

Objective 1. To develop a sustainable training capacity among the NGOs.

Rationale:

Various approaches to the institutionalization of training within the collaborating NGOs have been considered. Among them are the following:

- Each NGO develops its own training capacity.
- One NGO conducts all training for the project, drawing on training resources from others as needed.
- Training is distributed among several NGOs, each with regional responsibilities.
- Training is distributed among several NGOs on a topic specific basis.

Advantages and disadvantages can be cited for each approach. The only alternative that has been ruled out is for the training to be conducted by an organization external to the collaborating NGOs. The Mission has determined that this is the kind of issue that can best be addressed by the NGOs themselves. Consequently, the first task in developing training capacity is for the Expanded Committee (comprised of representatives of the collaborating NGOs) to determine which NGO(s) will provide training. They may select from the preceding alternatives or develop new ones.

Implementation:

- i) The Expanded Committee will determine the organizational structure and locus of training activities.
- ii) If training is centralized (not left in the hands of each NGO to provide its own), the NGO(s) conducting training will prepare supplemental budget requests to cover training costs.
- iii) The contractor will review, re-negotiate as necessary, and amend budget(s) accordingly, with USAID approval.
- iv) The training NGO(s) will identify a cadre of trainers within the country. Trainers for each intervention will be identified.
- v) The contractor will identify one or more experts in participative/adult/active training methods and contract for a short course on training methods for the cadre of local trainers. The expert(s) may be national or foreign.

Objective 2. To utilize proven training materials.

Rationale:

One of the frustrations of the project to date has been the failure of training to keep up with field activities. Much of this has been owed to the development of special materials, none of which have yet been finalized. The Mission believes that internationally available training materials on the technology and techniques of the child survival interventions are readily available; examples include PAHO/WHO, Medex, and Fundacion Santa Fe materials. As a result, the project will provide no further support for development of training materials other than translation of existing materials. It is recognized, however, that a training program may wish to tailor its products to the particular environment in which the trainees must operate. To that end, the individual trainers are encouraged to develop their own case studies, role plays, and supplemental materials.

Implementation:

- i) The contractor will review, with the cadre of trainers, available training materials in the topic areas covered in Phases I through III.
- ii) Upon selection of materials, the contractor will place a purchase order for the purchase or re-production of the materials in sufficient quantities so that each trainee may have a copy (as many as 1300 promoters and 90 supervisors may be trained during the life of the project).

Objective 3. To prepare field personnel in child survival technologies.

Implementation:

i) Immediately prior to the introduction of a child survival intervention, coordinators, supervisors, and promoters will participate in short courses that describe at least the following:

- the health problem to be addressed, its incidence and presentation,
- diagnosis of the problem and assessment of the severity of a case,
- treatment of the health problem with remedies available to the promoter,
- when, how, and where to refer cases,
- counseling to be provided to patients, and
- community education to be provided on the health problem.

Training for coordinators and supervisors will go into greater depth on these issues.

Objective 4. To raise the level of community knowledge of the etiology and control of threats to the health of children.

Implementation:

i) The contractor will, with the cadre of trainers identify community training materials (posters, pamphlets, charts, etc) on child survival topics and reproduce enough copies for each promoter in the project. These materials should be readied prior to introduction of the intervention they support.

3. Logistics

Objective 1. To ensure the timely delivery of adequate quantities of consumables such as (Phase I) ORS, contraceptives and promotional materials on EPI, family planning, and ORT to promoters; (Phase II) promotional materials for breast feeding; (Phase III) promotional materials and records for growth monitoring, scales, vaccines, syringes and needles, and thermos bottles.

Implementation:

i) The contractor will, with the approval of the Advisory Committee, sub-contract with one or more of the collaborating NGOs. As for the training function, the Expanded Committee (comprised of representatives of the participating NGOs) will determine the general organizational framework of the logistics function. Possibilities include the following:

- a single collaborating NGO handles the supply function for all participants in the project,
- more than one NGO manages supply, each with regional responsibilities,
- more than one NGO manages supply, each with commodity specific responsibilities, or
- each NGO manages its own logistics function.

ii) If the Expanded Committee decides upon a general organizational approach that centralizes project logistics (each NGO does not handle its own supply function), the contractor will prepare a scope of work and tasks to be performed and solicit proposals from the collaborating NGOs (it is recognized that it is not unlikely that the Expanded Committee may have already identified the NGO(s) that will manage supplies). The proposals must address the following issues:

- availability of storage facilities,
- procurement mechanisms for donated and purchased supplies,
- distribution capability to include vehicles, drivers, intermediary storage facilities, etc.,
- description of allocation or requisition system and how that will be implemented at minimal disruption to field activities,
- projection of future supply needs, and
- monitoring of cold chain effectiveness.

iii) The contractor will make recommendations to the Advisory Committee on the award of the logistics sub-contract and execute the sub-contract as approved by the Advisory Committee.

Objective 2. To ensure the timely procurement and distribution of cold chain equipment (Phase III).

Implementation:

i) The contractor will evaluate the service delivery infrastructure (i.e., NGO facility and field office locations, reliability of supply of electricity), estimated demand for vaccines by area, technology available at the time (i.e., solar, kerosene, or bottled propane gas refrigerators) and recommend to the Advisory Committee the following:

Equipment to be purchased- type and quantity
 Location of vaccine storage and distribution points
 Sourcing of cold chain equipment- domestic or foreign

ii) Upon the decision of the Advisory Committee, the contractor will prepare and publish/distribute a request for bids.

iii) The contractor will evaluate the bids and make recommendations to the Advisory Committee.

iv) The contractor will purchase and distribute refrigerators and, if necessary, refrigerated truck(s). The contractor will directly manage the procurement and distribution of non-consumable supplies.

4. Supervision

Objective 1. To assure the quality of services provided to program clients via the supervisory system.

Rationale:

Research on child survival programs has shown that program credibility, hence utilization, is a function of the quality and comprehensiveness of health care provided by outreach workers.

In the NGO programs currently supported by the project the promoters are volunteers. It may be difficult for supervisors to encourage steadily increasing coverage targets as a supervisor might do with a paid employee. Goal setting, which often is an important supervisory function, becomes less feasible with volunteers.

Quality assurance measures are competency based; such supervision has consistently demonstrated its superiority over supervision that focuses on clerical or administrative matters.

Implementation:

i) Supervisor training will be provided in competency based supervision.

ii) Supervisor training will cover the technical aspects of child survival.

iii) The contractor will prepare quality assurance checklists for supervisors with the Technical Committee(s). (See Appendix B for a discussion of quality assurance and the use of checklists in supervision.)

iv) The contractor will evaluate compliance with the quality assurance checklists by the supervisors.

v) Supervisors should be supervised. The contractor will recommend no project to the Advisory Committee for approval that does not describe how field supervision of supervisors will be accomplished. This description should cover both personnel and support (e.g., transport).

Objective 2. To assure frequent contact between supervisors and promoters (semi-monthly).

Rationale:

Research and experience have demonstrated the utility of supervisor-supervisee contacts in maintaining motivation. Such a source of motivation may be especially important in work with volunteer promoters where one of the incentives to participate may be the

Rationale:

Research and experience have demonstrated the utility of supervisor-supervisee contacts in maintaining motivation. Such a source of motivation may be especially important in work with volunteer promoters where one of the incentives to participate may be the opportunities for contact with health professionals and the status derived from those contacts.

Such contacts will complement and refresh formal training.

Implementation

- i) The supervisor to promoter ratio should be no more than 1:15; provision for this level of supervision should be in every contractor recommended proposal.
- ii) Provision of transportation, via purchase of motorcycles, reimbursement of travel expenses, etc. should also be described in every contractor recommended proposal.
- iii) Recommended proposals need not include provision of field supervision in accordance with items i and ii above where the objective is to experiment with a cost-reducing alternative.

5. Financial control

As noted earlier, the integrity of the financial control systems assisted by SCF is not questioned. Much of the contractor support here will be a continuation of past work. However, as collaborating NGOs increase in size or adopt cost-recovery schemes, they may out-grow their present financial control system and require assistance.

Objective 1. To ensure the control of project financial resources and verification of their use for intended project purposes.

Implementation:

- i) The contractor will provide technical assistance to collaborating NGOs in the establishment and operation of financial control systems where needed.
- ii) Periodic audits of all NGO accounts will be conducted by the contractor.
- iii) Audits by an independent external auditing agency of NGOs will be conducted on the following basis: an external audit will be conducted after the first year of operation under a project provided sub-grant or sub-contract; audits will be conducted on a random basis thereafter.

Objective 2. To provide timely and accurate financial data to program managers for use in improving the cost-effectiveness of program activities.

Implementation:

- i) The contractor will provide technical assistance to collaborating NGOs in establishment and operation of financial control systems. Special attention will be paid to presentation of data in forms easily grasped by program managers with little financial background.

6. Education and Promotion Through Mass Media

Objective 1. To increase knowledge levels in the child survival topics supported by the project. Changes in these levels will not be measured under the current project.

Rationale:

An unutilized component of the project to date is mass communication. The just completed KAP study on management of diarrhoea and breast feeding suggests a strong role for the media. Half of the respondents to the KAP stated they had radios and one-third had televisions. Presumably even higher proportions have access to electronic media (very few claimed to read newspapers); 71 percent of the mothers interviewed stated they had recently heard or viewed a child health message. These exposure numbers suggest that electronic media can reach wide audiences.

Objective 2. To improve child survival practices through promotion via electronic media. The annual monitoring system (described later) will assess progress toward this objective.

Rationale:

In addition to reach, the KAP study indicates that the Dominican media enjoy credibility; this makes the media a vehicle for not only information transfer, but for behavior change as well. While 98 percent stated that they pay attention to the advice of physicians on child health; 68 percent stated they pay attention to child care advice on the radio or television. A different set of questions compared the relative credibility of health providers. Physicians were the most credible (90 percent); promoters the least (2 percent). Given the relative inaccessibility of physicians compared to mass media and the current low credibility of promoters, these numbers argue for fuller utilization of radio and television.

Implementation:

- i) Selection of messages. The contractor will, with the relevant Technical Committee(s), identify the topics and messages to be addressed through the media. General topic areas will support the child survival intervention scheduled for introduction at the time the mass media campaign is launched (Phase I - diarrhoea management, birth spacing, vaccination campaign support; Phase II - breast feeding; Phase III - growth monitoring and direct provision of vaccinations).
- ii) Contracting for materials production and dissemination. The contractor will prepare and publish/distribute a request for bids and presentations. The contractor and Technical Committee(s) will review the proposals received and present the three deemed best to the Advisory Committee for final selection.
- iii) Upon approval by the Advisory Committee the contractor will sub-contract with the selected vendor(s) for production and dissemination of the campaigns.
- iv) The contractor and Technical Committee(s) will exercise oversight on development and dissemination of materials.

7. Program Monitoring

Objective 1. To assess the impact of each NGO on the health and well-being of women 15 - 49 years of age and children under five in its geographic area.

Rationale:

SCF has invested considerable resources and energy into the pursuit of a common health information system and has had some success in implementing similar systems with three of the NGOs. It is not clear that any of the currently employed alternative systems is inherently superior to the others. It does seem clear, however, that their implementation is spotty; doubt has also been voiced concerning their utility to decision makers. Ironically, it is no secret that these individual systems take on a significance within their programs disproportionate to their utility; their unique peculiarities are jealously defended. A case in point: the choice of colors on the growth monitoring chart was ardently debated for nearly a year, while the task of refining the health information system itself has not been concluded.

Implementation:

- (i) The monitoring system will be built around the six core child survival indicators identified by A.I.D. (Appendix A).
- ii) Data will be collected annually on a rolling basis.
- iii) The sampling methodology will follow that of cluster surveys (also called Rapid Surveys or WHO EPI sampling).
- iv) A cluster sample survey will be conducted in each NGO service area to measure impact on A.I.D. core child survival indicators.
- v) The surveys will be conducted by a research organization, not one of the collaborating NGOs. The contractor will prepare a scope of work to include tasks and expected outputs and will solicit bids. With Advisory Committee approval, the contractor will sub-contract with a research organization to conduct the surveys.
- vi) The contractor will disseminate the survey results to the collaborating NGOs.

Objective 2. To assess the impact of the child survival project on the health and well-being of target populations in project regions. In addition to impact data for each collaborating NGO, overall project impact will be estimated.

Implementation:

- i) The research organization, contracted in accordance with the procedure outlined in the preceding section, will also conduct cluster sample surveys in up to three areas not served by the project that possess characteristics similar to project served areas so that they may be reliable points of comparison.

ii) The research organization will weight the cluster sample results from the NGO service areas and, through comparison with the control sample results, estimate program impact.

iii) On the second iteration of this monitoring a baseline will exist permitting longitudinal comparisons and a better assessment of project impact.

Objective 3. To assess program coverage.

In addition to measures of program impact, both NGO managers and the USAID mission have the liveliest interest in the reach of the program.

Implementation:

i) The contractor will ensure, as a condition of financial support to sub-grantees, that quarterly information is provided on program coverage to include:

- number of families served,
- number of children under five years served, and
- women between the ages of 15 and 49 years served.

At present, all of the sub-grantees nominally collect such information.

ii) Note that beyond these basic coverage indicators, each NGO may develop its own information system.

8. Operations Research

This is not an operations research project. However, given the obstacles to program growth and sustainability, the contractor is encouraged to selectively fund NGOs that are refining innovative responses to these issues as mentioned in section E.1.b above.

F. End of Project Status

1. Coverage

a) **Families.** The project will reach 52,000 families.

b) **Children under five.** Seventy-eight thousand children under five years of age will receive project supported health services.

c) **Mothers.** The project will reach 57,000 mothers of under five children and other women of reproductive age.

2. Training Outputs

a) Training will be provided to 1300 promoters in five child survival interventions (CDD, ORT, Family planing, breast feeding, and growth monitoring) and operating the cold chain.

- b) Ninety supervisors and program coordinators will be trained in the child survival interventions, quality assurance, and cold change management.
- c) Up to thirty trainers will be trained in participative/adult/active training methods.

3. Audience Coverage by Mass Media

- a) It is estimated that 560,000 people in regions 0, 4, and 6 will hear or view three or more child survival messages on electronic media.

4. Impact

- a) ORS utilization will increase in project served areas from 27 percent of cases of childhood diarrhoea to 50 percent.
- b) EPI coverage. The percentage of children 12 to 23 months of age having received the full series of DPT vaccinations will increase from 50 to 75 percent in project served areas. The increase of coverage for measles vaccine will increase from 41 percent to 60 percent. The coverage provided by the full polio series will increase from 45 percent to 65 percent of children 12 to 23 months of age.
- c) Contraceptive prevalence will increase from 37 percent to 50 percent of women of reproductive age living in union.

5. System development

- a) Supervision/Quality Assurance - Supervisors will employ a quality assurance checklist and apply it twice monthly to each promoter under their supervision.
- b) Logistics - One or more NGOs will have demonstrated their ability to move adequate amounts of consumable supplies, including vaccines, to service delivery points.
- c) Monitoring - Credible baseline and follow up measures will be made on the A.I.D. core child survival indicators
- d) Financial control - External audits will report no major accounting discrepancies among the collaborating NGOs.
- e) Training capacity - A cadre of approximately thirty trainers will be prepared in technical and training methodology areas. Training materials in support of four child survival areas and cold chain operation will have been reproduced and distributed.

G. Staffing Requirements

1. Positions

<u>Position/Title</u>	<u>Duration</u>
Executive Director (expatriate)	2 years
Financial Director	2 years
Training/media Director	18 months
Contracts/procurement Director	2 years
Area Coordinator (2)	2 years
Accountant	2 years
Secretary	2 years
Secretary	1 year

2. Responsibilities

Executive Director. Overall contract management, coordination with USAID and sub-grantees/contractors, limited technical assistance in child survival, perform project planning, monitoring progress toward project objectives, reporting of project activities and accomplishments.

Financial Director. Control of project funds at both the contractor and sub-grantee/contractor level, technical assistance to sub-grantees/contractors, financial planning, financial reporting.

Training/media Director. Selection, acquisition, and distribution of training materials, organization and supervision of training activities, review of KAP survey results, identification of messages for media campaigns, identification of sub-contractors for media campaigns, supervision of media campaigns, and review and reporting of training and media activities and accomplishments.

Contracts/procurement Director. Assist client NGOs in preparation of sub-contract proposals, assist in development of all sub-contracting documents, project commodity and equipment needs, prepare procurement documents, supervise procurement process, review progress of sub-contracts and confirm deliverables have been achieved, report on sub-contract achievements and compliance.

Area Coordinator. Reside in health region, maintain continuous contact with client NGOs and SESPAS, monitor quality of care provided, re-inforce supervisory system, assist client NGOs in technical and administrative areas, convene coordinating meetings among NGOs and SESPAS.

IV. IMPLEMENTATION SCHEDULE

The redesigned project is front-loaded, as the schedule chart illustrates. This is due to two circumstances: 1) the project is behind schedule, and 2) some activities are moving ahead of the project's ability to support them. The contractor will have to perform some tasks continuously or as dictated by project development:

- Development and review of NGO proposals for sub-contracts.
- Financial monitoring and systems development.

- Technical assistance in information systems, logistics, training, etc.
- Coordination with the national vaccination campaigns.
- Contracting for external audits.
- Facilitating coordination among NGOs and with SESPAS.
- Aggregation of coverage data and narrative reports.
- Compiling financial, coverage, and narrative reports semi-annually.

Other tasks occur at discrete points during the project. The following description and chart (Exhibit I) identify some of the key activities the contractor will perform or facilitate:

Quarter 1

Training

Expanded Committee (EC) decides organizational locus of training.
 One or more NGO(s) develop training implementation proposals, to include budget(s) for supplemental funding.
 Proposal presented to Advisory Committee (AC) for action.
 Sub-contract amendment(s) executed with training NGO(s) as approved by Advisory Committee.
 Technical Committee (TC) and training NGO(s) identify cadre of trainers.
 Contractor identifies provider(s) of course on participative/adult/active training methods and contracts with one provider.
 Training materials on diarrhoeal disease (CDD) adopted or slightly adapted with cadre of trainers and training NGO.

Logistics

Expanded Committee (EC) determines organizational structure and locus of logistics function.
 NGO(s) develop proposals for management of logistics.
 Contractor reviews proposals and recommends to Advisory Committee (AC).
 AC review.
 Contractor amends sub-contract or sub-grant with NGO(s) for logistics management.

Impact Monitoring

No activity.

Media/communication

Contractor prepares and publishes request for presentations and bids for media campaigns.
 Contractor and Technical Committee (TC) review proposals and presentations and recommend to AC.
 AC review.
 Contractor and TC select CDD messages.

Supervision/quality control

Adopt/adapt quality assurance checklist (Technical Committee and contractor).

Reproduce quality assurance checklist.
Prepare cadre of trainers to introduce quality assurance and use of checklist in training for supervisors and coordinators.

Quarter 2

Training

Training methods course given.
Training materials on CDD reproduced or purchased.
Community educational materials on CDD selected and purchased or reproduced.
Course(s) on CDD given to NGO program coordinators (program chiefs) and supervisors.
Courses on CDD given to NGO promoters.
Community training materials distributed to promoters and supervisors.
Training materials for birth spacing adopted or adapted.
Community education materials for birth spacing adopted or adapted.
Training and community education materials for birth spacing purchased or reproduced.

Logistics

Contractor provides technical assistance as needed to logistics NGO.

Impact Monitoring

Contractor requests bids for conduct of cluster surveys.
Contractor evaluates bids and recommends to AC.
AC reviews.

Media/communication

Sub-contractor prepares CDD mass media material for contractor and TC review.
Sub-contractor produces CDD material.
Sub-contractor disseminates CDD material.
Contractor and TC select birth spacing messages.

Supervision/quality control

Quarter 3

Training

Course(s) on birth spacing given to NGO program coordinators (program chiefs) and supervisors.
Courses on birth spacing given to NGO promoters.
Distribute community education materials on birth spacing to promoters and supervisors.
Schedule and provide training in CDD as necessary to cover new entrants to program.
Adopt/adapt training materials on training materials on breast feeding with cadre of trainers and training NGO(s).
Training materials for cold chain operation and management adopted or adapted.

EXHIBIT I

CONTRACTOR SCHEDULE

	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	QUARTER 5	QUARTER 6	QUARTER 7	QUARTER 8
TRAINING	EC decides structure MOO(s) dev. implemen. plans Select methods course Identify trainers Adapt/adopt CDD matls	Give methods crse. Trn. supe.& coords. CDD Trn. promoters in CDD Select, dist. CDD matls Adopt/adapt FP matls Select FP matls	Trn. supe.& coords. FP Trn. promoters in FP Dist. FP matls Adopt/adapt BF matls	Trn. supe.& coords. in BF Trn. promoters in BF Dist. BF matls Adopt/adapt EPI matls Adapt/adopt cold chain	Trn. supe.& coords. in CCH Trn. promoters in CCH Adapt/adopt GN matls	Trn. supe.& coords. in GN Trn. promoters in GN Eval. QA forms	Trng of new workers QA trng if needed for supe.	Trng of new
LOGISTICS	EC decide structure MOO(s) dev. proposals Proposal review AC approves sub-cont.	T/A as necessary	Eval infrastructure for cold chain Reco. eqpt to AC Est. vaccine demand Publish tender	Eval tenders Purchase CCH eqpt Dist. CCH eqpt	Eval. integrity of CCH		Eval. integrity of CCH	
IMPACT MONITORING		Request bids for sample surveys Eval. bids	Contract w/ rec. grp. Surveys by rec. grp.	Disseminate results			Rec. grp. conduct survey	Dissem. res
MEDIA/ COMMUNICATION	Publish RFP Eval. RFP Reco to AC Select CD D message Execute sub-cont.	Sub prepares CDD matl Sub produces CDD matl Sub dissem. CDD matl Select FP message	Sub prepares FP matl Produce X dissem FP matl Select BF messages	Sub prepares, produces, & dissem. BF matl Select vacc. message	Prod., dissem. vacc. message Select and prep GN message	Prod. dissem. GN message	Re-broadcast msg. as needed	
SUPERVISION/ QUAL. ASSURANCE	Adopt/adapt QA checklist Reproduce QA checklist		Evaluate checklist compliance					

Logistics

Contractor evaluates infrastructure for cold chain.
Contractor recommends equipment to AC.
Contractor projects demand for vaccines and provides projections to logistics NGO.
Request for tenders for cold chain equipment published.
Contractor evaluates supply levels at service delivery points.

Impact Monitoring

Contractor sub-contracts with research group for conduct of cluster surveys.
Research group initiates field research.

Media/communication

Sub-contractor prepares birth spacing mass media material for contractor and TC review.
Sub-contractor produces birth spacing material.
Sub-contractor disseminates birth spacing material.
Contractor and TC select breast feeding messages.

Supervision/quality control

Evaluate supervisor utilization of checklist.
Advise program coordinators of results of evaluation.

Quarter 4

Training

Course(s) on breast feeding given to NGO program coordinators (program chiefs) and supervisors.
Courses on breast feeding given to NGO promoters.
Adopt/adapt training materials on vaccination with cadre of trainers and training NGO.
Reproduce or purchase training materials on vaccination.
Training materials for cold chain operation and management purchased or reproduced.
Schedule and provide training in CDD and birth spacing as necessary to cover new entrants to program.

Logistics

Contractor evaluates tenders and recommends to AC.
AC reviews.
Contractor purchases cold chain equipment.
Contractor distributes cold chain equipment.

Impact Monitoring

Contractor disseminates survey results.

Media/communication

Sub-contractor prepares breast feeding mass media material for contractor and TC review.

Sub-contractor produces breast feeding material.

Sub-contractor disseminates breast feeding material.

Contractor and TC select vaccination messages.

Supervision/quality control

Quarter 5

Training

Provide training to supervisors on cold chain management.

Provide training to promoters on cold chain operation.

Adapt/adopt with cadre of trainers and training NGO materials on growth monitoring.

Purchase/reproduce growth monitoring training materials.

Adopt/adapt community education materials on growth monitoring.

Purchase/reproduce community education materials on growth monitoring.

Schedule and provide training in CDD, birth spacing, breast feeding, and cold chain operation as necessary to cover new entrants to program.

Logistics

Contractor evaluates integrity of cold chain.

Contractor evaluates adequacy of supply at service delivery points.

Impact Monitoring

Media/communication

Sub-contractor produces vaccination material.

Sub-contractor disseminates vaccination material.

Contractor and TC select growth monitoring messages.

Supervision/quality control

Quarter 6

Training

Course(s) on growth monitoring given to NGO program coordinators (program chiefs) and supervisors.

Courses on growth monitoring given to NGO promoters.

Evaluate quality assurance forms as guides to revision of training content.

Schedule and provide training in CDD, birth spacing, breast feeding, and cold chain operation as necessary to cover new entrants to program.

Logistics

Contractor evaluates integrity of cold chain and adequacy of supply levels.

Impact Monitoring

Media/communication

Sub-contractor produces growth monitoring material.
Sub-contractor disseminates growth monitoring material.

Supervision/quality control

Quarter 7

Training

Schedule and provide training in CDD, birth spacing, breast feeding, growth monitoring and cold chain operation as necessary to cover new entrants to program. Provide quality assurance training to supervisors if indicated by review of quality assurance records.

Logistics

Contractor evaluates integrity of cold chain.

Impact Monitoring

Research group conducts cluster surveys.

Media/communication

Re-release of messages as recommended by Technical Committee and contractor (budgeted funds permitting).

Supervision/quality control

Quarter 8

Training

Schedule and provide training in CDD, birth spacing, breast feeding, growth monitoring and cold chain operation as necessary to cover new entrants to program.

Logistics

Impact Monitoring

Contractor disseminates results of survey.

Media/communication

Supervision/quality control

V. LESSONS LEARNED

The project to date has operated under a cooperative agreement. Despite the many advantages such an arrangement offers, it also places severe limitations on the Mission's options for assisting or re-directing a project when it encounters difficulties. A more appropriate assistance instrument may be a contract, especially when Mission staff possess extensive experience in the country, as in the present case. The experience gained with the project thus far suggests that a new technical assistance contract should emphasize the following:

1. Priorities should be set for the contractor. A.I.D. personnel, who designed the project and understand it, should provide guidance for the contractor on how the activities of a project should be phased.
2. Statement of clear objectives. As a corollary of the preceding, when a project has multiple objectives, as many do, A.I.D. should indicate which take precedence. It is acknowledged that this may often be difficult to do but it is, nonetheless, necessary. It is not appropriate for a contractor or grantee to make such decisions.
3. Statement of deliverables. Consistent with establishing priorities for a project is a statement of project deliverables. These state A.I.D. expectations in the clearest terms and provide task oriented goals and benchmarks that facilitate project management.
4. Preparation of explicit contingency plans. It is old news that development projects rarely unfold as planned. In this project the participants are to be congratulated for responding as well as they did to the inability of SESPAS, the major service delivery provider, to participate fully. The partial successes achieved by the project to date are owed, in large measure, to the existence of a ready fall back position and the speed with which that was adopted. In practical terms this means that project planners will need to identify critical assumptions -- those on which project success hinges -- and make explicit plans for how the project will respond if those assumptions do not hold up.

VI. RECOMMENDATIONS

In that this is a proposed redesign, recommendations are distributed throughout the entire document. To summarize those:

1. The amended project should be contracted to a private for-profit, private non-profit, or voluntary organization.
2. The objectives, in descending order, should be:
 - a) To strengthen the capacity of the NGOs to provide greatly expanded coverage in the future.
 - b) To extend child survival services to an increased number of beneficiaries (thirty percent more than presently targeted). Such expansion will mean reduced expenditures in other areas, for example, salaries for expatriate staff.
 - c) To increase knowledge of child survival practices and predispositions to practice those through use of mass media.

3. The introduction of the child survival interventions should be sequenced as follows:

- a) Phase I - management of diarrhoeal disease, child spacing, and support of national vaccination campaigns.
- b) Phase II - breast feeding.
- c) Phase III - provision of vaccinations on a routine, non-campaign basis and growth monitoring.
- d) Phase IV - management of acute lower respiratory infections and prevention of low birth weight.

4. In order to simplify the task of strengthening NGO capabilities to expand coverage, the systems or tasks should be addressed as follows:

- a) Two tasks should be subcontracted to organizations other than the participating NGOs, impact monitoring and production and dissemination of mass media materials.
- b) Two other tasks may be centralized, logistics and training. It is further recommended that no further project monies be invested in the development of new training materials; these should be adapted from currently available materials.
- c) One task, financial control, may require little additional support and development as it has been well managed thus far in the project.
- d) Two tasks should absorb most of the project efforts, service delivery and supervision. Service delivery should be strengthened through the following activities:
 - i) Paced growth of services. Each NGO should be supported in its efforts to expand services on the premise that through orderly expansion the NGOs, which are fundamentally sound, will develop the management skills needed to manage further expansion.
 - ii) Heightened interest in sustainability. The NGOs should be provided with information on cost recovery and cost-effective approaches to delivering services. They should not be expected, at this point, to achieve high levels of financial self-sufficiency.
 - iii) Cautious experimentation. It is likely that the NGOs will deliver services in slightly different ways. Up to a point this should be encouraged as it may lead to superior delivery strategies.
- e) Supervision should be dedicated primarily to ensuring the quality of services provided. Supervisors should be expected to closely and systematically monitor the comprehensiveness and quality of care given by health workers. The project should fully support the supervisory system.

Appendix A

Child Survival Core Indicators

1. Percent of infants/children (12 - 23 months) who have weight for age less than that which is two standard deviations below the mean.
2. Percent of infants/children (0 - 59 months) with diarrhoea in last two weeks who were treated with ORT.
3. Percent of children (12 - 23 months) who are vaccinated by age 12 months with BCG, DTP3, polio3, and measles vaccine.
4. Percent of women (15 - 49 years) delivered in the last 12 months who have received two doses of tetanus toxoid.
5. Percent of infants (0 - 11 months) who are being breastfed and are receiving weaning foods at an appropriate age.
6. Percent of women (15 - 49 years) in union who are currently using contraception.

Appendix C

Summary of NGO Activities

The following summary of the NGO activities is drawn from interviews with key staff members. All agencies currently under sub-contract in the project were contacted except ADOPLAFAM and Aguas Vivientes. This summary is in three parts: General Observations, Agency Outline of Promoter Activities, and Format for Future Analysis of NGO's (Appendix D).

1. General Observations.

Variation in NGO implementation was determined by each agency's history as well as by the date of approval. FUDECO and IDDI received approval one year into the project in July 1989. CARITAS and SSID, while their projects received approval only recently (2/90, 3/90), have a history of conducting similar projects and were quick to implement project supported activities. Other NGOs, such as AED, received recent approval (2/90) and are now initiating activities.

A total of 572 promoters were active among the NGOs that were contacted. Each promoter serves an average of 40 families, with variation from 40 to 60. The ratio of supervisors to promoters is approximately 1: 16, with a range from 10 to 25.

Some of the NGO's have developed alternative means of expanding their beneficiary populations. For example, promoters in FUDECO and FCH projects work with a special group of mothers who then expand the pool of educators in the community. FUDECO has expanded this pool of resources to include "ninos promotores" who receive instruction on caring for younger community members.

Other NGO's work with a community support group that makes major decisions regarding the promoter program. In FCH and SSID projects the community makes the decision regarding who will become the promoter. In part because of this community participation, promoters are often selected who have previous experience as a promoter in another program. In the field, many promoters interviewed could trace their careers as a promoter through more than one agency, often starting with the government program, SESPAS, and later moving to an NGO such as SSID or FUDECO.

Some of the NGO's such as SSID and FCH have implemented incentives rather than salaries for their promoters. While the salary is minimal (50 pesos monthly), the incentives emphasize the promoters' motivation of community service rather than financial gain. As examples, SSID provides school notebooks or shoes for the promoter's children. An additional incentive for the promoter is the possibility that she may become a supervisor of other promoters. CARITAS and SSID have supervisory personnel who were previously promoters.

2. Agency Outline of Promoter Activities

AED Accion Evangelica de Desarrollo

Their short history with the project results in activities that are now beginning. The goal is that forty promoters will be working with a caseload of 50 to 60 families under four supervisors. This NGO has no training experience and is currently seeking assistance in this from PLANSI. AED may offer birth spacing services in the future but does not presently include them.

Caritas Dominicana

Caritas' child survival activities proceed from 7 years of work in nutrition information provided through promoters. The 90 promoters serve their communities and monthly weigh children less than two years of age; children over two and at lower risk are weighed biannually. This tiered system of service allows for maximum attention to the younger children. Caritas has not only a well developed training capability, but also educational materials to support their training.

CIAC Centro de Investigaciones y Apoyo Cultural

This is a project that is proposed for approval. Haitian migrants of the bateyes form the needy population addressed by the proposed project. CIAC has a ten year history of literacy work using volunteer educators in each community. The health promoter program would be parallel to their current activities. Health and sanitation activities have been undertaken through a committee in each community.

FCH Fundacion Contra el Hambre

Each of the 64 communities served by FCH has a promoter who is supervised by one of four supervisors through visits every two weeks. The promoters work with five mothers who become resources in the community that augment the promoter's services. Promoters work for incentives rather than for pay. Approximately 4928 families are served by the promoter system; this equates to 77 families per promoter. FCH provides a full range of training services for the promoters and supervisors. They also purchase their own supply of ORS for distribution to the promoters.

FUDECO Fundacion de Desarrollo Comunitario

The child survival activities of this NGO are part of an integrated approach to community development. Promoters have been incorporated only in those communities where simultaneous effort on an adequate water supply has been developed. FUDECO has 160 promoters, each of whom provides services to 40 families. FUDECO has a well developed system of training through its centers, CAOTACO I and II, where promoters, supervisors and others receive training.

Each promoter works with an expanded group of mothers and older children in her community. The mothers are able to assist in visits to high risk homes. The "ninos promotores" assist in the preparation of oral rehydration solution for younger children.

IDDI Instituto Dominicano de Desarrollo Integral

The marginal barrio of La Zurza will be provided with 70 promoters working under two supervisors. Each promoter will serve 40 families. IDDI supports a nutrition center where children stay for up to three months. A volunteer physician consults once weekly. Full training services support the promoter activities, with four days of initial training and one day per month as follow up on specific topics. IDDI has developed four brochures to use in training.

SSID Servicios Sociales de la Iglesia Dominicana

Each of the 55 promoters serves 60 families with support of the three supervisors who visit every two weeks. The purposes of the supervisory visits include community education in addition to the formal promoter supervision. Promoters are selected by community groups. Training proceeds with an initial one week for each promoter, followed by a week of training every two months. SSID uses training personnel from the regional bank of trainers who work at different agencies (PLANSI, CONOPOFA, Caritas, Sociedad Medica Christiana). It is planned that the supervisors will do the bulk of the training. Promoters carry a number of items to their families including antiparasitics, contraceptives and acetaminophan.

PLANSI¹ Plan Nacional de Supervivencia Infantil

Of the 6000 promoters being supported, only 2000 have received training and thus are capable of providing services comparable to those of the NGOs. The remaining 4000 promoters assist only in point interventions such as the immunization campaigns every four months. Each trained promoter serves 50 houses. Supervisory meetings take place monthly. There is no transportation provision for the supervisors.

PLAN² Internacional

This large program supports the urban barrios of Herredia with 93 promoters. Each promoter serves 60 families; 6 supervisors meet regularly with the promoters. The promoters in this project are provided with ORS and chlorine that they can sell at cost. Training takes place through the personnel from PLANSI, who carry out training as directed by PLAN. This agency is one of three (SSID and IDDI are the others) that provide antiparasitic medications to the community.

¹PLANSI is the public health system that serves child survival needs on a national level. It is therefore not an NGO, but is included for the sake of comparison.

²PLAN International is an NGO not presently receiving project funds, but has an analogous system that is described for comparison.

Appendix D

Format for Analysis of NGOs

1. Promoters
 - number
 - types of services
 - growth monitoring
 - education
 - distribution of ORS, contraceptives, antiparasitics, acetaminophan, chlorine,
 - supervisor to promoter ratio
 - salary or incentive
 - promoter to family ratio
 - groups or community members who assist the promoter
 - recruitment and selection: by committee or employer
- 2 Supervisors.
 - number
 - names, history of being previous promoter
 - visits to promoter per month
 - activities during visit
3. Regional system.
 - number of coordinators of supervisors
 - monthly contact with supervisors
 - planning process of regional system
4. Communities served.
 - other projects that complement health programs such as agriculture, latrines, water.
5. Data system outline.
 - promoter cards
 - monthly data accumulated
 - analysis process
 - feedback of data to the community
6. Training
 - initial promoter training, who, what, time
 - regular educational meetings of sup. and promoters
 - available training personnel
 - available educational materials.

Appendix E

Developing Educational Materials

The three target groups for training activities are the coordinators, the supervisors of promoters and the promoters. Currently, participants are charged with the responsibility to teach what they learn to those who work more directly with the community-based promoter. For example, the regional coordinator attends training on breastfeeding and then teaches what she has learned to the supervisors who, in turn, teach the promoters.

As participants train supervisors who then train promoters, training quality is not necessarily maintained. Use of educational materials would increase the likelihood that training completed with each group is similar in quality. These materials will include clear instructional objectives, concise and limited text as background information, and suggestions for participative activities such as role plays, case studies, games, and demonstrations.

By working extensively with the cadre of trainers, who, presumably are more experienced in teaching, materials could be developed, pre-tested, and distributed as training progresses. In the long term, this plan enables the facilitators to develop their own educational support materials.

Each educational support document would include learning activities that illustrate active and participative methods to use with groups as well as individuals. Personal direct instruction of mothers in their homes is very different from teaching a community group. Both methods complement each other and can be used simultaneously to convey the same message in different ways. The design and implementation of personal as well as group teaching would be addressed as separate types of approaches to the same topic in the support materials.

The training sub-contractor(s) could work with selected trainers from the NGO's on a training activity with the promoters. Using experience with this promoter group as a pre-test, the instructional approach will be altered. Trainers would then train regional groups who would subsequently use the materials to train the supervisors who will, in turn, use the methods with their respective promoters. The end result would be a relatively polished set of materials that reflect an instructional approach that can be taught to supervisors for use with promoters in their work with mothers.

To follow an example, the sub-contractor works with trainers from NGOs to generate ideas for participatory activities that can be used with promoters. One of their ideas is a demonstration-return demonstration on mixing oral rehydration solution from the packet and from home ingredients. They carry out this activity with a group of promoters, receive feedback, and revise written guiding materials that reflect their experience. Each of the NGO trainers then proceeds to teach groups of supervisors who then teach their promoters.

The end result of the sub-contractor training work would be 1) a set of usable instructional units with participatory activities directed toward community groups, promoters and supervisors and 2) selected trainers who have participated in the their use and dissemination at each step.

Appendix F

Schedule of Team Activities

- 8/8/90 Team leader Michael Bernhart (MB) arrives.
- 8/9/90 MB meeting with Tim Truitt and Lee Hougen of A.I.D..
MB meets with Save the Children (SCF) staff in general meeting. Team member Sharon Erzinger (SE) arrives.
- 8/10/90 Team meets with Tim Truitt and Lee Hougen of AID.
Team meets with SCF staff member, Craig Sarsony.
- 8/11/90 Review of materials, schedule and major questions.
- 8/13/90 General strike, meetings with PLANSI and SCF rescheduled. Meeting with Mary Beth Allen, A.I.D..
- 8/14/90 Second day of general strike. Meeting at PLANSI with Dr. Johnny Rivas and Dr. Angelo Avila. Meeting at A.I.D. with Tito Coleman. Telephone interview of Jim Heiby at S&T/H/AR.
- 8/15/90 Team meetings with staff of Save the Children: Denise Urena, Juana Maria Mendez, Gita Palai. Meeting (MB) at UNICEF with Ilsa Nina.
- 8/16/90 National holiday. Contacted Karen Sorenson at Westport office of Save the Children (SE) by telephone. Developed analytic approach for future project design.
- 8/17/90 Team meetings at IDDI with Liliana Rocha, Ramon Seffer, and Erudina Bulges. Team meeting at SSID with Licenciado Andres Reyes. Meeting (SE) at SCF with Juana Maria Mendez. Team meeting at A.I.D. with T. Truitt and L. Hougen.
- 8/18/90 Reading, review and analysis of data for design options.
- 8/20/90 Team meeting at A.I.D. with T. Truitt. Team meeting at AED with Carmen Bulet. Team meeting at Plan International with Alexander Gray, Dr. Felix Alcantara and Francisco Urano.
- 8/21/90 Team meeting at FUDECO with Horacio Ornes and Benilda Rudecindo. Team meeting at SSID with Dr. Rafael Garcia. Team meeting at FCH with Luis Sena.

8/22/90 Meeting (MB) at A.I.D. with T. Truitt and L. Hougen. Visit (MB) to La Zurza, a marginal barrio, accompanied by Liliana Rocha. Visit (SE) to meeting of the Regional Coordinating Committee in San Juan.³ Visit (SE) to FUDECO training site CAOTACO I and home of a community promoter. Accompanied by Benilda Rudecindo and Denise Urena.

8/23/90 Visit (SE) to Barahona regional coordinator, Jennifer Metzler. Visits (SE) to three bateys where Haitian migrant laborers reside. Accompanied by Carlos Terrero of CIAC. Visit (SE) to SSID in Barahona with three supervisors to discuss their work. Visit (MB) to San Juan region accompanied by Josefina Heredia of FCH. Both team members met with multiple promoters and community members.

8/24/90 Meeting (SE) at Caritas with Maritza Martinez, Anny Diaz and Eulalia Jimenez. Meeting (MB) at CENISMI with Hugo Mendoza. Meeting at A.I.D. with T. Truitt and L. Hougen.

8/25-26/90 Writing re-design document.

8/27/90 Team meets with NGO representatives and Tim Truitt. Attending the meeting were: Ramon Seffer (IDDI), Matilde Garcia (AV), Dra. Josefina Chavez (FCH), Maritza Martinez (Caritas), Alta Gracia (ADOPLAFAM), Benilda Rudecindo (FUDECO), Denise Urena (STC). Team meets with Gita Pillai (SCF).

8/28/90 Team meeting with Lee Hougen, Glenn Patterson and

³Members of regional committee meeting at San Juan:

Fanny Celestes Diaz - SESPAS
Rosa Rodriguez - SESPAS
Josefina Heredia - FCH
Benilda Rudecindo - FUDECO
Fabio Junior
Isabel Montella
Felix Oriedo
Virtude Roa Caritas
Aldo Conde
Leo Balderon
Denise Urena - Save the Children

Clydette Powell to discuss health sector future plan.
USAID de-briefing and discussion with T. Truitt, L.
Hougen, Frances Conway, Mary Reynolds, Kathleen
LeBlanc, and Henry Walhous.

8/29/90 Team departs Santo Domingo.

Acronyms:

AED Accion Evangelica de Desarrollo
AV Aguas Vivientes
CENISMI Centro Nacional de Investigacion Materno-Infantil
CLAC Centro de Investigaciones y Apoyo Cultural
FCH Fundacion Contra el Hambre
FUDECO Fundacion de Desarrollo Comunitario
IDDI Instituto Dominicano de Desarrollo Integral
SSID Servicio Social de Iglesias Dominicana
PLANSI Plan Nacional de Supervivencia Infantil

Appendix G

List of Principle Contacts

USAID

Frances Conway, Deputy Director
Lee Hougen, Chief, HPD
Tim Truitt, Child Survival Coordinator
Mary Beth Allen, Project Dev. Officer
Mary Reynolds, Contracts Officer
Kathleen LeBlanc, Controller

Save the Children Federation (SCF)

Craig Sarsony, Director of Finance
Denise Urena, Research Coordinator
Juana Maria Mendez, Training Coordinator
Rafael Puriet, Finance
Gita Pillai, Information Systems Coordinator
Jennifer Metzler, Region IV Coordinator
Karen Sorenson (per telephone), Project Coordinator

AED Accion Evangelica de Desarrollo

Carmen Brulet, Health Coordinator

AV Aguas Vivientes

Matilde Garcia, Health Coordinator

CENISMI Centro Nacional de Investigacion Materno Infantil

Dr. Hugo Mendoza, Director

CIAC Centro de Investigaciones y Apoyo Cultural

Carlos Terrero, Region IV Coordinator

FCH Fundacion Contra el Hambre

Arq. Luis Sena, Director
Dra. Josefina Chavez, Health Coordinator
Josefina Heredia, Region VI Coordinator
Federico ?, Supervisor
Promoters (3), Sabana Yegua, Rinconcito

FUDECO Fundacion de Desarrollo Comunitario

Horacio Ornez, Director

Benilda Rudecindo, Technical Coordinator

Renilda Espinoza, Region VI Coordinator

IDDI Instituto Dominicano de Desarrollo Integral

Liliana Rocha, Health and Training Coordinator

Ramon Sefer, Information Systems Coordinator

Erudina Bulges, Area Supervisor

Promoters (2), La Zurza

SSID Servicio Social de Iglesias Dominicana

Andres Reyes, Director

Dr. Rafael Garcia, Health Coordinator

Supervisors in Barahona (Region IV)

PLANSI/SESPAS Plan Nacional de Supervivencia Infantil

Dr. Johnny Rivas, Director

Dr. Angelo Avila, Immunization Coordinator

Fanny Celeste Diaz, Region VI Health Educator

Rosa Rodrigues, Region VI MCH Nurse

Plan International

Alexander Gray, Director

Dr. Felix Alcantara, Health Program Coordinator

Francisco Urano, Supervisor of Promoters

UNICEF

Ilsa Nina, Technical Coordinator

ADOPLAFAM

Alta Gracia, Health Coordinator

Caritas

Maritza Martinez, Health Program Coordinator

Anny Diaz, Educator

Eulalia Jimenez, Administrator

Virtude Roa, Region VI Coordinator

PRITECH

Dr. Clydette Powell, Consultant
Glenn Patterson, Consultant

S&T/H/AR

Jim Heiby (per telephone)