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SANTO DOMINGO, DOMINICAN REPUBLIC



FINAL EVALUATION REPORT

CHILD SURVIVAL PROJECT IX

PLAN/AID

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Evaluation Team

Ramón J. Soto H., M.D., M.H.S.
Gustavo I. Tapia R., M.D., M.Sc.

With support from the PLAN/Santo Domingo Health Team
Ministry of Public Health and Social Assistance
Center for Popular Education

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EVALUATION TEAM

The final evaluation of the PLAN Santo Domingo/AID Child Survival Project IX was conducted by:

Ramón Jeremías Soto, M.D., M.H.S., Team Coordinator, who is currently on a Post-Doctoral Fellowship in the Fogarty Program of the University of Miami School of Medicine. Dr. Soto is Technical Assistant in the STD/AIDS Division of the Honduran Ministry of Health and Professor at the National Autonomous University of Honduras.

Gustavo Iván Tapia, M.D., M.Sc., is Health Coordinator in the PLAN Regional Office for the Caribbean and Central America.

Support was provided by:

Dr. Joe Valadez, PLAN International/IH

PLAN Health Team

Dr. Nelson Gómez
Baris Calderón
Daysi Rosado
Gladys Estévez
Ercilia Azcona
Violeta Novas

Dr. Rosa Robles, Director of the El Libertador Clinic, SESPAS

Dr. José Celis, CEP

LIST OF ABBREVIATIONS AND ACRONYMS

AIEPI	Integrated Management of Childhood Illness
ARI	Acute Respiratory Infections
ATS	Asistente Técnico de Salud (Technical Health Assistant)
BF	Breastfeeding
CDD/ORT	Control of Diarrheal Diseases/Oral Rehydration Therapy
CEN	Centro de Educación Nutricional (Center for Nutritional Education)
CEP	Centro de Educación Popular (Center for Popular Education)
CMC	Club de Madres Cariñosas (Caring Mothers' Club)
CONASUMI	Consortio Nacional de Supervivencia Materno Infantil (National Consortium for Maternal-Child Survival)
CS	Child Survival
DHP	Direct Health Providers (Physicians, Nurses)
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunizations
ENDESA	Demographic and Health Survey
HIS	Health Information System
IH	PLAN International Headquarters
INFOTEP	Instituto de Formación Técnica (Institute for Technical Training)
KPC	Survey of Knowledge, Practices and Coverage
MH/BS	Maternal Health/Birth Spacing
N/GM	Nutrition/Growth Monitoring
NGO	Nongovernmental Organization
ORS	Oral Rehydration Salts
PAHO	Pan-American Health Organization
PFV	Puestos Fijos de Vacunación (Permanent Vaccination Posts)
PLAN	PLAN International/Santo Domingo
PRODECO	IN Proyecto de Desarrollo Comunitario Integral (Integrated Community Development Project)
PSI	Proyecto de Supervivencia Infantil IX (Child Survival Project IX)
PVS	Promotores Voluntarios de Salud (Volunteer Health Promoters)
ROCCA	PLAN Regional Office for the Caribbean and Central America
SESPAS	Secretaría de Salud Pública y Asistencia Social (Ministry of Public Health)
SILOS	Sistemas Locales de Salud (Local Health Systems)
UASD	Universidad Autónoma de Santo Domingo (Autonomous University of Santo Domingo)
UNICEF	United Nations Children's Fund
UROC	Unidad de Rehidratación Oral Comunitaria (Community Oral Rehydration Unit)
URO	Unidad de Rehidratación Oral (Oral Rehydration Unit)
USAID	United States Agency for International Development
WHO	World Health Organization

Note some acronyms are not standard usage; modifications with translation from Spanish.

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EXECUTIVE SUMMARY

The evaluation was conducted during the period between December 1 and December 17, 1996. Visits were made to the Child Survival Project (PSI) operating areas, which included both health facilities and local organizations. Both qualitative techniques (focus groups and formal interviews) and quantitative techniques (survey of knowledge, practices and coverage) were used to gather the required data and information.

The principal achievements of the PSI are listed below:

There has been an increase recorded in terms of knowledge, practices and coverage in most of the interventions as compared to levels existing at the beginning and mid-point of the project. Seventy-eight percent of the mothers of children under age 2 years are communicating messages promoting maternal-child health to other mothers.

A strategically planned process for transferring responsibilities for implementation of PSI activities to local organizations has been installed. PLAN has encouraged the strengthening of local efforts as a basic strategy for achieving sustainability.

All of the local organizations with which PSI/PLAN has coordinated activities are in the process of integrating maternal-child health interventions and expanding both their approach and the quality of the services provided. The latter is particularly relevant in the case of SESPAS (Ministry of Health and Social Assistance) health facilities.

A particularly substantial benefit provided by this project to PLAN is the change in administrative and management focus, as the experience has led to a process of qualitative institutional growth in terms of effective and sustainable maternal-child health processes and technologies.

The PSI has created and strengthened the role of the Volunteer Health Promoters (PVS) as a valuable community resource. The PVSs show a vocation of service and a commitment to conducting maternal-child health prevention and promotion activities and have become the backbone of PSI operations.

The PVSs have maintained a high degree of enthusiasm despite the elimination of direct economic incentives. The current focus is implementing ongoing training, strengthening the sense of community ownership, facilitating the systematic incorporation of PVSs into the SESPAS health service centers, and taking advantage of every opportunity to give recognition to PVS efforts.

PLAN has successfully consolidated its credibility and leadership, perhaps to a large extent because it has begun to play a role as process facilitator rather than limiting its involvement to implementing CS interventions. Interinstitutional coordination with both government and

nongovernmental organizations (NGOs) acquired recognition during the final year of the PSI. This has required creativity, management skill and technical knowledge, ingredients which PLAN has been able to successfully integrate into its team of personnel.

The lessons learned are summarized below:

The process of local strengthening requires creativity and community commitment; community resources having both natural and technical credibility (i.e., PVSs) are needed as operational counterparts. Creativity and technical knowledge have led to the identification and shaping of instruments and technologies for evaluating and strengthening the human resources and local organizations that assume responsibility for maternal-child health interventions.

Implementation of PSI/PLAN has made it possible to acquire experience in coordinating activities with government institutions through formal mechanisms and agreements. It sets forth concrete commitments and provides an official "entity" that can be monitored by the communities and by the local government health service centers themselves.

It has been demonstrated that creating groups such as Caring Mothers' Clubs (CMC), which are formed by providing incentives, are not as sustainable as groups which occur naturally within the community.

The implementation of a simple technology (carrying case) in which mothers can keep their children's vaccination and growth monitoring cards has greatly improved the maintenance of these documents. This is an important outcome not only affecting children's health, but also for monitoring and evaluating interventions.

The most important recommendations are listed below:

- Continue to facilitate the training process as regards the coordination and transfer of technical and management knowledge and skills to local organizations and SESPAS.
- Establish a process of accompaniment with regard to the transfer of responsibilities to local organizations with a view toward providing technical and financial support in the process of strengthening local capability. Implementation of the interventions, however, should be the responsibility of local counterparts.

This process of accompaniment will make it possible to:

- ◆ Continue to promote the implementation of the Local Health Systems (SILOS) approach in the area of Herrera. This sustainable and effective strategy for improving maternal-child health will benefit the most vulnerable population groups.

- ◆ Facilitate a more participative process for analyzing information (by the community). Efforts aimed at developing the ability to analyze information for decision-making purposes should be continued. The transfer of the Health Information System (HIS) to local SESPAS health care service centers represents a valuable opportunity to strengthen a model of this type.
- ◆ Monitor the comprehensive strategic plan prepared by representatives of SESPAS, PLAN, the Center for Popular Education (CEP) and other organizations, which is intended to ensure the continuity of PSI activities.
- ◆ Support the SESPAS initiative of introducing the new WHO/PAHO (World Health Organization/Pan American Health Organization) package known as “Integrated Management of Childhood Illness” (AIEPI).
- ◆ The lessons learned from this project will have a greater likelihood of being both applicable and replicable if community structures are strengthened; if the exchange and analysis of information among the various health providers is facilitated; if PVSs are empowered to discuss and analyze, on an appropriate technical basis, the information gathered; if the concept of an interdisciplinary health team is accorded due relevance— if, in short, management systems are strengthened at the local level.

I. INTRODUCTION

The Dominican Republic's children and reproductive-age women are still at risk of dying from preventable diseases. According to UNICEF (The State of World's Children, 1996), 45 children out of 1000 live-births die before reaching five years. The most common causes of children's death are diarrheal diseases (17.7%) and acute respiratory infections (6.6%). These risks are even higher in poor urban slums and in rural areas, which points to the urgent need for child survival programs in these areas.

The peri-urban area of Herrera, where CS IX interventions have been carried out, is located in the western sector of the city of Santo Domingo, capital of the Dominican Republic. The neighborhoods included in the PSI were subdivided into six operating areas: Altagracia (consisting of the neighborhoods of El Palmar, El Abanico and Altagracia); Buenos Aires (consisting of the neighborhood of Buenos Aires); Duarte (consisting of the neighborhoods of Las Palmas, San Francisco and Duarte); Enriquillo (consisting of the neighborhoods of Enriquillo, La Venta, Los Transformadores and Los Pinos); Libertador (consisting of the neighborhoods of Libertador and Holguín Abajo); and Los Coquitos (consisting of the neighborhoods of Los Coquitos and Aeropuerto Viejo). These areas contain approximately 155,000 inhabitants.

A majority of the families live in dwellings located along the banks of streams, which have become dumping grounds for both solid and liquid waste. The continuing migration of families (which has been estimated at between 10 and 20% per year) in search of improved economic conditions and the prevailing low level of schooling are significant factors characterizing this area.

Residents come primarily from either rural areas or peri-urban areas located in other provinces of the country. This population has a high rate of unemployment which has influenced the intense informal commercial activities of street peddlers.

According to the HIS, the PSI has achieved a coverage of 2,315 children under age 2 years and 6,550 women between the ages of 14-49 years. The midterm evaluation, through the KPC survey, revealed that the level of literacy among mothers is quite low (less than 6%), which is lower than the average for Santo Domingo (8.9% according to ENDESA [Demographic and Health Survey] 1991). With regard to infant morbidity (children under 2 years), diarrhea and ARI (acute respiratory infection) constitute the primary causes of death, at 22.3% and 21% respectively.

In the area of Herrera, SESPAS has been the primary provider of curative health services through two health subcenters (Las Caobas, which provides outpatient and specialized care including emergency services and minor surgery, and Engombe, with 40 beds and basic specialized services) plus three peripheral clinics (La Banderita in Buenos Aires, Inocencio Díaz Piñeyro in Altagracia, and Libertador in Libertador), which provide care in the areas of

general medicine, pediatrics and gynecology-obstetrics. There are a number of clinics and private physicians' offices, as well as clinics operated by NGOs and community organizations, most of which include medical staff whose salaries are paid by SESPAS. Most of the medical staff hold two or more jobs in the government or private sector which result in a high rate of turnover with few mechanisms available to monitor compliance with established work schedules.

There are more than 20 community organizations, with varying degrees of development and interest, conducting athletic, cultural, educational and/or health activities. Most are governed by bylaws, but very few have obtained legal status as NGOs. There are two umbrella associations for neighborhood groups: the Association of Organizations of Herrera, with 14 neighborhood groups, and the Patronato, with 10 groups. However, from a structural standpoint, both continue to be organizationally weak.

PLAN continues to participate in a SESPAS-sponsored committee, to which advisory assistance is provided by PAHO, designed to coordinate the efforts of organizations working in Herrera and Engombe to establish a pilot SILOS (local health system) in the area. The lessons learned from the PSI as well as project achievements recorded in the process of transferring responsibilities to SESPAS and local organizations are being taken seriously in the implementation of this initiative.

II. METHODOLOGY

For conducting the final evaluation, the evaluators prepared a preliminary work plan which was discussed with the PLAN Country Director, the PLAN Headquarters (IH) Health Program Coordinator in Arlington, VA, the Health Coordinator for the PLAN Regional Office for the Caribbean and Central America (ROCCA), and the PLAN/Santo Domingo Health Coordinator. Following appropriate consultations, and bearing in mind both the specific needs of the evaluation and the requirements of PLAN/Santo Domingo, two modifications were made to the plan for carrying out the evaluation process (see Annex 2, Work Plan).

The evaluation team was divided into two subteams to cover the various tasks involved:

Subteam	Members of the Subteam	Subject Matter Covered by Each Subteam
Qualitative Evaluation Team	Leader: External Evaluator PSI Members: Health Coordinator, 2 ATSS (technical health assistants)	1. Achievements 2. Sustainability
Team conducting the Survey of Knowledge, Practices and Coverage (KPC)	Leader: ROCCA Health Coordinator PSI Members: SESPAS Representative, CEP Representative, Country Health Coordinator, and 3 ATSS	1. Achievements 2. Effectiveness

Joseph Valadez, PhD., MPH, ScD, Health Program Coordinator based at PLAN's technical support office in Arlington, VA, provided technical input in designing the evaluation strategy. Particularly he reviewed the approach to certain methodological issues in establishing comparisons with baseline information and the data generated by the midterm evaluation in terms of project effectiveness.

Data collection was carried out using both qualitative and quantitative techniques. Following a review of relevant documentation and preliminary interviews conducted with members of the staff of the PLAN Office, it was possible to better identify the key actors for gathering the qualitative-type information.

Information was obtained from: ATs, direct health providers (management and health care personnel from SESPAS and local organization health service centers, including ATs); technical- and political-level managers and managers of SESPAS maternal-child health programs (central level); key informants (leaders of grassroots organizations and directors of local NGOs, including PVSs; directors of the National Consortium for Maternal-Child Survival (CONASUMI); and representatives of the Santo Domingo Autonomous University (USAD).

Guidelines were designed for conducting focus groups with these individuals, together with guidelines for conducting interviews with institutional personnel and community residents. (Annex 4)

Focus groups were conducted as follows:

ATs: 5 supervisors participated, and the focus group was held at the PLAN Office.

Representatives of local community organizations: 7 representatives participated, and the focus group was held in the Las Palmas community center.

PVSs: 6 physicians (directors and epidemiologists from SESPAS health facilities) and 2 PVSs participated, and the meeting was held in a locale belonging to the Las Caobas Health Subcenter.

In all focus groups, a reporter was present to take notes.

Interviews of key informants were held in the offices of SESPAS, CONASUMI, the USAD School of Health Sciences, and local NGOs. Annex 3 contains a detailed list of the individuals contacted, along with their respective organizations and titles.

A tour was conducted of PSI neighborhoods in Herrera and Altagracia. Six health facilities (Díaz Piñeyro Peripheral Clinic, El Libertador Clinic, the Las Caobas Subcenter and the Engombe Subcenter [all pertaining to SESPAS], the El Palmar de Herrera community clinic and the medical center operated by the Center for Popular Education) were visited.

The forms for collecting qualitative data contain the items stipulated in the USAID guidelines for conducting final evaluations of CS IX projects concluding in 1996. They also include items of specific interest to PLAN that might contribute to enriching the documentation on lessons learned and recommendations for the future.

The qualitative data was processed and analyzed so that it served as the primary source for the presentation of outputs and for the documentation of sustainability issues presented in this report. The significant preliminary findings, in terms of both effectiveness and sustainability of PSI interventions, were presented in a feedback meeting held with representatives of the communities, SESPAS, NGOs and others. The meeting included workshops for discussing, analyzing and presenting recommendations on the evaluation findings. The workshops

generated significant contributions which enhanced the conclusions and recommendations presented in this document.

A special presentation of the results was made at the first "Growing Up Healthy" workshop of the PLAN/ROCCA Regional Network, for the purpose of sharing lessons learned with health coordinators and country representatives. Health representatives from the Dominican Republic, Haiti, Guatemala, Honduras, El Salvador and Nicaragua attended the meeting. The purpose of the meeting was to exchange experiences, lessons learned and methods employed by the PSI which could contribute to improved quality of child survival programs in all countries in PLAN/ROCCA.

The specific methodology used in conducting the **KPC survey** is described below.

The preparation phase of the survey took place in November 1996, while the field work phase was carried out in December of the same year. The questionnaire used in the survey is based on the questionnaire developed by Johns Hopkins University, which was modified, adapted to the local language, and tested by the PLAN/Santo Domingo health team and PVSs from the various neighborhoods where the project is being implemented. (Annex 4)

The core team in charge of conducting the survey included representatives of PLAN/Santo Domingo and members of the staff of SESPAS and CEP with technical assistance provided by the Health Coordinator for PLAN/ROCCA.

Thirty clusters were selected and ten mothers of children under age 2 were interviewed in each cluster, providing a total of 300 mothers interviewed. Training was provided to five supervisors and 15 surveyors (all PVSs). All neighborhoods in the project area were included in the sample selection.

The information was processed on a portable computer using the EPI-INFO (Expanded Program on Immunization Information) program, Version 6, with key indicators constructed to measure project interventions. The results were then compared to the findings formulated in the baseline and midterm surveys and to the findings of maternal-child health surveys conducted in the metropolitan region (Region 0) by CONASUMI (National Consortium for Maternal-Child Survival) and ENDESA.

To allow comparison between the baseline, midterm and final surveys, the methodologies and instruments were reviewed. Except for the rates of vaccination and exclusive breastfeeding, most of the indicators are entirely comparable. The baseline survey review identified some methodological differences between this study and the standard, Johns Hopkins University Rapid KPC survey. This differences concerned the measurement of vaccination and exclusive breastfeeding rates. The midterm and final evaluations followed the standardized methodology more closely.

Regarding Expanded Programme of Immunizations (EPI) coverage, the rapid KPC survey requires the Vaccination Card as the only source of information, whereas the baseline survey also used respondents' recall or a different definition of the vaccination rate. Certain results reflect this difference: in the baseline survey report (Results of the Baseline Survey. August/93 page 14, Section: Vaccination), the percentage of children having vaccination cards (76.1%) was lower than the reported vaccination coverage (DPT3 92.5% and Measles 81.8%). In the midterm(July/95) and final surveys (December/97), vaccination rates were measured using JHU standardized procedures. The information source considered valid was the Immunization Card; children without cards were reported as not immunized. In determining vaccination rates, the numerator included only those children from 12 to 23 months whose cards indicated vaccination, and the denominator included all children from 12 to 23 months whether they had cards or not.

Regarding exclusive breastfeeding rates, the baseline study combined predominantly breastfed children with exclusively breastfed ones, instead of presenting exclusive breastfeeding rates only (See the DIP [Detailed Implementation Plan], page 3- Heading C.1 Baseline survey results. Subheading Nutrition. Paragraph 2 -).

Because of these methodological differences, the final evaluation compares vaccination and exclusive breastfeeding rates only with the midterm results.

III. ACHIEVEMENTS AND LESSONS LEARNED

A. PROJECT ACHIEVEMENTS

The PSI has recorded significant achievements, both in terms of effectiveness as well as sustainability. Concerted efforts have been made to establish a sustained community-based process that is coordinated both technically and administratively by local organizations and institutions.

The sustainability objectives, together with the steps taken and results obtained, are described in Table 3. An analysis of PSI achievements is provided below, with individual consideration given to each objective stated in the DIP:

1) The creation and strengthening of a community resource (PVSs) having a vocation of service and a commitment to conducting maternal-child health prevention and promotion activities has occurred. The PVSs have become the backbone of PSI operations.

When the PSI was launched in 1993, a specific, vertical-type structure was created in PLAN to recruit and train community residents (primarily women) to work as promoters in conducting CS education and promotion activities.

Table 1 describes the human resources involved in CS activities. In 1993, 1994 and 1995, the PVSs perceived themselves as working for PLAN, with a few PVSs also acknowledging their association with local organizations. In 1996, the outlook is the exact opposite; there are no PVSs associated with PLAN, 68% identify with local organizations (NGOs or grassroots organizations), and 100% have agreed to work under SESPAS coordination.

There are a number of instances of evidence demonstrating PVS commitment to their community. For example, despite the fact that in February 1996 PLAN opted to eliminate the specific economic and material incentives given to each PVS, attrition was minimal. (Table 1)

In addition, neither the seven-month medical strike in SESPAS (October 1995-April 1996) nor the presidential elections (May-August 1996) prevented the PVSs from continuing to perform their activities, as demonstrated by the levels of coverage achieved for each CS intervention. The PVSs have accepted SESPAS coordination even with the uncertainty of the Ministry's capacity to efficiently respond to this activity.

The PVSs have demonstrated their technical capability and organization. Although between March and June 1996 PLAN has been gradually and selectively transferring responsibilities for implementation of PSI activities, this fact has not dampened the enthusiasm of the PVSs. On the contrary, they have viewed this situation as a challenge to be undertaken with a high sense of responsibility. Thus, there are currently 10 community PVS supervisors conducting activities previously performed by ATs (employees paid by PLAN).

This has required PLAN to institute a process of training and technology transfer that has been underway for the past 18 months. These changes were based on the recommendations formulated in the midterm evaluation and the changes made to PLAN's operating approach.

TABLE 1. HUMAN RESOURCES IN THE PSI, BY YEAR AND ORGANIZATION

YEARS	INSTITUTIONS ORGANIZATIONS	HUMAN RESOURCES				
		ATS	PVS	SUPERVISORS	PHYSICIANS	NURSES
1 9 9 3	PLAN	6	143	4		
	NGOS				7	4
	COMMUN. ORG.		23			
	SESPAS				35	13
	SUBTOTAL	6	143	4	42	17
1 9 9 4	PLAN	6	143			
	NGOS			2	9	4
	COMMUN. ORG.		36			
	SESPAS				46	14
	SUBTOTAL	6	143	2	55	18
1 9 9 5	PLAN	6	150	2		

	NGOS		16	13	18	6
	COMMUN. ORG.		57	8		
	SESPAS				63	17
	SUBTOTAL	6	150	23	81	23
1	PLAN	5				
9						
9						
6						
	NGOS		28	5	17	5
	COMMUN. ORG		77	3		
	SESPAS		153	10	73	18
	SUBTOTAL	5	153	10	90	23

Note: The subtotal figures for PVSs and Supervisors do not agree with the sum of the figures, as several belong to both NGOs and community organizations.

2) A full-fledged process of transferring responsibilities aimed at ensuring the implementation of PSI technical and administrative activities by local organizations has now been installed. PLAN has selected and implemented as its basic strategy for achieving sustainability the strengthening of local efforts. (See the document entitled *Fortalecimiento del Esfuerzo Local, PLAN Santo Domingo, Creciendo Sanos, Annex 5.*)

This strategy is manifested in two key concepts: reducing dependency of PLAN beneficiaries on the organization and promoting mutual support and interdependence among local organizations (governmental, nongovernmental and grassroots). The strategy is based on a process of moving from the direct implementation of interventions to local strengthening by empowering local organizations to manage interventions, in this case maternal-child health interventions.

The observations presented as part of the final PSI evaluation indicate that 100% of CS technical activities have been transferred to local organizations. Between March and June 1996, direct responsibility for the interventions has been transferred to these organizations, through the work of the PVSs and administrative support (in the form of a number of

commodities) provided by SESPAS. PLAN is to accompany this transitional process, particularly by providing technical and, to a lesser extent, administrative support.

Among the steps taken (Table 4) to record the achievements described in item 2, the following stand out: development of profiles for local institutions and organizations, which has made it possible to analyze their strengths and weaknesses; selection of those organizations whose capabilities meet the requirements for implementing interventions and processes in the field of maternal-child health; signing of agreements, notably the agreement between SESPAS and PLAN; management training for the directors and staff of the organizations; the process of transferring the HIS to local service facilities (currently operated by the PVSs); and support provided in installing specific services (UROs [Oral Rehydration Unit], PFVs [Permanent Vaccination Posts] and CENs) managed by the PVSs.

3) The results of the KPC survey show that almost 78% of mothers with children under age 2 years are communicating messages promoting maternal-child health to other mothers.

This is an important contributing factor of the impact achieved by the PSI. (See the section on project effectiveness.) It is also reflective of the sustained work of the PVSs and of the intensive activities that have been carried out, on a one-time basis, taking advantage of pre-established occasions (i.e., World Health Day, Breastfeeding Day, World AIDS Day, National Vaccination Day), which have turned into periods of several weeks for promoting maternal-child health with maternal involvement. To this end, it has been necessary to intensify educational activity involving the production of large amounts of educational materials and the implementation of a large number of talks, conferences, and video screenings, among other techniques used. (See Table 3 on PSI outputs.)

To achieve Objective C (70% of mothers communicating educational messages on CS), the primary strategy employed was the creation of CMC. (See Table 4.) However, these clubs never achieved true autonomy or commitment. In actuality, they were dependent on the existence of incentives (a basket of articles for the newborn baby) given to each mother; when delivery of the baskets was eliminated, the clubs gradually disbanded.

In order to counter the possible negative effect on PSI effectiveness, it was decided that the PVSs would assume a more proactive role in educating mothers in places where mothers tend to congregate naturally (i.e., health facilities, CENs, PFVs, UROs, fairs, etc.).

4) The PSI was expected to improve the management systems of local organizations. The midterm evaluation determined that local organizations have many weaknesses, especially in the area of management, i.e., that little has been done in this regard. It was highly unlikely that this objective (Objective D, Table 4) could be achieved with the vertical style and structure maintained by the PSI through mid-1995.

PLAN has made a series of strategic changes in the operation of its Santo Domingo office, many of them facilitated by the PSI. Its management/administrative system has benefited greatly and a positive working environment has been created for both the health team and the rest of the teams managing the organization's sponsorship programs. A greater degree of maturity can be seen in the health team which is now directed by a professional with considerable administrative capacity. Assistance and direction are provided by the ROCCA Health Coordinator and the Country Director. All of the above have contributed to the consolidation of PLAN's credibility and leadership.

These changes made it possible to formulate the previously mentioned strategy of local strengthening, together with an instrument for measuring the capabilities of local organizations to implement interventions. In this way, it has been possible to affirm that most organizations do not meet the required criteria.

Using the instrument designed by PLAN (Annex 5), 18 organizations (both NGOs and community organizations) have been rated. Seven were classified as "strong", four as "weak", five as "very weak", and one as "very strong". The latter organization is SESPAS. It has been estimated that 40% of local NGOs are currently undergoing a process of strengthening and maturation and that 100% of SESPAS facilities are able in principle to undertake the task. This is an acceptable way of measuring achievements of Objective D.

By way of commentary, we feel that the instrument may be highly sensitive, but it appears to have a relatively low degree of specificity, perhaps because the criteria, although strict, are quite general. For this reason, SESPAS health facilities were given the highest rating. Our observations indicate that SESPAS services are managed by professionals who are well-intended but who have little or no experience in process management, teamwork, or the public health approach (a weakness not detected by the instrument).

It is important to emphasize the facilitation role played by PLAN to ensure that local organizations benefit from training activities provided by the Institute for Technical Training (INFOTEP) in administration and the formulation of a proposal to develop a program of continuing education, with emphasis on management (in which the SESPAS Department of Human Resource Development is a participant). Also an offer was made by the UASD, through the Dean of the School of Health Sciences, to grant academic credits for training personnel and local volunteers.

5) Local organizations have integrated CS interventions into their work plans. SESPAS facilities have been conducting their interventions through the application of the technical guidelines of the Maternal-Child Program, but with little or no community projection, i.e., they have limited their activities primarily to curative activities, perhaps owing in part to the management weaknesses existing at the various levels. In comparison to the rest of the organizations, the evolution has been quite favorable as a result of the role played by the PVSs and the operation of the PFVs, UROs and CENs.

Accordingly, 100% of the local organizations with which the PSI has coordinated activities are in the process of integrating maternal-child health interventions and expanding both their approach and the quality of the services they provide (the latter is particularly applicable in the case of SESPAS health facilities). Several such health facilities have developed operating plans with the participation of PVSs.

6) To measure precisely the degree to which Objective F has been achieved, it would be necessary to conduct a cost study that it is beyond the scope of this evaluation. However, based on a number of criteria, we feel that most CS activity costs have begun to be absorbed by local organizations.

Thus, human resources (PVSs, Community Supervisors) constitute a community contribution. It is estimated that the two-hour work day of each PVS is equal to US\$1.70 (based on the minimum wage of US\$161.54, 23.83 working days in the month as established in the Dominican Labor Code, and the 8-hour work day), in addition to the professional resources provided by the organizations, including SESPAS (Table 1).

SESPAS has taken on the responsibility for providing commodities such as oral rehydration salts and vaccines. Others, such as educational materials, cards, registration forms, and training activities have been supported by PSI/PLAN, with sponsorship and technical contributions provided by SESPAS. The SESPAS-PLAN agreement signed in November 1996 formalizes coordination between the two organizations and establishes SESPAS's commitment to absorbing the operating costs of CS interventions.

In addition, local organizations have continued to conduct isolated activities aimed at obtaining funds directly, and some (NGOs) have established cost recovery quotas with regard to certain services. These organizations have benefited from the PSI experience and from the training and technical assistance facilitated by PSI/PLAN, to the point that they are being empowered, in terms of both capability and credibility, to seek funds from other national and international agencies.

Some effects that were perhaps not expected include: the change in the *modus operandi* of PLAN Santo Domingo, thanks in part to the accumulated experience provided by implementing the PSI, which has been extended to other PLAN offices in the Dominican Republic; the consolidation of PLAN leadership and credibility with government agencies and NGOs working in the country; the smooth coordination achieved with SESPAS; and the contribution of practical experience achieved at the local level in the process of systematization that provides an appropriate opportunity for implementing the SILOS approach in an urban setting.

In addition, a "negative" effect that was perhaps not expected was the disintegration of the CMCs, which had been considered as somewhat of an innovation, especially in terms of

promoting a specific intervention breastfeeding (BF). However, for the reasons set forth above, these clubs were not sustainable.

B. PROJECT EXPENSES

**TABLE 2. PSI BUDGET IMPLEMENTATION
FISCAL YEARS 1994-95 AND 1995-96
(IN US\$)**

Code/Description	7/1/1994 - 6/30/1995			7/1/1995 - 6/30/1996		
	Budgeted	Executed	Percentage	Budgeted	Executed	Percentage
B3. Travel/Perdiem Field-In Country	18,982.93	18,405.22	97	14,282.43	14,756.77	103.3
C1. Evaluation Consultants Fees	-	-	-	17,500.00	5,139.52	29.4
C2. Other Consultants Fees	13,615.71	1,565.41	11.5	12,301.86	5,139.52	41.8
C3. Consultants Travel/Perdiem	6,050.89	5,037.14	83.2	16,888.71	10,742.01	63.6
D1. Supplies	40,057.39	28,301.00	70.6	67,705.43	62,603.03	92.5
E3. Other Field	3,854.21	86.02	0.4	-	-	-

A comparison of fiscal years 1994-95 and 1995-96 reveals an increase in the percentages of expenditure execution in the final fiscal year. Since a no-cost project extension was approved, it is expected that all project funds will have been expended by the end of 1996; for example, the table does not include all of the expenses for conducting the final evaluation. Attached is a pipeline analysis for the project. (Annex 8)

C. LESSONS LEARNED

This project has left as a legacy a wide variety of very important lessons and experiences in the implementation of health interventions. Specifically, maternal-child health interventions in marginal urban areas that may be replicable in other cities and countries after appropriate adaptations to take into account the local context.

The most visible lessons learned include the following:

The PSI's vertical styles of management and leadership may have an excellent short-term impact but are unable to promote sustainable processes, particularly because they lead to a high degree of technical, administrative and financial dependency. In addition, they can lead to inefficiency and a working environment characterized by tension and unproductive competition. These styles are in direct opposition to strictly horizontal and, as a rule, disorganized styles, which fail to include even the minimum required control and which always tend to fail because they cannot produce an impact to achieve sustainability. Generally speaking, there are no magical formulas or prescriptions for directing community processes, such as those of the PSI. Accordingly, it is important to have installed a monitoring process which can measure the levels of effectiveness and sustainability achieved by a given program or project.

The process of local strengthening requires creativity and community commitment; community resources having both natural and technical credibility (for example, PVSs) are needed as operational counterparts. Creativity and technical knowledge lead to the identification and shaping of instruments and technologies for evaluating and strengthening the human resources and local organizations which assume responsibility for carrying out maternal-child health interventions.

Sustainability involves the institutionalization of processes, values and interventions, as well as the ability and willingness of local counterparts to assume responsibility for their financing. The implementation of PSI/PLAN has made it possible to acquire experience vis-à-vis the need to establish coordination with government institutions by means of formal agreements. These agreements set forth concrete commitments and provide an official "entity" that can be monitored by the community and local government health service centers.

Frequently, human resources are not valued to the full extent of their worth; direct economic or material incentives constitute the naturally accepted form of remuneration. Accordingly, this is the method most commonly used by social projects to ensure the availability of human resources at the community level. In addition, technical training is important in terms of specific project interventions or operations. But equally or more important is community commitment and the degree of credibility that a given resource may acquire through the PSI. This is most likely what has happened with PSI/PLAN. Although direct economic incentives

were eliminated, other options have been identified in terms of training, university-level academic accreditation, and credibility in the community and with the health service centers, that have made it possible to maintain both the quality and quantity of PVSs working in CS in their communities.

More specific lessons include the following:

There was a lack of vision when creating groups such as the CMCs ---not originating naturally in the community but as a result of interest in a material incentive. When the incentive was discontinued, these groups tended to disband, as is the case of the PSI. This is different from the situation observed in the case of the PVSs, where most are members of groups that were previously organized to respond to community needs.

The implementation of a simple technology such as the carrying case or the plastic bag that is both presentable and practical while providing the mother with a place to keep her children's health and growth monitoring cards has had a positive effect on the maintenance of these very important documents. It has also had a positive effect on the health care received by the children and on the monitoring and evaluation of project interventions.

IV. OUTPUTS AND EFFECTIVENESS

A. PROJECT OUTPUTS

The following table compares the targets specified in the Child Survival Project's Detailed Implementation Plan (DIP), with the results actually achieved by the end of the project's third year.

TABLE 3. PROJECT RESULTS AND OUTPUTS, BY INTERVENTION

Expected Outputs	Third Year (Dec/96)		
	Goal	Achieved	
		#	%*
EPI (Immunization Program) # of staff trained (PLAN, SESPAS)	20	48	240.00
# of PVSs trained in immunizations	155	175	112.90
# of permanent vaccination posts	15	18	120.00
# of vaccination campaigns conducted	4	6	150.00
# of children between the ages of 12 and 23 months who received all of their vaccinations (BCG, DPT, polio and measles) prior to the end of the year	2,200	4,036	183.45
# of pregnant women between the ages of 15-49 vaccinated with TT2	1,500	1,372	91.47
New children in the area who received the vaccination scheme	300	464	154.67
CDD/ORT (Control of Diarrheal Diseases/Oral Rehydration Therapy) # of staff trained (PLAN, SESPAS) in CDD	40	41	120.50
# of PVSs trained in CDD/ORT	155	173	111.61
# of institutional and/or community UROs	4	7	175.00
# of packets of oral rehydration salts distributed	55,000	60,900	110.73

Expected Outputs	Third Year (Dec/96)		
N/GM (Nutrition/Growth Monitoring) # of PVSs trained in infant nutrition	155	175	112.90
# of PVSs equipped for growth monitoring	155	148	95.48
# of PVSs trained in nutritional recovery	6	12	200.00
# of institutional Centers for Nutritional Education	6	5	83.33
# of children weighed in the past three months	3,440	5,175	150.44
MH/BS (Maternal Health/Birth Spacing) # of PVSs trained in maternal care	155	170	109.68
Control of ARI # of PVSs trained in control of ARI	155	176	113.55
# of SESPAS and NGO physicians trained in ARI	40	41	102.50
HIV/AIDS Prevention # of PVSs trained in HIV/AIDS	155	168	108.39
# of NGO and SESPAS physicians trained	40	60	150.00

* % achieved compared to target. $d = (c/b) * 100$

In addition, the following activities, not initially specified in the DIP but rather based on the recommendations presented in the midterm evaluation, were carried out with a view toward strengthening the interventions and making them more dynamic:

100,200 educational materials on nutrition were distributed; 4 special breastfeeding promotion campaigns were carried out; 13 health centers were added to enable PVSs to give talks on breastfeeding; 33 SESPAS staff members received training in maternal health care; 11,500 contraceptives were distributed; 100,200 educational materials on maternal health care, ARI and HIV/AIDS were distributed; and 16 screenings of films and videos on HIV/AIDS were held.

PSI outputs for 1996 clearly reflect the level of effort put forth by the PLAN health team. As mentioned in the preceding sections of this report, the individual PVSs constitute the backbone of direct operations. In addition, a high degree of local coordination with health service centers and organizations is evident. It is highly unlikely that the PLAN health team could, working by itself, have achieved such high levels of productivity.

B. EFFECTIVENESS OF INTERVENTIONS

PSI effectiveness was measured through the use of the KPC survey and observation of the procedures described in the section on methodology. The purposes of this survey were as follows:

To evaluate project achievements against the objectives set forth in the DIP for the following components: appropriate child feeding and nutrition, control of diarrheal diseases, control of acute respiratory infections, immunizations, maternal health care, family planning and prevention of HIV/AIDS.

To evaluate the effect of actions taken by the project subsequent to the midterm evaluation, based on the recommendation made by the evaluators.

To improve the ability of the PLAN health team, SESPAS, CEP and community health leaders to conduct KPC surveys.

The survey revealed the following:

Overall project coverage. With regard to the recommendation made in the midterm evaluation, the project successfully improved its coverage in the areas of Herrera and Altigracia. The percentage of project-affiliated mothers rose from 67% (as of the midterm evaluation, July 1995) to 80% (in December 1996), which in addition had a clearly positive effect on improving coverage in several project interventions.

Immunization. Conservation of children's growth monitoring and vaccination cards improved significantly. The percentage of mothers who were able to present their children's vaccination cards increased from 76% (baseline, August 1993) to 88% (December 1996). Child vaccination coverage (based on the vaccination cards) also increased as compared to the midterm evaluation. Coverage for **BCG** increased from 61.9% to 82.2%, coverage for **Polio 3** from 63.4% to 80.8%, coverage for **DPT 3** from 61.9% to 80.8%, and coverage for the **measles** vaccine from 63.4% to 78.7%. These levels of coverage are considerably higher than those reported by CONASUMI in a recent survey (November, 1995) conducted in the metropolitan region as part of its external evaluation. (Coverages in accordance with the vaccination card, as reported by the CONASUMI external evaluators were BCG, 59.9%; polio 3, 56.6%; DPT 3, 60.5%; and measles, 52.6%.)

Feeding and Nutrition. The project achieved considerable improvement in growth monitoring activities. In the baseline, only 34% of mothers were able to present a growth monitoring card, and of the total number of children with a card, only 54.4% had been weighed in the preceding four months (i.e., 18.7% of the total number of children surveyed). In this survey, 85.3% of the mothers were able to present their children's growth card, and 80.4% of these children had been weighed in the preceding four months (i.e., 68.7% of the total number of children surveyed). 25.4% of children under age 4 months are being breastfed exclusively.

This figure is much greater than that reported for the country as a whole, which includes both urban and rural areas (5.0%), particularly in view of the fact that the project is a peri-urban area, where figures are traditionally lower than in rural areas.

Control of Diarrheal Diseases. Diarrhea prevalence decreased from 53.6% (baseline, August 1993) to 22.3% (midterm evaluation, July 1995) and remained low (21.7%) in the current survey (December 1996). ORT coverage increased from 56.3% (baseline, August 1993) to 72.3% (December 1996).

Control of ARI. 60.9% of children with cough and rapid breathing were taken to a hospital, a health post or center, or a private physician.

Maternal Health. With regard to vaccination of pregnant women, possession of a maternal health card increased from 23.1% (in July 1995) to 47.7% (in December 1996). Coverage for tetanus toxoid vaccination (as shown by the vaccination card) increased from 17.7% to 44.3%. The survey also measured this coverage by applying the recall method, with the results showing that 88.0% had received two or more doses of tetanus toxoid.

HIV/AIDS. This is the most recent intervention, having been introduced subsequent to the midterm evaluation. This fact notwithstanding, 79% of all mothers indicated that they had received messages on HIV/AIDS prevention in the project area. 68.6% were able to mention two or more ways in which HIV/AIDS is transmitted without mentioning a single form of incorrect transmission. These figures are higher than those found in the midterm evaluation. During the mid-term evaluation (which constituted the baseline for the HIV/AIDS component), no mothers were able to list the three ways in which HIV/AIDS is transmitted (by sexual relations, by contaminated blood, and from mother to child); in the current survey, this figure increased to 15%. 70.6% of the mothers were able to mention two or more appropriate ways to prevent HIV/AIDS, while in the midterm evaluation, the corresponding figure was only 37.7%. These findings suggest that the project is successfully changing knowledge with regard to prevention of HIV/AIDS and that it is necessary to intensify efforts in order to continue to bring about significant changes in the area of HIV/AIDS prevention.

Through feedback meetings with members of the staff of PLAN, SESPAS, local NGOs, PVSs and other community leaders, the evaluation results were presented, and the reasons behind the findings were discussed, in an effort to explain and complement the data obtained. According to the participants, the data reflect the actual situation. During these feedback meetings, the commitment of local organizations (SESPAS, CEP and others), community organizations and PVSs, to sustain and improve project achievements was evident. For PLAN, this survey constitutes the final project evaluation. While for SESPAS and the CEP, which have assumed responsibility for the continuation of project activities, this survey constitutes their baseline.

V. SUSTAINABILITY

A. COMMUNITY PARTICIPATION

It could be said that the current capability of local community organizations to provide human, technological, financial and physical resources for sustaining activities at the conclusion of the PSI varies widely.

By applying the PLAN instrument, an assessment was conducted of the capabilities of eight community, grassroots, or neighborhood organizations, with the results showing that 100% are either weak or very weak and require direct financial support. According to the ATSS, most of the organizations have been strengthened by the presence of PSI/PLAN. Some of the concrete examples mentioned include the following:

PRODECOIN, which began as a neighborhood group, currently has legal standing as an organization. It has its own physical space and human resources (PVSs), and a health clinic staffed by two SESPAS-subsidized physicians and a small pharmacy. It has a very simple accounting system for controlling income and expenses, and generates funds through user cost recovery fees, excursions, parties and raffles.

Núcleo de Salud Las Abejas, which began with six members, today has a total membership of 26, nine of whom have become involved in PSI activities either as PVSs or Community Supervisors.

Padres Comunitarios, which began as a neighborhood group, has installed a URO and a permanent vaccination post, and now conducts regular environmental sanitation activities. One way it generates income is by offering funeral services.

Several community leaders are of the opinion that their organizations have been strengthened by PLAN through the provision of physical infrastructure, technical advisory assistance, and specific training in health interventions and administrative topics.

The characteristics of these organizations can be summarized as follows:

They reflect a heterogeneous degree of development, with some having achieved a significant degree of credibility, primarily in the area of health, as a result of the positive effects of the PSI as perceived by the community (decrease in child morbidity from diarrhea and ARI and in morbidity among women produced by maternal causes). This has encouraged a number of organizations to further their involvement in these activities (having facilitated the installation and operation of UROs and PFVs). From the financial standpoint, these organizations are very weak.

The directors have indicated their intention to sustain the achievements recorded as a result of the PSI through the contributions of volunteers (PVSs), efforts to obtain support from a number of different government and nongovernmental organizations, and coordination with SESPAS.

They feel that SESPAS, as the government organization charged with ensuring public health, is the most appropriate entity to coordinate activities with a view toward maintaining achievements and improving health status in the community. However, they recognize that the services provided by SESPAS are affected by a number of inefficiencies, such as the sporadic availability of drugs.

B. NONGOVERNMENTAL ORGANIZATIONS

The current capability of associated NGOs to provide the human, technological, financial and physical resources required to achieve the sustainability of project activities at the conclusion of the PSI is severely limited.

An analysis of the specific cases of CEP and PRODECOIN produces the following profile:

- Both conduct child survival interventions
- Both have medical staff paid by SESPAS
- Both have a locale donated by PLAN
- Both have community human resources (PVSs)
- Both have installed UROs and permanent vaccination posts
- CEP conducts activities in the areas of education and environmental sanitation and has a history of coordination with the UASD
- PRODECOIN is weaker in administrative terms as well as in the academic level of its directors, and therefore requires much greater technical support
- Both charge a cost recovery fee for some services, which is seen as being one of their primary sources of income. One of their goals is to continue to diversify the health services available at the clinics (for example, laboratory services)
- Although their management systems are weak, the support currently being provided by PSI/PLAN is serving to strengthen those systems

- Both need to develop their ability to analyze health information for decision-making, both for the staff involved in health interventions as well as at the community level, so as to involve communities in the process of determining their own health situation as well as in the search for solutions.

- Both are quite willing to coordinate activities directly with SESPAS, but are uncertain as to whether this organization will be able to provide an adequate response with regard to coordination of PVS activities, provision of basic commodities for health promotion and education, and delivery of appropriate care in the area of maternal-child morbidity.

PLAN needs to continue to explore the possibility of establishing partnerships with other national NGOs rated as strong in accordance with the criteria employed, to ensure the extension of PSI achievements and application of the lessons learned. This will not only ensure that such organizations will be of considerable use but also, and more importantly, improve the health status of mothers and their children.

C. COUNTERPART CAPABILITY AND DESIRE TO SUSTAIN ACTIVITIES

SESPAS has expressed the political will to continue the process of implementing and sustaining project activities. A concrete expression of this will is the cooperative agreement signed in November 1996 by the Minister of Health and the Director of PLAN.

This agreement sets forth PLAN's commitment in terms of encouraging PVSs to continue to work under the leadership of SESPAS; transferring the materials and equipment acquired for providing services in the area of Herrera; and coordinating efforts to support child survival, reproductive health and HIV/AIDS prevention projects identified by SESPAS and other organizations, provided that they meet PLAN requirements and eligibility criteria.

Accordingly, SESPAS commitments are: to officially recognize and accept those PVSs who opt to continue providing voluntary services under Ministry leadership, to assume responsibility for their supervision and continuing education, to facilitate the implementation of a process of decentralization, to continue implementation of child survival activities begun by PLAN, and to strengthen referral and counter-referral mechanisms by level of complexity in the area of Herrera.

Following is a brief overview of local health facilities operating in the area of Herrera:

- Child survival interventions requiring medical care have been carried out in the health facilities existing in the area.
- Most of these are attached to SESPAS, others are administered by local NGOs, generally with SESPAS support for medical personnel.

- Health facilities have enjoyed financial support provided by PLAN (infrastructure, drugs, furniture, equipment, commodities).
- Medical personnel have received training in child survival interventions.
- Health facility management/administrative systems are weak.

The principal weaknesses of SESPAS health facilities are:

- Low levels of management ability of health facility directors.
- Low levels of management and logistic capabilities of the Area and Regional levels to respond to local needs.
- Lack of ability to conduct epidemiological analyses of information at the local level.
- Minimal capabilities to mobilize local organizations.
- Weak system of supervision.
- Deficiencies with the timely and continuous availability of basic drugs and medical supplies.
- Low levels of technical support.
- Little experience in teamwork, with the exception of a few individual activities (vaccination campaigns).

However, the individuals in charge of the health centers are willing to assume responsibility for coordinating the activities of the PSI/PLAN PVSs. They feel that this is a significant opportunity to improve the quality of service. Some have had individual experience in coordinating PVS activities, although it has been acquired under the tutelage of PLAN.

Several of the facilities have prepared an operational work plan based on the overall strategic plan developed by SESPAS, PLAN, CEP and CONASUMI, in which they were likewise involved.

The health center directors have doubts with regard to the ability of SESPAS to undertake responsibility for coordinating and integrating PVSs into health teams. These doubts are explained in part by the above-mentioned weaknesses, but also by the fact that they have no practical experience with the concept of a health team, as their activities have been limited to clinical care based on a curative approach. In addition, they are uncertain as to SESPAS's financial ability to integrate PVSs as SESPAS employees, or at least to provide a level of incentive for PVSs sufficient to maintain their active involvement.

In addition, it is the opinion of the SESPAS Undersecretariate for Planning that there are a number of deficiencies that the institution needs to correct, i.e., the lack of management capability, the poor quality of services and the low degree of staff motivation. This undersecretariate feels that the implementation of a pilot model of decentralization using the SILOS approach represents a significant opportunity. It would be a timely move because work has already been carried out with the community, and one or two fora have been conducted at the community level. The undersecretariate also feels that efforts to transfer PVSs to SESPAS have broken down, and that this impacts negatively on institutional credibility. It is felt that SESPAS has not yet had a significant involvement because it has been involved in institutional reorganization activities.

An important specific issue is the process of transferring the HIS that PSI/PLAN has been promoting. For this purpose, an appropriate locale has been identified (in the SESPAS El Libertador Clinic). PLAN will donate a computer. The system is operated by trained PVSs, who input the data and obtain the required output. The idea is to conduct a monthly analysis of information with the participation of PVSs, SESPAS staff, ATs and the community. This process had been coordinated with staff at the SESPAS Data Processing Department, who feel that the potential exists to create a computerized HIS model at the local level.

D. SUSTAINABILITY PLAN

GOAL, OBJECTIVES, STEPS TAKEN AND RESULTS ACHIEVED

Goal: To achieve a sustainable health status for the maternal-child population

Objectives	Steps Taken to Date	Results
<p>A) 95% of the PVSs will belong to community organizations</p>	<ol style="list-style-type: none"> 1) Coordination meetings with representatives of the various levels of SESPAS, NGO leaders and community organizations 2) Development of the profile of local organizations (community, NGOs, SESPAS health service facilities) 3) Consultation meetings with the PVSs 4) Elimination of PVSs economic incentives 5) Rating and selection of local organizations for transfer of PSI resources and technologies 6) Signing of an agreement between SESPAS (Minister of Health) and PLAN (Country Director) to formalize the transfer of human resources (PVSs, Community Supervisors), materials and equipment 	<p>100% of PVSs belong to local organizations, and their technical coordination is the responsibility of SESPAS and CEP local service centers</p>
<p>B) 60% of PSI technical and administrative activities will be conducted by community groups, local NGOs and SESPAS</p>	<ol style="list-style-type: none"> 1) Steps 1-6 described in the preceding objective 2) Middle management training for NGO and SESPAS personnel 3) Development of the PVS Community Supervisor profile and selection of PVS Community Supervisors (PVSs having the greatest degree of experience and qualifications) 	<p>100% of PSI technical activities have been transferred to local organizations</p> <p>It is estimated that 70% of the PSI administrative activities (training, supervision,</p>

Objectives	Steps Taken to Date	Results
	<p>4) Recruitment and training of new PVSs</p> <p>5) Refresher training in PSI interventions for PVSs, community organizations and SESPAS</p> <p>6) Transfer of the HIS to local health service centers (training of PVSs in the operation of the HIS, coordination with the SESPAS central-level Data Processing Department)</p> <p>7) Installation of 7 UROs, 5 CENs and 18 PFVs in SESPAS and NGO operating units (most of these facilities are staffed by PVSs)</p> <p>8) Development of a comprehensive strategic plan to provide follow-up to the process of transferring the PSI to local organizations</p> <p>9) Technical advisory assistance provided to local organizations in the development of child survival projects</p> <p>10) Presentation, evaluation and approval of child survival projects to receive financial support from PLAN</p> <p>11) Coordination with the UASD and SESPAS for implementing the Project for Teaching Breastfeeding in the program of studies of the School of Health Sciences</p>	<p>coordination, planning) are being conducted by local SESPAS health service centers</p> <p>It is estimated that 20% of these activities are being conducted by local NGOs</p> <p>It is estimated that approximately 10% of administrative activities (procurement of materials, equipment and other commodities, facilitation of coordination among institutions) are conducted by PLAN</p>
<p>C) 70% of mothers with children under age 2 will have the ability to communicate PSI messages to other mothers</p>	<p>1) The PVSs have given educational talks to pregnant mothers in SESPAS and NGO health facilities</p> <p>2) Distribution to mothers of educational materials related to the various PSI interventions</p>	<p>77.5% of mothers with children under age 2 years are communicating maternal-child health messages to other mothers, according to the final KPC survey</p>

Objectives	Steps Taken to Date	Results
	3) Involvement of groups of mothers in educational campaigns (health fair, World Health Day, HIV/AIDS, breastfeeding, vaccination day).	
D) The project will improve management systems (supplies, maintenance, transportation, communication, health information system) in 60% of NGOs, SESPAS service centers and neighborhood organizations providing health care at the local level	1) Steps 1-10 described in Objective B 2) Coordination with INFOTEP and the SESPAS Department of Human Resource Development to implement a program of continuing education on management and technical topics 3) Coordination with SESPAS and the UASD School of Health Sciences to accredit the training received by PVSs and health personnel 4) PLAN has supported and promoted the SESPAS initiative to apply the SILOS approach in the area of Herrera	41% of NGOs and local organizations (7/17) have strengthened their management systems in accordance with rating criteria designed by PLAN 100% of SESPAS health facilities (5/5) have strengthened their managements systems in accordance with rating criteria designed by PLAN
E) Integration of the PSI will be initiated with 60% of NGOs, SESPAS service centers and neighborhood organizations	1) Steps 1-10 described in Objective B	100% of the local organizations selected are in the process of integrating the PSI into their work plans
F) 20% of project expenses will be maintained with community contributions and the remaining 80% will be covered by SESPAS and	1) Steps 1-10 described in Objective B 2) Local community organizations contribute human resources (PVSs and Community Supervisors) 3) SESPAS, through an agreement signed with the Minister of Health, has agreed to strengthen the ongoing provision of training,	Taking into consideration the contribution in terms of human resources in the form of PVSs and medical personnel, local organizations (NGOs, community and SESPAS) are contributing the

Objectives	Steps Taken to Date	Results
other NGOs	<p>supervision, and supplies for PVSs through appropriate budgetary allocations to health facilities</p> <p>4) Local NGOs have received technical assistance in project development and funds recovery through the sale of services, drugs and other activities (excursions, raffles, parties, etc.)</p>	<p>greatest percentage of PSI costs. An estimated contribution of US\$1.70 per day per PVS has been calculated</p> <p>SESPAS contributes the greatest percentage of PSI operating costs through budgetary allocations assigned to health facilities</p> <p>Through specific projects for child survival interventions that have begun to be implemented by local organizations, including SESPAS, PLAN contributes the remaining percentage in support of the PSI sustainability process</p>

VI. CONCLUSIONS

The PSI has had a positive impact from the standpoint of its effectiveness documented by the degree of coverage achieved and the increase in the awareness of healthful practices among the target population. Also its facilitation of processes has contributed to the sustainability of project interventions and achievements.

A substantial benefit for PLAN as a result of this project has been the change in approach with regard to its management and leadership styles. The experience has led to a process of qualitative growth at the internal level in terms of facilitating effective and sustainable maternal-child health processes and technologies.

The project made it possible to install a process for transferring responsibilities to local organizations in a planned and strategic manner, with the greatest weight given to SESPAS. Despite its weaknesses it is the institution that currently offers the greatest prospects for sustaining project interventions.

The PVSs have maintained a high degree of enthusiasm despite the elimination of direct economic incentives. The current focus is on implementing a project of ongoing training, strengthening the sense of community ownership, facilitating the systematic incorporation of PVSs into the SESPAS health service centers, and taking advantage of every available opportunity to give due recognition to PVS efforts.

PLAN has strengthened its credibility and leadership not only through its financial capability but also, and perhaps more importantly, because it has played a role as process facilitator as opposed to acting exclusively as an implementers of interventions. Interinstitutional coordination with both government and nongovernmental organizations has acquired recognition during the final year of the PSI. This has required creativity, management skill and technical knowledge, ingredients which PLAN has been able to successfully integrate into its team of personnel.

Implementation of PSI/PLAN has made it possible to acquire the experience to coordinate activities with government institutions through formal agreements which set forth concrete commitments and provide an official "entity" that can be monitored by the organized community and the local government health service centers.

The implementation of a simple technology such as the very presentable and practical carrying case in which the mother can keep her children's vaccination and growth monitoring cards has had a positive effect in terms of the maintenance of these very important documents. This important outcome not only affects children's health but also the monitoring and evaluating interventions.

The initial processes to enable the local health system approach to acquire recognition in the area of Herrera are now in place. PSI/PLAN has played a decisive role in terms of the experience acquired and lessons learned. Whether the country will benefit from an effective and sustainable model of maternal-child health care will depend largely on the coordinated effort of institutions such as SESPAS, UASD, OPS, PLAN and local organizations in the area of Herrera.

VII. RECOMMENDATIONS

(1) To continue facilitating the empowering process involving the coordination and transfer of technical and management skills to both local organizations and SESPAS will require specific technical support focused on those weaknesses that limit the ability of local organizations to sustain child survival activities.

(2) To establish a process of accompaniment in the transfer of responsibilities to local organizations that will make it possible to provide technical and financial support in strengthening local capabilities. Implementation of the interventions, however, must be the responsibility of local counterparts.

This process of accompaniment will make it possible to:

- ◆ Continue promoting the initiative of implementing the SILOS approach in the area of Herrera as an effective and sustainable strategy for improving the maternal-child health status of the most vulnerable population groups. A specific goal that has not yet taken place is for the intermediate level of SESPAS, Area D, to achieve a sustained presence in the sector. It may perhaps be necessary to locate the Area office in this sector. In this way, the directors of local facilities would enjoy greater technical and administrative support.
- ◆ Continue to fine-tune the mechanisms and instruments that have been used to evaluate the profile of local organizations. With regard to the transfer of responsibilities, PLAN has established credibility criteria for local organizations based on their legal status, community representativeness, prior proven experience, organizational structure, and has also developed appropriate instruments. The specificity of the measuring instruments needs to be improved. This will improve PLAN's perspectives of achieving success in selecting and supporting its counterparts as well as in achieving the sustainability of health activities.
- ◆ Facilitate a more participative process for analyzing information by the community. Continuous efforts need to be made to develop the capability to analyze information for decision-making purposes. The transfer of the HIS to SESPAS local service centers represents a valuable opportunity to strengthen a module of this type, which will in turn serve as a learning process for improving the national health information system.
- ◆ Monitor the overall strategic plan developed by representatives of SESPAS, PLAN, CEP and other organizations with a view toward providing continuity to PSI activities.
- ◆ Support the SESPAS initiative of introducing the new WHO/PAHO package known as "Integrated Management of Childhood Illness" (AIEPI) and support the training of members of the staff of SESPAS, NGOs, community organizations and PVSs in the AIEPI. This will make it possible to strengthen components currently being implemented and to include the identification and referral of cases of tuberculosis.

- ◆ Continue providing support to the UASD and SESPAS. PLAN has an opportunity to support an innovative child survival teaching model (specifically in the area of breastfeeding promotion) that is being conducted by the UASD under the sponsorship of SESPAS. The implementation of this proposal may enhance options for further collaboration between these organizations with a view toward strengthening maternal-child health interventions and processes at the community level. Examples include university-level academic accreditation of the training provided to PVSs and other local resources, development of self-teaching modules on health management subjects, and others, such as technical careers in community health.

We support the recommendations formulated in the midterm evaluation suggesting that PLAN facilitate the dissemination and exchange of lessons learned in the implementation of the PSI in the region.

The lessons learned from this project will have a greater likelihood of being both applicable and replicable if community structures are strengthened; if the exchange and analysis of information among the various health providers is facilitated; if PVSs are empowered to discuss and analyze, on an appropriate technical basis, the information gathered; if the concept of an interdisciplinary health team is accorded due relevance—if, in short, management systems are strengthened at the local level.

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IX. ANNEXES

ANNEX 1

Annex 1

PLAN/Santo Domingo
Child Survival Project IX

Final Report

Rapid Knowledge, Practices
and Coverage Survey

December 1996

**PLAN/Santo Domingo
Child Survival Project IX
Rapid Survey of Knowledge, Practices and Coverage**

Executive Summary

A Rapid Knowledge, Practice and Coverage Survey (Rapid KPC Survey) was carried out in December 1996 in Santo Domingo as part of the final evaluation of the Child Survival Project funded by USAID and implemented by PLAN International in the peri-urban areas of Herrera and Altagracia in Santo Domingo, Dominican Republic, from September 1, 1993 to December 31, 1996. The midterm evaluation of this project was conducted in July 1995. Subsequent to that evaluation and based on the recommendations of the external evaluator, a number of remedial actions were taken with a view toward improving project effectiveness and sustainability.

The purposes of the survey were as follows:

- ◆ to evaluate project achievements against the objectives stated in the Detailed Implementation Plan (DIP) for the following components: appropriate child feeding and nutrition, control of diarrheal diseases, control of acute respiratory infections, immunizations, maternal health care, family planning and prevention of HIV/AIDS.
- ◆ to assess the effect of the activities carried out by the project following the midterm evaluation based on the recommendations of the evaluators.
- ◆ to improve the ability of the PLAN health team, SESPAS and community health leaders to conduct KPC surveys.

The survey preparation phase took place in November 1996 and field work was conducted the following month.

The questionnaire used in the survey is based on the one developed by Johns Hopkins University, which was modified, adapted to the local language and field-tested by the PLAN/Santo Domingo health team and volunteer health promoters working in the various neighborhoods in which the project carries out activities.

The core team responsible for conducting this survey consisted of representatives of PLAN/Santo Domingo and members of the staff of SESPAS and the CEP (now transferred to the Volunteer Health Promoters working in the project area), with technical assistance provided by the PLAN Health Coordinator for the Caribbean and Central America (ROCCA).

Thirty clusters were selected and ten mothers with children under age 2 years were interviewed in each cluster, for a total of 300 mothers interviewed. Selection of the starting point was made, and five supervisors and 15 surveyors were selected from among the volunteer health promoters. All of the neighborhoods were included in the sample selection. The information was processed on a portable computer using EPI-INFO (Version 6), with key indicators constructed for the project interventions. The results were then compared to the findings identified in the baseline and midterm, surveys as well as to the findings of maternal-child health surveys carried out in the metropolitan region (Region 0) by CONASUMI and ENDESA.

The survey revealed the following:

Overall project coverage. With regard to the recommendation made in the midterm evaluation, the project successfully improved its coverage in the areas of Herrera and Altigracia. The percentage of project-affiliated mothers rose from 67% (as of the midterm evaluation, July 1995) to 80% (in December 1996), which in addition had a clearly positive effect in terms of improvement in the coverage of several of the project interventions.

Immunization. Maintenance of children's growth monitoring and vaccination cards improved significantly. The percentage of mothers who were able to present their child's vaccination cards increased from 76% (baseline, August 1993) to 88% (December 1996). Child vaccination coverage (based on the vaccination cards) also increased as compared to the midterm evaluation. Coverage for **BCG** increased from 61.9% to 82.2%, coverage for **Polio 3** from 63.4% to 80.8%, coverage for **DPT 3** from 61.9% to 80.8%, and coverage for the **measles** vaccine from 63.4% to 78.7%. These levels of coverage are considerably higher than those reported by CONASUMI in a recent survey (November, 1995) conducted in the metropolitan region as part of its external evaluation (coverages in accordance with the vaccination card, as reported by the CONASUMI external evaluators were BCG, 59.9%; polio 3, 56.6%; DPT 3, 60.5%; and measles, 52.6%).

Feeding and Nutrition. The project achieved considerable improvement in growth monitoring activities. In the baseline, only 34% of mothers were able to present a growth monitoring card, and of the total number of children with a card, only 54.4% had been weighed in the preceding four months (i.e., 18.7% of the total number of children surveyed). In this survey, 85.3% of the mothers were able to present their children's growth card, and 80.4% of these children had been weighed in the preceding four months (i.e., 68.7% of the total number of children surveyed). 25.4% of children under age 4 months are being breastfed exclusively. This figure is much greater than that reported for the country as a whole, which includes both urban and rural areas (5.0%), particularly in view of the fact that the project area of influence is a peri-urban area, where figures are traditionally lower than at the national level.

Control of Diarrheal Diseases. Diarrhea prevalence decreased from 53.6% (baseline, August 1993) to 22.3% (midterm evaluation, July 1995) and remained low (21.7%) in the current survey (December 1996). Oral Rehydration Therapy coverage increased from 56.3% (baseline, August 1993) to 72.3% (December 1996).

Control of ARI. 60.9% of children with cough and rapid breathing were taken to a hospital, a health post or center, or a private physician.

Maternal Health. With regard to vaccination of pregnant women, possession of a maternal health card increased from 23.1% (in July 1995) to 47.7% (in December 1996). Coverage for tetanus toxoid vaccination (as shown by the vaccination card) increased from 17.7% to 44.3%. The survey also measured this coverage by applying the recall method, with the results showing that 88.0% had received two or more doses of tetanus toxoid.

HIV/AIDS. This is the most recent intervention, having been introduced subsequent to the midterm evaluation. This fact notwithstanding, 79% of all mothers indicated that they had received messages on HIV/AIDS prevention in the project area. 68.6% were able to mention two or more ways in which HIV/AIDS is transmitted without mentioning a single form of incorrect transmission. These figures are higher than those found in the midterm evaluation. During the midterm evaluation (which constituted the baseline for the HIV/AIDS component), no mothers were able to list the three ways in which HIV/AIDS is transmitted (by sexual relations, by contaminated blood, and from mother to child); in the current survey, this figure increased to 15%. 70.6% of the mothers were able to mention two or more appropriate ways by which to prevent HIV/AIDS, while in the midterm evaluation the corresponding figure was only 37.7%. These findings suggest that the project is successfully changing knowledge with regard to prevention of HIV/AIDS and that it is necessary to intensify efforts in order to continue to bring about significant changes in the area of HIV/AIDS prevention.

Subsequently, through feedback meetings with members of the staff of PLAN, SESPAS, local NGOs, Volunteer Health Promoters and other community leaders, the results obtained were presented and the reasons behind the findings were discussed, i.e., qualitative information that would aid in explaining and complementing the quantitative data obtained in the survey. According to the participants, the data reflect the actual situation. During these feedback meetings, the commitment of local organizations (SESPAS, CEP and others), community organizations and PVSs, not only to sustain project achievements but to improve them even further, was evident. For PLAN, this survey constitutes the final project evaluation, while for SESPAS and the CEP, which have assumed responsibility for the continuation of project activities, this survey constitutes their baseline.

I. Background

A. Introduction

PLAN International is a private, international development organization conducting child-focused programs that has been working in Santo Domingo since 1987. Based on a review of the health status of mothers and children residing in its areas of influence, PLAN made a determination to strengthen its health activities. Accordingly, from 1988 to 1992 PLAN/Santo Domingo conducted a USAID-financed Child Survival Project (PSI V) in poor peri-urban neighborhoods located in the area of Herrera. Based on the favorable results obtained during that period, a decision was made to extend child survival activities to a nearby area known as Altagracia, and to that end implementation was begun, in September 1993, of a second USAID-financed Child Survival Project (PSI IX) (1, 2). [Missing text] ... final evaluation of the Child Survival Project financed by USAID and implemented by PLAN International in the peri-urban sectors of Herrera and Altagracia in Santo Domingo, Dominican Republic, from September 1993 to December 31, 1996. In July 1995, the midterm project evaluation was conducted. In December 1996, this Rapid Knowledge, Practice and Coverage Survey (Rapid KPC Survey) was conducted based on the USAID guide to evaluations and the methodological guidelines for conducting KPC surveys developed by the Johns Hopkins University Program of Support to Private and Voluntary Organizations (CSSP).

B. Baseline study

At the conclusion of the first project (PSI V), PLAN conducted a KPC survey as part of the final evaluation of that project. This KPC study became the baseline for the second project (PSI IX). By means of this survey, two areas — a project area and a control area — were studied for the purpose of assessing the effectiveness of the previous project. A total of 1,079 mothers of children under age 2 years were interviewed (544 from the PLAN area and 535 from the non-PLAN area). The results of the baseline study were presented in the DIP (1).

C. Purposes of the survey

- ◆ To evaluate project achievements against the objectives set forth in the Detailed Implementation Plan (DIP) for the following components: appropriate child feeding and nutrition, control of diarrheal diseases, control of acute respiratory infections, immunizations, maternal health care, family planning and prevention of HIV/AIDS.
- ◆ To evaluate the effect of actions taken by the project subsequent to the midterm evaluation, based on the recommendation made by the evaluators.
- ◆ To improve the ability of the PLAN health team, SESPAS, CEP and community health leaders to conduct KPC surveys.

D. Project population

The project target population consists of the sectors of Herrera and Altagracia, which are suburban areas of Santo Domingo (see Section C., Sample).

II. Methodology

A. Preparation

1. Ensure the availability of political, economic and logistic support

PLAN Santo Domingo assured itself as to the availability of support from PLAN management, SESPAS, the CEP and PVSs for conducting the KPC survey in the month of December 1996.

2. Ensure the availability of technical support

During this stage, the field office health coordinator contacted the PLAN/ROCCA health coordinator to obtain the necessary technical support.

3. Identify the evaluation team

The PLAN/Santo Domingo health team identified the team that would receive training in the application of this method so that it could be applied without any difficulties in the future.

4. Review the project design (PDO) for the maternal-child health project

During the month of November 1996, the Health Coordinator, the ATs and the Health Coordinator from the Regional Office for the Caribbean and Central America reviewed the following:

- ◆ Project objectives
- ◆ Expected project outputs
- ◆ Indicators for these objectives

5. Lists of communities and population by community

Lists of the communities served by the project were obtained, together with lists of the total population residing in each (see section C., Sample).

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B. The questionnaire

The following steps were taken in preparing the final draft of the questionnaire:

1. Identification of key indicators to be measured

A review was conducted of the DIP and other official project documents in order to identify the key indicators related to the objectives of the interventions implemented under the project, including the HIV/AIDS component.

2. Selection of questions to be included in the questionnaire

A review was conducted of the questions contained in the midterm KPC survey questionnaire, which was in turn based on the questionnaire developed by Johns Hopkins University (1993 version) (3), and a number of additional questions, considered essential for constructing the indicators identified in the DIP and other official documents, were added.

3. Adaptation of the questionnaire to the language customarily spoken by the mothers

During the midterm evaluation, the following steps were taken to adapt the questionnaire to the language customarily spoken by the mothers. To make this adaptation of the questionnaire, the following steps were taken during the midterm evaluation:

- ◆ The PLAN health team and the evaluation team performed the initial translation, with an attempt being made to use words and idiomatic expressions commonly used by the mothers (first draft).
- ◆ Subsequently, each of the questions was reviewed by a group of volunteer health promoters from the communities located in the project area (second draft).
- ◆ **Field-testing of the questionnaire:** The evaluation team and the supervisors and surveyors traveled to a community (which, although it did not belong to the project area, was characterized by conditions quite similar to those found in the project area), and surveyed one or two mothers, reading for each interview all of the questions contained in the questionnaire, exactly as they were written, with no words added and with no comments made, in order to verify the appropriateness of the questions and the time required to conduct each interview.

The above notwithstanding, during the current evaluation the questionnaire was once again revised. The final version of the questionnaire used in the current survey (December 1996) can be found in **Annex 4**.

C. Sample

Using the existing lists of neighborhoods and of the population residing in each, the survey team proceeded to perform a manual estimate of the number of clusters to be studied in each community, following the procedures prescribed by WHO (4). Toward this end, the classic table described in the Expanded Program on Immunization technical documents was constructed.

Since each neighborhood is divided geographically into small micro-zones, which coincide with the areas assigned to each health volunteer for carrying out their work activities, each such micro-zone was defined as one cluster. Armed with a numbered list of these micro-zones or work areas assigned to each volunteer, the team proceeded to select at random the areas to be surveyed within each neighborhood. Within each micro-zone, the initial household (starting point) was selected at random. To identify the second household and all successive households, the rule recommended by WHO, which involves always selecting the next closest household without leaving the area, was used.

List of Clusters

Neighborhood	Population	Accumulated Population	Clusters	PVS Areas (randomly selected)
Buenos Aires	34,423	34,423	1, 2, 3, 4, 5 6	64, 20, 45, 19, 33, 34
Altagracia	21,782	56,205	7, 8, 9, 10	149, 151, 81, 142
El Libertador	47,672	103,877	11, 12, 13, 14, 15, 16, 17, 18	02, 128, 70, 03, 14, 24, 27, 48
Enriquillo	26,338	130,215	19, 20, 21, 22	113, 110, 117, 87
Los Coquitos	2,821	133,036		
Duarte	49,154	182,190	23, 24, 25, 26, 27, 28, 29, 30	53, 59, 61, 86, 63, 56, 82, 54
Total	182,190	182,190	30	30

Sample interval: $182,190/30 = 6,073$

Random number: 523

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D. The survey team

1. The core team

The members of the core team charged with directing the survey were as follows:

- ◆ Dr. Rosa Robles, **Director of the SESPAS El Libertador Clinic**, as of that date in charge of a group of volunteer health promoters
- ◆ Dr. José Celis, **physician and epidemiologist with the CEP**, the organization responsible for health promoters
- ◆ Three ATs from the PLAN/Santo Domingo health team: Daysi Rosado, Gladys Estévez and Violeta Novas.

This core team received technical assistance provided by Dr. Gustavo Tapia, health coordinator for the PLAN International Regional Office for the Caribbean and Central America (PLAN/ROCCA) and from Dr. Joe Valadez, representative from PLAN International Headquarters responsible for providing technical assistance to grant-funded projects.

2. Supervisors and surveyors

Criteria used in selecting supervisors. Six supervisors from the various neighborhoods were selected by the technical health assistants (ATs), based on the following criteria:

- ◆ **Volunteer health promoter** with a history of **satisfactory performance** in discharging his or her duties.
- ◆ **Schooling:** high school or university-level
- ◆ **Prior experience** as a supervisor or interviewer in similar surveys (preferably in the midterm survey)
- ◆ **Good interpersonal relationships**
- ◆ **Satisfactory performance** during the training of supervisors and interviewers

Criteria recommended for selecting interviewers. Nineteen interviewers from all of the neighborhoods were recruited by the technical health assistants:

- ◆ **Volunteer health promoter**

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- ◆ Schooling: 6th grade of primary school, or secondary school
- ◆ Prior experience as an interviewer in similar surveys (desirable)
- ◆ Good interpersonal relationships
- ◆ Satisfactory performance during the training

As a result of the inclusion of questions on HIV/AIDS, sex was added as a criterion. Female surveyors were selected in order to facilitate woman-to-woman dialogue on subjects involving sexuality.

The primary function of the surveyor was:

- a. To complete the course for surveyors and learn the survey norms and procedures
- b. Gather valid and reliable information following the norms and procedures governing data collection (see the survey protocol)

The list of supervisors and surveyors is provided in the following table:

Supervisors	Surveyors	
Bartola Ortiz	Asia Mercedes	María A. Rubio
Yajaira Vargas	Belkis Félix	Marisela González
María Batista	Brasilia A. Rosario	Mercedes S. Cabrera
Mildred Ruíz	Braudilia Medrano	Miladys M. Amanda
Roma Rivas	Emely Bocio	Moreno
Yocasta Santana	Griselda Jiménez	Norma A. Mejía
	Justina Tejeda C.	Rosa Julia Peña
	Marcelina Guzmán	

E. Training of the survey team

Two activities were carried out at the local level for the purpose of providing training to the survey team:

1. Training of the core team (Days 2 - 4)
2. Training of surveyors and supervisors (Days 5 - 8)

1. Training of the Core Team and Final Preparation of the Survey

The individual responsible for training was the PLAN/ROCCA health coordinator. The objective of this training was to transfer knowledge and skills in the following areas:

- ◆ training of supervisors and surveyors
- ◆ adaptation of the generic questionnaire to the local context
- ◆ monitoring of survey implementation
- ◆ tabulation and analysis of data
- ◆ presentation of results
- ◆ application of the lessons learned for the implementation of future surveys

2. Training of Supervisors and Surveyors

The individuals responsible for this training were the members of the core survey team. The training was conducted based on the following Training Plan:

Course for Supervisors

Day 5 (12-5-96)

Time	Topic	Methodology	Responsible Individual
8:30 - 8:45	Opening session Instructions, expectations and administrative concerns	Group dynamics Discussion	Technical Health Assistant
8:45 - 9:00	Introduction to the survey (purpose, sample, validity, tasks and general procedures)	Brief presentation Discussion	ROCCA Health Coordinator
9:00 - 9:30	Supervisor and interviewer functions	Brainstorming Roleplay and discussion	Technical Health Assistant
9:30 - 10:30	Survey methodology - sample size - selection of clusters and households - survey protocol	Discussion Exercise	ROCCA Health Coordinator
10:30 -12:30	The questionnaire Purpose of the questions	Annotated readings, discussion Exercises	SESPAS representative, ATS
12:30 - 13:00	Lunch		
14:30 - 15:00	Practice in using date of birth to calculate age of the child in months	Group and individual exercises	ROCCA Health Coordinator
15:00 - 16:30	Practice (I). Technique for interviewing mothers and recording accurate and precise data	Roleplay. Analysis of the positive and negative practices observed	Supervisors
16:30 - 17:00	Feedback on practice (I)	Group discussion Analysis of positive and negative practices	ROCCA Health Coordinator

Course for Surveyors and Supervisors (Days 6 – 8)
Day 6 (6-12-96)

Time	Topic	Methodology	Responsible Individual
8:30 - 8:45	Opening session Instructions, expectations and administrative concerns	Group dynamics Discussion	ATS Survey Supervisors
8:45 - 9:00	Introduction to the survey (purpose, sample, validity, tasks and general procedures)	Brief presentation Discussion	ATS Survey Supervisors
9:00 - 9:45	Supervisor and interviewer functions	Brainstorming Roleplay and discussion	Survey Supervisors
9:45 - 10:45	Survey methodology - sample size - selection of clusters and households - survey protocol	Discussion Chalkboard exercises	ROCCA Health Coordinator
10:45 - 12:45	The questionnaire	Annotated readings of the questionnaire Discussion	Surveyor Supervisors
12:45 - 13:30	Lunch		
13:30 - 16:00	Practice interviews in the classroom (I)	Each supervisor candidate will participate in two interviews: one as an interviewer and another as the informant	Survey Supervisors Technical Health Assistant SESPAS representative
16:00 - 16:30	Feedback on practice (I)	Group discussion Analysis of positive and negative practices	SESPAS representative

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Course for Surveyors and Supervisors (Days 6 — 8)
Day 7 (7-12-96)

Time	Topic	Methodology	Responsible Individual
8:30 - 8:45	Review of the previous day	Discussion	ATS Supervisors
8:45 - 10:45	Practice interviews in the classroom (II)	Each supervisor candidate will participate in two interviews: in one as an interviewer and in the other as an informant. Supervisor candidates will observe and grade the interviews	Survey Supervisors Technical Health Assistant
10:45 - 11:30	Practice (III) in using birth date to calculate age of the child in months	Group and individual exercises	ROCCA Health Coordinator
11:30 - 12:30	Practice (IV) How to ask the questions contained in the questionnaire. Purpose of the questions. Reading and interpretation of vaccination and growth monitoring cards	Roleplay. Annotated reading of the questionnaire. Discussion. Exercises with vaccination and growth monitoring cards	SESPAS representative
12:30 - 13:30	Lunch		
13:30 - 15:00	(continuation of practice IV) How to ask the questions contained in the questionnaire. Purpose of the questions. Reading and interpretation of maternal health cards	Roleplay. Annotated reading of the questionnaire. Discussion. Review of the maternal health card	SESPAS representative
15:00 - 15:30	Feedback on practice (IV)	Brainstorming to identify the errors most commonly occurring in practice. Discussion on how to avoid these common errors	SESPAS representative
16:00 - 16:30	Evaluation of surveyors and supervisors	Interviewers: test and reports from supervisors Supervisors: Reports from	Survey Team

		the core team	
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Course for Surveyors and Supervisors (Days 6 — 8)
Day 8 (8-12-96)

Time	Topic	Methodology	Responsible Individual
8:30 - 10:00	Practice (V). Technique for interviewing the mother and recording accurate and precise data	Roleplay. Analysis of the positive and negative practices observed	Supervisors
10:00 - 10:30	Final comments on the questionnaire	Discussion	Technical Health Assistant
10:30 - 10:45	Visit to the practice neighborhood		
10:45 - 12:45	Practice in the field: Interviews of mothers with children under age 2 years	Interviewer candidates: Perform 2 interviews Supervisor candidates: Perform 1 interview, observe and grade interviews conducted by interviewers Team: Observe interviews and grade interviews conducted by supervisors	Evaluation team
12:45 - 13:00	Return to the classroom		
13:00 - 14:00	Lunch		
14:00 - 13:30	Feedback on the practice conducted in the field	Brainstorming and group discussion: Analysis of positive and negative practices	ROCCA Health Coordinator
14:30 - 15:30	Assignment of clusters (PVS areas) and distribution of lists	Allotment, discussion, negotiation	Technical Health Assistant Survey Team
15:30 - 16:00	Final preparation for the survey - Transportation - Supplies	Dialogue, distribution of supplies (questionnaires, pads of paper, pencils, erasers, pencil sharpeners,	ROCCA Health Coordinator

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		etc.)	
16:00 - 17:30	Reconnaissance of the survey area	Visit to the area	ATS and Supervisors

F. Gathering and analysis of data

1. Sources of information

The sources of information are mothers of children under age two years and the health cards for both the child (vaccination card, growth monitoring card) and the mother (vaccination card and prenatal check-up card) (4,5).

2. Survey protocol

Each supervisor is responsible for three surveyors. The surveyor completes one cluster per day (10 interviews per day). The first household or starting point for the cluster is selected at random. To conduct [missing text...]

Surveyor

1. The surveyor is dropped off at the **starting point** for the cluster. The starting point is the first household to be surveyed.
2. She knocks on the door, introduces herself, asks to speak with the mother and briefly explains the reason for her visit.
3. She asks if there is a child under age two years in the household and verifies the child's age by reviewing his or her birth certificate or health cards. **If there is more than one child under age two, the surveyor selects the youngest of all such children.**
4. The surveyor completes the interview with the mother by asking the questions and following the instructions contained in the questionnaire. **(She must be neutral, carefully taking note of the "skip to" prompts and mentioning the name of the child as indicated on the questionnaire.)** On arriving at the section dealing with HIV/AIDS, the surveyor tactfully asks the husband or any individuals accompanying the mother to please leave the room. Questions on HIV/AIDS are asked in private, with only the mother present.
5. Once the interview is completed, the surveyor **reviews the questionnaire to determine whether it has been completely filled out before leaving the home.**
6. She thanks the mother for her significant contribution, leaves the home and proceeds to the next house, which will be **the house closest to the initial house.**
7. The surveyor follows the same steps (2 through 6) in the second house and continues this procedure in subsequent households **until she has completed 10 surveys.**

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8. She delivers the revised questionnaires to the supervisor.

Supervisor

1. The supervisor receives the questionnaires that have now been revised by the surveyor.
2. The supervisor again reviews the questionnaires and provides feedback to the surveyors for whom she is responsible. If the supervisor finds errors in the questionnaires, she asks the surveyor to correct them prior to leaving the community.
3. She selects at random one questionnaire from each of her surveyors in order to verify the information contained on it. To this end, she once again goes to the house and verifies the correctness and accuracy of the information by re-interviewing the mother.
4. If required, the supervisor may assist the surveyor to ensure that the required number of surveys is completed on time.
5. The supervisor reviews each of the questionnaires prior to leaving the community.
6. The supervisor delivers the completed questionnaires (which have now been reviewed by both the surveyor and herself) to a member of the core survey team, who again reviews the questionnaires and forwards them to the data processing center.

F. Data analysis

The information was processed on a computer using the EPI-INFO package, version 6 (5). The following files were created to input the data: “.QES”, “.CHK” and “.REC”. Four computer operators input the data collected on the preceding day. To permit simultaneous data entry, four sets of files were created. Subsequently, the merge function was used to merge into a single file the “.REC” files used by the operators. Programs developed or adapted by the ROCCA Health Coordinator were used to analyze the information.

Once the results had been obtained, the evaluation team interpreted the findings and analyzed the corresponding causes and implications.

Key indicators were constructed to measure project interventions. The results were then compared to the findings formulated in the baseline and midterm surveys and to the findings of maternal-child health surveys conducted in the metropolitan region (Region 0) by CONASUMI and the Demographic and Health Survey (ENDESA).

To allow comparison between the baseline, midterm and final surveys, the methodologies and instruments used were reviewed. Except for the rates of vaccination and exclusive breastfeeding, most of the indicators are entirely comparable. The baseline survey

review identified some methodological differences between this study and the standard, Johns Hopkins University Rapid KPC survey. This differences concerned the measurement of vaccination and exclusive breast-feeding rates. The midterm and final evaluations followed the standardized methodology more closely.

Regarding Expanded Programme of Immunizations (EPI) coverage, the rapid KPC survey requires the Vaccination Card as the only source of information, whereas the baseline survey also used respondents' recall or a different definition of the vaccination rate. Certain results reflect this difference: in the baseline survey report (Results of the Baseline Survey, August/93 page 14, Section: Vaccination), the percentage of children having vaccination cards (76.1%) was lower than the reported vaccination coverage (DPT3 92.5% and Measles 81.8%). In the midterm(July/95) and final surveys (December/97), vaccination rates were measured using JHU standardized procedures. The information source considered valid was the Immunization Card; children without cards were reported as not immunized. In determining vaccination rates, the numerator included only those children from 12 to 23 months whose cards indicated vaccination, and the denominator included all children from 12 to 23 months whether they had cards or not.

Regarding exclusive breastfeeding rates, the baseline study combined predominantly breast-fed children with exclusively breast-fed ones, instead of presenting exclusive breastfeeding rates only (See the DIP, page 3- Heading C.1 Baseline survey results. Subheading Nutrition. Paragraph 2 -).

Because of these methodological differences, the final evaluation compares vaccination and exclusive breast-feeding rates only with the midterm results.

G. Feedback

Once the data had been obtained, the team proceeded to prepare graphics and visual HIV/AIDS to facilitate feedback.

1. Feedback meetings with members of the staff of PLAN, SESPAS, local NGOs, voluntary health promoters and other community leaders

The results obtained were presented in a workshop attended by PLAN staff, all of the directors (or their representatives) of SESPAS health centers, representatives of SESPAS from the central level (personnel responsible for the EPI, Breastfeeding and Diarrheal Disease Control Programs), representatives from NGOs and community organizations, and volunteer health promoters. Following the presentation of the evaluation findings, the participants broke out into groups to discuss the reasons behind the findings, i.e., qualitative information that would help to explain and complement the quantitative data obtained during the survey. According to the participants, the data reflect the actual situation. During these feedback meetings, the commitment of local organizations (SESPAS, CEP and others), community

organizations and PVSs — not only to sustain project achievements but to surpass them — was quite evident. For PLAN, this survey represents the final project evaluation, while for SESPAS and the CEP, which are the organizations that took on the responsibility for continuing the implementation of project activities, this survey constitutes their baseline.

2. Feedback meeting with directors of health programs in countries of Central America and the Caribbean

Immediately after the evaluation had been completed, the results were presented in a regional meeting held in Santo Domingo on December 17 and 18, 1996, with the participation of health representatives from the Dominican Republic, Haiti, Guatemala, Honduras, El Salvador and Nicaragua. The purpose of the meeting was to share experiences, lessons learned and methods used by the PSI to contribute to improving the quality of child survival programs conducted in the region. During the meeting, the evaluation team presented the most salient findings and the participants subsequently analyzed those findings, comparing significant aspects of the project to the situation observed in other countries. The participants concluded that the Santo Domingo experience was quite positive and identified essential key elements that were instrumental in ensuring the positive results recorded by the PSI.

Calendar of Activities

Activities	No. of Days	Date
<p>Prior to the arrival of the ROCCA Health Coordinator</p> <p>I. Initial preparations</p> <p>A. Begin the planning process</p> <p>B. Select, adapt, develop questions for the questionnaire</p> <p>C. Select sample</p> <p>D. Coordinate administration and logistics</p>	30 days	November 1996
<p>Arrival of the ROCCA Health Coordinator</p> <p>II. Training of the evaluation team</p> <p>A. Preliminary meetings with the PLAN Country Director and Health Coordinator, USAID officials, SESPAS (Day 1)</p> <p>B. Finalize survey preparations (Days 2-3)</p> <p>C. Training of the team: strengthening of the administrative staff of the organizations involved (Days 2-3)</p>	3 days	December 1996 1 2 - 4 2
<p>III. Training of supervisors and interviewers</p> <p>A. Training of supervisors (Day 4)</p> <p>B. Training of interviewers (Days 5-7)</p> <p>C. Final survey preparations (Day 7)</p>	4 days	5, 6, 7, 9 5 6, 7, 8
<p>IV. Data collection in the field (Days 8-9)</p> <p>A. Surveyors conduct interviews</p> <p>B. Supervisors supervise interviews</p> <p>C. Evaluation team supervises the entire process</p>	2 days	10, 11
<p>V. Data processing and analysis (Days 8-10)</p> <p>A. Computerized data entry (EPI-INFO, version 6.0)</p> <p>B. Data processing and analysis</p> <p>C. Preparation of presentation graphics</p>	3 days	10 - 12 10, 11 12 12
<p>VI. Feedback</p> <p>A. To PLAN, community leaders, NGOs and PVSs (Day 11)</p> <p>C. To the regional health team (members of Growing Up Healthy regional network)</p>	2 days	13, 17 13 17
<p>VII. Preparation of final report</p> <p style="padding-left: 20px;">Report in Spanish</p>		14, 15

Report in English (translation in the United States)	2 days	
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III. Results

A. General Information

Three hundred mothers of children under age 2 years were interviewed. All cases were selected.

Age of the child

The average age of the children was 10.8 months. Most of the children (53.0) were under age one year.

Age group	Frequency	Percentage	Cumulative
0-11 months	159	53.0%	55.3%
12-23 months	141	47.0%	100.0%
Total	300	100%	

Age of the women

The group of mothers interviewed is made up primarily of young women. The average age is 24.9 years, with a range of between 15 and 47. Forty-two mothers (14.0%) are teenagers, while 13 (4.3%) are over age 35 (see Figure 1).

Age group (years)	Frequency	%	Cumulative %
15 to 19 years	42	14.0	14.0
20 to 24 years	115	38.3	52.3
25 to 29 years	92	30.7	83.0
30 to 34 years	35	11.7	94.7
35 to 39 years	8	2.7	97.3
40 to 44 years	7	2.3	99.7
45 to 49 years	1	0.3	100.0
Totals	300	100.0	

Maternal education

94.3% of the mothers are literate (see Figure 2). 42.3% of the mothers attended secondary school while 52.0% studied at the university level.

Occupation

26.3% (79) of the mothers work in income-generating activities (Figure 3). The activities in which they work are many and varied. The most frequent activities in which mothers are involved include the following: salaried worker (6.0%) [missing text?] (see Figure 4).

Individuals caring for the child in the absence of the mother

Figure 5 shows that, when the mother leaves the home, most children either accompany her (30%) or are cared for by the grandparents (29.7%). Other caretakers include spouses or companions (10.0%), neighbors (9.7%) and older siblings (9.0%). None of the mothers take their child to a day-care center.

Affiliated families

Of the 300 women interviewed, 123 (41.0%) are affiliated with PLAN while 241 (80.3%) are affiliated with the child survival project (see Figure 6). Both PLAN and non-PLAN families are receiving support under the child survival project.

Project-affiliated	Frequency	Percentage	Cumulative
Yes	241	80.3%	80.3%
No	59	19.7%	100.0%
Total	300	100.0%	

B. Interventions implemented by the project

B1. Appropriate child feeding

Breastfeeding. 92.1% of the 63 children under age 4 months are being breastfed (see Figure 7), while 16 of those (25.4%) are being given **exclusive breastfeeding** (see Figure 8), i.e., are being given no semi-solid, solid or liquid nourishment other than breast milk. 83.7% of the children received **early breastfeeding** (i.e., were breastfed during the first 8 hours following birth). Some 20.0% of the children between the ages of 20 and 24 months continue to be breastfed (**prolonged or persistent breastfeeding**).

Introduction of food. 41.3% of the children between the ages of 5 and 9 months are being given solid or semi-solid foods (see Figure 8).

B2. Growth monitoring

Growth monitoring card. 85.3% of the children had a growth monitoring card (see Figure 9).

Growth monitoring coverage. Based exclusively on the card and not on recall, 67.7% of the children were weighed during the preceding four months (see Figure 10), and of these children who were weighed, 89.8% had normal weight for their age.

B3. Control of diarrheal diseases

Prevalence of diarrhea. 65 children (21.7%) of the 300 children under age 2 years had diarrhea in the two weeks preceding the survey (see Figure 11); 0.3% of the mothers were unable to recall if their children had diarrhea or not. 15.4% of the children with diarrhea had diarrhea lasting more than two weeks (which is suggestive of persistent diarrhea). 6.2% of the children with diarrhea had stools containing blood, which suggests the presence of dysentery (see Figure 12).

Management of diarrhea: Continuation of breastfeeding. Figure 13 shows that 82.8% of the children under age 24 months who had diarrhea in the preceding two weeks continued to be breastfed in an amount equal to or greater than customary.

Management of diarrhea: Continuation of liquids. Figure 13 shows that 79.6% of the children under age 24 months who had diarrhea in the preceding two weeks continued to be given liquids in an amount equal to or greater than customary.

Management of diarrhea: Continuation of feeding. 58.18% of the children under age 24 months who had diarrhea in the preceding two weeks continued to be given food in an amount equal to or greater than customary (see Figure 13).

Management of diarrhea: Oral Rehydration Therapy (ORT). Figure 13 shows that 72.3% of the children under age 24 months who had diarrhea in the preceding two weeks were given ORT.

ORT	Frequency	Percentage	Cumulative
No	18	27.7%	27.7%
Yes	47	72.3%	100.0%

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Total	65	100.0%	
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Management of diarrhea: Use of antibiotics and/or antidiarrheals. 22.7% of the children under age 24 months who had diarrhea in the preceding two weeks were given antidiarrheals and/or antibiotics (see **Figure 13**).

Source of advice or help for a child with diarrhea. The greatest percentage of mothers who have children with diarrhea go to the hospital (15.4%), to health posts (15.4%), to the volunteer health promoter (13.8%), or to relatives or friends (13.8%) to receive advice or assistance.

B4. Control of pneumonia

Prevalence of cough and rapid breathing. 92 children (30.7%) under age 24 months had cough and rapid breathing in the preceding two weeks, as shown in **Figure 15**.

Source of advice or assistance with cough and rapid breathing. 28.3% of the 92 children with cough and rapid breathing were taken to a private clinic (private physician), while 20.7% were taken to the general hospital. In addition, 18.5% of the children were taken to the health center (see **Figure 16**). 16.3% seek advice from relatives and friends, while 10.3% go to the health promoter.

Access to medical treatment. 60.9% of the children who had cough and rapid breathing during the preceding two weeks had access to medical treatment (medical treatment was interpreted to mean treatment received from a hospital, health center or private physician), as illustrated in **Figure 17**.

Treatment	Frequency	Percentage	Cumulative
No	36	39.1%	39.1%
Yes	56	60.9%	100.0%
Total	92	100%	

B5. Immunization

Percentage of children with a vaccination card. 79.6% of mothers were able to present the child's vaccination card during the interview, while 10.4% reported that they had lost the card and only 10% indicated that they had never been given a card (see **Figure 18**).

Vaccination Card	Frequency	Percentage	Cumulative %
Yes	264	88.0%	88.0%
Lost it	24	8.0%	96.0%
Never had one	12	4.0%	100.0%
Total	300	100.0%	

Vaccination coverage. As can be observed in **Figure 19**, vaccination coverage among children between the ages of 12 and 23 months, in accordance with vaccination cards presented, was as follows:

EPI Vaccines	BCG	PVO 3	DPT 3	Measles
Coverage %	82.2	80.8	80.8	78.7

Access to the Expanded Program on Immunization (EPI). Access to the EPI is defined as the percentage of children between the ages of 12 and 23 months who have received DPT 1. In Herrera, 87.2% of the children between the ages of 12 and 23 months have had access to the immunization program (see **Figure 20**).

Dropout rate. The percentage of dropouts between DPT 1 and DPT 3 was 7.3% (see **Figure 21**). This rate is calculated by using data for children between the ages of 12 and 23 months and applying the following formula (3):

$$\frac{\text{Number of children who received DPT 1, less number of children who received DPT 3}}{\text{Number of children who received DPT 1}} \times 100 = \text{Percentage of dropouts between DPT 1 and DPT 3}$$

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Knowledge of immunization. Figure 22 shows that 71.7% of the mothers are aware that nine months following birth their child should be given the anti-measles vaccine.

Likewise, 92.0% of the mothers indicated that a pregnant woman must be given two or more doses of the vaccine against tetanus in order to protect the newborn child.

B8. Maternal health

Possession of a maternal vaccination card. Percentage of mothers who possess a maternal health card for the birth of their most recent child under age 24 months. 77.7% had a maternal vaccination card. 47.7% of the 300 mothers were able to present their card during the interview (see Figure 23).

Tetanus toxoid coverage (based on the card). Percentage of mothers who have been given at least two doses of TT prior to the birth of their most recent child under age 24 months. Mothers with no card were considered to be unvaccinated. 88.0% of the 300 mothers indicated that they had been given two or more doses of tetanus toxoid during their most recent pregnancy. According to the card, 44.3% of the 300 mothers had been given two or more doses of tetanus toxoid (see Figure 24).

One or more prenatal visits (based on the card and on recall). Percentage of mothers who made at least one prenatal visit prior to the birth of their child under the age of 24 months. According to the data provided by the mothers (recall), 99.3% made a prenatal follow-up visit, while according to the card the figure was 40.3% (see Figure 24).

Maternal knowledge of reproductive health. 95.3% of the mothers know when the prenatal check-up visit must be made. 96.0% of the mothers know the number for where to obtain contraceptives (see Figure 25).

Know where to obtain contraceptive methods	Frequency	Percentage	Cumulative %
No	12	4.0%	4.0%
Yes	288	96.0%	100.0%
Total	300	100.0%	

Supplementation for pregnant women. 91.6% of pregnant women have been given prenatal pills (see Figure 26).

Vaccination card	Frequency	Percentage	Cumulative %

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Yes	264	90.4%	90.4%
No	28	9.6%	100.0%
Total	292	100.0%	

Care during childbirth. 79.0% of the mothers reported that they went to a health professional who cut the umbilical cord during the birth of their child under age 24 months (see Figure 26).

Use of modern contraceptives. Percentage of mothers of children under age 24 months who do not wish to have any more children in the subsequent two years (or who are not sure) and who are using a modern contraceptive (see Figure 26).

Use a family planning method	Frequency	Percentage	Cumulative %
No	97	46.6%	46.6%
Yes	111	53.4%	100.0%
Total	208	100.0%	

Use of the various contraceptive methods can be appreciated from the following table:

Method	Frequency	Percentage
Tubal ligation, vasectomy	37	17.8%
Norplant	11	5.3%
Injections	2	1.0%
Birth control pills	40	19.2%
Mini-pills	2	1.0%
Intrauterine device	10	4.8%
Diaphragm	2	1.0%
Condoms	8	3.8%
Foam or gel	0	0.0%

Exclusive breastfeeding	3	1.4%
Rhythm method/cervical mucus method	1	0.5%
Abstinence	1	0.5%
Coitus interruptus	0	0.0%

B9. HIV/AIDS prevention and control

Knowledge of HIV/AIDS: Transmission. Presented below is a table relating two variables: the ability to name correct forms of transmission (sexual relations, contaminated blood, and mother-to-child) and incorrect forms of transmission (casual contact: handshaking, kissing someone who has HIV/AIDS, hugging someone who has HIV/AIDS, from coughing, in the swimming pool, from mosquito bites, from toilets, from sharing glasses, cups, plates, silverware, clothing, towels, etc.).

Mentioned correct forms of AID transmission	Mentioned casual (incorrect) forms of transmission					
	No		Yes		Total	
	Freq.	%*	Freq.	%*	Freq.	%*
Did not mention	19	6.4%	1	0.3%	20	6.7%
Mentioned one	30	10.0%	11	3.7%	41	13.7%
Mentioned two	161	53.7%	29	9.6%	190	63.3%
Mentioned three	45	15.0%	4	1.3%	49	16.3%
Total	255	85.0%	45	15.0%	300	99.0%

* Percentage calculated on the total number of observations (300).

As can be seen in this table, those mothers who also mentioned incorrect forms of transmission are excluded. 53.6% of the mothers mentioned two correct forms of HIV/AIDS transmission without mentioning a single incorrect form, while 15.0% mentioned the three correct forms of transmission. 15% of the mothers still mentioned one or another form of casual contact as a form of HIV/AIDS transmission (shaking hands, kissing, hugging, sharing clothes, towels, etc.) (see Figure 27).

If those who mentioned incorrect forms of transmission are also included, 63.3% of the mothers were able to mention two forms of HIV/AIDS transmission, while 16.3% were unable to mention all three forms of transmission. 6.7% of the mothers were unable to mention a single form of HIV/AIDS transmission (see **Figure 28**).

Knowledge of HIV/AIDS: Prevention

70.8% of the 300 mothers were able to mention two or more appropriate forms of HIV/AIDS prevention (42.3% mentioned two appropriate forms, while 28.3% mentioned three forms). 20.3% were able to mention one appropriate form of HIV/AIDS prevention (see **Figure 28**).

Exposure to risky sexual behavior. The indicator calculated was the percentage of sexually active mothers exposed to risky sexual behavior (mothers with potentially unfaithful husbands or sexually active mothers with no stable sex partner and who do not always use a condom in all of their sexual relations). As can be seen from the following table, of all sexually active women, 11.5% are exposed to risky sexual behavior, whether from the potential infidelity of the husband or because the mother has sexual relations without having a stable sexual partner.

Description	Freq.	%	Cum.
Sexually active women with an unfaithful husband who do not always use a condom in their sexual relations	24	11.3%	11.3%
Sexually active women with no stable partner who do not always use a condom in their sexual relations	12	5.6%	16.9%
No possibility of risk (sexually active women without the above-mentioned risks)	177	83.1%	100.0%
Total	236	100.0%	

Perception of risk. Percentage of mothers exposed to risky sexual behavior (mother with a potentially unfaithful husband or sexually active mother with no stable sexual partner and who does not always use a condom in all her sexual relations) who perceive the risk (who classified themselves as being at a considerable risk). Of the total number of women exposed to risky sexual behavior, 44.1% were able to perceive the risk to which they are exposed.

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Women who perceive their risk	Freq.	Percentage	Cum. %
No	119	55.9%	55.9%
Yes	94	44.1%	100.0%
Total	213	100.0%	

Use of condoms. Percentage of mothers exposed to risky sexual behavior (mothers with potentially unfaithful husbands or sexually active mothers without a stable sexual partner) who always use a condom in all of their sexual relations. Of the total number of women exposed to risky sexual behavior, 94.7% do not consistently use a condom.

Attitude toward risk. Percentage of mothers who believe that their husbands have sexual relations with another woman and who are disposed to taking some appropriate step in this regard. 63.0% of the mothers who believe that their husband is unfaithful will take some action to resolve the situation.

Positive attitude toward someone with HIV/AIDS. Percentage of mothers who would live with an individual who had HIV/AIDS. 37.0% of the mothers indicated that they would live in the same house with an individual who had HIV/AIDS.

Would live in the same house with someone who had HIV/AIDS	Freq.	Percentage	Cum. %
Yes	137	46.9%	46.9%
No	133	45.5%	92.5%
Don't know	22	7.5%	100.0%
Total	300	100.0%	

C. Interventions in which the project no longer is active

C1. Tuberculosis Control

Prevalence of persistent cough. Figure 29 shows that 49 mothers (16.3%) reported that there was one or more individuals with a persistent cough in their homes (a cough lasting more than 15 days, which is suggestive of tuberculosis).

Source of assistance or advice for persistent cough. 20.4% (of the families who indicated that at least one family member had persistent cough) went to the general hospital. A

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like percentage (20.4%) went to a private physician, while 18.4% went to an area health post or center and 18.4% resorted to friends or relatives (see Figure 30). 2.0% went to the volunteer health promoter.

Access to medical treatment for management of persistent cough. Of the 49 individuals who had persistent cough for more than 15 days, 24 (55.8%) went to a health center or to a health professional for treatment (see Figure 31).

Medical Treatment	Freq.	Percentage	Cum. %
No	24	49.0%	49.0%
Yes	25	51.0%	100.0%
Total	49	100.0%	

Maternal knowledge with regard to tuberculosis. 54.0% of the mothers mentioned persistent cough as one way to recognize someone with tuberculosis. Other signs or symptoms related to recognition of someone with tuberculosis that were mentioned by the mothers included: mucopurulent expectoration, 18.7%; loss of appetite, 12.3%; loss of weight, 36.7%; fever/sweats, 12.7% (see Figure 32).

D. Message dissemination

Most of the mothers with children under age 24 months who were surveyed indicated that they had received health messages (see Figure 33).

77.5% of the mothers surveyed indicated that they had shared the health messages received with other mothers (see Figure 34).

IV. Discussion

A. General information

It is important to stress that the baseline conducted in August 1993 was performed in the PLAN area and in a control area and that, in the PLAN area, non-project-affiliated children were not included. By contrast, the current study was performed in the PLAN area only and included all children, both project-affiliated and non-affiliated.

Overall project coverage. Following the recommendation submitted in conjunction with the midterm evaluation, the project improved its levels of coverage in the areas of Herrera and Altigracia. The percentage of project-affiliated mothers increased from 67% (midterm

evaluation, July 1995) to 80% (in December 1996), which certainly also had a positive effect in terms of improvement in coverage for several project interventions (see Figure 35). This figure reflects the increased involvement of community organizations, volunteer health promoters and volunteer collaborators (from the Donor Services Department).

Age of the mothers. In the Dominican Republic, SESPAS policy defines at-risk pregnancy as any pregnancy occurring in women under age 20 or over age 35. According to the 1991 Demographic and Health Survey (ENDESA 1991), 13% of all women under age 20 have had children. The situation is similar in Herrera and Altagracia, where 14% of all mothers are under age 20. The pattern is typical of a predominantly young population in a developing country.

According to ENDESA 1991, 5.7% of the women in the Dominican Republic have no schooling whatsoever (6). In the project area, the same level was observed (5.7% are illiterate).

The relationship between **education**, particularly for women, and child health is well known. Well-nourished, healthy children develop better and take better advantage of instruction received in school. Similarly, a higher level of maternal education is associated with improved health practices and greater utilization of services (7).

Care of the child when the mother is absent. Grandmothers and grandfathers are the individuals who most frequently care for children when the mother is absent. There is no denying the socializing role played by the grandmother with respect to children. This strongly suggests that grandmothers should be taken into account in health education programs as the second most importance audience.

PLAN affiliates. With regard to the midterm evaluation, a slight decrease was observed in the percentage of PLAN International affiliates, reflecting the results of the progressive phase-out strategy adopted by PLAN. The above notwithstanding, active affiliation with the child survival project has increased noticeably.

B. Interventions implemented by the project

B1. Growth monitoring

The project improved growth monitoring activities noticeably. In the baseline, only 34% of the mothers were able to present a growth card, and of the total number of children with a card, only 54.4% had been weighed in the preceding four months (i.e., 18.7% of the total number of children surveyed). In the current survey, 85.3% of mothers were able to present the growth card, and 80.4% of these children had been weighed in the preceding four months (i.e., 68.7% of the total number of children surveyed) (see Figure 36). The percentage of children of normal weight, situated above the lower limit of the growth card,

also increased, from 85.7% to 89.8%, i.e., only 10% of all children were situated below the limit indicated on the growth card.

B2. Appropriate child feeding

Both the early introduction of breastfeeding as well as persistent breastfeeding have increased vis-à-vis the midterm evaluation. Exclusive breastfeeding has decreased slightly (see **Figure 37**). This can be attributed to the fact that the project dropped the Caring Mothers Club strategy (because it was an unsustainable PSI structure) in favor of a strategy of employing more sustainable structures (taking advantage of any group where pregnant women naturally tend to gather, as well as naturally occurring community women's groups) to promote exclusive breastfeeding.

Despite the fact that the area in question is peri-urban in nature, a high percentage (92.1%) of mothers in Herrera and Altagracia breastfeed their children under age 4 months.

Early breastfeeding. ENDESA 91 (6) reported that 33% of all mothers initiated breastfeeding on the first day following childbirth. In the project area, 83.7% of all mothers initiated breastfeeding within the first eight hours following delivery (see **Figure 38**).

Exclusive breastfeeding. According to the 1991 Demographic and Health Survey (ENDESA 91) (6), the most recent national survey available, only 5% of children under the age of 4 months in the Dominican Republic benefit from exclusive breastfeeding, and according to health authorities, the goal is to achieve a level of 15% by 1999. By way of contrast, in the project area (Herrera and Altagracia), 25.4% of children under age 4 months received exclusive breastfeeding, i.e., five times the percentage recorded at the national level (see **Figure 38**).

Persistent breastfeeding. According to ENDESA 91 (6), 12.2% of children between the ages of 20 and 21 months and 3% of children between the ages of 22 and 23 months continue to be breastfed, while in the project area 20% of all children between the ages of 20 and 23 months continue to be breastfed (see **Figure 38**).

The baseline study (1) conducted in August 1993 does not report the percentage of children under age 4 months who are breastfed nor the percentage of children under age 4 months who are breastfed exclusively.

These findings suggest that the project is contributing significantly to improving the feeding of young children.

B3. Control of diarrheal diseases

Reducing the prevalence of diarrhoea is one of the goals of the world summit for children (8). The prevalence of diarrhoea observed in the midterm evaluation (21.7%) is significantly lower than that seen in the baseline survey (53.6%). Both surveys were conducted during the same season, so that the differences observed in terms of the prevalence of diarrhoea cannot be attributed to seasonal variations. This strongly suggests that the preventive measures taken (breastfeeding promotion and maternal education in diarrhoea prevention, immunization against measles, etc.) are contributing significantly to the decrease seen in the prevalence of diarrhoea (see Figure 39). The current survey was not conducted during the same season of the year; however, as can be seen, diarrhoea prevalence remains low.

There is a significant percentage of diarrhoea that suggests the presence of persistent diarrhoea and dysentery, which require appropriate management in accordance with WHO guidelines (10, 11, 12).

Significant changes have been recorded with regard to the use of oral rehydration therapy (see Figure 40). The baseline survey reported that use of ORT was 56.3% (1), while in the current survey use of ORT was 72.3%. This coverage for ORT is greater than that seen at the national level. ENDESA 91 (6) reports that only 31.6% of children under age 5 years receive ORT (see Figure 40).

B4. Control of pneumonia

The presence of coughing and rapid breathing is suggestive of pneumonia; any child presenting such symptoms should be taken to a health unit staffed by a health provider with the ability to properly classify such cases and provide appropriate treatment. In Herrera and Altagracia, 66.9% of children with cough and rapid breathing were taken to one or another public or private health facility (hospital, health post or center, or private physician). There is an evident need to increase this percentage even further and to ensure that care provided to children is based on standard case management criteria dictated by PAHO (13) (see Figure 41). The presence of persistent cough (more than 15 days according to SESPAS) is suggestive of tuberculosis. Although tuberculosis control is not a component of the PSI, as a result of the significant percentage of cases of persistent cough that do not receive adequate treatment (see Figure 42), an appropriate analysis should be conducted with a view toward expanding this component in the future and establishing ties with the ARI and HIV/AIDS prevention components (see section C1., Control of Tuberculosis).

B5. Immunizations

Maintenance of children's vaccination and growth monitoring cards improved significantly. The percentage of mothers able to present their child's vaccination card

increased from 76% (baseline, August 1993) to 88% (in December 1996) (see **Figure 43**). Children's vaccination coverage (based on the vaccination card) also increased in comparison to the midterm evaluation: **BCG** coverage increased from 61.9% to 82.2% while **Polio 3** went from 63.4% to 80.8%, **DPT 3** rose from 61.9% to 80.0%, and **measles** vaccinations increased from 63.4% to 78.7% (see **Figure 44**). These levels of coverage are considerably higher than those reported by CONASUMI in a survey conducted recently (November 1995) in the metropolitan region as part of its external evaluation (coverages (according to the card) reported by the CONASUMI external evaluator were: BCG, 59.9%; polio 3, 56.6%; DPT 3, 60.5%; and measles, 52.6%) (17) (see **Figure 45**). When only vaccination coverages as measured by the vaccination card are compared, the figures observed for the PLAN area are also higher than those found in ENDESA 91 (see **Figure 46**).

In addition, an increase was observed in **access to the EPI** (measured as the percentage of children who received DPT 1), from 73.0% during the midterm evaluation (July 1995) to 87.2% in the current evaluation (December 1996). The **dropout rate** decreased favorably from 11.7% to 7.3% over the same period.

With regard to immunization coverages under the Expanded Program on Immunization (EPI), significant differences exist with regard to the methodologies used in the current survey and in the baseline conducted in August 1993. In the current survey, the source of information for vaccinations was exclusively the immunization card, so that a child without a card was classified as unvaccinated, as recommended by Johns Hopkins University and others (3, 4). In the August 1993 baseline survey, according to interviews conducted with project personnel and surveyors participating in the first survey, the immunization card method was combined with the recall method. According to these informants, if the mother did not present the card, the interviewers proceeded to ask her if she had been given each of the vaccines. Obviously, this combination of methods used in the baseline survey makes coverages appear higher than they actually were. Accordingly, although the levels of coverage observed in the current survey are not comparable with those reported in the baseline survey, they are comparable to those found in the midterm evaluation.

Overall, the above data suggest that the project is making a difference in the area of **Herrera and Altagracia** but that there is still more progress to be achieved, particularly in terms of maintenance of the immunization card. It is very possible that by merely improving maintenance of the vaccination card immunization coverage will increase considerably.

B6. Reproductive health

With regard to vaccination for pregnant women, possession of a **maternal health card** increased from 23.1% (in July 1995) to 47.7% (in December 1996). Vaccination coverage with **tetanus toxoid** (in accordance with the corresponding card) increased from 17.7% to 44.3%. Through the survey, this coverage was also measured using the recall method, with

the results showing that 88.0% indicated that they had received two or more doses of tetanus toxoid (see **Figure 47**).

The percentage of mothers who indicated having received at least one **prenatal check-up visit** is quite high when measured by the recall method (99.0%), while when measured by the health card method, the percentage drops to 40.3%, since very few mothers keep the prenatal check-up card (47.7%). This illustrates the importance of ensuring that the cards are retained if high levels of coverage are to be recorded. Comments made by PVSs indicate that this is possibly due to the fact that the cards are retained in SESPAS health service centers. However, there is also a possibility that opportunities for providing vaccinations are being lost: since such a high percentage of mothers do indeed comply with their prenatal check-up visit, it may be that the vaccine is not being given during such visits (14,15) (see **Figure 47**).

With regard to **family planning**, the percentages of mothers that know where to obtain contraceptive methods is quite high (96%). 53.4% of the mothers use modern contraceptive methods, as compared to 33.9% reported by ENDESA 91 for all women and 51.7% for women in union (6) (see **Figure 47**). It is important to know why mothers who know where to obtain contraceptives do not seek them or do not use them. This requires that additional qualitative studies be carried out.

B7. Prevention and control of HIV/AIDS

This is the most recent intervention, having been introduced subsequent to the midterm evaluation. Nevertheless, 79% of the mothers indicated that they received messages on HIV/AIDS prevention in the project area. 68.7% were able to mention two or more forms of HIV/AIDS transmission if we exclude from this group those mothers who in addition to mentioning the correct form also mentioned incorrect forms. If we include all mothers who mentioned two forms, the result is that 79.6% are aware of two or more forms of transmission. These figures are higher than those found in the midterm evaluation (see **Figure 48**). 70.6% of the mothers were able to mention two or more appropriate forms of HIV/AIDS prevention, while in the midterm evaluation this figure was only 37.7%.

During the midterm evaluation (which was the baseline for the HIV/AIDS component), none of the mothers were able to list three forms of HIV/AIDS transmission (by sexual relations, by contaminated blood, and from mother to child), while in the current survey it was found that this figure had increased to 15% (see **Figure 48**).

These findings suggest that the project is successfully changing knowledge with regard to prevention of HIV/AIDS and that it is necessary to devote increased efforts to bringing about additional significant changes in the area of HIV/AIDS prevention.

C. Interventions in which the project is no longer active

C1. Tuberculosis control

This component is not part of the child survival project. However, although data were collected under the tuberculosis component in part because of its relationship with ARI, the primary reason was as a result of its association with HIV/AIDS. The percentage of families where one or more family members has a persistent cough is relatively high (16.3%). These individuals with persistent cough should be investigated in order to rule out the possibility of tuberculosis. However, almost half of these individuals fail to seek assistance or medical advice. Considering that tuberculosis is the most common of the opportunistic infections affecting HIV/AIDS patients, this component should be included in the near future. (Figure 44)

V. Conclusions and recommendations

A. Conclusions

- ◆ The child survival project extended its coverage significantly by improving its ability to identify and affiliate new families moving into the project area, as recommended at the time of the midterm evaluation.
- ◆ Generally speaking, the project is effective and has contributed significantly to improving the level of health of mothers and children in Herrera and Altagracia. Maternal knowledge and coverage for services related to growth monitoring, breastfeeding, control of diarrheal diseases and immunizations, as well as maternal knowledge of HIV/AIDS prevention, have increased despite the fact that the project has been transferred to local organizations and community volunteers (SESPAS, NGOs and community PVS supervisors).
- ◆ Based on the recommendations issued at the time of the midterm evaluation, the project introduced an HIV/AIDS prevention component. The project generated significant changes in a relatively short period of time. To attain significant changes even greater than those generated (with regard to maternal knowledge, attitudes and practices) in the area of HIV/AIDS prevention would require an intervention of longer duration.

B. Recommendations

The following recommendations are directed primarily toward the local organizations (SESPAS, CEP) that will assume responsibility for continuation of project activities:

- ◆ Introduce the new WHO/PAHO package known as "Integrated Care for Childhood Illnesses" (AIEPI). Train members of the staff of SESPAS, NGOs, community organizations and Volunteer Health Promoters in the AIEPI. This will make it possible

to strengthen those components already in operation and include the identification and referral of cases of tuberculosis.

- ◆ Hold rapid focus groups in order to identify factors facilitating or constraining the adoption of exclusive breastfeeding during the first six months of life of children.
- ◆ Strengthen support groups for promoting and supporting breastfeeding based on previously existing structures (women's church groups, community organizations, etc.), avoid creating artificial parallel structures, and refrain from offering incentives that local organizations will be unable to continue. Incorporate other reproductive health components, including HIV/AIDS prevention, into these support groups.
- ◆ Conduct rapid focus groups in order to identify those factors that facilitate or constrain the use of modern contraceptive methods.
- ◆ Maintain and strengthen permanent vaccination posts and integrate into these facilities centers for nutritional education, in order to ensure that every child who is vaccinated will also be weighed.

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ANNEX 2

ANNEX 2

EVALUATION PLAN

Objective	Activity	Date	Support Required	Individuals Responsible
1. Conduct initial preparations	1.1 Begin planning	11/15	List of communities and population	PLAN/Santo Domingo Health Team
	1.2 Select, adapt, develop questions for questionnaire	to	Creation of core team, list of candidates for surveyors and supervisors	
	1.3 Select sample			
	1.4 Coordinate administration and logistics	11/30	Midterm evaluation report	
2. Discuss Child Survival Project (PSI) evaluation objectives, strategies and guidelines	2.1 Meeting of the evaluation team	12/2	Locale, USAID guidelines, PLAN requirements, PSI documents	Evaluation team, PLAN/Santo Domingo Health Team
	2.2 Meeting with the Health Coordinator			
	2.3 Meeting with the Director of PLAN Santo Domingo			
	2.4 Finalize survey preparations			
	2.5 Training for the core survey team			
3. Analyze documents related to the PSI	3.1 Gather relevant documents	12/2 12/3	Available documents, portable computer, diskettes (2)	Evaluation Team, PLAN/Santo Domingo Health Team
	3.2 Reading and analysis of documents			
4. Design data collection	4.1 Develop procedures based	12/4	Computer, printing and	Evaluation Team

Objective	Activity	Date	Support Required	Individuals Responsible
methodology and instruments	on guidelines, needs and documents		photocopying facilities	
5. Form five data collection teams for the rapid survey	5.1 Training of supervisors 5.2 Training of surveyors 5.3 Field test 5.4 Final survey preparation	12/5 to 12/9	Team of trainers Training site Refreshments Transportation	Rapid survey team
6. Gather the necessary data	6.1 Gather data from the rapid survey 6.2 Conduct <i>in situ</i> community visits 6.3 Visit individuals responsible for Ministry of Health maternal-child health programs 6.4 Meeting with relevant staff from NGOs involved with the PSI 6.5 Meeting with responsible individuals from other organizations involved with the PSI 6.6 Meeting with members of the staff of PLAN involved with the	12/10 and 12/11 12/5 to 12/11	Transportation for the rapid survey and qualitative data collection, field personnel, individual to act as recorder, battery operated portable cassette recorder (1), batteries (12), audio-cassettes (12), snacks (5) for participants in the Focus Group (F.G.), appropriate sites for F.G.	Evaluation Team PLAN/Santo Domingo Health Team

Objective	Activity	Date	Support Required	Individuals Responsible
	PSI			
7. Organize the data collected	7.1 Computerized data entry (EPI-INFO version 6.0) 7.2 Data processing 7.3 Data analysis 7.4 Prepare presentation of findings	12/10 to 12/12 12/12 to 12/13	Four professional data entry operators, computers, printing facilities, transparencies, photocopying facilities	Evaluation Team, PLAN/Santo Domingo Health Team
8. Organize the presentation of findings (feedback meeting)	8.1 Implement presentation of the evaluation results 8.2 Discuss the findings with the audience: • PLAN • SESPAS, NGOs, PVSs and community leaders 8.3 Outline recommendations	12/13	Locale, snacks, overhead projector, screen	Evaluation Team, PLAN/Santo Domingo Health Team
9. Prepare the first draft of the evaluation report	9.1 Prepare the report in accordance with the findings, feedback meeting	12/14 to 12/16	Computer, printing and photocopying facilities	Evaluation Team
10. Present lessons learned during the PSI to Health Coordinators from countries in the region	10.1 Discuss the lessons learned in the regional "Growing Up Healthy" workshop	12/17	Locale, snacks, audio-visual HIV/AIDS and equipment, simultaneous translation	Growing Up Healthy Regional Network

Objective	Activity	Date	Support Required	Individuals Responsible
(ROCCA)				
11. Prepare final draft of report	11.1 Send draft in Spanish to Dr. J. Valadez (Central Office in Washington)	12/21	E-mail	Dr. Gustavo Tapia
	11.2 Send draft with comments to evaluators	01/17/97		Dr. Joseph Valadez
	11.3 Send revised draft to PLAN/Santo Domingo	01/25		Dr. R. Soto - Dr. G. Tapia
	11.4 Send final version in Spanish for translation	01/26		Rezene Tesfamarian
	11.5 Send final version in English to USNO/USAID	02/28		

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ANNEX 3

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ANNEX 3

LIST OF INDIVIDUALS CONTACTED

PLAN International:

Mr. Rezene Tesfamarian, Country Director
Mrs. Elsa Grullón de Hart, Director Santo Domingo Office
Dr. Nelson Gómez, Health Coordinator
Ms. Violeta Novas (nurse)
Ms. Ercilia Azcona
Ms. Baris Calderón
Ms. Gladys Estévez
Ms. Daysi Rosado

SESPAS:

Central Level

Dr. Josefina Coen, Undersecretariate for Planning

Local Level

Dr. Juan Ramos, General Physician, Director of the Díaz Piñeyro Peripheral Clinic
Dr. Leandra Ditrén, Pediatrician, Director of the Las Caobas Subcenter
Dr. Manuel Félix Pérez, Epidemiologist, Las Caobas Subcenter
Dr. Rosa Robles, Physician and Health Practitioner, Director of the El Libertador Clinic
Dr. Alma Collado, General Physician, Director of Las Banderitas Clinic
Dr. Manuel Ferrer, Epidemiologist, Las Caobas Subcenter
Dr. Porfirio de la Cruz, Physician, Director of the Las Palmas Community Center Clinic
Dr. Soila Duquela, General Physician, El Libertador Clinic

CONASUMI:

Dr. Angel L. Alvarez, Executive Director

COMMUNITY:

Community Organizations and Local NGOs:

Sandra Solano, President, Integrated Community Development Project (PRODECOIN)
Dominga Marrero, Public Relations Secretary, PRODECOIN
Carlos Pimentel, General Secretary of PRODECOIN
Pedro Arias, Executive Secretary, Center for Popular Education (CEP)
Bernardo Medina, Treasurer, CEP
Rosalía de los Santos, Secretary/Assistant, CEP
Domingo Berroa, Vice-President, Las Palmas Community Center
José Concepción, President, Board of Community Neighborhood Parents

PVSs:

Máxima Mercedes, María Trinidad Sánchez Group

Gertrudis Morel, CEN Supervisor, Neighborhood of El Libertador

Brunilda González, CEP, Neighborhood of Buenos Aires

Magalis Guzmán, President, Women's Group of the Neighborhood of Holguín

Rosa Hilda Casado, Women's Group of the Neighborhood of Buenos Aires

Eliza Mota, Las Abejas Health Center, Neighborhood of Las Palmas

Autonomous University of Santo Domingo (UASD):

Dr. Diomedes Robles Cid, Dean of the School of Health Sciences (FCS)

Dr. Fernando Alvarez, FSC Planning Unit

Dr. Clavel Sánchez, FCS Advisor

ANNEX 4

ANNEX 4

DATA COLLECTION INSTRUMENTS

**GUIDE TO FOCUS GROUP TOPICS
TECHNICAL HEALTH ASSISTANTS (ATS)**

Date: _____ Beginning Time: _____ Ending Time: _____

Place: _____

Number of Participants: _____ Male: _____ Female: _____

- 1) What percentage of PSI technical activities (promotion, education, training, vaccination, weighing...) are conducted by _____ (community groups, local NGOs, SESPAS)?
- 2) What percentage of PSI administrative activities (purchasing, supply, distribution, organization...) are conducted by _____ (community groups, local NGOs, SESPAS)?
- 3) What percentage of mothers with children under age 2 have been empowered to communicate PSI messages to other mothers? How many of them are actually doing so?
- 4) Have the management/administrative systems (supply, maintenance, transportation, communications, health information system) been improved in _____ (community groups, local NGOs, SESPAS)? In what percentage?
- 5) What percentage of _____ (community groups, local NGOs, SESPAS service centers) have integrated PSI activities into their work plans?
- 6) What percentage of expenditures for PSI activities are contributed by _____ (community groups, local NGOs, SESPAS)?
- 7) What factors have contributed to or facilitated your maternal-child health activities in your area of influence?
- 8) What factors have constrained or limited your maternal-child health activities in your area of influence?
- 9) What are the positive effects of PSI/PLAN? Were they unexpected?
- 10) What are the negative effects of PSI/PLAN? Were they unexpected?
- 11) What has been, and will continue to be, the community contribution to the implementation of child survival activities, even after the conclusion of the PSI?

12) What is the current capacity of associated NGOs to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

13) What is the current capacity of SESPAS, not only in terms of human, technological, financial and physical resources, but also in terms of political will, for sustaining activities upon the conclusion of the PSI?

14) What is the current capacity of local community organizations to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

15) What other institutions will support the sustainability of child survival activities?

**GUIDE TO FOCUS GROUP TOPICS
REPRESENTATIVES OF COMMUNITY GROUPS**

Date: _____ Beginning Time: _____ Ending Time: _____

Place: _____

Number of Participants: _____ Male: _____ Female: _____

List of Participants:

- 1) What PSI technical activities (promotion, education, training, vaccination, weighing...) are performed by your organization?
- 2) What PSI administrative activities (purchasing, supply, distribution, organization...) are performed by your organization?
- 3) Have the management/administrative systems (supply, maintenance, transportation, communications, health information system) of your organization been improved as a result of PSI/PLAN? In what percentage?
- 4) How have you successfully integrated PSI activities into the work plans of your organization?
- 5) Does your organization contribute financially to the implementation of PSI activities? In what percentage?
- 6) What factors have enabled your organization to participate in the implementation of maternal-child health activities in your area of influence?
- 7) What factors have constrained your participation in the implementation of maternal-child health activities in your area of influence?
- 8) What are the positive effects of PSI/PLAN? Were those effects expected?
- 9) What are the negative effects of PSI/PLAN? Were those effects expected?
- 10) What will be the role played by your organization after the conclusion of PSI/PLAN?
- 11) What is the current capacity of local community organizations to provide human,

technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

12) What is the current capacity of local NGOs to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

13) What is the current capacity of SESPAS, not only in terms of human, technological, financial and physical resources, but also in terms of political will, for sustaining activities upon the conclusion of the PSI?

14) What other institutions will support the sustainability of child survival activities?

**GUIDE TO FOCUS GROUP SUBJECTS
HEALTH PROVIDERS (SESPAS, LOCAL ORGANIZATIONS, PVSs)**

Date: _____ Beginning Time: _____ Ending Time: _____

Place: _____

Number of Participants: _____ Male: _____ Female: _____

List of Participants:

<u>Name</u>	<u>Position</u>	<u>Place</u>	<u>Time</u>
-------------	-----------------	--------------	-------------

1) What technical maternal-child health activities (promotion, education, training, vaccination, weighing...) do your service centers conduct in the areas of influence of the PSI?

2) What administrative activities (purchasing, supply, distribution, organization...) do your service centers conduct in the field of maternal-child health in the areas of influence of the PSI?

3) Have the management/administrative systems (supply, maintenance, transportation, communications, health information system) of your service centers been improved as a result of PSI/PLAN? In what percentage?

4) How have you successfully integrated PSI activities into the work plans of your service centers?

5) Do your service centers contribute financially to the implementation of PSI activities? In what percentage?

6) What factors have enabled your service centers to participate in the implementation of maternal-child activities in their area of influence?

7) What factors have constrained participation by your service centers in the implementation of maternal-child health activities in their area of influence?

8) What are the positive effects of PSI/PLAN? Were they unexpected?

9) What are the negative effects of PSI/PLAN? Were they unexpected?

- 10) What will be the role played by your service centers upon the conclusion of PSI/PLAN?
- 11) What is the current capacity of local community organizations to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?
- 12) What is the current capacity of local NGOs to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?
- 13) What is the current capacity of SESPAS, not only in terms of human, technological, financial and physical resources, but also in terms of political will, for sustaining activities upon the conclusion of the PSI?
- 14) What other institutions will support the sustainability of child survival activities?

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**GUIDE TO FOCUS GROUP SUBJECTS
REPRESENTATIVES OF LOCAL NGOs**

Date: _____ Beginning Time: _____ Ending Time: _____

Place: _____

Name: _____

NGO: _____

Position: _____

Length of time in the position: _____

- 1) What PSI technical activities (promotion, education, training, vaccination, weighing...) does your organization carry out?
- 2) What PSI administrative activities (purchasing, supply, distribution, organization...) does your organization carry out?
- 3) Have the management/administrative systems (supply, maintenance, transportation, communications, health information system) of your organization been improved as a result of PSI/PLAN? In what percentage?
- 4) How have you successfully integrated PSI activities into the work plans of your organization?
- 5) Does your organization contribute financially to the implementation of PSI activities? In what percentage?
- 6) What factors have enabled your organization to participate in the implementation of maternal-child health activities in its area of influence?
- 7) What factors have constrained your participation in maternal-child health activities in your area of influence?
- 8) What are the positive effects of PSI/PLAN? Were they unexpected?
- 9) What are the negative effects of PSI/PLAN? Were they unexpected?
- 10) What will be the role played by your organization upon the conclusion of PSI/PLAN?

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11) What is the current capacity of local community organizations to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

12) What is the current capacity of local NGOs to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?

13) What is the current capacity of SESPAS, not only in terms of human, technological, financial and physical resources, but also in terms of political will, for sustaining activities upon the conclusion of the PSI?

14) What other institutions will support the sustainability of child survival activities?

**GUIDE TO FOCUS GROUP SUBJECTS
SESPAS MANAGERS**

Date: _____ Beginning Time: _____ Ending Time: _____

Place: _____

Name: _____

Position: _____

Length of time in the position: _____

- 1) Have PSI/PLAN activities been successfully integrated into the work plans of the SESPAS health service centers in the area of Herrera? How?
- 2) What factors have enabled SESPAS health service centers to participate in the integration of maternal-child health activities with PSI/PLAN in the area of Herrera?
- 3) What factors have constrained participation of SESPAS health service centers in the integration of maternal-child health activities with PSI/PLAN in the area of Herrera?
- 4) What are the positive effects of PSI/PLAN? Were they unexpected?
- 5) What are the negative effects of PSI/PLAN? Were they unexpected?
- 6) Have the management/administrative systems (supply, maintenance, transportation, communications, health information system) of the service centers been improved as a result of PSI/PLAN? In what percentage?
- 7) What is the current capacity of SESPAS, not only in terms of human, technological, financial and physical resources, but also in terms of political will, for sustaining activities upon the conclusion of the PSI?
- 8) What will be the role played by SESPAS in the area of Herrera upon the conclusion of PSI/PLAN?
- 9) What is current capacity of local community organizations to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?
- 10) What is the current capacity of local NGOs to provide human, technological, financial and physical resources for sustaining activities upon the conclusion of the PSI?
- 11) What other institutions would support the sustainability of child survival activities?

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IDNUM: ____

**PLAN/Santo Domingo
Questionnaire to Determine Knowledge, Practices and
Coverage in the Area of Maternal-Child Health**

The following questions are for the mothers of children under age 2 years (24 months).

General Information

-
- G0. Questionnaire Number: ____
- G1. Date of interview (month/day/year __/__/__
- G2. Name of interviewer _____
- G3. Supervisor _____
- G4. Neighborhood _____ Code: ____
- Address: _____
-

Name and age of mother

- G5. First and last name _____
- G6. Age (complete years) ____

Name and age of child under age 2 years (if there are two, select the younger of the two)

- G7. Name _____
- G8. Date of birth (dd/mm/yy) __/__/__
(Consult date of birth on birth certificate or child health card)
- G9. Age of (name of child) in months ____
(For children under age one month, indicate: 0 0 months)

Affiliation

- G10. With PLAN International:
1. PLAN family []
 2. Non-PLAN family []

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G11. With the Child Survival Program:

- 1. yes []
- 2. no []

Education/Occupation of the Mother

E1. What is the highest level of education that you reached?

- 1. none []
- 2. primary and **unable** to read []
- 3. primary and **able** to read []
- 4. secondary or higher []

E2. Do you work outside the home?

- 1. yes []
- 2. no []

E3. Do you participate in any activity to "generate economic income"?

- a. no, none []
- b. artisanry, weaving, etc. []
- c. selling agricultural products []
- d. selling meals or prepared foods []
- e. domestic employee/other services []
- f. store/shop, itinerant salesperson []
- g. salaried worker []
- h. open "san" and/or raffles []
- i. other (specify) _____ []

E4. Who takes care of (**name of child**) while you are working or while you are outside the home?

(you may check more than one response)

- a. the child accompanies the mother []
- b. husband/partner []
- c. older siblings []
- d. grandmother/grandfather []
- e. other relatives []
- f. neighbors/friends []
- g. the maid []

Child Feeding and Nutrition

Breastfeeding and introduction of foods

N1. Are you breastfeeding (**name of child**)?

1. yes -----> **SKIP TO N3**
2. no

N2. Have you ever breastfed (**name of child**)?

1. yes
2. no -----> **SKIP TO N4**

N3. After delivery, when did you first breastfeed (**name of child**)?

1. in the first hour following delivery
2. in the first eight hours following delivery
3. more than eight hours following delivery
4. don't remember

N4. a. Are you giving (**name of child**) water or teas?

1. yes
2. no
3. don't know

b. Are you giving (**name of child**) cow's milk, powdered milk or a milk-based formula?

1. yes
2. no
3. don't know

c. Are you giving (**name of child**) pap, such as the kind prepared with cornmeal, wheat, oats or rice?

1. yes
2. no
3. don't know

d. Are you giving (**name of child**) fruit or fruit juice?

1. yes
2. no
3. don't know

e. Are you giving (**name of child**) carrots, squash, mangoes or papaya?

1. yes
2. no
3. don't know

f. Are you giving (**name of child**) green vegetables such as spinach or watercress?

1. yes
2. no
3. don't know

g. Are you giving **(name of child)** meat or fish?

- 1. yes []
- 2. no []
- 3. don't know []

h. Are you giving **(name of child)** green beans, peanuts or pigeon peas?

- 1. yes []
- 2. no []
- 3. don't know []

i. Are you giving **(name of child)** eggs, cheese or yogurt?

- 1. yes []
- 2. no []
- 3. don't know []

j. Are you adding green vegetables such as cilantro, celery, or spinach to the food given to **(name of child)**?

- 1. yes []
- 2. no []
- 3. don't know []

k. Are you adding sugar or honey to the food given to **(name of child)**?

- 1. yes []
- 2. no []
- 3. don't know []

l. Are you adding oil, butter or margarine to the food given to **(name of child)**?

- 1. yes []
- 2. no []
- 3. don't know []

m. What type of salt are you adding to the food given to **(name of child)**?

- 1. ground []
- 2. grains []
- 3. none []
- 4. don't know []

N5. At what age should the mother begin to give foods other than breast milk?

- 1. should begin prior to age 4 months []
- 2. should begin between the ages of 4 and 6 months []
- 3. should begin after age 6 months []
- 4. don't know []

N6. What foods contain vitamin A for preventing night blindness?

(you may check more than one response)

- a. don't know or others []
- b. green vegetables []
- c. fruits of a deep yellow color []
- d. meat/fish []
- e. breast milk []
- f. egg yolks []

N7. Have you received orientation with regard to feeding your child?

- 1. yes []
- 2. no []----- > **SKIP TO N9**
- 3. don't know []----- > **SKIP TO N9**

N8. Through which media do you receive information on feeding your child?

(DO NOT read the options to the mother, as they require spontaneous responses.

You may mark more than one response, and ask twice "and what else?")

- 1. talks/courses []
- 2. videos, TV, radio []
- 3. pamphlets, brochures, magazines []
- 4. other []
- 5. don't know/don't remember []

Growth monitoring

N9. Does (name of child) have his or her child card (or growth monitoring card) for monitoring weight?

- 1. yes [] (ask her to show it to you!)
- 2. lost the card []----- > **SKIP TO D1**
- 3. no []----- > **SKIP TO D1**

N10. Look at the graph of the child and record the following information: Has the child been weighed within the past four months (August, September, October, November)?

- 1. yes []
- 2. no []

N11. Is the last weight of the child beneath the line indicating normal weight?

- 1. yes []
- 2. no []

Control of Diarrheal Diseases

- D1. Has (**name of child**) had diarrhea within the past two weeks?
1. yes
2. no -----> **SKIP TO D10**
3. don't know -----> **SKIP TO D10**
- D2. How long did this episode of diarrhea last?
1. less than two weeks (0-13 days)
2. two or more weeks (14 or more days)
- D3. Did (**name of child**) have poo-poo with blood with this episode of diarrhea?
1. yes
2. no
3. don't know
- D4. While (**name of child**) had diarrhea, did you breastfeed him or her...
(read the options to the mother)
1. more than usual?
2. the same as usual?
3. less than usual?
4. stop breastfeeding completely?
5. the child was no longer being breastfeed?
- D5. While (**name of child**) had diarrhea, did you give him or her other liquids (in addition to breast milk)...
(read the options to the mother)
1. more than usual?
2. the same as usual?
3. less than usual?
4. stop breastfeeding completely?
5. only gave him or her breast milk?
- D6. While (**name of child**) had diarrhea, did you give him or her pap or puree...
(read the options to the mother)
1. more than usual?
2. the same as usual?
3. less than usual?
4. stop breastfeeding completely?
5. only gave him or her breast milk?
- D7. When (**name of child**) had diarrhea, what treatments did you give him or her, if any?
(DO NOT read the options to the mother, as they require spontaneous responses.
You may mark more than one response, and ask twice "and what else?")

- a. nothing/none
- b. oral rehydration packets
- c. water and salt solution (home-made serum)
- d. cereal-based solutions
- e. home-made liquids, teas
- f. antidiarrheals or antibiotics
- g. other (specify) _____

D8. When (**name of child**) had diarrhea, did you ask for advice or help?

- 1. yes
- 2. no ——— > **SKIP TO D10**

D9. Who did you ask for advice or help when (**name of child**) had diarrhea?
(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice “and what else?”)

- a. general hospital
- b. health center/health post
- c. private clinic/physician
- d. pharmacy
- e. volunteer health promoter
- f. traditional healer
- g. midwife
- h. friends and relatives
- i. other (specify) _____

Knowledge with regard to management of diarrhea

D10. What things would make you seek help when (**name of child**) has diarrhea?
(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice “and what else?”)

- a. don't know
- b. vomiting
- c. fever
- d. dry mouth, sunken eyes, sunken fontanelle, little urination (dehydration)
- e. prolonged diarrhea (more than 14 days)
- f. blood in the poo-poo
- g. loss of appetite
- h. weak or indifferent
- i. other (specify) _____

D11. What do you do when your child has diarrhea?
(you may check more than one response)

- a. don't know

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- b. initiate liquids as soon as possible
- c. give the child more liquid than usual
- d. give food more frequently and in smaller amounts
- e. correctly prepare and administer ORS
- f. take the child to a health center
- g. feed the child more after the diarrhea, so
he or she can recover weight
- h. stop giving liquids
- i. stop feeding
- e. other (specify) _____

D12. How should you feed your child when he or she is recovering from diarrhea?
(you may check more than one response)

- a. don't know
- b. give foods more frequently
- c. give a greater amount of food during the day
- d. give foods high in calories
- e. give fewer foods, take some foods away
- f. other (specify) _____

Control of Acute Respiratory Infections

R1. Has (name of child) been sick with a cough during the past two weeks?

- 1. yes
- 2. no ----- > **SKIP TO R5**

R2. Has (name of child) had rapid breathing and was he or she breathing as though tired when he or she became sick?

- 1. yes
- 2. no ----- > **SKIP TO R5**
- 3. don't know ----- > **SKIP TO R5**

R3. Have you sought help to treat (name of child) when he or she was sick with a cough and/or had difficulty breathing?

- 1. yes
- 2. no ----- > **SKIP TO R5**

R4. Who provided you with advice or help in treating the cough or respiratory difficulty of (name of child)?

(you may check more than one response)

- a. general hospital
- b. health center/health post
- c. private clinic/physician

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- d. pharmacy
- e. volunteer health promoter
- f. traditional healer
- g. midwife
- h. friends and relatives
- i. other (specify) _____

R5. What things would make you seek help when **(name of child)** has a respiratory illness?
(you may check more than one response)

- a. don't know
- b. rapid and agitated breathing
- c. in-drawing (inter-costal retractions)
- d. loss of appetite
- e. fever
- f. cough
- g. other (specify) _____

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Tuberculosis

T1. Does any one in your family have a persistent cough that has lasted more than 15 days?

1. yes
2. no ----- > **SKIP TO T4**

T2. Have you sought help in treating this person who has a persistent cough?

1. yes
2. no ----- > **SKIP TO T4**

T3. Who provided you with advice or help in treating this person who has a persistent cough?

(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice "and what else?")

- a. general hospital
- b. health center/health post
- c. private clinic/physician
- d. pharmacy
- e. volunteer health promoter
- f. traditional healer
- g. midwife
- h. friends and relatives
- i. other (specify)_____

T4. How can you recognize when someone has tuberculosis?

(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice "and what else?")

- a. don't know
- b. persistent cough (more than 15 days)
- c. cold (catarrh)
- d. loss of appetite
- e. loss of weight
- f. fever, sweating (at night)
- g. other (specify)_____

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Child Vaccination

- V1. At what age should (name of child) receive the anti-measles vaccine?
1. specify in months [_ _]
 2. no answer [] (99)
- V2. How many anti-tetanus vaccines should a pregnant woman be given in order to protect the baby?
1. one []
 2. two []
 3. more than two []
 4. none []
 5. don't know []
- V3. Do you have a vaccination card for (name of child)?
1. yes [] (ask her to show it to you!)
 2. lost the card [] ---- > SKIP TO S1
 3. no [] ---- > SKIP TO S1

V4. Look at the vaccination card and record the dates of the vaccinations in the appropriate space

(day/month/year)

BCG	_ / _ / _
POLIO	RN _ / _ / _
	1st. _ / _ / _
	2nd. _ / _ / _
	3rd. _ / _ / _
DPT (Triple)	1st. _ / _ / _
	2nd. _ / _ / _
	3rd. _ / _ / _
MEASLES	_ / _ / _
	_ / _ / _

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S4. Do you know what a person has to do in order to avoid becoming infected with HIV/AIDS?
(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice "and what else?")

- 1. don't know []
- 2. abstinence (young people delaying sex) []
- 3. remaining faithful to one partner (having sexual relations with only one partner) []
- 4. reducing the number of sexual partners []
- 5. not having sexual relations with individuals who practice risky behaviors (sexual workers, drug addicts, homosexuals, unknown strangers) []
- 6. using condoms []
- 7. saying no to drugs, avoiding the use of syringes or other objects contaminated with infected blood []
- 8. making blood transfusions safer []
- 9. not getting close to someone who is ill when he is coughing, or covering the nose or mouth []
- 10. not going into the swimming pool []
- 11. avoiding mosquito bites []
- 12. not using toilets used by sick people []
- 13. not kissing sick people []
- 14. not hugging sick people []
- 15. not shaking the hand of a sick person []
- 16. not using glasses, cups, silverware or plates used by sick [] []
- 17. not using clothing or towels used by sick people []
- 18. other (specify) _____ []

S5. Ms. (name of woman), what do you think your chances of becoming ill with HIV/AIDS are?

(read the options to the mother)

- 1. none []
- 2. slight []
- 3. great []
- 4. don't know []

S6. Would you live in the same house with someone who is ill with HIV/AIDS?

- 1. yes []
- 2. no []
- 3. don't know []

Mrs. (name of the mother), at this time I'm going to ask you some very personal questions. Your answers are very important for this research, and so I'm going to ask

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you to trust me and to be sincere in answering (ask if you could speak with her alone).

A private interview with the mother its not possible ----- > **SKIP to S13.**

S7. At what age did you engage in sexual relations for the first time? ___ years
don't remember []
no answer []

S8. Mrs. (**name of the mother**), do you currently engage in sexual relations?
1. yes []
2. no []----- > **SKIP TO S10**
3. no answer []----- > **SKIP TO S10**

S9. Do you use a condom or a prophylactic in your sexual relations?
(read the options to the mother)
1. never []
2. almost never []
3. half the time []
4. almost always []
5. always []

S10. Do you have a husband (stable sexual partner)?
1. yes []
2. no []----- > **SKIP TO S13**

S11. Do you think your husband engages in sexual relations with another person?
1. yes []
2. no []----- > **SKIP TO S13**
3. don't know []----- > **SKIP TO S13**
4. no answer []----- > **SKIP TO S13**

S12. What do you plan to do about it?
(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice "and what else?")
1. nothing/don't know []
2. talk to the husband about HIV/AIDS []
3. try to get husband to seek information on HIV/AIDS []
4. use condoms in sexual relations with husband []
5. ask husband to be tested for HIV/AIDS []
6. ask for a separation or divorce []
7. other (specify)_____ []

S13. Mrs. (**name of the woman**), venereal diseases are diseases transmitted primarily through sex. What signs might a woman have who has been infected with a venereal

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disease?

(DO NOT read the options to the mother, as they require spontaneous responses.

You may mark more than one response, and ask twice "and what else?")

1. don't know
2. may not have any signs
3. vaginal flow/secretion
4. pain on urinating
5. vesicles (small blisters) on the genitals
6. ulcer(s) or chancres (sores on the genitals)
7. inflamed ganglia in the groin (lumps or knots)
8. wart(s) on or near the genitals
9. other (specify) _____

Maternal Health

M0. How many times were you vaccinated against tetanus when you were pregnant with (name of child)?

1. once
2. two or more times
3. not at all
4. don't remember

M1. Do you have your maternal health card from when you were pregnant with (name of child)?

1. yes (ask her to show it to you!)
2. lost the card ----> SKIP TO M5
3. no ----> SKIP TO M5

M2. Look at the maternal health/vaccination card and record the number of TT vaccinations in the appropriate space:

1. one
2. two or more
3. none

M3. Does the maternal health card have spaces to record prenatal check-up visits?

1. yes
2. no ----> SKIP TO M5

M4. If so, check to see if the mother went for prenatal check-ups:

- 1. one
- 2. two
- 3. three
- 4. four or more
- 5. none

M5. Are you pregnant at this time?

- 1. yes -----> **SKIP TO M9**
- 2. no

M6. Would you like to have another child in the next two years?

- 1. yes -----> **SKIP TO M9**
- 2. no
- 3. don't know

M7. Are you now using a method to avoid becoming pregnant or to delay your next pregnancy?

- 1. yes
- 2. no -----> **SKIP TO M9**

M8. What is the principal method that you and your husband are using now in order to avoid your becoming pregnant?

(you may check more than one response)

- 1. tubal ligation/vasectomy
- 2. Norplant
- 3. injections
- 4. birth control pills
- 5. mini-pill
- 6. intra-uterine device
- 7. diaphragm
- 8. condoms
- 9. foams and gels
- 10. exclusive breastfeeding
- 11. rhythm method/cervical mucous method
- 12. abstinence
- 13. coitus interruptus
- 14. other

M9. Where can you obtain methods to avoid becoming pregnant?
(DO NOT read the options to the mother, as they require spontaneous responses. You may mark more than one response, and ask twice "and what else?")

- a. general hospital []
- b. health center/health post []
- c. private clinic/physician []
- d. pharmacy []
- e. volunteer health promoter []
- f. grocery store/beauty parlor []
- g. midwife []
- h. friends and relatives []
- i. other (specify)_____ []

M10. After how many months of pregnancy should a woman go to see a physician, nurse or midwife?

- 1. after the first trimester, 1-3 months []
- 2. halfway through the pregnancy, 4-6 months []
- 3. during the last trimester, 7-9 months []
- 4. doesn't need to go []
- 5. don't know []

M11. How many times did you visit a health center (clinic or hospital) for your prenatal check-up when you were pregnant with **(name of child)**?

- 1. once []
- 2. twice []
- 3. three times []
- 4. four or more times []
- 5. none []

M12. Were you given vitamins (iron, folic acid and calcium) to avoid anemia when you were pregnant with **(name of child)**?

- 1. yes []
- 2. no []

M13. While you were pregnant with **(name of child)**, was the amount of food you ate...
(read the options to the mother)

- 1. more than usual []
- 2. the same as usual []
- 3. less than usual []
- 4. don't know []

M14. Did you have any of the following danger signs when you were pregnant with (name of child)?

(read the options to the mother)

1. vaginal bleeding []
2. premature labor []
3. intense headaches []
4. attacks (convulsions) []
5. swelling of the legs (edema) []
6. blood pressure []
7. fever []
8. pain or difficulty in urinating []
9. no weight increase []
10. none []-----> SKIP TO M17

M15. Did you seek help when you had these danger signs when pregnant with (name of child)?

1. yes []
2. no []-----> SKIP TO M17

M16. Who provided you with advice or help when you had these danger signs?

(you may check more than one response)

- a. general hospital []
- b. health center/health post []
- c. private clinic/physician []
- d. pharmacy []
- e. volunteer health promoter []
- f. traditional healer []
- g. midwife []
- h. friends and relatives []
- i. other (specify)_____ []

M17. When (name of child) was born, who tied and cut the umbilical cord?

1. the mother herself []
2. a family member []
3. midwife []
4. health personnel (physician or nurse) []
5. other (specify)_____ []
6. don't know []

Sharing What Has Been Learned

- C1. Have you heard health messages dealing with...
(read the options to the mother)
1. breastfeeding?
 2. child feeding?
 3. vaccinations?
 4. care of a child with cough, flu?
 5. care of a child with diarrhea?
 6. family planning?
 7. HIV/AIDS prevention?
 8. none -----> **End of survey**
- C2. Have you shared these health messages with another mother?
1. yes
 2. no

End of Survey

Thank the mother for her cooperation.
Review the questionnaire prior to leaving the house.

ANNEX 5

ANNEX 5

PLAN/Santo Domingo

Growing Up Healthy

Strengthening of Local Efforts

VI. Background

A. PLAN fundamental sustainability strategy

In February 1996, PLAN/Dominican Republic determined that its primary strategy for sustainability would consist of strengthening local efforts.

Local efforts are construed to mean all those initiatives of local organizations (government organizations and NGOs) that contribute to the improving the quality of life of the child, his or her family, and his or her community.

To strengthen local efforts is to undertake actions that promote and reinforce the initiatives of local organizations and to avoid interventions that replace, substitute, harm or inhibit such initiatives.

By working through highly credible governmental organizations and NGOs instead of directly with the project beneficiaries or community organizations, PLAN International seeks to:

- reduce dependency of beneficiaries on PLAN
- promote mutual support and relationships of inter-dependence among local organizations

B. What actions will PLAN undertake to promote and reinforce the initiatives of local organizations?

PLAN International is prepared to provide moral, technical and financial support to the initiatives of these organizations already operating in the PLAN area that will contribute to improving the health status of children, adolescents and mothers. Accordingly, PLAN will support, to the extent of its abilities, project proposals for solving problems in the area of child survival, safe childbearing, family planning, STD/HIV/AIDS prevention, and basic water and sanitation.

C. From direct implementation to strengthening local efforts

In order to apply the fundamental sustainability strategy and move from implementation to

strengthening local efforts, PLAN is defining guidelines and selecting/designing the procedures and instruments required to support the local initiatives of local organizations working in the areas of child survival, safe childbirth, introduction of safe/potable water and basic sanitation to benefit the communities in which PLAN works. Of these guidelines, procedures and instruments, the following are currently available:

- Eligibility criteria for local organizations
- Criteria and instruments for assessing and selecting initiatives
- Guidelines and forms for presenting proposals
- Sample agreements between PLAN and local organizations
- Forms for technical and financial reports
- Evaluation instruments
- Guidelines for activity follow-up

VII. Eligibility criteria for local organizations

A local organization that is eligible to receive direct support from PLAN is any local organization that...

- ◆ is recognized by the community
- ◆ has been legally incorporated or is in the process of becoming incorporated
- ◆ is already operating in PLAN areas
- ◆ has an established accounting system that meets the minimum requirements of the Government Office of the Controller (registered accounting books)
- ◆ has the ability to cover its operating expenses with funds other than those provided by PLAN
- ◆ has prior experience in child survival, safe childbirth, STD/HIV/AIDS prevention, water or sanitation projects
- ◆ has staff who have been trained in child survival, safe childbirth, STD/HIV/AIDS prevention, or water and sanitation
- ◆ is willing to sign a legal agreement with PLAN

- ◆ is willing to submit technical and financial reports as required by PLAN
- ◆ is willing to submit to external evaluations and audits by PLAN and to submit its books and appropriate records at any time.

VIII. Selection criteria for initiatives

PLAN will support only those initiatives or project proposals...

- ◆ that are submitted by eligible organizations (see section on Eligibility Criteria for Local Organizations)
- ◆ that are presented on a timely basis and in the formats required by PLAN (see Annexes 1 and 2)
- ◆ that fulfill the minimum technical/financial requirements set forth in the guidelines for submitting proposals
- ◆ that involve one or more of the following areas: vaccination (with emphasis on vaccination of women who are pregnant or of reproductive age), breastfeeding promotion, growth and development monitoring, control of diarrheal diseases, control of ARI (and particularly of pneumonia), risk-free childbirth, family planning, prevention of women's cancer (cervical-uterine/breast), prevention of STD/HIV/AIDS, basic water and sanitation
- ◆ that include one or more of the following activities: provision of technical assistance to institutions or community leaders and/or training of institutional personnel or community volunteers to improve management capabilities, promotion of the demand for services and/or the supply of services for the areas mentioned in the preceding paragraph
- ◆ that focus on substantial problems or weaknesses encountered in evaluations or surveys of knowledge, practices and coverage previously conducted by PLAN or other organizations

Rating of the Organizations Submitting the Proposal

IX. Absolute criteria

The organization has...		Yes	No
1.	Legal status		
2.	Accounting system		
3.	Locale		
4.	Five or more years implementing health programs		
5.	Experience in managing funds for international NGOs		
6.	Evaluation/audit report		
7.	Works in PLAN area		

If the response to one of these statements is No, the organization is not eligible to receive PLAN financing.

X. Relative criteria

Question #	Category and Criteria	Maximum Score	Response	Value	Score Attained
	I. General Information	10			
9	No. of administrative and program personnel	5	Two or more of each type of personnel		
11	Amount of time working in PLAN area	5	More than two years		
	II. Administrative Resources	10			
1	Locale	5	Own Loaned	5 2	

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Question #	Category and Criteria	Maximum Score	Response	Value	Score Attained
			Rented Shared	3 1	
2	Vehicle	2	Yes		
3 and 6	Type of accounting system	3	Manual Computerized	2 3	
	III. Health Resources	40			
1	Health worker (highest grade)	7	Doctorate/Masters/ specialization University degree Technician High School	7 4 2 1	
1	Health worker (experience in health programs)	5	5 or more years 3 or 4 years 1 or 2 years less than 1 year	5 3 2 1	
2	Courses received	6 *	1 or more from PSI 1 or more on women's health Environmental sanitation STD/HIV/AIDS management	1 1 1 1 2	
3	Description of position	2	Yes	2	
4	Institutional personnel	5 *	1 or more physicians 1 or more nurses 1 or more nurse auxiliaries Other	2 1 1 1	
4	Community human resources	5	6-8 promoters 9-11 promoters 12-14 promoters	2 3 4	

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Question #	Category and Criteria	Maximum Score	Response	Value	Score Attained
			15 or more promoters	5	
5	Community posts	5 *	URO-C Vaccination post Center for Nutritional Education Contraceptive Dist. Center Popular pharmacy	1 1 1 1 1	
5	Sanitary Health Units	5 *	1 or more units 1 or more with URO 1 or more with vaccination post 1 or more with Center for Nutritional Education 1 or more with CBD	1 1 1 1 1	
	IV. Community participation in health	10			
1	Works with community organizations	10	with 1-2 organizations with 3-4 organizations	5 10	
	V. Background in program management	30			
2	Health programs	15 *	2 or more PSI 1 or more on woman's health 1 or more on sanitation 1 or more on STD/HIV/AIDS	5 5 2 3	
3	Type of service	10 *	Technical assistance Training Service promotion	2 3 3	

Question #	Category and Criteria	Maximum Score	Response	Value	Score Attained
			(IEC) Service provision	2	
5	Project implementation with PLAN funds	5	1 or more health projects	5	
	Totals	100			

* Results from adding the score for all responses

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ANNEX 6

Analysis and recommendations:

Topic: Strategy for strengthening local NGOs and their role in sustaining the child survival program

GROUP B-1

1. Systematic and continuous evaluation of organizations in order to correct informal problems and improve the bases.
2. Take into account the voluntary work of the PVSs.
3. Promote the supply of educational materials.
4. Train NGOs and PVSs in the PSI.
5. Economic sustainability of a portion of NGO expenditures.
6. Develop programs jointly with NGOs and SESPAS.
7. NGOs should have direct and physical support from the communities.
8. Each PVS should have a form of personal identification that is recognized by the community and in other places where health promoters' activities take them.
9. There should be responsibility by NGOs in complying with actions.

ROLE OF THE NGOs:

1. Each NGO should take on responsibility with regard to community development.
2. Participate actively in all programs implemented by SESPAS and other NGOs.
3. Availability to serve as agents for multiplying knowledge with regard to training and orientation with the support and help of SESPAS and/or other agencies.
4. Staff members of organizations and NGOs should be able to identify problems existing in the community.
5. Availability of staff members of each NGO to provide service to the community without regard to time or place.

6. Beginning with the evaluation submitted, to be sure not to falter but rather to continue onward until 100% of the goals set are achieved.

Topic: Strategies for strengthening local NGOs and their role in sustaining the child survival program

GROUP B-2

1. SESPAS and other organizations should conduct systematic and ongoing evaluations in order to correct certain problems and improve the administrative bases of the NGOs.
2. Take into account the volunteer work and efforts of the PVSs.
3. Promote the supply of educational materials.
4. Training of volunteer personnel in all health-related components.
5. Economic sustainability of a portion of the NGOs.
6. Develop programs jointly with mutual respect and support from SESPAS and NGO.
7. NGOs should find direct support in community residents.
8. Each PVS should have a form of personal identification recognized by the community.
9. SESPAS should act responsibly in terms of complying with what has been offered and agreed to.

ROLE OF NGOS IN THE PSI

1. Each local NGO should take on responsibilities with regard to implementation of community efforts.
2. Participate actively in all programs implemented in the community.
3. Availability to multiply knowledge acquired with the rest of the community.
4. As members of NGOs, we must address the principal problems of the community and seek immediate potential solutions.
5. Availability of members of NGOs to provide services to the community without regard for time or place.
6. Beginning with the evaluation submitted, avoid stagnation, opting instead to continue

building on the achievements recorded.

Topic: Role of SESPAS in PSI coordination, supervision and monitoring, and role of PVSs in project sustainability

GROUP A

COORDINATION:

- Hold area-level meetings.
- Create a team to work in collaboration with the staff of area health centers and PVSs, with [participation] of the directors.
- Ensure coordination in the areas of education and operations.

SUPERVISION:

- Hold workshops with PVSs and SESPAS personnel from the area level.
- Educate SESPAS personnel with regard to the work performed by the PVSs in the health centers, in order to maintain inter-relationships and communications between the staff and the PVSs.

MONITORING:

- PVSs will be given a card so that they can identify themselves as such and so that the SESPAS staff can assess and monitor the work performed by the PVSs and provide them with support.
- Promotion of health services provided by health centers through the PVSs.

SUSTAINABILITY:

- Include PVSs in training events conducted by the institute for its staff.
- Encourage the PVSs to continue working in the community and to take advantage of initiatives undertaken by other programs, such as the EPI.
- Listen to the PVSs when they express their concerns, and take them into account.
- The PVSs should be responsible for maintaining contact between the community and SESPAS.

- Through the health center directors, SESPAS will conduct an assessment of the area in order to identify the problem and make recommendations for proper compliance with the previously established agreement.

- Strengthen SESPAS structures in order to ensure appropriate follow-up.

Topic: Findings with regard to knowledge, practices and coverage (final PSI evaluation), analysis and recommendations

GROUP C-1

EPI:

- Continue training events.

- Encourage the flow of mothers to permanent vaccination posts.

BCG:

A. All maternity centers should ensure application of the vaccination prior to the departure of the mother.

B. Increase the supply of the vaccine to a greater number of permanent vaccination posts.

TT:

A. Improve recording of data on cards.

PRENATAL CHECK-UP:

A. Require accountability with regard to the underrecording of the large difference between percentages indicated by recall and percentages indicated on the card.

B. We recommend post-partum check-ups.

DIARRHEA:

A. Increase the number of UROs.

B. Maintain training activities.

NUTRITION:

- Increase the number of nutrition centers.

BREASTFEEDING:

- A. Increase mechanisms for promoting breastfeeding.
- B. Promote the dangers of bottle feeding.

ARI:

- A. Greater promotion of the program at the institutional and community levels.
- B. Personnel who have received training should become multiplication agents.

HIV/AIDS:

- A. The program should be given greater promotion.
- B. Disseminate information on the various forms of transmission.
- C. Work more with adolescents.
- D. Use of condoms.

GENERAL CONCLUSION:

- A. Standardize criteria for all PSI components.
- B. Provide incentives to volunteer health promoters in order to ensure program sustainability.
- C. Increase coordination between NGOs and SESPAS.

Topic: Findings with regard to knowledge, practices and coverage (final PSI evaluation):
analysis and recommendations

GROUP C-2

ANALYSIS AND FINDINGS

1. DIARRHEAL DISEASES:

A significant decrease from the baseline to the midterm, but from the midterm to the final evaluation there was no change. Accordingly, new strategies for addressing the problems in this sector need to be identified. Investigate the stagnation to determine if the reason was a lack of stimulation to action.

2. USE OF ORT:

There has been a significant increase, from 53% to 72.3%. This is important, since as a guide to prevention it is felt that this should continue to be strengthened with the delivery of pamphlets for direct intervention with mothers in order to prevent diarrhea.

3. PREVALENCE OF VACCINATION CARDS:

Baseline, 76.0%

Midterm, 79.6%

Final evaluation, 88.0%

Analysis:

Mothers are improving their ability to maintain the vaccination card.

PSI growth card:

Midterm, 67%

Evaluation, 83%

Presentation of growth monitoring cards:

Baseline, 20%

Midterm, 48.7%

Final evaluation, 85.3%

Children weighed:

Midterm, 21.7%

Evaluation, 68.7%

Percentage of messages received:

Breastfeeding, 79.3%

Child feeding, 76.7%

Vaccination, 79.3%

ARI, 63.7%

CDD, 69.3%

Recommendation: continue providing orientation to mothers with regard to these subjects.

Family planning, 72.3%

HIV/AIDS, 79.0%

Exclusive breastfeeding:

Midterm, 28.3%

Final evaluation, 25.4%

Recommendation: continue implementing educational programs in breastfeeding promotion through support groups and prenatal and postnatal check-ups.

Reproductive health:

Results: Increase in all indicators measured.

Analysis: Check-ups were performed satisfactorily by the individuals in charge.

Recommendations: Preventive programs of continuing education for all pregnant women in the area.

Access to treatment for pneumonia:

There was a decrease in access to treatment for pneumonia from 69.8% to 60.9%. We feel that there is reason for concern in this regard and that the causes should be investigated in order to determine whether the decrease was the result of by the nonavailability of treatment or the fact that mothers were unaware of where to seek such treatment.

Percentages of mothers that shared the message with other mothers:

77.5% share the message

22.5% do not share the message

Knowledge of feeding: 78.6%

List of Participants:

Sister Carmen Torres Collado, Pan y Vino Medical Center

Carmen Rosalía Ramírez

Elisa Fernández Peña

Dr. Rosa Robles, El Libertador Clinic, SESPAS

Dr. Edilberto Berry, Primary Health Care, SESPAS

Lic. Teresa Narváez

Karen Quiroz

Juan Pablo Ganchoso

Dr. Juan Ramos, Díaz Piñeyro Clinic, SESPAS

Lic. Pedro Arias, CEP

Rosy Geraldo
Domingo Berroa, Las Palmas Community Center
Alexandra Meléndez
Gertrudis Morel
Yocasta Santana, PVS
Belkis Pilar Pérez, PVS
Justina Tejeda, PVS
Elisa Mota, PVS
Dr. Diomedes Robles Cid, Dean of the FCS, UASD
Brunilda González, PVS
Dr. Adalberto Rodríguez, EPI, SESPAS
Mery De Co
Braudilia Medrano, PVS
Yassetty Rodríguez, PVS
Marcelina Guzmán, PVS
Isabel Rojas
Griselda Javier, PVS
Asia Mercedes, PVS
Miledys Morel, COPRODESADEBE
Griselda Jiménez, COPRODESADEBE
Dr. Alma Collado, SESPAS
Máxima Mercedes, María Trinidad Sánchez Group
Roma Rivas, PVS
Marys Batista, PVS
Dr. Teodoxia Rosario, Director of Area D, SESPAS
Dr. Johnny Rivas, CONASUMI
María Aquino Rubio
Rosa Julia Peña
Brasilia Rosario, PVS
María Díaz, Neighborhood Board
Bartola Ortiz
Dr. Cecilia Michell, CDD/ORT Program, SESPAS
Yajaira Vargas
Emely Bocio
Gladys Rodríguez
Carlos Pimentel, PRODECOIN
Dr. José Selig, CEP
Dr. Hilda Cruz, SESPAS
Dr. Manuel Ferrer, Las Caobas, SESPAS
Dr. Rosa M. Cruz, Breastfeeding Program, SESPAS
Dr. Hilda Natera, EPI, SESPAS
Valentina Concepción
Amada Moreno

ANNEX 7

Annex 7

Graphic Presentation of KPC Survey Results

PLAN/Santo Domingo
Child Survival Project
December, 1996

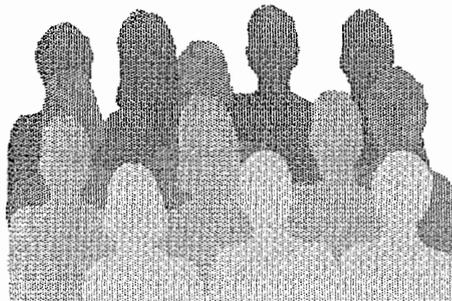
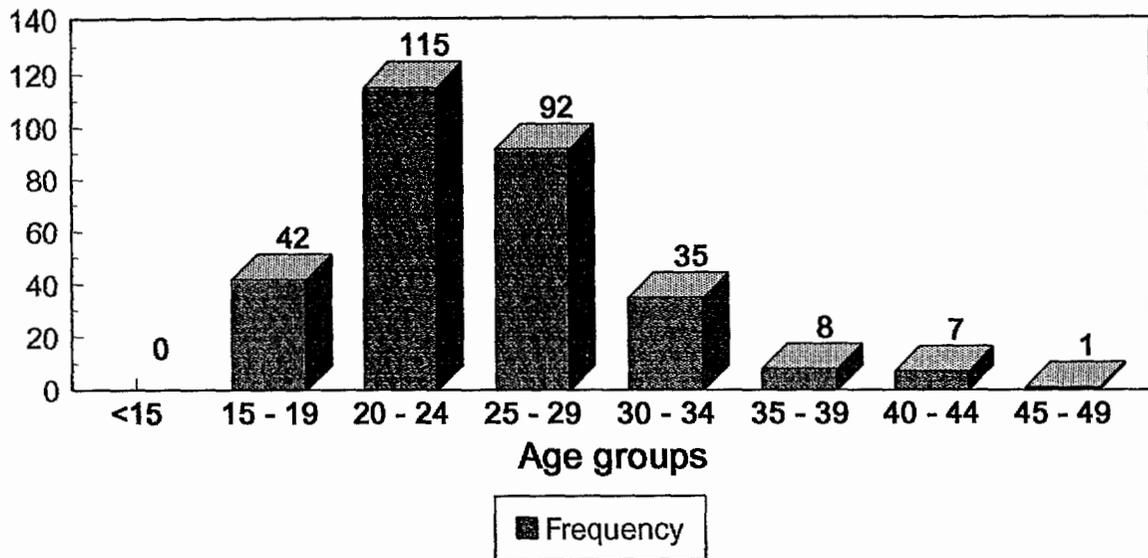
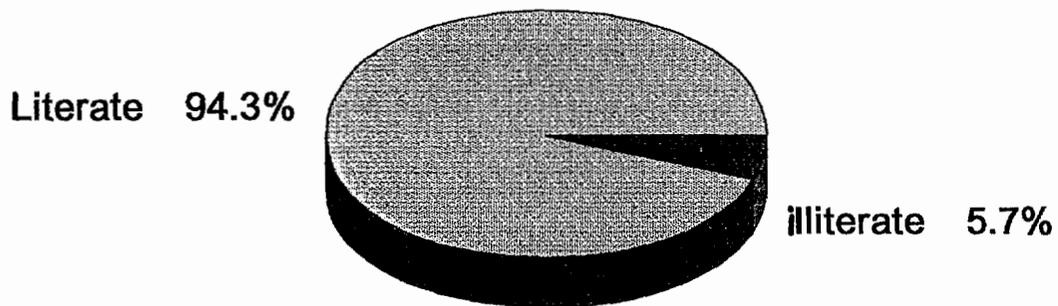


Figure 1. Age of mothers. Distribution by age groups



PLAN/Santo Domingo. KPC survey. December, 1997

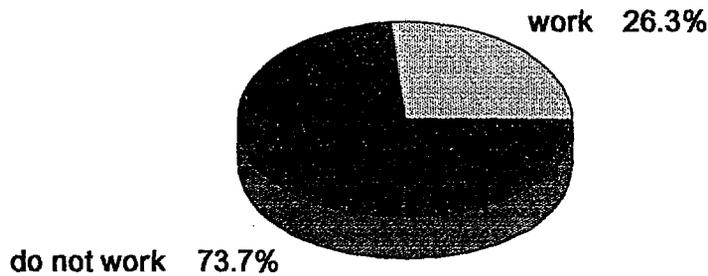
Figure 2. Mothers' literacy
Percentage of mothers who can read and write



PLAN/Santo Domingo. KPC survey. December, 1997

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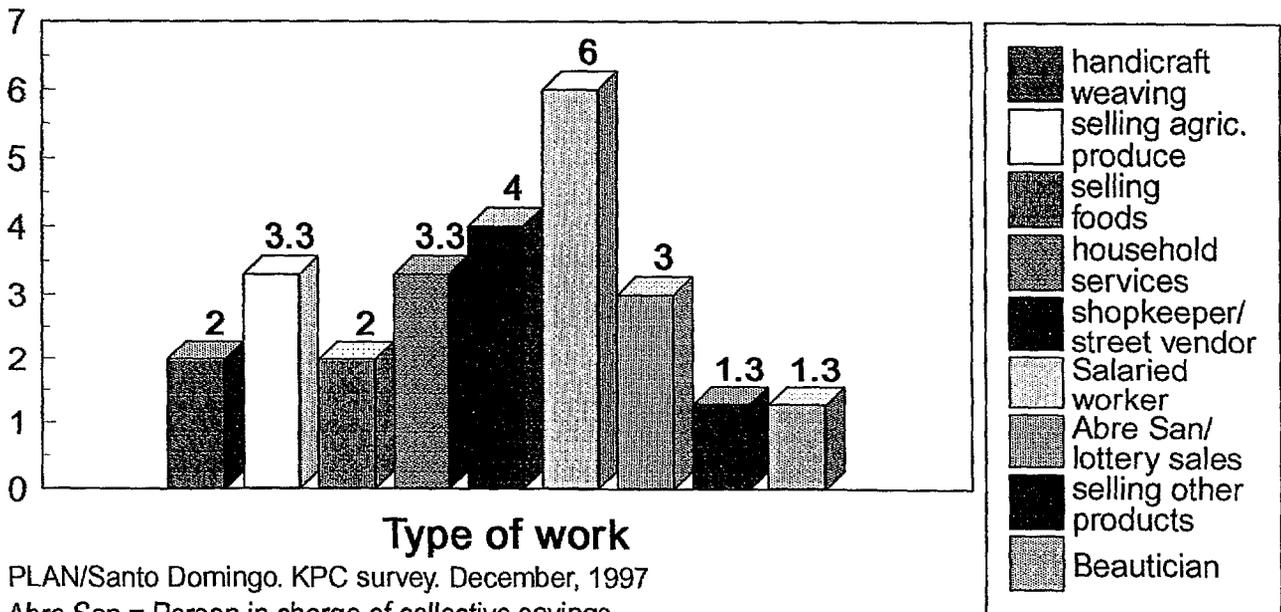
Figure 3. Mothers who work
 Percentage of mothers who work to earn income



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 4 . Type of income-generating work done by the mothers

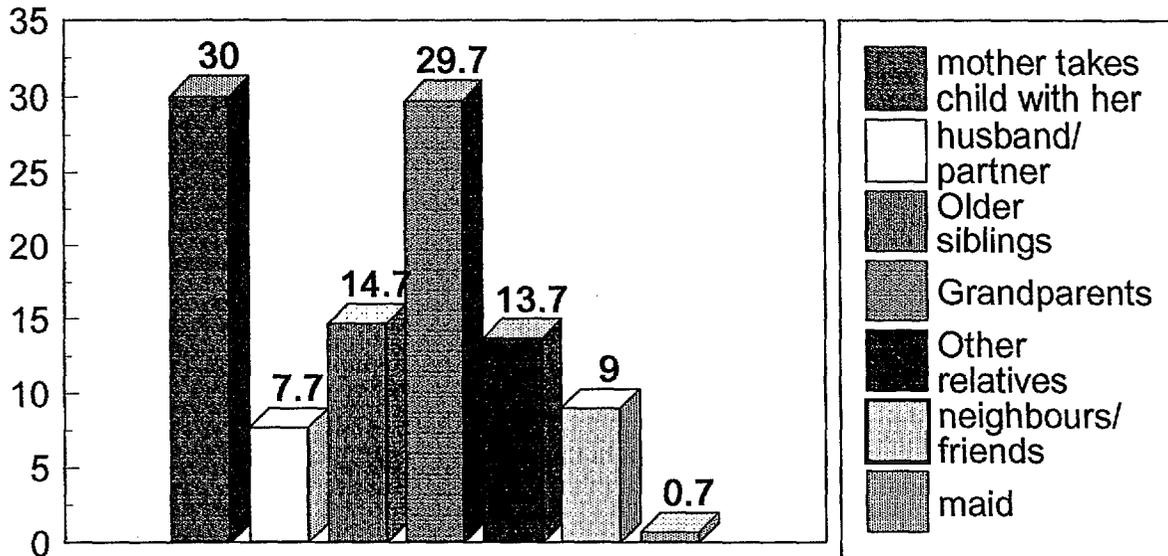
Percentage



PLAN/Santo Domingo. KPC survey. December, 1997
 Abre San = Person in charge of collective savings

Figure 5. Who takes care of children when the mother is away from home.

Percentage

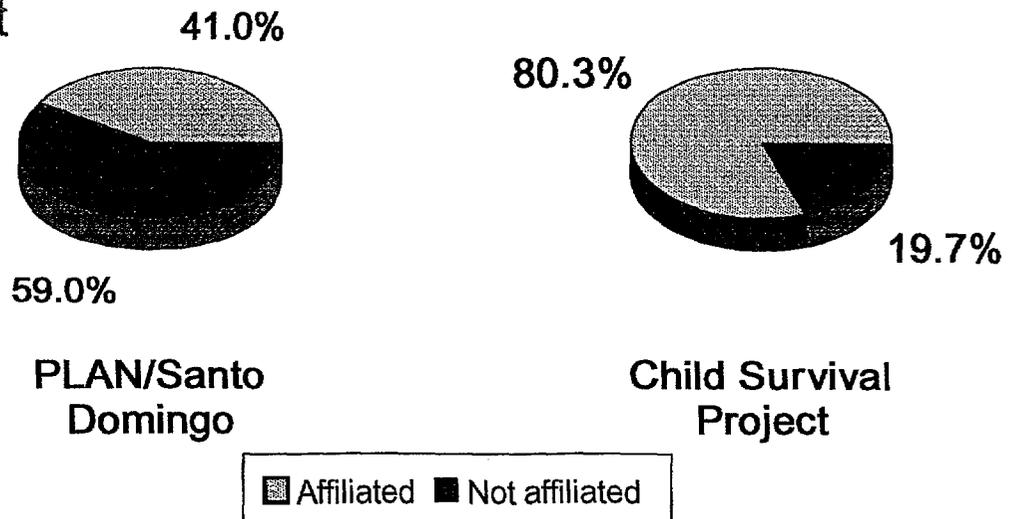


Persons in charge of taking care of children

PLAN/Santo Domingo. KPC survey. December, 1997

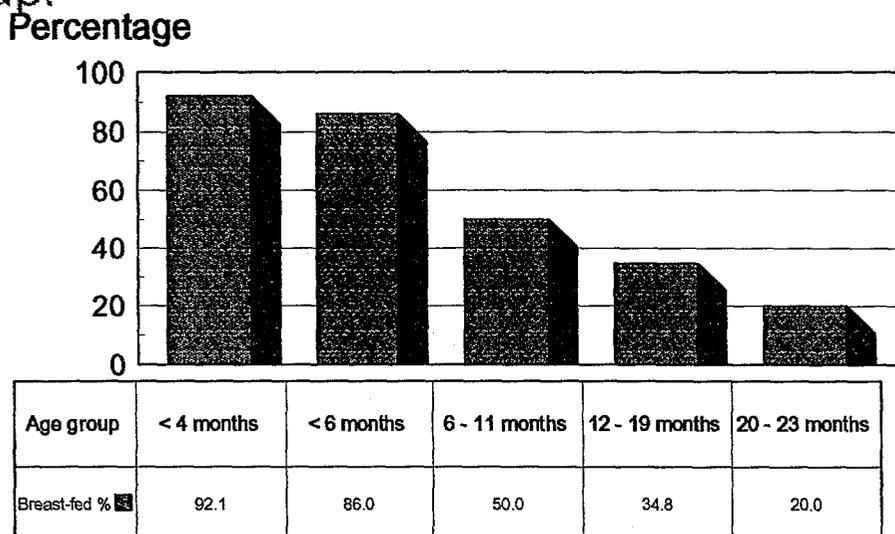
Figure 6. Families affiliated with PLAN and Child Survival Project.

% of families affiliated with PLAN/Santo Domingo and % of families affiliated with the Child Survival Project



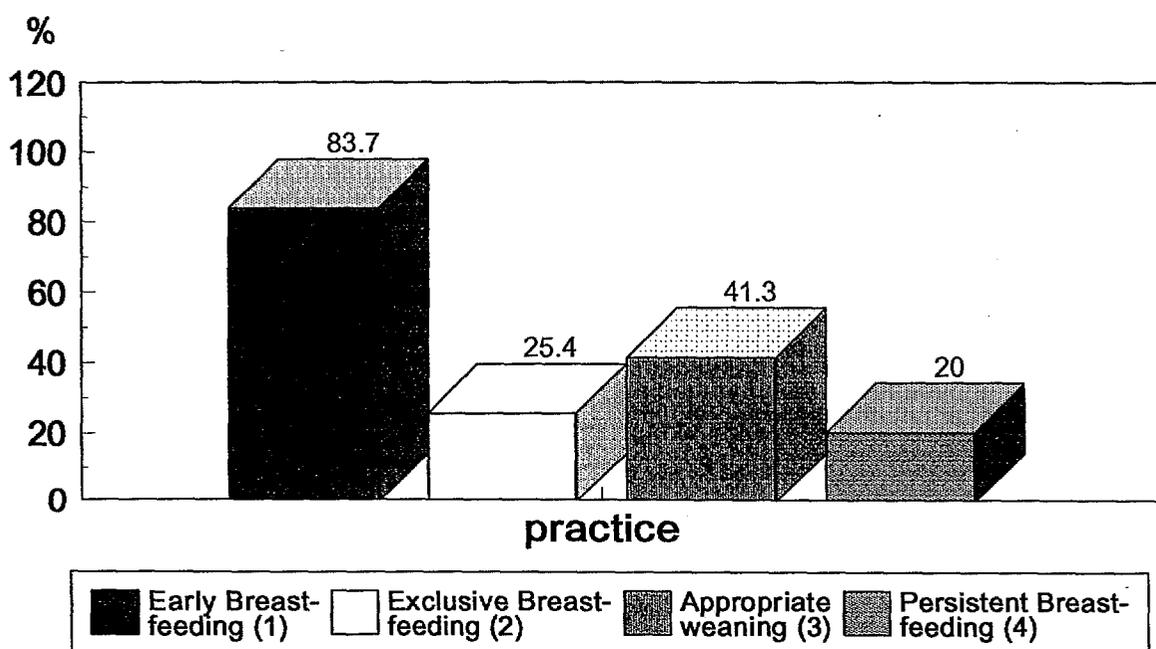
PLAN/Santo Domingo. KPC survey. December, 1997

Figure 7. Infants who are breast-fed.
 Percentage of children who are breast-fed by age group.



PLAN/Santo Domingo. KPC survey. December, 1997

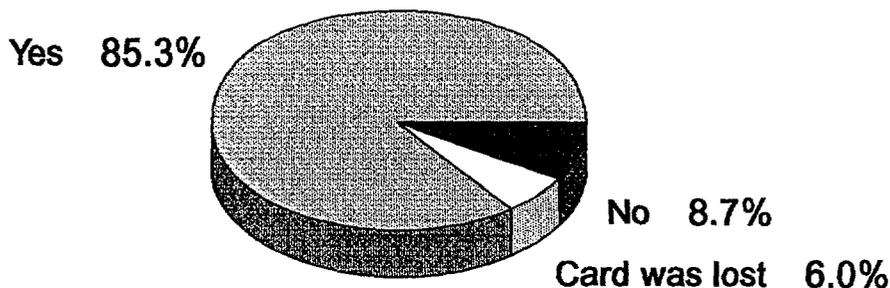
Figure 8. Appropriate feeding for children.
 % of children who receive appropriate feeding



PLAN/Santo Domingo. KPC survey. December, 1997

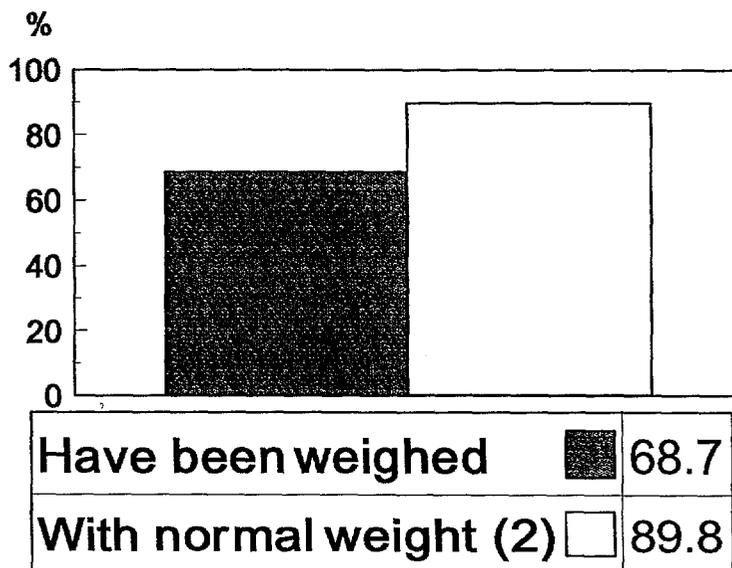
- (1) % of children who have been breast-fed during the first 8 hours after the childbirth.
- (2) % of children under 4 months of age who receive exclusive breastfeeding
- (3) % of children from 5 to 9 months who receive solid or semisolid foods
- (4) % of children from 20 to 23 months who are breast-fed

Figure 9. Children with Growth Monitoring Card. Percentage of children who have growth chart



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 10. Children who have been weighed and Children with normal weight for age. According to Growth Monitoring card



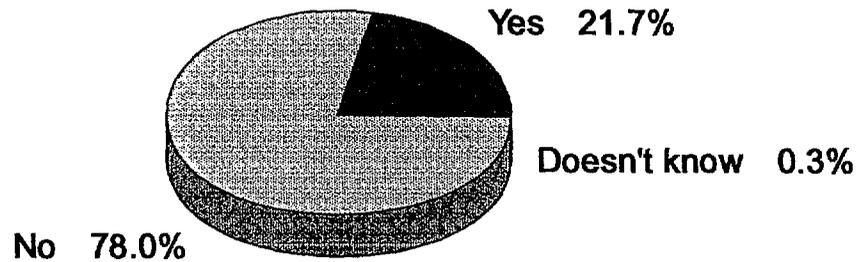
PLAN/Santo Domingo. KPC survey. December, 1997

(1) Percentage of infants and children who have been weighed in the last 4 months according to the Growth Chart

(2) Percentage of children who have normal weight for age according to the growth chart.

Figure 11 . Children with diarrhea Percentage of Children with Diarrhea in the last two weeks

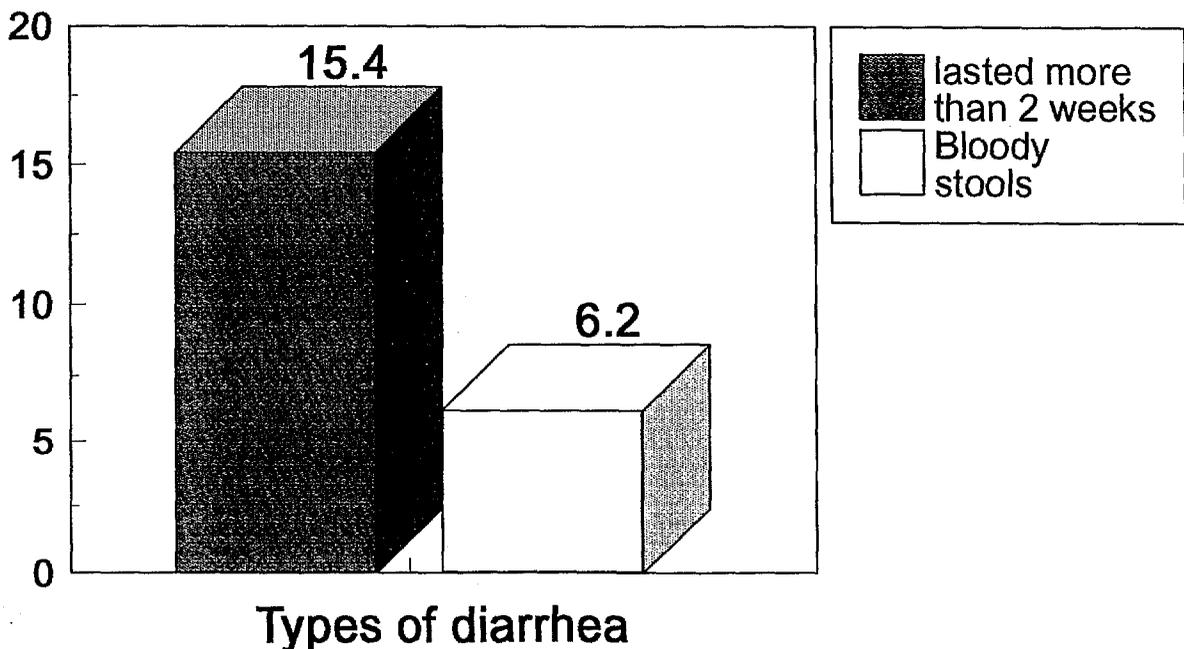
Has had diarrhea during the last two weeks?



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 12 . Persistent diarrhea and dysentery Percentage of children having diarrhea in the last two weeks who show signs of persistent diarrhea or dysentery

% of the total number of children with diarrhea



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 13. Case management of diarrhea at the household level.

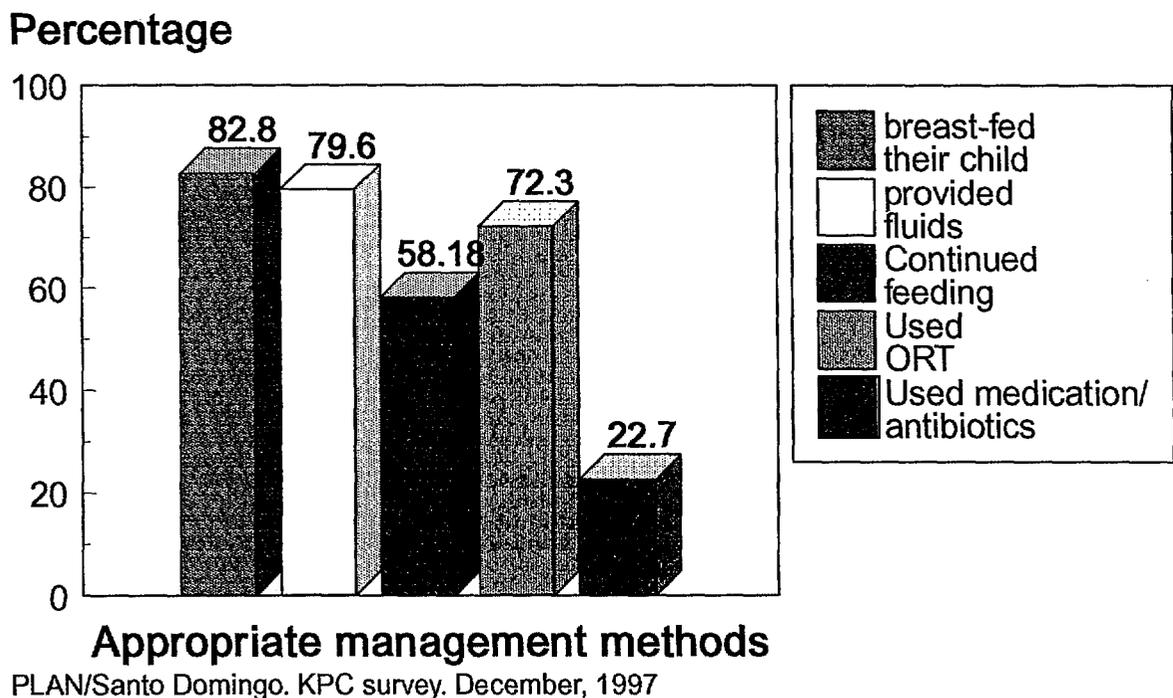


Figure 14. Source of Advice about Diarrheal disease control.

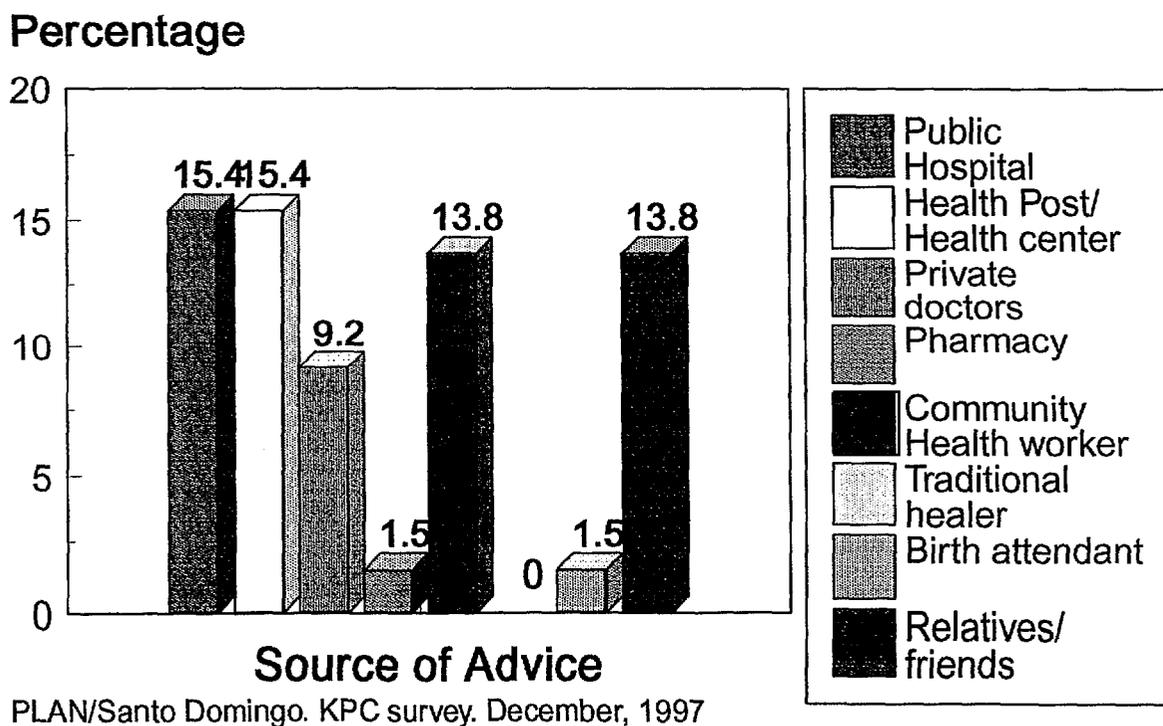
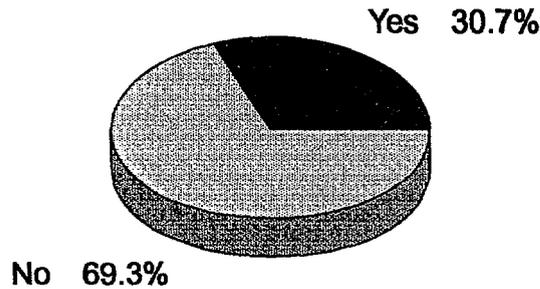


Figure 15. Children with cough and rapid/difficult breathing. % of children with cough and rapid breathing (signs suggesting pneumonia) in the previous 2 weeks.

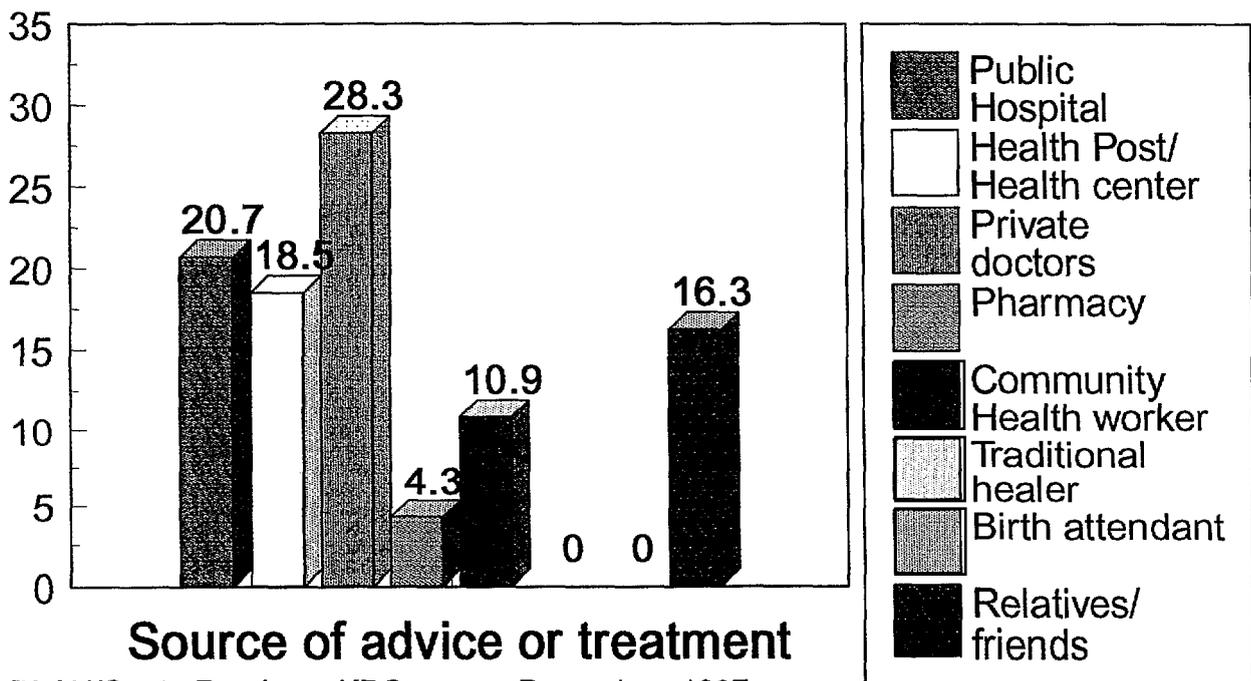
Children with signs suggesting pneumonia



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 16. ARI control. Source of advice or treatment

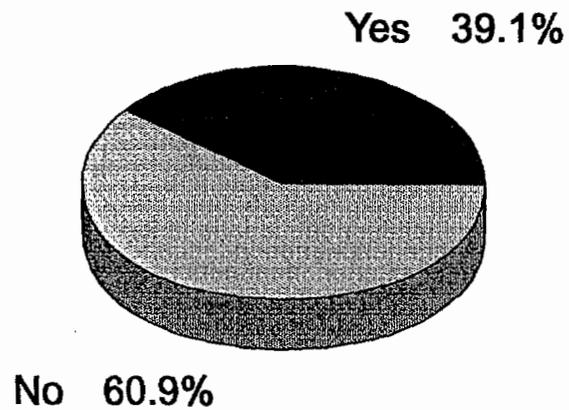
Percentage



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 17. Children with cough and rapid/difficult breathing who had received medical treatment.

Received medical advice or treatment

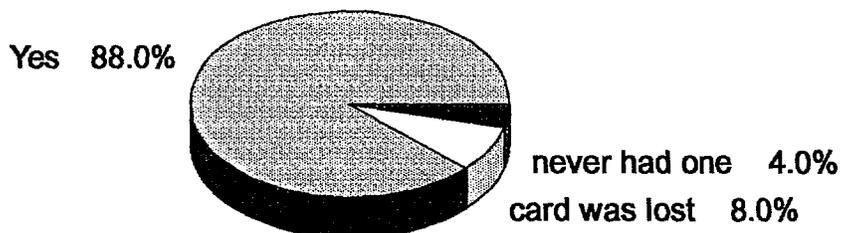


PLAN/Santo Domingo. KPC survey. December, 1997

Figure 18. Children with Vaccination Cards

Percentage of children from 12 to 23 months who have vaccination cards

Answer to question: Do you have an immunization card for (name of child)?

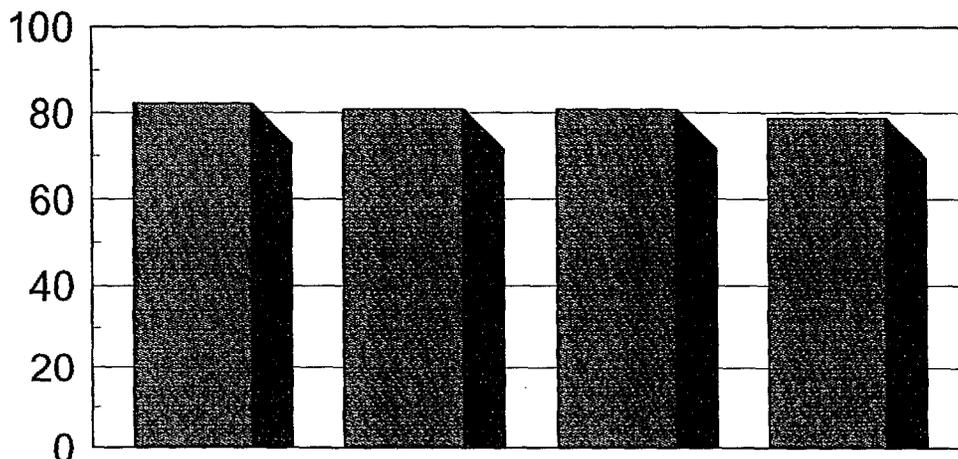


PLAN/Santo Domingo. KPC survey. December, 1997

Figure 19. Immunization Coverage

Percentage of children from 12 to 23 months who have received EPI vaccines

Coverage %



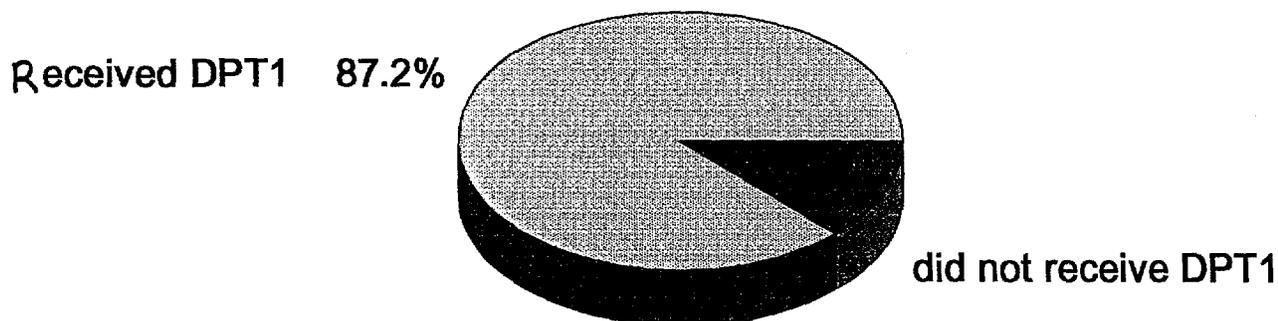
EPI vaccines	BCG	OPV 3	DPT 3	Measles
% Coverage	82.2	80.8	80.8	78.7

PLAN/Santo Domingo. KPC survey. December, 1997

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Figure 20. Access to the EPI program

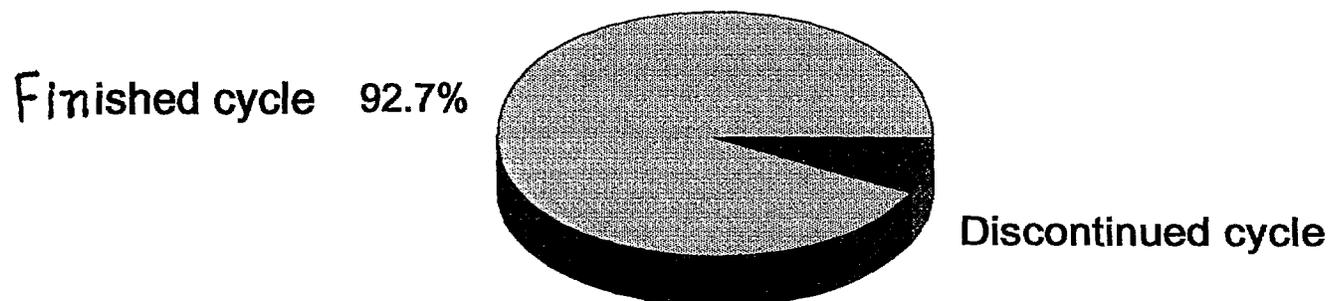
Percentage of children from 12 to 23 months who have received DPT1



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 21. Continuation/discontinuation rate

Percentage of children receiving DPT1 who continued cycle up to DPT3

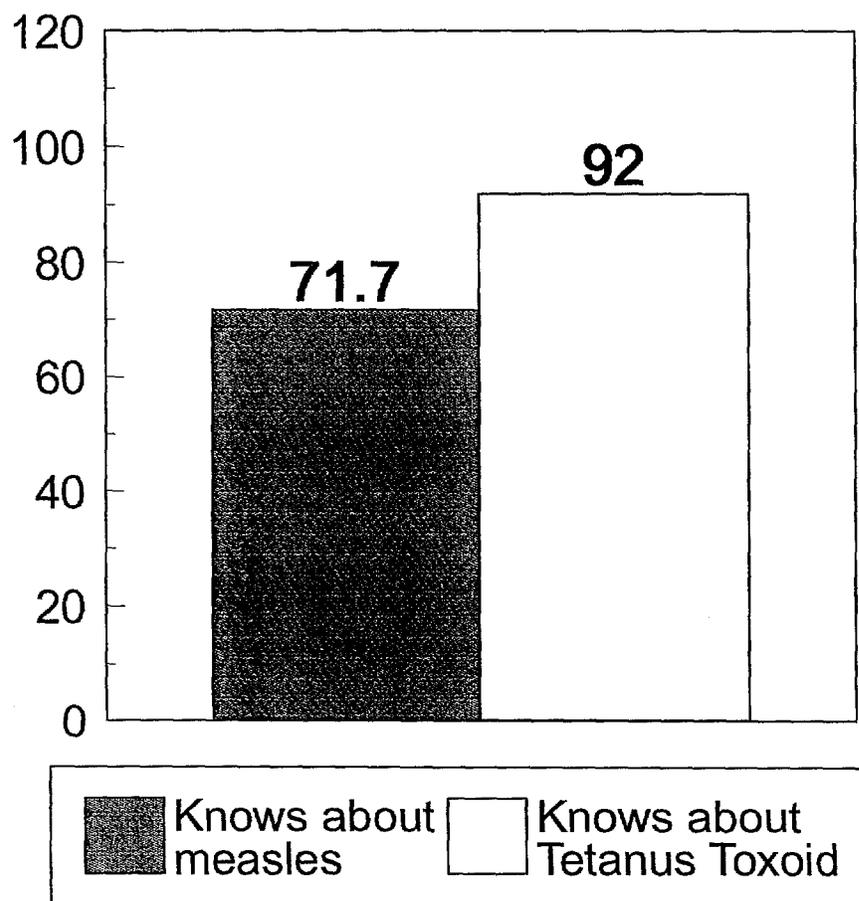


PLAN/Santo Domingo. KPC survey. December, 1997

Figure 22. Knowledge about Vaccination.

% of mothers who knows when children should receive the measles vaccine.

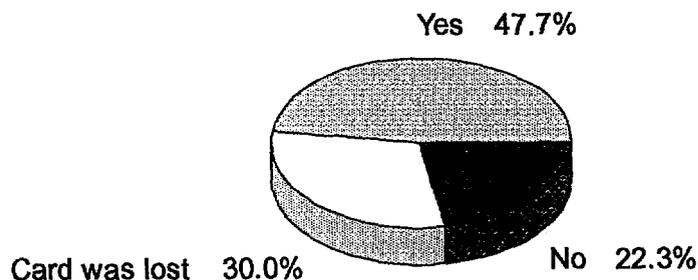
% of mothers who know how many tetanus toxoid injections a pregnant woman needs to protect the newborn infant from tetanus



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 23. Mothers having Maternal Care Card (Vaccination and Prenatal care visit record)

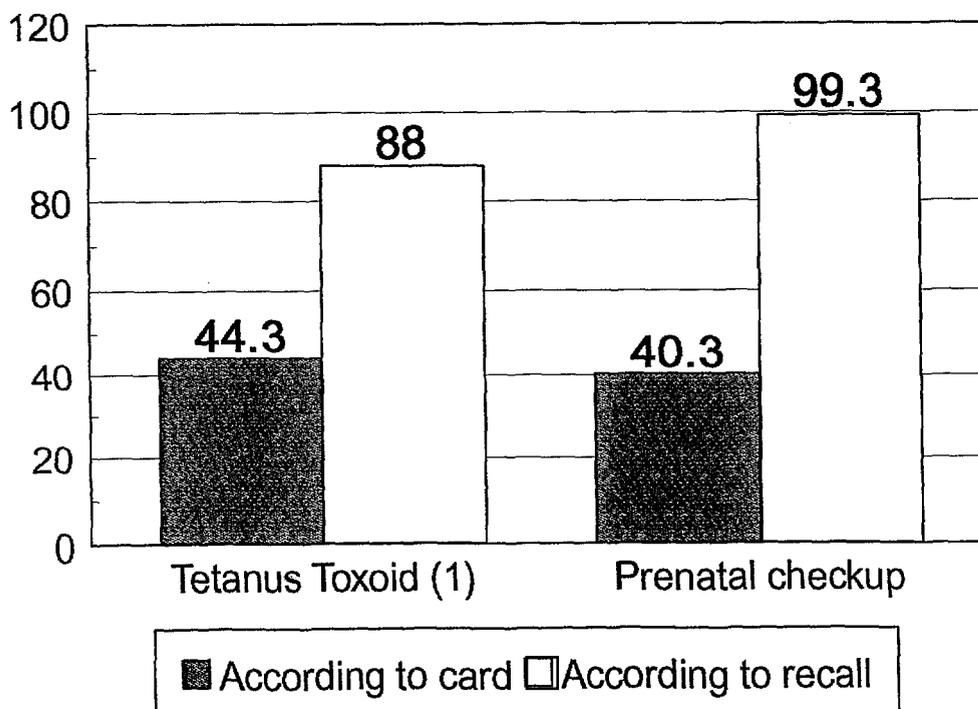
% of mothers who presented their maternal care card
 Answer to question: Do you have a maternal health card?



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 24. Mothers vaccinated against tetanus, and receiving prenatal care.

% of mothers of children under two years, who had received at least two doses of Tetanus Toxoid, and at least one prenatal checkup.

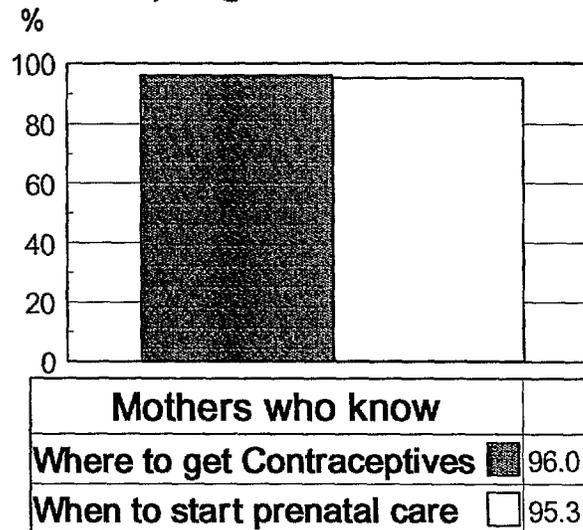


PLAN/Santo Domingo. KPC survey. December, 1997

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Figure 25. Mothers' Knowledge about Reproductive Health.

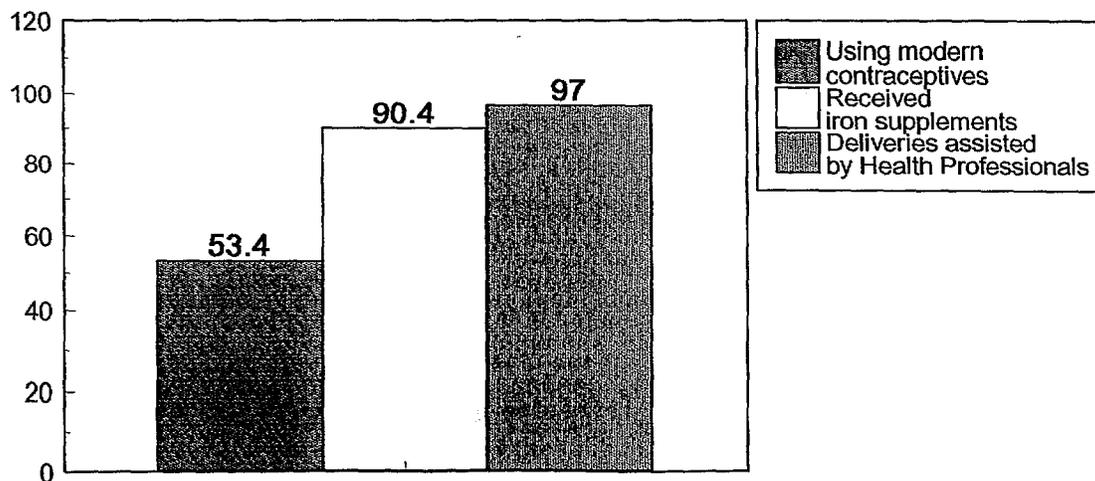
% of mothers who know where to obtain contraceptive methods.
 % of mothers who know when a pregnant women should begin prenatal care



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 26. Reproductive Health service Coverage.

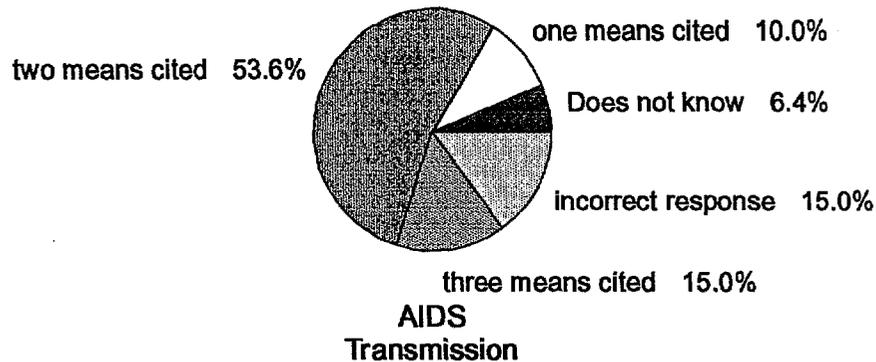
1. % of women who do not want to have more children in the next 2 years and are using modern contraceptive methods
2. % of women who have received iron supplements during pregnancy
3. % of deliveries assisted by a trained health professional



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 27. Knowledge of Mothers about HIV/AIDS infection transmission.

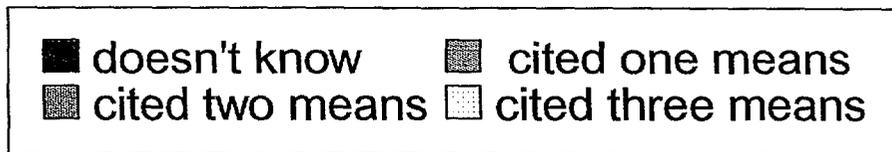
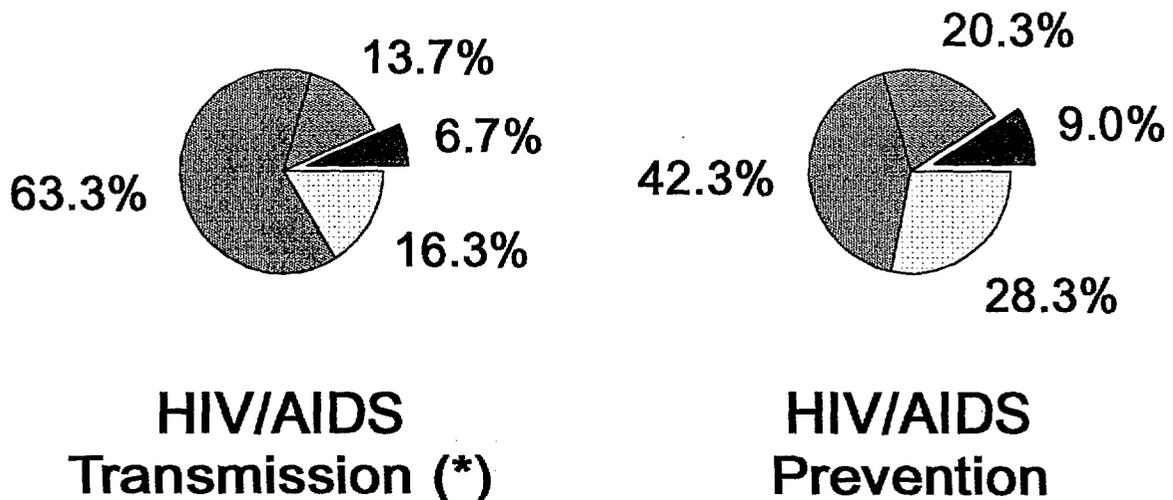
% of mothers who cited one, two, or three means of HIV/AIDS transmission, without stating any incorrect responses.



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 28. Mothers' Knowledge about HIV/AIDS transmission and prevention.

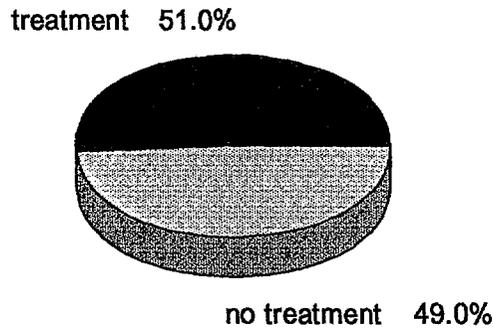
% of mothers who cited one, two, and three correct ways of HIV/AIDS transmission and prevention



PLAN/Santo Domingo. KPC survey. December, 1997

(*) percentages do not exclude mothers who gave incorrect answers as well

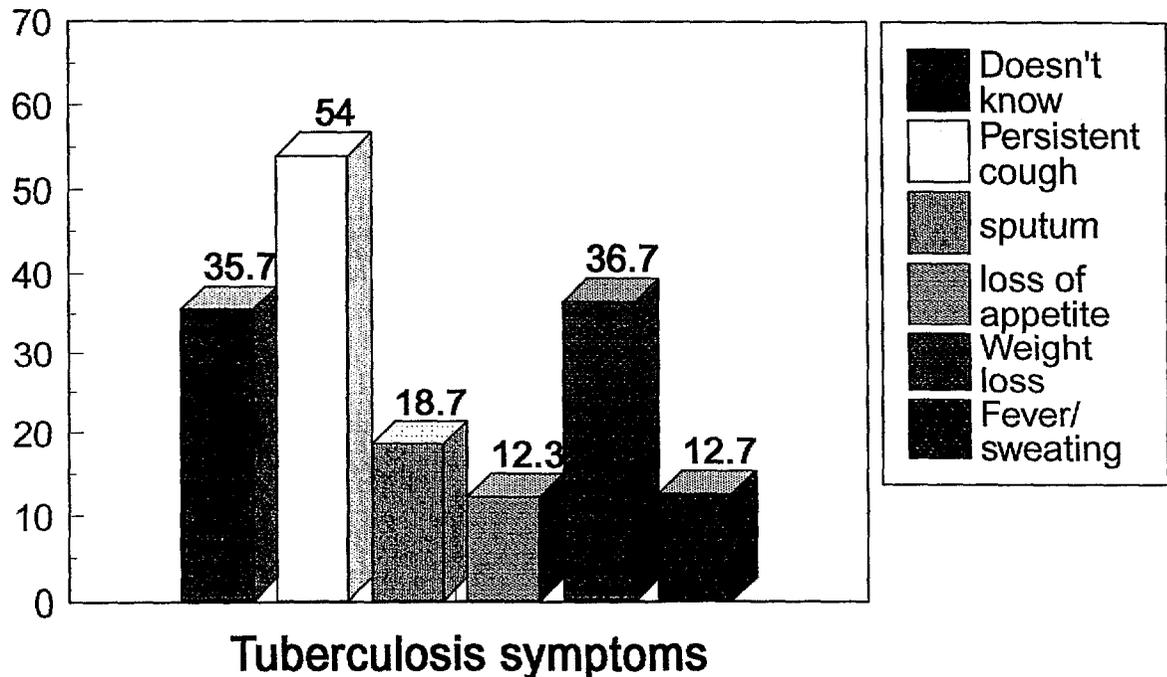
Figure 31. Tuberculosis Control. Children with persistent cough who had received medical treatment.



PLAN/Santo Domingo. KPC survey, December, 1997

Figure 32. Tuberculosis Control: Mothers' knowledge about symptoms suggesting tuberculosis.

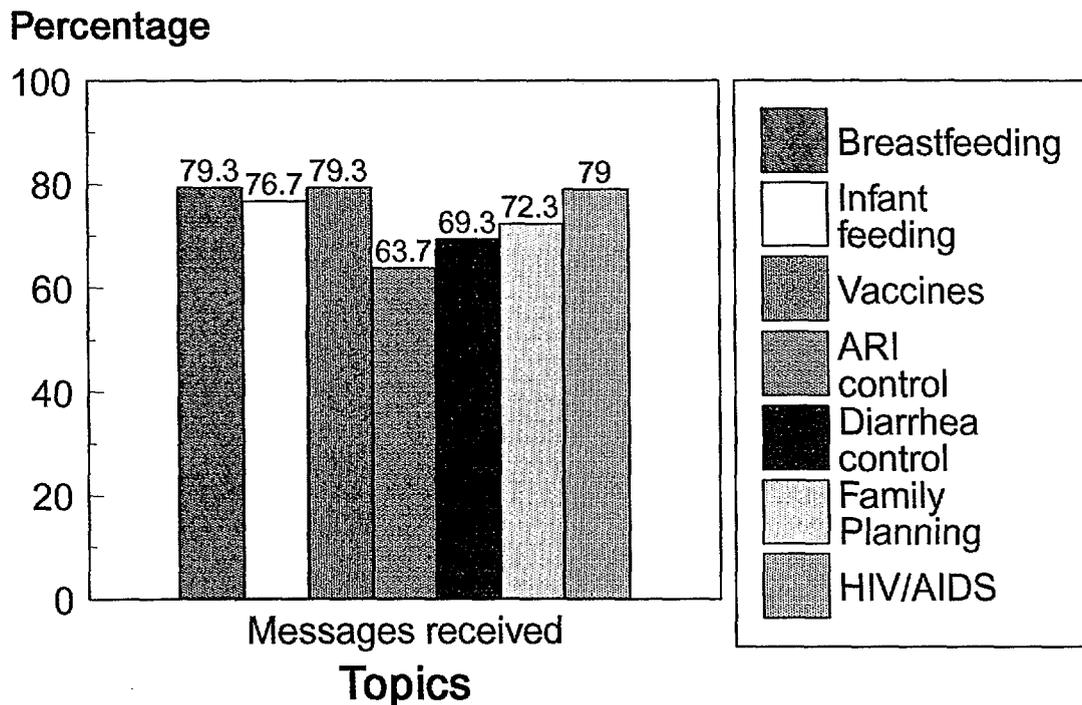
% of mothers who cite tuberculosis symptoms



PLAN/Santo Domingo. KPC survey, December, 1997

Figure 33. Health messages

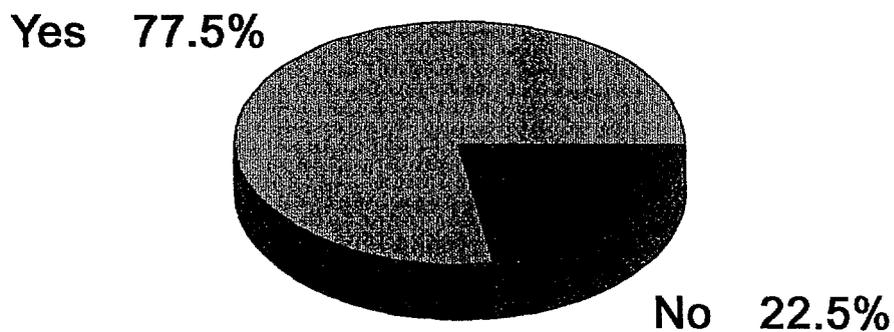
Percentage of mothers who had received health messages



PLAN/Santo Domingo. KPC survey. December, 1997

Figure 34. Health Information Sharing.

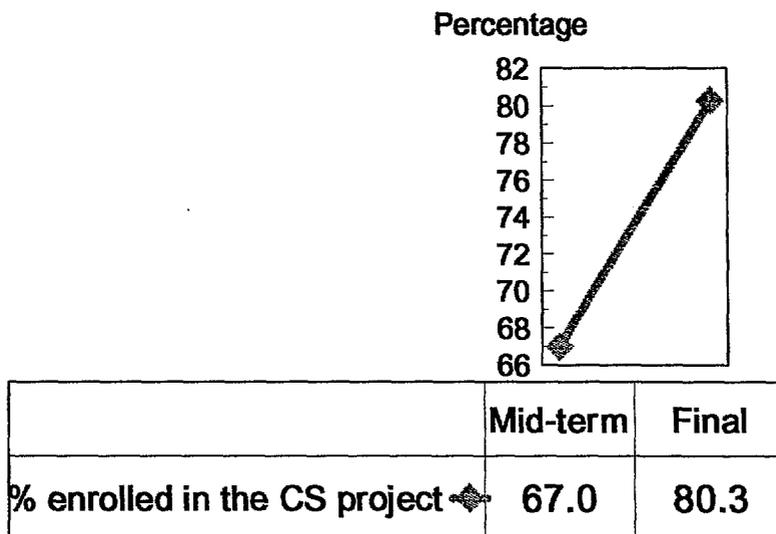
Percentage of mothers who have shared one or more of health messages with other mothers



PLAN/Santo Domingo. KPC survey. December, 1997

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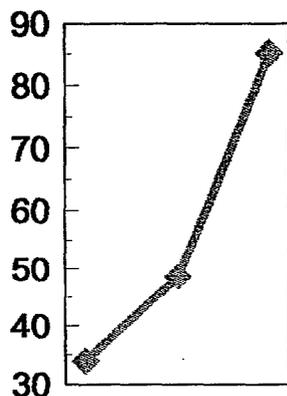
Figure 35. Families enrolled in the Child Survival Project. Comparison of enrollment rates found in mid-term and final surveys



PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

Figure 36. Growth Monitoring. Comparison between rates found in baseline, mid-term and final surveys

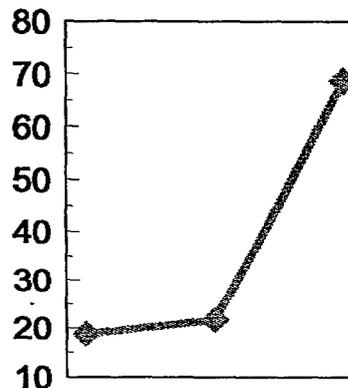
Children having Growth Monitoring Card
 Percentage



	Baseline	Mid-term	Final
% with Growth monitoring card	34.0	48.7	85.3

PLAN/Santo Domingo. KPC survey. August, 1993
 PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1996

Children who have been weighed in the last four months
 Percentage

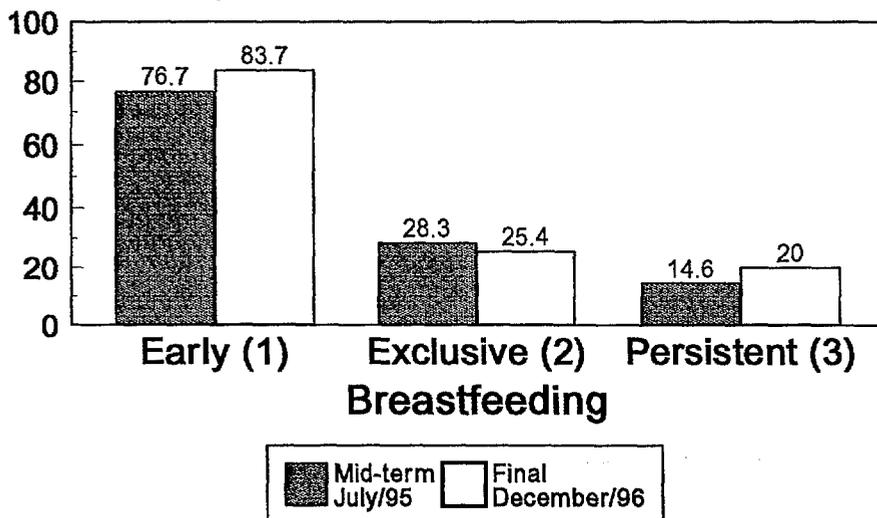


	Baseline	Mid-term	Final
% weighed	18.75	21.70	68.70

PLAN/Santo Domingo. KPC survey. August, 1993
 PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1996

Figure 37. Breastfeeding Practices.

Comparison between rates found in mid-term and final surveys

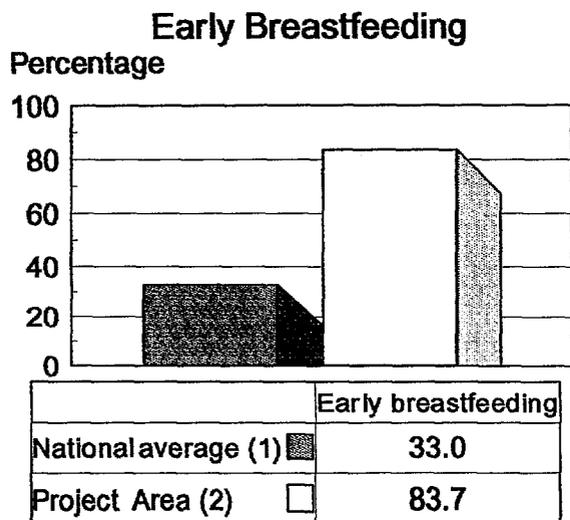


PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

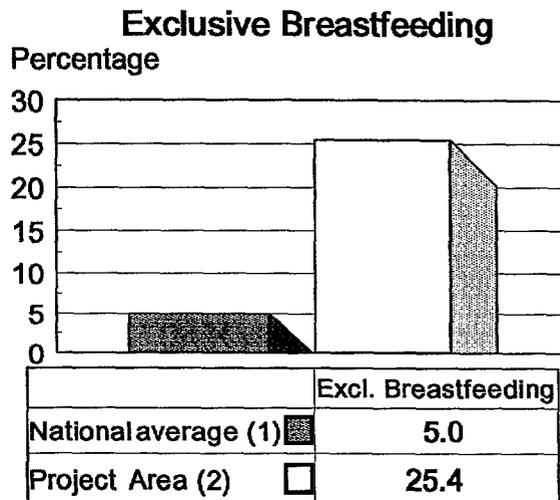
- (1) Children who were breast-fed during the first 8 hours after the delivery
- (2) Children under four months of age who are exclusively breast-fed
- (3) Children from 20 to 24 months who are still breast-fed

Figure 38. Breastfeeding Practices

Comparison between the project area and national average rates.

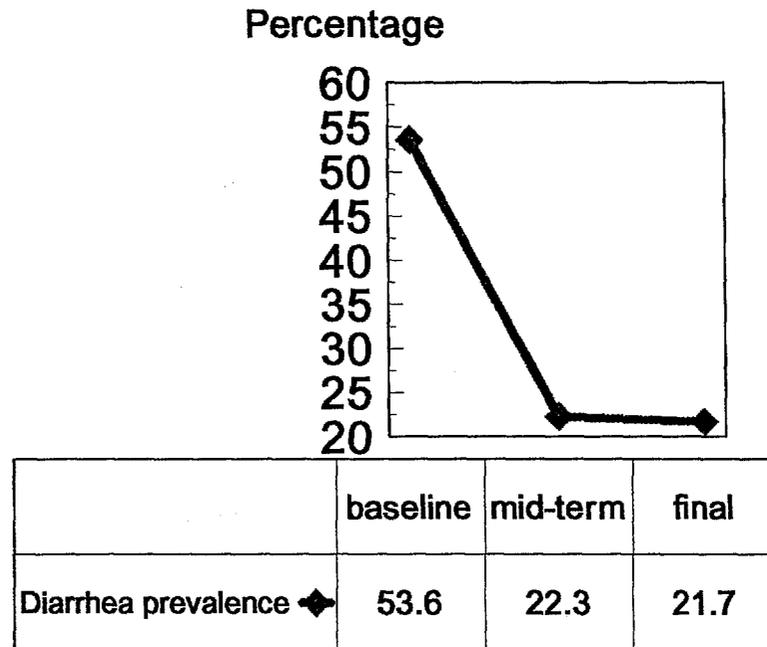


(1) UNICEF. The State of the World's Children 1995
 (2) PLAN/Santo Domingo KPC survey. December/96



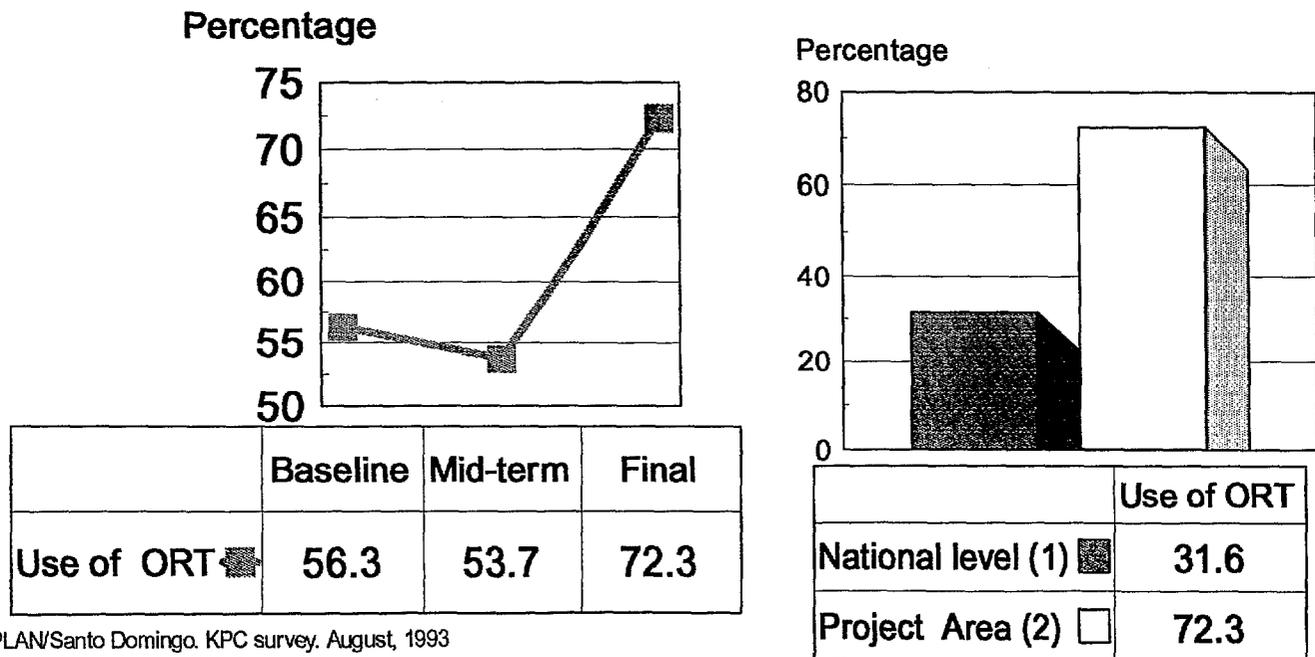
(1) UNICEF. The State of the World's Children 1995
 (2) PLAN/Santo Domingo KPC survey. December/96

Figure 39 . Prevalence of diarrheal diseases
 Comparison between baseline, midterm, and final survey results



PLAN/Santo Domingo. KPC survey. August, 1993
 PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1996

Figure 40. Use of ORT. Comparison between baseline, mid-term and final surveys. Comparison between project area and the national rates



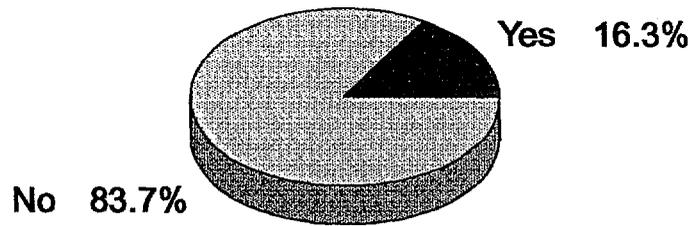
PLAN/Santo Domingo. KPC survey. August, 1993
 PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1996

(1) ENDESA 91
 (2) PLAN/Santo Domingo. KPC survey. December/96

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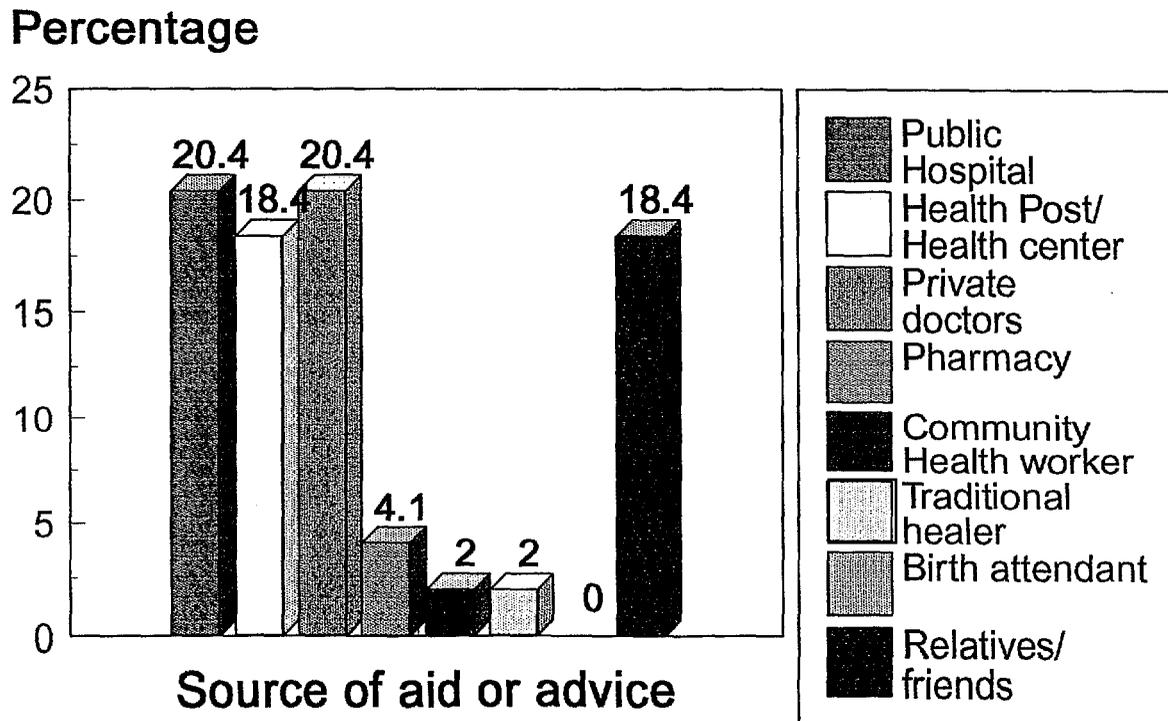
Figure 29. % of households in which one or more people have persistent cough (suggesting tuberculosis)

Answer to question: Is there a person in the family with a cough lasting more than 15 days.



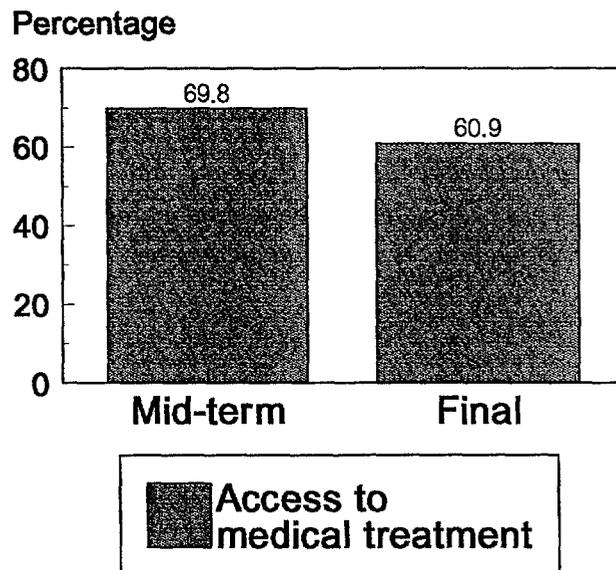
PLAN/Santo Domingo. KPC survey. December, 1997

Figure 30. Tuberculosis Control: Source of advice or treatment for people with persistent coughs



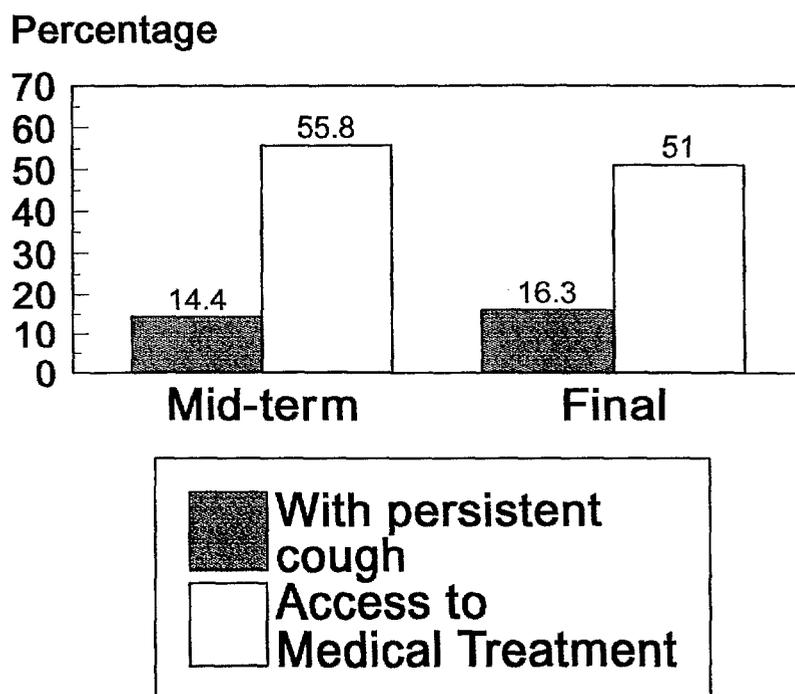
PLAN/Santo Domingo. KPC survey. December, 1997

Figure 41. Access to medical treatment for pneumonia. Comparison between mid-term and final survey results



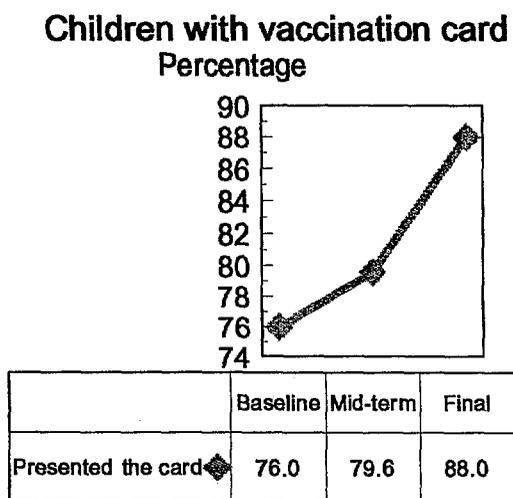
PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

Figure 42. Prevalence of persistent cough, and access to medical treatment for cases of persistent cough. Comparison between mid-term and final surveys



PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

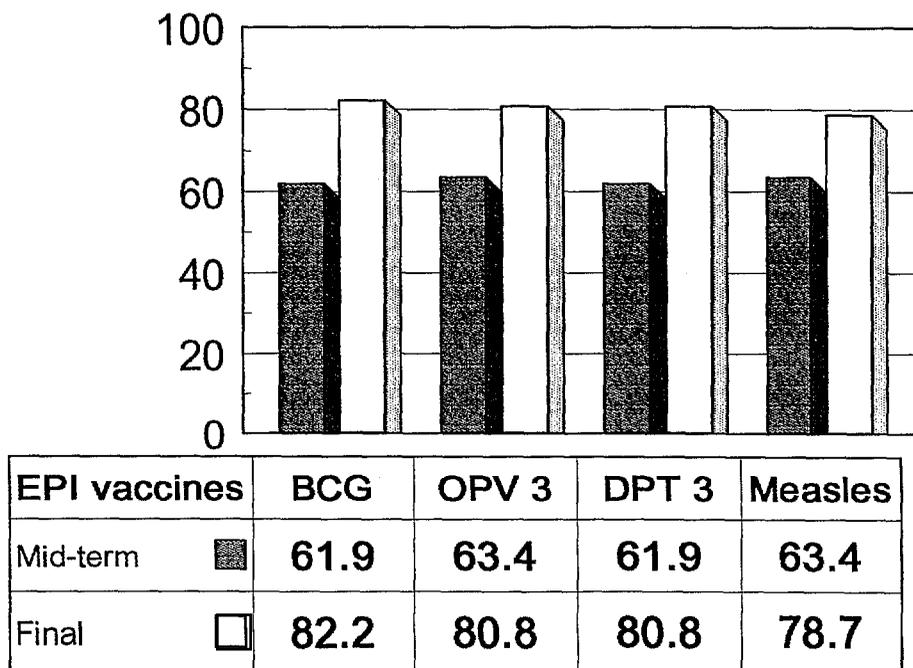
Figure 43. Children having vaccination card.
 Comparison between baseline, midterm, and final survey results



PLAN/Santo Domingo. KPC survey. August, 1993
 PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1996

Figure 44. EPI Coverage/Vaccination rates.
 Comparison between mid-term and final survey results
 (according to vaccination cards).

% of children vaccinated

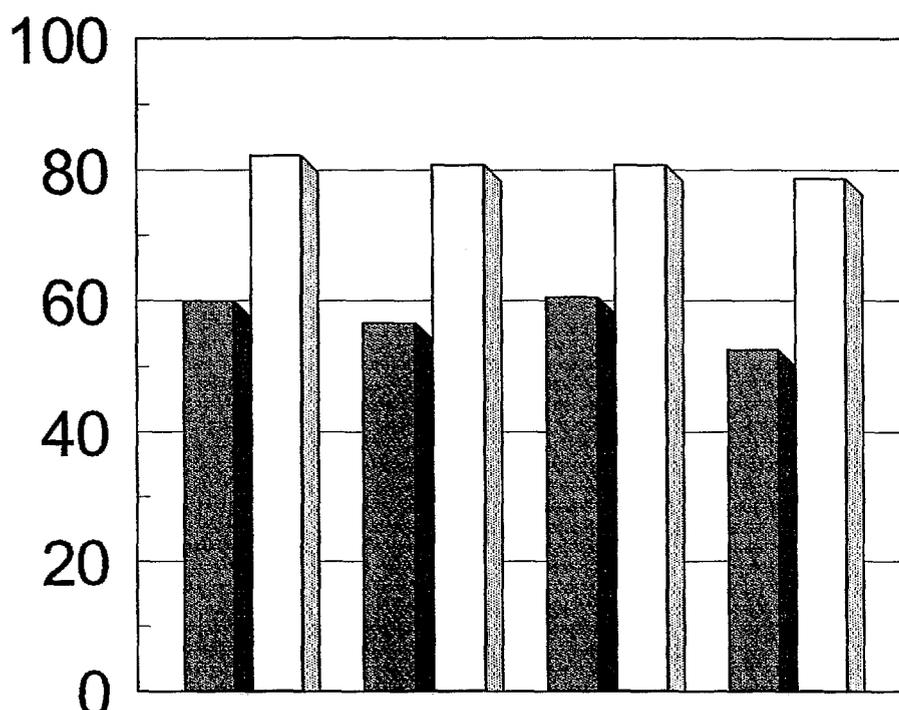


PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

Figure 45. EPI coverage/Vaccination rates.

Comparison between project area vaccination rates, according to cards, and Santo Domingo metropolitan area average EPI coverage, as reported by CONASUMI (An umbrella organization specialized in child and maternal health, funded previously by USAID)

% of children vaccinated



EPI vaccines	BCG	OPV 3	DPT 3	Measles
CONASUMI (12/95) ■	59.9	56.6	60.5	52.6
Project Area (12/96) □	82.2	80.8	80.8	78.7

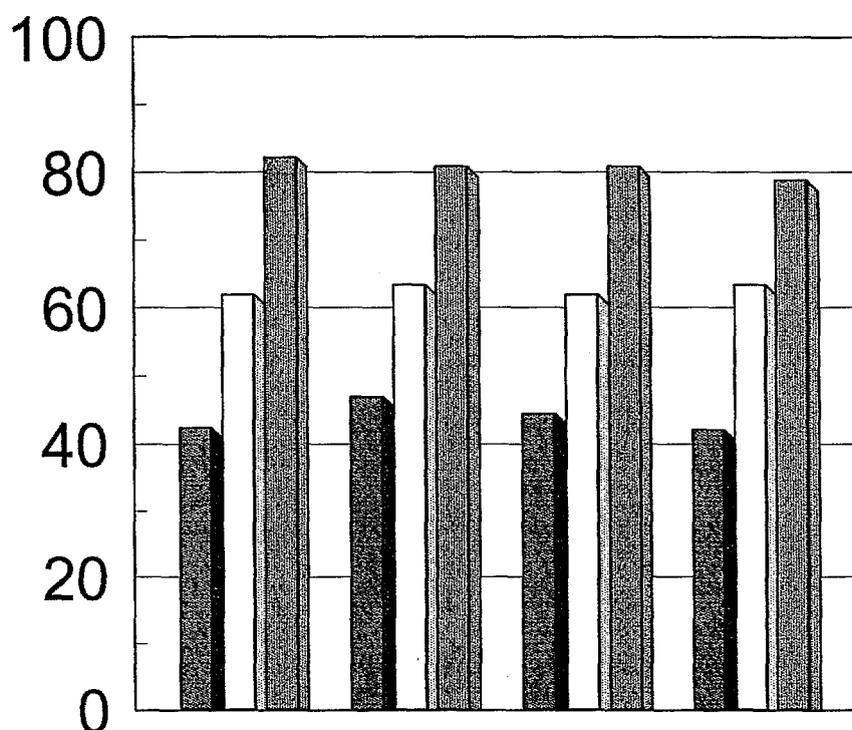
CONASUMI. Final Survey. December, 1995

PLAN/Santo Domingo. KPC survey. December, 1996

Figure 46. EPI Coverage/Vaccination Rates.

Comparison between the project area coverage, according to cards, and the national average rates reported in the last DHS survey

% of children vaccinated



EPI coverage e	BCG	OPV 3	DPT 3	Measles
National Average (1) ■	42.4	47.0	44.5	42.1
PLAN area July/95 (2) □	61.9	63.4	61.9	63.4
PLAN area Dec /96 (3) ▨	82.2	80.8	80.8	78.7

(1) ENDESA 91. Demographic Health Survey

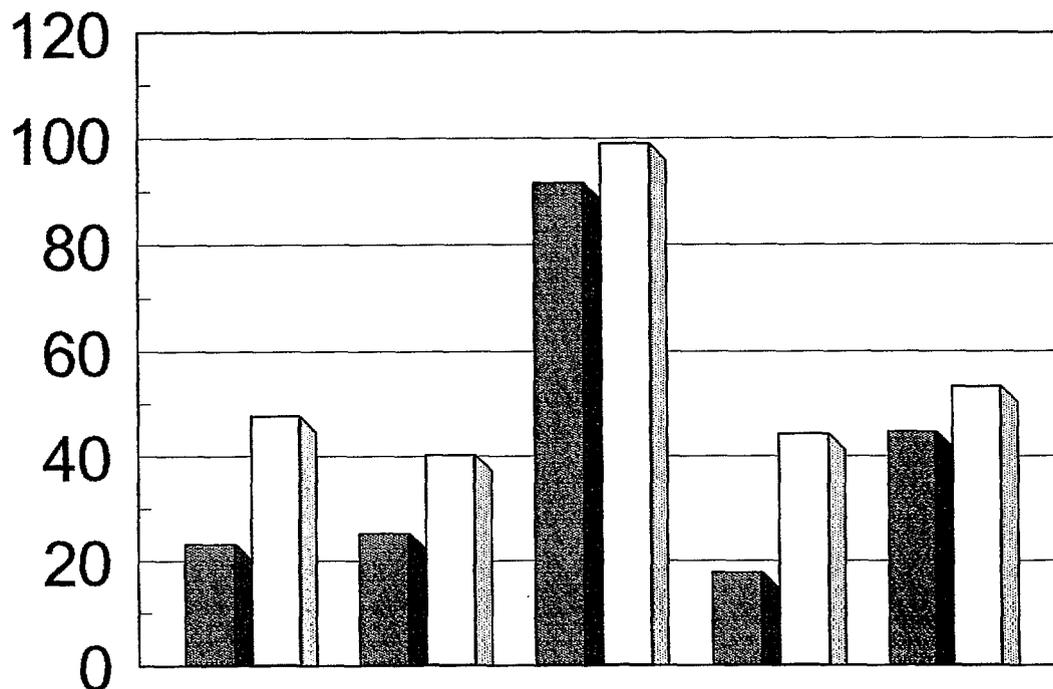
(2) PLAN/Santo Domingo. KPC Survey July, 1995

(3) PLAN/Santo Domingo. KPC Survey. December, 1996

Figure 47. Reproductive Health rates.

Comparison between the mid-term and final survey rates.

% of mothers



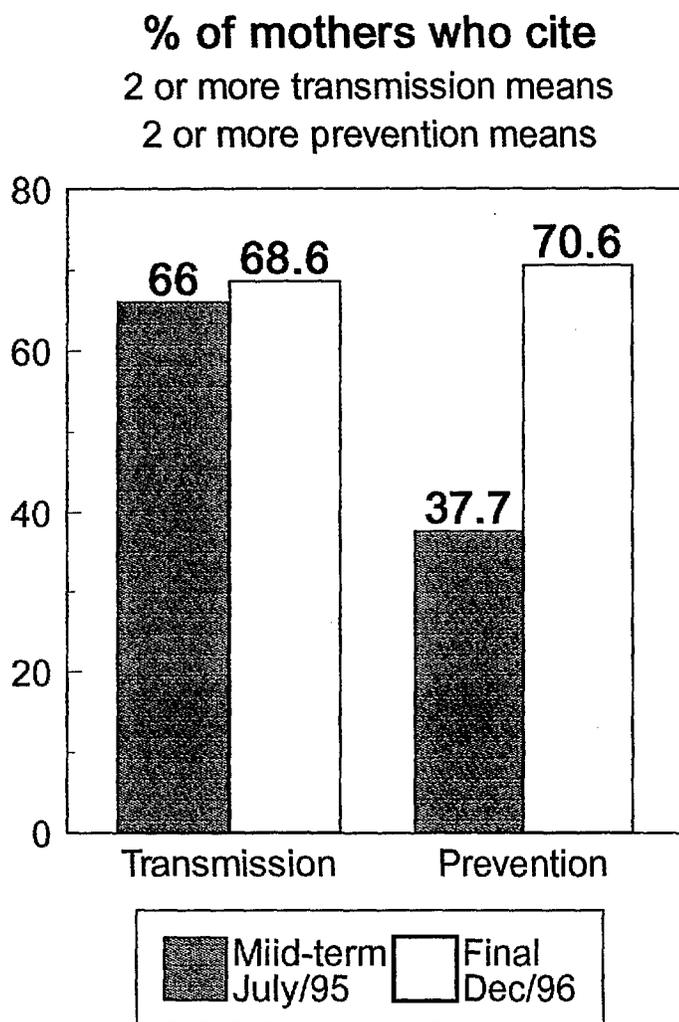
Reproductive Health rates	Have maternal card	Prenatal care (card)	Prenatal (recall)	TT 2 vaccination	Contraceptive use
Mid-term 	23.1	25.2	91.6	17.7	44.7
Final 	47.7	40.3	99.0	44.3	53.4

PLAN/Santo Domingo. KPC survey. July, 1995

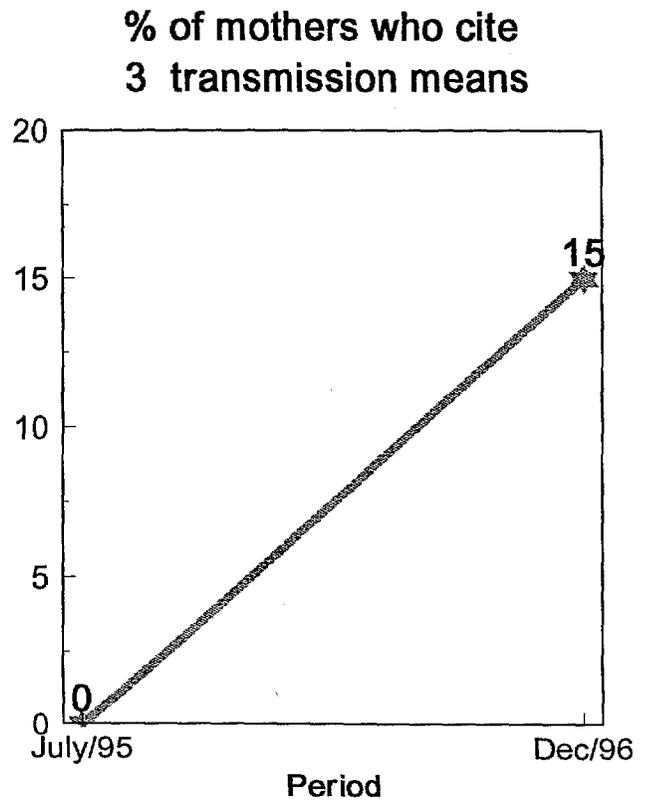
PLAN/Santo Domingo. KPC survey. December, 1997

Figure 48. AIDS Prevention. Knowledge of transmission means and ways to prevent HIV/AIDS infection

Comparison between mid-term and final survey results



PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997



PLAN/Santo Domingo. KPC survey. July, 1995
 PLAN/Santo Domingo. KPC survey. December, 1997

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ANNEX 8

END OF GRANT PIPELINE ANALYSIS: COUNTRY BUDGET
 (SANTO DOMINGO, DOMINICAN REPUBLIC)

		EXPENDITURES TO DATE (09/01/93 - 12/31/96)			BUDGET DEVIATIONS			TOTAL AGREEMENT BUDGET (09/01/93 - 12/31/96 incl.extension)		
		USAID	PVO	TOTAL	USAID	PVO	TOTAL	USAID	PVO	TOTAL
I. DIRECT COSTS										
A. PERSONNEL										
	1. Headquarters - n/a									
	2. Field, Technical Personnel - wages/salaries			0	.0	0	0	0	0	0
	3. Field, Other Personnel - wages/salaries			0	0	0	0	0	0	0
	4. Fringes - Headquarters & Field			0	0	0	0	0	0	0
	SUBTOTAL - PERSONNEL	0	0	0	0	0	0	0	0	0
B. TRAVEL/PER DIEM										
	1. Headquarters - Domestic (USA) - n/a									
	2. Headquarters - International - n/a									
	3. Field - In country	45,151		45,151	(7,151)	0	(7,151)	38,000	0	38,000
	4. Field - International			0	0	0	0	0	0	0
	SUBTOTAL - TRAVEL/PER DIEM	45,151	0	45,151	(7,151)	0	(7,151)	38,000	0	38,000
C. CONSULTANCIES										
	1. Evaluation Consultants - Fees	18,631		18,631	2,869	0	2,869	21,500	0	21,500
	2. Other Consultants - Fees	11,052		11,052	19,948	0	19,948	31,000	0	31,000
	3. Consultant travel/per diem	23,533		23,533	(8,208)	0	(8,208)	15,325	0	15,325
	SUBTOTAL - CONSULTANCIES	53,216	0	53,216	14,609	0	14,609	67,825	0	67,825
D. PROCUREMENT										
	1. Supplies									
	a. Headquarters - n/a									
	b. Field - Pharmaceuticals									
	c. Field - Other	117,567		117,567	698	0	698	118,265	0	118,265
	2. Equipment									
	a. Headquarters - n/a									
	b. Field									
	3. Training									
	a. Headquarters - n/a									
	b. Field									
	SUBTOTAL - PROCUREMENT	117,567	0	117,567	698	0	698	118,265	0	118,265
E. OTHER DIRECT COSTS										
	1. Communications									
	a. Headquarters - n/a									
	b. Field	149		149	(149)	0	(149)	0	0	0
	2. Facilities									
	a. Headquarters - n/a									
	b. Field									
	3. Other									
	a. Headquarters - n/a									
	b. Field	23,850	87,720	111,570	(2,850)	(6,022)	(8,872)	21,000	81,698	102,698
	SUBTOTAL - OTHER DIRECT	23,999	87,720	111,719	(2,999)	(6,022)	(9,021)	21,000	81,698	102,698
TOTAL - DIRECT COSTS		239,933	87,720	327,653	5,157	(6,022)	(865)	245,090	81,698	326,788
II. INDIRECT COSTS										
	1. Headquarters - n/a									
	2. Field (Budt. 17.1%/NICRA Increase 17.7%)	42,468	15,526	57,994	(558)	(1,557)	(2,115)	41,910	13,969	55,879
TOTAL - INDIRECT COSTS		42,468	15,526	57,994	(558)	(1,557)	(2,115)	41,910	13,969	55,879
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		282,401	103,246	385,647	4,599	(7,579)	(2,980)	287,000	95,667	382,667

Underspending of \$4,599 is offset by
 overspending on other portions of total budget.

TOTAL PROJECT

ANNEX 9

ANNEX 9

SLIDES RELATING TO THE EVALUATION OF PLAN/SANTO DOMINGO'S CHILD SURVIVAL PROJECT

1. The title of the presentation: Improving Health Programs
2. PLAN's Santo Domingo Health Team
3. Training session of Community Health Volunteers
4. Children with growth chart
5. Children weighed in the last four months
6. Children with vaccination card
7. Immunization activities at a Vaccination Fixed Post established by the project and sustained by a local NGO
8. Vaccination rates: Comparison with national levels
9. Vaccination rates: Comparison with levels found in the metropolitan area
10. ORT activities at the Popular ORT Unit established by the project and sustained by a local NGOs
11. Prevalence of diarrheal disease and use of ORT rates
12. ORT rates: Comparison with the national level
13. Breastfeeding promotion activities
14. Early and exclusive breastfeeding rates
15. Achievements regarding sustainability of the projects
16. The basic elements of sustainability
17. A matrix to classify the strategic alternatives
18. Searching a balance between sustainability and effectiveness
19. Moving forward
20. Up scaling the lessons learned and experiences to all PLAN's Country Offices in the Caribbean and Central America region

Note: Slides included in bound copy sent to USAID.