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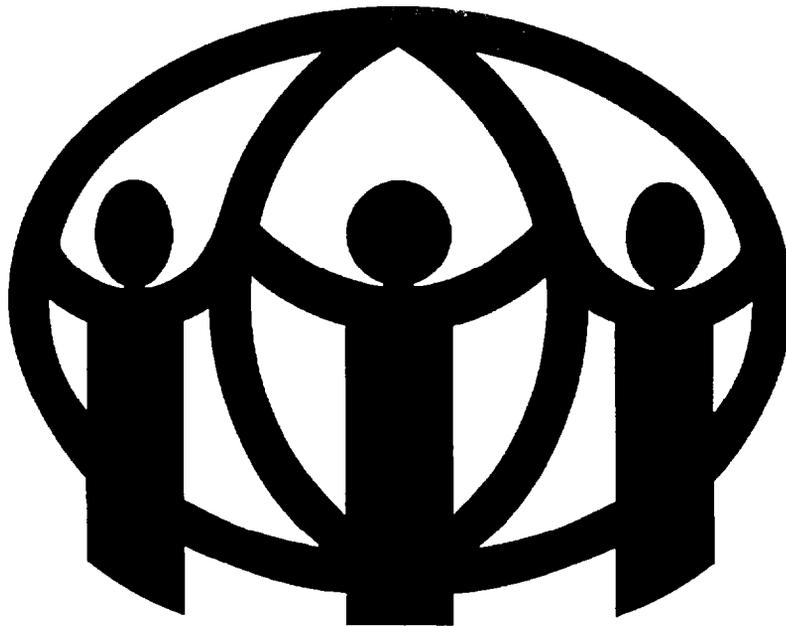
MID-TERM EVALUATION REPORT

for

CHILD SURVIVAL VII

OTR #PDC-0500-A-00-1007-00

NICARAGUA



Submitted to

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
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by

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GLOSSARY

AID	Agency for International Development
ADRA/I	Adventist Development and Relief Agency
ADRA/N	ADRA/Nicaragua
AER	Annual Estimated Requirement
APR	Annual Progress Report
ARI	Acute Respiratory Infections
BF	Breastfeeding
CASA	Central American Survival Assistance
CDD	Control of Diarrheal Diseases
CHC	Community Health Committee
c s	Child Survival
EOP	End of Project
FSD	Food Supported Development
FFP	Food for Peace - USAID
FFW	Food for Work
FP	Family Planning
GC	Growth Control
HC	Health Center
HP	Health Post
HQ	Headquarters
INPHRU	Instituto de Promoción de Recursos Humanos, Nicaraguan Governmental agency to promote people, give training, materials

MINSA	Nicaraguan Ministry of Health
OFSD	Office of Food Supported Development
ORT	Oral Rehydration Therapy
MTE	Midterm Evaluation
PAHO	Pan American Health Organization
PL480	Public Law 480, Food for Peace
PMA	World Food Program in Nicaragua
SILAIS	District Health Office
TA	Technical Assistance
URO	Unidade de Rehydatacion Oral
USAID/N	USAID Office in Nicaragua

PRELIMINARIES

A. INTRODUCTION

Evaluation Activities

From the outset, the evaluation team adopted a participative formula, first to determine the pulse of the project, and second, to review the eventual outcome at the time of completion. The evaluation made both quantitative and qualitative assessment of the progress accomplished, and of the chances of successful completion.

The team consisted of five members. To maximize the probing effectiveness of the team, the work load was divided into two major areas of examination: a programmatic area and a management area. The team was divided accordingly into Subteam A and Subteam B. Each subteam was to apply the same probing method but to different aspects of the project.

The time allotted to the evaluation exercise was ordered in such a way as to emphasize input from where the rubber meets the road, i.e. through interviews in the field. The team met for the first time on Monday night, July 12, to draft a time table of activities and distribute tasks. The second day was spent with the Project Director, discussing of the Scope of Work questions provided by USAID for the midterm exercise as a guide in order to hone in from the outset working hypotheses from answers received directly from the director.

The same day, Subteam A, made up of Mrs. Mena and Dr. Latchman, and assigned to the programmatic evaluation left for the CS Field office in Somoto leaving Subteam B behind in Managua to continue to work for one more day with the director on specifics related to management of the project such as personnel, equipment, and central funding.

Milton McHenry was able to spend a fair amount of time with the treasurer that is overseeing the project and with the other staff members, investigating the use of funds and equipment.

The third day, the programmatic team called a general meeting of the whole ADRA staff in Somoto. They first met with the supervisors to get acquainted and prepare an upcoming meeting with the Community Health Workers (CHW's). The meeting with the CHW's was divided into two parts. In the morning, the team interviewed them as a group. After lunch, each CHW identified his/her best and worse community on a map of the region. The names of all the communities were placed in a hat and randomly picked and listed. The same was done with the worst communities.

The good ones were then paired with the worst ones closest to them. As expected most pairs belonged to the same CHW, facilitating consequently the logistics of field visits. The ones which were not easily accessible were discarded and eight pairs of communities were retained. At that junction, the CHW's were divided into two groups: those whose communities were not likely to be visited and those whose communities were to receive a visit. The CHW's not elected were then interviewed on a one-on-one basis and sent home. The others were equally interviewed on a one-on-one basis by either one of the team members; then they were regrouped with the supervisors for a meeting to determine the logistics of the field visits.

The pairs of communities to be visited were grouped according to area. Three pairs were allotted to one team member to visit and the other three pairs were allotted to the other. The purpose of the preliminary visits was to test some working hypotheses, eliminate the obvious and help the team to spend time to focus on particular aspects of the program that needed attention.

The fourth day Dr. Latchman was able to visit four communities, 2 Health Centers (HC), 1 Health Post (HP), 4 Unidades de Rehidratacion Oral (URO) clinics, and interviewed 20 mothers, one mother suplente (corresponding to the leader of a mothers' club), one Health Committee Coordinator, 22 volunteers and 1 brigadista (volunteer previous selected by MINSA). Mrs. Mena was able to visit 3 communities, 8 mother suplentes, 1 Health Committee coordinator, 4 volunteers, 7 mothers. The introductions were facilitated either by the Zone Supervisor or the CHW of the area; but they did not participate directly in the interviews of the Health Committee members, the volunteers or the mothers.

Milton McHemy, a member of subteam B, arrived in Somoto that same day and was able to interview 3 Volunteers, 2 mothers, 1 URO clinic volunteer, (+ 1 nursery volunteer from another project), all chosen at random within reasonable distance from Somoto, mainly in the communities of Vulcan, Blanca Aros, Cusmayi, Museli, La Esperanza, Uniles Grane.

Milton also interviewed the two Peace Corps volunteers who are assigned to ADRA.

The fifth day, the team was joined by a contracted USAID representative, Felix Jimenez. He was assigned to visit some other communities chosen at random and to interview mothers and volunteers. The whole team interviewed also Dr. Dagoberto Bermudez, the SILAIS Director for Region I.

On the following Sunday, more intense interviews were carried out with the project Director and the Supervisors, working mostly on the Health Information System (HIS).

The second Monday was devoted to carrying on a mini-survey in communities that did not fall into the best/worst categories, using a 30 cluster method.

The mini-survey was completed the following day. Since Milton McHenry had to leave on Tuesday evening, a general meeting with the available staff in Somoto was held when he shared his findings and recommendations in the area of management.

Wednesday was devoted to more writing, completing missing data, and holding a debriefing session with available staff members covering the whole program.

Mrs. Elsa Mena devoted Thursday and Friday to report writing, while Dr. Gerard Latchman returned to Managua for debriefing sessions with USAID officers and other NGO's. (Dr. Latchman had to hide in Esteli during a twenty-four hour battle between the rebels and government forces and could not make it to Managua in time).

B. METHODOLOGY:

Since this is a midterm evaluation, the following mix of methods were used to collect data:

- 1) Informal one-to-one interviews of Staff, Health Providers, Volunteers and mothers.
- 2) Interview of CHW's, Volunteers and mothers in semi-focussed groups.
- 3) Use of an RA (Rapid Appraisal) survey, a modified version of a 30 cluster survey (called hereafter mini-survey) with a sample of 81 mothers, to measure the level of KAP.

C. GOAL AND OBJECTIVES OF THE PROJECT

The goal of the project is to increase the self reliance of families and communities by protecting mother and child health through improved delivery of basic health services, especially to under-fives, in one of the poorest and most disadvantaged areas of Nicaragua.

1. The objectives of the project are:

- a. (EPI) To increase the coverage of complete immunizations for children age 12 - 23 months from 77% to 85%.
- b. (EPI) 90% of mothers of children less than one year will know why their children should be vaccinated.

- c. (CDD) 90% of 156 communities will have trained CDD volunteers and functioning rehydration centers.
- d. (CDD) 80% of cases of diarrhea in the last two weeks will have been **treated at home** or in rehydration centers according to project protocol.
- e. (N) To decrease malnutrition rates according to the Navarro classification from **35%** to 28%.
- f. (N) 70% of mothers will participate in mothers' groups and will have received nutrition education through these groups.
- g. (MH/FP) To increase the number of women of reproductive age using modern contraception from 18% to 40%.
- h. (ARI) 90% of 156 communities will have volunteers trained to evaluate and refer respiratory infections according to project protocol.
- i. 90% of communities will have Health Committees made up of trained volunteers that meet monthly to review health activities.

2. The Purpose of Evaluation

The midterm evaluation attempts to establish:

- a) The degree of success of **ADRA/Nicaragua** and the level of progress in relation to the benchmarks stated in the DIP.
- b) The viability (on what conditions) of activities.
- c) The sustainability of the project.
- d) The effectiveness of systems to achieve project objectives.

I. ASSESSMENT OF ACCOMPLISHMENTS

A. As of the time of the midterm evaluation, how many months has this project been operating?

The project started on October 1, 1991. The midterm evaluation of the project was carried out between July 12 and July 23, 1993. Therefore, the project has been operating now for 21 months.

B. What has the project achieved to date in terms of measurable?

1. Inputs

Training sessions were held at all levels of the project from its inception.

a. MINSA/SILAIS staff:

Workshops on diarrheal diseases and acute infectious respiratory illnesses were provided by ADRA staff to the medical director and staff of the local SILAIS contingent in Somoto.

b. MINSA Health Center staff (Centro de Salud): Same as above.

c. MINSA Health Post staff: Same as above.

d. ADRA CS Project Director:

The CS Director, Dr. Gloria Toruno, received supplementary training on concepts/practices of breastfeeding in Mexico City in November, 1991. She also attended a conference in Washington DC on Pediatric Infectious Respiratory Disease in December of the same year.

e. Public Health Advisor:

The former Public Health Advisor attended the National American Public Health Association Conference in Atlanta, Georgia (November, 1991).

e. ADRA Supervisors:

One Supervisor, Dr. Maritza Valdivia, received training during a workshop provided by MINSA and PAHO on diarrheal diseases and infectious respiratory illnesses in Jinotepe. Three Supervisors attended a workshop of ProFamilia on methods of Family Planning and human relations, supervision of CHWs and community volunteers.

f. ADRA Community Health Workers (Trabajadores de Salud):

15 CHW's received training in 8-hour workshops on the use and implementation of the diarrhea resource manual produced by ADRA for the 186 communities as of April 1992.

g. Community Health Committee (ADRA and non-ADRA Volunteers called Brigadistas):

About 182 Volunteers received training in 13 workshops provided by the CHW's. One hundred and eighty-six Navarro classification methodology sessions were held. 186 Volunteers from specified communities were trained by the CS staff in the use and implementation of the diarrhea and cholera resource manuals (April, 1992). 13 two-day workshops comprising an average of 14 Volunteers were provided to complete this training phase. A group of 10 community volunteers were trained by professional staff of ProFamilia in indications and contraindications of Family Planning methods. 13 workshops were given by CS supervisory staff in order to train 156 health coordinators of all 156 Community Health committees on their function, roles, and responsibilities within the health committees. 156 Nutrition Volunteers attended 13 workshops on the preparation of foods distributed by the PL-480 Project provided by ADRA CS and INPHRU. 10 community volunteers were trained by ProFamilia in the area of reproductive health and family planning.

h. Mothers:

The PL-480 Project initiated support in the distribution of foodstuffs to the beneficiary population in the CS target zones. Before the closing down of the PL-480 program, the eligible beneficiary population for foodstuffs was $n = 16,869$. The population of children less than five years of age is $n = 10,116$; pregnant women comprised $n = 2,952$ of the total; and breastfeeding women comprised $n = 3,801$ of the total beneficiaries.

i. Foreign Volunteers:

A group of 8 volunteers from La Sierra University, California, were sent by ADRA/I for a 6-week assignment to lend support to the nutrition component of the CS Project in June-August 1992. Their work entailed orienting community volunteers and families with high risk children and infants on the initiation of home gardens.

j. Manuals:

ADRA staff produced four resource manuals, one on diarrheal diseases, which was finalized after review by 13 community volunteers comprised of women from various mothers' clubs and the medical personnel from MINSA/SILAIS. One is used as a training/resource tool for community health volunteers in the field. The second one is a manual on nutrition prepared with support from all ADRA CS staff, MINSA/SILAIS and INPRHU. The third manual is on Family Planning. The fourth manual is on cholera and is utilized as an instructional aid for community health volunteers working in the oral rehydration centers.

- k. Food support through the PI480 Program (for approximately one year only).
- l. Outside training support for nutrition, family planning, and small gardens.
- m. HIS.
- n. Procurement of ORS packages, antibiotics, antiparasite medicines, and (through ProFamilia) contraceptives.

2. Outputs (e.g. persons trained, mothers educated)

Number of persons trained:

- a) 163 volunteers trained in CDD.
- b) 156 volunteers trained in Nutrition.
- c) 156 volunteers trained in Immunization.
- d) 156 volunteers trained in Family Planning.
- e) 156 volunteers trained in Sanamiento Ambiental (Village Cleaning).

Total number of volunteers trained is 936.

- f) Number of mothers trained: 7059 (68% of mothers of reproductive age).
- g) Percentage of volunteers who have been trained in more than two area of intervention is 16%.
- h) MINSA personnel trained by ADRA:

In breastfeeding: 13 persons of the medical and paramedical personnel (SILAIS, Centers and Posts).

In CDD: 20 persons (medical and paramedical personnel), 6 medical doctors, 14 nurses.

- i) Mothers' groups covering 100% of mothers in a village - actual number determined by geography.
- j) On-going monthly support of regular MINSA immunization campaign.

- k) 136 URO Clinics established and delivering services.
- l) 7 volunteers working as breastfeeding consultants in the district hospital.
- m) Screening for and distribution of contraceptives.
- n) Screening, referral, and some antibiotic treatment for ARI cases.
- o) 20 volunteers capable of treating pneumonia according to protocol.
- p) 136 functional health committees.

3. Outcomes (e.g. immunization coverage, change in mother's use of ORT)?

- a) Marked diminution in the gravity of diarrheal diseases. It is too early to note a reduction in prevalence.
- b) Marked diminution amongst the children suffering from malnutrition. The percentage fell from 33% to about 23%.
- c) The baseline survey indicated a 77% immunization coverage amongst the 12-23 months old children. But figures from a recent Census of Region 1 indicates that it was 54% overall. If this is true, then the increase in coverage is all the more remarkable if the 54% figure is contrasted with the 85% actual coverage of CS target areas, according to the recent figures of the MINSA.
- d) There are less mothers at the Health Posts and Centers demanding Plan A diarrheal treatment showing that the UROCs are highly successful in teaching the mothers to take care of Plan A diarrheal conditions at home.

C. How many infants, children under five, and mothers have been reached by CS interventions to date?

Mothers: 10,340

Children: 8,529

One should note that there is a steady increase in the population of mothers.

It is not clear whether the project is working with a **fixed** universe of mothers, predetermined to take into account the drop out and the entry rate. It is assumed that those two rates are equal.

In terms of manpower, according to ADRA CS staff, at least 1 extra CHW would allow for a better distribution of the tasks at hand in terms of reaching the communities adequately. Reassigning areas would not relieve the problem. The major constraint for the moment is budgetary.

D. Is the focus of prioritization of interventions appropriate?

The focus of prioritization is appropriate, that is Diarrheal Diseases intervention followed by Nutrition and the others. However, with the introduction of ARA, the latter should occupy the third place.

III. ASSESSMENT OF EFFECTIVENESS

A. Has there been sufficient progress in meeting stated objectives and yearly targets?

The midterm benchmark for 4 out of 5 interventions has been reached and even overpassed. The overall rate of progress is slightly higher than estimated. At this point the tenvas political developments of recent weeks ant the termination of PL480 supplimentaxy feeding carry the most threat to continued progress.

PROGRESS COMPARED TO OBJECTIVES

OBJECTIVES	% OF OBJECTIVE REACHED
1. (EPI) To increase the coverage of complete immunization for children age 12 - 23 months from 77% to 85%. (The September-December ADRA Census showed that initial coverage was not 77% as found by the Baseline Survey but 54%).	Results: 75%. The ADRA Census data indicate that the coverage for that category was indeed 54%. Which means a gain of 21 points.
2. (EPI) 90% of mothers of children less than one year will know why their children should be vaccinated.	Results: 44%. Assuming that those who had their children immunized knew they had to do so (regardless of why), a result of 44% means that 50% of the objective has been reached at this juncture. Since we are at 58% of the life of the project, immunization is slightly lagging behind.

D. What proportion is that of the total potential beneficiary population of infants, children under five, and women of child bearing age?

- a) Children under 5: 17% = 84,104
- b) Lactating women: 22%
- c) Mothers of reproductive age (10-49): 41% = 105,334

II. ASSESSMENT OF RELEVANCE TO CHILD SURVIVAL PROGRAM

A. What are the major causes of child mortality and morbidity in the project service area?

The causes of child mortality in order of importance are diarrhea, malnutrition, and Acute Respiratory Infections (ARI). ADRA is not mandated to address the causes of death primarily. The methodology of ADRA in Nicaragua is to achieve the stated goal, improve the health of mothers and children by helping the local SILAIS to strengthen its delivery of services.

The causes of morbidity in order of importance are: ARI, diarrhea, malnutrition.

B. What are the child survival interventions on health promotion activities initiated by the project?

ADRA does not intervene directly with medical attention. ADRA provides workshops to the volunteers who in turn provide education and ORT packages to the mothers. The volunteers receive workshops in breastfeeding, importance of immunization, reproductive health, diarrhea prevention, growth control and nutrition. At the level of the volunteer clinics, demonstration accompany presentation of the manual. They are GC clinics, URGC clinics, Family Planning clinics. Thirty communities also have points of distribution for Family Planning items provided by ProFamilia.

C. Are the mix of project interventions appropriate to address the key problems given the human, financial and material resources available to the project and the community?

ADRA has been following the policies set by the government's primary health care program and therefore, does not have the freedom to reorder the interventions. In fact there is no need to do so, since both MINSAs and ADRA are placing emphasis on the same interventions and in the same order of priority. However, the MINSAs have been reluctant to allow ADRA to distribute antibiotics and other medicines, for its upcoming ARI intervention.

3.	(CDD) 90% of 156 communities will have trained CDD volunteers and functioning rehydration centers.	100% of objective reached.
4.	(CDD) 80% of cases of diarrhea in the last two weeks will have been treated at home or in rehydration centers according to project protocol.	100% of objective reached.
5.	(N) To decrease malnutrition rates according to the Navarro classification from 35% to 28%.	The actual result shows a rate of 23%, which means that the objective has been surpassed.
6.	(N) 70% of mothers will participate in mothers' groups and will have received nutrition education through these groups.	Results of mini-survey show that 93% of mothers knew about nutrition per education given by ADRA. Therefore, objective has been surpassed.
7.	(MH/FP) To increase the number of women of reproductive age using modern contraception from 18% to 40%.	Mini-survey showed that 35 % women of reproductive age are using a method. The variation tolerance is 10%. Therefore, at best, 45% of mothers, i.e 113% of objective has already been reached. At worst, 25% of mothers, i.e. 25% of objective has been reached. Since FP started late, the point reached is satisfactory.
8.	(ARI) 90% of 156 communities will have volunteers trained to evaluate and refer respiratory infections according to project protocol.	0% - Not yet started.
9.	90% of communities will have Health Committees made up of trained volunteers that meet monthly to review health activities.	100% of objective reached.

B. Are the targeted high risk groups being reached effectively?

The mothers suplentes have been on the look out for mothers and children at risk. The Nutrition Volunteer monitors the weight of babies every month and is able to identify those who are losing weight and those who are more at risk than others. Therefore, the targeted high-risk groups are being reached effectively.

C. If not, what are the constraints to meeting objectives and reaching high risk groups?

Distance and lack of transportation facilities are the major constraints. Further it seems that the concentration of high risk cases is inversely proportional to distance from and access to HP. Yet, the fact that the recent outbreak of cholera in the region was rapidly brought under control indicates that surveillance and intervention are effective despite difficulty of access.

IV. ASSESSMENT OF RELEVANCE TO DEVELOPMENT

A. What are the main community barriers to meeting the basic needs of children?

The barriers are poverty, education, culture. Literacy would sensitize some mothers to the health need of their children. Some mothers are so busy in the fields or carrying water that the health of their children is secondary. More outreach programs could help to remedy this situation.

B. What has ADRA done to date to increase the ability of families to participate and benefit from CS activities and services?

Food supplements from the PL 480 Program have been an incentive in the beginning. Fortunately the removal of food has not significantly impacted on the attendance of mothers to meetings and “charlas”. ADRA’s weekly meetings with the mothers are intense and regular. The distribution of the manuals to the volunteers, video shows and a few drama shows have made a significant impact on the level of participation by the community.

C. Is ADRA fostering an environment which increases community self-reliance, and enables women to better address the health and nutrition needs of their families?

In many communities there are many women taking the lead at the level of the Health Committee. ADRA is encouraging that. The mothers’ club are 100% under the leadership of the mother suplentes.

A gender analysis, checking the mix and impact of women on project success shows a gain in empowerment of females in the project area, especially amongst the one parent households headed by a woman.

On the other hand, giving the CHC's more power in their communities raises the status of the mothers that take part. Mothers are developing more self-confidence. This is most apparent when asking mothers about the lessons they have learned from the talks on family planning. The knowledge they gain about themselves tends to enthuse them. The knowledge among men also tends to make them respect the women more. Breastfeeding knowledge gives the women pride in what they can contribute.

V. ASSESSMENT OF COMPETENCE IN CARRYING OUT PROJECT

Are there any particular aspects of project design or implementation which may be having a positive or negative effect on meeting project objectives? Please take into account the following points:

A. Assessment of Design

1. Has the project limited its project area or size of impact population?

There has been an initial reduction in size and area. But that was done already at the time of the DIP writing. Later there was no reduction of area, but only a reduction in the number of communities from 186 to 156.

Due to budget limitations, the project was reduced. As the project was unfolding, the ability of the ADRA team was established. The Project Director feels that with another 4 health workers, the whole state of Nueva Segovia could have been covered with the project.

2. Has there been a careful expansion of project service activities?

There has been a reduction in the number of communities. But an increase in the number of mothers. We assume that if the birthrate in the area is constant, the number of mothers entering the project is the same as the number of mothers leaving the project. The ARI activities will be carried out as scheduled, around August 1993. It is not a new intervention in that it was already part of the DIP. It will be carried out in the same catchment area.

One area of expansion where ADRA could be effective without jeopardizing its health activities is, of course, literacy.

3. Has ADRA set measurable objectives of outputs and outcomes?

The answer is affirmative. Please check the objectives above or the more detailed DIP which was elaborated in 1991.

4. Has the project management been willing to make changes when appropriate, and can ADRA justify or give a reasonable explanation of the directions and strategies the project has undertaken?

The manager of the project has been responsive to needs and made changes. Additional strategies of how to use mother suplentes and integrating Volunteers into the Community Health Committees are examples of this.

Another example comes from the fact that the methods used at the beginning of the project for training CHW's was not too effective. With the help of the Peace Corps Volunteers, more participative teaching methods were readily adopted by the management which has led to a higher level of success.

B. Assessment of Management and Use of Data - HIS

1. Is the project collecting simple and useful data?

ADRA Nicaragua has conducted a 30 cluster sample baseline survey in December 1991. The survey made use of the help of already trained interviewers formerly from the ADRA CASA project. The DIP that followed a few months later was a replica with few data modifications. Most of the data collected by ADRA relate to the training activities and evaluation of KAP by ADRA. The government does not expect reports from the CHW's. However, the SILAIS Director has been counting on ADRA CHW's and even the Volunteers to bring in data that they could use. In fact, they are encouraging ADRA to be their primary source of reliable data.

Basic information from ADRA is used by MINSA. The latter has information of their own, but only for immunization. MINSA has elaborated forms for its own interventions. But ADRA has practically the same ones with much more information. In immunization, diarrhea, nutrition, ADRA has been cooperating with MINSA/SILAIS in providing all the data asked for by the latter.

The data collected are straightforward though not always simple. The system is not informationally overloaded. It is simply time consuming no matter how one looks at it.

MINSAs do not have an HIS at the level of Volunteers. But the HIS of ADRA is understood by all at the MINSAs. We have Volunteers of MINSAs/ADRA who manage well the ADRA HIS.

The coordinator consolidates the info from the volunteers and remits the summary to the **CHW** who passes it on to the Zone Supervisor.

2. Do the indicators need refinement?

They do not need refinement for the moment. They are appropriate because they indicate exactly how the volunteers are doing. Amongst at risk indicators for nutrition is large families with malnourished children. For diarrhea, if there are children with frequent cases of diarrhea during one month. And for BF, children who are not breast-fed. There is no overload of unnecessary indicators.

3. What is the balance between qualitative and quantitative methods of data collection?

The balance is tolerable with a ratio of 7:1 between quantitative and qualitative. The data collected is therefore clearly quantitative. Only the evaluation reports carry some qualitative elements providing indication on the effectiveness of the training.

4. Is the project using surveys for monitoring and evaluation?

In September 1992, ADRA/N did a survey to actualize the previous data called the 1992 CENSO (CENSUS). The volunteers are always adding new children or removing the transferred or deceased elements from the database. The project intends to use more surveys to monitor **KAP** of mothers.

5. How were baseline data used for project development?

Baseline data was available for project development. A baseline survey was done three months prior to the start of the project. Most of the data ADRA/N uses come from the baseline. The baseline, together with the DIP are the blueprint by which the project is carried forward.

6. Are data being used for decision-making?

Yes, data are being used for decision making. Each supervisor needs information to measure the rate of progress at different levels to know if each CHW is reaching his/her objectives in relation to the actual population increase. The data are used to monitor the supervision of all activities at all levels.

Not so much as for distribution of resources as to know the real percentage of whatever activities are to be tailored as to know if ADRA/N reached its monthly benchmarks. The mapping of parameters and variables using charts and graphs have allowed the staff to compare various elements of the project and based on the results of their analysis they have been able to make changes. For example, the timing of the ARI intervention and the phasing out of food supplements.

7. Is the project's routine health information system fully functional?

The HIS is fully functional, complete and streamlined. Forms are easy to fill in. Initially, there was an HIS, apparently easy, with designs and drawings. But it was modified because the information was never complete. And the Volunteers said that it was quite difficult to complete.

Further, the Volunteers were confused with the CDD indicators. The whole HIS was tested and it was found that there was not adequate clarification in the mind of the Volunteers collecting the data. ADRA/Nicaragua tested a new system without drawings and it was found to be exactly what the Volunteers needed.

8. Do the local staff have the management and technical capacity required to maintain the health information system?

Yes, at the level of hard copies and computer. Even in the absence of a Public Health Advisor, the HIS is being sustained. One of the ADRA supervisors is extremely knowledgeable of the system and is creative enough to assimilate and make full use of the computer to design new ways of streamlining the forms.

9. Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members?

ADRA/N has shared information with MINSA/SILAIS in all interventions, and also at the level of the HC's and HP's. The Project Director provides feedback to the staff and the community once a month during the monthly meeting. The Project Director shares findings and ongoing data collection concerns at a bi-monthly meeting with other NGO's regularly organized by USAID in Managua.

10. Is ADRA or project level making any attempt to maximize lessons learned by documenting, sharing, or institutionalizing their lessons?

The answer is positive. The CS manuals have been exhibited at an exposition in Tegucigalpa, Honduras, in February, 1993. ADRA/N CS project has shared its material with ADRA Honduras CS Project. The HIS has been recommended by USAID to other NGO's.

The EPI/INFO program is slowly being assimilated by the staff and is gradually becoming part of ADRA/N regular HIS.

C. Assessment of Community Education and Social Promotion

1. What is the balance between health promotion/social mobilization and service provision in this project?

The balance is sensible. The instruments used by ADRA/N include picture rolls, flip charts and videos. A higher percentage of resources is used for health promotion than for social mobilization.

2. Is the balance appropriate?

It is appropriate given the political atmosphere of the country. Mobilization at an individual level has come as a result of encouragement from the Supervisors. The most interesting one is the decision of one of the Volunteers to offer land and manpower to build a community center together with a community garden. Please cf. Appendix Q.

3. Is education linked to available services?

Unfortunately not. No literacy class are held by ADRA for the moment. Only evening classes are offered by government entities in a few areas. But here again access is a problem and those who really need it do not benefit.

4. Has the project carried out any community information, education, or communication activities?

The SILAIS has taken the lead with meetings and car-mounted loudspeakers broadcasting health and cleanliness messages through the cities and villages. ADRA is towing behind. Other informal meetings have taken place with community leaders through Rotary International meetings.

5. Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages?

The CHW's, the volunteers, the mothers, MINSA workers, all have had deep input.

6. Have the messages been tested and refined?

Feedback from Volunteers and mothers were constantly taken into consideration and the messages have been modified many times over before to make the maximum impact with minimum transmission effort.

7. How does ADRA ensure that messages to mothers are consistent?

Before the manuals, on which the Volunteers base themselves to make flip charts, were finalized the mothers were interviewed by the CHW's, Supervisors and in some cases by the Project Director herself. Therefore, the product as it stands today is consistent with what the mothers need to hear and learn.

8. Does the project distribute any printed materials?

The answer is affirmative. Please cf. Appendix 0.

9. Does ADRA pre-test printed material?

The manuals were pretested by the staff as explained above.

10. Do members of the community regard these materials as simple, useful, and of value?

They do. The literacy rate is satisfactory, though there is plenty of room for improvement. The design is simple with a lot of diagrams and pictures. Therefore, the uneducated understand also.

11. Has the project been creative in its approach to community education, such as incorporating any non-traditional or participatory education activities?

There is a tradition of classic education and arts in Nicaragua, Therefore, ADRA/Nicaragua did not need to be especially creative in its approach. The creativity is mostly apprehended at the level of the Volunteers and the mothers in the elaborate flipcharts with designs, graphics and paintings that they make in their effort to expand on the manual. ADRA/N has encouraged this activity in providing the Volunteers with paper, ink, pens, and paint.

12. Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

The supervision and monitoring system is fully functional and evaluation is fully integrated within the system. Therefore the level of learning of the mothers is continuously monitored and evaluated by the Volunteers whose learning in turn is evaluated by the CHW's.

It is not anecdotal as evidenced by the evaluation reports. When the staff will become more accustomed to the 30 cluster survey methodology, they will be perfectly capable to monitor level of knowledge on a regular basis.

D. Assessment of Human Resources for Child Survival?

1. How many persons are working in this CS project?

As in country staff, there are 23 full time workers that are employed by the Child Survival Project. Supporting them are two more part-time administrators and two full-time Peace Corps Volunteers. In ADRA/International there are 4 part-time workers (with support staff that help backstop the country with technical, financial and managerial assistance).

They are all overworked. An average of 6 extra hours per week per staff member. There are good records of time keeping, and activity monitoring. However, too much information on activities performed, not important to efficient management of time.

2. Does the project have adequate numbers and mix of staff to meet the technical, managerial and operational needs of the project?

Considering that there are two doctors and one medical student on the staff, the medical technical side is well taken care of.

On the managerial side, as far as the Somoto CS office is concerned, every component shows good organization, with the director, Dr. Gloria Torufio, demonstrating good leadership qualities to create an effective team spirit.

As far as covering operational needs, the CHW's are stretched very thin. Most of the CHW's have 12 communities to work in, one has 20, and being able to distribute the load would create a more effective impact. A HIS clerk/secretary for the office would relieve a lot of the paperwork load on the Supervisors, and give them more time in the field with the CHW's. Some of the comments from the Peace Corps volunteers, were:

- The supervisors would sweat blood for Dr. Torufio.
- It is incredible the amount of work the CHW's do -- and seem to enjoy.
- This group does not fit the "manaña" stereotype. There is a definite, maybe excessive work ethic.

There are a good mix of males and females, all qualified and fully trained. See CV's and training section.

But one CHW has 20 communities and it is the area with a higher degree of prevalence.

A constraint for some is the lack of horses and the peril of robbers near the Honduran border. Unemployed soldiers have turned thieves. Another lack is that of insurance covering at least the drivers of vehicles.

3. Do these staff have local counterparts?

Yes, at most levels of the MINSA in the area. The SILAIS medical director and the Medical Health centers' medical director correspond to, and, in fact, collaborate with the ADRA director. The medical doctors (please note the dual correspondence) and nurses at the SILAIS in Somoto, Medical centers and medical posts levels correspond to the level and function of the supervisors. The nurse at the health posts correspond with the Health Workers of ADRA and finally the brigadistas or MINSA volunteers correspond to the ADRA Volunteers. At the community level, the brigadistas and ADRA volunteers work so closely and belong to the same Health Committee that they are practically one and the same. The MINSA has recognized that equivalency and soon will be calling them or promoting them to be called Health Promoters rather than Volunteers or Brigadistas.

All full time staff is in country, and have counterparts in the MINSA. The main difference is that the CHW's of the MINSA do not go out to the communities. One problem that is still being worked on is the tendency in some communities to have both ADRA and MINSA CHW's requiring the same data. There are the cases where mothers are being asked to weigh their children twice. It would appear that the MINSA does not accept the data gathered by ADRA. This has been cleared up at the MINSA administrative levels, but at the local health posts, there is still a problem.

4. Are community volunteers taking part in this project?

The community volunteers form the backbone of the project. There are 936 Volunteers taking part in the 156 communities.

Much of the success of the Child survival project seems to be the result of the large number of Volunteer Health workers in the communities that ADRA has recruited and trained that are very active.

5. How many are in place?

There are 936 Volunteers in 156 communities.

6. Are they multi-purpose workers or do they concentrate on a single intervention?

They concentrate on a single intervention. There are 156 URO Volunteers, 156 FP Volunteers, 156 Nutrition Volunteers, and, in theory, 156 GM Volunteers. However, there are some Volunteers who are in charge of more than one intervention.

Part of the administrations stated policy to reduce the work load on the CHW's, is to have them trained in one intervention, with general knowledge of others.

One interesting case was reported where a "Nutrition" Volunteer was advocating family planing to a spontaneous gathering, because he had heard of the material.

A different perspective than other CS projects is the high percentage of men that are CHW's (ca. 40%) This is in some areas a positive influence where the community accepts the **authority** of the men easier. In other communities it is a problem due to the fact that the men are more mobile, and often leave to find work.

7. Is their workload reasonable?

Their workload is reasonable. They do not have to walk too much to reach those underneath their supervision. But it is hard for them to reach the workshop venues. Some have to walk for two hours. However, they receive a per diem during the workshop.

In fact the answer should be yes, without qualification. So much so that they are easily found working on material for workshops and "charlas" presentations in between scheduled meetings. The average CHW gives a talk on their specialization 2-4 times a week. Depending on their specialization they are usually available for "emergency" requests. All of the Volunteers interviewed seemed eager and happy to have the responsibility. As time goes by and the AR1 is implemented, the number of workshops at all levels will relatively diminish. This would free more

time for the CHW's to relate directly to mothers, reenforcing what the Volunteers are already teaching.

8. How many days of initial training and how many days of refresher training have they received since the start of the project?

Each group of CHW's was given a minimum of 8 hours of training at the beginning when they were recruited. Some received an additional day, although two days away from their families caused some problems. The CHW's offer an extra day each month for the Volunteers to gain some more education. Those who can not, or do not attend are usually reached in their homes.

After the AR1 seminars for the Volunteers, ADRA/N is planning to organize some mini-seminars for refresher courses.

9. Is there evidence ADRA carried out a needs assessment before embarking on initial and refresher training?

The interventions' priorities came from the baseline survey and other data obtained from the MINSA. The refresher courses are offered as much for their incentive value as to cover a specific need.

10. Was the training methodology appropriate for the nature of the health workers jobs?

The original training was considered too didactic for the people to be able to understand. With the help of the Peace Corps volunteers, the methodology was changed to suit the CHW's learning needs. Plays, play acting, role playing, and audio-visual aids are used to show cause and effect of various interventions.

The training methodology is now appropriate. The training curriculum has been developed and tested in other Spanish speaking countries by ADRA/I. The curriculum focussed on the mothers. And the fact that the Spanish language is standard for all Nicaragua, the transmission of knowledge is uniform.

11. Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

Yes, given the advanced training in Public Health that many of the CHW's already had before.

As the interventions were done, one by one, the training proved to be sufficient. With the continual monthly revisions, they are performing well.

E. Assessment of Supplies and Materials for Local Staff?

1. What educational or other materials have been distributed to workers?

Manuals, pens, pencils, notebooks and a sort of briefcase have been distributed to the CHW's. But the briefcase did not last long, given the difficult terrain and climactic conditions.

2. Do these materials or supplies give any evidence of being used?

Definitely yes. They look overused in some cases. Especially the manuals for they serve as models for larger chart creations and presentations. The Supervisors keep close contact with the CHW's to ensure that the supplies are regular and properly used.

3. Are they valued by the health worker?

More than ever, since they are much in demand by Volunteers. They are usually kept in plastic bags and always accompany the CHW's.

4. Are they appropriate to the health worker's job?

They are appropriate in that they serve as a refresher tool, on one hand, and as a didactic tool on the other.

5. Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

They have copies of manuals given by ADRA/N. From these, they create their own rota folios with material bought from the funds of the Health Committee and some ADRA help. Furthermore, most communities have a community center or meeting place which is offered free to ADRA staff for community presentations and charlas. Some Volunteers offer even their home.

F. Assessment of Quality

1. Do the local project staff have the technical knowledge and skills to carry out their current child survival responsibilities?

The Project Director is a medical doctor by training and has been working with children programs for a long time. She was already with ADRA's CASA project before the CS Project.

One of the supervisors is a physician, another one has been trained as a veterinarian, the third is an expert at information system. At least one of the CHW's is a Registered Nurse while the others have had one form or another of professional training.

The above mentioned CHW's is a former nurse in the MINSA health system. She provides insight on relations with the governmental health system.

2. Do the local staff counsel and support mothers in an appropriate manner?

The CHW's are constantly in contact with many mothers. They work very closely with the Volunteers and receive feedback directly from mothers. The Project Director sometimes accompanies the Supervisors and make direct visit to the mothers who are also Volunteers. The Volunteers on the other hand are very responsible and take their job seriously. Some even attend evening classes to pursue their personal education.

G. Assessment of Supervision and Monitoring

1. What is the nature of supervision and monitoring carried out in this project?

It is strong and streamlined from the Project Director all the way down to the mothers. Supervision is adequate at all levels. The constraints to supervision are mainly: 1) political, and 2) home economics. Political instability, coupled with the threat of violence or banditry, make supervision difficult in some cases. Furthermore, some mothers have to work and therefore they neglect to bring babies to be weighed. However, most Volunteers have taken it upon themselves to visit the mothers when they find out that the latter have not been active.

The CHW's would like to have more time to speak directly to mothers more frequently. So after ARI has started, there will be more time to spend with the mothers.

2. Is it field-based supervision?

The mothers are under two and sometimes three elements of supervision: the CHC coordinator (who is a Volunteer), the mother suplente, and sometimes the CHW, without counting the Puesto de Salud or Centro de Salud's director and staff. The suplente is the key to epidemiological vigilance, and as such is very responsible in her role.

3. Has supervision of each level of health worker been adequate for assuring quality of services?

The Supervisors evaluate the performance of the CHW's every three months. So it is adequate. There is also indirect supervision of the mothers on the part of the director of the Centro de Salud or Puesto de Salud. They give feedback to the mothers, sometimes using the ADRA manual! Two of the CHW's are so advance that they could become supervisors if need be.

However, some CHW's with more than enough communities, like Rosibel, with 21 communities, cannot cover the whole area adequately. On the average, a CHW cannot cover adequately more than 13 communities, without serious logistical problem, time being the most important constraint.

There is definitely a need of at least one more CHW.

4. From the viewpoint of the health worker has much of the supervision is counselling/support, performance evaluation, on-the-job education, or administration?

Supervision is carried out mostly on foot by the CHW's. The CHW's stay in the house of Volunteers when they are travelling far from their home base. Therefore, the presence of the CHW's for a longer period in the communities reenforces lessons learned in the minds of the mothers and neighbors.

Immunization is what provides more work of an administrative nature to the staff. But after registration, it is simply routine. ARI activities will provide more extended supervisory presence in the communities.

5. What are the monitoring and supervision requirements for the remainder of the project?

With the addition of ARI in August, the load at the level of the Volunteers will not increase really. But the load increases as one goes up the project ladder. More will fall on the shoulders of the CHW's and still more on the supervisors, because more vigilance, more monitoring, more information, more workshops, and mini-workshops. The committees have already chosen the ARI Volunteers. However, ARI simply will increase supervision, not administration time of the CHW'S.

The Volunteers need some reinforcements. Diplomas of supervision at all levels of supervision could be envisaged. Especially for the Supervisors and CHW's. This will also answer the need for greater incentives.

However, all Supervisors received as much training as the CHW's. The Supervisors feel they need some more training in sustainability and more knowledge in nutrition for example.

H. Assessment of Use of Central Funding?

1. Has administrative and technical support from ADRA/I and ADRA/N been appropriate in terms of timing, frequency and needs of the field staff?

The CS program received six group visits from ADRA/I TA teams since the beginning of the project. These have included two visits from the CS technical backstopper at ADRA/I. Five visits to backstop managerial aspects and three visits for financial back stopping. The indication of the staff is that ADRA/I has provided adequate back-stopping to the project to this point.

With regards to the ADRA/Nicaragua country office, there is no evidence that the administration has visited the Child Survival project area. Most CS staff felt that the country office has offered limited TA. The reason is that the country office has kept only the project accounting component in Managua and has delegated all other operations to its Somoto office.

2. If not, what constraints does the project face in obtaining adequate monitoring and technical support from ADRA regional or central offices?

The Nicaragua country office is receiving a new director who, in addition to having a degree in Public Health, can assist in some of the bilingual translation problems that the Child Survival project has.

3. How much central funding has AID given the CS grant for administrative monitoring and technical support of the project?

In the total 3 country grant of \$1,750,000, ADRA/I separated \$157,747 to cover the direct costs of backstopping the countries. Divided the same as the country budgets, this would be \$74,000 dollars.

4. Do these funds serve a critical function?

These funds are the only way to provide adequate technical backstopping for health, management, finance and contract compliance.

5. Do these functions appear to be underfunded or overfunded?

This project has had a steady stream of technical assistance. Fortunately some of the costs were shared with other ADRA/Nicaragua projects. There is a minimum of funds available to provide for backstopping from HQ.

6. Are there any particular aspects of AID funding to the central office of ADRA/International that may have a positive or negative effect on meeting child survival objectives?

The central funding of the project allows for more uniform and higher level technical assistance for the project than would be otherwise available for ADRA projects. This should have a positive effect on meeting the Child Survival objectives.

The negative aspect of course is the high cost of Central ADRA backstopping. Some of the technical backstopping could be found in-country or neighbor country at a lower cost, but the problem of project responsibility for centrally funded projects requires substantial involvement from ADRA/I. The staff indicates that they appreciate the ADRA/I involvement.

I. Assessment of ADRA's Use of Technical Support

1. What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained?

- a) Dr. J. Whitehouse visits were needed and prized especially in the area of refining the number and scope and order of priority of interventions.
- b) The project has made external use of expertise with data management when surveys were made.

2. Was the level of technical support obtained by the project adequate, straightforward and worthwhile?

Yes. The project still needs TA in inputting results of questionnaires of EPI/INFO or to train Corina to do it. Otherwise, the staff is capable to handle any technical problem that may arise.

- 3. Are there any particular aspects of the technical support (from all sources) which may have had a positive or negative effect on meeting project objectives? (For example, consultant visits, evaluations, workshops, conferences, exchange field visits).**

All the visits have had a positive impact. Consequently, the Project Director became more focussed, so was the program.

- 4. Is there a need for technical support in the next six months?**

Not for the moment.

Data Collection - The HIS system is up and running. Despite the usual heavy time involvement in getting the information to flow smoothly, the HIS system does not suffer from informational overload. They do not need any TA in that area for the moment.

- 5. If so, what are the constraints to obtaining the necessary support?**

N/A

J. Assessment of Counterpart Relationships

- 1. What are the chief counterpart organizations of this project and what collaborative activities have taken place to date?**

The only counterpart organization of this project is MINSA.

- 2. Is there any exchange of money, materials, or human resources between the project and counterparts?**

At the level of curriculum and pedagogical material there is a constant flow of exchange. But not at the level of medicine or other financial resources.

- 3. Does the counterpart staff have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?**

Dr. Dagoberto Bermudes, the SILAIS Director, is a physician by training. He has been in private practice for more than two decades before becoming very interested in Public Health. The Health centers are under the direction of a medical doctor aided by at least one Registered Nurse. The Health Posts are "manned" by a Nurse-in-charge. They all have received training at point on CS interventions.

4. Is there an open dialogue between ADRA and counterparts?

The SILAIS director holds regular meetings with all the actors in the health field in his region. There is a slight trace of competition resented by MINSA/SILAIS top echelon at the regional level. But at the field level, the dialogue is more than open.

K. Assessment of Referral Relationships

1. Identify the potential referral care sites and comment on access and service quality.

- a. The following table represents accessibility to a Health Center with a medical doctor attending.

Municipalities	# of communities	% of access
Somoto	32	89%
San Lucas	21	66%
Las Sabanas	8	67%
Cusmapa	14	100%
Yalaguinas	14	58%
Palaguinas	17	100%
Totogalpa	22	63%
Total	128	82%

The quality of care they receive is adequate, with more serious cases referred to the district hospitals. The SILAIS director let it be known that soon he will place at least two specialists in the Health Centers of Region I. (Please see Appendix U for more access information).

- b. There are 23 other communities that have access to at least a Nurse-in-charge in a Health Post. (Please see Appendix U).

2. Has the project made appropriate use of these referral sites?

The URO clinics are playing a pivotal role in screening diarrheal affected children before referring the more serious cases to the Health Centers. The screening procedure at the URO clinic level has made the Health Post and Centers a more serious trip in itself for afflicted mothers. Therefore ADRA/N CS has not only made appropriate use of referral sites, **but** has restituted to them the role that they were supposed to play for the community in the first place.

3. What is the continuity of relationships between the referral site and the community project?

The SILAIS has signed an agreement to take over where ADRA leaves. This means that the SILAIS will stock the URO clinics with ORT packages, and will supervise the Community Health Committees. This process will strengthen the relationships between the project and the referral sites and ensure its continuity.

4. Is the dialogue between project and referral site adequate?

The volunteers and their referrals are well received by most of the Health Centers and Health Posts. A few view the work of the Volunteer as competition to their own status in the community. But in general, mothers carrying a referral slip from their Community Health Committee are better received than those without.

5. Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

Apart from regular invitation of the service providers to ADRA organized seminars, ADRA works closely with SILAIS to take the latter's staff into the field for assessment of situation.

L. Assessment of PVO/NGO Networking

1. What is the evidence for good networking with other PVOs and NGOs working in health and CS Programs?

- a. **Good** working relationship was **observed** with ProFamilia, ProNorte, Cosude, and other NGOs.
- b. Family Planning issue: ADRA/N is not capitalizing on the offer of ProFamilia's 50 cordobas. In Ocotal, the cost of the vasectomy operation is 3000 cordobas.

- c. Dr. Marytza to be commended for working closely with ProFamilia. Though ADRA is benefitting highly from working with ProFamilia, the latter has a line item in its budget to cover the resources needed to do what ADRA is doing in preparing candidates for operation, including a medical examination. Therefore, the involvement of ADRA should be qualified.
- 2. Are there any particular aspects of the situation which may have had a positive or negative effect on networking?**

Not really. There is a collective perception amongst the beneficiaries that all NGO's, including state para social welfare organizations work together and not at cross purposes.

- 3. Can the project cite at least one lesson learned from other PVO's or other CS projects?**

It pays to pool resources. It is a win win situation for the PVO's and a gain for the beneficiaries. INPHRU shared conference facilities with ADRA which did not have to worry about renting an expensive venue for training purposes. ADRA was then able to marshall greater attendance to its training sessions at different levels by virtue of it being perceived as having obtained the sponsorship of INPHRU which is well respected in the community.

M. Assessment of Budget Management.

- 1. How does the rate of expenditures to date compare with the project budget?**

The Evaluation took place when 58% of the project time was completed. At this point approximately 40% of the total budget is spent. Of this the AID portion constitutes 48%, and the PVO amount is 7% Part of the reason that the PVO contribution is so low is due to the decision made not to work with ARI interventions until the later part of the project. The majority of the ADRA match is related to this intervention.

- 2. Is the budget being managed in a flexible but responsible manner, and can ADRA justify budget shifts that may have occurred?**

To reduce management complexity, ADRA has been inflexible in line-item flexibility in the budget use. However, as a result of the Evaluation, the budget will have to be adjusted.

3. **Can the project achieve its objectives with the remaining funding?**

Several of the objectives have already been met, the only one that still has to be initiated and completed is the one for ARI.

4. **Is there a possibility that the budget will be underspent at the end of the project?**

Due to an increase in the personnel budget caused by the need to hire security and custodial personnel for the Somoto office that previously were paid from the PL480 program, it is doubtful that there will be remaining funds at the end of the project.

5. **How do you rate the equipment that is available and its use for the project?**

The three vehicles that at present are being used, 1 Toyota Landcruiser II, 2 LWB Toyota Landcruisers, are being very heavily used. They are just adequate. Should one be lost due to breakage or other reasons, there would be a terrific strain on the project. The distances that have to be covered, and the terrain exact very heavy wear on the vehicles.

A random sample of usage of the 3 vehicles shows that they are accumulating more than 11,000 Km. per month. According to the control, some 25% of this is used in returning the supervisory staff to their homes on weekends and when else needed. There is a problem with public transportation that can fulfill the needs of the staff, considering the late hours worked. No evidence was detected that the vehicles were being used for personal reasons aside from providing transport to and from work.

The two computers that are working are doing the job. The one that is being used for the HIS information is overworked. The project director is loaning the project her personal computer to reduce the load.

6. **How well is petty cash handled?**

As the accounting and posting is done in the central office in Managua, there is just a petty cash box with a cashier in Somoto. The amount of the petty cash is \$1500.00 This lasts from 8-15 days. When needed the cashier takes her receipts to Managua and cashes a check there and returns with the cash for the petty cash.

There are banking services available in Somoto, but at present they are only used for payroll checks. The environment of Somoto is not conducive to more important transactions. The local bank was robbed a week prior to the visit of the evaluation team.

VI. SUSTAINABILITY

A. Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment?

For the volunteer the reward is leadership skill acquired, leadership recognition by the community, social satisfaction. For the mother suplante, the role of epidemiological vigilante confers to her respect and knowledge.

The project staff is better paid than their counterpart of MINSA/SILAIS. The fact that they put an average of 6 extra hours every week without pay shows the degree of satisfaction they derive to serve the communities.

B. Would those incentives continue once AID funding ends?

Food distribution by MINSA could be one.

C. What are the steps the project has undertaken to promote sustainability of effective CS activities at the end of funding?

Taught some Health Committee members how to develop revolving fund.

D. How is the community involved in planning and implementation of project activities?

The volunteers are grouped into Health Committees. They prepare meetings, discuss items on the agenda, pool resources together to purchase pedagogical material, TV, Videos, rota folio.

E. Do community members see this project as effective?

Given the constraints due to the political atmosphere, some mothers are hesitant to come and weigh their babies. However, the answer is yes. 100% of people interviewed answered by the affirmative.

F. Is there a demand in the community for the project activities to be sustained?

The answer is yes. Especially on the part of the Volunteers and the mothers.

G. Is the MINSA involved in the project?

Not directly. But they do provide some oversight. The MINSA director and the regional medical officer have been visiting the catchment area together with the ADRA staff. Referrals are made to the Health Centers and Posts by the Volunteers.

H. Does the MINSA see this project as effective?

Definitely yes. It would like to see more coordination, however. It would like ADRA to feed them regularly with ADRA's data. Furthermore, there are possibilities that food be obtained from MINSA through PMA. If such is the case ADRA staff say they will coordinate with MINSA on that activity.

I. Are there any concrete plans for the MINSA to continue particular project activities after funding ends?

According to the SILAIS director, the answer is yes. A convention to that effect will be signed soon.

J. Do local organizations see the project as effective?

Yes, especially PROFAMILIA, INPHRU, COSUD and PRONORTE.

K. Are there any concrete plans for project activities to be institutionalized by local NGOs?

The project will be institutionalized by MINSA. The SILAIS director has the will and the wherewithal to see that the convention he signs with ADRA will have lasting consequences.

VII. RECURRENT COSTS AND COST RECOVERY MECHANISMS

- a. Do the project managers have a good understanding of the human, material, and financial inputs required to sustain affective CS activities?**
- b. What is the amount of money the project calculates will be needed for recurrent costs?**
- c. Does the community agree to pay for any part of the costs of preventive and promotive health activities?**
- d. Is the government prepared to assume any part of the recurrent cost?**

- e. **What strategies is ADRA implementing to reduce costs and make the project more efficient?**
- f. **What specific cost-recovery mechanisms are being implemented to offset project expenditures? Some Health Committees have funds of their own. They are serious about fund raising activities. One idea that some are looking into is to purchase used clothing and sell to the community.**
- g. **Are the costs reasonable given the environmental in which the project operates; is the cost per potential beneficiary appropriate?**
- h. **Identify costs which are not likely to be sustainable.**

Please, note that none of these questions raised above in this section have been dealt with by ADRA yet. As with projects of this type, it is difficult at the midterm juncture to make a judgment on a program that has just started to make an impact on Region I. To quote a pertinent observation of another evaluator, a more meaningful time to answer those questions would be at the midterm evaluation after a second round of a three-year funding cycle.

B. Are there any steps the project and ADRA headquarters can take to make the project activities more sustainable?

ADRA/I could plan to organize SED Seminars for the Volunteers. The Volunteers have in general an entrepreneurial spirit. Therefore their leadership in the community could be secured by coupling their ADRA given knowledge with how to raise funds to run their own health program.

C. Are there any steps the project and ADRA headquarters should take to make the project activities more applicable, the staff more competent., or the services of higher quality?

Recommendations for project improvements have been made below in the recommendation section of the summary.

D. Are there any steps the project and ADRA headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by AID, or by ADRA?

ADRA/Nicaragua will share the lessons learned with nearby Honduras CS VIII Project or Haiti.

E. Are there any issues or actions that AID should consider as a result of this evaluation?

Not really except the following. Supervisors are often that staff level exhibiting more entrepreneurship and independent thinking and working without supervision really. They are in general potential project directors, AID could lend a hand in upgrading their skills to management level, thereby forming local highly skilled managers for a small initial investment.

IX. SUMMARY

A. Composition of the evaluation team:

Dr. Gerard Latchman, ADRA/I, Technical Support Unit
Milton McHenry, ADRA/I CS Manager
Elsa Zelaya Mena, Valle de Angeles School of Nursing
Felix Jimenez S., Development Associates
Gerard0 Vasquez, ADRA/N Country Director

B. Time spent:

11 working days
2 days travelling

C. Total costs:

Expenses were partly paid by ADRA/I and partly by ADRA/N. No exact figure obtained at this point in time.

D. Field visits:

The team interviewed the Region I SILAIS, 5 Health Center Directors, 3 Health Post In-charges at the counterpart level

Visit of 43 communities out of a total of 156

Total number of mothers (non-volunteers) interviewed: 140

Total number of volunteers interviewed: 40

Total number of “suplante” of mothers interviewed: 9

Total number of “Coordinators” of Health Committees: 3

Total number of URO volunteers interviewed: 15

Total number of FP volunteers interviewed: 6

Total number of Nutrition volunteers interviewed: 8

Total number of GM/N volunteers: 5

In addition, Milton McHenry had pre evaluation interview and a post evaluation debriefing session with USAID officers in Managua.

E. Quantitative/qualitative methods:

Semiformal, informal and formal interviews, Mini-survey of 81 mothers in 18 communities.

F. Main project accomplishments and measurable outcomes:

1. Inputs

Training sessions were held at all levels of the project from its inception.

- a. MINSA Silais staff: Workshops on diarrheal diseases and acute infectious respiratory illnesses were provided by ADRA staff to the medical director and staff of the local SILAIS contingent in Somoto.
- b. MINSA Health Center staff (Centro de Salud): Same as above.
- c. MINSA Health Post staff: Same as above.
- d. ADRA CS Project Director: The CS Director, Dr. Gloria Toruno, received supplementary training on concepts/practices of breastfeeding in Mexico City in November, 1991. She also attended a conference in Washington DC on Pediatric Infectious Respiratory Disease in December of the same year.
- e. Public Health Advisor: The former Public Health Advisor attended the National American Public Health Association Conference in Atlanta, Georgia (November, 1991).
- f. ADRA Supervisors: 1 supervisor, Dr. Maritza Valdivia, received training during a workshop provided by MINSA and PAHO on diarrheal diseases and infectious respiratory illnesses in Jinotepe. Three supervisors attended a

workshop of Profamilia on methods of Family Planning and human relations. Supervision of CHW's and community Volunteers.

- g. ADRA Health Workers (Trabajadores de Salud) (HW): 15 CHW's received training in B-hour workshops on the use and implementation of the diarrhea resource manual produced by ADRA for the 186 communities as of April 1992. The anticipated number was 11.
- h. Community Health Committee (ADRA and non-ADRA Volunteers called Brigadistas): About 182 Volunteers received training in 13 workshops provided by the CHW's. One hundred and eighty-six Navarro classification methodology sessions were held. 186 Volunteers from specified communities were trained by the CS staff in the use and implementation of the diarrhea and cholera resource manuals (April, 1992). 13 two-day workshops comprising an average of 14 Volunteers were provided to complete this training phase. A group of 10 community volunteers were trained by professional staff of Profamilia in indications and contraindications of Family Planning methods. 13 workshops were given by CS supervisory staff in order to train 156 health coordinators of all 156 Community Health committees on their function, roles, and responsibilities within the health committees. 156 Nutrition Volunteers attended 13 workshops on the preparation of foods distributed by the PL-480 Project provided by ADRA CS and INPHRU. 10 community volunteers were trained by Profamilia in the area of reproductive health and family planning.
- i. Mothers: The PL-480 Project initiated support in the distribution of foodstuffs to the beneficiary population in the CS target zones. Before the closing down of the PL-480 program, the eligible beneficiary population for foodstuffs was $n = 16,869$. The population of children less than five years of age is $n = 10,116$; pregnant women comprised $n = 2,952$ of the total; and breastfeeding women comprised $n = 3,801$ of the total beneficiaries.
- j. Foreign Volunteers: A group of 8 volunteers from La Sierra University, California, were sent by ADRA/I for a 6-week assignment to lend support to the nutrition component of the CS Project in June-August 1992. Their work entailed orienting community volunteers and families with high risk children and infants on the construction of family vegetable gardens.
- k. Manuals: ADRA staff produced four resource manuals, one on diarrheal diseases, which was finalized after review by 13 community volunteers comprised of women from various mothers' clubs and the medical personnel from MINSAs/SILAIS. It is used as a training/resource tool for community health volunteers in the field. The second one is a manual on nutrition prepared with support from all ADRA CS staff, MINSAs/SILAIS and INPRHU. The third

manual is on Family Planning. The fourth manual is on cholera and is utilized as an instructional aid for community health volunteers working in the oral rehydration centers.

- l. Food support through the PL480 Program.
- m. Outside training support for nutrition, family planning, and small gardens.
- n. HIS in place and running smoothly.
- o. Procurement of ORS packages, antibiotics, antiparasite medicines, and (through ProFamilia) contraceptives.

2. Outputs (e.g. persons trained, mothers educated)

Persons trained:

- a) 163 volunteers trained in CDD.
- b) 156 volunteers trained in Nutrition.
- c) 156 volunteers trained in Immunization.
- d) 156 volunteers trained in Family Planning.
- e) 156 volunteers trained in Saneamiento Ambiental (Village Cleaning)

Total volunteers trained is 936.

- f) Number of mothers trained: 7059 (68% of mothers of reproductive age)
- g) Percentage of volunteers who have been trained in more than two area of intervention is 16%.
- h) MINSA personnel trained by ADRA:

Breastfeeding: 13 persons of the paramedical personnel (Center and Post).

In CDD: 20 persons (medical and paramedical personnel), 6 medical doctors, 14 nurses.

- i) Mother's group covering 100% of mothers in a village - actual number determined by geography.

- j) On-going monthly support of regular MOH immunization campaign.
- k) 136 URO Clinics up and running.
- l) 7 volunteers working as breastfeeding consultants in the district hospital.
- m) Screening for and distribution of contraceptives.
- n) Screening, referral, and some antibiotic treatment for ARI cases.
- o) 20 volunteers capable of treating pneumonia according to protocol.
- p) 136 functional health committees.

3. Outcomes (e.g. immunization coverage, change in mother's use of ORT)?

- a) Marked diminution in the gravity of diarrheal diseases. It is too early to note a reduction in prevalence.
- b) Marked diminution amongst the children suffering from malnutrition. The percentage fell from 33% to about 23%.
- c) The baseline survey indicated a 77% immunization coverage amongst the 2-23 months old children. But more accurate figures from the recent Census indicates that it was 54% If this is true then the increase in coverage is all the more remarkable if the 54% figure is compared to the 85% actual coverage according to the recent figures of the MINSA.
- d) There are less mothers at the Health Posts and Centers demanding Plan A diarrheal treatment showing that the UROCs are highly successful in teaching the mothers to take care of Plan A diarrheal conditions at home.

G. Assessment of applicability and quality of CS programming:

Nicaragua is a country that needs CS Programs. The program is most appropriate. ADRA's CS is by all measure a first rate one run by highly capable and dedicated people. The CS program has benefited from the previous set up and staff of the Nicaraguan Children's Survival Assistance Project (CASA). Which may explain the thorough training, experience, and high quality of the staff.

It is not a new work, but an extension of the CASA with the same goal, though with different objectives and another catchment area. The impact of the program is already felt at the level of the community at large. One team member stopped

various unspecified mothers with infants and asked them typical KAP CS program questions. All answered correctly, attributing their knowledge to ADRA.

H. Relevance of lessons learned to be shared by others, and with other NGO's

1. CS Program Design

Nicaragua has a well established health care delivery system, though not adequate for the whole country. ADRA's aim is to be an adjuvant to make the system work and not to be a substitute for it. In that sense ADRA has done a very good job, most appreciated by the SILAIS as much as by the people the SILAIS serves.

ADRA's role has been to organize refresher courses and seminars for the health care personnel. It has been found that when an NGO serves the care givers as well as the people, in other terms not serve only the people and neglect the care givers, the impact of its program acquires synergistic proportions and is positively received by one and all. A degree of respect thus is established between the care givers and the ADRA people.

However, this places an extra load of work on the shoulders of the staff.

2. Training:

The key to successfully complete a CS Program is to focus on maximizing the most promising element in the chain of knowledge transmission through training. ADRA/N has found out that the Volunteers constitute that vital link and has consequently focussed their training on the Volunteers without neglecting the CHW's and the care givers. This is sensible in view of the fact that the community already had in place a network of Brigadistas or Volunteers, but the latter were not effective from lack of motivation and training. ADRA has been wise to build on that network, incorporating the Brigadistas and training them as ADRA Volunteers. Furthermore ADRA/N has been able to strengthen the Community Health Committee by including all the volunteers in the committees. This is relevant only for countries that have learnt to avoid duplication of social role and function. It might not work in some African countries for example, where everybody in the community wants a role or function to play at the social level so much that the dilution of responsibilities tend to create shallow institutions and the programs that depend on them.

Maybe, community leaders should be more than briefed on a CS Program on the outset. Maybe some training should be extended to them from the beginning so that the right community leaders would be identified and empowered by the community so as to avoid unnecessary misunderstanding and loss of resources in trivial social tug of wars.

3. Referral Service

The volunteers and their referrals are well received by most of the Health Centers and Health Posts, although a few view the work of the volunteer as competition to their own status in the community.

I. Key Findings and Recommendations

a. Design

Findings:

1. Wisdom of project administrators in size reduction.
2. Effectiveness of Peace Corps contribution and acceptance of project to adopt new methods of learning.
3. The mothers being the focus of the project is appropriate.

Recommendations:

1. That in future CS projects, the elder daughter of the house be included in the target to maximize adequacy and effectiveness of project.

Question:

1. What is happening with home and community gardens.

b. MIS & HIS

Findings:

1. HIS is well nurtured by Corina. No weakness. Appropriate and adequate. System could be more efficient with the use of spreadsheet program to permit easy accumulation of data.
2. Quality time lost in manual computation.
3. There is a need for a full time data entry secretary.

Recommendations:

1. That training be obtained using a local consultant to improve effectiveness and efficiency of MIS and HIS.

c. staff

Findings:

1. Good leadership on the part of Dr. Gloria Toruno. Great supervision on the part of the supervisors and CHWs.
2. Some confusion with equipment inventory.
3. The CHW's are stretched very thin.
4. Some problems between Volunteers and Health Center or Health Post nurses.
5. Large part of the success of the program due mostly to Volunteers.
6. High percentage of men (40%) amongst Volunteers.
7. Most Volunteers are satisfied.
8. Training of staff at all levels sufficient and satisfactory. Refresher program is sufficient for the moment.
9. Training methodology has been improved and is effective.
10. More women than men at all levels of project.
11. Drivers are polite, professional and effective. Drivers should drive more slowly. 1 child hurt by accident would defeat CS.
12. More care with the material produced by Volunteers.
13. Special congratulation to supervisor Isidro for conceiving a practical Navarro Rule.

Recommendations:

1. Need for 1 more CHW.
2. Staff should take some vacations.
3. Drivers should drive more slowly.
4. To backstop Peace Corps Volunteers with a strong adult education specialist for a week to train Health workers in community participation dynamics during workshop meetings.
5. Seek ways and methodologies to increase communication level between CHW's and Volunteers.

d. Supplies and Material for Local Staff**Observation:**

1. Adequate.

e. Quality**Findings:**

1. The Volunteers have created a solid viable community infrastructure.
2. Quality personnel. Good leadership. Dedication.
3. Good level of satisfaction amongst ADRA providers and beneficiaries.

f. Supervision and Monitoring**Findings:**

1. Adequate supervision by well trained, intelligent (professional level) supervisors.
2. Good supervision in terms of area coverage and intensity.

Recommendations:

1. Supervisors be given some incentive in the form of increased health knowledge through seminars or conferences. (Feel they should be more knowledgeable than the CHW's).
2. Some CHW's be provided with **muchillos** (backpacks), and torchlights for those working late at night.
3. Volunteers be provided with file holders.

g. Use of Central Funding**Findings:**

1. Administrative and technical support from ADRA/I needed and appreciated. Sufficient.
2. No constraint in obtaining adequate monitoring and TA from ADRA/I or central office.
3. Funds earmarked by USAID for Administrative Support and TA critical. Is the only source.
4. High cost of central backstopping.

Recommendations:

1. That regional backstopping resources be tapped.

h. ADRA's Use of Technical Support**Findings:**

1. The visits of Dr. Whitehouse have been much appreciated. Central funding requires central supervision in areas of financed and administration.

Recommendations:

1. Good calibre TA personnel to be sent to Nicaragua to match high performance potential of staff.

i. Counterpart Relationships

Finding:

1. It is good that ADRA does not depend on **MINSA/SILAIS**, though it follows its directives.

Recommendations:

1. ADRA should lead, therefore initiate activities, workshops, visits, sharing of HIS etc. and not wait for **MINSA/SILAIS**.
2. That better coordination with **MINSA/SILAIS** be achieved though there is practically no perceived difference between the Volunteers of ADRA and MINSA by the population.
3. ADRA could see how the benefits accrued to MINSA volunteers could be accrued also to ADRA volunteers.
4. Same recommendation for ADRA CHW's.

j. Referral Relationships

Findings:

1. Effective system of referral - Mother to Suplante to Volunteer to Health Post or Health Center to District Hospital.
2. Some difficulties with nurse at a few Health Centers and Health Posts. The are isolated cases.
3. The Volunteers do not yet have an "integral" sense of health for more effective vigilance.

Recommendation:

1. Help the volunteers to develop a more integral sense of health. This would provide a good area of collaboration with **MINSA/SILAIS**, in view of the fact that it is the SILAIS Director's battle horse.
2. That future DIP's recognize that the Volunteers are important to ALL areas of health.

k. PVO/NGO Networking

Findings and Observations:

1. Good working relationship observed with ProFamilia, ProNorte, Cosude, and other NGOs.
2. Family Planning issue: ADRA are not capitalizing on the offer of ProFamilia's 50 Cordobas. In Ocotal, the cost of the vasectomy operation is 3000 Cordobas.
3. Dr. Marytza to be commended for working closely with ProFamilia.

Recommendations:

1. Though ADRA is benefitting highly from working with ProFamilia, the latter has a line item in its budget to cover the resources needed to do what ADRA is doing in preparing candidates for operation, including a medical examination. Therefore, the involvement of ADRA should be qualified.

l. Budget Management

Findings:

1. 58% of project completed while 40% of budget spent.
2. No line item flexibility.
3. The objectives will be reached without extra funds.
4. There will not be any remaining funds.
5. Vehicles are barely adequate. Strain in case of breakdown.
6. Computers adequate. Printer just adequate.

Recommendations:

1. The Budget will have to be adjusted to reflect the actual personnel costs. Three additional line items will have to be added to cover personnel changes for treasury and security. The budget will also have to be adjusted to cover the costs of the vehicle maintenance to insure that they will continue to operate.

2. The matching funds are drastically underspent. **ADRA/I** management needs to intervene strongly to make sure that the match is met.
3. Although it appears that the Administrative regional director and the country director are supporting the project, there needs to be more direct contact with project staff.
4. Methods need to be designed to reduce the amount of the petty cash that is being transported by hand, and kept on hand in the office.
5. Administration needs to find better ways of managing the use of the project vehicles for transport of personnel outside of the office hours.
6. A third computer should be found to replace the inoperative one, and to return the private one back to the director of the project.

m. Sustainability

Findings:

1. 10% Health Committees have funds of their own.
2. Some healthy signs of sustainability. E.g only 2-3 % complaint level following cutting off of PL480 food.
3. Most mothers think program is by ADRA, but on behalf of SILAIS.
4. The local Rotary Club has expressed a desire to supervise volunteers when ADRA retires.
5. A higher degree of community unification than intended due to the cohesiveness and effectiveness of Health Committees.
6. A higher degree of responsibility than expected on the part of Volunteers.
7. A higher degree of responsibility of Mother Suplentes and Coordinators.
8. A higher degree of acceptance by the mothers.
9. A higher level of interest amongst community leaders in Somoto, especially Rotary International.

10. One of the objectives of the project was to unify communities. Somewhat of a surprise is the extent that this has happened in some of the communities. The coordination for environmental cleanup for instance that takes a fair amount of cooperation is visible in communities.

There may have been some hard feelings at the start when the volunteers and committee coordinators were chosen.

Recommendations:

1. Invite the SILAIS, Health Center and Health Post personnel to visit the field with ADRA staff more frequently. Apparently, the MINSA/SILAIS do not visit the field on their own.
2. A success story should not go unnoticed. Disseminate valuable information to the communities.
3. Think of efforts to socialize the experience, i.e. communicate the experience and benefits acquired to other communities.
4. Think already in terms of an evaluation of the impact of the program in two or three years.
5. That the tonic of the project from now on be based on the notion of sustainability.

n. Cost Recovery

Findings:

1. Per DIP, only AR1 intervention will need some cost recovery mechanism. Activities have not yet started.

If MINSA had the funding of ADRA for the project, the observation is that they would not have the motivation that ADRA has. Or in other words, if they were expected to work like the ADRA team does--they would not accept the load.

J. Planned or actual feedback of evaluation results:

All staff were always present to answer questions and share their opinions and feelings and discoveries. The team was impressed by the openness, intelligence, vivacity of the staff at all levels. It is obvious that the Nicaraguenses on the whole are not illiterate.

The first review of observations and recommendations of the management component of the evaluation planned for Tuesday, July 20, with Milton leading with the Director and Supervisors. The feedback was therefore immediate though slightly premature. But taking into account logistical considerations, we thought we should take full advantage of the CS manager's presence as he had to leave the following day.

The second feedback session on the whole evaluation exercise, but mainly, the programmatic part was planned for Wednesday, July 22, with all the staff including the ADRA director.

The Supervisors are planning to share the findings with the CHW's at the following payday when they will have a general meeting to discuss how can they respond to the evaluation.

There are plans to share in the findings with the USAID CS staff in Managua, and some other NGO's.

K. Author(s) of the midterm evaluation report:

This report is a summary of written and oral reports from four of the five members of the evaluation team. It is the result of the whole team with direct assistance from the ADRA Nicaragua staff.

This report is the product of a team effort and is submitted to ADRA Nicaragua and ADRA International for consideration.

Dr. Gerard Latchman, Team Leader

Maestro Milton McHenry

Maestra Elsa Zelaya Mena

Pr. Gerard Vasquez, ADRA Nica Dir.

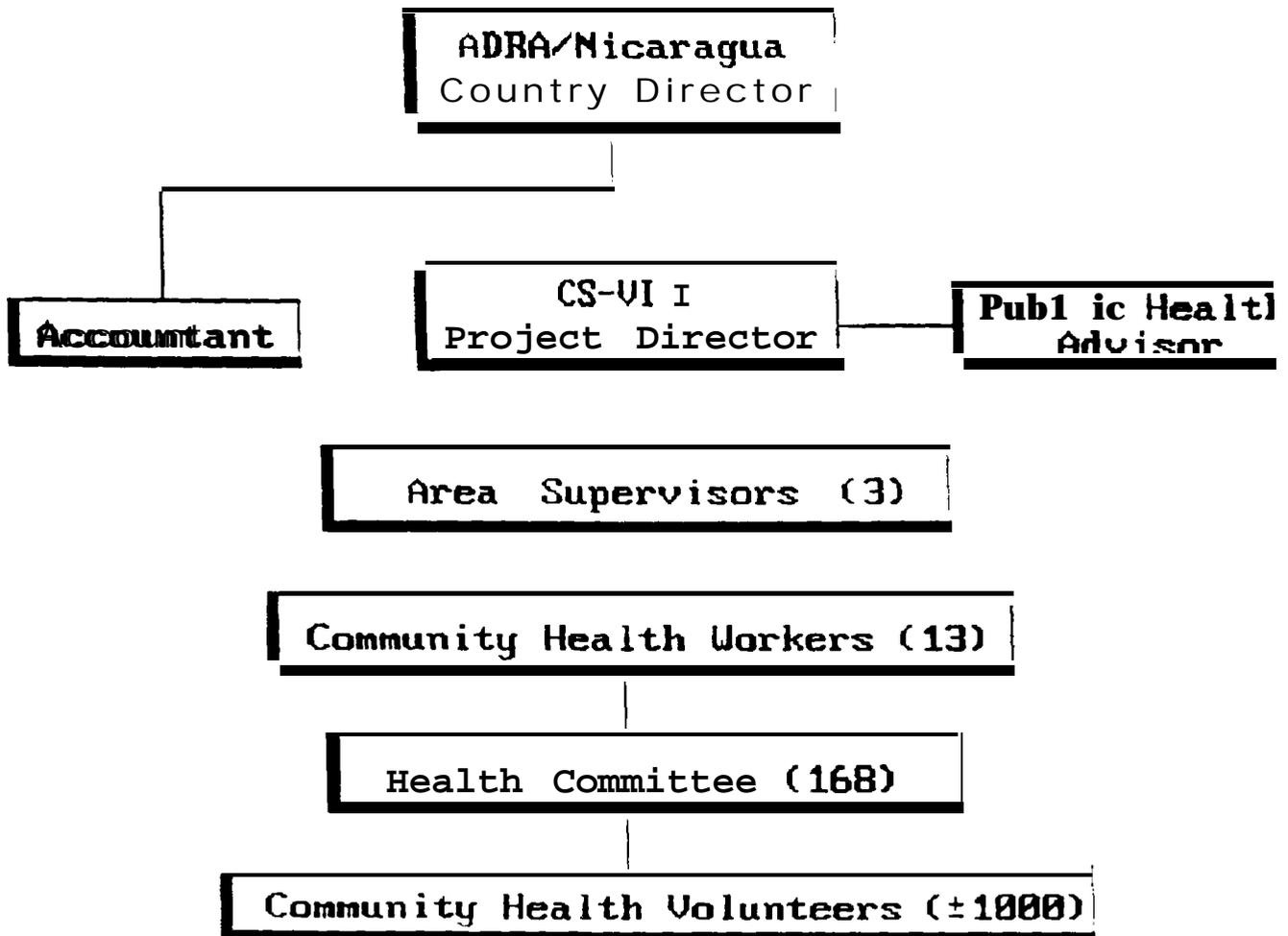
Lit. Felix Jimenez, Development Ass. Eval & Mon

APPENDICES

APPENDIX A

Organigram

ADRA I NICS-VII ORGANIZATIONAL CHART



APPENDJX B

General Map of Project Area

APPENDIX C

Map with location of 156 Communities of the Project