

## Annual Report

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Haiti SDSH

October 2010 to September 2011

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SANTÉ POUR LE DÉVELOPPEMENT  
ET LA STABILITÉ D'HAÏTI

# Santé pour le Développement et la Stabilité d'Haïti Pwojè Djanm

Annual Report — October 2010 to September 2011  
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# Annual Progress Report

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October 1, 2010 to September 30, 2011

## **Santé pour le Développement et la Stabilité d’Haïti — Pwojè Djanm**

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<b>Acronyms</b>	
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
BCC	behavior change communication
CA	Contracts and Administration
CBO	community-based organization
CBP	<i>Centre de Bienfaisance de Pignon</i>
CDS	<i>Centre pour le Développement de la Santé</i>
CM	community mobilization
CONASIS	<i>Comité national du système d'information sanitaire</i>
CS	<i>centre de santé</i> (health center)
CYP	couple years of protection
DRI	Development Relief International
DTP3	diphtheria, tetanus, pertussis (vaccine)
FBO	faith-based organization
FONDEFH	<i>Fondation pour le Développement de la Famille Haïtienne</i>
FP	family planning
FY	fiscal year
GUC	grants under contract
HIS	health information system
HIV	human immunodeficiency virus
ICC	International Child Care
IDP	internally displaced people
IV	Intravenous
LMS	Leadership, Management and Sustainability (Program)
MEBSH	<i>Mission Baptiste du Sud d'Haïti</i>
MIS	management information system
MSH	Management Sciences for Health
MSPP	<i>Ministère de la Santé Publique et de la Population</i> (Ministry of Public Health and Population)
NGO	nongovernmental organization
OBCG	<i>Oeuvre de Bienfaisance de Carrefour et de Gressier</i>
OBDC	<i>Oeuvre de Bienfaisance et de Développement Communautaire</i>
OFDA	Office of US Foreign Disaster Assistance [USAID]
ORS	oral rehydration salts
PBF	performance-based financing
PCR	polymerase chain reaction (test)
PMP	Performance Monitoring Plan

PMTCT	prevention of mother-to-child transmission
PNLT	<i>Programme National de Lutte contre la Tuberculose</i>
RH	reproductive health
SADA	Service and Development Agency
SCMS	Supply Chain Management System (PEPFAR USAID-administered project)
SDSH	<i>Santé pour le Développement et la Stabilité d'Haïti</i>
STI	sexually transmitted infection
STTA	short-term technical assistance
TB	tuberculosis
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	US Government
VCT	voluntary counseling and testing (for HIV)
WHO	World Health Organization
WINNER	The Watershed Initiative for National Natural Environmental Resources (Project)
ZC	<i>zone ciblée</i>

## EXECUTIVE SUMMARY

### Introduction

The *Santé pour le Développement et la Stabilité d'Haïti* (SDSH) Project is USAID Haiti's flagship health sector activity. It was awarded to Management Sciences for Health (MSH) in August 2007 for an initial period of three years. Two years later, the project received a one-year cost extension that increased the life-of-project funding from \$42.5 million to \$81.4 million and changed the completion date to September 30, 2012. (Currency is in U.S. dollars throughout this report.)

SDSH builds on the successes and lessons learned from earlier MSH projects, namely Haiti Health Systems 2004 (HS2004) and Health Systems 2007 (HS2007). Similar to its predecessor projects, SDSH was designed to increase access to and use of a package of integrated basic health services that covers maternal and child health, nutrition, family planning (FP), HIV/AIDS, and tuberculosis (TB). To achieve its objective, SDSH supports public, private, and nonprofit sector health care delivery and reinforces the capacity of Haiti's *Ministère de la Santé Publique et de la Population* [Ministry of Public Health and Population (MSPP)] to carry out its executive management and oversight functions at the central and departmental levels. SDSH is differentiated from earlier projects by its heightened focus on public sector institutional strengthening and capacity-building using a model that has proven successful with private sector partners.

Project service delivery activities are implemented through performance-based financing (PBF) subcontracts with 28 local nongovernmental organizations (NGOs) that operate 79 health facilities and through 81 MSPP public sector sites in 33 geographical areas known as *zones ciblées* (ZCs). The project's primary beneficiaries are (1) children and youth under 25 years of age, (2) women, and (3) special concerns groups including persons living with HIV, AIDS, and TB. SDSH currently covers 43 percent of the Haitian population, or 4,347,198 inhabitants.

As a testimony to the confidence placed by external benefactors in SDSH's ability to deliver results, the project not only met its contractual matching funds requirement in less than two years but also continues to leverage funds and substantial in-kind support from a wide range of contributors.

### Progress Highlights

By the end of the year 4, the majority of SDSH activities remain on track after several months of disruption due to the catastrophic January 2010 earthquake in year 3 of the project as well as the cholera epidemic that struck the country and the political unrest around elections during the last quarter of 2010. Noticeable progress was made during year 4 despite these new and unexpected challenges. Reconstruction and healing are far from complete, but our partners express an overwhelming sense of renewed purpose and the desire to move forward and to do better. (See annex A for a list of SDSH partners.)

The unprecedented cholera epidemic in October 2010 sharply diverted all forces from regular duties because this was the first time cholera had appeared in Haiti, and the health system was not prepared for it. Health sector partners joined forces with the MOH to contain the deadly epidemic; as of October 14, 2011<sup>1</sup>, the cumulative number of reported cholera cases was 473,649, of which 251,885 (53 percent) were hospitalized and 6,631 persons had died. The global attack rate was 4.6 percent, with 7.8 percent in Port-au-Prince and

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<sup>1</sup> *Health Cluster Bulletin* 29, November 7, 2011(English).

1.1 percent in South East. Overall mortality rate for Haiti since the start of the epidemic is 63.7 per 100,000 inhabitants, with important variations between departments.

The project tracks results for seven groups of indicators: HIV/AIDS, TB, maternal health, child health, FP and reproductive health (RH), MSPP executive functions, and other (a group that includes various contextual and project support indicators). SDSH exceeded or met targets for the majority of indicators in all groups with the exception of TB and maternal health, and targets were met for half of the indicators included in the heterogeneous “other” group. Indicator tables are included throughout the report. Annex C lists the annual results for fiscal year (FY) 2011. (See box 1 for a summary of the year’s achievements.)

## Challenges and the Way Forward

Of the indicators for which the SDSH project did not fully meet our targets, about one-third were within 2 to 7 percentage points of the target. In general, we fell short in meeting training targets, particularly for those activities that were to be implemented in conjunction with third parties. The eight-months delay in concluding a subcontract with JHPIEGO left a technical assistance void that is reflected by the suboptimal results in the first half of the year for the maternal health component of the project and for cases of sexually transmitted infections (STIs) detected and treated. Integrating HIV and TB services continues to be a challenge, due in part to the historically vertical nature of these national programs. Achievement of two child health indicators was compromised by a broken supply chain and competing priorities on the part of health sector authorities and implementing partners in the field because of the cholera response, which took most of the resources of an already ailing health system.

SDSH has endured turbulence with long periods of leadership transition over the year as a result of the resignation of the Chief of Party in January 2011 and the Technical Director and Deputy Chief of Party in April 2011. Filling these positions with suitable candidates turned out to be seriously challenging. MSH received few applications, good candidates perhaps hesitating to apply because of the country’s unstable political environment. A new Chief of Party was hired in mid-April, staff morale was suboptimal because of miscommunications and internal conflicts. MSH headquarters closely monitored project events and intervened several times with short-term technical assistance (STTA) to support the team. The MSH Chief Operations Officer and the Health Services Delivery Operations Director in the Center for Health Services facilitated a team-building workshop in February 2011 followed by technical and managerial support STTA of the country lead. These interventions culminated in a staff retreat held in early March 2011 to assess progress to date and plan for the future. Staff from SDSH, MSH Cambridge, USAID Haiti, and MSPP participated in the meeting, reaffirming their commitment to the objectives of the project, discussed its strengths and weaknesses, and formulated strategies to remedy perceived shortcomings and respond to new priorities.

Despite these challenges, the SDSH project in partnership with all the partners managed to meet or exceed results as demonstrated by the Performance Monitoring Plan (PMP) reports. The leadership and management challenges slightly affected the capacity-building prong of the PBF program because of a reduction in technical assistance efforts, but what we learned from this experience is that using PBF, SDSH has established a strong health service delivery system that could maintain health results. The PBF program is mature, running smoothly, and ready for scale-up, which is naturally the next phase. The main challenge for the next fiscal year will be to effectively transfer the contracts management and monitoring competencies to the MSPP.

### Box 1. Success Highlights

For **HIV/AIDS**, SDSH surpassed 16 of its targets including, most notably, increasing numbers in the “people” targets

- people benefitting from voluntary testing and counseling (VCT)
- people, including pregnant women, tested for HIV and getting their results
- HIV-positive women on antiretroviral (ARV) prophylaxis
- people newly put on antiretroviral therapy (ART)
- HIV-positive people receiving palliative care, including those co-infected with TB and HIV
- providers trained in prevention of mother-to-child transmission (PMTCT) of HIV according to international norms

SDSH also exceeded the target for the percentage of **TB** patients tested for HIV and receiving their test results.

Results for **prenatal** and **postnatal** activities were positive, with the project meeting or exceeding seven targets most notably these five:

- the percentage of pregnant women having their first prenatal visits during the first trimester of their pregnancies
- the number of births attended by a trained health worker [not including traditional birth attendants (TBAs)]
- the number of postnatal home visits within 72 hours of delivery
- the percentage of new mothers receiving a postnatal consultation within 42 days the percentage of pregnant women with a birth plan

In the area of **child health**, SDSH met or exceeded targets for ten of twelve indicators, most notably these six:

- the number of infants completely vaccinated
- the number of infants who received DPT3
- children receiving a first dose of vitamin A
- infant pneumonia cases treated with antibiotics
- children reached by nutrition programs
- numbers of mothers and caretakers trained in diarrhea prevention and management

Seven **FP** targets were surpassed, including—

- number of couple years of protection (CYP)
- the percentage of sites offering FP counseling and services (long-term and permanent methods)
- the percentage of people of reproductive age using a modern FP method
- the number of new FP users

SDSH met two and exceeded three targets for **public sector systems strengthening** activities related to the number of SDSH ZCs, including

- ZCs funded with PBF
- ZCs benefiting from the basic package of services supported by SDSH
- ZCs with a functioning information system for services

### HIV/AIDS

Although SDSH met or exceeded most of our HIV-related targets, we realize that much remains to be done. Of the 65 percent of pregnant women who are tested for HIV in Haiti, 3.6 percent test positive; 50 percent of those testing positive receive ART, and 9.2 percent of their babies are infected (WHO 2007) The challenges for HIV interventions in Haiti are well-known and daunting:

- limited funding
- limited quantities of medicines
- low-paid, unmotivated personnel and an insufficient number and high turnover of trained providers
- dilapidated facilities
- lack of or poor maintenance of equipment
- unreliable power
- often no running water or sanitation
- limited telecommunications capacity
- uninformed population
- widespread poverty—and the list goes on

In general, activities are not yet well coordinated, and program management is weak.

During this period, SDSH put the highest priority on HIV testing and counseling in high-density areas and targeted the most at-risk populations. In addition, SDSH emphasized making VCT easy and accessible to promote early testing for HIV-positives. VCT services are now provided at 37 sites (five more sites than the end-of-project target of 32). Annex B lists the SDSH HIV sites and their functions.

### Tuberculosis

This area has been the weakest link in project implementation, and several factors contributed to it. In fact, the project mandate was to support the implementation of the DOTS strategy adopted for the *Programme National de Lutte contre la Tuberculose* (PNLT) particularly to ensure continuity of TB prevention, detection, and treatment in the SDSH network. When we elaborated our TB objectives and activities in 2007, the MSPP National Tuberculosis Program had substantial support from the Global Fund for TB interventions in Haiti. We were not overly concerned that only 4 percent of the SDSH budget was planned for TB activities because many of the needed inputs (e.g., medicines, trainings, and equipment) were provided via the National Tuberculosis Program. Unfortunately, Global Fund support for these activities ended abruptly in 2010, and to date, neither SDSH nor other parties have been able to fill the funding gap. We continue to advocate through ongoing technical discussions with our MSPP counterparts for greater collaboration and interaction between the MSPP HIV and TB programs.

### Maternal Health

The project efforts to improve the maternal health program performance this year were based mainly on three strategic approaches: (1) strengthening service integration, (2) institutional capacity-building, and (3) reinforcing community interventions. This domain is recognized as an important programmatic area for the SDSH project as well as the whole health sector. Its complexity requires the involvement of different actors from various sectors in a holistic and coordinated manner. The project results in maternal health are satisfactory for the covered period

### Child Health

In regard to child health interventions, some of our partners reported stock-outs of the DPT vaccine and vitamin A, and we are following up with MSPP, departmental health authorities, and the United Nations Children's Fund (UNICEF) to resolve the problem. We learned from UNICEF that there are supplies of vitamin A in the country, so we are stressing the importance of better planning and timely ordering and distribution of supplies within departments.

## Family Planning/Reproductive Health

SDSH came close to achieving the year's target for Family Planning CYP. During the final year of the project, we will intensify our community mobilization efforts to inform people about long-term methods. Now that JHPIEGO's subcontract under SDSH has been smoothly renewed which allowed the addition of three experienced RH experts to the team, we are hopeful to address critical training needs to increase the number of providers trained to dispense long-term FP methods. It has been a challenge to address all the needs of the ambitious RH component with only one RH expert on staff.

## MSPP executive functions strengthening

Progress has been made through collaborative efforts with the MSPP and key health sector partners in all areas of support namely (1) strategic planning and decentralization, (2) Performance Based Financing, (3) governance and financial management, and (4) HIS. In these domains, the project interventions were carried out at the central as well as departmental levels. The design of a national health information system (HIS) was particularly challenging; given the enormity of the task and the need to have buy-in from all HIS committee members, the planning stage has taken longer than anticipated. We estimate that launch of the new HIS may get under way mid 2012, assuming that the MSPP team for the new government does not call into question the work done on the HIS to date.

With the assistance of the six new SDSH departmental advisors, who were hired this year, we will be able to provide the support needed to ensure that all health departments elaborate and implement a supervision plan for service delivery. Given the numerous external factors that influence the timely implementation of the planned interventions, particularly the complexity of the context and the multiplicity of actors with divergent interests, the project results for year 4 can be considered satisfactory.

## Other

The estimated percentage of the population covered by the project was about 43 percent at the end of September 2011. Since 2008, we have terminated contracts with some partners and negotiated awards with new partners. The net result is that today we remain close to the baseline value for population coverage, even though the number of service delivery sites today (160) exceeds the number in 2008 (148).

## I. SDSH Support to the Public Sector

### IA. Strengthening MSPP Executive Functions

One of the key elements of the SDSH project mandate is to contribute to the strengthening of the MSPP executive functions in order to support health system decentralization and reinforce the ministry leadership. In consensus with the MSPP and taking into account national priorities, the project had identified the critical management systems to be strengthened with its contribution and in collaboration with other MSPP partners. They are (1) strategic planning and decentralization, (2) PBF, (3) governance and financial management, and (4) HIS. In these domains, the project interventions were carried out at the central as well as departmental levels.

Given the numerous external factors that influence the timely implementation of the planned interventions, particularly the complexity of the context and the multiplicity of actors with divergent interests, the project results for year 4 can be considered satisfactory. SDSH met two and exceeded three of the eight indicators tracked for this component of the project, and was below the mark for three indicators as shown in table 1. (See annex C for greater detail.)

**Table 1. Strengthening MSPP Executive Functions Indicators**

<b>Met- 2</b>	Number of health departments with donor coordination mechanism (6)
	Percentage of departments implementing approved operational plan (100%)
<b>Exceeded- 3</b>	Number of ZCs funded with PBF (18)
	Number of ZCs benefitting from basic package of services supported by SDSH (33)
	Number of communes with ZCs where info system for services is set up and in use (33)
<b>Under – 3</b>	Number of departments with new financial and accounting management system set up and in use (7 for a target of 10)
	Number of departments implementing supervision plan for service delivery (80% of target)
	Number of departments supported to operationalize the national HIS (0, for annual target of 6)

### Performance-Based Financing

Because of the earthquake in year 3 of the project, we encountered delays in starting PBF in the public health facilities. PBF in the public facilities did not start until May 2010, when 11 of the targeted zones (ZCs) in the Departments of Centre (three ZCs), North (four ZCs), North-East (three ZCs), and South-Est (one ZCs) were contracted. By October 2010, an additional five were added in the health departments of North-West (three ZCs) and South (two ZCs), and in March 2011, the last two ZCs of Carice and Perches were added to the group bringing the total to 18 ZCs financed under PBF.

MSH headquarters commissioned an external evaluation of the impact of the PBF approach on health services in Haiti. A team of three consultants from Brandeis University's Schneider Institutes for Health Policy and two MSH staffers (one from Cambridge, one from Haiti) carried out the fieldwork in Haiti in February and March 2011. They obtained data from 15 SDSH PBF sites and 202 control (non-SDSH) MSPP sites.

Findings<sup>2</sup> of the evaluation suggest that, consistent with studies on evaluating PBF in other countries, such as Rwanda,<sup>3</sup> our results show that PBF has led to the improvement of health care delivery in Haiti. The growth

<sup>2</sup>Donald Shepard et al. (2011). *Impact of Performance-Based Financing in Haiti Report* (under review for publication).

rate in SDSH facilities is about 5.0 percentage points per quarter higher than non-PBF health facilities for incentivized services, and about 3.0 percentage points per quarter higher for non-incentivized services. The pure effect of incentives is 2.8 percentage points per quarter. Performance-based payment was valued by staff of health facilities.

- First, as indicated in the previous evaluation, recipients of PBF enjoy more flexibility in spending these payments compared to revenues from cost-based reimbursement that require carefully justified expenditures.<sup>4</sup> Under PBF, health facilities negotiate their budgets, provide services at a fixed price, and receive reimbursement quarterly. Thus, incentives offer health facilities greater autonomy to allocate their budget.
- Second, the implementation of PBF improves the capacity of health facilities in managing each patient's health information, which is critical for decision-making to meet the both patients' and providers' interests. Under PBF, health facilities are required to report the utilization of services monthly. Both directors and staff could use the information to interact with the community they serve and build better rapport.
- Third, health facilities receive technical assistance from experts from the PBF-implementing institution, MSH, which helps to improve health facilities' management systems and provide services more efficiently. Though not all health facilities meet their targets (e.g., coverage of first prenatal visit), they remain enthusiastic for performance-based payment.

In summary, in spite of the limitations of the study, using a difference-in-difference approach with panel data, the study suggested that appropriately designed PBF incentive systems hold accountable health facilities and staff for the outputs that are directly related to beneficial outcomes. Hence, this mechanism is likely to accelerate progress toward the Millennium Development Goals<sup>5</sup> to reduce child and maternal mortality.

### Health Information Systems

The project also supported the MSPP to set up, train, and the support use of HIS in the public sector sites in 33 communes (all ZCs). Much of the foundational work has been done at the central level by the National Committee for the Support of the Health Information System (CONASIS), of which SDSH is a major actor. SDSH was instrumental in designing and refining important aspects of the HIS, such as the list of program monitoring and evaluation indicators and the data collection and reporting tools. In collaboration with other committee members, SDSH provided technical assistance to the MSPP Planning and Evaluation Unit for the design of a tabulation plan for annual health statistics reporting, the methodology for an analysis of causes of death in Haiti, and the preliminary version of the HIS management procedures manual. SDSH continued the capacity-building of the staff in our network through training sessions in data collection, data reporting, and data use for decision-making. These trainings were tailored for specific programs such as the community-based information systems (21 participants), FP (18 participants), and cholera (40 participants) and also designed to respond to some of the issues identified in data quality assessments (24 participants). By the end of the fiscal year, we were able to support the MSPP for data validation in targeted zones (ZCs).

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<sup>3</sup> Basinga, P., P. J. Gertler, et al. (2011). "Effect on Maternal and Child Health Services in Rwanda of Payment to Primary Health-Care Providers for Performance: An Impact Evaluation." *Lancet* 377(9775): 1421–8.

<sup>4</sup> Eichler, R. and R. Levine (2009). *Performance Incentives for Global Health: Potential and Pitfalls*.

<sup>5</sup> Montagu, D., and G. Yamey (2011). "Pay-for-Performance and the Millennium Development Goals." *Lancet* 377(9775): 1383–5.

## Financial Management Systems

Work to streamline the financial management systems in the public sector, which started in year 2 of the project, somehow stalled in year 4 because of competing priorities of the counterparts at MSPP. In June 2011, a company was hired through a competitive bid to modernize and computerize the financial and accounting management system at the MSPP central office; the installation of Patchtree software is complete at central level, but the system is not yet fully functional and the project will continue to support its use during the next year. Seven of the ten departments have a new financial and accounting management system established with Quick books; the remaining three will be completed during the upcoming year. The project also supported the development of financial procedures manual that is pending validation by MOH. As part of the graduation strategy, *Centre pour le Développement de la Santé* (CDS) and *Centre de Bienfaisance de Pignon* (CBP) financial and management systems were enhanced both at the central level and in the institutions under their supervision.

## Service Delivery

With regard to departmental supervision of service delivery, all ten departments developed supervision plans; because of a shortage of technical assistance, only eight out of an expected ten departments were able to implement them in their respective catchment areas. Implementation was achieved in the Artibonite, Centre, Grand Anse, Nippes, North, North-East, West, and South-East. Six new departmental Technical Advisors were hired to fill vacant posts at departmental health directorates in the Grand Anse, North-West, Artibonite, West, South, and South-East departments. The departmental technical advisors are liaisons between SDSH implementing partners and department-level MSPP health authorities, and they facilitate and ensure the smooth functioning of SDSH activities. The new advisors participated in a week-long in-service training and orientation program at the SDSH central office before taking up their posts. In addition to a technical advisor, each of Haiti's 10 health departments benefits from the services of a full-time finance manager provided by the project.

## Policy Documents

During the second semester, the project supported the MSPP in streamlining policy documents and technical interventions through planning, preparation, and implementation notably in health communication and education. We achieved the following:

- provided support in the coordination of behavior change communication and community mobilization (BCC/CM) for the National Program to Fight STI/HIV/AIDS
- conducted planning interventions to promote vaccination in the World Health Organization's Expanded Programme on Immunization
- aided the definition of strategic guidelines for BCC/CM by DPSPE
- organized training in strategic communication using the communication for development (C4D) approach
- developed the Strategic Plan for Health Promotion
- developed the communication plan for the control of helminthiasis
- reviewed and updated the document for the Repositioning Family Planning framework (BCC/CM axes)

## IB. Support for Decentralized Services

With the support and encouragement of the MSPP, SDSH provided assistance to community-based and faith-based organizations (CBOs/FBOs) from the Centre, North-East, and West departments that had expressed interest in applying as “umbrella” organizations to be included in the SDSH Grants under Contract (GUC) Initiative (see box 2). During year 4 of the project, 43 CBOs were awarded grants through eight umbrella organizations in five departments (Grand Anse, Nippes, Nord, Nord-Ouest, and Sud). The objective of the GUC mechanism is to establish coalitions or partnerships with CBOs/FBOs to support decentralization of health care with a focus on SDSH priority services. The GUC Initiative coincides with USAID’s new strategy for Haiti that aims to strengthen local capacity and enable a more inclusive civil society.

SDSH organized several meetings with departmental health authorities and CBOs/FBOs to discuss the initiative, the requirements, priority focus areas, and other parameters. It was a long and labor-intensive process that demanded several trips to the field and many meetings and discussions with community organizations that had limited or no experience with donor-funded projects. Because this was a new initiative with untested partners, the USAID review and approval process took several months.

During a workshop held in March 2011 at the SDSH office in Port-au-Prince, selected proposals and work plans were further discussed and finalized. The umbrella organizations, with assistance from SDSH, were supposed to establish participative mechanisms to verify and ensure that—

- CBO grantees are well supervised and strengthened
- financial management of funds is adequate
- a Communal Health Council is established in each commune
- those interventions are implemented according to defined action plans

The largest number of subgrants managed by an umbrella organization is ten, and the smallest number is three. The cost of this initial investment was approximately \$232,000.

In addition to financial support, the umbrella organizations received technical support from the project during the second semester to enable them to gradually build up their capacity to manage and conduct the planned interventions in many aspects:

- rehabilitation and maintenance of the physical space for service delivery
- education on a healthy diet and nutrition
- prevention of malaria and HIV infection
- awareness of sexual violence
- creation of kitchen gardens
- promotion of—
  - breastfeeding
  - FP
  - maternal health and child health
  - cervical cancer screening
  - good hygiene
  - sanitation (treatment of drinking water, markets, use of latrines, livestock and fisheries)

It is too soon to assess the impact of the GUC mechanisms; at this point we can just mention the appreciation from the beneficiaries who felt empowered to choose interventions that could match their needs. According to one beneficiary, GUC negotiations represented the first time that local organizations

were asked to provide their inputs in the choice of interventions. Mario Coty<sup>6</sup> proudly said, “What is more important for us is that this is the first time that we [community organizations] have chosen the interventions ourselves instead of implementing the donor’s agenda. We are grateful SDSH project did not impose priorities on us but provided clear guidelines, and the selection process was objective.”

**Box 2. GUC Umbrella Organizations**

**Grand Anse**

- *Organisation Paysan Abricots et Bonbon* (OPAB)
- *Fondation Emmanuel* (FONDE)

**Nippes**

- *Fondation pour le Développement de Petit Trou de Nippes* (FONDEP)

**North**

- *Asosyayyon Fanm Boy* (AFB)

**North-West**

- *Association des Planteurs du Périmètre Irrigué de Baie de Henne* (APPIBH)
- *Organisation des Travailleurs pour le Développement de l’Anse a Foleur* (OTRA)

**South**

- *Jeunesse en Marche pour l’Avenir* (JMA)
- *Fédération des Associations pour le Développement de Les Anglais* (FADA)



Dr. Jocelyne Pierre Louis of the MSPP (on right) remits the grant to the Asosyayyon Fanm Boy representative.



Eight umbrella organizations’ representatives with MSPP and SDSH officials, April 11, 2011

<sup>6</sup> Commune de Petit Trou de Nippes, FODEF

## II. SDSH Support for Service Delivery

### IIA. HIV/AIDS

The project has supported a systemic approach to HIV/AIDS programming. This approach created a solid foundation by focusing all efforts on integration, effectiveness, and sustainability. SDSH's philosophy, based on the paradigm that the person living with HIV/AIDS is to be seen as a "whole," has been the cornerstone of the project interventions. This philosophy underlines the need for additional, innovative, and diverse approaches to the management of the disease; it also requires integration of HIV/AIDS-related services with FP, maternal and child health, and TB services.

Therefore, during the period covered by this report, the project put great emphasis on strengthening the integration of HIV prevention and management in the *Paquet de Services Prioritaires* offered at the service delivery sites. Another key element of the project strategic approach has been the extension of HIV counseling and testing with a focus on high-density areas and targeted toward most at-risk populations. Moreover, SDSH built on previous years interventions and achievements by—

- reinforcing its community-based PMTCT approach
- revitalizing the community palliative care and support component
- improving its partners' capacity in ART for AIDS patients
- improving diagnosis through DNA/PCR for young infants

In addition, the project implementation strategies were supported by constant and continuous coordination with other stakeholders particularly SCMS, the *Laboratoire National de Santé Publique*, the Caris Foundation, and others. Because of these partnerships, availability of medicines and commodities was guaranteed and technical support as well as training was provided to the network personnel.

#### Principal Accomplishments and Results

As a result, the project performance for the HIV/AIDS programmatic component was quite satisfactory despite the challenging context. In fact, 16 out of the 22 related indicators were met or exceeded as seen in table 2 and presented in detail in annex C, "SDSH Annual Results for FY11."

**Table 2. HIV/AIDS Indicators**

<b>Met – 1</b>	Number of ARV sites (6)
<b>Exceeded – 15</b>	Number of sites offering PMTCT services according to national and international norms (31)
	Number of pregnant women receiving VCT and getting results of tests (59,450)
	Number of providers trained in PMTCT according to international norms (52)
	Number of sites offering VCT services according to norms (37)
	Number of people getting VCT and receiving results of tests (98,374)
	Number of people newly on ARVs (805)
	Number of HIV-positive pregnant women on prophylaxis (722)
	Number of HIV-positive people receiving palliative care, including HIV/TB co-infection (17,413)
	Number of laboratories able to perform HIV tests (37)
	Number of laboratory tests (HIV, TB, syphilis) done by laboratories supported by project (311,779)
	Total number of people who ever received ARVs by end of reporting period (4,448)
	Number of providers trained in palliative care, including HIV and TB (28)
	Number of health workers trained in ART (30)
	Number of people trained in VCT (57)
	Number of individuals trained in laboratory services (25)
<b>Under – 6</b>	Number of HIV-positive persons treated for both HIV and TB (175, or 25% of target)
	Number of people receiving ARV at end of reporting period (3,041)
	Percentage of individuals put on ARVs and still active at end of reporting period (68%)
	Number of sites offering TB treatment for HIV-positive patients (13)
	Number of infants born to HIV-positive mothers receiving care and treatment (391 or 98% of target)
	Number of sites offering complete package of palliative care to HIV-positive persons (19)



### HIV Voluntary Counseling and Testing

SDSH expanded VCT services and made counseling and testing easier and more accessible in the partner organizations' catchment areas. VCT services are now provided at 37 sites (five more than the end-of-project target of 32). (See the list of SDSH HIV sites in annex B.) All VCT sites are fully functional with a laboratory technicians trained in both stock management and the performance of HIV rapid tests. SDSH collaborated with the MSH Supply Chain Management System (SCMS) Project for the training in management of laboratory supplies and medicines for 25 laboratory technicians, doubling its annual target of 10 for 2011. In total, 98,374 individuals were counseled and tested for HIV and received their test results in the project network.

HIV information and testing are offered systematically through SDSH-supported FP and maternal health services. They are initiated at the first prenatal contact and extended beyond postnatal follow-up. They are also integrated into STI prevention and management services. This year 311,779 tests for HIV, TB, and syphilis were completed by SDSH-supported laboratories.

### HIV and TB Co-infection

At present, 26 SDSH-supported sites perform TB counseling, testing, and treatment; all of them are also VCT sites, thus able to effectively perform both of the tests and to increase detection of HIV/TB co-infection among their patients. Thirty-two microscopes were provided to SDSH partners by AmeriCares. This generous gift included additional support for the training in the use and maintenance of the equipment. Consequently, the number of TB patients tested for HIV has increased; SDSH network sites tested 1,568 of registered TB patients for HIV, close to the annual expected objective of 1,735 TB patients to be tested for HIV.

## HIV Palliative Care and Support

SDSH's approach to palliative care is to integrate care and support to HIV-positive individuals and their children into ongoing HIV and non-HIV services. Furthermore, the project works with organizations to sensitize communities to the need to reduce HIV-related stigma and discrimination. Psychosocial services to HIV-positive individuals are organized through support groups at ZCs and NGO sites as well as through home visits made by social workers, health agents, and trained people living with HIV/AIDS. In addition, registered clients are oriented toward locally available complementary services, such as food distribution, income-generating programs and economic assistance, and legal support.

The community palliative care and support (including the assistance to orphans and vulnerable children) component of the SDSH project was the hardest hit by the post-earthquake emergency situation. Re-launching of related interventions was not possible until June 2011, after the response to the cholera outbreak. Representatives of 26 partner institutions participated in a two-day workshop to define key orientations based on lessons learned and taking into account the current context. A training workshop was also organized with the support of Measure Evaluation to enable SDSH partners to use the community-based information system for the monitoring and reporting of their activities.

SDSH palliative care sites and community mobilization activities reached 17,413 individuals exceeding the expected objectives of 15,000 for the annual year. The network was also successful at enrolling new clients in palliative care and support: 3,150 new patients were registered in contrast to the 2,850 expected.

## Preventing Mother-to-Child Transmission of HIV

The PMTCT component of the HIV/AIDS program of the project has received a major focus this year. Based on lessons learned and challenges met, SDSH implemented the following three strategic approaches to improve program performance in this domain:

- strengthening linkages between institutional and community levels to ensure better follow-up of all diagnosed HIV-positive pregnant women and lactating mothers
- increasing access to maternal health services through outreach strategies, such as regular mobile clinics around SDSH-supported sites
- supporting MSPP for the updating of national PMTCT norms and implementing them in the SDSH network

SDSH has surpassed its targets for this year by reaching 59,450 pregnant women for testing (148.6 percent of the annual target). Furthermore, of the 1,356 pregnant women who tested HIV-positive, 722 have received and completed their ARV prophylaxis, which represents 111 percent of the annual target of 650.

It is worth noting some key interventions that have contributed to these results. Community health workers and TBAs were enabled through continuous training to be fully involved in the PMTCT activities at community level. In compliance with the new national norms, PMTCT services were redesigned to be integrated into maternal health services. Special attention was paid to the preparation and update of birth and adherence plans at each visit to the prenatal clinic.

To enhance service quality, 52 nurses have attended training or refreshment courses on VCT and PMTCT organized in collaboration with *Institut Haitien de Sante Communautaire* (INHSAC). Fifteen of them have been trained to become case managers of HIV-positive pregnant women.

Continuity and completeness of PMTCT services was fostered by subsidizing costs for HIV-positive pregnant women for transport and delivery at the institutional level. The project provided direct financial support to pregnant women and to institutions where they choose to give birth. The TBA also received a modest compensation (\$12) to offset logistics costs incurred in liaising with a referral institution, monitoring the pregnancy using a birth plan, and following guidelines for safe delivery and care of the neonate.

DNA/polymerase chain reaction (PCR) testing for newborns was made available at all six SDSH ART sites and at six of the PMTCT sites in partnership with the Caris Foundation. In total, 406 specimens were collected and processed, 61 of them tested positive, and the infants were referred for adequate case management.



### Antiretroviral Therapy

Quality improvement was the main focus of the project in this programmatic area. The reinforcement of provision of palliative care and support made it easier to achieve timely identification of HIV-positive clients eligible for ART. In collaboration with the GHESKIO organization, refresher sessions were carried out to enhance health care providers' competencies and, consequently, improve treatment and patient follow-up strategies. Effective coordination mechanisms with SCMS ensured continuous service provision through uninterrupted availability of medicines and HIV commodities.

As of September 30, 2011, SDSH exceeded its target for two indicators: (1) number of new individuals who received ART (805 versus an annual target of 700) and (2) the number of persons receiving ART by end of the reporting period (4,448 versus an annual target of 4,234). The third ART-related objective—active patients receiving ART—was reached at 96 percent (3,041 patients active versus 3,175 expected). This improved

performance can be attributed to the emphasis placed on the patient follow-up and retention through the community palliative care and support activities as well as the strengthening of referral mechanisms within the network.

At the end of this reporting period, PCR tests were made available at twelve sites, all six ARV sites and six of the PMTCT sites in partnership with the Caris Foundation, to reinforce the sites capacity to provide pediatric AIDS case management.

### HIV/AIDS—Implementation Challenges

Although SDSH HIV/AIDS program performance was quite satisfactory for this period, much remains to be done to make a real impact on the epidemic at the national level and the population's needs. In fact, only 65 percent of pregnant women are tested for HIV in Haiti, and 3.6 percent of them are HIV-positive. Access to PMTCT services is still quite limited: 50 percent of HIV-positive pregnant women receive ART, and 9.2 percent of their babies are infected (WHO 2007). The challenges for the implementation of HIV interventions in Haiti are similar to those affecting the health sector; they are well-known and daunting:

- limited funding
- limited quantities of medicines
- low-paid, unmotivated personnel and an insufficient number and high turnover of trained providers
- dilapidated facilities
- lack of or poor maintenance of equipment
- unreliable power
- often no running water or sanitation
- limited telecommunications capacity
- uninformed population
- widespread poverty—and the list goes on

Moreover, coordination of HIV-related interventions needs to be reinforced and program management should be more structured.

Trained personnel for PMTCT interventions were in short supply before the January 2010 earthquake, and the situation has worsened since then. Many of the nurses and midwives trained in PMTCT in the SDSH network have either left the country or been hired away by other NGOs offering more attractive remuneration packages. Furthermore, PMTCT services delivery, especially at the health center level, is limited because of the shortage of pediatricians or trained pediatric nurses to provide guidance and oversight.

The project's financial situation—funding mechanisms and resources available—reduces its ability and flexibility to respond to emerging needs and extend maternal as well as PMTCT services in the partners' catchment areas. The strategic partnership approach used by SDSH helped leverage additional resources from Direct Relief International (DRI) to mitigate these shortcomings.

### IIB. Tuberculosis

This area has been the weakest link in project implementation, and several factors contributed to it. In fact, the project mandate was to support the implementation of the DOTS strategy adopted for the *Programme National de Lutte contre la Tuberculose* (PNLT) particularly to ensure continuity of TB prevention, detection, and treatment in the SDSH network. When we elaborated our TB objectives and activities in 2007, the MSPP

National Tuberculosis Program had substantial support from the Global Fund for TB interventions in Haiti. We were not overly concerned that only 4 percent of the SDSH budget was planned for TB activities because many of the needed inputs (e.g., medicines, trainings, and equipment) were provided via the National Tuberculosis Program. Unfortunately, Global Fund support for these activities ended abruptly in 2010, and to date, neither SDSH nor other parties have been able to fill the funding gap. We continue to advocate through ongoing technical discussions with our MSPP counterparts for greater collaboration and interaction between the MSPP HIV and TB programs.

### Principal Accomplishments and Results

SDSH exceeded one of the nine indicators tracked for this component of the project and was below the mark for seven as shown in table 3. Data were unavailable for one indicator. (See annex C for greater detail.)

**Table 3. Tuberculosis Indicators**

<b>Exceeded – 1</b>	Percentage of TB patients tested for HIV and received their test results (54% for annual target of 40%)
<b>Under – 7</b>	Number of TB patients tested for HIV & received test results (denominator is estimated incidence) (1568, or 90% of target)
	Number of people trained in DOTS (0, for annual target of 10)
	Number of sites offering integrated TB services (HIV/TB) (0 for annual target of 20)
	Number of persons trained for HIV and TB testing (18, for annual target of 20)
	TB notification rate 67 per 100,000 (64% of target)
	Percentage of expected new TB cases detected (34% for annual target of 75%)
	TB detection rate 40% of target
<b>Data not available</b>	Percentage of laboratories doing TB microscope analysis with >95% correct results

The only success registered by the project is in fact related to the TB/HIV co-infection. More than half (54 percent) of the network TB patients have been tested and have received their test results. Regarding all other indicators measuring TB detection and treatment, the project performance was not satisfactory.

### Tuberculosis—Implementation Challenges

At the national level, this year has been extremely difficult given that the PNLT faced major constraints related to the scarcity of human and financial resources. The interruption of the Global Fund support to the national program caused an unexpected increase in the need for SDSH contribution, but the percentage of resources allocated for TB interventions in the project budget was already too limited to meet its own needs.

Given the national standards, SDSH has no capacity to organize training activities on DOTS and depends on PNLT to achieve its training objectives. Service providers' training is supposed to be organized periodically by PNLT to respond to all stakeholders' needs including SDSH.

The weak integration of TB activities in the delivery of the SDSH-supported package made this program quite fragile. Community activities were interrupted or considerably reduced with the withdrawal of Global Fund support. Therefore, TB detection became a passive intervention, resulting in a major reduction of the detection rate in the network.

## IIC. Maternal Health

The project efforts to improve the maternal health program performance this year were based mainly on three strategic approaches: (1) strengthening service integration, (2) institutional capacity-building, and (3) reinforcing community interventions. This domain is recognized as an important programmatic area for the SDSH project as well as the whole health sector. Its complexity requires the involvement of different actors from various sectors in a holistic and coordinated manner. The project results in maternal health are satisfactory for the covered period. Following recent visits to SDSH sites, our maternal health team immediately took action to address logistical problems (e.g., stock-outs of birth plans) that negatively affected our maternal health results this year. We are working on strategies to address other factors that compromise our work with TBAs:

- the lack of supplies, equipment (birth kits), and training opportunities for TBAs
- the need for stronger coordination and oversight of TBAs by health facility personnel
- the need for continued community sensitization efforts

### Principal Accomplishments and Results

The targets were almost met or exceeded for seven out of twelve indicators (58 percent) despite the fact that most planned interventions were effectively implemented only during the second semester. SDSH was below the mark for five indicators as shown in table 4. (See annex C for greater detail.)

**Table 4. Maternal Health Indicators**

<b>Almost Met – 1</b>	Percentage of pregnant women receiving a second dose of tetanus toxoid (74%, or 99% of target)
<b>Exceeded – 6</b>	Number of follow-up postnatal home visits within 72 hours of delivery (54,186)
	Percentage of new mothers benefitting from postnatal consultation within 42 days (38%)
	Percentage of pregnant women with birth plan (84%)
	Number of prenatal visits by qualified personnel (271,303)
	Number of births with trained TBA (56,495)
	Number of births with trained health worker (not including TBA) (14,207)
<b>Under – 5</b>	Percentage of pregnant women doing first prenatal visit in first trimester (36% or 97% of target)
	Percentage of pregnant women with three prenatal visits (47%, or 94% of target)
	Number of mothers and caretakers received nutrition counseling (38,104 or 69% of target)*
	Percentage of sites with maternal mortality committee (27% or 37% of target)
	Number of people trained in maternal and neonatal health (37 for annual target of 100)



The project achievements in prenatal care are particularly encouraging considering the important challenges related to pregnancy follow-up in the country. All targets in this domain have been met (94 percent and over). It is also worth noting that 84 percent of pregnant women in the SDSH network have had a birth plan prepared, a big improvement compared to previous year results.

The SDSH network exceeded the expected results in terms of assisted deliveries, both at community (56,495 deliveries over a target of 55,000) and institutional (14,207/12,000) levels. The project logged in 54,186 postpartum/newborn visits within three days of delivery, surpassing annual benchmark of 45,000.

The project did not reach the objectives, however, for two community interventions aiming at setting up a maternal mortality committee and counseling mothers and caretakers on nutrition. This poor performance is

due to the fact that, for most of the year, CM activities focused on hygiene promotion and diarrhea management in response to the cholera epidemic.

During this period, SDSH has intensified CM efforts to promote prenatal visits according to Ministry of Health norms. The project has also strengthened linkages between community workers and health facility staff through regular meetings and exchanges. In addition, TBA training activities were revitalized and more than 700 TBAs have been trained this year.

Intensification of community outreach service delivery through mobile clinics resulted in increased access to prenatal care in the project catchment areas. Training maternal health service providers has been a matter of concern for SDSH given the negative impact of human resource shortages on services. Only 37 people were trained in maternal health, however, because of the numerous other concurrent training needs the project had to address. As an example, 52 service providers trained in PMTCT had to receive training in maternal health as a prerequisite.

### Maternal Health—Implementation Challenges

The critical personnel issue discussed in previous reports was not resolved until the end of 2010 with the renewal of the JHPIEGO subcontract. SDSH faced a major challenge with the loss of almost all trained field-level service providers who joined other programs (e.g., post-earthquake or cholera response efforts) offering more attractive remuneration packages. Nevertheless, in January 2011 SDSH regained full capacity to adequately guide and oversee its maternal health interventions.

Most service delivery points are still lacking sufficient and appropriate equipment and materials for provision of the full package of services according to the defined standards. The Ministry of Health initiative, *Soins Obstétricaux Gratuits*, implemented in some of the services delivery sites supported by the SDSH project, affected positively our interventions and contributed to the increased use of maternal health services. The concern about this SOG programme is its sustainability at the end of the projected 18 months of its implementation after raising much higher expectations from both mothers and providers with heavily subsidized services.



**Women making their first prenatal visit during the first trimester of pregnancy at Les Anglais**

## IID. Reproductive Health—Family Planning and Sexually Transmitted Infections

In FP, SDSH emphasized strengthening the usual strategic approaches defined in the national program. The project’s objectives were to (1) increase access to services through the reinforcement of outreach activities such as mobile clinics and community-based distribution and (2) improve service quality by service delivery sites capacity-building.

### Principal Accomplishments and Results

SDSH exceeded seven of the twelve indicators tracked for this component of the project and was below the mark for four indicators as shown in table 5. No target was set for one indicator. (See annex C for greater detail.)

**Table 5. Family Planning/Reproductive Health Indicators**

	<b>Exceeded – 7</b>	Number of people trained in FP/RH (76)
		Number of service sites offering FP counseling and services (long-term and permanent methods) (154)
		Number of sites with strengthened MIS (157)
		Number of CYP (282,809)
		Percentage of people of RH age using modern FP method (32%)
		Percentage of Depo-Provera users who get their next injection on schedule (93%)
		Number of new FP users (196,985)
<b>Under – 4</b>	Percentage of FP users using a long-term modern method (10% or 74% of target)	
	Percentage of sites offering at least 5 FP methods with at least two long term (51% or 93% of target)	
	Number of new cases of STIs detected and treated (34,930 or 85% of target)	
	Number of staff trained in long-term FP methods (3, for a target of 25)	
<b>No Target – 1</b>	Number of guides or manuals elaborated or revised to improve access or use of FP/RH services	

Consequently, SDSH exceeded its targets for most RH indicators (8/12). The project’s most notable achievements are related to the use of modern FP methods:

- 282,809 CYP this year, surpassing the annual target of 270,000
- 32 percent of people of reproductive age using a modern FP method
- the number of new users of FP by the end of the year at 196,985 (for an annual target of 170,000)

Moreover, the project obtained impressive results from the training activities (150 percent of the annual target) and the reinforcement of client follow-up that increased users’ retention as shown in table 5 (93 percent Depo-Provera users getting their next injection on time).

The provision of long-term FP methods in the network has been insufficient, however. Despite the fact that 51 percent of service delivery points are offering at least two long-term methods, only 74 percent of the expected results have been attained. It should also be recognized that, for various reasons, the project did not succeed in increasing the number of service providers able to offer long-term methods in the network.

SDSH community-based distribution efforts were further strengthened by closer supervision of the network community health agents and the training of additional health agents—35 working for Medi-Share and others from several ZCs. This year, SDSH had the opportunity to provide technical support to another USAID-funded project (WINNER) for the training of 30 trainers as well as 750 *Paysans Vulgarisateurs*. These trained community members will then promote FP, provide information on modern methods, and distribute condoms in their areas.

The obtained performance was also due to improved service quality by staff competency development through on-site training and regular supervision at service delivery points as well as enhanced FP service integration in the package of services offered with the project support. Efforts invested in the improvement of the management information system (MIS) at all supported sites contributed to a better client monitoring and follow-up, thus reducing clients' dropout rates. Coordination with the Leadership, Management and Sustainability (LMS) Program, another USAID-funded project also managed by MSH, ensured continuous availability of FP commodities in the network.

The project involvement in the updating and dissemination of FP norms and protocols allowed the constant adaptation of strategies and field interventions that contribute to improved quality of services.

### Reproductive Health—Implementation Challenges

In this domain, a major challenge for the project is still the adequate detection and treatment of sexually transmitted infections (STIs), as its accomplishments in this area fell short of expectations; only 87 percent of the target was reached (34,930/40,000). Main reasons for the shortfall are (1) STI detection is a passive intervention, (2) medicines to treat STIs may be unavailable or expensive, and (3) capacity for case diagnosis and management of STIs is limited.

Adequate coordination with departmental teams for the promotion and provision of long-term FP methods has remained an important issue for SDSH this year. Several factors influenced the functioning of existing mechanisms and made it difficult to effectively plan and organize permanent and long-term FP methods clinics to respond on time to the demand of services in the network. This lack of coordination also impeded the realization of training activities that are linked to the mobile clinics.

There is still a crucial need to stimulate FP service demand in the project catchment areas to increase recruitment of new users, promote the choice of alternative methods instead of dropping out the program, and create an environment supportive to FP use in the country.

## II.E. Child Health

SDSH aims at contributing to the implementation of Ministry of Health strategies to promote child health in the country. The project supports the provision of basic health services that include immunization, prevention, and control of childhood illnesses (particularly diarrhea and acute respiratory infections), nutrition education, and surveillance including administration of vitamin A at institutional as well as community levels.

### Principal Accomplishments and Results

Child health represents the project's best-performing programmatic area. By the end of year 4, SDSH exceeded in seven out of the twelve selected indicators as shown in table 6. Three others have been met and one almost met (96 percent of target). The target related to the training on child health care and nutrition was not met. As mentioned earlier, for most of the year, the focus of SDSH training effort was placed on empowering service providers and community members for their full involvement in cholera control. (See "Cholera Response" below and annex C.)

**Table 6. Child Health Indicators**

<b>Met – 3</b>	Percentage of weighings for children <5 years of age that show evidence of severe malnutrition (2%)
	Percentage of weighings for children <5 years that show high risk of severe malnutrition (8%)
	Percentage of weighings for children <5 years of age that indicate a weight-to-age ratio equivalent to low weight-for-age or very low weight-for-age
<b>Exceeded – 7</b>	Percentage of infants 0–11 months completely vaccinated (96%)
	Number of children ages 0–11 with DTP3 (124,584)
	Number of children reached by nutrition program (510,968)
	Number of children <5 years who received vitamin A (405,331)
	Number of infant pneumonia cases treated with antibiotics (14,518)
	Number of mothers and caretakers trained in diarrhea prevention (45,159)
	Number of mothers and caretakers trained in diarrhea management (45,159)
<b>Under – 2</b>	Number of children who received two doses of vitamin A (250,028 or 96% of target)
	Number of people trained in child health care and nutrition (111, or 37% of target)*



These achievements are particularly impressive given the fact that most routine activities at the community level were hampered by the cholera response during the first semester. The project mobilized available resources at all levels to revitalize all regular activities including closer monitoring of all registered children and focused technical assistance for problem solving and regular supply of commodities, materials, and tools. The strengthening of the service delivery monitoring process, the use of information for decision-making and technical assistance planning contributed greatly to the network performance improvement.

Another contributing factor to the positive outcomes in the training and education of mothers and caretakers on diarrhea prevention and management is the intensification of training and education activities at community level in the context of the response to the cholera epidemic. Health education sessions covered the advantages of exclusive breastfeeding, the importance of clean water and hygiene, danger signs to watch for, use of oral rehydration salts (ORS), and when to seek care from a health provider.

**Child Health—Implementation Challenges**

This domain possesses two important assets when compared with the other programmatic components: most service providers have the required competencies and the reference frameworks (strategies, norms and protocols) are well defined and known. The main issues that remain to be addressed are related to the



**A baby receives vitamin A while his mother looks on.**

constant availability of all vaccines and vitamin A (including appropriate storage capability), commodities, and tools needed to ensure continuity and quality in service delivery.

Another major subject of concern for SDSH has been the lack of financial resources to pursue its program for control of acute and severe malnutrition implemented with **USAID/HIGHER** a program whose funding ended in September 2010. This situation created a high level of frustration among the project partners unable to continue the provision of much needed nutrition services in their catchment areas.

Finally, the negative impact of the cholera epidemic on the organization of community activities during the first half of the period is worth noting. Supervision, community mobilization activities, even realization of rally posts were then considerably reduced because of the high level of effort and staff mobilization required to face the cholera epidemic, as discussed in the next section.

## Cholera Response

At the onset of cholera in late October 2010, SDSH mobilized its technical team and partners, joining with the MSPP, USAID, and other donors, to address the outbreak of cholera. Cholera was bringing new challenges on an ailing health system requiring additional resources for an effective response, and it diverted substantially the attention and resources dedicated to health service delivery, at least during the first three months.

MSH submitted to the Office of US Foreign Disaster Assistance (OFDA) an unsolicited proposal that was awarded with a grant of \$859,367 to respond to the cholera outbreak in the metropolitan area of Port-au-Prince; the grant covered a period of 90 days, starting in November 2010. This grant was developed as a complement to SDSH providing for unplanned costs related to the cholera response.

The initiative had a two-pronged approach to education, prevention, and treatment of cholera:

- a national training program in which (1) service providers at all levels—doctors, nurses, and other community health workers—would be trained in the prevention, diagnosis, treatment, and case management of cholera and supported to educate the population of more than 4 million people living in the catchment areas of the SDSH network and (2) the response would be coordinated through well-identified centers for treatment of cholera (*Centre de Traitement du Choléra*) and oral rehydration centers
- the reactivation in 50 internally displaced people (IDP) camps in the metropolitan area of its “health kiosks” approach successfully introduced and operated after the January 2010 earthquake

Participating local institutional partners were—

- *Fondation pour le Développement et l’Encadrement de la Famille Haïtienne* (FONDEFH)
- International Child Care (ICC)/Grace Children's Hospital
- *Œuvres de Bienfaisance de Carrefour et de Gressier* (OBCG)
- CDS
- *Centre de Santé* (health center) (CS) Saint Martin II
- CS Aurore du Bel-Air
- The USAID/WINNER Project

The objective was to reinforce information and awareness, prevention measures, and sanitation among the earthquake survivors living in the tent cities in three communes within the capital city of Port-au-Prince.

After a master training of trainers led by the US Centers for Disease Control and Prevention in collaboration with I-TECH, it was deemed necessary to merge the two prongs of the approach into one to maximize the impact of the partners’ training both nationally and in the urban camps and to offset the social and political (i.e., election-related) disturbances at the start of the program.

Key interventions included a cascade training approach starting with a training of trainers followed by departmental sessions at the institutional and community levels in partnership with the Ministry of Health, USG, and the SDSH partners’ network. Concurrently, interventions that were to be implemented in the IDP

camps were being prepared. Materials reproduction preceded various departmental and communal workshops that were held according to the planned agenda.

The major achievement for this intervention was that a great many individuals received needed training:

- 101 physicians and 214 nurses were trained through 16 one-day sessions
- 413 auxiliaries, through 31 two-day sessions
- 1,275 community health agents, through 50 one-day sessions
- 4,543 TBAs, through 162 one-day training sessions

In fact, from December 15, 2010, to April 30, 2011, 6,547 institutional providers and community workers were trained out of a total of 6,928 planned: 95 percent of the objectives were therefore achieved for the national training program.

In addition, many materials and commodities were procured and distributed: 300 megaphones with 4,800 batteries, 500 buckets, 150,000 Aquatabs tablets, 3,600 gallons of bleach, 1,800 waterproof backpacks for community workers, 1,800 raincoats, and 1,800 pairs of boots, not to mention the ORS from UNICEF and *Programme de Médicaments Essentiels*.

For the health kiosks in the 50 IDP camps, key interventions were based on BCC as the main strategy and included a packet of preventive services information on the topics of health education, sanitation, immunization, and nutrition monitoring; basic hygiene kits; deworming, zinc, ORS, and chlorine tablets; Aquatabs; and information on FP methods. Moreover, the kiosks served as meeting places for learning, information, knowledge sharing, and exchanges among health staff and camp residents to promote personal hygiene, hand washing, water treatment, sanitation, management of waste and human excreta, and actions to be taken in the event of diarrhea and vomiting.

Field supervision as well as direct support to promote new behaviors and personal engagement played a critical role in the achievement of the following program results:

- 378 health kiosks were organized to provide health services.
- 51,072 home visits were made for cholera prevention.
- 19,505 group education sessions were organized.
- 161,093 people representing approximately 90 percent of the population in the camps received messages about prevention and treatment of diarrhea.
- 110,000 printed educational booklets and leaflets were distributed in support of information education communication messages.
- 8,000 kits were distributed to prevent diarrhea.

In the 50 IDP camps participating, fewer than 200 suspected cases of cholera were recorded during this intervention; a consistent decline of new cases over the 90-day period was also observed. Thus, the objectives of this component have been largely exceeded.

In conclusion, both the national training program and the health kiosks approach have been a successful and positive experience not only for MSH and its partners, but also for the Ministry of Health and USAID/OFDA. It shows that resources and expertise coupled with a broad-based health-provider workforce at the institutional and community levels can defeat cholera over time.

SDSH also solicited and once again received support from DRI, this time for cholera-related activities in all 10 departments. Another SDSH-leveraged collaborator, Pure Water for the World, provided water purification

equipment and supplies in targeted areas. Beginning in January 2011, DRI distributed cholera-related equipment and commodities (e.g., ORS, buckets, soap, disinfectants, antibiotics, intravenous fluid) throughout (and beyond) the SDSH network. The project also secured places for 100 department-level service providers from the North and Grand Anse departments in training of trainers for cholera prevention and treatment sessions led by the US Centers for Disease Control and Prevention.

### III. Other Domains

SDSH met or exceeded five of the nine indicators tracked for this component of the project and was below the mark for three indicators as shown in table 7. No target was set for one indicator. (See annex C for greater detail.)

**Table 7. Other Indicators**

<b>Met- 1</b>	Percentage of the population served by project as of September 30, 2011 (42% compare to approximately 50% annual target)
<b>Exceeded- 4</b>	Percentage of matching fund covered (> 100%)
	Number of sites having BCC and information on basic health services (157)
	Number areas where at least one site (school or orphanage, health center, household) has clean water (450 schools and orphanages, 200 households, and 54 service sites)
<b>Under – 3</b>	Number of grants under contract awarded (43)
	Number of success stories transmitted to USAID (0 for a target of 12)
	Number of SDSH sites visibly showing USAID sign/logo (89 for a target of 147)
<b>No Target – 1</b>	Number of active local health task forces (0, annual target of 40)
	Number of highly visible events organized (done on an as-needs-arise basis)



### SDSH Communication and Public Relations

#### Focus on US Assistance to MSPP and Partners in the Cholera Response

In response to the cholera outbreak, SDSH promptly formed a task force that included the SDSH communications officer. Because of the severity of the epidemic, cholera dominated SDSH communications messages activities for several months. The Communications Unit issued weekly or twice weekly updates on MSPP and health sector partners' strategies and activities and their impact on the evolution of the epidemic. MSH headquarters also used the updates to disseminate the news through its international website.

During the first days of the outbreak, SDSH facilitated the dispatching of journalists and photographers from local media, *Le Nouvelliste* and *Le Matin*, to the worst-affected areas in the Artibonite and West departments to report on the situation on the ground. This resulted in timely articles and information on the detection, treatment, and prevention of cholera. See two of these articles at <http://www.lenouvelliste.com/article.php?PubID=1&ArticleID=85161> and <http://www.lenouvelliste.com/article.php?PubID=1&ArticleID=85106>.

SDSH provided comprehensive coverage of the USG-OFDA emergency cholera response activity, as discussed in the "Cholera Response" section of this report, and facilitated visits by the media to the camps included in this activity. At the health department level, we reported on all cholera-related activities, including the nationwide cascade training of health workers supported by USG. By March 2011, SDSH communication efforts resulted in (1) print coverage through *Le Nouvelliste* (see <http://bit.ly/mizzQL>) and *Mobilisation pour une riposte au choléra à Baie-de-Henne*; (2) nine audio reports and shows broadcast on major radio stations in the capital, and (3) three televised reports informing local audiences about cholera prevention activities and their anticipated impact.

## Public Events, Site Visits, Success Stories, and Branding

With the nation focused on the cholera response and two rounds of political campaigns and elections, no major public events were scheduled around SDSH activities. On the first anniversary of the earthquake, the SDSH Chief of Party and Communications Officer participated in a brainstorming session with the USAID Press Officer and Communications Team to generate post-earthquake reports and stories using previously published materials, impact stories, talking points, and video b-roll and clips. During the session, plans were made for field trips and/or one-on-one interviews for the USAID staff with the purpose of subsequently bringing international press to the same sites.

During the first semester, SDSH communications staff also produced a photo-narrative success story that was incorporated into the final report of the HIGHER post-cyclone emergency relief program that ended in 2010. The story depicted the results and impact of the program.

By the end of March 2011, the SDSH project had raised the visibility of USG-supported sites by placing durable sign boards containing the USAID logo at 89 SDSH-supported sites in eight health departments. The new SDSH departmental technical advisors in these departments will ensure that the posting is completed by the end of next quarter.

In May 2011, the project received support from Rebecca Bennett, a communication consultant. Rebecca trained the technical staff on drafting success stories and helped develop a draft communication plan. There were few communications activities in the second half of the year because the communications officer left the project at the end of June. The few activities were limited to finalizing the OFDA report and drafting three success stories.

## SDSH Project Management

The SDSH PMP was revised in November 2010 to take into account the contract extension period to September 2012. Indicators pertaining to the HIGHER Program's nutrition activities were eliminated since the program's activities, especially the outreach and community interventions were significantly reduced because of policy changes at the MSPP in April 2010. Other targets were increased or reduced according to results realized during the October 2009 to September 2010 period.

The SDSH monthly reporting form was revised to reflect the new MSPP policy regarding the measles-rubella vaccination for infants, and all SDSH partners began using the revised form in October 2010. The SDSH management information systems (MIS) guide was also updated, taking into account feedback from the field and changes to the monthly reporting form. With the addition of three new partners to and the exit of one partner from the SDSH network, the computer software application used to record project data was revised to reflect the new geographic areas, their associated demographics, and the updated monthly reporting requirements.

To facilitate results monitoring by SDSH staff, the SDSH Management Unit produces monthly data tables to show the progress of all project service delivery activities. An analysis of these tables allows staff to adjust strategies and interventions, as needed. This information is also used to inform the SDSH quarterly reviews and semiannual reports as well as periodic technical team meetings, such as the SDSH staff retreat that was held in March 2011. The unit designed and supervised data collection and reporting tools for the USG/OFDA grant-funded cholera control and prevention activities discussed in the "Cholera Response" section of this report.

The Management Unit worked closely with the SDSH Contracts Unit in the preparation of all award documents for SDSH partners, providing the list of objectives, expected deliverables, disbursement schedules, and the amount of performance-based award fees, or bonus payments, for meeting select indicators. The unit was also responsible for planning and implementing the in-service training of six new SDSH departmental technical advisors in collaboration with the project's Technical Assistance Unit.

Because of the unstable sociopolitical situation in the country during last year's presidential campaign and election period, SDSH had to forgo plans for the annual data quality assessment of partners' achievements in relation to a set of indicators that normally formed the basis for the award of performance bonus payments. An alternate plan was conceived, agreed upon by the partners, and implemented. It allowed for the award of performance bonus payments to partners who met targets for a random selection of indicators, and the majority of partners did receive bonus payments.

### Project Staffing

Project staffing has been the weakest area this fiscal year; SDSH has endured turbulence with long periods of leadership transition over the year as a result of the resignation of the Chief of Party in January 2011 and the Technical Director and Deputy Chief of Party in April 2011. Filling these positions with suitable candidates turned out to be seriously challenging, MSH received few applications, good candidates perhaps hesitating to apply probably due to the country's unstable political environment. A new Chief of Party was hired mid-April; staff morale was suboptimal because of miscommunications and internal conflicts. MSH headquarters closely monitored project events and intervened several times with STTAs to support the team. The MSH Chief Operations Officer and the Health Services Delivery Operations director in Center for Health Services facilitated a team-building workshop in February 2011 followed by technical and managerial support STTA of the country lead. These interventions culminated in a staff retreat held in early March 2011 to assess progress to date and plan for the future. Staff from SDSH, MSH Cambridge, USAID Haiti, and MSPP participated in the meeting, reaffirming their commitment to the objectives of the project, they discussed its strengths and weaknesses, and formulated strategies to remedy perceived shortcomings and respond to new priorities. To address staff morale issues, another team alignment workshop was held end of July 2011 with Jana Ntumba from the MSH Cambridge office to improve teamwork. The session was much appreciated by most of the staff involved because they were able to communicate openly and felt helped.

Besides the leadership positions, many other positions remained unfilled during this period because of slow recruitment processes as well as the changes in the labor market; many suitable candidates were expecting quite high salaries, above FSN scale for the positions considered, and those expectations delayed salary negotiations, and in some cases, resulted in losing the candidates in the process.

The JHPIEGO subcontract was finally concluded at the end of 2010, and a team of highly qualified technical advisors came on board early in 2011. To fill in the technical leadership gap, Ms. Nancy Nolan, a senior project management consultant, was brought in to assist in a variety of tasks in April 2011, and Dr. Sosthene Bucyana was hired to fill in the technical gap and focus on the implementation of HIV/AIDS activities. We also recruited two support staff to assist senior technical advisors who had been performing the functions of vacant posts in addition to their own. Six new departmental technical advisors were hired, and after their in-service orientation, they will take up their positions in six health department directorates in April and May 2012.

In total, 19 new personnel were recruited during the year; recruitment is ongoing for other open posts. With our reinforced and revitalized workforce, we are confident that we can achieve the level of results envisioned in our PMP. Particular attention will be paid to those interventions where our performance has recently failed to meet expectations.

Despite these challenges, the SDSH project in partnership with all the partners managed to meet or exceed results as demonstrated by the PMP reports. The leadership and management challenges slightly affected the capacity-building prong of the PBF program because of a reduction in technical assistance efforts, but what we learned from this experience is that using PBF, SDSH has established a strong health service delivery system that could maintain health results. The PBF program is mature, running smoothly, and ready for scale-up, which is naturally the next phase. The challenge for the next fiscal year will be to effectively transfer the contracts management and monitoring skills to the MSPP.

### **Finance and Systems Strengthening**

At the invitation of the National Haitian-American Health Alliance, MSH made a presentation on the SDSH PBF experience at the alliance's seventh annual conference in October 2010 in Port-au-Prince. The presentation highlighted successes and lessons learned over a period of more than 10 years using PBF to fund public and private health sector institutions in Haiti. A PBF orientation session was held in November 2010 for MSPP health directorate staff and two targeted ZCs in the department of South to explain and discuss the PBF strategy, performance objectives, and contractual requirements. In addition, in preparation for introducing PBF at all public sector sites later this year, an orientation meeting was held with all SDSH departmental finance managers in February 2011 to discuss and plan for the transition.

Within the framework of SDSH's "graduation strategy" for its partners, the project provided financial management support with Quick books software to computerize the accounting, administration, and finance systems at CDS, one of the network's largest and strongest NGO partners. An appropriate vendor and software were selected following a tender process; the software package will be installed at all CDS sites. Similarly, SDSH helped CBP, another NGO partner, procure appropriate software tools to handle all its finance and accounting activities, including revenue, payroll, inventory, budget, capital assets, and accounts payable and receivable. Accounting, finance, and administrative staff will be trained after the equipment and software have been installed.

### **Contracts and Administration**

In addition to preparing and negotiating agreements with one new private sector (OBDC in the West department) and two new public sector (Les Perches and Carice in the North-East department) partners, the Contracts and Administration Unit worked hand in hand with technical staff to get the GUC activity under way (see section IB, "Support for Decentralized Services"). The Contracts and Administration Unit also ensured the timely procurement and distribution of supplies and equipment for the OFDA emergency cholera activity and for all other project-related needs including hiring two consultants for the supervision of the OFDA activities and signing fixed obligation grants with the private partners involved in the program (ICC/Grace Children's Hospital, OBCG, FONDEFH and CDS). An assessment of all SDSH vehicles was undertaken and repairs made, as necessary. Many vehicles in the SDSH fleet are depreciating because of the bad conditions of roads, which increased the actual cost of vehicle repair compared to the budget.

Starting in July 2011, the renewal process for PBF subcontracts and memoranda of understanding for NGOs and the ZCs, respectively, was our central focus; USAID approval was secured for nine subcontracts totaling more than \$150,000. All subcontracts and memoranda of understanding were ready and signed in a timely manner except for Hopital Sainte Croix, because that institution was unable to submit an acceptable work plan with a budget. Technical assistance is being provided to correct the situation. All 33 ZCs will be managed through a PBF mechanism during the FY12. Consequently, we organized an orientation meeting on PBF for the representatives of the four departments that had come on board: West, Artibonite, Grand Anse, and Nippes.

The Contracts and Administration Unit continues to monitor all these contracts; payments requests for all the partners have been regularly processed upon submission of monthly and quarterly reports. Great improvement was observed in the reporting system in general ; and communication between project and partners is reinforced. SDSH Project successfully played a mediator role between CDS and the Departemental directorate of North East in their dispute over the sharing of operating costs of Fort-Liberté hospital.

### Infrastructure Renovation Work

In Artibonite, work was completed at the Coupe à l'Inde Dispensary. A needs evaluation for community health services section of Claire Heureuse Hospital got under way. The hospital also requested assistance to upgrade its maternity ward, and SDSH arranged for representatives from DRI to visit and assess the situation. In Grand Anse, SDSH renovated a food ration storeroom and installed a perimeter fence at the Corail Health Center. We evaluated water drainage needs at the Abricots Dispensary and called for bids for execution of the work.

In the North department, SDSH carried out several repairs at the Dondon Health Center, fixing a fence that had collapsed, cracks in the walls, and electrical and water systems and replacing broken windows. At the Saint Raphael Health Center, SDSH provided a temporary shelter for community health services while renovation work is ongoing in the maternity ward's labor, delivery, and postpartum recovery rooms; the laboratory; the pharmacy; two administrative offices; six consultation cubicles; and two waiting rooms. Minor renovations are under way at the Borgne Health Center (community room for providers) and at the Petit Bourg du Borgne Dispensary (replacing sections of the aluminum roofing and interior ceilings, providing door locks, and repainting). At the Ranquitte Health Center, renovation work entailed fixing cracks in the walls, reinforcing the foundation, and installing a perimeter fence and a security fence for providers' quarters.

Renovation work was completed at the Notre Dame des Palmistes Hospital in the North-West department. This work included setting up a counseling space for HIV, TB, and FP in the hospital's outpatient clinic. In the hospital laboratory, a small office for the head of the laboratory was rehabilitated, floor tiles replaced, and a septic tank installed for drainage of contaminated water.

At the Mme. Bernard Dispensary in the South, the dispensary layout was modified to accommodate a more spacious laboratory and a kitchen-dining area for staff.

In the department of West, an old storeroom was renovated to stock dry food rations at Pont Matheux. OBCG benefitted from rehabilitation work at its Brochette 99 site. A tender was launched for renovation work at the MSPP Health Directorate located in Turgeau, also in the department of West.

Lastly, renovation work on the new SDSH Office in Delmas 105 (Petionville) has proceeded as scheduled and was completed by August 2011.

## Conclusions: Challenges and perspectives

At the end of the Project 4th-year, SDSH is proud to report that the majority of its targets have been met or exceeded and that its interventions remain on track. SDSH fourth year has been severely affected by the cholera outbreak in October 2010 while the country was and is still heavily burdened by the consequences of the devastating January 2010 earthquake. Despite a disruptive but limited personnel turnover as a result of the competition created by an influx of humanitarian NGO and some turbulences in leadership transitions, the SDSH project with all the partners managed to meet or exceed results as demonstrated by the Performance Monitoring Plan (PMP) reports; we are confident to finish strongly the last year of the project. Using PBF, SDSH has established a strong health service delivery system that could maintain health results once the MSPP takes over the services. The PBF program is mature, running smoothly, and ready for scale-up, which is naturally the next phase. The challenge for the next fiscal year will be to effectively transfer the contracts management and monitoring competencies to the MOH. One of our top priorities through the end of the project is to reinforce the quality improvement efforts and interventions so that quality assurance becomes an integral part of service delivery within the SDSH network.

The future of Haiti seems quite rich of new opportunities that need to be seized; ready and willing to build on the progress made during the first 4 years of the Project, SDSH is leading the USG-funded interventions in HIV/AIDS in the country by aggressively choosing the new model of rapid HIV testing through the implementation of the finger-prick technique which will allow a correct diagnosis in a short 20-minute period and the immediate delivery of the test result to the client. Mobile VCT testing will become possible as well as home-based HIV testing and counseling, thus increasing exponentially the number of people who will be able to know their serologic status and have the opportunity to benefit from the available and accessible interventions of care and treatment. In addition, with leveraged contributions from Direct Relief International (DRI), the SDSH PMTCT program component will be revamped and expanded through the development of eight (8) Centers of Excellence and the offering of HAART regimens to HIV+ pregnant women according to the new MOH norms, thus scaling-up the ART platform of the project with a total 24 sites where a complete HIV case-management will be available. Newborns will continue to benefit from the Early Infant Diagnosis (EID) through DNA-PCR now offered in the most remote and inaccessible or hard to reach sites through the successful partnership with Caris Foundation. Based on good past experience, the MOU between MSH and the Caris Foundation has been renewed to continue with the training as well as the monitoring and collection of DBS from SDSH's network centers which are providing PCR/DNA for children born to HIV-positive women. Through collaboration with CHAMP, SDSH will increase this level of performance by strengthening community-based care, the field tracking of patients, and home visits.

We anticipate additional logistical challenges with the new PMTCT norms and protocols, including the need to fund the more costly regimens and to retrain existing staff. We will work more closely with our MSH/SCMS and MSH/Leadership, Management and Sustainability (LMS) colleagues to coordinate logistics support, including training for the SDSH HIV sites. SDSH will also promote and implement a strategy to involve men as partners in PMTCT, given the benefits of this approach on other services, such as chemoprophylaxis for the mother and the newborn, immunization, infant nutrition, family planning, and adherence to treatment.

A strong emphasis will be put on the management of HIV and TB Co-infection as demonstrated by the recent training provided to more than 60 lab technicians and the distribution of 32 microscopes offered by AmeriCares ( a strong partner of SDSH). In collaboration with the head of training for the Government of Haiti (GOH) National Laboratory, planning is under way for the training of another 86 lab technicians and

bacilloscopists from 43 SDSH facilities in HIV rapid testing using capillary blood. Counseling, testing and treatment will be expanded, testing for both HIV and TB becoming a routine intervention in the selected sites, emulating the successes reached in the project Community Palliative Care and Support component.

We realize the need remains urgent to improve the quality of RH services throughout the SDSH network. We will intensify our efforts to identify and implement high impact community interventions that require minimal financial input but can make a big difference in the quality of services offered, such as designating and organizing space to allow for privacy in FP counseling, reducing the waiting time for services, working with some sites to initiate RH services for the youth (to provide at a minimum education and information), and encouraging the de-medicalization of services. During the fifth year, the Family Planning and Reproductive Health component will expand through the reinforcement of the community-based distribution approach and the increased supply of long term and permanent contraceptives methods through renewed outreach activities with the expectation that SDSH will have exceeded all its target indicators for this program element.

Further focus will be put on strengthening the Child Health component; with the full participation of JHPIEGO, SDSH expect to achieve strong progress in Maternal, Newborn and Child Health (MNCH), in close cooperation with MOH-DSF (Direction de la Santé de la Famille). Linkages between community workers and the project's health facility staff will be strengthened and mobile clinics will resume facilitating increased access to prenatal care and child survival activities. As part of the prevention of diarrheal diseases, we will continue to ensure activities related to cholera prevention, education, and case referrals, in close partnership with the Ministry of Health, USG, and the SDSH partners' network.

SDSH support to the Executive Functions of MOH will be enhanced; in addition to its contributions in strengthening strategic planning and decentralization, promoting PBF as a results management approach, strengthening governance and financial management, and closely collaborating to improve HIS, SDSH will help establish a Contract Management Unit and an Internal Audit Unit with 2 Technical Advisors seconded to MOH for the majority of their time. SDSH will be working with MOH to streamline financial management functions to help prepare the Ministry's systems to become a direct recipient of funds from Donors who are willing to support the new administration.

The project management and particularly staffing will be strengthened for an improved coordination of the technical assistance; staffing for all open positions especially the key positions will be a priority for the next quarter. The work plan for the last year will be developed in light of new expressed priorities within our scope to ensure alignment with the new MOH administration. It is our expectation that we will finish stronger by September 2012.

# ANNEXES

## Annex A: SDSH Partners

MSPP/ZCs	NGO Partners
<b>Artibonite</b>	
Gonaïves; CS Saint Michel; CS de Marmelade; CS de Grande Saline N=4	Albert Schweitzer Hospital; Hôpital Claire Heureuse; CS Pierre Payen N=3
<b>Centre</b>	
CS de Belladère; CS Cerca la Source; CS Savanette N=3	Save the Children; Medi-Share N=2
<b>Grand Anse</b>	
CS des Abricots; CS de Corail N=2	Haitian Health Foundation; Ste Hélène; Léon Coicou H.C.; AEADMA (Association d'Entr'Aide des Dame-Mariens) N=4
<b>Nippes</b>	
CS de L'Azile; CS de Petit Trou; CS de L'Anse à Veau N=3	None N=0
<b>North</b>	
CS de l'Acul; CS de Borgne; CS de Dondon; CS de Saint Raphaël N=4	CBP; Dugué Clinic; CDS; Konbit Santé N=4
<b>North-East</b>	
CS de Mombin Crochu; CS Ste Suzanne; CS Vallières N=3	CDS North-East N=1
<b>North-West</b>	
CS La Tortue; CS Baie de Henne; CS Anse à Foleur N=3	Beraca Medical Center N=1
<b>West</b>	
CS Belle Fontaine; CS Cornillon; CS Aurore du Bel Air; CS de Tayfer ; Thomazeau ; Tayfer ; Cite Soleil N=7	St. Paul Clinic; CSNRR (Filles Charité); FONDEFH; FOSREF; Fermathe Hospital; Grace Children's Hospital; OBCG; SADA; CS Lucélia Bontemps; CDS Ouest; Hopital St. Croix N=11
<b>South</b>	
CS Les Anglais; CS de l'Ile à Vache N=2	La Fanmy; MEBSH N=2
<b>South-East</b>	
CS de Baïnet N=1	Sacré Cœur de Thiotte Health Center N=1
<b>Total ZCs:</b>	<b>Total NGOs:</b>
<b>N=33</b>	<b>N=29</b>

## Annex B: SDSH HIV Sites

Department	Institutions/Commune	VCT	PMTCT	ARV	Palliative Care	PCR	CD4	TB CDT
Artibonite	HCH Hop. Claire Heureuse, Dessalines	✓	✓		✓	✓	✓	✓
	CAL Rabeauto, Gonaives (ZC)	✓	✓		not ready			✓
	CAL Ste Michel, St Michel (ZC)	✓	✓		not ready			✓
	CAL Marmelade, Marmelade (ZC)	✓	✓		in process			✓
	CAL Pierre Payen, Saint Marc	✓	✓		✓			✓
Centre	Save the Children CSL, Maissade	✓	✓		✓			✓
Grande Anse	CSL Ste Hélène, Jérémie	✓	✓ community		✓			
	CSL Abricots	✓	✓					✓
	HHF CSL Klinik Pèp Bondye, Jérémie	✓	✓		✓	✓	✓	
	AEADMA CAL Dame Marie, Dame Marie	✓	✓	✓	✓	✓	✓	✓
Nippes	CAL Petit Trou, Petit Trou (ZC)	✓	✓					✓
	CAL Jules Fleury, Anse à Veau (ZC)	✓	✓					✓
	CAL l'Azile, l'Azile (ZC)	✓	✓					✓
North	CBP Hop. Pignon, Pignon	✓	✓	✓	✓	✓		✓
	CDS CSL La Fossette, Cap Haitien	✓	✓		✓	✓	✓	✓
	CSL CMC Dugué, Plaine du Nord	✓	✓ community		✓		✓	
North-East	CDS Hop. Fort Liberté, Fort Liberté	✓	✓	✓	✓	✓	✓	✓
	CDS CAL Ouanaminthe, Ouanaminthe	✓	✓	✓	✓	✓		✓
North-West	Hop. Beraca La Pointe, Port de Paix	✓	✓	✓	✓	✓	✓	✓
	CAL ND des Palmistes, La Tortue	✓	✓					✓
South	MEBSH Hop. Lumière Bonne Fin, Cavaillon	✓	✓		✓		✓	

Department	Institutions/Commune	VCT	PMTCT	ARV	Palliative Care	PCR	CD4	TB CDT
	MEBSH CAL Lumière, Finca, Cayes	✓	✓		✓	✓	✓	✓
	CSL CL.La Fanny, Cayes	✓						
	CAL de les Anglais (ZC)	✓	✓					✓
	CAL de l'Ile à Vache (ZC)	✓	✓					✓
West	CAL St Paul, Montrouis, Arachaie	✓	✓		✓			✓
	CSL Lucélia Bontemps, Croix de Bouquet	✓						✓
	CSL CNSRR (Filles de la Charité), Cité Soleil	✓						
	FONDEFH CAL Cl.Co. Martissant, PAP	✓	✓		✓	✓	✓	✓
	FONDEFH CAL CC Delmas 75, Delmas	✓	✓		✓			
	CSL OBCG, Carrefour	✓						
	SADA CAL Matheux, Archaie	✓	✓		✓			✓
	FOSREF CSL CEGYPEF, PAP	✓	✓					
	FOSREF CSL Christ Roi, Delmas	✓						
	FOSREF CSL Solino, Delmas	✓						
	Hopital de Fermathe	✓	✓	GHESKIO funded	✓	✓	✓	✓
	Hop. ICC Grace, Delmas	✓	✓	✓	✓	✓	✓	✓
<b>TOTAL</b> at end of September 2011	Includes currently functioning sites (indicated by ✓)	37	31 (includes 2 community- based)	6 SDSH	20	12	12	26

Note: CAL = health center with beds; CSL = health center without beds; CT = treatment center; Hop. = hospital. Not ready = the site has been designated but inputs (e.g., staff identified and trained, equipment, commodities, space) are not yet available. In process = preparations are underway to make site functional (e.g., staff, equipment, commodities, space)

Note: There are no SDSH HIV sites in the South-East department.

## Annex C: SDSH Annual Results for FY11

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
<b>HIV/AIDS</b>					
3.1.1.9 (F)	Number of sites offering the minimum package of PMTCT services according to national and international standards	#	19	31	Exceeded target
3.1.1.10 (F)	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	#	40,000	59,450	Exceeded target
3.1.1.10. c	Number of newborns of HIV-positive mothers benefiting from pediatric care	#	400	391	Achieved 98%
3.1.1.11	Number of diagnosed HIV-positive pregnant women having received ARV prophylaxis in a PMTCT setting	#	650	722	Exceeded target
3.1.1.12 (F)	Number of health workers trained in the provision of PMTCT services according to national and international standards	#	30	52	Exceeded target
3.1.1.13 (F)	Number of sites providing counseling and testing according to national and international standards	#	32	37	Exceeded target
3.1.1.14 (F)	Number of people who received counseling and testing for HIV and received their test results	#	85,000	98,374	Exceeded target
3.1.1.16 (F)	Number of people trained in counseling and testing (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	40	57	Exceeded target
3.1.1.17 (F)	Number of sites providing ART	#	6	6	Target met
3.1.1.18 (F)	Number of people newly placed on ARV during the reporting year	#	700	805	Exceeded target
3.1.1.18. a	Number of individuals who have received ART during the year	#	4,234	4,448	Exceeded target

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
3.1.1.19 (F)	Number of people receiving ART at the end of the reporting period	#	3,175	3,041		Achieved 96%
3.1.1.19. a	Percentage of individuals placed on ARV and found still in active treatment at the end of the reporting period	%	80	69		Exceeded target
3.1.1.20	Number of health workers trained to deliver ART services (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	10	30		Exceeded target
3.1.1.21 (F)	Number of sites providing treatments for TB to HIV-positive patients	#	20	13		65% achieved
3.1.1.22 (F)	Number of people provided with HIV-related palliative care (including those co-infected with TB and HIV)	#	15,000	17,413		Exceeded target
3.1.1.22. a	Number of sites offering a complete clinical package of palliative care to HIV-positive people	#	24	19		79% achieved
3.1.1.23 (F)	Number of HIV-positive individuals receiving treatment for both TB and HIV	#	700	175		25% achieved
3.1.1.24 (F)	Number of people trained to provide HIV palliative care (including TB/HIV co-infection)	#	20	28		Exceeded target
3.1.1.29 (F)	Number of laboratories with capacity to perform (a) HIV tests and (b) CD4 tests and lymphocyte tests, or all three	#	32	37		Exceeded target
3.1.1.30	Number of people trained in the provision of laboratory-related services (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	10	25		Exceeded target

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
3.1.1.31 (F)	Number of tests performed at supportive laboratories: (a) HIV testing (b) TB diagnostics (c) Syphilis testing (d) HIV disease monitoring	#	207,660	311,779		Exceeded target
<b>Tuberculosis</b>						
3.1.2.1 (F)	Tuberculosis notification rate	#/100K inhabitants	105	67		64% achieved
3.1.2.1. a	Tuberculosis detection rate	%	35	14		40% achieved
3.1.2.3 (F)	Number of people trained in DOTS	#	10	--		Training to be set by MSPP
3.1.2.4 (F)	Percentage of TB patients who were tested for HIV and received their results	%	40	50		Exceeded target
3.1.2.4. a	Number of TB patients who were tested for HIV and received their results	#	1,735	1568		Achieved 90%
3.1.2.5 (F)	Percentage of laboratories performing TB microscopy with over 95% correct microscopy results (quality control testing to be performed by the national laboratory within its mandate)	%	>95	--		No results yet from the Laboratoire National de reference.
3.1.2.6. a	Number of sites offering integrated TB services ( <i>only detection with referral for treatment</i> )	#	20	1		Not achieved
3.1.2.6. b	Number of people trained in TB and HIV testing	#	20	18		Achieved by 90%
3.1.2.7 (F)	Percentage of expected new TB cases detected	%	75	--		Reported annually
<b>Maternal Health</b>						

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
3.1.6.3 (F)	Number of postpartum newborn visits during the 3-day interval following child birth	#	45,000	54,186		Exceeded target
3.1.6.4 (F)	Number of prenatal care visits with skilled providers	#	245,000	271,303		Exceeded target
3.1.6.4. a	Percentage of pregnant women having the first prenatal visit during the first trimester of pregnancy	%	37	36		Achieved by 97%
3.1.6.4. b	Percentage of pregnant women who have had at least three prenatal visits	%	50	47		94% achieved
3.1.6.4. c	Percentage of pregnant women who have received a second dose or a recall dose of tetanus vaccine	%	75	74		99% achieved
3.1.6.4. d	Percentage of pregnant women making a birth plan	%	80	84		Exceeded target
3.1.6.5 (F)	Number of people trained in maternal and newborn health (women and men)	#	100	37		37% of target
3.1.6.6 (F)	Number of deliveries with a skilled birth attendant—TBAs not included	#	12,000	14,207		Exceeded target
3.1.6.6. b	Number of deliveries with assistance of a health facility–based skilled birth attendant	#	55,000	56,495		Exceeded target
3.1.6.6. c	Percentage of new mothers who have had postnatal consultations	%	35	38		Exceeded target
3.1.6.6. d	Percentage of sites that have at least one maternal health committee in their service area	%	35	27		77% of target;
3.1.6.6. g	Number of mothers and child caretakers having received nutritional counseling	#	55,000	38,104		69% achieved
<b>Child Health</b>						

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
3.1.6.2	% of children 0–11 months completely vaccinated	%	85	96		Exceeded target
3.1.6.7 (F)	Number of people trained in child health and nutrition.	#	300	111		37% of target achieved
3.1.6.11 (F)	Number of children reached by nutrition programs	#	450,000	510,968		Exceeded target
3.1.6.11. a	Percentage of weighings for children <5 years of age that indicate a weight-to-age ratio equivalent to low weight-for-age, very-low-weight for age.	%	12	10		Within the expected range (exceeded by 2%)
3.1.6.11. b	Percentage of weighings for children <5 years of age that show evidence of severe malnutrition	%	3	2		Within the expected range (exceeded by 1%)
3.1.6.11. c	Percentage of weighings for children <5 years of age that show high risk of severe malnutrition	%	9	8		Within the expected range
3.1.6.12 (F)	Number of children <12 months who received DPT3	#	118,000	124,584		Exceeded target
3.1.6.13 (F)	Number of children <5 years of age who received vitamin A	#	350,000	405,331		Exceeded target
3.1.6.13. b	Number of children <5 years of age who received two doses of vitamin A	#	260,000	250,028		96% achieved
3.1.6.14. a	Number of mothers and child caretakers trained about diarrhea prevention (exclusive breastfeeding, pure drinking water, and hygiene)	#	30,000	45,159		Exceeded target
3.1.6.14. b	Number of mothers and child caretakers trained in diarrhea management (danger signs and oral rehydration)	#	30,000	45,159		Exceeded target
3.1.6.19 (F)	Number of cases of pneumonia in children <5 years of age treated with antibiotics	#	10,000	14,518		Exceeded target
<b>Reproductive Health/Family Planning</b>						
3.1.7.2 (F)	Total number couple-years of protection (CYP)	#	270,000	282,809		Exceeded target

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
3.1.7.3 (F)	Number of people trained in FP/RH (women and men)	#	50	76		Exceeded target
3.1.7.3. a	Number of people trained in offering longer-term FP methods	#	25	3		25% achieved
3.1.7.6 (F)	Number of policies or guidelines developed or changed to improve access to and use of FP/RH services	#	--	--		Target not set; to be done as needed
3.1.7.8 (F)	Number of service delivery points offering FP counseling or services for long-term or permanent methods	#	142	154		Exceeded target
3.1.7.8 a	Percentage of sites offering at least five FP methods, of which two are longer term	%	55	51		93% achieved
3.1.7.12 (F)	Number of sites in which the MIS system has been reinforced	#	147	157		Exceeded target
3.1.7.13 (F)	Percentage of users of long-term contraceptive family planning methods	%	14	10		71% Achieved (target is for life of project)
3.1.7.13. a	Percentage of people of reproductive age using a modern contraceptive method (for FP)	%	30	32		Exceeded target
3.1.7.13. b	Percentage of Depo-Provera users who respect the replenishment delays	%	90	93		Exceeded target
3.1.7.13 c	Number of new family planning users	#	170,000	196,985		Exceeded target
3.1.7.14	Number of new cases of STI detected and treated	#	40,000	34,930		87% achieved
<b>Strengthening MSPP Executive Functions</b>						
FE.1	Number of health departments with donor coordination mechanism	#	6	6		Target met
FE.2.a	Percentage of departments implementing approved operational plan	%	100	100		Target met

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results 2010 to Mar 2011	Oct	Comments
FE.3.a.	Number of departments implementing supervision plan for service delivery	#	10	8		80% achieved
FE.4	Number of ZCs funded with PBF	#	16	18		Exceeded target
FE.4.a.	Number of ZCs benefitting from basic package of services supported by SDSH	#	31	33		Exceeded target
FE.5	Number of departments with new financial and accounting mgmt system set up and in use	#	10	7		Exceeded target
FE.6	Number of communes with ZCs where info system for services is set up and in use	#	31	33		Exceeded target
FE.7	Number of departments supported to operationalize the national HIS	#	6	--		MSPP not ready to launch new HIS
<b>Other</b>						
AD.1	Percentage of population served by project (as of March 31, 2011)	%	Approx 50	42		met
AD.5	Percentage of matching funds covered	%	100	>100		Exceeded target
AD.6	Number of areas where at least one site (school or orphanage, households, health center) has clean water	#	450 schools, 200 HH, 50 HC sites	450 schools, 200 HH, 54 HC sites		Exceeded or met target
AD.7	Number of highly visible events organized	#	--	0		No target set; done as opportunities arise
AD.8	Number of success stories transmitted to USAID	#	12	0		Target not met
AD.9	Number of SDSH sites visibly showing USAID sign/logo	#	147	89		Target not met

Indicator Code	Indicator	Unit Measure	of Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
AD.9.a	Number of active Local Health Task Forces	#	40	--	GUC grantees
AD.10	Number of sites having BCC and information on basic health services	#	147	157	Exceeded target
AD.12	Number of grants under contract awarded	#	40	43	Exceeded target