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SANTÉ POUR LE DÉVELOPPEMENT
ET LA STABILITÉ D'HAÏTI

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

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Semi-Annual Progress Report

October 1, 2010 — March 30, 2011

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Management Sciences for Health

784 Memorial Drive

Cambridge, MA 02139

Telephone: 617-250-9500

www.msh.org

Management Sciences for Health – Haiti

27, Frères 31, route de Frères, Delmas 105

En face rue La Pépinière

Pétion-Ville, Haiti

Téléphone: 509.2510.9901 @ 9902

Website: www.msh.org

mshhaiti@mshhaiti.org

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Contents

ACRONYMS	4
INTRODUCTION	6
SUMMARY OF FINDINGS AND DISCUSSIONS	6
I. SDSH SUPPORT TO THE PUBLIC SECTOR	10
IA. REINFORCEMENT OF MSPP EXECUTIVE FUNCTIONS	10
IB. SUPPORT FOR DECENTRALIZED SERVICES	11
II. SDSH SUPPORT FOR SERVICE DELIVERY	13
IIA. HIV/AIDS	13
PRINCIPAL ACCOMPLISHMENTS AND RESULTS	13
HIV VOLUNTARY COUNSELING AND TESTING	13
TUBERCULOSIS AND HIV CO-INFECTION	13
HIV PALLIATIVE CARE AND SUPPORT	14
PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV	15
ANTIRETROVIRAL THERAPY/ANTIRETROVIRALS	16
HIV—IMPLEMENTATION CHALLENGES AND SOLUTIONS	16
IIB. MATERNAL HEALTH	18
PRINCIPAL ACCOMPLISHMENTS AND RESULTS	18
MATERNAL HEALTH—IMPLEMENTATION CHALLENGES AND SOLUTIONS	19
IIC. REPRODUCTIVE HEALTH—FAMILY PLANNING AND SEXUALLY TRANSMITTED INFECTIONS	21
PRINCIPAL ACCOMPLISHMENTS AND RESULTS	21
REPRODUCTIVE HEALTH—IMPLEMENTATION CHALLENGES AND SOLUTIONS	22
IID. CHILD HEALTH	23
PRINCIPAL ACCOMPLISHMENTS AND RESULTS	23
CHILD HEALTH—IMPLEMENTATION CHALLENGES AND SOLUTIONS	24
III. OTHER DOMAINS	26
SDSH COMMUNICATION AND PUBLIC RELATIONS	26
SDSH PROJECT MANAGEMENT	27
FINANCE AND SYSTEMS STRENGTHENING	28
CONTRACTS AND ADMINISTRATION	28
INFRASTRUCTURE RENOVATION WORK	28
ANNEX ONE: SDSH PARTNERS	30
ANNEX TWO: SDSH HIV SITES	31
ANNEX THREE: SDSH SEMI-ANNUAL RESULTS FOR PERIOD ENDING MARCH 31, 2011	33

Acronyms	
AIDS	acquired immunodeficiency syndrome
ARI	acute respiratory infection
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
BCC/CM	behavior change communication/community mobilization
CA	Contracts and Administration
CBD	community-based distribution
CBO	community-based organization
CBP	<i>Centre de Bienfaisance de Pignon</i>
CDS	<i>Centre pour le Développement de la Santé</i>
cf.	compare, refer to
CONASIS	<i>Comité national du système d'information sanitaire</i>
CS	<i>centre de santé</i> (health center)
CTD	<i>Conseiller Technique Départemental</i> (Departmental Technical Advisor)
CY	calendar year
CYP	couple years of protection
DOTS	directly observed treatment, short course
DRI	Development Relief International
DTP3	diphtheria, tetanus, pertussis (vaccine)
EOC	emergency obstetric care
FBO	faith-based organization
FONDEFH	<i>Fondation pour le Développement de la Famille Haïtienne</i>
FP	family planning
GUC	Grants under Contract
HIS	health information system
HIV	human immunodeficiency virus
IUD	intrauterine device
IV	Intravenous
JHU/CCP	Johns Hopkins University Center for Communications Programs
LMS	Leadership, Management and Sustainability (Program)
LT or L-T	long-term
MEBSH	<i>Mission Baptiste du Sud d'Haïti</i>
MESI	monitoring, evaluation and surveillance interface
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)
OI	opportunistic infection
ORS	oral rehydration salts
ORT	oral rehydration therapy
OVC	orphans and vulnerable children
PBF	performance-based financing
PCR	polymerase chain reaction (test)
PLHIV	persons living with HIV
PMTCT	prevention of mother-to-child transmission
PWW	Pure Water for the World
RH	reproductive health
SADA	Service and Development Agency
SBA	skilled birth attendant
SCMS	Supply Chain Management System (PEPFAR USAID administered project)
SDSH	<i>Santé pour le Développement et la Stabilité d'Haïti</i>
SONUB	<i>soins obstétricaux d'urgence de base</i> (basic emergency obstetric services)
SONUC	<i>soins obstétricaux d'urgence complets</i> (complete emergency obstetric services)
STI	sexually transmitted infection
TB	Tuberculosis
TBA	traditional birth attendant
TT	tetanus toxoid
USAID	United States Agency for International Development
USD	United States dollar
USG	US Government
VCT	voluntary counseling and testing (for HIV)
vs.	Versus
VSC	voluntary surgical contraception
WHO	World Health Organization
WINNER	The Watershed Initiative for National Natural Environmental Resources (Project)
ZC	<i>zone ciblée</i>

SDSH SEMI-ANNUAL REPORT — OCTOBER 2010–MARCH 2011

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.

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, HIV and 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 78 health facilities and through 79 MSPP public sector sites in 31 geographical areas known as *zones ciblées* (ZC). 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 and AIDS (PLWHA) and tuberculosis. SDSH currently covers 42 percent of the Haitian population, or 4,254,166 people.

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.

Summary of Findings and Discussions

The majority of SDSH activities are on track after several months of disruption due to the catastrophic January 2010 earthquake in year three of the project. Overall, project achievements declined between project years two and three due to this external factor and its lingering effects. And, while the project is not yet seeing the level of results realized in the pre-earthquake period, progress was made during the first six months of project year four despite new and unexpected challenges. While the reconstruction and healing are far from complete, there is an overwhelming sense on the part of our partners of renewed purpose and the desire to move forward and do better.

We had barely recovered from the effects of the earthquake when we were faced with an unprecedented cholera epidemic in October 2010. Since this was the first time cholera appeared in Haiti, the health system was not prepared for it. Health sector partners joined forces with the MSPP to contain the deadly epidemic that killed at least 3,600 people and incapacitated over 150,000 by January 1, 2011.

The project tracks results for seven groups of indicators: HIV/AIDS, tuberculosis, maternal health, child health, family planning/reproductive health, MSPP executive functions, and other (includes various contextual and project support indicators). SDSH exceeded or met targets for the majority of indicators in all groups with the exception of tuberculosis 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.

Success Highlights

For **HIV and AIDS**, SDSH surpassed 14 of its targets including, most notably, the “people” targets: the number of people benefitting from voluntary testing and counseling (VCT); people, including pregnant women, tested for HIV and getting their results; people receiving antiretrovirals; HIV-positive people receiving palliative care, including those co-infected with TB/HIV; and providers trained in prevention of mother-to-child transmission of HIV (PMTCT) according to international norms. SDSH also exceeded the target for the percent of **tuberculosis** patients tested for HIV and receiving their test results.

In the area of **child health**, SDSH met two and exceeded targets for seven indicators, notably the number of infants completely vaccinated, children receiving a first dose of vitamin A, infant pneumonia cases treated with antibiotics, children reached by nutrition programs, and numbers of mothers and caretakers trained in diarrhea prevention and management.

Eight **family planning** (FP) targets were surpassed, including the percent of users using long-term methods, the percent of sites offering at least five FP methods with at least two long-term methods, the percent of people of reproductive age using a modern FP method, and the number of new FP users. Results for **antenatal and postnatal** activities were positive, with the project meeting its target for the percent of new mothers benefitting from a postnatal consultation within 42 days of delivery, and exceeding targets for the number of postnatal home visits within 72 hours of delivery and the percent of pregnant women having their first prenatal visits during the first trimester of their pregnancies.

SDSH met two and exceeded four targets for **public sector systems strengthening** activities related to the number of SDSH zones ciblées (ZCs): ZCs funded with performance-based financing, ZCs with the new financial and accounting management system set up and in use, ZCs benefiting from the basic package of services supported by SDSH, and ZCs with a functioning information system for services.

Of the indicators for which we did not fully meet our targets, about one-third of them 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-month delay in concluding a subcontract with JHPIEGO left a technical assistance void that is reflected by the subpar results for the maternal health component of the project, for family planning couple years of protection (CYP), and for cases of sexually transmitted infections detected and treated. Integrating HIV and tuberculosis services continues to be a challenge, due in part to the historically vertical nature of these programs. Achievement of two child health indicators was compromised by a broken supply chain and lack of initiative on the part of health sector authorities and implementing partners in the field.

An SDSH staff retreat was 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, reaffirmed 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. Even before the retreat, we had taken steps to remedy one of our most critical weaknesses—the large number of vacant posts (about 20) in the project.

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. The Chief of Party (COP) resigned and left the project in January 2011. A new COP was selected and will join the team in early May 2011. A senior project management consultant was brought in to assist in a variety of tasks. 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.

In total, 16 new personnel were recruited during the past six months; 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 performance monitoring plan. Particular attention will be paid to those interventions where our performance has recently been below par.

For HIV and AIDS, that means we will focus heavily on improving PMTCT services for mothers and babies. Heightened attention will also be paid to TB/HIV co-infection and to working with the MSPP to develop effective strategies for providing integrated TB and HIV services. We will also work closely with the third parties responsible for HIV and TB training to ensure that sessions are scheduled and implemented in a timely manner.

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., drugs, trainings, 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.

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 impacted negatively on our maternal health results this semester. We are working on strategies to address other factors that compromise our work with traditional birth attendants (TBAs), and 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, and the need for continued community sensitization efforts.

In regard to child health interventions, some of our partners reported stock-outs of the DTP 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.

SDSH came close to achieving the semester target for family planning CYP. During the final year of the project, we are intensifying our community mobilization efforts to inform people about long-term methods. Now that JHPIEGO has rejoined SDSH and added three experienced RH experts to the team, we are better able to address critical training needs to increase the number of providers trained to dispense long-term FP methods. It was a challenge to address all the needs of the ambitious RH component with only one RH expert on staff.

Progress has been made through collaborative efforts with the MSPP and key health sector partners in the design of a national health information system (HIS). 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 underway in the fall of 2011, 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 semester, we will be able to provide the support needed to ensure that all health departments elaborate and implement a supervision plan for service delivery.

The estimated percent of the population covered by the project was about 42 percent at the end of March. 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 (157) exceeds the number in 2008 (148).

I. SDSH Support to the Public Sector

IA. Reinforcement of MSPP Executive Functions

MSPP EXECUTIVE FUNCTIONS	
Met- 2	# health depts with donor coordination mechanism (6)
	% depts implementing approved operational plan (100%)
Exceeded- 4 	# ZCs funded with PBF (18)
	# depts with new financial & accounting mgmt system set up & in use (7)
	# ZCs benefitting from basic package of services supported by SDSH (33)
	# communes with ZCs where info system for services is set up & in use (33)
Under – 2	# depts implementing supervision plan for service delivery (4, or 80% of 6-month target)
	# depts supported to operationalize the national HIS (0, for annual target of 6)

SDSH met two and exceeded four of the indicators tracked for this component of the project, and was below the mark for two indicators. We met both the annual target of 6 for the number of health departments with a donor coordination mechanism, and the annual target (100%) for the percentage of departments that implement approved operational plans. We exceeded the number of public sector sites operating under performance-based financing (9 realized, cf. 6-month target of 8) and surpassed the life-of-project target (31) for the number of public sector sites that offer the SDSH-supported minimum package of basic health services (33 realized to date).

Information systems have been set up and are being used at public sector sites in 33 communes (all ZCs) (cf. end-of-project target, 31). And, 7 departments have a new financial and accounting management system, or 2 more than anticipated. By the end of the year, all 10 departments should be using the new system. Four out of an expected 5 departments implemented a supervision plan to monitor service delivery in their respective areas. This was achieved in the North, North-East, West, and South-East. With the recent addition of six new departmental technical advisors to our staff (discussed below), we are optimistic that that the remaining 6 departments will elaborate and implement their supervision plans by the end of the year.

Much 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 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. Barring any unforeseen events, we believe that the launch of the new HIS will take place this fall.

MSH headquarters commissioned an external evaluation of the impact of the performance-based financing 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 field work in Haiti in February and March of 2011. They obtained data from 15 SDSH PBF sites and 202 control (non-SDSH) MSPP sites. Preliminary findings (discussed by teleconference with the SDSH in-country team in

April 2011) are very encouraging. The final report is anticipated for June 2011 and the conclusions and recommendations will be included in our next semi-annual report.

Six *conseillers technique départemental* or departmental technical advisors) (CTDs) were hired to fill vacant posts at departmental health directorates in the Grande Anse, North-West, Artibonite, West, South, and South-East departments. The CTDs are liaisons between SDSH implementing partners and department-level MSPP health authorities and 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.

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. 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. Eight organizations were awarded umbrella grants. Six of the eight umbrella CBOs received a grant for their own organizations in addition to funds for sub-grants for 35 smaller community groups and associations. The umbrella organizations, with assistance from SDSH, will establish participative mechanisms to verify and ensure that CBO grantees are well supervised and strengthened, that financial management of funds is adequate, that a Communal Health Council is established in each commune, and that interventions are implemented according to defined action plans. The largest number of sub-grants managed by an umbrella organization is 10, and the smallest number is 3. The cost of this initial investment was approximately \$232,000.

During the next quarter, SDSH will review and analyze projects submitted by CBOs in the other five departments. In the coming months, GUC activity will be extended to an additional 12 communes and 24 umbrella organizations.

Grants under Contracts—Umbrella Organizations

Grande Anse:

*Organisation Paysan Abricots et Bonbon (OPAB) and
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) and
Organisation des Travailleurs pour le Développement
de l'Anse à Foleur (OTRA)*

South:

*Jeunesse en Marche pour l'Avenir (JMA) and
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, 11 April 2011.

II. SDSH Support for Service Delivery

IIA. HIV/AIDS

Principal Accomplishments and Results

HIV/AIDS INDICATORS	
Met – 1	# ARV sites (6)
	Exceeded – 14
	# sites offering PMTCT services according to national and international norms (22)
	# pregnant women doing VCT & getting results of tests (25,146)
	# providers trained in PMTCT according to international norms (18)
	# sites offering VCT services according to norms (33)
	# people getting VCT & receiving results of test (43,952)
	# people receiving ARV at end of reporting period (2,712)
	# sites offering TB treatment for HIV+ patients (13)
	# HIV+ people receiving palliative care, including TB/HIV (15,656)
	# labs able to perform HIV tests (33)
	# lab tests (HIV, TB, syphilis) done by labs supported by project (135,479)
	Total # people who ever received ARVs by end of reporting period (3,959)
	% individuals put on ARVs and still active at end of reporting period (69%)
	# sites offering complete package of palliative care to HIV+ persons (19)
# individuals trained in lab services (20)	
Under – 7	
# people newly on ARVs (341, or 97% of 6-month target)	
# infants born to HIV+ mothers receiving care & treatment (185, or 93% of 6-month target)	
# HIV+ pregnant women on prophylaxis (278, or 86% of 6-month target)	
# HIV+ persons treated for both HIV & TB (74, or 21% of 6-month target)	
# of providers trained in palliative care, including TB & HIV (0 for annual target of 20)	
# people trained in VCT (0 for annual target of 40)	
# health workers trained in ART (0 for annual target of 10)	

HIV Voluntary Counseling and Testing

VCT services are provided at 33 sites, one more site than the end-of-project target of 32. SDSH is on target for the number of individuals counseled and tested for HIV and having received their test results. The annual objective is to serve 85,000 people, and by the end of March 2011, the project had surpassed the halfway mark with 43,952 people tested (14,521 men and 29,431 women). All VCT sites have a laboratory technician trained in stock management and in the performance of HIV rapid tests. SDSH collaborated with the MSH Supply Chain Management System (SCMS) Project to obtain training in management of lab supplies and medicines for 20 laboratory technicians and stock managers, double our annual target for 2011. In collaboration with the head of training for the Government of Haiti (GOH) National Laboratory, planning is underway for the training of 86 lab technicians and bacilloscopists from 43 SDSH facilities in HIV rapid testing using capillary blood. See the table in Annex Two for a list of all SDSH HIV sites.

Tuberculosis and HIV Co-infection

Upon completion of the lab training mentioned above, AmeriCares, a disaster relief and humanitarian aid organization, will provide 30 microscopes to the SDSH partners whose staff are trained. (Nine partners whose technicians attended earlier trainings have already received microscopes.) AmeriCares' generous gift includes additional support for training in the use and maintenance of the donated equipment.

By the end of the six-month reporting period, the project had tested 47 percent of registered TB patients for HIV, greatly surpassing the six-month objective of 20 percent. With the additional trained lab personnel, we should be able to further increase the number of TB patients tested for HIV in the months ahead. At present, 24 sites perform TB counseling, testing, and treatment (CTT). Throughout the SDSH network, an additional 102 individuals (lab technicians, nurse-counselors, PMTCT managers previously trained in HIV rapid tests) will receive supplementary training next quarter in rapid HIV testing using capillary blood.

TUBERCULOSIS INDICATORS	
Exceeded – 1	% TB patients tested for HIV and received their test results (47%)
Under – 4	# TB patients tested for HIV & received test results (denominator is estimated incidence) (644, or 74% of 6-month target)
	# people trained in DOTS (0, for annual target of 10)
	# sites offering integrated TB services (TB/HIV) (0 for annual target of 20)
	# persons trained for TB and HIV testing (0, for annual target of 20)
Data Collected Annually – 4	TB notification rate
	% labs doing TB microscope analysis with > 95% correct results
	% expected new TB cases detected
	TB detection rate



One objective that we have not yet met concerns the training of providers in DOTS (directly observed treatment, short course), a strategy used worldwide to reduce the spread of drug-resistant TB by ensuring that patients adhere to their treatment regimen.

Our six-month objective was to have at least five persons from the SDSH network trained in DOTS. The training is organized periodically by the MSPP, and the plan is to include SDSH partners' staff in upcoming training events.

HIV Palliative Care and Support

This semester, we provided palliative care and support (PCS) to double the number of persons expected for the semester (15,656 people, cf. 6-month target 7,500) and are encouraged by this achievement. We've also exceeded our target for the number of sites providing HIV-related palliative care including TB/HIV (19 in six months, cf. 24 annual target). 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 local health task forces to sensitize communities to the need to reduce stigma and discrimination associated with HIV. Psychosocial services to HIV-positive individuals are organized through support groups at both zones ciblées and NGO sites. And, social workers, health agents, and trained people living with HIV (PLHIV) make home visits to clients.

During the next semester, SDSH plans to conduct an internal assessment of the project's PCS interventions in order to inform future planning for the SDSH network. We will focus in particular on the results and lessons learned from the family-centered palliative support activities that were piloted by four partners: Comité de Bienfaisance de Pignon (CBP) in the North, Grace Children's Hospital and SADA in the West, and MEBSH Finca in the South. These partners use a family-centered, holistic approach to address the needs of persons living with HIV and AIDS, including orphans and vulnerable children (OVC). Ultimately, SDSH aims to establish services around all SDSH-supported VCT sites, with each participating NGO or ZC partner encouraged to develop and test a package of services (e.g., psychosocial, supplemental food, tutoring and provision of school supplies for OVC, etc.) according to the needs of their respective communities.

Preventing Mother-to-Child Transmission of HIV

SDSH data show that the project exceeded three of its five PMTCT targets and came close to meeting the remaining two targets. SDSH has already surpassed the annual target (19) for the number of service outlets providing the minimum package of PMTCT services, with 22 sites fully functioning by the end of March 2011. In addition to these 22 sites, 5 other sites test pregnant women but are not yet equipped to provide care and treatment for HIV-positive women, and 2 sites have not yet begun their PMTCT programs. However, plans are afoot to ensure that all PMTCT-designated sites (31) are fully functional by the end of the next semi-annual period.

Network PMTCT partners have recently recruited a total of 21 nurses who will be trained in PMTCT with assistance from JHPIEGO; they will be deployed to sites that currently lack providers trained in PMTCT. Furthermore, in collaboration with Direct Relief International (DRI), we are planning to transform eight sites into PMTCT centers of excellence (discussed more fully in the Maternal Health section that follows). DRI is an international NGO that provides medical assistance to improve the quality of life for people victimized by poverty, disaster, and civil unrest and is one of several organizations that provide support to SDSH sites thanks to the advocacy efforts of the SDSH strategic partnership advisor.



A total of 25,146 pregnant women received HIV counseling and testing for PMTCT and received their test results, exceeding the six-month target by 26 percent (25,146 tested in six months, cf. 20,000 six-month target). Pediatric care was provided to 93 percent of the HIV-positive babies born to HIV-positive mothers, while 86 percent of HIV-positive pregnant women received ARVs to reduce vertical transmission. Care and treatment for newborns remains a challenge throughout the network, including at the six SDSH ARV sites. There are not enough trained personnel to provide services. The situation is especially critical at the health center level.

Taking into account feedback from the field, SDSH recently revised its strategy for ensuring continuity of treatment for HIV-positive pregnant women and proposed to provide direct support to pregnant women and the institutions where they choose to give birth. Moreover, women who elect to give birth at home, instead of in a health facility, will be encouraged to give birth with a skilled TBA. The TBA will receive modest compensation (less than USD\$10) to offset logistics costs involved in liaising with a reference institution, monitoring the pregnancy using a birth plan, and following protocols for safe delivery and care of the neonate. Because about 77 percent of Haitian women still give birth at home, working with trained TBAs is part of the MSPP's short-term strategy to improve pregnancy and delivery outcomes. The long-term strategy is to strengthen and expand institution-based services.

At the community level, 445 TBAs attended monthly sensitization meetings held by SDSH partner institutions. Topics covered included the importance of retesting for HIV-positive pregnant women and prophylaxis for HIV-positive women during the first 72 hours following delivery to avert vertical transmission to their infants. The TBAs also received training in family planning and care of the newborn.

SDSH worked (and continues to work) with the MSPP to prepare for the dissemination of the new national PMTCT norms, which are currently being printed. SDSH partners and staff were sensitized to the new standards.

Antiretroviral Therapy/Antiretrovirals

Polymerase chain reaction (PCR) tests are available at the six antiretroviral (ARV) sites as well as at six other sites (see the table in Annex Two). The six ARV sites function fairly well, but there is room for improvement. Despite ever-present challenges and constraints, SDSH exceeded three of six targets related to antiretroviral therapy (ART), met one target, and came close to achieving another. However, we did not achieve our ART training objective this semester.

SDSH exceeded objectives for (1) number of individuals who ever received ART (3,959 in six months, cf. 4,234 annual target), (2) the number of persons receiving ART by end of the reporting period (2,712 in six months, cf. 3,175 annual target), and (3) the percentage of individuals on ARVs still active at the end of the reporting period (69% in six months, cf. 80% annual target). We were on target for the number of service outlets providing ART per national and international standards (six out of six) and only slightly below target for the number of people newly initiating ART (341 achieved in six months, cf. 350 six-month objective).

HIV—Implementation Challenges and Solutions

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 in Haiti for HIV, 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.

Trained personnel for PMTCT interventions were in short supply before the January 2010 earthquake, and the situation has worsened since the quake. Many of the nurses and midwives who had been trained in

PMTCT by SDSH have either left the country or have been hired away by other NGOs who offer more attractive remuneration packages. This has become very problematic for SDSH partners that do not have the budgets to compete with the higher-paying organizations. Furthermore, PMTCT services, especially at the health center level, are limited due to the shortage of pediatricians or trained pediatric nurses in the country to provide guidance and oversight. When the new PMTCT norms and protocols go into effect, additional logistical challenges should be anticipated, including the need to fund the more costly regimens, and to retrain existing staff.

For project year four, our objective is to test 40,000 pregnant women, which equates to testing about 33 percent of all pregnant women in the SDSH catchment areas (denominator is 118,787 pregnancies, CY2010). We are constantly looking for ways to maximize the limited resources that we have so as to cover a greater number of women. While we have already greatly exceeded the project goal for raising matching funds for the project, we will continue to advocate for contributions and in-kind support from interested private sector parties.

During the reporting period, SDSH HIV experts collaborated with the SDSH engineer and contracts staff in the preparation of bid documents for the evaluation of physical infrastructure at all 37 SDSH HIV sites. The bids will be launched in May and a contractor (or contractors) selected to commence renovation works at these sites this summer.

There has been a noticeable improvement in partners' reporting on HIV activities since January 2011 due to the rigorous monitoring and increased exchanges that SDSH technical advisors have had with the partners. Technical advisors conduct regular site visits to SDSH HIV sites to monitor activity implementation and provide on-the-spot technical assistance. Over the next few months, we will focus on improving reporting from certain sites. We will work closer with MSH/SCMS and MSH Leadership, Management and Sustainability (LMS) colleagues to coordinate logistics support, including training, for the SDSH HIV sites.

Other activities planned for next quarter include: implementation of MSPP's new HIV strategies for VCT (proactive VCT with opt-out, rapid tests using capillary blood) and ART (tri-therapy); provider training in HIV rapid tests and new VCT and ART protocols; heightened attention to resolving critical supply chain issues (medicines, lab supplies, equipment); intensification of efforts to provide HIV testing to a greater number of TB patients; integration of HIV and syphilis screening and treatment and FP (focus on immediate postpartum FP) into PMTCT services; strengthen all existing PMTCT sites and transform eight of them into centers of excellence.

IIB. Maternal Health

Principal Accomplishments and Results

MATERNAL HEALTH	
Met – 1	% of new mothers benefitting from postnatal consultation w/in 42 days (18%)
Exceeded – 2	# of follow-up postnatal home visits within 72 hours of delivery (25,050)
	% of pregnant women doing 1st prenatal visit in 1st trimester (37%)
Under – 9 	# births with trained health worker (not including TBA) (5,717, or 95% of 6-month target)
	# births with trained TBA (25,778 or 94% of 6-month target)
	# prenatal visits by qualified personnel (114,102, or 93% of 6-month target)
	% pregnant women with birth plan (36%, 6-month target is 40%)
	% pregnant women with 2nd dose TT (36%, 6-month target is 37.5%)
	% pregnant women with 3 prenatal visits (18%, 6-month target is 25%)
	# mothers and caretakers received nutrition counseling (5,886, or 21% of 6-month target)
	% sites with maternal mortality committee (15%, 6-month target is 17.5%)
	# people trained in maternal & neonatal health (0, for annual target of 100)

SDSH logged in 25,050 postpartum/newborn visits within three days of delivery, surpassing the six-month benchmark of 22,500 (45,000 annual target). The 37 percent annual target for percentage of pregnant women making their first prenatal visit in the first trimester of pregnancy was achieved in fewer than six months. The percentage of sites with at least one maternal mortality surveillance committee in its service area is 15 percent (six-month target is 17.5%). However, the percentage of pregnant women effecting three prenatal visits was 18 percent, or 7 percent under the 25 percent (six-month target) expected.

An SDSH analysis of service statistics from the different regions revealed that 7 out of Haiti's 10 health departments had met the target for three prenatal visits per pregnant women. This was not the case in the Artibonite, Nippes, and the North departments, all of which have experienced a high turnover of trained staff during the past year. As a result, prenatal activities in the Nippes practically came to a halt, while in the Artibonite the suspension of community-based maternal health activities impacted services negatively. The North, too, had difficulties providing coverage due to staff shortages. While replacement personnel have been recruited, they have not yet benefited from SDSH-sponsored maternal health training. This is a top priority for SDSH during the next several months.

The percentage of pregnant women having received a second dose or booster of anti-tetanus (TT) vaccine was 36 percent, or 1.5 percent under the six-month target of 37.5 percent (75% annual). Site visits by SDSH technical staff noted possible underreporting of TT vaccinations done at outreach-rally posts. In some instances, this data was not always transmitted to and recorded by the fixed-site reference facilities.

We fell short in achieving the objective related to the percentage of pregnant women with a birth plan (36% realized vs. the 40% six-month target). Site visits by SDSH technical advisors revealed stock-outs of the birth plan form. SDSH headquarters remedied this by printing 46,000 birth plan forms that will be dispatched to the departments in April. The SDSH technical team is currently discussing the possibility of delegating this responsibility, and the required budget, to the departmental health offices where this could be more readily monitored by the SDSH technical advisor and finance manager.

The number of deliveries (5,717) with a skilled provider was nearly on target (6,000 six-month target), while the number of deliveries (25,778) with trained traditional birth attendants was lower than expected (27,500 six-month target), which indicates that many women continue to deliver at home without the assistance of a trained attendant. Results regarding postnatal care are on target, with 18 percent of women benefitting from a postnatal consultation within 42 days of giving birth (17.5% six-month benchmark). For the short term, SDSH aims to discourage home deliveries by untrained attendants and encourage women, who prefer to deliver at home, to use a skilled TBA. Our long-term objective is to reduce the number of deliveries by TBAs (skilled or not), while augmenting the number of deliveries performed by skilled providers.

Maternal Health—Implementation Challenges and Solutions

To encourage pregnant women to make at least three prenatal visits during pregnancy, SDSH has intensified community mobilization efforts and monthly meetings and exchanges between communities and health facility staff. Four technical posters (*fiches techniques*) were designed and distributed to SDSH partner institutions for posting on the wall as a handy update on the signs, symptoms, and actions to be taken for four different pregnancy-related complications: eclampsia, pre-eclampsia, hemorrhagic shock, and infection.

Within our budget limitations, we plan to provide equipment and materials to support mobile clinics and see what can be done to address some of the human resources shortages that continue to impact negatively on services (e.g., assist partners with organizational issues, rotate staff to work the mobile clinics, joint efforts with other health sector actors, identify new motivation initiatives, etc.).

To build momentum for TT vaccination, we will monitor the availability of vaccine stocks and patient records, and control for the completeness and timeliness of service reports. We are looking for a more sustainable solution to stock-outs of the birth plan forms and would like to see the departments take full responsibility for ensuring the availability not only of the birth plans but also of other necessary health forms and supplies. We are looking for opportunities to train as many health agents as possible in the use of the birth plan.

With leveraged support from Direct Relief International, SDSH is helping eight partner institutions to provide basic emergency obstetric care (EOC) at rural sites (a program referred to as SONUB) and complete emergency obstetric care (SONUC) at urban institutions. These are the same sites that will become centers of excellence for PMTCT services. They include: Centre de Sante (CS) de la Tortue and BERACA Hospital in the North-West, CS Ile a Vache in the South, AEADMA in Grande Anse, CBP in the North, Claire Heureuse Hospital in Artibonite, CDS CS Ouanaminthe in the North-East, and CS Petit Trou in Nippes. DRI will provide the needed material and equipment (final list to be drawn up in April by SDSH) and SDSH will work with partners and MSPP to update the EOC protocol for care. Also during the next quarter, SDSH plans to review the successful strategies and approaches used by the Haitian Health Foundation to improve maternal health outcomes in the Grande Anse and assess their potential for replication at other SDSH sites.

The critical personnel issue discussed in our last semi-annual report was resolved at the end of 2010 with the negotiation of a subcontract with JHPIEGO. There was an unfortunate gap of several months during which oversight for maternal health activities was not optimal. In addition, SDSH lost many of its trained field-level service providers during this period to other donor programs that offered better remuneration packages.

The new team of SDSH maternal health experts includes three obstetricians-gynecologists (one full-time, one at 75% time, one at 15% time), and a part-time (50%) senior paramedical (nurse) with extensive experience in working with community health workers and TBAs. The addition of the JHPIEGO maternal health team in early 2011 has reinvigorated SDSH efforts to address the many maternal and reproductive health challenges

in Haiti. We expect to see training targets reached in the coming months as the team intensifies efforts to catch up.



The project exceeded the target for number of women effecting their first antenatal visit during the first trimester of pregnancy.

IIC. Reproductive Health—Family Planning and Sexually Transmitted Infections

Principal Accomplishments and Results

The annual target (14%) for proportion of total modern contraception prevalence for long-term methods was nearly achieved this semester as the SDSH network achieved 11 percent prevalence. Likewise, the network nearly doubled its six-month target (15%) and logged in a 28 percent rate for the percentage of people in the reproductive age group using a modern FP method. We also exceeded the six-month benchmark (85,000) and logged 91,044 new FP users. SDSH fell short of meeting the 135,000 CYP six-month target, realizing 127,556 CYP, or 94 percent of the objective. We are confident that with the gradual but steady increase in use of long-term FP methods in Haiti, we will meet our end-of-project CYP target.

FAMILY PLANNING/REPRODUCTIVE HEALTH	
	Exceeded – 8
	# people trained in FP/RH (44)
	# service sites offering FP counseling & services (LT & permanent methods) (151)
	# sites with strengthened MIS (150)
	% of FP users using LT modern method (11%)
	% sites offering at least 5 FP methods with at least 2 LT (52%)
	% people of RH age using modern FP method (28%)
	% of Depo users who get next injection on schedule (92%)
# of new FP users (91,044)	
Under – 3	# CYP (127,556, or 94% of six-month target)
	# of new cases of STIs detected & treated (16,092, or 80% of 6-month target)
	# staff trained in LT FP methods (3, for six-month target of 13)
No Target – 1	# guides/manuals elaborated/ revised to improve access/use of FP/RH services (to be considered on an as-needed basis)

The annual target for the number of sites having an improved management information system has been met (147). SDSH greatly exceeded training objectives for FP service providers (44 trained vs. 25 planned). Plans were made and materials adapted for 750 agriculture extension workers (includes 30 trainers) who were trained in FP methods in collaboration with another USAID project, WINNER, in the West department. The workers provide FP information and distribute condoms within their communities. SDSH community-based distribution efforts were further strengthened by the training of 35 health agents who work for MEDISHARE in the Centre department. These agents, too, provide FP information and FP methods (condom, pill, injectables) within their respective communities.

SDSH now has 151 functioning service delivery points providing FP counseling or services, 9 more sites than anticipated by the end of the project in 2012. The annual target (55%) for percentage of service outlets offering at least five FP methods (including two long-term methods) was nearly met during this six-month period, with 52 percent of the sites achieving this objective.

While the majority of FP results were positive this semester, this was not the case for detection and treatment of sexually transmitted infections (STIs), as our accomplishments in this area fell short of expectations. The objective for the period was 20,000 new STI cases detected and treated, and we realized 16,092 or 80 percent of the target. A major reason for the shortfall is the lack of trained providers to do the work. As mentioned earlier, the SDSH network has lost dozens of trained providers over the past year to other donor programs that offered higher remuneration.

Reproductive Health—Implementation Challenges and Solutions

SDSH will continue to focus on promotion and provision of long-term FP methods, working more closely with department nurses in charge of FP to better coordinate activities within the departments. We have been discussing the possibility of elaborating departmental plans to reinforce FP in collaboration with MSH/LMS colleagues and departmental health authorities. We will continue to assist the central-level MSPP to elaborate a national plan to promote long-term FP methods.

Discussions are underway concerning the dissemination of the MSPP updated FP norms, and SDSH is ready to assist the MSPP, along with other health sector partners, with this task. We will continue to train providers in intrauterine device (IUD) and implant insertion and strengthen the supervision of staff to ensure that official norms are followed. Since the most practical way to serve communities in hard-to-reach areas is through mobile clinics and community-based distribution activities, we will continue to support these strategies, expand their use, and look for synergies with other projects and partners to make our funding stretch even further. In March 2011, we conducted an inventory of voluntary surgical contraception (VSC) needs (kits and expendable supplies for minilaparotomy and vasectomy) and UNFPA has indicated its willingness to procure the equipment and materials. The imminent availability of these items will contribute to future increases in CYP.

In line with the MSPP FP priorities, SDSH will strengthen efforts to promote the introduction of postpartum FP (IUDs) at the institution and community levels. We will also promote and support the integration of FP into departmental hospital maternity services. During the next few months, we will provide support to the MSPP for a workshop to develop national behavior change communication and community mobilization (BCC/CM) strategies to promote FP, particularly long-term methods.

As in the other technical areas, reaching our maternal health and family planning training targets has been elusive. So far, only a few people have been formally trained in maternal and newborn health. SDSH has limited funds available for training activities and often depends on other parties to organize and schedule training. In the case of training in long-term FP methods, delays were due to the eight-month hiatus in renewing our subcontract with our principal RH/FP technical assistance partner, JHPIEGO.

In theory, including staff from various organizations in training sessions is a very enriching experience for participants. However, it has proven to be a challenge for the organizing agencies to effectively coordinate the many different parties and identify dates and times that are convenient for all concerned. Moreover, it has been a challenge for us to get department authorities to elaborate and submit detailed training plans to SDSH despite our best efforts to date at follow-up. Even when plans are submitted, the high turnover of staff renders them obsolete before they can be implemented. We expect the situation to improve with oversight and follow-up from the new SDSH departmental technical advisors.

To improve maternal health outcomes, SDSH will intensify efforts to revitalize nonfunctioning community maternal mortality committees. SDSH began inventorying partner institutions to ascertain the number of existing maternal mortality committees. MEBSH in the South works with 3 committees, the Haitian Health Foundation in the Grande Anse works with 40, and SADA in the West has just started working with 4 committees. During the next quarter, SDSH will work with partners to update an operational guide for the committees and, on the technical level, will focus on efforts to promote the use of a birth plan by all pregnant women.

And finally, we realize there continues to be an urgent need to improve the quality of RH services throughout the SDSH network. We will intensify our efforts to identify and implement “quick fixes” that require minimal financial input but can make a big difference in the quality of services offered: designating and organizing space to allow for privacy in FP counseling, reducing the waiting time for services, and encouraging the demedicalisation of services. One of our top priorities through the end of the project is to reinforce our quality improvement efforts and interventions so that quality assurance becomes an integral part of service delivery within the SDSH network.

IID. Child Health

Principal Accomplishments and Results

CHILD HEALTH	
Met – 2	% infants 0–11 mos completely vaccinated (43%)
	% children weighings <5 yrs at risk of malnutrition (9%)
 Exceeded – 7	# children reached by nutrition program (327,272)
	# children <5 yrs received vitamin A (249,317)
	# infant pneumonia cases treated with antibiotics (8,032)
	# mothers & caretakers trained in diarrhea prevention (26,729)
	# mothers & caretakers trained in diarrhea management (26,729)
	% children weighings <5 yrs with low or very low weight for age (11%)
	% children weighings <5 yrs with severe malnutrition (2%)
Under – 3	# children 0–11 with DTP3 (57,684 or 98% of 6-month target)
	# children received 2 doses of vitamin A (54,523, or 42% of 6-month target)
	# people trained in child healthcare and nutrition (24, or 16% of 6-month target)

SDSH aims to improve basic child health services that include immunization, diarrheal disease control, acute respiratory infections (ARI), and nutrition education and surveillance, including administration of vitamin A. And, with the outbreak of cholera in October 2010, we had to suddenly turn our attention and concerted efforts to cholera prevention and treatment. We quickly designed and implemented supplementary diarrheal disease control activities to address cholera.

SDSH met the objective for the semester with 43 percent of children less than one year of age fully immunized (six-month target was 42.5%). However, the number of infants 0–11 months of age who received DTP3 was slightly under the mark (57,584 realized, cf. semester target 59,000). The number of children reached by nutrition programs (327,272) greatly exceeded the semester target (225,000 six-month target). The percent of children under five years of age weighed and showing evidence of severe acute malnutrition was 2 percent (better than the 3% benchmark) while the percent of children under five at risk of malnutrition remained steady at 9 percent (target).

For diarrheal disease prevention and control, we surpassed the training target for the number of mothers and other caretakers of children (26,729 sensitized, or 89% of the annual target). 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. The project also surpassed its objective for acute respiratory infections (ARI) as service statistics show that 8,032 children were treated with appropriate antibiotics, meeting 80 percent of the annual target in just six months. SDSH partners distributed vitamin A to 249,317 children under five years of age, greatly surpassing the six-month

benchmark of 175,000. We were under the mark, however, for the number of children who received two doses of vitamin A (54,523, cf. 65,000 target).

SDSH mobilized its technical team and partners, joining with the MSPP and other donors, to address the outbreak of cholera that was notified in late October 2010. By the end of December 2010, about 150,000 people in Haiti were infected and about 3,600 had died.

SDSH designed flyers and a booklet about cholera, and distributed them to all 10 departments to be used in health education sessions at institutional and community levels. In addition, MSH applied for and was awarded a USAID Office of US Foreign Disaster Assistance (OFDA) grant to implement cholera prevention and treatment activities in 50 camps in the Port-au-Prince metropolitan area that have been home to about 200,000 people (internally displaced persons) since the January 2010 earthquake. The activity was managed by SDSH senior staff. Six SDSH partner institutions (four NGOs, two public sites) were involved in the implementation and conducted health education sessions, tent-to-tent sensitization visits, oral rehydration therapy demonstrations in the camps, and consultations and treatment of mild cases of diarrhea and served as reference facilities for treatment of severe diarrhea and suspected cases of cholera.

The implementing NGO partners included FONDEFH, CDS, Grace Children's Hospital, Centre Medico Social de Petite Place Cazeau, and OBCG. The public sector partners were Centre de Santé (CS) Aurore du Bel Air and CS de Saint Martin II. Approximately 161,093 people were reached during 19,505 health education sessions held in the camps between January and March 2011. In addition, 51,072 families benefitted from home visits by health and social workers. While the education efforts focused primarily on cholera (how to recognize, treat, and prevent it), health workers also seized the opportunity to provide other child health services as well (sick child consultations, measles vaccination, distribution of ORS and antiparasitics). The final report for this activity will be submitted to USAID OFDA in April 2011 and will present the full picture of the tremendous coordination and effort involved (time, labor, materials) in the emergency cholera program.

SDSH solicited and once again received support from Direct Relief International, this time for cholera-related activities all 10 departments. Another SDSH-leveraged collaborator, Pure Water for the World (PWW), provided water purification equipment and supplies in targeted areas. Beginning in January 2011, DRI distributed cholera-related equipment and commodities (ORS, buckets, soap, disinfectants, antibiotics, IV fluid, etc.) throughout (and beyond) the SDSH network. SDSH also secured places for 100 department-level service providers from the North and Grande Anse departments in training of trainers for cholera prevention and treatment sessions led by the Centers for Disease Control and Prevention.

During the semester, SDSH also produced and disseminated informational brochures on PMTCT and two flyers—one that covered family planning topics and another that promoted exclusive breastfeeding—to all SDSH partners.

Child Health—Implementation Challenges and Solutions

SDSH and other nutrition surveillance data clearly indicate that childhood malnutrition remains a major threat to child health in Haiti. Nationwide about 300,000 Haitian children suffer from chronic malnutrition, and nearly half of child deaths in the country are directly or indirectly due to malnutrition. UNICEF estimates that 29 percent of children suffer from stunting and 10 percent from wasting.

Vitamin A is essential for the functioning of the immune system and the healthy growth and development of children. About 33 percent of Haitian children under five years of age show signs of vitamin A deficiency

(Micronutrient Initiative, 2005). For several years, Haiti, like many other countries, has used the opportunity provided by routine immunization contacts to deliver vitamin A to children who suffer from the deficiency. This was effective this semester for administering a first dose of vitamin A to 249,317 children. To ensure that all these children receive their second dose in a timely manner, we needed to develop new strategies. Community health workers will dispense vitamin A during home visits and visits to preschool and kindergarten classes. Plans have been made for the wide distribution of vitamin A during the upcoming Child Health Week in June. Mini campaigns to sensitize the public and providers to the importance of vitamin A will be conducted and promotional posters will be displayed in health facilities. Follow-up will be a priority for SDSH departmental technical advisors in the months ahead.

Distribution of the first dose of vitamin A was made in October 2010, and distribution of the second dose should have been done four months after the first dose. Partners in the West and North departments reported stock-outs of vitamin A in the first quarter of 2011, that is, during the period many children were due for their second dose of vitamin A. UNICEF reported that vitamin A was and is available in the country. However, due to a combination of factors (e.g., ineffective monitoring of health activities by departmental authorities, lack of initiative on the part of facility managers, poor coordination between MSPP departmental- and central-level directorates), some health facilities experienced stock-outs.



A baby receives vitamin A while his mother looks on.

III. Other Domains

OTHER INDICATORS	
Met- 1	# sites having BCC & information on basic health services (147)
Exceeded- 3	% of matching fund covered (> 100%)
	# SDSH sites visibly showing USAID sign/logo (89)
	# grants under contract awarded (43)
 Under – 4	% population served by project as of March 31, 2011 (42% cf. 50% annual target)
	# success stories transmitted to USAID (0, for 6-month target of 6)
	# active Local Health Task Force (0, for 6-month target of 20)
	# areas where at least one site (school or orphanage, health ctr, household) has clean water (140 schools & orphanages, or 62% of 6-month target; 50 households or 50% of 6-month target; 3 service sites, or 12% of 6-month target)
No Target – 1	# 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 USAID OFDA emergency cholera response activity, as discussed in the Child Health 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 the US Government (USG). In 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 broadcasted 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, Sites 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 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 posting of sign boards at an additional 60 sites in the West and Artibonite departments is ongoing. The new SDSH departmental technical advisors in these departments will ensure that the posting is completed by the end of next quarter.

SDSH Project Management

The SDSH Performance Monitoring Plan (PMP) was revised in November 2010 to take into account the contract extension period. Indicators pertaining to the HIGHER nutrition activities were eliminated since the program's activities, especially the outreach and community interventions, were significantly reduced due to policy changes at the MSPP in April 2010. Other targets were increased or reduced according to results realized during the October 2009–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 discussed above.

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 and semi-annual 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 USAID OFDA grant-funded cholera control and prevention activities discussed in the Child Health 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 *primes*, 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.

Due to 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 vis-à-vis a set of indicators which normally formed the basis for the award of performance bonus payments. A "Plan B" was conceived, agreed upon by the partners, and implemented. It allowed for the award of

performance bonus payments to partners that met targets for a random selection of indicators, and the majority of partners did receive bonus payments.

Finance and Systems Strengthening

At the invitation of the National Haitian American Health Alliance (NHAHA), MSH made a presentation on the SDSH performance-based financing (PBF) experience at the October 2010 Seventh Annual NHAHA conference 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 zones ciblées in the South department to explain and discuss the PBF strategy, performance objectives, and contractual requirements. And, 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 support for software to computerize accounting, administration, and finance systems at Centre pour le Développement et la Santé (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 assisted another NGO partner, Comité de Bienfaisance de Pignon, to 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 upon installation of equipment and software.

SDSH finance personnel were trained at MSH's US headquarters in the new finance and accounting management system, Navigator. Upon their return to Haiti, they in turn conducted training sessions for SDSH finance and accounting staff at the SDSH main office, and for finance managers in the field. Several follow-up sessions were necessary to ensure a smooth transition to the new system.

Contracts and Administration

In addition to preparing and negotiating agreements with one new private sector (OBDC in the West) and two new public sector partners (Les Perches and Carice in the North-East) the Contracts and Administration (CA) Unit worked hand-in-hand with technical staff to get the Grants under Contract (GUC) activity underway (see Section IB, Support for Decentralized Services at the Departmental Level). The CA 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. An assessment of all SDSH vehicles was undertaken and repairs made, as necessary. Upcoming activities include the launching of a tender for the renovation of 37 SDSH health facilities that provide HIV services; follow-up and provision of technical assistance to the GUC CBOs; and planning for the 2011–2012 SDSH partners subcontract process.

Infrastructure Renovation Work

In the Artibonite, work was completed at the Coupe à l'Inde Dispensary. A needs evaluation for community health services section of Claire Heureuse Hospital got underway. The Hospital also requested assistance to upgrade its maternity ward and SDSH arranged for representatives from DRI to visit and assess the situation

(without making any commitments). In the Grande 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 labor and delivery rooms, postpartum recovery rooms, laboratory, pharmacy, two administrative offices, six consultation cubicles, and two waiting rooms. Minor renovations are underway 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, 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 set up, 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 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, in the West department.

Lastly, renovation work on the new SDSH Office in Delmas 105 (Petionville) has proceeded as scheduled and is expected to be completed by early June 2011.

Annex One: SDSH Partners

MSPP / Zones Ciblées	NGO Partners
Artibonite	
Gonaïves; Centre de Santé Saint Michel; Centre de Santé de Marmelade; Centre de Santé de Grande Saline N=4	Albert Schweitzer Hospital; Hôpital Claire Heureuse; CS Pierre Payen N=3
Centre	
CS de Belladère; CS Cerca la Source; CS Savanette N=3	Save the Children; Medishare N=2
Grande Anse	
Centre de Santé des Abricots; Centre de Santé de Corail N=2	Haitian Health Foundation; Ste Hélène; Léon Coicou H.C.; AEADMA (Association d'Entr'Aide des Dame-Mariens) N=4
Nippes	
CS de L'Azile; CS de Petit Trou; CS de L'Anse à Veà N=3	None N=0
North	
Centre de Santé de l'Acul; CS de Borgne; CS de Dondon; Centre de Santé de Saint Raphaël N=4	Comité Bienfaisance de Pignon; Dugué Clinic; Centre pour le Développement et la Santé (CDS); Konbit Santé N=4
North-East	
CS de Mombin Crochu; CS Ste Suzanne; CS Vallières N=3	Centre pour le Développement et la Santé (CDS) North-East N=1
North-West	
CS La Tortue; CS Baie de Henne; CS Anse à Foleur N=3	Beraca Medical Center N=1
West	
Centre de Santé Belle Fontaine; CS Cornillon; CS Aurore du Bel Air; Centre de Santé Saint Martin II; Trou d'Eau/Crochu; Centre de Santé de Tayfer N=6	St. Paul Clinic; CSNRR (Filles Charité); FONDEFH; FOSREF; Fermathe Hospital; Grace Children's Hospital; Oeuvre de Bienfaisance et de Développement (OBCG); SADA; CS Lucélia Bontemps; Centre pour le Développement et la Santé (CDS) Ouest; St. Croix N=11
South	
CS Les Anglais; CS de l'Île à Vache N=2	La Fanmy; MEBSH N=2
South-East	
CS de Baïnet N=1	Sacré Cœur de Thiotte Health Center N=1
Total Zones Ciblées:	Total NGOs:
33	27

Annex Two: SDSH HIV Sites

Department	Institutions/Commune	VCT	PMTCT	ARV	Palliative Care	PCR	CD4	TB CT
Artibonite	HCH Hop. Claire Heureuse, Dessalines	✓	✓		✓	✓	✓	✓
	CAL Rabeauto, Gonaives (ZC)	✓	not ready		not ready			
	CAL Ste Michel, St Michel (ZC)	✓	not ready		not ready			
	CAL Marmelade, Marmelade (ZC)	✓	in process		in process			
	CAL Pierre Payen, Saint Marc	✓	✓		✓		✓	✓
Centre	Save the Children CSL, Maissade	✓	✓		✓			✓
Grande Anse	CSL Ste Hélène, Jérémie	✓	✓community		✓			
	CSL Abricots	✓	✓		in process			✓
	HHF CSL Klinik Pèp Bondye, Jérémie	✓	✓		✓	✓	✓	✓
	AEADMA CAL Dame Marie, Dame Marie	✓	✓	✓	✓	✓	✓	✓
Nippes	CAL Petit Trou, Petit Trou (ZC)	✓	in process		in process			✓
	CAL Jules Fleury, Anse à Veau (ZC)	✓	in process		in process			✓
	CAL l'Azile, l'Azile (ZC)	✓	in process		in process			✓
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	✓	in process		in process			✓
South	MEBSH Hop. Lumière Bonne Fin, Cavaillon	✓	✓		✓		✓	✓
	MEBSH CAL Lumière, Finca, Cayes	✓	✓		✓	✓	✓	✓
	CSL CL.La Fanmy, Cayes	✓						
	CAL de les Anglais (ZC)	✓	✓		in process			✓
	CAL de l'Île à Vache (ZC)	✓	✓		in process			✓
West	CAL St Paul, Montrouis, Archaie	✓	✓					
	CSL Lucélia Bontemps, Croix de Bouquet	✓						
	CSL CNSRR (Filles de la Charité), Cité Soleil	✓						

Department	Institutions/Commune	VCT	PMTCT	ARV	Palliative Care	PCR	CD4	TB CT
	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	✓	✓	✓	✓	✓	✓	✓
TOTAL at end March 2011	Includes currently functioning sites (indicated by ✓)	37	24 (includes 2 community- based)	6 SDSH	19	12	13	24

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 (staff identified and trained, equipment, commodities, space, etc.) are not yet available.

In process = preparations are underway to make site functional (staff, equipment, commodities, space, etc.)

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

Annex Three: SDSH Semi-Annual Results for Period Ending March 31, 2011

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
HIV/AIDS					
3.1.1.9 (F)	Number of sites offering the minimum package of PMTCT services according to national and international standards	#	19	22	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	25,146	Exceeded target
3.1.1.10. c	Number of newborns of HIV-positive mothers benefiting from pediatric care	#	400	185	Achieved 93%
3.1.1.11	Number of diagnosed HIV-positive pregnant women having received ARV prophylaxis in a PMTCT setting	#	650	278	Achieved 86%
3.1.1.12 (F)	Number of health workers trained in the provision of PMTCT services according to national and international standards	#	30	18	Exceeded target
3.1.1.13 (F)	Number of sites providing counseling and testing according to national and international standards	#	32	33	Exceeded target
3.1.1.14 (F)	Number of people who received counseling and testing for HIV and received their test results	#	85,000	43,952	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	--	Training postponed to June 2011
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	341	97% achieved
3.1.1.18. a	Number of individuals who have received ART during the year	#	4,234	3,959	Exceeded target
3.1.1.19 (F)	Number of people receiving ART at the end of the reporting period	#	3,175	2,712	Exceeded target

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
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	--	Training postponed
3.1.1.21 (F)	Number of sites providing treatments for TB to HIV-positive patients	#	20	13	Exceeded target
3.1.1.22 (F)	Number of people provided with HIV-related palliative care (including those co-infected with TB and HIV)	#	15,000	15,656	Exceeded target
3.1.1.22. a	Number of sites offering a complete clinical package of palliative care to HIV-positive people	#	24	19	Exceeded target
3.1.1.23 (F)	Number of HIV-positive individuals receiving treatment for both TB and HIV	#	700	74	21% achieved
3.1.1.24 (F)	Number of people trained to provide HIV palliative care (including TB/HIV co-infection)	#	20	--	Training not done
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	33	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	20	Exceeded target
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	135,479	Exceeded target
Tuberculosis					
3.1.2.1 (F)	Tuberculosis notification rate	#/100K inhabitants	105	--	Reported annually
3.1.2.1. a	Tuberculosis detection rate	%	35	--	Reported annually

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
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	47	Exceeded target
3.1.2.4. a	Number of TB patients who were tested for HIV and received their results	#	1,735	644	Achieved 74%
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	--	Reported annually
3.1.2.6. a	Number of sites offering integrated TB services (<i>only detection with referral for treatment</i>)	#	20	--	Not achieved
3.1.2.6. b	Number of people trained in TB and HIV testing	#	20	--	Training to be done by National Laboratory
3.1.2.7 (F)	Percentage of expected new TB cases detected	%	75	--	Reported annually
Maternal Health					
3.1.6.3 (F)	Number of postpartum newborn visits during the 3-day interval following child birth	#	45,000	25,050	Exceeded target
3.1.6.4 (F)	Number of prenatal care visits with skilled providers	#	245,000	114,102	93% achieved
3.1.6.4. a	Percentage of pregnant women having the first prenatal visit during the first trimester of pregnancy	%	37	37	Exceeded target
3.1.6.4. b	Percentage of pregnant women who have had at least three prenatal visits	%	50	18	72% achieved
3.1.6.4. c	Percentage of pregnant women who have received a second dose or a recall dose of tetanus vaccine	%	75	36	96% achieved
3.1.6.4. d	Percentage of pregnant women making a birth plan	%	80	36	90% achieved

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
3.1.6.5 (F)	Number of people trained in maternal and newborn health (women and men)	#	100	--	Training planned for next semester
3.1.6.6 (F)	Number of deliveries with a skilled birth attendant—TBAs not included	#	12,000	5,717	95% achieved
3.1.6.6. b	Number of deliveries with assistance of a health facility–based skilled birth attendant	#	55,000	25,778	94% achieved
3.1.6.6. c	Percentage of new mothers who have had postnatal consultations	%	35	18	Target met
3.1.6.6. d	Percentage of sites that have at least one maternal health committee in their service area	%	35	15	86% achieved; numerator 23 sites, denominator 157
3.1.6.6. g	Number of mothers and child caretakers having received nutritional counseling	#	55,000	5,886	21% achieved
Child Health					
3.1.6.2	% of children 0–11 months completely vaccinated	%	85	43	Target met
3.1.6.7 (F)	Number of people trained in child health and nutrition.	#	300	24	16% achieved
3.1.6.11 (F)	Number of children reached by nutrition programs	#	450,000	327,272	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	11	Within the expected range (exceeded by 1%)
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	9	Within the expected range
3.1.6.12 (F)	Number of children <12 months who received DPT3	#	118,000	57,684	98% achieved
3.1.6.13 (F)	Number of children <5 years of age who received vitamin A	#	350,000	249,317	Exceeded target

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
3.1.6.13. b	Number of children <5 years of age who received two doses of vitamin A	#	260,000	54,523	42% 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	26,729	Exceeded target
3.1.6.14. b	Number of mothers and child caretakers trained in diarrhea management (danger signs and oral rehydration)	#	30,000	26,729	Exceeded target
3.1.6.19 (F)	Number of cases of pneumonia in children <5 years of age treated with antibiotics	#	10,000	8,032	Exceeded target
Reproductive Health/Family Planning					
3.1.7.2 (F)	Total number couple-years of protection (CYP)	#	270,000	127,556	94% achieved; NGOs 92,782; public sector 34,774
3.1.7.3 (F)	Number of people trained in FP/RH (women and men)	#	50	44	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	151	Exceeded target
3.1.7.8 a	Percentage of sites offering at least five FP methods, of which two are longer term	%	55	52	Exceeded target
3.1.7.12 (F)	Number of sites in which the MIS system has been reinforced	#	147	150	Exceeded target
3.1.7.13 (F)	Percentage of users of long-term contraceptive family planning methods	%	14	11	Exceeded target
3.1.7.13. a	Percentage of people of reproductive age using a modern contraceptive method (for FP)	%	30	28	Exceeded target
3.1.7.13. b	Percentage of Depo-Provera users who respect the replenishment delays	%	90	92	Exceeded target

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
3.1.7.13 c	Number of new family planning users	#	170,000	91,044	Exceeded target
3.1.7.14	Number of new cases of STI detected and treated	#	40,000	16,092	80% achieved
Strengthening MSPP Executive Functions					
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
FE.3.a.	Number of departments implementing supervision plan for service delivery	#	10	4	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
Other					
AD.1	Percentage of population served by project (as of March 31, 2011)	%	50	42	84% achieved
AD.5	Percentage of matching funds covered	%	100	>100	Match realized to date is approx. \$74.7 million
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	140 schools, 50 HH, 3 HC sites	Below target
AD.7	Number of highly visible events organized	#	--	0	No target set; done as opportunities arise

Indicator Code	Indicator	Unit of Measure	Project Year 4 Annual Objective	Results Oct 2010 to Mar 2011	Comments
AD.8	Number of success stories transmitted to USAID	#	12	0	In process
AD.9	Number of SDSH sites visibly showing USAID sign/logo	#	147	89	Target met
AD.9.a	Number of active Local Health Task Forces	#	40	--	To be set up next quarter by GUC grantees
AD.10	Number of sites having BCC and information on basic health services	#	147	147	Target met
AD.12	Number of grants under contract awarded	#	40	43	Exceeded target

Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Tel: (617) 250-9500
Fax: (617) 250-9090
www.msh.org