



Santé pour le Développement et la Stabilité d'Haïti II

(SDSH II)

Work Plan Narrative

August 1, 2012 – July 31, 2013

Contract No: Contract No. 521-C-12-00008

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, Haïti

Telephone: 509.2510.9901 @ 9902

Website: www.msh.org

mshhaiti@mshhaiti.org

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Introduction

Management Sciences for Health (MSH) is pleased to submit to USAID/Haiti this work plan for the period August 1, 2012 – July 31, 2013 for the *Santé pour le Développement et la Stabilité d’Haïti II* (SDSH II). The project is being implemented as a Cost Plus Fixed Fee (CPFF) completion type contract in accordance with FAR 16.306(d)(2) for the contract period of 1 August 2012 to 31 July 2013. The total contract amount is \$19,997,826 (Contract Number 521-C-12-00008).

SDSH II builds on the previous project’s activities by continuing to provide healthcare services within target zones and expanding specific activities and practices where applicable, and by strengthening the capacity of the MOH to manage and monitor healthcare service delivery. SDSH II will work in all ten Departments of Haiti in collaboration with three main partners: URAMEL, Association Nationale des Scouts D’Haïti and Fondation pour la Santé Reproductive et l’Education Familiale (FOSREF). The project will issue performance based agreements to 28 NGOs working in 81 sites and 79 MSPP sites working within the 33 *zones cibles* for a total of 160 sites (10 Additional sites under this program have not yet been selected)

The overall purpose of this project is to continue, and in some instances expand, the provision of health services to people living in catchment areas currently supported by USAID SDSH, as well as to provide targeted assistance at the departmental level to support service delivery. This will be achieved through the delivery of a —package of primary healthcare services which will be based on the Government of Haiti (GOH)-defined basic package and which will include four program elements:

- 1) HIV/AIDS;
- 2) Tuberculosis (TB);
- 3) Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene (WASH) and Nutrition); and
- 4) Family Planning (FP). In addition, targeted health systems strengthening (HSS) assistance will increase the capacity of Departmental Ministry of Health (MOH) personnel to manage service delivery. This work will build on previous USAID/Haiti investments and link to current and future activities in health to support decentralization strengthen public sector capacity in managing and contracting service delivery, and support NGO service delivery.

The two primary objectives of the SDSH II project are:

- To improve access to and quality of services
- To strengthen the MSPP capacity to manage and monitor health services at decentralized levels

In order to achieve the expected results, the project will focus attention in the following areas:

- Maternal, newborn, and child health (MNCH) including WASH and nutrition

- Family planning and reproductive health (FP/RH)
- Detection, care, prevention, & treatment of infectious diseases (HIV/AIDS & TB)
- Support expanded services (case recognition, treatment) in selected sites
- Waste management
- Departmental level governance and leadership
- Departmental level financial systems
- Strategic information systems

Objective 1: Access to and Quality of Health Services Improved

The MNCH services provided are based on the package of services defined by the MOH and include self-care, health-seeking and preventative interventions related to nutrition and water, sanitation and hygiene (WASH), reproductive health and family planning, HIV/AIDS and TB prevention, detection, care and treatment, and identification, referral and care for vulnerable populations. This project will focus on continuing the provision of health services in USAID-supported catchment areas and scaling up underutilized technical interventions and better practices (where appropriate) within targeted areas.

The Project will put an emphasis on capacity building reinforcing, greater mobilization of populations, and better management of activities.

Objective 1.1: Maternal, Newborn and Child Health (MNC) services, including WASH and nutrition strengthened

1.1(a) Maternal and Neonatal Health

Infant and maternal mortality remain the highest in the hemisphere, with infant mortality estimated at 57 per 1,000 live births and maternal mortality at 630 per 100,000 (National Strategic Plan 2012-2016 MSPP). This project will continue the activities of SDSH in providing basic maternal and neonatal care at all targeted sites, while also increasing the number of sites offering specialized care and supporting community level birth planning activities. The desired effects of these activities include increasing the percentage of births attended by skilled healthcare professionals; increasing the number of antenatal care visits by skilled providers from USG-assisted facilities; increasing the number of functional (equipped, trained, and supervised) community health workers; increasing the number of post-partum/newborn visits within three days of birth in USG-assisted programs; increasing the percentage of births delivered by caesarean section; and increasing the percentage of women receiving active management of third stage of labor.

The project will provide basic maternal and neonatal services at all targeted sites and will increase the number of sites offering Emergency Obstetrical and Neonatal Care. Additional activities involve supporting efforts to increase the proportion of births that occur at healthcare facilities and improving newborn care services. The planned interventions are very similar to

those in previous years but they will be expanded and strengthened to improve the quality of services provided over the next 12 months. Focus areas to improve maternal and newborn health include:

- Better monitoring of pregnancy and childbirth through SONUB and SONUC including critical care of newborns (HBB Kangaroo, etc.);
- Family planning to significantly reduce the high rate of unmet needs (40%) and to contribute to the reduction of maternal mortality

Indicator 1.1.1: Number of births attended by skilled birth attendants (midwives, nurses, doctors) in USG-assisted programs

Target = 30,330

The project aims to strengthen the training and supervision of staff at all institutions in the SDSH network of 170 PPS. In order to achieve this, an initial inventory of trained personnel and resources will be conducted based on previous training reports. This baseline assessment will serve to identify HR shortfalls required to meet project targets in this area. Staff will also monitor the distribution of basic equipment and supplies being procured through SDSH and assure training is conducted to all relevant staff and that refresher training is also offered when needed.

Community involvement is a key element to increasing the number of facility-based deliveries with SBAs. The project will address this situation through a community approach emphasizing not only the commitment and participation of the population through community health workers and social mobilization committees, but also the strengthening of public institutions and private primary care along with referrals to support the community level.

Quality improvements will be introduced through routine supportive supervision visits using new tools such as a checklist of the essential tasks to be performed by the staff to ensure compliance with norms and standards to be implemented. This checklist will be developed in the first quarter and used systematically for supervision. Systematic feedback will be provided on a quarterly basis upon receipt of the PPS reports with recommendations and suggestions on the measures to correct deficiencies and gaps.

The project will also introduce management tools, notably partographs, and strategies to ensure smoother deliveries. These will be used at all institutions for eutocic/normal deliveries and will detect dystocia in time for effective treatment at health facility or its reference to the appropriate level of care. In this context, the protocols for the prevention and management of eclampsia are primarily focused on the use of misoprostol, uterotonics and the use of vacuum and forceps, which will be given particular attention in the training / retraining of personnel, coaching and in supervision training.

Indicator 1.1.1b: Number of deliveries with a trained traditional birth attendant (TBA)

Target = 55,000

These strategies are also based on capacity building, greater mobilization of populations, and better management of activities. Specifically all existing TBAs will be retrained along with new recruits. They will be trained to use simplified algorithms enabling them to follow the various actions step-by-step with a simple job aid in the form of a checklist. These checklists will be laminated and made available in their kits so that they can consult them whenever necessary.

Monthly meetings will be held at health facilities with the TBAs to assess the number of deliveries conducted, to monitor maternal and/or child deaths that may occur in their respective communities, to provide them with delivery kits and to review some important themes and recommendations (continuous training).

A periodic review will be established at least once per quarter to check the quality of delivery services that they offer to the population. The supervisors will conduct a survey of served clients to measure their level of satisfaction or dissatisfaction and take any necessary corrective measures.

Indicator 1.1.2: Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities (3.1.6-4)

Target = 335,000

The targeted number of ANC visits increases this year from 240,000 to 270,000, requiring the development of innovative strategies to reach or exceed these ambitious targets. Given the project's strategic orientation towards community health, an emphasis is placed on the contribution of the community health agents to better inform, sensitize and educate pregnant women about the benefits of prenatal visits. Providers at health facilities will establish a list of pregnant women by location that they will make available to the CHWs. These will encourage pregnant women to better meet their appointments and enable home visits to those who missed appointments in order to understand their challenges and to help with subsequent visits if possible. Incentives will be offered to those who fulfill their appointments, and will consist of a distribution kit containing soap, toothpaste and baby clothes. This kit will be issued at their 4th PNC visit but the information will be provided upon their first visit. The women's associations and groups within the community will also be challenged by providers to lend their support to awareness of prenatal visits by pregnant women and to integrate GBV and Child Protection groups. This theme (importance of prenatal visits) will be developed in social mobilization for family planning or vaccination of children, but also by the committees fighting against maternal mortality. Mobile clinics from the health centers will target over 5000 community members. Activities designed to build demand for prenatal visits will be closely monitored during coordination meetings at the departmental level or at different levels of supervision. An assessment of the effectiveness of all of these measures will be prepared quarterly and improvement measures will be taken when necessary.

Linkage will be established with other strategic partners such as WHO/PAHO in order to ensure that SDSH sites are enrolled in the "Manman ak timoun an sante" program (SOG plus) and Unicef to guarantee availability of vaccines and other commodities at all health facilities.

Indicator 1.1.3: Percentage of pregnant women with at least three antenatal visits in USAID supported program

Target = 51%

This target has remained the same at 50% of pregnant women, which unfortunately was not reached last year (48%). The strategy for this period is based on the innovations described in section 1.1.1. Among the reasons described justifying the failure of the return rate of women after a first visit was a delay in starting the visits, with many women attending their first clinic during their 4th or 5th month of pregnancy. Additional reasons included negligence or forgetfulness that the project hopes to correct through home visits by health workers; an ignorance of the benefits of prenatal care for the health of the mother and child that the project hopes to counter through its education program. In addition, intense community mobilization efforts, quality care improvements and better welcome and other suitable comfort appliances, such as water availability, and hygiene facilities, as well as shorter waiting times will help change these trends. The implementation of all these measures will significantly increase the number of pregnant women who will attend at least three ANC visits.

Indicator 1.1.4: Percentage of births by caesarean section

Target = 10%

Last year, the baseline for the caesarean section rate in the country is estimated at 5%, the projected increase to 10% aim at increase availability of services to pregnant women in need of this life saving procedure in more facilities. With the valuable support of Direct Relief International, the SDSH Project initiated last year the support of 8 EMONC health centers, 4 of which will provide C-sections. In order to make sure that these four centers of excellence will be able to perform caesarean section, we will organize trainings sessions on quality case management of Ob-gyn emergencies and complications for health providers. Special emphasis will be placed on the routine use of partographs to monitor every parturient. To this end, SDSH will ensure reproduction and dissemination of the MOH's partographs; organize training of service providers and monitoring of its proper use and the regular report on MESI. In order to improve organization and supervision of case management, we will review procedures, norms and treatment protocols in collaboration with MSPP and help to mobilize materials and equipment necessary for comprehensive EmONC for C-sections. We will work with the MSPP and NGO partners to ensure the availability of essential supplies for safe deliveries (Oxytocin, syringes etc...) and management tools such as partographs in all the 8 centers of excellence delivery rooms based on the MOH norms and standards for safe deliveries.

Indicator 1.1.5: Percentage of women receiving active management in third stage of labor through USG supported programs

Target = 80%

This objective is extremely important for reducing maternal mortality and can be achieved with simple technology if made accessible and usable at the institutions in the first level of the health system. The active management of the third phase of labor seems to be one of the major innovations of recent years in the fight against maternal mortality. However, its proper application requires careful training of personnel, continuous availability of commodities

(magnesium sulfate, oxytocin, misoprostol, drifts ergotamine, and antibiotics) from MOH and other partners, and the development and use of appropriate tools and checklists. As this indicator is new, the maternal and newborn health unit will take all necessary measures to enforce the guidelines and protocols relating to its implementation as rigorously as possible. Training sessions will be organized for early in the second quarter of the project and a monthly assessment of all elements of the process will be carried out at least during the first 6 months of the program, and an evaluation will be repeated every three months following the launch of the first phase of the process.

Indicator 1.1.6: Number of postpartum/newborn visits within three days of birth in USG-assisted programs (3.1.6-30)

Target = 63,000

Surveys in Haiti have shown that the proportion of neonatal deaths represents between 30-40% of infant deaths (less than 1 year of age). This phenomenon is not unique to Haiti and appears in most cases to be related to asphyxia at birth, causing approximately 814,000 neonatal deaths and 1.02 million stillbirths worldwide. It was established that 98% of these phenomena occur in developing countries. In Haiti, 27 newborns died per 1000 live births and 28% of these deaths are caused by hypoxic issues during childbirth. Most of these deaths can be prevented through a comprehensive approach to neonatal resuscitation called HBB (Helping Babies Breathe). This new practice has demonstrated its effectiveness and should only be applied at the institutional level. The project will therefore focus on capacity building of the providers at health facilities for the rigorous application of the HBB protocol. This requires the following skills:

- Rigorous management of childbirth;
- Ensuring quality routine care;
- Identification of the "critical moment," called Golden Minute or Minute or Gold;
- Ensuring continuous ventilation with maintaining a normal or slowed heart beat.

To this end, the overall strategy for prenatal visits described above will also play a key role here. It is essential to ensure the following interventions:

- Encourage most Haitian women to give birth at a health facility that provides the HBB approach, whenever possible;
- In the case that there is no facility in the vicinity, the HBB approach should be taught in order to be applied at home. The project will strive to promote HBB, mainly at the institutional level and for use in emergency situations only at the community level.

Taking into account the novelty of HBB in this project, steps will be taken to monitor all stages of its implementation in order to detect and correct any deficiencies and gaps and document lessons learned during its initial year.

The HBB approach will be coupled with the "Kangaroo Mother Care" for premature and low weight infants, representing an ideal global intervention to keep them alive. This practice has had humble beginnings at the project level but will soon be entrenched in the network of institutions and extended to the community level. The management approaches mentioned above for HBB will also be applied.

Indicator 1.1.6b: Number of women who receive a post-partum visit within 3 days of delivery.

Target = 46,200

The expected result of 40,000 for this indicator was met and exceeded last year and has increased to 46,200 this year. A postnatal home visit during this time period is essential for the survival of the mother and child as it can detect complications that were unforeseen during prenatal visits and even during the birth. This visit also provides health education for women and their children, especially regarding family planning for birth spacing and on the importance of immunization, growth monitoring, weight status and exclusive breastfeeding for the newborn well-being. Due to the importance of an immediate postnatal visit, the project will intensify the implementation of the various measures that have achieved previous results. One of these key measures is the training, supervision, and implementation of periodic monitoring every three months. Particular attention will be given to family planning in the immediate postpartum period and newborn monitoring to apply, if necessary, "HBB" and "KMC" (Kangaroo Mother Care). In addition, this visit can develop notions about the importance of immunization, growth monitoring, weight status and exclusive breastfeeding.

Indicator 1.1.7: Number of people trained in maternal /newborn health through USG-supported programs (*Disaggregated by sex*)

Target = 100

As noticed under indicator 1.1.5, training of services providers on the essential newborn care approach including "Helping Babies Breathe-HBB", Kangaroo Mother Care (KMC), and systematic use of APGAR score assessment will be conducted in coordination with MOH which has already started training staff providers. An assessment of the skills of the providers at both health facilities and the community level will be systematically conducted during supervisory visits, coordination meetings, and during other opportunities. More structured trainings will be organized with seminars, workshops or other events that will be used to enhance the knowledge and skills of staff. These meetings may involve supervision, field visits, performance monitoring and other activities.

The quality of training, regardless of the approach used, will be strictly monitored. A list of persons trained will be maintained and regularly reported to USAID and the project monitoring team from US headquarters.

1.1(b) Child Health

Child health services will be provided at all targeted sites and will include vaccination, diarrhea prevention and treatment, acute respiratory infection (ARI) treatment, and vitamin A supplementation, as well as preventative and curative services. Health staff will be trained in order to successfully implement Integrated Management of Childhood Illness (IMCI) and the project will work to increase the coverage of vaccines and immunizations. Particular efforts will be made during the year to provide the complete package of child health services throughout the network of institutional and community service providers. The priority package of services will be offered throughout the network at the institutional and community levels. Previously used interventions will remain in place, including growth monitoring and counseling activities,

outlining the relation between height and weight according to the national guidelines. Mothers and caregivers will be counseled every time a child is weighed, based on the growth of the child since the last weighing. Education on child nutrition will be also carried out.

Approximately 72,500 Rally posts (on average four per month and per health agent) will be also held with materials provided. Immunization services for children and pregnant women will be offered during these rallies along with nutrition services including MUAC (Mid upper arm circumference), administration of vitamin A, and management of diarrheic dehydration and deworming for targeted children. MOU will be signed between SDSH and other projects providing management and treatment for malnourished children to make sure a good follow up is done.

Indicator 1.1.10 : Percent of children under one fully vaccinated in USG supported programs

Target = 92%

SDSH II will continue to put emphasis on the immunization activities considering last year's results for the DTP3 doses administered to children less than 12 months were not satisfactory. Vaccines against measles, polio and tuberculosis will also be regularly administered to every child in all service delivery points and rally post of the Project.

SDSH II will work closely with DPEV and the departmental directorates in order to avoid stock out of vaccines and gas. The cold chain and the regular and accurate filling of temperature sheets will be closely monitored at all sites. Through participation in technical working groups, we will pro-actively advocate to MOH and development partners such as UNICEF to ensure stability for vaccination inputs procurement. Outreach strategies to reduce immunization drop-outs will be intensified. Behavior Change Communication (BCC) and Community Mobilization (MC) strategies in support of immunization activities will be supported. The project will support planning meetings in all ten departments to address ongoing issues related to the availability of requisite supplies to meet targets related to the above two interrelated indicators. Quarterly meetings will be conducted at each department to assure the availability of vaccines and supplies and to monitor the quality of implementation. A detailed schedule will be drafted for the introduction of the new Pentavalent vaccine and trainings will be conducted prior to usage.

Indicator 1.1.11: Number of children of less than 12 months of age who received DPT3 or Pentavalent3 from USG-supported programs

Target = 140,000

Refer to indicator 1.1.10

SDSH II will work closely with DPEV for the introduction of the Pentavalent and support the roll out activities throughout the network. A detailed schedule will be drafted for the introduction of the new Pentavalent vaccine and trainings will be conducted prior to usage.

1.1(c) Nutrition

All targeted sites will continue to provide the basic maternal and child nutrition services delivered under SDSH, focusing on pregnant and lactating women, and children. All sites will provide basic maternal and child nutrition services, including iron and folic acid

supplementation, promotion of breastfeeding, oral rehydration therapy, and vitamin A supplementation and deworming. Additional activities will focus on increasing linkages between nutrition and hygiene services with HIV/AIDS activities and scaling-up the number of facilities providing cholera treatment.

The expected results of these activities will be to increase the percentage of institutions with the capacity to rapidly establish cholera treatment centers or serve as oral rehydration points; increase the prevalence of exclusive breastfeeding of children under six months of age; increase the number of children under five who receive vitamin A from USG-supported programs, and decrease the prevalence of anemia among women of reproductive age.

There is a critical window of opportunity for improving child nutrition; it goes from pregnancy through the first 24 months of life. The deficits acquired by this age are difficult to reverse later. Therefore SDSH II has identified a package of direct interventions to improve nutritional status and growth in children including interventions to improve nutrition of pregnant and lactating women such as growth monitoring, screening at the community level, iron, vitamin A and zinc supplements, iodized salt, and the promotion of healthy behavior, including hand washing, exclusive breastfeeding and complementary feeding practices. These interventions are proven to have an impact on the nutrition and health of children and mothers. Strategic partnerships will be established between the main agencies committed in distribution of food and some of our partners in order to improve nutrition of pregnant and lactating women.

All services delivery points offering antenatal care will be supported for the screening of anemia among the pregnant women, thus reducing the consequences of iron and Vitamin A deficiency and the risks of death at delivery.

The network will be supported to promote interventions that encourage behavior changes and provide specific knowledge to the mothers and caregivers about

- Early initiation of breastfeeding
- Exclusive breastfeeding for six months
- Timely introduction of nutritionally adequate and safe complementary foods
- Continued breastfeeding for up to two years.
- Micronutrient supplementation
- Food fortification
- Appropriate feeding of infants and young children
- Appropriate nutritional care of sick children
- Appropriate management of malnourished children

Community health workers will be better supported and trained to effectively promote increased prevalence of breast feeding of children under six months of age, optimal infant and young child feeding, increased number of children under five who received vitamin A. When they are properly trained and supported, they can successfully support and counsel mothers to improve breastfeeding practices. Health worker training will include an emphasis on counseling skills and on supporting mothers to help establish and maintain good breastfeeding practices. In addition, SDSH will work to increase the percentage of institutions with capacity to rapidly establish

cholera treatment. These essential actions are aimed to protect, promote, and support healthy nutrition practices in the entire network

Indicator 1.1.12: Number of children under 5 years of age who received Vitamin A from USG-supported programs (3.1.9.2-3)

Target = 405,000

Improving the vitamin A status of deficient children has been shown repeatedly to enhance their disease resistance capacity and thus reduce their mortality and illness from infectious disease significantly and at low cost.

Unfortunately this target was not met last year due essentially to stock out at national level and inadequate data registration. This year, as per the national guidelines 1 dose of Vitamin A will be administered to children from 6 months to 5 years every 4 months the project will continue to put emphasis on the mothers and caregivers nutritional education and breastfeeding promotion and support will be key elements in the reduction of vitamin A deficiency among young children. Coordination with the World Bank will be made to avoid duplication. As usual supplementation will be integrated with existing programs to the greatest degree possible. Orientation will be provided for the use of the new carnet santé-nutrition to ensure reliable data.

Indicator 1.1.12a: Number of children under five reached by USG-supported nutrition programs (3.1.9-15)

Target = 511,000

SDSH II will continue to provide a package of direct interventions to improve nutritional status and growth in children including interventions to improve nutrition of pregnant and lactating women such as growth monitoring, screening at the community level, iron, vitamin A and zinc supplements, iodized salt, and the promotion of healthy behavior, including hand washing, exclusive breastfeeding and complementary feeding practices. Strategic partnerships will be established between the main agencies committed in distribution of food and some of our partners in order to improve nutrition of children under five.

Indicator 1.1.13: Number of USG assisted service delivery sites with the capacity to rapidly establish cholera treatment centers/units

Target= 35

In order to manage adequately cholera outbreaks in its catchment area, the project will elaborate and implement a contingency plan which will include materials of rehydration, since the health providers are already trained, refresher courses will be provided as needed

Indicator 1.1.14: Number of mothers and child caretakers trained on Diarrhea prevention (exclusive breastfeeding, clean water and hygiene)

Target: 45,000

In order to effectively prevent diarrheal diseases it is essential that households have good hygiene practices and access to safe drinking water and improved sanitation .The project will

improve access to clean water by promoting household water treatment products use. Mothers and caregivers will be also trained on the importance of hand washing as a common practice.

Indicator 1.1.14a : Number of mothers and child caretakers trained on exclusive breastfeeding

Target = 45,000

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants and young children and exclusive breastfeeding for 6 months is the optimal way of feeding infants. While breastfeeding is a natural act, it is also a learned behavior. Mothers and other caregivers require active support for establishing and sustaining appropriate breastfeeding practices. The project will continue to enable mothers to establish and sustain exclusive breastfeeding for 6 months, through education, training and distribution of promotional materials.

Indicator 1.1.15 : Number of mothers and child caretakers trained on Diarrhea management (danger signs and oral rehydration)

Target = 45,000

The project will promote the benefits of diarrhea treatment, identification of danger signs and education of mothers and caregivers on why ORS and zinc is the most effective way to manage acute diarrhea. The project will also ensure availability of these life-saving products by seeking them from MOH or other partners. Community health workers will promote timely treatment seeking, encourage appropriate home care, and facilitate referrals to facilities. Promotional and demonstration materials will be distributed.

Indicator 1.1.16: Number of people trained in child health and nutrition through USG-supported programs (Disaggregated by sex) (3.1.9-1)

Target= 300

Last year this target was not met, mostly because of non-compliance of the partners in the elaboration of training reports. This year the health workers of both level of services will be considered for training allowing reaching the target by the month of February. The registration of training data will be supervised

Indicator 1.1.17: Number of cases of child diarrhea treated in USAID-assisted programs

Target = 50,000

For the management of diarrhea cases, the project will proceed to the installation of oral and intravenous rehydration corners, in the sites where the needs have been identified. The use of a package of oral rehydration salts (ORS) and zinc will be systematic.

Indicator 1.1.18: Percentage of pregnant women who are anemic

Target = 40%

Anemia control and prevention in pregnancy is an important strategy to reduce maternal deaths. No doubt exists that iron supplementation during pregnancy prevents maternal iron deficiency and anemia, and increases hemoglobin concentrations. Therefore Antenatal care (ANC) is a widely used strategy to improve the health of pregnant women, to encourage skilled care during childbirth, and to provide iron and folic acid supplements and appropriate counseling messages about maternal care, nutrition, birth preparation, and the use of supplements. The project will ensure a complete package of 4 antenatal consultations for the targeted pregnant women including the promotion of anemia screening

Objective 1.2: Access to and integration of FP/RH intensified

The project will continue to provide the FP/RH services delivered through SDSH based on voluntarism and informed choice at all targeted sites and will scale-up certain activities, and strengthen linkages between FP/RH programs and other services. Special emphasis will be put on FP compliance regulations all staff at all sites will be oriented, trained and refreshed on the appropriate Federal Regulations. Likewise, staff will be instructed to provide quality counseling, comprehensive information on methods chosen and on side effects. These activities are expected to increase the modern method contraceptive prevalence rate, increase the couple years of protection in USG-supported programs, increase the percentage of sites offering at least five methods of FP including two long-acting and permanent methods, and increase the number of community health workers providing FP methods, including injectable refill options. FP/RH activities will include detection and treatment of sexually transmitted infections, increasing access to FP services among youth, people with disabilities and other vulnerable populations, as well as improving the linkages between FP/RH services and HIV/AIDS and maternal and child health services. Moreover, FP services should be provided after abortion / miscarriage, post-partum and GBV (rape cases, Emergency Contraception...)

This objective is covered in six sections, each focusing on ways to strengthen the family planning program in SDSH II. FP in Haiti is characterized by a high level of unmet need, estimated at 40%. These needs comprise both the spacing of births but also their limitations, especially considering that fertility is estimated to be around four children per woman. This means that with early motherhood being observed nationwide, many women will achieve their desired number of children at a very young age. These individuals will then be in need of either permanent or long-term methods. The project will include a critical dimension for increasing access to long-term and permanent methods, but overall, the strategy for intensifying FP during the next 12 months will focus on three main lines:

1) Strengthening the Community level

The project will create a critical mass of community health workers estimated at 1600 in order to offer the whole package authorized by the MSPP, including injectables. They will receive well-structured training / retraining, regular supervision and a quarterly assessment of the quality of services they offer. The application of injectables on this large of a scale will require regular monitoring of the quality of services for timely detection of incidents and accidents, and immediate corrections if necessary. Side effects associated with the products used will be tracked, and information and appropriate measures will be implemented to avoid jeopardizing

the chances of success. The CHWs will be supported by providers at the health institutions level with whom they will meet with monthly to review their activities, submit their reports, receive their endowment of contraceptives for the next month, and to discuss any constraints or difficulties in their work with their supervisors. All measures will be taken to ensure the availability of contraceptive commodities for the agents operating at the community level.

2) Improvement and strengthening of services at the institutional level for the SDSH II network.

Particular emphasis will be placed on cascade trainings / retraining of staff in contraceptive technology, legislative aspects, and management of FP activities. The equipment and materials will be provided along with the permanent availability of contraceptives in collaboration with LMS. The project aims to develop advanced strategies from selected fixed delivery points in order to reach populations in hard to reach areas. Lessons learned from these strategies will inform their expansion to other sites. This institutional level will also be closely monitored and evaluated at least every three months in order to identify gaps and areas for improvement. Departmental Technical Advisors and the Departmental Technical Managers will devote more time to the FP strategy at the departmental level and will receive all necessary technical, administrative and policy support from the Reproductive and Maternal Health Project Team. All the Centers of Excellence will provide all the FP methods.

3) The Mobile Team

The Mobile Team will facilitate increased access and range of methods available, including long-term and permanent methods. This requires close collaboration with the referral hospitals. This team will be reinforced by staff and resources to enable it to meet the important needs in CCV. It is intended to ensure two trips per month to train the staff of eight centers of excellence and to provide them with the training necessary to optimize their performance. The head of the mobile team will partner with the hospitals that have the necessary skills to offer the CCV to surrounding institutions but are insufficiently mobile to function at capacity.

Another innovation that will be included in this new plan to revitalize family planning is a commitment to address the sexual and reproductive health of adolescents. In Haiti, adolescents' access to sexual health and reproductive services has always been among the major challenges facing the health sector, along with early pregnancies and the high prevalence of sexually transmitted diseases. For these reasons, SDSH created the "Friends of Youth" in a dozen centers to integrate its activities in reproductive health and to support the sexual health and reproductive needs of adolescents, centered on education, advocacy and the provision of RH / FP services. These youth-friendly centers with different orientations undertaken by the project have since been abandoned. We propose to reinvigorate these centers this year and resume by intensifying activities in reproductive health for adolescents. The project will work in collaboration with the Scouts of Haiti, one of our major partners, on the selection, training and supervision of peer educators. We will also develop and disseminate educational brochures on RH / FP for adolescents and will integrate a component of training SR providers to further support the needs of adolescents at all health institutions within the SDSH II network. Institutions will be encouraged and supported to integrate adolescents in all of their activities in RH / FP, taking into account their specificity and particularity. Activities for teenagers will be very closely monitored and periodically evaluated to make continuous improvements as needed.

These strategies will have a positive impact on the following indicators:

Indicator 1.2.1: Couple-years of protection (CYP) in USG-supported programs (3.1.7.1-1)

Target = 347,000

Indicator 1.2.2: Percent of service outlets offering at least 5 FP methods including two long acting and permanent methods

Target = 40%

Indicator 1.2.3: Number of community health workers trained in provision of injectable contraceptives

Target = 1500

Indicator 1.2.4: Percent of people in reproductive age using a modern family planning method in USAID geographic targeted area

Target = 32%

Indicator 1.2.5: Number of Youth Friendly Centers activated

Target = 10

Objective 1.3: Support detection, care, prevention and treatment of infectious diseases including HIV/AIDS and TB

1.3(a): HIV/AIDS

HIV/AIDS services will continue to be supported at all targeted sites, while specific services will be scaled-up over the life of the project. Consequently, 8 new ARV sites and 10 new PMTCT sites will be developed and implemented, bringing the number of ARV sites to 21 and PMTCT sites to 40 at the end of the project. In addition, SDSH II will develop training plans, frameworks and benchmarks for HIV/AIDS services ensuring that HIV rapid testing is available at all services delivery sites and increasing linkages with TB programs. Particular attention will be put on loss to follow up patients through the implication of Community Health Workers (CHW) in the tracking of patients within the community. The desired effect of these activities includes increasing the number of adults and children with advanced HIV infection newly enrolled on antiretroviral therapy (ART); increasing the percentage of adults and children with advanced HIV infection receiving ART; increasing the percentage of individuals who received testing and counseling services for HIV and received their test results; increasing the percentage of HIV-positive pregnant women who receive antiretroviral (ARV) treatment to reduce the risk

of mother-to-child transmission in USAID geographic targeted areas; and increasing the availability of PEP. Sites not currently able to deliver testing services will have training plans created and a framework will be established for linking HIV-positive clients to HIV/TB treatment services, along with benchmarks for increasing TB screening within HIV programming.

Haiti suffers from one of the highest HIV prevalence in the region (2.2% in 2006, Source: EMMUS). The low level of education along with traditional beliefs increase the stigmatization and discrimination of people living with HIV and subsequently worsen access to health services, which already suffer from a lack of resources. Throughout the SDSH II project, MSH will address these issues as described below.

Recruiting new health care providers such as social workers and/or psychologists for additional VCT services will be financially supported by SDSH II which will also oversee the recruitment process in collaboration with the Health Departments (MSPP). In order to determine which trainings should be provided, SDSH II will conduct an assessment of training needs. The initial training of the newly recruited VCT personnel will be coordinated by SDSH II but handled by GHESKIO, I-TECH and INHSAC.

Additional health care providers for care and treatment of HIV and TB will be recruited through SDSH II support for the MSPP and initial and refresher trainings will be handled by GHESKIO, I-TECH and INHSAC with the coordination of SDSH II. The training will also include a specific session regarding TB patients' education and awareness.

SDSH II will assist the *Departments* (MSPP) with the process of opening new HIV/AIDS sites. SDSH II will help with the identification, renovation and/or re-organization needs of the facilities with the concerned partners, e.g. the four new identified VCT sites.

Regarding the PMTCT program, SDSH II will encourage the health care providers to promote HIV testing and re-testing of pregnant women before the end of pregnancy (3rd trimester) as well as specific PMTCT care and treatment with the participation of Traditional Birth Attendants (TBAs).

SDSH II will support the strengthening of the different HIV services (palliative care, ART, VCT, OVC, PMTCT) through the expansion of community activities. This will require SDSH II to support the recruitment process of the 18 social workers who will be in charge of all community activities for each site related to community care and support groups for PLWHA, OVC, and their families, including:

- enrollment of patients in palliative care
- follow-up of enrolled patients (HIV and TB)
- raising the awareness about the services offered in the health facility (VCT, care and treatment, TB, OVC, etc.) in the community and during specific events
- providing support groups to infected and affected people
- conducting home visits
- providing support to the health care providers of the health facility
- supporting the Child Protection and Gender Based Violence programs

The recruitment of these 18 social workers will be followed by initial trainings as well as refresher trainings for those already working. SDSH II will coordinate with GHESKIO, I-TECH and INHSAC for the organization of the trainings.

Through the implementation of 8 additional ARV sites, SDSH II expects to increase the number of newly enrolled patients for ART.

SDSH II will raise awareness with the selection committees on the importance of organizing regular meetings to provide a better follow-up of patients in order to encourage enrollment of eligible patients and to increase the number of patients under ART, as well as develop and implement HIVQual projects within the facility to improve delivery of quality services

Through the implementation of 21 additional sites offering OVC services, SDSH II expects to increase the number of OVC enrolled, the number of OVC having received at least one OVC service and the number of OVC remaining active at the end of the period.

To attract more OVC in the program, SDSH II will help expand the package of services offered by the health facilities to include legal support, fees for education and material support, etc. It will be necessary to improve the coordination between the different programs, particularly with Child Protection and Gender Based Violence.

Eventually, these interventions will have a positive impact on the following indicators:

- **Indicator 1.3.1:** Number of adults and children with advanced HIV infection newly enrolled on ART (3.1.1.6)
- **Indicator 1.3.2:** Number of adults and children with advanced HIV infection receiving antiretroviral therapy (3.1.1-10)
- **Indicator 1.3.3:** Percent of adults and children with advanced HIV infection known to be alive and on treatment 12 months after initiation of antiretroviral therapy
- **Indicator 1.3.4:** Number of HIV(+) individuals receiving treatment for both HIV and TB
- **Indicator 1.3.5:** Number of pregnant women with known HIV status
- **Indicator 1.3.6:** Number of HIV(+) pregnant women who received ART to reduce risk of mother to child transmission (3.1.1-39)
- **Indicator 1.3.7:** Number of individuals who received counseling and testing for HIV and received their results (by gender and age)
- **Indicator 1.3.8:** Number of eligible adults and children provided with a minimum of one care service
- **Indicator 1.3.9:** Number of people trained to provide HIV Palliative care (including TB/VIH)
- **Indicator 1.3.10:** Number of OVC enrolled during the period
- **Indicator 1.3.11:** Number of OVC having received at least one OVC service
- **Indicator 1.3.12:** Number of OVC remaining active at the end of the period

SDSH II will coordinate with the concerned partners and provide financial support to community activities dedicated to raising awareness through methods such as mass communication on the following topics:

- OVC services
- VCT services
- Palliative care services
- PMTCT and child health services

SDSH II will provide financial support and technical assistance for the promotion of the services mentioned above organized during specific events such as Carnival, World Child Day and World HIV Day. SDSH II will also continue the close collaboration with the community team of FHI/CHAMP for the tracking follow-up patient loss. These interventions are expected to contribute to reaching targets of the following indicators:

- **Indicator 1.3.2:** Number of adults and children with advanced HIV infection receiving antiretroviral therapy (3.1.1-10)
- **Indicator 1.3.4:** Number of HIV-positive individuals receiving treatment for both TB and HIV
- **Indicator 1.3.6. :** Number of HIV positive pregnant women who receive anti-retroviral to reduce risk of mother to child transmission (3.1.1-39)

SDSH will help the health facilities to identify partners involved and to develop and implement an efficient referral system for patients in collaboration with MSPP. This referral system will allow a systematic referral of patients between health facilities when necessary and ensure the continuum of care for the patient.

Further to the assessment of training needs coordinated by SDSH II regarding HIV/TB care and treatment, refresher and initial trainings of health care providers will be performed by INHSAC, GHESKIO, Nos Petits Frères et Soeurs, CIFAS and I-tech with the coordination and support of SDSH II. SDSH II will promote the organization of regular meetings with PNLT and PNLS at the departmental levels in order to provide a better integrated HIV/TB package of services.

Strengthening laboratory capacities through coordination and support of activities performed by partners should impact the following indicators:

- **Indicator 1.3.1:** Number of adults and children with advanced HIV infection newly enrolled on ART (3.1.1.6)
- **Indicator 1.3.2:** Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (3.1.1-10)
- **Indicator 1.3.7:** Number of individuals who received counseling and testing for HIV and received their results
- **Indicator 1.3.13:** Number of sites offering HIV counseling and testing according to national and international norms

SDSH II will support the recruitment of new lab personnel and the organization of trainings for lab staff (HIV/ TB tests, CD4, etc.) handled by the National Public Health Laboratory and GHESKIO, as well as ensuring an appropriate supply of lab tests from SCMS. SDSH II will also

strengthen lab test stock management by health facilities that are members of the SDSH II network through the training of lab staff and technical assistance visits.

Project staff will provide Technical Assistance to health care providers involved in the HIVQual project in order for them to achieve their objectives. The HIVQual project is dedicated to improve specific steps for the continuum of services for care provided in the identified health facilities.

SDSH II will monitor the organization of health care providers training for HIVQual, the EMR and MESI systems to strengthen the data reporting system. To increase the number of sites using EMR and MESI, the project will also make sure the sites benefit from the appropriate technical capacities (IT equipment, internet, access, task force, etc.).

SDSH II will assist in the implementation of a systematic PCR test offered to HIV exposed newborns handled by the CARIS Foundation. SDSH II will also provide the support required for the training of health care providers on dry blood spot collection.

SDSH II will check the availability of the norms document at the health facilities with the collaboration of MSPP and the Departmental Technical Advisors. SDSH II will also ensure the good application of the norms and protocols at the sites through Technical Assistance visits.

Through the Technical Assistance visits, SDSH II will be able to perform the interventions mentioned above as well as improve indicators dedicated to strengthening the reporting of data reporting, which will eventually have a positive impact on the following indicators:

- **Indicator 1.3.3:** Percent of adults and children with advanced HIV infection known to be alive and on treatment 12 months after initiation of antiretroviral therapy
- **Indicator 1.3.10:** Number of OVC enrolled during the period
- **Indicator 1.3.11:** Number of OVC having received at least one OVC service
- **Indicator 1.3.12:** Number of OVC remaining active at the end of the period
- **Indicator 1.3.16:** Percent of HIV exposed newborns receiving PCR test in PMTCT sites

Specific trainings coordinated by SDSH II and performed by SCMS will focus on the management of drug stock for health workers. Routine meetings with the HIV input providers and SCMS will be conducted regularly to assure proper drug management and evaluate risk of stock outs.

Throughout the year, SDSH II will conduct Technical Assistance visits and workshops which are aimed to:

- Monitor the work plan
- Follow up on the performed based Indicators
- Ensure a good understanding of all indicators
- Ensure all reports are done properly and sent on time
- Ensure the application in the field of norms and protocols for all programs (VCT, HIV, TB, PMTCT, OVC, etc.)
- Ensure an appropriate use of national health system tools
- Provide lab technical assistance

1.3(b): Tuberculosis

TB therapies will be scaled-up and the project will support the implementation of assessments, standards and case findings related to TB infection. These activities are expected to result in an increased notification rate in new sputum smear-positive pulmonary TB cases per 100,000 population, nationally; increased percentage of all registered TB patients who are tested for HIV through USG-supported programs; increased rate of new smear-positive pulmonary TB cases detected under Directly Observed Treatment Short Course (DOTS); and increased percentage of registered new smear-positive pulmonary TB cases that were cured and completed treatment under DOTS (treatment success rate) in USG-supported areas. SDSH II will work to scale-up the provision of isoniazid preventative therapy (IPT) at targeted sites and will support comprehensive infection control (IC) assessments and implementation of SOPs, Norms and standards at all targeted sites.

- These strategies will have a positive impact on the following indicators:
- **Indicator 1.3.17:** Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG supported areas (3.1.2-3)
- **Indicator 1.3.18:** Percent of all registered TB patients who are tested for HIV (3.1.2-28)
- **Indicator 1.3.19:** Percentage of estimated new smear-positive pulmonary TB cases detected under DOTS in USG supported areas
- **Indicator 1.3.20** (internal): Percentage of health facilities implementing infection control program
- **Indicator 1.3.21** (internal): Percentage of providers trained in TB and HIV screening

With Technical Assistance from GHESKIO, SDSH II will implement GenXpert experiment in 3 sites for TB drug resistance tests. Upon identification of the sites, implementation will start; SCMS will ensure appropriate supply of input, equipment and accessories, and LNSP will help with lab staff trainings to ensure expected performance by the sites.

Objective 1.4: Support extended services such as recognition, and or medical treatment of protection cases in a limited number of sites

SDSH II is bringing a new dimension to its mission by introducing two new programmatic axes of intervention: Gender-Based Violence and Child Protection. The Gender Based Violence program will support women and men that have been abused either sexually, mentally or physically. The Child Protection program will assist any child, ranging from newborns to 18 year olds, and will target children who are vulnerable to abuses such as sexual exploitation, trafficking and child labor.

Not all aspects of GBV and CP cases will be managed in the selected sites; therefore the project and its partners will put support systems in place to facilitate further procedures during September and October 2012. Institutions providing psychosocial, juridical and legal services related to GBV and Child Abuse will be mapped. Furthermore, partnerships will be established with other institutions for referrals and counter-referrals. A GIS map will be produced by the project with the support of URAMEL.

From September to December 2012, 210 institutional and community health services providers as well as professionals in the legal/judicial sector will be trained in GBV and Child Abuse case management. SDSH II will maintain coordination with GHESKIO, CARE and the National GVB cluster to share information about previous trainings conducted and maps produced. Training plan and reports will be produced.

Four indicators have been defined for the proper implementation of the project covering the scope of knowledge, aptitude and attitude. Gender-Based Violence and child abuse are deeply rooted social problems. While acting to disseminate knowledge and mitigate the consequences, a preventive approach aimed at changing attitudes in the general population and among the youth in particular is necessary.

Thirty institutions will be selected within the SDSH II network to provide clinical assistance to survivors of gender-based violence and child abuse and to refer them to psychosocial, juridical and legal service providers. Specific criteria will be defined for site selection.

1.4(a): Gender-Based Violence (GBV)

Activities aimed at treating, referring and reporting cases of GBV will be established at 30 selected sites, including the 8 Centers of Excellence. It is expected that these activities will increase the number of health institutions in targeted areas providing clinical assistance for GBV cases, and also increase the number of people reached by a USG-funded intervention providing GBV services, such as health care, legal, psychosocial counseling, shelters, hotlines, etc. This will involve training for staff on how to identify, manage and refer cases of GBV to the appropriate services offered at public and private institutions, as well as ensuring that survivors have access to the necessary national forms required for reporting and the National Operating Procedures for filing charges with law enforcement officials.

1.4(b): Child Protection

Thirty sites will be identified to implement child protection services along with training activities for community level and clinical level staff. Activities in this area are expected to increase the number of health institutions providing clinical assistance and referrals of child protection cases to appropriate legal and social services, and to increase the percentage of community and clinical health staff. The project will provide training to community level and clinical staff on recognizing and referring protection cases to social and legal services, and will identify sites that can be capacitated to treat protection cases.

Although Gender-Based Violence and Child Protection represent new interventions for MSH, the collaboration with direct partners such as URAMEL and ANSH and indirect partners such as FHI, CARE, GHESKIO and UNICEF will allow a better understanding of those programs and improve the interventions within the project network.

Indicator 1.4.1: Number of sites in USG targeted areas providing clinical assistance to survivors of gender-based violence

Target = 30

A needs assessment for Gender Based Violence (GBV) will be conducted in September in close collaboration with URAMEL and Association Nationale des Scouts D'Haïti (ANSH) to establish a baseline for support. In that same month the existing guidelines, technical sheets and protocols produced by URAMEL and UNICEF will be inventoried. In coordination with the national GBV cluster data collection tools will be evaluated and updated, new ones will be developed if necessary in order to be used in the selected centers.

Structures for the provision of HIV/AIDS, FP/RH, STI and maternal health services in the selected sites are already established. Our goal is to integrate GBV management within those established structures to ensure that accessible and safe services are available to survivors, such as provision of Emergency Contraceptive Pills, antibiotics and ARV, and that prevention mechanisms are put in place to reduce incidents of GBV. A typical route for GBV and Child Abuse victims will be defined and used in all selected institutions, along with routine mechanisms guaranteeing privacy and confidentiality. Technical sheets for the integration of GBV services with HIV/AIDS, STI, FP/RH, and maternal health in 30 selected sites will be produced with the assistance of URAMEL. Institutions providing psychosocial, juridical and legal services related to GBV and Child Abuse will be mapped; a GIS map will be produced by the project with the support of URAMEL...

To insure proper implementation of activities aimed at treating, referring and reporting cases of GBV and Child Abuse, Technical Advisors and Operations Associates will conduct a total of 90 monitoring visits in January, April and July 2013. A midterm evaluation will be conducted in each of the 30 sites in April 2013. Supervision plans and reports will be produced.

Indicator 1.4.2: Number of people reached by a USG-funded intervention providing Gender-Based Violence services (GND-6)

Target = 80

ANSH will also support SDSH II in ensuring a sustainable knowledge transfer to the communities on GBV and CP through specific activities from October 2012 to July 2013. Educational program will be implemented with 30 youth groups around the country. Fifteen existing multipurpose emergency cells and four Scout Community Centers will be staffed with trained scout physicians, and existing Advanced Trauma Life Support ATLS certified psychosocial agents to jointly manage and refer CP cases to SDSH II supported sites and partners. One hundred awareness activities will be organized with sport and cultural events and door-to-door brochure distribution reaching 10,000 people. Moreover, 90 monitoring visits will be undertaken by regional supervisors and departmental monitors from ANSH to support proper activity implementation.

In addition, Seven hundred Community Health Workers, 60 community based female organizations and 50 community based youth organizations will be oriented through information sessions by URAMEL-trained facility staff to recognize GBV and CP cases and to be aware of available services and engage in community mobilization and education. SDSH II will undertake information sessions which will be conducted between November 2012 and January 2013.

In order to ensure more community ownership in finding solutions to GBV issues in their neighborhood, Sixty representatives from 60 community based organizations and 50 representatives from 50 youth organizations will be trained under URAMEL's training curriculum from October to December 2012. This curriculum will be focused on GBV and child abuse case identification and referral, special techniques of awareness promotion, community mobilization and education on GBV and CP issues and the availability of GBV and CP services. SDSH will take opportunity of national events such as the National Woman Day and the National Child Day to raise awareness of the communities on child abuse and GBV through community radio and dissemination of brochures with information on CP and GBV.

Indicator 1.4.3: Number of USG supported sites providing clinical assistance and referrals of child protection cases to appropriate legal and social services

Target = 30

Any data collected on sexual violence and Child Abuse must respect established ethical and safety principles, such as security, confidentiality, anonymity, informed consent, safety and protection from retribution, and protection of the data itself. SDSH II will support minor modifications if needed to 30 selected facilities to improve privacy and ensure that medicine responding to needs of abused children is appropriately stocked.

Indicator 1.4.4: Number of community and clinical health staff trained to recognize and refer protection cases to appropriate legal and social services

Target = 210

Fifteen existing multipurpose emergency cells and four Scout Community Centers will be staffed with trained scout physicians, and existing ATLS certified psychosocial agents to jointly manage and refer CP cases to SDSH II supported sites and partners.

Objective 1.5: Waste Management & Infection Prevention

Since the end of the HS-2007 Project, an adequate emphasis had not been put on waste management by either the SDSH partners or the Project's central level staff. Trainings had not been systematically provided to the renew staff and commodities essential to waste management had not been supplied to health facilities. Consequently, activities addressing this component had not been conducted on a regular basis to respond to problems raised by partners or discovered by supervisory teams during visits.

During the execution of SDSH II, a particular focus will be placed on waste management in order to correct these incongruities (*or discrepancies*).

Indicator 1.5.1: Percentage of sites complying with the norms and standards of MOH waste management and infection prevention guidelines

Target: 95%

In the past, the Project provided technical assistance to the MOH to elaborate waste management and infection prevention guide. Follow up will be made with the ministry in order to obtain revised or updated norms and guide regarding waste management and then to share them with every public and private partners of the project.

Needs assessment will be also be carried out to establish issues for each sites. Material and equipment will be made available to support waste control throughout the project network. Supervision visits will also be conducted to ensure follow up of recommendation made and guarantee compliance to norms established. In addition, the project technical staff will continue to provide to the MOH the former support they used to offer by actively participating in technical working groups.

Indicator 1.5.2- Number of people trained in handling medical waste

Target: 300

While guarantying the dissemination of norms and guidelines throughout the health service delivery points, the SDSH II project will simultaneously conduct trainings related to the management of medical waste for service providers and other health facilities staff.

Thereby, during the early stage of the project implementation, training of trainers will be held for staff at the departmental level and will then be followed by a cascade of trainings for the benefit of technical, administrative and support staff at the institutional level as well as in the community. Technical staff at the central level will also be updated on medical waste management in order to provide appropriate technical assistance and recommendations during field visits.

Incinerators will be placed in some health facilities and training on their maintenance will also be planned for suitable personnel. Monitoring of their use will also be conducted on a regular basis..

Indicator 1.5.3: Percentage of institutions executing a monitoring plan for Waste management and infection Control

Target: 95%

As detailed in the previous 2 paragraphs, health center staff of the whole project will be capacitated to effectively managed auto generated bio medical waste. Every facility will be

required to prepare and submit a plan that describes their activities to monitor and evacuate waste production as well as to prevent and control infection within their work area. Infection control includes access to clean water for hand washing, hand sanitizer, drainage of used water, sanitation and pest control. Roles and responsibilities will be clearly defined for personnel in charge of waste management. And pictures taken before and after the execution of the plan will be helpful to show improvement.

Technical assistance will be provided by the departmental directorates and/or the Project central staff to both NGO partners and MOH targeted zones. Quarterly reports will be submitted by each partner and feedback will be given by either the MOH departmental level or the project central level. Regular supervision visits will also take place to ensure effective implementation of the partner scheduled plan and to measure real improvement in waste management using a predetermined evaluation checklist.

OBJECTIVE 2: MOH Capacity to Manage and Monitor Health Services Strengthened at Decentralized Levels

Objective 2.1: Governance and Leadership

The project will work to assist USAID in strengthening departmental management of service delivery. This is expected to increase the supervision of facilities by Departmental staff through the use of supervisory checklists, and increase the percentage of USG-assisted service delivery points implementing quality assurance/quality improvement approaches. SDSH II will focus on issues such as regular supervision of health facilities to improve the quality of services and to ensure that standards and protocols are followed. The financial system, technical capabilities, human resources and operations management will be reinforced in order to ensure health service delivery through the coordination of all stakeholders' efforts.

Indicator 2.1.1: Percentage of facilities that receive a supervisory visit through USG supported programs

Target = 100%

Supervision is an essential support to health service delivery and capacity building and is key to ensuring the provision of excellent quality care to the beneficiaries. The Project will ensure that every health facilities supported receive at least one supervision visit during each semester. These supervisory visits will be provided by the technical staff either from the departmental directorates or from SDSH central level. The project has already financed the training of technical staff in all ten departmental directorates on integrated supervision and on the use of the MOH's supervision guide.

The SDSH project will continue to provide direct support to all Departmental Directorates for the planning, execution and follow-up of supervisory visits to health facilities. The Departmental Technical Advisors will give assistance to conduct weekly meetings in the departmental office and to ensure an effective coordination of the visits that will stem from an initial annual supervision plan elaborated in the beginning of the fiscal year. The project will also continue to finance the provision of supervision by reimbursing per diem and transportation fees, and the reproduction of MOH supervision guide, checklists and tools. The Project will also ensure the use of the supervision notebooks in all health facilities documenting problem solved and recommendation made during every visit made.

Indicator 2.1.2: Number of patients referred from one facility to another

Target =900

The establishment of an efficient referral system remains a significant concern for the MOH; this unmet need does not guarantee the continuum of care for the benefit of the targeted population. The project will provide technical support to the MOH in its efforts to address this important issue.

Once assessment of the available service will be done for the defined referral networks under the leadership of the departmental directorates with the support of other partners such as the LMG Project, the SDSH Project will ensure implementation of the designed reference and counter reference system.

Indicator 2.1.3: Percentage of Centers of Excellence (COE) implementing quality assurance/quality improvement approaches

Target = 100%

In an effort to quickly improve the quality and efficiency of health care in the centers of excellence, the SDSH project will implement the improvement collaborative (IC) approach. The technical support of a consultant will be utilized to effectively apply and develop this concept. An orientation session on the IC will be held for the benefit of SDSH II technical staff in the central office, followed by meetings with MOH staff at the central level to introduce the concept and obtain approval to scale it up at all 8 centers of excellence. After gaining the approval of the MOH health office, the Departmental Directorates will be oriented on this new approach.

With the support of the consultant, two to three technical areas for the IC will be designated by SDSH with the input of MOH staff from the departmental level. Best practices and appropriate strategies will then be identified to address the selected weaknesses and will be applied in the field during the implementation process. Frequent supervision, monitoring and sharing of results will help to boost the pace of improvements and will create a sense of friendly competition among the multiple health facilities teams. A mid-term evaluation meeting will facilitate discussion on the implementation process, the innovations tested, the solutions found to

problems and the lessons learned, and will lead to rapid development of an effective model of care in all COE.

Indicator 2.1.4 (internal): Number of Health Departments with coordination mechanisms for principal donors and institutional reinforcement

Target = 6

Technical support to the Departmental Directorates remains a high priority for the project. Departmental coordination meetings with all implementing partners will be held quarterly to identify and address service gaps and ensure availability of care. The ongoing monthly "*groupes thematiques*" meetings that focus on specific technical domains will cover issues raised from the partners' coordination meetings. The Departmental Technical Advisors will provide support in the planning and realization of quarterly workshops with the technical focal points of the health facilities. Presentations followed by discussion will take place on the performance, lessons learned and difficulties encountered by the health facilities.

In order to assess the performance management of the Departmental Directorates and build consensus about their stage of development and identify improvements needed, a MOST (Management Organizational Sustainability Tool) workshop will be conducted in the South, and the North West departments. An action plan detailing improvement priorities will be developed and carried out. These measures will lead to significant progress in the management systems and practices, resulting in improved services and strengthened sustainability. A Leadership Development Program (LDP) will be implemented in one other department (North East) with the technical assistance of the Leadership Management and Governance (LMG) Project.

Objective 2.2: Departmental financial management strengthened

SDSH II will build the capacity of the MOH and MSPP to utilize proven Performance Based Financing (PBF) models in all 10 departments. This is expected to result in an increased number of health facilities with improved accounting, specifically for internal receipts, and an increased number of facilities meeting established national financial management criteria. The project will assist in monitoring the targets set by the departments in order to reward the departments which successfully plan, manage and achieve the preset results.

Currently, it is almost impossible to talk about strengthening the financial management system without considering a computerization of the accounting system. Given the stakes and implications of such an initiative at the departmental directorate and health facility levels, it is crucial to involve the central level of the Ministry in the choice of adopting a single software application for accounting and financial management.

Indicator 2.2.1: Number of facilities with improved accounting

Target = 80

Standard management procedures have not been applied in MOH sites causing financial management to remain a real issue in MOH health facilities. The SDSH II Project will work at the departmental and health facility levels to change financing and accounting practices.

In the current configuration of the Ministry of Public Health, it is difficult if not impossible to launch a project at the departmental level without the involvement of the central level of the Ministry.

Accounting related activities will be conducted once the MOH has approved single accounting software to be used in all decentralized units. The MOH is working with the Ministry of finance on this matter. The completion of this activity will be a giant step in strengthening the financial management system of MOH departmental directorates and health facilities.

The SDSH project supported the computerization of departmental directorates as part of institutional capacity building; the available equipment will allow a rapid computerization of the accounting departments to efficiently produce financial information for decision making.

Assessment will be conducted at the 80 MOH health facilities to estimate accounting equipment needs of these sites that will be supported by the SDSH II Project. After the acquisition of appropriate equipment, the approved software will be acquired and installed. Trainings for software utilization and on financial management will then be conducted for MOH accountants at both departmental and health facility levels.

In order to ensure the full implementation of the computerized accounting system and the strengthening of the financial management of departmental directorates and health facilities, it is crucial to establish a monitoring committee to oversee the implementation and enforcement of such a system.

This committee will be composed of representatives of the Ministry of Public Health, MSH and other partners involved at the departmental directorate level which will be identified by the Ministry. The members of this committee will be responsible for making regular visits to the various departments to establish and support the implementation and the application of the financial management system. Following these visits, a report on the evolution of the implementation of the financial management system will be sent to the Minister's office and to other members of the committee.

Indicator 2.2.2: Number of Departmental directorates using the MOH approved accounting system for an integrated financial management system (taking account all sources of funds for the Departmental Directorate).

Target = 10 Departments supported

The Ministry of Health does not have reliable information on the donor profiles contributing to the health system in Haiti. To date it has not had the means or the ability to capture these funds and direct the interventions of the various actors. After the development of an integrated

financial management system which takes into account all sources of financing involved in the departmental directorates, the Ministry will be able to have control of all stakeholders in the sector and know the actual amounts spent by donors and the area of intervention. To establish this system, the departmental directorates will elaborate with the technical support of the project the list of all donors involved in their respective departments including the area and sub-area of intervention. A table will be developed to facilitate the collection of data.

After the data has been collected and entered, with the support of the SDSH II Project a coding system will be developed and configured in the selected accounting software so that financial information can be produced according to sources of funding and area of intervention. The national accounting plan would also be used to comply with the monitoring of the national budget.

On a monthly or annual basis, the departmental directors will send a financial report to the central Ministry. This report will present financial information by budget item, sources of funding and area of intervention. After consolidation, the central ministry could easily and transparently publish the funds injected in the health sector for a fiscal year by department, budget item, area of intervention and sources of funding.

Objective 2.3: Strategic information systems strengthened

SDSH II will emphasize accurate and timely reporting of Strategic Information at all sites and will assist departmental level staff in data collection and analysis. The expected results of this include increasing the percentage of USG-assisted facilities that submit timely, complete and accurate reports to the national level, and strengthening the MSPP's monitoring of health services at decentralized levels. Specifically, SDSH II will work with MOH departmental level staff to assist in collecting, tracking and analyzing patient data, and ensure that data oversight activities are conducted. Additional activities will include the development of monitoring plans and benchmarks to ensure accurate and timely reporting of data into GOH and USG data management systems.

For several years, MSH has emphasized the production of reliable and timely statistics that are used to periodically measure performance indicators of different health projects in Haiti managed by the organization. This has resulted in the timely availability of strategic information for these projects. However, the information generated has not been sufficiently used by the project management office for performance monitoring, nor at the local level for decision making.

During the annual period August 2012 - July 2013, the monitoring and evaluation system will be strengthened and strategies used will contribute to the improvement of its main functions:

- Production of strategic information
- Monitoring of interventions and results
- Evaluation of the quality and coverage of services
- Support for Departmental Directorates of the MSPP for the operationalization of the Routine Health Information System (SISR) and for control of PBF

The production of strategic information requires the establishment of an information system for the production of reliable strategic information, necessary for monitoring and evaluation and for use at all levels for decision making. The main strategic focuses consist of:

- A) Improving the ability of staff at sites supported by the project to validate data and use the information
- B) The use of tools for collecting and reporting data for the MSPP at all sites
- C) The establishment of a system to ensure that data from all project sites are posted on MESI

The involvement of staff at all levels in monitoring results can contribute to improved performance. To this end, the project will emphasize capacity building for the use of information for decision-making by:

- A) Promoting of the use of a wall chart comparing objectives and results
- B) Supporting monthly performance analysis meetings at the local level
- C) Organizing a meeting every two months for analyzing project performance

Ensuring reliable strategic information and quality services to the population served requires a strict control of the data quality and periodic assessments of the quality and coverage of services. In meeting this need, SDSH has planned for the implementation of two major evaluation activities during the year 2013:

- A) Focus group to document the causes of under-utilization of antenatal services in the intervention area of the SDSH network of partners;
- B) Data quality control survey for 2013;

Mechanisms of collaboration with the MSPP will be strengthened at the departmental level for:

- A) The operationalization of HMIS by:
 - a. Improving the management capacity of the MSPP at the departmental level for their involvement in the process of collecting and reporting data and the use of information for decision making
 - b. Support the achievement of quarterly meetings to analyze performance at the departmental level
- B) The control of PBF by:
 - a. The organization of PBF monitoring meetings with the officials of the Departmental Directorates for the appropriation of this contractual approach
 - b. The involvement of senior departmental directorates in conducting surveys of quality control data and evaluate the results before the payment of performance bonuses

The activities above will contribute to the following indicators:

Indicator 2.3.1: Percentage of USG-assisted health facilities that submit reports to national level in on a timely basis

Target= 90%

Indicator 2.3.2: Percentage of facilities that receive a data quality assurance visit

Target= 100%

Indicator 2.3.4. (internal) : Number of operational research realized to document challenges to utilization of health services and best practices eligible for scale up

Target= 3