Annual Report: August 2012 – July 31, 2013

October 31, 2013

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Santé pour le Développement et la Stabilité d'Haïti (SDSH II)

Annual Report
August 2012 – July 2013

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMSTL	Active management of the third stage of labor
ANC	Antenatal care
ANSH	*Association Nationale des Scouts d'Haïti*
ART	Antiretroviral Therapy
ARV	Antiretroviral
COE	Centers of Excellence
CP	Child protection
CTD	*Conseiller Technique Départemental*
CYP	Couple years protection
DOTS	Directly Observed Treatment, short course
DRI	Direct Relief International
FOSREF	*Fondation pour la Santé Reproductrice et l'Education Familiale*
FP	Family planning
GBV	Gender-based violence
HBB	Helping Babies Breathe
HIV	Human immunodeficiency virus
IC	Improvement Collaborative
KMC	Kangaroo mother care
LMG	Leadership, Management, and Governance
LMS	Leadership, Management, and Sustainability Program
MCH	Maternal and child health
M&E	Monitoring and evaluation
MNCH	Maternal newborn and child health
MOU	Memorandum of understanding
MSH	Management Sciences for Health
MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Public Health and Population)
NGO	Nongovernmental organization
ORS	Oral rehydration salts
OVC	Orphans and vulnerable children
PBC	Performance-based contracts
PCHA	Polyvalent Community Health Agents
PCR	Polymerase chain reaction
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
PO	Purchase order
PWW	Pure Water for the World
RH	Reproductive health
SCMS	Supply Chain Management System
SDSH	*Santé pour le Développement et la Stabilité d'Haïti*
SDSH II	*Santé pour le Développement et la Stabilité d'Haïti II*
SIDA	Syndrome de l'immunodéficience acquise
SONUB	*Soins néonatals d'urgence de base*
SONUC	*Soins obstétricaux et néonatals d'urgence complets*
TB	Tuberculosis

TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
URAMEL	*Unité de Recherche et d'Action Médico - Légale*
USAID	United States Agency for International Development
USD	United States dollars
USG	United States Government
WASH	Water, sanitation, and hygiene
ZC	*Zone Ciblée* (target area)

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) awarded Management Sciences for Health (MSH) the *Santé pour le Développement et la Stabilité d'Haïti* II (SDSH II) project in August 2012 as an extension to the successful SDSH – *Pwojè Djanm* project (2007-2012). SDSH II continued to improve access to and quality of the Government of Haiti's defined basic package of services and strengthened departmental-level MSPP capacity to manage and monitor the delivery of health services.

A provider takes a woman's blood pressure at Cazale Health Center.

Through performance-based contracts and memorandums of understanding, SDSH II provided technical and financial support to 164 health facilities through 26 nongovernmental organizations (NGOs) working in 65 sites, as well as 99 public, MSPP-supported service delivery points within the 41 *Zones Ciblées* (target zones) across 10 of Haiti's departments. Twelve new sites were added throughout the life of the project. Health service delivery activities primarily benefited children, youth, young adults, women, and vulnerable populations, including persons with HIV/AIDS and tuberculosis, as well as survivors of gender-based violence. Through these 164 sites, SDSH II helped provide access to the Priority Package of Integrated Services (*Paquet de Services Prioritaires Intégrés)* for nearly 4.5 million people.

MSH collaborated with three local partners: *l 'Association Nationale des Scouts d'Haïti* (ANSH), for youth programs, peer counseling, and child protection; *Unité de Recherche et d 'Action Médico Légale* (URAMEL), for gender-based violence; and *Fondation pour la Santé Reproductrice et l'Education Familiale* (FOSREF) for youth-friendly services. Three international partners, Direct Relief International (DRI), Pure Water for the World (PWW), and the Caris Foundation, collaborated on the project as well.

Through both facility and community-based services, SDSH II provided 385,195 couple years of protection and increased the percent of women of reproductive age in the targeted areas who use a modern method of family planning to 34 percent from just 30 percent at the beginning of the project.

SDSH II placed a special emphasis on capacity building. The project trained 1,758 Polyvalent Community Health Agents to provide family planning services and educate their communities about healthy behaviors, including seeking antenatal care and HIV testing. They also educated caregivers about nutrition for the children in their care and using proper hygiene to prevent childhood diarrhea and other communicable diseases. Nearly 55,000 caregivers received information on child health, 698,936 children were reached by the nutrition program, and 111,900 children under one year of age were fully vaccinated.

SDSH II upgraded 11 sites to provide antiretroviral therapy and 11 sites to provide prevention of mother-to-child transmission services during the project year; 134,447 individuals were counseled and tested for HIV and received their results. Over 2,000 new patients were enrolled on antiretroviral therapy, and 875 HIV-positive women received antiretroviral therapy to reduce the risk of mother-to-child transmission of HIV.

To demonstrate that the consistent provision of high quality services is possible in Haiti, SDSH II established eight Centers of Excellence that will serve as mirrors of the integrated priority package and model facilities for the rest of the network. Each center provided integrated care for maternal, neonatal, and child health, reproductive health and family planning, and HIV and tuberculosis. Providers at each center were trained in emergency obstetric services, and all but one were able to provide caesarian section deliveries in case of obstetrical emergencies.

Through both facility and community-based services, the project significantly improved coverage of basic services. For example, SDSH II provided 385,195 couple years of protection and increased the percent of women of reproductive age in the targeted areas who use a modern method of family planning to 34%, from just 30% at the beginning of the project.

SDSH II strengthened the capacity of the *Ministère de la Santé Publique et de la Population* (MSPP, Ministry of Public Health and Population) at the central level, focusing on updating norms and guidelines, and at departmental level, to perform critical functions such as strategic work planning, financial management, and clinical supervision.

The project encountered numerous challenges throughout its implementation, including stock outs of essential vaccines and vitamin A and difficulties filling open positions and retaining qualified candidates. But the project persevered and gained momentum as the year progressed. The *Coup de Poing* efforts in July of 2013, consisting of a massive intensification of field activities at the most affected sites in the ten departments, particularly in the areas of HIV/AIDS and tuberculosis, maternal and child health, family planning, and waste management, produced dramatic results. The July results show great increases in the number of women seen by skilled providers for antenatal care, postpartum/newborn visits within three days of birth, the number of children under one year of age who received DPT3 or the Pentavalent3 vaccine from USG-supported programs, couple-years protection, pregnant women with known HIV status, counseling and testing for HIV, support to orphans and vulnerable children, and the percent of tuberculosis patients tested for HIV.

INTRODUCTION

The United States Agency for International Development (USAID) awarded Management Sciences for Health (MSH) the *Santé pour le Développement et la Stabilité d'Haïti* II (SDSH II) project in August 2012 as an extension to the successful SDSH – *Pwojè Djanm* project (2007-2012). For five years, SDSH provided access to essential health care for nearly half of the Haitian population.

Clients wait to be seen outside a clinic.

SDSH II, like its predecessor, focused on improving the quality of and access to Haiti's basic package of health services and strengthening the *Ministère de la Santé Publique et de la Population* (MSPP, Ministry of Public Health and Population). Through performance-based contracts and memorandums of understanding (MOUs), SDSH II empowered both private and public facilities to improve the quality of care they provided, and in turn reward their staff for jobs well done.

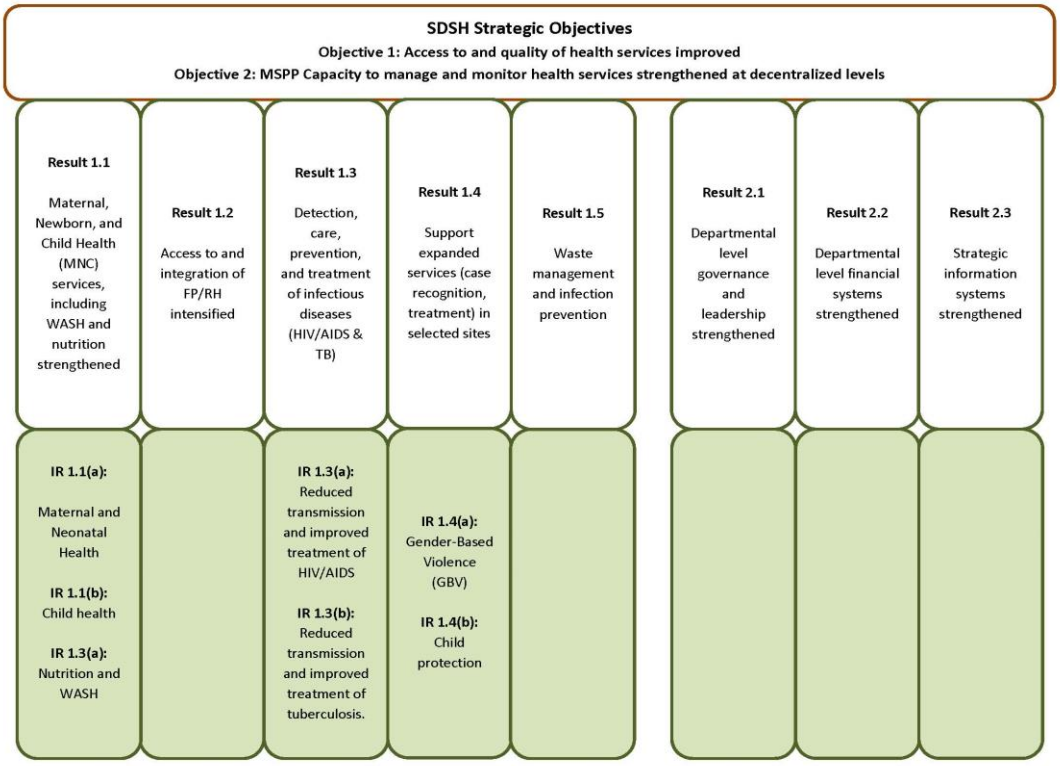
Project purpose and objectives

The overall purpose of this one-year extension project was to continue, and in some instances expand, the provision of the Government of Haiti's basic package of primary health care services to people served by USAID SDSH, and to continue targeted assistance to the departmental level MSPP to support service delivery. SDSH II implementation was guided by the following two objectives:

1. **Improve access to and quality of the Government of Haiti's defined basic package of services.** Support the delivery of a basic package of services and targeted infectious disease prevention, including HIV/AIDS, tuberculosis (TB), maternal and child health (MCH), water, sanitation and hygiene (WASH) and nutrition, and family planning (FP). Further emphasis will be placed on gender-based violence (GBV) and child protection.
2. **Strengthen departmental-level MSPP capacity to manage and monitor the delivery of health services**. Help to rebuild and reform the management of public health services and increase support to the MSPP in strengthening systems and governance at the departmental level.

The following results framework reflects the contractual commitments and shows the direct relationship between these elements.

Figure 1: SDSH II Results Framework



The elements of each Result Area and Intermediate Result will be discussed in further detail below.

Partners

MSH collaborated not only with its public and private partners but also with three experienced local partners:

- *l'Association Nationale de Scouts d'Haïti (*ANSH): youth programs, peer counseling, child protection
- *Unité de Recherche et d'Action Médico Légale* (URAMEL): gender-based violence
- *Fondation pour la Santé Reproductrice et l'Education Familiale* (FOSREF): youth-friendly services.

Partners and Roles	
ANSH	Youth/CP/GBV
URAMEL	GBV
FOSREF	Youth/CP
PWW	WASH
DRI	Supplies/Logistics
CARIS	PMTCT/Pediatric HIV

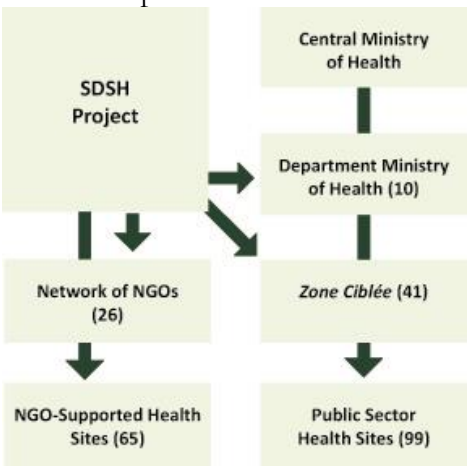
MSH also continued its work with three long-standing international collaborating partners. Direct Relief International (DRI) and Pure Water for the World (PWW) collaborated without funding or a direct contracting mechanism. The Caris Foundation received a subcontract for the management of pediatric AIDS.

This report covers the period of August 2012 to July 2013 and presents the strategies used to achieve the results obtained in each programmatic area. This work has been realized through the dedicated collaboration of the project's central and departmental staff and its field partners. MSH is taking this opportunity to thank all of them.

PROJECT DESIGN

SDSH II was designed to provide a consistent stream of funding for the delivery of essential services in hard to reach areas, while simultaneously improving technical quality, expanding service delivery, and building the departmental level MSPP staff's capacity to oversee all essential functions related to high quality service delivery.

Figure 2: SDSH II Contracting Relationships



The project retained the essential contracting approaches of the original SDSH project, using several funding mechanisms to assure continuity and expansion of services. The primary scheme was the performance-based contracts (PBCs) that were given to 26 NGOs and 41 *Zones Ciblée* (ZCs, target zones), which together supported 164 sites. This relationship is illustrated in Figure 2, and the mechanism is described in the next section.

In addition to the PBCs, the project also provided direct funding for specific activities (most notably the Centers of Excellence) though a series of purchase orders. SDSH II assisted the departmental directorates to facilitate priority activities through MOUs with all ten departments. These MOUs (officially referred to as Integrated Departmental Plans, or *Plans Departmental Intégré* in French) were agreed on according to specific work plans and budgets developed in collaboration with SDSH II's field teams in each department. This collaboration also built the capacity of departmental level staff.

To facilitate the relatively complex system of funding, SDSH II embedded project staff at the departmental offices in all ten departments. The departmental teams consisted of a minimum of one CTD (*Conseiller Technique Départemental,* Departmental Technical Advisor), a Finance Manager, and one or two drivers. The CTDs worked closely with the Departmental Directors through routine meetings and joint site visits, where they employed the supervision checklist developed by SDSH II to guide their supervisory activities in the 164 project-supported health facilities. SDSH II conducted 750 visits during this reporting period. These teams were further reinforced by central office staff in Port au Prince serving in each of the priority technical areas.

In addition to the usual administrative and logistics staff, the central office also consisted of a full finance office and a contracts office to manage the subcontracts, MOUs, and purchase orders. A robust monitoring and evaluation (M&E) unit was employed to monitor progress, assure quality data, and help build M&E capacity at the departmental level. A full project organizational chart can be found in Annex C.

Performance-based contracting and MOUs

MSH introduced PBC into its Haitian projects in the 1990s. This funding mechanism proved effective in improving performance at the facility level, and it continued to be a foundation of the

subcontracting program through SDSH and SDSH II. The Finance Manager embedded by SDSH II in each of the departments ensured efficient management of funds and supported MSPP facilities within the ZC. He or she managed the disbursement of expenses from these department accounts on behalf of the supported facilities and departments, with the goal of ensuring sound procurement and expense documentation procedures. Central office staff in Port au Prince provided both oversight and quality checks.

Table 1. NGO and ZC Achievement of Indicators

NGOs	ZC	Percent of Indicators Achieved
4	1	100%
4	1	80%
11	8	60% - 75%
5	10	40% - 50%
2	15	20% - 33%
0	6	0%

At the end of the contract period, SDSH II engaged three independent firms to validate the data collected in the facilities. The firms randomly selected representative indicators and sites representative of each NGO and ZC. They visited 67 selected sites in August 2013 and confirmed the data that had been submitted to the project throughout the year. Final bonus payments were made according to the validation of data, as summarized in Table 1.

The data show that achievement in the ZC facilities was markedly lower than the NGO-supported sites. Twenty-one ZC sites (51 percent) achieved 33 percent or fewer of their indicator targets as measured in the validation survey.

These scores are disappointing, especially considering that the targets set in the sub-agreements were considered to be reasonably challenging but attainable. It was fully expected that the ZC scores would be lower than the NGOs, who have received USAID support for a much longer duration. Nevertheless, this does indicate the need for intensified focus on the ZCs in the future. Supervisory visits must be increased with focused attention to follow-up of the recommendations made after the visits. Specific deficiencies should be targeted, and the departmental level staff must play a greater role in integrating quality assurance measures into the ZC sites.

Integrated Departmental Plans

Together with the CTDs and Departmental Directors, SDSH II supported Integrated Departmental Plans (*Plan Departmental Intégré,* in French), which were designed to provide direct support to the departmental directorates for priority activities within the sphere of SDSH II's objectives. They included the following activities:

- Supervision visits by appropriate departmental staff to the facilities in the field
- Some operational costs of the departmental directorate
- Coordination meetings
- Meetings with stakeholders working in the departmental directorate
- Monthly meetings in the targeted zones with Polyvalent Community Health Agents (PCHAs) and traditional birth attendants (TBAs)
- Trainings

The departments worked with the CTDs to develop work plans and budgets before signing an MOU with SDSH II. These activities build sustainability into the project. SDSH II worked with

departmental MSPP staff by providing mentoring and support as they transferred skills throughout the life of the project.

Centers of Excellence

SDSH II established a select group of facilities, termed Centers of Excellence (COE), which served as role-model clinics for others in the areas served by the project. These centers entirely respect the policies, norms, and requirements the MSPP has outlined as necessary for *Soins Obstétricaux et Néonatals d'Urgence de Base* (SONUB) and *Soins obstétricaux et néonatals d'urgence complets* (SONUC) (the two levels of emergency obstetric care) facilities. These centers demonstrate excellence in integrating basic reproductive health and family planning (RH/FP), maternal, newborn, and child health (MNCH), HIV/AIDS, TB, and nutrition, with an emphasis on achieving the highest quality of services. A COE is a point of contact and a resource, a hub for innovative approaches for disease prevention and management.

In consultation with the MSPP and USAID, SDSH II selected eight COE based on six criteria:

- Effective institutional leadership
- Geographic location with preference to health centers located in USG investment corridors
- An average of 30 deliveries per month
- A well-functioning prevention of mother to child transmission (PMTCT) program
- Experienced staff able to deliver antiretrovirals (ARVs) along with palliative care
- Prior investments with Direct Relief International (DRI)

SDSH II established the following COE:

Table 2. Centers of Excellence

Location	Selected Centers	Status
Nord Est	1. Ouanaminthe	SONUC
	2. Fort Liberté	SONUC
Nord	1. CBP Pignon	SONUC
Nord-Ouest	1. Beraca	SONUC
Ouest	1. Fondefh Martissant	SONUB
Grande Anse	1. AEADMA	SONUC
Artibonite	1. Hôpital Claire Heureuse	SONUC
	2. Pierre Payen	SONUC

In an effort to quickly improve the quality and efficiency of health care in the COE, SDSH II facilitated a network between all eight COE with the support and participation of the MSPP. This improvement collaborative (IC) approach catalyzed knowledge exchange between the centers and facilitated the training of 43 providers. The IC and COE are discussed further under Objective I.

Polyvalent Community Health Agents

To better serve Haiti's most vulnerable populations, particularly those living in remote areas, the MSPP launched a new initiative to provide more comprehensive training for community health workers. With the support of its partners, MSPP planned to train 4,000 Polyvalent Community

Health Agents (PCHAs) in 2013. SDSH II trained 1,758 of these agents, nearly half of the national target. With one PCHA for every 200 families, or approximately 1,000 people, they are being deployed to reinforce community sensitization and mobilization, strengthen local health committees, conduct regular household visits and more structured supervision visits, contribute to the rapid evacuation of obstetrical and neonatal emergencies, and monitor FP compliance during rally posts and mobile clinics.

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SUMMARY OF RESULTS

SDSH II placed continuous focus on measurable results and sustainable impact, with an emphasis on quality improvement. Although resources were limited for infrastructure improvement, the project was able to fund minor repairs at 20 sites. Both NGO and MSPP partners improved their capacity for leadership with the help of forms, guidelines, educational materials, and tool kits developed by SDSH II, as well as the distribution of norms and protocols for service delivery. Community participation and SDSH II-supported community-based services improved access to services for Haitians in remote areas.

Though the project encountered several challenges along the way, SDSH II achieved significant results in a number of areas. SDSH II met 68 percent of the key project indicators at a level of 80 percent or above, including the following:

- The number of children under five reached by U.S. government (USG)-supported nutrition programs (137 percent of target)
- The number of couple-years of protection (CYP) provided in USG-supported programs (111 percent of target)
- The percent of all registered TB patients who are tested for HIV (target: 70 percent, achievement: 86 percent)
- The percent of children under one fully vaccinated in USG supported programs (target: 92 percent, achievement: 84 percent)
- Percent of people in reproductive age using a modern family planning method in USAID geographic targeted areas (target: 32 percent, achievement: 34 percent)
- Number of people reached by a USG-funded intervention providing gender-based violence services (219 percent of target)

SDSH II faced obstacles in achieving the following indicators, but made significant progress toward meeting Haitian's needs in these areas:

- The number of deliveries with a skilled birth attendant in USG-assisted programs (48 percent of target)
- The percent of HIV-positive women who received antiretroviral therapy to reduce the risk of mother-to-child transmission in a PMTCT setting (goal: 89 percent, achieved: 67 percent)
- The number of people newly initiating antiretroviral therapy during the reporting period (Although the number of people initiating ART more than doubled during SDSH II over the last year of SDSH, we met only 64 percent of this target.)

A complete table of results can be seen in Annex A: Performance Monitoring Plan.

The Coup de Poing

In the fourth quarter, SDSH II implemented the *Coup de Poing* strategy to increase service uptake in the community. As part of the initiative, the Port au Prince-based technical staff traveled to the field to advise and mentor MSPP and NGO staff, which improved not just the field-based staff's technical skills, but morale as well, resulting in large gains toward the end of the project. The Port au

Prince-based staff reinforced the use of the supervision checklist during all visits to facilities. More stringent use of this checklist resulted in improvements in quality of service delivery and uptake. This explains much of the increase in the results in the final month of the reporting period, which can be noted in the following sections.

During July 2013, SDSH II mobilized funds to increase the number of mobile clinic visits that were made throughout the network. The mobile clinics, combined with intensified efforts at the facility level, resulted in huge gains in many areas. As demonstrated in the following sections, the *Coup de Poing* resulted in marked improvements in antenatal care (ANC) visits by skilled providers, postpartum/newborn visits within three days of birth, the number of children under one year of age who received DPT3 or the Pentavalent3 vaccine from USG-supported programs, couple-years protection, pregnant women with known HIV status, counseling and testing for HIV, support to orphans and vulnerable children (OVC), and the percent of TB patients tested for HIV.

OBJECTIVE 1: IMPROVE ACCESS TO AND QUALITY OF BASIC HEALTH SERVICES

This objective was the primary focus of activities and funding for SDSH II, in which technical and financial support was provided to 164 health facilities throughout Haiti's ten administrative departments to deliver quality services in the MSPP priority areas of maternal, newborn, and child health (including nutrition, water, sanitation, and hygiene), RH/FP, and the detection, care, prevention, and treatment of HIV/AIDS and tuberculosis. SDSH II-supported facilities also provided medical services and referrals to vulnerable children and ensured the provision of health services to survivors of GBV and referrals for legal assistance, psychological support, and educational opportunities.

Centers of Excellence

The eight COE established under SDSH II demonstrated that achieving the highest possible quality of services in the Haitian context is possible. The COE were models for integration of MNCH with RH/FP, nutrition, and HIV/TB that are replicable in facilities across the country.

The IC approach linked the COE together for a limited period of time to facilitate rapid improvements in maternal, neonatal and child morbidity and mortality, HIV/AIDS, and the unmet need for FP. As part of the approach, a quality team was established at each COE. The IC helped teams change their mindset to achieve results in a short period of time. They applied agreed upon quality standards for service delivery in the areas of cleanliness and courtesy toward patients, reduction of waiting time, wearing uniforms, scrupulous respect of the work schedule, and waste management. Staff at the COE focused specifically on infection prevention, particularly in the maternity wards and the delivery rooms, the maintenance of the cold chain, FP compliance with U.S. federal regulations, and the continuous provision of services.

The quality teams maintained journals for areas in which their centers were not meeting standards that they had power to change and identified improvements they could make. For instance, the team in the Ouanaminthe Health Center decided to operate laboratory and pharmacy services 24 hours a day, seven days a week, to meet the demonstrated needs of the health center and community for continuous services.

To ensure close monitoring of the IC, one staff member from each of the COE was designated as a focal point. The focal points tracked all developments and monitored the COE teams through phone calls, emails, and site visits. SDSH II staff mentored the focal points on basic but important management techniques, such as how to review health system data to plan for future interventions and basic service delivery requirements.

By the end of the project, all COE improved waste management and infection prevention at their sites, reduced waiting times, and provided a more welcoming environment for their patients. SDSH II supported the recruitment of additional providers and the development of materials to improve waste management and infection prevention, as well as educational flyers and posters. SDSH II worked with DRI to deliver equipment to each COE. However, some constraints were still pervasive and beyond the control or scope of the project, particularly stock outs of important commodities,

such as Vitamin A, Zinc, and vaccine commodities that were supposed to be provided by MSPP and UNICEF.

During the second quarter, SDSH II conducted an assessment of all COE, with the aim of making them fully functional by February 2013. SDSH II reported notable progress on the quality of patients' reception, timely staff attendance, waste management, facility cleanliness, infection prevention, and sanitation at five COE. In addition, COE have reported that partographs are used to monitor labor and delivery.

Result 1.1: Maternal, Newborn, and Child Health services including WASH and nutrition strengthened

SDSH II continued its predecessor's emphasis on improving emergency obstetric, neonatal, and perinatal care, and integrating WASH and nutrition by engaging active partners at the departmental, facility, and community levels.

1.1 (a): Maternal and Neonatal Health

Infant and maternal mortality in Haiti remain the highest in the hemisphere, with infant mortality estimated at 59 per 1,000 live births (DHS 2012) and maternal mortality at 630 per 100,000 (National Strategic Plan 2012-2016 MSPP). SDSH II sought to improve maternal and neonatal care, and thus reduce morbidity and mortality, by providing basic maternal and neonatal care at all sites, while also increasing the number of sites offering specialized care and supporting community-level birth planning activities. To achieve this, the project emphasized capacity building, securing a supply chain of essential commodities, and implementing some key interventions to ensure quality improvement. SDSH II focused its maternal health efforts on mitigating major maternal killers: post-partum hemorrhage, eclampsia, and infection.

MNCH Achievements

- 292,280 ANC visits to skilled providers
- 56,081 postnatal home visits within 3 days of birth
- 14,483 births attended by a skilled provider
- 698,936 children reached with nutrition monitoring services
- 89% of women received AMTSL at the COE

The project worked to increase the percentage of births attended by skilled healthcare professionals, the number of antenatal care visits by skilled providers, the number of functional (equipped, trained, and supervised) PCHAs, the number of post-partum/newborn visits within three days of birth, the percentage of births delivered by caesarean section, and the percentage of women receiving active management of the third stage of labor. The project trained 136 providers to deliver quality contraceptive counseling and method provision and better monitor pregnancy and childbirth, including active management of the third stage of labor and the management of essential commodities (magnesium sulfate, oxytocin, drifts ergotamine, and antibiotics). Newborn interventions included trainings for 45 providers on helping babies breathe and kangaroo mother care (KMC). The eight COE provided active management of the third stage of labor to approximately 89% of women delivering in their care.

The project developed, printed, and distributed 8,000 sets of information, education, and communication materials, including posters, protocols, checklists, and pamphlets to help improve the quality of services and engage communities. These materials facilitated the work of health workers and community groups at rally posts and community meetings (mothers clubs, maternal mortality surveillance committees, etc.).

Number of antenatal care visits provided by skilled providers

The project emphasized prenatal surveillance to ensure that pregnant women received at least three prenatal visits before delivery. SDSH II conducted regular social mobilization sessions to create demand for ANC, disseminated educational messages, and trained mothers' clubs and maternal mortality surveillance committees on topics related to safe motherhood (danger signs, recognition, and follow-up), at-risk pregnancies, and obstetrical emergencies. SDSH II coordinated with partners to ensure that vaccines and commodities were always available to pregnant women at all sites.

The project also supported improvements in care to entice women to attend ANC visits. When pregnant women missed an ANC appointment, TBAs and PCHAs followed up with them in their homes. The TBA or PCHA reported on several occasions that the reason the woman missed her appointment was that she either didn't have someone to watch her children or she had another obligation. In such cases, the community health workers helped mothers overcome these obstacles and arrange for follow-up visits at the clinic.

The project recruited additional skilled providers at selected sites, especially the COE, to ensure availability and improved quality of the essential package of ANC services. The IC instituted changes that improved the clinic environment, such as reducing wait times, coaching staff on creating a welcoming environment, and providing drinking water. SDSH II coordinated with Direct Relief International (DRI) and CODEVI to ensure availability of essential drugs and laboratory materials.

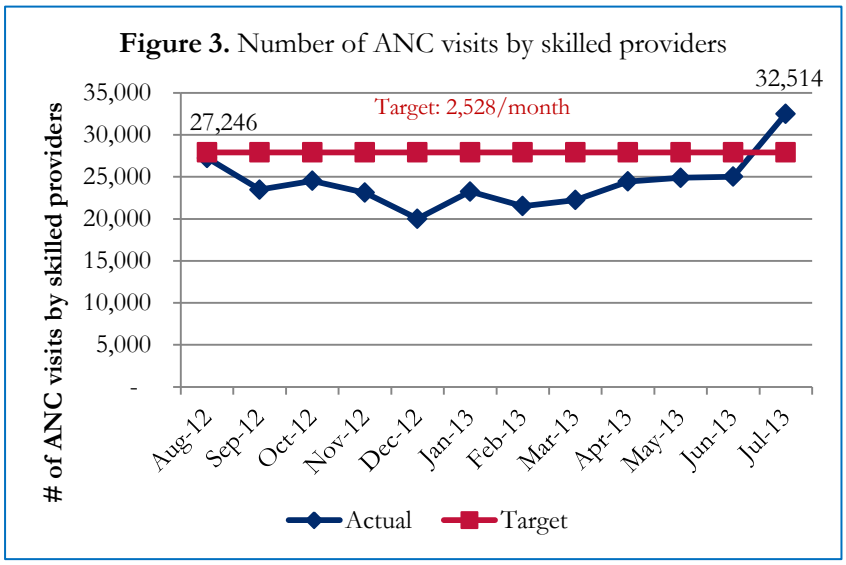


Figure 3. Number of ANC visits by skilled providers

Since the majority of pregnant women covered by SDSH II reside in remote areas, the project supported mobile clinics to reach women unable to visit the institutions. As seen in Figure 3, the *Coup de Poing* efforts in July 2013 boosted ANC attendance in the last month of the project, increasing visits to over 32,500 for the month, a more than 25 percent increase over the previous month and an increase of more than 35 percent over the life-of-project monthly average. The *Coup de Poing* increased availability of prenatal multivitamins and mobile clinics, directed clients to

facilities that offered reduced fees, developed a list of pregnant women for tracking, and distributed prenatal kits. All of these efforts helped the project achieve 87% of its life-of-project target (292,280 total ANC visits).

One reason it was difficult to attract women to facility-based ANC might have been that other NGOs offer incentives, such as food or baby clothing, to women attending ANC, which motivates them to travel to the clinics. SDSH II strived to counteract that by offering community-based services in women's homes and at markets. Unfortunately, funding was insufficient to fully realize the potential of the mobile clinics to reach women for ANC.

More than 290,000 pregnant women made at least one prenatal visit to a skilled provider, but only 45 percent achieved three prenatal visits as recommended by the national norms, missing the target of 51 percent. A limiting factor in achieving the ANC targets was the inability of some sites to offer laboratory tests. Furthermore, SDSH II-supported facilities required payment for ANC services, as well as for medicines and drugs at their pharmacies, which was not the case in many facilities competing with SDSH II. These fees acted as a deterrent and must be eliminated to increase ANC uptake in the project's catchment areas.

Increasing the number of births attended by skilled birth attendants (midwifes, nurses, doctors) in USG-assisted programs

Home delivery is an entrenched aspect of Haitian culture. With 64 percent of all births occurring at home according to the DHS 2012, encouraging mothers to deliver with a skilled attendant at a facility was one of the most challenging aspects of the project. Due to a lack of trained providers, proper infrastructure, and adequate equipment, only 26 percent of the 164 project-supported sites were able to provide safe delivery services, limiting the total number of women the project could serve. The number of births attended by skilled providers remained relatively flat throughout the life of the project, and SDSH II was only able to achieve approximately 50% of the life-of-project target—a target that increased by nearly 200 percent over the previous year's target. It should be noted that SDSH II realized a more than 10 percent increase in the number of births attended by skilled birth attendants compared to SDSH's achievement in this indicator in its final year.

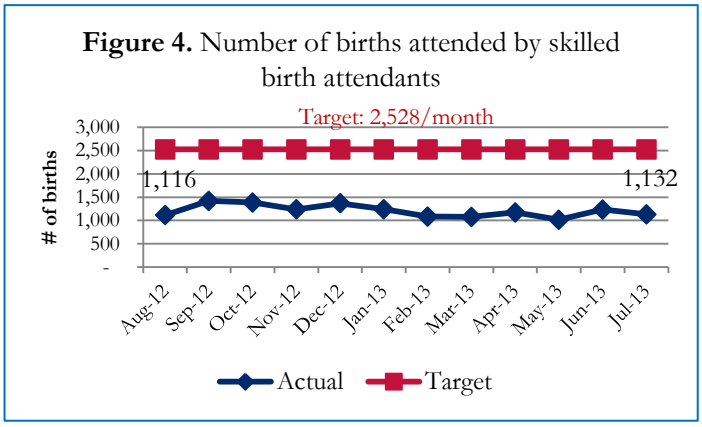


Figure 4. Number of births attended by skilled birth attendants

To fill the gap left by the inadequate access to facility-based deliveries, 100 TBA supervisors were trained at the eight COE institutions in collaboration with Direct Relief International, followed by distribution of TBA kits for safe deliveries. SDSH II subsequently organized refresher training for 2,000 TBAs to ensure safer home deliveries. When possible, nurse auxiliaries supervised TBAs during home deliveries. SDSH II conducted monthly meetings with the TBAs to ensure improved skills and quality assurance for safe deliveries. This cadre of health care workers meets an important

need in Haiti, where not only are there too few facilities with the capacity to care for laboring women, but women are more comfortable delivering in their homes. The TBAs and associated nurse auxiliaries were trained to make prompt referrals and arrange for emergency transportation in the case of complications.

To improve referrals for delivery, SDSH II selected 43 sites as part of a formal network of referrals and counter-referrals for tracking normal deliveries at 35 sites and both caesarean and uncomplicated deliveries at eight sites. SDSH II updated the information on the services offered at each site, contact information (phone and e-mail) for each institution, service schedules, and referral and counter-referral forms. The team developed a checklist for data collection, including the referral forms, and distributed it to all institution directors.

To improve service quality, the project continuously trained providers and conducted regular monitoring and supervision of maternal and neonatal services at the facility and community levels. In addition, the project supported the implementation of 31 maternal mortality committees who helped facilitate referrals of obstetrical emergencies, conducted evacuations of women in complicated labor, and promoted awareness of the importance of seeking prenatal care and developing birth plans, particularly for institutional deliveries of at-risk pregnancies. Besides training and coaching, the project provided 22 stretchers, 10 megaphones, and other materials, such as flashlights and boots, for the committees. These committees carried out 1,189 home visits and referred 300 pregnant women to health facilities.

Percentage of births delivered by caesarean section

With the training provided through the IC, the project achieved important changes in case management of obstetrical emergencies. In the eight COE, providers routinely used new tools, including partograms, to follow labor phases and pinpoint clear and timely indications for caesarian sections. SDSH II provided training sessions on quality case management of obstetric and gynecological emergencies for the eight COE.

During the reporting period, 2,554 deliveries were registered in the four major COE, *Hôpital Claire Heureuse, Hôpital Bienfaisance de Pignon, Hôpital de Fort Liberté,* and at *Hôpital Beraca*, of which 411 (16 percnet) of these deliveries were made by caesarian sections. This high percentage should be interpreted with consideration that the COE are referral centers and therefore receive more difficult cases, most of them coming from outside their catchment areas.

Percentage of women receiving active management of the third stage of labor

At least three providers at each COE were trained to systematically provide active management of the third stage of labor (AMTSL) to all parturient. In the other 35 sites providing delivery services, at least one provider was trained on AMTSL. The training emphasized that post-partum hemorrhage is the leading cause of maternal death and that the best way to prevent postpartum hemorrhage is through AMTSL, particularly the administration of an uterotonic and massage of the fundus after birth. SDSH II-trained providers exceeded the target set for the percentage of women who received AMTSL during delivery. Eighty-nine percent of all deliveries at the COE received AMTSL. As shown in Figure 5, SDSH II exceeded the target for women receiving AMTSL in each month of the project.

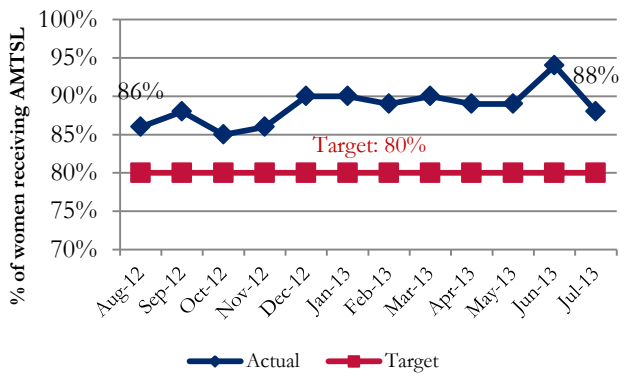


Figure 5. Percentage of women receiving active management of the third stage of labor

Number of postnatal/newborn visits within three days of birth

In accordance with MSPP norms, the project developed community strategies to promote early postnatal visits targeting women who delivered at home to ensure timely detection of life-threatening complications for both mothers and newborn babies. SDSH II trained PCHAs and TBAs on resuscitation of the newborn and the Kangaroo Mother Care approach. PCHAs were also taught to encourage pregnant women to deliver at the facility level, and in case of home delivery, to bring the babies to the facility within the first three days of life. The SDSH II network provided PCHAs and TBAs with supportive supervision visits at least once per month, using a checklist developed by SDSH II.

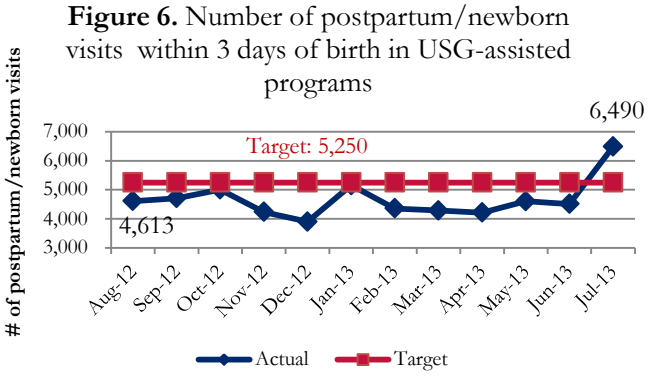


Figure 6. Number of postpartum/newborn visits within 3 days of birth in USG-assisted programs

As a result of these efforts, 56,081 newborns and mothers received postnatal visits within three days of birth. This represents 89 percent of the project target.

Helping Babies Breathe (HBB)

In August 2012, SDSH II developed a concept note on the *HBB Strategy: Managing Intrapartum-Related Hypoxic Events (Asphyxia) in Haiti.* HBB is a set of educational materials developed by the American Academy of Pediatrics, which is being distributed internationally by a consortium of child health organizations that teach health providers in resource-poor settings to perform neonatal resuscitation.

The HBB program was implemented by SDSH II under the direction of the MSPP, with support from USAID/Haiti. SDSH II trained 136 healthcare providers on maternal and neonatal services, 45 specifically on HBB and AMTSL. The group included obstetrician gynecologists, family doctors, nurses, and auxiliary nurses. This effort, along with other training initiatives, allowed the project to comfortably surpass its training targets for MNCH. In the fourth quarter, *Hôpital Beraca*, the principal SDSH private partner in the North West, organized the first cascade training of the HBB strategy by holding a training session for nurses.

1.1 (b): Child Health

Faced with endemic poverty and poor nutritional status, children in Haiti suffer disproportionately from a host of preventable diseases such as measles, diarrhea, and pneumonia. As a result, the under-five mortality rate in Haiti (88 deaths per 1,000 live births (DHS 2012)) is the highest in the Western hemisphere. To help improve the lives of Haitian children, SDSH II worked with the MSPP, the United Nations Children's Fund (UNICEF), and other partners to ensure availability of vaccines and appropriate commodities, such as Vitamin A, Zinc, and Albendazole. SDSH II and its partners supported the delivery of child health services at both the institutional and community levels. At the invitation of the MSPP, SDSH II participated in the State of Affairs in Child Health workshop, which led to the development of the national strategic plan for child health.

As mentioned above, SDSH II trained 1,758 PCHAs, with child health as a major focus. We also reinforced community networks to establish greater community involvement in child health through the creation of 1,790 Mothers' Clubs, orienting 54,442 mothers and caretakers on diarrheal management, safe water, hygiene, exclusive breastfeeding, and FP, using the training guide developed by the project.

Immunization

SDSH II facilitated the MSPP's introduction of the Pentavalent3 vaccine (diphtheria, tetanus, and whooping cough, hepatitis B, and Haemophilus influenza) by training institutional and community-level health care providers in all ten departments on the delivery of the vaccine. Unfortunately, stock outs of the drug at the national level hindered our ability to reach as many children as planned.

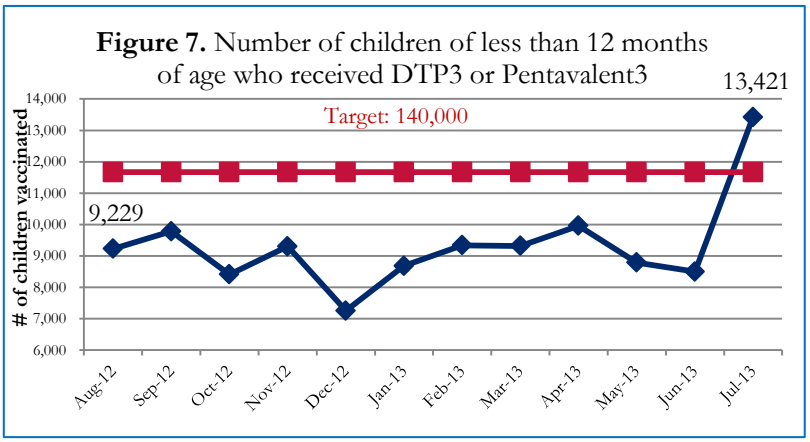


Figure 7. Number of children of less than 12 months of age who received DTP3 or Pentavalent3

The project considered a child fully immunized if he or she received three doses of either the Pentavalent3 or DTP vaccine during his or her first twelve months of life. The project provided

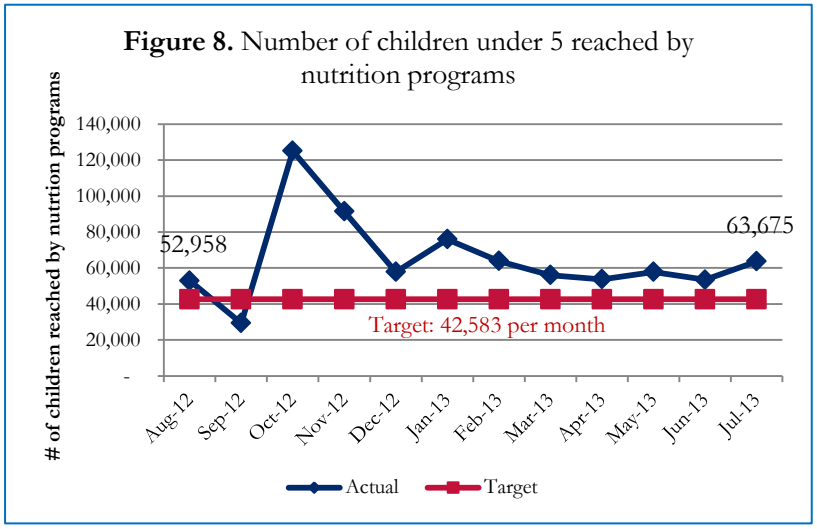
complete vaccination coverage to 111,990 children less than one year of age, which represents 80% of the expected target.

To mitigate the effects of the stock-outs, SDSH II provided transportation from the departmental warehouses to the facilities to fully stock the SDSH-II supported sites with vaccines during the *Coup de Poing* in July 2013. As can be seen in Figure 7, the *Coup de Poing* strategy led to a significant increase in vaccinations in the final month of the project.

It should also be noted that although SDSH II providers participated in the national vaccination campaigns, the children they reached during these national-level operations were not counted toward the SDSH II indicators. Additionally, SDSH II distributed 2,000 national vaccination cards to the NGOs and strengthened the operation of the cold chain across the country through the distribution of propane.

1.1 (c): Nutrition and WASH

SDSH II trained PCHAs to provide nutritional screening for children using the measurement of the mid-upper arm circumference at rally posts and in how to refer children to facilities for further evaluation. At the facility level, health workers provided nutritional counseling and height and weight measurements. The project trained 675 providers on child health and nutrition, far exceeding the target of 300.



Since very few sites offered management of acute malnutrition services, providers referred children to the ten departmental public hospitals, some to *Hôpital Communautaire de Référence*, and some to NGO facilities, such as *Terre des Hommes* in the South, and Food for the Poor and FONDEFH in the West for appropriate services. With MSPP support, all project partners provided systematic deworming of all children.

SDSH II coordinated with MSPP and UNICEF to increase availability of micronutrients at health facilities for women of reproductive age and supported the organization of nutrition sessions for all pregnant women. Despite efforts to maintain a reliable supply of micronutrients, stock outs of vitamin A occurred frequently during this period. Due to these stock outs, the project network achieved 75% of its target, assuring vitamin A supplementation to 304,456 children between birth and 5 years of age. Approximately 22% of women tested during ANC visits were found to be anemic.

SDSH II-supported health workers and facilities exceeded the goal for the number of children reached with nutrition programs, having reached 698,936 children (137 percent of target). Nonetheless, the project's capacity to support the management of acute cases of malnutrition remained limited.

The SDSH II partner Pure Water for the World (PWW) conducted water, sanitation, and hygiene (WASH) orientation sessions at the community level in all ten departments. PWW also installed biological water filters in schools, health centers, households, and orphanages. At both the institutional and community levels, health workers educated their respective communities on hand-washing techniques, hygiene, and cholera prevention, including water chlorination and food cleanliness. At the end of the reporting period, PWW has provided its package of services to 1,254 schools, 3,832 homes, and 254 health care facilities. They trained 2,444 teachers and reached 364,234 beneficiaries. In addition, PWW donated two state-of-the-art water purification units to two hospitals, one private and one public, given by the Dow Chemical Company. These systems have the capacity to provide an average of 15,000 to 20,000 gallons of water each day per unit, which is enough water to meet the demands of these hospitals and provide clean water to thousands of people living in the neighboring areas.

SDSH II promoted prevention of diarrheic dehydration and made ORS (oral rehydration salts) and zinc available in facilities and the community for early and immediate treatment. All service sites provided promotional materials such as hand washing items, ORS demonstration kits, and clean water products. SDSH II worked with mother's clubs to educate mothers on the proper use of the WASH materials as well as systematic use of zinc in the management of diarrhea. Through these efforts, the project reached 48,378 caretakers with messages about diarrhea prevention, including the benefits of exclusive breastfeeding, and 54,442 caretakers with information on diarrhea management, including the danger signs and how to use oral rehydration solution and zinc. Since January 2013, SDSH II rapidly established 32 sites as cholera treatment centers. These sites have trained personnel to manage cholera cases referred to them

Result 1.2: Increase Access To and Integration of FP/RH Services

With a modern contraceptive prevalence rate among women 15 to 49 years of age of just 22 percent (DHS-2012), Haiti has an unmet need for contraception of 35 percent among married women (DHS-2012). SDSH II sought to both increase the demand for contraceptive services through education and advocacy and decrease the unmet need by increasing access to and improving the quality of FP services. SDSH II provided RH/FP services in each of its 164 sites, scaled-up select activities, and strengthened the link between RH/FP programs and other health services. The project emphasized FP compliance regulations and trained 3,392 staff, of whom 1,653 were facility-based and 1,739 were community-based, on U.S.

Reproductive Health/Family Planning Achievements

- 385,195 couple-years protection
- 16 percent of service outlets offering at least five FP methods, including 2 long-acting and permanent methods.
- 34 percent of people of reproductive age using a modern FP method

federal regulations. SDSH II provided training on quality FP counseling and comprehensive information on FP methods and their various side effects.

To increase the percentage of sites offering at least five methods of FP, including two long-acting and permanent methods, SDSH II trained obstetrician gynecologists in the CBP, Ouanaminthe, and Beraca COE and procured donations of materials and equipment for tubal ligation and vasectomy services at those facilities. Unfortunately, identifying providers with the proper skills to provide long-acting and permanent methods of contraception was difficult in remote areas of the country. This need was filled by transporting skilled staff to rural facilities to provide services on a monthly basis, however, the funding for this activity was insufficient, and only 16 percent of facilities could provide long-acting or permanent methods of contraception by the end of the project.

SDSH II provided quality RH/FP services based on voluntarism and informed choice at all sites, while strengthening connections with other health services, including counseling and testing for HIV. The project emphasized FP training among institutional and community staff, instructing them to provide quality counseling and comprehensive information on the methods chosen and potential side effects. As a result, SDSH II provided 385,195 CYP over the course of the project, greatly surpassing the target of 347,000. Within the SDSH catchment area, 34 percent of reproductive age individuals were reported to be using a modern FP method at the end of the project, exceeding the target of 32 percent. As seen in Figures 9, SDSH II met or exceeded the target for CYP provided in most months and over the life of project.

Figure 9. Couple-years of protection (CYP) in USG-supported programs

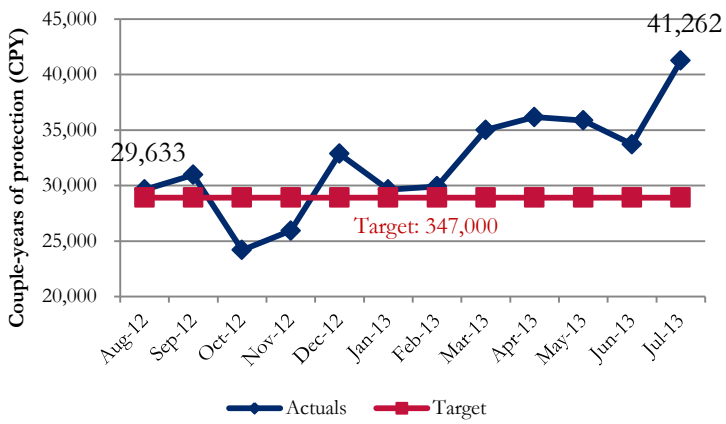
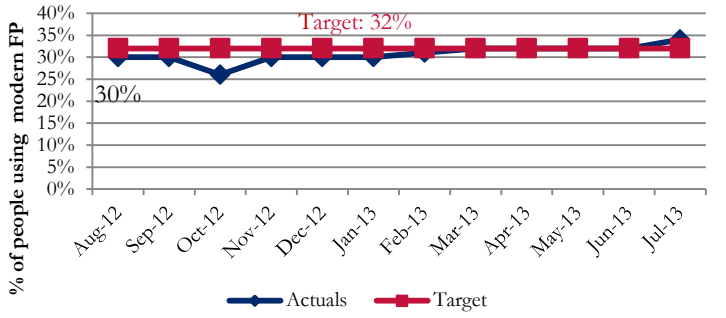


Figure 10. Percent of people of reproductive age using a modern FP method



SDSH II established ten youth-friendly centers in supported facilities that integrated detection and treatment of sexually transmitted infections, activities to improve access to FP services among youth, people with disabilities, and other vulnerable populations, and improved linkages to HIV/AIDS, maternal and child health services, and GBV into their FP/RH services.

Mobile clinics to provide FP and ANC to hard-to-reach populations
Much of Haiti's population lacks access to FP methods because of difficulties associated with transportation and the distance they live from a facility. The high cost of transportation and mountainous terrain make it nearly impossible for many to travel to facilities that offer FP services, especially during the rainy season, when logistical problems are exacerbated by flooding. To bridge this gap, the mobile team collaborated with referral hospitals and facilitated increased access and availability of long-term and permanent FP methods by taking services into hard-to-reach communities. Clinicians trained by the project visited remote villages to provide FP, ANC, and other services to communities who otherwise did not have access to modern contraception or RH services. These visits contributed significantly to the project's achievement of the CYP indicators.

The mobile clinics did not receive specifically-allocated funds under SDSH II, which impaired their performance. In August 2013, the *Coup de Poing* efforts allowed the project to increase the number of mobile clinics, resulting in an increase in FP, ANC, and counseling and testing indicators in July 2013.

Result 1.3: Support Detection, Care, Prevention, and Treatment of Infectious Diseases Including HIV/AIDS and TB

Knowledge of HIV/AIDS has increased substantially in Haiti in recent years, yet the data highlight some alarming aspects of the epidemic. Young women aged 20 to 24 have twice the infection rate of young men of the same age. The number of commercial sex workers is steadily increasing, and youth both in and out of school are engaging in unprotected transactional sex. The project team addressed these trends through quality improvement activities at the community and institutional levels.

HIV & AIDS and TB Achievements

- 68,755 pregnant women discovered their HIV status
- 875 HIV-positive pregnant women received ART to reduce the risk of mother-to-child transmission.
- 134,447 individuals received voluntary counseling and testing
- 2,032 adults and children with advanced HIV infection newly receiving ART
- 295 HIV-positive individuals received treatment for both TB and HIV
- 4,592 adults and children received ART

1.3(a): Reduced Transmission and Improved Treatment of HIV/AIDS
To ensure adequate access to and quality of therapeutic services for HIV-positive Haitians, SDSH II added 11 new antiretroviral (ART) therapy sites and 11 sites to provide prevention of mother-to-child transmission (PMTCT) services. The project supported a total of 21 ART and 20 PMTCT/VCT sites, and 5 sites that supported only counseling and testing. The sites were selected jointly by SDSH II, the Departmental Health Directorates, and USAID.

The project supported these sites to provide fully-functional ART and PMTCT services by assuring compliance with MSPP norms and standards, conducting routine supportive supervision visits, assuring the availability of commodities and supplies, assisting the departments with the collection, reporting, and validation of data, and using the data for decision making. SDSH II provided on-the-

job technical training to providers at the ART and PMTCT sites to strengthen their skills in assessing patients, determining eligibility for ARV, and monitoring patients already on ART.

The ART and PMTCT facilities provided a continuum of services that included prevention, treatment, and palliative care, with an emphasis on holistic care, human dignity, stigma reduction, strict confidentiality, and effective referral mechanisms.

Reliable stocks of commodities and drugs are essential to well-functioning ART and PMTCT clinics. In collaboration with the Supply Chain Management System (SCMS) and the Clinton Health Access Initiative, SDSH II monitored each site to ensure quality stock management at the health facilities in their network. SDSH II shared the new SCMS stock management tools with the 164 facilities, and, with support from SCMS, carried out e-mail and telephone monitoring to track requisitions, resolve stock outs, and ensure the constant availability of health commodities. The project ensured that the HIV rapid test was available at all service delivery sites and provided TB tests alongside the HIV finger prick.

A strong link between facility and community is essential to overcome stigma and improve access to quality HIV care. To encourage people to be tested and seek treatment, SDSH II trained 28 social workers within the SDSH II network to conduct domestic visits and lead support groups. They linked patients to facility-based care and encouraged adherence to ART and PMTCT.

ART enrollment

As a result of these efforts, SDSH II enrolled 2,032 new patients with advanced HIV infection on ART. Though this represents just 64 percent of the life-of-project target, Figure 11 shows that interventions gained momentum in the last four months of the project as the new ART sites were added.

As shown in Figure 12, the number of people newly enrolled on ART in SDSH II-supported sites more than doubled from the number of newly enrolled individuals in the last year of SDSH. Although we did not reach the ambitious target set for this year, the new ART centers were instrumental in increasing the number of people on treatment by 275 percent, with

Figure 11. Number of adults and children with advanced HIV infection newly enrolled on ART

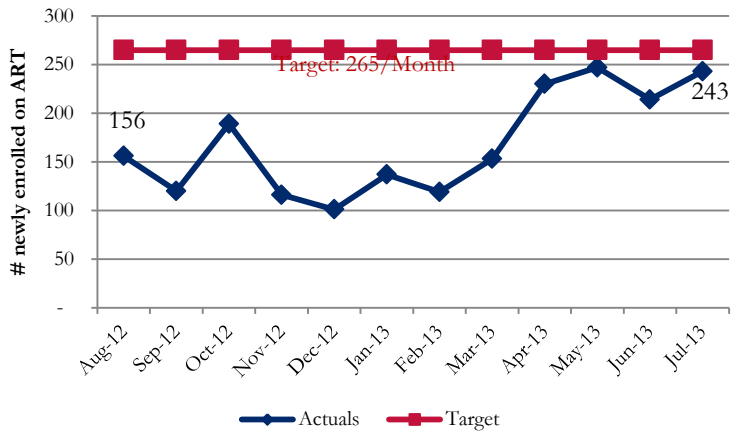
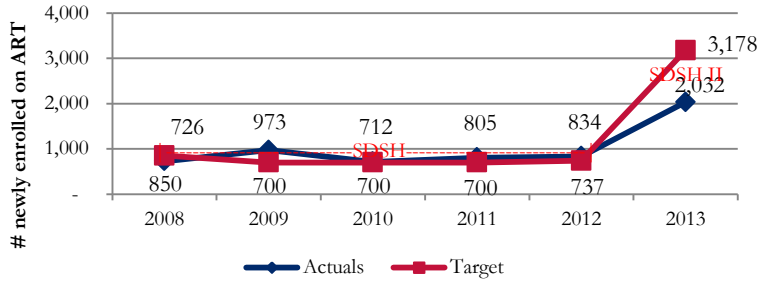


Figure 12. Progression of number of adults and children with advanced HIV infection newly enrolled on ART from SDSH to SDSH II



the actual number rising from 737 in 2012 to 2,032 in this project year. By the end of the project, 4,592 adults and children with advanced HIV infection were receiving ART.

HIV prevention among pregnant women

Over the course of the project, 68,755 pregnant women were tested for HIV and provided with their results. This represents 103%of the project target. Option B+, the provision of ART to all HIV-positive pregnant women for life, regardless of CD4 count, proved to be a powerful motivator for women to attend ANC and accept HIV testing. SDSH II struggled to meet its PMTCT indicators in the first moths of the project, but after the new PMTCT sites were operational, the rate of counseling and testing of pregnant women increased (months April through July). Furthermore, as is shown in Figure 13, the *Coup de Poing* intervention during the last month of the project improved recruitment of pregnant women for HIV testing by over 30% from the previous month, largely due to an increase in the number of mobile clinics.

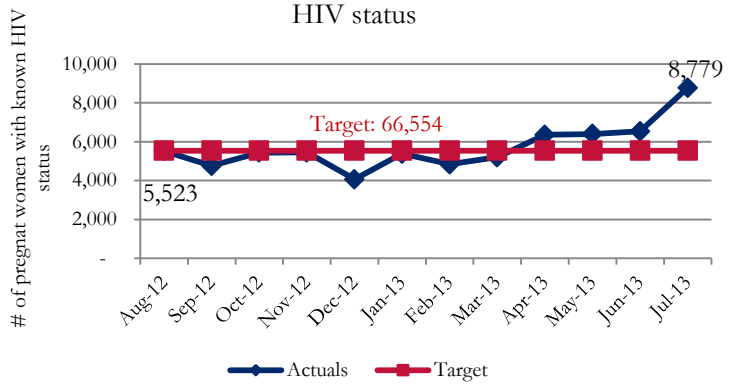


Figure 13. Number of pregnant women with known HIV status

While SDSH II did not meet the target for the percent of HIV-positive pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission, when compared to the last year of SDSH, SDSH II realized an impressive gain. USAID requested a target increase of more than 40 percent over SDSH's final year target. Despite losing a major HIV site in Fort Liberté to a CDC-funded MSPP project and adding other HIV sites that served smaller populations, SDSH II still achieved a 10 percent increase over the SDSH final year result.

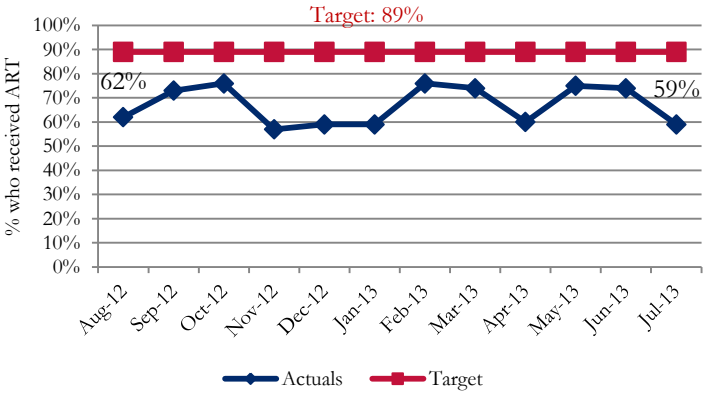


Figure 12. Percent of HIV+ pregnant women who received ARV for PMTCT

To ensure that babies born HIV-positive receive care as soon as possible, SDSH II trained healthcare providers in 12 facilities to provide polymerase-chain-reaction (PCR) and DNA screening to newborns whose mothers are HIV positive. The Caris foundation conducted visits to all PMTCT

and ARV sites to ensure providers were trained on the DNA/PCR methodology and the technique for collecting and transporting specimens for early diagnosis of HIV in infants.

Voluntary counseling and testing

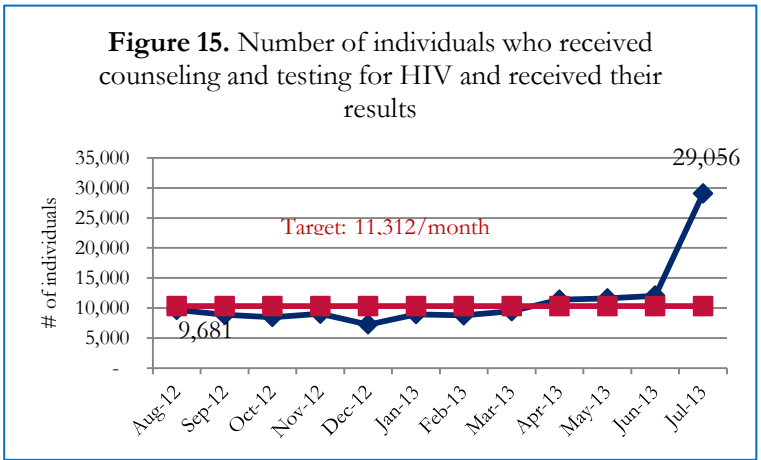


Figure 15. Number of individuals who received counseling and testing for HIV and received their results

The HIV/TB unit emphasized HIV testing and counseling in high-density areas, targeting most at-risk populations. SDSH II closely monitored the supply of commodities and anticipated stock outs through e-mail and telephone follow-up, thus assuring that no stock outs of HIV or TB testing commodities occurred during the project's duration. Nearly 134,500 individuals received voluntary counseling and testing for HIV and received their results, exceeding the target by more than 20,000 individuals. Figure 15 demonstrates that SDSH II's *Coup de Poing* produced amazing results in the last month of the project, improving recruitment of individuals for counseling and testing by nearly 250 percent over the previous quarter and more than 375 percent of the monthly average over the course of the project. The project achieved this by dispatching nurses and health agents into the communities. SDSH II provided technical and logistical support for this community-based push, and their presence in the departments was a big morale boost.

Community palliative care and orphans and vulnerable children

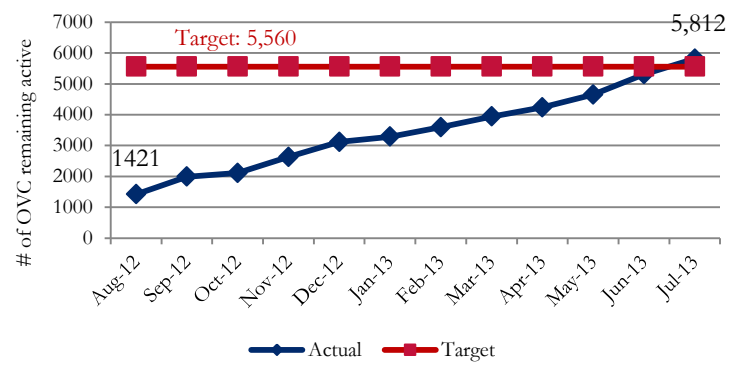


Figure 16. Number of OVC remaining active at the end of the period

SDSH II supported community palliative care for OVC in 31 sites. To increase the number of children receiving care and improve the quality of that care, the project trained 60 people, twice the project target. Providers referred OVC for services such as legal aid (help obtaining birth certificates or entering the school system), nutrition support, and additional social services provided by other organizations The SDSH II network enrolled 4,997 OVC into care, falling short of the target of 5,490 by just 9 percent, and provided at least one service to 5,703 children. However, the project surpassed its target of the number of OVC remaining in care by more than 250 children (Figure 16).

1.3(b): Tuberculosis

With an incidence of 213 new cases per 100,000 citizens each year, tuberculosis is of particular concern in Haiti, given the country's relatively high rate of HIV and the concerns of co-infection. To mitigate the disease burden, SDSH II supported and strengthened the PNLT (*Programme National de Lutte Contre la Tuberculose*) by reviewing the PNLT reporting system, assisting in the creation of the National Committee against Multi-Drug Resistant Tuberculosis (*Comité National de Lutte Contre la TB MDR*), assisting with data validation, and organizing a facilitators committee to improve the coordination between PNLT and the *Programme National de Lutte Contre le SIDA*. SDSH II facilitated the coordination and installation of three GeneXpert devices, which can diagnose TB and antibiotic resistance in a short period of time (approximately two hours).

To increase TB case detection and improve patients' treatment, the project applied the following strategies:

- Use of a questionnaire to screen all suspected TB patients in health facilities
- Capacity building of PCHAs to identify and refer patients with respiratory symptoms
- Active search for cases
- Home visits by providers to follow up with patients who have missed appointments
- The use of *accompagnateurs* to ensure the correct use of the Directly Observed Treatment Short Course (DOTS) strategy according to prescribed schedule
- Motivating institutional staff to ensure voluntary HIV testing and counseling of TB patients (and vice-versa).

Treatment for HIV/TB co-infection

SDSH II trained healthcare providers in 24 sites to provide systematic HIV and TB treatment. By the end of the project, 295 patients had received treatment for both HIV and TB. In addition to field support by the technical advisors, the central technical unit ensured coordination and training by USG-accredited training providers. SDSH II developed and implemented an effective referral system for TB/HIV co-infected patients. The percentage of all registered TB patients who were tested for HIV rose from 56 percent in August 2012 to 142 percent in July 2013, due to referrals of out-of-district patients.

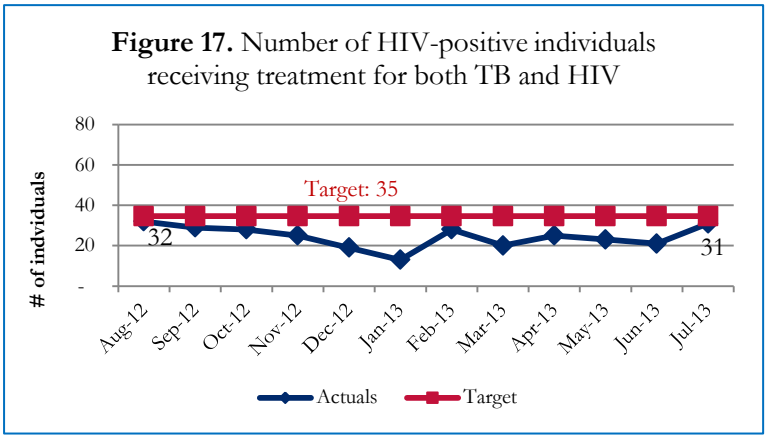


Figure 17. Number of HIV-positive individuals receiving treatment for both TB and HIV

Result 1.4: Support to Expanded Services of Protection Cases in Selected Sites

SDSH II introduced two new programmatic areas of intervention during the year, gender-based violence (GBV) and child protection (CP). The GBV program supported women and men that have been sexually, mentally, or physically abused. The CP program was designed to assist any child, from birth to 18 years old, who was vulnerable to abuses such as sexual exploitation, trafficking, and child labor. SDSH II focused on treating, referring, and reporting GBV and CP cases in 28 sites, including the eight COE. Beginning in mid-January 2013, the eight COE offered clinical assistance to survivors of GBV and referrals for CP cases. GBV and CP services were closely linked to existing SDSH II services, including RH/FP and HIV/AIDS prevention, care, and treatment.

1.4(a) and (b): Gender-Based Violence and Child Protection

To provide clinical, legal and psychological support for survivors of GBV and provide referrals for children in need of legal services, SDSH II trained 801 community members and 147 facility staff, including physicians, nurses, social workers, and psychologists in 28 sites, including the 8 COE, to identify signs (past or present) of abuse and provide referrals for care for both survivors of GBV and child protection cases. All selected sites have at least 44 patient visits per month and are located in areas where *Association Nationale des Scouts d'Haïti* (ANSH) has high concentrations of youth groups. Trainings covered medical care protocol, the importance of privacy and confidentiality at the facility level, the consequences of violence, and the need for accompaniment and support of survivors.

Trained staff and community members worked on educational programs with 90 youth groups and reactivated ten youth centers to offer information services and increase access to RH/FP services for youth. Through these centers, youth will have increased access to better information and education related to sexual health, reproductive health, FP, and GBV and CP.

Result 1.5: Waste Management and Infection Prevention

To identify waste management issues at SDSH II-supported sites, the project developed an assessment tool and evaluated 42 selected sites. This assessment was conducted in parallel with the lab and infection control assessment. It identified specific areas in need of improvement and provided recommendations that were incorporated into a training plan. The project also distributed supplies and basic equipment (such as waste containers, chlorine solution, thick household gloves, shovels, and boots) to select facilities to improve waste control. SDSH II reproduced brochures and posters

Providers at Cazale Health Center using proper waste management commodities

to raise awareness and change behaviors of both project staff and the general population about waste management.

SDSH II focused on improving waste management and infection prevention within the project network through the training of MSPP and project staff at the departmental level, addressing issues identified during previous supervision visits. The central and the departmental level staff were aware of the importance of this project component and ensured a close follow up of activities planned.

Build capacity of partners and project staff to handle medical waste

Two training of trainers sessions were conducted in collaboration with *Institut Haitien De Sante Communautaire* for MSPP staff and SDSH II Technical Advisors on the integration of new modules for waste management and infection prevention. These trainings equipped 34 participants from ten departments with a clear understanding of the importance and relevance of appropriate waste management and the necessary skills to manage and dispose of waste in an appropriate fashion.

These 34 trainers developed a cascade training that reached 1,249 health providers, 535 administrative staff, and 1,661 PCHAs from the 10 departments. Trainees developed a waste management plan presenting detailed activities, with specific responsible parties identified to implement the activities. This plan helped improve waste management at every facility and also improved the prevention of infection among staff and patients. The head of the facility and SDSH II staff (central and departmental level) ensured follow-up of the plan.

To guarantee proper implementation of waste management activities and application of defined standards, SDSH II developed a supervision grid that ensured waste management review during supervision visits made by technical staff of both the central and the departmental levels. The grid addressed key elements of waste management, such as availability of materials and equipment, cleanliness of the facility yard, availability of water, and existence and cleanliness of the incinerator.

As a result of these efforts, management improved significantly within the network, despite the need to maintain strategies and gains and to continue to emphasize the final waste disposal, which is now being addressed as a national issue. Following the project's call to action to address the larger waste management issue at the health facilities, the MSPP convened several meetings with the Ministry of Interior and DINEPA (*Direction Nationale d'Eau Potable et d'Assainissement*) to develop a plan to improve waste management and provide landfills.

OBJECTIVE 2: STRENGTHEN MSPP CAPACITY TO MANAGE AND MONITOR DECENTRALIZED HEALTH SERVICES

SDSH II actively supported the MSPP's efforts to decentralize health services while increasing its ability to manage health resources and commodities (e.g., vaccines and antibiotics), strengthen and systematize financial accounting systems, and improve the national health management information system by assisting departmental level staff with data collection and analysis. SDSH II increased supervisory visits to ensure that health centers followed all quality standards and protocols. To achieve health impact and improve the quality of services, SDSH II established PBC agreements with all 164 health facilities, as well as supplementary purchase orders for specific services and ten Integrated Departmental Plans to provide each department with funding for specific activities. This innovative approach motivated health staff to achieve their goals and improved reporting of finances and programmatic results.

Result 2.1: Departmental Level Governance and Leadership Strengthened

SDSH II strengthened the capacity of health departmental directorates to efficiently manage service delivery. To increase the percentage of USG-assisted service delivery points implementing quality assurance and quality improvement approaches, SDSH II introduced integrated supervisory checklists for supervision of health facilities by departmental staff. SDSH II worked with decentralized MSPP staff during the regular supervision visits to ensure that standards and protocols are adhered to, and financial management systems, technical capabilities, human resources, and operations management were strengthened.

MOUs for ZCs

The MOUs with the ZCs allowed the MSPP to become direct recipients of performance-based agreements. The direct involvement in this type of payment scheme was a new experience for the MSPP, and each step along this path served as capacity building toward the ultimate goal of having the MSPP assume control over the entire system. Sites within each ZC were directly supervised by the departmental team with guidance from the embedded CTDs. Therefore, the performance of these sites remained the direct responsibility of the site level leadership team and the MSPP's departmental directors. These directors were reinforced with project resources made available via the Integrated Development Plans. MOUs for departmental directorates include a budget for support for improving governance.

Integrated Departmental Plans

SDSH II provided technical assistance to the Departmental Directorates to assert their leadership by developing Integrated Departmental Plans (*Plans Départementaux Intégrés* in French) and related budgets, to assess their human resource needs, recruit staff, convene meetings, organize training sessions on MSPP programmatic priorities, and to perform joint formative supervision visits. With the support of USAID and other stakeholders who provided additional funding, the project helped develop renovation plans and provided materials and equipment to selected facilities for the strengthening of the referral networks. To reinforce local governance and leadership, the

Departmental Directorates organized routine departmental coordination meetings, which the CTDs attended.

SDSH supervision and support of MSPP sites (Zones Ciblees)

SDSH II conducted supervisory visits to MSPP health facilities to ensure that standards and protocols were followed and quality assurance and improvement approaches were implemented. During the visits, the SDSH II team worked with the health facilities staff to review the project objectives and current results, discuss current challenges, and revisit the FP requirements outlined under the Tiahrt amendment. All key technical elements of the defined priority package of services were reviewed with health providers, with a special focus on the cold chain management, waste management, and FP requirements. To provide comprehensive technical support and supervision to health facilities, SDSH II staff reviewed supervision checklists and included key technical elements and topic areas.

SDSH II conducted an assessment of the performance of institutions within the SDSH II network, identifying those with a low performance on key maternal health indicators. The analysis served as a basis to focus and coordinate the scheduling of field visits as well as the development of a performance scoring table which was used to propose and implement remedial actions. SDSH II also worked with Technical Advisors at the departmental and central levels to conduct a gap analysis on staff trained on integrated supervision and the use of the MSPP's supervision guide.

Support to the West Departmental Directorate for Cazale

During the second quarter of the project, the MSPP asked SDSH II to restart services at the Cazale Health Center, which was closed more than ten years ago. In close coordination with LMG, SDSH II provided technical assistance to the MSPP at the communal level for the development of the technical proposal for health services at Cazale. The SDSH II team worked with the MSPP to develop a budget that supported the provision of services for that facility, as well as a renovation plan and a complete list of materials and equipment. The center reopened in May 2013 and is serving a population of 8,800 people.

Result 2.2: Departmental Financial Management Strengthened

To build the capacity of the MSPP, SDSH II used proven PBC models in all ten departments. Through the PBC mechanism and combined technical assistance, SDSH II improved accounting (specifically for internal receipts) and increased the number of facilities meeting national financial management criteria. SDSH II monitored the targets set by the departments, rewarding those who successfully plan, manage, and achieve the preset performance indicators. For those who did not perform well, additional formative supervision visits were provided to bring them to a satisfactory level of functionality

SDSH II worked closely with the departmental team throughout the year. Efforts to support the MSPP to roll out a single software application for accounting across all ten departments never took root because the MSSP did not decide on the software they wanted to use.

However, other financial trainings reinforced local accounting capacity. One hundred staff in 26 ZC across seven departments received training on the management of internal receipts, and two departments were assisted with audit preparedness. The project's Finance Manager at the department level conducted routine site visits. The central team also conducted supervisory visits to address issues identified during routine reporting. The project team assisted the department in the development of budgets, reports, and routine activities. However, the overall effectiveness of these efforts was hindered by MSPP staff vacancies and a high turnover rate.

Result 2.3: Strategic Information Systems Strengthened

SDSH II emphasized accurate and timely reporting of strategic information at all sites and assisted departmental level staff in data collection and analysis. Specifically, SDSH II worked with departmental level staff to assist in collecting, tracking, and analyzing patient data and ensuring data oversight. By building information systems capacity, SDSH II increased the percentage of USG-assisted facilities that submit timely, complete, and accurate reports to the national level, while strengthening the MSPP's ability to monitor health services at decentralized levels.

As part of the implementation of the recently revised health information data collection system, SDSH II supported the MSPP by reproducing relevant forms and conducting three training workshops for 73 staff members in the Centre, North West, and South departments. These trainings improved the ability of staff to validate and utilize data, collect and report data for the MSPP, and ensure the production of reliable strategic information necessary for decision making at all levels.

SDSH II staff visited 104 sites supported by the project to strengthen the data collecting and reporting process. During these visits, a review of the collection tools was conducted to ensure provider compliance with the defined data collection and reporting procedures. Data collecting and reporting tools were reproduced and distributed to the whole network. SDSH II monitored monthly report transmission at the departmental level. Due to the support of the project, 87 percent of these sites have transmitted their timely, complete, and accurate monthly reports to the departmental level.

CHALLENGES

Project duration

Although SDSH II was effectively an extension of SDSH, there were several key elements that needed to be introduced or scaled up during a very short time. The pressure to introduce multiple changes during the first three months of a twelve-month project, while simultaneously addressing staffing shortages, finalizing 164 site level agreements, and negotiating revisions to the work plan and performance monitoring plan (PMP) created special challenges. Logistical, administrative, and financial challenges were compounded by the simultaneous closeout of SDSH with the start-up of SDSH II.

Human resources

The problem of identifying qualified staff was exacerbated by the influx of donor funding and new projects in response to the 2010 earthquake. The increase in demand drove salaries to historically high levels and diluted the pool of candidates. SDSH II sub-grantees struggled to retain experienced personnel, as many left for higher paying positions with other NGOs or even the MSPP. The project budget for sub-recipients remained static for over two years despite nationwide salary growth in the sector and a rapidly rising cost of living. The Port au Prince SDSH II office experienced attrition due to these factors as well, as the project lost experienced staff and had to recruit and train younger, less qualified personnel for many positions. The CTD positions were particularly difficult to fill, and many of these critical posts remained vacant for the first months of the project.

Human resource issues also impacted several of the departments. The departmental plans were delayed due to insufficient staff and because the MSPP often proposed interventions that were not in line with project activities. This resulted in lengthy discussions between MSPP and SDSH II in order to reach agreement on final plans. High staff turnover also reduced the effectiveness of capacity building initiatives when trained staff left for other opportunities.

Need for greater access to community-based services

The difficult access to health services, especially in remote areas served by SDSH II, is well known: rugged terrain prone to flooding, long distances to health facilities, poor transportation, and widespread poverty. SDSH II therefore recognized the importance of implementing mobile clinics to reach communities in need of FP, ANC, child health services, and HIV/AIDS screening. Unfortunately, funding constraints did not allow service providers to maximize the use of this strategy throughout much of the project. It was only during the *Coup de Poing* initiative that funds were identified to mobilize this resource. Once operational, the mobile clinics showed great success in reaching clients for ANC, counseling and testing for HIV, and FP.

The push for free services in Haiti and heavy reliance on donor funds limits the number of people who are willing to access fee-based services. Though many of SDSH II's services, such as ANC and FP, were provided free of charge, lab tests and medications often required payment. Because NGOs supported by other donors do not charge for these services, these fees served as disincentives to attend SDSH II-supported facilities

Stock outs of essential commodities

A key assumption of the project was the availability of essential commodities. Although the project worked with key actors to minimize stock outs, SDSH II did not have control over the supply chain. Stock outs of essential medical supplies, including vaccines, vitamin A, and zinc, which were expected to come from MSPP and UNICEF, resulted in lower-than-anticipated results for certain indicators.

Unmet assumptions

The project's ability to meet Objective 2 (Strengthen departmental-level MSPP capacity to manage and monitor the delivery of health services) was thwarted in certain areas by delays in finalizing key systems decisions. For example, SDSH II was not able to train the departmental level staff on the use of the new accounting software package because the MSPP did not reach agreement on the package to be used. Likewise, capacity building for M&E staff was hindered by a late decision on which software would be used for collection of national health data.

CONCLUSION AND LESSONS LEARNED

Despite many challenges, SDSH II ended on a sound note, with sustainable financing systems in place and a group of sub-recipients, both in the NGOs and the ZCs, who understand the essential mechanisms of PBC and managing for results. Throughout the course of the project, 164 sites and ten departments received timely funding that assured continuous service delivery. Essential services, such as emergency obstetric and neonatal care and ART, were scaled up, and new services, notably GBV and child protection, were introduced. Considerable trainings were conducted across virtually all of the project's technical areas, leaving behind more qualified service delivery staff at all levels. New skills acquired include essential life-saving measures such as KMC and HBB.

PCHAs display the bags provided to them by SDSH II. PCHAs are an integral part of the health system in Haiti.

The implementers learned several important lessons during this project, as presented below.

Expand and reinforce the PCHAs

The MSPP's efforts to reinforce community health services and develop the PCHA cadre of health workers has great merit. With the shortage of qualified facility-based health workers, the PCHAs have been the backbone of the health system in Haiti, providing essential preventive services. They are the key to successful coverage of basic services and the promotion of behavior change, especially in remote areas. The PCHAs who already received training need to complete the full curriculum and be trained in the final modules of the program. The MSPP needs strong support to recruit and train additional PCHAs to reach the target of 10,000 by 2015. Considering the uptake of modern FP methods by all women is still low at 22 percent (DHS 2012, p97) and Haiti has the highest maternal mortality rate in the region, all PCHAs must be trained to deliver injectable contraception. The introduction by the MSPP of a community-based package of services for the management of emergency obstetric and neonatal care is a promising idea for innovative practices to reduce maternal mortality.

Increase utilization of mobile clinics

The mobile clinics have proven effective in delivering services beyond the scope of the PCHAs. One of the lessons learned is to always include funding for these clinics in the agreements with the NGOs and ZCs, with specific line items elaborated. With the exception of the PCHAs, this is the single most effective strategy to improve access to essential services for large segments of the catchment populations served by USAID projects.

Expand the COEs
Despite some delays in making the COEs fully operational, this integrated model to improve the quality of health services is a good one to scale up in future projects. Therefore it is important to identify the next tier of COEs as soon as possible and begin training to upgrade providers' skills. Cross-fertilization through site visits between the most highly performing centers and the weaker sites has proven useful in the direct transfer of skills and experience. The IC approach has contributed to improvement in service quality and coverage in the existing centers and has the potential to improve the whole Haitian health system, if scaled up appropriately.

Emphasize initiatives and training at the departmental level
The skills transfer process for the management of PBC and the quality improvement strategies requires strengthened responsibility and accountability in the public health sector. Continuous support to departmental directorates is necessary for successful scaling-up of this approach.

One means for accomplishing this is to expand the Integrated Departmental Plans to allow the departments to access funding according to their priorities. It is essential that the national roll out of the DHIS2 information system is supported by future projects and proper reinforcement is provided at all levels to assure success. Departmental staff must continue to see added value from any collaboration.

Ensure basic infrastructure for all laboratories
Laboratories face significant unmet needs across the project's network. It is essential that sufficient resources are allocated in a timely manner and a prioritized strategy be elaborated across agencies for assuring these needs are met. The needs range from simple renovations and equipment shortages to serious training deficiencies for certain procedures and tests. Some facilities lack reliable power and water, while others face shortages of air conditioners or basic equipment. Data management and the transportation network for CD4 testing need to be reinforced as well.

Realign site level targets and establish realistic and challenging project targets
As mentioned above, site level targets for the one-year extension project were built on the targets from the previous project. A reassessment of targets on a site by site basis is recommended to allow for assignment of reasonable but challenging targets for future PBC schemes, with ZCs eventually reaching the same expectations as NGOs (the gap between results achieved by the NGOS versus the ZCs was discussed on page 8). Similarly, the project targets varied from relatively easy to achieve to nearly impossible under the conditions and funding constraints. A global realignment of targets is critical to assessing realistic progress.

Increase emphasis on supervision using checklists to standardize protocols
Site level supervision is key to improving the quality of service delivery. Due to the difficulties in hiring qualified CTDs and other project demands, SDSH II was slow to ramp up the number of supervisory visits. However, until the supervisory checklist was completed, there was no means to monitor the quality of those visits or the changes at the site level. SDSH II finalized a systematic checklist and a guide to accompanying corrective actions for specific deficiencies. These tools are essential for improving and documenting service quality and need to be refined with experience.

Most of the staff in the SDSH II network have been trained on how to analyze and use data to improve the quality of services. It is crucial that staff at the departmental and facility levels invest more time in the analysis of routine data and uses that information to improve services. It is reasonable that future PBCs and MOUs continue to contain indicators that track and reflect the use of data, thus requiring site managers to develop sound evidence-based business plans.

Expand gender-based violence and child protection sites

These two programs were designed to fill a critical gap in social services and need to be expanded and integrated into the routine services for all providers. The main lessons learned are to develop an education program to better inform the population about the availability of services, and to continue to support, accompany, and provide technical assistance to the personnel in order to offer the wide array of recommended services and not limit them to sexual violence management only.

Scale up Kangaroo Mother Care and Helping Babies Breathe

SDSH II introduced KMC and HBB, two critical life-saving interventions, during the year. They conform to international best practices and MSPP priorities. The introduction of these services has been well received and accepted by both MSPP and the sites providers. Continuous support to MSPP at the central and departmental level to scale up these practices will contribute to improve maternal and neonatal services throughout the country.

Reinforce family planning compliance mechanisms

A great deal of effort has been made to ensure FP compliance. To keep the momentum and preserve the gains, constant vigilance and close monitoring and follow-p of the required federal regulations is necessary at all delivery sites.

Assure adherence to waste management protocols

Enforcing waste management behavior change was a challenge for SDSH II. Despite trainings for all health facilities, proper disposal of medical waste required constant vigilance. Ultimately, this is an issue of individual behavior change and requires systematic routine follow-up. However, under a PBC scheme, payments can be linked to proper disposal of waste. In addition, a large unmet need for incinerators remains at many sites. A needs assessment must be finalized with a clear strategy and timeline for moving forward in this area.

Offer small incentives for postnatal visits

A small operations research initiative discussed in this report showed that minor incentives can be effective in increasing postnatal visits. This is an interesting idea to explore more fully and expand to other areas where incentives could prove effective.

Conduct needs assessment for all sites

SDSH conducted a needs assessment and attempted to fill some of the priority gaps at the end of the project in 2012. However, no additional funding was provided to address these issues under SDSH II, and there remain significant weaknesses at many of the sites. The availability of essential material and equipment is necessary for the provision of quality services at all sites.

ANNEXES

Annex A: Performance Monitoring Plan Results

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
Objective 1.1: Maternal, Newborn and Child Health (MNCH) services, including WASH and nutrition, strengthened						
1.1a : Maternal and neonatal health						
1.1.1	Number of births attended by skilled birth attendants (midwifes, nurses, doctors) in USG-assisted programs	Number	30,330	14,483	Which represents 48% of the target	Targets were too ambitious given the limited availability of maternity services in the network. Moreover, it was expected that the "SOG" (Soins Obstétricaux Gratuits = free obstetric care) program would have increased the number of institutional deliveries. Unfortunately, the program phased out and the women returned to their previous habits of home deliveries.
1.1.1a	Percent of births attended by skilled birth attendants (midwifes, nurses, doctors) in USG-assisted programs **(Custom) (Key Indicator)**	Percent	24%	12%	Which represents 50% of the target	**Numerator:** 14,483 (number of deliveries by trained personnel) **Denominator:** 123,953 (number of deliveries expected for the reporting period) See 1.1.1 The target level has been attributed by the donor based on previous EMMUS results. The denominator used during the survey is based on the number of declared deliveries, while the project uses as denominator the number of expected deliveries within the network during the period. If the same DHS/EMMUS denominator were used, the results

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
						would be 26.5%, and the target would be exceeded.
1.1.2	Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities **(3.1.6-4)(Key Indicator)**	Number	335,000	292,280	Which represents 87% of the target	
Objective 1.1: Maternal, Newborn and Child Health (MNCH) services, including WASH and nutrition, strengthened						
1.1.3	Percentage of pregnant women who have at least three (3) prenatal visits in USAID supported program **(Custom) (Key Indicator)**	Percent	51%	45%	Which represents 88% of the target	**Numerator**: 55,818 (number of pregnant women having benefited from 3 three prenatal visits) **Denominator:** 123,953 (number of pregnant women expected for the reporting period).
1.1.4	Percentage of births delivered by caesarean section (Hôpital Claire Heureuse, Beraca, Hôpital Bienfaisance/Pignon) and Fort Liberté	Percent	10%	16%	Target exceeded	**Numerator :** 411 (number of deliveries by caesarean section) **Denominator :** 2,554 (number of institutional births)
1.1.5	Percentage of women having received active management of third stage of labor (AMTSL) through COE USG supported programs	Percent	80%	89%	Target exceeded	Data comes from 8 Centers Of Excellence (CEO) **Numerator** : 4,583 (number of deliveries receiving third phase active management) **Denominator**: 5,169 (number of deliveries registered in the 8 COE).

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
1.1.6	Number of postpartum/ newborn visits within three (3) days of birth in USG-assisted programs **(3.1.6-30(Key Indicator)**	Number	63,000	56,081	Which represents 89% of the target	
Objective 1.1: Maternal, Newborn and Child Health (MNCH) services, including WASH and nutrition, strengthened						
1.1.7	Number of people trained in maternal/newborn health through USG-supported programs	Number	100	136	Target exceeded	Female: 109 Male: 27
1.1b : Child Health						
1.1.10	Percent of children under one fully vaccinated in USG supported programs **(Custom) (Key Indicator)**	Percent	92%	84%	Which represents 91% of the target	**Numerator:** 100,411 (number of infants under one year completely vaccinated) **Denominator:** 119,526 (number of infants under one year expected for the reporting period) Stock-outs registered for all vaccines during the reporting period negatively impacted results.
1.1.11	Number of children of less than 12 months of age who received DTP3 or Pentavalent3 from USG-supported programs **(Custom) (Key Indicator)**	Number	140,000	111,990	Which represents 80% of the target	Target higher than the number of children of less than one year expected (119,526), which in fact represents 94% of the real target.
Objective 1.1: Maternal, Newborn and Child Health (MNCH) services, including WASH and nutrition, strengthened						
1.1c : Nutrition and WASH						
1.1.12	Number of children under 5	Number	405,000	304,456	Which	Stock-outs registered in Vit A

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
	who received Vitamin A from USG-supported programs **(3.1.9.2-3) (Key Indicator)**				represents 75 % of the target	negatively impacted results.
1.1.12a	Number of children under 5 reached by USG-supported nutrition programs **(3.1.9-15) (Key Indicator)**	Number	511,000	698,936	Target exceeded	Out-of-district children account for some of the results, since the registers do not differentiate between in out of district service users.
1.1.13	Number of USG assisted service delivery sites with the capacity to rapidly establish cholera treatment centers/units	Number	35	32	Which represents 91% of the target	
1.1.14	Number of mothers and child caretakers trained on Diarrhea prevention (exclusive breastfeeding, clean water and hygiene)	Number	45,000	48,378	Target exceeded	
1.1.15	Number of mothers and child caretakers trained on Diarrhea management (danger signs and oral rehydration)	Number	45,000	54,442	Target exceeded	
1.1.16	Number of people trained in child health and nutrition through USG-supported programs **(3.1.9-1) (Key Indicator)**	Number	300	675	Target exceeded	Due to personnel turnover, the training needs have been increased.
1.1.17	Number of cases of child diarrhea treated in USAID-assisted programs	Number	50,000	32,110	Which represents 64% of the target.	Interventions against the cholera outbreak which contributed to strengthen community education and change behavior of mothers and caretakers on diarrhea prevention, and the introduction of Zinc in case management could be a determining

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
						factor in the case reduction and frequency of episodes.
1.1.18	Percentage of pregnant women who are anemic	Percent	40%	22%	Target exceeded	**Numerator:** 20,145 (Number of pregnant women with anemia). **Denominator:** 90,110 (number of pregnant women seen for first prenatal visit). This was measured by Complete Blood Count (CBC) testing or assessments of clinical signs for all pregnant women. Only 22% of them were found anemic during the reporting period. This result was due to the availability of micronutrients and iron folate.
Objective 1.2: Access to and integration of family planning/reproductive health (FP/RH) intensified						
1.2.1	Couple-years of protection (CYP) in USG-supported programs **(3.1.7.1-1) (Key Indicator)**	Number	347,000	385,195	Target exceeded	Community-based distribution of contraceptives is one of the factors having contributed to the results.
1.2.2	Percent of service outlets offering at least 5 FP methods including 2 long acting and permanent methods	Percent	40%	16%	Which represents 40% of the target.	**Numerator:** 25 (number of PPS offering 5 methods of family planning including two long term methods). **Denominator:** 157 (number of PPS offering FP services)

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
1.2.3	Number of community health workers trained in provision of injectable contraceptives	Number	1,500	147	Which represents 10% of the target.	Most CHW are already trained to provide injectables
1.2.4	Percent of people in reproductive age using a modern family planning method in USAID geographic targeted areas **(Custom) (Key Indicator)**	Percent	32%	34%	Target exceeded	**Numerator:** 366,804 (number of FP users) **Denominator:** 1,080,160 (expected number of women aged 15-49)
Objective 1.2: Access to and integration of family planning/reproductive health (FP/RH) intensified						
1.2.5	Number of Youth-Friendly Centers activated	Number	10	10	Target achieved	
1.2.6	Number of functional community health workers	Number	1,600	1,758	Target exceeded	
Objective 1.3: Support detection, care, prevention, and treatment of infectious diseases including HIV/AIDS and TB						
1.3a : HIV/AIDS						
1.3.1	Number of adults and children with advanced HIV infection newly enrolled on ART **(3.1.1-6) (Key Indicator)**	Number	3,178	2,032	Which represents 64% of the target	Delay in new site activation.
Objective 1.3: Support detection, care, prevention, and treatment of infectious diseases including HIV/AIDS and TB						
1.3.2	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) **(3.1.1-10)** at the end of the reporting period. **(Key Indicator)**	Number	6,125	4,592	Which represents 75% of the target	Delay in new site activation: This prevision was made on the implementation of new sites which unfortunately were delayed.
1.3.3	Percent of adults and children with advanced HIV infection	Percent	70%	70%	Target reached	**Numerator:** 107 (number of HIV patients newly enrolled on ART in

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
	known to be alive and on treatment 12 months after initiation of antiretroviral therapy **(Custom) (Key Indicator)**					August 2012 known to be alive and on treatment after 12 months) **Denominator:** 152 (number of HIV patients newly enrolled on ART in August 2012)
1.3.4	Number of HIV-positive individuals receiving treatment for both TB and HIV **(Custom) (Key Indicator)**	Number	415	295	Which represents 71% of the target	Diagnostic limitations especially in TB reduce results; some patients referred out of network were not counter-referred, but kept by those institutions
1.3.5	Number of pregnant women with known HIV status (includes women who were tested and received their results)	Number	66,554	68,755	Target exceeded	
Objective 1.3: Support detection, care, prevention, and treatment of infectious diseases including HIV/AIDS and TB						
1.3.6	Number of HIV positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission **(3.1.1-39) (Key Indicator)**	Number	936	875	Which represents 93% of the target	
1.3.6a	Percent of HIV positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission **(Custom) (Key Indicator)**	Percent	89%	67%	Which represents 75% of the target	**Numerator:** 875 (number of tested HIV + Pregnant Women under ARV prophylaxis). **Denominator:** 1,312 (number of pregnant women tested, HIV+)
1.3.7	Number of individuals who received counseling and testing for HIV and received their results	Number	123,746	134,447	Target exceeded	

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
1.3.8	Number of eligible adults and children provided with a minimum of one care service **(Custom) (Key Indicator)**	Number	24,235	22,495	Which represent 93% of the target	
Objective 1.3: Support detection, care, prevention, and treatment of infectious diseases including HIV/AIDS and TB						
1.3.9	Number of people trained to provide HIV palliative care (including TB/HIV)	Number	30	60	Target exceeded	Female: 39 Male: 21
1.3.10	Number of OVC enrolled during the reporting period	Number	5,490	4,997	Which represents 91% of the target	
1.3.11	Number of OVC having received at least one OVC service	Number	5,791	5,703	Which represents 98% of the target	
1.3.12	Number of OVC remaining active at the end of the period	Number	5,560	5,812	Target exceeded	
Objective 1.3: Support detection, care, prevention, and treatment of infectious diseases including HIV/AIDS and TB						
1.3.b : TUBERCULOSIS						
1.3.17	Case notification rate of new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas **(3.1.2-3) (Key Indicator)**	Rate per 100,000	80	57	Which represents 71% of the target	**Numerator:** 2,504 (number of new TB/TPM+ cases detected). **Denominator:** 4,426,889 (Total population covered by SDSH II)
1.3.18	Percent of all registered TB patients who are tested for HIV through USG-supported programs **(3.1.2-28) (Key Indicator)**	Percent	70%	86%	Target exceeded	**Numerator :** 2,160 (number of cases of TB/TPM + tested for HIV) **Denominator :** 2,504 (number of cases of TB/TPM + detected)
1.3.19	Percent of estimated new	Percent	20%	12%	Which	

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
	smear-positive pulmonary TB cases detected under DOTS in USG supported areas (case detection rate) **(Custom)**				represents 60% of the target	**Numerator:** 2,504 (number of new TB/TPM+ cases detected). **Denominator :** 21,064 (number of new TB/TPM+ cases expected in the global population)
Objective 1.4: Support extended services such as recognition, and or medical treatment of protection cases in a limited number of sites						
1.4a: Gender-based violence						
1.4.1	Number of sites in USG targeted areas providing clinical assistance to survivors of gender-based violence	Number	31	28	Which represents 90% of the target	
1.4.2	Number of people reached by a USG-funded intervention providing gender-based violence services **(GND-6) (Key Indicator)**	Number	80	175	Target exceeded	
1.4b: Child protection						
1.4.3	Number of USG supported sites providing clinical assistance and referrals of child protection cases to appropriate legal and social services	Number	31	28	Which represents 90% of the target	
Project Objective: Objective 1.1: Maternal, Newborn and Child Health (MNCH) services, including WASH and nutrition, strengthened						
1.4.4	Number of community and clinical health staff trained to recognize and refer protection cases to appropriate legal or social services **(Custom) (Key Indicator)**	Number	210	801	Target exceeded	Female: 236 Male:565
Objective 2: MOH capacity to manage and monitor health services strengthened at decentralized levels						

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
2.1 : Governance and leadership						
2.1.1	Percentage of facilities that received a supervisory visit through USG supported programs	Percent	100%	99%	Which represents 99% of the target	**Numerator:** 162 (number of PPS that received a supervisory visit) **Denominator :** 164 (number of PPS supported by SDSH during this quarter)
Objective 2: MOH capacity to manage and monitor health services strengthened at decentralized levels						
2.1.2	Number of patients referred from one facility to another	Number	900	1,870	Target exceeded	
2.1.3	Percentage of Centers of Excellence implementing quality assurance/quality improvement approaches.	Percent	100 %	100 %	Target achieved	
2.2 : Departmental financial management strengthened						
2.2.1	Number of facilities with improved accounting	Number	80	0	0	MSPP did not reach an agreement on the financial software package to be used.
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)	Number	10	0	0	MSPP did not reach an agreement on the financial software package to be used.
Objective 2.3 : Strategic information systems strengthened						
2.3.1	Percentage of USG-assisted health facilities that submit reports to national level on a timely basis	Percent	90 %	87%	Which represents 97% of the target	**Numerator**: 141 (number of sites that have submitted their report to Direction Sanitaire and there is record of receipt).

Code	Performance Indicator	Unit of Measure	Targets August 2012 – July 2013	Results August 2012 – July 2013	Assessment of Results	Comments / Recommendations
						Denominator: 164 (number of sites in network)
2.3.2	Percentage of facilities that receive a data quality assurance visit	Percent	100%	63%	Which represents 63% of the target	**Numerator**: 104 (number of sites that receive a data quality assurance visit) **Denominator**: 164 (number of sites)

Annex B: Table of Services Provided at the Centers of Excellence

The essential package of services to be implemented at each Center of Excellence

The COE will focus more on HBB and KMC techniques, AMSTL, the five FP methods most used in Haiti, and the complete PMTCT package, while offering, as requested by the MOH, all planned services. They will be progressively developed to become effective demonstration centers of excellence providing best practices in MNCH, FP, and HIV.

SDSH has developed guidelines for the promotion of the SONUB and SONUC based on the MOH 2011. It is a comprehensive list of interventions to be adapted in each of its centers of excellence depending of its status (either SONUB or a SONUC) and its level of development. Given SDSH previous successes in the implementation of the HIV/AIDS program, the following key activities listed in the HIV/AIDS section of the table below will be reinforced in each center SONUB or SONUC.

Below is a summary table of the key interventions per technical areas to be implemented at the COE.

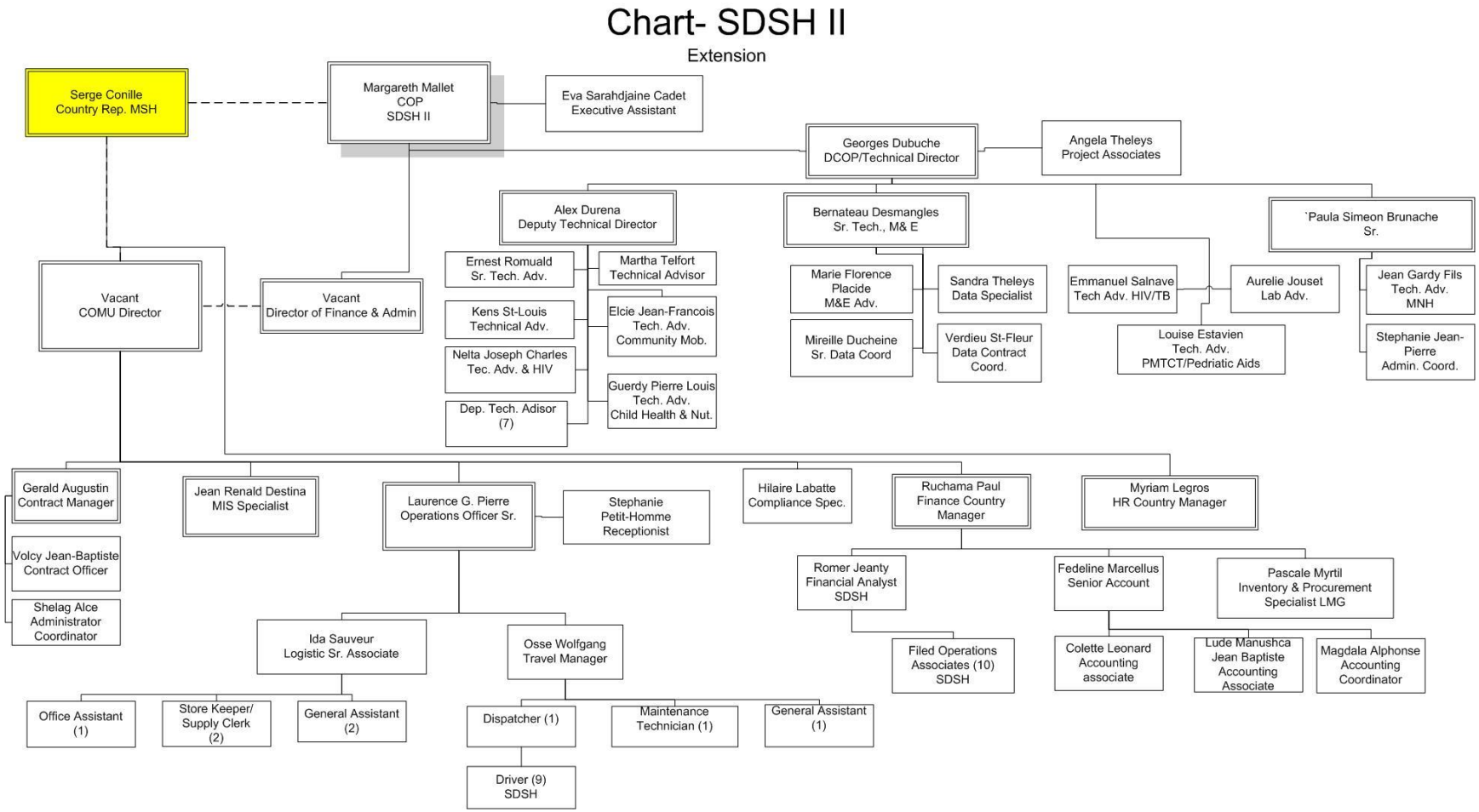
Technical domains	Relative level of funding in %	Major challenges/issues to be addressed (top priorities)	Key interventions SDSH II is supporting
Maternal Health	40%	Reduction of Maternal Mortality through strengthened EmONC	1) Antenatal care
			2) Delivery assisted by trained providers- AMSTL
			3) Postnatal care services
			4) Postabortion care
			5) PMTCT
Neonatal & Child Health		Strengthening newborn care services and C-IMCI	1) Exclusive Breastfeeding
			2) Resuscitation & Kangaroo Mother Care as needed
			3) Vaccination (EIP)
			4) Nutrition: growth monitoring, Vitamin A, and education
			5) Prevention and treatment of diarrhea
			6) Prevention and treatment of pneumonia
			7) Prevention and treatment of malaria (where applicable)
HIV/AIDS	37%	Accelerating prevention, treatment and support to people living with HIV (PLWHA)	1) Prevention including counseling and testing and PMTCT
			Opt out strategy for HIV counseling and testing
			PCR testing and rapid testing for SP
			Availability of CD4 testing and tritherapy
			2) Prevention & treatment of opportunistic infections
			3) Treatment and support for PLWHA (case management for HIV/AIDS, STI, TB)
			3) Auxiliary services: laboratory, pharmacy

Family Planning	18%	Unmet need	1) Provision of contraceptive methods, including injectables at facility and community level
			2) Provision of long term and permanent methods locally or through the mobile clinic
			3) Outreach for the hard to reach
			4) Provision of youth friendly clinical services
			5) Prevention and treatment of STIs
			6) Support to manage FP commodities (with LMS)
Tuberculosis	5%	Low detection & completion of treatment ratios	1) New cases detection to reach the target 70% (9,705 of expected cases)
			2) Treatment of TB case (completion>85%).
Cross cutting interventions			
Gender		Gender-based violence	Behavioral change communication
			Assistance to GBV victims
Child Protection		Child abuse	Identification, prevention of threats and harmful practices for children
			Referral to social services established for victims
Environmental protection		Wastes	Wastes management and infection control activities at facilities and community levels
WASH		Hygiene and sanitation	Conduct IEC/BCC for behavior change, training of mothers and caregivers to identify signs of danger for dehydration, and management of dehydration cases

Notice:

- SDSH II is mainly a community health program, thus interventions are focused mainly at the community level as the lowest level of the national health system. We will work with the MSPP to create the enabling policy environment and the needed capacity to make the eight COE fully functional by the end of the project
- Special attention will be given to the integration, the standardization of quality improvement, particularly for PMTCT, the use of efficient regimens according to national norms, and consideration of future parenting during pregnancy.

Annex C: Organizational Chart



Annex D: Success Stories

Rapid CD4 Testing Helps Baby Paul Receive the Care he Needs

Two year-old Paul had been sick for several days and on October 12, 2013, his aunt Marie brought him to the Jules Fleury Hospital in the Nippes department of Haiti. Two weeks prior, Paul's mother, who is HIV-positive, had left for Port-au-Prince in search of work, leaving Paul in the care of his aunt. Upon their arrival to the hospital, a nurse conducted a routine medical check-up and after learning of his mother's HIV status, immediately referred Paul for an HIV test, which was positive. Concerned about Paul's immune system and the progression of the HIV virus, the nurse recommended that Paul receive a CD4 test the next day.

Until recently, the Jules Fleury Hospital, like most health centers providing CD4 tests in Haiti, used a manual method, often requiring patients to wait up to two days for their results. For the estimated 175,000 people living with HIV in Haiti, poor access to laboratory services and longer wait times for CD4 tests can lead to delayed initiation of antiretroviral therapy, poor patient retention, and increased risk of death and suffering.

In 2013, through assistance from the PEPFAR- and USAID-funded *Santé pour le Développement et la Stabilité d'Haiti* (SDSH) project, the Jules Fleury Hospital received a PIMA CD4 test machine, which provides accurate test results within twenty minutes and does not require manual processing, allowing lab technicians to perform other duties while the test runs.

According to Joseph Borgelain, the in-charge of the Jules Fleury Hospital laboratory, quicker test results have helped improve patient care. "Before the PIMA CD4 test machine, it would have taken me about thirty minutes during which I would not have been able to do anything else. Now, I just have to collect one drop of blood from the patient and put the cartridge into the machine. While the machine is performing the test, I am able to conduct other diagnostic tests, including for tuberculosis," explained Joseph.

Within twenty minutes, Paul's test results were completed and he began antiretroviral therapy the same day. His health is now slowly improving.

SDSH II supported installation of four PIMA CD4 test machines in 2013, benefiting 7,224 people enrolled in HIV/AIDS care and treatment programs in 41 project-supported health facilities. "On top of being a very easy and rapid use machine, the PIMA is a much more reliable laboratory technique. I know that the results I am giving are of good quality, which ultimately benefits our patients," added Joseph.

Training of Medical Personnel on Gender-Based Violence Helps Victims Recover

Forty-nine year-old Gettie F. Consolabe has been working as a nurse at the Lumière Finca Health Center in Les Cayes in the South department of Haiti for more than 24 years. She is the HIV/AIDS program manager and in April 2013 she attended a week-long training on gender-based violence (GBV) for the first time in her career.

"I have learned a lot during this GBV training, especially regarding the needs in psychosocial care support," said Mrs. Consolabe. "I never thought a victim of violence could have psychological troubles as a result of the assault and would need psychosocial care to recover."

The USAID-funded *Santé pour le Développement et la Stabilité d'Haïti* (SDSH II) project launched the GBV program in 2013 in 28 health facilities. The GBV program trained medical personnel to encourage potential victims to come to the health center within 72 hours following assault to receive ART drugs to prevent HIV infection and contraceptive pills for unwanted pregnancy. Psychologists and social workers are also available to support patients. The project strengthened collaboration between medical and legal organizations to help victims of violence confront their assaulters.

"Owing to the GBV training, I am now familiar with legal aspects around this issue that I wasn't aware of before, such as my obligation to notify the Brigade of Protection of Minors when I encounter abused children during medical consultations. It also helped me recognize the different types of common wounds due to physical and/or sexual assaults. Besides, I have discovered new kinds of violence that I didn't suspect before this training: psychological and economic violence," added Mrs Consolabe.

Very few data are available in Haiti regarding the number of victims of physical and sexual violence. According to the URAMEL (*Unité de Recherche et d'Action Médico-Légale*) report,[1] 24,369 victims have been seen in institutions between 2002 and 2011, among which 67.5 percent were women. However, because of fear of reprisals and cultural taboo, victims often don't report crimes and it is very likely that the real number of victims is much higher. Since the SDSH II training, 187 victims have been seen by trained health workers in the 28 facilities. Out of those 187 patients, nearly 85 percent came after a sexual assault—98 percent of those victims were women.

[1] *Source : Unité de Recherche et d'Action Médico-Légale. Manuel de Formation, accompagnement et prise en charge pluridisciplinaire et intégrée des victimes de violences et d'agressions sexuelles, 6è édition. Port-au-Prince : Unité de Recherche et d'Action Médico-Légale ; June 2012.*

Newly Reopened Health Facility Allows Women to Safely Deliver Closer to Home

On July 4, 2013, 26 year-old Elina Jean-Baptiste of Cazale, Haiti began experiencing painful contractions as she prepared to deliver her child. Realizing she was going into labor, Elina walked to the Cazale health center and, with the help of trained nurses and a doctor, delivered a healthy baby girl named Dadeline. "The labor and delivery were very painful, but as soon as I arrived at Cazale, I knew I was in good hands," she said.

For the past decade, the town of Cazale has lacked a functioning health center, despite high rates of maternal and infant mortality and increasing rates of infectious diseases. Women often delivered at home in the absence of a skilled healthcare provider, thus increasing their risk of injury or death due to pregnancy-related complications.

Through assistance from the SDSH II and Leadership, Management, and Governance (LMG) projects, the Cazale health center has reopened its doors and is now providing a basic package of quality health care services to 8,800 people. Working in collaboration with the Ministry of Health, SDSH II and LMG provided laboratory equipment and materials focused on improving maternal and newborn health care.

SDSH II and LMG staff worked together to organize the delivery of health services and supported data management at Cazale. Since reopening in May 2013, the Cazale center has helped several women safely deliver their babies.

"The reopening of Cazale means a lot," said Elina. "Here I just had to get out of my house and walk to the health facility. Previously, I would have had to pay for a tap-tap, which is expensive."

Innovative Incentives for Maternal and Newborn Care

As 64 percent of women in Haiti give birth at home, SDSH II sought ways to encourage these women to visit a health facility within six days of birth to assess the wellbeing of the mother and baby. The team hypothesized that an effective innovation would be to offer kits containing baby care and maternal hygiene items to all women attending postnatal care services.

To test their theory, SDSH II applied for and won a grant from MSH to conduct a study to determine whether or not the monetary value of the kit influenced the likelihood of mothers visiting a health center within six days of birth. The kits were provided at four sites geographically distant from each other.

Kit A cost approximately US$6 and contained:

- 30 Aquatab tablets for water purification
- 3 individual packs of oral rehydration salts
- 1 pair of baby shoes
- 1 bar of soap for mother
- 1 bar of soap for baby
- bag for the market
- rolls of toilet paper
- 1 pack of 8 sanitary towels

Kit B cost approximately US$18 and contained everything in Kit A plus:

- 1 8.5 ounce bottle of shampoo for the mother
- 1 pack of 8 sanitary towels
- 2 toothbrushes
- 1 145g tube of toothpaste
- 1 towel for baby
- 1 adult towel
- 1 baby hygiene pack (talc powder, shampoo, body lotion, oil)

Kit A was available at two sites and Kit B was available at the other two. They were disbursed from May through July 2013 and the number of postnatal institutional visits was tracked. There was a significant increase in the number of postnatal institutional visits, from 10,919 in February through April 2013 to 11,841 for the period of May to July 2013. Additionally, there was a statistically significant difference in the average number of days between delivery and first postnatal visit in sites distributing a maternal incentive containing items of greater value, demonstrating that the value/content of the kits is an important consideration.

The results of this three-month pilot study indicate that offering a small incentive, such as these postnatal and newborn kits, may be an effective strategy to increase postnatal visits within six days of birth for women who deliver at home. As a result, early diagnosis of immediate postpartum complications for mothers and newborns can be performed and rapidly treated.

Annex E: Training Completed in SDSH II (August 1, 2012 – July 31, 2013)

Annex E: Training Completed in SDSH II (August 1, 2012 - July 31, 2013)									
Training Program	Location	Start Date	End Date	Males	Females	Total Trainees	Budget Amount	Actual Amount	Difference
Training of cholera Management	IC	09/10/2011	09/10/2011	12	0	12	$888	$888	$0
Child Protection and Gender Based	IC	03/13/2012	03/16/2012	38	10	48	$9,878	$9,878	$0
Waste Management on prevention	IC	08/20/2012	08/25/2012	9	25	34	$34,486	$34,486	$0
Workshop on DATA of HIV	IC	10/04/2012	10/05/2012	4	17	21	$1,778	$1,778	$0
Child Protection and Gender Based	IC	12/16/2012	12/19/2012	40	17	57	$18,566	$18,566	$0
Gender based Violence	IC	12/17/2012	12/21/2012	12	18	30	$18,811	$18,811	$0
Training of Trainers PCIME	IC	01/07/2013	01/18/2013	14	15	29	$20,505	$19,840	$665
Gender based Violence	IC	01/14/2013	01/18/2013	16	18	34	$11,210	$11,210	$0
Training of Trainers of ASCP	IC	01/21/2013	01/25/2013	13	22	35	$11,315	$11,315	$0
Training of Trainers of ASCP	IC	02/05/2013	05/05/2013	22	19	41	$8,349	$8,349	$0
Gender based Violence	IC	02/05/2013	02/09/2013	9	18	27	$8,677	$8,671	$6
Training of Trainers of ASCP	IC	02/18/2013	02/22/2013	2	8	10	$14,095	$14,095	$0
Training of Trainers of ASCP	IC	02/18/2013	02/22/2013	5	20	25	$14,062	$14,062	$0
Training of midwives	IC	02/19/2013	02/21/2013	10	17	27	$1,199	$1,199	$0
Training of midwives	IC	02/22/2013	02/24/2013	2	23	25	$1,234	$1,234	$0
Training Maternal and Neonatal Health	IC	02/25/2013	03/08/2013	3	25	28	$40,276	$40,276	$0
Training of midwives	IC	02/26/2013	02/27/2013	5	20	25	$823	$823	$0
Gender based Violence	IC	03/05/2013	03/09/2013	11	19	30	$8,911	$8,079	$832
Training of midwives	IC	03/07/2013	03/08/2013	9	16	25	$793	$793	$0
Infection prevention and waste	IC	03/07/2013	04/10/2013	16	3	19	$1,613	$1,613	$0
Infection prevention and waste	IC	03/07/2013	03/08/2013	4	10	14	$1,172	$1,172	$0
Training of ASCP	IC	03/09/2013	05/30/2013	22	12	34	$8,483	$8,483	$0
Training of ASCP	IC	03/11/2013	05/17/2013	24	10	34	$10,786	$10,786	$0
Training of ASCP	IC	03/11/2013	05/24/2013	2	5	7	$3,724	$3,724	$0
Training of ASCP	IC	03/11/2013	05/24/2013	12	13	25	$7,902	$7,902	$0
Training of ASCP	IC	03/11/2013	05/24/2013	19	5	24	$7,144	$7,144	$0
Training of ASCP	IC	03/11/2013	05/24/2013	11	22	33	$8,483	$8,483	$0
Training of ASCP	IC	03/11/2013	05/24/2013	3	9	12	$4,321	$4,321	$0
Infection prevention and waste	IC	03/12/2013	03/13/2013	4	17	21	$1,292	$1,292	$0
Training of Trainers of ASCP	IC	03/12/2013	03/16/2013	7	5	12	$1,457	$1,457	$0

Training of Trainers of ASCP	IC	03/12/2013	03/16/2013	15	3	18	$2,002	$2,002	$0
Training of Trainers of ASCP	IC	03/12/2013	03/16/2013	16	3	19	$1,928	$1,928	$0
Infection prevention and waste	IC	03/12/2013	05/13/2013	7	8	15	$1,624	$1,624	$0
Infection prevention and waste	IC	03/14/2013	03/15/2013	4	10	14	$1,429	$1,429	$0
Infection prevention and waste	IC	03/14/2013	04/11/2013	15	3	18	$1,829	$1,829	$0
Training of ASCP	IC	03/14/2013	05/24/2013	20	4	24	$6,979	$6,979	$0