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# Services de Santé de Qualité pour Haïti (SSQH) Central and South Contract No. AID-521-0-13-00011

## FY 2014

### Annual Report October 1, 2013 – September 30, 2014



## November 2014

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## ACRONYMS

<b>ANC</b>	Antenatal care	<b>HSIS</b>	Haiti Strategic Information Systems project
<b>ART</b>	Antiretroviral treatment	<b>IMCI</b>	Integrated management of childhood illness
<b>ASCP</b>	Agent de Santé Communautaire Polyvalent	<b>LARC</b>	Long-acting and Reversible Contraception
<b>ASRH</b>	Adolescent sexual and reproductive health	<b>LMG</b>	Leadership, Management, and Governance project
<b>BEST</b>	Bien et al Santé Timoun Project	<b>LMS</b>	Leadership, Management, and Sustainability project
<b>CAL</b>	Centre avec lits (center with beds)	<b>LTFU</b>	Lost-to-follow-up
<b>CAN</b>	Centre Ambulancier National	<b>M&amp;E</b>	Monitoring and Evaluation
<b>CDS</b>	Centres pour le Développement et la Santé	<b>MESI</b>	Monitoring, Evaluation and Surveillance Interface
<b>CHW</b>	Community health worker	<b>mHealth</b>	Mobile Health
<b>CP</b>	Child protection	<b>MMT</b>	Mobile Mentoring Team
<b>COP</b>	PEPFAR Country Operational Plan	<b>MNH</b>	Maternal and Newborn Health
<b>COR</b>	Contracting Officer's Representative	<b>MOU</b>	Memorandum of Understanding
<b>CQI</b>	Continuous Quality Improvement	<b>MSPP</b>	Ministère de la Santé Publique et de la Population
<b>CSL</b>	Centre sans lits (center without beds)	<b>NGO</b>	Non-governmental Organization
<b>DDS</b>	Direction Départementale Sanitaire	<b>OGAC</b>	Office of the US Global AIDS Coordinator
<b>DG</b>	Directeur Générale	<b>OVC</b>	Orphans and Vulnerable Children
<b>DHIS2</b>	District Health Information System 2	<b>PAP</b>	Port-au-Prince
<b>EPS</b>	Essential package of services	<b>PDI</b>	Plan Départemental Intégré
<b>FP</b>	Family Planning	<b>PEP</b>	Post-exposure prophylaxis
<b>FOSREF</b>	Fondation pour la Santé Reproductrice et de l'Education Familiale	<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>GBV</b>	Gender-based Violence	<b>PIH</b>	Partners in Health
<b>GHESKIO</b>	Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes	<b>PLHIV</b>	People living with HIV
<b>GIS</b>	Geographic Information System	<b>PMP</b>	Performance Monitoring Plan
<b>GOH</b>	Government of Haiti	<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>GTT</b>	Groupe Technique de Travail	<b>PNLT</b>	Programme National de Lutte contre la Tuberculose
<b>HCT</b>	HIV Testing and Counseling	<b>RBF</b>	Results-based financing
<b>HIFIVE</b>	Haiti Integrated Financing for Value Chains and Enterprises project	<b>SCMS</b>	Supply Chain Management System project
<b>HF</b>	Health facility	<b>SDSH II</b>	Santé pour le Développement et la Stabilité d'Haïti II project
<b>HMIS</b>	Health management information system	<b>SISNU</b>	Système d'Information Sanitaire National Unique d'Haïti

<b>SPA</b>	Service Provision Assessment	<b>UC</b>	Unité de Contractualisation (MSPP)
<b>SSQH-CS</b>	Services de Santé de Qualité pour Haïti Central-South project	<b>UEP</b>	Unité d'Évaluation et de Planification
<b>STI</b>	Sexually transmitted infections	<b>UNFPA</b>	United Nations Population Fund
<b>STTA</b>	Short-term technical assistance	<b>USAID</b>	United States Agency for International Development
<b>TA</b>	Technical assistance	<b>USG</b>	United States Government
<b>TB</b>	Tuberculosis	<b>WASH</b>	Water, Sanitation, and Hygiene
<b>TBA</b>	Traditional Birth Attendant	<b>YFS</b>	Youth-friendly services
<b>UADS</b>	Unité d'Appui au Direction Sanitaire	<b>ZC</b>	Zone Ciblées
<b>UAS</b>	Unités d'Arrondissement de Santé	<b>ZL</b>	Zanmi Lasante

## EXECUTIVE SUMMARY

SSQH-CS is pleased to present its Year One (Y1) Annual Progress and performance Report. Intensive efforts were deployed during the first year on project start-up, partnership development, and programmatic implementation. Key accomplishments demonstrate the breadth of activities completed during the reporting period: the project assembled its team and offices, met key deliverables set by USAID, smoothly sustained service delivery at 80 facilities during project transitions, established foundations in behavior change, started innovations (mHealth and gender approaches), and began technical interventions to support improvements in health services. A keystone to the project's approach and implementation has been ensuring the full investment and oversight of activities by MSPP-Central and each DDS to increase ownership and management of their health system.

Critical to the project's success in these accomplishments were several notable elements. Sustaining service delivery at the 80 facilities and surrounding communities, the project negotiated MOUs with each of the six DDS for the life of project, and accompanying Y1 budgets; it executed 19 NGO subcontracts; and it consolidated 644 health providers from the ZCs under project management. The team established monitoring systems, focusing on the people, processes, and technologies needed to report against the PMP, while making essential linkages among project, sites, and national databases such as MESI and DHIS2. A comprehensive site assessment of all 80 facilities, in conjunction with external data sources (i.e. SPA), informed a detailed baseline and provided necessary background for the project's site dashboard and profiles. Technical assistance under the project's objectives shows clear progress against mandated indicators by end of Y1. Those few indicators showing Y1 targets not quite being met will be prioritized for Y2. Trainings for ASCPs in the MSPP curriculum have begun, supplemented by sessions in mHealth technologies (i.e. CommCare) and additional technical areas (i.e. GBV, WASH, etc.).

As the project enters Y2 the stage for continued programmatic implementation and scale-up is set with all the key pieces in place, the project focus will continue to incorporate quality and improving efficiencies in the Haitian health system.



**Figure 1: ASCP using CommCare in the Community**

## INTRODUCTION

The Services de Santé de Qualité pour Haiti- Central and South (SSQH-CS) Project is a three-year (with the option of a two-year extension) health service delivery initiative in Haiti funded by the United States Agency for International Development (USAID). SSQH-CS supports the Ministère de la Santé Publique et de la Population (MSPP) to improve the health status of the Haitian population. Led by Pathfinder International, SSQH-CS partners with the Centres pour le Développement de la Santé (CDS); Deloitte Consulting, LLP ; Dimagi ; the Fondation pour la Santé Reproductrice et de l'Éducation Familiale (FOSREF); the Groupe Haïtien d'Étude du Syndrome de Kaposi et des Infections Opportunistes (GHESKIO); Partners In Health (PIH); and Zamni Lasante (ZL).

SSQH-CS has four objectives:

- (1) Increase the utilization of the Ministère de la Santé Publique et de la Population's integrated package of services at the primary care and community levels (particularly in rural or isolated areas);
- (2) Improve the functionality of the USG-supported health referral networks;
- (3) Facilitate the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels; and
- (4) Strengthen departmental health authorities' capacity to manage and monitor service delivery.

SSQH-CS works in six of the ten departments in Haiti, including West, Center, South, South-East, Nippes, and Grand Anse, providing clinical and community-based services for the catchment area's nearly 2.65 million people. Service delivery is the provision of MSPP's Essential Pack of Services, which includes services in HIV/AIDS (including clinical and psychosocial service support to Orphans and Vulnerable Children [OVC]); Tuberculosis (TB); Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene [WASH], and Nutrition); and Family Planning (FP). In addition, SSQH-CS supports Gender-Based violence (GBV) and Child Protection (CP) services at selected sites, as well as the provision of training and limited support for basic critical care (accident and emergency) for project sites within the Port-au-Prince and parts of the St. Marc USAID Development Corridors. A critical link between communities and facilities reinforced and supported by SSQH-CS is the Agents de Santé Communautaires Polyvalents (ASCP), who provide first level services in MCH, FP, STI/HIV/AIDS, TB, and nutrition. SSQH expects to support 2,500 ASCPs by project's end.



**Figure 2: SSQH-CS supported facilities**

SSQH expects to support 2,500 ASCPs by project's end.

Key project strategies for reaching these objectives include (1) strengthen the technical knowledge, skills, and capacity of health care providers at facility and community levels; (2) train and mentor health care leadership in management practices; (3) establish and strengthen service networks extending from the household to hospitals; (4) assess and where feasible, refurbish physical infrastructures and supply equipment to facilities; (5) promote community involvement and mobilization; and (6) implement the MSPP results-based financing (RBF) scheme.

This annual report covers the Year One (Y1) activities and results of SSQH-CS from October 2013 to September 2014. The report is divided into seven main sections: management, monitoring, and administration; cross-cutting activities; annual performance by objective; partner coordination; environmental reporting; challenges; and Success Stories. Finally, several resources in annex are included to support the report narrative.

## MANAGEMENT, MONITORING, AND ADMINISTRATION

SSQH-CS supports MSPP in the improvement of the health status of the Haitian population. The project team does this in close collaboration with USAID, local implementing partners, and other USG partners. Year One was hallmarked by the establishment of the SSQH-CS consortium, key stakeholder partnerships, project assets (including personnel and offices), data and management systems, and activity implementation.

### PROJECT MANAGEMENT

Project implementation occurs under the management of Pathfinder International, and draws from the expertise and established experience in Haiti of key implementing partners. Pathfinder brings to the project team technical expertise in service quality improvement, Sexual and Reproductive Health (SRH), Family Planning (FP), Maternal-Child Health (MCH), mHealth, and community engagement/mobilization. Deloitte excels in health systems strengthening, capacity building, Results-Based Financing (RBF), and data analytics. PIH and ZL have long legacies of working in HIV/AIDS, Tuberculosis (TB), and critical care in Haiti, as well as skilled experience in Water, Sanitation, and Hygiene (WASH), Child Health (CH), Child Protection (CP), Nutrition, and Gender-Based Violence (GBV). GHEKSIO also brings invaluable expertise in HIV/AIDS and TB, as well as strong work training and mentoring health providers. CDS is a key partner in training community health workers (CHW) and community mobilization, while FOSREF brings to the consortium deep roots working with Haitian youth, community outreach groups, and key affected populations (KAP). Finally, partner Dimagi designed the CommCare mobile health platform used with CHWs and facility staff and helps in collaboration with partners to develop specific technical applications and to customize them to the Haitian context. Under the management and coordination of Pathfinder, implementing partners work with service delivery networks (site and community levels), the Direction Départementale Sanitaire (DDS) and Unités d'Arrondissement de Santé (UAS), and MSPP at the central level to meet the objectives of this project.

As per the project contract, SSQH-CS has several reporting deliverables due to USAID throughout Year One. A summary table highlighting each reporting deliverable for the period and its status as of September 30, 2014 is below:

Deliverable	Due Date	Status
Year 1 Work plan	November 30, 2013	Submitted
Environmental Mitigation Plan and Report (EMPR)	November 30, 2013	Submitted
Performance Monitoring Plan (PMP)	December 30, 2013	Submitted
Quarterly Financial Reports	January 31; April 30; July 31, 2014	Submitted
Revised Branding & Marking Plan	March 31, 2014	Submitted
PEPFAR Semi-Annual Performance Report (SAPR)	April 2014	Submitted
Annual Tax Filing Report (VAT)	April 14, 2014	Submitted
Semi-Annual Progress Report	April 30, 2014	Submitted
Semi-annual PEPFAR Performance Report	April 30, 2014	Submitted
Annual PEPFAR Performance Report	October 10, 2014	Submitted

**Table 1: Summary of Contract Reports/Plans and Status To-Date**

A few reporting deliverables went through several iterations following feedback from USAID. Both the Y1 workplan and Performance Monitoring Plan (PMP) underwent revision per USAID’s request and was resubmitted. USAID’s invitation to revise the workplan enabled the team to adjust some activities to better reflect current implementing realities and known preferences of MSPP and USAID. More details about the PMP can be found in the *Monitoring Systems* section below.

In response to specific requests by USAID or as a result of the project adapting to its operating context, several changes in the project’s scope, budget, and/or timeline have been made. The below table is a Change Log for Y1 that captures all the significant changes, the date received, and estimated cost impact of the change, if known. Each of these has an impact on facilitating or challenging the attainment of the project’s results. More detail on the full impact of some of these changes may be found in the *Challenges* section.

Change	Summary of Changes	Date Received	Cost Impact (\$)
Support for HPs at <i>zones ciblées</i> (ZC)	Addition of 644 previously unbudgeted health workers at the ZC annually. This cost burden greatly reduces the project’s ability to invest in programmatic activities.	November 2013	USD \$1.2 million annually
Budget shifts in PEPFAR funds	Budget decreases in HIV prevention (PMTCT, prevention Lab, and HSS) and increases in treatment and care (adult, pediatric, HIV/TB, OVC), per PEPFAR mandate, for COP 2014 (FY15).	May 2014	Increased OVC funds for FY15 by \$484,861 and decreased funds for other services.

**Table 2: Y1 Change Log**

## MONITORING SYSTEMS

In close collaboration with USAID, MSPP, and other USG projects (including SSQH-North, HSIS, and SDSH II), SSQH-CS developed the PMP and submitted it on December 30, 2013. This document went through several iterations of refinement following key discussions and planning exercises in coordination with USAID, and particularly the PEPFAR team. During the project’s work to support USAID develop its FY14 PEPFAR targets, SSQH-CS updated its HIV/AIDS targets in a separate document and later folded them into an updated Summary Indicator Table. Further feedback from USAID in February and July 2014 informed subsequent revisions to the PMP, with the final version submitted in August. This version has a streamlined set of indicators that align more directly with SSQH-CS contractual mandates. Baselines and targets were also updated with USAID’s input. Many indicators which previously lacked baselines were informed by the facility assessment survey conducted by the project in March/April 2014. The PMP is accompanied by the required Performance Indicator Reference Sheets (PIRS) which define the details of indicator purpose, data sources, collection processes and frequency, etc. The Summary Indicator Table with Y1 data may be found in Annex A.

Monitoring activities this year focused on developing the people, processes, and technologies to report PMP indicators. First, the project built rapport with the M&E counterparts at the various levels of the Haiti health system – MSPP’s Unité d’Evaluation et de Planification (UEP), the DDS M&E and program staff, and counterparts at the project-supported health facilities. These relationships were critical in the successful transition, which is evident with the improvement in the number of monthly MSPP reports received as well as their accurate entry into the new the Système d'Information

Sanitaire National Unique d'Haïti (SISNU) otherwise known as the District Health Information System 2 (DHIS2), and illustrated in this document vis-à-vis our mid-year report.

Second, the project designed and supported processes necessary to collect, compile, and review indicator data. The project defined data collection procedures for indicators not reported to the Monitoring and Evaluation Surveillance Interface (MESI) or DHIS2, but part of the project's PMP (including indicators for TB and PLHIV retention).

Third, PMP reporting for SSQH-CS would not have been possible without supporting data systems. These systems come in many forms, from patient registers to the national health management information systems. SSQH-CS assisted central MSPP and the DDS in facilitating facility registers which were frequently in stock-out when the project began. The project worked with Futures Group and MSPP to facilitate the quantification of register stocks to inform needs forecasting. SSQH-CS also led the way in supporting the development and implementation of DHIS2, managed by Futures Group, which will soon become the national health management information system (HMIS) for Haiti. SSQH-CS was amongst the first to be fully operational in DHIS2, helping Futures Group to understand project data entry and reporting needs. The two projects (including leadership and technical teams) maintain excellent relationships and a strong partnership. In demonstration, a significant portion of this report's indicators were calculated using data exported from DHIS2, including all indicators for MCH and FP.

The project has also worked on data quality and M&E systems strengthening since the beginning of the project. All MSPP and PEPFAR reports underwent desk audit, and any suspected data quality issues were raised with the facilities for correction and/or explanation. All MSPP monthly reports entered into DHIS2 were verified by the project for accuracy; and all PEPFAR reports are being validated via CDC's system in conjunction with MSPP.

Some feedback has been provided to facilities to improve data quality and we expect year two to focus much more heavily on the quality of source data and overall M&E systems strengthening. For example, a considerable challenge for SSQH-CS and the national health system is the reporting burden. The MSPP monthly reports alone contain close to 3,000 data elements. In most cases, the report forms do not follow the logic of the site registers. The team hopes to work with MSPP, Futures Group, and other stakeholders in year two to explore the streamlining of reporting requirements and to assist in developing forms that are more consistent with register data.

## ADMINISTRATION

As of the final quarter of FY14, SSQH-CS has two fully operational project offices (PAP and Les Cayes), five approved key personnel reporting for duty, a project team of 56 staff, and a fleet of 8 vehicles with plans to increase the fleet size by 1-2 in Y2. The full SSQH-CS consortium is operational, with agreements and funding in place for smooth implementation. Service delivery in 80 facilities is provided by 19 NGO subcontractors and publically-managed ZC teams in six departments. Project offices are equipped and functional, with many items coming from SDSH II<sup>1</sup>, while others have been purchased using project resources. Selected STTA visits from Pathfinder's HQ office helped set up key IT equipment and systems in both project offices. An updated organogram may be found in Annex B.

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<sup>1</sup> Despite many useful items received from SDSH II, several key items including vehicles and certain IT equipment were useless given their deplorable state of condition. See "Challenges" section for more detail.

## ACHIEVMENTS AND RESULTS BY PROJECT'S OBJECTIVES

### OBJECTIVE I

#### INCREASE THE UTILIZATION OF THE MSPP INTEGRATED PACKAGE OF SERVICES AT THE PRIMARY CARE AND COMMUNITY LEVELS

SSQH-CS ensures the delivery of health services in the USAID-supported network and scales up access and use of MSPP's essential package of services (EPS) at facility and community levels. The project supports the delivery of services at all 80 sites and their surrounding communities. Grounded in the continuum of care from the community to facility level, the project brings essential services to the lowest possible levels while sharpening the quality of services along the continuum. Focused technical assistance targeted the improvement of service quality and integration, and support for CHW and traditional birth attendants (TBA) broadened the delivery of services at community levels. Mobilization and support of community groups worked to increase demand use for these improved services. Finally, the project acknowledges the efforts and good work provided by the 80 service delivery sites, which managed a transition from SDSH II to SSQH-CS seamlessly, and played a pivotal role in the project's performance.

During Y1, SSQH-CS coordinated with USAID and prepared two key concept notes addressing the focus and expansion of services in the project catchment area. The *Reorganization of HIV Services Delivery in the SSQH-CS Network* concept note (see *Objective 1 [HIV] for detail*) responded to upcoming changes in PEPFAR for FY15. The project also submitted *La Saline* concept note in August, which explored the possibility of expanding health services at La Saline, a NGO-managed site serving a large slum area in metropolitan PAP. The document reviews the health concerns endemic to an impoverished, over-populated, and under-served region of the capital, and analyzes the funding situation and lists expected activities and results. If approved, La Saline would become part of the SSQH-CS network for the remainder of the project.

Following coordination with USAID's HIV team in December/January, SSQH-CS developed a priority list of 23 sites (of the 31 PEPFAR-supported sites) providing HIV services for Y1 focused technical assistance, essentially in integration of services (HIV, MCH, TB, FP, GBV, WASH, CH, etc.). To help streamline efforts and coordinate interventions, the project used this 23-site priority list to guide all technical assistance during the first year, while maintaining service delivery at all sites. Details of the TA and project results are outlined below under each technical area.

Each technical area below includes a highlighted data table with indicators specific to the results mandated by the project contract. A full SSQH-CS Indicator Summary Table with Y1 Results is found in Annex A.

## HIV/AIDS

Indicators	Annual Target	Total Achieved to Date	% Target Achieved to Date
Number of adults and children with advanced HIV infection newly enrolled on ART	1,290	1,144	88.7%
	Comments: One of the reasons for the lagging data in this indicator is the decrease of the number of prenatal cases entering care, which is related to an absolute drop in the positivity in the overall prenatal population. While the data reported in the APR represented 10.5 months, this update represents the 12 month period. With added PMTCT/ART sites during Y1, we can expect this figure will increase in Y2. Large numbers of PLHIV enrollees come from prenatal program.		
Number of adults and children with advanced HIV infection receiving ART	2,996	3,101	103.5%
	Comments: Increasingly, patients are being identified before they fully develop AIDS.		
Percent of registered TB patients screened for HIV at project-supported sites	90%	Suggests over 90% screened 1242	Over 100%
	Comments: MESI shows more screened (n=1242) while MSPP reports show (n=849);		
Percent of HIV+ women who receive ART to reduce the risk of MTCT	90%	87%	97%
	Comments: Target nearly achieved for Y1		
Number of HIV+ eligible adults and children provided with a minimum of one care service	7,541	6,175	81.9%
	Comments: Proxy: people who have received one clinical visit per year. Indicator may change in Y2. Figures from Martissant & Delmas 75 had errors, thereby changing results presented in APR.		
Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART	77%	68.2%	88.6%
	Comments: Sites surveyed cover about 64% of active ART population. Figures include LTFU, drop out of treatment, transfers, and people who died. Overall, 11.7% were LTFU among ART sites.		

**Table 3: Mandated HIV Indicators**

Coordination with USAID's HIV technical team helped to produce several documents. Responding to USAID's request, SSQH-CS conducted a rapid service assessment of the 54 facilities providing HIV services during December 9-13, 2013. Results from the assessment informed the work plan and the project's contribution, in close coordination with SSQH-North, to the FY14 PEPFAR targets (submitted January 10). This included the development of individual targets per site for existing and proposed HIV/AIDS services for scale up. SSQH-CS analyzed results from the FY14 PEPFAR Country Operational Plan (COP) and coordinating with USAID on strategies and TB management. The project prepared the Semi-Annual Performance Report (SAPR) and Annual Performance Report (APR) in April and October respectively. HIV service additions were outlined, monitored, and reported in these documents.

As outlined in the FY14 PEPFAR APR, SSQH-CS provided financial, logistical, and technical assistance to 31 PEPFAR-supported sites, including provider salaries, training, supervision, coaching, and mentoring<sup>2</sup>. Sites were visited at least once per quarter by project staff and often accompanied by MSPP/DDS officials. During FY14, 31 sites received HIV testing and counseling (HTC) direct service delivery and treatment out the originally-targeted 29 sites, resulting in a 107% achievement for COP for FY14. Fifteen (15) sites received support for direct HIV/TB service delivery, and 21 sites received assistance for direct care and support, with 18 sites assisted to provide orphan and vulnerable children (OVC) support. SSQH-CS added HIV services to several sites this first year: seven (7) new HTC, three (3) new PMTCT, and six (6) new ART.

Service assessments for the 23 priority HIV sites and their supported communities began in Q1 and continued through Q4. These technical assessments included a four-part process: discuss project, assessment process, and care provision activities with facility directors; meet HIV care providers and conduct assessment; share key indicator data with facility staff for discussion; and generate assessment reports with focused TA recommendations for follow-up. Sites were prioritized for mentorship and training and the HIV project team started implementing its recommendations.

The team mapped out recommendations for HIV service upgrade based upon assessment results and drew from a site's ability to provide PMTCT or ART. The team assessed a site's existing and lacking resources (human, material, and capital), the target population, alternatives for seeking services elsewhere, the DDS leadership and participation, HIV prevalence, and opportunity for lab networking.

Technical assistance activities for these sites include: HIV management training for selected site personnel, on-site training and mentoring for institutional staff involved in PLHIV care (immunization, child care, outpatient clinic, inpatient ward, and laboratory, etc.); lab upgrading (i.e. manual CD4 count); and HIS (record keeping, register filling, data validation, and report posting to MESI); and on-the-job training by ensuring all standard procedures and patient consultations are co-performed by mentor and mentee. Infrastructure improvements have been completed at the OBCG and St. Paul clinics to prepare the sites for ART upgrades.

As part of the TA package provided to sites, a number of health providers received specialized trainings during Y1. At sites offering PMTCT, 118 clinical providers received training and mentoring, as well as close follow-up for data management over more than 160 clinical visits. A total of 77 doctors, nurses, nurse auxiliaries, social workers, and data clerks received clinical training and mentoring for services to infants born to HIV+ mothers, delivering TB services for seropositive individuals, and providing ART. In support of HTC services, 136 facility personnel received training in testing and counseling. Trainings and coaching sessions aimed at increasing clinicians' skills in treating HIV-related opportunistic infections, TB co-infection, and malnutrition. At all sites selected for upgrades, 20 lab technicians received training on manual chemistry for testing to monitor HIV patients, and 42 OVC health providers received training on responding to focused recommendations by PEPFAR and OGAC.

To improve HIV service delivery at the community level, SSQH-CS presented to USAID its "Community Strategy for Retention to Care and Adherence to Treatment" concept note. The USAID HIV technical

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<sup>2</sup> Training includes didactic presentations and discussions on case management, with a pre- and post-test; coaching pertains to the side-by-side accompaniment focusing on clinical and case management; supervision provides additional management support; and mentoring involves longer-term (3-5 days) on-site support blending all three with further assessment in coordination with DDS personnel.

team engaged SSQH-CS on the approaches and provided feedback that informed the strategy's development. Included in the strategy is the use of community adherence support groups, integrated community-based clinical and psychosocial services, and a "community-test-and-treat" approach, as well as plans for routine community-based monitoring, provided by ASCPs with CommCare. In Y1, 567 CHWs received training on patient tracking and knowledge of HIV symptoms in order to refer people to health facilities.

The project also prepared a patient adherence and compliance strategy note in collaboration with the "Eviter le VIH et sa Transmission project (EVIH-T)" and PSI to increase efficiency of care at HIV sites by measuring the number of patients on ART and their retention in care. Interventions will target selected medium- to high-yield project supported sites and employ a multi-pronged approach to increase utilization of HIV services, improve retention in care, and boost adherence. Ten project sites will lead implementation efforts in Y2.

At the national level and in coordination with the "Programme National de Lutte contre le SIDA (PNLS)", SSQH-CS staff disseminated national HIV guidelines and contributed to the national HIV/TB concept note that determined the third line regimen for patients<sup>3</sup> in the management of HIV/TB co-infection. SSQH-CS will support PNLS management of patients with third line regimen failure. The project has also coordinated with PNLS and the National Lab in the planned expansion of viral load testing to patients on treatment. A group involving SSQH-CS will elaborate a document on protocols (clinics, lab, and logistics), data management, and partners' roles in operationalizing viral load testing availability.

Finally, the team prepared a concept note on the "Reorganization of HIV Services Delivery in the SSQH-CS Network". This document responded to PEPFAR's request that HIV services at facilities seeing fewer than 24 clients per month be reduced and consolidated at referral facilities. The concept note makes the case for sustaining HIV services at selected sites below the client threshold (for either humanitarian or strategic reasons), proposes HIV service reduction in other sites, and details proposed sites to activate HIV services as well as fold key FOSREF sites into the network.

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<sup>3</sup> Per the current national guidelines for HIV management, patients who fail to adhere to second line regimen treatment must be evaluated by a national committee, chaired by the PNLS, in order to determine a remedial treatment plan.

## TUBERCULOSIS

Indicators	Annual Target	Total Achieved to Date	% of Target Achieved to Date
Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	67 per 100,000	74 per 100,000	110%
	Comments: Population figure of 1,152,671 used as this is the population of the catchment area of the sites that had new TB patients in this data (n=30)		
Percent of the estimated new smear-positive pulmonary TB cases that were detected under DOTS (case detection rate)	15%	37%	246.7%
	Comments: Target underestimated project's ability; Y2 target will be adjusted accordingly. All TB sites use DOTS		
Percent of project-supported facilities that have adopted an infection control plan	60%	33%*	55%*
	Comments: *Represents % achieved at mid-year; end-year data not available.		
Percent of patients receiving isoniazid preventive therapy	71%	86.6%	121%
	Comments: Target surpassed for Y1. Figure does not include TB+ patients who were put on anti-TB treatment (only eligible patients counted in denominator)		

**Table 4: Mandated TB Indicators**

In an effort to reduce HIV and TB co-infection as well as prevent new TB infections, SSQH-CS directed its integrated HIV/TB technical assistance in Y1 to the 23 priority sites. Seventeen (17) of the priority sites provide ART, and 15 sites provide isoniazid preventive therapy (IPT) for HIV patients. Technical teams reinforced site strategies for providing IPT and verified data through a review of client records. Mentoring teams shadowed providers to see how well they follow established procedures, standards, and norms. All 23 priority sites provide Directly-Observed Treatment, Short-course (DOTS), while 18 sites have TB diagnostic capacity. Those priority sites not having diagnostic capacities are situated near centers that do and refer patients accordingly.

During site supervision visits, project team members reviewed providers' surveillance of MDRTB cases, evaluated and/or established a process for sending specimens and referring patients to hospitals with GeneXpert networking capacities such as Hôpital Universitaire de Mirebalais. At the community level, the project supports auxiliary nurses to train CHWs in case finding of TB suspects (by identifying individuals experiencing a sustained cough and/or night sweats longer than two weeks) and refer them to diagnostic and treatment centers. Mentoring at the site level helps reinforce this element of CHW supervision.

The project's site assessment identified a total of only 6 of 19 priority sites having an infection control plan<sup>4</sup>. For those sites without a plan in place, the project technical unit made recommendations to facility providers on what issues to address to improve infection control. Emphasis on developing infection control plans at these sites will be made in Y2. Some common recommendations include switching TB rooms at a facility or adding better ventilation and advising that TB patients have their own waiting room away from other patients. One key issue facing the project is resource limitation for

<sup>4</sup>Four of the 23 priority sites had data missing on the presence of an infection control plan.

providing all the needed infrastructure improvements at various sites to bring their infection control and TB testing and treatment capabilities up to acceptable levels. Of the 23 priority sites in Y1, 10 require infrastructure improvements.

During Y2, the team plans to connect with the MSPP’s “Programme National de Lutte contre la Tuberculose (PNLT)”, which conducts quarterly visits and coordinate monitoring visits with them. Efforts will also include procurement and provision of personal protective equipment (PPE) at selected sites. Bi-annual comprehensive infection control assessments are also scheduled for Y2. Also slated for Y2 is to scale up the provision of IPT across TB sites in coordination with MSPP and USAID.

## MATERNAL AND CHILD HEALTH

Indicators	Annual Target	Total Achieved to Date	% Target Achieved to Date
Percent of pregnant women who have at least 3 ANC visits	53%	61.6%	116%
	Comments: 77 of 79 sites; increasingly early Prenatal visits and valuing services		
Percent of births attended by a skilled doctor, nurse, or midwife	7.9%	15.5%	197%
	Comments: All births were counted where data was of acceptable quality (n=52,444; Institutional Births: 8,117) Only 8 institutions excluded for insufficient data. Y2 target will be revised		
Number of postpartum/newborn visits within 3 days of birth	39,835	26,724*	67%*
	Comments: Represents about 80% of data: missing October 1 – November 15, 2013, plus technical barriers with some DHIS2 data. 73.7% of data on 79 sites. If trend normative and full dataset, value could be as high as 36244 (91%).		
Percent of children aged <1 year that are fully vaccinated in project catchment area	95%	60.6%*	64%*
	Comments: Represents about 80% of data: missing October 1 – November 15, 2013, plus technical barriers with some DHIS2 data. (n=37,753) Missing 23% of the data. If the data is normative, this value could be as high as 78.7% (83% of target). Also, the country has experienced major stock-outs in vaccines.		
Number of children <5 who have received Vitamin A from USG-supported programs	221,403	158,195	71.5%
	Comments: This is likely an undercount since children should receive 2-3 doses per year; but to avoid duplication of the 2 counting parameters 6-23 mos. and 12-59mos, we are counting only the 1st dose. Missing 21% of data.		
Number of children <5 reached by USG-supported nutrition programs	502,710	402,112	80%
	Comments: Data very incomplete (40 sites with 61.3% of their records). If all 76 sites performing weightings reported, target could easily be reached.		
Percentage of underweight children <5	4.8%	5.6%	87%
	Comments: Only 49 sites providing weighing results were analyzed		
Prevalence of exclusive breastfeeding of children under 6 months of age	43.7%	49.1%	112.4%
	Comments: This value was calculated by taking the number of mothers completing MAMA (n=3,692) at the sites that offered this intervention and dividing that number by 1.3% of the total catchment area population, which represents children under 6mos. Data from 22 sites from all 6 Departments		
Prevalence of anemia among pregnant women	19.2%	18.8% (8,738)	102%
	Comments: 56 of 77 sites used because of data errors (this was the least well reported of the prenatal data points) divided by their 1st PN visits.		

**Table 5: Mandated MCH Indicators**

### *Maternal and Neonatal Health*

Through service delivery financing and targeted TA, SSQH-CS supports and improves basic maternal-neonatal health (MNH) care at community and institutional levels, while strengthening referrals for obstetric and nutrition support services. At the site level, the project worked with HPs to ensure the use of MSPP standards and guidelines, and supervision and coaching sessions at 10 priority institutions<sup>5</sup> reinforced knowledge of and adherence to protocols in antenatal care, safe delivery (including AMTSL), post-partum, and essential newborn care.

The project team found that many sites either had delivery tables in poor condition or none whatsoever. It proved difficult for the team to find a decent stock of tables in country, as most vendors only keep a couple models in stock for show. However, SSQH-CS was able to locate one vendor with 44 delivery tables in stock and purchased them for distribution late in Q4. Priority will be made for remote sites and selected CALs that are very crowded and have an obvious need. Distribution is slated for early Y2.

Numerous project-supported facilities have a network of traditional birth attendants (TBA) or *matrons* that provide basic MNH services in the surrounding communities and serve as critical links with facilities. They identify pregnant women in the community, encourage antenatal visits (up to 4), help establish and monitor birthing plans, have birth kits for safe delivery in the community if woman does not deliver at a clinic, and are trained to identify danger signs and refer urgent cases to clinics and/or hospitals. In Y1, 66 project-supported sites used TBAs for community-based service delivery. TBAs were essential players in helping the project ensure 32,046 women received at least 3 antenatal visits. Linked to this impressive figure is the project's achievement of 102% of its target for the attending to pregnant women with a prevalence of anemia. In remote areas, certain facilities operate mobile clinics in coordination with CHWs, who help to mobilize the population at rally posts, typically twice monthly.

Under the *mSanté* program, the project developed a MCH application in CommCare and trained 309 ASCPs in its use. The application reinforces community-based service delivery while improving client data management and referral strengthening. During home visits, an ASCP uses the MCH application to ensure the pregnant woman has all the necessary vaccines, receives counseling on HIV testing and services, STIs, develops a birthing plan, refers her to the clinic for ANC visits, and tracks symptoms such as blood pressure and UTIs. This data is made available to the facility once the ASCP makes a referral, and facility personnel contact the patient to come in for a visit. Results from the facility visits are then sent back to the ASCP, allowing her to follow-up with the patient as part of the counter-referral. SSQH-CS provides post-training support directly to ASCPs and in coordination with facility personnel. Weekly meetings with ASCPs and their supervisors help identify problems, reviewing how ASCPs are using the applications, and what additional support is needed. (*For more detail on mSanté, see Objective 2*).

The project collaborates with facilities to reinforce MCH services within the surrounding communities. In one case, the team worked with CAL de Matheux, managed by SADA, and the Arcahaie community. The project team used P2C to help a focus group (8 women and 8 men) identify some of the barriers and facilitators to institutional deliveries. Examples of facilitators identified were known dangers of delivering at home and routine home visits by ASCPs to reinforce institutional delivery, while some barriers included socio-cultural pressure for woman to deliver at home and poor treatment of patients experienced at the facility. Results were presented to facility staff for follow-up and integration in their action plans.

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<sup>5</sup> Institutions include FOSREF, SADA, Fermathe, FONDEFH, Petit Place Cazeau, OBCG Carrefour, Cornillon, Tayfer, CDS, Casale, and Clinic St. Paul.

Careful coordination with and support to the DDS to help proper planning and budgeting for MNH service delivery at community levels and for the availability of essential medicines were key functions provided by the project team. SSQH-CS technical advisors also advised the DDS for Central Plateau on its recruitment efforts for a departmental community activity manager.

In March the project responded to a request from USAID and prepared a “MNH Referral Network Model” concept note outlining a model to improve maternal health in Haiti, specifically within the St. Marc Development Corridor. The network model included referrals for non-urgent care such as ANC or institutional delivery and obstetric complications, and urgent obstetric interventions. The proposed model included community mobilization to assist in the referral process, equipping and training ASCPs to use CommCare and other mobile technology tools to make referrals, and improving services at the facility level to better receive and treat in-coming patients, as well as to make counter-referrals for follow-up once the patient is discharged and returns to the community.

### *Nutrition and Child Health*

Building off of the site assessment data, the project teams visited priority sites and followed up with more in-depth review of facility capacities. Findings show that while each of the sites should provide general nutrition and CH services<sup>6</sup>, the reality is that there is a range of capacity to do so. Much of this variance depends upon the facility’s logistical capacity and stock. A commonly noted barrier is the inability to get necessary materials and stocks from the DDS to the facility.

According, a critical function the SSQH-CS team served in Y1 was to act as a bridge between the DDS and facilities to coordinate, troubleshoot, and follow-up on nutrition and CH issues. TA for facility personnel addressed problem or gap identification, target setting for facilities, action planning for sites and rally posts, and supervision of activity implementation. Team members worked with facility personnel to ensure vaccines and supplies were available ahead of planned rally posts, and coordinated with the DDS to see why sites may not have sufficient commodities. Feedback from this helps to inform the project’s logistics and commodity management support and coordination with partners such as LMS and SCMS.

Trainings and follow-up supervision with DDS accompaniment to ensure guidance is being followed aided facilities in providing vaccinations to children under one and screening for malnutrition and deworming. Through this process, the project observed increased engagement by key DDS personnel, such as with the CH director in Nippes, who became much more involved in monitoring services and supplies at sites. Thirty (30) nurses from 27 different institutions received a three-day joint training with DDS on acute malnutrition management. With ASCPs, trainings include components of nutrition and CH, including IMCI.

Project teams reviewed several facilities’ cold chain (CC) capacity (material and human resources) and found that while all targeted sites had CC, some faced problems of inadequate supervision or adherence to standards. The team made recommendations for follow-up, and the project coordinated with the DDS for the provision of propane and the delivery of vaccines. For approximately four months, Haiti experienced mass stock outs in BCG, pentavalent, and gas. The project responded by providing propane to four DDS, supported transportation of vaccines from PAP to DDS, and on to sites. Finally, the project

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<sup>6</sup> CH services include iron and folic acid supplementation, infant and young child feeding, growth monitoring and promotion, use of oral rehydration therapy, provision of vitamin A supplementation, and deworming.

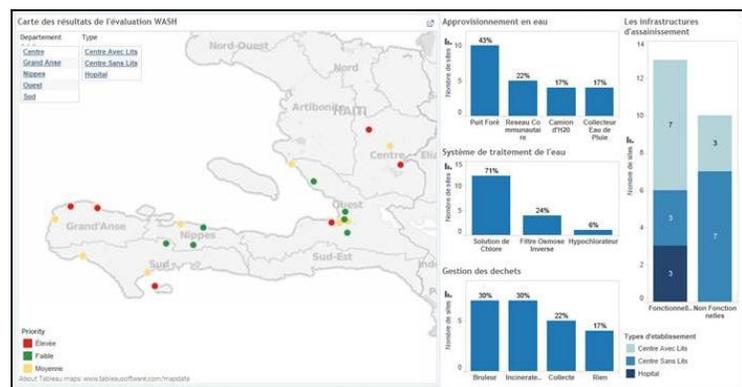
supported outreach activities for providing children with vaccinations by providing logistical support and service delivery at rally posts and home visits.

At the national level, the CH team coordinated with the Direction du Programme Elargi de Vaccination (DPEV) to identify strategies to help the sites achieve their annual goals. Priorities for Y2 will be to expand TA to more sites and to cement relationships and communication with national nutrition programs and to participate in relevant technical cluster groups. The project will also review immunization registers to ensure newly-approved vaccines are included.

### *Water, Sanitation, and Hygiene*

Given the specificity of content to be assessed at project-supported sites, the project team drew from the general facility assessment and SPA data and conducted a WASH-focused assessment of the 23 priority sites. This assessment used questionnaires and key informant interviews to determine infrastructure conditions and personnel capacities to preventing and managing WASH risks. Findings present a challenging situation: 30% (7 facilities) do not have structures deemed adequate to address WASH needs; and while 70% (16 facilities) have adequate infrastructure, they are not currently meeting the national and Sphere Project<sup>7</sup> minimum standards in WASH promotion. Toilets are rarely constructed to be fully accessible to the elderly, disabled, or pregnant women, and often the number of daily users per toilet exceeds acceptable amounts. Finally, water waste disposal requires reinforcement and support. WASH-related infrastructure improvements and rehabilitation will begin in Y2 in coordination with MSPP and USAID.

Challenges at sites are categorized into three main themes: use, water storage, and sanitation facilities. Capacity issues at the facility level can be addressed through training and supportive supervision of staff using the national and Sphere hygiene standards.



**Figure 3: Visual mapping and presentation of WASH results per site, by category (Data source: SSQH-CS WASH Assessment)**

To respond to some of the identified challenges, SSQH-CS incorporated WASH content into the ASCP trainings, including access to potable water, proper use of latrines, household water treatment methods, hand-washing with soap, and instruction on how to recognize, treat, and prevent diarrheal diseases such as cholera (see Objective 2). During the first year, 283 CHWs received training<sup>8</sup> in WASH promotion and prevention information. A detailed WASH training curriculum for ASCPs and HF staff will be developed in early Y2 in coordination with MSPP. SSQH-CS coordinated with the National Sanitation Cluster and contributed to discussions with USAID on site infrastructure needs and improvements. The team prepared a list of site renovations and infrastructure improvements for USAID’s consideration. Finally, to help MSPP raise awareness regarding the prevention of Chikungunya, the project produced and distributed 1800 posters.

<sup>7</sup> <http://www.sphereproject.org/>

<sup>8</sup> This content has not yet been formally approved by MSPP.

## FAMILY PLANNING AND REPRODUCTIVE HEALTH

Indicators	Annual Target	Total Achieved to Date	Total of Target Achieved to-Date
Modern method contraceptive prevalence rate (MCPR)	36.7%	21.2% (<25); 35.5% (>25); 29.2% (total)	80%
	Comments: 2,581,870 FP populations (all but 3 religious sites) x .244. Sites trained in inventory, which tended to confuse providers on reporting, especially for long acting method reporting; thus this may be an undercount. Challenges with availability of selected method stock (i.e. IUDs) have been problematic.		
Number of youth (aged 15-25) accessing reproductive health services	74,166	67,408	91%
	Comments: Target close to being achieved for Y1		

**Table 6: Mandated FP/RH Indicators**

Strengthening the quality and expanding use of FP services, in accordance with the objectives outlined in the MSPP national health policy, is a high priority for SSQH-CS. The project supports the provision of FP services and commodities at sites and their surrounding communities through personnel support, trainings, supervision, and TA for providers; and coordination with sites, NGOs, DDS, MSPP, and partners such as LMS on commodity management. During Y1, 74 of the 80 project-supported sites provided FP services (with at least 3 contraception methods offered). Those institutions not offering FP services did so due to their religious mandate. The project met its Y1 target by 100% for the percent of USG-assisted service delivery sites providing FP counseling and/or services (96.3% sites).

The project team worked with priority sites to increase the method mix available, particularly long-acting and reversible contraception (LARC), and by the end of Y1, added 18 new sites to offer implants (Jadelle). Efforts were made to add 5 more sites offering IUDs (in Grand Anse and Nippes), with providers trained in this method, but problems at these sites with commodity availability continue. One explanation for this is that LMS does not distribute IUDs at sites for reasons that providers have not, until now, been trained in offering the method per MSPP standards (doctor or mid-wife). Follow-up with sites benefitting from project-supported training is on-going to provide them with the necessary stock. The FP/RH team evaluated 10 of the priority sites to assess their capacity to offer permanent method availability, and found only four (4) sites with the personnel and operating rooms to do so. However three of these four sites require additional infrastructure improvements to ensure quality of service, and the team is currently working with the sites to complete the improvements. Efforts to scale up these services will be made in consultation with USAID and MSPP in Y2.

Project TA for providers at site and community levels includes a mix of supportive interventions. Trainings, supervision, and mentorship worked in concert to reinforce the provision of integrated FP services that adhere to MSPP standards and guidelines, while being in compliance with USG regulations. During Y1, SSQH-CS personnel trained 58 providers on the insertion and removal of implants and 16 on the provision of IUDs. During practice sessions, 277 FP clients received services (212 implant insertions, 10 implant removals, and 35 IUD insertions). SSQH-CS partners coordinated TA to support service integration, with the HIV and maternal health teams including FP counseling and services provision in their activities.

The project also trained 30 technical representatives from all 19 NGOs on integrated FP with existing HIV services. Youth-friendly SRH services, including health education, FP, STI, voluntary counseling and testing for HIV/AIDS and PMTCT, are provided in coordination with FOSREF's youth centers and clinic (*see Youth and Key Affected Populations section*).

At the community level, the project works to expand access to quality contraceptive information and services and strengthens referrals to neighboring clinics. Module III of the ASCP curriculum training, which covers RH, reinforces FP services and includes birth spacing, FP counseling, referrals for post-partum clients, LARCs, and the diagnosis, treatment, and referral of STI cases. As part of the National FP Campaign, the project mobilized CHWs, developed action plans using outreach strategies including rally posts and home visits, and reinforced their mandate in the provision of FP methods such as condoms, pills, and injectable contraception. As part of the ASCP trainings in CommCare, the FP application helps providers to counsel on mixed methods, covering the pros and cons (including side effects) of each using audio recordings and pictures. During Y1, 309 ASCPs received training on the CommCare FP application, and Creole-adapted tools for monitoring community outreach activities.

The National FP Campaign began in January and SSQH-CS, in collaboration with DDS and UNFPA, supported its efforts by increasing FP commodity and service (particularly LARC) availability and demand at sites and communities. Support included provider trainings and practice sessions, and through FP information, education, and communication (IEC) messaging. A FP caravan supported by the project traveled throughout the South East department, promoting FP services and education. In coordination with the FOSREF youth theater group, SSQH-CS produced a video sketch promoting FP consultations, which was selected by the Office of the First Lady to be the National Campaign's official media piece. Radio spots promoted FP Campaign activities and messages, and the project distributed 1720 t-shirts and 400 leaflets with FP slogans.

With regards to commodity supply management, SSQH-CS conducted two capacity building workshops in coordination with LMS for DDS RH managers and inventory management officials on the essentials of FP management, and commodity monitoring and quantification. At the site level, the project team worked with commodity and data management personnel to effectively track and report supply use and requisition (*see Obj. 3 for more detail*).

In March, the project submitted to USAID and received approval of its USG FP Compliance Plan. It embraces Pathfinder's rights-based approach to offering FP services and commodities, while complying fully with all USG requirements, including Tiahrt, Kemp-Kasten, DeConcini, Helms, Leahy, Biden, and Siljander Amendments and Policy Determination 3. The plan outlines the project's preventive actions to ensure compliance at all levels, review of all information, education, and communication (IEC) materials, and client surveying. It also identifies how the project will coordinate with other partners, including USG partners, NGOs, and MSPP affiliates, establishes processes for compliance files, and outlines how the project will respond to any suspected or known violations. The FP Compliance Plan narrative is supplemented by Y1 Compliance Activity Matrix, which itemizes compliance activities at project office, implementing partner, and USG partner coordination levels. During Y1, technical representatives from all 19 NGOs and 252 ASCPs received training on USG compliance trainings.

## GENDER-BASED VIOLENCE AND CHILD PROTECTION

Indicators	Annual Target	Total Achieved to Date	% Target Achieved to Date
Number of people reached by a USG-funded intervention providing GBV services	201	138	68.6%
	Comments: Figure represents 26 selected sites for Y1 (23 priority plus 3 extra) and not full 80 sites; data not captured in any site registry.		
Number of health institutions providing clinical assistance and referrals of child protection cases to legal and social services	31	26	84%
	Comments: Focus on 23 priority sites for Y1		
Number of children reached by child protection services	30	4,244	--
	Comments: Definition changed from children referred for child services (Institut de Bien-être Social et de Recherches) to OVCs. Y2 target will be revised.		
Number of community and clinical health staff and community-based actors trained to recognize and refer GBV and child protection cases to appropriate legal and social services	300	282	94%
	Comments: Figure represents CHWs trained within project network. Additionally, FOSREF works with youth (n=1,164) and CSW peer educators (n=435) in project network catchment area, who have all received training in GBV. This data is currently being validated. Once it is, this target will be largely overpassed.		

**Table 7: Mandated GBV and CP Indicators**

Efforts by the SSQH-CS team in the area of GBV included a technical evaluation of GBV services and capacities at the 26 priority sites, which: verified the availability of services, personnel (including social workers and psychologists), and provided feedback for improving these services. In general, sites provide comprehensive health care for survivors of GBV (HIV management, STI, and PEP/EC), and for those sites which lack resources (two sites), have partners with whom they refer cases (referral hospitals). However, the availability of personnel, particularly psycho-social support workers, was found to be widely problematic. Only 23 social workers and nine (9) psychologists were found at all 26 sites. At certain sites (such as Marmont, Lahoye, and St. Paul de Montrouis), no social workers or psychologists were found, and nurses tend to provide support (despite not always having appropriate training to do so). The team worked with social workers and psychologists from these sites in capacity reinforcement of recognizing and referring and/or treating GBV cases.

ASCPs serve as great opportunities for increasing services and referrals at the community level, but the challenge of GBV not being included in the national curriculum is problematic. The project team therefore supplemented the ASCP training materials with appropriate GBV content, and trained 282 ASCPs during Y1. Year Two will prioritize development of a GBV curriculum in coordination with MSPP.

The project also coordinated with the Ministry of Social Affairs (MAST) via Institut du Bien-Etre Social (IBESR) and UNICEF regarding the creation of standard national reporting forms.

Finally, SSQH-CS worked with youth and commercial sex worker (CSW) peer educators in communities to promote knowledge and use of GBV services in coordination with CHWs active in the area (*see Youth and KAP below*).

In support of the CP work, SSQH-CS developed a concept note for OVC Accompaniment, outlining how the project aims to increase OVC access to basic health and psychosocial services; orient, train, and monitor facility staff's knowledge and skills in OVC service provision; engage and support community support groups and strengthen links to facilities; support OVC school attendance via scholarships and supply kits; and set up referral networks for violence and sexual assaults. In response to a noted lack of knowledge by service providers on new guidelines for OVC strategies at sites, the project held a workshop for 35 social workers, psychologists, medical directors, and data officers from 18 facilities. Covered material included a conceptual framework for OVCs (including actions required at various levels), OVC and child protection (including risks and rights of children), and guidelines for service and case management (including education, housing, psycho-social support, health, nutrition, and others). The workshop provided training on home visits, training for CHWs, medical follow-up for OVC and psycho-social activities, and school support. At community levels, CHW home visits serve as an ideal entry point for reaching children, while recreational and support groups help maintain their mental and physical wellbeing.

An MOU between SSQH-CS and The Caris Foundation, implementer of the BEST (Bienet ak Santé Timoun) project, broadens OVC service coverage at SSQH-CS sites. This agreement will ensure implementation of the Haiti National Early Diagnosis (EID) service at all SSQH-CS sites where Caris is present (including training of service providers on EID, PMTCT, pediatric HIV, data collection requirements, lab support, and pediatric treatment protocols); support the tracking of specific patients (enrolled PMTCT mothers and HIV+ children); provide schooling of every HIV-infected patient and their siblings (aged 6-18); offer vocation training for older children and those transitioning to adulthood; support Kids and Mothers clubs; train sites on the new pediatric norms for management of Pediatric HIV; provide medical and non-medical supplies (such as deworming, Paracetamol, and mosquito nets); and support household economic strengthening (including microcredit and savings groups).

## YOUTH AND KEY AFFECTED POPULATIONS

SSQH-CS provides integrated YFS to selected sites in the project network, which includes SRH, FP, GBV, diagnosis and treatment of STI, prenatal care, and HIV services. For some sites that do not have experience working with youth groups or providing integrated services in a youth-friendly way, the project provided TA to help sites make them so. This included providing specialized support and training for young peer educators, training providers and mentoring them in youth-sensitive delivery of services, assisting providers and community groups in developing SRH/FP/HIV messaging tailored to young people, and helping communities build involvement of schools, parents, coaches, and other young people in programming related to SRH/FP/HIV. During Y1, SSQH-CS provided TA in YFS to 14 priority sites. The project technical team also worked with clinics and youth centers in the network to further integrate FP, GBV, and STI services into existing HIV services at these locations. Close involvement and participation of the DDS in the project's YFS technical assistance started early, with a workshop with departmental coordinators and trainers in Q2 to discuss project implementation. Subsequent departmental action plans for YFS technical assistance and community outreach activities resulted from this collaboration.

At community levels, volunteer peer educators (age 15-24) work in their own neighborhoods and schools with youth associations, community leaders, and conduct home visits to raise awareness about

YFS services, distribute condoms, conduct information sessions, and refer youth to clinics and youth centers. Peer educators receive training in SRH, FP, HIV, GBV, sexual negotiation, gender equity, and mass communication among other domains. During Y1, SSQH-CS helped leverage other USG funded initiatives to work with existing peer educators in the FOSREF network and provided refresher courses and recruited and trained new ones. Youth peer educators work closely with CHWs in the community and participate in the promotion of site services and referrals.

To reach key affected populations (KAP), particularly CSWs, a similar peer network of CSW leaders receives specialized training to conduct outreach and sensitize others in HIV prevention, distribute condoms, refer CSWs and their clients to FOSREF centers specializing in KAP services, and provide face-to-face information sessions. Peer educators and FOSREF centers also work closely with men who have sex with men (MSM) groups, sensitize them in STI and HIV prevention, provide condoms and lubrications, and make referrals to FOSREF's MARPs centers for specialized services.

### CRITICAL CARE SERVICES

Indicators	Annual Target	Total Achieved to Date	% Achieved to Date
Percent of project-supported sites certified to serve as critical care stabilization centers	24%	23%	96%
	Comments: Result is mid-year figure. Y1 focus was to support CAN activities during Carnival. Y2 will focus on improving number and quality of sites certified.		
Percent of sites demonstrating improvement in critical care practices	50%	0	0%
	Comments: Sites to be selected and strengthened in Y2.		

**Table 8: Mandated Critical Care Indicators**

In February, the SSQH-CS project met a request from MSPP and the Centre Ambulancier National (CAN) to develop a mobile solution for responding to communication and referral challenges for health emergencies during the 2014 Carnival celebrations in Jacmel and Gonaives. The project piloted the activity using 50 dual-SIM Haitian-made tablets (Surtab), which provides access for both Natcom and Digicel networks to ensure proper coverage during the celebrations. The project initially trained 53 CAN ambulance staff, of which 10 were assigned for the Jacmel celebrations and 22 for the Gonaives. Project staff provided a refresher training directly prior to both Carnival celebrations, and developed a dashboard reporting system to monitor and analyze data in real time during the events. Staff would download data every two hours, analyze, and share it with key stakeholders.

Prior the Jacmel celebration, SSQH-CS collaborated with MSPP, CAN, the South-East DDS, the Civil Protection Society, the police, and the Boy Scouts, to pilot test the emergency response application. The project provided a tablet and the application to five CAN ambulances, one Civil Protection First Aid Station, one CAN First Aid Station, and Hôpital St. Michel. The pilot provided a first experience for usage and generated feedback necessary to refine the application and its use ahead of the national celebration in Gonaives (March 2-4, 2014). During the Jacmel celebrations, staff from the ambulances and first aid posts received a number of patients and entered their information into the system using the mobile application, referring them to the hospital as needed. Ambulances received and provided care for 28 persons, out of which eight were brought to hospital.



**Figure 4: CAN ambulance staff using the emergency response application**

In Gonaives, SSQH-CS collaborated with MSPP, CAN, OFATMA, and the Clinique de la Première Dame to pilot the application. Information entered for each patient treated at the point of entry synched with the CommCare server at the completion of each record. Data recorded included the patient's name, address, age, sex, the type of incident and medical problem, clinical impressions, treatment provided, and whether or not the client was referred for more advanced care. The ambulance application also included the GPS coordinates of the location where the patient received care and where they were transferred (first aid station or hospital) as appropriate. Project staff monitored real-time data during a 12-hour window and prepared combined reports to the First Lady, the Minister and Director General of MSPP, and the heads of the two partner agencies (CAN and OFATMA) every two hours. Individual partner reports were also generated and emailed every two hours for monitoring purposes.<sup>9</sup>

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<sup>9</sup> Data collected did not represent all persons treated during Carnival, as not all providers were equipped with a tablet and application.

## COMMUNITY-BASED ACTIVITIES

Indicators	Annual Target	Total Achieved to Date	% Achieved to Date
Number of clients accessing services provided by project-supported facilities or CHWs	1,500,000	1,734,446	115.6%
	Comments: Target achieved for Y1		
Number of sites providing care and support for vulnerable groups	27	18	66.7%
	Comments: OVC sites as a subset of the 23 priority sites for Y1.		
Number of community emergency care committees	8	0	0%
	Comments: Original sites no longer active in FY14; they will be reactivated and increased in FY15.		
Number and percentage of health referral networks with UAS Coordinator supervisory visit documenting quality improvement in last 6 months	0	1	--
	Comments: 1 showing progress: Les Anglais; Y2 targets will be revised accordingly		

**Table 9: Mandated CBA Indicators**

### *Use of Community Resources*

SSQH-CS continued use of those CHWs and TBAs supported under SDSH II for service provision at the community level. Those CHWs targeted for Y1 training had already received training in MSPP's curriculum for module I, IV, and V. SSQH-CS completed the ASCP training for 481 CHWs in module II and III. (*See Objective 2*). In Y1, the project used TBA (*see Objective 1 [MCH]*), peer educators, and club de mères as entry points to spread community interventions.

### *Community Involvement*

The project's BC strategy includes engaging community actors to become active leaders and promoters of healthy behavior and service access. Each Department's communication and community mobilization heads provided key entry points for engaging community actors and the project collaborated with them to develop community mobilization plans and activities. Through this process, the project supported 11 sites in the West and three in the Center departments through action planning, technical assistance support, and resource development. Technical content in FP/RH, MCH (particularly exclusive breastfeeding and immunizations), HIV/AIDS, and GBV has been the focus of support for community meetings at over 114 rally posts and 150 members of mothers' clubs (*club des meres*), whose awareness efforts in the Center department alone have targeted over 9000 people in nearly 1500 households. The project conducted trainings of trainers in the use of the P2C using a French version of the game; a Creole version is currently in development. These trainings targeted community health managers and heads, who have mobilized 138 games in the communities of the 23 priority sites.

### *Monitoring at the Community Level*

A significant way that SSQH-CS has helped to strengthen linkages between community and facility activities is via the deployment of CommCare. With many remote communities in the project's network, providing community-level support for data validation would be exceptionally cumbersome for the project. CommCare enables ASCPs to enter data directly while minimizing room for errors. Through prompts and preset controls (i.e. such as a DOB cannot be entered as a future date), CommCare guides

the user through the data entry process and reduces opportunities for data to be incorrectly entered. This data is automatically sent to the facility. (*See Objective 2*). At the facility level, the project personnel work with facility staff to help validate data coming from ASCPs. SSQH-CS staff review facility registers to see how well they are completed and compare the tallies with the monthly reports submitted to MSPP. If something abnormal arises, the team member refers to the client file for clarification. (*See Objective 3*).

#### *Service Provision at the Community Level*

Much of the service provision outlined under this Objective involved delivery by CHWs and recently-trained ASCPs. In coordination with and supervision from facilities, these community health agents plan and conduct home visits and rally posts, and support facility-led mobile clinics where applicable. Each of these methods strives to bring quality services to the lowest level possible in an effort to surmount obstacles such as far distance from facilities and mistrust of institutions. As part of the project's *mSanté* program (*see Objective 2*), ASCPs equipped with mHealth technologies further ensure EPS delivery at the community level. A subset of community activities reported (May – July) by NGO service delivery partners included over 1,896 rally posts held, 225 mobile clinic visits, 196 clubs des mères, 2060 youth clubs, 2,105 community meetings, and 127,809 people reached with health-focused sensitizations.

## OBJECTIVE 2

### IMPROVE THE FUNCTIONALITY OF THE USG-SUPPORTED HEALTH REFERRAL NETWORKS

Indicators	Annual Target	Total Achieved to Date	% Achieved to Date
Number of CHWs per catchment population of USG-supported health referral networks	1,200	997	83%
	Comments: #CHWs per 1000 people (n = 0.37). The project did not recruit any new CHWs in Y1, but worked with the existing network. There was some loss of CHWs during the year. Note: This figure is for all six departments.		
Number of facilities receiving visits from mobile mentorship teams	9	6	66.6%
	Comments: MMT became active only in Q4, with four sites in Ouest and two in the Grand Sud visited and 53 persons trained.		

**Table 10: Mandated Objective 2 Indicators**

#### SUPPORT FOR CHWs

As part of the project’s efforts to increase the quality and demand for primary health services at the community level as well as to strengthen the referral and counter-referral networks linking communities with facilities, a major strategy is the comprehensive training of CHWs to bring them to a standard level of polyvalent agents, or ASCP. To become a polyvalent agent, CHWs must complete the MSPP five-module curriculum. Building off of SDSH II, which trained CHWs in three of the five modules (I, IV, and V) of the MSPP curriculum, SSQH-CS continued the training in the two remaining modules (II and III)<sup>10</sup>. Project staff bolstered some of the curriculum trainings by adding components on WASH promotion, data reporting, and specific CommCare applications. The project also strengthened some of the curriculum language on MCH, particularly on improved efficiencies of providing community-level health services for pregnant women and their newborns. These additions have been woven into the training and shared with MSPP for consideration and inclusion in future editions of the curriculum.



**Figure 5: ASCP training at Petite Place Cazeau**

<sup>10</sup> ASCP training module II covers health teams, communication, ethical behavior, health education, community diagnostics, family health and home visits, and the organization of community services. Module III covers health at the different stages of life, child health, and youth/adolescent health.

Attention rested on the CHWs connected with facilities within the 23 Y1 priority sites<sup>11</sup> in the West, South, and Grand Anse departments, where 1032 CHWs operate. Introduction to the trainings and discussions with the MSPP and DDS helped to gain their support and involvement in the remobilization of trainers previously used under SDSH II. Each facility site benefiting from the trainings received schedules to plan accordingly and update their work plans. Exceeding the Y1 target of training 400 CHWs, the project successfully trained 481 health workers as ASCP in Modules II and III of the MSPP curriculum. Specific content covered includes exclusive breastfeeding, iron and folic acid supplementation, FP counseling and birth spacing, and STI referrals. ASCP certification will take place in coordination with MSPP in Y2.

Of the 481 trained ASCPs, 283 received further training in community youth centers, peer education, and positive male involvement, and referring cases for GBV and child protection. A subset of the total ASCPs trained in Y1 (283) received trainings in WASH promotion and health behaviors.<sup>12</sup> All ASCPs trained and supported by SSQH-CS received necessary materials and commodities to perform their work, including flyers, contraceptives (pills and condoms), and other health promotion materials. DDS staff collaborated closely during the ASCP trainings, facilitating and supervising the trainings.

#### *mSanté Program*

Under its *mSanté* program, SSQH-CS employs CommCare, which uses a General Packet Radio Service (GPRS) network and runs on Android or Java-enabled phones to provide client data management, electronic decision support, enhanced client counseling through multimedia, and real-time data reporting. The project will provide a mobile device for up to 2,500 ASCP and one for each SSQH-supported health facility over the life of the project through individualized contracts with the recipients to promote safe care and prevent damage. SSQH-CS will develop CommCare applications to cover all major health areas included in the MSPP training curriculum for ASCPs: MCH, RH/FP, HIV/AIDS, TB, cholera, child protection, and GBV. Applications are already developed to:

- Register and tracks clients at the household levels and include GPS tagging to monitor community level service delivery;
- Guide ASCPs with electronic checklists, protocols, and algorithms to improve the quality of services delivered and counseling through audio and video prompting;
- Facilitate supervisors to monitor ASCP performance and provide technical support;
- Generate SMS reminders for ASCPs and supervisors to maintain household visit schedules and reinforce household service provision;
- Generate SMS reminders and educational messages for clients about appointments and care and drug adherence;
- Strengthen referrals and counter-referrals with dispensaries and facilities via client tracking and records sharing; and
- Report real-time service data from community-based providers to supervisors and program managers.

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<sup>11</sup> CHWs from the following health facilities received training in Y1: Hôpital de Fermathe, OBDC, FOSREF, Saint-Martin, Aurore du Bel-Air, /PPC/CDS, FONDEFH, OBCG, Clinique Saint Paul, SADA/Matheux, Cornillon, Tayfer, HHH, FINCA et Bonne Fin.

<sup>12</sup> This content has not been formally approved by MSPP.

This program includes job aids for mobile workforces, tools for supervision and evidence-based change, and a method to capture data in an electric repository that feeds into national health databases such as DHIS2.

A mHealth kick-off workshop with MSPP introduced CommCare early and developed an initial roll-out schedule. Under the ASCP trainings, the project developed FP and MCH applications during the first year, with plans to develop HIV and other applications in Y2. With each application and the corresponding training materials developed, the project piloted them with 50 CHWs at Fermathe clinic to evaluate content flow and application usability. Feedback was used to iterate refined applications, and 309 CHWs received the full CommCare trainings.<sup>13</sup> Applications include audio counseling messages, tracking of immunizations and clinic visits, and the flagging of danger signs for referral. SSQH-CS staff also provided troubleshooting, supervision, and performance monitoring to the pilot and subsequent trainings. Project staff developed a CHW supervisor application in consultation with the staff at Fermathe clinic. By the end of Y1, CommCare helped register and track over 2000 FP clients, 650 pregnancies, and 2400 children (predominantly at Fermathe site).

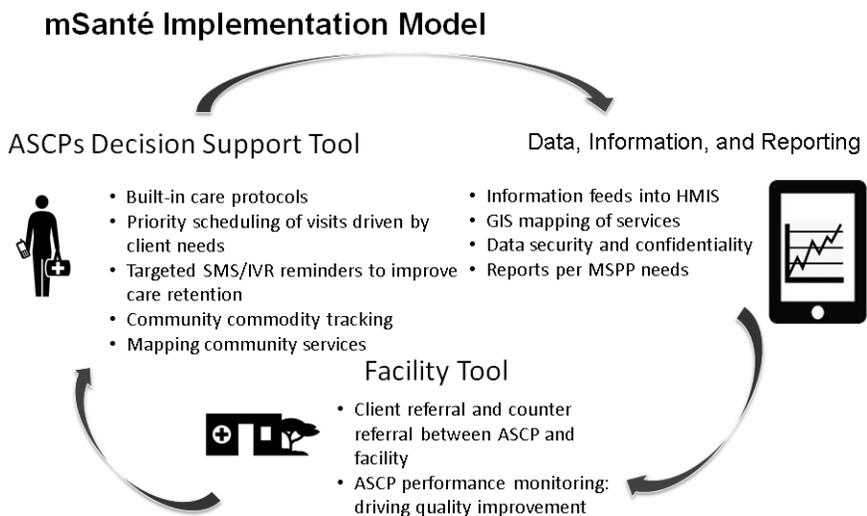
CommCare further works to strengthen the referral and counter-referral network. CommCare prompts ASCPs with patient symptoms, who are encouraged to refer clients to facilities if appropriate. They are able to track the status of these referrals, allowing them to view what occurred at the referral facility, or to encourage clients to complete the referral. At the clinics, applications are used to monitor incoming referrals (encouraging clients to attend) and enter referral information for ASCPs to view. The applications both encourage the usage of the health system and provide transparency to ASCPs and clinics on the status of referrals. At the Fermathe clinic, over 100 referrals have been created through use of the application.

CommCare content development during Y1 came from the SSQH-CS technical team and direct feedback from CHWs and clinic staff. Ideally, this content would be developed by MSPP and feed directly into the system, including audio counseling messaging. A focus for Y2 will be to capacitate MSPP to develop its own applications for the project's use.

## MOBILE MONEY

USAID's priorities for investing in mobile technologies for development include the use of mobile money for financial transparency and inclusion. SSQH-CS, in partnership with the HIFIVE project which acts as a broker between consumers, regulators, and service providers to promote the use of mobile money, use

<sup>13</sup> CHWs from the following sites received training in CommCare during Y1: Bel-Air, CDS, CMSPPC, Clinique St. Paul, Fondafh, Fosref, Fermathe, ICC Grace, Lafanmi, MEBSH, OBCG and PSCF.



**Figure 6: Illustration of how mSanté works to improve service delivery, data management, and the referral/counter-referral network.**

mobile technologies to make health-related financial transactions, including payments to ASCPs at the ZC. Mobile money has the potential to impact transparency and efficiency of financial transactions and to enable financial inclusion for the poor. In Q4, SSQH-CS began making mobile payments to ASCPs through Digicel's Tcho Tcho mobile service, with 184 paid in August, and 365 in September 2014. Year Two will see the full enrollment of all 644 ZC health staff paid via mobile money.

### POINT-OF-CARE DIAGNOSTICS FOR HIV/TB

During Y1, SSQH-CS examined lab capacities for HIV/TB services and evaluated sites that could potentially serve as facility hubs for mobile point of care CD4 and GeneXpert diagnostics. Selected sites would receive mobile devices for diagnostics and allow for batching for facilities nearby, as appropriate. The project looked at existing resources, patient volume, and location as part of the evaluation. Sites considered for point-of-care diagnostics include Lahoye, Petit Trou de Nippes, and Association d'Entre Aides des Dame Mariens, while departmental hospitals and private partner centers near project-supported facilities (such as Gheskio for OBCG and Martissant, and PIH for Maissade and Marmont) could also reinforce diagnostic capacities. These potential hubs will be developed in coordination with USAID and MSPP in Y2.

### MOBILE MENTORSHIP TEAMS

A key approach designed to routinize UAS/DDS oversight of facilities in the defined referral network and improve service delivery quality is the deployment of mobile mentorship teams (MMT). The project established one MMT to support referral networks quality improvement and to support facility teams on both clinical and managerial issues. Established in Q4, the MMT operates in four facilities in the West department, including within the Bel Air referral network, and two in the Grand South. The team is comprised of a doctor, a nurse, and a lab technician.

After the MMT completes an initial evaluation of the site (drawing from the project assessment data and touring the facility), the team conducts a week-long on-site training/mentoring with facility staff, including doctors, nurses, data clerks, social workers, and psychologists (if available).

Working side-by-side with facility personnel, the MMT reviews their use of registers, assesses how well they follow established protocols (such as infection control), and trains staff on new HIV services recently added to the site. The MMT also reviews the facility's stock procurement/storage system to assess the availability of commodities, MSPP registers, and forms and provides logistics management trainings as needed. Data validation checks include a review of patient charts, register logs, and statistical reports sent to the DDS to ensure data is correctly recorded along the way. Review of healthcare waste plans, procedures, and the availability of equipment such as segregated bins for the appropriate waste management and disposal. At the conclusion of the visit, the MMT documents its findings and compiles a report with recommendations and an action plan with defined point persons and timeline. SSQH-CS uses these reports to improve coordination with DDS and other partners such as SCMS or UNFPA to address gaps in areas such as commodity and equipment supply. The MMT returns to the facility a month later to assess progress against the action plan and provides follow-up mentorship.

Support from the MMT extends beyond the site to reinforce the referral system. In one case, the team found some patients were going to the hospital for their CD4 testing as referred, but continued to seek treatment there rather than returning to the referring clinic, thereby disrupting patient flow and service efficiency at each facility. Through the team's coordination and follow-up, these patients have been identified and encouraged to return to the lower-tier center for continued care.

One facility staff member also travels to the Gheskio center for an intensive, three-week training of trainers in the integrated package of essential services. This staff member then returns to her facility to train the rest of the staff.

General findings by the MMT show that while noted technical problems can often be addressed directly during the visits, administrative and operational issues often are more challenging to resolve. Common obstacles identified are insufficient or inappropriate staffing, no electricity and/or internet connectivity, and deficient lab facilities or equipment. When possible, the team offers support such as providing facility staff USB dongles for data upload to internet-based databases such as MESI. The MMT relays these issues to SSQH-CS for planning and follow-up, as appropriate.

Year Two will see increased engagement with DDS during site mentorship visits and follow-up. These joint visits will mentor DDS personnel to more effectively provide oversight to the referral network. Steps to strengthen the referral/counter-referral system will target loss to follow-up (LTFU) plan development and monitoring, review of referral/counter-referral logs and tools, and focused mentorship support to facility staff on identifying and addressing problems within the referral system. Finally, the MMT will also coordinate further with SSQH-CS to receive refresher trainings and technical input.

### OBJECTIVE 3

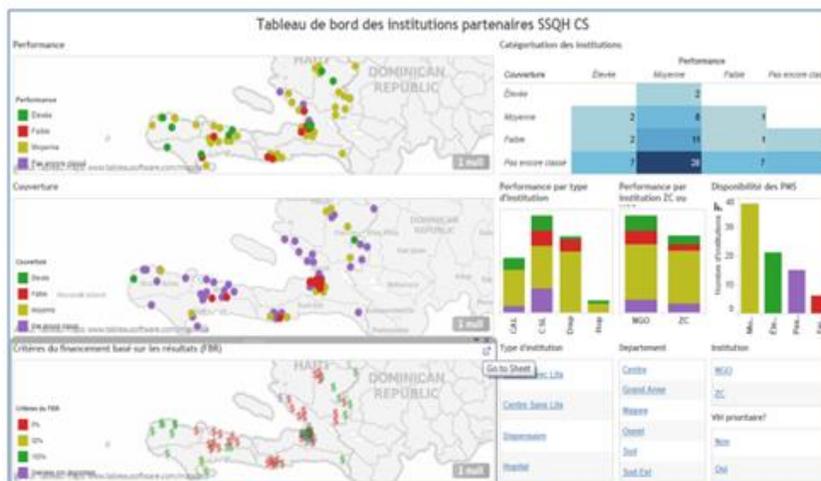
#### FACILITATE THE SUSTAINABLE DELIVERY OF QUALITY HEALTH SERVICES THROUGH THE INSTITUTIONALIZATION OF KEY MANAGEMENT PRACTICES AT FACILITY AND COMMUNITY LEVELS

##### FACILITY SITE ASSESSMENT

Indicators	Annual Target	Total to-date	% Achieved to date
Percent of project-supported sites maintaining auditable monthly financial reports	100%	79%*	79%
	Comments: *Calculated using a quarterly basis for Q3 and Q4. Of the NGO-managed facilities, 89% (40 of 45) meet this indicator. Overall, 62 of 78 sites are maintaining auditable financial reports.		
Percent of project-supported sites implementing a CQI plan.	100%	67.5%	67.5%
	Comments: Based on SSQH-CS site assessment, 52% (37/71) of sites for which data is available responded that the site had a CQI process. Of those 37 sites, 34 responded that they were implementing that plan. Separately, the assessment revealed that 52% (37/71) sites also have a process for following up on issues identified by the DDS. The project is now increasing the number of sites and harmonizing the approach.		
Percent of project-supported sites experiencing stock outs of vital products	10%	Cotrimoxazole: 8% Paracetamol: 16% Iron and Folic Acid: 16%	Cotrimoxazole: 125% Paracetamol: 62.5% Iron and Folic Acid: 62.5%
	Comments: Baseline and Final results use same 3 selected lifesaving drugs. Baseline figure is a snapshot of one month while end line represents full year.		
Percent of clients reporting satisfaction with services	65%	99%	152%
	Comments: 67 sites had exit interviews with 99% reported client satisfaction. Used baseline value performed mid-year.		
Percent of site-level quality improvement teams that are staffed and meet regularly as per established guidelines	50%	46%	92%
	Comments: Based on SSQH-CS site assessment, 46% (33/71) of sites for which data is available responded that they had a site management committee. The project is currently in the process of updating data for this indicator that covers the period of May through September 2014.		

Table 11: Mandated Objective 3 indicators

The SSQH-CS team completed site assessments for 80 of project-supported health facilities in all six departments in March-April 2014. Pre-assessment review of available data from the SDMA survey conducted by SDSH II and the SPA conducted by the “Institut Haïtien de l’Enfance pour le Compte du Ministère de la Santé Publique et de la Population” provided a foundation for the project. In order to support analysis of assessment data following collection, the project developed an interactive dashboard that aggregates the assessment analysis, a post-assessment site profile tool, and a site database to house all assessment data as well as relevant SPA data, HIV rapid assessment data, and other basic site information. Results from the assessments are used to classify sites’ performance and coverage<sup>14</sup>. Analysis to date reveals that: 11 partner sites are ranked as high performing (fulfilling 75% or more of performance criteria); 49 sites are ranked as medium performing (fulfilling between 50% and 75% of performance criteria); and 9 sites are ranked as low performing (fulfilling less than 50% of performance criteria). Performance is not yet classified for 11 sites due to gaps in data. Analysis also reveals that 16 sites are ranked as low coverage (less than 20% of catchment population served), 11 sites are ranked as medium coverage (between 20 and 75% of catchment population served), and 2 sites are ranked as high coverage (75% or more of catchment population served). Coverage for the remaining 51 partner sites is being calculated as additional MSPP monthly report data is entered into DHIS2.



In Q2, USAID’s HIV technical team requested that SSQH-CS prioritize 23 sites for HIV service upgrades and activation. In an effort to streamline resources and maximize investment, the project decided to form its site prioritization for Y1 technical assistance around these priority sites, aiming to improve both their performance and coverage.

The project is in the process of disseminating assessment data and findings to the SSQH-CS team of technical advisors, SSQH-CS partners, and government counterparts and stakeholders (DDS, UAS, and MSPP). As part of the information-sharing process, the project conducted a half-day session on actionable information use (AIU) with 25 SSQH-CS staff members; the session familiarized team members with assessment data in an analysis-ready pivot table format. The SSQH-CS assessment and analysis provides a useful baseline of site performance and coverage; its data informs project interventions and capacity building activities. Data also informs site CQI planning, report on the project PMP indicators, and monitor site performance overtime.

## CONTINUOUS QUALITY IMPROVEMENT

The project’s foundation for CQI started in-house with a series of staff and implementing partner trainings on Pathfinder’s ISQS model and Deloitte’s CYPRESS capacity building methodology. ISQS is a

<sup>14</sup> Performance is based upon availability and quality of services as well as quality referrals. Coverage is catchment area population and uptake of services.

quality-focused approach that relies on peer or team supervision and links technical issues (such as how well medical interventions are delivered), the system (how the organization functions to provide good services), and the client. ISQS visits include client interviews, facility reviews, service statistics, a self-assessment, and observation of services (with coaching), which generate information that can be used in the development of an action plan for implementation and follow-up. The CYPRESS methodology (Capacity, Performance, Results, and Sustainability) is a participatory management- and governance-centered approach that translates performance targets as established by the facilities into capacity development solutions that improve health system performance. It is a model that meets each facility at its own stage of management capacity, using a maturity model that breaks down performance achievement into “stages” of development (tailored for each technical area, such as financial management, commodity management, etc.). Through the integration of each of these models with the existing HEALTHQUAL framework, the team coordinated its approach to ensure that service delivery, management, and governance were all properly woven into the CQI model.

These approaches created a foundation for planning and technical assistance, especially in the area of CQI. Focus turned to working with the health facilities to either build upon existing CQI plans or start the process of creating a CQI plan, as necessary. SSQH-CS held a workshop with 60 participants representing 54 facilities in the project’s network for an orientation on CQI. The group discussed quality, CQI, the strengths and limits of the existing HEALTHQUAL framework, the project’s process of supporting the creation of a CQI plan, and the appropriate format and components of a strong plan. Break-out groups by facility level (hospital, CAL, CSL, and dispensaries) examined their roles within the plans’ development.

To date, the project has presented its CQI model for input to the technical staff from DDS South, DDS Grand-Anse, ZC sites Les Anglais and Ile a Vache, and to representatives from other facilities in the Grand-Anse. In addition, the project is working closely with the national HEALTHQUAL team to explore the path forward for expanding HEALTHQUAL to other health services.

## FINANCIAL SYSTEMS

Support to service providers to build and strengthen financial systems for tracking receipts and expenditures at the site level began during year one. Two principle objectives under this management area are to 1) assist facilities to produce auditable financial reports, and 2) help facilities to meet the financial management requirements for the RBF program. Baseline results from the site assessment show that 64% (41/64<sup>15</sup>) facilities were able to produce auditable financial reports. Interestingly, 78% (31/40) of non-dispensary level facilities did the same, highlighting the need to explore the relevancy of auditable financial statements for the smallest facilities. The figure below shows a summary of facilities, broken down by public/private management and service level, with auditable financial reports from the site assessment. However, only 52% (33/64) facilities possessed a bank account, a key prerequisite for the RBF program. Removing dispensaries from this calculation had a similar result as 83% of SSQH-CS-supported CSL, CAL, and HCR facilities possessed bank accounts. The results of the assessment are being used to inform financial management strengthening activities to help SSQH-CS achieve the two aforementioned objectives for this management area.

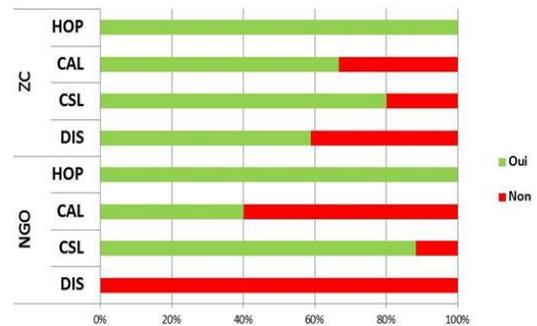
The year 1 actual value for auditable financial reports uses financial reports submitted to SSQH between May and September 2014 by facilities under NGO management to update the value (Baseline data is

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<sup>15</sup> Data on financial management systems collected during site assessment was confirmed for 64 out of the 80 partner sites.

carried over for ZC facilities since updated figures have not been collected.) Due in part to the data gaps filled between baseline and year 1 actual value and due in part to the continuous rigor that was applied to measuring the year 1 actual value (versus a one-day site verification), the project saw the percentage of sites with auditable financial reports decrease from the baseline to 51%. However, the year 1 figure is likely a more accurate representation of the status of auditable financial reports across sites. During Year Two, the project will initiate activities to work with ZC sites to adopt and submit auditable financial reports similar to those submitted by NGO facilities during year 1.

In June, SSQH-CS hosted a workshop with the NGO service delivery subcontractors to provide an overview of Y1 second semester subcontracting and CQI and financial reporting requirements. Project staff presented the financial reporting form to be used, which includes an expenditure breakdown by budget line per facility, an itemized list of expenditures per facility, a certification statement that all expenditures are in compliance with the terms of the subcontract and in line with the approved budget, and that a bank statement for the month is included. Workshop participants practiced completing the financial report template using real-life expenditure examples. The project intends to replicate similar activities with ZC sites in Y2.



**Figure 8: Sites with auditable financial reports, by category (Data source: SSQH CS Site Assessment)**

At the departmental level, the SSQH-CS team conducted a workshop with each of the DDS leadership and the project finance managers embedded at the DDS offices to cover issues of budgets, reimbursements (per the terms of the MOUs with the departments), as well as to introduce the scoping phase of financial management interventions. Participants developed a work plan for reviewing the tools, policies, procedures, and staff roles at each type of facilities within their department. Information from these reviews will inform different financial management models per facility type, so as to appropriately customize financial management support to facility needs and operations. These activities directly support the principle objectives of producing auditable financial statements and meeting RBF financial management prerequisites.

### CLINICAL RECORD SYSTEM

Efforts to help providers at facility and community levels maintain complete patient records included several foci of project TA. Project technical teams, through mobile mentorship, supervision, coaching, and remote support, routinely inspected patient files, verified data transposition into registers, and worked with data clerks to authenticate monthly statistical reports (see *Objective 1, 2 [MMT] and 3 [Data Management] sections*).

CommCare applications help providers to accurately record patient data through built-in system controls that limit opportunities for incorrect data entry. Applications ensure that dates of birth cannot be in the future and are of a valid age, or that correct immunizations can only be entered based on the age of the patient. They also use a patient history to ensure that data does not need to be re-entered, limiting error. An example of this is instead of entering a patient number, ASCPs can just pick from a list of registered patients. Once data has been entered for a patient (ex. an immunization), the application will not prompt that data be re-entered. Although the function is not yet operational at service delivery levels, CommCare has the ability to feed patient records directly into national health management information systems such as DHIS2, thereby eliminating opportunities for transposing errors.

## DATA MANAGEMENT

Efforts to support service providers to properly report, manage, and use data at the facility level included the development of site profiles to show performance, focused workshops on data use for decision-making, individualized coaching and training sessions with facility and DDS staff on data collection, entry, and use of registers.

During Y1, the project developed several tools to encourage data use across system levels, including an interactive dashboard that aggregates assessment analysis and a post-assessment site profile tool. The site dashboard provides a global view of performance, coverage, and RBF readiness across partner sites, as well as comparing these elements across site type, department, and site management. The dashboard was created using Tableau software<sup>16</sup>.

The post-assessment site profile (illustrative example included in Annex) is an Excel-based tool that automatically populates data on basic site information, service availability, quality, select RBF financial management readiness criteria, performance, and coverage based on an easy-to-use dropdown (populated by the user). The profile provides a more granular overview of a site's current state; it may be used by the project team, by the DDS', or by the sites themselves.

A site database also exists to house all assessment data as well as relevant SPA data, HIV rapid assessment data, and other basic site information that might be used in site performance monitoring and management. This database includes pre-defined queries that extract select data on service availability, quality, coverage, and RBF criteria for analysis. Additional analysis is then completed in Excel.

In March, Pathfinder/HQ held a training session for all staff on how to use data for decision-making. SSQH-CS team members hosted 24 representatives from facility sites (M&E officers, site-level data officers, and facility directors from Matheux and CDS Ouest) for the workshop, which covered topics such as why data is important for program management, breakout sessions on participants' experience with data use and related challenges, possible uses for existing data, and how participants could make better use of available data for programmatic decision-making.

To supplement skills development in data use and to help inform the CQI process with evidence, the M&E Team conducted three workshops with DDS and SSQH-CS project staff. Two Actionable Information Use workshops were delivered in August – one with DDS representatives at the Les Cayes office and another at the PAP office with more than 20 technical staff from a variety of consortium partners. The objectives of these workshops were to: 1) review site-level data sources for CQI and program planning; 2) identify key elements of performance and questions for program management; 3) practice using existing data and information for CQI planning; and 4) increase evidence-based decision-making and planning on the project overall.

In September, the team conducted a third workshop with all staff to review the results of the site assessment and train staff on the use of the facility performance database. Staff members were trained in intermediate data analytics techniques in Excel such as PivotTables using actual results from the assessment. They calculated measuring site performance on a number of parameters as identified

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<sup>16</sup> A Tableau Reader license is required to view and interact with the visualization and profiles and can be downloaded for free online at the following website: <http://www.tableausoftware.com/products/reader>.

during the August Actionable Information Use workshops. These practical exercises will inform CQI planning for facilities.

In collaboration with DDS, project team members helped prepare targets for the ZCs and provided TA at sites to compare data with observations at the sites. In Y1, 22 facilities in four departments received coaching and training on data management, and DDS counterparts accompanied these TA visits in five sites. Technical assistance also included support for submitting monthly statistical reports (uploading to MESI) and on how to address stock-out issues of selected HIV-related commodities, resulting in marked improvements in accuracy and quality of the reports.

To support facilities in their progress reporting for PEPFAR, project staff participated in meetings with OGAC, CDC, USAID, Nastad, and SSQH-North on indicators and report development. SSQH-CS team members accompanied USAID and OGAC personnel at the Delmas 75 Community Clinic for the inauguration of the PEPFAR/Haiti Site Improvement Monitoring System (SIMS), which provided feedback on how to conduct SIMS in HIV facilities. From this visit, USAID and OGAC were able to communicate site preparation needs to all HIV partners to help improve the process on future visits.

## INFECTION CONTROL

Through several TA methods, including supportive supervision, coaching, and MMTs, SSQH-CS works with facilities to ensure sustained TB-infection control standards, reinforce protocol use and adherence by staff, and coordinate with commodity procurement and management staff on supply chain. MMTs verify TB-infection control plans, including prompt detection of infectious patients and evaluation of facilities for airborne precautions such as proper ventilation. Teams verify that protocols are clearly posted and visible for facility staff and patients. Providers receive TB-infection control training as part of the HIV management support. (*Refer to Objectives 1 [HIV/TB] and 2[MMT]*).

## PERSONNEL MANAGEMENT

Capacity building workshops examined human resources at the facility level as part of a standard approach to holistically improve facility management and will continue to do so moving forward. As necessary, activities for strengthening HR management will be included in facility performance improvement plans.

## SUPERVISION

The team led reactivation efforts for the supervision teams and provided coaching to support the DDS' to develop new supervision plans and provided hands-on support to a specific DDS at the request of SSQH-CS's leadership. This included recruitment of the field finance staff seconded to the DDS, follow-up on requests for disbursement, and facilitating meetings on the implementation of mobile technology activities.

To further support the supervision plans, the SSQH-CS team conducted joint supervisory visits, analyzed the maximum number of activities that could be accomplished before the end of Year One, and facilitated coaching sessions for budgeting and how to submit the forms. As of September, 85% of the facilities in the West have received supervisory visits by the DSO with direct participation and support from SSQH-CS.

In June Supervisory visits were underway in four departments, and supervisory visit plans have been received from five departments. The project team continues to coordinate and follow up with all departments. The team conducted a review of the supervisory guidance from MSPP.

## REFERRAL/COUNTER-REFERRAL

The SSQH CS site assessment examined the baseline of referral practices among partner sites, revealing that:

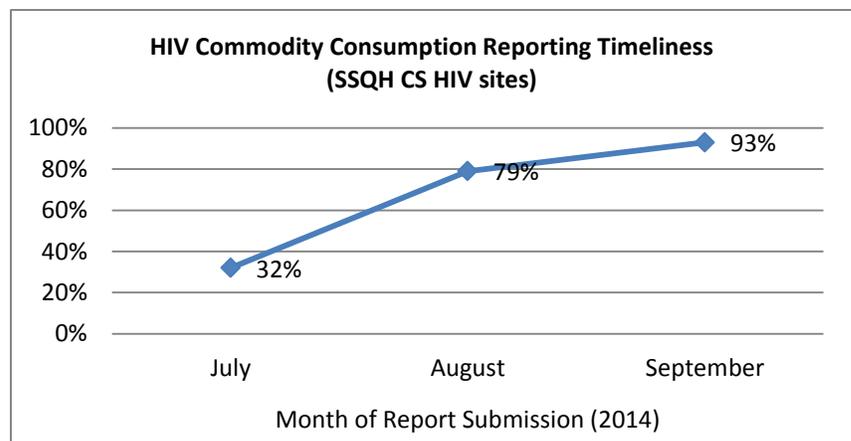
- 78% of sites responded that they always receive ASCP referrals to their institution;
- 46% of sites responded that they never have counter-referrals for ASCP referrals;
- 74% of sites responded that they always refer to tertiary institutions; and
- 24% responding that they send a copy of the patient file to the institutions to which they refer patients.

The project would not expect that the sites always refer all of the time, since of course referrals are not always appropriate; however, data revealed that although the facilities are referring patients, it is not done consistently. Therefore referral strengthening remains a part of the capacity building package for the facility level. Activities related to referrals and counter-referrals will be initiated in Year Two.

## SUPPLY-CHAIN MANAGEMENT

Support for supply-chain management, including cold chain and data management, began first with the creation of a database tracking supply chain, equipment, and related data using SPA and assessment results to gain an understanding of facility supply chain systems and stock-out prevalence. Analysis included examining and visualizing data by drug, facility type performance, and department

performance to gain a clearer window into facility capacity in managing health commodities. Building from this baseline data, the project provided TA to targeted sites, sensitizing stock managers and data clerks on the importance of report quality and timeliness. Emphasis was placed on the 23 HIV priority sites, reviewing ART, opportunistic infections (OI) drugs, and lab consumption commodity stocks. These sites received in-service training on the utilization of commodity management tools for stock management, drawing from the CYPRESS methodology to improve and build health facilities' capacity. As a result of this TA, the project saw an improvement in the completeness, accuracy, and timeliness of commodity reports submitted by facilities from 30% to 93% as of September 2014, as noted in the accompanying figure.



**Figure 7: HIV Commodity Consumption Reporting**

## OVERALL MANAGEMENT OF FACILITY

Recognizing the important role NGOs play in supporting capacity building and CQI activities for facilities in their networks, SSQH-CS engaged all 19 NGOs in working sessions to create budgets and action plans for the April-September period. Subcontract deliverables for this period included site-level monthly statistical reports, financial reports, and quarterly narrative reports on service delivery. NGOs received support in reporting against project indicators and using national databases such as MESI.

Key steps taken by the project in helping facilities improve their management capacities are well illustrated in the example of Les Anglais health center. SSQH-CS staff conducted a capacity building workshop designed to help the site review its functionality and key management practices, and to

develop performance improvement plans for addressing identified issues and weaknesses. The facility has experienced significant management challenges that have ultimately impacted the quality of care provided to patients, including an unmotivated staff, absenteeism, internal conflicts and a lack of trust among staff, waste management problems, and stock-outs of key drugs. The workshop helped the facility team examine management and leadership issues such as human resources, supply chain, finances, and organizational vision, mission, and goals. Outputs from this workshop include the development of an organizational chart, a roles and responsibilities matrix, a performance review system for staff evaluations, and development plans for each staff member. After sharing commodity management tools such as inventory sheets, stock management sheets, and daily consumption lists and how the facility could use them, workshop facilitators helped participants develop a performance improvement plan for the facility and established a current state analysis with incremental steps needed to achieve the desired future state. Perhaps most critical to viability of workshop outcomes was the establishment of a quality improvement team for monitoring the facility's progress against its performance improvement plan moving forward.

Recognizing that the project's model to improve management of health facilities must be sustainable, the team initiated efforts to engage the DDS in the scaling of capacity building workshops. A standard framework and tools already exist for replication, but the project recognizes that without engagement of the DDS, scaling will not be possible. Accordingly, a presentation to DDS South staff on the Les Anglais activities and the resulting discussion emphasized the importance of DDS involvement and oversight in these workshops. The team is currently working with DDS South to identify a point of contact for the workshops moving forward and develop a plan for coordination and roll-out of the workshops for the remaining South sites. The team is using the experience in South as an opportunity to identify lessons learned and incorporate the response to these lessons in the approach with the remaining Departments.

Moving forward, it remains critical to integrate the CQI and capacity building approaches of the project, and to align these approaches with departmental and national priorities and standards. The team will increase coordination with the national HEALTHQUAL team in Y2 to carefully coordinate a uniform approach to monitoring progress, shape the expansion of the framework to include all aspects of the essential package of services, and to develop training modules for sites without HEALTHQUAL. The project will also continue to improve the use of site data internally so that any project visit to a facility uses data to monitor CQI functions and progress and make decisions. Finally, as CQI further takes root at the facility level, continued coordination with SSQH-North will be critical to ensure technical content areas are effectively monitored and coordinated across the project consortium as appropriate.

## OBJECTIVE 4

### STRENGTHEN DEPARTMENTAL HEALTH AUTHORITIES' CAPACITY TO MANAGE AND MONITOR SERVICE DELIVERY

Indicators	Annual Target	Total Achieved to Date	% Achieved to Date
Percent of project-supported sites receiving 4 comprehensive supervision visits and reports by Department staff	60%	40%	67%
	Comments: One department targeted (West) with 14 comprehensive supervision visits		
Percent of project-supported sites that are addressing recommendations from site visits	50%	Data not available	N/A
	Comments: Focus for Y2 to provide data for indicator		
Percent of health facilities providing services in compliance with the national norms	50%	40%	80%
	Comments: Data is pulled from SSQH CS site assessment (April 2014). Compliance with national norms is determined when a site responded that a protocol was not only available and accessible at the facility, but was also used. Verification efforts for this indicator will be included in site visit and RBF assessment activities moving forward. This is defined as the percent of sites assessed that were observed to be using at least one set of MSPP norms during the assessment. This is was at mid-year.		

**Table 12: Mandated Objective 4 Indicator**

To help ensure recent gains made at the MSPP/Central level in establishing service delivery norms, protocols, and reporting tools are institutionalized at the facility and community levels, SSQH-CS works within the decentralized structure and strengthens departmental authorities' capacity in service delivery monitoring and management.

#### SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS

Well-functioning management systems require access to real-time information that is easily navigable and interactive. Incorporating data collected during the site assessment and from existing data sources such as the SPA, SSQH-CS developed post-assessment site profiles to provide a snapshot of each facility that can be easily modified as data is collected and/or updated. The team leveraged data visualization tools to develop dashboards that present service delivery, management data, and information on each facility. These visualization tools enhance the transparency into health facilities' performance and facilitate programmatic decision-making.

The project presented site profile drafts to stakeholders for their critical feedback. These profiles provide advisors and counterparts with easily viewable service delivery and management data, and information on each health facility prior to conducting supervisory visits, capacity building trainings, workshops, and/or when liaising with MSPP or the DDS. A project-developed Tableau-based, interactive dashboard aggregates assessment analysis and post-assessment site profiles to show the user a global view of performance, coverage, and RBF-readiness across partners' sites, as well as comparing these elements across site type, department, and site management.

An Actionable Information Use (AIU) workshop was held in early August with 20 SSQH-CS stakeholders and staff. Participants learned about and practiced application of the AIU framework and received training on how to analyze the site assessment results and use it to plan interventions, and to monitor and achieve project results. A similar workshop was held in Les Cayes with DDS counterparts and service delivery NGOs.

To further support the supervision plans, the SSQH-CS team conducted joint supervisory visits, analyzed the maximum number of activities that could be accomplished before the end of Year One, and facilitated coaching sessions for budgeting and how to submit the forms. A total of 33 health institutions saw 45 joint supervisory visits during Y1, covering technical areas such as FP, RBF, CQI, HIV/TB, BC, and M&E.

## RESULTS-BASED FINANCING

As part of the project's mandate to strengthen the DDS to monitor and manage service delivery, SSQH-CS will be the lead implementer of the newly-developed MSPP RBF scheme. Details of the uniqueness of Haiti's RBF scheme, including the management of inputs (service delivery operation costs) and outputs (RBF incentive payments) were outlined in an RBF Concept Note submitted to USAID (*see below*). To prepare for the launch of the scheme, the team coordinated directly with MSPP, SSQH-North, and LMG to finalize a list of criteria and assessment tool for RBF selection. Using the approved costing tool provided by MSPP, the project drafted RBF budgets per facility per department. This exercise illustrated significant resource constraints for the project, which would be responsible for financing both inputs and outputs under the scheme. As a result of this resource constraint and in collaboration with MSPP, SSQH-CS developed a RBF implementation plan and conducted an analysis of RBF-readiness in Nippes and Grand Anse using the site assessment data and MSPP assessment tools. Following a partners meeting in July, involving MSPP/UC, USAID, SSQH-North, and LMG, SSQH-CS presented its RBF implementation plan. This plan focuses on Grand Anse and Nippes as the first two departments to start RBF due to the manageable number of facilities there and the need to wait until the ongoing World Bank Impact evaluation in the Center and South completed before starting RBF in these departments. RBF rollout for the West and South-East departments, per the concept note, would be scheduled for Y3.

In coordination with MSPP/UC, the project introduced RBF at the DDS (Nippes and Grand Anse) to discuss strategy, training, and budget development. The RBF modules were finalized in consultation with each DDS. Modules were adapted with the assistance of the Groupe Technique de Travail (GTT) using those developed for the World Bank pilot (in the North-East).

For purposes of identifying qualified facilities, SSQH-CS looked at two key financial management functions to determine RBF-readiness: 1) the existence of a bank account, and 2) the requirement of two signatures to effect payment. Additional non-financial criteria included meeting a minimum number of staff and prevalence of commodity stock outs. Of the 15 sites in Grand Anse and Nippes, eight (8) qualified as being RBF-ready. With participation of MSPP's UC, Unité d'Appui aux Directions Sanitaires (UADS), and CIFAS units, the project team started five-day long RBF trainings for the 11 sites (divided into two departmental trainings), which includes trainings on health financing,



Figure 9: RBF training in Grande Anse

performance measurement and verification for RBF, and an orientation to MSPP's scheme and its implementation at each site. The departmental director opened the sessions to highlight the importance and role of RBF in increasing quality and coverage of services, and DDS personnel facilitated the trainings. Participants developed facility budgets and action plans for RBF implementation. In Nippes, 18 providers and DDS staff participated in the training and showed a mean pre- and post-test score improvement from 32% to 78%. In Grand Anse, 31 providers, DDS and UAS staff participated and showed a mean pre- and post-test improvement from 35% to 82%. Next steps will include further development of each facility's action plan in coordination with the DDS and UC, and to ensure facilities have the required registries and data collection tools before signing agreements.

*Concept Note on RBF Program Financing and Implementation Approach:* In July/August 2014, SSQH-CS prepared a concept note on RBF roll-out in the project's catchment area. The document provides analysis on the Haitian RBF scheme design and outlines three roll-out scenarios for consideration, including the pros and cons for each. The principle challenge facing the project in rolling out RBF as its designed is managing costs. While other country RBF schemes share operations and RBF incentive costs between the host government and implementing partners, Haiti's model includes no costs borne by the government. With both operational and incentive costs falling upon the implementing partner, the project proposed scenarios that including reducing service delivery operations budgets, capping RBF incentive payments, and phasing RBF roll-out by department.

*Contractual Mechanisms for RBF Incentive Payments for the Zones Ciblées:* Implementation of RBF poses some contractual considerations for the project and USAID. While project-supported facilities managed by NGOs have subcontracting mechanisms in place to easily introduce RBF and administer incentive payments, those facilities that are publically-managed facilities or ZC require additional considerations. As per the SSQH-CS contract, we cannot enter into a direct subcontracting relationship with GOH entities. Per USAID's recommendation that the project consider using Fixed Obligation Grants (FOG) as a contractual means by which RBF incentives could be paid to ZCs. In September 2014, the project prepared a FOG concept note for USAID's study. This document outlined how FOGs may be introduced for this purpose, the pros and cons associated with doing so, and also detailed alternative scenarios.

## CROSS-CUTTING ACTIVITIES

### BEHAVIOR CHANGE

Behavior change (BC) lies at the foundation of SSQH-CS. From helping to change perceptions about services and to reduce risky behaviors at the community level, to improving attitudes and practices of health practitioners at the facility level, to fostering more involvement and service oversight by departmental health authorities at the DDS level, SSQH-CS engages all tiers of the health system in BC activities. Data from these activities additionally feeds back to the SSQH-CS technical advisors and implementing partners to inform how best to focus their efforts to support all three tiers of the health system.

To help foster thinking and dialogue about risky behaviors and perceptions, SSQH-CS employs Pathfinder's behavior change facilitation game, *Pathways to Change (P2C)*<sup>17</sup>. The two main functions of the game are to better understand risky behavior and how it can be avoided, and to help health workers and peer educators to better understand the target population's perceptions and the facilitators and barriers to change. The game serves as a means through which SSQH-CS identifies how to customize and frame its technical assistance and community mobilization efforts. In addition, specific BC communication activities help to amplify key messages of national and project mass campaigns.

Internal project team work sessions helped each technical advisor identify the behavioral objectives for the project and map out the different approaches they could use to promote behavior change within the context of a large, integrated project. This helped identify three "buckets" of behavior objectives: household practices (such as early and exclusive breastfeeding), care seeking behaviors (e.g. uptake of FP, initiation of ART), and adherence and continuation (e.g. adherence to ART, to PMTCT regimen, continuation of FP).

The project team met with MSPP's Health Promotion and Environmental Protection unit (DPSPE) to present the project's vision for behavior change, to demonstrate tools to be used, and to validate the project's BC strategy through the leadership of MSPP. DPSPE program heads provided critical feedback on adapting P2C, including the revision of certain scenarios and behavioral objectives. The team planned training of trainers for the use of P2C at the ZC as well as coordination with the DDS BC and community mobilization personnel. Technical support for the DDS and ZCs included preparing action plans for BC activities and training in the use of P2C.

### MOBILE TECHNOLOGY TO IMPROVE HEALTH SERVICES

SSQH-CS pioneers the expansive use of mobile technology to support improved health outcomes in Haiti. The approach integrates flexible and responsive solutions using mobile applications, including CommCare, a cloud-based mobile decision support and case management platform for health workers in resource-low areas. SSQH-CS uses mobile applications such as CommCare, Interactive Voice Response, SMS, and closed user groups to improve communication while strengthening community and facility level referral systems. Local technologies, including the Haitian manufactured Surtab and Hansxom tablets, are used.

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<sup>17</sup> *Pathways to Change* is both a teaching and learning resource designed to make the problem of behavior change more understandable to community health workers and peer educators. When they use their game with their communities, it stimulates thinking that can motivate individuals and communities to change.

SSQH-CS strengthens health systems by improving the MSPP’s capacity to deliver services, manage client data, and make health service financial transactions through use of mobile technologies. Program strategies include:

- Implement mobile applications to facilitate training and deployment of ASCPs to provide quality community-level health services, strengthen referral and counter-referral networks, and facilitate real-time data collection and use;
- Strengthen key management practices by equipping community- and facility-level supervisors with a mobile application that facilitates real-time supervision of ASCP activities;
- Equip facilities, departmental health authorities, and the MSPP at the central level with dashboards built within the national health information systems (MESI and DHIS2) for data visualization to facilitate decision making and performance improvement;
- Expand the use of mobile money solutions to improve the efficient delivery of payments for ASCPs and other health management expenses.

CommCare also enables SSQH-CS to create a comprehensive training database, tracking activities by technical area and geographic location, thereby permitting the project to track the number of personnel trained by cadre, facility, training type, and/or other metrics.

## GENDER

SSQH-CS understands gender inequality as a structural driver of poor health outcomes in Haiti and prioritizes the removal of gender-based barriers to services through community-based and CQI activities. The project places women and adolescent girls at the center of programming through several avenues to ensure access to integrated services at community and facility levels. In project-supported facilities, youth-friendly services (YFS) and KAP services, including commercial sex workers (CSW), help to mitigate the heightened risk of illness and sexual and physical abuse faced by many women and adolescent girls. Youth outreach groups and peer educators sensitize community members in SRH, FP, GBV, and HIV prevention, and educate them on related services at youth-centers and clinics. The project reinforces gender equity through CHW engagement (many of whom are women) and their provision of gender-focused services (FP, SRH, maternal health, and GBV), and supports community groups such as *club de mères* to help address pressing health needs, while including male involvement to support family and community health. SSQH-CS prioritized the development of MCH and FP CommCare applications for ASCPs as a way to further place women and adolescent girls at the center of programming. (see *Objectives 1 and 2 for more detail*). Finally, indicators are desegregated by sex to closely measure the project’s progress.

To help sensitize the project team in recognizing how gender affects the population we serve access services, as well as help team members recognize their own pre-conceived attitudes pertaining to gender, Pathfinder conducted gender “pulse checks” with team members. One tool Pathfinder staff used is the SASA! “The Space between Us” game, in which team members engage in role playing to map out how people experience barriers or facilitators to service access. This mapping exercise is accompanied by a discussion to further flesh out concepts and to understand gender-based barriers to service access.

## **PARTNER COORDINATION**

### **MSPP – CENTRAL, UADS, AND DDS LEVELS**

During the initial months of project start up, SSQH-CS met with the MSPP central leadership (including the Ministère, the Directeur Général (DG), and members of the UADS, the body in charge of managing the DDS, and SSQH-North to align project activities with national action plans. At the departmental level, the project formalized partnerships and established service delivery support via MOUs for the November 2013 – April 2014 period in all six departments. In May, these agreements were extended for the life of the project, through September 2016. Under these agreements and in compliance with project contract requirements, SSQH-CS supports service delivery at the ZCs through direct payment of approved DDS expenditures and inclusion of health providers on the project's payroll. Budget reviews and activity planning for Year Two took place in September 2014.

In addition to service delivery, the project supported MSPP in several national initiatives in 2014. In January, SSQH-CS presented the project's mHealth strategy to USAID and the Minister and her cabinet, and the parties coordinated the program launch during 2014 Carnival celebrations in Jacmel and Gonaives. Since March, the project has supported MSPP in the preparation, launch, and coordination of the National FP Campaign, which runs through December. Since July, SSQH-CS has begun preparation for implementing MSPP's RBF scheme, conducting trainings and establishing necessary administrative groundwork with health facilities.

### **USAID**

The SSQH-CS team and USAID have worked hand in hand since project inception, meeting regularly to discuss strategy, implementation, and evolving priorities, and jointly visiting sites. SSQH-CS supported USAID, in partnership with others, on ways to strengthen USG project coordination and resource sharing. SSQH-CS has hosted several USAID delegations to its supported sites, including ones from the US Embassy in Haiti, USAID-Haiti and USAID/DC. In May, a special USAID/DC delegation, including Dr. Pablos-Méndez Assistant Administrator of the Global Health bureau, visited project-supported sites in Fermathe and Martissant to review services for OVC. He met with clinic staff, discussed services, and observed a club de mères meeting being held at the clinic. Dr. Pablos-Méndez discussed the utility of CommCare as a monitoring tool for ASCP supervisors. The team then accompanied an ASCP on a home visit and witnessed the use of CommCare in action, seeing how the applications help to reinforce community level service delivery. In September, SSQH-CS hosted USAID and JHPIEGO to present the project's work in MCH, particularly its work with community-based referrals using CommCare to reduce risk of maternal mortality through the "ending Maternal Mortality" initiative. The group visited Fermathe and Matheux sites, and made a recommendation to USAID to name Matheux as the first referral network for collaboration, including helping the site restart delivery and advanced support care for the maternity

### **SSQH NORTH**

The two SSQH teams have coordinated regularly since November 2013 in an effort to ensure unified project, particularly with the MSPP. The two teams have collaborated, exchanged work methodologies, and knowledge and experiences, and have harmonized approaches for the MOUs and NGO subcontracts for consistent support of service delivery. The two have co-participated in MSPP meetings, RBF planning sessions (USG, World Bank, and MSPP partners), and USAID briefings to share common successes and challenges. Most recently, the Central and South and North teams have worked to streamline and harmonize some procedures, including establishing common performance indicators.

Both projects also drew up a common strategy to upgrade health services to provide treatment and care for people living with HIV.

### NGO SERVICE DELIVERY SUBCONTRACTORS

Since the project's debut in October 2013, SSQH-CS has partnered with 19 local and international NGOs to deliver services at 45 dispensaries, clinics, and hospitals. This network of private organizations was supported previously under the SDSH II project, and SSQH-CS continued consistent levels of support through project transition via 5.5-month "bridge" subcontracts (November 2013 – April 2014). This period enabled the project team to sustain services uninterrupted while giving it time to conduct baseline assessments. During this period, MSPP finalized the RBF mechanism and started plans to pilot the scheme.

As the project prepared for the next phase of NGO subcontracts slated to take effect in May, it became evident the RBF scheme was not yet ready to pilot. At this point, SSQH-CS concluded, in consultation with USAID, to extend the bridge subcontracts through the end of Year One. This second phase of the bridge subcontracts, however, added new components for the partners to manage. Subcontracts included new deliverables such as requirements for site-specific Continuous Quality Improvement (CQI) plans, monthly financial reports, and clarified performance targets. A workshop for the NGO partners held in March provided a forum to review the new requirements and answer questions together. During this phase, the project required NGOs to present a technical proposal, budget, and work plan for continued funding. After an initial analysis of each NGO's facility coverage, general performance, and cost per service, the project requested a budget reduction of 7-8% from the five whose cost per service was highest. This reflects an effort by SSQH-CS to steer NGOs to a more results-based process that will ultimately be actualized by the MSPP RBF scheme. Efforts continued during the year to help the NGOs adapt to new subcontract requirements and changes in the national minimum wage. A second workshop in June focused in more detail on the financial reporting and CQI plan deliverables, providing examples discussed in a large group. When the GOH increased the minimum wage for CHWs, project personnel worked with NGOs on how to manage the increased costs without raising the total budget ceilings for the period.

Overall, the project aims to decrease the cost of service delivery at the site level while increasing the efficiency and effectiveness use of funds to reach established targets. Working with the NGOs on this movement has been challenging at times, but the project has made headway in this process. When SSQH-CS inherited the network of 19 NGOs, services were funded through a scattering of subcontracts and purchase orders and consistency of services required was not straightforward. Over the past 12 months, the project has consolidated all contracting mechanisms per NGO and clearly outlined services, targets, and deliverables required. The first wave of budget reductions was introduced in May and project personnel will include a second wave in December 2014.

### SDSH II

Project transition and resource transfers from SDSH II to SSQH-CS occurred fairly smoothly between October and December 2013. Service statistics from SDSH II's final year informed SSQH-CS' baseline data. In close collaboration and coordination with USAID and SSQH-North, SSQH-CS received part of SDSH II's asset disposition and final resource custody occurred in January 2014. It should be noted that several pieces of equipment included in the disposition plan and slated for SSQH-CS were not included in the full property transfer. Furthermore, fifteen of the vehicles transferred to SSQH-CS are non-functional at all or require significant and likely cost-prohibitive maintenance for their long-term utility to the

project. Only seven are really in position to serve the Project. SSQH-CS will coordinate with USAID on the decisions to be made about the fleet of vehicles.

#### HIFIVE

Coordination and partnership between SSQH-CS and the Haiti Integrated Financing for Value Chains and Enterprises (HIFIVE) projects started in December 2013, was formalized in January 2014 with a signed MOU, and is ongoing. The two projects have jointly negotiated with telecom provider Digicel to establish rates and a service contract for the Tcho Tcho mobile component. In March, SSQH-CS submitted a concept note to the HIFIVE Catalyst Fund for a \$50,000 grant to procure mobile telephones and tablets for CHWs and supervisors. This application was approved in June, and by August, SSQH-CS had purchased 300 tablets with the funds. These electronics have been used in CHW trainings in August and September 2014. CHWs and their supervisors will use these phones and tablets for service delivery and medical data management using Dimagi's CommCare applications.

#### LMG

SSQH-CS and the Leadership, Management, and Governance (LMG) project partner on the planning and coordination for implementing the MSPP RBF scheme. The two projects clarified roles and responsibilities in their collaboration early in the relationship, and coordinate on RBF training activities, serve as members of the GTT, where the projects discuss RBF with MSPP and the World Bank. SSQH-CS has met with LMG to harmonize interventions in support the MSPP/UC in rolling RBF out.

#### SCMS AND LMS

Since November, SSQH-CS has coordinated with the Supply Chain Management System (SCMS) and Leadership, Management, and Sustainability (LMS) projects on areas of mutual support to health facilities in terms of commodity availability and USG FP Compliance monitoring. Monthly meetings have helped to ensure coordination on jointly-shared areas of responsibility such as USG FP Compliance. In these meetings, project personnel discuss continued and streamlined support for sponsored facilities, share information on supervisory visits and updates on provider trainings in compliance and logistics management, and discuss any relevant infrastructure problems encountered at health facilities. SSQH-CS partnered with SSQH-North and LMS to host a workshop to share standardized tools adapted for ASCPs to educate them on USG FP Compliance guidelines and help monitor their adherence. The partnership with LMS has expanded to include MSPP/DSF, UNFPA, and SCMS to help with the national quantification process to ensure availability of FP/RH commodities. The team worked with RH officials at the DDS level on building capacity on stock management, M&E, and the quantification of FP products. The SCMS representative for the South department sits at the project's office.

#### HSIS

A critical partnership in health data management is with the Haiti Strategic Information Systems (HSIS) project, a program to support the Haitian government to manage its health information system, DHIS2. SSQH-CS is the first project in Haiti entering routine data into the new DHIS2 database. (*See Management, Monitoring, and Administration section*).

## **ENVIRONMENTAL COMPLIANCE**

In November 2013, SSQH-CS submitted its EMPR to USAID in accordance with the approved Initial Environmental Examination (IEE) (LAC-IEE-11-03) for Haiti and the SSQH-CS contract requirements. This document identifies the anticipated environmental impacts of program activities and necessary mitigation actions.

In May 2014, USAID indicated to SSQH-CS that the mission was re-evaluating the IEE and that the project's EMPR would not be approved until this examination was completed. In the meantime, the project has been instructed by USAID to follow the EMPR designed and approved under SDSH II.

All service delivery agreements (NGO subcontracts and DDS MOUs) include clauses on environmental compliance and specific guidance on medical waste disposal, including the designation of a point-person responsible for implementing activities for medical waste management. Sites, in coordination with the SSQH-CS team, make best efforts to adhere to the Recommendations for Medical Waste Disposal in attachment to the agreements. This includes guidance on construction, disposal of medical waste, disposal of sharps, handling and disposal of chemical containers, and instructions on building a simple drum incinerator for waste disposal.

## CHALLENGES

While SSQH-CS established strong foundations for smooth and successful implementation throughout the first year, several challenges persist and frame how and at what pace implementation continues. While SSQH-CS continues to work with USAID on jointly tackling some of these together, some have become realities the project must face and/or reflect changes to the project's scope.

Selected financial and administrative burdens not anticipated during the proposal stage but requested post-award have challenged smooth implementation and placed onerous encumbrance on limited resources. While the approved budget included no resources to support MSPP health providers, including doctors, nurses, CHWs, and supervisors, it was request to maintain the status quo with SDSH II. For SSQH-CS, this includes the payment of 644 health providers, an expense not anticipated during pre-award and a massive financial strain for the project's budget.

Further complicating this financial burden is the contract clause restricting SSQH-CS from directly paying the salaries of GOH civil servants<sup>18</sup>. Accordingly, SSQH-CS has had to bring all 644 individuals onto the project's payroll, which has placed further encumbrance on the project in terms of increased liability and the administrative burden of issuing payments. Prior to operationalizing mobile money solutions in August 2014, SSQH-CS was compelled to pay these individuals via check. While the implementation of electronic and mobile-based payments in Q4 of this year have eased the administrative challenges, the financial burden remains.

During the year, GOH raised the minimum daily rate, which has greatly affected our service delivery partners' budget. Another potential financial impact on the project will be the anticipated raise in the ASCP monthly salary, fixed by MSPP at 8000 HTG.

Recruitment efforts have faced several significant challenges which have contributed to protracted candidate searches and longer-than-anticipated job vacancies. The USAID restriction on compensating Haitian staff only in Haitian Gourdes and not in USD has caused several highly-qualified candidates to reject offers and pursue other opportunities.

Other recruitment challenges stem from imbalances between a dynamic employment market in Haiti, in which high-skilled professional frequently look for better opportunities, thereby inflating salaries due to competition as more job offers than available professionals exist, and a limited budget for personnel. Part of this dynamic employment market has also led some candidates to require allowances if the post is located away from their home, say in Les Cayes.

Delay in USAID's approval of a key request has affected implementation during Y1. With the removal of CARE from the SSQH-CS consortium in October 2013, an implementing partner was needed to fulfill the critical WASH, child protection, child health, and nutrition functions. Pathfinder turned to partner ZL to step into this role, which began limited work in February. A full Request to Subcontract to ZL was presented to USAID in early April, but formal approval of the request was not provided until late September 2014. While Pathfinder provided ZL with a pre-subcontract to help assemble a team of experts and begin limited activities, the organization reached funding thresholds in August and a resulting funding gap emerged until subcontract approval was granted.

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<sup>18</sup>“Contractors shall not enter into direct subcontracting relationships with GOH entities or directly pay the salaries of GOH civil servants.” Contract No: AID-521-C-13-00011, page 10.

In terms of implementing MSPP's RBF scheme, two obstacles prevented the project from rolling out the scheme during Y1: a rollout strategy has not been approved by USAID, and contractual restrictions impede the project's ability to implement RBF as it is designed with publically-managed facilities. In response, SSQH-CS prepared a concept note with three options for rolling out RBF in August. Once USAID, in coordination with MSPP, determines how it would like SSQH-CS to rollout RBF, the project will make any necessary adjustments to its approach. In the meantime, pre-RBF trainings have begun in several departments (*see Objective 4 section*). The project has discussed options with USAID to address the contractual obstacle with public facilities, including the viability of a Fixed-Obligation Grant, per USAID's request. A solution will be reached once the RBF rollout plan is determined.

Data collection, cleaning, and access have posed considerable problems for the project throughout the dataflow pipeline. Monthly facility reports are not always received timely or completely and once verified demand being hand-entered in DHIS2 by project staff, since the database is not yet rolled out to the DDS institutions. A second national database, MESI, poses its own set of problems: due to the iterative nature of the release of data by MESI, there are inconsistencies between what is reported by the project and what can be verified in the database. The recent addition of new PEPFAR indicators makes it difficult to accurately track data overtime. Registers and Ministry report forms do not always track project indicators, nor do they disaggregate by the same age groups.

The state/condition of assets received from the SDSH II project has created substantial operational challenges for the project. SSQH-CS received numerous non-functional vehicles, and/or vehicles that require significant maintenance to make them functional. This has placed considerable burden on the remaining vehicles and has added logistical challenges for smooth activity implementation. Furthermore, SDSH II recalled all vehicles stationed at the DDS instead of leaving them there for continued use under SSQH. Now the project faces requests from each DDS for vehicles the project does not have, given the deplorable state of those inherited by the project's predecessor. The approved budget does not afford resources for repairing the non- or partially-functional vehicles. Additionally, the project received only five functional laptops from SDSH II (out of 16 total), with the others having more than five years of use and are dysfunctional.

Import barriers have slowed down operations at times; first by way of causing delays in receiving a tax exempt letter from the Ministère des Affaires Etrangères et de Cultes, then by further restrictions by the GOH. The project surmounted obstacles to directly importing critical IT equipment with the help of USAID/Haiti. SSQH-CS requested the assistance of USAID and the equipment was eventually imported through the US Embassy in early April. Nonetheless, it took the project four months to receive the first shipment of IT equipment.

## SUCCESS STORY #1

### mSANTÉ PIONEERING MOBILE TECHNOLOGY TO IMPROVE ESSENTIAL HEALTH SERVICES IN HAITI

#### BACKGROUND

As reflected in Haiti's Demographic and Health Surveys 2005-06 and 2012, myriad natural disasters, cholera outbreaks, and a weak, fractured health system have resulted in setbacks in improving the health of mothers and their children, and combatting HIV.

At 630 maternal deaths per 1,000 live births, Haiti's maternal mortality ratio was extremely high in 2006. It is unclear how many Haitian women died in 2012 as a result of pregnancy and childbirth complications; no data were collected. Between 2006 and 2012, the ratio of children dying under age five increased—from 86 to 88 child deaths per 1,000 live births. HIV prevalence remained constant at 2.2 percent. Compounding these challenges, Haiti suffers from a high unmet need for family planning—currently 37.5 percent—and a high adolescent fertility rate (a 12 percent contribution to the total fertility rate of 3.5).

To realize meaningful progress and to improve health outcomes, Haiti's Ministère de la Santé Publique et de la Population (MSPP) has laid the foundation for a more cohesive and responsive health system. But the country requires targeted support and innovative approaches to realize its goals.

#### INNOVATION FOR PUBLIC HEALTH

USAID's Services de Santé de Qualité pour Haiti (SSQH-CS) project, in collaboration with the Haitian government and MSPP, integrates the use of mobile tools for health. Led by Pathfinder International with a consortium of partners, the project incorporates the use of mSanté activities and finance tools to improve the delivery of quality health services for the people of Haiti. Santé means health, and mSanté activities infuse technological innovation with traditional public health programming. mSanté uses Interactive Voice Response; SMS; and CommCare,<sup>19</sup> to improve communication, data reporting, and client case management, while strengthening community and facility-level referral systems.

#### PROMOTING QUALITY CARE AT THE COMMUNITY LEVEL

To date, SSQH-CS has trained 280 Agents de Santé Communautaires Polyvalent (otherwise known as community health workers or CHWs) to use CommCare to guide their work and streamline their data collection and reporting. These CHWs serve as critical links between Haiti's communities and the facilities that serve them. Software manufacturer Dimagi, Inc., worked in close partnership with Pathfinder to develop the project's CommCare applications. These "apps" cover major health services offered by CHWs, including integrated maternal and child health, family planning, and HIV services, and support the following:

- Registration and tracking of clients, including pregnant women, family planning clients, and people living with HIV;
- Guidance to CHWs through electronic checklists, protocols, and algorithms to improve the quality of services delivered, coupled with audio counseling content;
- Automatic SMS reminders for CHWs and supervisors to maintain household visit schedules and alert CHWs of services needed at households;
- GPS tracking to monitor community-level service delivery;

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<sup>19</sup> A mobile decision support and case management app for health workers developed by Dimagi, Inc.

- Referral and counter-referral through client tracking and record sharing functionalities; and
- Real-time reporting of data related to services offered at the community level for use by supervisors and program managers.

## **BETTER REFERRAL AND SUPERVISION**

These last two capabilities, related to referral and supervision, are key. SSQH-CS has begun equipping project-supported facilities with mobile devices enabled with a CommCare app that helps them track CHWs' work and accept referrals to their facility. Using cloud synchronization, the app allows facilities and CHWs to share client records via a mobile network—to view clients' records simultaneously, improve management of care and communication, and verify referrals. CHWs are also notified when their clients return to the community. This allows them to follow up and ensure health care is not limited to the clinic, thus being as pervasive as the mobile platform itself.

mSanté also strengthens key management practices by equipping supervisors at the community and facility levels with their own mobile application—to facilitate real-time supervision of CHWs' activities and develop performance improvement plans.

“With CommCare, I will now be able to see the data from the health workers I supervise. To see exactly what are they are struggling with and decide how to better mentor them,” says Hilarie Etienne, a supervisor from rural Fermathe that has worked as a CHW for 20 years. “I can say ‘Oh, Jonathan, I see you have only visited two clients last week. What is happening here?’ Or ‘Florian, this is how you can improve that.’ I supervise five health workers. Now I will have the data. I will know exactly what to emphasize with each one.”

## **MOBILE MONEY FOR FINANCIAL TRANSPARENCY AND INCLUSION**

Supporting community and facility-based providers to deliver quality integrated care is just one piece of the puzzle. SSQH-CS is poised to launch the use of mobile money— using mobile phones to make health-related financial transactions, including payments to CHWs like Etienne—through the Haitian mobile banking service Tcho-Tcho Mobile. Understanding that mobile money can impact transparency and efficiency of financial transactions, as well as enable financial inclusion for the poor, SSQH-CS is joining other USG-funded partners, including the USAID-funded HIFIVE project, to begin facilitating mobile money payments.

With the idea of sustainability as a constant goal, SSQH-CS strives to generate market demand for the use of mobile money by working with partners, like the HIFIVE project, in the creation of client education materials and mobile money systems—educational models and financial tools that can be scaled up nationally.

## **LED AND OWNED BY HAITI**

mSanté activities would not be possible without the critical leadership of Haiti's MSPP, which has provided content design, training, and the integration of community health information systems.

All mSanté applications have been developed with input from the local providers themselves. Early on, CHWs pilot tested the applications during their home visits and, each week, gathered as a group to provide feedback on how the tools could be improved. For example, when CHWs recommended the applications be translated from French to Creole, the project promptly made this important change.

When asked what it means to be part of all this mSanté innovation, CHW Etienne says, “We feel proud. We believe our input was used. That is one of the reasons we say we wish we had CommCare a long time ago.”

Today 2,137 family planning users; 661 pregnant women; and 2,494 children are registered to receive quality integrated care through mSanté.



**Figure 10: Etienne counseling a new mother using mSanté**

## SUCCESS STORY #2

### ST. PAUL HEALTH CENTER FILLS GAPS IN THE PROVISION OF ART FOR MONTROUIS PATIENTS

#### BACKGROUND

In Montrouis, the POZ clinic was the only health center providing anti-retroviral therapy (ART) services for a population of 38,205; however, due to funding constraints, the clinic was forced to stop providing treatment. As a result, ART patients did not have the ability to access care within their own community, and were forced to travel as far as St. Marc or Arcahaie to access services, 20km and 30km away respectively. This presented a significant barrier to the continuum of care for these patients. Several stopped ART treatment altogether. Those who continued to seek care, the situation created meaningful financial and social burden due to the distance they were forced to travel, threatening adherence and retention in care. Finding another solution for these patients was critical.

#### ACTIVITIES

Fortunately for the people of Montrouis, there was another clinic in the community that could offer ART services. The leadership of the St. Paul clinic recognized the need in their community and requested support from the Services de Santé de Qualité pour Haïti – Central South (SSQH-CS) project. In collaboration with St. Paul, SSQH-CS conducted an assessment in order to evaluate the capacity of the facility. The assessment looked at elements such as staff training on holistic HIV management and availability of CD4 testing. A few concerns were identified - the clinic was not part of any lab network and the lab lacked both the capacity to perform blood chemistry and the space necessary to perform other routine tests needed to manage ART patients.

Mentors from the SSQH-CS team held several training sessions for the St. Paul staff. Additionally, site managers (a physician and a nurse) attended a three week HIV management training held by the Ministère de la Santé Publique et de la Population (MSPP) Programme National de Lutte Contre le Sida (PNLS). Other preparations included a reorganization of the space, minor infrastructure improvements, and the creation of a selection committee for eligible patients.

St. Paul would also need to recruit a Social Worker in order to complete the HIV management team, and SSQH-CS worked closely with them to speed up recruitment. To address the site's need for CD4 testing, SSQH-CS came to an agreement with the Zanmi Lasante (ZL) team in St Marc to allow patients from St Paul's clinic to benefit from the ZL CD4 network.

#### IMPACT

After the first meeting of the selection committee, nine patients were enrolled for pre-ART counseling. Within just six weeks, 16 patients were enrolled on ART and more than fifteen received pre-ART counseling. Currently, 44 patients are receiving ARV treatment. Without SSQH-CS's intervention, many of these patients would have gone without treatment. This experience clearly shows how a multi-disciplinary approach and effective partnership can improve patient care and leverage existing resources to ensure continuity of care. SSQH-CS will expand this model of partnership and integrative approach to ensure quality ART care is being implemented at sites in Maissade, OBCG and Lahoye.



**Figure 11: A new patient receiving counseling at St. Paul**

## **ANNEXES**

- A. Indicator Summary Table with Y1 Data
- B. SSQH-CS Organogram
- C. Sample of Site Profile