

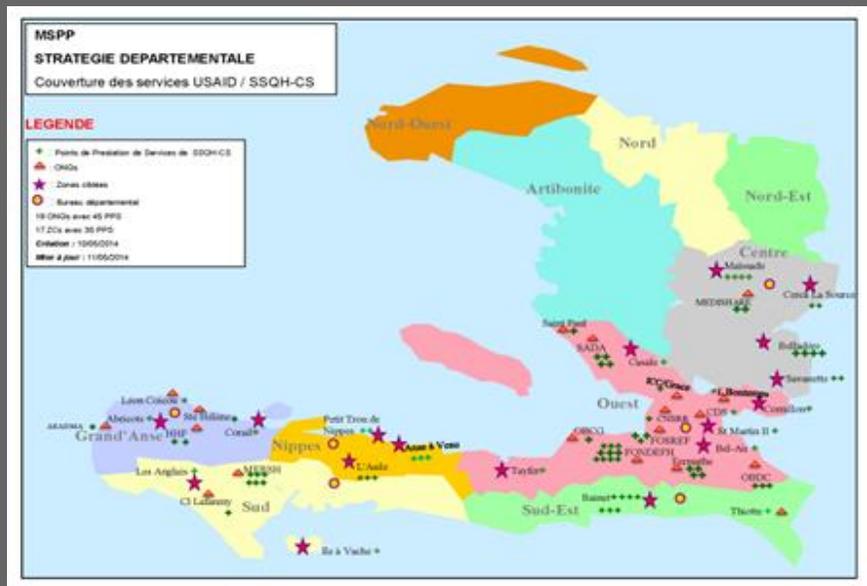


**USAID | HAITI**  
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# Services de Santé de Qualité pour Haïti Central and South (SSQH-CS) Contract No. AID-521-0-13-000 | I

FY 2014

Semi-Annual Report October 2013 – March 2014



April 2014

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## ACRONYMS

<b>ART</b>	Antiretroviral Treatment
<b>ASCP</b>	Agent de Santé Communautaire Polyvalent
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>CAN</b>	Centre Ambulancier National
<b>CDS</b>	Centres pour le Développement et la Santé
<b>COP</b>	Chief of Party
<b>CQI</b>	Continuous Quality Improvement
<b>DDS</b>	Direction du Département Sanitaire
<b>DG</b>	Directeur Générale
<b>DHIS2</b>	District Health Information System 2
<b>FP</b>	Family Planning
<b>FOSREF</b>	Fondation pour la Santé Reproductrice et de l'Éducation Familiale
<b>GBV</b>	Gender-based Violence
<b>GHESKIO</b>	Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes
<b>GIS</b>	Geographic Information System
<b>GOH</b>	Government of Haiti
<b>HCT</b>	HIV Counseling and Testing
<b>HIFIVE</b>	Haiti Integrated Financing for Value Chains and Enterprises
<b>LARC</b>	Long-acting and Reversible Contraception
<b>LMG</b>	Leadership, Management, and Governance Project
<b>LMS</b>	Leadership, Management, and Sustainability Project
<b>M&amp;E</b>	Monitoring and Evaluation
<b>mHealth</b>	Mobile Health
<b>MMT</b>	Mobile Mentoring Team
<b>MNH</b>	Maternal and Newborn Health
<b>MOU</b>	Memorandum of Understanding
<b>MSPP</b>	Ministère de la Santé Publique et de la Population
<b>NGO</b>	Non-governmental Organization
<b>OVC</b>	Orphans and Vulnerable Children
<b>PAP</b>	Port-au-Prince
<b>PDI</b>	Plan Départemental Intégré
<b>PEP</b>	Post-exposure Prophylaxis
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PIH</b>	Partners in Health
<b>PMP</b>	Performance Monitoring Plan
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>PPH</b>	Post-partum Hemorrhage

<b>RBF</b>	Results-based Financing
<b>SCMS</b>	Supply Chain Management System Project
<b>SDSH II</b>	Santé pour le Développement et la Stabilité d'Haïti II
<b>SSQH-CS</b>	Services de Santé de Qualité pour Haïti Central-South
<b>STTA</b>	Short-term Technical Assistance
<b>TA</b>	Technical assistance
<b>TB</b>	Tuberculosis
<b>TBA</b>	Traditional Birth Attendant
<b>UADS</b>	Unité d'Appui au Direction Sanitaire
<b>UAS</b>	Unités d'Arrondissement de Santé
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States Government
<b>WASH</b>	Water, Sanitation and Hygiene
<b>ZC</b>	Zone Ciblées
<b>ZL</b>	Zamni Lasante

## EXECUTIVE SUMMARY

The first six months of SSQH-CS focused on establishing foundations for solid programmatic implementation and submitting key deliverables to USAID. The team launched a rapid start-up, setting up the appropriate staff, equipment, facilities, and systems to guide the project forward. Key deliverables are on track. The Year One workplan, developed in close coordination with USAID and consortium partners, represents a clear roadmap for SSQH-CS and constitutes a negotiated approach with MSPP so as to increase their ownership and management of their health system. The project's Performance Monitoring Plan (PMP), based upon partners input and expertise and in coordination with USAID, was submitted. Service delivery has continued seamlessly during the transition between the Santé pour le Développement et la Stabilité d'Haiti II (SDSH II) and SSQH-CS projects. The SSQH-CS consortium partners with SSQH-North to ensure project uniformity in services and coordination with MSPP.

Other key elements for successful implementation are in place: negotiated MOUs with the six Directions de Département Sanitaire (DDS), 19 executed sub-contracts, and the consolidation of nearly 700 agents de santé working in the zones ciblées (ZC) under SSQH-CS management all lay the groundwork for sustained service delivery in the project's catchment area. In parallel, the project's monitoring & evaluation (M&E) unit drew from multiple national and partner databases and cross-checked the information to establish a comprehensive baseline. This was supplemented by two tiers of rigorous site assessments: the first assessed all sites providing HIV services in an effort to inform the establishment of the PEPFAR FY14 targets; the second extensively assessed all 80 health facilities in the SSQH-CS regions to provide the project a measure of services offered, facility and staff capacity, and referral network strength. The mHealth strategy, which will dialogue across all dimensions of SSQH-CS implementation, has launched and claimed early successes during Haiti's Carnival celebration; and the trainings of the ACSPs, the link between communities and health systems, are underway.



Community Health Worker using CommCare in the Community

As the project enters the second semester of Year One, the stage for strong programmatic implementation is set and many key actors are in place. Project focus will evolve from continued service delivery to incorporating quality and improving efficiencies in the Haitian health system.



## MANAGEMENT, MONITORING, AND ADMINISTRATION

The SSQH-CS supports site-level governance and accountability through structured mentorship and targeted technical assistance (TA) to build the capacity of facility managers and address gaps and deficiencies. This thrust aims to institutionalize functional and sustainable management systems that focus on quality assurance standards and continuous quality improvement. SSQH-CS also provides TA and support in partnership with the DDS and Unités d'Arrondissement de Santé (UAS) for service delivery, strengthening community-facility referral networks, and gap-filling at both the individual facility and network levels. Finally, SSQH-CS supports the development and implementation of host country systems, which includes the MSPP results-based financing (RBF) contracting mechanism for health service provider financing. This model, once finalized and piloted, will ultimately provide the basis for SSQH-CS' service delivery sub-contracting.

## PROJECT MANAGEMENT

SSQH-CS has met a number of key deliverables to date, and continues efforts ensure all Year 1 (Y1) deliverables are submitted on time. Below is a table highlighting each Y1 deliverable, its due date as established by the SSQH-CS contract, and its current status.

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

Deliverable	Due Date	Status
Environmental Mitigation Plan and Report (EMPR)	November 30, 2013	Submitted
Year 1 Work plan	November 30, 2013	Submitted
Performance Monitoring Plan	December 30, 2013	Submitted
Quarterly Financial Report	January 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 31, 2014	To be submitted
PEPFAR Country Operational Plan (COP), FY14		Submitted
PEPFAR Country Operational Plan (COP), FY15	October 31, 2014	To be submitted

## DEVELOPMENT OF YEAR 1 WORKPLAN

The SSQH-CS Year One workplan represents a joint and collaborative effort by the project consortium members, the writing of which was initiated during a partners' workshop in mid-October 2013 and sustained through its submission in December 2013. Following the initial partners' workshop, in which Pathfinder prepared and overview of the project, clarified partner roles and responsibilities, and fostered team building among the consortium members, SSQH-CS coordinated with MSPP and the individual DDS to gather input for the Y1 workplan. Pathfinder provided targeted short-term technical assistance (STTA) and remote support from HQ-based personnel to supplement the SSQH-CS team's efforts in preparing the Y1 workplan. In mid-November, the project submitted a first draft for comments ahead of the November 30<sup>th</sup> deadline, and in early December, SSQH-CS presented its Y1 workplan to the USAID team for review and discussion. USAID's comments and subsequent follow-up meetings with project partners formed the basis for a revised Y1 workplan, submitted on December 20, 2013.

While the final Y1 workplan represents the sole key deliverable per the SSQH-CS contract, many supplementary documents, which informed the workplan's development and content, were concurrently prepared by SSQH-CS during this period. Coordinating closely with USAID, in particular the HIV technical team, SSQH-CS prepared a HIV/AIDS activity narrative and comprehensive site list based upon the rapid 54-facility HIV service site assessment conducted during the week of December 9-13, drafted a response to USAID's specific questions on the first draft of the Y1 workplan (submitted December 15, 2013), and developed a response to USAID concerning the FY14 PEPFAR targets (submitted January 10, 2014). This latter piece involved close coordination with SSQH-North to develop individual targets per site for existing and proposed HIV/AIDS services for scale up.

The Y1 workplan includes indicators and activity coordination among the SSQH-CS consortium as well as those of other key partners, to attain expected results. Key interventions for this first year include: (1) establishment of a baseline, including a needs assessment<sup>1</sup> of all 80 health facilities covered by the project (which will define priorities and areas of needed investment to improve the health system), combined with analysis of data received from the USAID-Santé pour le Développement et la Stabilité de Haiti II (SDSH II) project and other data sources such as SPA and HealthQual; (2) training of providers at community and facility levels, production of BC materials, integration of community counseling and testing with family planning services, support for commodities management and availability, provision of households visits, OVC, strengthen and support community linkages with health facilities, (3) select and train community health workers to provide health services in the catchment areas of the supported health facilities; (4) capacity building and collaboration with DDS and UAS; (5) set up the foundation for mHealth activities which includes mBank, a referral system using COMMCARE, and applications for ASCPs.

#### DEVELOPMENT OF THE PERFORMANCE MANAGEMENT PLAN (PMP)

The SSQH-CS team developed the project's Performance Management Plan (PMP) in close collaboration with consortium members, USAID (in particular the HIV technical team), MSPP, and other USG projects (including SSQH-North, DHIS2, and SDSH II project. Central to the PMP's development were SSQH-CS efforts to obtain some databases from the MOH and other partners including SDSH II, clarify sources of data (with MSPP) and establish data verification processes with partners, review certain data collection forms, and harmonize selected indicators with SSQH-North. Initial indicator review and discussion occurred during the October SSQH-CS partners' workshop, during which each member shared input. Subsequent discussions with each consortium member helped to further refine the list of indicators, to identify tools that can be used for data collection, and to establish standard processes for data collection and recording. In support of USAID's development of the FY14 PEPFAR targets, SSQH-CS established specific, updated HIV/AIDS targets in a separate document and later folded them into the "final" version of the PMP.

The PMP summarizes the approaches that will be implemented to monitor performance and evaluate outcomes of the project, detailing indicators and tools to be used. Its approach emphasizes the production and use of timely, accurate, and verifiable data in the most cost-effective, comprehensive, and transparent manner possible. The set of indicators included in the PMP aim to assess change in quality and program performance and take into consideration anticipated findings from the needs assessment and structure of results-based schemes. Indicators were carefully selected to measure inputs, outputs, outcomes, processes, and impacts of program activities and accomplishments and places special focus on the expected results for the SSQH-CS project. The PMPs development involved the SSQH-CS M&E team with partner contributions.

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<sup>1</sup> Prior to the planned needs assessment conducted in March-April 2014, SSQH discussed with USAID and MSPP officials strategies to expand HIV treatment and care and in December 2013 conducted a rapid assessment of health facilities providing HIV services in collaboration with the International Alliance for Health and Social Development.

Currently, the SSQH-CS and North teams are discussing ways to harmonize and streamline indicators, in consultation with USAID, in order to offer a better platform to monitor the overall contribution of USG investments in the health of the Haitian people as well as to facilitate cross-country analysis and comparisons to better understand how regional dynamics and consequently tailored interventions have resulted in particular health outputs and outcomes.

## **OTHER KEY DELIVERABLES**

While the SSQH-CS contract included an approved Branding and Marking Plan, in March USAID requested that the project submit a revised, more detailed plan. Submitted on March 26, 2014 and approved shortly thereafter, the SSQH-CS Branding Implementation and Marking Plan articulates how the project will help USAID deliver its message “from the American people sponsored by USAID and supported by the Government of Haiti” and itemizes how, when, and in what manner the project will do so. Specifically, it outlines key project audiences and messages; the communications, branding, and marking strategies; and a project logo. It establishes how the project will use its logo in alongside those of MSPP and USAID|Haiti, and prohibits the inclusion of any individual SSQH-CS partner corporate logo, as per USAID regulation. The approved B&M Plan has been incorporated in all SSQH-CS partner subcontracts.

During this same period, SSQH-CS developed and submitted to USAID its USG FP Compliance Plan, which is currently under review. The development of this plan involved numerous meetings with USAID and other USG partners, including a FP Compliance workshop with USAID, SSQH-North, and the Leadership, Management, and Sustainability (LMS) project in March, during which the team established clear roles and responsibilities of each project, discussed how to set standards in training activities including common FP language to be used, and identified information sharing opportunities for all three projects. Subsequent planning sessions will focus on standardizing training materials and checklists for monitoring compliance at various project levels. Targeted STTA and remote support from Pathfinder HQ personnel helped the project’s FP Advisor and technical team amass all tools and resources developed on the subject, and prepare the narrative and activity matrix for the FP Compliance Plan.

The final project FP Compliance Plan was submitted in March 2014. It embraces Pathfinder’s rights-based approach to offering FP services and commodities, while complying fully with all USG requirements, including the 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.

Project-sponsored trainings in USG FP Compliance have begun and are detailed under Objective One.

## **COORDINATION**

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

At the project’s start up in October 2013, SSQH-CS met with the MSPP central leadership, including the Minister of Health and representatives from the different departments across Haiti, to introduce the project, help set the tone for collaboration, and ascertain Ministry expectations on this effort.

In coordination with the Minister of Health's cabinet, the Directeur Générale (DG), and members of the Unité d'Appui aux Directions Sanitaires (UADS), the body in charge of managing the DDS, SSQH-CS and – North presented the project and integrated its activities in the national action plans. The UADS appointed two point people for SSQH contacts at the MSPP, one for coordinating the project's technical activities and another for overseeing the management, laws, and budget issues.

In January 2014, the SSQH-CS leadership and technical team presented the project's mHealth strategy to USAID, the Minister and her cabinet, with further coordination and collaboration through February as the project prepared for the mHealth launch during Carnival. Subsequent meetings during the second quarter have led to the progressive understanding of the project by health authorities, who have continued their support of the project, thereby augmenting its potential impact. The project has also coordinated and supported MSPP in the preparation and launch of the National Family Planning (FP) campaign, which started in March 2014.

At the departmental level, the project visited each of the six DDS directors several times to discuss the project's orientation, collaboration mechanisms, and priority areas to be supported. On November 15, 2013, the project sent confirmation of support to continue service delivery at the zones ciblées (ZC) in each of the six departments, and by the end of February 2014, all six DDS had fully negotiated budgets and executed Memorandums of Understanding (MOU). An example of the MOUs is found in Annex 3. Key results stemming from these visits are the selection of technical activities to be supported by SSQH-CS during Y1, the confirmation of services offered and personnel working within the ZC, and the review and approval of department budgets, and the signing of memorandums of understanding (MOUs) for Y1.

The MOUs had originally been set for a 5.5 month period, sustaining support through April 30, 2014 and they are now being extended to the end of Y1. During this time, the project has supported DDS staff to perform supervision visits to the UAS and some health facilities and to conduct planning meetings. SSQH also agreed to maintain all contractors hired through SDSH II, comprising of more than 700 individuals.

## 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<sup>2</sup>.

## NGO SUBCONTRACTORS

After close discussion and coordination of how SSQH-CS would continue service delivery via NGO subcontracts with USAID and SSQH North, the project decided to continue the same level of service provided by SDSH II for a "bridge" period of 5.5 months, from November 15, 2013 – April 30, 2014. The primary purpose of this abbreviated subcontracting was to ensure service delivery while MSPP finalized the RBF mechanism the project plans to pilot.

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<sup>2</sup> Detail of this strategy is outlined under Objective 1 in this report.

The project sent introduction letters to all 19 NGO subcontractors in the six departments informing them of the new project and articulating its commitment to support service delivery. On November 15, 2013, all 19 NGOs had received new subcontracts under SSQH-CS with pro-rated budget ceilings based upon previous subcontract budgets under SDSH II. Final negotiated budgets for most were in place by the end of November, with only a couple final budget negotiations extending beyond this time, due to a delay in supporting documentation provision. USAID has received all Negotiated Memos for each of the 19 bridge subcontracts.

Since February 2014, the project has begun defining plans for continuing the subcontracts beyond the April 30, 2014 deadline. Given the MSPP RBF mechanism is not yet ready for a May 1 pilot (still awaiting finalization of the site selection and indicators); SSQH-CS – in consultation with USAID – decided to extend the bridge subcontracts through September 30, 2014. This next extension period, however, will introduce new deliverables, including individualized Continuous Quality Improvement (CQI) plans, monthly financial reports, and clarified performance targets. In March, SSQH-CS met with 18 of the 19 NGOs and explained the next phase of the subcontracts and their expected changes. Only one NGO was not present; the project followed up with this organization separately via telephone to explain the process. As part of the subcontract extension process, the project requested each NGOs to submit a brief technical proposal outlining how they provide services and a corresponding budget. Project team members have coordinated closely with the NGOs to answer questions and support the proposal development process. After the initial analysis of each NGO's facility coverage and general performance, the project requested a budget reduction of 7-8% from five. This was largely prompted by coverage redundancies and in one case, subpar performance during the first bridge period, and 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. This type of NGO cost-effectiveness analysis is an ongoing process that will continue beyond Y1.

#### USAID/SDSH II

In October and November, SSQH-CS met with the SDSH II team to discuss the new project, experiences and challenges during the latter's tenure, and to gather the SDSH II final year service statistics to use in the SSQH-CS baseline. SSQH-CS carefully coordinated with SDSH II, USAID, and SSQH North on the SDSH II asset disposition plan and transfer, and SSQH-CS received final resource custody 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.

#### USAID/HIFIVE

SSQH-CS has coordinated and strategized with the Haiti Integrated Financing for Value Chains and Enterprises (HIFIVE) project since December 2013 on options for collaborating on mobile money activities. By January 2014, the two projects had an MOU and SOW defined for a sustained partnership, and begun joint negotiations with telecom provider Digicel to establish rates and a contract.

In March, SSQH-CS submitted a concept note for the HIFIVE Catalyst Fund, which would provide a \$50,000 grant to SSQH-CS to support partners in the adoption of mobile money and procurement of telephones and tablets for CHWs and supervisors. The grant would support the provision of the equipment needed under SSQH-CS's mHealth strategy – specifically mobile phones and tablets but also solar chargers for ASCP and their supervisors. SSQH-CS would also benefit from HIFIVE's technical assistance to establish the necessary systems to ensure clients have the ability to cash out payments when delivered (via *Tcho Tcho*

payments). This Initial Proposal was accepted and in April 2014, SSQH-CS was invited by HIFIVE to submit a full proposal for the funding.

#### **USAID/LMG**

In early November, SSQH-CS met with USAID and the Leadership, Management, and Governance (LMG) project to discuss the current status of the RBF mechanism and the LMG achievements to date. During this time, SSQH-CS and LMG clarified roles and responsibilities and identified areas of future collaboration and potential overlaps in implementation of the RBF systems at the departmental level. The two projects discussed how to work with MSPP on RBF indicator harmonization and site selection, and specific strategies for the adoption of the RBF scheme, coordination of training activities, and approaches in rolling out the scheme once finalized.

#### **USAID/SCMS AND USAID/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. In March 2014, the projects furthered coordination on commodity quantification for FY14 and FP compliance plans. SSQH-CS submitted its USG FP Compliance Plan in March, per the request of USAID.

#### **USAID/DHIS2**

SSQH-CS has coordinated and strategized with FUTURES GROUP-DHIS2 project since December 2013. The two projects have an MOU and SOW defined for a sustained partnership, and have begun joint meetings with the MSPP. SSQH-CS is the first project in Haiti entering routine data into the new DHIS2 database. Further meetings and discussions are scheduled to review data entering, analysis and publication. SSQH-CS and FUTURES GROUP coordinated to ensure the availability of data collection tools at the site level in many departments in the Project's area.

#### **OTHER USG AGENCIES**

SSQH-CS met in November with USAID and CDC/Haiti technical staff on the HIV/AIDS program implementation strategy and current situation at facility level and global scaling up strategy at country level. This is of special interest for SSQH-CS, as the HIV and AIDS program is a national priority and is rolled down in all our supported sites. In February 2014, SSQH-CS coordinated with the CDC to receive HEALTHQUAL reports for SSQH-supported sites.

#### **SSQH-CS CONSORTIUM PARTNERS**

All SSQH-CS partners began working immediately with Pathfinder on the Y1 workplan in October 2013, with pre-subcontracts in place while final sub-contract details were negotiated. By January 2014, Deloitte, Dimagi, CDS, and FOSREF all had fully executed sub-contracts, with only PIH/ZL extending beyond this time as final details were negotiated. To date, only negotiations with partner Gheskio have yet to conclude with a signed subcontract, but the project and Gheskio have agreed upon an appropriate role for the organization. It is anticipated Gheskio will begin its implementation for the project during the second half of Y1.

In October 2013, partner CARE withdrew from the SSQH consortium and left a void in the technical areas of water, sanitation and hygiene (WASH), child protection, and nutrition. A replacement organization has been identified to fulfill the SOW and the project is coordinating with USAID on the approval.

In an effort to standardize processes and set expectations for all members of the SSQH-CS consortium, Pathfinder issued guidance to the team to outline the format and schedule for each partner in terms of technical and financial reporting, staff approvals, international travel requests/trip reporting, and success stories. Each partner writes a monthly update and shares two success stories annually in addition to having substantial involvement in contributing to key project deliverables such as programmatic and PEPFAR reports and annual workplans.

## OFFICE SET-UP, STAFFING, AND RECRUITMENT

### OFFICE SET-UP

In October 2013, SSQH-CS arranged to use a temporary office space within the Futures Group offices, and by November, a full search for a permanent space began. One was selected in December, and the project officially moved into its current Petion-ville location in January 2014. In Les Cayes, SSQH-CS identified a small office space, but decided to resume its search once it became clear the space could not fully meet the project’s needs. Unused portions of the lease amount were returned to the project by the landlord. In March, the project selected a more appropriate office space in Les Cayes and signed a lease.

Assets from SDSH II were fully transferred to SSQH-CS by January, including a number of vehicles, and the project procured additional IT equipment needed to make the two offices fully functional. A slight delay in receiving some IT equipment procured in the US occurred in February due to delays in receiving a required tax exemption letter from the Ministère des Affaires Etrangères et de Cultes. Despite the project receiving the letter, the GOH continued to deny the importation of the IT equipment. SSQH-CS requested the assistance of USAID and the equipment was eventually imported through the US Embassy in early April. While the project was successful in receiving the equipment, the prolonged process caused some delay in establishing a fully-functional office.

### STAFFING AND RECRUITMENT

The first six months of the project has seen significant time devoted to recruitment and review of the proposed project staffing structure by SSQH-CS management and Pathfinder HQ support. Recruitment efforts have been focused on bringing onboard the appropriate and skilled professionals, despite facing many barriers, including an imbalance between candidate qualifications and desired salary and/or compensation terms. The project’s candidate selection process includes three steps: short-listing of candidates based upon application review, candidate interviews, and final staff selection/offer. Final selections are made in coordination with appropriate partners and stakeholders. As the needs of the project have evolved, the SSQH-CS management team has reviewed and made necessary alterations to the organogram. All top advisors for each of the technical areas have assumed their post with the project, including the technical director (Central), FP, MCH, WASH, mhealth, HIV, TB, RBF, and M&E, with the only the technical director (South) and Finance and Admin Officer as the key positions yet to be filled. The current organogram can be found in Annex 1. Many partner staff have also reported for duty, and recruitment for the remaining vacancies is ongoing. Table 2 provides an overview of which SSQH-CS positions are filled, and which vacancies for which the project is currently recruiting.

Table 2: SSQH-CS Recruitment Progress To-Date

SSQH-CS – Central Office (PAP)			
Title	Status as of March 31, 2014	Title	Status as of March 31, 2014
COP	On duty	Communication Officer	Focus in Y2
Technical Director	On duty	Comm. Mobilization Coord.	On duty

Administrative & Financial Officer	Recruitment ongoing	CQI Specialist	Recruitment ongoing
Monitoring & Evaluation Specialist	On duty	Sr. Accountant	On duty
Contracts Officer	Consultant on duty	Accountant	On duty
Service Delivery Network Advisor	Recruitment ongoing	HR Manager	On duty
mHealth Advisor	On duty	Admin Assistant	On duty
MNH Specialist	On duty	Driver (5)	On duty
FP/AYSRH/Gender Advisor	On duty	Office Helper (2)	On duty
BCC Tech. Coordinator	On duty	Logistics Advisor	Consultant on duty
HIV/AIDS Advisor	On duty	IT Coordinator	On duty
Capacity Building Advisor (2)	On duty	RBF Officer	On duty
Commodity & Logistics Advisor	Final candidate identified	WASH Officer (pending USAID approval of partner)	Recruitment ongoing
Nutrition Officer (pending USAID approval of partner)	Recruitment ongoing	Child Protection Officer	Recruitment ongoing
M&E Officer	On duty	WASH Director (pending USAID approval of partner)	On duty
Child Health Officer (pending USAID approval of partner)	Recruitment ongoing	Admin and Budget Manager	Consultant on duty
Senior Driver/Fleet Manager	Recruitment ongoing		
<b>SSQH – South Office (Les Cayes)</b>			
<b>Title</b>	<b>Status as of March 31, 2014</b>	<b>Title</b>	<b>Status as of March 31, 2014</b>
Technical Director	Consultant on duty	BCC/Gender Coordinator	Consultant on duty
CQI Specialist	Recruitment ongoing	Drivers: 2	1 on duty; recruitment ongoing
mHealth Advisor	Consultant on duty	Admin & Budget Manager	Consultant on duty
Accountant	Final candidate identified	M&E Officer	Consultant on duty
Office Helper	Final candidate identified		

So far, SSQH-CS has filled 27 positions with permanent staff, eight with consultants pending approval for full-time employment, and 13 positions are still being actively recruited (including three having a final candidate selected). SSQH-CS continues efforts to fill one key position: Finance & Administration Officer. A strong candidate for the Technical Director – South position has been identified and SSQH-CS has brought him on as a consultant as a way to forward project implementation while allowing the project's management to temporarily evaluate the candidate prior to submitting to USAID for formal approval. Despite set-backs posed by a challenging project in a very complex situation that resulted in the early departure of some of the key staff, including the COP, the project has overcome many and now strongly forges ahead. Pathfinder's regional West Africa director agreed to take lead of SSQH-CS in January and Pathfinder and its partners were able to use well-skilled temporary personnel and HQ staff to implement the workplan and office set-up according to the timeline.

## CHALLENGES

While SSQH-CS has quickly established strong foundations for a smooth and successful project implementation, and has claimed several critical early wins in the first semester, several challenges persist and frame how implementation continues. SSQH-CS will continue to work with USAID on jointly tackling some of these together.

The unanticipated need to consolidate approximately 700 ASCPs under SSQH-CS has placed both an administrative and financial burden on the project. Since November 2013, project personnel have labored extensively to receive the full list of ASCPs from SDSH II and the DDS, cross-check it with individual DDS budgets, and devise a system of timely and efficient payment before the mobile money component is up and running. Critical to this process is establishing means to verify identities with workers and time worked. In March, project personnel had to physically tour all six departments and hand-issue 700 checks to workers. While this step is important to ensure that the DDS will be operational, it poses immense logistical and resource challenges. The financial impact is also staggering; it was not clarified prior to our contract with USAID that this would have to be covered and, as a consequence, was not considered in our original and approved budget. This financial burden has limited Pathfinder's ability to further invest in our partners and subcontractors for program implementation. This issue has been repeatedly discussed with USAID since November 2013.

Recruitment efforts have faced several significant challenges which have contributed to protracted candidate searches. The USAID restriction on compensating Haitian staff exclusively in Haitian Gourdes and not US dollars has caused several highly-qualified candidates to reject offers and pursue other opportunities. While the rationale behind this restriction may have good intentions, the result is that it severely hampers the project's ability to fill positions in a timely fashion with qualified and appropriate staff. Other recruitment challenges stem from budget constraints. Haitian wages show a dynamic market where high-skilled professionals are looking for better conditions all of the time. Such movement shakes the market and creates more offers than available professionals, which inflates final salaries due to competition. For certain positions, such as the Finance & Administration Officer, many of the qualified candidates are expatriates with unsustainable salary levels for the project, or are not available within a short period of time. Finally, some potential candidates who are based in PAP have been reluctant to take a post in the Les Cayes office without a lodging allowance, which conflicts with the project's budget and HR manual.

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 also slowed down operations. While the project holds the tax exempt letter from the office of the Ministère des Affaires Étrangères et de Cultes, it is still prohibited from importing essential items such as IT equipment on its own. While USAID has been very supportive in helping the team import equipment via the US Embassy, this extra step has its own process which further delays the arrival of goods and does not afford a long-term solution to the situation. It took the project four months to receive

the first shipment of IT equipment, and more is needed to meet the demands of a growing team and in the face of inadequate equipment from SDSH II.

PMP data collection has also proven to be a considerable challenge. SSQH-CS supports the use of national M&E systems such as MESI and DHIS2. Due to the iterative nature of the release of data by the MESI system, there are inconsistencies between what is reported by SSQH-CS and what can be verified in MESI. Furthermore, MESI reporting is still somewhat behind the evolution of indicators. Also, as DHIS2 has not yet rolled out to the DDS institutions, SSQH-CS is working with Futures Group to enter and verify all data being collected from the facilities through the MSPP reports. However, reporting by facilities is very inconsistent and many reports have proven difficult to track down, creating challenges in data completeness.

# TECHNICAL IMPLEMENTATION

## KEY FEATURES

The four objectives of SSQH-CS are interconnected and mutually dependent. Efficiencies and effectiveness in health service provision at the community and facility levels depend on critical changes in the health system that will:

- ✓ Optimize community health interventions by increasing coverage, reducing costs, and generating demand flow to higher service levels;
- ✓ Strengthen primary health care to impact improved health outcomes at lower costs for both community and facility levels;
- ✓ Invite the private sector to support quality improvement and system efficiencies at lower levels of health care provision, with support from mobile mentoring teams and adequate supervision;
- ✓ Utilize a strengthened referral network that will establish a flow of patients across the system and “rétroaction”;
- ✓ Be supported by proper policies, guidelines, commodities, and human resources that can adequately be managed at the UAS and DDS levels which will be supported and capacitated to enhance graduation at facility, NGO, and UAS/DDS over the course of the project; and
- ✓ Encourage accountability and efficiencies across the system through RFB schemes, quality standards, and a clearly articulated menu of services that are appropriately and competitively priced to favor high-performers, while making service provision sustainable and affordable for the MSPP in their goal of universal coverage.

To achieve the above-mentioned objectives and their interconnectedness, SSQH-CS adopts some key features that facilitate integration in a comprehensive model that provides and strengthens service delivery within a holistic health system approach.

## USING MOBILE TECHNOLOGY TO IMPROVE HEALTH SERVICES

SSQH-CS pioneers the use of mobile technology to support improved health outcomes in Haiti. The project integrates flexible and responsive solutions using mobile applications, including CommCare, a mobile decision support and case management application for health workers. 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 tablet, are used within the project.

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.

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 tablet 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: maternal and child health, (MCH), reproductive health/family planning (RH/FP), HIV/AIDS, Tuberculosis (TB), cholera, child protection, and gender-based violence (GBV). Applications are already prepared 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.

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.

So far, SSQH-CS conducted pilot home visits with an ASCP to collect additional data to improve the demo apps. A meeting with Fermathe's community health section and mission manager to prepare the piloting of the FP & MCH apps occurred in February 2014, and by March 31, the project launched the ASCP CommCare application with these two modules.

#### **CARNIVAL 2014**

In February 2014, SSQH-CS developed an emergency response mobile application for the national ambulance network, managed by the National Ambulance Center, for use during Haiti's Carnival celebrations. The application helps ambulances document and share information about patients with the referral hospital prior to patient's arrival to the facility. This communication network helped ambulances and referral facilities better prepare emergency care for patients. The project piloted the application communication network with five ambulances and one hospital in Jacmel, during regional Carnival festivities in the South East department on February 23. During the national Carnival celebration in Gonaïves (March 2-4), SSQH-CS equipped 28 ambulances, two first aid stations, and 12 hospitals with tablets and applications to improve communications and referrals during the events.

SSQH-CS has a four-pronged approach implementing sustainable mHealth solutions:

1. *Government Leadership and Ownership:* MSPP offers critical leadership for implementing mHealth interventions, providing content design, training, and integration of community health information systems. Through the management of content and solution designs, MSPP provides leadership and ownership to take activities to scale at a national level in the future.
2. *Integration with National HMIS:* While the national HMIS captures facility-level data, it lacks comprehensive community level data. SSQH-CS supports a more detailed and robust picture of the health status of the Haitian population by feeding community level data into the existing national health information systems.
3. *Public-Private Collaboration:* Through innovation and efficiencies, the private sector helps to ensure new mobile technologies are available. SSQH-CS collaborates with public and private sectors to maximize influence upon mHealth applications, using open-source platforms to allow MSPP, NGOs, and other stakeholders to utilize the applications at no cost. Technical assistance to project partners helps to bolster local capacity to build and configure the applications.
4. *Mobile Money for Financial Transparency and Inclusion:* SSQH-CS uses mobile technologies to make health-related financial transactions, including APCS payments. Mobile money can impact transparency and efficiency of financial transactions and to enable financial inclusion for the poor. SSQH partners with other USG-funded partners to facilitate mobile money payments. Sustainability is reinforced through the generation of market demand of mobile money as a method of financial transactions; SSQH-CS works with partners to create models, tools, client education materials, and mobile money systems that can be taken to scale nationally.



Presentation of CommCare to the First Lady

## ASCP TRAINING

During the second quarter, SSQH-CS organized the content and logistics for training ASCPs. An initial cadre of 67 selected ASCPs started trainings in March 2014, which will continue in their respective health facility catchment areas and in close coordination with community nurses. Those ASCPs already operating receive focused trainings in specific content areas either not covered in their previous trainings, or that have been challenging to master. Further ASCP trainings are planned for June and will reach a total of 400 ASCPs by the end of Year One. By December 2014, the project expects to deploy 1,000 trained ASCPs.

The SSQH-CS trainings are based upon the MSPP-approved curriculum; however, some adjustments to the material were made to strengthen its performance-based orientation, mainly on data reporting and inclusion of the mHealth component. Also, a careful review of the ASCP reference manual in February 2014 revealed a need to strengthen some of the content language around MCH, particularly around improved efficiencies of providing community-level health services for pregnant women and their newborns.



ACSPs trainings

All ACSPs trained and supported by SSQH-CS receive necessary materials and commodities to perform their work, including bags, flyers, contraceptives (pills and condoms), and other health promotion materials. The project expects ACSPs will be valuable resources to enhance health at the community level in expanded content areas such as WASH and GBV.

## SITE ASSESSMENT

The SSQH-CS team conducted a review of the 80 health institutions supported by the project across all six departments. The team began by compiling all data already available from previously conducted assessments, specifically the SDMA survey conducted by the SDSH II project and SPA led by the Institut Haïtien de l'Enfance pour le Compte du Ministère de la Santé. A review of these existing data sources helped ensure that the technical teams and M&E teams began the assessment process well informed about previous results. This step also helped minimize repetition of assessment questions asked at the site level, reducing the burden on health workers and facility managers.

This initial data review provided information used to develop an evaluation tool with qualitative and quantitative components. The tool focused on collecting information from sites that is not yet available through other sources as well as data needed to establish the project “baseline” for multiple key indicators. The capacity building team developed fact sheets for each site for all institutions, reflecting data available prior to the assessment. These site profiles will be completed after conclusion of the assessment, and will be one of the tools used to communicate site capacity to DDS, NGO, and IS counterparts. To facilitate data collection in the field, the SSQH-CS project developed a data entry application using CommCare platform on the SurTab device. Investigators conducting the assessment were able to enter data in real time, which allowed the team to better



monitor process and access certain information as soon as collected.

Assessors interviewing health providers

Conducting the assessment quickly required multiple teams of assessors in the field simultaneously. Short term staff were contracted through a competitive process and trained to represent the SSQH-CS project while conducting the assessment. The SSQH-CS team developed a clear description of necessary qualifications, advertised the position, selected candidates who met the criteria, conducted tests and interviews, and coordinated with the HR team to facilitate contracts. Additionally, these assessors were trained in the two-part survey methodology, including use of the questionnaire and the CommCare tool. This included a question-by-question review for clarification and confirmation of level of understanding of all team members. Additionally, the training highlighted the importance of certain topic areas and described the secondary objective of the assessment as an opportunity to introduce sites to project priorities. A practicum was led at six sites from the Ouest Department to pre-test the tool and provide quality assurance support and feedback to all assessment team members. Given the project's focus on sustainability and MSPP ownership, the team consistently included representatives of the MSPP/DDS in invitations for the practicum sessions and assessment activities. MSPP representatives (from the UADS in particular) accompanied the team throughout the process and reviewed the proposed tool. Further, the team provided official notification to the MSPP and health institutions to inform them of the calendar of visits of evaluation teams.

Logistical preparations for the site assessments started in February 2014, though consultations and preparation related to the tool development began at project start in October. Site assessments began on March 24 and concluded on April 30, 2014.

Assessment teams visited all 80 facilities in the project catchment area and met with facility and community representatives. Each team was made up of five people each, with one team per department to equal six teams total. Deployment of teams and logistical implementation were complex, but the team overcame these challenges and set a strong foundation for future project activities at the site level. The assessment provided a point of connection between SSQH-CS and the sites, and an opportunity



Assessors traveling to Ile de la Vache

for the extended team to introduce the core principles of the project.

As of the end of April, data was available from all institutions. Further, the use of mobile technology enabled immediate upload of results. This rapid access to data enabled analysis of quantitative data, and preliminary findings are included below. These findings constitute data from about half the partner facilities that had been uploaded as of mid-April. This initial analysis does not take into account the qualitative data collected by hand during the assessments since that data has not yet been transcribed into an analyzable format. An additional short term staff member will manually enter the information in the database before the end of May, and analysis of assessment findings will continue.

The project team has started preparation for subsequent planning and activities that will utilize the data collected. This includes developing tables for the SSQH-CS site database and refining requirements for the proposed post-assessment site report. Making the assessment data accessible and usable in the project database requires careful coordination and additional resources. The project team has developed an interactive data dashboard using Tableau, which will be shared with DDS counterparts to seek feedback on format and contents. The priority in these conversations will be to walk through findings in a participatory manner, and confirm utility of the assessment results for decision making.

Assessment results will also be used to inform the development of project activities, including prioritization of capacity building activities to help sites prepare for RBF implementation, improve management practices, and increase quality and availability of health services.

Table 3: Summary of Preliminary Findings as of April 16, 2014 of 50% of the SSQH-CS Sites

Site Data Summary	
Data from 27 sites had sufficient data to comprehensively analyze in terms of performance and coverage, and a limited number of sites have complete data but are yet to be conclusively identified due connectivity and case management issues. The project is in the process of resolving this through data cleansing.	
All 15 sites in Grand Anse and Nippes have been assessed, (some of Nippes sites are among those not yet conclusively identified)	Outstanding site assessment data is primarily from sites in the Ouest and Centre departments
Overall performance	
36/38 (approximately 95% of these sites) are ranked as medium performing	0/38 are ranked as high performing

	2/38 are ranked as low performing
Availability of MSPP minimum service package*	
<p>10/41 level 1 sites currently offer at least 75% of the MSPP minimum package of services for their respective level;</p> <p>No level 1 sites analyzed to date offer less than 20% of the MSPP minimum package of services for their respective level</p>	<p>31/41 (75%) level 1 sites currently offer between 20% and 75% of the MSPP minimum package of services for their respective level</p>
Services provided over the last three months (January – March 2014)	
<p>Relatively little variation in type of services provided over the last three months across departments between public and privately managed facilities and category type;</p> <p>Approximately 83% of all services provided included consultations with new and repeat FP users;</p> <p>The next most common type of service after FP was prenatal care (approximately 8% of all services provided)</p>	<p>Exceptions to this FP major rule were facilities under the Haitian Health Foundation (HHF), which provided mostly prenatal care, and did not provide any family planning consultations;</p> <p>Services offered the least frequently (per reporting) over the past three months across sites:</p> <ul style="list-style-type: none"> <li>○ Post abortion care: 45 total cases</li> <li>○ Sexual and gender-based violence, adults: 19 total cases</li> <li>○ Sexual and gender-based violence, children: 8 total cases</li> </ul>

## OBJECTIVE I

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

Table 4: Performance Indicators for HIV

Performance Indicator	Baseline Value	Target Y1	Achieved To Date FY14	% Achievement
<b>HIV</b>				
Number of pregnant women with known HIV status (includes women who were tested for HIV & received their results)	36,791	60184	20,291	34%
Number of HIV-positive pregnant women enrolled in PMTCT	439	1180	252	21%
Percent of HIV-positive pregnant women who receive ART to reduce the risk of mother-to-child transmission	89%	90%	89% (224/252)	89%
Number of HIV-positive pregnant women who receive ART to reduce the risk of PMTCT	470	1109	224	20%
Number of individuals who received Testing and Counseling services for HIV and received their test results	100,003	118555	61,325	52%
Number of HIV-positive adults and children receiving a minimum of one clinical service	12,263	9012	5,510	61%
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	2,189	3949	2,714	69%

SSQH-CS has maintained the support of the sites through the commitment and remarkable work of the facility and community health workers and the support and assistance of PEPFAR. Most indicators are on-track or close to being on-track despite the fact that some data had not been published by the time this document was authored. The sole indicator that is significantly off-track is the Number of HIV-positive pregnant women enrolled in PMTCT (21% of an aggressive target). We are planning to expand PMTCT prophylaxis services for the next five months to meet the annual target for this indicator. We will continue the strategies outlined in the technical document and work plan to meet the remaining HIV program indicator targets. Active mentoring and mobile teams will be deployed in the field to support the staff at the sites with strong involvement of community health workers, effective technical assistance from our partners.

SSQH-CS continued to adequately and successfully roll out the HIV interventions in the public facilities. While maintaining the provision of HIV services at the sites following approaches put in place by the previous SDSH project, most of the first six months of the project have been dedicated to site assessments and planning for the roll-out of services based on new schemes for community-based integrated quality HIV services with a strong focus on mentoring and coaching of site teams as well as UAS and DDS teams. SSQH-CS held several work sessions and meetings to set up targets for key aspects of the HIV program, including HCT, ART, PMTCT-option B+, OVC, early infant diagnosis (EID), both TB and TB-co infection, and pediatric HIV. Project work plans and performance monitoring plans were completed in which activities to support HIV services and expected results were clearly detailed. Targets were set for both the overall project and individual sites in all of the above areas.

In December 2013, SSQH-SC conducted a rapid facility assessment of HIV services offered at 24 sites in five departments (Ouest, Centre, Sud, Nippes, and Grande Anse) of Haiti. The findings of this assessment are intended to: 1) support validation of existing site inventories from the SDSH II Project and the Supply Chain Management System (SCMS) Project; 2) inform an evidence-based strategy for service improvement at SSQH HIV sites and 3) provide the project a real profile of the health facilities, including which HIV services they offer and how, facility catchment areas, and main bottlenecks to improve quality of services. With this diagnostic in hand, SSQH-CS has started and will continue to revisit its targets and planning to strengthen and expand services in selected health facilities including acquisition of equipment, optimization of human resources, revision of contracts as well as logistics for supplies and drugs, and strengthening referral systems to reinforce the continuum of care.

Results show that there are still problems with definitions related to characterization of HIV services and competing definitions according to various sources of information. The goal is to eventually reach a common understanding between, SSQH-CS, USAID, MSPP, and PEPFAR teams about the facilities that provide different services.

There are still some barriers for the provision of comprehensive primary health care services in the country that include: distinct logistics systems for tuberculosis and HIV (SMHC and SCMS); competition of human resources for disease programs; a minimum package of services not well-integrated, particularly the need to integrate family planning as a first step for PMTCT within HIV services. SSQH-CS will make additional efforts to implement a “smart integration” package for health care managers at facility and UAS/DDS levels in order to optimize opportunities for integration. SSQH-SC has already prepared plans to expand PMTCT—where there were concerns about the composition of services to classify a site as a PMCT provider—and ART to additional sites. In some of these sites, clients will be concentrated to one day per week in order to provide consultations in a more efficient way and optimize human resources. SSQH-CS will implement an aggressive approach through mobile mentorship teams following a networking approach.

During the bridge period, in accordance with MSPP guidelines, SSQH-CS has promoted and supported the provider-initiated testing and counseling (PITC) to all symptomatic or at-risk individuals as well as all pregnant women seeking care at our clinics. This “opt out” approach to case detection needs to be better integrated within primary care and women’s health. Antiretroviral therapy (ART) is offered to all HIV-positive pregnant women to prevent mother-to-child transmission of HIV (PMTCT). However, these high impact strategies need to be strengthened and expanded throughout our catchment area. Several mentoring activities have been carried out by short technical assistance teams in Les Anglais, Ile a Vache, Petit-Trou de Nippes, Hopital Bonne Fin and FONDEPH to support the delivery of care. Patient charts and registers were reviewed and follow up plans have been made. Staff at at Klinik la Fanmi and FINCA in Les cayes have participated in training sessions, with the HIV lead on the dissemination of SSQH-CS as a consortium is built on the efforts of many partners providing both implementation and technical assistance. The SSQH-CS collaboration includes a large group of local and international partner organizations. Centrally and at all the 28 sites, most activities occur in conjunction with local groups and institutions. SSQH-CS work occurs in partnership with several local NGOs, in addition to public MSPP clinics and facilities in the field.

The main partners providing technical assistance and normative are:

- The MSPP, who decides norms and guidelines;
- Pathfinder International for the integration of services and in particular FP with HIV/AIDS activities;

- Partners In Health & Zanmi Lasante who lead the TA on all areas of HIV services;
- FOSREF, who focus on MARPs, youth and adolescent; and
- CDS, who supports community-based strategies and training and a broad range of implementing partners such as:

In the South:

1. In Les Anglais and Ile a Vaches with the Ministry of Health through the health centers where we support integrated primary care in outpatient services including ART and TB treatment but only HCT at Les Anglais;
2. In Les Cayes Klinik La Fanmi provides HCT services ;
3. At Hopital Bonne Fin and FINCA, SSQH-CS supports comprehensive HIV services that include HCT and PMTCT services, antiretroviral drugs, laboratory tests and payment salary support for staff

In Grand Anse:

1. In Dame Marie with the Ministry of Health through the hospital, we support the provision of outpatient services including ART and TB;
2. In Jeremie, Klinik Pep Bon Dye offers outpatients HIV services but no TB treatment while in Ste Helene clinic PMTCT and HCT are available.

In the West:

1. In Port-au-Prince, the MOH clinic in Bel Air offers PMTCT and HCT;
2. FOSREF through its clinics: CEGYPEH in Christ Roi and Solino offers outpatients HIV services but not yet ART.

In Petion Ville OBCD through its clinics in Jalousie and Grenier offers HCT services.

1. In Fermathe, SSQH-CS supports community-based HIV services and refers them for ART to the Fermathe hospital;
2. In Delmas 31, ICC offers comprehensive integrated HIV services including, HCT, PMTCT, ART and TB treatment and diagnosis.
3. In Delmas 75 and Martissant, FONDEPH provides comprehensive HIV services including ART and TB treatment;
4. In Carrefour, OBCG offers HCT and PMTCT;
5. In Cite Soleil, the Sister of Charity through their clinic - CNSRR (centre nutritionnel soeurs Rosalie Rendue) offers HCT service.
6. In Croix-des-Bouquets, Lucelia Bontemps clinic offers HCT service;
7. In Montrouis, St Paul clinic offers HCT services;
8. In Cabaret, Sada Matheux offers outpatient ART and PMTCT services

In the Nippes:

1. In Anse a Veau, Petit trou de Nippes with the Ministry of Health, SSQH-CS supports the provision of outpatient PMTCT, HCT services and TB treatment and diagnosis;
2. In L'ASile, the MOH clinic offers HCT, PMTCT services, TB treatment and diagnosis

In the Central Plateau:

1. In Maissade, SSQH-CS support the provision of PMTCT services and HCT at the MOH clinic

SSQH-CS already identifies referral networks for additional services and sets up the process for reference and counter-reference. During the next six months, SSQH-CS expects to have 30 additional sites providing HCT; 8 sites for PMTCT, and 9 new sites providing ART. SSQH-CS has visited 24 sites and initiated the development of the site technical targets as well as the quantification plan for ARVs. Continuing and strengthening those activities are critical to set up a system for performance and sustainability. Logistical challenges (vehicles out of use) at the overall project level have hindered the mobility of our team in further aligning our vision and approach with the HIV national program, and analyzing and making site-focused recommendations accordingly. A multidisciplinary team approach will be considered. SSQH-CS was able to assist PNLs/MOH in the dissemination of the new national HIV care guidelines as well as produce its COP/PEPFAR plan for the current year. Coaching, mentoring and supportive supervision will seek to apply the existing protocols in SSQH-CS network for better patient care. In the adjusted work plan elaborated for the period, coach and mentors will be assigned to a group of sites for capacity building.

Table 5: Performance Indicators for Tuberculosis

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>TB</b>				
Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	57 per 100,000	67 per 100,000	98.9 per 100,000	165%
Percent of the estimated new smear-positive pulmonary TB cases that were detected under DOTS (case detection rate)	12%	15%	20.6%	158%
Percent of project-supported facilities that have adopted an infection control plan	TBD	60%	39.4% (26/66)	65%
Percent of patients receiving isoniazid preventative therapy	54%	67%	78.6%	131%

To date, SSQH-CS continues support to clinical sites in the provision of screening, treatment, and care for patients already diagnosed with TB, as well as those suspected of having it and those who are HIV positive. At the facility level, SSQH-CS supports sites in following the national TB protocol. While the project has yet to start implementation of specific activities beyond service provision to bolster TB results, certain strategies have been identified. One such promising strategy is the practice of a “cougher corner”, whereby patients with coughs suspected of being tubercular are invited to be screened, which helps to both diagnose the case while also physically removing the patient from other clients and protecting them.

Table 6: Performance Indicators for MCH

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>MCH</b>				
Percent of women who received 3+ antenatal care visits during pregnancy	48.2%	53.0%	57%	108%
Percent of births attended by a skilled doctor, nurse or midwife*	6.8%	7.9%	46%	
Prevalence of anemia among pregnant women	20.3%	19.2%	19.6%	N/A
Number of postpartum/ newborn visits within 3 days of birth	34,639	39,835	11,649	29.2%
Number of children under five who received Vitamin A from USG-supported programs	217,090	238,799	79,088	33.1%

\*Results limited to only 20 facilities that reported non-institutional births.

A large focus of SSQH-CS in the area of MCH during the first half year was supporting the dissemination of the new MSPP guidelines promoting state-of-the-art MCH interventions. Due to an absence of standardized MSPP training materials that are necessary for implementing quality standards, SSQH-CS developed a plan for a working group with the MSPP and NGO and partner trainers to review all relevant training materials for providers and identify any missing or inappropriate materials and take steps to fill the gaps. During the semester, the project trained 20 health providers from Fermathe Hospital on use of the partogram, a tool that enhances the quality of monitoring a woman’s labor.

Ensuring MCH commodity availability at project supported sites has also been an area of focus for the SSQH-CS team. The team coordinated with MSPP Family Health Direction (DSF) to analyze the supply chain of commodities (including Mgso4, iron, vitamin A, and immunizations) and fill gaps to avoid supply ruptures.

Traditional Birth Attendants (TBA), or *matrons*, play a critical role in ensuring pregnant women at the community level receive comprehensive pre- and postnatal care. When possible, they refer clients to facilities for care; at the community level, they are critical agents in helping women have healthy and safe deliveries. SSQH-CS provides support to TBAs in terms of incentives for referrals to facilities and supplies/commodities (gauze, caps, razors, soap, etc.) for safer deliveries at the community level.

Once the needs assessment is complete, the SSQH-CS project plans to design tailored activities for each level of health facility. Included in these individualized plans will be child health and nutrition activities.

Support for responding to obstetric emergencies aligned with the SSQH-CS project’s efforts to introduce a referral network in the Matheux Corridor. Spearheaded by the mHealth team, SSQH-CS introduced a strategy for strengthening the referral system in obstetric emergencies using CommCare Popozo in seven (7) sites during the second quarter. The SSQH-CS project has additionally provided TA to 12 sites on monitoring and supervising quality of obstetric care. During site visits and meetings with providers and ASCP, project staff discussed gaps in services and areas for improvement, as well as distributed protocols on MNH.

Other key activities this semester include: provision of MSPP registers [OBCG, FONDEFH (Marissant), and CMS de Petite Place Cazeau]; requisition of the Pentavalent vaccine and Vitamin A for OBCG, FONDEFH, and CMS de Petite Place Cazeau sites; provision of FP commodities for OBCG, FONDEFH (Martissant), and CMS de Petite Place Cazeau ahead of the national FP campaign; the development of a training plan on long-acting methods for LARC for FONDEFH (Martissant); acquired another standard-size waste disposal bin and supported the development of a waste management plan for OBCG. SSQH-CS also coordinated with sites in the West Department to ensure the availability of vaccines for child survival. This component will be strengthened with the community mobilization and large-scale ASCP deployment.

Table 7: Performance Indicator for Family Planning\*

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>FP</b>				
Percent of USG-assisted service delivery sites providing FP counseling and/or services	94%	96%	96.2%	100%

FP services represent the lion share of those sought by clients in the project catchment area. Preliminary findings from the site assessments indicate that the vast majority (83%) of services provided during the

second quarter (Jan – Mar 2014) were new and returning FP consultations. There is little variance of this trend across department, site type, or managing organization. Exceptions are limited to two facilities managed by the Haitian Health Foundation (HHF), Klinik Pep Bondye and Klinik St. Joseph, which predominantly provided pre- and postnatal, newborn, and postpartum care during the same period.

SSQH-CS began efforts to ensure project compliance with USG regulations on FP. In addition to submitting a full FP Compliance Plan (see “other deliverables” under Project Management), the project trained 32 project, partner, and NGO staff in USG regulations on FP Compliance using Pathfinder’s rights-based framework and legislative policy requirement materials. The SSQH-CS project identified additional groups to be trained, and will continue supporting and monitoring FP compliance across all areas of the project. The SSQH-CS staff planned the incorporation of the Tiaht Amendment and other FP legislative requirements in the ASCP trainings. During the second semester, SSQH-CS will translate the FP manual on compliance into French and Creole and use it to further train staff from partners and contractors.

The SSQH-CS project is a member of the National FP Committee for the organization and impact evaluation of the National FP Campaign. The project has played an important role in helping develop content and plan logistics for the campaign’s launching. Project-developed sketches, prepared and presented by FOSREF’s Youth Main Theatre Troup, with FP messaging were showcased at the FP Campaign launch in Les Cayes and Jacmel. So successful was the theatre sketch, that the Minister of Health and First Lady of Haiti requested it be used (the song & choreography) for the entire national campaign. The SSQH-CS project will adapt the sketch into video format for reproduction and distribution to all health sites in the country. Radio spots disseminated project-supported FP messages throughout the country.

The SSQH-CS project has developed other key FP IEC materials in coordination with MSSP for the national campaign. Materials include the printing of 10,000 campaign-themed t-shirts; 10,000 brochures and 20,000 leaflets for distribution at the 80 health sites, plus flyers and banners advertising community meetings to discuss FP campaign activities. In three project-supported departments of Nippes, Sud, and Grande Anse, SSQH-CS participated and supported “Les Tables Sectorielles” to mobilize stakeholders in the launching of the National FP Campaign.

The SSQH-CS project understands the importance of maintaining a regular stock of a variety of contraceptive methods to ensure availability and free choice. To support this, the project participated in monthly coordination meetings with LMG on the availability of FP commodities at site levels, including youth-friendly sites sponsored by partner FOSREF. Plans are set to upgrade 18 sites (three per Department) to offer permanent methods (vasectomy and tubal ligation) and refresher trainings for health providers of 30 sites on FP counseling and intrapersonal communication.

## DEVELOPED A FP DEMO MODULE FOR USAID VIDEO TO CONGRESS

Responding to a request from USAID to shoot a promotional video for the US Congress at one of the project-supported sites, SSQH-CS trained developed and trained some ASCP in the use of the CommCare FP demo application in her daily activities. The project prepared the staff of CMS Petite Place Cazeau for the filming and participated in the USAID video shoot at a rally post at Carradeux.

Table 8: Performance Indicators for Gender-based Violence

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>GBV</b>				
Number of people reached by a USG-funded intervention providing GBV services	175	201	TBD	
Number of health institutions providing clinical assistance and referrals of child protection cases to legal and social services	28	31	TBD	
Number of children reached by child protection services	TBD	Increase by 15%	TBD	
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	801	TBD	TBD	

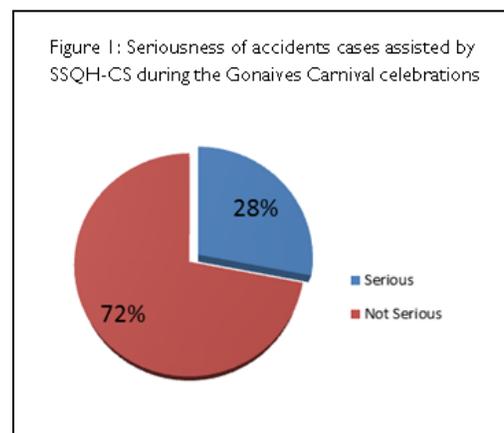
With the departure of partner CARE and the pending approval of a replacement organization to provide GBV and child protection technical assistance, GBV activities have had a delayed start. However, SSQH-CS has identified key staff to work in coordination with partner FOSREF in these two content areas.

Table 9: Performance indicators for Critical Care Services

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>Critical Care</b>				
Percent of project-supported sites certified to serve as critical care stabilization centers*	15	Increase by 5%	15	

\*Preliminary results based on facility assessments

In February, the SSQH-CS project responded to 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 SSQH-CS project piloted the activity using 50 dual-SIM tablets (Surtab), made in Haiti and which provided 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. Staff downloaded data every two hours, analyzed and shared it with key stakeholders.

Prior the Jacmel celebration, SSQH-CS collaborated with MSPP, CAN, the Sud-Est Departmental Delegation, 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 and referred them to the hospital as needed. Ambulances received and provided care for 28 persons, out of which eight were brought to hospital. Two additional cases were brought to hospital directly by the fire department, but were not recorded the system as they fire department staff did not have a tablet. One ambulance stationed outside of Jacmel in Carrefour Du Fort did not receive any cases and therefore did not use the application.

In Gonaives, SSQH-CS collaborated with MSPP, CAN, OFATMAMS, and the Clinique de la Première Dame to pilot the application, supplying tablets and training staff from 22 CAN ambulances, two CAN First Aid Stations, and the Clinique de la Première Dame. Information entered on 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.

All groups entered data from 5 PM - 6 AM daily during the celebration. SSQH-CS staff monitored the data in real time and prepared combined reports, which was submitted 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. It is important to note that this data does not represent all of the persons treated during Carnival, as not all care providers were equipped with a tablet and application.

A total of 303 patients were seen and treated from 5 PM Sunday March 2 through 5 AM Monday March 4, 2014. Sixty-three (63) cases were received and transported by the ambulances; 141 were treated at the Clinique de la Première Dame; and 99 were treated at the CAN first aid stations. Out of 303 clients, there were slightly more males (n=161) than females (n=142), and 36 were 18 years or younger.

Out of 299 persons for whom the type of case was specified, there were slightly more (n=157) medical conditions, including one childbirth. Another 142 persons were treated for trauma. The majority of the consultations occurred within the first 24 hours of Carnival, and the number of persons seeking care tended to increase at night, mostly from 1AM - 6 AM.

A total of 22 ambulances used the application during the Carnival and 63 clients were transported during 50 trips. The majority of the cases were not serious. There was one major car accident involving 7 people on Sunday March 2, 2014 and others on Tuesday March 4, 2014.

The ambulance attendants were required to refer any persons they brought into care. Roughly 40% were transported to first aid stations, and the other 60% to the hospital. First aid stations referred about 13% of their cases to the hospital, whereas la Clinique de la Première Dame, manned by physicians, sent less than 5% on for more intensive care.

The ambulance application was designed to capture the GIS location where of the ambulances collected clients. While not all ambulances were able to capture the GIS information due to problems with the network, a total of 15 GIS locations were captured, as depicted below.

Figure 1: Ambulance Client Contact Locations



Figure 2: Ambulance Client Contact in Gonaïves

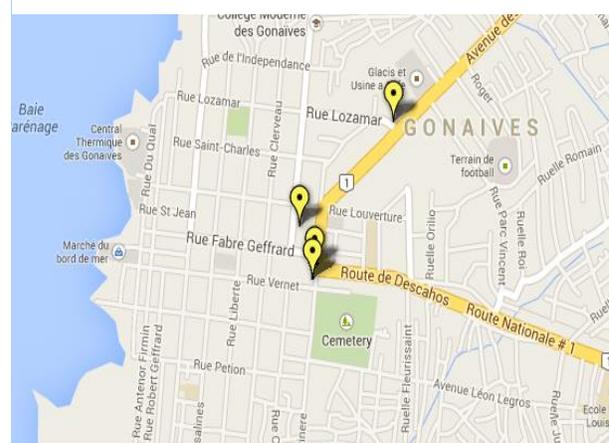


Table 10: Performance Indicators for vulnerable groups

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
<b>Vulnerable groups</b>				
Number of sites providing care and support for vulnerable groups*	27	30	27	

\*Preliminary results based on facility assessments

A recent change in the definition of vulnerable groups for PEPFAR affects data captured in the component. Some key affected populations, such as sex workers, intravenous drug users, men who have sex with men, and other groups including orphans and vulnerable children (OVC) were reclassified.

During the first semester, SSQH-CS has mainly provided vaccination and nutritional support to OVC. Next steps include working at the community level to establish facility boards to operate as watchdogs for service improvement.

## OBJECTIVE 2

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

Table 11: Performance Indicators for Objective 2

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
Number of CHWs per catchment population of USG-supported health referral networks	511	1,200	747	62%

#### CONTINUOUS QUALITY IMPROVEMENT

SSQH-CS recognizes the need to establish a common understanding of CQI across all stakeholders, including the project itself as well as MSPP, in order to be effective. While the project works to select a point person to lead this effort and develop the CQI component, important strides have been made already. The site assessments have gathered preliminary data on CQI processes and project staffs have set up mechanisms in the NGO subcontracts and DDS MOUs for the May 1 – September 30, 2014 period to include requirements on developing and following individualized CQI plans. Planning for how CQI will be incorporated and measured in the RBF scheme will occur in the second half of the year.

Preliminary results from the site assessments show that only 10/53 sites (19%) responded that they receive a counter-referral after referring a patient, and only 12/55 sites (22%) responded that they send a copy of the file reference in the annex to the institution that receives the patient. This two-part question serves as a “proxy” for the capacity of the site related to referrals, given that referral expectations differ across site types. The assessment data also yields promising results related to the consistency of service provision at the sites. Ninety-one percent (91%) of sites (50/55) offer all services, every day.

SSQH-CS will ensure that providers and administrators have a clear understanding of the role of each facility in the network and guidance on how to follow protocols e.g. for normal and emergency deliveries. SSQH-CS will work closely with staff to build their capacity to improve the quality of services along the continuum of care. Through training, coaching, protocols, and job aides (including algorithms), the staff will increase their ability to receive referred clients that includes case management through the reception and recording of referrals in patient records, registers and CommCare, and the assurance of the counter-referral portion of the loop to inform the referring facility and/or the ASCPs on health outcomes. Successful completion of the referral/counter-referral system is part of the continuous quality improvement plans. Key managers and other stakeholders will now be oriented on how to use data collected through mobile applications to improve preparedness and management of emergencies and high complex cases that requires secondary and tertiary level of care.

GeneXpert is not widely available to run rapid TB tests and to identify resistant strains. PIH has one machine and Gheskio has eight. SSQH-CS has received information that PEPFAR still has four machines that could be used in a rotational basis.

### OBJECTIVE 3

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

Table 12: Performance Indicators for Objective 3

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
Percent of project-supported sites maintaining auditable monthly financial reports*	66%	100%	66% (42/64)	66%
Percent of project-supported sites implementing continuous QI plans*	35	100%	35	35%
Percent of project-supported sites that have a system for documenting and following up on identified issues as part of continuous QI plan*	51%	70%	51% (33/65)	73%

\*Preliminary results based on facility assessments

The SSQH-CS project will strengthen the health system at the primary health care level by applying a phased graduation approach focused on mentorship to build DDS and UAS management and oversight capacity while strengthening facilities' technical and management skills to improve service coverage and quality. SSQH-CS' mentorship approach is based on PIH/ZL's with a mentoring structure within MSPP to improve health facility performance and supervision practices of UAS/DHDs. The graduation approach is closely linked to the site categorization matrix, used for project planning and performance monitoring (Figure 4).

The graduation approach takes into account a continuum of site maturity in service delivery, administration, and management. Placement of sites on the matrix is informed by measurement service delivery performance and service delivery coverage. The team is currently calculating performance and coverage measurements based on SPA data and results from the SSQH-CS site assessment process to categorize sites on the matrix. The management capacity of sites is assessed using a combination of SPA, SSQH-CS site assessment, and maturity model data to align management and service delivery performance. SPA and SSQH-CS management data are currently being analyzed; maturity model data collection is targeted for next quarter.

Categorization determines a site's graduation status. Sites classified as high performance/high coverage, high performance/medium coverage, or medium performance/high coverage qualify for support from Mobile Mentorship Teams (MMT). MMTs, under direction of the UAS or DDS, will provide onsite mentorship to support service quality and management improvements.

To transition to a higher stage, facilities will be supported to improve in a range of areas. MMTs will provide on-the-job training and mentorship on administrative, management, clinical skills, and CQI processes. Specifically, mentorship will include:

- 1) application of practices and case management for quality service delivery; 2) development of new skills and greater understanding of CQI for integrated care; 3) gathering and sharing best practices with an emphasis on institutionalization; and 4) linking mentors to mentees' achievements for recognition and accountability.

Once a site reaches high performance and at least medium coverage, they will be considered “graduated”. Once graduated, these facilities will no longer receive project technical assistance, but will be qualified to mentor lower-performing facilities. The team is currently exploring incentives for mentor participation; potential ideas include the use of RBF payments as part of this incentive scheme. Design and deployment of incentive schemes will be coordinated with UAS’ and DDS’.

The graduation approach for DDS/UAS will follow a similar mentorship structure. By periodically accompanying MMTs on facility oversight visits, UAS’/DDS’ will receive mentorship to more effectively provide oversight to the referral network and achieve graduation. Graduated UAS and DDS’ will mentor weaker UAS’ and DDS’, benefiting from resulting public recognition and access to resources.

	High Performance	Medium Performance	Low Performance
High Coverage (>50%)	A MMT (CB, CQI)	B MMT (CQI, CB)	C Training
Medium Coverage (40-50%)	D MMT (CQI, CB)	E Training	F Focus for Y2
Low Coverage (<40%)	G Training & CHWs	H Focus for Y2	I Focus for Y2

**Performance =** Combination of quality, service delivery and the capacity to solve health problems

**Coverage =** Catchment area population and uptake of services

**MMT=** Mobile mentorship team

**CB =** Capacity Building

**CQI =** Continuous Quality Improvement

Figure 3: Matrix of support strategy to health facilities according to their performance and coverage

The SSQH-CS capacity building team introduced core facility management, financial management, and data management principles and the SSQH-CS capacity building methodology to health facility and UAS staff during recent site assessments. The local Capacity Building Advisors trained 30 short-term evaluators in the SSQH-CS capacity building methodology and prepared them to articulate this approach to UAS and health facility staff. These assessments serve as a baseline to support the overarching counterpart-driven capacity building methodology that will pave the way for future performance improvement interventions tailored to the needs of each site. Analysis of the findings of these assessments and the stated needs and goals of UAS and health facility staff will inform the preparation and execution of future capacity building activities.

As discussed, the SSQH-CS team’s site assessment tool considered existing SPA data during its design phase. To the extent possible, the team avoided including questions that had already been asked on previous assessment such as the SPA. However in some cases, small duplications helped to emphasize to facility staff the training, materials, and equipment required to deliver quality health services. The team was also able to leverage existing SDSH II data in pre-assessment profiles, to familiarize assessment team members with a facility’s current state prior to assessment. As expected, existing data was of varying quality and completeness, and use of this data required flexibility and at times, data creation.

Performance and coverage measurements that inform site categorization are based on SPA data and results from the SSQH-CS site assessment. Sites are benchmarked based on these measurements.

The management capacity of sites also uses a combination of SPA, SSQH-CS site assessment (supplemented by maturity model data) to classify management performance and align this with service delivery performance. The project continues to find that existing data in many cases helps to supplement assessment data (as in the case of SPA data which helps to measure provision of the MSPP minimum package of services).

Unfortunately, the project did not receive HealthQual data in a timely-enough manner to incorporate it into the assessment process. However, HealthQual data will be used to validate site categorization whenever possible, and will be leveraged to the extent possible in implementation, given its significant role in the existing health system. HealthQual data will also likely be incorporated into data management and use efforts at the facility and UAS/DDS levels.

Some preliminary results show for the sites for which assessment data has been collected and analyzed to date, 29/37 (78%) of sites are ranked as medium performance and low coverage. This means that based on data available to date, these sites would be characterized as low functioning sites without the capacity to serve on a mobile mentorship team (MMT), or the capacity to add or expand services. These sites would not be a focus for SSQH-CS project capacity development efforts until year two. One site characterized as medium coverage and low performance would also not be a focus until year two. A limited number of sites (6) would receive training through the end of year one and into the beginning of year two based on categorization, while only one site analyzed to date qualifies as having the performance and coverage necessary to serve on an MMT (this site is the Casse health center without beds).

Only one site meets all 15 quantifiable RBF site selection criteria proposed by the project; this site is the Casse (Lahoye) health center without beds. Thirteen (13) out of 45 sites meet at least 80% (12/15) of the 15 quantifiable RBF criteria proposed by the project.

## OBJECTIVE 4

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

Table I3: Performance Indicators for Objective 4.

Performance Indicator	Baseline Value	Target Y1	Progress To Date	% Achievement
Percent of project-supported sites that are addressing recommendations from site visits*	51%	50%	51% (33/65)	102%
Percent of health facilities providing services in compliance with the national norms*	92%	50%	92% (55/60)	184%

\*Preliminary results based on facility assessments

The SSQH-CS project is working closely with the Contracting Unit of MSPP, LMG, and the World Bank to implement the national RBF scheme, which aims to increase utilization of health services, improve referral systems, and improve quality of care.

To ensure successful roll-out of the RBF scheme, the team developed a phased-approach which includes the following components: planning, preparation, and implementation. From November 2013 – April 2014, the team focused on the first phase - planning. It should be noted that while Haiti has a long history of piloting RBF schemes, this is the country's first attempt to move RBF from scheme to system. It represents a fundamental shift in a number of areas including financial management, DDS supervision, data management, and quality of care. As such, planning and preparation are critical to ensure integration of RBF with the health system.

Phase 1 – Planning: The objectives of this phase include selection of RBF indicators for year 1, finalization of site selection criteria, development of Year 1 budget, participating in putting in place the RBF pilot experience in the North East, and development of a detailed implementation plan. To this end, the team worked closely with the contracting unit within MSPP to refine quality and quantity indicators for different levels of care (i.e., health posts, health centers with beds, and health centers without beds). The purpose of this is to ensure that the facilities are not penalized for services that they do not offer.

In particular, the team consulted with technical experts (HIV, TB, Maternal and Child Health, WASH) within SSQH-CS and MSPP to define quality and quantity indicators appropriate for each level of care. Based on extensive consultation, the team developed and presented two sets of RBF indicators to MSPP. In turn, MSPP agreed to implement two packages: one for health posts and facilities without bed, and another for health facilities with beds.

In addition, the team developed RBF “readiness” criteria to guide discussions with DDS on selection of sites to be included in Year 1 roll-out. The core criteria include 1) financial management and 2) data management. Financial management refers to health facilities’ ability to manage basic accounting and the availability of a bank account to receive RBF incentives. Data management refers to the availability of key registries and patient record system that will allow the verification team to cross-check quantity of services provided. Health facilities that demonstrate competency in these two areas will be placed in a pool eligible to be selected as part of Year 1 implementation. For the health facilities that do not meet the core criteria, the team will develop a targeted capacity building plan in preparation for Year 2 roll-out. Based on preliminary analysis of the site assessment data, less than one-third (28%) of health facilities currently meet a majority (80%) of the core criteria.

Finally, in April, MSPP approved the RBF unit price. The team is currently working to Year 1 budget and aims to present the budget to USAID and MSPP in May-June. Looking forward, from June to October, the team will focus on phase two of the implementation - preparation. During this phase, the team will work closely with health facilities and Departments to prepare them for RBF roll-out. Activities include RBF training, mock-RBF visits at health facilities, and development of job-aids and standard operating procedures.

The project capacity building approach was shared among the project partners to develop a common understanding of the goal and a common language for all the technical areas of the project. As a second step, the overall approach was provided to the UADS representatives who gave input on the approach, highlighted priority areas for action, and recommended strategies for engaging with each of the distinct DDS entities. The SSQH-CS Capacity Building team worked closely with both the central level of MSPP and the departmental level to create a strong and positive relationship with the MSPP.

This win helped the team to develop a realistic and relevant budget to support key governance and leadership activities at the departmental level. Following this initial collaboration, activities are now underway to launch the capacity building process at the DDS level. Activities have been scheduled for May and June 2014, including an assessment of management capacity of the DDS entities as well as tailored workshops to develop new UAS entities and reinforce existing ones.

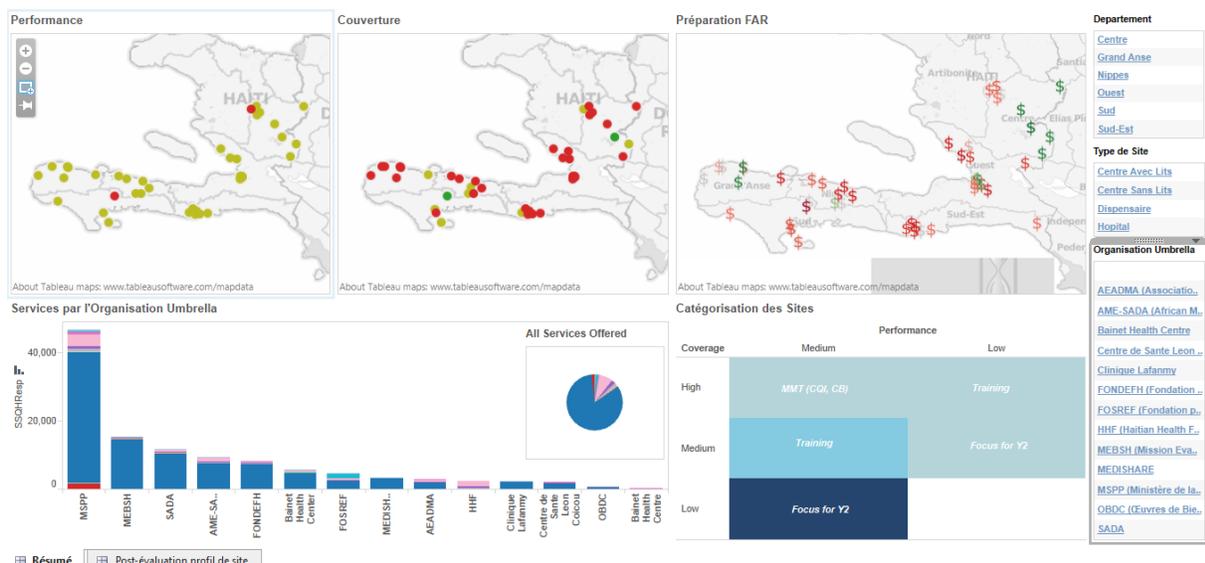
Haiti’s health system is rich in data sources, from historical indicator results to numerous studies and evaluations such as SPA, SSQH-CS’s own HIV Rapid Assessments, and the on-going site capacity assessments. Its greater challenge is finding ways to make the wealth of information useful and actionable for the various levels of the health system from facilities to the central level and donor teams. SSQH-CS plans to provide greater transparency into health system information and facilitate interpretation of these data sources to maximize measurable performance improvements.

Previous experience in other countries as well as recent experience in Haiti has demonstrated that the use of visualization can be an effective mechanism to promote organizational culture of data analysis and use. Accordingly, In addition to a complete site assessment report, outputs of the assessment data analysis process will include a site database (to be maintained and used moving forward), an interactive visualization of aggregate assessment data and site-specific post-assessment profiles. The partner will also explore this type of reporting at the facility level, to support health managers.

In addition, the project is in the process of coordinating closely with the team responsible for implementation of DHIS2, and is in the process of establishing a plan for rolling out DHIS2 at the DDS level. The project anticipates that support to the DDS and UAS in the areas of data management and use will include supporting the design of standard dashboards and reports that satisfy the strategic and management information needs of health managers, though these activities are not yet underway. Additionally, benchmarking facilities against their peers and providing routine feedback mechanisms to process owners such as facility teams will help them understand service quality and performance expectations. It will also help facilities realize how superior levels of the health system use data to inform decision-making. We will assist DDS and NGO teams to execute these activities with their facilities. Second, the project databases – both the site profile database as well as the M&E database – will be accessible by all program staff and will track site performance over time. Standard site profiles and performance information will be extracted before our program teams visit sites to help inform the activity prioritization process.

To facilitate country analysis, SSQH-CS implemented and process its databank using Tableau, which allows not just an interesting capacity to analyze data points, but also to generate analytical dashboard as in the figure below to contribute to allow a strategic display of information to the decision making process.

Figure 4: Example of dashboard view to the health assessment databank



Finally, we are planning to research the links between certain best practices and high performance. For example, if we see particular processes being observed in PMTCT programs that are correlated with high PMTCT results, we will share this information with health system stakeholders and seek to replicate those

processes in lower performing facilities. These strategies will assist Haiti's health system to extract maximum value from its wealth of data sources, something that has been lacking to date.

## SUCCESS STORIES

### ***mCarnival: Improving health at Carnival in Haiti using mobile applications***

In February 2014, the Ministère de la Santé Publique et de la Population's (MSPP) and the Centre Ambulancier National (CAN) asked SSQH-CS and USAID to develop a mobile solution for the 2014 Carnival celebrations in Jacmel and Gonaïves that would respond to the challenges of communication and referral during health emergencies. In response, SSQH-CS designed three mobile applications to connect ambulances and hospitals so that they could share case information. These applications permit the ambulance teams to collect key information about a patient and an accident and transmit that information to a hospital while en route to the facility; provide hospitals with patient information prior to the arrival of the patient; and register data on patients treated at *points fixes* (first aid stations).

SSQH-CS purchased 50 dual-SIM tablets (Surtab) made in Haiti for this pilot implementation. The dual-SIM provided the ability to access both Natcom and Digicel services in order to ensure network coverage during Carnival. Of the 53 CAN ambulance staff initially trained, 10 were assigned to the Jacmel Carnival and 22 to the Gonaïves Carnival. SSQH-CS provided refresher training for CAN ambulance staff prior to both Carnival celebrations. SSQH-CS staff developed a dashboard reporting system, and analyzed and sent data every two hours to the key stakeholders involved in the project, providing real time data on health emergencies occurring during Carnival in the Jacmel and Gonaïves areas.

A total of 303 patients were seen and treated from 5 PM Sunday March 2 through 5 AM Monday March 4, 2014. Sixty-three (63) cases were received and transported by the ambulances; 141 were treated at the Clinique de la Première Dame; and 99 were treated at the CAN first aid stations. Out of 303 clients, there were slightly more males (n=161) than females (n=142), and 36 were 18 years or younger.

The ambulance attendants were required to refer any persons they brought into care, transporting roughly 40% of patients to first aid stations and the other 60% to the hospital. First aid stations referred about 13% of their cases to the hospital, whereas la Clinique de la Première Dame, manned by physicians, sent less than 5% on for more intensive care.

The implementation of the CommCare emergency response applications was successful overall, though the short timeframe for the design and implementation of the applications presented challenges in preparing all the teams, particularly the hospitals, to receive patients using the CommCare applications. For future Carnivals, it will be helpful to spend more time orienting hospital staff on how to use the application in order to better complete the referral loop.

The network coverage and reliability during mass events such as Carnival presented additional challenges due to the high number of people using the system at the same time. The low level of internet and network coverage also posed a barrier for the nightly real time data monitoring and report generation. SSQH-CS staff gratefully accepted the use of the Presidential wireless internet connection to accomplish the reporting, which needed to be transmitted every two hours. Likewise, the low network coverage impeded the collection of regular GPS readings from the ambulances.

Overall, the pilot project using CommCare to document emergencies and to facilitate the ambulance and first aid services during Carnival was a success. Although the data collected through CommCare represents only part of the cases that were treated during Carnival, the pilot proves that this type of emergency response support and its data collection during a large event like Carnival is not only possible but of great value.

## **CSS Thiote**

It is not uncommon for community health workers in Haiti to face maternal deaths during their rounds. For this reason, maternal health features as one of the most important components of SSQH-CS in an effort to reduce maternal deaths.

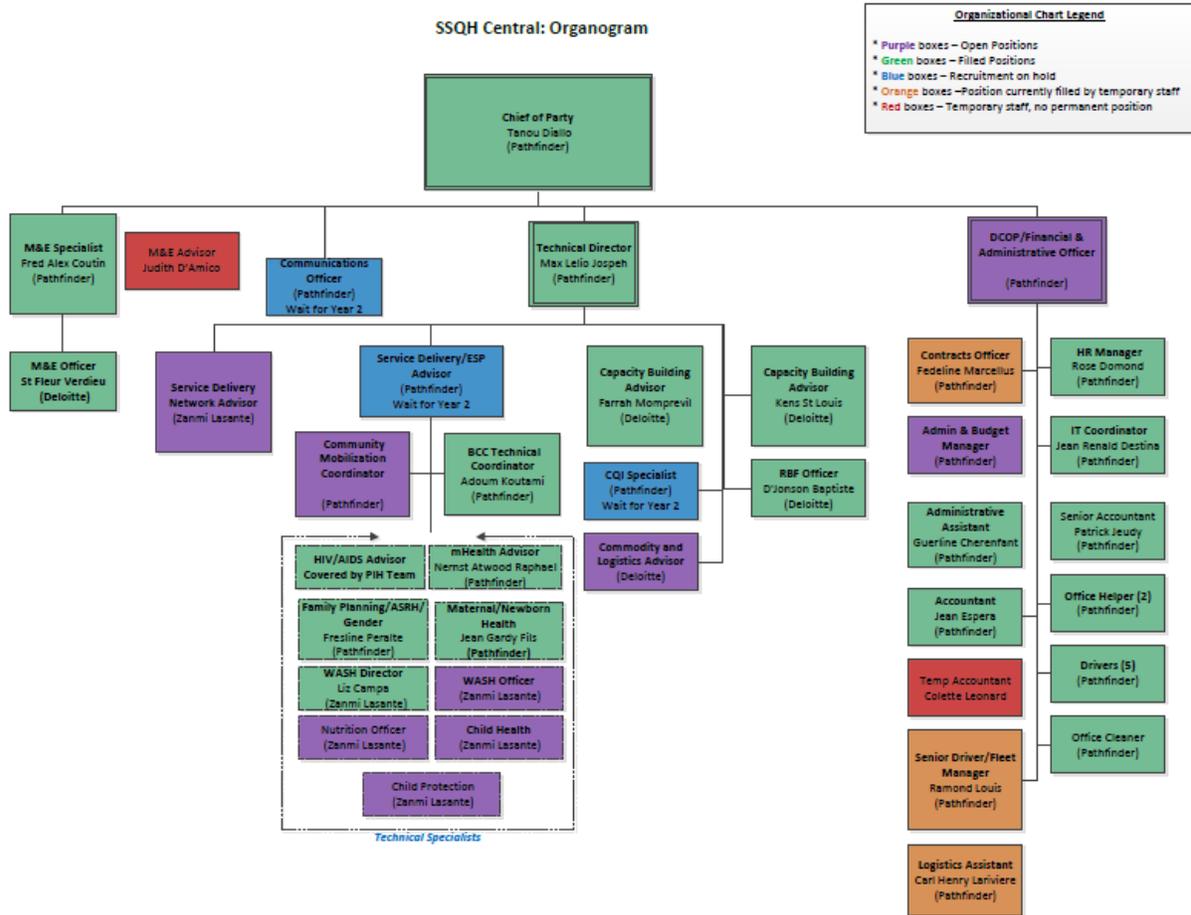
In CSS Thiote, SSQH-CS supports a community group called “Mothers Leaders”, an associate to promote positive behaviors in maternal, newborn, and child health. On December 17, 2013, members of the Mothers Leaders group and a TBA (matron) brought a pregnant woman to a health facility for care. The patient had not been able to access immediate emergency care because of the lack of a functioning referral system in her area to quickly refer her for emergency care at a higher level of the health system. The woman was eight months pregnant, and had been in premature labor for roughly 12 hours with severe pain and sustained bleeding. The clinical examination showed that the patient had a hard, contracted abdomen, her blood pressure was unstable and dropping dangerously, and there were no fetal heart tones, suggesting oxygen was not passing through the placenta and this was a still birth.

The patient was diagnosed as being at risk of a placental abruption, a significant contributor to maternal mortality, and the entire medical team was mobilized in the effort to save her life. After three hours, the woman delivered a stillbirth, passed the placenta, and then passed two large blot clots. However the woman survived, having avoided a placental abruption and not requiring surgery as a result of accessing care at the health facility. For the community and the health center who have experienced high rates of maternal mortality, this case was an unprecedented success.

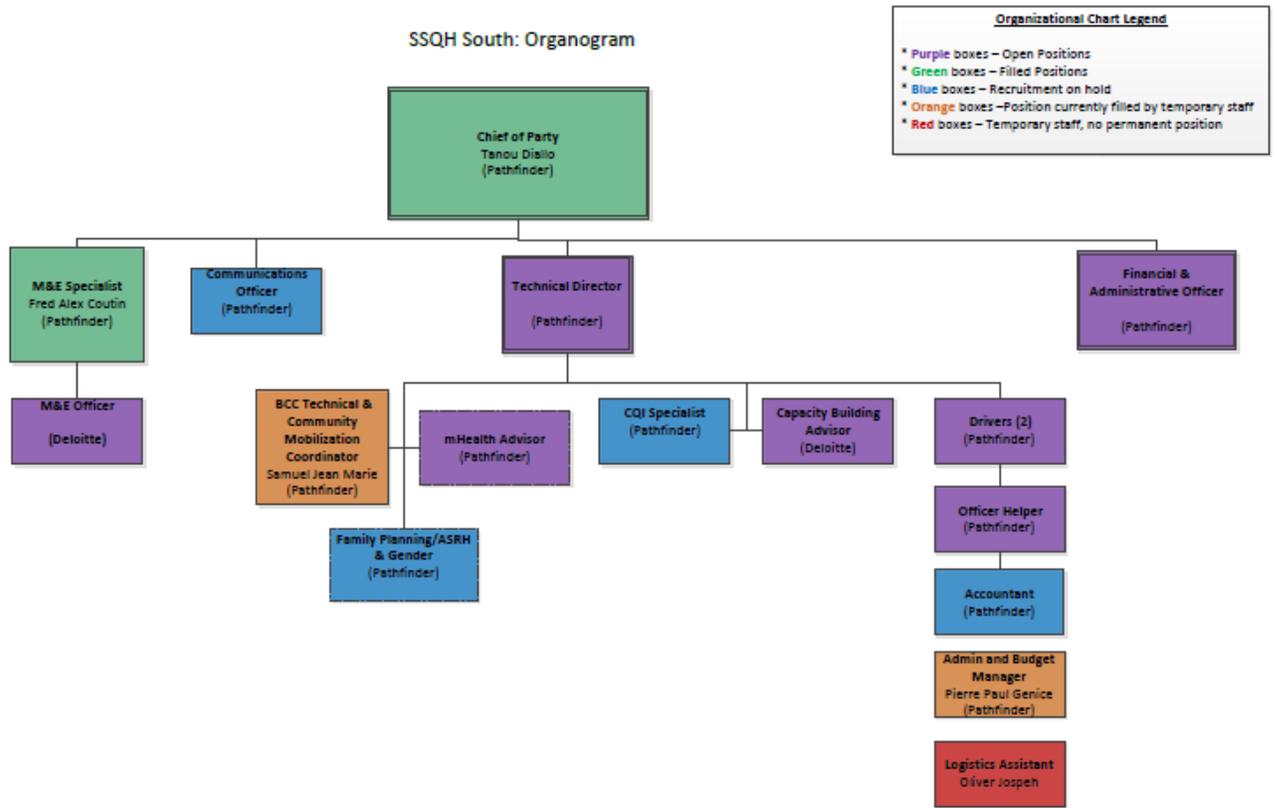
Without the “Mothers Leaders” organization, their training and supervision, as well as their direct linkages with the health center, the patient may not have received the proper health care in time and could have succumbed to her complication.

# Annexes

## Annex I. Organizational Chart – Central Regions



# Annex 2. Organizational Chart – South Regions



**MEMORANDUM OF UNDERSTANDING (MOU)**

**BETWEEN**

**LE MINISTERE DE LA SANTE PUBLIQUE ET DE LA POPULATION**

**AND**

**PATHFINDER INTERNATIONAL**

**NO. DU PROTOCOLE D'ACCORD : HT-401**

**DEPARTEMENT: DIRECTION DEPARTEMENTALE SANITAIRE DU CENTRE**

This Memorandum of Understanding (MOU) is made between Pathfinder International, responsible for managing the Services de Santé de Qualité pour Haïti Central and South (SSQH/CS), whose main offices are located at 89, angle Rues Dr. Wallon et Villate, Petion-Ville, HT 6140, Haïti, and the Ministère de la Santé Publique et de la Population (MSPP).

This MOU refers to Prime Contract No.: AID-521-C-13-00011

Project Title: Services de Santé de Qualité pour Haïti Central and South (SSQH/CS)

Health services will be provided to populations in the Zones Ciblées listed in the specified by the Direction Départementale Sanitaire. This MOU revokes and replaces all other verbal or written agreements previously signed between the two parties.

<b>FOR AND ON BEHALF OF PATHFINDER:</b>	Date: February 3, 2014
Name and Position: Caroline Crosbie, Senior Vice President, Pathfinder International	

<b>FOR AND ON BEHALF OF THE MINISTERE DE LA SANTE PUBLIQUE ET DE LA POPULATION:</b>	Date:
Name and Position:	

## A- PURPOSE OF THE AGREEMENT

This Memorandum of Understanding (MOU) supports MSPP and meets the request made by USAID to Pathfinder to provide health services in support of the USAID/Services de Santé de Qualité pour Haïti Central and South (SSQH/CS). This MOU is issued under Contract no. AID-521-C-13-00011.

## B- TERMS OF REFERENCE

The technical services supported by this MOU shall meet the *Paquet de Services Prioritaires Intégrés – PSPI* (sub-element of the Minimum Services Package of MSPP), the *Demande de Proposition Cadre de Référence*, and the standards and protocols in force at MSPP. The specific activities and services covered by this MOU shall include those associated with: child survival, including the medical care of sick children according to the integrated management of childhood illness (IMCI) approach, family planning and reproductive health with particular focus on maternal health, sexually transmitted infections and infectious diseases, particularly HIV/AIDS. These services shall be provided at both institutional and community levels.

All health care services provided and funded under this MOU shall comply with MSPP norms and standards and shall meet USAID regulations. In collaboration with the Direction Départementale, Pathfinder shall ensure that all transactions and operations of disbursement by Pathfinder directly to service providers and suppliers of goods and services shall be carried out according to the standards and conditions stipulated in this MOU and shall comply with Haitian legislation.

Through this MOU, strategies shall be developed to:

- a) Strengthen immunization, reduce "loss" and achieve full immunization of children
- b) Increase the level of use of family planning methods and reduce abandonment rates.
- c) Increase the use of maternal health care services by enhancing birth attendance and developing evacuation systems for obstetric emergencies.
- d) Develop and efficiently and effectively execute community-based approaches for monitoring the growth of the nutritional status of children and the care of malnourished children.
- e) Detect and treat TB-HIV patients in target sites.
- f) Develop care services for victims of gender-based violence.
- g) Identify abused children and refer them to specialized institutions.
- h) Develop measures for proper waste management.

The budget for the period from **16 November 2013 to 30 April 2014**, to be presented in Appendix I of this MOU are to be set

In the spirit of partnership and to develop public/private county networks, the employees of the Direction Départementale Sanitaire and the service providers under this MOU are encouraged to participate in SSQH activities. The SSQH project will assist the Direction Départementale Sanitaire by providing technical assistance to execute this MOU properly.

This MOU shall apply the recommendations concerning the disposal of various types of medical waste and to the enforcement of USAID regulations relating to family planning and abortion.

## C- FUNDING MECHANISM

The total cost of this agreement protocol to cover the period from 16 November to 30 April amounting to HTG 22,448,588.00 **is detailed in the attached budget**. The amounts approved may not be exceeded without the prior authorization of SSQH-C/S; the allocated funds are deemed sufficient in order to achieve the activities recorded in the action plan of the area and to meet the mandate of SSQH/CS.

On a monthly basis, the Direction Départementale shall submit to SSQH Financial Officer an itemized cost report, with accompanying supporting documentation, of costs to be met in support of the activities within the Département that is the subject of this MOU. Payment of documented costs will be made directly to vendors and suppliers directly by SSQH/CS. Salary payments to staff by SSQH/CS will be governed by separate agreements according to the staff rosters provided to SSQH/CS by the Direction Départementale Sanitaire.

The Direction Départementale Sanitaire shall:

1. document reasonable provisions undertaken to ensure that all purchases attributable to the project have been carried out at reasonable prices and are from reliable sources.
2. maintain complete, original accounting records of all costs attributable to the MOU for a period of three years, and, if requested, shall provide these records and their related supporting documents to Pathfinder or USAID.
3. ensure that the amount spent in the target area is not exceeded during the MOU period. It is not necessary to ask for approval from the SSQH project if some budget categories are being exceeded.

**Under this MOU, no wages, wage bonuses, or wage costs may be granted to employees or representatives of the Haitian Government.**

## D- PERIOD OF EXECUTION

The period of execution of this MOU is from 16 November 2013 to 30 April 2014.

This MOU may be terminated by either party at any time. Pathfinder reserves the right to review and revise the budget, as needed, or to discontinue activities in consideration of performance, the availability of funds, a change in the amount of work, indicators, or the continuation of the SSQH Project.

## E- REPORTING

Monthly statistical reports, quarterly narrative reports and other results or instruments required by this MOU will be submitted to the SSQH Project Office. They shall be submitted using the same format and procedure as followed under the SDSH project.

For each target area, the Direction Départementale Sanitaire shall forward to the SSQH Project Office the following documents:

- **Monthly statistical reports** within 15 days after the end of the month. Note that the first required report will be due on February 20, 2014, covering November and December 2013 and February 2014.
- **Monthly Report of Internal Receipts** within 15 days after the end of the month. Note that the first required report will be due on February 20, 2014, covering November and December 2013 and February 2014.
- **Quarterly narrative reports** within 20 days after the end of the quarter. This report will include: a report on training activities; a report about Behavior Change Communication/Community Mobilization activities; and "Success Stories" arising from activities carried out under this MOU. Note that the first quarter will cover the period November 16, 2013 – January 31, 2014 (report due February 20, 2014), and the second quarter will cover February 1, 2014 – April 30, 2014 (report due May 20, 2014).

The above-mentioned reports shall be prepared by the responsible party within each Zone Ciblee and shall be sent by the Direction Départementale Sanitaire to the SSQH Project Office. They shall better enable both parties to track the progress of contributions recorded in the action plan. The services, reports and outcome resulting from this partnership shall be approved by the Directeur Départemental on one hand, and by the Chief of Party of the SSQH Project or his representative, on the other. The Direction Départementale Sanitaire shall include the following statement in the technical reports arising from this MOU:

*“This activity was completed through the assistance of the United States Agency for International Development under Prime Contract Number AID-521-C-13-00011. The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development, the United States Government, or the prime contractor, Pathfinder International.”*

## **F- SPECIAL PROVISIONS**

### **F.1 - AUTHORIZED GEOGRAPHICAL CODE**

The geographical code authorized for disbursements under this MOU is 937.

### **F.2 - LONG-TERM ASSETS (NONEXPENDABLE EQUIPMENT)**

The purchase of long-term assets (purchase price of the unit greater than US\$500) is not authorized under this MOU.

### **F.3 - PHARMACEUTICALS AND DRUGS**

The purchase of pharmaceuticals and drugs is not permitted under this MOU. No disbursement will be made for the purchase of pharmaceuticals.

## **F.4 - DISPOSAL OF MEDICAL WASTE**

For each target area, the Direction Départementale Sanitaire shall appoint a person in charge of managing medical waste. The Direction Départementale Sanitaire shall provide Pathfinder with the name of the person in charge, who will:

- 1) ensure that: a) training based on international standards and recommendations has been given to those responsible for the handling and disposal of medical waste and (b) training materials and the guide already in place have been distributed.
- 2) Participate in or carry out field visits to ensure compliance with standards, as necessary.
- 3) submit to Pathfinder a description of the types of services offered in all clinics benefiting from USAID assistance, of the types of procedures in place and information regarding the access of these clinics to water and sewage, including any recommendations to be enforced.

## **F.5 - CREDIT TO MSPP/USAID/SSQH PROJECT**

The Direction Départementale Sanitaire shall credit USAID for its support in all forums, correspondence, and public events that are totally or partially funded under this MOU.

The logos and acronyms **“USAID/MSPP/SSQH PROJECT”** shall be visibly inserted in all publications, videos or other information/media (posters, leaflets, banners, advertising, documents, etc.) that are totally or partially funded under this MOU. The USAID Brand Identity (logo + tagline) will be placed at the left; SSQH/CS logo in the middle and the MSPP’s logo at the right.

## **F.6 - PROVISIONS REGARDING VOLUNTARY STERILIZATION PROGRAMS**

- 1) The Direction Départementale Sanitaire shall ensure that the funds released under this MOU are not used to pay for involuntary sterilization operations as a method of family planning or to force people to undergo, or provide them with financial incentives for, sterilization.
- 2) The Direction Départementale Sanitaire shall ensure that all surgical sterilization procedures are carried out only after the persons involved have voluntarily come to the institution and only after they have given their informed consent to the sterilization procedure. Informed consent means voluntary agreement, in full knowledge of the facts, of the individual informed about the surgical procedures to be carried out, about the side effects, the expected benefits, and with the option to change his/her mind at any time prior to the operation. The consent of an individual is considered voluntary when it is based on free will and when it has not been obtained by using any element of force, fraud, trickery, constraint or any other form of coercion or deception.
- 3) Furthermore, the Direction Départementale Sanitaire shall document the informed consent of the patient by mean of: (i) a consent document, written in the language that the patient understands and speaks, which explains the basic elements of informed consent, as indicated above, and which is signed by the individual and by a treating physician or assistant authorized by the treating physician; or (ii) when the patient cannot read, a certificate of the treating physician or the assistant

authorized by the treating physician certifying that the basic elements of the informed consent mentioned above have been verbally explained to the patient and that the patient has then agreed to proceed to the operation. The receipt of these verbal explanations shall be certified by affixing the thumbprint of the patient on the certification and the signature or thumbprint of a witness who speaks the same language as the patient.

- 4) The Direction Départementale Sanitaire shall keep in its records copies of informed consent forms and of certification documents for all voluntary sterilization procedures for a period of three years following the sterilization procedure.

## **F.7 – DRUG TRAFFICKING AND TERRORISM**

The Direction Départementale Sanitaire shall ensure that the funds released under this MOU are not used to provide assistance to, or via, sentenced drug traffickers and/or to possible drug traffickers.

## **F.8 - INCONSISTENCY BETWEEN ENGLISH VERSION AND TRANSLATION OF MOU**

In the event of inconsistency between any terms of this MOU and any translation into another language, the English language meaning shall control.

## **LIST OF APPENDICES**

- Appendix I: Objectives and budget of target areas for the period from 16 November 2013 to 30 April 2014.