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SERVICES DE SANTE DE QUALITE POUR HAÏTI (SSQH) EVALUATION REPORT

August 2016

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ACRONYMS

ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretrovirals
ASCP	*Agent de Santé Communautaire Polyvalent* (Community-Health Worker)
BCC	Behavior change communications
CAC	Community Action Cycle
CCS	Critical Care Services
CHC	Community Health Committees
CHWs	Community Health Workers
CP	Child protection
CSL	*Centre de Santé sans Lits*
DDS	*Direction Départementale de Santé*
DOTS	Directly observed therapy
FGDs	Focus group discussions
FP	Family planning
FP	Family planning
FY	Fiscal Year
GBV	Gender-Based Violence
GHT	Haitian Gourde
GOH	Government of Haiti
HIS	Health Information Systems
HTC	HIV testing and counseling
IPT	Isoniazid preventative therapy
IUD	Intrauterine device
IYCF	Infant and young child feeding
KI	Key informant
LAPM	Long-acting or permanent methods
LTFU	Loss to follow-up
MCH	Maternal and child health
MCSP	Maternal and Child Survival Program
MNCH	Maternal, Newborn and Child Health
MOU	Memorandum of Understanding

MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Health)
MTCT	Mother-to-mother transmission
MUAC	Mid-upper arm circumference
NGO	Nongovernmental organization
OVC	Orphans and vulnerable children
P2C	Pathways to Change
PM	Permanent methods
PMP	Performance Management Plan
PMTCT	Prevention of mother-to-mother transmission
POP	Progestin-only contraceptive pills
PSM	Procurement and Supply Management Project
PSPI	Paquet de Services Prioritaires Intégrés
QA	Quality Assurance
QI	Quality Improvement
RFB	Results-Based Financing
SBCC	Social behavior change communication
SDSH	*Santé pour le Développement et la Stabilité d'Haïti*
SHOPS	Strengthening Health Outcomes through the Private Sector
SISNU	Système d'Information Sanitaire Nationale Unique (national reporting systems)
SSQH	Services de Santé de Qualité pour Haïti
SSQH-CS	SSQH activities in Central and Southern Haiti
SSQH-N	Northern Haiti
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendants
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, sanitation. and hygiene

EXECUTIVE SUMMARY

BACKGROUND

Services de Santé de Qualité pour Haïti (SSQH) is a $95 million, three-year project funded by the United States Agency for International Development (USAID) that seeks to improve the health status and quality of life of the Haitian population by increasing the quality of primary care services, health referral networks, and facility- and community-based management practices, and enhancing the Government of Haiti's (GOH) capacity to manage and monitor service delivery at the departmental level.

To meet these objectives, SSQH supports Haiti's Ministry of Health (Min*istère de la Santé Publique et de la Population*, MSPP), the Direction Départementale de Santé (DDS), and 164 health facilities in all 10 departments to:

1. Increase the utilization of the MSPP's integrated package of services at the primary care and community levels).
2. Improve the functionality of the United States Government (USG)-supported health referral networks.
3. Facilitate the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels.
4. Strengthen departmental health authorities' capacity to manage and monitor service delivery.

To achieve these objectives, SSQH is working with the MSPP and the DDS to regularly monitor and supervise activities at the facility and community levels; provide training to health care staff, including community-based health workers and traditional birth attendants that follow MSPP protocols and standards; procure and provide essential equipment and supplies to health facilities; implement quality improvement activities; and provide logistics support to sites.

Since October 2013, Pathfinder International has led a consortium of local and international organizations to implement SSQH activities in Central and Southern Haiti (SSQH-CS) in six departments[1] and supporting 84 health facilities.

From October 2013 through July 2015, University Research Co., LLC (URC) led local and international partners implementing SSQH activities in four departments located in Northern Haiti (SSQH-N). In August 2015, implementation of SSQH-North transitioned to the Maternal and Child Survival Program (MCSP) led by Jhpiego.

EVALUATION PURPOSE, OBJECTIVES, AND QUESTIONS

The purpose of the evaluation was to assess the project's performance and assess the extent to which SSQH activities led to improved health outcomes. The evaluation aimed to answer the following questions specified in its Scope of Work:

1. To what extent has SSQH achieved expected results related to service delivery, as specified in the project's contract and Performance Management Plan (PMP) for Objective 1? What are the key issues that affect the delivery of health services?

[1] Departments supported by SSQH-CS are Centre, Sud, Sud Est, Ouest, Nippes, and Grand Anse. Departments supported by SSQH-N are Artibonite, Nord, Nord Est, and Nord Ouest.

2. To what extent has SSQH improved the quality of health services at the facility and community levels, and strengthened capacity of health authorities to manage and monitor service delivery? What are the barriers to improving quality?
3. How are community-based approaches and community health workers being used within the project to improve access and use of integrated health services? Which community-based activities to strengthen referrals and retention show evidence of leading to improved health outcomes within the integrated primary health care context? Which interventions are not working?
4. What could optimize the effectiveness and efficiency of the current project, as well as that of similar future projects? While answering this question, the evaluation should identify and discuss SSQH approaches and activities that should be continued or replicated and approaches and activities that should be changed.
5. As a result of the SSQH project, what has been the change in client (including patients and healthcare service providers) satisfaction? What are those changes attributed to and what impact have they had?

This report documents the findings and recommendations of a mid-term performance evaluation of SSQH.

MID-TERM EVALUATION METHODOLOGY

The evaluation employed a combination of quantitative and qualitative methods to answer the evaluation questions. Data collection methods included desk review, data extraction, key informant (KI) interviews, focus group discussions, and site visits. Data collection took place from October 2015 to January 2016. The evaluation team visited 23 facilities that met selection criteria. These criteria were: geographic accessibility, departmental distribution, facility status (i.e., private or public), facility type (e.g., dispensary, health center or hospital), population catchment area, and completeness of the basic health services package offered.

Because of the transition to Jhpeigo in 2015, data from SSQH-N projects were unavailable for the last quarter of Fiscal Year (FY) 2015. For this report, data for Year Two of SSQH-N are reported from October 2014 to June 2015.

FINDINGS AND CONCLUSIONS

1. To what extent has SSQH achieved expected results related to service delivery, as specified in the project's contract and Performance Monitoring Plan for Objective 1? What are the key issues that affect the delivery of health services?

Under Objective 1, SSQH is charged with ensuring the quality of health service delivery and promoting the uptake of the MSPP's integrated package of primary care services (Paquet de Services Prioritaires Intégrés – PSPI) and specialized referral services within each of its health districts. Tasks essential to meeting this objective are:

- Implementation of a continuum of care model that integrates Agent de Santé Communautaire Polyvalent (ASCPs) or the community-health workers with health facilities
- Increased access by expanding the range of services and ease of obtaining them from supported facilities

- Improved delivery of high-quality primary care services that meet clients' needs

Expected results related to PSPI include: maternal and child health (MCH); family planning (FP) and reproductive health; HIV and AIDS; tuberculosis (TB); gender-based violence (GBV) and child protection services; critical care services (CCS); nutrition and hygiene; and water, sanitation, and hygiene (WASH).

By the end of Year Two, neither of the SSQH projects achieved consistent increases in access or uptake of most of the services of the integrated package. In fact, there were decreases of more than 10 percent in a number of key indicators: use of family planning services; maintaining HIV-positive pregnant women on antiretroviral therapy (ART); percentage of children under one fully vaccinated in project areas; number of children under five who received vitamin A from USG-supported programs; percentage adoption of a TB infection control plan at all supported facilities; and number of individuals trained to implement improved sanitation methods (WASH measure).

Both SSQH projects did achieve increases in access to services for HIV testing, counselling, and treatment services, and increased identification of tuberculosis cases under the directly observed therapy (DOTS) program.

There were differences in achievement of indicators in Year Two between SSQH-N and SSQH-CS. SSQH-N did not achieve increases in access for: number of women who attended at least three prenatal visits; number of children reached by protection services; and number of people trained in child health and nutrition through USG-supported programs. SSQH-N also experienced an increase in prevalence of anemia among pregnant women. SSQH-CS missed its targets in Year Two for: percentage of births attended by skilled birth attendants (midwifes, nurses, doctors); number of youth (15 – 25 years) accessing reproductive health; TB patients screened for HIV at all SSQH-supported sites throughout life of contract; percentage of HIV-positive pregnant women who receive antiretroviral drugs (ARV) to reduce risk of mother-to-mother transmission (MTCT) during pregnancy and delivery; and number of community and clinical health staff and community-based actors trained to recognize and refer GBV and protection cases to appropriate legal and social services.

The evaluation team found that key issues that affect service delivery fall into two areas: the tangibles and intangibles. The tangibles can be categorized as supplies and equipment, trained service providers, and facilities' infrastructure that are easy to quantify. The intangibles are less apparent and concern issues such as the collaboration among SSQH staff and the facilities, and the social and behavioral aspects of the community that receives the services.

Each of these factors has its own barriers and motivators. From the interviews and facility visits the evaluation team saw that the majority of the tangible issues have not been addressed and that the intangible factors have not been incorporated into the program design.

Facilities needed an infusion of support in training and capacity building, infrastructure strengthening, management systems, and public education, but the two projects did not design a systematic, evidence-based plan to address these issues that would lead to improved service delivery.

Though both projects conducted needs assessments to identify where specific interventions were required, heath service providers reported that project support by SSQH-N and SSQH-CS focused on clinical and technical activities, i.e., MCH, HIV/AIDS, rather than on operational (administrative and management) and the facilities' infrastructure.

Training of the health providers at the clinic level remains a priority and has management support for service delivery scaled up in the training menu. Community health workers (ASCPs) are a critical link between the facility and clients. With their understanding of and trust from the community, they can be instrumental in increasing demands for services; conducting targeted outreach to address barriers to health-seeking behaviors; and providing basic services for family planning, antenatal, postnatal care, and infant and young child health. ASCPs are willing to undertake these tasks, but they expressed the need and desire for additional training, educational materials, and commodities to better provide these services.

The original assessment did not include operations and infrastructure. There were several major infrastructure issues that needed to be addressed. These included new waste management systems and the proper use of them, lack of potable water, and broken generators. On the technical side, there were needs (and requests) for technical support in training in MCH, nutrition, administration and management, and clinic supervision. There were also gaps in the supply chain that contributed to stock-outs.

Although neither USAID nor SSQH is responsible for procurement or distribution of all supplies and commodities needed to provide primary health services, stock-outs negatively affected project results. There is a long list of stock-outs of medicines and equipment and supplies that affected achievement of project indicators. Those reported missing at facilities include: progestin-only contraceptive pills (POP), intrauterine devices (IUDs), antibiotics, Oxytocin, and rape kits. Several ASCPs said they do not have: iron and folate tablets, oral rehydration salts, vitamin A, vaccines, oral contraceptives, weighing scales or mid-upper arm circumference (MUAC) measuring tapes for growth monitoring, service registers, and vaccination cards. There were several reasons given for the stock-outs, including poor management of stocks at facilities. The solutions were either for patients to purchase needed drugs and products at private clinics or wait until the next delivery; at some clinics refrigerated commodities are stored in separate buildings that are not easily accessible to staff during off hours.

The start-up of the two SSQH projects was not smooth and it took over a year for program activities to begin. Among the issues raised by subcontractors on the award were delays of six to nine months to receive operating funds from the primary contractor (USAID/Haiti released funds to the primary contractor well in advance of the program starting), and requiring the subcontractors to use funds from other programs to cover their implementing costs. In fact, because they have cost-reimbursement contracts, the partner organizations routinely have had to wait for many months to be reimbursed for funds spent on activities and operating costs.

Local NGOs also reported that there was poor communication among the team, resulting in confusion over the strategy, activities, and progress of the project. Government officials at the national and department level remarked several times that they were left out of the program planning and implementation.

2. To what extent has SSQH improved the quality of health services at the facility and community levels, and strengthened capacity of health authorities to manage and monitor service delivery? What are the barriers to improving quality?

The team evaluated SSQH performance in a range of areas associated with quality management of health services, including: health information systems (HIS); general management and supervision; management and supervision in support of the DDS; use of technology; communication and coordination of materials, supplies, and equipment and service delivery standards; and adherence to standard treatment protocols.

The evaluation team found a critical problem with routine reporting of SSQH data, with substantial drops reported in the percentage of USG-supported primary health care facilities that submit routine reports according to national HIS policy. Data are not collected properly or reported correctly or on time. Visits to the facilities identified major gaps with data recording, storage, and use for decision-making. Facilities and programs cannot be managed efficiently and effectively and assess quality improvement in the program without data to guide decision-making.

Quality improvement/quality assurance teams were reported to be established at health facilities with SSQH-CS reporting 100 percent of sites and SSQH-N reporting 50 percent. The evaluation team found that at 15 facilities where questions were asked specifically about Quality Improvement/Quality Assurance (QI/QA) committees, facility staff at five sites (33 percent) reported that they have a functioning QI/QA committee; two (13 percent) reported that there is a QA committee for HIV service unit only; three (20 percent) reported that there is no QI/QA committee but that quality issues are discussed during regular staff meetings; and five (33 percent) reported that they have no form of QI/QA discussion. These findings are at odds with the results reported in the PMPs, particularly for SSQH-CS in Year Two.

Commonly accepted and scaled-up technology application used in other countries by USAID programs for data collection, patient education and follow-up, and inventory tracking are not being utilized in Haiti. After two years of pilot testing and user training, the COMMCARE program has not been taken to scale. Technology applications can help improve the quality of service delivery with minimal disruption, especially for ASCPs. While the evaluation team heard different reasons to explain why there were delays and lack of technology tools in Haiti, there were numerous opportunities to introduce and support the use of technology for SSQH either through COMMCARE or other suitable platforms.

Both SSQH programs invested substantial resources into preparing training and capacity building tools for improving the Department staff's management and supervision of health services at the facility level, and by the end of Year Two were just beginning to use those tools for capacity building. SSQH-N and CS however, did carry out four supervisory visits to health facilities with Departmental staff in Year Two. Departmental directors found the training plans were driven by the SSQH programs' staff schedules and plans rather than those of the Departments. Department directors encouraged SSQH to tap experienced Departmental staff to participate in training and capacity building and to help inform the training content.

Achievement of SSQH results for increased service coverage and improved quality depends on the availability of commodities, medicines, and supplies. For SSQH-CS, only 53 percent of institutions implemented a timely and accurate procurement process for vital products. For SSQH-N, 18 percent of project-supported sites experienced stock-outs of vital products.

Through an analysis of facility data, the evaluation team found that SSQH facility staff did not adhere to service delivery standards in maternal health, PMTCT, and HIV care and treatment, even with clients who were in the facility for care. In all departments in SSQH-N, an average of about 50 percent of ANC clients were retained through their fourth visit. Of those antenatal clients 50 percent received a second dose of tetanus toxoid and only 50 percent were tested for HIV in the North East Department. SSQH-N reported that on average, 90-100 percent of ANC clients were tested for HIV.

Among facilities in the Centre department supported by SSQH-CS, more than 50 percent of ANC clients dropped out by the fourth visit. In the remaining departments, an average of 60-65 percent of

ANC clients were retained in ANC and received a second dose of tetanus toxoid. Only 10 percent and 16 percent of ANC first-visit clients were screened for HIV in Centre and Sud Est departments, respectively.

The analysis also showed that loss to follow-up (LTFU) of HIV-positive pregnant women was well above 10 percent (range: 16-23 percent) in five SSQH departments. Three departments in SSQH North, Artibonite, North, and Northwest, had LTFU rates higher than 10 percent in Year Two (20 percent, 16 percent, and 22 percent, respectively). Among SSQH-CS departments, Center and Grand-Anse had LTFU rates higher than 20 percent in Year Two (21 percent and 23 percent, respectively).

3. How are community-based approaches and community health workers being used within the project to improve access and use of integrated health services? Which community-based activities to strengthen referrals and retention show evidence of leading to improved health outcomes within the integrated primary health care context? Which interventions are not working?

Based on data collected by the evaluation team and a review of the *Système d'Information Sanitaire Nationale Unique* (SISNU or national reporting systems) data, ASCPs are an effective way to reach clients living in hard-to-reach areas with health education and basic preventive services. Monthly outreach events called Rally Posts and home visits are the most commonly used community-based health approaches. Service statistics show that ASCPs serve two-to-three times more clients for vaccinations against childhood diseases, family planning, and tetanus toxoid immunizations than facility-based health providers.

In many areas the ASCPs have not yet been trained for HIV care and treatment services, but their community-level presence makes them well-suited to provide ART to HIV-positive people, monitor adherence to treatment, and trace clients that are LTFU. There is confusion among health care providers over the recent policy to limit the responsibilities of the ASCPs to health education and health promotion and how this affects their ability to provide services.

The majority of family planning client visits in both SSQH-CS and SSQH-N areas occur at the community level where ASCPs provide temporary family planning methods, i.e., condoms, pills, and injectables. For clients interested in using long-acting methods (implants and intrauterine devices) or permanent methods (tubal ligation and vasectomy), ASCPs refer them to facilities where those methods are available. Several facility staff said there is demand for LAPMs distance to a facility, where they are provided and cost of transportation limit use. None of the ASCPs or staff interviewed reported use of mobile clinics for family planning but that could be an effective approach to increase access to and utilization of LAPMs.

ASCPs reported factors that limit their effectiveness: shortages of commodities and service registers, lack of supplies, equipment, and social behavior change communication (SBCC) materials.

Referrals, whether for emergency or non-critical services, are problematic, particularly for ASCPs serving hard-to-reach communities due to bad roads, and poor communication and transportation. SSQH-CS has started to set up community-supported transportation systems for emergency referral of pregnant women.

Both SSQH projects have community mobilization approaches and tools that have been applied to involve the community in health activities. SSQH-N has implemented community mobilization activities

in two departments to support grassroots groups promoting health-seeking behaviors within the population, build capacity of community-level providers to deliver quality health services, and promote use of health services. SSQH-CS reported that it was developing a community mobilization approach based on its HIV strategy which "builds upon home visits, and community support groups (i.e., *clubs des mères*).

Strengthening the capacity of Community Health Committees (CHC) and other local groups is needed to shore-up the community health program and provide needed support to ASCPs for organizing monthly Rally Posts and arranging referrals from the community to a facility.

Collaboration between health facilities, ASCPs, and CHCs exists, but is episodic and activity-based. Participatory planning with CHCs and other community members can enhance their participation and commitment to quality health service delivery.

4. What could optimize the effectiveness and efficiency of the current project, as well as that of similar future projects? While answering this question, the evaluation should identify and discuss SSQH approaches and activities that should be continued or replicated and approaches and activities that should be changed.

Program management by the prime contractors proved to be the critical obstacle in the effectiveness and efficiency of the SSQH. Slow start-up (establishing internal systems and financial structures in the country), poor management of projects' subcontractors and partners, lack of attention to problems that have a cross-cutting effect on service delivery (e.g., referral system, data management) and poor communication with the government, department, health care facilities, and partners hampered the progress of SSQH. Poor coordination, communication, and participation with departmental directors, facility directors, and sub-contractors impeded the implementation of SSQH. Its lack of communication and coordination with departmental directors, especially in the early stages of the project, created initial uncertainty, then distrust and a subtle rejection of SSQH plans. Departmental directors expressed frustration that they were not part of the project planning and questioned whether it fit the government's health strategy. The departmental directors reported that SSQH did not communicate their project's plans and objectives, or the dates when activities were being implemented in their clinics or departments. Departmental directors cited examples where contractors worked directly with facilities and did not involve or inform them about these events.

The referral system for SSQH health services is not operating in a way to provide efficient and effective health services. A functioning referral system can make cost-effective use of hospitals and primary health care services and helps build capacity and enhance access to better quality care.

At the core of an operational referral system is strong coordination between facilities and support for the patient by providers and others who can facilitate access to care. In other comparative donor-funded countries, community-based organizations and community groups are a vital part of referral systems. As a part of the team, they contribute to identifying needs, developing strategies, and implementing activities to help delivery their community access to care.

5. As a result of the SSQH project, what has been the change in client (including patients and healthcare service providers) satisfaction? What are those changes attributed to and what impact have they had?

Client satisfaction with SSQH services (as reported by different sources) is mixed, but overall, clients did not see improvements in the quality of services in the last two years. In focus group discussions, clients

did not know about SSQH or its role in the provision of care at the facility. Results for the client satisfaction indicator in the SSQH PMPs showed high levels of satisfaction for SSQH-CS (with a slight decline between Year One and Year Two) and very low levels for SSQH-N for Year One (32 percent). In interviews at facilities conducted by the evaluation team, health providers reported high client satisfaction, which they based on their informal conversations with patients and, as one facility staff said: "if patients come back to the facility they must be satisfied."

Over 50 percent of focus group participants cited that turnaround time for provision of services has not changed during Years One and Two, with the exception of faster turnaround for laboratory results. Absence of services at some facilities (such as those for caesarian sections, diagnostic tests, and emergency services), the heavy workload of service providers, and the increase in the number of patients were cited as the main barriers and challenges to health service access. Another area of concern for clients was referrals for services, because of the cost and limited means of transportation, poor road conditions, and potential inability of the reference facility to deliver the prescribed services.

Clients were positive about their interactions with staff at health facilities. A greater percentage of clients (89 percent) reported that their service providers were friendly, answered questions, and explained health-related issues to them. They also mentioned that service providers maintained their privacy and confidentiality during clinical visits. There was no difference between SSQH-N and SSQH-CS regarding these issues. Clients also found the facilities to be clean. About two-thirds of group participants had an average waiting time of 15 to 30 minutes, which they found acceptable. About 20 percent of participants mentioned that they had to wait two to three hours. There was no difference between SSQH-N and SSQH-CS participant responses to questions about waiting time.

Health providers reported general satisfaction with SSQH projects. They did report, however, that their workload increased as a result of additional data collection and management and supervisory duties under SSQH. Also, visits by SSQH staff are not coordinated with the DDS or facility, which disrupts service delivery.

RECOMMENDATIONS

Delivery of Health Services

- Conduct a full needs assessment, including technical, management, and infrastructure to design a program and prioritize implementation. Utilize existing research and conduct additional audience assessments to improve service delivery and reveal barriers to accessing care. Prioritize the number of indicators required by the contractor and, where possible, reduce the number.
- SSQH must engage with the GOH at the national and department levels to provide support to the MSPP and the DDS in the delivery of health care services. The projects should also coordinate with the other USAID partners, such as the Procurement and Supply Management Project (PSM) and the social marketing and demand creation project under Strengthening Health Outcomes through the Private Sector (SHOPS) project. Working with the PSM Project will help to address stock-outs and the logistics management capacity at facilities for monitoring of commodity stock levels, timely reporting, and accurate forecasting in order to guarantee availability of essential commodities. SSQH should ensure that facility stock rooms exist at each facility to meet basic standards and that supplies that need refrigeration are accessible to facility staff and ASCPs where electricity is not available.

- Conduct annual quality reviews and assessments of facilities to measure delivery and impact of programs' technical assistance and support. Establish a grade system for clinics and facilities based on improvements in services and technical skills provided.
- Address the needs reported by ASCPs for additional training, educational materials, commodities, and supplies to ensure they can fulfill their role in increasing demand for services, conducting targeted outreach, and providing basic services for family planning, antenatal and postnatal care, and infant and young child health.

Quality Management of Health Services

- SSQH facilities need intensive technical and management capacity building support and ongoing monitoring to ensure the quality of the data and the timeliness of reporting. To improve accurate and on-time reporting, SSQH should work closely with sites to determine the main barriers that prevent reporting and design systems to address and reduce them, including conducting regular data reviews with facility staff. For example, SSQH can create data management teams made up of data collection and systems managers that can troubleshoot reporting and data management at the facility level. This would include establishing daily procedures for data entry and ensuring the data are accurate. At times, these teams can help with the data entry when facility staff are not available to ensure timely data collection and reporting. There is a large backlog of data at many facilities that needs to be entered into national reporting systems (SISNU) and these technical teams can help manage this task. Technology developed under SSQH or other simple data collection tools should be employed and scaled up.
- SSQH should work with DDS staff to identify practical ways to strengthen mechanisms for QI/QA within facilities:
  - For facilities with existing QI/QA committees and sites that use regular staff meetings for discussions of quality, SSQH should provide assistance on better use of data for decision-making and problem-solving; adherence to service delivery standards; and conducting regular follow-up and supervision.
  - For facilities where a QI/QA committee is functional in just one unit, the project should work with facility managers to expand QI/QA activities to other units.
  - For facilities that currently do not have meetings or other means to discuss and address quality issues, SSQH should provide assistance to introduce QI/QA processes.
  - SSQH should work with facilities on ways to include ASCPs in QI/QA discussions and problem-solving.
- Accelerate management and supervision capacity building activities with DDS offices and identify ways to leverage use of and reinforce existing knowledge among DDS staff. Identify ways to increase the impact of the management capacity building and supervisory visits by consistently using the tools that were developed to assess issues at the sites and follow up on recommendations.
- Create an SSQH Technology Team to recommend existing technology applications that can contribute to the delivery of health services. Technology applications that are well-tested and scaled-up in other countries have immediate application in Haiti. M-CARE, MAMA, UREPORT,

and other applications can be used for training and capacity building, medical treatments compliance, well mother care, data collection, and other health service delivery issues. Accelerate scale-up of COMMCARE or a similar tool like MSante. Work with the government to develop content and to develop indicators for evaluating its scale-up and use. Document and monitor the utility of the various applications for ASCPs and their supervisors.

- Collaborate with the DDS, the United Nations Children's Fund (UNICEF), and other USAID partners such as the Procurement and Supply Management (PMS) Project to identify technical assistance needed to address supply chain problems. Strengthen the capacity of supply and commodity management staff at facilities and DDS to ensure accurate stock management, timely product forecasting, and requisition. Institute hand-held technologies to track commodities and supplies to monitor inventory and avoid stock-outs. These technologies are common practice under the new PSM and project so it could be expanded to SSQH.
- Work with the DDS and community health program managers to determine how to provide ASCPs with the means of communication and transport needed to perform their jobs.
- SSQH needs to identify facilities where adherence to service delivery standards is low and conduct training and supervisory visits to determine the barriers at the sites. Address behavioral barriers that deter women from visiting the clinics for care. Work with ASCPs and community health committee to develop outreach strategies for reaching pregnant women. Quality assessment teams at facilities need to develop internal plans to address poor adherence to service delivery standards, such as low rates of HIV testing for pregnant women at facilities. SSQH and the Departments should monitor data from facilities that have low adherence and high lost patient rates to determine the barriers affecting compliance. Conduct targeted research to understand barriers to compliance for a range of treatment protocols that require long-term treatment. Develop approaches to address barriers and increase compliance with facility staff, ASCPs, and community health committees. Ensure facility staff are reinforcing the need for compliance with treatment and are counselling patients about the problems related with stopping treatments.

Community Health Activities

- Ensure that ASCP training and supervision promotes and reinforces an integrated approach to behavior change communications (BCC) and service provision.
- Work with the MSPP to review and revise ASCP training materials and supervision guides. Conduct training, training follow-up, and supervision to improve the capacity of ASCPs in nutrition assessment and counseling, TB and HIV/AIDS counseling, client follow-up and treatment adherence, and provision of all authorized family planning methods.
- Develop, produce, and distribute BCC materials to ASCPs and make BCC information available through mobile technology and/or work with other USAID BCC partners that are developing materials.
- To reduce the number of clients that are LTFU problems and improve adherence to screening and treatment protocols, SSQH needs to develop multipronged approaches that include: research with patients to uncover barriers; processes at facilities that fast-track patients on long-term treatments; and use of existing mobile phone technology projects to send mobile messages to remind patients to take their medicines.

- Increase investments in community-based interventions. Design an integrated community mobilization plan that is inclusive of community health committees and ASCPs and train all actors in the mobilization approaches.
- Organize periodic meetings of facility managers, ASCP supervisors, ASCPs, and CHCs to strengthen communication and coordination between facilities and communities.
- Support the use of mobile clinics under SSQH to provide a full range of family planning methods in hard-to-reach areas. Record mobile clinic service statistics separately from other facility and/or community services in order to monitor the effectiveness of the approach.
- Identify and document examples of emergency transportation systems that are being used in project areas and determine what was done to set them up, how the emergency transportation is managed, and how the approach can be implemented in other departments.
- Rejuvenate *Clubs des Mères* and *Comités de Surveillance* to help promote use of ANC and facility-based deliveries, and to organize local referral mechanisms for obstetric and newborn emergencies.

Effectiveness and Efficiency

- Establish realistic priorities for clinical and management activities and identify indicators that are essential for monitoring the program.
- The program cannot experience a slowdown or break in services. Any new health systems strengthening project should prioritize establishing its internal administrative and financial structures to manage the program in Haiti.
- Institute quality assurance guidelines and reporting mechanisms to monitor service delivery gaps and holes as well as successes.
- Be ready with a plan for providing "emergency" problem-solving, support, and capacity building when acute problems in service delivery or management occur.
- Engage with the government at the national and department levels and listen in a supportive and collaborative way. Joint planning and implementation with government staff who are well-versed in their health system builds support and participant engagement.
- Given the size of the program and geographic distances among the facilities, SSQH program managers should be placed in each department (not in Port-au-Prince) to work closely with facility staff, partners, and departmental staff to help build relationships with the local staff and facilitate monitoring, supervision and problem-solving.
- Work and coordinate with other USAID-funded programs. USAID's vision is an integrated whole system approach rather than isolated or stand-alone activities.
- Assess the current patient referral system and develop practical interventions that will improve its functionality and efficiency.
- Health service delivery is a long-established program for USAID and there have been many successful activities that are documented from around the world. Future implementing partners should demonstrate knowledge and creativity in applying these practices in Haiti.

Client and Provider Satisfaction

- Seek regular, formal input from patients and the community on service provision at the health facility. Involve patients in the SSQH program through formal feedback mechanisms at the facility and in the community.
- Conduct patient flow analyses to assess waiting times and organizational efficiency of service provision and to improve client facilities such as seating, and handwashing facilities.
- SSQH and DDS offices should work with providers to ensure targets are achievable and workloads are reasonable to meet expectations for quality.

INTRODUCTION

PROJECT BACKGROUND

Services de Santé de Qualité pour Haïti (SSQH) is a three-year, $95 million project funded by USAID/Haiti whose objectives are to improve the health of the Haitian population by increasing the quality of primary health care services, health referral networks, facility- and community-based management practices, and enhance the Government of Haiti's (GOH) capacity to manage and monitor service delivery at the departmental level. The SSQH project began on October 1, 2013 and will end on September 30, 2016.

SSQH builds upon the work and accomplishments of the previous *Santé pour le Développement et la Stabilité* d'Haïti (SDSH) project. Whereas SDSH was a single contract that supported activities in all 10 departments of Haiti, there are two agreements for SSQH. Pathfinder International leads the consortium of partners implementing activities in six departments in Central and Southern Haiti (SSQH-CS). SSQH activities in Northern Haiti (SSQH-N) operates in four additional departments in Northern Haiti and was led by University Research Co., LLC (URC) from October 2013 through July 2015. SSQH-N project implementation was transferred in August 2015 to the Maternal and Child Survival Program (managed by Jhpiego).

The SSQH overall design is to support *Ministère de la Santé Publique et de la Population* (MSPP or Ministry of Health) and *Direction Départementale de Santé* (DDS) annual health plans by training of health care staff, including community-based health workers and traditional birth attendants (TBAs) according to MSPP protocols and standards; procuring and providing essential equipment and supplies to facilities; recruiting qualified staff; implementing quality improvement (QI) activities; and providing logistics support to facilities.

Results in the selected geographic regions in 10 departments are expected to be achieved through the delivery of a package of primary health care services, as defined within the draft MSPP Essential Package of Services. These include support for: 1) HIV and AIDS; 2) tuberculosis (TB); 3) maternal and child health (MCH), including water, sanitation and hygiene (WASH) and nutrition; and 4) family planning (FP).

SSQH also includes gender-based violence (GBV) and child protection (CP) services, as well as provision of training and limited support for critical care (accident and emergency) for selected sites within USAID-supported development corridors. SSQH support for community-based services supports the work of community health workers (CHWs) by facilitating supervision of this cadre of personnel, increasing health promotion and service provision and strengthening referral to health services. The project's support to orphans and vulnerable children (OVC) affected by HIV includes facility-based clinical and psychosocial service support.

In addition to supporting the provision of services, SSQH strengthens site-level governance and accountability through structured mentorship and targeted assistance to build the capacity of facility managers (private and public) to address gaps and deficiencies identified within routine data analysis and site assessments. The intention of governance and accountability interventions is to institutionalize and increase the sustainability of management systems and foster the application of quality assurance (QA) standards and continuous QI.

At the completion of SSQH an expected outcome is that the MSPP will assume greater responsibility for the management and performance monitoring of the overall health system, and increase its financial support for those activities.

The purpose of this evaluation was to assess the performance of two USAID/Haiti-funded health service delivery projects under *Services de Santé de Qualité pour Haïti* (SSQH). The two projects' objectives are to expand health services delivery at the community- and facility-levels as defined by the *Ministère de la Santé Publique et de la Population* (MSPP), improve the quality of services, support and improve referral networks, and strengthen the technical and management capacity of departmental health authorities.

SSQH OBJECTIVES

This evaluation assessed SSQH performance in relation to its four primary objectives, as well as the extent to which activities implemented by SSQH contractors improved health outcomes. SSQH objectives are:

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

EVALUATION PURPOSE

Evaluation Scope of Work and Questions

The evaluation was framed around five evaluation questions defined in the evaluation's *Scope of Work* (see Annex I):

1. To what extent has SSQH achieved expected results related to service delivery, as specified in the project's contract and Performance Monitoring Plan for Objective 1? What are the key issues that affect the delivery of health services?
2. To what extent has SSQH improved the quality of health services at the facility and community levels, and strengthened capacity of health authorities to manage and monitor service delivery? What are the barriers to improving quality?
3. How are community-based approaches and community health workers being used within the project to improve access and use of integrated health services? Which community-based activities to strengthen referrals and retention show evidence of leading to improved health outcomes within the integrated primary health care context? Which interventions are not working?
4. What could optimize the effectiveness and efficiency of the current project, as well as that of similar future projects? While answering this question, the evaluation should identify and discuss SSQH approaches and activities that should be continued or replicated and approaches and activities that should be changed.

5. As a result of the SSQH project, what has been the change in client (including patients and healthcare service providers) satisfaction? What are those changes attributed to and what impact have they had?

Findings, conclusions, and recommendations from this evaluation will be used to strengthen positive aspects of the projects and to determine any corrective action needed for the remainder of the project period. The primary audience for the evaluation is the United States Agency for International Development (USAID) Mission in Haiti and the Government of Haiti. Secondary audiences for the report include USAID/Global Health, and other implementing partners.

METHODS AND LIMITATIONS

The evaluation employed a combination of quantitative and qualitative methods to answer the evaluation questions. Data collection methods included desk review, data extraction, key informant (KI) interviews, focus group discussions (FGDs), and site visits. Data collection took place from October 2015 – January 2016. The evaluation team visited 24 facilities that met selection criteria for: geographical accessibility, departmental distribution, facility status (i.e., private or public), facility type (e.g., dispensary, health center or hospital), population catchment area, and completeness of the basic package of health services offered.

Because of the transition to Jhpeigo in 2015, data from SSQH-N projects were unavailable for the last quarter of Fiscal Year (FY) 2015. For this report, data for Year Two of SSQH-N are reported from October 2014 to June 2015.

Sixty-three *Agents de Santé Communautaire Polyvalent* (ASCPs or community-health workers) were interviewed and nine focus group discussions with 95 clients of SSQH-supported facilities were conducted. The team interviewed 32 key informants from MSPP, DDS, prime and subcontractors, facility managers, clinical directors, and other key staff.

Several factors limited the team's ability to collect and analyze data and draw conclusions.

- Aggregation of community-level service statistics with facility-level statistics for some project-related indicators limited the evaluation team's ability to effectively determine the contribution of different community-based approaches (e.g. Rally Posts, home visits) on access and use.
- Indicators for SSQH-N and SSQH-CS were not the same, making comparisons of data difficult for a number of the evaluation questions.
- Distance and accessibility of health facilities limited the number of health facilities, community sites, and ASCPs that could be visited. These factors also affected the profile of the clients participating in the focus groups.
- Clients did not reference HIV and GBV services in FGDs, perhaps due to social taboos or a lack of patients who received these services.
- The initial prime contractor (URC) for SSQH-North was no longer in Haiti at the time of the evaluation because the project implementation had been assumed by Jhpiego.
- SSQH-North activities were disrupted during the second half of Year Two because of the project transition. The project's Performance Monitoring Plan (PMP) was revised to reflect nine months of targets and results for the URC-led consortium and three months of revised targets and results for the Jhpiego-led consortium. Data for many indicators could not be collected for the last quarter by the contractor. Rather than trying to reconcile and weight the differing targets and results and missing data, the evaluation team decided to focus on the nine-month URC-led implementation period (October 2014 – June 2015) as the basis for analysis of SSQH-N during Year Two.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Question 1: To what extent has SSQH achieved expected results related to service delivery, as specified in the project's contract and Performance Monitoring Plan for Objective 1? What are the key issues that affect the delivery of health services?

Under Objective 1, SSQH is charged with ensuring the quality of health service delivery and promoting the uptake of the MSPP's integrated package of primary care services (*Paquet de Services Prioritaires Intégrés* – PSPI) and specialized referral services within its coverage areas. Tasks essential to meeting this objective are:

- Implementation of a continuum of care model that integrates ASCPs with health facilities
- Increased access by expanding the range of services and ease of obtaining them from supported facilities
- Improved delivery of high-quality primary care services that meet clients' needs

1. FINDINGS

During the first two years of the program, SSQH did not achieve consistent increases in access or uptake of all the services of the integrated package. There was a significant decrease in use of family planning services. In general, most basic services are offered at all the facilities (with some notable gaps that are described in the response to Question 5); there were cases where the services were sub-optimal (patient referral) or disrupted (vaccination and Vitamin A supplementation) because of commodity stock-outs These commodities were not provided by USAID, and therefore were out of the control of the SSQH project.

There was major improvement in the access and delivery of HIV testing, counselling, and treatment services, although gaps in the HIV service delivery still exist. SSQH facilities reported on the expanded training, supervision, and support for these activities.

Client satisfaction varied. For the indicator measuring client satisfaction, SSQH-CS reported high percentages (98 percent in Year One and 82.7 percent in Year Two) while SSQH-N reported low percentages (32 percent for Year One) The mid-term evaluation found that while clients were positive about some aspects of the care they receive at the facilities overall they did not see any improvements in the quality of services in the last two years (since SSQH started).

Tables in the following sections use color coding to indicate the proportion of results achieved vis-à-vis the performance target:

- Met the annual target: green = 90+ percent and above of the target
- Almost met the target: yellow = 75-90 percent of the target
- Did not meet the target: red =<75 percent and below the target

1.1 Maternal and Child Health Key Findings

Table 1.1 presents baseline data and SSQH-CS and SSQH-N targets and results for selected maternal and newborn health indicators.

Table 1.1. MCH: Actual versus Expected Results

Maternal & Newborn Health	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of pregnant women with at least three antenatal care (ANC) visits	31.0%	34.0%	31.0%	37.0%	19%
Prevalence of anemia among pregnant women	20.3%	19.3	21%	18.4%	21%
Percentage of births attended by skilled birth attendants (midwifes, nurses, doctors)	14.7%	17.0%	15.0%	19.0%	21.1
Number of women giving birth who received uterotonics in the third stage of labor	0	3,000	n/a	2,588	2,534
Percentage of newborns receiving postnatal health check within two days of birth	0	17%	9%	35%	14%

Maternal & Newborn Health	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percentage of pregnant women who have at least three ANC visits	42.2%	42.2%	42.2%	46.5%	44.3%
Prevalence of anemia among pregnant women	19%	19%	19%	11%	11.3%
Percentage of births attended by skilled birth attendants (midwifes, nurses, doctors)	6.8%	15.0%	15.5%	18%	15.60%
Percentage of newborns receiving postnatal health check within three days of birth	35%	35%	35%	41%	60%

Indicators show a good performance for SSQH-CS and a mixed performance for SSQH-N in maternal health. While facility staff received training in maternal, newborn and child health (MNCH) topics, there are gaps in results.

In SSQH-N there was a decrease in Year Two of the percentages of women with at least three antenatal visits and newborn health checks within two to three days of birth. Even if the facilities are equipped and ready to provide these services, getting women to facilities is a critical aspect of providing these services.

SSQH-N reported an increased percentage of births attended by skilled birth attendants (midwifes, nurses, doctors) while SSQH CCS showed a decrease in Year Two. ASCPs provide many antenatal and postnatal services to women in communities. (See section 3.1 of this report for more information). This eases the burden on women having to travel to the clinics. Home delivery continues to be the most common choice for childbirth in Haiti; however, facilities and *Agents de Santé Communautaire Polyvalent (*ASCPs or community-health workers) are working to encourage women to go to facilities for deliveries. Staff in two maternity units told the team that they are permitting TBAs to accompany clients into delivery rooms to make women more comfortable with being in the facility.

Despite educational and promotional efforts to increase the number of women who go to facilities for maternal health services, cost is likely to be an important factor in whether or not a woman goes to a facility. Staff at multiple facilities cited the cost of maternity care – from ANC to labor and delivery to postnatal check-up – as a factor in the low use of facility-based care. This was said to be the case, particularly for women who have previously had normal deliveries at home and do not foresee the possibility of a complication during a following pregnancy.

1.2 Child Health and Child Nutrition Findings

Indicators show that neither project achieved their performance targets for child health services. Two indicators – full vaccination and Vitamin A intake – were not met. One key reason was extended stock-outs of Vitamin A and vaccines, which was reported by the ASCPs, facility providers, and DDS. Although, those commodities are not procured by USAID and neither USAID nor SSQH is responsible for their provision or distribution, stock-outs negatively affected project results and ultimately children's health. [Additional discussion on stock-outs can be found in Section 2.5.]

Exclusive breastfeeding for children under six months of age and correct infant and young child feeding (IYCF) cut across health and nutrition services. SSQH-CS data show improvements over two years in the percentage of infants exclusively breastfed. The SSQH-N PMP reported problems with data collection that precluded reporting results.

Table 1.2.a. Child Health: Actual versus Expected Results

		Year 1		Year 2	
Child Health	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of children under one fully vaccinated in project areas	88.0%	95.0%	67%	95.0%	29%
Number of children under five who received vitamin A from USG-supported programs	140,114	134,706	98,656	135,630	50,836
Percentage of children under 6 months of age exclusively breastfed	0	43.7%	n/a	48%	n/a

Child Health	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percentage of children under one fully vaccinated in the project areas	83.7%	95.0%	60.6%	95.0%	45.3%
Number of children under five who received vitamin A from USG-supported programs	217,090	221,403	158,195	174,015	129,479
Percentage of children under 6 months of age exclusively breastfed	40%	43.7	49.1%	60%	53.7%

According to the 2012 Haitian Demographic and Health Survey, 22 percent of children under five were stunted (a 7.5 percent decrease from 2006), five percent were wasted, and 11.4 percent were underweight (a 6.7 percent decrease from 2006). Table 1.2.b presents baseline data and SSQH-CS and SSQH-N targets and results achieved for childhood nutrition indicators.

Table 1.2.b. Child Nutrition: Actual versus Expected Results

Child Nutrition	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Number of people trained in child health and nutrition through USG-supported programs	270	297	n/a	373	325
Number of children under five reached by USG-supported nutrition programs	171,250	157156	197,353	142159	133,277
Percentage of underweight children under five years of age	8%	7.4%	8.6%	6.7%	7%

Child Nutrition	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Number of people trained in child health and nutrition through USG-supported programs		806	511	639	580
Number of children under five reached by USG-supported nutrition programs	478,771	502,710	402,112	422218	443,328
Percent of underweight children under 5 years of age	5.8%	5.6%	6.5%	5.8%	5.3%

Growth monitoring, which is routinely conducted by ASCPs during monthly community Rally Posts, is found to be incomplete because they do not have the necessary equipment, i.e., measuring boards, mid-upper arm circumference (MUAC) tape or weighing scales, to collect the data. According to the United Nations Children's Fund (UNICEF) guidelines, stunting is indicative of the cumulative effects of undernutrition and infections since birth and is measured by height-for-age.[2] ASCPs generally weigh the children and 75 percent interviewed indicated they measure the children's MUAC but they do not measure height. None of the ASCPs interviewed had height measuring boards because the boards are heavy and cumbersome to carry from location to location; 25 percent of the ASCPs interviewed did not have weighing scales and/or MUAC tapes.

1.3 Reproductive Health and Family Planning Key Findings

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Table 1.3. Reproductive Health and Family Planning: Actual versus Expected Results

Reproductive Health and Family Planning Output	Baseline	Year 1		Year 2	
		Target	Actual	Target	Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of women of reproductive age using a modern family planning	20.5%	22.6%	17.0%	24.8%	20%
Number of youth (15 – 25 years) accessing reproductive health	36,582	36,769	51,958	28,500	32,115
Couple years of protection in USG-supported programs	164,348	147,231	111,423	n/a	n/a
Percentage of USG-assisted service delivery sites providing family planning counseling and/or services	95%	100%	100%	100%	100%

Reproductive Health and Family Planning Output	Baseline	Year 1		Year 2	
		Target	Actual	Target	Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percentage of women of reproductive age using a modern family planning method	33.3%	36.7%	29.0%	28.0%	15.3%
Number of youth (15 – 25 years) accessing reproductive health from baseline to the end of the contract	64,492	74,166	67,408	75,983	50,482
Couple years of protection in USG-supported programs	232,012	255,213	503,512	460,493	208,046
Percentage of USG-assisted service delivery sites providing family planning counseling and/or services	94%	96%	96%	98%	96.3%

[2] http://www.unicef.org/statistics/haiti_62654.html

Prior to SSQH, use of modern family planning in Haiti went from 25 percent in 2006 to 31 percent in 2012, an increase of 124 percent. Despite the fact that both SSQH-N and SSQH-SC report that 96-100 percent of their sites provide family planning counseling and/or service, in both project years, use of family planning was below the baseline as well as below the national prevalence in 2006.

Temporary contraception methods (condoms, pills, and injectables) are provided at all the facilities visited by the evaluation team and by the majority of ASCPs working at the community level. Twenty-five percent of the ASCPs reported progestin-only pills (POPs) to be out of stock in the past three months.[3]

Access to long-acting and permanent methods (LAPM) is very limited and products and some services are not free: long acting methods (implants and intrauterine devices [IUDS]) are provided at the level of *Centre de Santé sans Lits* (CSL) and higher. However, of 17 facilities eligible to provide long-acting methods that were visited by the evaluation team, four could not provide IUDs and one could not provide implants because there was no trained provider on staff. While the service itself may be free, clients that want to use long-acting methods must have the time and money needed to travel to and from the limited facilities that can provide them.

Unlike temporary and long-acting methods, permanent methods (PM), i.e., tubal ligation and vasectomy, have no contraceptive commodity or device but require expendable medical supplies, instruments, and specially trained health professionals to perform the surgical procedure. A health provider at one facility said they could provide PMs if they had the necessary expendable supplies. And a key informant at a nongovernmental organization (NGO)-managed facility said that a staff physician could provide tubal ligations but he would charge a very high price for the procedure and the NGO hospital would charge for the use of the surgical suite.

Another factor that may affect the provision of family planning is related to USG restrictions on setting numerical targets for family planning users or offering provider incentives for increased performance. One health provider told the evaluation team that providers don't pay as much attention to family planning because they do not have performance targets to achieve and no incentive for what they do achieve.

On a more fundamental level, neither SSQH nor other social marketing and SBCC programs have effectively addressed or removed barriers to family planning services and products in Haiti: lack of public education; fear of side effects; and not knowing how to manage side effects, rumors, and misinformation about modern methods.

1.4 HIV AND AIDS Key Findings

Table 1.4 presents baseline data and SSQH-CS and SSQH-N targets and results achieved over Years One and Two for selected HIV and AIDS indicators.

[3] Due to low utilization, USAID no longer procures the Progestin-only Pill (POP)

Table 1.4. HIV/AIDS: Actual versus Expected Results

HIV/AIDS Outputs	Baseline	Year 1		Year 2	
		Target	Actual	Target	Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Number of individuals who received HIV testing and counseling (HTC) services for HIV and received their test results	51,596	73,227	82,374	67,500	70,926
Number of HIV positive adults and children who received at least one clinical care service	5,142	6,530	5,379	5,250	6,707
Number of adults and children receiving ART (Current)	2,247	3,487	3,333	n/a	3941
Percentage of all registered TB patients screened for HIV	n/a	90%	90%	90%	89%
Percentage of HIV-positive pregnant women who receive ARV to reduce risk of mother-to-child transmission (PMTCT) during pregnancy & delivery	79.8%	90.0%	84.0%	90%	86%

HIV/AIDS Outputs	Baseline	Year 1		Year 2	
		Target	Actual	Target	Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Number of individuals who received HIV testing and counseling (HTC) services for HIV and received their test results	131,254	118,555	147,813	125,004	167,202
Number of HIV positive adults and children who received at least one clinical care service	6,209	9,012	7,102	5,400	6,992
Number of adults and children with receiving ART	2,397	3,949	3,140	2,736	3,824
Greater than 90% of all registered TB patients screened for HIV at all SSQH-supported sites throughout life of contract	86.0%	90.0%	95.0%	96%	73.7%
Percentage of HIV-positive pregnant women who receive ARVs to reduce risk of mother-to-mother transmission (PMTCT) during pregnancy & delivery	89.4%	94.0%	87.2%	93.0%	75.3%

The evaluation team visited 16 facilities that provided some combination of HIV testing, counselling, and treatment. Two facilities provided no HIV and AIDS services. Smaller facilities (dispensaries) referred patients, typically pregnant women, for testing and treatment. If the referral clinic was not close or convenient and the patient did not have transportation or the means to travel, it could result in a loss of services. Facility staff told the evaluation team that there was a strong focus on HIV and AIDS services under SSQH. But even with greater focus, SSQH-CS performed below par in two important measures of service provision.

Facility staff highlighted "loss to follow up" (LTFU) as a critical concern because of the ramifications of a patient going without his or her treatment. There were a few facilities that worked closely with ASCPs to locate these "lost" patients and establish support groups in communities to encourage patients to continue with treatment. Facility staff reported receiving support from both SSQH projects for HIV programs, especially in the area of supervision and outreach.

Maternity staff, especially at smaller facilities that do not treat HIV patients, reported that they do not always know the HIV status of its pregnant women or whether or not they are on treatment. This situation creates a critical gap in service delivery where staff, newborn, and potentially other women delivering in the facility, are exposed to HIV infection.

1.5 Tuberculosis Key Findings

Table 1.5 presents baseline data and SSQH-CS and SSQH-N targets and results achieved over Years One and Two for three TB outputs.

Table 1.5. Tuberculosis: Actual versus Expected Results

		Year 1		Year 2	
TB Output	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percent of the estimated new smear-positive pulmonary TB cases that were detected under DOTS (case detection rate)	12.0%	15.0%	63.0%	85%	100.0%
Percentage adoption of a TB infection control plan at all supported facilities	0%	100%	65%	100%	46%
Number of patients receiving isoniazid preventative therapy (IPT)	3,771	4,714	4,525	n/a	4834

TB Output	Baseline	Year 1		Year 2	
		Target	Actual	Target	Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percent of the estimated new smear-positive pulmonary TB cases that were detected under DOTS (case detection rate)	43%	43%	43%	53.8%	75.5%
Percentage of project-supported facilities that have adopted a TB infection control plan	%	60%	32.5%	60%	42.5%
Percentage of PLHIV newly enrolled in HIV clinical care who start IPT	61%	76%	86.6%	95%	83.8%

Both SSQH-CS and SSQH-N increased identification of TB cases under the DOTs program; however, poor performance in instituting infection control practices may have reduced the impact of case prevention and control efforts. Infection control for TB also has many of the same practices as general infection control. Nine out of 15 health facility managers interviewed by the evaluation team (three under SSQH-CS: six under SSQH-N) reported poor infrastructure at their facilities. These included limited space for patients, lack of running water, and inadequate waste management disposal systems. The majority of facilities are not set up with separate entrances or waiting areas or other facilities for TB patients. The evaluation team observed handwashing stations for staff and patients at most of the sites but few sites had usable toilets for patients.

Another aspect of TB infection control, i.e., waste management, was one of the first issues that SSQH-N and SSQH-CS addressed at the facilities. SSQH helped facilities set up disposal units and sites to burn waste and they trained facility staff on safe practices of hospital waste disposal. While the team did not have a waste management specialist, the team observed the majority of facilities had some type of incineration.

1.6 Gender-Based Violence and Child Protection Services – Key Findings

Table 1.6 presents baseline data and SSQH-CS and SSQH-N targets and results achieved over Years One and Two for GBV and child protection indicators.

Table 1.6. Gender-Based Violence and Child Protective Services: Actual versus Expected Results

GBV & Child Protection	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Number of community and clinical health staff and community-based actors trained to recognize and refer GBV and protection cases to appropriate legal and social services	320	400	123	150	148
Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines)	110	121	120	100	99
Number of children reached by protection services	0	300	13	248	117

GBV & Child Protection	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Number of community and clinical health staff and community-based actors trained to recognize and refer GBV and protection cases to appropriate legal and social services	801	300	282	353	186
Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines)	175	201	138	120	113
Number of children reached by protection services		n/a	4,244	4,456	5,440

Social stigma and fear of retribution by a violator if charges are made are still tremendous barriers to women seeking care for GBV and reporting cases to authorities. This is especially true in rural areas where both the abuser and abused live in the same community. Concerns about creating social stigma or creating problems for the woman may also affect how facility staff address GBV. Facility staff told the evaluation team that they often know about GBV and child abuse cases that occur in the community and they know when a patient has experienced abuse, but are reluctant to be proactive about addressing abuse and said that they only felt comfortable if the patient initiated the discussion or reported the abuse.

From interviews and program reports the evaluation team found that many GBV and child protection activities were focused more on advocacy with community organizations and police and community

leaders and less on training of facility staff and counselors – although some had started. Staff in four facilities reported they did not have rape kits.

1.7 Water, Sanitation, and Hygiene (WASH)

Table 1.7. WASH: Actual versus Expected Results

WASH	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Number of individuals trained to implement improved sanitation methods		297	181	237	136
Number of households with soap and water at hand washing station commonly used by family members in USG-assisted programs		n/a	n/a	6,211	n/a

WASH	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Number of individuals trained to implement improved sanitation methods	282	69	282	353	186
Number of households with soap and water at hand washing station commonly used by family members in USG-assisted programs	n/a	n/a	n/a	819[4]	379

There was a massive water and sanitation public health campaign following the 2010 earthquake and the outbreak of cholera. The USAID/Haiti social marketing project was very active in the clean water campaign and water purifiers were initially distributed for free in response to the cholera outbreak; it then shifted and purifiers were no longer distributed for free, but they were available for sale in shops, pharmacies, and by small vendors. In interviews[5] with mothers and women outside of clinics in urban areas, women were very familiar with how important it was to purify drinking and cooking water; they were also familiar with the purification brands and methods of purification.

Many of the facilities visited had a handwashing station near the main entrance; several had stations inside the facility in waiting areas; most had a bar of soap (one site manager said they always put out a bar of soap in the morning but it "disappears" during the day); only one facility was observed having a

[4] The original target for year two for SSQH CS was 127, 271. It appears from the SSQH CS Annual Report 2015 that the target number was revised to 819. For this evaluation report the authors are using the data from the SSQH reports.

[5] These interviews were conducted as part of an evaluation conducted of the Haiti SBCC program. The report was shared with members of the evaluation team.

handwashing station (with soap) adjacent to the latrines. The evaluation team was also informed of National Handwashing Day events held throughout the country on October 15, linked to the Global Handwashing campaign of the United Nations and the private sector. The team also observed posters and information while driving through rural towns.

While the evaluation team observed some WASH activities, the progress toward the indicators is limited for both SSQH projects and tells a different story. Neither project started activities to address household hand washing stations until Year Two. The SSQH-CS PMP notes that 46.2 percent of households surveyed (379 of 819) have hand washing stations with soap.

1.8. Conclusions: Key Issues that Affect Service Delivery

USAID/Haiti has focused on these health areas for over three decades and the issues that were prevalent in the 1990s are still issues today. The broad answer to the question of what are the key issues that affect service delivery can be categorized into the tangibles and intangibles. The tangibles can be categorized as supplies and equipment, trained service providers, and facility infrastructures that are easy to quantify. The intangibles are less apparent and are about issues such as the collaboration among SSQH staff and the facilities, social and behavioral aspects of the community that receives the services, and how they deal with health issues and services available to them.

Each of these factors has its own barriers and motivators. From the interviews and facility visits the evaluation team saw that the majority of the tangible issues have not been addressed and that the intangible factors have not been incorporated into the program design.

The key issue was that the clinics and facilities needed an infusion of support in training and capacity building, infrastructure strengthening, management systems, and public education, but the two projects did not design a systematic plan to address these issues that would lead to improved service delivery.

Though both projects conducted needs assessments to identify where specific interventions were required, heath service providers reported that project inputs by SSQH-N and SSQH-CS focused on clinical and technical activities, i.e., MCH, HIV, and AIDS, rather than on operational (administrative and management) matters and the facilities' infrastructure.

At health facilities providers reported a long list of stock-outs of vital medicines, equipment, and supplies, including: IUDs, antibiotics, Oxytocin, and rape kits. Several ASCPs said they do not have iron and folate tablets, oral rehydration salts, oral contraceptives, weighing scales or MUAC measuring tapes for growth monitoring, service registers, and vaccination cards. There were several reasons for the stock-outs: poor supply management at facilities led to stock-outs and the solutions were either for facility staff to purchase needed drugs and products at private clinics or wait until the next delivery; at some clinics refrigerated commodities are stored in separate buildings that are not easily accessible to staff during off hours. As noted previously, although vaccines and Vitamin A are not procured by USAID and neither USAID nor SSQH is responsible for their provision or distribution, stock-outs negatively affected project results.

Another finding is that the start-up of the two SSQH projects was not smooth and took over a year for activities to begin, which may have affected the delivery of health services. Among the issues raised by subcontractors on the award were delays of six to nine months to receive operating funds from the primary contractor (USAID/Haiti released funds to the primary contractor well in advance of the program starting), and requiring the subcontractors to use their own funds from other programs to cover their implementing costs. In fact, because they have cost-reimbursement contracts, the partner

organizations routinely have had to wait for many months to be reimbursed for funds spent on activities and operating costs. Local NGOs also reported that there was poor communication among the team, resulting in confusion over the strategy, activities, and progress of the project.

Training of the health providers at the clinic level remains a priority and it has management support for service delivery to be scaled up. ASCPs are a critical link between the facility and clients. With their understanding and trust of the community, they can be instrumental in increasing demand for services, conducting targeted outreach to address barriers to health-seeking behaviors and providing basic services for family planning, antenatal, postnatal care, and infant and young child health. ASCPs are willing to undertake these tasks, but they expressed the need and desire for additional training, educational materials, and commodities to provide these services.

1.9. Recommendations

- Conduct a full needs assessment, including technical, management, and infrastructure, to design a program and prioritize implementation. Utilize existing research and conduct additional audience assessments to improve the program design. Prioritize the number of indicators required by the contractor and, if possible, reduce the number.
- SSQH must engage with the GOH at the national and department levels to ensure commodities are made available to health facilities. The projects should also coordinate with the other USAID partners such as the Procurement and Supply Management Project (PSM) and the social marketing and demand creation project under Strengthening Health Outcomes through the Private Sector (SHOPS). Working with PSM will help to address stock-outs of commodities provided by USAID and the logistics management capacity at facilities for monitoring of commodity stock levels, timely reporting, and accurate forecasting in order to guarantee availability of essential commodities. SSQH should ensure that stock rooms exist at each facility to meet basic standards and that supplies that need refrigeration are accessible to facility staff and ASCPs where electricity is not available.
- Conduct annual quality reviews and assessments of facilities to measure delivery and impact of programs' technical assistance and support. Establish a grade system for clinics and facilities based on improvements in services and technical skills provided.
- ASCPs can be instrumental in increasing demand for services, conducting targeted outreach to address barriers to health seeking behaviors, and providing basic services for family planning, antenatal, postnatal care, and infant and young child health. ASCPs are willing to undertake these tasks, but they expressed the need for additional training, educational materials, and commodities to provide these services.

2. QUALITY MANAGEMENT OF HEALTH SERVICES

Question 2: To what extent has SSQH improved the quality of health services at the facility and community levels, and strengthened capacity of health authorities to manage and monitor service delivery? What are the barriers to improving quality?

SSQH underperformed in all the key activities related to quality as found in the indicators and defined by the team. Poor performance in data collection and reporting is a critical problem, which can undermine many aspects of management and service delivery. Stock-outs and inadequate management of products at facilities and lack of adherence to standard of care (excluding routine antenatal care services during facility visit) directly affect provision and quality of services. Quality improvement committees and

technology applications, designed to improve the quality of care, are not at scale and therefore have little to no impact on quality.

Improving the quality of health services requires attention to many different management, technical and clinical issues. Management issues are the focus of the evaluation's team's response to Question 2. The team evaluated SSQH performance in a range of areas associated with quality management of health services, including: general management and supervision, management and supervision in support of the *Direction Départementale de Santé*, health information systems (HIS), use of technology, communication and coordination and service delivery standards, and provider adherence to treatment protocols.

2.1 Quality Improvement and Quality Assurance (QI/QA) Key Findings

Table 2.1. Quality Improvement: Actual vs Expected Results

Quality Improvement	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of sites implementing continuous quality improvement plans	0	100%	n/a	75%	54%

Quality Improvement	Baseline	Year 1 Target	Year 1 Actual	Year 2 Target	Year 2 Actual
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percent of project-supported sites implementing continuous QI plans that incorporate a system to identify and follow-up on identified issues	48%	100%	68%	100%	100%

Given the emphasis on quality improvement in the SSQH project design and the reported results in the PMPs, the evaluation team expected to find numerous examples of quality improvement approaches being used by facility committees in SSQH-supported areas. At 15 facilities where questions were asked specifically about QI/QA committees, respondents at five sites (33 percent) reported that they have a functioning QI/QA committee; two (13 percent) reported that there is a QA committee for HIV service unit only; three (14 percent) reported that there is no QI/QA committee but that quality issues are discussed during regular staff meetings; and five (33 percent) reported that they have no form of QI/QA discussion. These findings are at odds with the results reported in the PMPs particularly for SSQH-CS in Year Two.

Recommendation:

- Assess the types of QI/QA committee that are in place, how they function, and how often they meet. Ensure that they are merged with existing structures at the facilities. Provide guidance on using facility data at committee meetings. Assess the utility of the committees to the quality of health service delivery.

- SSQH should work with DDS staff to identify practical ways to strengthen mechanisms for QI/QA within facilities:
  - For facilities with existing QI/QA committees and sites that use regular staff meetings for discussions of quality, SSQH should provide assistance on better use of data for decision-making and problem solving; adherence to service delivery standards; and conducting regular follow-up and supervision.
  - For facilities where a QI/QA committee is functional in just one unit, the project should work with facility managers to expand QI/QA activities to other units.
  - For facilities that currently do not have meetings or other means to discuss and address quality issues, SSQH should provide assistance to introduce QI/QA processes.
  - SSQH should work with facilities on ways to include ASCPs in QI/QA discussions and problem solving.

2.2 Health Information Systems

Table 2.2 Health Information Systems: Actual versus Expected Results

		Year 1		Year 2	
Health Information Systems	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of USG-supported primary health care facilities that submit routine reports according to national HIS policy.	0.0%	80.0%	Not reported in Year One	90.0%	49.0%

		Year 1		Year 2	
Health Information Systems	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percentage of USG-supported primary health care facilities that submit routine reports according to national HIS policy.	82.0%	82.0%	82.0%	90.0%	65.0%

Availability and use of data are essential for quality improvement approaches. There is a critical problem with routine reporting of data from SSQH-supported facilities, with substantial drops in numbers for both projects. Data are not collected properly, reported correctly or on time. Facilities and programs cannot be managed efficiently and effectively without data to guide decision-making. Management and supervision support to the DDS took more than a year and a half to develop before activities started.

The evaluation team learned of the problems with data reporting from the Ministry of Health (*Ministère de la Santé Publique et de la Population* or MSSP), DDS, subcontractors, and facility staff. Data collection and reporting at facilities and in communities remains labor-intensive and cumbersome. Most of the facilities visited during the evaluation had limited electricity and Internet connectivity, and computer access for data entry. Other than the limited application of COMMCARE, M-Health technologies are not being used for data collection. ASCPs reported shortages of immunization logs and health cards for documenting services provided during client visits, and said the facilities lack space and proper storage for files.

Furthermore, service delivery data are not being used for decision-making at the facility level. Facility managers reported that monthly data are not being used at facility meetings.

Recommendations

- SSQH and the government, including the facility managers, should design data collection and application guidelines and training for the facilities staff to create a "cultural shift" toward collecting and using data. The guidelines should reinforce the importance of collecting, reporting, and using data to deliver quality health care services. Staff throughout the facility should have active input in designing the data collection guidelines. Facilities should establish formal methods of feedback on the services they provide to their community. QA/QI teams should review data routinely to uncover problems and to make decisions for planning activities. If needed, incentives should be used to encourage timely reporting.
- SSQH facilities need intensive technical and management capacity building support and ongoing monitoring to ensure the quality of the data and the timeliness of reporting. To improve accurate and on-time reporting, SSQH should work closely with sites to determine the main barriers that prevent reporting, and design systems to address and reduce them, including conducting regular data reviews with facility staff. For example, SSQH can create data management teams made up of data collection and systems managers that can troubleshoot reporting and data management at the facility level. This would include establishing daily procedures for data entry and ensuring the data are accurate. At times, these teams can help with the data entry when staff is not available to ensure timely data collection and reporting. There is a large backlog of data at many facilities and these technical teams can help manage this task. Technology developed under SSQH or other simple data collection tools should be employed and scaled up.

2.3 Management and Supervision

Both projects reported many activities during the first two years of SSQH related to management and supervision, including training curriculum and programs, capacity building plans, and management tools for departmental staff. SSQH-N capacity strengthening focused primarily on financial management and supportive supervision/coaching and joint health visits. SSQH-CS worked closely with MSSP to develop checklists and tracking tools that were introduced and explained during capacity building workshops with the DDS. Start-up for some of these management and supervision activities has taken over a year and a half before activities finally occurred in Year Two. However, SSQH-N and SSQH-CS completed training in Results-Based Financing (RFB).

Department directors reported that capacity building is driven by the partner's expertise, schedule, and availability. Department staff recommended that SSQH develop a clear work plan and schedule for

capacity building of health services staff that can be implemented by the end of this contract cycle. One director told us, "These activities have not been carried out regularly or completely. This is an important element of improving the system."

During a group discussion, DDS directors told the evaluation team that SSQH is overlooking the technical expertise that exists among Department staff and recommended that the SSQH projects tap into it for valuable insights for capacity strengthening.

Recommendations

- Accelerate management and supervision of capacity building activities with DDS offices and identify ways to leverage use of and reinforce existing knowledge among DDS staff.
- Identify ways to increase the impact of the management capacity building and supervisory visits by implementing tools for assessing issues at the sites and for following up recommendations.

2.4 Use of Technology

Technology has not been used effectively in the SSQH project. Electronic patient records, mobile phone SBCC interventions, and digital training applications that are used extensively in other countries are still in pilot phases in Haiti. The COMMCARE technology and its applications for data collection, patient education, and monitoring compliance with medications and services has not been brought to scale after two years of development, even though it has been used successfully in other countries.

During the pilot evaluation, ASCPs who used COMMCARE reported that they liked it and that it was easy to use. They did mention problems with recharging their mobile devices (tablet computers) when using them during community visits. Currently, only 300 ASCPs and other facility staff have been trained to use COMMCARE. The evaluation team found staff that had the equipment and had been trained but were not actively using the platform. The evaluation team did not interview the COMMCARE team and did not discuss with them the reason(s) for delays in implementation.

The evaluation team found very few behavior change communication (BCC) tools, either for counselling or patient education, to be used by the ASCPs and at the facilities. In group discussions, ASCPs asked for current information on health practices and materials to use during their home visits. COMMCARE, through one of its applications, can provide convenient access to health information and communication and counseling materials for the ASCPs. This feature, if brought to scale, could offer a wealth of tools for ASCPs to address patient needs.

Other applications of COMMCARE, when refined and scaled up, are data collection, patient referrals, GPS tracking of service delivery, patient education, counselling content, and compliance reminders.

Recommendations

- Accelerate scale-up of COMMCARE or similar tools such as MSante. With the government, develop content and develop a timeline and indicators for evaluating the scale-up and use. Document and monitor the utility of the various applications for ASCPs and their supervisors.
- Technology applications, which are well-tested and scaled up in other countries, have immediate application in Haiti. M-CARE, MAMA, and UREPORT are a few that can be used for training and capacity building, compliance medical treatments, well mother care, data collection, and other health service delivery issues.

- Create an SSQH Technology team – or an external team – to recommend existing technology applications that can contribute to the delivery of health services.

2.5 Materials, Supplies, and Equipment

As already discussed in the Question 1 response, stock-outs of various products have a negative effect on the availability and quality of services. USAID procures contraceptives and antiretroviral therapy (ARVs) for Haiti but procurement of other commodities and medicines is not the responsibility of USAID or SSQH. While SSQH cannot control the availability of medicines and commodities that are purchased by the MSPP or other donors, it can strengthen their capacity to manage the availability and storage of commodities.

Table 2.5. Supply Management: Actual versus Expected Results

		Year 1		Year 2	
Supply Management	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of institutions implementing a timely and accurate procurement process for vital products.	0	50%	23%	56%	53%

		Year 1		Year 2	
Supply Management	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percent of project-supported sites experiencing stock outs of vital products		10%	13%	8%	18.8%

Regardless of which organization procures them, achievement of SSQH results for increased service coverage and improved quality depends on the availability of commodities, medicines, and supplies.

ASCPs across the departments regularly reported that they do not have all the medicines, supplies, and equipment required for the full range of community level services they are expected to provide or suitable gear for their work environment. Items reported as out-of-stock within the past three months included Vitamin A, iron and folate tablets, oral rehydration salts, progestin-only contraceptive pills, vaccines, service registers, and vaccination cards. Several ASCPs said they do not have weighing scales or MUAC measuring tapes for growth monitoring. Separately from supplies, all the ASCPs interviewed said they need rain gear (boots, raincoats), flashlights, and bags or backpacks to carry their service registers and supplies. They also reported needing mobile phones and credit or SIM cards to make calls. Currently, the ASCPs pay for SIM cards out of pocket and are not reimbursed. According to ASCPs interviewed, it is common practice for them to walk one or more hours to and from the health facility to pick up supplies and to attend meetings with supervisors. To facilitate their work, they said they need a transportation allowance or a means of transport, such as a motorbike, bicycle, horse, or donkey, depending on their location.

Recommendations

- Collaborate with the DDS, UNICEF, and other USAID partners such as the PSM Project to identify technical assistance needed to address supply chain problems.
- Strengthen the capacity of supply and commodity management staff at facilities and DDS to ensure accurate stock management, timely product forecasting, and requisition.
- Institute hand-held technology to track commodities and supplies to monitor inventory and avoid stock-outs. These technologies are common practice under the previous SHOPS project and new PSM projects, so could be expanded to SSQH.
- Work with the DDS and community health program managers to determine how to provide ASCPs with the means of communication and transport needed to perform their jobs.

2.6 Adherence to Service Delivery Standards

This analysis examines two health services – tetanus toxoid vaccination and HIV testing – that health providers should administer during routinely antenatal visits. SSQH facilities did not attain adherence to service delivery standards in maternal health, prevention of mother-to-mother transmission (PMTCT), and HIV care and treatment. In all departments in SSQH-N, an average of about 50 percent of ANC clients dropped out by the fourth visit and only 50 percent received a second dose of tetanus toxoid (Fig. 1). Only 50 percent of antenatal clinic attendees were tested for HIV in the Northeast. SSQH-N reported that on average, 90-100 percent of ANC clients were tested for HIV.

Figure 1. SSQH North – Completion of ANC 4th visit and uptake of tetanus toxoid in ANC (2015 up until

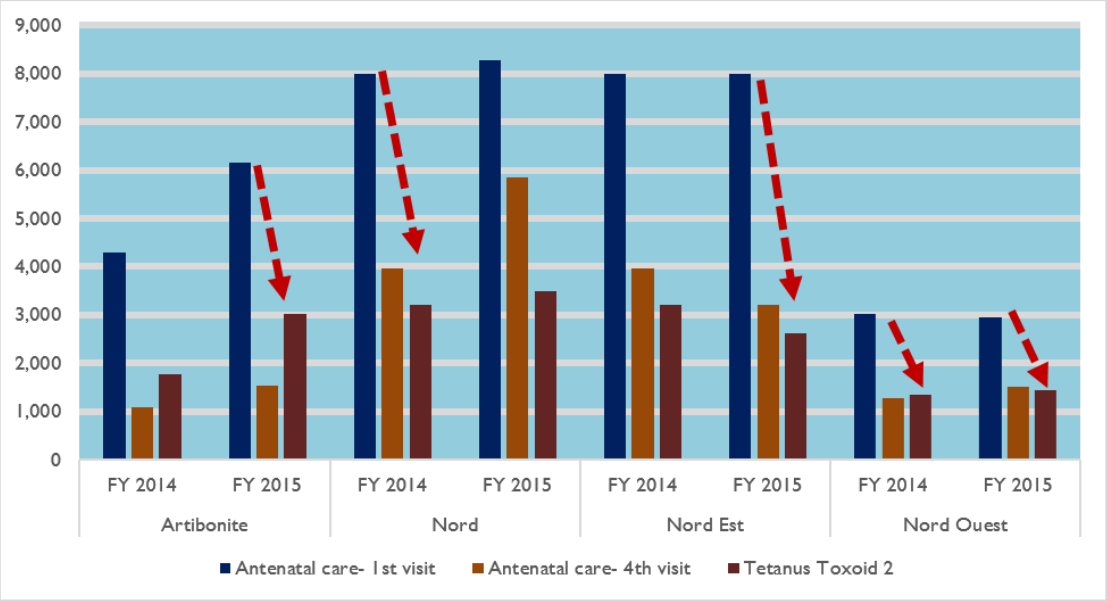
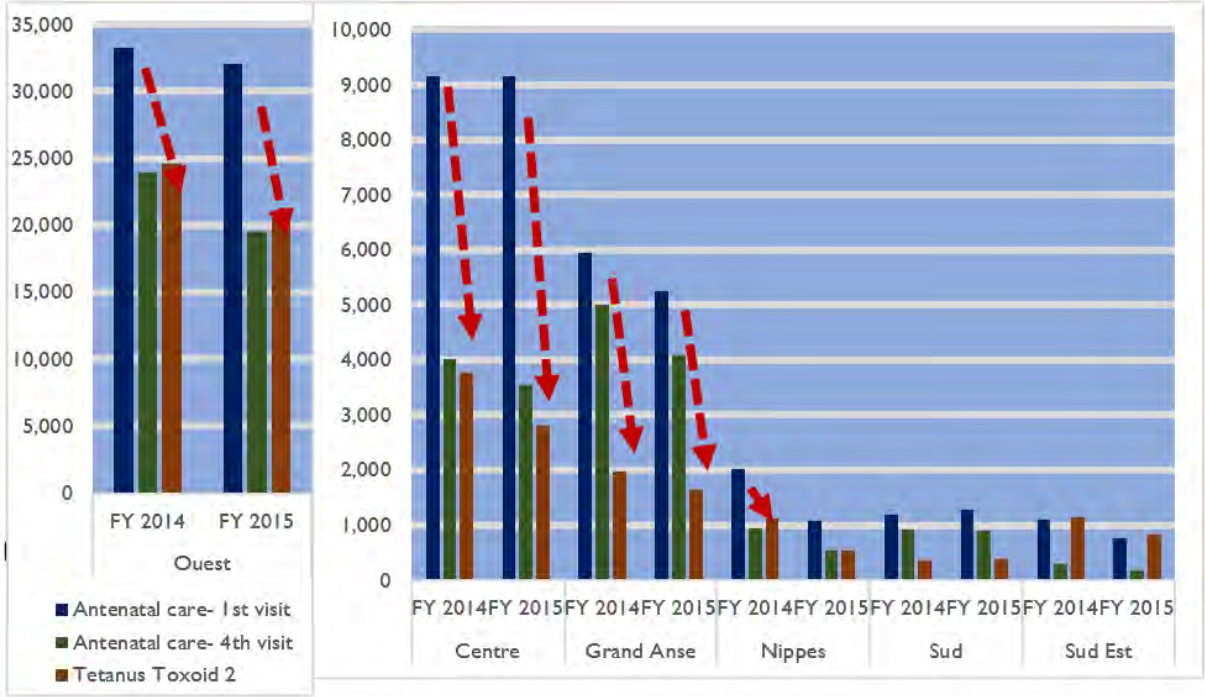


Figure 2. SSQH C/S – Completion of 4th visit and uptake of tetanus toxoid in ANC (2015 up until June)



Among facilities in the Centre department supported by SSQH-CS, more than 50 percent of ANC clients dropped out by the fourth visit. In the remaining departments, an average of 60-65 percent of ANC clients was retained in ANC and the same number received a second dose of tetanus toxoid (Fig 2).

Only 10 percent and 16 percent of ANC first-visit clients were screened for HIV in Centre and Sud Est departments respectively (Figure 4).

Figure 3. SSQH North – Screening for HIV at first ANC visit uptake (2015 until June)

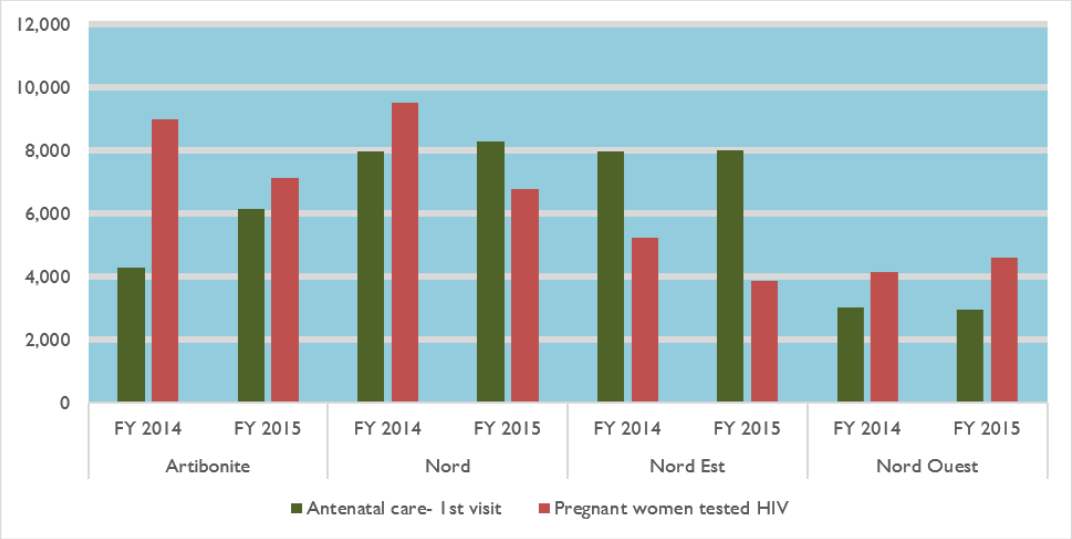
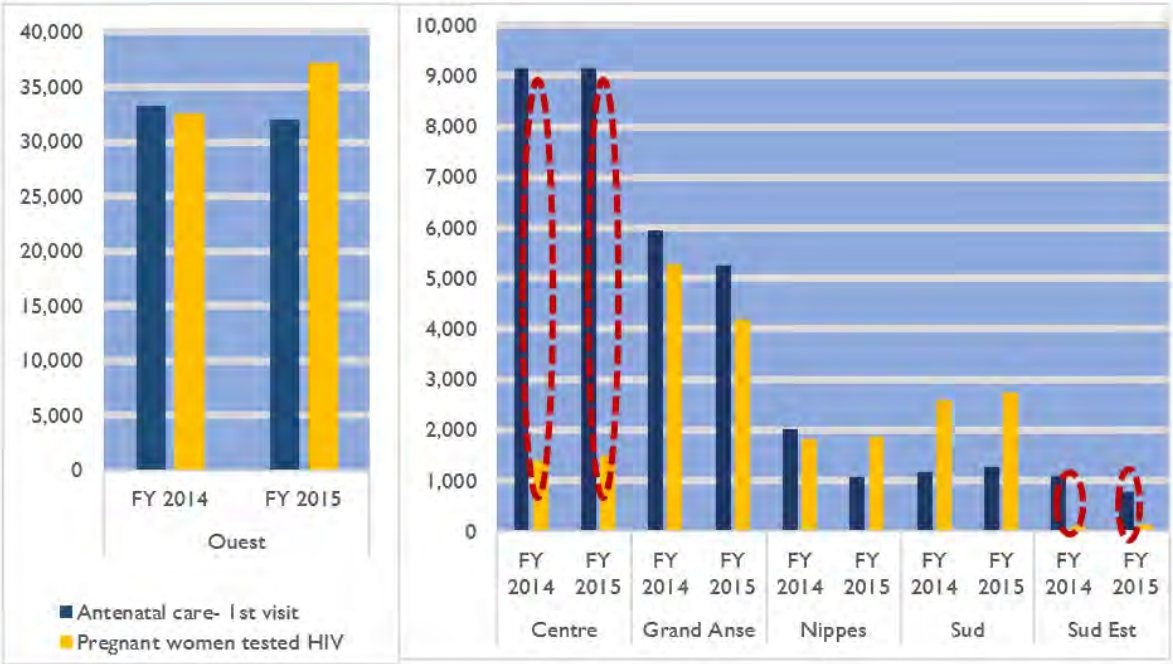


Figure 4. SSQH CS – Screening for HIV at first ANC visit uptake



The evaluation team did not uncover the reason for this problem with adherence. Reported increases in the number of patients at health facilities and staff shortages can contribute to providers neglecting to provide a routine service. These lapses in service provision can undermine the effectiveness and quality of the health services delivered.

Recommendations

- SSQH needs to identify facilities where adherence to service delivery standards is low and conduct training and supervisory visits to determine the barriers at the sites.
- Address behavioral barriers that deter women from visiting the clinics for care. Work with ASCPs and community health committee to develop outreach strategies for reaching pregnant women.
- Quality assessment teams at facilities need to develop internal plans to address low rate of HIV testing for pregnant women.
- SSQH and the Departments should monitor data from facilities that have low adherence and screening rates.

2.7 Loss to Follow-Up

Loss to follow-up of HIV-positive pregnant women was well above 10 percent (range: 16-23 percent) in five SSQH departments. For more information, see Figures 2.5 and 2.6 in Annex VI.

Three departments in SSQH North, Artibonite, North, and Northwest, had LTFU rates higher than 10 percent in Year Two (20 percent, 16 percent, and 22 percent, respectively). Among SSQH-CS departments, Center and Grand-Anse had LTFU rates higher than 20 percent in Year Two (21 percent and 23 percent, respectively).

Interventions to encourage adherence to ARV and other medical treatments need to be patient-focused and address the key obstacles that are creating drop-off rates. Physical reactions to drugs, attitudes of providers toward patients at health facilities, ease of access to regular treatment, and support from family and friends to continue treatment and ongoing behavioral support for adherence are important factors to successful adherence over time.

Both SSQH projects report focused activities involving community outreach with community health workers and facility staff through mobile clinics, targeted ASCP visits, and HIV support groups in communities. These are promising but are still small-scale.

Recommendations

- Monitor facilities with high lost-patient rates to determine the barriers affecting patient compliance.
- Conduct target research to understand barriers to compliance for a range of treatment protocols that require long-term treatment.
- Develop approaches to address these barriers and increase compliance with facility staff, ASCPs, and community health committees to develop a community-wide approach to addressing the barriers.
- Consider increasing the resupply of drugs to reduce the frequency of client visits, such as increasing ARV resupply from two months to three to six months.
- Ensure facility staff are reinforcing the need for compliance with treatment and are counselling patients about the problems related with stopping treatments.

3. COMMUNITY HEALTH ACTIVITIES

Question 3: How are community-based approaches and community health workers being used within the project to improve access and use of integrated health services? Which community-based activities to strengthen referrals and retention show evidence of leading to improved health outcomes within the integrated primary health care context? Which interventions are not working?

Nonprofessional workers are the backbone of the community health program and have evolved from being minimally trained volunteers to the current category of polyvalent community health agent or ASCP.[6]

3.1 Community Level Service Delivery Approaches

ASCPs working in the SSQH project areas are actively involved in community-based provision of preventive health services as well as health education and promotion, surveillance, and referral to health facilities. ASCPs primarily perform their work through household visits and regularly scheduled outreach events called Rally Posts.

Household visits are conducted to identify and refer cases or follow up with patients covering a wide range of service areas (e.g., HIV/AIDS, malaria, and tuberculosis; family planning, ANC and postnatal care (PNC), respiratory infections, diarrhea, nutrition, and hygiene), as well as for following up on referrals and tracing LTFU clients.

ASCPs interviewed by the evaluation team cited ANC and PNC visits and referral follow-up as the tasks most frequently performed during home visits. As shown in Table 1.1 (under Question 1 response) SSQH-CS exceeded the target for the percentage of newborns visited within three days of birth. The PMP noted that the achievement "is the result of success of community health worker follow-up during home visits to encourage women who have delivered to return for post-partum visits."

ASCPs described home visits as follow-up for a specific issue, i.e., an episode of diarrhea or a respiratory infection, or a missed vaccination. But home visits provide a good opportunity to identify and address multiple health issues facing a household if ASCPs have the knowledge and skills for such an integrated approach. For example, a visit to check on a child with diarrhea could also include assessment and counseling about hygiene (presence and correct use of latrine/toilet and hand-washing facilities) and nutrition (including optimal breastfeeding and infant and young child feeding), thereby covering multiple, interrelated factors related to diarrhea. SSQH-supported training of ASCPs is focused on the MSPP's integrated package of essential services and improving their interpersonal communication skills.

Rally Posts are scheduled to be held on a monthly basis at a designated community location, such as a school, church, or an individual's home. Growth monitoring, vaccination, and health education were the most frequently cited services provided at Rally Posts – followed by ANC (and tetanus toxoid vaccination), Vitamin A supplementation dosing, and family planning of education and provision of condoms, pills, and injectables. Breastfeeding and hygiene promotion were cited by only one group of ASCPs interviewed as included in the events. All ASCPs interviewed reported that health education is a

[6] Although there are several categories of workers engaged in community-level health services, notably *matrons* (traditional birth attendants or TBAs), the evaluation focused on ASCPs, as they are the community health workers that are paid by SSQH projects.

regular part of Rally Post activities but a majority said they do not have SBCC and promotional materials to use.

Tracing clients that are lost to follow-up was the task least reported by the ASCPs with only one reference to LTFU for family planning and one for ANC. SSQH partners, however, do report treatment follow-up activities involving ASCPs.

ASCPs occasionally accompany clients who need to go to a health facility, although most ASCPs reported that accompaniment depends on the particular case and condition of the client.

Recommendations

- Ensure that ASCP training and supervision promotes and reinforces an integrated approach to BCC and service provision.
- Clarify MSPP's ASCP policy to increase responsibilities for health education and health promotion and limit them for service delivery. The evaluation team heard many interpretations of the ASCP policy and recommends that MSPP or DDS release a statement clarifying the duties related to education and service delivery.
- Review and revise ASCP training materials and supervision guides to improve capacity in nutrition assessment and counseling, and TB, HIV and AIDS treatment, counseling and client follow-up.
- Develop, produce, and distribute BCC materials to ASCPs. Make BCC information available through mobile technology and/or partner with existing BCC partners.
- To reduce clients that are LTFU and improve adherence to screening and treatment protocols, SSQH needs to develop multi-pronged approaches that include research with patients to uncover barriers, institute processes at facilities that fast-track patients on long-term treatments, and develop individual and community support interventions.
- Use existing mobile phone technology projects to send mobile messages to remind patients to take their medicines. PEPFAR has many successful models of addressing LTFU that can be applied in Haiti and should be examined for viability. There are many behavioral interventions built around family and community support models that can be applied in Haiti.

3.2 Community Mobilization Approaches

Projects with a significant community-level focus often include strategies to foster participation of community leaders and members in addressing priority health issues and to involve the community in managing community-based health activities. Multiple key informants interviewed reported that neither SSQH-N nor SSQH-CS included sufficient plans or funding in the original proposal submissions. The project work plans, budgets, and PMPs were subsequently modified to add the community health component, including community mobilization strategies.

SSQH-N based its community mobilization approach on the Community Action Cycle (CAC). As described in project documents, CAC was to be used to identify existing community groups that could be trained to help coordinate health activities and support the ASCPs. Strengthening referral networks was to be an important function of the community groups. SSQH-N reported conducting various activities in the Artibonite and Nord-Ouest departments as part of the community mobilization approach: awareness-raising campaigns, training, and support to grassroots groups to promote health-

seeking behaviors within the population, capacity building of community-level providers to deliver quality health services, and the promotion of access to care across all technical intervention areas.[7]

SSQH-CS reported that it was developing a community mobilization approach based on its HIV strategy which "builds upon home visits, community support groups (i.e., *clubs des mères*), COMMCARE, psychosocial services, and peer accompaniment to reinforce and promote service delivery." Another component of the community mobilization approach is Pathways to Change (P2C), a board game to identify facilitators and barriers to service access and use for HIV, GBV, FP, and MCH and nutrition. P2C was used during ASCP trainings in 12 *Zones Ciblées* (targeted zones) and the project reported plans to expand its use. [8]

Work with community health committees (CHCs) frequently features prominently in community mobilization strategies to help forge links between community members and healthcare providers, assist with arrangements for referrals, and advocate with local authorities for resources. The PMP for SSQH-N reported that 499 community members participated in community-level quality improvement meetings in Year Two but such meetings were not reported to the evaluation team during interviews. Neither the ASCPs nor other facility staff reported that CHCs were a focus of the approaches or were being supported by the projects. Nine out of 12 groups of ASCPs interviewed said there are CHCs in the areas where they work; only one group said that the committee assists with organizing transportation for referrals. In general, the ASCPs had difficulty describing the activities of the CHCs, which suggests that there is insufficient collaboration between the committees and the ASCPs, that the role of the committees is undefined, and the possibility that committee members and ASCPs have not been trained to work together.

To take effect and produce positive change, community mobilization approaches require continuous support and follow-up over an extended period of time. Therefore, it is not surprising that at the time of the evaluation there was no evidence of the effectiveness of the community mobilization approaches used by SSQH-N or SSQH-CS in bringing about improved healthy behaviors, increased use of health services, or strengthened health referral networks. With only six to nine months of implementation experience in limited geographic areas, it is too early to determine effectiveness. That said, it is worth noting that none of the ASCPs or other facility staff interviewed by the evaluation team reported having participated in a Community Action Cycle session or a Pathways to Change game. As discussed below in section 3.3 Health Service Coverage at Community Level, the volume of community-level services is generally greater than that of comparable services provided at facilities. It is possible that some of the community-level service utilization has been prompted by community mobilization activities but other activities, such as ASCP training as well as long-established schedules for Rally Posts, are likely to be important contributors to community-level services.

Recommendations

- Increase investment in community-based interventions, including more work on community mobilization to promote healthy behaviors and increased use of health services.
- Design an integrated community mobilization plan that is inclusive of community health committees and ASCPs and train all actors in the mobilization approaches.

[7] SSQH-Nord Final Progress Report, Oct 2013 – July 2015 – DRAFT

[8] Services de Santé de Qualité pour Haïti (SSQH) Central and South Contract No. AID-521-C-13-00011. FY 2015 Semi- Annual Report: October 1, 2014 – March 31, 2015

- Rejuvenate CHCs and other community groups and develop their capacity to assist the ASCPs with Rally Posts, surveillance activities, and liaise between the ASCPs and community members.
- Organize periodic meetings of facility managers, ASCP supervisors, ASCPs, and CHCs to strengthen communication and coordination between facilities and communities.

3.3 Health Service Coverage at Community Level

Health personnel at all the facilities visited during the evaluation reported that ASCPs contribute to increased utilization of health services through their BCC activities and promotion activities as well as by the provision of authorized services. Service statistics taken from the national health information system (*Système d'Information Sanitaire Nationale Unique* or SISNU) show that for all client visits (new and follow-up), the number of visits reported at the community level exceeds the number at the facility level.

Table 3.1 presents data for the periods from November 2013 to June 2014 and from November 2014 to June 2015 for all institutional and community client visits for the areas included in the evaluation sample.

Table 3.1. Institutional and Community-Level Client Visits, Years One and Two

SSQH-N									
November 2013 – June 2014					**November 2014 – June 2015**				
Total	Institutional		Community		**Total**	Institutional		Community	
	#	%	#	%		#	%	#	%
600,067	233,916	39	366,151	61	**597,423**	223,318	37	374,105	63
SSQH-CS									
November 2013 – June 2014					**November 2014 – June 2015**				
Total	Institutional		Community		**Total**	Institutional		Community	
	#	%	#	%		#	%	#	%
562,483	268,259	48	294,224	52	**636,442**	262,458	41	373,984	59

The contribution of ASCPs to service coverage is particularly notable for vaccination, family planning, and antenatal care (TT vaccination). Table 3.2 shows institutional- and community-level data for selected services that ASCPs provide in the sampled areas of SSQH-CS for Years One and Two.

Table 3.2. SSQH-CS Service Provision, Years One and Two

SSQH-CS										
Service	November 2013 – July 2014					November 2014 – July 2015				
	Total	**Institutional**		**Community**		Total	**Institutional**		**Community**	
		#	**%**	**#**	**%**		**#**	**%**	**#**	**%**
Vaccin-ation	108,129	37,887	35	70,242	65	**93,076**	27,198	29	65,878	71
Family Planning	149,616	41,519	28	108,097	72	**106,358**	34,889	33	71,469	67
TT Vaccin-ation	55,625	24,906	45	30,719	55	**38,005**	15,807	42	22,198	58
STI/ HIV/ AIDS	84,532	41,858	49	42,674	51	**80,820**	39,091	48	41,729	52

SSQH-CS										
Service	November 2013 – July 2014					November 2014 – July 2015				
	Total	Institutional		Community		Total	Institutional		Community	
		#	%	#	%		#	%	#	%
Pre-vention										
TB Pre-vention and Control	29,781	13,917	47	15,864	53	29,729	14,318	48	15,411	52
Total	427,683	160,087	37.4	267,596	62.6	347,988	131,303	37.7	216,685	62.3

Data on SSQH-N service utilization in Year One (November 2013 – June 2014) is presented in Table 3.3. A change in the reporting format used by SSQH-N in Year Two did not allow comparable data extraction for November 2014 – June 2015.

Table 3.3. SSQH-N Service Provision, Year One

SSQH-N										
Service	**November 2013 – June 2014**					**November 2014 – June 2015**				
	Total	Institutional		Community		Total	Institutional		Community	
		#	%	#	%		#	%		#
Vaccination	50,048	10,243	21	39,805	79	Comparable data not available				
Family Planning	48,322	13,743	28	34,579	72					
TT Vaccination	13,635	5,202	38	8,433	62					
STI/HIV/AIDS Prevention	49,293	26,185	53	23,106	47					
TB Prevention and Control	25,544	9,848	39	15,696	61					
Total	186,842	65,221	34.9	121,619	65.1					

In Year One, SSQH-N departments provided a greater proportion of services at the community level than in SSQH-CS departments. In both SSQH-N and CS, the smallest difference between facility and community-based service is for sexually transmitted infection (STI)/HIV/AIDS prevention for pregnant women and women of reproductive age. In SSQH-N departments, the only service provided in greater proportion at the facility level is STI/HIV and AIDS prevention for pregnant women and women of reproductive age. Several key informants reported that many ASCPs have not yet been adequately trained in HIV and AIDS services, which may account for the lower levels of service provided by ASCPs. SSQH-CS reported that during the last quarter of Year Two, ASCPs began providing support and follow-up at the community level. According to the PMP, 1,441 HIV positive adults and children received care outside the facility.

A category of CHW called *Agent de Terrain* provides community-level HIV and AIDS care in some areas, although they were mentioned to the evaluation team at only one site, where support groups are used to improve ART compliance. According to the program manager at the site, four support groups of about 25 HIV-positive clients per group meet every two months. The meetings provide a venue for health education and social support as well as giving the clients their ARVs and scheduling check-up appointments. The support group clients receive a transport allowance of 250 GHT (Haitian Gourde) which helps ensure that they will attend the meeting and get their resupply of ARVs. The support groups allow the *Agents de Terrain* to meet with the HIV and AIDS clients without compromising confidentiality as a household visit might. While this approach has been useful in maintaining contact with clients and fostering ART adherence, expected reductions in PEPFAR funding and curtailment of transport allowances could affect support group participation.

ASCPs provide the majority of preventive services, such as vaccination and family planning services, and are important links between facility providers and clients. However, the ASCPs are not fully involved in HIV and AIDS treatment and follow-up. Approaches such as the support group described above may offer an alternative to household visits for client follow-up.

Recommendations

- Conduct training, training follow-up, and supervision for ASCPs in STI/HIV/AIDS prevention, care and treatment to increase follow-up and provide another mechanism for ARV distribution.
- Assess the effectiveness of support groups for ARV treatment adherence and the feasibility of continuing them without transportation allowance.

3.4 Community Level Access to Family Planning

As shown in Tables 3.2 and 3.3, the majority of family planning client visits in both SSQH-CS and SSQH-N areas occur at the community level where ASCPs provide temporary FP methods, i.e., lactational amenorrhea method (LAM), condoms, pills, and injectables, although not all ASCPs provide all methods. Table 3.4 shows the percentage of ASCPs that provide various combinations of methods.

Table 3.4. Percentage of ASCPs providing a range of temporary FP methods

LAM	Condoms	Pills	Injectables	% of ASCPs
X	X	X	X	12.50
	X	X	X	62.50
	X		X	6.25
	X	X		6.25
	X		X	6.25
	X			6.25

While it's encouraging to see that the majority of ASCPs provide at least three methods, gaps in availability of all temporary methods represent missed opportunities for meeting the family planning needs of clients living in rural communities.

For clients interested in using long-acting methods (implants and intrauterine devices) or permanent methods (tubal ligation and vasectomy), ASCPs refer them to facilities where those methods are

available. Several facility staff said there is demand for LAPMs but cost and distance to a facility limit access and use.

None of the ASCPs or staff interviewed reported use of mobile clinics specifically for family planning although there were reports of mobile clinics being used for ANC, vaccination, growth monitoring and general consultations. Mobile clinics have been used successfully in multiple countries to increase access to and utilization of LAPMs [9] and could be a viable option in Haiti as well.

Recommendations

- Verify which family planning methods the ASCPs are authorized to provide according to MSPP policy. Organize training and commodity distribution for ASCPs as needed to ensure that all ASCPs are able to provide all authorized methods.
- Support the use of mobile clinics under SSQH to provide a full range of family planning methods in hard-to-reach areas.
- Record mobile clinic service statistics separately from other facility and/or community services in order to monitor the effectiveness of the approach.

3.5 Referral Mechanisms

The referral system is widely considered by facility managers, staff, and ASCPs to be non-functional or even non-existent in peripheral areas. Referral forms and theoretical procedures are insufficient determinants of an effective referral system.

Referrals, whether for emergency or non-critical services, are problematic, particularly for ASCPs serving hard-to-reach communities. ASCPs working in SSQH-N areas were more likely to have referral and counter-referral forms than ASCPs working in SSQH-CS areas – although most respondents in both project areas said they rarely get back the counter-referral form. A facility manager said, "We use the referral forms but the system doesn't actually work."

ASCPs in SSQH-N areas were also slightly more likely to report calling ahead or trying to arrange transportation to a reference facility than ASCPs in SSQH-CS areas. Nevertheless, ASCPs and community health program coordinators in both SSQH-N and SSQH-CS areas said referring clients is a challenge due to bad roads, limited means of transportation, and poor communication. Another facility manager said, "There's no referral system. There are no vehicles, no way to get a sick person from here to a facility that can manage their care." Several facility managers reported that they frequently send clients directly to a facility in Port au Prince or Cap Haitien rather than lose time and money sending them to the designated reference facility for their area, as the perception is that the facility may not have the staff or equipment needed to provide health care and would have to refer the client to a clinic or facility believed to be adequately equipped.

SSQH-CS began implementing activities in the last quarter of Year Two for community-supported transport systems for pregnancy-related emergencies. The SSQH-CS PMP details the components of the referral process:

[9] Wickstrom, J., Yanulis, J., Van Lith, L., and Jones, B. 2013. Mobile outreach services for family planning: A descriptive inquiry in Malawi, Nepal, and Tanzania. *The RESPOND Project Study Series: Contributions to Global Knowledge—Report No. 13.* New York: EngenderHealth (The RESPOND Project).

> "The community must have a written plan clearly outlining where, how, and by whom the emergency transport will be provided; there must be a formal Memorandum of Understanding (MOU) established with the local health center and/or hospital and the USG implementing partner for referrals. The transportation system must be accessible to all pregnant women; there must be a registry for documenting requests for service and use of services; the system must have been used at least once since the last reporting period; the USG implementing partner must have assisted the community to develop and establish the emergency transportation system."

Several community level groups, *Clubs des Mères* and *Comités de Surveillance de la Mortalité Maternelle*, previously played active roles in community activities, including making arrangements to transfer women and newborns from the community to a facility in the event of a complication during or after labor and delivery. According to the ASCPs interviewed those groups have not been supported by SSQH and in many areas are no longer active or have limited involvement.

Recommendations

- Determine what is needed to make community health committees more effective and engaged with identifying feasible mechanisms to increase access to essential services.
- Improve the functionality of COMMCARE or another technology as a referral tool and expand its use.
- Identify examples of emergency transportation systems that are being used in project areas and determine what was done to set them up, how the emergency transportation is managed, and how the approach can be implemented in other departments. For example, the SSQH-CS annual report for FY15 cites a system that is working in the vicinity of Jérémie but additional details are not provided.[10]
- SSQH-CS should document community-supported transport systems and support scale-up in other areas.
- Rejuvenate *Clubs des Mères* and *Comités de Surveillance* to help promote use of ANC and facility-based deliveries, and to organize local referral mechanisms for obstetric and newborn emergencies.

4. EFFECTIVENESS AND EFFICIENCY

Question 4: What could optimize the effectiveness and efficiency of the current project, as well as that of similar future projects?

In projects of this size and scope, the importance of good program management and technical expertise cannot be overstated. They are equally important because without programming systems and policies in place and operating efficiently the technical expertise cannot be effectively implemented or perform at maximum capacity. Nor does the opposite of that scenario work: if there is good program management and less than adequate technical expertise the program will underperform.

Making sure staff and partners are regularly paid; engaging with the government at all levels all the time; building the technical and management capacity of institutions; and serving the community populations with primary health care are at the minimum the core of what must be done to be efficient and effective.

[10] SSQH-Central and South. FY 2015. Annual Report October 1, 2014 – September 30, 2015, page 25

4.1 Program Management

Program management by the prime contractors proved to be the critical obstacle in the effectiveness and efficiency of the SSQH. Slow start-up (establishing internal systems and financial structures in the country), poor management of projects' subcontractors and partners, lack of attention to problems that have cross-cutting effect on service delivery (e.g. referral system, data management), and poor communication with the government, department, health care facilities and partners hampered the progress of SSQH.

Recommendations

- Establish realistic priorities for clinical and management activities and indicators that are important to the program. Address the pressing problems. Concentrate activities to create efficiencies and effectiveness. Invest in activities that can be scaled up quickly across the sites without long, drawn-out pilot testing.
- The program cannot experience a slowdown or break in services. Any new health systems strengthening project should prioritize establishing its internal administrative and financial structures to manage the program in Haiti.
- Institute quality assurance guidelines and reporting mechanisms to monitor gaps and holes in service deliveries as well as successes.
- Be ready with a plan for providing "emergency" problem-solving, support, and capacity building when acute problems arise in service delivery or management occur.

4.2 Communication and Coordination

Poor coordination, communication, and participation with departmental directors, facility directors, and sub-contractors impeded the implementation of SSQH. Its lack of communication and coordination with departmental directors, especially in the early stages of the project, created initial uncertainty, then distrust and a subtle rejection of SSQH plans. Departmental directors expressed frustration that they were not part of the project planning and questioned whether it fit the government's health strategy. The departmental directors reported that SSQH did not communicate their projects' plans and objectives, or the dates when activities were being implemented in their clinics or departments. Departmental directors cited examples where contractors worked directly with facilities and did not involve or inform them about these events.

Facilities that came under SSQH support were also not involved in early project planning activities, resulting in confusion over the project's objectives, roles, and responsibilities, and how the contractors and subcontractors were expected to work with them. One facility director told the evaluation team that: "There was lack of coordination within the SSQH North consortium as there were too many members with responsibilities for different aspects and executing their mandate separately."

Sub-contractors and local NGOs were not engaged in program planning and strategic development. Prime contractors organized few regular partner meetings. NGO partner staff reported that they were not aware of what other partners were doing under SSQH or what had been accomplished.

Delays in financial disbursement from the prime contractor to local NGOs and Department staff in some instances caused delays in program implementation. NGO staff reported that long delays (up to nine months) required them to use funds from other programs to cover expenses for SSQH. Some

NGOs reported that financial disbursements were delayed because of lengthy approvals required by the home offices of the prime contractors.

Recommendations:

- Engage with the government at the national and department levels and listen in a supportive and collaborative way. Joint planning and implementation with government staff who are well versed in their health system builds support and participant engagement.
- Given the size of the program and geographic distances among the facilities, SSQH program managers should be placed in the departments (not in an office in Port-au-Prince) to work closely with facility staff, partners, and departmental staff to help build relationships with the local staff and facilitate monitoring and supervision and problem-solving.
- Work and coordinate with other USAID-funded programs. USAID's vision is an integrated whole system approach rather than isolated or stand-alone activities.

4.3 Improve Referral Systems to Create Efficiencies

As mentioned earlier, the referral system for SSQH health services is not functioning and is an obstacle to providing efficient and effective health services. A functioning referral system can make cost-effective use of hospitals and primary health care services and helps build capacity and enhance access to better quality care. In a cost analysis conducted for this evaluation, economies of scale were documented for services provided regularly at health facilities versus hospitals where they were offered infrequently.

A good referral system can help to ensure:

- Clients receive optimal care at the appropriate level that is not unnecessarily expensive.
- Hospital facilities are used optimally and cost-effectively.
- Clients who most need specialist services can access them in a timely way.
- Primary health services are well-utilized and their reputation is enhanced.

There are many models of referral systems that exist that can be applied in Haiti. At the core of these models is strong coordination between facilities and support for the patient by providers and others who can facilitate access to care. In other comparative donor-funded countries, community-based organizations and community groups are a vital part of referral systems. As a part of the team, they contribute to identifying needs, developing strategies, and implementing activities to help deliver their community access care.

Recommendations

- Develop and test a community-based and supported referral system for health facilities.
- Health service delivery is a long-established program for USAID and there have been many successful activities that are documented from around the world. Future implementing partners should demonstrate knowledge and creativity in applying these practices in Haiti.

5. CLIENT AND PROVIDER SATISFACTION

Question 5: As a result of the SSQH project, what has been the change in client (including patients and healthcare service providers) satisfaction? What are those changes attributed to and what impact have they had?

To answer questions related to client/patient satisfaction, the evaluation team examined project results for indicators for client satisfaction, conducted focus group discussions in nine health facilities in nine departments with a total of 95 respondents, and used data from key informant interviews and health facility assessments conducted at 24 sites. The data collection tool is included in Annex V. The sites where the focus groups were conducted is included in Annex VI.

5.1 Client Satisfaction with Services

Table 5.1. Client Satisfaction with SSQH services

		Year 1		Year 2	
Client Satisfaction	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Nov 2013 - Sept 2014	Nov 2013 - Sept 2014	Oct 2014 - June 2015	Oct 2014 - June 2015
SSQH-N					
Percentage of clients reporting satisfaction with services	32%	40%	32%	50%	n/a
		Year 1		**Year 2**	
Client Satisfaction	**Baseline**	**Target**	**Actual**	**Target**	**Actual**
	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Oct 2013 - Sept 2014	Oct 2014 - Sept 2015	Oct 2014 - Sept. 2015
SSQH-CS					
Percentage of clients reporting satisfaction with services	99%	65%	98%	90%	82.7%

Client satisfaction with SSQH services is mixed, but overall, clients did not see any improvements in the quality of services in the last two years. In focus group discussions, clients did not know about SSQH or its role in the provision of care at the facility. SSQH results for the client satisfaction indicator showed high levels for SSQH-CS (with a slight decline between Year One and Year Two) and very low levels for SSQH-N for Year One (32 percent). Facility staff reported high client satisfaction, based on their informal conversations with patients; as one facility staff told us: "If patients come back to the facility they must be satisfied."

Over 50 percent of focus group participants reported that the turnaround time[11] for provision of services has not changed during Years One and Two. This opinion was more pronounced in SSQH-CS departments than in SSQH-N departments. A majority of clients (30 of the 42 clients interviewed) in SSQH-CS departments did not perceive any change in the turnaround time of service provision, as opposed to 40 percent of clients in SSQH-N departments.

For participants who observed an improvement in turnaround time of services, a specific improvement mentioned was the faster turnaround time for laboratory results (from three days or more to the same

[11] Turnaround time of services provided (the amount of time from when a client is seen by a provider until the client leaves the health facility, including consultation, laboratory tests, and pharmacy contact).

day). Most participants who mentioned routine laboratory tests said they received results within the same day.

Recommendation

- Seek regular, formal input from patients and the community on service provision at the health facility. Involve patients in the SSQH program through formal feedback mechanisms at the facility and in the community.

5.2 Client Perceptions about Health Facilities

Across the nine locations, focus group participants mentioned that there has been an appreciable increase in the number of clients accessing services in the respective health facilities. Participants in most of the locations revealed that waiting space was crowded with patients and that there were not enough benches or chairs available in waiting areas.

About two-thirds of group participants had an average waiting time of 15 to 30 minutes and clients found this amount of time acceptable. About 20 percent of participants mentioned that they had to wait two to three hours. There was no difference between SSQH-N and SSQH-CS participant responses to waiting time questions. The majority of clients (78 percent) considered their facility clean and in good condition.

Clients were positive about their interactions with staff at health facilities. A greater percentage of clients (89 percent) reported that their service providers were friendly, answered questions, and explained health-related issues to them. They also mentioned that service providers maintained their privacy and confidentiality during clinical visits. There was no difference between SSQH-N and SSQH-CS regarding these issues.

Recommendation

- Conduct patient flow analyses to assess waiting times and organizational efficiency of service provision and to improve client facilities such as seating, and handwashing facilities.

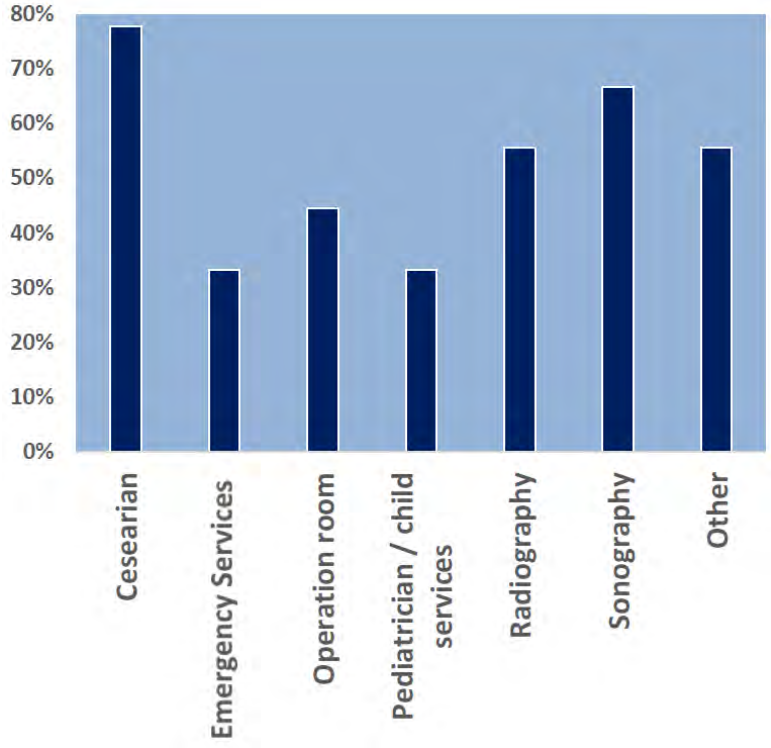
5.3 Client Difficulties or Barriers to Accessing Health Services

Absence of services at some facilities (such as those for caesarian sections, diagnostic tests, and emergency services), the heavy workload of service providers, and the increase in the number of patients were cited as the main barriers and challenges to health service access.

Figure 5 below illustrates focus group participants' perception of services that are missing in their respective health facilities. A majority of respondents (78 percent) mentioned that caesarian sections were not being done in their health facilities. In a few sites in the North, participants mentioned the absence of maternity services. In most groups, participants mentioned missing diagnostic equipment as a key limitation. Absence of operating rooms and emergency services, particularly ambulance services, were also cited.

The main concern expressed by participants was the heavy workload of the staff and the large number of patients they see each day. Distance from their home to the health facility was not a barrier to accessing health services as most participants in the interviews indicated they lived close by. Cost of services and cultural barriers did not emerge as barriers affecting access and utilization of services at facilities among the groups interviewed.

Figure 5. Focus group participants' perception of services missing in their health facilities



Recommendation

- Collaborate with MSPP and USAID partners to develop feasible plans to improve the functionality of the referral system.
- SSQH should identify referral mechanisms that are working and could be scaled-up. For example, the SSQH-CS annual report for FY 2015 cited an emergency transportation plan that is working in Jérémie. Other examples may exist as well and should be assessed for feasibility and effectiveness.

5.4 Awareness of SSQH Project among Clients

Clients in the focus group interviews never heard of SSQH nor did they understand that the facility was supported by SSQH. Consequently, clients could not give responses to the questions about SSQH's influence on the quality of service delivery. However, clients reported satisfaction with their last visit and commented positively on the treatment by the staff.

5.5 Health Care Provider Satisfaction

Many of the satisfaction issues for health care providers have been addressed in previous sections of this report. The information reported here is derived from key informant interviews and discussions with facility staff specifically related to satisfaction with the SSQH project.

Health providers expressed general satisfaction with the technical training they have received from SSQH; however, some facility staff identified the need for training and support on management of health facilities.

SSQH's focus on targets created additional strain on the health providers. Health facility staff felt the program was more interested in meeting targets than in improving the quality of care at the facilities. For example, ASCPs felt pressure to reach high targets despite the additional workload required, and facility managers complained of not receiving adequate resources from SSQH to produce expected results. As one facility director said: "SSQH expects increased results but with significantly reduced funds at the site level and support."

Other findings related to satisfaction among health providers that emerged from the assessments and interviews are as follows:

- There is additional burden on staff in smaller health facilities to be responsible for operation activities, i.e., for data collection, management, and supervision, that is outside of providing health care.
- Visits by SSQH staff are not coordinated with the DDS or facility; visits often interfere with service delivery.

Recommendations

- SSQH and DDS offices should work with providers to ensure targets are achievable and workloads are reasonable to meet expectations for quality.
- The SSQH Project should develop an annual training plan for supervisory staff, in addition to a monitoring plan with Direction Départementale de Santé and their facilities.
- SSQH managers should be located in each Department of Direction Départementale de Santé to provide departmental support, and to coordinate facilities with DDS and its subcontractors.

CONCLUSION

To summarize, the major finding of this evaluation is that the two SSQH projects had inadequate design and management plans to effectively achieve the objectives under SSQH. SSQH-N and SSQH-CS repeatedly underperformed and under-estimated what was needed in technical and management resources.

To answer questions related to client/patient satisfaction, the evaluation team examined project results for indicators for client satisfaction, conducted focus group discussions in nine health facilities in nine departments with a total of 95 respondents and used data from key informant interviews and health facility assessments conducted at 23 sites. The methodology for the focus groups is described in detail in earlier sections of this report.

In the end, the data show that fundamental principles of health service delivery and quality assurance were not adapted or instituted. The over-arching recommendation is to be a partner with the Government of Haiti and design an evidence-based program and management plan to address this complex assignment.

ANNEX I. SCOPE OF WORK

Assignment #: **119** [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: June 25, 2015
Last update: September 21, 2015

I. TITLE: Mid-term evaluation of Service Delivery Project, Services de Santé de Qualité pour Haiti (SSQH)

II. Requester / Client

■ USAID Country or Regional Mission
Mission/Division: Haiti / Health Office

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

■ 3.1.1 HIV	■ 3.1.6 MCH
☐ 3.1.2 TB	☐ 3.1.7 FP/RH
☐ 3.1.3 Malaria	☐ 3.1.8 WSSH
☐ 3.1.4 PIOET	☐ 3.1.9 Nutrition
☐ 3.1.5 Other public health threats	☐ 3.2.0 Other (specify):

IV. Cost Estimate: $300,000 (Note: GH Pro will provide a final budget based on this SOW)

V. Performance Period

Expected Start Date (on or about): September 21, 2015
Anticipated End Date (on or about): February 29, 2016

VI. Location(s) of Assignment: (Indicate where work will be performed)

Haiti, different geographic areas where project is implemented

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (*Check timing of data collection*)

■ Midterm☐ Endline☐ Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline☐ Midterm☐ Endline☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity** (Specify)

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFAR funded, check the box for type of evaluation

■ **Process Evaluation** (*Check timing of data collection*)

■ Midterm☐ Endline☐ Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline☐ Midterm☐ Endline☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and

outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. Background

Project being evaluated:

Project/Activity Title:	Service Delivery Project, Services de Santé de Qualité pour Haiti (SSQH)
Award/Contract Number:	SSQH North/URC: 521-C-13-000010 SSQH Central-South/Pathfinder: 521-C-13-000011
Award/Contract Dates:	September 30, 2013- September 30, 2016
Project/Activity Funding:	SSQH North/URC: $26,000,000 (URC) SSQH Central-South/Pathfinder: $36,547,014
Implementing Organization(s):	SSQH North: University of Research Co.(URC) SSQH Central:-South Pathfinder International
Project/Activity AOR/COR:	Kathleen Mathieu, COR SSQH North Reginalde Masse, COR SSQH Central-South

Background of project/program/intervention:

SSQH, a three-year $95 million project, provides access to a package of integrated health services at 164 health facilities throughout Haiti. Activities include regular monitoring and supervision of activities at facility and community levels; organization of trainings for service providers; training community health workers and traditional birth attendants in using Ministry of Health protocol and standards; providing sites with necessary equipment and supplies; recruitment of staff; quality improvement activities; and support for sites to manage logistics. The expected end result of the program is improved health status of the Haitian population, through improved primary care, improved health referral networks, improved management practices at health facilities and at the community level, and strengthened GOH capacity to manage and monitor service delivery at the departmental level. This project builds upon the earlier success of the six-year $101 million Santé pour le Développement et la Stabilité d'Haïti (SDSH) contract.

Describe the theory of change of the project/program/intervention.

At the end of the project, it is expected that results in maternal and child health (including Water, Sanitation, and Hygiene (WASH) and nutrition), reproductive health and family planning, HIV/AIDS, TB, and other infectious diseases, shall improve, and that the GOH should have made significant strides toward assuming primary responsibility for the management and performance monitoring of the overall health system, as well as increasing its financial support.

The SSQH project will achieve this change through support of the direct delivery of clinical and community-based services for people living in geographic areas previously supported by the USAID-funded Santé pour le Développement et la Stabilité d'Haïti (SDSH) contract. Support to geographic areas shall be achieved through the delivery of a "package" of primary healthcare services, defined within the draft MSPP Essential Package of Services, and shall include support for: 1) HIV/AIDS; 2) Tuberculosis (TB); 3) Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene (WASH) and Nutrition); and 4) Family Planning (FP). The contractor shall also support gender-based violence and child protection services at selected sites, as well as the provision of systemic training and limited support for critical care (accident and emergency) for sites within the USG-supported development corridors (see USG Haiti Strategy 2010-2015, http://www.state.gov/documents/organization/156448.pdf). Support for community-based services shall prioritize support for community-health workers (CHWs) linked to individual facilities,

facilitating the supervision of this cadre of personnel, as well as strengthening active referral to services. Support to Orphans and Vulnerable Children (OVC) affected by HIV shall include facility-based clinical and psychosocial service support.

In addition to supporting the provision of services, the contractor shall place emphasis on site-level governance and accountability through structured mentorship and targeted assistance to build the capacity of facility managers (public and private) to address gaps and deficiencies identified within routinized data analysis and site assessments. The intent is to ensure the institutionalization and functional sustainability of management systems that are not personnel dependent, fostering the application of quality assurance standards and continuous quality improvement. Health departments must also be included in the governance and accountability assistance as the respective health departments (and sub-department structures) remain responsible for ensuring sites adhere to quality assurance standards and implement continuous quality improvement.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

SSQH program supports the Ministry of Health (Ministere de la Santé Publique MSPP) in improving the health status of the Haitian population by enhancing the quality of health services in approximately 164 facilities. Emphasis is placed on:

1. increasing the utilization of the MSPP's integrated package of services at the primary care and community levels (particularly in rural or isolated areas);
2. Improving the functionality of the USG-supported health referral networks;
3. Facilitating the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels; and
4. Strengthening departmental health authorities' capacity to manage and monitor service delivery.

For reference, USAID Haiti Results Framework for Health attached as Appendix A.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

The SSQH Central South Contract is focused on six departments, and supports sites formerly supported by the precedent SDSH project: Centre, Ouest, Sud-Est, Nippes, Sud, Grand'Anse for a total catchment population of approximately 2,652,000 inhabitants. The SSQH North Contract is focused on four departments, and supports sites formerly supported by the precedent SDSH project: Nord Ouest, Nord, Nord Est, and Artibonite for a total catchment population of approximately 1,635,000 inhabitants.

IX. Scope of Work

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The SSQH project started on September 30, 2013 and is just past the midterm of the three year contract. The Mission would like to evaluate performance of the project at the facility and community levels in order to determine the extent to which the contracts have expanded delivery of health services as defined by the Ministry of Health as well as improve the quality of services, supported and improved the USG supported referral networks, and strengthened the departmental health authorities.

This mid-term evaluation will be conducted to evaluate the performance of the contractor in all of the objectives cited above and evaluate to what extent that activities implemented by the contractor have led to improved health outcomes. In addition, this mid-term evaluation will also look at how the consortium approach between the contractors and sub-contractors has facilitated or hindered efficient program implementation. Finally, this mid-term evaluation will inform the future program design for health service delivery projects.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID Mission and Health Office, Ministry of Health (Central and departmental levels)

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

This mid-term evaluation will be used to strengthen all positive aspects of the project. It will also serve to determine any corrective action needed for the remainder of the contracts and will inform early discussions by the USAID Health Office and Ministry of Health for any future program design for health service delivery projects.

D. **Evaluation questions**: Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

	Evaluation Question
1	To what extent has SSQH achieved expected results related to service delivery, as specified in the project's contract and Performance Monitoring Plan for Objective 1? What are the key issues that affect the delivery of health services?
2	To what extent has SSQH improved the quality of health services at the facility and community levels, and strengthened capacity of health authorities' to manage and monitor service delivery? What are the barriers to improving quality?
3	How are community-based approaches and community health workers being used within the project to improve access and use of integrated health services? Which community based activities to strengthen referrals and retention show evidence of leading to improved health outcomes within the integrated primary health care context? Which interventions are not working?
4	What could optimize the effectiveness and efficiency of the current project, as well as that of similar future projects? While answering this question, the evaluation should identify and discuss SSQH approaches and activities that should be continued or replicated and approaches and activities that should be changed.
5	As a result of the SSQH project, what has been the change in client (including patients and healthcare service providers) satisfaction? What are those changes attributed to and what impact have they had?

Other Questions *[OPTIONAL]*
(***Note***: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

The cost of implementing the package of integrated health services at a health facility per site will be assessed to determine average cost and range of costs, with breakdown by costing element.

E. **Methods**: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

■ **Document Review** (*list of documents recommended for review*)

1. Project Contract
2. Project semi-annual and annual reports
3. Annual work plans
4. Performance monitoring plans
5. Facility assessment, SIMS data, site visit reports
6. Data on DHIS2, MESI, eMR
7. Baseline VRS reports

■ **Secondary analysis of existing data** (*list the data source and recommended analyses*)

Data Source (*existing dataset*)	Description of data	Recommended analysis
DHIS2	National Information system for health data	
MESI	National HIV information system	
VRS Baseline Reports	Verification of data collected for results based financing	

■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

1. NGO service delivery implementers (performance and financial assessment)
2. Departmental directors (Ministry of Health sites) (performance assessment)
3. Central Direction of the MSPP (Ministry and General Director) (overall performance assessment)
4. Sub-contractors (collaboration and assessment of having several sub-contractors)
5. Health workers at sites and Community health workers

☐ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

■ **Group Interviews** (*list categories of groups, and purpose of inquiry*)

Health Personnel at site and community levels

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

Health site clients, what could be done to improve access, quality, and use of health services

☐ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

■ **Cost Analysis** (*list costing factors of interest, and type of costing assessment, if known*)

Costing data will be reviewed to determine the cost of implementing the package of integrated health services at a health facility per site, to determine the average cost and range of costs, with breakdown by costing element.

☐ **Verbal Autopsy** (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

☐ **Survey** (*describe content of the survey and target responders, and purpose of inquiry*)

■ **Observations** (*list types of sites or activities to be observed, and purpose of inquiry*)

Observe how services are provided at facility level (Health centers) in order to determine the impact of the project on service provision at facility level. Observe to what extent work at community level links individuals to health services and contributes to improved health outcomes. Take relevant photographs of facilities and community activities (and include in raw data).

☐ **Data Abstraction** (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

☐ **Case Study** (*describe the case, and issue of interest to be explored*)

☐ **Rapid Appraisal Methods** (ethnographic / participatory) (*list and describe methods, target participants, and purpose of inquiry*)

☐ **Other** (*list and describe other methods recommended for this evaluation, and purpose of inquiry*)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ■ No

List or describe case and counterfactual"

Case	Counterfactual

X. Human Subject Protection

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this analytic activity evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

XI. Analytic Plan

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

1. Document review will be utilized to determine evaluation criteria. Each project will be evaluated against the set of requirements outlined in their contract.
2. Deliverables provided by the partners (data reports, training materials and reports, and bi-annual and annual outcomes of the work) will be evaluated for completeness, accuracy and quality.
3. Implementation effectiveness will also be evaluated.
4. Project costing data will be evaluated against outcomes to evaluate cost/benefit ratios for the projects providing support.
5. Relevant national data (EMR/HMIS), MER/USG data, SIMS, RBF, and project specific data will be triangulated to assist in the above evaluations.
6. Key informant interviews will be utilized to add context and qualitative perspective to the quantitative data review.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Evaluators should collect sex-disaggregated data and examine data for gender gaps, both in terms of service providers but also beneficiaries.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XII. Activities

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

1. Early email communications to provide documentation
2. Initial phone call to further develop workplan, timeline, and protocol
3. In briefing at Mission level (including PCPS)
4. Planning meeting with technical team
5. Briefings with both contractors
6. Interviews with key informants
7. Site visits
8. Debrief meeting with Health and personnel from other USAID offices
9. Joint debrief with Ministry of Health and Mission

<u>Description of Activities</u>

Background reading – Several documents are available for review for this analytic activity. These include SSQH proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MCH

SPA). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID/Haiti, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID/Haiti**, as part of the TPM. This briefing may be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID/Haiti prior to the TPM.
- **In-brief with SSQH** to review the evaluation plans and timeline, and for SSQH to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID/Haiti **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **preliminary debrief** between the Evaluation Team and USAID/Haiti will be held at the end of the evaluation to present preliminary findings to USAID/Haiti prior to the team's departure from the field. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- A **Final Debrief** between the Team Leader and one key technical team member will be held approximately two weeks after the completion of data collection. This debrief will provide a detailed summary of the data collected and analyzed, and provide a framework to inform the first draft report.

- **Stakeholders' debrief/workshop** will be held with SSQH project staff and other stakeholders identified by USAID. This will occur following the Final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID/Haiti. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field. During site visits, evaluators will take photographs where relevant and appropriate.

Evaluation Report – The Evaluation Team under the leadership of the Team Lead will develop a report with evaluation findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

XIII. Deliverables and Products

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	September 23, 2015
■ Workplan with timeline	October 2, 2015
■ Analytic protocol with data collection tools	October 13, 2015
■ In-brief with Mission or organizing business unit	October 13, 2015
■ In-brief with SSQH	October 13, 2015
■ Routine briefings	Every 2 days (evening check-ins)
■ Out-brief with Mission or organizing business unit with Power Point presentation	October 30, 2015
■ Final Debrief Presentation with USAID	November 9, 2015
☐ Findings review workshop with stakeholders (SSQH and MOH) with Power Point presentation	November 10, 2015
■ Draft report to USAID	November 25, 2015
■ Final report – Electronic only 1. Edited, formatted 508-compliant report in English (posted to DEC) 2. Edited, formatted report translated to French	January 31, 2016
■ Raw data (including photographs)	January 31, 2016

■ Post to DEC	January 31, 2016
☐ Dissemination activity	
☐ Other (specify):	

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

XIV. Team Composition, Skills and Level Of Effort (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

Overall the Evaluation Team should have a complement of expertise that covers health systems strengthening (HSS), HIV/AIDS, maternal and child health (MCH), family planning and reproductive health (FP/RH). Four specialists would also give the evaluation team the ability to break into two groups for some of the site visits, and still have two technical specialists with a local evaluator on each team.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.
Qualifications:

- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- Background in primary health service delivery and/or health systems strengthening
- Subject matter expertise on one or more of the following areas: HIV/AIDS, maternal and child health (MCH), family planning and reproductive health (FP/RH)
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building

- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in Haiti is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: **Evaluation Specialist**

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English and French
- Experience working in Haiti is desirable
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Number of consultants with this expertise needed: 1

Key Staff 2: Title: **Health Systems Strengthening Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise on primary health care and health systems strengthening (HSS), covering the six building blocks to HSS. S/He will participate in evaluation planning, data collection, data analysis, and report writing.
Qualifications:

- Expertise working with health system strengthening in developing countries, with a firm understanding of the six building block for HSS
    - i. leadership/governance
    - ii. health care financing
    - iii. health workforce
    - iv. medical products & technologies
    - v. information and research
    - vi. service delivery
- Experience working on primary health care services and/or reforms
- Experience working on results based financing, health referral networks, continuous quality improvement is desirable
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in public health, or related field
- At least 5 years' experience in USAID health program management, oversight, planning and/or implementation
- Able to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in English and French
- Experience working in Haiti is desirable
- Experience in conducting USAID evaluations of health programs/activities

Number of consultants with this expertise needed: 1

Key Staff 3 Title: **Community Health Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in community health, and community approaches to primary health care, MCH, FP/RH and/or HIV. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.
Qualifications:

- At least 5 years' experience working on community health activities within primary health and/or health systems strengthening projects; USAID project implementation experience preferred
- Experience working on community health within at least two key content areas: a) primary health care, b) MCH, c) FP/RH, and d) HIV
- Strong background in strengthening health services at the community level
- Demonstrated understanding of community engagement for services, demand creation and prevention
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Experience conducting evaluations and/or related research, including development of data collection tools

- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations
- Proficient in English and French
- Experience working in Haiti is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Number of consultants with this expertise needed: 1

Key Staff 4 Title: **MCH & FP/RH Specialist**

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in MCH and FP/RH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 5 years' experience with MCH and FP/RH projects; USAID project implementation experience preferred
- Expertise in health systems and/or supply and demand for MCH and FP services
- Familiarity with HIV projects is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and French
- Experience working in Haiti is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local Evaluators is someone with evaluation methodological expertise needed for this activity, who will assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts to, as needed. The Local Evaluators will have a good command of English, French and Creole. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead. (2 Consultants)

Logistics and Program Assistant: Someone to support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English, French and Creole. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed. (1 Consultant)

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:

■ No

Staffing Level of Effort (LOE) Matrix (Optional):
This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable			Evaluation/Analytic Team			
		Team Lead /Evaluation Specialist Key Staff 1	HSS/Costing Specialist	Key Staff 3, 4	Research Assistant	Logistics/Program Assistant
	Number of persons →	1	1	2	1	1
1	Launch Briefing	.5	.5			
2	Desk review	5	5	3	3	3
3	Virtual Team Planning Meeting	2	2	2	2	2
4	Preparation for Team convening in-country					2
5	Travel to country	2	2	1		
6	Team Planning Meeting	2	2	2	2	2
7	In-brief with Mission	0.5	0.5	0.5	0.5	1
8	In-brief with SSQH	0.5	0.5	0.5	.5	1
9	Data Collection DQA Assurance Workshop *(protocol orientation for all involved in data collection)*	1	1	1	1	1
10	Prep / Logistics for Site Visits	0.5	0.5	0.5	0.5	3
11	Data collection / Site Visits (including travel to sites)	15	15	15	15	15
12	Data analysis	5	5	5	5	5
13	Debrief with Mission with prep	1	1	1	1	1
14	Final Debrief to USAID	1	1			1
15	Stakeholder debrief workshop with prep	1	1	0.5	0.5	1
16	Depart country	2	2	1		
17	Draft report(s)	10	8	8	5	5
18	GH Pro Report QC Review & Formatting					
19	Submission of draft report(s) to Mission					

Activity / Deliverable			Evaluation/Analytic Team			
		Team Lead /Evaluation Specialist Key Staff 1	HSS/Costing Specialist	Key Staff 3, 4	Research Assistant	Logistics/Program Assistant
20	USAID Report Review	3	2	2	2	2
21	Revise report(s) per USAID comments					
22	Finalize and submit report to USAID					
23	508 Compliance Review					
24	Upload Eval Report(s) to the DEC					
	Total LOE per person	51	48	46	39	44
	Total LOE	51	48	92	39	44

If overseas, is a 6-day workweek permitted ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

The Assessment Team will need to travel to regions within Haiti to observe activity and interview people. It may require a flight to Cap Haitian (30min. Approximately $200 roundtrip) and road trips of 3-4 hours to areas in the Central and Southern regions.

XV. Logistics

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access
Specify who will require Facility Access:
☐ Electronic County Clearance (ECC) (International travelers only)
☐ GH Pro workspace
Specify who will require workspace at GH Pro:
☐ Travel -other than posting (specify):
☐ Other (specify):

XVI. GH PRO Roles and Responsibilities

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)

- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID Roles and Responsibilities

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. Analytic Report

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

a. The report must not exceed 40 pages (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the Evaluation Report template, including branding found here or here.
c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.

d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID/GH/OHS and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
- Table of Contents (1 page);
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviews
        - Bibliography of Documents Reviewed
        - Databases
        - Photographs
        - [etc]
    - Annex V: Disclosure of Any Conflicts of Interest
    - Annex VI: Statement of Differences [if applicable]

The evaluation methodology and report will be compliant with the USAID Evaluation Policy **and** Checklist for Assessing USAID Evaluation Reports

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All data instruments, raw data sets (if appropriate), presentations, photographs, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

XIX. USAID Contacts

	Primary Contact	**Alternate Contact**
Name:	Michele Russell	James Maloney
Title:	Office Chief	Senior Advisor for M&E
USAID Office/Mission	USAID/Haiti	USAID/Haiti
Email:	mrussell@usaid.gov	jmaloney@usaid.gov
Telephone:	(202)216-6360, ext. 8192	(202)216-6360, ext. 8288
Cell Phone (optional)		

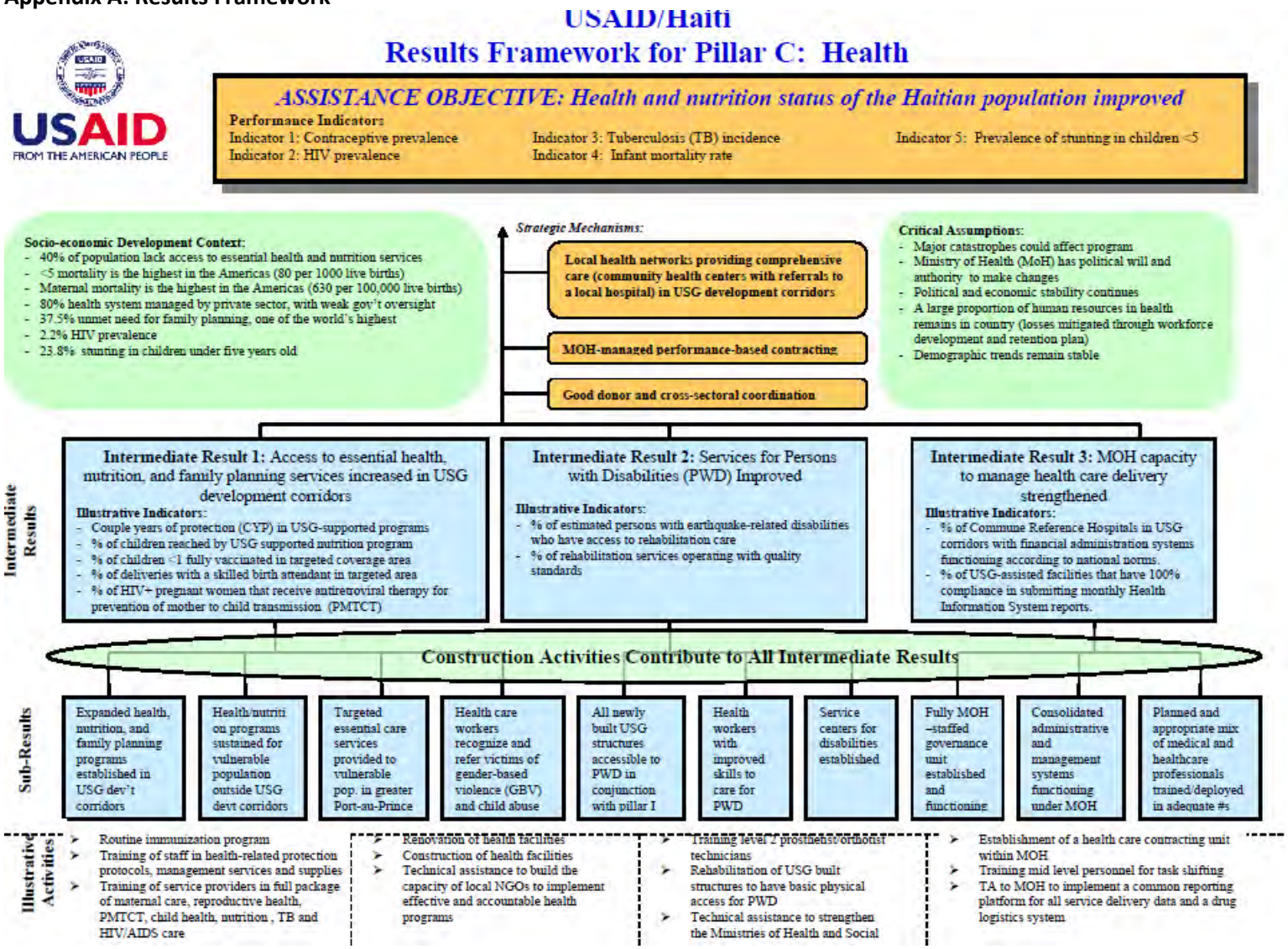
List other contacts [OPTIONAL]

Wenser Estime: westime@usaid.gov Health Service Delivery Team Lead Kathleen Mathieu: kmathieu@usaid.gov COR for SSQH North Reginalde Masse: rmasse@usaid.gov COR for SSQH Central-South Paul Vaca: pvaca@usaid.gov Haiti Program Office

XX. Reference Materials

Documents and materials needed and/or useful for consultant assignment, that are not listed above

Appendix A: Results Framework



ANNEX II. EVALUATION METHODS AND LIMITATIONS

Data collection took place over the course of four weeks in October and November. The team visited 24 facilities agreed to by USAID using simple random stratification sampling frame by ensuring representation of elements in the following strata: geographical accessibility, number of evaluators, departments, public/private health facilities, facility type e.g. health center/dispensary, sites evaluated in SDSH midterm evaluation, population catchment area and completeness of basic package of health services offered. At the community and health facility 63 CHWs and nine focus groups were interviewed. The data was enhanced by key informant interviews with 32 individuals whom were purposively selected.

The evaluation team experienced a number of limitations that impacted the analysis.

1. Incomplete data in DHIS 2.0 (SISNU). Projects' related data sets were blank for most of 2013 and mid- late 2015. SSQH-CS data sets were more complete than SSQH-N.

2. Aggregation of community-level service statistics with facility-level statics for some project related indicators limited the evaluation team's ability to effectively determine the contribution of different community-based approaches on access and use.

3. Distance and accessibility of some health facilities limited the number of health facilities, community sites and CHWs that could be visited.

4. Services such as HIV and GBV were not well represented in FGDs, perhaps due to the social "taboo" or lack of patients who have received these services.

5. Financial data for SSQH-N wasn't available therefore making unit cost estimates comparison and cost-efficiency analysis between consortiums not possible.

ANNEX III. PERSONS INTERVIEWED

USAID

Michele Russell, Supervisory Health Officer/Office Chief
James Maloney, Monitoring and Evaluation Technical Advisor
Susanna Baker, Deputy Health Office Chief
Paul Vaca, Program Officer
Wenser Estime, Service Delivery Team Lead
Reginalde Masse, Family Planning Team Lead
Marva Butler, Contracting Officer
Karen Cox, Senior Acquisition and Assistance Specialist
Webert Jose, Monitoring and Evaluation

Government

Dr. Florence Guillaume, Director MMSP
Dr. Georges Dubuch- DG of MMSP
Reynold Grand Pierre- Director, Family, Health
Dr Rony Pierre/North West Departmental Director

SSQH-N

Lucito Jeannis, Country Director JHPIEGO
Max Lelio-Joseph, Senior Community Advisor
Dr. Valerie Alice Francois, HIV Senior Advisor
Therese Foster, Chief of Party, SSQH-N
Dr. Rikerdy Frederick, Technical Director, SSQH-N
Alice Schultz

SSQH-CS

Nancy Nolan, Acting COP Pathfinder
Wolf Jean Philippe, MD, MSc, Health Strengthening Advisor
Farrah Montpreville, QI Advisor
Rita Badiani
Dr. Salnave

Partners

1. Fondation Pour le Développement et l'Encadrement des Familles Haïtiennes (FONDEF) – SSQH-CS
   - Dr. Marcelin - Coordinator of Technical Services
   - Agr Ketlher Lorvinski, Exec Director
2. Fondation Pour la Santé Reproductive et L'Education Familiale (FOSREF) –SSQH-CS
   - Dr Fritz Moïse/ National Director
3. ICC-SSQH -CS
   - Dr. Josette Bijou/ National Director CC
4. GHESKIO

- Sebastian Bayard, COP

5. Partners in Health
   - Wesler Lambert, Team Lead Partners in Health
   - Ryan Jiha, Project Manager for SSQH ZL/PIH
6. CDS
   - Dr. Pierre P. Despagne

USAID Implementing Partners

LOGIK

- Dr. Rachelle Cassagnol, COP
- John Wesley Poincy, Technical Director

Site visits

120 anonymous interviews with staff, ACSPs, and clients at 24 SSQH- N (12) and SSQH –CS(12) facilities

ANNEX IV. SOURCES OF INFORMATION

I. Bibliography of documents reviewed

1. SSQH North and CS contracts – (AID-521-C-13-00011)
2. Data Quality Assessment Checklist and Recommended procedures
3. Pathfinder International SSQH Central & South Contract 3 Year Budget request
4. SSQH Central & South and North list of sites
5. SSQH Central & South Department health offices service delivery contracts and budgets for Year1 and Year 2
6. SSQH Central & South NGO service delivery contracts and budgets
7. SSQH North and CS Performance Monitoring Plan (PMP) Year 1 and Year 2 narrative
8. SSQH North and CS Performance Monitoring Plan (PMP) Year 1 and Year 2 targets
9. SSQH CS Performance Indicator Reference Sheet (PIRS)
10. SSQH CS annual work plan for Year 1 and Year 2
11. SSQH North annual work plan for Year 1
12. SSQH CS annual report for Year 1 and Year 2
13. SSQH North annual report for Year 1
14. VRS baseline assessment reports for SSQH CS and North
15. MSPP Quality Checklist

II. Databases

1. Système d'Information Sanitaire National Unique (SISNU)
2. Monitoring Evaluation et Surveillance Intégrée (MESI)

ANNEX V. DATA COLLECTION INSTRUMENTS

1. KII Executive management level

SSQH – Mid-term Evaluation **KII** **<u>NGO Partners – Executive Management Level</u>**				
Zone/Department: (Circle one)	SSQH North		SSQH CS	
Commune:				
Organization Name:				
Facility Name:				
Facility Type: (Circle one)	HCR	CSL	CAL	Dispensary	Rally Post
Interviewee Name / Position:				
Date:				
Time Started:		**Time Ended:**		
Participant Names:				

Consent and Confidentiality: This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Your answers will be analyzed with many other health care providers and patients across the country to ensure that the resources of USG and partnerships with healthcare facilities reach those who need it. If you agree to participate in this evaluation, we will begin.

Consentement et confidentialité : This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Your answers will be analyzed with many other health care providers and patients across the country to ensure that the resources of USG and partnering with healthcare facilities reaches those who need it. If you agree to participate in this evaluation, we will begin.

Agreed _____

Refused _____

KII Facility Director

Agenda 1. Introduction of participants 2. Purpose of KII: SSQH Mid-term Evaluation: objective, expectations and tools to be used 3. Explanation of partner roles in SSQH 4. KII Questions 5. Conclusion		
Section 1: Background Information		
Questions		**Responses**
1	**What is your title and what are your major responsibilities at this organization?**	
Section 2: Service Delivery		
2	**How is your organization supported by the SSQH project?** *Probe: Financial, technical, monitoring assistance?*	
3	**Do you receive support from other donors and partners?** *Probe: who and how much each contributes as a % of total funding received* *Precise support other than financial (technical assistance, human resource support, donation etc.)*	
4	**Is your organization within a network?** *If so, does your organization manage a network of facilities?*	
5	**Are you satisfied with the support received from SSQH?**	

6	**What major differences did you observe between the last year of SDSH et the 2nd year of SSQH?** *Probe: differences in strategic approach, funding flexibility, logistics support specific technical areas?*	
7	**What are the main services your organization provides under SSQH?** *Probe: GBV, CP, TB, HIV, FP, MCH*	
8	**Are there any successful innovative strategies that your organization has implemented?** *Probe: how was this success measured? By whom? What implication did it have (in terms of quality improvement, efficiency)?*	
9	**What have been the main challenges faced by your organization for the provision of services under the SSQH project?** *(i.e. stock shortages, retention of staff, technical competence, funding arriving on time)* *Where the challenges properly communicated to SSQH?* *What has been done by SSQH to overcome these challenges?*	
10	**How can SSQH be improved to better**	

	facilitate the efficiency and effectiveness of service provision?	
Section 3: Partners		
11	**How do you coordinate with partners at the national and departmental levels?** *Probe: regular meetings, any other coordination platform set up either by MSPP or SSQH*	
12	**Is information on best practices, challenges and lessons learned shared with other partners under the SSQH project?** *Probe: members of the consortium, sub-contractor partners? How is it shared? What are the mechanisms used to facilitate this information sharing?*	
13	**What are the strengths and weaknesses of the consortium?** *Probe: Relationship with MSPP at all levels (Central, DDS, UAS)* *Responsiveness in managing significant changes coming from MSPP (ex: CHW new mandate, training curriculum, standard quota of 1/1000)*	
14	**Is your organization under a RBF contractual mechanism?**	

Additional remarks: **What were the key issues that affected the relationship between SSQH and the MSPP/DDSs?**   ***Conclusion:*** Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!

2. KII Facility manager

SSQH – Mid-term Evaluation **KII** **<u>Facility Directors/Managers</u>**	
Zone/Department: (Circle one)	SSQH North SSQH CS
Commune:	
Organization Name:	
Facility Name:	
Facility Type: (Circle one)	HCR CSL (& Maternity) CAL Dispensary Rally Post
Interviewee Name / Position:	
Date:	

Time Started:		**Time Ended:**	
Participant Names:			

Consent and Confidentiality: This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Your answers will be analyzed with many other health care providers and patients across the country to ensure that the resources of USG and partnerships with healthcare facilities reach those who need it. If you agree to participate in this evaluation, we will begin.

Consentement et confidentialité : This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Your answers will be analyzed with many other health care providers and patients across the country to ensure that the resources of USG and partnering with healthcare facilities reaches those who need it. If you agree to participate in this evaluation, we will begin.

Agreed _____

Refused _____

Agenda

6. Introduction of participants
7. Purpose of KII: SSQH Mid-term Evaluation: objective, expectations and tools to be used
8. Explanation of partner roles in SSQH
9. KII Questions
10. Conclusion

Section 1: Background Information

Questions		Responses
1	**What are your major responsibilities in your current position at this facility?**	
Section 2: Service Delivery		
2	**How is your facility supported by the SSQH project?** *Probe: Financial, technical, monitoring assistance?*	
3	**Are you satisfied with the support received by SSQH?**	
4	**What are the major services your facility provides under SSQH?**	
5	**Are there any innovative strategies that your facility has implemented?**	
6	**What have been the main challenges for the provision of services by your facility?** *(i.e. stock shortages, retention of staff, technical competence, funding arriving on time)* *What has been done to overcome these challenges?*	

7	**How can SSQH be improved to better facilitate the efficiency and effectiveness of the delivery of services?**	
Section 3: Partners		
8	**Is your facility within a network?** *If so, how many other partners are within the network?*	
9	**How do you coordinate with partners at the national and departmental levels?**	
10	**Is information on best practices, challenges and lessons learned shared with other partners/facilities?**	
Section 4: Personnel		
14	**How many staff are there at this facility?** *What are the main categories of staff?*	
15	**How is staff paid?** *(salary, in-kind remuneration?)*	
16	**Have personnel received in-service training under the SSQH project?**	
Section 5: Community Engagement		

17	**Are there mechanisms in your facility that promotes community engagement**? *(i.e. periodic client satisfaction surveys, suggestion box, etc)*	
18	**How do you assess client satisfaction of the quality of services?**	

Name of Department: Nord'Est	**Name of Organization or Facility:**
District Population: ☐,☐☐ ☐,☐☐☐	
Position(s) of Respondent(s):	**Sex of Respondent(s)** _____
Start time:	
End Time:	
Interview Result: *(**INTERVIEWER:** Circle the number corresponding to the interview outcome. If 'refused', also write 'REFUSED' in large print at the top of the front page)* Completed ----------1 Partially Completed ----------2 Postponed----------3 Refused ----------4	

SECTION 2

QU.	QUESTION	CODING CATEGORIES	SKIP
Q 1	**Have you heard of the Services de Santé de Qualité pour Haiti (SSQH) project?** *Avez-vous entendu parler du projet Services de Santé de Qualité pour Haiti (SSQH)*	Yes ----------1 No ----------→-2 Don't know---------3	**If No or DK, go to Q 3**
Q 2	**Do you know how SSQH supports community health services?**	Training _ __ Equipment and supplies _____	

QU.	QUESTION	CODING CATEGORIES	SKIP
	Savez-vous comment le SSQH prendre en charge les services de santé communautaire ? ***If yes, check all that apply***.	Payment _____ Supervision _____ Other (specify) ____	
Q 3	**What organization (or health facility) do you work with?** *Avec quelle ONG (ou institution sanitaire) travaillez-vous ?*	Name of facility CMSO Name of NGO: Other/specify	
Q 4	**How long have you been a CHW?** *Combien de temps avez-vous travaillé comme Agent de Santé Communautaire ?*		
Q5	**What category of CHW are you?** *Quelle est votre catégorie de personnel?*	Accompagnateurs----☐ Agents de santé-------☐ Agents de Santé ☐ Communautaire ☐ Polyvalent---------- Community health ☐ educator----- Matrone----------☐ Other---------- ---- Specify:	
Q 6	**Where do you do most of your CHW work?** *Où est-ce tu fais la plupart de votre travail en tant que ASC ?* ***Check all that apply.***	Hospital----------☐ Health Center with ☐ beds-- ☐ Health Center ☐ without beds- ☐ Dispensary ----------☐ Rally Post----------☐ Community-location - Households------- ----- Other—---------- ---- Specify:	
Q 7	**How many other CHWs work with this organization (or health facility)?** *Combien des ASC travaillent avec cette ONG (ou institution sanitaire) ?*	Don't know ☐	

QU.	QUESTION	CODING CATEGORIES	SKIP
Q 8	Have additional CHWs started working in this area since the start of SSQH? *Depuis le début de SSQH, est-ce que d'autres ASC ont commencé à travailler dans cette communauté ou département ?*	Yes ----------1 No ----------→---2 Don't know----------3	**IF NO or DK, Go to Q 10**
Q 9	If yes, how many? *Si oui, combien?*	# _____ Don't know _____	
Q 10 a	**Do you receive a payment for your work as a CHW?** *Est-ce que vous êtes payé pour votre travail comme ASC ?*	YES ----------1 NO ----------2 Don't know ---------3	If no or DK, Go to Q 11
Q 10 b	**If yes, is the payment a salary or incentive?** *Si oui, c'est un salaire ou une prime?*	Salary ----------1 Paid monthly Incentive --------2	
Q 10 c	**Do you receive a bonus for good work?** *Vous recevez un bonus pour le bon travail ?*	YES ----------1 NO ----------2 Don't know --------3	
Q 11	Do you receive in-kind remuneration? *Vous recevez une rémunération en nature ?*	Yes ----------1 No ---------→-----2 Don't know ----------3	**IF NO or DK, GO TO Q 13**
Q 12	What sort of in-kind remuneration is provided? *Quel type de rémunération en nature est-elle fournie ?*	Bicycle _____ Cap_____ Tee-shirt_____ Badge _____ Other_____ Specify:	
Q 13 a	Is your work primarily for health education and promotion or do you provide services? Est-ce que vous travaillez principalement pour l'éducation sanitaire et de la promotion ou vous donnez des services ?	Education/ Promotion ___ Service provision _____ Both _____	

QU.	QUESTION	CODING CATEGORIES	SKIP
Q 13 b	What are your responsibilities as a CHW with this organization (or health facility)? *Quelles sont vos responsabilités comme ASC avec cet organisme ?* ***Check all that apply.***	**Home visits for**: _____ • TB _____ • HIV _____ • ANC _____ • Delivery ___ • PNC _____ • FP _____ • Malaria _____ • ARI _____ • Diarrhea___ • Nutrition __ • Referral follow-up _____ • Tracing clients LTFU_____ • Other/ Specify_____ **Accompanying clients to health facility for:** • TB _____ • HIV_____ • ANC_____ • Delivery ___ • PNC _____ • FP _____ • Malaria _____ • ARI _____ • Diarrhea___ • Nutrition___ • Referral follow-up_____ • Other_____ Specify: **Outreach/Rally Posts for:** • Growth monitoring _____	

QU.	QUESTION	CODING CATEGORIES	SKIP
		• Vaccination _____ • Health education___ • ANC_____ • FP_____ • Vitamin A_____ • Other _____ Specify _____	
Q 14	Have you been trained for your work as a CHW? *Avez vous été formés pour votre travail comme un CHW ?*	YES ----------1 NO ----------2 Don't know ---------3	
Q 15	When were you trained? *Quand vous ont été formés ?*		
Q 16	Did SSQH support your CHW training? *Est-ce que SSQH a appuyé la formation ?*	YES ----------1 NO ----------→--2 Don't know ---------3	**IF NO or DK, GO TO Q 18**
Q 17	Who conducted your training? *Qui a dirigé votre formation ?*	SSQH ____ Facility ___ NGO ____ MSPP ____ Other: ____ Specify: ____ Don't Know ____	
Q 18	What training curriculum or materials are used? *Quel programme de formation ou les matériels sont utilisés ?*	MSPP_____ NGO_____ Other/Specify __SSQH____ Don't know	
Q 19	Did your CHW training include practicum (clinical practice)? *Votre formation de CHW comprenait-il stage (pratique clinique) ?*	Yes ----------1 No ----------→--2 Don't know ---------3	**IF NO or DK, GO TO Q 22**
Q 20	Where was the practicum conducted? *Où a eu lieu la stage pratique ?* ***Check all that apply.***	Hospital_____ Health Center with beds_____ Health Center without beds____	

QU.	QUESTION	CODING CATEGORIES	SKIP
		Dispensary _____ Rally Post_____ Community-location _____ Households_____ Other_____ Specify:	
Q 21	Who supervises you? *Qui est votre superviseur?* ***Check all that apply.***	No one _____ SSQH staff _____ Health facility staff _ • Doctor _____ • Nurse (Community health)_____ • Midwife _____ • Other/specify _____ UAS staff _____ • Specify _____ DDS staff _____ • Specify _____ NGO staff _____ • Specify _____ Comm Health Committee _____	
Q 22	How often are you visited by your supervisor? *Combien de fois vous sont visités par votre superviseur ?*	Weekly _____ Monthly _____ Quarterly _____ 1 x per year __ 2 x per year _____ Other _____	
Q 23	Is there a Community Health Committees in this department/UAS/NGO catchment area? *Y a-t-il un comité communautaire de santé dans cette zone de desserte ?*	YES ----------1 NO ----------→-------2 Don't know ------- --3	**IF NO or DK, GO TO Q 26**
Q 24	What assistance do you receive from the Community Health Committee? *Quelle aide recevez-vous du Comité Communautaire de Santé ?*	N/A	

QU.	QUESTION	CODING CATEGORIES	SKIP
Q 25	Are there any health volunteers (in addition to the CHWs) that work with you? *Y a-t-il des volontaires de la santé (outre les ASC) qui travaillent avec vous ?*	YES ----------1 NO ----------→-----2 Don't know ----------3	**IF NO or DK, GO TO Q 28**
Q 26	What do the health volunteers help you with? *Qu-est-qu'ils font, les volontaires de la santé ?*	Home visits _____ Rally posts_____ Client follow-up _____ Accompanying referred clients to facility _____ Other/specify _____	
Q 27	Do you report the services that you provide to this organization (or this health facility)? *Fournissez-vous des rapports statistiques et d'activités à cette institution sanitaire ?*	YES ----------1 NO ----------→-2 Don't know ---------3	**IF NO or DK, GO TO Q 33**
Q 28	How do you make your reports? *Comment faites-vous vos rapports statistiques?*	Paper forms -------- ☐ CommCare ----------☐ Mobile phone--------☐ Other (Specify) _____	
Q 29	Does anyone discuss your reports with you? *Est-ce quelqu'un discute ces rapports avec vous ?*	YES ----------1 NO ----------2 Don't know ---------3	
Q 30	If yes, who discusses the reports with you? *Dans l'affirmative, qui discute ces rapports avec vous ?*	Supervisor _____ SSQH _____ Community Health Committee__ Other/specify _____	
Q 31	Are your reports used to plan activities, track defaulters, follow-up referred patients? *Est-ce que vos rapports permettre de planifier des activités de suivi comme les perdus de vue, et les clients réferrés ?*	YES ----------1 NO ----------2 Don't know ---------3	

QU.	QUESTION	CODING CATEGORIES	SKIP
Q 32	If someone needs to go to a health center or hospital for an emergency, how do you arrange the referral? *Comment organisez-vous la référence si quelqu'un a besoin d'aller à un centre de santé ou un hôpital pour un cas d'urgence ?*	Use phone to call facility _____ Call for transport ___ Tell the commune leader _____ Other/specify _____	
Q 33	Do you have referral form that the client can take to the health facility? *Avez-vous le formulaire de référence que le client peut amener à l'institution sanitaire?*	Yes----------1 No ----------2 Don't know -------3	
Q 34	Do you receive a counter-referral form (or information) when the client returns home? *Recevez-vous une forme de contre référence (ou information) lorsque le client retourne à la maison ?*	Yes----------1 No ----------2 Don't know ----3	
Q 35	Do you have the equipment and supplies needed to perform your duties? *Avez-vous avez le matériel, fournitures et les médicaments nécessaires à l'exercice de vos fonctions?*	YES ----------1 NO ----------2 Don't know --------3	**IF YES, GO TO Q 35**
Q 36	If no, what equipment and supplies do you need? *Si non, quels matériel, fournitures et médicaments avez-vous besoin ?*	Weighing scales _____ Tape measure _____ MUAC _____ FP methods __<u>need more stock</u>_____ • Condoms ___ • Pills _____ • Injectables __ ORS _____ Vitamin A _____ Iron/folate _____ Antibiotics _____ ART _____ Vaccines _____ Syringes _____ Sharps boxes _____ Referral slips _____	

QU.	QUESTION	CODING CATEGORIES	SKIP
		Health cards ____ Health Education Tools_____ Promotion tools_____ Boots _____ Flashlight _____ Backpack _____ Notebook_____ Pen_____ Mobile phone with credits____ Other/specify _____	
Q 37	Who provides your equipment and supplies? *Qui fournit votre matériel, équipements et médicaments?*	SSQH _____ Facility _____ NGO _____ MSPP _____ Community Health Committee__ I buy myself _____ Other/specify _____	
Q 38	In the past 3 months have there been stock-outs (or breakage) of any items? *Avez-vous enregistré une rupture de stock sur les matériels, médicaments dans les trois (3) derniers mois ?*	Weighing scales _____ Tape measure _____ MUAC _____ FP methods _____ • Condoms ___ • Pills _____ • Injectables ___ ORS ____ Vitamin A ____ Iron/folate ____ Antibiotics ____ ART ____ Vaccines ____ Syringes ____ Sharps boxes ____ Referral slips ____ Health cards ____ Other/specify __ ___	
Q 39	If you run out of supplies or your equipment doesn't work,	Tell supervisor _____ Tell Comm Health Comm ____	

QU.	QUESTION	CODING CATEGORIES	SKIP
	what do you do? *Que faites-vous en cas de rupture de stock?*	Nothing _____ Wait for next delivery _____ Tell clients to buy _____ Other/specify	

Q 40	What would improve your performance as a CHW? *Qu'est-ce qui permettrait d'améliorer votre travail comme ASC ?*	1. ---------- 2. ---------- 3. ----------	

ANNEX VI. ADDITIONAL FIGURES AND TABLES

Fig 2.6.: SSQH CS- Loss to follow up among ART clients

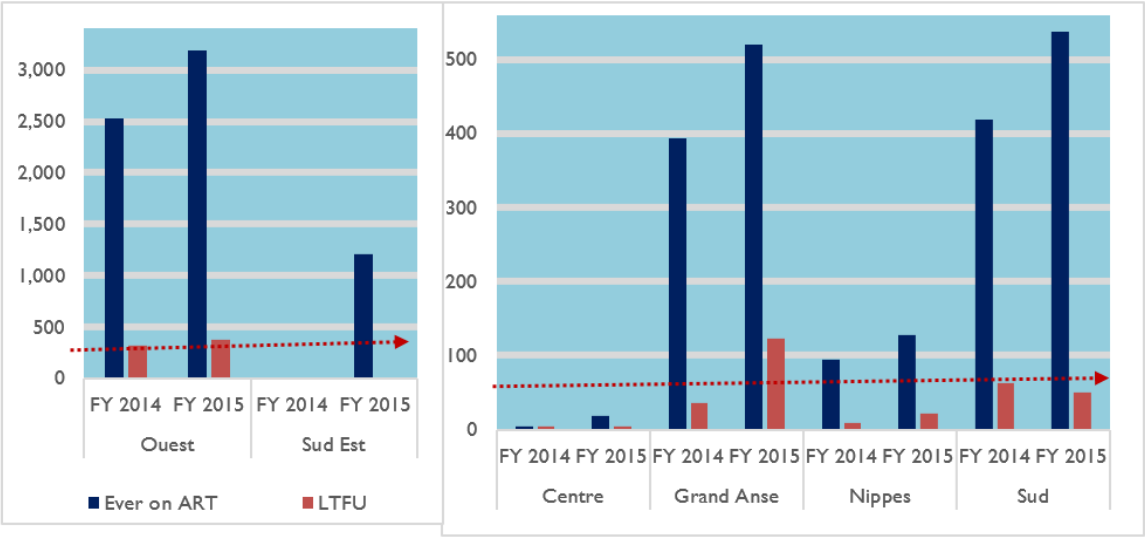
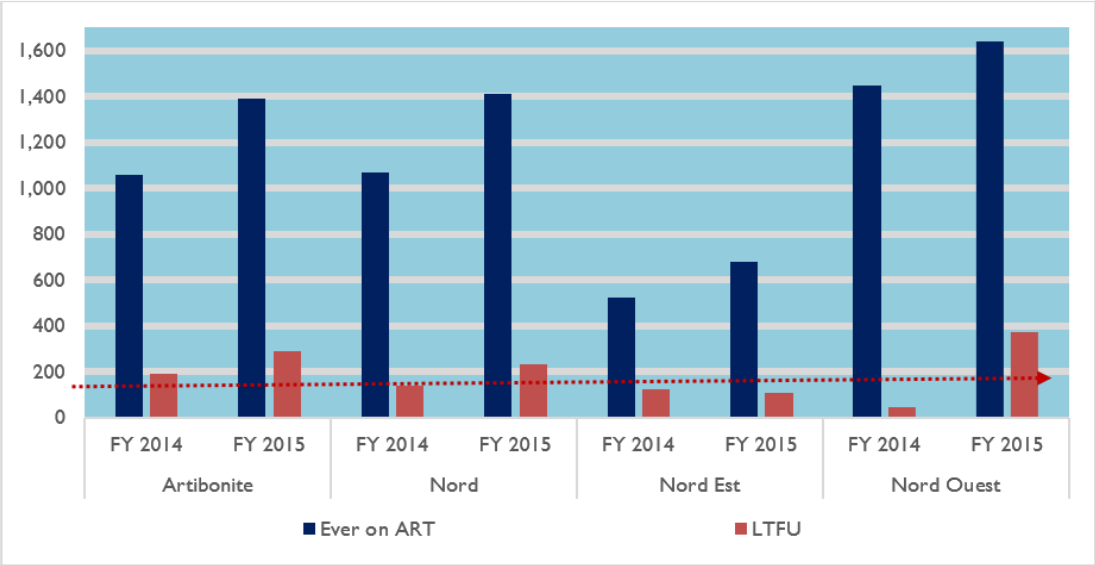


Fig 2.5.: SSQH North- Loss to follow up among ART clients



Health facility group	Number of respondents	Department/ Commune	SSQH North or CS	FP	MCH	HIV	GBV
FOSREF– CEGY PEF	12	Ouest- Bel-Air	CS	X	X	X	
FONDEPH– Delmas 75	10	Ouest – Delmas 75	CS	X	X	X	X
CDS de Marmont	11	Centre – Hinche	CS	X			
ICC Grace Hospital	9	Ouest – Delmas 31	CS	X	X		
CDS Pierre Payen	8	Artibonite – St Marc	North	X	X	X	
CDS La Fosette	12	Nord – Cap Haitian	North	X		X	
CDS Capotille	12	Nord-Est – Capotille	North	X	X		
CDS Notre Dame de La Nativité	9	Nord – Acul du Nord	North	X			
Hôpital Claire Heureuse	12	Artibonite – Marchand Dessalines	North	X	X		
Total	**95**	**Total**		**9**	**7**	**4**	**1**
Percentage				**100%**	**77%**	**44%**	**11%**

A total of nine client satisfaction focus group discussions (FGD) were conducted in the SSQH-N and C/S sites (Table 5.1). During the beginning of the field evaluation, a pilot focus group discussion guide was administered at FOSREF and FONDEF and the necessary adjustments were made according to feedback on the tested tools. Individual client satisfaction surveys were initially intended to collect quantifiable data to calculate the percentage of satisfaction according to specific categories (i.e. Health facility environment, personnel, services, etc.); however, at health facilities where focus group discussions were done, the evaluation team determined that there was no need to administer patient satisfaction surveys. Since, enough data was collected through focus group discussion; to the point that at least one discussion was conducted in each department of SSQH-N (except for the North West Department). A total of five focus group discussions were held in the north and four focus group discussions in the central and south. Therefore, the analysis of the change of client satisfaction was not be based on quantifiable information from the client satisfaction survey, but rather on qualitative data from the discussions. In this case, percentages according to thematic frameworks and subcategories will be calculated and used as a means to determine the key trends from the participating health facilities. Additionally, service assessments, key informant interviews and observations were used to elicit provider satisfaction with the services.

A. Limitation of using the group discussion method to answer this evaluation question. Patient responses/trust: it was difficult to gain participants trust during the focus group discussions. It seemed as

if respondents were holding back their thoughts on how they truly felt about services provided. Incessant passive interruptions by nurses during these group discussions most likely influenced clients' responses. Also, services such as HIV and GBV were not well represented, perhaps due to the social "taboo" or lack of patients who have received these services.

B. Group characteristics and types of services received by FGD participants. A total of ninety-five respondents participated in nine focus group discussions. The following are the characteristics of the groups involved in the client satisfaction focus group discussions:

1. Seven out of nine focus groups comprised of at least two respondents that have availed themselves of health services in their respective facilities for at least three years. The median number of years that participants have received services in selected health facilities is 3-7 years.

2. Majority of participant lived in close proximity to health facilities supporting their various catchment areas.

3. All participants in discussions have utilized family planning services at their respective clinics at least once, this conflicts with project poor performance access to modern forms of contraceptives to women of the reproductive age group.

4. The number of patients who received HIV and GBV services were relatively low (44 percent and 11 percent respectively); anecdotal evidence reveals that the underlying reason for low uptake of HIV and GBV services, was cultural perceptions and stigmatization; as majority of respondents didn't feel comfortable enough talking about suffering from HIV or being victims of GBV.

5. Forty-four percent of focus group participants received maternal and child health services. This finding partially supports project performance in the PMP as the uptake of key child health services (immunization and vitamin a) was not adequate in both years of the projects. Also considering the level of access of maternal health services by these select group of respondents, project's reasonably fair performance in maternal health may only be beneficial to the minority of clients (44%) who avail themselves of maternal health services.

ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Page **113** of **131**

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Brian Agbiriogu 09.14.2015

Signature Date

Brian Agbiriogu Consultant

Name Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Dee Bennett	20 Oct 2015
Signature	Date
DEE BENNETT	Managing Partner
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Blaise Mika Benjamin
Signature

Date 23 octobre 2015

Blaise Mika Benjamin
Name

Title Consultant

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Barbara J. Jones Date 8/21/2015

Name Barbara J. Jones Title Consultant

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Coralie Noisette Date 9/10/15

Name Coralie Noisette Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Rosemary Romano	10/20/15
Signature	Date
ROSE MARY ROMANO	CONSULTANT
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature _____ Date July 13, 2015

Name Patrick Pascal Saint-Firmin Title HSS Specialist

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