

PD-AAB-011-000-B1

521 - Proj 5210087 -  
PH- ②

162

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, AA/DSb

From: PHA/POP: Dr. R. T. Ravenholt, M.D., Director

Subject: Project Paper (PP) - Haiti, Population

12/18/77

Problem: Your approval is requested for the attached Project Paper

Discussion: This paper proposes Title X assistance for a new three-year "Maternal Child Health/Family Planning II" Project starting in FY 78 and terminating in FY 80. Planned obligations are \$975,000 in FY 78, \$1.4 million in FY 79, and \$1.5 million in FY 80 (these figures include centrally-funded contraceptives).

The Haitian Government has requested this assistance, and A.I.D. desires to respond affirmatively, in order to accelerate the progress of making contraceptives and information on Family Planning readily available to the entire Haitian population. The proposed assistance will increase the number of contraceptive users and subsequently precipitate a decline in the crude birth rate. Although the GOH has not established a demographic goal, it supports family planning services through the Ministry of Health, and in the MCH Division's 1976 annual report it commits the MOH to:

"During this second phase of our program we must redefine our objectives, improve the health of mothers and children, and diminish the rate of population growth, putting the accent on this second aspect which will become our principal objective."

Under this new project, A.I.D. will support the Ministry of Health in the training of community-level health workers and auxiliary nurses, the expansion of voluntary surgical contraception services, vehicles for mobile clinics, information and educational activities, contraceptives, and increased capability for supervising the MCH/FP program.

The MOH plans to increase the number of contraceptive users from an estimated 60,000 in mid-1977 to 143,000 in 1978, 192,500 in 1979, and 236,500 in 1980. In the final year 20% of women-in-fertile-ages will be contracepting.

Several other external donors will complement the A.I.D. assistance. The UNFPA will provide \$3 million during 1978-80 for clinical services, equipment, and supplies. The Pathfinder Fund will provide \$279,000

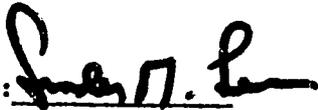
for empirical midwife training and community meetings. Columbia University will fund an experimental community-based distribution project at a cost of \$175,000 during 1978-80. Development Associates is budgeting \$66,000 for the training of indigenous medical practitioners. IPPF will provide \$33,000 for a pilot project involving condom vending machines, and Family Planning International Assistance will provide \$28,000 in 1978 to continue the pilot voluntary sterilization project.

This project conforms to all relevant agency and congressional guidelines, especially the Percy and Helms Amendments. The chief beneficiaries of this program will be low income women and men located predominately in rural areas of Haiti.

This Project Paper has been reviewed by all appropriate A.I.D. offices. None of the issues raised were such as to stand in the way of immediate project approval.

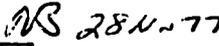
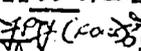
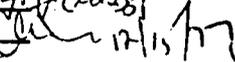
Recommendation: That you approve the project for funding for FY 78-80.

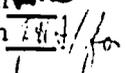
Attachment: Project Paper for Haiti

APPROVED: 

DISAPPROVED: \_\_\_\_\_

12/18/77

Clearances: PHA/POP: RTRavenholt  28 Nov 77  
PHA/POP: FEgi   
PHA/POP/AFR/LA: WDBair   
PHA/POP/LA: STaylor   
PHA/PROG: GDMcMakin   
AA/LA: AValdez   
LA/CAR: WRhodes   
LA/DR: MHBrackett  11/24/77

PPC/D: JWelty   
GC/PHA: RRichstein   
LA/DR: RGulbertson  11/30

Project Authorization and Request for Allotment of Funds  
Part II

Name of Country/Entity: Haiti

Name of Project: Maternal Child Health, Family Planning II

Number of Project: 521-0087

Pursuant to Part I, chapter 1, section 104 and chapter 2, Title X of the Foreign Assistance Act of 1961, as amended, I hereby authorize a grant to the Government of Haiti, the "Cooperating Country", of not to exceed Nine Hundred and Seventy-Five Thousand United States Dollars (\$975,000), the "Authorized Amount" to help in financing certain foreign exchange and local costs of goods and services required for the project as described in the following paragraph.

The project consists of providing assistance for the purchase of contraceptives; the development of jobs for sanitary agents; the development of auxiliary nurses and dispensaries and their supervision by district headquarters teams; the funding of voluntary surgical contraception (voluntary sterilization); the purchase of mobile units; the supervision at the national level of district-level staff; and the provision of information, education and communications activities (hereinafter referred to as the "Project").

I approve the total level of AID appropriated funding planned for this project of not to exceed Three Million Eight Hundred and Seventy-Five Thousand United States Dollars (3,875,000) Grant, during the period U.S. Fy 1978 through U.S. FY 1980, including the amount authorized above and additional increments of grant funding, during the period, subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of a Grant Agreement and amendments thereto by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential terms and covenants and major conditions, together with such terms and conditions as A.I.D. may deem appropriate:

A. Source and origin of Goods and Services

Except for ocean shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in the cooperating country, in countries included in A.I.D. Geographic Code 941 or in the United States, except as A.I.D. may otherwise agree in writing. Ocean shipping financed under the Project

shall be procured in any eligible source country except the cooperating country.

B. Commodities Procured in the United States

Except as AID may otherwise agree in writing, commodities procured from the United States with funds provided by the project will be procured by USAID through the use of project implementation orders (PIO/Cs).

C. Conditions Precedent

1. Conditions Precedent to Initial Disbursement

Prior to the initial disbursement or the issuance of the initial commitment document under the Project Agreement, the Cooperating Country shall furnish the following in form and substance satisfactory to AID:

a) An opinion of Counsel that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee; and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all its terms; and

b) The name(s) of the person(s) holding or acting in the office as authorized representative(s) of the Grantee together with specimen signature(s) of such authorized representative(s) and a statement of the nature and extent of his (their) authority for purposes of this project.

2. Conditions Precedent to Subsequent Disbursements. Prior to subsequent disbursements, Grantee will furnish in form and substance satisfactory to AID an implementation plan showing the time-phased strategy for carrying out the various sub-activities under the Project. This plan shall show all inter-relationships between sub-activities where appropriate.

3. Conditions Precedent to Disbursements for Training  
Prior to disbursements for training, a plan shall be submitted in form and substance satisfactory to AID outlining the formal and non-formal instructions to be offered; numbers of people to be trained by category (such as sanitary agent) and course manuals to be used by instructors for each type of course offered.

4. Conditions Precedent to Disbursements for Renovation  
Prior to disbursements for renovation, a plan shall be submitted in form and substance satisfactory to AID indicating the location of each

dispensary to be renovated or rehabilitated with Grant funds, the population to be served and other basis for selecting each dispensary to be improved, and a schedule for equipping and staffing each dispensary.

5. Conditions Precedent to Disbursements after the First Year. Prior<sup>to</sup> disbursements for personnel or operating expenses after the first year of the project, Grantee will submit in form and substance satisfactory to AID a plan to include the number, type, and location of personnel to be supported; their respective salaries (base plus supplement); type and frequency of supervision (for field personnel); and estimated operating costs by type of functional unit for the remainder of the project.

6. Final Dates for Meeting Conditions Precedent  
The final date after signature of the Project Agreement for meeting conditions precedent shall be:

- a) 60 days for Conditions Precedent to Initial Disbursements;
- b) 120 days for Conditions Precedent to Subsequent Disbursements;
- c) 180 days for Conditions Precedent to Disbursements for Training and Renovation;
- d) 365 days for Conditions Precedent to Disbursements for personnel and operating expenses.

#### D. Covenants

The Project Agreement shall contain covenants providing in substance that the Cooperating Country shall agree to:

1. Consider all possible ways and means of progressively increasing Government of Haiti revenues available for integrated rural health delivery (including family planning services) so as to lessen the dependence of this program on external donor contributions;

2. Consider formulation of official population policy giving family planning high priority, in the context of improved family well-being and in the context of national demographic goals; and

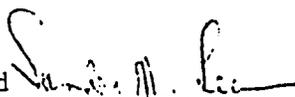
3. Expand the delivery of family planning services and information as rapidly as possible through the use of public and private channels authorized by the Division of Family Hygiene and extend as much as possible the availability and accessibility of contraceptive services and supplies.

4. Assure that all individuals participating in family planning programs (whether involving distribution of contraceptives or sterilization, or both), supported in whole or in part by funds provided hereunder, do so on the basis of an informed consent voluntarily given with knowledge of the benefits, risks, principal effects and available alternatives; and assure that no individual is coerced to practice methods of family planning inconsistent with his or her moral, philosophical, or religious beliefs.

5. Use no part of the funds provided hereunder for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.

6. Use no part of the funds provided hereunder to pay for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to practice sterilization.

7. Establish jointly with AID an evaluation plan as an integral part of the Project within 180 days from the date the Project Agreement is signed. Except as otherwise agreed in writing, this evaluation plan will include, during the implementation of the Project and at one or more points thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems, in this or other projects; and (d) evaluation to the degree feasible, of the overall development impact of the Project.

Approved 

Disapproved \_\_\_\_\_

Date 12/18/77

PROJECT PAPER

MATERNAL CHILD HEALTH / FAMILY PLANNING II

HAITI 521-0087

25 November 1977

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT AUTHORIZATION AND REQUEST          FOR ALLOTMENT OF FUNDS PART I</b>	1. TRANSACTION CODE <input type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE	<b>PAF</b> 2. DOCUMENT CODE <b>5</b>
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3. COUNTRY ENTITY <b>HAITI</b>	4. DOCUMENT REVISION NUMBER <input type="checkbox"/>
5. PROJECT NUMBER (7 digits) <input type="text" value="521-0087"/>	6. BUREAU/OFFICE A. SYMBOL: <input type="text" value="PHA"/> B. CODE: <input type="text" value="07"/>
7. PROJECT TITLE (Maximum 40 characters) <input type="text" value="Maternal Child Health/Family Planning II"/>	
8. PROJECT APPROVAL DECISION <input type="checkbox"/> A APPROVED <input type="checkbox"/> D DISAPPROVED <input type="checkbox"/> DE DEAUTHORIZED	9. EST. PERIOD OF IMPLEMENTATION YRS. <input type="text" value="0"/> <input type="text" value="3"/> QTRS <input type="text" value="1"/>

10. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>78</u>		H. 2ND FY <u>79</u>		K. 3RD FY <u>80</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	444	440		975		1400		1500	
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TOTALS				975		1400		1500	

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TOTALS					3875				

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED (\$000)				13. FUNDS RESERVED FOR ALLOTMENT				
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	C. GRANT	D. LOAN						
(1) PH	975							TYPED NAME (Char/, SER:FM/FSD)
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TOTALS				975				

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15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

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AGENCY FOR INTERNATIONAL DEVELOPMENT		PROJECT PAPER FACESHEET		1. TRANSACTION CODE <b>C</b> A = ADD C = CHANGE D = DELETE		PP	
3. COUNTRY/ENTITY HAITI		4. DOCUMENT REVISION NUMBER		2. DOCUMENT CODE 3			
5. PROJECT NUMBER (7 digits) [ 521-0087 ]		6. BUREAU/OFFICE A. SYMBOL PHA    B. CODE [ 07 ]		7. PROJECT TITLE (Maximum 40 characters) [ Maternal Child Health/Family Planning ] II			
B. ESTIMATED FY OF PROJECT COMPLETION FY [ 8 ] [ 1 ]		9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY [ 7 ] [ 8 ]    B. QUARTER [ 1 ] C. FINAL FY [ 8 ] [ 1 ]    (Enter 1, 2, 3, or 4)					

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	560	415	975	2306	1569	3875
(GRANT)	( 560 )	( 415 )	( 975 )	( 2306 )	( 1569 )	( 3875 )
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY		1149	1149		2638	3638
OTHER DONOR(S) *	480	913	1393	1565	2075	3640
TOTALS	1040	2477	3517	3871	7282	11153

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>78</u>		H. 2ND FY <u>79</u>		K. 3RD FY <u>80</u>	
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TOTALS				975		1400		1500	

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	D. GRANT	P. LOAN	H. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1) POP					3875		
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TOTALS					3875		

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

[ 2 ]    1 = NO  
                  2 = YES

14. ORIGINATING OFFICE CLEARANCE		15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION	
SIGNATURE <i>Lawrence E. Harrison</i>	TITLES USAID Director		DATE SIGNED MM   DD   YY [ 1 ] [ 1 ]   [ 0 ] [ 5 ]   [ 7 ]

AID 1330-4 (3-78)

\* This includes centrally-funded Title X recipients.

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT AUTHORIZATION AND REQUEST          FOR ALLOTMENT OF FUNDS PART I</b>	1. TRANSACTION CODE <input type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE	<b>PAF</b> 2. DOCUMENT CODE <b>5</b>
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5. PROJECT NUMBER (7 digits) <input type="checkbox"/> <b>521-0087</b>	6. BUREAU OFFICE A SYMBOL: <b>PHA</b> B. CODE: <input type="checkbox"/> <b>07</b>	7. PROJECT TITLE (Maximum 40 characters) <input type="checkbox"/> <b>Maternal Child Health/Family Planning II</b>
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8. PROJECT APPROVAL DECISION <input type="checkbox"/> A APPROVED <input type="checkbox"/> D DISAPPROVED <input type="checkbox"/> DE DEAUTHORIZED	9. EST. PERIOD OF IMPLEMENTATION YRS. <input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>3</b> QTRS <input type="checkbox"/> <b>1</b>
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10. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>78</u>		H. 2ND FY <u>79</u>		K. 3RD FY <u>80</u>	
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TYPED NAME (Chief, SER FM-FSD)	
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15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

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I. SUMMARY AND RECOMMENDATIONS

B. RECOMMENDATIONS: USAID/Haiti recommends the authorization of a three-year grant to the Government of Haiti to carry out this project at the following funding levels (\$000):

	1978	1979	1980	Total
Orals	\$ 123	\$ 240	\$ 260	\$ 623
Condoms	372	485	620	1477
Bilateral	480	675	620	1775
TOTAL	\$ 975	\$1400	\$1500	\$3375

C. DESCRIPTION OF THE PROGRAM

The activities proposed in this program are aimed at making family planning services available to over ninety percent of Haiti's population by the end of 1980. By 1980 there will be approximately 1,000,000 women in fertile ages (WIFA). To achieve an adequate demographic impact, the program objective will be to provide at least 20% of them (or their partners) with contraceptives. The condom will be the predominant method, accounting for about 75% of couples practicing family planning.

Services will spread from urban areas, where birth rates seem to be higher, to rural areas. Coverage of 22 existing urban clinics' service areas will be improved by use of satellite clinics and outreach workers. 170 rural dispensaries staffed by auxiliary nurses will be brought on line and 630 village workers called sanitary agents <sup>1/</sup> will extend coverage from the dispensaries. Family planning information and services will become increasingly available in child nutrition centers. An operational research project in household distribution of contraceptives (and basic medicines) will be implemented, and an urban condom vending machine project will begin with IPPF support. Contraceptives will also become more widely available through community organizations, through traditional midwives and through the armed forces. Voluntary surgical contraception will become more widely available through the establishment of seven VSC clinics by the end of 1980. Initial patient recruitment and contraceptive distribution by mobile units will increase and the project will continue to explore other approaches to non-clinical distribution of contraceptives, including the use of indigenous medical practitioners. These approaches to expanding coverage are intended to increase the prevalence of contraceptive use from about 60,000 couples by the end of 1977 to about 230,000 by the end of 1980.

<sup>1/</sup> These are called "agents sanitaires" in French, which connotes a much wider concept of health and well-being than the English "sanitary agent". However, this translation will be used in order to be consistent with English language Documents produced by the Division of Family Hygiene.

AID will fund the contraceptives, the development of sanitary agents, the development of auxiliary nurses and dispensaries, supervision of auxiliaries by district headquarters teams, voluntary surgical contraception, mobile units, national supervision of district-level staff, and information, education and communication (IEC) activities for a total of \$3,875,000. The GOH will contribute personnel, facilities and increasing budgetary allocations to the Department of Public Health and Population to expand family planning services throughout the emerging public health infrastructure. UNFPA is the largest other donor, contributing \$3,057,000 during the three years, principally for continued operation of 19 fixed clinics and for support of satellite clinics.<sup>1/</sup>

The project will continue to be administered by the Division of Family Hygiene of the Department of Public Health and Population.

The Government is embarking on the development of a national health system which will rely heavily on the models of service delivery developed by the Division of Family Hygiene, and which will rely on the Division for much of the training of lower level health workers. A strong bias toward family planning and non-clinical services will thus be built into the system from the start, and the Division's activities will become closely integrated with the Department's.

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<sup>1/</sup> AID will fund the operation of the other three fixed clinics in this system with non-Title X resources.

Most importantly, there has been a significant shift in the approach of the Government toward family planning which brightens the prospects for a vigorous program. The earlier focus on clinical maternal and child health services, of which family planning was an integral part, has evolved into greater emphasis on family planning as an instrument of demographic change as well as an effective health intervention. The first steps toward non-clinical contraceptive distribution have taken place and the attitudes of the program administrators have shifted significantly. In this regard, it is worth quoting from the 1976 annual report of the Division of Family Hygiene:

" Our objectives thus far have been oriented principally toward maternal and child health. We can now say that our health objectives are well understood by all at the national level of MCH/FP clinics. The fulfillment of our objectives is improving year by year. But it is time that we place this approach in the context of the Department of Public Health and Population and heighten our awareness that there exists right at home a problem of rapid population growth. During this second phase of our program we must redefine our objectives, improve the health of mothers and children, and diminish the rate of population growth, putting the accent on this second aspect which will become our principal objective." 1)

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1) Unofficial translation, pp. 83-84 of 1976 Annual report of the Division of Family Hygiene

## D. PROGRAM ISSUES

### 1. Salary Supplements

Since the inception of the program, the UNFPA has been providing salary supplements to DHF <sup>1/</sup> staff to pay for afternoon working hours. Without these supplements, all DSPP <sup>2/</sup> employees are expected to work 8 a.m. - 2 p.m. With the supplement, which is usually approximately 100% of the base salary, DHF employees continue to work from 2 p.m. to 5 p.m., rather than holding down an afternoon job to supplement income. (The monthly base salary for an MD is between \$155 and \$220; the average for a nurse is from \$155 to \$140).

As a matter of principle, UNFPA is proposing that the supplements be cut by 25% effective January 1978, and be further cut in subsequent years. There is strong feeling among the leadership of the DHF that this cut will lead to demoralization among staff and will slow the momentum of the project. USAID/Haiti is of the opinion that the full salary supplements are still necessary and that this will be the case until fundamental reforms can be made in the GOH salary structure. UNFPA is examining the question again after the October 1977 Donor's Meeting and is expected to reach a decision by late November 1977. If that decision is negative, USAID/Haiti is prepared to cover the gap, probably by using PL-480 Title I local currency.

### 2. Probable need for continued AID assistance

Due to the substantial resources required to support a program which will put family planning within reach of the Haitian population, and in view of the limited amount of resources the GOH can contribute now and in the short-

<sup>1/</sup> French abbreviation for Division of Family Hygiene

<sup>2/</sup> French abbreviation for Department of Public Health & Population

term future, it is probable that continued assistance from external donors for program operating expenses will continue to be needed beyond FY 1980. Haiti is one of the 29 relatively least-developed countries in the world and will require continued support for the family planning program if national development efforts are to succeed.

### 3. Contraceptive Mix--75% Condoms

Table 3a of this paper illustrates the striking increase in condom acceptors relative to pill acceptors over the past three years to the current level of 75% of all acceptors. While it is clear that oral contraceptives are not presently as freely available as they could be, the program has also experienced bottle-necks in condom supplies, and it is not at all certain that differences in availability can fully account for this phenomenon.

The initial provision of oral contraceptives is presently limited to physicians and nurses, who can use a checklist of questions for new clients. Auxiliary nurses will soon be authorized to prescribe orals, and the extension of this authorization to additional categories of project personnel is under the active consideration of the Haitian Government. Re-supply of orals under this project will be available from sanitary agents, community agents, and traditional midwives, in addition to physicians, nurses and auxiliary nurses.

Experience with approaches to community based distribution, including the operational research project in household distribution, will undoubtedly lead to greater availability of oral contraceptives (and condoms) as the

program proceeds. In the meantime, the condom will probably continue to be the method of choice.

It has been noted that the Haitian male is the dominant personality in most couples, and that he prefers to take responsibility for contraceptive decisions. This characteristic may also have a bearing on the contraceptive mix of this program.

Finally, it is expected that widespread introduction of family planning through the condom will have a synergistic influence on the use of other methods of contraception as the program progresses.

## II. PROGRAM BACKGROUND AND DETAILED DESCRIPTION

### A. BACKGROUND

#### 1. Demographic Situation

Overpopulation is a serious problem in Haiti. The population almost doubled in 40 years, growing from 2.12 million in 1920 to over 4 million in 1960<sup>1/</sup>. The 1971 census showed a population of 4,314,628<sup>2/</sup>. The Haitian Institute of Statistics estimates the 1976 population at 4,668,124, implying a net population growth rate of 1.6% between 1971 and 1976. However, current demographic data, shown in Table 1, below, indicate that the natural population growth rate is approximately 2.2% per year, implying a population of about 8,000,000 in the year of 2000.

The economic implications of such an increase are ominous, given the current limited (and decreasing) availability of arable land, the inadequate nutritional and health status of the average Haitian family, the pervasive poverty, the inadequate rural and urban employment opportunities, and the limited resources of the Haitian Government to address these problems.

It is thought that the gap between the growth rate estimated from total population numbers and natural increase implied by the difference between crude birth rates (CBR's) and crude death rates (CDR's) is due to outmigration by young males. This outmigration has caused there to be 28% more women than men in the 25-44 age groups, or a sex ratio of 78/100. Social structure is probably also holding down population growth, as wide variation in total fertility rates exists in Haiti, from about eleven children per woman in stable unions, to approximately three children per woman whose reproductive lives are characterized by interrupted relationships.

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1/ CELADE; Boletín Demográfico, Año V, No. 11, January 1973

2/ Haitian Institute of Statistics

Table 1

Summary Statistical Data, Haiti <sup>1/</sup>

Total Population	4,668,162
Rural Population (77%)	3,589,022
Urban Population (23%)	1,079,140
Crude Birth Rate	36.8/1000
Crude Death Rate	14.5/1000
Infant Mortality Rate (less than 1 yr.)	136.4/1000
Child Mortality Rate (1 - 4 yrs) <sup>2/</sup>	45/1000
Maternal Mortality Rate <sup>3/</sup>	13.7/1000
Average Life Expectancy at Birth	52.2 Yrs
Population Density/Arable Land	395 persons/Km <sup>2</sup>

## Sources:

- <sup>1/</sup> Haitian Institute of Statistics, 1976
- <sup>2/</sup> Haiti Health Sector Assessment, 1975
- <sup>3/</sup> Division of Family Hygiene, ESPP, 1976

In addition, it is clear that high infant and mortality rates are a major factor in the relatively high CDR.

If economic and health conditions improve in Haiti, it is likely that fewer young men will emigrate, and that there will be more stable and fewer interrupted relationships. Infant mortality is likely to be lowered by

health efforts already underway in Haiti. Therefore, these factors currently holding down the population growth rate, in combination with the young age structure (41% below age 15) suggest a potential for explosive growth which must be addressed promptly if national development goals are to be achieved.

## 2. HISTORY OF FAMILY PLANNING IN HAITI

### a. Organizational History

Although most foreign donors withdrew their economic assistance to Haiti during the period 1963-1973, all existing family planning activities (mostly those of private and religious organizations) which had continued beyond 1963 were halted in March 1971 by a Government communique. An exception was a modest project funded by Family Planning International Assistance (FPIA) and administered by the Center for Family Hygiene, a private organization which functioned much like an IPPF Affiliate. Much of the design philosophy that was to go into programs of wider scope was derived from this early experiment in developing family planning services and information. This project, which was based in three private clinics in the countryside to the east of Port-au-Prince, had begun in May 1971 and continued through April 1974. The experience gained in this project encouraged the Division of Family Hygiene to design a broader program, which began in mid-1974 with the UN Fund for Population Activities (UNFPA) providing the principal external funding.

In August 1971, the Division of Family Hygiene (DHF) had been created as a part of the Department of Public Health and Population (DSPP) and had been given a legal mandate to coordinate all family planning activity in Haiti and to end the fragmented efforts which had prevailed until then. But the de jure creation of the Division of Family Hygiene did not provide Haiti with a functioning organization to implement a family planning program.

In March 1972, the GOH signed an agreement with the UNFPA to support the creation of a de facto division within the DSPP, to integrate family planning and maternal and child health activities in the two principal maternity hospitals in Port-au-Prince, to train required personnel, and to support community education. The program got under way in May, 1972, with the Pan American Health Organization (PAHO) serving as executing agent on behalf of UNFPA. Clinical activities began in April 1973 and the DHF was officially inaugurated in the same month. This was known as the pilot project, or pilot phase, of the program.

The first multilateral donors' meeting was held in April, 1973, with the World Bank, the Inter-American Development Bank, UNFPA, PAHO, AID, and UNICEF present. The GOH agreed to present a plan for a national program of MCH/FP to succeed the Pilot Project, and a program plan was presented to the donors in a meeting in New York in December 1973.

This five-year program was designed to expand MCH/FP services in the urban and rural areas, to improve administration at the central, regional, and district levels, to train personnel, and to provide MCH/FP information at the community level. This program would be divided into two phases, the first

from April 1974 to December 1975, and the second from January 1976 to June 1979.

A tripartite agreement among the GOH, UNFPA, and PAHO was signed on May 23, 1974, for \$1,675,249 to implement the first phase of the program, which was delayed until August 1974 due to an extension of the pilot phase. A separate agreement was signed with Pathfinder for \$89,907 for the same period to provide additional staff support to the service outlets.

Prior to scheduled initiation of the second phase of the program (in January 1976), a delegation from the Division of Family Hygiene visited New York to review the program with representatives of UNFPA and PAHO/WHO in August 1975.

During these discussions, it was decided to use the unexpended balance on hand to extend the first phase activities until June 1976. Accordingly, the Division of Family Hygiene was requested to prepare a three-year program to begin 1 July 1976 and end 30 June 1979, which would constitute the second phase of the five-year program. This three-year phase was prepared by the Division of Family Hygiene and submitted to UNFPA and PAHO/WHO in late 1975. In February, 1976, an inter-agency meeting was held in Port-au-Prince with the participation of representatives of the Haitian Government and delegates of the agencies heretofore involved in financing the national MCH/FP program, i.e. the UNFPA, USAID and Pathfinder Fund. At that time, an evaluation of the first phase of the program was reviewed and the Government's proposal for second phase activities was discussed.

The proposal from the Government called for an expansion of the number of clinical facilities from 21 to approximately 42 over a three-year period, building upon the model of clinical services which had been established, in order to extend coverage to approximately one-third of the population of Haiti.

The donors agreed on the need for an integrated MCH/FP delivery structure but they concluded that adequate funding was not available from population sources to enable the clinical network to expand along traditional clinical lines. Agreement was reached during the February meeting that support for the 21 existing urban clinics would continue, but that the program should expand coverage along different lines utilizing auxiliary personnel, community agents, mobile teams, community-based distribution networks and other non-clinical delivery systems..

Following the February meeting, the Government began examining the possibilities for service expansion based on other than clinical methods, and by September 1976, the Division had submitted to the donor community a request to fund new approaches to service delivery to provide for greater coverage of the population.

This plan had three major new elements: first, the service delivery capacity of the fixed clinics would be expanded by use of travelling teams of clinical staff members, who would hold satellite clinics on a regular basis in sites outside the fixed clinics. These satellite clinics would be publicized

in advance by urban outreach workers called community agents who would also function as FP recruiters and motivators. Second, dispensaries would be established in the rural areas not served by fixed clinics or their satellites, to be staffed by auxiliary nurses and supported by a new category of community health workers, called sanitary agents. Third, rural MCH/FP activities would be strengthened by training traditional midwives (matrones) in better delivery practices, maternal and child health care, and family planning service delivery. Supervision of these new service outlets and personnel types was also proposed. <sup>1/</sup>

Each of these three principal means of expanding service coverage was in turn to be integrated with an emerging public health delivery system of the Department of Public Health and Population, and was to form part of the decentralization of the national health system, wherein each health district would gain greater responsibility and authority in administering all public health and family planning activities in its area.

In the multi-agency meeting of September 1976 these new initiatives in service delivery were quite well received by the donor community. Funding responsibilities for the three main areas of program expansion were divided among the major donors, with UNFPA taking responsibility for supporting the satellite clinics and the urban facilities, Pathfinder Fund agreeing

<sup>1/</sup> More detail regarding program structure, activities, personnel and supervision will be found in Section II B. "Detailed Program Description".

to support the expanded training of "matrones", and AID agreeing to support the major new initiative in the rural dispensaries and development of sanitary agents.

The most recent multi-donor meeting was held in Port-au-Prince in October, 1977 with the participation of UNFPA, PAHO, AID, Pathfinder, Development Associates, and PIEGO. Discussion centered on the report of accomplishments in the first 18 months of Phase II (1976 & January - June 1977) and on the budget arrangements for 1978. The primary issue discussed was the question of the level of continuing salary supplements, which is addressed in Section I. B. "Project Issues", above.

b. Government Policy

The official rationale for family planning in Haiti remains the promotion of maternal and child health and family well-being, although the Division of Family Hygiene has begun to move toward more explicitly stated demographic objectives in its approach to family planning. There have also been recent expressions of concern over Haiti's population growth at the highest levels of Government, and it appears that awareness of and sensitivity to the problem may be increasing. The USAID believes that the chances of developing a formal policy are improving; the US Mission in Haiti will lend its full support to the emergence of a policy. To this end, a centrally-funded Title X project to be carried out by the Battelle Population and Development Policy Program has chosen Haiti as one of the first countries for its activities in supporting population policy development.

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The objective of the Battelle project is to support data analysis and other activities as a means of providing population inputs to development planning. Proposed activities in Haiti include analysis of data from the Community health program of the Albert Schweitzer Hospital in Deschappelles, analysis of data from the Project Intégré (a community health and FP research project directed by the Division of Family Hygiene), the World Fertility Survey, and other sources, and preparation of a follow-up report to the March 1977 presentation to the cabinet and CONADEP (Conseil National de Développement et de Planification) on population growth and development objectives in Haiti.

c. Program Activities and Results to Date

First Phase: Clinical Establishment

From its inception, the government's approach to family planning was strongly clinical and relied on the establishment of maternal and child health care facilities as a means of delivering family planning services. The program was unable to simply add FP services to existing clinical facilities because such facilities were not able to deliver even basic health services and needed extensive upgrading to be able to deliver family planning services. Between mid-1974 and the end of 1975, eighteen maternal and child health/family planning clinics were strengthened in the major population centers of the country, in addition to two strengthened earlier in the capital city. As each clinic came on line, it began to provide family planning, prenatal, pediatric, maternity, and immunization services.

Each center required considerable capitalization and equipment to be able to function as a point of service delivery, and the staffs of the entire clinical and administrative network required extensive salary supplements to enable them to function full time. It is worth noting in this context that Haiti is the only country where the World Bank has recommended across-the-board government salary increases to enable the administrative mechanism of the Government to function, and it is still true that all public service activities in Haiti continue to require extensive salary support to enable employees to devote full time to their jobs.

The first phase of the program also saw a strengthening of the administration of the program at the central, regional, and district levels, and the development of service statistics systems.

AID's participation in the family planning activities of the Government of Haiti began in 1975 and the first project agreement for \$143,500 was signed in March of that year. AID's contributions to the Government program were concentrated in the fields of training, information and education, and national supervision of field services.

The AID project provided funds for constructing and equipping 2 training centers (Port-au-Prince, completed in the Fall of 1975, and Croix-des-Bouquets, dedicated in November 1976) and provided salary supplements for an additional pilot clinic in the Cul-de-Sac area east of Croix-des-Bouquets.

By the end of 1975, the training targets set for the AID project had been met and exceeded:

1. MCH/FP training courses had been completed for 236 people, including physicians, nurses, auxiliary nurses, statisticians, field administrators, community agents, and supervisors. (The target had been 182)
2. Six specialized seminars had been held to spread the family planning message to pharmacists, factory managers, agronomists, rural agricultural agents, rural extension agents, and truck drivers. Thirty to fifty persons attended each of the 2-5 day seminars.
3. In-service training of clinical and administrative staffs had progressed well; each clinic received between 2 and 3 visits from headquarters staff concerned with particular subjects, including nursing, pediatrics, data collection and motivation.

During 1975, information and education activities under the AID Project also expanded. There were approximately 3000 radio programs of 20-30 minutes each transmitted by 10 stations, and roughly 39 newspaper articles prepared by the Division of Family Hygiene were published for the urban readership of Port-au-Prince. In addition, 78 film showings were held and the program continued to rely on the direct personal contacts of approximately 100 community agents to motivate people to attend the family planning clinics.

#### Second Phase: Consolidation and Outreach

The Second Phase of the DHF'S MCH/FP program began in January 1976. The results of the first 18 months of that phase were presented at the October 1977 donor's meeting. Major achievements cited were as follows:

1. Maintenance of 21 existing MCH/FP clinics.
2. Expansion of fixed clinic coverage by use of 84 satellite locations, served by travelling teams from the fixed clinics.
3. Expansion of the MCH/FP program through the Organization for the Development of the Artibonite Valley (ODVA).
4. Improvement of Service Statistics System and research studies.
5. Strengthening administrative organization at central, regional and district levels.
6. Training of personnel, local and abroad.
7. Expansion of IEC activities.

During 1976, the ongoing program of the Division of Family Hygiene concentrated on consolidating the clinical facilities which had been opened during late 1974 and 1975, and on strengthening the capacity of these facilities to deliver services. No additional fixed clinics were opened during 1976, but satellite clinics began operating around 3 urban clinics, greatly expanding program activity. One of them, the Maternite Isaie Jeanty, had particularly good results, and by the end of the year service statistics showed the effectiveness of the satellite approach. Seventy-one percent of all pediatric visits for the clinic as a whole were attributable to the satellite clinics; 36% of all new female family planning acceptors were enrolled in the satellite clinics, as were 39% of all new male family planning acceptors.

Mention should also be made of non-governmental health facilities which began to receive contraceptives and assistance in family planning training

from the Division of Family Hygiene, although they were not under the direct administrative jurisdiction of the Department of Public Health and Population. These facilities consisted of two hospitals, two dispensaries, and a clinic which operated under non-governmental auspices but which became active in providing family planning services. In addition, there were 47 other institutions, primarily dispensaries, which began to participate in the vaccination program of the Division of Family Hygiene, but whose personnel did not receive salary supplements from the Division, and which did not operate under the direct administrative supervision of the Division.

During 1976 the Division of Family Hygiene also began providing support to the dispensaries which were administered by a semi-autonomous agency of the Haitian Government, the Organization for the Development of the Artibonite Valley (ODVA). The Division initiated the training of sanitary agents and auxiliaries to staff the dispensary network of the ODVA as a pilot training effort to gain experience for the larger national program of dispensary and sanitary agent development.

Similarly, the Division began working more closely with the Bureau of Nutrition of the Department of Public Health and Population in order to provide training and motivation in family planning methodology to the personnel of the Bureau's Child Nutrition Centers. The Division also provided support to Action Familiale--a non-sectarian organization which disseminated family planning information on all methods to interested couples and which provided instruction in the sympto/thermal method of family planning.

AID funding during 1976 and 1977 focused on provision of contraceptives; training; supervision; information, education, and communication (IEC) activities; and support of the Croix-des-Bouquets training center and associated clinics.

For 1976, AID contributed \$141,600 worth of contraceptives--300,000 cycles of oral contraceptives (which were provided through FPPIA) and 30,000 gross of condoms. In 1977, 490,000 cycles of orals (provided through FPPIA) and 61,500 gross of condoms were donated, and AID also funded minor renovations to a DSPP warehouse for condom storage.

During 1976, the Division completed the formation of training teams to carry out training programs for sanitary agents at the Croix-des-Bouquets training center, and this team initiated the first courses of instruction for sanitary agents to work in the Artibonite Valley. Training was also provided to 580 "matrones" during the year, and eighty-six resident physicians participated in orientation seminars. Similar seminars were held for auxiliary-nutritionists working under the Bureau of Nutrition, for nurse-hygienists working under the Division of Public Hygiene of the DSPP, for directors of factories which employed large numbers of women in the Port-au-Prince area, and for the staffs of nutrition-rehabilitation centers. Seminars were also held for taxi drivers and bus drivers, and an experimental program of condom distribution was begun under which 55 drivers were given initial supplies of condoms for distribution to their passengers, and were instructed to obtain resupplies of condoms from clinical outlets. A seminar was held with repre-

representatives of the Armed Forces of Haiti to begin discussions on a condom distribution program among the military forces.

Training of community agents continued during 1976 with a seminar at the Petion-Ville clinic and with in-service training courses for existing community agents. Thirty persons were trained abroad for a total of 105 months.

During the January 1976 - June 1977 time period, 43 supervisory visits were made by national staff to district and other fixed clinics; this represented 84% of the 51 planned visits to the 17 clinics outside the metropolitan area of Port-au-Prince.

In the field of I, E, & C, over 7000 radio programs of 20-30 minutes each were broadcast, 187 film showings were held, and 64 newspaper articles were published during the first 18 months of the second phase. The radio programs were prepared in a studio renovated with AID funds.

In 1976, AID provided support for 2 clinics in the Cul-de-Sac area. In 1977, AID also began supporting the Fond Parisien clinic, which will be used as a support base for the Household Distribution Operational Research Project. Operational costs of these three facilities will be absorbed by AID's Strengthening Health Services II Project (521-0026) beginning in January, 1978.

In 1977, twenty dispensaries began operations under ODVA auspices, and fifteen were upgraded under DSPP auspices. The project also sponsored the family planning aspects of training for the auxiliary nurses to staff these dispensaries, and the training of ninety sanitary agents who are in turn supported by the dispensary network.

AID bilateral funding increased from \$138,000 in 1976 to \$247,000 in 1977 in response to the increased opportunities for developing these new approaches to service delivery, as described below in the detailed project description.

Tables 2, 3a and 3b below show the contraceptive performance of the program through 1977.

FAMILY PLANNING ACCEPTORS

Table 2

Numbers of New Family Planning Acceptors by Sex and by Percent of women in fertile age, Haiti, 1974 - 1977

	1974		1975		1976		1977 <sup>1/</sup>	
	#	%	#	%	#	%	#	%
Total WIFA	902,700	100	916,750	100	933,140	100	949,800	100
Female acceptors <sup>2/</sup>	4,631	.50	14,912	1.6	14,995	1.6	19,724	2.1
Male acceptors <sup>2/</sup>	767	.08	9,554	1.1	26,298	2.8	37,856	4.0
Total acceptors	5,398	.58	24,566	2.7	41,293	4.4	57,580	6.1

Source: Tripartite Project Review; Maternal and Child Health and Family Planning,  
 Division d'Hygiene Familiale, Departement de la Santé Publique et de la Population:  
 Port-au-Prince, 1977.

<sup>1/</sup> 1977 figures are extrapolations based on data for Jan-June 1977.

<sup>2/</sup> Not including several thousand additional clients supplied through  
 non-governmental clinics and commercial sources.

Table 3a

Number and Percent New Acceptors by First Method Accepted, Haiti 1975 - 1977

	1975		1976		1977	
	#	%	#	%	#	%
Condom <u>1/</u>	11,593	47.2	28,318	68.5	42,962	74.6
Pill	6,144	25.0	7,872	19.1	10,592	18.4
Cream (Emko Foam)	2,982	12.1	3,554	8.6	2,662	4.6
IUD	1,342	5.5	1,380	3.3	710	1.2
Other	149	0.6	150	0.4	631	1.1
Unknown	2,350	9.6	15	0.04	18	0.03
	24,560	100	41,293	100	57,580	100

Source: Tripartite Project Review, DHF, 19771/ This is the sum of male acceptors and female condom acceptors.

TABLE 3b  
 PERCENT OF NEW FEMALE FP ACCEPTORS BY AGE GROUP  
 AND NUMBER OF LIVING CHILDREN, HAITI, 1975-1977

CHARACTERISTICS	GROUPS	1975	1976	1977*
AGE GROUP	less than 20	5.6%	6.3%	7.2%
	20 - 29	53.4	53.4	56.6
	30 - 39	30.8	26.2	22.9
	40 and over	6.1	4.2	2.9
	Unknown	4.1	9.9	10.4
NUMBER OF LIVING CHILDREN	0	7.5	4.5	5.0
	1-2 Children	32.7	39.9	44.7
	3-4 Children	23.2	26.7	26.2
	5-6 Children	12.1	12.7	10.4
	7 and over	6.1	5.7	4.5
	Unknown	18.4	10.4	9.2

\* Data for the six first months.

Source: Activities Reports, 1975, 1976, 1977.

Statistics Section, DHF.

The lack of significant increase in new female acceptors from 1975 to 1976 demonstrated the inadequacy of the fixed clinical network and underlined the need to expand the availability of contraceptives through other channels to allow adequate coverage of the population. The disappointing performance in 1976 was partly attributable to late deliveries of contraceptives and problems in the release of these commodities from the docks. As a result, the division was forced to ration its distribution of contraceptives with the predictable result that program expansion suffered. On the bright side, however, the record indicates that over 56% of the new female acceptors in 1977 were between the age of 20 and 29 and that 50% of new female clients had two or fewer children. The positive response so far of young women with small families is one encouraging sign for the future of the program.

Experience to date indicates that the contraceptive mix is heavily weighted towards condoms as shown in Table 3a. The DHF anticipates that this phenomenon is likely to continue over the next several years.

Continuation rates of new acceptors are not well known. The DHF has estimated pill continuation rates of 50% at 1 yr, 35% at 2 yrs, and 20% at 3 yrs, as its high estimates, and 35%, 20%, and 10% as its low estimates. A study of continuation rates was attempted in Port-au-Prince in 1976, but only 14% of the sample of 100 were located at the addresses they had given, and a subsequent study was begun in Gonaives, where 75% of the clinic's clients live in the town. It was found that 62% of those interviewed were

still active at the clinic, and that another 11% were still contracepting, but outside the clinic. Further study will be necessary to determine typical duration of contraceptive use.

Other services of the MCH/FP program saw increasing activity during the 1974 - 1977 period. Table 4, below, summarizes those services.

Table 4

Number of Persons Served by MCH Service, and percent of those in Need Served, Haiti 1974 - 1977.

	Prenatal		Child Screening		Delivery Care	
	#	%	#	%	#	%
1974	3,251	1.8	16,347	1.8	9,480	5.2
1975	16,322	8.9	43,109	4.7	21,841	11.9
1976	34,565	18.5	57,215	6.1	27,236	14.6
1977*	48,526	25.5	103,322	10.7	28,764	15.1

Source: Tripartite Project Review, DFH, 1977

\*1977 data are extrapolations based on data for Jan-June 1977.

## II. B. DETAILED PROGRAM DESCRIPTION

The objective of this undertaking is to make family planning services available to over 90% of Haiti's population by the end of 1980. In order to achieve a demographic impact, a corollary objective is for contraceptive to be used by 20% of couples of fertile age. By the year 1980, it is assumed that there will be one million women in the age group 15-45, such that a demographically effective program must involve approximately 200,000 women or their partners in a pattern of regular contraceptive use. The project proposed herein is designed to achieve a level of 236,000 contraceptive users by the end of 1980. This may have a substantial impact on the CBR, according to a report prepared for USAID/Haiti by Dr. John Anderson of the Center for Disease Control. That report appears as Annex K to this paper, and indicates that if Haiti has 236,000 continuing users of contraception in 1980, the CBR may approach 25.

The percent of WIFA using contraception will rise during the course of this program as shown below:

	<u>1978</u>	<u>1979</u>	<u>1989</u>
Population	4,828	4,865	4,945
WIFA	966	973	989
Contraceptive Users	143	192.5	236.5
Users as % WIFA	14.8%	19.8%	23.9%

The fundamental question is how to increase the service coverage of the population within the realities of the Haitian setting. Table 5, below, shows each type of service delivery outlet, the population to be served, and the number of anticipated contraceptive users. The project description which follows shall refer to each element of service delivery in turn as outlined in this table.

TABLE 5

## EXPANSION OF FAMILY PLANNING SERVICES AND PROJECTED CONTRACEPTIVE USE BY SOURCE OF SUPPLY, HAITI 1978 - 1980

	By end of 1978			By end of 1979			By end of 1980		
	Out-lets	Population Coverage (000)	F.P. Users (000)	Out-lets	Population Coverage (000)	F.P. Users (000)	Out-lets	Population Coverage (000)	F.P. Users (000)
Urban Fixed Clinics and Their Satellites under DSPP Administration	22	1,050	42	22	1,071	45	22	1,092	50
Urban Fixed Clinics Affiliated with Private Organizations	6	325	12	8	350	15	10	400	18
Mobile Units	2	50	2	4	100	4	6	150	6
Rural Dispensaries under DSPP Administration	50	500	20	85	850	34	120	1,200	48
Rural Dispensaries under Organization for Development of Artibonite Valley	35	350	14	50	500	20	50	500	20
Child Nutrition Centers	40	200	8	60	300	12	65	325	15
Traditional Midwives <u>1/</u> (Matrones)	3,000	1,000	20	4,500	1,500	30	6,000	2,100	40
Voluntary Surgical Contraception Clinics	3	200	.5	5	300	1.5	7	400	2.5
Operational Research Project in Household Distribution	3	20	2	3	20	2	3	20	2
Condom Vending Machines	150	400	.5	150	400	1	150	400	2
Armed Forces (Population Figure for Men Only)	N/A	10	4		15	6		20	8
Commercial Sector		1,000	13		1,100	14		1,200	14
Community Organizations, Coops Men's Groups	100	40	2	150	60	3	200	80	4
Action Familiale (Sympto-Thermal)	5	75	3	5	125	5	5	175	7
Totals		* 2,800	143		* 3,600	192.5		* 4,500	236.5

(Note\*: Totals for Population Coverage reflect overlapping service areas of various outlets)

1/ The acceptors referred in urban areas are included in lines 1 & 2. About 2/3 of matrones practice in rural areas.

1. Service Delivery Sites

a. Urban Fixed Clinics and Their Satellites under DSPP administration

There are twelve hospital outpatient clinics and ten freestanding clinics in this group. All are located in communities of high population concentration. Each of the clinics offers a full complement of MCH/FP services, and is staffed by a full professional staff - usually 1 doctor, 1 nurse, 1 nurse-midwife, 3-4 auxiliaries, an administrator, 5 community agents, and associated staff. The staff are generally regular employees of the Department of Public Health and Population, but they receive salary supplements from the Division of Family Hygiene to allow them to work a full day without the need to augment their inadequate government salaries with afternoon private practice.

The institutional capability to function as effective outlets of MCH/FP services had long been lacking in these facilities until the Division of Family Hygiene began providing the equipment, supplies, training, supervision, salary supplements, and administrative support needed to realize the full potential of these institutions. These clinics represent the first efforts in MCH/FP in Haiti, and they constitute the framework through which the program will carry out its activities of training, supervision, field support and contraceptive supply. Fixed clinics are supervised by the Central Offices of the Division of Family Hygiene. Ten of these clinics serve as headquarters of the district health offices, and have supervisory, training, and logistical responsibilities at the district level. These 10 fixed clinics

also have district supply depots(which will be renovated in 1978 by AID at a cost of \$2000 each). The district health centers will also be the sites for provision of surgical contraception services.

Continued support for 17 of the 22 fixed clinics is expected to come mainly from UNFPA and the GOH during the 1978-1980 period. AID, which supported three of these facilities during 1977 will shift funding for these three clinics from Title X to a public health project (Strengthening Health Services II - Project 521-0086), scheduled to start in 1978.

Two of the facilities have been assigned a catchment area of 75,000 people each, fifteen facilities cover 50,000 people each, and five 25,000 people each. Each facility is expected to enroll contraceptors equal to 20% of the women in fertile ages (WIFA) in their catchment area. This comes to 42,000 clients in 1978, 45,000 in 1979, and 50,000 in 1980.

Contraceptives at these and all DHF facilities are distributed to project participants without cost. Normally, 1 cycle of pills is given in each of the first 2 months, and 3 cycles per visit after that. Condoms have generally been distributed a dozen at a time, but the DHF is raising the norm to eighteen and will encourage much more liberal allocations at all delivery points. There is some variation in these protocols in case of unusual local circumstances or physician preference. \*Included in the number of users shown in Table 5 for urban fixed clinics are the users recruited by urban matrones, community agents, and satellite clinics.

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\*AID and the other donors will continue to encourage that contraceptives become as widely available and accessible as possible throughout the life of this project.

Satellite clinics, which are staffed by travelling teams (usually a physician, an auxiliary nurse, and a driver) and which are accompanied by a community agent from the area, take place on a regular schedule, at least once per month, in facilities such as community centers, literacy centers, coops, unstaffed dispensary buildings, and private dwellings. Each fixed clinic establishes at least four satellite clinic sites in order to increase the number of patients served within its catchment area. The satellite clinics operating so far have clearly demonstrated their ability to expand service delivery, by attracting clients to attend clinics closer to home.

For all urban catchment areas combined, 22% of all family planning acceptors were served by satellite clinics in the first half of 1977. At one urban center (Quatre Chemins des Cayes), 45% of family planning acceptors in the first half of 1977 were served through that center's satellite clinics.

Recruitment and motivation work for satellite clinics are performed by community agents, who serve as outreach workers from each fixed clinic.

b. Urban Fixed Clinics under Private Auspices

These clinics are not under the direct administrative jurisdiction of the DSPP but are active in providing clinical services to a significant proportion of the population. They do not receive salary supplements or significant quantities of clinical supplies other than contraceptives from the Government, but they do participate actively in family planning and

immunization programs sponsored by the Division of Family Hygiene. They include such institutions as the Albert Schweitzer hospital in Deschapelles and the Mennonite-supported hospital at Grande Riviere du Nord. The Division will continue to provide these facilities with contraceptive supplies and technical assistance, particularly in view of the fact that several of them provide the only health and FP services presently available in large areas of the country.

c. Mobile Units

The other service outlet and supply source for urban areas in this program will be mobile units. The first mobile unit, consisting of a modified VW van, was contributed by Brazil to President Jean-Claude Duvalier, who gave it to the DSPP for use in the national MCH/FP program. The unit functions Monday through Thursday providing services at approximately 16 locations per month, one visit per month for 3 months. Patients are thereafter referred to the nearest clinic for continuing supply. The mobile unit is staffed by a nurse, an auxiliary nurse, a nutritionist, and a driver. They are accompanied by a community agent from the area. Mobile units serve areas where satellite clinics have not been established.

The mobile unit now in operation in Port-au-Prince has shown promising results so far. During the May-September 1977 period, initial family planning services were provided to 484 women and 2412 men. In proportion to the time in operation, the mobile unit served more new acceptors than 15 of the 21 operating fixed clinics during the first six months of 1977.

This experience has convinced the DHF of the effectiveness of the mobile unit in taking family planning services to the poorest population groups in Port-au-Prince. AID will fund the acquisition of an additional unit for Port-au-Prince in 1978, one each for Les Cayes and Cap Haitien in 1979, and one for Gonaives during 1980. The project will also support the operational and personnel costs of the mobile units.

The contraceptive users expected to use these mobile units, as shown in Table 5, are quite modest in number (1,000 per unit per year--1977 experience so far would imply 7,000 per unit per year), and USAID estimates that these projections will be exceeded several times over. The Division of Family Hygiene, however, prefers to gain greater information on continuation rates for these units before raising the projected levels of contraceptive users attributed to them.

d. Rural Dispensaries under DSPP Administration

The extension of contraceptive services under the rural dispensary program of the DSPP and of the Organization for the Development of the Artibonite Valley (ODVA) is expected to reach approximately sixty-eight thousand fertile women, or their partners, by the end of 1980.

The aggregate population covered by these 170 dispensaries will be approximately 1.7 million people, and the target for contraceptors will be 20% of the WIFA in this population.

This dispensary program represents a major shift in the Haitian Government's philosophy of service delivery, from an expansion of clinical facilities along rather traditional lines to an emphasis on auxiliary and community-level personnel functioning in non-clinical settings. There are three major design elements in the program: A) the creation of a cadre of 630 community-based family planning and health workers called sanitary agents; B) the establishment of a network of 170 rural dispensaries to support the sanitary agents; and C) the implementation of a system of supervision and support to the dispensaries from the ten district health centers. The design of this system was initiated in mid-1976 as one of several new approaches to an expansion of service coverage as described in the preceding Section A.2.c, "Second Phase: Consolidation & Outreach". (The other main initiatives included a system of satellite clinics to deepen the coverage of the twenty-two urban clinics--to be funded primarily by UNFPA, and a greater reliance on traditional midwives for recruiting family planning clients--to be supported primarily by the Pathfinder Fund. A.I.D. agreed to provide funding for the system of sanitary agents and dispensaries, and during 1977 the first steps were taken to launch the new system).

Dispensaries are small buildings in rural communities where basic MCH/FP services are provided by a single auxiliary nurse. Dispensaries also serve as contraceptive sub-depots and some dispensaries have beds for inpatients. The auxiliary nurse usually lives nearby and may have regular hours or operate more on an "on call" basis. Each dispensary and the four sanitary agents reporting to it are expected to serve a population of 10,000 people.

Resupply of pills, and both initial distribution and resupply of condoms are available at dispensaries. It is probable that new procedures will be adopted soon, so that auxiliary nurses will be able to initiate pill supply using a checklist instead of physical examinations. Supervision of dispensaries is done by a team from the District Headquarters Office, which also provides logistical support and in-service training to the auxiliaries. The auxiliary nurses, in turn, provide backup and supervision for the sanitary agents and the traditional midwives, "matrones", working in the dispensary cachement area.

Dispensary development, supervision, and sanitary agent training will be funded by AID. This includes the renovation of 118 dispensaries which are in desperate need of repair, in addition to the fifteen renovations funded under the 1977 AID project. AID will also fund the operation and maintenance of the dispensaries at an approximate cost of \$560 per year under this project. Medical supplies more directly related to health care will be funded by a non-Title X AID project--Strengthening Health Services II.

By the end of 1980, 120 dispensaries under the administration of the DSFP will be operating and providing family planning services to approximately 48,000 persons. This includes acceptors served by sanitary agents, but does not include acceptors served by rural matrones.

e. Rural Dispensaries under Organization for the Development of the Artibonite Valley (ODVA) Administration

These dispensaries will perform services similar to those described above, except that they will function in the setting of a multi-purpose commu-

nity development project of the ODVA, a semi-autonomous government agency. Renovations will be funded primarily by ODVA and the district-level supervision and support will be provided by the staff based at St. Marc, a town on the western edge of the valley. The 1977 AID family planning project furnished a field vehicle to facilitate travel by the district health team at St. Marc, and the first graduating class of sanitary agents was assigned to the ODVA project. AID also provided \$35,000 in non-Title X funding in 1977 to renovate and equip five dispensaries and three health centers in the ODVA area.

There are currently 12 ODVA dispensaries functioning, with 35 to be in operation by the end of 1978, and a total of 50 by the end of 1980. Those dispensaries are expected to provide contraceptive services to about 20,000 persons in 1980, or 20% of the WIFA in their catchment area.

f. Child Nutrition Centers

The Bureau of Nutrition of the DSPP currently administers a network of nutrition centers with support from AID non-Title X funds. These centers serve to educate the mothers of malnourished children in patterns of food selection and preparation, using the improvements in their own children's nutritional status during three-month courses to reinforce the learning process. Each pre-school child participating in the program receives a well-prepared meal once a day, and the mothers participate in the preparation of these meals. The project is based on ten years of experience with this model in Haiti, and has shown promising results thus far. Each nutrition

center is managed by a specially trained auxiliary nurse, and the centers move from community to community once they have raised the level of child malnutrition above the second degree level in a given community.

During 1977, the Division of Family Hygiene trained the first group of auxiliary-nutritionists in family planning information and services, and completed the administrative arrangements with the Bureau of Nutrition to provide training and contraceptives to all the centers under the Bureau's aegis.

These auxiliary nutritionists are able to provide the same services as auxiliary nurses in dispensaries: resupply of pills and initial and resupply of condoms.

The number of nutrition centers providing contraceptive services is expected to increase from 20 by the end of 1977, to 40 by 1978, to 60 by 1979, and to level off at 65 in 1980. It is possible that the growth of the nutrition center program may be substantially greater than presently forecast, but this depends on the eventual design of a nutrition strategy for Haiti and is outside the scope of this Project Paper.

As indicated in the table on the extension of FP services, the 65 nutrition centers projected for 1980 are expected to enroll 15,000 women in programs of regular contraceptive use. Title X funding for this effort

will total approximately \$6,000 over the life of the project, and will consist of support for the training seminars that will be held for the auxiliary nutritionists. (These appear in the IEC portion of the AID Bilateral Budget).

g. Other service delivery outlets

Contraceptive services will also be offered through Voluntary Surgical Contraception clinics, condom vending machines, the armed forces, and household distribution and community-based outlets. These approaches are discussed below in section B.5 of this paper, following a description of the training, supervision, and I-E and C activities which constitute important AID-funded elements of the service outlets described above.

## 2. Personnel: Training and Activities

### a. Physicians

Physicians work in fixed clinics, satellite clinics, and at voluntary surgical contraception clinic sessions in this program. Training for physicians will include fellowships funded by UNFPA (8 in 1978, 2 in 1979, 1 in 1980) and training for a total of 91 physicians in voluntary surgical contraception techniques. More detail can be found in section II B 5.2, "Voluntary Surgical Contraception" of this paper.

### b. Nurses

Nurses work in fixed clinics, satellite clinics, and mobile units in this program. Nurses as well as physicians may insert IUD's, give initial pill supply, and perform pelvic examinations. Physicians and nurses attend periodic seminars in family planning conducted by the Division of Family Hygiene.

### c. Community Agents

Community agents are urban outreach workers serving fixed clinics. There are currently 140 community agents, who are supervised by 30 community agent supervisors.

Community agents are trained for one month in MCH/FP at the fixed clinics where they serve.

Their principal tasks are to recruit and follow up MCH/FP clients, to whom referral coupons are distributed to be turned in at the clinic visits. They also act as distributors for contraceptive resupply.

In addition, community agents function as information sources and organize community groups in preparation for visits of satellite clinics or a mobile unit.

Community agents receive salary supplements under the UNFPA support to the DHF project.

d. Auxiliary Nurses

There are two types of training for the auxiliary nurses who staff the dispensaries supported by this program: first, their basic training, and second, the refresher seminars held periodically to update skills.

Auxiliary nurses receive basic training from the Department of Public Health and Population in courses of nine month's duration at two schools of nursing, one in Port-au-Prince and another in Les Cayes on the southern peninsula. A third school in Cap Haitien (in the North) will graduate its first class of auxiliaries in 1977, and these three schools will produce a total of approximately 100 auxiliaries per year.

Supplemental training in the form of refresher seminars in basic MCH care, family planning, and basic administration is funded by AID. It is expected that there will be 2 seminars in 1978, 3 in 1979, and 4 in 1980, all conducted by the DHF. These will cost about \$2,000 per 5-day seminar. Development Associates will also fund 2 such seminars per year. (A one-week session to train the trainers for these seminars was held under D.A.I. auspices in September, 1977). During 1977, AID also provided non-title X funding for two-month in-service training courses for new auxiliary graduates at the Maternite Isaie Jeanty in Port-au-Prince.

AID will also fund supplementary salaries of \$30 per month per auxiliary to provide a living wage and to assure that auxiliaries will be able to devote full time to their work.

e. Sanitary Agents (Agents Sanitaires)

Sanitary agents are the basic health and family planning workers at the community level. They have specific responsibility for primary care in MCH/FP as distinct from the primarily motivational functions of the community agents. Sanitary agents are also expected to organize traditional medical practitioners (matrones and guerisseurs) in their areas, to promote environmental sanitation, and to serve as the primary point of contact between the DSPP and the rural populace.

Sanitary agents are the lowest level full-time salaried worker of the DSPP, earning about \$8 per month. (Sanitary agents attached to ODVA dispensaries are paid by the ODVA).

Each rural dispensary supports four sanitary agents with technical guidance, resupply of contraceptives and basic medicines, referrals, inservice training, and consolidated report preparation.

Sanitary agents are generally women selected from the population to be served, and are expected to cover 2500 people in their service area. The family planning acceptors recruited or referred by sanitary agents are included in the targets for the dispensaries to which the sanitary agents report. By the end of the project, the dispensary/sanitary agent network is expected to enroll about 68,000 acceptors in a pattern of sustained contraceptive use.

In late 1976, the first training team was formed to begin training sanitary agents. The first group of 24 trainees was destined for the prototype system of dispensaries in the Artibonite Valley (sponsored by the ODVA). The Division of Family Hygiene was able to launch the trial training effort while discussions were still underway in the Department of Public Health and Population to consider the official adoption of the sanitary agent/dispensary approach to rural health and FP care.

By early 1977, the DSPP had taken the policy decision to develop a national cadre of sanitary agents in coordination with the plan to decentralize and strengthen the public health system, and the Division of Family Hygiene was given the leading role in developing these workers.

Each training course\* lasts three months and consists of six weeks of instruction at the training centers and six weeks of field training. Approximately thirty candidates comprise each class. The schedule below shows the numbers of sanitary agents to be trained each year, and the number of courses.

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\* Unfortunately, it is not possible to annex a course outline to this paper. The pilot training courses have been completed, and the final course outline will not be published until December, 1977. The following subjects, as an illustration of the topics covered, were included on the final exam of the most recent course: family planning, maternal and child health, symptoms and treatment of common problems, first aid, immunization, and community development.

	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>Total</u>
# trainees	200	200	140	540
# basic courses	7	7	4	18

During 1977, 90 sanitary agents were trained under the current Title X project, such that the total number trained under this activity will be 630 by the end of 1980. There is a possibility that the Department of Public Health and Population will request the training of additional sanitary agents to strengthen other rural dispensaries, depending on the experience of the first several years. The 1980 level of 140 trainees may thus be substantially increased later in the program.

Under the AID project, trainees will receive \$7 for transportation and \$3 per diem during the course. The dormitory will be renovated at a cost of \$1000, and each graduate will receive a case in which to carry her supplies. Two in-service training seminars will be held in 1979 and again in 1980.

The training teams for sanitary agents will also be funded by AID. Training courses will be provided for the trainers, as will salary supplements, stipends for each course, and per diem during the courses.

f. Matrones

Matrones are the traditional midwives of Haiti. They are both men and women, generally middle aged ("d'un certain age"), who attend births and have not had formal training. They are generally illiterate.

Each of the fixed clinics is expected to train about 50 matrones per year in courses of between trainees each 15 and 25. In addition, about 500 matrones will be trained by private institutions, using the course outline and protocol of the DHF.

The course consists of 12 classroom sessions and four practical sessions, one per week over a 16-week period. A list of course topics is in Annex J. \_ \_ \_ .

Matrones receive a per diem payment of 25¢. for each training session they attend. Subsequent to this initial training, matrones attend monthly follow-up sessions where the auxiliary nurse goes over problems, presents a short refresher lesson, resupplies the matrones kits, and collects statistics. Matrones receive stipends of \$1 for each follow-up session they attend.

Matrones receive graduation a kit containing envelopes with a razor blade, 2 pieces of string, gauze squares, cotton balls, an umbilical band, and safety pins. The kit also contains soap, a soap dish, a bottle of sulfacol, a nail brush, and an antiseptic eye ointment. The possession of this kit is the mark of a trained midwife, and greatly enhances social status. Often a trained matrone commands a higher fee (in cash or kind) than an untrained midwife. Trained matrones are not employees of the DSPP and receive no government salary.

The trained matrones' primary responsibilities, in addition to attending deliveries, are to inform, recruit, and resupply family planning acceptors, to refer patients to prenatal care, and to teach child care.

Matrone training and supervision will be funded in this program by Pathfinder, at a cost estimated at \$174,000 for three years. Development Associates will fund national level supervision of matrones at a cost estimated at \$13,600 for three years. UNFPA will buy the materials to refurbish matrone kits at a cost of about \$16,550 for three years.

Matrones are expected to recruit an average of 10 new family planning acceptors per year. Users attributed to matrones shown in Table 5 reflect only the rural 2/3 of matrone-recruited users and urban matrones acceptors are included in the fixed clinic user targets. By the end of 1980, matrones in rural areas are expected to enroll about forty thousand clients in a pattern of regular contraceptive use. The matrones will represent one of the most cost effective elements of the overall program mix.

#### g. Guerisseurs

Guerisseur is a generic term covering several types of traditional healers such as "charlatans" and "docteurs feuilles". Development Associates will fund a pilot project in 1978 to provide training to guerisseurs. Each different type healer will be instructed in how better to do the treatments he already does, (such as giving injections) but trained guerisseurs will not become formal elements of the DSFP health system

It is planned to form a training team (nurse, auxiliary, adult educator, driver), to create a training guide, to select 30 guerisseurs for a pilot program, to train them 1 day per week for 3 months, and to follow-up with supervisory visits of the training team. \$12,100 has been budgeted by DAI for this activity in 1978. If it is continued in 1979 and 1980 life-of-project total will be approximately \$36,000. This pilot project will focus on the possibilities of extending family planning service delivery through the guerisseurs, but no estimates can be made at this writing as to the contraceptive delivery implications of this activity.

### 3. SUPERVISION

Haiti has a strong tradition of requiring direct supervision and follow-up to ensure task accomplishment. There are two types of supervision not yet discussed in detail in this paper: supervision of district MCH/FP clinics by national supervisory teams, and supervision of dispensaries by district supervisory teams.

#### a. National Supervision of Districts

There are four basic types of supervisory visits in this category. The first consists of the visits made by national supervisory teams (4 central staff persons and 1 driver) to the fixed urban clinics. Two trips of six days per clinic per year are planned with the emphasis on effective implementation of the outreach and training functions of the clinical facilities, and on the timely resupply of contraceptives from the central warehouse to the field depots. Second, voluntary surgical contraception will be offered at the field clinics by a visiting team from Port-au-Prince

as a precursor to the establishment of permanent VSC capability in five of the district clinics.

Third, selective supervisory visits by a team of, 3 staff persons and a driver are scheduled for 15 clinics for 4 days each. These visits will be made on an ad hoc basic to clinics with particular problems which need to be addressed.

Fourth, two persons from each district center will travel to Port-au-Prince each month for consultation with Central Office Staff. The AID project will continue to support these efforts in national level supervision by providing per diem for these visits, four jeeps and a pick-up truck (for contraceptive delivery), and driver salaries, and by renovating the central contraceptive storage facility.

b. District Supervision of Dispensaries

There are ten health districts in Haiti, and the network of dispensaries and sanitary agents will rely heavily on the backstopping of the district health staffs for both professional and administrative support.

Each district supervisory team will be composed of two staff members and will have a driver from the district headquarters office. These team will spend approximately fifteen days per month visiting the dispensaries in their district to perform IUD insertions, to resupply the dispensaries with contraceptives, to examine patients who wish to start oral contraceptives, and to perform on-the-job training as necessary. The teams will also monitor the effectiveness of the dispensary and sanitary agent operation, and will perform central reporting functions.

AID will fund the per diem for these visits at the rate of six dollars per day. The project will also fund in-service training courses for these teams--two each in 1978 and 1979 and one in 1980.

These courses will be run on a seminar basis. The topics will be planned on an as-needed basis year by year.

AID will fund the operating expenses and maintenance of three field vehicles to facilitate this supervision (these were provided by AID under a previous project). Finally, the AID project will provide the medical supplies necessary to perform IUD insertions, examinations, and related clinical services in a field setting and will renovate each of the ten district contraceptive depots in 1979.

#### 4. INFORMATION, EDUCATION, AND COMMUNICATION

The information, education, and communication (IEC) activities of this program involve mass media communications, orientation and information seminars, public education by community agents, and family life courses for girls (15-25 years) old. Mass media communications include radio and television broadcasts and newspaper articles. Radio programs will continue to be broadcast nationwide. Recording studio equipment previously provided by AID will facilitate the development of new radio programs, in addition to the basic library of sixty programs which are already on tape. These programs are of 10-20 minutes duration, with 20 separate messages, five of which deal exclusively with family planning. Broadcasts will continue at the rate of 10 per week over each of eleven stations, and the weekly radio courses for students will continue.

Videotape equipment funded under the 1977 bilateral project will allow the development of programs for the Port-au-Prince audience and will enable policy makers to become more immediately aware of public desires for family planning services.

Newspaper and magazine articles on family planning and population matters will continue to be published, and educational materials for the national program will be developed by the Center for Family Hygiene.

Increasing numbers (20-25 per year) of orientation and information seminars will be held for groups such as community leaders, educators, and industrial leaders, as well as for physicians, nurses, auxiliary nutritionists and other staff elements of the contraceptive delivery system.

The network of approximately 170 community agents and supervisors will be provided with transportation under the AID project to facilitate their work in recruiting family planning clients. Motorbikes and bicycles will be procured, and budgetary support for the rental of horses will allow for greater access to mountainous areas.

Movie equipment will be given to each of the districts by the end of 1978. The projectors, screens and generators for six districts are being purchased under the 1977 AID MCH/FP project, and will arrive in late 1977. Four more sets will be purchased in 1978 as part of this new AID project at a cost of \$10,444.

AID will also fund salary and expenses for a movie projectionist in Port-au-Prince and expenses, but no salary, for 2 assistants for him and for 2 assistants for each of the 10 districts. In each district, a community agent will act as projectionist and lead discussions following film showings.

UNFPA will provide funding for one course in family life at each of the 22 fixed clinics.

There is a need for technical assistance in Haiti to help in the development of new communications messages and to evaluate efforts to date. It is anticipated that central Title X funds will be used to provide such assistance. For example FPIA, which funded development of the original messages, will begin

5. OTHER SERVICE DELIVERY OUTLETS

a. Voluntary Surgical Contraception (VSC)

Following discussions in 1976 and early 1977 between the Division of Family Hygiene, the Association for Voluntary Sterilization, and Family Planning International Assistance, a pilot VSC project was launched in late 1977 with FPIA funding. This project will provide services at the two principal maternity clinics in Port-au-Prince, the Hospital de l'Universite d'Etat d'Haiti and the Maternité Isaie Jeanty.

The VSC objective will be to perform 500 procedures in each facility during the first twelve months of the project, approximately 450 female and 50 male.

The FPIA project will also provide training in mini-laparotomy, laparoscopy, culdoscopy, and vasectomy techniques for four staff physicians, four third-year residents and six second year residents. Eight first-year residents and interns will also be exposed to these techniques during their month of rotation through the OB/GYN service, in preparation for complete training during their second-year residency.

Overseas training will be provided to two staff physicians at St. Louis under PIEGO auspices, to two other physicians for a two-week observation trip to Colombia, and to a maintenance technician for a two-week course at the equipment manufacturer in the U.S.

The trainees will join the four Haitian physicians who have already received overseas training in vasectomy and female sterili-

staff and resident physicians described above.

The FPIA VSC project will fund renovations of the 2 clinical facilities and will provide the equipment and supplies needed to deliver VSC services. The FPIA budget for this project, which will extend through October 1978, is \$28,709, plus centrally funded equipment and supplies.

Beginning in fall 1978, AID will assume support of VSC activities in order to extend the availability of services. Training of staff physicians and residents will continue at the rate of twenty-two per year in Port-au-Prince, and training will be extended to Cap-Haitien, Les Cayes, and other provincial centers to involve approximately four physicians and residents per year in each center. By the end of 1980, seven teams of twelve persons each will be actively involved in both performing VSC procedures and in acquiring hands-on experience in improving their techniques.

AID will provide salary supplements and training stipends to these teams at an annual rate of \$6,000 per 12-person team. Each team will consist of one chief of service, one teaching associate, two staff physicians, two third-year residents, three second-year residents one anaesthesiologist and two social workers. AID will also fund local and international travel for training and observation.

Material and equipment will be provided by AID to partially support the establishment of a clinic in Les Cayes during 1978 and to procure additional materials for the two facilities in Port-au-Prince. Two other clinics will be added during 1979, and two in 1980.

The number of procedures to be performed, as estimated by the DHF on the table of service expansion, is rather small. In the opinion of USAID/Haiti, the number of procedures will increase much more rapidly as availability is increased.

b. Operational Research in Household Distribution

This centrally-funded research activity, carried out with the support of Columbia University's Center for Population and Family Health, represents a pioneering effort in determining the feasibility of household distribution of contraceptives in Haiti.

Beginning in October 1977 the DHF began a pilot study in three rural areas to determine the effects of door-to-door delivery of contraceptives on acceptance rates. This is one of a number of Community Based Family Planning Distribution projects supported by AID.

The three areas in the study contain about 2,000 households each. Each area has about six villages, and will be serviced by six Sanitary agents, one per village. Each household will be contacted once every four months by a sanitary agent who will explain the advantages of using contraceptives, and how to use them. He (or she) will give a four-month's supply to anyone who expresses interest. He will also collect the information necessary for evaluation.

The sanitary agent will be a resident of the village in which he works. An attempt will be made to recruit the agents from among traditional health workers, that is, midwives or traditional medical practitioners.

In one of the areas (Fonds Parisien) a clinic has been in opera-

be highly significant.

In some villages in each area, the health workers will supply certain basic medicines, as well as contraceptives, and will be trained in the use of these medicines, as well as in certain basic health procedures.

Ideally, the study will make it possible to determine the combination of health services which is most effective in increasing the rate of acceptance of contraceptives.

It is not contemplated that door-to-door distribution will continue indefinitely. After the first year an attempt will be made to leave a community pharmacy in each village, which will continue to service the community after the initial door-to-door distribution has ceased.

The project will continue through 1980. . Funding through Columbia University will total \$175,257 during 1978-1980 including \$50,000 during 1979-1980 for a feasibility study of a commercial marketing activity.

The results of the household distribution research project will have great importance for further refinements in the design of the Division's approach to service delivery.

c. Condom Vending Machines

The Division of Family Hygiene will launch a program of condom vending machines during the fall of 1977, with support from the International Planned Parenthood Federation (IPPF), drawing on their experience with similar projects in the Caribbean and Central America. Present plans call for one-hundred fifty machines to be put in place by the end of 1978, which will be located in stores, theaters, gas stations, men's rooms and other appropriate places.

One hundred of these machines will be located in Port-au-Prince and fifty in other health districts. The condoms will be distributed through the Division at a cost to the proprietor of one cent each. Each condom will be sold for a 10 centime coin (equivalent to U.S. \$0.02), and the owner of the facility where the machine is located will retain one US cent for each condom sold. It is estimated that 1½ gross per month will be sold in each machine.

The budget for this activity is approximately \$15,500 for 1978 and \$7,500 for 1979. USAID/Haiti estimates that the budget for 1980 will be \$10,000; thus the total during this project will be approximately \$33,000.

d. Armed Forces

During 1977, the Division sponsored one seminar for leaders in the Haitian Armed Forces and another for the medical staff of the armed forces to explore the possibilities for using their organizational structure for condom distribution. The response has been favorable and the Division expects to be able to begin providing condoms during 1978, with a goal of enrolling at least eight thousand men in a regular program of condom use by the end of 1980.

The armed forces are the most extensive organization of the Haitian Government, which each small town having a Chef de Section who serves as the local representative of the civilian government as well.

To assist the armed forces in providing contraceptive services to their members, district health offices will hold five-day seminars for the approximately fifty chefs de section in their districts, in three groups of 16-17 each. Five districts will be covered in 1979, and the other five in 1980. These seminars will cost about \$650 each, supported by AID, and will cover the philosophy of the family planning program, and the contraceptive distribution system.

e. Commercial Sector

At this time, there is no organized commercial distribution activity as part of this program. Estimates of commercial contraceptive use are about 12,000 couples per year. Pills cost about \$2.50 and a package of three condoms costs 25-50 cents in retail pharmacies. No significant increase in usage is expected, barring a subsidized sales program. The possibilities for this will be investigated under the Columbia University research project described above.

f. Community Organizations, Coops, Men's Groups

Pilot projects with rural agricultural cooperatives sponsored by the Center of Family Hygiene, a non-governmental Haitian organization, have shown promising results in contraceptive use by distributing condoms directly and by using these groups to recruit female clients. The Division of Family Hygiene plans to build on this experience to enlist the assistance of similar organizations to distribute contraceptives.

Potential groups include community councils, coffee production co-ops, drivers associations, domestic economy centers sponsored by the Department of Agriculture, and similar groups.

AID funding will partially support these efforts through several of the information and orientation seminars to be held under the program of information, education, and communication. The cost of each seminar will be \$1,000 and from three to five seminars directed to these types of organizations may be held each year, depending on the opportunities that arise.

In addition to the seminars held for these groups, support in the amount of \$700<sup>per community</sup> will be provided to 150 community councils on a one time-basis to purchase materials for family planning promotion. Fifty of these will be supported by Pathfinder during 1978, and fifty each year by AID during 1979 and 1980.

To facilitate this work, the Division of Family Hygiene will pay stipends of \$50/month to 17 community development agents for promoting this approach to community-based distribution, and for coordinating their efforts with the DHF.

The prevalence of contraceptive use attributed to such groups is projected at quite low levels in Table 5, but the Division of Family Hygiene feels that these groups may become more effective than current projections indicate as more experience is gained with these groups.

g. Action Familiale (Sympto/Thermal Method)

The Division of Family Hygiene has enlisted the assistance during the past three years of a local non-sectarian organization called Action Familiale d'Haiti, an affiliate of the International Federation of Family Life Promotion. Action Familiale currently provides family planning information and instruction in the sympto/thermal method in five regions of Haiti. The approach is to increase the awareness among couples of the possibility for family planning and to increase their knowledge of the various methodologies available. If desired, Action Familiale offers instruction and follow-up in the sympto/thermal method. Enrollees are followed closely over a nine-month period of gradually decreasing supervision to encourage thorough understanding of the method. There are presently about 1000 couples involved in the program under the supervision of 97 volunteer educators in twenty-one communities, and an additional 22 educators are now undergoing training in the methodology. If the couple is interested in other methods, Action Familiale refers them to the nearest DSPP outlet with family planning services.

The project has an important impact in its influence on people's awareness of the existence of more effective family planning services. It also plays a valuable role by maintaining close relationships with organized religious groups of all denominations in Haiti and by increasing support for family planning activities among influential political groups in Haiti.

UNFPA is funding this activity at a level of \$24,000 for 1978. There are no AID bilateral funding implications associated with this activity.

#### h. Other Private Programs

Several charitable organizations support MCH/FP activities in Haiti. Some receive subsidies from the Haitian Government, and the majority are given technical assistance (e.g. training) or materials (e.g. vaccines) by the DHF. The following agencies are providing services in collaboration with the DHF:

- Dispensaire - Hopital de Fermathe
- Hopital Albert Schweitzer
- Hopital Grande Riviere du Nord
- Haitian American Community Help Organization (HACHO)
- Dispensaire Hopital de la Gonave
- Dispensaire Lumière, at les Cayes
- Centre Regional de Gebeau, in Jeremie
- Centre de Diquini
- Service de Santé Forces Armées d'Haiti

The Division of Family Hygiene will continue to examine all possibilities for continued extension of family planning services through appropriate private and voluntary organizations.

#### 6. Relationship to other AID Health Projects

dc / A new AID health project (Strengthening Health Services II- Project #521-0086) will pick up funding for three fixed clinics previously financed under Title X. Pharmaceuticals for these clinics, other than contraceptives will be funded by the health project. In addition, AID has proposed a new project- Rural Health Delivery Systems (521-0091) to begin in 1979. The sanitary agent will be the lowest level worker in this system, and family planning will be an important element of his/her duties.

*not listed in Mark's list*

The leading role of the DHF in developing a health services delivery model for Haiti, which will be adopted by the entire DSPP, has built in a strong bias for family planning and community focus to the health care system for Haiti. The fact that the former deputy director of the DHF is now in charge of the DSPP planning unit will reinforce this bias towards FP in the emerging national health services.

The FPIA/AID VSC project will have a side effect of getting the medical school and the Port-au-Prince medical community involved in family planning, and will provide physicians with exposure to the philosophy of the program.

The relationship of this program to AID's Nutrition Improvement project (521-0075) has been discussed above with particular reference to the provision of FP services at child nutrition centers.

#### 7. Other GOH Involvement in Family Planning

The Department of Public Health and Population is planning to issue a circular to encourage compliance with existing norms which call for provision of family planning services at all government health facilities.

The Department of Social Affairs has approved a plan for the DHF to work with them in presenting family planning information in their training seminars and the Department of Agriculture has continued to call on DHF for a family planning presentation in each seminar they give for rural teachers under their National Office for Literacy and Community Action.

### 8. Centrally-Funded Title X Monies

Several components of this program described are centrally funded by Title X Monies. These include Matrone training and supervision by DAI and Pathfinder, Voluntary Surgical Contraception by FPIA, the household distribution project by Columbia University, and condom vending machines through IPPF. The project concerning population policy development which will be done in Haiti is also Title X funded at the central level through the Battelle Center. Both the World Fertility Study in Haiti and the household distribution project will provide information about knowledge, attitudes and practices concerning family planning in Haiti. The DHF has expressed interest in having its radio broadcast program evaluated, which could possibly be done with central Title X funds.

### III. PROGRAM ANALYSIS

#### A. TECHNICAL ANALYSIS

The technology used to reduce fertility in this program is the most direct and effective currently known: the availability and provision of modern contraception, both temporary and permanent. The particular contraceptives chosen, and the mix expected to result from free choice, modified by availability and normal medical precautions, will be appropriate to the Haitian population at this time.

Recognizing that there are not enough physicians and nurses to institute a nationwide network of fixed clinics, nor enough fiscal or human resources available to train personnel and establish such a system, the DHF has devised a system using appropriately trained community-level workers and local dispensaries to deal with the urgent problems facing Haiti in MCH and FP. The delivery system chosen takes advantage of the fixed clinics currently in place as both a point of origin for travelling clinic teams (for satellite clinics) and as the secondary referral point (after dispensaries) for sanitary agents and matrones working in rural communities.

Supervision at all levels of service sites and personnel has been designed into the program. As explained above, this is vital to the success of any such program in Haiti.

The mix of sources of contraception for users breaks down roughly as follows:

TABLE 6

Contraceptive users (000's) by Source of Contraceptive Delivery, 1978, 1979 and 1980, Haiti

Source/Year	1978		1979		1980	
	#	%	#	%	#	%
Fixed clinics & satellite clinics	62.5	43.7%	73.5	38.2%	85.5	36.2%
Mobile units	2	1.4	4	2.1	6	2.5
Dispensaries	34	23.8	54	28.1	68	28.8
Community <sup>1/</sup>	22.5	15.7	34	17.7	46	19.5
Household Dist. Research Proj.	2	1.4	2	1.0	2	0.8
Armed Forces	4	2.8	6	3.1	8	3.4
Commercial Sector	13	9.1	14	7.3	14	5.9
Sympto/Thermal Method	3	2.1	5	2.6	7	3.0
Total	143	100%	192.5	100%	236.5	100%

<sup>1/</sup> Matrones, condom machines, and community organizations

The DHF estimates that by 1980, about 75% of contracepting couples will use condoms. In fact, 75% of acceptors in the first six months of 1977 choose condoms as their preferred method. A literature search on this topic showed two developing countries with high proportion of condom users among acceptors. These were Jamaica, where condoms were the most popular contraceptive, chosen by 41% of users/1967 - 1972 <sup>during</sup> (Population Reports, H1 p.H-4), and India, where condom users represented 21% of all acceptors in 1968-69, 37% in 1969-70, 52% in 1970-71, and 43% in 1971-72. Condoms were the only method showing substantial growth in numbers of users in the 1973-1974 period in India. (Studies in Family Planning, Vol 6, # 8, p. 253). In all years no other temporary contraceptive had more users than condoms. (Studies in Family Planning, Vol 4, # 7, p. 186).

In Jamaica, a strong educational campaign stressing male responsibility is credited with the popularity of condoms. It is the Haitian male's wish to take responsibility that has frequently been mentioned by the DHF in explaining the expected high use rates for condoms.

Condom use is thought to be the precursor of use of more effective methods of contraception, such as oral contraceptives or sterilization, in Haiti. It is also felt that the sympto/thermal method taught by Action Familiale d'Haiti, while not as effective as other methods, serves to introduce people to the concept of family planning, and to inform them regarding alternate contraceptive methods and sources of such methods.

The high proportion of condom users does present one technical problem, however, in that Haiti will not fall within the AID/W guideline of one year's supply in country for condoms. The contraceptive deliveries and use analysis

presented with the budget of this paper shows that for all three years of this program, only about a half year's supply will be in the warehouses at any one time. USAID does not feel, however, that any logistical problems will be caused by this situation and we are confident that AID/W will be able to respond favorably to additional requests for condoms should the need arise.

The design of the family planning program for the next three years is technically sound and well attuned to the present situation in Haiti. The general state of the economy in Haiti and the limited GOH budgetary resources require that virtually every input come from external funds.

External funds in the program cover many basic items which the government would finance in a more developed country. These include salary support, operating expenses, and maintenance costs. The AID-funded project which is part of this program funds a smaller proportion of such costs than the UNFPA project primarily because AID is focusing on the portions of the program oriented towards rural community delivery systems.

There does not appear to be any part of this program which will lead to further degradation of the environment. Hopefully, this program will help to prevent further environmental stress due to population pressures and the scarcity of arable land.

This project is in compliance with Section 611 (a) and (b) of the Foreign Assistance Act.

#### B. FINANCIAL PLAN/BUDGET TABLES

There are four main sources of financial data concerning this program: First, the budgets of the various donors and the GOH. The AID detailed budget follows, and summary budgets for the other contributing organizations are contained in

in Annex B. Second, the Logframe, which lists inputs from all the donors in some detail (Annex A). Third, the Costing of Project<sup>1</sup> Outputs/Inputs Table which appears as Annex D. Fourth, the Summary Cost Estimate and Financial Plan Table, Annex C, where inputs are broken down into somewhat more traditional categories by donor agency.

The cost estimates for CY 1978 are relatively exact. For 1979 and 1980, there is progressive flexibility due to uncertainties concerning costs.

Those budget totals for other donors which have been estimated from current budgets and knowledge of future activities are marked with an asterix.

The detailed AID Bilateral Budget, and the AID Funding Summary follow below.

AID FUNDING SUMMARY (\$000's)

	1978	1979	1980	TOTAL
Orals	\$ 123	\$ 240	\$ 260	\$ 623
Condoms	372	485	620	1,477
Bilateral	480	675	620	1,775
Total	\$ 975	\$1,400	\$1,500	\$ 3,875

CONTRACEPTIVE DELIVERIES AND USEORALS (000's of cycles)

	CY 1978	CY 1979	CY 1980
Beginning of year stock	286	1,034	989
Deliveries	1,333	586	1,043
Use	585	631	663
End of Year stock	1,034	989	1,369

CONDOMS (000's of pieces)

	CY 1978	CY 1979	CY 1980
Beginning of year stock	5,578	8,843	10,266
Deliveries	13,065	15,873	18,600
Use	9,800	14,450	18,550
End of Year stock	8,843	10,266	10,316

PRICES USED FOR CONTRACEPTIVES

	78	79	80
ORALS (Cycle)	.21	.23	.25
CONDOMS (gross)	4.10	4.40	4.80

BILATERAL BUDGET

## SUMMARY

	<u>1978</u>	:	<u>1979</u>	:	<u>1980</u>	:	<u>TOTAL</u>
Sanitary Agent Development	\$ 87,908	:	\$ 91,108	:	\$ 60,104	:	\$ 239,120
Auxiliary-nurse and dispensary development	174,935	:	258,260	:	249,018	:	682,213
Voluntary Surgical Contraception	26,300	:	86,500	:	103,900	:	216,700
National Supervision & Support	70,158	:	56,818	:	40,360	:	167,336
Mobile Units	25,760	:	52,160	:	43,580	:	121,500
Information & Education	79,279	:	119,135	:	106,235	:	304,649
SUB-TOTAL BUDGET	\$ 464,340	:	\$ 663,981	:	\$ 603,197	:	\$ 1,731,518
Contingency & Other	(2.4%) 15,660	:	(1.6%) 11,019	:	(2.7%) 16,803	:	(2.4%) 43,482
GRAND TOTAL	\$ 480,000	:	\$ 675,000	:	\$ 620,000	:	\$ 1,775,000

SANITARY AGENT DEVELOPMENT

A. <u>Training Team Salaries</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
1 nurse (\$200/mo x 12 mos)			
2 auxiliaries (\$100/mo x 12 mos)			
1 educator (\$150/mo x 12 mos)			
1 driver (\$108/mo x 13 mos*)			
1. 2 teams in 1978 - 1979 and 1 team in 1980	\$ 16,008	\$ 16,008	\$ 8,004
2. Training Courses for Trainors	3,000	3,000	2,000
3. Stipends for each course (\$300/course)	2,100	2,100	1,200
7 courses in 1978, 7 courses in 1979 and 4 in 1980			

Driver salary is actual salary, and must, by Haitian law, be paid for 13 mos. Others are salary supplements, and are paid for only 12 mos.

	<u>1978</u>	<u>1979</u>	<u>1980</u>
4. Per diem during field training (\$6 per day x 10 days per month x 5 persons x 12 mos x # teams)	7,200	7,200	3,600

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Sub-Total Training Teams	\$ 28,308	\$ 28,308	\$ 14,804
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#### B. Sanitary Agent Trainees

200 trainees during 1978  
200 during 1979 and 140 during 1980

1) Transportation for sanitary agents, \$7 per trainee	\$ 1,400	\$ 1,400	\$ 980
2) In-service training courses at \$2,000 per course, 2 in 1979 and 2 in 1980	----	4,000	4,000
3) Per diem for trainees during courses (\$3 per day for 92 days)	55,200	55,200	38,640
4) Case for each trainee, \$10 per case (10% inflation)	2,000	2,200	1,680
5) Rehabilitation of trainees dorm	1,000		

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Sub-Total Trainees	59,600	62,800	45,300
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SANITARY AGENT DEVEL. TOTAL	\$ 87,908	\$ 91,108	\$ 60,104
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#### C. AUXILIARY NURSE AND DISPENSARY DEVELOPMENT

##### A. Auxiliary Nurse Development

95 auxiliaries by end of 1978,  
140 by end of 1979,  
170 by end of 1980.

1) Salary supplement (\$30 per month/auxiliary)	\$ 34,200	\$50,400	\$ 61,200
2) Training Courses for Auxiliary nurses (2 courses in 1978, 3 courses in 1979 and 4 courses in 1980)	4,000	6,000	8,000

	<u>1978</u>	<u>1979</u>	<u>1980</u>
3) Kits for Auxiliary nurses (100 kits in 1978, at \$10 60 in 1979 at \$11, 50 at \$12 in 1980--10% inflation)	1,000	660	600
Sub-Total Auxiliary Nurse Devel.	\$ 39,200	\$ 57,060	\$ 69,800

#### B. Dispensary Development

95 dispensaries during 1978  
140 during 1979 and  
170 during 1980

1) Renovation of selected dispensaries \$1,000 per dispensary in need of renovation	\$ 45,000	\$ 50,000	\$ 23,000
2) Operation and Maintenance of Dispensaries Expendable material, including alcohol, soap, aspirin, antiseptic, etc., and repair and upkeep of facilities at \$511 in 1978, + 10% = \$562 in 1979, + 10% = \$618 in 1980.	48,545	78,680	105,060
Sub-Total Dispensary Devel.	\$93,545	\$ 128,680	\$ 128,060

#### C. District Supervision and Support

1 team (3 persons) in each of 10  
districts travelling 15 days per  
month. Per diem at \$6 per day

1) Per diem 3 x 15 x \$6 x 12 x 10	\$ 32,400	\$ 32,400	\$ 32,400
2) In-service training for District Team Members (2 courses in 1978, two in 1979 and one in 1980)	4,000	4,000	2,000
3) Seminars for Chefs de Section 3 seminars/district x 5 districts x \$650/seminar 1979 and 1980	---	9,750	9,750
4) Vehicle operation & Maintenance (3 district vehicles at \$1,600 per year plus 10% inflation)	\$ 4,600	\$ 5,280	\$ 5,808

	<u>1978</u>	<u>1979</u>	<u>1980</u>
5) Supplies for IUD insertion examinations, referrals, and clinical support (\$99 in 1978 10% inflation each year) x 10 dist. 990		1,096	1,200
6) Renovation for 10 district: contraceptive depots @\$2,000 = \$20,000 (1978)		20,000	
Sub-Total District Supervision	\$ 42,190	\$ 72,520	\$ 51,158
<hr/>			
AUX. NURSE & DISPENSARY DEV. TOTAL	\$174,935	\$258,260	\$249,018

## II. VOLUNTARY SURGICAL CONTRACEPTION

3 teams in 1978 (for 6 months)  
5 in 1979 and 7 in 1980

A. <u>Salary Supplements</u> \$6,000 per team per year	\$ 9,000	\$ 30,000	\$ 42,000
B. <u>Travel</u> (local and international) per diem at \$100/mo/team	1,800	6,000	8,400
C. <u>Equipment and Supplies</u> at \$15,000 per clinic (1978, part of les Cayes and P-au-P, 2 clinics in 1979 and in 1980)	10,000	30,000	30,000
D. <u>Renovation of Clinical Facilities</u>	2,000	12,000	12,000
E. <u>Operation and Maintenance of VSC clinics</u>	2,000	5,000	7,000
F. <u>Central Support and Administrative Costs for establishing new clinics</u>	1,500	3,500	4,500
<hr/>			
LUNYARY SURGICAL CONTRACEP. TOTAL	\$ 26,300	\$ 86,500	\$ 103,900

<u>NATIONAL SUPERVISION &amp; SUPPORT</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
<u>A. Supervision Visits</u>			
1) Central office/district supervision 20 trips x 6 days x \$14/day x 4 professionals;	\$ 6,720	\$ 6,720	\$ 6,720
20 trips x 6 days x \$9/day x 1 driver	1,080	1,080	1,080
2) Selective Supervisory visits 15 trips x 4 days x \$14/day x 3 professionals;	2,520	2,520	2,520
15 trips x 4 days x \$9/day x 1 driver	540	540	540
3) District personnel visits at central office			
1 trip x 3 days x \$14/day x 2 professionals x 12 months x 10 districts	10,080	10,080	10,080
1 trip x 3 days x \$9/day x 1 driver x 12 months x 10 districts	3,240	3,240	3,240
4) Driver Salaries			
2 drivers in 1978 and 1979 (one for central office, 1 for district post)	2,678	2,938	6,500
4 drivers in 1980--above plus 2 for ODVA			
\$103 x 13 mos x 2 - 1978			
\$113 x 13 mos x 2 - 1979			
\$125 x 13 mos x 4 - 1980			
(assume 10% increase each year)			
Sub-Total Supervision Visits	\$ 26,858	\$ 27,118	\$30,680
<u>B. Vehicles</u>			
1 pick-up for central warehouse (\$9,500) and 2 Jeeps (Cherokee) for district posts (\$9,500)	28,500		
2 Jeeps for ODVA (1978)(10% inflation)		20,900	
<u>C. POL &amp; Maintenance of vehicle</u>			
@ 1,600 plus 10% inflation	4,800	8,800	9,680
<u>D. Central Contraceptive Warehouse</u>			
<u>Renovation</u>	10,000		
<u>NATIONAL SUPERVISION &amp; SUPPORT TOTAL</u>	<u>\$70,158</u>	<u>\$ 56,818</u>	<u>\$ 40,360</u>

<u>MOBILE UNITS</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
Mobile Unit equipped for Port-au-Prince at \$15,000 in 1978	\$ 15,000		
2 units in 1979 for Cap-Haitien, Cayes @\$15,000		\$30,000	
1 unit in 1980 for Gonaives..			\$ 15,000
<u>Personnel Costs</u>			
1978-2 teams, 1979-4 teams, 1980-5 teams	7,560	15,120	18,900
Team: 2 nurses @\$75 2 aux. @\$50 250 x 12 = \$3,000			
1 driver @\$60 x 13 = . 780 \$3,780			
<u>POL &amp; Maintenance</u> @ \$1600 per vehicle plus 10% inflation	3,200	7,040	9,680
<b>MOBILE UNITS TOTAL</b>	<b>\$ 25,760</b>	<b>\$ 52,160</b>	<b>\$ 43,580</b>

INFORMATION, EDUCATION & COMMUNICATIONS

<u>Radio and T.V. Programs</u>	\$ 12,000	\$ 15,000	\$10,000
<u>Seminars</u> (20, 1978--25, 1979 20, 1980)	20,000	25,000.	20,000
<u>Press</u>	12,000	15,000	12,000
<u>Material Production</u>	8,000	10,000	10,000
<u>Community Agents Transportation</u>			
1) Bicycles or horse rental	4,500		
2) Motorbikes (8)	4,000		
3) Operation & Maintenance	300	900	1,000

	<u>1978</u>	<u>1979</u>	<u>1980</u>
<b>F. <u>Community Organizations</u></b>			
1) Materials for FP promotion \$700/organization x 50 organi- zations in 1979 and 1980	---	\$ 35,000	\$ 35,000
2) Stipends for rural development workers to work with community organizations 17 workers x \$50/month x 12	---	10,200	10,200
<b>G. <u>Movie Equipment &amp; Personnel</u></b>			
1) Projectors, with case for 4 districts--\$1,111 each	\$ 4,444	---	---
2) Movie screens @\$688 x 4 dist.	2,752	---	---
3) Portable electric generators @ \$812 x 4 districts	3,248	---	---
4) Port-au-Prince 1 operator, salary \$175 x 13 = \$2,275 and stipend \$40 x 12 = \$480	2,755	2,755	2,755
2 assts. x \$20 stipend/mo x 12	480	480	480
5) Districts 2 assts. x \$20 stipend/mo x 12	4,800	4,800	4,800
<b>INFORMATION, EDUCATION &amp; COM. TOTAL</b>	<b>\$ 79,279</b>	<b>\$119,135</b>	<b>\$106,235</b>

## C. SOCIAL ANALYSIS

### 1. Intended Beneficiaries

The intended beneficiaries of this program are the urban and rural poor of Haiti. High fertility and poor health are characteristics of this target group. Through the use of local organizations (e.g., community councils), traditional health workers (e.g., midwives), and outreach workers (e.g., community agents), this project will reach the poor, including the poorest of the poor.

### 2. Types of Benefits

There will be two major types of social benefits. First, the immediate benefits of improved health, including reduced infant mortality, which will flow from program activities. Second, the immediate and long-term social benefits which will flow from the family planning activities.

Health benefits will be reflected in several ways: first, the preservation of many lives which are needlessly lost through diseases such as neonatal tetanus. Second, a reduction in physical suffering. Third, an increase in physical energy which will directly increase human happiness, permit breadwinners to be more productive, and increase the ability of children to benefit from schooling.

Social benefits stemming from family planning activities are important at the national level, but can be pictured most clearly at the family level. The typical rural Haitian family is caught in a vicious circle of small land holdings and a low income which does not provide a basis for an adequate diet or schooling for its children. (Less than 3% of rural children are able to finish six grades of education.) Without an education, these children are forced to become farmers. With many children subdividing the parents' land, each child has less land than held by his parent and the vicious circle continues.

For a couple which successfully practices family planning, there will be a number of social benefits. With fewer mouths to feed, the parents will be in a better position to adequately support their children. Parents will be able to afford to send their children to school both because they can dispense with the full-time services of their children and because they can pay either private tuition or fees related to public education. (Nearly 40% of the schools in Haiti are private. Children going to public schools must still pay for the custodial costs of the school and must wear the prescribed school uniform.) Parents will also have more time to spend with each other and with their children. As a family breaks out of the trap of the economics of survival, it will have more time to participate in community affairs and to become integrated into the larger national community. In short, a family which successfully participates in the family planning program should be able to achieve the social goals which AID has established for its programs.

### 3. Women in Development

The role of women in the program has been considered and the training or retraining of women to carry out essential tasks both in institutions and in the villages is included in the health planning for the national health system as a whole, and specifically to carry out the delivery of MCH/FP services.

The program will make three major contributions to the status of women:

- a. Health status will be improved through better timing and spacing of pregnancies;
- b. Economic status will be improved by allowing more time for greater participation in the labor force;
- c. The program itself will employ women at many levels, including administrators, doctors, supervisors, nurses, social workers, nurse auxiliaries, sanitary agents, and the traditional midwives or "matrones". The last three categories are the backbone of the delivery system in rural areas.

In addition, the program offers women the prospect of a greater role in determining their reproductive destiny. The medical, psychological, nutritional and economic benefits of timing and spacing of births are well known. Suffice it to say that Haiti's high levels of infant mortality and morbidity, malnutrition, maternal mortality and morbidity and overall family poverty can be attributed in large measure to the burden of excess fertility which Haitian women now bear and which this project will seek to lighten.

### 4. Possible Impediments

No particular public opposition to family planning has manifested itself in Haiti to date. The involvement of Action Familiale, an organization promoting the concept of family planning<sup>and</sup> the sympto-thermal method, in this program is thought by the DHF to blunt possible criticism and opposition by the Roman Catholic Church.

Since almost every Haitian family is a member of the target group, diversion of the benefits of this program to unintended beneficiaries is unlikely.

D. ECONOMIC ANALYSIS

The economic impact of this project can be assessed in three ways. First, is it, or will it point the way toward, the most cost effective way to attract acceptors of family planning? Second, will the micro-demographic effect (family size) have a substantial impact on family economic well being? Thirdly, will the expected national demographic effect be positive in terms of national income, balance of payments, per capita productivity, efficient use of budget resources, more equitable access to income opportunity and to public services, and finally in terms of overall economic welfare of the nation. This project will almost certainly give us an answer to the first question. It should give us a start at the micro-economic level of the family in terms of direct family economic benefits. It will only give indications as to macro-economic impact.

1. Cost Effectiveness

This project calls for the introduction or extension of use of various contraceptive methods through various outlets. The outlets involved in the program have been selected to provide the broadest possible coverage. The contraceptive methods have been selected on a combination of acceptability, as known to date, and potential effectiveness. We have some a priori ideas as to cost effectiveness: for example, the matrone may well prove extremely cost effective in terms of contraceptive use maintenance, providing both supply and motivation, but may prove less cost effective in gaining new acceptors. A voluntary surgical sterilization program seems very cost effective over time in its demographic impact, with no maintenance problem, no backsliders in that all acceptors are users, but capital investment costs, training costs, and the problem of full acceptability may reduce cost effectiveness beyond what makes sense. <sup>we</sup> have reason to believe that mobile clinics can

gain more acceptors, more cheaply in the short run, than stationary clinics; we don't have longer run data, and the mobile clinic may be a most inefficient way to reach larger numbers of permanent users.

The project, and especially its evaluation aspect, is designed to provide us with this cost effectiveness data. We will know the cost per outlet, the number of acceptors per outlet, i.e. the first cut at cost effectiveness. We will have data on number of continuing contacts with each outlet; we will have more data on infant and maternal mortality. It is highly unlikely that we will have data indicating that any method of contraception should be totally abandoned or any means of dissemination closed down, but we will have a clearer idea of the budget mix. As it is, the budget mix of this program is the best we have been able to develop in terms of covering a diversified group of family planning interventions, at acceptable cost and within the limits of present experience in family planning programs.

## 2. Family Economics

Over the short run, let's say one generation, the real income of a Haitian poor rural family can be expected to grow very little. Over the last two generations it has probably declined. It is obvious that the larger the family the poorer each member will be. One evidence of this is a harsh fact of life at or toward the bottom of the income scale. Many poor rural families stay about the same size on the same plot of land. An addition to the family means someone leaves: an older child drifts away, the father sometimes leaves, the newborn infant is allowed to sicken and die or the just-weaned elder sibling starves. From general observation, but little statistical data, the "critical mass" for

the poor family seems to be about five to six persons. This observed phenomenon should lay to rest the economic myth that children are an asset and "contribute to family income by carrying water or chasing goats." It is interesting to note that the highest number of acceptors expected under this project should be couples in the most fertile age cohort with from one to four children. Each accepting couple is clearly looking for an economic benefit, whether it is in terms of food, clothing, shelter, or in the better things of life such as literacy for their children.

### 3. Macro Economics of Family Planning

National production is obviously a function of population, resources, and technology. We can write this as a formula:  $K=F(\text{POP}, \text{RES}, \text{TECH})$  and we can make certain qualifications and assumptions. For example, we should

substitute active population for population if, over the period we are considering, the dependency ratio is expected to change. Similarly if we know that POP and RES are constant, we also know that only a change in Tech will change K (income). We also know that a decrease in RES may <sup>have</sup> a negative effect on Tech by reducing the number of ways in which RES can be used, i.e. both factors change. If RES and Tech grow more slowly than POP then income per person declines. This little formula shows us one harsh aspect of the development picture. If we substitute active population for population, and the dependency ratio is growing rapidly, i.e. lots of children, even if technology improves and the resources base widens the income available per person can decline, remain constant or grow very slowly at best. That is Haiti's situation today.

Haiti's population growth can be expected to have some or all of the following effects.

- a) Per capita income will grow slowly if at all; the additional income will be increasingly mal-distributed
- b) The Government tax base will slowly erode ; essential services in health, education will not be available
- c) Export earnings will be even less able to meet the import food bill
- d) Saving for investment in plant, equipment (new technology) will not be available.
- e) The land resource will be increasingly destroyed and less productive.
- f) The dependent population, young, aged, under and unemployed will grow.
- g) Pressures to emigrate will be strong
- h) Foreign assistance donors will turn increasingly to welfare, humanitarian and palliative programs; development will be slighted.
- i) Haiti will get poorer and poorer.

How much impact, given the present demographic situation, this sort of program can have on the short term population level is questionable. However, an early impact on the rate of population growth, with its positive long range impact is clearly both possible, economically feasible, and economically most desirable.

## E. INSTITUTIONAL ANALYSIS

The Government of Haiti has recently increased its budgetary allocation for the Department of Public Health and Population by a substantial amount, and has made strong commitments for increased future allocations to this sector.

Although routine operating budgetary allocations for the DSPP have not increased dramatically over the past several years, the proportion of those allocations specifically earmarked as contribution to AID-funded public health and population projects have increased much more substantially,

	(\$000)		
	GOH FY 76	GOH FY 77	GOH FY 78
Regular Budget	\$ 6,350	\$ 6,350	\$ 7,514
Earmarked for AID Projects	504	654	854
Total Operating Budget <sup>1/</sup>	\$ 6,134	\$ 7,004	\$ 8,368

The funds shown above earmarked for AID public health and population projects do not include attributions of regular GOH operational costs associated with these projects, but are direct cash contributions for discrete project elements. Moreover, the proportion of GOH budgetary resources allocated to the DSPP is 15% of regular operating allocations to all ministries, and 11% of the total operating budget (if one includes debt servicing and GOH counterpart contributions to other projects of International Financial Institutions). The GOH allocation to the DSPP thus compares very favorably to the budgetary proportions which other LDC governments dedicate to health and population activities.

More importantly, the GOH has recently signed an agreement with AID to contribute \$5.6 million in cash over a five year period (FY 1977-81) as part of a related AID project - Strengthening Health Services II (521-0086) - the total cost of which is \$13.125 million. This contribution of 43% is a rather remarkable expression of the GOH commitment to the development of public health and population services in Haiti. Similarly, AID and the GOH are in the process of developing a corollary project (Rural Health Delivery System (521-0091) which may involve a GOH cash contribution of an additional \$3.4 million during the period FY 1978-82, with a total project cost of approximately \$12 million.

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<sup>1/</sup> Source: Budget de Fonctionnement and AID Program documents

In addition, the GOH is providing a counterpart contribution of approximately \$1 million to a \$6.3 million loan from the Inter-American Development Bank for the development of health and family planning services in two geographic regions in Haiti.

Viewed in the context of the overall health and population sector, these contributions are, in the view of USAID/Haiti, rather substantial.

Discrete cash contributions to the Division of Family Hygiene are of a much smaller order of magnitude, although the percentage increase has been satisfactory. From a \$12,000 annual cash allocation in GOH FY 1976, the DSPP quadrupled its cash allotment to \$50,000 during 1977, and USAID/Haiti is anticipating annual cash contributions to increase to at least \$100,000 by 1980. The fundamental approach of USAID/Haiti in this matter is to encourage the provision of family planning services throughout the entire health infrastructure as one of its most important aspects. The DHF, far overshadows the other divisions of the DSPP in terms of its service delivery network, and it has taken the leading role in developing a model of service delivery with heavy emphasis on family planning. This model will most likely be adopted for the emerging national health service, and the adoption of the DHF norms will build in a strong bias toward family planning throughout the entire health structure.

Because of USAID/Haiti's desires to encourage the widest possible extension of family planning services, our approach has been to focus on GOH contributions at the Departmental level, rather than at the Divisional level, and to encourage vigorous family planning programs in the widest possible context.

#### Recipient Institution

The recipient of this AID grant will be the Division of Family Hygiene (DHF) of the Department of Public Health and Population (DSPP). This Division has jurisdictional responsibility for all family planning activities in Haiti, and has been the exclusive recipient of all previous AID Title X funding.

The management capability of the DHF benefits from the excellent leadership of its Director, Dr. Ary Bordes, and from the organizational structure which has been built up over the past four years. The level of professional preparation found among the DHF staff is high. The national director and the majority of district directors have MPH degrees. Most of the top staff have also attended non-academic courses abroad in family planning program management. During 1976-77, for example, six physician-administrators received MPH degrees, three administrators attended two-month courses in FP management, 15 nursing supervisors attended MCH/FP training courses (mostly at Downstate Medical Center in New York), and additional DHF personnel attended short-term training courses in IEC and related fields.

The organizational structure of the Division of Family Hygiene consists of the following sections:

- Technical Services
- Statistics, Evaluation and Research
- Education and Training
- Supervision
- Administration

At the end of 1977, the Division employed 540 people, of whom 63 were at the central office in Port-au-Prince, and 477 in the ten district centers. The list below illustrates the present personnel structure:

TABLE 7

	<u>Central Office</u>	<u>District</u>	<u>Total</u>
Physician/Administrators	8	55	63
Nurses	3	34	37
Auxiliary Nurses	1	93	94
Statisticians & Record Clerks	5	37	42
Educators, research assistants	7	1	8
Administrators	2	1	3
Accountants	2	--	2
Secretaries & Typists	11	4	15
Administrative Assistants	--	24	24
Drivers	7	14	21
Other support personnel	17	44	61
Community Agents	--	140	140
Supervisors of Agents	--	<u>30</u>	<u>30</u>
Total	63	477	540

These personnel figures do not include matrones or sanitary agents who receive no regular salary increments from the DHF.

The regular supervisory visits by both central and district staff members are a key aspect of the ability of the DHF to manage programs effectively. Program administration is a regular topic of the in-service seminars provided to staff personnel. The DHF publishes quarterly, semi-annual, and annual evaluation reports which make explicit performance comparisons among service delivery units and which address specific shortcomings as a management tool for upgrading program effectiveness.

A. RECIPIENT AND USAID ADMINISTRATIVE ARRANGEMENTS

The AID project will be implemented by the DSPP through DHF, which will also administer the external resources provided by UNFPA, Pathfinder, FPIA, DAI, Columbia University, IPPF, and other donors. AID project monitoring will continue to be the specific responsibility of the USAID/Haiti Population Officer, reporting to the USAID/Haiti Public Health Officer. Bilateral project agreements will be signed by the USAID Director and the GOH Secretaries of State for Public Health and Population, Finance, and other officials as appropriate.

The Department of Public Health and Population, including the DHF, will be responsible for all procurement under the project, except as USAID may be requested to assist in expediting certain orders. Major renovation activities funded by this project will require prior approvals by the USAID/Haiti Office of Engineering. Where renovation or rehabilitation is sufficiently sophisticated to require the services of a local contractor (as opposed to local labor), local engineering services will be included as part of the cost of the renovation or rehabilitation work to insure the work complies with acceptable standards.

## B. CONDITIONS PRECEDENT

### 1. Conditions Precedent to Initial Disbursement

Unless AID otherwise agrees in writing, prior to the first disbursement under the Grant, or to the issuance by AID of documentation pursuant to which disbursement will be made, Grantee will furnish in form and substance satisfactory to AID:

#### a) Legal Opinion

An opinion of Counsel that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee; and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all its terms; and

#### b) Authorized Representatives

The name(s) of the person(s) holding or acting in the office(s) as authorized representative(s) of the Grantee together with specimen signature(s) of such authorized representative(s) and a statement of the nature and extent of his (their) authority for purposes of this project.

### 2. Conditions Precedent to Subsequent Disbursement

Unless AID otherwise agrees in writing, prior to subsequent disbursement for the following specific activities, Grantee will furnish in form and substance satisfactory to AID an implementation plan showing the time-phased strategy for carrying out the various sub-activities under the project. This plan should show all inter-relationships between sub-activities where appropriate.

### 3. Conditions Precedent to Disbursement for Training

Prior to disbursement for training, a plan should be submitted in form and substance satisfactory to AID outlining the formal and non-formal instructions to be offered; numbers of people to be trained by category (such as sanitary agent) and course manuals to be used by instructors for each type of course offered.

### 4. Conditions Precedent to Disbursement for Renovation

Prior to disbursement for renovation, a plan should be submitted in form and substance satisfactory to AID indicating the location of each dispensary to be renovated or rehabilitated with Grant funds, the population to be served and/or other basis for selecting each dispensary to be improved, and a schedule for equipping and staffing each dispensary.

B. 5. Conditions Precedent to Disbursement After the First Year

Unless AID otherwise agrees in writing, prior to disbursements for personnel or operating expenses after the first year of the project, Grantee will submit in form and substance satisfactory to AID a plan to include the number, type, and location of personnel to be supported; their respective salaries (base plus supplement); type and frequency of supervision (for field personnel); and estimated operating costs by type of functional unit for the remainder of the project.

6. Terminal Dates

The terminal date for meeting the Conditions Precedent to Initial Disbursements is 60 days after signature of the Project Agreement. The terminal date for meeting Conditions Precedent to Subsequent Disbursement is 120 days from signature. The terminal date for submitting the training and construction plans is 180 days from signature, as is the terminal date for submission of the evaluation plan. The terminal date for submitting the plan for personnel and operating expenses is 365 days from signature.

7. Covenants

In signing the Project Agreement, the Government of Haiti will covenant to:

a. Consider all possible ways and means of progressively increasing Government of Haiti revenues available for integrated rural health delivery (including family planning services) so as to lessen the dependence of this program on external donor contributions;

b. Consider formulation of official population policy giving family planning high priority, in the context of improved family well-being and in the context of national demographic goals; and

c. Expand the delivery of family planning services and information as rapidly as possible through the use of public and private channels authorized by the Division of Family Hygiene, and extend as much as possible the availability and accessibility of contraceptive services and supplies.

### C. EVALUATION ARRANGEMENTS FOR THE PROJECT

Three evaluations are scheduled for this project. The first is scheduled for July 1979 or approximately 18 months after initial obligation to allow six months for analysis of data collected during the project's first year of operation. The project will be evaluated annually with the final evaluation scheduled for July 1981 or approximately six months after the end of the project. Each evaluation will be carried out under an IQC or other short-term contract arrangement.

Representatives of the Division of Family Hygiene (DHF) and of AID will participate in each evaluation. Although this is a multidonor project, representatives of the other organizations contributing to the project are not permanently resident in Haiti. Data on their participation will be provided by the Division of Family Hygiene in its quarterly and annual reports.

Each evaluation will review:

- progress toward achieving the outputs in the quantities specified in the project logical framework;
- performance of each of the organizations participating in the project in providing the inputs specified in the project logical framework.

The Division of Family Hygiene is providing the baseline data for this project; the final evaluation will use DHF data to measure the degree to which targets were reached and the purpose of the project achieved.

Each evaluation will include a review of the following data and an assessment of the implications of these data for family planning in Haiti:

- average cost per patient under each kind of family planning service supply outlet;
- contraceptive usage under each kind of family planning service;
- contraceptive distribution system;
- efficiency of motivation toward family planning as measured by the proportion of:
  - new cases to total registered minus number of dropouts;
  - coupons received in clinics to number of coupons distributed by community agents.

Each contract evaluation team will be responsible for devising a methodology which will measure the social and economic impact of this project.

In addition to the two evaluations in which representatives of the Division of Family Hygiene and of AID will participate,

- UNFPA will fund and administer an evaluation of contraceptive continuation rates;
- Columbia University Center for Population and Family Health will evaluate the results of its project in household distribution of contraceptives in Haiti.

These findings of these two evaluations will contribute to the evaluations described in this section.

ANNEXES TO 1978 - 1980HAITI FAMILY PLANNING PROJECT PAPER (521-0087)

- A. Logical Framework Matrix
- B. Summary Budgets for GOH and Other Donors
 

GOH	Columbia University	FPIA
UNFPA	Development Associates	
Pathfinder	IPPF	
- C. Summary Cost Estimate and Financial Plan
- D. Costing of Project Outputs/Inputs Table
- E. Map of Haiti
- F. AID/W messages relating to this project
- G. Statutory Checklist (pending)
- H. Grantee's Application for Assistance (pending)
- I. Bibliography
- J. Course Outlines
- K. Resource Support Services Report: John Anderson,  
Haiti, September 25 - October 1, 1977
- L. USAID/Haiti Certification of 25% contribution by the Government  
of Haiti
- M. Initial Environmental Examination

SUMMARY BUDGET  
GOH CONTRIBUTION\*

	1978	1979	1980	TOTAL
Personnel				
Central Offices	\$ 100	\$ 100	\$ 100	\$ 300
Fixed Clinics	584	584	584	1,752
Buildings <u>1/</u>				
Rental value	116	128	141	385
Utilities & maintenance	104	115	126	345
Duty free import privileges	145	160	176 <u>2/</u>	481
Aux. Nurse Training	50	50	50	150
Cash	50	75	100	225
TOTAL	\$ 1,149	\$1,212	\$1,277	\$3,638

1/ 10% inflation per year assumed

2/ assumed would increase 10% over 1979, as 1978 did over 1979

\* These attributions of GOH contributions are derived primarily from DHF calculations prepared for programming exercises with other donors to the program. See Section III-E Institutional Analysis above for USAID/Haiti's update on GOH contributions.

A N N E X B

SUMMARY BUDGETS FOR GOH AND OTHER DONORS

GOH

UNFPA

PATHFINDER

COLUMBIA UNIVERSITY

DEVELOPMENT ASSOCIATES, INC.

INTERNATIONAL PLANNED PARENTHOOD FEDERATION

FAMILY PLANNING INTERNATIONAL ASSISTANCE

## SUMMARY BUDGET

UNFPA - 1978, 1979 , &amp; 1980

	1978	1979	1980
10 Project Personnel	\$ 578,674	\$ 381,782*	\$ 192,692*
11 Consultants	(30,000)	(18,000)	(10,800)
13 Administrative support	(3,000)	---	
16 National Personnel	(545,674)	(363,782)	(181,892)
20 Sub-contracts & Grants	62,870	13,500	15,000
30 Training	40,800	24,000	15,000
31 Fellowships	(31,500)	(18,000)	(11,000)
32 Local Training	(9,300)	(6,000)	(4,000)
40 Equipment	379,766	500,000	500,000
41 Expendable	(252,987)	(400,000)	(400,000)
42 Non-Expendable	(126,779)	(100,000)	(100,000)
50 Miscellaneous	153,180	100,000	100,000
GRAND TOTAL	\$ 1,215,290	\$ 1,019,282	\$ 822,692

TOTAL ALL YEARS \$3,057,264

## Assumptions:

- UNFPA withdraws salary supplements @25% of original supplement/yr
- 1979 budget is two times the 1st 6 mos budget, except for equipment and salary adjustment
- 1980 budget follows trends between 1978 - 1979, except sub-contracts. equipment and miscellaneous.

\* AID estimate

## SUMMARY BUDGET

## PATHFINDER MATRONE &amp; COMMUNITY COUNCIL PROGRAM

	1978	1979 *	1980*
<b>I. Matrones</b>			
<b>A. Per Diem for Trainees</b>			
1 group starting in Jan (750 x \$1 X 12)	\$ 9,000	\$ 9,000	\$ 9,000
1 group starting in July (750 x \$1 x 12)	4,500	4,500	4,500
<b>B. Supervision Visit per   diem; # matrones x \$1 x 12</b>	18,000	36,000	54,000
<b>C. Per diem for Super-   visors; 2 visits/mo x   1 day/visit x \$60/day x   12 mo/yr x 59 areas</b>	<u>8,500</u>	<u>8,500</u>	<u>8,500</u>
<b>TOTAL FOR MATRONES</b>	\$ 40,000	\$ 58,000	\$ 76,000
<b>II. Community Council Program</b>			
\$700/community x 50 communities	35,000	35,000	35,000
<b>GRAND TOTAL</b>	\$ 75,000	\$ 93,000*	\$ 111,000*

TOTAL ALL YEARS \$279,000

Assumed same program all 3 years

\* AID estimate

SUMMARY BUDGET

COLUMBIA UNIVERSITY CENTER FOR POPULATION AND FAMILY HEALTH

HOUSEHOLD DISTRIBUTION PROJECT

	CY 78	CY 79	CY 80
<b>Personnel:</b>			
Central office	\$ 16,240	\$ 19,286	\$ 23,415
Field activities	2,000	7,600	1,200
Travel & Per Diem	500	2,600	2,600
Data Processing	4,000	6,000	4,000
Commercial sector study	--	20,000	30,000
Health Commodities	2,000	5,000	1,000
Clinic Services & Referrals	2,000	4,000	4,000
Vehicle	8,300	--	--
Fuel & Vehicle Maintenance	2,196	2,200	2,500
Communications, Supplies <sup>11</sup>	1,000	1,000	600
<b>TOTAL</b>	<b>38,256</b>	<b>67,686</b>	<b>69,315</b>

TOTAL ALL YEARS \$ 175,257

SUMMARY BUDGET 1978-1980

DEVELOPMENT ASSOCIATES

	1978	1979*	1980*
I. Healer Training	\$ 11,100	\$ 12,210	\$ 13,431
II. Auxiliary Seminars	4,000	4,400	4,840
III. National Level Matrone Supervision	4,100	4,510	4,961
Subtotal	19,200	21,120	23,232
5% overhead	960	1,056	1,162
TOTAL	\$ 20,160	\$ 22,176	\$ 24,394

TOTAL ALL YEARS \$ 66,730

\* Assumes same activities, 10% inflation on costs per year.

SUMMARY BUDGET  
IPPF CONDOM VENDING MACHINES PROGRAM

1978	1979	1980	TOTAL
\$ 15,500	\$ 7,500	\$ 10,000*	\$ 33,000

\* AID estimate

SUMMARY BUDGET 1978  
FAMILY PLANNING INT'L ASSISTANCE  
VOLUNTARY SURGICAL CONTRACEPTION PROJECT

	1978
I. Salaries	\$ 11,550
II. Fringe Benefits (13th mo)	500
III. Consultant	1,160
IV. Travel	3,232
V. Equipment and Supplies	6,500
VI. Remodelling \$2,000 - Maintenance \$2,400	4,400
VII. Administrative Overhead 5.85%	1,367
	<hr/>
	\$ 28,709

ANNEX C

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

(U.S. \$000)

Haiti Family Planning Project Paper (521-0087), 1978-1980

Source use	USAID/H	AID/W	GOH * L/C	UNFPA	Pathfinder	Columbia University	DAI	IPPF	FPIA	TOTAL
Contraceptives	---	2,100	---	---						2,1
Personnel	285	---	2,052	1,244		75			17	3,6
Facilities & equipment	681	---	730	1,380	105	36		33	11	2,9
Training	270	---	150	80	41		50			5
IEC	305	---								3
Supervision	191	---			133		14			3
Research	---	---				64				
Import privilege			481							41
Inflation: Figured into	3-year budgets at 20% for medical items and 10% for other commodities									
Contingency Factor	43	---	225	353	---	---	3	---	1	6:
TOTAL	1,775	2,100	3,638	3,057	279	175	67	33	29	11,1!
% of Grand Total	15.9%	18.8%	32.6%	27.4%	2.5%	1.6%	.6%	.3%	.3%	100%
+*See Section III E Institutional Analysis										



COSTING OF PROJECT OUTPUTS/INPUTS (CONTINUED)

	CENTRALLY FUNDED	AID BILATERAL	GOH	UNFPA	PATHFINDER	COLUMBIA UNIVERSITY	DEVELOPMENT ASSOCIATES, INC.	IPPF	FPIA	TOTAL
Matrone Training	0	0	0	0	41	0	0	0	0	41
Guerisseur Training	0	0	0	0	0	0	39	0	0	39
Chefs de Section	X	20	N.A.	0	0	0	0	0	0	20+ conf. face GOH
Nat'l District Supervisor	0	157	0	0	0	0	0	0	0	157
District Supervisor	0	126	0	0	0	0	0	0	0	126
Local Matrone Supervisor	0	0	0	0	133	0	0	0	0	133
Nat'l Matrone Supervisor	0	0	0	0	0	0	14	0	0	14
Renovate District Contraceptive Depots	0	20	0	0	0	0	0	0	0	20
Renovate Central Warehouse	0	10	0	0	0	0	0	0	0	10
Radio & TV	0	37	0	0	0	0	0	0	0	37
Newspaper Articles	0	39	0	0	0	0	0	0	0	39
Seminars	0	65	0	0	0	0	0	0	0	65
Other	0	96	N.A.	0	0	0	0	0	0	96 GOH
<b>TOTAL</b>	<b>2100</b>	<b>1775</b>	<b>3638</b>	<b>3057</b>	<b>279</b>	<b>175</b>	<b>67</b>	<b>33</b>	<b>29</b>	<b>\$11,153</b>

Object Output #'s correspond to the outputs in the logframe

indicates that this input contributes to the output; no breakdown is possible.

on an LOP basis

is an unknown quantity--not added into row total.

# DEPARTEMENT DE LA SANTE

- |   |                     |        |        |
|---|---------------------|--------|--------|
| ⊕ | HOPITAL             | BUDGET | M.S.P. |
| ○ | HOPITAL             | BUDGET | PRIVE  |
| ▲ | DISPENSAIRE HOPITAL | BUDGET | M.S.P. |
| △ | DISPENSAIRE HOPITAL | BUDGET | MISTE  |
| ◆ | DISPENSAIRE HOPITAL | BUDGET | PRIVE  |
| ◇ | CENTRE DE SANTE     | BUDGET | M.S.P. |
| ◊ | CENTRE DE SANTE     | BUDGET | MISTE  |
| ⊙ | CENTRE DE SANTE     | BUDGET | PRIVE  |
| ⊗ | DISPENSAIRE         | BUDGET | M.S.P. |
| ⊘ | DISPENSAIRE         | BUDGET | MISTE  |
| ⊚ | DISPENSAIRE         | BUDGET | PRIVE  |



ANNEX F

AID/W MESSAGES RELATING TO THIS PROJECT

STATE 310582, SUBJECT: POPULATION PROJECT

STATE 264847, SUBJECT: POPULATION PROJECT

SUBJECT: POPULATION PROJECT

REF: (A) P.P. REVISION SIGNED 12/81 (PROJECT 521-0071);  
(B) STATE 264847

1. PERIODICALLY DURING AID/W REVIEW HELD DEC. 28 RECOMMENDED THAT ONE-YEAR REVIEW BE APPROVED, SUBJECT TO AID/W APPROVAL OF STAFFING CONFIGURATION PROPOSED BY USAID/HAITI TO MANAGE THIS ACTIVITY. THIS RECOMMENDATION IS BEING SENT FORWARD FOR APPROVAL CLEARANCES AND FINAL AID/W APPROVAL.

2. DURING AID/W REVIEW AND AGENCY REVIEW, RECOGNITION WAS GIVEN TO THE AID/W REVIEW PROGRESS AND PLANNED ACTIVITIES. CONCLUSIONS WERE DRAWN THAT WHILE CERTAIN ACTIVITIES MIGHT NOT BE IDEAL FOR TITLE X FUNDING IN SOME SETTINGS, SOME OF THEM WERE APPROPRIATE FOR THE PRESENT STAGE OF THE AID/W PROGRAM AND AS AN OPPORTUNITY TO DEVELOP NEW THRUSTS IN 1977 WERE CONSIDERED TO BE A TRANSITION YEAR.

SUBSTANTIAL EMPHASIS WAS PLACED ON THE CONCEPT OF A TRANSITION YEAR IN WHICH NEW PROGRAMATIC EMPHASIS COULD BE DEVELOPED. AT THE SAME TIME ATTENTION WAS CALLED TO THE NEED FOR ACTIONS IN 1977 IN ADDITION TO ADEQUATE ACHIEVEMENT OF THE SPECIFIC OBJECTIVES OF THE P.P. REVISION WHICH WOULD GIVE CONFIDENCE THAT NEW PROGRAM EMPHASIS COULD BE MAINTAINED. THE FOLLOWING WERE SUGGESTED AS OTHER KINDS OF SIGNS THAT WOULD INDICATE THAT REAL CHANGE COULD BE EXPECTED:

A. MANIFESTATION OF INCREASED AID/W INTEREST BY ORGANIZING ITSELF FOR FAMILY PLANNING ACTION PROGRAMS AND PLANNING FOR VIGOROUS ACCEPTANCE LEVELS.

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OPTIONAL FORM 101  
(Formerly PB-412)  
January 1975  
Dept. of State

## TELEGRAM

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WOULD BE ASSUMED BY GOH, OTHER DONORS, OR USAID NON-TITLE X ACTIVITIES AFTER YEAR 1; (C) MUTUALLY-AGREED UPON FP PERFORMANCE TARGETS; (D) APPROPRIATE IMPLEMENTATION OF OPERATIONS RESEARCH IN NON-CLINICAL CONTRACEPTIVE DISTRIBUTION AS DISCUSSED WITH DR. BORDES; (E) APPROPRIATE IMPLEMENTATION OF VSC ACTIVITIES DESCRIBED IN THE GOH PROPOSAL TO AVS.

4. IN ADDITION TO THE ABOVE, PHA/POP CONSIDERS THE ESTABLISHMENT OF A FULL-TIME POPULATION OFFICER POSITION WITHIN USAID TO BE ESSENTIAL. THIS CONDITION IS ENTIRELY IN KEEPING WITH THE RECENT IG REPORT RECOMMENDATIONS.

5. REASONABLE FULFILLMENT OF THE ABOVE CONDITIONS DURING YEAR 1 OF THE PROJECT WOULD BE NECESSARY BEFORE FY 1978. FUNDS COULD BE ALLOTTED.

6. IF USAID CONCURS IN THIS GENERAL COURSE OF ACTION, PHA/POP PREPARED TO FURNISH AID/W TDY ASSISTANCE TO HELP USAID PREPARE PP.

7. THE USAID MAY WISH TO SUGGEST ALTERNATIVE COURSE OF ACTION SUCH AS A LIMITED BILATERAL PROGRAM WHICH IN 1977 WILL FOCUS ON CLEARLY IDENTIFIABLE FAMILY PLANNING ELEMENTS OF THE GOH PROGRAM AND/OR CENTRALLY FUNDED OPERATION RESEARCH, VSC ACTIVITIES, CONTRACEPTIVE REQUIREMENTS. PHA/POP HAS A PREFERENCE FOR A MORE VIGOROUS BILATERAL EFFORT IN HAITI LEADING TO WIDESPREAD AVAILABILITY OF CONTRACEPTIVES PARTICULARLY TO THE RURAL POOR. HOWEVER, IF THE USAID IS NOT OF THE OPINION THAT CONDITIONS EXIST FOR REASONABLE ASSURANCE OF ACHIEVING THESE OBJECTIVES IN THE NEAR FUTURE OR DETERMINES THAT IT CANNOT MAKE THE MANPOWER ALLOCATION NECESSARY TO CRAFT A MORE VIGOROUS APPROACH, WE WOULD COUNSEL AGAINST GOING FORWARD AT THIS TIME ON ANY LARGE SCALE VENTURE.

B. PLEASE ADVISE. ROBINSON

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ANNEX F

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GOH APPROVAL AND EFFECTIVE IMPLEMENTATION OF THE  
PLANNED OPERATIONS RESEARCH.

2. DEMONSTRATION OF GROWING INTEREST IN VOLUNTARY SURGICAL CONTRACEPTION METHODS.
3. WITH PROPOSED ONE-YEAR EXTENSION, FUNDING TOTALS THIS PROJECT THROUGH FY 1977 WOULD EXCEED DOLS ONE MILLION. THESE TOTALS COMPRISE CENTRALLY-FUNDED CONTRACEPTIVES AND BILATERALLY-FUNDED ACTIVITIES TO BE CARRIED OUT BY GOH DEPARTMENT OF FAMILY HYGIENE. ADDITIONAL AID POPULATION FUNDS ARE BEING USED IN HAITI BY DIRECT INTERMEDIARIES (E.G. FPIA, PATHFINDER FUND, COLUMBIA UNIVERSITY, PIEGO, IAVS, AMONGST OTHERS) AND INDIRECT INTERMEDIARIES (E.G. PAHO AS EXECUTING AGENCY FOR UNFPA FUNDS, WORLD FERTILITY SURVEY, IPPT). MANY OTHER DIRECT INTERMEDIARIES CAN BE TAPPED AS NECESSARY BY HAITIAN DEPARTMENTS THROUGH USAID, SUCH AS APHA UMBRELLA CONTRACT FOR RAPID PROVISION SHORT-TERM CONSULTANCY SERVICES ALL ASPECTS POPULATION FIELD, UNIVERSITY OF NORTH CAROLINA'S POPLAB FOR ASSISTANCE IN DEMOGRAPHIC FIELD, BATTELLE MEMORIAL INSTITUTE FOR HELP ON MORE EFFECTIVE USE OF NEW TECHNOLOGY, AMONGST OTHERS.
4. DURING RECENT SHORT TDY HAITI TO ASSIST USAID IN ITS PREPARING OF PROJECT PAPER REVISION FOR PROJECT 521-071, PHA/POP'S BLUMBERG DISCUSSED WITH USAID PUBLIC HEALTH TEAM THE FACT THAT CURRENT EXPANDED HEALTH AND POPULATION RESPONSIBILITIES PRECLUDE THE DEVOTING OF SUFFICIENT ATTENTION TO ALL THE SEPARATE BUT CLOSELY INTERRELATED PRESENT/POTENTIAL ACTIVITIES POPULATION FIELD. SUCH ACTIVITIES INCLUDE POPULATION POLICY, DEMOGRAPHIC DATA COLLECTION AND ANALYSIS, FAMILY PLANNING SERVICE DELIVERY SYSTEMS, TRAINING AND MANAGEMENT DEVELOPMENT, COMMUNICATIONS, BIOMEDICAL AND SOCIAL RESEARCH, AND EVALUATION. IN EACH SUCH ACTIVITY, ONGOING CONSULTATIONS WITH HAITIAN OFFICIALS WOULD BE REQUIRED FOR JOINT NEED ARTICULATION AND PROJECT FORMULATION. ADDITIONAL RESPONSIBILITIES RELATE TO BUDGET ANALYSIS, FUNCTIONAL ARRANGEMENT AND JUSTIFICATION OF AID FUNDING INPUTS, AND ONGOING MEASUREMENT AND REPORTING OF EFFICIENCY, EFFECTIVENESS, AND SIGNIFICANCE OF AID-ASSISTED HAITIAN ACTIVITIES POPULATION FIELD.
5. BASED UPON AID'S EXPERIENCE OTHER COUNTRIES, IT SEEMS

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6. CLEAR THAT EFFECTIVE MANAGEMENT OF SIGNIFICANT AID RESOURCES POPULATION FIELD HAS BEEN RELATED DIRECTLY TO ASSIGNMENT OF WELL-QUALIFIED FULL-TIME USAID POPULATION OFFICER, REPORTING TO USAID DIRECTOR, WITH ESSENTIAL SUPPORTING STAFF NECESSARY TO HELP HOST COUNTRY OFFICIALS TO DESIGN, CARRY OUT, MEASURE, AND COORDINATE SUCH ACTIVITIES. AID/W REGRETS APPARENT MISUNDERSTANDINGS ENGENDERED BY CERTAIN WORDS REF (B). AID/W CLEARLY UNDERSTANDS THAT THE AMBASSADORS AND THEIR MISSIONS HAVE THE RESPONSIBILITY AND AUTHORITY FOR DETERMINING PRIORITIES, STAFF CONFIGURATIONS AND PROGRAMS FOR THEIR COUNTRIES. AT THE SAME TIME, PHA/POP HAS THE RESPONSIBILITY FOR RECOMMENDING APPROPRIATE USE OF TITLE X FUNDS BASED IN PART UPON ITS APPRAISAL OF MANAGEMENT CAPABILITIES. WHAT AID/W SEEKS IS THE BEST POSSIBLE MARRIAGE OF BOTH SETS OF RESPONSIBILITIES IN A FINAL DETERMINATION OF METHODS TO PROCEED.

6. PLEASE ADVISE SOONEST RE USG/HAITI DECISION ON STAFFING CONFIGURATION PROPOSED FOR MANAGEMENT OF PRESENT/POTENTIAL AID INPUTS POPULATION ACTIVITIES. IF THERE IS A SUBSTANTIAL INTERRELATION WITH HEALTH PROJECT MANAGEMENT, WE WOULD APPRECIATE YOUR PLANS THIS REGARD ALSO.

7. PPC COMMENT: IT IS ESSENTIAL THAT PLANNING FOR NEW PROJECT FULLY CONSIDER ELEMENTS NEEDED TO STRENGTHEN INSTITUTIONAL CAPACITY OF GOH TO DELIVER FP SERVICES.

KISSINGER

BT

MHM

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Classification

A N N E X I

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DEPARTMENT OF PUBLIC HEALTH & POPULATION,

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## A N N E X J

### COURSE OUTLINES

#### Course Content: Auxiliary Nurse Seminars

These seminars will be taught slightly differently in different parts of the country. The topic covered in a given seminar will depend on the needs of the auxiliaries in that part of the country.

Seminar topics for which training plans have been drawn up include the following:

- Physical and human resources
- Health Problems
- Dispensary Organization
- Role of the Auxiliary in the Dispensary
- Family Planning
- Supervision
- Prenatal consultation & immunization

#### MATRONE COURSE TOPICS

- Anatomy and Physiology of reproduction
- Diagnosis of Pregnancy
- Prenatal Care
- Delivery Care
- Post-partum care for mother and child
- Nutrition for the new born
- Family Planning
- Maternal and childhood illnesses
- Role of matrone in community health

PROJECT REVIEW PAPER ADJUSTMENT

TO BE COMPLETED BY AID/W/TDY OFFICE

Original  Copy  
 Add  Delete

ANNEX  
 OBJECT CODE  
 2

3. COUNTRY/ENTITY

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER

521-15-580-037

5. BUREAU

a. Symbol L A  
 b. Code 3

6. PROPOSED PP SUBMISSION DATE

mo. yr.  
 05 76

7. PROJECT TITLE - SHORT (stay within brackets)

[Maternal Child Health/Family Planning II]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION

a. INITIAL FY [10] b. FINAL FY [79]

9. ESTIMATED TOTAL COST (\$000 or equivalent, \$1 = )

7. FUNDING SOURCE	FIRST YEAR FY 79			ALL YEARS		
	b. FX	c. L/C	d. Total	e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL (Grant)		2551	2551	1670	955	2625
PATHFINDER	41	14	55	635	212	847
Other U.S. 1. JISER	6	15	21	44	70	114
2. EPJA	5	30	35	5	30	35
HOST GOVERNMENT		287	287		4943	4943
OTHER DONOR(S) UNFPA	88	187	275	1617	3435	5052
TOTALS	140	524	724	2971	5455	7266

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

a. Appo- sition (Alpha Code)	b. Primary Purpose Code	c. Primry Tech. Code	FY 79		FY 77		FY 78		ALL YEARS		
			d. Grant	e. Loan	f. Grant	g. Loan	h. Grant	i. Loan	j. Grant	k. Loan	
PH			575		700		850			2625	2401
TOTALS			575		700		850			2625	

11. PROJECT PURPOSE(S) (stay within brackets)

Check if different from PID

2601

1. Make family planning services available to over 90% of Haiti's population by end 1980.
2. Increase # active contraceptors.
3. Provide prenatal care, child screening, and immunizations.

12. WERE CHANGES MADE IN PID FACESHEET DATA, BLOCKS 12, 13, 14, or 15? IF YES, ATTACH CHANGED PID FACESHEET.

Yes  No N.A

13. PLANNING RESOURCE REQUIREMENTS (staff/funds) Two months AID/W TDY assistance. Additional TDY may be required for social and economic analysis portions of PP and a period of four weeks is estimated for these two analyses.

14. ORIGINATING OFFICE CLEARANCE

Signature

Title S.L. Behoteguy  
 AID Representative

Date Signed  
 mo. day yr.  
 11 17 75

15. Date Received in AID/W, or For AID/W Documents, Date of Distribution

mo. day yr.

## MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE  
CENTER FOR DISEASE CONTROL

TO : Director, Center for Disease Control, CDC      DATE: October 26, 1977

THROUGH: Director, Bureau of Epidemiology (BE) *PHS*

FROM : John E. Anderson, Ph. D., Demographer, Program Evaluation Branch (PEB)  
Family Planning Evaluation Division (FPED), BE

SUBJECT: Resource Support Services Report: Project Proposal Paper--Haiti,  
September 25-October 1, 1977

- I. SUMMARY
- II. PLACES, DATES, AND PURPOSE OF TRAVEL
- III. PRINCIPAL CONTACTS
- IV. PROJECT PROPOSAL PAPER
  - A. Introduction
  - B. Program Targets
  - C. Quantified Demographic Goals
  - D. Regression Model: CBR and Percent of Married Women Using Contraception
  - E. TABRAP Model
    - 1. Input Data
    - 2. Results
- V. DISCUSSION

I. SUMMARY

I spent the week of September 25, 1977, consulting with Edwin McKeithen, Health and Population Officer, USAID/Haiti, on demographic aspects of the Project Paper that was under preparation. Carol Dabbs, an intern on TDY from the Office of Population, AID/Washington, was responsible for drafting the entire paper. While in Haiti I attempted to evaluate the relevant demographic data, most of which is from secondary sources. On my return to CDC, TABRAP, a computer model, was run to assess the potential demographic impact of the target number of contraceptive users set forth in the project paper. The results indicate that the proposed number of contraceptive users in 1980 could lower the crude birth rate from 37.0 to 30.0 or less. Continued rapid increase in the number of users would be necessary for further fertility reduction.

II. PLACES, DATES, AND PURPOSE OF TRAVEL

Port-au-Prince, Haiti, September 25-October 1, 1977, at the request of AID/POP/LA/Washington to provide technical consultation to the USAID Mission on the potential demographic effectiveness of family planning program targets proposed in the Mission Project Paper on family planning

currently being drafted. This travel was performed in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population/AID and CDC/BE/FPED.

### III. PRINCIPAL CONTACTS

#### A. USAID Mission

1. Edwin McKeithen, Health and Population Officer
2. Carol Dabbs, AID/POP Intern on TDY

#### B. Other

1. James Allman, Resident Advisor, World Fertility Survey, Haiti
2. Robert Hannenberg, Demographer, Center for Population and Family Health, Columbia University, attached to Division d'Hygiene Familiale, Ministere de Sante Publique et Population, Republique d'Haiti

### IV. PROJECT PAPER

#### A. Introduction

The purpose of the consultation was to evaluate the program objectives for the MOH program set forth in the Project Paper relative to their potential demographic effect, and conversely, to see how the stated demographic goals of the program, if there are any, can be used to arrive at program targets. The method used was to assemble and evaluate, as well as possible in the short period of time in Haiti, the demographic and program data relevant to these questions. The program goals were evaluated while in Haiti, using general "rule of thumb" type models such as the 30/30 rule and cross-national regression of CBR on percent of married women using contraception. On return to CDC, TABRAP, a computer model which attempts to take into account more of the factors involved than the regression model, was run to relate program targets and impact on the birth rate (D. Nortman and J. Bongaarts, "Contraceptive Practice Required to Meet a Prescribed CBR Target." Demography 12(3), 1975, pp 471-490). Because of the low level of quality and quantity of demographic data used as input to the model, the results should be viewed as illustrative of the range of possible outcomes, not as firm predictions of program impact.

#### B. Program Targets

Program goals have been set in a number of documents. The draft Project Paper calls for increasing active users to 255,000 by 1980 (see Table 1). The table shows the program emphasis on male acceptors of condoms, who make up about three-quarters of projected active users. The number of active users, both men and women in 1980, would be equal to 20% of the estimated number of women of childbearing age.

The numbers in Table 1 are of active users, not acceptors. Table 2 shows the estimated acceptors and users based on hypothetical "high" and "low" continuation schedules (high continuation = 50, 35, and 20% using at 1, 2, and 3 years; low continuation = 35, 20, and 10%). These targets are

from a different planning document and are not consistent with the targets in Table 1. They cover "fixed clinics" only, which served about 93% of all acceptors reported in 1976 by the MOH. Table 2 projects 107,000 to 123,000 active female users for 1979 and perhaps 70,000 active males, which may be close to the level projected in Table 1. The total number of new acceptors required in 1978 and 1979, according to Table 2, is 149.5 thousand and 177.8 thousand, respectively. The actual number of acceptors in fixed clinics reported in 1976 was 41,293, as shown in Table 3. Two-thirds of these were male condom acceptors. Females in all clinics accepted the method mix shown in Table 4.

#### C. Quantified Demographic Goals

In general, explicit demographic goals do not exist for the program. In a case of the Artibonite Valley Development Plan, covering one region of the country, a crude birth rate goal has been stated. The Valley has been found to have higher fertility than the national average of about 37 births per 1,000 population. In one planning document, the goal stated was to bring the crude birth rate down from 48 to 37 over the course of a 5-year plan (Planification du Programme Sanitaire Conjoint, ODVA-DSPP).

#### D. Regression Model: Crude Birth Rate and Percent of Married Women Using Contraception

A rule of thumb for family planning programs has sometimes been used called the "thirty/thirty" rule. Based on a cross-national regression of the crude birth rate and percent of married women using contraception, it has been stated that a country required about 38% of married women using contraception to have a crude birth rate of 30. This relationship has been expressed in terms of the regression equation  $CBR = 46.7 - .43X$ , where "X" is the percent of married women using contraception (D. Nortman, "Family Planning Factbook, 1976," Population Council). The crude birth rate in Haiti is reported to be around 37 per 1,000, considerably less than most pre-fertility decline populations. According to the regression model, a crude birth rate of 37 per 1,000 is associated with about 23% of married women using contraception. The actual current level of contraceptive prevalence in Haiti is not known, but it is probably much lower than 23% of married women.

The conclusion to be drawn is that the model does not fit the case of Haiti very well, chiefly because of the intervening variables not dealt with in the model. In one study, it was concluded that Haiti's relatively low fertility was due to late age at menarche and early menopause (related to nutrition) and the instability of marital unions (G. Berggren, N. Murthy, and S. Williams, "Rural Haitian Women: An analysis of fertility rates," Social Biology 21(4), 1974, pp. 368-378).

The importance of these intervening variables means that it is probably not necessary to reach 35% of married women to attain a 30 per 1,000 birth rate in Haiti, all other things remaining equal. However, if living standards improve, fertility and program requirements could increase.

### E. The TABRAP Model

The TABRAP model can be used 2 ways--yielding the annual number of acceptors required to meet specified crude birth rate targets, or yielding crude birth rates associated with recruiting a given number of acceptors. The model requires extensive data inputs. Many of these for Haiti were estimated or hypothetical values.

The model was run in both directions from the initial year of 1978, first estimating the potential effect on the crude birth rate of the targets listed in Table 1, and second to calculate the number of acceptors required to achieve several target crude birth rates by 1998--15, 20, 25, and 30 births per 1,000. Both applications require the same basic demographic input items, which are discussed in the following section.

#### 1. Input Items

**Initial Population:** By projecting forward most available population estimates (Table 5) a total population of about 4.8 million is obtained for 1978. The CELADE estimate of 5.7 million seems to be the only one which has attempted to correct for a census undercount. In order to be conservative in terms of program planning, the 5.7 million initial population was used in these projections.

**Mortality Level:** The computer program will accept a life expectancy at birth figure and select appropriate model life table values for making the projections. Available estimates of life expectancy suggest it is around 50 years, as shown in Table 6. This level of mortality was assumed to hold for the entire period of the projections.

**Fertility Rates:** Fertility in Haiti is generally taken to be below natural fertility levels, despite lack of widespread use of modern contraception. Three estimates shown in Table 7 indicate a total fertility rate of just over 5 births per woman; an intensive study of rural areas indicates wide variability, ranging up to a TFR of 6.8. The national average is probably closer to 5.2. The second set of rates shown in Table 7 were assumed for the projection.

**Age-sex Distribution:** The proportion of population by age and sex shown in Table 8 will be used for the initial year. This distribution probably contains some error due to age misreporting and census undercount, but it would be difficult to adjust using stable population analysis because of the effects of migration on the age-sex distribution.

**Proportions Married by Age:** The TABRAP model assumes a dichotomous marriage category, with all childbearing occurring within marriage. If this is true, age-specific fertility rates (ASF), age-specific marital fertility rates (ASMF), and the proportions married (PM) are related as follows:  $ASF = ASMF \times PM$ .

Since marriage and fertility patterns are radically different from this in Haiti, the rates used must be adjusted. Table 9 shows the percent of women by age in stable and unstable unions in one study in a rural area. An adjusted percent married has been calculated assuming that percent married is equal to all women in stable unions--married and placee--plus half of the women in unstable unions. The percents obtained in Table 9B resemble conventional percents married, but are somewhat lower than usual.

**Marital Fertility Rates:** Marital fertility rates were estimated using the relationship shown above and the adjusted percents married. Note that this is approximately equivalent to assuming that women in unstable unions have half the fertility of stable unions. The adjusted marital fertility rates estimated in this way, as shown in Table 9B, were used for the initial year of the projections after adjusting them to be consistent with a CBR of 37.0.

**Method Mix and Continuation:** Separate methods were not distinguished. Rather a relatively low continuation rate will be assumed reflective of the concentration of the program on condoms. Two hypothetical continuation schedules were used, based on the earlier projections--50, 35, and 20% and 35, 20, and 10% at 1, 2, and 3 years. These percentages were converted to a continuous exponential decay function

## 2. TABRAP Results

Table 11 shows the effect of given numbers of new acceptors on the crude birth rate from 1978 to 1980, calculated using the TABRAP model with the input parameters described in the preceding section. High and low continuation models are the schedules described above, both relatively low continuation schedules reflecting the method mix. Panel A of Table 14 uses the "active user" target shown in Table 1 as "new acceptor" targets. Because of the low continuation rates assumed, these acceptor targets would only result in 111 to 174,000 users in 1980, and according to the TABRAP model, a crude birth rate of around 30 per 1,000. The acceptor targets in Panel B are higher and would result in 252,000 active users in 1980 under the high continuation schedule. This approximates the target of 255,000 users in 1980 set forth in the draft project paper. The model indicates that achieving the acceptor targets shown in Panel B would result in a crude birth rate in the mid-20s. The models suggest, then, that recruiting 250,000 or more acceptors per year through 1980 was compatible with a crude birth rate of 30 per 1,000 or less. Given Haiti's current rate of mortality and out-migration, this would result in population growth of 1% per year or less. Even allowing for reservations about the input data, it can be concluded that meeting the user targets would have significant demographic impact.

Setting Acceptor Targets Based on Crude Birth Rate Goals: The TABRAP model was also used in the reverse direction; to determine the number of acceptors needed to achieve given target CBRs. Four separate models of decline were used, linear decline in crude birth rate from a current level of 37.0 to levels of 15, 20, 25, and 30 births per 1,000 population in 1998, a 20-year projection. The annual crude birth rate targets for each of these models are shown in Table 12.

Again, the input parameters described earlier were used for the model. The "low" continuation schedule only was used. If continuation is actually higher, the required number of acceptors shown will be higher than necessary.

The model resulting in the most rapid decline requires about 100,000 acceptors around 1980, less than the actual targets shown in Table 11. The number required increases rapidly, however, to about 300,000 in the mid-80s to over 700,000 at the end of the projection. The other models require correspondingly fewer acceptors per year. Because continuation rates are assumed to be quite low (only 35% continuing at the end of 12 months), the midyear number of active users shown in Table 14 is less each year than the number of new acceptors. The model resulting in a crude birth rate of 15 increases from about 20,000 to almost 500,000 active users in 20 years. Again, the number of active users around 1980 is considerably less than called for by the Project Paper.

Table 15 shows some of the effects on the population of the 4 fertility decline models. By 1998, if crude birth rate has fallen to 15 per 1,000, there will be 1 million fewer people than if it had only fallen to 30, about a 13% difference. The difference in the dependency ratio is even greater, with 37 persons under age 15 per 100 persons over age 15 in the low fertility projections, 55 per 100 under the high fertility projections, a difference of 33%. Finally, if the crude birth rate declines to 15 by 1998 and the mortality schedule does not change, the rate of natural increase will be approaching zero, compared to 1.6% per year under the high fertility model, and about 2% currently.

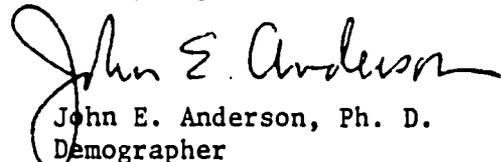
## V. DISCUSSION

The demographic data used, as discussed above, leaves much to be desired. In particular, it is not known how well the proposed method of dealing with proportion married and marital fertility reflects reality. The concept of use continuation has been developed mainly for IUDs and oral contraceptives, which have a well defined period of use, and for which discontinuation is a single discrete event. Continuation concepts developed for these methods may not accurately describe condom use. Data for condom

acceptors can be made more applicable to the concept of continuation as new acceptors are distinguished from resupply visits in the data system.

One factor not dealt with in the projections is out-migration, which has been fairly heavy in recent years. With a crude birth rate of 37 and a crude death rate of 15, Haiti has a rate of natural increase of 2.2%. But the rate of out-migration is perhaps 7 per 1,000 (Aaron Segal, "Haiti" in Population Policies in the Caribbean, 1975). This would reduce the population growth rate to about 1.5% per year. If this level of emigration continues, program targets may be considerably less than those estimated, particularly those projected 15 or 20 years in the future.

In spite of these reservations, it is felt that the projections are of some value, at least in attempting to relate demographic rates to program goals. They provide a plausible range of values of demographic impact and program targets. The TABRAP results indicate that the short-term goals through 1980 could have substantial impact on fertility, even under very low continuation schedules. But for continued fertility impact, the number of acceptors needs to keep increasing at a fairly rapid rate.



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TABLE 1

Active User Targets: 1977-1980

	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
Female	36,000	46,000	51,000	55,000
Male	<u>60,000</u>	<u>100,000</u>	<u>150,000</u>	<u>200,000</u>
TOTAL	96,000	146,000	201,000	255,000

Source: Draft Project Paper, p. 63

TABLE 2

Female New Acceptors and Active Users, Male Acceptors  
1976-1977 Fixed Facilities Only

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
Female New Acceptors	38	55	75	89	--
<u>Active Users</u>					
High Continuation	46	77	110	123	--
Low Continuation	43	69	97	107	--
Male Acceptors	--	--	74.5	88.8	108.3
TOTAL ACCEPTORS	--	--	149.5	177.0	--

Source: Haiti Maternal and Child Health and Family Planning Revised  
Programmation for 1978, UNFPA, AID, PATHFINDER

TABLE 3

Number of Acceptors by Sex,  
1974-1976, Fixed Clinics Only

	<u>1974</u>	<u>1975</u>	<u>1976</u>
Male	767	9,654	26,298
Female	4,631	14,912	14,995
TOTAL	5,398	24,566	41,293

TABLE 4

Female Acceptors by Method  
All Clinics

Total	16,066
Sterilization	1,486
Pill	8,441
Vaginal Creme	3,807
Condom	2,176
Other	156

Source Tables 3 and 4, Department de La Sante  
Publique et de la Population, Division  
d'Hygiene Familiale,  
"Activites de Protection Materno-Infantile et  
de Planification Familiale, Rapport Annual  
1976" Table XIV, Graphic VI

TABLE 5

## Estimates of Total Population

	<u>Year of Estimate</u>	<u>Population Estimate (Million)</u>	<u>Projected 1978 Estimate</u>
1.	1975	4.58	4.79
2.	1976	4.668	4.80
3.	(a) 1975	4.61	} 4.86
	(b) 1980	5.03	
4.	1978	5.72	5.72

## Source:

1. U.N. Demographic Yearbook, 1975
2. "Profil Demographique d'Haiti, 1976
3. J. Quinn and R. Bove, "A Quick Sketch of Haiti-1975, 2000." U.S. Bureau of the Census, ISPC, 1977
4. CELADE estimate in Chanlett and Cross, "An overview of Demographic Activities in Haiti," POPLAB, January 1977

TABLE 6

## Measure of Mortality

1. CDR 1976 14.5
2. CDR 1973 16.3
3. Expectation of Life at Birth, Male 49.0, Female 51.0
4. Expectation of Life at Birth, 50

## Source:

1. Profil Demographique d'Haiti, 1976
2. U.N. Demographic Yearbook, 1975
3. U.N. Demographic Yearbook, 1975
4. Chanlett and Cross

TABLE 7

Estimates of Age-Specific Fertility Rates  
Haiti

	<u>1</u>	<u>2</u>	<u>3</u>
15-19	58.8	55	76-115
20-24	203.7	208	211-278
25-29	259.3	247	257-299
30-34	244.6	222	228-309
35-39	180.6	172	160-236
40-44	88.2	90	80-121
45-49	<u>14.7</u>	<u>47</u>	<u>--</u>
TFR	5.25	5.20	5.06-6.79

1 Quinn and Bove, "Standard High Fertility Schedule

2 Chanlett and Cross

3 G. Berggren, N. Murthy, and S. William, "Rural Haitian Women: An Analysis of Fertility Rates," Social Biology 21(4), 1974, pp. 368-378

TABLE 8

Proportion of Population by Age and Sex, 1976

	<u>Total</u>	<u>Male</u>	<u>Female</u>
0-4	.1534	.0778	.0756
5-9	.1343	.0686	.0658
10-14	.1245	.0627	.0619
15-19	.1138	.0566	.0572
20-24	.0930	.0446	.0484
25-29	.0664	.0291	.0372
30-34	.0563	.0242	.0321
35-39	.0480	.0208	.0272
40-44	.0501	.0227	.0274
45-49	.0431	.0210	.0221
50-54	.0336	.0169	.0167
55-59	.0253	.0126	.0126
60-64	.0189	.0094	.0094
65-59	.0156	.0075	.0081
70 +	.0240	.0105	.0137
TOTAL	1.000	.4846	.5154

Source: "Profil Demographique," 1976

TABLE 9A

Percent of Women in Union by Type of Union,  
Stability and Age, Survey of Rural Haiti

	<u>Placed Unions</u>		<u>Married Unions</u>		<u>Never Married</u>	<u>Unknown</u>	<u>Total</u>
	<u>Stable</u>	<u>Unstable</u>	<u>Stable</u>	<u>Unstable</u>			
15-19	4.8	11.1	0.9	0.0	83.2	0.0	100.0
20-24	30.1	27.2	7.0	0.8	32.3	3.0	100.0
25-29	42.6	26.5	11.1	0.9	15.1	3.8	100.0
30-34	48.7	27.7	16.1	1.2	2.8	3.5	100.0
35-39	43.0	28.6	17.4	5.9	1.5	3.6	100.0
40-44	52.3	34.5	10.1	1.2	0.9	1.0	100.0
45-49	42.9	42.6	12.2	0.0	0.0	2.5	100.0

TABLE 9B

	<u>Adjusted Percent in Union*, Unions</u>	<u>Adjusted Age-Specific Marital Fertility Rates**</u>
15-19	11.3	487
20-24	52.1	403
25-29	67.4	369
30-34	79.2	283
35-39	77.7	224
40-44	80.2	112
45-49	75.4	---

\*Stable unions + 1/2 unstable unions

\*\* (Age-Specific Fertility Rate) / (Adjusted Proportion Married)

Source Panel A: S. Williams, N. Murthy, and G. Berggren, "Conjugal Unions Among Rural Haitian Women," Journal of Marriage and the Family 37(4), November 1975, pp. 1022-1031

TABLE 10

First Visits to Family Planning Clinics  
by Age, Females Only

<u>Age</u>	<u>Number</u>	<u>Percent</u>
< 20	1,100	6.7
20-29	9,141	55.2
30-39	4,298	26.0
40 +	690	4.2
Unknown	<u>1,313</u>	<u>7.9</u>
TOTAL	16,542	100.0

Source: Division d'Hygiene Familiale,  
Rapport Annual, 1976

TABLE 11

Haiti: Number of Active Users and Estimated Crude Birth Rate Associated  
with Two Sets of New Acceptor Targets 1978-1980, under Hypothetical  
High and Low Continuation Rates, TABRAP Model

	<u>New</u> <u>Acceptors</u>	<u>Midyear Active Users</u>		<u>CBR</u>	
		<u>High</u> <u>Continuation</u>	<u>Low</u> <u>Continuation</u>	<u>High</u> <u>Continuation</u>	<u>Low</u> <u>Continuation</u>
<u>A.</u>					
1978	146,000	61,743	44,618	35.0	35.6
1979	201,000	113,518	75,380	32.0	33.8
1980	255,000	174,127	111,175	28.5	31.8
<u>B.</u>					
1978	214,000	84,295	60,210	33.9	34.7
1979	294,000	162,468	107,724	29.1	31.8
1980	373,000	252,337	161,226	23.8	28.4

TABLE 12

Four Hypothetical Models of Crude Birth Rate Decline  
1978-1998

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
1978	37.0	37.0	37.0	37.0
1979	35.9	36.1	36.4	36.7
1980	34.8	35.3	35.8	36.3
1981	33.7	34.5	35.2	35.9
1982	32.6	33.6	34.6	35.6
1983	31.5	32.7	34.0	35.3
1984	30.4	31.9	33.4	34.9
1985	29.3	31.1	32.8	34.6
1986	28.2	30.2	32.2	34.2
1987	27.1	29.3	31.6	33.9
1988	26.0	28.5	31.0	33.5
1989	24.9	27.7	30.4	33.1
1990	23.8	26.8	29.8	32.8
1991	22.7	25.9	29.2	32.5
1992	21.6	25.1	28.6	32.1
1993	20.5	24.3	28.0	31.7
1994	19.4	23.4	27.4	31.4
1995	18.3	22.5	26.8	31.1
1996	17.2	21.7	26.2	30.7
1997	16.1	20.9	25.6	30.3
1998	15.0	20.0	25.0	30.0

TABLE 13

Haiti: Number of New Acceptors (1000's) Required, 1978-1997  
 Four Models of Fertility Decline, TABRAP Model

1998 CBR Target:	<u>1</u> 15.0	<u>2</u> 20.0	<u>3</u> 25.0	<u>4</u> 30.0
<u>Year</u>				
1978	27	16	0	0
1979	106	88	76	64
1980	111	87	66	45
1981	155	130	101	71
1982	183	151	115	79
1983	218	175	137	98
1984	249	200	154	102
1985	288	236	179	127
1986	325	266	202	134
1987	365	295	228	139
1988	385	309	233	145
1989	398	323	237	150
1990	407	325	236	148
1991	470	371	274	178
1992	508	401	294	190
1993	550	439	315	192
1994	594	473	339	206
1995	641	505	365	227
1996	689	544	393	243
1997	738	589	423	256

TABLE 14

Haiti: Number of Active Users of Contraception Required,  
1978-1997, Four Models of Fertility Decline, TABRAP Model

1998 CBR Target:	<u>1</u> <u>15.0</u>	<u>2</u> <u>20.0</u>	<u>3</u> <u>25.0</u>	<u>4</u> <u>30.0</u>
<u>Year</u>				
1978	20	20	20	20
1979	20	16	11	5
1980	48	40	33	25
1981	65	52	41	29
1982	90	74	57	41
1983	112	93	71	50
1984	137	111	86	61
1985	161	130	101	68
1986	187	153	112	76
1987	201	164	123	83
1988	215	175	134	91
1989	214	171	129	86
1990	254	205	152	99
1991	278	223	164	105
1992	313	249	183	118
1993	345	274	201	130
1994	377	300	218	137
1995	409	325	235	145
1996	442	350	253	157
1997	476	377	273	169

TABLE 15

Haiti: Total Population, Dependency Ratio and Rate of Natural Increase  
1978, 1988, and 1998, Four Models of Fertility Decline, TABRAP Model

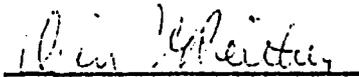
Fertility Decline CBR 1998 =	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<u>Total Population (1000's)</u>	<u>15.0</u>	<u>20.0</u>	<u>25.0</u>	<u>30.0</u>
1978	5,720	5,720	5,720	5,720
1988	6,939	7,017	7,095	7,176
1998	7,419	7,575	8,100	8,491
<u>Dependency Ratio*</u>				
1978	66	66	66	66
1988	56	57	59	61
1998	37	43	49	55
<u>Rate of Natural Increase**</u>				
1978	2.1	2.1	2.1	2.1
1988	1.2	1.4	1.7	1.9
1998	0.2	0.6	1.1	1.6

\*(Population  $\leq 15 \div$  Population  $15+$  ) X 100

\*\*Projections assume no change in death rates,  $e_0 = 50$

USAID/HAITI CERTIFICATION OF 25% CONTRIBUTION  
BY THE GOVERNMENT OF HAITI

Based upon the analysis of the overall GOH contribution to the Public Health and Population sector (described in section III E, Institutional Analysis) and based upon revisions in the Summary Budget of GOH contributions (ANNEX B), USAID/Haiti certifies that the Government of Haiti fulfills the statutory requirement of a 25% contribution to the total cost of this project. By eliminating the line item "Duty Free Import Privileges" as an attributed element of the GOH contribution, the total life of project cost is revised to \$10,672,000, and the GOH component of that cost is revised to \$3,157,000, or 29.6% of the Total cost.



Edwin T. McKeithen  
Population Officer



Parke Massey  
Assistant USAID Director

## STATUTORY CHECKLISTS

COUNTRY CHECKLISTA. GENERAL CRITERIA FOR COUNTRY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights?
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?
3. FAA Sec. 620(a). Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargoes to or from Cuba?
4. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?
5. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?
6. FAA Sec. 620(e) (1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?
- All AID projects in Haiti are aimed at the rural poor majority who comprise 95% of the population and whose average per capita income is less than \$100 per year. The Department of State has not determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights.
- Haiti's law regulating the use & control of narcotic drugs was signed on December 8, 1975. It provides stiff penalties for use & distribution of illegal drugs & Haiti cooperates with the U.S. controlling drug traffic.
- No
- Yes
- There is no evidence that Haiti is so indebted.
- There is no evidence that Haiti has taken such actions.

A

7. FAA Sec. 620(f); App. Sec. 108. Is recipient country a Communist country? Will assistance be provided to the Democratic Republic of Vietnam (North Vietnam), South Vietnam, Cambodia or Laos? No
8. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No
9. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property? There are no incidences of such action in recent years.
10. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? An investment guaranty agreement with Haiti is in effect.
11. FAA Sec. 620(o); Fishermen's Protective Act, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters, Haiti has taken no such action.
- a. has any deduction required by Fishermen's Protective Act been made? Not applicable.
- b. has complete denial of assistance been considered by AID Administrator? Not applicable.
12. FAA Sec. 620(o); App. Sec. 504. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default? a) Since rescheduling debts in 1970, Haiti has been current.  
b) No
13. FAA Sec. 620(s). What percentage of country budget is for military expenditures? How much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems? (Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RC).) 10. 8.7% of the \$106 million budget in FY 76<sup>1977</sup> is budgeted for the armed forces. No equipment breakdown is provided, but most of this sum is for administration. No sophisticated weapons are procured. We are not aware of PL 480 sales or development assistance funds having been used to cover military expenses.

A

14. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

15. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

The U.N. treasurer informed the U.S. delegation to the U.N. on August 29, 1975 that Haiti had made payments which removed the possibility that the country might lose its vote in the General Assembly because of arrears in its contributions. Haiti is continuing its voting rights and is being granted continued U.N. assistance.

16. FAA Sec. 620A: Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No

17. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

No

18. FAA Sec. 669. Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements on safeguards, etc.?

No

19. FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate?

No

B. FUNDING CRITERIA FOR COUNTRY

1. Development Assistance Country Criteria

a. FAA Sec. 102(c), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

b. FAA Sec. 201(b)(5), (7) & (8); Sec. 208; 211(a)(4), (7). Describe extent to which country is:

- (1) Making appropriate efforts to increase food production and improve means for food storage and distribution.
- (2) Creating a favorable climate for foreign and domestic private enterprise and investment.

B.1.a. With the assistance of AID & other donor the GOH is developing programs with measurable objectives in the fields of agriculture, health nutrition & population. Most of these programs are rural based.

b.(1) The GOH allocated 34% of its 1977 annual development budget to agriculture and assigned a high priority to agriculture development. Within its limited resources and with external assistance the GOH is increasingly providing extension and credit services to farmers and is undertaking resources to improve production and marketing.

(2) The GOH has taken a number of steps to create a favorable investment climate passing legislation to provide incentive for foreign and domestic investment, establishing a special office to facilitate investment, and encouraging and cooperating with private enterprise. With US assistance a study is being undertaken for expanding capital markets and domestic investment and enterprise through a proposed Development Finance Cooperation project.

- (3) Increasing the public's role in the developmental process.
- (4) (a) Allocating available budgetary resources to development.  
(b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.

- 3) An objective of this project is of local personnel in actual delivery of health services (agents sanitaires).
- 4) The GOH's development budget for 1976-77 is \$43.8 million. The is 8.6% larger than the amount allocated for 1975-76.

- (5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.

4.b) The budget for the department of Interior & National Defense is the largest of the operating ministries. However, included in the total are police, fire protection and other non-military costs. There has been no intervention in affairs of other nations.

- (6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

5) The GOH has established its intent to undertake reforms in public administration and fiscal management and has requested assistance from AID through an Administrative Improvement Project. Haiti is receiving or has requested assistance from external sources in these and in the special areas. Haiti has a much more open society now than it had several years ago, as evidenced by the recent return of many citizens to the country

c. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

6.c) Development assistance loans and grants were made until approximately mid-FY77, when it was determined that all future projects would be grant financed in accordance with decisions taken at UNCTAD IV concerning the least developed countries.

d. FAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?

d) No

2. Security Supporting Assistance Country Criteria

2 (a-c) Not applicable.

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

PROJECT CHECKLIST

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project;  
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure plus 10%)?

(a) Congressional Notification sent forward from POP/LA on 6 December, 1977.  
(b) No. \$975,000 instead of \$850,000.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

N.A.

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?

N.A.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

N.A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?

No Haiti is not a new independent country

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

N.A.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. private enterprise will be source for goods and services.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The GOH contribution is \$3.1 million specified under the terms of the grant for specific features of the project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No.

#### B. FUNDING CRITERIA FOR PROJECT

##### 1. Development Assistance Project Criteria

N/A

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

N.A.

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

The project will create new rural health care posts, called dispensaries, and new rural health workers, called sanitary agents.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

N/A

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

N/A

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

N.A.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

Will be included in ProAg

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

N.A.

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

U.S. assistance in Haiti and elsewhere places emphasis on encouraging economic, social and political institutions required for a viable democratic society. One purpose of the project is to develop and strengthen the administrative and technical capabilities of the DHF, part of the DSPP of the GOH. Another purpose will be to produce the basis for improving trained health manpower in the country. Particular attention will be given to using women as "agents of change" and deliverers of health and family planning services.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

One important goal of this program is to increase the flow of resources to rural areas concerned for increased economic and social benefits. This program is looking to appropriate governmental agencies to provide trained personnel and essential services.

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

Project paper contains economic and social analysis. While there is no accepted formula which demonstrate direct production (or economic) response to use of contraceptives, such a relationship is generally assumed. This project is necessary to the success of other development efforts in Haiti.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

No adverse effect on U.S. balance of payments position is expected.

2. Development Assistance Project Criteria (Loans only)

N.A.

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability?

N.A.

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

The positive steps taken by the GOH in increasing its annual development budget for economic and social benefits for the Haitian population through increased emphasis on public health, nutrition and assisting small farmer development and poor rural population is encouraging. Not applicable.

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

N.A.

STANDARD ITEM CHECKLIST

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? Yes
  
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? Yes
  
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed? Yes
  
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? Not applicable.
  
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? Yes
  
6. MMA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. Yes
  
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized, Yes

are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

Not applicable.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Yes

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

Not applicable

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

Not applicable

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

Not applicable

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?

Yes

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?

Yes

5. Will arrangements preclude use of financing:
- a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions? Yes
  - b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property? Yes
  - c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs? Yes
  - d. FAA Sec. 662. for CIA activities? Yes
  - e. App. Sec. 103. to pay pensions, etc., for military personnel? Yes
  - f. App. Sec. 106. to pay U.N. assessments? Yes
  - g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes
  - h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

Initial Environmental Examination

Project Location: Haiti

Project Title: Maternal Child Health/Family Planning II

Funding: \$1,775,000

Life of Project: 3 years

IEE Prepared by:

Date: November 8, 1977

Recommended Threshold Decision:  
Negative Determination (See Part IV)

Mission Director's Concurrence:  
Larry R. Harrison, Director (Signed on last page)

Assistant Administrator Latin America Decision:

Date:

Recommendation Approved:

Recommendation Disapproved:

## Description of the Program

Overpopulation is a serious problem in Haiti. The population almost doubled in 40 years, growing from 2.12 million 1920 to over 4 million in 1960.<sup>1/</sup> The 1971 census showed a population of 4,314,628.<sup>2/</sup> The Haitian Institute of Statistics estimates the 1976 population at 4,668,124, implying a net population growth rate of 1.6% between 1971 and 1976. However, current demographic data, as shown in Table 1 on p. 10 of this paper indicates that the natural population growth rate is approximately 2.2% per year, implying a population of about 8,000,000 in the year of 2000.

The goals addressed by this program are to reduce maternal and infant mortality rates from their current high levels and to prevent an increase in the population growth rate. The purposes are to make family planning services available to over 90% of Haiti's population, to increase the number of active contraceptors, and to provide prenatal care, child screening, and immunizations.

The geographic and climatologic settings of the communities where the program will operate vary greatly. The population density of Haiti is among the highest in the world (448/sq.km.)<sup>1/</sup> and arable land per capita is very small, only 44 acres per capita. By preventing births, this program will alleviate the pressures on Haiti's arable land. These pressures have taken the form of intensive farming on increasingly steep hillsides. The result of such cultivation has been a vicious circle of poor farming techniques leading to erosion, leading to use of more marginal land, etc.

No part of this program will lead to further degradation of the environment, as detailed below.

### I. Impact Identification and Evaluation

<u>A. Land Use:</u>	<u>Environmental Impact</u>
1. Changing the character of the land through	
a. Increasing the population	None
b. Extracting natural resources	None
c. Land clearing	Little
d. Changing soils character	Little
2. Altering natural defenses	None
3. Foreclosing important uses	None

<sup>1/</sup> Britannica Atlas, Chicago: William Benton, Publisher 1970  
<sup>2/</sup> FAO Production Yearbook, 1976.

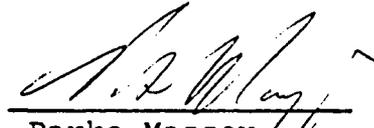
	<u>Environmental Impact</u>
4. Jeopardizing man or his works	None
B. <u>Water Quality:</u>	
1. Physical State of Water	None
2. Chemical and biological states	None
3. Ecological balance	None
C. <u>Atmospheric:</u>	
1. Air Additives	None
2. Air pollution	None
3. Noise pollution	None
D. <u>Natural Resources:</u>	
1. Diversion, altered use of water	None
2. Irreversible, inefficient commitments	None
E. <u>Cultural:</u>	
1. Altering physical symbols	None
2. Changes in cultural patterns	Little
F. <u>Socioeconomic:</u>	
1. Changes in economic/employment patterns	Little
2. Changes in population	Little
G. <u>Health</u>	
1. Changing a natural environment	Little
2. Eliminating an ecosystem element	None
3. Eliminating deleterious conditions	Little
H. <u>General</u>	
1. International impacts	None
2. Controversial impacts	None
3. Larger program impacts	Little

## II. Discussion of Impacts

In the short run, the project will have very little impact on the environment, but it will have an effect on cultural patterns in the area of Human Reproduction and Maternal and Child Health. Over a ten to twenty-year period, it will have a salutary effect on the economy and employment patterns. Also, the current population growth of 2.2% annually should progressively decline, thus having a positive impact on other AID-sponsored projects in Haiti.

## III. Conclusions and Recommendations for Threshold Decision:

From the description of the project and the foregoing identification and evaluation of its expected impacts, it is concluded that the project will not have a significant effect on the environment. A negative determination is therefore recommended.



Parke Massey  
Assistant Director  
USAID/Haiti

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																																				
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Reduce maternal and child mortality and morbidity</p> <p>Prevent increase in population growth rate</p>	<p>Measures of Goal Achievement:</p> <p>Infant mortality rate reduced from 136/1000</p> <p>Maternal mortality rate reduced from 13.7/1000</p> <p>Natural Population Growth Rate remains at or below 2.2%</p>	<p>Reports from Haitian Statistics Institute</p>	<p>Assumptions for achieving goal targets:</p>																																				
<p>Project Purpose:</p> <p>1. Make family planning services available to over 90% of Haiti's population by the end of 1980.</p> <p>2. Increase # active contraceptive users in Haiti</p> <p>3. Provide prenatal care to 75% pregnant women in program area</p> <p>4. Screen 80% 0-5 yr. children in program area.</p> <p>5. Immunize 80% 0-5 yr. children w/tetanus BCG, DPT, Polio</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>1. Clinics, dispensaries, sanitary agents, matrones, etc., in place and serving following populations at end of year indicated.</p> <table border="1" data-bbox="714 807 1046 925"> <thead> <tr> <th></th> <th>CY 78</th> <th>CY 79</th> <th>CY 80</th> </tr> </thead> <tbody> <tr> <td>POP covered (000's)</td> <td>2,800</td> <td>3,600</td> <td>4,500</td> </tr> <tr> <td>%</td> <td>58%</td> <td>74%</td> <td>91%</td> </tr> </tbody> </table> <table border="1" data-bbox="663 980 1056 1332"> <thead> <tr> <th></th> <th>CY 78</th> <th>CY 79</th> <th>CY 80</th> </tr> </thead> <tbody> <tr> <td>2 women</td> <td>45,000</td> <td>40,500</td> <td>51,000</td> </tr> <tr> <td>men</td> <td>98,000</td> <td>144,500</td> <td>185,500</td> </tr> <tr> <td>3 1/2</td> <td>56,250 29% total</td> <td>67,050 34% total</td> <td>NA</td> </tr> <tr> <td>4 1/2</td> <td>300,000 31% total</td> <td>357,600 36.4% total</td> <td>NA</td> </tr> <tr> <td>5 1/2</td> <td>786,990 80% total</td> <td>NA</td> <td>NA</td> </tr> </tbody> </table> <p>1/ Service projections limited to areas covered by urban clinics</p>		CY 78	CY 79	CY 80	POP covered (000's)	2,800	3,600	4,500	%	58%	74%	91%		CY 78	CY 79	CY 80	2 women	45,000	40,500	51,000	men	98,000	144,500	185,500	3 1/2	56,250 29% total	67,050 34% total	NA	4 1/2	300,000 31% total	357,600 36.4% total	NA	5 1/2	786,990 80% total	NA	NA	<p>1. Quarterly and Annual Reports from DHF.</p> <p>2. Program monitoring by donor representatives</p> <p>2-5 DHF, Quarterly and Annual Reports</p>	<p>Assumptions for achieving purpose:</p> <p>If maternal and child Health and Family Planning services are made available, 20% of Haitian couples will accept family planning</p>
	CY 78	CY 79	CY 80																																				
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PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of project: \_\_\_\_\_ to FY 80  
 From FY 78 \_\_\_\_\_ to FY 80  
 Total U.S. Funding 3,875  
 Date Prepared: 31 OCT 1977

Project Title & Number: Maternal Child Health/Family Planning II #521-0097

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	Magnitude of Outputs:				Assumptions for achieving outputs:
<u>Curative Service and Supply outlets</u> <u>in place and providing contraception:</u>	CY 78	CY 79	CY 80	DHIF quarterly and annual reports  Project monitoring by donor representatives	
1. OSPP fixed clinics/satellites	22/88	22/88	22/88		
2. Private fixed clinics	6	8	10		
3. Mobile units	2	4	6		
4. OSPP dispensaries	50	85	120		
5. ODA dispensaries	35	50	50		
6. Child Nutrition Centers	40	60	65		
7. Matrones	3,000	4,500	6,000		
8. Voluntary Surgical Contraception clinics	3	5	7		
9. Household Distribution Project	3	3	3		
10. Condom Vending Machines	150	150	150		
11. Armed Forces Network	NA	NA	NA		
12. Community orgs, corps, men's groups	100	150	200		
13. Action Familiale (Sympto-thermal)	5	5	5		
<u>Annual #'s Personnel Trained:</u>					
14. MD's OMIFA fellowships	8	2*	1*		
Voluntary Surgical Contraception	22	33	36		
15. Auxiliary nurses (seminars)	95	140	170		
16. Sanitary Agents	200	200	140		
17. Matrones	1,500	1,500	1,500		
18. Guerisseurs	30	30*	30*		
19. Chefs de Section	--	250	250		
<u>Annual Supervision Activities</u>					
20. Trips by Nat'l and Selective team	35	35	35		
Trips by District team to P-au-Prince	120	120	120		
21. By District team of Dispensaries (days)	1,800	1,800	1,800		
22. Matrones					
# matrones attend-no. session	1,500	3,000	4,500		
# supervisor visits matrone	118	118	118		
23. Nat'l Supervision of matrone training-# visits	80	80*	80*		
24. District contraceptive depots renovated	0	10	0		
25. Central Warehouse Renovated	1	0	0		
<u>I, E, C Annual Activities</u>					
26. Radio programs broadcast	5,000*	6,000*	6,000*		
27. Newspaper articles published	60*	75*	60*		
28. Seminars for opinion leaders, policy makers, ag. extension agents, etc. held	20	25	20		

Press clippings

\* AID estimate

	1978	1979	1980	All years		Assumptions for providing inputs:
AID: Central Funding: contraceptives	\$ 495,000	\$ 725,000	\$ 880,000	\$ 2,100,000		
Orals (\$23,000)		Orals (240,000)	Orals (260,000)			
Condoms (\$372,000)		Condoms (345,000)	Condoms (320,000)			
AID: Bilateral total	\$ 480,000	\$ 675,000	\$ 620,000	1,775,000	Budget in Section III A.	
Sanitary Agent Development	(87,908)	(91,100)	(60,104)			
Aux. Nurse & Dispensary Development	(174,535)	(258,200)	(247,011)			
Voluntary Surgical Contraception	(26,300)	(86,500)	(103,900)			
National Supervision & Support	(70,158)	(56,614)	(40,360)			
Mobile Units & Personnel	(25,760)	(52,160)	(43,500)			
I. E. and C	(79,279)	(119,130)	(106,235)			
Contingency	(3.2%) (15,000)	(1.6%) (11,912)	(2.7%) (10,863)			
COH: TOTAL	\$ 1,149,000*	\$ 1,212,000*	\$ 1,277,000*	3,638,000*	Budget in Annexes	Salary reform does not occur
Personnel	(684,000)	(684,000)	(684,000)			
Space	(224,000)	(243,000)	(267,000)			
Duty free Import Privileges	(145,000)	(160,000)	(176,000)			
Cash Contribution to DHF	(50,000)	(75,000)	(100,000)			
Auxiliary Nurse Training	(50,000)	(50,000)	(50,000)			
UNFFA: TOTAL	\$ 1,215,200	\$ 1,019,282*	\$ 527,000*	3,057,200*	Budget in Annexes	Salary supplement issue settled so that employees stay on the job in the afternoon-budget assumes 75% supplement 1978, 50% supplement 1979, 25% supplement 1980.
Personnel	(578,674)	(381,782)	(197,692)			
Sub-contracts and Grants	(62,870)	(13,500)	(15,000)			
Training	(40,800)	(24,000)	(15,000)			
Equipment	(379,766)	(500,000)	(500,000)			
Miscellaneous	(153,160)	(100,000)	(100,000)			
IAFPELLI: TOTAL	\$ 75,000	\$ 93,000*	\$ 111,000*	279,000*	Budget in Annexes	Continuing AID approval of project
Matrones training and supervision	(40,000)	(50,000)	(70,000)			
Community Council Development	(35,000)	(35,000)	(35,000)			
COLUMBIA UNIVERSITY:						
Household Distribution Project	\$ 38,256	\$ 67,686	\$ 69,315	175,257	Budget in Annexes	
DEVELOPMENT ASSOCIATES, INC.: TOTAL	20,160	22,176*	24,384*	66,730*	Budget in Annexes	Guerrisseur Training successful and continued; continuing AID approval of project
Healer Training	(11,100)	(12,210)	(13,431)			
Auxiliary Seminars	(4,000)	(4,400)	(4,840)			
Mat'l Matrone Supervision	(4,100)	(4,510)	(4,961)			
St Overhead	(900)	(1,056)	(1,162)			
IPPF:						
Condom Vending Machine Program	\$ 15,500	\$ 7,500	\$ 10,000*	33,000*	Budget in Annexes	Continuing AID approval for project
PFIA:						
Voluntary Surgical Contraception	\$ 28,709	---	---	28,709	Budget in Annexes	
GRAND TOTALS	\$ 3,516,915	\$ 3,821,644	\$ 3,814,401	\$ 11,152,960		

Let's see  
the  
Supplies  
inputs