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CONSULTATION AND TECHNICAL ASSISTANCE

HAITI

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I. SCOPE OF WORK

The consultants were in Haiti from January 13-January 26, 1979 for the purpose of evaluating the USAID/Haiti Project #0071, and making technical recommendations and an evaluation plan for the follow-up program. The purpose of the visit was communicated via an AID/APHA memo of December 21, 1978; during a meeting on January 12 in Washington with Bill Blair, Dave Denman, Moira Brackett, King Morgan and Suzie Olds; and in a letter from Win McKeithen delivered upon arrival in Port-au-Prince.

The task assignment as per the Denman/APHA memo included:

1. Evaluate Project 0071 in USAID/Haiti.
2. Make technical recommendations for follow up on Project 0087 (PES Format).
3. Make evaluation design for Project 0087. Special issues: coordination and interrelationship of USAID project with that of other donors, possible research for improvement of family planning service delivery, and identification of administrative bottlenecks to contraceptive distribution.

During the Washington meeting of January 12 the Haiti Desk (via Moira Brackett) made particular mention of the need to examine efforts for "motivating" clients; the PAHO Representative and AID wished a careful look at the Community-Based Distribution Project and the potential for commercial distribution; and AID expressed a need to look at how the logistical system (Strengthening Health and Rural Health Projects) is being piggy-backed onto Family Planning. The point was stressed by all present that the consultants should look to the local mission for their priorities during the visit.

Upon arrival in Port-au-Prince Win McKeithen handed the consultants copies of a letter outlining the local mission's priorities as follows:

1. Routine need for end-of-project evaluation of 0071.
2. Prepare evaluation plan for 0087; look at progress to date.
3. "Most importantly, even if it means not being able to complete above..." the letter requested:
 - * for each of 12 different types of sources of family planning determine contraceptive distribution per client visit for new and continuing clients for orals, condoms and foam, and determine quantities distributed for as many individual outlets as possible within each type of source (over 500 plus 2500 matrones);
 - * identify limiting factors, list suggestions, and how they can be carried out.

Individuals contacted and documents reviewed for this evaluation are listed in Appendices A and B.

This draft was reviewed by USAID/Haiti and comments and questions regarding various findings were forwarded to the consultants. Appendix C presents the mission comments and the consultant's replies. Corrections were made in the body of the report as applicable.

II. EVALUATION OF PROJECT 0087

The purpose of this Section is to summarize the current situation as background for the Recommended Evaluation Plan. Before proceeding to a summary of Program Components the Report draws attention to issues which were either of special interest to AID personnel or came to dominate the consultant's findings during the visit:

- * Contraceptive Distribution
- * Definition of Indicators and Measures for the End of Project Status
- * The Public Health Department's move toward Integration, Decentralization and Outreach
- * Future Direction of MCH/FP
- * Inter-Agency Coordination

In the next Section, these issues are dealt with in the body of the report rather than being highlighted at the beginning as they are here.

A. Special Issues

1. Contraceptive Distribution

The consultants wish to stress that while continuous examination and improvement of distribution is imperative, if any modifications in distribution are to be effective, the organizational issues outlined below in #3 must be equally scrutinized and resolved.

a. Policy for Distribution

- * Pills: Initiated only by doctors and nurses, including Nurse Auxiliaries with proper orientation/training; one-month supply issued at initial visit with two return visits required after one and two months; resupply of three-month packets assumed by Community and Health Agents; no return visits required after initial one-month supply when resupply assumed by Health Agents in at least one (Cap) Region, who give three-month packets.
- * Foam and Condoms: Initiated by any level of personnel (Medical, Community and Health Agents, Matrons, etc.); number of condoms per visit based on assumption that male clients seek monthly supplies, generally determined to distribution point; sampling of distribution records varied from 12 to 80; foam upon request with general opinion that it lasts about three months; initiation of foam considered interim until client makes visit to clinic where client may adopt more effective method.

b. Practice vs. Policy

In the few distribution points visited, policy was generally followed with exceptions made for pill clients who demonstrate an obvious familiarity or conversely, had problems with correct use. The consultants encountered no instance of routine monthly distribution of pills as was apparently found by local AID Mission at Thomazeau and Fond Parisien; inquiries indicated three-month supply -- perhaps confusion caused by fact that one envelope contains three cycles.

c. Variation Among Types of Sources

Division policy must be followed in 22 centers and 88 satellite clinics as well as any clinic formally recognized and supported by the Division including dispensaries, nutrition centers, factory programs and private clinics; the MCH/FP Policy Manual is furnished to all of these outlets.

d. Underlying Hypothesis Regarding Bottlenecks

The focus on possible administrative bottlenecks in supply distribution has resulted in large part from linking the current overabundance of pills and condoms with a client volume which has fallen short of original estimates, i.e., a hypothesis has been made that over-supplies have resulted from policies and practices which permit a distribution of only small quantities of contraceptives to clients.

This hypothesis must be carried one step further: if supplies could be distributed in larger quantities to each client, the sudden increase in flow would eventually ebb unless there was a corresponding increase in clients to sustain the flow, i.e., if the proliferation of supplies results from a bottleneck which has provoked drop-outs of active clients and discouraged potential clients, further causing oversupplies in geometric fashion, opening up distribution would not only result in an initial large movement of supplies to existing clients but would stimulate growth in the client load.

Although the hypothesis could be questioned because oversupply and a lower client volume than projected for 0087 could each stem from many other factors, the immediate problem is that a decision must be made before the upcoming evaluation regarding shipments of contraceptives during 1979; apparently there is no space left for storing pills or condoms either in Port-au-Prince or the districts and if no shipments were forthcoming during 1979 current supplies would carry the program through to the end of the year.

The consultants recommend an immediate analysis of:

- * original projections of total clients, anticipated pattern of method use, and estimates of needed supplies (by type)

- * actual client visits over the past few years, current method choice and schedule of shipments received and expected, for 1978-79
- * readjustment of supplies

N.B. *** REFER TO PES OF PROJECT 0071, SECTION 19 GOAL/SUBGOAL WHICH COMPARES ACTUALS AND PROJECTED FOR CY77.

Whatever the cause of oversupply or the lower number of clients, there are many aspects of distribution susceptible to improvement: these are outlined in the next part of this report: Evaluation Plan.

2. Program Indicators and Measures

The Project Purpose variously refers to Availability, Accessibility, Acceptors, Active Users, Couple-Acceptors, Continuing Users, etc. and relies on uniform targets of 50,000 and 25,000 in reference to population base. Examples of confusion regarding this terminology are evident in the PES for 0071 and further illustrations include:

- * Availability - the Project refers to 90 percent of the population having access to services, seemingly referring to physical location of services; how shall this be measured?
- * Active Contraceptive Users - will both men and women be equally counted? Does Active Client mean a visit within a 12-month period or longer? How about women contracepting outside the clinic system (e.g., IUD users) but not coming to the clinic? Would male users be only those obtaining condoms in a clinic system? Does active male count mean cumulative numbers of male acceptors?
- * Acceptor - does male acceptor mean first time as user for that particular outlet? (He may be counted as acceptor several times by different sources); how or why must unduplicated male counts be taken?
- * Couples Accepting - how many women does a male contraceptive protect? Is each individual male or female counted as one couple? How can the Project count those not currently in the system? Must all distribution points be statistically controlled through the Project?
- * 50,000 and 25,000 Population Base - does this take population density into consideration for each site?

Currently these terms are not well defined and it is difficult to measure progress toward goals. In the future, as the family planning delivery system reaches out beyond the traditional clinic system and utilizes community structures to promote and distribute non-medical methods it will become increasingly difficult to statistically control continuing users so that the Project should differentiate among targets by outlet.

In the next part of this report the consultants make recommendations concerning information collection, program indicators, measures, etc.

3. Status of the Department of Public Health (DSPP): Integration, Decentralization and Outreach to Rural Area

When in 1972 donor agencies decided to fund MCH/FP activities directly through the Division of Family Hygiene there followed several years of intense institutional development for this categorical program described on page 84 of the 0087 Project Paper: advanced education and short-term training for health manpower, formalized training for such traditional personnel as village midwives and herb doctors, creation of new categories of workers, centralized management information system, proliferation of norms and standards for service delivery and personnel performance, and national extension of MCH/FP services in 1975-76 through systematic training, clinic expansion and multidisciplinary team visits. These activities have been supported by ample supplies, consummables, vehicles and other materials, and led by a highly prepared cadre of professionals and para-professionals, now experienced in breaking new ground, accustomed to field work, and knowledgeable about the realities of bringing preventive health to Haiti's rural and urban population alike.

In sum, the Division has become an anomaly of sorts both within the DSPP and in the development sector of Haiti. The rest of the Department has benefited very little from such resources and must now be strengthened to assume its proper function in which the Division would be but one of the several health service Divisions. Absolutely vital to this shift is a very carefully planned transfer of responsibility so that the vast resources of the Division are utilized to ensure a speedy and effective effort. As specified in the Project Paper the Division was seen as taking a leading role in developing a model of service that would ultimately be adopted by the Department.

At present, this transition period has been defined in general terms. However, the consultants encountered several indications that the Division has not in fact been authorized to "play a leading role in development" of various aspects of the health system, but has followed the lead of the Department in a reversal of roles which was not taken into account when family planning goals and objectives were formulated for Project 0087 and 0071. The consultants see the need for a more detailed plan for transition of responsibilities and authority agreed upon by all parties if the family planning effort in Haiti is to proceed with as few impediments as possible during this time of flux.

a. Integration

Since 1973 selected clinic staff have been trained, oriented and supervised to perform MCH/FP duties in-house and in mobile clinics during a specified (afternoon) time period. UNFPA decided to reduce the supplemental salaries of MCH/FP clinic teams in 1978 and the Division had to determine how remaining supplements would be distributed. Apparently the Division anticipated integration --

when categorical programs would become incorporated into a single national health delivery system -- and the DHF Director has expressed support of such an approach. At the same time, AID pointed out this problematic situation -- mentioned on page 6 of the PROP 0087 -- and expressed its intention of covering the salary supplement gap using PL-480 Title I local currency.

In view of the current hold-up of these funds to the DSPP it is difficult to question the DHF decision to allocate total salary supplements for each district to be divided among all MCH/FP-related personnel, reverting to the same morning working hours as all DSPP staff. However, integration has had a negative impact in the absence of additional resources whether directly from AID or through the DSPP for general salary increases and strengthened management: there remain inequities of salaries as DSPP makes changes in staff size regardless of the fixed total supplement in each district, and there is yet no capability within the department to back up the Division's supervision and otherwise offset the Division's loss of control over separately paid staff.

Integration to date has apparently meant integrated salary, clinic hours, and personnel without integration at the Department level in philosophy, planning, implementation and supervision.

b. Decentralization (Regionalization)

Increasingly, the responsibility for supervision and implementation of health services rests with District Administrators and ultimately Regional Chiefs when Regionalization reduces the number of Districts. The process of delegating responsibility without yet infusing the Department with significant increases in resources to strengthen weak districts and alleviate chronic shortage of supplies has a negative impact on the Division. Back up and support for supervision and implementation must come from Districts or Regions; they in turn are responsible not to the Division or any other categorical program, but to the Director General who is also the Administrator of the Port-au-Prince District. The result is further diffusion of responsibility for ensuring progress toward MCH/FP objectives. To date, other than a shift of responsibility there is no assurance built into the system that District Chiefs will follow up on Division recommendations following supervisory visits. As a point of fact, many District Administrators are highly conscientious and effective of their own accord due to the particular personalities of each; a recent replacement of one skilled and highly trained Administrator points out the weakness of depending upon an individual as opposed to a system.

c. Outreach (Extension)

Much of the FP effort over the past two-and-a-half years, since the joint donor agency meeting in 1976, has been tied to the extension of health services beyond basic health centers, and in particular the development of a new level of health personnel, the Health Agent (Agent de Sante or Agent Sanitaire).

Due to the considerable emphasis on the Health Agent as the future hope for maximizing family planning service delivery within the health system by Outreach to rural areas, the consultants wish to provide an extensive review of the current situation which if ignored could cause this valuable component to fall far short of its vision.

One obstacle stems from an approach toward manpower development which is unfortunately shared by many family planning programs worldwide: training is equated to Human Resource Development with the result that insufficient attention is given to the other critical aspects of developing workers, new ones in particular. The essential prerequisite for development of human resources is a well-defined and documented vision based on realistic expectations of worker performance; from this evolves development: detailed task analysis, performance standards, requisite skills, qualifications for selection of workers, job descriptions, work protocols, training programs integrally related to previously defined skill needs, and a supervision and support system. This prerequisite is only sporadically and partially fulfilled at the moment in the Rural Outreach effort.

In mid-1976 the Division initiated developmental activities for the Rural Health Agent, an appropriate assignment in view of its experience in creating other para-professionals (community agents, lay midwives, etc.) and in opening up services in rural areas; but not particularly an appropriate function from an organizational point of view. Detailed tasks and necessary tools for deployment of agents were drafted and a pilot training program carried out for ODVA which would further contribute to evolution of the overall Health Agent development.

Before the end of 1976 the Department delegated authority and responsibility for development of the Health Agents as well as their ultimate supervision and support system to the Bureau of Nursing and the Office of Para-medical Training; the Division was to continue the actual training without responsibility or authority for finalizing tasks, skills, work protocols and procedures, etc. although their input into this process was to continue.

In this transfer of authority over developmental aspects of the Health Agent effort there appears to be a considerable weakening of the effort to create a rural para-medical component through which MCH/FP would be delivered. The focus of authority at present is in the Office of Planning, with technical assistance from the Bureau of Nursing and Office of Para-medical Training, who have received relatively little in the way of resources to enhance their capabilities. In over two years the Department has published only the administrative manual for use of the agents without yet issuing an approved set of specific activities and tasks and treatment protocols, so crucial to effective training and appropriate supervision and evaluation. Nor has a support system evolved except as a well-described plan, to deploy agents, supply them with necessary equipment, and ensure sufficient supervision and evaluation.

The Evaluation Team will have to pinpoint the problem further but it seems to be threefold:

- * separation out of the Training function from overall Human Resource Development, so that those who most heavily influence the formation of agents have little control over official definition of their role or with their placement, performance and evaluation; and those who do have such control have little to do with their training;
- * delegation of training responsibilities to a stronger, more experienced staff than those responsible for overall development and support structure, with the result that detailed work protocols, materials, direction and supervision have not kept pace with the production of trained agents;
- * assignment of implementation authority to a Planning Office.

The above analysis is based on several incidents which came to the attention of the consultants and include the following:

- * In order to train agents, train trainers, and develop model curriculum, the Division has established components of a system which subsequently must give way as Department-approved instruments, tools, etc. become finalized: during the consultants' visit the Planning Office held a two-day meeting with Health District Administrators on the topic of Health Agent supervision; reporting forms developed by the Division for several hundred agents trained or in training over the past two years, were scrapped as "too complicated" and a revised system recommended.
- * The timetable of the Health Agent ODVA project was delayed when the Division initiated plans for the second group and the Department would not proceed until the first group had been evaluated. Although a good idea, no evaluation was ever forthcoming and three months later the Division again requested -- and this time received -- permission to proceed with their training.
- * Many agents who completed training had to wait several months to assume their posts, some had to be re-trained, and others worked several months without salaries because the support system of physical facilities, qualified auxiliaries for supervision, non-family planning supplies, approval for payroll and receipt of salaries as well as other support activities had not materialized.
- * Most Health Agents are currently working without their professional materials other than MCH/FP supplies and with minimal or no supervision. This has undermined the reputation of the Health Agents in their areas due to the considerable gap between expectations and reality regarding their role, both on the part of the community and the workers. The fact that they have FP supplies and educational materials does little for the FP effort since the reasoning behind their comprehensive para-medical role was to meet perceived needs of the communities while delivering family planning services. Not only is there some loss of credibility as described by agents

during an ODVA visit, since pre-training and training activities raised the level of expectation on everyone's part, but without providing other health services there is a disappointing response to family planning and other preventive services.

- * The Division continues to provide direct technical assistance to the Outreach effort in MCH/FP aspects of Health Agent training, supervision and supplies, particularly in the ODVA area; during 1977-78 it trained trainers, oriented auxiliaries and supervisory teams, and brought trainers together to develop a model curriculum. However, it has relinquished responsibility in all but the ODVA area for determining when and how Health Agent training and deployment shall take place; Regional Administrators in Cap and Cayes have picked up this task despite the absence of an infrastructure by mobilizing what resources they can attract. At one point the Cap Administrator managed to keep his first group of Health Agents working out in the field for three months without salaries by marshalling moral support and giving the effort priority for scarce transportation and supplies.

Recommendations are made by the consultants in the next part of this report regarding analysis of how the DSPP changes impact on the Family Planning effort in Haiti.

4. Future Direction of MCH/FP in Haiti

As a direct result of the plan to strengthen the Department of Health, the Division and donor agencies apparently recognize to varying degrees that there will be considerable lag time from planning to implementation and that the Division must in some areas slow its pace. A realistic approach is reflected in the draft project proposal between the Division and UNFPA in what might be termed a three-pronged attack. Although alluded to in AID agreements the consultants wished to make note of this approach since the UNFPA agreement will likely be finalized prior to the AID evaluation and might subsequently impact on it:

- * match the pace of the Division with pace of the DSPP regarding delivery of MCH/FP through health institutions and peripheral health agents, ensuring that at least the MCH/FP component adheres to norms and standards, and where possible sharing its expertise with other Department personnel and District level officials;
- * extend education and ultimately services -- first non-medical followed by medical -- throughout the existing community structure in Haiti using community agents, political and military governing structures, educational-agricultural-social development systems, and direct community development activities headed up by a Division professional;
- * seek collaboration of all commercial channels.

5. Inter-Agency Coordination

While Win McKeithen of AID and Dr. Rathusser of PAHO have provided some continuity for the MCH/FP program for at least three years, changes among donor agency personnel in Haiti, Washington and New York, as well as absence of representation, makes coordination difficult and brings a strong negative influence to bear on the MOH perception of donor agency expectations and further burdens local mission personnel. It was surprising to the consultants that UNFPA is about to sign another agreement for over \$6 million and there was no local representative with whom to discuss the program.

An example of confusion aggravated by lack of continuity is the dual topic of MCH and Family Planning; at times it has been difficult for the consultants to focus on one, the other, or both. Historical documents help to clarify to a certain extent but further confusion is encountered when attempting to define expectations, measures and acceptable program indicators.

In general, the consultants were not able to provide much perspective on inter-agency coordination.

B. Program Components

1. Service Outlets

a. Fixed Clinic System (DSPP and Private)

The 22 clinics are and have been fully functioning although as described elsewhere the personnel, salaries and activities in MCH/FP including satellite clinics have been integrated into the rest of the system so everything is done during the morning. The private clinics have been functioning and are reporting to the DHF. The consultants did not have time to visit any of them or to investigate their relationship with the DHF. Impact of integration is discussed in the Evaluation Plan.

b. Satellites

Satellite clinics are directly responsible to the 22 fixed DSPP clinics and ideally reach four localities per fixed clinic. The most striking change in performance dates from February 1978. The change is readily apparent from the monthly chart of mobile clinic (satellites) reports maintained by the Division's Supervision Section: one can see at a glance a high level of reporting drops off markedly at the time integration came about. Satellite clinics must now be held during morning hours, competing for personnel, time and vehicles for all clinic services.

One of the consultants met with the Port-au-Prince MCH/FP Metropolitan Administrator as well as Division Supervision staff and several community agents to specifically discuss problems plaguing satellite clinics dependent upon the five Port-au-Prince centers. Time did not permit review of satellite clinic experience in other districts other than to establish the fact that Cap Haitian is awaiting a separate mobile unit before attempting outlying clinic services

due to scarcity of vehicles, particularly in light of the stepped up rural dispensary effort in that region without a comparable increase in resources. Gonaives clinics continue because mobile clinics have long been a pattern in that region rather than abundance of vehicles; nor are rural dispensaries being developed yet as they are in Cap and Cayes. Thus it appears that where vehicles are few in number (most everywhere other than Port-au-Prince) prioritization rather than commitment takes precedence, particularly when they must be conducted in the morning with everything else.

c. Mobile Units

The self-contained VW Van, although temporarily out of commission during the visit, is regarded as the answer to satellite clinics because they are programmed specifically for such activities, not in competition for other services, and not dependent upon space or facilities in the poorest communities where mobile or satellite clinics are usually held. The Division's Supervision Section had posted a three-month schedule (January-March) with 16 morning locations and eight afternoon locations, each to receive a visit a month for three months. Locations are selected for their severe health problems and environmental conditions; a major objective is to encourage the community to continue services at the closest of the five city health centers after the three monthly visits which permit three doses of tetanus for clients coming the first time.

A continuing source of frustration for the Port-au-Prince Mobile Unit Supervisor was lack of a vehicle from the Division for supervisory visits she schedules far in advance; the day the consultant accompanied the supervisor there were vehicles but no chauffeur available.

d. Rural Dispensaries - ODVA and DSPP

ODVA - The relationship between the Division, the ODVA and the rest of the Department of Public Health is very well documented in Division reports (May 1978) and clearly spells out what each is responsible for in the extension of health services into dispensaries and to the health agent level. A consultant spent an entire day visiting two of the most advanced basic health centers and interviewing all levels of personnel and encountered a situation which is documented in a report by the Division's Chief of Supervision, following a visit he made the week prior to the consultant's visit:

- * Four currently "functioning" basic health centers (one burned down recently) renovated and staff assigned, two dispensaries identified for each center and four Health Agents assigned to each of these 12 facilities; nine additional sites identified (three basic health centers with two dispensaries each); Health Agents on-site and receiving salaries after initial months of inactivity when the first group had to be re-trained; all auxiliaries are in the four health centers since those assigned to dispensaries (only a few) have no lodging facilities, dispensaries are not in proper state, and/or no transport available.
- * Two of the most advanced centers -- L'Estere and Boccozele -- were renovated, equipped with adequate office/clinic furniture, 12 good beds and mattresses

at L'Estere, MDs assigned and in place; they expressed community-oriented philosophy in apparent sincerity (the Boccozele MD voluntarily extended his obligatory two-year residency in St. Marc and receives only the minimal salary more than a full year after the residency); auxiliaries in place, health agents in place, plenty of contraceptives, MCH/FP education materials.

- * Lacking were drugs other than MCH/FP; vehicle broken down and no word from DSPP as to repair date, L'Estere refrigerator broken down and request for repair still pending with District Administrator-Assistant even though DHF personnel offered to replace it temporarily; at L'Estere there were no clients at all; the staff said clients show only on market days (two) and average attendance those days has gone down from about 17 to 10 recently; the community is accustomed to attending one of three private, religious health clinics in the same area because they always find drugs; the Boccozele center is more isolated and slightly better stocked due to lower client volume but erratic transportation poses hardship to staff while mobile clinic is impossible for two dispensaries assigned to it; the auxiliary walks as far as she can to supervise as many of the 12 health agents as possible, usually not more than four.
- * As mentioned elsewhere, Health Agents were trained but the first group had to be re-trained after a lengthy delay and the second group's training was delayed by the DSPP; support system is minimal and consists of MCH/FP supplies, salaries, supervision where agents are attached to one of four basic health centers. While on-site, consultant was besieged with questions concerning rumoured increase in ODVA Health Agents' salaries which are apparently a little below the Department's salary policy.

In general, the ODVA project has been slowed down; 35 dispensaries were scheduled to open but only 12 have actually opened officially and nine others have been identified. Of the 12, some are not sufficiently readied to be fully functioning although all have Health Agents.

DSPP - The consultants did not have sufficient time to analyze the situation since this component has been decentralized; in Cap and Cayes the Health Agents have been trained and placed in dispensaries, some of which were already functioning, others which were renovated or received additional resources from DSPP. Success is apparently largely dependent upon how well the Regional Administrators can divert existing resources to the rural dispensaries since very little support has come from the DSPP. The MCH/FP component has adequate supplies and materials but can only function as well as the overall structure, which is somewhat vague at this point. It was difficult to pinpoint who within the DSPP has implementation responsibility for this effort.

e. Fees

The consultants were unable to investigate this area other than to obtain specific information at each site visit; e.g., in the Cap Hospital anyone

seeking MCH/FP services paid nothing, while in a rural dispensary everyone routinely paid two or three gourdes for everything including drugs.

f. Matrons

Training of these lay midwives has exceeded most objectives; activities and plans are well documented and 51 separate delivery outlets are currently reporting to the Division. A negative influence on the current situation is that since integration of services it is difficult for central staff to enforce reporting requirements and it has fallen off, nor to enforce recommendations coming out of supervisory visits or DHF plans for continued expansion of training.

The Pathfinder support was withdrawn, due in part to disappointment that matrons were not recruiting many family planning acceptors. This is indeed unfortunate as the national midwife training program is highly innovative, has contributed greatly to a public support base by bringing traditional personnel into the MCH/FP system rather than displacing them, and has great potential for future growth in family planning as many external factors currently affecting service utilization are changed.

g. Factory Program

Most activities took place in 1978 and should come out in the Division's report. The Supervision Section is primarily responsible for its organization and in conversations with staff members certain problem areas have emerged. Factory owners are highly concerned that their workers not become pregnant and subsequently burden them with maternity benefits or staff turnover, but they apparently expected resources beyond the Division's means to institute programs.

- * Factory owners are either not able or not willing to complement resources available from the Division; some have physicians who currently provide what medical services are required and those few who monopolize this lucrative business are apparently uncooperative or uninterested in adding family planning to their responsibilities; others do not have physicians or other organized medical care resources and would be totally dependent upon the Division or existing health centers in the city.
- * Many factories have small numbers of workers making it impractical for the Division to systematically visit them all for either educational or medical services; yet the factory owners are not able to permit workers out en masse to attend centralized educational or clinic services because of security risks -- security checks are done each evening when workers leave for home.
- * Some factory owners previously interested in FP subsequently polled their workers and felt that too few were either eligible or interested to merit allocation of necessary resources.

Division and factory owners have communicated in letters and group meetings; a map has been charted with factory locations and assignments to one of five existing MCH/FP centers which will ultimately assume responsibility for factory activities in their area although Chancerelles will be disproportionately burdened.

h. Surgical Facilities (See Evaluation Plan)

2. Information, Education, Communications (IEC)

The Division's efforts in this area have been properly focused on diffusion of general information and messages concerning the importance of MCH/FP services. To this end there has been a proliferation of radio, newspaper, cinematic and TV messages prepared in Port-au-Prince and distributed to the Districts. A well-organized Health Education Section of the Division prepares and monitors annual implementation plans as well as year-end reports and has printed materials for both clients and personnel.

Unfortunately there seem to be three major obstacles to moving beyond the informational phase and undertaking efforts in what might be more appropriately termed "behavioral change" which could impact both on service utilization and attitudes toward MCH/FP concepts. First, the Health Education Section has in reality been fulfilling two other essential functions which have not been sufficiently recognized to the extent of allocating adequate support, but rather have strained the Section's information/education resources. Secondly, neither the Department of Public Health nor the individual Health Districts have a health education structure through which the Division could translate generalized information into more specific educational efforts aimed at special needs of different areas: programs prepared in Port-au-Prince are necessarily broad, but after five years of recruitment-type activities further penetration into the population requires a more careful analysis of barriers to utilization of service which are surprisingly varied from one geographic area to another; this need is recognized by the Division, and suggested strategies are outlined in the Section's Report prepared in June 1978. Thirdly, whatever ideas, plans and action are undertaken to promote the use of family planning, if the service delivery system is defective then people can't use the services and in the consultants' view the system has many problems which may inhibit utilization.

a. Multiple Functions of Health Education Section of Division

More by accident than design the H.E. Section has evolved into a unit responsible not only for health education and information, but for Human Resource Development, and Management of the Community Agent Component of the Program. Although competently carried out by the Section Chief it is severely straining resources.

Health Education and Information - to date routine dissemination through radios, newspapers, publication of patient education materials, TV, guidelines and manuals for personnel performing educational tasks, upgrading community agent skills in IEC activities.

Human Resource Development - development of new categories of para-professional personnel (Community Agents, Contraceptive Distributors, Health Agent Trainers and Supervisors, etc.) and development of new roles for existing traditional and institutional personnel (home visiting for health auxiliaries, first aid for leaf doctors, MCH/FP education activities for nutritionists, nurses, doctors and auxiliaries, etc.); development of training curriculum and trainers, as well as administration of training programs; orientation seminars in MCH/FP to encourage various interest groups to assume responsibilities in MCH/FP (pharmacists, agronomists, etc.).

To the great detriment of the program such broad activities are lumped under "training/orientation" without recognizing that training cannot be done in a vacuum, that someone has to identify and develop the role, function and tasks which determine which skills are to be trained; so that HRD activities are greatly underestimated and underrated when it comes time for program planning, decision-making, allocation of resources, etc. although the activities themselves are surprisingly well carried out. Inattention to HRD or its recognition as a separate entity seems also to be at the root of the poor showing with regard to the Health Agent/Outreach effort as described earlier. The major thrust of AID support to the family planning effort in Haiti is toward the development of human resources, yet it has not been clearly labeled as such and elevated to a position equal to other major activities; it is instead tacked on to the IEC function in the Health Education Section where the Chief is highly capable but resources are inadequate.

Management of Community Agent Component - the 145 community agents and supervisors are primarily IEC personnel and their development is properly integrated into the IEC function; however, as with any other personnel management activity it requires a great deal of time and effort to supervise them and the H.E. Section is staffed and budgeted primarily to produce materials and conduct educational activities, not to monitor 145 workers deployed around the country.

The agents and supervisors represent a largely untapped resource of information on the needs of the population and their attitude toward MCH/FP services. As the only categorical MCH/FP personnel other than the Division's central staff, their surveillance cannot be left to routine local supervision, or feedback will never impact on decision-making at the highest levels. This became clear when an evaluation was conducted without input from the H.E. staff that had developed and trained them; it concluded that the agents were not contributing effectively. The H.E. Section Chief assembled sufficient statistical information to prove otherwise; yet any time given over to this innovative component of MCH/FP necessarily detracts from IEC resources.

Neither donor agency agreements nor internal planning documents have effectively articulated the real but unconscious commitment to the community agent concept as a distinct component of the program deserving of central office attention, continuous analysis, and systematic modification of their role to keep pace with the evolution of family planning in Haiti.

While all functions described above are essential to the success of the MCH/FP effort and the Section Chief is appropriately qualified, they have not yet been accorded full recognition as equal functions which merit separate resources reflected in the H.E. staffing pattern and annual objectives of the DHF and Section. Decisions continue to be made in other parts of the Division which impact on the future of Health Agents and Community Agents but the H.E. Section is not involved because it is viewed largely as the training/education office; its developmental role is clearly overlooked.

b. Lack of National IEC Structure

Without a specific IEC counterpart at the District level the central office is totally dependent upon the interest and commitment of the District Health Administrator, Community Agent Supervisor and medical personnel to make IEC a priority, to carry out activities programmed in Port-au-Prince, and to do so with sufficient enthusiasm to ensure that messages are effectively communicated; it is clearly inadequate to expect that all personnel "should be doing" education without having the means to support or enforce it. Obviously such dependency slows down the momentum of education efforts from their point of origin. Most damaging of all, absence of a counterpart or advocate, or otherwise specifically delegated individual to monitor IEC activities, undermines the status and credibility of the central office staff because they must constantly cajole and nag anyone and everyone to devote some of their time to carrying out the program in the spirit with which it was conceived.

c. Factors Inhibiting Use of Services

The expressed desire of AID personnel both in Washington and Haiti was that the consultants assess the family planning effort with regard to effective means of promoting the use of family planning services. While this must indeed be done, the consultants identified organizational problems which are serious enough to discourage clients from making use of existing services. These factors are described throughout this report including a series of questions in the Recommended Evaluation Plan under the heading of "Service Outlets" which should help the Evaluation Team to focus on key factors.

The information coming out of the World Fertility Survey indicated an extremely high awareness of family planning and knowledge about contraceptive methods even in remote regions of different parts of the country: more information and more exhortation are not likely to increase service use. However, in the process of conducting some very needed research on attitudes and practices it

would be very possible to sample client reactions and drop-out characteristics to aid in exposing and correcting deficiencies in the service delivery system.

In general, the H.E. Section is very efficient in meeting programmed activities, it has well documented plans, and ideas abound for informing, educating and encouraging service use. With regard to Mass Media, it is certainly highly utilized within the constraints imposed by having only a single, centrally located staff; more effective use must be preceded by a national IEC structure. Three films have already been produced by the Family Hygiene Center on MCH/FP, FP and Community Participation in Health, with a fourth on the way; use of the films would also be more effective through a decentralized structure. Recruitment to FP continues to be greatly influenced by Community Agents as reported in the Annual Report (55 percent of FP coupons distributed were turned into the clinic by clients; 13,528 coupons returned -- primarily from new women acceptors -- compared to 20,059 new women acceptors). Training activities meet targeted dates, numbers and personnel; seminars continue to be held with many types of interest groups. Decentralized IEC efforts continue in spite of the lack of specifically designated personnel; the H.E. Chief requested that Districts submit detailed maps of their areas which provide such details as locations of Community Agents and Health Agents, major and secondary roads, foot paths, etc. Although request as an IEC campaign planning tool it in fact coincides with the consultants' suggestion as outlined in the Recommended Evaluation Plan for measuring services availability. Unfortunately only Cayes District has responded to the request which is further indication of the need to examine the level of commitment to IEC outside the central office or even outside the Section within the Division.

It is apparent that the need is not for promotional ideas, but rather strengthening of the IEC structure at all levels, allocation of adequate resources for Human Resource Development and Community Agent Management so these functions don't divert time and energy from IEC efforts, and improvement of the service delivery system at the same time that research is conducted to furnish better understanding of current attitudes and practices regarding family planning. From the H.E. Section Report of June 1978 and the draft UNFPA Agreement, there is little doubt in anyone's mind that the days of routine dissemination of standardized messages is over; but moving ahead calls not only for generating better information about the target population -- it calls for improving the structures that are necessary for delivery of both clinic and educational services.

3. Human Resource Development/Training

To reiterate Section #2 above, the major thrust of the AID effort in family planning is toward development of human resources on a very large scale, yet the HRD function has not been elevated as a component equal to other major components of the program and equally deserving of attention and resources; it has been tacked on to the IEC effort primarily because the H.E. Section Chief has

a facility for carrying out this role. A Division Manpower Specialist in 1975-76 introduced many HRD concepts into the FP effort and they have been integrated into the H.E. Section's activities; however, until HRD is accorded recognition as a distinct entity it will continue to compete for IEC resources.

Training should only be viewed in the context of overall HRD but has been equated in PRGP Agreements and Division Plans with developmental activities, i.e., the terms are used interchangeably yet resource allocation seems to be more focused on curriculum development and training delivery than on the more subtle and time-consuming (expensive) development activities. The previous section of this report deals more extensively with the subject.

Training of new kinds of personnel has been preceded by intensive developmental activities such as task analysis and design of supervisory and support systems. On the other hand, training/orientation of all levels of personnel engaging in new activities has been a more definitive training activity which has not required a great deal of pre-training work. Training curriculum, Community and Health Agent manuals or field guides, trainer aids and reports on training programs are all well documented and accessible to donor agencies.

4. Supervision

The Section of Supervision organizes both routine and selective supervisory visits; it has documented annual plans, implementation of plans, charts for making progress of activities, results of supervisory visits, and definitions of routine and selective supervision. The section has been responsible for supervising 22 clinics and satellites, the ODVA rural health extension project, the factory program, the Port-au-Prince mobile unit, private clinics offering MCH/FP, and identification of problem areas in each district in order to send multidisciplinary teams for the selective visits which provide technical assistance.

The major problem is the shift from specially designated clinic teams in afternoon hours to diffusion of responsibility among all clinic personnel (MCH/FP-related) during the same morning hours that all services are offered. Results and recommended action plans following supervisory visits do not rest with the District Administrator. Personnel apparently still receive supplemental salaries from the Division and are probably fairly responsive. However, central staff supervisory teams formerly exerted a great deal of influence over all staff performance since MCH/FP staff had been oriented and trained by them, received separate salaries, and worked separate hours. This is no longer true.

The future of effective supervision will therefore depend upon imbuing regional and district senior staff with concepts which are currently practiced admirably by DHF central staff.

5. DHF Administration

a. Inventory/Supplies

During an interview with the Division's staff member in charge, it emerged that there is considerable difference between UNFPA shipments and AID

shipments making contraceptive supplies more prone to "stockpiling" or "over-supply" -- UNFPA supplies are calculated each year according to utilization of each center, adjustments are made, supplies ordered for the year, and as they are shipped the Division receives advance notice so they can plan for space, etc. For AID, the staff member does not participate in yearly estimates and requests for contraceptives, and often does not even receive advance notice (copy of shipping form from U.S.) of shipments, but rather receives notice from the airlines that contraceptives have arrived. Once they arrive, it takes him a minimum of three weeks to request and receive authorization from the Health Department to claim the shipment and he must also make room in the Port-au-Prince depot which means notifying centers around the country to come and take supplies. Thus he is often faced with leaving contraceptives in customs, and some airlines (Air France in particular) charge storage, e.g., he will shortly have to pay \$514 a month, or a dollar for each carton of condoms, for a recent shipment because there is no space to put them. At the moment there are some 11,000,000 condoms in Port-au-Prince alone and he feels that since most health centers are also fully stocked, they probably don't need supplies for the rest of the year; same holds true for pills. Another problem faced is lack of advance notice via copy of bill of lading which shows value of goods to customs officials; this causes further delay and hassle. With regard to logistics for all other supplies, monthly utilization reports from centers are centrally located and analyzed to make internal adjustments among centers' shipments; this was evidenced by the ready availability of the reports and penciled notations up to the current month.

b. Vehicle Problems

There was little time to examine the issue carefully but one very obvious problem is prioritizing use of vehicles from the Division. The Administrator is highly competent but his lack of background in health service delivery appears to enter into decisions as to who or what shall take precedence when there is a shortage of vehicles or chauffeurs. Even though a supervisory visit to the Mobile Unit was scheduled long in advance -- they are posted in the DHF office -- and in spite of several reminders by the physician responsible, the consultant and physician were without a vehicle and the consultant had to supply transportation. Many stories were repeated by other DHF medical staff, saying they are often frustrated by lack of vehicles because they may be tied up by such administrative tasks as going to the bank to pick up payroll, etc.

c. Equipment

A major problem is maintenance of equipment; a refrigerator may be unusable for an inordinate period of time (e.g., L'Estere in ODVA Project) but the most notorious difficulty is with motor vehicles. There are parts of Haiti where there are no auto repair mechanics, yet private vehicles are ingeniously kept working with scotch tape or whatever.

III. RECOMMENDED EVALUATION PLAN FOR PROJECT 0087

The Evaluation Team will give attention to the 0087 Project and the extent to which its objectives are being met at that approximate midpoint of the three-year span of the project. Such focus, though appropriate for assessing AID's support effectiveness, is an artificial separation from other DSPP program activities which are funded by the MOH or supported by other donor agencies. Since AID's interest is to have the activities which it supports contribute toward an overall goal and fit together with and complement other efforts toward that common purpose, the Evaluation Team will try to consider the AID-supported accomplishments within the broader context of the general endeavor. It will be of special interest to see how multiple donor contributions are coordinated. It is desirable therefore that where appropriate, the DSPP try to organize some of the data according to three types of support source relevant to the 0087 Project objectives: AID, other outside donors, GOH contributions.

As described in the PROP Narrative the primary sign of the Project (0087) is to promote family planning. In order to do this, the Project supports the development of the contextual structure and program of the DSPP, especially in MCH/FP but also in various parts of general public health administration. The evaluation will look at both areas to see what progress has been made. Expenditures of funds for relevant activities other than specific family planning promotion are budgeted. Nevertheless, family planning achievements will be the essential indicators of both family planning efforts and more general supportive activities.

This section of the report provides guidelines for evaluation, but it also makes technical recommendations concerning the operation and conduct of the program in light of the current situation. The Evaluation Team will have opportunity to judge the extent to which consideration will have been given to those recommendations by the time of their visit.

The Evaluation Team visit (August-September 1979) is planned well in advance by joint agreement between the Ministry of Health and AID, so that appropriate data should be collected and made available by the time of that visit; the team could not be expected to collect its own data. Assuming that the visit may be about September 1979, analysis of data for 1978 and the first half of 1979 should have been completed and placed in the hands of the team. Most of the required information can be derived from the present reporting and statistical system of the DHF.

However, additional data collection and handling may be necessary if some of the technical recommendations of the present report are followed. In following our suggestions for data presentation to the team, some retrospective tabulations for 1978 may be possible. For new types of concurrent data collection, it is recommended that a three-month period, (April, May and June 1979) be used as a sample time period. It is believed, however, that most, if not all,

the new recording, reporting and analyzing procedures which may have to be initiated for that purpose would be of sufficient value and also without undue burden so that the procedures could be made permanent and continue on for the remainder of the three-year project.

The team will review the submitted data together with MOH personnel and will attempt to appraise and interpret the data from those discussions and from its own observations. It would then compare to outputs and inputs as specified in the original Logical Framework Matrix, summarize factors affecting program progress, and make appropriate recommendations.

In addition to the report from the consulting team which includes the PES for 0071, Summary of the Current Situation as of January 1979, and Recommended Evaluation Plan, the evaluation team will also have the PROP for 0087 which includes an evaluation plan on page 30, and the PES Format which it should study prior to the visit.

IV. EVALUATION PLAN SUMMARY

A. Input

To estimate family planning investment, expenditures can be classified as:

- * clearly and fully for family planning
- * for MCH, nutrition and other family planning-related activities or purposes
- * for non-family planning functions, including general administration

For the second and third categories, a ratio would be obtained of the number of family planning client visits or contacts to the total number of visits or contacts for all purposes under the particular item being considered. The result would be a factor used to extract the family planning proportion of the expenditure. This would be the most rigid definition and could be tempered according to decisions on relevancy of activities to family planning.

Capital investments and certain other expenditures may not lend themselves to such treatment because of the time lag that must occur before client response becomes manifest. Caseload projections would at least give magnitude of planned emphasis.

B. Outputs - Program Components

1. Service Outlets

a. Fixed Clinic System (DSPP and Private)

Twenty-two clinics were established prior to the project to maintain family planning services. In measuring performance of these 12 hospital outpatient clinics and ten free-standing clinics, there are more important factors to consider than their mere physical presence or state of renovation:

- * To what extent are they maintaining family planning services?
- * How is the family planning service organized and fitted into the operation of the hospitals and their clinics?
- * At what times are family planning services available?
- * What space is assigned?
- * What staff time is allotted?
- * What contraceptives are distributed and included in the program?
- * What record system is used?
- * What fees are charged?
- * To what extent is time diverted to District Health Administration from either the hospital-based family planning system or the free-standing clinic-based family planning system?

It is the impression of the consultants that the effectiveness of the clinics is seriously threatened at present by a number of pressing issues. As described in the second section of this report, MCH/FP services were rendered in the afternoons and personnel received appreciable salary supplements, but now clinics are open mornings only as in former years and reduced salary supplements continue to larger numbers of staff. This may be expedient politically but the same morning hours are expected to absorb the family planning work including satellite clinics. Either morning sessions were not formerly at optimum utilization or now some other service is displaced.

The problem is compounded by departmental uncertainties and vacillations about policy on salary supplements, both as to its continuation and its amount. Each district has a fixed total amount so that changes in staff size mean personnel have no consistent monthly remuneration. Morale is poor, family planning may not only not be promoted well but is perhaps even discouraged. Personnel should be adequately remunerated for their work; yet if those who have general health responsibilities receive financial incentives for one service they may favor this type over all others. DHF supplements for separate, additional hours had overcome this problem.

On the other hand raising and stabilizing salaries will not in itself guarantee that personnel will do better work since salaries are never enough. Workers in the DSPP are notorious for irresponsibility in serving the hours scheduled and for which they are paid. Physicians are the worst offenders. The department does not impose discipline to limit their negligence. The effect is contagious and demoralization percolates down through all staff levels. Inevitably the service suffers and community confidence is eroded. In part the attitude of the physicians results from many of them being placed in unwelcome rural locations by mandatory assignments. An adequate supervisory system would not only monitor practices but would help militate against professional isolation, as has been clearly demonstrated by the DHF for separately identified MCH/FP workers.

There must also be a realistic delegation of responsibility in order to lessen dependency upon the physician, both for client care and clinic management. Other personnel should be given more responsibility in patient care, responsibility which they now carry tacitly and irregularly. The physician is not the appropriate person to have titular authority over administration, personnel and recording and reporting. Yet these are precisely the areas of the family planning effort which have suffered most since the integration of working hours, salaries and personnel.

There are 15 other clinics under different auspices with family planning services which are partly supported by the DHF. Comparable quantitative data are needed on their organization, staffing, and function. Completeness and reliability of reporting by all types of clinics should be appraised.

b. Satellites

The team should examine the following barriers to successful satellite clinics (referred to as clinique mobile as opposed to unite mobile);

- * this type of clinic is most vulnerable to vehicle breakdowns, competition for scheduling; all but one Port-au-Prince health center are dependent upon the division central office to send out vehicles making competition that much greater
- * satellite clinics have reverted to morning hours, coinciding with the centers' services
- * personnel previously uncompensated and untrained in community health concepts are less inclined to go out on satellite clinics and less apt to relate well to clients in the community
- * community agents are key in recruiting clients for satellite clinics and are particularly sensitive to health center personnel attitudes toward agents and clients alike and in Port-au-Prince they stated in a meeting that a great deal was left to be desired
- * the community is wary of delays and cancellations to which satellite clinics are especially prone so it is becoming increasingly difficult for agents to bring clients in -- few will show until they hear the vehicle's loudspeaker announce the clinic, yet some vehicles don't have a speaker system; selected clinic sites are sometimes controversial in the community and inhibit attendance.
- * past experiences discourage clients, such as shortages of supplies when client numbers exceed expectations; absence of an MD or nurse to treat a particular kind of medical problem; clinics are necessarily conducted in the poorest least accessible parts of the city or outskirts where it is difficult to find suitable space, and there were more space possibilities in afternoons when commercial or government offices are not used; only those activities which can be carried out in the open can be offered (blood pressure, vaccinations, etc.)

The Evaluation Team should also determine how many clinics have satellites, how frequently they are held, by what staff, when, and the urban-rural distribution.

c. Mobile Units

One such unit operates in Port-au-Prince, another was scheduled to start in 1978 and two in other cities in 1979. The DHF Supervision Section should be able to provide answers to needed questions before the pattern is replicated in the rest of the urban communities:

- * conformity to schedule, frequency of visits to each site, types and numbers of clients, availability of services between visits, coordination with community agents, cost, impact on attendance at fixed clinics, methods of selecting locations, and extent to which vehicle breakdown has restricted services.

d. Rural Dispensaries - ODVA and DSPP

The ultimate plan calls for 170 dispensaries, 50 of them in the ODVA project. Problem areas have been described in the first section of this report. The team will want to determine how the division has modified the ODVA plan and for both ODVA and DSPP dispensaries:

- * How many were renovated?
- * How many are open and operating with health agents; auxiliaries; regular supervisory visits from the district? and how many of the placed auxiliaries were trained to supervise health agents?
- * How adequate are facilities for storage, refrigeration, sterilization of instruments and other purposes in addition to client care?
- * What is staff turnover rate?

e. Fees

The team will want to determine uniformity of the fee system in the Fixed Clinic system as well as the Private Clinic System; how is it applied in satellite clinics and rural dispensaries; have there been changes in fee collection (i.e., clinics instituting fees after historically free services and vice versa) and what are community attitudes toward fees. Experience with fees has differed immensely depending upon the community's previous experience.

f. Matrones

Continued reporting of matrone activities and future training and supervision will be equally influenced by integration and decentralization.

The team will want to examine progress of the matrone component with this in mind.

g. Factory Program

As a result of the problems encountered in the factory program as described in the first section, the division has outlined its options and the team will want to assess progress in this light:

- * educational sessions on-site in factories of a certain size or in central locations for several small factories
- * scheduled appointments at one of the five health centers or mobile unit sites
- * training in MCH/FP of a medical auxiliary where factory owners are willing to pay the salaries

The team will also want to assess the extent to which the five health centers are able to absorb these additional activities, use of the community agent, and tracking system between health centers and factories to ensure women at risk are given appointments, no-shows are followed up, and clients maintained in the system.

h. Surgical Facilities

Assessment should be made of the number of surgical facilities renovated or equipped with AID assistance and other funds, their locations and affiliations, the extent to which they are made available for family planning surgery, the assignment of staff time and the training of qualified personnel.

2. Information, Education and Communication (IEC)

The team will want to assess the functioning of IEC in light of the three major factors outlined in the previous section:

- * Imposition of multiple functions on the H.E. Section responsible for IEC
- * Absence of decentralized IEC responsibilities other than arbitrary delegation to personnel already fully occupied
- * Deficiencies in the Service Delivery System

In addition the team should scrutinize certain other factors involved in the implementation of IEC within the division:

- * Participation of the H.E. Section in overall planning and decision-making; or otherwise assess the extent to which IEC efforts bring people into the service system who are ultimately lost when the service delivery system fails to keep them in, and yet those responsible for IEC are not involved in service delivery monitoring and improvement.
- * In the same vein, participation of the H.E. Section in planning of research efforts and follow-up; IEC personnel recognize the need to know more in order to improve their IEC strategy and are in a good position to recommend research.
- * Special projects, such as the Columbia CBD system, Community Development, and FPIA condom machines often have separate budgets but it should be determined whether associated IEC activities are integrated into the H.E. Section with appropriate allocation of additional resources.

- * Examine expectation of seminars for opinion leaders since the wording in 0071 (pp 7-8) implies that this activity would secure widespread support at the highest policy levels; such ambitious hopes for obtaining commitment is unlikely to be realized through seminars particularly when they are not followed up with specific action plans for participating in the program; they are useful for broadening the public support base. Indicators for success should be clarified.
- * Although ideas are reflected in various documents to indicate change, verify the division's intent to move beyond routine information dissemination, request specific plans, determine why H.E. Section was unable to program IEC activities specifically toward findings of small studies carried out in various parts of the country (lack of resources, lack of decentralized structure, etc.).

3. Human Resource Development/Training

Since the H.E. Section documents its activities very well and the Division's Annual Report is very detailed, the team will have little difficulty evaluating the progress of training activities. The area which is most difficult to evaluate is the most subtle: developmental aspects. The team would hopefully include a specialist in Human Resource Development who could determine:

- * whether the HRD functions (role determination, task analysis, identification of requisite skills and qualifications, etc.) are actually being carried out
- * by whom they are being carried out; and whether by specific delegation of responsibility or tacitly; and whether those responsible also have authority to make necessary decisions concerning Worker Role and Function and ultimate establishment of support system
- * whether appropriate resources, staffing pattern, etc. are allocated to HRD functions

4. Supervision

The organizational changes of Integration, Decentralization and Outreach to Rural Areas call for greater emphasis on ongoing supervision not only by the Division, but by District staff. A number of issues should be highlighted in determining whether in fact Districts do move in this direction to ensure that diffusion of responsibilities for the family planning effort is to be monitored through a decentralized supervisory system backup by other levels of the DSPP:

- * A clear distinction should be made between clinical backstopping and supervision. When a mobile unit visits a community and gives care to all clients who have been collected by the local worker, that

is not supervision, although it is educational for the staff. The scheduling of mobile clinical service is dependent on the health needs of the people. Physicians are clinical consultants; they usually make poor supervisors.

- * When supervisory duties are shared with demands of work at a fixed facility, the former invariably suffers. Auxiliaries responsible for a clinic are not likely to go out in the field on schedule to supervise health agents.
- * Supervision should be more selective than routine. Regular service reports should be used as clues for making a supervisory visit. The occurrence of significant events warranting immediate investigation should be met by prompt supervisory visits. For example, the consultants encountered a situation where two deaths of newborn infants from tetanus came to the hospital from a single village. The situation called for emergency notification of the Health Officer by staff followed by a visit to the community; but staff had not been oriented in this manner and had planned to submit their written report at the routine time.

5. DHF Administration

a. Inventory/Supplies

Immediate recommendations include

- * ensure that copies of shipping form from U.S. be forwarded to DHF (this is done sporadically) so the Administrative Section has two-three months' notice of shipment
- * supply the staff member in charge with a list of planned shipments, whether yearly or for five years; he currently has no indication of planned shipments from AID

Since there is an immediate need to ease the flood of condoms and pills, refer to the PES/0071, Item #9, as well as the First Section of this report (Current Situation) Special Issue #1 -- Contraceptive Distribution System -- and this Section #6, in order to compare projections and actuals with regard to need for the different contraceptive methods.

b. Vehicles

The Evaluation Team should determine what process the Administrator currently uses to prioritize use of vehicles since it appears that the health and medical services personnel have the greatest difficulty in obtaining vehicles even when the request was approved. If there is a vehicle breakdown or a chauffeur is out sick, who gets bumped? Administrative errands seemingly are never neglected. Often the medical staff left without a vehicle is offered money for gas but this is quite unsatisfactory for several reasons including the fact that roads are in terrible condition where supervisory visits must be made, several people and equipment cannot fit into small, private cars, and the

chauffeur is often needed to help out in the visit.

c. Equipment

The Evaluation Team should determine data currently collected on use and problems with equipment such as:

- * number of inoperative vehicles, their dates of acquisition, duration and current period of incapacity, reasons for break-down; number of operating vehicles and uses
- * number of health facilities in which gas refrigerators have been installed and operating, problems encountered, length of time inoperative, etc.

If no data, then recommendations should be made with regard to record-keeping for the purposes of analyzing problems and seeking solutions, i.e., alternative forms of transportation, use of thermos jugs for immunization materials, etc. Also identify clearly who is responsible, process for requesting repairs, etc. whether DHF or other parts of the DSPP.

6. Contraceptive Distribution

In the first section of this report the consultants describe the current situation (Special Issue #1) with regard to Policy for Distribution, Practice vs. Policy, Variation among Sources, Underlying Hypotheses Regarding Bottlenecks, and recommendation of an immediate analysis of projected vs. actual clients. In this section the consultants review factors other than bottlenecks which contribute to over-supply and low client volume, recommended analysis of distribution, and practical modifications in current practice with regard to pills and condoms.

a. Factors Other Than Administrative Bottlenecks

- * Over-abundance -- this may be due to differences in projected vs. actual continuing usage, projected vs. actual drop-outs, projected vs. actual method choice, and of course, projected vs. actual new acceptors. In PES/0071 #19, it was pointed out that original estimates were 38,000 continuing pill users while actually appears to have been less than 20,000; yet cycles were calculated at 490,000, not allowing for new users who don't require 13 cycles, and only 103,000 cycles were actually distributed. Differences between projected and actual numbers or patterns of use may be totally unrelated to distribution practice.
- * Drop-outs of actives and barriers to potential clients -- this may be due not only to administrative bottlenecks in distribution but also to such significant factors as method side effects, overall quality of service delivery, attitudes of personnel, and of course socio-cultural

factors which reside in the community, e.g., in Cap community agents felt for instance that exclusive use of Norinyl was negatively affecting continuation and recruitment of new clients. Furthermore, it should be noted that client use of MCH/FP in Haiti is erratic and unpredictable in the health care system; past experience and the reputation of public health services in general could be limiting factors.

The evaluation team will want to secure data on the following to check against the relevant factors listed above:

- * Projected vs. Actuals over the past three-four years by total continuing users, new users, method choice, drop-outs, sex
- * calculations used to estimate supply needs (are they adjusted for new users? Drop-outs?)
- * side effect complaints in various parts of the country (the example of Norinyl was not encountered in other parts of the country); community agents will be very helpful in this effort

OVERALL EVALUATION OF THE SERVICE DELIVERY SYSTEM WILL ANSWER MANY QUESTIONS ABOUT FACTORS INFLUENCING DROP-OUTS AND BARRIERS TO POTENTIAL CLIENTS.

b. Analysis of Contraceptive Supply Distribution Practices

The evaluation team should be presented with data on amounts of contraceptives distributed to clients for the years 1975 through 1978 and the first half of 1979:

- by method
- by areas and individual distribution points (for those reporting)
- by types of distribution outlets (condom machines, Rural Health Agents, etc.)

This data should also indicate total amount and total visits in order to derive the average supply distributed per visit by method, e.g., 1,000 new and continuing pill users made 2,500 visits during the same period in which 9,000 cycles were distributed, (with 600 continuing and 400 new). The data would indicate:

- * trends during that period, pointing up possible generic administrative problems
- * differences in preference for methods which might be a reflection of staff bias, training and resources

- * differences by areas and distribution points which would give clues to needs for supervision, training, relocation, procedural changes or community outreach
- * differences by types of outlets which would help appraise the accomplishments and potentials of new exploratory approaches, including: condom machines, Rural Health Agents, Community Agents, etc.

c. Practical Modifications of Current Distribution Practices

Pills: Although pills can be purchased commercially without prescriptions, it is ironic that some personnel in the government program put barriers in the way of liberalizing non-physician distribution of pills for resupply.

Areas susceptible to modification include:

- * Rural extension effort -- since Health Agents will assume resupply after the initial or at most one return visit, for the greater convenience of clients, the rural extension effort via dispensaries and development of agents must continue and be strengthened; an evaluation of its current status and progress is discussed elsewhere.
- * To avoid future opposition from medical community regarding Health Agent role in pill supply or initiation, examine pill distribution checklist for Health Agents; are they written? uniform? sufficiently detailed to prevent errors/abuse?
- * Ensure that their experience is closely scrutinized and when sufficiently documented, permit them to initiate pills.
- * Some community agents resupply on a limited basis; redefine their role to include routine resupply and ultimately initiation of pills following satisfactory health agent experience.
- * A variable in return visit policy and practice is the extent to which a woman understands pill use which is influenced by clinic personnel skills and attitudes; ensure pill distribution guidelines for personnel, detailing effective patient instruction; standardized protocol for determining whether client needs two or more return visits; i.e., elaborate the policy already written in DHF manuals to ensure effective and uniform practice.
- * The CBD training program (community-based distributors of the Columbia Program) would be a valuable tool for orienting and training any personnel involved in initiating and resupplying.

- * Whenever and wherever possible apply any results from the CDB study to areas which are ready, e.g., Cap where the Administrator permits limited initiation of pills (where health agents work out of a dispensary run by a Nun).
- * Have Jacmel and Gonaives surveys produced relevant information on client pill attitudes?

Condoms: There is much greater potential for opening up access to distribution of larger number of condoms per client. Some personnel seem to prefer monthly visits for tighter control of the client. Men should be permitted to take larger amounts of condoms at less frequent visits.

d. Possible Modifications - Recommended Studies

- * A number of small studies could be done in each type of facility to compare physician and non-physician opinions with regard to pill management: a sampling of clients would be seen independently by both to find out what the two types of practitioners do differently, what the non-physician missed, etc. Prior to the study the non-physician or non-medical worker would have been given a checklist of questions to ask women and would have been trained in its use. Such studies would be useful in
 - demonstrating to physicians the safety of the procedures
 - effective training of distributors
 - need for revision of the checklist
 - guides to supervision
- * Distributors could be required to make note of all instances where women are denied pills due to suspicion of contraindication and when women are referred for higher opinion; such data would be useful for supervision.
- * A statement should be prepared and presented to the evaluation team concerning the range and variety of possible sites and situations for which non-medical personnel might be considered for initiation of pills and the factors involved in permitting them to do so as well as possible practice and procedures. Examples include factories, other industrial establishments, commercial outlets, health and community agents, auxiliaries, village distributors, etc. Findings of past special studies would be helpful. This list would permit the team to focus on the relevant factors listed so that during their visit they could formulate recommendations for ultimate implementation.
- * To investigate the extent of reliable complaints of side effects (such as Norinyl in Cap) and the possible impact on acceptance and continuation,

a special study monitoring a sample cohort should be done. A possible by-product might be criteria for identifying women whose past history suggests susceptibility to the drugs. One question is whether the program should offer a choice of brands or have a second brand for those adversely affected by Norinyl.

e. Summary - Contraceptive Distribution

Discontinuity of flow of contraceptives completely destroys a family planning program. Fortunately, the DHF has not permitted this to happen. With integration of family planning and MCH services into the general and district administration, it is imperative that the unreliable pattern of distribution of medications NOT extend to contraceptives.

It is possible, however, that irregular flow of contraceptive supplies occurs to private affiliated units such as Mission hospitals or to other units in the DSPP such as Nutrition Centers as seemed to be indicated in conversations with the Director of Nutrition. The consultants did not have the opportunity to investigate this.

At the moment the country appears to be saturated with pills and condoms but a normal situation should look something like this:

- * Contraceptives should be issued from central and district warehouses on the basis of monthly reports on amounts given to clients deducted from amounts on hand and previously received. This should be supplemented by quarterly reports of physical inventory. Supplies on hand should be adequate for at least two or three months. The evaluation team should have access to central record files on each distribution outlet, from which assessment can be made of continuity of supplies flow, excessively high or low inventories and unexplained losses. The physical layout of storage shelves should ensure first in-first out sequence of handling supplies and obviate unduly prolonged shelf storage. This system appears to be functioning fairly well with UNFPA supplies.

Since this report has called attention to serious problems concerning the importing pipeline of AID-purchased contraceptives, the evaluation team should investigate whether or not the problems persist at the time of their visit.

To the extent that financial transactions are associated with handling of supplies, the evaluation team will give attention to the monitoring system.

C. End of Project Status

1. Program Indicators and Measures

a. Prevalence of Contraceptive Practice

The DHF has a well developed service statistics system which necessarily collects quite different types and amounts of information for male

as compared with female clients. Consequently, it is not possible as yet to add the two together in a manner that will permit acceptable estimation of the prevalence of contraceptive practice in terms of the number of women protected by contraception. Data are available on the number of different women served during a year but not the number of different men. There are counts of new male acceptors and monthly counts from units of return male client visits which cannot give an annual unduplicated count. The number of condoms given at a visit may vary from 12 to 30. No information exists on the number of times any one man visits nor the usual, average or median number of condoms taken per man per year.

IT IS NOT RECOMMENDED THAT DETAILED INFORMATION CONTINUE TO BE ROUTINELY COLLECTED ON DISTRIBUTION OF CONDOMS -- AND OTHER BARRIER-TYPES OF RENEWABLE CONTRACEPTIVES -- TO IDENTIFIED INDIVIDUALS.

This is not feasible for personnel and is unacceptable to clients. The present practice of keeping a daily log of "visits" and number of condoms given should be continued without attempting to identify the client by name or number. From this would be known the volume of client contacts and the total amount of condoms issued, both useful for administrative purposes with respect to the overall program and for monitoring the work of clinics or individual workers. Since control of client ID and name promotes an atmosphere over control of supplies, elimination of this step eases the recording burden and eliminates pressure to track clients in such a manner as to encourage staff to be much more generous about distributing quantities of supplies per visit, a desirable spin-off.

To estimate average condom use in Haiti it is recommended that a cohort of male clients be selected and data collected on the number of condoms taken by them during a period of time. This can be done in a number of ways, each of them aimed at including all condoms taken by the participants from all sources during the period:

- (1) A retrospective analysis could be done if by chance any distribution outlet happens to have collected the needed information. This would require a clientele who are unlikely to have access to other sources of supply in the area.
- (2) Selected distributors in areas where clientele are unlikely to obtain their condoms from more than one source would keep track of the uptake by their clients during a time period.
- (3) In a number of areas with multiple distribution points, all active clients would be given identification cards and numbers and would be required to present the card whenever supplies are issued to them. The ID number would indicate

both the distributor who issued the card and the individual client. At each visit, the respective distributor would record on a slip of paper --

- * the ID number of the client
- * the number of condoms given

Twice a month, the collected slips would be placed in an envelope with name of distributor on it and sent to the central evaluation unit. The latter would learn the following:

- (a) Number of clients registered by each distributor;
- (b) Multiple sources of supply used by the clients;
- (c) Frequency of taking supplies (the envelopes would be dated for the half month of mailing);
- (d) Number of condoms taken by each client;
- (e) Number of visits to each distributor;
- (f) Number of condoms issued by each distributor;
- (g) Number of condoms given per visit by each distributor;
- (h) Rate of registration of new clients;
- (i) Dropout patterns among clients.

The cohort should cover a sufficient number of distribution points from different parts of the country with enough men in each, without necessarily attempting to obtain a statistical sampling. Even ten men from each of ten points might give a reasonably useful gross estimate of the average rate of uptake of condoms, but would not be enough for some of the other information listed.

The data should be collected for a full year. Condom count (c) is started with the first uptake by a man and includes his next to last uptake. The number of days elapsing (d) between his first and last uptake is used as indicated below to derive the uptake per year:

$$\text{Uptake per year} = C \times \frac{365}{d}$$

Until the year's observation is completed preliminary estimates can be made from shorter periods of data collection. For example, in preparation for the evaluation team, cohort could be followed during April, May, June and July. The number

of condoms minus those taken at the last visit would be (c). The number of days (d) would be between the first visit in April and the last one in July, 122 or fewer. The answer would be easily available by September.

Although there is no certainty that the condoms were used, these are the numbers taken and as far as the program is concerned, the number consumed. Regardless of wastage, the number of different men is the same.

The average year's uptake among the cohort is the condom factor (K) and when divided into the total number of condoms distributed to clients it provides the number of man-years of contraception. Although this is an understatement of the number of different men who may have received various numbers of condoms during the year, it might be added to the number of different female clients serviced to derive the number of clients of both sexes served, statistically speaking. Of greater accuracy and meaning, would be the number of couple-years of protection (Wishik and Chen: International Institute for the Study of Human Reproduction, 1973), reflecting the prevalence of contraceptive practice. Without the factors for the contraceptive methods, there follows a best guess at interpreting the data in the 1977 DHF report (page 62, Table 16) as an illustration:

Method	Number	Factor (?)	Number of C.Y.P.	% of C.Y.P.
IUD	1560	# x 2.5 years	3900	13.1
Pill	103148	# ÷ 13	7935	26.6
Creams	3945	# ÷ 4	986	3.3
Condoms	15874 gross	#(144/yr)	15874	53.1
Sterilization	118	118 x 10 yrs	1180	3.9
			<u>29875</u>	<u>100.0</u>

If there were 800,000 women of childbearing age in Haiti, this would be a contraceptive practice level of 3.7% from the services in the supported clinics. It becomes dramatically evident how great an impact there is from a relatively small number of IUD insertions and sterilizations. Data on contraceptive practice derived from the Haiti part of the World Fertility Survey should be made available to the evaluation team.

b. Number of "New" Acceptors

The consultants of the present report attribute less importance than is usually given to the number of "new" acceptors, particularly for condom users who may be "new" at several distribution points. The definition is notoriously arbitrary in general clinic services. For example, it was noted that clinics in Haiti tend to define most clients in general care for ambulatory illness as new acceptors, since they find it impossible to maintain individual case records and focus more on the episode of illness. We concur in the invisibility of trying to maintain case records for general health care of older children and adults.

c. Productivity

The number of different clients served and, to a lesser extent, the number of visits made can be helpful in assessing the productivity of different units or workers. Such comparisons should be made and used by supervisors in deriving clues to supervision and by administrators in monitoring staff work.

d. Method Choice

For family planning the distribution among contraceptive methods chosen by clients is greatly influenced by attitudes of staff; few IUD insertions are done in DSPP clinics but many more are done in the private clinics. The best stimulus to increased IUD "choice" is probably to give technical training and assistance to personnel.

e. Quality

It is not recommended that great effort be made to evaluate the quality of family planning work, such as by age and parity of clients. At present, the Haiti program is still aiming at getting enough quantity of public response. The postpartum interval that elapses before starting or renewing contraception is useful for increasing staff effort at the strategic time when a woman is more likely to be ready for, as well as in need of, contraception for the sake of her own and the infant's health. It would therefore be at least important as age and parity if "quality" is to be examined.

f. Availability - Accessibility

The DHF reports indicate the extent to which the different clinics have met their respective assigned targets. Of greater importance is the extent to which they have met the community need. It is true that population estimates contribute to the definition of targets, but it is preferable to point the workers' goals toward the actual community rather than a number on paper. This is done by defining "service catchment areas" within which the people have reasonable access to the clinic or workers' base. These people constitute the denominator against which numbers of candidates for different services are estimated. It is recommended that this be done for every local health unit or outreach worker. (Estimated time required to do this is about 15 minutes). The gross estimate of catchment area can be refined by doing a client "location analysis" about every two years. A sample of active clients is pinpointed on the catchment area map to see where they do and do not come from for service. This is especially helpful in identifying geographic reasons for dropout and indicators for relocating services, modifying transportation arrangements, changing clinic schedule time, reducing number of routine revisits or establishing peripheral resupply depots.

N.B. The H.E. Section requested a similar map as an IEC planning tool and at least one (Cayes) District has responded, i.e., such mapping is not only feasible it is already a perceived need by the DHF.

g. Discontinuation

Another family planning program statistic is the continuation or discontinuation pattern among those who have started contraception under the service. We understand that a continuation study has been done under UNFPA auspices. The findings should be made available to the evaluation team. A simple approach which might be suggested is to take all clients who visited in January 1979 and see what percent of them began their present episode of contraception during each of the previous years. If preferred, this can be done concurrently, such as during the month of April or May 1979 on all clients who visit at that time.

2. Impact

It is not expected that indirect benefits from the program will be evident so soon. Nevertheless, baselines should be established for measurement of future changes. These should be designed by defined geographic areas within which data could be maintained on nature, timing and amounts of program input. For example, as local health agents are introduced into new communities, immediate and remote effect should be expected. For example, women with obstetrical complications would be referred to the hospital, as a consequence of which the hospital would have more abnormal cases and higher mortality among its patients. It is inappropriate for the maternity hospitals to have 95 percent normal deliveries. Similarly, antepartum care should start earlier in pregnancy and more infants should have received last doses of complete immunization series in response to itinerant services coming into the communities. More remote criteria of impact might include: infant deaths, child deaths, birth weights, children growth and development, maternal deaths, deaths from diarrhea, tetanus of the newborn, number of children under five years of age per family. These and other criteria demonstrate the relationship between family planning and general health and social status and the inappropriateness of focusing only on narrow specific family planning impacts.

3. Cost

On the basis of methods suggested in this report on measuring funding inputs and amounts of contraceptive practice, data should be prepared and made available to the evaluation team on:

average cost per family planning visit
average cost per couple-year of protection conferred

D. Means of Verification

1. Statistical System

In different parts of this report, reference is made to recording and reporting in the statistical system. The most developed system exists within the DHF. It is essential that this be utilized and built upon in the new administrative

setup. At the same time, the goal should be for simplification and less routine record-keeping. It is recommended that consideration be given to eliminating keeping files of case records in ambulatory care. Instead, the individual client should carry an attendance card with summary of past contacts and the health unit or worker should keep a chronological ledger of daily activities with identification of clients served. Donor agencies must avoid over-burdening service and administrative personnel with record-keeping required primarily to help the donors monitor the expenditures of their donations.

Most health locations have inadequate facilities for record filing. Rather than aiming to improve these, it might be better to consider eliminating much of the need in certain types of health unit for recording/reporting.

The DHF has not been able to get 100 percent cooperation of all family planning service outlets in submission of periodic activity reports. This is a natural item for attention of the District Health Officers who should also be involved in information feedback to working staff.

In general, reporting (accuracy, timeliness, formats) is and will continue to be impacted upon by integration and decentralization as well as outreach. The team should be looking for changes, modifications or failings in the reporting system during the transition period, e.g., the Rural Health Agent reporting format was changed during a DSPP meeting with District Health Officers although the Division had developed a format and had used it for several months with Health Agents: what was the rationale behind the change? Will it be feasible to implement? Will it provide what is needed to measure the family planning component of the outreach effort?

2. Research

Health research has not been strong in Haiti so the family planning effort is dependent upon superficial and possibly erroneous information in planning services delivery. It is not recommended that a large research activity be instituted but rather that a number of studies beyond the usual needs of administrative monitoring be carried out. These should be selected for specific applicability to problems in the program. The evaluation team should consider the following topics to determine during their visit whether studies in these areas would be appropriate and subsequently recommended:

- side effects from Norinyl
- Safety of autonomous giving of contraceptive pills by non-physician personnel
- Contraceptive practices of men with more than one sexual partner -- demographic implications
- The high cost of medications in Haiti
- Resistance to family planning

The DHF has conducted research-type efforts as described in their Annual Reports; these should be perused and the team should determine whether they provided useful information and whether any action was taken to follow them up. If not, why not? It should also be determined whether these efforts are preceded not only by goals and objectives, but by commitment either from DHF or districts to integrate findings into overall program planning.

3. Evaluation

There is need for a strong central evaluation unit which receives copies of data directly and promptly from local units, workers and outlets. The evaluation unit should have the capability to process data for reports to administrators and extract indexes and ratios for rank-ordering of local units. Such indexes would be fed back to district administrators and supervisors in fashion readily appraised for use in field supervision and monitoring:

- * Mexico has such a system which appears to be highly organized but also computerized. Much evaluation can be done manually, if computer is not available.

In any event, field personnel should not be burdened with data processing and requiring district offices to analyze data is only duplicative of the central office work. Unduplicated female clients for 1977 alone was over 34,000 and new male acceptors over 38,000. Manual evaluation restricts cross tabulations to a minimum and if the program grows anywhere near the original projected number (200,000 couples) manipulation of data will become increasingly cumbersome.

E. DSPP: Integration, Decentralization and Outreach to Rural Areas

Three major changes in administrative policy, structure and practice in the Department of Public Health (DSPP) are taking place and have been described in the first section of this report. The evaluation team will need to look at these very carefully to identify strengths and weaknesses as well as transitional hazards, since the family planning effort is directly affected. Essentially, for donor agencies, it means accountability for MCH/FP quality and efficiency is more diffuse than in the past. Integration, decentralization and outreach to rural areas beyond the fixed clinic system are all in keeping with good management and service delivery principles and practices. Unfortunately, due to historical necessity, some sacrifices are inevitably going to be made in the process of change:

- * replacing established/strong structure with undeveloped/weak one
- * length of lag time between giving something up and replacing it
- * loss of administrative monitoring and data

1. Integration

Following are a number of considerations which the evaluation team will need to take into account in view of the situation described in the first section of this report:

- * Where in the DSPP is integration controlled? There appears to be no equivalent to an Office or Bureau of Health Services Administration to not only plan, but establish and implement this policy.
- * The confusion about working hours and salary supplements has been mentioned (Service Outlets) and warrants attention; previously compensated personnel are expected to do the same work in less time for less money.
- * Previously uncompensated personnel did not receive the same training, orientation and routine supervision afforded previously compensated personnel. How does this affect their performance?
- * During transition, coordination is crucial, e.g., health agents were trained but no placements/support structure ready for them; or placed without needed medicines or properly trained supervisors. IT WOULD SEEM PREFERABLE FOR DHF INVOLVEMENT TO BE RELINQUISHED MORE GRADUALLY TO ENSURE NOT ONLY A PLANNING BUT AN IMPLEMENTATION ROLE.
- * The present and future supervisory system has not been clarified. When family planning and other services disappear as separate service entities, how will service personnel receive general supervision and how will they obtain assistance on technical aspects of special types of service? Will there be two kinds of supervisors or only generic ones with technical consultants to them?
- * Ambiguity exists about responsibility for distribution of supplies, so that things may fall into the cracks between the DSPP, the DHF and the Regional and District Offices.
- * How will cooperation be obtained from hospitals under different auspices for such services as family planning surgery? What assurances are there that hospital administrators or their regional administrator will be committed to such collaborative efforts?
- * Where is the vested authority on technical policy and who ensures compliance? For example, Nutrition Center personnel do some family planning work; they do not initiate use of the birth control pill until the infant is a year old; the DHF has a different policy.
- * Is there integration at departmental levels in planning and implementation, and does it extend to other programs as well as DHF? e.g., Nutrition Center personnel go back to communities and follow up on children who had attended the centers; should this not be integrated or coordinated with other health work among those families?

- * Since family planning is now integrated into the morning hours it is important to look at overall DSPP clinic organization; what are the patterns of clinic traffic? Hours of actual staff attendance? Client waiting time? Expediting resupply of contraceptives? Efficiency in absorbing IUD insertion and other special family planning work into the general activities? Use of only general all-purpose sessions or schedules for different types of service? Extent to which non-physicians are permitted to perform different functions compared to DHF development and use of this type of worker?
- * Delegation of responsibilities -- physician role: in view of such great dependence upon young physicians rotated every two years or more often, what safeguards in training and supervision need to be strengthened? Can service stability be promoted by giving more authority and responsibility to non-physician personnel?
- * Record and reporting system -- are separate forms to be used for MCH/FP and other special services? How are data to be recorded for different types of services? Where will the analyses be done? Will only summary totals move up the line? Who will enforce timely reporting? On what basis and with whose authority will changes be made in content/format for reporting?
- * Patient Education -- one of the most important potential benefits to the family planning program that should derive from integration is the capitalizing of opportunities for introducing family planning in the course of rendering all other types of health care and education. Are such concepts introduced in training and supervision of personnel? Which personnel? To what extent do staff practice them? Examples include mothers bringing children for immunizations, antepartum and postpartum patients, nutrition programs, training of midwives and herb doctor/first aid (guerrisseurs), hospital obstetrical and other care.
- * High Risk Patients -- Integration of special services into general health work broadens the scope of staff responsibility and almost certainly increases their work load. Consequently, it becomes more obligatory for staff to be selective in the search for more vulnerable clients and in maintaining contact with them. This is done by the definition of "high risk". Criteria for such definition should be established for different types of client and categories of service. For example, specific danger signs concerning an infants' poor weight should warrant advising the mother of the importance of avoiding pregnancy until the child's health status is stabilized.

2. Decentralization

For several years, the health program has been organized into districts, but authority has remained centralized. Now, responsibility for services delivery including MCH/FP is being transferred to the District Health Officers. A number of aspects deserve the attention of the evaluation team.

- * No central unit has been established such as Local Health Administration, within the DSPP, to which the District Health Officers will directly relate. Authority rests with the Director General who is also the Health Officer of the District of Port-au-Prince and carries other duties as the Minister's Deputy.
- * There is ambiguity on the extent to which the Planning Unit is involved with program implementation and operation relating to decentralization as well as the other administrative changes.
- * Further uncertainty is engendered by the existence of an echelon above the District Health Officers or Regional Health Officers, of which there are at present two and more planned. The planned bureaucracy seems heavier than warranted or desirable in the decentralized portions and weak at the center, and geographic/transportation patterns are often more difficult among districts combined into a region than between each district and Port-au-Prince, e.g., it seems unlikely that the Jeremie District Administrator could easily communicate with the Regional Administrator in Cayes, and it appears to be an unnecessary extra layer between Jeremie and Port-au-Prince.
- * At the same time, the Regional and District Health Officers are given insufficient time and staff. Each is responsible for the District Hospital as well as the public health program, although some may have a deputy for the hospital work. Probably, all also maintain a private practice. The pattern of central administration is not replicated in the districts in terms of a chief nurse, health educator, etc.

3. Outreach to Rural Areas

The success of the Haiti family planning effort will stand or fail according to the effectiveness of outreach beyond the fixed health facilities. A number of different approaches include mobile units, satellite clinics with visiting staff, agents de sante in rural areas, community agents in urban areas, more peripheral volunteers in villages, community councils and commercial outlets. The situation is in rapid flux with experimentation and policy changes.

The evaluation team should examine changes in strategy from that described in the Project Agreement (page 84) in which the division would play the leading role and MCH/FP goals and objectives should be modified if appropriate depending upon the situation at the time of their visit.

The evaluation team should also examine current lines of authority and recommend a more detailed plan for the interim period during which the department is strengthening its resources to ensure that the DHF plays a substantive role in proportion to its human and material resources, and is phased out over an agreed period of time.

The following considerations should be taken into account by the evaluation team:

- * To what extent can the family planning effort be effectively realized through DHF support and direct supervision of health agents if these agents are handicapped by lack of support in all other aspects of their work?
- * Community agents were trained and deployed prior to the 1976 decision to reach out beyond the clinic system using health agents (now referred to as Agents de Sante, but previously referred to as Agents Sanitaires which translated "Sanitary Agents"); and the Community Agent role is well defined and documented in a Manual as an information and education worker, recruiting and following up MCH/FP clients; health agents are trained as para-medical workers who perform basic and simple curative care as well as education and delivery in MCH/FP. A Manual describes their role but work protocols detailing tasks, etc. were still in draft form at the time of the consultants' visit.

The evaluation team should:

- verify whether health agent tasks and protocols for para-medical services have been approved, finalized, documented and distributed;
- determine whether the supervisory and support system is in place where health agents are deployed; whether it is adequate; where inadequate, what tasks are health agents performing and not performing.
- determine whether there is any official revision of the community agent role to include contraceptive supplies, initiation of pills, and para-medical tasks;
- attempt to assess whether such revised tasks are being carried out in certain parts of the country; determine whether they could be officially recognized and appropriately documented;
- ascertain how health agents are placed and if appropriate distinguish between policy and practice; how stable these placements are (the health agent's status may have a great deal to do with whether they're resident of the area and length of stay);
- review training curriculum utilized in ODVA, Cap and Cayes and any other area that may have initiated Health Agent Outreach program.

- * The evaluation team should be furnished with the most recent document showing planned number of health agents in the field, current number actually placed, and specific information indicating level of support to those in place: are they receiving all work materials and medicines relating to tasks? Is dispensary functioning with auxiliary? Is auxiliary specifically trained in philosophy of health agent utilization? Does dispensary receive routine supervisory visits from district office?
- * In general there is definitive distinction between health agents and community agents but in Cap at least the regional administrator is looking toward revision of community agent role, feeling that after four years of educating, informing, recruiting and following up they should more directly be involved in health care delivery. The evaluation team should assess the feasibility of this action and determine whether similar intentions exist in other parts of the country.
- * Team should also be furnished with plan for Outreach with: dates, numbers and locations for dispensary construction or improvement, health agent supervisor training and deployment, logistical system (description and dates where appropriate) including medical and non-medical supplies, shipment and distribution points, frequency of supply, quantities, salary schedules; level of development of supervisory structure nationally, including worker report forms, overall reporting of data, collection and analysis system, data presentation format and frequency.
- * Role of the Planning Office -- as in other areas, the role of the Planning Office is somewhat ambiguous since it seems to be fulfilling an implementation function without necessary resources; it should play a key role in planning for the implementation but it is unclear who will do the actual implementing; the director is former Deputy to the DHF Director and as such is highly familiar with MCH/FP efforts and goals.
- * Role and current resources of the Office of Para-medical Training and Bureau of Nursing should be determined; what additional resources have they accumulated in the way of field experience, training, manpower, funds, etc. over the past two or three years to aid them in what is apparently implementation functions in the rural health agent effort.
- * Role of the division is ambiguous as described above; while responsible for training it does not have authority or final approval regarding health agent tasks; they have no decision-making role or control over general direction and development of the Outreach effort but do have materials other than MCH/FP which might possibly be funneled to health agents until the DSPP can take over as supplier; however, if they are to be merely trainer and supplier, these activities must be documented with the agreement of everyone concerned including donor agencies.

- * The team should be provided with the most recent documentation of the status of each of a number of experimental and pilot projects such as ODVA, Petit Goave, and the CBD system of Columbia.
- * The DSPP does not employ part time workers although apparently has some interest in doing so; part time work would permit use of the most peripheral village workers except for less reliable volunteers. The policy warrants discussion.
- * The UNFPA Agreement made mention of a system of unpaid resident informants for surveillance of births, deaths, pregnancies and other selected events; the status of this effort should be assessed.

F. Future Direction of the MCH/FP Effort

As outlined in the first section the most recent documentation is in the UNFPA agreement to be signed sometime in July. The team will want to peruse this document.

G. Inter-Agency Coordination

Haiti is blessed with support from numerous agencies; among them are: UNFPA, PAHO, UNICEF, IDRC, IPPF, FPIA, PIEGO, UNESCO, IDB, Pathfinder and AID. Their work has not been well coordinated. The evaluation team should explore this matter in terms of redundancies, incompatibilities and waste as well as weaknesses in planning. Constructive coordination would be the aim.

The AID Mission officer in charge (McKeithen) obviously has a great deal of administrative responsibility which does not permit him to spend more time than he already does for program content and development. The fact that other donor agencies do not have resident officials places an even greater burden on the AID Mission when in reality it should be shared. The evaluation team should also examine additional needed support for the Mission and the extent to which other donor agencies should contribute to program monitoring.

V. EVALUATION PLAN - CRITERIA

A. Service Outlets - Distribution

1. Number, locations, types, auspices, facilities, equipment, personnel.
2. Changes made: dates, nature of change (e.g.):
 - funded by program for physical renovation or addition;
 - supplies furnished;
 - program staff furnished;
 - funded for own operation, etc.
3. Geographic coverage
 - a. National rural
 - Catchment area maps for each rural service outlet and estimated population total in each. From this, aggregated estimate of national program coverage of rural geographic areas.
 - Percent of estimated rural population in service catchment areas.
 - b. National urban
 - Arbitrary criteria for defining sections of cities served by urban outlets. Then, similar procedure to 3a above.
 - Percent of estimated urban population in service catchment areas.
 - c. Local
 - Sample location analysis of clients. For each service outlet, a list of named rural communities or urban sections and estimated population in each community or section within its catchment area. Identification of places of residence of a sample of clients (e.g., all visits during August, 1979). Inspection of patterns of distribution of clientele that may be inappropriate to the population distribution. Use as clues for investigation for possible explanations. Compare with program objectives, trends.
4. Special study of satellite clinics and mobile units.
 - Difficulties in establishing locations and maintaining service; number of locations, relationship to fixed facilities (equipment, personnel, records, clients, referrals);

Types of local facilities used;

Schedules of visits, intervals between, types of visiting personnel, transportation sources and problems; categories of service rendered and amounts (e.g., immunizations); number of client visits, number of different clients served; extent of influence, communities of residence of clients; types and number of cooperating community workers, channels of communication between them and visiting teams.

Preparation for team visits and follow-up; referrals to fixed service facilities -- number, types and effectiveness; nature and amount of interim services in the communities.

B. Service Volume

1. Number of client contacts, by years, by categories of service, maternal health, family planning, child health.
 - a. Trends over time, increase achieved during project period;
 - b. comparison with program objectives;
 - c. internal comparison among local outlets, according to size of unit staff.
2. Amounts of contraceptives distributed to clients, by different contraceptive methods, by types of distributors.
 - a. Ratio of distributed amounts to number of relevant client contacts;
 - b. comparison with program objectives;
 - c. time trends;
 - d. internal comparison among local service outlets.
3. Number of single immunization procedures (if possible, by disease groups).
 - Given to pregnant women
 - Given to young children (within defined age groups)
 - Given to others
4. Number of rehydration packets given directly to families.

5. Amounts of other medications issued to clients, by types of medication.

Ratio to number of client contacts for general use.

6. Policies on distribution authority and responsibility of different types of personnel for contraceptives, for medications. Criteria for issue, amounts per visit, contraindications.

C. Service Utilization (Population Participation--By Rural Catchment Areas Urban Sections and Nationally)

1. Number of different clients during year, by category of service (maternal health, family planning, child health).

May be necessary to estimate by average number of visits per client -- obtained by sample study.

2. Number of condom users (by sample study -- see reports).
3. Number of male and female sterilizations.
4. Number of couples -- years of contraceptive protection by each contraceptive method.
5. Continuation patterns for categories of service and contraceptive methods (special studies).
6. Number of completed immunization series.
7. Ratios of number of different clients to estimated number of candidates for respective categories of service; measures of amount of "need" defined, e.g., number of pregnant women during a year equals almost twice number of live births per year; number of infants and young children; number of potential family planning clients; number of diarrheal episodes calling for rehydration treatment.

D. Quality of Service (Special Data Collection on Sample of Clients Probably Necessary)

1. Appropriate timing of service -- examples: Trimester of pregnancy at admission to antepartum care; age of infants at admission to health supervision; postpartum interval at initiation of contraception; age and parity at initiation of contraception; days of diarrheal disease before institution of rehydration therapy.

2. Emphasis on high risk clients -- examples:

Percent of obstetric cases in hospital maternity services with complications at time of admission; infants with low birth weight or severe degree of undernutrition -- average number of contacts for health supervision during months after first admission.
Number of referrals by midwives to physicians for care of pregnancy complications.

E. Efficiency

1. Productivity of personnel.

Number of "worker-years" of staff time devoted to direct personal services and education, by categories of workers. Ratio of staff time to number of client contacts.

2. Cost

Total "direct" costs for personal services (excluding administration, facilities, training, etc.). Ratio of costs to number of client contacts.

F. Impact of the Program

A longer period of time is required to measure most effectiveness indexes such as maternal mortality, infant mortality, disease incidence, family welfare. But some criterion can be selected for fairly immediate relationship to program efforts, such as: incidence of tetanus of the newborn, incidence of measles or other disease against which immunizations are offered, birth weight, weight at first birthday. Such events among program clients reveal failures even among those served. Beyond that, level of accomplishment in the population at large calls for a general surveillance system for vital events and sample community surveys. It would be useful to decide on criteria, obtain a baseline for them and plan periodic measurement on future trends.

G. Administrative Structure and Process

1. Policies

Restrictions on eligibility for care; fees charged. Bases for selection of outlets and for frequency of sessions.

Personnel selection and remuneration.

Roles of different categories of personnel.

2. Ministry Table of Organization; lines of authority;
 Division of Hygiene Table of Organization;
 Locus of planning responsibility.
3. Decentralization
 Regions and districts
 Division of authority between center and periphery
 Liaison relationships between central administration, program direction and decentralized officials.
 Transitional status during decentralizing process.
4. Program manuals and rules, at different levels.
5. Records and reports system
 Forms used
 Channels of submission
 Completeness of meeting procedure requirements - promptness
6. Vehicles and other large equipment
 Number on hand - distribution
 Operating condition and time out of use
 Maintenance and responsibility for assignment
 Percent of time used
 Source of funding
7. Medications, contraceptives and other renewable supplies
 Categories
 Amounts on hand and distribution of current inventory
 Warehouse and depot locations
 Distribution pathways and responsibility
 Inventory and fiscal accounting systems
 Ordering system and responses -- delays and discontinuities
 Sources of funding
 Policies and practices in issuing materials to clients

8. Program integration

- Family planning into MCH
- MCH into general care
- Hospital and ambulatory care
- Referral pathways
- Special, vertical or campaign activities and regular decentralized services
- Transitional status during integration process

9. Community outreach

- Urban neighborhood workers
- Urban community councils
- Rural village workers
- Scope of service and education
- Population participation
- Transportation resources and problems

10. Program evaluation

- Administrative location of evaluation personnel
- Numbers, categories and qualifications of personnel
- Freedom of access to needed information
- Scope of evaluation -- routine and special; flexibility of focus
- Statistical equipment and services available
- Audiences receiving reports, feedback done
- Relationship to administrative and planning decisions

11. Interagency coordination

- Between Ministry and non-governmental services -- hospitals, factories
- Among donor agencies
- Among relevant governmental agencies

H. Information, Education and Communication

1. IEC Function Within Division

- a. Documentation of IEC plans, goal achievement, method for measuring impact, delegation of authority, division of responsibility, lines of communication (i.e., progress reports, job descriptions, organizational charts, etc.);
- b. allocation of resources to IEC activities, adequacy, insufficiency, appropriateness (staff, time, vehicles, funds, etc.);

- c. relationship between IEC function and rest of Division: IEC activities' adaptation to policy changes in services delivery, evaluation results, introduction of new services or projects; and conversely whether IEC results are fed into Division policy and decision-making, planning, etc.;
- d. quality of IEC projects, documentation of such.

2. IEC Function at Regional Level

- a. Lines of authority and responsibility between Division and Region IEC personnel; mechanism for ensuring that Division IEC plans are implemented at Regional level; supervision and follow-up by Division;
- b. adequacy of resources to carry out IEC activities (staff, vehicles, etc.);
- c. method for incorporating Regional service changes into IEC efforts.

3. Relationship Between IEC and Services Delivery/Client Attitudes and Use

- a. Method for selecting research topics/special studies regarding client utilization of services, attitudes, quality, etc.;
- b. action taken as a result, orientation of IEC toward problems identified, authority to implement such action;
- c. IEC input into selection of research topics and into policy or procedural changes in services delivery; particularly use of outreach and community-based workers in assessing client needs and recommending service delivery changes to meet those needs so that IEC effectiveness in recruiting new or keeping old clients is not diluted by loss of clients through service barriers, poor quality, etc.

I. Staff Development and Training; General Human Resource Development

1. Human Resource Development Function at Division

- a. Identify individuals authorized to determine the role and function of each type of personnel including especially new types of personnel; method for implementing modifications and changes in job functions via training, supervision, reporting, evaluation; to whom trainers are accountable for ensuring that training meets skill needs of workers; to whom supervisors are accountable for ensuring that workers performed as expected;

- b. existence in writing of detailed task listings, work protocols and procedures, personnel policies, supervisory structure, evaluation;
 - c. training facilities and training program methodologies.
2. Relationship Among Division, Region and DSPP Offices Responsible for Development of Human Resources
- a. Who has ultimate authority for determining the function and tasks of personnel and for making changes; who is responsible for implementation of change; who ensures that training, supervision and evaluation in the field relate back to the functions and tasks;
 - b. who ensures that worker evaluation is based upon a mutual understanding between the worker and supervisor of expectations emanating from the appropriate office (DSPP, Division, Region);
 - c. how is worker evaluation fed back into planning so changes are made in functions or worker activities;
 - d. are staffing and other resources adequate for the Human Resource Development function;
 - e. is there documentation of the above process as well as written agreement regarding division of responsibility among Division, Region and other DSPP personnel.

N.B. The Mission response indicated lack of clarity on page 17, Section 3, #8:

The intent of these two paragraphs is to point out that expectations regarding Development of Human Resources is expressed in PROP Agreements and DHF Plans in such a way as to assume that such functions as task analysis, personnel evaluation, and matching skill needs to training objectives are carried out. However, resources are allocated strictly to training functions such as curriculum development, per diem for trainees, etc. Resources such as Health Education Section staff and budget does not reflect or recognize the time-consuming development activities necessary for new types of personnel or modification of existing worker roles. Training programs are expected to produce health agents without adequate time or resources before training to ensure that tasks and activities are developed by whomever shall ultimately assure that training produced agents capable of fulfilling expectations upon which supervisors shall evaluate their performance, i.e., HRD is insufficiently supported, and interchangeably referred to as "training" which is a much narrower function.

J. Research

Locus of research personnel

Number, categories and qualifications of staff

Bases for focus on particular subjects

Relevance and utility to program

Liaison relationship to programs - access to data
and intimacy of feedback

Subjects covered recently; findings

Quality of work

Cost and funding sources; budget

Facilities available

Transportation access to field

APPENDIX A
CHRONOLOGY AND PERSONS CONTACTED

Chronology and Persons Contacted:

- 1/12 - Briefing AID Washington - William Baer, David Denman, Moira Brackett, King Morgan, Suzanne Olds, Howard Hough.
- 1/13 - Arrive Port au Prince p.m. - McKeithen's home
- 1/14 - Team read and discuss documents
- 1/15 - a.m. - AID/Haiti - Larry Harrison, Polly Harrison, William Boynton, Win McEithen, Joel Cotten, Firmein
Family Hygiene Div. (Dr. Verly, Dep. Dir; Dr. Bordes absent)
p.m. - Team preparation of two-week schedule; McKeithen
- 1/16 - a.m. - Family Hygiene Div. - Dr. Verly, Dr. Serge Armand (Supervision Chief), Mme. Gehy (R.N., Matrone Program; Mme. Mallebranche on leave)
p.m. - Dr. Laurent Eustache (Health Education Chief), M. Pierre Jerome (Asst. Chief, Statistics; M. Guy Celestin on leave)
- 1/17 - a.m. - Family Hygiene Div. - Dr. Pintro (Supervisor, ODVA Project)
p.m. - Minister of Health, Dr. Verrier, Chief of Planning Office, Dr. Evariste Midy
Bureau of Nutrition - Dr. William Fougere, Director
- 1/18 - a.m. - Cap Haitian - Team, B. Ormond AID/Haiti, Dr. Serge Armand; & brief stop in Gonaives, visit with Dr. Jacques Sajous,
p.m. Director Gonaives District; Dr. Angrand, Director of Cap Region, preparation for Friday schedule
- 1/19 - a.m. - Cap Hospital - Dr. Leveille, Director
& La Fossette Health Center in Cap
p.m. Quartier Morin Dispensary; Habitation Defou Health Agent; Supervisor Nere Deborah Leroy, WHO Consultant
- 1/20 - a.m. - Meeting with Cap Community Agents; meeting with Dr. Angrand, Dr. Leveille
- 1/21 - a.m. - Return Port au Prince - Harrison's home
p.m. Team meeting; discussion of trip, documents, notes to date (Bordes, Celestin & Marseilles - Administrator - returned from Africa)
- 1/22 - a.m. - Jewell to ODVA all day - with Dr. Laurent Eustache, & Dr. Pintro; pick up Dr. Goudret (M.D. Boccozele);
p.m. visit Health Center L'Estere; visit Health Center Boccozele; meeting with community council Boccozele; Leana Dieujust & Elza Paul
Wishik - Family Hygiene Div. - Dr. Bordes; Dr. Rathausser, PAHO Rep

- 1/23 - a.m. - Family Hygiene Div. - Dr. Laurent Eustache, Dr. Bordes
& Mr. Roger Rochat, CDC/Atlanta, in Haiti to evaluate CBD
p.m. Project
- 1/24 - a.m. - Ministry Health Planning Office, Dr. Midy
& M. Celestin, Family Hygiene Div. Statistics
p.m. Dr. Bordes (Jewell - re: IEC)
- 1/25 - a.m. - Family Hygiene Div. - Inventory Logistics System
(M. Sylvio Albert)
Mobile Unit (Jewell) - Macajou/Port au Prince area -
Dr. Legros, Director of Port au Prince Metropolitan MCH/FP
Program, Dr. Polynice, Div. Supervisor for Mobile Unit
Field visit made to Petit Goave - Dr. Wily Dien Dorenc
Noon Dr. Bordes
p.m. AID - Harrison, McKeithen, Boynton
- 1/26 - a.m. - McKeithen, Cotton (AID Evaluation), Boynton
p.m. Minister of Health, Dr. Verrier, Director General, Dr.
Des Louches
Wishik Departure - Jewell at Family Hygiene Div.
(Eustache/Bordes)
- 1/27 - a.m. - Jewell, writing
p.m. Eustache, Div. IEC Office, review reports/plans
- 1/29 - a.m. - Meeting AID Washington
p.m. Report writing

APPENDIX B
RESOURCE DOCUMENTS

Resource DocumentsAID

- * PROP Revision, 521-0071, CY1977, Maternal Child Health/Family Planning, with attachments: In-House Review, Annex I, Advice of Program Change
- * Project Paper, Maternal Child Health/Family Planning II, Haiti, 521-0087, 11/25/77
- * Draft of UNFPA Agreement with Division, July 1979-1983
- * "A Note on Knowledge, Attitudes and Practice of Contraception in Haiti Based on Preliminary Findings of the 1977 Haiti Fertility Survey," James Allman, Resident Adviser, World Fertility Survey, Port au Prince, Haiti, September 1978

Documents of the Division of Family Hygiene (translated loosely from the French):

- * Six Month Report (January-June, 1978)
- * Annual Report (January-December, 1977)
- * Tripartite Project Review, MCH/FP, Haiti, October 10-14, 1977
- * Description of Program Activities for MCH/FP in Collaboration with the Armed Forces

Documents from the IEC Section:

- * Report concerning the New Orientation of the MCH/FP Communication Program, 6/28/78
- * "Information, Education, Communication: Introductory Manual in Health Education," 1978, Edith Lataillade and Laurent Eustache, M.D.
- * Training Curriculum for Community-based Distributors; Rural Health Agents; Trainers of Agents; Herb Doctors

Documents from the Supervision Section:

- * Report - Supervisory Visit and Inter-Departmental Meeting, May 1978, Pont Sonde, ODVA
- * Outline of Responsibilities of the Division in the Joint ODVA-DSPP Project
- * Report - Supervisory Visit to the Joint ODVA-DSPP Project, January, 1979

- * Purpose and Function of Mobile Clinics, March 1977
- * Purpose of Selective Supervision, August 1978
- * Work Plans for 1978 including Description of General and Specific Objectives; Activities and Resources to be used; Calendar and Milestones

Documents from the Nursing Section:

- * Instructions to Nurses and Health Auxiliaries Training Matrons
- * 11-month statistical report of Matron Activities (Jan.-Nov. 1978) and Report Forms

Document from Cap District:

- * Three-page Description of Health Agents Activities and Tasks; Report Forms

Appendix C
Comments

Comments

Comments in response to April 30, 1979 dated (received much later) memo from "MCH/FP Project Committee, USAID/Haiti."

The consultants appreciate the careful review of their reports made by AID Mission. The review and comments add the values of longer term, in-depth familiarity with the situation. Most of the material is in agreement with the tenor of the reports and opinions of the consultants. Only selected items in the Mission statement are here chosen for additional comment.

Item 4 (page 4). The warehouse and depots are very important for the supply chain. At all these facilities, the specific physical layout, procedures and record system should be carefully designed to support the concept of "First In, First Out - FIFO".

Item 5 (page 4). The crucial issue is that, whatever the objectives or targets, the program does not have an adequate system for measuring the prevalence of contraceptive practice.

Item 10 (page 21). As indicated in the reports, the consultants suffered under a confusion of conflicting AID desires and understanding of the purpose of the consultation. In the effort to straddle, we may well have fallen between. Apparently, the confusion continues. On the one hand, we are asked "to provide more concise guidelines and tasks for the evaluation team scheduled to visit Haiti in August-September, 1979." On the other hand, a PAHO attachment includes a set of rather detailed terms of reference for evaluation of a five-year period (1974-1979) by a multi-agency team, presumably including AID ("other agencies"), and under the overall direction of the PAHO country representative.

Under the circumstances, the consultants are electing to do the following in response to the Mission comments. Except for several corrections (see below) it is suggested that the report be left as is. The recommendations would seem to be more meaningful when seen in their documented and explanatory context. At times, the material was more suggestion for consideration by program officials than outright recommendation. The coexistence of comments on program modification and methods of evaluation should not weaken the former. In addition, a separate outline for evaluation is submitted even though it is unclear how this would be used by the evaluation team.

Item 16 (page 31). We fully agree that the distribution of contraceptives should be liberalized. The reasons given for restricted procedures were by way of explaining local practices and are not the opinion of the consultants. The section has been deleted.

Item 17 (page 31). Similarly, the felt need to obtain data for donors rather than the donor requests was the thought intended. The section has been modified.

Items 17 (pages 33 and 39). Repeatedly, the consultants' report emphasized the desirability and advantages of non-physician contraceptive distribution. We believe that this is not a matter for reconsideration in Haiti. Nevertheless, the safety argument keeps being raised everywhere, including Haiti. There exist few, if any, good studies on comparative clinical risk. We suggested a simple methodology for such a study that could easily be replicated in different places so as to give indigenous relevance to the evidence. Otherwise, the polemic is resurrected in each country, especially by the medical profession. To our knowledge, the research done and planned in Haiti will not face the medical issues.

Item 19 (page 33). We agree that when pill distribution is done well, there are fewer complaints and less dropout. Both clients and staff are subject to the common tendency to blame almost anything on the pill. Having an alternative pill merely eases the pressure a bit. A well designed research study along the lines suggested by AID Mission could be a useful effort for the next year.

Item 20 (page 39). We were told that the average condom consumption among users was 288 per year! We cut the number in half. A still lower figure is more likely and would indicate a larger number of practices.

Project 521-071

Item 2. The indirect estimation of number of pill users was necessary because of incomplete data. It is expected that a direct count will be possible in the future.

Item 3. The items in this list added up to "total condom users ever", not to current users. Repeated references in the consultants' reports indicate the gross deficiencies in counting condom users and the great need for instituting a system to do so. For this reason, the method was presented in detail (pages 35 and 37). It is urged that a panel of condom users be established immediately and that data start being collected even during the short time remaining before the forthcoming evaluation team visit.

It is unfortunate that so long a time has elapsed since January without more use of the consultants' reports in preparation for the evaluation team. The consultants made every effort to produce their report promptly without time for joint review of the draft and at the cost of some errors. It had been hoped that new data for a greater year could be made available to the evaluators.

Appendix D

Resource Support Services Report: Haiti, Jan. 21-25, 1979

MEMORANDUM

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

Appendix D

TO : William H. Foege, M.D.
Director, Center for Disease Control (CDC)
Through: Philip S. Brachman, M.D.
Director, Bureau of Epidemiology (BE) *PSB 2/14/79*

DATE:

FROM : Deputy Director, Family Planning Evaluation Division (FPED) *PR*
Bureau of Epidemiology

SUBJECT: Resource Support Services Report: Haiti, January 21-25, 1979

I. PLACES, DATES, AND PURPOSE OF TRAVEL, AND CHIEF CONTACTS
II. RESULTS AND COMMENTS

- A. Background
- B. Project Design
- C. Status
- D. Impressions on Value of Resident Advisor

I. PLACES, DATES, AND PURPOSE OF TRAVEL, AND CHIEF CONTACTS

Haiti, January 21-25, 1979, to conduct a site visit of Columbia University's project "Operations Research and Household Delivery" supported by Contract AID/PHA-C-1107 with local Mission support through Project No. 932-0632.

Division of Family Hygiene, Ministry of Public Health
Ary Bordes, M.D., Chief, Division of Family Hygiene (DFH)
Adeline Verly, M.D., MPH, Assistant Chief, DFH
Robert Hanenberg, Ph.D., Technical Advisor, Research Section, DFH
Wilner Pierre-Francois, Coordinator, Household Contraceptive
Distribution Project
Jules Moleon, Chief, Research Section
Kercy Jacob, Research Section

AID/Port-au-Prince
Willard (Bill) Boynton, M.D., Public Health Officer
Win McKeithen, III, Population Officer

Others
Sam Wishik, M.D., APHA Consultant
Noreen Jewel, APHA Consultant

II. RESULTS AND COMMENTS

A. Background

Columbia University's consultation in family planning and maternal and child health to the Division of Family Hygiene began in 1966 with a consultation from Dr. Sam Wishik. About 1976, Dr. Gary Merritt, AID/W, Dr. Martin Gorosch, Center for Population and Family Health, (CPFH), and JoAnn Revson (CPFH) collaboratively designed a household

distribution project for Haiti which was intended to test the effectiveness of distributing contraceptives under 3 different strategies. The first comparison was to determine the relative effectiveness of distributing contraceptives alone versus contraceptives and simple medicaments (anti-parasitic, anti-dehydration, vitamins, aspirin, etc.). The second was to determine the relative effectiveness of having medical facilities as resupply points (clinic or mobile unit) versus local depots (individual or pharmacy) and the third was to determine the difference in cost per acceptor and per couple-year of protection in a clinic facility versus household distribution combined with development of community pharmacies and depots. Three areas of rural Haiti were selected for study. Each household in each area was to be visited and contraceptives (oral or foam) to be offered to all eligible women and condoms to all eligible men. Eligible was defined as a sexually active adult. A checklist was to be used to exclude sexually active women who were pregnant, less than 3 months postpartum if breastfeeding, and women who had health contraindications.

At the time this study was designed, contraceptives were distributed only through physician-based clinics and both fertility levels and methods of fertility control in Haiti were poorly defined. The primary focus of the Division of Family Health was on integrated maternal and child health and family planning program built upon medical and clinical infrastructures and indigenous practitioners (Agents de Santé). The full details of the project "Operations, Research, and Household Delivery" are described in agreement 78-8 of Project No. 932-0632 between AID and CPFH and the Department of Public Health and Population of the Republic of Haiti. It includes the establishment of community-based pharmacies and a timetable for the research.

Perhaps the biggest single change in research strategy, which has occurred during the project, has been the deletion of simple medicaments from the strategies. The medicines were to be made available by AID/W but in fact were never made available. However, Mr. McKeithen (AID/Port-au-Prince) states that AID was primarily interested in the impact of household distribution of contraceptives and requested that Columbia continue the research effort to evaluate the effect of distributing contraceptives door to door.

Robert Hanenberg, Ph.D., was assigned to the Division of Family Hygiene by CPFH in September 1977, following one month intensive training in the French language. During my three days in Haiti I visited the Division of Family Hygiene to discuss the status of the research project and their impression of the effectiveness of Dr. Hanenberg as a technical advisor. Since Dr. Hanenberg plans to resign his post March 30, 1979, I also inquired about management of the project following his departure.

B. Project Design

The study consists of 2,000 households in 5-6 villages in each of 3 areas. In each village 400 households are selected contiguously beginning with the headman's house and, therefore, are non-representative of the villages from which they are chosen. A single distributor with minimal literacy ability is chosen from each village. Contraceptives are distributed during a 4-month time period by the distributors, and a survey is conducted in the household as the contraceptives are distributed. Thus, each area has 3 rounds of prevalence surveys.

C. Status

Area 1, Fond Parisien, had had prior MCH and Family Planning activity and had had a family planning clinic. Household distribution was begun in January 1978, and the third round was conducted between September and December 1978. Illustrative preliminary results of rounds 1, 2, and 3 are shown in Table 1 and for rounds 1 and 2 in Tables 2, 5, 6, 9, and 10.* Table 1 shows that there was a slightly greater than 3-fold increase in the use of modern contraceptives between the baseline survey (round 1) and the second survey (round 2). There was little change in contraceptive prevalence between round 2 and 3 except for a decline in prevalence in village number 3. Table 2 shows that condoms and pills each showed about the same level of increase between rounds 1 and 2. The increase in contraceptive prevalence was fairly evenly distributed between ages 20 and 44 (Table 5) and among women with different family sizes (Table 6). During round 1, the baseline survey, 8.6% of the women were pregnant, 17.2% breastfeeding, and 74.2% were neither pregnant nor breastfeeding (Table 9). The proportions were approximately the same in round 2. The proportion of breastfeeding women using modern contraceptives increased from 8% to 33% between rounds 1 and 2. The proportion of women neither pregnant nor breastfeeding who were using modern contraceptives increased from 3% to 11% (the latter figures are not shown in Table 9, but can be easily calculated from the data shown).

Tables 10 and 11 demonstrate illustratively how one can examine transitions between states of pregnancy, breastfeeding, and use of modern contraceptives in longitudinal studies such as this one.

When round 3 is complete for Fond Parisien, it is intended that the distributors will continue to provide supplies as part of a commercial distribution system. The cost of the supplies to the distributor will be 5¢ (U.S.) for 4 cycles of pills or 75 condoms and 10¢ for 1 tube of cream. The planned retail price will be 20¢ per cycle or per 8 condoms and 40¢ per 1 tube of cream.

The second area for examining the effectiveness of contraceptive distribution is San Marc. Round 1 was conducted September-December 1978 and round 2 is being conducted (January-April 1979). I visited San Marc

*Tables are not numbered sequentially because they correspond to tables prepared by R. Hanenberg with same numbers.

with Dr. Hanenberg and Mr. Pierre-Francoise to observe their careful review of distributors' reports. The third area is Leogane which I visited to observe a training session (11 female and 1 male recruits for 5 distributors' jobs).

D. Impressions on Value of Resident Advisor

During his 15 months in Haiti, Dr. Hanenberg has designed forms for the field research, assisted with supervision, and most importantly in verification of results of the research project, has provided formal teaching to the Research Division in demography, statistics, and data processing (and feels they should have teaching in questionnaire design and data analysis). He prepared a list of special tabulations which would be of particular policy interests and which could be derived from the Haiti fertility survey. Dr. Hanenberg presented this at a WFS conference in Port-au-Prince October 25, 1978. He computed the number of current users of contraceptives from the preliminary data of the World Fertility Survey and submitted that report to USAID/OP August 7, 1978. He prepared a multi-country comparison of fertility survey data for Dr. Verly. He and Jean Kerby Jacob prepared a report in French on continuation rates of family planning acceptors (published in French July 1978 with an English abstract). Finally, Jim Allman, Robert Hanenberg, and Pierre Paisible co-authored a paper "Results of the World Fertility Survey Pretest in Petit Goave" (a report to the Canadian funding agency in French in 1978).

Dr. Bordes and Dr. Verly each reported they were pleased with Dr. Hanenberg's work and that they were anxious to have his position replaced. The chief value of refilling his position was that he improved the quality of data and was the only professional capable of demographic analysis of the data. Finally, his role in professional development of staff was valued.

I identified 3 ways in which this assignment could be improved. The value of technically trained persons, such as Dr. Hanenberg, would be markedly enhanced by receiving adequate logistics support from AID Missions. The Resident Advisor received inadequate support from the AID Mission because Mission policy does not provide for the same services for staff and contract persons. For example, Dr. Hanenberg estimated that he spent 2 of his first 12 months "processing papers;" he waited 6 months to get his car through customs. He is required to obtain various government papers (e.g., for car) periodically, and each paper consumes about one day.

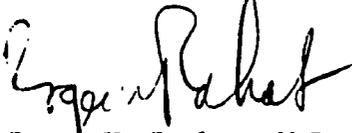
Second, Dr. Hanenberg entered his assignment with limited experience in research in fertility and fertility control subject matter. His demographic training, high motivation to obtain good quality data,

and perseverance have led to good results. However, with a broader background in fertility control methods and research, he might have explored additional projects such as abortion epidemiology. Dr. Verly indicated that induced abortion occurs moderately frequently in urban areas and that in at least one government hospital 50% of medical beds were often filled with women with complications from induced abortion. She expressed an interest in studying the subject further. I also believe Dr. Hanenberg's work is of sufficient quality that he should be encouraged to submit both the study of family planning continuation rates as well as his analysis of the Fond Parisien rounds 1, 2, and 3 analysis for publication.

Finally, I think it is unfortunate that Dr. Hanenberg is leaving at this particular point in the research study. He had invested a good deal of effort in developing a project, he has been received very favorably by the Haitians with whom he works (in contrast to the last advisor who was requested to leave because of incompatibility). And, he understands the study design and data collection problems well enough to draw appropriate inferences from the data.

Win McKeithen, USAID, characterized Dr. Hanenberg as having conducted a "superb job," in part, because he was "low key" and competent. "People came to him for advice." He was "very active in the field." The 3 most important outcomes of his activities were: 1) For the first time in Haiti, pills were distributed by non-physicians using a checklist; 2) women were demonstrated to be better than males in distributing contraceptives, and 3) the prevalence of contraception in the baseline survey at Fond Parisien varied inversely with the distance from the distribution site.

I would recommend continuing to assign a Resident Advisor for the duration of the household distribution research project. The chief skills required for a replacement would include "problem-solving ability," technical demographic skills, writing skills, language skills (French and possibly Creole), a high level of motivation, and a good sense of humor in frustrating situations. He should be able to assist in applying the findings of operational research on a larger scale within the national program.


Roger W. Rochat, M.D.

PRELIMINARY RESULTS
DO NOT QUOTE

Table 1

PERCENT OF WOMEN AGE 15-49 IN 1,600 HOUSEHOLDS USING A MODERN METHOD OF CONTRACEPTION:
FOND PARISIEN, HAITI, HOUSEHOLD DISTRIBUTION PROJECT, ROUNDS I, II, AND III, 1978

Village	Sex of Distributor	Round I (Jan-April)		Round II (May-Aug)		Round III (Sept-Dec)	
		No. Women	% Contra- cepting	No. Women	% Contra- cepting	No. Women	% Contra- cepting
1. Fond Parisien	Male	536	6.2	542	11.4	--	11.2
2. Ganthier	Female	466	4.7	475	15.1	--	15.2
3. Galette Chabon	Female	448	2.9	405	27.4	--	16.8
4. Beauge	Male	--	1.2	--	2.8	--	3.0
5. (Dropped) ¹	Male	--	--	--	--	--	--
Overall			3.9		13.9		

¹Data from village 5 not included in analysis because distributor reported incorrect information.

Table 2

PERCENT OF WOMEN AGES 15-49 USING VARIOUS KINDS OF CONTRACEPTIVES,
BY METHOD: FOND PARISIEN, HAITI, ROUNDS I AND II (1978)

Method	Round I	Round II	Absolute Percent Increase	Relative Percent Increase
ALL METHODS	3.9	13.9	10.0	256
Pills	2.2	6.0	3.8	173
Condoms	0.4	4.5	4.1	1025
Foam	0.2	2.8	2.6	1300
IUDs	1.1	0.6	-0.5	- 45

NOTE: The absolute percent increase is the difference between the third and second columns. The relative percent increase is the quotient of the fourth and second columns times 100.

Table 5

PERCENTAGE OF WOMEN USING MODERN CONTRACEPTIVES,
BY AGE: FOND PARISIEN, HAITI, ROUNDS I AND II (1978)

<u>Age</u>	<u>Round I</u>	<u>Round II</u>	<u>Absolute Percent Increase</u>	<u>Relative Percent Increase</u>
TOTAL	3.9	13.9	10.0	256
15-19	0.0	2.0	2.0	*
20-24	3.0	15.2	12.2	407
25-29	7.6	23.1	15.5	204
30-34	6.9	20.2	13.3	193
35-39	5.1	23.4	18.3	359
40-44	1.6	14.2	12.6	788
45-49	5.2	5.7	0.5	10

NOTE: The absolute percent increase is the difference between the third and second columns. The relative percent increase is the quotient of the fourth and second columns times 100. The relative percent increase is not defined when an entry in the second column is zero.

Table 6

PERCENTAGES OF WOMEN AGES 15-49 USING MODERN CONTRACEPTIVES, BY NUMBER
OF LIVING CHILDREN: FOND PARISIEN, HAITI, ROUNDS I AND II (1978)

<u>Number of Living Children</u>	<u>Round I</u>	<u>Round II</u>	<u>Absolute Percent Increase</u>	<u>Relative Percent Increase</u>
TOTAL	3.9	13.9	10.0	256
No Children	0.0	3.5	3.5	*
1 child	1.7	16.7	15.0	882
2 children	4.2	16.3	12.1	288
3 children	10.4	22.3	11.9	114
4 children	5.7	21.1	15.4	270
5 children	9.6	24.8	15.2	158
6 children or more	7.4	24.4	17.0	229

NOTE: See the note on Table 5

Table 9

PERCENT DISTRIBUTION OF WOMEN BY RISK OF BECOMING PREGNANT
AND FOR THOSE AT RISK OF BECOMING PREGNANT BY USE OR NON-USE OF MODERN CONTRACEPTIVES:
HOUSEHOLD CONTRACEPTIVE DISTRIBUTION PROJECT, FOND PARISIEN, HAITI, 1978

	Round I (Baseline)	Round II
Already Pregnant	8.6	7.5
Breastfeeding	17.2	17.1
Using Modern Contraception	1.4	5.6
Not Using Modern Contraception	15.8	11.5
Neither Pregnant Nor Breastfeeding	74.2	75.4
Using Modern Contraception	2.5	8.3
Not Using Modern Contraception	71.7	67.1

Table 10

TRANSITIONS OF WOMEN AGES 15-49 TO AND FROM STATES OF PREGNANCY, BREASTFEEDING
AND USING MODERN CONTRACEPTIVES BETWEEN ROUNDS I AND II: FOND PARISIEN, HAITI (1978)

Round I	Round II					
	User		Non-user			TOTAL
	Not Breast- feeding	Breast- feeding	Pregnant	Breast- feeding	Other	
User						
Not breastfeeding	1.1	0.0	0.4	0.0	1.0	2.5
Breastfeeding	0.3	0.8	0.1	0.1	0.1	1.4
Non-user						
Pregnant	0.2	0.5	2.8	3.1	1.8	8.4
Breastfeeding	1.6	3.4	0.8	6.2	3.2	15.2
Other	4.9	0.8	3.1	1.4	62.5	72.7
TOTAL	8.1	5.5	7.2	10.8	68.6	100.0

NOTE: This table excludes 57 women who were not in the survey area during both rounds. Thus, the bases of the percentages differ from the bases of the percentages in Tables 1, 2, 5, 6, 7, and 9. The sum of the frequencies in the table is 100.0 percent.

Table 11

FREQUENCIES IN THE CELLS OF TABLE 10

Round I	Round II					TOTAL
	User		Non-user			
	<u>Not Breast-feeding</u>	<u>Breast-feeding</u>	<u>Pregnant</u>	<u>Breast-feeding</u>	<u>Other</u>	
User						
Not breastfeeding	21	0	7	0	19	45
Breastfeeding	6	15	1	1	2	25
Non-user						
Pregnant	3	9	54	60	35	161
Breastfeeding	30	65	16	119	64	294
Other	94	15	59	27	1205	1400
TOTAL	154	104	137	207	1325	1927

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Appendix E
Project Evaluation Summary (PES)

PROJECT EVALUATION SUMMARY (PES)

13. SUMMARY

A two-year project (1975-76) was extended to the end of 1977 for a total cost of \$1,200,000. The primary purpose was to build into the Division of Family Hygiene of the Haiti Department of Health the institutional underpinning necessary to expand Family Planning services toward national coverage. Such expansion would take place mostly after 1977 with increased AID support. A second three-year project is currently under way (1978-80). The major components of the 1975-77 project included:

- a. Development of Training Capability - Training manuals were developed by the IEC Section of the Division and curricula designed and used for various categories of trainees, especially certain types of outreach workers. In keeping with new administrative decentralization and integration of MCH/FP into general health services, the IEC Section trained others to become trainers in their respective areas. It is essential that such training decentralization be carefully guided, supported and monitored to avoid leading to diluting and weakening rather than intensifying the training activities.
- b. Establishment of new clinics - This has been done, but somewhat short of target.
- c. Establishment of statistical and evaluation system and capability - This has been done.

Goals and targets in numbers of "Continuing Users" (Annex I, PROP 0071) seems to have come close to estimates depending upon definition of the term; goals in amounts of contraceptives distributed were met by about 25% but do not appear to have taken into account new acceptors during the year who would not use a full 13 cycles.

14. EVALUATION METHODOLOGY

Reasons - To assess the extent of achievement of purposes
 - To identify from this terminated project (December, 1977) problems contributing to shortfalls and factors contributing to successes, which might be applicable to the current AID-supported program
 - To find evidence of impact of the supported manpower training capability on the continuing activities of the Department of Health

Methods - Two Consultants spent two weeks in Haiti (1/13-26/79). This look backward at Project #521-0071 was done together with a pre-evaluation overview of the current project (#521-0087). The report for the latter contains lists of documents perused, persons contacted, places visited and activities observed. The 1977 Annual Report of the Division of Family Hygiene furnished information which was supplemented by review of other documents and by discussions with administrators and statisticians. Personal visits were made to groups of current trainees at the training facilities, to on-the-job former trainees and to their trainers and supervisors. Special attention was given to the matter of Rural Health Agents, which constituted the major emphasis shift in the third year revision from the original two-year project.

15. EXTERNAL FACTORS

Three major changes in administrative policy within the Department of Health took place which seriously affected forward progress during the last year of the project (and since). These changes include Integration of MCH/FP into general health services, District Decentralization (Regionalization), and Outreach beyond the existing clinics, and have had difficult going during the transition period, with some disruption of the timetable for training and placing personnel for an expanded service plan. The subject is discussed more fully in the Report on Project 0087, since most of the detrimental effects have been felt after 1977.

16. INPUTS

Three model clinics were opened and 19 other clinics were offering Family Planning Services as scheduled. Contraceptive supplies were made available in all Family Planning outlets. Planned supervisory visits were made by individuals from the central DHF Office, but less by mobile supervisory teams for dispensaries because so few of them were completed by the end of 1977: the planned opening of 15 dispensaries by the DSPP did not occur and in the collaborative project with the Artibonite Valley Development Organization (ODVA) only 12 of 20 planned facilities were opened to varying degrees. Trained auxiliaries had to be concentrated in four of the facilities or remained unplaced because eight dispensaries are either inaccessible or not fully readied. Health agents were placed in all 12 areas but many are unsupervised and all have only MCH/FP-related supplies.

In general most training targets were reached or exceeded, including personnel involved in the Rural Health Agent effort (supervisory teams, dispensary auxiliaries, Trainers of Agents, and Agents) in Cap, Cayes and ODVA in spite of the failure of the Department to open rural dispensaries in Cap and Cayes, and to open all of the planned dispensaries in ODVA. A Rural Health Agent (the first) group had to be re-trained because it took so long to place them; a second group's training was delayed three months when the DSPP decided to evaluate the first group before training a second group; when no evaluation was forthcoming the Division received permission to proceed.

17. OUTPUTS

Two family planning training centers are completed and opened. Key staff were trained. Nearly 20 seminars were conducted for opinion leaders 75-77. Data system was instituted and personnel trained for it. Many other seminars for interest groups were held; re-training conducted for all levels of personnel in family planning.

18. PURPOSE

To establish and institutionalize family planning training capability: the original plan called for a highly centralized training pattern. This was changed, in keeping with the move toward giving more autonomy to the District Health Administrators. The IEC Section of the Division trained trainers in the two regions of Cap and Cayes as well as ODVA, and all trainers participated in development of curriculum design for the Rural Health Agents which they now use to train new Agents in their respective areas. In addition the Section continued an active program of centralized training of all categories of personnel and representative groups in the citizenry.

To measure achievement, a complete service statistics recording and reporting system was established with consultation assistance from the Center for Population and Family Health of Columbia University. Prompt summary reports are issued periodically and feedback data are made available to the Supervision Section of the Division.

19. GOAL/SUBGOAL

The PROP for 0071 expressed goals for CY77 in terms of cycles of orals and gross of condoms to be received, stored, and distributed, as well as expected levels of FP Users, Orals and Condoms. There is no indication if Continuing Male Condom Users is assumed to be cumulative numbers of new acceptors each year; and continuing pill use estimates vary (PROP 0087), page 26). The Division Annual Report provides counts of cycles distributed, condoms (gross) distributed, unduplicated female clients seen, numbers of new female acceptors by method, and number of new male acceptors.

<u>GOALS CY77</u>	<u>ANNUAL REPORT CY77</u>
490,000 cycles of orals 61,500 gross of condoms	103,148 cycles of orals (under 25%) 15,874 gross of condoms (over 25%)
<hr/>	
Continuing Pill Users by end of CY77 ----- 38,000	Unduplicated Female Users 34,079 New 20,059 New Pill 11,522 Active Prior Year 14,020 Actives 58% Pill Use 8,131 New/Old Total Pill Users 19,653
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Continuing Condom Users by end of CY77	New Male Users 38,282 New Female Condom Users 4,272 Active Female Condom Users (22%) 3,084 Cumulative Males Prior Years 36,719 Total Condom Users 82,357
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*Number of Cycles seems to have been derived from computing 13 cycles by continuing pill users at end of year without taking into account new pill users which would reduce total cycles distributed by half of the number of new pill users, i.e., 11,000 new pill users would use about 70,000 rather than 143,000.

The 34,079 unduplicated count of women represents 3.6% of women in child-bearing ages in the country (est. 949,800 for 1977 as per Tripartite Project Review); if Couple-Acceptors include total Men and Women it must be determined whether New Males

would be added to active women (34,079 + 38,282 = 72,361, i.e., 7.6% of WIFA) or Cumulative Males would be added (34,079 + 75,001 = 109,080, i.e., 11.5% of WIFA). Confusion in Terminology is dealt with in the Consultants' Report on 0087. The Active Women figure of 3.6% compares favorably with the previous year of 2.5%.**

With regard to Active Women compared to WIFA in targeted areas, this figure reaches 15.4% compared to the previous year of 12.3%. The Division's target for new Female Acceptors was 40,000 so that over 50% of the goal was reached.

** N.B. On page 2 of the PROP for 0087 the Program Objective specifically refers to percentage of Women in Fertile Age "or their partners", acknowledging that condoms are the predominant method and will account for 75% of contracepting couples, i.e., 3.6% of WIFA is not as accurate an indicator as 7.6% or 11.5% depending upon Male User definition.

20. BENEFICIARIES

The major hope is for reduction in infant, child and maternal mortality and for improvement in family health and welfare, as well as reduction in the population growth rate. No definite data can be forthcoming as yet. Relevant information may be found in the soon-to-be issued Report of the Haiti part of the World Fertility Survey.

21. UNPLANNED EFFECTS

Under the project, as for some years before, the Family Hygiene Division carried responsibilities and initiated activities which are more usually conducted at a higher Departmental level. The hope, if not the definitive plan, was for the pattern to move upward in the Department and to be spread to other program units. This has now happened in several respects. The training of health officers in the Districts is complete and two Regional Offices have been established; there is also increasing decentralization of authority. The change has had an effect on Information, Education and Communications activities as well as Training, and Human Resource Development in general; but it has not yet influenced the statistical and evaluation practices outside the Division.

22. There is a reasonable limit to the extent to which a central unit can give and monitor direct services in different parts of the country. A system of decentralization must be established. It is essential, however, that the assumption of decentralized authority be carefully paced in keeping with acquired capabilities rather than with merely paper or structural changes. The previous centralized strengths should not be relinquished before the more local units are staffed and prepared. The transition calls for close collaboration and documented agreement between the old and the new, with shared responsibility in decision-making and planning.

23. SPECIAL COMMENTS OR REMARKS

The PES was conducted during the same visit in which the Consultants were assessing the current situation of the subsequent Program Year. Many concerns rising from this PES are likely to be dealt with in more depth in the Report of 0087.