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EVALUATION REPORT
Seventh-Day Adventist World Service

HAITI

AID MATCHING GRANT PROGRAM
NUTRITION AND MATERNAL/CHILD HEALTH

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* This evaluation report was written by the two MSH evaluators, who are solely responsible for its contents. We extend sincere and warm thanks to SAWS headquarters and field staff for their complete, candid, enthusiastic support for this evaluation, and for their indefatigable hospitality and interest.

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ABBREVIATIONS AND GLOSSARY

AID	Agency for International Development (Washington, D.C.)
AOPS	Association of Private Health Organizations
ASHA	American Schools and Hospitals Abroad
BON	Bureau of Nutrition (now DON), GOH
CAMEP	Autonomous Metropolitan Agency for Potable Water
CBI	Caribbean Basin Initiative
CARE	Cooperative for American Relief Everywhere
CDC	Centers for Disease Control
CDSS	Country Development Strategy Statement
CINEC	Community Integrated Nutrition and Education Centers
CRS	Catholic Relief Services
CWS	Church World Services
DHF	Division of Family Hygiene
DSPP	Department of Public Health and Population, GOH
EOP	End of Project
GDP	Gross Domestic Product
GOH	Government of Haiti
gourde	5 Haitian gourdes = US\$1.00
HAVA	Haitian Association of Voluntary Agencies
IHSI	Haitian Statistical Institute
IMF	International Monetary Fund

LAC/DR Bureau for Latin America and the Caribbean/Development Resources
LDC Less Developed Country
MCH Maternal Child Health
MGP Matching Grant Program/Project
MSH Management Sciences for Health
NGO Non-governmental Organization
OVI Objectively Verifiable Indicator
PAHO Pan American Health Organization
PID Project Identification Document
PP Project Paper
PPC (Bureau for) Program and Policy Coordination
PPE Program and Policy Evaluation
PVO Private Voluntary Organization
RDA Recommended Daily Allowance
SAWS Seventh-Day Adventist World Service (SDA's voluntary relief and development agency)
SAWS/H SAWS/Haiti, Port-au-Prince, Haiti
SAWS/I SAWS/International headquarters, Washington, DC
SDA Seventh-Day Adventist Church
USAID AID Overseas Mission
VOLAG Voluntary Agency
WFP World Food Program
WHO World Health Organization

I. EXECUTIVE SUMMARY

The SAWS/Haiti Matching Grant program is an example of the triumph of the virtues traditionally ascribed to PVOs of being: flexible, action- and results-oriented, practical, and decentralized. From its inception, the project has built on the strengths of existing human and physical infrastructure and mystique, and has adapted to such institutional constraints as limited home-office support. On this count, it is indicative that the home office appears to display similar qualities of flexibility and responsiveness to identified problems: SAWS/I was quick to take the necessary steps to build its human resources to respond to the need, apparent very early in the life of the Matching Grant, for help with program planning, design, and evaluation.

The directors of the SAWS/H MG have been extremely attentive monitors of the progress of their project, constantly adjusting and adapting the project and its components as difficulties have arisen. Because they were able to build on well-functioning, established logistics and financial systems, they have been able to concentrate on other aspects of program operations.

The successes of the Haiti project have occurred in the area of nutritional recuperation and rehabilitation, although the project is still too young to assess the durability of these improvements or the range of any spontaneous spread effect. Rates of improvement surpass other similar projects evaluated in Haiti, although the SAWS project is not invariably the least costly. Furthermore, participation in followup surveillance weighing and maintenance of improvement is quite good; this provides support to the hypothesis that growth surveillance is attractive enough in itself as a preventive health intervention to merit its position as the centerpiece of the SAWS project. It also suggests that SAWS/Haiti management should now move quickly and firmly to limit its project focus to food supplementation, growth monitoring, education, and a modest effort at home gardening.

To do this, however, SAWS/Haiti will have to improve its systems of supervision, education, and evaluation and should get technical assistance as soon as it is possible to do so. Supervision responsibilities and schedules will have to be refined and standardized so that nutrition centers function more efficiently and effectively. Training style will have to be made more participatory and problem-oriented, and training content for trainers and mothers rigorously limited to a well-defined universe of most important messages. Evaluation will have to be restructured according to a minimum set of pertinent indicators and the paper in the management information system simplified, regularized, and made more consistent in format and concept. Finally, program strategy must be thoughtfully revised around the perspective that the surveillance contact is the core intervention upon which only a limited set of other interventions and messages can be structured.

To date, the SAWS/Haiti program cannot be described as one which has involved real community participation in any phase. SAWS/Haiti, which cares about community participation, will have to do more to encourage it if SAWS programs are to have any life after PL 480. The program most decidedly reaches the neediest and is biased in no way against them, but its potential for wider impact from growth surveillance (e.g., on siblings), for the proliferation of such eventually non-dependent activities as kitchen gardens, and its overall capacity for sustainability, replicability, and diffusion will be ultimately constrained unless it is better integrated into the fabric of community life.

II. BACKGROUND

A. Description of this Evaluation

The Office of Program Planning and Evaluation of the AID Bureau of Food for Peace and Voluntary Assistance (FVA/AID/W) is responsible for the planning, monitoring, and evaluation of centrally-funded Matching Grants to Private Voluntary Organizations (PVOs). In June 1983, FVA contracted with Management Sciences for Health to:

"Design, carry out, and synthesize a series of evaluations of AID-supported PVO health sector programs in order to provide information that should lead to improvements in the impact of PVO activities and assist AID and other national and international organizations with policy and program guidance in relationship to PVO health sector projects."

The first series of evaluation reports were intended to be field tests of methodology and reporting format as well as evaluations of program performance. Draft reports were to be reviewed for content by the PVO concerned and by FVA; FVA was also to review the methodology and formatting adopted, before and after the series of initial field visits. The total evaluation enterprise was conceived of as a joint, cooperative effort among AID, MSH and each PVO. Its objective was not only to analyze and improve programs by understanding their strengths and weaknesses, but to ultimately arrive at an evaluation approach that could be standardized and used as a model for subsequent evaluations of PVO programs in the health sector.

The decision was made to evaluate the programs of four PVOs in a total of four countries, as follows: Seventh-Day Adventist World Service (SAWS), in Haiti and Tanzania; Meals for Millions (MFM), in Honduras; and the International Eye Foundation (IEF), in Honduras. Selections were made from the universe of PVOs which had received Matching Grants, according to several criteria: 1) programs must have health and/or nutrition components as their main focus; 2) programs must not have been over-studied or over-evaluated; and 3) perhaps most important, the PVO and its country program directors must want to have an evaluation performed and be prepared to participate in its execution in the field. The site selections for the field-test series were made primarily in Latin America; SAWS/Haiti was selected because it is one of SAWS most mature programs. Africa (SAWS/Tanzania) was included to provide geographical balance and a larger perspective to analytical considerations.

The field visit required two full weeks, excluding international travel and a three-day pre-trip period for team preparation of field protocols and strategy. During the travel period, the team consisted of the SAWS/I Executive Director (Richard O'Fallon), the two senior SAWS/Haiti staff members (James Fulfer, Project Director, and Olive Fulfer, Director of Community Health), the SAWS/H field supervisor (Marie Alexandre), and the Agricultural Training Officer, Jacques St. Hubert Nevelus. During the time in Port-au-Prince/Diquini (Haiti's capital and the site of SAWS/H headquarters), the MSH team worked closely with the Fulfers, Marie Alexandre, and the Training Officer, Ginette Isaacs, and had the full support of the SAWS/H headquarters staff (see Appendix A). The evaluation team visited four of the program's ten sites (Roulin, Ranquette, La Fossette, and Diquini, in that order).

In each site, interviews were carried out with directors (nutrition agents) and assistants at nutrition centers, program participants (mothers), and community leaders and members who had some connection with the project. In all four sites but one (because of timing) a full day's program was observed from beginning to end. Site selection was based on: geographical location (representation from the two main regions where SAWS/H had MG projects); urban vs. rural location (which affects accessibility); age of project (all sites selected had been established long enough to justify evaluation); and absence or presence of problems.

B. The Seventh-Day Adventist Church and the Seventh-Day Adventist World Service

From its beginning 120 years ago, the Seventh-Day Adventist Church (SDA) has had as its primary goal that of following the example of Christ, who "went around doing good and healing all who were ill," and who "went through the country teaching everywhere" (SAWS, March 1981). Adventists now work in 190 countries of the 218 recognized by the United Nations and operate 345 medical institutions and 441 schools above the elementary level in 70 countries outside North America.

The Seventh-Day Adventist World Service (SAWS) was organized by the General Conference of Seventh-Day Adventists at World Headquarters in Takoma Park, Maryland, as a voluntary agency in 1956. It is a further development of earlier efforts of the Church to help meet the needs of its own members following the two World Wars, which also included the relocation of refugees in cooperation with other volunteer agencies. While the organization has a particular responsibility to SDA members, its resources are available, based on need, to all races, creeds, colors, religions, sexes, and without regard to politics or national origin.

SAWS strives to develop and operate programs directed to the neediest sector of the population in developing countries. While SAWS has traditionally provided short-term material relief and continues to do so, it now makes available a wide range of technical as well as material resources in such areas as community development, agriculture, environmental health, sanitation, maternal/child health, nutrition, low-cost housing, literacy, and income generation, working through its own registered agencies and local representatives in each project country. SAWS in 1981 was supporting humanitarian and developmental programs in 55 countries, is one of the ten largest voluntary agencies in America, and is one of six such agencies authorized to distribute PL 480 Title II commodities, which it has been doing for almost 30 years in Africa, Latin America, and the Caribbean region.

SAWS is funded by contributions from its own membership and from grants. AID grants have included ASHA grants, OPGs, Outreach Grants, freight allotments and now a Matching Grant. The amounts and proportions of these funds for a recent typical year are shown in Appendix G. The AID Matching Grant in the period 1 October 1981 to 30 September 1982 represented 16% of all US Government support to SAWS and 12% of all SAWS income.

C. The SAWS Matching Grant

In March 1981, SAWS/International headquarters in Takoma Park, Maryland, submitted a proposal (SAWS/I, 1981) to the PVO office of AID/W for a Matching Grant entitled "Extending Agricultural, Family Health, and Nutritional Development Programs to Target Communities from Existing SAWS Institutions." The planned universe to be covered by the project was 16 countries.* SAWS had sponsored health and nutrition education programs in the Philippines, Vietnam, India, Tanzania, and Guyana. Of these, the program in Tanzania was to serve as a model for the program proposed for the Matching Grant and plans were already under way to expand agricultural outreach to Tanzania (SAWS/I, March 1981).

The problems that the MG was to address were the standard problems of poor communities in Third-World countries: poor environmental and sanitary conditions; malnutrition in children under five; lack of trained health, medical, and agricultural extension personnel; and absence of small businesses that would encourage farmers to grow more food. The MGP was seen by SAWS as a chance to utilize its substantial material resource base for more developmental sorts of programs; to implement a wide spectrum of health and agriculture-related interventions; to develop and strengthen its own organizational capacity for decision-making, planning, and implementing programs; and to help field personnel to think in more innovative, programmatic ways.

The goal of the MG was to improve the health, nutrition, and socioeconomic conditions of the population within a defined radius of the health-care and educational institutions operated by SAWS in targeted countries (see Appendix E). The purposes were: to adapt, implement, and test community-based integrated health and nutrition methodology in selected communities in target countries; to support new community-based programs in designated communities in six countries; and to expand communitybased programs in ten countries with a package of primary health care and nutrition services. The planned outputs of the MG were improved community health programs in a minimum of 40 communities in the environs of 47 SDA health institutions in 13 countries in five years.

* The SAWS Matching Grant was approved in October 1981. The LOP funding level was US\$4.3 million, one-half to be provided by AID, the other half by SAWS. Implementation was authorized for 17 countries instead of the 16 proposed (SAWS/I, October 1982). These were by region:
 (Africa) Burundi, Ghana, Kenya, Rwanda, Tanzania, Zimbabwe; (Asia) Bangladesh, Pakistan, Sri Lanka; (Latin America/Caribbean) Bolivia, Haiti, Honduras, Jamaica; (Pacific) Papua-New Guinea, Philippines, Sarawak.

The planned strategy to achieve the MG goals, purposes, and outputs included a number of key components such as: community health committees, needs assessments and project planning, use of SDA institutions as bases, and training of host country nationals as health promoters. This strategy attempts: 1) to improve the social development of selected countries, and particularly the health status of children under age five, by using community health promoters to train mothers in nutrition and child rearing and by training communities in improved hygiene and sanitation; 2) to improve agricultural development by training agricultural workers, encouraging vegetable and kitchen gardening, and by improving marketing; 3) to improve economic development by helping set up agribusinesses run by community health committees; and 4) to improve resource conservation by encouraging better fuel efficiency and better water catchment and distribution systems, planting of nurseries, and by exploring potential for adoption of wind and solar energy.

D. The Program Environment in Haiti

1. The demographic-disease pattern

The problem the Matching Grant set out to address in Haiti was stated by SAWS in its project proposal document (SAWS, 1981) as follows:

"Malnutrition among children 0-5 is the leading cause of morbidity and mortality in the country. The 1978 National Nutrition Survey demonstrated that 73% of all children under five were malnourished and 16% of these were suffering from moderate to severe marasmus. In a country where other communicable diseases, such as malaria, tuberculosis, dysenteric disorders, and measles are major causes of mortality, it can be shown that malnutrition truly exacerbates the impact of these diseases as well as taking life in its own right."

The SAWS document assigned the causes of the project "problem" to overpopulation (almost 700 persons per square kilometer of arable land; AID, October 1982), lack of available nutritionally adequate foodstuffs, and poor understanding of nutritional balance and sanitary food preparation. The groups most affected by these factors and their sequelae are children under five and women of childbearing age; these two groups, in this order of priority, are the main targets of the project itself.

2. The economic context

The growth rates achieved in the 1970s in real GDP, international trade, foreign loans and grants, and investment have come to a halt in Haiti. The average annual growth of real GDP is estimated to have been only 0.3% in FY 1981 and 1.0% in FY 1982, because of deepening worldwide recession, the impact on agricultural production of Hurricane Allen in 1980, and GOH fiscal management problems in FY 1980 and FY 1981. Despite an economic austerity program, the current recovery is incomplete and fragile and foreign exchange pressures will be a recurrent problem. The continuing need for fiscal austerity will keep the country's overall development budget low, curtail availability of counterpart funding, keep the issue of recurrent costs at the forefront of all development planning, and compromise the government's already severely limited ability to provide basic services, including health services, to the rural and urban poor.

Despite overall growth in the economy in the 1970's, poverty remains a desperate problem in Haiti. The best available data indicate that real per capita annual income (in 1980 US\$) in Haiti increased only from \$210 in 1970 to \$270 in 1980. Haiti is the only country in the Western Hemisphere to be included on the United Nations' list of 30 "relatively least developed countries." The World Bank estimated that in 1979 more than 80% of the population had an average income of under \$150. Conditions of absolute poverty afflict more than half of Port-au-Prince's population and more than 90% of the rural agricultural population (USAID, CDSS FY 1985).

Early weaning and bottle feeding are growing problems resulting from increasing poverty. Alvarez and Murray (1981) compared current rural weaning patterns with those they had observed during research eight years before: in the earlier study, weaning time was "the traditional mandated 18 months or so"; in the later study it had dropped to slightly under 12 months. This changing pattern is directly related to the severity of economic pressures that have been increasing on all sides over the past decade. "Women can no longer afford to remain economically inactive for extended periods of time," say Alvarez and Murray, "but must return as soon as possible to their marketing activities."

But by far the biggest economic repercussion is on a family's capacity to obtain, purchase, grow, or prepare the food or water it needs. Food prices have risen as much as 300 to 400% over the past decade, and the Haitian farmer is confronted with more difficult problems than ever before: decreased rainfall, erosion, soil deterioration, and fragmentation of holdings all serve to decrease response to his efforts. It has been estimated that average calorie and protein intake in rural areas in 1982 was more than 40% below WHO/FAO levels. For the country as a whole, this deficit ranges from 18 to 32% (see Table 1).

Another economic problem affecting health is the growing dependency on purchase of cooking fuel (charcoal) instead of gathering firewood. Fuelwood has become increasingly scarce and its price has risen accordingly. Fuel availability affects thoroughness and frequency of food preparation and the boiling of water.

3. Significant Sociocultural Factors

In their longitudinal analysis of food-related beliefs and behaviors in a community of Haitian peasants, Alvarez and Murray (1981) call into doubt the premise that has dominated design and implementation of nutrition programs: that nutritional ignorance on the part of peasants is an important cause of the nutritional stress. They conclude that the failure of the Haitian population to achieve nutritional well-being is principally due to factors lodged for the most part in a deteriorating rural economy and that rural Haitian food knowledge is adequate to produce well-nourished children.

The question is, then: is there any room for program action, short of overhauling entire village economies? Some nutrition planners in Haiti advocate less emphasis on donated food supplements and/or cooking lessons, which are rather expensive interventions in terms of number of children reached per dollar invested (King, 1979), and on the cognitive, "informational" element in nutrition programs. They prefer to emphasize the concept of malnutrition as an illness, the "rights" of children to adequate food; the strategies used by nutritionally "successful" parents at comparable poverty levels; and the ancillary role of kitchen gardens as important economic and dietary contributions.¹

E. Relevant AID, USAID, and Host-Country Policies and Strategies

1. AID

The strategic goal of AID activity in the health sector, as articulated in a May 1983 document (AID, 1983) is, through the primary health care approach, to assist developing countries to: a) reduce mortality among infants and children under 5 years of age and b) reduce disease and disability in infants and children, women of reproductive age, and other members of the labor force. The rationale for the strategy is to help those groups identified epidemiologically as at highest risk and to enhance productivity and overall economic development. Participation of the private sector, in-country and off-shore, is to be encouraged as appropriate.

The strategy of AID's Bureau for Latin America and the Caribbean (LAC/DR, April 1983) is to concentrate its resources on implementing AID health policy in those countries which face greatest resource constraints and with the highest mortality and morbidity rates: Haiti, Honduras, Bolivia, Peru, and El Salvador. The largest weight is its portfolio, as projected 1982 to 1990, is to be given to: extension of health services (down from 65 to 40%); extension of water and sanitation (up from 25 to 30%), disease control (up from 5 to 15%), and technology development and transfer (up from 0 to 10%). The share of the portfolio dedicated to planning and PVOs will remain at 5%.

The AID Nutrition Policy (May 1982) assigns highest priority to a) alleviating undernutrition (inadequate food consumption and biological utilization of nutrients) and b) to improve nutrition through sectoral programs in agriculture, health, food aid, population, and education as well as through direct-nutrition programs.²

Finally, the AID PVO Policy is to support PVOs "of recognized standing with discrete programs in high-priority sectors" and to give such PVOs independence and flexibility in project design, as long as AID overall policies and priorities contribute the parameters for PVO activities which use AID funds.

2. USAID

The core objective of USAID/Haiti's sectoral strategy in health and nutrition as set forth in the FY 1984 CDSS was "to improve the basic health and nutritional status of the poorest of the population (primarily rural), especially children."³ Four strategy priorities were to set the guidelines for both public and private action in the sector: a) improving access to health care, with emphasis on cost-effective preventive interventions; b) concentrating resources on environmental sanitation and safe potable water, controlling major communicable diseases, and reducing malnutrition and fertility; c) installing a more cost-effective delivery system for preventive and curative health care; and d) installing revenue-generating mechanisms for maintaining the health care system.

However, the FY 1984 CDSS also proposed reorientation of mission strategy over the CDSS period toward greater emphasis on resource conservation, agricultural production and agro-industrial development, with parallel efforts in health and family planning to enhance productivity of the rural labor force and moderate the growth of Haiti's population. The health program would be implemented increasingly by PVOs and community organizations in concert with GOH health programs. The FY 1985 CDSS spells out the Mission's intent to increasingly use food aid as a development tool and encourage coordination of Title II MCH programs with development assistance project activities.

During 1982 USAID/Haiti undertook numerous steps to improve design and implementation of its Title II program and enhance program-monitoring effectiveness and development impact through personnel changes, modifications of reporting requirements, and closer collaboration with the PVOs in the implementation of their programs. A special Title II office was established in the Mission to coordinate various Title II activities and a highly qualified and professional program manager contracted to oversee Title II activities. In FY 83, over 45% of the \$45 million of U.S. assistance being provided to Haiti was being obligated through NGOs and the Mission undertook a concentrated effort to expand and strengthen the role of the private sector in development activities of high priority, especially in the health/population sector.⁴ Because of the closer relationship spawned by Outreach Grant activities, the Office of Private Voluntary Development in the AID Mission has assumed a major role in reinforcing PVO collaboration. USAID organizes monthly PVO meetings in conjunction with the World Food Program and takes advantage of all opportunities to bring the Volags together (Stephens et al., 1983). The tide seems to have turned from the conditions of the late 1970s when PVO relations with AID and, in some cases with one another, were often cool, if not hostile.

3. Host Country

In December 1982, the Haitian Department of Public Health and Population (DSPP) reaffirmed its commitment to "Health for All by the Year 2000" in a document entitled "New Orientation of the DSPP". It set forth a seven-point strategy which has been very difficult to implement given current economic pressures.⁵

There has been growing concern in the GOH about coordination and monitoring of PVO activities, in part because of leadership changes in the DSPP and the BON, in part because of increasing awareness in the GOH of the sheer number of PVOs and the resources they command, and in part because of frank nationalism. At present, there is a feeling of ambivalence among the PVOs about the new GOH interest in their activities. There is appreciation of nationalistic motives and the need for coordination, at the same time there is worry about controls and a potentially extractive posture. In the case of SAWS, there is a generally wary but essentially open attitude on both sides. SAWS is appreciative of its personal relations with the DSPP and the material contributions the DSPP has made. These totalled U.S. \$57,198 over the March 1982-March 1983 period, of which US\$51,880 were in contraceptives (see Appendix G); most of these supplies were of AID origin but the DSPP willingness to share is acknowledged.⁶

III. THE SAWS/HAITI MATCHING GRANT

A. Goals, Purposes, Outputs, and Strategy

In 1981 when the Matching Grant was awarded to SAWS/I, SAWS/Haiti was already involved in School Feeding, Maternal/Child Health, and Food-for-Work Programs. SAWS/Haiti had also been conducting a nutritional program in conjunction with food distribution and wanted to make the program more effective by establishing a number of what were then termed "Health Care Centers" (SAWS/H, Matching Grant Proposal, 1981). This was theoretically consonant with the goals set forth in the SAWS umbrella Matching Grant Proposal (March 1981).

The goals and purposes set forth in the first Matching Grant Proposal for Haiti prepared by Olive and Jim Fulfer in 1981 were as follows:

<u>Final Goals</u>	<u>Intermediate Goals (= to purpose)</u>
1. Decrease incidence of severe malnutrition by early detection and prompt intervention.	1. Establish 10 health-care centers.
2. Develop reservoir of trained and fully functioning indigenous health workers and agriculture auxiliaries.	2. Establish a SAWS Center for training Community Health Workers and agricultural auxiliaries.

The proposal was reviewed by SAWS/I, which sent it back to the field for modification and some redesign because it was too ambitious in its detail. The history of the evolution of the subsequent proposal is presented and analyzed in detail below, but the goal and purposes articulated in that proposal are presented here, since they have constituted the operative statements during much of the project life. The revised project goal, as set forth in the Project Proposal Workbook (SAWS/H, 1982), was: "increased health status of mothers and children in the Republic of Haiti." The new project purpose was: "to decrease prevalence of malnutrition in children ages 0-5 in ten target areas of Haiti." The planned outputs, objectively verifiable indicators (OVIs), and the target dates for each output are presented in Appendix A, following the format used by SAWS in its Workbook.

The underlying strategy for the SAWS/H MG was to use PL 480 Title II foods as an incentive for mothers of small children to congregate on a regular basis for growth surveillance for children and health and nutritional education for mothers. The plan for doing this was set forth in the first SAWS proposal (and never explicitly re-stated in subsequent revisions); the basic procedure would be

"to choose, in counsel with the community leaders, a person who will be trained as a Community Health Worker. SAWS will provide the training, materials, and back-up supervision. The program will work in conjunction with the MCH Feeding Program. Along with the Community Health Worker, a person will be selected to be trained to function as an assistant in the Health Care Center. These Health Care Centers will be located in the most needy areas of the country, five in the north and five in the south. The project is scheduled for a three-year period from FY 1981-1982 to FY 1983-1984....

The project advocated an integrated approach as the only "chance of success" in the Haitian context and did not advertise itself as being particularly innovative, noting that CARE, CWS, CRS, and other PVOs were also conducting health education and nutrition programs at the village level, and adding:

"There are no really innovative components to this project, but we have sought to combine food supplementation along with informal, experience-based learning, education in sanitation, food preparation, vegetable production, and growth monitoring" (SAWS/Haiti, 1982).

B. Planned Resource Inputs

It is not possible to consider the inputs to the SAWS/H MG Project without taking into account the fact that the project was in large measure predicated on and generated by previous activity, that is, SAWS/Haiti's experience with disaster relief, School Feeding, food-for-work, and most importantly, Maternal/Child Health programs. These, in their turn, were rooted in the pre-existing infrastructure and pool of human resources developed through over 100 years of SDA presence in Haiti; a network of 246 churches and 113 schools; an Adventist College and secondary school; and the experience and health-services base offered by the Adventist Hospital/ Polyclinic, which had been expanded and improved partly with the help of ASHA grants.⁷

1. Human resources

It is SAWS/Haiti's contention that the services provided through the MG could not have been provided with any adequacy were it not for the field support staff funded under the Outreach Grant. Of about 70 positions in the MG organization chart (see Appendix P), half are supported by the MG budget.

The staff available to the MG for its activities is distributed among categories of responsibility as follows: 17 management positions (directors supervisors and inspectors), 4 support positions, 31 outreach worker positions (clinic-based), and 19 service workers at central field headquarters. The ratio of central office to field personnel is 40:31, but the mobility of the field supervisors and transport workers blurs the difference somewhat and effectively evens the balance. The proportion of central-office management personnel is really quite small for an operation which provides national coverage to approximately 75,000 recipients in close to 500 locations; this is in keeping with the SAWS management philosophy of keeping overhead low and using existing infrastructure, human and physical, to the maximum. It is important to note that SAWS/I overhead runs at only 2%, the figure used in budget submissions to date.

The pivotal decision-making positions in the SAWS/Haiti staff structure are the directorial slots, primarily the positions of Director and Associate Director for Child Health, occupied by Jim and Olive Fulfer, respectively. These are the only expatriate positions, recruited for and hired by SAWS/I; the rest of the staff is Haitian, hired and paid locally. Staff turnover in the MGP has been low.⁸ This is explained partly by salary structure, partly by management style, and partly by the special Adventist context.⁹

2. Financial and Other Material Inputs

Formal budgetary allocations to the Matching Grant Project are presented in Appendix A. The budget is divided into five sections, as follows:

- a) Project support: all administration of the program, e.g., salaries, office rent, telephone and other related charges, office expenses, etc.
- b) Training materials: e.g., film and/or slide projectors, design and printing of materials, etc.
- c) Educational expenses: those related to activities authorized under specific projects intended to teach and train the people targeted in the program; includes seminars, curriculum development, etc., but only when the activity demands specific disbursement of money.
- d) Development project support: expenses destined for purchasing of equipment, construction of minor buildings or facilities, financial support for special projects under the main one, and the evaluation of the program; includes costs for activity supports for the core of the program.
- e) Transportation: costs of transport and mobilization, purchase and maintenance of program vehicles.

By far the largest proportion of the total three-year budget of \$325,480 goes to project support -- 65%, 77%, and 83% in each of the three consecutive years, with an average over the life of the project of 76%. The balance is divided among training materials and supplies for the home gardens component, evaluation, and vehicle purchase and maintenance. The PVO/AID funding percentages are 50/50. The budget does not, however, reflect the planned (and very central) input of PL 480 food. This was projected in the first revised Project Proposal (SAWS/H, 1982) at 996,500 lbs. for a total value of US\$114,726 over the life of the project.

Beyond these basic programmed inputs which were made explicit in budget presentations, there two types of "unanticipated" inputs which were not only of material value but also have participatory dimensions:

- a) 1200 hours of labor (2 x 600) contributed by SDA pastors doing MPH thesis work for Loma Linda University, at Bassin-Bleu and St. Louis du Nord projects.¹⁰
- b) Pharmaceuticals and commodities received from the DSPP (see appendix G).¹¹

IV. ACTIVITIES TO DATE IN THE PROGRAM

A. Project Phases

1. The Project Development Phase

The SAWS umbrella Matching Grant Proposal was submitted to AID/W in March 1981 and would not be formally signed until October of that year. And, in March 1981, Jim and Olive Fulfer were sent by SAWS/I to Haiti, with a mandate to develop a country-specific Matching Grant Project. There was some sense in SAWS that the proposal had been largely an "armchair" exercise and the consensus was quite clear that the proposal established only broad parameters for country projects which had to be aligned individually with local needs and established local health-care priorities. The proposal logframe was seen primarily as a program outline, and the proposal states:

"... It is not intended that the services and programs offered in this Matching Grant Proposal be implemented in each of the sixteen countries listed, nor in every community in the environs of the institutions operated by SAWS in these countries."

The intent was that feasibility studies and baseline surveys would be carried out in the six new target countries and each target community would decide its needs.

The Fulfers embarked upon an intense period of reacquainting themselves with Haiti; making a series of site visits; consulting with the DSPP and Bureau of Nutrition, other Volags, the country team of Management Sciences for Health, the USAID Mission in Port-au-Prince, and the members of the SDA community throughout Haiti. Their focus during this period was to acquire a field perspective on Haiti's problems; avoid what they frequently termed "reinvention of the wheel"; come to a more precise assessment of need; arrive at a plausible level of effort; identify potential human resources; and explore possible sites. During this period, the Fulfers were very much on their own, inexperienced in project design and with little background in evaluation; their support during this period came primarily from the MSH country team and from personal contacts in the DSPP and other Volags.

While there was never any question in the Fulfers' minds that the MG was epidemiologically important and certainly appropriate in terms of need, they concluded that the umbrella MG concept was unrealistically grand for the Haitian context. The Fulfers then produced a country-specific design which proposed rather ample primary health care/family planning services, community growth surveillance, a home gardens program, and the requisite training facility and curriculum. At its core, the design was an expansion, intensification, and upgrading of the MCH concept which was already part of the SAWS/H portfolio of activities, within the parameters of the umbrella MG.

The first project design shown in Appendix A, Table 5, was structured rather logically, although not according to the AID Logical Framework, on the basis of: a) Statement of Problems, b) Final Goals, and c) Intermediate Goals. This design, although its goals and purposes were quite clearly articulated, was viewed by SAWS headquarters as being overly ambitious; as the Fulfers themselves now say, "It had everything in it but the kitchen sink." Furthermore, it lacked certain elements required for formal AID approval, primarily the Logical Framework and an integrated work plan, although a set of Project Activity Targets by Fiscal Year was provided. The proposal as it stood was disapproved by SAWS/I. However, when the umbrella Matching Grant Proposal was signed in October 1981, the Fulfers were given authorization to proceed with the implementation of the project and funding began to flow.

Meanwhile, there was growing consensus in SAWS headquarters, fueled by insistence from the Fulfers on the urgency of the need for programming help from the central office, that it was necessary to hire a highly qualified, full-time Program Planning and Evaluation Officer. The understanding was that the Fulfers could proceed with project activities while the SAWS/I recruitment and hiring process went on. The basic concepts and overall approach of the Fulfers' schema were seen as sound, if somewhat grand; the more precise articulation of goals and objectives and the refinement of outputs and indicators could follow.

The SAWS/I Program and Evaluation Officer, David Syme, formally took up his duties on 1 January 1982, but the Fulfers were already deep into their task. The process of project design, or re-design, would thus overlap with project implementation, so that in the case of the SAWS/Haiti MGP the frontier between the two phases is quite blurred. The implications for implementation, monitoring, and evaluation are analyzed later in this document.

2. Project Implementation Phase

a) Site Selection Surveys and Infrastructure

The formal implementation date given by SAWS/I (1982) is 1 November 1981, but as early as June 1981, Olive Fulfer was already active as the MG Project Director and a facility was being prepared for the Training Center as part of the warehouse-office complex being constructed under the AID Outreach Grant. Between June and August 1981, the Project Director observed and analyzed similar projects in Haiti being carried out by other PVOs and the DSPP, reviewed relevant literature, and compiled resource materials and training aids.

Table 6 in Appendix A presents the "Project Activity Targets" and the "Project Implementation Plan and Schedule" that were included in the first SAWS/H Proposal and which guided almost the entire first year of implementation. The table also shows the general activities under the project; in Section VI.A these will be examined in more detail as 'Outputs'. It is important for the reader to remember that these data are not treated formally as outputs, because they are not derived from what became the formally approved operative Logical Framework in the revised proposal (Project Proposal Workbook, 1982). They are, however, the only written guide to what was supposed to happen and the only baseline against which to project the activities of the first year of implementation of the Haiti MGP. It is also important to remember that, because the Fulfers had had no training in proposal preparation, the level of detail which is supposed to be a distinguishing feature of 'activity targets' as opposed to 'outputs' is not always consistent.

By December 1982, ahead of schedule, SAWS/Haiti, operating for most of the period without an approved formalized Project Proposal and Logical Framework, had succeeded in selecting ten sites, five more than stipulated in the umbrella Matching Grant Proposal (see Appendix H for site list and descriptions) and putting them into operation with the required number of personnel (community health workers and assistants) who had gone through one training course at SAWS/H. Five of the ten centers had established demonstration gardens and had initiated programs of individual home gardens and nutrition baseline surveys¹² had been carried out in all sites.

During the early months of the implementation period, the major problems were practical ones: lack of transportation was a barrier to supervision and the distribution of supplies, delays in completion of the warehouse/office/training center complex made training activities trying, goats and insects and drought afflicted some gardens. The nutrition baseline survey at St. Roc produced some data that did not make sense when compared with some national-level survey data; the resulting re-survey proved that the skepticism was justified.

Selection of the Gros Mangle site, located at the remote end of the island of La Gonave, in itself accessible only by undependable boat service, proved to be beyond SAWS/Haiti's ability to supervise and service adequately.¹³ It is, in fact, worth noting that the selection of all MGP sites in Haiti was frankly empirical, rather than based on any consistent criteria. In two instances the primary motive for choice was SAWS/Haiti's desire to explicitly attempt the very difficult: the Diquini and La Fossette sites are two of the largest and most deprived slums in Port-au-Prince and Cap Haitien, respectively, urban areas which typically generate some of the worst rates of malnutrition and infant mortality in the country. The location of the Diquini center on the SAWS compound itself offered a singular opportunity for close supervision and easier experimentation with different project solutions.

The assumption of the project designers was that, given the overall levels of malnutrition in Haiti, one site was as good as any other. This is not quite the case -- malnutrition is not perfectly evenly distributed in Haiti -- but the levels identified in the baseline surveys qualify all sites selected by SAWS as eligible for special attention on the basis of need. Finally, since SAWS is not constrained geographically as are the other PVOs, there was no necessity to adhere to any regional criteria.¹⁴

b) Financial Systems

The first-year evaluation of the umbrella MG (SAWS/I, October 1982) noted that "financial planning has taken considerable time and effort in establishing the most appropriate system for disbursement and control of funds and has been hampered somewhat by the delay in project designs," although by the time of that writing, the system and methodology were established and disbursements flowing.

In the early days of implementation, SAWS/Haiti partook of these systemic problems, due largely to problems of coordination between SAWS/I and SAWS/Regional. The financial management system which evolved seems to be working effectively, at least in the case of the Haiti MG, and enables SAWS/I to have instant control of and wide access to financial information at any stage of a program.¹⁵ The field, organized as a SAWS/Local Unit, prepares a budget presenting all the components of a particular project; this is presented in local currency and must be approved by the SAWS/Local Unit, after which it is sent to the SAWS/Regional Office, SAWS/Inter-America in Miami, Florida, for consideration and approval. When the Regional Office approves the budget, it is sent to SAWS/I for consideration and approval. Once the budget is approved, SAWS/I sends forms to the field where the local administrators of the project must schedule all drawdowns of money for their activities. These forms circulate through SAWS/Regional offices and serve also as a means of keeping records of financial disbursements.

c) Training

In 1979, under the direction of Loma Linda University School of Public Health located in Loma Linda, California, using the facilities of the Adventist Institute, SAWS/H had developed a curriculum for training health promoters which SAWS/I had included in its umbrella MG as a suggested model for other such training activities under the program. The curriculum was considered innovative and emphasized use of parables and stories designed to be easily remembered and informative. Each story contrasted the good, bad, and neutral sides of an issue and were easily taught, especially when supported by audiovisual materials. The first phase of the two-phase training included: basic nutrition, food groups, balanced diet, food supplementation; food preparation; diet analysis; breastfeeding and weaning methods; weighing and charting; control of infectious diseases, anemia and xerophthalmia; home crafts and sewing; and money management in food purchasing. The second phase encompassed: further instruction in nutrition, simple treatments, sanitation, prenatal care, immunization, and family planning, with other skills (e.g., case referral) added in modular fashion as indicated by competency evaluation.

However, the SAWS/Haiti Training Officer is an RN trained partly in Haiti and with a background of experience and relationships with the Haitian Department of Public Health and Population (DSPP), and shares the educational orientation which has until recently characterized the DSPP's approach to training and non-formal education. This approach has been changing gradually since 1980; the DSPP has been working closely with the MSH country team and learning from its own experience, to produce more technologically appropriate training materials, e.g., subject-specific modules in Creole and French, posters and laminated flipcharts, flannelboards and pictures, road-to-health growth cards, etc.

Early in the implementation period, the DSPP and MSH made these materials available to SAWS/H, but no training in their utilization was provided. Nor was there any explicit transfer of the curriculum framework used by the DSPP for training its own health workers (Agents de Sante), nor did SAWS do any formal scaling down and restructuring of the DSPP content for its own program, which is much shorter and more modest in scope. The decision was made during the implementation period to make promoter training periods three weeks in duration, with one-week refresher sessions at three-month intervals (although the refresher schedule was imperfectly observed). Decisions were made as to overall content which, as of the SAWS/H quarterly Report of December 1982, included a list of 23 specific topics.¹⁶ In addition to these topics, it was decided that trainees should also be taught how to do community nutrition/health surveys; organize local health committees, manage the clinic (including storeroom and supply maintenance); carry out the daily clinic program, manage community and clinic surveillance, weighing, home ORT and Oralite preparation, recuperation of Gomez III children, and referrals; and deliver a lengthy series of nutrition messages (see Appendices I and J).

However, there was no development of a standardized curriculum with determined subject matters assigned fixed blocks of time, no regularized alternation of lecture and practicum, and no priorities except for the traditional DSPP emphasis on the three food groups (an emphasis from which the DSPP is retreating, for a variety of practical and pedagogical reasons.)

A clinic schedule or sequence was evolved for the mothers of children who were identified as malnourished through nutrition surveys. It was determined that each clinic would rotate four groups of mothers, approximately 25 in number, through a four-month cycle, so that each mother would bring in her child(ren) once a week four times a month for a series of 16 sessions. Each session was to include the following elements during a four-hour period from 9:00 a.m. to 1:00 p.m.:

1. Welcome song and grace
2. Preparation of milk for children
3. Lecture: the three food groups
4. Weighing of children, recording on Road-to-Health charts
5. Simple first aid treatments
6. Lecture on Subject x and demonstration on food preparation
7. Bathing of children
8. Singing the nutrition song
9. Saying grace
10. Meal for children
11. Distribution of take-home food supplements.

The curriculum for the entire 16-week sequence reflects the indeterminate quality of the promoter curriculum and the heavy emphasis on the three food groups (see Appendix Q).

d) Program Changes during Implementation

Since the inception of the MGP, SAWS/I had become increasingly aware of the need to upgrade its own programming and decision-making capacity, enhance the effectiveness of its projects, and ultimately to be able to demonstrate impact achievement. Central to the development of all of this was to acquire a viable yet practical evaluation capacity (SAWS/I, October 1982). With the arrival of David Syme, SAWS/I was able to undertake initial evaluatory activities which consisted of a post-facto analysis of the project design. Two basic facts emerged from analysis:

- The proposal OVIs as submitted and revised for AID were too general in nature to lend themselves to good evaluation.
- More local inputs into design and community participation in the whole management process would enhance the overall success of the program.

In consequence, SAWS/I decided that instead of using the vague, unfocused multi-national Log Frame which would be difficult to adapt to local needs, it would be better to design a specific project Log Frame for each country, with its own clearly-specified and measurable indicators. SAWS/I then developed a simplified MG proposal workbook, which was sent to all countries which had submitted PIDs or Proposals (like the Fulfers), filled in by the country MGP Project Team, and returned to Washington for review by the SAWS/I Project Committee and approval. Most, including SAWS/Haiti's, were returned to local areas for further modification. SAWS also provided workshops in development planning, project design, monitoring, and evaluation to all those likely to be involved in the MGP, including country staff, staff, institutional personnel, and key administrative staff from regional and area offices.¹⁷

Table 7 in Appendix A is a composite presentation of the current status of the SAWS/Haiti MGP Logical Framework. In the left-hand column is a re-working and refinement of the Fulfers' first Project Proposal done for the Proposal Workbook exercise. In the right-hand column are changes in the program which occurred since the Workbook was completed (e.g., changes in project sites) and modifications which SAWS/H is now contemplating, partly as an outcome of discussions that occurred in the course of this evaluation and partly as a consequence of SAWS/Haiti's most careful monitoring of the implementation process. None of the modifications have yet been formally submitted to or approved by AID.

3. Community Participation

The ideal of community participation has been central to SAWS/I thinking since its first ventures in developmental activity. One of SAWS/Haiti's basic objectives in its Outreach Grant projects has been to have each project supervised by a committee of five persons chosen from the local community. "Maintenance of community participation" is one of the six major assumptions in the Haiti MG Logical Framework. The concepts of the SAWS project director as "facilitator", of "community resources" in project identification, of mutual determination of objectives and plans, and of community implementation with facilitator monitoring, are the essence of the Project Proposal Workbook for all development aid requests to SAWS/I.¹⁸

Cohen and Uphoff (1979) have defined participation "as a descriptive term denoting the involvement of a number of persons in situations or actions which enhance their well-being, e.g., their income, security, or self-esteem." With this in mind, it is useful to examine the experience of the SAWS/H MGP in the light of the four kinds of participation Cohen and Uphoff have identified: 1) participation in decision-making; 2) participation in implementation; 3) participation in benefits; and 4) participation in evaluation. They suggest that participation be considered in terms of what kind of participation, who is participating in it, how it is occurring and in what context. We feel that this is an economical, reasonable and thorough way of approaching this subject and have used their model as an organizing device for this portion of our evaluation (see Appendix L).

One of the most interesting dimensions of community participation in the SAWS/H MG is the variability among sites. Because of this variability and because of the thought-provoking commonalities that emerge nonetheless, we present relevant anecdotal material on each site in tabular form. Appendix O summarizes community participation at SAWS/H sites in decision-making and implementation. Community participation in benefits and evaluation raise other issues and do not display variability among sites; they are considered separately.

a) Decision-making

Participation in decision-making "centers on the generation of ideas, formulation of options, evaluation of options, and making and choosing among them, as well as the formulation of strategies for putting selected options into effect" (Cohen and Uphoff, 1979). Three types of decisions can involve participation: initial decisions, which involve "the identification of local needs and how they will be approached through a particular project"; on-going decisions, which involve choices related to "structure and content of activities already in process as well as new decisions relative to both the project's goal and the process by which they aim at those goals"; and operational decisions, which involve choices related "to specific local organizations which have been established by the project or linked to the project in an effort to involve local people in the delivery aspects of the enterprise".

In the case of the initial decision-making phase in the SAWS/H projects, the role of Adventist Church leaders and/or members was crucial in all sites; only in Moustiques, Ranquitte, and Roulin was a non-Adventist community group pivotal in promoting the concept of a MG nutrition center. Even in these cases, there were already SAWS-supported Food-for-Work activities in place so that the institutional contacts were, in effect, already established and it is not clear that the promotion of the community as an MG site was a pure emergent of spontaneous community consensus. There is nothing wrong in this and there is a lot to be said for building on a community track record. The point we are making is that, in general "participation in identification of local needs and how they might be approached through a particular project" was, in the SAWS/H MG Projects, largely an initiative of a small group of leaders, in most cases Adventist Church leaders, in some cases only a single leader, who identified nutrition as a central problem of highest priority. The decisions about whether to start a project, what to do, and its design were ultimately made by the SAWS Country Directors. This is not to say that project participants disagree; given the indices of poverty and malnutrition in Haiti, it would be surprising to find a community that would repudiate a nutrition program. The question that remains unresolved in the larger as well as the smaller context is: given alternatives -- and a most pertinent example is the option of an income-generating project- what would the project communities have preferred?¹⁹

b) Implementation

Participation in implementation is approximately equivalent to what SAWS/Haiti Management has described as its "after-the-fact" approach to this component of project activity. "Resource participation," in the SAWS/H context, comprises community contributions of labor, cash, and materials to the physical infrastructure of the nutrition center and its maintenance, including provision by the community of free or low-cost space or land for project activity, and the contributions of mothers. Information, which Cohen and Uphoff suggest is a commodity a community can offer to a project, is in effect provided on request through nutrition survey and surveillance activities, but it is not elicited or offered for other purposes we were able to identify, for example, data on local food production and consumption patterns for tailoring nutrition education. Community contributions have not been recorded and information about them is available only through anecdotes; except for rental amounts, there is no quantified or easily quantifiable (e.g., hours worked) data on these contributions that measure their value in terms of commitment or as project inputs.

Table 10 summarizes community participation in implementation as expressed in contributions of labor, cash, and materials, excluding mothers' contributions. It is clear that the more rural sites are, overall, more forthcoming with their contributions. The more urban (Diquini, La Fossette) or periurban the site (Saintard, St. Roc), the less there is of this kind of participation.

Participation in project administration and coordination is related to decision-making and constitutes another possible avenue for contributions of information (and advice). The key element in this component is the nutrition agent/health-care worker herself and her assistant, both of whom are supposed to come from the community. In some cases, these workers did facilitate community participation; in others they did not.²⁰

Participation in on-going and operational decisions has varied somewhat. In Bassin-Bleu, Moustiques, and Roulin, community representatives appear to participate in decisions related to implementation, primarily related to building and to possible follow-on projects. In all other sites, both on-going and operational decisions, primarily those related to project supervisors and SAWS/H Management, are made sometimes (but not always) in consultation with clinic staff.

We chose to define Cohens and Uphoff's final dimension of participation in implementation, "enlistment," in terms of membership and attendance in project activities. This is, as they point out, not the same thing as participation in benefits. On balance, clinic attendance and attendance at surveillance and follow-on weighing, planting and maintenance of home gardens,²² are quantifiable, verifiable indicators of commitment to project objectives and their implementation. In data available were often inconclusive.

We were able to evaluate only three clinic registers (Diquini, La Fossette, and Ranquitte). Although attendance rates were quite high overall, we think largely due to the food incentive, mothers' costs in time and travel are also high and there is variation among centers which correlates instructively with childrens' nutritional improvement; attendance at follow-up weighing is an even more sensitive indicator since the food incentive is absent. We found clear correlation between attendance and movement of children out of lower into higher nutritional status (Gomez categories): in La Fossette, where attendance was poorest, improvement was lowest, and in Ranquitte the reverse was true; Diquini was in a middle range on both measures. Mothers' participation as expressed in contributions of money, food, and labor is hard to capture. There has been no policy applicable to all sites of whether to ask for regular cash contributions from mothers, nor has there been an ideological commitment made to the appropriateness of this in an environment of extreme, generalized poverty; there is a fear that such a requirement might keep the neediest out of the program.²³

c) Benefits

Participation in benefits (and harmful consequences) can be material (participation in access to private goods resulting in an increase in either consumption, income, or assets), social (public goods, i.e. services or amenities) or personal (self-esteem, political power, and/or sense of efficacy). The matter of benefit incidence, together with spread effect, is discussed in detail as a dimension of program impact, in the context of what kind of benefits, their extent and effectiveness (the "how" of participation in benefits), and their distribution in the population (the "who") and the characteristics of the beneficiary population.

There are two issues which can appropriately concern us here. One is the question of whether Adventist Church membership precludes or favors any portion of the putative target population. We have seen that Adventist Church membership is an important linkage which enables whole communities to become potential beneficiaries of Matching Grant projects. This would, in our view, only be a matter of concern if communities which did not have such linkages were excluded from participation, but there is absolutely no evidence of this; furthermore, the need in Haiti is acute enough and SDA presence generalized enough so that responding to the development request of SDA pastors and church members did not sideline any significant geographic area or socioeconomic stratum, particularly the least advantaged. One can argue, in fact, that it would have been foolish or at least wasteful not to have used existing church infrastructure or not to have answered church-generated requests for developmental activities.²⁴ Our questions about the religious affiliation of clinic clients indicated that only a tiny percentage of mothers on the days we visited were SDA members; a poll of the mothers attending the Diquini clinic, right on the SAWS compound, turned up only three Adventists out of the 25 mothers present.²⁵

B. Impact

1. Nutritional Impact

This section will discuss achievements according to indicators chosen by SAWS in its project design,²⁶ as well as indicators selected by the evaluators. By all indicators, the program is making an outstanding impact on child growth both during the clinic program and during the several follow-up weighings subsequent to the clinic program. However, it should be noted that the program is very young. The first of the 10 centers was in operation at the end of CY 1981 while the last became a going concern only at the end of CY 1982. Thus the study of sustained impact on child growth is limited to periods averaging seven months. Likewise a study of impact on siblings is premature at this time. Where information is not yet available because of program newness or imprecision of data-gathering, we have noted what we consider desirable indicators for which data should be compiled and analyzed in the future.

The SAWS indicators are examined first. The reader reminded that these indicators were originally intended to reflect changes in a community population which encompasses the clinic population. Thus records do not always distinguish between children in the clinic program and those who come from weighings.

Following a discussion of these community level indicators, an impact study has been made to determine changes that have occurred in what will be called the clinic register population, which includes and distinguishes between children in the clinic program and children being weighed and recorded in the register. It is this population that will be considered the "targeted" or semi-self-selected population for SAWS in the future.

In order to determine effectiveness of targeting as well as change in nutritional status and participation rates, the team selected three cohorts from three center registers for detailed analysis.²⁷ These were as follows:

<u>Center</u>	<u>Cohort</u>	<u>Number of children at entry</u>
Ranquitte	March 1982-	119
Diquini	August 1982-	160
La Fossette	December 1982-	125

V. RESULTS TO DATE IN THE PROGRAM

A. Outputs

SAWS/Haiti formally contracted in its revised MGP Proposal to produce the outputs listed in Table 11. The Program is on target, in terms of time and numbers, with the establishment of nutrition centers and slightly over or ahead of target in terms of health workers trained and demonstration and home kitchen gardens in place. The program is behind target with its self-help projects, the numbers of children who have been through the program, and the number of children being weighed monthly.

Output production in terms of mothers' learning levels (numbers 3 through 7) was hard to assess because there has been no testing, formal or informal, of what mothers really know about child growth monitoring, food sanitation, garden production, good nutrition habits, or healthful sanitary practice. The only firm data that are gathered are "the numbers of educational lectures given in the community" (a total of 2789), a statistic that is almost completely uninformative.

Calculation of per capita food distribution is confounded by the absence of time parameters on the indicator (no. 9). However, it appears that the amount of supplementation distributed is much higher than the target level. SAWS/H is considering giving mothers milk and food at the noonday meal at the recommendation of the evaluation team, primarily because in some sites mothers compete with children for food; when they do not, they suffer as they must sit, hungry themselves, watching their children eat.

Perhaps the most impressive indicator, because it is so expressive of a number of different sorts of impact, is the percentage of mothers (72%) who continue to participate in the monthly weighing program after their children have gone through the four-month program. There is no food reward for this kind of continuation -- this is not the same as readmission to the program -- so that it can be understood as a proxy for behavioral change. Since there are a number of problems with the program's educational activities, the 72% is even more impressive; it suggests that growth surveillance, in and of itself, is seen as valuable. This merits further qualitative and quantitative exploration in subsequent evaluation and justifies extremely close attention to the maintenance of the pertinent register data. At the risk of drama, the evaluation team feels that this indicator, together with improvement in nutritional status, is the most important statement about the value and impact, as well as the potential durability, of the SAWS/H MG Project.

Because we feel this is so important, the subject of nutritional impact is considered separately at some length in the section which follows. We follow this with a discussion of the impact of teaching mothers which, in our view, is next in importance programmatically.

SAWS Output Indicator: Percent of community preschool children being weighed.

Achievements: The number of children being monitored should be cumulative. The latest report showed that 2125 children were being weighed in April 1983 in the 10 centers. The available "community" population estimates for the 10 sites were 7155 under-five-years-olds but as indicated earlier, the estimates are very fragile and too flawed to permit assessment of community coverage or impact.

Among the 2125 children are an estimated 1248 program children from the four-month cohort ending April 1983. This figure is derived from the number of mothers participating in the clinic program multiplied by 1.2, the average number of living under-five children per mother (1040 mothers x 1.2 = 1248).

While we have said that the current number of children monitored should be cumulative, we know from other data that the 2125 does not accurately reflect the children reached over a 12-month period. Table 11 shows the actual number of attending mothers in three cohorts (four-month cycles) for a total of 12 months in the 10 centers. From the total 2485 mothers who participated, we arrive at an estimated 2982 under-five children in the program.²⁸

As of April 1983, it seems accurate to state that there were 1250 children in the program and another 900 being weighed, and that approximately 2800 children had moved through the four-month nutrition clinic program during the preceding 12-month period. The actual number of children weighed in three cohorts making up a 12-month period and the estimated number in the program over 12 months is shown in Table 12. The children being weighed have gradually increased in numbers from under fifty in March 1982 to more than 500 a few months later, and by January to 900.

SAWS Impact Indicators: Percent of community children in second-and-third-degree malnutrition at baseline and subsequent intervals.

Achievements: Baseline data were taken between January and December 1982. SAWS plans to make follow-up surveys in the 10 sites on or before December 1983 and at the end of the MG Program, despite the problems discussed above in defining the community population.²⁹ SAWS is aware that these surveys are before-and-after comparisons highly susceptible to external influencing factors. (A control village is not out of the area of possibility since SAWS has taken baseline data in additional sites that were not selected for program communities.) SAWS also knows these surveys will not measure benefits to participating families from outside the community. However, the community survey will not constitute the sole or principal impact data source. The center registers, uniformly coded and kept up to date under careful supervision, will be a central evaluation source. Use of the registers in future evaluation is discussed elsewhere in this report.

Baseline data for the 10 centers demonstrated an average rate of 51% second-and third-degree malnutrition with 36% in second degree and 15% in third degree. Roulin had the highest rate of third-degree malnutrition (21%) and rates of combined second and third degree were highest in Ranquitte and Belladere (70% and 64%, respectively; see Table 13). Table 14 shows cases of kwashiorkor and marasmus during the period March 1982-April 1983.

SAWS Impact Indicator: Mortality rate among under-five community children.

Achievements: No baseline mortality figures are yet available for the 10 communities. SAWS had hoped to obtain this information from the Census Bureau but must seek another approach, due to the problems of matching SAWS targeted areas with those delineated by the Census Bureau.

As will be seen below, SAWS appears to be saving a number of third-degree malnourished children from death; how long they are saving them is still a question because of the program's short life. SAWS has also achieved significant weight-for-age improvement among third-degree children without, however, moving all children out of third degree. These two factors could inflate third-degree rates and falsely reflect the program's achievements. Thus it is very important to assess mortality together with nutritional status.

SAWS Impact Indicator: Percent of community children in nutrition clinics and being weighed only, who gained, remained the same, or lost weight monthly (not against standard).

Achievements: The evaluators thought SAWS had wisely chosen this simple procedure of noting weight gain, lack of gain, or loss as an immediately discernible monitoring device for the centers and the central office. Monthly weight notations that are standstills or losses are circled in the registers for increased attention. SAWS has tried to take emphasis away from striving for ideal weight (and the too frequent negative sanctions and discouragement for not attaining it) and to reinforce the value of weight gain per se. Results obtained for combined program and weighed children for the three-time cohorts are presented in Table 15.

SAWS Impact Indicator: Percent of program children in the youngest age groups.

Achievements: Age composition for children entering the three nutrition clinics is shown in Table 16. An average 76% were three years of age or younger; 73% of Ranquitte's client population, 82% of Diquini's and 70% of Fossette's was under age 3 and an average of only five percent were above four years old. SAWS has been giving some thought to limiting program participants to age 4 and under, rather than the current 5-year ceiling. However, according to these percentages such an adjustment would not significantly reduce the workload, although it would be closer to AID Targeting Policy.

SAWS Impact Indicator: Percent of children in seriously malnourished categories at entry into programs.

Achievements: Table 17 shows the distribution of Gomez categories of nutritional status at entry for the three cohorts studied, on the left side by center and on the right side by age group. There was wide variation in the extent of second- and third-degree targeting: 85% of the children entering the Ranquitte group were in second- and third-degree malnutrition, while 35% of La Fossette children were in these two categories. Averaging the three centers showed the following:

Normal	11%
First degree	37%
Second degree	38%
Third degree	14%

Thus nearly 90% of children enrolled in the nutrition centers were in some degree of malnutrition and over 50% were in serious (second-degree) or severe (third-degree) malnutrition.

A further aid to reading the right side of the table is the cumulative percentages by each age group by second degree, by third degree, and by combined second and third degree:

<u>Age Group</u>	<u>Cumulative % in Second Degree</u>	<u>Cumulative % in Third Degree</u>	<u>Combined Cumulative in 2nd & 3rd</u>
6 months	3	10.5	5
7-12 months	13	21	14
13-18 months	29	39	31
19-24 months	45	51	46
25-36 months	74	67	72
37-48 monthss	95	88	94
49-60 months	100	100	100

The largest percentage of third-degree children was in the 36-48 month group, followed closely by the 13-18 month group, 21% and 18% respectively. Though the under-six-month group was the smallest in number, there were a surprising 6 cases out of 404 children with third-degree malnutrition and 5 cases of second degree. For combined percentages of second-and-third-degree malnutrition, the 25-36 month age group was most affected, followed by the 37-48 month age group, 26% and 21% respectively.

It is useful to compare the degree of targeting second-and third-degree malnourished within the surveyed community by comparing the percentages in these categories in the baseline survey with the percentage actually in the SAWS program (see Table 18).

The above results suggest that the program is highly successful in reaching the most malnourished in the community surveyed. The variation comes from the fact that some centers are accepting more children from peripheral areas who are severely malnourished, while others have not yet reached all of the most nutritionally at risk. Again because of problems of definition of community and the boundaries of the baseline population, comparison can only be suggestive.

Impact Indicator: Percent of nutrition clinic program children in second- and third-degree malnutrition at the beginning and at the end of the four-month program.

Achievements: Table 19 shows that, in the three registers sampled, there were 132 second-degree malnourished children who completed the four-month program and were weighed at the fourth month. This represented 85% of the 155 who had entered the program in the first month. Of the total of 23 who dropped out, seven from Ranquitte had come only once. Ten of the 16 who dropped out of the La Fossette program came three times but were not present at the fourth monthly weighing; at their third weighing, half of the 10 children were gaining and the other half were failing. These figures are reflective of an important aspect of the SAWS program, that is, the great variation in center performance. Ranquitte

was most successful, with the greater number of children moving out of second-degree malnutrition into first-degree and normal, and the greater number of third-degree entrants into second and first degree, an outstanding 80% and 76%, respectively. La Fossette had the poorest results, with improvement in only 32% of second-degree entrants and in 33% of third-degree entrants, despite the fact that Ranquitte had the highest rates of second- and third-degree entrants, while La Fossette had the lowest; and despite the fact that La Fossette had fewer under-three children than the other two centers. A clue to this variation is most plausibly found in the excellent attendance rates at Ranquitte compared to La Fossette, where rates of attendance were quite poor. This, in turn, has other explanations which will be addressed analytically below.

In sum the average results for the three centers are most impressive. A recapitulation of the percent of children improved in the two grades of serious and severe malnutrition is in Table 20.

Because of their importance to assessment of program achievements, the third-degree entrants were analyzed in further detail in Table 21. Out of 56 entrants in third-degree malnutrition in the three nutrition centers, 49 completed the four-month program; the other seven came only once. However, the average weight-for-age percentile for those dropouts was 55, compared with 51 for the other 49 entrants, so that they were not the extreme cases. 59% of the third-degree entrants moved to second degree and 10% to first degree. Although 15 children (31%) did not actually move out of third degree, an analysis of those 15 revealed that 13 of them did improve in weight-for-age by an average of 12 percentage points; many of these were in extremely low weight-for-age status so that although they made large gains, they did not move up into an improved nutritional status category. If these are included, we can say that 96% of the third degree entrants improved their weight-for-age.

Table 21 suggests that, although the numbers are too small to draw definitive conclusions, the under-one-year-olds are most successfully recuperated, probably because in general, recuperation is much more difficult in the second year of life and after four years of age.

Impact Indicator: Improvement in Second- and Third-Degree Entrants, in Followup Growth Surveillance (percentages)

Achievements: From the three registers studied, it was possible to follow 42 of the third-degree entrants. The results are presented in Table 22. In the followup growth surveillance, 78% of the 42 children who had entered in third-degree malnutrition continued to move into improved nutritional status categories. More than a quarter of them were in mild (first-degree) malnutrition or normal after the followup period (which averaged 4-10 months) percent improvement by center was Ranquitte, 93%, Diquni, 72%, and La Fossette, 67%.

Again the numbers are small, but the same trends of success were apparent for the three centers. Furthermore, it should be noted that, of the 17% who remained in third degree, more than half nonetheless improved weight-for-age.

. It was also possible to follow 81 second-degree entrants through subsequent growth surveillance. The results were good, but less spectacular than those obtained for third-degree entrants (see Table 24): 10% declined, 1% died, and of the 15 who remained in second degree, 8 (53%) improved their weight-for-age.

Impact Indicator: Percent of nutrition clinic program children in all nutritional status classifications at entry who improved weight-for-age during the four-month cycle.

Achievements: Table 23a shows program results for all entrants. The top part of the table provides a summary of nutritional status changes in percentages for the 343 children who were weighed in the first and the fourth month of the cycle. Again, there is wide variation in center performance in terms of percentages of children who improved weight-for-age: Ranquitte showed 98% of its children improved over the four months, Diquini, 93%, and La Fossette 35%, an average of 82%.

Table 24 provides a breakout of these results by age group. It is important -- and surprising -- to find that, when all entrants are taken together, more children gained in the difficult second year of life, although, when third-degree entrants are considered separately, the poorest improvement rates were in this same cohort.

These are unusually good results for improving child growth. In the 1979 King study of the Bureau of Nutrition rehabilitation centers, the percent of children who improved or stayed the same percent weight-for-age, after an average program stay of 5.4 months, was 71%, compared with the 82% for the SAWS children, despite the fact that the rehabilitation centers supplied 85% of the nutrients required by the children in on-site feeding while the SAWS program provides only four meals a month on-site, with the rest taken home.

Impact Indicator: Percent of children in all nutritional status classifications at entry who improved weight-for-age at several months after leaving the program.

Achievements: The bottom part of Table 23a shows the results of followup weighings, that is, the extent to which children sustained earlier weight gains and/or continued to make progress.²⁹ Of the 343 who completed the four-month program, 248 (72%) continued to come for weighing, a very respectable rate for followup attendance.

The results for children in followup, albeit of limited duration, are far better than SAWS expected, with an average 70 percent improving their weight-for-age or remaining at the same weight-for-age percentile over the interval. An average of 19% did drop off; again La Fossette made a very poor showing among the three centers, with 44% of its children failing in followup.

Impact Indicator: Percent of times program children attended (were weighed).

Table 25 shows that attendance was generally good for those children who came more than the first time only and who were weighed on the fourth month of the program cycle. In percentages of total weighings, the results were:

Ranquitte,	99.8%;
Diquini,	97.0%; and
La Fossette	93.3%.

While the variation among centers was not dramatic, there was a clear correlation between results and attendance rates, i.e., best growth progress, followup numbers, and growth progress were associated with the best attendance.

Output Indicator: Number of kitchen gardens planted.

Since no data are gathered on amounts planted or harvested in the demonstration and home gardens, we have concluded that the amounts produced, while they add quality and variety to the meals given at the centers and to home diets, do not merit the labor involved in compiling production and distribution data for use as an impact indicator. This should be compiled as an output indicator for management purposes only.

2. Economic Impact of Food Supplementation

In the nutrition clinics, SAWS distributes three dry rations for participating mothers plus two children; they also serve milk and provide foods to add to those brought by the mothers for making a demonstration meal on child-weighing/mother-education days in the clinic. The monthly ration amounts have been split in the past and given bi-monthly, but will now be given every week in alternate rations of bulgur and milk/cornmeal and oil, in an effort to improve attendance rates during the month. Up to this time, mothers have not been served milk nor have portions of the demonstration meal been planned for them. It has been understood that mothers could finish any leftover food following the child feeding session. As for the dry rations, sometimes counsel is given that adequate amounts of the food must be reserved for the younger family members. However, SAWS and its clinic directors recognize that the extent of family poverty is more often the deciding factor as to how effectively this can be applied.

Impact Indicator: Annual value of food distributed in the community

Achievements: Appendix M shows the value by community of the Food-for-Work and the Nutrition Clinic rations distributed over a 12-month period. These estimates, based on market values for each of the foods, range from a high of \$31,165 in Ranquette to \$6,902 in Saintard. Because, as indicated earlier, our knowledge of the precise populations of the project communities is constrained, we cannot assess the impact on the total community of this food value. However, we can calculate the impact on the Food-for-Work beneficiary family or the Nutrition Clinic beneficiary family.

For the Food-for-Work family, the food distributed represents a local market value of between \$65 to \$78 for the three-month period. For the Nutrition Clinic family, the food is worth about \$60 annually, or \$12 per capita. This can be compared with an average per capita income of under \$100 for most of the population. Thus the value of the food supplement to these families is clearly a significant contribution, whether it is exchanged or sold (as it often is the case of Food-for-Work), or used for the family.

The lower section of Table 26 shows the amounts of food distributed to the 2,485 mothers attending the nutrition clinics over a 12-month period. A total of 217 metric tons were made available for take-home distribution and for on-site use. In the last four months there were 1,040 mothers and 2,080 children in the program who were receiving food. Assuming that the food was distributed evenly throughout the 12-month period, the mothers and children received a total of 91 metric tons in kilograms by beneficiary and by family (mother plus two children) as follows:

Output Indicator: . Number of calories and proteins delivered daily to the family unit.

Achievements: Table 27 shows the nutritional value of foods distributed at the family level in Food-for-Work families and in nutrition clinic participating families. The amounts are:

	<u>Food-for-Work: Daily Availability to Family Unit</u>	<u>SAWS Nutrition Clinics: Daily Availability to Family Unit</u>
Energy Cals	4,623	3,069
Protein Grams	130	118

Output Indicator: Percent of nutritional requirements potentially met at the family unit*

Achievements: Assuming families of five with two children under nine years of age, one child between 13 and 15, and one adult male, plus one adult female with extra needs of pregnancy or lactation, the family unit would require 12,000 Kcals daily and 255 protein grams. These requirements are met in the Family Units benefiting from the two programs as follows:

	<u>Food for Work</u>	<u>SAWS Nutrition Clinics</u>
Percent of Daily Energy Cals Potentially Met with Foods Provided	397%	26%
Percent of Daily Protein Grams Potentially Met with Foods Provided	51%	46%

*See Appendix L, Daily Food Requirements for the Haitian Population.

<u>Food</u>	<u>By Beneficiary</u>	<u>By Family Unit</u>
Bulgur	1.9 (kilos)	5.8 (kilos)
Cornmeal	1.8	5.4
Milk	1.8	5.4
Oil	.85	2.6
CSM	.9	2.8
	7.25 kilos	22.0 kilos

The programmed (AER) rates are 4.9 kilos per beneficiary, or 14.7 kilos for the three rations monthly, a total 61.7 metric tons for the months. Thus, the amount of food being distributed in the SAWS centers is above the programmed amount; it appears to be well utilized and could be used for mother-feeding on clinic days, but should be regularized on the AER.

3. Training impact

Because of limited field time, it was not possible to systematically test mothers' knowledge or visit homes to observe their behavior. Since all of the four centers visited were also at different places in the four-month training cycle and since mothers' learning is not phased, any orderly pursuit of knowledge levels was effectively precluded. Evaluation of educational quality and impact was therefore limited to: a) examination of teaching materials and curricula, b) problem-solving discussions with the Training Officer and Project Directors, c) observation of teaching of mothers in three centers, and d) informal topical interviews with groups of mothers about their knowledge levels.

A major problem is information overload and imbalance. Mothers get more than they need to know, qualitatively and quantitatively. This is largely due to the obsession with the three basic food groups. According to Alvarez and Heurtelou (1983), Haitian mothers already know these and function accordingly where possible. This, together with heat, length, and pedagogical style, severely limit attention and absorption of meaningful and useful information.

Another limiting factor is the fundamental ethical and pedagogical premise of mothers' nutrition training. The nutrition agents who are the teachers of mothers do not start with the knowledge that mothers already have and basically assume a zero base; as indicated in Section II.D.3, this is inaccurate. Nor does training content take into account the realities of mothers' economic and material constraints; for example, the flannelgraph display pictures of cows or large and fresh-looking fish are remote from most Haitians' possibilities and are consequently almost meaningless for many mothers. Mothers observed responding in glazed-eye silence to nutritional lecturing became alert and startlingly responsive when one of the Haitian members of the evaluation team interrupted and began a discussion with others about their nutritional problems and knowledge.

The distortion produced by an excessive emphasis on the subject of the three food groups leaves little time for adequate treatment of equally, if not more important nutritional subjects such as breastfeeding, ORS preparation, feeding frequency, weaning, and home gardening. Similarly, important topics such as environmental sanitation and family planning get short shrift; although the SAWS directors are firmly committed to family planning, it is not clear that the nutrition agents are all similarly committed or that they, themselves, have the information or teaching skills to deal adequately with this topic. Thus, while the list of Health Promoter Training Topics and, to a lesser extent, the Calendar

for Nutrition Clinic Training would lead one to expect fairly well-balanced subject-matter distribution, reality appears otherwise. De facto priority is accorded to the food groups but no priority is ascribed to the gamut of other topics in conformity with some clear picture of teaching objectives. This not only limits impact on knowledge and behavior but makes measurement of impact problematical.

Unfortunately, although nutrition agents are told to reinforce messages and test mothers' knowledge throughout teaching sessions, this occurs only erratically. Pedagogical style is repetitious but excessively so and predicated on rote learning and one-way discourse; the organization of clinic furniture (rows of benches vs. the teacher's platform or desk) both expresses and consolidates this style.

Since role-playing and problem-solving teaching strategies are not used (e.g., "the problem of the child with diarrhea"), since there is little opportunity for hands-on learning and display of learning (e.g., ORS preparation), and since there is no consistent oral testing, it is hard to assess what information is being absorbed, and whether or not it is producing attitudinal or behavioral change. However, it seemed to the evaluation team that, while the time dedicated to nutritional lecturing is lengthy -- too lengthy, in fact, as is the entire period mothers must spend in the clinic (four to five hours) --, the educational payoff is not proportionate. Furthermore, it was clear that the one-on-one educational opportunity afforded by child-weighing and weight recording on Road-to-Health charts is being largely missed, partly due again to pedagogical style and partly to poor organization of weighing sessions. This may be in some cases the only contact with a mother; in all cases it is an important one with large potential for exchange of information and counselling.

Finally, nutrition agents do not have adequate understanding of the audio-visual materials available to them or their most effective use. The materials themselves, many of which have been given to SAWS by the DSPP, are in general good but their incorporation into teaching could be improved substantially.

4. Cost effectiveness

SAWS/Haiti supplied the evaluators with a list of expenditures (see Appendix N) incurred under the Matching Grant and was able to estimate all other contributions including contributions in kind. The 12-month period selected for the Matching Grant costs spanned Fiscal Year 1982 and Fiscal Year 1983, in order to reflect the increase in salaries, etc. as the number of operating centers increased. Title II food costs were estimated for the third and fourth quarter of FY 1982 and the first and second quarters of FY 1983 (April 1982-March 1983). Table 28 shows cost according to source and budget heads.

SAWS' contributions in cash and in kind more than equalled the AID funds provided under the Matching Grant. However, as a source of program inputs, AID was by far the largest contributor, as shown in the summary of total costs shown below:

USG	\$173,053	67%
SAWS	59,288	24%
GOH	500	
Community	22,656	9%
Total	<u>\$255,497</u>	<u>100%</u>

By selected budget heads, the costs were divided as follows:³⁰

Labor costs	\$55,843	22%
Training	18,166	7%
Transportation	52,836	21%
Food	90,704	36%
Medicines	24,543	10%
Rent & construction	3,900	1%
Equipment, furniture & supplies	8,705	3%
Technical assistance	800	
Total	\$255,497	100%

In a 12-month period, there were an estimated 2982 children in the nutrition clinic program, 2485 mothers were educated in four-month cycles, and there were 4638 child weighings. The 2485 mothers were considered to represent 2485 participating families. The annual costs for these categories of beneficiaries are:

\$46.73	per participant (total of all enrolled children and mothers, or, 5467)
\$85.68	per nutrition clinic program child
\$55.08	per child weighing
\$102.82	per mother educated
\$102.82	per participating family.

In order to compare these costs with other programs studied in Haiti in 1979 (using costs for 1978) (Fort, 1979), we first adjusted the 1978 costs to the most recent quarter for which a cost of living index was available, the first quarter of 1982. The index was increased from 279.5 to 409.8, or 130 points, representing a 47% increase (IHSS, 1982). Comparisons for program children and educated mothers are presented in Table 29 in Appendix A.

One further comparison can be made between the SAWS program and others, based on cost per improved child (an improved child is one who gained or maintained weight-for-age against the standard).

<u>Program</u>	<u>Current or Corrected Costs</u>	<u>Percent of Improvement</u>	<u>Cost per Improved Child</u>
SAWS	\$85.68	82	\$101.10
BON	100.00	71	\$129.00
Integrated Project	37.00	72	47.36

Assuming five members to a family, there are an estimated 12,425 beneficiaries (of SAWS food rations delivered to mother and of mother education), an annual beneficiary cost of \$20.56. 83% of the population receive less than \$100 in rural areas and we can assume our families are among the lower income groups. Thus, cost per beneficiary as percentage of income is .2056 or approximately 21%.

VII. ANALYSIS OF THE PROGRAM

A. Summary of Results

The major success of the SAWS/Haiti Matching Grant Program is in the area of nutritional recuperation and rehabilitation, although the project is still too young to assess the durability of these improvements or the range of any spontaneous spread effect. Rates of improvement surpass other similar projects evaluated in Haiti, although the SAWS project is not invariably the least costly. Participation in followup surveillance weighing appears quite good; this provides support to the hypothesis that growth surveillance is attractive enough in itself as a preventive health intervention to merit its position as the centerpiece of the SAWS project.

While this indicates that growth monitoring, with and without food supplementation as incentive, is alone a potent health intervention, the evaluation team felt that improvement in the quality of the SAWS education of mothers in health and nutrition would enhance the possibility that attitudinal and behavioral change could last and spread. SAWS/Haiti could get much more mileage than it is getting from its efforts at health education but will have to make modifications in its training curricula and style and corresponding changes in the content and objectives of supervision. Evaluation, in addition to the adjustments to be suggested below, could be adapted in its design to encompass the experimental dimensions of a program that is more innovative than its managers think. The SAWS/Haiti project could, with only minor adjustments, serve as a laboratory for the assessment of growth monitoring, with and without ancillary components, as a factor in improvement of health status.

B. Analysis of the Proposal Development Process

1. The Issue of Home Office Support

The overall policy which governed the inception of the SAWS/Haiti MGP was determined in the institution's Washington headquarters, as were the original ideas about core intervention strategies: community-based integrated nutrition education (CBIHNE) and community-based integrated agriculture development (CBIAD) (SAWS, March 1981). However, the country directors had almost total de facto autonomy in the original design of the Haiti project. In some measure, this seems always to have been SAWS' intent: the umbrella proposal is quite explicit in eschewing mandated uniformity of services and programs for all Matching Grant countries and communities; needs and solutions were to be identified locally and central and regional offices were to provide technical assistance (largely unspecified) and limited funds. It may be idiosyncratic that the Haiti project directors felt effectively isolated from the home office in their early tasks; it is not clear whether this sense of isolation derived from their own inexperience in program design, a reflection of an explicit laissez-faire or decentralist policy on the part of SAWS/I, or remoteness by default on either or both sides.

A reasonable conclusion is that it was all three. SAWS/International Headquarters staff is small. SAWS perceives itself as unique in many aspects of its management style and different from many other PVOs (Syme, 1982). Where many agencies spend considerable time and commit heavily of their resources in setting up logistical and managerial support infrastructure prior to project implementation, SAWS has been able to utilize and build upon a well-developed infrastructure. The ability to maximize use of existing systems is reflected in the MGP overhead rate of 2%.

Interface; and a Deputy Executive Director of SAWS/I. The reflection from the field experience is that there have been shortfalls in such technical support of various sorts ranging from project design to specific help with nutrition problems, in substantive project monitoring, and in field visitation. The SAWS house organs have recently contained references to the need for more central and field staff with professional skills specific to demands of development work.

On the field side, the experience (or the sense) of having been more or less on their own, left a residue of field independence. This is reinforced by the absence of acute need which, in turn, reflects SAWS experience, infrastructure, and sophistication in disaster response: SAWS/H has had no major logistical problems or delays with commodities or container shipments, an efficiency it replicates in its own internal logistics and early resolution of delays in disbursement. However, difficulties in communicating anything larger than a letter or smaller than a container between the U.S. and Haiti intensify a feeling of distance. The evidence from the materials available in Washington and Port-au-Prince is that documentary communication is limited. The home office does review quarterly progress reports, but the review has more to do with the quality and style of the reporting than with substantive matters. This concern is valid, given SAWS/Haiti's admitted lack of experience in monitoring and reporting and the need for proper evaluation, but there is, as noted above, need for support and guidance in technical areas.

C. Analysis of Program Management to Date

1. The Issue of Programming and Supervision

The quantity and quality of supervision is at the heart both of SAWS/H MGP results and limitations. The supervisory system is essentially three-tiered. The upper tier is composed of the Project Director, Jim Fulfer, and the Associate Director for Community Health, Olive Fulfer; the former primarily supervises central office activities, finance, and logistics, the latter is primarily responsible for field site activities and programming. The formal division is in reality quite blurred and, in fact, both individuals are intensely involved on a 24-hour basis with the functioning and underlying conceptualization of the MGP. It is the intensity of this supervision, the flexibility of response to ongoing evaluation processes that, in the view of the evaluation team, constitutes a major strength of the project; the centralist, personalistic nature of this supervision constitutes, nevertheless, a limitation on program effectiveness, in the light of weaknesses at lower levels.

The second tier is occupied by the Training Officer, who does not often leave Port-au-Prince, to whom report two MCH Outreach Supervisor-Inspectors, now in in-service training but not funded by the MG. At the same level as the Training Officer is a temporary Field Supervisor, to whom report three Program Supervisors and the Agronomist in charge of the garden project; the former supervise the health care workers and their assistants on a somewhat erratic schedule; the latter supervises the village-level agricultural promoters and visits each site four times a month.

The weakest supervisory links, with the exception of the Agronomist, whose task is well specified and whose activity is vigorous, are in the second tier. The role of the Field Supervisor is currently well filled by a trilingual

MPH, but her presence is temporary: the job is hard and the salary low. There is feeling that the mid-level supervisors need more training, perhaps a special course in supervision, as well as training in reporting techniques and use of data-collection forms (to be designed) that more easily, fully, and accurately capture issues of service quality, problems, and alternative solutions.

The self-confinement of the Training Officer to the capital is particularly limiting in combination with these other factors and leaves supervision of the program largely dependent on field visits by the Fulfers and the Program Supervisors. Nevertheless, major difficulties have been identified before too much damage has been done, and it has been possible to make useful adjustments to the content of some program components, to food distribution schedules, and to site-specific management and community issues. The principal victims of weaknesses in the supervisory system have been clinic procedures: for example in most sites delivery of services is unduly time-consuming, e.g., food preparation and weighing. Because the Fulfers do not speak Haitian Creole and have limited French-language ability, they are not able to adequately assess the educational dimensions of the project either in terms of quality of delivery or levels and retention of learning by mothers.

2. The Issue of Evaluation

The refined project design included a detailed evaluation plan. The philosophical core of evaluation, for the Haiti team and for SAWS/I, had three components: respect for "soft," less quantifiable data, as well as "hard," statistical data; the concept of evaluation as a tool, not a judgment, to determine what happened and why; and an opportunity to objectively identify weaknesses as well as strengths.

The design for the project had at its core provision of services not only to mothers and children in its nutrition clinics, but community growth surveillance and nutritional motivation, which would also serve as the mechanism through which the most malnourished children would be selected for the clinic program. The design also envisaged evaluation of nutritional status and mortality for the total population of the communities chosen as project sites, to be accomplished through baseline and followup community surveys. This plan offered the major advantage of measuring benefits to the community and not just those to direct project participants.

In order for surveys to accurately measure program effect, the surveyed area must be constant, i.e., the boundaries of the targeted area must be delineated and program activities limited to the children and mothers who live therein. However, SAWS/Haiti encountered difficulties in the defining of its target populations in the 10 sites. Baseline surveying and obtaining a population base were complicated by imperfections in house-to-house surveying, especially in the urban and peri-urban areas of La Fossette and Diquini. Even at other sites, SAWS did not consider its population estimates of under-five children and women of childbearing age to be sufficiently reliable to draw any conclusions about program coverage. Demographic data from the Census Bureau of the Potable Water Commission (CNEP) did not always correspond to the SAWS intended target area.³¹

The second problem with which SAWS grappled was the ethical one of turning away a seriously malnourished child because he/she did not live within the target area, however that was defined.

The third problem arose from the growth surveillance activity. Again, mother-child pairs from both targeted and non-targeted populations have been coming, but SAWS/H has become aware that their staff and resources do not permit open-ended child-weighing, although it is alert to the advantages of growth surveillance for as many children as possible and has advised its personnel of its high priority.³² SAWS management also understands that their program as designed under the Matching Grant will be judged primarily by the effectiveness of their treatment of under- and malnourished children, and not by how many children they can weigh a month.

SAWS/Haiti and the evaluation team concluded that it would be most feasible and still informative to evaluate on the basis of a presenting, rather than a community sample. Project impact would therefore be read against a base of those entering the program or participating in surveillance, instead of against a "community" baseline.

SAWS/H management is unusually sensitive to the importance of good-quality data for ongoing evaluation, concerned about its ability to gather such data in an efficient way, and worried about losing crucial data with the passage of time and about not knowing with any accuracy "where they have been." The absence of baseline mortality data, never gathered, will limit EOP evaluation and impact assessment, but it is not clear now that the costs in time, money, and accuracy of beginning to gather such difficult statistics now would be justified. Information is not being collected, nor is there program followup (e.g., home visits) on dropouts. Lack of systematic analysis of the data centerpiece of the program, the clinic registers of surveillance statistics and progress of program participants, impedes well-founded decision making; anecdotal data, which may or may not be applicable to a particular site, are being used for cross-program determinations. The most important example of this is the pending decision to extend clinic enrollment time from four to eight months, based on evidence from Diquini and Saintard that mothers were keeping children's weight down in the last weeks of participation in order to assure eligibility for readmission. Register analysis of three sites, including Diquini, indicates that this phenomenon is not so prevalent as thought, throwing the program duration time once more into question.

Finally, SAWS is aware that their entire management information system needs reworking. Clinic managers are responsible for recording and re-recording too much information that is not used, because it is not essential, because it is too diffused, or because it is not recorded in usable fashion (e.g., cahier de consommation/PL 480 food-use notebook; cahier de recettes et dépenses/income from sale of bags and containers and from mothers' contributions; cahier premiers soins/first aid notebook recording use of pharmaceuticals by name of patient and ailment; menu notebooks; and attendance and daily weight records). In addition to these daily requirements, excessively time consuming since there are no checklists, managers must provide separate monthly reports on services provided, which only partially coincide with the service statistics set forth in the Project Evaluation Plan; on PL 480 and drug stocks; on attendance;

on children's four month weight progress; plus register maintenance. Because of the attentiveness of SAWS supervision, this situation is not as damaging as it might be. Still it is time-consuming, negatively affects interaction between mothers and clinic staff, limits precision of ongoing monitoring and evaluation, and will ultimately affect the quality of EOP evaluation.

To date, there has been no real external evaluation of the SAWS/H MGP. In October 1982, SAWS/I put out a document entitled Evaluation Report 1981-1984, which included some summary data based on internally-collected output information and some process reporting, together with the results of baseline data collected on nutritional status of children 0-5 in five project sites. The document also included a two-page report of a visit in April 1982 by Transcentury Foundation's Training Director, Jane Watkins, to the St. Roc site; the report was highly favorable, noting only problems of measurement of success and the unlikelihood of village self-sufficiency in food production.

Other external evaluation, if it can be so called, has been random and informal, by AID/W visitors and representatives of the BON and the DSPP. The current evaluation is effectively SAWS/Haiti's first. It was seen as an opportunity to make crucial mid-course corrections and to examine larger questions of impact, cost-effectiveness, and fit with AID policy and the appropriateness of such a fit. SAWS/I had particularly high hopes about the provision of technical assistance by the evaluation team and the salutary effects of the evaluative process itself in exploring, participatorily with SAWS/H management, the question of where the project "was." Both SAWS entities also hoped for an accessible, user-friendly, jargon-free evaluation document.

VII. CONCLUSIONS AND RECOMMENDATIONS

A. General Conclusions

1. The SAWS/Haiti Matching Grant Project is appropriately focused in terms of country economic and nutritional realities. It is also harmonious with AID and USAID policies on use of food supplementation as a health education resource, increased attention to MCH and preschool feeding, and growth surveillance as a preventive health intervention.
2. The Project is less clearly congenial with policy when it is considered as a nutrition intervention with wide multisectoral dimensions which would enhance its cost-effectiveness. The original concept of the "Community Health Workers" appears to have become reduced to the concept of the "Nutrition Agent," and the educational role of the clinic staff correspondingly constrained. Problems in balance, content, and style of nutrition and health education further limit program breadth.
3. The Project has enjoyed, with other PVOs in Haiti, the benefits of good relationships with the USAID Mission, largely due to the USAID's commitment to staffing well to address PVO needs and issues. An additional by-product of this area of USAID policy has been improved relationships among all PVOs, enhancing opportunities for mutual learning, leverage in policy areas, and rationalization of areas of responsibility, to the benefit of the MGP and the SAWS program overall.
4. Host-country/PVO relationships are presently in flux, marked by increased attention by the GOH to PVOs and the resources they represent and by ambivalence in the PVO community about the implications of this attention. Institutionally, SAWS/H shares this ambivalence and has worked with the PVO community toward policy changes which have increased overall program efficiency. At a personal level, SAWS/Haiti's relationships with the GOH (DSPP and BON) have been amicable and productive, if not extensive.

B. Conclusions about Areas of Special Interest

1. Impact

a) In terms of the outputs formally contracted for in the Project Log-Frame, the SAWS/H MGP is on target in terms of time and numbers with the establishment of nutrition centers, and over and ahead of target in terms of health workers trained and kitchen gardens in place. It is behind target with its self-help projects, the numbers of children who have been through the program, and the number of children being weighed monthly.

b) The nutritional impact of the project, as measured by a number of indicators developed by the evaluation team, appears to be substantial. The program a) appears to be saving a number of third-degree malnourished children from death; b) has achieved significant weight-for-age improvement among third-degree children without, however, moving all children out of third degree; c) is moving 71% of second-degree children to first-degree or normal and 69% of third-degree children to second or first degree; d) has achieved absolute weight gains in 96% of third-degree children; 3) is showing success in recuperating

third-degree children under age one and, more impressively, producing gains in the age group that is most difficult, e.g., the second year of life; and f) is showing impressive continued rates of improvement in followup surveillance, with 78% of children who had entered in third degree and 68% of those who had entered in second degree, improving their weight-for-age. Attendance at followup weighing is a very respectable 72% of original entrants. These are unusually good results for improving child growth compared to other similar national programs. In a 1979 study of BON rehabilitation programs, the percent of children who improved or stayed at the same percent weight-for-age after an average program stay of 5.4 months was 71%, compared with 82% for the SAWS children, despite the fact that the rehabilitation centers supplied 85% of the required nutrients in on-site feeding, while the SAWS/MGP provides only four meals a month on-site, with the rest taken home.

c) There is great variation in center performance as measured by these indicators. The urban center of La Fossette produced improvement, as measured by movement into a higher Gomez category, in only 32% of second-degree entrants and in 33% third-degree entrants, although it had the lowest absolute numbers of such entrants; produced weight-for-age improvement in only 35% of its children; and 44% of its children failed in followup weighing and showed lowest percentages of attendance at followup weighings.

d) There is a clear correlation between program results and attendance rates, i.e., best growth progress, followup numbers, and followup improvement were associated with the best attendance.

e) The MGP provides to beneficiary Family Units 26% of RDA energy calcs and 42% of protein grams. This is above programmed (AER) rates, which suggests that SAWS has enough tolerance in available food quantities to give mothers milk and a noonday meal at the weekly sessions, the absence of these produces considerable stress and, in at least one site, diminishes the amount of food available to the children since mothers eat from the child's plate. It also suggests that nutritional impact can be achieved at high levels without generating excessive dependency through very large donations.

f) The economic value of food distributed through the MGP is approximately \$60 per family or \$12 per capita, compared to \$65-78 per family per three-month period in Food-for-Work programs. Annual average per capita income in Haiti is \$100; thus the cash equivalent of the MGP to beneficiary families is substantial, again at lower levels of potential dependency.

g) The MGP, largely because of limitations of training and supervision, is missing an important opportunity for impact, which would in turn lead to greater spread effect, benefit distribution, and potential for sustainability. This is the opportunity offered by the nutrition surveillance encounter, in some cases the only encounter with some mothers, for imparting key health and nutrition messages; for generating community awareness of the symptoms of under-nourishment, for example; and in general taking full advantage of growth monitoring as a low-cost preventive health-care measure with major nutritional significance.

h) The MGP kitchen garden activity is essentially an additive activity which introduces more quality and variety to meals given at the centers and to home diets. It is not clear what level of program importance is ascribed to this activity, and if its potential impact might be greater.

i) SAWS/Haiti has serious misgivings about their technical and managerial capacity for doing anything meaningful with the self-help component of the MGP and about the wisdom and ethics of proliferating redundant skills for which there is little or no identified market. In the absence of likelihood that these projects can become truly income-generating and in the absence of technical staff with the experience and backing to make them so, it is improbable that the current level of participation can be sustained or additional participation motivated.

j) The impact of the educational content of the MGP appears to be weak overall, but particularly weak in priority subject areas such as treatment of diarrheas and ORT preparation and use (although Oralite packets are distributed), vaccinations, environmental sanitation, and family planning.

2 Spread Effect and Benefit Incidence

a) The MGP coincides with the broad parameters of AID targeting policy in its emphasis on children 0-5 and is congenial with the more refined targeting objective of reaching malnourished children 0-3. 76% of the project client population is under age 3; SAWS finds it ethically stressful to turn away children in Gomez III who happen to be over age three. The project is also harmonious, in its inclusion of two difficult urban sites, with increased policy interest in the worsening nutritional status in urban areas identified in Haiti and elsewhere. Any decision to increase attention to urban areas or more strictly adhere to the "age 3 and under" target is a policy issue between SAWS and AID; a more strict age limitation would not substantially reduce workload.

b) SAWS/H is in the process of requesting an amendment to the MG in the amount of \$10,000 to purchase scales, teaching materials and supplies, and pay for travel and per diem to extend its nutrition/education program to include the 80 MCH programs which now receive PL 480 Title II food through SAWS. The regular training will be modified to a one-week session where the basics of evaluation, organization, and education will be taught, with emphasis on growth surveillance, early detection, and prompt intervention measures. This would serve not only to "spread" the MGP and enhance benefit incidence, but also to refine its character and objectives which presently have difficulties of diffuseness of goals and objectives.

3. Cost-Effectiveness

a) Costs of the MGP per annum per beneficiary are as follows: \$46.73 per participant (total of all enrolled children and mothers), \$85.68 per nutrition clinic program child, \$55.08 per child weighing, \$102.82 per mother educated, \$102.82 per participating family. Per-child costs are less than for the BON and Schweitzer Hospital programs, and more than for MOH Integrated Centers, and the CWS and HACHO programs. Per-mother costs are less, again, than BON, and HACHO, and more than MOH Integrated Centers and CWS. The most reliable comparisons are with the BON and MOH centers. The only major difference is in the cost-per-program child, \$85.68 for SAWS and \$37.00 for MOH Integrated Centers, a difference substantial enough to merit investigation by SAWS/H. The evaluation team feels that, because of the nutritional impact being achieved by SAWS, the comparative cost-effectiveness is satisfactory. However, we are less content with the high apparent cost-per-educated-mother, in the light of our judgement about the quality, range, and durability of the education imparted.

4. Sustainability, Replicability, and Self-Sufficiency

SAWS/Haiti is operating on the assumption that, through village-level education and community cooperative effort, levels of nutritional well-being for the targeted child population can be improved. Given the realities of chronic food deficits and levels of absolute poverty that afflict 50% of the urban and 90% of the rural population, there is no reason to expect program self-sufficiency; some measure of outside support must continue for some time to come. The issue becomes whether the program is designed and, more importantly, conducted in a manner that will minimize chances of dependency formation among recipients.

SAWS/H has made a preliminary decision to extend each program cycle from four to eight months, based on anecdotal evidence that a large percentage of children were failing after leaving the program and that some mothers were deliberately withholding food before exit weighings of their children so that they would not have to "graduate." The evaluation team's careful analysis of three clinic registers indicate that these numbers are not, in fact, large.

5. Innovation

The SAWS/H Project Proposal was explicit about not being innovative and emphasized its integrated character (food supplementation; informal, experience-based learning, education in sanitation, food preparation, and vegetable production; and growth-monitoring). However, the growth-monitoring component is, in fact, innovative and productive of the greatest identifiable impact to date, while the other elements of the integrated model are as yet weak and their impact indeterminate. Despite this, there is promising research potential that could be realized in the program at relatively little cost.

6. Project-Specific Issues

The question was raised prior to this evaluation as to whether Adventist-Church membership precluded or favored any portion of the putative target population. While such membership has constituted an important linkage that has enabled whole communities to become potential beneficiaries of MG activities, we found no evidence that communities or individuals were excluded from program participation or that project activities were being used as springboards for winning or holding converts, although the majority of clinic personnel are themselves Adventists.

7. Management Issues

a) The several changes in goals and purposes and their corresponding outputs and indicators reflect a laudable attempt at clarification and refinement of focus. In general, the implementation process has gone on unperturbed except for the addition of the self-help projects which now appear to be an unfeasible component. However, the change process has had a largely negative effect on SAWS/H capacity to evaluate.

SAWS/H is also undergoing ad hoc change in its project focus. Management instincts are to concentrate on nutritional improvement and education, and retain only those program components that constitute incentives to participation (e.g., first aid treatments) or which reinforce nutritional activities. Growth surveillance is under consideration as an additional program output in the revised project Log Frame.

b) Site selection has been essentially opportunistic, based on variable criteria of existing human and physical infrastructure, accessibility, and some degree of urban/rural mix. The assumption has been that malnutrition is evenly distributed across Haiti. This has not been prejudicial but suggests lines of thought for any program extension.

c) There are major strengths in the SAWS/H project which derive from pre-existing human and physical infrastructure; well-functioning logistics and financial systems; a tradition of low overhead; a salary schedule which is locally competitive (although too low to attract certain types of expatriate employees); a shared set of values, orientations, and quality of commitment which provides cohesiveness; a participatory management style which surpasses language barriers; and staff educational levels which are relatively high for Haiti.

d) The concept of supervision as a collaborative and constructive resource and not a potentially punitive, hierarchical activity is alien to Haiti. Distance and transportation make development and establishment of an effective supervisory system difficult. While supervision at the directorial level is excellent -- although somewhat limited by the directors' lack of Creole competence -- lower-level supervision has been inconsistent and limiting to the program's impact, especially in the areas of clinic management and education.

e) Clinic management is generally weak. Sessions are too long and inefficiently sequenced, and their content reflects the indeterminate quality of the promoter curriculum, unproductive biases in content, and a counterproductive pedagogical style.

f) The weakest structural links in the MGP are training and evaluation. Training is traditional, unidirectional, largely unadaptive, erratically focused and overly inclusive, unstandardized and unscheduled, and not experiential. Evaluation has major problems which derive from problems with definition of the target population and "community," lack of baseline mortality data, data which are scattered in a large number of data-collection instruments, and from the collection of unnecessary information; some indicators, e.g., "number of persons using condoms," are not accurately framed. At the same time, some information that could facilitate assessment of program progress and impact, such as attendance figures, exit and reentry rates, and learning impact, is not gathered systematically or presented in standard indicator format and the reporting system is out of synchrony with itself and with evaluation needs. The importance of these weaknesses is magnified by the potential for impact through growth surveillance and the substantial opportunities for learning afforded by a project which, in effect, is a laboratory.

g) The role of home visits, supposed to occupy one-fifth of health worker time, is not clear. Home visits are reported in numbers in quarterly clinic summaries, but their content and purpose is not yet rationalized.

C. Recommendations

There are three major areas of recommendations which proceed in more or less logical order. Once determinations are made in these areas, lower-level, more precise recommendations can be applied in the appropriate areas.

1. Project goals and purposes. We recommend that SAWS/Haiti follow its instincts toward simplification of project design, emphasis on growth surveillance as the centerpiece of the project, formalization of followup surveillance as a major project component, and elimination of the self-help component. This will affect the number of beneficiaries in the treatment and follow-up phases of the program, which SAWS will have to decide upon in light of available human resources and PL 480 food supply levels. It would also affect the home visit component of clinic activity which we recommend be abandoned as cost- and time-ineffective in any case; the program would then depend on clinic attendance and weighing rallies. Also we recommend that SAWS reconsider its decision to extend its program cycle to eight months, except where there are clearly higher, well-analyzed failure rates in a given site (which may, however, have causes rectifiable through other means). Keeping to the four-month cycle may shorten life-at-site of the project, so that SAWS can move to other sites with the same activity. We recommend that the life of the program overall be extended, at a minimum to December 1984, to allow completion of more than one full cycle plus evaluation time.

SAWS/H could then re-think its program as a two-step intervention activity. The first stage establishes a locale, provides enough cycles of recuperation to reduce the pool of second- and third-degree malnutrition cases, diffuses nutrition education, establishes community-operated growth surveillance; the second stage provides some minimal level of supplementation and periodic but less frequent supervision. The MG amendment now being requested is consistent with this approach and we recommend its approval.

2. Evaluation. If these recommendations are followed, then we recommend that: a) SAWS/H formally abandon the community baseline concept and accept as baseline the "treated" population; b) consider the clinic registers the heart of their evaluation system and modify them minimally (so as not to require rewriting) so that they are marked uniformly and readily recognizable with: identification of new entrants into the clinic program; identification of children leaving the clinic program, preferably with reasons; identification of children being weighed only; sibling admissions; and joint coding of mothers and children; and adjust maintenance of other indicators accordingly.

3. Technical Assistance. SAWS/Haiti needs technical assistance in three areas: a) supervision and clinic management; b) curriculum development and training approaches; and c) the rationalization of their management information system. The precise content of the necessary modifications can only be spelled out when SAWS/H makes its management decision about setting the parameters on its Matching Grant as discussed in C.1 above. In general, the technical assistance should focus on clarification of objectives in these three areas, rationalization of schedules, unification and reduction of data instruments and indicators, refinement of the indicator universe and incorporation of a very few management indicators into that universe. The strength of the SAWS/Haiti MGP is its flexibility; the point of any technical assistance should be to foster this characteristic and simplify systems to the minimal components needed for effective management and delivery of services and their assessment in terms of efficiency, cost, and impact.

FOOTNOTES

¹Nutrition messages can also be reminders of "old" concepts, such as the nutritionally sound traditional food categorization schemes and the priority custom has always given to the abundant feeding of lactating women and young children. Messages can make explicit reference to the rising costs of food and to the reality of widespread stress and outright hunger during certain times of year, and should of course be delivered by speakers of colloquial Creole. Nutrition surveillance is an important vehicle for imparting key messages, generating community awareness of the symptoms of undernourishment and its status as an illness that requires certain kinds of healing efforts, and helping parents make the minor adjustments in family food allocation that could mitigate the nutritional "compromises" between parents and children that have resulted from growing scarcity. In a subsequent analysis, Alvarez and Heurtelou (1982) point to the need for nutrition education programs to take into account the variability by community in pre-existing and potential economic conditions, most especially with regard to food availability and seasonality. The pedagogical implication of this -- the need to observe and listen -- goes against the grain of the entire Haitian educational tradition based on authoritarian, rote memorization and discussion-less procedures. Community surveillance strategies can emphasize positive group and individual reinforcement for growth rather than negative sanction for failure to achieve against a standard, and utilize mothers whose children do well as role models. Finally, nutrition programs can also offer locally needed and valued inputs, some medical, some agricultural, some nutritional, as incentives for participation.

²AID Nutrition Policy is to be effected through: 1) identifying projects based on analysis of nutrition and food consumption problems; 2) including nutrition as a factor in project design; 3) targeting sectoral projects to highest risk groups; 4) monitoring and evaluating nutrition impact of projects; 5) complementing sectoral programs with nutrition projects; 6) utilizing the private sector, especially the food industry, wherever feasible; 7) encouraging nutrition policy integration into sectoral planning; and 8) coordinating with LDC governments and other donors to achieve nutrition goals.

The expression of intersectoral integration between nutrition and health is explicit in the nutrition policy and emphasizes attention to nutrition objectives through primary health care, growth monitoring as a low-cost preventive health care measure with major nutritional significance, breast-feeding and proper infant feeding practices, environmental health (disease control, health education, and environmental sanitation.)

The food assistance component of the AID nutrition policy addresses the utilization of agricultural commodities under Titles I, II, and III of PL 480 and calls for significant changes in use of Title II food (donations of food for famine relief, combatting malnutrition, and promoting economic and community development). The policy asks for better targeting, specifically to reach malnourished preschool children and pregnant and lactating women; appropriate ration sizes; and inclusion of nutrition education along with the supplemental food. It suggests use of Title II food to address seasonal household shortages; as a resource for health, education, family planning, and income-generating activities; and as one of the few means available to AID for addressing the growing problem of urban malnutrition in the developing world.

A subsequent AID targeting policy draft document (PVA, 1983) recommends directing the limited food resources available through PL 480 and especially PL 480 Title II MCH programs to the nutritionally vulnerable, at-risk members of poor households. At-risk groups are defined as children under five, with emphasis on malnourished children and children under three; and women of childbearing ages, with emphasis on pregnant and lactating women. Priority is to be given to geographic areas of poorest nutritional status or to groups or locations defined by appropriate socioeconomic indicators (e.g., income levels, landholding, food production, percent landless laborers, unemployment rates). Targeting strategies should be developed on a country-by-country basis, according to country problems and priorities; the sociocultural and political feasibility of reaching target groups; necessary program components (e.g., educational materials and curricula, training, growth surveillance systems, manpower and administrative needs); cost and coverage considerations; seasonality; and the presence of functional groups with special problems.

³The USAID/Haiti Mission's long-term approach to addressing malnutrition in Haiti was based on a long-standing and persistently frustrated commitment to an integrated nutrition, health, and agricultural strategy which would link increased agricultural production for both domestic production and export, and preventive interventions (establishment of a nutritional surveillance system, expanded programs in nutrition education/training for rural health personnel, and improved home gardening through agricultural extension services) in the context of the National Rural Health Delivery System (RHDS). However, anticipating worsening food shortfalls over the next few years, the Mission has also committed itself to a shorter-term strategy of continuing supplementary food provision, with increased attention to maternal-child health (MCH) and pre-school feeding programs because they are most readily targeted to the groups at highest risk; because trained PVO staff are normally available at the site of final distribution, insuring appropriate food use, often carrying out nutritional and medical surveillance, and sometimes educating in nutrition and home production.

Some of the possible approaches contemplated by the USAID in a March 1983 Title III PID as flexible and selective ways for maximizing scarce AID resources included several which are germane to the SAWS MGP, in theory or in practice:

Encouragement of community participation in, involvement with, and ultimate responsibility for the availability of primary health care.

Encouragement of active collaboration by PVO's in the operation of health facilities under DSPP norms and policies, e.g., sharing the GOH financial burden for primary health care.

Provision of non-clinical contraceptives at the community level.

Promotion of cost-effective, multisectoral nutrition interventions and the use of child-growth surveillance to prevent serious malnutrition among vulnerable groups.

Collaboration with other donors in the promotion of oral rehydration therapies in the treatment of diarrhea and vaccination against communicable diseases, e.g., TB, polio, diphtheria, tetanus, measles, whooping cough.

⁴Of Haiti's \$10 million CBI allocation, \$9.0 million will be used to fund NGO operations in Haiti. Among the indigenous organizations who will be directly implementing development projects using these monies will be the Association of Private Health Organizations (AOPS) of about 180-200 licensed private health facilities. Also with USAID encouragement and assistance, the indigenous and international voluntary agencies operating in Haiti have established an umbrella coordinating body, the Haitian Association of Voluntary Agencies (HAVA). The Mission has a close, positive relationship with HAVA and will coordinate its future efforts to strengthen NGOs operating in Haiti with this organization (CDSS FY 1985).

⁵ Strategy implementation is, however, severely constrained by insufficient financial resources, severe budgetary skew toward personnel costs (90%), and excessive drain from certain fixed facilities. Budget allocations to the health sector are not small in percentage terms (15%, according to the 1983 USAID Title III PID) and the trend in absolute and percentage terms has been upward, from G61.9 in 1982 to an estimated G92 million for FY 84. The problem is a small overall volume of general government revenues, further affected by fiscal austerity measures begun in late 1981 (CDSS FY 1984). Because of possible undercount in the preliminary 1982 Census results, it is hard to talk with assurance about per capita implications, but in 1982/83 per capita government health allocation was estimated at around US\$2.82, compared to US\$20.00 for Honduras and US\$73.60 for St. Kitt's/Nevis (Cross, 1982). This issue is not commitment to health but the effects of a relatively small amount of resources spread over a large population in very great need.

⁶The establishment of the Association of Private Health Organizations (AOPS) was encouraged by the Ministry of Health, and the Bureau of Nutrition (BON) has established a commission on "complementary food intervention for the most at-risk" and issued invitations to all the PVOs to meet and discuss the inter-related dimensions of nutrition, food aid, and community development. The BON has also established norms for supplementary feeding (September 1982). The principal effort at coordination, as well as control, was the Presidential Decree of December 1982, "On the Establishment and Operations of the Private Voluntary Agencies Working in Haiti." The most important sequelae of the decree are: the establishment of a joint NGO Activities Coordinating Committee composed of seven high-level government officials from relevant ministries and seven NGO representatives designated by the NGOs in concert (whose mandate is of a breadth which worries some PVOs); establishment of standardized by-laws; and agreements about PVO prerogatives with regard to, among other things, customs duties. One item of considerable concern is the requirement that all PVOs maintain their bank accounts at the National Credit Bank.

Most GOH-NGO problems have derived from questions of duties. As of 1982 the Haitian government was in substantial arrears to PVOs at average levels of US\$100,000/yr. per PVO. Also in arrearage was the GOH contribution for inland transport, originally accorded at US\$1,000/mo. but reduced to US\$657.50/mo. as of 1982. Finally, the right to duty-free petrol had been revoked for almost every PVO in the wake of the IMF austerity requirements of early 1982. In May 1984, in a meeting of the four PVOs and representatives from the Directorate of Customs, the Port Authority, and the Ministry of Finance, accord was reached on reimbursement of port charges in default and restoration of duty-free privileges on petrol products related to Title II imports; inland transport arrears were not discussed but there was agreement to expedite, though not eliminate, inspection of duty-free commodities and equipment.

7 SAWS involvement in development assistance in Haiti began as a humanitarian response to drought and famine in 1976. The approval in August 1978 of AID's worldwide Title II Outreach Project permitted all four of the US voluntary agencies then working in food distribution in Haiti (CARE, CRS, CWS, and SAWS) to increase or begin regular food distribution. SAWS/H was able to develop a growing network of Title II services to new recipients, together with the corresponding additional infrastructure, human resources, and vehicular support; improved the efficiency of its logistics system (storage, forward planning, stock maintenance, inventory control and handling) and the reliability and timeliness of commodity distribution; reduced distribution costs and food losses; expanded capacity for a larger food reserve; extended its commodity control through community surveillance and a system of end-use checkers and supervisors; and enhanced its community organizational skills through promotion and training of 50 local health committees.

Between 1979 and 1982 SAWS increased the number of recipients by 194% (from 25,000 to 73,500) and the volume of commodities by 233% (from 1,216 MT to 4,050MT) (Stephens et al., 1983). The SAWS/H Operational Plan for FY 84 predicts an increase to 85,500 recipients, which breaks down as follows: School Feeding, 50,000 recipients in 350 locations; Maternal/Child Health, 18,000 recipients in 40 locations; and Other Child Feeding, 1,500 recipients in 20 locations. SAWS now has three trucks for inland transportation of commodities, but only one was operational as of June 1983 due to the maintenance problems endemic to Haiti. An additional 10-ton truck is in the Outreach budget for this year, and it is hoped that another one will be acquired in the near future.

All of SAWS/Haiti's material, human and skills resources are, in effect, inputs to the MG. While they are not "planned" in the sense that they would appear in the Inputs column of a Logical Framework, they were taken into account both by AID in awarding the MG and by SAWS/H in gauging its capacity to support a certain kind of program. This existing resource base is a sine qua non for the MG; as such it should be considered an Input. In fact, the whole question of what constitutes an input to the SAWS MG must, except for the budget itself, be defined empirically. This is because the dedicated attempt at elaborating a Logical Framework for the project is somewhat confused on the subject of inputs. The Project Proposal workbook (SAWS/H, 1982) which was the first revision to the original proposal lists the following, together with the budget, as program inputs:

1. a) Site selection
 - b) Equipment purchase
 - c) Equipment
2. to a) Baseline
6. b) Trainee selection
 - c) Pretest curriculum development
 - d) Training
 - e) Post-test
7. Contractual Agreement with USAID/Haiti
 - PL 480 food obtained
 - Food distributed to centers
 - Food distributed to mothers
8. Self-help group organization
 - Selection of leaders
 - Follow-up

9.
 - a) Curriculum development
 - b) Staff selection and hiring
 - c) Pre-test
 - d) Staff training
 - f) Staff placement

10. Evaluation

⁸Early in the program, three support staff members were let go because they were unqualified; in the first quarter of 1983 one health worker and two agricultural auxiliaries were dismissed for not meeting their commitments. In all instances, the problems were handled without serious consequences and with little negative impact on staff morale. Planned human resource levels have remained at projected levels, with only temporary disruptions.

⁹Salary parameters are set interactively on an international and country-specific base: salary structures are studied in a representative sample of the countries in which SAWS has field missions and an agreed-upon scale is established division-wide; each country mission assesses its own situation annually and adjusts its own rates within the established international parameters. In Haiti the same rate holds for all SAWS entities, which reduces pressure on the SAWS Outreach and MG programs to pay more simply because they get AID funding. In any case, the SAWS/Haiti scale measures up favorably against those of other PVOs (e.g., CRS and CWS).

Personnel selection has also been governed by attention to experience and training levels and Adventist Church membership provides a shared set of values, orientations, and a quality of commitment that brings a cohesiveness to the total personnel structure not typical of most Haitian organizational cultures. The management style of expatriate directors is almost consistently participatory, despite the language barrier at the lower echelons where Haitian employees do not have English-language capacity.

Beyond this, there is a SAWS commitment to human resources development and in-service training. At upper management levels, this is buttressed by the offerings of the School of Health at Loma Linda University and by growing interest in SAWS/I in attracting and fostering specialized professional skills suitable for work in international development. Unfortunately, this interest is not always harmonious with SAWS salary levels; while these are reasonable in the Haitian context, they attract only the most committed expatriates or those without major family support responsibilities.

In general, however, educational levels of those resources available to the MG are quite high for the Haitian environment; this again may correlate with the effects of church membership on access to education and with the capacity to attract a certain calibre of personnel. Half of the trainees in the two courses SAWS/Haiti has given in nutrition, sanitation, and community development, who constituted the pool from which the MG clinic staff was drawn, have completed 10 grades or more (see Appendix A Table 3). The supervisory and clinic-management problems discussed later in this document would seem to have less to do with academic preparation and more to do with cultural perceptions of what is meant by supervision and management and with lack of more precise training in those specific skills.

¹⁰It is difficult to cost out this contribution. Strictly speaking, the "1200 hours" indicates only that Loma Linda University requires that 600 hours be committed to thesis work; according to this formula the two pastors would only have provided one person-month of labor to the project. In fact, both pastors were resident in their communities for approximately six months and worked long hours promoting projects at their sites and getting them started. They also went through the SAWS training program for MGP workers. Furthermore, there were less tangible contributions: the availability of the two pastors contributed to the rationale for the project and two of its 10 siting decisions.

¹¹The potential for DSPP contributions in kind was known from the outset of the project (SAWS/H, 1981). However, the levels of that contribution were not foreseen and it is not clear that they could have been. The contributions of the DSPP between March 1982 and March 1983 were valued over \$57,000 so that the amount is far from insignificant.

¹² Nutrition baseline surveys collect data on child's sex, age, date of birth, weight, mother's name, any vaccination; summary sheets calculate age and Gomez category, and noted if child admitted to program. Household surveys made by each health worker gather data on: head of household, mother's name, marital status, whether using family planning, pregnant/lactating, number of children 0-5, vaccinations, children admitted to program, children 7-14, children attending school, history of TB or malaria, presence of latrine, water source, general address, number of children.

¹³Responsibility for the center was turned over to the staff of the center's locale, a medical polyclinic supported by the Orlando, Florida Rotary Club. Activities had never been initiated at Platon and Besace, also included in the list of sites in the original proposal. Bassin-Bleu, Saintard, and St. Louis du Nord were substituted for Gros Mangle, Besace, and Platon because they offered accessibility (Saintard), vigorous expressions of local interest (Saintard), and existence of human and physical infrastructure available for project use (Bassin-Bleu, St. Louis du Nord, and Saintard).

¹⁴ A decision was made in the late 1970s to partition Volag program responsibility by geographical area in order to reduce duplication. The Volags agreed that CARE would work in the North and Northwest, CRS in the South and Southwest, and CWS in the Central Region and the Island of La Gonave, responsibilities already largely de facto. SAWS agreed to consult with the other PVOs to avoid duplication.

¹⁵SAWS has its own system of accounting and auditing which follows generally accepted auditing practices. SAWS as a whole is audited internally every year and is open to external audit at any time for any specific project or as an entire agency. All records, books, and documents are kept in the SAWS/Local Office and copies of monthly or quarterly balances are sent to SAWS/Regional Offices and SAWS/I. In the case of SAWS/H, the financial planning and control system established for Outreach Grant management also served the purposes of the MGP, so that all that was required was that a separate account be set up for the MGP. SAWS/H assigns high priority to budget issues and financial management and describes its achievements in this area as the result of "good planning and thrift," a reflection of SAWS institutional commitment to a philosophy of "stewardship."

16 Health Promotor Training Topics

- 1) Relationship between good nutrition and health.
- 2) The three food groups.
- 3) The advantages and importance of mother's milk for infants.
- 4) Nutrition for children, pregnant women, and nursing mothers.
- 5) Prevention of vitamin-A deficiency by using yellow fruits and dark leafy vegetables.
- 6) Treatment of severe cases of child malnutrition, 3rd degree, kwashiorkor and marasmus.
- 7) Importance of weighing children from 0-5 years old each month to prevent malnutrition.
- 8) Learning to prepare the individual's growth chart and record weight.
- 9) Principles of kitchen gardening.
- 10) How to prepare simple recipes for balanced meals and AK-1000.
- 11) Causes, prevention, and treatment of diarrhea.
- 12) Ways of purifying drinking water.
- 13) Importance of latrines and how to build a simple latrine.
- 14) Handling, conservation, preparation, hygiene of food.
- 15) Importance of personal hygiene, daily bath and hand-washing.
- 16) Motivation and methods of family planning.
- 17) Prevention of infectious child diseases by vaccination.
- 18) Prevention, precautions, treatment of malaria, tuberculosis, worms.
- 19) First aid treatment for children.
- 20) Identifying high-risk pregnant mothers.
- 21) Importance of collaboration between SAWS workers and leaders in the community.
- 22) How to do home visiting and motivate mothers.
- 23) How to prepare the following monthly report forms:
 - a) Food distribution
 - b) Various activities realized at the nutrition clinic
 - c) Record books for all children from 0-5 in the community
 - d) Attendance of mothers at teaching sessions
 - e) Budget books.

¹⁷Pilot training was held in Haiti in April 1982 by SAWS/I staff and three independent trainers contracted from the New TransCentury Foundation, for delegates from Antigua/Barbuda, Barbados, Dominica, Haiti, Jamaica, St. Lucia, and Guyana. Workshop objectives were to create understandings of development programs vis-a-vis relief activities; develop skills for problem analysis, decision-making, and project design; to clarify and strengthen SAWS organizational policies and procedures; and to orient personnel to the basic needs for and methods of carrying out evaluation. Workshops used group learning and hands-on techniques and were linked to the new Proposal Workbook developed by SAWS/I. Subsequent four-day workshops, longer by participant request, were held in Kenya, Zimbabwe, and Mexico City, with more scheduled in India (Pune) and the Philippines in 1983, plus followup training for the Caribbean region. As of March 1983 the workshops had graduated 135 participants from 25 developing countries. TransCentury also conducted a four-day "training for trainers" workshop in Washington for SAWS/I and SAWS General Conference staff and participants from Foster Parents' Plan and W.I.C.K, to enhance the training capacity of SAWS staff in conducting overseas workshops and seminars.

¹⁸The philosophical and practical dimensions of community participation, in a recent instance contrasted editorially with "community cooperation" (Interface, March 1983), persistently engage the attention of SAWS/i staff; in January 1983 a Small Development Project Fund was to begin disbursements to provide agile small-grant (\$10,000 limit) financing for well-designed projects with a strong community participation emphasis.

¹⁹The SAWS/H directors are quite straightforward in saying that, although "the rationale at the start was to integrate community participation into the program" and to consider community organization and leadership availability before final site selection, considerations were deliberately sacrificed or overtaken by issues of accessibility or available infrastructure or by substantive preferences, such as desire to experiment in a difficult urban context. A major criterion that was not violated was community probity: no community was selected for the MGP where there was evidence of "extractive" leadership. This is important in Haiti when the entire Conseil Movement has been persistently burdened with often well-substantiated accusations of pilferage and political manipulation.

²⁰The nutrition agent is the "hinge" person, or can be when this role is clearly perceived and relations are good, between community and project. In the two urban sites we visited, this role did not seem to be well realized: La Fossette is an urban environment which requires great skills and strength for achievement of any reasonable community relationship and, in both urban sites, the pedagogical and interactive style used by the nutrition agents was not conducive to a two-way flow of information or anything that might be called participation through the sharing of knowledge or opinion. We found that generally where the project managers have confidence in a nutrition agent, they are extremely active in seeking information and advice and securing participation. Where this confidence is guarded, relationships become basically hierarchical and participation by the agent(s) reduced accordingly.

²¹The planting of home gardens has been perhaps the most participatory component of the MGP, although there is variance across sites, generally correlating with the length of time the MGP has been operating. Demonstration gardens have been planted at all sites; men and women of the community donate labor for clearing, planting, and maintenance, production is used for clinic feeding program, and seedlings are distributed to those who want to start their own home gardens. The agricultural promoters (jardinie) are chosen or volunteer -- the process is not clearly defined or philosophically guided and seems simply to happen -- and seeds and inputs are donated by SAWS.

The two newest sites, Saintard and St. Louis du Nord, had no individualized home gardens as of the beginning of summer 1983, but 407 gardens were planted in the other eight sites during the January-April 1983 quarter. The gardens have been besieged by goats, drought, insect pests, and lack of space, and the variety of foods planted to date is limited; these sorts of problems have moved SAWS to promote cultivation of indigenous vegetables, especially greens. Except for Mcustiques, where 200 home gardens have been planted, representing an estimated third of all households, levels of participation as measured by the proportions of households involved, is low; the activity will have to be "older" before further interpretation is possible.

22 The final measure of participation in implementation is participation in what SAWS calls "self-help" projects, the sewing, woodworking, and basketry activities now going on in five sites. Levels of participation are not quantifiable because there is no consistent recording of membership, attendance, production expenses, or sales. SAWS/Haiti has serious misgivings about their technical and managerial capacity for such projects and about the wisdom and ethics of proliferating redundant skills for which there is little or no identified market. In the absence or likelihood that these projects can become truly income-generating and in the absence of technical staff with the experience and backing to make them so, it is improbable that the current level of participation can be sustained or additional participation motivated. SAWS/H management recognizes that all communities are asking for income-generating opportunities but is increasingly persuaded of the inadvisability of continuing a component that complicates an already difficult program and which they feel they cannot do well.

23 SAWS' decision about charging fees for services is made on a site-by-site basis and clinic managers are told not to worry about it, so that some ask for nothing, some for \$0.10/wk, (St. Roc), and some for \$0.20/wk. (Roulin, Saintard, La Fossette) and participation rates are estimated from 40% (Saintard) to 80% (St. Roc). Some mothers in all sites bring in beans, charcoal, fruit, vegetables, greens, soap, and/or cleaning supplies in small daily quantities, but there are no figures on this and, indeed, recording this sort of contribution would be an awful task. However, arguments can be made for requesting a small, regular contribution (\$0.10/wk.) in all sites; CRS has concluded that the participant contribution or fee is a crucial barrier to feelings of complete dependency and we share that view, particularly if there is a SAWS/H management decision about use of funds that is shared with clinic managers. In one case, a clinic manager complained about the lack of a small fund for local-level operating expenses; in La Fossette, where lack of water is a severe problem for clinic operation and teaching purposes, the purchase of a drum for storage is important, but clinic managers lack discretionary funds for such purposes. Furthermore, these contributions, though small, mount up. The cash amounts collected in La Fossette, Roulin, Saintard, and St. Roc ranged from \$32 to \$48.00/month. These monies, together with the earnings from sale of PL 480 containers which clinics are allowed to keep, are to be used for purchases of foods, additional PL 480 commodities and what mothers contribute. However, clinic managers cannot count on a fixed amount monthly and cannot accordingly plan for larger purchases. At the same time, outside of erratic recording in a school notebook, no real accounting is made of either income or expenses.

24 We did see one instance of strain between SDA clinic staff and community representatives; the several interpretations of the problem led us to conclude that there were questions of personality and politics that went beyond church-related issues and were too complex to comprehend in a short field visit.

25 What we were not able to explore in depth was the possibility that program participation might be used as a springboard for winning or holding converts. There are currently polarized views in the Christian community about what constitutes the church's mission. One is a more traditional view which uses the terms 'mission', 'witness', and 'evangelism' interchangeably; the vertical relationship of the church and God is the focus, with

the primary emphasis upon verbal proclamation of gospel. The second, a more recent view, arose out of the ecumenical movement: "... the 'social gospel' preoccupies itself with the horizontal relationship of the church to people at the expense of more evangelistic endeavor" (Syme, June 1983): SAWS defines itself as nonsectarian in its outreach and seeks an orientation that lies somewhere between these views.

26 Not all the SAWS indicators are comprised by the LogFrame in the revised Project Workbook Proposal. Some are "emergents" from SAWS/H documents, e.g., quarterly reports of clinic activities.

27 It cannot be stated with certainty that the children selected were all in the clinic program for the four months, or were not in the program during the followup period. This is due to the current lack of uniformity and clarity in making notations in the registers. However, since attendance rates were all quite high, and since SAWS had emphasized the seriousness of the attendance problem for families receiving food, the evaluators considered the assumptions to be safe in most cases. If there is bias, they would be on the side of showing lesser rather than better results for the in-program findings, and they would err on the side of better rather than poorer results for the followup findings.

28 Some of these 2982 program children are counted more than once, i.e. are one-time or two-time readmissions, since the readmission notations made in the clinic registers analyzed were not uniformly nor consistently made and it was not possible to arrive comfortably at a readmission rate. In the study of three center registers analyzed further along, there were notations to indicate that in the Diquni cohort, only nine out of 160 were readmitted; in La Fossatte, it appeared that 5 out of a cohort of 125 children were readmitted, a rate of 4-6%.

29 Followup data on these 238 children were available for varied intervals averaging seven months; the shortest post-program span was four months, the longest 10 months. The categories of gain or loss require some explanation. "Improved % weight-for-age after 4th month" means that the latest weight entry available in the register, after conversion to a weight-for-age percentile, was compared with the fourth month (graduation from program) percentile. "Stayed at same percent weight-for-age as at 4th month" means that the child made no further weight-for-age gains (though perhaps gained absolutely) and therefore sustained growth. "Reduced % weight-for-age since 4th month" means that the child was failing against the reference standard, that is, was actually losing weight, remaining at the same weight, or not gaining enough weight for sustained weight-for-age growth. The comparison is made between the latest available weight entry and that made at the 4th month. Should the child have reduced his weight-for-age compared with the 4th month, we further checked to note whether it had made any progress since the initial month in program and made this a separate category, "Weight-for-age percent above that at entry into program". Thus, while this category is a negative insofar as growth gain subsequent to the program, it is at the same time a positive overall program result.

30 Food is the major cost. It includes not only Title II rations for mothers and children in the nutrition clinics but also Food-for-Work rations for families in some of the communities. SAWS/I also donates \$13,000 worth of food supplements. In addition, mothers bring foods for the demonstration meals or provide fees to buy beans, spices, etc. The next big item is labor costs. Significantly, SAWS/Haiti trained and staffed all of its clinics; it did not use any civil servants paid by the GOH to take on additional work for the program. Transportation costs always figure prominently in Title II programs, and cover both ocean and inland freight. Medicines are not insignificant in the program inputs. They comprise supplies of antibiotics, Vitamin A, contraceptives, and anti-helminthics supplied through the DSPP. SAWS/I also donates substantial quantities of ointments, first aid supplies, vitamins, minerals, and antibiotics.

31 In fairness, this problem confounds the most meticulous scientists: sheer population density, the distances many Haitians are prepared to travel for any kind of health service, the nature of settlement and farming patterns in Haiti (unlike Africa, for example, where family organization, space, and tenure arrangements make settlement boundaries more easily identifiable), have led many analysts to let target populations or catchment areas, in effect, define and select themselves.

32 Growth surveillance is important both as a service and as an evaluation mechanism; it permits continuing identification of failing children who are not and have not been in the nutrition clinic program and so provides an opportunity for greater coverage of the most malnourished in the clinic treatment program; continued surveillance of children who have graduated from the program; knowledge of lasting benefits for graduate mothers by monitoring siblings of former program children; contact with mothers not in the clinic program and benefits that surveillance can provide in sensitization/motivation about child care needs. If planned well, even a single contact permits delivery of a couple of top-priority messages and one-on-one feedback exchanges with mothers.

APPENDICES

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* Appendix A includes all tables referred to in the text with Arabic numerals.

TABLE 1. Difference Between Food Availability and Food Needs, Haiti

	<u>Total Supply</u>	<u>Total Recommended</u>	<u>% Deficit</u>
Food in Kg/year	410	503.5	18.4
Energy Cals/Day	1901	2375	20.0
Protein Grams/Day	41.1	60	31.5
Animal Protein Gr/Day	7.1	10.5	32.4

Source: USAID, CDSS FY 1984, Port-au-Prince, 1982.

TABLE 2. SAWS/HAITI MATCHING GRANT PROJECT
GOALS, PURPOSES, OUTPUTS, AND
OBJECTIVELY VERIFIABLE INDICATORS

<u>Goal</u>	Increased health status of mothers and children in the Republic of Haiti	Decreased national infant mortality rates
		Decreased national maternal mortality rates
		Decreased national disease-specific morbidity rates for children 0-5
		Decreased national disease-specific morbidity rates in mothers 15-45
<u>Purpose</u>	Decreased prevalence of malnutrition in children between ages 0-5 in 10 target areas of Haiti:	1. Decrease from 10% to 5% prevalence of malnourished children (Gomez Category III) in 10 target communities by January 1985.
	Belladère Moustiques	2. Decrease from 30% to 20% prevalence of malnourished children (Gomez Category II) in 10 target communities by January 1985.
	Besace Platon	3. Decrease from 40% to 35% prevalence of malnourished children (Gomez Category I) in 10 target communities by January 1985.
	Diquini Ranquitte	
	Gros Mangle Roulin	
	LaFossette St. Roc	
<u>Outputs</u>	1. 10 nutrition training centers established by January 1983 at Belladère, Besace, Diquini, Gros Mangle, LaFossette, Moustiques, Platon, Ranquitte, Roulin, and St. Roc.	1. 10 nutrition centers operating by January 1983 in: Belladère, Besace, Diquini, Gros Mangle, LaFossette, Moustiques, Platon, Ranquitte, Roulin and St. Roc.
	2. 1 nutrition assistant trained for each center by January 1983 (total 10)	2. 1 nutrition assistant trained for each nutrition center by January 1983 (total 10)

At completion of each 4-month training period:

- | | |
|--|---|
| <p>3. 900 mothers in each training center community trained in child growth monitoring by January 1985 (total 9,000).</p> <p>4. 900 mothers in each training center community trained in food sanitation and prepared by January 1985 (total 9,000).</p> <p>5. 900 mothers in each training center community trained in production of table vegetables and prepared by January 1985 (total 9,000).</p> <p>6. 900 mothers in each training center community trained in good nutrition habits by January 1985 (total 9,000)</p> <p>7. 900 mothers in each training center community trained in healthful sanitary practice by January 1985 (total 9,000).</p> <p>8. 3 mothers' self-help organizations established in each target community by September 30, 1984 (total 30).</p> <p>9. All mothers received PL 480 food supplements during period of training totalling 9,000 recipients by September 1984.</p> | <p>3. 50% of all mothers trained able to:</p> <p>a) weigh child</p> <p>b) record weight on growth chart</p> <p>c) identify early signs of malnutrition</p> <p>4. 50% of mothers able to demonstrate how to:</p> <p>a) boil water/milk</p> <p>b) sanitize hands and utensils</p> <p>c) protect prepared food from contamination</p> <p>5. 50% of mothers growing a minimum of two vegetables in their own table garden</p> <p>6. 50% of all mother able to identify 3 basic food groups and prepare a nutritionally balanced meal.</p> <p>7. 25% of all mothers either;</p> <p>a) have built a simple pit latrine at their home</p> <p>b) show evidence of burying fecal waste.</p> <p>8. Each target area has a minimum of 4 self-help organizations meeting at least once a month by January 1985.</p> <p>9. 120 lbs of food supplementation given per mother trained, by 30 September 1984.</p> |
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TABLE 3. Educational Levels, Trainees in SAWS/H Courses in Nutrition, Environmental Sanitation, and Community Development

	1982		1983		Total	
	No.	%	No.	%	No	%
Grade Levels ^a						
6 grades or less	2	3.3	-	0.0	2	2.6
7th	12	20.0	3	17.7	15	19.5
8th	5	8.3	5	29.4	10	12.9
9th	8	13.3	4	23.5	12	15.6
10th ^b	21	35.0	2	11.8	23	29.9
11th	7	11.7	3	17.7	10	12.9
12th	2	3.3	-	0.0	2	2.6
Beyond 12th grade	3	5.0	-	0.0	3	3.9
TOTAL	60	100.0	17	100.0	77	100.0

Table 4

SAWS/Haiti Matching Grant Budget, Year I

	YEAR I	
	Local Currency*	US Dollars
<u>A. Project Support</u>		
1. Program Coordinator	65,000	13,000
2. Health Training Officer	21,500	4,300
3. Field Health Consultant	10,000	2,000
4. Community Health Workers	22,800	4,560
5. Health Workers Assistants	18,000	3,600
6. Agriculture Ext. Workers	12,000	2,400
7. Agriculture Train. Officer	20,000	4,000
8. Trainee Allowance	11,000	2,200
9. Administrative Support	120,500	24,100
Subtotal	<u>300,800</u>	<u>60,160</u>
<u>B. Training Materials, Misc.</u>		
1. Training Supplies, Equip.	25,000	5,000
2. Health Care Center	15,000	3,000
3. Teaching Aids	15,000	3,000
4. Agriculture Worker Supplies	7,500	1,500
Subtotal	<u>62,500</u>	<u>12,500</u>
<u>C. Development Project Support</u>		
1. Evaluation		
<u>D. Transportation</u>		
1. Vehicle Purchase/Maint.	100,000	20,000
<u>TOTALS</u>	463,300	92,660
<u>FINANCING</u>		
USAID/MG - 50%	231,650	46,330
SAWS/Washington - 25%	115,825	23,165
SAWS/Division - 25%	115,825	23,165

*U.S. \$1.00 = 5.00 Haitian gourdes.

Table 4 (continued)
SAWS/Haiti Matching Grant Budget, Year II

	YEAR II	
	Local Currency*	US Dollars
<u>A. Project Support</u>		
1. Program Coordinator	75,750	15,150
2. Health Training Officer	37,500	7,500
3. Field Health Consultant	12,000	2,400
4. Community Health Workers	50,000	10,000
5. Health Workers Assistants	39,600	7,920
6. Agriculture Ext. Workers	37,500	7,500
7. Agriculture Train. Officer	24,000	4,800
8. Trainee Allowance	33,000	6,600
9. Administrative Support	132,750	26,550
Subtotal	442,100	88,420
<u>B. Training Materials, Misc.</u>		
1. Training Supplies, Equip.	5,000	1,000
2. Health Care Center	45,000	9,000
3. Teaching Aids	30,000	6,000
4. Agriculture Worker Supplies	7,500	1,500
Subtotal	87,500	17,500
<u>C. Development Project Support</u>		
1. Evaluation		
<u>D. Transportation</u>		
1. Vehicle Purchase/Maint.	43,000	8,600
<u>TOTALS</u>	572,600	114,520
<u>FINANCING</u>		
USA ID/MG - 50%	286,300	57,260
SAWS/Washington - 25%	143,150	28,630
SAWS/Division - 25%	143,150	28,630

*U.S. \$1.00 = 5.00 Haitian gourdes.

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Table 4 (continued)
SAWS/Haiti Matching Grant Budget, Year III

	YEAR III	
	Local Currency*	US Dollars
<u>A. Project Support</u>		
1. Program Coordinator	85,500	17,500
2. Health Training Officer	41,250	8,250
3. Field Health Consultant	12,000	2,400
4. Community Health Workers	60,000	12,000
5. Health Workers Assistants	42,000	8,400
6. Agriculture Ext. Workers	42,000	8,400
7. Agriculture Train. Officer	25,250	5,050
8. Trainee Allowance	33,000	6,600
9. Administrative Support	146,000	29,200
Subtotal	489,000	97,800
<u>B. Training Materials, Misc.</u>		
1. Training Supplies, Equip.	2,500	500
2. Health Care Center	15,000	3,000
3. Teaching Aids	5,000	1,000
4. Agriculture Worker Supplies	10,000	2,000
Subtotal	32,500	6,500
<u>C. Development Project Support</u>		
1. Evaluation	25,000	5,000
<u>D. Transportation</u>		
1. Vehicle Purchase/Maint.	45,000	9,000
<u>TOTALS</u>	591,500	118,300
<u>FINANCING</u>		
USAID/MG - 50%	295,750	59,150
SAWS/Washington - 25%	147,875	29,575
SAWS/Division - 25%	147,875	29,575

*U.S. \$1.00 = 5.00 Haitian gourdes.

Table 4 (concluded)
SAWS/Haiti Matching Grant Budget, Life of Project

<u>LIFE OF PROJECT</u>		
	<u>Local Currency*</u>	<u>US Dollars</u>
<u>A. Project Support</u>		
1. Program Coordinator	228,250	45,650
2. Health Training Officer	100,250	20,050
3. Field Health Consultant	34,000	6,800
4. Community Health Workers	132,800	26,560
5. Health Workers Assistants	99,600	19,920
6. Agriculture Ext. Workers	91,500	18,300
7. Agriculture Train. Officer	69,250	13,850
8. Trainee Allowance	77,000	15,400
9. Administrative Support	<u>399,250</u>	<u>79,850</u>
Subtotal	1,231,900	246,380
<u>B. Training Materials, Misc.</u>		
1. Training Supplies, Equip.	32,500	6,500
2. Health Care Center	75,000	15,000
3. Teaching Aids	50,000	10,000
4. Agriculture Worker Supplies	<u>25,000</u>	<u>5,000</u>
Subtotal	182,500	36,500
<u>C. Development Project Support</u>		
1. Evaluation	25,000	5,000
<u>D. Transportation</u>		
1. Vehicle Purchase/Maint.	188,000	37,600
<u>TOTALS</u>	1,627,400	325,480
<u>FINANCING</u>		
USAID/MG - 50%	813,700	162,740
SAWS/Washington - 25%	406,850	81,370
SAWS/Division - 25%	406,850	81,370

*U.S. \$1.00 = 5.00 Haitian gourdes.

TABLE 5

SAWS/HAITI FIRST PROJECT DESIGN, 1981

<u>Statement of Problems</u>	<u>Final Goals</u>	<u>Intermediate Goals</u>
1. Malnutrition, contributing factors	1. Decrease incidence of severe malnutrition by: early detection and prompt intervention.	1. Establish ten Health Care Centers.
2. Lack of knowledge	a. Nutritional education	a. Twenty Community Health Workers trained by SAWS health training office will each teach a group of 25 mothers every Monday another group on Tuesdays, etc., for four days each week, making a total of 2,000 mothers. After four months a new group of mothers with the most needy children will be chosen for the program.
3. Inadequate well-baby supervision	b. Anthropometric monitoring	b. Weigh and record on road to health chart all village children 0-3. Refer children who do not gain weight to nutrition program. This early intervention will prevent rather than just measure malnutrition.
4. Disease	c. Reduce incidence of endemic and infectious diseases	c. 1) Immunize against major infectious diseases. 2) Provide prophylactic measures for control of endemic diseases such as helminths, anemia and xerophthalmia. 3) Provide oral rehydration salts for control of diarrhea.
5. Poor sanitation	d. Improve sanitary practices	d. Teach control of insects, sanitary disposal of human waste, and purification of drinking water.
6. Inadequate production of legumes and fresh vegetables	e. Increase number of families raising kitchen gardens	e. Five agricultural auxiliaries trained by SAWS agriculture training officer will each be assigned to work in four to five villages around the Health Care Centers. Five to seven families in each target village will be helped to establish kitchen gardens with emphasis on legume and leafy vegetable production.
7. Poverty	f. Food assistance	f. PL 480 Title II commodities will be distributed to mothers and children admitted to the nutrition program.

TABLE 5 (Continued)

<u>Statement of Problems</u>	<u>Final Goals</u>	<u>Intermediate Goals</u>
. Overpopulation	g. Provide opportunity for control of family size through family planning	g. The Community Health Worker will: <ol style="list-style-type: none"> 1) Introduce child spacing concepts and advantages through education. 2) Provide a dependable supply of acceptable contraceptives. 3) Provide counseling and referrals as indicated.
. Lack of nutritional education	2. Develop a reservoir of trained and fully indigenous health workers and agriculture auxiliaries.	2. Establish a SAWS Center for training the Health Workers and agricultural auxiliaries.
	a. Teach nutrition classes to 18,000 village mothers in a three-year period	The training center will: <ol style="list-style-type: none"> a. Develop a curriculum for training the Health Workers. The training program will be conducted on a modular basis two times each year in areas in which they will be expected to function. <p>Provide monthly supervision at site of Health Care Centers.</p> <p>Provide lesson plans, flip charts and other teaching aids to be used in teaching the village mothers.</p>
	b. Screen and choose the most needy children in the village for the health education/nutrition program	b. Establish criteria for eligibility to the program which will include children who fail to gain weight for two consecutive months whether in first, second or third-degree malnutrition, those with more than fifty worms, and pregnant women and children at high risk. Prevention rather than curative measures are emphasized.
	c. Establish baseline data	b-e. Provide supplies and equipment such as scales, road-to-health charts and arm bands.
	d. Monitor growth and development of 36,000 children in nutrition programs at Health Care Centers	
	e. Also weigh and record on road to health charts monthly progress of all target village children from 0-3 years	

Statement of ProblemsFinal GoalsIntermediate Goals

f. Supervise food for Peace distribution	f. Provide PL 480 Title II foods which will be distributed in conjunction with the health education/nutrition classes. Educational emphasis will, however, be on wise preparation and use of local foods.
g. Administer prophylactics and supplements	g. Procure and distribute medications and supplements such as oral rehydration salts, vitamin A, iron, immunizations, protein supplements and worm medicine.
h. Keep records and submit monthly reports	h. Establish a system for reporting and evaluating results of program.
<u>The five agriculture auxiliaries will:</u>	Agriculture training officer will:
a. Establish a network of kitchen gardens (for five to seven families in four to five villages) in and around each of five Health Care Centers	a. Establish a demonstration garden at five SAWS Health Care Centers for motivational and training purposes. He will train and supervise local agro-extension auxiliaries.
b. Promote backyard composting	b. Provide technical and material assistance.
c. Promote planting of legumes and leafy vegetables	c-f Teach nutritional value of foods.
d. Identify and promote the use of ten common wild leafy plants suitable for food which grow in Haiti, such as the papaya leaf	
e. Promote the concept that bodies need vegetables to be beautiful and healthy	e-f Emphasize that the garden is for family consumption and not for commercial purposes.
f. Promote the concept that bodies need protein-rich legumes to grow and be strong	
g. Show the local community that <u>they can</u> increase their supply of nutritious foods.	g. Motivate, demonstrate, and educate on the village level, in supervisor visits.
h. Keep records and submit monthly reports.	h. Establish, in counsel with the directors, a system of reporting and evaluating results of the agricultural program.

TABLE 6. SAWS/H Project Activity Targets by Fiscal Year: * Implementation Plan and Schedule, and Project Activities

Project Activity Targets	Implementation Plan and Schedule	Project Activities
FY 1981-82	Sept. 1981 - Jan. 1982	
a) Complete and equip training center	a) Complete and equip training center	
b) Choose Training Officers for health education/nutrition and agricultural programs	b) Hire training officer for nutrition/health program who will assist director to:	Oct. 1981 - Training Officer (Isaacs) hired
c) Establish pilot Health Care Center	- develop curricula for teaching community health workers	Nov. 1981 - Curriculum development activity reported as "continuing"
d) Choose with help of SAWS Committee ten locations for Health Care Centers	- prepare lesson plans and visual aids to be used at the village level	
e) Establish and equip centers, organize community health committees	- conduct training seminar for three field supervisors for health care centers	Dec. 1981 - First Community Worker training held in temporary quarters for 14 women** chosen by their communities for training as CHWs. Three supervisors trained in this 1st group. Three weeks' duration.
f) Develop curriculum for training community health workers	c) Establish pilot Health Care Center for training purposes near SAWS training center	
g) Develop curriculum for teaching mothers in the villages	d) Do baseline surveys of target villages supervised by director, training officer, and supervisors	Jan. 1982 - Nutrition baseline surveys in Moustiques, Ranquette, Roulin
h) Train 20 Community Health Workers	e) Work out reporting and evaluation system (director and training officer)	
i) Train three Field Supervisors	f) Hire Agricultural Training Officer who will:	Nov. 1981 - Agricultural Training Officer (Nevelus) hired
j) Train five agriculture auxiliaries	- plant demonstration garden at site of pilot center	
k) Establish demonstration gardens in five centers	- survey needs and organize plan for establishing kitchen gardens in villages surrounding Health Care Centers	
l) Establish a nursery at the training center for providing plants for gardens		

* July-June.

** All training until June 1982 was held in temporary quarters (33 individuals).

TABLE 6 (cont.). SAWS/H Project Activity Targets by Fiscal Year: Implementation Plan and Schedule and Project Activities

Project Activity Targets	Implementation Plan and Schedule	Project Activities
<u>FY 1981-82</u>	<u>Sept. 1981 - Jan. 1982</u>	<p>All ten of the initial sites were selected throughout this period: Belladère, Besace, Diquini, Gros Mangle, La Fossette, Moustiques, Platon, Ranquitte, Roulin, St. Roc</p>
	<p>g) Establish criteria and choose, with the approval of the SAWS committee, ten sites for establishing Health Care Centers</p> <p>h) Have SAWS Health Adviser register intent with the proper GOP authorities</p> <p>i) Organize Community Health Committee at each Center</p>	<p><u>Jan. 1982 - Logistics</u> - system of monthly visits initiated - nutrition clinics opened in St. Roc, Moustiques, and Roulin</p>
	<u>Jan. - June 1982</u>	<p><u>Feb. 1982 - Training of 2nd group of 16 Health Workers. Three weeks' duration</u></p>
	<p>a) Recruit and train 20 Community Health Care Workers to staff ten Health Care Centers which will be functioning by 30 June 1982</p> <p>b) Recruit and train five village Agriculture Auxiliaries</p> <p>c) Establish demonstration gardens at five centers by 30 June 1982</p>	<p><u>June 1982 - Two pastors trained, for Bassin-Bleu and St. Louis du Nord. Five days' duration</u></p>
		<p><u>March 1982 - Gardens thriving in St. Roc, Moustiques, Roulin; Ranquitte and Belladere start Nutrition Clinics at same time - 63 home gardens reported</u></p>
		<p><u>Feb. 1982 - Site for demonstration project chosen and approved (Diquini at edge of SAWS compound)(Feb. 1982)</u></p>
		<p><u>April 1982 - Move into new office space in warehouse complex</u></p>
		<p><u>June 1982 - Training Center com-</u></p>

TABLE 6 (cont.). SAWS/H Project Activity Targets by Fiscal Year: Implementation Plan and Schedule and Project Activities

Project Activity Targets	Implementation Plan and Schedule	Project Activities
FY 1982-83	July - December 1982	
<p>a) Conduct training seminars in November and May for Community Health Workers</p> <p>b) 3840 health and nutrition demonstrations will be given to 4000 mothers</p> <p>c) Five agriculture auxiliaries will assist in planting kitchen gardens in four villages around each of five Health Care Centers; seven families in each village will be assisted in planting gardens (=140)</p> <p>d) Conduct training seminars for Agriculture Auxiliaries in August and February</p> <p>e) Weigh children from 0-3 in target vilages each month</p>	<p>a) Conduct training seminar for Community Health Workers in November 1982</p>	<p><u>Aug. 1982</u> - refresher training for 17 individuals (2 new). Five days duration</p> <p><u>Sept. 1982</u> - training for 19.3 weeks duration</p> <p><u>Dec. 1982</u> - refresher training for six. Five days duration</p> <p><u>July 1982</u> - nutrition center opens at Diquini</p> <p><u>Aug. 1982</u> - nutrition center opens at Bassin-Bleu</p> <p><u>Sept. 1982</u> - nutrition activities begin at Gros Mangles, garden planted (but eaten by goats)</p> <p><u>Dec. 1982</u> - nutrition centers open at La Fossette and Saintard</p> <p>- decision made to substitute St. Louis du Nord for Gros Mangle (where distance and transport major obstacles)</p> <p><u>Dec. 1982</u> - self-help sewing projects under way in Belladère and Roulin</p>

TABLE 6 (concl.). SAWS/H Project Activity Targets by Fiscal Year: Implementation Plan and Schedule and Project Activities.

Project Activity Targets	Implementation Plan and Schedule	Project Activities
<u>FY 1982-83</u>	<u>July - December 1982</u>	
f) Evaluate program in December 1982		<p>The Haiti project is briefly described in the 1st year Evaluation Report (SAWS/I, October 1982), but no formal internal or external evaluation was performed.</p> <p>- Nutrition baseline surveys completed as follows:</p> <p><u>Sept. 1982</u> - St. Roc (repeated in Dec. because of skepticism about results)</p> <p><u>Oct. 1982</u> - Bassin-Bleu, La Fossette, St. Louis du Nord</p> <p><u>Nov. 1982</u> - Belladère, Diqini</p> <p><u>Dec. 1982</u> - Saintard, St. Roc (repeat)</p>

TABLE 7. Brief Review of Project Activities by Project Year, by Project Site

Bassin-Bleu	Belladere	Diquini	La Fossette	Moustiques
<p>Summer 1982- nutrition clinic organized</p> <p>Aug. 1982-nutrition clinic opened</p> <p>Oct. 1982-nutrition baseline survey</p>	<p>March 1982- nutrition clinic opened, kitchen kitchen garden program started</p> <p>Nov. 1982- nutrition base- line survey</p> <p>Dec. 1982- daily self-help sewing project in place</p>	<p>Feb. 1982-site chosen and approved as demonstration nutrition clinic site for trainee practicums</p> <p>July 1982- nutrition center opened, Bergamoth selected as prim- ary target pop.</p> <p>Nov. 1982- nutrition base- line survey</p> <p>Spring 1983-sewing and basketry proj- ects in place</p>	<p>Oct. 1982- nutrition base- line survey</p> <p>Dec. 1982- North Haiti SDA mission remodel- ing building for clinic, site for demonstration garden selected; nutrition clinic activities being conducted in SDA church with volunteers</p>	<p>Jan. 1982- nutrition clinic opened, followed by kitchen garden program, nutri. baseline survey</p>

TABLE 7 (concl.). Brief Review of Project Activities by Project Year, by Project Site

Ranquitte	Roulin	Saintard	St. Louis du Nord	St. Roc
January 1982- nutrition base- line survey	Jan. 1982- nutrition clinic opened followed by kitchen garden program, nutrition baseline survey	Dec. 1982- nutrition baseline survey, community workers complete 1st phase of training, clinic organization completed, agricultural training officer begins contracts; Saintard becomes 10th MGP project on schedule	Oct. 1982- nutrition baseline survey	Oct. 1982- mothers' classes begun
March 1982- nutrition clinic kitchen garden program started	Oct. 1982 food for work project ended- grain grinder purchased for clinic and com- munity use in in akamil processing			Jan. 1982- nutrition clinic opened, followed by kitchen garden program
Nov. 1982- inauguration new nutrition center and medical clinic complex	Dec. 1982 - self-help sewing project in place			Dec. 1982- nutrition base- line survey
Spring 1983 sewing and wood- working projects in place				Spring 1983- sewing and woodworking projects in place

TABLE 8. Calendar for Nutrition Clinic Training

	<u>Month 1</u>	<u>Month 2</u>	<u>Month 3</u>	<u>Month 4</u>
<u>Week 1</u>	Importance of a good diet The 1st food group Whole milk preparation	Review 3 food groups Akamil preparation Review diarrhea and home ORT Importance of latrines How to build a latrine	Review 3 food groups Practical recipes Vaccinations for children	Review 3 food groups Review domestic hygiene Causes and importance of malaria, prevention and treatment
<u>Week 2</u>	Review 1st food group 2nd food group Causes of malnutrition Signs of kwashiorkor and marasmus Importance of mother's milk Demonstration of preparation of powdered milk Importance of personal hygiene	Review 3 food groups Feeding of pregnant women Importance of tetanus shots of pregnant women	Review of child feeding and 3 food groups Causes, signs, prevention, treatment of TB; BCG	Review 3 food groups and practical recipes Vaccinations for children BCG/TP
<u>Week 3</u>	Review 1st and 2nd food group Food preparation hygiene Need for home gardens	Review infant feeding, mother's milk Importance of family planning Methods of family planning	Three food groups Water hygiene, making a filter	Review 3 food groups Akamil Family planning
<u>Week 4</u>	Review 3 food groups Importance of weighing How to feed infants Weighing infants	Review: importance of diet for pregnant women, 3 food groups, weighing	Review: 3 food groups, importance of latrines, child diarrhea, typhoid	Weighing. Evaluation. Graduation or readmission

Table 9. Comparison of Original and Modified Project Goals, Purposes, and Related Objectively Verifiable Indicators (OVI and Modifications Either Made or Under Consideration

	<u>Original</u>	<u>Modified or Under Consideration</u>																				
<u>Goal</u>	Increased health status of mothers and children in the Republic of Haiti	Improved health status of mothers children in the Republic of Haiti																				
<u>OVI's</u>	Decreased national infant mortality rates Decreased national maternal mortality rates Decreased national disease-specific morbidity rates for children 0-5 Decreased national disease-specific morbidity rates in mothers 15-45	Lower infant mortality rates Lower rates of malnutrition																				
<u>Purpose</u>	Decrease prevalence of malnutrition in children between ages 0-5 in 10 target areas of Haiti: <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Belladère</td> <td style="width: 50%;">Moustiques</td> </tr> <tr> <td>Bésace</td> <td>Platon</td> </tr> <tr> <td>Diquini</td> <td>Ranquitte</td> </tr> <tr> <td>Gros Mangle</td> <td>Roulin</td> </tr> <tr> <td>LaFossette</td> <td>St. Roc</td> </tr> </table>	Belladère	Moustiques	Bésace	Platon	Diquini	Ranquitte	Gros Mangle	Roulin	LaFossette	St. Roc	Decrease prevalence of malnutrition in children between ages 0-5 in 10 target areas of Haiti: <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Bassin-Bleu</td> <td style="width: 50%;">Ranquitte</td> </tr> <tr> <td>Belladère</td> <td>Roulin</td> </tr> <tr> <td>Diquini</td> <td>Saintard</td> </tr> <tr> <td>LaFossette</td> <td>St. Louis du Nord</td> </tr> <tr> <td>Moustiques</td> <td>St. Roc</td> </tr> </table>	Bassin-Bleu	Ranquitte	Belladère	Roulin	Diquini	Saintard	LaFossette	St. Louis du Nord	Moustiques	St. Roc
Belladère	Moustiques																					
Bésace	Platon																					
Diquini	Ranquitte																					
Gros Mangle	Roulin																					
LaFossette	St. Roc																					
Bassin-Bleu	Ranquitte																					
Belladère	Roulin																					
Diquini	Saintard																					
LaFossette	St. Louis du Nord																					
Moustiques	St. Roc																					
<u>OVI's</u>	<ol style="list-style-type: none"> 1. Decrease from 10% to 5% prevalence of malnourished children (Gomez Category III) in 10 target communities by January 1985. 2. Decrease from 30% to 20% prevalence of malnourished children (Gomez Category II) in 10 target communities by January 1985. 3. Decrease from 40% to 35% prevalence of malnourished children (Gomez Category I) in 10 target communities by January 1985. 	<ol style="list-style-type: none"> 1. Save 80% of children who enter the clinic program in 3rd-degree malnutrition. 2. Improve weight-for-age in 75% of 2nd and 3rd degree malnourished children (malnourished at entry) 3. Reduce infant mortality from rate at baseline*. 																				

* Baseline = children chosen for program according to criteria of age and nutritional status (Gomez II and III) plus all children presented for weighing and Road-to-Health charts. A child with kwashiorkor is automatically considered to be in 3rd-degree malnutrition.

Table 10. Community Resource Contributions to Project Implementation
(excluding mothers' and Adventist Church Contributions)

<u>Site</u>	<u>Labor</u>	<u>Cash</u>	<u>Materials</u>
Bassin-Bleu	yes	yes	yes
Belladère	limited	no	no
Diquini	no	no	no
La Fossette	no	no	no
Moustiques	yes	yes	yes
Ranquitte	yes	no	no
Roulin	yes	yes	no
Saintard	no	no	no
St. Louis du Nord	yes	yes	yes
St. Roc	yes	yes	limited

a) Primarily stones, gravel, poles, and roof thatch.

TABLE 11. Number of Mothers Who Participated in 10
Nutrition Clinic Programs in Three Cohorts
of Four Months Each up to April 1983

Bassin-Bleu	204
Belladere	289
Diquini	282
La Fossette	193
Moustiques	283
Ranquitte	302
Roulin	299
Saintard	103
St. Louis du Nord	203
St. Roc	327
	<hr/>
	2485

TABLE 12. Number of Children Weighed and in SAWS MGP

<u>Cohort</u>	<u>Children Weighed</u>	<u>Estimated Children in Progr</u>
March 1982-	698	676
August 1982-	1815	1058
January 1983-	2125	1248
		<hr/>
		2982

TABLE 13

Baseline Surveys for SAWS Nutrition Clinics:
 Dates Completed, Number Surveyed, and Nutritional
 Status (According to Weight-for-Age,
 Harvard Standard by Gomez Classifications)

Center	Date Survey Completed	Number in Survey	Nutritional Classification for Under-Five Children (by Percentages)			
			Normal +90 W/A	First Degree 89.9-75 W/A	Second Degree 74.9-60 W/A	Third Degree 59.9 and under
Bassin Bleu	10-82	208	16	31	39	14
Belladère	11-82	266	12	24	47	17
Diquini	11-82	229	24	41	24	11
La Fossette	10-82	169	11	32	44	13
Moustique	1-82	182	41	23	23	13
Ranquitte	1-82	215	6	24	51	19
Roulin	1-82	153	22	28	29	21
Saintard	12-82	255	36	23	22	19
St. Louis du Nord	10-82	218	14	32	42	12
St. Roc	12-82	130	22	36	34	8
		<u>2024</u>				
Average			20	29	36	15

TABLE 14

Three Cohorts During Period March 1982-April 1983,
Number of Cases - Percent of Kwashiorkor and Marasmus

	Number of Cases		Number of Children	Percent of Cases	
	<u>Kwashiorkor</u>	<u>Marasmus</u>	<u>Weighed</u>	<u>Kwash.</u>	<u>Marasm.</u>
1st. Cohort March 1982-	19	111	698	2.7	16.0
2nd Cohort Aug. 1982-	43	225	1815	24.0	12.0
3rd Cohort Jan. 1983-	77	100	2125	3.6	4.7

TABLE 15

Weight Gains, Stasis, and Loss, Three Cohorts

	<u>First Cohort March 1982 -</u>	<u>Second Cohort August 1982 -</u>	<u>Third Cohort January 1983 -</u>
% who gained	74	75	80
% who remained at same weight	20	21	11
% who lost	6	4	9

TABLE 16

Age Composition at Program Entry
in Three Nutrition Clinics, SAWS/Haiti
(in percentages)

Age Group	Ranquitte (N = 119)	La Fossette (N = 125)	Diquini (N = 160)	Total (N = 404)
6 Months	3	7	6	6
7-12 Months	9	14	19	14
13-18 Months	17	18	12	15
19-24 Months	20	7	16	15
25-36 Months	24	24	29	26
37-48 Months	22	21	15	19
49-60 Months	5	9	3	5
TOTAL	100	100	100	100

TABLE 17

Distribution of Gomez Categories of Nutritional Status at entry for 3 Cohorts in Three SAWS Nutrition Clinics, by Center and by Age Groups*

BY CENTER					BY AGE GROUP			
In Percentages	Normal	First	Second	Third	In Row Percentages	Normal	First	Second
Ranquitte	1%	14%	64%	21%	6 Months	26	26	22
La Fossette	16%	49%	29.5%	5.5%	7-12 Months	17	47	26
					13-18 Months	5	37	41
Diquini	14%	44%	26%	16%	19-24 Months	15	32	41
					25-36 Months	10	38	43
Average for Three Centers	11%	37%	38%	14%	37-49 Months	5	36	43
					49-60 Months	4	32	32
					Total 404 N	11	37	38

* Normal is 90% weight-for-age and above; first degree is 89.9-75% weight for age; second degree, 74.9-60% weight-for-age; and third degree is 59.9% and below.

TABLE 18. SAWS Program Coverage Compared with Prevalence of Malnutrition Identified in Baseline Surveys

Center	Date of Baseline Survey	Second- and Third-Degree Malnourished	
		Baseline	In Program (By Cohort)
Ranquitte	1-82	70%	85% (March 1982-)
La Fossette	10-82	57%	35% (Dec. 1982)
Diquini	11-82	35%	42% (Aug. 1982)
Average		54%	54%

TABLE 19

Rates of Changing Gomez Classifications
of Second- and Third-Degree Preschool Entrants
Who Completed the SAWS 4-Month Nutrition
Clinic Program and Were Weighed at the Fourth
Month (3 Cohorts, 3 Centers, March 1982-April 1983)

CENTER	Entering Second Degree (N = 132)					Entering Third Degree (N = 49)				
	Number	Improved Second to First	Second to Normal	Same Remain in Second	Declined Second to Third	Number	Improved Third to Second	Third to First	Same Remain in Third	Died
Ranquitte	70	53	3	14	--	21	13	3	5	
La Fossette	21	7	--	11	3	3	1	--	2	
Diquini	41	26	5	10	--	25	15*	2	8	
TOTAL	132	86	8	35	3	49	29	5	15	0
Percent	65	6	27	2			59	10	31	--
		71					69			

* A tabulation of all third-degree entrants showed that 13 of the 15 children who remained in third-degree in fact improved their weight-for-age by an average of 12 percent points.

**TABLE 6 (cont.). SAWS/H Project Activity Targets by
and Project Activities**

<u>Project Activity Targets</u>	<u>Implementation Plan a</u>
<u>FY 1981-82</u>	<u>Sept. 1981 - Jan.</u>
	<ul style="list-style-type: none"> g) Establish crit with the appro committee, ten establishing H h) Have SAWS Heal register inten GOF authorities i) Organize Commu mittee at each
	<u>Jan. - June 198</u>
	<ul style="list-style-type: none"> a) Recruit and tra Health Care Wor ten Health Care will be functir b) Recruit and tra Agriculture Aux c) Establish demon at five centers

TABLE 20

Summary, Percent of Children Improved in SAWS MG Program

	<u>Percent of Second-Degree Improved (Moved to First Degree or Normal)</u>	<u>Percent of Third-Degree Improved (Moved to Second or First Degree)</u>
Ranquitte	80	76
La Fossette	32	33
Diquini	76	68
Average	71	69

TABLE 21

Third-Degree Malnourished Children in Four-Month Program: Changes by Age Group, (in numbers and percentages)
(N = 49)

<u>Age Group in Months</u>	<u>Improved</u>		<u>% Improved</u>	<u>3rd remain in 3rd</u>
	<u>3rd to 2nd</u>	<u>3rd to 1st</u>		
6	3	4	100	0
7-12	3	1	80	1
13-18	5	0	63	3
19-24	3	0	50	3
25-36	6	0	75	2
37-48	6	1	70	3
49-60	2	0	40	3

TABLE 6 (cont.). SAWS/H Project Activity Targets b
and Project Activities

Project Activity Targets	Implementation Plan
FY 1982-83	July - December
a) Conduct training seminars in November and May for Community Health Workers	a) Conduct train for Community Workers in No
b) 3840 health and nutrition demonstrations will be given to 4000 mothers	
c) Five agriculture auxiliaries will assist in planting kitchen gardens in four villages around each of five Health Care Centers; seven families in each village will be assisted in planting gardens (=140)	
d) Conduct training seminars for Agriculture Auxiliaries in August and February	
e) Weigh children from 0-3 in target vilages each month	

TABLE 22

Percent of Second-and Third Degree Entrants Who Improved
in Followup Group Surveillance

<u>Center</u>	<u>Number</u>	<u>3rd to 2nd</u>	<u>3rd to '1st</u>	<u>3rd to Normal</u>	<u>Remain in 3rd</u>	<u>Died</u>
Ranquitte	14	9	3	1	1	0
Diquini	25	11	5	2	5	2
LaFossette	3	2	0	0	1	0
Number	<u>42</u>	<u>22</u>	<u>8</u>	<u>3</u>	<u>7</u>	<u>2</u>
Percent		52	19	7	17	5

TABLE 23

Improvement in Second-Degree Entrants, in
Followup Growth Surveillance

<u>Center</u>	<u>N=</u>	<u>Number Improved</u>		<u>2nd Remain in 2nd</u>	<u>2nd to 3rd</u>	<u>Died</u>	<u>% Improvement by Center</u>
		<u>2nd to 1st</u>	<u>2nd to Normal</u>				
Ranquitte	8	7	0	1	0	0	87.5
Diquini	41	22	12	6	0	1	83.0
La Fossette	32	9	0	15	8	0	28.0
						Average	68.0

TABLE 6 (concl.). SAWS/H Project Activity Targets
and Project Activities.

<u>Project Activity Targets</u>	<u>Implementation Plan</u>
<u>FY 1982-83</u>	<u>July - December</u>

- f) Evaluate program in
December 1982

Table 23a
 Nutritional Status Changes in Preschool Children
 Attending SAWS Nutrition Clinic Programs
 and Weighing Sessions, in Three Haitian Centers,
 June 1983 (in percentages)

	Ranquitte March 1982 cohort	La Fossette December 1982 cohort	Diquini August 1982 cohort	All Centers
After 4-month SAWS Nutrition Clinic Program	Percent all age groups. (N=108) ¹	Percent all age groups (N=75) ¹	Percent all age groups (N=160) ¹	Average Percent (N=343) ¹
Improved percent of weight in age	98	35	93	82
Stayed at same percent weight for age	-	5	3	3
Reduced percent of weight for age	2	59	4	15
Died	-	1	-	negl
TOTAL	100	100	100	100
Subsequent weighing ² of program children	(N=24)	(N=64)	(N=160)	(N=248)
Improved percent weight for age after 4th month	83	48	68	64
Stayed at same percent weight as at 4th month	-	2	9	6
Reduced percent weight for age since 4th month	8	44	10	19
Weight for age percent above that at entry into program	4.5	6	11	9
Died	4.5	-	2	2
TOTAL	100	100	100	100

¹Only those weighed the first and fourth month are included, or 343 out of 404.

²The range of months during which the subsequent weighings occurred was for the three centers:

Ranquitte, 4-9 months; La Fossette, 4-6 months; Diquini, 8-10 months. The average interval is 7 months.

TABLE 24
Percentage Who Gained Weight-for-Age
by Age Group, in Three Nutrition Centers

	<u>Ranquitte</u>	<u>Diquini</u>	<u>La Fossette</u>	<u>Average %</u>
6 months	100	70	29	62
7-12 months	100	93	25	83
13-18 months	100	95	58	88
19-24 months	95	96	0	87
25-36 months	100	96	50	79
37-48 months	100	92	33	79
79-60 months	75	100	0	<u>50</u>
				82

TABLE 25a
Attendance at Followup Weighings

<u>Center</u>	<u>Number Weighed 1st and 4th Months</u>	<u>% Attended 4/4 months</u>	<u>% Attended 3/4 months</u>	<u>% Attended 2/4 months</u>
Ranquitte	108	99	1	
Diquini	160	88	12	
La Fossette	75	79	16	5

Table 27
 Nutritional Value of Foods Distributed
 During 12-Month Period in 10 Communities
 with Nutrition Clinics, by Beneficiary and
 by Daily Availability of Calories and Protein Grams*

Food	FOOD FOR WORK				
	Kilos per Month per Beneficiary	Grams Daily per Beneficiary	Grams Daily for Worker & 4 Dependents	Calories** Daily for Worker & 4 Dependents	Protein** Daily for Worker & 4 Dependents
Bulgur	14.9	497	2,485	8,797	278.
Cornmeal	10.6	353	1,765	6,425	139
Milk	4.5	150	750	2,700	269.
Oil	3.2	107	535	4,729	-
CSM	5.3	177	885	3,363	177.
TOTAL	38.5	1,254	6,420	26,014	863.

Food	NUTRITION CLINICS				
	Kilos per Month per Beneficiary	Grams Daily per Beneficiary	Grams Daily for Mother & 2 Children	Calories Daily for Mother & 2 children	Protein Daily for Mother & 2 Children
Bulgur	1.9	63	190	673	11.2
Cornmeal	1.8	60	180	655	14.2
Milk	1.8	60	180	648	64.6
Oil	.85	28	85	751	-
CSM	.9	30	90	342.	18.0
TOTAL	7.25	241	723	3,069	108.

*These are averages of foods delivered over the 12-month period to FFW beneficiari
 The programmed rations are, in kilos per month: bulgur, 4.54 kilograms; cornmeal
 2.27 kg; milk, 2.27 kg; and oil, .35 kg.

** Per 100 grams:	Bulgur	Cornmeal	Milk	Oil	CSM
calories	354	364	360	884	380
protein	11.2	7.9	35.9	-	20

Source: FFP, PL 480 Title II Commodities Reference Guide.

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Table 26
 Estimated Amount of Title II Food Distributed in the 10 MG
 Communities over 12 Months March 1982 to April 1983,
 by Community, Program, Commodity, and Number of Beneficiaries

Center	No. of Workers	No. of Months	FOOD FOR WORK					Total MTS	
			Total for 12 mos. (in kilos)						
			Bulgur	Corn	Milk	Oil	CSM		
Bassin Bleu									
Belladère									
Diquini									
La Fossette									
Moustiques	75	3	4,500	2,250		630	1,125	8.5	
Ranquitte	195	3	8,163	6,115	810	1,710	2,061	18.9	
Roulin	60	3	2,045	2,045		720	1,026	5.8	
Saintard									
St. Louis du Nord									
St. Roc	50	3	2,265	1,704		600	855	5.4	
TOTALS	380	3	16,973	12,114	810	3,600	5,067	39.0	
Center	No. of Mothers ¹	No. of Mothers ²	No. of Mothers ³	NUTRITION CLINIC					Total MTS
				Amount of Food Dist. (in kilos)					
				Bulgur	Corn	CSM	Milk	Oil	
Bassin Bleu	-	100	104	4,740	4,403	2,239	4,387	2,075	17.8
Belladère	88	100	101	6,705	6,229	3,167	6,206	2,935	25.2
Diquini	50	100	132	6,531	6,068	3,085	6,045	2,859	24.6
La Fossette	-	96	97	4,508	4,189	2,129	4,173	1,973	16.97
Moustiques	100	86	97	6,589	6,122	3,112	6,099	2,884	24.8
Ranquitte	100	100	102	7,052	6,551	3,331	6,527	3,087	26.55
Roulin	100	100	99	6,936	6,444	3,276	6,420	3,036	26.1
Saintard	-	-	103	2,370	2,202	1,119	2,193	1,037	8.9
St. Louis du Nord	-	100	103	4,740	4,403	2,239	4,387	2,075	17.8
St. Roc	125	100	102	7,630	7,088	3,604	7,062	3,340	28.7
TOTALS	563	882	1,040	57.8	53.7	27.3	53.5	25.3	217.0

¹First Mother Cohort, March 1982, 4 months; ²Second Mother Cohort, August 1982, 4 months; ³Third Mother Cohort, January 1983, 4 months.

Source: SAWS distribution records, Manifests. N.B.: Amounts are those actually distributed, not amounts programmed.

TABLE 28. Total Costs for SAWS Nutrition Clinics for a 12-Month Period Ending May 1983, by Source of Funds and by Selected Budget Heads

<u>Source</u>	<u>Selected Budget Heads</u>	<u>Amount</u>
A. USG-SAWS/W		(2)
(1)		
	<u>Labor Costs</u>	\$50,660 (65%)
	Management:	
	Expatriate \$18,180	
	Local 12,767	
	Service Providers (Local) 19,713	
	<u>Training</u>	\$18,166 (23%)
	(Omits salary of training officer included above, or \$7335)	
	Allowance, supplies, training facility, teaching aids, agricultural supplies	
	<u>Administrative Support</u>	\$ 9,189 (12%)
	Transportation	

(1) This amount includes the USG 50% share of Matching Funds and SAWS/W 25% share. The other SAWS 25% share is included under SAWS/I below.

(2) Computation of fiscal year amounts by item is shown on a separate sheet.

Total Costs - 2

B. SAWS/I	<u>Partial Labor Costs</u>	5,183 (15%)	\$33,283
	Director, Exp. 1/6 time @ 18,500		
	Fiscal officer 1.10 time @ 13,500		
	Secretary, 1/4 time @ 3000		
	<u>In-Kind</u>	27,200 (82%)	
	Food supplements \$13,000		
	Ointment 2,000		
	Vitamins, minerals 3,000		
	antibiotics, etc.		
	Beds, linens 6,000		
	First aid supplies 1,500		
	Furniture and miscellaneous 1,700		
	<u>Cash Donations</u>	900 (3%)	
	(construction)		

Total Costs - 3

C. USG

	(1)	<u>Labor Costs</u>		
1. Outreach Grant		Supervision, Inspectors, Drivers		\$4,223
		<u>Inland Transportation</u>		
		<u>Trucks, Jeeps, Maintenance and operation</u>		
		<u>Warehousing</u>		
2. Title II Foods	(2)	<u>For Nutrition Clinics (12 months)</u>	\$58,048	\$58,048
		Bulgur 57.8 MT @ \$256	\$14,797	
		Cornmeal 53.7 MT @ \$181	9,720	
		CSM 27.3 MT @ \$262	7,153	
		Milk 53.5 MT @ \$110	5,885	
		Oil 25.3 MT @ \$810	20,493	
		<u>217 MT</u>		
		<u>For Food-for-Work Programs in communities with Nutrition Clinics (12-month period)</u>	\$10,956	\$10,956
		380 workers x 5 rations x 3 months		
		Bulgur 16.97 MT @ \$256	\$ 4,344	
		Cornmeal 12.1 MT @ \$181	2,190	
		Milk .81 MT @ \$110	89	
		Oil 3.7 MT @ \$810	2,997	
		CSM 5.1 MT @ \$262	1,336	
		<u>39 MT</u>	<u>\$10,956</u>	

NB This amount is included under community below (Item E).

- (1) The outreach grant given SAWS/Haiti totalled \$633,428 for three years and was to provide accessibility and supervision to 430 distribution points. MG nutrition centers share is 2% for 10 out of the 430 centers. This is prorated over three years.
- (2) 1983 prices, quoted by SAWS/Haiti; amounts according to manifests.

C. USG (cont.)

3. Maritime and Ocean Freight	Nutrition Clinics @ 154/MT Food-for-Work @ 154/MT	\$33,418 6,006	\$39,424
			\$19,048
4. Pharmaceuticals and Commodities (received from the Ministry of Health -prorated three years)	Division of Family Planning: FP Supplies: 1/3 of \$51,880 Piperazine and antibiotics 1/3 of \$2,304 Division of Nutrition: Scales 1/3 of \$360 Albums 1/3 of \$720 Flannellos 1/3 of \$414 N + A 1/3 of \$180 Health Services Mgmt. Growth charts 1/3 of \$1200 Books 1/3 of \$ 140	\$18,043	
			558
			447
5. Technical Assistance	MSH counsel (Robde, Genece, Burns)	300	

Total costs - 5

D. GOH

Technical Assistance

MOH
DON, Counsel
FP: training assistance

500

E. Community

Rent or construction of nutrition centers

\$3,000

\$22,656

Mothers' fees: (\$.10 to \$.20 a week with 20% to 80% participation (100 mothers a center)

3,900

Fresh vegetables, fruits, beans for demonstration(real value from \$32 to \$48 monthly)

4,800

Participation in Food-for-Work: value of food received for work in terms of ccc prices plus ocean transport

10,956

Total
Costs

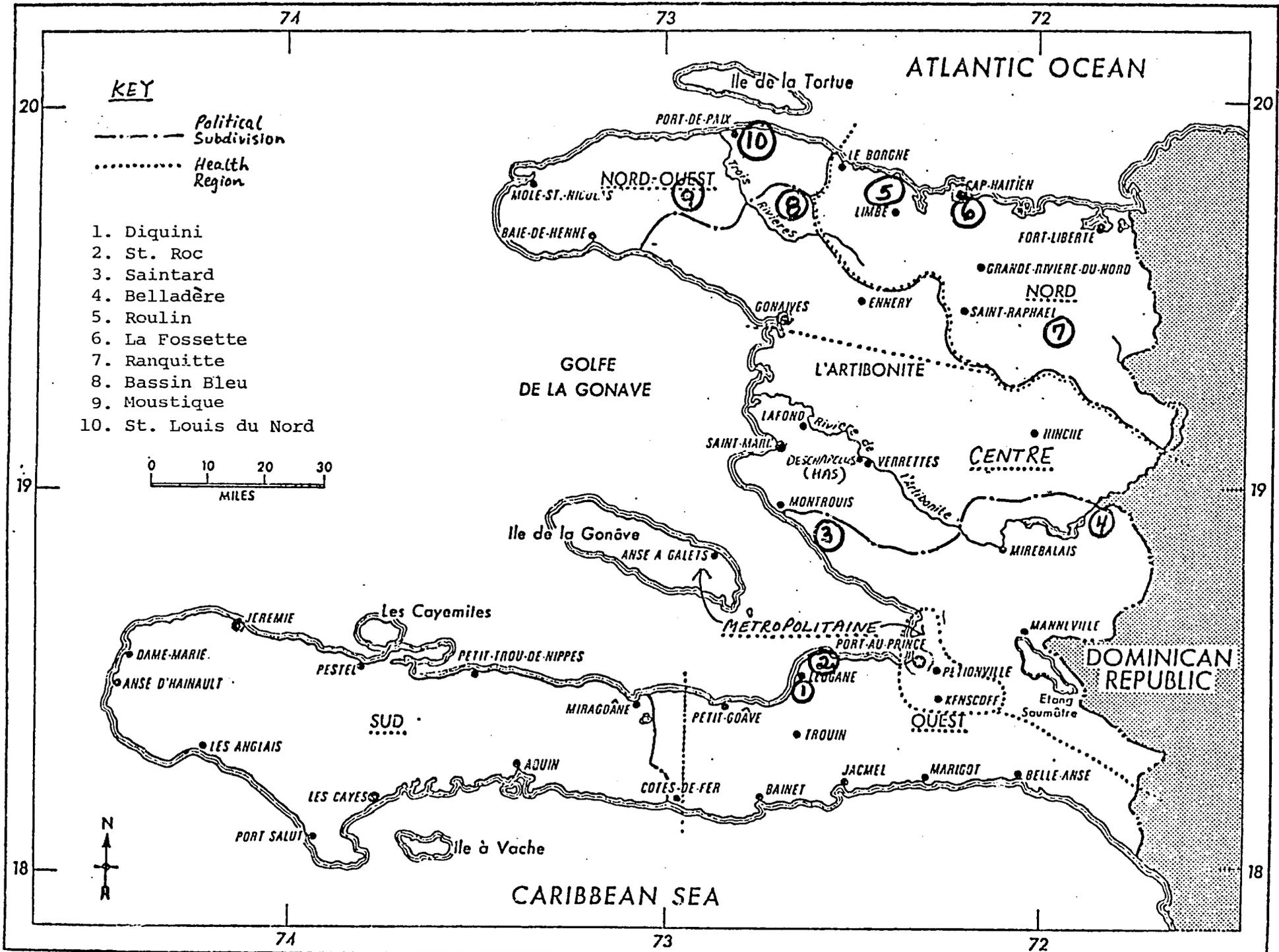
\$255,497

TABLE 29. Comparison of SAWS 1982-83
Nutrition Clinic Program Costs
with Other Programs in Haiti
Studied in 1979

	<u>Per program child</u>	<u>Per educated mother</u>
SAWS, 1982-83	\$ 85.68	\$102.82
BON Rehabilitation Center (inflated by 47%)	\$100.00	\$201.00
Integrated Center (MOH)* (inflated by 47%)	\$ 37.00	\$ 95.55
CWS* (inflated by 47%)	\$ 10.30	\$ 25.58
HACHC (inflated by 47%)	\$ 73.50	\$147.00
Hospital Schweitzer (inflated by 47%)	\$367.50	Not applicable

* The author reported that only direct costs were available on the Integrated Center.

** The author noted that several costs were omitted, including equipment, rent, and training.



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Appendix D

List of Persons Contacted

Max Aimable, Assistant, Ranquitte

Odette Baker, Assistant, La Fossette

Lydie Benoit, Nutrition Agent, La Fossette

John O. Burns, MSH/Haiti

Homère Calixte, Supervisor

Joseph Coblentz, Assistant, Office of Private Voluntary Development, USAID/Haiti

Joel Corten, Evaluation Officer, USAID/Haiti

Fred Emmanuel, Controller

Jasmin Erienne, Nutrition Agent, Ranquitte

Ann Fitzcharles, Office of Private Voluntary Development, USAID/Haiti

Eddie Génécé, MD, MSH/Haiti

Sue Gibson, Chief, Health, Population, and Nutrition, USAID/Haiti

Irlène Joseph, Assistant, La Fossette

Rita Joseph, Aide, Roulin

Brenda Marchant, Administrative Assistant, SAWS/I

Jacques St. Hubert Névelus

Marie Paulette Péan, Assistant, Roulin

Cassius Prévalus, Nutrition Agent, Roulin

Ivy Salomon, RN, Supervisor, Ranquitte

Wiliame Samuel, Nutrition Agent, Diquini

David R. Syme, RN, MPH, Deputy Executive Director and Director of Program Planning and Evaluation, SAWS/I

Serge Toureau, MD, Director General, DSPP

Jan Ulrich, Assistant Office of Private Voluntary Development, USAID/Haiti

LOGICAL FRAMEWORK: The following logical framework is a program outline which illustrates SAWS objectives for the MG program in broad terms. More specific indicators may be established by community members and staff at a later period when beneficiaries are actively participating in the planning process.

NARRATIVE OBJECTIVE

VERIFIABLE INDICATORS

Program Goal: The broader objective to which this project contributes:
To improve the health, nutrition and socio-economic conditions of the rural population within a defined radius of the health care and educational institutions operated by SAWS in targeted countries.
Sub Goal:
To expand community health and agricultural education outreach programs from SAWS health care and educational institutions.

Measures of Goal Achievement:

- Beginning in 1982:
Annual improvement of health and economic conditions of beneficiaries, measured by:
- Decrease in nutrition and sanitation related infant morbidity and mortality in target communities.
 - Increase of garden vegetables in target communities.
 - Increase supply of protein-rich legumes and their byproducts at affordable prices in target communities.
 - Develop attitudinal and participatory community support for the establishment of permanent health information dissemination in target communities.

Project Purpose:

Over a three-year period SAWS will support a community development process that will emphasize new programs in designated communities of six countries, and expand ongoing programs in designated communities of ten countries within the overall context of SAWS integrated community development framework in the following areas.

1. Community nutrition awareness.
2. Health and sanitation reforms.
3. Improved gardening practices.
4. Improved production of protein-rich legumes.
5. Small community operated agro-businesses.
6. Data collection system in place.

Conditions that will indicate purpose has been achieved:
End of project status:

1. A minimum of 40 communities in the environs of 47 SAWS health-care institutions in 13 countries will have community health outreach programs focussing on nutrition sanitation and general health principles.
2. A minimum of 30 communities in the environs of 38 SAWS education institutions in 16 countries will have community health outreach programs or agricultural extension programs focussing on better methods of growing garden vegetables and legumes rich in proteins.
3. A minimum of 10 impact areas will have small community projects utilizing some appropriate technology to preserve seasonal foods or produce food byproducts.
4. Community committees established and managed by local leaders in all impact areas organized to provide health nutrition information.

Outputs:

Program Planning:

1. Feasibility studies for new impact areas and new country programs implemented.
2. Planning system implemented.

Country Programs:

3. Trained group of local national community health educators working from each health-care center.
4. Trained group of national agricultural extension workers based at each educational center.
5. Small agro-businesses established in target communities.
6. Information system in place in each target country.

Program Support:

7. Training needs assessment and comprehensive training plan for field staff developed.
8. Field staff and communities trained in basic health education needs.
9. Administrative support systems refined and functioning.
10. Functional evaluation system developed.

Project Inputs:

1 Program coordinator	16 country directors
1 Health/Nutrition director	Technical consultants
1 Agricultural director	Project funds
1 Planning/Evaluation director	Program structure and network
1 Food technology consultant	Regional staff support
1 Regional directors (SAWS)	

Magnitude of Outputs:

Program Planning:

1. Feasibility studies for 6 new countries and 29 new impact areas and programs completed by end of year 3.
2. Systematic application of planning processes implemented in 100% of all projects and programs by end of 3 years.

Country Programs:

3. Four to six trained community health educators based at each health-care center and working in target communities.
4. Four to six trained agro-extension workers based at each educational center and working in target communities.
5. Community groups organized to plan and establish small agro-businesses in each target community.
6. Each community worker trained in data collection, responsible for locally based program, provide data to national director. National director supply baseline data to SAWS/Washington monitoring reports as required.

Program Support:

7. Comprehensive training program plan for each country developed and at least one training program being implemented in each country by end of year 1.
8. All field staff have participated in training activity by end of year 1.
9. Reporting system fully implemented in all programs by end of year 1.
10. An evaluation of all projects in all impact areas will be conducted using the evaluation system by end of year 3 in 16 countries.

Implementation Target (Type and Quantity)

	<u>1st year</u>	<u>2nd year</u>	<u>3rd year</u>	<u>Total</u>
AID	602	797	752	<u>\$2,151</u>
SAWS	601	797	753	<u>\$2,151</u>

MEANS OF VERIFICATION

Means of Verifying Goal:

Case studies by international agencies

Government statistics

Census reports

Evaluation reports

Planning documents

Community reports

Means of Verifying Purpose:

Project reports

On-site visits and surveys

Special office reports

Evaluation reports

Planning documents

Community reports

ASSUMPTIONS

Assumptions for Achieving Goal Targets:

- No major global conflict
- World economic system does not deteriorate
- Climatic conditions do not change radically
- Political situation in countries remains stable
- That SAWS relationship with private donors is maintained to sustain its matching funds capability.

Assumptions for Achieving Purpose:

- Communities are willing to cooperate and work together.
- Communities can be motivated to have control over their own physical wellbeing.
- Local and national governments want development initiation at community level.
- Leaders exist in communities.
- New techniques can be successfully transmitted to various distinct cultures.
- AID funding will be acceptable to national governments.
- Political climate is conducive to community organization and programs.

Means of Verifying Outputs:

- Existence of comprehensive training plan for countries and regions.
- Reports on workshops and seminars.
- Project Reports.
- Existence of project proposals.
- Existence of feasibility studies.
- Existence of appropriate country technology guidelines.
- Community committee reports on funds.
- Field office reports.
- Evaluation reports.
- Field visits.

Means of Verifying Inputs:

- Financial Reports
- SAWS Office Reporting System
- Annual Audit Report
- Personnel Reports

Assumption for Achieving Outputs:

- Training is relevant, effective and culturally appropriate.
- Participation of communities is active, not passive.
- Evaluation system designed is relevant and effective.
- Time for training will be allowed by communities and SAWS.
- Staff turnover is minimal.

Assumptions for Providing Inputs:

- Funds available when needed.
- Qualified personnel available as programmed.
- Sufficient coordination will be maintained.
- Advice provided by technical staff will be utilized by SAWS staff and community committee.
- SAWS will sustain its normal program and projected income.

Appendix F

Seventh-Day Adventist World Service, Inc.
Statement of Support and Revenue
Annual Matching Grant Financial Report
Period: October 1, 1982 - September 30, 1982

Public Support and Revenue

<u>I</u> <u>Public Support</u>		<u>% of</u>	<u>% of</u>
		<u>Sub-Total</u>	<u>Total</u>
Contributions:			
Individual	199 637	20.0	5.0
General Conference of Seventh- Adventist	300 000	30.0	7.5
Gift in Kind	499 637	50.0	12.4
	<u>999 274</u>	<u>100.0</u>	<u>24.9</u>
Sub-Total Public Support			
 <u>II</u> <u>Revenue</u>			
Investment Income			
Miscellaneous			
Sub-Total Revenue			
Total Public Support and Revenue	<u>999 274</u>	100.0	24.1
 <u>III</u> <u>Government Support</u>			
<u>US Government</u>			
AID Matching Grant			
AID OPG	483 607	16.0	12.0
AID/ASHA Grants	579 728	19.1	14.0
	<u>1 966 241</u>	<u>64.9</u>	<u>48.0</u>
Total Government Support	<u>3 029 576</u>	100.0	75.0
 TOTAL	4 028 850		100.0

Appendix GPharmaceuticals and Commodities from DSPPDivision of Family Hygiene

Piperazine syrup 16 gallons	128.00
Piperazine tablets 23,000	230.00
Tetracycline syrup 84 fl.	840.00
Eye ointment 108 tubes	37.80
Oralite 2,725 bags	408.75
Aspirine tablets 31,000	100.00
Multivitamins & iron 51,000	306.00
Oral contraceptives 31,000 cycles	49,600.00
Condoms 36,000	2,160.00
Iodine solutions 11 bottles	130.00
Penicillin inj. 40 vials	26.00
Depropovera inj. 10 vials	120.00
Tongue depressors 1,000	12.00
Applicators 150 pkgs.	20.00
Glass syringes 2	7.00
Printing materials	60.00
<u>Subtotal</u>	<u>\$54,183.55</u>

Division of Nutrition

Scales 9	360.00
Albums 18 a \$40.00 each	720.00
Good groups images	
for flannellograph 26 envelopes a \$15.00 each	390.00
Flannellograph 3 a \$8.00 each	24.00
Vitamin A 30,000 a \$6/1000	180.00
<u>Subtotal</u>	<u>1,674.00</u>

Health Management Office

Growth Chart 8,000	1,200.00
Books for Teacher 8	80.00
Books for nutrition agents 80 sets	60.00
	<u>\$ 1,340.00</u>

Grand Total\$57,197.55

Appendix II

Description of Project Sites

	Bassin-Bleu	Belladere	Diquini	La Fossette	Moustiques
Location/ Accessibility	distant; all-weather road generally accessible; 1 hr. from Gonaives	distant	at edge of SAWS compound at southern edge of Port-au-Prince	in Cap Haitien; easy access	distant; river barrier, 12 mis. by horseback
Population:					
mothers of child-bearing age	430	637	875	1,250	625
children 0-11 mos.	95	138	140	270	135
children 1-5 yrs.	250	372	510	730	365
Infrastructure	no elec. or water	elec. water	elec. water	elec. no water but plumbing	no elec or water; water storage drum system
Nutritional Status:					
Gomez I no. of	31% 208	24% 266	41% 229	32% 169	23% 182
Gomez II children	39%	47%	24%	44%	23%
Gomez III weighed	14%	17%	11%	13%	13%
Staff (as of June 1983)	1 nutr. agt. 1 asst. 1 SDA pastor (doing thesis)	1 nutr. agt. 2 assts.	1 nutr. agt.	1 nutr. agt. 2 assts.	1 nutr. agt. 1 asst.

	Ranquitte	Roulin	Saintard	St. Louis du Nord	St. Roc
Location/ Accessibility	distant; difficult access	near Cap Haitien; moderate ease of access but far from Port-au-Prince	near Port-au-Prince; easy access on main highway	in north; distant 2 1/2 hrs. from Gonaives + 2 1/2 hrs. via Port-au-Paix	close to Port-au-Prince, 3 kms. from SAWS compound
Population:					
Others of child-bearing age	600	854	795	1,800	875
Children 0-11 mos.	130	185	170	390	189
Children 1-5 yrs.	295	500	465	1,315	511
Infrastructure	no elec or water; water source capped as community action project, piping destroyed	no elec. or water	no elec. or water	no elec or water	no elec. or water
nutritional Status:					
omez I no. of	24% 215	28% 153	23% 255	32% 218	36% 130
omez II child.	51%	29%	22%	42%	34%
omez III weighed	19%	21%	19%	12%	8%
Staff					
as of June 1983)	1 supervisor 1 nutr. ag't. 1 ass't	1 nutr. ag't. 2 ass'ts.	1 nutr. ag't. 1 ass't.	1 nutr. ag't. 1 ass't 1 SDA pastor (doing MPH thesis)	1 nutr. ag't. 1 ass't.

Appendix ITraining Course Curriculum Summary*General Introduction

1. Food crisis. Nutritional problems. World Wide and locally.
2. Each nutrition agents must understand that the involvement in this field of solving the problems of child malnutrition is an apostolate and love for the fellowmen is the basic principle.
3. Survey methods.
To discover the causes of child malnutrition.

Objectives

Identified the malnutrition problems in the community for children 0-5 and recognized the real needs for the establishment of a nutrition clinic.

In order to do so it is essential for the nutrition agents to visit the families, help them cooperate and release informations on health problems, specially those affecting the children of 0-5.

The nutrition agents learn how to fill the survey forms.

A practical work is done in the community.

- II. Importance of making contact with the community leaders to discuss about the malnutrition problems and the program that we hope to establish in order to help the mothers and the children.

* English translation from Creole text prepared by SAWS/Haiti training staff.

- 2 -

Basic principles for the organisation of a nutrition clinic.

Have a 5 members committee members.

Have a secure storeroom for the food.

Materials needed.

Daily program.

Job description for the nutrition agents.

Works conditions according to SAWS and AID.

Health classes

1. Relationship between nutrition and health.

2. Importance of eating a balanced diet.

Recognizing the tree food groups.

The proteins groups build the body. It is symbolized by a house. Its¹ meat milk eggs - legumes mixed with cereals. The legumes mixed with cereals have the advantages to be less expensive and it's easier to be stored.

AK 1000 preparation : 2 portions of grains

1 portion of legumes

grounded - and cooked with greens or fruits for the children.

The second group protects against diseases. It is represented by a padlock used to secure the door of the house.

all the vegetables and all the fruits. One or two of them

- 3 -

- The third group serve to heat the house. It's give energy and help the body to accomplish all the movements. It is represented by fire.

In this group we find all the sugars and oils (Oil butter -coconut) The roots (cassava, sweet potato, and plantain - breadfruit - yam, etc/and cereals.

Every day each person specially small children should eat a mixed diet to secure proper growth.

Cereals should always be mixed with legumes in the proportion of 2 parts of cereals to one part of legumes.

Green dark leafy vegetables or yellow vegetables or fruits should be eaten every day to protect the eyes, the skin etc.

Eggs and milk are good food. Mother's milk is the best food for the baby and should be given the first day after delivery..

It is not necessary to know away the colostrum and give a purgative to the newborn as it is the customs because the colostrum has the virtue to clean the newborn intestines. It also immune the baby for a short times against some diseases.

Mothers' milk is free of bacteria and prevents diarrhea that is the number 1 killer of the infants in Haiti.

Mothers' milk is readily available and a mother doesn't have to spend money

- 4 -

Nurse the child as long as possible even until two years of age.

A pregnant mother and a nursing mother should eat more of the building food. A nursing mother should drink 2 or 3 more water or juices that she usually had before to increase the milk flow.

To know if a child is growing properly the weigh have to be taken every month. The child that is in good health increases weight every month. If she is stationnary or is loesing weight that means, he has to eat more building foods. He has malnutrition.

On the very severe cases of malnutrition the child has either oedema what is kwashiorkor or is very skinny what is marasmus.

The treatment is as follow. The firs, week - milk formula.

- 1.liter of water.
- 5 spoonful of milk
- 5 spoonful of oil.
- 10 spoonful of sugar

1/2 or 1 cup about 5 to 6 times a day according to the age and body weigh
The following week continue with AK 1000 3 times a day. With green leafy vegetables - a cup of milk 2 or 3 times daily - and all other food available.

Rules for the children with malnutrition

Infants from 3 to 12 months.

Mother's milk + 3 to 5 meals daily (AK 1000 porridge - vegetables or fruits puree).

Children from 12 to 24 months.

Mother's milk + everything an adult eats but crushed and 5 times daily.

Older than 24 months.

half of what his father can eat daily.

Give a capsule of vitamine A every 4 months from 6 months old to 7 years old to prevent xerophthalmia.

Weighing sessions

Learning how to use the chart "Chemin la Sante".

Record at least 20 weighs on a chart. At the end of the class the nutrition agent must be able to weigh the children and record correctly and ^{explain} each

nutrition simply to the mothers.

Mother Child Health

The mothers health is important for the well being of her baby. It is important for the mother to take good care of herself when she is pregnant and whenever she presents some abnormalities she should go to a health care center. (lower abdominal pain, passing water or blood through the vagina persistent headache, oedema.)

To protect her baby against tetanus she must take 3 doses of vaccine between the third and the 7 months.

- Iron pills should be taken the 3 last months.
- Importance of good nutrition during pregnancy.
- After the baby is born he should received a vaccin against tuberculosis BCG one dose and after 3 months, 3 doses of vaccine against the 4 great child killer:

Tetanus
Difteria
Pertussis
Polio.

The three first ones are an injection in one single vaccine called DeTePer and the fourth one is a sirup given through the month to be swallowed.

Use a family planning method in order to give the child a chance to grow and get enough mother's milk and also for the mother to get more strenght.

Importance of hygiene and sanitation for the health

To be in good health:

Keep the house clean.

Aeration of the house is necessary to prevent diseases.

Taking care of swamp - having a waste disposal system and using latrines helps prevent - diarrhea, typhoid fever, yellow fever, malaria.

Good sanitation keeps away rats, flies, mosquitoes that transmit infectious diseases.

How water and food can be contaminated through stools elimination on the grounds.

Suggest simple ways to build latrines .

Water from river is not good to drink.

Teach simple methods to purify water: use of 2 or 3 drops of chlorox for one liter of water.

The baby's hair should be washed very often.

Tradition tells the mother to put nutmeg and oil on the baby's hair and to cover it with a hat for a few months to prevent the closure of the pores. This way many babies develop scalp problems.

The hands should be washed after defecation and before eating.

Taking regular bath with soap and wearing clean clothes help to prevent skin diseases that are so common here.

The teeth should be cleaned every day.

D I A R R H E A

What is diarrhoea? loose stools. The body loses water.

Causes of diarrhoea

Drinking unclean water.

Using bottle feeding for the baby.

Not handling properly the food.

Many infants in Haiti die of diarrhoea.

That can be prevented.

Demonstration with a water filled with water and having a hole at the bottom. When the water flows at the bottom and is not replaced the bottle soon becomes dry. But if at the same time the water is coming out from the bottom you keep replacing it at the top, the bottle will never get empty.

It is the same with the infant body if replaced. If when diarrhoea started you give the water loss by oral serum the child will not get dehydrated and will not die.

- 2 -

- 1 liter of boiled water.
- 1 teaspoonful of powdered salt.
- 2 tablespoon of sugar.
- Lemon juice.

After each watery stools the child must received a cup of oral serum.

If he is vomitting give the serum gradually one teaspoonful at the time but constantly.

Precautions to avoid diarrhea

1. Give mother's milk
2. Use a cup and a spoon dont use a bottle to feed the baby.
3. Always boils the water.
4. Cover all the ustensils that will be used for the baby. Keep them flies away.
5. Always wash the hands before preparing the foods and feeding the baby.
6. Build latrines to avoid contamination.

When the infant has diarrhea he become weak. So it is important for the another to continue nursing him.

The older child should be given food easy to digest like porigde - cereals. This way he will recuperate rapidly when the diarrhea is gone.

Tuberculosis

When someone doesn't have a balanced diet it is easier for him to get tuberculosis. It is a contagious disease that can be dangerous for the whole family and specially for the children.

However tuberculosis can be treated with medication and good nutrition.

The patient and his family must take some precautions to protect the other members.

First aids specially for the children included:

Treatment of diarrhea.

Treatment of malnutrition.

Taking care of non complicated fever, cough, burn - wound, worms, skin diseases, conjunctivitis.

The agent is instructed to refer to a health center all complicated cases for which treatment requires more advanced training.

Nutrition Messages*

Mothers' milk:

1. Nurse the newborn the first day.
2. The first milk is a good laxative for the newborn.
3. Mother's milk keep the baby in good health.
4. Mother's milk make the baby strong.
5. When the mother nurse the baby often, the milk increase.
6. Mothers' milk never get spoiled, even if she stop nursing for days she can always nurse again. Just throw away the first drops of milk.
7. Mothers milk is sufficient to feed the baby until 3 months of age.
8. A nursing mother should eat more and drink twice more water.

Foods for the baby

1. After 3 months beside the mothers' milk baby should receive: porridge, fruits puree. Use a cup and a spoon.
2. Always put milk in the porridge use also milk to prepare the soup.
3. Use a clean pot to prepare the babys' food.
4. Small children cannot stand hunger like adults. They should eat 3 or 4 times a day.
5. Milk is like meat, eggs are like meat. Beans soup add to corn, rice or millet is like meat. They are fortifying foods.
6. Put in a separate plate the food for the child so you can verified what amount he has eaten. Always mash the food.
7. It's better to give the child fresh food. When the cooked food stay too long in room temperature germs will grow in it.

* English translation from Creole text prepared by SANS/Haiti training staff.

8. Children don't like dry food. If you don't have meat, make a sauce with fish or beans soup with vegetables.

Weaning : Before you wean a child get him:

1. Used to cooked food.
2. When you first wean a child, give him a lot of attention so he will not be sad and give him more food.
3. When the mother is dividing the food she must give keep enough for the small children and for her.

Diarrhea: When the baby has diarrhea:

1. Keep nursing him, give him oral serum, give him fruit juices, tea. Give him a lot of liquid.
2. When a child has diarrhea with a foul odor, it's a serious disease, oral serum will not be enough for him. He has to be taken immediately to the doctor.

When a child just had diarrhea you must give him more food in order bring him up quickly.

3. The nursing mother should always wash her breasts before feeding the baby to prevent diarrhea.
4. Bottle feeding is the greatest source of diarrhea.
5. It is important to wash the child hands before he eats.
6. Each family must use a clean latrine, because stools on the ground is a cause of diarrhea.

Sick Children

1. When a child is sick, he needs more care.
2. When a child is sick encourage him to drink and to eat.
3. When you taking the child to the health clinic or to the hospital always bring his growth chart along.
4. Don't wait until the child get very sick to take him to the health clinic.
5. When a child has oedema, red and broken hairs take him to the health clinic or the nutrition clinic because he is very sick.
6. When a child has oedema, the best medicine is the "enriched milk" diluted.

After the oedema disappears, give him beans soup, vegetables, cereals, more often in order for him to recover fast.

Family

1. When a family is not well organized it is the greatest cause of child malnutrition.
2. When a mother is pregnant too often, this is a cause of malnutrition also.

Food for the family

1. you can grow food to be sold, but grow crops in order to eat also.
Every day the children must eat beans and vegetables.

2. You may sell from your large crops but the kitchen garden must be used for the children.
3. When you get eggs from the chicken keep some of them to feed the children because eggs keep the children in good health.

Basic Framework for Describing and Analyzing Participation
PROJECT CHARACTERISTICS
TASK ENVIRONMENT

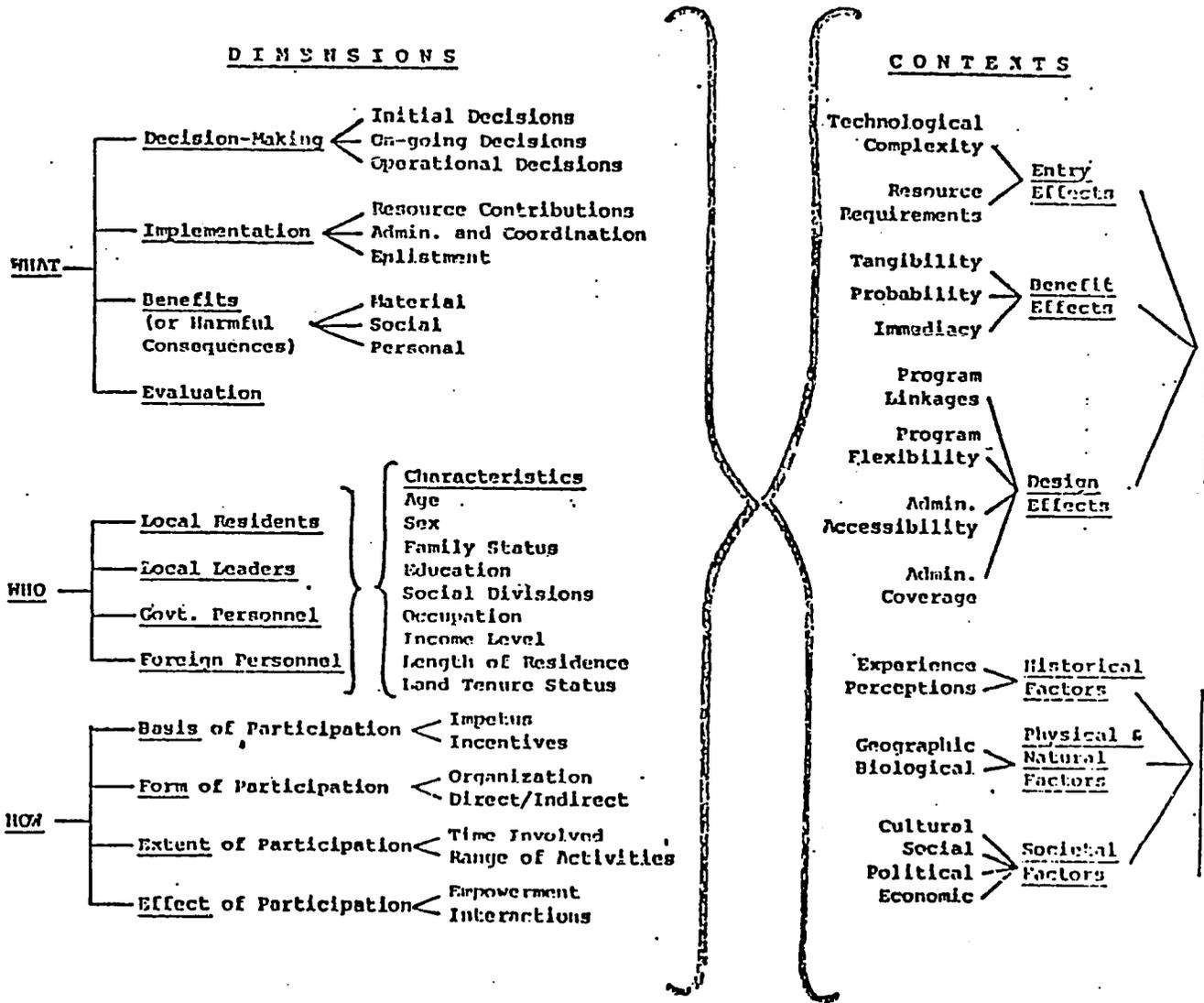


Figure 1: Basic Framework for Describing and Analyzing Rural Development Participation

Source: J. M. Cohen and N. T. Uphoff. Participation and Rural Development: Clearing Away the Underbrush. 1979. Mimeo.

Appendix L
Daily Food Requirements

Groupe d'Age	Poids Kg	Energie		Protéines ³ gms	Vit. A ⁴ Ng	Ribo- flavine Ng	Acide folique Ng	Fer ⁵ Ng	Calcium ⁶ Ng	Acide Ascorbique Ng	Vit. D ⁷ Ng	Thia- mine Ng	Nia- cine Ng	Vit. E ⁸ IU
		Kcal	NIJ ²											
Filles et Garçons														
1 - <1	7.3	820	3.4	23	300	0.5	60	10	0.55	20	10	0.3	5.4	0.
4 - 3	13.4	1360	5.7	27	250	0.8	100	10	0.45	20	10	0.5	9.0	0.
4 - 6	20.2	1830	7.6	34	300	1.1	100	10	0.45	20	10	0.7	12.1	1.
7 - 9	28.1	2190	9.2	41	400	1.3	100	10	0.45	20	2.5	0.9	14.5	1.
Garçons Adolescents														
10 - 12	36.9	2600	10.9	50	575	1.6	100	10	0.65	20	2.5	1.0	17.2	2.
13 - 15	51.3	2900	12.1	62	725	1.7	200	18	0.65	30	2.5	1.2	19.1	2.
16 - 18	62.9	3070	12.8	63	750	1.8	200	9	0.55	30	2.5	1.2	20.3	2.
Filles Adolescentes														
10 - 12	38.0	2350	9.8	48	575	1.4	100	10	0.65	20	2.5	0.9	15.5	2.
13 - 15	49.9	2490	10.4	52	725	1.5	200	24	0.65	30	2.5	1.0	16.4	2.
16 - 18	54.4	2310	9.7	50	750	1.4	200	28	0.55	30	2.5	0.9	15.2	2.
Homme Adulte⁸														
Activité modérée)	65.0	3000	12.6	62	750	1.8	200	9	0.45	30	2.5	1.2	19.8	2.
Femme Adulte														
Activité modérée	55.0	2200	9.2	48	750	1.3	200	28	0.45	30	2.5	0.9	14.5	2.
Femme Enceinte⁹														
	-	+350	+1.5	63	750	+0.2	400	28	1.10	50	10	+0.1	+2.3	3.
Femme en Lactation¹⁰														
	-	+550	+2.3	76	1200	+0.4	300	28	1.10	50	10	+0.2	+3.7	2.

Manuel sur les Besoins Nutritionnels de l'Homme, OMS, Genève, 1974.

Cette référence générale est basée sur les travaux suivants:

- 1.1 Besoins Energétiques et Besoins en Protéines, Rapport d'un Comité Spécial Mixte FAO/OMS d'Experts, Genève, 1973.
- 1.2 Besoins en Vitamine A, Thiamine, Riboflavine, et Niacine, Rapport d'un Groupe Mixte FAO/OMS d'Experts, Genève, 1965.
- 1.3 Besoins en Acide Ascorbique, Vitamine B12, Acide Folique, et Fer, Rapport d'un Groupe Mixte FAO/OMS d'Experts, Genève, 1970.
- 1.4 Besoins en Calcium, Rapport d'un Groupe Mixte d'Experts FAO/OMS, Genève, 1962.

NIJ = Kcal; NIJ = 239 Kcal.

Rapport protéique pour des régimes dont la valeur protéique est 60% par rapport à celle de l'oeuf ou du lait (p.77 référence 1.1)

Exprimé en microgrammes de Retinol. I.U. = 0.3Ng de Retinol.

Appendix L (cont'd)

- 5 Apports recommandés pour un régime dont moins de 10% des calories sont d'origine animale (p. 52 référence 1.3)
- 6 La moyenne entre les deux limites recommandées par l'OMS a été utilisé.
- 7 Exprimé en microgrammes (Mg) de cholecalciferon. 1I.U. Vitamine D = 0.025 µg Vit. D₃.
- 8 Homme et Femme de référence (p.29 référence 1.1).
- 9 Les besoins en plus des besoins de la femme adulte pour les deux derniers trimestres de la grossesse, sauf pour le calcium qui est seulement pour le 3ème trimestre.
- 10 Les besoins en plus des besoins de la femme adulte pour les premiers 6 mois de lactation.

Appendix M
 Market Value of Foods Distributed in 10 Communities with Nutrition Clinics
 one/12 month period (starting from May 1982 and ending April 1983) by
 Community, by Kilograms Distributed and Market Value over the Period

COMMUNITY	FOOD FOR WORK					Total Value of Food for Work	NUTRITION CLINICS					Total Value of Nutrition Clinic Foods	Total Value Over a 12 Month Period
	Value of Foods Distributed Over 12 Month Period						Value of Foods Distributed Over 12 Mo.						
	Bulger	Cornmeal	Milk	Oil	Cost		Bulger	Cornmeal	CSM	Milk	Oil		
Bassin Bleu							3176	2642	1388	2325	2656	\$12,187	\$12,187
Belladère							4492	3737	1964	3289	3757	\$17,239	17,239
Diquini							4376	3641	1913	3204	3660	\$20,453	20,453
La Fossette							3020	2513	1320	2212	2525	\$11,590	11,590
Moustiques	3015	1359		806	697	\$5,868	4415	3673	1929	3232	3692	\$16,941	22,809
Ranquette	5469	3669	429	2186	1278	\$13,034	4725	3931	2065	3459	3951	\$18,131	31,165
Roulin	1370	1227		922	636	\$4,155	4647	3866	2031	3403	3886	\$17,833	21,948
Saintard							1588	1321	694	1162	1327	\$ 6,092	6,092
St-Louis du Nord							3176	2642	1388	2325	2656	\$12,187	12,187
St. Roc	1518	1022		768	530	\$3,838	5112	4253	2234	2472	4275	\$18,346	22,184
	11372	7268	429	4685	3141	\$26,895						\$151,000	\$177,895

Value of Foods, Spring 1983

		Kilo
Marmite (5lbs)		
Cornmeal	\$1.35	.67
Bulger	1.50	.60
Milk	1.20	.53
Oil (gallon)	5.13	1.28
CSM	1.40	.62

Source: Market Survey, June 1983
 Ulrich food data, May 1982.

Appendix N

Estimated Expenditures for 75% of the
Matching Grant Total for 12 Months by Line Item, 1982-83

<u>Item</u>	<u>Seven Months in FY 1982</u>	<u>Five Months in FY 83</u>	<u>Total</u>
Program Coordinator	\$ 10,194	\$ 7,986	\$18,180
Health Training Officer	3,225	4,110	7,335
Field Health Consultant	1,063	259	1,322
Ag Training Officer	793	3,317	4,110
Community Health Workers	3,386	11,481	14,867
Health Worker Assistants	1,015	515	1,530
Ag Extension Workers	898	2,418	3,316
Training			
Allowances	1,823	657	2,480
Supplies	3,137	852	3,989
Teach. Facil.	5,487	4,972	10,459
Teaching aids	227	54	281
Ag. Supplies	489	468	957
Admin. Support			
Transportation	7,444	1,745	9,189
			<u>\$ 78,015</u>

Remaining 25% share SAWS/I: \$19,503

Appendix OCommunity Participation in Decision-Making and ImplementationBassin-BleuBelladereDecision-Making

SDA pastor in MPH programs at Loma Linda interested in nutrition, got a helper from the community, requested inclusion in MG. Worked with community church, community leaders and DSPP district doctor, held meetings in church-sponsored school.

SDA pastor requested site visit by SAWS after identifying major nutritional problem. Survey carried out, no other nutrition support provided. SAWS approached DSPP district doctor, agreement to work together. Building made available by GOH. DSPP district doctor gets monthly report on center activities.

Implementation

Community under leadership of Adventist/pastor, raised money to build nutrition clinic with thatched roof and dirt floor man contracted to build slow, stopped before completion. Pastor transferred, clinic continued to meet in Adventist school in afternoon. New pastor now helping community to get materials to finish clinic. Community has also begun foundation for depot to store food for all projects; now pays \$25/mo for rent. SAWS has given a limited amount of donated funds and a prefabricated building for the depot.

Community also participates in school feeding and Food-for-Work programs.

Mothers do not contribute money on a weekly basis; the feeling is that they cannot afford to do so.

Pastor's wife supervises nutrition program, teaches community sewing program. There is no community council and only "self help" activity is sewing group which is strong.

No data on mothers' contribution

Community helpers worked with supervisor with sewing, food preparation and distribution, clinic activities, now given Food-for-Work.

DiquiniDecision-Making

Participation in MCH program at Adventist Polyclinique reported conditions of acute need in adjoining peri-urban slum of Bergamoth. SAWS directors visited, decided against putting clinic there. Available building at edge of compound remodelled with MCH funds (porch, stove, bathing area), selected for convenience for supervision, training. Concept of community participation deliberately sacrificed;

Implementation

"Self-help" activity in sewing, basketry with a fairly sophisticated product, but basically a "recipient" site.

La Fossette

Building built by community donatin, in 1954 as community center, abandoned, occupied by squatters. Adventist Church leaders advised SAWS of acute need, made arrangement with community to clean up for use as center. Clinic staff selected by SAWS because of previous MCH experience.

Basically a "recipient" site. Mothers contribute \$0.20/wk. or small amounts of fresh vegetables but contributions vary widely and attendance is apparently lower than at any other site since most responsive to food distribution as opposed to other services, e.g., weighing and education. Mothers who contribute are resentful of non-contributors. Adventist Church is made available to project for community weighings.

Major attitudinal problems:

- a) Community feels food should be given to all and an iron door had to be installed to keep non-participants in check.
- b) Clinic staff is reproached because program does not accept all Adventists.
- c) Mothers' attendance largely food-dependent.
- d) Mothers compete with children for food.

Moustiques

Ranquitte

Decision-Making

SAWS promoted meeting of representatives of 8 communities as part of Food-for-Work inspection tour. This community had built 12 mis. of road to Bassin-Bleu, including large river crossing, and had heard SAWS "building nutrition centers" requested for community. SAWS responded and community built well-constructed thatched-roof site, contributed money for cement slabs; Adventist Church private funds given for materials.

Community group involved in Food-for-Work activity. Conseil Communautaire representatives went to SAWS to request nutrition center.

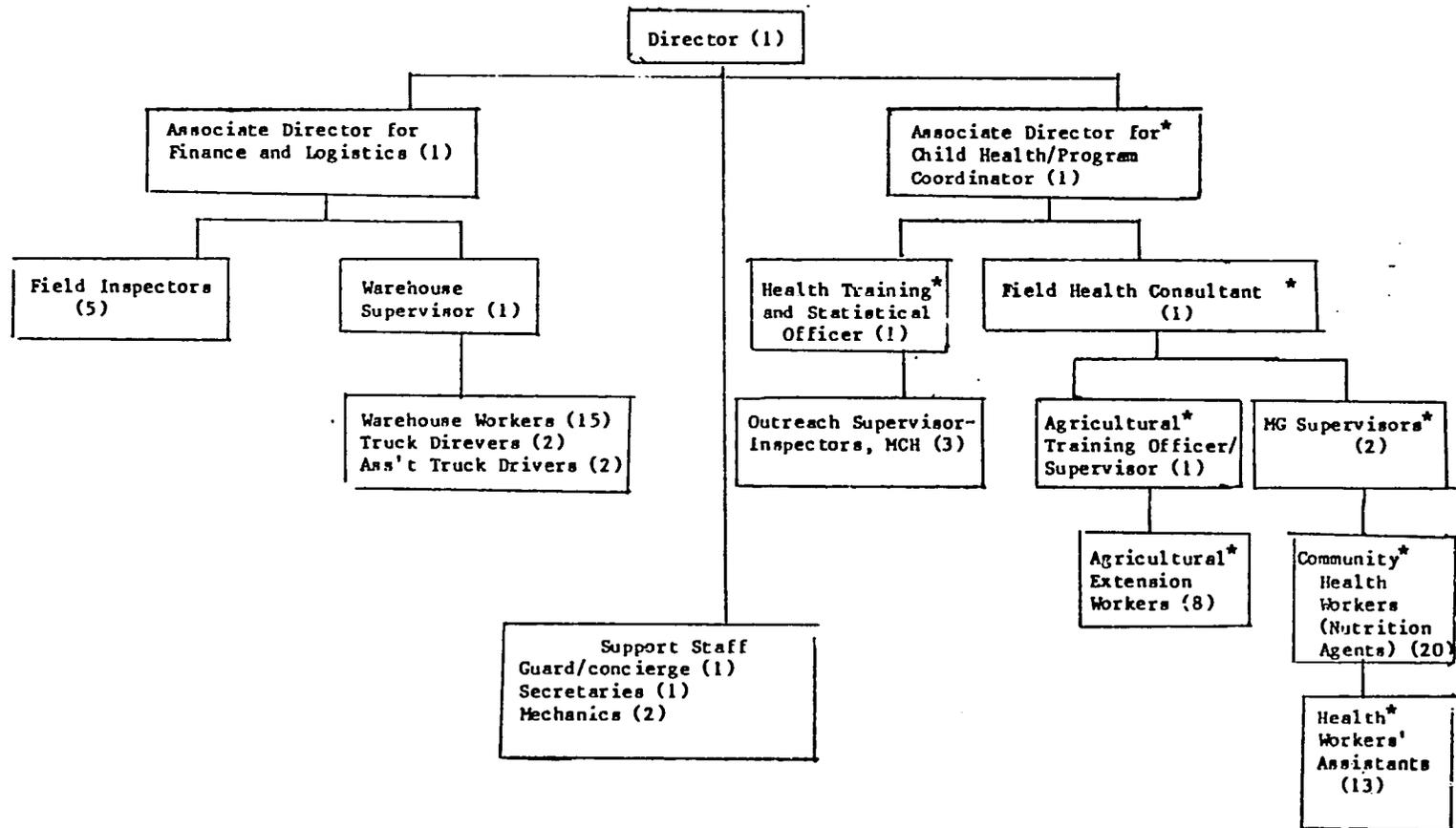
Implementation

Strong community group, with leaders, regular sessions, good Conseil Communautaire. Has good rural Akamil mill activity, by far most vigorous home garden progress (n=200).

Indications of stress in relations between Adventists and community, Conseil. Evidence (sabotage?) of struggles over water. Strong clinic manager but impression of not much community participation. Two self help sewing groups.

Appendix P

Organization Chart, SAWS/Haiti Matching Grant and Outreach Grant Staff (N=71)



* Supported by Matching Grant Budget.

	<u>Month 1</u>	<u>Month 2</u>	<u>Month 3</u>	<u>Month 4</u>
<u>Week 1</u>	Importance of a good diet The 1st food group Whole milk preparation	Review 3 food groups Akamil preparation Review diarrhea and home ORT Importance of latrines How to build a latrine	Review 3 food groups Practical recipes Vaccinations for children	Review 3 food groups Review domestic hygiene Causes and importance of malaria, prevention and treatment
<u>Week 2</u>	Review 1st food group 2nd food group Causes of malnutrition Signs of kwashiorkor and marasmus Importance of mother's milk Demonstration of preparation of powdered milk Importance of personal hygiene	Review 3 food groups Feeding of pregnant women Importance of tetanus shots of pregnant women	Review of child feeding and 3 food groups Causes, signs, prevention, treatment of TB; BCG	Review 3 food groups and practical recipes Vaccinations for children BCG/TP
<u>Week 3</u>	Review 1st and 2nd food group Food preparation hygiene Need for home gardens	Review infant feeding, mother's milk Importance of family planning Methods of family planning	Three food groups. Water hygiene, making a filter	Review 3 food groups. Akamil Family planning
<u>Week 4</u>	Review 3 food groups Importance of weighing How to feed infants Weighing infants	Review: importance of diet for pregnant women, 3 food groups, weighing	Review: 3 food groups, importance of latrines, child diarrhea, typhoid	Weighing. Evaluation. Graduation or readmission