

PD-AAA - 028

AN EVALUATION OF MATERNAL-CHILD
SUPPLEMENTARY FOOD PROGRAMS IN HAITI

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EXECUTIVE SUMMARY

Title II MCH food supplement programs have been implemented in Haiti since 1959. Apart from the 1979 evaluation of Mothercraft Centers, this represents the first evaluation of the MCH program since its inception. The study took place during the months of July and August, 1982, and was based on a survey of nutrition centers and interviews with key officials. A stratified random sample of 39 sites (6 percent) out of 519 were visited, with proportionate representation by the four PVCs (CARE, SAMS, CWS AND CRS) and the WFP. A questionnaire was administered to center responsables or an assistant, and 62 mothers of enrolled children were interviewed.

The results show program strengths in the areas of mothers' satisfaction, accessibility to participants, staff training capabilities, and staff understanding of program objectives.

Weaknesses were found in selection of beneficiaries, monitoring of progress, turnover of participants, supervision of operations, impact on agricultural practices, and coordination between health sector and private development programs.

Recommendations are made to achieve the following changes.

1. Better definition and uniform application of selection criteria.
2. Closer monitoring of progress linked to termination of healthy children, intervention in cases of failure to progress, and elimination of indefinite enrollment.
3. Reconsideration of optimum program size and ration-beneficiary adjustments.
4. Integration of food supplementation activities with on-going and planned nutritional surveillance.

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5. Closer supervision and control of center operations by PVC and AID staff, with assistance from district health personnel where feasible.
6. Strengthening community participation through artisanal activities and provision of medical services.
7. Improved communication and coordination between PVCs and the DSPP-ECN at both the national and district levels in the areas of program guidelines, site selection, and other aspects.
8. Expanded GCH role in national nutrition planning, supervision and training of MCH staff, and provision of supplies.

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I PURPOSE

This evaluation assesses programmatic and institutional strengths and weaknesses of Haiti's Maternal Child Health (MCH) programs supported by AID Title II food commodities. The analysis addresses current program effectiveness in meeting PL480 Title II objectives, and explores alternative institutional arrangements for improving program coordination.

II BACKGROUND

The Title II Food for Peace program, which includes MCH, Preschool Feeding, School Feeding, Other Child Feeding, and Food for Work projects, was initiated in Haiti in 1959. Maternal Child Health activities were evaluated within the context of the Nutrition Improvement Project in 1979 (1), but this is the first evaluation focussed specifically on the MCH program.

Supplementary feeding activities are administered through four Private Voluntary Organizations (PVOs) --CARE, Catholic Relief Service (CRS), Church World Service (CWS), Seventh Day Adventist World Service (SAWS) -- and indirectly via the U.N. World Food Programme (WFP). The Government of Haiti (GOH) provides institutional support through its network of medical personnel under the Departement de la Sante Publique et de la Population (DSPP), as well as supervision, training and materials through the Division of Nutrition (DON). Within AID, Title II activities are administered by the Office of Private Voluntary Development (OPVD), which recently created a Title II section with two full-time staff and a third person to begin in September.

Current rosters list a total of 519 distribution sites for MCH foods. About half (51%) are described as Nutrition Centers, while 23 percent are located in medical facilities such as dispensaries clinics, health centers and a few hospitals. Cinecs (Centre Integre de Nutrition Education Communautaire) make up one fifth of the sites. These "headstart" programs for five-year olds, all administered

by CARE, prepare children for school performance using nutritional surveillance and skill development. The remaining 6 percent of MCH sites include a variety of settings such as orphanages, churches and schools, although some might be more properly classified as Other Child Feeding. For purposes of this evaluation, Preschool Feeding Programs are considered MCH activities, and the generic term "center" is used to designate any type of distribution site.

Title II food commodities currently distributed in MCH programs include bulgur wheat, ground corn, nonfat dry milk and soybean oil. Soy fortified grains were used in earlier years, but last year the PVOs decided to maximize food quantities and therefore the number of beneficiaries by purchasing the less expensive nonfortified commodities. Some centers receive additional foods such as beans, rice and flour from other agencies.

The objectives of the Title II - MCH Program are as follows:

1. To improve the nutritional status of preschool children and/or pregnant and lactating women.
2. To change nutritional knowledge and practices of the mother.
3. To achieve greater access and utilization of health services.
4. To reduce fertility.
5. To involve women in community development and income generating activities.
6. To strengthen local private or governmental institutions in the delivery of nutrition and health services.
7. To institutionalize a nutrition planning capability at the national level.
8. To stimulate agricultural production.

III METHODS

The study methods included a sample survey of MCH centers, interviews with administrators, and use of official documents.

The project began July 5 and ended August 19, 1983. The first week was devoted to instrument development and recruitment of field interviewers. The author drafted the survey questionnaire based on program objectives and the scope of work statement for the evaluation. In week two, the questionnaire was revised with the assistance of three section chiefs from the DON and three representatives of the PVOs. The instrument was pretested at three sites in the Port-au-Prince area, and this also served as a training exercise for the survey teams. Appropriate revisions were made. The next three weeks were spent collecting the survey data and conducting interviews with officials. Data analysis and report writing took place during the final two weeks of the study.

The survey questionnaire consisted of two parts: one administered to the center responsible, the other to two or three mothers of children enrolled at a center (see attachment I). The responsible questionnaire included 50 items covering five major areas: distribution activities, nutritional surveillance, education components, management operations and community participation. The mothers' questionnaire consisted of 16 items related to aspects of the child's participation, use of food rations, perceived benefits and difficulties encountered.

Thirty sites, representing 6 percent of all MCH centers, was set as the target sample. These were randomly selected, stratifying by PVO in terms of proportionate representation in the total. Anticipating the need for substitutions, an additional 30 "back-up" sites were selected in the same fashion. In the event that primary sites could not be reached, back-up sites in the same area were visited. Also, survey teams were given lists of back-up sites with instructions to include them in addition to primary sites where circumstances of proximity and logistics made it convenient. In this way the final sample included 39 sites, 23 of which were in the original sample (see Table I). It was possible to interview mothers at 23 of the centers. A total of 62 mothers were questioned averaging between 2 and 3 mothers per site.

The timing of the survey posed logistical problems because many people in Haiti take their vacation in the latter part of July. Consequently, a large number of centers were closed, or the responsables were unavailable for interviewing. In some cases back-up sites had to be substituted, while in others, an assistant or another somewhat informed person was questioned. Thus some questionnaires were incomplete where the interviewee could not provide all the desired information. Moreover, transportation arrangements were hampered by the fact that about half of the AID drivers were on vacation at this time, yet the demand for agency vehicles was heavier than usual. For these reasons it is suggested that future evaluation surveys of this nature be planned to take place during other times of the year.

The author conducted semi-structured interviews with various government officials and representatives of PVOs. These included the following persons.

Ms. Beti Astolfi, Representative, CARE
Mr. Jim Fulfer, Director, SAWS
Mr. John Muilenberg, Director, CWS
Ms. Elizabeth Monosiet, Nutritionist, CRS
Mr. Guy Gunubu, Representative, WFP
Dr. Fayla Lamothe, Director, DON
Dr. Serge Turceau, Director General, DSPP
Dr. Eddy Genece, Consultant, MSH

IV DESCRIPTION OF MCH CENTER ACTIVITIES

Centers distribute dry (raw) or wet (cooked) rations, or both. Fourteen centers surveyed give dry rations only, 9 give wet only, and 16 distribute both types of food (Tables II-A and II-B). Most centers distribute dry rations once or twice a month, although a few do so 3 or 4 times a month, and one dispensary gives dry rations 5 days per week (see tables).

All the centers surveyed receive wheat and/or corn, milk and oil for distribution. In addition 16 sites receive beans,

7 vegetables, 5 meat and 2 rice.

The majority of MCH beneficiaries are children. Only 18 centers give food supplements to pregnant women and 7 give to lactating women. Even at these places, the number of maternal recipients is small (2). The number of beneficiaries per center varies widely. In our sample it ranged between 5 and 500 persons with an average of 175 participants (Table I). In all but a few instances, reported number of beneficiaries corresponded closely with PVO programmed numbers on current lists.

Except for the Cinecs, the MCH centers do not keep statistics on the number of beneficiaries in different age groups, and the responsables were unable to provide good estimates of age distribution. Several respondents said that it was difficult to determine the age of children by their height because of long-term growth retardation. Consequently, children up to 15 years of age receive food supplements. All of the responsables were aware, however, that MCH foods are targeted for children 0 - 5 years. In the case of Cinecs, children in the intern program (50 participants) are 5 - 6 years old, and those in the externe, dry distribution program (200 participants) are 1 - 4 years old.

The best data on age composition of participants was obtained from the mothers (Table III). The largest age group was that of children between 1 and 2 years. The 0 - 5 age range encompassed 72 percent of the sample. Twenty-five percent of the participants were over age 5.

Responsables were asked to estimate whether the majority of beneficiaries were either male, female, or equally represented by gender. Five respondents were unable to make a judgement. Seventeen estimated the sex ratio to be about equal. Of those who did note a sex bias, 13 cited a preponderance of girls while only 4 thought boys were more numerous. This finding suggests the possibility

that girls may experience a degree of nutritional disadvantage in this population.

The expected duration of beneficiary enrollment in an MCH center (i.e. time required for nutritional recuperation) is generally 4 - 6 months. In cases of severe malnutrition, and in areas with critical food shortages, the recuperation period may be longer. Nevertheless, there is little justification for prolonged or indefinite enrollment in food supplement programs which can serve only a fraction of the needy at a given time. The survey data indicate that beneficiary enrollment extends well beyond acceptable limits in a large number of cases (Tables IV-A and IV-B). Six centers reported having no norms for length of enrollment; 6 places provide indefinite supplements (i.e. the beneficiary group is more or less permanent); and 10 sites report a normative enrollment of 7 - 12 months. The data provided by the mothers indicate that duration of beneficiaries is actually much longer than that suggested above. One-third of the children of mothers interviewed had been in the program over a year, 18 percent over 2 years.

There appears to be a serious program weakness in the area of ensuring a regular turnover of participants. Several factors may contribute to this problem: inappropriate selection criteria and poor monitoring of participants; food sharing within the family which slows target child progress; and the disincentive to child recuperation posed by the practice of maintaining (family) food supplements as long as the target child remains underweight.

To forestall the latter situation a few centers have adopted a policy of withholding food rations when a child fails to gain weight. In other places, home visits are made to investigate potential causes of the lack of improvement.

Food sharing with other family members, particularly older children, is common. More than three-fourths of responsibles

responded affirmatively to the question about food sharing, and 48 out of 62 mothers acknowledged this practice. In one community where mothers were contacted at home without advance notification, the interviewers observed first-hand three instances of family sharing of rations targeted for a particular child. Given the magnitude of undernutrition in all segments of the population, it is unrealistic to expect that food sharing will not take place. Rather, emphasis should be placed on programmatic components which foster the speedy recuperation of the most needy individuals.

Recommendation: Beneficiary selection criteria need to be more clearly defined and stringently applied (see next section). Some action should be taken in cases of failure to progress, preferably beginning with home visits and individualized instructions, followed by temporary withholding of rations until a measure of nutritional improvement is demonstrated. All centers should be expected to establish normative enrollment periods based on the local situation, including guidelines for action in cases where termination criteria are not met within the target period. In no case should participants be enrolled indefinitely.

V SELECTION AND TERMINATION OF PARTICIPANTS

Selection of program beneficiaries is largely the purview of the responsables. At five centers surveyed (4 in the south, 1 in the central plateau), community health workers (agents de santé) make referrals to the centers, which in these cases are medical dispensaries linked to the Rural Health Delivery System. Three centers reported having auxiliary nutritionists on staff for participant recruitment.

In response to the question about beneficiary selection criteria more than half the centers indicated using criteria based on nutritional status, including evidence of malnutrition, second or third degree malnutrition, underweight or weight loss (Table V). Five centers use family economic situation. The rest of the sites (22%) either

apply no selection criteria (i.e. all who come are accepted), admit participants on a first come, first serve basis, or restrict entrants by age only. Thus, on the basis of selection criteria it seems that in close to a third of cases, little if any effort is made to target the food to the most nutritionally deprived.

In some areas, the available quantities of food commodities may be sufficient to meet the demand of eligible residents, and in fact 36 percent of respondents said they did not have to refuse interested participants. At the same time, however, 70 percent of respondents said there were children in the catchment area who needed help but the parents did not bring them to the center for a variety of reasons. Moreover, 63 percent of mothers interviewed said they knew other mothers who would like to enroll in the center. Responsables reported that a good many do not come because they live too far, are not aware of the program, lack money for transportation, consultation or proper dress, or do not recognize the signs of malnutrition. Thus the weakness here may be inadequate surveillance and referral.

Attrition of enrolled participants was estimated to be low to moderate, most commonly due to illness, distance, family difficulties, pregnancy and child bearing of the mother, or lack of motivation. Some mothers feel that the food ration is too small to make the effort of attendance worthwhile. About 40 percent of responsables said they sometimes expell participants because of disciplinary problems, irregular attendance, failure to gain weight, or to make room for serious cases of malnutrition.

In the case of Cincos, selection of participants is not based on nutritional deprivation. In fact, severly malnourished children, those in poor health or with other handicaps are excluded from participation. Participants are enrolled on a more or less first

come, first serve basis. . The Cinec responsible interviewed by the author said she selected children who evidence potential for successful performance in the program. Many interested families are turned down, including two on the day of our visit. As with other centers which must refuse applicants, the explanation given is lack of room.

Responsables and PVO officials alike are constantly wrestling with the dilemma of choosing between serving larger numbers with smaller rations, or increasing food rations by cutting enrollment. For example, the Corps du Christ nutrition center in Cité Simone recently decided to reduce its bimonthly ration from one pound of grain to three-quarters of a pound, because of the heavy demand of truly malnourished children (half its beneficiaries are infants). Can a ration that small have a significant impact? In areas such as this one where need is acute (La Gonave is another), larger food allotments should be considered.

In many centers, however, more selective distribution practices should be implemented, and in some cases larger rations allocated to a reduced number of needy recipients. The survey showed that the least selective centers tended to be those with large enrollments (more than 200 beneficiaries). The larger programs (Cinecs excluded) also were weak in areas of monitoring, regulation of duration, education and supervision. Thus the question of optimum program size needs careful reconsideration in terms of overall effectiveness.

With regard to selection of beneficiaries, the needs of pregnant and lactating women seem to be given less priority than those of children per se. This issue should also be reexamined in light of the fact that a large proportion of infant malnutrition begins in the early months when breastmilk provides the main source of nourishment. In maternal feeding programs post-partum

supplementation is currently used primarily as an incentive for family planning; lactation alone is not the primary eligibility criterion. Emphasis on maternal nutrition during lactation as well as pregnancy would seem to be an equally important intervention for preventing infant malnutrition.

Recommendation: All MCH centers should be reviewed to assess the adequacy of selection practices, measures taken to recruit the most needy, need for ration-enrollment adjustments, and optimum program size. Eligibility and needs of pregnant and lactating women should be emphasized.

VI NUTRITIONAL SURVEILLANCE

Growth monitoring is an essential component of nutritional intervention. Children are regularly weighed in 84 percent of the centers surveyed. Six centers do not monitor weight, four because they have no scale, two because the enrollment is too large to handle it. Most centers who monitor weight do so on a monthly basis, a few as often as weekly. In all but one case, the weights are recorded on growth charts (Chemin La Santé), or in a notebook. How the weight data is used by supervisory staff varies widely. Only 14 centers document growth on regular report forms (Registre de Surveillance Nutritionnelle, Table VI). In some cases the recording of weight seems to be a perfunctory task without specific guidelines for action, although all responsables said they do discuss child progress with mothers. The prolonged or indefinite enrollment documented for a significant proportion of centers seems to indicate that growth monitoring is inadequately linked to both termination of healthy children and inattention to those who fail to progress.

In the case of Cinecs, nutritional surveillance is carefully designed and documented. The small number of interne participants (approx. 50) allows for close monitoring and personal attention.

Daily feeding of two meals ensures optimal intake by target children. An indepth evaluation of Cinecs is currently underway which will assess quantitatively the nutritional impact on participants. The Cinecs are thought to be generally successful in their educational and developmental components. In terms of Title II objectives, however, the absence of targeting for the nutritionally deprived represents a weakness that should be addressed.

For the typical nutrition center, ideally recruitment of participants should be linked to an ongoing nutritional surveillance system such as that developed for the Rural Health Delivery System (RHDS). At present this system is operative in the southern district only, with plans to expand to northern areas in the next few years. In the RHDS, specially trained community health workers conduct, in addition to basic health screening, education and simple care, regular nutritinnal surveillance activities at the village level. The agents de sante hold monthly weighing sessions for all children at "postes de rassemblement". Underweight children, or those who lose or fail to gain weight over a reasonable period, are referred to a health center with a nutritional supplementation program. Severely malnourished children are referred to intensive recuperation centers where daily cooked food is provided along with structured education for mothers (the CERN model).

Since its inception the RHDS plan has been modified in several ways. The number of CERNS (Community Nutrition Education and Rehabilitation Centers) was first reduced due to low cost effectiveness, then discontinued altogether when external funding ended. At present the health centers provide only supplementary dry feeding, but this too will be phased out for a number of reasons: the dispensaries lack adequate storage facilities and management personnel to adequately implement the feeding programs; the selection process tends to create community dissatisfaction because some families get referred while others do not; and the dry distribution approach does not seem to

appreciably benefit the target child. The new emphasis in the RHDS will be on local level education through food preparation demonstration programs (foyers de demonstration) conducted by the health agent, and on allocation of food to family units (as opposed to individual children) through Food-for-Work by PVOs. The bases for selection of such families have not yet been determined.

The design, implementation and modifications of the RHDS have taken place without coordinated planning with the PVOs. This is unfortunate. The PVO nutrition centers must be linked with an ongoing surveillance system for targeting and regular turnover to take place. The responsible can do some surveillance, and most do make at least some home visits, but the time available for this is limited. Moreover, it is senseless to have government and private programs doing basically the same work yet uncoordinated in planning and implementation. (SAWS has begun some integration with the RHDS in the South).

The phasing out of CERNS and supplementary feeding in the RHDS will undoubtedly affect demand on PVO sponsored feeding programs. And certainly substitution of Food-For-Work to families must be integrated with PVO plans for that category of Title II projects. In the meantime, there seems to be no plans in any sector to support intensive recuperation centers for severely malnourished children. The only mechanism for curative intervention at present is the crisis-oriented "Traitement Rapide" in which the health agent, recognizing a significant number of severe cases in a community (for example, following a drought), requests the district health office to send out a special team for intensive treatment-demonstration lessons. Clearly a great deal of discussion, planning and coordination needs to take place between governmental and private sector nutrition activities. The issue of institutional coordination is addressed more directly in Section XI.

Recommendation: Growth monitoring needs to be directly linked to termination of recovered children as well as intervention in cases of failure to progress. All nutrition centers need to be provided scales and growth charts. Expansion of Cinecs, which already comprise 20% of centers must be judged against alternative programs which select for nutritional need. Identification of needy individuals can be most effectively accomplished through an ongoing surveillance system such as the RHDS. Coordination between PVO and public health sectors is needed.

VII EDUCATIONAL COMPONENTS

In terms of long-term benefits and dietary change, education constitutes the most important component of the nutrition program. Mostly aimed at the mother (Cinecs emphasize child education), instructional activities include a variety of approaches including informal advice to individuals, specialized teaching on home visits, didactic instruction at distribution sites, and "mother's club" type meetings in the demonstration foyers.

The RHDS gives primary emphasis to education as the most cost-effective preventive strategy. The approach currently in use was developed in the "Integrated Rural Health Project" (1975-78) tested in the Petit Goâve area. That pilot project demonstrated long-term benefits in reduced child mortality. In addition to nutrition surveillance activities, the health agents hold demonstration meetings for mothers once or twice a week. The meetings are open to anyone interested, plus mothers of malnourished children are actively recruited. The meetings cover 10 standard lessons on health and nutrition, following the health agent guide book (Gid Edikasyon Pour Travayè Sante). Health agents are given a monthly budget for the purchase of foods to use in the demonstration lessons. Current emphasis is on the preparation of Acamil (AK1000) and oil-sugar enriched milk.

All but three nutrition centers surveyed provide some form of instruction (Table VII). The General subject areas include child health and nutrition, food preparation, oral rehydration, growth monitoring and care of sick children. About half the centers claimed to teach family planning. The dispensaries include some nutrition education within a broad health curriculum including hygiene, vaccination, tuberculosis, parasites and other topics. Although a large number of centers explain the use of growth charts, most places keep the actual charts on the premises because earlier experience with take-home cards did not work well.

The interviews with mothers indicated that food preparation, child care and hygiene, and oral rehydration therapy are indeed taught at a significant number of centers (Table VIII). It appears from these data, however, that growth monitoring and family planning receive very little attention, contrary to what the responsables indicated, or have low interest for mothers.

The regularity, depth of coverage, and level of attendance for the educational sessions is very uneven across centers. Because the survey involved a single visit per center, many of which were not operating on that day, it was not possible to assess the level of effort and consistency of instruction. In the author's judgement, however, about one-third of centers conduct regular, structured teaching sessions. The responsables indicated that mothers have limited interest in learning things; they come mainly for the food and sit through lectures if that is required. Where attendance is voluntary, there tends to be an initially high interest followed by rapid attrition.

The RHDS approach also faces the problem of attrition in the Foyers de Demonstration. An initial group of 50 mothers may quickly dwindle to 20 or less within the first few meetings. Now the health agents are trying out incentive activities to keep the mothers coming (to monthly weighing as well as demonstrations) such as providing Vitamin A and iron, and deworming children.

Mothers are very interested in learning handicrafts such as sewing, embroidery, crochet and other practical skills (see Section X). These activities could serve as a powerful incentive for participation in health education components.

Very often the instruction in food preparation focuses primarily on how to use the food supplement commodities. Some basic instruction of this nature is necessary, but it is more important to emphasize use of locally produced food rather than imported commodities which may not be available in future years. With the Title II corn meal, this is not a problem, but bulgur, oil and milk are not available locally. (For example, the Foyers de Demonstration are currently promoting oil enriched milk as a nutritional recuperation food).

Recommendation: PVOs should review the educational activities of their centers to assess level of effort and participation, followed by measures to strengthen this component where needed. A requirement for the establishment of new distribution centers should be the inclusion of a well-developed education plan to be handled by a trained individual. Instruction emphasizing preparations dependent on imported food should be discouraged. Instruction on growth monitoring and family planning should be emphasized.

VIII THE MOTHERS' PERSPECTIVES

When asked why they originally brought their children to the nutrition center, about half the mothers said because of illness or poor health. Others said it was because of signs of malnutrition. Fourteen (22%) mothers mentioned the need for food, and 8 (13%) said they wanted to learn things. Most significant about these results is the role of child illness in triggering utilization. This would seem to place the dispensaries in a key position for referring appropriate patients to a nutrition center.

Of the 62 mothers interviewed, only a minority (24%) said they had difficulty getting to the center. The majority of respondents walk less than an hour to reach the site (Table X). All but five mothers said their children had no problems eating the food. When asked whether in their own opinion, their child had made progress, 20 (33%) said yes, much progress, 30(48%) said moderate progress, and 12 (19%) said no progress at all. Children of these 12 mothers who perceived no progress had been enrolled in a center for an average of 5 months.

Table XI depicts the major program benefits perceived by mothers. Improved health and nutrition was mentioned most frequently. Other priority benefits included the food supplement itself, improved child development and cognitive skills, acquisition of medicines, and increased child self-care. Five mothers said they saw no benefits in the program.

Forty-nine (49%) of the mothers said that they had changed their cooking habits since coming to the center. These women said they now prepare more often beans (sauce pois) with corn (maïs moulu) or rice, vegetables (especially carrots and greens) and meat when it is available.

Despite the fact that the interview situation predisposed the mothers to respond in a positive manner, it appears that they are generally pleased with the program.

IX STAFF TRAINING, SUPERVISION AND NEEDS

Nine of the responsables at surveyed centers are men. Sixteen out of the 39 directors hold jobs in addition to running the nutrition program. They are employed as nurses, auxiliaries, doctors, teachers, agricultural agents, community development leaders and various kinds of administrators. Seven responsables have children of their own enrolled in the center; 13 centers have assistants with enrolled children. A center operates with an

average of two assistants, who are usually paid, but in some cases parents of enrolled children volunteer their help. Twenty-eight of the responsables are paid for directing the center, 9 are not (this information was unavailable for two). Of those who indicated the source of their salaries, the breakdown was by DSPP (12), Education Nationale (5), PVO (5), Mission group (3) and Dept. of Agriculture (1).

Formal training received by the responsables is depicted in Table XII. Those with medical backgrounds usually had no additional training in nutrition. About one-third of the responsible had attended a nutrition seminar. Others were trained as teachers or school directors. When asked what additional training they would need to better run the center, respondents noted training in nutrition and assessment, first aid, disease prevention, hygiene and program management (Table XIII.).

The PVOs and the DON have devoted considerable effort in the past year to develop and improve their training programs for nutrition center staff. SAWS has a newly constructed training facility with up-to-date materials, a carefully designed curriculum, and a full-time training supervisor. The other PVCs conduct training in collaboration and with the assistance of DON staff. The DON has given priority to training, devoting much time to planning seminars and developing curricula which are subsequently made available to the PVOs. The DON training activities are funded by AID via the DSPP, the required paperwork and inevitable bureaucratic complications make scheduling of seminars a difficult task.

Operational needs perceived by responsables include more food, building renovation and furnishing, educational materials, pure drinking water and trained personnel (Table XIV).

About two-thirds of responsables demonstrated a fair understanding of program objectives (Table XV).

With regard to supervision, responsables were asked how long it had been since the center was visited by officials from the DSPP or the Division d'Hygiene Familiale. Seven had been visited within the past month, 3 had been visited 2 - 3 months before, 8 were visited 6 - 9 months ago, 4 a year ago, 2 two years ago, 7 four years ago, and 4 had never been visited. These data and other evidence indicate that supervision of nutrition centers is irregular and inadequate.

PVO inspectors make periodic visits, but typical inspections involve mainly the control of inventories, storage conditions, transport mechanisms and beneficiary-ration allocation. Programmatic components receive little, if any, attention. Exceptions to this rule include CWS whose nutrition supervisor closely monitors its centers at La Gonave, and the Cincos which are supervised by a full-time staff person at Care. The nutritionist at CRS is also in regular contact with its southern centers other than the clinics tied in with the RHDS. SAWS monitors closely the eight places it considers to be "organized MCH centers", but the other 60 are minimally supervised. The most obvious cases of poor control encountered in the survey were nutrition centers sponsored by Care (3), which has the largest program but a small supervisory staff.

Recommendation: Roughly a third of responsables need basic training in nutritional assessment and intervention. Others could benefit from, and desire to receive, retraining in nutrition and related areas. Given the strength of the DCN and PVOs in this area, and with the support of AID, training needs can be satisfactorily met. On the other hand, supervision and control of nutrition centers is seriously inadequate. While some segments of PVO programs are well supervised, a large proportion is in need of more frequent

visits for control of programmatic components. PVOs should assess their own staff capabilities to meet this need and where necessary, expand supervisory personnel and/or negotiate supervisory services from district level DSPP personnel.

X COMMUNITY INTEGRATION

Overall, community participation in nutrition center activities was low. Apart from medical services, few centers provide activities that might involve people other than beneficiaries. Where general interest activities take place these include arts and crafts classes, prayer meetings, gardening clubs, literacy classes, and linkages with multipurpose community development projects. Local institutions which participate in center activities primarily involve churches, dispensaries, schools and community councils. When asked what additional kinds of activities participants would like to find at the centers, the responsables most often said medical services, followed by sewing classes, craft or trade schools, primary schools, horticulture projects and family recreation. "Artisanat" activities seem to be a particularly effective way to get mothers interested in the center.

The integration of horticulture demonstration projects and home visits by agricultural extension agents with nutritional surveillance has been tried in the RHDS. The rationale is that long-term improvement in the nutritional quality of rural diets requires changes in the types of food produced by farm families for their own consumption. Thirty extension agents were seconded or hired from the Department of Agriculture by the DON to fulfill this purpose. The extension program has had limited success in the south, and, mainly because the cost would be excessive, it will not be expanded to other areas as part of the RHDS. In place of this, the DON has chosen a "community intervention" approach that emphasizes food conservation and promotion of Acamil as well as the traditional extension emphasis on small animal husbandry and consumption crop production.

Sixteen (47%) of the survey centers reported that an extension agent has been known to visit families in the area. It appears that overall, the nutrition program has had very limited impact on agricultural practices.

Recommendation: Community interest may be encouraged by the provision of artisanal activities and medical services.

XI GOVERNMENT AND INSTITUTIONAL ARRANGEMENTS

Governmental involvement in Title II MCH programs at present includes assistance with staff training, provision of materials and supplies, and some supervision and salary support of center personnel. Specific kinds of assistance reported most frequently by responsables were the provision of scales, growth charts, contraceptive supplies, educational materials and training seminars (Table XVI).

AID, PVO and DSPP officials have all expressed a desire for increased government participation in the MCH program. More specifically, AID would encourage a larger role in nation-wide nutritional planning and major responsibility for training and supervision. The PVOs would like more supplies, made available easily and directly to the organization. Apart from that, some volags would prefer that the government have no other role in their operations, including training and supervision. Other PVOs would like to relinquish some responsibilities for monitoring and training to the DSPP. For its part, the DON and DSPP indicate willingness to adopt an expanded role in all of these areas provided that the collaborating agencies agree to follow the norms and guidelines established by the DON, and to accept a certain degree of regulation and governmental control.

Although coordination has increased in recent years, the PVOs have continued to operate more or less independently of one another and of the COH. Within the broad guidelines for Title II MCH activities, one finds considerable variation in how particular agencies design and implement their programs. There is strong resistance to taking on an additional administrative layer of government regulation when program operations are already bureaucratically constrained by parent agency and AID superstructures.

Despite the understandable desire for agency autonomy, increased coordination will be necessary to strengthen the MCH program in currently weak areas. Most importantly, targeting of resources (both at the level of site and beneficiary selection) should be linked to nutritional surveillance. Coordination also would be beneficial in areas of planning, establishment of norms, and staff supervision, monitoring and training.

There are organizational and administrative obstacles to coordination. Within AID, management is project-specific, and there is little intersectorial communication and planning. The offices for Public Health and Private Voluntary Development have minimal interaction despite the overlapping nature of the programs they administer. There exists no regular forum for PVO representatives to exchange ideas with health care delivery planners.

The DSPP is based on a decentralized structure comprised of four departments and twelve districts. Rural health care delivery, including nutritional surveillance, is managed at the district level by an appointed district health officer. In contrast, PVO programs are centrally administered from Port-au-Prince. The volags do not have a comparable district level infrastructure to provide linkages at that level. In the past, PVO requests have been directed to the national DSPP offices, whose officials refer the matter to the district level, where the volags are less inclined and prepared to handle it.

At the central level, there already exists a multilateral structure for coordination of nutritional activities in Haiti. This DON-based Committee for the Coordination of Food Aid is composed of a DON nutritionist, a representative from the DSPP External Assistance Section, and three PVO representatives (including the AID Title II Manager) chosen at an organizational meeting. This committee is currently working on a food aid policy manual that will include standards and guidelines for program operation. Such a document could serve as a focus for discussion

and initial action in moving toward greater government-agency cooperation.

Everyone recognizes the many difficulties and hidden agendas that impede the type of mutual cooperation that is essential to make a national health and nutrition program work. Despite this recognition, limiting factors cannot be used to justify the status quo. After 25 years of Title II MCH programs in Haiti, little if any improvement has been achieved in the nutritional status of its children (4). Moreover, numerous studies document limited success and in some cases detrimental effects of supplementary feeding programs for mothers and children in the developing world (5). Faced with such a compelling challenge, those involved in food aid must devise new and innovative means to make the program meet its objectives. The alternative is to do away entirely with supplementary feeding.

Recommendation: PVOs should work more closely with the DSPP and the DCN in the areas of planning and standardization of program guidelines. The location of new MCH centers should be decided in consultation with district health officers to avoid duplication of effort and to maximize coverage of underserved communities. A starting point for such interaction can be the DON Committee for the Coordination of Food Aid. In turn, the GOH should assume greater responsibility for national nutrition planning, training, supervision and materials, including the development of administrative staff to support this role.

Where possible, AID should facilitate government-PVO coordination, beginning with regularly scheduled (at least quarterly) meetings between public health and private development sectors. Conceivable these would include representatives of the Title II section, the PVOs, the RHDS, MSH and the DCN. Priority should be given to the issue of integrating rural nutritional surveillance with MCH supplementary food programs. In some areas it may be possible for center responsables to be trained to function in a capacity analogous to the agent de sante. Strategies for improving referral networks and district-level supervision and monitoring should be explored.

FOOTNOTES

1. King Joyce M., AID Role in Haiti's Mothercraft Network: From 1976, toward the Future, 1979. Catherine J. Fort, Cost-effectiveness of Mothercraft and Other Alternatives for Haiti, 1979.
2. One exception to this is the state operated clinic at Thomazeau, where food is distributed exclusively to pregnant women and mothers who practice family planning. Lactating women per se are not eligible.
3. a. Demisseau - Prior to visiting this site the author contacted the Care inspector for information. He told me that Demisseau had not picked up its allotment for three months at the area depot in Kenscoff managed by Père Sicot. He did not know why this was the case and said perhaps I could find this out during my visit. He also informed me that another satellite center of Kenscoff (Viard), which had been selected in the survey sample, had been recently suspended, but did not indicate why. At Demisseau the responsible said they needed the food very much, but that for 3 months it had been held up at Kenscoff for unexplained reasons. He also informed us that prior to that only 5 children were distributed food, yet the center is programmed to feed 100 beneficiaries.
b. Carrefour Shada - The day we visited this center, the responsible was not present. The assistant who lives on-site told us she was not preparing the cooked food that day because of a death in the family. She said that the center normally cooks for 300 people every day (the site is programmed for a daily net distribution for 300 children), that a truck delivers the food daily for reasons of security and limited storage capability, and that people of all ages partake in the food -- parents, older siblings, anyone who cares to eat. About 20 people from the neighborhood, who had gathered to watch us, verified what she said. Teenagers and adults said they ate there regularly and liked the food very much -- rice and beans, mais moulu, bulgur and milk. One of the mothers interviewed, however, said that the center was a sham, no food or education.

Two weeks later, on the way to visit a site in Thomazeau, we stopped in Carrefour Shada and there were no signs of food preparation. The same assistant told us that the responsible would be coming in later with the food to cook. We told her we would stop in on our way back from Thomazeau to take some pictures. When we returned, two pots of ground corn and milk were cooking and tables set to serve about 30 people. The responsible had not been able to come, we were told, because she had a sore on her foot, but somehow the ground corn had

arrived. Some of the children there told my assistant that the meal had been prepared for our benefit only.

c. Anse a Foleur - The survey team was informed in Anse a Foleur by the former responsible and neighborhood women that the center had been closed for 2 years since its building was destroyed. There were no signs of the receipt of Title II foods, but a DSPP official visits monthly and the Care warehouse books in Port-de-Paix indicate that delivery has not been stopped.

d. Bonneau - According to the most up-to-date list of centers prepared by Care for use in this survey, food is distributed at a centre de nutrition in Bonneau. The Care warehouse manager in Port-de-Paix, however, directed the team to the Dispensaire St. Joseph. This site was visited and the responsible described their MCH program. She said she had lived there for two years and had only recently heard that there was supposed to be another nutrition center in Bonneau. On the way back to the blazer, the team was stopped by Mr. Louisfen Louis, who said he was the director of the nutrition center they were looking for. The center turned out to be his house, and his wife, the responsible. She was unable to answer any questions about the center's program. The house showed no evidence of serving 50 children cooked food six days a week (as programmed by Care and verified by Louis). -- no cooking facilities, no plates, no tables, just one basically empty room. Louis said that most of the children programmed live within a five minute walk of the center, yet when asked to see a mother he said it would be impossible to reach one. Louis requested money from AID for a new building, clothing and toys for the children in his center. He also requested that the number of children programmed be returned to the original 90, which was cut to 50 after inspection by AID's Jan Ulrich.

e. Two other sites from Care's Port-de-Paix list could not be reached. No one in the area had ever heard of Bonal, and the warehouse manager did not have Savane Môle on his list or know of its location. Neither the warehouse staff or the manager could assist the survey team in giving directions to any of the sites visited in the Port-de-Paix area.

4. The National Nutrition Survey conducted in 1978 by the Division of Nutrition with the assistance of the Centers for Disease Control found high levels of protein-calorie malnutrition. Almost three-quarters of Haitian children under five years of age are malnourished, with almost 30 percent suffering moderate or severe malnutrition. (2^o or 3^o Gomez classification). These rates are comparable to those found in the mid-1950's by Jelliffe and Jelliffe (The Nutritional Status of Haitian Children, Acta Tropical, Vol. 18, 1961).

5. Beaton, George H. and Hossein Ghassemi. Supplementary Feeding Programs for Young Children in Developing Countries. The American Journal of Clinical Nutrition 35:864-916, 1982.
Jackson, Tony. Against the Grain. London:Oxfam, 1979.

TABLE I. SITES VISITED IN MCH EVALUATION SURVEY

TYPE OF SITE	NAME	LOCALITY	REGION	PVO	BENEFICIARIES
CINEC	de L'Ecole Normale	Martissant	West	CARE	51
Centre de Nutrition	Afè Neg Coumbite	Demisseau	West	CARE	5
Centre de Nutrition	Immaculée Conception	Carrefour Shada	West	CARE	300
Centre de Nutrition	Notre Dame du Rosaire	Mahotièrè	West	CARE	500
Centre de Nutrition	Cité Drouillard	Port-au-Prince	West	SAWS	200
Centre de Nutrition	Corps du Christ (Cité Simone)	Port-au-Prince	West	SAWS	200
Centre de Nutrition	Aide aux Enfants	Port-au-Prince	West	SAWS	84
Clinique	Christianville Foundation	Gressier	West	CWS	200
Orphelinat	Le Bon Berger	Cote Plage	West	CWS	34
Centre de Nutrition	Sans Fil	Port-au-Prince	West	CRS	450
Centre de Sante	-	Thomazeau	West	WFP	100
CINEC	-	La Croix	Artibonite	CARE	250
CINEC	-	Mapou Rollin	Artibonite	CARE	250
Centre de Sante	-	Sous Canal	Artibonite	SAWS	20
Centre de Nutrition	-	Carries	Artibonite	CWS	150
Centre de Nutrition	Mission Mennonite	Savane Haleine	Central	CWS	140
Centre de Nutrition	Mission Mennonite	Paloate	Central	CWS	120
		(Maissade)			
Centre de Nutrition	-	Nan Mangot	Gonave	CWS	239
CINEC	-	Campêche	North	CARE	250
CINEC	-	Chabaud (Limbe)	North	CARE	250
CINEC	-	Bas Limbe	North	CARE	250
CINEC	-	Dubourg	North	CARE	254

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<u>TYPE OF SITE</u>	<u>NAME</u>	<u>LOCALITY</u>	<u>REGION</u>	<u>PVO</u>	<u>BENEFICIARIES</u>
Centre de Nutrition	de l'Hôpital	Cap Haitien	North	WFP	43
Hopital Justien	-	Cap Haitien	North	WFP	200
Dispensaire	St. Suzanne	Cap Haitien	North	CARE	100
Dispensaire	Ambroise Holly	Trou du Nord	North	CARE	100
Centre de Nutrition	-	Belle Place	Northwest	CARE	100
Dispensaire	St. Joseph	Bonneau	Northwest	CARE	30
Centre de Nutrition	-	Couyote	Northwest	CARE	57
Centre de Nutrition	-	Aviation	Northwest	CARE	100
Centre de Nutrition	-	La Coupe	Northwest	CARE	51
Centre de Nutrition	-	Bonneau	Northwest	CARE	50
Centre de Nutrition	L'Eglise Chretien	Thiotte	Southeast	SAWS	20
Centre de Nutrition	-	Fond Parisien	Southeast	CARE	30
Dispensaire	-	Béroud	South	CRS	250
Dispensaire	St. Joseph	Mazenod	South	CRS	375
Centre de Nutrition	de l'Hôpital	Torbeck	South	CRS	376
Dispensaire	St. Antoine	Aquin	South	CRS	100
		Vieux Bourg	South	CRS	120

TABLE II - A. DRY FOOD RATIONS PER BENEFICIARY

Center ^{a/}	Bulgur (lbs)	Corn (lbs)	Milk (lbs)	Oil (ltr)	Frequency per month
C.N. Drouillard	1	1	1	.33	2
C.N. Simone	.75	.75	.75	.25	2
C.N. Demisseau	1	1	1	.33	4
Cinec La Crois	2	2	3.5	1	1
Cinec Mapou Rol.	5	5	5	.33	1
Disp. St. Suzanne	.5	.75	1	.17	20
Cinec Dubourg	5	5	10	1	4
Disp. Ambroise H.	2	3	3	1	8
Hop. Justien	5	5	5	1	1
Cinec Chabaud	3.25	3.75	7	-	1
Cinec Campêche	6	10	12	1	1
Disp. Sous Canal	5	5	5	1	1
C.N. Shada	2.5	2.5	2.5	.5	4
C.N. Bérourd	5	5	2.5	.33	2
Disp. Mazenod	5	5	3	.33	1
Disp. Torbeck	4	4	2	.25	2
C.N. Aquin	-	5	5	-	1
Disp. Vieux Bourg	4	4	3	.33	1
C.N. Paloate	2	-	2	.17	4
C.N. Fond Parisien	3.75	3.75	3.75	.25	1
C.N. Thiotte	10	10	10	1	2
C.N. Savane Haleine	3	-	2	.50	2
C.N. Carries	5	-	5	.33	4
C.N. Nan Mangot	1.5	-	1	.25	4
C.N. Mahotièrre	2.5	2.5	2.5	1	4
C.N. Aide Enfants	10	10	10	2	2
Disp. Thomazeau:	7	7	7	.5	2

^{a/} Quantities unavailable for C.N. Sans Fil, Disp. St. Joseph.

TABLE II - B COOKED FOOD RATIONS PER BENEFICIARY / DAY

Center ^{a/}	Bulgur (lbs)	Corn (lbs)	Milk (lbs)	Oil (ltr)	Frequency per week
Cinec Martissant	.30	.30	.30	.04	5
C.N. Drouillard	.40	.40	.40	-	4
C.N. Simone	.20	.20	.20	-	4
C.N. Demisseau	.60	.60	.25	-	1
Cinec La Croix	.25	-	.15	.01	5
Cinec Mapou Rollin	.20	.20	.20	?	5
Cinec Dubourg	.25	.25	.20	.02	5
C.N. Hop. Justien ^{b/}	1.16	1.16	1.16	.05	5
Cinec Chabaud	.30	.30	.20	.01	5
Cinec Campeche	.24	.24	.25	-	5
C.N. Paloate	.26	.26	.27	-	5
C.N. Fond Parisien	.33	.33	-	-	5
C.N. Savane Haleine	.25	.25	.07	-	5
C.N. Belle Place	.18	.18	.22	.02	6
C.N. Aviation	.25	.25	.29	.01	6
C.N. La Coupe	.20	-	.24	.01	6
C.N. Bonneau	.20	.20	.20	?	6

^{a/} Quantities unavailable for Cinec Bas Limbe, C.N. Sans Fil, C.N. Carrefour Shada, C.N. Carries, Dispensaire St. Joseph, C.N. Couyoute.

^{b/} Hospital feeding, hence high ration

TABLE III. AGE OF BENEFICIARIES AS REPORTED BY MOTHERS

Age range	No. of respondents (%)*	
Less than 1 year	15	(15)
1 to 2 years	22	(22)
2 to 3 years	13	(13)
3 to 4 years	8	(08)
4 to 5 years	14	(14)
5 to 6 years	9	(09)
More than 6 years	17	(17)
	TOTAL: 98	

* Percentages do not add up to 100 due to rounding.

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TABLE IV - A. EXPECTED DURATION OF BENEFICIARY ENROLLMENT*

Length of time	No. of centers (%)	
Variable, no norm	6	(15)
Indefinite period	6	(15)
2 - 3 months	5	(13)
4 - 6 months	9	(23)
7 - 9 months	2	(05)
10 - 12 months	8	(21)
Not applicable	3	(08)
Total:	39	100

* As reported by responsables, not entirely consistent with reports from mothers (see table below).

TABLE IV - B. DURATION OF BENEFICIARY ENROLLMENT REPORTED BY MOTHERS

Length of time	No. of respondents (%)	
Less than 6 months	31	(60)
7 to 12 months	11	(18)
12 to 24 months	9	(14)
More than 24 months	11	(18)
Total:	62	100

Up until time of interview.

TABLE V. BENEFICIARY SELECTION CRITERIA

Criteria	No. of centers (%)	
Evidence of malnutrition	10	(26)
2nd or 3rd degree malnutrition	7	(18)
Underweight or weight loss	6	(15)
Family economic situation	5	(13)
First come, first serve	3	(08)
Within age range (Cinec)	2	(05)
No selection, all accepted	6	(15)

TABLE VI. DOCUMENTATION FORMS USED AT CENTERS

Type of form	No. of centers
Rapport de l'Inventaire et la Distribution des Aliments	33
Feuille d'Inscription	24
Rapport Mensuel de Supplementation Nutritionnelle	20
Controle de Distribution de la Vitamine A	21
Visite à Domicile	20
Registre de Surveillance Nutritionnelle	14
Other forms (activities of dispensary, vaccinations, prenatal care, agents de santé, matrones).	12

TABLE VII. SUBJECT AREAS TAUGHT AT CENTERS

Subjects	No. of Centers
Child Nutrition	36
Child Health	34
Food Preparation	32
Oral rehydration	30
Growth monitoring	28
Care of sick children	25
Family pl ;	20
Use of growth chart	17
Hygiene	16
Vaccination	7
Illness prevention	3
Other	10
(latrines, breastfeeding, importance of Vitamin A, tuberculosis, intestinal parasites, pure water)	

TABLE VIII. THINGS LEARNED BY MOTHERS AT CENTERS

Subject area	No. of respondents
Food preparation and nutrition	34
Child care and hygiene	20
Oral rehydration therapy	12
Embroidery	8
Crafts	8
Sewing	7
Home management	6
Songs	4
Principles of nutrition	4
Family planning	2
Nothing learned	12

TABLE IX. REASONS GIVEN BY MOTHERS FOR BRINGING CHILD TO A CENTER *

Reason	No. of respondents (%)	
Illness or poor health	32	(52)
Signs of malnutrition	9	(14)
Need for food	14	(22)
To learn things	8	(13)
Inability to eat	4	(06)
Learn proper behavior	2	(03)
Need for vaccination	2	(03)

* Some respondents gave more than one reason.

TABLE X. TRAVEL TIME TO CENTER REPORTED BY MOTHERS

Time	No. of respondents (%)	
Less than 15 minutes	26	(41)
15 to 30 minutes	10	(16)
30 to 60 minutes	10	(16)
1 to 2 hours	8	(13)
More than 2 hours	9	(14)
Total:	62	(100)

TABLE XI. PROGRAM BENEFITS SEEN BY MOTHERS

Benefits	No. of Respondents
Improved health and nutrition	30
Food Supplement	15
Child Development and cognitive skills	18
Acquire medicines	7
Child Learns self-care and hygiene	5
Illness treated	4
Food preparation skills	3
Improved Child behavior	3
Improved spirit	2
No benefits seen	5

TABLE XII. TYPE OF TRAINING OF RESPONSABLES

Type	No. of respondents
Nutrition seminar*	14
Medical specialty (doctor, nurse, auxilliary)	11
Normal or preschool training	5
School director	2
No training	3
Information unavailable	4

* 4 at PVCs, 3 at BON, 1 at District Level, 6 unspecified.

TABLE XIII. INFORMATION AND TRAINING NEEDS PERCEIVED BY RESPONSABLES

Need areas	No. of Respondents
Nutrition and assessment	5
First aid	4
Retraining	3
Disease prevention	2
Hygiene	2
Trained assistant	2
Give vaccinations	2
Program management	2

TABLE XIV. OPERATIONAL NEEDS SEEN BY RESPONSABLES

Need areas	No. of Respondents
More food	6
Building renovation and furnishing	6
Educational material	4
Pure drinking water	4
Food storage facilities	4
Trained personnel	3
Greater food variety	2
Road reparations	2
Medicines	2
Money	2
Other	10
(soap, kitchen utensils, charcoal, electricity, latrines, clothes, toys, family planning supplies, growth charts, typewriter).	

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TABLE XV. STAFF UNDERSTANDING OF PROGRAM OBJECTIVES

Perceived aims	No. of Respondents
Improve nutrition	24
Improve health	14
Improve growth and energy	11
Improve school performance and mental development	9
Nutrition education for parents	5
Saves lives	3
Promote social skills	3
Community and national development	3
Teach self-care	3
Economic aid to families	2
Incentive for prenatal care and family planning	1

TABLE XVI. TYPES OF ASSISTANCE PROVIDED BY THE DSPP

Assistance	No. of Centers
Scales	20
Growth charts	18
Contraceptive supplies	17
Training of personnel	17
Educational materials	15
Vitamin A	6
Salaries of personnel paid	5
Vaccines	4
Medicines	3
Other (iron, height measure)	2

ATTACHMENT

Survey Instruments

MCH EVALUATION QUESTIONNAIRE

Date de la visite _____

Nom du centre _____ Région _____

Nom de la responsable _____

Questions sur les activités de distribution

1. Depi kombyin tan nou gin program manje icit-la? _____

2. Kombyin moun sant-la bay manje icit-la? _____

Kombyin ti moun? _____

Kombyin fam ansint? _____

Kombyin nouris? _____

3. Ti moun ki laj nou bay manje nan sant-la?

Mwin de 1 an _____ 4 - 5 _____

1 - 3 an _____ Plis ke 5 an _____

4. Dapre ou, pi fòr ti moun ki recevwa manje se ou byin ti fiy ou byin ti gason?

ti fiy _____ ti gason _____

5. Eske nou bay manje-a kru nan sant-la? oui _____ non _____

5b. Kombyin fwa pa mwa ou byin pa seminn nou bay manje-a kru?

_____ fwa pa (seminn mwa)

5c. Ki kantite de shak manje-a kru nou bay ti moun-yo?

Ki manje

Ki kantite

6. Eske kantite-la toujou minn? oui _____ non _____

7. Eske nou kwit manje-a nan sant-la pou bay ti moun icit? oui _____
non _____

7b. Kombyin fwa pa seminn ti moun-yo manje icit-la? _____

7c. Ki kantite de shak manje-a kwit nou bay ti moun-yo?

Ki manje

Ki kantite

_____	_____
_____	_____
_____	_____
_____	_____

8. Eske kantite-yo toujou minm? oui _____ non _____

9. Eske nou bay manje fam ansinc? oui _____ non _____

9b. Kombyin fwa pa seminn ou byin pa mwa nou bay manje fam ansint?

_____ fwa pa (seminn mwa)

9c. Ki kantite de shak manje-a nou bay fam ansint?

Ki manje

Ki kantite

_____	_____
_____	_____
_____	_____
_____	_____

9d. Eske kantite-a toujou minm? oui _____ non _____

10. Eske nou bay manje nouris? oui _____ non _____

10b. Kombyin fwa pa seminn ou byin pa mwa nou bay manje nouris?

_____ fwa pa (seminn mwa)

10c. Ki kantite de shak manje nou bay nouris?

_____	_____
_____	_____
_____	_____
_____	_____

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- 10d. Eske kantite-a toujou minm? oui _____ non _____
11. Normalman, konbyin tan ti moun-yo dwe pase nan sant-la? _____
12. Eske gin ampil ti moun ki kite program avan tan sa-a rive?
kèk _____ moite _____ ampil _____
- 12b. Dapre ou, sou shak 50 ti moun nou ginyin nan sant-la, kombyin kapab kite program avan lè? _____
13. Dapre ou, pou ki sa yo kite program-nan? _____

14. Eske sa konn rive ke ou prann desisyon voye ti moun ale avan lè fixe rive? oui _____ non _____
- 14b. Pou ki sa? _____

15. Moun ki rete pi lwin, kombyin tan yo mashe pou rive nan sant-la?

- 15b. Moun ki rete pi pre, kombyin tan yo mashe. _____
- 15c. Pi fò moun-yo, eske yo rete pi lwin ou byin pi pre?
pi lwin _____ pi pre _____
16. Ki moun ki shwasi ti moun ki pou swiv nan sant-la? _____
17. Sou ki base ti moun sa-yo shwasi? _____

18. Eske gin ti moun ki ta bezwin vini min nou oblije refise yo?
oui _____ non _____
19. Sa ou di manman yo pou esplike pouki sa pitit-yo pa kapab jwin manje nan sant-la?

20. Eske ou fe efò pou inskri ti moun pi grav? oui _____ non _____
21. Kombyin moun ki la jodi-a? Ti moun _____
Fan ansint _____ Nouris _____

Questions sur la surveillance nutritionnelle

22. Eske gin manman ki gin ti moun ki fe malnitrasyon e ki pa vini nan sant-la? oui _____ non _____
23. Pouki sa yo pa vini? _____

24. Ti moun ki nan sant kounye-a, eske ou prann pwa yo? oui _____ non _____
- 24b. Kombyin fwa pa mwa ou peze yo? _____
- 24c. Eske ou make pwa ti moun sou grafik "Chemin La Sante"?
oui _____ non _____
25. Eske ou pale avek manman sou progres pitit-li? oui _____ non _____
26. Eske ou fe visit lakay moun ki nan program-nan? oui _____ non _____
27. Lè gin ti moun nan sant-la ki malad, kote ou voye yo? _____

28. Apre manman vini prann manje pou pitit-yo, eske yo konn bay manje-a lèt moun lakay-yo? oui _____ non _____
29. Ki lèt kalite manje manman-yo ta vle jwin nan sant-la pou pitit-yo?

Questions sur les activités éducatives

30. Eske ou fe edikasyon manman nan sant-la? oui _____ non _____
31. Sou ki matiyè ou fe edikasyon?
_____ lasante ti moun
_____ nitrisyon ti moun
_____ preparasyon manje
_____ siveyans kwasans ti moun
_____ fason pou sevi ak grafik "Chemin La Sante"
_____ swinje ti moun malad
_____ preparasyon serom pou diare
_____ planing
_____ lèt matiyè

32. Eske Depateman La Sante konn ede ou nan program-nan? oui _____ non _____

_____ formasyon nou	_____ balans
_____ materyel d'edikasyon	_____ materyel planing
_____ grafik "Chemin La Sante"	_____ lòt bagay

33. Lè manman vini nan sant-la, ki konsey yo mande nou? _____

Questions sur la direction du centre

34. Di mwin tout fòm rapòr nou sevi nan sant-la.

_____ Feuille d'Inscription
_____ Rapport Mensuel de Supplémentation Nutritionnelle
_____ Registre de Surveillance Nutritionnelle
_____ Contrôle de Distribution de la Vitamine A
_____ Rapport de l'Inventaire et la Distribution des Aliments
_____ Visite à Domicile
_____ Autre Rapport

35. Kombyin asistan kap travay nan sant-la ave'ou kounye-a? _____

36. Ki kalite fomasyon ou te recevoi pou aprann dirije sant-la? _____

36b. Ki kote? _____

37. Eske ou recevoi yon salè pou travay ou ap fe nan sant-la? oui _____
non _____ Ki les ki pay sa-a? _____

38. Eske asistan-yo te gin fomasyon tou? oui _____ non _____

39. Kombyin tan depi moun Departman La Sante visite sant-la? _____

39b. Ki les ki te vini? _____

40. Ki jan de ranseyman ou fomasyon ou ta bezwin an plis? _____

41. Dapre ou-minm, pouki sa nou bay ti moun ak manman manje nan sant-la?

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42. Ki profi ti moun-yo tire nan program-nan? _____

43. (Responsable) Eske ou gin lòt travay ou fe en deyò sant-la? oui _____

non _____ Ki jan? _____

44. Eske ou gin pitit pa ou nan sant-la kounye-a? oui _____ non _____

45. Eske asistan gin pitit nan sant-la? oui _____ non _____

Questions sur les relations communautaires

46. Eske gin lòt group non katie ki interese nan travay n'ap fe? (pa examp, legliz, lekòl, dispensè, etc) _____

47. Ki sa ou ta bezwin pou dirije sant-la bi byin? _____

48. Eske gin ajan agrikol ki konn visite famiy nan katie-a? oui _____

non _____

49. Apa de manje ak edikasyon, ki lòt sevis sant-la fe pou katie-a?

50. Ki jan lòt aktivite moun zonn-la ta rinmin jwin nan sant-la?

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Questions Pour les Mères aux Centres

Nom du centre _____ Mère no. _____

1. Kombyin ti moun ou ginyin nan sant-la? _____
2. Ki laj yo ginyin? _____
3. Pouki sa ou te minnin pitit ou nan sant-la? _____

4. Kepi dombyin tan ou ap vini nan sant-la? _____
5. Eske pitit ou manje byin sa yo bay pou li icit-la? oui _____ non _____
6. Apa de manje yo bay ou nan sant-la, ki lèt kalite manje ou bay pitit ou?

7. (Pour les enfants qui mangent au centre): Jou pitit ou manje nan sant-la, eske ou bay li lèt manje lakay ou ? oui _____ non _____
8. Dapre ou-minm, eske pitit ou fe progres depi l'ap vini manje icit?
_____ li pa fe progres
_____ li fe progres
_____ li fe ampil progres
9. Ki sa ou oue sant-la fe de bon pou pitit ou? _____

10. Kombyin tan ou mashe pou rive isit-la? _____
11. Eske ou gin difikilte pou vini isit avek pitit ou? oui _____ non _____
11b. Ki kalite difikilte? _____
12. Ki sa yo montre ou isit-la? Ki sa ou aprann isit-la?

13. Eske ou konnin lèt manman ki pa nan sant-la min ki ta rinmin vini avek pitit yo isit-la? oui _____ non _____

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