PD-AAT-248
44838

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Haiti

3. PROJECT NUMBER: 521-0159

4. BUREAU/OFFICE: LAC — 05

5. PROJECT TITLE (maximum 40 characters): Urban Health and Community Development II

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 04 DD 30 YY 89

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 84 B. Quarter 3 C. Final FY 88

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 84 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	100	350	450	383	1,717	2,100
(Grant)	(100)	(350)	(450)	(383)	(1,717)	(2,100)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.				160	145	305
Other U.S. 2.						
Host Country					452	452
Other Donor(s)				634	633	1,267
TOTALS	100	350	450	1,177	2,947	4,124

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1)						2,100		2,100	
(2)									
(3)									
(4)									
TOTALS				-0-		2,100		2,100	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510 | 920 | 700 | 800

11. SECONDARY PURPOSE CODE: 720

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BU	NUTR	PVON			
B. Amount						

13. PROJECT PURPOSE (maximum 480 characters)

Assist the Medico-Social Complex of Cité Simone (CMSCS) to:

1. improve health services outreach;
2. strengthen its overall community development program; and
3. achieve greater financial self-sufficiency.

14. SCHEDULED EVALUATIONS
Interim MM 05 YY 86 | MM YY
Final MM 01 YY 89

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☒ 941 ☐ Local ☐ Other (Specify): _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

Approved: D. K. Shannon, CONT

17. APPROVED BY
Signature: Harlan H. Hobgood
Title: Director, USAID/Haiti
Date Signed: MM 05 DD 25 YY 89

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

AID 1330-4 (8-79)

PROJECT AUTHORIZATION

Name of Recipient : Complexe Médico-Social de la Cité Simone

Name of Project : Urban Health/Community Development II

Number of Project : 521-0159

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Urban Health/Community Development II Project for the Complexe Médico-Social de la Cité Simone. The Project involves planned obligations of not-to-exceed Two Million One Hundred Thousand United States Dollars ($2,100,000) in grant funds over a five-year period effective May 1, 1984, subject to the availability of funds, to help in financing foreign exchange and local currency costs for the Project.

2. The Project («Project») consists of (a) support to the Recipient to carry out a program of urban community development directed at improving the health and socio-economic status of the population of the Cité Simone area of Port-au-Prince and (b) support to increase the Recipient's institutional capacity for greater long-term financial self-reliance.

3. The Cooperative Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to such terms and conditions as A.I.D. may deem appropriate.

Harlan H. Hobgood
Director
USAID/Haiti

Date 5/25/84

Clearances:

PHO : PSGibson
DRE : BBurnett
RCO : FObey
CONT : DShannon 5/25/84
D/DIR : PDichter

PROJECT PAPER

URBAN HEALTH AND COMMUNITY DEVELOPMENT - PHASE II

521-0159

May 1984

Haiti

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* Illustrations used or adapted from: Etude d'Améliorations Physiques des Cités Simone, Jean-Claude, Linthau, Brooklyn et Wharf. Cooperative Housing Foundation, Port-au-Prince, 1981.

** Scheyer, S., et al. "Evaluation and Plan for Future Activities of the Cité Simone Complex". University Research Corp., Washington, D.C., 1984.

I. BACKGROUND

A. The Project Setting: Cité Simone

Throughout the Latin American/Caribbean Region as well as much of the world, an unprecedented urbanization has occurred which has placed tremendous pressures on already inadequate public and commercial sectors for employment, services and shelter.1/

Urbanization in Haiti, like that of other Latin American and Caribbean countries, results from perceptions of urban advantages and adverse economic and social conditions in rural areas including inadequate rural non-farm employment, lack of schools, social infrastructure and the need for access to markets. As severe soil erosion and pressure on arable land grow, there is added incentive for peasants to migrate. During the period from 1960 to 1982, Haiti's urban population grew from 12.2% to 26%.2/

According to the preliminary 1982 national census, the Port-au-Prince metropolitan area now contains 720,000 people, including large slums where living conditions are frequently worse than those of rural areas.2/

In many ways, the Cité Simone area typifies the kind of urban squatter settlements mushrooming throughout Latin America and much of the developing world. Its population of nearly 100,000 is more than 10% of the entire capital. The people live almost entirely in hundreds of one-story shacks crowded over less than one square mile of low lying land fronted by the Bay of Port-au-Prince. Flooding occurs frequently, both from the sea and from the mountains inland. The mean elevation of the area is .3 meters, so that drainage and sanitation are constant problems. Socio-economic surveys indicate that inhabitants are largely illiterate and have very low per-capita incomes. Some residents, rather recent migrants, maintain close ties with their places of origin. Others are of second and third generation city dwellers, born and raised in Cité Simone or other marginal slum neighborhoods.

Initial settlement in the Cité Simone area began in 1958 with the construction of homes for 52 families. The first major influx occurred in the summer of 1966, when a fire destroyed much of La Saline district near the port and many of its victims settled in the Cité Simone neighborhood now known as "Brooklyn". Following this fire, more or less continual migration into Cité Simone has occurred, as shown in Table I-1.3/

1/ Latin American/Caribbean Regional Strategy and Plan; U.S. AID Document, 1983

2/ Resultats Préliminaires du Recensement Général, Septembre 1982. Institut Haitien de Statistiques et d'Informatique.

3/ Etude d'Amélioration Physique des Cités Simone, Jean-Claude, Linthau Brooklyn, Boston et Wharf: Cooperative Housing Foundation, 1981.

In 1974, The Centre Haitiano-Arabe, a private, non-profit group of Haitians of Middle Eastern descent, opened a small dispensary, funded solely from local sources, to provide free health care to Cité Simone residents. Gradually, they combined their efforts with those of other groups working to improve the living conditions in the area, starting with Foster Parents' Plan and the Salesian priests. Then, in July 1980, the Centre Haitiano-Arabe incorporated under Haitian law with a Roman Catholic congregation, the Sisters of the Charity of St. Vincent de Paul, forming the Complexe Medico-Social de la Cité Simone (CMSCS) to provide health and social services to residents of the area.

The area now commonly referred to as "Cité Simone" actually includes three zones divided into nine neighborhoods. The Cité Simone Medico-Social Complex (CMSCS) conducted a census of the entire area during the summer of 1983 and recorded the population of each neighborhood as follows:

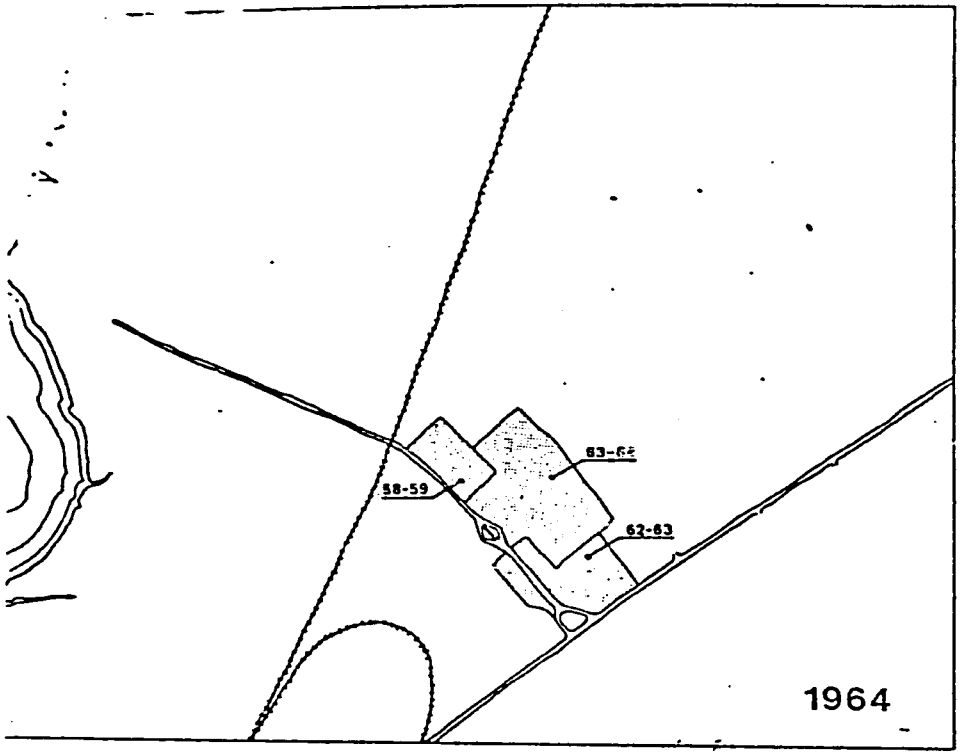
1983 Cité Simone Census[1/]

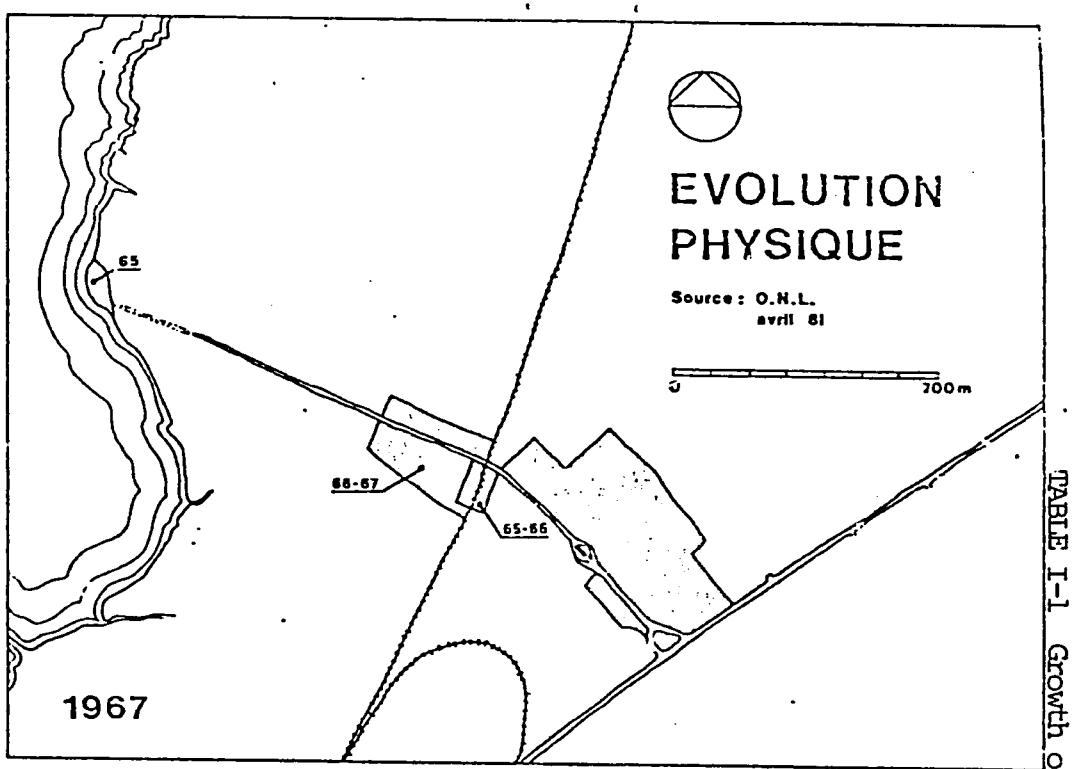
Zone	Neighborhood		Population	
Boston	Boston		23,905	
	PSC Pele		6,935	
	Trois Bébés		10,982	
		Subtotal:		41,822
Brooklyn	Brooklyn		17,978	
	Wharf		2,685	
	Linthau		5,030	
		Subtotal:		25,503
Cité Jean-Claude	Cité Jean-Claude		2,645	
	IIeme Cité Simone		8,944	
	Cité Bennett		1,310	
	Unclassified		1,967	
		Subtotal:		14,866
		Grand Total		82,191

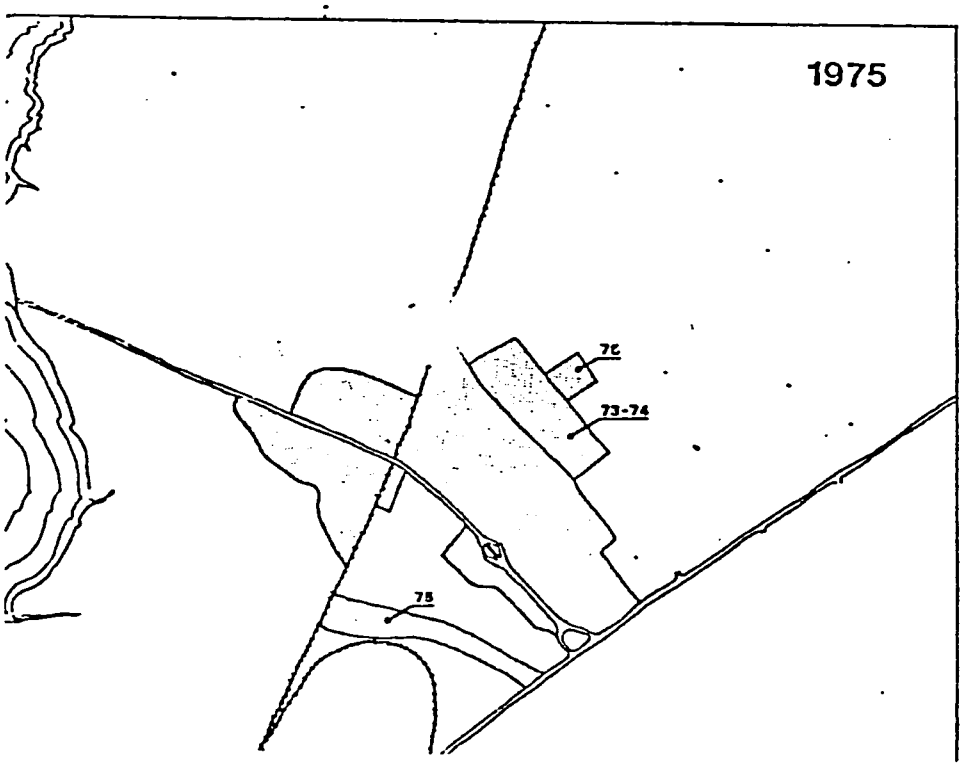
Since the Census was conducted by CMSCS community health workers who normally work in Boston and Brooklyn, coverage in Cité Jean Claude is viewed as a significant undercount. In addition, the health workers did not adequately record houses visited where population could not be verified. The Brooklyn population is generally considered to be more than 30,000 people. Despite the area's severe environmental and socio-economic problems, residents of Cité

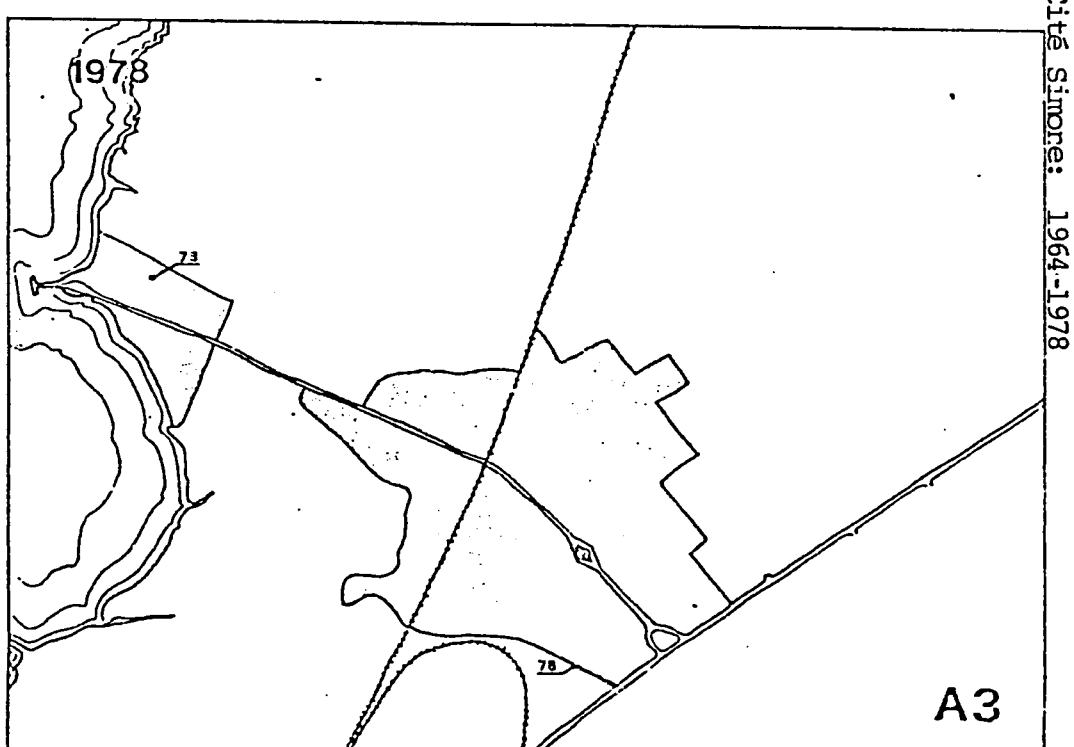
1/ "Report on the Health Status of Residents of Cité Simone". CMSCS Report, December 1983.

TABLE I-1 Growth of Cité Simone: 1964-1978









A3

Simone have and are benefiting from services and opportunities rarely available in other urban slum neighborhoods. In two zones there are well-organized and active community councils. More importantly, all residents have access to the comprehensive primary health care infrastructure and a variety of social services which the Complexe Medico-Social de la Cité Simone provides.

B. AID Assistance in Cité Simone: The Complexe Médico Social (CMSCS)

1. USAID Support for CMSCS

USAID/Haiti's involvement with the Complex began in 1980, when it initiated a four-year grant of $1,243,000 to support overall CMSCS program goals and operating expenses for various health, education, and vocational training programs and administration. AID's objectives in providing this OPG were to address the needs of the urban poor, to strengthen an indigenous private institution and to gather data and experience upon which to build future urban oriented projects. During this 4 year period, much has been learned and accomplished. CMSCS activities have had significant and measurable positive effects on the population; the health activities have significantly contributed to lower infant mortality rates; the social education and training components have grown and expanded.

The obvious dedication and effectiveness with which CMSCS management is tackling some of the world's worst health and social problems, however, has enabled the Complex to identify other critical research issues and problems which should be addressed. The USAID/Haiti Mission and AID/W, through centrally-funded projects, have supported some of these initiatives. Thus, in addition to the OPG, three additional AID-sponsored projects are now on-going:

(a) Through the S&T Health Office's PRICOR project, CMSCS is studying the effects of alternative methods for training Traditional Birth Attendants (TBA's) on maternal mortality and pregnancy outcome. The project compares two training techniques, the standard 20-lesson course which the Family Hygiene and Nutrition Division of the Ministry of Health now offers and a shorter, three-session intensive course developed at CMSCS. The research project began in July 1983 and will extend through March 85 with an approved budget of $78,000.

(b) The S&T/Population Office of Research is funding a one year study of the most effective means for using trained Traditional Birth Attendants (TBA's) to promote family planning in an urban setting. This one-year grant to the Haitian Arab Center of $58,000 also offers family planning counseling and contraceptive services. TBA's are directly involved in recruitment of women for family planning services and provide acceptor follow-up in their neighborhoods.

(c) For some time both USAID and CMSCS have been concerned by the serious dependency of CMSCS on foreign donations which can vary enormously from year

to year. As a first step toward a partial solution, USAID, with CBI/ESF funds, authorized the Cité Simone Income Generation Project (USAID/Haiti Cooperative Agreement No. 521-0169 Input No. 11), to establish a profitable manufacturing enterprise that will contribute a part of its net profits to direct budgetary support of CMSCS health and social service programs. Witherspoon International Cooperation, a non-profit business counsulting firm, was engaged to prepare a product feasibility study and work with the CMSCS to establish a "for profit" organization to support the Complex's activities.

3. Other Sources of Support

CMSCS also receives numerous other donations from international and indigenous private voluntary organizations, including: Foster Parents' Plan, the Haitian-Arabe Center, Oxfam, the Sisters of Charity, Friends of Children, War Against Hunger, and Misereor. The Canadian government, through Canadian International Development Assistance (CIDA), began providing modest support to CMSCS in 1982, increased this funding in 1983 and now promises to continue its assistance in the future. Other foreign governments which contribute modestly to the Complex include the French, Belgian and Dutch. CARE, Church World Services and the European Economic Community (EEC) contribute food commodities for CMSCS schools and nutritional centers. The Government of Haiti provides in-kind support in the form of salaries for DSPP personnel assigned to work in CMSCS facilities and electricity free of charge. CMSCS obtains additional income from the sale of handicrafts, baked goods and other products made at various CMSCS facilities and from modest user fees charged at clinics and health facilities.

4. Description of Current CMSCS Services

a. Primary Health Care Services

CMSCS health care now includes public health programs; child nutrition surveillance and rehabilitation, immunizations for mothers and children and pre-natal and maternity services, training and supervision for Traditional Birth Attendants; control of endemic diseases, particularly tuberculosis; and emergency treatment and general hospitalization. In September 1983, the Haitian-Arab Center also opened a family planning center in cooperation with the Haitian Baptist Convention.

The CMSCS health care system focuses on the priority problems presenting the highest risk to the population served, e.g., malnutrition, diarrhea and communicable diseases. Its active approach attempts to seek out, identify, register and follow all families and individuals living in Cité Simone. CMSCS has trained a network of 100 community agents called "Collaborators", who provide a liaison between CMSCS programs and their target population. These collaborators are a crucial aspect of this "active" approach and help strengthen the close working relationship that exists between the Complex and the community it serves. Residents of Cité Simone nominate and select the collaborators from among themselves. Each collaborator then follows a standard CMSCS training program supplemented with continuing education

sessions. The Complexe then assigns each collaborator responsibility for coverage of a specific area of Cité Simone with 100-150 families. CMSCS directors estimate that each collaborator can provide adequate coverage for 1,000 individuals, thus they anticipate the present 100-person cadre has a total potential outreach of 100,000 residents.

b. Human Resources Development Activities

The human resources development programs of CMSCS have evolved through concern for two underserved groups: (1) mothers of severely malnourished children, providing them the skills to better care for their families, initially mainly health education and home economics, then expanding to marketable skills, e.g., sewing, handicrafts and commercial cooking; and (2) adolescents, (both students and dropouts), providing extra-curricular activities and remedial education for young people who had little schooling, few job opportunities and "nothing to do." In 1979, CMSCS directors initiated a third focus for these efforts: adult men, providing vocational training, literacy classes, and job placement services.

This evolution has been significant since for each of these three target groups a separate facility now exists which provides a wide variety of educational, vocational and social services tailored to meet the needs and aspirations of its clientele. Thus, the Brooklyn Mothercraft Center gives some 250 mothers of severely malnourished children the chance to learn sewing and/or handicrafts while their children are being rehabilitated, and the Boston Cultural Center provides remedial education and handicrafts skills training for approximately 300 adolescents. For the third group, the Brooklyn Centre Familial provides a vocational/technical school where up to 75 men train for jobs in local industry.

C. Impact of CMSCS Programs

With the combined resources of its many donors, and particularly the strong AID support, CMSCS programs have touched and improved the lives of Cité Simone residents increasingly over the past four years. The major differences are noted below.

1. Health Status Improved

A 1981 baseline study 1/ of more than 500 area women with children under 18 months old provides a framework for assessing the impact of CMSCS health programs. In 1983, CMSCS performed a census of the entire Cité Simone area, using a protocol which recorded many of the same indicators as the baseline survey. A comparison of the results of the two studies provides an indication of the impact of CMSCS programs.

1/ Berggren, et al, The Baseline Survey of Nutritional Status and Health of Mothers and Children in Cité Simone, 1981.

a. Infant Mortality Reduced

The most significant difference between the two studies is the change in infant mortality rates. The infant mortality rate during the first year of life dropped from an estimated 184 in 1978-80 (based on retrospective data) to 84 in the Brooklyn area according to the 1982-83 census report. Although causal relationships for this substantial decline cannot be established, a number of program-related factors may have contributed to this reduction in infant mortality:

(1) An increased percentage of infants in the 0-1 age bracket and children in the 1-5 age bracket in Cité Simone have been monitored for nutritional status.

(2) The successful integration of Traditional Birth Attendants (TBA's) into the CMSCS program resulted in expanded prenatal coverage which now includes 71% of all pregnant women.

(3) Deaths from neo-natal tetanus have been all but eliminated from Cité Simone; in 1982, only 2 were reported, and none in 1983. In 1979, there were an estimated 35 deaths due to neo-natal tetanus in Cité Simone. By 1983, at least 55% of all pregnant women had received complete immunization protection and 85% received partial protection against the disease prior to delivery.

In summary, although a cause and effect relationship cannot be clearly established between reductions in infant mortality and the Complex's program, the high level of compliance that exists and has been verified in using its services suggests that they have had an impact on the overall infant mortality rate in Cité Simone.

b. Family Planning Coverage Increased

According to CMSCS records, 3,286 babies were born either at home or in the hospital in Cité Simone during 1982, for a crude birth rate of 40 births per 1,000 population. Although family planning services have been available at the Isaie Jeanty Maternity in Chancerelles, no FP services were locally available in Cité Simone until the Haitian Arab Foundation opened a family planning center in September 1983. The Cité Simone census found that 10.5 percent of women in union and not pregnant were practicing family planning, which is similar to contraceptive use in other urban areas. In the first three months of operation, over 800 women visited the new FP center and more than 75% began using a contraceptive. Family planning coverage increased during this brief period from 10.5% of women at risk of pregnancy to an estimated 15.6%. If this rate of acceptance and subsequent use continues, within one year more than 25% of women at risk will be contracepting, with excellent prospects for still higher increases in later years. Moreover, experience gained in Cité Simone will have substantial value in other urban slums.

2. Economic Status Improved

While the human resources development activities have not been so carefully documented, these programs have made substantial progress in meeting human social and economic needs, including the following:

a. Job Placements Increased

The Centre Familial in Brooklyn now provides evening classes for Cité Simone men in electronics, tailoring (including the use of industrial sewing machines), welding and literacy, as well as job placement services for all residents and is still evolving to meet the needs of male residents. The center started the six-month courses in July 1979; as of January 1983, it had 311 graduates (127 in electronics; 114 in sewing; 70 in welding). Seventy-seven graduates from the center continued their vocational training at the Institut National de Formation Professionelle (INFP), which offers a nationally recognized degree. Most importantly, the Centre Familial's administrator made job placements in local business and industry for over 400 persons, more than 200 of whom had completed the CMSCS training program. In fact, fully 64% of the center's graduates actually found jobs.

b. Individual Earnings Raised

At the Brooklyn Mothercraft Center, some 250 women are enrolled to learn sewing and make a variety of handicraft items for sale at the center. While the Complex, through various donor groups, heavily subsidizes most of these programs, a bakery cooperative, which opened in September 1982, now functions as a fully self-supporting operation with 8 women employees who earn as much as $120 each per month. Furthermore, the Cooperative indirectly supports an additional 20 families who buy patés and other baked products wholesale from the bakery, and then sell them retail throughout Cité Simone.

D. Summary: Problems to be Addressed in the New Project

The data collected and analyzed to date indicates that CSMCS has accomplished a great deal with the AID OPG support from 1980-84 in providing essential services to the residents of Cité Simone. At the same time, AID and CMSCS have gained invaluable experience and data on delivering health and human services to an urban slum population of nearly 100,000. CMSCS health interventions have had significant and measureably positive effects on the population; its community development, education and training activities, which have grown and expanded, are now at a point requiring a somewhat more professional orientation for the future.

It is clear, however, that CMSCS cannot maintain its present level of basic services and activities without continued AID support for a minimum five-year period. Despite the growing contributions of other donors, AID funding under Urban Health and Community Development I (521-0136) provided approximately 45% of the CMSCS operating budget. Under this new project, CMSCS leadership plans

to implement a number of self-financing schemes to significantly increase its financial self-sufficiency. While these schemes are developing, CMSCS needs continued AID funding to: (1) help sustain existing services and (2) implement several targeted, short-term interventions designed to improve service delivery which will not significantly increase the recurrent costs to CMSCS.

This project will assist the CMSCS to expand its institutional capacity, its self-sufficiency and its ability to respond to the needs of Cité Simone residents. The primary thrust of the project will be to assist CMSCS improve the organization and management of its programs so they are results-oriented and within its institutional means to support financially. This will be accomplished by:

1. More effective targeting of resources in order to achieve more cost-effective use of available support.

2. Developing and expanding the management information system (MIS) of the Complex to facilitate the design, testing and evaluation of innovative, cost-effective service delivery alternatives and to control costs.

3. Improving the CMSCS institutional capacity for vocational and job training.

4. Expanding research and evaluation activities.

5. Exploring opportunities for expanding revenues through formal fund raising and increased user payments.

II. RATIONALE/STRATEGY

A. Project Conformity with AID Strategies

1. LAC Regional Strategy

The activities funded under this project conform directly with and are, to a large extent, aimed at achieving the two major objectives of the LAC Health Strategy, i.e., (1) to reduce mortality among infants and children under 5 years of age, and (2) to reduce disease and disability in the labor force. Further, productive employment opportunities will be provided to members of the Cité Simone labor force. The project also responds to the LAC Regional Strategy emphasis on providing improved services to rapidly growing urban population centers and its focus on supporting Private Voluntary Organizations, particularly indigenous ones.

2. USAID/Haiti Country Development Strategy Statement

With this project, USAID/Haiti is supporting the development of an indigenous private institution offering comprehensive Primary Health Care and Human Resource Development services which will continue to move toward greater self-sufficiency, primarily through income-generating activities. The project thereby also conforms with USAID/Haiti country and sectoral development strategies for health, human resources development and strengthening private sector institutions.

B. Project Conformity with GOH/DSPP Health Objectives

In December 1982, the Haitian Ministry of Public Health and Population (DSPP) launched a major new policy for improving the health status of the Haitian people. An essential feature of this document was its official acknowledgment of the important contribution private voluntary agencies in Haiti can make in providing targeted health care services. The Ministry further suggested that PVO's:

1. Participate in national health programs, e.g., immunization, nutrition surveillance, family planning.

2. Take responsibility for all or part of basic health services in a particular area.

3. Train and supervise their medical and para-medical staff in accordance with DSPP norms.

4. Provide health data and service statistics in accordance with DSPP norms.

CMSCS comprehensive primary health activities comply fully with these recommendations. CMSCS directors have consistently emphasized activities to resolve those problems which represent the highest risk to their target population. Moreover, CMSCS leadership is making the maximum efforts possible

to inform other groups about its activities so that its successful interventions may be replicated in both the private and public sectors. Thus far, as discussed below, CMSCS has had significant impact on the design of other primary health care activities.

Private Sector: In the private voluntary sector, CMSCS provides an important, successful and cost-effective service delivery model for other PVO's in the country. This model is already being replicated in both urban and rural areas. For example, in the nearby La Saline area, the Michèle B. Duvalier Foundation Pediatrics Clinic has trained a corps of 10 community agents whose role is based on that of the Cité Simone collaborator. In 1983, the Haitian Association Private Health Organizations (AOPS) adapted the CMSCS Primary Health Care model, with some modifications, for use in the rural community health programs of its member groups. This protocol for PHC service delivery relies on trained community agents to first register and then maintain close, regular follow-up on all families in the area the health center serves. This enables the institution to provide broader coverage and more effectively monitor the health status of the population in its service area. In addition, AOPS has arranged with CMSCS to train physicians for these rural community health programs.

Public Sector: The CMSCS success in obtaining wide health service coverage in Cité Simone has stimulated DSPP efforts to expand its effective PHC coverage in rural areas. CMSCS leaders also work closely with the DSPP in formal and informal arrangements to record and extend the service model. CMSCS directors maintain good relationships and regularly exchange the results of their research, as well as technical, epidemiological and program information, with appropriate DSPP counterparts. Finally, the Complexe is currently negotiating with the State University of Haiti Medical School to serve as a field placement site for medical students.

C. Project Strategy Issues

1. Revolving Capital Loan Fund

A major project objective is to improve the economic status, and particularly the per-capita income, of Cité Simone residents. To achieve this objective, the CMSCS Long-Term Plan and the PID proposed that the Complex use up to $100,000 in AID project funds for establishing a revolving capital loan fund to finance small businesses or cooperatives.

After careful review of AID regulations for financing intermediate credit institutions, we have determined that substantial expansion of the Complex management systems must occur before initiating such an effort; AID/Washington also voiced reservations concerning this activity. However, the need for a modest source of small business capital remains. We have discussed the AID regulations and management requirements and have jointly agreed to use these project funds to finance studies and Technanical Assistance to strengthen the management capacity of the Complex, particularly CMSCS training components to develop the administrative and financial structures needed to establish and

manage revolving funds. In the long run, these can initiate real improvements in the economic status of residents and improve CMSCS self-financing capabilities.

2. Environmental Sanitation Component

In developing the project we considered whether this project should also attempt significant improvement in environmental sanitation, e.g., drainage, or at a minimum, undertake a major survey or feasibility study to determine appropriate infrastructure interventions.

Long term, significant improvements in the living conditions and health status of residents of Cité Simone clearly require substantial investments of money and materials for infrastructure development, drainage, sanitation, improved recreation and housing; however, several other donor groups, notably the German Government, BID and the World Bank, working through the GOH Public Housing Office (EPPLS), have already made substantial funding commitments to undertake large-scale improvements in the area. Any further infrastructure development activities should include collaboration with these institutions. Detailed, fully-developed plans already exist for primary, secondary and tertiary roads and drainage canals, water resources development, low-cost housing and latrines for the entire Cité Simone area 1/. Because of these other donor commitments and because of the enormous costs involved, we have concluded that these critical interventions lie beyond the scope and financing of the present project as well as the institutional mandate of CMSCS.

3. Proliferation of Activities

In this project, the Complexe will undertake a number of new development activities in addition to its existing programs. The question of how CMSCS can avoid administrative and/or financial overextension as it expands its role to assist in the economic development of the Cité Simone area has been posed. While the Administrative Feasibility Analysis discusses this issue in greater detail, we wish to clarify two points at the outset:

First, all of the "new" activities under the proposed project (e.g., operations research; strengthened job training) have evolved from existing CMSCS activities and are included in the CMSCS Long-Term Plan. Furthermore, AID's previous project with the Complexe has also supported community development, income generation and vocational training activities as well as Primary Health Care programs.

1/ Etude d'amélioration Physique des Cités Simone, Jean-Claude, Linthau, Brooklyn et Wharf. Cooperative Housing Foundation, 1981.
Plan d'Aménagement Directeur de la Zone Nord-Ouest de Port-au-Prince (Cité Simone et Quartiers Avoisinants. GOH Office National du Logement, 1982.

Second, the proposed "new" programs actually add few recurrent costs to the CMSCS budget. Most of these interventions require initial investments to strengthen existing programs, such as developing new curricula for vocational training instructors already in place. Activities that do require additional investment on a recurrent basis are those which CMSCS leaders expect will strengthen cost effective program management or help generate greater self-sufficiency.

D. Project Rationale

In 1980, USAID/Haiti recognized that a purely rural development emphasis in Haiti would not be sufficient to offset the already serious problems of rural-to-urban migration. The Mission thus supported the Urban Health/Community Development Project in an effort to respond to the essential needs of a portion of Haiti's urban poor in a substantial and significant way. Evalution activities undertaken in the past year indicate clearly that this effort has led to significant improvements in the health status and living standards of its target population, the residents of Cité Simone.

USAID/Haiti's initial OPG to CMSCS provided funds to support the institution's overall health and social service programs, particularly operating expenses for new and expanded facilities. Although it provided some funds for technical assistance and research activities, the primary objectives consisted of expanding service delivery and increasing health coverage. The Long-Term Plan (Annex 6 a) which CMSCS directors recently prepared calls for a different orientation. This project, based substantially on the CMSCS plan, consolidates, rather than adding, services, emphasizing the following major objectives: (1) strengthening the health delivery system by modifying it in ways which place more emphasis on interventions of greatest need and impact; (2) developing the human resources development component by placing much greater priority on assisting CMSCS residents to develop marketable skills in order to respond to opportunities for small-scale income generation and the local job market; and (3) significantly improving the capacity of the Complexe to finance these activities from internal resources.

With reference to the third point above, CMSCS now depends on foreign donor support for funding most of its service programs. Two major disadvantages result from this dependence: 1) great year-to-year fluctuation in funding often occurs, making multi-year planning difficult, if not impossible and 2) reduced institutional autonomy results as the Grantee must conform to some extent more to the Grantor's policies and priorities, rather than setting its own objectives. In their long-term plan, CMSCS leaders have set this policy: to freeze or sustain all programs at existing levels until stable, on-going sources of finance can be identified. In order to find these additional resources, CMSCS directors are strongly committed to developing autonomous means of supporting the costs of their service programs. In their Long-Term Plan, they have laid the groundwork for a number of self-financing mechanisms, which are discussed in detail in the pages which follow.

III. PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of this project is to improve the health, socio-economic status and standard of living of Cité Simone residents. AID project support aims at achieving this goal through direct budgetary assistance to the Complexe Medico-Social de la Cité Simone (CMSCS), an indigenous private voluntary organization (IPVO) incorporated by groups of individuals who have assumed responsibility for providing the nearly 100,000 residents of this urban slum with comprehensive Primary Health Care and a wide variety of Community Development support activities for nearly a decade.

Achievement of the project goal will be measured in terms of improvements in health status, longer life expectancy and increased per capita income among members of the target population.

The project purposes are to strengthen the institutional capacity of CMSCS to: 1) deliver health services; 2) develop human resources and 3) achieve a significantly higher level of financial self-sufficiency within the Life of Project period.

Project activities are described within the general headings of "Health", "Human Resources Development", and "Self-Financing" activities. On the broadest possible level, however, this project seeks to improve the organization and management of all CMSCS programs and to develop innovative and results-oriented responses to the needs of the target population that lie within the institution's financial means to support.

B. Anticipated End of Project Status

As part of their Long-Term Plan, CMSCS directors have clearly defined objectives and indicators for all planned project interventions. By the project completion date, they expect to achieve the following:

1. Improve Institutional Management Capacity

The LOP budget provides $16,000 to purchase new computer hardware and software and $65,000 for technical assistance in project evaluation. By the end of the project, CMSCS will have an automated, program-based budgeting and planning system completely in place and be able to use information from this system for planning program implementation and evaluation of the three major project areas.

2. Improve CMSCS Primary Health Care Activities

New interventions in Primary Health Care will require nearly 20% ($217,000) of planned project health funds. These funds are expected to assist CMSCS administrators to achieve the following:

Infant Mortality Rates throughout Cité Simone will continue to decline; CMSCS technicians state they hope to achieve an IMR of 55 throughout the area within the Life of Project period. In order to achieve this objective, they will increase immunization coverage against diptheria, pertussus and tetanus (DPT), polio, tuberculosis and measles to 90% of all children under 5, implement further interventions to decrease malnutrition of infants and children and motivate more women, especially mothers, to take advantage of CMSCS services. With $95,000 in project funds, CMSCS Primary Health Care technicians will also implement a major public education and community outreach campaign to promote breastfeeding which should impact significantly on planned reductions in infant and child mortality and morbidity, as discussed in detail in the "Project Activities" Section of the PP.

CMSCS health professionals plan further to define and identify high risk populations, including children within the 0-5 age group, and design and implement, within the resources available, the most cost-effective means to further reduce infant and child mortality. In order to achieve this objective, they will use up to $120,000 in AID project money to establish an Operations Research Fund to test and document cost-effective alternatives for health service delivery. The research will focus on priority problems presenting the highest health risk to the most vulnerable population. CMSCS researchers view Operational Research activities primarily as a means to improve services, but this type of research can also provide an essential incentive to attract and hold qualified, talented Haitian staff. In addition, as CMSCS further develops its abilities to design and carry out such research, opportunities for research grant and foundation support will increase susbtantially.

3. Professionalize Human Resources Development Activities.

The project budget allocates $137,000 for new initiatives in Human Resources Development/Training activities. CMSCS plans to use these funds to accomplish the following objectives by the end of the project:

By upgrading CMSCS technical skills training programs and providing task-specific, competancy-based training relevant to actual needs in local business and industry, marketable skills among the population will have increased. CMSCS will use $75,000 in project training funds for short-term technical assistance, training materials and equipment to design improved curricula and prepare the 22 vocational training instructors to teach new job training courses, on subjects selected through direct contact with local industrial leaders. Some project funds will also be used to provide industrial equipment for trainees. By the end of the project, CMSCS leaders plan that at least 2,500 persons will have received job skills training, with an estimated 1,500 job placements made.

These project inputs in the CMSCS education and job training components will strengthen the organization and management of skills training, the documentation of these activities and their evaluation. CMSCS will hire an

Employment Training Coordinator to organize and manage these efforts to upgrade the quality of its training facilities. Technical Assistance in educational technology will be used to establish results-oriented criteria for evaluation of training activities and to improve methods used for assessing and monitoring student progress in all educational and training facilities, for men, women and adolescents.

CMSCS directors will integrate the service statistics from these programs into the expanding automated Management Information System. They plan to establish more clearly defined, quantifiable goals for monitoring educational/training progress and for evaluating their effectiveness. The Employment Training Coordinator will be able to use this information to improve skills training development and assessment. Adult and child literacy rates throughout the population will be known and efforts organized to increase them.

4. Significantly Increase CMSCS Self-Financing Capacity

Fully 75% of the LOP budget supports on-going CMSCS operating costs, paying for basic salaries and purchasing commodities needed to maintain the existing level of services. The objective of self-financing efforts, then, consists in significantly improving the capacity of CMSCS to finance the costs of its programs in Primary Health Care, Human Resources and Community Development with concurrent shifting of AID funds away from operating costs and into new, more experimental activities. The project budget provides up to $30,000 for Technical Assistance to identify and implement practical cost-recovery schemes which include testing the feasibility of raising user fees in health service programs and increasing sales of handicrafts made at CMSCS facilities.

By the end of the project, CMSCS will also have established a US-based, tax-exempt organization (the "Friends of Cité Simone") to receive and transfer donations for it from private individuals and groups. The LOP Budget provides $25,000 for developing fund-raising materials and strategies.

Finally, the LOP Budget includes a $100,000/Contingency Fund for the primary objective of allowing CMSCS to identify and develop these and other self-financing activities, as discussed in greater detail in the following section of the Project Paper.

C. Project Activities

The project consists of a five-year $2.1 million Cooperative Agreement between USAID/Haiti and the Complexe Médico-Social de la Cité Simone. CMSCS will use AID project resources to finance selected institutional operating expenses and new program interventions in (1) management and administration (2) health services delivery (3) human resources development and (4) self-financing activities as summarized in the summary budget provided in Table III-1 below and discussed in detail in the project Financial Plan.

TABLE III - 1

AID PLANNED INPUT FOR LOP
(Operating Expenses and Program Additions)
(in US $000)

	Year 1*	Year 2	Year 3	Year 4	Year 5	Total
1. Operating Expenses						
1.1 Salaries	232.2	231.6	231.6	223.8	191.8	1,111.0
1.2 Supplies/Equipment	76.4	76.5	78	79.4	81	391.3
Subtotal (OE)	308.6	308.1	309.6	303.2	272.8	1502.3
2. Program Additions						
2.1 Management/Admin						
2.1.1. Computer/DP Systems	1	11	2	1	1	16.0
2.1.2. Evaluation/TA		25		40		65.0
Subtotal (Mgt/Admin)	1	36	2	41	1	81.0
2.2 Health						
2.2.1 Operatns Research	24	24	24	24	24	120.0
2.2.2 Breastfeedg Promotion	69	24				93.0
2.2.3 Expanded Immunization	1	1	1	1	.5	4.5
Subtotal (Health)	94	49	25	25	24.5	217.5
2.3. Human Resources Dev.						
2.3.1. Improved Voc. Trg.	52	49	12	12	12	137.0
Subtotal (Human Res. Dev.)	52	49	12	12	12	137.0
2.4. Self-financing Activities						
2.4.1. Svc Fees Increased (TA)	15	15				30.0
2.4.2. Fund Raising (Materials)	15	10				25.0
Subtotal (Self-financing)	30	25	-0-	-0-	-0-	55.0
Subtotal (Prm Additions)	181	171	39	63	35.5	490.5
Sub-Total (All Programs)	485.6	467.1	348.6	381.2	310.3	1,992.8
Contingency						107.2
GRAND TOTAL						2,100.0

* Note that throughout this PP, Project "Fiscal Year 1" begins on the date of the Cooperative Agreement, May 1, 1984.

The most important project activities include:

1. Strengthening Institutional Management Capability and Information Systems

In their Long-Term Plan, CMSCS administrators identified a number of priority service activities. In particular, public health education and research/evaluation activities need expansion and strengthening. CMSCS plans to conduct a series of short-term, targeted operational research projects (4 to 5 studies per year) to design and test more cost-effective alternatives for Primary Health Care problems. They will also improve the efficiency and effectiveness of all service delivery through the development and use of automated management information systems.

The design and implementation of data collection and analysis systems to evaluate interventions, revise project activities and make management decisions forms a priority project objective. Such a system is now partially implemented; CMSCS management uses a microcomputer for both technical and administrative activities. A large data-base already exists, providing information on many indicators of population characteristics, epidemiological status, and service statistics for CMSCS health centers, and, due to the network of community collaborators, an adequate data collection system is in place.

The LOP budget includes funds for modest additional purchases of computer hardware and software, in accordance with a computer specialist's recommendations, to assist them (1) complete the implementation of automated program planning and program-based budgeting and (2) expand the information system to include all CMSCS centers and establish clearly defined, quantifiable goals by which to monitor progress. The work of the Employment Training Coordinator, a new position under this project, will play a key role in completing this second objective.

Finally, because of its mission and the quality of its work, CMSCS has attracted a well-trained professional staff. Its unique registration and medical records system provide a patient information data base rarely seen in developing country. The active, close and detailed follow-up the community collaborators conduct in all households enables CMSCS technicians to keep this record system well-maintained and up-to-date. The combination of a well-trained staff and excellent record and data system gives CMSCS the potential to become a model center for (1) training health professionals and (2) conducting operational research. It is expected that CMSCS can largely realize this potential during the five-year project.

2. Targeted Interventions in Health Service Delivery

Over the next five years, CMSCS health service technicians will focus their efforts on health problems which present the highest risk to children under five and women of reproductive age, expecially the nuli-para (women who have never given birth) and the grand multi-para women (women who have had more than three children) who constitute the most vulnerable population groups. Thus, programs will include child nutrition, diarrhea control, immunization, pre-and post-natal care and tuberculosis control surveillance.

The planned interventions which will strengthen PHC services include the following:

a. Upgrade Community Outreach

CMSCS technicians will increase coverage to include the entire Cité Simone population (approximately 100,000 people), using a reorganized community collaborator network. The computerized family registration system now partially in place will facilitate this process. Additional in-service training will upgrade collaborator skills to include house-to-house distribution of contraceptives and Oral Rehydration Therapy.

During the project, CMSCS directors will develop specific interventions to increase immunization coverage to 90% of the target population. The CMSCS immunization program objectives are: 1) to immunize all children under 5 against diphtheria, pertussis, tetanus (DPT), polio and measles and 2) to immunize all pregnant women, and as many women of childbearing age as possible, against tetanus. With the collaboration of the DSPP, CMSCS will establish sales posts for Oral Rehydration salts at the ten existing Foyer de Demonstration in Cité Simone in order to promote Oral Rehydration Therapy among Cité Simone residents.

b. Promote Breastfeeding

In Cité Simone, researchers have clearly documented both the widespread practice of infant bottlefeeding and its negative effects. Results of the 1980 Baseline Survey on Maternal and Child Health in Cité Simone (Berggren et al, 1981) indicated that over half (56.3%) of some 500 mothers surveyed began bottle-feeding infants during the first month of life; furthermore, infants who were bottle-fed within the first month were four times as likely to die before the age of one year as those who were exclusively breastfed during that critical period.

During the first two years of the project, CMSCS technicians plan a major campaign to counteract and try to change this behavior, using a protocol developed by AID consultants in collaboration with CMSCS1/. The program will also attempt to learn why mothers begin bottle-feeding so early and how health care providers may promote exclusive breastfeeding at least during the first three months of life.

Design of this program follows a pre-test/intervention/post-test model. During the pre-test or diagnostic phase, technicians will identify all mothers with children between 0 and 13 months (an estimated 2,000 women), using census data and clinic records. They will then conduct a baseline survey on this target population to assess mothers' knowledge and practices of infant feeding, mothers' and infants' nutritional status and related measures.

1/ Alvarez, M. "Challenging the Bottle: Proposal for a Breastfeeding Promotion Campaign in Cité Simone, Haiti." AID S&T/Nutrition document, April 1983.

Technicians will also conduct a qualitative survey on a subsample of this population using focus group research, in-depth interviewing and participant observation in households to provide more detailed accounts of infant feeding beliefs, practices, constraints and attitudes than is possible to grasp through a purely quantitative survey instrument.

CMSCS plans to undertake three types of interventions:

- In-Service Training on the importance of breastfeeding for health personnel at three levels of the system: professionals (doctors and nurses); secondary (auxiliaries, nurse's assistants and delivery room personnel); and primary care workers (community collaborators and TBA's).

- Health Care Systems Modifications: establishing a "well-baby clinic" and urge mothers to bring new-born infants there for registration and check-up at least twice during the first month of life in order to closely monitor infant feeding practices; conducting monthly follow-up of new borns; developing educational materials, e.g., films, posters, etc., for presentation in clinics, health centers and waiting rooms.

- Community Education: modifying curriculum at CMSCS educational facilities to include information on the topic of breastfeeding; developing audio and visual strategies, such as mobile loudspeakers and engaging local artists in the community to design displays for visual messages; developing films that can be shown at Cité Simone community centers.

The evaluation phase will examine: (a) results of in-service training programs for health personnel through pre- and post-training tests of their level of knowledge and competancy on the subject of breastfeeding; (b) changes in infant feeding practices measured by repeat administration of the baseline survey to 1000 randomly selected women from among the target population; and (c) most importantly, evaluating impact of the program on child morbidity and mortality, through routine follow-up of all children's health records.

c. Increase Operations Research Activities

An active CMSCS Research and Evaluation Division was created in 1982. In 1982-3, Tulane University supported a CMSCS study on the optimal age for immunizing children against measles. The Division just completed a census on the entire population of Cité Simone, providing health, socio-economic status and service delivery data on a number of indicators. In addition, the Division currently manages two operations research projects: (1) a PRICOR (Primary Care Operations Research) study on the impact that alternative programs for training Traditional Birth Attendants (TBA's) have on maternal mortality and (2) a study on the effectiveness of using TBA's to deliver family planning services.

During the five-year AID project, the CMSCS Research and Evaluation Division plans to expand its activities to maintain a level of 4 to 5 studies each year on cost-effective alternatives for improving health services delivery and

identifying means of further reducing infant and child mortality. In particular, the program aims at identifying specific high risk groups and mounting special intervention efforts for them, such as the two examples described below:

(1) Infants with Low Birth Weight

A study of 1000 consecutive births at Cite Simone Hospital revealed that:

- 11.5% of newborns weighed less than 2.5 kilograms
- First-born children accounted for 32% of all deliveries, but 51% of low birthweight infants.
- 77% of stillborns had low birth weight.
- Infants with low birth weight had 14 times the risk of dying in the first 3 months of life as that of infants weighing more than 2.5 kilograms at birth.

Thus, low-birth-weight infants constitute a "high risk group". Research on this factor will seek to identify new ways of (1) reducing the incidence of low birth weight, (2) increasing the survival of those born with low birth weight and (3) documenting the importance of this factor as a cause of mortality in the post-natal period.

CMSCS technicians plan a study to first identify risk factors associated with the incidence of Low Birth Weight. They will select mothers according to these risk factors for special pre-and post-natal care and family planning. The infant will receive close follow-up until it reaches one year of age.

(2) Nutritional Status and Child Mortality Due to Diarrhea

A study of 300 deaths of children aged 0-5 years between July 1981 and September 1982 indicated the following:

	All Children 0-5 Years	% Deaths From Diarrhea
Normal Children	38.0%	2.5%
Malnourished Children:		
1st Degree	42.0%	13.5%
2nd Degree	18.0%	20.4%
3rd Degree	1.9%	63.6%

These results suggest that while only 1.9% of all children 0-5 years old living in Cité Simone suffer from 3rd degree malnutrition by Gomez standards, they account for 63.6% of all diarrhea-related mortality. Conversely, only 2.5% of children dying of diarrhea came from the normal group.

CMSCS technicians therefore hypothesize that children with 2nd or 3rd degree malnutrition represent a high risk group that should receive special attention in order to: (a) prevent 2nd degree malnourished children from falling into the 3rd degree category and (2) decrease the case fatality rate for diarrhea.

Mothers of 2nd and 3rd degree malnourished children will therefore become the focus of an intensive motivational effort to explore the reasons underlying their inability to keep their children healthy and to define measures the mother can take to insure her child's survival. CMSCS researchers plan the following interventions:

Every day for a 20-day period, these mothers, in groups of 15, will attend one of the 10 Foyers de Demonstration scattered throughout Cité Simone for special instruction on infant feeding, oral rehydration and family planning. During this time, the children of these women will receive nutrition supplementation. Community collaborators will help carefully monitor the child's growth for one year.

Researchers will assess the impact of this program in terms of malnutrition rates, case fatality rates for diarrhea among malnourished children and target mothers' use of contraceptives before and after the program.

2. Developing Human Resources

Project interventions in CMSCS Human Resources Development programs serve a twofold purpose: (a) to increase the economic advantages of CMSCS training activities to Cité Simone residents through increasing job placement and (2) to strengthen the management and efficiency of the training centers. In order to accomplish these purposes, CMSCS will undertake a variety of activities aimed toward the following objectives:

- Increasing the quality of inputs to the various training programs in terms of the relevancy of the curriculum, improving the training material and qualifications of instructors;

- More appropriate organization of each activity based on its stated objectives;

- An improved overall support system for training and job placement activities through better coordination and administration.

The project training component concerns three CMSCS training facilities: (1) the Centre Familial, which offers 6-month, fairly traditional courses for men in electronics, tailoring, welding and literacy as well as job placement services; (2) the Mothercraft Center, where some 250 women learn sewing, make a variety of handicraft items sold at the center and operate a successful bakery cooperative; and (3) the Boston Cultural Center program for some 300 adolescents, which provides remedial education and practice in a broad spectrum of artistic and craft activities.

CMSCS directors plan to implement the project training component during the first two years of the 5-year project. (Annex 6b provides the complete implementation schedule and protocol for the project training component). Their plan includes the following activities:

- Establishing a steering committee for training activities, as both a decision and policy-making body, composed of CMSCS directors, administrators of the various training centers and an overall Employment/Training Coordinator in the position of an observer.

- Strengthening the four skills training programs at the Centre Familial, with an emphasis on training programs in electronics and industrial sewing machine operation, two skills in high demand in the existing Port-au-Prince job market;

- Setting up short on-the-job skills training courses at the request of local manufacturers;

- Evaluating and improving the remedial education and skills training programs for adolescents at the Boston Foyer Culturel;

- Increasing vocational training opportunities for women (who form the highest percentage of factory workers in Port-au-Prince), through encouraging them to enroll and participate in classes at the Centre Familial and conducting Train-the-Trainer seminars for instructors at the Mothercraft Center;

- Setting up a central data processing system for training activities which will be integrated into the CMSCS institutional Management Information System. This will include files for all students and records of their skills level and employment status, as well as a regular reporting system for each center's training activities.

- Establishing an automated Skills Bank of who can do what, as a resource for potential employers;

- Creating a permanent position for an Employment Training Coordinator at CMSCS.

The major implementation steps in undertaking and completing these activities consist of:

a. Strengthening Skills Training Programs

Requirements for improving and strengthening skills training programs in the Mothercraft Center and the Centre Familiale include some short-term Technical Assistance in educational technology and administration. This phase of the project training component includes the following activities:

- Analysis of the skills and attitudes of the target population;

- Identifying skills actually required for factory jobs and the technology used in the workplace;

- Development/revision of course content and curriculum. This includes: task analysis for specific jobs in industry, drafting student manuals or adapting existing manuals, drafting teachers' manuals, developing admissions and performance tests and scripts for audio-visual training materials; acquiring training materials and tools needed to accomplish training program objectives;

- Design of course course validation criteria;

- Training instructors in the use of course materials;

- Design and installation of a system of academic records and follow-up information on each student.

CMSCS plans to contract Resource Training Center (RTC) specialists in educational technology to assist with these activities. RTC, or the Centre d'Appui aux Formations (CAF), specializes in assisting public and private institutions develop and implement non-formal, competancy-based job training programs. Since its establishment in 1980, RTC, a GOH Department of Education agency strongly supported by USAID/Haiti, has designed and implemented on-the-job training courses for numerous organizations in Haiti.

In addition, setting up the operational procedures for the revised training programs will require the short-term assistance of a specialist in educational planning and administration.

b. Providing Short-Term Skills Training Courses upon Request

CMSCS will serve as a site for setting up short-term skills training programs (not to exceed one week) for manufacturers located in the nearby Industrial Park. The Training Coordinator will administer these courses, with RTC assistance. Short courses have a twofold objective: (1) increasing CMSCS effectiveness in finding jobs for Cité Simone residents and (2) promoting the training programs among manufacturers. The Training Coordinator's responsibilities for this effort include:

- Establishing and maintaining contact with manufacturers and potential employers to promote the training services;

- Drafting agreements with employers, CMSCS and RTC which establish each party's contribution to course preparation and execution;

- Coordinating implementation of the agreements.

c. Upgrading Remedial Education and Skills Training at the Boston Cultural Center

The Training Coordinator will establish criteria for monitoring the aptitudes and skill levels of young people enrolled in the Boston Cultural Center Program. The Coordinator will further ensure that the CMSCS institutional Management Information System includes data concerning these skill levels, literacy rates and numbers of enrollees in the various educational/handicraft/recreational programs.

d. Establishing a CMSCS Employment Training Coordinator's Position

In order to carry out these activities, and for better administration and organization of training activities, CMSCS plans to set up a Training Coordinator's position as a permanent CMSCS staff member as soon as possible during the project. The position calls for a person with solid administrative expertise and experience, a general understanding of educational/employment problems and some good experience in community development or as an animateur. The Coordinator should have a degree in social science or administration; however, the position does not require a degree in educational technology. Finally, the Coordinator needs a natural commitment to and understanding of the Mission of CMSCS.

The scope of work for the Employment Training Coordinator includes the following responsibilities:

- Targeting potential employers and promoting CMSCS training services to them;

- Organizing short course skills training programs;

- Installing and managing an information system for students' and trainees' academic records and follow-up;

- Ensuring a continuous assessment of training activities; attendance statistics, achievement and placement statistics, records of training activity costs;

- Ensuring that the various centers' activities complement each other and that each center remains informed of other center activities;

- Submitting regular joint training activities reports to the CMSCS Board of Directors which CMSCS will include in its monthly technical and other reports.

- Developing the self-financing capacity of SMSCS training activities through contracting with manufacturers to purchase CMSCS training services and/or contributions of program graduates who have been successfully placed in jobs.

3. Increase Self-Financing Activities

During its first years, CMSCS sustained a steady growth in its service programs, largely due to the foreign donor support which provides most of its funding. CMSCS directors recognize the inherent risk in such heavy dependency on outside donor support and realize that the long term solution rests in the generation of income from local sources. They have thus initiated a number of steps which will lead to greater self-reliance. Within the context of this project, these steps include the following:

a. User Fees/Health Services Pre-payment Schemes

The Cité Simone residents represent the "poorest of the poor" in Haiti; they cannot possibly pay the full costs of needed health and social services which CMSCS provides. Nevertheless, preliminary examination of residents' willingness to pay for services suggests that some latitudes for revisions of user fees do exist and that they show significant potential for increasing the self-financing capabilities of CMSCS programs. The most effective use of this potential, however, will require careful analysis of several outstanding issues as discussed below:

Existing CMSCS User Fees vs. Real Service Costs

Over the last few years, CMSCS leaders instituted a system of token fees-for-services to help offset operational expenses at two of its health facilities, the CHAPI out-patient clinic and the Cité Simone hospital. In order to reduce administrative costs and simplify procedures, these facilities generally charge flat rate fees. CMSCS directors admit the need to revise fee schedules. The CHAPI clinic now charges one gourde ($0.20 US) per prescription, regardless of how many items are purchased; thus, a client pays as much for a single medication as for several. Table III-2 below presents the complete fee schedule for the Cité Simone hospital:

Table III-2

Cité Simone Complex Hospital User Fee Schedule

Service	July 81- June 83	July 83-Present
X-Ray	$2.00	$3.00
Admission	2.00	2.00
Emergency Admission (Night hours)	1.00	3.00
Minor Surgery	5.00	10.00
Major Surgery	8.00	15.00

Both the CHAPI clinic and the hospital provide auxiliary services, such as laboratory tests, free of charge. The chart below shows the total revenues these facilities earned from all user fees and the percentage of the total CMSCS budget these fees represent; it indicates that during Fiscal Years 1981, 1982 and 1983, user fees accounted for only 1.29%, 2.07% and 2.05%, respectively, of total CMSCS income. The Project Financial strategy proposes to raise this percentage to at least 5% during the 5-year LOP, aiming at an annual income of at least $35,000 from user fees.

CMSCS User Fees Income

	1980/81	%	1981/82	%	1982/83	%
CHAPI	$ 6,774	1.29	$ 6,776	.94	$ 6,772	.87
Hospital	0	0	8,200	1.13	9,022	1.18
Income: Total User Fees	6,774	1.29	14,976	2.07%	15,694	2.05
CMSCS Total Budget	$526,953		$772,764		$767,256	

As part of its PRICOR project, CMSCS recently analyzed the absolute costs of its maternity care services, based on prorated costs of personnel, administrative costs, materials, vaccines, medications, equipment and hospitalization. The chart below summarizes these costs, the current monthly average number of patient visits and current charge for each of these services. Results further emphasize the wide discrepancy between service costs and user fees:

Cost of Maternal Care Services at CMSCS*

Type of Service	Cost	User Fee	No. per Month	Facility
Laboratory Test (all)	$ .72	0	1,200	CHAPI
Pre-natal Visits	3.30	0	290	CHAPI
Normal Delivery	31.97	3.00	95	Hospital
Caesarian Delivery	210.17	15.00	6/year	Hospital
Home Delivery	3.27	2.00	60-80	Woman's home, with TBA
Post-natal Visit	$ 2.38	0	250	Hospital

* Table adapted from Pipp, M., "Cost Analysis of the Maternal Care System in Cité Simone". PRICOR report, 1983.

Issues Concerning Increased User Fees

Major factors inhibiting CMSCS cost-recovery efforts through fees-for-services include, first and foremost, the absolute poverty in the area; Cité Simone residents are clearly the poorest of the poor (estimated annual per capita income was $150 in 1983). Second, residents do have access to other public, PVO and private health services, for instance, the DSPP/DHFN Isaie Jeanty maternity hospital, which, although overcrowded, is within walking distance of Cité Simone, or the Michelle B. Duvalier Foundation Pediatric clinic in the downtown slum of La Saline.

Mounting evidence indicates, however, that despite poverty and access to free or nearly free health services (1) the Haitian poor recognize and value quality health care and will pay more for it and (2) although they have access to other services, and are price-sensitive, they also recognize indirect costs, such as transportation and waiting time. Thus, increases in user fees do not necessarily reduce service utilization in the long run, given adequate quality and convenience.

A March 1984 DSPP study compared user fee charges, earned revenues and patient visitation rates at five public and private voluntary health facilities in Port-au-Prince and neighboring towns; the survey included the DSPP/DHFN Isaie Jeanty Maternity hospital adjacent to Cité Simone. Results indicated that little relation occurred between user-fee rates and frequency of service utilization, rather, that the range and quality of services, particularly availability of auxiliary care, e.g., X-Ray, laboratory and pharmaceutical services in addition to medical consultations, correlated positively with higher volume of clientele[1/].

Finally, CMSCS directors indicate their own service records show that while patient demand for hospital and clinic visits decreased slightly after they increased user fees, and after the November 1983 opening of the Bon Repos Medical Center (about 10 kilometers from Cité Simone), demand had returned to previous levels within a few months. As shown in Table III-1 above, the hospital raised several standard fees in July 1983, for instance, charges for major surgery increased from $10 to $15. During the previous 6 months, hospital doctors performed 165 operations, averaging 27.5 per month. During the four months after rates increased, they performed only 75 operations (average: 18.75 monthly). In November, however, the number of surgeries (34) actually surpassed previous levels and by February 1984, it reached an average 29 operations per month. These results suggest then, that even for the "poorest of the poor", well-managed hospital facilities can increase user fees for selected services without reducing their long-term patient load.

Planned Project Activities and Interventions

This project component includes several phases, starting with analysis of the CMSCS user fee financing system, including an analysis of the demand for services and an assessment of past fee schedules in regard to the population's demands. CMSCS administrators will use results of this analysis to devise alternative fee schedules, develop pre-payment plans and a drug sales program as discussed below:

Increased Revenues for Services: CMSCS administrators propose testing two payment schemes for curative services at the CHAPI out-patient clinic and the hospital:

Scheme 1: A pre-paid capitation plan for health care which will provide registered Cité Simone residents who subscribe to the plan with access to services at CHAPI and the hospital for a set premium which will be established after reviewing future costs and revenues and consultation with the community.

1/ Lerebours, G. Revenues et Dépenses de Cinq Etablissements Sanitaires, DSPP Unité de Planification et d'Evaluation, 1984.

Scheme 2: CHAPI and the hospital will institute increased fees for services based on a percentage of the real cost of each service offered. Anyone not registered in the pre-payment plan will have to pay these higher fees.

Increased Revenues from Drug Sales: Again, two schemes will be tested:

Scheme 1: CMSCS pharmacies will adopt the AGAPCO system (the DSPP semi-autonomous drug sales agency). They will sell patients the DSPP/AGAPCO standard list of 74 generically named drugs according to the most recent AGAPCO price structure.

Scheme 2: CMSCS pharmacies will charge clients a flat percentage, say 20%, of the total cost of all drugs used in the facility. The price structure will be established according to guidelines discussed below. This should reduce the price of some more expensive, priority drugs, e.g., certain antibiotics, while increasing the price of others.

Finally, evaluation of these interventions will occur on the basis of the following criteria: (1) program popularity, in terms of the number of voluntary participants enrolling in each program, (2) cost of implementing each plan in terms of administration procedures, etc., and (3) cost vs. revenues for each plan.

CMSCS administrators will enter and analyze all data collected on their micro-computer according to the above criteria in order to identify the most cost-effective and equitable pricing structure possible. These results will be shared with other Haitian health institutions to help solve the continuing problem of health care financing.

Guidelines for User Fee Increases

For both short and long-term impact, CMSCS clearly provides benefits which far exceed costs. Furthermore, strong justification exists for charging little or no user fees for its preventive health services (e.g., immunizations) which serve greater Public Welfare goals, (i.e., social benefits far exceed private demand). For curative services, however, greater justification for revenue collection exists. Indeed, without a rational fee system, health care facilities may actually encourage inappropriate utilization of scarce health resources and services. CMSCS administrators note, for instance, that doctors do tend to over-prescribe medications, with the knowledge that no matter how many drugs a patient buys, the price remains the same. Planned revisions in the CMSCS user fee system, then, serve two objectives: first, to provide revenues for program operations and second, to promote efficiency by providing disincentives for over- or inappropriate service utilization.

Thus, the key operational question emerges: how can CMSCS continue expanding its health coverage for the urban poor with low-cost, highly effective preventive services while increasing production of relatively expensive curative care to meet an apparently growing demand? Activities of this project component must define the answer within the constraints of the Cité Simone environment: widespread, unrelenting poverty among a user population who cannot bear the full costs of services.

USAID project support to CMSCS regarding this problem will consist of technical assistance, training and support for operations/management research initiatives aimed at the following issues:

- Determining an appropriate fee pricing structure for curative services which balances the need for revenues with the public's ability and willingness to pay.

- Assessing the feasibility of a pre-payment scheme or other forms of eligibility fees to help defer the cost of CMSCS health services.

- Assessing the potential of a revolving drug sales fund to cover replacement costs of basic medicines.

- Using automated data processing systems to improve health care financial management.

The structure of user fee schedules will be characterized by (1) minimum or no fees-for-services with a high "public good" content, e.g., well-baby clinics, immunizations, pre-natal care; (2) low charges for drugs against diseases such as tuberculosis or malaria, which relate directly to articulated health priorities, and (3) higher charges for elective or curative services more consistent with the real costs of such services.

b. Sales of CMSCS Products

Between Fiscal Years 1980/81 and 1981/82, sales of handicrafts and other items produced in CMSCS centers increased from $13,397 to $20,232 (or from 1.85% to 2.64% of the total budget). The project will provide short-term technical assistance to assist CMSCS to identify ways of achieving further growth in marketing these products. The several handicraft production activities will place greater emphasis on the existing and potential demand for such products consistent with costs and other commercial aspects.

c. Fund Raising

CMSCS also plans to improve its independent fund-raising activities which has traditionally provided a far greater source of support. Although CMSCS administrators, especially the Sisters of Charity, have widespread fund-raising contacts in Europe, they have yet to tap the potentially greater resources in the US. In order to develop more effective fund-raising strategies which will significantly tap new sources of foreign voluntary contributions, the CMSCS Board of Directors will complete the following steps:

(1) Set up a not-for-profit tax-exempt corporation in the US for the purpose of soliciting and receiving funds from private donors, groups and organizations for the Complex. Efforts to complete this process are well underway; in March, CMSCS directors legally incorporated an organization in the State of Maryland named the "Friends of Cité Simone, Inc." and filed application papers to obtain IRS non-profit status for this organization, which will permit individuals and corporations to make US tax deductible contributions to the Complex. They submitted this application in April; the IRS certibifation process normally takes approximately four months.

(2) Establish appropriate overhead rates for CMSCS fund-raising activities and make provisions to fulfill the financial and reporting requirements of foreign donor groups, including annual independent audits.

(3) Identify individuals in the US willing to act on behalf of the new not-for-profit organization on a volunteer basis to assist in fund-raising.

(4) Set realistic target rates for fund-raising activities.

(5) Develop media strategies and produce effective promotional materials.

USAID/Haiti has provided some initial Technical Assistance to CMSCS to start these activities; project funds will support additional efforts, primarily to develop publicity strategies and fund-raising materials. The "Financial Plan and Budget" section of the Project Paper discusses this financing option further and provides (in Table V-1) projections of revenues CMSCS expects to receive through its improved fund-raising activities.

d. Industrialization

The Cité Simone Income Generation Project (USAID/Haiti Cooperative Agreement No. 521-0169/11): the most ambitious of the several efforts CMSCS has undertaken to create an indigenous financial base, this plan proposes establishing a competitive manufacturing enterprise that will allocate part of its profits to direct budgetary support of CMSCS. In order to study the development of this industrial program, CMSCS contracted Witherspoon International Corporation (WIC), a private non-profit US business development firm. The current status of this project: WIC is now developing a feasibility plan, including marketing surveys and analyses, production plan and complete initial start up and employee training plans. The potential product selected for manufacture is a processed wood material which can be cut and hand-finished into a variety of novelty items (key chains, paper-weights, etc.); CMSCS has located an available production site for the factory.

Development of this program is still at a preliminary stage; initial projections indicate it will take several years before significant profits can be expected.

Although AID supports the Cité Simone Industrialization Program, this project is not funding it. We include discussion of the program here, however, because the industrialization program demonstrates the serious commitment of CMSCS directors to the policy of economic self-reliance.

d. Self-Financing/Contingency

Finally, the LOP budget includes up to $100,000 in Self-Financing/Contingency funds, set aside for the primary purpose of further identifying and developing

self-financing mechanisms. These activities could include preparing additional fund-raising materials, undertaking strategies for increasing products sales and similar efforts, but exclude operating expenses, i.e. salaries and supplies for on-going services delivery at the Complex. In order to use these funds, then, CMSCS directors will provide USAID/Haiti with detailed information on (1) the intended purpose of the funds requested and (2) documentation showing how the proposed activity will contribute to greater financial self-reliance for the Complex.

IV PROJECT ANALYSES

A. Technical Feasibility Analysis

This project builds on the already-established technical resources of CMSCS for implementing the four major component activities:

1. Improved Management Capacity

Project interventions proposed for improving management and strengthening CMSCS administration depend as much on the commitment of its leadership as on AID Project funding. In that regard, the quality of the original project proposal which CMSCS submitted for AID funding in November 1983, and which formed the basis for both the PID and PP, demonstrate the institution's competance and commitment. Similarly, the CMSCS Long-term Plan represents a substantial and positive achievement, demonstrating great progress in the institution's capacity for project design and conceptualization. The Project Administrative/Institutional Analysis discusses these issues in detail.

2. Expanded Health Services Delivery and Operations Research

Health services clearly form the strongest, best organized and carefully planned of all programs carried out at CMSCS. The health interventions used have already proven effective in reducing the high rates of mortality and morbidity among the urban poor in Cité Simone. This project refines the earlier priority objectives on the basis of data carefully collected and analyzed over the past four years. CMSCS will expand community service outreach to include the entire Cité Simone population and further design and implement specific health services. These newly focused programs include special activities aimed at infants with Low Birth Weight and other high risk groups, expanded immunization and interventions to improve infant feeding practices. As previously noted, when its directors obtained a micro-computer, CMSCS was able to exponentially improve its data management and analysis capacity. The expanded community outreach and new health interventions are refinements of on-going activities entirely within the existing technical capabilities of CMSCS. They will require greater organization and management efficiency, but with the assistance of an improved computer-assisted management information system, they are feasible. They also do not increase recurrent costs to CMSCS.

Achieving CMSCS five year goals for substantial, further reductions in Infant Mortality Rates may pose more difficulties. Evaluation activities performed to date document the remarkable achievements of CMSCS in improving the health status of its population, despite living conditions that rank among the worst in the world. The reductions in Infant Mortality Rates from 184 per 1000 live births (1980) to 84 per 1,000 (1983) were achieved solely through application of selected health programs, without any significant environmental improvements in the area. This achievement is a prime example of the effectiveness of targeting interventions to tackle the specific problems responsible for most infant and child mortality in the area. CMSCS leaders

hope to now reduce the IMR even further, from 84 to 55 during the 5-year project, using and refining these same basic interventions. USAID believes that achieving an IMR of 65 in the fifth year of the project is a more reasonable goal which is itself a remarkable achievement. Unless significant improvements in overall living conditions in Cité Simone take place, however, either objective seems a formidable one. The fact that other donors have initiated serious, long-term efforts to improve infrastructures in the area for drainage, sanitation, housing and water resources development strengthens substantially the likelihood of achieving significant further reductions in the IMR over the Life of Project period.

3. Human Resource Development Programs

CMSCS Human Resources Development programs clearly lag behind health activities technically. While CMSCS directors indicate their commitment to upgrade these programs and the project includes funds for this undertaking, the process will require careful management and attention in order for the planned improvements to occur.

Evaluations performed to date provide conflicting recommendations for upgrading these activities, ranging from none to substantial change in structure. The CMSCS Long Term Plan presents a careful and realistic discussion of the difficulties and program reorientation required to upgrade existing education and training programs. At the same time, the plan envisages the far more complex task of establishing and managing a revolving fund for small capital loans to residents to start their own businesses or cooperatives.

As explained earlier, although AID and CMSCS have concluded that the capital revolving fund lies beyond the Complexe's existing institutional capacity, the objective of assisting residents to become economically self-sufficient has been retained. The project strategy however, is to concentrate on the transfer of marketable skills to residents, and the placement of graduates in the local job market. While this presents a more conservative approach, the strategy, if implemented successfully, will significantly strengthen the CMSCS training programs, enabling them to undertake more ambitious activities in the future as well as providing substantial benefit to residents now. At the same time, we feel strongly that until these programs establish a more professional and results-oriented approach both toward their clients and within the institutional structure of the Complex, larger undertakings (including the planned opening of a secondary school, not AID-funded, in the Boston Cultural Center) will produce little success.

The project thus focuses on selected interventions, upgrading those CMSCS programs most directly aimed at increasing Cité Simone residents' per-capita income at least cost. In addition, CMSCS will institute some broad changes in the activity reporting system for more effective evaluation of these activities. There are two essential steps in this process.

First, training curriculum and instructors' skills must be upgraded. The project provides funds to develop and test new curricula for training programs

and to teach existing staff instructors in their use. CMSCS expects to use training models developed by the Resource Training Center (RTC) which have proven successful in a number of on-the-job training programs in Haiti. CMSCS also proposes to contract with the RTC to assist in the curriculum revisions and staff training.

Second, CMSCS must begin seriously evaluating the impact of its Human Resources Development programs. The CMSCS Long-Term Plan notes that the impact of CMSCS educational programs has not been measured other than in terms of numbers enrolled. No systematic follow-up to assess progress in literacy classes, job training and placement or crafts production now occurs.

A detailed evaluation of training activities in the three CMSCS vocational educational facilities which AID supports (the Mothercraft Center, Centre Familial and Boston Cultural Foyer) found the first two demonstrated considerable success in developing job skills and income generating activities and in placing graduates in paid positions. In contrast, the Boston center for youth needed to undertake "serious self-examination with respect to goals, marketing strategies, quality control and follow-up"1/.

The CMSCS Plan identifies four planned steps for upgrading the Boston Center program, as well as the other programs:

- Improve quality control, in part through proper supervision of student activities.

- Develop production incentive schemes to stimulate students into better utilizing the time they spend at the center.

- Institute a system to monitor students' progress from month to month and year to year, including periodic follow-up and counselling of students.

- Determine which training activities most enhance program objectives and channel resources accordingly.

The project provides resources to assist CMSCS to implement these steps over the LOP project. In particular, the Employment Training Coordinator's Scope of Work includes setting up a system to monitor and evaluate all CMSCS training programs.

The centers, especially Boston, need to set priorities regarding balance between craft production and/or educational training opportunities. The evaluation of CMSCS training programs pointed out, for instance, that school uniforms made at the Boston Center sell well, but the center never pushes production. Change depends on CMSCS leadership and is clearly as much a question of commitment on the part of CMSCS top management and the management/organizational skills of center directors as a need for funds.

1/ Alvarez, M. "Moving on in Cité Simone: Urban Job Training Under Conditions of Economic Stress". USAID/Haiti document, July 1983.

4. Self-Financing Activities

The impoverished residents of Cité Simone have exceptional needs for preventive and curative health care, educational and economic opportunities, yet they lack the resources to pay for all of these services. For almost ten years, the founders of CMSCS have provided cost-effective health coverage and social services for this especially needy population; these services have already achieved a measurable impact. Nevertheless, and despite growing external donor support for these services, CMSCS needs more financial resources in an absolute sense. The most critical issue facing CMSCS today is that of finance; it will govern most decisions and form the basis for any structural adaptations in CMSCS programs or objectives over the next 5-10 years. CMSCS directors have developed a long-term financial strategy which calls for investing now in industrial development while increasing user fees and placing more emphasis on all the income-generating aspects of the program. This will enable the institution to significantly increase its self-reliance within the next five years. In the meantime, CMSCS needs the continued full support of its current sponsors to sustain the level of service that now exists.

Thus, the Technical Feasibility Analysis for this project concludes with a discussion of the major self-financing mechanisms supported under the new project:

a) User Fees/Health Pre-payment Schemes

Haitians, including the poor, already make considerable out-of-pocket expenditures for health care. One interpretation of preliminary data from a Tulane University survey in rural, northern Haiti indicated average annual health expenditures totaled $24.60 per family1/. A 1978 study in the Jeremie area, among rural Haitians with an estimated annual per capita income of $100, indicated even higher health ependitures of $8-$20 per person per year (including traditional healers and houngans, as well as scientific medicine)2/.

Even using the lower total from the Tulane study, one may assume that Cité Simone Urban area residents are as "cash-rich" as their rural counterparts (and equally concerned about health care). With a registered population of 22,000 families, then, at $24.60 per year, one arrives at an astounding $541,000 in estimated health expenditures, (or approximately 70% of last year's entire CMSCS budget). In practice, user fees accounted for only 2.05% of this amount ($15,694).

1/ Data interpreted by: Cross, P., "Financial Analysis and Financial Projections Prepared for the Département de la Santé Publique et de la Population". MSH, Boston, 1982.

2/ Coreil, J. "Allocation of Family Resources for Health care In Rural Haiti." Department of Preventive Medicine and Community Health, University of Texas, Galveston, 1983.

Obviously, many factors (including the accessibility of other health facilities, indigenous healers and the influence of voudou practices) affect how much Cité Simone residents can or will contribute to pay for the health and other services of CMSCS. Nevertheless, a serious, well-organized and systematic study of how CMSCS can utilize user fees or pre-payment schemes to increase income without reducing service access for the most needy would surely indicate ways for the Complex to earn significantly more than it presently does.

b. Increased Sales of CMSCS Products

Various handicraft items are produced in the three CMSCS vocational facilities but sales have never achieved their potential. Overall sales dropped particularly in 1982 after the Boston Center's founder left. They are now rising again with the development of several new items such as dolls. Selected CMSCS handicrafts are available through Zin d'Art, an AID assisted project to facilitate development of marketable handicraft items. Planned project innovations to strengthen the overall organization/management of CMSCS craft programs (especially student monitoring and quality control) should further increase sales. The project may provide modest funds for Technical Assistance to identify new marketable handicraft items.

c. Increased Fund-Raising

Most of the present CMSCS financing comes from foreign donor groups, as discussed in other sections of the PP. Initial efforts to improve and increase fund-raising efforts in the US show great promise, particularly in the establishment of a tax-exempt organization (now in process) to raise funds for CMSCS. The success of this approach has the added advantage of allowing CMSCS greater autonomy in both soliciting funds and channeling resources to meet its own institutional priorities, rather than those of various donor groups.

B. Institutional/Administrative Feasibility Analysis

1. CMSCS Organizational Structure

a) Board of Directors

Under the statutes of its incorporation, the 7-member CMSCS Board of Directors votes on all major decisions. The Board consists of Dr. Carlo Boulos, President and founder of the Complexe; Sr. Marie-Helene of the Sisters of Charity, Vice President; Fr. Arthur Volel of the Salesian priests, three members of the Haitian Arab Foundation and one Cité Simone resident. Although the Board does not hold regular formal meetings, members of the Board regularly take ad hoc advisory roles in solving problems and trouble-shooting.

b) Central Management

Dr. Carlo Boulos, a former GOH Minister of Health, serves as the CMSCS Technical Director. His role consists of supervising physicians and CMSCS

health staff, maintaining liaison with relevant GOH Ministries (including Social Affairs and Education as well as the DSPP), and carrying out public relations functions.

Sr. Marie-Helene Van Keerbergen, the General Administrator, prepares budgets and acts as the principal fund-raiser. With the assistance of an accountant/bookkeeper and two secretaries, she also manages the day-to-day operations of CMSCS, prepares all quarterly and annual financial statements and monthly Technical Reports.

Although the Board of Directors has much potential authority, in practice, CMSCS administration is highly centralized. Dr. Boulos and Sr. Marie-Helene have executive roles and most decisions require their concurrence. An intermediate position, CMSCS Coordinator (currently held by Dr. Reginald Boulos), was added last year, however, and this position will clearly occupy an increasingly important role in CMSCS institutional management. Dr. Reginald Boulos has taken a dynamic and pivotal role in developing the CMSCS research capacity, computerization, the industrial program and other recent project innovations.

c) Staffing

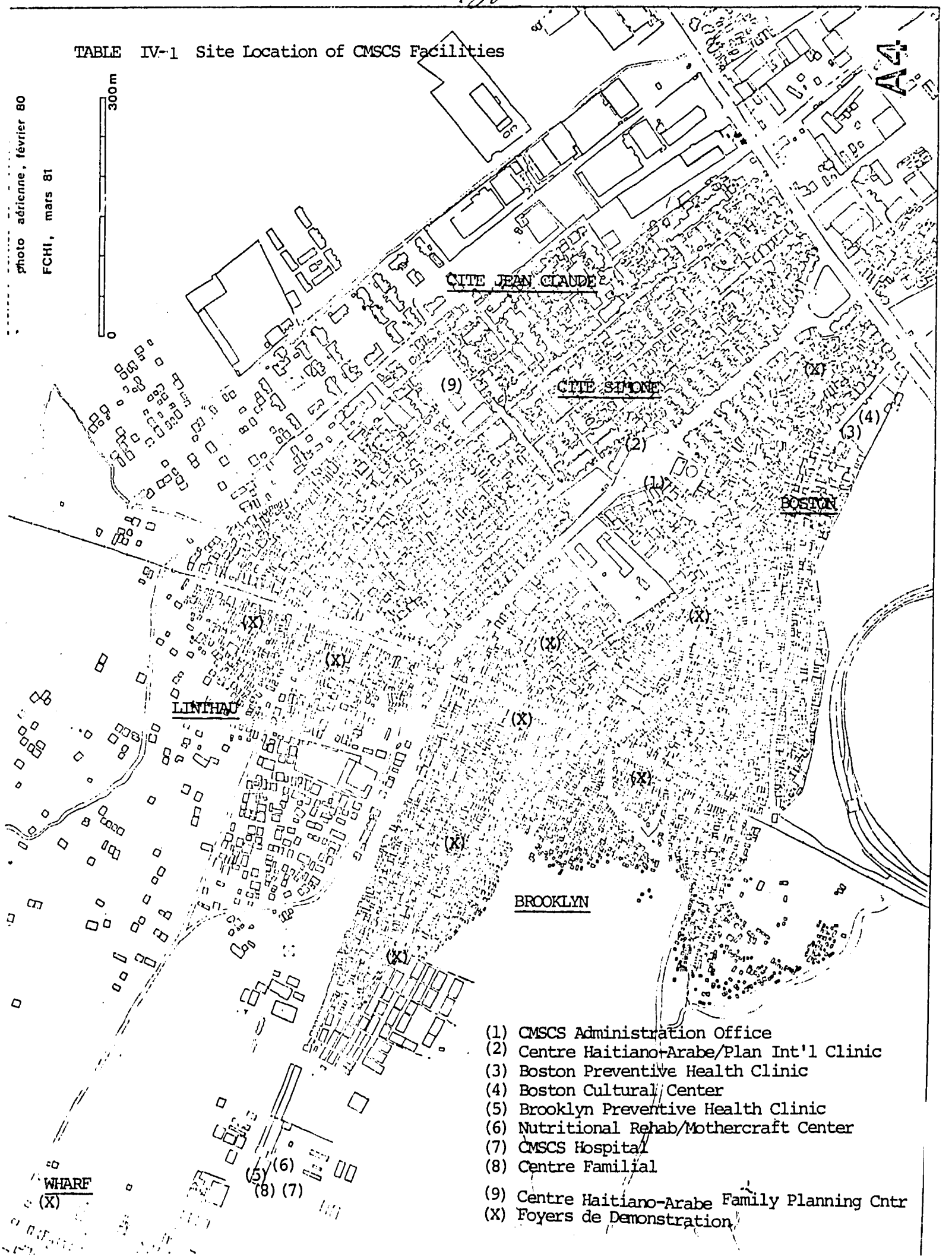
CMSCS top management, then, traditionally consists of this two-person team, whose roles separate roughly into technical and administrative functions. In general, the other CMSCS facilities replicate this management style, with a technical director, usually a physician, and an administrator, one of the twelve Sisters of Charity.

Except for the Sisters, Haitian nationals make up the entire CMSCS personnel list; no long-term foreign advisors presently work on the staff. The Complexe has 386 employees, counting para-medical health workers (100 community collaborators and 30 Traditional Birth Attendants, each of whom earns a stipend of $30 per month). Professional health staff include 25 medical doctors (3 of whom have Public Health Degrees), 19 nurses (including 4 Public Health nurses) and 37 auxiliaries. The monthly payroll totals approximately $40,000. Six donor groups now pay all CMSCS salaries: USAID, the DSPP, Foster Parents' Plan, Canadian International Development Assistance (CIDA), the Haitian-Arab Foundation and Oxfam.

2. Physical Facilities

CMSCS facilities now include more than a dozen buildings located in three of the nine area neighborhoods, as marked on Table IV-1 attached.

TABLE IV-1 Site Location of CMSCS Facilities



In Cité Simone proper, the original CMSCS dispensary still exists, now called the "Centre Haitiano-Arabe/Plan International" after its principal supporting donor groups, (or more often by the acronym "CHAPI"). Across the street from this outpatient clinic, a former residence for the Sisters of Charity now houses the CMSCS central Administrative Office, including the Research and Evaluation Division with its micro-computer. The new Centre Haitiano-Arab Family Planning Center is located near these two facilities.

A 5-minute walk away and just off the National Highway, the Boston Medico-Social Center provides remedial education and training services for adolescents and serves as the Primary Health Care outreach clinic and referral site for the 60 community collaborators working in the Boston area.

In Brooklyn, near the water's edge and about 1 kilometer from the National Highway, stand the remaining permanent CMSCS facilities: a second Primary Health Care center for the 40 collaborators who work in Brooklyn; the Nutritional Rehabilitation and Mothercraft Center, the 70-bed hospital and the Centre Familial vocational training facility.

Finally, in ten locations scattered throughout the slum area, are Foyers de Demonstration, where Complex nutrition auxiliaries provide instruction in nutrition, sanitation, child care, etc., to participating women in their own environment, using food and equipment common to their daily life.

AID project funds do not include any support for additional facility construction or renovation. CMSCS directors plan to expand one of these facilities in the near future, however, using funds from other donors. The Sisters of Charity are adding a second story to the Boston Cultural Center, to house a secondary school. USAID has declined to provide funds for this activity both because of the long-term recurrent cost implications as well as the unresolved technical issues, as already discussed in the Technical Feasibility Section of the Project Paper.

3. Administration and Management

a) Management Decentralization

Since it began, CMSCS has benefited from an exceptionally talented and dedicated leadership. The present top managers, Dr. Carlo Boulos and Sr. Marie-Helene, form a dynamic team with decades of experience between them, and are fully capable of running this nearly $1 million annual operation themselves. At the same time, no one recognizes better than they the danger in developing an over-centralized administration dependent entirely on one or two individuals--no matter how competent--to maintain its continuity and vision.

The real underlying challenge to CMSCS over the next few years, then, consists of (1) finding equally energetic leadership with the ability and commitment to manage the large institution to support these two remarkable people and (2) establishing the necessary management systems throughout the various CMSCS

programs that will enable them to evolve and mature in responding creatively to the needs of the population.

This necessary but difficult decentralization process has begun; CMSCS has already established a Research and Development Division with a separate cost structure in the Complexe. Similarly, CMSCS plans to create separate administrative and management structures for its new self-financing and vocational training programs.

Thus, as noted above, new leadership is emerging, particularly with the addition of a central CMSCS coordinator to join the top management team. The development of new management styles and systems for CMSCS programs will be more difficult. Nevertheless, this important process needs AID's support and encouragement and forms a critical element in the design of this project.

b) Accounting and Financial Management

In 1980, the accounting firm Peat, Marwick and Mitchell audited CMSCS financial and bookeeeping systems and certified (1) the viability of its accounting procedures, and (2) the institution's ability to provide adequate management control over AID funds for the planned project. CMSCS has provided AID with satisfactory financial reporting under the UHCDI project. However, CMSCS plans to begin an annual external audit process to meet the requirements of various donors.

c) Personnel Policy and Management

At the present, CMSCS has a largely ad hoc personnel system, based on immediately available funding and inadequate and somewhat subjective information provided from center directors to top management. For instance, while health professional staff (doctors, nurses and auxiliaries) receive significantly higher salaries than DSPP employees, educational and training staff receive salaries approximately 20% lower than those of most public school teachers in Haiti. The establishment of a rational and well-organized Personnel Management System forms an important priority for the 5-year project. This system needs the following:

(1) Accurate and functional job descriptions clearly defining employees' responsibilities, supervision given or received, and qualifying educational requirements.

(2) Standards and procedures for performance evaluation, efficiency ratings, employee discipline and recognition, incentives and rewards.

(3) Policy and procedures for selection and promotion.

d. Budgeting/Planning Process

Over the past year, CMSCS instituted a number of innovations in its budgeting and planning system which promise to increase its capacity to more effectively

manage available funds, prioritize budgeting decisions and, finally, better demonstrate the use of all funds to donor groups.

These revised processes evolved as a response to the institution's particular financial management needs. Since it first opened, CMSCS sustained steady growth in financial support from outside donors, enabling the institution to continually expand its service programs--until last year, when reduced contributions from foreign donor groups led to funding deficits for the first time. At present, CMSCS has no real defense against such reductions; the institution relies on foreign donor support for fully 70% of its annual budget of approximately $750,000.

CMSCS budgetary planning traditionally occurred at the top management level, with Sr. Marie-Helene making most budgeting decisions, based on whatever funds she had available as the result of her own energetic fund-raising efforts with as many as two dozen separate funding groups. The system was hard to manage and often made it difficult to show donor groups how their individual contributions did or did not complement the whole. The fact that each CMSCS facility also had a separate budget further complicated the process.

Nevertheless, the system worked well enough until the deficits occurred, and CMSCS had to confront the possibility of having to cut back services. Thus, last year, CMSCS leadership, working with consultants, took action to rationalize and simplify the budgetary system. The use of the micro-computer facilitated this process, which included the following steps:

(1) CMSCS established a single Program-Based Budget. The system classifies expenditures according to function, e.g., preventive or curative health care, training, etc., rather than by physical facility, since several functions may occur in any one facility.

(2) The new budget relates capital expenditures to operating costs, separating expenses for construction, renovation and large equipment from operating expenses such as salaries, medications, training supplies, etc.

(3) It establishes, for the first time, a baseline operating budget, showing just how much the Complexe needs to sustain services at the existing level, with no expansion in scope or coverage of services.

(4) Finally, for future planning, it adds increased operating cost estimates to total cost estimates for expanded programs, facilities, or equipment.

While the improved budgeting system cannot solve all the financial constraints CMSCS faces, it does ensure increasingly efficient financial management, an essential step in this process.

4. Management Information Systems

CMSCS management began using a micro-computer for operations research activities and to monitor health services statistics last year. Management

quickly realized the computer's potential for expanded administrative and budgeting functions, and adapted Software programs to these uses as discussed above.

In their Long Term Plan, CMSCS directors identify the following steps for further improvement of their Management Information System during the Life of Project period:

a) Complete implementation of automated program planning and Program-Based Budgeting.

b) Provide consistent monthly cost and accounting information to keep the Program-Based Budget up-to-date.

c) Expand the Information Management System to include CMSCS educational and training programs.

d) Establish clearly defined, quantifiable goals (process- and service-oriented targets) for monitoring all programs; including educational/training programs.

e) Conduct monthly monitoring of program process indicators against targets.

f) Conduct monthly monitoring of epidemiological indicators against targets.

g) Provide monthly feedback to program directors.

In order to carry out these steps, CMSCS needs additional computer hardware and software. They will purchase this with project funds, following a computer specialist's recommendations and in accordance with AID regulations regarding computer procurements.

5. Linkages with Other Organizations

a) Catholic Church

In its endeavors to assist Cité Simone residents, the Complexe has always worked closely with the local Catholic Church, a very active part of Cité Simone. This on-going cooperation has resulted in a combining of resources that avoids duplication and provides complementary services.

A community of Salesian fathers were the first active donor group in the Cité Simone area. One priest in particular, Fr. Arthur Vôlel, has worked in the Brooklyn area for nearly fifteen years, assisting residents in community organization and self-help projects to improve water supply, build latrines, houses and schools. Fr. Volel is highly respected in the Brooklyn community and serves as a permanent member of the CMSCS Board of Directors.

b) Community Councils

In the Cité Simone area, community councils (Conseils Communautaires, indigenous community organizations) currently exist in Brooklyn and Boston; a third is starting to organize in the Cité Jean-Claude. The strength of the councils differs greatly; CMSCS directors report that the Brooklyn council is, by far, the most active and responsible organization. CMSCS leadership confers with the councils and their members whenever possible and appropriate; for instance, they consulted with the Brooklyn council before raising user fees a year ago. Community collaborators also work closely with the councils and the councils choose the collaborators who work in the area.

c) Relationships with Private Voluntary and Government of Haiti Institutions

The active leadership and support which CMSCS has provided to the newly-established Association of Private Voluntary Health Organizations (AOPS), as well as its close and on-going cooperation with the GOH Department of Public and Population (DSPP) has already been discussed. This successful collaboration has resulted in maximum opportunity for replication of successful Complex programs throughout Haiti.

In addition to the DSPP, the variety of CMSCS programs requires that its leaders maintain close working relationships with several other GOH Ministries and Agencies as well. Since its establishment, these government institutions have included the Ministries of Plan, Social Affairs, Education and the Public Housing Office.

6. Administrative Capacity and Resources

The existing CMSCS management structure, with some modifications and Technical Assistance support, has the capacity to implement the proposed project interventions, as discussed below:

a) Expanded Primary Health Care Services and Operations Research

The CMSCS health services system, as noted above, has a well-managed infrastructure already in place; this project simply builds on the existing system. The budget includes funds for short-term Technical Assistance to collaborate with CMSCS health staff in the development of selected new activities; overall, however, we foresee no serious implementation problems for this aspect of the program.

b) Upgrading Human Resources Development Programs

The proposed "social" programs present more difficulties. Although these programs can contribute significantly to increasing the per-capita income of Cité Simone residents, their administrators must strengthen and professionalize existing program management in order to realize this potential. In addition to providing Technical Assistance to help the Complex

plan and carry out proposed improvements in these programs, AID recommends that OMSCS establish a strong new position: an Employment Training/Placement Coordinator, with the responsibility for developing contacts with local industries to identify job training needs and employment opportunities and for monitoring the success of all training efforts. The successful implementation of planned measures to improve these training programs further assumes that OMSCS leaders and the Board of Directors support the Coordinator's efforts, especially in integrating information from OMSCS training programs fully into the larger institutional, automated Management Information System.

c) Increased Self-Financing Capacity

The proposed project's increased emphasis on achieving a substantial degree of self-reliance represents a clear departure from the original OMSCS objective as a purely charitable institution. Nevertheless, this policy change represents a firm decision on the part of OMSCS directors who recognize and accept the responsibility of providing a strong foundation for future OMSCS initiatives. The Industrialization Program's legal incorporation as a for-profit business enterprise, with a management structure independent from that of OMSCS health and social service programs, demonstrates their commitment to this policy.

C. Beneficiaries/Social Soundness Feasibility Analysis

1. Project Beneficiaries

The target population of this project consist of the approximately 100,000 people who live in nine Port-au-Prince slum neighborhoods collectively known as "Cite Simone O. Duvalier." This total area covers less than one square mile; it extends from the Haitian-American Sugar Company (HASCO) plant on the south, the "Operation Double Harvest" plantation to the north, National Highway No. 1 on the east and the bay of Port-au-Prince in the west.

The founders of OMSCS have sought to obtain a valid definition of their target population since 1975, when they first began work in the area, in order to evaluate the impact and coverage of their programs. Directors carried out a number of surveys and fractional censuses between 1978 and 1981. The most important of these, the Baseline Survey of Nutritional Status and Health of Mothers and Children in Cité Simone, (Berggren, et al, 1981), surveyed over 500 women with children under 18 months old on a broad range of demographic, health and socio-economic status indicators. In 1983, OMSCS performed a census of the entire Cité Simone area, using a format which recorded many of the same indicators as those used in the 1981 survey. Taken together, then, the results of these two studies provide a useful profile of the Cité Simone population.

The Berggren study noted that while families living in Cité Simone are mobile, they tend to move far less than one would imagine and that a stable sub-group lives within the mobile population. Some families move into the slum, stay for a while, then move on, while others have lived in Cité Simone or similar peri-urban neighborhoods like it for years. For example, only 37% of the women surveyed (aged 15-59) had been born in rural areas, and a full 20% had

lived in Cité Simone for 20 years or more. Thus, for a sizeable portion of this population, a lifetime of urban poverty is the norm; they have never experienced the advantages of rural life, e.g., growing their own food, owning land, yet they also lack any upward mobility in the urban setting.

The Berggren study found that 70% of the mothers in Cité Simone claimed to have had no schooling whatever; 50% of all women worked for money, with the percentage increasing as they became older. Market women formed the largest occupational group (44% of all women). Only 6% of all women worked in factories; 4% indicated they were employed in "cottage industries," largely as seamstresses. The survey further indicated that even those who worked did so in their neighborhoods, selling items on their own door-steps and so on; 70% of all women claimed to spend no full days outside their homes ever. This suggests that much of the economic activity of Cité Simone residents takes place within the boundaries of the slum itself and reinforces the idea of an insular community, largely cut off from other opportunities in Port-au-Prince.

Results of the 1983 census largely confirm this impression. Community collaborators, working as data collectors, counted a total of 82,191 persons in the nine neighborhoods surveyed. Table IV-2 shows an Age Pyramid of this population based on the census results; 52% of residents are women; almost 12% are aged under 5, and the young adult age group (20-30 years old) accounts for slightly more than 20% of the total population. Census results further indicated only 13% of adults (over 20) held salaried or factory jobs, and 22% reported no source of income whatsoever. Other commonly-listed occupations included commerce (27%); sewing (5%); and construction (4.5%).

Social and environmental conditions in Cité Simone remain harsh, although some improvements are evident. Results of the 1983 survey found the following percentages of children attending school by age group:

Age Group	% In School
5 - 10	72%
10 - 15	74%
15 - 19	26%
All children (5-19)	57%

Housing consists of crowded one-story dwellings, often with more than one family, which are slowly being converted from poorly constructed scrap to sturdy cinder block compounds of 6-8 units each. The Salesian fathers, working with area residents, have built more than 200 of these compounds in the past two years. The number of latrines and public baths has gradually increased; in the 1983 survey, over half the population reported that they had access to a latrine, compared with only 16% in the 1980 Berggren survey. Serious problems of sanitation and drainage still exist, however, and due to the enormous costs involved, the present project makes no attempts to tackle these problems.

TABLE IV - 2

CITÉ SIMONE

AGE PYRAMID

SOURCE: 1983 Census

2. Social Soundness Analysis

Surveys snow that urban populations have nearly tripled in the developing countries over the past 30 years; and tnat the rates of increase have further accelerated most notably in the poorest developing countries. This phenomenal growth in urban populations results only in part from growth in the total LDC population. As noted in the Background Section of this PP, massive migration from rural to urban areas over tnis time period forms an even more significant factor.

This migratory trend primarily results from increasing pressures of population growth juxtaposed against inadequate employment and income opportunities in rural areas and small urban centers. Clearly, better employment and income opportunities, as well as increasing and cheaper transportation and communication facilities exist in the urban area of the LDC's. The location of industries, focus of government administration and concentration of opportunities for acquiring education and skills also play an important role in the urbanization phenomenon.

The major source of concern resulting from this pattern of urbanization relates to quality of life. The majority of migrants who move to urban areas invariably end up in densely populated slums and squatter settlements; they simply cannot afford anything better. In such settlements, appalling living conditions often prevail, characterized by inadequate housing and waste disposal systems, lack of potable water facilities, road networks, electricity, access to governmental services, etc. Another major source of concern is the swelling ranks of urban unemployed, often twice or more the rate prevailing in rural areas.

These and other problems notwithstanding, studies conclude time and again that urbanization will continue and that once they move into cities, few people are willing to leave. Clearly, urban areas, despite the many negative conditions, provide some incentives to attract migrants. While sociologists may disagree about what these incentives are, they certainly include better economic opportunities. The rural migrants want jobs for their survival, food for their families and a future for their children. They want the simple satisfactions of working toward something better, an end to misery and a beginning of hope.1/ The present project must be reviewed in this context. The brief summary above of the urbanization process taking place in LDC's and its consequences poses a number of serious challenges to the countries concerned, including Haiti.

The Republic of Haiti, with a total population of 5.6 million, is classified as the poorest in the Western Hemisphere. Port-au-Prince, the capital and largest city, contains approximately 1 million people. Large slum settlements exist in Port-au-Prince, and Cité Simone, the focus of this project, is one of them. Its population of approximately 100,000 lives over less than one square

1/ Laguerre, M. Urban Life in the Caribbean: A Study of a Haitian Urban Community. Schenkman Publishing Co., Inc., Cambridge, Ma., 1982.

mile of territory. Unemployment is high, with living conditions marked by lack of sanitation. The residents of Cité Simone form part of a large wave of migrants who during the past 30 years have come from rural Haiti into the capital, largely in search of economic opportunity.

The objectives of this project consist of improving the health and socio-economic status of this target population. In carrying out these objectives, particularly in the health delivery and social service sectors, the methodology employed to effect change remains basically the same as the already proven interventions CMSCS has used so successfully in the past. It involves the transmission of new values and/or skills in ways that cause no conflicts with any existing values in local Haitian traditions and culture. Moreover, the project assists virtually all segments of the population in need in a systematic and equitable manner. In this regard, the project is expected to have a strong positive impact on the Cité Simone receiver, one that will significantly enhance health and employment prospects and will allow for the development of character, discipline and pride among individuals and in the community as a whole. Finally, for both indigenous and foreign donor groups, the Complex serves as a facilitator, entry point into the community, channel of communication and fund-raiser.

In a larger perspective, the concern looms as to the potential impact of this urban oriented project on migration patterns within Port-au-Prince and the country in general. Will substantially improved health service and employment opportunities result in increased numbers moving out of rural areas and into the city? Will it result in disruptive movements and pressures within Cité Simone and Port-au-Prince? What are the long term implications?

Data collected already strongly suggest that Cité Simone residents, particularly new arrivals, have a keen awareness of the activities of the "Complex" and the advantages of living in the area. This awareness, without doubt, creates a pull factor which concerns the project. In terms of the strictly physical and geographical realities of the situation, however, the data also indicate that areas covered by the project have definite residential density thresholds; when the population reaches these levels, as it has in various zones, a voluntary migration to less crowded areas occurs. Thus, we anticipate that as Cité Simone reaches these levels, the population will stabilize regardless of the strengthened services factor. Although the population density attained may exceed optimal levels in terms of project intervention standards and capacity, the data suggest that current migration rates are not likely to exceed absolute threshold levels in this area. The project's overall magnitude is relatively small, thus minimal probability exists that continued activity will result in highly disruptive migration patterns within Port-au-Prince or Haiti over the Life of Project.

We conclude therefore that the presence of CMSCS has little influence on the flow of rural-to-urban migration in Haiti as a whole. A more likely possibility is that CMSCS encourages <u>intra-urban</u> migration, i.e., the existence and awareness of its services among the poor <u>already</u> living in

marginal areas of the capital city may encourage them to shift to Cité Simone[1]. The Berggren study found that 24% of the women surveyed, in Boston and fully 49% of those in Brooklyn had spent their childhoods in other urban areas of Port-au-Prince, which corroborates this theory.

Despite this factor, the advantages of support to CMSCS clearly still far outweigh disadvantages when one considers the enormous impact of its interventions on Infant Mortality Rates, malnutrition, employment, etc., in the area and, equally important, the example this institution provides as a model for similar initiatives in Haiti, a model that other public and private organizations have already begun to follow in both rural and urban areas.

In broader terms, it seems overwhelmingly evident that the trend of migration from rural to urban areas in developing countries, including Haiti, will continue unabated for some time to come, and constitute a problem currently beyond the control of most LDC governments. Clearly, the situation requires policies aimed at containing population growth, large scale governmental and private sector promotion of employment in rural areas, (through the development of non-farm activities, in addition to agricultural development); and the incorporation of regional development perspectives into national development strategies.

In the near term, however, development strategies emphasizing these aspects are unlikely to effect current trends of urban migration. In Haiti, as in most other LDC's, both the magnitude of urban problems and the increasing rates of urban growth call for solutions within the urban context that will make a significant impact in the near future. Development specialists must identify and select new strategies to combat directly the unacceptable quality of life and unemployment now occuring in urban areas. The present project addresses this immediate, critical need.

The evidence emerging from CMSCS project activity to date suggests that indigenous resources and expertise can develop an effective, appropriate model to improve not only health services in a major slum area, but create employment opportunities and establish a viable multi-purpose service institution as well. CMSCS provides an integrated approach which identifies the complementarities among various forms of assistance and provides a package tailor-made to suit the needs of all involved groups. The potential for both private and governmental agencies to replicate the CMSCS model in other slum areas of Port-au-Prince and possibly more important, in the smaller cities of Haiti, is, perhaps, the greatest contribution of the Complexe Médico-Social.

D. Economic Feasibility

1. Beneficiaries

The project will benefit approximately 100,000 urban poor in Cité Simone. These beneficiaries are amongst the poorest people in the developing world and

1/ Lowenthal, I., Personal Communication, March 1984

are in desperate need of health, human resource development and income generating services. The project will assist CMSCS to provide services in these three interrelated areas. They are discussed in turn.

2. Health

a. Introduction

The health status of Haiti's urban poor continues to deteriorate as more and more people move into urban slums like Cité Simone. Recent estimates of infant mortality indicate a rate of 184 in urban areas like Port-au-Prince compared to 125 for rural areas (1983). Sickness and disease in Haiti's overcrowded, impoverished, unsanitary slums drain the nation's economic resources, public and private, and hinder growth in productivity, employment and income. The economic costs of illness and death are reflected in lost wages (and output), treatment costs for hospitalization and out-patient services, e.g., costs of physicians, medications, etc., and lost leisure time. Other costs, which are less easily quantified, include the extra caloric intake required with poor health, travel and waiting costs for treatment, and psychological or anxiety costs attributable to sickness. The project anticipates a substantial investment in the prevention and treatment of serious health problems of approximately 100,000 urban poor in Cité Simone.

b. Benefits of Improved Health Care

Health care is a basic human need, one which has been effectively denied to the majority of Haiti's poor for a long time. Despite the concentration of health care resources, hospitals, physicians, pharmacies, etc., in the urban area of Port-au-Prince, access to curative and preventive care has been a problem for the urban poor. The health status of the urban poor appears to be deteriorating in response to an accelerated rate of in-migration, the resulting overcrowded conditions and the lack of basic hygienic, sanitary and health care services in urban ghettoes. One such area is Cité Simone, a densely populated cardboard and tin-roof city of approximately 100,000 people, living on one square mile of poorly drained, unsanitary land. The Complex Socio-Medical of Cité Simone (CMSCS or the Complex), organized to serve the 10,000 poor then living in Cité Simone, provides population-based health care to the 100,000 residents.* Forty percent of the Complex's health budget finances preventive health care. The remainder supports curative services at the hospital and out-patient center, e.g. diagnosis and treatment, surgeries, etc. Probably the most directly-related and important benefit of improved access to and utilization of health services is reduced mortality, particularly among infants and young children. Another benefit closely associated with mortality is reduced morbidity.

* All residents of Cité Simone's 4 sections are registered by CMSCS as they become officially registered by civil authorities. Thus, services and impact can be measured in terms of a known target population.

Improvements in productivity, measured in terms of increased work output (in quality and quantity) are the result of longer lives, less off-work time due to worker and family sickness, as well as the improved physical and mental condition of the worker. However, this is only one of the economic benefits which accrue from an investment in human health. There are also direct savings of health treatment and burial costs resulting from prevention and from cure in the early stages of illness as well as indirect benefits which accrue to society. Other examples include:

- By focusing on prevention, eg., immunization, education, pre-natal care, etc., the costs associated with institutional curative care will be lowered for currently serious health problems.

- Improved health is associated with increased ability to absorb nutrients, as well as the ability to resist disease. The combined effect is equivalent to increased consumption of food.

- While a reduction in infant (and child) mortality increases the net investment per child--as research suggests most infant child deaths are "replaced" with another birth, there is less wastage to the family and society.

- Increased efficiency in formal schooling and informal education due to a greater capacity of well-nourished children to learn, as well as their increased attendance.

- A growing body of research suggests that a sustained reduction in the rate of infant and child mortality precedes a decrease in fertility and the desirability of large families. Hence, sustained improvement in the health status of Haiti's poor would, in the long run, result in increased demand for family planning and lower the number of unwanted and unplanned children.

- A private program coordinated with the Ministry of Health and Population's (DSPP) national plan to provide "Health for All by the Year 2,000" serves to increase the effectiveness of public health expenditures. Moreover, the CMSCS approach to delivery of health care services is not only consistent with national objectives but also is a model being replicated by other PVO's.

c. Quantifiable Benefits and Costs

The objective of the health component is to improve the health services provided to residents of Cité Simone. Because of the availability of good census data on infant mortality and the fact that the IMR is considered a reliable and sensitive indicator of a population's general level of health, the quantification of benefits will focus on the IMR.

Simply stated, the impact of the project is measured by comparing the IMR under two conditions--one with the project, the other without. As a conservative estimate, it is assumed the IMR would remain at the 1980 level if

the CMSCS Project were to return to a 1979 (pre-AID) level of expenditure. It is estimated that the augmented CMSCS project budget would reduce the IMR from 84 to 75 by the 3rd year, and to 65 in the fifth (and final) year. By comparing the projected number of infant deaths under these two alternatives, one can estimate the number of infant lives saved through the project.

Table IV-3
Infant Mortality Rates

	No Project			With Project			Difference
Year	Births	IMR	Deaths	Births	IMR	Deaths	in Deaths Averted
1	3,400	184	626	3,400	84	286	340
2	3,400	184	626	3,300	80	264	372
3	3,400	184	626	3,150	75	235	390
4	3,400	184	626	2,950	70	207	419
5	3,400	184	626	2,700	65	176	450
	17,000		3,130	15,500		1,168	1,971

In terms of deaths among young children, good statistics are not readily available. From the 1979 Baseline Survey in Cité Simone, however, the CMR (Child Mortality Rate) was estimated at 57 (deaths per 1,000 children aged 1-4). Assuming that the CMSCS mix of health and social services that produced a 54% decline in the IMR would have one-half the proportionate effect reported on child mortality, it is estimated that 787 child deaths will be averted under the project. Solely in terms of infant and child morality, then, the project is expected to result in the avoidance of 2,758 infant and child deaths over the LOP.

Health services affect morbidity as well as mortality and the impact on morbidity extends to a great many more people than it does with mortality. Also, a good proportion of CMSCS health services are targeted to adults and older children (at least 30%). Hence, it is estimated 70% of the total health costs at CMSCS should be attributable to averted infant/child deaths and morbidity.

The total project expenditures for health are projected to be about $1.3 million. With 70 percent of this being attributable to infant and child lives saved, it is conservatively estimated that it costs $330 per infant/child death averted. The benefits clearly justify this meager expenditure.

d. Cost-effectiveness

Annual institutional health care expenditures per capita (1983) for Cité Simone and the rest of Haiti are as follows:

	Expenditure (FY 83)
Cité Simone	$6.24
DSPP	$5.00*

It would appear that average per capita expenditures are approximately the same for CMSCS and Port-au-Prince. IMR estimates for the two areas, however, are markedly different.

	1978	1983
Cité Simone (Brooklyn)	184	84
Port-au-Prince	147-19%	180

Hence, it appears that a similar GOH investment of six dollars per capita in the Port-au-Prince area has not produced results comparable to those at Cité Simone. While a number of other economic and social factors may be involved, it is apparent that CMSCS is cost-effective.

Finally, when we consider that forty percent (40%) of Cité Simone's health expenditures are for low-cost, high-return interventions such as immunizations, Oral Rehydration Therapy and patient education, we can be confident in the conclusion that CMSCS provides cost-effective health and nutrition services. Based on the above analysis, it can be concluded, therefore, that the Urban Health project appears to be cost-effective and justifies the planned level of investment.

3. Human Resource Development

The human resource development program, which includes basic literacy education, vocational training, and job placement activities, will improve the economic and social welfare of the beneficiaries and thus have synergistic effect on their health status. The logic of providing these services as complementary to the health program is compelling. However, it is essential that the management and quality of these programs be upgraded if this component of the project is to fullfill its potential in the development of the community.

*The average per capita expenditure (FY 1983) for the nation as a whole was about $5.00 (Health Sector Strategy Assessment, AID 1984).

While the Alvarez Report basically argues that the vocational training programs are cost-effective, no reliable quantitative data exist to test this judgement. Cost data by program component coupled with individual participant data, including earnings before and after training, are required to evaluate the economic soundness of the training programs. A data collection program will be developed so that cost-benefit analyses could be performed to determine which program components are economically sound and which components need to be modified or discarded. The objective of the training program should be income increases which justify the training costs as an investment. Training which leads to job placements producing no income advantage over the non-trained are not economically sound. Developing the data collection procedures for analyzing the effectiveness of the training programs will be one of the first tasks of the new Employment Training/Placement Coordinator.

Given the growth potential of the manufacturing sector, its proximity to Cité Simone, and the relatively high earnings possible there, increased emphasis will be placed on cultivating manufacturing employer contacts and developing short-term courses to meet specific employer needs for trained employees. Industrial employers will also be encouraged to become envolved in the management function of the CMSCS human resource development program, perhaps as members of an advisory board which could recommend curriculum reforms, placement procedures, etc. While training for manufacturing and other high-earning sectors will be encouraged, most Cité Simone residents will in fact be employed in the informal sectors. The ability to produce and market quality products, including clothing, prepared food, and handicrafts is expecially important if income gains are to be made in the informal sectors. The training programs should focus on upgrading production quality standards for products with ready markets. Increased emphasis on marketing would also be appropriate.

As suggested by the World Bank's Haiti Vocational Training Subsector Memorandum (December 1982), curriculum reform will focus on developing short-term (less than one year) courses which are designed for immediate job placements. While CMSCS training programs will be job placement oriented, it is clear that in many cases jobs will not immediately be available. Unemployed training graduates quickly lose skills learned in the training program. As suggested by the Alvarez Report, the skills learned in the formal training program could be retained and even upgraded if limited earnings opportunities were created in the training facilities which are not fully utilized. For example, the industrial sewing machines at the Centre Familial could be made available during off-hours for unemployed graduates to continue their skill development and begin to generate some income.

The economic soundness of the training programs could be further enhanced if the physical plant and equipment were utilized on a full-time basis. Part-time use of equipment and/or buildings should be curtailed.

Clearly, there is no shortage of tasks for the proposed new Employment Training/Placement Coordinator. It is essential that this position be given the authority and backing necessary to improve the management and delivery of the human resource development program.

4. Income Generation

The management of CMSCS has committed itself to increasing the income generating potential of the Complexe so as to achieve a substantial degree of self-sufficiency. The objective is sound. There are many avenues for increasing the self-financing capacity of the Complexe. Foremost amongst these is the increased reliance on user fees for health and human resource development services. The Complex is currently collecting only a fraction of the client population's spending on health care. As the result of planned project terventions, curative services and drugs will be priced much closer to costs. Likewise, the fee schedules for training and job placements will be re-evaluated. Consideration will be given to asking clients to make back payments for these services over time after the service has been rendered. This will be especially applicable for those trained and placed in paying jobs.

As indicated by the Alvarez Report, there is considerable room for increasing the income of the trainees and the Complexe through improved quality control and marketing of products produced by the trainees. Income generation from an industrial project may also offer some potential as a permanent source of income, however, given the client population, it is probable that the effort will not be as significant a funding source as hoped. The difficulties of developing and managing a new profitable firm should not be underestimated. Only if the Complex gains access to exceptional business management talent and a sound feasibility study should it proceed to risk scarce capital resources in this area.

Currently, the Complex is generating about 5 percent of its revenues internally. The goal is 25 percent within 5 years, with 10 percent coming from user fees and sales and 15 percent from the industrialization programs. Increased emphasis should be placed on user fees and marketing of products produced, even if the industrialization effort is more successufl than anticipated in this analysis.

While the goal of reducing dependence on outside donors is laudible, it should be realized that given Haiti's poverty, the Complex will be dependent upon these sources for the forseeable future.

Every effort will be made therefore to increase the already high level of effectiveness of the Complex in dealing with foreign donors and private charitable organizations.

V. FINANCIAL PLAN AND BUDGET

A. CMSCS Financial Strategy

The need for long-term, dependable financing constitutes the single most critical and difficult problem facing the Complex. CMSCS directors have carefully examined the range of options available to them for meeting this need in order to develop a viable financial strategy. As noted above, CMSCS now receives income from a variety of sources. In order to better analyze the long-term potential of these different resources, CMSCS administrators developed a computerized budgetary scheme for total monetary inputs according to six categories of existing and/or potential sources of income. Table V-1 below shows projected, 5-year inputs of all these resources as well as projected revenue increases resulting from the various self-financing schemes implemented throughout the course of the project. The section below discusses each of these six categories, along with a comparative analysis of past and projected future income from each one:

1. Self-Generating Income

This includes all existing, institutional sources of funds "built-in" as part of CMSCS activities: user fees, sales of handicrafts, token payments for students' tuition and such. It also includes money paid to CMSCS for training, e.g., AOPS payments to CMSCS for training physicians to work in its community health programs. These revenues are small, but gradually increasing. They now provide about 5% of the funds required for the CMSCS annual operating budget; CMSCS directors anticipate that by the end of the Project, they will double this percentage.

2. Business Profits/Fund-Raising

This includes projections for both improved fund-raising efforts and the proposed Industrialization project. These have the potential to provide significant resources over the long-term, although CMSCS may not realize this income for at least 2-3 years.

The establishment of a U.S. based organization, Friends of Cité Simone, INC. (Acronym:"FOCUS") will allow greater institutional autonomy than other categories of financial assistance, a critically important factor. Similarly, to the extent that CMSCS owns any business activities it undertakes, this autonomy is also possible through the Industrialization Program. Overall, CMSCS leaders regard this category as an optimal resource.

3. Foreign Donor Assistance

The CMSCS budget lists ten different foreign donor groups by name, making this by far the largest category of support; all together, it provides over 70% of this year's funding. The list also shows that, except for AID and one or two others, most of these donors are non-U.S. organizations. These sources tend to be unstable; over time, various donor organizations may suddenly stop

TABLE V - 1. CISCS Future Sources of Income

SOURCE	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
	$	%	$	%	$	%	$	%	$	%
I SLF GEN										
ENTREES										
Disp Chap	16000	1.44	17000	1.63	18000	2.08	19000	2.11	20000	2.32
Boston	14000	1.26	15000	1.44	17000	1.97	18000	2.00	20000	2.32
Brooklyn	20000	1.80	20000	1.92	22000	2.54	22000	2.44	25000	2.90
Hospital	12000	1.08	12000	1.15	14000	1.62	15000	1.67	18000	2.09
Training	1600	0.14	1800	0.17	2500	0.29	3500	0.39	6000	0.70
SUBTOTAL	63600	5.73	65800	6.33	73500	8.50	77500	8.60	89000	10.32
II BUS PROF /FUND-RSG.										
1- FOCUS	0	0.00	23580	2.27	61080	7.06	98580	10.95	98580	11.43
2- Business (1)	0	0.00	0	0.00	0	0.00	3000	0.33	5000	0.58
3- Business (2)	0	0.00	0	0.00	0	0.00	3000	0.33	5000	0.58
4- Business (3)	0	0.00	0	0.00	0	0.00	0	0.00	3000	0.35
5- Business (4)	0	0.00	0	0.00	0	0.00	0	0.00	3000	0.35
6- Business (5)	0	0.00	0	0.00	0	0.00	0	0.00		0.00
	0	0.00	0	0.00		0.00		0.00		0.00
SUBTOTAL	0	0	23580	2.267133	61080	7.061435	104580	11.61123	114580	13.28341
III FOR ASST										
USAID	491100	44.25	480100	46.16	350100	40.47	367200	40.77	309500	35.88
Can.Gvt	76000	6.85	66000	6.35	66000	7.63	66000	7.33	66000	7.65
Fr.Gvt	0	0.00	0	0.00		0.00	0	0.00		0.00
Others	5000	0.45	8000	0.77	8000	0.92	8000	0.89	8000	0.93
Plan Int	90000	8.11	60000	5.77	30000	3.47	30000	3.33	30000	3.48
Oxfam	30000	2.70	30000	2.88	15000	1.73	0	0.00	0	0.00
Children	12000	1.08	12000	1.15	12000	1.39	0	0.00	0	0.00
Communaut	25000	2.25	25000	2.40	25000	2.89	25000	2.78	25000	2.90
Misereor	10000	0.90	10000	0.96	10000	1.16	5000	0.56	3000	0.35
G.C.F.	10000	0.90	10000	0.96	10000	1.16	5000	0.56	5000	0.58
S.O.S	6000	0.54	6000	0.58	6000	0.69	6000	0.67	6000	0.70
Others	25000	2.25	12500	1.20	17000	1.97	25000	2.78	25000	2.90
SUBTOTAL	780100	70	719600	69	549100	63	537200	60	477500	55
IV LOC H CON										
C Hat Ara	24000	2.16	24000	2.31	24000	2.77	24000	2.66	24000	2.78
R.Boulos	4800	0.43	4800	0.46	4800	0.55	4800	0.53	4800	0.56
Anonymes	25000	2.25	25000	2.40	25000	2.89	25000	2.78	25000	2.90
--------	0	0.00	0	0.00	0	0.00	0	0.00		0.00
--------	0	0.00	0	0.00	0	0.00	0	0.00		0.00
--------	0	0.00	0	0.00	0	0.00	0	0.00		0.00
Others	0	0.00	0	0.00	5000	0.58	5000	0.56	5000	0.58
SUBTOTAL	53800	5	53800	5	58800	7	58800	7	58800	7
V GOV HAITI										
San Pub	65000	5.86	65000	6.25	70000	8.09	70000	7.77	70000	8.12
Aff Soc	15000	1.35	15000	1.44	15000	1.73	15000	1.67	15000	1.74
Educ Ntle	1800	0.16	1800	0.17	1800	0.21	1800	0.20	1800	0.21
Electric	5500	0.50	5500	0.53	5700	0.66	5800	0.64	5900	0.68
SUBTOTAL	87300	8	87300	8	92500	11	92600	10	92700	11
VI RES GRANT										
Pricor	35108	3.16	0	0.00	0	0.00	0	0.00	0	0.00
Tulane	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Other	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Ford Fdt.	40000	3.60	40000	3.85	0	0.00	0	0.00	0	0.00
Other Res	50000	4.50	50000	4.81	30000	3.47	30000	3.33	30000	3.48
SUBTOTAL	125108	11	90000	9	30000	3	30000	3	30000	3
GRAND TOTAL	1109908	100	1040030	100	864980	100	900680	100	862580	100

supporting CMSCS; some groups have given large, one-time-only donations. Moreover, foreign donors often have their own program priorities which may be at variance with those of the Complex.

In order to strengthen its autonomy while continuing fund-raising activities among foreign donors, the CMSCS Board of Directors has established a US-based, private non-profit organization to receive tax-free donations directly or CMSCS, as discussed above. They believe that this mechanism has the potential to provide more stable, long-term contacts with potential donor groups.

4. Local Haitian Contributions

This includes donations from Haitian families and individuals, the Haitian-Arab Center, church groups and other local, private sources. Such donations tend to provide small (about 5% of the budget this year), but reliable income for CMSCS programs. Plans to increase funds from this source are underway.

5. Haitian Government Support

GOH in-kind contributions to CMSCS programs have increased steadily over the past four years, and now account for roughly 8% of CMSCS annual operating expenses. This total is expected to increase slightly in the future, but in view of the government's own limited financial resources, more substantial GOH support is unlikely.

6. Research Grants

The several research activities now being implemented at CMSCS have been described above; this year, research grant funds total about 11% of the budget. These research activities are expensive to implement, however, and for the most part, they do not contribute substantially to covering operational expenses. Nevertheless, they have the potential for becoming an increasingly important source of funds for CMSCS.

On the basis of their analysis of the above factors, CMSCS directors developed a financial strategy for meeting short- and long-term funding needs. The CMSCS strategy emphasizes finding ways of increasing indigenous sources of income through implementation of the various income generating methods already described: increasing user fees and drug sales, the proposed health care pre-payment scheme and increasing sales of handicrafts, continued efforts to develop and implement operations research grants and proceeding as quickly as possible with accelerated fund-raising and industrialization activities.

B. Life of Project Budget and Financial Plan

Table V-2 presents the planned AID Inputs over the 5-year Life of Project Period. AID will provide assistance for the four primary activities already discussed: (1) Management/Administration, (2) Health services delivery (3) Human resources development and (4) Self-financing or income-generating activities. In the project budget, these four categories are further

subdivided into recurrent costs ("Operating Expenses ") or new activities ("Program Additions"). Note that while Operating Expenses in the LOP Budget include an annual 2% inflationary increase, the budget total actually shows an overall decline in recurrent costs financed with AID funds over the 5-year period, as the projected results of the several AID-supported income generating activities take effect; these projected revenue increases are consistent with those shown the preceeding Table V-1. In the LOP Budget, the impact of anticipated increasing revenues is arbitrarily shown in annual reductions of salaries for health services personnel (line item 2.2.1), both for simplicity and because health services salaries are, in fact, by far the largest single expenditure in the budget.

Thus, AID will provide ressources to the project as follows:

1. Strengthening Management/Administration

AID funds for CMSCS administration pay the salaries of two administrative assistants working in the CMSCS Central Bureau, as well as for office supplies, equipment, Xerox services, etc. Management Program Additions funded under the AID project include the purchase of additional computer hardware and software, as previously discussed in the PP and in accordance with AID regulations for data processing procurements. The budget also includes Technical Assistance funds under this budget category for evaluations at mid-and end-of-project schedules.

2. Health Services Delivery

As noted above, salaries for health services personnel form the largest single form of AID support for CMSCS programs. In addition to paying salaries for doctors, nurses, auxiliaries and other medical/technical staff (many of whom receive small salary supplements from the DSPP as well), AID project funds pay the full stipend ($30 per month) of 100 CMSCS community collaborators and 30 Traditional Birth Attendants--those para-medical workers who form the vital network that assures the effectiveness of CMSCS community outreach efforts. CMSCS also relies substantially on AID support for recurrent costs of equipment and medical supplies, especially pharmaceuticals.

The "Activities" section of the Project Description describes in detail planned Health Program Additions for Operations Research and Breastfeeding Promotion, financed with AID funds under this project. Table V-3 below presents summary budgets for these two project interventions. CMSCS will use funds budgeted for "Expanded Immunization" (line item 2.2.3) to purchase two microscopes needed for tuberculosis control efforts and measles vaccine often unavailable locally.

Table V-2
AID PLANNED INPUT
OVER LIFE OF PROJECT
(In US $000)

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.	Management/ Administration						
1.1.	Operating Expenses						
1.1.1.	Salaries	13.1	13.1	13.2	13.5	13.8	66.7
1.1.2.	Supplies /Equipment	9.0	9.0	9.2	9.3	9.5	46.0
1.2.	Program Additions						
1.2.1.	Computer Equipment	1.0	11.0	2.0	1.0	1.0	16.0
1.2.2.	Evaluation/TA	0	25.0	0	40.0	0	65.0
	Subtotal (Admin.)	23.1	58.1	24.4	63.8	24.3	193.7
2.	Health						
2.1.	Operating Expenses						
2.2.1.	Salaries	163.6	162.9	161.8	152.6	119.2	760.1
2.2.2.	Eqpmt/Supplies/Meds.	46.4	46.4	47.3	48.2	49.2	237.5
2.2.	Program Additions						
2.2.1.	Operations Research	24.0	24.0	24.0	24.0	24.0	120.0
2.2.2.	Breastfeeding Promotion	69.0	24.0	0	0	0	93.0
2.2.3.	Expanded Immunization	1.0	1.0	1.0	1.0	0.5	4.5
	Subtotal (Health)	304.0	258.3	234.1	225.8	192.9	1215.1
3.	Human Resources/ Development						
3.1.	Operating Expenses						
3.1.1.	Salaries	55.5	55.6	56.6	57.7	58.8	284.2
3.1.2.	Training Materials	21.0	21.1	21.5	21.9	22.3	107.8
3.2.	Program Additions						
3.2.1.	Voc. Trng Improvements	52.0	49.0	12.0	12.0	12.0	137.0
	Subtotal (Human Res.)	128.5	125.7	90.1	91.6	93.1	529.0
4.	Self-Financing/ Activities						
4.1.	User Fees Increases(TA)	15.0	15.0	0	0	0	30.0
4.2.	Fund Raising (Matrls)	15.0	10.0	0	0	0	25.0
	Subtotal (Self-Fin.)	30.0	25.0	0	0	0	55.0
	Sub-total (All Programs)	21.44	21.44				
	Contingency	485.6	467.1	348.6	381.2	310.3	107.2
	GRAND TOTAL						2,100.0

Table V-3

Detailed Budget for Health Program Additions

I.	Operations Research	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.	Salaries						
1.1.	Principal Investigator	4,000	4,000	4,000	4,000	4,000	20,000
1.2.	Investigator	6,000	6,000				12,000
1.3.	Data Processing Tech.			6,000	6,000	6,000	18,000
	Subtotal (Salaries	10,000	10,000	10,000	10,000	10,000	50,000
2.	Supplies/Equipment						
2.1.	Supplies Materials	7,680	7,680	7,680	7,680	7.680	38,400
2.2.	Equipment	3,600	3,600	3,600	3,600	3,600	180,000
2.3	Telephone	200	200	200	200	200	1,000
	Subtotal	11,480	11,480	11,480	11,480	11,480	57,400
3.	Local/Int'l Transp.	2,160	2,160	2,160	2,160	2,160	10,800
	Subtotal (All)	23,640	23,640	23,640	23,640	23,640	118,200
	Contingency	360	360	360	360	360	1,800
	GRAND TOTAL	24,000	24,000	24,000	24,000	24,000	120,000

II.	Breastfeeding Promotion	Number of Staff	Year 1	Year 2	Total
1.	Salaries				
1.1.	Principle Investigator	1 full time	7,200	3,600	10,800
1.2.	Social Scientist	1 full time	9,000	4,500	13,500
1.3.	Fast Investigator	1/2 time	4,500	2,250	6,750
1.4.	Data Processing Technician	1 full time	3,000	1,500	4,500
	Subtotal		23,700	11,850	35,550
2.	Public Health Education/ Supplies Materials				
2.1	Materials Development	Designing Distribution	23,554		23,554
2.2	Media Equipment	Video Film	4,850		4,850
	Subtotal		28,404	0	28,404
3.	In-Service Training Costs	All Levels of Health Care Providers	10,000	0	10,000
4.	Technical Assistance	2 Part-time Consultants	4,200	10,100	14,300
	Subtotal		66,304	21,950	88,254
	Contingency		2,696	2,050	4,746
	GRAND TOTAL		69,000	24,000	93,000

3. Human Resources Development

AID project inputs for operating expenses in CMSCS Human Resources Development activities cover salaries of vocational training instructors, monitors and remedial education instructors for men at the Centre Promotion Familiale and adolescents at the Boston Cultural Center. AID funds will also purchase and develop training materials, equipment and raw materials for handicraft production at these facilities and at the Brooklyn Mothercraft center.

The Project Description discusses, in detail, program additions funded with AID resources to improve and strengthen CMSCS Humar Resource Development programs. Table V-4 below presents a summary budget for this particular activity.

4. Self-Financing Additions

The LOP Budget provides up to $55,000 in project funds for supporting planned Self-Financing initiatives. Specifically, these funds are for Technical Assistance to analyze, plan and implement increases in user fee schedules and for the preparation of fund-raising strategies and materials, especially films, brochures, etc.

5. Contingency

The Life of Project budget includes approximately $100,000 in contingency funds, allocated for the primary purpose of allowing CMSCS greater flexibility in identifying and developing activities contributing to greater self-reliance. Priority activities for using these funds include further development of fund-raising strategies and materials, technical assistance to identify ways of increasing fees, sales of handicrafts, etc., as apposed to operative expenses, i.e., salaries and supplies for on-going services delivery. CMSCS will submit to USAID information on (1) the intended use of the funds requested and (2) where appropriate, documentation explaining how the proposed activity will contribute to greater financial self-reliance for CMSCS, before USAID approves any commitments for use of these funds.

C. Financial Plan

Finally, in order to emphasize the fact that AID resources provide only a part (although a very significant part) of CMSCS real financial needs, Table V-5 presents total anticipated expenses for the Complex during the next five year period.

Part I shows total Operating Costs only (i.e., all recurrent costs, for salaries, equipment, medications, etc). Note that this is a baseline budget, with no funds for any expansion of programs or activities.

Part II shows the anticipated value of all Program Additions, i.e., AID funded Program Additions, and new activities supported by other donors. Thus, the bottom line of expenses totaled in Table V-5 is equal to the total projected income shown in Table V-1.

Table V-4

III.	Vocational Training Activities						
1.	Coordinator's Salary	6,000	12,000	12,000	12,000	12,000	54,000
2.	Equipment/Materials	10,000	10,000	0	0	0	20,000
3.	Technical Assistance						
3.1.	Short Term (4 months)	24,000	12,000	0	0	0	36,000
3.2.	CAF or eqvlnt (10 mths)	12,000	15,000	0	0	0	27,000
	Total	52,000	49,000	12,000	12,000	12,000	137,000

TABLE V-5. CMSCS Future Expenses

C O M P L E X E C I T E S I M O N E

BUDGET WORK SHEET # YEAR 1983/89
OPERATING COST
FILE CCSB4AA

PRINT: A1 TO K52

I. OPERATING COSTS	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89	TOTAL 5YR
SALAIRES							
SANTE							
Curatif	168107	168107	171469	174899	178396	181964	1042943
Preventif	111990	111990	114230	116514	118845	121222	694790
EDUCATION	151091	151091	154113	157195	160339	163546	937375
GEN.REVENUS	30553	30553	31164	31787	32423	33072	189552
CULTUREL	13656	13656	13929	14208	14492	14782	84722
RECHERCHE	31036	23605					54641
FORMATION	0	0	0	0	0	0	0
ADMINISTRATION	24772	24772	25267	25773	26288	26814	153686
SUB TOTAL	531205	523774	510172	520376	530783	541399	3157710
FONCTIONNEMENT							
SANTE		0					
Curatif	80403	80403	82011	83651	85324	87031	498823
Preventif	44643	44643	45536	46447	47376	48323	276967
EDUCATION	26124	26124	26646	27179	27723	28277	162074
GEN.REVENUS	39979	39979	40779	41594	42426	43275	248031
CULTUREL	15000	15000	15300	15606	15918	16236	93061
RECHERCHE	17695	11503					29198
FORMATION	0	0	0	0	0	0	0
ADMINISTRATION	6500	6500	6630	6763	6898	7036	40326
ENTRETIEN	15000	15000	15300	15606	15918	16236	93061
SUB TOTAL	245344	239152	232202	236846	241583	246415	1441542
OPER.SUB TOTAL	776549	762926	742374	757222	772366	787814	
CAPITAL		0	0	0	0	0	
CONST.NOUVELLE	0	0	0	0	0	0	0
AMENAGEMENT	0	0	0	0	0	0	0
EQUIPEMENT	14700	14700	14994	15294	15600	15912	91199
			0				
SUB TOTAL	14700	14700	14994	15294	15600	15912	91199
TOTAL	791249	777626	757368	772516	787966	803725	4690450
II. NEW PROGRAMS							
1. AID Inputs		180000	171000	39000	63000	35500	
2. Other Donor Inputs		152282	111712	61000	60000	30000	
GRAND TOTAL		1109908	1040080	872516	910966	869225	

VI. PROJECT IMPLEMENTATION

A. Implementation Plan

The project Implementation Plan schedules an FY 1984 authorization with an initial A.I.D obligation of $450,000. USAID/Haiti will obligate these fund in a May 1, 1984 Cooperative Agreement with the Cité Simone Medico-Social Complex. A.I.D. will make further funding available in annual increments. A first quarter FY 1985 obligation will facilitate timely project implementation. Table VI-1 shows critical project milestones in project implementation.

Although the CMSCS fiscal year begins in July, the project implementation plan schedules annual project cycles to coincide with the budget year of A.I.D. This should facilitate USAID in scheduling early fiscal year project obligations, avoiding the problems of late FY obligations and ensuring the availability of funds for planned activities.

Each year CMSCS will prepare an annual Plan of Action and Budget and submit them to USAID/Haiti for approval, so that as each new fiscal year begins, no delays in project implementation will occur.

B. Methods of Financing

1. Project Advance

USAID will fund local project costs using the Periodic Advance method upon the submission of documentation to AID by CMSCS. CMSCS will submit detailed annual budgets and work plans for AID review and approval. Based upon these plans, USAID/Haiti will establish a project advance fund adequate to enable CMSCS to implement scheduled project activities and which AID will periodically replenish. The Project Agreement will define detailed procedures governing the advance, disbursement and replenishment.

2. Methods of Implementation and Financing

a. Methods of Implementation and Financing Chart

Method of Implementation		Method of Financing	Approximate Amount
Operating Costs Commodities Training Other Programs	Cooperative Agreement	Direct Reimbursement, Including Periodic Advances	$1,954,700
Technical Assistance	USAID PSCs	Direct Payment	145,300
TOTAL			$2,100,000

TABLE VI - 1

CRITICAL CHECKPOINTS OVER LIFE OF PROJECT: URBAN HEALTH/COMMUNITY DEVELOPMENT II

	FY 84				FY 85				FY 86				FY 87				FY 88				FY 89			
I. DOCUMENTATION/OBLIGATION SCHEDULE	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Initial Obligation of funds			X																					
2. Annual Budgets/Plans of Action Submitted							X				X				X				X					
3. Annual Management Reviews Held				X				X				X				X				X				
4. Subsequent Obligations of Funds					X				X				X				X				X			
5. JPIP Developed/Quarterly Reviews Held			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
6. Project Evaluations												X								X				
II. PROJECT ACTIVITIES																								
1. Management Administration Improved																								
1.1. MIS Upgraded/In Place				X	X	X																		
1.2. Personnel Management Plan Submitted						X																		
2. Health Services Activities Improved																								
2.1. Operations Research																								
2.1.1. Protocols Developed for Priority Studies/Plans Apprvd					X				X				X				X							
2.1.2. Priority Studies Conducted					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
2.1.3. Reports Submitted								X				X				X				X			X	
2.2. Breastfeeding Promotion Project Conducted				X	X	X	X	X	X	X														
2.2.1. Diagnostic Phase Completed (KAP, Clinical Tests)				X	X	X																		
2.2.2. Intervention Phase Completed					X	X	X	X																
2.2.2.1. Health Personel In-Service Training Conducted					X	X	X	X																
2.2.2.2. Well-Baby Clinic Opened								X																
2.2.2.3. Public Health Education Materials Developed					X	X	X																	
2.2.2.4. Community Education Campaign Conducted						X	X	X																
2.2.3. Evaluation Phase Completed							X	X	X	X														
3. Human Resources Development Programs Upgraded																								
3.1. Employment Training Coordinator Hired				X																				
3.2. Remedial/Vocational Education MIS Developed				X	X																			
3.3. Training Courses Selected/Curriculum Developed					X																			
3.4. Instructors Trained						X																		
3.5. Courses Implemented							X																	
3.6. Coordinator Submits 1st Evaluation Report								X																
4. Self-Financing Capacity Improved																								
4.1. Fees-for-Services System Analyzed/Improved					X	X	X	X																
4.1.1. Fees System Alternatives Tested (Pre-Payment Scheme)									X	X	X	X												
4.1.2. Drug Sales Program Tested													X	X	X	X								
4.1.3. Results Evaluated																	X	X	X					
4.2. US Fund-Raising Organization Established			X																					
4.2.1. IRS Tax-exempt Status Obtained					X																			

b. This project does not entail any deviation from the general methods of financing utilized by AID

c. The accounting and procurement systems utilized by the recipient of the cooperative agreement were established by the local branch office of U.S. Certified Public Accounting (CPA) firm. It is believed that the procedures followed are satisfactory for carrying out the project.

C. Contracting Procedures

The USAID/Haiti Project Manager will collaborate with CMSCS officials in defining Technical Assistance needs and developing scopes of work for consultants. USAID/Haiti will contract for all technical assistance funded under this project.

D. USAID Monitoring Requirements

The USAID Project committee will monitor this Project and will have the following responsibilities:

1. Project Management and Monitoring

The Mission's Population and Health Office (PHO) will assign the USAID/Haiti Project Manager. The Project Manager will work closely with CMSCS directors and staff, representatives of other participating agencies, and long and short-term consultants to ensure that CMSCS meets the provisions of the AID Project Agreement. The Project Manager will also work closely with other USAID Health and Population officers to assure complementary implementation and close coordination of all Mission-funded health and population projects.

The Mission's Development Resources and Evaluation Office (DRE) will monitor project implementation and ensure that adequate control and management methods are being used. DRE will also prepare and negotiate the Project Agreement and review all materials submitted to satisfy the Conditions Precedent to Disbursement.

2. Joint Reviews

AID, CMSCS and representatives of other donor groups will hold bi-annual joint reviews as an essential feature of project implementation.

3. Evaluation

The Mission's Project Manager working with the Mission's Evaluation Office, will coordinate periodic evaluations.

4 Disbursement

The Mission Controller will review disbursement requests and disbursements to ensure conformity with AID regulations and adequate financial control.

5. Contracting

The Regional Contract Officer will work with the Project Manager and CMSCS in the procurement of technical assistance services.

6. Reporting Requirements

CMSCS will submit to AID the following reports to assist the Mission in monitoring the Project:

a) Monthly technical reports on service statistics from all CMSCS facilities.

b) A quarterly JPIP report of completed activities and project expenditures as well as expenditure projections for the following quarter.

c) An Annual Plan of Action and an Annual Budget, beginning with Project Fiscal Year 1, describing in detail the results from the prior year, and planned project activities for the coming year. The Action Plan will include planned operational studies, results of all activities and research, organizational and management changes planned, a staffing plan and a timetable of activities. The Annual Budget will include detailed personnel lists and lists of planned commodity purchases, showing AID local currency requirements as well GOH and other donor contributions for each budget expenditure.

E. Evaluation Plan

In addition to the quarterly reports which CMSCS submits to USAID, bi-annual project reviews with all donors and the USAID project officer's continued monitoring, two major joint evaluations will occur: (1) the first evaluation during FY 1986 and (2) the second during FY 1989.

1. FY 86 Evaluation

The first evaluation will review each of the major project components to examine (1) whether the project is meeting its planned purpose and outputs; (2) if the project is accomplishing activities and tasks in keeping with the implementation schedule in Table VI-1. The evaluation team will assess overall project management and supervision and analyze technical assistance needs. If team members detect problems, they will offer specific steps to remedy identified difficulties.

2. FY 89 Evaluation

The final evaluation, scheduled shortly before project completion, will concentrate on project impact to determine (a) progress in attaining project purposes, i.e., strengthening the CMSCS institutional capacity, measuring improvements in Cité Simone residents' health and socio-economic status and significantly reducing CMSCS dependency on outside donor support; and (b) make recommendations for the overall direction of further AID activities with CMSCS.

For each evaluation, AID and CMSCS will define the evaluation protocol. USAID will recruit a team of multidisciplinary expert consultants to undertake the required assessments.

F. Conditions Precedent, Covenants, Special Provisions and Substantial Involvement Understandings

To facilitate planned, orderly project implementation, the Conditions Precedent to grant disbursements, proposed covenants and Substantial Involvement Understandings for the Grant Agreement are included in Annex 5.

ANNEX 1. PID Approval Message

Page 1

DEPARTMENT OF STATE

TELEGRAM

AMERICAN EMBASSY, PORT-AU-PRINCE

UNCLASSIFIED

Classification

NNNNVV ESB123BRA363
RR RUESPR
DE RUEHC #5666/01 0270846
ZNR UUUUU ZZH
R 270634Z JAN 84
FM SECSTATE WASHDC
TO AMEMBASSY PORT AU PRINCE 2778
BT
UNCLAS STATE 025666

AIDAC

E.O. 12356 N/A
TAGS:
SUBJECT: HAITI URBAN HEALTH AND COMMUNITY DEVELOPMENT II -- PID (PROJECT NO. 521-0159)

Rec: 2/3/84

1. BUREAU REVIEWED AND APPROVED SUBJECT PID ON JANUARY 13, 1984. THE MISSION IS THEREFORE AUTHORIZED TO PROCEED WITH DEVELOPMENT OF THE PP AND APPROVAL OF THE PROJECT SUBJECT TO THE GUIDANCE PROVIDED BELOW. A TECHNICAL NOTIFICATION IS REQUIRED BEFORE MISSION CAN AUTHORIZE THIS PROJECT.

A. PROLIFERATION OF ACTIVITIES: THE COMPLEX HAS GROWN RAPIDLY FROM ITS INCEPTION AS A SMALL HEALTH DISPENSARY AND HAS TAKEN ON A WIDELY EXPANDED ROLE IN PROVIDING SOCIAL SERVICES AND ASSISTING IN THE ECONOMIC DEVELOPMENT OF THE CITE SIMONE AREA. WITH THIS BURGEONING OF NEW PROGRAMS AND ACTIVITIES, MANY OF WHICH WILL BE ASSISTED BY THIS GRANT, THE BUREAU IS CONCERNED THAT THE COMPLEX NOT BECOME OVEREXTENDED, EITHER FINANCIALLY OR ADMINISTRATIVELY. THE MISSION IS URGED TO ASSIST THE COMPLEX IN CAREFUL PLANNING FOR THE INTRODUCTION OF THESE NEW PROJECTS AND ACTIVITIES, AND NOT TO PLACE TOO GREAT AN EMPHASIS ON THE DEVELOPMENT OR EXPANSION OF NEW PROGRAMS/PRIORITIES. IF PROPOSED NEW ACTIVITIES, SUCH AS THE REVOLVING FUND AND INDUSTRIALIZATION PROGRAM, ARE DETERMINED TO BE FEASIBLE (SEE PARA C BELOW) AND ARE INCLUDED UNDER THIS PROJECT, THEY SHOULD BE CONSIDERED PILOT PROJECTS, TO BE EXPANDED GRADUALLY. THE COMPLEX'S SUCCESS TO DATE HAS BEEN IN THE PROVISION OF A WIDE VARIETY OF HEALTH AND OTHER COMMUNITY SERVICES. WHILE A BALANCE MUST BE ACHIEVED BETWEEN THE SOCIAL SERVICE FUNCTION WHICH THE CMSCS PERFORMS AND THE NEED FOR REVENUE GENERATING ACTIVITIES TO SUSTAIN ITSELF FINANCIALLY, THE CMSCS SHOULD NOT BE DIVERTED FROM ITS ORIGINAL OBJECTIVES.

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ACTION TAKEN

Date:

By:

B. FINANCIAL VIABILITY: THE ISSUE OF THE FUTURE FINANCIAL VIABILITY OF THE CMSCS, ESPECIALLY AFTER THE TERMINATION OF A.I.D. FUNDING, WAS RAISED AT THE DAEC. WHILE WE RECOGNIZE THAT EXTERNAL FUNDING WILL BE REQUIRED FOR THE FORESEEABLE FUTURE, THE BUREAU WISHES TO ENSURE THAT THE CMSCS TAKE ALL NECESSARY STEPS—TO ARRANGE FOR DEPENDABLE, LONG-TERM FINANCING PRIOR TO THE EXPIRATION OF THIS GRANT. IN ORDER TO ACHIEVE THIS OBJECTIVE, THE BUREAU WOULD STRONGLY RECOMMEND THAT FUNDRAISING EFFORTS BE MADE A PART OF THE PROJECT. THE CMSCS SHOULD RECEIVE TECHNICAL ASSISTANCE IN FUNDRAISING TECHNIQUES AND METHODS BOTH FOR MOBILIZING LOCAL RESOURCES AND TO ACQUIRE FOREIGN CONTRIBUTIONS, AS WELL AS THE MATERIAL SUPPORT COSTS OF FUNDRAISING ACTIVITIES. THIS T.A. AND SUPPORT COSTS MAY BE FUNDED BY THE A.I.D. GRANT, OR, THROUGH OTHER DONORS.

IN TERMS OF THE INCOME RECEIVED FROM THE COMPLEX'S SELF-GENERATING INCOME ACTIVITIES, THE BUREAU BELIEVES THAT THESE FUNDS SHOULD BE MAXIMIZED AS SOON AS

UNCLASSIFIED Stat 25666

POSSIBLE. YEARLY BENCHMARKS SHOULD BE ESTABLISHED FOR ALL ASPECTS OF SELF-GENERATED INCOME, INCLUDING THE INDUSTRIALIZATION PROGRAM AND USER FEES. ANNUAL EVALUATIONS SHOULD TAKE PLACE TO REVIEW CMSCS'S PROGRESS IN MEETING THE TARGETS AND TO ASSESS THE ONGOING AND NEW SELF-FINANCING PROGRAMS TO DETERMINE THEIR FUTURE POTENTIAL FOR REVENUE GENERATION, AS WELL AS THEIR RECURRING COST IMPLICATIONS. ONE POTENTIAL STRATEGY TO PURSUE TO MOVE THE COMPLEX TOWARDS FINANCIAL SELF-SUFFICIENCY, IS THAT A.I.D.'S SUPPORT OF THE CMSCS, PARTICULARLY FOR THE OPERATING EXPENSES, SHOULD DECLINE STEADILY OVER THE 5 YEAR LIFE OF THE PROJECT. TO COVER THE COSTS CURRENTLY FUNDED BY A.I.D., THE MISSION MIGHT

CONSIDER A COVENANT OR, AT THE LEAST, REACHING SOME UNDERSTANDING WITH CMSCS THAT NEWLY MOBILIZED PRIVATE SECTOR FUNDING OR PROCEEDS FROM THE INDUSTRIALIZATION PROJECT SHOULD BE CHANNELED INTO SUPPORT FOR THE BASIC OPERATING BUDGET OF CMSCS, WHILE A.I.D. FUNDING WOULD BE SHIFTED INTO NEW, MORE EXPERIMENTAL ACTIVITIES.

C. FEASIBILITY OF SELF-FINANCING MECHANISMS: THE PROPOSED EXPANSION OF USER FEES AND FEES-FOR-SERVICES IN CMSCS CLINICS AND FACILITIES WAS DISCUSSED AT THE DAEC. SINCE ONE OF THE PRIMARY OBJECTIVES OF THIS PROJECT IS TO ASSURE CMSCS'S FINANCIAL VIABILITY AND THE EXPANSION OF THIS FEE SYSTEM HAS A STRONG POTENTIAL FOR REVENUE GENERATION, THE MISSION SHOULD EXAMINE THE FEASIBILITY OF USER FEES EITHER IN THE PROJECT DEVELOPMENT PHASE OR, AT THE LATEST, IN THE FIRST PROJECT YEAR. IN ORDER TO UNDERTAKE THIS STUDY, THE MISSION SHOULD CONSIDER ADDING A FINANCIAL ANALYST TO THE PROJECT DEVELOPMENT TEAM OR TO THE T.A. FUNDED UNDER THE GRANT. IN ADDITION, THE BUREAU STRONGLY RECOMMENDS THE ADDITION OF A HEALTH ECONOMIST TO THE PP DEVELOPMENT TEAM TO CARRY OUT PRELIMINARY FEASIBILITY ANALYSES OF ALL OF THE HEALTH RELATED SELF-FINANCING MECHANISMS PROPOSED BY THE COMPLEX, PARTICULARLY THE HOSPITAL INSURANCE SCHEME, WHICH WE UNDERSTAND IS IN THE VERY EARLY STAGES OF CONSIDERATION.

D. REVOLVING FUND: WITH REGARD TO THE OTHER SELF-FINANCING MECHANISMS PROPOSED BY THE COMPLEX, THE BUREAU EXPRESSED RESERVATIONS AS TO THE APPROPRIATENESS OF THE CMSCS AS THE INSTITUTIONAL BASE FOR THE REVOLVING FUND. DURING PP DEVELOPMENT, THE MISSION SHOULD ANALYZE CAREFULLY THE ADMINISTRATIVE CAPABILITY AND FINANCIAL EXPERTISE OF CMSCS TO UNDERTAKE SUCH AN ACTIVITY, THE DEMAND FOR THIS FUNDING, AS WELL AS PAYBACK CAPACITY OF THE POTENTIAL RECIPIENTS. THE BUREAU WOULD EXPECT THAT, IF THE MISSION DECIDED TO UNDERTAKE THE REVOLVING FUND WITH CMSCS, IT WOULD BE INITIATED AS A SMALL PILOT PROGRAM, PERHAPS USING THE GENERAL TYPE OF SMALL COOPERATIVE CREDIT SCHEME ESTABLISHED BY THE AGRICULTURAL CREDIT BANK UNDER THE STRENGTHENING RURAL CREDIT SERVICES PROJECT. BECAUSE THE PID DOES NOT FULLY EXPLAIN THE BASIS ON WHICH THE LEVEL OF FUNDING WAS DETERMINED FOR THE REVOLVING FUND, IN ORDER TO COMPLY WITH SECTION 611(A) OF THE FAA, A DEMAND STUDY SHOULD BE UNDERTAKEN TO DETERMINE THE AMOUNT OF FUNDING EARMARKED FOR THIS PURPOSE. IF THE CMSCS ADOPTS THE REVOLVING FUND

APPROACH, THE PP DEVELOPMENT TEAM SHOULD EXAMINE THE T.A. AND TRAINING NECESSARY TO ESTABLISH THIS FUND.

E. REPLICABILITY OF CITE SIMONE PROGRAMS: ALTHOUGH WE RECOGNIZE THAT IT IS NOT WITHIN THE INSTITUTIONAL MANDATE OF THE CMSCS TO REPLICATE ITSELF OR TO EXPAND SERVICES BEYOND CITE SIMONE, THE BUREAU BELIEVES THAT THE SUCCESS OF SEVERAL OF THE CMSCS ACTIVITIES WARRANT EFFORTS TO EXPAND THEM BEYOND THE CONFINES OF THE CITE SIMONE POPULATION. THE MISSION SHOULD ENCOURAGE, TO THE MAXIMUM EXTENT POSSIBLE, THE TRANSFER OF SUCCESSFUL PROGRAMS AND METHODOLOGIES BOTH TO PUBLIC AND PRIVATE SECTOR AGENCIES. WHEN APPROPRIATE, THE MISSION SHOULD ASSIST THE DSPP TO ADOPT THOSE HEALTH PROGRAMS OR PRACTICES WHICH HAVE HAD A BENEFICIAL IMPACT ON THE HEALTH STATUS OF THE RECIPIENTS.

F. TECHNICAL ASSISTANCE: AFTER LENGTHY DISCUSSION AT THE DAEC OF THE TECHNICAL EXPERTISE REQUIRED TO EXECUTE SEVERAL OF THE NEW PROGRAMS, THE BUREAU WOULD SUGGEST THAT THE MISSION REVIEW CAREFULLY THE TECHNICAL ASSISTANCE NEEDS FOR ALL NEW ACTIVITIES, ESPECIALLY THE NON-HEALTH RELATED AREAS SUCH AS VOCATIONAL AND SKILLS TRAINING. ALTHOUGH CITE SIMONE HAS ONGOING PROGRAMS IN THE EDUCATION AREA, WE UNDERSTAND THAT A RECENT EVALUATION OF THIS ACTIVITY SUGGESTS THAT SPECIALISTS IN SEVERAL AREAS, SUCH AS EDUCATION TECHNOLOGY, BE MADE AVAILABLE TO THE PROGRAM.

2. NON-FORMAL EDUCATION (NFE) CONSULTANT: MISSION SHOULD CONSIDER USE OF THE S AND T/EDUCATION FIELD TECHNICAL SUPPORT PROJECT, WHICH HAS AN ONGOING CONTRACT WITH CREATIVE ASSOCIATES, INC. TO FIND AND RECRUIT NFE CONSULTANTS. THE MISSION PAYS THE DIRECT COSTS OF THE CONTRACT ONLY, WITH OVERHEAD AND OTHER INDIRECT COSTS COVERED BY S AND T/ED. THE CONTACT IN AID/W FOR USE OF THIS CONTRACT IS JIM HOXING, S AND T/ED, RM. 6090, SA-18. HIS PHONE NUMBER IS (703) 235-8980.

3. GC/LAC ALSO RECOMMENDS THAT THE MISSION USE THE SERVICES OF THE REGIONAL CONTRACTING OFFICER TO ASSIST IN NEGOTIATING THISAGREEMENT. SHULTZ

BT

#5666

AID 2020-28 (1-72)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 84 to FY 89
Total U.S. Funding $2,000,000.00
Date Prepared: 5/14/84

Project Title & Number: Urban Health/Community Development II - 521-0159

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: To improve the health, socio-economic status and standard of living among the approximately 100,000 residents of Cité Simone, one of the poorest urban areas in Haiti.	Measures of Goal Achievement: Infant Mortality Rate decreased Life expectancy increased Annual per-capita income increased.	DSPP and CMSCS health statistics IHS socio-economic statistics	Assumptions for achieving goal targets: 1. Cité Simone population stabilizes 2. Favorable economic condition in US continues so more industries located in Haiti, providing more jobs. 3. Foreign & Govrnt donor support continues. 4. CMSCS management remains committed to successful project implementation.
Project Purpose: To strengthen the institutional capacity of the Complex Medico-Social de la Cité Simone (CMSCS) to: 1. Provide health services 2. Develop human resource capabilities of Cité Simone residents. 3. Significantly increase its level of financial self-sufficiency.	Conditions that will indicate purpose has been achieved: End of project status. 1. Program-based planning/budget system completed with data on all CMSCS functions. 2. PHC outreach includes 100% target population with special effort on public health edu., Ops. Research, immunization. 3. Competancy-based job training relevant to local labor market developed; remedial/vocational trainers' skills upgraded. 4. Income from user fees, etc. increased.	Project Evaluations CMSCS Service Statistics Special reports on OR activities Monthly & Quarterly Tech Reports JPIP Financial Reports	Assumptions for achieving purpose: CMSCS ret retains qualified health staff and upgrades HRD staff. Better health status increases residents' productivity, employment rates & income. Better economic status enables residents to pay more for services. Better quality control increases handicraft sales. US donors respond positively to CMSCS fund-raising efforts & the needs of the Haitian people.
Outputs: 1. All programs evaluated. 2. Community collab. skills upgraded to distribute ORS, contracep; breastfeeding promotion campaign, PHC outreach, nutrit. surveil, immuniz, OR studies done. 3. Task-specific job trg curriculum desgnd & instructors trnd; job placmt and # trainees increased. 4. User fees analyzed and increased; US tax-exempt organization, strategies, materials developed for fund-raising.	Magnitude of Outputs: 1. Impact of all interventions known & results used to revise prgms. 2. Breastfeeding campaign 5000 women; 60% children w/normal nutritl status, 90% immunized against DPT, polio, measles. 3. 5 new job trg courses implmtd; 22 instruct. trnd; 2500 graduate remedial/vocational edu prgms w/1500 job placmts. 4. User fees and sales provide 15% CMSCS budget; fund-raising income increased 20%.	Project Evaluations Monthly & Quarterly Tech Reports Service Statistics Annual Management Reviews	Assumptions for achieving outputs: Natural or economic disasters do not seriously increase problems in Cité Simone. CMSCS interventions continue to receive full community support & impact positively on population. Employment Training Coordinator re receives full support of CMSCS management. Socio-economic status, employment and literacy rates of populatinn can be verified.
Inputs: See Financial Plan.	Implementation Target (Type and Quantity) Infant Mortality reduced to 55/1000. Life Expectancy increased 2 years. Annual per-capita income increases $15.	Annual Management Reviews Service Statistics Financial Reports	Assumptions for providing inputs: AID & other donor support continues as scheduled.

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COMPLEXE MEDICO SOCIAL DE LA CITE SIMONE

273, Blvd. J. J. DESSALINES
P. O. BOX 1666
PORT-AU-PRINCE, HAITI

Phone : 2-0336 - 2-3464 - 2-1814
Telex : 3490244

Centre Haitiano Arabe
Plan International

Centre Medico Social
de Boston

Centre Medico Social
de Brooklyn

Centre Culturel
pour la Jeunesse

Centres de Démonstration
Centre Hospitalier Ste. Catherine Labouré

Trois établissements de Couture
et d'Artisanat

Centre de
Promotion Familiale

November 29, 1983

Mr Harlan Hobgood
Director
USAID/HAITI

Dear Mr Hobgood,

We are pleased to submit to your mission for approval our proposal for the follow-up project of Cite Simone entitled "Urban Health and Community Development".

As you know, for the last nine years, the Complexe Medico Social has been providing health and education care to the poor people of Cite Simone. Although a major improvement has been achieved, much remains to be done. However, we feel now that the Complexe should go one step further during the course of the next 5 years by strengthening its vocational training program in order to respond better to the needs of the private sector and by promoting income generating activities within the Cite Simone area.

The activities outlined in our project follow the Government strategy (1) to achieve the"Health for All by the Year 2000" and (2) to improve the socio-economic status of the residents of Cite Simone.

We would greatly appreciate the approval fo the proposed project in order that the funds could be available by April 1, 1984.

We will appreciate your comments on the attached proposal and we are ready to discuss any changes that you feel would be appropriate before presentation of the project to Washington.

We thank you for your cooperation and we kindly ask you to receive our most sincere regards.

Dr Carlo Boulos
President - Director General
CMSCS

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

JAN 25 1984

LAC/DR-IEE-84-17

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Haiti
Project Title and Number	:	Urban Health and Community Development #521-0159
Funding	:	Two Million Dollars (G)
Life of Project	:	Five Years (FY'84-'88)
IEE Prepared by	:	USAID/Port au Prince
Recommended Threshold Decision	:	Categorical Exclusion
Bureau Threshold Decision	:	Concur with Recommendation

Copy to : Harland H. Hobgood
Director, USAID/Port au Prince

Copy to : Wendy Stickel, LAC/DR

Copy to : IEE File

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James S. Hester Date 6 January 1984

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

Rec: 2/2/84

UNITED STATES GOVERNMENT

memorandum

DATE: November 30, 1983

REPLY TO ATTN OF: REMS/ENG, James Talbot

SUBJECT: Initial Environmental Examination (IEE) for OPG Proposal on Cite Simone Complex

TO: DRE, David Adams

According to the information given to me by Kathy MacDonald, I cannot believe that the project action related to supplying materials for wells and pumps will have a significant effect on the environment. Thus, according to Environmental Procedure 216.2 it is recommended that the Proposed Project be excluded from IEE requirements at this time.

If project activities should change at some later stage of design or execution to include extensive well-drilling and water withdrawal from the Cite Simone area, or use of alternate sources of water whose quality is unknown or suspected of contamination (esp. fecal caliform), then an IEE would be required.

cc: PHO, Kathy MacDonald

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

*U.S. Government Printing Office: 1976—241-530/3018

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

AGENCY FOR INTERNATIONAL DEVELOPMENT

MISSION TO HAITI

For U.S. MAIL:
USAID / HAITI
Department of State
Washington, D.C. 20520
For INTERNATIONAL MAIL:
USAID / HAITI
P.O. Box 1634
Port-au-Prince, Haiti, W.I.

MAY 25 1984

Dr. Carlo Boulos
Director
Complexe Médico Social
de la Cité Simone
P.O. Box 1666
Port-au-Prince, Haiti

Dear Dr. Boulos:

Subject: Cooperative Agreement
No. 521-0159

Pursuant to Section 104 of the Foreign Assistance Act, as amended, the Agency for International Development (hereinafter referred to as "A.I.D." or "Grantor") hereby provides to the Complexe Médico-Social de la Cité Simone (hereinafter referred to as the "Complex" or "Recipient") the sum of Four Hundred Fifty Thousand Dollars ($450,000) to help finance the Urban Health/Community Development II Project (the "Project"). The Project will support the overall program of the Complex in the Cité Simone area, particularly in community health care and operations research, human resources development and increasing the Recipient's long-term financial self-reliance, as more fully described in Annex 3 entitled, "Summary Project Description."

Additional amounts of up to $1,650,000 for a total not to exceed $2,100,000 will be provided in future increments to the Complex to support the Project, subject to the availability of funds for this purpose and to the mutual agreement of the Complex and A.I.D. to proceed with the Project. This Cooperative Agreement is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Recipient in furtherance of program objectives from May 1, 1984 through the estimated completion date of April 30, 1989.

Dr. Carlo Boulos
Directeur
Complexe Médico Social
de la Cité Simone
Boite Postale 1666
Port-au-Prince, Haiti

Monsieur le Directeur,

Objet: Accord de Coopération
No. 521-0159

Conformément à la Section 104 de la loi sur l'Aide Etrangère, telle qu'elle a été amendée, l'Agence Américaine pour le Développement International (ci-après dénommée "AID" ou "Donateur"), accorde par la présente, au Complexe Médico Social de la Cité Simone (ci-après dénommé le "Complexe" ou "Bénéficiaire"), la somme de Quatre Cent Cinquante Mille Dollars ($450.000) pour lui permettre de financer le projet: Santé Urbaine/Développement Communautaire II (ci-après dénommé "Le Projet"). Le Projet financera tout le programme du Complexe dans la zone de Cité Simone, particulièrement dans le domaine de la santé communautaire et de recherche opérationnelle, du développement des ressources humaines et de l'accroissement des ressources financières, comme décrit plus en détail à l'Annexe 3 sous le titre, "Description Sommaire du Projet".

Des fonds additionnels jusqu'à concurrence de $1.650.000 pour un total ne dépassant pas $2.100.000 seront plus tard décaissés pour les besoins du Projet du Complex, sujet à la disponibilité des fonds à cette fin et à l'accord mutuel entre le Complex et l'AID pour exécuter le Projet. Cet Accord de Coopération entrera en vigueur à la date de la présente et s'appliquera aux engagements pris par le Bénéficiaire pour atteindre les objectifs du programme du 1er mai 1984 au 30 avril 1989, date probable d'achèvement.

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This Cooperative Agreement is made to the Recipient on condition that the funds will be administered in accordance with the terms and conditions as set forth in Annex 1, the Schedule; Annex 2, the Program Description; Annex 3, the Summary Project Description; Annex 4, the Standard Provisions; Annex 5, Procedures to obtain Disbursements; and Annex 6, the Assurance of Compliance which have been agreed to by your organization.

Please sign the original and six (6) copies of this letter to acknowledge your acceptance of the Cooperative Agreement, and return the original and five copies to this office.

Sincerely,

F.E. Obey
Grant Officer
USAID/Haiti

ANNEXES:
1. Schedule
2. Program Description
3. Summary Project Description
4. Standard Provisions and Alterations in Grant
5. Procedures to Obtain Disbursements
6. Assurance of Compliance

Acknowledged:

COMPLEXE MEDICO SOCIAL DE LA CITE SIMONE (CMSCS)

By: _____
Dr. Carlo Boulos

Title: _____
Director, CMSCS

Date : MAY 25 1984

Fiscal Data:

Appropriation :	72-1141021.6
Budget Plan Code:	LDAA-84-25521-CG81
PIO/T No. :	521-0159-3-40081
Project No. :	521-0159
Estimated Amount:	$2,100,000
Amount Obligated:	$450,000
Funding Source :	USAID/Haiti

L'Accord de Coopération est passé avec le Bénéficiaire, à la condition que les fonds soient administrés selon les termes et conditions énoncés à l'Annexe 1, Calendrier; à l'Annexe 2, Description du Programme; à l'Annexe 3, Description Sommaire du Projet; à l'Annexe 4, Dispositions Courantes; à l'Annexe 5, Conditions d'Obtention de Remboursement, et à l'Annexe 6, Aquiescement, qui ont été acceptés par votre organization.

Comme approbation à l'Accord de Coopération, nous vous prions de bien vouloir signer l'original et six copies de la présente et de nous retourner l'original et cinq copies pour nos dossiers.

Dans l'attente, veuillez agréer, Monsieur le Directeur, nos salutations.

Harlan H. Hobgood
Mission Director, USAID/Haiti

Clayton E. McManaway, Jr.
American Ambassador

ANNEX No. 1

SCHEDULE

A. Period of Agreement

1. The effective date of this Cooperative Agreement (CA) is the signature date by the Grant Officer as shown on the cover letter, and the estimated completion date is April 30, 1989.

2. Funds obligated hereunder are available for program expenditures for the estimated periods of May 1, 1984 through April 30, 1989, as shown in the financial plan below.

B. Amount of Agreement and Payment

1. AID hereby obligates the amount of $450,000 for purposes of this CA.

2. Payments will be made as follows:

a. For all costs incurred within Haiti--in accordance with the procedures set forth in Annex 4, Standard Provisions, Section 9A entitled "Payment-Periodic Advance", and Annex 5, Procedures to Obtain Disbursements.

b. For all Technical Assistance, USAID/Haiti will make direct payments to the various contractors employed.

C. Reporting

1. Annual Plan of Action and Budget - Beginning with Project Fiscal Year 1, the Complex will submit an Annual Plan of Action and an Annual Budget, describing in detail the results from the prior year, and planned project activities for the coming year. The Action Plan will include planned operational studies, results of all activities and research, organizational and management changes planned, a staffing plan and a timetable of activities. The Annual Budget will include detailed personnel lists and lists of planned commodity purchases, showing AID local currency requirements as well as GOH and other donor contributions for each budget expenditure.

ANNEXE No. 1

CALENDRIER

A. Durée de l'Accord

1. Cet Accord de Coopération (AC) entrera en vigueur à sa signature par le Donateur, comme indiqué dans la lettre, et sa date d'achèvement est en principe le 30 avril 1989.

2. Les fonds engagés par la présente sont disponibles pour les dépenses du programme pendant une période allant du 1er mai 1984 au 30 avril 1989, comme indiqué dans le plan financier ci-après.

B. Montant de l'Accord et Paiement

1. Par la présente, l'AID affecte le montant de $450.000 pour les besoins du présent AC.

2. Les paiements seront effectués comme suit: a. Pour toutes les dépenses locales, conformément aux procédures prescrites par l'Annexe 4, Dispositions Courantes, Section 9A, Paiement-Avance Périodique, et par l'Annexe 5, Conditions d'Obtention de Remboursement.

b. Pour tout service technique, l'USAID paiera directement les contractants.

C. Rapports

1. Plans et Budgets Annuels

A la 1ère année du Projet, le Complexe soumettra annuellement un Plan d'Action et un Budget, décrivant en détail les résultats des années précédentes et les projections pour les années à venir. Le Plan d'Action incluera des études opérationnelles planifiées, les résultats de toutes les activités et recherches, les changements d'ordre organisationnel et administratif, un plan du personnel et un calendrier des activités. Le Budget Annuel comprendra la liste détaillée du personnel et les listes des produits achetés en donnant pour chaque article du budget la participation de l'AID, aussi bien que celle du GOH ou de tout autre donateur.

2. Technical Reports - The Complexe shall submit quarterly technical reports on the activities of all facilities and programs supported under the project. Two copies of each quarterly technical report shall be submitted. In addition, quarterly reviews of the Complexe's program in Cité Simone will be carried out by the Board of Directors of the Complexe and representatives of the donors present in Port-au-Prince, including A.I.D. Copies of reports issued after such meetings will be provided to A.I.D. The Complexe shall further provide special reports as requested.

2. Rapports Techniques - Le Complexe devra soumettre des rapports techniques trimestriels sur les activités de tous les services et programmes financés par le projet. Les rapports trimestriels ou techniques devront être soumis en deux copies. En plus, des révisions trimestrielles du Programme du Complexe de la Cité Simone seront faites par le Conseil d'Administration du Complexe et les représentants des donateurs présents à Port-au-Prince y compris l'A.I.D. Les copies des rapports préparés après ces réunions seront envoyées à l'A.I.D. Le Complexe devra présenter, sur demande, des rapports spéciaux.

3. Financial Reports - The Recipient shall submit to the responsible AID Controller all reports required under the Standard Provisions entitled "Payment - Periodic Advance" via the USAID Project Manager. Copies of the annual financial report of the Complexe will also be provided to A.I.D.

3. Rapports Financiers - Le Bénéficiaire soumettra, par l'intermédiaire du responsable du Projet de l'USAID, au Bureau de Comptabilité de l'AID, tous les rapports requis dans le cadre des Dispositions Courantes intitulées "Paiement - Avance Périodique". Les copies du rapport financier annuel devront être soumises à l'AID.

D. Evaluation

At the end of second year, an evaluation will be carried out to identify problems in all components of the Project. At the end of the fourth year, an impact evaluation will be carried out to assess the impact of the project in achieving its purposes and objectives. It is hereby agreed that the Recipient will permit USAID, acting on behalf of the Recipient, to contract for the consulting services required to conduct the evaluations of the project.

D. Evaluation

A la fin de la deuxième année, une évaluation pour identifier les problèmes de toutes les divisions du Projet sera effectuée. A la fin de la quatrième année, une évaluation sur son impact sera effectuée en vue d'évaluer les progrès du projet en ce qui a trait à ses buts et objectifs. Il reste entendu que le Bénéficiaire accordera à l'USAID l'autorisation de passer des contrats pour les services techniques nécessaires à l'évaluation du projet.

E. Financial Plan and Budget

The CA will total $2,100,000 over a five-year period, subject to the availability of funds to A.I.D. for this purpose and to the mutual agreement of A.I.D. and the Complexe to proceed. A detailed budget setting forth the agreed

E. Plan Financier et Budget

L'Accord de Coopération s'élèvera à une valeur totale de $2.100.000 répartis sur une période de cinq ans sujet à la disponibilité des fonds de l'A.I.D. destinés à ce but et à l'accord mutuel intervenu entre l'A.I.D. et le Complexe

uses of A.I.D. Cooperative Agreement funds is provided in Table I. The Recipient may not exceed the obligated amount set forth and project funds budgeted for Technical Assistance may not be used for other purposes; however, reasonable adjustments in the use of A.I.D. funds budgeted for other activities and not exceeding 15% of any line item, may be made in the use of A.I.D. funds without prior USAID/Haiti approval.

F. Procurements of Goods and Services

AID requirements regarding source, origin and Competitive Negotiation for all goods and services procured under the CA will be followed in accordance with the Standard Provisions of Annex No. 4.

G. Special Provisions

1. In Annex 4, Standard Provisions, delete the words "Grant" and "Grantee" wherever they appear, and substitute in lieu thereof the word "Cooperative Agreement" and "Recipient".

2. Of the Standard Provisions, the following shall be deleted: 7, 8A, 8B, 9B, 12B, 15B, 15C.

3. Alterations in Grant dated july 1982, are herein attached and made a part of this Cooperative Agreement.

4. No payment will be made to the Recipient on account of indirect costs.

pour progresser. On trouve dans le Tableau I un budget détaillé formulant l'utilisation acceptée pour les fonds du CA de l'A.I.D. Le Bénéficiaire ne peut dépasser le montant affecté et les fonds de projet comptabilisés pour l'Assistance Technique ne peuvent être utilisés à d'autres fins; cependant, des ajustements raisonnables relatifs à l'utilisation des fonds de l'A.I.D., comptabilités pour d'autres activités et ne dépassant pas 15% de n'importe quelle rubrique, peuvent être faits sans qu'on ait besoin de l'approbation préalable de l'USAID/Haiti.

F. Acquisitions de Fournitures et Services

Conformémenent aux Dispositions Courantes de l'Annexe 4, les règlements de l'AID en ce qui a trait à la source, l'origine, et la négociation compétitive doivent être observés pour toute acquisition de fournitures ou de services dans le cadre de cet Accord de Coopération.

G. Dispositions Spéciales

1. A l'Annexe 4, Dispositions Courantes, remplacer les mots "Don" et "Donateur" par "Accord de Coopération" et "Bénéficiaire.

2. Parmi les Dispositions Courantes, les articles suivants peuvent être éliminés: 7, 8A, 8B, 9B, 12B, 15B, 15C.

3. Les modifications apportées au l'Accord de Don daté de juillet 1982 sont en annexe et font partie de l'Accord de Coopération.

4. Aucun paiement ne sera fait au Bénéficiaire sous le compte "Coûts Indirects".

H. Conditions Precedent to Disbursement for Contingency Funds

The Life of Project Budget includes approximately $100,000 in contingency funds, allocated for the primary purpose of allowing the Complexe greater flexibility to identify and develop activities contributing to greater financial self-reliance. Priority activities for using these funds include further development of fund-raising strategies and materials, technical assistance to identify ways of increasing fees, sales of handicrafts, etc., as opposed to operating expenses, i.e., salaries and supplies for on-going service delivery. Before any disbursement or issuance of any commitment documentation to use these funds, unless USAID Otherwise agrees in writing, the Complex shall submit USAID, in form and substance satisfactory to AID, information on (1) the intended use of the funds requested and (2) where appropriate, documentation explaining how the proposed activity will contribute to greater financial self-reliance for the Complexe.

H. Conditions à remplir avant le Décaissement des fonds pour les Activités Imprévues

Le Budget du Projet comprend environ $100,000 en Activités Imprévues. Ces fonds sont alloués principalement pour permettre au Complexe d'être plus flexible dans l'identification et le développement d'activités ayant une plus grande auto-dépendance auto-financière. Les programmes prioritaires relatifs à l'utilisation de ces fonds comprennent d'autres stratégies et matériels, l'augmentation de fonds, l'assistance technique pour identifier les moyens d'augmenter les frais, les ventes de produits artisanaux, etc., en opposition aux frais de fonctionnement, tels, salaires et fournitures. Avant tout décaissement ou avant l'émission de tout document relatif à l'utilisation de ces fonds, sauf si l'USAID consent autrement par écrit, le Complexe soumettra à l'AID en forme et en substance, (1) l'utilisation présumée des fonds demandés et si possible (2) une documentation expliquant comment cette activité contribuera-t-elle à une plus grande auto-dépendance du Complexe.

TABLE I

AID PLANNED INPUTS
OVER LIFE OF PROJECT
(In US $000)

	Year 1*	Year 2	Year 3	Year 4	Year 5	Total
Management/ Administration						
Operating Expenses						
Salaries	13.1	13.1	13.2	13.5	13.8	66.7
Supplies/Equipment	9.0	9.0	9.2	9.3	9.5	46.0
Program Additions						
Computer Equipment	1.0	11.0	2.0	1.0	1.0	16.0
Evaluation/TA	0	25.0	0	40.0	0	65.0
Subtotal	23.1	58.1	24.4	63.8	24.3	193.7
Health						
Operating Expenses						
Salaries	163.6	162.9	161.8	152.6	119.2	760.1
Eqpmt/Supplies/Meds.	46.4	46.4	47.3	48.2	49.2	237.5
Program Additions						
Operations Research	24.0	24.0	24.0	24.0	24.0	120.0
Breastfeeding Promotion	69.0	24.0	0	0	0	93.0
Expanded Immunization	1.0	1.0	1.0	1.0	0.5	4.5
Subtotal	304.0	258.3	234.1	255.8	192.9	1,215.1
Human Resources/ Development						
Operating Expenses						
Salaries	55.5	55.6	56.6	57.7	58.8	284.2
Training Materials	21.0	21.1	21.5	21.9	22.3	107.8
Program Additions						
Voc. Trng. Improvements	52.0	49.0	12.0	12.0	12.0	137.0
Subtotal	128.5	125.7	90.1	91.6	93.1	529.0
Self-Financing/ Activities						
User Fees Increases (TA)	15.0	15.0	0	0	0	30.0
Fund-Raising (Matrls)	15.0	10.0	0	0	0	25.0
Subtotal	30.0	25.0	0	0	0	55.0
Subtotal (All Programs)	485.6	467.1	348.6	381.2	310.3	$1,992.8
Contingency						107.2
GRAND TOTAL						$2,100.0

Note: The Project "Fiscal Year 1" begins on May 1, 1984, and does not refer to the AID fiscal year schedule of October 1 through September 30.

ANNEX No. 2

URBAN HEALTH AND COMMUNITY DEVELOPMENT II

Cooperative Agreement (Project No. 521-0159)

Cooperative Agreement No. AID-521-G-0159

Program Description

A. Purpose of Cooperative Agreement (CA)

The purpose of this CA is to assist the Complexe Médico-Social de la Cité Simone to carry out and evaluate its overall community development program, by (1) strengthening and expanding its programs providing preventive and curative health services and human resources development (especially employment skills), in the Cité Simone area of Port-au-Prince, Haiti, (2) increasing its institutional capacity for long-term self-reliance. The accomplishment of this purpose will be measured by an increase in the number of persons in these areas who are reached by the programs of the Complexe, by a resultant improvement in their health and socio-economic status and in the increased financial self-sufficiency of the Complex.

B. Description of Activities

The Recipient will perform the activities under this Cooperative Agreement as described below and in the summary of the Recipient's proposal entitled "Summary Project Description" hereby incorporated as part of this Agreement, as Annex 3. To the extent of any inconsistency between the Summary Project Description and the Covering Letter and Annexes 1, 2, 4 and 5 of this Agreement, the Covering Letter and Annexes 1, 2, 4 and 5 shall control.

ANNEXE No. 2

SANTE URBAINE ET DEVELOPPEMENT COMMUNAUTAIRE II

Accord de Coopération (Project No. 521-0159)

Accord de Coopération AID-521-G-0159

Description du Programme

A. But de l'Accord

Le but de l'Accord est d'aider le Complexe Médico-Social de la Cité Simone à exécuter et evaluer son programme général de développement de la communauté, (1) en renforçant et à répandant ses programmes en fournissant des services de santé préventifs et curatifs, le développement des ressources humaines, l'éducation et la compétence dans l'emploi, et les activités auto-suffisantes dans l'aire de la Cité Simone, et (2) en augmentant sa capacité institutionnelle. L'exécution de ce dessin sera mesurée par l'augmentation du nombre de personnes de ces aires qui seront atteintes par les programmes du Complexe et par une amélioration de leur état de santé et de leur statut socio-économique, et dans l'amélioration de l'état financier du Complexe.

B. Description des Activités

Le Bénéficiaire exécutera les activités dans le cadre de cet Accord de Coopération, comme décrit ci-après, et dans le sommaire de la proposition du Bénéficiaire ayant pour titre "Sommaire de la Description du Projet" inséré dans la présente et faisant partie de cet Accord (Annexe 3). En cas de contradiction entre la Description Somaire du Projet d'une part et de la Lettre de Couverture et les Annexe 1, 2, 4 et 5 cet Accord d'autre part, la Lettre de Couverture et les Annexe 1, 2,4 et 5 prévaudront.

C. Specific Objectives

The specific objectives of this CA are as follows:

1. To strengthen the management capability of the Complexe Médico-Social de la Cité Simone to implement its overall community development program in the Cité and neighboring areas, which are among the most impoverished zones in Port-au-Prince.

2. To improve the health and nutritional status of a large portion of the residents of the Cité Simone area, (with emphasis on children under five years and their mothers) through a strengthening and expansion of relevant Complexe programs, including operations research activities.

3. To improve the income-earning capabilities of adult residents of the Cité Simone area through expanding the vocational and artisanal training programs and other educational and community development programs of the Complexe.

4. To increase sources of financial support for the Complexe through interventions including improved financial management; increased fees-for-services, based on careful and systematic analysis of residents' ability and willingness to pay; and the development and implementation of more effective fund-raising strategies.

D. Responsibilities of the Complex

1. The Complex will expand the coverage of its existing community health programs to include the entire population of the Cité Simone area and its environs (an estimated 100,000 people), providing services which

C. Objectifs Spécifiques

Les objectifs spécifiques de l'Accord sont les suivants:

1. Renforcer la capacité gestionnaire du Complexe Médico-Social de la Cité Simone à exécuter son programme général de développement communautaire dans la Cité et les aires avoisinantes qui sont les zones les plus peuplées de la capitale.

2. Améliorer le statut sanitaire et nutritionnel d'une grande partie des résidents de la Cité Simone (spécialement les enfants de moins de cinq ans et leurs mères) par le renforcement et l'expansion des programmes qui ont rapport au Complexe, y compris les activités de recherche opérationnelle.

3. Améliorer les capacités de gagner des revenus des adultes résidant dans la Cité Simone par l'expansion des programmes de formation vocationnelle et artisanale, et les d'autres programmes éducationnels et de développement communautaire du Complexe.

4. Augmenter les sources de support financier au Complexe par: l'amélioration de la gestion financière; l'augmentation de la somme symbolique payée pour les services, d'après une analyse systématique de la possibilité et de la volonté du patient; et le développement et l'exécution d'une stratégie plus effective d'accroissement des revenus.

D. Responsabilités du Complexe

1. Le Complexe étendra la couverture de ses programmes de santé communautaire existants pour inclure toute la population de la Cité Simone et de ses environs (approximativement 100.000

will include the following: population delineation and registration of vital events, child growth monitoring, nutritional surveillance and rehabilitation, promotion of oral rehydration, breastfeeding and expanded immunization.

2. The Complex will conduct operations research projects to identify, develop, test and document the results of cost-effective interventions targeted at further reductions in morbidity and mortality among "high risk" groups within its target population, especially children under five.

3. The Complex will strengthen the management, effectiveness and evaluation of its current remedial and vocational education programs for adults and adolescents through (a) upgrading instructor skills, (b) increased student monitoring, incentives and quality control and (c) integrating training center utilization and outcome statistics (skills development measures, job placement records, etc.) into the overall Complex Management Information System. The Complex will further include this information in all its technical and financial reporting documents.

4. The Complex will develop new vocational training courses and curriculum, based on task analyses of available jobs in local industry.

5. The Complex will consult with AID when problems arise and on the following points in project implementation:

personnes), en fournissant des services qui comprendront: la distribution de la population et l'enregistrement des évènements vitaux, le contrôle de la croissance des enfants, la surveillance et la réhabilitation nutritionnelles, la promotion de la réhydratation orale, l'allaitement au sein et la vulgarisation de l'immunisation.

2. Le Complexe dirigera des projets de recherche sur les informations en vue d'identifier, de développer, de tester et de documenter les résultats des interventions basés sur le rapport côut/efficacité dirigés vers des diminutions ultérieures de la morbidité et de la mortalité parmi les groupes à "haut risque" au sein de la population visée, spécialement les enfants de moins de cinq ans.

3. Le Complexe renforcera la gestion, l'efficacité et l'évaluation de ses programmes d'éducation corrective et professionnelle pour les adultes et les adolescents par (a) l'engagement d'un coordonnateur pour la formation des employés; (b) l'amélioration des capacités des instructeurs; (c) l'augmentation du contrôle, des encouragements, et du contrôle de la qualité de l'étudiant; (d) l'intégration de l'utilisation du centre de formation et des statistiques des résultats obtenus (l'augmentation des compétences, nombre de positions remplies, etc.) dans le système général d'information sur la gestion du Complexe qui incluera ultérieurement cette information dans tous ses rapportes techniques et financiers.

4. Le Complexe développera de nouveaux cours et des programmes de formation professionnelle basés sur les analyses des emplois disponibles dans l'industrie locale.

5. Le Complexe consultera l'AID quand des problèmes se présenteront et sur les points suivants au cours de l'exécution du projet:

a) The appointment of a project-funded Employment Training coordinator;

b) The appointment of a project-funded Data Processing technician;

c) to assure that AID regulations are followed in procurement of project-funded computer hardware and/or software.

6. In accordance with the financial strategy specified in its Long-Term Plan, the Complex will sustain all its programs at the same budget level which currently exists until stable, long-term financing for program additions has been identified. In particular, first year project funds for salaries and personnel costs will be provided for the same positions and at the same salary levels set in the previous grant; with the exception of two new positions: (1) the Employment Training Coordinator, whose salary is funded under new training program costs, and (2) the Data Processing technician, whose salary is budgeted under Operation Research funds.

7. The Complex agrees that its Board of Directors will, within 90 days of the date of this Agreement, meet to establish a Personnel Management Plan for the Project activities herein described and submit this Plan for USAID/Haiti review and approval. The Plan will include: (a) accurate and functional job descriptions clearly defining each employee's responsibilities, supervision and educational requirements, (b) standards and procedures for performance evaluation, discipline and recognition, incentives and rewards, and (c) policies and procedures for selection and promotion.

a) la nomination d'un coordonnateur pour la formation des employés qui sera payé à partir des fonds du projet.

b) la nomination d'un technicien en traitement de données dont le coût sera à la charge du projet.

c) s'assurer que les règlements de l'AID soient suivis pour l'acquisition d'un matériel et/ou d'un logicien.

6. Conformément à la stratégie financière spécifiée dans son Plan à long terme, le Complexe maintiendra ses programmes au niveau budgétaire existant actuellement jusqu'à ce que soient identifiées des sources de financement stables et à long terme pour des additions au programme. Particulièrement au cours de la 1ere année, les fonds du projet pour les salaires et les coûts du personnel seront fournis pour les mêmes positions et aux mêmes niveaux de salaire fixés dans le don antérieur à l'exception de deux nouveaux postes: (1) Un Coordonnateur à la Formation Professionnelle, qui sera payé à partir des coûts du nouveau programme de formation, et (2) Un Technicien en Informatique dont le salaire est budgétisé dans le cadre des fonds de Recherche Opérationnelle.

7. Le Complexe convient que, dans les 90 jours à partir de la date du présent Accord, son Conseil d'Administration établira un Plan de Gestion du Personnel pour les activités du projet décrites dans la présente et le soumettra à l'examen et à l'approbation de l'USAID/Haiti. Ce plan comprendra (a) des descriptions justes et fonctionnelles des fonctions définissant clairement les responsabilités, la supervision et la formation de chaque employé du Complexe payé par l'AID, (b) les standards et les procédures pour l'évaluation du rendement, la discipline et la reconnaissance, les stimulants et les récompenses et (c) les politiques et les procédures pour la sélection et la promotion.

8. The Complex agrees to strengthen and improve its self-financing capabilities and to seek, during the period of this CA, additional funding sources both private and public, in Haiti and outside, in order to provide for the continuation of its services at the level which will exist at the time of termination of this CA. Technical assistance funds for this purpose are provided in the CA, to assist the Complex to establish unified and effective self-financing systems.

8. Le Complexe convient de renforcer et d'améliorer ses capacités d'auto-financement et de chercher au cours de la période de cet AC des sources additionnelles de financement tant privées que publiques, dans le pays et hors d'Haiti, de façon à prendre des mesures en vue de la continuation de ses services au niveau qui existera au moment de l'achèvement de cet AC. Les fonds pour l'assistance technique à cet effet sont prévus dans l'AC, pour aider le Complexe à établir des systèmes unifiés et efficaces d'auto-financement.

9. The Complex will channel newly mobilized private sector funding or proceeds from the Industrialization Program or increased fees-for-services into support for its basic operating expenses, while shifting AID funds into new more experimental activities.

9. Le Complexe canalisera le financement du secteur privé nouvellement mobilisé ou les produits du Programme d'Industrialisation ou l'augmentation des frais pour service vers le soutien pour ses dépenses de base de fonctionnement et fera passer les fonds de l'AID à de nouvelles activités plus expérimentales.

E. Substantial Involvement Understanding

Unless USAID otherwise agrees in writing, the following procedures shall be addressed:

1. Representatives of USAID/Haiti and the Complexe will participate in quarterly reviews and Annual Management Reviews to verify progress in implementing the project and to help resolve any problems.

2. USAID/Haiti will review, recommend modifications and concur in all Complexe Operations Research proposals funded under this Cooperative Agreement.

3. USAID/Haiti will review and concur in plans and expenditures proposed for expanded services coverage, immunization and promotion of breastfeeding funded under this CA.

E. Entente d'Engagement

Les critères suivants doivent être satisfaits, sauf si l'AID en décide autrement par écrit:

1. L'USAID/Haiti et le Complexe participeront aux examens trimestriels et aux Révisions Annuelles sur la gestion pour vérifier l'état d'avancement de l'exécution du projet et aider à résoudre tous les problèmes.

2. L'USAID/Haiti examinera toutes les propositions de recherche sur les opérations financées dans le cadre de cet Accord de Coopération, recommandera les modifications à y apporter et les dirigera.

3. L'USAID/Haiti examinera et donnera son consentement pour les plans et les dépenses proposés pour l'extension de la couverture des services, l'immunisation et la promotion de l'allaitement au sein financés dans le cadre du présent AC.

4. USAID/Haiti will review and concur in the user fee schedule changes, health care fund-raising èfforts, pre-payment plans, drug sales programs and other self-financing innovations carried out under this project and in the use of contingency funds.

5. It is hereby agreed that the Recipient will permit USAID/Haiti, acting on behalf of the Recipient, to contract for all required Technical Assistance funded under this project.

6. USAID/Haiti will review potential candidates and concur in the appointment of the Employment Training Coordinator, and Data Processing Technician to be paid from the Cooperative Agreement.

7. USAID/Haiti will review and approve the Personnel Management Plan of the Complex Board of Directors.

4. L'USAID/Haiti examinera et donnera son consentement aux changements du barême de frais des usagers, aux plans de paiement anticipé des soins de santé, au programme de vente des médicaments et autres innovations auto-financières exécutées dans le cadre de ce projet.

5. Il demeure entendu que le Bénéficiaire donnera l'autorisation à l'AID de passer des contrats en son nom pour tous les services techniques financés par ce projet.

6. L'USAID/Haiti examinera les candidats potentiels et donnera son consentement à l'engagement du Coordonnateur pour la Formation des Employés et du Technicien en Informatique devant être payés à partir des fonds de l'Accord de Coopération.

7. L'USAID/Haiti examinera et approuvera le Plan de Gestion du Personnel du Conseil d'Administration.

ANNEX No. 3

SUMMARY PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of this project is to improve the health, socio-economic status and standard of living among the approximately 100,000 residents of Cité Simone, one of the poorest urban slums in Port-au-Prince, with living conditions marked by overcrowding, lack of potable water and poor sanitation. Improvements in health status, life expectancy and increased per capita income in the target population will indicate achievement of this goal.

The project purposes are to assist the Complexe Médico-Social de la Cité Simone (the "Complexe") (1) improve health services outreach, (2) strengthen its overall human resources development program, (3) achieve a critical level of financial self-sufficiency within the Life of Project period.

B. Project Components

1. Strengthen Management Capacity of the Complexe

The Complexe will upgrade its Management Information System to (1) complete implementation of automated program planning and program-based budgeting, and (2) expand the existing Information System to include all CMSCS activities, establishing clearly defined, quantifiable goals for monitoring progress. Complex administrators will undertake Operations Research activities aimed at improving program cost effectiveness, management and financially self-sustaining activities. The Complex will further keep USAID/Haiti fully informed of the progress of the interventions through quarterly reports and Annual Management Reviews.

ANNEXE No. 3

DESCRIPTION SOMMAIRE DU PROJET

A. But et Objectif du Projet

Le but de ce projet est d'améliorer l'état de santé, le statut socio-économique et le standard de vie des 100.000 résidents de la Cité Simone, un des bidonvilles les plus pauvres de Port-au-Prince. Les conditions de vie sont marquées par la surpopulation, le manque d'eau potable et d'hygiène. L'amélioration de l'état de santé et de l'espérance de vie et l'augmentation du revenu per capita de la population visée consacreront la réalisation de cet objectif.

Les objectifs du projet sont d'aider le Complexe Médico Social de la Cité (le "Complexe") à (1) améliorer l'extension des services de santé, (2) renforcer son programme d'ensemble de développement des ressources humaines, (3) atteindre un niveau critique d'auto-suffisance financière au cours de la durée du projet.

B. Composantes du Projet

1. Renforcer les capacités de Gestion du Complexe

Le Complexe augmentera son Système de Gestion d'Information pour (1) compléter l'exécution des programmes automatisés de planification et le budget élaboré d'après les programmes; (2) élargir l'actuel Système d'Information pour y inclure toutes les activités du CMSCS, en établissant des buts bien définis pour contrôler les progrès. Les administrateurs du Complexe entreprendront des activités de recherche opérationnelle visant à améliorer l'efficacité des programmes face au coût, à la gestion et aux activités auto-financées. Le Complexe tiendra USAID au courant des progrès de ses interventions en soumettant des rapports trimestriels par la révision annuelle du système de gestion.

2. Health Services and Operations Research

Over the next five years, health service operations of the Complexe will strengthen their focus on problems which represent the highest risk to the target population, e.g., nutrition; diarrhea control; immunization; pre- and post-natal care and control measures for tuberculosis.

The Complex will increase coverage to include the entire Cité Simone population (approximately 100,000 people) using the collaborator network. The computerized family registration system now in place will facilitate this process. Additional in-service training will upgrade collaborator skills to include house-to-house distribution of contraceptives and oral rehydration therapy. With the collaboration of the DSPP, at least ten sales posts for Oral Rehydration salts will be established in Cité Simone in order to further promote Oral Rehydration Therapy among Cité Simone residents.

The Complexe will undertake special campaigns to increase immunization coverage to 90% of the population. Immunization program objectives consist of (1) immunizing children under five against diphtheria, pertussis, tetanus (DPT), polio and measles and (2) immunizing women of child-bearing age and all pregnant women against tetanus.

Complexe technicians also plan a major, two-year campaign to promote breastfeeding among mothers of Cité Simone, as studies have clearly documented the widespread practice of early [illegible]t bottle feeding and its correlation with increased Infant Mortality Rates in the area. The Complexe health team plans three types of interventions to counteract and change this behavior:

2. Services de Santé et Recherche Opérationnelle

Au cours des cinq prochaines années, les opérations sanitaires des services du Complexe se concentreront davantage sur les problèmes qui représentent les plus grands risques pour la population visée, par exemple: la nutrition, le contrôle de la diarrhée, l'immunisation, les soins pré- et post-natals et les mesures de contrôle de la tuberculose.

Le CMSCS augmentera sa couverture pour inclure toute la population de la Cité Simone (environ 100.000 personnes). Le système informatisé d inscription des familles dont on se sert maintenant facilitera ce processus. Une formation sur le tas augmentera les qualifications des collaborateurs pour y ajouter la distribution des contraceptifs à domicile et la thérapie de réhydration orale. Avec la collaboration du DSPP on établira à la Cité Simone au moins dix postes de vente de sels de réhydratation orale afin de promouvoir davantage la thérapie de Réhydratation Orale parmi ses résidents.

Le Complexe entreprendra des campagnes spéciales pour que 90% de la population soit immunisée. L'objectif du programme est d'immuniser: (1) les enfants de moins de cinq ans contre la diphtérie, la coqueluche et le tétanos (DPT), la polio, la varicelle, (2) les femmes en âge de procréer et toutes les femmes enceintes contre le tétanos.

Les techniciens du Complexe planifient une importante campagne de deux ans pour promouvoir l'allaitement maternel parmi les mères de la Cité Simone, vu que des études ont clairement documenté la pratique très étendue de l'alimentation au biberon et sa relation avec l'augmentation du taux de mortalité infantile dans la zone. L'équipe sanitaire du Complexe prévoit trois types d'intervention pour contrecarrer et changer cette attitude:

a) In-Service Training of health personnel at three levels of the system: professionals (doctors and nurses); secondary (auxiliaries, nurses' assistants and delivery room personnel); and primary care workers (community collaborators and Traditional Birth Attendants).

b) Health Care Systems Modifications: establish a "well-baby clinic," and urge mothers to bring new-born infants there for registration and check-up at least twice during the first month of life for close monitoring of infant feeding practices; conduct monthly follow-up of new-borns; develop educational materials, e.g., films, posters, etc., for presentation in clinics and health centers.

c) Community Education: modify curriculum at Complexe educational facilities to include information on breast-feeding; develop audio and visual strategies, including use of mobile loudspeakers and engaging local artists in the community to design displays for visual messages; develop films to show at Cité Simone community centers.

Evaluation of the effectiveness of all these interventions will occur through pre- and post- implementation surveys on infant feeding knowledge and practices among mothers and trained health personnel and by changes in child morbidity and mortality.

a) Formation sur le tas du personnel de santé à trois niveaux du système: professionnel (médecins et infirmières); secondaire (auxiliaires, assistantes-infirmières, personnel de salle d'accouchement, et les travailleurs en soins primaires (collaborateurs communautaires et sages-femmes).

b) Modifications des systèmes de soin de santé: établir une clinique pour bébés bien portants et encourager les mères à les y amener pour les inscrire et pour un examen complet au moins deux fois au cours du mois suivant leur naissance afin de contrôler de très près les pratiques d'allaitement du bébé, avoir un suivi mensuel des nouveaux-nés, développer un matériel éducatif par exemple: films, affiches, etc., et les exposer dans les cliniques et les centres de santé.

c) Education communautaire: modifier les programmes d'étude dans les établissements éducationnels du Complexe pour y inclure des informations sur l'allaitement au sein, développer des stratégies audio-visuelles comprenant l'utilisation de hauts parleurs mobiles et l'embauchage d'artistes de la communauté pour préparer des films afin de les présenter dans les centres communautaires de la Cité Simone.

On arrivera à évaluer l'efficacité de toutes ces interventions par des enquêtes avant et après l'implantation, sur la connaissance et les pratiques d'alimentation des bébés parmi les mères et le personnel sanitaire formé par les changements dans le taux de morbidité et de mortalité des enfants.

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Finally, during the five-year AID project, activities of the Complexe Research and Evaluation Division will expand to maintain a level of 4 to 5 studies each year on cost-effective alternatives for improving health services delivery and identifying the means of further reducing infant and child mortality. In particular, the program will try to identify specific "high risk groups", e.g., infants with low birth weight and mothers likely to have severely malnourished children, in order to mount special intervention efforts to protect these groups.

3. Upgrading Human Resource Development Activities

Within the context of this project, the Complexe will improve the remedial education, vocational training and job placement programs at three facilities: the Centre Promotion Familiale, which provides job training and placement services for men; the Mothercraft Center, where 250 women learn sewing, make handicrafts and operate a successful bakery cooperative; and the Boston Cultural Center, which provides remedial education and vocational training for up to 350 adolescents.

In order to oversee and strengthen the management and administration of project training activities, the Complexe will establish an Employment Training Coordinator as a permanent staff position. Planned interventions for the training component of the project will then focus on the following activities:

First, the Complexe will increase the marketable skills among the population, upgrading the technical skills training programs and providing competancy-based

Finalement au cours des cinq années de la durée du projet de l'AID, les activités de la Division de Recherche et Evaluation du Complexe s'élargiront afin de garder un niveau de 4 à 5 études par année sur les alternatives rentables pour l'amélioration de la prestation des services de santé et l'identification des moyens pour réduire ultérieurement le taux de mortalité chez les enfants et les bébés. Le programme essaiera en particulier d'identifier les groupes à risque élevé spécifiques, par exemple les bébés pesant très peu à la naissance et les mères à même d'avoir des enfants souffrant de malnutrition à un degré sévère afin d'organiser des efforts d'intervention spéciaux pour les protéger.

3. Amélioration des Activités de Développement des Ressources Humaines

Dans le contexte de ce projet, le Complexe améliorera les programmes d'éducation corrective, de formation professionnelle et les services d'embauchage dans trois établissements: le Centre de Promotion Familiale qui fournit la formation pour l'emploi et les services d'embauchage pour les hommes, le centre de puériculture où 250 femmes apprennent à coudre, à fabriquer des produits artisanaux opèrent avec succès une coopérative de boulangerie et le Centre Culturel de Boston qui fournit l'instruction corrective et la formation professionnelle jusqu'à un maximum de 350 adolescents.

Afin de superviser et de renforcer la gestion et l'administration des activités du projet de formation, le Complexe établira une position permanente de Coordonnateur en Formation pour l'emploi: les interventions prévues pour le volet de formation du projet se concentreront sur les acitivtés suivantes:

Premièrement, le Complexe augmentera les possibilités commerciales dans le peuple en améliorant les programmes de formation des capacités techniques et

training for jobs actually available in local business and industry. The project's training component includes curriculum design and upgrading existing instructors' skills to teach short-term courses, developed through direct contact with local industries. The project budget includes funds for Technical Assistance in educational technology to help the Complexe implement this activity.

fournissant la formation basée sur la compétence pour les emplois disponibles actuellement dans le commerce et l'industrie locale. Le volet formation du projet comprend la préparation de programmes d'étude et l'amélioration des qualifications des instructeurs afin qu'ils puissent suivre des cours à court terme préparés par un contact direct avec les industries locales. Le budget du projet comprend des fonds pour l'assistance technique en technologie éducative pour aider le Complexe à exécuter cette activité.

Second, the Complexe will strengthen the management and administration of its education and job training components, particularly with regard to documentation and evaluation. Directors will establish results-oriented criteria for evaluating training activities, improving assessment methods and monitoring student progress in all training facilities. Finally, they will integrate service statistics from these programs into the automated Management Information System newly in place (for Primary Health Care Programs) and establish clearly defined, quantifiable goals making it possible to monitor progress within these programs and evaluate their effectiveness.

Deuxièmement, le Complexe renforcera la gestion et l'administration de ses volets d'éducation et de formation pour l'emploi, particulièrement en ce qui concerne la documentation et l'évaluation. Les directeurs établiront des critères orientés vers les résultats pour l'évaluation des activités de formation, l'amélioration des méthodes d'évaluation et le contrôle des progrès des étudiants dans tous les établissements de formation. Finalement, ils intègreront les statistiques du service dans un système informatisé de Gestion de l'Information fonctionnant maintenant pour les programmes de Soins de Santé Primaire et établiront des objectifs quantifiables clairement définis permettant de contrôler l'état d'avancement de ces programmes et d'en évaluer l'efficacité.

Self-Financing Activities

Within the context of this project, the Complexe will initiate a number of steps leading to greater self-reliance. These steps include the following:

a) Complexe administrators will refine the recently-implemented program-based planning and budgeting system to assure management efficiency and provide donors with more complete financial information on the use of funds.

4. Activités d'auto-financement

Dans le contexte de ce projet, le Complexe entreprendra un certain nombre de démarches conduisant à une plus grande auto-dépendance, dont:

a) Les administrateurs du Complexe perfectionneront l'efficacité de la gestion du nouveau système de planification et de budgétisation, basé sur le programme et fourniront aux donateurs des informations financières plus complètes sur l'utilisation des fonds.

b) The Complexe will increase user-fee schedules on the basis of feasibility studies and careful analyses of Cité Simone residents' real abilities and willingness to pay for services. During the Life-of-Project period, project administrators will test several alternative payment schemes, including a health services pre-payment plan and a drugs sales program based on the existing GOH/DSPP AGAPCO model.

c) During the project period, the Complexe Board of Directors will develop and implement fund-raising strategies to use in both the U.S. and Haiti. As an intial step, the Complexe already has incorporated a non-profit organization in the U.S. and applied for tax-exempt status from the IRS (a "501 C3" classification), a process which will take approximately four months. This will enable the Complex to receive tax-free gifts from U.S. donors. Project funds will be used to design and test publicity materials, films, brochures, etc. to be used in fund-raising.

d) The Complexe will seek to establish pay-back schemes whereby Complexe trainees successfully placed in an income-earning position, as well as their employers, would reimburse the Complexe for costs associated with the trainee's education.

b) Le Complexe augmentera les barêmes des frais des usagers en se basant sur les études possibles et les analyses minutieuses des possibilités de payerdes résidents de la Cité Simone. Au cours de la durée du projet, les administrateurs de projet expérimenteront plusieurs arrangements alternatifs de paiement y compris un plan de paiement anticipé pour les services de santé et un programme de vente de médicament basé sur le modele existant du GH/DSPP/AGAPCO.

c) Au cours du projet, le Conseil d'Administration du Complexe établira des stratégies efficaces d'appels de fonds à utiliser tant aux Etats-Unis qu'en Haiti et développera le matériel publicitaire, les films, les brochures, etc. Comme partie intégrante de ce processus, le Complexe a déjà constitué aux Etats-Unis une organisation à but non lucratif et a fait une demande d'exemption d'impôt au Bureau d'Impots sur le Revenu (IRS) (a"501"C3), un processus qui durera environ quatre mois. L'organisation aura alors l'autorité légale de recevoir des donateurs américains des dons éxonérés pour le Complexe.

d) Le Complexe cherchera à établir des systèmes de remboursement au moyen desquels ceux qu'il aura formés et qui ont des occupations rémunératrices aussi bien que leurs employeurs lui rendront les valeurs dépensées pour leur éducation.

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CENTRE HAITIANO ARABE
PORT AU PRINCE
HAITI

TITLE OF PROJECT : ALTERNATIVES FAMILY PLANNING SERVICES DELIVERY PROGRAM IN AN URBAN HAITIAN SLUM - II

SUBMITTED BY : DR CARLO BOULOS
PRESIDENT
HAITIAN ARAB CENTER
PORT AU PRINCE, HAITI

SUBMITTED TO : USAID/HAITI
PUBLIC HEALTH OFFICE
PORT AU PRINCE, HAITI

PERIOD : THREE YEARS

STARTING DATE : SEPTEMBER 1, 1984

ENDING DATE : AUGUST 30, 1987

APRIL 15, 1984

INTRODUCTION.-

For the past 10 years, operations research and experimental projects in family planning have gathered extensive data. Analysis has lead to a better definition of the problems and to more effective approaches to service delivery.

In Haiti, the results of a rural community based household contraceptive distribution program indicated high acceptance and use of modern methods with substantial decline in pregnancy prevalence. This approach was improved in another geographical area using volunteers working for the malaria control program (Bordes et al, 1983). Recently in Cite Simone, an urban slum of Port au Prince with a population of around 100,000 it was shown that the availability of family planning services supported by a community collaborator doing door-to-door promotion resulted in increased contraceptive utilization within a very short period of time (Boulos et al, 1984).

The lessons learned from initial activities should now be used to insure greater contraceptive use, at lower costs, and to focus on the highest risk groups and those often excluded from family planning programs.

PURPOSE.-

The purpose of this project are to:

(1) insure continuous support for the family planning service program in Cite Simone.

(2) expand the range of methods offered, especially to meet an apparent large demand for female sterilization.

(3) to better provide methods of family planning to specific high risk groups such as teenagers, high parity women and men.

(4) to study the factors related to contraceptive continuation and dropping out so as to improve use rates and better deal with problems contraceptives users face in using such methods as the IUDs, OCs and DMPA.

(5) to further refine methods of data collecting, handling and analysis to document contraceptive use patterns in an urban slum and to examine the use of alternative micro-computer based information systems in third world family planning service delivery programs.

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BACKGROUND

Setting: The Complexe Medico-Social de la Cite Simone.

1.- Cite Simone.

Cite Simone is a 5km2 area located on the outskirts of Port au Prince, with a population in excess of 100,000. Living conditions are marked by crowding and lack of sanitation, and the income level of most families is so low that Cite is considered one of the poorest sections of Port au Prince. The residents of Cite are part of a large wave of migrants that have come from the rural areas into the capital, in search of various economic opportunities. Some residents are relatively recent migrants and maintain close ties with their places of origin. Others are second and third generation city dwellers who have been born and raised in marginal neighborhoods in Port au Prince.

The income level in Cite Simone is very low. Socio economic studies point out that in some areas, the average family income is able to meet only one third of absolute minimum requirements for survival.

Cite Simone is divided into three major zones: Brooklyn(pop.40,000), Boston (pop. 40,000) and Cite Jean Clauce (pop. 20,000). These areas are in turn subdivided into neighborhoods; there are nine such neighborhoods.

2.- The Complexe Medico-Social

The Complexe Medico-Social de la Cite Simone, a private non profit organization, provides comprehensive health services to a defined urban population of 100,000. Services include health surveillance and education; immunization; nutritional surveillance; targeted supplemental feeding and nutritional rehabilitation; prenatal and maternity services; control of endemic diseases, particularly tuberculosis; and curative care including hospitalization.

Health facilities at the Complexe include two neighborhood health centers; one multi-specialty clinic; a general 70-bed hospital serving the entire Cite Simone area; 10 nutrition demonstration centers scattered throughout Cite Simone; a nutrition rehabilitation center; a rehydration center; and a center for the training of midwives. In addition, the Complexe maintains three vocational training centers. One is geared to the training of women; another is dedicated to train adult men in various technical skills; and a thrid center caters to youth and offers academic and vocational training programs for young men and women. It also offers a variety of other services to some 2,000 youth in the community including library privileges, studyhall, and other recreational, cultural and social activities.

The Cite Simone health-delivery system is organized by zones and sectors. The Boston zone includes the neighborhoods of Boston, Trois Bebes, and Pele; the Brooklyn zone includes the

neighborhoods of Brooklyn, Wharf and Lintheau. The Cite Jean Claude zone inludes the neighborhoods of Cite Jean Claude and Cite Simone II. Each neighrborhood is in turn subdivided into sectors (see annexe 1).

Boston and Brooklyn zones are served by community collaborators who are assigned approximately 200 families, each. The Cite Jean Claude zone until now has no collaborators but the Complexe plans in a near future to assign collaborators to the families living in this zone. Each neighborhood health center (Boston and Brooklyn) maintains in its files comprehensive data on its target population. This work is facilitated by the use of a coding system which allows the easy identification of each family on the basis of its zone and sector of residence and of the community collaborator (CHW) assigned to it. Thus, a mother in a family may have the following number:

2	09	24	136	01
neighborhood	sector	collaborator	family No	individual number

This person lives in neighborhood 2 (Brooklyn), sector 09, and is followed by community collaborator no 24. The last two digits correspond to the individual number and 01 is generally assigned to mothers. Thus the system links individually each person registered in Cite Simone to his or her community health worker. The identification number is used on all records pertaining to that person - whether hospital, health center, nutrition center and makes possible complete record linkage of individuals and families.

While this system is not unique in Haiti - it is being used at the Albert Schweitzer Hospital district and three other smaller community health projects - it is the most comprehensive primarly because the entire population of 100,000 is within 5 to 10 minutes walk from the nearest health facility. Thus, information becomes immediately available for any program delinquent and the entire denominator for any study is within easy access.

The Complexe employs approximately 350 people. Its personnel includes 26 MDs of which 4 ~~of them~~ have an MPH degree.

Because of its extensive demographic surveillance system, its information gathering capacity and the high level of training of its staff, the Cite Simone Complexe provides a unique location for conducting operational research in maternal and child health and in family planning.

Family Planning in Cite Simone.-

Until recently, family planning activities were centered around TBAs, Traditional Birth Attendants who had successfully completed a standard training program and were invited to cooperate in Complexe activities. Cite Simone currently employs 30 TBAs. They were expected to find potential clients in the community. Once found, the client was referred to the public

health nurse who is in charge of TBA supervision. She would usually do a general evaluation of the client who was then referred informally to one of the physician working in the Complexe and willing to prescribe a contraceptive method. It is therefore conceivable that the unstructured family planning program did not reach an extensive number of people.

In September 1983, the Haitian Arab Center, a Haitian private, non profit, voluntary organization sponsoring the CMSCS, opened a family planning center in Cite Simone in order to make family planning services easily available to the 100.000 people living in Cite Simone.

This was part of an operations reseach project to develope a cost effective approach for making family planning services widely available to the urban poor . In addition, the project studied the possible role of TBAs in increasing contraceptive utilization.

Preliminary results based on the first six months of operations were impressive: contraceptive use rose from an estimated 10.5% of women 15 - 49 years old in union to approximately 17.2% of women at risk, an increase of almost 60%.

Approximately 1074 women visited the Center, an average of 15 women per working day, and 830 women accepted a modern contraceptive method (see annexe 2).

The Center is currently staffed by two physicians (part-time), a nurse midwife, a recordkeeper and a guardian/janitor. It is open 5 days a week from noon to 6 p.m.

The promotion strategy consists of having TBA's and trained community Health Worker to visit local women and encouraged them to attend the Center.

In general, services offered by the Center include:

a) family planning education and motivation.
b) taking a medical history.
c) physical examination by a physician.
d) provision of an appropriate method suited to clients need and interest.
e) follow up care, if necessary
f) treatment and management of eventual complications, if they occur

The range of contraceptive methods offered so far includes: oral contraceptive (OCs), condoms, IUDs and Depo Provera (DMPA). The introduction of natural family planning methods and sterilization will be added when the appropriate staff and mechanism are found.

The preliminary data showed that in zone where a dynamic community health worker was assigned the task of personnaly visiting all the women and informing them of the existence and functionning of the family planning center, the results were such as impressive. On the other hand, for several reasons, TBA's specially trained for the program were not able to give a lot of effort and time to the program.

Recently, a new family planning promotor (a nurse) was assigned to a new zone and it is expected that the number of new acceptors in this zone will increase substantially in the months ahead.

A number of findings deserve considerations:

1. The number of adolescents currently pregnant was striking. 19% of women 15-19 years old were currently pregnant. This is very high compared to other parts of Haiti, where adolescents fertility is very low. This group of women deserves particular attention, due to the high risk associated with their pregnancies.

2. Although 25% of the acceptors choose the condom, the numbers of males visiting the Center was insignificant.
Some reasons for this may be:

A. Both TBA's and the community health workers mostly visit women and encourage them to attend the clinic. One of the major reasons for this is the fact that in Cite Simone women are often the most stable person in the house. Why do you mean some is probably heads of households?

B. Staff at the Family Planning Center have noticed that many women want their visits to the Center to be kept a secret from their husbands. It appears that many men do not want their wives to practice any form of family planning. Therefore, it was decided not to invite men to the Center. However, a specific approach should be designed to provide family planning for men. — and include Men in F.P. for women.

3. The use of a micro-computer at the Center has allowed rapid compilation and analysis of the data collected. Thus, after only four months of activities, a review of family planning research activities in Cite Simone was done and the modifications needed were implemented.

PROJECT GOALS

The present project will seek to:

1. Increase utilization of family planning services thru increased availability of services during the next 3 years.

2. Determine whether specific education programs can increase awareness of family planning services among young adolescents, thus improving the utilization rate and decreasing pregnancy rates.

3. Define specific approaches to motivate males to be more involved in family planning and to increase awareness of their role in helping their wives to plan their families.

4. Improve project management with the use of a micro-computer and adapted software.

5. Document the most cost effective ways of providing Family Planning services to the urban poor.

6. Study the factors related to why acceptors abandon contraceptive use and to develop strategies to improve

continuation rates.

7. Assess the demographic impact of the program in regard to both reduction in fertility and improvements in maternal and child health.

PROJECT DESIGN.-

a) The Family Planning Center.

Funds requested for this project will cover operating expenses for the Family Planning Center of Cite Simone. The Service delivery component will be conducted by part time physicians, a full time nurse, part time TBAs and family planning motivators. The site of the center will be changed to a more easily accesible place near the main road in Cite Simone. Some equipment has already been purchased by the Center during the first year but additional equipment such as sterilizer and various medical instruments will be purchased from the new projects funds. A sterilization unit will be added to the Center. This will have the advantage of not having to send women to Chancerelles Hospital, where waiting time and poor quality of services have discouraged women from attending their sterilization unit.

Services offered by the Family Planning Center will include as before:

a) family planning education and motivation.
b) history taking and physical examination by a physician.
c) counselling and motivation
d) provision of an appropriate method.
e) follow up care.
f) treatment and management of complications.

Besides offering oral contraceptives(OCs), condoms, IUDS, and sterilization, clients wishing to practice a natural family planning method will be invited to attend a weekly session on natural family planning held by specialists of natural family planning.

Potentials acceptors can visit the Center at any time it is open. After the first visit, the Center will set an appointment day for clients revisits or resupply.

Target Population.-

For study purposes, the target population will be the universe of women 15-49 years old and sexually active men living in Cite Simone and registered by the Complexe Medico-Social de la Cite Simone. Though a census conducted in 1983, the Complexe was able to determine the exact number of women and men by age group and by neighborhood. je le donte

Additional information, such as pregnancy rates, contraceptive use and other background characteristics will be obtained by a contraceptive prevalence survey planned for the last trimester of 1984.

In all neighborhoods, all women aged 15-49 years of age regardless of marital status will be given family planning information by community health worker home visits, group sessions and other forms of public advertising.

Community health workers and nurses will receive special training on how to promote family planning.

Three specific approaches will be tested in order to compare effectiveness:

.-1) The same approach that was used and tested during the first year of operations research project activities. This consisted of using either a community health worker or a nurse to invite women living in Cite Simone to attend the Family Planning Center. In addition, the 10 nutrition demonstration centers of the Complexe Medico Social will also be used to transmit family planning messages. From the census results and from the Complexe's records, a list of all women at high risk (i.e. women with high parity, with TB or malnutrition) will be given to the nurse and the collaborator in order to make a special effort to motivate these people to participate to the program.

.-2) Women 13-19 years will be invited to attend weekly sessions at one of the Complexe Centers. The course will be designed as a sex education program to prepare adolescents to be ready for their sexual activities. This is important since:

a) many of them may be already sexually active without their families knowing it.

b) many of their pregnancies may be unwanted.

.-3) men will be also invited to attend regular weekly meetings with the directors of Centers of Boston and Brooklyn. A special education program will be designed in order to:

a) increase the men's sense of responsability and awareness in creating a new family.

b) increase the men's motivation to also use family planning methods.

In each session, there will be a distribution of condoms and appointments for vasectomy will be made at these sessions.

END OF PROJECT STATUS

This is a Three year project targeted to a population of over 100,000 persons, with a specific target population of 12,000 women

in union and 10,000 men.

It is expected to enroll at least 50% of the women (i.e. 6000 by the end of the 3 years) and to increase condom use to more than 50% of the eligible men.

In special high risk groups such as adolescents and grand multi-paras, contraceptive use will be expected to be much higher than in the general population.

MANAGEMENT PLAN.-

The Haitian Arab Center will administer the Family Planning Center. The coordinator of the CMSCS will be employed by the Haitian Arab Center to coordinate the work of the Center and oversee the management. A physician with large experience in Family Planning services will be employed to supervise the services and make the coordination with the DHF structure.

EVALUATION OF PROGRAMS.-

A. Baseline Survey

This project will follow a previous year of activities. It was expected that a contraceptive prevalence survey will be carried out at the end of the first year of operations. This will serve as a Baseline Survey for the second project.

B. Operational Data.

Data will be collected at the Family Planning Center and entered on a daily basis in a microcomputer which has already been acquired. The capacity of the micro computer will be increased for this project.

A special project record will be kept for all women 15-49 years old identified and registered in Cite Simone. These women will constitute the target population. Data will also be collected on all men attending the weekly session and the numbers of condoms they receive.

In addition to the basic tabulations to provide regular monitoring of activities, data will be transfered on diskettes to Columbia University in New York for more extensive analysis. Staff members of Columbia University's Center for Population and Family Health will serve as consultants in the areas of questionnaire design, survey research and data processing and analysis.

STAFFING

Reginald Boulos, M.D., M.P.H. — Time
Investigator/Coordinator — 20%

Dr. Reginald Boulos is the Coordinator of CMSCS and director of its Division of Research and Evaluation. He is also an influential member of the Haitian-Arab Center and has been the project director of the Family Planning operation research project in Cite Simone since it started.

He has conducted epidemiologic research on Measles in Cite Simone with a Tulane University study and is presently one of the senior investigators for a PRICOR sponsored research project looking at the roles of TBAs in Maternal Health.

His role will be:

1) The overall coordination of project
2) Oversight/Management of project.
3) Design of data collection instruments.
4) Supervision of data collection, processing and data analysis.
5) Preparation of Reports (Interim, Annual, and Final)

Mrs Evelyn Armand, R.N. — Time
Nurse — 100%

Mrs Armand is a nurse/midwife who has been working for the Family Planning Center since it started. She received extensive training in Family Planning both from the Division d'Hygiene Familiale and abroad.

She will be responsible for the day to day operations of the Center.

Frantz Mode, M.D. — 10%

Dr. Mode is the director of the Brooklyn Health Center. He has been involved in Community Health Activities for the past seven years in Cite Simone. During this period, he developed extensive relations with the families of Cite Simone and is very well respected within Cite Simone.

With Dr. Fequiere Joseph, the director of the Boston Health Center, he will conduct the weekly Saturday session with adolescents and fathers of Cite Simone.

to fellow??

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Serge Pintro, M.D., M.P.H.

Time
20%

Dr Pintro has been working for many years with the Division of Family Hygiene carrying field supervision of their Family Planning activities. His role will be:

1.- setting up of norms for the professional staff of the Center and for TBAs which are in conformity with DHF norms.
2.- quality control of services to ensure that all norms are respected.
3.- keeping track of adverse effects, complications and other problems associated with contraceptives and ensuring that patients suffering form such effects receive appropriate care.
4.- up-dating inventories of drugs and supplies.

In summary, Dr Pintro will be primarly in charge of the clinical aspects of the study.

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Joe D. Wray, M.D.,M.P.H.
Consultant

Dr Wray is the Deputy Director of the Center for Population and Family Health of Columbia University. Dr Wray will advise in the area of questionnaire design, project record design and data analysis.

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James Allman, Ph.D
Consultant

Dr Allman is the resident advisor in the Division of Family Hygiene of the MOH and a Research Associate of the Center for Population and Family Health of Columbia University. He will advise both on the study design and in the data analysis.

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Dr Carlo Boulos, M.D.,M.P.H.
Consultant

Dr C. Boulos is the Director General of the Complexe Medico-Social de la Cite Simone and a former Minister of Health of Haiti, with very large experience in Community Health. He will advise on the Community aspect of the project and will be consulted for problems solving.

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Tom Lyman Fenn, M.S.
Consultant

Mr Fenn is a Computer specialist from Columbia University. He will help in the selection of appropriate hardware and in the design of adapted software for the project.

CALENDAR.-

September 1984 ?	Beginning of operations and establishing the sterilization unit. Beginning of data collection (service statistics) Baseline survey.
January 1985 ? ? ?	Beginning of sterilization activities. Report of activities for the period september-december 1984.
January 1986 ? ? ?	1985 Annual report
January 1987 ?	1986 Annual report
September-December 1987	Preparation of final report.

Interim report of activities will be submitted every three (3) months.

Calendar has a lot of gaps.

Estimate for new building?

Financial responsibility

What happens to previous agreement

BUDGET.

	YEAR 1	YEAR 2	YEAR 3
PERSONNEL:			
Dr. R. Boulos	7,200	7,200	7,200
Mrs E. Armand	4,400	4,400	4,400
Dr. S. Pintro	3,000	3,000	3,000
Part-Time Physicians (3)	9,000	9,000	9,000
Yard Boy	1,200	1,200	1,200
Record Keeper	2,000	2,000	2,000
Computer Operator/Secretary	3,600	3,600	3,600
Motivators #?	5,000	5,000	5,000
	35,400	35,400	35,400
		wages don't increase?	
SUPPLIES:			
Drugs ?? cc's?	2,000	2,000	2,000
OFFICE EXPENDITURES:			
Building Maintenance Rent	3,000	3,000	3,000
Utilities	600	600	600
Supplies	200	200	200
	6,400	6,400	6,400
Consultants ?	1,000	1,000	1,000
Travel/Per Diem	2,000	2,000	2,000
Prevalence Survey Cost	2,000	2,000	2,000
TBAs incentives	1,000	1,000	1,000
	6,000	6,000	6,000
Sterilization.-			
implementation Costs	In Kind		
TOTAL	49,800	49,800	49,800

TOTAL AMOUNT OF PROJECT US $ 149,400.

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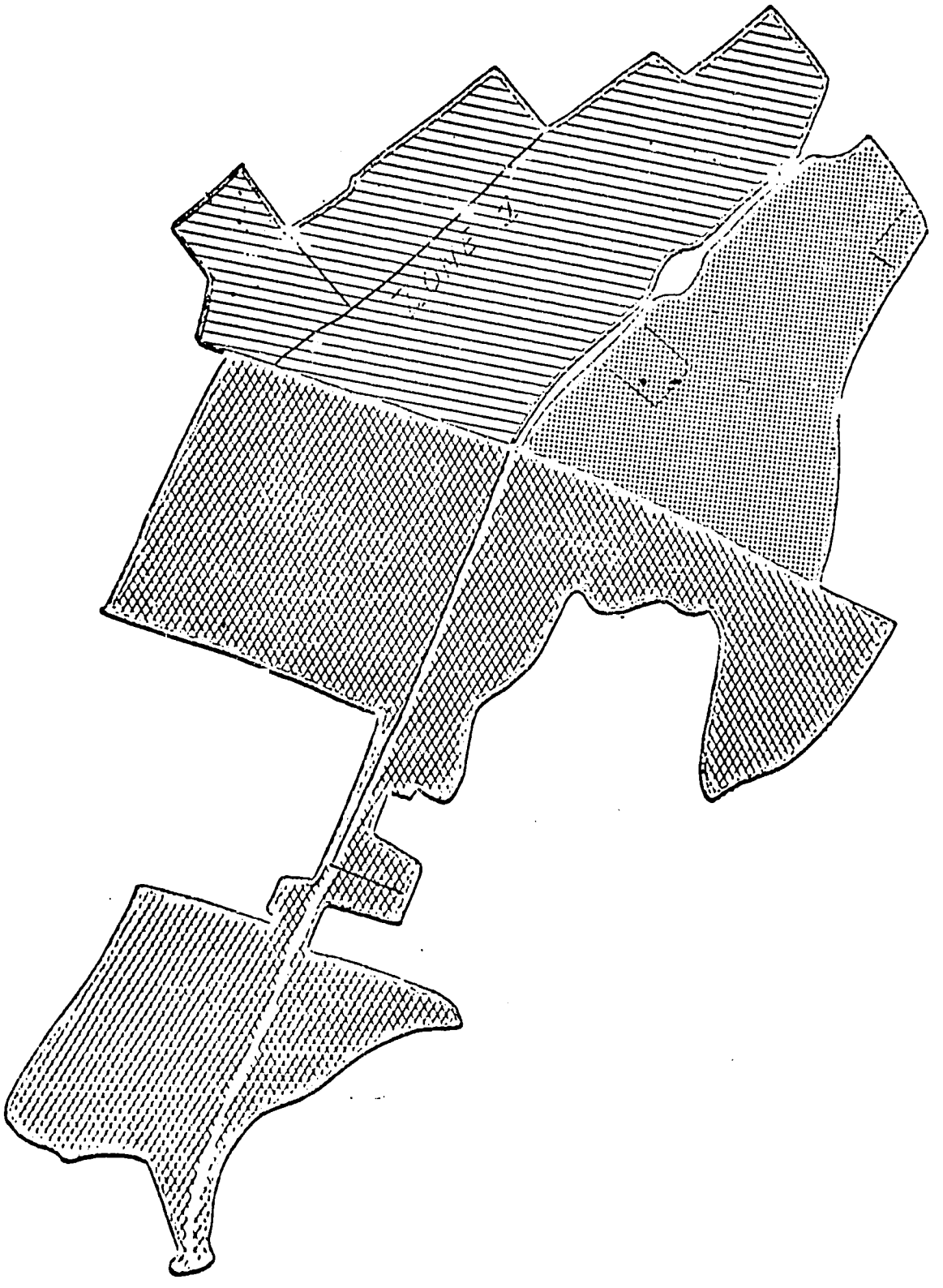

CENTRE HAITIANO ARABE
PORT AU PRINCE
HAITI

TITLE OF PROJECT	:	ALTERNATIVES FAMILY PLANNING SERVICES DELIVERY PROGRAM IN AN URBAN HAITIAN SLUM - II
SUBMITTED BY	:	HAITIAN ARAB CENTER PORT AU PRINCE, HAITI
CONTACT PERSON	:	DR. CARLO BOULOS
SUBMITTED TO	:	USAID/HAITI PUBLIC HEALTH OFFICE PORT AU PRINCE, HAITI
PERIOD	:	THREE YEARS
STARTING DATE	:	SEPTEMBER 1, 1984
ENDING DATE	:	AUGUST 30, 1987

MAY 5, 1984.

INTRODUCTION.-

For the past 10 years,operations research and experimental projects in family planning have gathered extensive data.Analysis has lead to a better definition of the problems and to more effective approaches to service delivery.

In Haiti,the results of a rural community based household contraceptive distribution program indicated high acceptance and use of modern methods with substantial decline in pregnancy prevalence.This approach was improved in another geographical area using volunteers working for the malaria control program (Bordes et al,1983). Recently in Cite Simone, an urban slum of Port au Prince with a population of around 100,000, it was shown that the availability of family planning services supported by a community collaborator doing door-to-door promotion resulted in increased contraceptive utilization within a very short period of time (Boulos et al,1984).

The lessons learned from initial activities should now be used to insure greater contraceptive use, at lower costs, and to focus on the highest risk groups and those often not reached by family planning programs.

PURPOSE.-

The purpose of this project are to:
(1) insure continuous support for the family planning service program in Cite Simone.

(2) expand the range of methods offered ,especially to meet an apparent large demand for female sterilization.

(3) to better provide methods of family planning to specific high risk groups such as teenagers, high parity women.

(4) to offer different methods of family planning to men.

(5) to study the factors related to contraceptive continuation and dropping out so as to improve use rates and better deal with problems contraceptives users face in using such methods as the IUDs, OCs and DMPA.

(6) to further refine methods of data collecting,handling and analysis to document contraceptive use patterns in an urban slum and to examine the use of alternative micro-computer based information systems in third world family planning service delivery programs.

BACKGROUND

Setting: The Complexe Medico-Social de la Cite Simone.

1.- Cite Simone.

Cite Simone is a 5km2 area located on the outskirts of Port au Prince, with a population in excess of 100,000. Living conditions are marked by crowding and lack of sanitation, and the income level of most families is so low that Cite is considered one of the poorest sections of Port au Prince. The residents of Cite are part of a large wave of migrants that have come from the rural areas into the capital, in search of various economic opportunities. Some residents are relatively recent migrants and maintain close ties with their places of origin. Others are second and third generation city dwellers who have been born and raised in marginal neighborhoods in Port au Prince.

Cite Simone is divided into three major zones: Brooklyn(pop.40,000), Boston (pop. 40,000) and Cite Jean Claude (pop. 20,000). These areas are in turn subdivided into neighborhoods; there are nine such neighborhoods.

2.- The Complexe Medico-Social

The Complexe Medico-Social de la Cite Simone, a private non profit organization, provides comprehensive health services to a defined urban population of 100,000. Services include health surveillance and education; immunization; nutritional surveillance; targeted supplemental feeding and nutritional rehabilitation; prenatal and maternity services; control of endemic diseases, particularly tuberculosis; and curative care including hospitalization.

Health facilities at the Complexe include two neighborhood health centers; one multi-specialty clinic; a general 70-bed hospital serving the entire Cite Simone area; 10 nutrition demonstration centers scattered throughout Cite Simone; a nutrition rehabilitation center; a rehydration center; and a center for the training of midwives. In addition, the Complexe maintains three vocational training centers. One is geared to the training of women; another is dedicated to train adult men in various technical skills; and a thrid center caters to youth, and offers academic and vocational training programs for young men and women. It also offers a variety of other services to some 2,000 youth in the community including library privileges, studyhall, and other recreational, cultural and social activities.

The Complexe receives assistance from national organisations such as the Ministry of Health(DSPP), the Ministry of Social Welfare, from international organisations including International Foster Parents Plan, USAID, Oxfam, appropriate Technology International, Catholic Relief Services, Misereor, Friends of Children, Cardinal Leger, SOS/PG(Belgium); and from many private donors including Haitian families and supporters from abroad.

The Cite Simone health-delivery system is organized by zones and sectors. The Boston zone includes the neighborhoods of Boston, Trois Bebes, and Pele; the Brooklyn zone includes the neighborhoods of Brooklyn, Wharf and Lintheau; The Cite Jean Claude zone inludes the neighborhoods of Cite Jean Claude and Cite Simone II. Each neighrborhood is in turn subdivided into sectors (see annexe 1).

Boston and Brooklyn zones are served by community collaborators who are assigned approximately 200 families, each. The Cite Jean Claude zone until now has no collaborators but the Complexe plans in a near future to assign collaborators to the families living in this zone. Each neighborhood health center (Boston and Brooklyn) maintains in its files comprehensive data on its target population. This work is facilitated by the use of a coding system which allows the easy identification of each family on the basis of its zone and sector of residence and of the community collaborator (CHW) assigned to it. Thus, a mother in a family may have the following number:

2	09	24	136	01
neighborhood	sector	collaborator	family No	individual number

This person lives in neighborhood 2 (Brooklyn), sector 09, and is followed by community collaborator no 24. The last two digits correspond to the individual number and 01 is generally assigned to mothers. Thus the system links individually each person registered in Cite Simone to his or her community health worker. The identification number is used on all records pertaining to that person - wheter hospital, health center, nutrition center and makes possible complete record linkage of individuals and families.

While this system is not unique in Haiti - it is being used at the Albert Schweitzer Hospital district and three other smaller community health projects - it is the most comprehensive primarily because the entire population of 100,000 is within 5 to 10 minutes walk from the nearest health facility. Thus, information becomes immediately available for any program delinquent and the entire denominator for any study is within easy access.

The Complexe employs approximately 350 people. Its personnel includes 26 MDs of which 4 have an MPH degree.

Because of its extensive demographic surveillance system, its information gathering capacity and the high level of training of its staff, the Cite Simone Complexe provides a unique location for conducting operational research in maternal and child health and in family planning.

Family Planning in Cite Simone.-

Until recently, family planning activities were centered around TBAs, Traditional Birth Attendants who had succesfully completed a standard training program and were invited to cooperate in Complexe activities. Cite Simone currently employs 30 TBAs. They were expected to find potential clients in the community. Once found, the client was referred to the public health nurse who is in charge of TBA supervision. She would usually do a general evaluation of the client who was then referred informally to one of the physician working in the Complexe which would then prescribe a contraceptive method. It is therefore conceivable that the unstructured family planning program did not reach an extensive number of people.

In September 1983, the Haitian Arab Center, a Haitian private, non profit, voluntary organization sponsoring the CMSCS, opened a family planning center in Cite Simone in order to make family planning services easily available to the 100.000 people living in Cite Simone.

This was part of an operations reseach project to develcpe a cost effective approach for making family planning services widely available to the urban poor . In addition, the project studied the possible role of TBAs in increasing contraceptive utilization.

Preliminary results based on the first six months of operations were impressive: contraceptive use rose from an estimated 10.5% of women 15 - 49 years old in union to approximately 17.2% , an increase of almost 60%.

Approximately 1074 women visited the Center, an average of 15 women per working day, and 830 women accepted a modern contraceptive method (see annexe 2).

The Center is currently staffed by two physicians (part-time), a nurse midwife, a recordkeeper and a guardian/janitor. It is open 5 days a week from noon to 6 p.m.

The promotion strategy consists of having TBA's and trained Community Health Worker visit local women and encouraged them to attend the Center.

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In general, services offered by the Center include:

a) family planning education and motivation.
b) taking a medical history.
c) physical examination by a physician.
d) provision of an appropriate method suited to clients need and interest.
e) follow up care, if necessary.
f) treatment and management of eventual complications.

The range of contraceptive methods offered so far includes: oral contraceptive (OCs), condoms, IUDs and Depo Provera (DMPA).

Natural family planning methods and sterilization were delayed until the appropriate staff and mechanism are found.

The preliminary data showed that in zone where a dynamic community health worker was assigned the task of personally visiting all the women and informing them of the existence and functionning of the family planning center, the results were impressive. On the other hand, for several reasons, TBA's specially trained for the program were not able to give a lot of effort and time to the program.

Recently, a new family planning promotor (a nurse) was assigned to a new one and it is expected that the number of new acceptors in this zone will increase substantially in the months ahead.

A number of findings deserve considerations:

1. The number of adolescents currently pregnant was striking. 19% of women 15-19 years old were currently pregnant. This is very high compared to other parts of Haiti, where adolescents fertility is very low. This group of women desserves particular attention,due to the high risk associated with their pregnancies.

2. Although 25% of the acceptors choose the condom, the numbers of males visiting the Center was insignificant.

Some reasons for this may be:

A. Both TBA's and the community health workers mostly visit women and encourage them to attend the clinic. One of the major reason for this is the fact that in Cite Simone women are often the most stable person in the house.

B. Staff at the Family Planning Center have noticed that many women want their visits to the Center to be kept a secret from their husbands. It appears that many men do not want their wives to practice any form of family planning. Therefore, it was decided not to invite men to the Center. However, a specific approach should be designed to provide family planning information and services for men.

3. The use of a micro-computer at the Center has allowed rapid compilation and analysis of the data collected . Thus,

after only four months of activities, a review of family planning research activities in Cite Simone was done and the modifications needed were implemented.

PROJECT GOALS

The present project will seek to:

1. Increase utilization of family planning services thru increased availability of services during the next 3 years.

2. Determine the extent to which specific education programs can increase awareness of family planning services among young adolescents, thus improving the utilization rate and decreasing pregnancy rates.

3. Develop approaches (1) to increase awareness of their role in helping their wife to plan their family and (2) to motivate males to be more involved in family planning.

4. Improve project management with the use of a micro-computer and adapted software.

5. Document the most cost effective ways of providing Family Planning services to the urban poor.

6. Find out why acceptors abandon contraceptive use and develop operational techniques to improve continuation rates.

7. Assess the demographic impact of the program in regard to both reduction in fertility and improvements in maternal and child health.

PROJECT DESIGN.-

a) The Family Planning Center.

Funds requested for this project will cover operating expenses for the Family Planning Center of Cite Simone. The Service delivery component will be conducted by part time physicians, a full time nurse, part time TBAs and family planning motivators. The site of the center will be changed to a more easily accesible place near the main road in Cite Simone.

A building will be constructed with funds provided by the project .At the end of the project,the building will remain the property of the Haitian Arab Center and will be used for Family Planning activities as well as other activities of Community developpement. Some equipment has already been purchased by the

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Center during the first year but additional equipment such as sterilizer and various medical instruments will be purchased from the new project funds. A sterilization unit will be added to the Center.
This will have the advantage of not having to send women to Chancerelles Hospital, where waiting time and poor quality of services have discouraged women from attending their sterilization unit.

Services offered by the Family Planning Center will include as before:

a) family planning education and motivation.
b) history taking and physical examination by a physician.
c) counselling and motivation
d) provision of an appropriate method.
e) follow up care.
f) treatment and management of complications.

Besides offering oral contraceptives(OCs), DMPA, condoms, IUDS, and sterilization, clients wishing to practice a natural family planning method will be invited to attend a weekly session on natural family planning held by specialists of natural family planning.

Potentials acceptors can visit the Center at any time it is open. After the first visit, the Center will set an appointment day for clients revisits or resupply.

Target Population.-
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The target population will be the universe of women 15-49 years old and sexually active men living in Cite Simone. Through a census conducted in 1983, the Complexe was able to determine the exact number of women and men by age group and by neighborhood.

Additional information, such as pregnancy rates, contraceptive use and other background characteristics will be obtained by a contraceptive prevalence survey planned for the last trimester of 1984. Not Needed

In all neighborhoods, all women aged 15-49 years of age will be given family planning information by community health worker home visits, group sessions and other forms of public advertising.

Community health workers and nurses will receive special training on how to promote family planning.

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Three specific approaches will be carried out:

.-1) The same approach that was used and tested during the first year of operations research project activities. This consisted of using either a community health worker or a nurse to invite women living in Cite Simone to attend the Family Planning Center. In addition, the 10 nutrition demonstration centers of the Complexe Medico Social will also be used to transmit family planning messages. From the census results and from the Complexe's records, a list of all women at high risk (i.e. women with high parity, with TB or malnutrition) will be given to the nurse and the collaborator in order to make a special effort to motivate these people to participate to the program.

.-2) Women 13-19 years will be invited to attend weekly sessions at one of the Complexe Centers. The course will be designed as a sex education program to prepare adolescents to be ready for their sexual activities. This is important since:

a) many of them may be already sexually active without their families knowing it.

b) many of their pregnancies may be unwanted.

.-3) men will be also invited to attend regular weekly meetings with the directors of Centers of Boston and Brooklyn. A special education program will be designed in order to:

a) increase the men's sense of responsability and awareness in creating a new family.

b) increase the men's motivation to also use family planning methods.

In each session, there will be a distribution of condoms and appointments for vasectomy will be made. ~~at these sessions~~.

END OF PROJECT STATUS
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This is a three year project targeted to a population of over 100,000 persons,with a specific target population of 12,000 women in union and 10,000 men.

It is expected to enroll at least 30% of the women (i.e. 3600 by the end of the 3 years) and to increase condom use to more than 35% of the eligible men.

In special high risk groups such as adolescents and high parity women,contraceptive use will be expected to be much higher than in the general population.

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MANAGEMENT PLAN.-

The Haitian Arab Center will administer the Family Planning Center. The coordinator of the CMSCS will be employed by the Haitian Arab Center to coordinate the work of the Center and oversee the management. A physician with large experience in Family Planning services will be employed part-time to supervise the services and make the coordination with the DHF structure.

It is important to emphasize the support offered by the Complexe Medico Social to the Family Planning Center. The structured Health program of the Complexe have allowed the FP center to obtain quickly extensive data on the population it serves. Employees of the Family Planning Center, particularly the motivators were recruted trought Complexe's personnel for they have had extensive contact with the population. The nutrtional demonstration centers, the Hospital Maternity and the two neighborhood Health centers will offer continuing support in recrutment of potential users and motivation.

During the next three years, Complexe coordinator which is also the Family Planning project coordinator will work to integrate more efficiently the activities of the FP center to the daily routine activities carried out at the different facilities of the Complexe. It is expected that at the end of the project, Family Planning activities will become an integrated part of the Complexe Health Program and that the Center will be used only as a referral point for IUD's insertion and sterilisation.

EVALUATION OF PROGRAMS.-

A. Baseline Survey

This project will follow a previous year of activities, under a predecessor project. A contracetive prevalence survey will be carried out at the end of that project. This will serve as a Baseline Survey for the second project.

B. Operational Data.

Data will be collected at the Family Planning Center and entered on a daily basis in a microcomputer which has already been acquired. The capacity of the micro computer will be increased for this project.

A special project record will be kept for all women 15-49 years old in Cite Simone. These women will constitute the target population. Data will also be collected on all men attending the weekly session and the numbers of condoms they receive.

In addition to the basic tabulations to provide regular

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monitoring of activities, data will be transfered on diskettes to Columbia University in New York for more extensive analysis. Staff members of Columbia University's Center for Population and Family Health will serve as consultants in the areas of questionnaire design, survey research and data processing and analysis. All raw and processed data and all publications made from this data will remain the property of the Haitian Arab Center.

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STAFFING

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Reginald Boulos, M.D., M.P.H. — Time 20%

Investigator/Coordinator

Dr. Reginald Boulos is the Coordinator of CMSCS and director of its Division of Research and Evaluation. He is also an influential member of the Haitian-Arab Center and has been the project director of the Family Planning operation research project in Cite Simone since it started.

He has conducted epidemiologic research on Measles in Cite Simone with a Tulane University study and is presently one of the senior investigators for a PRICOR sponsored research project looking at the roles of TBAs in Maternal Health.

His role will be:

1) The overall coordination of project
2) Oversight/Management of project.
3) Design of data collection instruments.
4) Supervision of data collection, processing and data analysis.
5) Preparation of Reports (Interim, Annual, and Final)

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Mrs Evelyn Armand, R.N. — Time 100%

Nurse

Mrs Armand is a nurse/midwife who has been working for the Family Planning Center since it started. She received extensive training in Family Planning both from the Division d'Hygiene Familiale and abroad.

She will be responsible for the day to day operations of the Center.

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Frantz Mode, M.D. — 10%

Motivator

Dr. Mode is the director of the Brooklyn Health Center. He has been involved in Community Health Activities for the past seven years in Cite Simone. During this period, he developed

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extensive relations with the families of Cite Simone and is very well respected within Cite Simone.

With Dr. Fequiere Joseph, the director of the Boston Health Center, he will conduct the weekly Saturday session with adolescents and fathers of Cite Simone.

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Serge Pintro, M.D., M.P.H. — Time

Clinical Supervisor

20%

Dr Pintro has been working for many years with the Division of Family Hygiene carrying field supervision of their Family Planning activities. His role will be:

1.- setting up of norms for the professional staff of the Center and for TBAs which are in conformity with DHF norms.

2.- quality control of services to ensure that all norms are respected.

3.- keeping track of adverse effects, complications and other problems associated with contraceptives and ensuring that patients suffering form such effects receive appropriate care.

4.- up-dating inventories of drugs and supplies.

In summary, Dr Pintro will be primarly in charge of the clinical aspects of the study.

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Joe D. Wray, M.D.,M.P.H. — NO CHARGE

Consultant

Dr Wray is the Deputy Director of the Center for Population and Family Health of Columbia University. Dr Wray will advise in the area of questionnaire design, project record design and data analysis.

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James Allman, Ph.D — NO CHARGE

Consultant

Dr Allman is the resident advisor in the Division of Family Hygiene of the MOH and a Research Associate of the Center for Population and Family Health of Columbia University. He will advise both on the study design and in the data analysis.

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Dr Carlo Boulos, M.D.,M.P.H. — NO CHARGE

Consultant

Dr C. Boulos is the Director General of the Complexe Medico-Social de la Cite Simone and a former Minister of Health of

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Haiti, with very large experience in Community Health. He will advise on the Community aspect of the project and will be consulted for problems solving.

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Tom Lyman Fenn, M.S. *NO CHARGE*
Consultant

Mr Fenn is a Computer specialist from Columbia University.He will help in the selection of appropriate hardware and in the design of adapted software for the project.

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Antoine Augustin M.D.,M.P.H. *NO CHARGE*
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Dr Augustin is the director of the Complexe's 70 bed hospital and the chief of the TBA program. He will direct the continuing training of TBAs and also will help implement measures to best insure participation of hospital's personnel in recruting clients among women who have delivered their baby at the hospital.

CALENDAR

September 1984	Beginning of operations and establishing the sterilization unit . Beginning of data collection (service statistics) Baseline survey.
January 1985	Beginning of sterilization activities. Report of activities for the period september-december 1984.
January 1986	1985 Annual report
January 1987	1986 Annual report
September-December 1987	Preparation of final report.

Interim report of activities will be submitted every three (3) months.

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BUDGET

	YEAR 1	YEAR 2	YEAR 3
PERSONNEL:			
Dr. R. Boulos	7,200	7,200	7,200
Mrs E. Armand	4,400	4,400	4,400
Dr. S. Pintro	3,000	3,000	3,000
Part-Time Physicians (3)	9,000	9,000	9,000
Yard Boy	1,200	1,200	1,200
Record Keeper	2,000	2,000	2,000
Computer Operator/Secretary	3,600	3,600	3,600
Motivators ( )	5,000	5,000	5,000 ?
	35,400	35,400	35,400
SUPPLIES:			
Drugs	2,000	2,000	2,000
Contraceptives (DHFN)	------ in kind -------		
OFFICE EXPENDITURES:			
Utilities	600	600	600
Supplies	200	200	200
	800	800	800
OTHER DIRECT COSTS			
Consultants	1,000	1,000	1,000
Travel/Per Diem	2,000	2,000	2,000 ?
Prevalence Survey Cost	2,000	2,000	2,000 ?
TBAs incentives	1,000	1,000	1,000
	6,000	6,000	6,000
CAPITAL EXPENDITURES			
Building Construction	20,000	---	---
Maintenance	500	500	500
Sterilisation equipment	4,000	1,000	1,000
	24,500	1,500	1,500
TOTAL	68,780	45,780	45,780
Miscellaneous & Conting.	3,000	3,000	3,000
Grand Total	71,780	48,780	48,780

TOTAL AMOUNT OF PROJECT US $ 169,340.

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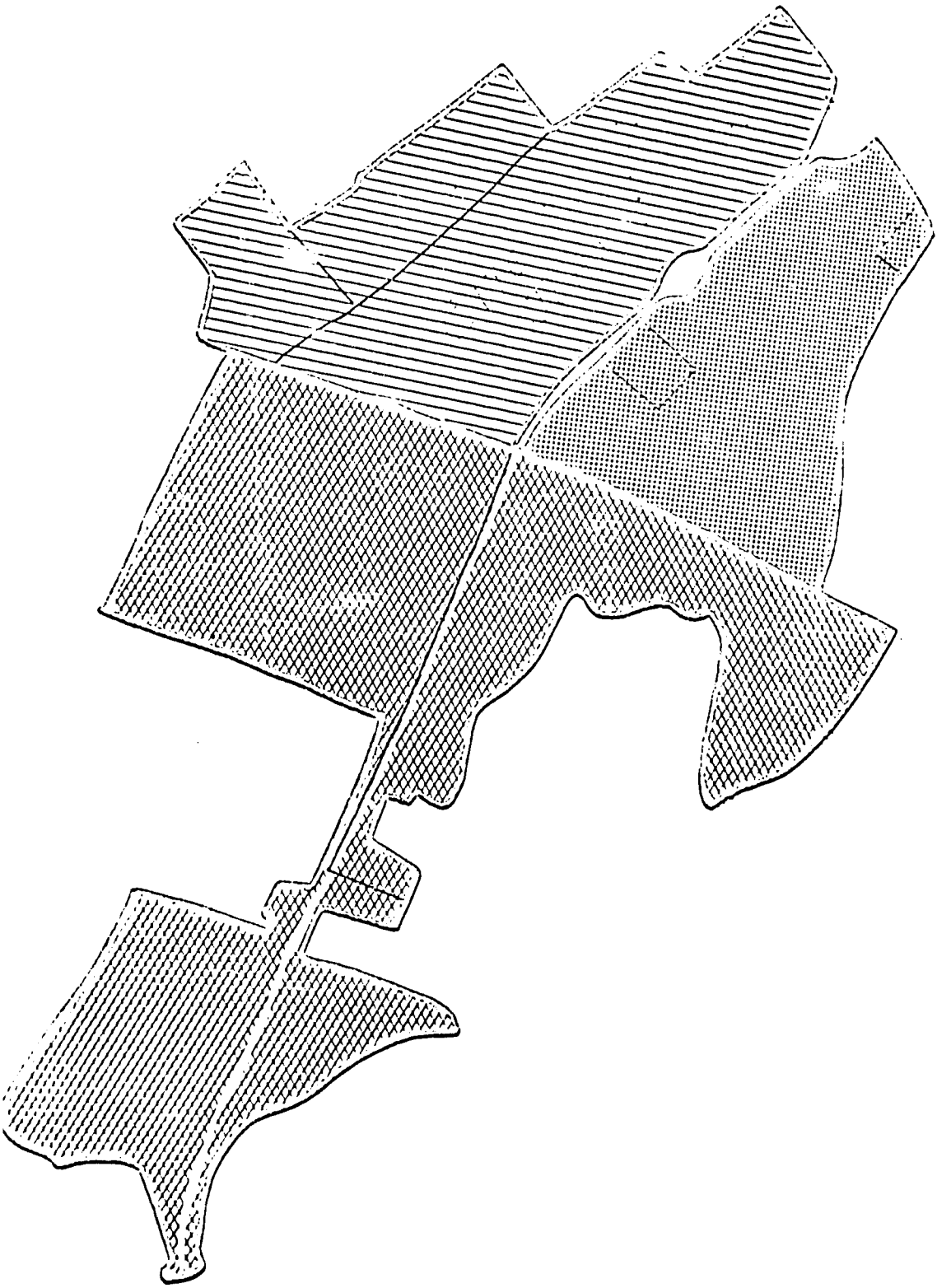

CENTRE HAITIANO-ARABE

PORT AU PRINCE

HAITI

CITE SIMONE FAMILY PLANNING OPERATIONS RESEARCH PROJECT

REPORT OF ACTIVITIES
SEPTEMBER 1983- FEBRUARY 1984

April 1984

This report has been prepared by the Division of Research and Evaluation of the Complexe Medico Social de la Cite Simone with the assistance of the Center for Population and Family Health, Columbia University.
We wish to acknowledge the useful comments and suggestions of USAID/Port au Prince staff, Sue Gibson, Richard Metcalfe and Katy McDonald on an earlier draft report.

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Introduction

This report provides a review of family planning operations research activities in Cite Simone for the period September-February 1984. It updates and includes materials from report No 1 covering activities in 1983. The results of this new project, even at this early stage, are impressive and very encouraging. For example:

1. The Family Planning Center which opened September 5, 1983 was visited by 1074 women in union between the ages of 15-49 years.

2. Over 75% of these women accepted a contraceptive method; 65% accepted OCs, 27% condoms, 3% IUDs,and 5% DMPA(depo provera), and a few contraceptive foam.

3. Family planning coverage increased by over 60% in the target population, from 10.5% of women at risk to an estimated 17.2% in less than six months.

4. The important variation in acceptance in the three experimental zones (13% of target population accepting in zone 1, compared with less that 6% in zones 2 and 3 raises the possibility of a new, more simplified outreach approach which could substantially increase acceptance in the two zones where progress has been less impressive.

Before presenting some detailed findings, the report reviews the operations research strategy and provides background information.

BACKGROUND.-

The aims of this family planning operations research (OR) project are:

1) to increase access to modern contraceptives for those who desire services.

2) to test different approaches to contraceptive delivery in order to identify simple, low-cost ways of providing services to those who wish to control their fertility. As in other OR activities in Haiti, particular attention focuses on (a) community-based initiatives, (b) using non-medical personnel, and (c) increasing awareness and understanding of the benefits of family planning among the population.

In Cite Simone, given the lack of contraceptive services available,a first task was to establish a Family Planning Center where local women could be supplied. This was done during

the summer of 1983 and on September 5 the Center opened its doors. It is currently staffed by two physicians (part-time), a nurse midwife, a record-keeper and a guardian/janitor. It is open 5 days a week from noon to 6 p.m.
Local women are invited to attend the Center and usually arrive around 1 p.m. The nurse greets them and opens a file for them. The physician works every day from 4 to 6 p.m. and sees only patients that are referred by the nurse as presenting any type of contraindication based on their history.

In general,services offered by the Center include:

a. family planning education and motivation.
b. history taking
c. physical examination by the physician.
d. counselling and orientation.
e. the provision of an appropriate method tailored to the clients needs and interest.
f. follow-up care.
g. treatment and management of eventual complications.

The range of contraceptive methods offered so far includes: oral contraceptives(OCs), condoms, IUDs, and depo provera (DMPA), and starting in February when supplies became available, contraceptive foam. The introduction of natural family planning methods and sterilization will be added when appropriate staff and mechanisms are found.

Particular attention in the initial phase of activities was to study what role traditional birth attendants might play in the provision of family planning services. Three service delivery models are being tested:

Model 1. Making the public aware of the new FP Center through advertising, and promotion by a community health worker.

Model 2. Making women 15-49 years old aware of FP by individual visits to their homes by 16 specially trained TBAs who refer interested woman to the FP Center.

Model 3. Same as model 2 but the TBAs are supposed to meet with the women at the FP Center, and resupply them at their homes after acceptance of a method.

We wished to test the hypotheses that (1) the family planning acceptance rates will be higher with models 2 and 3, where TBAs actively recruit, and (2) that continuation rates will be higher with model 3, where the TBAs participate in service delivery at the Center and maintain contact with acceptors through household resupply.
The results presented in Table 1, and our experience to date, allow us already partially to test our hypotheses.

RESULTS.-
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The data in line (7) of Table 1,indicate that 13.3% of the target population in Zone 1, where only advertising was used and no TBAs were involved, accepted a modern method compared with less than 6% in the other two Zones where TBAs were active. Thus our initial hypothesis of improved service delivery using TBAs is not being supported. This is surprising; if improvements in access to contraceptive services were not as important as indicated in Tables 1-4, it would also be a discouraging finding.

TABLE 1.-
TARGET POPULATION AND CONTRACEPTIVE ACCEPTANCE
SEPTEMBER1983-FEBRUARY 1984
CITE SIMONE FAMILY PLANNING PROJECT.-

NEIGHBORHOODS	ZONE 1 C.SIMONE 2 C.J.CLAUDE	ZONE 2 BROOKLYN WHARF LINTHO	ZONE 3 TROIS BEBE BOSTON	TOTAL
	16.10%	35.43%	48.46%	100.00%
(1)population(1983)	11589	25503	34887	71979
(2)women 15-49 years old [30% of (1)]	3476	7651	10466	21594
(3)women in union [70% of (2)]	2433	5356	7326	15116
(4)women 15-49 pregnant [12.8% of(2)]	444	979	1339	2763
(5)women in union and not pregnant [(3) - (4)]	1989	4377	5986	12353
(6)new contraceptive acceptors (Sept 83/Feb 84)	264	236	330	830
(7)FP new acceptors as % of target population [(6)/(5)]	13.3	5.4	5.5	6.7

It was very difficult to test Model 2 compared with Model 3 for two major reasons: 1) Some TBAs would not come on the specific day on which they were to invite their clients to the Center; and 2) the women would come on days when they were not invited. Therefore, a TBA would come on a specific day and mostly meet women that were referred by another TBA for another day and who could not make it on that appointed day. TBAs have not been involved in any resupply, so it is important for model 3 to be revised.

We believe the important impact of the program in Zone 1 was largely due to the approach to promoting the Family Planning Center which was used. One dynamic community health worker was assigned the task of personally visiting all the women in zone 1 and informing them of the FP Center's existence, its functioning, and the services provided.

As we can see from Table 2, the one community promotor in Zone 1 helped bring in more new Family Planning acceptors than the TBAs in Zones 2 and 3 during the months of September through December 1983. In January and February 1984, he was ill with malaria.This explains why women visiting the center and new acceptors in Zone 1, fell off sharply then.

In February 1984, a new approach was tried in Zone 3. A dynamic public health nurse began work as a promotor.The increase in new acceptors was striking, both compared to the other two zones and in comparison with new acceptors recruited in Zone 3 in the previous 5 months.

Encouraging the two Family Planning promotors in Zones 1 and 3 and monitoring their results is the new operational research strategy for the immediate future. The use of TBAs will continue in Zone 2 as a control to the new approach.

TABLE 2
MONTHLY RECRUITMENT OF WOMEN WHO COME FOR CONSULTATION
IN THE THREE OPERATIONS RESEARCH ZONES,
CITE SIMONE FAMILY PLANNING PROJECT,
SEPTEMBER 1983 - FEBRUARY 1984
(percentages in parentheses)

Month	zone1	zone2	zone3	Total
September	134	110	107	351(32.3)
October	95	53	59	207(19.0)
November	67	26	48	141(13.0)
December	35	26	62	123(11.3)
January	3	33	40	76(7.0)
February	18	45	126	189(17.4)
Total	352(32.2)	293(27.0)	442(40.7)	1087(100.)

Although the TBAs were specially trained for the program, they were not able to give a lot of time and effort to it. The reasons included: First, they had other duties to perform concerning their regular prenatal care and delivery activities. Second, they were involved in a PRICOR study which aims at improving maternal and child health. Third, they were not highly motivated to participate in the family planning project due to unrealistic hopes for additional revenue which were not satisfied. In general, they were not content with the $0.20 paid to them for each woman referred by them who visited the FP Center. This became a serious issue soon after the project got underway and slowed the number of Center visits from Zones 2 and 3 at various points.

Our new operations research hypothesis is that by adding the activities of a family planning promotor to Zone 3, Center visits and the numbers of new acceptors in this zone will increase substantially in the months ahead. This appears to be the case already, if the increase in acceptors in February continues (see Table 2).

Further, there is some empirical support for this hypothesis in operational research conducted in rural areas of Haiti. The post-door-to-door contraceptive distribution in Leogane, for example, was run by one paid field promotor, well motivated and very much involved in community activities. With good logistics and some very limited support for motivation from the DHF central staff this approach expanded contraceptive access and use from the initial target population of 12,000 in January 1981 to over 40,000 people at present at very low cost (see Bordes et al,1982).

Although we believe that the role of the Family Planning promotor is critical to success of activities in Zone 1, we should note that the Family Planning Center is located in Zone 1. This may also be an important factor contributing to the success of activities in this area, as well as the role of the community worker. Monitoring patterns of contraceptive acceptance, use, and continuation during the months ahead will help shed light on this issue.

Additional work will be needed to edit and analyze the Census of Cite Simone, taken in summer 1983. When this is completed, we will be able to get a better idea of the impact of the program on fertility and health of mothers and children.

As a first step toward assessing the demographic impact of the project, the register of women pregnant in Cite Simone will be put on the Computer. We will thus be able to trace changes in pregnancy prevalence by zone each month. We hypothesise that there will be declines in the percentages of women pregnant as the distribution of contraceptives reaches more women.

A number of additional findings deserve consideration:

1. An estimated 6 percent of all women 15-49 years old were using modern contraceptive before the Family Planning Center opened in September 1983 (n= 1296). This meant that only 10.5% of women at risk (ie. in union and not pregnant) were protected from unwanted pregnancy. The opening of the Family Planning Center is dramatically changing this situation. In less than six months, 830 new family planning acceptors have been recruited out of 1074 women who visited the Center. If we assume that all the new acceptors are new users, we can estimate that contraceptive prevalence has increased to 9.8% of all women in Cite Simone and 17.2% of women at risk - an increase of almost 60%. Of the 830 new acceptors, 64.5% accepted oral contraceptives, 26.6% condoms, 3.3% IUDs, and 5.2 % depo provera and .5% foam (see table 3).

TABLE 3
CONTRACEPTIVE METHODS ACCEPTED BY WOMEN
AGED 15-49 YEARS FROM ZONES 1-3, VISITING CENTER,
SEPTEMBER 1983 - FEBRUARY 1984
CITE SIMONE, HAITI
(percentages in parentheses)

	Methods Accepted					
	OC	IUD	CONDOM	FOAM	DMPA	TOTAL
Zone 1	170	7	74	0	13	264 (31.8)
Zone 2	158	4	61	0	11	214 (28.4)
Zone 3	207	16	86	4	17	330 (39.8)
Total	535 (64.5)	27 (3.3)	221 (26.6)	4 (.5)	43 (5.2)	830 (100.)

2.- Over 60 % of those who accepted a modern method were between 20 and 29 years old (see table 4), and there were no significant differences in age between visitors who accepted a method and those who did not. Almost 50% of the women visiting the Center had had between 1-3 children (see table 5). There was little variation by zone in the percentage of women visiting the Family Planning Center who accepted a modern method ; 76 % accepted in Zones 1 and 3 compared with 81 % in zone 2.

TABLE 4
DISTRIBUTION OF WOMEN 15-49 YEARS OLD
WHO ACCEPTED A CONTRACEPTIVE METHOD
BY AGE GROUP AND ZONE
SEPTEMBER 1983 - FEBRUARY 1984
CITE SIMONE, HAITI
(Percentages in parentheses)

AGE GROUP	ZONE 1	ZONE 2	ZONE 3	TOTAL
15-19	10	6	18	34 (4.1)
20-24	80	57	104	241 (29.0)
25-29	96	86	98	280 (33.7)
30-34	53	45	55	153 (18.4)
35-39	16	28	44	88 (10.6)
40-44	6	9	7	22 (2.7)
45+	3	5	4	12 (1.4)
TOTAL	264	236	330	830 (99.9)

TABLE 5
WOMEN 15-49 YEARS VISITING THE FAMILY PLANNING CENTER
WHO ACCEPTED A MODERN CONTRACEPTIVE METHOD
BY PARITY AND ZONE
SEPTEMBER 1983 - FEBRUARY 1984
CITE SIMONE, HAITI

PARITY	ZONE 1	ZONE 2	ZONE 3	TOTAL
0	2	0	0	2 (0.2)
1	27	17	48	92(11.4)
2	61	34	56	151(18.7)
3	54	44	65	163(20.2)
4	40	39	43	122(15.1)
5	33	36	37	106(13.2)
6	16	27	27	70(8.7)
7	12	25	18	55(6.8)
8	4	9	12	25(3.1)
9	5	5	13	20(2.5)
Total	254(31.5)	233(28.9)	319(39.6)	806
Distrib. of General Pop.	16.1%	35.4%	48.5%	100%

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3. The important numbers of adolescents currently pregnant was a striking finding. As we can see from Table 6, based on preliminary results of the 1983 Special Census of Cite Simone, 19% of the young women 15-19 years old are currently pregnant. This is very high compared to other parts of Haiti where adolescent fertility is very low. This group deserves particular attention; further analysis and program activities will explore what the implications of this findings are for Family Planning activities.

TABLE 6
ESTIMATED PERCENTAGE OF ALL WOMEN
AGED 15-49 YEARS CURRENTLY PREGNANT, BY AGE GROUP,
CITE SIMONE, SUMMER 1983
CENSUS RESULTS

Age Groups	Currently Pregnant
15-19	19.0
20-24	16.5
25-29	14.5
30-34	12.6
35-39	8.0
40-44	3.7
45+	4.9
Total	12.8

4. We were surprised to find during the six months of the Family Planning Center's functioning an apparently important demand for female sterilization. The physician, nurse, and record-keeper all reported receiving frequent inquiries concerning the possibility of having sterilization done at the Center.

The discussions with potential clients, generally women with 3 or 4 children who wished to stop childbearing, suggest that if the Center could offer sterilization on its premises, the number of clients would be significant. Although the project initially planned to establish a system for referral to other institutions for sterilization, given the lack of good, nearby facilities, the large potential demand in Cite Simone, and the interest on the part of the Center's physician (Dr. Metayer, who has considerable training and experience in sterilization), it might be useful to set up facilities in Cite Simone and develop operations research strategies for testing how recruitment, referral, and counseling could best be done in poor slum neighborhoods where demand and need appear great.

5. An important element in the timely presentation of project results was the installation and use of a micro computer. This allowed the project team to assess the impact of the Family Planning promotion strategy a few months after service delivery began and to make changes to improve delivery based on the

number of new acceptors in the 3 zones. A good system is increasingly being made better. For example, the tabulation of data on the first four months of activities took about two weeks to complete using the Statpak program. Modifications to DBASE II, made by Tom Fenn from Columbia University allowed the project director to do the more extensive tabulations for this report in only twelve minutes ! (see Boulos et al, 1984)

A limiting factor now, especially in regard to processing of the 1983 census data which will allow assesment of the demographic impact of the project, is data entry capacity. Assistance from Columbia University's mainframe computer in New York will help solve this problem as well as acquiring another micro computer at Cite Simone.

Future Research Needs and Activities

In the future, beginning with the data from March, the project team expects to monitor service statistics on a monthly basis and will study trends and changing patterns at the beginning of each month.This will allow changes in approaches to service delivery based on the perfomance of the community outreach staff, and the responses of the women they are attempting to serve.

Contraceptive continuation is another area which will receive particular attention in the months ahead. Follow up studies of acceptors will be done using service statistics on return visits or, for women who do not return for resupply, based on special home visits.

At the suggestion of USAID/Haiti , the project staff has prepared a three year follow on operations research project proposal for years 1984-1987.

New features will include setting up a sterilization unit at the Family Planning Center, which will be moved to a more central location, special outreach for high risk groups (adolescents and grand multiparas), efforts to involve men in family planning activities, detailed studies of the demographic and health impact of the project, and a through study of contraceptive continuation with particular attention to what can be done to encourage high use rates over time.

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