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REPORT ON
MID TERM EVALUATION
FAMILY PLANNING OUTREACH PROJECT
(521-0124)
A Project Agreement between
the Government of Haiti and
the U.S. Agency for International Development

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Abbreviations

BN	:	Bureau of Nutrition
CNP	:	Conseil National de Population
CRS	:	Commercial Retail Sales
DHF	:	Direction d'Hygiene Familiale
DSPP	:	Department of Public Health and Population
FP	:	Family Planning
FPO	:	Family Planning Outreach Project
FY	:	Fiscal Year
GOH	:	Government of Haiti
HFS	:	Haitian Fertility Survey
IHSI	:	Institut Haitien de Statistique et Investigation
JHPIEGO	:	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDS	:	Multi-Round Demographic Surveys 1975-77
MCH/FP	:	Maternal Child Health/Family Planning
ONAAC	:	National Organization for Literacy and Community Action
PAHO	:	Pan American Health Organization
R & E	:	Research and Evaluation
UNFPA	:	United Nations Fund for Population Activities
USAID	:	United States Agency for International Development
SNEM	:	National Service of Endemic Diseases

EXECUTIVE SUMMARY

1. Purpose and Scope of the Evaluation

The primary goals of the Family Planning Outreach Project supported by USAID are the delivery of family planning services through all public health institutions and 75% of health facilities run by private, non-profit groups; access to contraceptives through both community-based and commercial distribution; and high-level government commitment to "review of an outline" for a population policy. The project is funded by AID for four years (FY 82-85) at \$9.615 million and is developed around five program objectives.¹ The program builds on the existing National Family Planning Program which has been supported by USAID since FY 75.

An evaluation team was invited to conduct the mid-term evaluation planned for the end of FY 83 to examine (a) whether purpose and outputs are being met and (b) if activities and tasks are being accomplished in keeping with the Project Paper Implementation Schedule. The team assessed the program as requested in the Statement of Work, organizing its tasks around the five objectives which are described in the Project Paper as follows:

1. Strengthen DSPP/DHF Management Capability
2. Improve Quality and Quantity of Clinical Services
3. Expand Community and Private Support
4. Develop and Implement Commercial Program
5. Stimulate Development of Population Policy

The team members were selected for their experience in four different functional areas in order to concentrate on the tasks set out in the Statement of Work, with the following focus:

1. Overall management capability in the context of regionalization and integration;
2. Financial management, economic analysis, cost effectiveness;
3. Service statistics, national fertility surveys, census data, projections;
4. Health systems delivery, outreach, manpower requirements, training.

In order to conduct the evaluation, team members read all pertinent documents; interviewed staff in the central DSPP and Division Offices, the North and South Regions, USAID, related health and technical assistance projects, and other donor agencies; visited field services; compiled and analyzed financial and service data; and held follow-up meetings to substantiate findings prior to report preparation and de-briefing.

2. Accomplishments of Family Planning Program 1971-83

The Division of Family Hygiene was formed in 1971 within the Department of Public Health and Population (DSPP) with the mandate to set policy for

¹ Actually, five years from date of AID Project Authorization (9/26/81); initial obligation 9/29/81, i.e., FY 81 funds -- USAID POP Officer.

maternal and child health and family planning (MCH/FP), including supervision and coordination of all activities carried out in the public and private sector. The Division operated in a semi-autonomous manner during the 1970's due to its significant external funding sources (UNFPA/PAHO, USAID and private organizations), the relatively weaker infrastructure of the DSPP, and a system of salary supplements which permitted direct supervision of service providers. Since 1977 Division functions have been increasingly integrated into the DSPP and/or decentralized to Region and District Offices and it has thus operated in an increasingly interdependent fashion within the public health sector, focusing primarily on quality assurance, data analysis and planning, and provision of supplies.

In general, family planning services have been accepted by the population and supported by the public sector, with occasional and weak opposition expressed by the Catholic Church and some religious groups.

- * Services are institutionalized throughout the country in over 180 hospitals, clinics and dispensaries; uniform standards of care serve as the basis for a national quality assurance program; an experienced cadre of technical personnel, has developed through short and long-term training both within Haiti and overseas, and now occupy positions at all levels in medical services, education and management; new categories of personnel have been created including more than 150 paid workers who have been integrated into the public health system, and whose primary functions include recruitment, education and contraceptive distribution at the community level; many more hundreds of volunteers and 550 health agents participate in a rapidly expanding community-based service program; nearly 7,000, traditional mid-wives have been trained, are supervised, and provided with basic materials and annually refer thousands of men and women for family planning.
- * the documented met need of women at risk of unplanned pregnancy is estimated by the evaluation team to be between 8.5 and 12%; men have been making use of family planning services in extraordinarily high numbers compared to world-wide programs and outnumber the number of reported female acceptors;
- * a communication, information and education program has provided systematic radio, television and newspaper coverage and distributed a wide variety of materials throughout the country for over eight years; in-service training and workshops have provided a basic orientation in family planning to thousands of health and human service staff as well as targeted segments of the population such as taxi drivers, the press, community leaders, teachers and others;
- * a voluntary sterilization program has been instituted and has increased clients from one to two thousand in two years if current 1983 rates continue; and
- * an administrative support system is in place which provides transport and supplies.

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- * a voluntary sterilization program has been instituted and has increased clients from one to two thousand in two years if current 1983 rates continue; and
- * an administrative support system is in place which provides transport and supplies.

The achievements of the past two years are reflected in the above summary and more specific details are contained in the report. The emphasis during this period has been: renewed efforts to effectively use the Community Agents, particularly in the Port au Prince area where their supervision had fallen off; development of the sterilization program including overseas training in order to conduct in-country training of larger numbers of physicians, and renovation of facilities; expansion of the corps of voluntary collaborators in the community program particularly in such districts as Hinche, Belladere, and Miragoane; continuation of training and seminars but which fell far short of objectives; during 1980-81-82 total women seen was 60,000, 65,000 and 83,000, in the previous two years there were 200,000 and 240,000 female visits respectively, 52,000 and 65,000 new male acceptors, 8.6 million and 11 million condoms distributed and numbers of institutions reporting family planning services increased from 161 to 189.

3. Current Status and Findings

Demand and need for family planning services in Haiti is high as evidenced by the level of community acceptance of contraceptives when made easily available under demonstration project conditions; the numbers of induced abortions; and the abandonment of newborn babies in hospitals. Of special interest is the very enthusiastic response of men to family planning services, and their much greater participation than in most countries. The evaluation concentrated on the ability of the Family Project Outreach Project - both its design and its on-going performance - to meet this demand.

3.1 Management Capability

The Division's functions have been altered significantly through decentralization of service delivery responsibilities in clinics and community programs to the four Regional offices and integration of a number of functions (education, training, planning, data collection) to other DSPP Divisions. Furthermore it will shortly merge with the Bureau of Nutrition and will have a separate Population Section. All modifications in the DHF role and functions have a direct impact on the Family Planning Outreach Project activities, and are more fully described below.

While regionalization and integration have been proceeding for the past few years, the recent transfer of personnel and support from the Division to other parts of the DSPP and Regions has accelerated the changes in the Division's management responsibilities and capability. In general the sum total of functions of planning and evaluation, quality assurance, operations research, supervision and training, logistical support, financial management and overall direction and leadership are not concentrated in a few offices, but instead are dispersed throughout the Department and down to region and district levels. An assessment of the Division's management capability for those functions which remain to it shows that direction is adequate overall, except in research and evaluation (below). The task of managing functions outside the Division which are critical to family planning is very challenging. An assessment shows many potential strengths but a need to act

quickly to consolidate a fragmented decision-making process for all family planning responsibilities and ensure accountability and effective use of resources earmarked for the Family Planning Outreach Project.

Administrative activities, particularly financial accountability, are well defined and carried out by Division Staff. Transport, personnel, storage and supply systems operate quite smoothly and problems stem for the most part from factors which are beyond the Division Chief's scope of responsibility. A serious problem is underexpenditure of funds, and a future problem may be delegation of administrative responsibilities to regional offices, particularly in the area of finances.

A management information system includes an annual compilation of monthly statistical reports from the 180 institutions and hundreds of community and health agents, with limited analysis of some cross tabulations and targeted objectives. Great effort is exerted by many central, regional and district level statisticians and clerks to process the data in as useful a form as possible. The value of the data is severely limited, primarily because of problems with the type of information submitted but also complicated by incomplete reporting and a cumbersome manual system. The serious weakness in service information interferes with planning and evaluation from the national level to service delivery sites. Expansion and liberalization of contraceptive distribution through thousands of volunteers and health and human service workers over the next few years also poses a challenge as to how contraceptive prevalence can be calculated as reporting becomes more diffuse and less controlled. The potential for research and evaluation, including demographic analyses, is not well exploited.

3.2 Quality and Quantity of institutionally-based services

Uniform and comprehensive standards of care make it possible for the Division to exercise its quality assessment role with Regional and District Offices who are responsible for direct staff supervision. A weak data system and lack of responsibility for direct delivery of services, limits the Division's ability to assure quality. Supervision and training are therefore critical and the evaluation shows that both areas are scheduled to receive badly needed attention: the DSPP has just directed Regions to restructure staffing patterns at regional and district levels to provide for one MCH/FP Officer (A physician or public health nurse), who will require a job orientation, and skills in supervision and training needs assessment; and the DHF has just drafted a plan for systematic supervisory visits to the field for quality assurance.

A complementary community education program to enhance quality and quantity is not yet adequate but should be enhanced by the DSPP's requirement for a Health Education Officer (public health nurse) at the region and district levels. Operations research has been largely focused on longer-term questions which help to shape policy. It has not conducted many small-scale, simple interventions to assess quality issues which could produce immediate program changes: cause of program drop-out and/or method dissatisfaction;

ultimate effectiveness of extraordinarily high distribution of condoms through the Armed Forces program; and differences in client use of community and/or clinic services from one area to another.

A major barrier to effective contraceptive use is the extremely narrow range of contraceptives available in Haiti. An emerging alternative is voluntary male and female sterilization which is rapidly increasing and promises even greater use over the next few years. USAID provision of contraceptives world-wide is not responsive to individual country needs.

3.3 Community-Based Program

The liberal distribution of pills and the expanding network of volunteers and other human service programs willing to inform, educate and supply contraceptives offers the best possible assurances of access to family planning. Operations research is supportive of this effort and the only unanswered question is the commitment of decision-makers to implementing any recommendations arising out of the studies. Availability of a broader range of contraceptives is as critical to this program as it is to clinic services described above.

Some problems exist with the division of responsibilities between the Division which can only design community-based models and establish necessary relationships at the national level, and the Regions and districts who are responsible for implementation. The DSPP has directed the regions to appoint a community development specialist to be responsible for these programs, which may lead to increased local collaboration.

3.4 Commercial Program

The Division has been carrying out modest commercial activities with sales of condoms, pills and vaginal tablets, primarily in Port-au-Prince, since 1978. Studies have been conducted and assessments made by consultants to determine the feasibility of a national commercial sales program to ensure greater physical and financial access to contraceptives for low and marginal income people. At issue are the interest and capability of the Division and the DSPP for implementing a program, and the financial feasibility.

3.5 Development of a Population Policy

It is acknowledged by the Division and DSPP that a population policy transcends the public health sector, and the current best hope lies with an inter-departmental committee which grew out of seminars in 1981 and 1982 with DHF and AID support and assistance from Battelle Institute. Successful activities of the committee could lead to creation of a permanent commission with high level commitment from the government and private sector. An information system is critical to achieving the FPO Project objective of producing an outline of a Population Policy for review by the GOH.

4. Recommendations.

In addition to the objectives of the Outreach Project the evaluation team has taken into account the DSPP thrust toward regionalization, integration and focus on seven health priorities in making its recommendations to both the GOH and USAID. The overall conclusion is that the design of the Outreach Project envisions all possibilities for making family planning services accessible, and the DHF/DSPP is the only viable mechanism for ensuring a successful program of services. Therefore the recommendations are all focused on strengthening and improving aspects of the existing delivery system. However, they include suggestions to the DHF/DSPP for reaching out even further into other government sectors and the private sector to overcome limitations imposed by a public health delivery system, particularly for the community-based program, the commercial program and development of a population policy.

Furthermore, the evaluation points out that constraints and problem areas are related more to coordination and management techniques required to implement and follow through on planned activities of the system in place, and not so much to technical professional expertise and resources which are available in Haiti in both the public and private sector. A notable exception is in the area of research and evaluation which is not surprising. Most countries continue to struggle with the complex demographic variables which enter into social and economic policies, while they have developed reasonably effective service delivery systems since the mid 1960's.

The following recommendations represent a SUMMARY of the most important recommendations regarding the major components of the Outreach Project, as well as the commitment to using the evaluation in the spirit for which it was intended in the project agreement. Detailed recommendations are contained after each of the sections listed in the Table of Contents.

4.1 Implementation of Recommendations in the Evaluation Report

During interviews with DHF, DSPP and USAID all parties agreed to the necessity for using the evaluation to reinforce the strengths of the Family Planning Outreach Project, identify constraints and problems, and institute changes to overcome them.

* Convene a meeting of DHF, DSPP, USAID to discuss this evaluation report, come to an agreement regarding which recommendations are appropriate and will be implemented, and by whom, and convene quarterly meetings thereafter to review progress and meet any needs that arise for successfully carrying out the recommendations.

4.2 Management of Resources to Meet Project Objectives

Nearly \$300,000 has been underspent in two years for multiple reasons, but the mechanisms exist to avoid future such situations.

* Assign specific budget oversight responsibilities to individuals in the DHF, provide them with a financial analysis of the previous two years, and with quarterly estimates of expenditures to date establish a clearly defined process required to expend these funds including WHO will identify needs and HOW this will be done, the policy and timelines for regions and districts to present proposed activities to the DSPP unit and DHF staff person responsible; when plans change during the year or expenditures are low, reprogram funds to other family planning activities within the DSPP, or on sub-contract and with mini-projects to professional associations, private agencies or qualified individuals.

* During the next annual DHF planning process with regional and district staff and other DSPP units, particularly the Health Education Directorate, specifically address the experiences with planned and actual expenditures; request the planning group to incorporate strategies into the new Plan; and during monthly meetings at the DSPP with regional directors, furnish information regarding progress of using resources for identified needs.

* USAID provide assistance to the DHF staff to reduce time and energy required for USAID procedures when expenditures are requested by the DHF; use more person-to-person communications and fewer letters; assess and eliminate documentation when not essential or unreasonably burdensome to DHF staff; and collaborate personally in written justifications where such documentation is required.

* USAID facilitate DHF sub-contracting and mini-project approach by simplifying procedures and collaborating personally during the process of selecting grantees; the approach described in the Project Paper (pp. 50-51) is appropriate in general but is unnecessarily complex - work with DHF staff to devise a simpler method.

* It is critical to the success of expanded participation of voluntary agencies, and others in the private sector, that the DHF have the resources and capability required to provide quality assurance, financial accountability and coordination at the national level. Thus, if the approach of sub-contracts and mini projects succeeds, then specific staff at DHF must be designated to negotiate with and monitor all of these activities, to plan for the resources required and to signal the need for assistance if their capabilities are strained.

4.3 Accountability for Project Funds

The DSPP is in a transitory period, during which it is restructuring regional and district staffing patterns as well as the central DSPP, and it has drawn professionals from the DHF to assist. Some will continue to carry out specific family planning functions and some will not, but for the moment the DHF continues to pay salaries from both UNFPA and USAID categorical grants.

* The DSPP and USAID as well as other donor agencies should come to an understanding during the FY 84 budget approval process regarding the extent to

which Family Planning Outreach funds in the future should support units outside the DHF which fulfill functions required to carry out the family planning objectives. This does not require a change in the Project Agreement, since functions have not been changed - rather, they have been delegated to other DSPP units.

* The DHF provides sound accountability for Project funds and should continue to do so until the DSPP central financial management system is equally reliable; and the DHF Administrator should recommend a specific method for tracking expenditures for activities carried out by regions, districts and other DSPP units, as agreed to in the above recommendation. (Refer to Section on Management for a chart illustrating the distribution of functions related to family planning).

4.4 Research and Evaluation

The unreliability of service statistics have plagued all health programs and it is not within the DHF capacity to resolve the system problems. The ability to identify needs for research, and to conduct more meaningful evaluation is severely hampered. In addressing problems of service statistics for the Family Planning Outreach Project the DHF should conserve its energies by concentrating on improvements which are in its power to control, while it can continue to provide training and technical assistance as part of the overall effort to improve DSPP service statistics.

* Select information for analyses at the national level that is most useful (since a great deal of information collected on monthly reports may be useful for supervisors but not for national planning); adopt uniform terms and definition for all levels of reporting, which currently vary considerably; consider using daily reports which are sent directly to the DHF, rather than monthly reports which must first go to the DSPP; develop a strategy for simplified service statistics for the community program which is heavily dependent upon volunteers and para-professional staff for whom reports are more burdensome; adopt methodologies for calculating contraceptive prevalence which are less dependent upon reporting, such as those formulas contained in this evaluation report, NB: the formula used in this report estimates prevalence which is similar to the preliminary results from 20% of the sample survey in the Westinghouse study, and it is based on information readily available to the DHF, i.e. during those years in which there is no survey being conducted, useful rates may be estimated from available service data.

* In the program planning and budgeting process make a distinction between "Operational Research" of the type in which Columbia University is involved and which has long-term implications for policy, and "Applied Research" or "Investigative Studies" which are short-term, less costly, can be carried out by DHF/R&E staff, and are very much needed by service program personnel to make immediate changes. The applied research/investigative studies are too often submerged when staff are assigned to longer term operations research, with the result that budgeted expenditures are not used to meet service program needs, particularly to address the major questions of

why so many women drop out of the program and what is the actual impact of 7,000,000 condoms distributed through FADH. DHF staff positions in the R&E Section should be filled, and consideration be given to sub-contracts and mini-projects to pursue needed investigative studies.

* Extend scope of evaluation activities conducted at DHF to examine the demographic value of the annual family planning goals, and to address a specific question: CAN RESULTS EXPECTED AT THE END OF THE PROJECT BE ACHIEVED OVER THE NEXT THREE YEARS? If the answer is different from the results described in the Project Agreement, establish more practical goals in collaboration with funding sources. Since this is precisely the area in which most countries have few answers, consideration should be given to exchange of information, technical assistance, training and workshops through international organizations and with programs in other countries with similar population dynamics, possibly in collaboration with the IHSI and Ministry of Plan.

4.5 Quality and Quantity of Services

The expansion of services through the public and private health clinic system is necessarily limited by the inaccessibility of the system to rural areas, and its relatively small size (300 to 325 establishments) and the fact that the private sector has no convenient organizational structure through which to systematically promote services. A very large number are associated with the Catholic Church which is unlikely to offer any family planning other than natural methods. The institutional system is critical however, because of its role in providing medical family planning services and support (quality assurance and continuous supply of materials) to the community program.

* Expand the use of all community personnel attached to institutions (community agents, health agents, matrones, etc.) many of whom do not yet have the support and supplies to provide all services contained in their job descriptions; the use of this personnel varies considerably among districts and regions; it should be a task of the newly appointed community development specialist to implement this recommendation.

* Through mini-projects and sub-contracts with the DHF which will provide quality assurance, assist experienced groups, clinics and individuals to extend services among private organizations with demonstration projects which offer on-the-job training (AOPS, ASPHA, Ste. Croix, Cite Simone, Schweitzer Hospital, Dr. Lolagne who does more free sterilizations than any single individual in the country even though he is not paid by the DSPP).

* Method choice in Haiti is impossibly narrow for women to successfully plan pregnancies over the 30 or more years of fertility; even though sterilization, pills and condoms will likely be the most widely used, they are not appropriate at all times or for all individuals; back-up and alternative methods are essential: NFP, foam, jellies and creams, IUDs, the sponge, depo-provera. Community-based personnel are the key to promoting and counselling for effective contraceptive use and require training; USAID contraceptive supply system must be responsive to Haiti's needs; professional

training in medical methods, simple attitudinal surveys, and introduction of seldom-used or new methods (IUD, sponge) under special conditions with intensive client follow up, can all broaden the range of methods. Of over 300 IUDs inserted in a year, two-thirds were done in five out of the 180 institutions offering family planning, thus indicating that IUDs are used if the service is available and promoted. The growth of the sterilization program is very encouraging and should be carefully monitored by the DSPP and USAID to ensure that the DHF does not encounter obstacles, including adequate support to the social work aides.

* Training priority should be given to the newly appointed regional and district personnel for MCH/FP, training, health education and community development: the strategy of the Directorate of Health Education, to tailor training to specific needs as opposed to routine seminars for large groups, should be reinforced and reflected in the DHF 1983-84 Plan.

* Supervision as a training topic in regions and districts should be a priority: supervision in the field by local personnel should incorporate on-the-job-training (or in-service training) as envisioned by the Directorate of Health Education: the DHF Supervision strategy being drafted will provide the support required to ensure quality of services if implemented as planned.

* Education and information activities, as planned by the Directorate of Health Education will emphasize face-to-face education as opposed to mass distribution of materials. This is consistent with fertility and contraceptive prevalence surveys which show that a large percentage (80-85%) of Haitians are already aware of family planning. If plans of the Directorate are implemented, education and information will provide needed support to both the institutional and community-based programs; should be in DHF Plan.

4.6 Community-based Program

The approach and progress of this program are very promising and represent an excellent means of increasing accessibility to needed family planning services. Results are uneven from one region and district to another.

* Emphasis for training should include the regional community development specialists; this person should be responsible for incorporating and supporting the work plans for promoters and voluntary collaborators; the community development specialists should work very closely with central DHF staff, particularly at the beginning, to ensure consistency and quality of community efforts throughout the country.

* Results and final proposals from DHF staff responsible for the programs in Leogane and Arniquet should be discussed by regional directors a.s. DSPP with the DHF and decisions made on specific strategies for incorporating results into on-going services. Should be in DHF Plan.

4.7 Commercial Program

The results of commercial activities over the past several years has not been significant enough to implement a full-scale commercial retail sales

program nor is it clear whether the DHF or DSPP in general are very interested. Several options are open to the DHF.

* Among all options available it is recommended that the commercial retail sales program be carried out on a pilot basis with very specific objectives that must be reached before decisions will be made regarding the future of this program.

4.8 Development of a Population Policy

Everyone interviewed agreed that this objective transcends the DHF and the DSPP in general. Two seminars in the past have provided some assistance in working toward this objective and a working group is currently drafting guidelines for the future, hopefully leading to a National Population Commission that would include representative of all sectors.

* The DHF/DSPP should increase its representation on the working group both to promote its family planning health objectives among other sectors on the group, and to develop relationships with agencies who will ultimately be critical in reaching the family planning objectives. Among other resource people at the DSPP the current Director of the Unité de Services Déconcentrés has a background in population planning. The DSPP needs to enhance its involvement in these early stages so that by the time a National Population Commission is formed it will be an active member agency.

* Since population policy development is being studied by nearly all countries, planning professionals in all sectors would benefit from international conferences and workshops; mid-level technicians in planning units of various agencies would greatly benefit from training. USAID should assure all agencies of this willingness to support both training and the development of a technical unit within a Population Commission.

INTRODUCTION

1. Problem Statement

Haiti is a rural and agricultural country and vulnerable to a changing tropical climate and uncertain rainfalls. It is mountainous, overexploited and one of the poorest countries in the Western Hemisphere. The 1982 population is estimated here to be about 5.36 million, with a yearly rate of growth of 1.5 percent since 1971 which is due in part to out-migration¹. Estimates of the Haitian Institute of Statistics show a birth rate of 37 and a death rate of 14 during the 1975-1980 period, representing a 2.3 percent rate of natural increase. The UN has estimated the birth rate to be higher - at about 42 during this period and the death rate slightly higher, with a resulting natural increase of 2.8 percent. The fertility rate in 1977 was close to 5.5. Population density approaches 700 persons per square kilometer of arable land.

The infant mortality rate in 1971-75 was 124 per thousand for the entire country, according to the World Fertility Survey. Other estimates range up to 150 and for Port au Prince up to 200 per 1,000. The National Nutrition Survey in 1978 found 60 percent of Haitian children under five suffering from some degree of malnutrition, and an estimated 40 percent with second to third degree protein-calorie malnutrition.

Life expectancy is low, a high proportion (nearly 80%) of the population is illiterate, per capita income is about \$290 per year, the minimum daily wage is \$2.64, and the rate of migration to the capital city is over 6% per year.

Demand for contraceptive services in Haiti is high. The Haiti Fertility Survey in 1977, and the results from 20% of the sample from the 1982 Westinghouse Contraceptive Prevalence Survey show well over 80% of women in childbearing age are knowledgeable about family planning. Need is evidenced by the numbers of induced abortions and abandoned children.

2. Strategy

While there is no official population policy in Haiti, government plans reflect concerns regarding population growth and availability of resources. Family planning services were initiated in 1971 with maternal and child health services when the Division d'Hygiene Familiale was created to provide coordination for all MCH/FP services. Services increased from a pilot project in Port au Prince funded by PAHO to a national program in 1975-76 with both UNEFPA/PAHO and USAID support. The DHF continues to be the executing agency, providing quality assurance, technical resources (training and supervision) and material support from the national level.

In September 1981 a new five year Family Planning Outreach Project was approved for \$9.6 million to begin in FY 81 (including \$5 million for condoms and pills). The purpose is to assist Haiti to develop a cost-effective national FP program building upon the experience to date, and the existing national infrastructure. Implementation is through 5 interrelated activities:

¹ Since these figures are lower than previous published data, readers are referred to Demographic Annexes I-V - USAID POP Officer.

- * Formulation of appropriate population policies reflecting full GOH commitment and support for voluntary FP and controlled population growth to facilitate achievement of social and economic development goals.

- * Improving the organization and management of the national program.

- * Improving the quality and quantity of FP services available.

- * Expansion of the participation of private and voluntary organizations, other governmental and local community groups in providing FP information and services.

- * Create retail access to contraceptives at reasonable prices.

This project is being implemented by the Department of Public Health and Population (DSPP) and its Division of Family Hygiene (DHF) which is charged with monitoring and coordinating all maternal and child health and family planning activities in Haiti. There are two critical assumptions for project success: that the AID Rural Health Project is able to achieve improvements in general health services in rural areas and that other donor support remains available.

Total cost of the program is \$17.9 million of which USAID will contribute \$9.6 million, the GOH \$6.5 million and the UNFPA \$1.8 million. (This does not include the \$2.2 million which is estimated as necessary for the contraceptive retail sales program). AID will finance the purchase of contraceptives, FP medical supplies and equipment, in-country and U.S. training, technical assistance, local costs for staff, supervision, evaluation, community outreach, operational research and promotional, informational and educational expenses.

3. Evaluation Methodology

An interim evaluation was scheduled for July of 1983 and was performed instead during the month of October. The purpose of the evaluation was to determine the extent to which program targets and goals have been met and to recommend strategies for improving program performance in the future. Thus the evaluation report covers all of the major five objectives of the project.

Team members were selected from specialty areas of program management, health care financial management and economic analysis, health system delivery and outreach, and demography and statistics. The team initiated its work by participating in a regularly scheduled Monday morning staff meeting at the DHF, and a DHF staff person was delegated to arrange all host country meetings and field trips. Field trips were made to both the North and South Regions including the Miragoane and Leogane projects which have been the focus of operations research for community-based distribution. Team members also met with staff outside the DHF and DSPP to pursue their areas, including natural family planning and demographic analysis. Extensive documentation was

provided to the team by both USAID and the DHF. Tasks were delegated to ensure that all Project objectives were assessed and other team members briefed regarding activities outside their area of focus.

At the end of three weeks the team members began to prepare their written report, and during the fourth week de-briefings were held with USAID and the DSPP and DHF. Some individual staff meetings with team members continued into the fourth week in order to verify findings and discuss recommendations. Two team members departed at the end of four weeks while a third member stayed mid-way through the following week. The team leader stayed a full five weeks to ensure that a complete draft report was presented to the USAID Mission.

The team pursued the evaluation within the following framework: the five objectives of the Outreach Project, progress to date, strengths, weaknesses and recommendations; current DSPP policies which directly affect the way in which the DHF carried out the project; the overall appropriateness of the Project design for Haiti; the ability of the DHF to implement the Project and meet documented demand; and identification of possible alternatives to either the design, or mechanisms for carrying it out.

FAMILY PLANNING SERVICES IN HAITI: RESULTS AND IMPACT

1. Family Planning Program Results

In this section, program service statistics are used to assess the magnitude of female and male acceptance of contraceptive methods, and use of these methods.

1.1. Quality of service statistics: some issues

The first phenomenon which appears to affect the quality of the DHF program service statistics is under-reporting. Since 1980, all the annual reports mention the fact that not all the monthly reports which should be sent by health centers and other components of the program, reach Port-au-Prince to be analyzed. DHF also published coverage indices which measure this phenomenon (Table 1). The coverage index used by DHF is the ratio of the number of monthly reports received to the number of reports theoretically expected, i.e., the number of reporting units in the various programs multiplied by the number of months in the reporting period (12 or 6).

Table 1

DATA COVERAGE INDEX FOR THE MAJOR
SUB-PROGRAMMES, 1980-1983

	1980	1981	1982	1983*
Institutional	67%	57%	66%	75%
Community	73%	17%	34%	25%
Armed Forces (FADH)	49%	58%	56%	65%

Of course, these figures cannot be taken to represent the proportion of the volume of activity which is recorded. First, there appears to be some uncertainty about the exact number of institutions offering FP services, and even more so on the normal number of reporting units in the community program; thus, the expected number of monthly reports might be overstated. Second, the institutions which report irregularly are generally the smaller ones, i.e. the dispensaries, and non-reporting may well correspond in most instances to the absence of activities, or to a very small volume of activity; it is therefore impossible to extrapolate from the available reports, because the supposedly missing reports would in any event "weigh" much less in terms of acceptors. It also happens that a center, in order to spare the always scarce reporting forms, reports the activities of two or three months on one form, thus giving complete coverage of activities although appearing to be incomplete.

On the whole, based on the limited amount of direct observations made by the consultant, under-reporting here does not appear to be a quantitatively important phenomenon. The only way to find out would be a control survey, checking the reported statistics against a count of individual clinical records in a sample of institutions for a sample of months or terms (and an adaptation of such a formula in the community program and the FADH program).

* First 6 months.

The second phenomenon which affects acceptance data is a very common one: multiple counts. In any program, a woman who is a previous acceptor but changes method, or changes center, is likely to be counted as a "new acceptor" for a second (or third, etc.) time. Often, the statistical system is geared to distinguish those "new on the method", from those "new on the program".

This is not the case here. Thus, as the program develops, an unknown amount of duplication takes place and artificially swells acceptance statistics. It is always difficult to assess the magnitude of this phenomenon, and it is always best to build counter-measures in the statistical system.

As regards male acceptance, one of the sources of duplication does not exist--that is, changes of method. On the other hand, changes of source of supply are likely to be more frequent for men than for women in the Haitian program. so, on the whole, the overcount problem may be just as real in their case, if not worse.

The only realistic way to make use of the program statistics, for the purpose of this evaluation, is to take them as they are, in the hope that the biases offset each other or have a negligible net effect.

1.2 Female Acceptance

Table 2 presents the numbers of female "new acceptors" in the program, by method, from 1973 (the initial year of the program) to mid-1983.^{1/} A total of 257,582 new acceptors were recorded during that period. This figure corresponds to 25 percent of an estimated 1,018,000 women who were "at risk" at one time or another during the period^{2/}. This is a substantial percentage, although obviously not indicative of the level of contraceptive prevalence at any time during the period.

^{1/} Strictly speaking, there are new acceptances here rather than new acceptors (see previous sub-section). However, the standard term of "new acceptors" shall be used through the rest of the report.

^{2/} See Annex I.

Table 2

NUMBER OF NEW FEMALE ACCEPTORS BY TYPE OF METHOD, 1973-1983

Year/Method	1973	1974	1975	1976	1977	1978
PILL	...	1607	6380	8441	11522	16112
CONDOM	...	1607	2023	2176	4272	3354
FOAM	...	1105	3113	3807	2605	3440
IUD	...	502	1401	1486	1044	1112
STERILIZATION	...	-0-	1	35	118	177
OTHERS (**)	...	201	2646	156	616	123
TOTAL	4295	5022	15564	16101	20177	24318
	1979	1980	1981	1982	1983(*)	
PILL	25205	25433	23742	32336	12038	
CONDOM	3302	3527	9368	13738	4467	
FOAM	3938	3817	1841	1054	216	
IUD	925	480	267	375	10	
STERILIZATION	238	624	1211	1686	988	
OTHERS (**)	339	519	54	212	55	
TOTAL	33947	34400	36483	49401	17874	

(*) first 6 months (**) "Modern" or "scientific" methods only.

N.B. The figures for sterilization in 1982 and 1983 differ from those published by DHF; these include respectively 26 and 85 male sterilization, which are subtracted here.

It is possible to calculate crude acceptance rates by relating the numbers of new acceptors in each year to the estimate of the number of women at risk (see Table 3).

Table 3
ESTIMATED CRUDE ACCEPTANCE
RATES (FEMALES), 1973-1982

YEAR	New Acceptors ('000)	Women at Risk ('000)	Rate (percent)
1973	4.3	667.0	0.6
1974	5.0	672.7	0.7
1975	15.6	678.3	2.3
1976	16.1	683.9	2.4
1977	20.2	689.5	2.9
1978	24.3	695.1	3.5
1979	33.9	700.7	4.8
1980	34.4	706.4	4.9
1981	36.5	712.0	5.1
1982	49.4	717.6	6.9

Table 4 shows the distribution of all female new acceptors according to method adopted.

Table 4
NUMBER AND PROPORTION OF FEMALE NEW
ACCEPTORS BY METHOD, 1974-1983 (*)

Method	Number	Percent
Pill	162,816	64.3
Condom	47,834	18.9
Foam	24,936	9.8
IUD	7,702	3.0
Sterilization	5,078	2.0
Others	4,921	1.9
Total	253,287	100.0

(*) The distribution for 1973 is not known.

Almost two-thirds of the new acceptors adopted the pill; more generally, "resupply methods" are by far the most practiced. Methods with an inherently high continuation rate - the IUD and sterilization - account for only 5 percent of all acceptors, or 1.3 percent of all women at risk.

The respective contributions of the various sub-programs to these results are presented in Table 5, covering only the last three years.

Table 5

NUMBER AND PROPORTION OF FEMALE NEW
ACCEPTORS CONTRIBUTED BY THE MAIN
SUB-PROGRAMS, 1981-1983

	1981		1982		1983(*)	
	Number	Percent	Number	Percent	Number	Percent
Institutional (**)	15,529	42.6	22,310	45.2	10,046	56.2
Community	15,963	43.8	22,230	45.0	7,412	41.5
FADH(***)	4,270	11.7	4,017	8.1	315	1.8
Others	721	2.0	844	1.7	101	.6
Total	36,483	100.0	49,401	100.0	17,874	100.0

Until recently, the institutional and community programs appeared to supply in equal shares the bulk of the total number of acceptors. But during the first semester of 1983 a sharp drop has taken place in the activities of all programs except the institutional one, leaving the latter in a better position in relative terms.

1.3 Male Acceptance

Apart from a small number of sterilizations (26 in 1982 and 85 in 1983), male contraception is based on the distribution of condoms. Table 6 gives the number of "new" male acceptors of condoms per year.

- (*) First 6 months
- (**) Includes sterilizations
- (***) Haitian Army

Table 6

NUMBER OF MALE NEW ACCEPTORS
OF CONDOMS, 1973-1983

Year	:	New Acceptors	:	Year	:	New Acceptors
1973		712		1979		71,587
1974		767		1980		59,067
1975		9,729		1981		51,977
1976		26,981		1982		65,092
1977		38,282		1983 (*)		24,853
1978		43,322				
<hr/>						
TOTAL						
392,369						

(*) First 6 months.

The possible biases of these data were mentioned earlier. On balance they appear to represent an overestimation of the actual number of new acceptors. Taking this into account, these figures can be related to the numbers of men aged 15-59 years (the target population according to DHF) in order to assess crude acceptance rates (see table 7). The estimation of the target population is presented in Annex II.

Table 7

MALE CRUDE ACCEPTANCE RATES
FOR CONDOM, 1973-1982

Year	New Acceptors (000)	Target Population (000)	Rate (percent)
1973	0.7	1,168.3	0.1
1974	0.8	1,191.5	0.1
1975	9.7	1,214.6	0.8
1976	27.0	1,237.8	2.2
1977	38.3	1,260.9	3.0
1978	43.3	1,284.1	3.4
1979	71.6	1,307.2	5.5
1980	59.1	1,330.4	4.4
1981	52.0	1,353.5	3.8
1982	65.1	1,376.7	4.7

The predominance of male acceptance and of condoms among methods used (cumulatively, male acceptors outnumber female acceptors by 52 per cent since the beginning of the program) is a rare characteristic of this program. It is also one that makes difficult the assessment of the impact of the program because, as will be seen, the patterns of use of the condom are practically unknown.

1.4 Use of contraception

The levels of acceptance say little about contraceptive prevalence, because the use of contraception after acceptance may be short-lived or sporadic. The aim of the program is to obtain a high number of users, and acceptance alone does not accomplish that. In this section, an attempt is made to assess continuation levels and the prevalence of modern contraception in the country.

It should be easy to estimate the number, at a given date, of women who are using a method supplied by the program, since these methods for the greater part necessitate resupply visits, which should be recorded in the statistics. Unfortunately, this is not the case:

- resupply visits are not distinguished from other types of subsequent visits;
- subsequent visits are not classified according to method used; and
- statistics are not presented by calendar month.

It is therefore necessary to estimate independently the number of users. I shall first estimate the number of female new acceptors, who were continuing users at various dates since the beginning of the program (at mid-year for the years 1974 to 1983).

The statistical treatment adopted for the various methods has been the following:

- a) Sterilization: The numbers of acceptors are simply added up, assuming that there has not been, during the few years since this activity started, any loss through aging (beyond 50) or by mortality; and the numbers at mid-year have been interpolated.
- b) IUD: A hypothetical continuation table has been applied to the new acceptors recorded by the service statistics. The table is a simple, linear one, allowing for 1 acceptor dropping out each month out of an initial 100; it most likely overstates the actual number of users, but the numbers are small anyway.
- c) Pill, condom, foam etc.: Annex III explains in detail the method used and its rationale. The following all-method continuation rates have been estimated for the female acceptors of the mix of methods and for the recent years:

Month	$\frac{6}{74}$	$\frac{12}{51}$	$\frac{18}{32}$	$\frac{24}{17}$	$\frac{30}{6}$ (percent)
Rate					

Table 8 gives the results of these estimations

Table 8
ESTIMATION* OF THE TOTAL NUMBER
OF FEMALE USERS OF CONTRACEPTION
(MALES' CONDOMS EXCLUDED), 1974-1983
(000)

YEAR	WOMEN PROTECTED BY				TOTAL
	STERILIZATION	IUD	PILL & AL.	TOTAL	
1974	--	0.2	4.5	4.7	
1975	--	1.1	9.5	10.6	
1976	--	2.3	16.5	18.8	
1977	0.1	3.1	21.9	25.1	
1978	0.2	3.7	22.4	26.3	
1979	0.5	4.1	28.1	32.7	
1980	0.9	4.0	35.5	40.4	
1981	1.8	3.6	38.4	43.8	
1982	3.2	3.0	48.1	54.3	
1983	5.1	2.5	33.0	40.6	

* See formula, Annex III.

By relating these figures to the numbers of women at risk, one obtains a preliminary estimate of the prevalence of methods supplied by the program among women. The percentages of users, calculated in this fashion, would be:

1974	0.7	1979	4.7
1975	1.6	1980	5.7
1976	2.7	1981	6.2
1977	3.6	1982	7.6
1978	3.8	1983	5.6

These are rather modest results, but they do not include the use of condoms distributed to men. Before turning to this aspect, let us compare these estimates to those drawn from the 1977 Haitian Fertility Survey. The latter put the number of users of oral contraceptives and other female scientific methods at about 22,600, and that of IUD at about 3,000; there is good consistency here. The estimate obtained by HFAs for female sterilization (1,500) was statistically not significant (small number of respondents) and in gross contradiction with service statistics. (see Table 8)^{1/}

Condom use is the major unknown feature of the program. Here again, resupply statistics by month are missing. And in spite of repeated mentions, in DHF reports, of the need to study condom use and its impact in terms of couple-years of protection^{1/}, no such study has been done.

Statistics of the quantities of condoms distributed do not help much. On the one hand, DHF points out that they are underestimated, since some health centres report acceptors and resupply visits but not quantities supplied. On the other hand, it is known and admitted that some of the condoms distributed are not used for contraceptive purposes, but this has not been even roughly estimated, and cannot be without a survey. In any event, the figures are the following (in thousands):

<u>Year</u>	<u>Condoms distributed</u>
1976	917
1977	2,285
1978	5,805
1979	7,612
1980	9,618
1981	8,667
1982	11,691
1983 (6 months)	5,687

In order to estimate the number of users, it may be wiser to work from data on the number of visits. Annex IV explains the method used to estimate by this means the number of users of condoms. Table 9 gives the corresponding results.

^{1/} See the 1977 and 1978 reports, for instance.

Table 9

ESTIMATE OF THE NUMBER OF MALE CONDOM
USERS, 1975-1983 (MID-YEAR)

YEAR	CUMULATED (000)*	ESTIMATED (000)
1975	11.2	4.0
1976	37.5	13.5
1977	75.0	27.0
1978	108.6	39.1
1979	153.2	55.2
1980	174.0	62.6
1981	182.6	65.7
1982	176.1	63.4
1983	171.5 (**)	61.7

If we compare these estimates with the numbers of condoms distributed each year, we find an increase in the number of condoms per user and per year, which probably reflects progress in the reporting of quantities distributed. In 1982 and 1983, the number is 184 condoms per user on a yearly basis, which indeed corresponds to a year's needs when allowance is made for waste.

How can we combine these results with those obtained for female users of contraception? Again there are great sources of uncertainty here, not only because we do not know how the condoms are used and with whom, but also because there may be some duplication of contraceptive use within couples in union. Rather than selecting one arbitrary hypothesis, a low estimate and a high estimate are presented, adding respectively one third and three quarters of the estimated number of male users, to that of female users (see table 10).

* See formula, Annex IV

** Since mid-1980

Table 10

ESTIMATES OF THE NUMBER OF WOMEN
PROTECTED BY MODERN CONTRACEPTIVE
METHODS THROUGH THE PROGRAM, 1975-1983
(MID-YEAR - IN THOUSANDS)

YEAR	SEPARATE ESTIMATES		COMBINATION	
	FEMALE	MALE	LOW	HIGH
	ACCEPTORS	ACCEPTORS	ESTIMATE	ESTIMATE
1975	10.6	4.0	11.9	13.6
1976	18.8	13.5	23.3	28.9
1977	25.1	27.0	34.1	45.4
1978	26.3	39.1	39.3	55.6
1979	32.7	55.2	51.1	74.1
1980	40.4	62.6	61.3	87.4
1981	43.8	65.7	65.7	93.1
1982	54.3	63.4	75.4	101.9
1983	40.6	61.7	61.2	86.9

The corresponding rates of prevalence are given in Table 11.

These rates obviously do not take into account the use of "traditional" and "natural" methods. Since the objective of this calculation is to assess the impact of the program, there would be no justification for including them. Further, these are methods with low or very low indices of efficiency, and in assessing the impact of family planning on fertility they can be ignored without much harm.

The rate of prevalence, while significant (around 10 percent), seems to be markedly lower than has been sometimes estimated in Haiti, even though an attempt was made to avoid a downward bias. It may be that service statistics understate acceptance and use in a high proportion, but there is no evidence available to judge this. The evaluation visit did not permit time to assess such a bias, even on a sample basis, so the estimates are the best that can be presented under the circumstances. The results of the Contraceptive Prevalence Survey will soon be available and should provide a more solid assessment. By comparing with the estimates in this evaluation or any other estimates, the Survey will also permit the program to devise better criteria for estimating prevalence in future years on a routine basis in the absence of surveys.

Table 11

ESTIMATES OF THE RATES OF
CONTRACEPTIVE PREVALENCE AMONG
FEMALES AGED 15-49 AND IN UNION
1975 - 1983

: YEAR	RATES OF PREVALENCE (percent)		:
	Low Estimate	High Estimate	
: 1975	1.8	2.0	:
: 1976	3.4	4.2	:
: 1977	4.9	6.6	:
: 1978	5.7	8.0	:
: 1979	7.3	10.6	:
: 1980	8.7	12.4	:
: 1981	9.2	13.1	:
: 1982	10.5	14.2	:
: 1983	8.5	12.0	:

2. IMPACT OF FAMILY PLANNING PROGRAM ON FERTILITY

This section attempts to answer the questions which naturally arise about the effects that the program may have had on demographic trends in this country. It is first necessary to review the present state of knowledge about these trends.

2.1 Demographic trends in Haiti

The latest operation in demographic data collection in Haiti, the 1982 Census, has enumerated about 5,053,800 persons, as against 4,330,000 in 1971. The apparent growth rate, between the two censuses, is thus 14 per 1,000 per year. This is a rather low rate for this region, and some people have first doubted that it could correspond to the reality.

It is well to note here that for a long time, in the absence of direct observations, estimates of the levels of fertility, mortality and population growth in Haiti (by the UN or other institutions) have been based on analogies with other countries of the Caribbean area; in the '60s and early '70s, the idea of a high fertility and a high rate of population growth has thus become popular. Yet, all the statistical evidence goes against this idea (see Annex V):

- (a) The apparent growth rate, between the 1950 and 1971 censuses, was 16 per 1,000; so perhaps it should not have been such a surprise to find a rate of 14 for the next intercensal period.
- (b) To that, it may be answered that mortality was thought to be declining. But the 1977 Haitian Fertility Survey (HFS) has shown that the levels of infant and child mortality were very high, and that they actually tended to rise because of urbanization. It does seem that mortality has changed very little, if at all, in the last decade.
- (c) The emigration factor has been frequently neglected or understated in cursory estimates of the growth rate. But it can be shown to be quantitatively quite significant.

On close examination, it appears that the growth rate cannot have been much higher than the questioned 14 per thousand. For the purpose of various estimates needed in this report, a rate of 15 per thousand has been used (see Annex V).

This report is more particularly concerned with fertility levels and trends. As said earlier, the level of fertility is moderate, as amply shown by the HFS. This is explained by:

- (a) Biomedical factors. A high age at menarche, as well as a low age at menopause, have been observed in Haiti. Both are related to malnutrition, which through some forms of anemia may also explain an apparently high rate of fetal losses. Postpartum amenorrhea is long, partly because of prolonged breastfeeding which is common in rural areas.

- (b) Socio-cultural factors. The nuptiality pattern results in a low prevalence of the stable (marié and placé) types of union: at the HFS, only 43 percent of all women were in a stable type of union (39 percent of women in the 20-29 age group, usually the most fertile); 65 percent of women aged 20-24 had not yet entered a stable form of union. As a result average age at first birth is high. This pattern is conducive to moderate fertility. Indeed, it is essentially geared to that result, as a response to unfavourable economic conditions which induce couples to postpone and to minimize the economic burden of childbearing. The high mobility of population compounds this effect by creating a deficit of adult males in the country (through emigration) and by causing frequent separations (through internal migration). Interestingly, the proportion of stable unions is markedly lower in Haiti than in comparable Caribbean countries. Finally, the use of contraception has increased recently and is likely to play a role, the magnitude of which should be assessed.

2.2 Possible role of program in present trends

The widespread opinion among demographers, although not supported by hard data since the 1977 HFS, is that fertility is declining in Haiti.

Presumably attitudes towards family size, which never were conducive to a really high fertility in this country, have further evolved under the influence of "modern", imported family models, an influence to be largely ascribed to the migration phenomenon and contacts with the large Haitian community overseas. This factor, plus urbanization and perhaps education, must have induced new behaviours with regard to nuptiality and childbearing. As said earlier, objective economic difficulties seem to supply the rest of the explanation to changing nuptiality and fertility patterns.

2.2.1 Possible role of changes in union patterns

Although the concepts used were not the same in both instances, it seems at least that between the 1971 census and the 1977 HFS, the proportion of women engaged in a stable type of union has dropped significantly.¹ This trend certainly has had an impact on fertility, but it is virtually impossible to measure this impact because of the lack of details on (a) the actual changes in union patterns and (b) fertility patterns within the various types of union and their changes over time.

Let us only say that, assuming:

- that the proportions of women in stable unions had remained the same between 1971 and 1977,
- and a consistent distribution of women among the other categories (including a slight rise in the proportion of those never in union),

¹ In 1971: 17.8 percent married, 34.4 percent placées;
In 1977: 15.8 percent married, 27.3 percent placées

the mean number of children ever born to women aged 15-49 in 1977 could have been 4 to 5 percent higher. This suggests that the effect of changes in union patterns was significant, but does not permit any serious conclusion on the effect of these changes on fertility levels during the period.

2.2.2. Possible role of the use of contraception

What can the impact of the family planning program have been on the decline of fertility which has taken place between 1971 and 1977 (and seems to continue)? The question can be explicitly formulated in two possible ways, which seem closely related but in fact lead to wholly dissimilar approaches:

- (A) What effect has the programme had on selected fertility indices (such as the crude birth rate or age-specific fertility rates)?
- (B) How many births have been averted by the program?

The first question can be answered by comparing indices of fertility after the program has been in operation for some time with projections of the same indices in which the programme is not taken into account. It is important to note that the question can be posed with reference to the crude birth rate (if the primary concern is population growth as such) or to the general fertility rate (if that concern is fertility as such), but that the answer can be supplied only by an analysis of the age-specific fertility rates, the other indices being much too crude for the purpose of projections.

In the present case, we lack good data for such an exercise. One set of pre-program age-specific fertility rates (ASFR) was calculated from MDS data. These rates are visibly underestimated, since they are lower than those calculated from HFS data for the years immediately preceding the later survey. The HFS, on the other hand, has supplied estimates of ASFRs, for the period 1969-1977, based upon pregnancy histories. It is probably best to use these data to compare pre-program and post-program fertility. Because fluctuation in the levels of ASFRs based on yearly periods show a substantial incidence of datation errors, three-year averages are used here.

Age-Specific Fertility Rates (per 1,000)

Age groups	1969/1971	1974/1977
15-19	70.1	56.5
20-24	214.4	202.3
25-29	270.9	254.1
30-34	241.2	232.1
35-39	201.8	179.4
40-44	126.1	110.1
45-49	61.6	61.6

There seems to have been a decline in virtually all age groups. Taking into account the age structures of the 15-49 group, as observed by the 1971 census and the HFS, we can derive estimates of the general fertility rate (GFR):

	1969/72	1974/77
Estimated GFR (per 1,000)	170.8	157.8

Changes in the age structure do not seem to have played a role in this decline, since the total fertility rate (TFR), which is not affected by age structure, has declined in the same proportion as the GFR, that is, 8 percent:

	1969/72	1974/77
Estimated TFR	5.93	5.48

In order to ascribe a share of these declines to the program, we should compare the levels of fertility observed in the last place to independent projections based on the earlier estimates. Such an exercise would be of dubious value here, essentially because we have no idea of the trends of fertility prior to 1973 (supposed to be the "natural" trends), hence, no basis to formulate a reasonable assumption that would guide the projection. It will be better, at this stage, to examine what use we can make of the methods based on births averted.

There are basically three approaches to question (B) above.

The first approach (illustrated by the Potter and Wolfers models) is based upon an assessment of the measure in which the use of contraception prolongs the period during which a woman is not pregnant. It measures births averted as the ratio between the duration of contraceptive use on the one hand, and the length of time (specified by age of mother) which is occupied by the total process of one birth (i.e. the average marriage duration per birth in the absence of contraception) on the other hand.

The data required for such calculations include some information which is available for Haiti (number of acceptors by method) but also some which is available only partially (such as the age of acceptors, which is too seldom recorded) or not available (contraceptive status of acceptors¹, interval between last delivery and acceptance, contraceptive continuation tables including pregnancy rates, average duration per birth, etc.). While a parameter can always be estimated, the accumulation of sources of uncertainty would deprive the exercise of any value in the present case.

¹/ New users or previous users.

The second approach is based on the use of ASFRs. In its many variants, it maintains the original idea (by Lee and Isbister) of estimating the number of births averted in a group of women (specified by age) as the product of the number of women in the group, times the decline in the ASFR for users of the program, times the average continuation rate for the period considered. Here again, it is clear that we lack data to use this method. We could use our earlier estimates of continuation rates, but the problem of estimating the ASFRs for users of the program would remain. An interesting stratagem for such an estimation was devised by Kelly, using the data on age and parity (number of children ever born) which are normally collected for each new acceptor in a program; unfortunately these data are not available to us either.

We are thus left with a third approach, which relies on a few empirical rules. For instance, it is said that five IUDs inserted in a given year prevent one birth each year for at least five years (Ross). These rules of thumb give only approximative indications on the number of births averted, because they do not take into account the variations of continuation and of fertility among age groups or among parity categories. Besides, such rules are lacking as far as pill and condom acceptance are concerned, because of the large variations in continuation and efficiency of these methods.

Other rules aim to estimate couple-years of protection provided from data on the quantities of contraceptives distributed. This type of data being admittedly of dubious quality in the present case, the use of this approach is not advisable either.

The only method which we can use, is to go back to our estimate of the number of women protected, and to make assumptions on the fertility which they would have experienced if they had not been protected. This approach has been widely criticized on the grounds that the necessary assumptions cannot but be arbitrary. In the absence of a program, women now users of the program might have a fertility higher than average (in most instances, acceptors tend to exhibit higher past fertility than other women). Or, they might have a lower fertility (acceptance proves a determination to limit family size, which could have been put into effect anyway). We shall try to avoid part of such criticisms by selecting two fertility assumptions.

We shall be able to work out estimates of births averted from 1976 to 1983. As we have seen earlier, the GFR seems to have declined from 171 to 158 per 1,000 between 1969/72 and 1974/77. Selecting in that range a fertility rate which would be applied to the women protected, would imply an assumption on the share of the decline which is due to the program, hence, would incorporate a predetermined answer to the question posed. Instead, we shall reason that, from 1976 onwards:

if none of the decline were attributable to the program, the women would have had, in the absence of protection, the "low" fertility rate of 1974/77, i.e. 158 per 1,000;

-- if all of the decline were attributable to the program, those women would have had, in the absence of protection, the "high" rate of 1969/72, i.e. 171 per 1,000. Table 11 gives the results of the calculation, in which the low GFR has been applied to the low estimate of women protected and the high GFR has been applied to the high estimate of women protected.

Table 12

TWO ESTIMATES OF THE NUMBER OF
BIRTHS AVERTED BY THE PROGRAM,
1974-1983 (thousands)

YEAR	WOMEN PROTECTED (*)		BIRTHS AVERTED	
	LOW ESTIMATE	HIGH ESTIMATE	LOW ESTIMATE (GFR = 0.158)	HIGH ESTIMATE (GFR = 0.171)
1976	14.8	17.5	2.3	3.0
1977	26.0	33.2	4.1	5.7
1978	34.7	47.2	5.5	8.1
1979	43.1	61.3	6.8	10.5
1980	53.1	76.8	8.4	13.1
1981	61.3	87.9	9.7	15.0
1982	68.8	95.7	10.9	16.4
1983	68.9	95.2	10.9	16.3

(*) Average number of women protected from April of the preceding year to March of the current year, to adjust for the delay between conception and birth; obtained by interpolation from Table 10.

In total, allowing for a few hundred births averted in 1974 and 1975, a minimum of 60,000 births and a maximum of 90,000 births may have been averted by the program from its inception to the end of 1983. The actual figure probably lies in between, especially as we must remember that an impact of the changes in union patterns has been detected and concurs in the fertility decline, and that some contraception (including modern methods) is practised outside the program.

These figures can be compared to the number of women aged 15 to 49, and to the total population. These comparisons suggest that, without those births being averted, the GFR in 1983 might have been 9 to 13 points higher, while the crude birth rate (CBR) might have been 2 to 3 points higher. But the levels of the GFR and of the CBR cannot be assessed.

This is not methodologically the best possible estimate of the impact of the program, but it probably gives a fair idea of the order of magnitude of that impact.

As regards the future course of events, that is, the possible evolution of fertility indices in the years ahead, to chart it at this stage would be an unwarranted enterprise.- Our knowledge of the past trends, of the present situation, and of the linkages between program activities and fertility change, is too limited to supply a basis for reasonably good projections.

MANAGEMENT CAPABILITY

1. Program Management: Decision-Making Level

1.1 Functions of the Division of Family Hygiene (DHF)

The DHF is the executing agency within the Department of Public Health and Population (DSPP) for the Family Planning Outreach Project and its management capability is therefore critical to the successful accomplishment of project goals and objectives. However, the functions required to plan, implement and evaluate family planning clinic and education services are not confined to the DHF, and an assessment of its capability must include its ability to negotiate and influence decisions and actions outside its direct supervision and authority, as well as its ability to maintain an accounting of widely dispersed family planning activities.

- * The primary function of the DHF, as with other directorates of the DSPP, is normative, i.e. it is responsible for assuring quality of services according to established standards of care, but not for direct service delivery. To carry out this function the DHF maintains and up-dates norms and standards to reflect changing conditions and medical technology; systematically monitors quality of services in the field through each of the four regional offices; provides technical assistance and MCH/FP supplies; and provides resources for training and education.
- * Another major function is research and evaluation including analysis of service statistics; operations research to provide information for policy decisions regarding service delivery patterns; applied research or investigative studies for more immediate changes in service programs; and evaluation of programs to determine whether it is progressing toward its major goals.
- * A third function of the Division is to undertake special program initiatives such as the commercial retail sales of contraceptives, sterilization services, and community-based projects. The DHF role is to develop appropriate guidelines and methodologies and provide necessary direction at the national level while incorporating them into on-going services.
- * The financial and administrative support role of the DHF are related to the above three functions, particularly the logistical support which ensures an uninterrupted flow of MCH/FP supplies to the field. It also has responsibility for grants management.

The DHF and the Bureau of Nutrition are about to be amalgamated and many questions remain to be answered regarding delegation of responsibilities and the merger of normative, research/evaluation, program development and administrative functions. At the Minister's request the two agencies have formed a committee to design a final reorganization. It is also envisioned

that there will be an office of population within the new agency which is expected to participate in activities related to demographic analysis, research and training, but its role and functions have not yet been elaborated.

1.2 Regionalization and Integration: Impact on Family Planning Functions

The delegation of responsibilities for various aspects of family planning to parts of the health system other than the DHF has evolved over the years as a result of two policies within the DSPP: decentralization of service delivery responsibilities to regions and in turn to their districts (regionalization); and the strengthening of the DSPP's central support and human resource systems, including the eventual integration of those which were developed independently by various departmental programs (integration). From the inception of the DHF in 1971 until the late 1970's, family planning - allied with maternal and child health services (MCH/FP) - constituted one of the few health programs within the DSPP with sufficient resources to develop and implement standards of care, provide in-country and overseas training for personnel at all levels, develop a national data system, and promote and support the delivery of services with accompanying education and material assistance. With UNFPA and USAID funds the DHF essentially developed and strengthened segments of the national delivery system in order to offer a categorical service, and used a system of salary supplements for personnel to deliver services in the afternoon after the usual DSPP clinic hours. Thus it was able to supervise the service providers and launch a national program with much stronger focus than would otherwise have been possible.

Since the late 1970's the DSPP has been taking steps to implement regionalization and integration of services and functions. For programs which were more developed - most notably the DHF, Bureau of Nutrition (BN) and the National Service of Endemic Diseases (SNEM) - this often had the effect of restraining forward movement of services delivery, a reduction of functions, or limitations on supervisory responsibility. An example of the changes brought about by DSPP policies can be seen in the development of human resources. In 1975 in order to conduct community outreach, the DHF developed a cadre of urban MCH/FP community agents, whereas a strong DSPP might have responded to the need by developing an outreach worker for all public health activities. Later, during 1977-78 when MCH/FP was to be expanded into rural areas, the DHF was often compelled to delay or postpone training and other developmental activities: the DSPP had begun by this time to assume responsibility for rural health planning rather than continuing to allow categorical efforts to develop and extend the weak rural delivery system. In a related move the DSPP decided that services should be integrated, so salary supplements were distributed among all DSPP personnel and MCH/FP afternoon clinics were incorporated into the morning hours. To this day decisions regarding hiring, training and supervision of personnel rest with the regions, and until recently their staffing pattern did not reflect diverse service programs or specific national health goals.

Evaluation and technical assistance missions since 1976 have documented the problems inherent in decentralization of services and integration of support functions, the frustration experienced by professionals

at the national level due to delays in training and expansion of services, and reliance on regional and district personnel who were often less experienced to implement recommendations for improved services. At the same time, it is widely acknowledged that the success of any service delivered and supported by the public health sector will ultimately depend upon the quality of the system as a whole, clear delegation of responsibility to qualified personnel, and commitment within the DSPP at levels higher than the DHF. Ironically the new DSPP administration and many regional staff are composed of professionals who until recently were successfully implementing health programs and who best understand the limitations of weak DSPP and regional district structures. The top management of the DSPP, the regions, and the DHF expressed to the Mission their overriding concern for the successful implementation of changes intended to remedy problems they had confronted in the past, and which will have a direct bearing on the Family Planning Outreach Project. These changes include:

- * reorganization of regional and district staffing patterns, with specific delegation of responsibilities for MCH/FP to a public health physician or nurse, at both the region and district level; responsibilities for training to the Region and District Health Nurse; responsibilities for health education to a public health nurse at the region and district level; and responsibilities for the community program to a community development specialist at the regional level;
- * a planning process which obtains input from all DSPP agencies, the regions and their districts, establishes national priorities based on needs identified by the normative and technical DSPP units, and permits regions and districts to develop their own strategies for implementing national goals, and which this year resulted in health area plans such as that produced by the DHF for 1983-84;
- * a newly created directorate for health education and training, a function which previously existed only as a technical office within health programs; it is expected to provide education staff in the field, and will incorporate the office of medical and paramedical training; the director was formerly the chief of the DHF education office;
- * a delivery system throughout the country extending into rural areas with health agents as the base, serving eventually 2,000 people each, and physicians placed at the level of communes;
- * identification of national health priorities which currently number seven and include family planning and childhood immunization, nutrition and diarrhea; and
- * continued efforts to strengthen functions which are expected to benefit all of the DSPP programs, such as administrative support, logistics and transport, and a personnel system which will integrate as staff those working in the DHF community programs who were trained as categorical service providers without status or benefits in the public health system.

It should be noted that under another USAID project agreement, about \$17 million is provided for strengthening the rural health delivery system, and currently supports many of the changes described above.

1.3 DHF Accountability and Management

As Table 1 illustrates the role, functions, activities and tasks for providing family planning services are distributed throughout the public health system due in large part to regionalization and the strengthening and integration of central functions. Nevertheless the DHF as the executing agency continues to be accountable for effective and efficient use of resources to achieve project goals, and it must therefore have the capability for managing them however widely dispersed they may be.

It is important to note that the move toward regionalization and integration had particular implication for DHF management when its former Chief was appointed Director General of the DSPP in late 1982, then Minister in early 1983. To expedite changes in the DSPP he drew on the most experienced professionals within the public health system with whom he was familiar, including many DHF personnel and the Director of the BN. Many personnel continue to be paid from DHF categorical grants (UNFPA and USAID) although not all of them will continue to carry out MCH or FP-related activities. The DSPP has specifically stated that this is a transitory period, necessitated by the need to move quickly to institute reorganization using the most competent professionals at hand, whatever their source of salary. They also point out that such reorganization and the pace with which it is being implemented will be of direct benefit to such categorical grants as the Family Planning Outreach Project.

Questions which remain unanswered at the end of the evaluation must be addressed by the DSPP, the DHF and funding agencies, all of whom agree that the health system must be strengthened. How long will the transitory period last? Will support of DSPP reorganization from categorical grants speed progress toward project goals or divert resources away from them? Is it necessary to re-allocate funds to support the distribution of family planning responsibilities throughout the system? If so, how can the DHF continue to ensure accountability? Will strengthening of the health system be timely enough for the Family Planning Outreach Project to achieve expected goals in the 2-3 years remaining?

The major challenge facing the DHF is to manage a categorical grant for family planning through integrated MCH/FP/Nutrition services, within the context of a public health system committed to multiple national priorities, decentralization of service delivery, and the merger of technical and support functions, including training and education, for all health programs.

TABLE 1

MATRIX OF FAMILY PLANNING OUTREACH FUNCTIONS
AND UNIT RESPONSIBLE

Functions	Adminis- tration	(Planning)	Quality Control	Service Delivery	Education Training	Evaluation	Community Program	SPECIAL PROJECTS	
								Steriliz- ation	Commercia Sales
Direction D'Hygiene Familiare (Sections)									
. Administrative	X								
Quality Control		X	X						
. Research and Evaluation		X				X		X	
. Community Program		X					X		X
DSPP - Other Units									
. General Management	X	X							
. Planning Office		X							
. Combined Services									
Field Support		X		X					
. Education									
Health and Training		X			X		X	X	
. Statistics Office						X			
Region/District									
. Director General		X							
. Interlocutor PM/FP				X	X				
. Interlocutor									
Health Education					X				
. Specialist									
Community Development							X		
. Specialist									
Institutional Personnel									
DSPP/Private				X					
. Community									
Volunteers							X		
. FADH				X					

1.3.1 In-House Functions

With regard to those normative and program development functions specifically assigned to it, the DHF continues to provide adequate leadership and management. The next two sections highlight strengths and weaknesses related to the offices of research and evaluation, and administration. With regard to the remaining activities of quality assurance, development of the sterilization program, planning, monitoring and the community program, staff are experienced and competent, maintain up-dated plans and progress reports, and have in place systematic approaches to fulfilling their roles:

* Norms and Standards - Standards of care were documented and interviews with staff at the DHF regarding need for revisions and up-date was verified in the field, i.e., staff reflected the current situation with regard to standards of care. A plan for systematic and selective supervision was being prepared by the Evaluation Office of the DHF (which will have coordinating responsibility) and it ensures that DHF technical staff will routinely assess and assure quality of care and compliance with standards, identify and direct attention to areas of need, and follow-up on results.

* Sterilization Program - planned objectives were progressing well, goals are clear, information required to operate the program were readily available, i.e., description of facility and manpower needs as well as resources identified to meet needs.

* Community Program - documents provide philosophy, approach, objectives and progress to date; staff organization includes systematic work plans and feedback to make any needed changes in design; description of program at central level was verified in the field.

* Planning - The 1983-84 plan contains a detailed list of objectives intended to accomplish goals of the Family Planning Outreach Project as well as MCH services; an attached budget showed detailed allocation of funds for regions and districts in several categories of expenditures; the process of producing the plan included personal visits, meetings and submission of written documents from regions and other agencies within the DSPP; plan coordination is provided by the Research and Evaluation Director.

While the plan appeared to be adequate on paper, a number of observations should be made:

* In view of the major changes in the DSPP and the DHF, including the departure of many top management staff from the DHF, removal of the health education and training unit and the dismantling of a separate supervision unit, it might be expected that the 1983-84 plan would reflect reorganization within the DHF, but it does not. It was difficult to ascertain precisely how the DHF is adjusting to these changes, what reorganization and new efforts would take place as a result, and how the DHF intends to coordinate with other DSPP units.

As reflected in the charts, functions required to implement Family Planning Outreach objectives are dispersed throughout the DSPP, yet the plan for 1983-84 does not provide sufficient information regarding the necessary lines of communication among all those responsible for these functions.

- * Considering the very significant underexpenditures at the DHF in the past two years, it might be expected that planned activities would be quite different from the previous years in those areas, but in fact the activities are strikingly similar to past plans.
- * Also missing from the plan are: precisely how results from the Miragoane project will be incorporated into on-going services; how in fact improvements in service data will be improved other than through seminars; how information and education needs of special programs will be met -- e.g. the community program and the sterilization program.
- * Overall Program Monitoring - the DHF Chief was in the process of holding meetings with each of the regional directors and staff in the field, using the latest six-month report of activities as a structure for the meeting; mission team members participated in one of the meetings which included discussion of the strengths and weaknesses of the region signaled by the six-month report, description of the 1983-84 plan and the process used to synthesize the region's specific input and the restructuring of regional staffing patterns and expected job responsibilities; organization and follow-up of meetings, tied closely into the planning process, is provided by the Research and Evaluation director. The procedure appears effective and the DHF Chief was very informative and responsive to Regional Staff.

1.3.2 Shared Functions

There are a number of indications that the task of DHF management, to provide direction to activities within the Family Planning Outreach Project which are widely dispersed, is unwieldy. This is especially noticeable in the areas of training, supervision and research (applied), where their successful implementation is greatly dependent upon close coordination among several levels and individuals.

Funds for these three activities have been consistently underspent despite the considerable needs expressed by most field personnel. In FY 82 the budget was underspent by \$200,000, and in FY 83 by \$93,000, two-thirds of which were for seminars, supervision and research. While some underexpenditures - such as the FY 82 sterilization budget - seem to be attributable to lengthy approval procedures - this does not appear to be the case with training, supervision and research. With regard to research one of the reasons for underexpenditures (none of the \$12,000 was spent in FY 83) is insufficient staff: many were absorbed by long-term operation research such as the Westinghouse project, while some staff positions at the DHF have not been filled in this area.

The various levels and offices which have responsibility and decision-making authority regarding some aspects of the three areas mentioned include:

* medical personnel responsible for field supervision and direct services, who could identify weaknesses in skills requiring training or more intensive supervision and on-the-job training; and who can identify topics for applied research needed to make immediate changes in programs;

* regional and district directors who must weigh training, supervision and research needs from a larger geographic perspective, and through whom requests must be communicated; they will also determine whether results of investigative studies will be incorporated into their programs;

* DHF technical personnel in all sections who can identify problems requiring supervision, training or investigative studies, who can view needs from a national perspective, facilitate exchange of information and prevent duplication of effort;

* the Directorate of Health Education and Training which has the education and training expertise to design programs which will meet needs identified by supervisors;

* DHF financial office which monitors expenditures throughout the year; and

* executive staff of DSPP, DHF and the regions who have decision-making authority regarding final plans and allocation of resources.

In general, the management policies and the organizational structure of the DHF does not reflect the complex decision-making process or management tools required to match resources with needs. Thus there have been under-expenditures in areas where needs are not yet met, and annual plans continue to allocate resources to the same areas. Personnel at the DHF seem to be aware that the resources are there but they did not feel they had the authority to obligate the funds on their own.

Another potential problem for DHF management is that a new Directorate of Health Education and Training, at the same level within the DSPP as the DHF, has been established to provide expertise in these two areas. But the process for coordinating, for identifying DHF needs and designing methodologies for meeting them, and for allocation of funds in these areas from the Family Planning Outreach Project has not been developed, or was not evident in any DHF plans or documents.

In conclusion, the DHF capability to be accountable for and to effectively manage Family Planning Outreach resources and achieve stated goals within the next two years has become increasingly dependent upon many other units within the DSPP as well as the regions, over none of which it has authority. The DHF continues to provide adequate direction and leadership for normative functions, i.e. quality assessment and assurance, development of

special programs, and financial administration as described in the next section. Performance in these areas have not been significantly hampered by the departure of key staff or change in functions, and in fact it may improve with the restructuring of region and district staffing patterns. Management in the area of research and evaluation is problematic, as discussed in a later section of this report.

For those functions which are shared with other DSPP agencies and regions, the DHF does experience problems as reflected in the underutilization of resources and absence of plans to address it, or to address the need for much greater coordination.

1.4 Recommendations

* Since the DHF does not have authority over regions or the other DSPP units, most notably the new Directorate of Health Education and Training, the DSPP must assist the DHF in addressing management problems by using existing lines of communications from the Direction General or the Unite de Services Deconcentres and the DSPP-wide planning process to ensure that functions and responsibilities for carrying out objectives of the Project Agreement are sufficiently supported, clearly delegated, and routinely monitored.

* A Management Study conducted with the assistance of Westinghouse in 1981 provided many suggestions regarding DHF management, many of which are still relevant. This study should be reviewed to determine whether some recommendations would address any of the problems described above.

* Using the DHF supervisory system, and in coordination with the Directorate of Health Education and Training, devise mechanisms to ensure that needs are identified, resources earmarked, programs developed and designed and funds obligated; specific staff should be delegated responsibility for various budget line items and the Administrator should provide quarterly expenditure reports; anticipated underexpenditures should be re-programmed or considered for sub-contract to private associations, clinics, successful programs and interested individuals for demonstration projects and training.

* The DSPP and donor agencies should come to agreement regarding the extent of support to be provided to DSPP units and regions who share responsibilities for carrying out objectives of categorical grants such as family planning. This should not result in changes in the Project Agreement, since functions have not been changed, but rather re-assigned.

* To promote management of resources, consideration should be given to using the recommendations contained in the evaluation report as a departure: identify which DHF staff units or region/districts staff shall be responsible for carrying out various recommendations, and who at the DSPP level will monitor progress; meet quarterly to review progress, constraints and pattern of expenditures.

2. Administrative Management

2.1 Financial Analysis and Recommendations

2.1.1. Financial Provisions of the Agreement

The Agreement calls for a total USAID expenditure of \$9,615,000 for five years (FY 81-85). It provides for a total of \$5,127,000 of bilateral assistance (divided between direct expenditures from USAID and reimbursement of local DHF expenditures) and \$4,488,000 of contraceptive commodities procured by AID/Washington. An additional amount of \$2,155,000 for a pilot test and funding of a Commercial Retail Sales (CRS) program was deferred until the viability of such a program is demonstrated.

The USAID contribution is to be supplemented by a GOH contribution of \$6,555,000 over the life of the project (largely in Title I expenditures and in-kind contributions) and \$1,810,000 from the UNFPA.

2.1.2 Obligations

Obligations to date by USAID lag behind the plan. Planned obligations through FY 83 for bilateral assistance were \$269,000 under target. Contraceptive commodity provision through FY 83 was only \$16,000 under target. USAID explains that bilateral assistance obligations to date are less than planned due in large part to the inability of the DHF to absorb more funds, under program constraints.

Table B-1

Planned Obligations Under FP Outreach - (\$000)*

	<u>Bilateral</u>	<u>Contraceptives</u>
Planned Obligations thru FY 83	2206	1932

Actual Obligations Under FP Outreach - (\$000)*

	<u>Bilateral</u>	<u>Contraceptives</u>
Actual Obligations thru FY 83	1937	1916
Figures in parentheses (FY 81)	(637)	(216)
are non-additive. (FY 82)	(600)	(900)
(FY 83)	(700)	(800)
Planned Obligation for FY 84	1600	1200
Planned Obligation for FY 85	1590	1372
Total Planned Obligations	5127	4488

* Per Memo from P.S. Gibson - 10/21/83.

2.1.3 Status of Grant Expenditures

Actual expenditures for FY 81, 82 and 83 as of June 30, 1983, according to the Joint Project Implementation Plan, were: \$913,000 for bilateral assistance and \$1,665,000 for contraceptive commodities. Accrued expenditures for bilateral assistance were \$1,024,000 as of the same date.

An examination of direct USAID expenditures was not made, but attention was directed towards DHF reimbursable expenses and their supporting documentation.

DHF reimbursable expenses have been under the amounts that USAID authorized for expenditure in the Project Implementation Letters (PILs). At the same time USAID has withheld permission for the DHF to spend funds requested for specific items. For example, PIL No. 6 as amended (dated April 11, 1983) refused to authorize \$170,760, \$74,000 for contractual services, \$48,000 for renovations, \$43,000 for vehicles and \$5,260 for filing cabinets) and requested additional documentation. Thus, while AID has not authorized all requests for expenditures, DHF in FY 83 had an unexpended balance of authorized expenditures of \$93,043 (see table B-2)

In Fiscal Year 82, as shown in Table B-3 underexpenditures by the DHF were even greater, totalling almost 30% of the \$671,830 in their budget.

(Table B-2)

DEPARTMENT OF PUBLIC HEALTH AND POPULATION
DIVISION OF FAMILY HYGIENE

SUMMARY OF EXPENDITURES
SEPTEMBER 1-30, 1983

Budget Category	FY 83 Budget	September Expenditures	Cum. FY83 Expenditures	Unexpended Balance
Salaries	498.887.00	1.381.87	436.322.94	62.564.06
Transport	37.300.00			(8.298.45)
Vehicle Maintenance		2.392.12	27.009.73	
Gas Diesel		1.506.75	18.588.72	
Seminars	48.345.00	2.997.45	21.332.02	27.012.98
Supervision & Support	83.594.00	4.135.00	56.470.00	27.124.00
Eval. & Research	12.000.00			12.000.00
IEC	10.350.00	430.80	13.266.99	(2.916.99)
Travel				
Social Workers	6.840.00	420.00	4.425.00	2.415.00
Natural FP	30.000.00		21.614.16	8.385.84*
Program Support	20.000.00	4.392.15	46.857.14	(26.857.14)
TOTAL	<u>747.316.00</u>	<u>17.656.14</u>	<u>645.886.70</u>	<u>93.043.00</u>

* Action Familiare claimed this money before the end of FY 83. For purposes of this evaluation this money is spent.

Table B-3

DEPARTMENT OF PUBLIC HEALTH AND POPULATION
DIVISION OF FAMILY HYGIENE

SUMMARY OF EXPENDITURES
SEPTEMBER 1982

	<u>Budget 1982</u>	<u>Sept. 1982</u>	<u>Cum. FY 82</u>	<u>Unexpended Balance 1982</u>
Salary	374.000.00	35.079.58	307.938.87	66,061.13
Material IEC	52.875.00	16.90	399.80	27.928.26
Community Agents		556.60	3.179.08	
Natural FP			21.367.76	
Medical Supplies	74.175.00	2.337.50	24.197.45	45.025.05
Rénovation		48.00	4.952.50	
Per diem for supervisor	82.280.00	4.197.50	57.994.00	20.933.59
Service Contract		177.09	3.352.41	
Office furniture	60.000.00	18.80	1.233.20	45.729.95
Training		427.50	13.036.85	
Vehicles Maintenance	28.500.00	3.519.46	15.353.18	(1.918.83)
Gazoline		2.050.50	15.065.65	
Total	<u>871.830.00</u>	<u>48.429.43</u>	<u>468.070.85</u>	<u>203.759.15</u>

* Action Familiale

7.117.76

2.1.4 Analysis of Expenditure Shortfalls in FY 82 & 83

In both fiscal years the salary line item is underspent. Knowledge of past DHF trends and projected activities in the coming fiscal year should enable the DHF to reduce the salary budget based on the estimated number of months that some positions may be vacant.

In both fiscal years, the line item for training and seminars was underexpended. In FY 82, 74% of the funds budgeted (\$45,730) were not used while in FY 83, the unexpanded amount was \$27,013, or 56% of the funds planned. Since there is both a need and a desire for training the continued shortfall in this line item is especially serious.

In FY 82, the voluntary sterilization program failed to spend \$65,958 or 42% of funds budgeted*. In FY 83, however, the program appears to be progressing better. The delay in spending the full amounts requested in FY 82, DHF personnel explain derived from USAID request for justification of renovations, and approval took sometimes longer than a year. For example, locating the original plans of facilities that were 70 years old proved extremely time consuming. An arrangement has been worked out now whereby the plans can be reviewed by USAID through a site visit and this has cut down delays. Complaints were also heard about lead time in ordering sterilization equipment like operating room tables as long as 18 months. One would recommend extra efforts to cut down delays like these.

In FY 83, \$12,000 provided for research was not spent. The Director of Research and Evaluation explained that his staff were fully absorbed with such long term projects as the Westinghouse Contraceptive Prevalence Survey and were therefore unable to carry out short term projects which had been planned and initiated. By contract, grant funds budgeted for Action Familiale were fully drawn down in each of the two fiscal years involved. Another troublesome area in FY 83 was Supervision and Support \$83,594, almost a third (\$27,124) was not spent.

Based on discussions with DHF management personnel, it appears that underexpenditures derive from a variety of situations: lack of coordination among national, regional and district levels regarding supervision and training needs, staff perception of how much authority they have to obligate expenditures, delays in staffing, and development of activities which must precede expenditures (e.g. field testing of print materials or attitudinal studies), lengthy procedures for justifying certain expenditures, and departures from planned activities.

2.1.5. Integration and Regionalization of DHF Resources outside the DHF:

Since the DHF is a staff office, many of its expenditures and resource allocations are obligated by the Regions and other DSPP Offices. Since more program functions are being integrated into the DSPP and delegated to the Regions, it becomes increasingly necessary to ensure that resources supplied to the DHF for Family Planning Outreach are being used for family

* Correction: \$14,000 of this amount was used for sterilization commodities (PIO/C) USAID Population Officer.

planning purposes. The Project Agreement is quite specific as to how the funds provided are to be used, and any reprogramming by the DSPP must be justified within this context. Over the past several months the DSPP has moved quickly to expedite regularization and integration as described above, and in the process of re-assigning personnel and accompanying resources to other job responsibilities, the USAID Family Planning categorical grant funds (as well as other DHF categorical funds) are being reallocated. The DSPP has assured the team that the resulting changes are transitory, and that the need to expedite reorganization required faster decision-making than would have been possible if changes in project plans and DSPP budgets had been necessary. The resources affected are:

- 13 staff on the DHF payroll but working outside the DHF include four drivers, regional administrators, the director and several staff of the new health education directorate the director of the DSPP office of regionalization and others. Some, particularly those in the education unit, will continue to carry out MCH/FP activities while some will not. Many are paid by the UNFPA, but since the AID grant is based on the overall DHF capability, the Outreach Project is affected by any transfer of DHF resources.
- IEC equipment and a vehicle for the director of regionalization have been transferred from the DHF.

As mentioned earlier in the report, integration of the DHF into the DSPP may be a logical move for the public health system, and indeed the Westinghouse management review in 1981 recommended eventual integration of supply, transport and finance functions to provide a central point of control, cut down on duplicative operations, produce a single set of management standards, reduce the size of the administrative support staffs required, save money and produce more efficient and effective organization. Nevertheless, in FY 83 the DHF employed 346 people in a relatively simple organization with only a few, clearly defined objectives. Its management and financial systems are relatively sophisticated, control is centralized, and its funding sources are generous and stable. The DSPP, on the other hand, with about 8,000 employees is a large, underfunded organization with an inadequate administrative and financial structure which is currently undergoing unprecedented changes. There is therefore a consensus among DHF and DSPP top management that the supply, transport and finance functions are still too weak to permit integration. Still, as the DSPP strengthens its other functions and regionalization progresses, DHF control over project resources becomes dispersed as sections are transferred to the DSPP like that of the Health Education Unit. DHF accountability is going to be increasingly complex, which threatens to weaken its administrative capability.

2.1.6. Recommendations

2.1.6.1. Authorize reprogramming of under-expended funds:

In both FY 82 and FY 83, the line item for transportation was overexpended (\$1,919 and \$8,198). The amounts allocated to reimbursable expenses, indicate a significant increase in maintenance costs in FY 83. The

vehicles are now at an age where maintenance costs will tend to become a larger part of the transportation budget.

Program Support, was overspent by \$26,857 DHF has requested a contingency that was initially rejected, then authorized in PIL 6 at \$20,000. It is not unreasonable to have a contingency fund of 5%. In FY 83, this would have amounted to \$37,366. The purposes for which this "program support" were used include equipment, office supplies, medical equipment, medical supplies, maintenance and miscellaneous services. Some of these amounts evidently went for support to the voluntary sterilization program, which had underspent in the previous fiscal year. It is not possible to determine the precise utilization of the funds, but the expenditure categories used overlap what one would consider to be operating expenditures. These types of expenditures appear reasonable and should be allowed as grant expenditures out of the funds budgeted for FY 83.

The final overexpenditure was \$2,917 for per diem of the cinema operators in the health education program.

Overexpenditures in FY 83 totaled \$38,072, roughly 5% of the amount budgeted for that fiscal year. Reprogramming provisions at the level of 5-10% within budget ceilings are routine, and even go as high as 15%. If program support is funded at 4-7% of the budget, transportation is funded at levels that fully take into account the historical costs of operating the motor pool and a reprogramming provision is built into the implementation agreement at the level of 5-7%, a more realistic budget will result.

Other recommended reprogramming mechanisms which DHF and USAID should jointly discuss include:

- building estimated staff turnover into the salary line item to avoid underspending;
- identification of reasons for underspending major amounts of dollars in training, supervision and operations research (better termed "applied" research, which is more immediate and short-term); institution of a monthly report on expenditures to date for the personnel responsible for these areas so they can better monitor progress; and specific strategies for committing funds which are running under planned expenditures.

The DHF should consider mini-projects, sub-contracts, and personal services contracts for those areas where under-expenditures derive from lack of personnel time to implement planned activities, and AID should assist in simplifying the process.

2.1.6.2. Integration of DHF Administrative Functions

The DHF continues to be accountable to the Project Agreement, and therefore it should present a plan for use of resources outside the DHF to support functions related to the Outreach Project Agreement; and present an accompanying timetable for transfer to DSPP of personnel, equipment and vehicle or other resources currently paid for by DHF, which are not related to

the Project. The diagram of functions in the previous section of the report reflects the delegation of responsibilities throughout the DSPP and into the regions. The attached spread sheets show the relationships between family planning-related functions and DHF resources. The transitory period in which many personnel no longer directly involved in MCH/FP continue to be paid by the DHF, may be justified by funding sources as a necessary investment in the future of the health delivery system upon which their projects are dependent.

The plan and timetable should be incorporated into the FY 84 budget approval process. It is further recommended that USAID support DSPP plans to postpone any integration of administrative functions of the DHF until it is clearly demonstrated that its systems are equally stable and accountable.

2.2. Financial Management and Recommendations

2.2.1. Annual Operating Plans

There is a delay each fiscal year in USAID reimbursement of DHF expenses due to the late submission of the required DHF budget/operating plan. For example, in FY 84, a budget was unofficially transmitted in early October, 1983 by the DHF administrative officer to the Population Officer. At this point it still awaits DSPP and Ministry of Plan approval.

Last year the first reimbursement check from USAID was not received by DHF until February 22, 1983 according to their records. Since PIL 6 was transmitted on January 12, 1983 and reimbursement requests were available for the first months of the new fiscal year (FY 83), there appears to have been an unnecessarily long delay on USAID's part in getting that first check out*.

While there is mention of cash flow problems in the latest Joint Project Implementation Plan, analysis of the Receipts Journal and General Ledger at the DHF shows there was enough money to operate comfortably until the USAID check arrived. First, the reimbursement for September only arrived in late October. Second, there were other revenues from UNEPA, Operations Research, special projects and various credits due from reimbursement of four months expenses. Three, there was working capital provided by a substantial USAID advance. Fourth, there were funds borrowed from the other revenue accounts and the \$10,000 collected from commercial sales that were paid back when USAID reimbursements resumed.

2.2.2. FY 84 Budget Submission: Analysis and Suggestions

A summary of the unofficial FY 84 budget - broken down by the five project objectives - is attached as Table B-4. Salaries should be adjusted for a projected staff turnover rate as mentioned earlier. Line Item 260 A is Program Support requesting \$40,000 and includes \$10,000 for a customs deposit which when subtracted leaves Program Support with a low proportion of around 3% of the Local Cost Reimbursement budget. Consideration of funding program support is recommended. A discussion, based on last year's utilization of

* But USAID did not officially receive the budget and plan for FY83 until Jan 1983. USAID POP Officer.

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Table B-4

Budget 521-0124
SUMMARY

Code

I. USAID DIRECT PAYMENTS

	Total	Adm Services	Dev. Comm.	CRC	PO1.	Pol
A. Equipment	149105	60940	60665	-	27500	-
B. Med. Supplies	82500	-	82500	-	-	-
C. S.T. Consultants	60000	30000	10000	10000	5000	5000
D. U.S. Training	78000	-	22000	10000	10000	16000
Sub-total	369605	110940	175165	20000	42500	21000

II. LOCAL COST REIMBUSSEMENT -

241 A Surveillance of maternity	60396	-	-	30000	-	20000
240 B IEC (Contrat)	24000	2500	4000	12500	-	5000
110 C Salaries	422676	148770	42650	276112	27144	-
230 D Per Diem	104680	45900	34560	22320	1900	-
250 E Allowances/fees	9720	-	9720	-	-	-
170 F Transport	444424	22500	21924	-	-	-
200 G Training local	102960	55000	5705	26305	5950	10000
231 H Action Familiale	30000					
190 I Renovations	70000					
260 J Contingency						
230A K Mass Media	10350					
260A L Other	40000					
Sub Total	976206					
I + II	<u>1345811</u>					

this line item, should take place so that the DHF can explain why it needs these operating costs to support its ongoing programs. Another reason for this line item stems from the small number of line items for a budget of this size. More detail is needed to make real sense to the DHF. Finally, six vehicles are requested - two for voluntary sterilization and four for the motor pool, As our discussion under transportation will indicate, provision of at least some if not all of these vehicles is recommended. The USAID funded pool will be almost six years old by the end of FY 84 and the average of vehicle in the motor pool is demonstrably less functional than it used to be. One vehicle is completely out of commission due to the accident that occurred in July 1983.

The line item for transport is less than was spent in FY 83 not accounting for more maintenance, higher prices for spare parts, labor and gasoline and a requested addition of six new vehicles. Since budgets should reflect economic realities and the amounts provided in the last two fiscal years were inadequate, we recommend raising the line item for transport. If USAID is concerned about the justification for vehicles, it should discuss the problem with the DHF. This is an historically low budget line item which will be overspent repeatedly until agreement is reached to meet the needs.

2.2.3 DHF Accounting and Disbursements

The DHF Accounting System, Disbursement Controls and Accounting Personnel are well documented and functional. The books are closed for the prior month generally within two weeks of the end of the month. Receipts and disbursement are precisely identified in the General Ledger and appear to be properly registered. The system is manual but relatively efficient and effective. Total demurrage cost for FY 83 was easily identified. The Chief Accountant was aware of PIL provisions such as project funds not being used for transport of condoms and felt DHF was complying with them. She was unable to explain, however, a September entry for "transport de 28 colis à Jérémie". The amount is minimal, but an explanation should be requested to ensure that it is an isolated incident and not a general practice.

Grants management is difficult in part because of its complexity. As an example, there are five funding sources for salaries. However, the chief accountant demonstrated a thorough knowledge of the payroll and had a typed, annotated official payroll list for FY83 which backed up her explanations. The Administrator also was intimately familiar with expenditure patterns and the new budget. He expressed concern about continued underexpenditures.

2.2.4. Recommendations

With regard to the FY84 DHF Budget, all parties should work closely (DHF, DGPP, USAID and possibly Ministry of Plan) to reach an early agreement; the Controller should process reimbursement of vouchers received, as quickly as possible; special attention should be paid to DHF cash flow needs during the period prior to approval of the FY84 budget; and the Controller should identify the source of the cash flow problem noted in the most recent JPIP, and why there was a change from the early part of FY83.

With regard to budget format, it is recommended that the DHF provide more detail for line items with large amounts (e.g. the \$60,000 for the Maternity Surveillance project). The Administrator is in the process of disaggregating the USAID budget by region and for the DHF; USAID should review these documents with him in order to specify line items which would be more useful for submission of the FY85 budget.

It is recommended that the DHF accounting system not be converted from a manual system for the time being in view of the amount of work which will be required to amalgamate with the Bureau of Nutrition as well as the supervision and technical assistance which will be required for regional and district levels as they become increasingly responsible for DHF expenditures. Considering the length of time it would take to convert to an automated system, plans could be made for the eventual transfer.

Three line items have been routinely overspent (transport, program support and cinema per diems). If recommendations are followed for reprogramming (see 2.1.6.) this should not continue. Nevertheless, should the DHF identify potential overexpenditures during the coming year it should notify USAID and negotiate needed changes in advance.

2.3. Administrative Support Functions and Recommendation

2.3.1. Demurrage Costs

A problem exists in getting USAID-provided equipment and commodities released from GOH customs because the procedure is lengthy and complex. Three different Control numbers have to be assigned by customs before the DHF's duty free entry of externally provided provisions can be effected. Due to these delays, demurrage charges are being incurred by the DHF which in FY83 amounted to \$3,524. Furthermore the more time spent in point of entry storage, the greater the risk of pilferage, spoilage and damage, and the greater the risk of breakdown in the orderly flow of contraceptives. The only solution is to post a refundable deposit to cover the potential value of import duties on imported commodities that might ultimately be determined to be taxable. \$10,000 would be required and it is fully refundable when termination of such a deposit arrangement is desired. The DHF requested this amount in the FY84 budget as part of the \$40,000 requested for "Program Support". Given the severe financial constraints facing the GOH it is not likely such a deposit could come from the DHF. Since the current U.S. Treasury borrowing rate is around 9%, the cost of providing this deposit would roughly be \$900 per year. The amount saved in the coming year, assuming a continuation of past experience with customs and increase in imports of contraceptives, is likely to be greater than the \$3,524 paid last fiscal year.

2.3. Supply and Storage

DHF supply functions appear to be working well: a visit to the small DHF storage room and an examination of the receiving, stock, storage and release system revealed no problems; a requested analysis of distribution of contraceptives by region and type was quickly produced from records; field visits provided no evidence of supply shortages or inventory diversion stemming from DHF procedures. A complete assessment of supply functions at the

region and district was not possible within this evaluation, although several interviews revealed only occasional delays while stock was low which sometimes resulted in temporary shortages. The only problem was flooding in the main DHF storeroom in June 1983, and the problem has evidently been corrected.

The DHF has a motor pool of 37 vehicles. Twenty four out of these vehicles were provided by USAID roughly five years ago. The remaining 13 were provided by the UN about eight years ago. Of the USAID vehicles, 15 are under the direct control of the DHF office (including some in the Western Region) and 9 are located in the regions. Six UN vehicles are at the central office and 7 are in the regions. Other than the vehicle temporarily assigned to the DSPP (see 2.1.5.) another out of commission, and another destroyed, all USAID vehicles (and UN vehicles) are operating. Given their age they are not functioning well, and breakdowns and upkeep are increasing. Vehicles stationed in the regions are routinely brought into the capital once a month for servicing and inspection. Repairs of DHF vehicles in the regions are only authorized where there is a breakdown. Gasoline is supplied to the regions automatically each month for each vehicle, and gas consumption, service records and trip information are maintained for each.

2.3.4. Personnel

Special effort is made by the Director and the Administrator to insure attendance, good performance and a complete working day. Rotation of employees to provide new challenges is advocated by the Administrator to increase interest and motivation. Nevertheless the DHF faces problems affecting the morale of all personnel. The DHF Chief is aware of many of these problems and makes an effort to maintain morale by providing timely salary payments and delegating authority to professional staff, but the following situations make it difficult:

* Only 35 out of the approximately 350 people working for or paid directly by the DHF are currently DSPP employees. This means that 90% of DHF staff do not enjoy the job security, pension rights, and other benefits that a GOH government employee would. Integration of DHF employees into DSPP is lagging behind what appeared to be targeted.

* Morale is also affected by the upcoming amalgamation with the Bureau of Nutrition. Staff have concerns about their current job status, where they will be physically located, who their new boss will be and whether they will continue to be employed.

* The GOH is currently behind schedule for absorption of USAID salaries by the DHF through the DSPP budget. USAID is aware of the current budgetary constraints, but consideration should be given to the long term consequences for staff of this GOH delay.

* It appears that DHF employees were expecting a salary increase this year and the original DHF budget prepared in the Administrator's absence, contained a provision for a 10% raise. This would have been the first increase in several years but the budget was not approved by the DSPP.

* The relative salary parity of DHF employees has changed. DHF employees were paid at a higher rate than DSPP employees, until DSPP employees received a large raise two years ago. The effect of this raise was to leave DHF employees, already lacking security and pension rights, at a lower salary level than DSPP employees.

* There has been a transfer of significant numbers of top professionals from the DHF to the DSPP: the health education unit was completely moved out of the DHF; the Assistant Chief position has been vacant for many months pending amalgamation with the Bureau of Nutrition; and others have been transferred to regions and central DSPP offices. While these moves may benefit the DSPP and in the long term strengthen the public health sector, the immediate impact on those who remain at the DHF is quite different, and concerns were expressed by some staff about their ability to carry on their activities effectively. For staff at the support levels who are less informed than professional staff, the loss of personnel and changes in functions is particularly difficult and they equate the loss of talent with the loss of prestige for the DHF.

* DHF staff are aware of the possibility, recommended by the 1981 Westinghouse Management study, that when DSPP functions are stronger the administrative and financial support functions of the DHF may be integrated. They view such a move as the end of their ability to maintain their current level of professional performance, if transferred prematurely.

Of the approximately 350 staff paid by the DHF, two-thirds are in the regions. These personnel are funded by five different sources. Thirty-five are DSPP employees and receive their salary from the GOH and all but one receive a salary supplement from UNEPA. 237 positions were authorized to be funded by USAID, although 254 were actually paid according to the payroll list we saw. 73 are supposed to be funded by Title I and four are funded by the Operations Research project.

In the coming year, USAID is requested to fund 178 positions in the community development program at a cost of \$276,112 and 74 in the central office at a cost of \$216,564 for a total of \$492,676 for 252 positions. Supervision and transportation cost to support them total approximately \$160,000. (Some staff receive salaries from two different sources, so budget figures do not always represent the total salary levels.)

Given the DHF need to secure funding from whatever sources are available, it is unlikely that the complexity of payroll and grant reimbursements will diminish, and therefore no recommendations are made to attempt to simplify the system.

Another problem that runs through DHF personnel management is the basic lack of a classification system which ties skills, job level, and other relevant factors with pay scales. This lack of a basic civil service system is a severe impediment to the rationalization of a personnel management system. Such a system would include uniform pay scales, a basic examination to test job skills, provisions for performance appraisal, promotion and a career ladder. While this evaluation does not examine the question further, interviews pointed out problems arising from arbitrary salary ranges,

non-existent job standards and vague job progression possibilities. There was no evidence of systematic personnel performance at the DHF, such as analysis of relative workloads of its staff and measures of work outputs.

Per diems are paid according to salary scale - \$15, \$25, and \$35 - and there was no evidence of justification for this range. A review of expenditures for per diems in the central office and in the north region showed a high volume of travel relative to the rest of expenditures, especially by staff at the highest professional levels.

2.3.5. Procurement

A thorough review of procurement experience was not conducted, but some problems were frequently cited as examples: in Leogane, it took almost 9 months to procure a bicycle for one of the workers responsible for the distribution program. For sterilization, abnormally high delays are reported for acquisition of needed medical equipment and renovations.

2.3.6. Grants Administration

There is an apparent need for closer communication between USAID and the DHF in expediting administrative procedures. The lead time necessary for moving requests through the system may not be well understood by the DHF, nor are USAID needs for justification. Several exchanges of correspondence have taken place to answer simple questions. The request for motorcycles for the sterilization social work aides, the request for vehicles, the desire to renovate facilities for sterilization are reasonable and necessary program requests if the project is to run successfully. Other administrative needs include: better packaging of condoms for the Commercial Section, and advance notice and discussion of changes in the type of pill and cutoff of Neo Sampooon without an American product to substitute. The USAID Mission has requested USAID/Washington assistance in getting better packaging for condoms and is pursuing the possibility of continuing supply of Neo Sampooon with the Japanese, but whether it will be successful remains to be seen. GOH attitude toward lack of control over commodities supplied by USAID is justifiably one of frustration, since it is trying to distribute contraceptives that people like and want to use. Changing pills on a unilateral basis without consultation overlooks the program needs.

2.3.7. GOH Contribution

USAID is aware that the GOH is required to spend a growing amount for DHF salaries during the course of the project, and that this has not happened. The GOH is spending Title I funds for salary support and for program operating costs such as gasoline, building maintenance, electricity, medical supplies, etc. But such funds are not regularly supplied, for example, in the northern region. In addition, the DHF allocation which was \$300,000 (1,500,000 gourdes) in FY83 is being reduced to 1,200,000 gourdes. In-kind contributions are being provided according to the agreement.

2.3.8. Regional Administration

An effort to strengthen the regional offices and assign personnel primary program responsibility for MCH/FP and related services is underway. Attention must therefore be directed towards assuring simultaneous improvements in the financial and administrative capabilities. A review of the administration in the northern region should be taken into account, as steps are taken by the DHF to strengthen regional capabilities:

* the post of office administrator had been vacant since June, and the acting administrator is, by training, a sanitary inspector. He is not aware of any regional budget or operating plan and knows only which payments are due monthly to support the hospital, dispensary, etc. He pays whatever bills are most pressing from the money available;

* the regional office receives 27,100 gourdes from the DSPP sometime during the first half of the month to cover their monthly operating expenses and 32,400 gourdes to pay the health agents. They are supposed to receive 94,470 gourdes a quarter from Title I funds to cover operating expenses but in FY83 they claimed to have received this amount from the DSPP only once, plus a supplement of 15,228 gourdes for a total of 109,698 gourdes. Another check had just arrived at the beginning of FY84. Lack of regular payments from Title I hampers regional performance and is a serious constraint. DHF also supports the programs in the north and automatically sends out checks for personnel plus gasoline (35 gallons for the mobile clinic) each month. Everything requires a requisition and a spending plan showing how the requested funds will be used. The north region appears to receive less money than it would be entitled to because it lags behind in requests and justification.

* The gasoline budget developed by the regional director covers 700 gallons a month, 160 of which are for his vehicle. Actual expenditures for gasoline in September were 40% greater than the budget.

* The North has 11 working vehicles: 5 of them large 8-cylinder GMC Sierra work wagons, 3 of them large trucks; the remaining are a mobile clinic, a Cherokee and a Toyota Jeep. There is also a Cherokee that evidently has had a motor problem for the past three years that is too expensive to fix. The size of the vehicles and the high costs of operating and repairing them are a serious problem for regional staff.

* A review of expenses for August and September revealed a number of weaknesses, inconsistencies and questions about appropriateness of expenditures, but these were not discussed with the regional director so it was not possible to characterize the problems. In some cases there was no indication that purchases were received by the region or incorporated into the inventory; payments and receipts did not reconcile; a high proportion of the small budget is spent on travel to Port au Prince, and some travel had either inadequately documented justification, or seemed to be unnecessary (e.g. three people to Port au Prince to pick up cheques); both DHF and regional records showed reimbursement for similar trips; supporting documentation is generally inadequate or lacking. Since a financial audit was conducted for the region, this evaluation did not attempt further analysis.

2.3.9. Recommendations

- * Since the savings are 4 times greater than the cost, provision of a deposit at GOH Customs for DHF use would be highly beneficial and is here recommended for FY 84 and FY 85.
- * Any integration of DHF supply and storage into the DSPP should be postponed until the DSPP is capable of providing an equally effective support system.
- * Whether the drive from Cayes and Cap-Haitien is still a worthwhile and cost effective method of maintenance each month should be reviewed by a transport analyst.
- * The transport management appears to be of a high quality and should be left in the DHF for the foreseeable future. A review should be made of the amount and price per gallon currently provided to the regions, and revised if necessary. It is also recommended that USAID consider the provision of the vehicles requested by DHF. Such vehicles should be smaller than the current vehicles and should be diesel. The vehicle damaged in the July accident should be sold as should the non-functional Cherokee in the North. If the Cherokee cannot be sold, it should be stripped down for spare parts. Revenues generated should be added to the transport line item in the budget of the selling unit.
- * To raise morale the DHF Chief should reassure all levels of employees that steps are being taken to act quickly on the merger of DHF/BN and a reasonable timetable of integrating DHF personnel into DSPP employment status will be established. Perhaps this could be accomplished through special general sessions.
- * It is recommended that USAID provide funding and technical assistance if the GOH is interested in the development of a basic civil service system. Such an effort would benefit all USAID projects throughout the GOH sector.
- * USAID should work with the DHF in conducting a review of travel patterns and per diem payments and developing a voucher format which reflects the purpose of travel in order to ensure effective budgeting, allocation of resources needs, and reduction of unnecessary costs.
- * An effort should be made to identify bottlenecks in the procurement process and to determine how they best can be solved.
- * If the project is to run successfully, requests for equipment and other resources require proper justification which could be accomplished by meetings. USAID assistance should include collaboration with the DHF to complete a process they may not well understand. Such collaboration can shorten the turnaround times on requests.
- * It is recommended that USAID reinstate Neo Sampoo until the new US product to replace it is actually on the scene and that contraceptive procurement as to type, needs, preferences, be coordinated with DHF.

* It is recommended, that USAID request a report on GOH Treasury and Title I expenditures in FY 82 and 83 according to the agreement indicating the transfer of funds to the DHF or the DSPP and the actual disposition of such funds.

* It is recommended that future external assistance purchase smaller, diesel vehicles that are easy to maintain in the local market.

* Dispatch DHF personnel to train and strengthen regional administrative staff, to ensure that they are capable of accounting for DHF resources.

2.4. Cost Analysis

The evaluation report includes an estimate of 60,000-90,000 births averted between 1973-1983. According to the Project Paper, the net present value of every birth averted is \$592 at a discount rate of 10% and \$514 at 15%. Assuming \$592 is the proper value and using 60,000 births avoided the value of the Haitian family planning program over the last 10 years is \$35,520,000. The total USAID cost through FY 83 was \$7,800,000 (\$4,384,000 in Bilateral Assistance and \$3,416,000 in contraceptives). If one assumes all other donor assistance to be equal to USAID investment to date then the benefits outweigh the costs by more than 2 to 1. Furthermore, once a family planning delivery system has been established and the target population undergoes attitudinal changes which take many years of intensive resources, it can be assumed that the cost benefits will increase in subsequent years. Thus the return on each additional dollar invested in FY 84 should be higher than the ratio over the last 10 years.

Within the family planning program, the community-based effort is less costly than the institutional system. The community program has the advantage of using fewer and less expensive facilities, employing volunteer and lower cost workers, and being physically closer and more responsive to client needs. Expansion of this delivery system should therefore be encouraged.

The institutional system is necessary and cannot be dismissed because of expense. Medical services (sterilization, IUD insertion) are essential, administrative support is required for the community program, and training, supervision, research, planning and evaluation are all critical to a national program.

The Westinghouse management review recommended the development of simple cost analyses that can be matched with the results of the various DHF programs to track cost effectiveness. With this data, the DHF would be better able to demonstrate the high benefit costs ratios and values of the family planning program within the next fiscal year.

Given lack of cost centers and of readily available and quantifiable program achievements indicators, this evaluation does not go beyond this quick analysis. The important concepts are outlined above and data indicates that the value of family planning is high and the trend positive. This is sufficient to justify the continued, if not broadened, support of USAID.

3. Program Statistics and Evaluation

One of the objectives of the FPO Project is "to improve the organization and management of public FP programs, so that they are result-oriented, flexible and within Haitian means to support". And one of the five main project activities, in effect, aims to "strengthen DSPP/DHF program management capability".

Monitoring project output is obviously an important task with regard to sound management. In this respect, the project agreement states that "improved use of service statistics and streamlining of the information and decision-making systems are necessary". USAID views on the subject were articulated in the Project Paper:

"Improved use of statistics will be a cornerstone of management improvement. Presently, masses of numbers are collected through the DSPP and collaborating health facilities. These numbers are summarized and receive partial analysis. With expanded analysis these statistics could contribute to improve management, if they could be collected and analyzed in a timely fashion."

Such developments were viewed as ultimately fostering a "planning for services...based...on information gathered for decision-making."

A few months before the FPO Project started, a management study by Westinghouse consultants had come to the conclusion that "the major technical activity weakness (was) in evaluation". That report stressed the need to:

- monitor service performance on a regular basis,
- compare target achievements in programs and across programs.
- provide trend analyses of program performance over extended time period,
- determine costs and effectiveness of specific programs.

The question which we consider to be of great importance, is how much has the situation improved in this sector.

3.1. The FP service statistics system

The collection of information on program activities is based upon reporting by a variety of field units or agents delivering FP services. Processing and analysis are mostly done centrally, although the Health Regions are beginning to take on part of that work.

3.1.1. Data Collection

The procedures for data collection vary between programs.

In the institutional program, daily FP reports are filled out by the person in charge of statistics in each center. The same person compiles these reports into a monthly report. The center retains one copy of each report and sends one copy of the daily reports and two copies of the monthly report to the Regional Statistical Unit through the Health District. The Regional

Statistical Unit, after cross-checking the information, sends the daily reports to DHF and one copy of the monthly report to the Central Section of Statistics (SCS) in Port-au-Prince, retaining a copy of the monthly report for analysis.

In practice, things do not always function according to this scheme; for instance:

- Some dispensaries do not fill in daily reports; this habit has been adopted because of the shortage of forms, and is virtually sanctioned.
- Some centers send the copy of the daily reports directly to Port-au-Prince.
- In some regions, the centers are requested to prepare four copies of the monthly reports, and the additional copy is sent by the Regional Statistical Unit to DHF.

In addition to misunderstandings on the procedures, problems are encountered with the forwarding of reports at all levels: There is no established system for the transmission of reports, which are sent as the opportunity arises (passage of a car); there is no covering letter, hence no evidence of dispatch or of reception. Regions claim that reports sometimes get lost en route or in Port-au-Prince. Deficiencies in reporting seem to affect mostly the private centers, who do not cooperate in the best way with Regional Statistical Units.

In the community sector, monthly reports of FP activities are compiled by the agents ("collaborateurs volontaires" in the rural program, "agents communautaires" in the urban program). Those reports are forwarded to the supervisors ("promoteurs" in the rural program; "superviseurs" in the urban program), then to DHF through the Health Districts.

In the Armed Forces (FADH) sector, each distribution station fills in a monthly report, which is forwarded to the Infirmary of the local Military Department, then to the Central Health Service of the FADH, then to DHF.

In the "Multisectoral" program, monthly reports are prepared by the distribution units (operating in factories) and forwarded directly to DHF.

The nature of information gathered varies from one program to another, making it impossible to truly compare results of different sectors. Basically, the numbers of new acceptors (male and female) and of previous acceptors ("anciens, "anciennes") are recorded in all cases. The institutional sector has a complex system to separate acceptors from previous years from the rest of "subsequent visits" recorded during a year. There is some confusion however on the reporting forms at the dispensary level which raises questions about the related concepts in the field, which affects the reliability of data. The community sector, FADH, and multisectoral programs do not use that system; this hints of possible overestimates of the number of "old" users in these programs. In general, the report formats for the dispensary level, the hospital and clinics, community agents and others, vary

widely in terminology and type of visit leaving open many possibilities for personnel to incorrectly interpret the information they are asked to provide. The terminology used in summarizing daily reports for the month and monthly reports for the year, also differs, opening up further possibilities for misinterpretation.

The age of acceptors is recorded in three institutional sector by age interval. It is also recorded in the community sector, though not reported by DHF. The age of "old" users is not recorded, nor is parity. The number of living children is recorded, by interval, in both the institutional and community sectors, though not reported.

It is fair to say that system suffers from the way in which it has developed; as new sub-programs came into operation, reporting systems were devised taking into account the characteristics and constraints of each of these programs. It is now realized by DHF that there is a need for uniform reporting, if the overall results of the program are to be correctly assessed and comparisons are to be made among sub-programs. This does not imply imposing complicated tasks on the personnel of non-clinical sectors. On the contrary, there is a need to simplify reporting in the health centers. For the purpose of evaluation, it would be enough to know the numbers of new acceptors in the program and new acceptors in each method; the age and parity of these acceptors; the number of resupply visits and the quantities of contraceptives supplied.

3.1.2. Data processing and analysis

In line with the integration of several DHF functions with DSPP, health centers MCH/FP statistics are centrally collected by SCS. Part of the data (those on morbidity and pediatric activities) are processed by this unit. Then the reports are forwarded to DHF who processes the other data. While the DHF could work directly from the daily reports to shorten this process, the idea apparently does not appeal to them, and daily reports are used only to cross-check on the monthly reports when these are received.

Analysis of FP data is done at DHF; results of the institutional sector are incorporated by SCS in its general statistical reports. FP results are published by DHF in six-month and annual reports. These reports include data by health center, region and sub-program, on male and female new acceptors by method, total number of visits, number of subsequent visits and of "old" users, and quantities of condoms distributed. Essentially, an account is given of what has happened during the year. There is little analysis of trends and inter-program comparison and demographic evaluation. There is also little evaluation. But these comparisons can be interpreted only taking into account the methods and hypotheses of targeting: Are the objectives modest? ambitious? realistic? Are target populations reasonably well known? Are the possibilities of each sub-program reasonably well assessed? Stimulating (i.e., both ambitious and realistic) targeting requires thorough knowledge of what is already going on.

The Health regions have undertaken analysis of health statistics. The South region has produced several annual reports, and the North region issued one in 1982. DSPP has issued guidelines for the preparation of these regional reports. Actually, as the Regions' responsibilities increase, there will be a greater need for direct and detailed monitoring at decentralized geographic levels. This aspect is examined in the next section with regard to FP which, for the time being, occupies an extremely limited space in regional reports.

3.2. Program needs in statistics and evaluation

The development of a good system of service statistics has been correctly addressed, on paper, as an essential contribution to "an efficient system for programming and evaluation" (DHF: Justification). However, the use which is currently made of statistics currently could be improved in order to move closer to a thorough program evaluation. For instance: the amount of contraceptive use and the general prevalence of contraception should be estimated; the continuation rates and the efficiency of the various methods should be assessed, as well as the frequency and the causes of changes of methods; the relative impact and cost-effectiveness of the various sub-programs should be studied; the determinants of the trends detected should be investigated.

Data processing and analysis are clearly geared to the production of retrospective reports, which include a huge mass of information, only part of which is really useful. Monitoring and evaluation would require a much more rapid frequency of analysis (at least quarterly), centered on a few key indicators of program performance. Publishing data by health center is of limited utility, while monitoring at brief intervals the results obtained in the four Health Regions and the various sub-programs would help detect problems and orient the strategy.

In the context of decentralization, monitoring the activity of the individual centers clearly is the responsibility of the Regional Offices. The role of the central statistical units, in particular the Statistics and Evaluation Section at DHF, will be to perform more specialized analyses, especially to assess the impact and efficiency of the program as a whole and of its components. This should be done on the basis of service statistics and of operational research, and implies some rethinking on the functions of these two activities.

Service statistics should be simplified and used for the rapid production of indices of the volume of activities and the health and demographic impact of the program, the aim being to orient decision-making. Operational research and investigative studies should answer the questions left open by routine monitoring. It is striking that the following questions are explicitly raised by various yearly statistical reports:

- Is the apparent rise in maternal mortality in health centers due to delayed referring of patients by the "matrones", or is the referring timely but simply increased in numbers?

- What are the cause for the low and decreasing use of IUDs and how could this trend be reversed?
- What are the patterns of actual use of the millions of condoms distributed?
- Are the extraordinarily high figures of condom distribution by the North region FADH program due to a strong demand and a particularly efficient system, or to some other cause?
- but have not been answered by the research group at DHF. These and other questions would make good topics for short practical studies by the research and evaluation office of DHF:
- What is the real coverage rate of FP service statistics?
- What is the frequency of multiple counts in acceptance statistics?
- How is the pill actually used by (a sample of) acceptors? What is the failure rate? etc.

While longer term operations research (household distribution in Miragoane, community activities in Arniquet) is also necessary, short term applied research or investigative studies are essential for making more immediate changes in program operations.

At the regional level, the need for trained personnel will be even greater with decentralization. In theory, a Regional Statistical Unit should comprise one Professional Statistician, and four Technicians. This is far from being the case now. If, for lack of local capacity, the essential analyses continue to be made at central level, the Regions will experience long delays in analysis and limited feedback in their efforts to present annual plans and make realistic program decisions.

At the health centers' level, there is a continuing need for training and refresher sessions. Routinely, two seminars take place each year in Port-au-Prince. The actual need is greater than this, and would be even greater if statistical procedures were revised as needed and suggested in various sections of this report. The key factor is the capacity of DHF to identify these needs and to organize refresher sessions or, better still, to supervise the application of its statistical "Norms" in the centers, thus identifying the problems at that level. The fact that the funds made available by the Project have not been used as needed for statistical training is disturbing, because the needs have not been overestimated. In this case, the DHF experienced problems inherent in the principles of DSPP integration which did not permit an independent action.

3.3 Recommendations

To summarize the recommendations in the area of service statistics, research and evaluation:

- The contents of the service statistics (kind of the information requested) should be the same for all the FP sub-programs.
- These contents should permit the measurement, at brief intervals, of contraceptive prevalence as well as of acceptance; they should also give important demographic information about the acceptors and the continuing users.
- DHF should apply this information to the monitoring, at reasonably short intervals, of program impact and of the relative performances of regions and sub-programs.
- Applied research should include among its objectives answers to questions which arise regarding the mode of operation of FP services and which cannot be answered on the basis of routine statistics. Such research should not be overshadowed by operations research.
- Regional statistical personnel will have to be technically assisted by DHF in FP statistics matters, through regular training and punctual interventions. The contents of a regular, regional FP report should be outlined in consultation with regional authorities.
- DHF should study procedures to secure and speed up the flow of information from the field to Port-au-Prince.
- Technical assistance to DHF in FP evaluation matters should be considered by USAID if the Division sets up an appropriate unit headed by an evaluation-minded professional. In the meantime, the means made available to DHF by the Project are sufficient to cover the essential needs (training), and the Division should be encouraged to use them.

IMPROVE QUALITY AND QUANTITY OF FAMILY PLANNING SERVICES

I. Institutional Services

1.1. Permanent Facilities

Family planning services have been made available to the population through an institution-based system (public and private institutions, FADH, health agents, community health workers, social work aides and midwives), a commercial network and a community system.

There are a total of 327 institutions, 189 of which (58%) report family planning activities.

Table 1 - Distribution of Institutions offering/not offering FP services

Regions	Institutions Total	Institutions with PF	Institutions without PF
North	70	45	25
South	85	51	25
Transversale	79	46	33
West	93	47	46
TOTAL	327	189	138

The project objective for 1986 is the extension of FP services to all public institutions and 75% of all private and joint institutions. At present, these objectives have been met to the following percentages.

Table 2 - Number of institutions offering family planning services by service association

<u>Type of Institution</u>	<u>Total</u>	<u>With PF</u>	<u>Percentage</u>
Public	180	140	78
Private/Mixte	147	48	33

Therefore, better than three-fourths of the public institutions offer FP services, whereas only one-third of private institutions do--though the planned 1986 objective for public institutions seems to be realistic, it will be more difficult to reach the objective set for the private/joint sector. Indeed of 147 private institutions, 80 (54%) are Catholic. The introduction of natural FP methods should be envisaged for Catholic institutions that are reluctant to supply the other methods.

During the second six months of 1982, the institutional system's share in the recruitment of new acceptors was 5.2% for pills, 6.5% for foam and 28% for condoms. Less than half the users were resupplied by the institutional system (48.7%). These figures are eloquent and show how important is the role played by other distribution channels, especially the community system. In the institutional system itself, it is impossible to quantify the percentage of the population served by FP services by permanent facilities, that is, to know the number of FP clients that go regularly and solely to the institution to receive FP services. In fact, the institutions' activities reports include contraceptive users for whom mobile elements associated with institutions, such as health agents, community health agents and midwives, are responsible. We can, therefore see that the institutional system on the whole includes community-type distribution, and that the true participation of institutions is less than the figures cited above.

Finally, two comments must be made considering the institutional system:

1. Apart from voluntary sterilization, the variety of contraceptive methods supplied in the institutions is practically the same as that offered by field agents. In other words, the program does not sufficiently utilize qualified, or likely to become qualified, staff (doctors, nurses) to widen the choice of contraceptive methods to be made available to the population.

2. Five hundred fifty health agents, one hundred eleven community health workers and almost seven thousand certified midwives are part of the institutional system. They represent a very significant potential resource for facilitating the rural population's access to contraception. Although all these agents are qualified to resupply pill users and supply condoms, individual performances are eminently variable and non-systematized. Certain agents do not have FP activities (midwives for example); others will only do referrals, others will resupply; and, finally, others supply the first pill users.

As for private and joint clinics, they should play a significant role in family planning services, that is, they should educate their clientele in family planning and supply services in proportion to their capacity. Several of them receive DSPP support, either in staff or supplies, which obligates them to apply Department standards and directives.

To make better use of these resources, the DHF's objective is to motivate the MCH/FP staff to give supplies and equipment and collect data. However, in contrast to government institutions, which are directed by the same department, private institutions have an independence that makes it more difficult to establish communication with each of them.

1.2. Mobile Clinics

Interviews with mobile clinic staff from Cap-Haitien, Les Cayes, and Petit Goâve showed that the operating methods of these clinics varied very widely from region to region. This diversity in the use of the mobile clinic bears witness to the Regional Director's desire to adapt clinic use to local conditions, but the adoption of general guidelines appropriate to all mobile clinics seems appropriate.

1.2.1. In Cap-Haitien

The mobile clinic, consisting of a nurse, an auxiliary, a condom distribution agent and an archivist, goes into the field four times a week. The schedule, established monthly by the nurse of the clinic, presently covers seven villages. Each village is visited every 15 days, and one village is concentrated upon for a year and a half (1-2 years). After announcing its arrival in the village by loudspeaker, the staff undertakes a series of activities, including prenatal consultation, vaccination, vitamin A distribution, nutritional surveillance (weighing of children and education of mothers). In the case of FP, sensitization is done with the loudspeaker, and all interested people are individually educated by the nurse or auxiliary. The pills are given at the rate of one cycle per acceptor or user, and 32 condoms are given.

For all 7 villages, 99 women use the pill and 47 men use the condom. The clinic staff refer 5 to 6 requests for voluntary sterilization to the hospital per month. The clinical examination and anamnesis* of the first pill acceptors is very summary. The clientele of the mobile clinic is essentially composed of village inhabitants. Practically no one who lives more than a half-hour away comes to the clinic. When the work in the village has finally ended, however, pill and condom users are told to go to the dispensary for resupply. The dispensary could be located at 2, even 3 hours of walking time from the village, and it is more than doubtful that this advice is followed by many users.

1.2.2. Constraints

- the clinic team is unfamiliar with its target population. No special effort is made to identify and motivate the at-risk women if they fail to present themselves spontaneously on the day of the visit.
- the choice of villages to visit is left up to the clinic staff, without rationale criteria.
- the clinic team has only chance and sporadic contacts with volunteers or health agents. The latter are not used to prepare the population for the arrival of the mobile clinic.

* Taking of medical history

- there is no liaison between clinic personnel and the midwives, who refer interested people to dispensaries and not to the mobile clinic.
- when the clinic leaves a village for the final time, no resupply structure or means for taking charge of the users is set up. The users are referred to the dispensary, which is often too far to hope for continuation of the method.
- In the opinion of even the nurse and auxiliary, there are more women in the course of a year who begin oral contraception, continue for two or three months, then stop, than there are continuing users.
- it is not known why so many women stop using the pill, even though the clinics come regularly, unless research is done on these women and they are asked.
- the supervision exercised by the regional bureau on the mobile clinic is practically non-existent.

1.2.3. In Les Cayes

The mobile clinic goes to peri-urban areas three times a week. Every trip is done with the community health worker of the concerned locality. Work sessions include prenatal consultation, post-natal consultations, sick children consultations, vaccination and nutritional surveillance. The mobile clinic visits 12-13 localities per month. From the point of view, activities are somewhat limited: at each visit, on the average, the clinic distributes 20-30 condoms and resupplies 2-3 pills users.

1.2.4. Constraints

Through the MCH work sessions are well-organized, the contribution of the mobile clinic to the FP program is very limited. In fact, the mobile clinic only goes to localities near the urban center, all of which have an community health worker who not only resupplies pill and condom users, but also recruits and supplies first users of pills. In the case of referrals for specialty specialization, these same localities are visited by the social work units attached to the maternity hospital, which also limits the mobile clinic's contribution in the area of voluntary sterilization.

1.3. The Armed Forces (FADH)

The medical services of the military districts and sub-districts have generally participated in the FP program since 1977 by offering FP services, generally condoms and pills, to soldiers, national security volunteers and military families. The number of military medical formations offering these

services went from 14 in 1978 to 49 in 1979, 63 in 1980, back to 49 in 1981, then back up to 55 in 1982. The reasons for these fluctuations should stimulate investigation. In any case, it is especially largely through the section chiefs and their deputies that the distribution of contraceptives are distributed.

In the case of the pill, the situation is as follows:

Acceptors and Users of Pills - FADH

Year	New Acceptors FADH	New Acceptors Total country	% FADH	
1979	9.446	25.205	37%	-
1980	8.536	25.433	33%	9.292
1981	4.270	23.742	18%	11.450
1982	4.017	32.336	12%	10.11

Although there has been a reduction in the number of new acceptors, probably due to a market saturation effect, which, all things considered, limited, it can be noted, by contrast that there has been, throughout the year, an increase in the number of women who return for resupply, with a continuation rate that seems higher than the institutional continuation rate.

As for condoms, FADH participation in the program is impressive.

Condoms: New acceptors and numbers of condoms distributed - FADH

Year	New Acceptors FADH	New Acceptors Total	% Accept. FADH	Condoms Distrib. FADH	Condoms Distrib. Total	Percentage Distrib. FADH
1979	1	105.296	29%	5.252.686	7.12.148	60%
1980	1	62.294	30%	8.858.480	9.16.299	92%
1981	1	61.345	13%	7.077.179	8.66.926	82%
1982	1	78.830	7%	7.997.143	11.40.511	68%

All in all, here as well, we find a reduction in the number of new acceptors through the years, probably due to the same saturation effect as the one observed for pill acceptors, the number of condoms distributed by the FADH remains impressive, as is the number of condom resupply visits, which rose from 176 and 813 in 1978 to 262 and 971 in 1982. This leads us to assume that there is a good continuation rate.

Although the average number of condoms distributed per visit has remained around 30 through the years, in the first six months of 1983, we have observed a strange anomaly of 160 condoms per visit distributed by the FADH in the North. In the course of its field visit, the team went to the FADH office in Cap-Haitien to try to understand the situation, not only as to the quantities of condoms per visit, which could be explained by an underestimation of the number of visits, but also with respect to the total number of condoms, which exceeded 1.3 million in 1982.

Six districts are under the jurisdiction of the FADH of Cap-Haitien. Each district has a person responsible for health, who goes to Cap-Haitien 3 or 4 times a month to acquire new supplies in terms of the status of his stock. The district chiefs in turn supply the section chiefs of the rural areas, who distribute the contraceptives to the clients; all the section chiefs completed a seminar on FP Organized by the regional DSPP office. The section chiefs come regularly every month to the district to get new supplies. The Cap-Haitien office receives 10-12 cases per month from the Regional DSPP Office; that is, 60,000 - 72,000 units.

Out of six districts, only the figures for the Cap-Haitien district, however unreliable are available: for every successive month of 1982, 683 people invariably received a total of 26,208 condoms. No data were available as to the number of soldiers per district, the number of families, the recording of births, etc. In the absence, therefore, of information and satisfactory explanations, the team could not explain the distribution of 160 condoms/visit, which should be investigated further.

In conclusion, the FADH, in spite of certain particular problems such as the one mentioned above, is an important channel for reaching the rural population, and the work done by the FADH deserves to be emphasized.

The following are their major problems.

- The National Administration of the FADH Health Service issued a directive which strictly limits the distribution solely to the families of soldiers and National Security Volunteers. The latter are therefore not authorized to distribute the contraceptives more widely to the civilian population with which they are in permanent contact.
- The unavailability of other contraceptives, especially vaginal tablets and Depo-Provera, which, according to the Chief FADH Physician are in demand and acceptable by the population.
- The FADH's incapacity to satisfy the growing interest on the part of the soldiers in vasectomies, since it lacks staff that has been trained in this area.

- Finally, we mentioned the problem of the reliability of statistical reports, which should be more closely examined.

1.4. Midwives

More than 7,000 midwives have been trained to participate in the FP program. Their tasks in this area consist of:

- informing new mothers of FP and sensitizing them to it;
- referring women to the dispensary for oral contraception;
- distributing condoms and resupplying pill users.

During the first six months of 1983, certified midwives referred a total of 3,164 people (1,652 women and 1,512 men) to FP, for an average of 0.5 people referred per midwife in six months.

Constraints

The major problems concerning midwife participation in the FP program are the following:

- Many trained midwives are inactive. For example, in the District of Les Cayes, out of 985 trained midwives, only 207 (21%) are considered to be active.
- Although the midwives are qualified to resupply pill users, they have no stock at their homes. Some of them take advantage of their trip to the dispensary to procure some cycles of pills that they distribute parsimoniously (one cycle) to women who request them.
- A lack of more systematic supervision of midwives by the dispensary auxiliaries.

1.5 Recommendations

The expansion of the quality and quantity of FP services requires that a wide range of methods be made available, because each has its own limitations. It is therefore only by implementing all potential methods - and practically all of them are envisioned in the Project - that it will be possible to increase the program's coverage substantially while assuming quality service, a condition that is indissociably linked to the very success of its expansion of the institutional distribution of contraceptives:

1. More than half of the private institutions belong to the Catholic Church, and are thus unlikely to promote methods other than natural ones.
2. Difficult access to institutions for a large majority of the rural population, who must not be asked to cover too long a distance to obtain FP services.
3. The relatively limited number of permanent facilities: 327 for the entire country, for an average of 1 per 18,500 inhabitants.

In the face of such a situation, it seems clear that the community approach is essential and must be extended to all available channels (see "Community Program" below).

Despite its limitations, the institutional system still has an important role to play in the expansion of the Program, and the purpose of the following recommendations is to maximize the contribution of the institutional system to the Program.

1.5.1 Make the contribution of this staff to the FP program more valuable by:

- Applying the norms that authorize them not only to resupply but also to supply new acceptors with the pill. A checklist has been prepared by the DHF for this purpose, which should be translated into Creole and given to each of these agents during a short "in-service" training session, which could be carried out in the course of supervision visits or during the visit of the agent to the dispensary or health center.
- Making better use of their knowledge of the problems encountered by pill users, their complaints, fears and reasons for abandoning the method.
- Emphasizing the importance of acceptor follow-up, of their becoming responsible for the acceptors and of their eventual referral to a dispensary or health center.
- Authorizing them, when useful, to distribute other contraceptives that could be finally introduced into the Program.

1.5.2 Permanent Facilities

1.5.2.1 Dispensaries

Ensure the back-up of pill users in a more systematic way, and be ready to face their possible complaints (support, advice, referral) by improving auxiliaries knowledge (see "Training" chapters).

1.5.2.2 Health Center

Be a referral health center for any woman having serious problems and be capable of dealing with them (support, advice, treatment).

Promote the use of other contraceptive methods previously tested at the hospital level.

Develop support facilities for the mobile sterilization team.

Promote the vasectomy, which has been newly introduced into the program.

1.5.2.3 Hospitals

Offer an extended range of clinical contraceptives (IUD, Depo, Sterilization) and test the introduction of new methods (sponge).

Ensure the clinical training of health center doctors in the insertion of the IUD, the prescription of Depo and the vasectomy.

1.5.2.4. Private and Joint Clinics

*Staff Training

1. FP sensitization and motivation;
2. Contraception technology;
3. Gathering and submission of data including the identification of target population;
4. Setting up of a programming system, supervision and follow-up of their MCH/FP activity.

*Supervision visit by the DHI to ensure the quality of the service (norms and standards).

*Methods for establishing agreements between the DHI and private institutions

1. DHF sub-contract with organizations or associations such as AOPS, the Public Health Association of Haiti (ASPHA);
2. DHF sub-contract with experienced organization or institutions such as the Albert Schweitzer Hospital, the Complexe Medico-Social de la Cité Simone, Bon Berger in St. Michel, etc.;
3. DHF sub-contract unit particularly active, experienced and interested individuals to develop certain aspects of the FP program.

1.5.3. Mobile Clinic

The main recommendation concerning the use of the mobile clinic derives from the very finality of this instrument, which should be considered above all as a spear-head that brings MCH/FP services to rural populations located far from permanent facilities. It is all the more necessary that these activities not be one-time interventions, but that a system be implemented to ensure the follow-up and continuity of the coverage of the population after the clinic has gone. The principles that should guide the use of the mobile clinic can be summarized as follows:

1. Stimulate interest in and acceptance of contraception in a large number of villages located far from dispensaries.
2. For a relatively limited time - to be determined in terms of the target populations to be covered - ensure regular MCH/FP services such that the immediate needs in the areas of vaccinations, examination of pregnant women and the nutritional status of children and the recruitment of a satisfactory number of FP acceptors (again in terms of the target population) are satisfied.
3. Set up a user resupply and follow-up structure by calling upon members of the community (midwives, voluntary collaborators, health agents);

To this end, it is recommended that the strategy for mobile clinic use, instead of going to peri-urban areas or a reduced number of villages many times for a very long time, should go to distant rural areas, cover the population both from a health educational point of view and from a services point of view for a reasonable period of time, and set up a follow-up system emphasizing local community possibilities.

1.5.4 FADH

- Through their contact with the civilian population, the section chiefs and soldiers constitute an important channel for contraceptive resupply. It is recommended that the

circular that limits the distribution of contraceptives received by the FADH only to military dependents and national security volunteers be abrogated, so that the diffusion of contraceptives in rural areas can be maximized as much as possible.

By its very nature, the FADH is essentially composed of a male population, thus a target population for the expansion of the vasectomy program. Such an opportunity to sensitize, educate and motivate these potential clients must not be neglected, but, to the contrary, must be taken advantage of. To do this, the following is recommended:

- In-service training for FADH needs at all levels (regional and district heads and section chiefs) in order to explain to them the why, how and innocuousness of the vasectomy.
- Enable FADH doctors to benefit from training in this technique by giving fellowships to a certain number of them (training of trainers).
- Promote the training of a larger number of doctors at the national level in vasectomies.
- Should the need arise, provide the equipment necessary for the proper operation of vasectomy clinics.
- FADH medical institutions could usefully participate in any pilot project to enhance certain contraceptive methods (Depo-provera) and/or to introduce new ones (sponge).
- It is recommended that a study be undertaken within the female FADH clientele to study the pill continuation rate, which seems to be higher than the rate for governmental institutional clients. If this study confirms that there is a significant difference, knowledge of the reasons for such a difference could enable the necessary corrections to be brought to bear to improve the continuation rate for institutional acceptors.
- Finally, it is recommended that an investigation be carried out on the methods used to distribute and use condoms distributed by the FADH, especially in the North region, in order to get a better measurement of the demographic impact of such a wide distribution.

1.5.5 Midwives

Parallel to continuing the midwives' training program, which is to be extended to all midwives (12,000), it is important to increase the value of their participation to the FP program. To do this, several methods must be envisaged:

- * Identify the most active midwives through a better analysis of their activities reports to the dispensaries, and select such midwives according to criteria to be defined.
- * Group into an elite body those midwives who could have certain benefits compared to other certified but inefficiently active midwives, so as to stimulate the latter to become more active.

Note: The creation of such a body of midwives is presently being studied at DHF, but no formula as to benefits to be given to them has been decided upon. USAID should be prepared to support any appropriate measure to stimulate the creation of this body of midwives (badges of recognition, material encouragement during in-service training seminars, supplementary equipment, etc.).

- * Be sure that the dispensaries, who are responsible for resupplying the midwives with small supplies (gauze, soap, blades, etc.), have not exhausted their stock, and connect the midwives' demand when they come to the dispensary to be resupplied.
- * After training a group of midwives, be sure that there is better follow-up on the dispensary's part of the new certified midwives to decrease attrition.
- * Be sure that the norms are adhered to; that is, that the midwives resupply pill users.
- * Facilitate this activity for them by enabling them to have a small contraceptive depot at their home.

2. Contraceptive Methods

A program that claims to be national aims, by its very nature, to reach all clients likely to use contraception. To do this, it is necessary, on one hand, to develop channels of distribution that are as varied and extensive as possible in order to reach the entire population, and, on the other hand, this population must be furnished with a sufficiently wide choice of methods so that every man and woman finds the most appropriate method for him or herself in the program.

2.1. Pills and Condoms

The present program is characterized by a striking distortion between the efforts that have been made to increase the distribution channels that surpass greatly the purely institutional and medical framework, and on the other hand, the limited choice of contraceptive methods offered to the population. Although numerous operational research studies have demonstrated the interest and the need to go beyond the institutional framework, no effort of this nature has been undertaken to increase the variety of available contraceptives. Apart from voluntary sterilization, which is beginning to increase rapidly the result is that the program practically depends on two methods, the pill and condoms, the real effectiveness of which--under the conditions of use of Haitian society--has yet to be measured.

Percentage Distribution of New Female Acceptors
by Contraceptive Methods

<u>Year/Method</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u> <u>(1st semester)</u>
Pills	74.8	73.9	65.1	64.6	67.3
Condoms	9.8	10.3	25.7	28.7	25.0
Foam	11.7	11.1	5.0	2.2	1.2
IUD	2.7	1.4	0.7	0.5	0.6
Sterilization	0.7	1.8	3.3	3.7	5.5
Other	1.0	1.5	0.1	0.3	0.3

Pills and condoms have, for three years, constituted over 90% of the methods accepted. Voluntary female sterilization has gone from less than 1% in 1979 to more than 5% in 1983, and is in third place among the choice of methods accepted. In 1982, 375 IUDs were inserted, of which 325 (86.7%) were inserted in eight institutions alone. The rest were inserted in institutions where none of which did more than 10 insertions during the entire year.

Institutions inserting more than 10 IUDs in 1982

District/Region	Institution	No. of Insertions
North	Gens de Nantes	30
Gonaives	Bon Berger	46
Gonaives	Anse Rouge	22
St-Marc	Deschappelles	105
St-Marc	St-Nicolas	28
Port-au-Prince	University Hospital	12
Port-au-Prince	Anse-à-Galets (La Gonave)	67

The total in 1982 for Depo-Provera was 133 new acceptors, 124 of which were recorded in 3 institutions:

Fort Liberté	21
Bombardes (Port-de-Paix)	56
St. Louis du Nord (Port-de-Paix)	47

Finally, for the 1,054 acceptors of vaginal foam, institutional participation was only 9.5% as 954 acceptors were recruited through district and regional community programs.

The limited choice of methods not only manifests itself in the limited range of contraceptive products offered, but within a given type of contraceptive, there is practically no variety.

For example, therefore, Norinyl (Noriday) is by far the most available pill (812,416 cycles distributed by the DHF to the regions between January and June 1983, compared to 31,428 cycles of Eugynon and 30,760 cycles of Neogynon). AID must certainly deal with its own constraints concerning the donation of contraceptives, but other organizations, such as the UNFPA, could usefully compensate for AID limitations in this area.

The condoms offered by the program are all colored. A study is being planned to determine the population's color preference in this area, and should the need arise, other ways of presenting condoms must become available within the program.

It is not enough to tell oneself that Depo-Provera and IUDs are not appreciated by the population and by medical personnel due to ignorance and without any other evaluation process. Both are effective methods adapted to many FP programs throughout the world. As for the IUD, however small it may be, the Chancerelles results demonstrate that if it is available and supplied

by people who are interested in it, people are ready to accept it. As for Depo-Provera, apart from the South region--for purely particular reasons--all doctors with whom the team had occasion to speak recognize the value of this method, and speak well of its being enhanced within the program.

Finally, other methods, such as vaginal sponges, could also bring about a widening in the choice offered to future acceptors.

2.2. Voluntary Sterilization

This program began in 1976 in two Port-au-Prince hospitals. It was later extended to most of the regional and district hospitals, and in 1983, 21 institutions (including 4 private ones) supplied voluntary sterilization services. It is expected that there will be 24 such institutions by the end of the year.

Sterilization Operations

Year	Mini-Lap	Laparo	Culdo	Vasectomy	Total
1976					36
1977					118
1978					177
1979	230	24	27	1	282
1980	566	44	6	8	624
1981	1061	146	1	3	1211
1982	1366	320	-	26	1712
1983*	707	281	-	85	1073

* 1st semester

The mini-lap still represents the majority of the operations (65%), but laparoscopy is becoming more popular, as is the vasectomy. In 1982, 70% of all women who accepted sterilization had more than 5 living children; 38% were between 30 and 34; 31% were 35-39, and only 19% were 25-29. If the program is to have a significant impact on population growth, patients in the 25-29 age group must be motivated more, and a greater number of male and female acceptors must be recruited beginning with the third living child. This program relies on a number of obstetricians trained by JHPIEGO in Baltimore, Tunisia and Jamaica, as well as surgeons and urologists trained locally by the program head. In addition to these doctors, there is a corps of 12 social work aides attached to maternities who educate, motivate and recruit candidates from among the new mothers, sensitize couples in the community and who are responsible for following up cases.

The program's norms and standards stipulate that a minimum of two living children of either sex, as well as the written consent of the couple, are necessary before one can gain access to voluntary sterilization. If the couple is not living together, the signature of a close relative is necessary in addition to the signature of the client. Operation follow-up involves: home visit by the social work aide after 72 hours; after one week, hospital visit to remove the bandages and examine the wound; and finally, two months, six months and one year after the operation.

The program is well-accepted by the population and the potential demand is extremely encouraging, as the team was able to observe during field visits. In Cap-Haitien, the Chief Physician of the Maternity carries out 25-30 sterilizations per month. The Maternity staff includes another gynecologist and four doctors who are all able to do ligatures, and have done so. Unfortunately, since the end of contract salary in 1982, they have become disinterested in this activity and do ligatures only for caesarians. However, at the Maternity, over 50 women per month are hospitalized for septic abortions, and many of them are anxious to have a ligature. In addition to the human constraint, there are others of a material nature: there is a lack of small supplies (gauze, bandages, drapes) and the lack of an appropriate place to do vasectomies. Because of the lack of supplies, it was sometimes necessary to postpone sterilization requests. If these constraints could be met, it would be possible to reach 60-75 sterilizations per month at the Maternity alone, not to mention the possibilities for expansion in 4 and eventually 6 health centers with beds. In Les Cayes, the Chief Physician of the Maternity Hospital, who has just returned from Brazil, where he underwent training in vasectomies, does an average of 12 sterilizations per week at the hospital. In addition, he goes to the 4 sub-districts four times a month where he operates on 4-6 patients by laparoscopy in health centers with beds. He intends to train the Medical (social service) residents and sub-district doctors in vasectomies quite shortly. Here also the demand is great and these cases are postponed, not only ligatures but vasectomies as well.

At Miragoâne, the Chief Physician of the Maternity returned from Tunis in May 1983. Since his return, he does about 6 sterilizations per week by mini-lap, since he has no laparoscope available to him. He will be trained very shortly in vasectomies by the national head of the voluntary sterilization program. Two other general practitioners from two health centers with beds will be trained in this technique as well. Finally, travel is planned to three other places to carry out vasectomies.

At Petit-Goâve, the Chief Physician of the Maternity Notre-Dame at Hospital has been trained in laparoscopy. He has the necessary supplies and equipment and carries out 8 operations per week. As he alone is responsible for all maternity services, he cannot always meet the demand immediately. He is awaiting a colleague who will help him before he travels to health centers (which are in need of some renovations). Finally, let us make mention of a

private doctor, Dr. Lolagne, who sterilized 59 men and 187 women, or an average of 30 per month, from February through September 1983 under difficult conditions.

Favorable conditions for greatly extending the voluntary sterilization program are present:

- Interest and demand on the part of the population.
- A trained group of doctors able to train others locally.
- An interest on the part of doctors to acquire new operational techniques.
- A network of extension agents (health agents, social work aides, community agents, voluntary collaborators, FADH, etc.) who are able to motivate the people.
- A will on the part of the national program head to extend the services, especially through the setting up of mobile teams able to operate (laparoscopy and vasectomy) in health centers with beds.

There are constraints, however:

1. Great mobility of medical staff that sometimes leaves only one doctor per clinic, which is insufficient to carry out the routine work and, at the same time, meet the increasing demand for sterilization, including travel by the mobile team.
2. Lack of awareness by extension agents (at present, recruitment especially is carried out by social work aides) and the general population.
3. Lack of transportation for the social work aides.
4. Lack of appropriate equipment:
 - The trained doctors do not all have laparoscopes.
 - Absence of Tredelenbourg table.
5. Poor condition of existing equipment. This is the case, for example, at the University Hospital of Port-au-Prince, where the fiber optic sheath of the laparoscope is badly damaged.
6. Lack of adequate support structures. The sterilized patients cannot recover under good conditions. Sometimes they are directed toward obstetrical/gynecological beds, and sometimes they must be content with corridors and porches on which to stretch out for a period of time.

7. Lack of support structures for vasectomies. Men do not wish to come to gynecology departments for sterilization. They have nowhere to go after the operation to rest and recover.
8. Lack of slide projector and a camera to mount on the laparoscope, much less a video system to facilitate teaching.
9. The necessity to standardize anaesthesia procedures and post-operative medicines used, to reduce the cost of operations and facilitate procurement.
10. Lack of reanimation equipment and emergency medicines to be able to handle possible incidents.
11. Lack of stimulation and encouragement for doctors after the elimination of the salary supplement.

2.3. Natural FP Methods

Natural FP methods (sympto-thermal) are taught to interested couples by "Action Familiale d'Haiti (AFH)", a non-governmental, ecumenical, non-medical and non-professional organization founded in November 1971. At the national level, the AFH is directed by a National Committee composed of a coordinator, an animator and a national administrator, as well as regional representatives (diocesans). In the regions (5 of the 7 dioceses), activities are carried out by 165 educators (mostly men) and 15 supervisors. The educators are recruited from among user couples who practice the method with success and are anxious to teach it to their fellow citizens. In the same way, the supervisors are chosen from among the experienced educators. The following remunerations are given:

<u>Staff Title</u>	<u>Amount</u> US \$/Month
National Coordinator (1)	200 (full time)
National Animator (1)	200 (full time)
National Administrator (1)	150 (full time)
Regional "Responsible"*	120 (full time)
Regional "Responsible"*	60-80 (part time)
Supervisor**	20-40 (part time)
Supervisor**	60 (full time)
Educator (165)	20 (part time)

* 8 for both categories

** 15 for both categories

User training is done through home visits: two visits/week for the first three months, then one or two visits a month for the following three months. In the course of these visits, the woman's cycle is explained. Women are taught to observe mucus and take daily temperatures, plot them on a graph and interpret the results. Special cases (post-partum, post-menopause) are explained.

A new user is considered to be registered if he has practiced the method and correctly plotted three thermal curves on the graph. She is considered to be autonomous after six complete curves if she knows how to interpret them correctly.

From 1980 to 1982, 6,617 couples were registered, among whom 286 pregnancies and 379 drop-outs due to loss of interest were noted. We could conclude that there is a failure rate (pregnancy) of 4.3%, or 10% if drop-outs are added. In truth, it is impossible to arrive at an effectiveness rate based on these figures for several reasons:

1. The computation has not been done using the classical "survival tables" procedures.
2. Pregnancy does not automatically mean failure if desired pregnancies are eliminated.
3. The failure rate, and "failure" has yet to be defined, could be much higher since only "registered" couples are taken into consideration. All who began the method but who dropped out or became pregnant before having their three or six correct curves are not considered.

At Hinche, for example, a retrospective study showed that among 151 couples registered, with 6-40 months of use, there were 28 pregnancies, which gives a 20% failure rate among people who can be considered as being well-trained in the method.

In any case, the question to be asked is whether there is a place for the natural method in the national FP program, and if so, how much support is reasonable to give it?

The answer to the first question is "yes" for several reasons:

- There are couples, Catholic and others, who for various reasons (confessional, fear of other methods) wish to adopt a natural FP method and who are motivated enough to submit to the discipline that is required. They have the right to practice whatever method they choose, as does everyone.
- It is a means of extending and informing people about FP, and therefore motivation for couples who abandon the natural method in favor of other, less exacting, methods.

- To the degree that it is acceptable and used correctly, it could bring about an increase in the total number of FP users.

In order to answer the second question consider: there are two major constraints in the extension of the natural FP method.

1. At the level of the AFH, the constraints are above all financial. Contributions received up to now by the AFH are the following:

Donor Agency Contributions to the AFH - (US \$)

Organization	1976-77	1978	1979	1980	1981	1982
MISEREOR	40.230	41.183	65.943	82.534	43.488	41.705
UNFPA	27.000	15.500	19.399	-	-	-
USAID	-	-	-	26.500	28.875	30.000
TOTAL	67.230	54.683	85.342	109.034	72.363	71.705

At this time, the AFH is at a financial impasse which has required it to reduce the number of its animators by almost half (100 instead of 165), lower their salary (\$15 instead of \$20), and has made it impossible for the AFH to publish the didactic materials that it has produced (three brochures).

A request for aid has been addressed to USAID for \$781,911 in funds and \$18,500 in food over a three-year period (Oct 83 - Sept 86). This request proposes the following:

- To train 100,000 people in how to observe the cervical mucus.
- To inform 350,000 people about the woman's cycle ("Fertility Awareness").
- To motivate 150,000 people (without being specific).

The project is unacceptable as formulated (will 350,000 or a total of 600,000 people be reached? What is the difference between "train", "inform" and "motivate"?). The project lacks specifics as to the definition of its overall objectives, does not specify operational objectives, makes no allusion to the methodology being contemplated, to programming, to evaluation methodology nor the results hoped for in terms of acceptors/users. It is both ambitious and imprecise at the same time.

The second constraint relates to the fact that up to now, the AHP has a monopoly on teaching and disseminating the natural methods through its educators, ignoring the hundred or so Catholic institutions throughout the country and managed by Catholic sisters. But, as mentioned at the beginning of this report, a natural PF program cannot ignore such a resource, and it is imperative that these institutions offer to their clientele natural FP methods in the absence of other means.

2.4. Recommendations

2.4.1. Pills, Condoms

- Diversify the types of pills available by eventually calling upon other donor agencies (UNFPA). The availability of three types of pills must be planned for:

Normal dosage

Weak dosage

Dosage made up entirely of progesterone, especially desirable for lactating mothers.

- Introduce colorless condoms if it is proven that the receptivity of the population for this presentation justifies it.

2.4.2. IUD, Depo-Provera

The strengthening of these methods calls for surrounding them with every guarantee of success, including:

- A study of the population's attitudes and those of the medical corps vis-à-vis these methods. A follow-up of IUD acceptors could produce much useful information on this subject.
- The promotion of these two methods through sensitization campaigns for medical and paramedical personnel, extension agents and the general public.
- The selection of hospitals and health centers with concerned and trained people in position of responsibility to launch a pilot program.
- The extension of these methods to other institutional structures in terms of the results (acceptability, continuity).

2.4.3. Introduction of New Contraceptive Methods

Promote the use of the vaginal sponge, on an experimental basis at first, then on a larger scale.

2.4.4. Voluntary Sterilization

- Accelerate the training of doctors in laparoscopy and vasectomy.
- As to vasectomies, use existing local capability by sub-contracting already-trained doctors so that they can travel and train their colleagues.
- Include FADH doctors in this training program, as well as private sector doctors.
- Acquire didactic supplies (projector, slides, movie camera and video equipment for video recordings through the laparoscope).
- Ease the administrative procedure relating to the renovation of hospitals and health centers, in order to improve voluntary sterilization facilities needed for the expansion of the sterilization program.
- Promote sterilization via:
 - professional doctors' association
 - the publication and the distribution of explanatory brochures (on technique, simplicity, effectiveness, safety) for the target population (factories, FADH).
 - the production of posters.
- Acquire mobile units with equipment to permit the carrying out of voluntary sterilization operations under good conditions in rural areas lacking reception structures.
- Through a personnel sub-contract, encourage Dr. Lolagne to pursue his sterilization activities (sensitization, information, motivation and survey) by providing him especially with the necessary equipment, that is, a sterilizer a battery-powered projector and a laparoscope. Use him also to train other surgeons.
- Carry out in-service training of paramedical personnel and social work aides, as well as extension agents so that they can distribute information on sterilization and, especially on vasectomies, in the course of their interpersonal communication with the population.
- Supply about fifteen motorcycles to the social work aids to enable them to travel, re-recruit and ensure the follow-up of former acceptors of other FP methods.
- Maintain a certain number of training fellowships abroad to encourage greater participation in the program by doctors.

2.4.5. Natural FP Methods

As for the Action Familiale d'Haiti:

- Maintain an interest in their activities, encourage them to review their project proposal;
- Furnish short-term technical assistance to help them design a technically valid project;
- Eventually fund a request for assistance for such a project for as long as practical, quantitatively and qualitatively measurable results emerge from the project, and as long as the amount of the requested assistance remains within reasonable limits (\$50,000 to \$60,000 per year, for example).
- While awaiting the submission of such a project, continue funding support of the AFH to enable them to continue their recruitment of new users of the natural method (planned amount \$34,000 for 1983-84).
- Fund a small evaluation study to obtain a better measure of the true effectiveness of the method (failure rate, reason for abandonment, what has happened to the drop-outs, etc);

As for religious institutions:

- Through the "mini-project" component, give financial support to any request from Catholic institutions presenting a structured and technically valuable project (for example, respond favorably to the request from the sisters of Hôpital Immaculée Conception, Clinique St. Jean, Limbé). Apart from the immediate impact on the population coming to the center, such assistance could have stimulating effects on the other Catholic institutions still only minimally active in FP.
- Require that religious institutions agree to supply information on the entire set of FP methods, both natural and others, and refer clients who are uninterested in the natural method to other governmental and private institutions that furnish other FP services.

3. Programming

Regionalization, besides giving the Regional Health Director responsibility for carrying out the FP program, has led to a decentralization in the planning of objectives, which are prepared by the regions, then reviewed and adapted by the Dir into national objectives and policy, and finally returned to the regions for implementation. Decentralization has the advantage of making it possible to take local contingencies into account and bring about planning that is more realistic than if it is done only at the national level.

3.1. Content

The 1983-84 planning objectives, assigned by regions and/or districts, are expressed for the most part in quantitative terms, and mention the following inter alia for each region or district:

- The number of new acceptors among women of child-bearing age (15-49) to be recruited;
- The number of at-risk women to be protected; that is, the number of users to be reached;
- The number of new male acceptors to be recruited;
- The number of institutions offering FP services; the number of community agents and health agents that should actually participate in the program.
- The number of voluntary collaborators, cock-fighting rinks, coffee centers, ONAAC education centers, operational health units actively involved in the FP program;
- The number of sterilization operations to be carried out;
- The number of pharmacies, shops and peddlars to be enrolled in the commercial program;
- The number of pills, foam tablets and condoms to be sold through the commercial program;
- The extension of the FP program through the multi-sectoral approach;
- The training program abroad and the number and types of in-service seminars to be carried out locally.

3.2. Limitations

This planning, despite some weaknesses, has the virtue of having been done. We do, however regret:

- the absence of planning for all the districts (only those of the Transverse region and the West region are mentioned).
- the absence of planning for the extension of the program based on the results of operational research on home distribution of contraceptives by voluntary SNEM collaborators, which has potential that remains neglected, unfortunately, for the distribution of FP services to a major sector of the population.

- the lack of precision as to the objectives or intention relating to "the improvement of the system for collecting statistical data at the health region or district level".
- same comment concerning the item, "Carrying out Operational Research for the Purpose of Evaluation".
- finally, sometimes the indicator mentioned with respect to an objective does not relate to that objective.

For example:

- the objectives for the community program are to have a certain number of voluntary collaborators for each region or district. The indicator mentioned is, "the number of voluntary collaborators achieved," which is normal, but the number of acceptors recruited, by sex, to be reached specifically by this program is not indicated.
- This is also true for the commercial program where the objective relates to the quantities of pills, condoms and foam tablets sold, and the indicator should relate to the number of men and women who have actually used the methods sold by this program.

At the regional level, the total population, women of child-bearing age and at risk of becoming pregnant, who are to be served by each dispensary and health center are indicated in the plan. However, the percentage of this population to be reached in the coming year has not been indicated for each facility.

For example, for the South region, the overall objective is to recruit as new acceptors 2% of all women of child-bearing age during 1983-84 (6,509 acceptors). For the Les Cayes district, there is a listing of the number of women of child-bearing age by dispensary and health center, but this list fails to mention the number to be recruited through each entity in terms of the regional objective. This is also the case for women at risk of becoming pregnant--regional objective: have 7% of the users coming from this target population (10,029 users). The "sectoral" objective for the dispensary and health centers mentions the totality of the target population without specifying the number of users that each institution is to reach.

3.3. Recommendations

First, it is important to emphasize the effort undertaken by the DHF and the Regions to establish detailed, regional and sometimes district-level planning which, despite some gaps, is nonetheless a precious instrument, enabling the people in positions of regional and national responsibility to

monitor the operation of the program. The following recommendations can be made after the analysis of this planning:

- Include the gradual extension of new channels for the distribution of contraceptives in the planning as pilot projects or the results of operational research demonstrate their acceptability, feasibility and effectiveness.
- Include any pilot project for new approaches (new contraceptives, private sector, vasectomy camps) in the planning.
- Decentralize the planning as far as the district and sub-district level.
- Be sure of the coherence of the objectives and indicators.
- Specify the type, objectives and steps for operational research.
- Include the objectives and indicators concerning private sector participation in the national FP program in a more systematic and specific way.

4. Supervision

4.1. Qualitative Supervision

Supervision of the quality of program implementation at all levels is one of the key factors in the success of the program's extension, because acceptance of the services by an ever-larger population depends in large measure on the quality.

In the course of field visits, the team was able to see how weak the program is in this area. The norms and standards, which are clearly specified in the DHF Norms and Work Manual, are not always adhered to. Therefore, in the course of these field contacts, the team was able to observe that:

- the explanations given by the personnel that normally distributes the pill are not always sufficiently clear, specific and well-understood by the acceptor, which results in apathy and frequent dropping out;
- there is no standardization for pill resupply, which varies from one to three cycles, and more;
- follow-up of the acceptors leaves much to be desired (one visit per month for the first three months and an examination of the packet to monitor how the pill is taken are provided for in the plans);

- counter-indications for the pill, a list of which is in the Norms Manual, are frequently not reviewed before giving the pill to a new acceptor (every agent qualified to supply pills to women needs to carry a copy of this list, in Creole, on him in a plastic pouch);
- visual support materials for education sessions (posters, booklets, brochures, flannelographs) are often lacking;
- statistical reports concerning the activities of the midwives and health agents are not used at the dispensary level, which is the first level of supervision.
- the number of condoms given to a client at each visit--which should normally be 36--exceeds 100 in the North region;
- not all those who are qualified to supply new acceptors with the pill do so (in addition to medical and paramedical personnel, health agents and community agents are qualified to supply new acceptors).

The main reason for the non-adherence to the norms and standards is a lack of supervision at all levels, which is demonstrated in the existence of field personnel who, unstimulated and insufficiently monitored, tend to neglect several important aspects of the tasks assigned to them, especially:

- the individualized and personalized education of FP acceptors and users, the monitoring and follow-up of these acceptors and users.
- the supervision of the itinerant personnel attached to the dispensary, especially the health agents and midwives.
- the compilation of statistical reports on their activities.
- the identification of problems that might arise.
- the technical assistance to solve them (advice, small individual "in-service" training sessions, reports to higher levels).

The DHF is quite aware of the importance of supervision to ensure that the program runs smoothly, and, in the course of this team's work, it put the finishing touches on the design for a supervision program, which specifies the goals, means and methods that have been envisioned to strengthen supervision (see Appendix I).

4.2. Recommendations

The evaluation team has, with great satisfaction, noted the measures taken by the DHF and DSPP to strengthen supervision at all levels. Without wishing to pre-judge the specific problems that will be identified in the course of these visits, nor the solution that will be proposed, the evaluation team would like to call attention to the fundamental role of the MCH/FP

"spokesperson" and the regional health educator. They are responsible for daily supervision, follow-up and routine evaluation of FP activities, contacts with implementing agents, both in institutions and in the community, the identification of problems, the bringing of solution, etc. It is therefore essential that the agents who are promoted to these new positions be well-informed of the tasks and responsibilities that are required of them.

To this end, the following recommendations have been made:

- Bring together these agents for a training seminar of several days duration, during which their tasks and functions, as well as the means to carry them out, will be discussed, specified and decided upon. The following should be especially emphasized:
 - Supervision does not only mean monitoring, but implies the identification of problems and their solutions;
 - The regional and district supervisors must assume a management support role for the field staff; that is, taking responsibility for this staff in order to ensure permanent, individualized and personalized training;
 - Supervision must be selective the number of visits made to institutions and/or field staff, as well as the time spent at or with each, must correspond to the institution's and/or field agents' problems;
 - They are also responsible for ensuring the follow-up and application of the recommendations carried out by the DHF supervision team;
 - Finally, it is also the responsibility of the MCH/FP "spokesman" and Regional Health Educator to identify continuing training needs and propose appropriate solutions (in-service training seminar, training sessions in "model" institutions);
 - A practical supervision manual, the result of such a seminar, given to each MCH/FP "spokesman" and Regional Educator, could give them useful guidance in their new functions.

4.3. Quantitative Supervision

The objectives assigned to the regions and districts are expressed in terms of new acceptors to be recruited (expressed as a percentage of target population) and in terms of users at the same time, while the national objective--as well as the Project's--is expressed in terms of users. In practice, the result is the setting up of a complex data collection system by which one attempts to bring out the number of new male and female acceptors

and, at the same time, estimate the number of users (male and female) using criteria that are unclear and poorly defined. The number of new pill acceptors in the program is confused with previous pill users who return for the first time during the year; the number of visits is confused with the number of acceptors or users, etc. The data on condoms are just as confused, and the multiplicity of distribution channels does not at all contribute to making the collection of reliable data easier. With the setting up of a regional program, the time seems to have come to find a simple method which uses easily available information to achieve a better understanding of the development of the program, enable the supervisor to assess program achievements and as a result enable the planner to plan the efforts necessary to reach the objectives that have been set.

The introduction of the contraceptive prevalence concept in the planning/supervision represents a very strong instrument in this area. The contraceptive prevalence rate represents the percentage of individuals eligible for contraception who, at any given time, actually use a contraceptive method offered by the program. This concept can be applied at all levels of planning, analysis and supervision: national, regional, district, sub-district and health sectors. It is a permanent program evaluation instrument which makes it easily possible to compare the performances of various regions and sub-regions. This method, therefore, applies not only to people in positions of responsibility at the national level, but also to regional directors, district and sub-district administrators, as well as MCH/FP people. The methodology for using contraceptive prevalence is described in Appendix 2.

4.4. Recommendations

With the knowledge offered by the introduction of the contraceptive prevalence concept in the monitoring and supervision of the FP program, the following is recommended:

- That the DHF authorities decide to introduce this method in the bi-annual program evaluation;
- That the concept and methodology be explained to the MCH/FP "spokespeople", the Regional Director, the district and sub-district administrators, as well as the regional statisticians during two-day regional seminars, using local figures for practical demonstrations;
- That the MCH/FP "spokespeople", in turn, initiate the field agents in the contraceptive prevalence concept;
- That particular attention be paid, during field supervision visits, to the good management of contraceptive stock movements at all levels.

5. Health Education

5.1. Organization of Health Education Services

5.1.1. Central Level

Pursuant to the DSPP integration policy, the Health Education Section of the DHF was detached from the Division and promoted, in February 1983, to the

"Directorate of Health Education" within the DSPP, bringing together into one entity the existing health education units of the various DSPP technical divisions (DHF, Nutrition, Malaria, Tuberculosis, etc.).

The human resources planned for the Directorate of Health Education include:

<u>Office of Director:</u>	1 Director 1 Secretary
<u>Strategy:</u>	1 Section Chief
<u>Mass Communications:</u>	1 Section Chief 1 person responsible for cinema presentations 1 person responsible for the press
<u>Communication Training:</u>	not specified
<u>Production Department:</u>	1 Section Chief 1 Designer 1 Radio Operator 4 Silk Screen Technicians 1 Photographer
<u>Medical and Paramedical Training:</u>	not specified

At present, many positions in this staff are not yet filled. Apart from the Director, the Directorate of Health Education has six people and three abroad for study. The Director is seeking qualified candidates and has already conducted interviews to recruit the missing personnel.

The FY 84 budget for the Directorate of Health Education is estimated at \$335,477, not counting staff salaries.

5.1.2. Peripheral Level

Parallel with the integration of health education resources at the central level, there has been a decentralization of the responsibilities concerning program implementation. In each region and district, a Regional Educator and District Educator will be appointed, who will be responsible for organizing, coordinating and supervising all health education activities. This person will be assisted in his work by a health officer, a SNEM educator, an auxiliary nutritionist, a nurse-hygienist and a community agent supervisor. Therefore, a peripheral corps of about 25 persons will ensure the implementation of the health education program, not only in terms of the national policy set forth in this area, but also taking into account the needs, priority problems and specific nature of the region or district.

5.2. Strategy

The regrouping into one directorate of all health education functions that were carried out by SNEM, DHF, DHP, the Nutrition Division and the Office for the Control of Tuberculosis, and the regionalization of the implementation of these activities by the appointment of people responsible for health education at the district and regional levels has been accompanied by a revision of the strategy in this area. In the past, the efforts of the various divisions led to a dispersion of resources, a confusion of messages and a lack of interest of the peripheral level for health education activities. Emphasis was placed especially on indirect communication (use of mass media), neglecting the significant potential for communication that the DSPP staff, community structures and other field development agents represents.

The new strategy, national in its content and coverage and decentralized in its implementaton, is composed of three phases spread out over time in the course of which emphasis will be placed more and more on the increasingly active participation of the community in the identification, planning and implementation of the health education program, with the technical and logistical support of the DSPP. Indirect communication will progressively take on a support role for the direct communication carried out by the DSPP staff and other development agents. The program strategy has nine priority educational objectives: the fight against diarrhea and diarrhetic dehydration, vaccination, tuberculosis, nutritional and deficiency diseases, maternal mortality and morbidity, child mortality and morbidity and overpopulation and malaria. Supervision will be provided at the national level by the Directorate of Health Education, and at the local level, by the person responsible for education at the regional and district level. Evaluation measures of program efficiency are set forth--the number of activities carried out/number planned and cost--and effectiveness (the degree to which target program objectives have been met) through the use of service statistics and field surveys.

5.3. Limitations

The central integration and peripheral regionalization of health education responsibilities and activities causes a series of problems to arise at each of these levels:

- Central level - The Directorate of Health Education is skeletal in relation to the human resources needed to carry out the program that has been envisaged.:

All funds available for health education activities and disbursed up to now in various divisions should be made available to the Director of Health Education such that he will have overall budget to carry out the national health education program successfully, in whose establishment the heads of these various sections participated.

- The Directorate's budget, coming from several divisions and donor agencies, must include an analytical system for accounting for the use of funds in the areas for which they were budgeted. Therefore, for example, the funds made available to the Directorate of Health Education by the DHF for the FP education program must in fact be used for FP education, sensitization and information activities.
- The fact of having so many priorities raises the question of how much of a priority FP will receive. If all priority objectives must be taken into consideration with the same attention, it could be feared that the importance that FP information, education and communication--major concern of the support from USAID--deserves may not be given to it.
- A series of no less important questions arise at the peripheral level:

The regional and district people responsible for education, and their team, lack experience in the production of radio programs, communication techniques, management and supervision;

The field staff, whether it is attached to the DSPP or other development agencies and on which interpersonal communication essentially depends is not versed in these techniques either.

In addition to the technical support that will be brought to it by the Directorate of Health Education, this decentralization requires financial and logistical means for each region and district;

Finally, here again, the place to reserve for FP in all the planned educational activities remains a subject for legitimate concern on the part of USAID.

5.4. Recommendations

The evaluation team recognized the value of the reorganization that was carried out, which has resulted in the creation of a Health Education Division at the central level and in the placement of people responsible for health education at the regional and district levels.

The Johns Hopkins University technical assistance mission to the Health Education Division (August-September 1983) made a series of technical recommendations in its report to maximize the effectiveness of this new structure. These recommendations are supported without reservation by this team. In addition, we recommend that, for the following reasons, the National Director and the regional heads give FP a privileged place in the implementation of educational activities during 1983-84:

- Since 1980, no new printed material on FP has been produced and distributed. Whereas posters encouraging the use of oral rehydration salts can be seen everywhere, no FP poster was seen by the members of this team neither in health institutions nor in public places.

- Participation in the FP Program by many agents outside of the health structures can be made fully profitable only if they are supported in their interpersonal communication activities by a national and regional FP information campaign.
- .. The success of the introduction of new FP methods into the program (Depo-Provera, IUD, sponges) rests, among other things, upon public information as to their availability, and to counter rumors, and on the training and information of medical and paramedical staff and development agents on this subject.
- Finally, the vasectomy program, still at its beginning, must also benefit from information and awareness campaigns intended for the target population, in order to assure it of as much success as possible.

6. Medical and Paramedical Training

6.1. Basic Training

6.1.1. Nurses/Auxiliaries - Specialists in Community Health

There are seven schools in Haiti for the training of paramedical personnel: three nursing and three auxiliary schools in Port-au-Prince, Cap-Haitien and Les Cayes, and a community health school in Port-au-Prince.

In the past five years, the number of graduates is the following: 629 nurses, 829 auxiliaries and 64 community health nurses. In all these schools, the student's training curriculum for FP was revised in 1981. A detailed curriculum was developed by two successive consultants. It presents the body of theoretical and practical knowledge that the students must acquire. The nursing curriculum is well-done, detailed, precise, exhaustive and presents cognitive and practical objectives and standards of practical experience (methodology). The students who have completed this course should be well-trained to carry out the multiple tasks (communication/motivation, prescription, service) in the area of FP that await them in DSPP institutions.

Practical MCH/FP training sessions for nurses are held in the second and third years of study. In Port-au-Prince, this practical work is done in the maternity at the University Hospital, which has brought about problems of competition with the medical students (births, pre-natal, post-natal) and is detrimental to the quality of the practical training. The auxiliaries have two months of practical training at Chancerelles, and the community health nurses specialize in the districts and the community.

In Les Cayes, the one-month practical training is done in the third year at the Arniquet center. AID funds the room and board expenses for the students (11 in 1982-83) and the teachers, and travel for the supervisors. Management support includes a teacher from the school, professor in community health, and center staff. Supervision is done by the regional nurse.

In the area of FP, during their practical training, the students learn to give advice and select and serve acceptors (the pill and condoms). They only have theoretical notions about the IUD and Depo-Provera.

6.1.2. Training of Midwives

6,735 midwives were trained from 1976 to 1982. The purpose of this was:

- to improve delivery conditions (delivery and post-partum hygiene);
- to refer pregnant women to the prenatal clinic
- to refer children for pediatric consultation and vaccination;
- to refer for FP and/or supply (condoms).

A midwives' training guide for the training of trainers was designed by the DHF. It gives a detailed review of the objectives for teaching teachers (doctors, nurses and auxiliaries) and explains the methodology to use in training midwives.

The trainers received five days of training at the DHF where they went in groups of fifty. Then, once they had returned to their respective institutions (district hospitals, health centers and dispensaries), they trained several thousand midwives through the years. The latter come to the institution one day a week for four months. Each session brings together 25 midwives and, at the end of the training, they receive a certificate and a UNICEF kit. The supervision of the midwives is provided by the auxiliary of the dispensary where the midwives come once a month to give an account of their activities and to obtain supplies.

Constraints

- Too many student nurses in Port-au-Prince, which causes difficulties for the smooth operation of the theoretical courses and practical training. A quota of 60 students (including those who had previously failed) was instituted for first-year students in 1983-84.
- Inadequate structures for practical training, especially in the University Hospital. To remedy this situation, it is planned that, beginning this year, all practical training will be done in the Carrefour, Chancerelles and Croix-des-Bouquets health centers.

6.1.2. Medical Training

About 80 medical students are graduated each year from the National University of Haiti. The introduction to FP for third-year students began timidly three years ago by the showing of a film received from the DHF on contraceptive methods. In 1982, theoretical instruction in FP was introduced more formally within the framework of the obstetrics-gynecology course, and FP was taught in the third and fourth years in 1983. In addition, in the course of their clinical instruction (one month in third year and one month in fourth) in the University Hospital maternity section, the students work in situations experienced by FP acceptors/users. They sometimes attend the demonstration of an IUD insertion, but this is rare. Obstetrics/gynecology residents are trained in mini-lap and laparoscopic procedures.

6.1.2.1. Constraints

Although progress has been made during the last few years, FP instruction for medical students remains insufficient and too limited too much to the simple introduction to contraceptive technology. Having been trained in a hospital and clinical setting, the students are poorly prepared in their studies to face the problems that they will encounter in the field during their civil service, such as, going beyond the diagnosis and treatment framework of the patient and becoming attached to the community framework. Apart from his role as a physician, the young doctor will have to organize, plan, implement, direct, and supervise the work of a poorly disciplined team and animate a group of non-medical community agents, all of which are tasks for which his studies prepare him poorly.

6.2. On-the-Job-Training

6.2.1. Present Situation

The training and in-service training of medical and paramedical personnel and other community agents, as well as for the technical services staff responsible at the national and regional levels for (administration, statistics, health education, etc.) takes on fundamental importance if the qualitative and quantitative expansion of the FP program is to be achieved. To this end, the Project provides for a foreign and in-country training component, as follows:

USAID Budget Allocated to Training
US \$

Beneficiaries	In-country Training	Overseas Training	Total
Administration Services	19.500 -	34.255	53.755
Sterilization	43.500	45.000	88.500
Community Program	19.940	-	19.940
Commercial Program	56.000	44.000	100.000
Population Policy	20.000	20.000	20.000
	30.000	112.000	142.000
Total	188.940	255.255	444.195

As indicated in the financial section of this report, during the last two years, several thousand dollars allocated to on-the-job training were not spent. There are many reasons for this underspending:

- the arbitrary and routine planning of in-service training seminars for all staff of a particular type, which sometimes led the Health Education Section to oppose these seminars as being inappropriate.
- a lack of communication and adequate administrative mechanism between the region, responsible for carrying out the seminar, and the DHF, responsible for funding it. This, on one hand, made it impossible to organize the seminar, and, on the other hand, made it impossible to use the funds allocated for this purpose.

- the reorganization of the section in charge of training, which has been integrated into the new Directorate of Health Education, but is not yet sufficiently structured to be completely operational.
- the organization of seminars whose funding was planned for by the project and by other agencies and departments different from the DHF, without consideration to the already available project financial resources.

This underspending does not mean that no on-the-job training was done. In fact, in the course of the last two years, many doctors, administrators and FP program heads have benefited from grants for training and study trips abroad, and many in-service training seminars have been held in the country for various staff categories (medical, paramedical, community agents, health agents, mid-wives, etc.). See Appendix 4.

As is the case for other areas of activities such as planning, programming, health education, supervision and implementation, regionalization has also conferred on the peripheral heads more autonomy concerning on-the-job training. Therefore, the regions, districts and sub-districts (regional nurse, MCH/FP people, regional health educator) must identify the weaknesses and problems and carry out in-service sessions if this seems to be the most appropriate way to solve them. The regional and district staff must carry out in-service training seminars with the technical support of resource people from the DHF and other directorates.

The DHF program for FY 84 provides for a series of grants and seminars, and specifies for each type of seminar the functions, qualifications and number of participants, the number of seminars set forth as well as the duration of each. It would be tedious to reproduce the exhaustive lists here. Let us note however that from October 1983 to September 1983, 13 grants for study abroad and 33 local seminars for over 1,000 participants have been planned.

6.2.2. Constraints

The planned program is ambitious. People responsible for local programs (MCH/FP people, regional health educators, people responsible for regional community programs) have just been or are about to be appointed, and they themselves must be trained before they can fully fill the role of trainers and supervisors that is expected of them.

At the same time, the Directorate of Health Education, which, through its Training Department, must play a decisive role in the technical support of the peripheral in-service training seminars, is itself undergoing structuring. Only when the Training Department becomes fully operational will it truly be able to bring to the regions the technical and logistical support that they need.

The planning for on-the-job training envisages only grants and in-service training seminars. But many of these are for routine in-service training of staff categories that attend these same seminars every year.

It seems to be understood that the bringing together 30 people for 5 days is not the only way to address the question of in-service training at least in theory. What is missing is its being put into practice.

Finally, in-service training is not an end in itself. Its ultimate goal is to improve the performance of various functions (collection and analysis of data, supervision, administration, management, planning, giving of FP services to the population, follow-up of acceptors, etc.). The indicators for the results of the seminars that are set forth in the plan are all purely quantitative. (The number of seminars held compared to the number planned). But the criteria for the evaluation of their effectiveness, that is, solving problems and improving the quality of the services rendered by the trained people, remain to be defined.

6.1.3. Recommendations

Though the theoretical training of nurses and auxiliaries in FP seems to be satisfactory, the quality of the practical training leaves something to be desired. Conditions are better in Les Cayes than in Port-au-Prince (congestion and competition with doctor trainees), where steps have been taken to remedy this situation. Indeed, as of this year (1983-84), Port-au-Prince nurses will carry out their practical training in health centers in Carrefour, Chancerelles and Croix-des-Bouquets in order to relieve the congestion of the University Maternity Hospital.

On the other hand, the training of doctors is not sufficiently oriented toward truly priority health problems, and their practical training must be their opportunity to go beyond the hospital-clinic setting, to become better integrated into the health team and to acquire a better feel for community health problems.

The following is recommended:

- Improve the conditions for the carrying out of the practical training of doctors and paramedical staff based on the Arniquet experience, which seems to have been satisfactory.
- For this purpose, select institutions (health centers, hospitals) that participate in projects oriented toward the community (Cité Simone, Miragoâne).
- A part of the USAID project funds earmarked for training--which have not all been used--could usefully be programmed to improve the practical training of nurses, auxiliaries and medical students, which would accordingly reduce the necessity for having them systematically undergo in-service training after they have completed their studies. Such in-service training, unfortunately, is often more theoretical than practical.

- That the Department of Medical and Paramedical Instruction of the Health Education Division, in collaboration with the people responsible for medical and paramedical training at the University and at nursing and auxiliary schools, apply itself to improving the basic training of medical students, especially in the area of community health communications techniques, organization, management and the supervision of priority programs.
- Finally, it is to be noted that a dialogue has begun between the Dean of the Medical School and JHPIEGO, in order to introduce instruction in Reproductive Health at the school. It is recommended that the USAID Mission in Haiti lend its full support to the implementation of such a project.

6.2.3. Recommendations

Naturally, the recommendations address themselves to the problems identified in this chapter:

- Keep an up-to-date list at the central office of the Health Education Division of all in-service seminars carried out in the country with the following information: date, duration, number of participants, category/function/qualification of the participants, trainers, subjects, funding source, real cost of the seminar (actual expenses).
- Delegate to the Health Education Division the technical responsibility (quality control and equivalency) for the seminars planned at the regional and district levels:
 - In order to ensure that planned seminar corresponds well to an identification of needs and problems, and that it is likely to solve them. In presenting a seminar plan, the region or district must mention what problems the seminar proposes to solve and how they plan to measure the seminar's impact on this problem; that is, to carry out its qualitative evaluation (follow-up, survey, performance).
 - In order to ensure that the proposed program will contribute adequately to the meeting of the objectives.
 - In order to be able to ensure technical and logistical support if necessary.
- Develop the administrative mechanisms necessary to ensure better use of the funds earmarked for continuing training and to re-program unused financial resources before specified deadlines. (See the Administration/Management section of this report.)

- Give priority to the training of MCH/FP "spokespeople" and regional health educators and their team, who have a primary role to play in permanent staff training.
- Appoint without delay the staff that will be responsible for the various departments of the Medical and Para-Medical Staff Training Department of the Health Education Division (at present, there are only department heads).
- Envisage means other than in-service training seminars for carrying out in-service training, such as:
 - The personalized and individualized training of field agents during supervision visits by the MCH/FP "spokesperson" and Regional Health Educator.
 - Identify "model" institutions and, for one week, for example, send certain people to them to benefit from practical training, which is often more necessary than participation in a new routine in-service training seminar.

7. Contraceptive Supply System

7.1. Central Logistical System

The DHF is responsible for receiving and supplying contraceptives to all institutional and community structures.

As soon as notification is received from the airline that packages have arrived, a letter requesting a customs exemption is addressed to the Ministry of Finance by the DHF so that they can be discharged from Customs. Upon receipt, the accounting is checked between the shipping waybill and the products that are really received, and the quantities of contraceptives received are recorded on the stock sheets. These contraceptives are stored in two warehouses, one at Chancerelles and the other at the DSPP garage. Institutions are supplied on the request of the regional bureaus and the institutions themselves, via the District Administrator.

The reserve stock of contraceptives at the DHF is fairly low, without being critical. Several lots of pills have recently been damaged by water, and there are 78,000 condoms left in the warehouse, and two million condoms that have been waiting to be discharged from airport customs. The keeping of stock sheets is excellent and up-to-date.

7.2. Situation in the Field

In Cap-Haitien: the Regional Bureau has a reserve of 120,000 pill cycles. As for condoms, the situation is more worrisome: there are only 81,000 left. (A monthly distribution had just been completed). The Bureau

distributes 10-15 cartons of 6,000 units per month, 6-10 of which are for the FADH. Requisitions to the DHF are made when there are about 15 cartons left, and delivery time is 15 days to a month. Stock sheets are well kept and up-to-date.

In Les Cayes: the Regional Bureau has 113 cartons of pills (67,800 cycles). 3,600-4,000 go out each month, which gives us a reserve of 1-1 1/2 years, which were used up quickly. (We have noted that this information does not appear in the statistics of the 1982 annual report nor in the 1983 1st semester report). He has now exhausted his stock and cannot satisfy the demand, which appears to be great. 20,000 doses were ordered from the DHF.

At Petit-Goâve: there was a stock-out of condoms 4-6 months ago which lasted 1-5 months. The dispensaries visited were all supplied with pills and condoms.

7.3. Constraints

At the central level, the time between arrival of the contraceptives and their discharge from Customs is too long (often several months), which involves high storage fees (several thousand dollars).

In the field, apart from the Depo-Provera situation in Petit-Goâve, there are no major problems; there are at most short-term situations which sometimes, but rarely, lead to temporary stock-outs.

In addition, the products received are sometimes approaching the expiration date.

7.4. Recommendations

Expedite the customs clearance procedure. It seems that a letter of guarantee from the donor agency would permit the immediate customs clearance of all arrivals.

Place orders with the donor agency in sufficient quantity such that the delays will allow for a six-month to one-year reserve at the national level.

Monitor more closely the status of the stock sheets at the regional level so that orders can be placed with the DHF in sufficient quantities to constitute a minimum three-months' reserve.

Store cartons to allow for the application of the first-in, first-out rule.

Investigate what happened to the 2,000 doses of Depo-Provera in Petit-Goâve and why their use is not included in the statistical report.

With UNFPA, follow-up on what has become of the Depo-Provera order.

8. Studies and Research

The studies and research needed for the development of the FP program may be categorized into two types:

- Fundamental Studies
- Operational Research/Specifically targeted investigations.

8.1. Fundamental Studies

The essential purpose of this research is to instruct the planners and people in positions of political responsibility so that they can better zero in on the magnitude of the problems caused by population increases on the country's development potential, and helps them to establish a population policy that takes into account economic, social and demographic inter-relationships.

In this category, more or less long and exacting research of a certain magnitude concerning the inter-relationships between population factors and development is planned. This category includes the study of basic demographic phenomena such as: the development and determination of fertility, the development and cause of mortality, studies of internal and external migratory phenomena, as well as studies of the inter-relationships between population growth, age distribution and the geographical distribution of the population on socio-economic variables.

This type of research could be undertaken by various agencies (ministries, National Institute of Statistics, Plan, DSPP) and can call upon various investigation techniques, such as surveys, census analysis, project data, compilation of national statistics, etc. Little research of this type is presently being done, and recommendations on this point have been made in the Population Policy section of this report.

8.2. Operational Research and Specifically Targeted Investigations

The following are included in this sector:

- Research whose purpose is to investigate the technical, administrative and financial feasibility of new innovative approaches to help extend the FP program.
- Studies and surveys necessary to evaluate the impact of the program on contraceptive practices and fertility.
- Investigations that will shed light on certain particular problems that could arise during program implementation.

A certain number of activities of this type are being carried out or were partially carried out in the past:

- Research project for the extension of the community program in Miragoâne, Léogane, St. Marc and Fond Parisien (see the Community Program and Private Sector section).
- Contraceptive prevalence survey (see the section of Prevalence).
- Survey on pill continuation in Gonaives based on a compilation of records.
- Survey on the acceptance of and population attitudes toward the IUD (interrupted because of a lack of personnel, which was busy with the Prevalence survey).

8.3. Responsibility for Operational Research

The responsibility for identifying operational research priorities, mobilizing human and material resources to carry them out successfully and supervising their execution belongs to the Evaluation and Research Section of the DHF. The resources for carrying out operational research varies according to the type of research envisaged, from "heavy" with a significant financial and technical resource need, as in the case of the Miragoâne research project, to simple, such as making use of the knowledge of the field staff (especially the community agents), whose experience has remained up to now an untapped source of information.

Special surveys, the use of existing data, pilot projects, etc. are also part of the arsenal of techniques useful in operational research.

The management capability of the DHF and the specific functions of the Evaluation and Research section in this area are discussed and analyzed in the sections, Management at Decision-Making Levels and the Statistical Section of this report.

8.4. Recommendations

Whatever its field may be, the fundamental purpose of operational research is to improve program operation, test available new avenues to increase the quality and quantity of rendered services and bring realistic solutions to the problems encountered.

Throughout this report, a series of problems and questions have been identified and discussed, and a certain number of operational research projects have been proposed that are likely to solve them.

It is recommended that the following operational research be undertaken:

- A national survey on the continuation of pill use by source of supply (institutional, community, private sector, FADH).
- An acceptability and continuity study for IUDs (Chancerelles).
- A study of condoms acceptability (color-presentation) and use.
- A follow-up study on the acceptors of new contraceptives (sponges, Depo-Provera, IUD).
- A pilot study on the commercial sale of contraceptives.
- A study on the level of unsatisfied FP demand.
- An evaluation of the true effectiveness of the sympto-thermic method.
- The continuation of operational research with a view to the extension of the community program, notably through the use of national SNEM agents.

Clearly, all this research cannot be carried out at the same time, and the DHF must set priorities.

Finally, to make the results of this research fully profitable, considering that its implications are all practical, it is recommended that the positive knowledge acquired from these studies and this research be progressively introduced into the planning, programming and implementation of the national FP program.

EXPANSION OF COMMUNITY AND PRIVATE SECTOR SUPPORT FOR FAMILY PLANNING

A major thrust of the national family planning program over the past four to five years has been to increase access to family planning services through community-based, as opposed to institution-based, services. Until the late 1970's the community activities were primarily educational and referral in nature and were limited to 120-140 Community Agents doing outreach and education in large towns and cities, training and supporting traditional mid-wives who referred clients to family planning, general orientation in MCH/FP for staff and volunteers of various agencies and associations, and some collaboration with private non-profit health organizations and factories. By 1979 the DHF had initiated activities to significantly expand the range of services offered and the type of community infrastructures used, in order to provide greater access to services for those who would not or could not use institutional services.

1. Community-based Delivery System: Structures and Human Resources

Both formal and traditional structures are used to reach the community, and among the more successful activities have been those undertaken with:

* **Community Action Committees** - By law each of the 565 Rural Sections has two formally recognized CACs, many of which are actually a federation of several sub-CACs which evolved within one Rural Section. The CACs are made up of volunteers and are provided overall direction and assistance by the National Organization for Literacy and Community Action (ONAAC) which has family education monitors, community development workers and adult literacy teachers. There are currently 490 CACs and sub-CACs with over 700 volunteer collaborators involved in the MCH/FP program.

* **ONAAC Staff:** at the time of the evaluation the North and South Regions were providing a month of training for ONAAC family education monitors, including a week of MCH/FP, with the expectation that they would participate in education and contraceptive distribution activities. There are about 98 family education centers throughout the country. The exact number of other ONAAC personnel directly involved in MCH/FP activities is not available, but most are expected to lend assistance as more CACs are incorporated.

* **Ilôts du Developpement** - The Ilôts are defined geographic areas chosen by the Department of Agriculture for integrated development projects, and which were somewhat left on their own. The Division has 4-5 in which it is working with over 100 volunteers to integrate information, education and contraceptive distribution into development activities.

* **Coffee-Grower Centers** - These groups are made up of 7-15 coffee growers who are given assistance and money by the Department of Agriculture to regenerate their crops. The DHF is working with 4-5 of them to carry out information and contraceptive distribution activities.

* **Haitian Research Center for Promotion of Women (CHREPROF)** - This is a private institution with various local chapters throughout the country and the

DHF is developing new strategies for cooperation. MCH/FP topics have been included in staff and volunteer training.

* Cock Fight Arenas - Owners and referees have been recruited as volunteers in close to 100 arenas to do information and referral in family planning, and to some extent to distribute contraceptives.

* National Services of Endemic Diseases (SNEM) - A pilot project is being conducted in Miragoane with the support of paid SNEM staff and volunteers which promises to lead to much greater use of the nation-wide structure developed for eradicating malaria. Over 80 volunteers successfully completed training and are currently participating in the program.

2. Program Methodology

2.1. Contraceptive Distribution

The community-based family planning services which are self-sufficient, i.e., not dependent upon referral services provided by dispensaries and health centers, are primarily condom distribution, re-supply of pills for continuing female clients, and initiation of pills for new female clients. At the time of the evaluation, it was difficult to identify precisely who was initiating pills because the decision to do so and the ability to carry it out depends upon a number of factors at all levels, namely: a) existence of job descriptions and/or norms and standards for different categories of personnel and volunteers; b) approval of administrators at the regional, district and sub-district level; c) quantity of supplies and the logistical supply system to ensure continuity; and d) supervision to ensure appropriate client referral and skill level of workers and volunteers.

The DHF quality assurance functions carried out by the Office of Norms and Standards, include the documentation of instructions for pill initiation and re-supply, and the office intends to translate the documentation into Creole for use in the field. Health Agent job descriptions do not currently include initiation of pills, although the same is true for Community Agents, a number of whom do initiate pills. Support of administrators is mixed regarding the initiation of pills, and many agents do not yet even resupply pills, in part because supervisors have not implemented this task and in part because of the lack of a logistical system to ensure supplies. At the time of the evaluation the DSPP Director General instructed the DHF Chief to implement a supply system for Health Agents for pills and condoms.

2.3. Training and Education

It is expected that the Health Education Directorate of the DSPP will provide the accompanying information, education and communications activities required to promote the community-based services, as well as training and basic orientation for collaborating personnel. The IEC activities have been minimal, as described in the previous section of this

report, but the 1983-84 plans for both the DHF and the Directorate of Health Education include objectives and activities designed to emphasize face-to-face communications and education. Training and orientation has been an integral part of the human resource development aspect of the community program, and continues to target specific groups for week-long seminars. Plans for 1983-84 will continue similar activities of the past year: a week of MCH/FP during the month-long training for the ONAAC family education monitors in each of the four regions; re-training of community agents and auxiliaries who supervise community-based personnel; seminars for community leaders, volunteers working at cock fight arenas, coffee grower groups and CHREPROF; and other supportive training activities.

2.4. Supervision

The DHF has as its function the development of strategies for expanding and strengthening the community program, quality assurance regarding family planning services provided, and initial contacts with necessary agencies and individuals at the national level, and contacts at the local level in collaboration with regional or district staff. The regional and district offices have the responsibility for implementing programs and for their on-going operations. Nevertheless, since the strategies and the personnel currently working on the program originated with the DHF the program is still viewed by many as belonging to the DHF, although salaries are sent to the regional offices for distribution. Many community workers continue to look to DHF personnel for direction, and have maintained direct relationships, partly because the DHF office and/or personnel are more accessible.

The restructuring of regional and district staffing patterns by the DSPP includes personnel assigned specifically to MCH/FP, health education, and the community program (at the regional level only). The personnel responsible for the community program is categorized as a community development specialist in the draft version of the regional structure about to be implemented, and it is expected that future supervisory responsibilities will be more clearly defined and that greater regional support will be forthcoming for the community efforts.

2.2. Organizational Strategy

In addition to the cost of DSPP salaried staff (Community Agents, Health Agents, Promoters and Sterilization Social Workers), donated time of ONAAC and other salaried staff, travel, materials and equipment, a certain amount of resources are allocated to the corps of volunteers. Initially volunteers received annual bonuses or honorariums but this led to problems when budgets, planned expenditures or cash flow interfered with uniform and timely awards, and many volunteers confused one-time bonuses with salaries reimbursement for time or expenses. It was therefore decided that communities involved in the program would benefit through community development activities leading to cooperatives and possibly other beneficial efforts.

Initial contact in communities are undertaken by DHF and/or district personnel and the community is asked for volunteers who form a health committee, select officers and organize a small fund among themselves to be

used to undertake cooperative projects. As the communities become organized, the DHF Promotors and sometimes Health Agents assume responsibility for on-going communications, and the DHF provides the resources for basic orientation and seminars for collaborators. The first step in organizing education and contraceptive distribution activities is a survey of the community, after which geographic areas are assigned to the volunteer collaborators.

3. Operations Research

3.1. Mini-Projects

The original Project Agreement envisioned a series of mini-projects ranging in amounts as high as \$10,000 for a total of \$30,000 in 1983 to \$45,000 in 1984 and 1985. The intent of the mini-project approach is to mobilize the private voluntary sector in support of the family planning community program by demonstrating methods for stimulating local initiative, effective structures for reaching and actively involving rural communities, and ways in which local efforts can become self-sufficient. To date the mini-project approach has not been used.

3.2. Demonstration Projects

Between 1977 and 1981 a household distribution project was designed and conducted in rural areas near Leogane, St. Marc and Fond Parisien, resulting in significantly higher levels of contraceptive acceptance and use than measured in the baseline data, and a decline in pregnancy prevalence was experienced in the two areas where the distribution of contraceptives was most liberal. This DHF research effort was carried out with technical assistance from Columbia University. To some extent the activities in the Leogane area were incorporated into the DHF community development program, with modifications in its design to make it more financially feasible. The most recent twelve-month figures for the program show a very high amount of oral contraceptives and condoms are distributed by 55 volunteers. If used appropriately and continually, the contraceptives would be meeting needs of 40% of women at risk of pregnancy and 35% of men aged 15-59, about four times the amount of met need estimated for the national program and at an incremental cost of \$1.20 per year per user according to figures of the DHF Research and Evaluation Office.

Once the feasibility of community-based distribution was demonstrated in the three rural areas, the DHF undertook an operations research project in Miragoane with a program design which took into account the experiences of the first project. Basically the project uses 80 malaria volunteer workers with support from the health district administrator and staff, SNEM, the Research and Evaluation Office of DHF with the assistance of Columbia University, and the Community Program Office of the DHF. There are over 6,000 malaria volunteers throughout the country, concentrated in lower altitudes where the risk of malaria is highest. They use their homes as depots for distribution of chloroquine tablets and as pick-up points for blood test slides they do for individuals in the community who suspect they may have malaria. The depots are being enlarged in the Miragoane area to include distribution of oral

contraceptives and condoms, and perhaps some other basic materials such as oral rehydration packets. The demonstration phase includes collection of baseline data and two or three rounds of household distribution. Salaried workers are not built in, and volunteers are not given monetary incentives directly but rather income-generating cooperatives will be developed to benefit the community. Supervisory systems and methods for providing incentives for community collaboration will be examined by the project. There have been delays in implementing the development of the cooperatives because of the length of time and the procedures required to obtain approval and secure the funds from USAID through the Columbia University Operations Research grant. This has produced a hesitancy at the DHF to pursue any activities related to a mini-project or sub-contract approach to carrying out project objectives.

4. Impact of Community-based Approach to Family Planning Services

The most tangible result of the community program is reflected in the annual service statistics which show that nearly half of the female clients are initiated and/or supplied by community-based workers, and a much greater number of male clients are supplied by the community program than through institutions of the DSPP. Reporting is very low, however, and so statistics do not adequately reflect the volume of services provided by this effort. Furthermore, by its very nature, this program activity is diffuse and more difficult to measure than institution-based services. In particular, the numbers of visits related to condom distribution is irrelevant and not comparable to institutions where individuals seeking supplies are more easily counted. Community-based workers use varied methods for making supplies available which are not susceptible to counting.

Another obvious outcome of the community program is the significant departure from pre-1978 attitudes regarding the distribution of oral contraceptives. Increasingly, community-based outlets under DHF and DSPP supervision are initiating pills as well as re-supplying women who first started in a clinic. It should be noted that oral contraceptives are available in pharmacies without prescription, although many medical professionals working in both the private and public sector are reluctant to see wide-spread distribution without direct medical supervision. Nevertheless, medical professionals supportive of the trend toward liberalizing pill distribution point out that the risk of unplanned and unwanted pregnancy is greater than the risk of pill use, that written guidelines in French and Creole can ensure that women understand the contraindications and side-effects, and that drugs of a more powerful nature are available in pharmacies without prescription.

Less measurable, but no less evident, is the impact that the community program has had on the participation of non-DHF resources in family planning services. Many more regional, district and field personnel have become directly involved in the task of broadening access to family planning because community activities are decentralized, closer to the personnel in the clinics of smaller towns and rural areas, and use a wide variety of structures and individuals. The DHF is far less visible in this particular family planning effort than in the 1970's when services were more dependent upon institutions staffed by DSPP personnel with DHF money and supplies. Agencies

and officials from other public sectors such as agriculture, adult literacy and the malaria program have become increasingly supportive of integrating MCH/FP into their own areas of community activity in recognition of the interdependence of health, social and economic variables in reaching their objectives. The operations research projects, in addition to providing documentable outcomes for decision-making, promote the participation of non-DHF resources in family planning by serving as a focus of activity for officials and organizations who will be needed later on to incorporate research results into on-going programs. This is especially true for the regional and district administrators who are ultimately responsible for implementation of all community-based services in their geographic areas.

5. Constraints

A major limitation of the program is the narrow range of contraceptives available to the entire national program, particularly to community-based distribution efforts. A mix of pills, a product similar to the Neo Sampooon foaming tablet, other contraceptive creams, jellies and foam, as well as instruction in natural family planning methods, are critical as back-up methods and alternatives if the Outreach Project hopes to sustain the encouraging results of the first few years of the community program. At the moment the program is completely dependent upon one brand of pill and on condoms.

After a time, when volunteers and paid workers with few para-medical skills confront increasing numbers of clients who are dissatisfied or unable to use medical methods for very long periods, the corps of the community program will become discouraged as they are less able to maintain continuation rates. Psychological and medical contraindications for all modern methods are overwhelming in the face of the thirty-years or more span of fertility during which a woman may want none, one, two or three children. Personnel trained in family planning counseling and medical services are greatly challenged by today's contraceptive technology, so it can hardly be expected of lay workers that they will face the challenge more effectively with so few method choices at hand. A strong possibility exists that growing disillusionment with a single brand of pill and the condom, with only permanent contraception (sterilization) and faulty natural family planning techniques as alternatives, will create resistance to family planning in general.

Another constraint on the program is the diffusion of supervision from the national, regional, district and community levels, complicated by the voluntary nature of the corps of workers who are responsible for making the system work. The DHF is responsible for strategy and furnishes salaries for those who are paid, but the regional and district personnel are responsible for execution of the program, including assurances of a regular flow supplies to the field. There are certain geographic areas where regional and district personnel are collaborative, such as Belladere and Hinche; but the only current answer to the question of how to ensure effective supervision seems to be that everyone "ought" to cooperate. There are many regional and district personnel who are aware of their responsibility for all services provided in their area but who do not see the community program as a

priority. Others are openly critical of the way in which the DHF envisions it. The future success of the community-based program will depend very largely on how much support, attention and imagination are exercised by regional and district offices and how much leadership will be provided by the four community development specialists that are to be named by the regions: the normative functions of the DHF and the technical and material assistance it supplies are not sufficient to ensure the expansion of the program, and a cooperative spirit from field personnel cannot be mandated.

* Community-based Public Health Personnel - Community Agents number about 130 including one supervisor for every five agents. They are assigned to health centers in the largest health districts and have been in place since 1975 when they were created by the DHF as a corps of outreach workers for institution-based services. During the past year and a half a great deal of time has been devoted to reinforcing the effective use of this group of workers. They are assigned to an area with about 200 families, and organize their outreach activities around registers of MCH/FP clients as well as periodic door-to-door surveys to identify women and children at risk. Activities have always included supply visits for continuing female clients, as well as distribution of condoms, and in recent years some community agents have been trained to initiate pills and orient clients to the sympto-thermal method of family planning.

Health Agents number about 550, are assigned to rural dispensaries, and are expected to provide basic para-medical services to the rural population out in the communities, referring more serious health problems to the dispensaries or higher levels. For most health agents equipment and materials are not yet routinely provided and supervision has not yet been systematized; however they are expected to make supply visits for continuing female clients and to distribute condoms.

Promoters, numbering about 15, were developed by the DHF Community Development Office to organize and supervise the thousands of volunteers who are expected to eventually participate in education and contraceptive distribution activities throughout the country. They in turn report to four supervisors at the DHF. Sterilization Social Work aides, numbering about 12, are not trained social workers but rather are community workers with special orientation in educating about sterilization for men and women, and following up clients to ensure that they do not experience complications or emotional problems. Traditional mid-wives, nearly 7,000 of whom have been trained in improved techniques for home-based delivery, are expected to continue as referral sources for family planning.

6. Recommendations

6.1. Reinforce National and Regional Commitment to Community-based Approach

Regional offices have been directed by the DSPP to appoint a community development specialist at the regional level to be responsible for the development and operation of community activities. The DHF Community Program Office should be provided with all resources required to ensure

effective personnel selection, training, orientation, job descriptions, and technical assistance for these individuals.

Should the DSPP decide at some future date to establish a directorate for community programs to support all health services it is recommended that those who are appointed to organize the directorate be requested to take into account the successful experiences to date, and to solicit maximum input from those who have developed the expertise over the past 4-5 years.

6.2. Contraceptive Choice

The same recommendation contained in the section of the report regarding quality of services is applicable here, with a special emphasis on the need to support lay workers who are less skilled in counseling clients in the effective use of methods with which they are not very satisfied, and from which they experience side effects.

6.3. Operations Research

Revive the mini-project idea, expanding the potential pool of skills and resources available to include any individual, agency and professional group in a position to put their ideas into effect with assistance of a grant; increasing the amount of individual grant awards to meet needs identified in proposals; and simplifying the grant award process. USAID should assist in the simplification of sub-contracting and/or grant award process, reporting, and accountability procedures during and after the project. Any existing problems with funding the cooperatives in the Miragoane project should be resolved quickly, since the DHF regards this particular experience as a precursor of any future mini-projects and has been unhappy with difficulties to date. To ensure realistic proposals the DHF should establish the total dollars it has available, letting potential grantees know that one or more will be awarded and that decisions will be based on total amount available in relationship to receipt of proposals with good chances of success.

Incorporate into the DHF/DSPP/Regional Plans for 1983-84 and beyond, specific objectives and actions to incorporate research results into on-going programs. It is evident that the DHF Offices of Community Programs and Research and Evaluation are committed to operations research, since their staff are currently involved in the Miragoane project. The same is true with the District Administrator who has given a good deal of personal attention to the effort. The plan documents of the DSPP should reflect this commitment in the form of specific objectives, because it is unclear as to how personnel and resources outside the DHF will make use of the results. It is further recommended that the Miragoane District Administrator, as well as staff of the DHF, be asked to draft the objectives for review and final inclusion in the plan document by integrating contraceptive distribution into their on-going home-based services to their communities, as well as some door-to-door canvassing and services built into the first several months of the demonstration project.

COMMERCIAL PROGRAM

1. Objective, History and Results to Date

As a part of the Family Planning Outreach Project, assistance is provided in order to determine the viability of contraceptive retail sales (CRS). Given the scarce financial resources available for services in the public sector and the increasing awareness of and demand for modern contraception, it was felt that CRS could provide reasonably priced alternatives to free distribution through government services for low and marginal income people. While CRS would not be strictly a commercial venture since it would have a built-in subsidy as a social marketing program, it should generate sufficient revenues to pay for itself. It was not assumed that self-sufficiency would be obtained within the life of this project, but sales receipts were planned to offset at least the costs of advertising and repackaging.

CRS started through DHF in 1978 with the sales of condoms from machines. At one time there were 250 machines with Tahiti condoms for a dime each*. All machines were in Port-au-Prince and sales appeared to be going well with over 9,000 condoms sold in the first three months. However, this method of distribution was found to be problematic and the machines were phased out in 1981 when retail sales of condoms were initiated through pharmacies, boutiques and even street vendors. In June of 1980 the DHF Commercial Section was established to maintain all commercial sales, and later on CRS was broadened to include Neo-Sampooon foam tablets and some pills. The CRS program as envisioned in the Project Paper has actually been through only one phase to date: market research and planning. The second phase, that of pilot testing, should have been completed by now according to Project objectives, and the publicity, repackaging and sales promotion campaigns should have taken place. While there have been a number of studies on how to implement CRS, the current status of the project is that the DHF Commercial Section is still trying to sell an inadequate range of products without the advertising it feels it needs to produce better results.

The current Director of CRS is a hard-working and competent individual who has had to learn retail sales and marketing on the job. In the last three fiscal years the section has sold \$10,438 worth of contraceptives, with proceeds placed in a separate account of the DHF. Prices are:

	<u>DHF Price to Vendor</u>	<u>Resale Price</u>
Condoms/Pharmacies	.02	.05
Condoms/Boutiques	.015	.02
Neo-Sampooon Tube (20)	.80	\$1.00 - \$1.20
Neo-Sampooon unit	.04	.06
Pills	few are sold - price irrelevant	

Correction:* Ten Haitian cents or U.S. \$0.02. Condom machine project initiated and funded by PPF/Western Hemisphere for 2 years. USAID POP Officer.

Using the same figures as the Project Paper for Couple Years of Protection (CYP) - 200 condoms, 20 cycles of pills and 160 foam tablets distributed, to allow for drop-out and ineffective use - the sales for 1983 show that the CRS provided 758 CYP (42 CYP/condoms, 716 CYP/Neo Shampoo and .6 CYP/pills). For FY 82 the CRS provided 621 CYP. Even though the CYP calculations are conservative compared to calculation used in other documents, the fact is that the CRS is still very small and the improvement from one year to another is slight. The figures above also reflect a dramatic drop in condom sales and a corresponding rise in sales of Neo Shampoo.

The total cost of the Commercial Section excluding contraceptives and indirect program management costs is approximately \$49,000 per year. This takes into account salaries for the five people in the section, (\$27,144), driver, gas, vehicles, supplies, administrative and financial services, and overhead (rent, electricity, storage) estimated at 80% of direct salaries (\$27,715). FY 83 receipts were \$4,718, less than 10% of total costs, and if contraceptives and management costs were added, the proportion recovered is even less.

The cost of providing 757 CYP (again excluding costs of indirect management and contraceptives) would be \$64.54 per CYP. Without specific criteria against which to measure these figures, it is difficult to judge them. Nevertheless, considering the very small volume of sales and the fact that the structure in place and already paid for could accommodate a much greater volume, this figure is high.

An examination of these disappointing results reveals that 85% of pharmacies in Port au Prince, are participating in the CRS (115 in all) but that the number of boutiques has dropped from a high of 175 in 1981 (when machine sales were discontinued) to only 30 at the end of FY 83. It appears that expansion of pharmacies is unlikely in the capital, but potential remains for involving the 55 pharmacies outside the capital, as well as for involving boutiques, supermarkets and small convenience stores. However there are at least four conditions which have to be met to expand the program:

- 1) stable supply of contraceptives at a reasonable price that Haitians want to buy,
- 2) more favorable GOH, importer, retailer and medical/pharmacist attitudes,
- 3) a repackaging, marketing and advertising program that is effective, and
- 4) a program management that is entrepreneurially capable and properly motivated.

2. Potential Demand and Product Deficiencies

All the the studies done on a CRS in Haiti show a credible potential demand on paper. The most detailed study, an impressive piece of work, was

done in 1982 by CRESHS (Centre de Recherches en Sciences Humaines et Sociales). Using this study's percentage figures for the population as distributed, by age and sex and the popular figure of a current Haitian population of 6,000,000 which is probably high, the potential population market to be covered is:

Male (between 15 and 64) - 25.8% of pop. - or 1,548,000
Females (between 15 and 44) - 22.9% of pop. - or 1,374,000

The size of this potential market plus the high awareness of modern contraceptive methods shown in studies and the growing demand for such methods makes all the marketing analyses assume that there is a real and a large demand out there. There are several significant factors to be taken into account, however.

First, 92% of all industrial activity and 94% of all salaried workers live in the metropolitan area of Port au Prince. For Cap Haitien, the second biggest city, with a population of 60,000 the percentage of the country's salaried workers drops to only 2-3% of the total. Thus, the credible market demand would seem limited to the roughly 22% of the population living in urban areas.

Second, the CRESHS survey was based on household income of \$50-200 per month, with an average of roughly \$125/month. This study, similar to other studies, demonstrated a willingness of such consumers to pay \$1-2 per month for a modern contraceptive that they wanted to buy. This \$1-2 cost figure appears to be applied by some of the market demand analyses out of context. That is, there is assumed to be a willingness across the board to pay this amount whereas it is clearly a willingness in the study that is dependent on significant household income levels.

Third, the Tulane study cited by MSH deduced a rural willingness and capacity to pay \$24.60 per year for basic medical care. These figures seem high in relation to all the disposable rural income figures available and conceivably one derived from a small, non-representative sample. Since only 40% of the gross domestic product comes from agriculture in Haiti and it must support the roughly 80% of the population, according to the CRESHS study, living in rural areas plus absentee owners, the level of disposable rural income for health would appear to be lower than the Tulane figures estimate.

Fourth, only 5% of the urban respondents in the CRESHS study were currently purchasing contraceptives through the private sector, which is far broader than the CRS of the CS/DHF. Given the high average monthly income in relation to the costs of contraception in the private sector and given the wide availability of contraceptives through pharmacies - up to 20 types, including all brands of pills, foam, tablets and even injections - over the past several years and the market knowledge thereof, it seems that there is a constrained demand for purchase of such contraceptives in the market as it currently exists. It is precisely because of this lack of demonstrated demand and the consistency of this lack of demand, despite private commercial efforts which we must assume are much more aggressive than the CS/DHF program, that we

find no compelling documentary evidence to demonstrate that a full-fledged CRS would unleash a large pent-up demand for such products. Note - This is not to say that such a demand might or would not exist. Rather it is to say that no pilot or research test has convincingly shown that it does exist.

Fifth, there are some major attitudes in the studies that need to be considered. Haitians express a deep concern about the healthiness of modern contraception that needs to be dealt with. The Porter, Novelli Focus Group research favored purchase of contraceptives at pharmacies with adequate medical explanations by trained personnel. The CRESHS study showed fears about infection and non-serious health problems plus a desire for more information on contraceptives from health professionals. The pharmacy study also raised the need for better information. This concern about health and a desire for some sort of consultation is perhaps one explanation for the level of currently constrained demand and any expanded CRS must address this problem head-on. (Resupply through commercial outlets after an initial consultation is not seen as a problem).

There also appears to be a high dropout rate both in the commercial as well as the free distribution program. More research needs to be done on how to keep acceptors on modern methods and to avoid dropout rates which appear to be as high as 50% in some areas. The Contraceptive Prevalence Survey should provide additional information as well as some future direction.

Radio and TV advertising and government involvement seem to present no problems. The Porter, Novelli study points out that consumers feel that a commercial program should not replace free clinical distribution but should supplement it.

Importers and pharmacists have indicated that a competitive effort would be unacceptable to them. Pharmacists and the medical profession have also expressed concerns that contraceptives are prescriptive drugs although they have always been available without a prescription. While community based distribution has taken place and been largely accepted throughout the official medical community, any CRS which does not secure the support of the importers, pharmacies and medical community seems likely to encounter resistance.

The impact of the free distribution of contraceptives on CRS has yet to be fully weighed. 31% of the CRESHS respondents got their contraceptives through free distribution as opposed to the 5% who purchased them. Key markets such as the Armed Forces, a natural focus group for CRS, have a generous distribution program which appears to supply more than the military and their families.

Product Deficiencies

The attempted sale of the USAID contraceptives available appears to have been hampered by a strongly apparent dislike of condoms in transparent packaging and of Noriday side effects. The studies document this consumer dislike and the sales results of the CS/DHF apparently confirm it. A desire

for a condom that is discreetly packaged has been expressed over the past three years. USAID is still providing the CS/DHF condoms in transparent packaging. There are also indications that colored condoms may not be very desirable. If condom sales have dropped from 108,000 in FY 80 to only 8,400 in FY 83 yet more than 18,000,000 free condoms of the same kind were distributed from the main warehouse in the national programs. Tahiti condoms may be acceptable for a free distribution program but perhaps not in a commercial one. It is clear that any expansion or continuation of the CRS should be based upon the provision of a distinctly packaged, differently named condom from the free distribution program.

Since there is a large demand for Neo Sampoo, it is regrettable that USAID will not resupply Neo Sampoo. It is hoped that an American substitute can be successfully introduced into Haiti. Neo-Sampoo is at present the only credible alternative to the two major types of contraceptives provided, pills and condoms, and has fewer side effects and being safer and more convenient to use. The acceptance of Neo Sampoo has been impressive in a CRS that has otherwise not been very successful. Packaging of individual vaginal tablets - with proper identification and information - unlike the currently unmarked foil packets - could provide an alternative.

With regard to pills, since pharmacists like them and they are both cheaper for USAID to supply and readily available, any CRS should stock one of the popular brands being sold now in the private sector repackaged as a distinct product to be supported by advertising. Given the high awareness among women of pills, their efficiency and their acceptability to many, pills must be a mainstay of any CRS program. Special attention should be paid, based on focus group research, on picking a pill with the fewest side effects since it is these side effects which discourage consumers from using them. Advertising must also meet the need for specific and accurate medical guidance regarding contraindication and side effects.

Expansion of the program into the sponge or injections should be considered if financially feasible. The current lack of choice in contraception seems to impact negatively on the program and override the wide spread knowledge of the advantages of family planning and expressed desire for such planning among many Haitians. The fact that there is indication of strong dislike for condoms and pills, as well as a preference for Neo-Sampoo, must be accommodated. While it is possible to adopt an attitude of indifference to client preference in a free distribution program, any CRS that does not meet and cater to the expressed consumer preferences in its market is doomed to failure. A study of the results of the CS/DHF to date underlines this point.

3. Pricing Policy and Cost Estimates

In a CRS, prices have to be reasonable and must take into account the elasticity of demand for contraceptives. There is a consensus that prices should be in the \$1-2 range, so that the pricing schedule developed in the Manoff International draft might be adjusted upward in the case of pills and

some of the extra revenues generated used to offset condom prices which seem higher than the other two methods.

Changing the price of 10 cents a condom to 3 for 25 cents and making that the primary method of distribution would meet study preferences for purchases of three at a time and reduce the cost by 20%. Packaging in units of 3 may produce a savings that would reduce the subsidy necessitated by this price change.

Raising the price of the pill to \$1.00 a cycle at retail and 60 cents at base price would help make feasible the lower condom prices as well as the sale of vaginal tablets at 3 cents a unit. For the pill, with a base price of 60 cents, the distributor would get a 15 cents markup or a 25% profit margin and the retailer a 25 cents markup or a 25% profit margin. A similar pricing strategy should be in effect for vaginal tablets so there is no preference for the distributor/retailer to push one method over another based on profit margin.

Suggested Prices for CRS Program

<u>Product</u>	<u>Base Price</u>	<u>Dist. Markup</u>	<u>Profit Margin</u>	<u>Retailer's Markup</u>	<u>Profit Margin</u>	<u>Price to Consumers</u>
Condom/1 Unit	\$0.05	\$0.02	29%	\$0.03	30%	\$0.10
Condom/3 Units	0.14	0.04	22%	0.07	28%	0.25
Pill/Cycle	0.60	0.15	25%	0.25	25%	1.00
Tablet/Tube (20)	0.60	0.14	25%	0.25	25%	1.00
Tablet/1 Unit	0.03	0.01	25%	0.01	20%	0.05

This pricing policy would provide the highest returns on condoms, since they appear to be the product requiring the biggest push in the commercial market. It would also mean a substantial subsidy if the packaging costs cited in Manoff International draft are correct (5.5 cents per unit plus associated expenses, for a total cost of 6.8 cents per unit). The commodity costs plus freight (6.3 cents per unit) would have to be added to packaging, so a CRS condom would cost 13.1 cents excluding program management and advertising costs.

Pills, however, are estimated to cost 23 cents per cycle including freight plus 8 cents for packaging and display costs or 31 cents per cycle.

Vaginal tablets are estimated to cost 5.75 cents per tablet including freight and packaging and display costs should run another 8 cents per tablet for a total of 13.75 cents per tablet.

Costs of Packaged CRS Contraceptives In U.S. Cents Versus Base Price

<u>Product</u>	<u>Base Price</u>	<u>Total Cost plus Freight/Packaging</u>	<u>Profit/Unit (Loss)/Unit</u>	<u>Estimated Unit/Year 1</u>	<u>\$ Profit (Loss)</u>
Condom/Unit	5	13.1	(8.1)	2,062,750	(167,083)
Pill/Cycle	60	31	29	092,092	26,707
Tablet/Unit	3	13.75	(10.75)	708,400	(76,153)
Total Profit (Loss) - U.S. \$					(\$216,529)

(This represents the subsidy to be extended that related to the packaged contraceptive (including freight) to be sold to the distributor. It does not come close to representing the subsidy of a CRS program in Haiti).

Total advertising costs are estimated to be \$170,400 in year 1, according to the Manoff International Draft (cf. p. 57).

Total direct program costs - excluding DHF, DSPP and USAID management costs and all supporting overhead costs - are estimated to be \$1,138,249 including the advertising, packaging distributing and contraceptive costs.

Estimated receipts - using our suggested pricing policy - would be:

2,062,750 condoms x 8.9 cents per unit*	=	\$183,584
92,092 cycles x \$1.00 per unit	=	\$ 92,092
708,400 tablets x 5 cents per tablet	=	\$ 35,420

* Assumes that 1,370,000 condoms are sold at 3/25 cents and 692,750 at 10 cents/unit.

for a total revenue of \$311,096 or \$24,000 more than estimated in the Manoff International report using its estimates for quantities sold and recommended sales prices.

In the first year, the net cost of the program - excluding DHF, DSPP and USAID management and overhead/support costs - would therefore be \$827,153 assuming that newly packaged, new products that would be introduced and advertised actually generate the sales that are projected. These sales are simply assumed to be 5% of all women in Port au Prince, Cayes, Gonaives and Cap Haitien between the ages of 15-49 and 5% of all men of reproductive age. In year 2, those figures increase to 8% across the board and in year 3 to 11%. While these figures are possible on paper, we doubt that they are realistic given the experience of the CRS in the CS/DHF to date and of contraceptives sales in general in the private sector. The increases that would have to be generated from the current CS/DHF base are astronomical

- from 12 cycles of pills to 92,092 cycles
- from 8400 condoms to 2,062,759 condoms, and
- from 114,362 tablets to 708,400 tablets.

Further, all of these products would be new if a U.S. substitute for Neo-Sampon is used. While new pills and condoms are desired, acceptance within the commercial sector by distributors, retailers and consumers may not come easily because of their negative attitude toward the pills and condoms previously distributed.

The figures used for numbers of people reached - 5% of the urban population at risk in a year and 11% after three years - seem optimistic considering the length of time it has taken (1975-1982) for a national program to reach current levels, estimated at 10% of women at risk based on DHF service reports. Either the CRS would reach people not currently served, or it would attract people willing to pay for a product they receive free, and in either instance the goal appears overly optimistic.

The cost estimates in the Manoff International Report all seem high for Haiti if one objective of a CRS is to hold down costs and make the cost/benefit ratio more favorable.

Packaging costs for condoms at 6.8 cents per unit and for pills and tablets at 8 cents are likely to seem excessive to the DSPP. The current Minister of Health, has written that family planning programs should be locally managed and financed in order that a program so sensitive to a country's future not depend upon the vagaries of international donor assistance. Given this perspective, USAID should push American suppliers through AID/Washington to see if better products and packaging along the lines of the research done by Corbin Advertising can not be achieved more cheaply in the USA at the point of manufacture. Special efforts should be made to improve upon the current situation to meet known consumer preferences without producing a repackaging cost equal to the cost of the condom itself, excluding distribution and display needs.

Similarly, the budget for the CRS program outlined on pages 57/58 of the Manoff International report seem unnecessarily high. No rationale is provided for why it is necessary to have a full-time resident advisor for two years at an average cost of \$108,000/year. Short-term, carefully structured technical assistance based on GOH requests should be adequate to oversee a CRS program on an ad hoc basis. Oral and other contraceptives and proprietary products like Bufferin and Clairol are already successfully distributed in Haiti. Advertising and media support is locally available and Ron Levy from Corbin/Jamaica, who evidently has social marketing experience, is close by to assist an average cost of \$8,333 per year over 3 years for a driver and \$12,000 per year average for a secretary are out of line with the current market in Haiti. It is not clear why \$80,000 is required for travel in the first 3 years nor why the program has to be carried out through a consulting company adding \$105,000 of overhead to the budget. It is not realistic to expect a foreign consultant to be Co-Director of the CRS.

In Haiti there is local distributing and retailing capability to build on. The manufacture and distribution of Serum Oral is being done locally. A successful poster campaign has been mounted and one sees posters advertising Serum Oral everywhere. This is an example of a successful local social marketing program in which CRS would find some talent.

Importers of contraceptives like Reibold, Villedrouin, Paulemond, Commerce S.A., Mallebranche, Trans World, Dobbaco and Delva have experience to offer. In July, 1981, Kercy Jacob found 17 types of oral contraceptives, 3 vaginal barriers and several types of condoms being sold in a sample of only 14 pharmacies in Port au Prince. While it is impossible to know how many cycles of pills the private sector imported since pills are included with pharmaceutical and medical products, the customs figures for FY 78-79 document that 1500 tons of these types of products were imported and almost 7 million dollars in import duties were collected. With inflation and an increasing middle class, we could assume these figures have nearly doubled. There appears to be a base of commercial skills to be drawn on within Haiti that should be enlisted to participate in any CRS.

To summarize, sales estimates are too optimistic in our opinion and commodity, freight, repackaging, distribution and retail costs are high, and hard to reduce. We recommend therefore that program direction and support costs be held to the minimum necessary to make the CRS feasible and that local talent be involved.

1.8 GOH and USAID Roles

While legally there seems to be few impediments to CRS, there is a definite question as to the extent of backing within the GOH toward the CRS program. In none of the evaluation team was there a real enthusiasm for the CRS. The Director of the DHF openly questioned whether it was possible to sell condoms through boutiques and supermarkets. The head of the CS/DHF, while enthusiastic and hard working has a difficult situation. Among staff there is a lack of experience and drive typical of most commercial ventures, and, of course, a job situation with relative security (although none of the staff are DSPP employees) and a stable salary. There are no commission schedules, sales overrides or bonus schemes to motivate people. The lack of incentives was evident when two of the staff were reading novels in the office during the follow-up interview rather than working outside signing up new outlets and trying to distribute contraceptives.

At the higher levels of the DSPP there were no expressions of commitment - but neither were there any impressions that the program should be terminated. The former CS assistant Director and later DHF CS chief specifically stated that a resident advisor is unacceptable.

The results of the CS/DHF to date are so constrained, it is not surprising to find basically a neutral and passive attitude within the GOH. Whether USAID wants to commit several million dollars in such an environment as currently exists is questionable. Also, it is now clear how the private sector importers and medical/pharmacist community will resist any CRS that is not acceptable to them.

In the alternative, there has been discussion of a parallel program, that is, CRS would function along side a private sector program which would benefit from CRS advertising (perhaps even contribute towards it) and from an exemption of import duties. The quid pro quo is that the private sector would

pass any savings along to the consumer. (Import duties according to Kerby Jacob run 0.72 gdes kilo for pills and 5.80 gdes/kilo for condoms, or 14.03% of the sales price for pills and 41% for condoms. This discrimination in duties perhaps explains the abnormally high prices of condoms in the private sector here.

Options Available

1. Shut down CS/DHF based on several years of experience, constrained results and high cost of each CYP obtained.

Option 1 would waste all the sunk costs in CS/DHF to date. It also reinforces in the GOH the belief that international donor agencies are simply not reliable. It deprives Haiti of 757 CYP, which may not be made up elsewhere. Even if these CYP are expensive, they represent real consumers and births averted.

2. Continue CS/DHF but accept the limited role that it can play in Haiti's family planning outreach.

To make the program more cost/effective, only a skeleton staff will be needed to pass by the 115 pharmacies and 30 boutiques currently selling contraceptives and restock them on a regular basis. One person with transport support should be able to do this. Another person to keep records, make reports, oversee the restocking and to make marketing calls as time permits, including restocking when the first person is on leave or sick, will also be required. Both of these people can be lower level than the current Director and Assistant Director. They would be attached to either the Administrator's or Evaluation/Research Office and would get their secretarial support there. By cutting the costs of the program back to roughly \$7000/year and providing better packaged condoms, new tablet packets and a new pill, sales should grow more than enough to offset the sharply reduced costs. Any advertising and display costs would be the pharmacists' responsibilities but the CS/DHF would assist in trying to develop a cooperative program among participating outlets to prepare some small displays and innovative packet dispensers and even some posters. By pooling the effort of 145 outlets, proper displays could be developed at a reasonable cost that could be offset by increased sales.

Should the new products catch on, the CS/DHF could be strengthened to take advantage of this happy event.

Option 2 is a more reasonable decision. It provides for a steady state program that will continue the 757 CYP and hopefully, with better products, expand these CYP. It will not appear to be an arbitrary cutoff of funds to the GOH and displaces only 3 persons, who can hopefully be absorbed elsewhere in the DHF, if they desire to stay there.

3. Mount a carefully structured, well defined pilot program perhaps in Cap Haitien or Cayes, where given the much smaller concentrated population, the costs should be lower and the effects, given the novelty of the program, should be easier and clearer to monitor.

New products, new packaging and an aggressive but cheap advertising campaign should be developed. The groundwork is pretty well done in all the reports already developed. If the pilot CRS works there, transporting it to Port au Prince and the other 2 cities proposed in the Manoff International report will bring economies of scale as well as increase the potential market by up to 20 times.

Running such a test will give USAID a real measure of potential demand and permit USAID/GOH to see if the markets promised in these studies actually materialize. Short-term consultants using local talent and Corbin/Jamaica could put together an inexpensive program in a short time. The current Director and his assistant, could be dispatched to either Cap Haitien or Cayes to put their knowledge of how to market in pharmacies and boutiques to work for the pilot test. So could the Operations Research team to provide high level technical survey support.

Such a pilot could revitalize the CS/DHF and, if the results are positive, make a follow-on virtually a fait accompli. Since the amounts involved would be minimal in contrast to the millions envisioned by the Manoff International and other reports, the cost effectiveness of running such a test should be high.

No such pilot should be envisioned, though, until the newly packaged condoms with a different brand name, new pills and new tablets are available. Enough of the basic work has been done by the Corbin report and others so that a credible selection of brand name, logo, coloring and packaging can be readily made. Finally, Randi Thompson, Betty Ravenholt, Shirley Barnes, Edith Lataillade and Ron Levy (Corbin/Jamaica) among others, would be able to help out in this tiny pilot program.

Option 3 is a reasonable next step. It tests whether the one questionable hypothesis running through all the reports - the potential demand - can be empirically verified. Given new products, packaging and promotion and given the low cost of such a pilot, using the local resources available, the overseas consultants intimately familiar with the proposed CRS program and the tiny population to be tested, this appears to be a highly cost effective as well as necessary step if CRS is to go forward.

4) Decide that the studies done demonstrate the reasonableness of a significant demand for CRS already existing follow up on the Manoff International report, with a finalized budget, and go forward with a full-pledged CRS program if the GOH is agreeable.

Option 4 is a much riskier alternative. The size and complexity of the program plus the high cost of undertaking it argue against funding it based on the information currently available. The pilot outlined in Option 3 would be a condition precedent to Option 4 in any commercial undertaking so that a real market test of demand could be evaluated before committing several million dollars of scarce resources.

5. Recommendation

Option 3 - a small scale pilot test of CRS with new improved products outside Port au Prince using local resources and consultants already familiar with the proposed pilot and Haiti is recommended. This pilot test should go forward immediately since it is already behind the schedule foreseen in the Project Paper. If the pilot is successful, expansion of CRS should be confined to urban areas for the immediate future. Nothing should be done yet to cut off rural or urban consumers of contraceptives from their current free channels of distribution. Instead, innovative programs like the Miragoane SNEM distribution and the Leogane household distribution projects should be promoted for the rural areas. Conversion of the Armed Forces at an early stage may be considered if salary levels there permit it, because of the natural focus of such a market. Community programs and distribution through the agents de santé should continue without any charge until it can be demonstrated that rural poor in Haiti can and will purchase contraceptives commercially, and credible and convenient rural outlets are widely available.

Preprinting of prices on all CRS contraceptives sold should be considered. If demand is strong, prices should be regularly increased, with almost all of the increases going to offset the subsidies extended CRS. If changing the costs of these products is an expensive proposition, a careful balancing of the additional revenues to be generated versus the added packaging costs should be made. All advertising - oral and printed - should support the set prices so outlets cannot easily mark up beyond the profit margins we have outlined above. They are generous especially when considered as a percentage returned on the actual cash outlaid to generate this profit margin.

Assuming a successful pilot test, which will be operated by the DHF commercial section with assistance from consultants and the Research and Evaluation Section, the question arises of who should operate the follow-on CRS: the DHF, the DSPP, a private voluntary organization under subcontract from DHF, a semi-autonomous government entity like AGAPCO, or the private sector?

There are advantages and disadvantages to each of the above depending on the commitment of GOH. At this point in time, we would recommend a private voluntary organization under contract to the DHF as the best program manager. It is unlikely that CRS is going to be able to be a private sector undertaking given the fact that it has functioned to date in the DHF. Selection of one importer over another is likely to produce resentment among the users. It is also unlikely that the private sector would be interested in a subcontract for running the CRS program on terms suitable to a social marketing undertaking. Keeping it wholly within the DHF would be too confining. Putting it in the DSPP would submerge it in an even larger and markedly less efficient bureaucracy where it would not have adequate administrative and financial support. While an AGAPCO-type of semi-autonomous special purpose government entity offers some benefits it still does not provide CRS the freedom and flexibility that it will need to be successful.

Thus the best alternative would seem to be a private voluntary organization that is non-profit and has experience in family planning and hopefully social marketing. It would operate with day to day freedom being subject only to supervision from the DHF Commercial Section. The Director of the Commercial Section would oversee the program and be responsible for handling the paperwork, and making reports. He would be located in the DHF building, report to the DHF Director and have no line responsibility in operating CRS. He would coordinate CRS with the DSPP and the rest of the GOH and would receive an occasional trip to present a paper or review another CRS project in a foreign country so that he develop additional capabilities for his oversight function.

There must be an effective working relationship between the CRS program and the DHF/DSPP since salary scales, bonuses and opportunities within CRS may well engender resentment from the government workers. If CRS could be detached from the bureaucracy through such a cooperative arrangement with a private non-profit agency it will be necessary to provide the environment that a successful commercial program needs.

When the private voluntary organization is selected, purchase of consulting services from two or three importers/distributors should be considered to obtain their support and to take advantage of their knowledge of the market here. Exclusivity should be avoided whenever possible. Consideration could also be given at this time to the feasibility of a parallel program in the private sector as described above. However, since existing commercial distribution and retail channels are proposed, reasonable generous margins already provided for, and since sales volume would likely be high if a decision to mount a CRS program is actually made, there should be both enough involvement in program design and immediate benefits for the private sector, especially pharmacies, so that opposition is likely to be minimal and a parallel program not required.

DEVELOPMENT OF A POPULATION POLICY

The FPO Project has as a long term objective "the achievement of a substantial and sustained reduction of the family size in Haiti". This objective, and a satisfactory development of the Project itself through Government agencies require a political commitment from the Government. To help build up that commitment, USAID proposes to support the creation of an awareness and understanding of the impact of population growth on national development, and the development of a capability for the formulation, implementation and evaluation of related policies.

Activities envisioned include "sector-specific policy research aiming at understanding Haiti's specific determinants of fertility and their interaction with development parameters" on the one hand, and awareness seminars and workshops on the other. Among other "mechanisms" and strategies" suggested to stimulate the process, was the establishment of a "national committee on population and development of appropriate programs, monitor population and development dynamics and recommend policies and programs to the Government.

Such a range of activities is beyond the capacity of DHF to organize and control, and the Project did envisage the active participation of the Ministry of Planning and the Institute of Statistics, especially in the preparatory analyses. Actually, although population matters are part of the mandate of DSPP, and this Department has formulated for itself demographic objectives¹, the tendency detected by the evaluation team is to consider that the FP program has essentially health objectives, and that the formulation of a population policy is a task for the Government as a whole. Two observations should be made here:

- (a) It is perfectly correct that the formulation of a population policy should be entrusted to a multisectoral institution, since implementing and evaluating that policy will also be a multisectoral affair.
- (b) The situation also implies that DSPP start considering FP activities -- an important tool of the population policy -- as a field of multisectoral interest, and work on ways and means of enlarging their scope in collaboration with other Departments. In fact, achieving the demographic objectives of DSPP will certainly require the active involvement of the educational and the information sectors on a substantial scale, hence, cooperation and coordination will be of vital importance².

1. In terms of infant mortality and fertility indices, including reaching a CBR of 33 per 1000 in 1986 and 20 per 100 in 2000.

2. Small-scale actions, involving DSPP and the Department of Education and Information are underway.

In fact, initiative in the area of population policy has come essentially from the Ministry of Planning. Following its December 1982 Seminar on Population, Resources and Development, the Institute of Statistics (IHSI) has pressed on, suggesting a working group on population policy questions and tentatively formulating a description of the possible make-up and role of a "Conseil National de la Population" (CNP).

A working group has been set up by the General Direction of the Ministry of Planning. It includes two representatives of the General Direction, one of whom is the group coordinator; two more representatives of the Ministry of Planning, delegated by the Directions of Programming and of Regional planning; two representatives of IHSI; and one representative of DSPP (Dr. W. Dieudonné of DHF).

The Working Group has produced two summary documents on Haiti's demographic and economic situation, and is now working on a preliminary document which will outline possible population policies and propose ways and means to institutionalize them. The idea is for this document to serve as a basis for the Government judicial experts to prepare a law defining the national population policy and creating the GNP. The draft document should be ready early in 1984.

There has been little or no consultation of other Departments by the Working Group; this is foreseen to take place during the coming months. On the other hand, an effort has been made to sensitize groups of planners from technical ministries (Agriculture, Education etc.) through demonstrations of the "Resources for Awareness of Population Impact on Development" (RAPID) model; this microcomputer-based model¹ is located in the Ministry of Planning. Although the present structure and presentation of the model could be improved (and the evaluation team has offered suggestions in this respect to its operator), this is a tool with a great potential for sensitizing decision-makers. Assistance should be considered to enable the Ministry of Planning (in collaboration with the Future Group) to fine-tune the instrument and its presentation and organize sessions for top officials of the Ministry itself and other sectors.

The Ministry of Planning states its intention to introduce explicit population policy elements into the next 5-year Plan (1986-1991). Clearly, sectoral studies will be needed in order to assess the nature and implications of the linkages between population dynamics and socio-economic development, especially with regard to migration/urbanization and fertility on the one hand, and agriculture, education and health on the other.

The current Plan (1981-1986) mentions a few population-linked problems:

1. Developed by the Futures Group (Washington).

- Low agricultural productivity is linked to soil degradation and fragmentation of holdings under demographic pressure.
- Low rural levels of living have caused migration to the urban centers and urbanization in catastrophic health conditions.
- Planning has to address the specific problems of categories of population who have insufficient access to the benefits of economic growth.
- Human resources are underutilized. Unemployment and underemployment are common in urban as well as in rural areas.
- The educational system has difficulties catching up with the growing numbers of uneducated youth.

In all these areas, detailed studies will be needed, and will have to be designed to answer the question of which population policies could help solve specific economic or social problems. The need for such research efforts is seen by the Working Group, although their urgency is not realized (it takes months to correctly investigate such problems in a sound fashion and to produce studies which cannot be dismissed on grounds of technical weakness). USAID should make clear its willingness to fund such studies, possibly giving IHESI the opportunity to identify and to commission them.

It is important to note that demographic/economic patterns in Haiti are quite distinctive, and that a population policy should not be defined in a dogmatic fashion, but on the basis of studies of the specific problems of the country.

In future, responsibility for commissioning relevant studies, defining appropriate strategies and monitoring their implementation, will rest with the GP. That Council will be provided with a technical support unit. There will be a need for training at that level, as there is a need right now in the Ministry of Planning and other Departments.

It is unfortunate that the University (UEH) does not possess a Chair of Population Studies -- not so much to provide technical demographic training as such, as to deal with population and development issues -- as part of the economic and social curricula. With regard to population studies applied to planning, it is to be noted that the training center for statisticians (CEFORS) will soon open a "Centre des Techniques de Planification et d'Economie Appliquée", which seem to be the appropriate place to train planners in population-related techniques. USAID could consider awarding each year a fixed number of fellowships, preferably for additional training of mid-level members of various planning units in the Government. Training at higher levels might not have as great an impact, and poses problems of choice of institutions. Everyone knows of the excellent program developed by Michigan University with ILO assistance, but language poses a problem.

The future role of DSPP in the formulation of a national population policy is an open question. The Department retains its formal attributions in population matters, and its future structure includes a "Service de la Population". On closer examination, it appears that this unit will deal essentially with migration and epidemiological problems (there certainly is a need for more work in the latter area at DSPP). Also DSPP will clearly have the responsibility for a major component of the population strategy, the FP program. But equally clearly, the Government's preoccupations with population are more diversified (migration is a very serious issue), the approach will be multisectoral and, for the time being, IHSI and the Ministry of Planning are the key partners for anyone who wishes to help this process develop successfully.

Recommendations

In conclusion the following recommendations are made to the DHF, the DSPP and USAID with regard to the FPO Project objective of developing a population policy:

- * The DHF and DSPP should take advantage of the opportunity offered by the existence of a multisectoral Working Group to more vigorously promote their family planning objectives. The Working Group will eventually become a Conseil National de la Population with representatives from education, information, agricultural and other sectors whose collaboration is required for the DSPP and DHF to achieve its own objectives. This recommendation might be carried out by increasing the representation on the working group since the single representative from DHF/DSPP is far outnumbered by other agencies, to include a DSPP staff person with decision-making authority over various units within the DSPP. The current Director of the unit of Decentralized Services (Unité de Services déconcentrés) has background in population planning and should be used as a resource.
- * USAID should make clear to the Working Group and the Statistics Institute that it is willing to fund the detailed studies required to select appropriate population policies and once a National Population Council is formed USAID should express its willingness to support the development of a technical support unit.
- * USAID should award fellowships for additional training of mid-level staff in various planning units of Government departments, particularly the new Center about to be opened by CEFORS.
- * The DHF should develop a complete description of functions of its Service de Population, including the precise manner in which it will relate to similar agencies and units of other departments and how it will participate in a National Population Council.

APPENDICES

BIOGRAPHY OF TEAM MEMBERS

Norine C. Jewell, MPH - Currently Executive Director of the Family Planning Association of Maine; provides technical assistance on a consultant basis 1-2 months a year; worked in Haiti for the Centre d'Hygiene Familiale and the Division d'Hygiene Familiale; has worked in Chile and Niger with Peace Corps, the U.S. Government Family Planning Program in Washington and the Louisiana Family Planning Program. Born in Canada, resides in Maine.

Jean LeComte, M.D. - Currently a public health consultant with a base in Brussels, Belgium; formerly Chief of the Rural Preventive Health Services, Ministry of Health, Morocco; staff member of Population Council, Taiwan and Morocco; MCH/FP Advisor, WHO in Tonga; and Division Head at International Fertility Research Program, North Carolina.

Alain Marcoux, degrees in Demography and Economic Sciences - Currently a consultant in applied demographic analysis and population studies with a base in Rome, Italy; formerly in Tunisia with the National Institute of Statistics, University of Tunis, National Family Planning Office and the Population

James Robinson, MPA - Currently -a consultant with the World Bank in Washington; formerly senior finance and budget advisor for the Ministry of Local Government in Egypt; vice-president, chief administrative and financial officer, The American University in Cairo; Egypt; Occupational Safety and Health Administration, Washington; National Institute of Public Affairs; Peace Corps Volunteer, Ivory Coast.

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William H. Foegen, M.D. Director, Centers for Disease Control through: Dennis D. Tolsma Acting Director, CHPE

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LIST OF PERSONS INTERVIEWED

- USAID: Ms. Sue Gibson
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M. Paul Hartenberger
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M. Guy Fred Célestin, Chef de Section, R & E
M. Silvio Albert, Chef d'Administration
Dr. Lambert Jasmin, Chef de Section, Normes Medicales
Dr. Gadner Michaud, Assistant Chef
Dr. Jacqueline P. Louis, Assistant Chef
Mme. Georgette Mallebranche, Infirmière/Sage-femme
M. Fritz Pierre, Sociologue
M. Kercy Jacob, Section Commerciale
M. James Allman, R & E
Dr. Edouard, Projet Miragoane
M. Pierre François, Projet Miragoane
Mme. Irene Lafontant, Assistant Chef
Dr. Wooly Dieudonné, Chef de Section Dev. Communautaire
M. Jean Jacques, Chef d'Approvisionnement
- DSPP: Dr. Serge Toureau, Directeur General
Dr. Adeline Verly, Directeur, Unité des Services Deconcentres
Dr. Laurent Eustache, Directeur, Direction d'Education Sanitaire
Mme. Alphonse, Directrice, Bureau de Nursing
M. Guillet, Directeur, Bureau de Statistique
- REGION DU NORD:
- Dr. Marc Angrand, Directeur Regional
Mme. Marie Paul Edith Geffrard, Infirmiere
Mme. Camille, Auxiliaire
Dr. Lubin, Medecin Chef, Maternite
Serge Eloi Charles, Medecin Chef, Pédiatrie
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Fritz Magloire, Service Regional Approvisionnement
Jocelyne Prophète Jean-Jacques, Infirmiere regionale
Angelina Laine, Infirmiere Hygieniste PF
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M. Roger Fabien, Superviseur Agents Communautaires
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Mme. Hériraux, Statistique
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REGION DU SUD:

Dr. Josette Bijoux, Directeur Regional
Dr. Ulrick Montas, Assistant Chef de region
Soeur Solange Gerard, Directrice Ecole d'Infirmiere
Mme. Caridad Rho, Auxiliaire Dispensaire Carrefour route
Mme. Nativita Calixte, Infirmiere clinique mobile
Mme. Jeanette Domerson, Auxiliaire clinique mobile
Mme. Yvette Désir, Auxiliaire clinique mobile
Mme. Hermine Lubin, Auxiliaire clinique mobile
Dr. S. Louissaint, Medecin Chef maternite
M. Jacques Fortune, Travailleur social
M. Choudry Pierre Pyland, Service regional d'Approvisionnement
Dr. Nicolas Elie, Medecin Superviseur Regional
Mme. Ginette Charles, Programme de Matrones
Mme. Yvette Henri Pierre, Agent Communautaire
Mme. Tussina, Superviseur, Agent de Santé
Statisticien Regional

MIRAGOANE:

Dr. Yves Alexandre, Medecin Chef District
Dr. Mompont, Medecin Chef Maternite
Jean-Claude Clouis, Travailleur social

PETIT GOAVE:

Dr. Michel Leandre, Medecin Chef District
Dr. Camille Archange, Chirurgien Hopital Notre Dame
Dr. Fritz Lolagne, Obsteticien gynecologue privé

MINISTERE DU PLAN:

M. Yves Blanchard, Secretaire d'Etat
M. Edouard Berrouet
Mr. Duberval

ACTION FAMILIALE D'HAITI:

Pere Welters

CITE SIMONE:

Soeur Marie Helene Van Keerbergen
Dr. Reginald Boulos

INSTITUT NATIONAL DE STATISTIQUE:

M. Courbage
M. Fortunat

UNDP:

Mme. Edith Lataillade

Background to Demographic Analyses

Annex I - V

Alain Marcoux

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ANNEX I

ESTIMATION OF THE NUMBER OF WOMEN AT RISK SINCE THE BEGINNING OF THE PROGRAM

"Women at risk" are defined as those aged 15 to 49 and in union, that is, either married, placées, or engaged in one of the types of union without cohabitation which are common in Haiti.

A. Women at risk in 1971

There were about 1,076,900 women aged 15-49 at the 1971 census. This figure should first be inflated to correct census undercount, which for the purpose of this report is taken to be 5 percent (see Annex V). Then, the proportion of women in union must be applied to the estimated number of women aged 15-49. It is best to use the categories applied in the Haitian Fertility Survey of 1977, which are more precise than those used at the censuses. The proportion of women in union at the Survey was 57.4 percent. Since it seems that there is a slight decline of this proportion (see Section 2 of the report), it will be rounded upwards in 1971.

The estimate (in thousands) of the number of women at risk in 1971 is therefore:

$$1,076.9 \times 1.05 \times 0.58 = 655.8$$

B. Women at risk in 1982

The 1982 census gives a total population count of about 5,053,800 persons. This figure will be inflated by 6 percent to correct estimated undercount (see Annex V). The proportion of women aged 15-49 has to be estimated, since data by age are not yet available. I shall use the proportion observed at the Haitian Fertility Survey, or 23.5 percent. As regards the proportion of women in union, it will be that observed at the same Survey, rounded downwards.

The estimate (in thousands) of the number of women at risk in 1982 is therefore:

$$5,053.8 \times 1.06 \times 0.235 \times 0.57 = 717.6$$

C. Women at risk 1973-1983

The number of women at risk by year from the beginning of the program up till now, is obtained by simple interpolation for the years 1973-1981, and by extrapolation for 1983.

The estimates are:

1973	667.0
1974	672.7
1975	678.3
1976	683.9
1977	689.5
1978	695.1
1979	700.7
1980	706.4
1981	712.0
1982	717.6
1983	723.2

It is possible to estimate, although roughly, the total number of women who were at risk at one time or another during the period. To do that, we must use estimated age distributions of the women at risk in 1973 and 1983:

<u>Age Group</u>	<u>Number in 1973</u>	<u>Number in 1983</u>
15-19	46.9	55.7
20-24	96.7	132.3
25-29	125.2	151.1
30-34	110.7	119.3
35-39	116.7	103.2
40-44	88.6	83.1
45-49	71.0	78.5
TOTAL	655.8	723.2

The group of women at risk at one time or another can be taken to be the sum of:

- (a) women at risk in 1973,
- (b) women aged 15-24 and at risk in 1983 (who entered the group between 1973 and 1983) and
- (c) women aged 15-49 but not in union in 1973 who entered a union between 1973 and 1983.

We have: (a) = 655.8
 (b) = 55.7 + 138.3 = 188.0

(c) can be estimated in two parts:

- (c1) women aged 15-29 in 1973 who subsequently entered a union, and
- (c2) women aged 25-49 in 1973 who subsequently entered a union.

Women aged 15-24 in 1973 were aged 25-34 in 1983, so:

$$(c_1) = (151.1 + 110.3) - (46.9 + 96.7) = 126.8$$

The estimation of (c_2) entails the use of estimations of the proportions of women marrying in the various age groups. The details can be omitted here. The result is : $(c_2) = 47.6$

We arrive at a final estimate of:

	(a)	655.8
+	(b)	188.0
+	(c ₁)	126.8
+	(c ₂)	47.6
		<u>1,018.2</u>

(which must be a slight underestimation because it neglects the effect of mortality, between 1973 and 1983, on women of groups (b) and (c) after they entered a union).

ANNEX II

ESTIMATION OF MALE TARGET POPULATION, 1973-1983

At the 1971 census, there were about 1,068,600 men aged 15 to 59 years. Inflating this figure by 5 percent for supposed undercount (see Annex V) gives us an estimate (in thousands) of:

$$1,068.6 \times 1.05 = 1,122.0$$

For 1982, our estimated total population is 5,357,000 (see Annex V). Applying to that figure the proportion of men aged 15 to 59 observed at the 1977 Haitian Fertility Survey, we get this estimate:

$$5,357.0 \times 0.257 = 1,376.7$$

Estimates for the years 1973-1981 are derived by interpolation, and for 1983, by extrapolation:

1973	1,168.3
1974	1,191.5
1975	1,214.6
1976	1,237.8
1977	1,260.9
1978	1,284.1
1979	1,307.2
1980	1,330.4
1981	1,353.5
1982	1,376.7
1983	1,399.9

ANNEX III

ESTIMATION OF NUMBERS OF FEMALE
CONTINUING USERS OF PILL, CONDOM,
FOAM AND OTHER METHODS, IUD AND
STERILIZATION EXCLUDED

To estimate the number of continuing users of all female "resupply" methods, it is necessary to estimate the continuation rates of those methods. And, since service statistics do not give the detail of previous acceptors showing up during a year ("anciennes contraceptrices") by method, it is necessary to consider all those methods together. Obviously, the rates thus calculated will be all-method continuation rates.

In order to have an idea of some continuation rates in the table, I first compared the number of "anciennes contraceptrices" to that of new acceptors from previous years.

Table III-1 gives these data for the complete years since 1974.

Table III-1

FEMALE NEW ACCEPTORS, MINUS IUD AND
STERILIZATION, AND "ANCIENNES
CONTRACEPTRICES": 1974-1982

YEAR	NEW ACCEPTORS	"ANCIENNES CONTRACEPTRICES"
1974	4,520	...
1975	14,162	...
1976	14,580	9,811
1977	19,015	14,020
1978	23,029	13,246
1979	32,784	15,062
1980	33,296	22,219
1981	35,005	24,476
1982	47,340	29,264

Let us suppose that all the "anciennes contraceptrices" are users of the pill, condom, foam and other modern methods, and compare their numbers to those of new acceptors of the same methods in the two previous years, then in the three previous years:

ANNEX IV

ESTIMATION OF THE NUMBER
OF USERS OF CONDOMS

Let us consider the numbers of male new acceptors and of subsequent visits from 1979 to 1982 (in thousands):

Year	New Acceptors	Subsequent visits
1979	71.6	227.9
1980	59.1	394.1
1981	52.0	276.5
1982	65.1	421.2

The subsequent visits concern both new acceptors asking for resupply during the year, and acceptors from previous years. The wide variations in the number of these visits may be primarily attributed to variations in the behaviour of new acceptors: let us suppose that in 1979 and 1981 the new acceptors made one subsequent visit on the average, as against two for the new acceptors of 1980 and 1982. By subtraction, we get an estimate of the number of visits made by previous acceptors:

1979	156.3
1980	276.0
1981	224.6
1982	291.0

The average number of condoms supplied per visit during that period was 24, corresponding to 1/6th of the quantity necessary to ensure one couple-year of protection. Therefore, we convert these numbers of visits into numbers of equivalent-full time users, by dividing them by 6: ^{1/}

1979	26.0
1980	46.0
1981	37.4
1982	48.5

^{1/} This implicitly assumes no waste of contraceptives so it could be an overestimate of the corresponding number of users.

IV-2

Let us now add to this the estimated number of new acceptors of the year who are users at mid-year; we shall take this to be 40 percent of these new acceptors (i.e. 80 percent of the estimated acceptors of the first semester) for the two years where continuation seemed to be better, and one third for the two other years. The resulting estimate of the total number of users is:

1979	54.4
1980	65.7
1981	58.2
1982	70.2

If we now compare these estimates to the cumulative numbers of new acceptors over three years (including the current year) we find ratios of users to cumulated acceptors of:

1979	0.36
1980	0.38
1981	0.32
1982	0.40

The pattern is fairly regular with an average of 0.36. Since what we need is a means to estimate the number of condom users for the whole period, I chose to do that by applying this ratio to the series of cumulated numbers of acceptors as said hereabove. The results appear in Table 9.

ANNEX V

ESTIMATES OF POPULATION SIZE AND GROWTH, 1971, 1982

The apparent growth rate of the Haitian population between 1971 and 1982 was estimated at about 14 per 1000 (14.0 with the arithmetic formula and 14.2 with the geometric formula). It is sometimes claimed that there has been an under-registration of population at the census, and that the growth rate must have been higher.

These two propositions must be distinguished: there certainly has been under-registration (all the censuses suffer from this defect), but this does not imply a higher population growth rate unless it is shown that the 1971 census fared better from the standpoint of coverage; there is no evidence that this is the case.

The apparent growth rate should be confronted with independent estimates of the birth, death and net emigration rates.

- (1) The crude birth rate was estimated at 39.8 per 1000 for the year preceding the 1971 census, and at 35.1 per 1000 by the 1971-1975 Multiround Demographic Survey (MDS). The most reliable source of data on fertility, the HFS, produces an estimate of 36.6 per 1000, confirming the estimate of 37 per 1000 made in 1976 by IHSI. We can base a reasonable estimate on the apparent decline from the level of 39.8 per 1000 in 1970/1971* to 36.6 per 1000 in 1975/1976 (the middle of the reference period for HFS estimates); the average decline would thus be a little over 0.6 per thousand per year. If one assumes that the decline has continued at the same pace through the 1976/1982 period, the average crude birth rate for 1971/1982 come out to be 36.0 per 1000. In any event this must have been the level in the middle of the intercensal period (in 1976/1977) and thus, can be used as the average level whatever the trend is supposed to have been.
- (2) There is no evidence of a mortality decline during the intercensal period. The crude death rate was estimated at 16.5 per 1000 in 1970/1971 (from census data, by the Brass method) and at 16.2 per 1000 by the MDS. The IHSI has estimated it at 17.3 per 1000 at the middle of the intercensal period, using new HFS data on infant and child mortality. However, this estimate uses data from the MDS for mortality after age 5, while there might have been a decline in adult and adolescent mortality between 1971 and 1977. To be on the safe side, it will be better to use an average rate of 16.5 per thousand.

* In order to stay in line with census periodicity, periods going from September of one year to August of the next are used here.

- (3) The magnitude of net emigration is obviously difficult to assess. The rate was estimated at 4 per 1000 by the MDS, at a time when the flow of migrants was not at its peak. Over the 1971/1982 period, a widely accepted estimate is 20,000 to 25,000 persons per year on the average, which implies an average rate of 4 to 5 per 1000 (4.5 per thousand is used here).
- (4) In the end, the growth rate and its components may have been, on the average during 1971/1982:

Crude Birth Rate	36	per 1000
Crude Death Rate	16.5	"
Rate of Natural Increase	19.5	"
Net Emigration Rate	4.5	"
Rate of Population Growth	15	"

The question of population size remains open. Unfortunately, no scientific estimate of the magnitude of under-registration at censuses is available. The above estimate only suggests that the 1982 census as compared to that of 1971, has had a 1 percent higher rate of under-registration. Since partial evidence (such as comparison with a FADH household count) suggests that the 1971 census was of reasonably good quality, and based upon informed judgment by resident experts, the rate of under-registration may be assumed to have been 5 percent in 1971 and 6 percent in 1982.

IMPROVING THE QUALITY AND QUANTITY
OF
FAMILY PLANNING SERVICES
-
HAITI

October 2 - November 2, 1983

Dr. J. LeComte

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BACKGROUND TO SERVICES DELIVERY

ANNEX I - IV

Jean LeComte, M.D.

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ANNEX I

Supervision Programming

Considering the norm-setting role of the DHF, the main purpose of the supervision carried out by the Division is the technical and administrative management and supervision of people in positions of responsibility at the regional, district and sub-district levels in order to enable them to implement the program according to the norms, which guarantees its public acceptance.

The supervision program provides for specific supervision objectives for every type of program or activity:

-MCH

- Family Planning (FP) - Extend FP throughout all health regions
- Promote adherence to the FP norms
- Consolidate and extend voluntary female sterilization
- Promote voluntary male sterilization

-Protection of children

-Diarrhea/Breastfeeding

-Training of nursing staff

- Observe the work of every nursing staff member in accordance with his/her level of training.
- Identify pre-service and in-service training needs
- Obtain the necessary educational materials in case of such a need.
- Supervise MCH/FP activities at all levels

-Traditional midwives' program

- Check on its operation and plan for its extension.

The supervision team is multi-disciplinary and consists of 2 to 5 members chosen from among the DHF sections depending on the activities to be supervised. The members of this team are chosen from among the following sections/programs:

- MCH and feeding supplements for pregnant women
- Vaccination and oral rehydration
- FP and voluntary sterilization
- Community development
- Evaluation and research
- Operational research
- Administration and sub-sections
- MCH/FP-related nursing care
- Training
- Traditional midwives
- Armed Forces (FADH)
- Sale of contraceptives
- Food distribution

The supervision schedule calls for two steps:

1. Routine supervision from October 1983 through March 1984 at the rate of 21 trips in the districts of all regions.
2. Beginning in April 1984, selective supervision depending on the major problems encountered during the preceding period.

The schedule for the first period has already been established, with trip dates, places to be visited and the composition of the team. The duration of each supervision visit varies from 5 to 6 days so as to enable the supervision team to make an in-depth analysis of the entire set of problems that have arisen.

The achievement of the program envisages the following methodology:

1. Preparation

- Sending the supervision schedule to all Regional Directors and District Administrators;
- Letter to the Regional Director and District Administrators announcing the dates, purposes and composition of the supervision team.

2. In the field

- Meeting with the Regional Director/District Administrator and MCH/FP contact person, explanation of the purpose of the visit and establishment of a work schedule.
- Implementation of the schedule with the participation of all interested program heads.
- Travel in the field with the participation of the MCH/FP contact person.
- In every institution visited, the setting-up of a supervision record where all the observations and recommendations that must be addressed are entered: address particularly the party (parties) responsible for carrying them through successfully and set a time limit for putting them into effect.
- This record, which will be reviewed during every visit, will make it possible to follow the degree of implementation of the recommendations and therefore the improvement of the activities to the most peripheral level.
- Synthesis meeting with the Regional Director/District Administrator, MCH/FP contact person, a member of the regional staff concerned and a representative from each of the institutions visited. Explanation of the problems and performances, and notification of the recommendations in the regional/district record.

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ANNEX II

The Use of Contraceptive Prevalence in Programming/Supervision

1. Methodology

At the regional level, the overall objective set forth in terms of users must be reflected at the level of every health training group that is responsible for ensuring service to a given population. This step is necessary in order to make it possible, on one hand, to measure quantitatively the program's progress and, on the other hand, to evaluate the performance of each sector. To set realistic objectives in each sector, a series of criteria must be taken into consideration, such as:

- Eligible staff (health agents, community agents, certified/active midwives, volunteer collaborators, promoters, social work aides).
- Presence of a mobile unit.
- Trained staff and support structure for voluntary sterilization.
- Number of existing users.

After a period of 6 months to 1 year, this experience will make it possible to draw certain practical conclusions. If, for example, a sector is far from having achieved its objectives, a survey must be carried out by the MCH/FP contact person to identify the reasons for this and remedy them. (Are the objectives set too high? Lack of qualified personnel? Lack of informational, educational and motivational activity? Lack of supervision? Has stock of contraceptives run out? Was an incident concerning one or more acceptors?).

Where performance is very satisfactory, the MCH/FP contact person can pay particular attention to identifying the reasons why this is so and derive lessons that could eventually be applied elsewhere.

Number of Depo Provera Users

This is the total number of injections carried out in the sector, district, sub-district or region during the last three months. This figure is furnished by the institution(s) where Depo Provera is available.

Number of Vaginal Foam Users

As in the case of Depo Provera, it is the total number of tubes distributed in the sector, district or sub-district during the last three months. It is based on stock movement from the distribution points.

Number of Sterilizations

Add all tubal ligatures and vasectomies carried out in the sector, district, sub-district or region.

Number of Natural Method Users

This is the number of women who regularly practice this method. This figure can be obtained at institutions that supply this method, as well as the office of the Regional Director of "Action Familiale d'Haiti."

Contraceptive Prevalence

This figure represents the number of women who presently use a contraceptive method offered by the DSPP program (excluding the commercial sector). It is obtained by dividing the total number of users by the target population.

Graphic Notation

At the region, district and sub-district level, make a bar diagram representing the contraceptive prevalence by method and total.

Indicate the date and to the operation again every six months to measure changes over time.

3. Follow-up of the supervision program includes:

- A report from each member of the supervision team to be submitted to the Team Leader within 8 days.
- A synthesis of the supervision visit by the Team Leader to be submitted to the Head of the Evaluation/Research Section, who will inform the Director of the DHF, so that the necessary actions falling within the jurisdiction of the DHF can be taken.

After a period of six months, during which 21 visits of this type will have been made, the Evaluation and Research Section will draw up a global report of the routine supervision program, and depending on this report, draw up a specific supervision schedule.

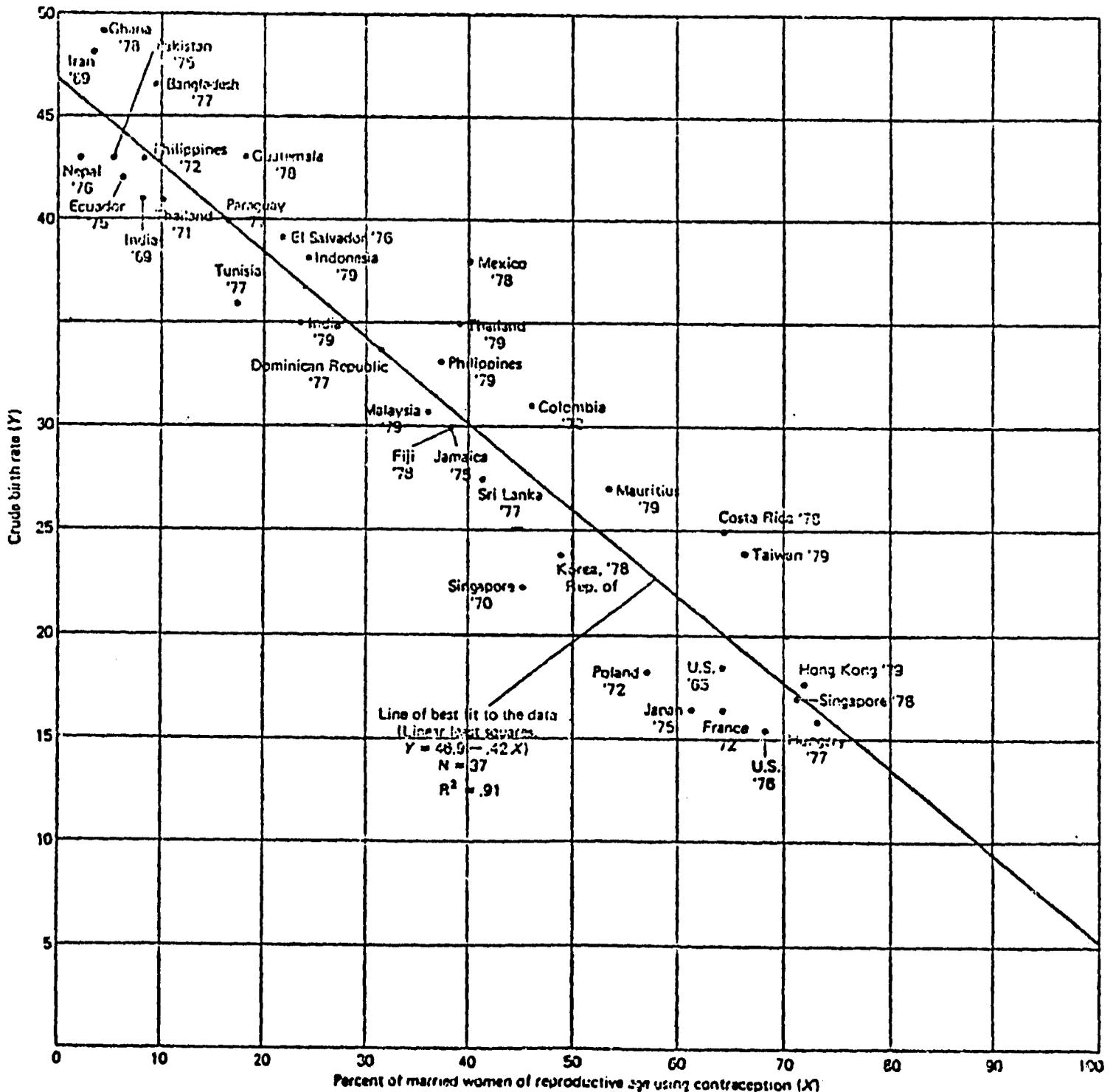
This report will include the following subjects:

- Number of visits planned and number actually carried out.
- Constraints.
- Major problems disclosed during the supervision and the solutions envisaged.
- Follow-up of the recommendations.

Apart from the supervision carried out by the multi-disciplinary DHF team, the daily monitoring of MCH/FP activities is also strengthened at the regional and district levels. Indeed, within the framework of regionalization, every region and district will be given a MCH/FP contact person (a doctor or nurse-hygienist) and a regional health educator responsible for supervising all activities related to their respective areas. The appointment of this staff was in progress while this mission was in Haiti.

This somewhat long explanation of the supervision program is worthwhile, because it demonstrates unambiguously the will of the DHF heads to strengthen this too long neglected activity.

FIGURE 4 Contraceptive prevalence rates among married women of reproductive age and crude birth rates one year later



As shown in Figure 4, the line of best fit to 37 points (32 countries, five with points at two time periods) relating the prevalence rate and the crude birth rate a year later sug-

gests that every 2.4 percentage point increase in contraceptive prevalence (X-axis) is associated with a one point decline in the birth rate (Y-axis). According to the regression relation, the CBR would

be 47 if no couples practiced contraception, and 5 if all couples did.

¹ The other important variables are marriage patterns, prevalence of induced abortion, prevalence and duration of lactation, and the age structure.

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ANNEX III

Description of the Functions of the Health Education Directorate

The function of the Directorate is to define the overall strategy and norms of the health education program, train and supervise the peripheral level in the organization and implementation of the program, coordinate and supervise all public and private sector health education activities, orient and train present health education staff, promote the teaching of health education in medical and para-medical training schools, produce and distribute educational support materials and define and experiment with new community participation approaches in education for health.

The function of the Coordinating Committee, composed of a member from each section and directorate of the DSPP carrying out health education activities, is to determine the content at the national level of the health education program, identify studies and research to undertake, participate in program evaluation and determine the sources of funding for each activity, as well as the methods of financial participation for each division.

The Administrative Section is responsible for the budget, expenses, staff, supply and transportation.

The Medical and Para-Medical Training Section, in collaboration with the Nursing Division of the DSPP and the Medical School, identifies the needs and changes that must necessarily be made in curricula to introduce within them elements of education for health. This Section evaluates the technical and pedagogical capacities of the professors and organizes their training, evaluates staff on the job training needs and organizes in-service training, and defines a strategy for further training and its method of application.

The Strategy and Evaluation Section defines and experiments with different approaches to stimulate community participation in education for health, conducts audio-visual perception surveys, establishes contacts with other sectors and organizations concerned with education for health problems, ensures that the staff is informed and keeps it up-to-date on innovations, disseminates laws, manuals, norms, etc. in the area of the giving and administration of services, organizes a documentation office for the DSPP and analyses and evaluates the information.

The Mass Communication Section trains and supervises the peripheral level in the organization of radio programming, plans television activities, organizes educational cinema programs at the national level, organizes journalistic activities and supervises all communication activities concerning the mass media.

The Education in Communication Department organizes all training activities in the area of education for health, trains and supervises the peripheral structures in the organization of direct communication, the education of school and out-of-school groups and supplies adequate materials and supervises all education activities for direct communication.

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The purpose of the Production Section is the design, production, determination of use and distribution of all DSPP educational materials.

Budgetary Estimates - Directorate of Health Education
1983-1984

Staff	-
Office Supplies	11,468
Operation (electricity)	14,600
Equipment (central level)	48,275
Equipment (peripheral level)	25,546
Preparation of norms	11,750
Scientific Information	16,000
Brochures	35,750
Booklets	40,000
Posters	45,000
Radio	28,000
Slides	7,600
Films	3,200
Puericulture	10,500
Newspapers	3,000
Training	18,828
Orientation of peripheral staff	4,200
Training and Supervision	11,760
Total	<u>335,477</u>

ANNEX IV

On-the-Job Training

It was not possible for the members of this team to obtain an exhaustive list of all the in-service training seminars and training activities that were carried out within the framework of the project.

A very incomplete list from the DHF is given here for illustrative purposes.

List of seminars carried out in 1981 and 1982

Joint DSPP-DIRP seminar (DIRP - Information and public relations)

Duration: November 16-20, 1981

Number of participants: 40: 27 from the provinces, 13 from the capital

Seminar: Training of Trainers

Duration: October 12-23, 1981

Number of participants: 13

Population Seminar (Battelle)

Duration: April 6-10, 1981

Participants: 50

Supervision workshop

Duration: December 16-18, 1981

Joint DSPP-DHF seminar

Duration: April 10-23, 1982

Participants: 73

Workshop for obstetricians and head nurses of maternity hospitals

Duration: December 6-10, 1982

Participants: 35

In-service training for supervisors and community agents of Port-de-Paix, Gonaives, Hinche

Duration: March 1-5, 1982

MCH/FP orientation seminar for doctors, nurses and auxiliaries working in rural areas

Duration: November 9-13, 1981

In-service training seminar on MCH for school teachers, nurses and auxiliaries with a view to integrating FP into para-medical instruction

Duration: March 8-9, 1982

Participants: 11

In addition, other seminars were organized by ministries and private organizations without the financial participation of the project. The organizers invited DHF staff to orient the participants on FP. Thus, FP was represented during the following seminars:

- Heads of the Community Integrated Nutrition and Education Centers (CARE).
- School teachers and inspectors (National Pedagogical Institute)
- Three seminars for AOPS
- Seminar for social work aides (Department of Social Affairs).
- Seminar organized by Protestants

During field visits, the team learned of other seminars that were either carried out or envisaged for the near future, or even noted their existence with their own eyes.

Thus, in Cap-Haitien, the regional nurse organized four seminars in 1983:

- 1 for midwives on MCH/FP
- 3 for doctors, nurses, auxiliaries and health officers on oral rehydration
- 1 planned for ONAAC staff at the end of October on FP.

In addition, other seminars were organized in the districts and sub-districts without the mission's being able to obtain further information. The North Regional Chief of the FADH Health Service participated in FP training organized by the regional office, as well as another in Port-au-Prince, and all the section chiefs completed an orientation session organized by the North Regional Office.

In Les Cayes, during the mission's visit, a seminar on FP was being held for about twenty ONAAC agents in order to initiate them into the sensitization, motivation and re-supply of contraceptive users.

On the other hand, the mission was also able to detect some gaps. In Cap-Haitien, the mobile clinic nurse had never completed in-service training in FP since she left school two years before, and the last time that the auxiliary had completed an in-service seminar was three or four years before in Port-au-Prince.