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PROJECT EVALUATION

URBAN HEALTH AND COMMUNITY DEVELOPMENT II (521-0159) EXTENDED COMMUNITY HEALTH AND FAMILY PLANNING (521-0181) AND COMMUNITY HEALTH OUTREACH (521-0169)

HAITI, APRIL 1986

Report Prepared by PRITECH Consultants: Polly F. Harrison, Ph.D. Catherine Overholt, Ph.D. Maggie Huff, M.B.A.

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LIST OF ACRONYMS

ADIGCOM	Association pour le Développement Integré de Grand Goave et de Grande Colline
AEDC	Alliance pour l'Enfance et le Developpement Communautaire
AMOSSE	Association Mixte des Oeuvres de Santé du Sud-Est
AOPS	Association des Oeuvres Privées de Santé
CA	Cooperative Agreement
CHAPI	Centre de Santé Haitiano-Arabe Plan Internacional
CMSCS	Complexe Medico-Social de la Cité Soleil (Simone)
CODEVA	Coude à Coude Develloppement de la Vallée
CODIPP	Cooperation pour le Développement Integré et la Promotion Paysanne
DA	Development Account (also called Dollar Account)
ECH	Eye Care Haiti
FHASE	Fondation Haitienne de la Santé et de l'Education
HAC	Haitian-Arab Center
IAF	Inter-American Foundation
MSPP	Ministère de Santé Publique et de Population
NGO	Non-Governmental Organization
00	Oral Contraceptive
PACT	Private Agencies Collaborating Together
PIP	Plan International de Parrainage (Foster Parents' Plan)
VIP	Ventures in People

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EXECUTIVE SUMMARY

The purpose of this evaluation was to review three private sector health projects, the Social-Medical Complex of Cite Soleil (CMSCS) and two projects (AOPS I and II) of the umbrella organization, AOPS (Association des Oeuvres Privees de Sante). Its objective was to analyze issues of importance and interest: 1) to the project, in order to determine strengths and weaknesses and suggest appropriate modifications and future directions, and 2) to USAID/ Haiti, with a view to designing and adapting a new generation of PHC projects to closely address goals and strategies set forth in the USAID/Haiti Action Plan, and to amend the Action Plan if appropriate. The evaluation was also to appraise project performance to date, identify lessons learned from implementation, and determine appropriate technical and organizational elements for extended health and family planning activities in Haiti. Subject areas of particular interest were program management and administration, financial management, and technical results and concerns. Sites assessed included the Complexe Medico-Social Cite Soleil and eight AOPS sites chosen to be representative in terms of size, management approach, jeographic distribution, and relative success or failure in program implementation.

Both AOPS and Cité Soleil should be considered successful projects. Both are fully compatible with the USAID/Haiti Action Plan, to a degree that suggests that the Plan itself is well rooted in the possibilities in Haiti for private sector health delivery and for public/private-sector coordination and collaboration.

The CMSCS is a PVO in a massive urban slum in Port-au-Prince, which is charged with: expanding and improving primary health care services and conducting operations research to determine cost-effective interventions for mortality and morbidity reduction; strengthening effectiveness of human resource development activities, particularly remedial education, vocational training, and job placement for adults and adolescents; increasing its own self-financing capability; and improving its own institutional management capacity. It began receiving AID funding in 1980 with a four-year grant of US\$1.243 million.

AOPS is charged with expansion of coverage of health services provided by indigenous and international PVOs, by helping finance costs of design, implementation, and evaluation of comprehensive community health and family planning outreach activities to be carried out by a selected group of those institutions. Its role comprises the promotion of collaboration and coordination within the private sector and between the private and public sectors, in accordance with national health priorities; provision of technical assistance and training for community health personnel; and development of the information system which lies at the heart of an innovative outreach strategy which has come to be called "the AOPS model." The key elements of the model are:

- 1) Focus on infants, children, and mothers
- 2) Emphasis on a limited set of priority interventions
- 3) Total registration and longitudinal data collection in a defined population (ranging from 10,000 to 50,000 people) with identification and followup priority groups

- 4) The rally post, organized around the growth monitoring intervention and immunization
- 5) Ongoing monitoring of coverage and impact and follow-up of highest-risk groups
- 6) A standard, basic service delivery plan.

As the project has evolved, there is a growing feeling that there are two other distinguishing features that could become standard model components:

- 7) Active involvement of the community of mothers, and
- 8) Performance-based or results-oriented incentives for outreach workers.

AOPS was perceived and implemented as a nationwide enterprise and should not be seen as a pilot project. However, it may usefully be considered a large operations research project which has been phased and flexibly funded (US\$716,000 over the last three years) to permit rollover of lessons learned into successive funding. The questions it asked were: 1) can a PHC outreach program of the sort historically associated with the public sector, be institutionalized in the private sector? 2) can the model, once re-designed for greater effectiveness and coverage, then be replicated in the public sector?, 3) does the new model in fact increase coverage and, if so, is there measurable impact in terms of mortality and morbidity reduction and decreased fertility; and 4) can private institutions find viable ways of meeting the recurrent costs of PHC outreach?

AOPS is ahead of targets in terms of number of project sites (25 projects now active) and population covered (352,264 against an EOP goal of 500,000). It has fulfilled all the criteria and process steps stipulated in the Cooperative Agreement for the project selection process, and orientation phase, training and continuing education, program operation, and supervision. It is following appropriate financial management and accounting procedures; providing technical assistance through field visits, seminars, and a newsletter; and facilitating private and public sector linkages. A number of research activities are beginning to provide data and operational guidance. A monitoring and evaluation system is in place for all projects, but needs simplification, quality control, and refresher training for all participants.

A tally was done of all AOPS projects to look at quality of performance, population coverage, age, and institutional sponsorship. The results were: four projects which covered 43 percent of the total population were evaluated "exemplary"; five projects, with a coverage of 24 percent, were ranked as "good performance with minimal functional problems"; three small projects which covered 8 percent of the population were currently in operation but with moderate problems; and seven projects with a coverage of 22 percent of the total were diagnosed as having structural and functional problems but worth saving. Thus, of 20 projects given an evaluative classification, nine are functioning comfortably and effectively, and another three are functioning with relatively few problems; these twelve projects cover 237,000 people, or 75 percent of the total population covered by all the AOPS projects.

Although the data are uneven, it appears that in the AOPS projects that are functioning fairly well, there have been dramatic increases in coverage, all

well above national 1983 levels. Pignon, for example, went from 21, 14, 43, and 1 percent coverage for DPT, polio, BCG, and measles, respectively, to 73, 65, 95, and 64 percent as of March 1986. In Cité Soleil, coverage for three doses of DPT and polio rose from 37 and 27 percent in 1983, to 56 and 50 percent, respectively, in 1985; measles was introduced in 1983 and stood at 54 percent in 1985. In the few projects where data were available for tetanus toxoid immunization, rates ranged from 25 to 50 percent coverage of pregnant women identified: in Cité Soleil, the 1985 coverage rate was 65 percent.

Family planning is doing less well, partly due to ideological resistance in individual institutions, partly to inadequate training at all health worker levels. There is, however, evidence that the project can produce effects: Pignon has a contraceptive prevalence rate of 31 percent, Mirebalais 11 percent, Marigot 9, and Cayes-Jacmel 8, all above the 1983 national average of 7 percent.

ORT also needs a push, in the AOPS projects as well as nationally. The data available in Mirebalais show increases in mothers' knowledge or ORT associated with drops in infant mortality. In Cité Soleil, where ORT promotion has been a constant program element, 90 percent of mothers knew about ORT and 77 percent had used it for their child's most recent diarrheal episode; 12 percent of all packets of ORS sold in Haiti are sold in Cité Soleil.

The package of growth monitoring and nutrition education is about to be a focus of operational research for both AOPS and Cité Soleil, because of doubts about these interventions as they are being implemented in most sites. Nevertheless, the few data that are available suggest that the intervention has impact potential. In Belle Anse, children with regular attendance at rally posts showed better growth than those with less frequent attendance: the numbers of registered children in Gomez II and III fell, and the percentage of children showing weight gain rose from 59 percent at the 7th rally cycle to 77 percent at the 13th cycle and the percentage showing weight loss dropped from 21 to 15 percent.

In sum, the AOPS projects show both that real improvements can be produced by the model in the areas of family planning, ORT, and growth monitoring/nutrition education and can very quickly surpass national achievement and status levels in those areas, but that only a few of the projects are now realizing this potential.

Cite Soleil is also on track with the large majority of its contractual commitments. It has achieved its targeted coverage, and, at the same time, it is showing steady gain in the number and quality of its preventive and curative services. As one example, the average number of prenatal visits at CMSCS facilities has risen to five; the WHO norm is three. It is making adjustments in an area of primary concern to this evaluation, the ability of the Complex to cope with its greatly increased complexity, size, and comprehensiveness; the evaluation makes some qualitative recommendations about these adjustments.

In another area of concern, the financing of the project, the CMSCS has broadened its revenue base through a combination of patient fees, product sales, and school fees. Average monthly revenues from outpatient and prescription fees increased by 21.5 percent over the previous year and, although costs also increased, revenues grew at a higher rate and contribute directly to the operating costs of centers. The evaluation makes recommendations about possible additional sources of savings and income, including fundraising, an area where the Complex is resuming efforts that had become stalled.

Finally, the CMSCS is vigorously engaged in a number of research projects. The most important research areas to date have been family planning, immunization, and maternal health. While there is no research strategy as such, a research and evaluation unit has been set up and all the research so far has either already been useful programmatically or promises to be so. The largest important gap, where this evaluation recommends that systematic work be undertaken, is in the area of alternative financing solutions and service costs.

Similarly, there is no explicit operations research strategy in AOPS but, again, the ongoing work appears promising for program purposes, particularly in the area of task allocation for health workers. The evaluation recommends that priority be given to systematic research on incentives for community health workers.

In terms of institutionalization and sustainability, the AOPS and Cité Soleil projects are restructuring the way health care is thought about and done in Haiti. Not only have the projects permitted experimental feedback into the public sector, but they have produced structural changes in the AOPS grantee institutions, and have elevated consciousness about provider accountability. At the heart of sustainability, in the AOPS philosophy, is the creation not only of an outreach infrastructure, but of a community of knowledge which will, in its turn, generate a critical mass of demand that will endure even if the money stops. The evaluation supports AOPS' intention to redouble its energies for the balance of AOPS II, supported by technical input from AOPS III, in the area of empowerment for mothers, that is, giving them the knowledge and tools to take charge of their children's health in a variety of ways. The possibilities for empowerment, as well as savings in financial and human resources, will be enhanced by limiting efforts to an even smaller group of priority interventions and information cores.

Costs are an issue both for sustainability and replicability. A major cost issue for AOPS has centered on the role of the doctor as technical leader and manager of each project and the associated costs of that presence. The evaluation team was concerned about the impact of doctor turnover and has recommended improved pre-training screening to reduce this liability. Another costrelated issue derives from CHW demands or hopes for cash incentives or salaries. The solution to this is likely to be found in the development of incentive systems that are performance- or results-based, and in prioritizing and refining CHW role content.

Other replicability issues are those of project size and appropriateness for public sector adaptation. The team's conclusion was that this is an area where further cost data, not available at the time of the evaluation, will be required to make a determination on the most cost-effective program size. With regard to public-sector appropriateness, the team concluded that there was no reason implicit in the AOPS model or any of its components, per se, why the public sector could not implement that model, except that it has historically done so only erratically. Other models tried in Haiti have had their experience with unsuccess, not only in terms of continuance, but in terms of impact. The AOPS model has, like its ancestors in Petit Goave and Deschappelles, displayed staying power, albeit in a short lifetime, and has also displayed in a shcrt lifetime some real capacity for impact, effectiveness, and the flexibility to adapt. If the MSPP is willing to participate in a rational division of labor with the private sector, it could conceivably afford to implement even a doctor-centered, vehicle-dependent model in a smaller geographical area. The cost-effectiveness analysis would be necessary to appraise what seems on its face to be a high-cost model in the light of cost per unit of impact, lay outside the purview of this evaluation.

The principal recommendations of the evaluation to both AOPS and Cite Soleil are that both need to strengthen different dimensions of their management capacity, as well as the agility, responsiveness, and accessibility of their monitoring and evaluation systems. The latter is particularly crucial for AOPS, since that system is the spinal column of its activist outreach orientation. AOPS could profit from more cross-fertilization among grantees and more coordination and collaboration with the public sector. In the area of financial management and planning, AOPs needs to know more about its program costs, particularly with regard to project size, worker task load, and expectations in terms of time to achieve expected results. Its larger grantees need to do program budgeting and improve financial control mechanisms.

Cite Soleil should assure itself a solid financial base before it launches into new endeavors. While it strives to accomplish self-reliant objectives, it will continue to need the full support of its current donors for at least the next five years. AID should not precipitously withdraw support, but should undertake a gradual, planned phaseout over the course of a few years while the Complex is, simultaneously, acquiring new revenue sources, overhauling and strengthening its financial management and information systems, and attending to the needs of an ever-growing and volatile urban population.

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PROJECT EVALUATION URBAN HEALTH AND COMMUNITY DEVELOPMENT II (521-0159) EXTENDED COMMUNITY HEALTH AND FAMILY PLANNING (521-0181) COMMUNITY HEALTH OUTREACH (521-0169)

I. INTRODUCTION

A. SCOPE OF WORK *

1. <u>Purpose</u>

The purpose of this evaluation was to review three private sector health projects: Urban Health and Community Development II (521-0159), Community Health Outreach/AOPS (521-0169), and Extended Community Health and Family Planning/AOPS(521-0181). The evaluation was to analyze issues of importance and interest:

- o To the project, in order to determine strengths and weaknesses and suggest appropriate modifications and future directions, and
- o To USAID/Haiti, with a view to designing and adapting a new generation of PHO projects to closely address goals and strategies set forth in the USAID/Haiti Action Plan, and to amend the Action Plan if appropriate.

The evaluation was also to appraise project performance to date, identify lessons learned from implementation, and determine appropriate technical and organizational elements for extended health and family planning activities in Haiti. Its focus was directed toward the following major issues, which we have used as the topic headings for this Evaluation Report.

- Progress in meeting project objectives.
- Achievement of anticipated project outputs.
- o Relationship of project activities to the USAID/Haiti Action Plan.
- o Program management and administration.
- o Financial management
- o Technical results and concerns.

2. Project Team: Composition and Responsibilities

The evaluation team was composed of:

o A Health Education/Community Development Program Analyst/Team Leader (Polly Harrison, Ph.D.). This individual was asked to examine technical issues related to training (health and other), health education strategies, community participation, and the effectiveness and appropriateness

^{*} The Scope of Work is presented in its entirety as Appendix A.

of outreach strategies, as well as to examine the effectiveness of the rally post strategy and the evolution of this outreach system, including its effect on demand for services. She was also to review research activities conducted under the projects and determine their appropriateness, relevance, adequacy, and quality, and suggest future operations research in response to technical concerns and recommendations.

- o Financial Management and Administration Consultant (Maggie Huff, M.B.A.). This individual was to be primarily responsible for addressing issues of program and financial management and administration, to examine issues related to program sustainability and replicability, and to cover but not be limited to, the following: 1) review systems used by recipients and subgrantees to assure accurate accounting, reporting, and recordkeeping for the use of project resources; 2) assess adequacy of financial monitoring and supervision of subgrantees; and 3) analyze appropriateness of project resources allocation and frequent budget adjustments.
- o Economist (Catherine Overholt, Ph.D.). This individual was, to the extent possible, to address the issues of cost-effectiveness, sustainability, and replicability. She was also to assess income-generating capability and activities of implementing institutions, e.g., user fees, including their effect on the projects, service utilization, and the relationship to Action Plan sector objectives dealing with financial issues. Particular attention was to be paid to levels of recurrent costs.
- o Primary Health Care Specialist (Serge Pintro, M.D., M.P.H.). This individual was charged with the responsibilities for general assessment of the quality and quantity of specific project interventions, including: nutrition/growth monitoring, ORT promotion, vaccination coverage, TB treatment, family planning services, and referral systems. He was also to provide guidance for further study of these activities.

The team members, while each addressing specific issues, were required to work in a highly collaborative manner, and the final evaluation report was to integrate and demonstrate linkages between overlapping issues. The present report has been so organized and integrated.

3. Methodology

The evaluation procedure was quite straightforward and included the usual reviews of background documentation and available data; interviews with staff of the implementation agencies/organizations associated with the projects and with USAID personnel; and site visits to a sample of eight subgrantee implementing institutions. The latter included interviews with clients as well as providers; client interviews also entailed some informal testing of mother knowledge.

The projects selected for the AOPS site visits were chosen to be representative in terms of size, management approach, geographic distribution, and relative success (or failure) of program implementation. There were four small programs (10,000 people covered: Duplessis, La Vallée, Cayes-Jacmel, Carrefour-Poy), two intermediate programs (25-30,000 people: Belle Anse, FHASE), and two large programs (50,000 people: Mirebalais, Pignon). There were groups which represented small PVOs (e.g., Carrefour-Poy), large PVOs (Eye Care, FHASE), grass roots community organizations (CODEVA, Duplessis), and missionary groups (Pignon).

Project selection frankly addressed projects which had had or were having operational difficulties, so that these could be analyzed against a background of what apparent success looked like: for example, the CODEVA project at La Vallée had experienced prolonged work stoppage; Duplessis and Carrefour-Poy had had continuous performance but major problems; the FHASE project at Freres and the AMOSSE/La Montagne project had had continuous performance, but were experiencing some problems. And finally, there were the frame-of-reference projects which have had relatively smooth sailing despite intermittent operational difficulties (Mirebalais, Pignon, and Belle Anse).

a. Site Descriptions

AOPS provided the team with brief preliminary descriptions of the sites to be visited, with the reason for selection. These reasons were kept very much in mind during each site visit and, in fact, provided substantial food for thought for the evaluators.

1) Carrefour-Poy

1.1 Description

This is a government-owned health center which, because of massive under-utilization, was turned over to a private group. Under the terms of the agreement, the group was to assume all operating costs for the center, including staff salaries, supplies, etc. In a short period of time after the center reopened, attendance at the curative clinic improved tremendously. Eventually, the group approached AOPS for a grant to undertake a community health program.

1.2 Reason for selection

This is an example of a possible model for private-public sector interaction. It is of interest to know how this formula is working and how services are being financed. In addition, the group has experienced considerable management problems in launching the community health program. It will be interesting to have a better understanding of why these problems occurred and how they could have been avoided.

2) Mirebalais

2.1 Description

The Mirebalais area community health program (MARCH) is a subdivision of Eye Care Haiti, an indigenous PVO with a nationwide eye health program. Activities began in the summer of 1983 and the program is not yet three years old. Initial support for the program came from the Inter-American Foundation, Ventures in People, and Eye Care. The program started with a registered population of 20,000 which quickly grew to 30,000. MARCH applied for a \$20,000 AOPS grant for program expansion to 50,000 people, the total now being served.

2.2 Reason for selection

This exemplifies a local health program by a nationwide PVO with a specialized focus (eye health). The program is managed locally but receives some degree of central support. A viable approach for the extension of health service coverage in Haiti could be for PVOs not otherwise engaged in primary health care, but with an existing outreach infrastructure, to add selected services to their program (such as ORT, immunization, growth monitoring). It will be useful to know whether this is a realistic alternative and whether the marginal cost of adding these new activities is affordable. In addition, MARCH represents one of the few programs which has expanded to 50,000 persons. MARCH has also made a serious attempt to gather data to evaluate the impact of its program.

3) Pignon

3.1 Description

The Bienfaisance Hospital in Pignon was started by Dr. Theodore, a USAF colonel who returned to his native village. Pignon has received two grants from AOPS, one to set up a program for 10,000 persons, the other to expand it to 50,000 persons. The program now covers two areas: Pignon and St. Raphael.

3.2 Reason for selection

This site was selected for several reasons:

- o The St. Raphael center is a government health center with MOH staff which has been integrated into a private program. It differs from Carrefour-Poy in that the MOH is still paying salaries and some operating costs. The problems attendant to this arrangement could be explored.
- o It is a hospital-based community health program. What is the basis for allocating resources to community health as opposed to curative hospital services?
 - While, like MARCH, it covers 50,000 people, it has totally different management implications.
 - 4) Belle Anse

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4.1 Description

Belle Anse is an isolated coastal town which, until the advent of the AOPS project, had no medical staff and only two children out of a population of 40,000 had been vaccinated. The program has received two grants from AOPS, one to cover the initial 10,000 people, the other for program extension to 22,000.

4.2 Reasons for selection

Belle Anse represents a program where everything started from scratch. At the other sites, some type of health service delivery unit had existed in the past. Therefore, the program provides an illustration of what can be accomplished in totally virgin areas. In addition, the Belle Anse staff spent a significant

amount of time evaluating the growth monitoring component of their project. This is an area which is of particular importance to all the other projects. Finally, a visit to Belle Anse illustrates the types of logistics problems AOPS faces in providing assistance to institutions scattered throughout the country.

5) La Vallée

5.1 Description

The program in La Vallée was one of the original programs funded by AOPS (June 1983). The program is run by a community group called CODEVA and is one of the very few such programs within AOPS where the people in charge are representatives of a grass roots community organization.

5.2 Reasons for selection

The program has experienced severe difficulties in setting itself up and maintaining itself. These difficulties threatened the very existence of the project which, in fact, stopped all activities for over a year. Activities have since resumed. A visit to La Vallée will allow evaluators to pursue a number of issues, particularly issues pertaining to management and technical staff conflicts, AOPS assistance, recurrent costs, community participation, etc.

6) Cayes-Jacmel

6.1 Description

The Cayes-Jacmel center is a MOH-operated center receiving support from two private groups in Jacmel: Eye Care Haiti and Foster Parents' Plan. The program covers 10,000 people.

6.2 Reasons for selection

This illustrates another formula for private-public sector cooperation with a very unique, results-oriented incentive program. It will be of interest to know whether the formula works and whether it is replicable.

7) Duplessis

7.1 Description

The Duplessis program, which covers 10,000 people, is also run by a grass roots community group. Management-technical staff problems there have not been as acute as in La Vallée but the project has experienced implementation problems.

7.2 Reasons for selection

In contrast to La Vallée, the Duplessis project never stopped activities. Significant shortfalls in the project discovered by AOPS staff are in the process of being corrected. This is an example of a community group with limited resources attempting to ensure that key services are available to its members. The question of how they have maintained their activities since AOPS support ceased is relevant here.

8) FHASE

8.1 Description

This is a peri-urban program run by a foundation which receives the bulk of its support from well-to-do Haitians. The project has received two grants from AOPS, one to cover 10,000 people, the other to expand to 30,000 people.

The principal purpose of the foundation is to build a state-of-the-art modern hospital. Currently, only outpatient services are being provided.

8.2 Reasons for selection

Management for this project is quite different from all the others in terms of orientation, philosophy, and methods. In addition, this is the only peri-urban program sponsored by AOPS. Finally, this project represents the group of inter-mediate institutions slated to expand from 10,000 to 25,000 persons.

9) Cite Soleil

Cité Soleil, the site of the Urban Health and Community Development II Project (521-0159), was dealt with independently and the team spent a total of six working days in that site in interviews, observation of service delivery, document review, and records analysis.

B. SUBJECT PROJECTS

1. Urban Health and Community Development II (521-0159)

The Social Medical Complex of Cité Soleil * (CMSCS) is a Haitian-based PVO which has the goal of improving the health, social, and economic status of 100,000 residents in Cité Soleil, an urban slum in Port-au-Prince. This fiveyear project began in May 1984 and has LOP funding of US\$2.1 million. The purpose of the project is to strengthen the Complex's overall health and community development programs by:

- Expanding and improving primary health care services and conducting operations research to determine cost-effective interventions for further reductions in mortality and morbidity.
- Strengthening the effectiveness of human resource development activities, particularly remedial education, vocational training, and job placement for adults and adolescents.
- Significantly increasing the self-financing capability of the Complex through revisions in user fees, improved fundraising, marketing of CMSCS products, and establishing a manufacturing enterprise that will allocate part of its profits to direct support of CMSCS.

^{*} Prior to the fall of the Duvalier regime, this area was called Cite Simone, named after Jean-Claude's mother.

o Improving the institutional management capacity of the CMSCS with the assistance of a computerized program-based budgeting and planning system.

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

Initial settlement in the Cite Soleil area began in 1958 with the construction of homes for 52 families. The first major influx occurred in the summer of 1966, when a fire destroyed much of the <u>La Saline</u> district near the port and many of its victims settled in the Cite Soleil neighborhood now known as "Brooklyn." Following this fire, there began more or less continual migration.

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

1983 Cité Soleil Census					
Zone	<u>Neighborhood</u>	Population			
Boston	Boston PSC Pėlė Trois Bėbės Subtotal:	23,905 6,935 <u>10,982</u> 41,822			
Brooklyn	Brooklyn Wharf Linthau Subtotal:	17,978 2,685 <u>5,030</u> 25,503			
Cite Jean-Claude	Cité Jean-Claude IIIéme Cité Simone Cité Bennett Unclassified Subrotal: Grand Total:	2,645 8,944 1,310 <u>1,967</u> <u>14,866</u> 82,191			

Subsequent census work indicates that the 82,000 figure is a substantial undercount. The operative figure has been 100,000, but current estimates and ample evidence of increasing migration suggest that 120,000 is more realistic.

a. Project Background

In 1974 the Haitian-Arab Health Center was established by Dr. Carlo Boulos to serve the 7,000 students of the schools operated by the Salesian Fathers. Shortly thereafter, the Center decided to expand its services and, in 1975, the Sisters of Charity of St. Vincent de Paul were invited in by the Salesian Fathers on behalf of Dr. Boulos to administer the growing program. The program incorporated existing services, including those supported by Foster Parents' Plan, and added new ones between 1974 and 1979: pediatric services for the preschool population, prenatal and postpartum care, nutrition and other health prevention and education services, and home economics demonstration centers for women, financed by OXFAM. Hospital care during this time was provided by institutions in other parts of the city and residents of Cite Soleil were at times turned away for lack of space. By 1979 it had become obvious that a facility was needed to provide acute care for clients referred by the other centers, emergency care, safe deliveries, and other medical services not provided by the two preventive health clinics in Boston and Brooklyn or the original clinic (CHAPI) which serves as a secondary level of health care backup for the other clinics. By 1981 a 70-bed hospital was constructed, with a major part of its operations supported by USAID. In addition to inpatient care and ambulatory services, it houses the training program for traditional midwives, using them in the delivery room as part of on-the-job training. To complement the clinic and hospital-based services, a corps of health collaborators was developed through the years, which now includes over 100 volunteers who conduct education and outreach activities. The CMSCS has just asked AID for support for more volunteers to respond to the real and expanding size of its target population.

In addition to the day-to-day administration of the health service program, one of the major accomplishments of the Sisters has been the development of the social and education component of the Complex between 1977 and 1981. This includes: a remedial education program for adolescents; adult literacy; elementary skills training in industrial arts and handic afts for young people; home economics, basic skills in a variety of technical areas, and handicrafts for mothers and male heads of households; marketing and sales of some products for the direct benefit of the participants in the training programs; job placement; and organized recreation, sports, and cultural events for children and youth.

Furthermore, the Sisters have contributed significantly to the ability of the Complex to transform modest facilities into adequate health and social service centers, to construct new facilities, and to provide maintenance of existing ones, by seeking out funds from diverse private and public organizations in Europe and the U.S. Facilities now include three health centers and the hospital; a cultural center, including large areas for training and cultural events; a library, school rooms, and a cafeteria; the nutrition recuperation center areas for training mothers and a cafeteria; ten homes converted into demonstration centers; a small building for the training of fathers (male heads of households); and an 3,000-square foot building to house the initial industrial activities envisioned by the Complex.

By name, the units incorporated by the Center are the following:

Centre Haitian-Arabe Centre Medico-Social de Brooklyn Centre Medico-Social de Boston Foyer Cultural de Boston Centre Hospitalier Ste. Catherine Labouré (70 beds) Centre de Formation des Pères Papa-Yo Centre de Formation des Mères Centre de Formation des Matronnes Centre de Distribution des Aliments 10 Foyers de Demostration Nutritionelle.

In the pursuit of its goals, the Complex has been able to engage the support of national organizations (the Ministries of Health and Social Welfare, the National Housing Office, and the Catholic Church) and of international organizations. The latter include: International Foster Parents' Plan, the Agency for International Development, OXFAM, SOSPG of Belgium, Josiah Macy Foundation, Appropriate Technology International, Misereor, Caritas, Catholic Relief Services, CARE, Church World Services, Friends of Children, the Rotary Club, and Cardinal Leger. The CMSCS also benefits from the support of many national and international independent private donors and from community support. In all but the newest squatter zones, there are well-organized and active community groups which interface with the CMSCS's outreach arms.

The Complex's fixed delivery sites are supplemented by the work of 100 Community Collaborators; thirty trained matrons; a food distribution program which supports the prenatal, nutrition, and TB-control efforts; and ten home demonstration projects. The Complex also serves as facilitator, as an entry point into the community, as a channel of communication, and as a fund-raiser.

USAID/Haiti's involvement with the Complex began in 1980 when it initiated a four-year grant of \$1,243,000 to support overall CMSCS program goals and operating expenses for various health, education, and vocational training programs and administration. AID's objectives in providing this OPG were to address the needs of the urban poor, to strengthen an indigenous private institution and to gather data and experience upon which to build future urban-oriented projects. The 1984 USAID PP notes that "during this four-year period, much has been learned and accomplished. CMSCS activities have had significant and measurable positive effects on the population; the health activities have significantly contributed to lower infant mortality rates; the social education and training components have grown and expanded." In sum, Cité Soleil benefits in turn from services and opportunities only rarely available in other urban slum neighborhoods.

Community Health Outreach (521-0169); AOPS I) and Extended Community Health and Family Planning (521-0181; AOPS II)

The purpose of the AOPS projects is to expand coverage of health services provided by indigenous and international private voluntary health institutions, by helping finance the costs of the design, implementation, and evaluation of comprehensive community health and family planning outreach activities to be carried out by a selected group of those institutions. The project supports the creation of catchment areas which would increase the total population covered by such services to 500,000 over the life of the project. In so doing, the project was to be consistent with the Haitian National Health Plan and was also to achieve several sub-purposes, including the following:

- o Promoting collaboration between the private and public health sectors in such a way that national priority goals are met.
- Promoting collaboration among private institutions to avoid duplication of services and wasted resources.
- o Involving private health institutions in the implementation of the National Health Plan, by coordinating their efforts with GOH/DSPP district and regional health authorities and by setting specific targets for the realization of the local plans.
- Expanding the AOPS data bank and assisting private institutions in selfevaluation.

The project was to also explore management issues involved in the provision of primary care services for large population segments as those related to questions of logistics, procurement of supplies, appropriate incentives for professional and paraprofessional health care providers, supervision, and private/public sector interaction.

Under the AOPS projects, AOPS is to provide financial and technical assistance to individual institutions to enable them to plan, administer, and implement community health and family planning outreach programs. Activities include:

- Identification of the at-risk population; child growth monitoring and nutrition counseling; prenatal care, including anti-tetanus toxoid immunization, physical examination, determination of risk status, and referral of complicated cases; provision of dietary supplements to high-risk groups as indicated; immunization of children and women of childbearing age; promotion of breastfeeding and oral rehydration therapy; detection and treatment of major endemic diseases; organization of family planning services, especially TB and malaria; and registration of vital events.
- Arrangement and provision of necessary training for community health personnel.
- o Development, use and refinement of registration, record, and information systems to facilitate program monitoring and evaluation.
- o Development and implementation of administrative and financial procedures which will ensure proper utilization and accounting for project funds, including quarterly activity and financial reports to USAID.

AOPS I officially began on 29 March 1983 with the signing of a Cooperative Agreement for a total estimated amount of \$280,000. AOPS II began in June 1984 as an extension to AOPS I, with additional LOP funding of \$436,000, which brings USAID support to the AOPS program to a total of \$716,000 over the past three years.

AOPS I was to provide this financial and technical assistance to 15 institutions with a total estimated population of 150,000. AOPS II was to expand AOPS activities and assist 22 private health institutions through the creation of five catchment areas of approximately 50,000 people each, one in the North, two in the Transverse Region, one in the West and one in the South, a total potential population of 300,000 people, as follows:

- o Six (6) existing AOPS institutional programs with registered populations of 10,000 people were to expand coverage to 25,000 each. The assumption was that these institutions had already acquired the expertise to successfully manage a Community Health Outreach Program and that their program expansion would involve no additional personnel needs with the exception of additional community volunteers.
- o Eleven (11) new institutions were to receive technical and financial assistance to implement a community health program targeted to 10,000 persons per institution. As such, each institution was expected to field a community health team made up of a physician, a nurse, a record-keeper and an appropriate number of community volunteers. This new group of eleven (11) institutions would contribute 110,000 new registrants to the program.
- o Five (5) institutions with unusual resources, such as external financial or technical support, superior logistics and management back-up, or other special characteristics, were to be enrolled to provide services to registered populations of at least 50,000 persons. There would be one such institution for each of Haiti's four regions, except for the Transverse Region where two will be located.

a. Project Background

For decades much of the health care available in Haiti, especially in rural areas, has been provided by NGOs, many of them supported by religious groups. More than 200 such programs have been identified. Usually serving a small geographic area, they are typically hospital or clinic-based, heavily curative in orientation, operated by a small staff of physicians and/or nurses, and, like the public sector, constrained by financial resources and limited in outreach. In 1982, these organizations operated 49 percent of the rural health facilities and accounted for an estimated 1.8 million outpatient visits (for an estimated population of 4 million persons). Most of these visits were for curative treatment, and service statistics revealed limited success in preventive services. For example, in the North Health District, with an estimated under-five population of 120,000 in 1982, service statistics from private institutions revealed that in 1982 a total of 10,636 doses of DPT, 1,615 doses of polio, 6,976 doses of BCG and no measles vaccines were administered. Less than one percent of the under-five children were being weighed monthly and ORT was rarely used. For an estimated 30,000 pregnant women, 696 prenatal visits were reported and less than six percent of eligible couples were using a modern method of contraception.

In this situation, many of the NGO physicians and nurses, as well as program directors, were painfully aware of the need for more effective efforts. Given their limited resources, however, and the constant demand for curative services at their facilities, they simply saw no way to do so. In spite of this, there were continued, if limited, efforts to connect the public and private systems, dating back to the 1960s, and the MSPP has provided some direct support since then, including certain drugs and vaccines and physicians and nurses who were secunded to the NGO health facilities.

In 1982, the Ministry of Health and Population held a national conference at which these organizations were asked to strengthen the provision of primary health care (PHC), and to mobilize the private health sector in Haiti in the implementation of the National Health Plan. The response of the NGOs was generally positive, but there were both questions about how best to participate effectively and doubts about the feasibility of attempting to take on more responsibility. After some discussion among the NGOs, it was agreed that an organization should be established to coordinate efforts and develop an approach, and L'Association des Deuvres Privées de Santé (AOPS) was born.

In planning a package of PHC activities that could be recommended to NGOs, the fundamental need was for an approach that offered a reasonable likelihood of success and was feasible to implement within the very real resource constraints of the NGOs. The key elements of the strategy, which we will refer to hereinafter as "the AOPS model," were:

- o Focus on infants, children, and mothers.
- o Emphasis on a limited set of priority interventions: promotion of oral rehydration therapy; promotion of breastfeeding; immunization of children under five with DPT, polio, measles and BCG vaccines; prenatal care and family planning; control of tuberculosis and malaria; and growth monitoring and targeted supplementation.
- o Total population registration and longitudinal data collection by individual institutions, each institution covering a defined population ranging from 10,000 to 50,000 people, with identification and follow-up of priority groups: women in union and their children under five.
- o The rally post, an outreach approach to service delivery in which health personnel visit a designated place--health post, school, church--to provide preventive services to a local target population from a defined area, gathered there by community health workers.
- Ongoing monitoring of coverage and impact of selected interventions, particularly ORT, immunizations, growth monitoring and family planning. This was to include:
 - Multipurpose, longitudinal surveillance of priority health problems, with the accent placed primarily on the identification of individuals in need of special care rather than on the determination of incidence and prevalence rates.
 - Linkage of surveillance to service delivery, through feedback loops which allow identification of non-participants and delivery of special services to high-risk groups (i.e., targeted supplementation to malnourished children).
- o A standard, basic service delivery plan.

The challenge faced by AOPS was to develop an approach that could be managed and implemented, with minimum disruption of on-going activities, by the institution. The focus was on making the program fit the capabilities of the manager and the resources of the institution, rather than vice versa, and thus avoiding the pitfall of designing strategies that required large infusions of external resources or were beyond the capabilities of those who were supposed to execute them. With those caveats in mind, a basic service delivery plan was devised that includes the following steps:

- o The NGO health care group identifies a geographic area with a population of 10,000 in the health district it serves (in one case, the PVO planned a program for 30,000 people). The area is then divided into sectors of approximately 1,000 people each.
- o At the same time, the PVO sends a physician, typically a community health physician or <u>medicin de commune</u>, for one month of full-time training in Cité Soleil, an urban slum in Port-au-Prince where the Complexe Medico Social is operating the most comprehensive population-based community health program in Haiti. The training covers the entire methodology of the PHC activities and is intended to groom the physician to be the local program director.
- o In each of the sectors of 1,000 people, community councils or other community groups are contacted by PVO administrators and apprised of the project. Specific project goals, priorities, and a detailed <u>modus operandi</u> are explored before agreeing on a final implementation plan. Community health workers (CHWs) are chosen by the community and are expected to be literate, older, stable, and respected individuals who have an independent source of income.
- On completion of their training, the physicians return to their districts where they initiate the training of the 10 or more community health workers who have been selected, as well an auxiliary nurse and a recordkeeper. The overall training period is one month to six weeks, although not in one solid time block, and includes: census-taking and registration of the total target population; promotion of the essential elements of primary health care, including the use of oral rehydration, growth monitoring, immunization, family planning, and prenatal care; and rally post operations.
- Once trained, the CHWs carry out the initial census/population registration in the area for which they are responsible. This is also to constitute the baseline survey for purposes of evaluation.
- o On completion of the registration, the CHWs review the records for each family with the PVO center administrator and record-keeper and draw up, from these records, a list of priority individuals in each group to be served (children under three years of age, pregnant women, and women eligible for family planning) at the regular rally post gatherings.
- o When preparation for rally post activities are completed and schedules for each sub-district are established, each CHW notifies his target population of the date, time, and location of the rally post in their area.

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- o At the scheduled time and place, the CHW meets the NGO center team--a physician, an auxiliary nurse, a record-keeper, and several community volunteers--to assist in carrying out the rally post PHC activities.
- Between the regular rally post gatherings, the CHW carries out necessary follow-up activities as instructed by the team. These include home visits when indicated, recording vital events, identifying newly pregnant women, selling ORS packets, etc.

In reality, AOPS I and II came to be collapsed by time, vicissitude, and different institutional needs and experiences, into one project. Most of the projects did not finish their re-censuses and begin the rally posts that would mark their entry into the full-expansion phase of the project until March 1985. Thus, at the time that this evaluation was begun, the fully-expanded AOPS project had only been up and running for a little over a year.

II. PROGRESS IN MEETING PROJECT OBJECTIVES AND ACHIEVEMENT OF ANTICIPATED PROJECT OUTPUTS

AOPS I AND II

No explicit output, effectiveness, or impact indicators were set forth in the Cooperative Agreements which constituted the basis for AOPS I and II, nor were precise targets established. The project designers were well aware that they were entering largely uncharted territory and there was no desire, on the part of AOPS or the USAID, to make any unnecessary commitments. AOPS I/II is useful-ly thought of as a single, large operations research project.* The questions that it asked were: 1) is it feasible to institutionalize a primary health care outreach program, of the sort historically associated with the public sector, in the private sector? and 2) is it possible to replicate a model for such delivery that is based on full population registration, a limited number of priority interventions, and on the tactic of growth monitoring at rally posts?

A third question, which is only implicit in the Cooperative Agreements, is: can coverage, most importantly effective coverage, be increased in a substantial and durable fashion, using the proactive AOPS approach in lieu of the essentially passive, facility-based MSPP approach? The USAID did not, in fact, heartily embrace the concept of full population registration which lies at the heart of the AOPS model; it considered such a strategy a special technique for very well tended projects with a high density of technical assistance and external support, such as the two projects from which the AOPS approach was derived, the Schweitzer Hospital at Deschappelles and the MSPP project at Petit Goave. AOPS, on the other hand, thought that full population registration was, in the Haitian context, the only way to get even close to guaranteeing coverage and to identify and care for those needful and high-risk clients who, for one reason or another, did not present themselves for primary health care services.

Although no targets or indicators were specified in the Cooperative Agreements, AOPS was committed under those agreements to periodic reporting which would permit assessment of problems and progress, as well as to evaluation of operational results and program impact. Implementation evaluation was to look at, for each institution, achievement of the following markers, to follow each other in consecutive quarters of one implementation year: 1) completion of staff training, 2) completion of census, 3) surveillance and service program set up, and 4) adequate population obtained.

Interim program impact was to be scrutinized using four basic parameters: 1) immunization (status of children 0-5 years old), 2) nutrition (proportion of malnourished children in regular attendance at nutrition supplementation sessions, 3) prenatal care (proportion of pregnant women fully immunized against tetanus; average number of prenatal visits); and 4) family planning (number of new and continuing acceptors; contraceptive distribution). End-of-project impact was to be evaluated along two parameters: 1) nutritional status of the

^{*} It is important to note that AOPS was not conceived of as a pilot project, of which there have been a despairing number in Haitian development history. AOPS was perceived and implemented as a nationwide enterprise, which took instruction from the MSPP pilot project at Petit Goave and from the Schweitzer Hospital experience, and which shared a common approach and overall administrative and support structure.

universe of children 0-5 years of age in the last month of the project, and 2) pregnancy prevalence rates during the last month of the project. In addition, by its end, the project would be expected to answer the following questions:

- Is the project strategy an effective way for private institutions to fulfill the role given to them by the MSPP in the document "Vers la Santé pour Tous en Haiti"?
- o Has coverage for basic services in fact increased in project areas?
- o If such an increase can be documented, has there been a measurable impact in terms of mortality and morbidity reduction and in terms of decreased fertility?
- o Have the private institutions developed viable ways of meeting the operational costs associated with the provision of outreach services?

As part of the Cooperative Agreements, AOPS did commit itself to a sequence of events and processes. This chapter will first explore, summarized in modified tabular fashion for purposes of economy, the degree to which that sequence has been satisfied as part of progress achieved in program management and administration. The second part of the chapter will look at achievements in terms of quality, expressed in rankings. The third part will look at achievements in terms of coverage and interim impact.

A. PROGRAM MANAGEMENT AND ADMINISTRATION

1. <u>The Selection Process</u>

AOPS will identify 15 (AOPS I)/22 (AOPS/II) private institutions operating in Haiti and invite them to submit requests for financial assistance to AOPS, for participation in the implementation of community health and family planning programs for the benefit of potential populations of from 10,000 to 50,000 each. Institutions will be selected according to availability of funds and will have to fulfill the following criteria and have:

o Membership in good standing in AOPS.

 MSPP permission to provide public health services (this is a condition of membership in AOPS).
 Technical and physical resources and the capability for immediately undertaking community activities. This means that, at

25 projects are now active under AOPSI/II, with another 5 projects which were identified or recruited which did not get funded, in part or fully, for a variety of reasons (see Table 1). Because of the variable evaluation of the individual AOPS projects (see Table 2) and because of lack of clarity in the Cooperative Agreements about "old" and "new" projects, one cannot make a clear statement about where AOPS is in the number of projects, although it seems to be well along if, indeed, it has not already surpassed objectives in this regard. As for population coverage, the Cooperative Agreements indicated a total coverage of 450,000. Present real coverage is 352,264 and several projects are under consideration for expansion (Las Cahobas, Duplessis, and Thomazeau

the minimum, the institution must already have a permanent care starr (MD, auxiliary nurse, record-keeper) and a physical structure to house the program. Financial capability to sup-0 port the community health program. 0 Commitment to implement the major elements of a community health program. Each institution will agree to: -Respect the norms set by the Ministry of Health

(MSPP) with regard to the National Health Plan.

- Cooperate with the MSPP and regional and district administrators.

- Prepare periodic activity reports for MSPP and AOPS.

- Accept on-site inspections of progress and utilization of funds provided through AOPS.

Ad ad hoc committee of AOPS, made up of its president, vice-president, secretary, treasurer, and project director, will screen all applications and submit their recommendations to the Executive Board of AOPS for preliminary selection. The selections will be submitted to USAID officials for their approval. Once USAID approval has been obtained, the AOPS Executive Board may make the final selection. The Board may delegate this authority to a subcommittee of its choosing.

AOPS will then provide a detailed briefing to each selected institution on the different aspect of the project. It will also provide help to each selected institution in design of a comprehensive community health and family planning project most appropriate to the community served. to 25,000 and Fermathe to 50,000), so that attainment of projected coverage appears probable.

All projects to date have satisfied the stipulated criteria.

This committee, now effectively the Comite de Gestion, fulfills this role, as well as sharing the responsibilities for the general daily activities of AOPS. The USAID has approved all projects for funding.

AOPS has briefed all institutions and provided technical assistance on project design.

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2. The Orientation Phase

This place involves orientation of the community health physician who will be in charge of the institutional outreach program and the training of the auxiliary personnel. For institutions with a program already in place, this phase will only involve orientation of new personnel. For institutions beginning a new program, orientation of the community health physician will take place in Cite Soleil and selected rural sites.

Institutions implementing programs for 25,000 or 50,000 persons will go through similar steps, although orientation of a second community health team for institutions covering 50,000 people will be done by the first (experienced) team.

3. Staffing and Human Resources

The Executive Board of AOPS will appoint a project director who will provide general oversight for this project. This director will be a member of the board of AOPS and will serve on a voluntary basis. He will supervise the project coordinator and the project staff who will be responsible for day-to-day project management. A project coordinator experienced in both public health and program management will be recruited and employed with AID concurrence.

4. Training and Continuing Education

AOPS will support the training of

a. Local program directors (n=22)
b. Community health physicians (n=22) who will, in turn, train
c. Auxiliary nurses (n=22)
d. Record-keepers (n=22)
e. Community volunteers (ColVols) (N=300) See Training and Continuing Education section below.

So far this second generation of training has only occurred in Pignon and Mirebalais.

Technical Director (Augustin) appointed, backed by a Project Coordinator (Fanfan) for AOPS I. Three more coordinators (Simeon, Robin, Lauredent) will back up the Technical Director for the balance of AOPS II and for AOPS III.

To date, 45 doctors have been trained to serve as local program directors; of those, 23 are no longer working with the institutions that sent them for training, although net training loss is only 11, still a 24% attrition (see discussion in text under Staffing and Human Resources).

During the training phase, the organization will delineate the catchment area, meet with local leaders, and identify a community collaborator for each sector 1,000 people. After completing their training, community collaborators will enumerate the target population. The enumeration process will include distribution of Road-to-Health (child growth surveillance) cards for all children under five, to record each child's growth and weight gain over time, as well as his immunization status. AOPS will also hold discussions with and provide approval of the "Community Participation Fund" which, within certain limits, can be used by the institution to obtain community participation for the program.

5. <u>Program Operation</u>

The community health team, in collaboration with local community leaders, will establish "rally posts" at selected community gathering points, e.g. markets, public water fountains, etc., where they will provide direct health services delivery. At least one rally post will be established in each area of 1,000 persons for regular provision of priority services.

6. Supervision

Program supervision will be on the basis of on-site visits by the AOPS program coordinator. These visits will also serve as occasions for offering technical All projects have trained at least one nurse auxiliary and one record-keeper; some projects have trained more than one archiviste. All projects have trained the minimum number of ColVols, but some (e.g. Pignon) have trained more so that it is highly likely that the N of 300 has been well surpassed.

All active projects but Bonne Fin have completed their censuses and recensuses for their present coverage.

All the stated community contacts have occurred. Distribution of Road-to-Health cards is standard and constrained only by availability of cards, made available to AOPS by the MSPP.

Analysis of the accounting systems of the projects visited indicates that clarity about income and expenditure streams is sometimes lacking. However, most projects seem to know what they have for community motivation.

All projects, except for Bonne Fin which has activated only one sector, have had at least one round of rally posts (see section on Coverage).

The AOPS project is actively supervised by project coordinators, of which there are now 4. assistance in the resolution of any problems which may be encountered during the implementation phase.

7. Monitoring, Evaluation and Research

a. Monitoring

In order to ensure that the project is being executed as planned and in order to provide technical assistance in program implementation, joint project monitoring between AOPS central staff and regional and district directors will occur with the five institutions which will be implementing large projects. These joint monitoring activities are expected to strengthen private sector cooperation with the MSPP, increase MSPP personnel awareness of the problems faced by private institutions, and ensure the MSPP norms are respected.

b. Evaluation

For each institution, implementation evaluation will be conducted on a quarterly basis by AOPS staff. The implementation schedule will be as follows:

lst	quarter:	completion of
		staff training
2nd	quarter:	completion of
		census
3rd	quarter:	surveillance and
		service program
		set up
4th	quarter:	adequate popula-
		tion coverage
		obtained.

Each institution will provide periodic data to permit assessment of problems and progress. Reports will include:

1) Census data giving baseline information on coverage for cerservice.

2) Rally post data giving infor-

Of the large projects currently in place (Mirebalais, Pignon-St. Raphael, Freres/FHASE, and the AMOSSE group at Jacmel), only the AMOSSE group appears to have engaged in the active participation of the MSPP in project monitoring, since the project's technical director is also the MSPP commune doctor.

Each institution has been providing periodic data of this sort. However, there has been wide variability in timing, format, indicator parameters, and content (see discussion below on Monitoring and Evaluation). mation on the nutritional status of children and progress being made in immunization and family planning. In addition, epidemiologic data on priority health problems will also be available. 3) A final report comparing baseline coverage with coverage one year from the start of the project.

Evaluation of local progress and problems will be carried out by AOPS on a quarterly basis as mentioned above, and also at the end of the project's lifetime. Evaluation will cover two aspects: Operational results and preliminary program impact. Operational results will be measured at the end of the project. The following parameters will be utilized:

1) Immunization: status of children 0-5 years old.

2) Nutrition: proportion of malnourished children in regular supplementation sessions.

3) Pre-natal care: proportion of pregnant women fully immunized against tetanus, and average number of prenatal visits.

4) Family planning: number of new and continuing acceptors; contra-ceptive distribution.

AOPS will retain expert assistance to simplify methods of institutional data management, self-evaluation, and epidemiologic surveillance based on the International Classification of Disease (ICD) System, and in the establishment and maintenance of a central statistical bank for project impact analysis. The census format used will be reviewed by the MSPP and the USAID.

A limited evaluation of impact will be carried out at the end of the project by using as a baseline, data obtained during the census phase of the program. For each institution, the following parameters will be used: These data are being gathered but, again, in somewhat erratic fashion and with some real problems in easy, ongoing access to data (see discussions below on Coverage and on Monitoring and Evaluation).

AOPS and technical consultants have established evaluative criteria and participated in PAHOsponsored hospital complexity study. All projects have completed their baselines and, in some cases, recensused. AOPS will also profit from the epidemiologic and MIS work under way at Cite Soleil. The necessary simplification of the census format, which was based on the MSPP and Petit Goave formats, will occur as part of the Maissade Save-the-Children project under AOPS III. Improvement of evaluation/record systems should occur in the wake of this evaluation.

1) Nutritional status of the universe of children 0-5 years of age in the last month of the project.

2) Pregnancy prevalence rates during the last month of the project.

In addition, AOPS will provide expert consultation for examining the strategy implications for population-based community outreach programs with regard to the extension of health services by the private sector in Haiti. Specific questions to be examined include:

1) Is the project strategy an effective way for private institutions to fulfill the role given to them by the MSPP in the document "Vers la Sante pour Tous en Haiti"? (Effectiveness)

2) Has coverage for basic services in fact increased in project areas?

3) If such an increase can be documented, has there been a measurable impact in terms of mortality and morbidity reduction and in terms of decreased fertility? (Impact)

4) Have the private institutions developed viable ways of meeting the operational costs associated with the provision of outreach services? (Institutional Viability)

8. Financial Management

a. Financial assistance

Financial assistance to institutions will be in the form of individual grants to each institution. Grant finds will be disbursed on a quarterly basis Baseline exists.

Baseline exists but only compiled at Mirebalais.

These questions are being addressed in preliminary fashion under the present evaluation.

The procedures indicated in this section are all being followed. See chapter on Financial Management for a full discussion.

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according to the institution's plan. Prior to receiving subsequent funds, each institution will be required to submit a progress report to AOPS. A copy of such reports will be forwarded to AID as well as a general program assessment and a financial report, the latter two being prepared by AOPS staff. Grants will cover the following illustrative expenses:

o Cost of training 1 medical director for 1 month for each institution.

o Cost of training auxiliary nurses, medical record-keepers, and community collaborators at each cooperating facility.

o Cost of the initial census and registration.

o l year of salary for an auxiliary nurse and a medical r_{e} cords technician, or the equivalent to be used for community health activities.

o Purchase of equipment and materials needed for community health activities.

The estimated amount needed by each cooperating health institution to launch and support a community health initiative covering a population of approximately 10,000 for one year is US\$10,000.

b. Monitoring community health demonstration of subgrants

This is occurring.

AOPS central staff will be responsible for program monitoring and providing central accounting services for disbursed funds.

o A project coordinator will have overall responsibilities for project monitoring. He will report to the project director (a member of the AOPS Board) who in turn will report to the entire board of AOPS.
o Disbursement requests from participating institutions to AOPS will be reviewed by an accountant attached to the project and by the project coordinator, for conformity with the agreement linking the institution to AOPS.

o Central office expenditures will be authorized by the project coordinator in agreement with the AOPS treasurer. Final responsibilities for disbursement will rest with the AOPS treasurer and president.

c. Procurement Procedures

All goods and services will be obtained in the most efficacious and economical manner in conformity with USAID requirements. It is expected that procurement of drugs and vaccines will follow MSPP, AGAPCO, and DHF norms respectively.

Procurement of a project vehicle will require a waiver of AID requirements to permit local procurement.

d. Reporting

AOPS will prepare and submit quarterly activity and financial reports to USAID so that funds flow smoothly. AOPS will submit the following in English, at the time and in the quantities specified:

o Technical reports

Two copies of each quarterly technical report shall be submitted.

o Financial reports

The recipient shall submit to the responsible AID Controller all

Not evaluated.

Reporting has been somewhat erratic over the past six months, partly because of the country's unsettled political condition; the most recent available PISR was dated 30 September 1985, as one example. Reporting needs to be standardized and simplified (see sections on Monitoring and Evaluation and on Supervision). reports required under the Standard Provision entitled "Payment-Periodic Advance via the USAID Project Manager."

o Special reports

The recipient shall provide special reports as requested.

9. AOPS General Assistance to Member and Other Institutions

In addition to its specific assistance to the institutions discussed above, AOPS will organize and implement within the framework of this project:

a. Regional seminars to inform all private institutions of current intervention strategies in the field of community health and family planning. Three such seminars are planned in the early phases of the project implementation, one in the North, one in the South, and one in the metropolitan area.

b. Visits by AOPS officers and staff to all private health institutions operating in Haiti and provision of technical assistance when requested.

This will primarily be in the area of management. The AOPS technical team will furnish assistance in program planning, implementation, execution and evaluation to any institution which so desires. In addition. AOPS will furnish assistance in project design and facilitate institutional contacts with MSPP authorities. For institutions not yet recognized by the MSPP, AOPS will outline the steps necessary for such recognition and assist the institution in the endeavor. Other assistance will include setting up an emergency relief system

Between November 1982 and March 1986, AOPS organized and sponsored 16 seminars and workshop. Seven of these were given in 1985 and dealt with the subjects of: the community approach to primary health care, interpersonal relations, maternal protection, vaccine-preventable disease, the vaccination campaign, sanitary education, and mother mobilization. The 3 regional seminars were given, one each in Cap Haitien, Jacmel, and the metropolitan area.

AOPS technical assistance is accomplished through regular supervisory visits and on request. It is important to note that AOPS is limited in its ability to mandate technical changes and must depend on its capacity to awaken demand for its technical advisory services.

Not done.

for vaccines and ORT in case of unforeseen shortages at the district level.

c. Publication of a newsletter in order to promote an exchange of ideas and to institute a program of resource sharing.

d. Preparation of a document which summarizes current government norms for health institutions.

e. Inform private health institutions of current government activities in the field of health. This information will be conveyed via the newsletter and occasionally via special reports. The aim of this activity will be to make private institutions aware of the elements of the National Health Plan and the general goals, policies, and norms of the MSPP. In addition, institutions will be kept abreast of new developments in the field of primary care.

All private institutions capable of meeting on their own the full cost of a community health program will be invited to participate in all phases of the program outlined above. This will include training of physicians and auxiliary staff, assistance with census, service delivery, and evaluation.

10. Private and Public Sector Linkages

The project is governed by the 1983 GOH Health Services Act which regulates the activities and responsibilities of the MSPP.

The regionalization process, as defined by the MSPP, is characterized by centralization of legal and normative authority and administrative decentralization A newsletter has been instituted and three issues had been distributed to a mailing list of 1,000 as of 30 September 1985. Another issue was in press while while this evaluation was in the field. It does not yet function as an active instrument of resource-sharing.

Document on norms not yet prepared.

This sort of information is not an explicit or major feature of the AOPS newsletter as it is now constituted.

This has not yet occurred. All projects presently in the AOPS project get project funding, so that none are assuming full costs and using AOPS only for technical assistance. Also, no projects to date provide technical assistance to the larger project.

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a way as to improve coverage at manageable

projects to be executed unthe terms of this grant are aced within the context of the .983 Health Service Act under the supervision of regional and district directors. In addition to supervision, it is anticipated that the district authorities will provide the necessary support in terms of technical assistance, manpower, equipment, and supplies.

Appropriate backup services will be provided at the district and regional hospitals and other health facilities, as required in the following areas:

a. Supplies (particularly contraceptive devices) to be obtained through the DHF. In addition, a limited amount of free drugs and oral rehydration packets are expected to be available from the DHF which will capitalize a revolving drug sales fund for each institution.

b. Referrals to secondary and tertiary care government institutions for complicated cases.

c. Supervision. Depending upon its importance, the private institution may in turn be requested to supervise government health agents or other personnel operating in its catchment area.

d. Information. As the project proceeds, the Director General of the MSPP and the Regional District Administrator will be kept informed. Specific linkages and other considerations will regularly be discussed and reviewed with all parties, private and governmental. Clearance for all projects was obtained from the appropriate regional and district representatives of the MSPP. Varying from project to project, the MSPP supplies some personnel and commodities. Constraints to the AOPS project derive almost completely from constraints on MSPP resources, rather from any institutional obstruction.

In some projects (e.g., FHASE, AMOSSE) AOPS clients have access to AGAPCO facilities for pharma-ceuticals.

Referral from AOPS activities to the facilities of the public sector is erratic and ad hoc. Some projects refer to their own facilities.

MSPP Agents de Santé have been recruited with some success by individual projects and are therefore supervised by them. To our knowledge, no AOPS project currently supervises MSPP personnel working outside that project.

This occurs on a largely informal, ad hoc basis in most projects and needs to be systematized.

Central coordination between AOPS and the various directors will ensure that program content and policies, as passed on by AOPS technical staff to the member institutions, are in conformity with MSPP norms, priorities and qoals. It is anticipated that central AOPS staff will consult with the Director and staff of the Direction of Family Hygiene/ Nutrition (DHFN) and the Direction of Health Education (DES) for purposes of ensuring that program content is in conformity with the norms of these two directorates.

For the most part, AOPS procedures are so harmonious with MSPP policy that there is no present urgent need for this sort of coordination. Cite Soleil has done pioneering work in criteria for measles immunization and the resulting norm has been adopted by the MSPP. The principal lack of congruence appears to lie in the area of the rally post concept, but this is a methodological rather than a medically substantive issue. Where a discrepancy may arise is in relation to recommendations for packet and home solution use.

B. QUALITY OF OVERALL PROJECT PERFORMANCE

A tally was done of all the AOPS projects from the date the first grant agreements were signed in June 1983, to look at quality of performance, population coverage, age, and institutional sponsorship. Coverage figures were assembled for the 25 active AOPS projects (see discussion of coverage below), and an evaluation score was assigned (See Table 1). The scoring is self-explanatory: a score of 5 means that the project is exemplary in some important way; 4 means good performance with minimal functional problems; 3 means that the project is currently functioning but has some moderate problems; 2 means that the project has both structural and functional problems but is nevertheless worth saving; and, finally, a score of 1 means that the project is showing little activity but retrieval is still possible.

The projects are presented classified according to these categories in Table 2. Although they are listed, the following projects were not scored, for the reasons indicated: Montrouis is functioning actively but has opted for the "barefoot doctor" model, which is not compatible with the AOPS approach; Bonne Fin has chosen to proceed incrementally by sector, again not compatible with the philosophy of AOPS, which has not proceeded with funding beyond the first tranche of US\$3,000 for the initial census. These two projects have a present coverage of 15,146 and 1,679, respectively. Bethel (10,209) and Grande Colline (10,000 est.) were also not included because they are too new to fairly evaluate; however, Bethel has just completed its census and is reported to have done a good job; Grande Colline has not yet done its census.

The results of the classification are the following:

1. Four projects, with a coverage of 133,935, or 42.5 percent of the total active coverage figure of 315,230, were evaluated as "exemplary." These are: Belle Anse, particularly effective in its work with growth monitoring; Pignon which, in addition to its rapid growth, has been particularly active and effective in family planning activities; Mirebalais, distinguished for its system of registration and record-keeping; and Cayes-Jacmel, which demonstrates that even a government commune doctor can have an effective program and that Agents de

				AGE EN MONTHS			STARTUP TIME, IN	
				FROM DATE OF		AGE IN MONTHS	MONTHS FROM SIGNING	
ADFS			DATE GRANT	6kant	DATE OF	FRUM DATE OF	OF GRANT AGREEMENT	
1 DR		FOPULATION	AGREEMENT	AGREEMENT TO	BEGINNING	BEGINNING OF	TO DATE OF BEGINNING	EVALUATION
11	PROJECTON	COVERED	SIGNED	JULY 1, 1986	OF SERVICES	SERVICES	OF SERVICES	SCORE
1	Montrouis	15,146	Jun. 1983	36	Oct. 1903	32	4	\م
1	La Vallee	10,685	Jun. 1983	36	Nov. 1983	31	5	2
1	Las Cahobas	9,516 \b	Jun. 1983	36	Dec. 1983	30	6	2
п	Marebalais	52,000	Jun. 1983	36	Nov. 1983, Mar. 1985	31	5	5
1	Gras Morne	9,131	Sep. 1983	73	Jan. 1984	29	4	3
1	Pont Sande	0.168	Sep. 1983	33	Feb. 1984	28	5	3
1	Fonds Parisien	7,270	Sep. 1983	33	Feb. 1965	16	17	2
1	Belle Anse	22,000	Jan. 1984	30	Jul. 1964	24	6	5
1	Bonne Fin	1.679	Jan. 1984	30	Feb. 1985 \g	16	14\6	١.
11	Themassique	10,355	Jan, 1984	30	Sep. 1984	21	9	i
1	Pignon	29,293	Jan. 1984	36	Jan. 1984, Apr. 1985	29	1	5
11	St. Rafael Pignon	20,682	Apr. 1985	15	Jan. 1986	S	10	·
1 11	Freres (FHASE)	30,155	Apr. 1984	27	Oct. 1984	20	· · · · · · · · · · · · · · · · · · ·	4
1 (11)	Thosazeau	10,392 \b	Apr. 1984	27	Jul. 1984	24	3	2
1 (11)	Duplessis	10,682 \6	Apr. 1984	27	Apr. 1984	26	1	2
11	Marigot	10,000	Jan. 1985	17	Apr. 1985	14	3	-
11	Cayes-Jaceel	9,960	Jan. 1985	17	Apr. 1985	14	3	5
11	La Hontagne	8,265	Jan. 1985	17	Apr. 1985	14	3	4
11	Eazale	10,000 \c	Jan. 1985	17	ຸ່າ	?	2	1
11	Carrelour-Poy	10,644 \d	Jan. 1985	17	Aug. 1985	11	6	. 7
11	Fonds des Negres	8,309	Apr. 1985	15	Jun. 1985	13	2	-
11	Fernathe	18,998 \e	Apr. 1985	15	Jul. 1985	17	ī	
11	Quartser Horsn	8,725	Apr. 1985	15	Nov. 1985	1	8	2
11	Bethel	10,209	Jul. 1985	12	\9	١.	۱	10
11	Grande Colline	10,000 \c	Jul. 1985	12	١ġ	\g	/ð	\g
	TOTAL COVERAGE	352.264 \h				70		

	TOTAL COVERAGE	352,264 \h	20	6
a.	AQPS 1=AID 521-0181. AQPS 11=AID 521-0169.		Average mo. of months from date of beginning of ser-	Average no. of of months from
b .	Possible extension to	25,000.	vices individual	signing to
٢.	Estimated.		on base of 22	500,000
d.	Population served; coa	plete census = 68,77].	projects}	

e. Possible extension to 50,000."

f. Usually takes 6 months to take and analyze census.

g. Unrated = project no longer funded by ADPS and "out of touch" but still active (Montrouis) or too new to rate (Bethel, Grande Colline). Bonne Fin has chosen to work by sector and has only been partially funded.

h. N=25 projects for which coverage was calculated, as of April 30, 1986.

##Not listed: Chambellan (CanSave/AEDC), Cootson Hills (Baptist Missionaries), Taifer (Episcopal Church; begun

April 1984), Deluge (DASH), and Milot (CKDSSP), which did not get funded, in part or fully, for a variety of reasons. All had an estimated population of about 10,000, a total of 50,000.

•EVALUATION SCORE CODE:

Smexemplary

4=good performance, minimal functional problems

3=currently in operation, moderate problems

2=structural and functional problems but worth saving

l=little activity but retrieval possible

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TABLE 2 EVALUATION RANKINGS, # ACTIVE ADPS I AND II Projects (AS OF APRIL 30, 1986)

	i 5		4		2			2	1		
	PROJECT Site	P0 P.	PROJECT SITE	POP.	PROJECT Site	POP.	PROJECT Site	POP.	PROJECT Site	POP.	
	Belle Anse	20,000	Freres	30,155	Gros Morne	9,131	Dupleseis	10,682	Cazale	10,000(est.)	
	Cayes-Jacmel	9,960	La Hontagne	B,265	Pont Sonde	8,168	Thomazeau	10,392			
	Pignon- St. Rafael	29,293 20,682	Fermathe	18,998	Marigot	10,000 (est.)	La Vallee	10,685			
	Mirebalais	52,000	Thomassique	10,355			Las Cahobas	9,516			
			Fonds des Negres	8,309	•		Quartier Morin	8,725			
							Fonds Parisien	7,270			
							Carrefour- Poy	10,644			
Total No. of Sites & Associated Pops. (no. and % of total N of 315,230**)	4	133,935 (42.52)	5	76,082 (24.2%)		27,299 (8.72)	7	67,914 (21.5%)	1	10,000 (3.22)	

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##This figure represents the total population coverage figure of 352,264 minus Bethel (10,209)
and Grande Colline (10,000 est.) which are too new to evaluate. Bonne Fin (1,679; incompletely
censused), and Montrouis (15,146, active but not within AOPS).

+EVALUATION SCORE CODE:

5= exemplary

4= good performance, minimal functional problems

3= currently in operation, moderate problems

2= structural and functional problems but worth saving

1= little activity but retrieval possible

Sante, given good support, can contribute powerfully to good results. (It is worth noting that the Cayes-Jacmel project which is, with La Montagne and Marigot, part of the AMOSSE group, has five more Agents than does La Montagne, a fact that may be associated with its greater success, since the responsible commune doctor is the same. Of these exemplary projects, only Cayes-Jacmel is a small (9,960) project.

2. Five projects, with a coverage of 76,082, or 24.2 percent of the total, achieved a ranking of 4, that is "good performance with minimal functional problems." Of these, only Frères (30,155) and Fermathe (18,998) are large projects. The others--Thomassique (10,355), Fonds des Négres (8,309), and La Montagne (8,265) are small projects.

3. Three projects--Marigot (10,000 est.), Gros Morne (9,131), and Pont Sonde (8,168)--were evaluated at 3, that is, currently in operation, but with moderate problems. These were all small projects and covered a total of 27,299 people, or 8.7 percent of the total. It should also be noted that it is only its shortness of staff which relegates Gros Morne to this category; it is, in every other regard, an exemplary project, with vigorous community support, which is run by an Agent de Santé who is a member of the "groupmente communautaire," and an auxiliary nurse who does the record-keeping. Gros Morne also lacks a doctor.

Seven projects, with a coverage of 67,914, or 21.5 percent of the total 4. were classed as 2, that is, with "structural and functional problems but worth saving." These were all small projects, ranging from 7,270 (Fonds Parisien) to 10,685 (La Vallée). However, of these, Las Cahobas (9,516), Thomazeau (10,392). and Duplessis (10,682) are under consideration for expansion to 25,000 coverage, pending resolution of the problems they are facing. Las Cahobas has the will to proceed but has had problems with doctor turnover, is one of the relatively few projects that has had major difficulties with ColVol turnover, and seems to be having problems adjusting to financial realities; the project is now pending further assessment and agreement among the AOPS coordinators about whether an extension to 25,000 is advisable. Duplessis, which has a vigorous community leader and community support, has had a series of non-productive doctors; the project could be turned around with a new doctor and some technical assistance. As another example of real structural problems, Quartier Morin is instructive: the project has been slow-starting and, although the census was carried out without problems, the rally post model was replaced with a curative mobile clinic approach that is incompatible with the AOPS philosophy.

Finally, only one project was assigned a "1": Cazale, with an estimated 10,000 coverage, has a new doctor who has shown encouraging interest in proceeding actively with the project. Until now, the project has been dormant.

In summary, of the 20 projects that were given an evaluative classification, nine are functioning comfortably and effectively and another three are functioning with relatively few problems. These twelve projects cover 237,316 people, or 75.3 percent of the total population covered by all the AOPS projects. The average age of the 25 AOPS I/II projects is about 25 months from the date each project grant agreement was signed; the earliest signing was June 1983 (Montrouis, La Vallée, Las Cahobas, and Mirebalais), the most recent July 1985 (Bethel and Grande Colline). Average number of months from date of beginning of services, calculated on the basis of the 22 projects which can be fairly said to have started, is 20, with a range of 32 months for Montrouis to five months for St. Raphael (which is essentially a geographic expansion of Pignon). Finally, the average number of months from signing to startup is 6 months, with a range from 17 for Fonds Parisien to 1 for Pignon and Duplessis. There is no easily discernible pattern or relationship among age, startup time, and quality of project as reflected in the evaluation scorings. Six months is the amount of time indicated in the Cooperative Agreements deemed necessary for the project startup activities and seems entirely reasonable; in this regard the AOPS I/II project has done very well indeed.

C. COVERAGE AND IMPACT

The 20-month average age of the family of AOPS I/II projects is adequate time to have developed some coverage data, some idea of effectiveness, and at least preliminary impact data as measured by more direct indicators, e.g., vaccinations given/series completed and high-efficiency family planning methods delivered. However, although population coverage data are available from the censuses, these are not disaggregated in standardized form for easily accessible, ongoing use for more precise coverage calculations, e.g., numbers of children in standard one-year age cohorts from birth to age five, women in fertile age, or women likely to be pregnant or actually pregnant at a given point in time. Furthermore, as indicated earlier, there are no established coverage targets to calculate percentages of achievement; while the evaluation team does not disagree with the decision to hold off on establishment of such targets given the experimental nature of the AOPS strategy, it is hard to talk about impact in the framework of pre-established objectives. A few individual projects have established quantifiable goals. FHASE, for example, has committed itself to the following targets: 80 percent of children under age 3 with full vaccination series (intermediate target for 1985-1986, 60 percent), 100 percent of women vaccinated with tetanus toxoid, 24 percent of women in union using some kind of family planning method, and 90 percent of pregnant women in union receiving prenatal care. In general, coverage, effectiveness, and impact data are not adequately available in any AOPS project at present; this problem and related issues are discussed below in the section on Monitoring and Evaluation.

1. Immunization

The assumption has been made that the baseline for coverage by selected interventions was, for most AOPS project areas, something close to zero. Table 3 indicates that, with the exception of Pignon, Fréres, and La Vallée which were already being partly covered by the passive services of private hospital and clinic services already in place, pre-AOPS immunization coverage was almost nonexistent. This was due to several, rather typical interacting causes: systems deficiencies (logistics, poor-quality services); client beliefs about proper care for certain kinds of illnesses; and interaction between the two (e.g., the system refused children brought for vaccination even if they were

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				(In pe	rcentage	s)*						
	POPULATION	L				VAC	DINE					
1	(AS OF		DPT	1	POLIO		1	BCG		М	ASLES	
PROJECT SITE	30 APRIL 1986)	(a)	(b) (c	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
Pignon	29,293	21.0	38.0 73	.0 14 .0	28.0	65 . 0	43.0	83 .0	95.0	 1.0	18.0	64 .0
Mirebalais I	52,000	1.0**	38.0***35	0 1.0	** 36.0	29 .0	n.d.	n.d.	63.0	0.0**	42.0**	29.0
		 	54	.0		55.0	 					51.0
Gros Morne	9,131	4.0	13.0 18	0 4.0	n.d.	18.0	12.0	42.0	44 .0	0.0	5.0	12.0
St. Rafael	20,682	n.d.	n₀d₀ 18	0 n.d.	n₊d.	13.0	n.d.	n.d.	42.0	 n.d.	n.d.	25.0
Duplessis	10 ,682	n.d.	n₀d₀ n₀o	.n.d.	n₊d.	27 . 0	n.d.	n.d.	79 .0	n.d.	n.d.	72 .0
Fr er es (FHASE)	30,155	9.0	65.0 74	0 9.0	65.0	74 . 0	29.0	88 <u>.</u> 0	82 .0	0.0	37.0	46 .0
La Montagne	8,265	n.d.	n.d. 52	0 n.d.	n₊d.	42 .0	n.d.	n.d.	83.2	 n.d. 1	n₊d.	60 .0
Cayes-Jacmel	9,960	n.d.	n.d. 47	0 n.d.	n.d.	39 .0	n.d.	n.d.	78.1	n.d.	n.d.	70 .0
Marigot	10 ,000	n.d.	n.d. 22	2 n.d.	n.d.	22 .2	n.d.	n.d.	65.0	n.d.	n.d.	51.0
Thomazeau	10,392	n.d.	n.d. 58	0 n.d.	24 .0	57 . 0	n.d.	26 .0	49.0	n.d.	23.0	50.0
Balle Anse	22 ,000	0.0	33.0***n.c	. 0.0	7.0*	**n.d.	25.0	75 _• 0*1	'≭n.d.	0.0	56.0	n.d.
Pont Sond a	8,168	0.0	n.d. n.o	. 0.0	5.0	n.d.	n.d.	n.d.	n.d.	0.0	18.0	n.d.
La Vallèe	10 ,685	9.0	27.0 n.0	. 5.0	21.0	n.d.	8.0	13.0	n.đ.	1.0	14.0	n.d.

VACCINATION COVERAGE, AOPS 1 AND 11, SELECTED PROJECTS, SELECTED DATES

- * Data are for 0 through 3 years except where otherwise indicated.
- ** No age parameters given. Because of lack of clearly disaggregated data, it is hard to make statements about progress with this intervention at Mirebalais. This is unfortunate because of the general high quality of that project and the efforts that have been made in monitoring and evaluation.
 - (a) National rates as of 1983 (RHDS Evaluation, Boston University, summer 1984): Children 0-5 immunized (percent): DPT (13.9), polio (10.0), measles (1.5), and BCG (1.8). In March 1984, figures were only slightly better, e.g., in Belle Anse, 2 percent each for DPT, polio, and measles, and 27 percent for BCG. Figures are for completed series.
 - (b) After one year of project coverage.

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- (c) As of 30 March 1986.
- *** This is an average of data from 4-7 railies in each of the project's 12 sectors. In sectors where 7 railies were held, the figures went up to 45 percent (DPT), 45 percent (pollo), 79 percent (measles), and 85 percent (3CG) of the over 2,000 children under age 3.

only mildly ill, a policy which has since been changed by the MSPP due to findings from the Cite Soleil and AOPS projects).

Table 3 summarizes available vaccination coverage data from selected AOPS I/II projects. In all cases where longitudinal data are available, it is clear that there have been dramatic increases in coverage and praiseworthy absolute levels, all far above the national levels for 1983 (RHDS Evaluation). And, although only BCG surpasses the 80 percent vaccination target (characteristically easiest because it is only one injection), the pace of expanded coverage is impres-Even allowing for plateau effect, there is reason for optimism that sive. rates of capture will be high enough to make it possible for projects to have to deal only with new births in the future. The most successful projects, as measured by these impact data are: Pignon, La Montagne, and Freres (FHASE). One would expect coverage percentages to be similarly high for Mirebalais and Belle Anse, yet, given the apparent quality of the data collection efforts in those projects, one has to believe the numbers. Because of the time it took to get these figures, the evaluation team was not able to pursue the reasons for the disparities in coverage among this group of exemplary and seemingly wellfunctioning projects.

Data on the impact of tetanus toxoid immunization of pregnant women were even less readily available. Because neither baseline figures nor current denominators are provided in regular reporting procedures for virtually all AMOSSE projects, the evaluation team did not have time to do the necessary sleuthing to be able to talk about program effectiveness of the prenatal care component. In the La Montagne, Marigot, and Cayes-Jacmel sites of the AMOSSE project, coverage figures for TT vaccination were 50, 25, and 43 percent of the pregnant women identified in each of those project sites (N=203, 228, and 212, respectively). Data from La Vallée in 1985, before the project was interrupted, showed a rate of 47 percent of women in fertile age vaccinated with tetanus toxoid, compared to none for the preceding year. These figures are well above those reported in the public sector; however, given the potential impact of this intervention on child survival in Haiti, these coverage and impact levels will need improvement.

Immunization activities have been carried out in Cité Soleil over the last eight years and included mostly vaccination against diphtheria, pertussis, tetanus, polio, and tuberculosis; in 1982, measles was added. Unfortunately, there had been no evaluation of the immunization program prior to 1983 when a major survey was carried out. In 1984, an order evaluation took place using a cluster sampling technique. This was done to evaluate the use of that technique and to compare these results with the 1983 survey results. Table 3a compares a random sample estimate of the proportion of adequately vaccinated children (3 doses or more) with the estimates from the cluster survey and the results of the 1983 survey.

TABLE 3a

	1983 Survey	Random Sample of Clinic Records		Survey Random Sample of Clinic Records		CLUSTER	SUR VE Y
		1984	1985	Respondent Answer	Clinic <u>Records</u>		
DPT	37,77	43,96	56%	30,21	42,23		
POLIO	27,72	36,46	50%	22,32	36,58		
MEASLES		5,88	54%	14,77	7,88		
BCG	85,43	87,08	90%		56,70		

VACCINATION COVERAGE, CITE SOLEIL, 1983-1985

The data show a slight increase over a year of the coverage for DPT and Polio (20 percent increase for DPT and 35 percent increase for Polio). After the 1983 survey, the directors of the community health program were informed of the immunization coverage and were asked to take actions to increase this coverage. The master five-year master plan for the Complex calls for 85 percent coverage by the 1988. If coverage continues to rise as new actions are being taken, it is likely that the objective will be obtained. New strategies are being defined now and will constitute subjects for future operational research.

2. Family Planning

Data on contraceptive prevalence are quite scant, primarily due to the incipient nature of this intervention in most projects (see discussion of family planning in Chapter VI). The most vigorous project, Pignon, has reported a contraceptive prevalence rate of 31 percent, almost three times that of Mirebalais, the next runner-up with 11 percent, followed by Marigot with 9 and Cayes-Jacmel with 8 percent, respectively (see Table 4). As of March 1986, Pignon had 658 family planning acceptors of which 71 were on the pill, 90 had received Norplant, eight had IUDs, 34 were using Depoprovera, 60 had been given condoms, 154 had had tubal ligations, and 241 had had vasectomies. All of these rates surpass the national 1983 figure of 7.11 percent of women ever-in-union using family planning methods. AOPS must deal here with the reluctance in individual projects to address the family planning issue and can only use persuasion to attain more vigorous effort in this area, despite the fact that family planning has been mandated as part of the Nouvelle Orientation and is integral to the Cooperative Agreements.

3. Nutrition

With the exception of Belle Anse and, in less measure, Mirebalais, there has been no longitudinal analysis of nutritional status data collected through census and rally post growth monitoring activities. This is partly due to the fact that recensus activities are only recently complete for some projects, to the lack of focus on the topic, to missing data in the records systems of some projects, and to the fact that the required analysis is rather more complicated than simply counting in short time frames when rates of change are not dramatic. Because the change identified between the first and seventh cycles at Belle

TABLE 4

CONTRACEPTIVE PREVALENCE (UTILIZATION), AOPS I AND II, SELECTED PROJECTS, SELECTED DATES (in percentages)

PROJECT SITE	POPULATION AS OF 30 APRIL 1986	(a)	(b)	(c)
Belle Anse	22,000	0.0	12.0*	n.d.
Fréres (FHASE)	30,155	n.d.	3.0	n.d.
Gros Morne	9,131	n.d.	7.0	n.d.
La Vallee	10,685	2.0	6.0	n.d.
Mirebalais	52,000	1.0	11.0	11.0
Pignon	29,293	n.d.	26.0	31.0
Thomazeau	10,392	n.d.	8.0	n.d.
La Montagne	8,265	n.d.	n.d.	1.25
Cayes-Jacmel	9,960	n.d.	n.d.	8.0
Marigot	10,000	n.d.	n.d.	9.0

- (a) As of RHDS Evaluation, Boston University, Summer 1984. Percent of women ever in union using family planning methods in 1983 = 7.11
- (b) After one year of project coverage.
- (c) As of 30 March 1986.
- * As of October 1985.

Anse was small (see Table 5), the project managers decided that it would be necessary to analyze each child's growth as measured against the expected rate of weight yain for a child of similar weight-for-age on the Harvard standard; in other words, age was disregarded and only speed of weight gain measured. This analysis revealed, first of all, that the most severely malnourished children displayed increased growth velocity compared to normal children. The data from the end of the 13th Belle Anse cycle suggest that those data become less sensitive with time as more change has a chance to occur. The change in Gomez categories between the 1st and 13th cycles is evident without additional manipulation: while there is a slight falloff in the Normal category, there is clear improvement in the numbers of children in Gomez II and III. The percentage of children in Gomez III dropped from 7.5 to 4.0 between the 1st and 13th cycles, not unlike the change from seven percent to three percent in Mirebalais between 1983 and early 1986. The percentage of children in the Belle Anse project who showed weight gain improved from 59 percent at the seventh rally cycle to 77 percent at the 13th cycle, and the percentage showing weight loss dropped from 21 to 15 percent.

TABLE 5

CHANGE IN NUTRITIONAL STATUS ACCORDING TO GOMEZ WEIGHT-FOR-AGE CLASSIFICATION, BETWEEN THE FIRST AND SEVENTH CYCLES, AND THE 13TH CYCLE OF RALLY POSTS, JANUARY - FEBRUARY 1986, BELLE ANSE PROJECT, AOPS

GOMEZ CATEGORY	FIRST RALLY	SEVENTH RALLY CYCLE	END 13TH CYCLE
Normal	29.6	29.5	28.0
Grade I	36.9	35.1	43.0
Grade []	26.0	28.2	19.0
Grade III	7.5	6.2	4.0*
Weight Change			
Weight up		58.8	77.0
Weight same		20.2	7.9
Weight loss		21.0	15.1

* These figures, extracted from the latest Belle Anse report to the AOPS Central Office, do not sum to 100.0. No explanation is given for the discrepancy nor could we identify one is the text.

In the absence of improvement (and probable deterioration) in the socioeconomic status of this population, the gain may well be attributable to the effect of the AOPS I/II project. Children with regular attendance at rallies (75 percent of this particular number) showed better growth than those with less frequent attendance (see Table 6).

4. Oral Rehydration Therapy

The coverage and effectiveness data for this intervention range from skimpy to non-existent. One report from the La Vallee project indicates that, of 50 mothers trained, 86 percent "knew" ORT, compared to the 58 percent who "knew" nutrition and the 70 percent who "knew" family planning; there is no information on how this was ascertained and what the implications were for behavior.

The Mirebalais project, however, reports that knowledge of ORT jumped from zero when ORT was introduced in late 1983, to 87.7 percent as of March 1986; use for the last diarrheal episode rose from zero to 40 percent of mothers whose children had a recent bout of diarrhea. This report is based on survey data and must be considered the most reliable information to date in the AOPS project on the subject of ORT. Figure 1 is a graphic--and dramatic--presentation of change in child mortality associated with the introduction of ORT. It is the only more or less straightforward impact statement available for this intervention.

5. Morbidity and Mortality

The 31 March report to CAN/SAVE from the Mirebalais project to CAN/SAVE associates increases in immunization coverage and contraceptive prevalence, and the decrease in prevalence of severe malnutrition, with a decline in infant mortality from 125/1000 live births in 1983 to 94/1000 in 1984. The report ascribes much of the decline to a significant reduction in neonatal tetanus due to vaccination of women at risk of pregnancy and to increased utilization of ORT (see Figure 1). Without knowing very much about the quality of the methodology used to gather these data, we feel that the time period and the sample size involved make this a fairly tenuous assertion at this point in the project's lifetime.

Unfortunately, it is not possible to take any exercise in correlation (to avoid specifying causality) very far because regular, consistently reported data on attendance are not readily available. For instance, Mirebalais, which works very hard at data-collection and compilation, shifted the time categories for reporting rally post attendance between 1984 and 1985. In 1984, attendance was reported by calendar month but in 1985 reporting periods were by cycles or periods of differing lengths; thus, it is not possible to say whether more or fewer pregnant women and children zero to five years of age came in given. successive, standard periods. The 1984 Mirebalais data, on the other hand, can be charted easily and can neatly reveal such programmatically important findings as the increases in attendance corresponding to "special outreach months" ranging from double to almost triple the attendance in months in which no special outreach efforts are made. Neither calculation accounts for the effect of program variability, perhaps most importantly the percentage of posts carried out as compared to the number programmed, and the implications of any such discrepancy in terms of population coverage. For example, between June 1985 and March 1986 in the AMOSSE projects, La Montagne, Marigot, and Cayes-Jacmel realized 79 (60 out of 76), 59 (46 out of 78) and 66 (50 out of 76) percent, respectively, of the rally posts scheduled for that period.

TABLE 6

NUTRITIONAL IMPROVEMENT (MEAN PERCENT OF EXPECTED WEIGHT GAIN) BY ATTENDANCE AT RALLY POSTS AFTER FIVE RALLIES (7-MONTH PERIOD), BELLE ANSE, 1985 (N = 388)

ATTENDANCE	MEAN PERCENT OF EXPECTED WEIGHT GAIN *
2 times (N = 21)	93
3 times (N = 73)	93
4 times (N = 104)	97
5 times (N = 190)	98

* Significant at p = 0.05

240 -ORT INTRODUCED IN 1983 <u>§</u>§§§§§ 220 -§§§§ şşşş §§§§§ **4444** 200 -§§§ 77777 §§ <u>§</u>§§§§§ 4444 999 **§**§§§§§ qqqq 99999 180 -11111 §§§§§§ **11111** <u>§</u>§§§§§ ┇┫┫┩ §§§§§**§**¶¶¶¶¶ **§§§§**§§ 11111 19999 **55**5551**99999** §§§§§§**19999** 19999 160 -§§§ 99999 **§**§§§§§ 77777 999 **§**§§§§§ <u>5</u>55555 19999 1111 δŞ 99999 § § § 140 -<u>5</u>§§§§§ 199999 **§**§§§§§ **§**§§§§§ 99999 **§**§§§§ 11111 99999 §§§§§§ **9999** 9999 **§**§§§§ 99999 120 -**§**§§§§§ 199999 **§**§§§§§ 79999 5§§§§§ **11111 §**§§§§§ 199977 <u> 5555</u> 11111 §§§§ 99999 <u>5</u>5555 <u>5</u>§§§§§ 99999 11111 199997 100 -<u>5</u>55<u>5</u>5 **§**§§§§ 1111 111 şşşş 19999 <u>5555</u> 99999 §§§ §§§ 1111 <u>5</u>55555 99999 **§§**§§§ 99999 §§§§ 11111 80 -99999 **§**§§§§§ **§**§§§§§ 99 şşş 111 99999 **5**5555 **§**§§§§ şşşş 11111 11111 §§§§§|**1111 §**§§§§§ şşşş 19999 60 -**5**§§§§**|11111 §**§§§§ 999 **§**§§§§§ **§**§§§§§ 5555 11111 <u>5</u>§§ **\$**§§§§ § § § <u>5</u>55555 11111 40 -55555 55 666 <u>§</u>§<u>5</u>§§ 99999 <u>5</u>5555 <u>§</u>§§§§§ **§**§§§§ 5555 **\$**§§§§ 11 11191 <u>§</u>§§§§§ **§**§§§§§ 55 555 99999 20 -**\$**§§§§ 77999 11111 55555 **5**5555 79999 <u>§</u>§§§§§ 59999 4444 **§**§§§§§ 77777 <u>5</u>§<u>5</u>§§ 99999 **§**§§§§ 79979 **§§§§§** 99999 **§**§§§§ 99999 **\$**§§§§§ 199999 **§**§§§§ §§§§§ §§§§§ | 11111 0 -11111 şşşşş 99999 11119 1981 1982 1983 1984 W/0 W

ORT KNOWLEDGE AND CHILD MORTALITY MIREBALAIS, 1981-1984 (UNADJUSTED)

W = KNOWLEDGEABLE ABOUT ORT

W/O = NOT KNOWLEDGEABLE

FIGURE 1

CITE SOLEIL

In the Logical Framework of the Urban Health/Community Development II Project Paper, a commitment is made to the following outputs:

- All programs evaluated. 0
- Community collaborator skills upgraded to distribute ORS, contraceptives; ٥ breastfeeding promotion campaigns, PHC outreach, nutritional surveillance, operations research studies done.
- Task-specific job training curriculum designed and instructors trained; 0 job placement and number of trainees increased.
- User fees analyzed and increased; US tax-exempt organization strategies, 0 materials developed for fund-raising.

Achievement of project purposes and outputs, to be determined through project evaluations, monthly and quarterly technical reports, service statistics, financial reports, and annual management reviews, was to be indicated by the following conditions and magnitudes of outputs:

- Program-based planning; budget system completed with data on on all CMSCS 0 functions.
- PHC outreach includes 100 percent of target population, with special ef-0 fort on public health education, operational research, and immunization.
- Competency-based job training relevant to local labor market developed; 0 remedial vocational trainers' skills upgraded.
- Income from user fees, etc., increased. 0
- Impact of all interventions known and results used to revise programs. 0
- Breastfeeding campaign for 5,000 women; 60 percent of children with normal 0 nutritional status and 90 percent immunized against DPT, polio, and measles.
- Five new job training courses implemented; 22 instructors trained; 2,500 0 graduate remedial/vocational education programs with 1,500 job placements.
- User fees and sales provide 15 percent of CMSCS budget; fund-raising in-0 come increase by 20 percent.

The implementation target indicators set forth in the PP Logical Framework were mortality reduced to 55/1000, life expectancy increased two years, and annual per-capita income increased by \$15.00. No other coverage, effectiveness, or impact targets are specified in either the PP or the Cooperative Agreement.

The format currently being used by the CMSCS for reporting to the USAID is the Project Implementation Status Report (PISR). In the section of the PISR entitled "Major Outputs Achievement Status," which subsumes end-of-project outputs, reporting period achievement status, and cumulative achievement status, the CMSCS has organized its response under a sensible modification of the major project components, adding a fifth component which breaks apart the rather peculiarly lumped "Health Services and Operations Research." The reporting categories now being used, which we adopted for this progress analysis are: 1) improve institutional management capacity; 2) improve primary health care activities, 3) develop human resources activities, 4) increase self-financing capa-city, and 5) increase operations research activity. 41

1. Improve Institutional Management Capacity

"The Complex will upgrade its Management Information System to 1) complete implementation of automated program planning and program-based budgeting, and 2) expand the existing Information System to include all CMSCS activities, establishing clearly defined, quantifiable goals for monitoring progress.

"Complex administrators will undertake operations research activities aimed at improving program cost-effectiveness, management, and financial self-sustaining activities.

"The Complex will further keep USAID/Haiti fully informed of the progress of the interventions through quarterly reports and Annual Management Reviews." Computer hardware and software were purchased to facilitate data analysis and the development of an automated, program-based planning system. The rudiments of a planning and budgeting system are suggested in Chapter V of this evaluation; as yet the system is not in place.

No clearly defined, quantifiable goals for monitoring progress have been selected yet, although the substance of such indicators is provided in the PP. A minimal set of these in the form of coverage, effectiveness and a few key impact indicators should be decided upon by the CMSCS and AID, perhaps in conjunction with a similar determination for the AOPS and Mobilizing Mothers projects.

See Section E below, "Increase Operations Research Activities."

Reporting to the USAID was standardized as of March 1986 with adoption of the PISR for that purpose. The reporting period covered was 1 April 1985 to 30 September 1985. A PISR was due 30 March 1986 but was not yet available, reasonable enough given the political disruption during the intervening months which affected both the USAID and the Internal reporting from CMSCS. the centers and Hospital is on a quarterly basis. These two principal reporting modalities should be combined and both done guarterly. Financial accountability is well reported and could even be simplified (see Chapter V).

Project implementation has improved because the directors of each Center now have increased autonomy in the conduct of activities, meeting biweekly with the CMSCS manager to report on program status. An Assistant Project Coordinator and a Training Coordinator have been hired.

2. <u>Improve Primary Health Care Activities</u>

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

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

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

The CMSCS presently covers 100,000 population, now totally registered, with existing Col-Vols. Uncensused areas or those which need re-censusing because of population turnover and/or immigration will be censused beginning in September. The CMSCS has asked AID for funds for 50 more ColVols to cover the anticipated total for the Cite Soleil population of 150,000. Twenty new ColVols were trained between April and September 1985 to cover the last 15,000 new patients registered in that period.

Because this is Vaccination Year at the CMSCS, a seminar was conducted to train ColVols and other health workers in immunization delivery. Vaccination coverage increased from 45 to 69 percent for all immunizations of children under 5. Complex technicians also plan a major, two-year campaign to promote breastfeeding among mothers of Cite Soleil, as studies have clearly documented the widespread practice of early infant bottle feeding and its correlation with increased Infant Mortality Rates in the area. The Complex health team plans three types of interventions to counteract and change this behavior:

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

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

c) Community Education:

modify curriculum at Complex educational facilities to include information on breastfeeding; develop audio and visual strategies, including use of mobile loudspeakers and engaging local artists in the community to design displays for visual messages; develop films to show at Cite Soleil community centers. Data analysis now being completed at Tulane University for the Breastfeeding Promotion Followup Study. Interventions will be designed on the basis of these research findings. Evaluation of the effectiveness of all these interventions will occur through pre- and postimplementation surveys on infant feeding knowledge and practices among mothers and trained health personnel and by changes in child morbidity and mortality.

The anti-diarrhea/ORT program is being evaluated, using a short questionnaire on knowledge and use of ORT.

Data on immunization coverage are being updated and coverage evaluated.

A Vitamin A coverage survey with Helen Keller International is pending AID/W central funding.

A Nutritional Status Survey and an evaluation of the Nutritional Rehabilitation Center and feeding practices in the neonatalogy section of the Ste. Catherine Laboure Hospital are in the design phase.

3. <u>Develop Human Resource Development Activities</u>

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

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

First, the Complex will increase the marketable skills among the In the period from April to September 1985, the first literacy class of 25 people was graduated as part of the new curriculum addition of a literacy class of 4 levels equipment to primary school, with a total enrollment of 50 students, and a volunteer electrical engineering teacher hired. An Advanced Electronics course was added to the Centre Papayo curriculum. Two new Vocational Centers were constructed in Boston and Brooklyn. population, upgrading the technical skills training programs and providing competency-based training for jobs actually available in local business and industry. The project's training component includes curriculum design and upgrading existing instructors' skills to teach short-term courses, developed through direct contact with local industries. The project budget includes funds for Technical Assistance in educational technology to help the Complex implement this activity.

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

4. <u>Increase Self-Financing Capacity</u>

Within the context of this project, the Complex will initiate a number of steps leading to greater self-reliance:

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

Documentation of these activities (e.g., numbers of students, status, training costs, etc.) is in the collection of notebooks maintained by each sister-administrator. Evaluation and monitoring criteria (including follow-up of trainees) and quantifiable goals remain to be established. Service statistics not yet integrated into central MIS since that system is in the early stages of implementation following purchase of necessary hardware and software.

Not yet in place.

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

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

d) The Complex will seek to establish pay-back schemes whereby Complex trainees successfully placed in an income-earning position, as well as their employers, would reimburse the Complex for costs associated with the trainee's education. Revenues for the Complex are being generated by patient fees, product sales, and school fees, which are collected at each center and used to support its operating costs. Patient fees are the largest source, received from outpatient curative visits at CHAPI, prescriptions at the CHAPI pharmacy, X-rays at the hospital, and hospital admissions. A 1985 change in fee structure provided a 21.5 percent increase in revenues for CHAPI and St. Catherine Laboure Hospital.

The Friends of Cité Soleil (FOCUS) acquired legal status as a U.S.-based ronprofit to provide the major fundraising effort for the CMSCS. A fundraising pamphlet has been produced. Success to date has been limited, due to lack of a definite strategy, inhouse professional expertise, and high priority. A U.S. public relations firm has been engaged to work with the Complex to fundraise on a continuing basis.

Handicraft sales were increasing through an affiliation with Zin d'Art and U.S. Embassy promotion, until political instability affected all the country's crafts endeavors.

A pig cooperative, with technical assistance from IICA, is being established. The CMSCS is also involved in the formation of a cooperative bakery with an Oxfam grant.

5. <u>Increase Operations Research Activities</u>

During the five-year AID project, activities of the Complex's Research and Evaluation Division

OR and Other Studies Under Way or Recently Completed:

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

1. Study of acceptability of oral contraceptives and dropout patterns.

2. Clinical trial of Norplant.

3. Attitudes and practices among condom users in Cité Soleil.

(The Family Planning Center is moving to a larger, more-economical, more appropriate location, as a result of the Contraceptive Prevalence Survey recommendations by technical consultants.)

4. Breastfeeding practices and the fight against the bottle.

5. Erythromycin, uterine and vaginal infections, and low birth weight, and, alternative approaches to reducing the risk of infections and mortality in premature infants.

6. Alternative training programs for traditional birth attendants (with AOPS).

7. Methodology for immunization coverage evaluation.

8. Impact of measles immunization and mortality.

(This study has already produced a change in MSPP norms for measles vaccination.)

No management OR activities have been undertaken and, although user fees have been put in place or increased, no explicit OR has been applied to this area.

III. PROJECT STRATEGY

A. RELATIONSHIP TO AND COMPATIBILITY WITH THE USAID/HAITI ACTION PLAN

The Scope of Work asks that the Evaluation Report "clearly and specifically describe" how the projects relate to and address objectives of the USAID/Haiti Action Plan; the goars, indicators, and benchmark actions for FY86-88 of the Plan are presented here in Appendix B. The Health Sector goal of the Plan is to reduce the infant mortality rate in Haiti to 50/M by the year 2000 from the 1985 baseline estimate of 125/M, with interim benchmark performance indicators of 115/M for 1988 and 90/M for 1990.

The Plan shares with the Nouvelle Orientation of the MSPP a commitment to six key primary care interventions. Those are:

- 1. Immunization of children under 24 months against diphtheria, pertussis, tetanus, measles, and polio, and BCG vaccination against tuberculosis.
- 2. Improved diarrhea management, including use of oral rehydration salts, earlier treatment, and continued feeding.
- 3. Immunization of all women against tetanus.
- 4. Control and treatment of malaria at the community level.
- 5. Promotion of breastfeeding.
- Nutrition surveillance and education of mothers in appropriate weaning and infant feeding techniques.

The Mission's Health Strategy is composed of four elements, whose purpose is to increase the availability of the key PHC interventions on a continuing basis:

- 1. Improving public sector management of resources.
- Improving technological packages for delivery of primary health care services.
- 3. Developing and strengthening self-financing mechanisms for meeting recurrent cost requirements.
- 4. Improving private sector support for primary health care.

Both the AOPS and Cité Soleil projects are fully consistent with the USAID Health Sector goal. Neither project sets forth in formal documentation any specific commitment to preestablished mortality- and morbidity-reduction indicators. However, the Cité Soleil project does commit itself to measure achievement of its goal ("to improve the health socioeconomic status, and standard of living of Cité Soleil residents") by measuring improvements in health status, longer life expectancy, and increased per capita income among members of the target population. A number of the AOPS projects have set targets for themselves which are primarily coverage and effectiveness targets intermediate to the ultimate goal of mortality and morbidity reduction, with the assumption that each intervention delivered contributes to that reduction. Furthermore, both AOPS and the Cité Soleil projects are also fully committed to an emphasis on a limited set of priority interventions which embrace the six PHC interventions which constitute shared priorities for the MSPP and the USAID.

The elements of the AOPS and Cite Soleil projects are also consonant with the elements of Action Plan strategy. Element 2, which seeks to improve technological packages for delivery of primary health care services, has as its 1987 target, cost-effective technical packages of community-based services and support which can effectively reach 50 percent of the child population and which can be extended to the rest of the population as resources permit. Both projects are, in several important ways, essentially large operations research endeavors which test such packages for delivery to entire target populations in circumscribed areas. These include: improving the technical skills of PHC providers; development of community service methodologies; and use of such innovative techniques as population-based approaches, the rally post, and community-level data-gathering and analysis. The CMSCS health service technicians are committed, as part of the Complex's five-year plan, to focus their efforts on targeted interventions in health service delivery and on health problems which present the highest risk to children under five and the most vulnerable groups of women of reproductive age. Among these are the improvement of community outreach; promotion of breastfeeding; and increased operations research activities related to the key PHC interventions. These approaches are described and analyzed in Chapter VI, Technical Issues.

With regard to element 3, which intends to develop and strengthen self-financing mechanisms for meeting recurrent cost requirements, the Cité Soleil project is engaged in a number of cost-related endeavors. The CMSCS has committed itself to significantly increase its own self-financing capacity. Included in this effort are the establishment of different kinds of user fees and prepayment schemes, as well as sales of CMSCS products and fund-raising. CMSCS has committed itself to carrying out short-term, targeted operational research projects to design and test more cost-effective alternatives for PHC problems. AOPS attention to financing issues is focused more narrowly on issues of incentives for CHWs and what package(s) of monetary and non-monetary incentives can be produced to reward those key links in community health outreach. These efforts are discussed in more detail in Chapter V, Financial Management.

In terms of population coverage, the USAID goal is "to assist PVO institutions to extend PHC services to an additional 500,000 people and target resources more explicitly on child survival." The benchmark indicator for that year is that a total of 10 PVOs began implementing child survival programs impacting a population of 250,000. As of 30 April 1986, the active AOPS projects were already covering 352,264 persons, without counting the expansions now under consideration for Las Cahobas, Thomazeau, Duplessis (all to 25,000) and Fermathe (50,000). As for the focus on child survival, that is the exact focus of the AOPS and Cité Soleil projects and, in our view, is indisputably responsive to current Agency priorities.

Table 7 presents a summary of coverage now being provided for child survival activities by different PVOs in Haiti, some of which are already using or will be using the AOPS model, that is, a focus on infants, children, and

TABLE 7

PRIVATE-SECTOR COVERAGE OF THE HAITIAN POPULATION WITH EXTENSIVE OUTREACH SERVICE NETWORKS, INCLUDING POPULATION-BASED PROGRAMS, AS OF APRIL 1986 (All Figures Are Rounded Estimates)

AOPS I and II Projects	400,000 _	1,000,000***** AOPS Projects
ICC* CARE*	500,000 - 500,000 _	1,000,000 large US PVOs
CMSCS** MINV* Save the Children*** ADRA*** Foster Parents' Plan*** Albert Schweitzer*** Leogane, St. Croix*** Secours Ecumenique d'Entreiade**** Plaisance Hospital*** Pilatte Hospital*** Cooperants (French)**** Jean Rabel, Equipe	$ \begin{array}{c} 100,000 \\ 100,000 \\ 50,000 \\ 50,000 \\ 40,000 \\ 160,000 \\ 110,000 \\ 120,000 \\ 50,000 \\ 40,000 \\ 60,000 \\ 40,000 \\ \end{array} $	940,000 all others
La Saline**** Bon Repos****	10,000 10,000 2,350,000	

* U.S. PVOs with the largest programs.

- ** An AJPS member, but with its own independent project funding. CMSCS has requested that it expand to 150,000.
- *** U.S. PVOs with less coverage; this should include SAWSO as well, but no data were available.
- **** Indigenous PVOs or those with non-U.S. Government funding.
- ***** When AOPS III projects are included and all AOPS I/II expansions are complete.

mothers; emphasis on a limited set of priority interventions; total population registration with identification and follow-up of priority groups; the rally post; and a standard basic service delivery plan. The Table 7 totals indicate that the private sector as a whole, and AOPS in particular, is already far surpassing what now seems to be rather modest USAID goals for child survival. In 1982, there were only two population-based community health programs in the country: one at Albert Schweitzer, with a registered population of 160,000, and one at Cité Soleil, with a registered population at the time of 80,000. Three years later, the number of persons enrolled in population-based programs had jumped to 610,000, with an additional 400,000 persons covered by extensive outreach service networks operated by scattered PVOs around the country. As of 1986, these combined entities are already covering about one-half of the entire population of six million.

We must, nevertheless, be circumspect about references to coverage: child survival activities are covering only a subset of the entire population, that is, children under five and women of fertile age, and we have not begun to talk about effective coverage. At the same time, we do know that MSPP coverage of the Haitian population, because of the large number of constraints internal and external to the public health sector, is basically passive and opportunistic, and that large portions of its putative target population are simply not being reached at all.

B. INTEGRATION AND COORDINATION BETWEEN PUBLIC SECTOR AND OTHER PRIVATE-SECTOR HEALTH PROVIDERS

Integration and coordination with the private sector, in this case AOPS (of which the CMSCS is a member), is a matter both of substance and of process. The USAID describes a benchmark for this relationship: "While competition for human and financial resources continues between the public and private sector, mechanisms for discussing differences have been established; moreover, public/ private sector collaboration in this sector is better than in most other sectors." In the case of AOPS and the public health sector, it seems to the evaluation team that this condition has already been attained and that there is relatively little competitiveness between the two subsectors. In fact, the Cité Soleil and AOPS projects virtually define USAID strategy element 4, "improving private sector support for primary health care," which includes the crucial dimension of private-public sector collaboration for the purpose of eliminating redundancy, stimulating complementarity between public and private programs, and encouraging creativity and innovation.

In terms of substance, we have already noted the congeniality between AOPS and the MSPP in terms of their focus on infants, children, and mothers, and on a limited set of priority interventions. A recent article (Augustin, et al, 1985) notes:

"Focus on infants, children and mothers. The PCH elements stressed in the <u>Nouvelle Orientation</u> of Haiti's MSPP was oriented toward the needs of infants, children and mothers. The UNICEF campaign for a 'child survival and development revolution' was getting under way with its stress on GOBI-FFF, and those interventions are both similar to the <u>Nouvelle Orientation</u> and focused on mothers and children. It should be noted explicitly however, that the AOPS approach was planned with a similar focus, not as a matter of blind conformity or slogan-following, but because in Haiti (as indeed in most poor populations of the Third World --whether urban or rural) it makes eminent sense. Most of the gross excess of mortality in those populations is in fact occurring in infants and young children and much of that mortality is potentially preventable by the application of a short list of relatively simple and inexpensive interventions--namely those in the <u>Nouvelle Orientation</u> or GOB1-FFF-delivered to mothers and children."

There appears to be no rivalry between the MSPP and AOPS. In fact, in March 1983, serious thought was given at high levels in the DSPP to assigning to AOPS the role as intermediary between the DSPP and all the private voluntary agencies in Haiti. This role would have included: 1) screening, in cooperation with regional or district public health authorities, all requests by PVOs to develop health activities in Haiti; 2) coordination and control of all PVO medical and paramedical activities, taking into account the public health structure at the regional and district levels; and 3) educating all PVOs on their obligations for integration within the National Health Plan. In other words, AOPS would have had a lead role in both the public and private sectors for supervision, evaluation, and coordination. With the subsequent changes in MSPP organization and staffing, and with the expansion of AOPS activity vis-a-vis its member organizations, this charge was never formally assigned. It would be unlikely, however, that such a gutential role would even have been imagined if AOPS had been seen as either potentially competitive or troublesome.

The same article describes the process defined for AOPS/MSPP collaboration: AOPS and its member NGO organizations, as well as the MSPP which had called for NGO participation in the first place, were committed to genuine collaboration and, from the beginning, it was understood that AOPS as the coordinating organization, the NGO itself, and the Ministry would contribute resources.

AOPS, with financial support from USAID, was able to provide a variety of resources for program planning, start-up, monitoring and evaluation, including:

- 1. The development of the basic plan.
- 2. The one-month training program for technical directors.
- 3. Technical assistance in initiating the program.
- 4. Census/registration forms and other record forms.
- Assistance in data management, analysis of results, and evaluation of progress.
- 6. The sum of \$10,000--one dollar per person in the total population to be covered--for start-up costs, to be used for equipment, supplies, renovations, CHW training, and other expenses at the discretion of the NGO.

The Ministry, acting entirely in accord with the principle that the NGOs were a fully integrated part of the Haitian PHC delivery system, agreed to provide resources, mainly for program implementation as follows:

- 1. Personnel--physicians and/or auxiliary nurses--to be secunded to the NGO.
- 2. Cold chain equipment and vaccines.
- 3. Essential drugs and contraceptives.
- 4. Growth charts and, if necessary, scales.

The NGO, to be eligible for AOPS assistance, must be registered with the Ministry and also have its specific community health program approved by district health officials. Thus, each NGO program is fully integrated into Ministry's district-level health plans. In addition, the Ministry requires the participating NGOs to:

- 1. Emphasize the priority interventions, as described above.
- 2. Take responsibility for all or part of basic health services for a defined population in a specific geographic area.
- 3. Supervise other health personnel, especially community health workers and volunteers (e.g., midwives).
- Train and supervise their paramedical personnel according to Ministry norms.
- 5. Develop new programs and facilities in areas of the country not adequately served by the Ministry.
- 6. Provide regular reports of health data and service statistics, using Ministry norms (DSPP, 1983).

Perhaps the best example of what has been possible in terms of private-public sector integration is the AMOSSE project group (La Montagne, La Vallée, Marigot, and Cayes-Jacmel) in the south of Haiti. Amosse is the acronym for the Association Mixte des Deuvres de Sante du Sud-Est, and the emphasis is on the term "Mixte." It is under the District Director of the MSPP, who is also the Technical Director of AMOSSE, and provides good evidence that a well-integrated, public-private sector project can serve as a model for what a commune doctor can achieve under such an arrangement. The project coordinates the activities of Foster Parents' Plan (Plan International Parrainage), Eye Care Haiti (ECH), and AOPS. MSPP priorities are followed and the guiding principle is cooperation; in fact, the decision was made, a priori, to use three underutilized MSPP clinics and to combine activities. AMOSSE became the outreach and management mechanism for the public health sector in the area, at the same time that the public sector was enabled to make a substantial contribution in terms of fixed facilities, and human and material resources, as well as to contribute in ongoing fashion to maintenance of MSPP norms and to general supervision. The MSPP provides its staff doctors and auxiliaries to support the project, that is, they form the nucleus of the rally post teams, and also provide the vaccines, cold chain, alcohol, syringes, etc. The MSPP

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also provides the on-site doctors for Marigot and Cayes-Jacmel. The AMOSSE administrator is an ex-employee of the MSPP and is particularly valuable because he knows both sectors, understands MSPP problems and objectives, and has helpful contacts.

Nevertheless, AOPS' experience with integration has varied regionally, particularly at the outset when the project founders engaged in their first promotional visits. In one region, the director was dynamic and already interested in innovative outreach approaches, and logistics were easier. In another, the director wanted to determine the zone the AOPS project should be selected from; in another, the director was powerful and committed but wanted more control than AOPS was comfortable with; and the fourth region is still not well organized and has major logistical problems. This is to be expected, since the MSPP has been in the process of establishing regionalization as well as a new logistics system; at the same time, it indicates that integration has been harder work than enunciation of easy pieties would suggest.

AMOSSE is not an exception, however; other AOPS projects, e.g., Pignon, have similar relationships or have steppe in (Belle Anse) where the MSPP simply has not been able to function. At the same time, not all projects display an actively integrationist stance and some give an impression of having essentially perfunctory MSPP relationships. While AOPS is dealing with a fair amount of heterogeneity and may consider itself unable to control this aspect too intensely, there is at least one thing AOPS could do to make the integration effort more even across projects. As things stand now, the AOPS coordinators do not explicitly or regularly incorporate entry and exit interviews with local-level MSPP authorities when they come into a region to do either scheduled or ad hoc supervisory visits. This would not be difficult or excessively time-consuming, and would serve to enhance coordination to the possible benefit of both sides. There have been problems with logistics and supplies in projects where the MSPP has had the responsibility for such provision; while this may simply be a problem of non-availability, a more regularized contact might be rewarding.

Finally, there is the USAID role vis-a-vis public-private sector integration and coordination. AOPS was established as an AID project to do precisely that and, of the approximately 200 PVOs providing some kind of health delivery in Haiti, 90 were AOPS members as of April 1986; of those, 32 have signed a contract with AOPS. The role to which USAID/Haiti committed itself in the AOPS Cooperative Agreements was "to endeavor to encourage all private voluntary health service groups to join with AOPS and the Department of Public Health and Population (MSPP) in implementing the national health plans," as well as "to facilitate collaboration and coordination between the MSPP and private sector health agencies." The team's impression is that AOPS is doing most of this work and that AID's integrative role appears to have been much more activist in the past; at present it seems to be largely passive and benign. If AOPS is doing this work and there are no striking problems, then it is probably just as well to leave that situation alone. At any point where discontent or competitiveness show signs of setting in, then the USAID nealth office might serve an intermediary role, and should assume the responsibility for keeping its finger on that particular pulse. The evaluation team did get some glimmers of stress between projects which were exiting the AOPS system. however, one of the limitations of the evaluation was that we did not include site visits to any of those projects as a part of our sample and were left at the level of rumor and innuendo.

IV. PROGRAM MANAGEMENT AND ADMINISTRATION

A. STAFFING AND HUMAN RESOURCES

The organizational structures of AOPS and the Complexe Medico Social de Cité Soleil are quite different, as is to be expected from their patterns of historical evolution, the concentration of their responsibilities, and the distribution of the infrastructure for which they are responsible. An annotated "organigram" for each institution is presented below (Figures 2 and 3), followed by a brief discussion of major issues which confront them.

1. AOPS

a. The central level

There are two major issues with regard to the organizational structure of AOPS. One is the role of the four coordinators. As this evaluation was concluding, no decision had yet been reached about whether the coordinators would continue to be regional, one each for Port-au-Prince and the South (Fanfan), the Transverse and the North (Simeon), and one to cover monitoring and evaluation overall (Robin). One possible revision to this division of labor would make one coordinator responsible for AOPS III projects (Robin), another for general matters of mother education and family planning (Lauredent), another (Fanfan) full-time and one (Simeon) half-time for AOPS II and evaluation.

In the view of the evaluation team, there are good arguments for a division of labor based both on regionality and special expertise which would, however, involve the addition of new staff and skills. Three of the present coordinators are doctors and all have varying degrees of community health outreach experience and skills; one coordinator (Lauredent), not a doctor, does have special skills in mother education and, in conjunction with the four monitrices who will be working in that area, particularly in Mirebalais and the Cite Soleil project, should have design and oversight responsibilities for this area of the project as a whole. Another (Fanfan) has been developing some interesting techniques for monitoring and evaluation and should be allowed to continue to work in this area, in conjunction with a statistician the evaluation team recommends should be added to the staff to pull together that very important aspect of the AOPS projects; this is discussed in more detail below in the section on Monitoring and Evaluation. The other two coordinators would have regional responsibilities, assuming their disposition to do that, for both AOPS I/II and III projects, which would permit them a continuing relationship with those projects and with the Ministry of Health regional and district authorities with whom we have recommended more regularized liaison.

There is another area of expertise that is not represented on the AOPS staff, which the team considers crucial. There are a number of issues that may be said to be issues of "micro-management": showing and helping institutions how to set up their programs and assure that things do not deteriorate; providing technical reinforcement for setting up and running rally posts with really productive, time-sparing efficiency flows; setting up, with the help of the central-level AOPS accountant, reasonable, simple, standard ways of budgeting and reporting on expenditures; and so forth. At present, there is no one on the AOPS staff who has the technically developed management skills which

FIGURE 2

INSTITUTIONAL STRUCTURE, AOPS (MAY 1986)



FIGURE 3

INSTITUTIONAL STRUCTURE, CMSCS (MAY 1986)



- * New positions under discussion, pending USAID approval and corresponding funding.
- ** Position to be upgraded; similarly pending approval.

could speed up the institutionalization of projects and their smoother operation, as well as profit from the lessons learned to date.

Finally, there is the matter of overall project direction. The present General Secretary will be increasingly involved in the setting up and operation of the Child Survival Institute and has already come to be stretched quite thin. An Executive Director should be hired for the AOPS projects as soon as possible and some determination will have to be made about the overall attribution of responsibility for the AOPS I/II and the AOPS III projects. Although the latter are part of the Mobilizing Mothers project, they are larger replications of the model used to date and there are good administrative arguments that can be made for keeping responsibility for all the AOPS projects in one management core. Certainly from the standpoint of supervision, monitoring, and evaluation, as well as the relation of these to the development and continued testing of the AOPS model, there are good reasons for considering all AOPS projects as parts of the same whole. In any event, the Executive Director should be both technically qualified and a vigorous implementer, and someone who can provide adequate oversight for the crucial reporting and analytical functions for satisfaction of the bureaucratic requirements of AID; for communication with the MSPP; and for the adequate, ongoing broad-gauge supervision and analysis the project needs to fulfill its central role as an operational research model for a new approach to health care in Haiti.

It is also crucial for the executive levels of AOPS to assure the continuance of one of the attributes that the evaluation team considers one of the major strengths of the project. While there has been one instance of a small group of projects which seemed to be going well turning out to be quite troubled, in general the sense is that upper levels of AOPS program management are well in-Although the evaluation team found problems in the reporting system formed. (discussed below in the section on Monitoring and Evaluation), within AOPS reports are circulated and absorbed quickly and, since the addition of the Auditor position (Robin), there is no sense of being out of touch with projects. If there is to be elimination of the Auditor position, which was seen as temporary in any case, then the Executive Director should be mandated to perform ongoing audit activities or delegate them explicitly to another staff member. However this oversight responsibility may be delegated, no request for project extension or for follow-on funding should be answered affirmatively without a central management investigative visit. In the case of extension requests, both the Executive Director and the AID project officer should make a site visit to see how the project is operating before funding is approved.

The courage to terminate or withdraw support from a project which augures poorly, even after being given a reasonable amount of time and technical assistance, is an expression of strong management will. It is not atypical, especially in relatively small societies where such sanctions are not easily applied, for organizations to look away from inappropriate behavior and let institutional life go on. In this light, it is important to note that AOPS, in fact, withdrew or withheld support from several projects which displayed discouraging signs. In two projects there was reason to believe that project funds might not be well used. In two others, the institution had rather strong views on the model that should be used for primary health care delivery, views which were incompatible with the AOPS model; support was terminated or has been suspended until such time as such philosophical and technical decisions are resolved to everyone's satisfaction.
b. The field level

Since all AOPS projects are set on a pre-existing base, are found in different localities, have different histories, and have had recourse to different pools of human resources variously funded, it is not surprising that all AOPS projects are organized somewhat differently. Typically, the staff of the AOPS field project institutions includes: one physician, one auxiliary nurse, one record-keeper (archiviste), and ten community health workers. The physicians are, by and large, one to two years out of medical school, the auxiliary nurses have received nine months of training in a nursing school, and the community health workers and archivistes have received one month of training by the physicians. Of the first group of 16 AOPS institutions, all received some form of external support from expatriate organizations, usually church groups. Despite this external support, the financial situation of these institutions was quite modest. Only one institution in this group (Pont Sonde) had managed to acquire some measure of financial autonomy through the operation of a fee-for-service curative care center. Thus, most of these institutions were quite limited in their operations and, correspondingly, in the amount of available, adequately qualified staff. For this reason, MSPP staff which the Ministry no longer had the funds to support or could not support logistically have become a primary source of staffing for the AOPS projects, under different support arrangements and combinations of funds.

At the beginning of the AOPS I project, none of the newly participating institutions had a full-time manager attached to the community health program. The person with overall responsibility tended to be a priest, pastor, nun, or physician, with other duties besides those of coordinating the community health program. Table 8 describes this initial condition. Table 9 describes the current situation, with the added emphasis on the presence of a doctor as the leader of the project, together with the evaluation rankings assigned to each project.

TABLE 8

SURVEY OF MANAGERS OF THE 16 AOPS I INSTITUTIONS

SITE	MANAGER	OTHER_RESPONSIBILITIES
Montrouis	Priest	Seminary, school, community development
La Vallèe	Social worker	Community development
Las Cahobas	Pastor	Church activities
Fds. Parisien	Pastor	Church, school
Pont Sonde	Priest	Church, community development
Gros Morne	Physician	Hospital administrator
Pignon	Physician	Hospital administrator
Taifer	Priest	Church, school
Thomassique	Priest	Church, community development
Belle Anse	Physician	Health Center
Thomazeau	Physician	Health Center
Duplessis	Lawyer	Community development
Frères	Physician	Hospital construction
Bonne Fin	Physician	Hospital administration
Quartier Morin	Pastor	Church, community development
Mirebalais	Administrator	Eye health program

TABLE 9

INSTITUTIONAL SPONSORSHIP AND PROJECT ADMINISTRATION, ALL CURRENTLY ACTIVE AOPS PROJECTS AS OF APRIL 1986

	EVALUATION	INSTITUTIONAL	LEADERSHI	P/ADMINI STRATION
PROJECT	RANKING	SPON SOR SHIP	M.D.	OTHER
 Montrouis La Vallee 	* 2	 Episcopal Church Community Group (CODEVA) 	.A . 	 * nurse * head of community group; problems with
 Las Cahobas 	2	 Baptist Missionary Convention 		doctor turnover * pastor; problems with doctor turnover
Mirebalais	5	Eye Care/March	* pd. by project	
Gros Morne	3	Community Group/Hopital Aima Mater		* Agent de Santê; have no doctor
Pont Sonde	3	Catholic Priest 		* teacher; was set up by prlest, one of AOPS founders
Fonds Parisien	2	Pastor	Ì	* pastor
Belle Anse	5	Medicos Mundi	 *	(
Bonne Fin	**	Missionaries/Hopital Lumiere	+	1
Thomassique	4	Priest/community group/MSPP/Hopital Bientalsance	* denotes services	* prlest; have no doctor
St.Raphael Pignon			* pd. by MSPP?	1
Freres	4	FHASE/World Vision/MSPP/community group	* pd. by FHASE	1
Thomazeau	2	Small PVO formed by 2 expatriate	¦ ∗ Ⅰ	
Duplessis	2	Community group (CODIPP)		<pre>* teacher/community leader; drs.pd.by project, turnover </pre>
Marlgot	3	AMOSSE/Eye Care/Foster Parents! Plan/MSPP		prooreins
Cayes-Jacmel	5	"	*	
La Montagne	4	11	*	
Cazale	1	Episcopal clinic	* new	
Carrefour-Poy	2	Community support group (UEU)/MSPP Centre Mixte		<pre>* nutritionist; drs. pd. by project; turn- over problems</pre>
Fonds de Negres 	4	Community group		* Salvation Army offi- cer; have no doctor (left to take res!- dency at University Hospital)
Fermathe	4	Baptist mission I	*	
Quartier Morin	2	Baptist missionaries/Maison Compassion		* pastor
Bethel	**	Same as Thomazeau	*	
Grande Colline	** (Community group (AD1GCOM)		* 1

* No longer functioning within AOPS.

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** Too new to rate or only partially functioning.

The question has been raised as to whether the presence of a doctor in the pivotal leadership role in an AOPS project is crucial. Looking at the evaluative rankings--an admittedly imprecise and intuitive activity--it would seem that there is a positive correlation between the presence of a qualified, com-Of the projects ranked as 5 mitted doctor and a well-functioning project. ("exemplary"), all have competent and committed medical leadership. Of those ranked as 4, two have active medical leadership (La Montagne and Freres); one (Fermathe) has strong medical backup as well as strong Baptist mission support. In contrast, Thomassique has no doctor but is supported by an extremely forceful community group, "Tet Ansam." Fonds des Négres has just lost a very good doctor and the implications of this for the project are not clear; this will be a key project to watch, in order to see if, once well started with good medical support, a project built on the AOPS model can go continue comfortably and effectively on its own. In fact, all the projects which have been ranked as 3 and above and which do not have a doctor or continue without one, should be carefully watched, since they should provide some reasonable response prior to the design of AOPS IV, as to whether a doctor is essential for startup but less important as a project matures, or not necessary at all under certain circumstances. This group would include: Thomassique, Fond de Négres, Gros Morne, and Pont Sonde; it might also include a project which has moved outside the AOPS fold, that is, Montrouis, for purposes of history and comparison.

One thing that is clear is that all projects which have had problems with doctor turnover have had problems attaining adequate functioning. Some of these, e.g., Duplessis, La Vallée,* and Duplessis, all have powerful community-based leadership. It is not clear where the direction of causality moves. Do projects with strong community leadership generate conflictive situations for doctors, who have their own professional predispositions to want to run things? Or, have these strong communities simply been unlucky enough to be saddled with doctors who are not really interested in doing primary health care, despite exposure to a month of training at Cité Soleil, and whom the community has finally had the courage to fire?

An easy answer to those questions would have required more on-site investigative time than the evaluation schedule allowed. However, we have concluded that there is an argument to be made for a continuum. At the positive end, where the best-functioning projects are found, one also finds the combination of strong medical leadership and active community support. At the negative end, where projects are functioning least well, there is weak community support and an uncommitted doctor. Returning to the positive end, the next best option is an active community with a weak and uncommitted doctor (who can always be fired). And, finally, the next-to-worst scenario is a committed doctor who has a lethargic or hostile community which he alone can only change with difficulty (see Figure 4).

^{*} The case of La Vallèe, now on its fifth doctor, is instructive. Dr. #1 was trained at Cité Soleil but left after mutual misunderstanding, apparently about money; he is currently working successfully at La Montagne. Dr. #2 got part of the Cité Soleil training, but CODEVA did not like his bedside manner. Dr. #3 was a social service doctor who seems to have run afoul of community leadership. Dr. #4, also a social service doctor, was a motivated woman who organized the files and got rally posts started, but who again appears to have encountered difficulties with community leadership. Dr. #5 has little real interest in preventive health and is in conflict with an expatriate nurse who wants to restart the program.

FIGURE 4

Best Worst Functioning Functioning Strong Good Weak and/or Strong Weak and/or Medical Paramedical Uncommitted Medical or Uncommitted Leadership Leadership Doctor Paramedical Doctor Leadership Active Active Active Lethargic Weak Community Community Community or Hostile Community Support Support Support Community Support

THE AOPS PROJECT MANAGEMENT OPTION

Consensus developed in the evaluation team, despite initial cynicism on the part of two of its members, that, at least during the startup and consolidation phases of an AOPS project, the presence of a committed doctor, with an orientation to primary health care, is necessary. Still, while the presence of such an individual may provide quality control, technical expertise, overall supervision, and prestige to the endeavor as a whole, it is more likely than not that the doctor will not have the necessary administrative skills. Similarly, projects which may have the advantage of a strong community leader acting in an administrative role may have high powers of motivation but still be untutored in the requisite management capabilities to make the project run well.

Optimally, an AOPS project should have a technical and an administrative chief. The doctor provides the technical supervision and quality control and the administrator runs things. Interestingly, the projects which function best have both those sets of skills, in various combinations, vested in different individuals (e.g., AMOSSE, Mirebalais, Pignon, Belle Anse). In projects where doctors either do not or cannot administer, or where community leaders cannot manage, there are problems.

Both the community leaders spearheading AOPS projects and the doctors who are their technical supervisors need training in basic management skills. These should be taught with only marginal amounts of theory and primarily organized around the practicum. At present, community leaders receive no project training and the four weeks of doctors' training at Cité Soleil is 80 percent dedicated to the technical aspects of the priority primary health rare interventions, with relatively brief amounts of time dedicated to the very important matters of registration/record-keeping/follow-up and more routine administrative issues. While there must necessarily be differences in the substance of training for doctors and project administrators, we recommend that they be trained at the same time: the doctors will need some management training, the administrators substantially more, but it would also be useful for administrators to be given some basic understanding of the technical and health goals of the project. The ancillary matter of attrition in the corps of medical directors trained at Cité Soleil is dealt with below under "Training."

2. Cite Soleil (CMSCS)

Figure 3 presented the organizational structure of the CMSCS (see page 58. Like all "organigrams," it does not deal with the issues even when appearing quite structurally reasonable. What is not conveyed by this particular organigram is the extent of the CMSCS workload, which seems to the evaluation team to be reaching the point of unmanageability. The sense of the management of the project is that there is not a management problem in the sense of undue concentration of responsibility. The basic problem perceived at the Complex is less a management issue than a financial one which redounds negatively to management, that is, the constant search for money, the hustle, the generation of proposals which may run the risk of being focused on what some donor or university wants to know rather than what needs to be known for the Haitian context. Since, to date at least, the research projects which have been generated seem to be generally appropriate, the issue is not one so much of research quality, but the energy and high-level technical skill needed to keep the pocketbook functional.

The solution now being studied is the addition of the new positions (starred in Figure 3), which will be funded under a \$750,000 amendment under consideration by the USAID. While the team supports approval of this amendment for these purposes, we wish to record our concern that the appropriate skills be brought to the filling of the proposed positions. Perhaps the most important skills package, and the one about which the CMSCS and the USAID should be most exigent, is that of the Business Manager. We are concerned about the combining of two sets of skills that is being contemplated for that position. The incumbent will be expected to: 1) be familiar with numbers and supervise the activities of the Administrative Assistant, be responsible for day-to-day accounting activities, and deal with issues of financial management with the various donors; 2) coordinate the self-financing component of the project, of which a major dimension is fund-raising; and 3) play a role in marketing. This is simply too large a portfolio and it is improbable that someone can be found in the Haitian context who dominates all these skills at the necessary levels of expertise. There are basically two jobs here: financial management and fundraising/market-The latter can be enhanced by short-term technical assistance, but the ing. former should be provided in-house, in ongoing fashion, with the necessary technical preparation to assume full responsibility for this area, leaving to existing project administration the substantial role of operations (see Chapter V on Financial Management).

Another crucial staffing issue for the CMSCS is the number of Community Volunteers (ColVol) available to do the Complex's outreach work. In theory, the ratio of population to Community Volunteer is 1,000:1, or, approximately 200 families per ColVol. In practice, this has not always worked out, partly because of staff inexperience, partly because some prior censuses have undercounted, and partly because of migration. In Carrefour-Poy, for example, the staff was so initially overwhelmed by procedures and data that some ColVols were assigned sectors far too large to manage. In Cité Soleil, constant immigration and emigration, particularly in the border neighborhoods and those spatially more vulnerable to squatters, produce a constant need for census verification and there are some areas that have not yet been censused. This instability, shifting densities, difficult geographical configurations, and a population which grows steadily, make assignment of ColVols in Cité Soleil a delicate business. Furthermore, the fact that the population of Cité Soleil is not only larger than previously estimated but still growing, has moved the CMSCS staff to feel that they will need at least 10 to 12 more ColVols to deal with the Linteau squatter area alone. To not only handle the population in the areas already being covered (est. 100,000+), but to expand to a coverage of 150,000, the CSMCS will need another 50 collaborators; that request has already been made to USAID. The rationale is that the support structure already exists for such an expansion and could, in fact, support up to 200,000 population. The only additional requirement would be for ColVol salaries: \$45 per month per capita or \$50,000 per year); no more doctors would be needed. The present funding level for Cité Soleil is \$750,000 per year to cover 100,000 people or \$7.50 per year per capita. The addition of 50 collaborator salaries at \$45/mo. to cover another 50,000 people would produce a project cost of \$300,000 per year, or a total of 150,000 people at a lower per capita cost of \$5.20.

According to the Project Paper, the Complex is committed to "increase coverage to include the entire Cité Soleil population (approximately 100,000 people) using the collaborator network." Since that base population has changed in size, and it is that demographic fact to which the Complex is trying to respond with an increase in the number of ColVols, the request for additional funds seems reasonable. Given the quality of care available through the CMSCS facilities, for a population which has no other easy access to quality health care, especially in a politically sensitive and volatile urban area, extension of coverage at relatively low per capita cost should be a high priority in the USAID health portfolio. Given the Complex's commitment to intensify its fundraising endeavors and enhance the income-generation capability of several of its components, at least some of the additional cost for expanding coverage to the entire, real population of Cité Soleil can conceivably be recuperated, depending of course on other factors such as operating costs, success in restructuring user fee schedules, and fundraising results.

B. TRAINING AND CONTINUING EDUCATION

Because the CMSCS provides training for the AOPS field project staff and because it appears that that linkage can, and should in our view, become strengthened and better elaborated, we will discuss the subject of training and continuing education for the CMSCS and AOPS as a whole. A distinction will be made where that is appropriate.

This section will deal only with the process and content of training for each program personnel level; the issue of worker incentives is dealt with in Chapter V on Financial Management.

1. Doctors

a. Training curriculum

As the CMSCS and AOPS programs have evolved and are currently structured, doctors have been the driving force and are the linchpin of the two community health outreach approaches. It is hard to see how the urban-located, fixedfacility-based Cite Soleil activity could function without doctors in the key leadership positions, and we have already discussed the issue of the doctor as administrator of the AOPS field projects (see IV.A, Program Management and Administration: Staffing and Human Resources). This section will deal with the issue of the quality and extent of the training given to these doctor-administrators.

To date, 45 doctors have been trained at Cité Soleil in a one-month training program which costs each institution \$1,000 per capita. Continuing education is supposed provided in 1-day workshops given regularly every three months. An underlying concept is that of the "training cascade," that is, that each doctor-administrator, after training at the CMSCS, will return to the field project and train the ColVols and the archivistes, as well as provide additional training to the auxiliary nurses, in the range of skills needed to implement the AOPS delivery model.

After training, the doctors are supposed to be capable of organizing, supervising, and evaluating a community health program. This capability includes the following functions, as set forth in the CMSCS/AOPS training outline, "Programme d'Entrainement en Medecine Communautaire" (presented in Appendix C in its entirety.):

- 1. Organize a community health program.
- 2. Define the population to be served, including the specific target sub-populations.
- 3. Organize a health center or re-orient an existing Health Center/ Dispensary/Hospital Center.
- 4. Organize rally posts.
- 5. Provide the maternal-child populations with appropriate, good-quality primary health care.
- 6. Supervise and train project health staff.
- 7. Evaluate the results of training efforts, as well as that of the rally posts.
- Be capable of collecting/supervising the collection of project management and impact data.
- 9. Be capable of identifying constraints to implementation and develop new strategies as circumstances require.

The curriculum content is paced as follows:

Day	1:	Pre-test Program overview, tour of the Complex
Day	2:	Introduction to demography and census, use of the household register
Day	3:	Introduction to demography Practicum: mapping

- Days 4-6: Introduction to demography Practicum: interview techniques
- Day 7: The Community Collaborator (ColVol): definition, selection, tasks, and supervision
- Day 8: MSPP priorities, long-term and intermediate objectives Practicum: interviews
- Day 9: Elements of public health planning Practicum in public health planning
- Day 10: Nutritional surveillance of preschool children Organization of a health center
- Day 11: Nutritional surveillance: concept, utility, indicators The battle against diarrhea-associated mortality; promotion of breastfeeding and oral rehydration therapy
- Day 12: Prenatal clinic care: objectives, content Breastfeeding practices in Cité Soleil
- Day 13: Prevention of low birthweight Rally post organization
- Day 14: The concept of surveillance applied to other health programs Organization of health center records, dossier classification
- Day 15: The anti-tuberculosis program
- Day 16-18: Rally post organization
- Day 19: Evaluation Integration of traditional birth attendants into the health system Health indicators: selection, value, utilization
- Day 20: Supervision and continuing education of personnel Introduction to management of a health system
- Day 21: Nutritional rehabilitation: rehabilitation center management Techniques of nutritional rehabilitation Rehydration, management of cases of severe malnutrition Milk bank
- Day 22: Characteristics of health care in community medicine Utilization of health indicators in program evaluation
- Day 23: Interpersonal relations; techniques of taking/getting information Evaluation of health programs; review of epidemiologic methods
- Day 24: Free discussion
- Day 25: Free discussion
- Day 26: Post-test

We understand that this curriculum is being modified, as are the curricula for all other health worker levels who will be trained at the new Haitian Public Health Institute (HPHI) being set up in Cité Soleil under the Mobilizing Mothers for Child Survival project. The Institute is already training some PVO staff outside the AOPS group, although this is being done sporadically on a request basis; for example, the fledgling institute has recently trained all the CARE field supervisors in the Expanded Program in Immunization (EPI). CMSCS and AOPS technical leadership are beginning the process of compiling curricula and training mate als from a number of public-and private-sector sources, with the idea of distilling from the best of these the curriculum structure, content, and materials to be utilized in training for all levels at the Institute. The team expressed its concern that this exercise not generate yet another costly round of wheel-reinvention; we were assured that this was not the intent. Our suggestion would be that the best of these, most importantly the very excellent set of modules and ancillary materials produced for the training of the Agents de Santé, be used as training texts; selections of readings would be made to fit the AOPS model and the lesser amount of time being accorded to training at No level will require the extensive (3 months) and elaborate each level. training that was given to Agents in the heyday of the Rural Health Deliver project; those individuals were to be basically community-level providers of selected services who functioned as satellites and depended for their provisioning on fixed facilities to which they also referred patients for higher-level care. Additions to that material that are specific to the AOPS module, e.g., record-keeping, monitoring and evaluation for a population-based activity, could be produced and taught as separate modules.

In general, the course as it has been taught could be strengthened if the following adjustments were made:

1. The flow of the curriculum should be re-ordered to more closely reflect the actual flow of the field activity, i.e., personnel selection; censusing; rally post organization; priority interventions, their content, purpose, and implementation; follow-up; monitoring, evaluation, and feedback.

2. Material that is specific to the functioning of the Complex, e.g., nutritional rehabilitation centers and milk bank, should be eliminated, since they apply only to a limited subset of projects and could be presented in 1-day continuing education workshops for projects for whom it is relevant.

3. Increased weight must be given to record-keeping, administration, and supervision, which are crucial to the program. The amount of time devoted to these areas is inadequate for doctors' management needs and certainly to their current responsibility for training ColVols and archivistes. With regard to the last point, we will recommend below that the doctors' responsibilities in the training cascade be re-thought and correspondingly adjusted. If the doctors are relieved of responsibility for the initial training of ColVols and archivistes, then more time in their own training can be dedicated to some pasic management skills. Doctors who come through the medical education sequence in Haiti, as in most places in both the developing and developed world, are not trained as administrators.

4. Even if the doctors' role in the training cascade is adjusted, they will still need some pedagogical skills for continuing education and day-today supervision. There is a well-generalized lack of pedagogical skills among even the most knowledgeable and committed members of the project teams visited. An explicit module needs to be developed for use in all CMSCS and AOPS activities in: training skills, productive provider-client interaction, role-playing, focus groups, mutual feedback, and very simple, non-threatening testing techniques for use not only with health delivery personnel but for communitylevel supervisory and evaluative contacts as well.

b. Training attrition

Of the 45 doctors trained in the Community Health Program at Cité Soleil (see Table 10), 23 (51 percent) are no longer working for the institutions which sent them for training. This looks like a more dramatic loss than it is. Of the 23 "losses," four were transferred to other AOPS-affiliated projects, either because the project they were originally trained for did not survive or is no longer functioning within AOPS, or because they were needed at higher levels in the AOPS organization or for projects that showed more promise. This is a chronic stress that afflicts most organizations, including AID, that is, the upward movement of staff members who distinguish themselves in the field and then are "stolen" for higher administrative purposes. In the case of AOPS, these judgment calls do not seem to have prejudiced projects which might otherwise have survived.

This adjustment still leaves a net training loss balance of 42 percent, still quite high. However, of the remaining 19 losses, eight were trained by institutions which are no longer functioning projects, which reduces the net training loss to 11, or 24 percent. This means that, of the doctors trained to run AOPS projects, approximately one-quarter have not worked out or have been attracted elsewhere (e.g., the Fonds de Negres doctor who, understandably, left to take a residency at the University Hospital in Port-au-Prince). However, a training cost of \$1,000 per capita, these losses are not trivial. Furthermore, the team suggests (see Chapter V), Financial Management) that this training fee is too low and that consideration be given to raising it. This would increase the institutional investment in physician training.

There is, nonetheless, a set of chicken-and-egg questions. Can one excuse from calculations of training loss doctors who have been affiliated with projects which have not survived as components of the AOPS project? Are those trained doctors victims of circumstance, for instance, a community which is, for one reason or another, too difficult to work with? Or is the doctor the problem? If the doctor had been better prepared and better oriented toward the realities and skills required in community health work, would the project have survived? Four projects (La Vallée, Las Cahobas, Duplessis, and Carrefour-Poy) have had persistent doctor turnover problems; each of these had to train the doctors they already had on site and were thus dealing from the very outset with faits accomplis. At the same time, all of these projects also have powerful community groups or leaders which have generated substantial stresses for doctors who, admittedly, are not culturally or professionally very good about being told what to do. This returns us to the question of whether the project is training the right people the right way. Are doctors too expensive and too potentially unstable as a trainee population? It costs \$1,000 to train each doctor; those who stay in some community health system, either within AOPS or outside it, cannot be worse off for having been trained, but those who leave cost money and time. Still, the doctor is a crucial component in the startup of an AOPS project (see IV.A.1.b); before s/he is cast aside as an unduly costly training investment, some intermediate curative steps might be undertaken. One is obviously improvement of the power of the training itself, so that doctors are better able to manage and more firmly dominate the material crucial to their role. The other is pre-training screening. Some effort should be made by each AOPS area coordinator, perhaps in conjunction with Cite Soleil trainers, to screen doctors before training. There are certain things that can be known about a doctor <u>in situ</u> before he is trained; in fact, the existence of a non-committed doctor should be considered before projects are accepted for AOPS support. Either the community and the AOPS coordinator can agree to try to replace the doctor from the outset, or the project should be eliminated from consideration if the doctor cannot be replaced. The issue is not necessarily having a doctor, but having one who cares and is motivated; in the absence of such an individual, the project should not be supported or thought should be given to training of an individual with good paramedical preparation and experience.

TABLE 10

COMMUNITY HEALTH PROGRAM DOCTORS DIRECTLY TRAINED BY AOPS FOR AOPS III (N=6)

		Name	<u>Title</u>	Institution (a)	Date Training <u>Began</u>
*	1.	Michelina C. E. Vallario	MD	ADIGCOM, Grande Colline, Petit Goave	18 Nov.85
	2.	Hubert Fenelon	MD	Thiotte	17 Feb. 86
*	3.	Antoine Noguerre Success	MD	Minnesota	17 Feb. 86
	4.	Henri Menager	MD	Save the Children, Maissade	17 Feb. 86
	5.	Max Antoine Balince	MD	Carrefour-Poy	17 Feb. 86
	6.	Ariel Henri	MD	Diquini	17 Feb. 86

a/ The institution which sent the individual for training.

<u>Code</u>: * = doctors who have left, either to leave the country or who are now working in institutions not affiliated with AOPS.

- + = doctors who have left the institution which trained them but who have been transferred to other projects affiliated with AOPS.
- t = projects no longer in operation or not affiliated with AOPS.

TABLE 11

COMMUNITY HEALTH PROGRAM: DOCTORS DIRECTLY TRAINED BY AOPS FOR AOPS II (N=15)

	Name	<u>Title</u>	Institution (a)	Date Training Began
1.	Lionel Barthelemy	MD	Marigot	Nov. 84
2.	Harry Jolicćeur	MD	La Montagne	Nov. 84
* 3.	Moreau Mie Michael	MD	Disp. St. Andrè	Jan. 85
* 4.	Jean L. Dargout	MD	Ctre Carrefour-Poy	Jan. 85
5.	Vilvaleix Laurent	MD	AEDC, Chambellan	Jan. 85
* 6.	Pierre R. Jn Baptiste	MD	Ctre Armée Salut, Fonds des Négres	Apr. 85
† 7.	F. Toussaint	MD	Ctre Cookson Hills, Rivière Froide t	N.D.
8.	Gerard Agenor	MD	Hop. Mission Baptiste, Fermathe	Jan. 85
† 9.	Fritz Jocelyn	MD	Bas Fonds Philom. †	Jan. 85
10.	Antoni Constant	MD	Hop. Pignon, St. Raph.	Apr. 85
11.	Guerrier Martineau	MD	Hop. Pignon, St. Raph.	Apr. 85
12.	Harry Renė	MD	Eye Care, Mirebaiais	Nov. 34
13.	Jose Augustin	MD	Centre de Duplessis	18 Nov. 85
14.	Newton Jeudy	MD	Siloe Jacmel	18 Nov. 85
15.	Yolene Charles	MD	FHASE, Frères	18 Nov. 85

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TABLE 12

COMMUNITY HEALTH PROGRAM: DOCTORS DIRECTLY TRAINED BY AOPS TO DATE FOR AOPS I (N = 24)

		Name	<u>Title</u>	Institution (a)	Date Training Began
	1.	Muller Pierre Louis	MD	Clin. St. Paul, Montrouis	June 83
+	2.	Laroche W. Charles (trans- ferred to Ford Parisien)	MD	Hop. Betsaleel, Las Cahobas	June 83
+	3.	Wilson Myrthil (trans- ferred to AMOSSE/Jacmel	MD	Hop. St. Joseph, La Vallee	June 83
*	4.	Camille Pierre Marie	MD	Hop. St. Joseph	Jan. 84
*	5.	Joel Charles	MD	Hop. St. Joseph	
*	6.	Carine Cleonhat	MD	Hon, St. Joseph	Nov. 84
*	7.	Maymone Chérubin	MD	Disp. Sacre Coeur, Pont Sonde	Oct. 83
ł	3.	Frantz Simèon (trans- ferred to Central Office	MD	Hop. Alma Mater, Gros Morne	
*	9.	Adolphe Leclerc	MD	Ctre. Christ Pour Tous. Fonds Parisien	Oct. 83
	10.	Lysie Peck (AOPS II)	MD	Ctre. Christ Pour Tous	Mav 84
ŕ	11.	Gilberte Coriolan	MD	Ctre de Taifer t	Jan. 84
•	12.	Herman Van Oven	MD	Ctre de Belle Anse	Jan. 84
*	13.	Mie Carmelle Duthil	MD	Hop, Cienf., Pignon	Jan. 84
*	14.	Felert Cadet	MD	Disp. Thomassique	Jan. 84
	15.	Stephen Nelson	MD	Hop. Lumière, Bonne Fin	Apr. 84
	16,	Gerard Bros	MD	Ctre Thomazeau	Apr. 84
	17.	Mie José Bros	MD	Ctre Thomazeau	Apr. 84
*	18.	Nancy Xantus	MD	FHASE, Hopital Comunautaire Frères	Nov. 84
*	19.	Yves A. Mathieu	MD	Ctre de Duplessis, Hatte Dufort	Apr. 84
†	20.	Jacques Lucas (trans ferred to Carrefour- Pov)	MD	Ctre Orianie, Fond Verettes †	Apr. 84
†	21.	Charles Marso	MD	Orianie t	Nov. 84
•	22.	Ferrer Bien Aimé	MD	Maison Compassion, Quartier Morin	Jan. 84
t	23.	Kettely Laurenceau	MD	Jeunesse Chretienne t	Oct. 83

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c. Continuing education

Continuing education for project doctors is provided in workshops every three months. Since the AOPS institutions began their projects on a staggered basis, the doctors' level of experience is correspondingly variable among projects. However, they all face similar problems and the basis training concept here is that those who have already faced those problems in the field will share their experience and act as co-trainers.

Between November 1982 and March 1986, AOPS has organized and sponsored 16 seminars and workshops in Haiti (see Table 13 for complete listing). Seven of these were given in 1985 and dealt with the subjects of: the community approach to primary health care, interpersonal relations, maternal protection, vaccine-preventable diseases, the vaccination campaign, sanitary education, and mother mobilization.

Most of these were one-day workshops, and largely theoretical. The AOPS (and Cite Soleil) approach to training has been, generally, to use formal training to provide theory; on-site experience to provide practicum; and seminars and workshops to highlight special issues and problems, for instance, vaccination campaigns or remotivating professional opinion toward a more supportive posture on oral rehydration therapy.

Under AOPS III and the Mobilizing Mothers Project, both AOPS and the HPHI should develop not only longer-term training but a scheduled series of short courses, workshops, and seminars, the latter oriented systematically toward priority health issues, with a balanced blend of both theory and practice. The AOPS projects themselves offer a sufficiency of field sites for observational visits which would provide more cross-fertilization among projects. That role is largely vested in the coordinators. While the coordinators can transmit the lessons of experience, they cannot be as powerful as the opportunity to see for oneself. Mirebalais, for example, can provide on-site training in registration/record-keeping/and followup. Pignon can provide on-site exposure to what is involved in an aggressive family planning program. Belle-Anse can do the same for growth monitoring and the AMOSSE projects can be a revelation to despairing commune doctors. Although boarding facilities vary from place to place, all sites have the potential for providing living space for short, experiential training visits from other project staff.

TABLE 13

SEMINARS AND WORKSHOPS HELD BY AOPS, NOVEMBER 1982-MARCH 1986

DATE	PLACE	TITLE/SUBJECT MATTER
17-21 November 1982	Ibo Beach	Seminar on family planning
21-27 February 1983	Cormier Plage, Cap Haitien	Utilization of community health services
15-16 April 1983	Castel Haiti	Annual congress, oral rehy- dration therapy
21-24 October 1983	Hotel Concorde Cayes	Seminar on setting up a com- munity health program
28 January 1984	Castel Haiti	Workshop on follow-up sheets
May 1984	Castel Haiti	Annual congress, information on vaccine-preventable diseases
July 1984	Castel Haiti	Workshop, statistical re- porting
14-16 September 1984	Jacmel Le Jacmiellienne	Nutrition
1-3 February 1985	Hotel Imperial Cap Haitien	Seminar, the community ap- proach to programming pri- mary health care
16 March 1985	Castel Haiti	Workshop, reflections on the factor of interpersonal re- lations
13 April 1985	Castel Haiti	Annual congress, maternal protection
17 April 1985	N.D.	Workshop, the vaccination campaign
18 May 1985	Castel Haiti	Workshop, vaccine-preventa- ble diseases
25 October 1985	Kaliko Beach	Seminar, sanitary education
7 December 1985	N.D.	Workshop, mobilizing mothers for child surveillance
15 March 1986	N.D.	Workshop, evaluation

2. Community Health Workers (ColVols)

a. Recruitment and selection

Each Community Volunteer Collaborator (ColVol) is assigned responsibility for a geographic subset of a project of approximately 1,000 persons. The basic components of the ColVol role are the following competencies:

- o Carry out registration activities and report vital events.
- o Identify priority groups, particularly children under five (and their mothers) and pregnant women.
- Participate in rally post activities, including group education, weighing, and individual counselling.
- o Provide limited village-based services, particularly oral rehydration therapy and the distribution of oral contraceptives and condoms.

The ColVol occupies a role at the interface between the health delivery institution and the community; as such, the selection process of these individuals can make or break a project. An excellent review study by J. Smucker (April 1986) of community participation in selected primary health care service delivery systems * summarizes, for a number of programs in Haiti, the qualities of community-level health workers and of the community systems that are intended to or do support them. The best-performing community-level workers:

- o Understood their role well.
- o Displayed rapport and respect for local people
- o Worked in the communities that selected them.
- Received appropriate critique, guidance, and direction, through a supervision system characterized by continuity.
- o Male or female, varying according to competing responsibilities and the appropriateness of their interactive style.
- o Could enlist personal relations, relatives or close friends, to support them in their work.

^{*} The programs reviewed included: Division of Family Hygiene and Nutrition (DHFN), MOH: Household Distribution of Contraceptives, DHFN; Amelioration de la Nutrition, DHFN; Family Planning, DHFN; Action Familiale d'Haiti; Child Feeding Programs, including Adventist Development and Relief Agency (ADRA), Community Integrated Nutrition and Education Centers (CINEC/CARE); Hospital Albert Schweitzer Community Health Program; Petit Goave Integrated Health and Population Project, DHFN; Service National des Endemies Majeures (SNEM); and AUPS, including Mirebalais, Pignon and Jacmel.

- o Did not have to compete with other health workers in the same localities doing similar work.
- o Got adequate resupply of the necessary materials.
- o Also worked on other community projects.
- Selected through community councils or other community leaders, not by program staff unfamiliar with the area.
- o Were people in whom the community had confidence.
- o Were credible people with demonstrated leadership qualities.
- o Were not the most economically needy, too busy trying to manage their personal affairs, or so involved in other activities (e.g., commerce) that they did not have sufficient time to devote to the program.
- o Received supervision that encouraged and motivated them to high standards.
- o Tended to be high-status members of the community.
- o Tended to be volunteers who were somewhat older (over 45) and wealthier.
- o Received good support by community leaders who were honest and encouraging.
- Gained increased status in the community, through some kind of uniform, title, and/or public ceremonial recognition.
- o Lived in more stable communities with less demand for wage and seasonal labor.
- o Were often recruited through their churches.
- o Were trained on a task-by-task basis.
- o Tended to be better educated.
- o Were able to enlist the support of volunteer assistants.
- o Tended to be newer workers, that is, they had not yet reached a plateau in performance because the work had become too routine.
- Came from communities where a dialogue had first been established by the program with community leaders, whose consent and participation was enlisted a priori.
- o Were stable and mature, i.e., not less than 25 years of age.
- Were capable individuals motivated out of interest in the program and a desire to help.
- o Were asked to volunteer on a flexible schedule for a relatively short period of time, unless some sort of incentive could be anticipated.

- o Were between 25 and 45 years of age.
- o Were associated with services that were credible and acceptable.
- o Were not community council officers.
- o Were able to pass a literacy/numeracy test appropriate to the skills to be required by the program.
- o Received some kind of incentives, either to their communities or themselves, that were valued by both.

These findings can, and perhaps should be, easily turned around to constitute a set of criteria for selection of community health workers in Haiti overall.

The Smucker study itself (which included three AOPS projects in its sample) as well as a recent PRICOR study of 45 ColVols from three AOPS project sites (Thomassique, Mirebalais, and Gros-Morne) provide useful data on how well AOPS community-level workers respond to these criteria. The study revealed that practically all ColVols were members in good standing of some organized community group. All were literate and most had completed primary school. They represented a variety of occupational backgrounds. Their characteristics were as follows:

- o Average age 28.5 years, with a range from 17 to 54.
- o Sex. 78 percent men, 22 percent women.
- o Number of children. Approximately one-third had no children, 33 percent had one to three, and 33 percent had four or more.
- o Years of residence. Over 69 percent were born in their assigned village.
- o Marital status. 35 percent single, 56 percent married, and 9 percent in common-law marriages.
- o Religion. 65 percent Catholic, 35 percent Protestant.
- Occupation. The most important occupation for health workers was agriculture (40 percent), followed by tailoring (11 percent) and teaching (7 percent). Seven percent said they were unemployed.
- o Schooling. 51 percent with completed primary school and 24 percent with some degree of secondary school education.

While time did not permit meticulous scrutiny of the degree to which other the ColVols in other AOPS projects and in Cité Soleil have satisfied the more qualitative (and much harder to determine) of these criteria, it would appear that many of the criteria were satisfied in more or less intuitive, serendipitous fashion. Some individual projects have set forth formal, written criteria for selection. For example, the Mirebalais project included some rather simple but apparently fruitful criteria; adult, good health, village resident, well known and respected in the community, no personal animosity to any family to be served by the program, past interest shown in community development, currently employed in gainful activity, literate, and recommended by the community. For the most part, what seems to have been shared among projects is a certain commonality in the ColVol selection process, of which the AMOSSE experience is not atypical. The MSPP regional director (who also became the technical director for the AMOSSE project) helped the head of AMOSSE to choose a pool of potential ColVols. Both men met with community leaders, and explained the program and its personnel requirements. Each group of leaders presented several candidates who were required to be able to read and write, were economically self-sufficient (that is, not dependent on income from the AOPS project for survival), and a member of the community. Each candidate was tested for reading and writing ability, interviewed, and selected from the proferred pool.

The AMOSSE approach does contain a component which does not seem to be adequately addressed in all AOPS projects, that is, the rigor with which ColVol literacy and numeracy are tested. The ability to find willing and adequately literate individuals in some areas of Haiti is constrained. In some zones, literacy is so low that the project almost had to teach literacy before at least some of the ColVols could do the community census adequately. In Duplessis, the Coordinator had to re-do all the forms for one sector because of the low literacy rates, and Duplessis is not a particularly remote site.

Given the centrality of the record system to the effectiveness of the AOPS population-based approach, a number of questions are raised:

- o Should there be a standard literacy test for all ColVols?
- o Is a more literate ColVol better than a less literate one who has better community rapport, if the situation is such that the two must be mutually exclusive?
- o Is the problem generalized enough to be a problem? This should be discussed by AOPS executive and technical staff, including all coordinators. If the evidence is anecdotal and really not significant, then the issues should be dismissed, at the same time that vigilance is not relaxed. If it is a problem, then it needs to be discussed and policy decisions made about firmness with community leaders on selection and testing, or, in extreme cases, special literacy education.
- What does this mean for replication of the AOPS model in the public sector, especially in such remote areas as Bombardopolis where overall literacy levels will be substantially lower than the national average? It goes without saying that these issues become absolutely crucial for the archivistes: limited field observation of some of the archivistes in action suggested that literacy and numeracy skills required for those individuals should be rigorously tested and demanded.

As AOPS proceeds with its operational research into the role of the CHW, we would suggest that some of these selected criteria, including some of the "softer," qualitative ones, be applied as control variables in consideration of ColVol effectiveness.

b. Training and continuing education

Each community has a somewhat different history and inventory of volunteer workers, each with somewhat different skills and levels of preparation. Because of this variation, AOPS has let itself be guided by the principle that training of the ColVols should be flexible and adaptive to the realities of the environments from which each group of volunteers springs.

For instance, Pignon, which already had access to Agents de Santé trained by the MSPP, trained such individuals only in new material, e.g., the AOPS recordkeeping system, while new ColVols were trained from scratch. This principle has guided the corresponding training approach at Cité Soleil, where the ColVols for each Center are trained by the doctor in charge of that Center; as in the case of the doctor-administrators, there is not yet a written curriculum or training manual, although there is now consensus that standardization in written form is necessary. The Cooperative Agreements indicate that each ColVol will get a total of six weeks of training.

At each site visit, questions were asked about how ColVol training had occurred; in all cases, the answer was that training was viewed primarily as a continuing education activity with, at most, a one-week block of startup training, with special attention to priority and problem areas. In all AOPS projects, and in Cité Soleil, ColVols are considered to be always in the process of formation, and continuing education (<u>recyclage</u>) is largely unscheduled and ad hoc. Cité Soleil schedules one week of recyclage per year for each of its worker levels but, just as there is not yet any formal curriculum, there is no schedule for continuing education, which is carried out on an as-needed basis.

The subject of census-taking provides a good example of the variability not only among projects but internal to each project itself. As each project copes with a number of real pressures, it displays a flexibility and adaptive capacity which are admirable but which complicate the route to standardization. The Cité Soleil experience is a good case in point. While the overall training time for ColVols indicated in the project documents is six weeks, in Cité Soleil training for censusing actually takes place over a two-month period which includes substantial hands-on experience; for example, the new collaborators for the forthcoming (September) re-census will start their training in June. This period will provide training at the CMSCS for new ColVols, initially with theory and then with instructions for practice; trainees are sent into the field with forms to fill out, with individual critiques following in iterative fashion until mastery is satisfactory. However, the CMSCS has also evolved another training model to respond to programmatic urgency. A "high-speed" course utilizes the experienced archiviste, a home visitor, and the ColVol supervisor. This team does two days of re-censusing, with new ColVols as observers; the theory comes through lecture later, after the urgantly needed data have been gathered and are being processed. In either case, the body of ColVols that has already had full-fledged field experience in a given area, in this instance censusing, functions as trainers for new cohorts of ColVols. Since very few projects have had major problems with censusing, it would appear that, whatever the census training model used, it has been effective. This will permit more attention to be paid to other, weaker areas.

In sum, ColVol training to date has occurred in ad hoc, somewhat modular fashion. This was a reasonable startup decision. However, what has happened is that there now appears to be substantial unevenness among ColVol competency levels among projects. There also appears to be some variation in ColVol competency within projects, simply because people vary. More explicit standardization of ColVol curriculum, together with regular, brief, on-site testing of ColVol skills as part of the project's ongoing supervisory activity, should smooth out this unevenness. When the new curriculum becomes available, we would suggest that ColVols in all projects be tested for competency in that curriculum and the appropriate catchup training provided.

c. The ColVol's role

Given the diversity of the AOPS project institutions and their various emphases and methodological approaches to the training of ColVols, one can anticipate that health workers from those different institutions might have different expectations or understandings about what they are expected to accomplish. These different understandings or expectations could, in turn, have significant repercussions on the willingness of these workers to carry out those tasks and the priority they would assign to them. The PRICOR three-site study mentioned earlier found that the three tasks most frequently mentioned through spontaneous elicitation were: home visits (82 percent mentioned spontaneously), census (66 percent), and rally posts (55 percent). Approximately one-third of the 45 ColVols interviewed spontaneously mentioned health education for ORT, drug sales, motivation, weighing babies, and keeping records. An insignificant number mentioned such other tasks as participation in seminars, family registration, immunization, first aid, filling out forms, giving medications, preparation of weaning food, family planning, visits to community councils, and blood tests. Overall, this is an accurate perception of the ColVol job profile and it is heartening that such a high percentage of Colvols see the home visit as the highest priority and the most obviously salient feature of their role.

Health workers indicated that they encounter many difficulties in performance of these tasks. The most frequently mentioned is the distance they have to walk to cover their territories, a complaint mentioned by 82 percent of the workers interviewed. The second categories of complaint, mentioned by 47 percent of all health workers, encompass a list of problems grouped under the rubric of "poor working conditions." More than a third complained of an inadequate salary or the lack of one, and one-quarter complained that their health work competes with their other work. Less than one-fifth referred to poor motivation on the part of the community, which is heartening and is an important feature of the other side of the coin, which is worker satisfaction. Fiftyfive percent saw as the positive dimension of their work either non-monetary personal profit (55 percent), the good to the community (52 percent), or personal satisfaction (20 percent). One-third referred to the positive effects of monetary profit, but it is not clear how meaningful that is since we do not know how many of the ColVols interviewed were getting any monetary incentive to be happy about. Nonetheless, ColVol desertion rates do not seem to have been high, certainly not in comparison with the attrition among doctors trained under the AOPS project. In the Southwest region, 35 out of the 130 ColVols have deserted since 1983, or 27 percent over three years. In the anecdotal case of La Vallée, one of the projects most troubled by doctor turnover, out of ten ColVols trained, the two who left had simply left the area. This suggests that at least part of whatever ColVol attrition there is, is due to emigration, in turn a function of poor economic opportunities in so many rural areas.

At present, the amount of time dedicated by most ColVols to project activity is approximately five days a month. One day is spent every five weeks at his or her rally post, two days are spent every five weeks helping another ColVol, and two days are spent every five weeks in household visits to approximately 200 families. If ColVols are really doing all the household visits they are responsible for, it may be that they are actually spending more than two days a month in that aspect of their activity. Although several ColVols assured team members that the home visits are very quick, just checking up on special cases, reminders, and so forth, it is first of all not clear that all household visits should be so speedy and, secondly, as the ColVols themselves observe, distance and travel time are a real problem. In some projects (e.g., Pignon), the ColVol will also spend time with the archiviste, who may call in a ColVol for questions or will work collaboratively on the followup activities (fiches de suivi) for which s/he is responsible. Some projects also have meetings of the ColVols, archivistes, and project management, but these most typically occur at the end of a rally post day and can be considered under the time budget for that activity. In general, however, it appears that really active ColVols in a dynamic project may be spending more than five days a month in project activity, a fact that bears implications for considerations of appropriate incentives (see Chapter V, Financial Management).

The time budget also has important implications for task allocation and priority-setting. In a study being carried out by PRICOR and AOPS, the data from which are just beginning to be analyzed, an attempt is being made to look in a systematic way at the issue of CHW task allocation. The principal hypothesis is that there is an ideal way of allocating tasks to community health workers to maximize the impact that they can have on infant and child mortality through four priority interventions: ORT, immunization, growth monitoring, and family planning. Two sub-hypotheses are that 1) it is possible to estimate the timeuse-effectiveness for the tasks associated with each of these four interventions and 2) that a health worker might have the same or greater overall impact on the health of his/her community by focusing activities on a small set of rouseholds, perhaps 20 percent of the target population, rather than by diluting efforts over an entire catchment area. The objectives of the study were: to test the hypothesis that, for every unit of time a CHW spends to make a mother competent in the use of ORS, s/he must spend 21 times this unit in the promotion of family planning in order to maximize the number of child lives saved; to determine the relative effectiveness of promoting priority health care interventions by CHWs to all women in selected communities, or to focus promotion activities on women at high risk of losing a child; and to determine whether women at high risk of losing a child are more highly motivated to utilize available health services than women not at high risk. Limited initial analysis indicates that, not surprisingly, a limited list of mothers appears to be more manageable for a health worker to deal with at any one time, that mothers who feel that they have been specially selected are more apt to attend educational sessions, that a focus on a selected group of mothers does not seriously affect the overall pattern of knowledge for the villages involved, and that, in sum, a screening system for at-risk children is both advantageous in terms of net CHW productivity and not disadvantageous for mothers of non-risk children who acquire apparently adequate levels of knowledge at rally posts. While there is a lot of analysis still to be done and a need for considerably more analytical precision, the early indications are that this piece of operational research can go a long way toward making a reasonable portfolio for the characteristically over-burdened, under-compensated CHW.

3. <u>Traditional Birth Attendants (TBAs)</u>

The evaluation team could look only very fleetingly at the issue of TBAs and their training. In Cité Soleil there are nine trained midwives, assigned to different sectors according to density and access, who appear to perform an active liaison role between the community and the hospital. The CMSCS encourages hospital deliver'es. In the FHASE project at Frères, midwives have been incorporated into mother education and are being trained using the excellent laminated black-and-while flip chart put out by the MSPP, but there is, again, no written curriculum; one is soon to be produced at the HPHI and, on the basis of very limited field observation, seems to be vital to control the quantity and prioritizing of training emphasis.

A recently completed PRICOR/CMSCS study had as its objective to develop a solution to the following operational problem: what type of training should be provided to traditional birth attendants so that they perform tasks judged to be critical in the reduction of maternal, perinatal, and neonatal mortality? The most important finding of the study was the lack of difference between a control and a study group with respect to pregnancy outcomes. TBAs who were trained in a new, shorter, well-prioritized training program were shown to be equally as effective as those who followed the longer, standard, MSPP course. Furthermore, the results demonstrated that the short course was more effective in training TBAs to refer high-risk mothers for prenatal care and hospital delivery: the mean number of prenatal visits among high-risk mothers was significantly higher among high-risk mothers attended by TBAs trained in the short course. These findings suggest that the course to be developed at the HPHI should be shorter and competency-based.

4. Principal Training Issues

The training cascade from doctor to archivistes and ColVols is not working. The basic idea of training doctors (at Cité Soleil) for one month, who would in turn train auxiliaries, archivistes, and ColVols, has inherent problems. Doctors are not, in Haiti as elsewhere, trained in community health, pedagogical techniques, administration and management, or information systems. One month of the very best training is insufficient to the task of adjusting to these historical inadequacies. In the case of the Cité Soleil curriculum, the administrative, managerial, and information system issues are dealt with only in the last week of training and are not incorporated into the training experience as a whole. This leaves doctors ill-prepared to either use or teach these skills at the community level and conveys, surely unintentionally, the message that they are not very important. Doctor turnover further disrupts the training flow.

Furthermore, leaving the training of ColVols in the hands of doctors widely variable in their preparation and motivation contributes to the persisting variability in CHW competence. The doctors themselves range from young doctors doing their year of social medicine as a transition from medical school, some of whom care about public health and many more who do not and who look on the social year as a burden; to seasoned, highly committed doctors with excellent knowledge and experience, although even these may not have the management and pedagogical skills they need or want. The ColVols range from very well trained Agents de Santé to very inexperienced individuals selected by community consensus of some kind. The lack of a standard, written curriculum or even a training guide does nothing to repair these imbalances.

Finally, where the doctor has been able to whip the information system into shape, he has done so at the cost of great personal involvement, a lot of follow-up time, and/or the addition of another staff member to provide an audit

and maintenance capability to the project staff. There is no way of saying how much of this would have been necessary anyway, in a model which has not really been tried and evaluated in an extensive way in Haiti. Still, it seems clear that more substantial, direct training would have been more effective, but this is one of the glories of hindsight at which evaluators are so skilled.

We recommend the following training strategy, based on a core of centrally placed, properly prepared individuals, to do training in technical substance, management, record-keeping, monitoring, evaluation, and basic accounting.

a. ColVols

There is some consensus that the MSPP Itinerant Training Team model which was integral to RHDS-1 is both valid and useful. The HPHI will be designing a core curriculum or course outline in the technical areas of growth monitoring, ORT, immunization, and family planning, plus the associated monitoring, information system, and mother-training skills. The Training Team(s) would then be prepared in this approach and proceed through each institutional project with appropriate continuing education. Any new ColVols should be trained from the outset using this curriculum. The doctor who will be responsible for each group of ColVols should participate in the training, perhaps as a co-trainer in the technical areas but surely as a co-participant in the monitoring, information system, and mother-training skills.

b. Archivistes

The archivistes should all rotate through a re-training exercise and, given the centrality of their role and the importance of having solid data as soon as possible, this should not wait until the HPHI is operating. This re-training could be done now at Mirebalais. Mme. Bertrand at Cité Soleil could be given the responsibility of getting this under way; since she has not been through the doctor training course at Cité Soleil, she should be incorporated into the next one.

The suggested model is that the archivistes should be trained for one week, with the team doctor, in groups of six, that is, the two archivistes from each of two projects and the doctors from each of two projects, each trio to be trained as a team in the structure, purposes, and functioning of the populationbased registration and monitoring system. Mirebalais does not currently have the capacity to handle more than six trainees at one time, and it is not clear that this aspect of the project should be expanded in any substantial way at this point. This should be a very hands-on course; however, it is crucial to convey the major message of the AOPS philosophy with regard to the information system. The population-based system is not a researcher's toy; it is the spinal column of this approach to community health, the philosophy of which centars on an extremely activist outreach which will capture all members of the priority target groups for key interventions in a massive way at the outset of a given project. Only careful attention to these data will provide the outreach and analysis essential to making this approach really work.

Some projects may feel that their ColVols do not need extensive retraining, although in some projects ColVols associated with AOPS III/Child Survival will have to be retrained in special, selected skills training. The decision may be made to test ColVol competence and then decide whether they need retraining or not. However, the assumption should be made that all archivistes could profit by additional training, and this should not be optional for the institutions involved. They should, in fact, see it as an opportunity.

In order to get all its archivistes up to speed and adequately train those who will be coming on board with new projects, AOPS should consider the addition, at the central level, of a professional with formal statistical and administrative skills, who would be able to train; provide ongoing audit, supervision, and continuing education; and develop the simple reporting formats that will 1) promote the rapid feedback of data on achievements at the local level and 2) keep AOPS more consistently abreast of project status. It would also be possible to assign to this individual the responsibility for being sure that all technical-cum-statistical reports are timely and complete. If this position were to be added, Dr. Robin could abandon her auditor's role and adjust her responsibilities to parallel and not replicate those of Dr. Simeon. The audit role has been extremely important and useful in the period when AOPS was trying to get a more generalized, in-depth understanding of the workings of the recordkeeping system, but now that the major deficiencies have been identified and are on the way to being addressed, the audit role should be assigned to an individual with statistical expertise and Dr. Robin's considerable skills as a physician in public health more broadly utilized.

c. Auxiliaries

Auxiliaries should be trained at Cité Soleil, at the HPHI. At present, the auxiliary in the AOPS projects seems to be quite marginal to both the doctor and the ColVol in terms of active participation in the program. This role, particularly in the education of the mothers with whom they come into individual contact at rally post, could be enhanced and some technical skills will need upgrading. However, this can fall under the activities of the HPHI.

C. MONITORING, EVALUATION, AND SUPERVISION

1. Monitoring and Evaluation

a. Introduction

Small-area registration systems have been set up in many countries to monitor changes in birth and death rates, to provide data on the causes of morbidity and mortality, and to determine the impact of various interventions on health and demographic status (e.g., Khanna, INCAP, Narangwal, and Matlab). The published results from these projects have provided immensely valuable information on patterns of illness and death, the interactions of contributory factors, and demographic change in developing countries, as well as the impact and effectiveness of specific health care interventions. However, using total population registration and demographic surveillance as a routine but essential component of primary health care remains relatively rare. This is due, no doubt, to the fact that population registration, outside the context of generously-supported research projects, is a formidable undertaking (Augustin, et al., 1985).

While a population-based surveillance system has been shown to be feasible within the context of a service program in Haiti (Berggren, 1981), the resources available to that program (Petit Goave), including foreign resident advisors and significant donor support, were far in excess of those available to the small AOPS facilities, operated more often than not by a church-related organization. Thus this project, and in different dimension the CMSCS project, provide an opportunity to determine to what extent a modest, service-oriented PVO, with limited staff, can carry out population-based surveillance activities.

The AOPS model has, as an organizing hypothesis, the contention that selective health surveillance at the village level, based on total population coverage. is feasible and can be a very effective way to monitor, improve, and assess the impact of low-cost primary health care in rural areas. This is based on findings from the literature that a consistent feature of effective health service projects is vigorous outreach resulting in remarkably complete population coverage; in almost all of these successful cases, almost all of the target population was surveyed at the project's outset and received services thereafter (Gwatkin, et al, 1980). Thus, utilization of population-based epidemographic surveillance becomes a necessary part of health care service delivery. Used in this context, epidemographic surveillance is to provide the necessary baseline data for program monitoring and evaluation, while at the same time constituting an effective screening tool for identification of sub-populations in need of special care. Furthermore, a population-based epidemiographic approach can identify non-participants in program interventions and allows ongoing follow-up and evaluation of coverage and utilization of services. Both AOPS and Cite Soleil have adopted this approach, which makes monitoring and evaluation truly integrated processes at the heart of the AOPS and CMSCS management information systems. The data generated and, at least theoretically available in easily accessible, ongoing fashion, are combined with data generated from selected smalk-scale sample studies gathered for purposes of further exploration and enrichment.

The overall sequencing of this approach is described in Chapter I. The sequence of documents in the system, presented in Appendix D, is as follows:

The basis of the surveillance program is the family register. When each baseline census is carried out, as well as in subsequent recensuses, all families in each sector (and therefore, all mothers and children) are registered on family register forms by name, birth date, and marital status. The form is a variant of that used in the Khanna project (Wyon and Gordon, 1981) and also records data on family composition, family size, immunization, and pregnancy status. In addition, it contains an optional section for fertility history and records some socioeconomic parameters. Each household has a unique identification number which uses the same numbering system in all areas. The mother of a family may have the following number, for example:

2 03 34 198 15

zone sector community worker family no. individual no.

This number means that the mother lives in zone 2 of section 03, is followed by community health worker 34, and is family member 15 in family #198. The family register form is kept in a central file (in Cité Soleil, in each Center and, in AOPS, in each health delivery facility).

o To each family register (registre de menage/rejis mennaj) or dossier are attached individual sheets (fiche individualle) for women of childbearing age (15-45 in some projects, 15-49 in others) and for infants and children

under three (although some projects include children up to five). On the reverse of the children's fiche is a growth chart, not color-coded; mothers retain the four-color-coded chart at home and bring it, in some cases along with a vaccination card, to each rally post.

- o Each fiche is updated at each rally post attended by that mother and whichever child(ren) she brings in. The updated information is also entered on the family register, typically not as the rally post is going on since the pace is usually intense but later that same day or subsequently, either by the archiviste alone or by the archiviste in conjunction with someone else (the doctor or the community health worker(s) varying from project to project). Usually, the data entered during a rally post include attendance rates, weight, nutritional status, vaccinations administered and, for rally posts where a doctor provides medical care, the pathologies presented and the Rx prescribed. Other data gathered, either during rally posts or home visits by ColVols or in both, include survival status for children under three and, for women in union, contraceptive use, pregnancy, probable date of delivery, actual data of delivery, and pregnancy outcome.
- The names and identification codes of all children under three (in some 0 projects all under five) and all pregnant women are then recorded on follow-up sheets (fiche de suivi). The children's fiche also carries information on nutritional status, vaccinations completed, and recall dates. For women, there is space for enrollment for prenatal care, enrollment in family planning, probable dates of conception and delivery, and TT vaccination status. Inspection of the follow-up sheets belonging to a ColVol allow easy determination of the extent of the coverage attained by the program served by that particular worker. Thus, after each rally post cycle, program decision-makers should, theoretically, have in hand data specific to each health worker/sector on rally post attendance and coverage for immunization, prenatal care, and family planning. Delinquents, that is, members of priority groups who have failed to attend a rally post, can be identified by name and address as noted on the family register sheet. They, as well as members of at-risk or high-priority groups (e.g., infants under one year, severely malnourished children, etc.) may be--and should be--the object of special domiciliary visits by the community health worker for purposes of motivation.

When such a system is well maintained, it can provide data against the following selected surveillance parameters (Augustin, et al., 1985):

PARAMETER

SOURCE OF DATA

Infant mortality rate	Pregnancy register Follow-up sheets
Proportionate mortality	Pregnancy register
Priority health problems	Follow-up sheets Individual records
Crude birth rate	Pregnancy register; census
Pregnancy prevalence rate	Idem.
Prevalence of malnutrition	Follow-up sheets Individual records
Coverage of immunization	Follow-sheets Individual records Census
Contraceptive prevalence	Census Individual records Follow-up sheets.

b. System implementation

The censuses carried out for the Cite Soleil and, in the great majority, for the AOPS projects, seem to have gone well. There is no way for the evaluation team to check the accuracy of the censuses as such; however, the family registers reviewed appeared to have been meticulously done. The condition of the individual fiches and the degree to which the new information thereon is integrated onto the family register is variable: the stronger projects have this data transfer fairly well up to date and those projects where this is not the case have been recognized and are working on it. The question can be raised-and it is mentioned here as something that should be considered when the system is reviewed under the technical assistance for the Save-the-Children Maissade project--as to whether it is really necessary to incorporate <u>all</u> the data all the time from the individual fiches onto the family register and whether it is not a more productive investment of time to be sure that the follow-up sheets and lists are up to date and used effectively.

So far, nothing has occurred that suggests that total population registration is not a very useful way of identifying members of high-risk groups who are targeted for primary health care interventions, as well as and those who do not show up at rally posts and need to be contacted by community health workers. And so far, the system has lent itself to reading coverage performance at reasonably reliable levels. Augustin, et al. (1985) think that pregnancy registration can also be an effective way of monitoring the impact of services not only on the fertility rate, but also on the infant mortality rate, if and when pregnancy outcome is determined in each case and the newborn is followed for at least one year. Determining mortality rates for various diseases may also be feasible if a "verbal autopsy" system is set up and when the pregnancy registra-

tion system and follow-up of newborns is complete. Trends in child mortality rates can be monitored through a system whereby, for each child who does not appear at a rally post, a home visit and subsequent determination of status are made. Nevertheless, surveillance activities which monitor changes in incidence and prevalence of acute conditions (such as diarrhea) are probably beyond the Special studies are needed to capacity of the average PVO health center. Similarly, crude death rates assess the impact of interventions such as ORT. cannot be reliably determined through this system, since 60 percent of the population (males over five years and females 5-15 and over 45 years old) is not enrolled in the longitudinal follow-up system; since no preventive interventions are directed at these groups in the AOPS model, determining the overall death rate is not a priority in any case. Retrospective infant and child mortality rates which were computed from data collected during the initial censuses of the first sixteen AOPS projects were unreliable, as they generally are in such surveys in developing countries.

Because of the commitment to reduce levels of infant and child mortality, some way needs to be found to determine those levels. AOPS plans to test the hypothesis that a feasible and reliable way of obtaining infant and child mortality data is through the strict operation of a pregnancy registration program, a measure which is not beyond the capability of the ColVols. Special studies will be conducted by trained researchers from outside the AOPS and CMSCS instiutions in order to verify results and provide complementary data, probably through the Child Survival Institute in conjunction with Johns Hopkins University. Such endeavors should take heed of the findings of the follow-up survey (February 1985) carried out under the PRICOR TBA study, which attempted to follow up all the women in Cite Soleil who had had a pregnancy during the period of the study. The quality of those data turned out to be quite poor, primarily due to probable underreporting of deaths. Many women who did report a death were reluctant to state the age or cause of death, attributed by the PRICOR analysts to traditional beliefs in Haiti regarding the process of birth and death, topics not readily discussed with strangers.

The potential of the population-based registration and follow-up system is considerable. At present, however, except for the censuses, the quality of implementation of the system is uneven across projects. This unevenness has to do both with the functioning of the system and some features of its basic structure which make it less agile and effective than it might be. None of these operational limitations is irremediable and all reflect the relatively short time many projects have been functioning, the defects in the training cascade discussed in section IV.B. above, and the varying quality of technical supervision among projects. The larger, older projects which have access to more sophisticated and frequent technical assistance (e.g., Mirebalais, Belle Anse, Pignon) do quite well although they, too, could profit from a relatively small set of structural adjustments in their monitoring and evaluation activities.

- Functional issues

In general, the projects which have had problems with their monitoring and evaluation systems have been problem projects in general. These difficulties have included the following:

 Although in all sites visited, dossiers seemed to be well taken care of in bulk and many projects had devised very careful storage for them, they are often out of numerical order.

- o The family registers were not all up to date, the age groups were out of place, and newborns and pregnant women had not been recensused or recorded for an unduly long time.
- o Individual children's fiches did not carry the growth curve and code numbers were sometimes incomplete.
- o The majority of pregnant women and children under one had not been followed up.
- o Families did not know or had not noted their code number so that only the ColVol was able to find the family dossiers rapidly when they were needed for rally posts. Where no alphabetical listing of families had been made, this had the potential for becoming a major problem.
- o Children 0-1 were not identified and carried on on follow-up sheets.
- o Migration data were customarily lacking, although there may be good reason for dropping these data.
- o Immunizations administered during special national vaccination campaigns, as well as those received at health facilities outside the project system, had not been incorporated into the family dossiers and individual records; sometimes the data on vaccination cards and Road-to-Health charts were not in agreement.

These functional problems tended to appear en masse and to do so in a minority of the projects visited. However, almost all projects displayed a limitation which the evaluation team thought was crucial to project success, that is, 1) the "data schism" between the ColVols and the archivistes and project managers, and 2) the slow and somewhat unsystematic feedback and availability of summary data available to project managers. These are not unrelated but we will consider each of them in their turn. First of all, the data schism. ColVols are the "hinge" of the AOPS system, the crucial interface between clients and the preventive health system. For them to function to the optimum, they should have access to the data that are the result of their labors, for at least two reasons: 1) they need the information--and promptly--to do their follow-up work; and 2) they need it as an incentive for their labor.

The form in which these data are fed back to the ColVols is just as important as the fact of their getting them. They should be returned from the archiviste(s) and the project managers in a form which is not only efficient but is summarized so that ColVols can see how they are doing, that is, with some running tally of percentages of coverage by sector. For larger projects, this may not be possible on an individual basis; in that case, attendance, service, and follow-up data should be summarized monthly for the whole project in some form that is easily accessible, e.g., a large, hand-lettered wall chart, which would display key project data for the month, projected against baseline, with running percentages: "We said we would have X percent of children under age 1 with completed vaccination series by the end of our first project year; we have succeeded in vaccinating X percent."

Not only is the registration/monitoring system the operational backbone of the AOPS approach, it can also constitute a substantial incentive for all levels of health worker, perhaps in inverse degree to the amount of cash incentive in-

volved. Certainly, coupled with a cash or valued in-kind incentive, information can constitute a persuasive source of motivation. At present, however, with only one exception where lack of achievement of targets was used in a fashion that bordered on being punitive, no level of health worker had a full and ongoing grasp of: 1) what the baseline was, 2) what the numerical targets were, 3) what progress had been toward those targets in relation to baseline, or 4) where their achievement level stood to date with regard to all interventions.

A Save-the-Children consultant, in collaboration with the SCF Health Unit, staff has developed a program using a data base software package which is tailored to Child Survival activities. The program aggregates and analyzes information captured by village health workers. Indicators can be easily retrieved and reported using the system. The denominators required for descriptive statistics are available due to the initial family enrollment data entry and with continual information updates. AOPS management has already spoken to SCF about getting some technical assistance through the Maissade Child Survival/ AOPS III project, with an eye to simplifying the information-gathering/recordkeeping system. We suggest that AOPS use the same opportunity to look at the SCF program (which will be used if the SCF proposals for Cameroon and Mali, now under review in the FVA/PVC office in AID/Washington are approved) to see if it might be useful at AOPS headquarters and in a few large AOPS projects. More importantly, the system should be reviewed to see how it might inform AOPS' paper system. A good Management Information System can be a simplified paper version of a machine system; we are not recommending computers for every AOPS project.

A related issue is unevenness among projects in the utilization of the followup sheets which not only constitute an extremely powerful tool but which make the AOPS model substantially different from other health delivery models and are crucial to its optimal implementation. The follow-up sheet is far too important to be thought of on a piecemeal basis. It should be used as an integrated, aggressive tool for following up not only on children under age one and pregnant women, but for special at-risk subpopulations, e.g., children who have not shown up for vaccinations at any appropriate point in their series; children in Gomez II and III, whether or not their vaccination series are completed; not only pregnant women at any point in their pregnancy but women who were pregnant and are estimated to have given birth; and women enrolled in family planning programs who have not shown up for their next cycle of pills, their DepoProvera shot, and even condom supplies if once served. AOPS has hired four monitrices to work with different projects on an as-needed basis (for example, one is working with the innovative technique of marketing simulation for health education in the FHASE project); the suggestion has been made that a menitrice could also spend one week in each sector of a project to work with mothers of children in Gomez II and III and make a list of those for followup. This is a useful suggestion but care must be taken that this not be just a bandaid for what may be a structural deficiency.

- Structural issues

The follow-up issue suggests that the more important difficulties in monitoring and evaluation are issues of structure: categories, definitions, organization, and standardization. AOPS, despite the attractiveness and potential of its basic model, has been hampered by the very quality that makes it attractive, that is, local-level capacity for decision-making and innovation. The variousness of the AOPS institutions has generated different views on certain dimensions of the monitoring and evaluation system, most notably in the area of agegroup definition and reporting formats. Interestingly, in most cases discrepancies have occurred where AOPS, in its laudable desire to be institutionally respectful, has not provided firm or clear guidelines on reporting procedures. In some instances, this has to do with the fact that AOPS has not decided on its own priorities and policies, either because experience has suggested that modifications are advisable, or because the full implications of certain classifications had not been realized earlier. The major structural issues are the following:

- o Dates and authors are lacking on the large majority of the AOPS documents, both field and centrally generated. This makes monitoring and evaluation frustrating and estimations of change over time impossible without major sleuthing.
- o Baseline data are not required on any documentation and, where they are presented, the presentation is confusing. A number of projects have submitted tables on activity data, e.g., number of vaccinations but, in the absence of adequate labels and baseline data, it is impossible to calculate percentages and so get at estimates of coverage.
- Percents are typically not presented and, where they are, are not referenced so they can be interpreted.
- o Children birth to one year are not always categorized independently, nor is there disaggregation of the one- to two-year cohort. If there is a policy determination that the most vulnerable age groups are birth through a child's first and second years, then all projects should be required to provide the necessary data for those cohorts in disaggregated form.
- o There is variance in cutoff points for different kinds of service, e.g., three versus five years of age, as well as such variations as including children from five to six years, thus capturing "all" pre-school cohorts for nutritional follow-up of Grade II and III children.
- Categories are not defined with consistency or clarity. For example, "diarrhea" is used as a reporting category without a standard definition, e.g., "an episode of diarrhea within the last two weeks, diarrhea being defined as X number of X-type stools" (preferably according to WHO guidelines).
- o There is no unitary way of designating age cohorts, e.g., age 0 through 12 months, 13 through 24 months. The meaning of the usage, "age 1-4 years" may mean 1 to 4 or 1 through 4 years.
- o Because reporting forms provide space only for date of birth and no space for age in months or years, it is time-consuming for those monitoring or evaluating to calculate ages for purposes of assessing progress toward targets or to identify sub-groups for follow-up.
- o Projects are not using a consistent tabular format for reporting coverage, so that comparability among them is ponderous and tenuous.

- Number of rally posts completed out of total base number is not consistently reported. For example, in the AMOSSE project as of April 1986, Marigot had finished five rally post cycles, La Montagne had finished seven, and Cayes-Jacmel had finished six; in the Belle Anse quarterly reports, there was even wider variability among sites in the number of rally posts completed. Comparability (for example vaccination coverage over time or among sites) was possible only at a gross level. However, where no information is provided on the number of rally posts completed, making any comparison at all may be unfair.
- o There has been no standard format for the narrative portion of quarterly technical reports or, until recently, for the quantitative reporting of outputs. Project managers and coordinators will want to embellish and append and they should certainly do so, but there should also be a standard core of comparable information which is provided on a regular basis, either quarterly or after each rally post cycle.
- o A number of projects must report to several donors. For example, FHASE must report to World Vision and AOPS; World Vision requires monthly reporting, which is quite burdensome, and AOPS requires a quarterly report. One function that AOPS might serve is to explore other donors' real needs and see whether there might be some useful redundancies: for instance, could the World Vision indicators have enough of a resemblance to the AOPS and the AID Child Survival Reporting System indicators so that they would only have to be recorded and reported once?
- The new guarterly summary of output information is a good step in the 0 right direction but its value would be greater if: the sheet were dated. located, and signed; if items were categorized around an intervention, e.q., family planning, in a visually clear way; if there were an explicit place for the quarter to which the report is referring; and most importantly, if each line item with which some specific target is associated would have by its side the baseline datum as well as the target. An example of this last would be the following: "0-1 year-olds receiving BCG (at baseline, 0%; target 80% of children 0-1 (N=), so that quarterly achievements against baseline and targets are clear at a glance. The baseline data and coverage targets would only have to be looked up and logged once; subsequent reports would simply copy them. An elegant addition could be to leave space for the last quarter's achievements, e.g., in the January-March 1986 guarter, Pignon had 96 children (73% of the baseline number) who had completed series of DPT; in the April-June 1986 trimester, one could see if that percentage had improved.

It was not clear at the time of this evaluation whether or not AOPS was going to try to follow the MSPP formats for activity reporting. Until recently, that system has been very cumbersome, characterized by the usual plethora of often redundant forms which are irritating and burdensome for health facility staff. The Ministry's management information system is presently being simplified--the 15 February 1986 reporting form for rally post activities is only one, easily-used page with some well-considered indicators which looks as if it will, nevertheless, require some refresher training for proper utilization. If this system is completed in the near future and if AOPS is asked to use it, any revision of AOPS reporting forms should attempt to incorporate these data in as economical a way as possible.

- o It is not clear that all AOPS projects can now provide the information required by the AID/Washington Child Survival Reporting System. Since the indicators for that system were being revised at the time of this evaluation, there was little point in doing a detailed analysis of the fit between data available and what AID is going to require. This fit should, however, be analyzed now that those indicators appear to be in final form.
- Despite the existence of the family registers and the follow-up sheets, there still appears to be a felt need to use the traditional system of little notebooks. A project may have a notebook for midwife training (names, dates, topic treated in that day's training, present/absent) or for expenses (e.g., by monitrices for daily purchases by mothers for food demonstration); the project manager's own individual files, e.g., work plans; and notebooks based on the follow-up sheets. This last item could be substituted for by a looseleaf binder for follow-up sheets; copies could be made by photocopier for luxury projects or with carbon paper for the majority of the AOPS group, and one copy kept at the facility and one given to the respective ColVol for promotion at the household level. The resulting notebook then becomes the base for monitoring of how many hard, usually high-risk cases, can be brought in for primary health care, a surely useful piece of operational research.

In sum, AOPS must overcome at least some of its desire not to be authoritarian and proceed to prescribe some standards for reporting of age groups, for project targets, for definitions of categories, and for presentation of data. If this is not done, then the project's ability to summarize and analyze effectiveness and, eventually, impact data across all its constituents will continue to be impaired in terms of quality, frequency, timeliness, and ease.

In addition to coming to some closure on targets, categories, and definitions, and devising a standard outline and format for quarterly technical reporting, it would be useful for AOPS to develop a brief set of simple standard tables as models for use by field projects. This would allow supervisors to get a quick grasp of current achievement levels; for field workers to know how well they are doing and so be motivated to do more; and for headquarters management to be more easily able to report to the MSPP, to donors, and researchers and evaluators. If a selected group of these were drawn up in a larger format for posting in the community, perhaps on the outside wall of the community health facility or some community center, mothers, fathers, and the community at large could find out how well they were doing in terms of making their children at least somewhat healthier.

The centrality of the registration, record-keeping and monitoring system, together with the fact that the training cascade simply did not work for this component of the project, led AOPS to pay close attention to exactly what was happening with that system. The association charged Dr. Winnie Robin with the auditing responsibility for that system. Her procedure has been the following:

- o She arrives at Project X.
- o She takes one population sector at random (N=200 families, 1000 persons).
- o She reviews the dossiers for all: the family register, the individual fiches for children under five and women of childbearing age, and the follow-up fiches.

o She identifies errors and then looks to see if the same errors appear in another sector; if so, then there is a systematic training error which requires on-site review with the whole team but, if not, the problem is probably with a single individual who needs special attention.

The amount of time required to correct failure in the information system is variable and depends on the size of the base population, how fundamental the problem is, and whether the problem is one of basic misunderstanding (e.g., Carrefour-Poy) or lack of guidance, or whether it has derived from interruptions in the project (e.g., La Vallée). For four projects which have major problems with their information systems (La Vallée, Thomazeau, Fonds Parisien, Duplessis), one week each was scheduled for technical assistance, with one day of almost immediate follow-up and three days of follow-up two months later.

Dr. Jean-Claude Fanfan has drawn up an extremely thorough outline (included as Appendix E) of what a thorough supervisory visit should address, which includes a checklist for information system review, coded according to their up-todateness (fully up-to-date or up to last cycle of rally posts), adequacy, and correctness.

- o File Maintenance
 - a. File storage?
 - b. File safety?
 - c. Sectors separated?
 - d. Dossiers set up?
 - e. Alphabetical listing of families in notebook?
 - f. Availability of Road-to-Health cards.
 - g. Availability of vaccination cards.
- o Household Dossier
 - a. Dated?
 - b. Number of code correct?
 - c. Number of code clear?
 - d. Dossier in order?
 - e. Classified correctly by age group?
 - f. Dates of birth noted?
 - g. Vital events noted?
 - h. Services delivered registered?
 - i. Newborns enrolled?
 - j. Availability of new registry forms.
- o Individual Children's Fiches
 - a. Dated?
 - b. Number of code correct?
 - c. Year of birth noted?
 - d. Date of service noted?
 - e. Growth curve marked?
 - f. Nutritional status noted?
 - g. Availability of blank forms.

- o Individual Women's Fiches
 - a. Dated?
 - b. Number of code noted?
 - c. Date of service noted?
 - d. Enrollment at high-risk pregnancy?
 - e. Enrollment for DPA?
 - f. Enrollment for family planning?
 - g. Pregnancy history?
 - h. Data on last pregnancy?
 - i. Availability of blank forms.

o Follow-up Fiches Children 0-3 Years

- a. Date?
- b. Notation of sector code?
- c. Notation of individual code?
- d. Notation of data of birth?
- e. Nutritional status noted?
- f. Date of service noted?
- g. Children seen at least once.
- h. Absence of children over age five.
- i. Availability of blank forms.
- o Follow-up Fiches (Fiches de Suivi) Women 15-45
 - a. Date?
 - b. Notation of code?
 - c. Notation of date of birth?
 - d. Enrollment for family planning?
 - e. Enrollment DPA or DDR?
 - f. Notation of vaccination date?
 - g. Pregnancy history?
 - h. Women not see for 5 months
 - i. Availability of blank forms.

This level of detail here seems appropriate and does not include anything that is not really important to the system. However, observations were made by some of the field staff interviewed that the system was too complicated; AOPS is planning to utilize the expertise of the Save-the-Children staff which will be working on the Maissade project under AOPS III as part of the Mobilizing Mothers for Child Survival project, to review the entire information system and examine options for simplifying it. Whatever changes are made to the information system in the wake of any technical assistance from Save-the-Children, they should not produce the kind of structural change that would invalidate or confuse the data that have already been accumulated. Ther is a lot of good information already available in well-tended systems such as Pignon or Mirebalais, certainly in Belle Anse and, with perhaps a little more digging, in the smaller projects such as those around Jacmel. One of the greater values of the existing system, which has been carefully evolved through years of testing and comparison among programs, is its longitudinality; marginal simplifications or additions should not be allowed to prejudice the data that have already been collected.
2. Supervision

The philosophy of supervision that seems most generalized in the AOPS and Cite Soleil projects is that, like continuing education, supervision should be going on all the time and everyone should be doing it. And, like the philosophy of continuing education, the guiding concept is one of support, not rigidity and The project manager, whether or not that is a physician; the castigation. archiviste; the central-level coordinators, training supervisors, and auditors; the members of the executive committee; and the seemingly endless and everwidening stream of evaluators, researchers, potential funders and other human resources; are all performing as supervisors in some way. Frequent meetings, either called on a regular basis or in response to some need or problem, provide another forum for the questioning, checking of knowledge, and troubleshooting that should be the stuff of supervision. A couple of project managers noted that they try to give positive feedback at the onset of each interaction with ColVols, but there were few opportunities to test that claim, perhaps due to the anxiety and tension which is typically produced when visitors are evaluators on whom the well-being of one's program and one's self depend. At the same time, there was, in several projects visited, a sense of comfort in the relationship between ColVols and the project directors; if this is generally the case, then the quality of supervision being provided in the AOPS and Cite Soleil projects is a healthy advance over the hierarchical, punitive, and onesided model that is widely characteristic of public health ministries.

As AOPS was organized at the time of this evaluation, there were three coordinators for technical assistance: one Regional Coordinator for Port-au-Prince and the South, one Regional Coordinator for the Transverse region and the North, and one for Evaluation Coordinator or Auditor. While in theory the supervisory schedule is organized around the concept of a quarterly visit by each Regional Coordinator to each site, with visits sometimes lasting as long as two weeks, projects with problems tend to get visited much more frequently, as often as twice a month. There are also other, program-related peaks for visiting, such as ColVol preparation, in which supervisor participation has entailed six weekly visits of three days each. The "Auditor" position is meant to "supervise the supervisors," but as backup for regional coordinators; this permits the coordinators to look like what they, in fact, are: supporters and helpers. The risk that the coordinators will be too "nice," that is, not sufficiently critical of project operation and personnel, is guarded against by the Auditor role. For example, no project can get an extension unless the Project Coordinator and the Evaluation Coordinator agree and forward a memo or concurrence to the AOPS Executive Committee.

The existence of the Project Evaluation Coordinator is crucial for the control dimension of AOPS supervision. It controls for the very human managerial tendency to "protect" one's projects; a single point of view on project accomplishments and problems; and the relative insulation enjoyed by a central-level oversight function which can soak up local-level disappointment and even resentment deriving from criticism.

Regional supervisors have not followed any standard sequence or structure in their visits to the field and some kind of standardization would be useful. An excellent start on this has been made by Dr. Fanfan, who devised to the Supervisor's Checklist referred to in the preceding section and included as Appendix C. This tool should be simplified, sent around in draft to the project directors for their comment and input, and worked through with all the project coordinators and, perhaps, with the USAID project manager.

The supervisor's checklist should also be integrated with the quarterly project reporting process. A component should be included in the Supervisor's Checklist which will assure that, at the time the next quarterly report is due, the necessary information will be available, for example, will the project staff be able to provide the required information on family planning users?

AOPS and CMSCS management share the theory that the best supervisor for community volunteers is the community itself, which is in the best position to assess level of effort, interest, commitment, and honesty. It is hard to argue with that, but the determination of community assessment means that project managers and supervisors have to make a systematic effort to identify and talk with key people in the community. This is not always easy to do in any consistent, nonpersonalistic way. Furthermore, in a largely illiterate community, with limited media access and limited prior exposure to certain kinds of information, there is often no one in the community who can validate the adequacy of the health facts provided by community-level workers and the degree to which they are understood and internalized by those being supposedly educated. This is the most difficult area of supervision for any program and an area where more rigorous testing, of both deliverers and clients, should be applied.

The draft Supervisor's Checklist incorporated two tables based on ColVol and mother knowledge of key concepts in Oral Rehydration Therapy (definition of diarrheal, when ORT should be begun, and fluid preparation and administration), nutrition (feeding during diarrheal episodes, weighing, use and uderstanding of Road-to-Health chart, nutrition education, preparation of Akamil), family planning (motivation, method knowledge, and method use); and immunization (vaccine types and purpose, appropriate age, tetanus toxoid ever and when). There are some problems with this methodology as the tests are now devised, administered, The universe of knowledge for ColVols and mothers should not and reported. necessarily be the same. The concepts included should be reviewed to see, first of all, if they are really necessary and if something important has not been omitted and, secondly, if the data provided will respond to the requirements for Tier II of the Child Survival Reporting System. The administration of the questionnaires to mothers is quite problematic and needs to be thought through. In the one case where the evaluation team was able to see mothers tested, the site was an extremely large and disorderly rally post, where it was almost impossible to comfortably select a small sample of mothers; interview them while they were waiting for attention instead of waiting until the end of the morning when everyone was hot, tired, and cross; and achieve even a minimal level of privacy. If mother-testing is to occur at rally posts, then the testing needs to be scheduled with the other activities of the post; if it is to occur during home visits in a random sample of mothers, then ColVols will need to be taught how to do this in some way that would be even remotely trustworthy. ColVol-testing should occur in some other fashion, perhaps integrated with routine meetings, and should require more detail and actual demonstration of key competencies.

Finally, the presentation of test results in quarterly reports, should include enough detail on each question so that it is clear what mothers and ColVols were being asked; information on the sample, including numbers and how it was drawn; and an explanation of the scoring system. This should be standard across all projects, including Cite Soleil.

The Mobilizing Mothers includes the concept of mother-testing and should be used to refine and test this approach; the concept of integrating and even pairing mother-testing with CHW-testing is an excellent one which should be elaborated upon.

D. RESEARCH

1. Cité Soleil

a. Current Research

Cite Soleil is carrying out the following research activities: In 1982, the CMSCS created a Research and Evaluation Division (Unite Recherche de Programmation et d'Enseignement) which has been increasingly active over the past three years. The purpose of this unit is to do research, plan and program, and train CMSCS personnel, as well as training AOPS doctors, nurses, and auxiliaries. At present, training does not follow any fixed schedule but is provided on demand, nor is there yet any program of seminars and workshops. When the Haitian Public Health Institute is set up, there will be a continuous training schedule with standard curricula which will be made available in ongoing fashion not only to AOPS but to any interested NGO.

There are two types of evaluation going on simultaneously in the Cité Soleil project. One is continuous monitoring based on the follow-up sheets held at each Center. These provide data on "In-Center" coverage of pregnant women and all children under age five. Each year, the CMSCS contracts for technical assistance to help establish appropriate sample sizes and do a random sample of all records (e.g., 25 percent of each set of dossiers, random start, to look at immunization coverage: percent of children 12-18 months with complete coverage and percent of children ages 2-6 months with one dose of DPT). This permits statements about levels of immunization coverage; age; vaccines; date of birth; child nutrition levels; attendance, etc. At present, the workload and organization of the Unit does not permit ongoing access to these data.

The other evaluation approach used in teh CMSCS project has been the epidemiological field cluster survey, last done in July 1985 with technical assistance from Tulane University. The survey found only 10-12 percent uncovered. The survey being prepared for September 1986 will be of the whole population, since it will be a complete re-census.

Finally, the CMSCS relies on special studies, described in summary below. The following studies have been or are currently being implemented:

TITLE: ERYTHROMYCIN, UTERINE AND VAGINAL INFECTIONS, AND LOW BIRTH WEIGHT OBJECTIVE: Explore the utility of erythromycin treatment for women in fertile age, with the goal of increasing the birth weights of their progeny.

Continuous data are also being gathered through the maternity on alternative approaches to reducing the risk of infections and mortality in premature infants. The control variables are: mother's educational level (year of school

completed), nutritional status; socioeconomic status; medical problems during pregnancy; and tobacco and alcohol use.

PRINCIPAL INVESTIGATOR:Reginald BoulosPROJECT COORDINATOR:Dr.BrutusASSISTANT PROJECT DIRECTOR:Louis Marie BoulosFUNDING:AID

TITLE: CHALLENGING THE BOTTLE: BREASTFEEDING PRACTICES AND THE FIGHT AGAINST THE BOTTLE OBJECTIVE: Reduce bottle use and promote breastfeeding practices in an urban environment.

PRINCIPAL	INVESTIGATOR:	Louis	Marie	Boulos
COORDINATO	R:	Louis	Marie	Boulos
FUNDING:		AID		

TITLE: THE IMPACT OF MEASLES IMMUNIZATION ON NUTRITION AND MORTALITY OBJECTIVE: Self-explanatory. The research also produced findings on the appropriate age in Haiti for administration of measles vaccing (9 months). Part of this study, begun in 1983, has been published in the New England Journal of Medicine (29 August 1985) and subsequent data are in the process of analysis at Tulane University. A second phase of the project is looking at the correlation between nutritional status and measles vaccination.

PRINCIPAL INVESTIGATOR:	Elizabeth Holt (Tulane University)
CO-INVESTIGATOR:	Reginald Boulos
CONSULTANT:	Neil Halsey (Johns Hopkins University)
FUNDING:	AID and Tulane University

Preliminary results on mortality impact reveal that only 2 of the 20 children vaccinated in October 1982 had died at age 12 months or more. In comparison, of the 1200 similarly aged infants not vaccinated, 66 had died at age 12 months or more. Furthermore, the rate of hospitalization for children who had not had measles was lower than for those who had.

TITLE: METHODOLOGY FOR IMMUNIZATION COVERAGE EVALUATION: CLUSTER SURVEY VIS-A-VIS RANDOM SAMPLING

OBJECTIVE: To explore the most economical yet scientifically valid way of monitoring and evaluating the Project's immunization program in Cite Soleil.

PRINCIPAL	INVESTIGATOR:	Jean	Taffauro)			
FUND:		AID,	through	the	project's	Evaluation	Component

TITLE: MATERNAL CARE RESEARCH PROJECT/ALTERNATIVE TRAINING PROGRAMS FOR TRADITIONAL BIRTH ATTENDANTS

OBJECTIVE:

1) Develop a solution to the following operational problem: what type of training should be provided to traditional birth attendants so that they perform tasks judged to be critical in the reduction of maternal, perinatal, and neonatal mortality?

2) Validate the solution by testing it in the field. The overall objective of the research project thus required an analysis of factors related to maternal/ perinatal and neonatal mortality and morbidity. The research project thus provided an opportunity to describe the process of birth in a marginal peri-

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urban environment and to determine a) the extent to which maternal care influenced maternal, perinatal, and neonatal morbidity; b) the risk factors associated with a negative pregnancy outcome; c) the principal causes of maternal morbidity and neonatal and infant morbidity and mortality in the Cité Soleil setting; d) the factors that affect utilization of maternal-child health services in a setting where accessibility and availability of care is assured; e) the relationship between utilization of services and survival; and f) the extent to which small-area registration systems with a population-based orientation is feasible within the context of a service program.

The objective of the study was to test the hypothesis that a new, shorter training program developed during Phase II of this research program, when applied in the field, would in fact lead to the performance by TBAs of tasks which would lead to a reduction in maternal morbidity and perinatal morbidity and mortality, as compared to the performance of TBAs trained in the traditional manner. The most important preliminary finding is taht TBAs who were trained in a new, shorter, well-prioritized training program were equally as effective as those who followed the longer, standard, MSPP course, and more effective in referral of high-risk mothers for prenatal care and hospital delivery.

PRINCIPAL INVESTIGATOR: Antoine Augustin FUNDING: PRICOR

TITLE: STUDY OF ACCEPTABILITY OF ORAL CONTRACEPTIVES AND DROPOUT PATTERNS OBJECTIVE: Self-explanatory.

PRINCIPAL INVESTIGATOR:	Kathy Maturnovski (Michigan University)
CO-INVESTIGATOR:	Reginald Boulos
FUNDING:	Michigan University

Study completed. Principal finding was that, although initial acceptance rates of oral contraceptives are high, continuity rates are very low.

TITLE: ATTITUDES AND PRACTICES AMONG CONDOM-USERS IN CITE SOLEIL OBJECTIVE: To better understand apparently high rates of discontinuation of condom use by males in the urban area.

PROJECT COORDINATOR:	Michaelle Leonard
FUNDING:	Family Health Institute

TITLE: CLINICAL TRIAL OF NORPLANT, CITE SOLEIL OBJECTIVE: Self-explanatory. Research has also included documentation on acceptability and discontinuance.

PR INC IPAL	INVESTIGATOR:	Reginald	Boulos
FUNDING:		No data	

This study is ongoing (N=40 to date) and is being replicated in the AOPS Pignon project (Hopital Bienfaisance, N=100 to date), with Drs. Guy Théodore and Guerrier Martineau as co-investigators. An initial finding is that, while acceptability of the method is in the middle range (neither highly nor little acceptable), continuance rates to date are high.

TITLE: STUDY OF ORT KNOWLEDGE AND USE

OBJECTIVE: Self-explanatory. Begun at the same time as measles study and constitutes a one-page module in that study which includes questions on whether or not people know ORT, do they use it, and how they use it, with emphasis on packet use with no detail on homemade solutions.

PRINCIPAL INVESTIGATOR:	Louis Marie Boulos
CO-INVESTIGATORS:	Tessa Wardlow and Reginald Boulos
FUNDING:	Tulane University

b. Projected or recommended research

There are a number of areas where the CMSCS research staff and the evaluation team feel work could be usefully done. Some are more well developed than others. They are:

TITLE: PROMOTION OF FAMILY PLANNING METHODS, CENTER FOR FAMILY EDUCATION, HAITIAN ARAB CENTER (HAC)

OBJECTIVE: There is a need to restructure the Center and, therefore, re-evaluate it and do a re-census in Cité Soleil. The fundamental issue is to determine which contraceptive methods offer both a high rate of acceptability/acceptance and a high rate of continuance.

An ancillary question is: what are the incentives to 1) start and 2)to continue any given method?

Studies to date indicate that:

Acceptance rates for the pill are high, continuance low Acceptance rates for the IUD (sterile) are low, continuance high Acceptance rates for Norplant are medium, continuance high Acceptance rates for Depoprovera are medium, continuation high Acceptance rates for cremes are zero.

FUNDING:

Columbia University (?) Center for Family Education, HAC

TITLE: COST-EFFECTIVENESS ALTERNATIVES FOR IMPROVING HEALTH SERVICES DELIVERY OBJECTIVE: Self-explanatory. The emphasis planned is to be on TBC and Nutritional Rehabilitation. We would recommend a larger purview.

FUNDING:

No further data

TITLE: STUDY OF DIARRHEA-RELATED MORTALITY OBJECTIVE: Self-explanatory.

FUNDING: PAHO or Johns Hopkins Tier III Evaluation Support

TITLE: REAL VACCINATION COVERAGE

OBJECTIVE: Research, including measles research at Cité Soleil, has produced recommendations on the appropriate ages by which children should have completed each vaccination. The CMSCS would like to do a study of real, constant coverage, which would provide the basis for promotion of immunization at the proper

ages, that is, targeted, age-specific immunization. The central research question is: what can we find out, through analysis of data accumulated to date, about what has been the average ages for all vaccinations, by type, by site, controlled for by age of program? This research should be extended to include the AOPS projects.

TITLE: EVALUATION OF THE EFFECTIVENESS AND IMPACT OF THE ROAD-TO-HEALTH CARD OBJECTIVE: There is increasing questioning in the scientific community of the value of the Road-to-Health Card now widely used for growth monitoring. A tentative hypothesis is that the card is useful for screening but not for monitoring; in Haiti, as elsewhere, it is used for both purposes. An ancillary effect is that the growth curve may be evaluated but not the child. In addition, there is mounting evidence that the card is grossly underutilized as a motivational and educational tool, so that while the card itself may have some value, the process of its use is almost completely a waste. Both Cité Soleil and the AOPS projects offer excellent opportunities for pursuing these very important issues, although the difficulties of measuring the impact of this intervention should not be discounted.

TITLE: USER FEES

OBJECTIVE: Some pieces of fragmented research address the question of user fees. For instance, TBAs get incentives for clients motivated and contunuing in use of family planning methods, e.g., condoms, and there has been scrutiny of the results of these incentives with different kinds of TBAs and ColVols. However, this has been done in a very general way and there has been no ensuing analysis. Similarly, this evaluation has looked (see Chapter V) at the various incentive systems for ColVols, but there needs to be a systematic review of all these approaches to see which, if any, have been effective and design some explicit operaitons research.

TITLE: THE EFFECTIVENESS AND IMPACT OF FOOD SUPPLEMENTATION

OBJECTIVE: Food is distributed at the CMSCS and is also distributed in some AOPS projects. Experience with this component has raised the following questions: what is the effect/association of food supplementation in a given project with immunization rates and nutritional levels; what is the effect of not providing food if a child does not show continuous weight gain; is there any incentive for families to "change sectors" (urban setting) to get food, for example in TBC programs; and at what point in the rally post sequence should food supplementation be provided or should it be provided at another time and/or place "by prescription?"

TITLE: VITAMIN A DISTRIBUTION

OBJECTIVE: A project proposal has been recently been submitted to AID/Washington, which will include a survey on the number of children in Haiti who have received Vitamin A, including number of doses and the age at which it was received and the degree to which this accords with expected compliance; the percentage of the base population which has not received Vitamin A; and, out of the total number of children who were referred by the project to an opthalmologist, how many were diagnosed as having a Vitamin A deficiency?

FUNDING:

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Helen Keller International

2. AOPS

a. Current research

There has been a series of PRICOR-supported studies through AOPS which have been recently compiled in book format. These are briefly described here according to the chapter headings in that document. Where findings have been produced, these are presented here.

TITLE: THE TASKS OF COMMUNITY HEALTH WORKERS AND TASK EXPECTATIONS OF CHWS

The study settings for this group of studies were three rural sites chosen because they represent three different patterns of community organization, Mirebalais, Thomassique, and Gros-Morne. One urban site, Cité Soleil, was chosen to reflect the implications of the study for urban health programs and because the CMSCS project has been accumulating impact data over recent years, most especially on ORT and measles.

The principal hypothesis governing the study was that there is an ideal way of allocating tasks to community health workers to maximize the impact they can have on infant and child mortality; for this research, the tasks under consideration were limited to ORT, immunization, growth monitoring, and family planning. Two sub-hypotheses were that 1) it was possible to estimate the timeuse-effectiveness for the tasks associated with each of the four interventions and that 2) a health worker might have the same or greater overall impact on the health of his or her community by focusing activities on a small set of households, perhaps 20 percent of the target population, perhaps particular subgroups, rather than by diluting efforts over an entire catchment area. The key operational problem was to determine those "best" proportions of personnel time, commodities and economic resources devoted to each CHW task that will 1) maximize overall value of health benefits to the community while ensuring that 2) no resource levels are exceeded, but that 3) all minimum performance levels are met (or exceeded). An ancillary question was: should an equal amount of effort or time be allocated to all identified tasks?

FINDINGS: The preliminary findings which have appeared so far are primarily descriptive and provide a profile of a sample of CHWs in the three rural study sites. Those have been presented in this document in Chapter IV.A. and will not be repeated here.

TITLE: THE EFFECTIVENESS OF PRIORITY HEALTH INTERVENTIONS IN HAITI: ORT OBJECTIVE: To determine whether knowledge of ORT was associated with a fall in the 1984 infant mortality rate (IMR) and the one- to two-year mortality rate. Knowledge was defined as giving correct responses to a set of questions exploring the mother's capacity to prepare and to administer ORT.

FINDINGS: Pricr to the introduction of ORT, death rates were similar for children of mothers knowledgeable or not knowledgeable about ORT. In fact, in the 1982 birth cohort, fewer children from the group of knowledgeable mothers survived. This phenomenon was reversed for the 1983 birth cohort, primarily in the 12- to 23-month cohort where the mortality rate was 120/1000 for knowledgeable mothers vs. 200 per thousand for non-knowledgeable mothers. This difference persisted in 1984: 40/1000 vs. 90/100. Knowledgeable mothers were more likely to be literate and to have fewer children. More research is needed to appraise the flow of causality among these factors and more analysis required to adjust for confounding factors.

TITLE: THE IMPACT OF MEASLES VACCINATION

OBJECTIVE: To determine whether immunization of children with measles vaccine is associated with a reduction of childhood mortality. This study is described in the earlier section on research at Cite Soleil.

TITLE: BIRTH INTERVAL AND PREGNANCY OUTCOME IN RURAL HAITI

OBJECTIVE: To explore the contention that the increased mortality associated with a shortened birth interval may be treated to the replacement phenomenon: women who have already lost an infant are more likely to develop a new pregnancy. Their previous infant death experience, evidence of higher risk, rather than the short interval, accounts for the increased mortality risk for the subsequent death.

FINDINGS: The study documents that, in a situation where women given birth twice over a period of two successive calendar yhears, the replacement phenomenon may be in effect. Women giving birth twice over a period of two successive calendar years are four times more likely to lose their child. The study suggests that focusing on these women, who may contribute less than 15 percent of all births, will allow the prediction of as many as one-third of all infant deaths. Preventing these births would reduce the infant mortality rate by 10 percent. In a setting such as that of rural Haiti, post-partum contraception will be an intervention with a significant potential for reducing infant mortality.

TITLE: TASK ALLOCATION

OBJECTIVE:

1) To test a hypothesis formulated in Phase I of this study, that for every unit of time a CHW spends to make a mother competent in the use of ORT, s/he must spend 21 times this unit in the promotion of family planning in order to maximize the number of child lives saved.

2) To determine the relative effectiveness of promoting priority health care interventions by CHWs to all women in selected communities or to focus promotion activities on women at high risk of losing a child.

3) To determine whether women at high risk of losing a child are more highly motivated to utilize available health services than women who are not at high risk.

Cash incentives were awarded at the program's conclusion, varying relative to the percentage of women the CHW succeeded in making competent in the principles of ORT and the preparation of ORS and in the knowledge and utilization of family planning, as evidenced by pre- and post-training questionnaire evaluation. Participants were given as an incentive the right to participate in rural credit clubs and all participants were entitled to a free medical consultation.

FINDINGS: The exercise revealed that a limited list of mothers appears to be more manageable for a CHW to deal with at any one time. Furthermore, mothers who feel they have been specially selected are more apt to attend educational sessions, while the focus on a selected group of mothers did not seriously affect the overall patterns of knowledge for the villages as a whole. With the exception of some seemingly aberrant change in knowledge levels about diarrhea, knowledge levels were changed in the direction and degree one might expect. Since focusing on mothers with high-risk children does not appear to severely penalize other mothers who acquire their knowledge at rally posts, it would appear advantageous to institute a screening system for identification of atrisk children. In settings where the brunt of the educational effort takes place at rally posts, additional educational sessions in the village targeted to mothers of at-risk children have a potential of improving community knowledge with regard to key interventions.

b. Projected or recommended research

TITLE: THE HEALTH STATUS OF NON-USERS OF HEALTH DELIVERY SERVICES

OBJECTIVE: One of the central assumptions of the AOPS model is that mothers will keep coming to rally posts. Inherent in this assumption is that mothers will keep bringing any given child until his/her vaccination series is complete. Assuming the registration/record-keeping/follow-up system is working well, there are ample data for determining how many mothers really do this. However, we do not know 1) whether mothers will continue to come to rally posts after vaccination series are completed, or 2) why they will do so. There may be a transition period during which mothers will continue to show up for weighing simply out of newly-habituated behavior, because they have been told that it is good to do so and have no reason to question whether, as a matter of fact, weighing their children is meaningful for them. However, sooner or later, mothers will, consciously or unconsciously, evaluate whether there is any reason (barring another pregnancy or another baby) for them to continue attendance at rally posts. The research focus would be on: 1) why mothers now come to rally posts, and 2) how mothers behave when their children have completed the vaccination series on which they have embarked, and why they do what they do.

TITLE: MOTHER COMPETENCY AND PARTICIPATION IN GROWTH MONITORING

OBJECTIVE: To determine whether the educational potential and ultimate impact of growth monitoring, with emphasis on correct weighing and use of the Road-to-Health Card, can be enhanced by participation of mothers through clubs or specialty groups. This would be combined with the Evaluation of the Effectiveness and Impact of the Road-to-Health Card referred to earlier as projected/recommended research at the CMSCS.

TITLE: FAMILY PLANNING CONTINUANCE PATTERNS

OBJECTIVE: To use ColVols to 30 women, recruited for family planning, to track continuance, discontinuance, and dropout over time. This could be merged with operations research on the effectiveness of the addition of a family planning station to rally posts.

TITLE: INCENTIVES FOR COMMUNITY HEALTH WORKERS

OBJECTIVE: There is a matrix of incentives that describes the different incentive systems that have been or are being used in Haiti: 1) cash or non-cash, 2) to worker or to community, 3) sporadic or standardized/regularized; 4) available to individual workers or to groups or workers, 5) simple or complicated. These need to be systematically field-tested, with a guiding hypothesis being that performance-based or results-oriented incentives are the most appropriate and productive.

V. FINANCIAL MANAGEMENT AND PLANNING

This section summarizes issues related to basic bookkeeping and donor accountability, financial management, financial planning, financial sustainability and strategies for self-sufficiency for the Complex Medico Social de la Cité Soleil (CMSCS), the Association des Ouevres Privées de Santé (AOPS), and the grantee institutions of AOPS. Our information is based on interviews with accounting and administration staff and on a review of books and documents where they were available. Both time and available information prohibited system audits and extensive direct data analysis by the team members.

A. CMSCS

1. Donor Accountability

CMSCS appears to meet minimum standards for donor accountability. Receipts are retained at the central administrative level where they are reviewed. Those that are considered allowable under the AID Cooperative Agreement are itemized and reported on the AID voucher system. Dr. Reginald Boulos and Sister Héléne review these reports. In our experience, this type of documentation and reporting was considered to meet the minimal standard for the MSPP's reimbursable dollar funds (DA) by the AID controller's office. Although the reporting procedures for the Cooperative Agreement are better documented and controlled than the whole CMSCS financial system, the AID reporting system is more complex and cumbersome than it needs to be. The same information is copied from one document to another several times. This is a waste of staff time and paper. More importantly, the transfers increase the possibility of human error. The system should be simplified.

2. Financial Management and Control

The guiding principle for financial management at Cite Soleil is that each facility or center within the Complex is expected to manage and control its own resources. This basic financial management principle is a sound one. It allows for flexible, decentralized decision-making yet provides appropriate incentives for using resources effectively. The central administration of the Cité Soleil Complex establishes each center's personnel needs in consultation with the Sister who runs the center, and pays the Center's monthly salaries. Each month it also provides a lump sum financial allocation to the Sisteradministrator. This allocation and the revenues that each center collects are expected to cover all its non-salary operating decisions concerning the operation of the center. She purchases all of her own materials and supplies, and has responsibility for all minor equipment repairs and maintenance at her cen-She makes the decisions about whether patients can be exonerated from She summarizes the monthly financial transactions of the center in a ter. fees. notebook and remits this record and supporting receipts to the central administration at the end of each month. If the center's expenses exceed its financial resources, the Sister incurs a "deficit" to the Complex, and she is expected to cover this deficit and make ends meet during the next month. The financial management issues related to each center are discussed below under each center's associated income-generating activities.

The series of notebooks and receipts that are kept by each Sister-administrator constitute the basic financial record-keeping system for CMSCS and are the fundamental source of financial information. The financial transactions that are recorded in the notebooks are consolidated in the general ledger each month, but the notebooks provide the basic tool for cash management. The central administration reviews each center's monthly revenues and expenses, compares expected vs. actual revenues, and makes changes in the monthly financial allocations to the center based on this information. The financial information appears to be little used for other financial analysis and decision-making, except in the case of special projects.

The notebooks for each center document CMSCS financial activities and provide useful information on expenditures and revenues. The revenues from fees charged at the hospital are probably the most accurately recorded, as a series of hospital reporting procedures back up this information. The systems for reporting revenues at the other centers are less well documented. Cash and in-kind donations received at each center are not systematically recorded. While cash donations represent only minor income, in-kind pharmaceutical and food donations may represent a more significant source of income. Salaries, which reflect the majority of costs at each center, are accurately recorded in each of the notebooks by the central administration at the end of the month. Other expenditures are probably accurate enough to provide useful data for analysis.

The notebooks are an inadequate financial information tool to help the Complex address issues of financial management and cost control. The line items, for example, are extremely broad and appear to be inconsistently defined over time and across centers. This system does not represent sufficient information to analyze, either at the end of a month or at the end of a year, the changes which have occurred in expenditures and to make informed decisions regarding center operations. The centers have little way of knowing whether changes are due to changes in environmental conditions, i.e., the impact of price changes on their activities, or to changes in center activities.

This financial record-keeping system does not provide adequate financial control, i.e., safeguarding, monitoring, and documenting the Complex's financial activities. It is clear that there are reporting inconsistencies which distort information provided by the notebooks and that there are leakages--of information rather than money--from the system. The distortions may be minor, and the integrity and thrifty habits of the sisters probably assure as much control and fiscal responsibility as a tighter system would. However, designing and implementing an adequately controlled system would require considerable time and effort, and the relative benefits of investing this time and effort may be small. A more sophisticated accounting system may also be beyond the absorptive capacity of the Complex at the present time. A modest investment of time and effort directed at enhancing cash management and record-keeping procedures would provide a more useful management tool that could be used to address revenue generation and cost control issues. Over the longer term, the limitations and weakness of the "little notebook system" must be overcome and replaced by an accounting system if the Complex is to survive and flourish.

Like many non-profit groups that are dependent on a variety of donors, CMSCS does not consolidate its budget planning, and the centers themselves do very little in the way of annual budget planning. Most budgeting is done by funding source, like the budget for the Cooperative Agreement with AID. The Cooperative Agreement budget is allocated among the central administration and the

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various programs and centers of Cite Soleil. Consolidated budgeting for the Complex may not be necessary, but more attention to budget planning at the program or center level would be beneficial. The Complex presently responds to financial shortfalls by looking for additional sources of funding rather than attempting to restructure activities to fit within expected resources. Establishing budgetary procedures by center would help identify clear expectations for the need for financial resources and guidelines for their use. Budget planning would also help the central administration to more systematically anticipate its annual resource needs.

3. Income Generation

Several activities at CMSCS presently are generating revenues for the Complex: patient fees, product sales, and school fees. These fees are collected and retained at each center and are used to support its operating costs. Revenues must increase at a faster rate than costs if they are to contribute to selfsufficiency goals. For this reason, both revenues and expenditures from the last two years for each center are summarized below. The reader must be cautioned that two years is too short a period of time on which to base strong conclusions. Nevertheless, the data are informative and useful for determining some future courses of action.

Patient fees currently represent the largest source of revenue generated by the Complex. Fees are charged for outpatient curative visits at the CHAPI center, for prescriptions at the CHAPI pharmacy, for X-rays at the hospital, and for hospital admissions. The fees are used to cover the operating expenses of the facility or center in which they are collected. The 1985 change in the fee structure provided a substantial increase in revenues for the CHAPI Center and St. Catherine Laboure Hospital. Table 14 below illustrates the changes in the fee schedule between 1981 and 1985.

TABLE 14

CITE SOLEIL FEE SCHEDULE (in US Dollars)

	1981	1983	1985*
Hospital X-Ray Hospital Admission	2.00	3.00	3,00
Pediatric	2.00	2,00	3,00
Maternity	2.00	2.00	3.00
Internal Medicine	2.00	2,00	5,00
Minor Surgery	5.00	10.00	15.00
Major Surgery	8.00	15.00	45.00
Emergency Admission	1.00	3.00	5.00

CHAPI visit CHAPI pharmacy

0.20/prescription

0.10/item

* Fees changes implemented in March/April 1985

0.20/prescription

An assessment of how revenues contribute to the operating expenses of each center and to the overall financial status of the Complex is examined below.

4. CHAPI Center

CHAPI Center fees for outpatient curative visits were increased in early 1985 from US \$0.10 to \$0.20. Similarly, the prescription charge of US\$0.20 for an unlimited number of items was eliminated and replaced with a charge of \$0.10 per item. Table 16 illustrates the results of these changes. During FY86, average monthly revenues from outpatient and prescription fees increased by 21.5 percent over the previous year. Revenues as a percent of the total operating costs of the Center increased from 24.5 to 31 percent. At the present time, the revenues collected at the CHAPI Center are used to cover all of its non-salary costs. Salaries continue to be supported by the Complex.

An important effect of the change in the fee structure has been on pharmaceutical utilization. Table 15 below illustrates these changes.

TABLE 15

AVERAGE NUMBER OF MONTHLY PRESCRIPTIONS DISPENSED AT CHAPI PHARMACY, BY NEIGHBORHOOD LOCATION OF PATIENT

	FY84	FY85	FY86*
Boston	1150	1092	1156
Brooklyn	1618	1393	1263
CHAPI	2413	1967	1195
TOTAL	5181	4452	3614

Monthly average based on data from first six months of FY86.

TABLE 16

CHAPI CENTER REVENUES AND EXPENDITURES (FY85 and FY86 in US Dollars)

	JULY 1984 - JUNE 1985		JULY 1985 -	MARCH 1986
	TOTAL	X/MONTH	TOTAL	X/MONTH
REVENUES				
Dispensary Fees	28,740*	2,395	26,190	2,910
EXPENSES				
Salaries	70,006	5,834	56,932**	6.325
Pharmaceuticals	33,300	2,775	22,600	2,510
Mat/Supplies/Repairs	14,040	1,170	4,735***	526
TOTAL	117,346	9,779	84,267	9,362

* April revenues estimated.

** March salaries estimated from previous month.

*** Expenses for TB and ORL clinics are substantially below previous year.

TABLE 17

, i i i i i i i i i i i i i i i i i i i	JULY 1984 -	JUNE 1985	JULY 1985 -	MARCH 1986
· •	TOTAL	X/MONTH	TOTAL	X/MONTH
REVENUES				
Admissions X-rays	11,850 <u>4,990</u>	988 416	12,154 5,013	1,350 557
TOTAL	16,840	1,404	17,167	1,907
EXPENSES Salaries Mat./Supplies/Repairs	159,140 59,480	13,262 4,957	136,320* 54,145	15,147 <u>6,016</u>
TOTAL	218,620	18,219	190,465	21,163

ST. CATHERINE LABOURE HOSPITAL REVENUES AND EXPENDITURES (FY85 and FY86 in US Dollars)

* March salaries estimated from previous month.

While the number of prescriptions dispensed at the CHAPI Center pharmacy had already declined by 16 percent between FY84 and FY85, this downward trend was accelerated when fees were increased in March/April of FY85. The average number of prescriptions dispensed each month during the first half of FY86 was 23 percent less than the previous year and 43 percent lower than what had been dispensed in FY 84. If we can assume that donated pharmaceutical supplies remained relatively constant during this period, the center was able to reduce its pharmaceutical expenditures by 10.5 percent. Unit prescription costs, however, have risen from \$0.62 to \$0.69 between FY85 and FY86, although patients are now paying almost 15 percent of this cost.

Prescription costs require regular and careful monitoring. As costs increase, fees for prescriptions should be increased commensurately. A more detailed recording of expenditures in this center's notebook may help to identify specific areas to target for cost control and or least reduction. It may be possible to raise fees so that clients are paying a greater share of the costs. If prescription fees were raised to \$0.15 per item, this would cover over 20 percent of unit prescription costs. In this medium term, revenues from outpatient and prescription fees should be expected to gradually begin to cover a portion of salary costs.

5. St. Catherine Labouré Hospital

The results of the changes in the fee structure for hospital admissions and Xrays are presented in Table 17. Average monthly hospital revenues increased by 35.8 percent between FY85 and FY86. However, it is important to observe that total operating costs also increased, although at a slower rate of 16.2 percent. Revenues as a percent of total operating costs increased from 7.7 to 9 percent. While there has been little analysis of the unit costs of hospital services, a 1983 PRICOR study by M. Pipp (referred to in the Project Paper), identified the unit costs for normal and Caesarian deliveries as \$31 and \$210 respectively. If we assume that these costs have increased by no more than 10 to 20 percent, then patients are paying roughly 8 to 9 percent of the cost of a normal delivery and about 17 to 19 percent of the cost of a Caesarian delivery. Unit cost estimates for other hospital services would be useful to obtain. With these costs in hand, targets for the portion of costs to be recovered by fees could be established. Costs also could be monitored and the fee structure changed commensurate with increases or decreases in costs.

Utilization appears to be unaffected by fee increases. Seventy-eight fewer surgeries were performed at the hospital tin 1985 than in 1984 (209 vs. 287), but this situation seems to be due to the reduced availability of the surgeons rather than reluctance of patients to pay higher fees. The number of deliveries actually increased by 304 (1699 vs. 1395). In a recent study by Anne Becker (1985), cost was demonstrated not to be a major factor in determining whether a woman chose to deliver at the hospital.

The hospital receives a monthly financial allocation from the Complex. This allocation and the revenues it collects from fees are intended to cover all non-salary expenditures. In FY85, the hospital's monthly allocation of approximately US\$3,400 and average monthly revenues of \$1,400 provided \$4,800 to cover monthly non-salary expenditures. Since these expenditures averaged \$4,957 per month, the hospital incurred a monthly internal "deficit" to the Complex of about \$150. During FY86, the allocation from the Complex was reduced to a monthly average of \$3,170 to reflect the declining AID contribution to the support of the Complex's operating costs. Average monthly revenues increased to \$1,900. Non-salary costs have increased to a monthly average of \$6,000. These figures imply that the hospital's monthly deficit to the Complex has decreased to around \$930. According to the notebooks, the hospital has a current accumulated deficit to the Complex of around \$5,000. This internal deficit certainly contributes to the monthly deficit problem that CMSCS is experiencing as some donor funds are reduced or withdrawn.

Given that the hospital's operating costs represent over one-third of the Complex's total operating costs it is important to identify mechanisms to contain and/or reduce hospital costs, and to increase revenues. The long-term financial viability of the Complex depends on developing and implementing such actions. While it is unrealistic to expect the hospital to strive for selfsufficiency, the hospital should not absorb any greater share of the Complex's resources. To achieve this goal, CMSCS will have to analyze hospital costs and develop mechanisms for their control which include implementing improved budgeting and financial management procedures. One strategy would be the hiring of a business manager for the Complex who could assist the Sister-administrator in these tasks.

There is probably some latitude to increase fees at the hospital. If, for example, fees for deliveries were increased by only \$1, it would bring in \$1,600 in additional revenues and probably would not affect utilization. Fees for adult hospitalization also might tolerate an increase without affecting utilization. Changes in policies regarding fee exemptions offer another source of increased revenue. Few patients who were admitted to the hospital in 1985 were exempted from fees: 7 surgical patients for a total of \$307 in foregone income, and 42 general medicine patients for a total of \$120 in foregone income. However, hospital records show 287 patients were exempted from X-ray fees for a total of \$3,570 in foregone income (most patients had multiple Xrays). Many of the X-ray patients were referred by a sister at another center with a note requesting a free X-ray (mostly for TB patients). One strategy to deal with this problem would be for the cost of the X-ray to be paid from the budget of the center making the referral. Finally, some entirely new sources of revenue could be developed. While fees for surgery in the Cite Soleil community may be close to the maximum that families can pay, the Complex could consider opening a few of its beds to private surgery patients. These patients would pay the full cost for surgical care and a premium for private quarters. If a market exists for private patients at the hospital, the revenues obtained could make a significant contribution to hospital operating costs.

6. Boston and Brooklyn Centers

Table 18 below provides data on revenues and expenses at the Boston Center for the last two fiscal years. School fees and revenue from product sales are used to cover the non-salary operating expenses at this center. Revenue from the sale of products made by students at the vocational training center increased by 16.2 percent over the last year. This year, sales and school fees contributed 8.7 percent to total costs, up from 6.8 percent in FY85. Total costs of the Center have increased by 9.6 percent and are wholly accounted for by salary increases. Expenditures on materials and supplies actually decreased. This decrease is most likely the Center's response to increases in the prices of materials and supplies and a need to keep its operating costs within the financial allocation from the Complex.

TABLE 18

BOSTON CENTER REVENUES AND EXPENDITURES (FY85 and FY86 in US Dollars)

	J	ULY 1984 -	JUNE 1985	JULY 1985 -	MARCH 1986
	-	TOTAL	X/MONTH	TOTAL	X/MONTH
REVENUES Sales		4.829*	402	4,207	467
School Fees		3,292	274	2,453	272
TOT	FAL	8,121	676	6,760	739
Salaries Mat./Supplies	s/Repairs	92,490 24,200	7,708 2,108	79,563 17,260	8,840 1,918
	TOTAL	117,690	9,816	96,823	10,758

* Includes payments to mothers.

TABLE 19

BROOKLYN CENTER REVENUES AND EXPENDITURES (FY85 and FY86 in US Dollars)

	JULY 1984 - JUNE 1985		JULY 1985 - MARCH 1986	
-	TOTAL	X/MONTH	TOTAL	X/MONTH
REVENUES Sales (Mothercraft)	18,760*	1,563	12,790	1,421
EXPENSES Salaries * Mat./Supplies/Repairs	78,900 37,140	6,575 3,095	64,720 26,750	7,191 2,972
TOTAL	116,040	9,670	91,470	10,163

Includes payments to mothers.

Table 19 above provides similar information for the Brooklyn Center. Revenues from the sale of products made by the mothers who attend the Center support its operating costs. During FY86, average monthly sales declined by 9.9 percent, and their contribution to total costs was reduced from 16 to 14 percent. While this situation is troublesome, the political instability of the last six months undoubtedly played a large role in the decline of sales. Informal conversations with individuals responsible for similar crafts programs which are dependent on an external sales market revealed similar slumps in revenue. Total operating costs for the Brooklyn Center have increased by 5 percent, mainly as a result of increased salaries. Expenditures for materials and supplies, which include payments to mothers for product fabrication. have declined. Since prices for materials and supplies are known to have increased, the decline in expenditures is most likely a response to decreases in sales and a need to keep operating costs within the financial allocation made by the Complex.

Both the Boston and Brooklyn Center harbor potential for expanding the revenue base of the Complex as well as the income-generating capabilities of the individual participants. The recommendations of the Maria Alvarez report (1983) concerning these issues remain valid. To increase the sales of products she recommended that skill levels of trainees needed to be evaluated and upgraded and that marketing efforts needed to be expanded. She also recommended that cooperative enterprises, such as a bakery, be organized to utilize the skills and expand the opportunities for trainee graduates. More aggressive marketing and sales require, at the minimum, an investment in resources to guarantee the quality of the products, and a thoughtful assessment of the business environment. The Complex needs to be committed to maintaining close supervision of both quality and quantity of products. Recommendations related to cooperatives and business require a completely different kind of ability than the Complex currently has. Some of these recommendations, such as development of a bakery, are being implemented. However, the Complex still requires someone with appropriate business experience to manage production, marketing, and sales of the Complex's products and to assist in the organization of the cooperative enterprises.

7. CMSCS Complex

The revenues and operating expenses reported in each of the center's notebooks for FY85 and the first nine months of FY86 are consolidated in Table 20 below. Total operating expenses and revenues for FY86 are projected based on monthly averages.

The total operating expenses for FY85, according to the information reported in the notebook, were \$689,180. Operating expenditures, according to the budget worksheet in the project paper, were expected to be \$762,926, a difference of nearly \$74,000. Research expenditures which are not recorded in any notebook account for \$35,000 of this discrepancy. Although budgeted and actual expenditures can be expected to differ, a discrepancy of \$39,000 illustrates the problems inherent in the Complex's record-keeping.

For FY86, operating expenses were budgeted at \$742,374. If spending for the next three months continues at the average rate, FY86 operating expenditures will total \$765,579, without including research expenses. This is three percent above budgeted expenditures and 11 percent higher than last year's expenditures. This increase illustrates the need to implement financial management procedures.

Based on the projections, total revenues for FY86 will be 15.5 percent above last year. Revenues from health fees were expected to be \$55,000. If coll.ction continues at the present rate, revenues from health fees will exceed that goal by almost \$3,000. Revenues from fees and sales are an important source of revenue for the Complex, contributing 10.9 percent of operating cost. However, fees and revenues cannot realistically be expected to make a much larger contribution to operating costs, at least within the next two to four years. Although revenues from fees increased by 15 percent the last year, the contribution to operating costs increased by only 0.4 percent. While there probably is some room to increase fees, and they certainly must be increased commensurate with cost increases, the Complex will have to rely on other strategies to achieve self-sufficiency.

8. Strategies for Financial Management

a. Fundraising

Fundraising is considered the major strategy required to move CMSCS towards financial self-sufficiency. Last year, "Friends of Cite Soleil" (FOCUS) acquired legal status as a U.S.-based nonprofit to provide the major fundraising effort for CMSCS. However, fundraising efforts through this organization have not been very successful to date. There are several reasons why.

First, the organization does not have a professional staff. In order to reduce overhead costs, CMSCS primarily relied on Mrs. Kathleen Boulos to oversee the implementation of the first steps of Friends of Cité Soleil. While it saves CMSCS a great deal, the Complex now realizes that it will have to spend money in order to raise money. The second problem was the lack of a definite strategy which made decisions difficult. The absence of startup costs also limited the range of actions that could be taken. Finally, the CMSCS directors appear not to have accorded fundraising a high priority. Only limited fundraising was achieved last year.

TABLE 20

CONSOLIDATED REVENUES AND EXPENDITURES FOR THE CMSCS (in US Dollars)

	FY85	FY86 (through March, 1986)
REVENUES			
Dispensary Fees Hospital Admissions X-Rays Product Sales School Fees	28,740 11,850 4,990 23,589 <u>3,292</u>	26,190 12,154 5,013 16,997 2,433	
TOTAL	72,461	62,787 (83,716 projected	ł
EXPENSES		101 11007	
Salaries			
Hospital Boston Brooklyn CHAPI	159,140 92,490 78,900 70,000	136,320 79,663 64,720 56,932	
SUBTOTAL	400,530	337,635	
Mat/Supplies/Repairs			
Hospital Boston Brooklyn CHAPI	59,480 25,200 37,140 47,340	54,145 17,260 26,750 27,335	
SUBTOTAL	169,160	125,490	
Central Administration	55,710	45,748	
Other Programs	63,780	65,311	
TOTAL	689,180	574,184 (765,578 projected for FY86)	

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A public relations firm based in Washington, D.C., is being engaged to work with CMSCS to fundraise for Friends of Cite Soleil on a continuing basis. A representative of the firm was in Port-au-Prince at the time of the evaluation, but the team was unable to meet with her.

b. Industrialization

The ind:strialization plan envisioned establishing a competitive manufacturing enterprise that would allocate its profits to the direct budgetary support of CMSCS. A feasibility study was undertaken by Witherspoon International Corporation, a private, non-profit business development firm based in the U.S. The study proved to be unusable and a more satisfactory feasibility study has not been undertaken.

Given the complex nature of an industrial undertaking and the current political and economic instability, such a strategy seems ill advised, right now at least. Smaller, less complex efforts would have a greater chance of success.

c. Other endeavors

The Complex has invested \$5,000 to start a pig cooperative. The pigs and technical assistance are being provided by IICA, and the profits from this endeavor will directly support the operating costs of CMSCS. The Complex has no experience in this area. The risks, therefore, should not be underestimated. Nevertheless, it is a less complicated undertaking than an industrial complex and IICA's experience in this area is considerable.

While these team members know little about pig production themselves, informed sources report that the estimations on pig production may be overly optimistic. Unanticipated losses could occur, given that no mortality is expected among adults and the mortality estimates for newborns are very low. Dr. Theodore, at Pignon, also reported difficulties in feeding the pigs during the instability of the last six months. This problem should be anticipated for the future. The longer-term problem for pig production is to whom and how CMSCS will market the pigs. If this effort is to be a profitable one, these issues must be dealt with now, rather than on an ad hoc basis when pigs need to be sold.

The Complex is also involved in the formation of a cooperative bakery with a grant from Oxfam. This effort also represents a new area of work for the Complex where it lacks experience. The Complex will need to acquire sufficient human resources and expertise to adequately provide financial, organizational, and management assistance for establishing this and other production cooperatives. This effort will not contribute to income generation for the Complex unless it is restructured. Individuals who work in the bakery will earn income but the Complex will receive no monetary benefit. If the money for starting the bakery enterprise were loaned rather than granted, the Complex could earn the interest on the loan. The interest could contribute directly to the Complex's operating costs and/or to a capital fund for new loans. Given that the bakery is a business endeavor, it is not unreasonable to expect the business to be capitalized by an interest-bearing loan.

In the short run, interest on loans would represent a minor revenue source. If, however, the Complex were to provide credit source for small business ventures in the Cité Soleil area, it could develop this area as a new source of revenue. Obviously, this is a major decision which would require a different focus and different personnel than presently are available at CMSCS. However, it may be a less complicated idea than that of an industrial complex. Given that the bakery enterprise is already getting under way, an expansion of this type of activity merits consideration.

Both public and private institutions in Haiti and abroad view the Complex model as an ideal place to provide training for health personnel. Physicians and other health professionals from private institutions throughout Haiti have been trained at the Complex, as well as a number of students from schools of public health in the United States. Recently, AOPS has chosen the Complex as the training center for all of the physicians that will be in charge of community health outreach programs in rural Haiti. The Complex views this external interest in training as an opportunity to expand its training efforts in the near future. Two areas are to be explored: training new graduates in medicine from the University of Haiti who are interested in public and community health programs, and students (mostly American) interested in a field program after having completed their MPH as part of a MPH field experience.

Training at the Complex represents a potential source of income. The Complex needs to establish a tuition fee structure for training efforts that adequately reflects the direct and indirect costs to CMSCS for conducting training. The fee for training AOPS doctors, for example, is too low.

In conclusion, CMSCS activities over the last ten years have expanded in number, complexity, and comprehensive focus. As a result of this expansion, the Complex is outgrowing its present management and control mechanisms. It will have to adopt or replace these mechanisms with a system that addresses its needs as a more complex organization. While CMSCS has broadened its revenue base over the last two years, it also will have to develop more aggressive fundraising efforts if it is to sustain its expanded network of activities.

B. AOPS

Financial accountability at AOPS is a much simpler task than it is at CMSCS. In addition to the more focused institutional activities, there is, with the exception of AOPS membership fees,* only the Cooperative Agreement with AID as the major funding source. Since the AOPS system's raison d'etre is donor accountability to one donor, it fulfills AID reporting requirements well. This statement assumes, however, that it is not necessary for AOPS to document the details of expenditures of each sub-grantee.

The AOPS accounting system appears to provide good financial control. Except for small purchases that are paid from a petty cash fund, most expenses are paid by check. There are duplicate carbons from all checks, and the ledgers provide references to these carbons. Receipts are also maintained in files. A monthly reconciliation of the bank statement allows the accountant to verify the accuracy of his records. A minor change should be made in the filing system, so that receipts are attached to the appropriate check carbons. It will be quite difficult to match them up after the fact during an on-site audit.

Since the Cooperative Agreement is virtually the sole source of funding, AOPS budgeting activities are for the Cooperative Agreement. A restructuring of the

sub-grantee section of the budget might be more useful if accounting data were also collected according to the budget line items.

The accounting system only collects cost information by budgeted line items in the Cooperative Agreement. Some of the line items provide useful financial management information, but costs need to be recorded (and budgeted) in more useful categories. It might be useful for AOPS to separate its own institutional support costs (e.g., AOPS secretaries and accountant) from the costs of its direct support to grantees and their programs (e.g., supervision, training, and technical assistance). Monitoring the trend between these costs provides some measure of AOPS's own cost efficiency. But the most useful change in the system would be for AOPS to begin to collect cost information in more detail on the activities of the grantees. Since these costs are the majority of the AOPS budget and they represent the direct program service costs, more cost information collected in consistent categories should be highly relevant to management.

These suggested changes in the collection of cost data at AOPS would require developing and implementing a simple and clear reporting format for the grantees. However, without this change, the possibilities for fruitful financial analysis at the AOPS level are limited. Some of this type of analysis can be done presently with individual grantee records as outlined below.

C. AOPS GRANTEES

The institutional and program capacity to deal with financial issues varies greatly among the AOPS grantees. These variations are caused by the size and stage of implementation of the programs, and more critically, by the size, structure, experience, and stability of the grantee institution. Our assessment of issues related to financial management control, and sustainability for each of the grantee institutions is summarized below.

1. FHASE

Although it is currently only offering outpatient services, FHASE's basic purpose is to establish a modern hospital. It is supported by well-to-do Haitians, and the facility itself gives an impression of comparative affluence. However, the administrative staff is over-burdened because of limited core funding.

The FHASE community medicine program is currently covering a population of 30,155. Funds to operate the program come from the AOPS grant, World Vision, and some of FHASE's core funds. Currently grant installments from AOPS are months behind schedule. This cash flow problem is stressing the program, and FHASE is borrowing from other sources. The program coordinator believes that it is a bureaucratic problem at AOPS.

FHASE appears to have good institutional capability to accurately budget for planned program costs. Program outputs, such as numbers of immunizations, are budgeted on the basis of unit costs and quantities projected each month. The

^{*} In this fiscal year to date, 32 members organizations have paid membership fees of \$100. These funds are used for printing community health outreach program cards which are sold at cost to member organizations.

World Vision funds that cover part of the community medicine program are budgeted quite precisely on a monthly basis, in addition to the annual budget. This is a World Vision requirement and the more flexible AOPS system is probably making administration of program funding a little simpler in this particular case.

FHASE appears to have good financial control and donor accountability. Except for minor expenses through petty cash, most expenses are paid by check. References to check numbers or cash transactions provide audit trails back to source documents. Revenues and expenses are collected by funding source and by program. Peat Marwick audits FHASE each year and is responsible for their financial statements.

Funds from World Vision and AOPS are accounted for jointly in one journal, and then separated for reporting to each of the two donors. There was no indication that this has a negative impact on donor accountability, and it should provide a useful source of consolidated information on program expenses.

Costs are also collected by a limited number of line items. The coordinator has used this financial information along with collected health statistics to monitor trends in gasoline costs, for example, and program changes were made that reduce the program's fuel consumption. Since the World Vision and AOPS funds supporting this program are being accounted for jointly, there is an internal reporting system that combines expenses from both sources. Additional expenses that come from FHASE's core funds can also be identified. Although it has not yet been done, the data are available to do an analysis of recurrent program costs versus the investment costs of initial training, surveys, etc. Since the program expanded from a population coverage of approximately 10,000 to 30,155 in the fall of 1985, it would also be possible to identify the marginal costs of program expansion. Average costs for coverage before and after program expansion can also be calculated.

When the AOPS grant is finished, FHASE will most likely seek other donor support for the program's recurrent costs or use its own core funds. Fees are currently being charged in the outpatient clinic (\$1 per consultation and \$1.20-\$4.00 for law exams) and drugs are being sold (\$1.00-\$2.00 per treatment). These fees currently bring in about \$2,000 per month, but they support the outpatient clinic rather than the community health program. There are no charges for the community health program and no plans to initiate any.

2. CODIPP/Duplessis

CODIPP is a grass roots community group that was organized in 1970 and officially became an NGO in 1984. It is providing community health outreach through rally posts to approximately 10,000 people in Duplessis. While the AOPS grant was used to initiate the community health outreach program, it now has been operating without financial support from AOPS for approximately one year.

We visited the health facility and a rally post in Duplessis and the president's office in Port-au-Prince where records were supposed to exist. We also reviewed the financial reports that AOPS had received.

It does not appear that CODIPP does any budget planning now, although it must have assisted in preparing a budget for the original AOPS grant. There do not appear to be any financial records, and all transactions may be handled with cash. The only record of the AOPS grant that exists now are the three quarterly financial reports which were sent to AOPS while the grant was operative. Copies were kept at the president's law office, as this was an established procedure. The treasurer of CODIPP died in January of this year, but it seems that the president handled and continues to handle all finances related to the program. In other words, there seem to be no systems for budgeting, financial control, or donor accountability, and no financial information to analyze.

The president is able to recall most of the monthly recurrent costs from memory: doctor \$300, nurse \$30 (plus 130 from MSPP), archiviste \$40, transport \$60, and \$350 for collaborator (ColVol) incentives, food, and sundry expenses. This totals \$780 a month. Some of these expenses, such as two-thirds of the doctor's salary and one-third of the nurse's, are for the clinic rather than the rally posts. The source of the funds which cover these expenses is vague, e.g., the president's law practice and some of his friends.

The important point about this program is that it has continued for approximately a year after the exhaustion of AOPS funds. CODIPP is hoping to extend its population coverage from 10,000 to 25,000 with another AOPS grant. The president also has clear ideas about required inputs and the marginal costs of program expansion. It would be useful to compare his mental estimation of costs with projected costs for the expansion of the FHASE or MARCH program.

3. Eye Care Haiti and MARCH/Mirebalais

Like CMSCS, Eye Care's budgeting is focussed on the donor and sources of funds. However, by contrast with CMSCS, an annual consolidated budget can be constructed by using several budgets that are themselves consolidations of a number of grant or program budgets. Like FHASE, Eye Care has an accounting system that provides good financial control and donor accountability. Peat Marwick audits the books annually. However, someone from the AID controller's office imposed a separate system that was a complete duplication of what already existed. The result is that too many little notebooks, receipts, and xeroxing are required to meet monthly reporting requirements.

The MARCH program has 13 separate funding sources: AOPS, IAF, AID (Child Survival Grant), PACT, PRICOR, VIP, patients' receipts, and a variety of churches and women's groups that have made small contributions. Since information on all sources of funds for the MARCH program seems to have been collected in detail, and since the program has extended population coverage once and plans to extend again, the program should offer good financial information on recurrent and development costs, and the marginal cost of expansion. To a certain extent this is being done as they budget for a second AOPS grant. Recurrent operating costs for the past year with a population coverage of 50,000 were \$71,109. The Eye Care accounts offer possibilities for useful financial analysis, especially if similar analysis were done with the FHASE data so that the two programs could be compared.

Eye Care has a number of strategies for self-sufficiency. "Mini-pharmacies" are going to be established. Each collaborator will sell drugs, and the profits will provide at least part of his/her financial incentive. Women's clubs are also being established. The women will be trained by collaborators, and the planned annual \$2.00 membership fees will help to support the collaborator. Beyond these efforts, Eye Care is sufficiently well-established and has a more diverse portfolio of donor support. It is therefore in a better position to continue attracting donor support.

4. Baptist Haiti Mission/Fermathe Hospital, Kenscoff

The Baptist Haiti mission has been established in Haiti for roughly 40 years. It has earned a very solid reputation for a variety of successful programs that have improved the quality of life and offered income-generating opportunities to the rural population in the very mountainous area around Kenscoff and Furcy. The mission's "in-house" programs (funded by church and individual contributions) are planned and accounted for with a consolidated computerized system, while "field programs," such as the AOPS grant, are kept separately. This is primarily because it allows the mission to comply with donor reporting requirements more easily.

AOPS funds, like other small grants, are kept in a separate bank account, and a checkbook is the main record. Receipts are saved and labelled with a reference to the check number. Financial reports for AOPS are completed with this information and submitted with the receipts. A separated record of the budget balance is maintained for internal use. This should provide adequate financial control and donor accountability.

Like FHASE, the Baptist Haiti mission has been troubled by cash flow problems with the AOPS grant. The second installment payment had been delayed for some time, and, at the time of our interview, they were borrowing funds from other sources to cover the costs of the program. They understood that it was a "red tape" problem either with AOPS or between AOPS and AID.

Although the mission did its own budgeting and revised the AOPS budget three times, the coordinator said it would make no difference if AOPS had prepared it since the allowable expense categories were too narrow to permit a useful budget exercise for the planned program. Salaries could not be paid under the grant, and personnel costs were the major expense.

Grant funds at this point were only \$3,000, and the coordinator did not mention any financial information that had been gathered or analyzed. However, she felt quite certain that by far the largest marginal benefits would be gained by adding 10 or 12 health agents to the program at a monthly cost of \$60 each; establishing health posts in the very remote areas would be the next best investment.

The mission is already funding many of the program's costs. Generally speaking, if grant funding is lost for a particular mission program, the mission will seek out another donor, or, failing that, cut the program back to a level that can be funded without donor support. Strategies for the self-sufficiency of the community health program are no different. The training program for the health workers will not be expanded without further donor funding. The pig program, which was intended to provide family incomes that might be used to pay for health services, will be phased out after the grant.

Although the mission expects to be able to sustain the community health program, management also believed such programs were worthwhile even when they stopped operating. The pigs, hopefully, would multiply. The educational impact of the program would remain, and perhaps spread. Finally, subsidized health services create a demand for such services.

5. Pignon

Dr. Théodore returned to Haiti a few years ago to build a hospital and serve this country. If there had been no AOPS program, he would have only built his hospital, continued doing a number of surgeries each week, and had little if any impact on the community. Instead, he ran into Tony Augustin and the community outreach program. The result of that acquaintance has been a significant health impact on the surrounding Pignon area.

It was virtually impossible to obtain reliable financial information regarding this program. Donor accountability is probably acceptable. Funds from AOPS are accounted for in a separated journal, but it was not discovered whether financial transactions were by cash or check. Receipts are available to document all AOPS expenditures. An accountant supervises two assistants for Dr. Theodore's bookkeeping and accounting procedures. None of these individuals or the books were available during our visit. Procedures for financial management and control were not revealed.

Revenues for this program come from Dr. Theodore's fundraising efforts in the U.S. The MSPP is supposed to provide salary support for the doctor and auxiliary, but neither have been paid by the MSPP since last September and Dr. Theodore now pays their salaries. He estimated that about 20 percent of his hospital budget goes to support the community outreach program, but the size of the hospital budget could not be determined. Given that Dr. Theodore's program is similar in structure to the Eye Care and FHASE programs, his annual recurrent costs are probably in the neighborhood of \$75,000 to \$85,000. Like FHASE and the Baptist Mission, Dr. Theodore complains about the cash flow problems with the AOPS grant and AID.

Support for this program seems assured even when the AOPS funding runs out. Dr. Theodore had, in fact, run the program on his own between the first and second AOPS grant. He has several strategies for generating revenues for the continued support of the community outreach and hospital programs. The most ambitious is the pig project which is already under way. Dr. Theodore is beginning to use pigs as incentive payment to collaborators, and the idea seems to be meeting with acceptance.

6. Union d'Entraide Humanitaire/Carrefour-Poy

The UEH health center at Carrefour-Poy is a former government health center. Because of massive underutilization, the center was turned over to UEH in April 1984. Under the terms of the agreement, the group was to assume all operating costs for the center, including staff salaries, supplies, transport, etc. Mme. Josette Volcy has been managing the facility since it reopened. In a short period of time, attendance at the curative care clinics improved tremendously.

Mme. Volcy reported that the clinic and community outreach program are supported by: revenues contributed by members of the Association (9 members, according to Mme. Volcy); outpatient charges at the clinic for curative services; and sales of AK-1000. Annual expected income from members if \$48,960. Mme. Volcy expects 1,600 patients per month at a fee of \$1.40 (\$26,880/year). However, the doctor reported that he usually sees about 30 patients per day. When two doctors are seeing patients, the maximum number is around 60. This patient volume would yield a maximum of \$20,000 per year. However, not all patients pay the full fee; the second family member pays a reduced amount, thus, revenues from patient fees are likely to be overestimated. Revenues from AK 1000 sales also would appear to be overestimated, since the estimates do not account for purchase costs. Another source of revenue for the center is a UNICEF grant, and it is presently seeking a World Vision grant.

An accountant does all the bookkeeping for the center and he had all the financial records. He was not available nor could Mme. Volcy describe her financial record-keeping system. We were unable to assess donor accountability and financial management systems. There, apparently, is no program budgeting other than what she does for grant proposals.

Mme. Volcy estimated her monthly operating expenses at \$3,759 for the clinic. In the AOPS file, she reports monthly salaries totaling \$2,958 and other expenses of \$2,400. Costs of pharmaceuticals were not included. Salaries for Community Health Outreach included a salary of \$650 for the doctor who, in addition, is paid \$200-\$250 for gas. Relative to other places, this is a fairly high rate. Six to eight of the 48 collaborators work every day at the clinic and are supported on the UNICEF grant or on other funds. It was not clear what other incentives are paid to collaborators.

7. AMOSSE at Cayes Jacmel

AMOSSE brings together three organizations who are engaged in community outreach programs: Cayes Jacmel, Marigot and La Motagne. Each of these locations runs its own program, but management and record-keeping are consolidated under one system. The program is funded by AOPS, IFPP, Eye Care Haiti, and the MSPP.

AMOSSE appears to have good institutional capability to accurately budget its program costs. Program costs are budgeted by broad category and by source of funding. Recurrent costs for this program are close to \$74,000 for a target population of 50,000. However, more detailed information for carrying out financial analyses is not available.

Financial control and donor accountability are probably adequate. The bookkeeping system for the AOPS friends is a series of receipts and a bank book. Since the AOPS funds are used primarily to pay ColVols, transactions are all in cash. Collaborators sign receipts for these incentive payments. The AOPS controller has conducted a site audit at least once. Peat Marwick audits the Eye Care funds each year.

Financial management is oriented to control the program expenditures so that they do not exceed the program budget. This laudable objective has been basically achieved, no doubt due to the close coordination between the program director and program administration.

AMOSSE is considering a pig project as a replacement for the AOPS funds. Since the AOPS funds have been basically for incentive payments, cash incentive payments to collaborators, auxiliaries, and doctors would be replaced with pigs and technical assistance for pig production. At the moment, this idea does not appear to be popular with collaborators.

If we can assume that the AOPS grantee institutions which the team visited are representatives of the larger group of grantees, we find some common strengths and problems.

Most programs seem to remain committed to the community outreach program once they embark upon it and continue to find funds to operate it one way or another. They are not terribly concerned about the issue of recurrent costs if they see the program as a priority. Most grantees, however, have been unaware of the cost implications of the program before they start it, and perhaps find themselves with more fundraising work than they expected.

Along this line, most of the grantees seem to have some difficulties in planning and budgeting for their program resource needs. While the smaller programs (those serving communities of 10,000) struggle along fairly adequately on an ad hoc basis, those that are expanding and/or are already large, need to be better able to forecast and manage their financial resources if their programs are to be sustainable. It is particularly important to identify the marginal costs of program expansion, so that programs can do better forecasting of required financial resources. It is also important to determine the average cost of program operations that are related to programs of different sizes and program size to capture economies of scale which would also indicate how long it takes a program to develop efficient operations.

The timely flow of funds from AOPS to the grantees appears to be a problem for most of the grantees. Clearly, the grantees need some guidance on the submission of their requests, but AOPS also needs to develop some better procedures to reduce the bottlenecks. AOPS and AID together should examine and revise the procedures so that funds can flow in a more timely fashion.

D. WORKER INCENTIVES

The performance-based incentives which reward volunteer collaborators and providers play a critical role in the success of the community outreach programs. Incentives are available to either individual workers or to groups of workers and are either regularized and have the appearance of salaries, or are sporadic. The incentive system has been extensively examined by Jacqueline Smucker, and the team concurs with her conclusions which are detailed below.

> The Mirebalais program is committed to regular incentive payments for the CHWs. It is thought that for people to work as unpaid volunteers requires them to have otherwise adequate income. In the rural areas of Haiti, where financial resources are extremely limited, it is asking too much to request that people serve as unpaid volunteers. Furthermore, to attain quality work from unpaid volunteers would require a greater investment in the paid staff needed to constantly motivate the volunteers to continue their work.

> CHWs at Pignon perform the same tasks as at Mirebalais, but the compensation is different. At Pignon they receive no regular incentive payments but may receive occasional bonuses of \$10.00 to \$15.00 at a one- to three-month interval. Bonuses are based on performance

as judged by the program director. Bonus payments may also be made to doctors and nurses working in the program. In addition to bonuses, CHWs have access to resources within program-sponsored community projects. For example, CHWs have first access to the pigs and goats distributed through community-based projects. CHWs also face a system of disincentives for poor performance. Good performance may result in program funds being made available to the community for such things as animals, wells, and road projects. The rationale for this approach is that the CHW is not working for the program but for the community. The community thus applies pressure on the CHW to assure that community projects are implemented. In addition, it is a program requirement that the president of the community council or a representative attend every meeting held with the CHW. This is done to ensure the community's awareness of the CHWs' efforts. In instances where CHWs are not performing adequately, community-wide meetings are called; the worker's performance is discussed and the community is asked to replace the worker. As this type of action serves to publicly shame the CHWs, they work to avoid this disgrace.

The AOPS program at Jacmel (AMOSSE), is currently initiating another incentive system in which the community health teams will be rewarded on a results-oriented basis. In this system, doctors, nurses, and CHWs receive incentive payments based on a point system. Points are established for accomplishments within each of four program phases. Phase I involves the establishment of program infrastructure. Phases II through IV focus on the achievement of certain demonstrated competencies on the part of mothers, and levels of immunizations. Incentive payments are skewed in favor of doctors and nurses. Under this plan, three doctors receive a total of \$3,000; and 30 CHWs receive a total of \$4,500. Doctors receive \$50.00/point, nurses \$20/point, and CHWs \$5.00/point. Doctors and nurses are paid employees, while CHWs receive no salaries. CHWs, however, are entitled to participate in a pig distribution project.

The incentives at Mirebalais and in several other programs are, for all practical purposes, not incentives but salaries. Fees-for-service arrangements have been used to advantage, but this arrangement is more applicable to curative services. In primary health care programs, incentives which are directly linked to an individual's performance seem to be the most appropriate.

The incentive approach at Pignon places a strong emphasis on negative consequences for failure to perform. It does not inspire workers to higher achievement beyond the standard norm. It is strongly authoritarian and dependent on the cult of personality. It does not, therefore, lend itself to be thought of as a replicable model.

The competency-based incentive system at Jacmel is just getting under way. As noted above, this system is skewed in favor of professional staff. It is unlikely that the skewing of incentive payments in this direction will have a very positive effect on volunteer motivation.

Another approach that has been used as an incentive is based on a collective model. In this approach, volunteer effort is rewarded with the privilege of membership in a cooperative. While this

approach may encourage one to step forward as a volunteer, it does nothing to reward performance. There is no link between job performance and benefits derived through the cooperative. Additionally, cooperatives are difficult to set up and maintain in Haiti. The concept of cooperatives is not well understood. To involve staff in the management of a cooperative takes unnecessary time away from their other responsibilities.

The recent political changes in Haiti have generated requests from ColVols for salaries, as opposed to incentives bonuses, a not unreasonable expectation in a difficult economic context. For the sales of program quality, however, salaries could be counterproductive, not to mention their potential impact on recurrent cost burdens. AOPS should assist grantees in developing incentive systems that are performance based.

VI. TECHNICAL ISSUES

This chapter was to have been entitled "Technical Results and Concerns," in order to respond to that rubric in the Scope of Work. However, we chose to construe technical results as matters of coverage and impact, in the context of project achievements discussed in Chapter III. Thus, this chapter deals only with the technical concerns or issues the team perceived during site visits.

A. GROWTH MONITORING

Earlier, in the context of a proposed research topie, we referred to increasing concern about the value--particularly the educational and motivational value-of the growth monitoring mechanism as it is currently employed. In the AOPS and CMSCS programs, growth monitoring, together with immunization, constitutes the backbone of the rally post and it is the sequence of the growth monitoring procedure that is the organizing device for those rallies.

The major issues for growth monitoring were thrown into sharp relief during contact with some of the more problematic AOPS projects, at the same time that contact with the stronger projects suggested that, with thoughtful attention, the intervention could be made much more effective than it currently seems to be. One group of issues is simply mechanical and should be attended to with relative ease. This includes the following:

1. Availability of growth cards. Many projects are out of growth cards or about to be. An attempt was undertaken toward the end of this evaluation to reorder these through the RHDS-I project but there appeared to be difficulties with release of funds.

2. Lost cards. Clients who lose cards also affect the value of the intervention, especially when there are problems in the project's record-keeping system. If the mother does not know the family dossier number, or has no identification card, or there is no alphabetically cross-coded list of project families, there is no other record of the enrolled child's health history; very few mothers seem to be able to accurately reconstruct this. Dossiers can also get misfiled or, in situations of high mobility like that of Cite Soleil, not get transferred from one sector or center to another.

3. Counterproductive learning environment. As we will discuss below, rally posts are rarely tranquil experiences, but some are more chaotic and pressured than others, primarily because the spatial order of things is not well thought out. This can make it hard for a mother to grasp what is really going on and for health workers to tell her. Still, the mechanical part of this issue, that is, the structure of the rally post, is susceptible to modification.

What is harder to modify is the quality of the content of the growth monitoring encounter, which is a primary site for maternal motivation and at least some education. The growth monitoring exchange between mother and providers-weighers, scribes and record-keepers, and upper-level personnel who staff the rally posts--is virtually unexploited for any productive or enduring purposes.

4. Underutilized educational opportunities. There is some variability in the way the growth monitoring sequence is organized among rally posts. For example, sometimes there is a record-keeper who writes down the weight, called by whoever

is managing the scales, both in the mother's dossier and on the Road-to-Health Card; other times, the weight is called out to the mother, who is then responsible for reporting it to the record-keeper; who may be sitting some distance away, often in a swarm of noise and bodies. The opportunity for error is obvious, confusing the facts and eventually confounding the statistics. At some point in the sequence, varying again from project to project, the growth slope is supposed to be produced by joining the previous point on the chart with the current one, to determine whether growth has actually occurred. Very often, this line is not drawn, so that the crucial messages and possible related interventions either do not occur or occur without the mother really understanding why. When some health worker or archiviste does draw the line, the mother is at best a passive viewer. Informal mother-testing at a couple of several sites visited suggest that there is a very good chance that most mothers did not really understand what the chart was all about and what it implied for action.

As for action, the reality must be faced that Haitian mothers' options for action are severely constrained by reality. A query to a mother whose child displays no weight gain or loss is most likely to produce the answer that the child was sick or that there was no money for food. In the case of the former, there may be some possibilities for medical intervention, for example, ORT for a child who has been losing weight due to diarrhea. In the case of the latter, the task is not easy. Mothers who explain weight loss as being a function of limited economic means need more than a brief exchange on the beauty of the three food groups. The implications of these realities for nutrition education are discussed below.

Upgrading the quality of growth monitoring goes beyond simple tinkering. It will require some thoughtful operational research which not only addresses issues of pedagogy and content, but looks at other supportive mechanisms such as mother motivational groups. Such research should also explore questions of why mothers come to rally posts and why growth monitoring has attraction for them. Research with another PVO several years ago (Harrison and King, 1983) suggests that Haitian mothers will continue to bring their children in for weighing even when a pre-existing food incentive is withdrawn; this means that growth monitoring has developed some meaning for mothers that is not well understood. In that understanding may lie at least some of the response which could either enhance the power of the intervention or at least make evaluators and program staff less anxious.

B. ORAL REHYDRATION THERAPY

Again, the issues are both mechanical and educational. However, in the case of ORT, there are some real technical issues which have come to be of increasing concern in other countries and which have prompted some rethinking about ORT at WHO, AID, and PRITECH, among others.

1. Packet availability. Not all sites visited had packets on hand in their central facility, nor did ColVols have them in their own homes for distribution. In some places, ORT was available at a <u>Poste de Vente</u>, which was fine, but the ColVols should have had packets for emergency distribution, promotion, and education, in any event. In one site, ORS was available only in the facility pharmacy, which was closed. We saw only one where packets were available for distribution at rally post. In the worst case, the clinic pharmacy had no ORS,

and Kaopectate was being prescribed by the doctor; the same doctor also prescribed Kaopectate and ORS on the same prescription paper and both were to be purchased. There was very little information readily available on the number of packets distributed. The little information available suggests that packet movement differs widely among projects, partly due to availability but also due to the vigor with which a project promotes ORT. For instance, it was estimated that, at La Vallée, 65-75 packets were sold monthly in the AGAPCO dispensary, compared to the 600 per month "pushed" by Pont Sonde; the populations served by the two projects are 10,685, and 8,168, respectively, so that the difference cannot be explained in any major way by differences in population size. Pignon, which services a population of 29,293, moved 3,651 packets through 12 postes de ventes in the first quarter of 1986. There is no easy way, as the AOPS reporting system is not constituted, to determine how each project distributes ORT, on what basis (some projects give away packets and, in some, packets are sold, either by the Colvel or by the poste de vente), in what quantities, and in what ratio to how many children in the most vulnerable age groups. In the Supervisor's Checklist drafted by Dr. Fanfan, there is a line item for packets distributed. Another line item should be added which responds to the indicator in the Child Survival Reporting System, which asks whether there are packets on hand.

2. Commitment to ORT. Despite the major efforts that have been made by the MSPP in ORT over the last few years, there appears to be a crisis of confidence and commitment to the intervention. This derives from a general doubt about ORT as a technology, which responds in part to an old enthusiasm in Haiti for intravenous rehydration and partly to mothers' disillusion with ORS because it does not stop diarrhea and their preference for OTC preparations which stop Some mothers dislike the taste of ORS because it is not sweet. stooling. It also derives from resistance to packet dependence, because packets have sometimes not been available and because they cost money. Active and powerful individuals in the AOPS projects expressed concerns that ORT was badly oriented in its emphasis on packets and voiced a preference for training mothers how to make sugar-salt solutions or adding "a little sugar and salt" to the rice water they already use. The recipes that the team members heard prescribed by project field workers were extremely casual and there was little effort to teach mothers how to mix precisely according to the approved sugar-salt solution recipe carried on the Road-to-Health Card. AOPS has just sponsored a "mini-ICORT" meeting in Haiti, which was meant to remotivate upper-level health personnel, address some of the newer scientific issues. and resolve technical concerns.

Beyond that, it may be necessary for the MSPP and AOPS to articulate a policy decision on ORT that is disseminated to all projects and is in accordance with recently revised WHO strategy. AOPS is covering an increasing number of people and, while it may not feel that it can impose policy on independent institutions, it a) already has a lot of say and b) it can make it easier for some policies to be implemented. It can do a better job of getting a handle on availability and use of packets, and it could consider performing or supporting a logistical role to enhance packet availability. It could determine what indigenous preparations could upgraded for efficacy, in conformity with WHO guidelines. And, it could upgrade the teaching of ORT. AOPS had considered the possibility of having a stockpile of ORS on hand as emergency coverage for MSPP stockouts, but has at least temporarily abandoned the idea as constituting a disincentive to the ministry.

Education about ORT. In a number of projects, ORT education seems to be 3. very "soft" in terms of content and very permissive, lacks clarity, and includes little if any hands-on training; one mother demonstration suggested that mixing has not become a well-internalized manual skill. In some sites, some mothers did not know what a packet was. This suggests that, first of all, ColVol training in ORT needs to be much more vigorous and rigorous than it seems to have been, and that a good, solid refresher training unit needs to be offered for all AOPS field project staff, including doctors. The principal role of ColVols with regard to ORT is to make mothers competent in the use of ORT, to motivate them to use it, and to ensure that ORS is available and accessible at the village level. ColVols should be trained to carry a few packets with them when they go on home visits, so that they can both educate and respond to need on the spot. Their refresher training should continue to be competency-based, either be based on the manual prepared by Dr. Eustache, which was used for the Mirebalais study, or based on whatever Cite Soleil is using as its approach. The Eustache manual should be reviewed first, since results from the Mirebalais training showed some areas of content weakness. The promotion of ORT has been a constant element of CMSCS programs and these appear to have been effective. Recent independent evaluations showed that 90 percent of mothers in Cite Soleil knew about ORT and 77 percent said they had used it for their child's last diarrheal episode, and a recent marketing study showed that 12 percent of all packets sold nationally in 1986 were sold in Cite Soleil.

Enhancing ORT use should be a priority for AOPS. There is ample evidence in Haiti that, in a hospital setting, ORT can reduce the case-fatality rate due to diarrhea; estimation of the impact of ORT use on infant and child mortality in community-based programs is more difficult to accomplish. However, preliminary research findings in Mirebalais suggest that knowledge of ORT is associated with a fall in infant mortality and mortality in the one- to two-year-old cohort, and indicates that redoubled efforts in ORT will be justified.

C. BREASTFEEDING

The promotion of breastfeeding in the AOPS projects needs more attention and should be handled systematically in an organized manner. There is now a good basis on which to build such an intervention. Research in Cite Soleil uncovered dramatic attrition in levels of breastfeeding due to the various pressures of urbanization. A major study in Cite Soleil, described in Section IV.D., includes a carefully planned breastfeeding campaign, designed to follow a pretest/intervention/post-test model. The diagnostic phase has been completed and the intervention phase will comprise three types of activities: seminars for health care personnel, some of which have been conducted during the last six months; a continuing education program involving regular meetings on breastfeeding has been implemented, and some special hospital-based practices have already been instituted. These include the addition of an auxiliary nurse whose primary responsibility is to form operational links between the maternity and outreach clinics. Her role will be to make sure that women who have delivered in Cite Soleil, regardless of place of delivery, come as early as possible to the outreach clinic for registration. Special attention will then be given to educating mothers in appropriate infant feeding practices. Several types of mass and face-to-face communication will be used during these visits, to reinforce the importance of breastfeeding. Since 1984, several modifications have been implemented in the CMSCS hospital: mothers are not allowed to bring bottles

into the maternity wards and a nurse provides education services to mothers both in the maternity and neonatology wards.

At present, there is no explicit breastfeeding intervention in any AOPS project visited, although breastfeeding posters were found in almost every facility and, in some projects, bottles were not much in evidence. In Mirebalais, for example, not one of the 150 mothers present at the rally post visited had brought bottles with them.

At the same time, none of the ColVols interviewed placed sufficient, if any, emphasis on breastfeeding and the topic is essentially neglected as part of the project's educational content. Breastfeeding is so prevalent in rural Haiti that an assumption is made that there is no need to really discuss it. While this is true, there is surprising attrition in rural areas in other countries where this had long been assumed to be the case and there are urbanizing areas where the problem is growing. A case in point was the team's visit to the Carrefour-Poy clinic, where 15 out of 52 mothers were bottle-feeding their babies while they waited for attention. In discussing why mothers were bottlefeeding, the team was surprised to discover that they were being taught to do so at the rally post, where an effort was being made to teach mothers "correct" bottle-feeding practices in the belief that, since they were going to do it anyway, they might as well do it right. Even assuming rural mothers need less help in this regard, it still leaves out of the picture the crucial questions of weaning, immediate lactation, and appropriate feeding during and after illness, most importantly in the context of diarrheal disease.

D. IMMUNIZATION

The immunization component of the AOPS and CMSCS programs has been the most successful in terms of measurable impact. For all of the projects visited, except La Vallée where service was interrupted for about a year, the vaccination coverage of the target population has increased; there are no signs yet that the increase will abate, although increases cannot be expected to be so dramatic as in the past when the baseline stood at zero. While the growth monitoring component structures the rally posts, it may be that immunization is the principal activity in terms of client interest. Since we do not really know why mothers come to rally posts at all, this distinction is just hypothetical. There has been no nationwide study of which the team was aware that has been done on knowledge attitudes, and practices in Haiti with reference to immunization, nor have any of the projects explored the reasons why mothers do not bring their children for immunization. A proposal has been made to the National Academy of Sciences for research which will look at the health status of non-participants; the study will use immunization as a proxy both for participation and health status and could get at some of these unknowns. At Mirebalais, where there may be a better sense of mothers' alarms, mothers of children who have just been vaccinated are given two aspirins to administer to forestall the side-effect that seems to most concern mothers, that is, fever. Unless the project has uncovered some reason why this should not be a general practice, AOPS should consider recommending it to all projects.

As in many vaccination programs, one should expect a plateau effect to occur. This will be largely accounted for by hard-core resisters. A reasonable hypothesis is that the bulk of that group will be composed of children under
two months, whose mothers prefer not to subject them to the dangers of cold air (<u>serain</u>), the tumult of the rally post, and the trauma of injection. At the same time, some very tiny babies were being brought in to Pignon and Mirebalais rally posts, an encouraging sign of what attentive promotion can produce.

E. FAMILY PLANNING

Except for Pignon, the impact and effectiveness of the AOPS family planning component have been quite limited. In Cite Soleil, a substantial amount of research has been undertaken but family planning activities are not reported in the CMSCS quarterly or project status reports and are limited to the activities of the Center for Family Education in the Haitian Arab Center. The Center will be restructured, after first being evaluated. This evaluation did not look at that program subcomponent for the CMSCS, with the exception of reporting on research activities (see Section IV.D). A general problem in Haiti is that, frequently, a lot of women are recruited for family planning, but dropout and discontinuance rates appear to be high. There is little understanding of the reasons for this, a condition which the Cite Soleil project is attempting to answer in the urban context.

Although most AOPS member institutions lack significant family planning programs, those which do have active programs are impressively active. Pignon offers male and female sterilization services, and these have the highest adoption rates. Both Pignon and Mirebalais have systematic programs for DepoProvera, and Pignon has been providing Norplant to interested women. Pignon has produced a very well done, six-page folder in Créole on family planning, "Lopital Byenfezans nan Piyon: Live pou planin familyal," which could be adapted for use in other programs.

Other projects are nowhere as far along, although some are getting ready to move. AMOSSE found that family planning outreach activities were weak and hired an anthropology student to explore the logic of how people in the area understood family planning. A useful finding was that there was no knowledge of ad hoc methods and a belief that pills and sterilization where the only options. The project is now attempting to educate mothers who deliver in the Jacmel hospital as soon as possible after their babies are born, to inform and convey the concept that family planning is an individual decision. In La Vallee, promoters are only just coming to learn about family planning and delightedly learned about DepoProvera while the evaluation team was visiting them. At the other extreme is La Vallee, where the only method discussed is natural family planning, although a few ColVols independently promote other methods and report substantial interest among women.

In general, however, the ColVols seem much more motivated to carry out interventions other than family planning. Perhaps because of the locus of the doctor training, or perhaps because motivation to do family planning in Haiti not generally well developed for a variety of reasons, there does not seem to have been a systematic training focus on family planning. Family planning should be a more explicit and thorough component of all levels of AOPS field team training and an explicit, thorough family planning training module should be offered to all interested institutions. AOPS may have as project members, institutions whose belief system may include only natural family planning. In this case, AOPS should attempt to ascertain whether the training given is adequate, since AOPS has committed itself contractually to include family planning in the package of interventions described for AOPS I and II.

In theory, ColVcls should be able to: 1) educate and inform women and men on where to go, for what, why, and how much it costs (if it does); 2) refer clients, perhaps using a coupon/incentive system, for Depoprovera, IUDs, tubal ligation, and vasectomy; 3) distribute condoms and pills; and 4) follow up on users. The team also suggests that, as part of their training in family planning, ColVols be trained not only to recruit as many women as possible to family planning, but to select 30 of them for follow-up in order to track continuance, discontinuance, and dropout. The existing follow-up sheets could be adapted to incorporate the necessary procedures and a simple protocol, based on a treatment algorithm, could be devised for ColVols to gather the necessary data. This approach might best be tried first in Pignon, where family planning is already active, or in Mirebalais, and could be structured as operations research.

A decision has been made by AOPS that all large projects should follow the example of Pignon and have a promoter for family planning. This would permit setting up a separate station for family planning at rally posts, as well as more attention overall to the family planning component of the program. A recent MARCH report observed:

"The rally post has the major advantage of reaching a large number of mothers. Since the community health team always brings with it contraceptives, since these mothers know that the contraceptives are available and yet few of them avail themselves of contraceptives, we have concluded that addressing the problem of availability alone is only dealing with one-half of the problem, the other half being effective demand. In an attempt to create this demand, we feel that it will be necessary to employ one additional member of the community health team whose sole responsibility will be family planning. When a team member is asked to take responsibility for family planning when he already has other responsibilities, he will always put these other responsibilities first. In our case, this has been true not only for the physician and the nurse, but also for other personnel. They all skirted the promotion of family planning, giving a variety of excuses...."

At the same time, the addition of another station of any kind to the rally post should be contemplated carefully. Mothers already spend a lot of time at rally posts and it may be that the family planning post should be added only when a project's rally posts are running smoothly. It should be kept in mind that, once rally posts are, in fact, running well and some kind of plateau is reached of children who are already vaccinated, the motivation for mothers to come may be diluted and/or limited to 'ew children only. We still do not have a basis for knowing what will keep mothers coming to rally posts, especially after children have completed their series of vaccinations. Because of these questions, we recommend that the inclusion of a family planning station be tried first at one program site to see how well the rally post can absorb another activity and what happens to levels of adoption. This could constitute another small operations research activity.

F. FOOD SUPPLEMENTATION

The evaluation team saw two projects where feeding was going on in association with outpatient visiting and a rally post. The first example was Carrefour-Poy, where children in Gomez II and III and pregnant mothers are given supplementary meals and PL-480 food in a feeding area next to the clinic which also serves as the site for a School Feeding Program. The second was Duplessis, where distribution of powdered milk was carried out as the terminal station after the completion of all rally post components. It is not unusual for feeding activities to be chaotic and both examples displayed both a certain amount of chaos and understandable desperation. After a long, hot morning, which was probably prefaced with only the scantiest of breakfasts, one could hardly expect anything else. At the same time, association of feeding and food distribution with a rally post may overburden the structure of the event. While the food reward is highly valued, the long hot waits are not, and any program has to consider the tradeoffs.

In one AOPS project (FHASE), food is distributed on a prescription basis to pregnant women and to children in Gomez II and III, which may be a sounder approach but which also has costs. In Cite Soleil, the Nutrition Surveillance program and the food distribution program have both been reorganized, since the CMSCS directors felt that the existing system did not reward mothers for good preventive health behavior. In fact, mothers with malnourished children, regardless of the immunization status of those children, were referred to the food distribution center and given food, while children with good nutrition and complete vaccination coverage did not receive supplementation. This was seen as a disincentive to immunization compliance.

As a result, in February 1986 a new approach was designed and tested. Good distribution is now linked with an incentive system whereby mothers with complete vaccination status and a set of minimum number of nutritional surveillance visits recorded will be enrolled in the food distribution program, regardless of the nutritional status of their children. The right to supplementary feeding is cut off for children who have failed to gain weight over a threemonth period, even if t ey are Gomez II and III children. The ethical and behavioral implications of these new criteria are weighty enough so that they should be included in the operations research being contemplated at the CMSCS.

Because of the complexity of feeding programs in general, and because of the enduring questions about the incentive effects of supplementary food, it would be rash to attempt to explore the issue of feeding within the bounds of this evaluation. Research into food supplementation tends to generate some rather fragile research designs and AOPS should not attempt anything unduly elaborate. However, it would certainly be worth understanding what is the best way to incorporate supplementary feeding into the AOPS model and whether the approaches being used now are appropriate, and some operations research by AOPS in this area could be valuable. The projects where innovative approaches are being tried should be checked to be sure that there is an adequate baseline against which to project change; if not, one should be assured through the research itself. It might be possible to do some comparative research in a well-run project, e.q., FHASE, where another approach to food supplementation is being There are also some important questions to be asked about the role of tried. food supplementation in attracting clients to preventive health activities. For example, the SAWS (now ADRA) project found that mothers who received food supplementation for their malnourished children continued to return for growth

monitoring even after their children continued to return for growth monitoring even after their children were graduated from feeding programs, despite the SAWS suspicion that some mothers had deliberately withheld food from their children so as to maintain them in the feeding program. These questions could be linked to the operations research on the new CMSCS criteria for food distribution.

G. THE RALLY POST

Every project runs a rally post slightly differently in terms of layout, sequence, and flow, management of records, availability or non-availability of medical services at the post, the panoply of interventions offered, deployment of personnel, number of people attending, and frequency. We will describe the rally post model used in the MARCH project at Mirebalais as the most complete expression of this delivery approach.

The full community health team from MARCH, including physician, nurse, recordkeeper, and CHWs, goes on outreach three times a week. They take with them the drugs, equipment, and supplies necessary to conduct priority health activities at the rally post. Since MARCH incorporates a community eye health program, the team is accompanied by ophthalmic assistants who do eye screening. In addition, since with more than 100 mothers and children attending an average rally post, all team members are quite busy, two or three CHWs from other sectors not being served that day come to the rally post to give a hand. One worker is generally assigned the task of crowd control.

At the rally post, work is divided among team members into substations:

Substation	1:	registration (mother checks in and picks up family dossier)
Substation	2:	weighing and individual nutrition education, usually by a CHW,
		sometimes by an auxiliary, or both; recording of weight on
		dossier and Road-to-Health Card
Substation	3:	group demonstration education, usually by another CHW
Substation	4:	immunization and deworming; in some projects, Vitamin A adminis-
		tered to children and lactating mothers
Substation	5:	examination by the MD (includes prenatal care, family planning;
		can include curative care)
Substation	6:	eye exam
Substation	7:	drug dispensing

Not all the patients go through all the substations. For instance, the physician will see just sick children referred by the nurse, all pregnant women, and adults who desire a consultation. Preventative activities--weighing, education, immunization, prenatal examinations, and family planning--are provided free of charge. Patients who want a special consultation with the MD pay a modest fee. In the MARCH program, suspected malaria cases are treated gratis at the rally post with chloroquine. Pregnant women in prenatal care also receive iron-folic acid tables, and children receive Vitamin A and anti-parasitic medication free of charge. Projects vary in the way they handle the provision of medical care. Some (e.g., Duplessis, Carrefour-Poy, Mirebalais) provide medical care by the attendant doctor at the time of the rally post. Some (e.g., FHASE, Pignon) refer rally post patients to their own facilities at the time of the rally post. Some refer to MSPP facilities; for instance, FHASE refers all pregnant women to MSPP clinics for prenatal care. Cité Soleil provides some medical care at the time of the rally but also refers to its own facilities for higher levels of care. Some projects have a food supplement component and refer malnourished children for special nutrition education and a food packet. It is AOPS' institutional opinion that all projects should provide some curative care at rally posts but feel that they cannot impose this policy on participating institutions; AOPS projects are not required to provide curative care at rally posts, and it is worth noting that MSPP rally posts, when they were consistently functioning, did not provide curative care and only referred clients for curative care at MSPP facilities.

There are several distinguishing features of the population registration-cumrally post strategy being used by AOPS that produce important effects:

1. The determination of an area of influence, which is then divided into sectors (200 families=1,000 persons) for which one health worker is basically responsible, makes possible:

a. A sense of identification and responsibility of that worker for that sector.

b. The ability to speak about "planned coverage" as opposed to "theoretical coverage;" the latter means that, in theory, individuals from an approximate area should come to a certain fixed facility for services. Under such a system, it is only possible to talk about "number of visits," which may or may not coincide with the "number of children vaccinated." In a situation where a real population is completely registered, however, it is possible to talk about "real coverage" and "effective coverage," as well as "number of children vaccinated: and "percent of some baseline number of children vaccinated." The population registration-cum-rally post strategy is, by definition, activist and results-oriented; in contrast, the typical public health approach is passive and linear, with any ability to talk about proportions of anything but a national population severely circumscribed. In such a loosely-based, reactive system, objectives for each intervention can only be grossly quantified.

c. The rally posts appear to be a simpler and more effective way to facilitate primary health care delivery. While the AOPS rally posts are substantially larger than the rally post optimum normed by the MSPP for management by the Agent de Santè--and, in the case of Duplessis, the rally post called for the day of the evaluation visit was overwhelmingly and unmanageably large--they still seem to be simpler and better organized, more purposeful and orderly in their functioning. Furthermore, they provide a larger preventive care package.

d. The population registration model is more forceful in its attempt at demand creation. It is more probable that demand will be created under a system in which an activist sense of responsibility is generated and a set of prioritized, quantified objectives has been established.

In order for these important advantages to be realized, several things have to happen. First, it has to be possible to carry out full censuses in the average rural community environment. In the case of both AOPS and Cité Soleil, this generally seems to be a job which gets done with relative ease, efficiency, speed; there has been no evidence so far that any completed census has proven to be wildly off base, and there are indications that they may have done a better job at capturing real numbers than prior censuses. Secondly, the activities subsequent to census must be provided at an acceptable level of quality. This means, first of all, that the ongoing record-keeping and follow-up activity must be accurate and attentive and that there must be adequate incentives for all members of the outreach team, most importantly the CHWs, to engage in that activity. It is precisely these crucial elements which are the hardest and most costly to do and which are most dependent on the effectiveness of the cascade of training and reward. These issues are discussed in detail in earlier sections.

Finally, the rally post itself must provide enough attractions to keep mothers bringing themselves in for pre-natal attention and bringing their children for preventive care. In the view of the evaluation team, the major limitations in some of the rally posts visited has been the way they are organized and, in almost all of them, the quality of mother education. The easiest of these is organization of the rally post. This is a largely mechanical issue with which AOPS should be providing some consistent technical assistance. It is clear from observation that the better-organized rally posts do a better job of moving mothers and children through the round of attention more quickly and offer an environment which is more propitious for health education. A poorlyorganized, chaotic rally post is painfully slower and may imply a stay of four to five hours for a mother just to get her child weighed and vaccinated; it also offers in infinitesimal opportunity for educating mothers and mothers sometimes leave in frustration and anger. AOPS should consider producing a few simple, clearly-illustrated pages, perhaps as part of its bulletin, on possible sequences for rally posts based on those in operation whose functioning is reasonably efficient; Mirebalais was the best example we saw of a large post that was well run in a relatively small space. These sheets should be sell annotated so that all the events that should occur at each substation are sufficiently detailed. The rationale for the sequencing should also be made clear, together with the objectives for each substation. There should also be objectives for the rally post as a whole, e.g., no mother should leave a rally post without knowing whether her child has gained or lost weight and no mother should leave without knowing when she must return for the next vaccination. These instruction sheets could also provide hints on simple actions which make the rally post less trying and more productive, things as simple as having enough benches, which most communities should be able to provide; shade; a couple of buckets of clear, clean water; signs with symbols marking the content of each station which communities, mothers' groups, and CHWs might make up, etc. Projects could also be given some policy guidelines, such as the optimum number for a rally post and the optimum time to have a feedback/follow-up session after each rally post. For new projects or those having organizational problems, AOPS could facilitate some site visits. Consideration might also be given to making one project in each region a demonstration site for others, as well as for other PVOs and MSPP personnel.

H. MOTHER EDUCATION

AOPS leadership is already aware of the limitations both of the growth monitoring encounter and of the traditional forms of mother education which have been used in Haiti. These have typically included the one-way lecture that has typified primary health education in Latin America from its inception, and the rote repetition of key phrases, in prose or song. In Haiti, perhaps the most persistent subject matter is the three basic food groups. Haitian health educators have increasingly recognized the remoteness of such concepts from the possibilities most Haitians have in their economically constrained lives, and have tried to incorporate more practical attention to the realities of rice and beans and the use of wild native greens to substitute for the leafy vegetables so rarely available in the Haitian countryside. Still, the glazed eyes of Haitian mothers during lecture sessions do not lead to high hopes for the potential benefits of nutrition education as it is now offered.

The FHASE project is presently profiting from the presence of one of four AOPS monitrices who have been engaged to work with projects in mother education. The monitrice observed at Fréres gave a spirited rendition of the health education lecture, in which a lot of time was spent on the three food groups, with lesser amounts of time on family planning and ORT. She asked for feedback from mothers but only as response to her question, "Do you understand?," to which the invariable answer was a chorus of "Oui!" The presentation may have been her attempt to respond to what she though a team of outside evaluators might hope and expect to hear.

Actually, the more interesting portion of the monitrice's activity was the marketing simulation she subsequently did at the community level, in which mothers worked through the problems of how to buy a decent diet for their children with limited economic resources, an activity which time did not permit us to see. This is a promising innovation which AOPS is going to pursue further.

Whatever pedagogical method is adopted, there is a remaining question: however you convey the information, how much of it do mothers retain? One of the great limitations to determining this and, at the same time, assessing project effectiveness, is the chronic difficulty of assessing mothers' knowledge and, even Immunizations can be tracked with coverage data and harder, their behavior. analysis of dropout rates, data accessible, if with some difficulty, in the AOPS information system. However, ORT use rates, especially in the absence of associated rates of diarrhea prevalence, incidence, and reported severe dehydration, are impossible to gather in the absence of additional survey work. One of the AOPS coordinators has prepared a small test for mothers which he has tried to use as an exit survey after mothers have completed their rally post activity. However, the test as it stands is too long and only a very orderly rally post operation will lend itself at all to such an approach. It may be that there is still an opportunity for this sort of thing, if the instrument is focused on one very small group of questions and is time-limited to provide some horizontal and longitudinal comparison. For instance, all institutions could be sent a small test for mothers of three questions of understanding of the real meaning of the growth curve and asked to administer it in the forthcoming quarter to X number of mothers exiting a rally post over X period of time, being sure that they are not interviewing the same mothers. If ten mothers were interviewed at each rally post per month (N=8, or 80 mothers), that might be enough to just get a sense of whether mothers were getting the message: done over a three-month period, the N would be 240, a quite respectable number. A ColVol from an adjoining sector could be asked to help with the administration of the test; a small stipend for each correctly filled-out form and each fieldlevel tabulation by the project's archiviste might produce a higher-quality product. The same approach might be tried with ORT knowledge and use, appropriate feeding during diarrheal illness, and knowledge of family planning methods. The trick would be to ask a few simple questions that would capture

major holes in information with some reliability. Mother educators could also use the focus group as a dissemination and feedback methodology.

AOPS is also pilot-testing another mother education approach, which is really a child health incentive program, described by August and Myers (1985) as a <u>Club</u> <u>des Méres</u>." In this program, mothers who had successfully learned and applied five areas of child health (regular weighing of children, completing their immunization schedules, being familiar with growth charts, knowing how to use ORT, and knowing how and when to use the elements of family planning) would be eligible to purchase a "club card." The card would entitle mothers to join a rotating credit gorup, modeled on the traditional sol or cengle, a simple savings and credit mechanism whereby a few people who share a high level of mutual trust will pool a certain sum of money monthly; each month one person takes the pot. The difference between the club and the traditional cengle is that the club would add a matching loan fund, supplied by an as yet unnamed donor source.

The pitfalls and strategies of this approach are described by Lewis (1986), who concludes that the approach might best work in conjunction with another innovation recently introduced by AOPS in the Mirebalais area, the "affinity group." A monitrice recently hired for the Mirebalais project has included in her nutrition messages to relatively high-risk mothers, the need for peer support through an affinity group. Basically, the least competent mother is selected (ostensibly at random) to select one other trusted friend; they then together select a trusted third friend and the three of them select a fourth, and so on. The size of the group depends on how long this unanimous selection can go on, for as soon as one women vetoes a choice of that group, the choice is annulled. These affinity groups should provide a useful base not only for the formation of a cengle, but for the sort of problem-solving, two-way communication chronically lacking in nutrition education in Haiti.

1. Mother Education and Community Participation

The concept of the affinity group should not just be seen as another gimmick for making health education more effective. What the Mirebalais project is attempting to do is to use the Gros Morne "groupman" as the model with, in this case, a focus on maternal-child health. Gros Morne is the site of the Grepin agricultural development project, set up in the mid-1970s to develop and apply a new model of grass roots community development through the creation of small peasant groups which would act as action groups to reinforce their own sense of determination and pool their resources for income-generation activities. The model now has over 600 such peasant groups in Gros Morne and is being replicated in other parts of Haiti.

The purpose of the Mirebalais version of this approach is meant to lead to the empowerment of the principal beneficiaries of its activities, mothers of children under five. This empowerment is to be effectuated at two levels: social change brought about through the creation of viable mothers' action groups; increased capability by mothers to take control directly of those key interventions which could save the lives of their children. In addition, the program is instituting activities to meet the special needs of mothers at high risk of losing a child. These mothers will be taught child survival techniques and will also be enrolled in economically supportive, income-generation projects. Finally, special activities will be implemented with a view to strengthening the service delivery infrastructure of participating villages. Under this subcomponent, villages would receive sub-grants to be used for the realization of some pressing community service need, as identified by the villagers them-selves.

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VII. PROJECT PERFORMANCE AND PROSPECTS

The purpose of this chapter is to respond to the following questions, articulated by USAID/Haiti and which correspond to what AID/Washington requires as the major output of any evaluation. These questions, which follow from the description and analysis of a project's outputs and achievements, are:

A. Are the AOPS and Cite Soleil projects compatible with the USAID/Haiti Action Plan?

B. What impact have the projects had or, if it is too early to ask questions about impact, what is the effectiveness of the projects? An associated question, only implicit in the Cooperative Agreements, is: can coverage, most importantly, effective coverage, be increased in substantial measure through this project approach?

C. Is it feasible to institutionalize a primary health care outreach program, of the sort historically associated with the public sector, in the private sector and, having done so, are the projects sustainable and/or replicable? More specifically, is the AOPS model suitable for replication in the Haitian public health sector?

This chapter should be considered, together with Chapter VIII which summarizes the recommendations which have emerged throughout this evaluation, as a summary of lessons learned about the AOPS and Cité Soleil projects.

We add here that it has been difficult to evaluate these projects in tandem, although there were good institutional and substantive arguments for so doing. They share many common features, their personnel overlap, and many of their technical and research concerns are mutually applicable. Because of limitations of time, the evaluation team was forced to divide up labor and emphasis between the CMSCS and AOPS projects. The result was that the evaluation dealt more globally with AOPS within the parameters of the question: will this work in the public sector? The emphasis in Cite Soleil was more on issues of finarcial management and planning, since it is the financing of that project that is of most concern to its leadership and to the USAID. The evaluation also looked at the management needs of the CMSCS, because its rapid expansion and extension raise the same preoccupation that attends any speedily growing institution: can the management structure support and absorb growth and, if not, what needs to be done for that to happen? Finally, the evaluation looked at the universe of research that is in place or being contemplated both for ADPS and the CMSCS to, first of all, inventory it and assemble it for scrutiny as a body of work and. secondly, identify areas where more work needs to be done.

We have referred many times in this document to "the AOPS model." The question asked repeatedly throughout this evaluation was: is there, in fact, something that can be called "the AOPS model?" The underlying question here is: is there something that one can copy or use to restructure the public sector's approach to health delivery? While this is primarily a matter for the discussion of replicability, we chose to discharge the primary question here so that we can feel comfortable writing the rest of this chapter.

The evaluation team has concluded that there is, indeed, something that can be called "the AOPS model." In the various project documents, AOPS describes the basic components of its approach as comprising:

- 1. Full population registration.
- 2. A limited number of priority interventions, and
- 3. Rally posts, organized around the growth monitoring intervention.

Implicit in the first component but not spelled out in the project documents, is a concept that has increasingly become a distinguishing feature of the AOPS approach, that is,

4. Follow-up of highest-risk groups.

And, as the project has evolved, there is a growing feeling that there are two other distinguishing features that could become standard project components, which are:

- 5. Performance-based or results-oriented incentives for outreach workers, and
- 6. Active involvement of the community of mothers.

We argue that the first four of these components are irreducible and synergistic, that is, that the elimination or weakening of any single component would not only reduce the mechanical sum of its parts, but would dilute the dynamism that gives the model its potential for impact and which distinguish it from the largely passive, facility-based primary health care approach. Components 5 and 6 have more to do with sustainability and replicability but may be seen as the features which distinguish the AOPS model from high investment and/or high recurrent cost versions of this outreach approach, of which Petit Goave and the Schweitzer Hospital programs are the primary examples. These components are associated with and respond to the question in the Cooperative Agreement which asks: have private institutions developed viable ways of meeting the operational costs associated with the provision of outreach services?

A. COMPATIBILITY WITH THE USAID/HAITI ACTION PLAN

Chapter III describes how the AOPS and Cite Soleil projects relate to and address objectives of the USAID/Haiti Action Plan. The chapter concludes that both the AOPS and Cite Soleil projects are fully consistent with the AID Health Sector goals. Furthermore, both projects emphasize the six PHC interventions which constitute shared priorities for the MSPP and the USAID, as well as the Agency's commitment to Child Survival. Because of their heavy emphasis on operations research, both projects will be in the position to feed back findings that will be germane to Element 1 of the Mission's Health Strategy, improving public sector management of resources, as well as feeding back technical findings which can enhance the substantive quality of MSPP services. One example of this is the finding that nine months is the appropriate age for administration of measles vaccine in the Haitian context, which has been converted into an MSPP norm; this permits more precise targeting of this intervention and assures that the vaccine, when administered, will be optimally efficacious. Another finding, which implies economies for the MSPP, is that a shorter, wellprioritized training program for TBAs is equally as effective as the longer. standard, MSPP course, and more effective in referral of high-risk mothers for prenatal care and hospital delivery. The PRICOR/AOPS CHW task allocation studies

now going on should provide additional, similar guidelines for training and support economies for that category of health worker in the MSPP.

One of the roles the USAID can play in the health sector in Haiti is as a catalyst between the public and private sectors, acting as messenger and motivator. This will enhance the possibilities that the useful experiences of the private sector, specifically in the AOPS and CMSCS projects, are transmitted to the public sector and their incorporation into public sector policy and practice facilitated as appropriate. It should be noted that the AOPS model derives neavily from the MSPP-supported Petit Goave project, so that what is happening is not a one-way imposition or intrusion but an iterative exploration into the best way to deliver health services in Haiti.

These achievements also pertain to Element 2 of the Mission Health Strategy, improvement of technological packages for delivery of primary health care ser-The 1987 target for this element is "cost-effective technical packages vices. of community-based services and support which can effectively reach 50 percent of the child population and which can be extended to the rest of the population as resources permit. Both the AOPS and Cite Soleil projects are, in several important ways, large operations research endeavors which test such packages for delivery to entire target populations in circumscribed areas. These include: improving the technical skills of PHC providers; development of community service methodologies; and use of such innovative techniques as population-based approaches, the rally post, and community-level data-gathering and analysis. The CMSCS health service technicians are committed, as part of the Complex's five-year plan, to focus their efforts on targeted interventions in health service delivery and on health problems which present the highest risk to children under five and the most vulnerable groups of women of reproductive Among these are the improvement of community outreach; promotion of age. breastfeeding; and increased operations research activities related to the key PHC interventions.

With regard to Action Plan Element 3, which purports to develop and strengthen self-financing mechanisms for meeting recurrent cost requirements, the Cite Soleil project is a number of cost-related endeavors. The CMSCS has committed itself to significantly increase its own self-financing capacity. Included in this effort are the establishment of different kinds of user fees and prepayment schemes, as well as sales of CMSCS products and fund-raising. It has also committed to carrying out short term, targeted operational research projects to design and test more cost-effective alternatives for PHC problems. Several activities at the CMSCS are, in fact, already generating revenues for the Complex--patient fees, product sales, and school fees--and technical assistance has been engaged to revive the project's attempts at fund-raising. In its most recent status report, the CMSCS stated as one of its objectives for this fiscal year, operations research activities which will address cost-effective alternatives for improving health services delivery. AOPS attention to financing issues is focused more narrowly on issues of incentives for CHWs and what package(s) of monetary and non-monetary incentives can be produced to . and those key figures in community health outreach.

As for Element 4 of the Action Plan, improving private sector support for primary health care, the AOPS and Cite Soleil projects are the leaders and integrating force of that effort.

B. COVERAGE, EFFECTIVENESS, AND IMPACT

There are three large dimensions to evaluation of the performance and prospects for the AOPS and Cite Soleil projects. The first is coverage, that is, the size of the population theoretically reached by services. The second is effectiveness, the degree to which a project can efficiently implement the services to the population it claims to cover. The term may also be applied to behavioral changes produced in the client population which could positively affect the health status of that population. An alternative term here is "effective coverage." The third dimension is impact, or the changes in health status of the covered population.

1. Coverage

a. Overall coverage

The USAID goal is "to assist PVO institutions to extend PHC services to an additional 500,000 people and target resources more explicitly on child survival." The benchmark is for a total of 10 PVOs to begin implementing child survival program impacting a population of 250,000. As of 30 April 19896, there were 25 active AOPS I/II projects* already covering 352,264 persons, without counting the expansions under consideration for Las Cohobas, Thomazeau, Duplessis (all to 25,000), and Fermathe (to 50,000). This is already beyond the AID benchmark and the addition of the expansions will take AOPS to its total target of 500,000. Cité Soleil has totally registered its 100,000 target population and is appropriately seeking an amendment to cover the real population for which it has assumed responsibility; compensating for undercount and the addition of new squatter areas, this figure will probably rise to a total coverage of 150,000. Uncensused areas or those which need re-censusing because of population turnover and/or net immigration will be censused beginning in September. The CMSCS has asked AID for funds for 50 more community collaborators (ColVol) to cover the increase. It is worth noting that when, to the 1 million population to be covered by AOPS I/II/III and Cite Soleil are added the 1 million population covered by ICC and CARE (the two largest US PVOs) and the population covered by smaller US and indigenous PVOs (see Table 7), there will be a population of approximately 2.5 million covered by the private sector with extensive outreach service networks. About one-half of this number are covered by programs predicated on full population registration.

It is important, nevertheless, to be circumspect: child survival activities cover only a subset of the entire population, that is, the approximately 40 percent that are children under five and women 15-45. At the same time, the MSPP's coverage of the Haitian population, because of the many constraints internal and external to the public health sector, is basically passive and opportunistic; large portions of its putative target population are simply not being reached at all and it, too, is dominated by the maternal-child components of the national population requiring health care. Neither the public sector nor the private sector dedicated to child survival are providing full health care to an entire population of all ages and both sexes.

^{*} This number drops to 24 if Montrouis, which has adopted the "barefoot doctor" model, is excluded. However, since its coverage of 1 5,000 was generated through the AOPS project, we include it here.

Furthermore, 100 percent of these maternal-child populations are not present at every single rally post. Analysis at Belle Anse indicates that, even in a strong project, the average percentage of children 0-35 months who present in a given rally post cycle ranges from a low of 46 to a high of 66 percent.

a. Immunization coverage

All AOPS projects do not have their monitoring and evaluation systems fully functional and only a few projects are up to date with the information needed to assess coverage by intervention. Nor do all projects yet share common reporting categories, so that comparison and global statements about coverage are not possible, even with major detective work. Since no precise targets were articulated (quite correctly, in our view, for an experimental project), progress against coverage objectives cannot be stated. Baselines (percent of coverage already achieved or in place at project startup) vary from project to project, but it is safe to say that existing coverage for any intervention was quite low. The highest baseline coverage was for BCG immunization (43 percent) at Pignon, where as active private sector hospital was already providing that service; all other baselines for all interventions were well below that.

- Immunization

The reader is referred to Table 3 for a summary of available vaccination coverage data from selected AOPSI/II projects. In all cases where longitudinal data are available, it is clear that there have been dramatic increases in coverage and praiseworthy absolute levels. In Cite Soleil, for example, immunization coverage for three doses of DPT and polio rose from 37 and 27 percent in 1983, to 56 and 50 percent, respectively, in 1985. Measles immunization was introduced in 1983 and stood at 54 percent in 1985. BCG immunization stood at 90 percent.

There are fewer data on rates of tetanus toxoid immunization rates for pregnant women. In the few projects for which data were available, rates were 50, 25, 43 and 47 percent of the pregnant women identified in each project site; in the last site, there had been no tetanus toxoid immunizations administered whatsoever in the preceding year, although the MSPP target for this intervention is 30 percent. The CMSCS Master Plan has targeting for 85 percent. In Cite Soleil, where 50 percent of pregnant women had received complete immunization against tetanus, 1985 coverage was 65 percent. A new prenatal care approach instituted at the CMSCS has produced an increase in the average number of prenatal visits from four to five; the WHO recommends a minimum of three visits. It should be remembered that, because of the nature of the immunization intervention, to talk about coverage in a well-run program with a functioning cold chain is also to talk about effectiveness and impact.

2. Effectiveness

a. Family planning

Effectiveness in the area of family planning is defined here in terms of contraceptive prevalence. The MSPP national target for this intervention is 25 percent. This is somewhat inaccurate since, in the case of vasectomy and tubal ligation, both methods that terminate further fertility options for a given couple, it is appropriate to speak of impact. With this caveat, we will speak of family planning in terms of effectiveness; coverage is, as indicated earlier, assumed at an approximate percentage. We do not consider "number of family planning talks given" as a worthy indicator of anything, given the characteristic inadequacies of that mechanism. We feel similarly about lectures on nutrition.

Data on contraceptive prevalence are quite scant, primarily due to the incipient nature of this intervention in most projects. The most vigorous project, Pignon, has reported a contraceptive prevalence rate of 31 percent, almost three times that of Mirebalais, the next runner-up with 11 percent, followed by Marigot with 9 and Cayes-Jacmel with 8 percent, respectively. As of March 1986, Pignon had 658 family planning acceptors of which 71 were on the pill, 90 had received Norplant, eight had IUDs, 34 were using Depoprovera, 60 had been given condoms, 154 had had tubal ligations, and 241 had had vasectomies. A11 of these rates surpass the national 1983 figure of 7.11 percent of women everin-union using family planning methods. AOPS must deal here with the reluctance in individual projects to address the family planning issue and can only use persuasion to attain more vigorous effort in this area, despite the fact that family planning has been mandated as part of the Nouvelle Orientation and is integral to the Cooperative Agreements.

b. Oral Rehydration Therapy

Effectiveness is here defined in terms of knowledge. Since there are no reliable data available on levels of CHW knowledge, we will talk here about mothers' knowledge.

The data available for this intervention are, with the exception of Mirebalais and Cité Soleil, simply non-existent, at least in any reasonably accessible way that inspires any confidence. An example of the fragility of most of the few data that are available is a report from La Vallée that indicates that, of 50 mothers trained, 86 percent "knew" ORT, compared to the 58 percent who "knew" nutrition and the 70 percent who "knew" family planning; there is no information on how this was ascertained and what the implications were for behavior.

The Mirebalais project, however, reports that knowledge of ORT jumped from zero when ORT was introduced in late 1983, to 87.7 percent as of March 1986; use for the last diarrheal episode rose from zero to 40 percent of mothers whose children had a recent bout of diarrhea. This report is based on survey data and must be considered the most reliable information to date in the AOPS project on the subject of ORT. There are no other data available on the effectiveness, not to mention the impact of this intervention, which was discussed in Chapter VI.

In Cité Soleil, where the promotion of ORT has been a constant program element, recent independent evaluations have shown that '90 percent of mothers in Cité Soleil knew about ORT and 77 percent had used it for the last episode of diarrhea of their children. A marketing study showed that 12 percent of all packets of ORS sold in Haiti are sold in Cité Soleil.

3. Impact

a. Nutrition

Evaluation of nutritional impact is, as numerous analysts have observed, a very dicey business. With the exception of Belle Anse and, in less measure, Mirebalais, there has been no longitudinal analysis of nutritional status data col-

lected through census and rally post growth monitoring activities. This is partly due to the fact that recensus activities are only recently complete for some projects, to the lack of focus on the topic, to missing data in the records systems of some projects, and to the fact that the required analysis is rather more complicated than simply counting in short time frames when rates of change are not dramatic. Because the change identified between the first and seventh cycles at celle Anse was small (see Table 5), the project managers decided that it would be necessary to analyze each child's growth as measured against the expected rate of weight gain for a child of similar weight-forage on the Harvard standard; in other words, age was disregarded and only speed of weight gain measured. This analysis revealed, first of all, that the most severely malnourished children displayed increased growth velocity compared to normal children. The data from the end of the 13th Belle Anse cycle suggest that those data become less sensitive with time as more change has a chance to occur. The change in Gomez categories between the 1st and 13th cycles is evident without additional manipulation: while there is a slight falloff in the Normal category, there is clear improvement in the numbers of children in Gomez II and III. The percentage of children in Gomez III dropped from 7.5 to 4.0 between the 1st and 13th cycles, not unlike the change from seven percent to three percent in Mirebalais between 1983 and early 1986. The percentage of children in the Belle Anse project who showed weight gain improved from 59 percent at the seventh rally cycle to 77 percent at the 13th cycle, and the percentage showing weight loss dropped from 21 to 15 percent.

In the absence of improvement (and probable deterioration) in the socioeconomic status of this population, the gain may well be attributable to the effect of the AOPS I/II project. Children with regular attendance at rallies (75 percent of this particular number) showed better growth than those with less frequent attendance.

b. Morbidity and Mortality

A recent report from Mirebalais associates increases in immunization coverage and contraceptive prevalence, and the decrease in the prevalence of severe malnutrition, with a decline in infant mortality from 125/1000 live births in 1983 to 94/1000 in 1984. The report ascribes much of this decline to a significant reduction in neonatal tetanus due to vaccination of women at risk of pregnancy and to increased utilization of ORT (see Figure 1 for a graphic presentation of the association between knowledge of ORT and child mortality). It is the view of the evaluation team that, beyond statements about immunization coverage, that further attributions of causality at this point are highly tenuous. This is perhaps less the case in the area of the nutrition status analysis carried out at Belle Anse, where an attempt is made to analyze the intervening variable of rally post attendance, and there appears to be some causal link that goes beyond simple correlation. The data from Mirebalais are presently at the level of correlation only; no causal inferences should be drawn until there are more data on ORT utilization, incidence of diarrhea and severe dehydration, and diarrhea-related mortality and morbidity.

C. INSTITUTIONALIZATION, SUSTAINABILITY, AND REPLICABILITY

1. Institutionalization and Sustainability

Both Cité Soleil and AOPS are restructuring the way health care is done in Haiti. Their size and, in the case of AOPS, its nationwide distribution have moved them past the point where they can be considered pilot projects. The AOPS project offers a place to understand in a systematic way the major problems in health care in Haiti in a sort of national laboratory. The flexibility of the AID funding mechanism project phasing, and the absence of rigid output parameters has fostered experimentation and permitted incorporation of lessons learned into successive funding.

Not only did these projects permit the experimental feedback into the public sector that was discussed earlier in this chapter, but they have produced structural changes in the AOPS grantee institutions. Traditionally facility-based and curative in orientation, the project participants have altered their perceptions toward preventive care and changed their patterns of service delivery. For both the public and private sectors, an important lesson is being conveyed: that of provider accountability. The population-based approach, in effect, commits the provider to offering proactive services to an entire, explicitly-stated community of clients, not just those who present themselves at a fixed facility. Coverage is projected against a real baseline and achievement of a stated target becomes an ever-present guideline. The growing tendency to reward outreach workers on the basis of results or performance increases consciousness about provider accountability.

a. AOPS

A recent report from the Mirebalais Community Health Program to CanSave discusses the strengths and limitations of the AOPS model in a useful way that leads the present analysis to questions of sustainability and replication. Concluding that selective child survival interventions in the Mirebalais are has resulted in increased effective coverage of preventative services and noting an associated decline in infant mortality, the report notes:

"Paradoxically, this experience has brought to the fore the limitations of a purely technical approach to a child survival strategy. The advantages of a selective, limited approach to child survival are manyfold and include the following:

"The approach can be successfully implemented by a community health team with an average degree of commitment to their work and to the betterment of the community. This is a lowest common denominator strategy which may still result in the saving of children's lives.

"The approach is particularly suited to institutions with limited means.

"The approach is technologically feasible.

"The approach does not strain the capabilities of community health workers."

The report notes, however, that there are limitations:

"It may by-pass, or be inefficacious, for households in dire poverty, those households we have described as living in 'life-threatening' poverty.

"It is a top-down approach which, of itself, only requires a passive level of community participation. The health team implementing the approach might see no need to make true community participation a reality. Community participation in this instance, means 'increasing people's control over the social, economic, and environmental factors determining their health.'

"It does not address the underlying determinants of ill health."

A possible response to this analysis is that all outreach services have to do is to be sure that mothers and babies get immunized, that babies get weighed, that ORS packets and contraceptives are available, and that some minimal curative and referral activities occur; if this is all, then community participation is noble but not necessary. That is probably true enough in a situation where demand is already created and a clientele is already motivated to seek those services. In a situation where that demand does not exist, where it is young or tentative, and/or there are no adequately persuasive incentives supporting it, then it is the AOPS and CMSCS perspective that they not only have to put into place an outreach infrastructure but they must generate a community of knowledge which will, in its turn, generate demand that will endure even if the money stops. This perspective is the foundation of the design of AOPS III.

There has not yet been time to really test the durability of the individual AOPS projects. However, the of 30 projects which experienced at least some startup activity, ten projects have already or soon will expand their population coverage. Only four have never really entered the fold (Cookson Hills, Taifer, Deluge, and Milot); two are tentatively outside the fold (Chambellan and, partially, Bonne Fin); one is outside the fold but apparently doing well with a somewhat different model (Montrouis); and one is inactive but retrievable. The remaining 23 are active, not all without problems, but active. Over half of these appear to be running solidly, with their major limitations residing in the monitoring and evaluation system, in the process of being addressed, and in the health education components, primarily in family planning, ORT, and nutrition. Both of these derive from deficiencies in the training cascade from doctors to CHWs.

Other issues for sustainability are essentially issues of staffing. A much discussed phenomenon is that of doctor turnover. The rate is not low. The gross turnover, that is loss to individual projects, is not low: of the 45 doctors trained in the Community Health Program at Cité Soleil, half are no longer working for the institutions which sent them for training. When this figure is adjusted to account for transfers within the AOPS group, it falls to 24 percent, that is, one-quarter of all doctors trained have not worked out or have gone elsewhere. This is disconcerting for the project and represents a loss of training investment.

Other staffing issues have to do with conflicting demands between curative and outreach preventive activities, which seem to have been largely resolved, or at least do not appear to threaten the well-being of the preventive program. Similarly, the periodic problems with logistic support from the MSPP which have derived from the confusion generated by decentralization, from civil strife, and from funding constraints, do not seem to impair the ability of most of the projects to keep going and coping skills seem to be quite highly developed.

This is also the case for financial support. Aside from the startup funds provided through AOPS, and the commodities supplied by the MSPP, each project is responsible for covering the costs of its programs. Since the health center team has to be paid anyway, the additional costs (primarily the archiviste and incentives for the community and/or the CHWs) are relatively limited. Many of the PVOs are operating a variety of programs--schools, development projects, churches, etc. -- in addition to their PHC programs so that providing funds for health activities is just part of a constant struggle to raise the necessary money. PHC activities are provided free of charge, but most programs charge a small fee for curative services at their clinic. The institutional and program capacity to deal with financial issues varies greatly among the ADPS grantees, due to the size and stage of implementation of the programs, and, more critically, by the size, structure, experience, and stability of the grantee institution. Most programs seem to remain committed to the community outreach program once they embark coupon it and continue to find funds to operate it one way or another. They are not terribly concerned about the issue of recurrent costs if they see the program as a priority. Most grantees, however, were unaware of the cost implications of the program before they started it and perhaps have found themselves with more fundraising work than they expected. At the same time, in retrospect it is quite astonishing that so much has been accomplished with such limited resources: \$160,000 per year under the two years of AOPS I, all done with one project field coordinator, one project jeep, and the project's founders.

It is probably not a good idea to be too cavalier about the issue of recurrent costs, nevertheless. The recent political changes in Haiti have generated requests from ColVols for salaries, as opposed to incentive bonuses in cash or kind, a not unreasonable expectation in a difficult economic environment. For the sake of program quality, however, salaries could be counterproductive, not to mention their potential impact on recurrent cost burdens. The solution to this threat to sustainability is likely to be found in the development of incentive systems that are performance- or results-based, and in prioritizing and refining the CHW's role content.

It is too soon to be able to project the institutional break-even point at which sustainability is assured. For instance, how much of recurrent costs can drop out of the AOPS model as it ages and its target populations are swept for initial coverage, i.e., all children who should be vaccinated and are not, have been completely vaccinated, so that only the newborn cohorts and new mothers need coverage? An associated question is: how long is it necessary to have a doctor managing the project and how long is it necessary for a project to be vehicle-dependent? The majority opinion on the evaluation team was that a doctor may, in fact, be necessary for project startup and institutionalization. This is based on the finding that all projects which have had problems with doctor turnover have had problems attaining adequate functioning; the bestfunctioning projects are characterized by a combination of strong medical leadership and active community support. The next best option is the project situation in which the community is active even though the doctor is weak and uncommitted (see Figure 4). (The vehicle decision is project-specific; some projects are, primarily for geographic reasons, more needy than others and this decision should be determined on a case-by-case basis).

As yet, there are no answers to these questions within the AOPS group of projects. The best guidance may be the experience of the Schweitzer Hospital at Deschappelles, which gave birth to the rally post concept. Schweitzer moved away ten years ago from the vehicle-supported approach. After ten years of intensive rally post motivation, they now can cover vaccination for 50 percent of the population without vehicles. This would mean that it is possible to inculcate enough knowledge and motivation in enough mothers to generate a critical mass of demand so that vehicles and doctors can be phased out in a tenyear period.

It is not altogether impossible that the AOPS projects, perhaps paradoxically the larger ones, could speed up this process, since they have already profited by the learning curves traced by Schweitzer and the Petit Goave project. This evaluation recommends that AOPS intensify the cross-fertilization process among its projects and that interaction could also serve to accelerate the rapidity with which individual projects become self-sustaining.

The AOPS philosophy is that sustainability is more likely when the locus of control is the mother, who is motivated and taught to take charge of her child's health. The Mirebalais project has, consequently, initiated a program of empowerment of mothers, to be effectuated at two levels: social change through the creation of viable mothers' action groups; and increased capability by mothers to take direct responsibility for those key interventions which could save the lives of their children, with special attention to the needs of mothers at high risk of losing a child. Not only is this expected to serve to create a critical mass of knowledge and demand, but it should contribute to sustainability by reducing project costs: the initial methodology, local-level research and problem-solving groups, followed by testing of both knowledge and behavior, has been found to be substantially lower in cost than other largescale promotion techniques and, as the critical mass grows, promotion costs should decrease even further. The approach should take as a control variable at baseline, the attendance figures from rally posts, as well as immunization rates as proxies for impact, so that subsequent evaluations can assess the value of this approach for project sustainability.

b. Cité Soleil

Similarly, there are no indications that Cité Soleil is not sustainable. However, CMSCS activities over the last ten years have expanded in number, complexity, and comprehensive focus. As a result of this expansion, the Complex is outgrowing its present management and control mechanisms. It will have to adopt or replace these mechanisms with a system that addresses its needs as a more complex organization. The CMSCS has broadened its revenue base over the last two years through a combination of patient fees, increased last year; product sales, including a more profitable restructuring of pharmaceutical prices; and school fees. Training fees and interest on small business loans represent other future sources of income. CMSCS has recognized the need to develop more aggressive fundraising efforts if it is to sustain its expanded network of activities, and is taking steps to do so. Given these adaptions and staff additions, there is no reason to think that the CMSCS as an institution will not survive and grow.

D. REPLICABILITY

There are two major issues of replicability: the appropriate size of new projects and the degree to which the AOPS model is replicable in the public sector.

1. Project Size

There was some difference of opinion on the evaluation team as to whether AOPS should continue to finance projects of 10,000 population. A preliminary assumption was that project failure, or at least relative unsuccess, was more likely to have occurred in the smaller projects. However, more careful scrutiny does not support this view. First of all, while the larger projects (Belle Anse, Pignon, Mirebalais) have all been assessed as "exemplary," the fourth project so assessed is Cayes-Jacmel, a 10,000 project. Belle Anse does not want to become larger. Pignon has two functional nuclei and is only in some ways considered a single, unitary project. Mirebalais is a special case: it gets special central-level attention, is near Port-au-Prince, and is well supported by other donors.

Of the group of five projects given a ranking of 4, that is, "good performance with minimal functional problems," only Frères and Fermathe are larger projects. The others, Thomassique, Fonds des Négres, and La Montagne are all small. The projects evaluated at 3 ("currently in operation but with moderate problems") are all small. All 12 projects are viewed as functioning adequately, with technical assistance needed primarily for those in the last group.

In summary, there is no powerful reason for claiming, on the basis of the experience of these 12 projects, that projects of 10,000 population are not worth it. It may, however, be said that projects which are already functioning well and are larger to begin with, may merit priority for assignment of new funds.

What is more interesting is the fate of potentially larger projects which are having problems. These are, as they should be, being decided on a case-by-case basis. Duplessis has vigorous and committed community leadership and needs a good, committed doctor to reanimate them in the area of primary health care. This being accomplished, the population base for expansion certainly exists. Las Cahobas, on the other hand, appears to have some fundamental cultural problems which cause unease about the degree to which the project can effectively expand. Carrefour-Poy, while sharing much of the same history and problems as Duplessis, may be a more promising focus of expansion.

A group of projects that did not get proper attention in the evaluation and which might have given some clues to the merits of project size selection were the projects intended to be part of the AOPS selection but which have fallen out. Review of the anecdotal data on these projects (Cookson Hills, Deluge, Chambellan, Milot, and Montrouis) suggests that size was not, in fact, a causal factor in the disappearance of these projects from under the AOPS umbrella. In half the cases AOPS had a question about project management, in the other half there was a philosophical divergence on the most appropriate delivery model.

The more appropriate question about size turns on economies of scale: whether, given startup costs, it is simply not more cost-effective to work with larger projects, or at least projects which display potential for expansion after the necessary systems are in place for some basic population nucleus. This question

can only be answered when there are some more precise answers about costs, which will require more data than were available for this evaluation.

2. Public Sector Replication

An excellent summary statement on this subject appears in a recent AID-commissioned paper (Smucker, 1986). We do not feel we can improve upon that.

"The question has been raised as to whether programs that are successful in the private sector can be successful in the public sector. In order to answer this question it is first necessary to note the relevant differences between private and public sector programs.

"The delivery of primary health care services in the public sector is constrained by a number of factors; primary among them is lack of adequate finances. Lack of finances results in logistics problems, limited program supervision and resupply problems. The public sector has also been characterized by patronage and lack of accountability. This has resulted in some instances in the hiring of under-qualified employees and limited performance expectations. Continuing employment is often more dependent on one's connections than on performance. There is no merit based promotional system. Lack of accountability and supervision has resulted in instances of abuse and corruption.

"The private sector on the other hand is often better financed. It generally places greater emphasis on employee qualifications and job performance. More attention is paid to supervision. In private voluntary organizations with a religious or humanitarian orientation, commitments made on the basis of faith and conviction, rather than for reasons of salary and power, make a significant difference. Private sector programs tend to be smaller, more flexible, more independent and more integrated into the local community than public sector programs.

"The quality and effectiveness of primary health care programs is not categorically dependent upon whether the program is based in the private or public sector. In the evolution of primary health care programs in Haiti, elements have been borrowed back and forth between the two sectors. What is crucial, however, is that certain programmatic elements be present. These include adequate finances, qualified personnel, supervision, resupply accountability and the ability to establish good working relationships at the local level. Any program which includes these elements should be successful. At present more of these elements are present in the private sector than in the public sector, but it is not inconceivable that the public sector could develop the capacity to implement quality programming. There would have to be enough pressure exerted and support given for the public sector to make the necessary changes. If there is not sufficient will or support to make these changes in the public sector, programming will continue to falter."

There is no reason implicit in the AOPS model that would be sufficient in itself to make that model unfeasible for the public sector. There is no reason why the public sector cannot carry out any of the essential components of the AOPS model, except that it has historically done so only erratically. The major question of recurrent costs pertains to any other model that the public sector might choose to adopt, and perhaps in greater measure. While doctors are important for startup, there is a surplus of that profession in Haiti and at least some of them might be motivated toward involvement in an innovative activity which is no more poorly rewarded financially than other field assignments in the public sector. Vehicles are not essential for all projects. Finally, given the fact that AOPS and other population-based and outreach activities already cover about half of the potential client population, this would reduce the public sector's charge perhaps to something more financially manageable, assuming the MSPP were prepared to divide up responsibility for preventive health care in some rational way.

VIII.RECOMMENDATIONS *

- A. MANAGEMENT AND ORGANIZATION
- 1. Integration and Coordination Between the Private and Public Sectors
- a. AOPS coordinators should explicitly and regularly incorporate entry and exit interviews with local-level MSPP authorities when they come into a region to do scheduled supervisory visits, in order to facilitate coordination to the benefit of both. (p. 55)
- 2. Staffing and Human Resources
- a. AOPS would profit from someone on the staff with management, more specifically, micro-management skills, to help projects set up their programs, develop most efficient rally post models, setting up simple budgeting and reporting systems, etc. This could be reinforced by, though not adequately substituted for, by a simple management procedures manual for the basic components of the AOPS model. (p. 55)
- b. AOPS needs a technical qualified Executive Director with good implementation skills who can handle the reporting and documentation requirements that are so crucial to an experimental project. (p. 58)
- c. Approvals for new projects or extensions of existing projects should pend a central management investigative visit by the Executive Director and the AID project officer. (p. 58)
- d. Optimally, an AOPS project should have a technical and administrative chief, with the doctor providing the technical supervision and quality control and the administrator running things. Both should be given adequate training in basic management skills, taught with only marginal amounts of theory and primarily organized around the practicum. (p. 62)
- e. The new business manager for the CMSCS should not be asked to be responsible for day-to-day financial management, coordinate the self-financing component, and play a role in marketing and fundraising. There are basically two jobs here: financial management and marketing/fundraising. The latter can be enhanced by short-term technical assistance, but the former should be provided in-house, in ongoing fashion, with the necessary technical preparation to assume full responsibility for this area, leaving to existing project administration the substantial role of operations. (p. 63)
- f. AID should support expansion of the Cite Soleil project to cover the additional 50,000 people who, with the original 100,000, represents the true population of the area. This will entail the hiring of another 50 ColVols. (p. 64)

^{*} For the reader's convenience, each recommendation is accompanied by the page of text which contains the relevant discussion.

3. Training and Continuing Education

- a. Curricula for training the various levels at the Haitian Public Health Institute should not be rewritten arbitrarily in a costly re-inventing enterprise. Even if AOPS is going to reduce the CHW load to a few priority interventions, the existing MSPP materials, reprinted, can be extracted from and/or used as reference texts for training. (p. 67)
- b. Physician training curriculum could be improved by:
 - Reordering the flow of the curriculum to more closely reflect the flow of field activity.
 - Eliminating material that is specific only to the CMSCS, e.g., milk bank.
 - Giving increased weight to record-keeping, administration, and supervision.
 - Giving doctors training in pedagogical skills. A module should be developed for use in all CMSCS and AOPS activities in: training skills, productive provider-client interaction, role-playing, focus groups, mutual feedback, and simple testing techniques. (pp. 67-68)
- c. Doctors should be screened by AOPS central management before being supported for training at Cité Soleil. (p. 68)
- AOPS and the HPHI should develop not only longer-term training for health d. professionals, but a scheduled series of short courses, workshops, and seminars, oriented systematically toward priority health issues, with a balanced blend of both theory and practice. At least some of the AOPS seminars and workshops take place at an AOPS project site rather than at a hotel. These seminars, accordingly, would become exchange visits, where information about each projects would be presented and discussed among the participants. These exchange sessions should take place in centers where programs are functioning particularly well, in general or in some aspect of particular interest (e.g., Pignon, Mirebalais, Cayes-Jacmel, Gros Morne), in order that they serve as motivators for the improvement of sites that are functioning at less than optimal levels and so that they can serve as a source of special lessons learned (e.g., Pignon/family planning Mirebalais/record systems, Gros Morne/community organization, etc.). (p. 82)
- e. AOPS should consider recommending and providing a simple, standard literacy/numeracy for all ColVols and archivistes, based on some of the documentation for which they will be responsible. (p. 77)
- f. When the adapted ColVol curriculum becomes available, ColVols in all projects should be tested for competency in that curriculum, including demonstrations of skills as appropriate, and appropriate catchup training provided in systematic fashion. (p. 72) This could be provided through an Itinerant Training Team. (p. 82)
- g. All archivistes should rotate through a re-training exercise as soon as possible. The appropriate site would be Mirebalais, if this is logistically feasible. They should be trained for one week, with the team doctor, in groups of six, that is, the two archivistes from each of two projects and the doctors from each of two projects, each trio to be trained as

a team in the structure, purposes, and functioning of the population-based registration and monitoring system. While the course should be very "hands-on," it should not fail to emphasize the major message of the AOPS philosophy with regard to the information system. The population-based system is not a researcher's toy; it is the spinal column of this approach to community health, which centers on extremely activist outreach. (p. 82)

- h. AOPS should consider the addition, at the central level, of a professional with formal statistical and administrative skills, who would be able to train, provide ongoing audit, supervision, and continuing education, and develop the simple reporting formats that will 1) promote the rapid feedback of data on achievements at the local level and 2) keep AOPS more consistently abreast of project status. This individual would also have the responsibility for being sure that all technical-cum-statistical reports are timely and complete. (p. 84)
- i. Auxiliaries should be trained at the HPHI and their role, which is not quite marginal, could be enhanced by deeper skills in interpersonal communication, pedagogy, and technical areas where the project as a whole needs strengthening, i.e., family planning, ORT, and non-traditional education on appropriate feeding practices. (p. 84)

4. Monitoring and Evaluation

- a. Re-training in the reporting system for the AOPS projects needs to enhance the understanding of all levels of health worker in the purpose of the system, so that there will be comprehension of the negative impact of such events as: files out of numerical order, registers not up to date, age groups out of order, non-recording of newborns and pregnant womer, absence of the growth curve, incomplete code numbers, lack of identification of children 0-1, "outside" immunizations not recorded and discrepancies between dossiers and Road-to-Health Cards unresolved. They should also understand why every family needs to know its code number. (p. 89)
- b. All projects should have an updated alphabetical list of all families, cross-identified by code number. (p. 89)
- c. The mechanics of the reporting system are such in most projects that the ColVol is effectively separated from the data which are the results of their labors. They need the information, promptly, to do their follow-up work and they need it as an incentive. The form in which these data are fed back to the ColVol should be an efficient summary of a running tally of percentages of coverage by sector so that they can see how they are doing. Larger projects can substitute a large hand-lettered wall chart which would display key project data for the month or cycle, projected against baseline, with running percentages. (p. 89)
- d. AOPS should take advantage of the technical assistance that will be available through the Save-the-Children project at Maissade, and should look particularly at the SCH data base software package which is tailored to Child Survival activities. (p. 90)
- e. The power of the follow-up sheet does not appear to be well appreciated in most field projects. The follow-up sheet, together with the activity and

orientation which surrounds its preparation and use, is what marks the biggest difference between the passive, more traditional dossier system and the activist thrust of AOPS. Follow-up sheets should be prepared on time with appropriate frequency, in duplicate, one for the ColVol and one for retention in a log which would be available in ongoing fashion for monitoring, evaluation, and supervision. (p. 90)

- f. All AOPS and CMSCS documents and correspondence should be dated with day, month, and year, and authorship attributed. (p. 91)
- g. Baseline data should be presented on all reporting documents where they are relevant, adequately labelled as to date, portion of the population, cohort, and description. (p. 91)
- h. Percentages should be included on all coverage and impact reports, referenced adequately so they can be interpreted. (p. 91)
- i. There should be a policy determination about priority age groups. We recommend that both the 0-12 month and 13-24 month cohorts be assigned priority, the former for obvious reasons and the latter because so much diarrheal mortality and morbidity reside them attributable to weaning. If this policy is adopted, then all projects should be asked to provide the necessary data for those cohorts in disaggregated form. (p. 91)
- j. The target populations of AOPS-affiliated projects be standardized, that is, target populations and reporting on those should be in categories that are standard for all AOPS projects, e.g., age groups for target children. Not only should these be consistent among AOPS projects, they should be compatible with public MSPP guidelines for target populations for primary health care. (p. 91)
- k. AOPS should consider recommending a standard volicy for cutoff of provision of services. (p. 91)
- 1. Definitions and categories should be standard and there should be a unitary form for designating age cohorts. Reporting forms should provide space for age in months and years, as well as date of birth, for speed and purposes of cross-checking. (p. 91)
- m. There should be a standard tabular format for reporting coverage and impact data which all projects are required to use. (p. 91)
- n. There should be space left for number of rally posts completed, together with the associated figures for the female and child populations covered in each sector, so that the appropriate statistical calculations can be made even when all rally posts have not been completed. (p. 92)
- o. In situations where a project must report to more than one child survival donor, AOPS should look into serving as a coordinator so that perhaps the same indicators or pieces of data might be used. (p. 92)
- p. All AOPS project centers should collect evaluative data on a quarterly basis, in order to prepare timely reports on each project's progress and activities. These data will allow a regular and periodic evaluation of the status of each project, for feedback to all project staff and for feed-

forward to AOPS. These reports should not only include quantitative data (of the type now included in the sheet entitled "Etat Evolutif," but should include qualitative administrative data as well. We suggest that one sheet contain the quantitative data as well. We suggest that one sheet contain the quantitative data with perhaps two-three additional formatted pages for comments on administrative issues, problems, achievements, and critical decisions. AOPS should design and furnish an adequate supply of these forms, assure that the reports are submitted regularly, and provide the necessary technical assistance with the reports indicate that there is a need therefor. Should the report itself require editing for archival purposes of for provision to donors or researchers, AOPS will be responsible for this as well. (p. 92)

- q. The quantitative quarterly summary of output information would be more useful if: the sheet were dates, located, and signed; if items were categorized around an intervention in a visually clear way; if there were an explicit place for the quarter to which the report is referring; and if each line item with which some specific target is associated would have by its side the baseline datum as well as the target. An elegant addition would be the last quarter's achievements for that line item, if space would permit. (p. 92)
- r. AOPS and the CMSCS should review the indicators required by the AID/Washington Child Survival Reporting System to be sure that the data being gathered will respond to those requirements in a comfortable, ongoing fashion. (p. 93)
- s. AOPS should consider putting together a small, user-friendly manual on its registration and reporting system for use by staff, donors, and researchers and evaluators.

5. Supervision

- a. AOPS central files do not contain a relatively uniform, standard set of documents on each project. Some of the key documents, financial reports and, most importantly, technical reports are circulated and then filed separately. Either this separate filing system should be eliminated and copies of technical reports filed in each project dossier or a photocopy should be made so that the two files can be maintained; there should be protection copies made of every technical report in any case.
- b. Project dossiers need cleaning out, dating, and refiling so that the earliest documents are on the bottom. There are documents that are milestones in the life of each AOPS project--agreements, technical and financial reports, periodic supervision and monitoring reports, census and re-census reports, etc., which should appear in every project dossier. AOPS should task one of its technical officers to make up a standard checklist of these which would be affixed to the inside front cover of every project dossier, with the date each was received. The point of this is not bureaucratic angst but to have an adequate chronicle of an operations research project.
- c. The draft version of the Supervisor's Checklist should be simplified, sent around in draft to the project directors for comment and input, and worked

through with all the project coordinators and, perhaps, with the USAID project manager. It should also be integrated with the quarterly project reporting process. (pp. 96-98)

- d. A registry of each supervisor's site visit be kept at each site. This log should note the important points, problems, and solutions proposed during the visit. The purpose of this recommendation is to introduce a pattern into those visits, to provide immediate feedback for discussion and action at the project level, and maintain a record of visits and related outcomes. It may be a good idea to use the same format for these supervisory records as for the qualitative portion of quarterly reports, at least in some condensed form. This needs to be thought through.
- e. AOPS area coordinators should prepare specific work plans in line with clearly preestablished supervisory objectives, prior to both regular and special site visits, but particularly the former. These plans should include detailed calendars and appropriate strategies.

6. Research

- a. The CMSCS should consider pursuing the following research topics:
 - Motivation for family planning adoption (p. 101)
 - Cost-Effectiveness Alternatives for Improving Health Services Delivery. This should include not only TBC and Nutritional Rehabilitation, but a repetition of studies on hospital unit costs and other service units which can generate income (p. 101)
 - Real Vaccination Coverage (pp. 101-102)
 - Evaluation of the Effectiveness and Impact of the Road-to-Health Card (p. 102)

including incentives for community workers (p. 102)

- The Effectiveness and Impact of Food Supplementation (p. 102)
- b. AOPS should consider pursuing the following research topics:
 - The Health Status of Non-Users of Health Delivery Services (p. 105)
 - Mother Competency and Participation in Growth Monitoring (p. 105)
 - Family Planning Continuance Patterns (p. 105)
 - Rally Post Attendance, Continuance, and Motivation (p. 128)
 - Review of AOPS Project Dropouts

7. Financial Management and Planning

- a. CMSCS
 - Revenues from fees for health services at Cite Soleil have increased substantially. If revenues from fees are to continue to contribute to self-reliant noals, the costs of service delivery must be identified and carefully monitored. Targets for the percent of costs that should be covered by fees (i.e., 10 percent of unit prescription

costs) need to be established, and fees should be raised commensurate with increases in costs.

- Fees for some services probably can be increased (although not before the political situation stabilizes). Deliveries and surgeries are two candidates. However, rather than launch a major research effort, the Complex should experiment with small increases, monitoring utilization carefully. Prescription charges might also tolerate slight increases, to perhaps 10 percent of unit costs. Free X-ray charges should be suspended; sisters who want free X-rays for patients at their center should provide the funds from their own budgets.
- CMSCS should entertain the idea of admitting private surgical patients at the Laboure Hospital. This option would only be viable if the fees that would be charged would more than cover all the direct and indirect costs of providing the service.
- Cost containment/control mechanisms or strategies need to be developed for the hospital. As a way of beginning, the PRICOR study by M. Pipp, which identified unit costs for normal and Caesarean deliveries, needs to be repeated. Such a study will help identify the magnitude of cost increase and areas which are subject to control measures. Similar analysis needs to be conducted for other service units.
- Budgeting procedures need to be developed and implemented at each center or sublevel of activity. Sister-administrators should be assisted as needed to operate their facilities within their budgets. Timely flows of information will be required.
- Bookkeeping procedures for the notebooks need to be standardized for all centers and expenditures line items disaggregated into meaningful categories.
- The financial management capability of CMSCS needs to be strengthened. The sisters who have been with the Complex many years have had the opportunity to accommodate to increasingly more complicated activities. Newer sisters, however, do not have as full an understanding of their responsibilities. They need assistance in carrying out effective financial management.
- A business manager with a strong finance background would provide invaluable assistance in carrying out recommendations. Reginald Boulos and Sister Héléne are stretched too thin to adequately carry out their tasks. A business manager would: assist the sister administrators in developing their center budgets; establish sound financial management procedures; establish a management information system to assure the timely flow of information for decision-making; provide the necessary financial technical assistance to the nascent cooperatives; and help expand product sales. The business manager should not be directly responsible or involved in fundraising.
- Targets need to be established regarding the percent of operation costs that product sales must cover. Sales volumes need to increase. The recommendations in the Alvarez report which speak to improving production quality and expanding marketing efforts are still valid.

- The industrial complex idea should be tabled.
- CMSCS should be charging participants the full cost of any training programs. Fundraising efforts need to receive priority attention. The most promising area for fundraising is through the Friends of Cite Soleil in the U.S. All energies over the next two years should focus on actions and activities to make fundraising efforts successful.
- Cité Soleil should assure itself a solid financial base before it launches into new endeavors. While it strives to accomplish selfreliant objectives, it will continue to need the full support of its current donors for at least the next five years. AID should not precipitously withdraw support, but should undertake a gradual, planned phaseout over the course of a few years.
- Product sales can and should be increased.
- b. AOPS
- AOPS and AID should carry out studies on those programs with adequate data to determine the marginal cost of program expansion, the average cost of program operations by size and length of experience, and the annual recurrent costs of the program as it reaches "plateau" level. The model for the community outreach program consists of one vehicle, one doctor, one auxiliary, one record-keeper (archivist), one collaborator/1000 population, and performance-based incentives for collaborators. The annual costs for this model seems to be between \$70,000 to \$85,000. There are, however, wide variations on the theme which could have large impact on costs but not necessarily on program outcomes. One of these variations is the size of the population base per collaborator. In some programs, one collaborator serves a population of 2,000, but works more hours. The impact of these differences should be investigated. Costs analyses will provide the necessary basis for grantees, AOPS, and AID to make more informed decisions regarding future program planning.
- Grantee institutions need more management technical assistance, particularly in the area of financial management. The coordinators, who are all physicians, are untrained and unprepared to provide this assistance. The coordinators should have some minimal financial management training to provide better routine assistance. In addition, the next coordinator to be hired should have a finance/statistics background and would receive sufficient training to supervise the health aspects of the program. Such a person is not intended to add an extra person to make extra visits to the grantees, but rather to have available within the coordinator group the expertise necessary to help organizations who are having difficulty with the financial record.
- A program administrator/manager should be designated by the grantee institution to receive training from AOPS or another appropriate institution in financial and program management. The program model, therefore, should include a designated manager.

- All grantee programs that are serving a population larger than 20,000 should be required to do program budgeting. This effort will identify annual program requirements and expected sources of funding for the grantee institutions. The AMOSSE budget is a good example of a quite simple budget exercise while FHASE represents a much more sophisticated effort.
- Some of the grantee organizations have developed good financial management and cost control techniques/mechanisms. A forum for sharing this information and experience among all the grantee organizations should be implemented be AOPS. Workshops on technical aspects of program management similar to the AOPS workshops on technical aspects of health interventions are needed.
- While most programs meet minimum standards of donor accountability, AOPS should continue the practice of on-site audits to assure that these standards are maintained. The AOPS accountant should provide guidance to the grantees on financial accountability and control procedures. Financial reporting procedures to AOPS need to be standardized.
- Several grantees reported that checking accounts for their community outreach program were too expensive to maintain. Smaller programs operate on the basis of a savings account and cash. AOPS should explore alternatives for helping grantees deal with this problem.
- As AOPS funding draws to its conclusions, grantees have evolved different strategies to keep their program going. Grantees could benefit from sharing their experiences. The most difficult part of this program to keep funded seems to be the incentives payment for collaborators. Most programs are trying to develop community based financing strategies, rather than rely on donor funding. A few grantees are trying to establish pig projects as funding mechanisms. Mirebalais has an interesting and creative idea for cooperative savings and borrowing among rural mothers (Augustin, Lewis, Doro) which could support collaborators and generate family income. This idea merits further development and a trial run. It will, however, require substantial inputs of time, effort, technical assistance, and patience.
- The recent political changes in Haiti have generated requests from collaborators for salaries as opposed to incentives bonuses. It is not unreasonable for collaborators to want to regularize this income. However, AOPS should assist grantees in developing payments that are performance-based. Anything less risks the success of these programs.

8. Technical Issues

a. The quality of the growth monitoring encounter needs to be substantially upgraded, through some intensive training in nutritional problem-solving and focus group work and through a rationalization of the sequencing and staffing of the rally post. (pp. 127-128)

- b. AOPS, the CMSCS, and the MSPP may need to articulate a policy decision on ORT that is disseminated to all projects and is in accordance with recently revised WHO strategy. The policy on packets first, with substantially diminished enthusiasm for sugar-salt solutions, is not being followed at the field level in Haiti, where packet availability appears to be a problem and commitment to packets is limited in any case. (p. 129)
- c. Commitment to ORT in general needs a push. There is a need for energetic and crisp re-training and promotion at policy and leadership levels for intervention. (pp. 128-130)
- d. The promotion of breastfeeding in the AOPS projects needs more attention and should be handled systematically in an organized manner. This effort should be rooted in the operational research on this intervention carried out at Cité Soleil. (pp. 130-131)
- e. Family planning should be a more explicit and thorough component of all levels of AOPS field team training and an explicit, thorough family planning module should be offered to all interested institutions. ColVols should be able to educate and inform women and men on where to do, for what, why, and how much it costs; refer clients, perhaps using a coupon/ incentive system for DepoProvera, IUDs, tubal ligation, and vasectomy; distribute condoms and pills; and follow up on users, dropouts, and discontinuers. A simple algorithm could be devised for ColVols to gather the necessary data, perhaps beginning at Pignon or Mirebalais. (pp. 132-133)
- f. We recommend that the CMSCS work with the Division of Family Hygiene and Nutrition (DHFN) of the MSPP, so that family planning services can be made available through the public sector to the men and women of Cite Soleil. The system should be standardized so that all women who seek family planning services in Cite Soleil facilities are referred to the nearest public sector facility that can provide the services they require.
- g. The new family planning promoter position should be filled only in projects whose rally posts are sufficiently efficient to absorb it and should perhaps be evaluated in the first site to see how well it works and what happens to levels of adoption.
- h. AOPS should join forces with the CMSCS in the investigation operation research on food supplementation (pp. 134-135)
- i. Environmental hygiene should be promoted at the CMSCS and implemented through the Mayor's office (<u>Mairie</u>), community action groups, and neighborhood committees.

APPENDICES

- A. EVALUATION SCOPE OF WORK
- B. USAID ACTION PLAN
- C. PROGRAMME D'ENTRAINEMENT EN MEDICINE COMMUNAUTAIRE
- D- MONITORING AND EVALUATION REPORTING FORMS
- E- SUPERVISOR'S CHECKLIST

Health

UNITED STATES GOVERNMENT

memorandum

Private Sector

for

February 14, 1986

REPLY TO ATTN OF:

DATE

USAID/Haiti: Debra Kreutzer, Public Health Office UN

JOW

EUBLECTI

TOI

Request for PRITECH assistance Brojects Evaluation

ST/H ALIN Randlov and LAC/DR/HN

1. - <u>Summary</u>:

USAID/Haiti is preparing a combined evaluation of three private sector health projects: Urban Health and Community Development (521-0159); Community Health Outreach (521-0169); and Extended Community Health and Family Planning (521-0181<3>). A three to four person team is required to carry out evaluation per Scope of Work below. Mission requests PRITECH provide technical assistance for approximately fifteen person-weeks (twelve person weeks in Haiti, from 4/7 to 5/6 three person weeks in U.S. from 5/7 to 5/14).

2.- Scope:

PROJECT EVALUATION

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UR3AN HEALTH AND COMMUNITY DEVELOPMENT II(521-0159) EXTENDED COMMUNITY HEALTH AND FAMILY PLANNING (521-0181) COMMUNITY HEALTH OUTREACH (521-0169)

I. Purpose:

The purpose of this evaluation is to review three private sector health projects: Urban Health and Community Development II .(521-0159); Community Health Outreach - AOPS I (521-0169) and Extended Community Health and Family Planning-AOPS II (521-0181). The evaluation will analyze issues of importance and interest :

1. to the projects, in order to determine strengths and weaknesses and suggest appropriate modifications and future directions, and

2. to USAID/Haiti, in view of designing and adapting a new generation of PHO projects to closely address goals and strategies set forth in the USAID/Haiti Action Plan, and to amend the Action Plan if appropriate.

OPTIONAL FORM NO. 10 (REV. 1-40) GSA FPMR (41 CFR) 101-11.6 3010-114 The evaluation will appraise project performance to date, identify lessons learned from implementation, and determine appropriate technical and organizational elements for extended health and family planning activities in Haiti. The evaluation; will focus on the following major issues:

1. Relationship of Project Activities to The USAID/Haiti Action Plan.

2. Progress in Meeting Project Objectives

3. Achievement of Anticipated Project Outputs

4. Financial Management

5. Program Management and Administration

6. Technical Results and Concerns

Background.

PROJECT DESCRIPTIONS

. Urban Health and Community Development II (521-0159):

The Social Medical Complex of Cité Simone is a Haitian-based PVO which has the goal of improving the health, social, and economic status of 100,000 residents in Cite Simone, an urban slum in Port-au-Prince. The purpose of the project is to strengthen the Complex's overall health and community development program by:

- (.). Expanding and improving primary health care cervices and conducting operations research to determine cost—effective interventions for further reductions in mortality and morbidity.
- b Z. Detrengthening the effectiveness of human resource development activities, particularly remedial education, vocational training, and jcb placement for adults and adolescents.
- (A. Significantly increasing the self-financing capability of the Complex through revisions in user fees, improved fundraising, marketing of CMSCS products, and establishing a manufacturing enterprise that will allocate part of its profits to direct support of CMSCS.
- A. Improving the institutional management capacity with the assistance of a computerized program-based budgeting and planning system.

This five-year project began in May 1984 and has LOP funding of \$2.1 million.

Cité Soleil

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Community_Health_Outreach_(521-0169) and_Extended_Community Health_and_Family_Planning_(521-01816: AoP.S II)

-3-

Promoting collaboration between the private and public health sectors in such a way that national priority goals are met.

422 Promoting collaboration among private institutions to avoid duplication of services and wasted resources.

C - F Involving private health institutions in the implementation of the Mational Health Plan, by coordinating their efforts with GOH/DSPP district and regional health authorities and by setting specific targets for the realization of the local Plans.

BY Expanding the AOPS data bank and assisting private institutions in self-evaluation

The project will also explore management issues involved in the provision of primary care services for large population segments as they relate to questions of logistics, procurement of supplies, appropriate incentives for professional and para professional health care providers, supervision, and private/public sector interaction.

. Activities include:

1. Identification of the at-risk population, child growth monitoring and nutrition counseling, immunization of women and children, promotion of breastfeeding and oral rehydration, detection and treatment of endemic diseases, organization of family planning services, and registration of vital events.

2. Arrangement and provision of necessary training for community health personnel.

3. Development and use of registration, record, and information systems to facilitate program evaluation.

4. Development and implementation of administrative and financial procedures which will ensure proper utilization and accounting for project funds.

Extended Community Health and Family Planning Project began in June 1984 as an extension to Community Health Outreach. The latest LOP funding of \$436,000 brings USAID support to the AOPS program to a total of \$716,000 since March 1983.

III. <u>SCOPE_OF_WORK</u>

A. <u>General Duties</u>

Bach member of the evaluation team will accomplish the following:

.

*1. review background documentation and available data on the Projects.

2. interview staff of the implementing agencies/organizations associated with the projects and USAID personnel to discuss project goals, achievements, problems and strategies.

3. make site visits to (a representative sample of sub-grantee) implementing institutions, interviewing field staff and clients.

. . .

. . . .

4. assess project accomplishments, outputs and objectives by relating them to pre-established verifiable indicators (per Project Papers, Cooperative Agreements and the USAID/Haiti Action Plan).

5. recommend additional or alternative approaches to project implementation and coordination to achieve improved delivery of services and achievement of goals.

6. produce a written evaluation report by May 15 in accordance with the attached AID/W guidelines (Annex II), a draft of which is to be submitted before leaving Haiti.

7. schedule and conduct a debriefing on evaluation findings and recommendations.

*Documents will include: USAID/Haiti Action Plan Project Papers and Cooperative Agreements Financial Reports Technical Reports and Research Results Previous Evaluations Project Files National Health Plan Institutional Records -5-

B. Specific Tasks:

This review of Cite Simone (521-0159) and AOPS (521-0169 & 521-0181) will cover, but is not limited to, the following:

1. Financial Management

a. review systems used by recipients and subgrantees to assure accurate accounting, reporting and record keeping for the use of project resources.

b. assess 'adequacy of financial monitoring and supervision of sub-grantees.

c. analyze appropriatenesss of project resource allocation and frequent budget adjustments.

d. assess income-generating capability and activities of implementing institutions (e.g. user fees) including their effect on the projects and their relationship to Action Plan sector objectives dealing with financing issues.

2. Program Management and Administration

a. determine extent to which projects have been successful in achieving the outputs established in their Cooperative Agreements. What management techniques are applied in very successful vs. less successful programs? What does a successful manager do? Is there a difference between physician and non-physician managed programs?

b. determine if rally post activities continue when AOPS financial assistance ends. What are community responses to this outreach system? Is a demand for services being created? Are any community resources mobilized? How does this relate to Action Plan recurrent cost objectives?

c. determine if technical assistance needs are adequately identified and met.

d. determine what steps are taken for continuous internal evaluation and monitoring.

e. assess adequacy/effectiveness of AOPS/CMSCS central management/administrative systems and management information systems.

f. At sess adequacy/effectiveness of AID project management.

The following are technical issues and concerns which have been raised during the course of Project Implementation. In some instances sufficient data may not be available, or time may not permit in-depth analysis. Where this is the case, the evaluation team will propose preliminary terms of reference for future operations research which will provide the necessary information.

> a. assess whether the outreach strategy developed by AOPS is a feasible strategy for PVOs to obtain increased coverage for priority health interventions.

b. assess the effectiveness of the AOPS strategy in increasing coverage for health services.

c. in cases where <u>impact</u> data are available, assess whether the population-based outreach strategy has had an impact on:

- 1. Nutritional status
- 2. Tetanus related mortality
- 3. Diarrhea related mortality
- 4. Infant mortality

(Impact data available in Belle Anse and Mirebalais).

d. identify areas in service delivery (e.g. family planning, growth monitoring) which may need strengthening and recommend appropriate steps for such improvement.

e. examine the impact of the growth monitoring and nutrition education on the prevalence of malnutrition in Cite Simone. What is the extent and significance of "repeators" at the Nutrition Rehabilitation Center?

f. examine reasons for consistent "non-participation" in programs of a core of families in each coverage zone. Suggest steps to decrease levels of non-participation.

g. assess the adequacy of Community Collaborator training/supervision and discuss the actual vs. potential role of the Community Collaborator.

h. examine the "marketability" of the skills being taught in the Cite Simone vocational training programs and their role (actual vs. potential) in supporting operating costs.

i. review overall TB control strategy used in Cite Simone assess appropriateness of changes being made. j. assess the adequacy/appropriateness of health education strategies used for the different interventions and suggest alternatives for improvement.

k. determine the extent to which AOPS and CMSCS are adhering to MSPP norms on priority programs; reporting; collaboration with district and regional GOH/MSPP personnel. Suggest ways to strengthen collaboration with the MSPP.

1. examine various research projects undertaken by AOPS and Cite Simone. Discuss their quality, appropriateness, and utilization of results. Discuss relevance of research activities 'undertaken to objectives set forth in the USAID/Haiti Action Plan.

m. to the extent possible, assess project levels of cost/effectiveness (of approaches), j sustainability and replicability. Particular-attention should be paid to levels of recurrent costs.

n. determine effect of user-fees implemented in Cite Simone on the utilization of services.

C. Team Composition & Qualifications

The evaluation team will include the following:

1. <u>Health Education/ Community Development Program Analyst</u> (Team Leader) - This individual will examine technical issues related to training (health and other), health education strategies, community participation, effectiveness and appropriateness of outreach She/he will examine effectiveness of the rally post strategies. strategy and the evolution of this outreach system, including its effect on the demand for services. She/he will review research activities conducted under the projects and determine their appropriateness, relevance, adequacy and quality, and will suggest future O.R. in response to technical concerns and recommendations. This individual will be responsible for coordinating the activities of the team members and will organize and submit the draft and final reports to USAID. She/He will report directly to the Chief, PHO-USAID/Haiti, will work closely with Project Officer, and Coordinator and Directors.

Qualifications: Fluent French or Creole; at least five years experience in developing countries (some of which must be health related); previous evaluation experience; academic background in health, social science, non formal education; or a related field.

2. Financial Management and Administration Consultant

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This individual will be primarily responsible for addressing issues of program and financial management and administration. He/she will also examine issues related to program sustainability and replicability. For questions of financial management, he/she will be assisted by a member of the USAID/Haiti controller's staff.

Qualifications: Fluent French or Creole; at least 3 years work experience in developing countries; experience with AID project management and procedures; academic background in management/administration, health or social sciences, or related field.

3. <u>Primary Health Care Specialist</u> - This individual will be responsible for general assessment of the quality and quantity of specific project interventions including: nutrition/growth monitoring; ORT promotion; vaccination coverage; TB treatment; family planning services; referral systems - and will provide guidance on further study of these activities. He/she will be responsible for preparing the draft report in French.

Qualifications: Haitian M.D. with extensive experience in primary health care programs; Fluent French or Creole; previous evaluation experience desirable.

4. <u>Economist (Optional)</u>: For issues of cost effectiveness, replicability and sustainability, USAID recognizes that it would be desirable to include the services of an economist on the evaluation team. USAID requests that PRITECH propose, based on availability of appropriate personnel, a list of team members and available dates which does not exceed the level of effort or total budget set forth below.

N.B. The team members, while each addressing specific issues, will be required to work in a highly collaborative manner, under direction of the team leader. Their combined report should integrate and demonstrate linkages between overlapping issues. The report should clearly and specifically describe how the projects relate to and address objectives of the USAID/Haiti Action Plan. The team leader will be responsible for ensuring necessary coordinatior.

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CONTRACTOR EVALUATION REPORT

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(Per AID/W Instructions)

The Contractor Evaluation Report will include the following:

1. An executive summary, including purpose of the evaluation, methodology used, findings, conclusions and recommendations. It will also include comments on development impact and lessons learned. It should be complete enough so that the reader a can understand the evaluation without having to read the entire document, I. E. The summary should be a self-contained document.

2. A copy of the Scope of Work under which the evaluation was carried out. The methodology used will be explicitly outlined and each scope will contain the requirement to assess how (and how successfully) the project or program being evaluated fits into the Missions's overall strategy. Any deviation from the Scope will be explained.

3. A listing of the evaluation team, including host country personnel, their field of expertise and the role they played on the team.

4. A clear presentation of the evaluation recommendations, in a separate section of the report if convenient, so that the reader can easily locate them.

5. A discussion of any previous evaluation(s) reviewed with a brief description of conclusions and recommendations made in the earlier report(s). The evaluators will discuss briefly what use was made of the previous evaluation(s) in their review of the project.

6. A separate section on development impact of the project, particularly for End-Of-Project or Ex-Post Evaluations. This section should clearly present the development benefits resulting from the project.

The project's lessons learned should be clearly presented. These 7. should describe the causal relationship factors that proved critical project success or failure, including necessary political, policy, to economic, social and bureaucratic preconditions within the host country and AID. These should also include a discussion of the techniques or approaches which proved most effective or had to be changed and why. relating to replicability and Lessons sustainability will be discussed.

8. A paginated table of contents.

9. Project Evaluation Summary (PES).

APPENDIX

USAID ACTION PL

C. <u>HUMAN RESOURCE DEVELOPMENT</u>

1. <u>Health</u>

- Goal: Reduce infant mortality rate	to 50/1000 by the year 2000
- 'Base Period Indicator:	1985 125/1000 (estimated)
- Benchmark Performance Indicator:	1988 115/1000
- Target Date Indicator:	2000 50/1000
- Assumptions:	, ,
 USAID continues to work in public solution The MSPP accepts a major revision shifting emphasis from sprays availability of chloroquine for tree of the UNICEF and PAHO continue to political support for the ORT and solution Benchmark Actions: FY 86/FY 87 	sector; sion in the malaria program; i.e., ing techniques to widespread. eatment; provide the lead in mobilizing immunization (EPI) programs.
The following are health sector bench FY 87 Action Plan: (1) Improving the Management of Publi	marks described in the FY 86/
 Financial Management: Design management systems and train of staff in financial management. Progress: The MSPP made management by implementing region health region. Workplans: Assist district an annual plans and budgets and monin Progress: Two of four regions progress 	and test decentralized financial district and regional accounting major improvements in financial onal accounting systems in each ad regional directors in preparing toring programs. repared adequate plans.
- <u>Management Information</u> : Continu information system. <u>Progress</u> : The RHDS project development of an excellent new h	to strengthen the management contributed greatly to the health information system.
- Personnel Management: Reintroduc personnel management system. Progress: The system is bein actions as recruitment and traini	e the use of the computerized ng used to plan such personnel ng.
- AGAPCO: Expand AGAPCO pharmac medical and laboratory supplies. Progress: This was done.	y network to include provision of

- <u>Reorganization of SNEM</u>: SNEM to be reorganized and decentralized. Progress: Little accomplished because of change of SNEM Director.
- Malaria Surveillance: Improve monitoring of malaria prevalence by designing surveillance system.
 Progress: Little apparent progress due to organizational problems in SNEM and with AID technical assistance.
- <u>Malaria Research</u>: Support CDC operational research on epidemiology and entomology. <u>Progress</u>: The CDC helped the SNEM conduct research on resistance to fenithrothion and chloroquine.
- <u>GOH Support to Malaria</u>: Negotiate with GOH to increase their support of malaria control activities. <u>Progress</u>: No progress. The GOH claimed to be unable to increase support.
 - Japanese Aid: Seek multiyear commitment from Government of Japan to provide insecticides. <u>Progress</u>: Not done because USAID no longer wants to encourage vector control activities using expensive insecticides.
 - <u>Priority Programs</u>: MSPP to introduce supervisors manual, develop specific targets and monitor use of activity reporting format. <u>Progress</u>: This has been done for ORT and immunization programs.
 - <u>Peace Corps</u>: Orient and support six Peace Corps Volunteers assigned to public health outreach program. <u>Progress</u>: The PCVs are working successfully as cold chain technicians.
- (2) Increasing the Mobilization of Community Resources
 - <u>Community Outreach</u>: Undertake a comprehensive evaluation of various community health outreach approaches. <u>Progress</u>: A study is underway.
 - Health Education: Test various health education messages on child health protection. Progress: USAID decided to delay until S/T project in health communication would be funded to assist in this effort.
 - <u>Village Health Workers</u>: Seek stronger support for the use of village health workers. <u>Frogress</u>: A village health worker element will be a part of the planned RHDS Amendment.

- User Fees: Conduct operations research on users fees and non-monetary mechanisms for sustaining volunteers. Progress: This issue is under active discussion. USAID wants to study the problem further before making a final recommendation.
- Recurrent Costs: Work with GOH to ensure that funds generated by health facilities are maintained for their operating costs. Progress: Delayed until comprehensive studies, now planned for FY 86, can be undertaken.
- (3) <u>Increasing the Collaboration of the Public Sector with PVOs and</u> <u>Improving Performance of PVOs</u>
 - <u>Child Survival</u>: Assist PVO institutions to extend PHC services to an additional 500,000 people and target resources more explicitly on child survival. <u>Progress</u>: A total of 10 PVOs began implementing child survival programs impacting a population of 250,000.
 - Financing: Encourage PVOs to become more self-reliant primarily through collection of fees and drug sales. Progress: Discussions taking place with the Complex Medico-
 - Social de la Cite Simone (CMSCS) and AOPS.
 - <u>Public/Private Sector Cooperation</u>: Improve collaboration between <u>MSPP</u> and PVOS. <u>Progress</u>: While competition for human and financial resources continues between the private and public sector, mechanisms for discussing differences have been established; moreover, public/private sector collaboration in this sector is better than in most other sectors.

- Benchmark Actions: FY 87/FY 88

The following are benchmarks established for the FY 87/FY 88 period:

- .(1) Improving the Management of Public Sector Health Resources
 - Health Information System:
 - Forms are revised after a critical evaluation of one year's use. 1st. 2 FY 88.
 - Disease and intervention specific rates are being regularly reported by district. 3rd. Q FY 88.
 - <u>Personnel</u>: GOH determines ratios of various personnel per population and per institution by district, the range of variation in salary level for different positions and the likely attrition for various types of personnel, and estimates the necessary inscription rates for various institutions based on this information. 2nd. Q FY 87.

- Restructuring Malaria Program: 50% of COLVOLs (voluntary · collaborators) have a reliable supply of chloroquine and have ' treated an average of five cases of malaria per month during the season of peak transmission. 3rd Q FY 87. Privatizing AGAPCO: Privatize AGAPCO (the community pharmacy agency). 3rd Q FY 87. - Priority Programs: - Regional and district specific ORT and EPI annual work plan completed. 1st Q FY 87. - ORT use during last episode of malaria rises from 35% in FY 85 3rd. Q FY 87. to 50%. - Complete vaccine coverage rises from 12% in FY 85 to 35%. 3rd. ~ Q FY 87. The entropy States and Telling Trating الج المرجعية الج · [? < ; } . (2) Increasing the Mobilization of Community Resources Health Care Financing Studies: The first generation of studies has been reviewed by a working group of public and private health care providers. 2nd Q FY 87. THE PARTY BETTER Expansion and Diversification of COLVOLS Network: The - 80% of present COLVOLs retrained. 1st. Q FY 87. 55/- 2000 new COLVOLs trained. 4th Q FY 88. - 50% of COLVOLs provide ORT packets. 2nd Q FY 88. man and shares (3) Increasing the collaboration of the Public Sector with PVOs and Improving Performance of PVOs . 11. j. w - Child Health Institute: The OHI has developed and begun evaluation protocols for implementing all child survival projects. 1st Q FY 87. - Cite Simone: The Complexe Medico Social de la Cite Simone has trained health workers for the staff of the child survival projects. 2nd. Q FY 87. - Child Survival: At least two new PVO child survival projects, impacting a population of 100,000, have begun project implementation. 1st Q FY 87. - Private/Public Sector Collaboration: A study of the problem of overlap in the provision of services by public and private providers is completed. 3rd. Q FY 87. - AOPS: the Association of Private Sector Health Organizations has extended coverage to 150,000 people more than are currently covered (current number to be determined in the FY 86 evaluation). 1st. Q FY 88.

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CISCS/AOPS

PROGRAMME D'ENTRAINEMENT EN MEDECINE COMMUNAUTAIRE

19/11/85 au 18/12/85

:). OBJECTIF GENERAL DU STAGE: A la fin du stage, les participants devront être en mesure d'organiser, de superviser et d'évaluer un programme de médecine communautaire .-

2). FONCTIONS FUTURES DES PARTICIPANTS ET OBJECTIFS EDUCATIONNELS

FONCTIONS DES PARTICIPANTS	·····	OBJECTIFS EDUCATIONNELS
1.1. Organiser un programme de médecine communautaire		
 <u>1.1.1</u> Définir la population à desservir Définir les groupes de populations cibles en fonction des objectifs du programme de médecine communautaire 	<u>2.1.a</u> .	 Etre en mesure d'organiser un relevé de por las concevoir et élaborer un plan de travail ave calendrier d'exécution fermer les énumérateurs faire collecter les données necessaires et s perviser la collecte des données tabuler le registre de ménage en fonction de informations nécessaires dépuiller les registres de ménages analyser les données
	<u>2.1.b</u> .	Etro en mesure d'utiliser les données - pouvoir définir les groupes cibles du progra - pouvoir utiliser ces informations pour mett: place le système et l'évaluer
<u>1.1.2</u> . Organiser un centre de santé ou rationaliser l'ancien centre de Sm.té/ Dispensaire /centre hospi- tulier	<u>2.1.c</u> .	Fixer des objectifs intermédiaires en conformi avec: les objectifs généraux du M.S.P.P Fouvoir identifier les contraintes avant la mi en exécution du programme
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APPENDI)

	MS DES PARTICIPANTS		OBJECTIFS EDUCATIONNELS:
		2.1.2.	Organiser la formation sanitaire en vue d'atteindr ces objectifs dans les déleis fixés
		<u>2.1.f</u> .	Pouvoir augmenter l'utilisation des différents ser cos de la formation sanitaire en agissant sur l'ac cossibilité des soins à la population de la locali
		2.1.5.	Pouvoir organiser un système de santé pour fourmir des soins intégrés, continus et globans
rasse	niser des postes de mblement si néce s-	<u>2.1.h</u> .	Pouvoir définir la population de chaque poste de r semblement
58 <u>.</u> 7(- 20	<u>2.1.i</u> .	Pouvoir utiliser les services des agents de santé C.V. et de toute autre personne de la communauté p augmenter l'accessibilité des soins
		<u>_2.1.1</u> .	Pouvoir organiser ces projets de rassemblement à i tervalle régulier et founir les soins de santé pri maïres de qualité
2.2.4. Dispo ciblo núces	enser aux populations de les soins de santé desaires et de bonne	<u>_2.2.A</u> .	Pouvoir organiser un sour programme de protection maternelle et infantile avec système de surveillen nutritionnelle et de vaccination.
quali	Lté	-	Pouvoir organiser un sous programme de planificati familiale avec système de surveillance
		-	Pouvoir organiser un sous programme de lutte contr la tuberculose avec système de surveillance
2.5. Superso	rviser et former le onnel de santé	2.3.	Pouvoir assurer la formation initiale du personnel de santé en fonction des tâches qu'il sura à accor
		2.3.E.	Pouvoir assurer la formation continue du personnel santé en se basant sur l'évaluation de leur travai
		2.3.0	Pouvoir superviser le personnel de santé
2.4. Evalution Evalution	uer les activités de la prmation sanitaire et	2.4.A.	Pouvoir déterminer le niveau d'attainte des object d'une façon continue ou périodique
gram gram	s en fonction du pro- ne mis à exécution	<u>2.4.3</u> .	Pouvoir identifier les contraintes en cours d'esté- tion
		<u>2.4.C</u> .	Pouvoir feire collecter les données sanitaires rel tives à l'administration des soins et pouvoir su- perviser la collecte des données
·		2.4.2.	Pouvoir formuler de nouvelles stratégies au crs o les objectifs ne sont pas atteints dans le délai firé

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פר נכ	HORAIRE	LIEU	SUJET	MONIT
19/11/85	9:00 - 11:00	CPF	Test d'évaluation initiale (qualitative)	3
	11:30 - 14:00	CFF	Présentation d'un programme de Medecine communautaire - visite du C.M.S.C.S.	1 - 3
20/11	9:00 - 11:00	רקכ	Introduction à la démographie et au recencement (1)	3
	11:30 - 14:00	CPF .	Utilisation du registre de ménage comme outil du relevé de population.	4
21/11	9:00 - 11:00	CPF	Introduction à la démographie (2)	3
	11:30 - 14:00	Eoston	Exercices pratiques: relévé topographique	6
22/11	9:00 - 11:00	CPF	Introduction à la démographie (3)	3
	11:30 - 14:00	Chapi	Exercices pratiques: les techniques d'interviews	7
25/11	9:00 - 11:00	Brooklyn	Présentation du collaborateur volontaire : définition, critères de choix, taches et supervision	9
	$10:30 - 1^{l_{2}}$	Brooklyn	Programme élargi de vaccina-i tion	9
25/11	9:00 - 11:00	CPF	Présentation des priorités du MSPP - fixation des objectifs finaux et intermédiaires	2
	11:30 - 14:00	Chapi	Exercices pratiques:inter- views	7
27/11	9:00 - 11:00	CPF	Eléments de planification sanitaire	3
	11:30 - 14:00	CPF	Exercices pratiques de plani- fication sanitaire	3

D. PE	HORAIRE	LIEU	SUJET	MONITOUR
8/11/85	9:00-11:00	Boston	Suivi Nutritionel des pre-sco- laires	10
ı	11:30-14:00	Boston	Organisation interne d'un centre de santé	10
?/11	9:00-11:00	CPF	Surveillance Nutritionnelle: concept, outil, indicateurs	3
	11:30-14:00	CPF	Lutte contre la mortalité due à la diarrhée - ^P romotion Allaitement maternel et réhydratation orale.	5
2/12	9:00-11:00	CPF	Clinique Prénatale: objectifs - contenus	11 .
	11:30-14:00	CPF	Pratiques de l'allaitement maternel à la Cité Simone	7
3/12	9:00-11:00	CPF	Poids faible à la naissance - préventior.	l
	11:30-14:00	CPF	Organisation des postes de rassemblement	l <u>t</u>
4/12	9:00-11:00	CPF	Concept de surveillance appli- qué à d'autres programmes de santé	3
	11:30-14:00	Brooklyn	Organisation des archives d' un centre de santé - classe- ment des dossiers	9
5/12	9:00+14:00		Programme de lutte contre la Tuberculose	12
6/12	9:00-11:00	CPF	Organisation des postes de rassemblement (l)	<u>!</u> _
	11:30-14:00	CPF	Organisation des postes de rassemblement (2)	4
9/12	9:00-10:00	CPF	Séance d'évaluation	1-2-3-4
	10:00-11:30	CPF	Intégration des matronnes dans un système de santé	2
	12:00-14:00	CPF .	Indicateurs de santé: choix, valeur, utilisation	3

DATE	HORAIRE	LIEU	SUJET	MONIT
10/12/85	9:00-].1:00	CPF	Supervision/Formation continue du personnel	3
,	11:30-14:00	CPF	Introduction au management d'un système de santé	1-2
11/12	9:00-10:00	Brooklyn	Récupération Nutritionnelle: management d'un centre	9
•	10:00-11:30	CPF	Techniques de récupération nutritionnelle	13
	12:00-13:00	CHOSCAL	Rehydratation, management des cas de malnutrition grave	14
	13:00-14:00	CHOSCAL	Banque de lait	15
12/12	9:00-11:00	CPF	Caractéristiques des soins de santé en médecine communau- taire	3
	11:30-14:00	CPF	Utilisation des indicateurs de santé sans l'évaluation des programmes	l
13/12	9:00-12:00	CPF	Relation inter personnelles - techniques de prise d'informat-	3
	12:30-14:00	CPF	Evaluation des programmes de santé - revue des méthodes épidémiologiques	l
16/12	9:00-14:00	CPF	Journée de discussion libres	3-4
17/12	9:00-12:00	CPF	Journée de discussions libres	3-4
18/12	9:00-12:00	CPF	Test d'évaluation	1-2-
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CODE DES MONITEURS DE STAGE

- 6 -

- 1. Dr Réginald Boulos
- 2. Dr Antoine Augustin
- 3. Dr Louis Marie Boulos
- 4. Dr Fanfan Jean-Claude
- 5. Dr Joseph Féquière
- 6. M. Dominique Douilly
- 7. Dr Michaelle Boulos
- 8. M. Gérard Félix
- 9. Dr Frantz Modé
- 10. Dr Joseph Marzouka
- 11. Dr Elrick Métayer
- 12. Dr Camille Clermont
- 15. Mile Suzanna Molnar
- 14. Dr Jean Thomas
- 15. Miss Delourdes Jules

CPF: Centre de Promotion Familiale, Brooklyn, Cité Simone

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GROSSESSE ACTUELLE

a) Date des dernières règles____

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M2 = 2eme degre

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M - Miste

G = Cenerale

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© \$\$ s.c.s.•



PROGRAMME DE SANTE COMMUNAUTAIRE

Fiche de Suivi des Enfants (0 - 3 ans)

Zone:

Sectour

	Secteur:								Institution:												
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PROGRAMME DE SANTE COMMUNAUTAIRE

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(Fiche de Suivi des Femmes de 15 - 45 Ans)

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ASSOCIATION DES OEUVRES PRIVÉES DE SANTÉ

P.O. Box 76 Port-au-Prince, Haïti

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Au	:	Comité de Gestion	
Du	:	Dr. Jean-Claude Fanfan	
Objet	:	Additif à la réponse au mémo du 24 février envoyé au comité de Gestion le 26 février 1986.	
Date	:	10 mars 1986	

- Plan détaillé de l'assistance technique prévue pour les institutions suivantes :
- Hopital St Joseph de la Vallée (CCDEVA) Centre de Duplessis (Hatte Dufort)
- Centre de Thomazeau
- Centre Shrist pour tous (Fonds Farisien)

I- Evaluation de la Situation

-1-

ETAPES

1- Ordonner toutes les fiches (Par ordre numérique)

2- Fiches individuelles :

- Tracer les courbes de poids (C-3) Calculer la date probable d'accouchement (Femmes) Vérifier les numéros de code.
- 3- Registre de ménage : Classer les noms par groupe d'âge sans enlever les anciens noms. Transcrire sur le registre les informations des fiches individuelles.
- 4- Fiche de suivi : Transcrire les informations du registre sur les fiches de suivi (0-3ans Femmes 15 à 45 ans et femmes enceintes)
- 5- Tableaux statistiques à partir des informations tirées des fiches de suivi.

II- Plan d'urgence

A- Recyclage du Personnel.

1- Les collaborateurs volontaires

- Evaluation des collaborateurs volontaires
- Cours sur mini recensement
- Cours sur motivation communautaire
- Cours sur Education des mères :
 - Serum Oral
 - Nutrition
 - Plannification familliale
 - Vaccination
- Pratique de prise de poids
- Interprétation du chemin la Santé
- 2- L'Audiliaire et le Médecin
- Les Méthodes de contraception (choix et indication)
- Les vaccins : (Age et voie d'administration, assepsie- chaine de froid)
- Suivi nutritionnel (Pesé- Education individuelle)
 Recommandation sur SRO
- Recommandauton Sur Sho
- Sélection des femmes enceintes à risque
- Planification des postes de rassemblement (Réquisition de matériel) Calendrier des postes
- Utilisation des fiches
- Technique de poste de rassemblement.

3- L'Archiviste

- Protocole des fiches :
- Registre de ménage
- Fiches individuelles
- Fiches de suivi
- Indexe alphabétique
- Chemin la Santé
- Dynamisme des archives :
- Organisation des archives
- Constitution d'un dossier
- Mise à jour des dossiers
- Rapport et Evaluation
- B- Technique de Poste de Rassemblement
- 1- Rétablir la régularité des postes Batir un calendrier des postes (secteur-col vol-Date)
- 2- Motiver la présence des groupes cibles
 - (O-3 ans Femmes 15-45 ans Femmes enceintes)
- Faire des invitations individuelles dans les cas spéciaux (déjà 2 doses, abandon)

2-

- Faire des convocations des groupes cibles par l'intermédiaire des groupements (marché, église, conseil etc)
- 3- Réquisitionner le matériel nécessaire pour chaque type de service à offrir :
 - vaccin; seringue, aiguille, coton, alcool, glace,
 - médicaments: Vit A, Fer Folate, Pillule, Vaccins

Archives : les dossiers, les fiches de suivi, d'autres fiches vierges, indexe alphabétique, courbe de poids- cartes- crayon- plume

Pesé : balance Education : matériel éducatif

4- Prévoir une personne distincte pour chaque station séparement :

- Education de groupe Auxiliaire et col vol.
- Archives 1 archiviste + aide
- Suivi nutritionnel 1 col vol + 1 aide
- Vaccination 1 auxiliaire + 1 aide
- Prénatal 1 médecin ou infirmière
- Pharmacie 1 aide

5- Détacher chaque service d'un de l'autre au poste Mettre chaque station dans un point éloigné de l'autre

6- Accomplir tous les gestes du poste :

- Faire l'éducation du groupe des mères
- De classer le dossier de la famille présentée par ordre d'arrivé
- Remettre ce dossier à la mère
- Compléter le dossier s'il y manque des fiches individuelles
- Motiver la famille si elle est irrégulière. ce qui peut être vu sur le dossier.
- Peser les enfants (C-3 ans)
- Inscrire le poids des enfants sur le chemin de la Santé et sur la fiche individuelle infantile,
- Tracer la courbe de poid de l'enfant sur son chemin de la santé
- Faire l'éducation individuelle de la mère suivant l'allure de la courbe de l'enfant
- Vacciner les enfants (O-1 an) les femmes enceintes et les femmes de 15 à 45ans.

- Inscrire les doses avec leur date sur les fiches individuelles, les cartes de vaccination des femmes enceintes et les cartes chemin de la santé.

-3-

- Faire des remarques aux bénéficiaires sur l'espacement et le nombre des doses à recevoir.

- Donner la vitamine A, du Fer folate, du SRO, des pillules ou autre le cas échéant.

- Motiver les femmes en union à la contraception

- Examiner la femme enceinte et l'aider à préparer l'accouchement.

C- Travaux de bureau après les postes

- 1. Tracer la courbe de poids sur le graphique dela fiche **infantil**e à partir du poids trouvé au poste de rassemblement
- 2- Transcrire les informations et les services donnés au poste de rassemblement sur les fiches de suivi
- 3- Controler le nombre de présence par catégorie :
 - Famille présente
 - Enfants 0-3 ans pesés
 - Enfants O-1 an vaccinés aux différents vaccins
 - Femmes enceintes suivies et vaccinées

4- Crienter les prochaines invitations suivant les cas d'abandon, les cas de malnutrition et les gens qui ne manquent que les dernières doses.

5- Préparer les rapports statistiques mensuelles.

Mini recensement

1- Registre de ménage

- Chaquescol vol prend le lot de registres de ménage pour visites domiciliaires afin de :
- a) Réparer les nouveaux nés (O-1 et O-3 ans) et les femmes enceintes les enregistrer.
- b) Enregistrer la date des doses de vaccin donnés à ces groupes, (0-3,15-45ans)
- c) Enregistrer la date probable d'accouchement des femmes enceintes.
- d) Enregistrer le dernier poids des enfants 0-3 ans

2- Etablir un index alphabétique sur les cahiers portant le No des secteurs

- a; Acheter 1 cahier par secteur
- b) Mettre une lettre chaque 2 pages
- c) Porter le nom des chefs de ménage avec leur numéro de famille suivant les lettres.

3- Fiche individuelle

- Etablir une nouvelle fiche ou completer la fiche établie (O-3 et 15 à 45 ans)
- Tracer courbe de poids (0-3 ans) sur cette fiche
- Transcrire les DDR et DPA et vaccin des femmes enceintes sur cette fiche
- Transcrire les vaccins avec la date des doses sur cette fiche.

4- Fiche de suivi

Transcrire les informations des registres sur les fiches de suivi.

5- Tableaux statistiques

Plan à moyen terme

-4-

- 1- Evaluation du programme (couverture et éducation)
- 2- Mise en place d'un personnel suffisant et de collaborateurs motivés
- 3- Entente définitive entre responsable et personnel pour éviter les arrêts de travail.
- 4- Planification pour 5 cycles de postes : Matériel - logistique - équipement
 - Calendrier définition de tache.
- 5- Exécution de 5 cycles de poste de rassemblement efficace
- 6- Exécution régulière des travaux d'après poste
- 7- Mise à jour : (migration, femmes enceintes, nouveaux nés et décès)
- (hitgradion, lemmes encembes, nouveaux nes et ucces)
- 8- Intégration des programmes complémentaires : (P.F et assistance aux mères)
- 9- Rapport Evolution etEvaluation

EVALUATION

A- Phase d'évaluation de la situation d'actuelle.

- a) Objectif .- Présenter un rapport statistique sur l'institution après 1 semaine
- b) Technique d'évaluation :

 Comparaison des donnés du rapport avec les donnés des fiches de suivi se trouvant à l'institution
 Vérification de la méthode employée sur les tableaux statistiques présentés dans le rapport.
- B- Phase du plan d'urgence
- a) Objectif : 2 mois après l'évaluation, rendre l'institution apre à fournir des services efficient aux groupes prioritaire actuels
- b) Technique d'évaluation :

- Constater une liste suffisante des enfants de O-3 ans et des enfants nés dans l'intervalle de 1 an (3,5% de la population) sur la fiche de suivi O-3 ans

- Constater une liste des femmes enceintes avec la date probable d'accouchement sur la fiche de suivi 15-45 ans

- Constater la liste des femmes pratiquant la contraception (fiche de suivi) - voir, si dans un poste de rassemblement, les services sont donnés dans la discipline avec des stations séparees et effectives.

- C- Plan à moyen terme
- 1- Objectif : Dans 8 mois après la phase (B), l'institution doit :
- a) Vacciner 60% des enfants ayant atteint l'âge de 1 an pendant ces 8 mois au DT Per et Polio
- b) Vacciner 80% des enfants ayant atteint l'age de 1 an dans ces 8 mois (*
- c) Vacciner 80% des feines :enceintes
- d) Eduquer 80% des mères du SRO_PF Nutrition Vaccination
- e) Peser et faire suivi nutritionnel de 80% enfants de 0-3 ans
- f) Frésenter au moi's 3 rapports d'évolution statistique

2- Technique d'évaluation :

a) Compter tous les enfants ayant atteint l'age de lan pendant les mois de travail après le mini recensement.

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- b) Compter le nombre d'enfants pesé pour cette même période
 c) Calculer le pourcentage des services fournis par type de service
 d) Poser des questions aux mères lors des postes de rassemblements.

Calendrier d'exécution

1- Evaluation de la	situation actuelle :
25 au 28 février 86	: une semaine à CCDEVA
4 au 7 mars 86	: une semaine à Duplessis
11 au 14 mars 86	: une semaine à Thomazeau
18 au 21 mars 86	: une semaine à Fonds Parisien
24 mars	: l jour de suivi à CODEVA
25 mars	: l jour de suivi à Duplessis
26 mars	: l jour de suivi à Thomazeau
27 mars	: 1 jour de suivi & Fonds Parisien

2- Plan d'urgence terme :

3 jours par semaine dans chaque institution calendrier à présenter.

Dron Claude Fanfan


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