

PO-AAU-870
50597

UNCLASSIFIED

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

HAITI

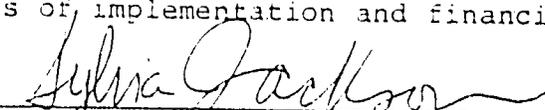
PROJECT PAPER

VOLUNTARY AGENCIES FOR CHILD SURVIVAL

AID/LAC/P-378

Project Number: 521-0206

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET				1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete		Amendment Number		DOCUMENT CODE 3	
2. COUNTRY/ENTITY HAITI				3. PROJECT NUMBER 521-0206					
4. BUREAU/OFFICE USAID/HAITI				5. PROJECT TITLE (maximum 40 characters) Voluntary Agencies for Child Survival					
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 07 30 92				7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY 87 B. Quarter 4 C. Final FY 91					
8. COSTS (\$000 CR EQUIVALENT \$1 =)									
A. FUNDING SOURCE		FIRST FY 87			LIFE OF PROJECT				
		B. FY	C. L/C	D. Total	E. FY	F. L/C	G. Total		
AID Appropriated Total		3000	-0-	3000	12000	-0-	12000		
(Grant)		(3000)	(-0-)	(3000)	(12000)	(-0-)	(12000)		
(Loan)		()	()	()	()	()	()		
Other U.S.	1.								
	2.								
Host Country									
Other Donor(s)									
TOTALS		3000	-0-	3000	12000	-0-	12000		
9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) CS	530	540		-0-	-0-	12000	-0-	12000	-0-
(2)									
(3)									
(4)									
TOTALS				-0-	-0-	12000	-0-	12000	-0-
10. SECONDARY TECHNICAL CODES (maximum 3 codes of 3 positions each)								11. SECONDARY PURPOSE CODE	
440		540		550		560		660	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code		EU		ER					
B. Amount									
13. PROJECT PURPOSE (maximum 430 characters)									
To develop institutional capabilities of PVOs and to improve PVO service delivery programs thereby increasing the availability of child survival health interventions.									
14. SCHEDULED EVALUATIONS					15. SOURCE/ORIGIN OF GOODS AND SERVICES				
Interim		MM YY	MM YY	Final	MM YY				
		11 83			05 91				
					<input type="checkbox"/> 000 <input checked="" type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify)				
16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)									
USAID/Haiti Controller Clearance									
I have reviewed and approved the methods of implementation and financing for this project.									
					 Sylvia Jackson, A/Controller, USAID/Haiti				
17. APPROVED BY		Signature			Date Signed			18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION	
		Gerald Zarr			MM DD YY 07 30 92				
		Title					MM DD YY		
		Mission Director					18 11 97		
		USAID/Haiti							

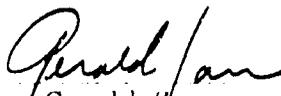
PROJECT AUTHORIZATION

NAME OF COUNTRY : Haiti

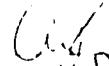
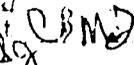
NAME OF PROJECT : Voluntary Agencies for Child Survival

NUMBER OF PROJECT : 521-0206

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Voluntary Agencies for Child Survival project for Haiti, involving planned obligations of not to exceed \$12,000,000 (Twelve Million United States Dollars) in grant funds ("Grant") over a five-year period from date of Authorization, subject to the availability of funds, to help in financing the local currency and foreign exchange costs for the project.
2. The project ("Project") has two major components: (1) the delivery of essential child survival interventions and (2) organizational development. VACS will support technical assistance, research and service delivery activities, all of which have as their common objective the improvement of child survival-related health services and the increased availability of those services.
3. The Project Agreements, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with AID regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as AID may deem appropriate:
 - a. Source and Origin of Goods and Services. Goods and services financed by AID under the Grant shall have their source and origin in countries included in AID Geographic Code 941 or in Haiti, except as AID may otherwise agree in writing. Ocean shipping financed under the Grant shall, except as AID may otherwise agree in writing, be financed only on flag vessels of countries included in AID Geographic Code 941 or Haiti.


Gerald Zarr
Director, US AID/Haiti
July 30, 1987
Date


DRE:RByess: June 12, 1987:vacs4

DRE, AFord 
PHO, CBMcDermott 
CONT, SJackson 
D/DIR, LEMorse 

List of Acronyms Used

ADDR:	Applied Diarrheal Disease Research Project
AMEC:	African Methodist Episcopal Church
AOPS:	l'Association des Oeuvres Privees de Sante (The Association of Private Health Organizations)
CMSCS:	Complexe Medico-Social de la Cite Soleil (Social Medicine Complex of Cite Soleil)
EPI:	Expanded Program for Immunization
HHF:	Haitian Health Foundation
IHE:	l'Institut Haitien de l'Enfance (Haitian Child Health Institute)
INHSAC:	l'Institut Haitien pour la Sante Communautaire (Haitian Community Health Institute)
MSPP:	Ministere de la Sante Publique et Population (Ministry of Public Health and Population)
ORT:	Oral Rehydration Therapy
PACD:	Project Activity Completion Date
PAHO:	Pan American Health Organization
PVO:	Private Voluntary Organization
REACH:	Resources for the Awareness of Child Health
UNICEF:	United Nations International Children's Emergency Fund
USAID:	United States Agency for International Development
VACS:	Voluntary Agencies for Child Survival Project

Table of Contents

1.	PROJECT SUMMARY	1
2.	PROJECT BACKGROUND	
1.	Problem Statement	3
2.	Project Goal and Purpose	4
3.	Project Inputs and Outputs	4
4.	Development of Child Survival Activities in Haiti.....	5
4.1.	MSPP & USAID Health Policies and Strategies	5
4.2.	Development of the Service Delivery Model	6
3.	PROJECT DESCRIPTION	
1.	Service Delivery	11
1.1.	PVO Health Service Delivery Programs	11
1.1.1.	Proposal Review and Selection Process	13
1.1.2.	Other Service Delivery Projects	15
1.1.3.	Grant Management & PVO Technical Supervision	16
1.2.	Institutional Program Support	19
1.3.	Research Activities	21
2.	Organizational Development	22
2.1.	Technical Assistance	24
2.1.1.	Institutional Management	24
2.1.2.	Service Delivery Management	25
2.1.3.	Management Training	25
2.2.	Technical Assistance Team	25
2.2.1.	Responsibilities and Expertise	25
4.	PROJECT IMPLEMENTATION PLAN	
1.	Project Authorization	28
2.	Procurement and Contracting Procedures	28
2.1.	Technical Assistance Grant	28
2.2.	Direct USAID Grants	28
2.3.	AID/W Buy-Ins	29
3.	USAID Monitoring Requirements	29
3.1.	Project Management	29
3.2.	Evaluation	30
3.3.	Contracting	30
3.4.	Reports	31
4.	Disbursement Procedures	31
5.	Methods of Implementation & Financing	32
6.	Implementation Schedule	34
5.	PROJECT ANALYSES	
1.	Technical Analysis	37
1.1.	Feasibility and Impact	37
1.2.	Factors Affecting Service Utilization	38

2.	Social Considerations	40
2.1.	Beneficiaries and Project Location	40
2.2.	Participation	40
3.	Institutional Analysis	42
3.1.	Summary	42
3.2.	Description	43
3.2.1.	AOPS.....	43
3.2.2.	IHE	49
3.2.3.	INHSAC	51
3.3.	Conclusions	53
4.	Economic Analysis	55
4.1.	Feasibility of Proposed Project	55
4.2.	Cost Per Beneficiary of Service Delivery Alternatives	55
4.2.1.	VACS	56
4.2.2.	VACS Including Cost of TA to Private Sector Institutions.	57
4.2.3.	MOMS Health Service Delivery	57
4.2.4.	Public Sector Health Care Delivery	57
4.2.5.	No Project/Curative Medical Care	58
4.3.	Recurrent Costs	60
4.4.	Technical Assistance for PVOs	61
6.	VACS PROJECT BUDGET	63
7.	ANNEXES	
A.	List of AOPS Grantees	
B.	Core Support for AOPS, IHE, INHSAC from other USAID Projects	
C.	Statutory Checklist	
D.	IEE	
E.	Port au Prince 2979	
F.	Logical Framework	

✓

1. PROJECT SUMMARY

The Voluntary Agencies for Child Survival (VACS) Project will provide technical assistance and service delivery support to predominantly private agencies implementing Child Survival activities.

VACS will provide support to private voluntary organizations (PVO) community health outreach programs offering child survival interventions: ORT, immunizations, growth monitoring and family planning. These simple, low-cost interventions provide effective methods to reduce childhood mortality. Grants to PVOs will be awarded to maintain on-going outreach programs, to expand total population coverage or to expand the services being offered. By the PACD, 1,000,000 people will be covered by PVO community outreach programs supported by the VACS Project. Of this total population, 16% or 160,000 are children under the age of five and 24% or 240,000 are women of reproductive age.

The provision of long-term technical assistance will help develop and promote local health organizations. Three Haitian institutions, The Association of Private Health Organizations (AOPS), The Haitian Child Health Institute (IHE) and The Haitian Community Health Institute (INHSAC), with which USAID has collaborated closely during the past four years on child survival programs, will be the primary recipients of this TA. The long-term TA team will help these institutions develop their management systems, including personnel, information, education, communications and financial management. The team will work with the institutions to define their future objectives and initiate long-range program planning. The TA team will also provide assistance for PVOs implementing community health programs to identify and resolve problems of service delivery, logistics, supply, recordkeeping and evaluation. Operations research to be funded by the project will consider the issues of program sustainability.

VACS will serve as a "Buy-In" mechanism to several projects: 1) Resources for the Awareness of Child Health Project (REACH) will provide a long-term Expanded Program for Immunization (EPI) advisor and short term Child Survival consultants; 2) Applied Diarrheal Disease Research Project (ADDR) will provide TA for research on diarrheal diseases and ORT use; 3) the LAC/PAHO Accelerated Program of Immunization for the Americas Project will concentrate on immunization programs and; 4) Johns Hopkins University will participate in research being conducted at Cite Soleil on a new measles vaccine. One Child Survival fellow from Johns Hopkins University will be working on survey research and evaluation activities.

Because of the numerous organizations and activities to be supported, the VACS Project is designed to consolidate management responsibility for various grants in the TA/grant management organization. Other funding mechanisms such as the buy-ins and cooperative agreements will have to be managed directly by the Public Health Office of USAID/Haiti.

VACS is a four year project with a \$12 million budget divided by the

major line items as follows:

I. TA	\$ 1,762,000
II. PVO and Core Support Subgrants	6,855,000
II. Direct USAID Grants	1,850,000
III. Project Coordinator	183,000
IV. Buy-Ins	1,250,000
V. Financial Management Review	50,000
VI. Evaluation	50,000

2. PROJECT BACKGROUND

2.1 Problem Statement

Although the mortality rate in Haiti is the second highest in the Latin American and Caribbean region, it has declined significantly during the past three decades. During the same period of time, however, the total fertility rate has only declined slightly, from 6.15 in the 1950s to 5.87 in the 1980s. The combination of declining mortality, stable fertility and migration rates resulted in an average annual growth rate of 2.0 for 1980-1985. If these trends were to continue, Haiti's population could double between 1985 and 2013, a period of 28 years.

In light of the country's rapid population growth, AID and other donor agencies are concerned about the prospects for development. Haiti's high infant mortality rate of 125/1000, almost twice the rate for Latin America as a whole, discourages family planning and results in a fertility rate that is unlikely to decline significantly in the near future. Mortality of such proportion denies children their inalienable rights of health and longevity and robs the country of its human resources.

Diarrhea and related dehydration are the leading causes of death among Haitian children. The mortality incidence is 25,000 children annually. An important contributing factor to diarrheal disease is malnutrition. The 1978 National Nutrition Survey found that 15% of surveyed children were acutely undernourished and classified as severely or moderately wasted. "Extrapolating these figures nationally, about 127,000 children (15.9% x 795,000, the estimated number of children 3-59 months of age) were in critical need of nutritional support at the time of the survey."¹

Common childhood diseases such as measles and respiratory infections, which are communicable and preventable, also exacerbate the problems of diarrhea and malnutrition. Preliminary data of research being conducted at Cite Soleil indicate that 34% of infants 11 months of age have suffered from naturally acquired measles and that children who had had naturally acquired measles were of significantly lower nutritional status than infants who had not had measles. The data appear to indicate that the mortality rate for children who survived to age twelve months was lower among those children who were vaccinated than among those who were not.

Research conducted in Mirebalais, Haiti, indicates that if women who give birth in one calendar year can be prevented from giving birth in the next calendar year, the infant mortality rate can be reduced. This finding is substantiated by data from three Subsaharan African countries which indicate that "... short birth intervals are associated with substantial excesses of mortality among children born

¹MSPP Bureau of Nutrition, Centers for Disease Control, Agency for International Development. "National Nutrition Survey, 1978."

either at the start or the end of such an interval. The excess in risk is strongest and most consistent during the first two years of life... If all children were preceded by a birth interval of at least 24 months, infant mortality rates in Sub-Saharan Africa would be reduced by an estimated 5-22 percent. Longer intervals would produce even greater reductions."

Given the inadequacies of the health care system and the generally poor economic conditions of the country which significantly contribute to many health problems, it is imperative to address the preventable causes of childhood mortality through simple, effective health care interventions.

2.2 Project Goal and Purpose

The goal of the Voluntary Agencies for Child Survival Project is to decrease infant and child mortality.

The purpose of the project is to develop institutional capabilities of PVOs and to improve PVO service delivery programs thereby increasing the availability of child survival health interventions.

2.3 Project Inputs and Outputs

The provision of long term technical assistance will be an important project input. By June, 1991, the PACD, this assistance will result in improved PVO management capabilities and more effective child survival service delivery activities.

The VACS Project will provide financial support (grants) to PVOs with rural-based health programs in order to help on-going outreach programs increase their population coverage or increase the types of services available, and to develop new outreach programs in currently unserved areas. Approximately 1,000,000 people will be covered by community health outreach programs implemented by 15 or more PVOs by the end of the project.

By June, 1991, roughly 52% of the rural population will be covered by PVO health programs. Of that population, 70% of children 0-12 months and 50% of children 0-48 months will have received vaccinations against DPT, polio, measles and BCG; 50% of women of reproductive age will have received tetanus toxoid inoculations; 50% of mothers will know how to prepare correctly and use oral rehydration solution (ORS) for each bout of childhood diarrhea; 50% of children under five years will attend growth monitoring sessions on a regular basis and 12% of women of reproductive age will use a modern contraceptive method.

The Haitian institutions which provide support services to the PVOs and

²Maine, Deborah, Regina McNamara, Joe Wray, Abdul-Aziz Farah and Marilyn Wallace. "Effects of Fertility Change on Maternal and Child Survival: Prospects for Sub-Saharan Africa." Paper prepared for the Policy and Research Division, Population, Health and Nutrition Department, The World Bank.

which form the collaborative base for USAID's health initiatives in the private sector -- the Association of Private Health Organizations (AOPS), the Haitian Child Health Institute (IHE), and the Haitian Community Health Institute (INHSAC) -- will be functioning at full capacity. Core staff will have been defined and recruited and personnel procedures will be well established. The administration of these institutions will have been defined and regularized. Financial management, information, communication and logistics systems will be fully operational. These institutions, which provide technical, research and training support for the PVOs, will be recognized by the Ministry of Health and Population (MSPP) as well as their peers and donor organizations as credible, efficient and effective local resources.

2.4 Development of Child Survival Activities in Haiti

2.4.1. MSPP and USAID Health Policies and Strategies

In 1982, the Ministry of Health and Population (MSPP) developed an innovative new Primary Health Care (PHC) policy and associated strategy. The policy, called the "New Orientation," determined that the MSPP would give priority to improving the health of rural Haitians by concentrating on the control of six priority health problems. These problems include dehydration due to diarrhea, vaccine preventable diseases, malnutrition, malaria, short birth interval and its demographic consequences, and tuberculosis. The strategy which was proposed for implementation of this policy called for the reorientation of MSPP resources from expensive, predominantly urban institutions, whose role was exclusively curative, to the support of a new class of minimally trained health worker, the "Health Agent," who would organize "rally posts" at the village level where growth monitoring, oral rehydration therapy (ORT) education, immunization, and the provision of family planning services would occur. The strategy, as it has evolved, calls for the sequential development of national programs to combat the six priority health problems. Targets for morbidity and mortality reductions associated with these problems have been established.

The Voluntary Agencies for Child Survival (VACS) Project is consistent with the MSPP's "New Orientation." VACS will address the health problems of children under the age of five years and women of reproductive age through the promotion and provision of several of the priority interventions: oral rehydration therapy (ORT), vaccination against preventable diseases, growth monitoring and birth spacing.

The project will contribute to the achievement of the MSPP's stated objective to reduce the infant mortality rate to 50/1000 by the year 2000.

The "New Orientation" recognized the role that Private Voluntary Organizations play in the delivery of health services, particularly in rural areas of the country, and called for PVOs to increase their efforts to deliver primary health care (PHC) services. VACS will provide assistance to PVOs to expand and improve their service

delivery programs and will promote greater collaboration between public and private sector health agencies.

The VACS Project conforms to the USAID/Haiti Child Survival strategy now in the final stages of development, as well as to the guidelines of the new AID Health Policy Paper. The AID policy requires that priority be given to Child Survival activities, e.g. those programs which will help reduce mortality rates in children under the age of five and women of reproductive age. Child Survival interventions are designed to reduce infant and child mortality caused by diarrhea, vaccine preventable diseases, malnutrition, low birth weight and high parity.

The health services to be supported by the VACS Project will help achieve the national objectives proposed in the USAID/Haiti Action Plan for the period FY 88-89: to reduce the infant and child mortality rates to 110/1000 and 25/1000 respectively; to immunize 50% of children with measles vaccine and three doses of DPT by the age of 12 months; 50% of mothers will correctly administer ORT to their children during episodes of diarrhea; and to achieve 11% contraceptive prevalence rate.

By working with both Haitian and American private voluntary organizations, VACS will respond to AID's private sector initiative and will promote greater collaboration with American PVOs.

A major component of the VACS Project will be the provision of long term technical assistance to help identify and resolve administrative and management problems within collaborating institutions and their service delivery programs. The management focus of the project is particularly relevant to the AID Health Policy Paper's statements on issues of program sustainability such as those related to finance, supervision and logistics.

2.4.2 Development of the Service Delivery Model

Following the request by the MSPP that PVOs take a more active role in the delivery of primary health services, The Association of Private Health Organizations (AOPS) was formed to develop a rural service delivery model and to support PVO activities. AOPS now has 100 PVO members, 45 of which have initiated community health outreach programs (Annex I).

In 1982, prior to the creation of AOPS, most PVOs were only providing curative health care services out of clinics or dispensaries. In developing a feasible approach for improving community health through increased service availability, consideration had to be given to the financial, personnel and logistical constraints of the PVOs. Using the experience of other primary health care models which had been developed earlier by the Hospital Albert Schweitzer in Deschappelles, the MSPP in Petit Goave and the Complexe Medico-Social de la Cite Soleil in Port au Prince, AOPS developed an approach for community health outreach programs.

The AOPS model was purposefully designed to make basic health interventions available to vastly increased numbers of people than can be served from fixed facilities; to target the most vulnerable groups of the population; to permit follow-up of problem cases, program drop-outs and non-participants; and to develop a system of on-going program monitoring.

Within a total catchment population that a PVO determines that it can cover, the "AOPS model" is based on the following principles:

Mothers and children under the age of five are targeted as the population at greatest risk of morbidity and mortality.

Priority interventions for ORT, immunizations, growth monitoring, breastfeeding promotion, prenatal care and family planning are emphasized.

Census of the catchment population and registration of the targeted "at risk" population are done.

"Rally posts" are established at designated locations to be visited monthly by a community health team (physician, nurse, record keeper, village health worker) of the sponsoring PVO.

Continuous evaluation of population coverage and intervention impact is made.³

In 1986 an evaluation was conducted of USAID-funded activities being implemented by AOPS and the Complexe Medico-Social de la Cite Soleil (CMSCS). The evaluation team found the AOPS approach to be "...a successful model for expanding primary health care coverage and reducing infant mortality." The evaluation report noted programmatic strengths including the technical approach, incorporation of lessons learned and patterns of service delivery stressing preventive rather than curative care.⁴

The rationale for the VACS Project, however, is based on the various programmatic weaknesses which have come to the attention of USAID/Haiti and which were cited in the evaluation report. Management problems both at the central AOPS level and at the PVO program level need to be addressed in order to improve supervision, financial management and planning, program implementation and maintenance and sustainability. These issues will be addressed in more detail in subsequent sections of the Project Description.

³ Augustin, Antoine, Joe Wray, Maryse Gourdet, Winnie Robin, James Allman and Reynold Monsanto. "Mobilizing Private Voluntary Organizations for Child Survival in Haiti."

⁴ Harrison, Polly F., Catherine Overholt and Maggie Huff. "Project Evaluation: Urban Health and Community Development II, Extended Community and Family Planning, and Community Health Outreach." Technologies for Primary Health Care (PRITECH) Project, 1986.

3. PROJECT DESCRIPTION

The Voluntary Agencies for Child Survival Project has two major components: (1) the delivery of essential child survival interventions and (2) organizational development. VACS will support technical assistance, research and service delivery activities, all of which have as their common objective the improvement of child survival-related health services and the increased availability of those services.

Because there will be numerous organizations receiving technical and financial assistance under the project through grants or buy-ins to centrally funded projects, USAID/Haiti must "streamline" the management structure of the project. Therefore, the principal grant recipient, i.e. the technical assistance organization, will prepare subgrants for other participating organizations. The project will use an umbrella mechanism for a pool of unprogrammed funds to be available on a competitive basis for PVOs wishing to implement service delivery programs. Using an outside organization as an intermediary for grant making and management tasks will simplify the management burden for USAID/Haiti and the implementing PVOs.

Diagram 1

VACS Function

Technical Assistance

- Management TA for:
- 1) Institution Building
- 2) Service Delivery

and

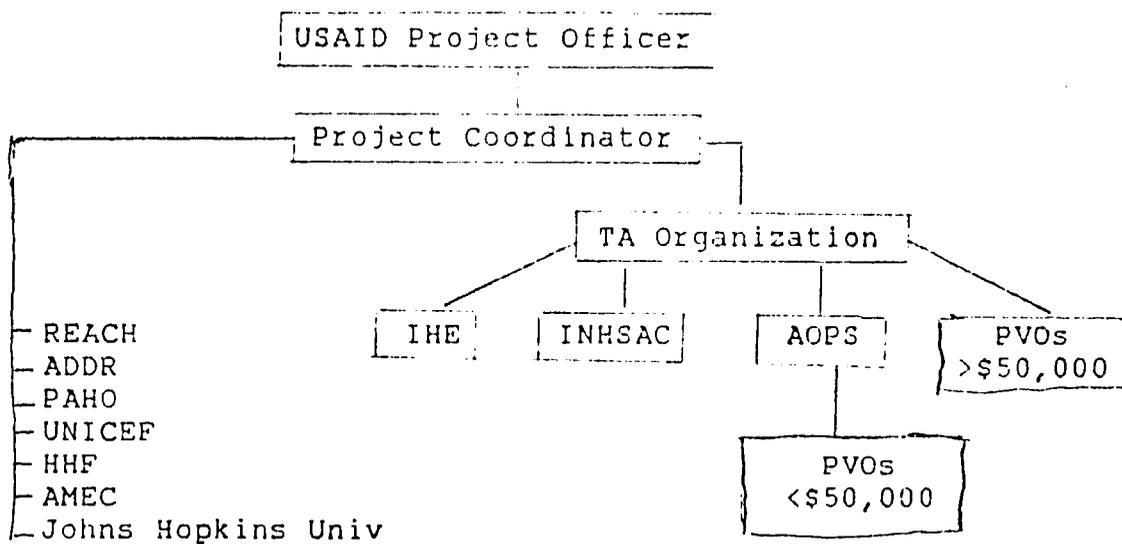
- Technical Support for
Service Delivery & Research through:
- 1) REACH - immunization program development
- 2) ADDR (Applied Diarrheal Disease Research) - Harvard
- 3) Measles study and Child Survival Fellows - Johns Hopkins

Child Survival Program Grants

- PVO Outreach Programs
- Core Support (AOPS, IHE, INHSAC)
- PAHO
- UNICEF

Diagram 2

VACS Grant Management



The VACS Project will continue to support new and expanded service delivery activities being implemented by Haitian and American PVOs. The project will also continue the efforts begun under previous grant agreements to build strong indigenous health institutions which have training, research and technical assistance capabilities.

Now that AOPS and numerous PVOs have been implementing community health outreach programs for several years, aspects of the approach which work well and those which are problematic have become apparent. While the approach itself is recognized as a good one, there have been some implementation problems which need to be corrected. VACS will capitalize on the success of the approach to provide services to an increased number of people by providing financial assistance to nongovernmental service delivery programs while at the same time providing technical assistance to deal with deficiencies in the management and organization of the implementing agencies.

Research activities concerning measles vaccine and diarrheal disease will contribute to the improvement of the technologies available to prevent and treat those diseases which cause thousands of childhood deaths annually. This research is very important for the development of health services in Haiti and will have global applications as well. Operations research will help improve the actual delivery of services.

3.1 Service Delivery

3.1.1. PVO Health Service Delivery Programs

As part of its commitment to reducing infant and child mortality rates in Haiti, USAID has been supporting community outreach programs implemented by PVOs in rural areas. These programs, which follow the "AOPS model," are designed to offer simple, low-cost health services to the population in a given area. Under the Community Health and Development Project and Mobilizing Mothers for Child Survival Projects (referred to as AOPS I & II and MOMS respectively) and AID/W activities funded by FVA/PVO, PVO programs in Haiti currently cover an estimated population of 1,400,000 with 2,000,000 population coverage expected by 1989. Approximately 35 PVOs have received AOPS grants of \$10,000 to \$50,000 to establish community outreach programs serving catchment populations of 10,000 to 50,000.

As described earlier, community outreach services are provided by PVO personnel at locations outside a fixed facility and with a focus on preventive health care. Registration of the population through a census facilitates client follow-up and motivation. "Rally Posts" held once a month by the PVO health team are the gathering points for mothers to bring their children for vaccinations, growth monitoring, and nutritional surveillance. The outreach team also gives demonstrations for the preparation and use of ORT, provides family planning counselling and dispenses contraceptives.

The "menu" of services currently offered by AOPS-assisted organizations varies from program to program but must include at least

one of the following child survival interventions: ORT promotion, immunization, growth monitoring and nutritional surveillance, and family planning promotion.

The VACS Project will continue to make funds available to PVOs for the delivery of child survival technologies. Under this project, new or expanded community outreach programs will make child survival services available to approximately 1,000,000 people previously unserved by community outreach health services, of whom 140,000 are children under the age of 5 and 240,000 are women of reproductive age. With additional financial assistance, on-going programs will expand the services currently offered and strengthen their outreach efforts for the catchment population currently being served. This will help increase utilization rates. Technical assistance will be used to plan appropriate operations research studies which will help the PVOs strengthen their efforts to find ways to make their programs self-sustaining.

Other PVOs with well established community health outreach programs and sufficient management capacity will expand their population coverage. AOPS anticipates that three on-going programs will expand their programs to increase their catchment populations from 50,000 to 100,000. Several will expand to cover 50,000, and several others will expand to 25,000. New programs may be initiated in at least six locations with one program of 25,000, four programs of 50,000 each and one of 100,000. Other programs will be initiated or expanded depending on the results of the grant award process (see section 3.1.1.1.)

PVOs have put a great deal of effort into the successful development of outreach programs for 10,000 or more people and will continue to receive support as they further expand their service delivery operations. While it is important and useful to build upon the successes already achieved, the zeal to increase the number of people being served should not supersede the provision of services of good quality as the primary program objective. Careful evaluation will have to be made of the on-going programs and a PVO's expansion capability. Before expansion is approved, problems encountered by several PVO programs merit across-the-board scrutiny by AOPS and IHE. These issues include: personnel, i.e. motivation, job satisfaction, performance, remuneration and individual qualifications for positions; additional training and supervisory requirements; record keeping and reporting accuracy; and community attitudes.

The PRITECH evaluation found no conclusive evidence to indicate that population size was a determining factor in the success or failure of PVO outreach programs. Among the programs analyzed by the evaluation team, small (10,000 population) programs were as likely to be successful as medium (25,000) to large (50,000) ones. The issue of program size is primarily one of economies of scale: whether, given the start-up costs, it is more cost-effective to work with large projects or projects which have more potential for expansion after the basic systems have been established. At the present time, however, available cost data are insufficient to answer the questions. Factors

which were found to influence project success regardless of size were: the presence of both administrative and technical skills; strong community leadership; low physician turn-over rate; and a high level of commitment on the part of program personnel.

AOPS will, therefore, be encouraged to work with PVOs in order to initiate some smaller (10,000 population) programs in areas currently unserved. It should be remembered that the initial focus of the AOPS approach was to develop programs which could fit the existing capabilities of the PVOs and not require excessive or long-term inputs of finances, personnel or management. The development of new outreach programs serving 10,000 people will be given a higher priority by AOPS despite the greater effort required to start a new program than to expand an existing one. Out of 200 PVOs in Haiti which provide health care, AOPS has approximately 100 members, 45 of which have started community health outreach programs. AOPS will encourage some of its other PVO members or recruit new members to undertake outreach activities.

3.1.1.1 Proposal Review and Selection Process

As has been done under AOPS I & II and the MOMS Projects, PVOs will be required to submit a proposal to receive the grant money to establish or expand a community outreach program. The level of interest already expressed by PVOs for program grants exceeds the amount of money available for this purpose under the VACS Project. Due to the varying nature and financial requirements of the PVOs, the VACS Project will make service delivery program grants available through two channels: AOPS and the TA/grant management organization.

AOPS-member PVOs may apply to AOPS directly to receive small grants for their community outreach programs. Approximately \$475,000 will be programmed for this AOPS pool and will be available to PVOs requesting less than \$50,000. AOPS will provide TA for proposal development and revisions when necessary, review the proposals and submit those selected for funding to USAID for concurrence. AOPS will have the primary responsibility for managing those grants and supervising the programs. It is expected that AOPS will continue to use the criteria that have been used to date to evaluate the merit and feasibility of proposals.

Other PVOs, either non-AOPS members or those needing more than \$50,000, wishing to solicit support for their service delivery activities will be required to submit a project proposal to the TA/grant management organization, which will announce an "open-season" for proposal submission twice a year. This will be a competitive process and funds will be awarded on the basis of conformity and responsiveness to established criteria. (AOPS, IHE and INHSAC requirements for operating funds will be handled separately and are described in section 3.1.2 below).

Like AOPS, the organization will be responsible for providing TA to PVOs for proposal development or revision. It will be the responsibility of the organization to investigate the proposals with

regards to their feasibility, location, cost, etc. The organization will request technical comments on the proposals from appropriate members of the health community. Copies of all proposals with the organization's and reviewers' comments and funding recommendations will be forwarded to USAID for concurrence. At the discretion of the VACS Project Officer, the proposals may be submitted to a larger Mission review committee for final approval.

The criteria for proposal evaluation and selection will be:

1. Proposing organizations will have fulfilled all application requirements to be recognized as PVCs by the Haitian Government.
2. Proposed programs are consistent with MSPP policies and have been approved by the MSPP District or Regional Director.
3. Record keeping and reporting is consistent with AOPS requirements and the national HIS.
4. Proposed programs include at least 2 of the standard child survival interventions. (ORT promotion, vaccination for communicable childhood diseases and neonatal tetanus, nutrition surveillance and growth monitoring, breastfeeding promotion, family planning.)
5. In addition to an explanation of the problem that the program will address, proposals will define:
 - total population coverage and location
 - CS interventions to be implemented
 - target population for each intervention
 - targeted intervention objectives
 - implementation strategy and schedule
 - training needs and how they will be met
 - program supervision
 - budget with details
6. If an organization has previously received funds for program implementation, some evaluation of their "track record" will be made. The difference between what was proposed and what was achieved will be determined for:
 - population coverage
 - intervention objectives (i.e. % immunized)
 - number of community health committees established and still functioning
 - number of community health workers trained, still on job
 - percentage of tasks accomplished before requesting funds for new or additional activities.
7. If a new organization is requesting funds, it will be determined that the organization has adequate staff and

facilities to support an outreach program. The proposal will be reviewed to determine that the program makes sense in terms of what other groups are doing; that activities are planned for areas not already being served by other groups; that issues of sustainability are addressed; costs are reasonable.

8. Programs proposing to use expatriate personnel will include at least an equal number of Haitian staff in comparable positions. Expatriate personnel will be expected to stay in Haiti for a minimum period of 1 year. Expatriate personnel should be functional in French and/or Creole.
9. Organizations which propose to undertake their own training programs rather than utilizing the INHSAC facilities will explain their rationale. Training programs should be described in terms of who will do the training, what the training will cover, how many and what category of personnel will be trained, what training materials will be used and/or developed, duration of training, and cost.
10. Proposals address issues of sustainability:
 - plans for continuation after grant funds are depleted
 - financing mechanisms
 - community participation

USAID concurrence will be required on all proposals whether funded through AOPS or the grant management organization.

Grant funds will be made available to PVOs in increments based on performance and the implementation schedule. AOPS and the grant management organization will jointly establish the guidelines for disbursements. This system will require close program supervision and will provide the incentive for PVOs to implement program activities on a timely basis. For their part, AOPS and the grant management organization will have to assure the timely flow of funds once requirements are met.

3.1.1.2 Other Service Delivery Projects

USAID/Haiti has received unsolicited proposals from two American PVOs and from UNICEF. Each of the proposals presents a viable program and the activities are in keeping with USAID's Child Survival Strategy. If approved by the AA/LAC, Cooperative Agreements will be signed by USAID/Haiti and the PVOs and a grant will be made to UNICEF in support of these Child Survival programs.

The Haitian Health Foundation (HHF), based in Storrs, Connecticut, will work in the District of Jeremie providing coverage to 50,000

people. The project will provide community-based health care services for immunizations, ORT and nutrition surveillance. Clinic based services will also be available and will include dental care and trauma treatment, which will not be supported with project funds. This will be a three year project with a budget of \$850,000.

The Service and Development Agency of the African Methodist Episcopal Church (AMEC), headquartered in Washington, D.C., will undertake a three year project to be implemented in several different areas with total population coverage of 100,000. Mobile health teams will conduct monthly rally posts where ORT, growth monitoring, family planning, immunization, TB referrals, presumptive malaria treatment and health education will be provided. Participation in the rally posts will be open to both church and non-church members. Grant funding under this project is \$600,000.

The UNICEF project is based in Leogane where an integrated community development project is already underway. In addition to a health component, agriculture, literacy education and water resource development are included. The VACS Project will provide support primarily to the community-based health component. Other activities of the project will be based in outlying slum areas of Port au Prince where health services are poor. The population to be served by the project numbers 170,000. ORT, vaccination, breastfeeding promotion, growth monitoring and family planning will be available. USAID's participation in this UNICEF project will be primarily for training of community health workers and the provision of some commodities. USAID's contribution will be \$400,000.

The VACS Project will be the buy-in mechanism for USAID/Haiti's participation in the PAHO Accelerated Immunization Program in the Americas. The project will implement the activities which are described in the EPI National Plan of Action.

The proposals for these projects are on file in the Public Health Office of USAID/Haiti.

3.1.1.3 Grant Management & Technical Supervision of PVO Programs

The VACS Project will use a combination of the grant making/management and program supervision methods which have been used under AOPS I & II and the MOMS Projects.

The TA organization, which will be the principal grant recipient under the VACS Project, will act as the grant maker and manager for the operating support grants to AOPS, JHE, INHSAC and for some of the PVOs.

For PVOs which receive their program grants through AOPS, AOPS will provide technical supervision and grant management as it has been doing. For the PVOs receiving grants through the TA/Management organization, grant management will be handled by the organization; technical supervision will be the responsibility of AOPS (if the PVO is an AOPS member.) It is important for AOPS to maintain its

supervisory role in technical/programmatic issues while being relieved of the management burden for the large grants. For non-AOPS members, routine technical supervision will be delegated to the grant manager which will be assisted by IHE, the VACS Project Coordinator and/or the VACS Project Officer.

It will be imperative that AOPS, IHE and the grant management organization establish a collaborative working relationship which will be mutually beneficial. The organization will want to have access to AOPS' and IHE's technical expertise and experience as it seeks to refine institutional management and supervisory systems and AOPS and IHE should utilize to the fullest extent the expertise that the organization will be able to offer in institutional development and health management.

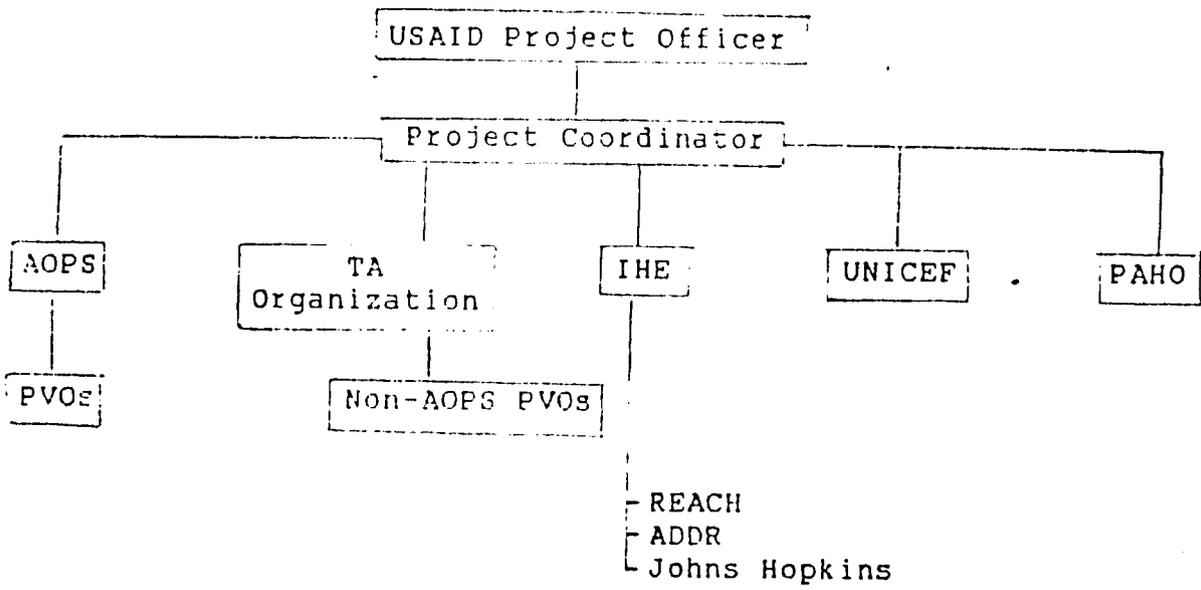
The arrangements for grant management and technical program monitoring for various project activities will require a greater degree of variety and flexibility than usual. However, these arrangements will be discussed and agreed upon by the TA organization, AOPS and USAID before AOPS or the organization begin making PVO program grants.

For the AMEC and HHF projects which will be funded through direct cooperative agreements, the USAID VACS Project Officer and the VACS Project Coordinator will be responsible for grant management. Since both the AMEC and the HHF are or intend to become members of AOPS, technical supervision of their activities will be the responsibility of AOPS. These arrangements will require good collaboration on the part of AOPS and the VACS Coordinator to assure adequate information exchange and coordination.

The UNICEF grant will be managed by the USAID Project Officer and the VACS Coordinator. USAID will have a minimal role in technical aspects of project implementation.

Diagram 3

VACS Technical Supervision



3.1.2. Institutional Program Support

The VACS Project will provide operating funds to IHE, AOPS, and INHSAC as has been done under the AOPS I & II and Mobilizing Mothers grant agreements. Until September, 1989, the VACS Project will complement the financial support currently being received by these institutions from the MOMS and the Private Sector Family Planning Projects. VACS will provide continued support for their operating costs when the other grants expire. (See Annex II for a summary of the funds available from other projects.)

Specifically, IHE will continue its role of providing TA to other PVOs in the Child Survival program and monitoring/evaluation for the PVO service delivery programs. A Child Survival Fellow assigned to IHE from The Johns Hopkins University is now conducting a survey to collect data on Tier I and II indicators of intervention coverage for PVC programs. The survey, data analysis and development of a Tier I and II evaluation tool and reporting system will receive continuing support from VACS.

IHE will also undertake new operations research activities on sustainability issues for community health programs including community financing and methods of and volunteer remuneration; streamlining of rally post operations; alternative vaccination outreach strategies; rapid epidemiologic assessment of health and nutritional status of children under 3; alternative methods for estimating infant and child mortality; and methods for improving pregnancy outcome and reducing maternal and perinatal mortality. A second national level infant mortality survey will be conducted in 1991 and will be based on the methodology being used for the mortality survey currently being conducted with technical assistance from a Child Survival Fellow and faculty members of the Johns Hopkins University.

IHE is planning to review the research related to pregnancy outcome that has been conducted to date in Haiti, to identify issues which have not yet been investigated and to organize a colloquium with international experts to discuss the topic.

It will be important for IHE to continue its efforts to develop in-house data processing and analysis capabilities and the documentation center. The permanent staffing needs of IHE need to be carefully considered in light of the activities planned for the next four years. The professional staff, which is currently dominated by physicians, needs to be evaluated and expanded to ensure that the in-house technical expertise necessary to conduct evaluations and survey research is available. Qualified individuals should be identified and hired before the departures of several expatriate researchers and a computer specialist result in work-delaying vacancies.

AOPS will strengthen its role as the primary provider of technical assistance to PVOs implementing service delivery programs. AOPS plans to improve its own technical coordination capacity through improved record keeping and logistics management and health intervention

redesign. With an improved in-house record keeping system AOPS will be able to help the PVOs set up more reliable records. Improving the system for data reporting will probably require some retraining of the PVO record keepers as well as close supervision and verification of the data by the AOPS Coordinators. The Technical Director of AOPS and the five Coordinators will work closely with the VACS technical assistance team to identify and resolve management problems which negatively affect service delivery.

AOPS expects to revamp the ORT component of the PVO health programs because the promotional strategy currently used at Rally Posts is not particularly effective thus limiting the use and impact of ORT.

AOPS will also start to put greater emphasis on nutritional surveillance and family planning which have been neglected by the majority of outreach programs. Improvement in these service components will require refresher training, equipment and supplies.

During the life of the VACS Project the AOPS Coordinators will be working with PVOs to help them establish new outreach programs, to expand population coverage and increase the services offered by existing programs.

As mentioned previously, the VACS Project will serve as a "buy in" mechanism to the centrally funded REACH project which provides TA in expanded programs for immunization (EPI) and other child survival interventions. While AOPS and IHE have been doing well at responding to TA requests from PVOs, there are particular areas of need where in-house expertise is either not sufficiently developed or existing human resources are stretched too thin to respond quickly and completely to the PVO requests for assistance. REACH will provide a long-term technical advisor and short-term consultants who will work with Child Survival projects either supplementing and reinforcing the assistance provided by in-country institutions or complementing it with assistance which surpasses the current capabilities of AOPS and IHE.

The long-term REACH technical advisor will work principally through the AOPS Technical Director during the initial part of his or her residence. Through AOPS, the advisor will be referred to member institutions (100 out of 200 health PVOs in Haiti) which require technical support on EPI or other Child Survival technologies. The advisor will also serve to identify institutions or program areas where AOPS assistance could be increased, upgraded or rendered more effective. AOPS and IHE should greatly benefit from the combination of TA which will be available to them from the VACS and REACH projects

During the course of the VACS Project, the INHSAC training program will be firmly established. As the reputation of the program becomes known, it is expected that there will be increased demand for participation by private practitioners interested in community health and PVO personnel. If INHSAC is recognized as a viable source for public health training, the MSPP may be encouraged to send its personnel there as well. As enrollment increases, support for

additional administrative and training functions (including curriculum development and training of trainers) is expected.

INHSAC is currently exploring the possibilities of affiliation with a school of public health at an American university. Such affiliation would serve to increase INHSAC's credibility in Haiti, provide instructional opportunities for short courses, generate revenues through research contracts and internships for foreign students.

After its core programs are functioning efficiently, INHSAC should consider developing some mobile training programs. These would be particularly useful to PVO personnel who cannot leave their work or family responsibilities to attend the INHSAC courses in Port au Prince.

3.1.3 Research Activities

The VACS Project will "buy-in" to several centrally-funded research/technical assistance projects which will contribute to the development of technical interventions for child survival and to improved service delivery. The research will be conducted at health facilities such as the Complexe Medico-Social de la Cite Soleil (CMSCS) or by institutions such as IHE. Technical assistance will be provided through the centrally funded projects by the sponsoring university or agency.

CMSCS, in collaboration with The Johns Hopkins University School of Hygiene and Public Health, will conduct studies on a measles vaccine referred to as the "Zagreb Strain," in Cite Soleil. The objective of this research project is to determine the minimum age at which measles vaccine can provide the greatest protection from the disease. Standard practice has been to give measles vaccinations to children no earlier than at 9 months. There is some indication, however, that infants can be safely vaccinated at 5-6 months. Those extra months of protection are extremely important for malnourished or low weight infants at greatest risk of mortality.

A proposal entitled "Determinants of ORT Demand in Haiti" has been submitted to the Harvard Institute for International Development for buy-in funding through the Applied Diarrheal Disease Research Project (ADDR). The proposal was developed by Management and Resources in Community Health (MARCH), which is the community health program sponsored by Eye-Care Haiti in Mirebalais. The study will be a collaborative effort of MARCH and IHE and will be conducted in Mirebalais.

This three-year research project will consider the problem of ORT use in Haiti and how to develop strategies to improve ORT promotion by health workers and increase its use. Specifically, several questions will be addressed: a) the factors which differentiate users from non-users; b) Of these, the factors amenable to change (decision variables) and not amenable (constraints); c) the issue of how this change can be actualized; d) the role of health providers in implementing these changes; and e) how providers will best acquire the

necessary motivation and commitment to perform their role adequate.

One of the two Child Survival Fellows from The Johns Hopkins University will be supported by VACS for her second year at IHE. She is working on a field survey and development of an evaluation tool and reporting system for the following Tier II indicators of Child Survival:

- a) the percentage of the target population which is fully immunized with various antigens by the antigen specific target age.
- b) the percentage of mothers using ORT for their child's last episode of diarrhea.
- c) the percentage of women of reproductive age using a method of contraception.
- d) the percentage of children under the age of five being regularly weighed.

As described in the preceeding section, the REACH Project will provide a long-term EPI advisor to work primarily with AOPS. REACH consultants will also be provided for short-term TA assignments on other Child Survival interventions or issues. In addition to being available to provide assistance with service delivery implementation problems, these consultants could work with IHE on the development of various operations research protocols.

3.2 Organizational Development

The establishment and development of local institutions working to improve private sector health services has been an important element of AOPS I & II and the MOMS Projects. Continued support to these institutions is necessary if they are to have a chance to develop to their full potential. "Institution building" is a long process with problems along the way. Experience acquired during the past four years now makes it possible to examine the strengths and weaknesses of the internal operations of AOPS, IHE and JNHSAC and the activities which they support. USAID/Haiti personnel as well as the institution officials, recognize that organizational and management problems are hampering program effectiveness. VACS will respond to these institutional requirements by providing long term technical assistance through a team of resident advisors with expertise in management and organization development.

Organizational development (OD), which is rooted in the behavioral sciences, is oriented towards change; change within the environment of an organization which will make it more efficient effective and consequently more productive. OD is a program of planned interventions designed to improve the management of an organization.

Just as there are differing theories of organizational development and varying strategies for implementation, every organization is different

and has a different set of problems and needs. The OD requirements of an older organization are likely to be different than those of newly created institutions such as AOPS, IHE, INHSAC and many PVOs. Much of the OD literature concerns changing the existing management styles in established organizations. While that may be needed to some degree in these Haitian institutions, of greater need is the introduction of appropriate management systems which will permit them to grow.

The management problems which AOPS, IHE, INHSAC and the PVOs are now experiencing may not be unusual in new organizations. One OD theorist who has dealt with the problems of new or growing organizations, describes periods of "evolution" and "revolution" during the organization's life. "Each evolutionary period is characterized by the dominant management style used to achieve growth, while each revolutionary period is characterized by the dominant management problem that must be solved before growth will continue."⁵

AOPS, IHE, INHSAC and the PVOs appear to be in the first stage of organizational growth called creativity. During this stage the organization's founders, who are typically technicians or entrepreneurs, have dominant leadership roles as they try to create a product and a market. During this evolutionary period, management problems will arise which cannot be adequately handled by the existing management arrangements and are outside the scope of expertise of the founding leaders. Thus the advent of the first revolutionary period during which management expertise must be sought and solutions found if the organization is to continue to function and grow.⁶

OD can foster change and growth through several different strategies which are generally interpersonal or directive in nature. The selection of which strategy to use or how to combine them must be determined by the nature of the organization, its maturity and ability and/or willingness to direct its own change or growth process. Before selecting a strategy, however, the OD practitioner must analyze the organization in order to diagnose the environment of the organization and its problems and to develop an implementation plan. Therefore the differences in organizational structures, institutional objectives and personalities within AOPS, IHE and INHSAC will make it likely that, although they may each have similar problems, different strategies for addressing the problems will have to be developed for each institution.

Management has been defined as "working with and through individuals and groups to accomplish organizational goals" and can be applied to any type of organization. Planning, organizing, motivating, and controlling are the key managerial functions within any organization or at any managerial level.

The process of management requires three types of skill: technical,

⁵ Hersey, Paul and Kenneth H. Blanchard. Management of Organizational Behavior: Utilizing Human Resources. Third Edition. Prentice-Hall, Inc., 1977, p.299.

⁶ Ibid., p.300.

⁷ Ibid., p.3.

human and conceptual.

"Technical skill: Ability to use knowledge, methods, techniques and equipment necessary for the performance of specific tasks acquired from experience, education and training.

Human skill: Ability and judgement in working with and through people, including an understanding of motivation and an application of effective leadership.

Conceptual skill: Ability to understand the complexities of the overall organization and where one's own operation fits into the organization. This knowledge permits one to act according to the objectives of the total organization rather than only on the basis of the goals and needs of one's own immediate group."

The amount of skill mix required changes at the different levels of management, however, human skill is critical at all levels.⁸

Considering the Haitian institutions to be in the first, creative stage of development, and recognizing that they are managed primarily by technicians, ie. physicians, helps focus attention on the management issues which the institutions currently face. Given the fact that they will continue to be managed primarily by physicians, the challenge is to determine the most appropriate OD strategy for each of these institutions to pursue in order to help them best achieve their objectives.

3.2.1 Technical Assistance

3.2.1.1. Institutional Management

AOPS, IHE and INHSAC are relatively young institutions, AOPS having been established in 1983, IHE in 1985 and INHSAC in 1986. While all of them are involved in Child Survival activities, their programs and objectives differ as do their administrative structures and management systems. Each institution has a unique set of problems and will require technical assistance tailored to its needs. The administrative hierarchies, methods of decision making, and lines of authority need to be assessed and possibly restructured or redefined. Financial management, information, communications and personnel systems are generally in need of remedial action. The evaluation report stressed the need to simplify and reduce the redundancies of some of the financial and administrative reporting systems.

Objective setting and long term planning are areas of priority need in all the institutions. An important output of the VACS project will be the development of long range plans for each of the institutions.

⁸ Ibid., pp.6-7.

During the life of the VACS Project the institutions will have the opportunity and assistance needed to consider their development and begin the planning that will be required for the future.

The technical assistance team will work with each institution to determine the specific needs of the institution and to develop the most appropriate implementation strategy for meeting those needs.

3.2.1.2 Service Delivery Management

The quality of services offered is greatly determined by the managerial effectiveness of the sponsoring organization. Personnel problems which result in low staff morale cause absenteeism and poor performance. Logistical problems result in supply shortages. Financial management problems result in programs operating in the red. These problems and others can be found at the AOPS, IHE and INHSAC level as well as in the PVO field programs.

One of the most critical issues for service delivery programs is that of sustainability. The ability of local communities to continue outreach programs after external resources are no longer available is unclear. Questions of financing, personnel motivation and supervision, commodities supply and record keeping must all be examined. The technical assistance team will be expected to assist AOPS and IHE develop operations research activities to thoroughly explore the issues and test potential solutions.

The provision of technical assistance for institutional or service delivery management will not be restricted to AOPS, IHE or INHSAC although they will receive the majority of attention from the TA team during the first year of residence. The PVOs operating community health outreach programs will also benefit from TA. However, it is essential to concentrate on improving the operations of AOPS, IHE and INHSAC which have been established to serve and support the efforts of PVOs over the long term.

It will be the prerogative of the TA team to determine how it can best respond to the program management needs of the PVOs. The team may choose to work directly and exclusively with the PVOs or it may choose to work with the PVOs in collaboration with AOPS and IHE. Different PVOs will have different needs, but a collaborative approach between the TA team and AOPS would be informative and instructive to both.

3.2.1.3 Management Training

During the life of the VACS Project, two or three individuals will be selected for long-term training programs in administration and management applicable to health services. The training will be at the master's degree level in an American university. Funds will be requested from the Training for Development Project.

3.2.2 Technical Assistance Team

3.2.2.1 Responsibilities and Expertise

In order to bolster its project management capacity, USAID will procure the services of an organization to manage a number of grants which will fund the operating costs of local institutions and service delivery programs of PVOs. The organization will also provide technical assistance to the institutions and PVOs in organizational and program development. The organization's responsibilities for grant management and technical assistance will be carried out by an in-country team for a period of three years. A Cooperative Agreement will be signed by USAID/Haiti and the organization selected through a competitive process.

Approximately \$1.7 million will be available to support the costs of the in-country team and related expenses of the organization. Following a pre-qualification process, organizations will be invited by USAID/Haiti to submit proposals which define the approach to the technical assistance and grant management components of the VACS Project that the organization would use. The approach will propose methods of problem identification, problem-solving strategies and technical procedures which respond to the institutional and programmatic problems which are described below. Proposals will also specify the mix of technical advisors to implement the approach: the number of long and short term advisors; expertise of long and short term advisors; the amount of short term consultations over the life of the project; positions to be filled by expatriates and Haitians; personnel to be hired out-of-country and locally.

There are financial and technical advantages and disadvantages to all combinations of advisors, i.e. long term versus short term, expatriate versus Haitian, off-shore versus local hiring, etc. Therefore the creativity that organizations display in the composition of the technical assistance team will receive significant consideration during the selection process. Of particular importance will be the overall understanding of the technical and grant management problems as reflected in the organizations' proposals.

Proposals will demonstrate the organization's experience and capabilities, as well as those of the long and short term advisors, for undertaking the TA and grant management responsibilities which the VACS Project will require.

Some of the areas of institutional weakness mentioned in the previous section which will require TA are: personnel systems, including staffing needs, job descriptions and qualifications, policies for hiring/firing, promotions, pay scales and benefits; budgeting and financial management; financial and programmatic long term planning; objective and goal setting; information and communication systems; methods of decision making and lines of authority; fund raising; proposal writing and grant management. In the PVO health outreach programs, there are problems with: record keeping and reporting systems; personnel selection, supervision, motivation and remuneration; logistics coordination and supply; community utilization of services; community participation and financing mechanisms.

After assessing the strengths and weaknesses of the institutions, the TA team will determine what in-country training needs to be provided to institutional personnel. The team will identify qualified local organizations and contract with them directly to provide appropriate seminars and workshops.

The TA team will also help in the identification and selection of appropriate candidates for long-term management training (section 3.2.1.3) and will make recommendations about the most pertinent disciplines and appropriate universities.

As part of its technical assistance role, the team will provide guidance in proposal writing and grant management for the PVOs which intend to submit proposals for community outreach program grants. The team will investigate and review all proposals submitted, request technical critique from qualified individuals, prepare comments on the proposals and make recommendations to USAID for funding concurrence.

In addition to its technical assistance role, the TA team will act as the grant maker and manager for the AOPS, IHE and INHSAC operating grants and for the PVO program grants in excess of \$50,000 or grants to non-AOPS members. Grant management will be a major responsibility of the team and will entail preparing the grant agreements, establishing the accounting procedures, monitoring the use and flow of funds, evaluating progress towards the achievement of objectives and reporting to USAID on a quarterly basis. Grants for AOPS, IHE and INHSAC will have to be prepared within three months after the arrival in-country of the team, but PVO program grants will not be awarded until the TA team has established itself and is familiar with AOPS and the community health outreach approach.

4. PROJECT IMPLEMENTATION PLAN

4.1 Authorization

The present project was included in the FY 1988-89 Action Plan under the title of "Management Assistance for Child Survival". At the Action Plan Review of February 10 and 11, 1987, the Mission was given authority to proceed with the development of the PID. The Mission subsequently developed the PID and reviewed it in May, 1987. We notified AID/W of the outcome of the PID review in Port-au-Prince 2979, in which it was stated that the project title had been changed to "Voluntary Agencies for Child Survival" and that the LOP amount had increased from the previously reported \$10 million to \$12 million. The project as described in the present document will therefore be authorized in the field for the LOP amount of \$12 million.

4.2 Procurement and Contracting Procedures

Inasmuch as contracting is key to the implementation of this project, it is important that the procurement and contracting mechanisms be spelled out in some detail here. As shown in the financial plan (section 5), there are three principal grantmaking channels: the Technical Assistance Cooperative Agreement (which in turn will serve as the channel for subgrants to indigenous PVOs), the core support grants to INHSAC, IHE and AOPS, and the AID/W-level buy-ins. Each of these will be discussed in turn below. For the purpose of clarity, the recipient of the Technical Assistance CA will be referred to in this section as the Prime Grantee.

4.2.1 Technical Assistance Grant

This is the largest single element of the project, and is composed of two parts: first, the provision of technical assistance to local PVOs active in the health and child survival sectors, and second, the development of a grantmaking mechanism through which the prime grantee will review subgrant proposals from those organizations. The Cooperative Agreement itself will thus subsume both the costs of the TA team and of the subgrants.

The prime grantee will in turn make three core support grants, to INHSAC, AOPS and IHE. Among the purposes of the AOPS grant will be to provide it with funds to make subgrants for small projects of less than \$50,000. The terms of the AOPS subgrant mechanism will be laid out in detail in the AOPS grant.

4.2.2 Direct AID grants

Provision has been made in the budget for direct AID grants under the project, and the Mission has already received three grant from local organizations. These are for the Haitian Health Foundation (HHF), the African Methodist Episcopal Church (AMEC), and UNICEF. Other grant proposals will be solicited over the course of the project. AID/W has been notified about the nature of the first three grants, but the Mission must solicit specific authority to allow for negotiation of

those Cooperative Agreements without consideration of other sources. Because UNICEF is an international organization, AID can provide a grant (OPG) directly without considering other sources.

4.2.3 AID/W Buy-ins

There are four buy-ins for ongoing direct contracts and cooperative agreements to be funded from this project, as shown in the Financial Analysis and the Methods of Implementation and Financing table. Arrangements have been made to transmit the appropriate PIO/Ts to AID/W for negotiations of three of the buy-ins this fiscal year before the closing date arrives. The four buy-ins are the following:

Measles vaccine research and one Child Survival Fellow, through the Johns Hopkins University;

Research on ORT demand in Haiti, through the Applied Diarrheal Disease Research Project of the Harvard Institute for International Development;

Long-term technical assistance for immunization program development and short-term Child Survival technical assistance, through the REACH project with John Snow, Inc. (for FY 1988); and

Service delivery activities for immunization, through a collaborative AID/W/LAC/DR and PAHO project.

Because these are ongoing, centrally-funded grants and contracts, there are no issues relating to competition which demand Mission attention.

4.3 USAID Monitoring Requirements

Although the raison d'etre of the project lies in its relieving the Mission of the management burden of so many subgrants, it is nevertheless a management-intensive project. All of the grants, subgrants and contracts will require unrelenting Mission oversight, as detailed below:

4.3.1 Project Management

The project demands the attention of a full-time project manager within PHO, at least during the first year or two of implementation. That person will in turn recruit a project coordinator. The role of the project coordinator will be to monitor the day-to-day implementation of the project and to report to the Project Officer on the progress of the technical assistance program and the subgrant process. The Coordinator will act as a liaison between the Mission, the prime grantee and the subgrantees. The Coordinator will review funding requests and vouchers, and will aid in commodity procurement and the preparation and submission of annual grantee and subgrantee work plans and budgets. Because the Coordinator will play such an important role in providing information to grantees, it is important

that this person be recruited as early in the life of the project as possible.

4.3.2 Evaluation

A mid-term evaluation which will be project-funded is planned for the end of the second project year. The mid-term evaluation will assess the performance of the TA team, AOPS, IHE, INHSAC, HHF and AMEC to determine if the project purpose and level of outputs are being met in accordance with the implementation schedule. The evaluation team will assess overall project management, technical assistance and the role of the project coordinator. The evaluation team will make recommendations to resolve any problems in project management and program implementation.

Whether a final evaluation will be necessary will be determined near the end of the project. That evaluation will be mission-funded, unless an impact evaluation is called for, in which case arrangements may be made with AID/W to assist with funding. Among the more interesting issues for that evaluation to examine are the future role of AID in supporting private-sector health programs.

Funds have been budgeted for a public accounting firm to provide accounting and financial management services. The financial management review will be scheduled after the mid-term evaluation in order to add to the scope of work any financial or internal control weaknesses noted during the mid-term evaluation.

4.3.3 Contracting

The Prime Grantee will be chosen competitively, and the Mission will solicit expressions of interest and statements of qualifications from appropriate US-based organizations early in the life of the project. A Mission review committee will evaluate the submitted documents and invite those best qualified to submit a proposal. Once an organization is chosen, AID will negotiate a Cooperative Agreement with it which will describe the terms of the technical assistance and the subgranting mechanism in detail.

The AID direct grants will be negotiated noncompetitively, with appropriate authority obtained from AA/LAC.

The principal issues relating to contracting not discussed directly above concern the arrangements between the prime grantee and the subgrantees. While the final mechanism for subgranting cannot be worked out until the prime grantee is chosen, the broad details of the procedure will be as follows:

The prime grantee will propose a mechanism for reviewing and evaluating proposals from local PVOs. Typical proposals will be sponsored by PVOs already providing health care services, and will request an LOP funding greater than \$50,000 to implement child survival community outreach services. (Grants smaller than \$50,000 will be handled by the AOPS umbrella grant.) The prime grantee will

Project Officer may convene a Mission panel to review the proposals and dossier before concurring. Once USAID concurrence is obtained, the prime grantee will proceed with the awarding of the grant. Monitoring and payment will be the responsibility of the prime grantee, which will provide USAID with regular implementation reports.

4.3.4 Reports

The following reports will be submitted by the prime grantee:

The direct AID grantees (HHF, AMEC and UNICEF) will provide the following reports, for review by the Coordinator:

First, quarterly implementation reports, covering activities initiated or completed during the reporting period and progress to date;

Second, quarterly financial reports for expenditures incurred during the quarter, and projected expenditures for the next quarter, or such other financial reports as might be required by the AID Controller;

Third, annual implementation plans covering scheduled project activities for the coming year, staffing requirements and annual budgets indicating local currency needs; and

Fourth, reports on any commodities received and distributed over the quarterly reporting period.

Other reports may be required as well, depending upon the specific nature of the grant, and these will be specified in the grant agreements with these organizations.

4.4 Disbursement Procedures

A table showing the Methods of Financing is given below, broken down by individual grants and contracts.

4.5 Methods of Implementation and Financing

TA	Type of Assistance	Method of Implementation	Method of Payment	Amount
TA Organization (Includes Subgrants)	Coop. Ag	US Organization	Periodic Advance or LOC	\$8,617,000
Project Coordinator	Direct Contract	PSC	Direct Pay	183,000
HHF	Coop. Ag	US PVO	Direct Reimburse or Periodic Advance	850,000
AMEC	Coop. Ag	US PVO	Direct Reimburse or Periodic Advance	600,000
UNICEF	Grant	Non-profit Int'l Organization	Direct Reimburse	400,000
PAHO	Grant (buy-in)	Non-profit Int'l Organization	Direct Reimburse	405,000
REACH	Direct Contract (buy-in)	Profit Making Contractor	Direct Reimburse	500,000
Johns Hopkins	Coop Ag (buy-in)	University	LOC	245,000
ADDR (Harvard IID)	Direct Contract (buy-in)	Non-profit Organization	Direct Reimburse	100,000
Financial Mgmt Review	Direct Contract	Profit Making Contractor	Direct Pay	50,000
Evaluation	Direct Contract	Profit Making Contractor	Direct Pay	50,000
Total				\$12,000,000

The prime grantee will be responsible for establishing a system of payment for each of the subgrants which conforms to the guidelines of USAID's Grantee Manual on Fiscal and Accounting Procedures. Once the system has been established, the Mission should not need to oversee directly any advances or reimbursements.

4.5 General Covenants

Covenants will be written into every subgrant relative to the institution.

The following illustrative covenants may be used for AID direct grants under the project:

Prior to approval of any subgrant under the project, USAID/Haiti will:

review and approve all subgrants and subgrant agreements to the core participating institutions, and any amendments to these subgrants, prior to their execution;

review and approve any proposed change of personnel from those mentioned in any proposal to be funded under the project;

review and approve plans for (a) publicity and information dissemination; (b) evaluation; (c) resource development activities; (d) technical assistance; and (e) international travel, prior to authorizing disbursement for these line items; and

review and approve the subgrantmaking mechanism for the AOPS cooperative agreement, to assure that proper accounting systems and qualified financial personnel will be in place.

4.6 Project Implementation Schedule

<u>Activity</u>	<u>Date</u>
1. Project Paper Approved	July, 1987
2. 1st Obligation	July, 1987
3. Buy-In PIO/Ts Signed	July, 1987
4. Advertisement for Letters of Application (for TA/Grant Mgmt)	August, 1987
5. Cooperative Agreements signed with Haitian Health Foundation African Methodist Episcopal Church	September, 1987
6. Grant Made to UNICEF	September, 1987
7. Child Survival Fellow Starts 2nd Year	September, 1987
8. Letters of Application Received, Reviewed & Proposals Requested from Qualified Organizations	October, 1987
9. Annual Child Survival Report (IHE)	October, 1987
10. Project Coordinator Recruited	December, 1987
11. Proposals Submitted & Reviewed	December, 1987
12. Proposal for TA/Grant Mgmt Selected	January, 1988
13. PAHO Immunization Project Begins	January, 1988
14. Cooperative Agreement for TA & Indirect Subgrants Signed	February, 1988
15. Measles Study Begins (Hopkins/CMSCS)	February, 1988
16. TA Team Arrives in Haiti	March, 1988
17. INHSAC Begins 2nd Year of Courses	March, 1988
18. Seminar to Present Results of 1987 Mortality Survey (IHE)	March, 1988
19. Grants Prepared by TA firm for AOPS, IHE, INHSAC	April, 1988
20. TA Team Submits Workplan	April, 1988
21. AOPS Begins Making Subgrants to PVOs	May, 1988
22. REACH Long Term Advisor Arrives in Haiti	May, 1988

23. ADDR Project Study Begins	July, 1988
24. 1st Short Term, In-Country Training Course	August, 1988
25. 1st "Open Season" for PVO Proposals Announced	September, 1988
26. Annual Child Survival Report (IHE)	October, 1988
27. PVO Subgrants Signed by Grant Mgmt Organiza.	November, 1988
28. Short-Term In-Country Training Course	January, 1989
29. Participants Selected for Long-term Training in the U.S.	February, 1989
30. INHSAC Begins 3rd Year of Courses	March, 1989
31. 2nd "Open Season" for PVO Proposals Announced	April, 1989
32. Final Evaluation of MOMS Project	April, 1989
33. PVO Subgrants Signed by Grant Mgmt Organ.	July, 1989
34. Financial Management Review	July, 1989
35. 3rd Open Season for PVO Proposals	September, 1989
36. Annual Child Survival Report (IHE)	October, 1989
37. PVO Subgrants Signed by Grant Mgmt Organ	November, 1989
38. Short-term In-Country Training Course	December, 1989
39. 3rd Obligation	December, 1989
40. VACS Mid-term Project Evaluation	February, 1990
41. INHSAC Begins 4th Year	March, 1990
42. Financial Management Review	April, 1990
43. 4th Open Season for PVO Proposals	April, 1990
44. INHSAC Affiliates with a U.S. University	May, 1990
45. PVO Subgrants Signed	July, 1990
46. Short-term In-Country Training Course	August, 1990
47. Annual Child Survival Report (IHE)	October, 1990

- | | |
|---|----------------|
| 48. Final Obligation | December, 1990 |
| 49. Visit by LAC/DR/HPN Staff | January, 1991 |
| 50. Begin Planning of 1991 National Mortality
and Service Utilization Survey | January, 1991 |
| 51. INHSAC Begins 5th Year of Courses | March, 1991 |
| 52. TA Team Leaves Country | April, 1991 |
| 53. Individual Grantee Evaluations | May, 1991 |
| 54. Field Data Collection for National Survey | May, 1991 |
| 55. PACD | June, 1991 |

5. PROJECT ANALYSES

5.1 Technical Analysis

The VACS Project is designed to capitalize on the successful community outreach strategy currently being used in Haiti for making child survival technologies available to increased numbers of the population at risk. Experience to date with the population-based approach indicates that it is far more effective in obtaining adequate coverage of services than the passive approach to service delivery available through fixed facilities. The 1986 PRITECH evaluation found that "AOPS is a successful model for expanding primary health care coverage and reducing infant mortality."

The project will increase the number of PVOs with child survival outreach programs, expand the catchment population of existing outreach programs and/or increase the health interventions being offered by the program. Under the VACS Project, it is expected that 1,000,000 people in addition to those currently being served by outreach programs will be located in the new and/or expanded catchment areas.

Like the AOPS I & II, the Mobilizing Mothers for Child Survival, and the Urban Health and Community Development Projects, VACS-sponsored child survival outreach programs will promote preventive health interventions, education and greater involvement of mothers in the health care of their children. While being able to capitalize on the successes of the basic implementation strategy, the experience to date will permit new and existing programs to benefit from the "lessons learned" and to refine the approach with the technical assistance that will be provided by VACS.

Long and short term technical assistance will be available throughout the life of the project to address the organizational and service delivery management problems which have become apparent to USAID and PVO officials. The findings of the evaluation report and the acknowledgement within the institutions themselves have already brought to light some of the major weaknesses of administrative and programmatic structures. The expertise of the TA team will help define the problems and identify methods to improve the functions of the institutions and the services they offer.

5.1.1 Feasibility and Impact

PVO community outreach programs are proving to be a feasible way to make low-cost health care available to people who otherwise have very limited access to service. Statistics show that for the registered portion of the 400,000 catchment population covered under the AOPS I & II Projects:

- 33% of mothers say they used ORT for their child's last episode of diarrhea
- 52% of children under 5 had received their third DPT shot
- 50.9% of targeted children had received polio vaccinations

- 54% of targeted children had received measles vaccinations
- 58.6% of targeted children had received BCG vaccinations
- 50.9% of targeted children had growth cards
- 7.2% of women in union report using a modern method of family planning.

Mobilizing Mothers for Child Survival Project, within the registered catchment population:

- 30% of mothers report using ORT for last diarrhea episode
- 15% of children 12-23 months of age received DPT vaccinations
- 12.9% of children received the third dose of polio vaccine
- 13.6% of children received measles vaccinations
- 29.7% of children received BCG vaccinations
- 16% of children had growth cards
- 5.3% of women in union report modern contraceptive use.

The CMSCS has been providing preventive care and health education to Cite Soleil residents for 10 years. During that time the infant mortality rate has declined from 200/1000 to 80/1000. In 1986 the incidence of neonatal tetanus was zero.

While utilization rates have not yet reached the targeted objectives, these statistics indicate what coverage can be provided within a relatively short time period and can have significant impact.

5.1.2 Factors Affecting Service Utilization

A three-phase study for the purpose of developing a screening tool for use by health personnel serving population-based systems, identifying the high-risk segment of the population not using services, and determining if low use is associated with poor health status has been started in Haiti. During the first phase, which has been completed, maternal knowledge and perceived reasons for non-use were investigated using qualitative research methods.

Service providers, service users and non-users were interviewed to identify barriers to immunization use, which were then used by the survey as a proxy for service utilization. The barriers were categorized by the researcher into "user factors" and "system factors."

It was found that among users, the most important barriers to immunization use are competing priorities such as meeting the daily subsistence needs of the family and completing household chores; market activities for buying, selling and socializing; and family problems such as illnesses which deplete household finances or marital discord.

Lack of motivation was another barrier. This encompassed a low value

⁹-----
Coreil, Jeannine. "Maternal Factors in the Use of Preventive Health Services in Haiti. A Qualitative Assessment of the Characteristics of Users and Non-Users of Immunizations."

attributed to health within some families and may extend to being negligent about seeking curative as well as preventive care. Other people were not convinced of the utility of immunizations. Some women were discouraged by their child's lack of growth despite their efforts and discontinued the immunization series. A few women were fatalistic about a child's chance of survival and found preventive measures not to be worthwhile.

The cost of the services was not a barrier to use since they are provided for free, but other economic constraints, such as travel costs and the demands of daily subsistence were influential. Not having proper or clean clothes made women reluctant to attend the rally post with their children.

Some women expressed fear about the side effects of immunizations. For those mothers whose children had unexpectedly developed fevers or swelling after the first immunization, there is great reluctance to continue the series.

The manner in which mothers were treated at the rally posts by the health personnel was a factor in determining continued use. Some women had been embarrassed or insulted by the way in which the health personnel addressed them or discussed their child's poor health status in front of other women.

Generally it was found that women have very little understanding of the immunization schedule, the required doses and the diseases which the vaccines can prevent. Having very little knowledge about immunization and its importance, the mothers were not adequately motivated to bring their children to the rally posts.

System or program factors were considered to be less important than user factors in perceptions of underutilization. The accessibility of the rally post is an important factor. Poor roads frequently make it difficult for the health team to arrive on time or even on the scheduled rally post day in isolated areas. Unpredictability of the rally post schedule and inconvenient location were more influential factors in non-use than was distance. Rally posts held at inconvenient times which conflict with other activities, i.e. the market, or at peak market hours which attract large numbers of people thus requiring long waiting periods, discourage attendance. Inadequate notification in the community of upcoming rally posts also contributes to low attendance.

Mothers' satisfaction with the services and the way they are treated by the personnel are important. The curative services offered during the rally posts are strong incentives to attend if the services respond to the clients' felt needs and are affordable. Five gourdes (\$1.00) for a consultation was considered by clients to be too expensive.

Overall, user rather than system factors appeared to be more influential as barriers to service utilization. System factors, however, are more amenable to change which could encourage use and

increase immunization coverage. Although it is not feasible to try to change all system factors which negatively effect utilization, the study report suggested that consideration be given to the following programmatic revisions:

- use animal transport rather than vehicles for the health team in areas where access is poor and/or unreliable.
- retrain health personnel to be more sensitive in the way they deal with clients.
- use gifts as incentives for rally post attendance.
- improve the rally post notification system.
- minimize scheduling conflicts with other community activities.
- improve collaborator utilization of social networks to encourage new mothers or non-users to attend rally posts.

5.2 Social Considerations

5.2.1 Beneficiaries and Project Location

The beneficiaries of the VACS Project will be children under the age of five and women of reproductive age. These people constitute the group within the Haitian population at greatest risk of morbidity and premature mortality.

The MSPP, which receives financial assistance from USAID as well as other donor agencies, is unable to adequately provide and maintain services in many areas of the country. To fill the gap, approximately 200 PVOs both foreign and domestic, are providing health care in Haiti. VACS-supported PVO service delivery programs will be located throughout Haiti, primarily in rural areas which are under- or unserved by the MSPP.

Eighty percent of the Haitian population lives in rural areas and is generally illiterate, poor and has limited access to social services. The economic and environmental conditions undermine the health of rural people early in their lives.

5.2.2 Participation

The change in government which occurred in February, 1986, has resulted in a transitional period for Haiti. This transition is likely to continue for the next few years as a new, democratically chosen government takes office and begins to institute new policies. The Haitian people, repressed by the former government for almost three decades, are frustrated by the economic and social conditions of the country and are anxious for change.

Although Haitian communities are not generally characterized by feelings of cohesion or a collective good, in the past there were usually a few people who were willing to volunteer some of their time for community efforts. It was on these volunteers that many PVO programs relied for assistance and community motivation. The changing political climate and worsening economic conditions, however, now make it difficult to find community collaborators willing to work on a

strictly voluntary basis.

Haitians are not well acquainted with concepts of participation and community development since the government thwarted most efforts of community organizing during the last 30 years. The majority of the Haitian population has never enjoyed the freedom to congregate or organize. The formation of political parties and power brokering in preparation for the up-coming national election may provide the initial steps in community organizing. So despite many problems, this transitional period may provide opportunities for community development unknown in Haiti for many years. Establishment of community councils, mothers groups, income-generating activities and credit schemes may be ways to consolidate interest and support for community health programs.

Local participation and support are essential factors in project sustainability. Perhaps now more than ever before, PVOs may be able to mobilize interest and create a demand for their services. Only when people have access to reliable, affordable services which respond to their needs are those services valued and sustained. Therefore, it is up to the PVOs to provide quality service.

5.3 Institutional Analysis

5.3.1 Summary

The Association of Private Health Organizations (AOPS), the Haitian Child Health Institute (CHI) and the Haitian Community Health Institute (INHSAC) are private institutions which have been created to meet particular needs of the Ministry of Public Health and Population (MSPP)-mandated Priority Health Programs/Nouvelle Orientation, designed to attain the goal of Health for All. Both AOPS and INHSAC are recognized by the GOH as Private Voluntary Organizations (PVO). The IHE has completed all requirements and filed for PVO status but, to date, has not been officially recognized as such.

The AOPS was created in 1982 with both the blessing and assistance of the MSPP. USAID provided core support and funding for initial program activities. Originally designed to promote and coordinate PVO participation in the Priority Programs, during its first three years AOPS became increasingly involved in every aspect of Primary Care Service Delivery through the private sector, including such areas as research, training, management, logistics and others. Although AOPS' role grew and expanded, its original mandate and strategy of promotion and coordination remained the same. The need for other institutions to assume the responsibilities of certain program areas (e.g., training and research) became evident.

In 1985, with the launching of AID's Child Survival Action Program (CSAP), Haiti, with the poorest health indicators in the Western Hemisphere, was deemed a priority or emphasis country. AID funds were made available to support a new health project in the private sector called "Mobilizing Mothers for Child Survival" (MMCS). Included in the MMCS Project were funds to create two new institutions, the IHE and INHSAC. In the sense that both IHE and INHSAC are directed and staffed by individuals who have been intimately associated with AOPS, and both organizations began with program activities which had already been underway under the AOPS umbrella; neither should be viewed as an entirely new partner in the Haitian health community. Both are, in fact, offspring of AOPS. Though their physical settings are new and their roles more clearly defined or focused than AOPS', they have been created not to meet new needs, but to meet the ongoing needs and address issues related to the rapidly expanding role of the private voluntary sector in the national priority health programs. In this context, IHE and INHSAC are not nascent institutions, but bordering on adolescence, much like AOPS, which is only a little further along in terms of organizational development.

At this stage in their development, AOPS, IHE and INHSAC share many of the same needs and problems that other growing organizations do. As they prepare to meet increasing demands, serve more clients, provide more services and struggle for self-sufficiency, their operational and management systems must evolve and develop more businesslike characteristics. Management and administrative procedures must change from informal to more formal; responsibility and authority need to be increasingly delegated away from the center; information systems must

be automated; training must change from ad hoc to continuous programs, including retraining; and every activity must be accompanied by questions of affordability and sustainability. All three organizations must develop an ability to carry out self-assessments and re-think their strategies on a regular basis, to respond to an ever-changing environment. All this must be accomplished, too, without losing the basic essence of being PVOs -including flexibility, shared values and attitudes, a service orientation and a certain independence or freedom from the constraints faced by government agencies.

5.3.2 Description

5.3.2.1 AOPS

AOPS was created in 1982 to coordinate the participation of the Haitian private voluntary sector in the National Priority Health Programs; and to promote a particular model of primary care delivery. The model is based upon outreach using community health workers (1/1000 population) at highly accessible assembly points (rally posts) such as a school, church, marketplace or unoccupied house, to deliver primary care/child survival services on a regular and frequent basis (every 4-6 weeks). The health workers, selected by the community, are trained, supervised and supported by a team from a nearby health facility, including at least one physician, a nurse and a recordkeeper. The team from the fixed facility attends each rally post, bringing necessary supplies (ORS, vaccines, scales, drugs); and the community health workers organize and announce the rally post, assist with service delivery and are responsible for follow-up of identified problem cases. Fundamental to this model is the total population registration which is conducted by the community health workers and fixed facility team prior to the initiation of rally posts.

AOPS provides training of the fixed facility's physician to implement the model, and initial funding to carry out the census (registration), obtain supplies and initiate a small community development or income generating activity to attract or encourage participation in the program. AOPS-supported institutions now serve populations ranging from 10,000 -100,000 people, at a start-up cost of \$1 per person. Grants of \$10,000, \$25,000 and \$50,000 have been issued to member organizations to implement the Community Health Outreach Program.

Of the over 200 health PVOs in Haiti, approximately 90 are AOPS members. Almost 40 are recipients of funds and support to implement the Community Health Outreach Program. An AOPS institutional membership costs \$100 per year, which contributes to headquarters support - staff salaries, operating expenses, meetings and seminars, and quarterly publications/newsletters. To date, in addition to its membership dues, USAID has been nearly the sole financial support for AOPS.

AOPS is very much a member-run organization. The 90 person General Assembly (1 representative from each member institution) elects and

empowers the 15 member Executive Board to direct and monitor the Management Committee, which is composed of the President, Secretary-General and Treasurer. Until recently the Management Committee was responsible for providing day-to-day management and supervision of all AOPS activities and its full-time staff. These duties were carried out on a voluntary, part-time basis. In 1986, with an increasing number of activities and a corresponding need for increased management and supervision, AOPS created two new full-time professional positions: Technical Director and Executive Director. The Management Committee continues to oversee the efforts of the two new directors, but is no longer to maintain day-to-day control.

The current structure continues to call for strong member participation in the direction of AOPS, and the transition to professional full-time management has not yet been entirely successful. The transfer of responsibilities to the new directors has not been complete (e.g., the Management Committee continues to sign checks and be involved in procurement); responsibilities are not clearly defined between the two directors; management practices and procedures are not clearly articulated; and the links or relationships between different elements of the new structure have not been clearly established.

Included in AOPS' core staff are administrative personnel and technical staff including three area (geographic) coordinators, a coordinator for evaluation and statistics, and a coordinator for MCH/Family Planning. The coordinators are responsible for the technical development and technical quality of grantee programs. They travel extensively to monitor, supervise and provide technical assistance as needed. Currently the coordinators are supervised by the Technical Director. The Technical and Executive Directors report separately to the Management Committee; and there are no clear links between administrative and technical personnel, activities or responsibilities.

As a result, there has been little progress in implementing the recommendations of an April 1986 evaluation which addressed management, financial, technical and operational issues. The 1986 evaluation, conducted by PRITECH, points to areas of weakness and sets forth recommendations which continue to be valid and necessary if AOPS is to become a more solid, responsive institution - able to truly coordinate the efforts of the private sector in Priority Programs. The following are excerpts from the recommendations offered one year ago by PRITECH:

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...

The accounting system only collects 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 trends between these costs provides some measure of AOPS' 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. ...Without these changes, the possibilities for fruitful analysis at the AOPS level are limited.

In primary health care programs, incentives which are directly linked to an individual's performance seem to be the most appropriate.

...issues for sustainability are essentially issues of staffing. A much discussed phenomenon is that of doctor turnover. The rate is not low: that is, loss to individual projects is not low: of the 45 doctors trained in the Community Health Program..., 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 projects and represents a loss of training investments.

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.

AOPS would profit from someone on the staff with management, more specifically, micro-management skills, to help projects set up their programs, develop more 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.

Approvals for new projects or extensions of existing projects should pend a central management investigative visit by the Executive Director and AID Project Officer.

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 practicum.

Doctors should be screened by AOPS central management before being supported for training...

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.

All archivistes should rotate through a re-training exercise as soon as possible. ... They should be trained for one week, with the team doctor ... 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.

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 feed-back 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.

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.

All AOPS...documents and correspondence should be dated with day, month, and year, and authorship attributed.

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 there 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.

AOPS should consider recommending a standard policy for cutoff of provision of (AOPS) services.

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.

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.

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 projection copies made of every technical report in any case.

Project dossiers need cleaning out, dating, and refileing 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 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.

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.

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.

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.

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 by 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 conclusion, 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 incentive 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.

(End of PRITECH Evaluation excerpts).

In short, AOPS must get its own house in order. The mandate from its membership is clear: to provide support and assistance which will enable PVOs to develop effective and efficient primary health care service delivery programs. To do so will require that AOPS itself develop more adequate and appropriate (businesslike) management systems. Current areas of weakness are not surprising, given the rapid growth of coverage and responsibilities AOPS has sustained since its inception.

AOPS has succeeded in modifying its structure and some of its operating procedures to accommodate requirements made apparent through the PRITECH evaluation. The new project, VACS, will provide resources and technical assistance necessary for AOPS to continue and improve the implementation of these and subsequent changes. If AOPS aims to play a leadership and coordinating role in the evolving Haitian environment, it must further develop the will and ability to undergo regular self-assessment; re-think and alter its strategies appropriately; and create the businesslike attitudes and practices which will enable it to institutionalize rational methods of delivering health care services to the Haitian population, and sustain these efforts.

5.3.2.2 IHE

The IHE was established in 1985 to serve as a research and documentation center for Primary Health Care/Child Survival; and to coordinate the identification and provision of technical assistance to private health institutions (both members and non-members of AOPS). Start-up funds were provided under the MMCS Project to hire core

staff, procure facilities, support operating expenses, undertake limited research and provide some technical assistance to Child Survival PVOs. Until very recently the IHE operated out of the AOPS office building, shared some AOPS facilities (including personnel in key positions) and focused its efforts on AOPS-member institutions. For many on the outside it has been confusing and difficult to distinguish IHE from AOPS. For those on the inside, however, the creation of a new organization has been very real; fraught with the difficulties of setting up shop, hiring personnel, defining roles (both individual and institutional), providing services, launching program activities, seeking a broad base of support and trying to satisfy donor demands for results, productivity and clarity.

Fortunately, the technical domain of the IHE (research and technical assistance) was already budding in a previous incarnation, as activities of AOPS. The Director and Executive Board of IHE were intimately linked to AOPS and well known to USAID, thus eliminating the need to spend start-up time and resources on becoming familiar with the context and environment for this new institution.

Before operations even began, the committee representing AID-funded Child Survival projects (U.S. based and Haitian PVOs) in Haiti, requested that, as one of its research activities, the IHE take charge of monitoring, evaluation and technical assistance for the Haiti Child Survival Program. This was the first major technical task assigned to the IHE - and would involve a series of surveys, studies and field activities over several years. Resources to support this effort were provided under MMCS and the second year of AID's CSAP.

Recognizing the tremendous potential for such an institution to coordinate and facilitate PHC research in Haiti, many U.S. and international organizations have been quick to try to link up with and support the IHE (the NAS, AID-funded research program, UNICEF, Applied Diarrheal Disease Research - ADDR Program, and a variety of prestigious U.S. universities and schools of public health). This, along with USAID's generous support, has had an ambiguous effect on the organizational development of the IHE. On one hand, it is an extraordinary accomplishment to demonstrate such a broad base of support for a new and, as yet unproven institution. On the other hand, each contribution to the IHE comes with its own set of requirements, pressures and demands to demonstrate progress and achievement - thus forcing almost all institutional attention, energies, resources and efforts to be directed toward technical activities - and leaving organizational development and institutionalization efforts trailing far behind.

Although the IHE has neither the depth nor breadth of experience that AOPS has, it is not unwise to assume, and prepare for the eventuality, that it will face the same organizational problems as AOPS (e.g., strategy, management systems, administrative procedures, information flows, financial management, sustainability). If these problems are not anticipated, and warded off early, the IHE risks its ultimate survival, and the valuable contributions it might offer to improve the delivery of primary care/child survival services in Haiti.

Within the context of a very unstable political environment in Haiti; the unpredictable ebb and flow of donor support; and the tenuous nature of GOH support for the private health sector, it is best not to try to accomplish too much too fast. The IHE leadership should pause for a moment - and reflect seriously about how the Institute should develop over the next several years. To date, little serious long-term planning has taken place based on any rational strategy. Rather, the IHE has responded (not inadequately, it must be noted) and reacted to immediate influences, such as the availability of resources and funding, with little consideration for the effects on the larger picture of institutionalization or long-term organizational development.

It is important to note, however, that, even with its multitude of technical preoccupations, the leadership of the IHE has given some thought to institutional development issues, and has requested short-term technical assistance in management, financial management and organizational development. While ad hoc short-term TA may serve to help identify specific problems and propose solutions or means to arrive at solutions, through the VACS Project it will be essential to provide the IHE with long-term assistance which is both vigorous and sensitive. Advisors who are familiar with a variety of organizations at different stages of their evolution will be required to help the IHE articulate a rational strategy; plan according to that strategy; and allocate resources in a way that clearly supports its plans. Management and administrative systems should be developed as tools which can be used by the IHE personnel to assure the success of planned activities, and the meeting of institutional objectives.

The institutional issues which currently, and will likely continue to plague the IHE include: personnel management - staffing patterns, recruitment processes, personnel performance evaluation, salary scales, motivation and incentives; financial management - accounting, program budgeting, controlling recurrent costs, reporting to a variety of donors, and revenue generation; logistics - vehicle distribution and control, computer access, distribution of office space, and flow of documentation and information; and management/coordination of expatriate technical assistance - logistic support, provision of counterparts, scheduling of short-term consultants, and institutionalization of transferred skills and techniques--to name just a few. All of these issues will need to be formally addressed under the VACS Project.

5.3.2.3 INHSAC

This newest of the Port au Prince based Child Survival PVOs was officially established in May 1986 as an outgrowth of both AOPS' physician training in community health outreach and the Complexe Medico-Social de la Cite Soleil (CMSCS) training of a variety of health professionals and paraprofessionals in primary care service delivery. Like the IHE, INHSAC was mandated by the Child Survival Coordinating Committee to take charge of the variety of training efforts required to implement the Haiti Child Survival Program. Also

like the IHE, resources were provided under MMCS and 1986 CSAP to establish the institution.

The INHSAC has a permanent staff of five professionals, a part-time curriculum committee and an impressive list of occasional, part-time instructors/professors including doctors, MSPP officials, community development experts, expatriate professors and other international luminaries from the field of Public Health. Eventually INHSAC intends to have a full-time core teaching staff.

Only recently did INHSAC move into its new permanent facilities, which are located in Cite Soleil, and begin to implement its curriculum (a modularized program of public health/child survival training activities). Until then the program was an ad hoc combination of CMSCS training, AOPS doctors' training and special courses developed for Child Survival PVOs.

It is premature to assess how INHSAC, in its own locale, with its own program, is performing. To date, however, in its makeshift form, INHSAC has responded well to requests for training from AOPS and other Child Survival PVOs. INHSAC has also made significant efforts to coordinate activities, approaches, materials and course content with the MSPP. INHSAC is working to convince the MSPP to send its staff and students from State run health professional schools to INHSAC for training in community and primary health care.

INHSAC will serve as the base for a variety of training under Child Survival and other USAID-funded health and population projects. The demand is strong to provide high quality, technically appropriate, timely and effective training - including training in management and program administration. Though INHSAC itself is new, it is built upon a broad base of training experience, a thorough understanding of Haitian health systems and the programs it is to serve, and a strong will to become a reknowned institute of public health learning.

As part of MMCS and the MSPP's Rural Health Delivery Systems Project, INHSAC will also be the base for AID's Centrally-funded HEALTHCOM, Communications for Child Survival Project. A long-term advisor for the development of communications, education and mass media activities to promote ORT and EPI is housed in and operates out of INHSAC. This activity/arrangement might also serve to increase collaboration with the MSPP.

Since its inception, INHSAC has been clear about its objectives, curricula, internal regulations and overall management practices, including rules governing participation in INHSAC courses. For its current tasks and duties, INHSAC seems well suited and organizationally prepared to execute its responsibilities adequately and appropriately.

There is some fear, however, on the part of donors and some local institutions, that the founders of INHSAC have ambitions of it becoming a certified international school of public health. These fears include the notion that INHSAC will try to develop too quickly,

doing too much too fast; that it will abandon the current essential training services it is being created to provide; and that it will be a bottomless pit for donor funds, with no end to recurrent costs. These fears may be unfounded; and are certainly premature. It is encouraging to find that the leaders of INHSAC are considering long-term goals; are facing the inevitability of organizational evolution and are trying to channel that evolution in a positive direction; and are giving thought to income generation through future activities in order to sustain the essential training activities which donors are anxious to fund today. Of equal importance, however, is to encourage INHSAC to evolve rationally - and in its current environment, slowly. Like AOPS and IHE, INHSAC will have important management, administrative and organizational development issues to face. It must move systematically through an organizational maturation process before new goals and major expansion are attempted. The VACS Project should provide the technical assistance and develop the management tools needed to do so.

5.3.3 Conclusions

AOPS, IHE and INHSAC are three separate organizations with different mandates, different organizational goals, different management structures and different personalities. As numerous as their differences, however, are the qualities and characteristics they have in common. All three are at a rather critical (make it or break it) juncture in their organizational development; all rely heavily on donor (especially USAID) funding; and all are created to improve and expand the delivery of primary health care/child survival services in Haiti. They are indigenous PVOs which started small and, due to their success, have been called upon to provide more services, serve a growing number of clients and often replace or compete with more costly, imported expatriate services. AOPS, IHE and INHSAC are all highly visible within the Haitian and the international public health communities, and have a very short window of time in which to prove their viability.

In order for these organizations to survive, grow and flourish, there are some fundamental qualities they must all adopt. First, they must develop a "marketing orientation." This means they must take time to assess, with their clients (Haitian and U.S. PVOs, MSPP, research programs, U.S. universities), existing needs and the services they can provide to meet those needs. Although marketing does not necessarily mean profit making, eventually they should examine potential for marketing their services for a fee. It is possible, particularly for IHE and INHSAC to develop high quality, culturally appropriate training and technical assistance services which would merit both local and international purchasing. INHSAC, for example, should consider creating courses which would be attractive and useful for health care professionals from Francophone African countries. USAID Missions in Africa might consider sponsoring participants. The IHE might develop an approach to providing technical assistance which would enable it to compete or collaborate with U.S. or international consulting firms. Revenues generated from these and other activities could help sustain the activities of expanding and improving health

care in Haiti.

To develop these or other advanced organizational orientations, AOPS, IHE and INHSAC will need to become more businesslike. They must be clear about their own roles; where they overlap and should support one another, and where they should remain independent. They must develop an ability to conduct organizational self-assessments - pinpoint management problems; determine operational, recurrent and overhead costs; identify growth opportunities; and develop rational strategies and action plans. They must develop appropriate management tools which will enable them to track activities, progress and problems and control the quality of services they provide. And, they must institutionalize the systems which allow them to function best. This will call for intensive and ongoing training of personnel; formalization of administrative procedures; delegation of authority and responsibility to appropriate levels of their management systems; and complete openness to periodic evaluation and re-assessment of strategies, policies and procedures.

The VACS Project should provide the resources and technical assistance to help AOPS, IHE and INHSAC continue their organizational evolution in the most positive and productive manner possible. Technical assistance should bring substantial skills which can be transferred effectively to institutional and program managers. Management tools should be developed which are effective, flexible and adaptive to a changing environment. The institutions themselves, AOPS, IHE and INHSAC should prepare for some very critical self-assessment; and be open to developing their own new attitudes and "nouvelle orientation".

5.4 Economic Analysis

Health care is a basic human need. Good health can and should be one of the fruits of development. Moreover, there exists a substantial body of evidence compiled which indicates that specific measures to improve health care for the vast majority of a population can have a major development impact. However, the lack of good baseline data on morbidity, mortality, and productivity in rural areas precludes detailed direct calculations of the benefits from improved health that can be expected from a project.

Thus it is difficult to predict in advance the amount of suffering that will be avoided from improved health status, or the increased person years of work that will become available as a result of this project. Even if this could be done, conceptual difficulties in putting a dollar value on suffering preclude calculation of benefits that could be compared with costs.

Given the above reservations, economic analysis of the proposed project can, however, be useful in indicating the feasibility of the project by comparing it to alternative ways of offering similar health care and examining issues important in the long run for sustained primary health care to children and mothers. The analyses focuses on comparing the cost per beneficiary under each possible alternative to the proposed project.

5.4.1 Feasibility of the Proposed Project

The VACS project consists of two components: 1) institutional development of the private sector organizations, and 2) grant funding to PVOs to support service delivery costs. The project budget is divided as follows between the two components: \$3 million for technical assistance to the private sector organizations, and \$9 million for service delivery. The project funds will support activities over a 4 year period.

The economic analysis of this project entails a cost-effectiveness analysis of alternatives to health service delivery through the PVOs, based on the cost per beneficiary. In addition, an effort is also made to outline some of the economic issues related to: 1) recurrent costs and 2) the technical assistance aspects of the project which seek to support private sector health institutions.

5.4.2. Cost per Beneficiary of Service Delivery Alternatives

The VACS project envisages disbursing grants to PVOs over the 4 year life of project to carry out four primary health care interventions: oral rehydration therapy (ORT), birth spacing, nutrition surveillance, and vaccination against preventable diseases. The project targets children under 5 and women of reproductive age. The total amount of grants to be awarded to PVOs to carry out these activities over the next four years is projected to be \$9 million.

To determine cost effectiveness, the project can be compared with

several other alternatives to the project and to previous child survival experience. Unfortunately, data which indicate population coverage of the four interventions are not readily available for all the alternatives to be compared in this analysis. Therefore, as a proxy, the rate of immunization coverage, one of the most important interventions offered under the project, will be compared among the alternatives. Cost per beneficiary will be determined for the following alternatives: VACS; VACS including the cost of TA to private sector institutions; MOMS (the forerunner to VACS) health service delivery program; and Public Sector health care delivery.

5.4.2.1 VACS

The total cost of the VACS project over the next 4 years will be \$12 million. Of this, \$9 million is allotted for grants to PVOs to provide health delivery services. In analyzing cost per beneficiary, only the \$9 million directly attributable to increased service delivery will be considered as a cost in this scenario. As a result, average yearly cost of the project in this case is considered to be \$2.25 million.

The catchment population throughout this analysis is defined as the number of people estimated to live in the zone covered by the particular service delivery organization. The effective rate of coverage is defined as the percentage of the catchment population actually availing itself of immunization services.

Under the AOPS I & II projects and MOMS which is ongoing, PVOs cover a catchment population of about 900,000 people with 1.2 million targeted by the MOMS PACD. With the advent of VACS, PVOs estimate increasing the number of persons in the catchment population at the rate of roughly 25% per year so that by the end of the project, the catchment population will equal 2.2 million people. The average number of persons in the catchment population per year during the four years of the project then is 1.63 million people (see table below). At present, the effective rate of coverage is about 40% of the catchment population and by the end of the project, the actual number of beneficiaries will be 60% of the catchment population.

Catchment Population over Life of Project
 (in millions)

Present coverage	.90
End of Year 1	1.13
End of Year 2	1.41
End of Year 3	1.76
End of Year 4	2.20

 Average catchment population
 over life of project 1.63

With VACS, the cost per beneficiary amounts to \$2.30 per year, calculated as follows:

Cost per Beneficiary with VACS

a) Catchment population	1.63 million persons
b) Effective rate of coverage by immunization services	60%
c) Actual number of beneficiaries	978,000 persons
d) Total project cost per year	\$2.25 million

Average cost per beneficiary per year \$2.30

5.4.2.2. VACS including the cost of TA to private sector institutions

Since it is difficult to separate out institutional costs from service delivery costs in the technical assistance component of the project, it might be justifiable to attribute the total project cost to increased service delivery. This is hypothetical, since we know that in actuality, a certain portion of these funds is in fact used strictly for institutional development and will not have a direct impact on service delivery. It is useful in economic terms, however, to complete this exercise in order to arrive at a high estimate of cost per beneficiary with VACS.

Total cost per year becomes \$3 million if the cost of TA is included. With an average effective coverage of 978,000 persons per year, the cost per beneficiary becomes \$3.06 per year when the cost of TA is included.

5.4.2.3. MOMS Health Service Delivery

The cost of VACS can be compared to that of the existing MOMS private sector health initiative which has been almost entirely financed by AID over the last 3 years. Similar to VACS, grants have been provided to PVOs to carry on their health care activities with similar kinds of interventions. The cost of supporting these programs through the PVOs has been \$1.3 million per year, reaching a target population of 900,000 clients. Also, coverage per person has been at the rate of about 40%; that is, not all of the target population benefitted from services. In this case, effective population coverage is .36 million persons. Calculated in this way, the cost per beneficiary thus far has been \$3.61.

5.4.2.4. Public Sector Health Care Delivery

As an alternative solution, USAID could invest a similar amount of resources in the public sector to provide said services. Presently, USAID is contributing funds to public sector primary health care projects which offer similar interventions. The cost of project

activities is approximately \$3.825 million per year. The catchment population is roughly 4 million persons per year and of these, the number of people actually receiving immunization services is roughly 15%, or 600,000 persons. At this rate, cost per person is about \$ 6.38 per year. Once again, cost per person with VACS is far below public sector costs. This is shown in the table below.

Given the current state of the public sector, however, this effort must be supplemented with private sector initiatives. This does not negate the possibility of a continuing support to the public sector so it can eventually provide or contract with private agencies to provide adequate health care to reach the vast majority of the population.

Cost per Beneficiary of Alternative Approaches

	VACS no TA	VACS w/TA	MOMS	Public Sector
Catchment Population (millions)	1.63	1.63	.9	4
Effective rate of coverage	60%	60%	40%	15%
Actual number of beneficiaries	.978	.978	.4	.6
Total cost per year (millions)	\$2.25	\$3	\$1.3	\$3.825

Cost per beneficiary per year	\$2.30	\$3.06	\$3.61	\$6.38

The significant reduction in cost per beneficiary with VACS over the previous PVO service delivery project, MOMS, is attributable to the fact that major start-up costs have already been covered before the commencement of VACS, which is now in effect capitalizing on those earlier investments. The reduction in cost is also attributable to improvements in efficiency of service delivery due to the strengthening of private sector institutions such as AOPS.

5.4.2.5. No Project/Curative Medical Care

Another alternative to financing VACS would be, of course, no project. In this case, the target population would attempt to procure health services by seeking curative medical care at fixed health centers, which are fewer in number and less accessible than PVO rally posts, or alternatively, seek help from traditional folk healers. The VACS approach differs in that it is preventive in nature and, as will be shown below, is also less expensive.

The PVOs cover a large population due to their numerous centers and extensive community outreach. The existing fixed public health centers would provide coverage to a much smaller group of people, serving only those in the immediate vicinity. Those having to travel long distances would do so only in cases of emergency and not for preventive medical reasons, but rather when a problem was already advanced and serious. While no hard data exist at present on the amount spent by the average rural family on health care per year, limited data are available on the cost of certain curative interventions and an estimate can be made as to the amount a family would be required to spend per year where VACS-funded PVO services are not available.

Comparison can be made by assuming that a family which does not have access to preventive health services of the kind offered with VACS will require some number of curative medical interventions a year. It is reasonable to believe that at least one serious case of diarrhea will occur per household each year. A curative approach to diarrhea would likely be to seek hospitalization due to serious dehydration. The cost of a hospital stay (if there is a hospital accessible) would be about \$2.00. This is the quoted price for Belladere hospital stay of any length and illness of any severity. Costs at other hospitals may be higher, and this excludes travel costs, loss of output, and other psychological costs.

A recent study stated that families which practice birth control spend up to \$25 per year on family planning. Alternatively, the family would not practice birth spacing and therefore would have more children, which would over the long run be more expensive than family planning. To be conservative in our estimates, the measure of comparison to VACS-funded PVO interventions in family planning should be the equivalent cost of birth control on the market or through fixed health care facilities. The stated cost of \$25 seems quite high at first glance, and since the study which quotes this cost is limited in geographic scope, there may be reason to assume that cost is actually somewhat lower and costs roughly \$20 per year.

Families which do not have access to nutritional surveillance may eventually have to deal with a serious case of malnutrition, which would require consultation or hospitalization and medication.

Immunizations are provided at fixed health centers and hospitals. And yet, it is doubtful that a family would seek immunizations on a preventive basis, particularly if the health facility were a great distance away from home. In that case, it might be assumed that lack of immunization leads to serious illness and that the family would need to seek consultation with a physician at a health center for the cost of \$1 per visit or hospitalization at \$2.

Typically, then, if VACS-funded PVO services were not available, a 5-member family could at a minimum expect to incur the cost of \$20 per year for family planning, and suffer at least one major illness, requiring hospitalization, and in addition, seek three physician consultations. The cost to the family for health care without the

VACS project for the year can be inferred to be:

Curative Health Care Costs	
Family Planning	\$20.00
Hospitalization	2.00
Consultations	3.00

Cost per family	25.00
Cost per person	\$ 5.00

It should be clear that this is only a rough estimate. Without the VACS project, primary health care would not reach such a wide group, and the human cost of illness and suffering is, of course, unaccounted for. This simple analysis does make it clear, however, that, curative health care is more costly in economic and human terms and that coverage is much more limited, making the costs even greater from a macro perspective than they appear in the above individual family cost analysis.

The comparison of costs per person of the various alternatives is shown in the table below. The reduction in primary health care resulting from VACS shows that it is the most cost-effective method at present for providing this basic coverage to the target population.

Cost per Person	
With VACS	\$ 2.30
With VACS (including cost of TA)	3.06
MOMS	3.61
Public Sector	6.38
Without Project (Curative health care)	5.00

In conclusion, even if the cost of TA to private sector institutions were entirely attributed to the cost of increasing service delivery, the cost per person with VACS is more cost-effective than any other possible alternatives considered here.

5.4.3. Recurrent Costs

The possibility of passing on recurrent costs to the beneficiaries is dependent, first and foremost, upon the ability of the beneficiary to pay. In Haiti, per capita rural income is currently estimated to be \$150 per year. Given the estimated cost per person of child survival health care for the target group of \$3.06 per person (high estimate), this indicates that were the family to be paying for health care under VACS, the cost to the family would be less than 2% of its yearly income per year for preventive health care. This is conceivably

within the ability of the family to afford.

It appears feasible for PVOs to eventually charge user fees for services offered to cover variable costs of operation. While the target population may be able to afford primary health care of the nature offered by VACS, it remains to be seen whether they are willing to pay for such services. The problem is one of educating the target group to seek out and demand preventive health care services. Culturally, Haitians, like most other populations, are inclined to follow the curative approach to medical care, which in the long run also results in higher medical costs to the family. A recent study showed that individuals were paying between \$8-10 per year for health services out-of-pocket, though this was usually for curative treatment. It is not at all clear, however, that if PVOs were to begin charging for services now there would be such a great demand for those services. An output of the project will be to educate the target population on the benefits of preventive care and to create a demand for that kind of medical care.

Cultural change takes place slowly and is predicated upon a number of variables which differ from country to country and even region to region. It is therefore impossible at this time to determine when adequate demand for preventive services will have been created so that PVOs can begin charging user fees for services. Operations research in the project should address this issue and should also carry out demand studies in project areas to determine what cost of services families are willing to bear over the life of the project.

5.4.4. Technical Assistance for Private Sector Health Organizations

Support to private sector institutions in this project includes technical assistance to improve financial and administrative management. Also, long term planning in objective setting for these organizations is an area of priority to be addressed in the project.

The central concern, from an economic point of view, is how these organizations will become self-sustaining in the future, whether they will be able to sustain themselves, or if this is even a long-term goal. USAID support to the private sector arose due to the public sector's inability to offer wide enough quality coverage to Haitians in the area of child survival. Due to the urgency of the situation, additional ways of reaching this group were sought by going through private sector organizations. In some ways, private sector support can be looked upon as a short-term or interim measure. However, private sector organizations offer valuable services in the area of health care and in training health care professionals. They are also developing expertise in the area of research. Therefore, there is an interest in seeing these organizations continue to operate on their own merit, in addition to the support they give to PVOs for increased rural health care delivery.

It is unlikely that these organizations will become self-sustaining in terms of charging for services. What is more likely is that they will

become sophisticated enough to win grants and support from a variety of health organizations. It is important for these private sector organizations to develop long-term planning capabilities. Numerous possibilities exist for self-sustainability; it is important to develop a timeframe and framework for defining and attaining goals in this area.

Global Project Budget

	Year I	Year II	Year III	Year IV	Year V	TOTAL
PROJECT TOTAL	3,000,000	1,490,350	2,270,683	2,759,983	2,478,984	12,000,000
I Technical Assistance	0	153,000	484,333	567,333	557,334	1,762,000
II Indirect Subgrants	0	1,180,350	1,694,350	2,150,650	1,829,650	6,855,000
A Large PVO Subgrants	0	500,000	1,000,000	1,078,000	745,000	3,323,000
B AOPS Subgrant Fund	0	75,000	200,000	100,000	100,000	475,000
C Core Support Grants	0	605,350	494,350	972,650	984,650	3,057,000
1 INHSAC	0	177,850	178,850	381,150	228,150	966,000
2 AOPS	0	250,500	192,500	321,500	346,500	1,111,000
3 IHE (CHI)	0	177,000	123,000	270,000	410,000	960,000
III Direct AID Grants	1,850,000	0	0	0	0	1,850,000
A HHF	850,000	0	0	0	0	850,000
B AMEC	600,000	0	0	0	0	600,000
C UNICEF	400,000	0	0	0	0	400,000
IV Project Coordinator	0	57,000	42,000	42,000	42,000	183,000
A Coordinator	0	40,000	40,000	40,000	40,000	160,000
B Vehicle	0	17,000	2,000	2,000	2,000	23,000
V Buy-Ins	1,150,000	100,000	0	0	0	1,250,000
A PAHO	405,000	0	0	0	0	405,000
B REACH	500,000	0	0	0	0	500,000
C Johns Hopkins	245,000	0	0	0	0	245,000
D ADDR	0	100,000	0	0	0	100,000
VI Financial Mgmt Review	0	0	50,000		0	50,000
VII Evaluation	0	0	0	0	50,000	50,000

AID Direct Grant Budget

1	INHSAC	0	177,850	178,850	381,150	228,150	966,000
	a Salaries	0	28,350	28,350	53,150	53,150	163,000
	b Equipment	0	15,000	15,000	10,000	10,000	50,000
	c Supplies	0	0	0	15,000	15,000	30,000
	d Transport	0	12,000	13,000	15,000	15,000	55,000
	e Maintenance, utils	0	21,000	21,000	25,000	25,000	92,000
	f Training of Trainers	0	11,000	11,000	8,000	5,000	35,000
	g Training, per diem	0	5,500	5,500	10,000	10,000	31,000
	h Publications	0	15,000	15,000	25,000	25,000	80,000
	i Courses	0	70,000	70,000	70,000	70,000	280,000
	j HealthCom TA	0	0	0	150,000	0	150,000
2	AOPS	0	250,500	192,500	321,500	346,500	1,111,000
	a Salaries	0	85,000	95,000	190,000	210,000	580,000
	b Vehicles, POL	0	101,500	16,500	16,500	16,500	151,000
	c Office expenses	0	10,000	12,000	15,000	15,000	52,000
	d Bulletin	0	5,000	5,000	6,000	6,000	22,000
	e International Travel	0	4,000	4,000	4,000	4,000	16,000
	f Training seminars	0	15,000	25,000	50,000	50,000	140,000
	g Evaluation	0	10,000	10,000	10,000	10,000	40,000
	h Local travel	0	20,000	25,000	30,000	35,000	110,000
3	IHE (CHI)	0	177,000	123,000	270,000	410,000	980,000
	a Salaries	0	0	0	105,000	110,000	215,000
	b Evaluation, surveys	0	40,000	25,000	25,000	160,000	250,000
	c Local Travel	0	0	0	5,000	5,000	10,000
	d Intl Travel	0	0	0	4,000	4,000	8,000
	e Bldg Maintenance	0	6,000	6,000	6,000	6,000	24,000
	f Info Dissemination	0	8,000	8,000	8,000	8,000	32,000
	g Operations Research	0	25,000	25,000	25,000	25,000	100,000
	h Technical Assistance	0	0	50,000	75,000	75,000	200,000
	i Office Expenses	0	0	0	8,000	8,000	16,000
	j Vehicles, POL	0	48,000	9,000	9,000	9,000	75,000
	k Seminar	0	50,000	0	0	0	50,000

Estimated Technical Assistance Budget

I Technical Assistance	0	153,000	484,333	567,333	557,334	1,762,000
A IT Advisors	0	85,000	240,000	325,000	325,000	975,000
B Accountant	0	8,000	12,000	20,000	20,000	60,000
C Secretary	0	5,000	8,333	13,333	13,334	40,000
D Office Space, utilities	0	10,000	13,333	23,333	13,334	70,000
E Two vehicles	0	35,000	4,000	4,000	4,000	47,000
F Two Computers	0	5,000	5,000	0	0	10,000
G Office Equipment	0	5,000	10,000	0	0	15,000
H ST Consultants	0	0	151,667	151,667	151,666	455,000
I In-country training	0	0	40,000	30,000	20,000	90,000



ASSOCIATION DES OEUVRES PRIVÉES DE SANTÉ

P.O. Box 13489 Delmas Haiti Tél: 5-2646

LISTE DES INSTITUTIONS QUI FONT LE PROGRAMME DE L'AOPS ET LEUR POPULATION

AOPS I COMPTE 521-0169

<u>INSTITUTION</u>	<u>LOCALITE</u>	<u>POPULATION</u>	<u>REMARQUES</u>
Alma mater Grepin Project	Gros Morne	10.000	Termine
Ass. Medical des humbles	Thomazeau	10.000	Dechouque
Health Council	Belle Anse	22.000	En Cours
Clinique St. Paul	Montrouis	10.000	Discontinue
Hopital Betsabel	Lascahobas	25.000	En cours
COOEVA	La Vallee	10.000	En cours
Dispensaire Sacre Coeur	Pont Sonde	10.000	En cours
Christ pour Tous	Fonds Parisien	10.000	En cours
Centre de Sante Taifer	Taifer	10.000	Discontinue
Hopital Bienfaisance	Pignon	20.000	En cours
" " " "	St Raphael	30.000	En cours
Mirebalais	March I	50.000	En cours
Centre de S. Thomassique	Thomassique	10.000	En cours
Hopital Bonne Fin	Bonne Fin	10.000	Discontinue
FHASE	Freres	50.000	En cours
'NDIP	Duplessis	25.000	En cours
Centre d'Orianie	Fonds Verrettes	10.000	Discontinue



ASSOCIATION DES OEUVRES PRIVÉES DE SANTÉ

P.O. Box 13489 Delmas Haiti Tél: 5-2646

LISTE DES INSTITUTIONS (SUITE)

AOPS II COMPTE 521-0181

<u>INSTITUTION</u>	<u>LOCALITE</u>	<u>POPULATION</u>	<u>REMARQUES</u>
Alliance Francaise	Chambellan	10.000	Discontinue
Maison de la Compassion	Morne Pele	10.000	En cours
Union d'Entraide Humanitaire	Carrefour Poy I	50.000	En cours
" " " "	Carrefour Poy II	10.000	En cours
Mission Baptiste	Fermathe	50.000	En cours
Centre de sante Casale	Casale	10.000	Discontinue
Hopital Bienfaisance	Dondon	50.000	En cours
Hopital Bombardopolis	Bombardopolis	30.000	Projection
FHASE Extention			
Jacmel AMOSSE	Cayes Jacmel		En cours
" " " "	Marigot	30.000	En cours
" " " "	La Montagne		En cours
CROSS	Petit Anse	10.000	Projection
DASH	Montrouis	10.000	Projection
Comite de S. de Gressier	Gressier	10.000	En cours
Morne l'hopital	Savane Pistache	10.000	En cours
Bas Fonds Philomene	Delmas	10.000	Proj. A L'AID
WS (armee du salut)	Fonds des Negres	10.000	En cours
Mirebalais March I	Marche Canard	50.000	En cours
AMH	Bethel	10.000	Discontinue

<u>INSTITUTION</u>	<u>LOCALITE</u>	<u>POPULATION</u>	<u>REMARQUES</u>
Cookson Hills	Riviere Froide	10.000	Stoppe
AOIGCOM	Grande Colline	10.000	Stoppe
Siloe	La Voute	10.000	En cours



ASSOCIATION DES OEUVRES PRIVÉES DE SANTÉ

P.O. Box 13489 Delmas Haiti Tél: 5-2646

LISTE DES INSTITUTIONS (SUITE)

AOPS III COMPTE 521-0194

<u>INSTITUTION</u>	<u>LOCALITE</u>	<u>POPULATION</u>	<u>REMARQUES</u>
Baptist Church	Thiotte	50.000	En cours
Minnesota	Belladeres	50.000	En cours
AMOSSE Jacmel	Bainet	Ex 50.000	En cours
Carrefour Poy	Arcahaie	Ex 50.000	EN cours
Save the Children	Maissade	50.000	En cours
Mission Baptiste	Fernathe	Ex 15.000	En cours
Hopital Bienfaisance	Dondon	Ex 50.000	
AMG	Leogane	20.000	Projet AID
	RÉLANCE	335,000	

<u>INSTITUTION</u>	<u>LOCALITE</u>	<u>POPULATION</u>	<u>REMARQUES</u>
CODEVA	La Vallee/Jacmel	10.000	En cours
AMOSSE	Marigot	10.000	En cours
Baptist Mission	Lascahobas	10.000	En cours
Christ pour Tous	Fonds Parissien	10.000	En cours
COOIP	Duplessis	10.000	En cours
Union d'Ent. Humanitaire	Carrefour Poy	10.000	En cours
Dispensaire Sacre Coeur	Pont Sonde	10.000	En cours
Alma Mater Grepin Proj.	Gros Morne	10.000	En cours
Maison Compassion	Morne Pele	10.000	En cours

Summary of AOPS, IHE and INHSAC Core Support Budgets from Other USAID Projects (no institutional contributions included)

	AOPS	IHE	INHSAC	Total \$\$	Catchment Population
FY 83	*				
AOPS I	\$100,000				100,000
FY 83-86	*				
AOPS II	\$190,000			\$ 190,000	300,000
FY 85-89	*				
MOMS I	\$640,000	\$401,927		\$1,041,927	500,000
FY 86-89	*				
MOMS II	\$200,000	\$675,000	\$525,000	\$1,400,000	175,000
FY 86-89	*				
PSFP	\$192,500	\$350,000	\$349,840	\$ 892,640	
Total	\$1,322,500	\$1,426,227	\$874,840	\$3,524,567	1,175,000

* Figures do not include PVO subgrants for outreach programs or cost for purchase of IHE building.

- 7 -

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project. A Congressional Notification was submitted for the project; it expired on July 20.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? No engineering plans will be required. All subgrants will be subject to prior AID approval.
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? N/A.
4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A.

71

- 8 -

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? N/A.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not executed? Information and conclusions whether assistance will encourage regional development programs. Part of these funds will be used as buy-ins to international programs.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
 (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
 (a) N/A.
 (b) Project is entirely NGO-based.
 (c) N/A.
 (d) N/A.
 (e) N/A.
 (f) N/A.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A.
9. FAA Secs. 612(b), 636(b). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. The US does not own surplus Haitian currency.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.

12

- 9 -

11. FY 1987 Continuing Resolution Sec. 521. N/A.
 If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?
12. FY 1987 Continuing Resolution Sec. 558 (as interpreted by conference report). This is not an agriculture project.
 If assistance for agricultural development activities (specifically, any testing or feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?
13. FY 1987 Continuing Resolution Sec. 559. No.
 Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 007," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in order to assist the establishment of facilities specifically designed for the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work clothes or leather wearing apparel?

13

-- 10 --

14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in R.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible:
- (a) stress the importance of conserving and sustainably managing forest resources;
 - (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas;
 - (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management;
 - (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices;
 - (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded;
 - (f) conserve forested watersheds and rehabilitate those which have been deforested;
 - (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing;
 - (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation;
 - (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas;
 - (j) seek to increase the awareness of
- (a) Yes, an IEE is appended.
 (b) - (k) N/A.

U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(q)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? (a) - (d) No.
16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? Not a Sahel project.
17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FAA Secs. 102(b), 111, 113, 201(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and (a) This is a health project.

- 12 -

insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

(b) - (e) N/A.

- b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used? Yes.
- c. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Yes.
- d. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? This is not a bilateral project.
- e. FAA Sec. 120(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes.

- 13 -

- f. PAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. See Social Soundness analysis.
- g. FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No.
- Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No.
- Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.
- h. FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? No.
- If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? No.
- i. PAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes, per AID HB13.

77

- 4 -

- j. FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? As much as possible.
- k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the most sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity? N/A.
- l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? (a) - (b) No.
- m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest land; or (d) the construction of dams or other water
- (a) - (d) No.

13

- 15 -

control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

2. Development Assistance Project Criteria (Loans Only)

- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.
- b. FAA Sec. 610(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?
- c. FY 1987 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?
- d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacity?

INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Haiti
 Project Title : Voluntary Agencies for
 Child Survival (521-0200)
 Funding : \$12,000,000
 LOP : 5 years (87-92)
 IEE Prepared By :



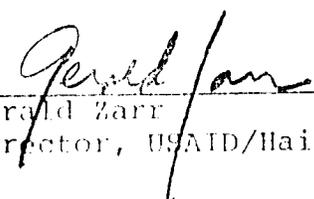
 Ron F. Ruybal
 Mission Environmental Officer

6/22/87
 Date

Should Decision
 Recommended :

Categorical Exclusion, because
 22 CFR Part 216.2 (c) states
 programs involving nutrition,
 health care or population and
 family planning services do not
 require an IEE.

Concurrence :



 Gerald Zarr
 Director, USAID/Haiti

July 30, 1987
 Date

Pending 3027

UNCLASSIFIED
 AID 05/04/87
 DIR:GZARR
 DRE:RBURNS:MP
 1.AFORD:DRE, 2.MWHITE:PHO, 3.D/DIR:LEMORSE
 DIR AMB DCM

AMEMBASSY PORT AU PRINCE
 SECSTATE WASHDC

E.O. 12356: *Hide* N/A

SUBJECT: VOLUNTARY AGENCIES FOR CHILD SURVIVAL
 521-0204 (VACS)

2979

1. MISSION REVIEWED AND APPROVED PID FOR SUBJECT PROJECT ON APRIL 24 (NAME WAS CHANGED FROM PREVIOUS MANAGEMENT ASSISTANCE TO CHILD SURVIVAL TO THE MORE DESCRIPTIVE VACS)
2. THE ACTION PLAN LEVEL DESCRIPTION WHICH WAS APPROVED AT THE ACTION PLAN REVIEW HAD A LOP OF DOLS 10 MILLION. THIS WAS A VERY EARLY ESTIMATE OF THE PROJECT NEEDS, SINCE THE LEVEL OF CHILD SURVIVAL FUNDING TO BE MADE AVAILABLE TO THE MISSION WAS NOT DETERMINED UNTIL SHORTLY BEFORE THE ACTION PLAN REVIEW BEGAN. WHILE THE PID WAS PREPARED AT THE DOLS 10.0 MILLION LEVEL, BOTH THE DESIGN TEAM AND THE MISSION REVIEW CONCLUDED THAT AN ADDITIONAL DOLS 2.0 MILLION LOP FUNDING WAS NEEDED. THE ADDITIONAL FUNDS WILL BE USED FOR EXPANDED TECHNICAL ASSISTANCE AND U.S. AND INDIGENOUS PVO SUB-GRANTS; THE PID REVIEW DEMONSTRATED THAT TA COSTS WERE UNDERESTIMATED AND THAT THERE WERE GREATER NEEDS FOR PVO SERVICE

-

UNCLASSIFIED

2

DELIVERY PROGRAMS THAN ORIGINALLY ESTIMATED.

3. PP WILL THEREFORE BE PREPARED AT THE DOLS 12.0
MILLION LOP LEVEL. THIS WILL NOT AFFECT THE FY 87
OBLIGATION LEVEL OF DOLS 3.0 MILLION. ##

UNCLASSIFIED

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORKLife of Project:
From FY 87 to FY 91
Total U.S. Funding \$12.0
Date Prepared: April 87

Project Title & Number: Voluntary Agencies for Child Survival

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Decrease infant child mortality</p> <p>Improve family planning practice</p>	<p>Measures of Goal Achievement:</p> <p>Mortality rates</p> <p>Contraceptive knowledge</p> <p>Contraceptive prevalence</p>	<p>Survey data</p> <p>Survey data and service statistics</p>	<p>Assumptions for achieving goal targets:</p>
<p>Project Purpose:</p> <p>Improve Child Survival service delivery</p> <p>Improve institutional capabilities</p>	<p>Conditions that will indicate purpose has been achieved: End of project status:</p> <p>= PVO community outreach programs</p> <p>= target population receiving CS interventions</p> <p>= target population registered & regularly attending Family Posts</p> <p>= surveys & ops research activities</p> <p>= visits by AOPS coordinators to PVOs</p> <p>= technical personnel trained</p> <p>= personnel recruited & hired</p> <p>= TR requests from PVOs</p>	<p>AOPS records</p> <p>IHE records</p> <p>INHSAC records</p> <p>service statistics</p>	<p>Assumptions for achieving purpose:</p>
<p>Outputs:</p> <p>Increased CS intervention delivery</p> <p>Increased population coverage</p> <p>Increased # PVO outreach programs</p> <p>Improved institutional management</p>	<p>Magnitude of Outputs:</p> <p>50% (PVOs increase services from 2 to 4)</p> <p>1,000,000 additional people</p> <p>10</p> <p>IHE, AOPS, INHSAC</p> <p>50 PVO Programs</p>	<p>AOPS & IHE records</p> <p>Survey data</p> <p>Long-range planning documents</p> <p>Financial records</p> <p>Personnel records</p> <p>Supply records</p> <p>Site visit reports</p>	<p>Assumptions for achieving outputs:</p> <p>PVO outreach programs begun under AOPS, MONS Projects continue to function.</p>
<p>Inputs:</p> <p>Service delivery support</p> <p>Institutional core support</p> <p>Technical assistance</p>	<p>Implementation Target (Type and Quantity)</p> <p>\$5.675 million</p> <p>\$3.105 million</p> <p>\$2.937 million</p>	<p>USAID Controller disbursements</p>	<p>Assumptions for providing inputs:</p> <p>Proposals from PVOs are received and approved.</p>