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UNCLASSIFIED

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

HAITI

PROJECT PAPER

FAMILY PLANNING OUTREACH

(AMENDMENT No. 1)

AID/LAC/P-363 CR AID/LAC/P-085

Project Number: 521-0124

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number 1

DOCUMENT CODE 3

2. COUNTRY/ENTITY

HAITI

3. PROJECT NUMBER

521-0124

4. BUREAU/OFFICE

LAC

5. PROJECT TITLE (maximum 40 characters)

Family Planning Outreach

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
01 9 31 08 9

7. ESTIMATED DATE OF OBLIGATION  
(Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY 81 E. Quarter 4 C. Final FY 88

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

A. FUNDING SOURCE	FIRST FY <u>81</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	480	372	853	9,115	4,833	13,948
(Grant)	480	373	853	9,115	4,833	13,948
(Loan)						
Other U.S.					2,808	2,808
Host Country					10,155	10,155
Other Donor(s)						
TOTALS	480	373	853	9,935	18,886	28,721

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO- PRIATION	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) PN	444	440		9,015		4,333		13,948	
(2)									
(3)									
(4)									
TOTALS				9,015		4,333		13,948	

10. SECONDARY TECHNICAL CODES (maximum 3 codes of 3 positions each)

450 510 244 740

11. SECONDARY PURPOSE CODE

534

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

A. Code BRW B. Amount 30W

13. PROJECT PURPOSE (maximum 430 characters)

To assist the Government of Haiti (Ministry of Public Health and Population) to establish a cost-effective national family planning program.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
01 7 8 3 01 3 8 3

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 104 page PP Amendment)

This amendment increases project funding and extends the PACD to continue project activities, make organizational changes in the structure of the public sector family planning program, and undertake additional research and technical assistance.

I have reviewed and approved the methods of implementation and financing for this P.P.

17. APPROVED BY

Signature

Tit

Gerald J. Zarr  
Director, USAID/Haiti

Date Signed

MM DD YY  
01 31 81 7

Charles E. Brooks  
18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY  
01 31 81 7

PROJECT AUTHORIZATION  
AMENDMENT NO. 3

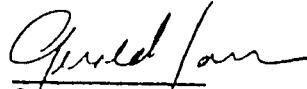
Name of Country : Haiti  
Name of Project : Family Planning Outreach  
Number of Project : 521-0124

1. Pursuant to Section 104 of the Foreign Assistance Act, as amended, I hereby authorize an increase in the planned obligations of the Family Planning Outreach Project of not to exceed Four Million Three Hundred Thirty Three Thousand United States Dollars (\$4,333,000) in grant funds over the planned life-of-project, subject to the availability of funds in accordance with the AID/OYB allotment process, to help in financing foreign exchange and local currency costs of the project. Therefore, total planned obligations for this Project may be effected in an amount not to exceed Thirteen Million Nine Hundred Forty Eight Thousand United States Dollars (\$13,948,000).
2. The Project Assistance Completion Date, which is September 30, 1987, is further extended to September 30, 1989.
3. The Project Agreement shall be subject to the following essential terms and covenants and major conditions, together with other such terms and conditions as A.I.D. may deem appropriate:

Except as A.I.D. may otherwise agree in writing, the Grantee, acting through the Ministry of Health and Population, shall covenant and agree:

- A. That within 90 days of the date of this Grant Agreement Amendment, it will:
  - i) Assign qualified personnel to work as family planning officers in each of the regional and district offices and provide their names to A.I.D.
  - ii) Identify and place a well-trained Haitian, acceptable to A.I.D., with experience in family planning, to work as the National Family Planning Coordinator in the Unit of Regional Coordination in the Ministry of Health and Population.

- B. Within 60 days of the receipt by the MSPP of the final audit report from the A.I.D. Office of the Regional Inspector General, it will submit a plan, acceptable to A.I.D., for appropriate management corrections based on the recommendations of the audit report. The plan will contain specific actions and completion dates for each of the recommendations.
  - C. That it will direct the District Directors and the District Family Planning officers to insure that family planning is integrated into workplans and daily activities of each public health center.
4. Except as expressly amended or modified hereby, the terms and conditions of the original authorization remain in full force and effect.

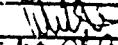
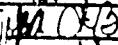
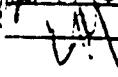


Gerald Zarr  
Director USAID/Haiti

MAR 31 1987

Date

Clearance:

A. Ford, DRE   
M. White, PHO   
C. Brooks, CONT   
L. Morse, D/DIR 

## Glossary

AVSC	Association for Voluntary Surgical Contraception
CPR	Contraceptive Prevalence Rate The percent of women in the population using modern contraceptives usually expressed as a percent of the women of fertile age (WIFA) or a percent of the WIFA in a sexual union or a percent of those "exposed to pregnancy".
CBR	Crude Birth Rate
CDC	Centers for Disease Control
CONAPO	National Council of Population
D.A.	Development Assistance Funds
Depoprovera	Three month injectable contraceptive
DESE	Division of Health Education
DHFN	Division d'Hygiene and Nutrition
FAD'H	Armed Forces of Haiti
FHI	Family Health International
FP	Family Planning
IEC	Information Education and Communication
INHSAC	Haitian Institute of Community Health
IUD	Inter Uterine Device
ISTI	International Science and Technology Institute
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JH/PCS	Johns Hopkins Population Communication Service
Laparoscopy	Method of female sterilization

2

MCH	Maternal and Child Health
MSH	Management Sciences for Health
Minilaparotomy	Method of female sterilization
MSPP	Ministry of Public Health and Population
Norplant	Trade name for 5 year contraceptive implant
PAHO	Pan American Health Organization
RTI	Research Triangle Institute
S&T/POP	Office of Population/Science and Technology Bureau AID/W
SNEM	National Service for Control of Endemic Diseases
TA	Technical Assistance
UNFPA	United Nations Fund for Population Activities
Vasectomy	Method for male sterilization

PROJECT PAPER AMENDMENT  
FAMILY PLANNING OUTREACH  
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- Annex 8 - Projected Commodity Requirements
- Annex 9 - Initial Environmental Examination

## I. PROJECT SUMMARY AND RECOMMENDATION

### A. Recommendation

The Project Committee recommends approval of a \$4.333 million grant supplement to the Family Planning Outreach Project, increasing the life of project funding to a total of \$13.948 million. The amendment will also extend the project for two years for a life of project total of eight years.

### B. Summary

#### 1. Background

This project was originally obligated in September, 1981 by a grant agreement with the Government of Haiti (GOH) for \$9.615 million of assistance to be provided over a five year period. The purpose was to help the GOH, through its Ministry of Public Health and Population (MSPP) as implementing Ministry to develop a national Family Planning (FP) Program. The project focused on five activities: improving the management of the national FP program; improving the quality of FP services delivered; expanding the participation of PVCs and community groups; establishing a commercial retail sales program; and formulation of a national FP policy.

At the time the project was started, the structural organization of the public health sector was undergoing change. The immediate implementing agency was the Division of Family Health, a part of the Ministry of Public Health and Population, which during the life of the project took on the responsibilities of the Bureau of Nutrition to become the Division of Family Health and Nutrition (DFHN). As the implementation of the project got underway, important elements of the DFHN were absorbed into other MSPP divisions, resulting in a loss of key personnel and fragmentation of the authority for decision-making related to the family planning program.

While the project initially showed some positive results, it was followed by evidence of breakdown in the organizational capacity of the MSPP/DFHN to deliver family planning services. Results of a nationwide contraceptive prevalence survey in 1983 indicated an apparent decline in contraceptive use from the modest levels of the late 1970's. Although drawing positive conclusions about many aspects of the FP Outreach project, the mid-project evaluation conducted in October 1983 gave little evidence of progress toward established service delivery goals. Many of these problems ensued as a result of the GOH's reorganization of the Ministry of Health and Population which, although beneficial in the long run, disrupted what had been a steadily growing maternal and child health and family planning program under the unified direction of the Department of Family Health. The complexities of integrating the two were compounded with further integration of responsibility for FP into the overall health system, and exceeded the organizational capacity of the MSPP to cope with and maintain a focus on family planning. The decentralization of planning and implementation authority to regional and district offices with apparently inadequate growth in their capabilities has further reduced the ability of the DFHN to establish and enforce priorities, and to supervise and evaluate progress. In spite of these organizational problems, the

1983 evaluation concluded: "The overall conclusion is that the design of the Outreach project envisions all possibilities for making family planning service accessible and the DHF/DSPP is the only viable mechanism for ensuring a successful program of services".

A major difficulty in evaluating progress to date has been this dismemberment of DHF responsibilities, leaving the division ill equipped to provide well supported documentation of its family planning efforts. While there has been a major effort to produce periodic reports, the gap in information has made it impossible to measure the impact of project financed contraceptive distribution on contraceptive prevalence or birth rates in Haiti.

The project as amended takes into consideration the organizational problems and inadequacy of the logistic/reporting/evaluation system encountered in the original design. Recognizing, at the same time, the key and necessary role of the MSPP in the universal delivery of FP services throughout Haiti, the amendment emphasizes strengthening the organizational infrastructure of public sector entities involved in family planning at the central/regional and district levels, with the intent to improve their managerial and technical capability to effectively deliver a wide range of contraceptive services. Assistance in the development of a national population policy will also be continued. Efforts in developing commercial retail sales activities, however, will be addressed in the Private Sector Family Planning Project.

## 2. Project Amendment Description

Activities described in the amendment will take place over a two and a half year period (March 1987 - September 1989) and include the following:

### a. Improved Organizational Structure

Project assistance will be provided to help the DHF strengthen its capacity to coordinate and evaluate FP activities. A key element of the amended project will be the addition of a full-time national FP program coordinator who will monitor and give direction to FP activities carried out by various national, regional and district health officers. A resident technical advisor will be provided to assist the coordinator. A FP Project Management Committee will be formed to plan and monitor project activities and coordinate FP activities with other donors. Regional and district health offices will be strengthened with the addition of FP officers who will supervise FP activities for their respective areas. A biannual action plan for family planning will be developed by the DHF in collaboration with the national and regional coordinator.

### b. Management System and Administration

This component will finance activities designed to improve the management and administration of the public sector FP program:

- 1) A recently developed Health Information System will be used to provide routine client information to the Technical Support Unit of the DHFN. Additional information will come from reports on contraceptive distribution, ad hoc client surveys and training activities.
- 2) TA will be provided to assess and recommend improvements on the DHFN system for the procurement, storage and distribution of FP equipment and supplies.
- 3) FP coordinators will review supervisory roles, clarify and make recommendations on appropriate responsibilities.
- 4) TA will be provided to gather more accurate information on contraceptive use and distribution, personnel and facilities involved in the delivery of FP services. This is a priority activity which will begin immediately, and will clarify assessment of previous activities as well as provide a basis for appropriate adjustments in the area of management.

c. Service Delivery

Personnel will be trained, physical facilities refurbished, and equipment and contraceptives provided for at least one central referral clinic in each of the 15 public health districts. These centers will offer a full range of contraceptive services, including surgical methods. The delivery of non-surgical contraceptive services will be expanded to include all 163 public health facilities. Non-clinical contraceptives will continue to be available from the network of several hundred community-based agents. Also, limited support will be provided to PVOs delivering family planning services, including natural family planning, while the new private sector FP project is getting underway.

d. Information, Education and Communication (IEC)

Implementation of a successful IEC strategy depends upon the quality of the product as well as on the quality and extension of the IEC campaign. Therefore, the amendment will initially emphasize expansion and improvement in the quality of service by establishing model referral centers offering a complete range of services in each district. Research efforts will examine the barriers to care: for example, are travel time and expense a major obstacle to patients seeking care, are negative provider messages (conscious or not) discouraging patient continuation, or, are women interested in controlling fertility but confused about methods, where to seek care or reluctant to ask medical personnel?

The technical assistance will work with the DHFN, the DESE, the Haitian Community Health Institute (INHSAC) and other private family planning groups to develop a two year (or longer) strategy for IEC. The Johns Hopkins Population Communications Services (PCS) Project will contribute toward development of an IEC strategy, and assist in development and diffusion of family

planning messages. They will also recommend and help implement monitoring and evaluation of the communication strategies, assist in defining target audiences, identify channels of communication, and aid in monitoring and evaluation.

In conjunction with training seminars and other on-the-job training available to family planning workers through the Project, AID child-survival funds will support IEC training and development activities at INHSAC. Through INHSAC, family planning workers and supervisors will have access to communication resources--training, research, materials production and diffusion, as well as opportunities for collaboration on program planning and evaluation.

IEC technical assistance will be provided through a buy-in to the S&T/H funded PCS project with Johns Hopkins University. In addition, the PCS project will contribute funds and short-term TA from its core funding from AID/W. Counterpart Title III funds to the project will be available for support of IEC local costs, e.g, posters, printed materials, artistry, radio spots, per diem and transportation costs.

e. Training

The Amendment will continue training in FP services under the project. This will include training of medical and paramedical personnel in surgical and non-surgical contraceptive methods, clinic and dispensary personnel in supervisory skills and logistics, training in communication, training of trainers, seminars for community and health agents, and management and evaluation skills training for coordinator and supervisory level personnel. There will also be observatory travel on national policy development for key GOH and MSPP personnel dealing with population and development. Title III funds will be used to train FP promoters and volunteers.

f. Research and Policy Development

The Amendment will finance three research studies related to the future of FP services, and various studies which contribute to the development of the National Population Policy. The three studies include expanded clinical research on Norplant, biomedical research on the comparative risks of pregnancy and use of modern contraceptives, and research on the use of the IUD in Haiti. Each of these studies will provide some answers to important questions on future program efforts. Results of studies on population growth and development will be disseminated through publications, seminars and coordination meetings. Support will be provided to CONAPO, and GOH officials will make appropriate observational tours.

### 3. Summary Financial Plan

With the addition of \$4.333 million in population funds, the LOP total increases to \$13.948 million. The financial plan for the \$13.948 million project total is presented in the Financial Analysis Section. Contributions for the amended project also include Title III funds (\$1.45 million).

#### SUMMARY BUDGET FOR EXTENSION (\$000)

	<u>Amendment</u>	<u>Title III</u>	<u>Total</u>
Technical Assistance	528	-	528
Training	150	181	331
Research	700	44	744
IEC	147	100	247
Contraceptives	1,767	-	1,767
Equipment, Supplies and Renovation	270	100	370
Policy Development	150	-	150
Operating Costs	351	933	1,351
PVO Support	100	25	125
Evaluation/Audit	<u>170</u>	<u>67</u>	<u>170</u>
TOTAL	4,333	1,450	5,783

## II. PROJECT BACKGROUND

### A. Progress to Date

At the time the original Family Planning Outreach project was developed in 1981 USAID estimated a Haitian population of 5.5 million people living a marginal existence on only 8,000 square kilometers of arable land. The population growth rate had been mitigated by a high death rate, nuptiality patterns and traditional practices favoring lower fertility, and out-migration. However, these factors were seen to be changing, placing upward pressure on the population growth rates. Meeting the requirements of socio-economic development, reducing unemployment, lessening environmental degradation and reducing the high levels of maternal and infant mortality would require reductions in human fertility and a slowing of the population growth rate.

The Family Planning Outreach Project was designed to assist the newly reorganized Ministry of Public Health and Population through its Division of Family Hygiene and Nutrition (DHFN), to develop a nationwide family planning service delivery network. This network would include both public and private sector health facilities and work through fixed facilities, mobile teams and various community agents. Initially, it was expected to also develop commercial retail contraceptive sales activities.

While long term benefits are expected from the MSPP reorganization, it became apparent that the DHFN could not administer a cohesive family planning program given the delegation of various FP responsibilities to other divisions of the MSPP and region and district offices responsible for implementing the integrated health program. By 1983 it appeared from the Westinghouse supported contraceptive prevalence survey that the levels of contraceptive use had in fact fallen from their relatively low levels of 1977.

Subsequently, there appears to have been some recovery from this decline, but the nature of service statistics reporting is such that firm conclusions on the levels of active users being served cannot be drawn. Quantities of contraceptives adequate to have made a significant impact on contraceptive prevalence have been dispensed from the Port-au-Prince warehouse. However, there is no documented evidence that the high distribution rate of contraceptives has resulted in significantly higher use rates. For example, the level of use (and impact) of the unusually large proportion of condoms dispensed in the program contraceptive mix has not been reviewed sufficiently in light of the unique sexual and cohabitation patterns of Haiti. Further attention to these issues is given in Annex 3, which concludes that an in-depth review of these questions should be a priority action addressed early in the amendment project.

Other significant accomplishments under the project are noted in detail in Annex 2. These include the extension of family planning services to a reported 88% of the public health sector facilities and 47% of the private; training of nearly 800 persons; renovation and equipment of 14 surgical centers; initiation of IEC activities; operations and bio-medical research and contraceptive prevalence surveys.

Considerable progress has been achieved in MSPP policy toward family planning, especially in the use of outreach workers. However, performance has not matched the stated GOH policy. Substantial improvements must be made in coordination, organizational structure and management systems if the MSPP is to achieve its objectives of assuring the populace convenient and continuous access to family planning.

B. Rationale for the Amendment

If Haiti is to improve the economic situation of its people as measured by increases in per capita GNP, stem the degradation of its natural resources, or to provide even rudimentary social services to its population, it is obvious that the rate of population increase must be reduced. The MSPP recognized this when, in 1982, it formulated a new public policy, the "Nouvelle Orientation" (New Orientation). The "Nouvelle Orientation" specifies that resources should be preferentially allocated to support six priority public health programs. Family planning--to prevent short birth intervals and rapid population growth--constituted one of those six priorities. The MSPP posed as a goal the reduction of the Crude Birth Rate (CBR) from levels of 35/1000 to 20/1000 by the year 2000.

In spite of this publicly pronounced interest in family planning, a true political commitment on the part of the leadership of the Duvalier regime to the systematic, effective implementation of a service delivery system designed to make quality services widely available never took place. Fortunately, there is reason to be optimistic that such a commitment will be present in the new administration. The Government has recently recognized officially a private family planning association, PROFAMIL. Moreover, the president of the Conseil Nationale de Gouvernement (CNG), General Henry Namphy, has told the senior officials of the MSPP that he is personally committed to the formulation of a national population policy and a strategy to realize the goals of the policy. A National Population Commission (CONAFO) charged with responsibility for the formulation of such a policy was legalized in 1986.

In addition to the survey data referred to earlier, there is good practical evidence that rural Haitians want to use modern effective contraceptives to space or to limit births. In the catchment area of the Hospital Albert Schweitzer, 170,000 people benefit from a community health program which features an effective family planning service delivery component but not a particularly aggressive IEC component. Contraceptive prevalence in this population is between 20 and 25%. In the Miragoane district, the DHFN in collaboration with Columbia University, conducted an operations research program in to provide pills and condoms at the community level using the malaria volunteer as a distributor. A survey found that contraceptive prevalence was nearly 20%. The MSPP in a recent seminar to discuss these results recommended that this experience be expanded nationwide as soon as feasible. This activity will be undertaken in the SNEM project amendment.

USAID has proposed assisting the Government to meet its goal of lowering the population growth rate as one of the centerpieces of its strategy articulated in the Action Plan. The proposed amendment responds to known weaknesses of the existing program--adding technical assistance, training, and a firmer line of responsibility for the FP program. But, its success will require political will and direction from the highest levels of the government. In order to achieve this, an updated RAPID presentation will be shown to government officials and opinion leaders in the spring of 1987. Government officials from key Ministries, e.g., Commissariat National, Education, Health and Population will be invited to make observational tours to see country programs with direct relevance for Haiti. In addition, the Title III policy reforms specifically target an increase in the contraceptive prevalence rate as a benchmark indicator of progress and hence a requirement of "loan forgiveness".

In reviewing the progress to date of the project, the Mission has been forced to redefine its objectives for the medium term. The Mission's objectives are to:

- a) be in a position to conduct policy dialogue with the GOH on development of a national population policy and on the importance of family planning services;
- b) keep the contraceptive distribution system intact--or provide an alternative--for the 50,000 to 100,000 men and women now making use of contraceptives it provides;
- c) increase the contraceptive prevalence rate to at least 11% by 1989; and
- d) conduct the survey, operations and biomedical research necessary for a more comprehensive and ambitious follow-on project.

The options considered to address these objectives are discussed below:

(a) Abandon the Effort

For a variety of cultural, political, policy and organizational reasons, Haiti has not yet demonstrated a capacity to make effective use of AID resources in dealing with its problems of rapid population growth. Thus, it might be prudent for AID to disengage from the public sector. This would be a more viable option if the issue of population growth were not so critical to achieving all other U.S. and GOH socio-economic goals. A highly probable consequence of this option would be the release of several hundred family planning workers; another would be a breakdown in the MSPP's logistics system supplying contraceptives to all 15 districts. Following this politically painful lesson, AID would not be in a position to engage the government in policy dialogue on population. Further, abrupt cessation of our assistance would also mean that private and voluntary organizations would lose access to contraceptives via the only established national distribution system.

(b) Place Exclusive Emphasis on the Private Sector

A new private sector family planning project has been authorized and, in other countries, this approach has proven very effective. However, private agencies in Haiti have had access to family planning assistance for quite some time. Until recently none of them have demonstrated substantial interest, commitment or leadership in this area. Even if presently expressed enthusiasm is followed by commensurate performance, it will take some time to get organized, a time during which present public sector services would disintegrate. Hence, in order to accomplish the three objectives described above, this is not a viable option for the next two years.

(c) Maintain Skeleton Support to the Public Sector Awaiting Review of Key Issues

This approach might protect AID investments in the public sector in the short run. It would risk a substantial decline in the already weak public sector and will make it much more difficult to revive it for implementation of a future project. The skeleton approach provides no rationale or opportunity for even modest improvement of the unsatisfactory performance of the public sector. Neither would it permit the experimentation, research and review necessary for new project design. It would also remove any leverage we have in policy dialogue, since the observational travel, technical assistance and salaries paid for under the project would encourage political commitment to family planning. Clearly, this option would not satisfy three of the four AID objectives described above in "Rationale".

(d) Seek Modest Improvements in the Public Sector During a Design Period

This alternative, which was chosen, will achieve organizational improvements consistent with overall Mission support for the reorganization and decentralization of the MSPP. It provides adequate support to maintain and somewhat improve the service now being provided by the MSPP family planning program through increased technical assistance, training, policy dialogue, and improved direction and commitment through identification of key persons to work full time on F.P. It also provides for research and study of key constraints to public sector family planning. At the same time, this approach does not prematurely commit USAID support to major programmatic changes that may not withstand the scrutiny of the planned new project design.

### C. Major Objectives

Based on the experiences in the Project to date, and the conclusion reached above concerning the nature and extent of future AID assistance in the population sector, the FPO amendment will seek to accomplish the following objectives:

1. Demonstrate USAID support for the new Government in an area of mutual concern (i.e., family planning);
2. Contribute to the public sector goal of reducing population pressure on natural resources and increase public awareness and support for this program through promulgation and implementation of an effective Population Policy;
3. Assist the GOH in its strategy of decentralization and building service-delivery and management capacity in the regions and districts;
4. Focus long term commitment on FP within the MSPP and train, support and develop the personnel necessary for a successful FP program over the long term.

### D. Other Donor Support

The decision to extend the current project was made after consultation with USAID's closest collaborators in the donor community, the United Nations Fund for Population Activities (UNFPA) and the Pan American Health Organization (PAHO). This project amendment evolved from consultations between these three agencies. We agree on certain principles, such as the need to have an individual at the highest level of the MSPP responsible for the coordination of the various agencies of the Ministry which must play a role in the implementation of a family planning program. We also agree that additional autonomy to plan and implement the program must be given to the regional directors and that, at the same time, the Minister must hold those regional directors accountable for the realization of the objectives which they propose. We agree that, ultimately, new strategies must be developed which emphasize innovative techniques for the community based distribution of contraceptives. We agree that much more effective information and education programs must be developed.

USAID has worked closely with both PAHO and UNFPA in the development and implementation of the present project and this amendment. PAHO serves as the executing agency for much of UNFPA activity in Haiti and provides valuable counsel both to the MSPP and to USAID. UNFPA has a resident representative in Haiti whose appreciation of the Haitian program and assistance in planning is most useful. UNFPA has been phasing down its support to the public sector family planning program, especially in the area of salary support. They have broadened the scope of their support, however, to include population awareness education in the public schools and have encouraged the development of a demographic analysis unit, the Population Division of the MSPP, and the National Population Council (CONAPO). It is expected that a UNFPA country program assessment will recommend substantial changes in their FY 87 support to Haiti.

Nevertheless, the Haiti representative states that UNFPA will continue to provide Depo-Provera contraceptives as requested, as well as support IEC activities if a national strategy and program is developed by MSPP. While this support is valued, the Family Planning Outreach Project is not dependent upon it. It should be noted that additional support for the project not included in the budget will become available from centrally-funded (AID/W S&T/POP) cooperating agencies such as JHPIEGO, Futures Group, AVSC, Family Health International and CDC. Increasingly, these activities will be jointly funded as the FP Outreach Project "buys in" to the central projects.

### III. DESCRIPTION OF PROJECT AMENDMENT

#### A. Project Goal and Purpose

The goal of the project remains the same as the original project, i.e., to improve the health and socio-economic condition of the Haitian poor. The purpose continues to be that of assisting the GOH to establish a cost-effective National Family Planning Program. The Project supports this program so that, in conjunction with the efforts of private sector organizations, nationwide contraceptive prevalence will rise from current levels of approximately six percent to levels of 11 percent by the end of the project in September 1989.

#### B. Project Activities

The Division of Family Health and Nutrition will retain its normative role in determining family planning policy and procedures. It continues to be the focal point in managing external assistance to family planning in the public sector. However, with the integration of many previous DHFN functions into other sector wide divisions of the MSPP and with the regions being made responsible for planning and implementation, the DHFN has lost some of its capability to direct, support and evaluate these family planning activities. The first two components described below are designed to assist the DHFN in accomplishing its objectives by building on the positive elements of integration and decentralization, providing for more coordination at the MSPP level and strengthening the planning and implementation capabilities of the regions and districts. Other areas of assistance include service delivery, IEC, training and policy development.

An annual Operational Plan for Family Planning will be developed by the DHFN under the supervision of the National Family Planning Coordinator and in collaboration with the Regional Family Planning Officers. The plan will be submitted for USAID approval and will contain a staffing plan for Project needs, the proposed budget and a time-phased implementation plan for all project activities. The Plan will describe the strategy of achieving identified objectives, the personnel and material resources required to do so, and the facility or office that will bear responsibility for the activity. The Plan will also describe any necessary collaboration or contribution by NGOs, as well as NGO obligation towards DHFN in view of their participation in the program.

#### 1. Organizational Structure of National Family Planning Program

##### a. National Family Planning Coordinator

A National Family Planning Coordinator will be named to coordinate and monitor the implementation of FP activities at the regional and district levels. He/she will be placed in the unit of Regional Coordination. The appointment of this coordinator will encourage a more cohesive organization of public sector offices and personnel involved in the design and delivery of family planning services.

A resident technical advisor for planning, management and evaluation will be hired by A.I.D. to assist the National F.P. coordinator and to also assist the various offices of the MSPP involved with F.P. at the national, regional and district level.

b. Family Planning Project Committee

A Family Planning Project Committee will be organized and chaired by the National Coordinator to plan and give direction to the project. The Committee will be comprised of the National Coordinator; the Director of the Division of Family Hygiene and Nutrition (DHFN); the four regional health directors or their family planning officers; the Executive Secretary of the National Population Council (CONAPO); and the USAID Project Officer. Chiefs of other MSPP administrative units and representatives of PVOs will be invited when appropriate. This Committee will meet quarterly and will discuss plans, progress and problems.

c. Regional Level

The primary responsibility for planning, implementation and evaluation of the operational programs will be at the regional level with assistance from the central level. Each regional office will be strengthened by the assignment of a family planning officer who, together with the regional health directors, will participate in planning, support and supervise the districts in planning and implementating family planning activities, and organize district and regional training programs in cooperation with DESE and the Haitian Community Health Institute (INISAC). The FP officer will assure the maximal use of material, logistical means and equipment available for FP at the regional level. He will collect and tabulate statistical data and provide a monthly report to DHFN. He will assure coordination with the regional representatives of the SNEM, FAD'H, and PVOs to expand FP service delivery.

As regional FP officers are added and trained, attention will be given to strengthening the Regional Office capacity in statistical reporting, evaluation, logistics and accounting. Regions are expected to assume a greater role in these areas as well as the planning, training and supervisory responsibilities.

d. District Level

A person responsible for family planning will be reassigned in each district and will assure the maximal use of material, logistical means, and equipment available for FP at the district level. He will make sure that FP activities are carried out in all facilities of his district. He will collect and tabulate statistical data and provide a monthly report to the region. He will assure coordination with regional representatives of the SNEM, FAD'H, and private sector in order to expand FP service delivery.

The officers assigned family planning responsibility at the regional and district level as part of the health office team will play a lead role in planning, managing and supervising the family planning program under the direction of the regional and district health officers. Insofar as support from the USAID health project, Rural Health Delivery System, is effective in improving regional level management, further delegation of some of the present DHFN responsibilities can be passed to the regions. At this time it is prudent to limit the regional and district responsibilities to the above-mentioned roles until it is clear that increased capacity has been developed.

e. Local institutional level

The District Directors and District FP Officers will assure that FP activities are integrated into workplans and daily activities of each public health center.

By September 1989, it is expected that an organizational structure will have been developed which is capable at national, regional, and district levels of planning, coordinating, managing, supervising and evaluating a family planning program (clinic and community based) of national coverage. Full time family planning personnel will be in place at national, regional and district levels to assure adequate coordination and emphasis on family planning within the integrated, decentralized health system.

2. Management System

a. Information Collection System

A computerized management information system will be implemented to provide reliable data on new and active users compared with contraceptive distribution data. Family Planning client information will be provided on a monthly basis to the Technical Support Service of the DHFN. The Technical Support Service of the DHFN will use this information in order to prepare periodic reports in which they will present both comparative tables of the contraceptives provided to the various regions and their

effective use. These reports will serve as feedback to the regions and districts and to all distribution points. Data on active users and couple years of protection will be used to monitor and evaluate project progress.

During this period, in order to gain more in-depth information ad hoc surveys will be conducted on client profiles, continuation rates, client satisfaction, clinic performance and contraceptive use.

For each training activity the DHFN will keep a record of course duration and content, numbers and characteristics of participants, costs and results of pre- and post-test evaluation. Project training in management skills is described in Section 3, Training Program, below.

Copies of supervisory reports will be forwarded to the research and evaluation unit (DHFN) for analysis and summary.

b. Logistics

The Division of Family Hygiene will continue to order, receive, warehouse and distribute family planning equipment and contraceptive supplies. One of the first project activities will be the request for TA from the Centers for Disease Control (CDC) to review and recommend ways to upgrade its logistical capability. This will include the DHFN's ability to project requirements and order supplies, maintain an adequate inventory of contraceptives at all service points, and report in a timely and complete fashion to project management.

c. Supervision

The National Family Planning Coordinator, the DHFN and the regional F.P. officers will supervise the work of those responsible for FP at the regional, district, and community-level. They will ensure that responsibilities are carried out in accordance with job descriptions. Progress in this area will be periodically reported to the Family Planning Project Committee. In order to facilitate this task, a supervision form will be designed and will be made available to the regions.

d. Research

A nationwide household-based survey will be undertaken in the summer of 1987 to clarify the presently confusing picture of number of users, amounts of contraceptives distributed, levels of

contraceptive prevalence, pattern of condom use and the use of other contraceptives. (A survey protocol is provided in Annex 4). Investigations will also examine the number of health facilities actually providing F.P. service vis-a-vis the number that could provide service, types and numbers of community outreach workers and volunteers and the number of F.P. clients they serve, client satisfaction with the service and reasons for the apparent low level of use of contraceptives. An immediate project priority will be the provision of technical assistance to develop the most effective method for review of these issues. This study will be supplemented by the statistics produced by the management information system and the logistics system, supervisory and training reports and reports of operations research.

e. Personnel

DHFN will hire a computer specialist to maintain the MIS and train staff in its use. An inventory stock manager will be hired twice each year to determine stock levels below the central warehouse.

3. Service Delivery

A nationwide system of family planning service delivery will be in place so that 60% of the population will be no more than a one hour walk from a health facility or community agent or a family planning delivery point. In order to achieve this goal facilities will be upgraded, personnel trained and equipment and contraceptives provided for at least one central referral clinic in each of the 15 districts so that a full range of contraceptive services are offered at these facilities. Services will include foaming tablets, condoms, IUDs, orals, sterilization, and referral for natural family planning methods, Norplant and injectables. Contraceptives will continue to be provided to non-governmental organizations providing FP.

Personnel to be trained will include surgeons and nurses for sterilization, IUD insertions; nurses and para-medical assistants for supplying orals, condoms and foaming tablets, and social workers for informational and counselling activities (see Training Program in Section 5 following).

Other health facilities will be renovated to provide voluntary sterilization services. In most cases mini-laparotomy will be the procedure for female sterilization with vasectomy for males. Mini-lap kits and vasectomy kits will be provided. OB/GYN tables, lamps, instruments, equipment carts, stethoscopes, blood pressure cuffs, and scales will also be supplied. A full supply of contraceptives will be maintained and informational materials provided.

JHPIEGO will provide TA for training and the Association for Voluntary Surgical Contraception (AVSC) will assist with developing standards and improving quality control.

In all other public health facilities non-surgical methods (orals, condoms, foam) will be available on a regular basis. In certain centers, minor improvements may be necessary but the major program inputs will be training, supervisor, information materials and contraceptive supplies.

In those districts where community agents are presently working to recruit F.P. clients, their responsibility for distribution of non-surgical methods of contraceptives (foam, condoms, orals) will be emphasized. This cadre of workers includes 106 urban community workers, 13 rural F.P. promoters, and 400 health agents attached to dispensaries. In one or two districts there will be experimentation to revitalize the use of community volunteers (other than the 1,000 SNEM Col Vols), who have been organized and supervised by the DHFN to provide family planning services. Additional training will be provided and supervision by DHFN personnel increased. Particular attention will be given to reviewing the degree of client follow-up provided, continuation rates and the impact of house-to-house visits.

With some modification, the Armed Forces (FADH) clinic and community program involving 30 centers will be continued. Emphasis will continue to be placed on the use of condoms but at a reduced level of distribution per person. A referral clinic will provide voluntary sterilization services (male and female) and other contraceptive methods for the members of the Armed Forces, their families and the surrounding community. Other FADH clinics will provide non-surgical methods.

The limited FP services provided by five mobile "clinics" will continue. However, review will be made to assure that they are adhering to U.S. policy, that they make contact with village leaders; that clients receive adequate counseling; and that continuing supply points for contraceptives are identified. Supervision by regional FP officers will reinforce supervision and follow a more formal schedule for visits.

4. Information, Education and Communication (IEC)

There are substantial requirements for IEC in this family planning program. Although surveys show there is a widespread awareness of family planning in Haiti, the target population is not sufficiently motivated to use contraceptives because information on the points of distribution is insufficient; there is misinformation and unfavorable rumors about particular methods; and certain methods are not always properly used.

Four kinds of messages must be transmitted:

- a. The availability of family planning services: where, when, by whom, etc.--through mass media; posters; promotional materials, logos; signs for distributors, popular music; and interpersonal communication by health, malaria, agricultural and other community agents.
- b. Proper use of contraceptives and recognition of potential side effects. Printed communication materials for the non-literate population will be used by health facility personnel and community agents.
- c. The effects of high fertility on family health and welfare, family economy, cost of education, etc.
- d. The most important issues on population policy to address with national leaders, e.g., impact of high fertility given the reductions in mortality, on social, economic and cultural development. This can be done through research reports, seminars, RAPID presentations and selected mass media.

FP/IEC technical assistance will be provided by the Johns Hopkins/PSC project to:

- a. provide an IEC strategy and program design;
- b. participate in the design and production of prototype materials including those for illiterate audiences;
- c. assist in design and production of materials including for non-literate audiences;
- d. develop an IEC pilot campaign in several districts, with careful attention to target audience selection; material preparation with pre-test and impact measures; and experimentation with various media and promotional approaches and evaluation.

Coordinating responsibilities for F.P./IEC will come from the AID population officer, the TA contractor, and the IEC officer who will be hired for the DHFN.

##### 5. Training Program

Although a significant number of health personnel are well trained in family planning, there are continuing requirements for training in new technology, new methods and new categories of workers. Most of the in-country training will be carried out at regional and district facilities which is a major reason for requiring full-time family planning personnel at those levels. The major training requirements will be for the following:

- a) Train 20 physicians and 20 nurses to perform voluntary sterilizations in the referral centers. Training to be carried out by DHFN with JHPIEGO assistance.
- b) Retrain or update skills of lead clinic or dispensary F.P. personnel in 150 to 170 other centers. This training will take place at the district level by regional and district personnel with assistance of DESE and DHFN with technical assistance from qualified institutions as needed. Preparation for this training will require an initial training of trainers course.
- c) Improve management, organizational, supervisory, and evaluation skills for F.P. committee members, national and regional F.P. officers, supervisors and selected district personnel through:
  1. observational travel to such locations as Zimbabwe, Morocco and Mauritius, Colombia, Mexico or others.
  2. two week management training course in-country at national level by DHFN with technical assistance from qualified institutions.
  3. one week training for supervision, logistics and the computerized management system in-country at the national level, planned by the National F.P. Coordinator and regional F.P. officers, and carried out by DHFN with technical assistance provided by CDC.
  4. selected attendance at family planning management and community outreach training programs in the U.S.
- d) Training for the development of a national population policy will include:
  1. Observation travel (Mexico and Nigeria)
  2. International seminars and selected U.S. training
  3. In country training and seminars.

Participants will be identified by the MEPP or other concerned ministries.

## 6. Research Development

The project will finance technical assistance to carry out research that will assist the GOH in developing a rational, long term family planning program consistent with goals for improving family welfare. These studies will help to develop improved service delivery approaches.

The activities to be carried out under this component include the following:

- a) Expanded clinical research on NORPLANT in three private health centers plus an operational study of the wider use of NORPLANT in public centers in Haiti. The operational study will look to the implications for facility and personnel requirements, training, logistics, supervision and client demand in the public sector. The study will also review the possible impact of Norplant on future demand for orals, injectables, and sterilization. The Family Health International will provide technical assistance and will manage the project. A preliminary proposal for NORPLANT activities is contained in Annex 7.
- b) Biomedical research identifying the levels of maternal mortality, especially focusing on the relationship of age specific parity, birth interval, and age of first child to the risk of maternal death. This will provide important data, in the Haitian context, on the relative health risk of pregnancy compared to the use of modern contraceptives (including NORPLANT).
- c) In 4 districts, clinical research will be conducted on the use of the IUD in order to better promote this method.
- d) Other research subjects in FP will be identified by the DHFN and health regions. Protocols will also be developed and revised as needed. Preliminary ideas for additional research are the use of matrones for FP, and the impact of voluntary sterilization on a national level.

#### 7. Policy Development

The project will finance technical assistance to carry out research and analysis that will assist the GOH in developing a rational, long-term population policy consistent with goals for socio-economic growth. The Directorate of Population is currently preparing an updated RAPID presentation for national and regional leadership with technical assistance from the Futures Group. Directorate of Population staff members will be trained in micro-computer use and in integrating population variables into development planning. Assistance will be provided for demographic studies in each development sector which will enable CONAPO to articulate and implement a population policy. These studies will be printed and disseminated widely among political leaders and policymakers. Limited financial support will be provided for furniture and renovation of office space for the CONAPO secretariat.

C. Project Inputs - A.I.D. Inputs

1. Technical Assistance

- a. Long term resident assistance  
(management, planning and evaluation) 24 person months
- b. Short-term technical assistance
  - 1. management training 2 person months
  - 2. evaluation 3 person months
  - 3. policy development 2 person months
  - 4. logistics 1 person month
  - 5. service delivery training  
(including training of trainers) 4 person months
- c. Program assistance - local hire 24 person months

2. Technical Assistance financed by AID/W Cooperating Agencies

- a. evaluation (CDC) 3 person months
- b. logistics (CDC) 2 person months
- c. service delivery training  
& curriculum development (JHPIEGO) 4 person months
- d. IE&C (Johns Hopkins/PCS) 2 person months
- e. Quality Control for surgical  
Programs (AVSC) 4 person months

3. External Short-Term Training

- a. observational travel for project  
leaders 15 person weeks
- b. Family Planning Organization and  
management for leaders (4 weeks) 24 person weeks
- c. Integration of Population variables  
in development 24 person weeks

4. Training financed by AID/W Cooperating Agencies

Additional training will be provided as required for trainers and surgical teams by qualified AID/W cooperating agencies.

<u>5. Operating Costs</u>	<u>Person Years</u>
<u>a. Salaries</u>	
(1) National F.P. coordinator - full time	2.5
(2) DHFN Staff (26 employees)	
1 Physician	2
2 Statisticians	4
2 Accountants	2
1 Computer Programmer	2
1 Stock Controller	2
1 Warehouse Supervisor	1
3 Secretaries	4
15 Support Staff (stock boys, guardians, janitors, mechanics, chauffeurs, etc.)	16
(3) Contraceptive Inventory Evaluator	0.5
<u>b. Operating Costs for National Coordinator's Office</u> (rent, electricity, telephone, mail, maintenance).	
6. <u>Renovation</u> - to bring referral centers to acceptable standards for minor surgery - approximately	4 centers
7. <u>Medical Equipment</u>	
Surgical equipment including operating table, gyn tables, lamps, mini-lap and vasectomy kits, IUD insertion and removal kits, resuscitation units, equipment carts and sterilization units. Various items as required for	20 centers.
8. <u>Expendable Medical Supplies</u> for surgical activities (gauze, drugs, gloves, catgut, antiseptic, etc.) for	7 centers
9. <u>Ancillary equipment</u> for non-surgical family planning - (blood pressure, scales, etc.) as required for approximately	30 centers

10. Vehicles

Vehicle placement and condition will be reviewed to assure a well functioning vehicle assigned full time as follows:

National Family Planning Coordinator	1
DHFN	4
Regional F.P. officers & Rural Supervisors	4
District F.P. officers (sterilization program)	15
Estimated requirements for new vehicles	3

11. Operations and Biomedical Research

a. FHI maternal mortality & pregnancy surveillance	1
b. FHI Norplant	1
c. IUD Study	1

12. Evaluation Research

Various studies to produce one report on levels & pattern of contraceptive use and service delivery	1
Audit	1
Interim Evaluation	1

13. IEC Material

a. posters calling attention to family planning and identifying supply locations	1000 units
b. printed illustrated materials for use by clinic and community personnel in explaining the various contraceptives available and explaining proper use of pill - 3 publications of 3,300	10,000 units
c. logos and home signs for distributors and other simple promotional materials	10,000 units
d. local costs of mass media program developed in consultation with Johns Hopkins PCS (including necessary locally-hired personnel for DHFN)	1 program

14. Office equipment

a. micro-computers for National Coordinator and unit of research DHFN	4
b. Typewriters as needed by national, regional and district offices	4

- c. Desk calculators as needed by DHFN and Regions 5
- d. Hand calculators for District, community supervisors and SNEM supervisors 50
- e. Desk, chair and file for National Coordinator, and Regional FP Officers 5 sets

15. Contraceptives

a. Assumptions

As noted previously, the issue of contraceptive use must be reviewed in the first six months of this project. Revisions may be made in the type and amounts of contraceptives to be ordered. For purposes of this amendment the following assumptions were made:

1. There are enough U.S. supplied pills and condoms in country or on order to carry the project through July 1987.
2. At the end of the program period (September 1989) there should be up to a one-year supply on hand.
3. Projections for contraceptives include those needed for the Private Sector Project, but payment will be made by the Private Sector Project for contraceptives distributed to the private sector.
4. Pill use is projected to increase by roughly 5 percent a year, and condom use by roughly 4 percent a year. However, it is conceivable that as a result of the increasing spread of AIDS and the fact that condoms provide protection, the use of condoms could increase far beyond present levels (from increased use in disease prevention rather than pregnancy prevention). In such an event, current projections of condom demand would become outdated.
5. UNFPA will continue to provide Depo, foaming tablets and some pills.
6. FHI will continue to provide NORPLANT.
7. Work tables are provided in Appendix 8.

b. Estimated quantities

condoms	30,000,000 units
orals	3,072,000 cycles
IUDs	2,000 units

16. Policy Development

- a. Various studies to provide reports to CONAPO
- b. Seminars for policy development
- c. Renovations and office equipment for CONAPO.

17. PVO Support

- a. Contribution to Action Familiale for natural family planning activities.
- b. One year of operating costs for sterilization training clinic in Port-au-Prince. AVSC is providing equipment.

D. Project Inputs - Government of Haiti

PL-480 Title III Counterpart Funds

1. In-Country Training

- a. management training for project leaders (2 weeks) 24 person weeks
- b. supervision, logistics and management info system (1 week) 60 person weeks
- c. surgical contraception for surgeons and nurses (2 weeks) 100 person weeks
- d. training of trainers for service delivery (2 weeks) 40 person weeks
- e. family planning update (non-surgical method) doctors, nurses & auxiliaries working in family planning (one week) 200 person weeks
- f. seminars for community agents and health agents (three days) 400 person weeks
- g. Family Planning promoters (one week) 40 person weeks
- h. update in family planning for doctors and nurses of FADH and rural police officers - (one week) 600 person weeks

<u>2. Personnel (176 Employees)</u>			<u>Person-Years</u>
1	Administrative Assistant	(UCDR) full time	2.5
1	Assistant Administrator	(DHFN) half time	1
3	Chauffeurs	(DHFN)	6
1	Maid	(FADH)	2
1	Physician	(West Region)	2
4	Accountants	(4 Regions) half time	4
4	Regional Commun. Supervisors	(4 Regions)	8
1	Social Worker Supervisor	(West Region)	2
15	Social Workers	(4 Regions)	30
19	Promoters	(4 Regions)	38
20	Community Agent Supervisors	(4 Regions)	40
106	Community Agents	(4 Regions)	212
3.	<u>Renovation</u> - to bring referral centers to acceptable standards for minor surgery approximately		6 centers
4.	<u>Expendable Medical Supplies</u> for surgical activities for approximately		3 centers
5.	<u>Operating Expenses</u>		
	a.	Per diem for supervision (national, regional, district)	
	b.	Gasoline and maintenance for 24 project vehicles	
	c.	Office supplies	
	d.	Printing of client record and management information and logistics system forms	200,000 units
6.	<u>Research</u>		
	Community outreach program		1 study
7.	IEC mass media program		1
8.	<u>FVO Support</u>		
	Contribution to natural family planning activities		

E. Project Outputs

1. An organizational structure will have been developed capable at national, regional, and district levels of planning, coordinating, managing, supervising and evaluating a family planning program (clinic and community based) of national coverage. Full time Family Planning personnel will be in place at national, regional and district levels to assure adequate coordination and emphasis on family planning within the integrated, decentralized health system.
2. A management information system will be in place capable of producing reliable and timely data on new and active users compared with contraceptive distribution data and using active users and couple years of protection as measures of program progress.
3. A nationwide representative survey will be completed to produce a mid-term review of levels of accepters, patterns of contraceptive use, continuation rates, contraceptive prevalence, client satisfaction, and relation of contraceptive quantities distributed to users recorded. Other various studies will be completed to determine the numbers and efficiency of health facilities and community outreach personnel distributing contraceptives.
4. A nationwide system of family planning service delivery will be in place. This system will be composed of the following:
  - a. One or two Referral Centers in each health district where a full range of surgical and non-surgical contraceptive services will be available daily (a total of 25 in the public sector plus one specialized surgical center in the private sector).
  - b. In all other public sector health centers (a total of 163) and dispensaries non-surgical contraceptives (orals, condoms, injectables, foam) will be available daily.
  - c. Community based distribution of non-clinical methods (orals, condoms, foam) by :
    1. community agents - urban (106) + supervisors (19)
    2. rural family planning promoters (19) with volunteer collaborators
    3. health agents attached to dispensaries (400)
  - d. mobile clinics (5)
  - e. Armed forces clinic and community program (30 centers)

5. Contraceptives will be distributed or sterilizations performed in the second year of the extended project at the level of more than 90,000 couple years of protection (CYP) estimated as follows at this time but subject to substantial revision based on the findings of the CDC review described previously:

condoms	-	240/CYP
IUD	-	0.5/CYP
Foaming tablets	-	150/CYP
Injectables	-	4/CYP
Norplant	-	0.2/CYP
Orals	-	13 cycles/CYP
Sterilization	-	0.2/CYP

Based upon experience gained from other FP programs, these contraceptive rates would imply a contraceptive user prevalence of 11% from the project. This estimate will be re-examined, however, following the review by CDC.

6. Mass media messages and IEC material will be diffused and available to further assist institutional and community personnel in person to person communication on:
- desirability of family planning
  - proper use of methods
  - understanding and dealing with side effects
7. A biomedical and operations research study will be conducted to build on pre-introductory trials now underway to evaluate the safety, efficacy and acceptability of NORPLANT contraceptive subdermal implants in Haiti. The total number of women enrolled in the study will increase from 250 to 1800 per year. A national registry of users will be established.
- Information/education materials appropriate for use by Haitian clients and providers will be developed. A study will be conducted to examine factors for expansion to additional centers in the public sector.
8. An operations research study will be conducted on the acceptability of the IUD in order to promote use of this method in public centers.
9. Biomedical research will be conducted to clarify the reproductive health risk (maternal mortality and morbidity) in Haiti associated with maternal age, parity and birth interval. This will be disseminated throughout the health system by seminars and policy directives indicating the priority to be given to family planning as a health intervention.
10. With active participation by MSFP, CONAFO will have implemented a national population policy that includes reproductive health concerns and strong support for family planning.

IV. SUMMARY COST ESTIMATES AND FINANCIAL PLAN

The \$4.333 million amendment increases the present \$9.615 million project to a new LOP total of \$13.948 million in grant funds. The total cost of activities to be funded during the extended project period of FY 87-89 and covered under the amendment is \$4.843 million, of which \$510,000 derives from funds unspent under the original project.

A.I.D. Summary Cost Estimates  
(LOP \$000)

	<u>Expenditures/ Accruals To Date*</u>	<u>Unexpended Balance</u>	<u>Amendment</u>	<u>Total</u>
Technical Assistance	154	-	528	682
Training	256	-	150	406
Research	-	-	700	700
IEC	-	-	147	147
Contraceptives	3,929 **	333	1,767	6,029
Equipment, Supplies & Renovation	985	-	270	1,255
Policy Development	-	-	150	150
Operating Expenses	3,525	-	351	3,876
PVO Support	199	52	100	351
Evaluation & Audit	57	30	170	257
Contingency	-	95	-	95
Project Total	9,105	510	4,333	13,948

\* As of March 10, 1987

\*\* Funding was allotted directly to  
AID/W for procurement of contraceptives.

Summary Financial Plan for Amendment  
(includes \$510,000 carryover)  
( \$000)

	<u>AID</u>	<u>Title III</u>	<u>Total</u>
Technical Assistance	528	-	528
Training	150	181	331
Research	700	44	744
IEC	147	100	247
Contraceptives	2,100	-	2,100
Equipment, Supplies, & Renovation	270	100	370
Policy Development	150	-	150
Operating Expenses	351	933	1,284
PVO Support	152	25	177
Evaluation & Audit	200	-	200
Contingency	95	67	162
Total	4,843	1,450	6,293

Total cost estimates for the amendment are approximately \$6.3 million, and include \$4.3 million in 1987-89 DA funding; \$.5 million in carryover from the original project; and \$1.4 million in Title III funds. A detailed cost estimate is presented in Annex 5.

A.I.D. (D.A.) Financial Plan for Amendment  
Foreign Exchange and Local Currency  
(includes \$510,000 carryover)  
(\$000)

	<u>FX</u>	<u>LC</u>	<u>Total</u>
Technical Assistance			528
Long-Term	288	-	
Short-Term	180	-	
Local Hire	-	60	
Training	150	-	150
Research			700
Norplant	465	-	
Maternal Mortality	150	-	
Other	-	85	
IEC	147	-	147
Contraceptives	2,100	-	2,100
Equipment and Renovation			270
Equipment	55	-	
Supplies	84	-	
Renovation		14	
Vehicles	45	-	
Office and W.H.	67	5	
Policy Development	150	-	150
Operating Expenses			351
Salaries	-	255	
Coord. Office	-	96	
PVO Support			152
Action Familiale	-	100	
FOGEPEF	-	52	
Evaluation and Audit			200
CIX Survey	-	100	
Evaluation	60	-	
Audit	40	-	
Contingency	95	-	95
<b>TOTAL</b>	<b>4,076</b>	<b>767</b>	<b>4,843</b>

V. PROJECT IMPLEMENTATION

A. Project Management

1. Administration and Coordination

Project administration will be divided between USAID/Haiti, DHFN, Family Health International, Population Communication Services, and Futures Group.

a) USAID-Haiti

USAID will administer project funds and coordinate project activities as they relate to long-term technical assistance; short-term technical assistance; out-of-country participant training; procurement of contraceptives; and project evaluation. The USAID role will consist of monitoring and coordinating overall project inputs including those of FHI, PCS, and Futures Group; identifying and arranging short-term technical assistance; procuring U.S.-purchased items not procured by FHI, PCS, or Futures Group; ensuring that all U.S. requirements and conditions are met; and keeping all necessary parties informed of overall project progress. A full-time locally contracted program assistant will continue to assist the USAID Population Officer.

For administration, USAID will contract through an 8(a) firm who will arrange for the recruitment, payment and support of a long-term resident technical advisor to coordinate and monitor project activities and to provide technical assistance to the National Family Planning Coordinator. A job description is provided in Annex 7.

b) DHFN

The DHFN will continue to be responsible for implementation of project activities as they relate to the following: in-country participant training; conducting research and IEC activities; distributing contraceptives to regions, districts and the private sector; in-country renovations in collaboration with USAID Engineering office; arranging payment to local suppliers for renovations; distributing medical equipment, supplies, office equipment and vehicles; providing support to the private sector; hiring personnel for and conducting the contraceptives use survey with TA provided by CDC; managing all local currency expenditures (including Title III funds); and formal reporting. The National Family Planning Coordinator and the USAID resident technical advisor will assist the DHFN in their responsibilities, and will monitor program and fiscal expenditure progress. Progress activity reports will be submitted to USAID on the last day of the month of each U.S. fiscal year quarter (i.e., December 31, March 31, June 30, and September 30).

c) Family Health International

The project will provide an estimated \$460,000 in funds for support of biomedical research on NORPLANT and \$150,000 in funds for research on maternal mortality. FHI will administer these funds and monitor research related activities conducted by participating local institutions. FHI will negotiate and execute sub-agreements with the DHFN and three private health institutions

(Cite Soleil, Hopital de la Bienfaisance at Pignon, and Centre de l'Armee du Salut at Fonds des Negres). The sub-agreements will elaborate project activities and budget; delineate a work schedule; and define specific roles and responsibilities of the project directors and project staff. FHI will provide technical assistance as defined in the sub-agreement for implementation of the research component; monitor progress of project activities; set up an acceptable accounting system and monitor foreign exchange and local currency expenditures; procure NORPLANT contraceptives and U. S. equipment/materials; and ensure that all parties are kept informed of progress in the research component.

d) Population Communication Services

The Project will provide an estimated \$147,000 in funds for support of IEC activities in Haiti. PCS will administer these funds and monitor IEC related activities conducted by the DHFN. After a project development visit, PCS will negotiate and execute a sub-agreement with the DHFN which will elaborate project activities and budget; delineate a work schedule; and define specific roles and responsibilities of the project director and project staff. PCS will provide technical assistance as defined in the sub-agreement for implementation of the IEC component; monitor progress of project activities; set up an acceptable accounting system and monitor foreign exchange and local currency expenditures; procure U.S. equipment and materials; and ensure that all interested parties are kept informed of progress in the IEC component.

e) Futures Group

The project will provide an estimated \$150,000 in funds for support of population policy development activities in Haiti. Futures Group will administer these funds and monitor training-related activities conducted by the Directorate of Population. Futures Group will negotiate and execute a sub-agreement with the DOP which will elaborate the project activities and budget; delineate an implementation schedule; and define specific roles and responsibilities of the project director and project staff. Futures Group will provide technical assistance as required to train personnel; monitor progress of project activities; set up an acceptable accounting system and monitor foreign exchange and local currency expenditures; procure U.S. material and supplies; and keep all interested parties informed of progress in the policy development component.

2. Project Monitoring

USAID/Haiti will monitor the implementation of all project activities on a continuous basis. Participating cooperating agencies, (FHI, PCS and Futures Group) and short-term technical assistance consultants will be required to brief/debrief USAID during all project site visits; provide USAID with trip reports summarizing observations, conclusions, recommendations and decisions; provide USAID with routine project activities reports; and provide to USAID additional project information as requested. The Family Planning Project Committee will meet quarterly and the DHFN will submit quarterly progress reports to USAID. For participant training, the training institution will be requested to complete a trainee report. In addition, after completion of training, participants will be requested to prepare a brief statement to USAID on their training experience and its applicability to their anticipated work.

B. Procurement Plan

1. Technical Services (external)

USAID will prepare a PIO/T for contract negotiation and execution with an 8(a) firm to provide 24 months of resident technical assistance.

Other technical services will be purchased through authorized "buy-ins" to relevant centrally-funded S&T/POP projects. The USAID Mission Population Officer or the resident advisor will prepare PIO/Ts for the purchase of various short-term technical assistance services in such areas as family planning service management; record keeping and logistics; program, planning and evaluation; and training of trainers. In addition, this project will add funds to three centrally-funded cooperating agencies, FHI, PCS, and Futures Group, for research, IEC, and Policy development activities, respectively. The Mission will prepare the PIO/Ts for contract negotiation/execution by AID/W on Mission behalf.

Finally, USAID will negotiate and execute a personal service contract for local hire program assistance.

2. Commodities

- a) U.S. source drugs, equipment and expendable supplies will be purchased either through an AID/W IQC with a procurement service agency (PSA) or through contract with the 8(a) firm who provides the long-term TA.
- b) U.S. manufactured vehicles will be procured through a separate AID/W IQC with a PSA.
- c) Contraceptives will be purchased by AID/W S&T/POP through funded PIO/Cs.

3. Other Local Cost Use of Development Assistance Funds

Local Costs for personnel, operating expenses, renovation, materials, research, PVO support, etc., will be on a reimbursable cost basis to the Division of Family Hygiene against a bi-monthly advance and supported by payment vouchers. All personnel except the national coordinator and his or her administrative secretary will be paid according to the MSPP scale. The MSPP will be permitted to exceed this rate and use other contracting procedures for these two persons who will be selected with USAID concurrence.

4. Use of Title III Counterpart

Title III counterpart which has been programmed as an integral part of this project will be approved and reimbursed according to standard Title III Bureau procedures with USAID concurrence.

C. Consideration of Small and Disadvantaged Firms

Under this project, approximately 6 percent of project funds will be expended for long-term technical assistance to be contracted with an 8(a) firm. Twenty-five percent of project funds will be obligated through buy-ins to specialized technical agencies which have already obtained, through competition, S&T/FOP centrally-funded contracts or agreements. To the extent possible, Gray Amendment entities have been utilized by ST/POP. As short-term technical assistance assignments are identified, the Mission will request from AID/W a list of Gray Amendment entities who can provide the required services.

Five percent of project funds will be obligated for Equipment and Supplies to be purchased for MSPP health institutions. The technical advisor contractor will prepare PIO/Cs for contract negotiation. Execution will be done by AID/W, on the Mission behalf, with an approved IQC/PSA agent. Gray Amendment entities will be utilized to the extent possible. The Mission will identify several IQC/PSA 8(a) firms who have appropriate experience in the procurement of health equipment and supplies.

Methods of Implementation and Financing

<u>Item</u>	<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Approximate Cost (\$000)</u>
<u>A. Technical Assistance</u>			
1. Resident Advisor	PIO/T for 8(a) contract	Direct pay	288
2. Program Assistant	Local PSC	Direct pay	60
3. Short-term	Various Buy-ins to S&T/POP with PIO/Ts	Direct pay	180
4. Biomedical Research	Buy-in to S&T/POP Coop. Agreement with Family Health International (PIO/T)	Direct pay	615
5. IEC	Buy-in To S&T/POP Coop. Agreement with Johns Hopkins /PCS (PIO/T)	Direct pay	147
6. Policy Development	Buy-in to S&T/POP Coop. Agr. with Futures Group (PIO/T)	Direct Pay	150
<u>B. Training</u>			
1. Short-Term External	PIO/P-AID/W training	Direct pay	150
<u>C. Commodities</u>			
1. Contraceptives	AID/W central (Funded PIO/C)	Direct Pay	2,100
2. Vehicles	IQC - PSA	Direct pay	45
3. Medical Equipment and Supplies	IQC - PSA or 8(a) contract	Direct pay	139
4. Office Equipment and Supplies	IQC - PSA or 8(a) contract	Direct pay	72
<u>D. Operating Expenses</u>			
	H.C. Procurement	H.C. reimbursement	351
<u>E. PVO Support</u>			
	H.C. Procurement	H.C. reimbursement	152
<u>F. Renovation</u>			
	H.C. Procurement	H.C. reimbursement	14
<u>G. Evaluation Research</u>			
	H.C. Procurement	H.C. reimbursement	160
<u>H. Audit/Evaluation</u>			
	PIO/T and USAID contract	Direct pay	100
<u>I. Contingency</u>			
	-	-	95
TOTAL			4,843



	<u>Quarters</u>												
	.86/ 4	. 87 1	. / 2	. 3	. / 4	. 88 1	. / 2	. 3	. / 4	. 89 1	. 2	. 3	. 4
Observational travel				X		X							
National committee review of CDC assessment and initiate required action re contraceptive distribution and expansion or contraction of community agent FP activities							X	X					
Semi annual report of DHFN and FP coordinator					X		X		X		X		X
FHI expands Norplant research				X	X	X	X	X	X	X	X	X	X
FHI carries out reproductive risk survey				X	X	X	X						
Prepare new contraceptive requirements projection with CDC assistance	X					X			X				
Order vehicles				X	X								
Order drugs, equipment and expendable medical supplies				X	X								
Print IEC materials and begin mass media campaign				X	X		X						
Carry out planned in-country training activities				X	X	X	X	X	X	X	X	X	
Renovate additional surgical centers				X	X	X	X						
Carry out audit	X												
Develop PID for new project								X	X				
Interim Evaluation						X							

Quarters

.86/ . 87 . / . 88 . / . 89 . .  
 4 1 2 3 4 1 2 3 4 1 2 3 4

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PF design											X	X
Review of supervision protocol				X								
Quarterly Statistical Summary by DHFN			X	X	X	X	X	X	X	X	X	X
Preparation of Annual Operation Plan by DHFN with regional officers and coordinator			X	X			X	X				

E. Evaluation and Audit Plan

Although the Amendment covers a two and 1/2 year period, progress made under the Amendment will be an important input into the design of a new family planning project to begin in FY 1989. The research studies to be carried out under the project will provide answers to some of the important questions related to this future project.

An interim project evaluation is needed, however, to assess the effectiveness of the organizational changes in the MSPP made under the Project and to make recommendations on the direction and extent of future public sector programming. The evaluation will be undertaken in early 1988 and will be combined with an evaluation of the Private Sector Family Planning Project.

VI. CONDITIONS PRECEDENT AND COVENANTS

The current project agreement contains a condition precedent prior to disbursement each fiscal year, a requirement for submission of an annual Operational Plan for that fiscal year. There is also a condition precedent to disbursement for renovation requiring appropriate information on the facility to be renovated. These will be retained, along with the various standard covenants. In addition, the following covenants will be added:

Except as A.I.D. may otherwise agree in writing, the Grantee shall covenant and agree:

- A. That within 90 days of the date of this Grant Agreement Amendment, it will:
- i) Assign qualified personnel to work as family planning officers in each of the regional and district offices and provide their names to A.I.D.
  - ii) Identify and place a well-trained Haitian, acceptable to A.I.D., with experience in family planning, to work as the National Family Planning Coordinator in the Unit of Regional Coordination in the Ministry of Health and Population.
- B. That within 60 days of the receipt by the MSPP of the final audit report from the A.I.D. Office of the Regional Inspector General, it will submit a plan, acceptable to A.I.D., for appropriate management corrections based on the recommendations of the audit report. The plan will contain specific actions and completion dates for each of the recommendations.
- C. That it will direct the District Directors and the District Family Planning Officers to ensure that family planning is integrated into workplans and daily activities of each public health center.

## VII. AMENDED PROJECT ANALYSES

As stated in the 1983 mid-term evaluation, there is little evidence to suggest that the basic project design was faulty. An exception may be that the project placed too much confidence in the ability of the Rural Health Delivery System project (authorized June 1980) to rapidly strengthen the administrative and management structure of the MSPP. The project designers also may have underestimated the difficulty of coordinating the various MSPP departments and decentralized levels to maintain an emphasis on family planning within an integrated system.

The demographic situation, particularly as related to use of contraceptives, is not clear. However, there is no evidence to suggest that the original project was incorrect in its interpretation of the situation at that time, namely, that there was substantial demand for family planning services, and that the problem was essentially one of effectively meeting that demand. Nevertheless, with the uniquely complex fertility and nuptuality patterns in Haiti, it will take exceptional efforts to achieve and measure changes in the birth rate associated with family planning.

The Amendment addresses these factors by placing a high emphasis on coordination, personnel and organizational issues to attempt to strengthen the priority given to family planning services. It also calls for an early review of the contraceptive use situation to provide a more realistic basis for future programming. Some minor update of the technical and social analyses found in the Family Planning Outreach PP follow. However, most of the conclusions of the various analysis are still sound.

### A. Technical Analysis

The Haitian population has a fertility rate inimical to reproductive health, contributing to both high maternal and infant mortality. The crude birth rate, 36 per 1000 persons, is lower than expected, given the estimated 6-8% rate of modern contraceptive use. This is due largely to patterns of nuptuality and maternal age, breast feeding, and possibly abortion. The high crude death rate (16-17/1000) and out-migration (4-4.5/1000), are the other major demographic factors which have kept the annual growth rate below 2%. However, even a growth rate as low as 1.6% presents a tremendous future burden on a country with the population density of Haiti (nearly 700 persons per square kilometer of arable land).

For instance, at this rate of growth, Haiti's total population will double in approximately forty years.

The "natural" controls on the growth rate cited above, i.e., post-partum ammenorrhoea from breast feeding, postponed initiation of childbearing, the lower fertility of less stable unions, etc., could easily change in a direction that would increase fertility and the corresponding growth rate. Decreased opportunities for emigration to the U.S. and other countries (e.g., Bahamas) could well increase the supply of younger males in the population. The contraceptive prevalence survey of 1983 suggests that the number of stable unions, which have had higher fertility in the past, may be on the increase. Urban practices may be changing the pattern of delayed first births. A survey carried out in 1984 by the Haitian Arab Center in an urban area (Cite Simone) of Port-au-Prince showed an alarmingly high adolescent fertility rate--19 percent of women aged 15-19 were found to be pregnant. This increase in fertility could be partly responsible for the failure of the birth rate to decrease despite the increased availability of contraceptives. With a contraceptive prevalence of 6-8% nationwide and substantially higher in Port-au-Prince, one would expect some indication of the beginning of a decrease in the birth rate at least in the urban areas. For example, a slight decrease might be seen in the annual number of births reported in hospitals. This has not yet proved to be the case.

Although there are many inconsistencies in the information available, it appears that there has been some recovery from the drop in contraceptive prevalence noted between the 1979 Haitian Fertility Survey (HFS) and the 1983 Contraceptive Prevalence Survey (CPS). The HFS indicated that 6.5%\* of women "in union" were using an efficient method of contraception (i.e., orals, IUDs, "female scientific methods" or male or female sterilization). The CPS indicated that in 1983 the percentage of women "exposed to pregnancy" using modern methods had dropped to 3.9%. A survey carried out in July of 1985\*\* asked questions concerning health problems as well as family planning of a smaller sample of women nationwide outside Port-au-Prince. The results obtained indicate a contraceptive prevalence for modern methods of 5.5% or as much nationally as 6.8% if extrapolated to include Port-au-Prince.

As discussed in Annex 2 it is difficult to relate DHFN service statistics and commodity distribution to levels of contraceptive prevalence. Nevertheless, the increase in the numbers of "users" reported by DHFN suggests that the trend, albeit undramatically, is at least moving in the right direction. However, these are not the kind of increases in contraceptive use which will have a significant impact on the national birth rate.

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\* According to the CPS (p. 87), use of the same denominator as the CPS yields a 1977 prevalence rate of 5.4% as compared to 3.9% in 1983.

\*\* Enquete National Pronacodiam, PEV PF-1985 (Diarrhea, Immunization & Family Planning Survey, MSPP, PAHO, MSH and Columbia University).

Significant choices had to be made in including and assigning relative priority to various program components. To include the various elements of service delivery with the support mechanisms of management information, logistics, training, supervision, IEC and evaluation, is complex. To have several service delivery approaches with fixed facilities, Armed Forces, community agents and SNEM/Col Vols, compounds the problem. To then arrange for delivery of three surgical and four or five non-surgical contraceptive methods adds to the management burden, as does operations, bio-medical and policy research.

Population program experience around the world, however, has demonstrated that no one contraceptive method is ideally suited for exclusive emphasis. Nor have programs been successful using one delivery approach, especially if facility based. Most of the support mechanisms mentioned are essential for proper service delivery; IEC and policy development is required.

The emphasis on a broad spectrum of contraceptives thus continues to be valid. Although both male and female sterilization have gained rapidly in acceptance, it would be inappropriate to focus exclusively on these methods which are not useful for clients at all stages of their reproductive life. There have not been any particular surgical problems in connection with the recent expansion of sterilization. The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) emphasizes safety in the training. However, given general health conditions and the scarcity of resources in the health system, special attention must continue to be given to quality control, especially with surgical methods.

To date, the acceptance of the Inter Uterine Device (IUD) has been disappointing. Nevertheless, it could play a more important role for women who cannot use the pill due to a potential health risk or other reason. Foaming tablets and Depoprovera, though not supplied by USAID and available only in limited quantities from the United Nations Fund for Population Activities (UNFPA), are important for different reasons to some clients.

The policy of extended medical supervision of community agents for supplying the pill makes this method particularly important in the Haitian context. However, reported continuation rates have not been good. It appears that clients need better explanation of possible side effects and instruction in proper methods of pill use. More attention must be given to assuring constant supply at the user end of the system.

Initial research with Norplant has been promising and this method may well ameliorate the problems of apparent failures of method use with the pill and lack of continuation. Further Norplant research especially to review the implications for expanding service delivery will make an important technical contribution.

It is still not clear what impact the independent free distribution of large numbers of condoms is having on fertility; this is one of the technical questions that requires an early answer. Many programs in other countries have been less successful in emphasizing male participation; it is important to learn more about this experience.

The result of various service delivery approaches especially focusing on community outreach was good. In fact about 50% of the users came from the community outreach component. However, it appears that the DHFN was unable to manage, supervise and maintain supply to all of the different groups involved. Some improvements in MSPP/DHFN management capability are expected in this period but it is prudent to streamline a bit as well. Consequently, the private sector will be handled by a separate project including efforts to build on the experimentation by DHFN with commercial sales. Few programs have found management of commercial approaches to be the forte of government institutions. Likewise expansion of the mobile "clinics", work with matrones (TBA's) and the mini-projects will be postponed for later reconsideration. Although the armed forces (FADH) activity went through a "down" period it is said to be coming back to strength. This will be continued, particularly as it represents a good approach to the male population and can bring management inputs of its own. Expansion of support to other types of community volunteers will also be held to a slower pace than might otherwise be desired. Although difficult to document, the private natural family planning program has apparently had some success in recruiting users of these methods. As the private sector project gets organized, this activity may be shifted to that source of support.

#### B. Social Soundness Analysis

The social acceptance of providing family planning services is more clear today than in previous years. Of the fertile age women in union, forty-eight percent said they did not want any more children when interviewed in the 1983 CPS (compared to 42% in 1977). The numbers knowing about at least one method of contraception increased from 82% in 1977 to 87% in 1983. Furthermore, responses to the CPS of 1983 indicated that 46% of those not contracepting at that time wanted to use family planning in the future. Only 11% said they did not want to do so.

The rapid growth of the voluntary surgical contraception program (5,000 in 1985) and of the levels of 20 to 25% contraceptive prevalence achieved in rural experimental programs confirms the readiness of the Haitian population for family planning.

A paper prepared for USAID/Haiti by Ira Lowenthal May 1984, "Two to Tango: Haitian Men and Family Planning", refers to the breakdown of traditional sexual and marriage patterns with urbanization and the economic conditions of poor slum dwellers. Lowenthal calls special attention to the strong sense of paternal responsibility of the Haitian male, especially in the rural areas. Although children are highly valued, the difficulties of supporting them in the present economic situation are real and burdensome. "Regardless of how they are phrased, men's concerns in this area are already quite salient and are likely to provide the primary incentive to male participation in any family planning program."

Although there is well-documented receptiveness to family planning in Haiti, this should not automatically lead to the assumption that simply providing the services will prompt people to act. In order to assure that services are utilized, an effective IEC campaign should provide information about specific services available and where to obtain them. People need to be encouraged and triggered into the decision to become a family planning acceptor, even after hearing about a method and being informed and convinced about a certain method. A skilled health worker, a friend, a radio announcement, or the sight of a poster or pamphlet will prompt a decision to act.

Communication is also important in the re-confirmation of action and in the maintenance of family planning behavior. Within those first critical weeks of using a method, a client needs to be able to contact a health professional, community health worker or volunteer for re-assurance about the action taken. Such contact, as well as information available through the mass media, provides answers to questions about the method chosen and helps counteract fears arising from misinformation and rumor. The IEC activities to be undertaken in this project have been designed for a careful mix of field-level interpersonal communication, sensitive client communication at service points, and mass media messages to help achieve the objective of increased contraceptive prevalence by 1989.

While the project intends to support a vigorous IEC campaign, IEC efforts will be effective only if they reach the people. It is useful, therefore, to reflect on social factors which may have a negative impact on efforts designed to increase family planning utilization in Haiti. Recently, the Catholic Church has vocalized its opposition to the family planning program. The Church has the ability to prevent IEC materials from being distributed or broadcast, if it so desires. It is unclear what impact the Church may have on the IEC program during the next two years. Religious leaders who work closely with the rural population have the ability to initiate misinformation, particularly if the leaders are not well informed, or the ability to counteract misinformation, if they so desire. It is important therefore, that the MSPP and PVOs working in the area of family planning ensure, at least, that the religious community is well informed about the national program in order to minimize the circulation of incorrect information and rumors.

The Church has expressed its opposition to the voluntary surgical contraception program, particularly to the sterilization camps supported through this project. Recent criticisms have led USAID and DHFN to conduct an informal survey among physicians and clients to confirm or disprove these allegations. Data from the survey will be used to design corrective actions, if necessary, and results will be communicated to Church leaders.

The Church has expressed its desire to promote responsible parenthood and has expressed its acceptance of natural family planning methods. This project will support PVOs active in the area of natural family planning so that service delivery may be expanded and improved. Natural family planning will be available as a viable option to couples who wish to use it.

AID 1020-20 (1-78)  
SUPPLEMENT 1PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKINSTRUCTION: THIS IS AN OPTIONAL  
FORM WHICH CAN BE USED AS AN AID  
TO ORGANIZING DATA FOR THE PAW  
REPORT. IT NEED NOT BE RETAINED  
OR SUBMITTED.Life of Amendment  
From FY 1986 to FY 1989  
Total U.S. Funding 4,333 million  
Date Prepared: August 1986

Project Title &amp; Number: Family Planning Outreach 521-0124

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1)	Measures of Goal Achievement: (A-2)	(A-3)	Assumptions for achieving goal targets: (A-4)
To improve health and social/ economic welfare of poor Haitians.	<ul style="list-style-type: none"> <li>- Reduction in completed family size;</li> <li>- Reduction in maternal, infant, child mortality;</li> <li>- Reductions in age-specific fertility particularly in women over 35;</li> <li>- Increases in active family planning users and higher continuation rates.</li> </ul>	<p>Health service statistics Multi-Round Household Surveys.</p> <p>Epidemiologic Surveillance.</p> <p>Contraceptive Prevalence Surveys in 1983 and 1987 National Census in 1982.</p>	<ol style="list-style-type: none"> <li>1. External funding and support continue at current planned levels.</li> <li>2. GOH recognizes population growth as problem and develops/implements appropriate policies and programs.</li> <li>3. MCH/FP services and contraceptive use are positively related to reductions in mortality and morbidity among women and children.</li> <li>4. GOH will increase its commitment of funds and staff to sustain an effective national FP program.</li> <li>5. Haitians will avail themselves of FP and basic health services.</li> </ol>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Project Title & Number: Family Planning Outreach 521-0124

Life of Amendment  
From FY 1986 to FY 1989  
Total U.S. Funding 4,333 million  
Date Prepared: August 1986

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>To assist the Haitian Government to establish a cost-effective national family planning program.</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <ol style="list-style-type: none"> <li>1. Tested integrated service models serving 60% of the population.</li> <li>2. Contraceptives available throughout Haiti.</li> <li>3. 11 pct. of target population continuing users of effective FP methods.</li> <li>4. Program management control and surveillance system in place and functioning.</li> <li>5. Evaluation/operations research is continuing program activity.</li> </ol>	<p>(B-3)</p> <p>Surveys of users.</p> <p>Service Statistics on active users and Couple User Protection (CUP) Quarterly, semi-annual/annual reports.</p>	<p>Assumptions for achieving purpose: (B-4)</p> <ol style="list-style-type: none"> <li>1. GOH/MSPP will provide increasing support and priority for MCH/FP services.</li> <li>2. Cost effective service models are tested and effective in regional/national applications.</li> <li>3. Health services management improves so that supplies are available in all MSPP facilities.</li> <li>4. Better training and supervision will improve quality of services.</li> <li>5. Haitians will value FP and become satisfied users when quality services are available.</li> </ol>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Project Title & Number: Family Planning Outreach 521-0124

Life of Amendment  
From FY 1986 to FY 1989  
Total U.S. Funding 4,333 million  
Date Prepared: August 1986

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
<p>a) Organizational structure capable of coordinating, managing, supervising and evaluating a national FP program.</p> <p>b) Management information system capable of producing reliable and timely data on new and active users compared with contraceptive distribution data.</p> <p>c) Studies and surveys of levels of acceptors, patterns of contraceptive use, effectiveness of logistics and information system, efficiency of various distribution approaches and client satisfaction.</p> <p>d) Operations research reviewing management and program requirements for expanded use of NORPLANT.</p>	<p>a) One national coordinator, thirty staff professionals at national level.</p> <ul style="list-style-type: none"> <li>- four regional FP officers with statisticians, logisticians, &amp; accountants.</li> <li>- fifteen district FP officers</li> <li>- 170 part-time lead FP persons in public health facilities; other part-time MSPP personnel in integrated system.</li> </ul> <p>b) One client record system producing monthly reports.</p> <ul style="list-style-type: none"> <li>- one contraceptive flow reporting system producing monthly reports.</li> <li>- DMFN and national coordinator producing monthly statistical summaries and quarterly analysis.</li> </ul> <p>c) One review of contraceptive use.</p> <ul style="list-style-type: none"> <li>- one review of special emphasis on condom use</li> <li>- one review of logistics record keeping system with recommendations.</li> </ul> <p>d) One study with recommendation for expansion program.</p>	<ul style="list-style-type: none"> <li>- Quarterly, semi-annual and annual reports.</li> <li>- Reports of CDC assisted contraceptive review.</li> <li>- Reports of Columbia University assisted Operations Research SNEM Col-Vols.</li> <li>- Reports of FHI assisted biomedical research.</li> <li>- Resident TA and USAID population officer reviews.</li> <li>- Reports of RTI and FUTURES assistance to policy development.</li> <li>- Review with PAHO and UNFPA.</li> </ul>	<ol style="list-style-type: none"> <li>1. GOH will assign and support required personnel.</li> <li>2. Overall health system management will improve so FP program improvement can be effective within the integrated system.</li> <li>3. Technical assistance will be timely and effective.</li> </ol>

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Date Prepared: August 1986

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>e) nationwide system of family planning service delivery.</p> <p>f) Development and utilization of IBC material.</p> <p>g) Biomedical research clarifying the relative health risk in Haiti of pregnancy as compared to that of family planning methods; clinic trials of new contraceptives.</p> <p>h) Progress on MSPP FP policy and National Population Policy Development.</p>	<p>Regulated Outputs: (C-2)</p> <p>e) surgical referral centers in every district (25)</p> <ul style="list-style-type: none"> <li>- all health facilities in public sector providing FP (163)</li> <li>- community agents providing non-clinical FP (500)</li> <li>- mobile teams (5)</li> <li>- armed forces clinic and community program (30)</li> <li>- 90,000 couple years of protection provided in last year</li> <li>- sixty percent of population within one hour walk of FP outlet.</li> </ul> <p>f) printed material in 200 fixed facilities and for 1400 community agents</p> <ul style="list-style-type: none"> <li>- TV, Radio and Newspaper coverage.</li> </ul> <p>g) One research of maternal risk</p> <ul style="list-style-type: none"> <li>- one research on expansion of Norplant use.</li> </ul> <p>h) CONAPO established and MSPP Division of Population participating with FUTURES and RTI assistance.</p>	<p>(C-3)</p>	<p>Assumptions for achieving outputs: (C-4)</p>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Project Title & Number: Family Planning Outreach 521-0124

Life of Amendment  
From FY 1986 to FY 1989  
Total U.S. Funding 4,333 million  
Date Prepared: August 1986

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)	(D-3)	Assumptions for providing inputs: (D-4)
1. Project funded TA	36 person months + 24 local-hire person-months	Reports of TA contractors	a) USAID and GOH and Title III Bureau will make required funds available in timely fashion.
2. Non-project funded TA	15 persons-months	Reports of individual training programs and PIO/T's	b) Qualified personnel are available to fill the required positions.
3. Project funded Training (external)	63 persons-weeks	Reports of DESE on Training and IEC	c) Commodity procurement procedures can quickly supply project needs.
4. Key personnel working on project	56 persons-years	Quarterly and Annual reports of DHEN and Coordinator	d) Procedures for buy-in to S&T/POP project continue to be relatively simple.
5. Renovation	346 PY (Title III) 3 centers	Purchase Orders	e) UNFPA continues to provide contraceptives and support to CGRPO as complement to this project.
6. Medical & office equipment supplies	for 25 referral centers, 5 offices (incl computers), 30 non-surgical centers	PIO/C's and shipping documents	
7. Operating expenses	19 offices, operation 24 vehicles, supervision for 4 regions and 15 districts and 163 centers (incl Title (III) 3 new	Report of Research and Reviews from FHI, Columbia University, KDC	
8. Vehicles	condoms 30 million units oral 3.1 million cycles IUDS 2000 units	Payment vouchers for local cost reimbursement DHEN	
9. Contraceptives	21,000 units of printed material mass media to be determined	Financial reports - USAID/Controller	
10. IEC	3 studies 5 studies for CGRPO		
11. Policy, Biomedical & Operations Research	1 review of contraceptive use and 1 interim evaluation.		
12. Evaluation			

BACKGROUND AND PROGRESS TO DATEI. BackgroundA. Summary of Original Project Rationale and Design

At the time the original Family Planning Outreach project was developed in 1981, USAID estimated a population of 5.5 million people living a marginal existence on only 8,000 square kilometers of cultivable land. Accelerating population growth and decreasing out-migration were cited as important factors in the ever-more apparent deterioration of the natural resource base supporting the largely agrarian economy and putting excessive demands on the hillsides, making a mockery of the economic hopes and plans of rural Haitians. The increasing availability and use of cost-effective health interventions such as oral rehydration therapy and vaccinations, and intensive efforts to control diseases such as malaria, tuberculosis and yaws, led to significant and rapid decline in infant mortality. Hence, the health gains of the years preceding the project were seen as upsetting the traditional balance between births and deaths and increasing demographic pressures. Having one of the world's highest ratios of population to arable land, a largely illiterate population facing diminishing agricultural yields and an expanding food deficit, Haiti's government officials gradually came to accept the idea of family planning and concerted public efforts to limit population growth.

In planning for national economic and social development, Haitians were becoming increasingly aware of the negative impact of continued population growth on the achievement of development goals and objectives. Despite natural disasters, heavy outmigration, and poor health conditions, the rate of natural increase (RNI) had nevertheless, increased from below 1.8% annually in the sixties to 2.3%\* in 1981. The lack of access to convenient family planning services of adequate quality was viewed as a key problem to be addressed by the GOH in its efforts to cope with excessive population growth and achieve development goals. The USAID responded to this problem by developing with the GOH a project designed to establish a cost-effective national family planning program to build upon an existing network of private and public organizations already providing basic health-related services to the Haitian people.

The estimated costs for the FPO project were \$20.13 million with AID providing \$11.77 million in population grant funds, the United Nations Fund for Population Activities (UNFPA) contributing \$1.8 million and the GOH providing \$6.5 million as the counterpart contribution. The project goal was to assist the GOH to improve the health and socio-economic welfare of the rural poor; the purpose of the project, to assist the GOH to establish a widespread network of family planning services through the following activities:

\*The 1982 census figures suggest this may have been an overestimate.

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1. improvement of the organization and management of the national family planning (FP) program;
2. improvement of the quality and quantity of maternal and child health and family planning (MCH/FP) services;
3. expansion of the participation of private and voluntary organizations and other governmental and local community groups in providing MCH/FP services;
4. increasing the availability of contraceptives at reasonable prices through rural and urban commercial channels;
5. formulation of appropriate population and family planning policies.

Included in the project's planned outputs were the following: 1) all government health facilities and 75% of private facilities would be actively counseling and providing appropriate family planning services; 2) development of models of integrated community health and family planning services capable of serving 60% of the population; 3) provision of subsidized contraceptives and basic drugs throughout the country; 4) and increase in the number of continuing users to the equivalent of 25% of the target population (i.e., women aged 15 to 45 at risk of pregnancy).

The project was designed to be implemented primarily by the Department of Public Health and Population (now a Ministry--the MSPP) and its Division of Family Hygiene (now the Division of Family Hygiene and Nutrition--DHFN). Project inputs from D.A. funds included contraceptives, medical supplies and equipment, local costs of transport, personnel and per diem, foreign as well as local training, technical assistance, evaluation and operations research. Other inputs included social marketing materials and TA for poster campaigns, radio spots and other mass media messages, non-professional skill development training and promotional expenses associated with F.P. in general and commercial contraceptive marketing in particular.

#### B. Summary of Original Project Implementation

While Haitian policymakers have been slow to recognize the urgency of the country's demographic situation, a national family planning program has received government support since 1971, when the Division of Family Health (DFH) was established. In 1973, the DFH began program operations in hospitals and health centers. In addition to family planning, the DFH has been responsible for Maternal and Child Health (MCH). Initially, it operated almost exclusively through fixed facilities in urban centers. Beginning in 1977, however, mobile clinics and community outreach were added to the program.

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During the 1970s USAID had specific limited projects with the DHF in support of family planning. At the end of the decade a decision was reached to develop a national primary health care system, which would provide infrastructure for delivery of family planning as well as basic health services. The Rural Health Delivery System project (or RHDS) was designed to provide primary health care services and improve management of the MSPP. This project included integration of semi-autonomous health institutions such as the Department of Family Hygiene, the Bureau of Nutrition (BON) and the malaria control service (SNEM). Responsibility for their activities was to be increasingly assumed by the various sector-wide divisions of the MSPP. For example, Family Planning training and IE and C would now be under the direction of the Department of Health Education (DESE), data collection would become primarily the responsibility of an embryonic unit of research and evaluation of the MSPP and service delivery would be monitored by a unit for decentralized functions and planned and implemented by the regions and districts. At this time the DHF became the DHFN as nutrition was added to its mandate.

In 1980, the MSPP began integrating family planning and MCH into its sector wide program which was to be expanded to rural areas and strengthened at the Central, Regional and District levels. The DHF was to focus its activities on innovative approaches to family health and to supplementing MSPP efforts rather than having direct administrative responsibility for MCH and family planning. Additionally, DHFN was to set norms for maternal and child health care in Haiti and ensure the maintenance of standards. It was during this period (1981) that the Family Planning Outreach Project was designed to support the family planning activities of the DHF.

As implementation of the new project got underway, so did the absorption of important elements of the DHFN into other MSPP divisions. This was also accompanied by the transfer of many of the experienced personnel of DHFN to other divisions. Several had substantial promotions and have subsequently left the Ministry. While the early days of the project saw some good results, there soon began to be disturbing evidence of breakdown in the organizational capacity of the MSPP/DHFN to deliver family planning service. Results of a Nationwide Contraceptive Prevalence Survey in 1983 indicated an apparent decline in contraceptive use from the modest levels of the late 1970's.

#### C. Mid-Project Evaluation and Accomplishments to Date

Although drawing positive conclusions about many aspects of the F.P. outreach project, the mid-project evaluation of October 1983 gave little evidence of progress toward service delivery goals. A very significant conclusion was drawn, however: "The overall conclusion is that the design of the Outreach Project envisions all possibilities for making family planning service accessible and the DHF/DSPP is the only viable mechanism for ensuring a successful program of services".

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Reviewing the evaluation report, USAID reports, the 1983 Nationwide Contraceptive Prevalence Survey a 1985 Limited Contraceptive Prevalence Survey one cannot but be disappointed in the progress to date. Beneficial as the reorganization of the Ministry of Health and Population may be in the long run, the steps have not been taken to assure continuing priority to what had been a steadily growing semi-vertical family planning program under the unified direction of the Department of Family Hygiene. The integration of family planning with maternal and child health was compounded with further integration into the overall health system. This was more than the organizational capacity could cope with and maintain a focus on family planning. The decentralization of planning, implementation and evaluation to regional and district offices with apparently inadequate growth in their capabilities has further reduced the ability of the DHFN to establish priorities, and to supervise and evaluate progress.

A major difficulty in evaluating progress to date is this dismemberment of DHFN responsibilities leaving them ill-equipped to provide well supported documentation of their family planning efforts. There has been a major effort on their part to produce semi-annual and annual reports which do indeed provide much interesting information. The reports describe a philosophy of service delivery and community outreach which is among the more positive of the hemisphere. However, performance does not match philosophy and there are significant gaps in the information. Inconsistencies stem from the way of counting accepters, inadequate knowledge of the use of condoms and a probable inordinately high drop out rate. There is possibly an exceptional level of coital frequency and probably wastage. This and the inadequate system for reviewing contraceptive distribution at the service delivery point makes comparison of contraceptive supply and user numbers difficult. With the levels of contraceptives provided by USAID and UNFPA and amounts disbursed from the central warehouse in Port-au-Prince, one would expect to see an impact on contraceptive prevalence and even on birth rates consistent with the reasonably high levels of users reported by the DHFN. However, there is no documented evidence of this being the case. There has been a tendency on the part of some to equate DHFN calculations of "National Coverage" with "Contraceptive Prevalence" - an equation that the method of calculating "National Coverage" does not permit. It would be unwise to engage in much conjecture without better information than is presently available. For this reason, a priority action in this amendment period will be to carry out the studies and review necessary to clarify these issues. (See Appendix 3).

Keeping in mind the caveats mentioned, it is still worth reviewing the substantial level of activity noted, for example, in the 1985 annual report of the DHFN. The report does indicate that family planning services are being provided in 166 or 88% of the public institutions and 86 or 47% of the private or mixed institutions. Although the number of female "users" reported in the program dropped from 83,000 in 1982 to 65,000 in 1983 that number had reached 103,000 in 1985. Contraceptives distributed from Port-au-Prince were sufficient for that number and more but impact in contraceptive prevalence and the birth rate is yet to be documented. A bright side of the performance is the rapid increase in sterilization from 1,712 in 1982 to 4749 in 1985.

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Additional accomplishments noted from other sources are as follows:

1. USA Training

FP Mngt and Community Program 3-4 weeks (7 by JHPIEGO)	43
IEC (3-4 weeks)	18
Fertility Management (one week)	17
Mini-lap and Laparoscopy - vasectomy (1-2 weeks)	33
Population and Development/Pop policy (one week)	12
Natural FP (one week)	8
Total (persons)	<u>131</u>

2. In country training

1984 4 one week seminars for FP  
120 nurses sponsored by Dev. Asso.  
1985 2 one week seminars for 60 FP  
nurses (D. Asso)  
1986 Two week VSC training for 20  
MD, 20 nurses sponsored by JHPIEGO

One week family planning community  
agents-promoters-health agents  
auxilliary - nurses SNEH ColVols

1983-4-5 Three one week seminars  
at DHFN for 30 OBGY involved  
vsc program

3. Facilities renovated

On region request 14

4. Mobile team for VSC at  
District Health  
Facilities

one or two a month for the  
past two years 60

5. Equipment and drugs provided

Equipment ORT tables, Treatment tables, kits,  
thermometers, filing cabine's,  
anesthesia apparatus, etc., 775,000

6. Support to private sector

Action Familiale  
Cite Soleil  
CEGYPEF 166,000\*

7. T-Shirts distribution

FP methods design 48,000  
during carnaval 34 units

8. Miragoane Pilot Project

Using SNEH ColVol for  
contraceptive distribution

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9. Three days retreat in Jacmel  
FEB 85 followed by national review and diagnosis  
FP program current situation  
New resolutions (50 govt, private sector, USAID and UNFPA participants)
10. Mid term evaluation  
By team of 4 (Oct. 83)  
Recommendations included in final report
11. Contraceptive Prevalence Survey 1983  
By Westinghouse
12. Technical assistance  
1982 feasibility of social marketing  
1983-1984 contraceptive situation (CDC)  
1984 information and education (J. Hopkins)  
1984 Action Familiale evaluation
13. New natural family planning project  
July 85  
Proposal for Developing pilote project at St. Jean hospital of Limbe (north)
14. Research (maternity surveillance) 83-85  
Research project with FHI assistance:  
Phase I pilote project with:  
3 maternity:  
University hospital  
Mathie hospital  
Petit-goave hospital  
  
1982 Haitian women attitude toward menstruation  
1984 male attitude  
1985 norplant clinical trials with FHI assistance  
1985 low-dose oral contraceptives for lactatives mothers with FHI assistance

15. <u>Financial Status</u>	
1) obligation to date	\$9,615,000
2) expenditures and accruals	
a) Contraceptives	3,929,000
b) Training	256,000
c) Equipment, Suppl. & Renov.	985,000
d) PVO Support	199,000
e) Other local costs reimburs. to DHFN	3,525,000
f) Evaluation	57,000
g) technical assistance	<u>154,000</u>
Subtotal	9,105,000
3) Unallocated	510,000
4) Total expenditures accruals and balance	9,615,000

Accomplishments in development of internal program policy and approach are significant. The DHFN has been willing to try innovative and forward looking approaches to service delivery. Significant emphasis has been placed on outreach through community agents and volunteers and efforts have been taken to broaden the alternative means of contraception available. For example:

1. Efforts have been taken to make available several types of IUDs, foaming tablets, injectables and condoms in the program. It is not clear why the IUD use has declined; Depo would be used more if supplies were more readily available.
2. Additional surgical methods have been added with successful emphasis on both female and male sterilization and clinical trials of Norplant.
3. Institutions providing natural family planning instruction have been included.
4. Various types of community agents have been used to distribute non-clinical methods including initiation of orals with a CONTRA indication check list. Operations Research has been particularly important in this area and DHFN is willing to expand on lessons learned in the successful use of SNEM Volunteers.

While ideas and service delivery policy are excellent, performance has been marred by organizational shortcomings, inadequate supervision, short falls in the logistics system at the end use point and lack of appropriate evaluation. Consequently, results are not clear but even at least they are not at a level consistent with the objectives or with the investment made. Nevertheless, the basis appears to have been built for future improved performance if certain key changes are made, especially in organization and management.

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A. Review of Annual Report 1985 Department of Family Hygiene and Observations re Levels of Users and Contraceptive Prevalence

1. Service Points

a. Institutional

There are a total of 372 health institutions in the country, 188 public (51%) and 184 mixed or private (49%). Of the 188 public, 163 (88%) offer F.P. service. Of the 184 mixed or private, 86 (47%) offer F.P. service.

b. Community Outreach

- |   |     |
|---|-----|
| 1) Community Agents - Urban community FP promoters who inform, supply contraceptives and refer clients  | 106 |
| 2) Promoters - Rural "area" worker who work through volunteers (numbering "a thousand") to inform, supply and refer client  | 13  |
| 3) Regional supervisors for the above   | 4   |
| 4) Health agents - Rural community multipurpose health workers, a group of four or five attached to health centers or dispensaries. Their tasks include information, contraceptive supply and referral of FP clients. | 397 |

- c. Haitian Youth Volunteer Organization (JVH)  
Port-au-Prince organization for social development with distribution of non-clinical contraceptives.

2-3

distribution  
points

d. Armed Forces

- |  |    |
|--|----|
| Centers for contraceptive supply to soldiers, their families and the community centers | 30 |
|--|----|

e. Operations Research

- |   |                  |
|---|------------------|
| Columbia University with SNEM volunteers; household distribution of FP information and supplies | 50<br>volunteers |
|---|------------------|

## 2. Users Reported

The DHFN reports separately on:

- a. Women users (all methods but sterilization)
- b. Male users (condoms)
- c. Sterilization (male and female)

A distinction is made between new users and others (or continuing) users. The DHFN recognizes the probable confusion of terms and states that probably a substantial number of new users should have been counted as other users. A continuing user might be registered as such on any subsequent visit but this is not clear. DHFN calculations of "National Coverage" are based only on women clients.

### a. Women users (all methods but sterilization)

Of the 103,125 users reported, 65,769 (64%) were reported as new users\*. These total users were reported from the various programs as follows:

<u>Sector</u>	<u>Total Women Users Reported</u>
ALL	103,125 (100%)
Institutional	41,935 (41%)
Community Outreach	44,956 (44%)
Health Agents	5,947 (5%)
Youth Volunteers	793 (1%)
Operations Research	2,911 (3%)
Armed Forces	6,585 (6%)

### b. Sterilization

Since this activity has been given special emphasis, personnel and reporting procedures, it is generally conceded that the reporting is more complete and precise. Assuming this to be the case, there has been some impressive progress both in male and female sterilization.

\* The term "new accepters" or "new users" is used. However, there is no term for "other" users. The "total users" is either reported as such in the community program or derived from "subsequent visits" in the institutional program reports plus new accepters.

\*\* Of these, 50,985 (49%) were reported in the West Region where Port-au-Prince is located.

<u>Country</u>	<u>All Types</u>	<u>Mini-Lap</u>	<u>Laparoscopy</u>	<u>Vasectomy</u>
Total 1985	4,749 (100%)	3,149 (66%)	718 (15%)	882 (19%)

Growth in the sterilization program over the years is indicated as follows:

	TOTAL	MALE	FEMALE
1976	36	-	36
1980	624	8	616
1981	1,211	3	1,208
1982	1,712	26	1,686
1983	2,502	303	2,199
1984	3,398	387	3,011
1985	4,749	882	3,867

NOTE: The 18,572 sterilizations performed since 1981 (most of which should still be in the fertile age group) represent about a 2% prevalence from this method.

c. Male Condom Users

By the very nature of the method and its lack of requirement of medical supervision or extensive education, condom programs around the world have had much greater flexibility in their distribution methods and considerably less reporting requirements. Thus it is not surprising that the Haitian program's use of condoms is unclear. Nevertheless, few if any programs in other countries have had the relative emphasis on condoms in the total contraceptive supply mix that has the Haitian program. For example, in 1985 there were 21 million condoms disbursed from the central warehouse in Port-au-Prince. This compares to the approximately 25 million condoms AID provided annually to Mexico with an additional 15 million commercial market in a country of 65 million inhabitants. Recognizing the difficulties of following more precisely the use of this particular method, the program must still make a greater effort to study this issue (preferably by survey and logistic reports, not by service statistics).

The program reports some 87,000 new male acceptors of condoms with 23% from the institutional program, 69% from the Community Program, and 4 and 2% respectively from the health agents and the Armed Forces. On the other hand, "Supply Visits" by men to distribution centers were reported totalling 27,549 with the majority reported in the Community Program (54%) and the Armed Forces (30%). In the visits registered, the DHFN reports a recorded and estimated distribution of 13,014,000 condoms.

d. National Coverage

The DHFN has calculated a growth in "National Coverage" of total female users based on the total of "new" female acceptors in a year plus other female users, (which derived somewhat imprecisely from female revisits\*). This is clearly not as useful as would be a more precise estimate of "Active Users" or of contraceptive prevalence, which are both impossible to derive from present service statistics. Incidentally, while the new health information system will help to clarify this, it fails to provide an essential cross check, that of amounts of contraceptives distributed. This is another reason for placing greater emphasis on logistics reports in this amendment period--see Logistics.

A further minor note of divergence arises from the change in denominator (women at risk of pregnancy) arising from recalculations based on the 1982 census and the Haitian Fertility Survey. For purposes of making some internal comparison and looking at trends in "total users" over time the following table has been readjusted to discard this change in 1985:

<u>YEAR</u>	<u>WOMEN AT RISK (000)</u>	<u>TOTAL FEMALE USERS OF FP (000)</u>	<u>"NATIONAL COVERAGE" %</u>
1980	601	60	10.0
1981	612	65.5	10.7
1982	623	83.2	13.3
1983	635	65.2	10.2
1984	647	71.9	11.1
1985	659*	103.1	15.6**

Assuming reporting has been similar throughout this period, there has been some recovery from the reduction of users that occurred during 1983, the year of greatest negative impact of the reorganization.

e) Contraceptive Prevalence

Attempting to make some estimate of how these "National Coverage" figures translate into contraceptive prevalence is fraught with uncertainty and is probably unfair to the program. Yet these two have been compared by some as if they were the same measure, raising more scepticism about reported results. Thus the following calculations are made to show how these measures may differ.

\*Although the CDC report of June 6, 1985 suggests that an unduplicated count of total clients can be derived, it is not clear from the report forms or conversations with DHFN that this is in fact being done.

\*\*These figures have been readjusted to the old trend - The DHFN report, using a new denominator based on 1982 census, showed 608 & 16.9%.

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For example, one might assume that only one fourth\* of the new users were in the program at any given time (they come in at different times and some stay only a short while). Additionally assuming that only one third\* of the subsequent visits represent separate individuals (active users), the 1985 picture in terms of female contraceptive prevalence based on these user figures might be estimated as follows:

Total Users 1985	103,100
New Users	65,800 / 4 = 22,000
Revisit Users	37,300 / 3 = 12,400
Active Users	34,400
Women at Risk	608,000
Active Users as % of Women at Risk	5.6%

This 5.6% plus the 2% of women protected by sterilization would produce a contraceptive prevalence of 7.6%\*. This bears some resemblance to the results of a national survey on diarrhea, immunization and family planning carried out in 1985 among 708 women with children under 5 living in areas outside of Port-au-Prince. Program activity has been stronger and previous contraceptive prevalence higher in Port-au-Prince. Thus an extrapolation from this 5.5% figure to nationwide averages including Port-au-Prince would be significantly higher. In the 1983 CPS the use of modern contraceptives was almost four times as high in Port-au-Prince as in the rural areas. Thus, including estimates for Port-au-Prince, the 1985 prevalence study may have indicated 6.8 to 7% on a national basis.

The use of the substantial amounts of condoms distributed does not show up in nearly the proportion you would expect in either the 1983 CPS or the 1985 Diarrhea, Immunization, FP survey. In the 1983 CPS, condoms represented about 13% of the modern methods; in the 1985 survey, about 4.3%. In terms of national level warehouse disbursements the couple years of protection expected from condoms would be roughly equal to those of pills (using a high estimate of 240/year--if more usual levels were used, the CYP for condoms would be even higher).

Given the exceptional use of condoms in the Haiti program one would have hoped these surveys had taken some special steps to probe this issue more completely, particularly since the interviews were only of women in union. Additionally, according to focus group interviews reported by Allman in "Condom use in Haiti", a good deal of the condoms are used with casual partners--which would not show up in interviews with women in union. However, this does not fully explain the discrepancy--another issue which must be reviewed in the proposed evaluation.

\*NOTE: These are only assumptions for purpose of illustration; the real relationship must be explored as par of the proposed evaluation

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Much of the above suggests that by reason of the way users are counted, the DHFN may have overestimated the impact of its coverage. Often the degree of overestimation can be determined by reference to contraceptive distribution. At this time this does not seem possible in Haiti. In the first place neither the service statistics nor the logistics reports are set up to provide this information regularly. What is available with clarity and regularity is disbursement from the Port-au-Prince warehouse. Although shipments are documented and regions and districts report on distribution; this information is not collated regularly nor is it analyzed.

Additionally, however, disbursements from the Port-au-Prince warehouse represent a level of contraceptive distribution considerably greater than the two CPS results imply. For example, the following amounts of contraceptives were disbursed from the Port-au-Prince warehouse in 1984 and 1985:

CONTRACEPTIVE	1984 AMOUNT	CYP PROVIDED	1985 AMOUNT	CYP
Condom (240/CYP)	15,302,630	64,000	21,563,000	89,000
PILL (13/CYP)	926,000	71,230	1,140,000	87,637
Foaming Tablets (180/CYP)	126,000	700	141,800	800
IUD (0.5/CYP)	100	200	90	180

In pills alone this roughly 80,000 CYP/Year is enough for 13% contraceptive prevalence.

A 1984 inventory of regional warehouse did not turn up exceptionally high stock levels at these levels nor do the 1985 reports. A limited sample of district reports showed some excess but there also have been reported shortages from time to time at local institutions.

#### F. Conclusion

From the above it should be clear that not enough is known about the level of users and the pattern of contraceptive distribution and use. There may well be more family planning service delivery being provided than some have thought to be the case. Several indications point in that direction. However, two important surveys call this into question. The review proposed is essential to further evaluation and future project design. Despite the present confusion, there is little doubt that present levels of activity are inadequate to impact substantially on fertility or on reproductive health. There must be a significant improvement in performance if these benefits are to be secured.

APPENDIX 4

In this section we discuss some of the activities which have been proposed for evaluation of family planning program efforts and the inputs needed to carry out those activities. All the activities discussed below -- a family planning survey (with a possible supplementary survey), evaluation of service statistics and client record-keeping, and assistance in logistics management -- are activities in which the Division of Reproductive Health (DRH) of the Centers for Disease Control (CDC) has provided technical assistance throughout the developing world. CDC will be available to provide assistance to Haiti in these areas through its Resource Support Services Agreement with USAID/S&t/POP.

I. Family Planning Survey

Rationale

It is advisable, as a means of evaluating various aspects of the family planning program and the current status of family planning and closely related areas in Haiti, to conduct a nationwide family planning survey. The Family Planning and Family Health Survey carried out throughout Haiti in 1983 provided a large amount of information, but did not address several issues (e.g. condom use patterns, male involvement and continuation rates) sufficiently which have come to be recognized as particularly important in evaluating family planning efforts and behaviors in Haiti. In many demographic respects, (as will be discussed below), Haiti differs from most of the world and requires a survey specifically designed with the nation's characteristics in mind. However, the 1977 Haitian Fertility Survey was designed to be comparable to a large number of other surveys around the world. Likewise, the 1983 survey did not seem to take Haiti's uniqueness into account as much as it might have. A new survey would be designed to investigate these issues, while updating much of the data which were collected in 1977 and 1983.

The most compelling reason for carrying out a survey is that it is the best way of addressing several of the issues listed in the section of this document entitled: "Evaluation" (page ). Those issues which the survey will be designed to clarify include: the number of users of each contraceptive method (including the sources of those methods); contraceptive prevalence (overall and for each method); patterns of condom use; client satisfaction; and the reasons for the low use of family planning. In regard to each of these topics the survey will provide programmatically useful information on trends and progress. For example, it will be important to know if there is any indication of a drop-off in breast-feeding, which would be exerting an upward push on fertility, or that early childbearing has become either more or less common, or the degree to which changes in patterns of sexual unions may be influencing fertility.

The turnaround time required for getting survey results should be relatively short. One goal of this type of survey is to provide information quickly. In light of the fact that they are programmatically oriented, it is imperative that findings be timely. Neither the 1977 nor 1983 surveys provided results quickly. Estimates of the time necessary to report findings can be seen in the timetable below.

Content

Such surveys are designed to cover a wide range of family planning, fertility, and related subjects and are flexible enough that questions relating to issues of special interest to executing or funding agencies can be easily included in them. This survey will be designed such that issues of particular interest in Haiti will be specifically addressed.

Reliable information is needed regarding contraceptive prevalence and the mix of methods used. This information is useful both in itself and for estimating the numbers of users of each method nationwide.

The survey will also yield information on the source (e.g. clinics, promoters, armed forces, community agents) of contraception for current users and those who have used in the recent past. These estimates of prevalence and source will be important in assessing family planning service statistics and thereby improving them.

A major issue needing to be addressed is that of the pattern and extent of the use of condoms. At present there is a large discrepancy between the reported number of condoms distributed and the estimated number used in the population, with the former greatly exceeding the latter. A module on condom use will be in the questionnaire, which will obtain such information as numbers of condoms obtained and used. It will investigate some hypotheses concerning the discrepancy, including whether a large number of condoms are being used with casual partners or whether condoms are being used as a backup with "women's" methods. Such condom use may not have been detected in earlier surveys. If the results of the survey support estimates of condom use than closer scrutiny will have to be made of the distribution side of the equation.

This module will be geared toward solving the puzzle of the discrepancy between reported distribution and estimated use of condoms. Since males can provide more complete information than females in regard to condoms obtained and used, it remains a possibility that female knowledge may not be sufficient to yield a complete picture of patterns of condom use and supply. The results of the survey pretest will be evaluated in regard to adequacy of information given by women on condom use. If it appears that women may not be providing sufficient information another means of assessing condom use will be employed. The most likely approach will consist of interviewing male condom users regarding their patterns of use. These results would be extrapolated to the whole population. If such a supplementary survey were to be performed, it would also address itself to this area of male involvement in contraceptive decision-making, not just to condom use.

Since it is thought that continuation of methods is substantially lower in Haiti than in other places, a module will be included to allow estimation of continuation rates of, at least, oral contraceptives and possibly some other methods.

Also, questions on client satisfaction will be formulated so as to find out where services might be changed to improve continuation and prevalence. These questions will deal with both service and method satisfaction. This survey approach to satisfaction has a major advantage over interview of clients selected from records in that it obtains information from past, as well as current, clients. It will be important to know if dissatisfaction led to discontinuation among past clients.

Estimates of women in need of contraceptive services will be made. "Women in need" are defined as women who are sexually active, fecund, and are not using any contraception, but who say they do not want to become pregnant. This evaluation allows a program to estimate the number of women constituting its primary target group.

In Haiti there is a need to examine the proximate determinants of fertility, especially the effect on fertility of breastfeeding and the patterns of cohabitation and sexual activity. Fertility rates in Haiti are lower than generally expected in a population with as little contraceptive use as is found there. This, in all likelihood, stems from long breastfeeding duration, a preponderance of unstable unions, and greater use of less effective methods than is generally recognized. This survey will examine current levels and recent changes in these factors to see how trends in them are affecting or are likely to affect fertility levels.

In addition to the aforementioned, other topics usually included in family planning surveys and useful for Haiti as well are likely to be examined. These include: levels of unplanned pregnancy; reasons for not using contraception, knowledge of contraception and sources of contraception; desired fertility; and actual fertility.

Lastly, some other topics may be included in the questionnaire if interest is expressed in them by the agencies involved in the survey. Among these topics are: male involvement in family planning decision-making, certain aspects of adolescent fertility; and potential demand for sterilization services. In order to keep the questionnaire from becoming overly long, some areas touched on in the earlier surveys will be omitted.

#### Design

The survey will consist of interviews with women between the ages of 15 and 44. (Previous surveys have gone up to age 49. However, for the purposes of this survey it appears that little would be gained from including 45-49 year old women, except for comparability with earlier surveys, which is not a primary goal). Because of the reportedly high levels of sexual activity and fertility among women outside of formal unions and because of the stated objectives of estimating total numbers of FP users and women in need of FP services, it will be necessary to interview all women, regardless of their union status. The survey is to cover the entire nation of Haiti, but will not be designed necessarily to provide usable results for small geographic areas.

In general, the same type of sampling used for the 1983 survey will be employed. A multi-stage cluster sample of households will be drawn, using the most current sampling frame available. Then, within selected households interviewers will attempt to talk with every 15-44 year old woman. The sample size will be determined at a later date and will depend on such factors as cost and the number of respondents needed to obtain good estimates of all issues covered. At this point, we would guess that about 3500-4000 women will be interviewed.

CDC Technical Assistance

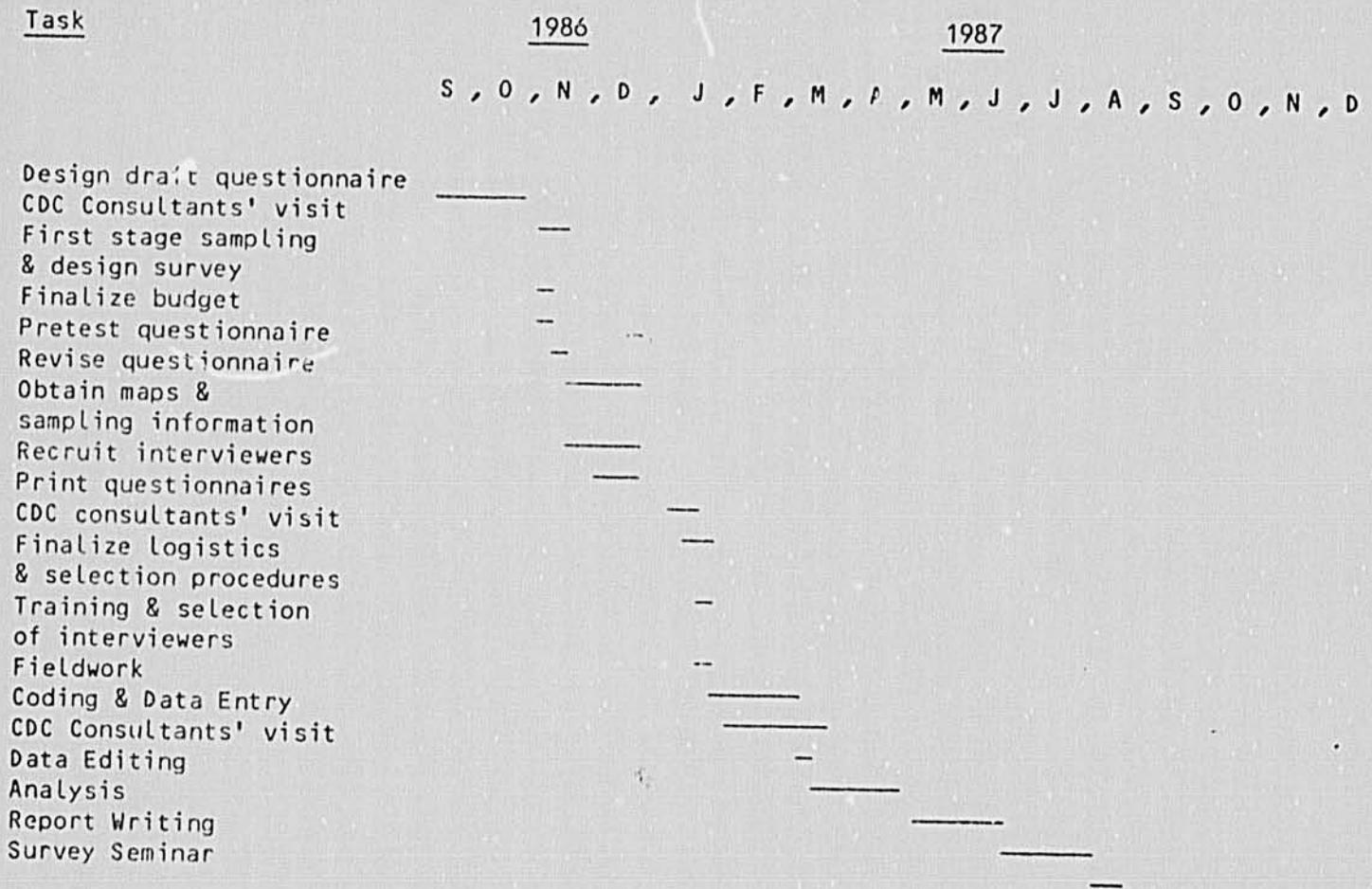
The Centers for Disease Control (CDC) can provide the necessary technical assistance for planning, conducting, and analyzing such a family planning survey. CDC, through its RSSA with AID, can cover costs of technical assistance, but cannot provide the in-country costs involved in the actual conduct of the survey. The survey would be conducted by an in-country executing agency, not as yet determined.

It is envisioned that the initial technical assistance trip will consist of 2 CDC consultants (1 demographer and 1 public health advisor) coming to Haiti for 2-3 weeks in November. That trip would be primarily one to plan the survey. The tasks carried out then would be: working out the plans for the survey with the executing agency; drawing a sample of areas in which interviewing will occur; refining the draft questionnaire (which will be drafted prior to the visit); pretesting the draft questionnaire; and drawing up a survey budget.

A second visit will take place about 2 months later by the same consultants. This visit will probably last about 3 weeks. During that time the tasks accomplished will be: working out the details of the fieldwork logistics; finalizing household and respondent selection procedures; training interviewers; selecting interview teams; starting field work; and starting coding and data entry onto computers. It is likely that another consultant visit will be necessary late in the fieldwork phase for the purpose of checking on fieldwork procedures and setting up data editing procedures.

Data analysis can be performed at CDC, in Haiti, or in both places, depending on availability of computers and data analysts in Haiti. CDC can provide virtually unlimited computer access for analysis of survey data, as well as staff to carry out the analysis if the data cannot be analyzed in Haiti. A trip will be made to Haiti by a CDC person, or to CDC by the survey director, to coordinate efforts on analysis and reporting of findings. If the agencies involved decide that it will be beneficial once a survey report is written a seminar can be held for appropriate agencies and individuals in Haiti in order to disseminate findings.

Timetable



Budget

A preliminary estimate of the costs involved in the survey indicate that it would require in the vicinity of \$69,000 to perform the survey from start to finish, exclusive of technical assistance costs, which do not come out of the survey budget. An additional \$25,000 has been budgeted for a supplementary survey of condom use and male roles in contraceptive decision-making.

<u>Item</u>	<u>Cost</u>
<u>Salaries</u>	
Supervisors	\$ 7,000
Interviewers	\$12,000
Coordinator	\$ 2,500
Clerical (Coding, Data Entry)	\$ 3,600
Secretarial	\$ 400
Programmer	\$ 2,000
Subtotal	\$ <u>27,500</u>
<u>Per Diem</u>	
Supervisors	\$ 8,000
Interviewers	\$18,800
Coordinator	\$ 1,400
Subtotal	\$ <u>28,200</u>
<u>Transportation</u>	
Fuel	\$ 4,000
Maintenance	\$ 4,000
Subtotal	\$ <u>8,000</u>
Interviewer supplies, shipping office supplies, maps, etc	\$ <u>2,000</u>
Pretest costs(per diem, vehicles, etc.)	\$ <u>1,000</u>
Seminar on survey results	\$ <u>2,000</u>
TOTAL FP SURVEY	\$68,700
Supplementary survey of male condom users and male decision- making roles	\$25,000
GRAND TOTAL	\$93,700 =====

## II. Service Statistics, Patient Record-Keeping & Contraceptive Distribution Reporting

At the time of the Haitian Fertility Survey in 1977 there was close agreement between program statistics and survey results in regard to the number of users of family planning methods. Since that time there has developed a major discrepancy between the number of users estimated from survey statistics, which have indicated growing number of client contacts, and from surveys, which have revealed little change in use of modern methods since 1977. The general consensus is that the disagreement arises from shortcomings in the patient records system, which in their current state, do not allow any realistic estimation of prevalence of contraception.

However, a new health information system is being implemented in order to improve the accuracy and usefulness of client and contraceptive distribution records. This new system should eliminate most of the problems encountered in regard to service statistics and patient records in the past. At the same time, information of distribution of contraceptives will come into the system from monthly reports. The remaining need, once the new system is in place will be to reconcile the two data sources-- client records and monthly contraceptive distribution reports. Once these reports are reconciled, project personnel will be able to estimate with reasonable accuracy such measures as couple-years of protection. The system should also allow a translation of service statistics into estimates of contraceptive prevalence of fp methods provided by the system.

The Division of Reproductive Health at CDC has extensive experience throughout the developing world in giving technical assistance to providers of family planning services for the purpose of improving fp client record-keeping systems and evaluating fp service statistics. Through its RSSA with AID, DRH can send an expert in this area to Haiti to assess the operation of the new system, to reconcile client records and contraceptive flow statistics, and to make recommendations in that areas. The first visit will take place to help analyze the reporting requirements, initiate the system and participate in training early in CY 1987. At least one return visit by a CDC consultant will tentatively follow at a time to be determined, to evaluate progress in these areas and to make further recommendations.

## III. Logistics

It is widely recognized that the system of contraceptive logistics now in place has severe deficiencies. There have been serious problems in maintaining adequate supplies of contraceptives at service delivery points. The system has been unable to project successfully requirements of contraceptives according to where and when they are needed. Shipments of contraceptives are often made automatically, with regard to neither stocks on hand nor projected needs. Existing reports on stocks and requirements have not been adequately utilized for purposes of reordering contraceptives or for planning shipments. There also appear to be some remaining problems in other

areas of logistics, such as storage and warehousing procedures and keeping track of inventories and shipments at all levels (central, regional, district, and facility).

The improvements which need to be made would benefit the program in two areas, both of which are important to the establishment of a successful family planning program. First, the logistics system must establish and maintain good management of supplies. Adequate stocks should be available throughout the system, with resupply shipments based on reports detailing current and projected needs. Secondly, the logistics system should be employed as a tool in program evaluation. Monthly reports on contraceptive flow will be provided by those charged with logistics management. These reports will be used in conjunction with data from the new health information system to give valuable information for evaluating the progress of the FP program, as discussed in the previous section on "Service Statistics".

This is another area in which CDC has substantial experience in lending technical assistance throughout the world. During the aforementioned CDC consultant's visit for examining record-keeping and service statistics, assistance will also be given in all relevant logistics. The consultant will also make recommendations in regard to what kinds of training would be most useful in terms of both client record-keeping and logistics management. Decision will be made regarding what personnel should receive training in which particular areas of record-keeping and logistics. CDC has also carried out training courses on these topics and would, in all likelihood, be available to provide this service in Haiti.

DETAILED COST ESTIMATE  
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ITEM	SOURCE	
	D.A.	TITLE III
	=====	=====
<b>1. Technical Assistance</b>		
a) Resident Advisor 24 mos @ 12,000	\$288,000.00	
b) Short-term 12 mos @ \$15,000	\$180,000.00	
c) Program Assistant 24 months @ \$2500	\$60,000.00	
Sub-Total:	\$528,000.00	
<b>2. Training</b>		
a) Management Training 24 person weeks @ \$200/week		\$5,000.00
b) Supervision and Logistics 60 person weeks @ \$200/week		\$12,000.00
c) Surgical contraception 100 person weeks @ \$200/week		\$20,000.00
d) Training of Trainers 40 person week @ \$200/week		\$8,000.00
e) Family Planning update non-surgical 200 pers. week @ \$150/week		\$30,000.00
f) Seminars for Community Agents and Health Agents 400 person weeks @ \$100/week		\$40,000.00
g) Family Planning Promoters 40 person weeks @ \$150/week		\$6,000.00
h) Update for FADH - 75 person weeks medical -525 person weeks rural police officers @ \$100/week		\$60,000.00
i) External Training:		
1) Observational travel 15 p.w. @ \$2,000/week	\$30,000.00	
2) FP Organization (U.S.) 24 p.w. @ \$2,500/week	\$60,000.00	
3) Policy de velpt. seminars 24 person weeks @ \$2,500/week	\$60,000.00	
Sub-Total:	\$150,000.00	\$181,000.00

DETAILED COST ESTIMATE  
(Continued)

ITEM	SOURCE	
	D.A.	TITLE III
-----		
3. Operations & Biomedical Research		
-----		
a) Norplant	\$465,000.00	
b) Maternal Mortality	\$150,000.00	
c) IUD Study	\$25,000.00	
d) Other	\$60,000.00	\$44,000.00
Sub-Total:	\$700,000.00	\$44,000.00
-----		
4. IEC		
-----		
a) Consultation, research, pilots & prototypes (JH/PCS)	\$115,000.00	
b) Posters 1,000 @ 2.00	\$2,000.00	
c) Printed Materials 10,000 @ 1.00	\$10,000.00	
d) Logos, signs, etc. 10,000 @ 2.00	\$20,000.00	
e) Local Costs of Mass-Media		\$100,000.00
Sub-Total:	\$147,000.00	\$100,000.00
-----		
5. Contraceptives		
-----		
a) Condoms 30,000,000 @ 0.046	\$1,380,000.00	
b) Orals 3,072,000 @ 0.15	\$461,000.00	
c) IUD 2,000 @ 2.00	\$4,000.00	
d) Shipping for 1987-89 stock	\$156,000.00	
Balance to be funded by PSFPP	(\$234,000.00)	
Sub-Total:	\$1,767,000.00	
Balance due on order from 1986	\$333,000.00	
Sub-Total for contraceptives	\$2,100,000.00	

DETAILED COST ESTIMATE  
(Continued)

ITEM	SOURCE	
	D.A.	TITLE III
<b>6. Equipment, Supplies and Renovation</b>		
<b>a) Medical and Ancillary Equipment</b>		
20 Centers @ 2,000	\$40,000.00	
30 Centers @ 500	\$15,000.00	
Sub-Total:	\$55,000.00	
<b>b) Expendable Medical Supplies</b>		
8 Sterilization @ 15,000	\$80,000.00	\$40,000.00
2 Other Surgical @ 2,000	\$4,000.00	
Sub-Total:	\$84,000.00	\$40,000.00
<b>c) Vehicles</b>		
3 @ 15,000	\$45,000.00	
Sub-Total:	\$45,000.00	
<b>d) Office and Warehouse Equipment</b>		
Micro Computer 5 @ 10,000	\$50,000.00	
Typewriters 4 @ 1,000	\$4,000.00	
Desk Calculator 5 @ 200	\$1,000.00	
Hand Calculator 50 @ 40	\$2,000.00	
Furniture 5 sets @ 2,000	\$10,000.00	
Warehouse pallettes	\$5,000.00	
Sub-Total:	\$72,000.00	
<b>e) Renovation</b>		
10 Referral Centers @ 5,000	\$14,000.00	\$36,000.00
50 Non-Surgical @ \$580		\$24,000.00
Sub-Total:	\$14,000.00	\$60,000.00
<b>Sub-Total for Equip, Suppl, Ren</b>	<b>\$270,000.00</b>	<b>\$100,000.00</b>

DETAILED COST ESTIMATE  
(Continued)

ITEM	SOURCE	
	D.A.	TITLE III
<b>7. Personnel</b>		
(Salaries are illustrative, Scale will relate to MSPP)		
<b>a) National Level Person Years</b>		
1. Coordinator	2.5 @ 16,000	\$40,000.00
2. Admin. Sec. (UCDR)	2.5 @ 6,000	\$15,000.00
3. DHFN Staff (\$7000/mo x 30 mos)		\$210,000.00
		\$33,000.00
4. Contraceptive Stock Spec.		\$5,000.00
<b>b) Regional Level</b>		
1. Regional Physician	2 @ 800	\$1,600.00
2. Reg. Community Supervisor	8 @ 2,900	\$23,200.00
3. Accountant	4 @ 6,000	\$24,000.00

DETAILED COST ESTIMATE  
(Continued)

ITEM	SOURCE	
	D.A.	TITLE III
d) Referral Center		
1. Social Workers 30 @ 2,760		\$82,800.00
2. Social Work Supv 2 @ 4,320		\$8,640.00
e) Community		
1. Promoters 38 @ 1,728		\$65,644.00
2. Comm Agent Supv. 40 @ 1,728		\$69,120.00
3. Community Agents 212 @ 1,200		\$254,200.00
f) Inflation (approx 5%)		\$22,796.00
Sub-Total:	\$255,000.00	\$600,000.00
8. Operating Expense		
a) Office rent and op. expenses for Natl Coord 24 mos @ 4,000	\$96,000.00	
b) Per diem for supervision 5,000/mo x 24		\$120,000.00
c) Gasoline & Maintenance 24 vehicles x 200/month x 24		\$115,000.00
d) Office Supplies		\$48,000.00
e) Client Records & Management Forms 200,000 @ 0.25		\$50,000.00
f) DHFN & MSPP office space, electricity, mail, tel, maintenance		
g) Referral Center (FP portion) 25 @ 4,000		
h) F.P. portion of 163 other centers @ approx 1,200		
Sub-Total:	\$96,000.00	\$333,000.00

DETAILED COST ESTIMATE  
(Continued)

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ITEM	SOURCE	
	D.A.	TITLE III
	=====	=====
9. Policy Development		
-----		
a) Buy in to OPTIONS project for CONAPO support and IHSI studies	\$100,000.00	
b) Seminars for population and development	\$25,000.00	
c) Renovations & Office equipment for CONAPO	\$25,000.00	
Sub-Total	----- \$150,000.00	
10. Interim PVO Support		
-----		
Interim contribution to Action Familiare, North Region natural family planning, & CEGYPEF	\$152,000.00	\$25,000.00
Sub-Total:	----- \$152,000.00	----- \$25,000.00
11. Evaluation & Audit (Local Costs)		
-----		
a) CDC review	\$100,000.00	
b) Evaluations (interim)	\$60,000.00	
c) Audit	\$40,000.00	
Sub-Total:	----- \$200,000.00	
Sub-Total Items 1-11:	----- \$4,748,000.00	----- \$1,383,000.00
12. Contingency	\$95,000.00	\$67,000.00
-----		
TOTAL:	----- \$4,843,000.00	----- \$1,450,000.00
	=====	=====

Note: Cost estimates include \$510,000 carryover from original project.

SCOPE OF WORK  
POPULATION ADVISOR

Responsibility:

The Population Advisor will plan, monitor, and coordinate all USAID/Haiti funded Family Planning Outreach project-related activities. The Advisor will report to the USAID Population Development Officer and will be based in Port-au-Prince. The duration of assignment is two years.

Duties:

The Advisor's tasks will include,--but not be limited to, the following:

1. Provide technical assistance to the National Family Planning Coordinator in program management, implementation, and evaluation.
2. Plan, coordinate, monitor and report on all activities conducted under the auspices of the Family Planning Outreach Project (no. 521-0124).
3. Monitor expenditures under the USAID (D.A.) portion of the project budget, including: short-term technical assistance; short-term participant training; commodities; information, education and communication; research; policy development; and project evaluations.
4. Review, coordinate and monitor activities of A.I.D. cooperating agencies (such as JHPIEGO, Management Sciences for Health, Family Health International, Johns Hopkins University/Population Communication Services, Futures Group, Centers for Disease Control, etc). Provide logistical support for cooperating agency technical assistance advisors.
5. Coordinate with the DHFN, SDEM, DESE and UNFPA in the planning and implementation of USAID supported population activities.
6. Prepare project plans; prepare documentation required for the procurement of goods and services (e.g., PIO/Cs, Purchase Orders, PIO/Ts); prepare PIO/Ps for participant training; and prepare project progress reports in collaboration with the National Coordinator and DHFN.
7. Keep USAID apprised of the adequacy of available contraceptive supplies; make contraceptive projections; and provide in-country logistical support for commodities if required.

Minimum Qualifications:

1. Master's degree in health or family planning administration or related field.
2. Five years experience in the planning, organization, management and evaluation of family planning programs in a developing country, preferably in a Francophone country.
3. Knowledge of and experience with AID policies, regulations procedures and documentation processes.
4. Professional proficiency in French (FSI tested level of 3/3). Creole language proficiency desirable.

ILLUSTRATIVE BUDGET FOR  
POPULATION ADVISOR

	Year 1	Year 2	Total
1. Salary	\$45,000	\$47,000	\$92,000
2. FICA, Health Insurance, and Medical Evac Ins.	\$10,350	\$10,810	\$21,160
3. Travel & Transpo.			
Intl Travel (RTx2)	\$1,200	\$1,200	\$2,400
R&R Travel	\$1,200		\$1,200
Excess baggage	\$220	\$220	\$440
Air Freight (UAB)	\$2,000	\$2,000	\$4,000
Sea Freight (2500 lbs)	\$5,000	\$5,000	\$10,000
Vehicle	\$3,000	\$3,000	\$6,000
Storage (5000 lbs)	\$1,200	\$1,200	\$2,400
4. Allowances			
Post Differential (20%)	\$9,000	\$9,400	\$18,400
Temporary Lodging	\$1,000	\$0	\$1,000
Education	\$12,000	\$12,000	\$24,000
Quarters	\$18,000	\$19,000	\$37,000
Housing Maintenance	\$2,000	\$2,000	\$4,000
Security	\$3,000	\$3,000	\$6,000
Furniture & Appl.	\$15,000	\$0	\$15,000
Per Diem (AID/W)	\$1,000	\$1,000	\$2,000
Per Diem, in-country	\$3,000	\$3,000	\$6,000
5. Other Costs			
DBA Insurance (2.7xsal)	\$1,215	\$1,269	\$2,484
Passport, medical	\$1,000	\$0	\$1,000
Invitational Travel	\$1,000	\$0	\$1,000
Subtotal	\$136,385	\$121,099	\$257,484
Contingencies			\$30,516
TOTAL			\$288,000

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ANNEX 7

HAITI: Proposal for Expansion of NORPLANT® Pre-introductory Trials

December 1986

Submitted by:

Family Health International  
One Triangle Drive  
Research Triangle Park, North Carolina  
USA

I. STATEMENT OF WORK

Family Health International (FHI) proposes a four-year program to build on pre-introductory clinical trials now underway in Haiti to evaluate the safety, efficacy and acceptability of NORPLANT<sup>®</sup> contraceptive subdermal implants. The first two and one-half years of the project would provide for continued follow-up of women enrolled in the original pre-introductory trials and during a bridging period supported by the DHFN, and increase the total number of women enrolled in the study by 600 per year among the three participating centers. Funds are included to permit regular follow-up of acceptors for five years, the approved duration of NORPLANT<sup>®</sup>. A national registry of NORPLANT<sup>®</sup> users will also be established, and information and education materials appropriate for use with Haitian clients and providers will be developed. The total project cost for the first two and one-half years is estimated at \$457,095.

A program to commence in the second half of year three will be submitted for funding at a later date. This program will implement provider training in-country, establish necessary logistics systems, provide for expansion to additional centers, and fund studies to assess the factors related to and impact of the introduction of NORPLANT<sup>®</sup> into the Haitian family planning program. Funding levels to cover program costs in the second half of year three and for year four are estimated at \$463,002.

NORPLANT<sup>®</sup> is currently approved for marketing in Finland, where it is manufactured by Leiras Pharmaceuticals; commercial distribution approval has also been received in the Dominican Republic, Ecuador, Indonesia, Sweden and Thailand. The NORPLANT<sup>®</sup> system consists of six Silastic<sup>®</sup> capsules, each

approximately 3.4 cm in length and containing 36 mg of levonorgestrel, a synthetic progestogen widely used in oral contraceptives (Ovral).

Pre-introductory trials of NORPLANT<sup>®</sup> began in three Haitian Centers in November 1985 (See Table I) to provide data for Haitian medical personnel and policymakers regarding the suitability of NORPLANT<sup>®</sup> for Haitian women. The majority of the initial caseload of 250 women were enrolled in just 6 months, indicating a high level of acceptability and potentially strong demand for the product. The Haitian investigators carrying out the initial studies have expressed enthusiasm for the method and have requested an expansion of caseloads to accommodate the increasing demand. The proposed project would extend the studies in these three centers in preparation for marketing approval in Haiti, and will provide a basis for planning for expansion of the program to additional centers. During the second year steps will be taken to establish a Haitian training capability for NORPLANT<sup>®</sup>.

**Table I**

**Status of Initial FHI-Sponsored NORPLANT<sup>®</sup> Studies in Haiti**

Site	Caseload	Initiation	Date Adm. Completed
Comp. Med. Soc. de la Cite Soleil	100	Nov. 1985	July 1986
Hopital de Bienfaisance	100	Nov. 1985	August 1986
Centre de l'Armee de Salut	50	Nov. 1985	February 1986

## II. WORK PLAN

### A. Continued Follow-up of Ongoing Pre-introductory Trials

Enrollment of NORPLANT<sup>®</sup> acceptors in the three pre-introductory trials began in November 1985. The protocol under which these initial 250 women were recruited specifies regular follow-up of the women every six months until the implants are removed. Since enrollment of all 250 cases was completed by August 1985, an interim bridging phase has been negotiated with the DHFN that will increase the caseload at the three existing centers by 50 cases each. The DHFN will fund in-country monitoring and data collection costs and FHI will continue to provide the implants and technical support as with the first 250 cases. The 150 new cases are expected to be enrolled beginning in January 1987 and will follow the same protocol and semi-annual follow-up schedule.

Admission costs and follow-up through the 18-month visits for the initial 250 cases were funded through FHI's Cooperative Agreement with USAID/W. Admission costs and the first two follow-up visits for the interim 150 cases will be funded by the DHFN. Funding is requested in this proposal for continued follow-up of all 400 cases, beginning with the 24-month follow-up visit for the initial 250 cases and with the 6-month visit for the interim 150 cases. In calculating field costs, an estimate was made of the expected continuation rates at each follow-up interval. Although follow-up of acceptors will continue for five years, field costs for all follow-up visits are included in the first project year, as well as removal costs for all cases continuing for the full five year use period.

B. Expansion of Caseloads at Existing Centers

Approval will be sought from the Haitian government to increase the caseloads at the existing centers in Pignon, Fond des Negras, and Cite Soleil by an additional 600 cases per year (total 1200 cases in two years). These additional cases will be allocated among the three centers on the basis of anticipated demand for the method in the areas served. Admission criteria specified in the protocol used in the pre-introductory studies now underway will be used in selecting women for these continued studies. However, the follow-up schedule, originally specifying 1, 3, 6 and 12 months and semi-annually thereafter, will be changed to 1, 6 and 12 months and annually thereafter until removal of the implants. Data will be collected at admission and scheduled follow-up visits using abbreviated forms for these new cases. (Women enrolled in the original pre-introductory studies and during the bridging phase will be maintained on the existing follow-up and data collection protocol.)

Funding is included to enable investigators to exercise their responsibility for follow-up of women enrolled in these studies until removal. All implants still in place five years post-insertion will be removed at that time. Once approval for use of NORPLANT<sup>®</sup> within the general program in Haiti has been obtained, providers will assume financial responsibility for integration of NORPLANT<sup>®</sup> into their regular service program, without reimbursement for follow-up.

C. Establishment of a National Registry

A national registry system will be developed and tested within the context of the expanded trials at existing centers in order to maintain a centralized record of all NORPLANT® acceptors. A manual registry is now maintained by the FHI consultant to this project. An early task in this component will be to determine the most appropriate agency to maintain the national registry on a permanent basis. This system will be especially important when new centers are added and the implants become an integral part of the national service program. At that time extensive data on each client will not be necessary, but essential sociodemographic data will continue to be important for service statistics. The registry will also enable service providers to identify women who have used the implants for five years and who have not returned for removal and to permit acceptors to be contacted if further study is necessary at any time following the insertion of the implants.

D. Development of IE&C Materials

In preparation for a generalized use of NORPLANT® in Haiti, culturally appropriate IE&C materials will be developed. Materials developed for use in other countries will be collected, modified and tested in the context of the existing Haitian centers, and will be modified as needed. Several local groups have expertise in the development of IE&C materials. FHI will be responsible for obtaining review and assuring that materials developed for Haiti are accurate and convey the essential information about NORPLANT® to potential users.

E. Development of an In-Country Training Center

Pending continued interest of providers, clients and Haitian officials in the introduction of NORPLANT<sup>®</sup> to the general program, a national training center will be needed to develop additional centers and providers of the method. During the second year of the expanded program, work will begin on establishing a Haitian training center. Consideration will be given to the Haitian Public Health Institute recently established in Cite Soleil, the only urban site in the pre-introductory studies. Necessary modifications to upgrade the service facility to a training center will be made. Current investigators will act as local consultants in developing the training program and supervising the clinical practice. (Two of the current investigators have already trained their assistants in insertion techniques.)

Education and training materials will be developed based on the experiences of Haitian, as well as other international investigators. A comprehensive package of articles on NORPLANT<sup>®</sup> will be developed to provide trainees, once the training center is operational. These materials will include information on the development of the method, research results and current activities.

Proper counseling of acceptors has been shown to have an important effect on acceptability and user satisfaction with the method. In addition to clinical training materials, the development and testing of counseling techniques will also be of major importance. Service providers must be trained in this area as well as in the clinical aspects of insertion and removal.

Some of the costs of the development of training materials, and all costs of implementing in-country training programs are included in years 3 and 4, to be requested at a later date.

F. Acceptability, User Satisfaction and Other Research Studies

Special research studies to determine product acceptability, motivational factors for acceptance and barriers to acceptance will be developed as needed in the second year of the project. Funding for these studies will be requested in years 3 and 4.

III. PROJECT MANAGEMENT

FHI will have responsibility for overseeing and managing all phases of the project, which will be carried out through close coordination with FHI's local NORPLANT® coordinator, government officials, private and public sector providers. Regular on-site visits will be made by FHI to advise, monitor, and evaluate all project activities. FHI staff will make regular visits to insure that study procedures are being followed. Patient clinic records will be examined and any problems relating to the studies discussed. A study subcontract which outlines the responsibilities of FHI and the Principal Investigator, the data analysis plans and cost reimbursement procedures will be agreed upon for each individual center participating in the project.

An FHI program coordinator will have overall responsibility for the project to assure that project components are carried out in a timely, cost effective way in consonance with project goals. The FHI coordinator will be responsible for maintaining financial accountability of the project.

B. PROGRAM BUDGET

I. A. Continuation and Expansion of NORPLANT Trials in Current Centers  
(Pigeon, Fond des Negres, Port-au-Prince)

FIELD COSTS	YEAR 1	YEAR 2	1/2 YEAR 3	SUBTOTAL	1/2 YEAR 3	YEAR 4
Personnel						
Direct	13,500	15,000	8,000	36,500	8,000	16,000
Fringes	3,105	3,450	1,840	8,395	1,840	3,680
International Travel	2,200	2,200	1,250	5,650	1,250	2,500
Study Supplies/Printing	1,000	500	250	1,750	250	500
Computer Services						
Key punching	1,500	1,500	750	3,750	750	1,500
Computer Time	1,500	3,000	1,500	6,000	1,500	3,000
Other Purchased Services						
Translations	500	1,000	250	1,750	250	500
<b>FIELD SUBTOTAL</b>	<b>23,305</b>	<b>26,650</b>	<b>13,840</b>	<b>63,795</b>	<b>13,840</b>	<b>27,680</b>
<b>FIELD COSTS</b>						
NORPLANT <sup>®</sup> Supplies	8,355	8,355	4,178	20,888	4,178	8,356
Freight	500	500	250	1,250	250	500
Subcontracts with 3 Investigators						
1. Continued Follow-up						
Ongoing Trials	31,367	-----	-----	31,367	-----	-----
2. Continued Follow-up						
Bridging Cases	26,991	-----	-----	26,991	-----	-----
3. Expansion of Caseload						
(600 cases/year)	44,535	60,285	39,903	144,728	39,908	97,456
Monitoring and Coordination						
Local Travel	800	800	400	2,000	400	800
Consultant (Dr. Brutus)	4,200	4,800	2,700	11,700	2,700	6,000
Conference to Discuss						
Preliminary Findings	-----	10,000	-----	10,000	-----	-----
<b>FIELD SUBTOTAL</b>	<b>116,748</b>	<b>84,740</b>	<b>47,436</b>	<b>248,924</b>	<b>47,436</b>	<b>113,112</b>
G.S.A. (at 342 NTDC)	38,134	17,376	7,265	62,775	20,834	20,666
<b>TOTAL</b>	<b>178,187</b>	<b>128,766</b>	<b>68,541</b>	<b>375,494</b>	<b>82,110</b>	<b>139,778</b>

1. E. Expansion to Additional Centers  
 (Proposed per center budget for 100 annual client caseload, projecting  
 6 new centers in each of years 3 and 4)

FBI COSTS	COST/CENTER	1/2 YEAR 3	YEAR 4
Personnel			
Direct	2,500	15,000	15,000
Fringes	600	3,600	3,600
International Travel	200	1,200	1,200
Study Supplies/Printing	100	600	600
Computer Services			
Keypunching	100	600	600
Computer Time	100	600	600
<b>FBI SUBTOTAL</b>	<b>3,600</b>	<b>21,600</b>	<b>21,600</b>
<b>FIELD COSTS</b>			
Local Travel	150	900	900
NONPLANT <sup>2</sup> Supplies	1,200	7,200	7,200
Medical Supplies	200	1,200	1,200
Freight	150	900	900
Data Collection	4,150	24,900	24,900
Research Assistant Consultant	200	1,200	1,200
<b>FIELD SUBTOTAL</b>	<b>6,050</b>	<b>36,300</b>	<b>36,300</b>
<b>G &amp; A</b>	<b>3,281</b>	<b>15,844</b>	<b>15,844</b>
<b>TOTAL</b>	<b>12,931 /CENTER</b>	<b>77,586</b>	<b>77,586</b>

II. Development and Implementation of Registry System

FBI COSTS	YEAR 1	YEAR 2	1/2 YEAR 3	SUBTOTAL	1/2 YEAR 3	YEAR 4
Personnel						
Direct	1,500	750	250	2,500	250	500
Fringes	350	175	58	583	58	115
International Travel	200	200	50	450	50	100
Graphics	500	-----	-----	500	-----	-----
Supplies	300	600	-----	900	-----	-----
<b>FBI SUBTOTAL</b>	<b>2,850</b>	<b>1,725</b>	<b>358</b>	<b>4,933</b>	<b>358</b>	<b>715</b>
<b>FIELD COSTS</b>						
Research Assistant	1,500	1,500	750	3,750	750	1,500
Consultant	500	-----	-----	500	-----	-----
Local Travel	150	150	75	375	75	150
<b>FIELD SUBTOTAL</b>	<b>2,150</b>	<b>1,650</b>	<b>825</b>	<b>4,625</b>	<b>825</b>	<b>1,650</b>
G & A	1,700	1,143	402	3,250	402	804
<b>TOTALS</b>	<b>6,700</b>	<b>4,523</b>	<b>1,585</b>	<b>12,808</b>	<b>1,585</b>	<b>3,169</b>

111. Development of Training Center and Training Materials

FIH COSTS	YEAR 2	1/2 YEAR 3	SUBTOTAL	1/2 YEAR 3	YEAR 4
Personnel					
Direct	1,500	750	2,250	750	1,000
Fringes	350	175	525	175	250
International Travel	1,000	500	1,500	500	1,200
Consultant Fee	1,000	500	1,500	500	500
Supplies	600	-----	600	-----	100
Graphics Usage	1,000	-----	1,000	-----	-----
Other Purchased Services					
Translations	500	-----	500	-----	-----
<b>FIH SUBTOTAL</b>	<b>5,950</b>	<b>1,925</b>	<b>7,875</b>	<b>1,925</b>	<b>3,050</b>
<b>FIELD COSTS</b>					
Facility Modifications	500	-----	500	-----	-----
Supplies - Office	500	-----	500	-----	200
Supplies - Medical	1,000	-----	1,000	-----	500
Travel (6 Trainees)	-----	-----	-----	1,400	1,400
Training Consultants	500	-----	500	1,000	1,500
<b>FIELD SUBTOTAL</b>	<b>2,500</b>	<b>-----</b>	<b>2,500</b>	<b>2,400</b>	<b>3,600</b>
<b>G &amp; A</b>	<b>2,873</b>	<b>655</b>	<b>3,528</b>	<b>1,471</b>	<b>2,261</b>
<b>TOTAL</b>	<b>11,323</b>	<b>2,580</b>	<b>13,903</b>	<b>5,796</b>	<b>8,911</b>

IV. Development of I-E & C Materials

FHI COSTS	YEAR 1	YEAR 2	1/2 YEAR 3	SUBTOTAL	1/2 YEAR 3	YEAR 4
Personnel						
Direct	1,500	1,500	375	3,375	375	-----
Fringes	350	350	87	787	87	-----
Consultant	4,200	2,700	600	7,500	600	-----
International Travel	2,500	1,500	-----	4,000	-----	-----
Printing	1,500	2,500	1,250	5,250	1,250	-----
Graphics	1,000	-----	-----	1,000	-----	-----
Other Purchased Services						
Translations	500	-----	-----	500	-----	-----
Freight	200	-----	-----	200	-----	-----
<b>FHI SUBTOTAL</b>	<b>11,750</b>	<b>8,550</b>	<b>2,312</b>	<b>22,612</b>	<b>2,312</b>	<b>--0--</b>
FIELD COSTS						
Local Travel	400	200	100	700	100	200
Radio Announcements	-----	500	250	750	250	500
Consultant	1,200	1,200	600	3,000	600	2,000
<b>FIELD SUBTOTAL</b>	<b>1,600</b>	<b>1,900</b>	<b>950</b>	<b>4,450</b>	<b>950</b>	<b>2,700</b>
G & A	4,539	3,553	1,110	9,202	1,110	918
<b>TOTALS</b>	<b>17,889</b>	<b>14,003</b>	<b>4,372</b>	<b>36,254</b>	<b>4,372</b>	<b>3,618</b>

V. Studies - User Acceptance

FBI COSTS	YEAR 2	1/2 YEAR 3	SUBTOTAL	1/2 YEAR 3	YEAR 4
Personnel					
Direct	4,500	1,500	6,000	1,500	4,500
Fringes	1,050	350	1,400	350	1,050
Travel	1,500	750	2,250	750	1,500
Study Supplies/Printing	1,000	-----	1,000	-----	1,000
Computer Services	-----	250	250	250	500
Keypunching	-----	-----	-----	-----	2,000
Computer Time	-----	-----	-----	-----	-----
Other Purchased Services	-----	-----	-----	-----	-----
Translations	1,000	-----	1,000	-----	2,000
FBI SUBTOTAL	<u>9,050</u>	<u>2,850</u>	<u>11,900</u>	<u>2,550</u>	<u>12,550</u>
FIELD COSTS					
Subcontract	2,000	-----	2,000	15,000	-----
FIELD SUBTOTAL	<u>2,000</u>	<u>--0--</u>	<u>2,000</u>	<u>15,000</u>	<u>--0--</u>
G & A	3,757	969	4,726	6,069	4,267
TOTAL	<u>14,807</u>	<u>3,819</u>	<u>18,626</u>	<u>23,919</u>	<u>16,817</u>

VI. Distribution and Inventory System

FBI COSTS	1/2 YEAR 3	YEAR 4
Personnel		
Direct	3,000	1,500
Fringes	700	350
International Travel	1,500	200
Graphics	500	-----
Supplies	300	300
Freight	200	200
	<hr/>	<hr/>
FBI SUBTOTAL	6,200	2,550
FIELD COSTS		
Printing	500	300
Supplies	500	200
Research Assistant	1,500	1,500
	<hr/>	<hr/>
FIELD SUBTOTAL	2,500	2,000
G & A	2,958	1,547
TOTALS	<u>11,658</u>	<u>6,097</u>

ANNEX 8  
PROJECTED COMMODITY REQUIREMENTS

It is still impossible to obtain precise data on contraceptives distributed below the central level and/or commodities dispensed to users. In the absence of such data, the following forecasts are based upon reports from the DHFN with the knowledge that only with the implementation of the technical assistance proposed in this project will better data become available.

A. Pills

The 1985 Annual Report of the DHFN showed that 79 percent of all "new acceptors" of contraception from DHFN sources were users of pills. This is consistent with the 1983 Contraceptive Prevalence Survey which indicated 71 percent of all current users of modern methods were pill users.

DHFN figures show that the proportion of all new acceptors who are pill users has been increasing since 1974, as shown in Table I, and has been in the 75 to 79 percent range during the most recent 2 years with data available.

TABLE I

Proportion of New Acceptors Who Are Pill Users  
 (Excluding Sterilization Acceptors)

<u>Year</u>	<u>% Pill Users</u>
1974	32
1976	53
1978	67
1980	75
1982	68
1984	75
1985	79

Source: 1985 DHFN Annual Report, Table 30, Page 48

Thus, the most recent report of 79 percent will be used for estimating future commodity needs.

DHFN service statistics state that there were 103,125 females using contraceptive methods, obtained from DHFN sources, in 1985. Since we are assuming that the proportion of 79 percent of pill users can be applied to

this total, there would be 81,469 pill users, each using 13 cycles per year, for an estimated total of about 1,060,000 cycles dispensed to clients. This amount closely corresponds to the 1,033,000 cycles, which is the projected quantity of all brands of pills from all donors to be issued from the central warehouse, based on issues through October 1986. It also closely corresponds to the 1986 "Estimated Product Use" from the CPT table completed in May 1985 of 1,048,000 cycles. The figure of 1,060,000 will therefore be used for the 1986 estimated product use for pills.

Pill use is projected to increase roughly 5 percent per year for the next several years, as the proportion of users employing pills may increase even further and the total number of users of all methods increases, particularly as new private sector agencies begin providing family planning services using project commodities (given the low prevalence of use, the increase of 5 percent represents approximately a one percentage point increase). It is not foreseen in the medium-term that either the number of sterilizations or IUD users will increase enough to affect the projected modest increase in pill use (neither of these two methods are commonly employed in Haiti.)

The Contraceptive Procurement Tables were prepared using the above estimates from central warehouse data as a base, since, as mentioned above, data for lower level issues from warehouses and distribution to clients are not available. It is assumed that 50 percent of the following year's estimated use will be kept in stock in the central warehouse (See Appendix 1). This assumes that the quantities of contraceptives in the pipeline between the central warehouse and the periphery contain a sufficient amount to ensure continuing availability. Until further technical assistance, we will employ this assumption for lack of a better one.

#### B. Condoms

The 1985 DHFN Annual Report showed 10 percent of new female acceptors to be condom users. Using the DHFN figure of 103,125 total female acceptors, and assuming 10 percent are condom users, we arrive at an estimate of 10,313 users. Using DHFN data, we estimate an average of 240 condoms per year\* are dispersed to each user for a total of 2,475,000 condoms. DHFN service statistics also provide data on the actual number of condoms distributed to male users (but not to females). In 1985, this figure was 10,032,155 condoms (Table 35, page 56).

Therefore:

	10,032,155 condoms distributed to men
+	2,475,000 estimated distribution to women
=	12,507,155 condoms distributed in 1985,

which will be used as the estimated product use for 1986. Based on actual issuance figures through October 1986, we estimate that 17,250,000 condoms will be issued from the central warehouse in 1986. This is obviously far out of line with both service statistics and previous survey data and so will not be used to estimate future requirements. Thus, our assumption that condom use

\*This is recognized as being larger than most programs, but we will accept this figure until better data comes from the survey and the outside auditor.

One additional note should be made regarding future use of condoms. It is conceivable that as a result of the increasing spread of AIDS and the fact that condoms may provide protection, the use of condoms could increase far beyond present levels, primarily from increased use in disease prevention, rather than pregnancy prevention. In such an event, current projections of condom demand would become outdated. The annual review of these figures is will increase roughly 4 percent per year for the next several years, particularly as private sector agencies begin providing family planning services, is applied to the 12,500,000 figure.

(IN 000 s)

Country: HAITI  
 Project No. 521-0124 - 521-0189  
 Program: \_\_\_\_\_  
 Product: 52mm condoms  
 Source of Data for Beginning-of-Year Stock: \_\_\_\_\_  
 Date: Dec 1985

	CALENDAR YEARS					
	1986	1987	1988	1989	1990	1991*
1. Beginning-of-Year Stock (PLEASE READ INSTRUCTIONS TO FILL IN THIS LINE ITEM)	3,075	8,509	6,750	7,000	7,250	7,500
PLUS						
2. New Supply of Same Product						
(a) AID supplies received in 1985 to date	13,734					
(b) additional AID quantities scheduled for shipment but not yet received	4,200	7,000				
(c) other sources of supply of same product (host country/other donors)	0	0	0	0	0	0
MINUS						
3. Estimated Product Use	12,500	13,000	13,500	14,000	14,500	15,000
MINUS						
4. Desired End-of-Year Stock Level (equal to 30% of estimated use in subsequent year)	6,500	6,750	7,000	7,350	7,500	
EQUALS						
5. NET SUPPLY SITUATION/AID REQUIREMENT (negative number signifies additional supplies of product required from AID; positive number signifies no AID requirement and need to calculate line item #6. (1+2-3-4=5))	2,009	-4,241	-13,250	-13,500	-14,250	
6. ONLY WHEN SURPLUS EXISTS (i.e. when #5 is positive), ACTUAL END-OF-YEAR STOCK LEVEL = #4 + #5.	8,509					

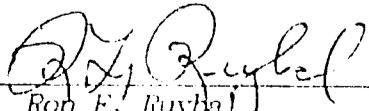
(IN 000.s)

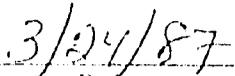
Country: HAITI  
Project No. 521-0124 - 521-0189  
Program: \_\_\_\_\_  
Product: Femenol  
Source of Data for Beginning-of-Year Stock: \_\_\_\_\_  
Date: Dec 1986

	CALENDAR YEARS					
	1986	1987	1988	1989	1990	1991*
1. Beginning-of-Year Stock (PLEASE READ INSTRUCTIONS TO FILL IN THIS LINE ITEM)	158	703	575	600	625	650
MINUS						
2. New Supply of Same Product						
(a) AID supplies received in 1985 to date	1,505					
(b) additional AID quantities scheduled for shipment but not yet received	0	0	0			
(c) other sources of supply of <u>name</u> product (host country/other donors)	100	100	100	100	100	100
MINUS						
3. Estimated Product Use (both projects) (for public sector only, reduce to 1100 all years)	1,060	1,100	1,150	1,200	1,250	1,300
MINUS						
4. Desired End-of-Year Stock Level (equal to <u>50</u> % of estimated use in subsequent year)	550	575	600	625	650	
EQUALS						
5. NET SUPPLY SITUATION/AID REQUIREMENT (negative number signifies additional supplies of product required from AID; positive number signifies no AID requirement and need to calculate line item #6. (1+2-3-4=5))	153	-872	-1,075	-1,125	-1,175	
6. ONLY WHEN SURPLUS EXISTS (i.e. when # 5 is positive), ACTUAL END-OF-YEAR STOCK LEVEL = #4+#5.	703					

INITIAL ENVIRONMENTAL EXAMINATION

*Project Location:* Haiti  
*Project Title:* Family Planning Outreach Project  
Paper Amendment No. 1 (521-0124)  
*Funding:* \$13.948 DA  
*LOP:* 8 Years (FY 81-89)  
*IEE Prepared By:*

  
\_\_\_\_\_  
Ron F. Ruybal  
Mission Environmental Officer

  
\_\_\_\_\_  
Date

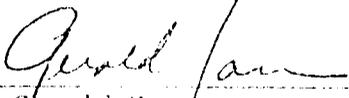
*Threshold Decision*  
*Recommended*

Categorical Exclusion, because

(1) 22 CFR Part 216.2 (c) states programs involving nutrition, health care or population and family planning services do not require an IEE.

(2) Structural renovation to existing structures will be minor and not have an adverse effect on the environment.

*Concurrence:*

  
\_\_\_\_\_  
Gerald Zarri  
Director, USAID/Haiti

MAR 24 1987

\_\_\_\_\_  
Date