A.C.P.S.
"LA SANTÉ POUR TOUS"

ASSOCIATION DES OEUVRES PRIVÉES DE SANTÉ
P.O. Box 1213 Port-au-Prince, Haïti

FACE SHEET

Project Title	:	COMMUNITY HEALTH ACTION PROGRAM
Project location	:	HAITI
PVO name	:	Association des Oeuvres Privees de Santé
Location	:	Haiti
Headquarters	:	92 Chemin des Dalles, Port-au-Prince, Haiti
Contact person	:	Père Octave Lafontant , Vice-President or Dr. Antoine Augustin, Secretary
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CONTENTS

HAITI IN NUMBERS

Population (1982)	5.195.200
Birthrate	35.5[2]
Death rate	16.5[2]
Infant mortality rate	149/000[2]
Mortality rate (1 - 4yR)	45/1000[2]
Maternal mortality rate	350/100000[3]
Total number of deaths/yR	85000[6]
Total number of live births/yR	170000[4]
Total number of infant deaths (o-11mo)/yR	25000[4]
Infant deaths 0-1 month	10000[4]
- tetanos	6000[5]
Infant deaths 1-11 months	15000[4]
- from diarrhea	12000[4]
Deaths over 5 years /year	40000[4]

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1 IHS - DIFPAN 1980

2 IHS

3 DHF - DSPP

4 RGS estimates

5 Based on DSPP estimates

6 Based on IHS data

A. PROJECT PURPOSE AND DESCRIPTION

1. Introduction

Health services in Haiti are currently being provided within the context of two major institutional settings: the Ministry of Health (DSPP) and the various private voluntary health organizations. In recent years, the ministry has intituted a vast program of expansion of health services in rural areas, the aim of which is to make these services accessible to the majority of the population of Haiti. In seeking to enlist the support and cooperation of private health institutions in the endeavor, the ministry invited all such institutions to participate in a colloquium (april 1982), during which the major objectives of the DSPP's program were exposed.

It was in an effort to bring about the cooperation and coordination of private health institutions efforts towards the goal of good health for all that the Association des Oeuvres Privees de Sante was founded. In spite of its being rather young, the Association brings to the fore the collective experience of its member institutions in the field of health. Some of these institutions have been working in Haiti for decades and it is because of this past experience that they have proposed that AOPS develop a program which would allow its members to better coordinate their activities, to share their resources and to increase the coverage of their services at manageable cost.

2. Project Goal and Purpose

The goal of the project is to bring about an improvement of the health status of the Haitian poor.

The purpose is to assist private voluntary health organizations operating in Haiti in the implementation of community health and family planning programs for the benefit of the indigent population they serve.

The assistance will be in the form of technical assistance provided by AOPS or by outside consultants and financial assistance by AOPS to some institutions to enable them to implement community health activities. Several related subpurposes are to be served by this grant :

a. to encourage private institutions to adopt a preventive approach to primary care in such a way that evaluation of program impact can be made. In its initial years of operation, the project will provide direct financial assistance to ten (10) private health institutions to help them implement community health programs. Each such institution will select a defined population as the target of its preventive services. The members of such a population will have to be enumerated, counted and registered. Specific priority target groups such as children under five, pregnant and lactating mothers, and fertile women will be identified from family register sheets and appropriate strategies will be designed to meet their specific health needs.

Technical assistance will be provided to any other private institution with the same community health implementation needs.

b. to inform all private voluntary health institutions of current intervention strategies in the field of community health and to offer them technical assistance in the implementation of community health and family planning programs which they feel their ressources allow them to support. Such assistance may be in the form of consultations on the analysis of specific local health problems, on steps to take to re-orient their program towards a preventive approach, on organizing nutrition, maternal and child health and family planning programs, on training of auxiliary staff, on the evaluation of their programs and on the analysis of service statistics.

c. to promote an exchange of ideas and experiences amongst all private institutions as they relate to community health and family programs.

d. to offer a central bank for data sharing, pooling and evaluation. In that respect several AOPS member institutions such as the Ste Croix Hospital in Leogane, the Lamothe Fondation, the Eye Care community health outreach program in Mirebalais and the complexe Medico Social de la Cite Simone, have agreed to seek ways of standardizing their informatio retrieval and health intelligence gathering operations so as to facilitate data pooling and cross national comparisons of morbidity and mortality. These institutions collectively have a target population representing 200,000 persons. This, added to the 100,000 persons to be registered by the 10 institutions whose community health program implementation will be funded through this grant will bring the total participating population to a minimum of 300,000 persons.

e. to help all private health institutions coordinate their activities in order to promote a rational utilisation of ressources.

f. to coordinate private institutions activities with government health programs and with the activities of public institutions.

g. to provide appropriate core support for project coordination, administration and evaluation.

2.1 Target group of beneficiaries.

While the project will reach all members of the various target populations connected to all participating institutions (funded or not), specific beneficiaries will particularly include the rural indigent poor, and among these, children under five, pregnant and lactating mothers and fertile women.

3. General Description of Project

The project will have two major components :

3.1 Financial and technical assistance by AOPS to 10 institutions for the purpose of implementing community health programs.

3.2 General assistance by AOPS to other private health institutions.

a, Targets

Targets fot the first component include the provision of integrated community health services to a defined population of 100,000 persons. During the project's lifetime, ten institutions will be selected for direct funding; 3 in the first cycle, 3 in the second and 4 in the third. This corresponds to the provision of services to 30,000 people in the first cycle, 30,000 in the second and 40,000 in the third.

Targets for the second component include direct contact and on-site visit by AOPS staff of all 214 private institutions working in Haiti. Subsequent sub-targets may be defined at a later date depending on the results of the visits and the types of request for assistance received.

b, Description of services

The project provides for financial and technical assistance by AOPS to individual institutions so as to allow them to implement community health programs. The elements of such a program include :

1. training of local program directors (community health physicians) at central location, by AOPS, (probably at Cite Simone Complexe), for a per of one month.

2. training by the returning physician of an auxiliary nurse, a statistical assistant and 10 community collaborators (1 month)

3. census and baseline survey of the target population (10,000 persons per institution).

4. implementation of health surveillance program with
   - nutritional surveillance and provision of dietary supplements
   - immunization of children and women of child-bearing age
   -promotion of oral rehydration therapy
   - promotion of breast-feeding
   - detection and treatment of major endemic illnesses (particularly T.B.)
   - organization of family planning services
   - recording of vital events

c, Selection of Institutions *

All currently identified private institutions operating in Haiti will receive a notification of the plans for implementation of the community health program and will be invited to submit to AOPS requests for financial assistance for participation in the program. Institutions will be selected depending on the availability of funds and will have to fulfill the following criteria :

1. membership in good standing in AOPS
2. permit to operate delivered by DSPP (this is a condition of membership in AOPS)
3. technical and physical capability for immediate program implementation; this mean that the institution must already have a core staff (MD, aux. nurse, statistician) employed and that a physical structure (building) exists to house and administer the program.
4. financial capability to support the program once assistance for implementation comes to an end .
5. approval of the institution's application by the executive committee of AOPS.

* for AOPS funded programs

d, Services to be provided by AOPS

AOPS will provide the following services to the institutions * enrolled in the program :

1. technical assistance in the implementation and administration of the program.
2. training of local project directors.
3. central accounting services for disbursed funds.
4. evaluation of local program progress and problems.
5. maintenance of a central statistical data bank for project impact analysis.

e, Institutions requirements

Each institutions selected for the project will agree to abide by the following conditions :

1. respect the norms set by the Ministry of Health with regard to the national health plan.
2. Cooperation with the DSPP s PIMS
3. provision of periodic reports of activity to DSPP and AOPS.
4. acceptance of on site inspection of progress and utilisation of funds provided through AOPS.

Furthermore, each institution will agree to implement the major elements of the community health programs.

f, Financial assistance

Financial assistance will be in the form of grants by AOPS to individual institutions. The grant will cover the following expenses:

1. cost of training 1 MD for 1 month (includes MD per diem) 1.000 dollars

* the ten institutions selected for project funding

rep. 4

2. cost of training auxiliary nurses, medical record keepers and community collaborators
3. cost of initial census
4. 1 year salary for auxiliary nurse and medical record technician
5. equipment purchase

4. End of Project Status

At the end of the Project, ten private health institutions will provide basic primary care services to 100,000 persons, a target populatio which will have been defined and registered, priority groups will have been identified and specific services will be provided to these groups by a trained team of community health physician, auxiliary nurse, communit collaborators and record keepers. Baseline data will be available from each of the participating institution concerning its own target population of 10,000 persons. In terms of output, 10 physicians , 10 auxiliary nurses and 10 record keepers will have received additional training in community health and 100 community health workers will have been trained.

From an operational point of view, the number of children regularly enrolled in health and nutrition surveillance will be expected to have increased and so will immunization coverage against common chilhood diseases. Family planning services will be more accessible to the population and coverage for pre-natal services improved.

B. PROJECT BACKGROUND

1. DSPP activity in project area

The project utilizes as terms of reference the general strategy adopted by the DSPP for the extension of health services and the improvement in the quality of care at the level of public institutions. The legal basis for such a strategy is the August 1971 Health Services

Act and the Regionalization decree of 1975. National Health Policy as defined within this context includes the following elements :

- regionalization of health services
- modernisation of the secondary and tertiary sectors
- extension of basic health services particularly in rural areas
- coordination of the activities of the private sector

The Regionalization process, as defined by the DSPP, is characterized by centralisation of legal and normative authority, and administrati decentralisation in such a way as to improve health coverage at manageable cost. For this purpose, the process provides for the building of many new health facilitites, the renovation of others, the training of a new type o health auxiliaries, the health agent, and improvements in the quality of services provided at health centers and hospitals.

These points werediscussed for the benefit of private health institutions at a meeting organized by the DSPP in early April 1982. AOPS was founded at that time, and since then, the organization has sought practical ways to help its member institutions adopt an appropriate approach to the health needs of the population they seek to serve, with a particular focus on the needs of children and their mothers.

B.2. Priority needs, as defined by the DSPP (May 1982), incorporate the following elements :

1. campaign against diarrheal diseases
2. immunization
3. control of tuberculosis
4. improvement in nutritional status
5. family planning
6. campaign against endemic diseases

These needs reflect a number of health problems which have been documented in Haiti (see table of cause of death p. 11). Amongst the most important one may list :

B.2.1. DIARRHEA

Incidence and Prevalence.- The incidence of diarrhea is very difficult to ascertain in Haiti. One may expect seasonal and geographic variations throughout the country. It is known that 40% of pediatric admissions to the University Hospital is for diarrhea. DSPP estimates that 7% of all hsopitalisations in the country are for diarrhea. In the first year of life, diarrhea accounts for 54% of hospitalisations while 28% of hospitalized children 1 to 4 y.o. have this disease. In Cité Simone, an urban slum area on the outskirts of Port-au-Prince, diarrhea accounts for 54% of hospitalisations in the children under one year of age and 28% in children 1 to 4 years of age.

A comparaison of two studies performed at a 3 year interval provides the following data on the prevalence of diarrhea and the average number of diarrheal episodes per child in one year. The studies were carried out in 1978 and 1981.

	1978	1981
Prevalence of diarrhea °the week before°	47%	53%
Episodes of diarrhea in one year	22	28

Prevalence of diarrhea in Haitian children, 1978 and 1981 and number of episodes of diarrhea in one year.

Diarrhea related mortality .- It is difficult to rate diarrhea as a cause of death in Haiti. The synergism between diarrhea and malnutrition is so frequent that to make the part of responsibility of each of these two factors in causation of death is difficult. It could probably be said safely said that diarrhea is the number one cause of death of infants under one year of age while malnutrition ranks over diarrhea as a cause of death in the 1 to 5 y.o.age group. Overall, diarrhea ranks as the number one cause of death in this country. Evidence for this comes from several sources: most hospital deaths are in the pediatric age group, and in this age, diarrhea accounted for 40% and 48% of the deaths respectively at HUEH 1963-1964 and 1976-1979 (Pape 1982). In Cité Simone, diarrhea was said to account for 63% of all deaths for the age group 0 to 5 years and 85% of deaths of infants under 1 year of age (Berggren 1980). More recent data shows diarrhea accounting for 64% of deaths of children 1 to 5 years of age (Complexe Medico Social 1982).

A linkage is traditionally made between the high incidence and availability of potable water. It is known for example that only 0.6% of rur haitians dispose of potable water. The following table summarizes the water situation in Haiti.

Type of service	Urban areas	Rural areas	All areas
Piped water at home	22%	0.1%	5.8%
Access to public fountain	21%	0.6%	5.6%
Without available source of water	51%	99.4%	88.4%

Source. Rapport d'évaluation en vue de la decennie de l'eau 1980-1990 (fev. 1980)

CAUSE OF DEATH

(in hospitalized patients)

1.	Diarrhea	36.20 %
2.	Tuberculosis	12.44 %
3.	Malnutrition	8.32 %
4.	Cardiovascular disorders	8.02 %
5.	Pneumonias	7.75 %
6.	Cerebro-vascular disorders	7.54 %
7.	Gastro-intestinal disorders	6.8 %
8.	CNS disorders	5.46 %
9.	"Dehydration"	3.64 %
10.	Tetanus	3.46 %

SOURCE : DSPP section centrale de statistiques. Janvier-Juin 1981.

Interaction between diarrhea and malnutrition

The interaction between diarrhea and malnutrition has been emphasized. Malnourished children are more likely to have diarrhea and diarrhea is a more lethal disease in nutritionally deprived populations.

Diarrhea and malnutrition are linked closely in indigent populations. In Cité Simone, for example, the majority of hospital admissions is for diarrhea. Part of this comes from the fact that the Complexe Medico-Social of Cité Simone maintains a nutrition recuperation center, thus reducing the need for hospitalizations. Nevertheless, all children admitted to the Complexes hospital, Hopital Sainte Catherine, are evaluated nutritionally and the diagnosis of malnutrition made accordingly. In such a setting, the frequency of malnutrition as a diagnosis noted in hospital charts is the highest recorded, 21.5% , higher than the diagnosis of diarrhea. Hardly any children were admitted for "pure" malnutrition. It should be noted, though, that most children admitted to the hospital are nutritionally impaired, irrespective of their admission diagnosis. This is particularly true of children admitted for diarrhea, and truer still for children whose deaths were recorded as being due to diarrhea (see next section).

B.2.2. MALNUTRITION

Malnutrition, as a cause of death, is under-reported in Haiti (412 deaths were reported by the Bulletin of Epidemiology of the statistics office, DSPP, for an entire year). In addition to being a direct cause of death, malnutrition is an underlying factor in deaths reported from other causes.

Prevalence of malnutrition

Haiti has been the field of many nutrition surveys. The following prevalence rates were obtained during the 1978 survey :

TABLE : Severity of malnutrition in pre-school Haitian children

	Rural areas	P-au-P	All areas
"acute" malnutrition Weight/height	16.8 %	10 %	15.9 %
"chronic" malnutrition Weight/age	28.6 %	15.7 %	26.7 %
2nd + 3rd degree Weight/age (Gomez)	29.5 %	14.6 %	27.3 %

SOURCE : Haiti National Nutrition Survey 1978.

A comparaison of data obtained in 1978 and 1981 shows the following :

Year of survey	Severe malnut.	Moderate maln.	Mild mal.	Normal
1978	4 %	26 %	46 %	25 %
1981	6 %	27 %	45 %	22 %

SOURCES : Haiti Nutrition Status Survey 1978
DSPP : Résultats préliminaires de l'enquête sur l'état Nutritionnel dans la Région Sanitaire du Sud Haiti 81.

Aside from children under five, other high risk groups include pregnant and lactating mothers and persons with chronic illnesses.

Malnutrition-Related Mortality

We have already explored the role of malnutrition as an underlying factor in diarrhea related deaths. Cité Simone data (Complexe Médico Social 1982) shows that while only 1.9% of Cité Simone children 1-5 y/o has 3rd degree malnutrition, this group contributes 63.6% of all hospital deaths in this age group.
18% of children 0-5 have 2rd degree malnutrition. This group contributes 20.4% of hospital deaths. 42% of children 0-5 have 1st degree malnutrition, contributing to 13.6% of hospital deaths. While 38% of children 0-5 year old are normal normal children contribute 2.6% of all hospital deaths.

Degree of malnutrition	% of all children 0-5yr old	% of hospital deaths 0-5yr old
Normal	38	2.6
1st degree	42	13.5
2rd degree	18	20.4
3rd degree	1.9	63.6

Table: distribution of universe of children 0 to 5 years of age and children dying of diarrhea, by nutritional status (Gomez)
SOURCE : Complexe Médico Social de la Cité Simone - Rapport Mensuel d'octobre 1982.

In addition to deficiencies in protein and caloric intake, nutritional anemias and avitaminoses are frequently seen in Haiti. It is estimated that 30% of children under five and 38% of mothers suffer from anemia. Vitamin A deficiency affects a significant number of persons and rates of 0.52/1000 of Xerophthalmia have been documented in 1979.

2.3. DISORDERS OF EARLY INFANCY

With approximately 170,000* live births per year in the country and 25,000* infants dying before age 1, not enough stress has been placed on the fact that probably 10,000* of these babies will die before 1 month of age. Tetanus remains still a major cause of death in this age group. According to D.S.P.P. figures,

* RGS estimates.

3.5% of infants whose birth are recorded, die from tetanus. Prior to vaccination of pregnant women with tetanus toxoid, the Albert Schweitzer hospital district reported that 14% of all infant deaths were due to tetan Similar data were recorded at the Project integre de Petit Goave. Tetanus death rates are steadily declining due to the training of traditional birt attendants and the immunisation of pregnant women with toxoid. Out of 323 institutions reporting to the DHF, 219 (67%) provided tetanus toxoid vaccines to pregnant women (DHF, 1982). (see table)

TABLE . Tetanus immunisation for pregnant women

DISTRICT	No. OF INSTITUTIONS REPORTING	VACCINE PROVIDED
South	84	68
North	70	52
North West	31	20
Jacmel	12	3
St Marc	19	12
Gonaives	10	3
Petit Goave	8	3
Hinche	9	7
Belladeres	11	5
P-au-P	28	16
Metropolitan area	38	28
Total	323	219 (67%)

Source. Protection Materno-Infantile et Planification Familiale
Rapport Annuel 1981 DHF Juillet 1982

It is becoming increasingly recognized that weignt at birth plays an important role in infant survival. The proportion of newborn infants weighing less than 2.5 kilos is not known. Data over 1000 consecutive births at Ste Catherine's hospital in Cité Simone show a proportion of low birth weight infants at 11 %.
It is to be expected that these low birth weight infants will account for a disproportionate share of the infant mortality in this setting.

B. 2.4. TUBERCULOSIS

Estimates from the Tb control Bureau (DSPP), and the Crusade against Tuberculosis (CAT), put the prevalence of this disease at 2-3 % of the population (100-150,000 people affected). Official reports quote 4888 new cases per year.

In 1980, Tuberculosis was said to account for 12.9 % of all deaths in adults age 15-44

It is the number one cause of death of adults age 15-49 (Hospital Albert Schweitzer and Projet Integré de Petit Goave), the second cause of deaths in all persons over 1 year of age and the 10th cause of death for children under one.

B. 2.5 MALARIA

This illness is transmitted by Anopheles albimanus and is caused primarily by plasmodium falciparum in Haiti. The transmission cycle is more active during the rainy season. The slide positivity rate has varied from 0.2 % in 1968 to 3.2 % in 1972, 15 % in 1978 and 7.95% in 1981. Malaria ranks fourth amongst the major communicable diseases in Haiti.

While at Albert Schweitzer hospital malaria is said to be the seventh cause of death in the population (Tafforeau, personal communication), two malaria related deaths were recorded at Ste Catherine's hospital in Cité Simone (October 1982 report).

B. 2.6. MEASLES

There are 180,000 new cases of measles every year in Haiti. Only 19 % of these cases are reported (Halsey 1982). Measles affects primarily children one to two years of age with the range from six (6) months to twenty-one years. Children with measles are hospitalized

for complications of the disease. In a study of 100 cases of measles hospitalized at Albert Scweitzer hospital in 1981, 58 had pneumonia, 13 diarrhea and 41 were malnourished. Mortality from measles is underreported. There were 2 cases reported to the DSPP in 1979 and none in 1980. Over a 3 year span, the hospital Albert Schweitzer reported 28 cases of death due to measles. The case fatality rate in unknwon.

B.2.7 Respiratory diseases

They constitute a frequent cause of outpatient visits (ranking 5th) Most of these illnesses are URIs; occasional cases of pneumonias are seen.

Respiratory disease rank fourth as cause of death and over 1% of all hospital deaths are related to this cause. It should be noted that many cases of pneumonias treated in a hospital setting are measles-related and this fact is frequently unrecognized. Based on a series of 100 children treated for measles at Albert Schweitzer hospital, 58% presented with pneumonia.

C. CRITICAL SERVICES AND SERVICE DELIVERY STRATEGIES

The types of services and the choice of appropriate service delivery strategies must be conceived within the framework of DSPP norms governing the operation of all health institutions in Haiti, the set of priorities identified by the DSPP, the experience gathered on the field in Haiti, and the capacities (technical, physical or ortherwise) of private institutions to implement these strategies.

DSPP norms are defined in manual of norms issued by the various branches of the DSPP. The reader is referred to individuals manual of norms for further details.

We have already reviewed the priorities that have been defined

by the DSPP. Our focus in this section will be primarily in the area of Maternal and Child care services in general with particular attention paid to nutrition, immunisation, management of diarrhea, pre-natal and maternity services and family planning.

C.1 Nutrition Strategy in Haiti

Four major strategies have been applied in the health field to combat malnutrition in Haiti: the centre d education et de recuperation nutritionelle", the "foyers de demonstration", nutritional surveillance with targeted supplementation and finally the "centre integre de nutrition et d'éducation communautaire".

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C. 1.a. THE CERN.

Their conception is said to originate with Bengoa in 1955. Their implantation in Haiti dates to 1964. The objectives of these centers are to recuperate the child nutritionally and to provide nutrition education to the mother.

Selection of children

Selection is on the basis of nutritional criteria of need. Children are generally under 5 years of age and selection is made between children with 2nd degree or 3rd degree malnutrition (Gomez classification).

Operation of Center

Centers are opened 6 days a week. Selected children come to the center daily where they are fed a nutritions diet. The average length of stay is 4 months and the number of children enrolled at any one time is 30.

Each mother is supposed to work at the Center once a week. She is taught to properly select and cook appropriate food for her children

Evaluation

The CERNs have been the subject of frequent evaluations. Beaudry-Darismé and Latham have measured the impact of CERNs on malnourished children. Briefly summarized, their conclusions are that :

1. most children attending CERNs improve nutritionally between admission and discharge

2. 75% of children gain weight

3. Mortality amongst treated children is reduced compared to controls

4. Positive results correlate closely with the incidence of infectious disease

5. One year follow-up of CERN children show that most have not lost weight, but weight gain has been slight

6. There is a better selection of food by mothers of CERN children.

7. Mothers think that CERNs have improved the status of their children.

One of the major criticisms of CERNs has been their high cost of operation. CERNs have been implanted by several organizations amongst which one may cite, the Bureau of Nutrition, HACHO, Projet Intégré de Petit-Goave and Church World Service. A comparaison of operating costs of each program (reported by Joyce King) follows :

PROGRAM	COST PER CHILD	COST PER MONTH
DSPP	$ 59.00	$ 119.00
HACHO	39.00	78.00
PROJET INTEGRE	25.00	65.00
C.W.S.	6,70	16.00

C.1.b. Foyers de Demonstration

As an alternative to CERNs, foyers de demonstration have been set up to reach the same objectives as CERN's.

Foyers function on a 2 week-cycle basis, operating 6 days a week. As with CERNs, malnourished children under five are recruited to come to the foyer daily and be fed nutritious meals. Mothers are tought how to select, purchase and prepare appropriate food for their children.

Once the two week-cycle is over, mothers bring the child to a health center two weeks later for weighing. At that time, mothers receive a food supplement packet for each child under five. The child is followed on a biweekly, then a monthly, then quaterly basis until he joins the ranks of all children routinely enrolled in the nutrition surveillance program.

On the basis of nutritional impact, preliminary data from Petit-Goave published in 1979 showed that,

1. CERN children gained more weight then "foyer" children
2. Both CERN's and "foyer" were effective in decreasing mortality rates in children under five

Cost comparisons between the two intervention methods revealed a cost per child of $ 25.00 for CERN, $ 6.80 for the FOYER and costs per month respectively of $ 65.00 and $ 16.00 (King 1979).

The Projet Integre study suggested that demonstration methods are more effective than purely theoretical methods of nutrition education. These methods combined with targeted supplementation, are utilized in nutrition surveillance programs.

C.1.c. Nutrition Surveillance

In a nutrition surveillance program, all children under five are weighed on a regular basis and the weight recorded on "road to health" cards. This allows early detection of faltering growth and early application of corrective action. Furhtermore, the mother herself can visualize on a card how well her child is growing and this is a good starting point to teach her about nutrition.

In Haiti, rallye posts (postes de rassemblement) have been successful utilized in several programs to carry out nutrition surveillance. The advantage of rallye posts is that they bring the program to the children rather than require that children and their mothers walk several hours to the center to be program participants. At the Projet Integre of Petit Goave, rallye posts were no farther than one hour's walk from the families' home.

Several requirements must be fulfilled in order to have a successful nutrition surveillance program:

1. the community must be motivated to participate in the program
2 the surveillance team must faithfully respect rallye post rendez-vous dates.

Nutrition surveillance was established at Albert Schweitzer hospital in 1967.

Currently surveillance is performed by many other programs including the Complexe Medico-Social de la Cité Simone, Afè Nèg Coumbite, the Fermathe hospital Community Health Program, Centre de Pediatrie Michèle B.Duvalier and the Cayes District.

The program may have helped reduce the proportion of children with 3r degree malnutrition in Cite Simone, and may have contributed to the reducti in infant and child mortality rates at Albert Schweitzer hospital district Berggren 1981).

It is a less costly program to carry out than either CERN or FOYER, and rallye posts can be utilized not only for nutrition surveillance but for health education, health maintenance examination, vaccination.

C.1.d. The CINECS

The "Centre Integre de Nutrition et d'Education Communautaire" are joint nutrition prevention and kindergarden institutions sponsored by the Ministry of Education within the framework of the GOH-world bank program.

CINECS are managed by a home economics teacher assisted by a nutrition auxiliary they provide food supplements tochildren 1-5 years old as well home economics nutrition, agriculture, hygiene and family planning courses to the children's parents.

The impact of these programs has not been fully evaluated.

C.1.e.The Campaign against Malnutrition , an overview of strategies

In this brief strategic review of choices available in nutrition intervention it may appear superficially that an intervention program should be selected primarily on the basis of its relative performance in terms of impact and costs. Yet there are may pitfalls in attempting to select one int vention strategy rather than another on the basis of published evaluations. Fougere has made pertinent criticisms of such an evaluation. Basically these interventions are difficult to compare one to the other because they are not designed to take care of the same problem.. While surveillance is primarily a preventive approach, "foyers" and "CERN" are curative

as well as preventive types of program and it is difficult to conclude that CERNs should be phased out if one considers that 4% of all Haitian pre-schoolers (that is to say over 35.000 children) suffer from 3rd degree malnutrition. Some programs such as that of the Complexe Medico Social de la Cite Simone, have seen fit to maintain all three phases of intervention, namely surveillance, foyers and a CERN, in order to properly take care of its target population. In this context, the alternative to a CERN is not a FOYER, but rather hospital care.

C.2. Immunisation

Immunisation is an effective method of preventing illness. In fact, in Haiti, one facet of immunisation, that of pregnant women against tetanus, may be the only clear-cut, life-saving intervention to have had a c finite measurable positive impact. In its review of priorities, DSPP states the following:

Vaccines will be used in Haiti on the following schedule:

BCG	0 - 15 years of age
DTP	0 - 6 " "
TETANOS	all women 15 - 45 years of age
POLIO	0 - 6 years of age
MEASLES	0 - 6 " "

Source: DSPP Politique de Sante.Priorities and Strategies 1982.

Effective immunisation programs must fulfill certain requirements

1.a strict respect for the "cold" chain from manufacturer to user

2.reception of all doses prescribed

3.safe technique of administration

Several methods have been employed in Haiti to immunise the population against various illnesses:

vaccination given at a base center

rallye points vaccinations

vaccination campaign.

C.2.1. Vaccination at the CENTER

It is the most commonly used method in Haiti. The dispensary or health center awaits the spontaneous arrival of children from the community seeking to be vaccinated. This method is not very costly but it depends on the motivation of mothers who must at times travel long distances to reach the nearest health post. The following table shows the performance of such center-based programs at a national level:

Table Performance levels for BCG, DTP and POLIO Vaccines, 1981

	Targeted	Reached	Performance%
BCG	98500	56565	57
DTP	160600	45782	29
POLIO	240900	10515	7

Source: Protection Materno-infantile et Planification Familiale Rapport annuel 1981. DHF 1982

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As one may expect, first dose performance levels are higher for triple dose vaccines (DPT and polio) than third dose performance

DPT and Polio doses, 1981

	1st dose	2nd dose	3rd dose
Polio	49 968	21 839	16 124
DPT	84 663	47 140	50 074

SOURCE : Protection Materno-Infantile et Planification familiale. Rapport annuel 1981. DIF 1982.

c.2.2. RALLYE POINTS

To reach a better population coverage, rallye points have been utilised to vaccinate children and their mothers. This method has been tried at the Albert Schweitzer Hospital district and at the Project Intégré in Petit Goave. The object is to bring the vaccine to the people rather than the reverse. The vaccine team goes to rallye points selected to eliminate distance as a factor in absenteism.

With this method, the Albert Schweitzer hospital was able to report 90% coverage of its target population. In the process tetanus neonatorium was practically eradicated in the district.

Cost components of such a program includes personnel, transport and maintenance of the cold chain and at times these costs may be quite high.

In programs which serve concentrated population segments (such as city based or peri urban programs) a combination rallye point approach may be set up : since the population is concentrated, distance is not a major factor. However, the population must be sought out and given specific rendez-vous dates by community collaborators. The target population must be well defined to identify delinquents.

C.2.3. Vaccination campaigns

These are organized on a large scale, using mass-media advertising to motivate the population. Such programs were organized in P-au-P. against polio (1974) and measles (1980). The most recent campaign to date was a joint CAT-DHF campaign sponsored by Rotary International. The following results were obtained:

April - July 1982 vaccination results.

	TOTAL	BCG	DPT	POLIO	MEASLES
1st round	30893	21407	19462	18475	
2nd round	24864	12164	16164	16204	
3rd round	17100	6122	13568	13484	
4th round	5646	-	-	-	5646

Source: DHF, 1982

This illustrates that in vaccination campaigns, it is difficult to motivate populations to sustain the same level of participation for 3rd as opposed to 1st doses.

Campaigns are particularly well suited for one dose vaccinations. The crusade against TB has successfully combined campaign and rallye post techniquesto reach over 70% of rural population coverage for BCG.

C.3 Management of diarrhea

The campaign against diarrhea is the first priority listed by DSPP. It is to be executed at the national level by the adoption by all health institutions of oral rehydration therapy as a treatment tool.

Oral rehydration therapy is already being utilized routinely in many health institutions throughout the country including HUEH, A.Schweitzer hospital and Complexe Medico-Social de la Cite Simone. While this technique has not completely replaced intravenous rehydration, it has lessened the need for I.V. rehydration in the institutions where it has been used. In Cite Simone, for example, the proportion of children treated with I.V. rehydration has fallen from 50% in 1980 to 5% in 1982.

No definite statement can be made as to the effectiveness of oral rehydration therapy in reducing diarrhea-related deaths when such therapy is used on a community basis. Current available data covers only institutional use of oral rehydration therapy in Haiti. Pape has reviewed diarrhea-related mortality rates at HUEH (table):

Mortality and Rehydration method at HUEH

METHOD	CASE FATALITY RATE(MORTALITY)
I.V. 1976-1979	40%
I.V. Sept 1980	48%
Oral rehydration Sept. 1980	13%
I.V. April 1981	14%
Oral rehydration 1981 April	1%

Source: Pape Introduction et Promotion des liquides de rehydratation orale en Haiti 1981

It is doubtful however that the two groups of children (I.V. vs. oral rehydration) are comparable. In the past, many children currently treated with oral rehydration would have been sent home on antidiarrheal therapy. Their fate would be unknown and they would not have been included in the 40% and 48% case fatality rates reported by HUEH in 1979 and 1980.

Nevertheless, it appears that case fatality rates have generally declin at HUEH in the last year. One reason for this may be that (Davis, personal communication) many children arriving in a pre-acidotic stage are now being treated immediately with oral rehydration.

The delay between diagnosis and treatment is effectively reduced thus catching the baby before he has become frankly acidotic.According to Pape, costs for I.V. rehydration are evaluated at $8.00 a day while average costs for oral rehydration are only 12 cents a day (excluding personnel costs).

At Cite Simone, comparative costs for I.V. vs oral rehydration were compiled by ROISIN, with the following results:

		TIME	AVERAGE COST
1980	I.V.	1st semester	$5.30
1980	I.V.	2nd semester	3.98
1980	Oral rehy.	2nd semester	0.13

The adoption of oral rehydration therapy on a community level basis is dictated not by evidence of a positive impact on community - wide decrease in diarrhea- related mortality (no such evidence exists in Haiti at this time) but by the fact that no viable alternative appears to exist in the treatment of these disorders.

C.4 Pre-Natal and Maternity Care

National programs in maternal health have focused primarily on the training of traditional birth attendants. This effort began in the 1948 when a joint Haitian-American program funded under the auspices of the Inter-American Cooperative Service for Public Health began identifying and training TBAs in rural areas.

In 1976, a new TBA training program was intituted by the DHF Its objective was to train 1000 TBAs a year. To date, more than 6000 TBAs have been certified (DHF 1982).

These TBAs performed 25690 deliveries during 1981 and have reported 37 maternal deaths (1.5per 1000) and 359 still births (14.2per 1000). It is estimated that trained TBAs performed 14% of all deliveries in Haiti and that 34% of all deliveries were performed under controlled settings. either a trained TBA or in a hospital environment.

The impact of the program on maternal, peri-natal and neonatal mortality and stillbirth rates is unknown. Data from A. Schweitzer hospital and from the Projet Integre de Petit Goave suggest that a TBA training program coupled with a tetanus vaccination program will reduce tetanus-related neonatal death rates. The fact that TBAs report fewer maternal deaths and still births than hospitals (1.5 per 1000) vs (3.5 per 1000) and(14.2 per 1000 vs 48 per 1000) may reflect the...

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fact that they are either underreporting deaths or that they are referring complicated cases to the hospital as they were trained to do. The national 3.5/1000 maternal mortality rate is probably an optimistic figure if the international College of obstetric of gynecology definition of maternal death is accepted. Maternel death is defined as : any death from any cause in a woman known to be pregnant within 90 days of the time of death.

From the point of view of alternative strategies, the choice varies between training more TBAs or increasing the number of maternity beds. An alternate choice is to improve the services currently provided by institutions with maternity beds in rural areas. These institutions report maternity bed occupancy rates of 31% in 1981. If rural maternity bed occupancy rates mached those of au-Prince metropolitan area, one would expect 98.000 hospital deliveries in Haiti (74000 in rural areas) rather than the 36150 registered in 1981.

2.5. FAMILY PLANNING

DHF estimates that there were 35272 new acceptors of family planning services in 1981 (DHF 1982). To reach these goals, the following strategies were adopted :

1. In urban areas :
   - domiciliary visits and referals by community collaborators
   - referral of potential clients to F.P. centers
   - distribution of condoms in the home
2. In rural areas
   - domiciliary visits and referals by community collaboration
   - utilization of gaguères, CIRECROF centers, development islands for motivation and distribution of condoms
   - mobile clinics

Since January 1978, an experimental program of home delivery of contraceptive devices including oral contraceptives, foam, condoms etc.. was instituted by the D.H.F. In such a program, all women 15-49 years of age living in a household are given family planning information, and offered a supply of oral contraceptives, condoms or foam.

As a result of this program, the prevalence of oral contraceptive and foam use increased in the experimental areas and the proportion of pregnant women declined (Bordes et al, 1981)

While this approach appears to provide for an efficacious means of increasing the utilization of contraceptive methods, it has not yet been adopted widely. Cost per acceptor for a clinic based program have been put at $ 89.06 (Renson 1980) while the cost per acceptor of the household distribution project is $ 24.73 (Bordes et al, 1981).

A.O.P.S. basic strategy

The strategy adopted by AOPS borrows fundamental elements from the modus operendi developed by the DSPP for the implementation of its rural health delivery service program. These elements include

a. the training of a front-line health collaborator who will help deliver primary care
b. the utilization of the concept of the defined catchment area, definition to be obtained through census and registration
c. the implementation of specific intervention programs in the field of nutrition, maternal and child health, curative care including oral rehydration therapy and family planning. In nutrition, the accent will be made primarily on nutrition surveillance and targeted supplementation. Maternal and child care services embrace many activities including immunization of children with DPT, polio, BCG and measles vaccines, immunization to be carried out at rallye points, using a well defined target group so as to be able to identify delinquants. Women of child bearing age are to be immunized against tetanus and pregnant women are to be examined to detect possible complications. While the program will rely primarily on tetanus,toxoid vaccine to eliminate newborn tetanus, it will at the same time encourage private institutions to supervise the activities of TBAs working in their catchment area and possibly integrate these TBAs in their system of care.

In the area of curative services, the program will seek to encourage private institutions to adopt a basic drug list, some of which

will be made available to community workers in the field. The major push will be in the promotion of domiciliary oral rehydration therapy for the treatment of diarrhea.

In the area of family planning, AOPS will explore with its member institutions the options currently involved in Haiti.

All private institutions will be encouraged to adopt some type of family planning method

D. PROJECT ANALYSIS

The project is designed to provide low cost primay care services t priority targets groups within selected defined population systems. In its selection of an appropriate strategy to meet the health needs of these priority groups, the project utilizes as terms of reference healt priorities developed by the ministry of health of Haiti for implementation of its rural health delivery project and programs which have been designed within this context.These programs in turn have been based on experience developed in Haiti through several government demonstration project (such as Projet Intégré de Petit Goave).

In its impact on socio-cultural values and traditions, the project will address itself to some of the more direct contributing causes of mortality in Haiti : taboos and ignorance leading to inappropriate food intake, unsanitary practices leading to the development of disease (such as tetanus), negative attitudes towards family planning, and unsafe or inappropriate health practices in the management of disease states (foll treatment of diarrhea, management of pregnancy etc).

While over its lifetime the project is expected to directly affect 100,000 persons, each participating institution may increase of its own volition its catchment area. Furthermore, other private institution not dependant on technical or financial assistance from the AOPS progra have already expressed an interest in utilizing the same operational framework to carry out their community health program. In addition, these institutions have expressed an interest in data pooling in order to arrive at more valid evaluation of the impact of specific interventio

The selection process of project participant institutions will use as a criteria the institution's ability to meet the costs of project operations without benefit of external support. This criteria can be me by many institutions for which adoption of the project will mean not so much the addition of new staff, building, equipment and materials but

re-orientation of the institutions' activities, utilizing the same resources, to community health work.

E. Project design and implementation

1. Implementation plan for institutions receiving financial assistance from AOPS.

The project will enroll three groups of institutions over its lifetime (18 months). The first group of three institutions will start implementation operations in April of 1983, the second group of three institutions in July 1983, and the third group (4 institutions) in October 1983. Initially, all private health institutions will be contacted and invited to attend regional seminars where the objectives of the program will be exposed. At that time, interested private health institutions will be requested to apply for participation. Following this initial contact, the project will be conducted in 4 separate stages for each group of participating institutions.

STAGE I Recruitment and selection

Selection of institutions will be as described in project description. An ad-hoc committee of AOPS made up of the president, vice-president, secretary, treasurer and project director will screen all applications and submit their recommendations to the full executive board of AOPS who will have final responsibility for institution selection. The board may delegate this authority to a sub-committee of its choosing.

Once chosen, the institutions will be notified of their selection and will be contacted by AOPS staff for a detailed briefing on the different aspects of the project. AOPS staff will help each institution design a project which is most appropriate to the community it serves while respecting the general objectives of the project. Particular attention will be placed in this phase on obtaining appropriate community participation for project implementation and execution. The selection process of the field staff (community collaborators) will be refined and incentives appropriate for each community discussed and evaluated. AOPS recognizes that each community differs with regards to community spirit, the ease of obtaining true volunteers and the extent of community organization. Because of this, the project allows each institution to plan with its community the execution of the program and to define appropriate community incentives. The project provides for a "community participation fund" which

within certain limits, can be used by the institution in the manner it judges as most appropriate to obtain community participation on the program. This may take the form of monetary incentives to community collaborators, execution of a community project (such as a well or a school building for example) as an incentive for complete registration of the population and complete immunization of all children, etc. The manner of utilization of the fund will have to be discussed beforehand with AOPS staff and approved before the funds can be disbursed. As a by-product of this activity, AOPS will be interested to determine which incentives have had the most success in the various communities where they have been applied.

STAGE II Training Phase

This phase involves on the one hand the orientation of community health physicians who will be in charge of each institutional program and on the other hand the training of auxiliary personnel.

Community health physicians will receive their orientation over a 4 week period at cooperating private institutions. The orientation program will cover the major strategies utilized by the project with special attention paid to nutritional surveillance (1 week), control of diarrhea (1 week), family planning (1 week), TB control, record keeping, family registration, administration and supervision (1 week). It is expected that much of this orientation will take place at the Cité Simone Complexe

During this phase, the institution will have selected the auxiliary staff which will include 1 auxilliary nurse, 1 record keeper and 10 community collaborators.. Upon his return to the institution, the physician is expected in turn to train this auxiliary staff for their future function (6 weeks) and lay the groundwork for preparation of the census.

STAGE III

Census and distribution of "road to health" cards to individual

physical boundaries of the catchment area

families and determination of rallye points.

This phase includes delimitation of the catchment area and contact with community leaders following which the actual enumeration and card distribution takes place.

The catchment area is then divided into 10 sectors, each sector assigned to a community collaborator.

STAGE IV PROGRAM OPERATION

This includes :

a) health education conducted by all members of the team

b) immunization of children against diphteria, tetanus, pertussis, measles, polio.

c) health surveillance of children under five. This includes nutritional surveillance, targeted food supplementation and curative service.

d) pre-natal care including immunization with tetanus toxoid, examination , determination of at-risk status and referral of complicated cases.

e) family planning using whatever method(s) the institution feels is most appropriate for it to administer.

STAGE V EVALUATION

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

1st quarter : completion of staff training

2nd quarter : completion of census

2rd quarter : surveillance programs set up

4th quarter : adequate population coverage obtained

F. MONITORING RESPONSIBILITIES

AOPS central staff will be responsible for program monitoring

a) a project coordinator will have overall responsibilities for project monitoring. He will report to the project director (a member of the board of AOPS acting as project officer) who in turn will report to the entire board of AOPS.

b) disbursement requests from participants institutions to AOPS will be reviewed by an accountant attached to the project and by the project coordinator for conformity with the agreement linking the institution to AOPS. This agreement will cover disbursement of funds

for these specific expenses :

1. cost of orientation of MD.
2. training costs of auxiliary staff
3. cost of census and registration
4. salaries (12 months) for auxiliary staff
5. cost of materials and supplies.

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

G. PROCUREMENT PROCEDURES

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

Procurement of project vehicles will be governed by local reliable availability of spare parts and local servicing capabilities. A waiver of donor agency requirements may be necessary for speedy vehicle purchase.

H. DISBURSEMENT PROCEDURES

AOPS will conform to donor agency requirements for disbursement procedures.

I. PRIVATE AND GOVERNMENT FACILITY LINKAGES

Back up support will be required from government institutions in the following areas :

- Supplies (particularly contraceptive devices) to be obtained through DHF. In addition, a limited amount of free drugs and oral rehydration packets are expected to be available from the DHF
- Referrals to secondary and tertiary care government institutions for complicated cases.

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

Once the institutions have been selected, notification of such will be made to the Director General' office (DSPP) and to the Regional Director. Specific linkage considerations will be discussed

by all parties concerned at that time.

J. OPERATIONAL RESEARCH NEEDS

In attempting to define operational research needs of relevance to private health institutions, the first point to be made is that much research has been carried out by an army of consultants in Haiti. The results of such research has not been widely disseminated. The first priority then is to avoid repetition.

While a consensus has emerged on the type of intervention to advocate for Haiti, this consensus has been based on field data gathered from demonstration programs with much research money back up. It is not known how these programs will fare when executed by the average hard-pressed institution. Operational research goals should be to define for such institutions the potential or probable restraints which will limit the efficacy of the services they offer and the success of their various interventions and how to overcome these restraints.

In the area of nutrition, the first constraint resides in the mother who does not participate with her children in the surveillance programs. One needs to have a profile of such mothers, determine why they do not participate and how they can be motivated to increase their rate of participation.

The second constraint lies in the utilization of food supplements. Much research has been accomplished in this area but the fact remains that much of this food is not used as planned. One needs to know how this can be corrected.

On a nation-wide basis, it may be advisable to determine the relative need for foyers de demonstration and for CERUs, the major assumption being that the roles of these two types of institutions are not interchangeable.

In the area of oral rehydration, it may be useful to determine what constraint may preclude its use in the home. One that comes to mind immediately is that no one liter recipient is in widespread use in Haiti. Since the product is manufactured locally, one may explore whether it should not be programmed for use with 750 cc bottles (such as Rhum Barbancourt bottles) which are very common in Haiti.

Another point to be defined is the extent of the need for stationary rehydration centers attached to a health center.

In the area of maternal health, one needs to determine whether TBAs are truly adept at recognizing complications of pregnancy and whether they refer these complicated cases to health centers for delivery.

A corallary to this operation is to determine t what extent TBAs. could integrated in the staff of centers with maternity beds.

In the area of family planning, much research has already been accomplished in Haiti. Aside from exploring the role of TBAs. and other auxiliary health personel in the promotion of family planning one may also want to explore in more details whether there are other significant factors aside from the availability of services, which may limit contraceptive use and how to overcome these factors.

K. AOPS assistance to non-funded institutions

As described in "project purpose", the role of AOPS will not be limited to providing assistance to the ten institutions designated for funding. Other activities to be carried out by AOPS within the framework of this project include :

1. regional seminars to inform all private institutions of current intervention strategies in the field of community health and family planning. Three such seminars are planned in the early phases of project implementation one in the North, one in the South, and one in the metropolitan area.
2. visits by AOPS officers and staff of all private health institutions operating in Haiti and provision of technical assistance when requested.
3. publication of a news-letter in order to promote an exchange of idea and to institute a program of resource sharing.
4. Having a document which summarizes current government norms in use in health institutions.
5. inform private health institutions of current governement activities in the field of health. This information will be conveyed via the newsletter and occasionally via special reports.

Furthermore, AOPS will explore the feasibility of creating a data management center at its central offices and will seek expert advice on the use of computers in health service program evaluation.

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

L. PROGRAM ADMINISTRATION

The executive board of AOPS will appoint a project director who will provide general oversight for this project. This director will be a member of the board of AOPS and will serve on a voluntary basis. He will supervise the project coordinator and the project staff who will be responsible for day-to-day project management.

Financial assistance to institutions will be in the form of individual grants to each institution. Grant funds will be disbursed on a quarterly basis (see implementation evaluation). Prior to receiving quarterly funds, each institution will be required to submit a progress report to AOPS. A copy of such reports will be forwarded to AID as well as a general program assessment and a financial report, the latter two being prepared by AOPS staff.

Program supervision will be on the basis of on-site visits by the AOPS program coordinator. These visits will also serve as occasions for offering technical assistance in the resolution of any problems which may be encountered during the implementation phase.

M. EVALUATION

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

1. immunization: status of children 0-5 years old.
2. nutrition : proportion of malnourished children in regular attendance at nutrition supplementation sessions
3. pre-natal care : proportion of pregnant women fully immunized against tetanus, and average number of pre-natal visits.
4. family planning : number of new acceptors

A limited evaluation of impact will be carried out at the end of the project by using as a baseline data obtained during the census phase of the program. For each institution, the following parmeters will be used :

1. nutritional status of the universe of children 0-5 years of age in the last month of the project.
2. pregnancy prevalence rates during the last month of the project.

An overall success rating will be devised for each institution and this will be correlated with the method of community motivation emplayed by the institution to obtain community participation

N. FINANCIAL ANALYSIS

Donor agency contribution ($ 200000.00) will finace core support for AOPS management and administration of the program, this for a period of 18 months (April 1, 1983 to September 30, 1984). In addition this grant will provide the source of sub-grants to 10 institutions to cover training costs, the cost of some materials and supplies, and limited (1 year) salary support for auxiliary nurses and record keepers.

Recurrent program costs will be funded by participating institutions and by AOPS. In addition to $ 50000.00 in initial expenditures by private institutions, for project implementation, all salary and otherr recurring costs (after project implementation,) for project maintenance at the institutional level will be met by the institution. This will be formally agreed upon beforehand by the institution and this will be a major condition of participation. These recurring costs are not expected to represent a significantly new burden for the institution as one of the main thrust of the project is to re-direct current institutional resources towards more preventive, rather than curative, activities.

Recurring costs for long term technical assistance capability for AOPS are expected to be met through an expansion of its dues-paying membership base (the dues are $ 100.00 per institution) as well as through other fund-raising activities as authorized in its statutes.

Initial implementation expenditures of $ 250000.00 will provide primary care services which will be of direct benefit to a defined population of 100,000 (a cost per capita of $ 2.50 on an annual basis). In addition, technical assistance provided by AOPS within the context of this project to all private institutions requesting it will affetc the quality of services and will contribute to an extension of coverage to an additional number of persons (the exact number cannot be estimated at this time)

LIFE OF PROJECT FINANCIAL PLAN

Category of assistance	FY 83 (april 83-Sept 83)	FY 84 (oct. 83-Sept 84	Cumulative
A. USAID			
1. Salaries	32616	36784	69400
2. Of. supplies	8200	7800	16000
3. Transport	20000	6000	26000
4. Materials	8040	5360	13400
5. Training	21000	10000	31000
p.33 6. Community fund	27000 30 000	15 000 18000	45000
USAID SUBTOTAL	116356	83944	200000
B. Other funds	29780	20220	50000
GRAND TOTAL	146 135	104164	250000

EXPLANATION OF BUDGET ITEMS

	FY 83		FY 84	
1. Salaries				
AOPS				
Coordinator (MD, MPH)	960	5760	10720	11520
Accountant	360	2160	4320	
Secretary	360	2160	4320	
Driver	300	1800	3600	
Subtotal		11130 / 11,880	22960	
INSTITUTIONS				
Auxiliary nurses	(6)	10368	6912	(4 aux. RN) 12,096
Record keepers	(6)	10368	6912	(4)
TOTAL SALARIES		32616	36784	

2. Office expenses include medical forms and census forms
3. Transport : includes purchase of all-terrain vehicle, registration, insurance, fuel and maintenance costs.
4. Materials : includes equipment used for community health program such as scales, cold chain refrigerators etc.
5. Training : includes the cost of three regional seminars to introduce all private health institutions to community health program and per diem for training of MDs who will run the 10 selected programs.
6. Community participation fund (see Stage I, recruitment and selection, page 29) : this fund which averages out to $ 4500.00 per institution is provided to be used in the manner each institution judges as most appropriate to obtain community participation in the program.

B. Other funds. Each participating institution will bear part of the cost of the program out of its own resources. Expected contributions by institutions include :

1. Salary of MD who will run program for each institution
   10 MDs.....12 months each 300.33 $ 3604.00
2. Office expenses incurred at the level of
   each institution (10 institutions)..... $ 9260.00
3. Equipment and materials..... $ 4700.00

General remarks. As noted in project implementation, 6 institutions will be funded in FY 83 and 4 in FY 84. Each institution will employ 1 auxiliary nurse and one record keeper as well as 1 MD. The funds to cover 12 month salary costs will be committed at the time of institution selection.

APPENDIX

ABOUT AOPS

AOPS is a private, non-profit organization which was founded on April 2, 1982. The two major objectives of the Association are to help all private health institutions coordinate their activities, and to collaborate with the Ministry of Health of Haiti in a joint effort to extend health services in the country. AOPS seeks to do so through the following activities :

- establish an inventory of all private health institutions. To a large extent, this has already been done and AOPS has identified 214 private institutions working in Haiti.
- contact all institutions in order to determine their specific needs. This is being done.
- encourage periodic meetings between representatives of private institutions to share experiences in the field of strategies in the area of health care. In that contect, AOPS has organized a 5 day seminar to discuss practical approaches to family planning. The seminar was attended by 49 participants representing institutions or organisations.
- establish lines of communications with the DSPP in order to be better informed of DSPP programs and priorities and be able to transmit this information to individual private health institutions.

AOPS is led by an executive committee of 15 members drawn from all 6 health regions of the country. Aside from its officers (president, vice-president, secretary, assistant secretary, treasurer, assistant treasurer), there are 6 regional representatives and 3 at large members.

The following institutions are represented on the executive committee :

Dispensaire du Sacré-Coeur, Pont-Sondé
Hopital Grover Boling, Darbonne
Fondation Médico-Sociale de Lamothe Pétion-Ville
Cookson-Hills Health Center, Rivière Froide
Convention Baptiste d'Haiti
International Child Care
Hopital Beraca, La Pointe des Palmistes

Bethesda Health Center, Cap-Haitien
Clinique St. Pierre, Mirebalais
Complexe Médico -Sociale de la Cité Simone, Port-au-Prince
Dispensaire de l'Eglise des Rachetés d'Haiti, Port-au-Prince
Hopital Saint Joseph, La Vallée de Jacmel
Hopital de Bonne Fin, Cavaillon
Hopital Sainte Croix, Léogane

Ten other institutions are currently on the AOPS membership list (as of Dec. 10, 1982) for a total of 25 institutions :
Dispensaire Episcopale de Gros Morne
Clinique St. Paul de Montrouis
Roots
Centre Médico-Social de la Hatte-Dufort
Centre de Santé de Lascahobas
Dispensaire-Hopital Morne-Pelé
Centre médical de Cormier
Eye Care
Oeuvre de Bienfaisance de Pignon
Armée du Salut, Fond-des-Nègres

Many other institutions have requested information about AOPS and a dialogue is being established between AOPS and private institutions, whether they are members or not.

All members of the AOPS executive council work on a voluntary basis and they are statutorily prohibited from receiving any remuneration for their services.

PROJECT AUTHORIZATION

Name of Recipient : Association des Oeuvres Privées de Santé

Name of Project : Community Health and Family Planning

Number of Project : 521-0169 Input No. 3

1. Pursuant to Section 531 of the Foreign Assistance Act, as amended, and Chapter VI of the Supplemental Appropriations Act of 1982 (P.L. 97-257), I hereby authorize a cooperative agreement with the Association des Oeuvres Privées de Santé (AOPS) of not-to-exceed Two Hundred Eighty Thousand Dollars,

to design , implement and evaluate a comprehensive community health and family planning program with private voluntary health institutions consistent with the Haitian National health plan. The Cooperative Agreement will be used to help finance the foreign exchange and local currency costs of implementing this community health program.

2. The project consists of expanding and coordinating private voluntary health sector activities in community health and family planning in accordance with the Haitian national health plan. Specific assistance will be provided to 15 private voluntary health agencies serving a total of 150,000 persons to develop community health outreach programs. Additional assistance and public health information will be provided to all private voluntary health organizations affiliated with AOPS.

3. The project includes funds for the necessary purchase of a heavy duty 4-wheel drive diesel vehicle at an estimated cost of not to exceed $15,000. U.S. manufactured heavy duty Jeep vehicles are widely used and effectively serviced in Haiti by the local dealer. A waiver of AID regulations is herein authorized to permit proprietary procurement by the recipient of a heavy duty 4-wheel drive, diesel motor vehicle from the local American Motors Corporation dealer.

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

Harlan H. Hobgood
Director, USAID/Haiti

3/29/83
Date

Clearances:
PHO:S.Gibson
PVD:M.Baldwin
DRE:S.Rhodes
A/CONT:F.Ryder
A/D/DIR:D.Shannon
A/RCO:FHayden