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UNCLASSIFIED

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

HAITI

PROJECT PAPER

PRIVATE SECTOR FAMILY PLANNING

AID/LAC/P-565
CR P-457 CR P-364

Project Number: 521-0189

UNCLASSIFIED

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: C (A = Add, C = Change, D = Delete)

Amendment Number: 2

DOCUMENT CODE: 3

COUNTRY/ENTITY: Haiti

3. PROJECT NUMBER: 521-0189

4. BUREAU/OFFICE: USAID/Haiti 5

5. PROJECT TITLE (maximum 40 characters): Private Sector Family Planning

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 06 DD 30 YY 92

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 86 B. Quarter 3 C. Final FY 92

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

A. FUNDING SOURCE	FIRST FY 90 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(2,714)	(500)	(3,214)	(8,192)	(8,196)	(16,388)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		500	500		1,242	1,242
Other Donor(s)						5,457
TOTALS $	2,714	1,000	3,714	8,192	9,438	23,087

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) POP	420	440		7,901		8,138		16,388	
(2)									
(3)									
(4)									
TOTALS				7,901		8,138		16,388	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 430 920 840

11. SECONDARY PURPOSE CODE: 442

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

A. Code	BR	BV				
B. Amount						

13. PROJECT PURPOSE (maximum 480 characters)

To increase the availability and effectiveness of Family Planning Service Delivery.

14. SCHEDULED EVALUATIONS
Interim MM 10 YY 89 MM YY Final MM 05 YY 92

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☒ 000 ☐ 941 ☒ Local ☐ Other (Specify)

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

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

Claire Johnson
Acting Mission Controller

17. APPROVED BY
Signature: Franz Herder
Title: Acting Director, USAID/Haiti
Date Signed: MM 07 DD 17 YY 90

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

PROJECT AUTHORIZATION

Amendment No. 2

Name of Country : Haiti
Name of Project : Private Sector Family Planning
Number of Project : 521-0189

1. Pursuant to section 104 of the Foreign Assistance Act of 1961, as amended, the Private Sector Family Planning Project for Haiti was authorized on August 20, 1986 and amended on August 24, 1988. The authorization is hereby further amended as follows:

a. In paragraph 1, delete the words and figures, "planned obligations of not to exceed Eight Million Two Hundred and Fifty Thousand United States Dollars ($8,250,000) in grant funds over a four year period from the date of initial obligation..." In lieu thereof, add the following:

Planned obligations not to exceed $Sixteen Million Three Hundred Eighty Eight Thousand United States Dollars ($16,388,000) in grant funds over a five year period from the date of authorization.

b. In paragraph 1, change the last sentence to read "The planned life-of-project is five years and eleven months from the date of initial obligation."

c. In paragraph 2, add the following at the end: (iii) a grant agreement with an international organization to implement public sector activities which will include the procurement and management of all MSPP commodities (e.g. vehicles, clinical equipment, and contraceptives). (iv) AID/W Buy-ins and local contracts to provide project elements not included in the cooperative agreement or the grant agreement.

d. In paragraph 3, which states "Goods and services financed by A.I.D. under the cooperative agreement shall have their source and origin in A.I.D. Geographic Code 000 or in Haiti", add the following:

"except as A.I.D. may otherwise agree in writing."

2. The authorization cited above remains in force except as hereby amended.

~~Gerald Zarr~~
Acting Director
USAID/Haiti

7-17-90
Date

Drafted: PPS: GSpence 6/22/90
Clearances: PPS: RFanale
PPS: SGregoire 6/22/90
PPS: AFord 6/22/90
HRO: MWhite 6/22/90
ACONT: CJohnson 6/25/90
D/DIR: FHerder 7-17-90

TABLE OF CONTENTS

I. SUMMARY AND RECOMMENDATIONS Page 1

A. Recommendations

B. Project Summary

1. Rationale for Amendment
2. Summary Project Description
3. Budget and Method of Implementation

II. BACKGROUND AND RATIONALE FOR AMENDMENT Page 5

A. General Overview

B. Project Background and History

C. Project Accomplishments/Activities

1. Institutional Development
2. Service Delivery and Support Activities
3. Training
4. Contraceptive Management
5. Research and Evaluation
6. Information, Education and Communication
7. Contraceptive Social Marketing
8. National Population Policy
9. Other Commercial Sector/Policy Activities

D. Rationale for Amendment

1. The PVO Sector
2. The Private Commercial Sector
3. The Public Sector

III. REVISED PROJECT DESCRIPTION Page 23

A. Project Goal and Purpose

B. Project Outputs

C. Strategy Overview

D. Project Activities

1. Contraceptive Prevalence
2. Institutional Development
3. Service Delivery
4. Training
5. Information, Education and Communication
6. Research in Family Planning
7. Commodity and Logistics Support

C'

IV. REVISED IMPLEMENTATION ARRANGEMENTS Page 45

A. Overview

B. Implementation of Project Components

C. Implementation Responsibilities

1. Cooperative Agreement Recipient
2. International Organization Grant Recipient
3. Social Marketing Contractor
4. USAID Monitoring Requirements
5. Evaluation Plan
6. Audit Plan
7. Implementation Schedule

D. Implementation Plan and Financing Methods

1. Financing Methods
2. Commodity Procurement Plan
3. Revenue Generation Guidelines
4. Financial Plan and Project Budget

V. ANALYSES Page 59

ANNEXES

A. Revised Logframe
B. Supplementary Financial Tables
C. Institutional Analysis

LIST OF ACRONYMS

AOPS.....	Association of Private Health Organizations
CA.....	Cooperative Agreement
CONAPO.....	National Commission on Population
CBD.....	Community Based Distribution System
CDS.....	Center for Health and Development
CHI.....	Child Health Institute
CPFO.....	Center for the Promotion of Female Workers
CPR.....	Contraceptive Prevalence Rate
CSM.....	Contraceptive Social Marketing
CYP.....	Couple Years of Protection
DASH.....	Development of Health Activities in Haiti
FORSREP.....	Foundation for Female Reproductive Health
FP.....	Family Planning
FHI.....	Family Health International
GOH.....	Government of Haiti
IEC.....	Information, Education and Communication
IHSI.....	Haitian Inst. of Statistics and Information
INHSAC.....	Haitian Institute of Community Health
IPPF/WHR.....	International Planned Parenthood Federation Western Hemisphere Region
LOP.....	Life of Project
MCH.....	Maternal Child Health
MSPP.....	Ministry of Public Health and Population
MWRA.....	Married Women of Reproductive Age
NFP.....	Natural Family Planning
PACD.....	Project Assistance Completion Date
PAPFO.....	Port-au-Prince Field Office for IPPF/WHR
PAHO.....	Pan American Health Organizatoin
PROFAMIL.....	Association for the Promotion of the Haitian Family
PSFP.....	Private Sector Family Planning Project
UNFPA.....	United Nation Fund for Population Activities
VACS.....	Voluntary Agencies for Child Survival
VSC.....	Voluntary Surgical Contraception

I. SUMMARY AND RECOMMENDATIONS

A. Recommendations

Pursuant to review and approval of the proposed amendment to the Private Sector Family Planning Project (521-0189) by the USAID/Haiti Project Review Committee, it is recommended that the USAID/Haiti Mission Director approve the Project Paper amendment described herein for an additional Eight Million One Hundred Thirty Eight Thousand United States Dollars ($8,138,000) in grant funding for a new total of Sixteen Million Three Hundred Thirty Eight United States Dollars ($16,388,000). Additional funding provided under the amendment will be allocated as follows: Five Million Ninety Six Thousand Dollars ($5,096,000) to amend the cooperative agreement with the International Planned Parenthood Federation/Western Hemisphere Region; One Million Dollars ($1,000,000) for a grant with the PanAmerican Health Organization, a Public International Organization, to support Family Planning/Population activities within the Government of Haiti; and Two Million Forty Two Thousand Dollars ($2,042,000) for other project elements including contraceptive social marketing. This amendment will promote a multi-sectoral approach to increase demand and access to family planning services and extend the project assistance completion date for fifteen months from March 31, 1991 to June 30, 1992. The authorization of the amendment will permit the Project to increase its scope of activities and respond to the current favorable situation in Haiti for decreasing the population growth rate. The longer project time frame will also allow USAID sufficient time to design a follow-on project.

B. Project Summary

1. Rationale for Amendment

The Private Sector Family Planning Project (PSFP) was authorized on August 20, 1986 and amended on August 24, 1988 to extend the Project Assistance Completion Date (PACD) eighteen months to March 31, 1991. The first amendment increased the authorized life of project (LOP) funding from $3.25 million to $8.25 million. Project outputs were revised and the number of beneficiaries increased by 141 percent due to expanded coverage.

The recent mid-term evaluation concluded that, despite the chaotic political and economic situation of the past several years, PSFP is well on the way to reaching its proposed goal and may even surpass its quantitative objectives by the PACD. In the opinion of the evaluation team, the PSFP's complex implementation strategies, encompassing both the private voluntary and private commercial sectors, are well adapted to the Haitian context and yield promise of sustainability beyond the present funding structure. Recent events have also conspired to open a window for resumed USAID support of Government of Haiti (GOH) population

and family planning efforts. The US Congress has authorized resumption of such activities and the local context at the present time is also highly favorable to their future success.

There are thus compelling reasons to extend the Project for one year beyond its present PACD, to June 30, 1992:

1) To provide necessary time and funding, including $2.4 million to cover expanded activities within the present PACD, to implement mid-term evaluation recommendations aimed at increased institutional development and retention of acceptors in the private volunatry organization (PVO) sector;

2) To provide time and funding to expand the scope of contraceptive social marketing and other promising initiatives in the commercial sector; and

3) To provide a bridging mechanism which will allow the mission to initiate resumption of activities in the public sector pending the design of a comprehensive follow-on project in FY 1992.

The fifteen month extension and the balance of the funding provided by the second amendment will enable USAID to complete planning of a coordinated population and family planning strategy. This strategy will seek to combine resources and services from the public sector, non-governmental organizations, and the commercial sector to form the basis of a new project in FY92.

2. Summary Project Description

The goal and purpose remain the same as in the original project. The goal is the reduction of the population growth rate in Haiti, and the purpose is to increase the availability and effectiveness of family planning service delivery. Generally, the breadth and the scope of activities will increase, as will measures of achievement.

Under this amendment, the PSFP will continue to support family planning (FP) activities implemented by local PVOs. New strategies will increase local institutional development and combine present aggressive efforts to attract new users with those aimed at retaining users. The amended project will also continue support for commercial FP activities. This effort will be two-pronged: It will combine contraceptive social marketing (CSM) activities to increase the availability of quality contraceptives at affordable prices, with measures to encourage insurance companies and employers to provide FP services. The major new activity for the PSFP during its one-year extension will be assistance to the public sector. For the most part, this assistance will be channeled to the Ministry of Public Health and Population (MSPP) to revitalize its family planning program. To a lesser extent, it will also be used to develop and implement a strong national population policy. An effective national family

planning program can flourish only in a positive policy climate with concerted cross-ministerial and cross-sectoral support. The expected result will be an increase in the nationwide contraceptive prevalence rate from the current estimate of 9.7 percent to 16 percent by the end of the amended project.

Specific planned activities under the amendment are as follows:

o PVOs will offer a variety of methods in an expanded service network. The number of service facilities will increase by 20 per cent, and three model clinics will provide training.

o The MSPP will provide services in 252 hospitals, clinics, and dispensaries. Wherever possible, the focus will be on clinical, long-term methods such as NORPLANT implants. Fourteen medical centers and seven mobile teams will specialize in male and female voluntary surgical contraception (VSC). MSPP outreach workers will provide temporary methods such as orals, condoms, and contraceptive creams.

o The GOH will continue action to develop a national population policy and will support educational initiatives directed at promoting smaller family size.

o Service delivery in the public and private sectors will be supported by technical assistance in training and management practices.

o A nationwide information, education, and communication (IEC) campaign will increase the level of new family planning acceptors, as well as the level of those continuing method use.

o Applied field and operational research will identify innovative ways to increase availability of contraceptive methods.

o A nationwide advertising campaign will support commercial retail sales of selected contraceptives in 200 pharmacies and other purchase points.

o Both geographic coverage and contraceptive prevalance rate will increase under the amended project. The number of couples reached by the program will increase by an estimated 360,000, bringing the total under the project to approximately 600,000 couples of reproductive age.

o Women, especially, will benefit from the family planning services provided with a lessened child raising burden, improved maternal health achieved by the spacing of births, and by decreased maternal and infant mortality.

3. Budget and Method of Implementation

The Cooperative Agreement (CA) recipient, International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), will continue to have responsibility for project management and

supervision of PVOs. Buy-ins to AID/W central contracts will fund the final evaluation, as well as research, population policy development, and commercial retail sales.

Public sector activities will be supported through a Handbook 13 grant to the Pan American Health Organization (PAHO). The Mission will continue to hire Personal Services Contractors (PSCs) to perform project monitoring. Counterpart local currency support for both public and private sector activities will come from funds generated by PL-480 programs. The following is the USAID budget allocation summary for the amendment.

Summary Budget
($000)

Item	Orig & 1st Amdt	2nd Amdt	Total
IPPF	6,468	5,096	11,564
PAHO	-	1,000	1,000
NORPLANT (1)	234	200	434
Contraceptives	1,128	466	1,594
Population Policy	100	200	300
Population Advisors	180	386	566
Operations Research	-	100	100
Evaluation (2)	-	80	80
Audit (2)	-	80	80
Social Marketing (3)	-	200	200
TIPPS (4)	-	30	30
Internat. Training	90	300	390
Factory Workers Center	50	-	50
TOTAL	$8,250	$8,138	$16,388

NOTES:
1) NORPLANT ($87) not included in orig/1st Amdt.
2) Evaluation and audit included under CA in orig/1st Amdt.
3) Social Marketing included in IPPF in orig/1st Amdt.
4) TIPPS ($50) not included in orig/1st Amdt.

II. BACKGROUND AND RATIONALE FOR AMENDMENT

A. General Overview

The rapid population growth in Haiti poses serious problems in view of the country's natural resource limitations and difficulties of the economy to provide employment for the present/future labor force. Haiti has a present population of 6 million people and a total fertility rate of 6.4 children per woman. This represents an increase in fertility from the level ten years ago of 5.5 children per woman. The increase in fertility, along with declines in mortality, mean the rate of natural increase has augmented from 2 percent to 3 percent per year over the last decade.

To meet the gravity of this situation, USAID/Haiti supports a wide range of population and FP activities. These activities include: modern urban clinics providing a wide range of contraceptive methods, including long-term methods for both men and women; factory based and community based distribution services of temporary methods; rural PVOs supplying contraceptives as part of child survival programs; research on the application of new methods such as NORPLANT; Family Life Training in Catholic school systems; the introduction of a progestin pill for lactating women; contraceptive social marketing (CSM); private and public initiatives aimed at a coherent national population policy; and the introduction of family planning cost-benefit analysis to industrial employers and insurance companies.

The major portions of the Mission's portfolio reside in the PSFP. In addition, FP activities are supported with funding from the Voluntary Agencies for Child Survival Project (VACS) and the Expanded Urban Health (EUH) Project. There are also several centrally funded activities through US based population projects which are part of PSFP. These include Family Health International (FHI), Technical Information on Population for the Private Sector (TIPPS), The Futures Group/, The Futures Group/SOMARC, and the Association for Voluntary Surgical Contraception (AVSC).

USAID was the major donor for Government of Haiti's (GOH) population and FP activities in the MSPP until the cut-off of bilateral aid in November of 1987.

B. Project Background and History

In 1986, USAID/Haiti developed the PSFP in response to the unmet need for family planning services in Haiti and the deterioration of the public sector health program. At this time, studies indicated that, despite major donor commitment to FP activities in the public sector, between 1977 and 1984, contraceptive prevalence rates had declined in Haiti. These same studies also indicated, however, that there was widespread knowledge of, and interest in, FP services among the population.

To meet this latent unmet demand, USAID prepared a population assistance project focused on developing the private sector infrastructure for FP services. Private sector institutions provide nearly half of primary health care services in Haiti. Over two hundred PVOs have an extensive network for community health outreach, particularly in the rural areas. Although less than half of these institutions were offering FP services, it was recognized that many others would offer them if support were provided.

PSFP was authorized on August 20, 1986 with $3,250,000 LOP funding allocated for a cooperative agreement (CA) with a US based PVO and $234,000 for the purchase of contraceptives through AID/W. The Project PACD was September 30, 1989. The IPPF/WHR was selected as the CA recipient through a limited competition of qualified PVOs. A CA was executed in the amount of $3,016,000 for a 30 month period through February 28, 1989.

On September 21, 1988, in the wake of discontinuation of USAID assistance to the public sector following the aborted election in November of 1987, the Project was extensively amended. The goal and purpose remained the same, but the PACD was extended until March 31, 1991, funds totalling $5 million were added to the budget, the scope of work was substantially enlarged, and new elements were added.

The goal of the PSFP is to reduce the population growth rate in Haiti and its purpose is to increase the availability and effectiveness of FP service delivery. To achieve these, the objectives of the first amendment in 1988 were as follows:

- An increase in the FP usage from 4-5 percent to 12.5 percent;
- The development of a network of sixty PVOs to provide FP services;
- The development of six major service delivery and four major support institutions;
- The development of a national population and FP policy; and
- The development of a social marketing infrastructure for contraceptive products.

To achieve these outputs, the following inputs are currently provided under the first amendment:

- Technical assistance through a CA with IPPF/WHR, focused on grant management, institutional development, and training, information, education, and communication (IEC) program development;
- A Population Advisor at USAID;

- Research on NORPLANT through a buy-In with FHI;
- Technical assistance to develop a CSM program through a Buy-In with SOMARC;
- Technical assistance for the development of a national population policy;
- Contraceptive commodities; and
- Construction and renovations.

C. Project Accomplishments/Activities

A recent mid-term evaluation of the PSFP confirmed that the Project is well on the way to reaching its proposed goal and may even surpass its quantitative ojectives by the PACD. The evaluation concluded that the Project has a well designed implementation strategy which includes all elements needed both to accomplish its goal and to continue beyond the present funding structure. The Project's activities and accomplishments are summarized below:

1. Institutional Development

The Port-au-Prince Field Office (PAPFO) of IPPF/WHR opened in February of 1987 with a resident project manager and local staff. At the present time, PAPFO is staffed by four manager/technicians and ten administrative support employees. The professional staff consists of the Director who is an MD with years of FP experience in Haiti, a Management Advisor, a Research and Evaluation Advisor, and a Finance Officer.

As specified in the original Project Paper, the CA recipient provides overall project management and technical assistance to local PVOs who implement FP planning services and/or have responsibility for specific functional areas. The functions performed by IPPF/WHR and PAPFO may be subdivided into four categories: 1) financial management and control, 2) institutional development technical assistance, 3) programmatic technical assistance, and 4) commodities procurement and management technical assistance. The objective of the IPPF assistance is to develop the capacity of indigenous PVO service providers and technical assistance institutions to plan, implement and sustain FP activities on their own.

According to the mid-term evaluation, this strategy has already achieved commendable results. There are presently four major local PVOs operating as support institutions, and six major and twenty nine small local PVOs providing FP services. Another eighteen small PVOs are under consideration for service implementation. In addition to providing services and support functions, the PVOs are currently able to write annual work plans incorporating achievement targets; they have standard, written general administration, management, financial, and personnel

procedures; and they can generate monthly service statistic records substantiating their work. At the time of the mid-term evaluation, these organizations had increased the number of couple-years of FP protection being offered in the private sector from near zero to nearly sixty thousand.

An integral element of the overall institutional development strategy is to develop permanent, in-country support for PVO FP activities. To this end, PAPFO has executed subgrants and provided technical assistance to four major Haitian PVOs with technical support functions. These PVOs and their primary roles in the project are described below:

o The Association of Private Health Organizations (AOPS) is a membership organization of over 80 non-profit health providers offering a variety of primary health care services through fixed centers and community outreach programs. Through a system of sub-sub-grants, AOPS provides its affiliates with the funding and technical assistance needed to improve or initiate FP services.

o The Haitian Association for the Promotion of the Family (PROFAMIL) is an IPPF affiliate which operates three model clinics where FP techniques and norms are taught. It has responsiblity for warehousing contraceptives and has established a supply system for the other PVOs. In addition, PROFAMIL has developed a pilot community based distribution program.

o The Haitian Institute for Community Health (INHSAC) was created to develop in-country capacity to meet educational needs of PVOs active in health care. It is responsible for developing FP training curriculum, training PVO staff involved in FP, and producing FP educational materials.

o The Child Health Institute (CHI) was established as a technical assistance and research center. CHI collaborates with the project to expand FP research and evaluation capabilities to service providing PVOs.

Although generally positive about the progress being made, the mid-term evaluation included valuable institutional development suggestions. One such suggestion involved the need to define the division of labor and responsibilities between the two CA recipient offices. In the opinion of the evaluators, PAPFO managers have not been given adequate authority to make basic operational decisions. As a result, there is often a considerable lag between the time a PVO identifies a need or makes a request and the time it takes for IPPF/WHR management in New York to respond. The evaluation team strongly recommended the transfer of responsibility to make operational decisions to PAPFO.

A second important institutional development recommendation concerned the need to refine the functional roles of the four major support institutions. According to the evaluation team, each of these PVOs has made commendable progress in its particular area of expertise. A problem exists, however, due to

a certain amount of duplication of efforts. For example, at the present time, AOPS and, to a lesser extent, PROFAMIL, both manage sub-sub-grants to small PVOs. The evaluation team suggested that such duplication lessens the functional impact of the institutions concerned; a more effective, efficient strategy would be for each organization to have a unique, well defined support role.

2. Service Delivery and Support Activities

According to the mid-term evaluation, twenty nine small local PVOs out of the sixty originally planned, or 48 percent of the total, are currently providing FP services. The six scheduled major service delivery PVOs are currently operative or just beginning operations: DASH, the Foundation for Female Reproductive Health (FOSREF), the Bienfaissance Hospital/Pignon, the Center for the Promotion of Women Factory Workers (CPFO), the Center for Development and Health (CDS), and the AOPS Voluntary Surgical Contraception Project (AOPS/VSC). In addition, the PSFP has helped the Soeurs de Sagesse to implement a family life program.

There is a wide variation in the types of services implemented by these institutions. The Soeurs de Sagesse, for example, implement a population and family life education curriculum, developed under the auspices of the UNFPA, in their large school system. Other PVOs provide FP method delivery. Some in this latter group offer a complete menu of methods, including male and female VSC (e.g. PROFAMIL, FOSREF), while other provide more limited menus consisting of condoms, vaginal foams, and oral contraceptives (e.g. CPFO). The medium of service delivery varies as well. Some organizations have modern urban clinics while others promote community based service delivery. As mentioned above, the Soeurs de Sagesse provide family life education classes in their schools.

Original project estimates calculated 250,000 married women of reproductive age (MWRA) in the project catchment area. According to the mid-term evaluation, nearly 175,000 MWRA, or 70 percent of the proposed PACD total, currently have access to project services. Of these, 17,000 out of an expected 40,000 MWRA, or 43 percent of the expected PACD total, already use these services. Tables One and Two, extracted from the mid-term evaluation, show 1) the growth in couple years of protection (CYP) for all methods since project onset and 2) the distribution of new acceptors by methods used.

Comparison of data from contraceptive prevalence surveys implemented during the past several years also suggest that the PSFP has had a positive impact. According to the 1987 Mortality, Morbidity, and Service Utilization Study (EMMUS), the contraceptive prevalence rate (CPR) for modern methods was 4.9 percent in 1987. The recent national Contraceptive Prevalence Survey (1989) suggests, however, that the present CPR is 9.7 percent. In other words, in the two intervening years between the studies the CPR has almost doubled. The time lapse between

TABLE ONE

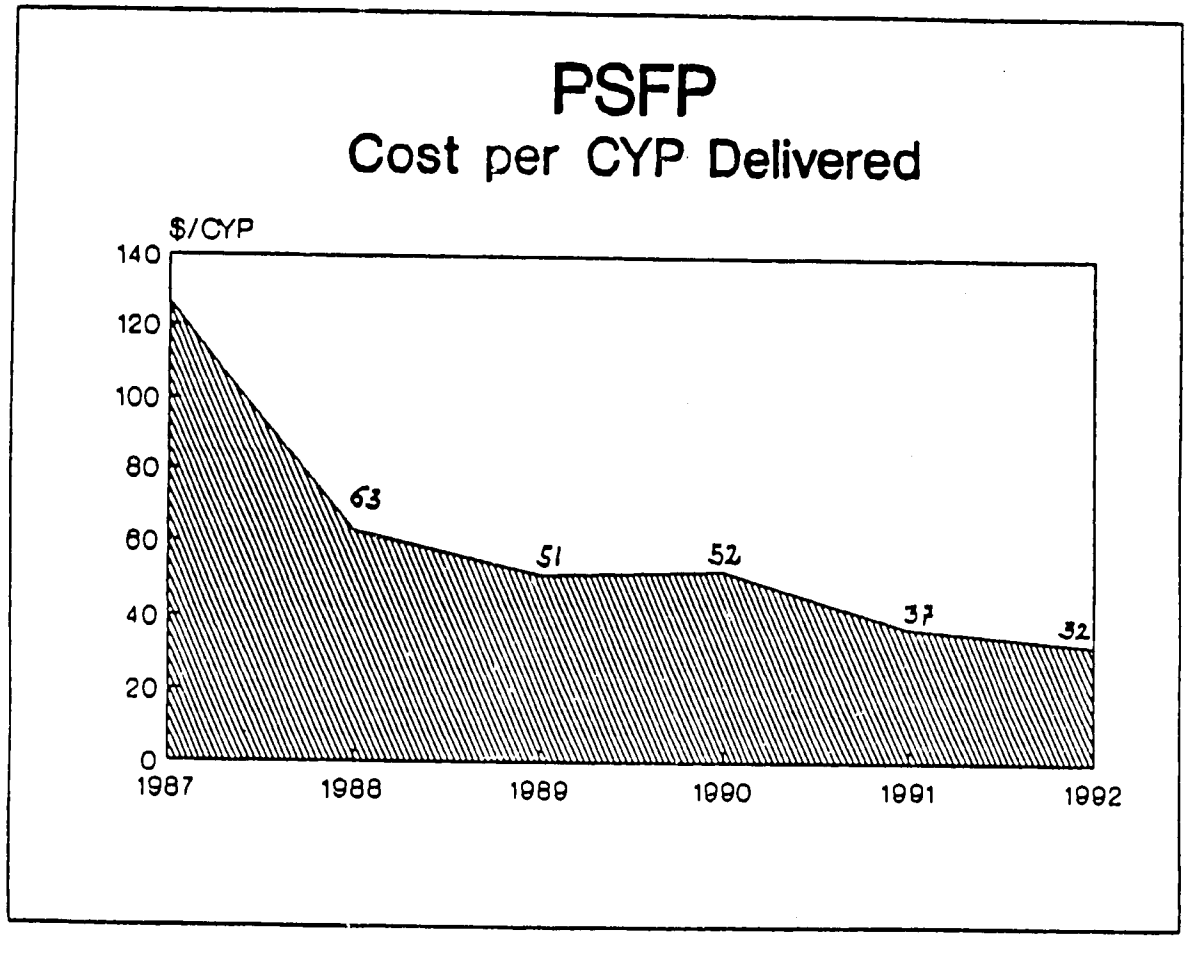
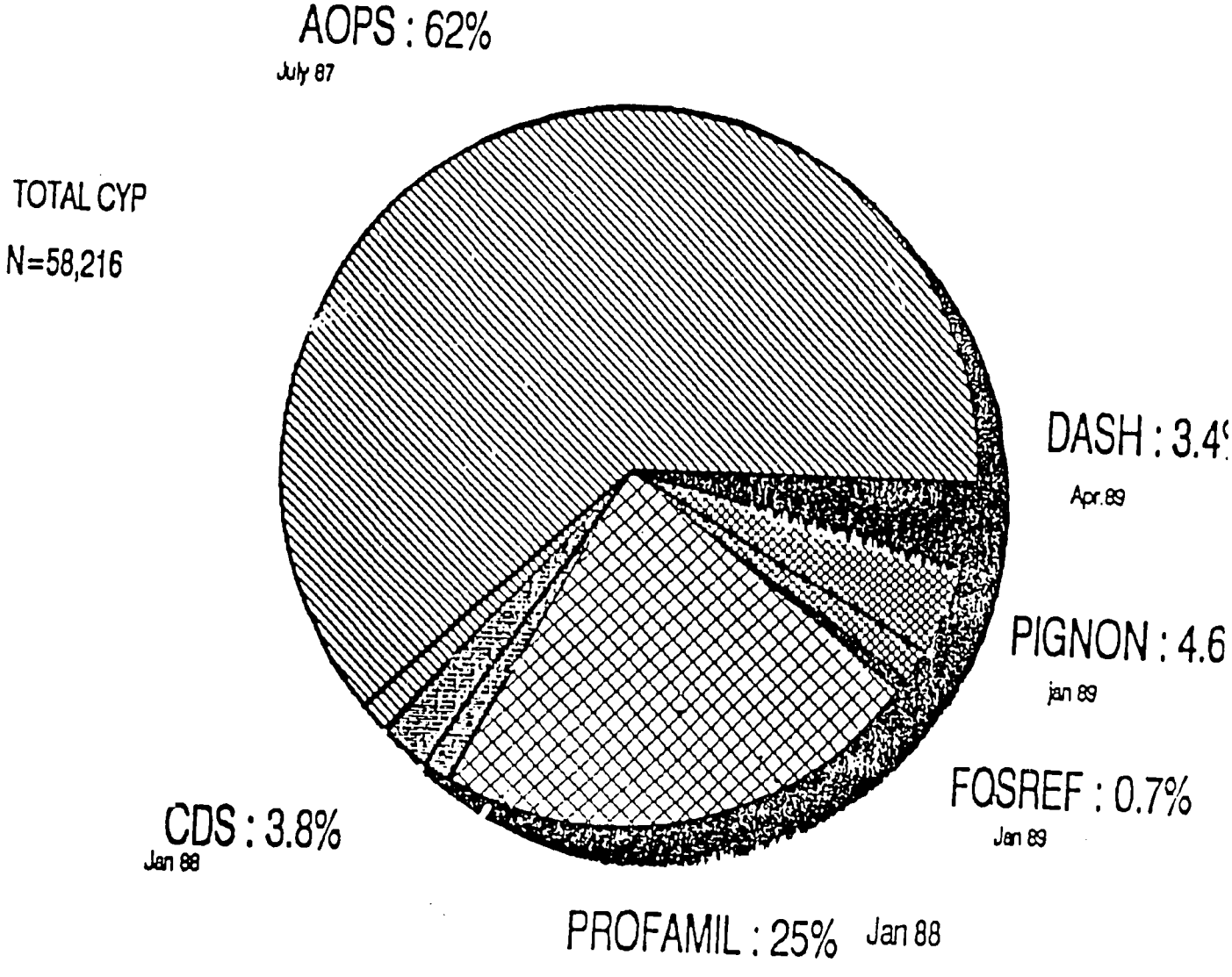

PSFP
Cost per CYP Delivered
$/CYP
140
120
100
80
60
40
20
0
63
51
52
37
32
1987
1988
1989
1990
1991
1992

TABLE TWO

PSFPP/IPPF-1989

CYP BY PVOs



the two studies corresponds with implementation of FP services by participating PVOs and the near cessation of FP services in the public sector after the withdrawal of U.S. bilateral aid. These data must be translated cautiously, however. The sample communities of the most recent study are not necessarily those in the PSFP catchment area, and there may be other factors affecting this apparent CPR increase. Nevertheless, the data appear to suggest positive project impact.

Despite praise for the advances in this area, the mid-term evaluation had important recommendations to make in terms of PSFP service delivery. The most cogent of these concerns the retention of current users. At the present time, the major emphasis is on attracting new users. The objective of PSFP under the current amendment is to increase the CPR to 12.5 percent.

Such an increase can only be achieved by including a strong strategy to retain current acceptors, combined with an aggressive one to gain new acceptors. The CYP measure is also seriously affected by retention of users. The mid-term evaluation notes that in the those organizations which offer permanent methods, the CYP is high. In contrast, in those PVOs which offer temporary ones, the CYP is low due to poor client retention. Obviously, due to the complexity of organization needed to provide such methods as VSC, the majority of project PVOs can only provide temporary methods. The mid-term evaluation team thus strongly recommended a concerted effort to combine attracting new clients and retaining old ones. Such an effort needs to include a strong IEC component, with emphasis on client counseling and follow-up.

A corollary to the above recommendation was one to decrease the number targeted to implement FP services from sixty to forty PVOs. According to the evaluation team, at this strategic point in its development cycle, PSFP should consolidate its gains and do the fine-tuning needed to make its service delivery even better. The emphasis of the early years on quantity of services must change to one emphasizing quality. A decrease in the number of targeted PVOs from sixty to forty would make available time and other resources needed to achieve this transition. With fewer new PVOs to manage, more attention could be given to current service providers.

3. Training

According to the mid-term evaluation, the project has accomplished nearly 70 percent of the proposed training objectives under the current amendment. The evaluators particularly commended the FP curriculum developed, the numbers of upper level PVO staff trained, and efforts to develop a VSC counseling training program.

As discussed above, INHSAC plays the focal role for the PSFP in terms of developing FP training curiculum, training PVO staff involved in FP, and producing FP training materials. Under the current amendment, specific goals were established for the training center in terms of the numbers of Level A (doctors and nurses), Level B (auxilliaries), and Level C (community outreach workers) staff to be trained. At the time of the evaluation, INHSAC had almost met its PACD goals for levels A and B. Level C training, however, was notably unsuccessful. INHSAC teachers are not properly trained to teach at this level, and PVO managers are not willing to send their community workers to Port-au-Prince for training.

In addition to the mid-term evaluation, INHSAC has recently benefited from an evaluation of its role in the Mission's child survival program, VACS. Results of both assessments suggested the need to redefine INHSAC's goals and objectives, particularly as they relate to the training of field level personnel. As a result, the Mission recently convoked a week long session devoted to this purpose attended by relevant staff from INHSAC, the two CA recipients for PSFP and VACS, the Mission, and the two evaluation teams. Recommendations from this session include a redesign of Level C curriculum and developing PVO in-house capacity to train Level C staff.

4. Contraceptive Management

Contraceptive management includes procurement, storage, distribution, reporting, control, and estimation of needs. As reported above, PROFAMIL handles initial control and storage functions, as well as distribution to AOPS and the other major service suppliers, except Pignon. The latter PVO receives supplies from the MSPP. As many institutions have yet to develop the capacity to estimate their contraceptive needs, this function is presently performed by outside technicians at the request of the Mission.

According to the mid-term evaluation, procurement has proceeded smoothly with no major shortages. PROFAMIL has established an excellent record in central stock management and its sub-sub-grantees have well controlled supply and storage operations. Problems are evident, however, in the other institutions. For example, some shortages were reported for AOPS sub-sub-grantees and these institutions lack inventory control systems and monthly reporting forms. As a result, the evaluation team recommended that, given PROFAMIL's performance, it should be made responsible for estimating all PVO contraceptive needs and all institutions should have adopt PROFAMIL's storage and control system guidelines.

5. Research and Evaluation

As discussed above, the principal role of CHI in the PSFP is to provide project partners with a research and evaluation capability that will enable them to effectively design, organize,

and implement their FP activities. This role includes the development and implementation of a service statistics system, baseline and knowledge, aptitude, and practice (KAP) surveys, and operational and other types of applied research to support PSFP activities. CHI performs approximately these same functions for VACS, the Mission's umbrella child survival program.

At the time of the mid-term evaluation, CHI was coordinating the collection and analysis of contraceptor acceptor statistics and providing ongoing training to the project PVOs in the proper collection and reporting of service data. The Institute had also recently completed a large national contraceptive prevalence survey which included many KAP questions, especially concerning condom use. The evaluation team was critical, however, of other aspects of CHI's operations. First, although regularly collecting service statistics, CHI pools data for the entire project and makes only rudimentary analyses. There is no attempt at interpretation, nor to give feedback to service providers. Second, there are no baseline data with which to calculate prevalence rates by PVO catchment area, thereby measuring real project impact, and no means to track ongoing users. And third, CHI had yet to perform any operations research which would assist the PVOs to improve service delivery. In the opinion of the evaluators, CHI has some management problems and a talented staff which is nevertheless pulled in too many directions with too much work.

6. Information, Education, & Communication

Early in the project, the focus was to make INHSAC responsible for the creation and production of IEC materials. To this end, IPPF/WHR created a production unit at INHSAC, complete with an offset press, drafting furniture, and video equipment. This unit has only recently become operational, however, due to delivery delays, the receipt of damaged materials, and electrical problems. INHSAC has produced some materials with outside technical and financial assistance provided through buy-ins. A booklet and posters on FP methods were developed in collaboration with PATH/PIACT, a booklet on the use of orals with assistance from FPIA, and one on NORPLANT with FHI.

In July 1989, representatives of the major PVOs and the MSPP banded together to form an IEC Task Force. The goal of this task force is to create an effective, coordinated IEC effort. The first task of the group was to formulate a work plan which includes IEC objectives, selected strategies, proposed activities, proposed inputs, and a detailed schedule. It was too early to assess this effort at the time of the mid-term evaluation. The evaluation team underlined the importance of the Task Force's work, however, in terms of meeting PSFP's objectives. As discussed above, the retention of users must become the number one priority if PSFP is to meet its objectives. This priority will be impossible to implement without a strong IEC package which includes training materials for field level workers, information materials for dissemination to clients, and methods for improving provider/client relations.

7. Contraceptive Social Marketing

USAID/Haiti's interest in this area began in 1988 as a result of research which suggested that, as in many such developing countries, CSM would be a viable means of raising contraceptive usage in urban and semi-urban communities. The study identified two factors which seriously impede FP acceptance and usage in such communities: Lack of sufficient and/or correct information concerning modern FP methods and limited access to such methods. In addition, the study concluded that many elements needed for a sucessful CSM program (e.g. a solid commercial infrastructure, receptive consumer attitudes, lack of legal barriers) were already in place in Haiti.

In February of 1989, the Mission contracted a buy-in with The Future's Group SOMARC Project to direct this project component. The objective of this effort is to increase contraceptive demand through a concerted educational and advertising campaign and accessibility through an expanded commercial distribution network. The Mission supplies funding through the buy-in to support development and promotional activities; Commerce S.A., the pharmacutical firm chosen by SOMARC as its local agent, finances its own contraceptive purchases with the anticipation of cost recovery through product sales.

The first phase of this project, which is already in progress, is testing the marketability of Minigynon, a 21-day low-dose oral contraceptive. In collaboration with SOMARC, Commerce S.A. utilizes international and local technical and research assistance to identify content and media for the advertising messages. Focus groups for both men and women have been an important part of this process. The attitudes and concerns expressed in these group discussions have enabled the technical staff to target appropriate educational messages. Focus groups have also helped identify the CSM campaign's logo, name, and colors. After initial training sessions for pharmacists and pharmacist assistants representing 200 different sales points, CSM will enter the action phase when the product is launched in June. It is anticipated that this effort will account for sales of about 60,000 cycles of Minigynon during the first year of operations.

8. National Population Policy

USAID has traditionally been a major actor in the FP and population area in Haiti. Even during the period in which all bilateral assistance was cut, the Mission maintained an active dialogue with the MSPP, including the key office in terms of population policy, the National Commission on Population (CONAPO). As a result, MSPP decision makers have continued to work with USAID to develop this critically needed policy. The effort to develop this policy has necessitated a great deal of consensus building. Many elements within the GOH, especially the Haitian Institute for Statistics and Information (IHSI), are not yet convinced of the place of FP in socioeconomic development

of the family and the nation. To assist and intensify this dialogue, USAID/Haiti thus contracted a buy-in with The Futures Group's program to assist CONAPO in the development of demographic software. CONAPO and staff presented their projections for high, medium, and low scenarios of population growth at the first National Conference on Population Policy in June 1989. This conference was jointly organized by the IHSI and MSPP with support from the United Nations Fund for Population Activities (UNFPA), and was attended by the President and his cabinet.

Despite recent political events and changes in the government, the Mission anticipates continued support for the development of a National Population Policy. This document will include not only demographic trends but will refer to the effect of population growth on Haiti's socioeconomic future and the role of FP in national development plans.

9. Other Commercial Sector/Policy Activities

In 1988, a feasibility study concluded that many private businesses, especially large industrial employers of women, would be interested in knowing the costs and benefits of providing FP services to their employees. This study also concluded that many local health and FP service providers have the capacity to learn to do cost-benefit analysis and provide this service to interested firms.

In June of 1989, the Mission thus contracted a $50,000 buy-in with TIPPS. The purpose of this contract was to develop local capacity to conduct cost-benefit analyses for the private commercial sector. At the present time, TIPPS staff have trained personnel of four major PVOs in this methodology; scheduled a luncheon for business leaders to present this methodology and discuss FP policy and activities; and have initiated contact with major health insurance providers to determine the feasibility of initiating FP service coverage for insurance clients. Preliminary data from one insurance provider suggest that maternity related procedures account for 11 percent of all payable claims and that that the average such claim is US$398 per patient. Both the service providers and business managers contacted in the course of this work have been enthusiastic. In the opinion of PSFP managers, the potential for this approach in the commercial sector has only been scratched.

D. Rationale for Amendment

There are several compelling reasons to increase PSFP funding and extend its present PACD to June 30, 1992:

1) To provide time and funding, including $2.4 million to cover expanded activities within the prsent PACD, to implement mid-term evaluation recommendations aimed at increased institutional development and retention of current users in the PVO sector;

2) To provide time and funding to expand the scope of CSM and other promising activities in the private commercial sector; and

3) To provide a bridging mechanism which will allow the Mission to initiate resumption of activities in the public sector pending the design of a comprehensive follow-on project.

The one year extension and the balance of the funding provided by the second amendment will enable USAID to complete planning of a coordinated population and FP strategy. This strategy will seek to combine resources and services from the public sector, non-governmental organizations, and the commercial sector to form the basis of a new project in FY92.

1. The Private Voluntary Organization Sector

As for the PVO sector, there are two important reasons to increase PSFP funding and extend the present PACD. First, as mentioned above, the evaluation team made important recommendations which, if promptly and conscientiously implemented over a sufficient time period, would greatly enhance the impact and viability of PVO efforts. And second, $2.4 million is needed to cover expanded activities within the present PACD.

First, as previously discussed in this section, the mid-term evaluation specified several important ways to strengthen institutional development and reach project CPR targets. These recommendations require additional funds and time to implement in a coherent, effective fashion. The first body of recommendations concerns institutional development. These include 1) the provision of technical assistance to PROFAMIL to enable this organization to perform contraceptive forecasting for the entire project; 2) more directed technical assistance to AOPS to increase its grants management capacity; 3) the transfer of five PROFAMIL PVOs to the AOPS management umbrella; and 4) a more strict division of functional responsibilities among the PVOs leading to increased effectiveness and efficiency.

The second important group of recommendations are concerned with improving the quality of PVO service delivery. According to the mid-term evaluation team, PSFP has developed effective, aggressive methods of attracting new users. However, they caution that the project will never reach CPR targets without a equally concerted effort to retain these users. To retain users, PSFP must give top priority to client counseling, follow-up, and the development and production of IEC materials.

For the most part, these recommendations correspond with conclusions drawn from quantitative and qualitative FP research in Haiti. Overwhelmingly, the data over the past ten years have suggested that 1) there is widespread knowledge of FP and desire to have fewer children, but 2) both men and women are constrained from becoming acceptors by lack of information about and/or

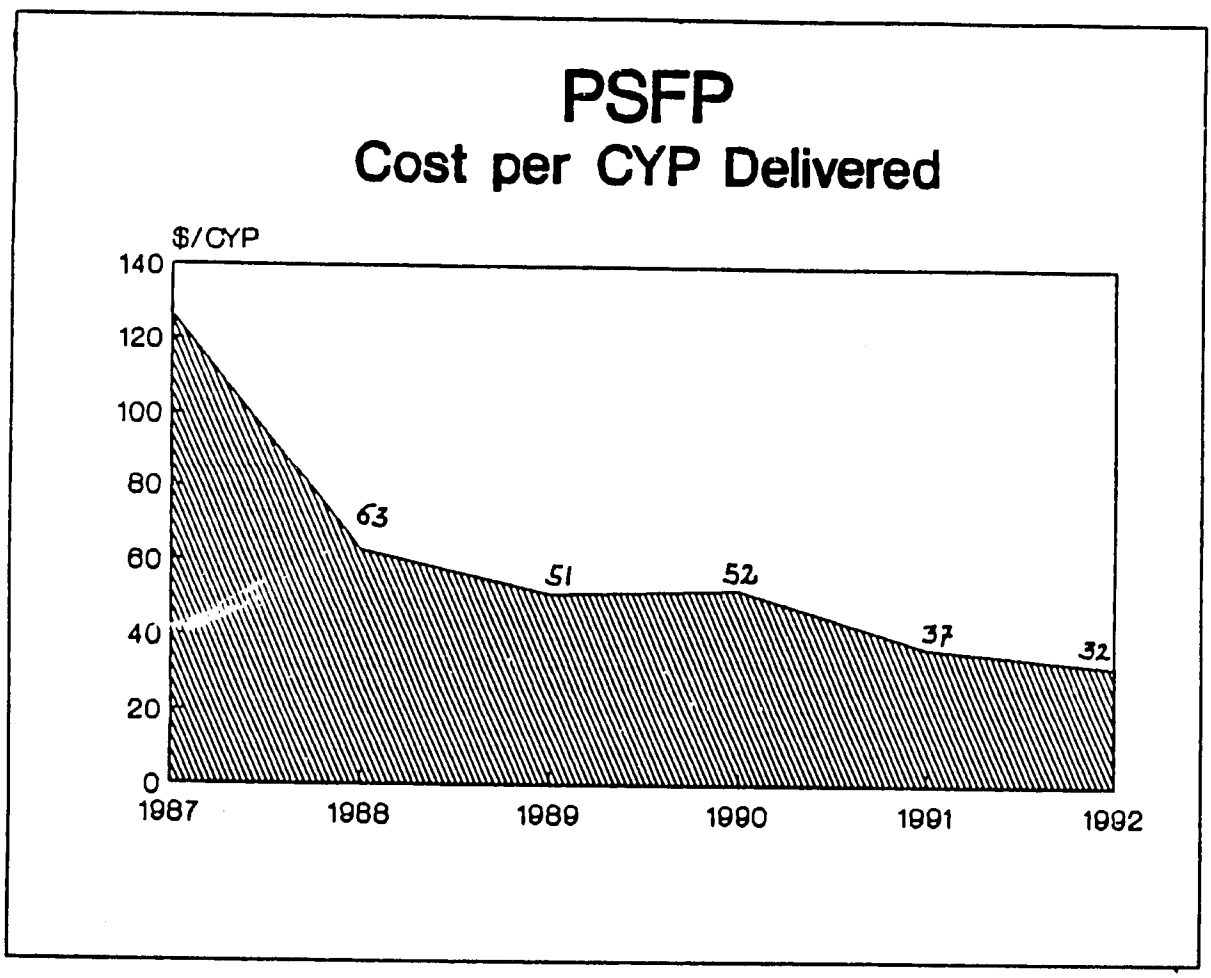
access to FP methods. For example, during the recent Contraceptive Prevalence Survey, over 81 percent of men and women of reproductive age interviewed professed knowledge of FP, while only 11.3 percent of the women and 17.1 percent of the men said that they had ever used FP. At the same time, other studies indicate that almost 50 percent of women of reproductive age do not want more children, and that most women who have used a FP method but stopped did so primarily because of presumed side-effects. These findings suggest, as did the mid-term evaluation recommendations, the urgent need to improve communication with clients, particularly with regard to preparing them to deal with side effects.

Several project components have doubled in scope in response to unanticipated opportunities. For example, as a result of its initial success, VSC was expanded to include five additional clinics. Moreover, the four core institutions and PAPFO have grown to proportions unanticipated by the project, especially in the areas of management and higher level technical and administrative staff. The unanticipated development of these institutions is a normal and positive outcome, albeit one which is costly in the initial years. Heavy, up-front investments will be concluded, however, by the end of 1990. The expected outcome of this will be a reduction in the cost of CYP beginning in 1991. Table Three on page 19, which is extracted from Rusdy's report entitled "Analysis and projection of costs for Private Sector Family Project as implemented by the cooperative agreement with IPPF" (1990), shows the expenditure curve in terms of cost per CYP delivered.

2. <u>The Private Commercial Sector</u>

There are also important reasons to provide additional time and funding to expand activities in the private commerical sector. The largest component of this sector's effort, CSM, is an innovative, appropriate means to address specific, well identified impediments to FP acceptance: 1) lack of information concerning methods and their possible side-effects and 2) inaccessibility of methods. As discussed above, numerous bodies of data have identified these factors as the principal contributors to the low CPR in Haiti. CSM will ammeliorate the impact of these factors by implementing an intensive mixed media advertising and information campaign and by increasing the number of FP method supply points in critical urban and semi-urban areas. The first phase of this effort, a campaign to promote Minigynon, a low dose oral contraceptive, is presently operational. Present estimates project sales of 60,000 cycles of orals in the first year of operations. It is anticipated, however, that CSM will have an impact which exceeds its quantity of sales. First, it is reasonable to assume that the effects of the information and advertising campaign will carry over into other project sectors. For example, even women targeted by urban PVOs and the MSPP will be stimulated to accept orals as a result of the CSM campaign. Second, CSM will accelerate the laborious process of opinion and behavior change by focusing its efforts on the critical urban and semi-urban areas. It is a tenet of social change that impetus

TABLE THREE



Adapted from S. Rushdy " Analysis and projection of costs for Private Sector Family Planning Project as implemented by the cooperative agreement with IPPF". 1990.

usually originates in the center (i.e. urbanized areas) and spreads to the periphery (i.e. more rural areas). Thus as more urban women become oral contraceptive users, more of their rural sisters will be encouraged to follow suit.

The quantitative results of this first CSM phase are yet to be counted. Nevertheless, based on its judgement of CSM's performance in similiar contexts elsewhere in the developing world and its potential, overall impact in Haiti, the Mission has already drafted phases two and three. Phase Two will incorporate other temporary methods and will also promote other family health products, such as oral rehydration salt packages, through the same 200 pharmacy-strong network. Phase Three will focus on the promotion of long-term methods, such as NORPLANT and the Copper-T IUD, through physicians. These expanded activities will cost an additional $600,000 and will necessitate the increased time commitment requested in the proposed amendment.

The other commercial sector activity to be supported by the proposed amendment is the one concerned with cost-benefits analysis managed by TIPPS. As reported in section C.9 above, everyone involved with this effort to develop local health provider capacity to conduct FP cost-benefit analyses for local businesses is excited about its potential. Local PVO health service providers are enthusiastic about its possibilities in terms of cost recovery and, therefore, FP service delivery sustainability. Cost-benefit analysis suggests a potential for them to provide FP services to businesses, especially to large industrial concerns which employ mostly women. The response on the employer side has been equally positive. In addition to the obvious financial benefits to be gained, business managers appear equally cognizant of and disposed towards the overall national development benefits to be derived from the provision of FP services. The additional time and $30,000 requested for this activity under the proposed amendment will allow TIPPS to disseminate its initial findings and approach among a wider range of companies.

3. The Public Sector

The last and perhaps most compelling reason to extend the PSFP's PACD and expand its funding base is to allow the Mission to resume support of public sector population and FP activities. As mentioned previously, USAID/Haiti had traditionally been the major international donor in this area until November of 1987. At this time as the result of the aborted elections, the US Congress suspended virtually all bilateral aid. The result was a near death blow to the GOH population and FP program.

In the decade before 1987, donor commitment to the public sector, most notably by USAID and the UNFPA, produced relatively few results. The executing body within the MSPP for FP at this time was the Division of Family Hygiene and Nutrition (DHFN). Perhaps in part due to the emphasis placed on other maternal/child health (MCH) programs during this period, but probably more due to the

lack of commitment to FP at the DHFN, the program was remarkable only in terms of its failure. Despite near universal knowledge of FP, the contraceptive prevalence rate fell from around 10 percent in 1977 to only 5 percent in 1983. During this period, Haiti recorded what may be the only international case of FP acceptance rate retrogression.

As discussed above, it was as a result of this failure in the public sector that USAID began institutional strengthening of the private sector in 1986. In mid-1987, based on critical changes in MSPP policy and structure, the Mission began negotiations for a large amendment to the bilateral project, Family Planning Outreach (521-0124). These changes, which were effected after six months of negotiations between the Mission and MSPP, were to have a notable impact on MCH and FP operations. First, the MSPP established specific MCH and FP objectives as part of its "New Orientation of Health for all by the Year 2000". As a result of this new policy, FP became one of six MSPP health priorities. Second, in 1986, the MSPP abolished the DHFN and created a new priority programs office of which FP is an integral part. A highly motivated, US-trained MPH, who reports directly to the second in command at the MSPP, was appointed National Coordinator of MCH and FP. And third, in 1986 the GOH created CONAPO as a division within the MSPP, but with a wide mandate for formulation, implementation, and integration of population policy. An equally highly motivated, well-trained MD was appointed as Director.

Ironically, it was at this most promising point over the last decade in terms of FP and population potential in the public sector, that US bilateral assistance was suspended as a result of the abortive election in 1987, when the $13.95 million Family Planning Outreach was terminated. The UNFPA, the other major donor, maintained its presence but reduced its level of activity in response to the political instability.

Throughout the period of rupture of assistance, USAID/Haiti maintained an active policy dialogue with the MSPP. And, with the goal of developing an effective, national FP program, the Mission has sought to affect certain activities in the public sector. The first was an expansion of the NORPLANT pre-implementation trials from three PVOs to include two public sector clinics. The MSPP formally accepted this method as part of the national program in July, 1989. The second activity was the introduction of Ovrette, a progestin only pill suitable for lactating mothers, simultaneoulsy into the PVO and public sector programs. In consultation with AID/W, USAID/Haiti began to implement these activities in late fall of 1989. The Mission also made available some PL-480 local currency funding to the public sector: $150,000 in FY89 and $500,000 in FY90.

In the opinion of the Mission, the time has come to resume significant funding to the public sector. The population crisis in Haiti demands a strong national policy commitment and the concerted effort of all sectors. The present focus on the PVO and commercial sectors excludes the critical public sector. Lack

of funding to the public sector also hinders USAID/Haiti effort to assist the GOH in the formulation and promotion of a national population policy. The inclusion of funding for the public sector under the proposed amendment would provide a bridging mechanism to allow the Mission to resume direct support pending the design of a comprehensive follow-on project to include all sectors.

Support for MSPP FP activities could double the geographical and population coverage of the PSFP. Approximately one half of all medical facilities in Haiti are MSPP or so-called "mixed" facilities which are, in part, supported by the MSPP. Haitian beliefs and low literacy levels favor promotion of long-term methods such as VSC and NORPLANT, which are particular strengths of the MSPP program. According to the recent contraceptive prevalence survey, long-term methods are becoming increasingly popular. As a result of past Mission training efforts, MSPP staff are particularly well-versed and effective in VSC. In 1985-86, before the cutoff of funds, they performed most of the 80,000 such clinical procedure done nationally. During 1989, when the MSPP lacked critical medical equipment and supplies and vehicles for the VSC teams, the number of VSC performed decreased to 700.

The GOH does not constrain private sector FP activities; in fact, it has encouraged expansion of FP in PVOs. There is a on-going information channel between the private sector and MSPP, which has a strategy of public-private partnerships to make use of private sector organizations, such as PVOs, to deliver basic services.

The propitious organizational and policy climate described in the paragraphs above bodes well for the resumption of support to the public sector. In fact, the context for this support has probably never been better in all the years of USAID assistance. Moreover, the Mission's belief is that family planning will continue as a priority health concern at the MSPP regardless of changes in the government. With respect to the GOH, an understanding of the need for and a commitment to the FP concept has been institutionally internalized at the technician level. If the past is a good indicator, these technicians will continue to guide and influence priority FP programs irrespective of who is in power.

III. REVISED PROJECT DESCRIPTION

A. Project Goal and Purpose

The PSFP's goal will remain unchanged. As stated in the original Project Paper, the goal is to reduce the population growth rate in Haiti. Progress toward this goal will continue to be measured by a reduction in the crude birth rate and an increase in the number of contraceptive users. Only the rate of increase in number of contraceptive users will be changed, from 12.5 to 16 percent, to reflect the expanded scope of activities.

The PSFP's purpose also remains as originally written: To increase the availability and effectiveness of FP service delivery. Output and quantifiable measures of achievement, however, will be changed to reflect the project's increased scope of activities and suggestions from the mid-term evaluation. The PACD will be extended 15 months through June 30, 1992.

B. Project Outputs

Following are the revised outputs for the project, to be achieved through the activities described in section D. below:

1. Improved capability of project institutions to attract and retain FP users (increased prevalence).

2. Expanded institutional capacity of project-assisted agencies to plan and deliver FP services.

3. Expanded FP geographic coverage and contraceptive method mix.

4. Research results applied to improve FP delivery.

5. National strategy for Information, Education and Coordination (IEC) formulated and implemented.

C. Strategy Overview

The major change under the proposed amendment will be to initiate support to the GOH/MSPP for population and FP activities. This support will permit the GOH/MSPP to develop a multi-sectoral, cross-ministry national population policy and an effective FP program which maximizes the involvement of the public, PVO, and commercial sectors. This strategy supports the MSPP's policy of developing private partnerships for the delivery of health services and allows each sector to perform according to its comparative advantage. This strategy will be elaborated in greater detail in the follow-on project for FY92.
Support for MSPP under this amendment and from local currency counterpart funds generated by PL-480 activities will target specific, limited spheres of activity such as VSC, supervision, training, operations research on community based delivery, and

NORPLANT pre-implementation trials. There will be no attempt to address the full spectrum of MSPP needs at this time. Instead, during the period of the amendment, the Mission will work closely with the MSPP, the PanAmerican Hea'th Organization (PAHO), and other donor agencies to do a needs assessment and develop a master plan. In collaboration with these organizations, USAID/Haiti will develop a follow-on project for FY92 which will address these needs and coordinate the resources and efforts of all concerned agencies.

The Mission will continue support of PVO and commercial sector activities. The extended PACD and increased funding will allow implementation of important mid-term evaluation recommendations. A new emphasis under this amendment, for example, will be on the retaining present FP users. There is momentum now in demand creation and it is thus appropriate to focus future attention on continuation. This amendment will highlight activities involved with IEC, counseling of users, and the quality of services. Qualitative research will also be needed to increase understanding of the gap between FP knowledge and practice.

In the opinion of USAID/Haiti, population and FP activities will not be self-sustainable in Haiti for the forseeable future. Donors can anticipate funding these activities at least for the next ten to fifteen years. At the present time, there is a limited demand for FP services and even less understanding of the effects of high fertility levels on the overall life of the nation. In the opinion of all those familiar with the situation in Haiti, real sustainability can only only occur through increased demand for FP services. The amended project is designed both to raise demand for FP services and increase awareness and support for a national population policy at all societal levels.

The amended project will explore all presently feasible avenues for sustainability and cost recovery. CSM will promote the sale of short term and long term methods through pharmacies and private doctors. The project will also support other commercially related activities designed to apprise employers and insurance companies of the cost-benefit advantages of FP. This will include assistance to organizations who supply medical services, including FP, on a fixed fee basis to urban industrial employers.

D. Project Activities

This section describes the PSFP activities under this amendment. Table Four lists activities planned under the present amendment, the status of these activities at the time of the mid-term evaluation in December of 1989, and the revised activities planned under the proposed amendment.

1. Contraceptive Prevalence

Due to the expanded population covered by the proposed amendment, the targeted CPR will increase from 12.5 percent to 16 percent. According to the recent Contraceptive Prevalence Survey, the

TABLE FOUR
PROJECT ACTIVITIES: PLANNED UNDER AMENDMENT NO.1,
CURRENT STATUS, & PLANNED UNDER AMENDMENT NO.2

ACTIVITIES/OBJECTIVES: AMENDMENT NO. 1	INTERIM STATUS DEC 31,1989	UNDER AMENDMENT NO.2
1. CONTRACEPTIVE PREVALENCE		
12.5% in target population using contraception.	10.4% of MWRA using contraception nationally (1989 Contraceptive Prevalence Survey)	16% of MWRA in Haiti using contraception.
82,100 beneficiaries targeted in FP activities (new acceptors)	39,423 new acceptors by Oct 31, 1989	new acceptors (cumulative) PVO's -67,000 MOH -32,000 CSM - 4,000 TOTAL 103,000
2. INSTITUTIONAL DEVELOPMENT		
		Major public sector donor coordination initiated with PAHO, UNFPA, and World Bank.
	CA country office staffed & providing admin./grant/TA support to PVOs.	PAPFO exercising autonomy in operational decisions.
Effective management structure in place in 10 major PVOs.	Effective management structures in place in 6 major service PVOs and 4 support institutions	Unchanged.
	2 major PVOs giving sub-sub-grants to small PVOs.	All sub-sub-grants under AOPS umbrella management.
		Profamil providing contraceptive support to all PVOs.
INHSAC capable of providing training in FP and undertaking IEC activities.	INHSAC undergoing major restructuring. (See 4. Training & 5. IEC.	Unchanged.
CHI develops population unit w/research and evaluation capacity.	(See 4. Training & 6. Research in FP.) Financial management system needs improvement.	Unchanged. Financial managment problems resolved.

AMENDMENT NO.1 ACTIVITIES/OBJECTIVES	INTERIM STATUS DEC 31, 1989	UNDER AMENDMEND NO.2
Service statistics system developed for program monitoring and evaluation.	Operant but no feedback to PVOs and no continuing user tracking mechanism.	Unchanged. Targets: PVO feedback and user tracking mechanisms implemented. Reduced PVO administrative costs per CYP. Social marketing of contraceptives in commercial outlets operational. CSM Phase II strategy developed. PVO/factory owners fee-for-service agreement signed.
3.SERVICE DELIVERY		
FP services initiated or improved at 60 PVOs.	29 PVOs offering FP assisted by 4 major local support institutions.	FP services initiated or improved at 40 PVOs. Emphasis will be on continuing users rather than on increased recruitment of PVOs.
3 model clinics operating.	PROFAMIL has 3 model clinics operating.	Unchanged.
Pilot collaborating physicians network.	Scheduled for CY90.	Unchanged.
Pilot program for CSM developed.	CSM in early stages of implementation	CSM of orals operational in 200 pharmacies.
Service provision expanded to factories.	3 PVOs serve over 75 factories in capital area.	Unchanged.
Provide FP Services through CBD. Serve 2000 beneficiaries/yr.	CBD being carried out in 3-4 communities by PROFAMIL/CDS/Pignon. 1,000 served in 1989.	Unchanged. Target: 4,000 beneficiaries/ served by PVOs/MSPP.
Expand VSC services through PVOs.	VSC available in 4 PVO facilities.	Increase VSC services in 5 PVO clinics. Initiate/improve VSC services in 21 MSPP clinics.

ACTIVITIES/OBJECTIVES UNDER AMENDMENT NO. 1	INTERIM STATUS DEC 31, 1989	UNDER AMENDMENT NO.2
4. TRAINING		
Staff of 60 PVOs trained: 1,125 class room hours provided.	INSHAC has provided 766.3 hours of training. 3 persons receiving training in US.	INSHAC trains 317 PVO staff, 1,500 total class room hours.
		300 MSPP staff and 70 GOH teachers trained by INHSAC.
		200 COLVOLS trained by MSPP
		300 Pharmacy staff trained in CSM.
		20 MSPP staff trained in NFP.
		17 youth groups provided Family Life Training.
INSHAC training materials developed.	Instructional manuals on NORPLANT and orals printed and distributed.	Unchanged. Training manual for Level C developed.
5. INFORMATION, EDUCATION AND COMMUNICATION (IE&C)		
IEC materials prepared & being used: 5-7 brochures/booklets, 4 "photo-roman", draft training film.	2 booklets produced. Task Force formed with representative of public & private sectors.	Unchanged. Target: Brief descriptions of side effects, counterindications, etc. for all methods developed.
		Inter-PVO IEC training team developed.
		120 field workers trained in IEC techniques.
		Participatory group IEC manual developed.
		Posters advertising clinic services developed.
		Multi-media CSM advertising/educational campaign launched.

ACTIVITIES/OBJECTIVES: UNDER AMENDMENT NO. 1	INTERIM STATUS DEC 31,1989	UNDER AMENDMEND NO.2
6. RESEARCH IN FAMILY PLANNING		
8 operational research projects conducted. CHI technical monitoring and evaluation capacity established.	No operation research conducted. CHI lacks number of senior staff needed to complete research objectives.	4 operational research & 6 mini-prevalence studies completed. Staff skills upgraded by resident technical assistance.
Conduct national CPR KAP study.	Study conducted and preliminary analysis completed.	Results analysed; report writen; results presented to National MCH/FP Coordinating Committee.
Continue NORPLANT Research.	NORPLANT research on-going in both PVO &. MSPP facilities.	Research finalized & method to be implemented on national basis.
		PVO/MSPP CBD strategy identified by operations research/pilot programs.
7. COMMODITIES AND LOGISTICS SUPPORT		
Provide contraceptives for 82,100 PVO beneficiaries & CSM.	PVO contraceptive orders placed for 90-91. CSM provides own supplies.	PVO orders for 92 placed. Mission supplying Ovrette to MSPP.
Provide 16 vehicles.	18 vehicles provided.	21 vehicles for PVOs. 7 vehicles for MSPP.
Develop PROFAMIL distribution system. system.	PROFAMIL supplying most PVOs with contraceptives.	PROFAMIL estimating all PVO needs & providing management TA to PVOs.
Equip 10 urban clinics & VSC providers.	3 urban clinics equiped.	Unchanged.
		Renovate/supply 21 MSPP VSC facilities.

current CPR for married women of reproductive age (MWRA) is approximately 10.4 percent nationally. Thus the CPR will increase by approximately 5.5 percent by the PACD. At that time, this increase will be documented by CHI's second Mortality, Morbidity, and Utilization of Services Study (EMMUS), which will be funded under VACS.

At the time of the midterm evaluation, PVOs had registered approximately 39,423 new acceptors, roughly half of the present amendment's proposed total of 82,100. The number targeted under the proposed amendment will increase by 43 percent to 103,000 new acceptors. Although the PVO target will decrease to 67,000, as a result of a reduction in the number of new PVOs to be registered which will be discussed below, the new PACD target will increase due to expansion in the other sectors. Approximately 4,000 and 32,000 new acceptors will be targeted in the private commercial and public sectors, respectively, under the proposed amendment. The cumulative LOP total is thus 103,000 new acceptors.

2. Institutional Development

A major institutional development activity under the proposed amendment, which will have impact on all three sectors, will be the Mission's continued participation in the new, PAHO sponsored MCH/FP Coordinating Committee. This committe, which involves representatives of all major MCH/FP donors and service providers, meets bimonthly to discuss topics of mutual concern. For example, at a recent meeting at which AIDS donors were also present, representatives discussed condom needs and procurement. They determined the number of condoms needed nationally, formulated plans for the joint public/private sectors training of warehouse managers, and developed a contingency strategy to alleviate shortages in either sector.

All activities undertaken during the proposed amendment are designed to promote institutional development and the future sustainability of FP activities in Haiti. The formation of a multi-sectoral IEC Board of Directors or the introduction of management practices to improve contraceptive logistics, for example, also increase the institutional capacity of participating organizations to provide quality, long term services. The activities specifically targeted under this rubric are as follows:

o The Public Sector: A major activity under the proposed amendment will be directed toward increasing coordination among public sector donors. Multi-donor participation and coordination in national FP activities at the present time are critical. As mentioned previously, USAID/Haiti has traditionally been the major FP donor in Haiti, followed by the UNFPA. At the present time, UNFPA is gearing up for a substantial increase in its involvment in population, with a $2.4 million, four year program and the assignment of a new country representative. The World Bank also has a FP component in its new health sector loan to address needs in the West Region, including Port-au-Prince.

PAHO will be executing agency for the FP components of both these programs. With the addition of the USAID public sector component, PAHO will be in a unique position to coordinate all major donor FP activities in the public sector.

PAHO has a highly professional, experienced management team, backed by a competent cadre of technicians with FP experience in Haiti. The Mission presently works with the MSPP through PAHO to promote its Child Survival EPI activities. The results have been highly satisfactory. Vaccination coverage has nearly doubled since assistance began three years ago.

It is obvious that the urgency of the present population growth rate and the need to develop a strong national FP program demand strong donor coordination. The programmatic and budgetary requirements to meet this situation are too great for any one donor; the urgency is too great for duplication of efforts or waste of other precious resources. The Mission is thus collaborating with PAHO in the formation of an advisory board, consisting of all the major actors, whose purpose is to channel all resources to the public sector in the most effective fashion.

As mentioned above, activities under this amendment will not address the full spectrum of MSPP institutional development needs. Instead, the mission will work with PAHO, UNFPA, and the World Bank to identify these needs and develop a long range multi-donor plan to address these issues.

o <u>The Private Voluntary Sector</u>: A major change in the private sector component under this amendment concerns the transfer of certain major project management responsibilities from the CA's main office in New York to the field office in Haiti. This transfer of responsibility, as recommended in the mid-term evaluation, will greatly enhance the effectiveness of the CA recipient by decreasing the amount of time needed to make and implement decisions. Project managment will also be improved by being closer to the Haitian PVOs implementing the project, and thus more responsive to their needs. In the past, most management issues needing resolution had to be passed to and adjudicted by the New York office. Under the new amendment, each CA recipient office will have a well defined, seperate sphere of duties and responsibilities.

The second major change relates to the functional responsibilities of two of the major PVOs. In the past, AOPS and PROFAMIL shared responsibility for providing support to smaller PVOs. Under this amendment, because of its unique position as a support organization with affiliates throughout the country, AOPS will assume all responsiblity for managing sub-sub-grantees. PROFAMIL, which has established an excellent record in logistics, will expand this support function to include contraceptive procurement and provision for all PVOs. Table Five lists the organizations participating in the private sector component by their areas of functional responsibility.

TABLE FIVE
PROJECT PVOS AND THEIR REVISED MAJOR
FUNCTIONAL RESPONSIBILITIES

ORGANIZATION	TYPE OF FUNCTION
IPPF/WHR	General Policy, Grant Management, Technical Assistance Procurement
PAPFO	Planning, Budgeting, Reporting, Analysis, Coordination, Disbursement Technical Assistance
AOPS	Sub-sub-Grant Management of 40 PVOs Reporting, Planning, Evaluation
PROFAMIL	3 Model Clinics Contraceptive Logistics Clinic-based Services, including VSC Model Community-based Service Delivery
CHI	Operations Research, Surveys Evaluation, Service Statistics
INSHAC	Training, Curriculum Development Educational Material Production
CDS	Clinic-based Service Delivery Community-based Service Delivery
DASH	Factory-based Service Delivery (70 locations)
PIGNON	Hospital-based Service Delivery Community-based Service Delivery
FOSREF	Clinic-based Service Delivery, Including VSC
AOPS/VSC	VSC Service Delivery
CPFO	Female Reproductive Health Education Service Delivery to Factory Women

o The Private Commercial Sector: Local CSM management functions will continue to be the responsibility of Commerce, SA with SOMARC providing overall direction and supervision of operational activities and technical assistance. Whenever possible, in order to develop national CSM capacity, SOMARC and Commerce S.A. will use local consultants and advertising and media agencies to help provide this technical assistance. By the proposed PACD, CSM will be institutionalized in a network of commercial outlets, which will include pharmacies and the offices of private doctors.

Under the proposed amendment, TIPPS will continue and enlarge its efforts to inform the business community of the cost-benefits to be gained from FP related activities. Local service providers have already been trained to perform cost-benefit analyses for business managers. This amendment will allow TIPPS staff to help PVOs utilize these skills in more effective presentations and to disseminate the message to a wider range of companies. Particular attention will be paid to collaboration with the Haitian Industrial Association (ADIH) and OFATMA, the parastatal organization responsible for workers compensation and maternal health programs in private sector enterprises. By the PACD, the three PVOs which provide FP services to approximately eighty urban industrial employers will have formulated a cost recovery plan and will be providing these companies with a fee-for-service FP program.

3. Service Delivery

Changes and additions in service delivery capacity under the proposed amendment are as follows:

o The Private Voluntary Sector: A major change under this amendment will be a decrease in the number of PVOs targeted to implement FP services. Instead of the sixty presently specified, only forty PVOs will be targeted by the new amendment. As suggested in the mid-term evaluation, this change will allow project managers to concentrate on improving the quality of services. The emphasis will change from one on the quantity of service providers to one of the quality of services provided by the present group of PVOs. Better quality services, which include improved client counseling and follow-up, will yield positive results in terms of improved continuation rates. As the mid-term evaluation also suggested, it is critical at this point in its development cycle to change the project's focus from one on attracting new acceptors to one of continued use by acceptors.

Under this amendment, there will also be expanded PVO community based distribution (CBD) activities. PROFAMIL will expand its CBD areas around Furcy in the Western Department to include Ki-Croix and Godet and to rural areas around Port-de-Paix in the North Department. A needed addition to the Furcy program will be a part-time physician, whose salary will be defrayed by income generated from FP fees. It is

anticipated that the presence of a doctor, even on a part-time basis, will greatly enhance participant motivation as FP is the only medical service available in this area at the present time.

The PVOs will also be able to expand VSC service delivery as a result of the proposed amendment. At the present time, there are four PVO sites offering such services. As part of the special VSC services sub-grant being implemented by AOPS, this number will be augmented by five for a total of nine VSC service sites by the proposed PACD.

o Contraceptive Social Marketing: The number of FP service delivery points will be enhanced under the proposed amendment through support of CSM activities. The first phase of this program, which is already in progress, will soon culminate with the sale of Minigynon, a 21-day low dose oral contraceptive, in commercial points of purchase. In June, over 200 pharmacies in the metropolitan Port-au-Prince area and in provincial capitals will be selling this new product with the support of a large multi-media information/advertising campaign. Pharmacists and their assistants will be trained to provide proper counseling in contraindications and possible side effects; the multi-media campaign will reinforce these messages and encourage women to seek out the product in their local pharmacies. The target population is young urban and semi-urban women who are employed, and thus have some disposable income, and who want to space births. In February of 1991, SOMARC will evaluate this first phase and, based on the results, may expand the sale of this product into other commercial outlets.

In September of 1990, the second phase will begin with research on the feasibility of introducing other "Sante Plus" ("Health Plus") products. Products under consideration for sale in pharmacies at the present time include oral rehydration salts packets and a progestin oral contraceptive appropriate for nursing mothers. Other ideas involve the introduction of an inexpensive oral for sale through PVOs and the promotion of NORPLANT and the Copper T-380A interuterine device to private physicians. The CSM effort will not include brand names distributed at no cost either by the MSPP or the PVOs. For example, as Ovrette, a progestin oral, is presently distributed by both these groups, the CSM managers will select another brand should they decide to target an oral to lactating women. Phase Three of CSM to introduce these new Sante Plus products will begin in February of 1991.

Population Science International (PSI) and DOBACO, a local pharmacutical supply firm, have recently launched a second CSM marketing effort specifically for condoms. At the present time, this effort targets middle class urban males with a relatively expensive brand name condom through a sophisticated radio and TV campaign. PSI and DOBACO have asked the Mission's assistance in the procurement of a less expensive model to target to working class urban males. USAID/Haiti will supply these condoms under the proposed amendment.

o The Public Sector: The MSPP provides FP services through a network of 158 hospitals, clinics, and dispensaries. Approximately one half of all health facilities in Haiti are MSPP or so-call "mixed" facilities which are, in part, supported by the MSPP. Several nospitals and clinics provide long term methods such as VSC, NORPLANT, and injectibles and all facilities stock supplies of temporary methods such as orals, condoms, and foams. The UNFPA supplies MSPP contraceptives and will continue to do so under the proposed amendment. The one exception will be the procurement of Ovrette, a progestin oral which is appropriate for lactating women. As discussed above, the MSPP and USAID/Haiti have collaborated in the effort to introduce this contraceptive since the fall of 1989. The Mission will continue to supply Ovrette under the proposed amendment.

The proposed amendment will support both the expansion and the improvement of public sector service delivery capacity. For example, in terms of improved services, funds from PL-480 generated activities will be programmed for supervisory and quality control activities. These monies will enable central office supervisors to visit the regions and districts and those from the regions and districts to visit the hospitals, clinics, and dispensaries under their jurisdiction. As will be discussed below, training will also enhance the ability of supervisors and other staff to provide quality FP services.

The major public sector focus under this amendment will be on the clinical delivery of long term methods such as VSC and NORPLANT. Due to the infrastructure already in place, this effort has the most potential for a major impact in the short time allotted to the new PACD. Tenative, experimental steps will be taken, however, to expand the delivery and variety of temporary methods.

Long Term Methods: The attention to be given to long term methods under this amendment is not without precedent. Such methods were promoted by the MSPP in the mid-1980s and this effort was the most successful part of the program. Indeed, the area the hardest hit in the past several years since the suspension of US assistance has been clinical contraception, including VSC. The majority of the over 8,000 clinical procedures done during 1985-86 were performed by MSPP mobile medical teams. At the present time, these teams are largely unable to function due to lack of transportation and equipment. The current figures for 1989 which estimate only 700-800 such procedures for the period suggest the enormity of the problem of lack of resources at MSPP.

As witnessed by results of the 1989 contraceptive prevalence survey, the knowledge and demand for VSC, as well as for other hospital and clinic based methods, is high. For example, among the women of reproductive age queried, female sterilization was the fourth most widely recognized method, after orals, condoms, and injectables; for women, VSC was the third most utilized FP method, after orals and injectables.

The problem is not shortage of physicians trained to perform these services. USAID/Haiti supplied technical training during the last bilateral project and most of the staff who implemented this program are still in place. The problem revolves, rather, around the critical lack of medical equipment and supplies and transportion. The proposed amendment targets twenty one MSPP facilities for full VSC services. Operations will be run out of seven "key" facilities, whose experienced personnel will form mobile teams to serve another two facilities each, in addition to their home facility. Prior to full scale implentation, an assessment will be done to ensure that the all twenty one MSPP locations selected have adequate facilities, patient counseling, and follow-up. USAID will provide funds for operating room refurnishing and medical equipment. The Project will also finance vehicles for the mobile team and some retraining of medical staff in proper counseling and clinical techniques.

As discussed in Section II, the MSPP has collaborated in NORPLANT research activities since late fall of 1989 when the GOH approved this method for national use. At the present time, pre-implementation trials are being conducted in three MSPP facilities. As a result of an additional $100,000 buy-in with FHI, the number of MSPP facilities offering NORPLANT will increase to nine by the PACD. This method is considered an ideal one in Haiti for women in their twenties who have reached ideal family size. NORPLANT allows these women to limit births until they reach thirty five when MSPP norms permit VSC.

Temporary Methods: Temporary methods such as orals, condoms, and foams will continue to be provided through the MSPP's network of 158 facilities. Funding under this amendment will take tentative steps toward rectifying the present lack of community based distribution (CBD) of these methods in the public sector. As discussed above, availability and lack of information about methods have always been major problems with FP acceptance in Haiti. The latter problem will be addressed in all sectors through a major IEC effort to be discussed below. Availability, however, remains a major constraint despite the number of MSPP facilities and the expansion of PVOs into the FP field. The MSPP needs a community-level promotion system similiar to that being implemented by some PVOs to extend the service delivery reach of its fixed facilities. CBD would allow direct distribution of and counseling in temporary methods and also help bring new and continuing acceptors into fixed facilties for long term methods.

One important activity under the proposed amendment will thus be the development and testing of several pilot CBD models using community promoters. The design of this effort will be critical. The MSPP, whose present budget is already 80 percent dedicated to salaries, cannot take on more personnel. In fact, the new World Bank health loan specifies that no funding will be expended for additional salaries. On the other hand, research has shown that the use of volunteers is problematic in Haiti. Even when people take on responsibilities clearly defined as "volunteer", they expect some sort of remuneration. When no salary is forthcoming, the volunteers abandon their work. In the

past, community based GOH health efforts have involved the payment of small stipends to people who have nevertheless been called "volunteers".

Given these restrictions, there are two possibilities for CBD which presently suggest themselves which will piloted under the proposed amendment. The first involves the use of GOH employees already in place for CBD and the second concerns free lance community promoters who support their participation through the sale of temporary methods. The first approach will test the use of teachers in Domestic Science Centers to do CBD. These centers, which are run by the Ministry of Agriculture and Natural Resources and serve predominately rural areas, train young women in such home economic skills as sewing, cooking, and child care. After training in FP motivation and counseling skills, the teachers will provide orals, condoms, and spermicides. If successful, this effort could be expanded, for example, to include similiar centers run by the Ministry of National Education. The second pilot effort will test the use of fifty community promoters in each of the four MSPP regions. As the teachers, these community promoters will be trained in FP motivation and counseling skills. Unlike the teachers, however, the community promoters will be encouraged to charge acceptors for supplies of temporary methods. Both types of pilot efforts will be reinforced by the multi-media IEC campaign to be discussed below. And, as will also be discussed below, these CBD pilot activities, which have potential for both private and public sectors, will be carefully evaluated. If successful, they will be incorporated as a full fledged CBD effort in the follow-on project.

The MSPP will also expand the variety of temporary methods offered under the proposed amendment to include natural family planning (NFP). As with VSC, NFP is an approach to fertility reduction which has successful precedents in Haiti. Action Familiale d'Haiti (AFH), a PVO with a nominal affiliation with the Catholic Bishops Conference, promoted these methods from 1977-1986 in several rural areas. During this period, AFH was supported by the MSPP and USAID/Haiti. An evaluation of this activity suggests that while these methods, which require periodic sexual abstinance, are not for everyone, there is a wide audience for whom they are an appropriate choice. The recent Contraceptive Prevalence Survey also indicates the relative popularity of these methods despite limited promotion. Seventeen percent of Port-au-Prince males and 6 percent of rural females in union who were utilizing FP at the time of the study were using NFP.

The MSPP has received several requests from Catholic hospitals for assistance in the implementation of NFP programs. Although activities have yet to be developed, they will probably involve a combination of hospital and community based delivery. For example, since most of these facilities have maternity services, NFP, especially exclusive breast feeding for six months as a means of contraceptive, could be effectively promoted to post partum women. Community promoters could provide follow-up

and, after the initial six month post partum period, introduce a choice of other NFP methods, i.e. the sympto-thermic or the cervical mucus methods. The promotion of exclusive breast feeding as a means of contraception will be espcially appropriate in terms of the Mission's child survival objectives. The Mission will request the services of the centrally funded Natural Family Planning Project at Georgetown University in the design of this program and will also be able enlist the assistance of ex-members of the now defunct AFH.

Table Six summerizes the various methods presently used by the various sectors and their planned use under the proposed amendment.

4. Training

As a result of its recent evaluation and restructuring and in order to become a full fledged school of public health, INHSAC has identified three major goals and has opted to create two new operational units. Its priority goal in terms of training is "To assure the theoretical and practical training in community and public health of the personnel of health institutions and other categories of personnel interested in health activities." In addition to the Training and Administration units, the Institute will now have an IEC Unit and a Research and Evaluation Unit.

Under the proposed amendment, INHSAC will target training for 402 PVO staff involved with FP. The new life of project target will be 1,500 training hours. A preliminary to this effort will be an upgrading of the skills of the trainers. The entire training staff will spend at least four days per year attending workshops geared toward improving their teaching skills. FP training courses for levels A and B (medical personnel) will be revised and, based on recommendations from the midterm evaluation, the curriculum for Level C (community health workers) will be redesigned. Instead of training all Level C staff, however, INHSAC will concentrate on developing PVO capacity to do this training in-house. The PVOs will identify levels A and B staff members and INHSAC will then develop their skills in a Training of Trainers Program. As a result of this training, these PVO staff members will be able to design Level C courses particular to their organizational needs and do their own training of Level C personnel as needed.

CHI will also be involved in training PVOs. Activities targeted under the proposed amendment include training in the use of systems analysis for four PVOs, training in the use of computerized health information systems for six PVOs, and training in maintaining unified FP record keeping systems for 10 PVOs.

TABLE SIX
PROPOSED USE OF
CONTRACEPTIVE METHODS BY SECTOR

PUBLIC	PVO	PRIVATE COMMERCIAL
LONG-LASTING METHODS		
VSC- Mobile VSC teams, VSC in fixed facilities to be strengthened.	VSC in model urban clinics. VSC To be expanded to model rural clinics.	
NORPLANT: To be offered in 9 public facilities.	NORPLANT in 3 PVO centers.	NORPLANT training to private physicians may be included in expanded social marketing activity (Phase III of CSM)
Injectibles provided by UNFPA.	Injectibles provided by UNFPA.	Injectibles may be included in expanded CSM if donor/private funds can be obtained (Phase III) Cu-T 380A detailed to private physicians through CSM (Phase III).
TEMPORARY METHODS		
Pills - Low-Femenal provided by UNFPA.	Low-Femenal provided by USAID	Pill social mardeting to be launched in June 1990 Minigynon) Pill social marketing expanded to rural areas (Phase I).
Ovrette, a progestin oral for nursing women to be provided by USAID with a national/ regional introduction.	same	Progestin-only pill to be included in expanded CSM (Phase III)
Condoms - UNFPA.	Condoms: Provided by USAID.	USAID/Haiti will provide a limited supply to PSI /DOBACO CSM effort.
Spermicidals provided UNFPA	Provided by USAID	Spermicidals, sponge, etc. of interest for addition to CSM activities.
Natural Family Planning: Pilot program in several Catholic facilities.		

INHSAC will also have responsibility for training personnel in the public sector. As with the PVO sector, the emphasis will be on levels A and B personnel. Staff from the four MSPP health regions will be trained as follows:

Transversal	100
North	60
West	80
South	60
Total	300

INHSAC will also be responsible for training seventy teachers in the Ministry of Agriculture and Natural Resource's Domestic Science Centers. These teachers will learn to do FP motivation and counseling for orals, condoms, and spermicides.

The MSPP will also initiate a Family Life Training course developed by staff for seventeen groups of young people in mostly provincial areas throughout the country. These youth will either be in their terminal year of secondary school or, where no such schools exist, of an appropriate age and literacy level to receive this training. The following groups will be trained by region:

Transversal	6
North	3
West	5
South	3
Total	17

In order to initiate pilot CBD programs in four communes, the MSPP will also need to train 200 community promoters. MSPP Level B staff, previously initiated into Training of Trainers techniques at INHSAC, will conduct these Level C courses in motivation, counseling, and the correct use of temporary methods. There will be a total of eight Level B Trainers/Supervisors, two for each of the four groups of fifty community promoters.

Training in NFP techniques has yet to be identified, although there are several promising options. One would be to initiate a small buy-in with the Natural Family Planning Project at Georgetown University's Institute for International Studies in NFP.

SOMARC and Commerce S.A. will be responsible for training pharmacists and pharmacist assistants in the proper counseling techniques for Minigynon, the progestin oral contraceptive. They will hold workshops for this purpose and will be assisted by international and locally hired training consultants.

Finally, under the proposed amendment, the Mission will initiate an invitational travel and training program for Haitian FP professionals. Due to its cultural/linguistic uniqueness and political situation, Haiti has long been the most isolated country in the Latin American/Caribbean region. Information starvation is endemic. As a result, many professionals do not

have state-of-the-art training for their work nor do they have interchange with colleagues outside of Haiti. This dearth of information and training is especially pertinent in the field of IEC in general and for MSPP and CONAPO technicians in particular. For example, most lower level technicians in both offices lack the necessary skills to assume larger roles and responsibilities. GOH FP and population activities are thus constrained by lack of fully developed human resources past the upper managerial level.

To help rectify this situation, USAID/Haiti will initiate a multi-pronged approach. First, external technical assistance will be provided wherever it will be profitable. For example, a buy-in with Options II will continue provision of needed assistance in terms of setting regional contraceptive use targets and other national population policy concerns. Second, the Mission will initiate a buy-in with the new Family Planning Management Training Project to conduct a comprehensive assessment of MSPP training needs. This assessment will particularly focus on need to develop lower level personnel for expanded technical and/or managerial roles. And third, the Mission will allocate $300,000 of the proposed amendment's funding specifically for invitational travel and training. For example, one MSPP and three PVO staff members will be sent to a state-of-the-art FP communications workshop in Tunis specifically for francophones.

5. Information, Education, and Communication

As discussed repeatedly above, IEC will be a major activity of the proposed amendment. An IEC Task Force with representatives from all the major PVOs and the MSPP has already been formed. A Task Force Coordinator, a recent MPH from Tulane, has been seconded on a half-time basis from AOPS where she also serves as IEC Coordinator. The Task Force works under the supervision of an IEC Board of Directors which includes the directors of all major PVOs, the MSPP National MCH/FP Coordinator, the PAPFO Director, the local CSM Director, and Mission staff. The Task Force has day long meetings on a bi-weekly basis to plan activities and training. Every three months, group members will present a resume of completed activities and their work plan for the coming trimester to the Board of Directors. This work plan will be implemented based on Board approval.

The Task Force will have responsibility for the planning and implementation of all IEC activities. These responsibilities include the assignment of tasks and responsibilities, monitoring the implementation of IEC activities, assuring coordination of schedules, review and approval of materials design, training curriculum, and media spots, advising the Board on the allocation of IEC resources, and periodic reporting of IEC progress to the Board.

In determining roles and responsibilities and the mechanisms for implementation of the wide range of activities called for in the IEC plan, the Board of Directors and the Task Force will have to balance two, somewhat contradictory, needs:

a) The need to produce immediate results/products, or, work done efficiently and effectively in the short-term; and

b) The need to develop IEC capabilities and sense of responsibility for these activities in the various sectors for continued IEC efforts at the the community, clinic, and national level.

The implementation strategy will take into account at which level the capacity to perform an IEC function will be needed, as well as at which level the function can be most effectively performed. For example, each of the collaborating organizations will carry out clinic education and outreach activities. Front line staff in each organization will need skills in group education, communication, and community organization. Management staff in each organization will also need to be able to coordinate, supervise, and support their work. The implementation strategy will thus allow for the development of these skills in each organization.

More expensive and technical IEC functions will be addressed at the multi-institution level through the Task Force. For example, the capacity to develop and produce a radio spot is not an essential skill for each organization. More appropriately, radio spots will be developed by one of the organizations or an outside agency by pooling resources of the collaborating organizations. Each organization will need, however, to be able to identify their media and audio-visual material needs and to arrange for their development. The Task Force will need to establish links with commercial agencies which can provide media services.

The commercial sector in Haiti is also an important potential resource for carrying out some of the proposed IEC activities. Several Haitian advertising agencies, including those which have already worked with the CSM component, are experienced in the development of media campaigns. These agencies have skills in the use of focus groups, field testing of information/advertising messages, and other communication methodologies. In technical aspects, these agencies are well equipped to produce quality audio-visual materials. They can also be expected to be administratively efficient and able to produce quality results in a relatively short time period. The local CSM Director will serve as an important resource person for media activities.

As with the CSM component, the PVOs and the MSPP will directly contract the services of the advertising and media companies, and thereby ensure quality and relevance to their own programs. This approach will combine the FP and community education expertise of the former two groups with the for-profit sector's efficiency and technical quality. It will also establish a model for continued collaboration between the commercial and service provider sectors for post project activities in IEC.

IEC at the clinic and community levels will be the responsibility of each service delivery organization. Participating organizations will receive funds to enable them to carry out and

support field IEC activities in their programs, including the funds for sending personnel to project-sponsored training events and purchase of IEC materials to be developed through the project. Control and management of IEC resources by each organization will encourage ownership of IEC activities. By establishing mechanisms to combine resources to carry out joint activities, however, this approach facilitates continued collaboration in IEC.

o IEC Training: INHSAC will coordinate training as it has both the technical and administrative capacity to conduct the workshop series. The IEC experience will also be beneficial to the Institute in terms of development of future Level C programs. The methodology and staff development acquired during this activity will be transferable to other INHSAC FP and MCH training efforts. CPFO will provide important technical input on participatory training methodologies and insight into women's issues.

o Print Materials: Three types of print materials will be developed:

1) Materials on side effects, contraindications, and instructions for correct usage.

2) A manual for health workers with group education activities.

3) Posters advertising clinic services.

Responsibility for development of these materials will be divided between the Task Force and INHSAC. The Task Force will identify materials needs and concepts and INHSAC will develop these concepts into the form to be field tested. After field testing, which is the responsibility of the Task Force, the INHSAC Production Unit will produce these materials in their final form. Depending on time and cost factors, INHSAC may contract artwork and additional concept development to a commercial agency.

o Media Activities/Audio Visual Materials: Media activities will be contracted out to a commercial agency which will develop radio spots to advertise clinics and their hours. The agency will need to work closely with the Task Force, however, to develop satisfied client testimonials and the spots on the variety of methods available. To develop socio-drama spots, the agency will also need to work with someone familiar with a problem-posing approach to health education.

o Technical Assistance: The Board of Directors and Task Force members will need technical assistance in order to carry out their various duties. This assistance will include the following:

o Team building, conflict resolution, and organizational skills;

- IEC needs assessments;
- Management and supervision of IEC activities; and
- Development and pre-testing of IEC materials.

6. Research in Family Planning

At the time of the midterm evaluation, the major general research activity which had been completed was the development and implementation of a national contraceptive prevalence survey. And, as previously reported, there has been ongoing applied research in the implementation of NORPLANT services in the PVO and public sectors under the present amendment. The latter activity will continue under the proposed amendment as discussed above. An additional centrally funded buy-in of $87,000 to FHI will allow these pre-implementation trials to expand to five more sites. Upon approval of the FDA, private and public sector project managers will use the experience gained in these trials to implement NORPLANT on a national basis.

Research under the proposed amendment will shift from general surveys to more applied, operational research activities. As discussed above, one important new line of inquiry, which will have application in both the public and private sectors, will involve testing approaches to community based service delivery. As discussed above, the MSPP has proposed resumption of its community based system utilizing community volunteers or COLVOLS. This approach had previous success, most notably in the Mirogane area. The MSPP will test the efficency and effectiveness of several strategies, however, before implementing this approach on a national basis. The MSPP will experiment with different models in various regions of the country which will test the impact of such elements as the use of satisfied FP-using couples as promoters and partial cost recovery as a means of sustaining FP promoter efforts. Other elements to be tested include methods of supplying contraceptives and various approaches to community FP promoter training. A qualified AID/W centrally funded contractor will furnish the MSPP with assistance in the design and implementation of this operations research.

In collaboration with the new Research and Evaluation Advisor based at PAPFO, CHI will conduct four operations research or applied studies for the private sector. Among the topics to be studied under the proposed amendment are reasons which inhibit utilization of condoms and reasons for discontinuation of other FP methods.

Under the proposed amendment, CHI will also conduct 8 small area contraceptive prevalence surveys to determine exact coverage in areas where PSFP institutions are active. The lack of baseline data in these areas has been a major problem. As a result of the lack of these data, project managers have had to rely on other indicators, such as national CPR and CYP, to estimate the

Project's impact. The implementation of these small scale prevalence studies will be an important step toward rectifying this problem for the follow-on project in FY92.

7. Commodities and Logistics Support

In order to achieve the LOP objective of raising the CPR from 9.7 to 16 percent, the Project will require the same commodity inputs outlined in the previous amendment, plus additional contraceptive inputs for the public sector. At the present time, the Mission will schedule only the purchase of Ovrette, the progestin oral, for the public sector. Should the FDA approve NORPLANT during the proposed PACD, however, it will add this contraceptive to the procurement list for both the private and public sectors. A major institutional development effort in the public sector will be concerned with contraceptive supply and logistics. The MSPP has always been plagued with problems related to this area. Even when demand was relatively high, potential acceptors were often discouraged by lack of supplies in provincial towns and rural areas. The quality of supply has been equally problematic. MSPP storage facilities are often inadequate to the task of maintaining quality contraceptive supplies. MSPP staff have been trained in contraceptive supply and quality control during previous USAID/Haiti supported projects. The present problems are more related to lack of materials, proper storage facilities, and vehicles to transport supplies. The newly formed FP Coordination Advisory Board has already initiated efforts to build links between the MSPP and PROFAMIL's logistic and distribution system. Vehicles and medical equipment and supplies plus funds for operational costs will be provided to the MSPP to revitalize its mobile teams for clinical contraception.

IV. REVISED IMPLEMENTATION ARRANGEMENTS

A. Overview

The project was authorized on August 20, 1986 as a three year-project with a LOP funding of $3.25 million. The project was amended on August 24, 1988 to extend the PACD to March 31, 1991 and increase the total funding by $5 million. Under this second amendment, project funding will be increased by an additional $8,138,000 in grant funding for a new total of $16,338,000 and the revised PACD will be extended for fifteen months to June 30, 1992.

The bulk of the project amended activities will be implemented under an amended Cooperative Agreement (CA) with IPPF/WHR and a grant to PAHO. The Cooperative Agreement with IPPF/WHR was originally signed on August 29, 1986 to provide central administration and management. The CA recipient selection process involved a limited competition among six qualified non-profit organizations, and the most responsive was selected in accordance with Handbook 13 guidance. The request for Application mentioned follow-on work. The CA with IPPF/WHR was extended by the first project amendment to March 31, 1991. Although the size of the first amendment and this amendment is greatly in excess of the value of the original Cooperative Agreement, the expanded activities under this amendment differs primarily in magnitude --not in scope--from those in the original CA.

It is expected that under this second project amendment a revised CA will be mutually agreed upon between USAID/Haiti and IPPF/WHR and the Agreement will be extended to June 30 1992.

It is proposed that PAHO receive an international organization grant to implement the public sector component of the project. PAHO is currently functioning effectively as executing agency for the expanded program of immunizations (EPI) component of the Mission's child survival project and has sufficient capability to administer the public sector component. PAHO is also currently serving as the executive agency for UNFPA funding and the World Bank loan to Haiti in health and FP.

B. Implementation of Project Components

The private sector component of the amended project will be implemented under the Cooperative Agreement with IPPF/WHR. Private sector activities under this amendment will remain essentially the same. The exceptions will be a) a decrease in the number of PVOs targeted to initiate FP from sixty to forty and b) increased concentration on reducing client drop-out rates by better counseling, IEC, and follow-up. The results should be increased use of PVO facilities; an increase in CYPs; and an improved cost-benefit ratio, as measured by the total CYPs delivered vis-a-vis total PVO component costs, beginning in 1991.

The CSM component will be implemented through a Mission Buy-in to a AID/W contract with Futures Group/SOMARC. All arrangements with the local company doing CSM will be the responsibility of SOMARC.

PAHO, as the implementing institution for the public sector component, will be responsible for the procurement and management of all MSPP commodities (e.g. vehicles, clinical equipment, and contraceptives).

Coordination of the three project components will require the establishment of a Project Advisory Board comprised of the USAID Project Manager, the PAHO Family Planning Advisor, the PAPFO Director, the MSPP MCH/FP Coordinator, and the local manager of CSM. The members of the Board will select the chairman. The Board will meet at least every two months to review project progress and resolve any problems of coordination of efforts.

The Advisory Board may request the presence of project and non-project personnel as they feel necessary. The USAID Project Manager will serve as the Board's secretary and notify members of meetings and distribute the minutes of previous meetings. The Board is empowered to make policy recommendations and to note if action is taken by those responsible.

C. Implementation Responsibilities

1. Cooperative Agreement Recipient

The CA recipient, IPPF/WHR, will be responsible for management of the participating PVOs. Specifically, the duties of IPPF/WHR are:

a) Preparation and execution (with approval from USAID) of sub-grant agreements with approximately ten PVOs active in FP or disposed to be more involved in such a program. Preparation and execution of sub-contracts as appropriate in conjunction with project activities. AOPS, with direction provided by IPPF, will continue to manage the sub-sub-grantees.

b) Provision of technical assistance (either from internal resources or by sub-contract) to the sub-grantees in accordance with the budget for technical assistance and the concurrence of the sub-grantee and USAID. A new stipulation in the CA will be the use of Haitian or otherwise local consultants whenever possible.

c) Administration, accounting, and reporting of all project funds in accordance with USAID regulations concerning cooperative agreements.

d) Maintenance of an in-country office with technical and support staff as agreed upon by USAID. A new stipulation will state that this office, PAPFO, will have major operational responsibilities for grant management.

e) Provision of coordination and overall project management to assure that project objectives are met and that project activities are planned, executed, and reported in a timely fashion.

f) Procurement of equipment and supplies from US or indigenous sources in accordance with budget and sub-grantee and/or recipient's needs.

g) Liaison with the USAID Population Office, Project Manager, other NGOs, PVOs, and Ministry officials active or interested in FP activities. A new stipulation will require the PAPFO Director to serve as a member of the Project Advisory Board.

h) Timely preparation and submission of reports as follows:

i) Quarterly implementation reports covering activities initiated or completed during the reporting period, a financial statement containing disbursements during the period, balance of funds in the budget, and projected expenditures and activities anticipated in the next reporting period. With the exception of the first, these are all new reporting requirements.

ii) Annual implementation plans (calendar year basis) covering planned project activities for the coming year, staffing plans, and annual budgets indicating local and U.S. currency requirements.

iii) A final report at the end of the Project summarizing and analyzing accomplishments, and recommending future directions for USAID assistance and any policy or domestic legal reforms for consideration by the host government.

Reporting requirements for the sub-grantee institutions conform to AID standards and are included in the sub-grant agreements.

2. <u>International Organization Recipient</u>

The grantee, PAHO, will be responsible for project management and achievement of project objectives in the public sector, and specifically for FP activities in the MSPP. These duties are described as follows:

a) administration, accounting, and reporting of project funds assigned to the public sector in accordance with USAID regulations concerning public international organizations grants.

b) maintenance of a resident advisor with support staff to assume full-time grant management responsibilities.

c) provision of coordination and management to assure that the project's public sector component objectives are met and the activities are planned, executed, and reported in a timely manner.

d) procurement of equipment and supplies in accordance with the budget and the recipient's needs.

e) liaison with the USAID Population Office, UNFPA, UNICEF, World Bank, IPPF/WHR, and Ministry officials active or interested in MCH/FP activities.

The grantee will prepare and submit in a timely manner the following reports:

a) Quarterly implementation report covering activities which were initiated or completed during the reporting period, a financial summary of expenditures incurred by line item, balance in the budget, and anticipated expenditures for the next reporting period. The quarterly report should include service statistics covering number of new acceptors by method, the number of continuing acceptors by method, and the number of CYP provided.

b) Final report at EOP summarizing and analysing accomplishments, recommendations on future directions for USAID assistance, and any policy or operational reforms for consideration by the host government.

3. Social Marketing Contractor

The CSM component will be implemented by The Futures Group's SOMARC Division through a Mission Buy-in to their centrally funded contract. This contract calls for SOMARC to be responsible for the supervision of a local CSM firm and development of a sales strategy including pricing, advertising, product selection, distribution, and detailing. The pharmaceutical firm, Commerce S.A, is the local sales agent. The following are the specific responsibilities of SOMARC:

a) Administration, accounting, and reporting of project funds assigned to this component in accordance with AID regulations pertaining to this activity.

b) Maintenance of a resident program manager to administer the CSM activities.

c) Provide technical assistance from internal sources when possible and, when not reasonable, to obtain consultants through sub-contracts.

d) Provide USAID, as requested, reports on market research, sales figures, and other pertinent data concerned with the distribution of contraceptives through the commercial sector. In addition, SOMARC shall provide USAID with detailed reports due at the end of each phase as follows: Phase I, March 1991; Phase II, February 1991; and Phase III, March 1992. These reports will detail the phase's planned activities and to what extent they were completed, any major decisions, problems, or developments during the phase, and a brief description of activities planned for the next phase.

4. USAID Monitoring Requirements

Due to its complexity and nature, the Mission is unable to support the expanded project with the current staffing pattern. An additional Personal Services Contractor (PSC) will be required to work as liason with PAHO and the MSPP. The USAID/Haiti Population Advisor will be Project Manager, assisted by this new PSC and a qualified FSN project assistant manager (a PSC).

The USAID staff will work closely with the representatives of the participating agencies and the responsible Haitian institutions implementing project activities. They will also oversee the work of technical advisors, both resident and expatriate, centrally funded project personnel, and short-term consultants to ensure the provisions of the various agreements are met.

5. Evaluation Plan

A third party evaluation team was utilized for the project's mid-term evaluation. With the expansion of the project's scope to include CSM and public sector participation, the evaluation terms of reference will expand to encompass team members with specialties in all project components. The final evaluation for the public sector and private sector components under the amendment will be conducted formally by outside, independent evaluators. The USAID project management will initiate the process through local contracts using AID Standard Contracting Regulations.

6. Audit Plan

IPPF/WHR, a U.S. PVO, as prime grantee is required to have audits conducted at least every other year on an organization wide-basis to include coverage of sub-grants and sub sub grants under OMB Circular A133. Within the CA grant budget, funds have been budgeted for annual audits under the sub-grant line item. Funds also have been budgeted under the project for a non-federal close-out audit in the event IPPF/WHR's A133 audits do not satisfy AID requirements or because of specific concerns. If a close out audit is deemed necessary the Regional Inspector General (RIG) will be responsible for supervising the audit. It will be conducted by a local CPA firm under contract with the Mission.

7. Implementation Schedule

A schedule for project implementation is shown in Table Seven. This schedule is illustrative in nature showing the activity, the action agent or agents, and date action should be taken.

D. Implementation Plan and Financing Methods

1. Financing Methods

AID/W Buy-ins will be used primarily to implement project components and procure goods and services not included in the CA and grant. Mission will finance these Buy-ins through Advice of Charge (AOC).

The methods of implementation and financing under the amended project are as follow:

- IPPF/WHR Cooperative Agreement ($5,096,000): USAID/Haiti will amend Cooperative Agreement No. 521-0189-A-60-6122-60 with IPPF/WHR to change the expiration date to June 30, 1992, to add funds and change the scope as appropriate to meet the amended project's objectives. The financing mechanism will continue to be through Letter of Credit. Sub-grants to the major PVOs will be made on the basis of periodic advances through the grantee.

- PAHO Grant ($1,000,000): USAID/Haiti will sign a grant with PAHO designating the organization as the executive/administrative agency to manage public sector FP planning and population activities.

- Social Marketing ($230,000): The Mission will add $30,000 to the AID/W Buy-in No. 936-3035.01 with TIPPS and $200,000 to the Buy-in with SOMARC.

TABLE SEVEN
PROJECT IMPLEMENTATION SCHEDULE

DATE	ACTION	ACTION AGENTS
06/28/90	Amendment Authorized	USAID
07/01/90	IEC Campaign Operational	IPPF
07/15/90	C.A with IPPF/WHR Amended	USAID/IPPF
07/15/90	Grant with PAHO signed	USAID/PAHO
09/31/90	Commodities for MSPP ordered	PAHO
09/31/90	Market Research Phase II (CSM)	SOMARC
02/15/91	Annual work plans (PVOs)	IPPF
03/01/91	Commodities in country	USAID
03/31/91	Sub-Grants to PVOs Appr.	IPPF/USAID
03/31/91	OR projects designed	POP Council/MSPP
03/31/91	Phase III CSM starts	SOMARC
04/01/91	MSPP Mobile units activated	MSPP/PAHO
05/15/91	Operation research activated	POP Council/ MSPP
06/01/91	New project development/begins	USAID
06/15/91	Commodities ordered	USAID
07/01/91	MSPP MIS systems installed	PAHO/MSPP
08/01/91	Final report on NORPLANT research	FHI
09/01/91	Contraceptive projections for 92-93	PROFAMIL/USAID/TA
10/15/91	New project paper completed	USAID
11/01/91	second commodity order in-country	USAID
11/01/91	Arrangements for final evaluation	USAID/PAHO/IPPF
01/01/92	RFP on CA published	USAID
01/01/92	Contraceptive orders placed	USAID
04/01/92	CA recipient selected	USAID
05/01/92	Final evaluation	USAID
06/30/92	PACD	USAID/PAHO/IPPF
07/01/92	New Project start	

o Evaluation ($80,000): The Mission will sign a local contract for the final evaluation.

o Audit ($80,000): As with the evaluation, the Mission will sign a local contract for the final audit.

o USAID Population Advisors ($386,000): USAID will secure the services of three qualified staff members to monitor the project through PSCs.

o Population Policy ($200,000): The Mission will put $200,000 into a Buy-in with the new OPTIONS II Project which will begin October 1, 1990. This will be a continuation of the work done during the first amendment through a Buy-in under CA No. DPE-3035-C-00-6062-00.

o Research ($300,000): The Mission will put $100,000 toward a Buy-in under AID/W contract DPE-C-4074 with the Population Council to fund operations research on CBD. Another $200,000 will be added to continue pre-implementation NORPLANT research trials with FHI under AID/W contract DPE-CA-4047-00.

o Contraceptives ($466,000): Contraceptives will be centrally purchased through S&T POP.

o International Training ($300,000): The Mission will Buy-in to OIT's contract for international training and education for short term international training for project participants in the private and public sectors.

Table Eight summarizes the methods of implementation and financing under the amendment.

2. Commodity Procurement Plan

a) Procurement Under the CA:

o Vehicles: IPPF/WHR will procure 3 additional vehicles (for a total of 21 vehicles).

o Clinic Supplies: Clinic supplies and equipment will be procured; source and origin will be AID. Geographic Code 000 or Haiti.

b) Procurement Under the PAHO Grant: Procurement of commodities will be accomplished by PAHO according to AID regulations outlined in Handbook 13, Page 5-4.

o Vehicles: PAHO will procure 7 vehicles and 2 motorcycles.

TABLE EIGHT
METHODS OF IMPLEMENTATION AND FINANCING

Description of Project Elements	Method of Implementation	Method of Financing	Auth. To Date	Present Amend.	Amount (000)
Technical/Management/ Administration of Private Sector (IPPF)	Cooperative Agreement (CA)	LOC	6,222	5,096	11,318
Technical/Management/ Administration of Public Sector (PAHO)	Grant (HB 13)	LOC		1,000	1,000
Social Marketing (SOMARC)	Buy-in AID/W centrally funded CA	Advice of Charge	246	200	446
Contraceptive Procurement	Centrally purchased AID/W contract	Advice of Charge.	1,128	466	1,594
Project Monitoring (3 staff members)	PSCs	Direct Payment	180	386	566
Population Policy (OPTIONS)	Buy-in AID/W centrally funded CA	Advice of Charge.	100	200	300
Out of Country Training	Buy-in OIT's PIET contract	Advice of Charge	90	300	390
Social Marketing (TIPPS)	Buy-in AID/W centrally funded CA	Advice of Charge	50	30	80
NORPLANT Research (FHI)	Buy-in AID/W centrally funded CA	Advice of Charge	234	200	434
Operations Research	Buy-in AID/W centrally funded CA	Advice of Charge		100	100
Evaluation					
Private Sector	Local Contract	Direct Payment		50	50
Public Sector	Local Contract	Direct Payment		30	30
Audit	Local Contract	Direct Payment		80	80

o Clinic Supplies: PAHO will procure clinic supplies and equipment for use in 21 MSPP facilities and 7 mobile units.

o Office Equipment: Approximately 50 calculators, 5 typewriters, 1 computer, and 1 printer will be procured.

3. Revenue Generation Guidelines

As mentioned in Section III, the proposed amendment will pilot several efforts aimed at sustainablity which will charge small fees for contraceptives and services. USAID, PAHO and IPPF/WHR will thus develop revenue generation guidelines for the project. These guidelines will conform to standard USAID provisions which state that: "All program income earned during the project period shall be retained by the recipient and in accordance with the grant or other agreement, shall be added to funds committed to the project by federal sponsoring agency and recipient organization and be used to further eligible program objectives in accordance with a plan and budget approved by USAID in writing."

4. Financial Plan and Project Budget

The total cost of activities to be financed from July 1, 1990 to June 30, 1992 is $13,398,000, of which USAID will contribute $8,138,000. The IPPF/WHR support grant to PROFAMIL for this period is $268,000. The GOH's contribution using PL-480 proceeds is $592,000. The World Bank and UNFPA will each contribute $2,000,0000 and $2,400,000, respectively. Table Nine gives total project costs for this period with breakdown by donor and foreign exchange and local currency needs.

a) Obligation Schedule

The project will be authorized with a funding amendment of $8.138 million, to be obligated based on the availability of funds. The CA amendment and the grant will also be funded on the same basis. In the case of the CA, it will be necessary to obligate additional funds in FY 90. The FY 91 obligations should be sufficient to maintain adequate resources to reach the PACD.

The other components, ie. the public sector can be forward funded in FY 91 to allow for the period of implementation in FY92. Based on agreement with the GOH, PL-480 generated funds will be used for local currency costs.

a) Budget Tables

Table Nine lists project costs from July 1, 1990 to June 30, 1992 by donor and foreign exchange and local currency needs.

Table Ten outlines the USAID contribution in terms of additional funding requirements by project component. Additional tables detailing the budgets of the IPPF/WHR sub-grantees may be found in Annex C. These budgets are illustrative showing programming under the amendment of the D.A. funds which are expected to be available. Annex C also contains a budget for the grant to PAHO. Estimates for other project components contained in Table Ten are based on historical costs in this project as follows:

o Social Marketing ($200,000): This element was costed based on present monthly actuals, approximately $10,000, for 18 months (present funding level should be expended by December, 1990), plus 10 percent for inflation.

o TIPPS ($30,000): This estimate is based on actual direct and indirect costs for similar activities, e.g $13,720 for labor and labor overhead, $6,925 for travel, transportation, and per diem, $2,500 for information dissemination.

o Contraceptives ($466,000): Based on past usage rates and estimates of new acceptors, it was calculated that the project needs 180,000 units of Lo Femenal at $.13 per unit; 235,200 units of Ovrette at $.13 per unit; and 6,000,000 condoms at $.045 per unit. A 15 percent inflation rate on unit price was added to this total, plus 6 percent for handling fees and 15 percent for shipping.

o Population Policy ($200,000): This Buy-in estimate was calculated from the actual expenditure rate of the present Buy-In, approximately $6,000 per month, plus a $2,000 per month increase for expanded activities due to resumption of work with the public sector.

o International Training ($300,000): This is calculated from project data documenting conference/meeting costs at approximately $2,000 per participant, short term training of three to six weeks costs from $10,000 to $15,000 per participant, and long term training costs at approximately $50,000 per participant for an advanced two year degree. It was further calculated that the project would send approximately 20 participants to conferences and seminars, thirteen for short term training, and two for advanced degrees.

o Population Advisors ($386,000): This estimate was calculated based on project actuals for one off-shore and one national PSC in managerial positions and one national PSC in a support position, plus projected costs for one more off-shore managerial PSC.

o Operations Research ($100,000): This element was costed based on estimates of the need for $40,000 for labor and labor overhead (e.g. 100 days of technical assistance at $250 day and 150 days at $100 per day); $22,000 for travel, transportation, and per diem, (e.g. 12 round trip air fares at $600 each); $8,000 for other direct costs such as communications and reproduction; and the remainder for general and administrative costs, fees, and contingency.

o Norplant ($200,000): This element was costed based on present monthly actuals, approximately $9,000, for 19 months (present funding level should be expended by November, 1990), plus 10 percent for inflation.

Table Eleven lists USAID Funding requirements by fiscal year.

TABLE NINE
PROJECT COSTS FROM JULY 1, 1990 TO JUNE 30, 1992 BY DONOR
AND FOREIGN EXHANGE (EX) AND LOCAL CURRENCY (LC) NEEDS
(000)

	AID GRANT FX :	LC	USAID TOTAL	OTHER DONOR	PL-480	TOTAL
I. TECHNICAL ASSISTANCE						
IPPF/WHR	1171	2843	4014	67		4081
PAHO	130		130	1100		1230
TIPPS	8		8			8
SOMARC	50		50			50
OPTIONS	50		50			50
FHI	50		50			50
OP. RESEARCH	25		25			25
POP. ADVISORS	386		386			386
SUBTOTAL	1870	2843	4713	1167	0	5880
II. TRAINING						
IPPF/WHR	171	482	653	67		720
PAHO	620		620	1100	339	2059
TIPPS	22		22			22
SOMARC	150		150			150
OPTIONS	150		150			150
FHI	150		150			150
OP. RESEARCH	75		75			75
INTERNAT. TRAVEL	300		300			300
SUBTOTAL	1638	482	2120	1167	339	3626
						0
III. COMMODITIES						0
IPPF/WHR	107	203	310	67		377
PAHO	150		150	1100	63	1313
CONTRACEPTIVES	466		466			466
SUBTOTAL	723	203	926	1167	63	2156
						0
IV. OTHER COSTS						0
IPPF/WHR	58	61	119	67		186
PAHO/MSPP	100		100	1100	190	1390
EVALUATION	80		80			80
AUDIT	80		80			80
SUBTOTAL	318	61	379	1167	190	1736
TOTAL PROJECT COSTS	4549	3589	8138	4668	592	13398

TABLE TEN
ADDITIONAL USAID FUNDING REQUIREMENTS
BUDGET SUMMARY (000)

	AUTHORIZED TO DATE	THIS AMENDMENT	TOTAL
I. IPPF COOP. AGRMT.			
WHR	1937	1326	3263
PAPFO	260	637	897
AOPS	678	774	1452
PROFAMIL	770	727	1497
CHI	498	182	680
INHSAC	498	345	843
CDS	74	92	166
CPFO		60	60
FOSREF	306	158	464
PIGNON	115	220	335
DASH	106	123	229
SRS. DE SAGESSE	49	111	160
AOPS/VSC	266	341	607
OTHER SUBGRANTS	465		465
MD NETWORK	100		100
FP SURVEY	100		100
SUBTOTAL	6222	5096	11318
II. SOCIAL MARKETING			
SOMARC	246	200	446
TIPPS**		30	30
SUBTOTAL	246	230	476
III. INTERNAT. ORG. GRANT			
PAHO		130	130
PAHO/MSPP		870	870
SUBTOTAL		1000	1000
IV. OTHER ELEMENTS			
CONTRACEPTIVES	1128	466	1594
POP. POLICY	100	200	300
INT. TRAINING	90	300	390
AUDIT***		80	80
EVALUATION***		80	80
POP. ADVISORS	180	386	566
OP. RESEARCH		100	100
NORPLANT	234	200	434
WORKERS CENTER-CPFO	50		50
SUBTOTAL	1782	1812	3594
TOTAL	8250	8138	16388

TABLE ELEVEN
USAID FUNDING REQUIREMENTS
BY FISCAL YEAR (000)

	FY90	FY91	FY92	TOTAL
IPPF/WHR	1600	2328	1168	5096
PAHO/MSPP	200	528	272	1000
SOMARC		175	25	200
TIPPS	30			30
CONTRACEPTIVES		466		466
OPTIONS II		150	50	200
INTERNAT. TRAININ	50	150	100	300
AUDIT			80	80
EVALUATION			80	80
POP. ADVISORS	80	206	100	386
OP. RESEARCH		70	30	100
FHI		150	50	200
TOTALS	1960	4223	1955	8138

V. ANALYSES

The original Social Analysis and Institutional Analysis of the PVOs as included in the PSFP Project Paper and the Amended Initial Environmental Examination included in the PSFP First Amendment remain valid for this amendment. Annex C contains an Institutional Analysis of the MSPP.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

ANNEX A

Life of Project:
From FY to FY
Total U.S. Funding $

Date Prepared

Project Title & Number: Private Sector Family Planning (521-0189) Amendment No. 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal:	Measures of Goal Achievement:		Assumptions for achieving goal targets:
To reduce the population growth rate in Haiti.	Fertility rate declines	National Census Fertility Surveys	Political conditions offer sufficient stability to implement project.
	16 % of MWRA using contraception nationally.	Contraceptive Prevalence Survey.	GOH will continue to support FP promotion.
Project Purpose:	Conditions that will indicate purpose has been achieved End-of-Project Status.		Assumptions for achieving purpose:
To increase the availability and effectiveness of Family Planning Service delivery.	40 PVOs providing basic or improved FP services. 21 MSPP facilities offering VSC services.	Project Evaluation Quarterly Reports Service Statistics	PVOs and MSPP have capacity to implement project activities.
	Contraceptives being marketed at 200 commercial sales points.		Haitian public, especially rural population can be motivated to purchase/ accept contraceptive materials on continuing basis.
	Haitians better informed about FP issues and service.	Knowledge, Attitude, and Practice survey	
Outputs:	Magnitude of Outputs:		Assumption for achieving Outputs:
1) Improved capability of project institutions to attract and retain FP users. attract and retain FP users.	102,000 New Acceptors 70 percent user retention rate Major public sector FP donor coordinating committee functional.	Service Statistics Quarterly Reports Project Records Project Evaluation Site Visits	Economic, nutritional and environmental pressures coupled with growing AIDS concern, will encourage public acceptance of FP Programs.
2) Expanded institutional capacity of project assisted agencies to plan and deliver Fp services.	PROFAMIL providing contraceptive support to 40 PVOs AOPS managing all sub-grants.		Research will be presented in a form adaptable for practical use.
3) Expanded FP Service coverage and contraceptive method mix.	GOH has established research/ evaluation capacity.		The Government of Haiti will successfully encourage the Haitian public, especially the rural population, to support the national Family Planning Strategy.
4) Research results applied to improve FP delivery.	Reduced PVO administrative costs per CYP.		
5) National IEC strategy formulated and implemented.	INHSAC has capability to provide FP training and IEC materials. CSM Phase II strategy developed. Two PVOs have signed fee-for-service agreements with 10 private companies. 3,000 beneficiaries being served by CBD. CSM has trained 300 pharmacy staff. 4 operations research projects to test new CBD approaches developed. NFP added to MSPP method mix. Inter-sectoral IEC training team operational. INSHAC has trained 317 PVO and 370 MSPP staff. IEC training manual developed and distributed. Multi-media campaign launched. NORPLANT Research finalized and method launched nationally. 6 Mini-prevalence surveys completed.		
Project Inputs:	Implementation Target (Type and Quantity		Assumptions for providing inputs:
Technical assistance	$4,697,000	Evaluations and audits on annual basis to fund planned Grantee and Contractor records and quarterly reports.	Adequate incremental funding available activities.
Training	2,072,000		
Commodities	460,000	MSPP records and reports.	PVOs will provide suitable personnel to staff project activities
Contraceptives	466,000	Project training records.	Contraceptive materials will be made available countrywide on a regular basis at affordable prices.

IPPF-WHR

PAPFO

FEDERATION INTERNATIONALE DE PLANIFICATION FAMILIALE, REGION DE L'HEMISPHERE OCCIDENTALE, INC.
MAIL: IPPF/WHR HAITI FIELD OFFICE - PAP/MAF - P. O. BOX 407103 - FT. LAUDERDALE, FL 33340
SIEGE LOCAL: IPPF-WHR/PAPFO - ANGLE RUES RIGAUD & FAUBERT No. 16 - PETION-VILLE, HAITI
Tél.: 7-1103
7-2312
Fax: 7-2314

May 21, 1990

Mr. David Eckerson
Chief of Section for
Population,Nutrition and Health
USAID/Haiti/HRO

RE: Request for Additional Funding and Project Extension: Cooperative Agreement No. 521-0189

Dear David,

On behalf of IPPF/WHR I would like to formally request an extension of the Private Sector Family Planning Project until June 30, 1992 and an appropriate increase in the funding authorization, as described in the attached summary budget, under our Cooperative Agreement (No. 521-0189) with USAID.

This request is the result of a series of ongoing discussions and working sessions between both our organizations and, I believe, addresses the major concerns raised by each. You will find attached, in addition to the budget itself, a list of assumptions on which the planning figures are based. I think it worth while to highlight the fact that the level of funding shown was intentionally limited based on a figure provided by your office and does <u>not</u> indicate the level of funding that would be required to maintain all project activities at their currently approved levels. To stay within the budgetary limit a reduction of approximately 13% in project spending will be required between October 1, 1990 and June 30, 1992.

"ORGANISME A BUT NON LUCRATIF"

Saeed Meckbel, *President* • Jill Sheffield, *Chairman, Board of Directors* •
T.M. Roulston, *Vice-President* • Fernando Tamayo, *Vice President* • Jorge Rib *Secretary* • Frederick Smith, *Treasurer* •
Herman Sanhueza, Regional Director

62

We have discussed, in the past, a number of possibilities for reducing project activities in order to keep spending within the prescribed limits. The budget summary presented in this request is neither an indication of IPPF/WHR's position on the appropriate strategy for achieving this reduction, nor a commitment to fund each institution at the levels shown. Our analyses indicate that required cost savings can be obtained, after the application of routine cost cutting measures, by eliminating marginal performers and secondary (to project outputs) institutions or by shortening the project by a full calendar quarter. We anticipate that the most appropriate of these measures (or a combination there of) will emerge from our continuing dialogue and ongoing assessment of institutional performance and actual project expenditures.

Please do not hesitate to contact IPPF/PAPFO should you have any questions regarding this request. I look forward to your reply and a continued open collaboration with your office.

Sincerely,

Dr. Rudolph Magloire
Project Manager

cc. Andrew Haviland
Marie France Semmelbeck
Francisco Di Blasi

63

Amendment to Extend PSFPP

Cooperative Agreement No. 521-0189

Appendix to Amendment Budgets
Assumptions for Indicative Planning Figures

The budgets developed for this amendment to extend the Private Sector Family Planning Project (PSFPP) completion date until June 30, 1992 are based on the set of assumptions listed below. Any changes in the facts or circumstances which currently support these assumptions may result in a funding shortfall. This is especially true, for example, with regard to the return of any gains on gourde/US dollar exchanges to the project as a counter balance to inflation. It must also be noted that the amounts budgeted per institution and per line item, while based on past observed expenses, are indicative figures for planning purposes only. Changes in the allocation of available resources will be reviewed each year in the work plan/budget process.

1. The present funding obligation and authorization will be exhausted, at the current spending rate, as of September 30, 1990. Additional funding is needed, therefore, to reach the current project completion date of March 31, 1991 and to cover the extension until June 30, 1992. Funding is thus needed for a period of 21 months covering the period October 1, 1990 through June 30, 1992.

2. Funding at the 1990 approved budget levels, minus major capital expenditures, will be needed to support the current level of family planning activities and institutional development. Accordingly, the amendment budgets are based on 1990 budgeted amounts for each institution, with the following exceptions:

   a.) All sub-sub-grantees have been placed under AOPS (PROFAMIL sub-grantees transferred to AOPS as per the Mid-Term Evaluation proposal) except for two institutions that are programed under the VSC activity. Sub-sub-grantees have been programmed for 18 months, instead of 21, to account for advanced funds in the pipeline.

   b.) The CPFO grant was reduced to family planning services and appropriate IEC without the major subvention for institutional development as previously provided.

64

c.) PL 480 institutions have been placed under the Cooperative Agreement as of October 1, 1990 as there is no indication that PL 480 funding will continue after this fiscal year.

d.) Audit costs are now a direct cost for IPPF/WHR and local audit costs have been doubled over past observed expenditures. Both of these changes are required in order to comply with OMB circular A-133.

3. Foreign currency costs (ie. US expenditures) will not increase due to inflation more than the 7% over 1990 levels provided for in the indicative planning figures.

4. Local currency costs will be financed at an exchange rate of 6 gourdes to 1 US dollar (6:1) and any additional gains on exchange will remain in the project to cover anticipated inflation at the local level. No other provisions to offset inflation have been built into the budget such as an across the board percentage increase on local cost. (NOTE: An action such as that would be immaterial given the following assumption.)

5. Total available additional funding to meet the current project completion date and to finance the extension until June 30, 1992 is limited to the total US Dollar figure shown in the indicative budgets. In order to reduce anticipated project expenditures to this level an overall reduction of 13% has been applied, except in the following areas:

-Capital expenditures (equipment, etc..) which are already minimal

-Annual mandatory audits required under OMB circular A-133

-Close of project evaluation

This reduction can be achieved through routine cost cutting measures and by eliminating funding to marginal performers and institutions that are secondary to project outputs or by shortening the length of the project by three months. Since the appropriate strategy will be selected in the annual budgeting process, the summary budgets presented in this amendment for individual institutions are not a commitment of continued funding under the PSFPP.

Extension Amendment for the Private Sector Family Planning Project — Budget Projections by Institution
Cooperative Agreement No. 531-0197 — Budget Periods: October 1, 1990 through June 30, 1992

Line Item	IPPF/WHR NY	IPPF/WHR PAPFO	ADPS	PROFAMILIA	INPRESAO	CMI	CDS	CPFG	CTPP	PROMEN	PCCPSP	Ecuador de la Familia	USD	CONVERTED TO US DOLLARS	CONVERTED TO US$ NEEDS
++FOREIGN EXCHANGE(Fx)++															
Consultants															
Vehicles			23,000		20,000										
Clinic Equipment							5,250							40,500	40,000
Office Equipment	4,500	5,000	8,750	8,750	8,750	3,500		1,750	3,700	27,750			50,000	92,000	92,000
Training (US)	1,550	10,527												44,730	44,780
Travel, International	157,811	3,075	5,135	7,513	3,445	3,205								18,477	18,477
Technical Assistance, Intl	138,485													184,485	184,485
U.S. Trst. Costs														138,485	138,485
Salary/Benefits	500,154														
Overhead/other	-24,822													500,154	500,154
Audit	40,000													424,332	424,332
Evaluation	60,000													40,000	40,000
														60,000	60,000
++ SUB-TOTAL FX +	1,325,635	18,602	37,285	16,263	31,795	7,205	5,250	1,750	3,700	27,750	0	0	50,000	1,536,137	1,536,137
++LOCAL CURRENCY(LC)++															
Construction/Renovation		13,050			21,750					34,256				69,056	11,509
Salaries/Benefits		1,827,000	1,455,792	2,622,589	1,255,599	699,055	405,761	251,213	465,855	757,949	253,464	253,825	1,078,217	11,775,039	1,962,822
Rent/Utilities		223,046		285,936	139,499	31,211		34,256	36,540	30,453	103,451		125,280	1,006,934	167,914
Training/IEC		242,583	228,375	380,625	152,256	25,644	26,244	34,256	34,256	60,901	41,867		18,270	1,346,455	224,442
Local Workshops			194,850											194,980	32,480
Local Transport/PerDiem		52,118	172,853	98,763	42,440	72,471		3,616	9,125	15,225		195,750	20,830	693,456	116,409
Gas/Vehicle Maint/Ins.		147,530	133,980	155,295	91,350	60,900			64,959	159,863	49,481			863,258	142,876
Sub-Grants to PVO's			1,959,005											2,073,819	345,637
Supplies(Office/Clinic)		230,963	65,742	377,276	46,360	57,474	39,063	24,170	54,610	32,239	87,544	130,500	261,000	1,396,733	232,790
Gp Research/Surveys		609,000												609,000	101,500
Acceptor Clubs			76,125											76,125	12,688
Physician Network				195,603										195,603	32,601
Annual External Audit			87,500	87,500	57,500	87,500	52,500	26,250	43,750	43,750	43,750	45,000	36,000	641,000	106,833
Evaluation														0	0
Technical Assistance		223,375												223,375	37,229
Misc Operating Exp.		29,308	20,450	60,900	15,225	15,225			3,806	7,613	3,806		16,910	182,243	30,541
++ SUB-TOTAL LC +	0	3,712,553	4,418,797	4,264,516	1,822,163	1,050,481	522,968	373,761	713,341	1,142,842	950,395	654,375	1,662,371	21,359,177	3,559,862
TOTAL FX and LC														5,095,000	

NOTE: Foreign currency amounts are displayed in US Dollars. Local currency amounts are displayed in Sources
Actual US Dollars needed to finance the local currency costs are calculated at 6 sources to 1 US dollar as shown in the column "CONVERTED TO US$ NEEDS"
Drafted MAY 10, 1990

Extension Amendment for the Private Sector Family Planning Project — Budget Projections by Institution
Cooperative Agreement No. 521-0139 — Budget Periods: October 1, 1991 through June 30, 1995

Line Item	IPPF/WHR NY	IPPF/WHR PAFFO	ADSS	FPCFAMIL	INMASC	CMI	CDE	CPFG	DPSM	FIRMOM	FORMEF	Grant to USG Expense Activity	USG	TOTALS	CONVERTED TO US$ NEEDS
FOREIGN EXCHANGE(FX)															
Capitalization:															
Vehicles			20,000		20,000									40,000	40,000
Clinic Equipment							5,550			27,750			60,000	93,000	93,000
Office Equipment	4,500	3,000	3,750	8,750	8,750	3,500		1,750	3,700					44,700	44,700
Training (US)	1,550	10,825												12,475	12,475
Travel, International	157,911	3,750	9,135	7,613	3,045	3,045								184,485	184,485
Technical Assistance, Intl	126,436													126,436	126,436
U.S. Dist. Costs															
Salary/Benefits	500,154													500,154	500,154
Overhead/other	424,236													424,836	424,836
Audit	40,000													40,000	40,000
Evaluation	60,000													60,000	60,000
SUB-TOTAL FX	1,325,636	18,725	37,885	16,363	31,795	7,334	5,550	1,750	3,700	27,750	0	0	60,000	1,536,137	1,536,137
LOCAL CURRENCY(LC)															
Construction/Renovation		2,610			4,350					6,511				13,811	11,509
Salaries/Benefits		345,400	291,159	524,536	257,120	139,911	61,152	50,243	93,177	153,590	124,693	59,725	215,643	2,355,213	1,962,612
Rent/Utilities		44,609		57,135	27,938	6,242		6,351	7,536	6,693	20,077		35,056	201,377	167,814
Training/IEC		58,513	45,675	76,125	30,450	5,329	5,329	6,251	6,251	12,180	6,374		3,654	269,330	224,442
Local Workshops			33,776											38,776	32,480
Local Transport/PerDiem		12,424	35,572	19,793	8,458	14,474		723	1,627	3,045		37,150	4,176	137,691	116,409
Gas/Vehicle Maint/Ins.		29,506	26,756	31,059	18,270	12,180			12,972	31,973	9,876			172,652	143,876
Sub-Grants to PVO's			393,601										21,153	414,754	345,628
Supplies(Office/Clinic)		46,193	13,149	75,455	9,272	11,495	7,612	4,534	10,962	4,566	17,509	26,103	52,200	279,348	232,790
Op Research/Surveys		121,860												121,860	101,500
Acceptor Clubs			15,225											15,225	12,688
Physician Network				39,121										39,121	32,601
Annual External Audit			17,500	17,500	17,500	17,500	10,500	5,250	8,750	8,750	8,750	9,000	7,200	128,200	106,833
Evaluation														0	0
Technical Assistance		45,675												45,675	38,063
Misc Operating Exp.		5,822	6,990	12,130	3,045	3,045		761	1,523	761			3,382	36,649	30,541
SUB-TOTAL LC	0	742,571	983,741	852,923	376,432	210,056	104,594	74,752	148,608	222,568	170,080	132,975	317,474	4,271,825	3,559,854
TOTAL FX and LC	1,325,636	761,296	921,626	869,286	408,228	217,403	109,344	76,502	146,308	256,319	190,050	132,975	378,474	5,807,963	5,096,000

NOTE: All amounts are displayed in US Dollars. Local currency costs are budgeted and shown at the official exchange rate of 5 gourdes to 1 US dollar (5:1).
Actual US Dollars needed to finance the local currency costs are calculated at 6 gourdes to 1 US dollar as shown in the column "CONVERTED TO US$ NEEDS"
Drafted MAY 10, 1990

Extension Amendment for the Private Sector Family Planning Project
Cooperative Agreement No. 521-0189
Budget Period: October 1, 1990 through June 30, 1992

SUMMARY BUDGET BY INSTITUTION

Line Item	IPPF/WHR NY	IPPF/WHR PAFFO	ADPS	PROFAMIL	*TOTALS*	CONVERTED TO US$ NEEDS
FOREIGN EXCHANGE(FX)						
Commodities						
Vehicles			20,000		20,000	20,000
Clinic Equipment					0	0
Office Equipment	4,500	5,000	8,750	8,750	27,000	27,000
Training (US)	1,850	10,627			12,477	12,477
Travel, International	157,311	3,075	9,135	7,613	177,634	177,634
Technical Assistance,Int'l	136,486				136,486	136,486
U.S. Inst. Costs					0	
Salary/Benefits	500,154				500,154	500,154
Overhead/other	424,836				424,836	424,836
Audit	40,000				40,000	40,000
Evaluation	60,000				60,000	60,000
* SUB-TOTAL FX *	1,325,636	18,702	37,885	16,363	1,398,586	1,398,586
LOCAL CURRENCY(LC)						
Construction/Renovation		13,050			13,050	2,175
Salaries/Benefits		1,827,000	1,455,792	2,622,529	5,905,321	984,220
Rent/Utilities		223,046		285,926	508,972	84,829
Training/ISC		342,563	223,375	380,625	951,563	158,594
Local Workshops			194,880		194,880	32,480
Local Transport/PerDiem		62,118	177,858	98,963	338,939	56,490
Gas/Vehicle Maint/Ins.		147,530	133,980	155,295	436,805	72,801
Sub-Grants to PVO's			1,968,005		1,968,005	328,000
Supplies(Office/Clinic)		230,963	65,742	377,276	673,980	112,330
Op Research/Surveys		609,000			609,000	101,500
Acceptor Clubs			76,125		76,125	12,688
Physician Network				195,603	195,603	32,601
Annual External Audit			87,500	87,500	175,000	29,167
Evaluation					0	0
Technical Assistance		228,375			228,375	38,063
Misc Operating Exp.		29,308	30,450	60,900	120,658	20,110
* SUB-TOTAL LC *	0	3,712,953	4,418,707	4,264,616	12,396,276	2,066,046
TOTAL FX and LC						3,464,632

NOTE: Foreign currency amounts are displayed in US Dollars. Local currency amounts are displayed in Gourdes. Actual US Dollars needed to finance the local currency costs are calculated at 6 gourdes to 1 US dollar as shown in the colum "CONVERTED TO US$ NEEDS".

Extension Amendment for the Private Sector Family Planning Project
Cooperative Agreement No. 521-0189
Budget Period: October 1, 1990 through June 30, 1992

SUMMARY BUDGET BY INSTITUTION

Line Item	INNSAC	CHI	CDS	CFFD	*TOTALS*	CONVERTED TO US$ NEEDS
FOREIGN EXCHANGE(FX)						
Commodities:						
Vehicles	20,000				20,000	20,000
Clinic Equipment			5,250		5,250	5,250
Office Equipment	8,750	3,500		1,750	14,000	14,000
Training (US)					0	0
Travel, International	3,045	3,806			6,851	6,851
Technical Assistance,Int					0	0
U.S. Inst. Costs						
Salary/Benefits					0	0
Overhead/other					0	0
Audit					0	0
Evaluation					0	0
* SUB-TOTAL FX *	31,795	7,306	5,250	1,750	46,101	46,101
LOCAL CURRENCY(LC)						
Construction/Renovation	21,750				21,750	3,625
Salaries/Benefits	1,235,599	697,056	405,731	251,213	2,641,629	440,271
Rent/Utilities	139,689	31,211		24,256	205,157	34,193
Training/IEC	152,250	26,644	26,644	34,256	239,794	39,966
Local Workshops					0	0
Local Transport/Per Diem	42,440	72,471		3,616	118,527	19,754
Gas/Vehicle Maint/Ins.	91,350	60,900			152,250	25,375
Sub-Grants to PVO's					0	0
Supplies(Office/Clinic)	46,360	57,474	38,063	24,170	166,067	27,678
Op Research/Surveys					0	0
Accector Clinics					0	0
Physician Network					0	0
Annual External Audit	87,500	87,500	52,500	26,250	253,750	42,292
Evaluation					0	0
Technical Assistance					0	0
Misc Operating Exp.	15,225	15,225			30,450	5,075
* SUB-TOTAL LC *	1,882,163	1,050,481	522,988	373,761	3,829,373	638,229
TOTAL FX and LC						684,330

NOTE: Foreign currency amounts are displayed in US Dollars. Local currency amounts are displayed in Gourdes. Actual US Dollars needed to finance the local currency costs are calculated at 6 gourdes to 1 US dollar as shown in the column "CONVERTED TO US$ NEEDS".

Extension Amendment for the Private Sector Family Planning Project
Cooperative Agreement No. 521-0189
Budget Period: October 1,1990 through June 30, 1992

SUMMARY BUDGET BY INSTITUTION

Line Item	DASH	PIGNON	FOSREF	Soeur de la Sagesse	VSC ACTIVITY	*TOTALS*	CONVERTED TO US$ NEEDED
FOREIGN EXCHANGE(FX)							
Commodities:							
Vehicles							
Clinic Equipment		27,750				0	0
Office Equipment	3,700				60,000	87,750	87,750
Training (US)						3,700	3,700
Travel, International						0	0
Technical Assistance,Intl						0	0
U.S. Inst. Costs						0	0
Salary/Benefits							
Overhead/other						0	0
Audit						0	0
Evaluation						0	0
* SUB-TOTAL FX *	3,700	27,750	0	0	60,000	91,450	91,450
LOCAL CURRENCY(LC)							
Construction/Renovation		34,256				34,256	5,707
Salaries/Benefits	455,885	767,949	623,464	293,625	1,078,217	3,229,140	535,190
Rent/Utilities	36,540	30,450	100,495		125,280	292,755	48,793
Training/IEC	34,256	60,900	41,869		18,270	155,295	25,883
Local Workshops						0	0
Local Transport/PerDiem	9,135	15,225		195,750	20,850	240,960	40,160
Gas/Vehicle Maint/Ins.	64,859	159,863	49,491			274,203	45,700
Sub-Grants to PVO's					105,814	105,814	17,636
Supplies(Office/Clinic)	54,810	22,828	37,544	130,500	251,000	356,591	59,432
Op Research/Surveys						0	0
Acceptor Clubs						0	0
Physician Network						0	0
Annual External Audit	42,750	42,750	43,750	45,000	36,000	212,250	35,375
Evaluation							
Technical Assistance						0	0
Misc Operating Exp.	3,806	7,613	3,806		14,910	32,135	5,356
* SUB-TOTAL LC *	713,041	1,142,843	950,399	664,875	1,660,371	5,133,528	855,588
TOTAL FX and LC							947,038

NOTE: Foreign currency amounts are displayed in US Dollars. Local currency amounts are displayed in Gourdes. Actual US Dollars needed to finance the local currency costs are calculated at 6 gourdes to 1 US dollar as shown in the column "CONVERTED TO US$ NEEDS".

Extension Amendment for the Private Sector Family Planning Project
Cooperative Agreement No. 521-0187
Budget Period: October 1, 1990 through June 30, 1992

SUMMARY BUDGET TOTALS

Line Item	*TOTALS*	CONVERTED TO US$ NEEDS
FOREIGN EXCHANGE(FX)		
Commodities:		
Vehicles	40,000	40,000
Clinic Equipment	93,000	93,000
Office Equipment	44,700	44,700
Training (US)	12,477	12,477
Travel, International	184,485	184,485
Technical Assistance,Int	136,485	136,485
U.S. Inst. Costs		
Salary/Benefits	500,154	500,154
Overhead/other	424,836	424,836
Audit	40,000	40,000
Evaluation	60,000	60,000
* SUB-TOTAL FX *	1,536,137	1,536,137
LOCAL CURRENCY(LC)		
Construction/Renovation	50,054	11,014
Salaries/Benefits	11,776,067	1,942,409
Rent/Utilities	1,006,284	167,614
Training/IEC	1,345,651	224,442
Local Workshops	194,860	32,430
Local Transport/PerDiem	698,456	116,409
Gas/Vehicle Maint/Ins.	863,259	143,876
Sub-Grants to PVO's	2,073,815	345,637
Supplies(Office/Clinic)	1,336,739	222,790
Op Research/Surveys	609,000	101,500
Acceptor Clubs	76,125	12,688
Physician Network	195,405	32,601
Annual External Audit	641,000	106,833
Evaluation	0	0
Technical Assistance	223,375	37,063
Misc Operating Exp.	183,243	30,541
* SUB-TOTAL LC *	21,359,177	3,559,863
TOTAL FX and LC		5,096,000

NOTE: Foreign currency amounts are displayed in US Dollars. Local currency amounts are displayed in Gourdes. Actual US Dollars needed to finance the local currency costs are calculated at 6 gourdes to 1 US dollar as shown in the column "CONVERTED TO US$ NEEDS".

* SEE APPENDIX TO AMENDMENT BUDGETS FOR BUDGETING ASSUMPTIONS

SUMMARY BUDGET: PAGE 4

ILLUSTRATIVE BUDGET FOR GRANT TO THE PAHO

IN SUPPORT OF FAMILY PLANNING PROGRAMS OF THE MSPP

COMMODITIES		
Vehicles		
4 WD Drive Jeeps (7)	$140,000	
Motorcycles 350 cc (2)	$9,000	
Clinic Supplies /a	$105,000	
Office Equipment /b	$25,000	
Office Supplies	$15,000	
A/V Equipment	$20,000	$314,000
SERVICES		
IEC M[illegible]ials Design	$30,000	
Printi[illegible]sts	$70,000	
Radio [illegible]nsmissions		
Port-a[illegible]nce stations	$56,000	
Provin[illegible]	$19,000	$175,000
SALARIES/BENEFITS		
Admin Asst. c/	$38,000	$38,000
TRAINING		
IEC	$15,000	
Training Trainers	$19,000	
Local Workshops	$30,000	
VSC Workshop	$13,000	$77,000
RENOVATION/CONSTRUCTION d/	$60,000	$60,000
VEHICLE OPER, MAINT, INS. e/	$144,000	$144,000
BUDGETTED COSTS	$808,000	$808,000
CONTINGENCY (5%)	$40,000	$40,000
TOTAL PROJECT COSTS	$848,000	$848,000
PAHO COSTS		
Operating Costs	$42,000	$42,000
Overhead (13%)	$110,000	$110,000
TOTAL GRANT	$1,000,000	$1,000,000

a/ $5,000 for start-up and recurrent costs for 21 VSC clinics (e.g. minilap and vasectomy kits, operating tables, linen).
b/ Includes 1 computer and printer, 5 typewriters, 50 calulators
c/ Other project staff salaries covered by other donors.
d/ An average cost of $3,000 for each of 20 centers
e/ An average of $500/month for gas, maintenance and insurance for 12 jeeps

INSTITUTIONAL ANALYSIS OF THE MSPP

A. Overview

The Ministry of Public Health and Population (MSPP) has been the primary GOH institution charged with health care since 1953. The MSPP has the dual responsibility of providing public health services and supervising both public and private health facilities. Compared with others, the MSPP is a relatively young ministry, having been elevated from Department to Ministry status only in 1984. Despite its relative youth, as compared with the Ministry of Natural Resources and Agriculture, for example, the MSPP is generally regarded as one of the most effective government institutions. Since the formulation of its "New Orientation of Health for all by the Year 2000"in 1983, has made considerable advances in primary health care, most particularly in the eradication of immunizable diseases.

Following the model of other ministries, the MSPP divides the country into four health regions---the Tranversal, the West, the North, and the South---each with a Regional Director of Health. Regions are composed of fifteen health districts, each with a District Director of Health, and one hundred thirty three communes. Theoretically, the commune health center, serving 10,000 inhabitants and having a physican, an auxilliary nurse, and several health agents, is the basic unit of the system. In actuality, less than 15 percent of communes have such facilities and the health agent program is almost moribund due to budget cuts in 1984. At the present time, the MSPP has approximately 188 institutions, including 15 hospitals, 26 health centers, and 147 dispensaries. So-called "mixed" institutions, which are private but receive some government assistance, account for another 184 medical institutions: 9 hospitals, 24 medical centers, and 151 dispensaries.

The World Bank estimates that GOH/MSPP expenditures on health is around $6 per capita. While this amount constitutes a significant proportion of public expenditure, its effectiveness is seriously compromised by the fact that over 80 percent of it is spent on salaries. The new $34 million, five year World Bank health loan has a major policy dialogue element related to management and efficiency of staffing.

B. Family Planning & Population

In 1971, the GOH reorganized the Department of Public Health to create the present Department of Public Health and Population. From this time until 1986, the MSPP's Division of Family Hygiene (DHF), later the Division of Family Hygiene and Nutrition (DHFN), was made responsible for the supervision and

coordination of MCH/FP activities. At the present time, these functions reside in the MCH/FP Office, which is one of the six health priority offices created in 1987. In 1986, the GOH also manifested growing interest in questions of population and in the adoption of a population policy by establishing the National Population Council (CONAPO).

USAID/Haiti has traditionally been the major international donor in this area. From 1971 to 1987, USAID/Haiti supported FP activities of the DHFN through several bilateral grants, including the Family Planning Outreach Project (521-0124) from 1981 to 1987. USAID assistance in population was, for example, $5.5 million in FY86. By comparison, UNFPA, the next largest donor, has provided a total of $15.4 million since 1972. Other major donors include the GDZ in the Central Plateau and the World Bank. In FY88, the US Congress suspended almost all bilateral aid, and USAID/Haiti terminated the Family Planning Outreach Project, in the wake of the aborted election in November of that year.

In the decade before 1987, donor commitment to the public sector, most notably by USAID and the UNFPA, produced relatively few results. Perhaps in part due to the emphasis placed on other MCH programs during this period, but probably more due to the lack of commitment to FP at the DHFN, the program was remarkable only in terms of its failure. Despite near universal knowledge of FP, the contraceptive prevalence rate fell from around 10 percent in 1977 to only 5 percent in 1983. During this period, Haiti recorded what may be the only international case of FP acceptance rate retrogression.

It was as a result of this failure in the public sector that USAID began institutional strengthening of the private sector in 1986. In early 1987, however, based on critical changes in MSPP policy and structure, the Mission began negotiations for a large amendment to the bilateral project, Family Planning Outreach. These changes, which were effected after six months of negotiations between the Mission and MSPP, were to have a notable impact on MCH and FP operations. First, the MSPP established specific MCH and FP objectives as part of its "New Orientation of Health for all by the Year 2000". As a result of this new policy, FP became one of six MSPP health priorities. Second, in 1987, the MSPP abolished the DHFN and created a new priority programs office of which FP is an integral part. A highly motivated, US-trained MPH, who reports directly to the second in command at the MSPP, was appointed National Coordinator of MCH and FP. And third, as mentioned above, in 1986 the GOH created CONAPO as a division within the MSPP, but with a wide mandate for formulation, implementation, and integration of population policy. An equally highly motivated, well-trained MD was appointed as Director.

Ironically, it was at this most promising point over the last decade in terms of FP and population potential in the public sector that US bilateral assistance was suspended and the $13.95 million Family Planning Outreach was terminated. The UNFPA, the

other major donor, maintained its presence but reduced its level of activity in response to the political instability.

Throughout the period of rupture of assistance, USAID/Haiti maintained an active policy dialogue with the MSPP. With the goal of developing an effective, national FP program, the Mission has sought to affect certain activities in the public sector. The first was an expansion of the NORPLANT pre-implementation trials from three PVOs to include three public sector clinics. The MSPP formally accepted this method as part of the national program in July, 1989. The second activity was the introduction of Ovrette, a progestin only pill suitable for lactating mothers, simultaneoulsy into the PVO and public sector programs. In consultation with AID/W, USAID/Haiti began to implement these activities in late fall of 1989. The Mission also made available some PL-480 local currency funding: $150,000 in FY89 and $500,000 in FY90.

In the opinion of the Mission, the time has come to resume significant funding to the public sector as part of the PSFP. The population crisis in Haiti demands a strong national policy commitment and the concerted effort of all sectors. While anxious to resume assistance, however, the Mission is cognizant of many organizational and structural dificiencies in the Ministry which impede good FP service delivery. First, as discussed above, nearly 80 percent of its present budget is devoted to salaries. Of the approximately $6 per capita the GOH expends on health, almost $5 goes to support MSPP personnel. Obviously, any attempt to resume activity in this area must address, as does World Bank funding, management and efficiency of staffing.

Second, there is the serious need to upgrade the training and professional skills of intermediary level technicians at both the MCH/FP Office and CONAPO. Both of these institutions lack the technical depth needed to develop and implement full fledged programs. Although both have highly motivated subordinates, at the present time the MCH/FP National Coordinator and the CONAPO Director are implementing their respective programs almost single handedly. Their respectives staffs do not have the professional and technical skills needed to assume more responsibility. Should either director leave government service for whatever reason, their programs would experience serious disruptions.

Third, another serious, less amenable, personnel problem is involved with the assignment of needed health professionals to the districts and regions outside of Port-au-Prince. With few exceptions, most of these areas lack basic amenities: electricity, potable water, adequate housing, adequate schools, and the company of peers. As a result, after their two year rural social service obligation, few doctors or nurses are willing to take such assignments. Moreover, those who do serve in the rural areas often have bad attitudes toward their rural clienteles. Many studies have shown that a major reason rural people underutilize some MSPP facilities is the lack of courtesy and politeness of their personnel.

A fourth problem, probably a corollary to the one discussed above, it that of unethical behavior on the part of some MSPP staff. Certain unscrupulous personnel are known to charge fees for medical supplies and services which should be dispensed without charge, for example, VSC. In part, this unethical behavior may also be due to the suspension of salary supplements since 1984 for doing FP work. Many staff still resent this suspension and may thus feel justified in charging clients for services.

Two final impediments to effective FP service provision through the MSPP are the lack of field supervision and logistical support. Both of these were major contributors to the FP acceptance retrogression rate discussed above. As a result of lack of adequate supervision, MSPP staff are often late or absent from their posts and/or perform their duties in an unsatisfactory manner. Lack of logistical support means that those clients, who persevere despite other impediments, often do not find FP supplies. In other words, those clients who do seek out FP services in MSPP facilities, often find no staff to serve them due to absence or tardiness or they find no contraceptives.

While not negating these impediments, the Mission believes 1) the positive reasons to resume assistance outweigh them and 2) the strategy developed for resumption will capitalize on MSPP's strong points while minimizing its weaknesses. The strategy involves a three pronged approach: Targeting, the use of an intermediary international organization, and close monitoring. First, support for MSPP under this amendment and from local currency counterpart funds generated by PL-480 activities will target specific, limited spheres of activity such as VSC, supervision, training, operations research on community based delivery, and NORPLANT pre-implementation trials. There will be no attempt to address the full spectrum of MSPP needs at this time. These activities were identified based either on need (e.g. training, supervision) or, as will be discussed below, they are areas in which the MSPP has particular strength.

Second, the intermediary for the resumption of assistance will be the PanAmerican Health Organization (PAHO). PAHO has a highly professional, experienced management team, backed by a competent cadre of technicians with FP experience in Haiti. The Mission presently works with the MSPP through PAHO to promote its Child Survival EPI activities. The results have been highly satisfactory. Vaccination coverage has nearly doubled since assistance began three years ago. Moreover, UNFPA is gearing up for a substantial increase in its involvement in population, with a $2.4 million, four year program and the assignment of a new country representative. The World Bank also has a FP component in its new health sector loan to address needs in the West Region, including Port-au-Prince. PAHO will be executing agency for the FP components of both these programs. With the addition of the USAID public sector component, PAHO will be in a unique position to coordinate all major donor FP activities in the public sector.

76

And third, in collaboration with PAHO, the Mission is in the process of developing an effective plan to monitor MSPP FP activities. In this regard, the Mission is working with PAHO in the formation of an advisory board, consisting of all major donors, whose purpose is to channel all resources to the public sector in the most effective fashion and to oversee the use of these resources.

Moreover, there are many positive reasons to resume assistance to the MSPP at this time. First, approximately one half of all medical facilities in Haiti are MSPP or so-called "mixed" facilities which are, in part, supported by the MSPP. Support for MSPP FP activities could double the geographical and population coverage of the PSFP. Second, Haitian beliefs and low literacy levels favor promotion of long-term methods such as VSC and NORPLANT, which are particular strengths of the MSPP program. According to the recent contraceptive prevalence survey, long-term methods are becoming increasingly popular. As a result of past Mission training efforts, MSPP staff are particularly well-versed and effective in VSC. In 1985-86, before the cutoff of funds, they performed most of the 80,000 such procedures done nationally. During 1989, when the MSPP lacked critical medical eqipment and supplies and vehicles for the VSC teams, the number of VSC performed decreased to 700. Moreover, a recent trip to inspect the physical condition of these VSC facilities confirmed the viability of resumption of USAID assistance to this activity. All five of the North Region's VSC centers visited were in good condition, although lacking needed supplies to perform VSCs. Operating equipment was in place and well maintained and staff claimed to have waiting lists of over 150 people.

Third, the GOH does not constrain private sector FP activities; in fact, it has encouraged expansion of FP in PVOs. There is a on-going information channel between the private sector and MSPP, which has a strategy of public-private partnerships to make use of private sector organizations, such as PVOs, to deliver basic services. Each sector is encouraged to perform according to its comparative advantage.

Fourth and most importantly, the Mission's strategy is that family planning will continue as a priority health concern at the MSPP regardless of changes in the government. With respect to the MSPP, an understanding of the need for and a commitment to the FP concept has been institutionally internalized at the technician level. If the past is a good indicator, these technicians will continue to guide and influence priority FP programs irrespective of who is in power.

This propitious organizational and policy climate bodes well for the resumption of support to the public sector. In fact, the context for this support has probably never been better in all the years of USAID assistance.