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WORLD VISION RELIEF AND DEVELOPMENT, INC.

**FINAL EVALUATION REPORT
LA GONAVE VITAMIN A PROJECT
LA GONAVE ISLAND, HAITI**

Beginning Date: August 31, 1988

Ending Date: August 31, 1991

Submitted by:

Fayla Lamothe, M.D., M.P.H./Ministry of Health (Team Leader)

Charlene Heclvert/MOH Epidemiologist (Rapporteur)

Florence Dyer, M.D., M.P.H./WV Haiti

Vatany Amirthanaygan, M.Sc.N./USAID Mission

Advisers:

Alex Fleury, M.D.

Philippe Larco, M.D., M.P.H.

Submitted to:

PVO Child Survival Grant Program

Office of Private and Voluntary Cooperation

Bureau for Food for Peace and Voluntary Assistance

515 22nd Avenue, NW, Room 103C, SA-2

Washington, DC 20523

PVO Headquarters Contact:

Milton Amayun, M.D., M.P.H.

World Vision Relief & Development Inc.

919 W. Huntington Drive

Monrovia, CA 91016

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I. EXECUTIVE SUMMARY

World Vision/Haiti's Vitamin A Project is a three-year project which began in August 1988. It is being implemented in seven out of eleven sections of La Gonave Island, Haiti. A final evaluation was carried out from June 17, 1991–August 9, 1991. The evaluation team consisted of four members representing the Ministry of Health, World Vision Haiti, EYECARE, and USAID Mission.

Project achievements were assessed from the following sources of information:

- Interview with key informants;
- Review of management records;
- Survey to elicit knowledge regarding Vitamin A; and
- School and dispensary visits.

The evaluation report was completed in French and shared with project staff and the district MOH staff.

II. BACKGROUND

In 1985, World Vision Haiti began its child sponsorship program on the island of La Gonave, Republic of Haiti. In October 1987, World Vision received a grant from the Bureau of Food for Peace and Voluntary Assistance/Office of Private Voluntary Cooperation (FVA/PVC) to implement a Child Survival Project on the island on a phased basis. The following year, the FVA/PVC provided funds for a Vitamin A project covering the population serviced by the CS project.

The island of La Gonave is located 30 kms. west of Port-au-Prince, the capital of Haiti. The island population is nearly 73,000 of whom an estimated 49 percent are children 0-59 months and women 15-45 years.

This Vitamin A project is a \$372,991 three-year project designed to reduce Vitamin A deficiency among children 6-83 months through an integrated program of short- and long-term preventive Vitamin A interventions within an existing Child Survival project. USAID funding comprises approximately 67 percent of the total project budget. The project initially served the entire island (11 sections) focusing on children 0-83 months and mothers who recently delivered. After the midterm evaluation of the CS project in 1988, the evaluation team recommended that interventions, including Vitamin A activities, be concentrated on seven (75% of total population) out of 11 sections.

Vitamin A interventions included: Vitamin A capsule (VAC) distribution among children 6-83 months and women within 30 days of delivery, and promotion of the consumption of Vitamin A-rich foods. The strategies for the delivery of the interventions made use of a community-based and managed health system run by a cadre of workers—health committees, health agents, TBAs, mother health assistants, schoolteachers and schoolchildren; garden demonstrations and establishment of nurseries at school and at selected localities; and strong health education and training

components. Localities were visited by project staff through rally posts scheduled in advance with health committees.

III. METHODOLOGIES

A. Survey

The objectives of the survey were to elicit the following information:

1. Level of knowledge and practice of mothers with children 0-83 months/other caretakers and of schoolchildren regarding Vitamin A
2. Vitamin A Capsule coverage among children 6-83 months and postpartum mothers

The primary sampling unit consists of the seven target sections: 1) Palma, 2) Petite Source, 3) Grand Source, 4) Grande Lagon, 6) La Source, 9) Pointe-a-Racquette, and 11) Petite Anse. Three sample sections were picked out randomly—Palma, Grand Source, and Petite Anse. A list of all localities in the three sampled sections were drawn. Out of this list, a locality from each of the three sampled sections was randomly chosen.

Mother/Caretaker

The sample size consists of 340 families each represented by the mother or a caretaker (representing approximately five percent of nuclear families in the target area) and 623 children 6-83 months (four percent of estimated total number of under-sevens in the target area). The latter excludes 25 children noted to be under six months or over 83 months old. If a locality has less than the number of eligible children, then two localities are chosen.

Health agents in charge of the sampled localities were notified to inform mothers and caretakers to bring their children to a rally post. Mothers/caretakers were also advised that incentives will be given such as candies, toothpaste, soaps.

Schoolchildren

All primary schools from each of the seven sections were listed. One school was randomly picked out of each section listing. A total of 62 schoolchildren were sampled.

For comparison, another sample was taken consisting of 20 mothers from each sampled locality who were marketing (60 total) and schoolchildren (62 altogether) who were not in school.

The survey instrument consists of questionnaires drafted in French then translated into Creole. It has closed and open-ended questions for mothers/

caretakers and a separate one for schoolchildren. Questionnaires were pretested in one locality using randomly selected mothers of under sevens and schoolchildren. A sample of the questionnaires is in Appendix A. Knowledge questions focused on three areas:

- Identification of a Vitamin A Capsule
- Sources of Vitamin A
- Role/function of Vitamin A

Survey forms were numbered and precoded to facilitate data entry and analysis. Input base was prepared under the guidance of a computer specialist. Data entry, editing, tabulation and analysis were done on the computer using EPI-INFO tailored for Vitamin A data processing. Data obtained from the 60 sampled mothers and 62 sampled schoolchildren were tabulated and analyzed manually.

Training of interviewers lasted for 2.5 days. The topics include survey methodology, interview techniques, and supervision. Three days were spent for the actual field survey. There were four teams—each team with a supervisor and two interviewers. The evaluation team members supervised the correctness of entries and the completion of questionnaires. They also observed the interviewers during the interviews.

The work assignment during the actual survey is given below:

Section No.	Localities	Team No.	Nurse Auxiliaries
3	Nan Cafe Grande Source	I	Evelyne Joseph Jertha Joseph
11	Boucan Lamarre Fond Plaisir	II	Monicia Francois Versyl Sylvestre
1	Grande Plaine Morne Chandelle	III	Violette Meradin M.L. Excellent
		IV	Madaleine Simeon Clerna St. Lot
		V	Michel Philistin
		VI	Georgette Jean Denis

B. Interview

Health Committees. A structured questionnaire was designed for interviews of health committee members. The content of the questionnaire was culled from the sustainability guide provided by FVA/PVC. Six health committee members representing five sections served as respondents.

Nurse Auxiliaries. Twelve nurse auxiliaries—nine CS/Vitamin A staff and three Wesleyan Hospital staff—were also interviewed regarding their knowledge of the role of Vitamin A, target group for VAC distribution, dose interval, usefulness of the project, and relationship between Vitamin A deficiency and Protein-Energy Malnutrition. Sample questionnaires are given in Appendix B.

C. Site Visit/Observation

The evaluation team visited three facilities: project base/dispensary, Episcopal dispensary in Nouvelle Cite, and the Wesleyan Hospital. The staff at the Episcopal dispensary were out at the time of visit. The evaluation team looked into VAC storage/resupply, recordkeeping, procurement, and distribution using a questionnaire (Appendix C).

D. Record Review

Project written materials reviewed include the DIP, annual and midterm evaluation reports, monthly and quarterly reports which include a health information system, training curriculum, etc.

IV. FINDINGS

A. Survey

A total of 349 mothers/caretakers were interviewed and 648 children sampled as seen in the table below:

Table I. Number of Respondents by Section

No. of Respondents		
Section	Mothers/ Caretakers	Children 6-83 Months
Grand Source	114	182
Petit Anse	127	234
Palma	108	232
Total	349	648

Twenty-five children's records were excluded from the analysis since the age groups were inappropriate.

School Children

Sixty-two school children from seven schools were interviewed. The distribution of children according to the school they represent is given in the following table:

**Table II. Distribution of Respondent School Children
According to School and Location**

SCHOOL	NUMBER OF RESPONDENTS			TOTAL
	Grand Source	Petit Anse	Palma	
Pentecost	5		13	18
Nazarene	9	15	4	28
Wesleyan	4		1	5
Baptist	1			1
Catholic	1			1
National	--	5		5
Christian Alliance	--		4	4
TOTAL	20 students	20 students	22 students	62

The age distribution of the respondents is as follows:

- 48 percent are 5-9 years old
- 45 percent are 10-15 years old
- 7 percent are more than 15 years old

One respondent is a 23-year-old elementary student.

Among 62 questioned children, 77.4 percent received training on Vitamin A. Most of them are in kindergarten (49 percent), and preparatory stage (33 percent) in spite of their relatively advanced ages.

In order to obtain the respondents' level of knowledge on Vitamin A using the three knowledge questions, correct and incorrect responses were classified accordingly: 1 = yes or correct; 2 = no or incorrect.

The following scores were obtained using a number of combinations:

- Very Good* = 1.1.1
- Satisfactory* = any combination with two correct answers, i.e., 1.1.2; 1.2.1; 2.1.1
- Unsatisfactory* = any combination with one correct answer, i.e., 2.2.1; 2.1.2; 1.2.2
- Poor/Fail* = 2.2.2

Twenty-seven percent (16/59) of respondents scored very good; 29 percent (17/59) satisfactory; 22 percent (13/59) gave only one correct answer while 22 percent (13/59) answered incorrectly to all three questions.

Among the schoolchildren with failing scores, 11 did not receive training sessions, and were, therefore, totally ignorant of Vitamin A. Students from Boucan Lamarre scored the highest—"very good/fail" score was 9/1. This is in contrast

to the students' performance from Grande Plaine who scored 1/8. Only a quarter of the respondents indicate that they advise others on the importance and sources of Vitamin A.

Vegetable gardens were virtually nonexistent in the schools visited. The respondents could not give any reason why there were no gardens.

Mothers/Caretakers

1. Background Characteristics of Respondents

Place of Residence. There is an almost equal distribution of respondents according to residence as observed in this table:

Table III. Distribution of Respondent Family's Residence

Locality	Frequency	%	Cumulative %
Boucan Lamarre	72	20.6%	20.6%
Fond Plaine	55	15.8%	36.4%
Grande Plaine	43	12.3%	48.7%
Grande Source	49	14.0%	62.8%
Morne Chandelle	65	18.6%	81.4%
Nan Cafe	75	18.6%	100.0%
TOTAL	349	100.0%	

Age Distribution of Respondents. Almost 50 percent of respondents are 21 to 30 years old. Other respondents' age distribution is found on the table below:

Table IV. Age Distribution of Respondent

Respondents' Age (In Years)	Frequency	%	Cumulative %
<18	4	1.2%	1.2%
18-20	23	6.6%	7.8%
21-30	168	48.4%	56.2%
31-40	85	24.5%	80.7%
>40	29	8.4%	89.0%
Don't know (respondent is a caretaker)	38	11.0%	100.0%
TOTAL	347	100.0%	

Number of Living Children Under Seven in Respondent Families. Thirty-seven percent of respondent families have one living child, while sixty percent have two to three live children.

Similar background characteristics were obtained among 60 mothers from the sampled sections randomly interviewed in the markets.

2. Knowledge of Vitamin A

The scoring system for schoolchildren was used to assess respondents' knowledge of Vitamin A. Out of 60 sampled mothers in the market, less than half (42 percent) scored very good, i.e., correct answers to three questions.

In the studied sample who came to the rally posts, respondents from Boucan Lamarre scored well (17/2) and the reverse is true (2/11) in Grande Plaine. These findings are almost similar to the results of the schoolchildren's scores in the same areas. This could partly be explained by the difference in performance of the assigned nurse auxiliaries and their health agents.

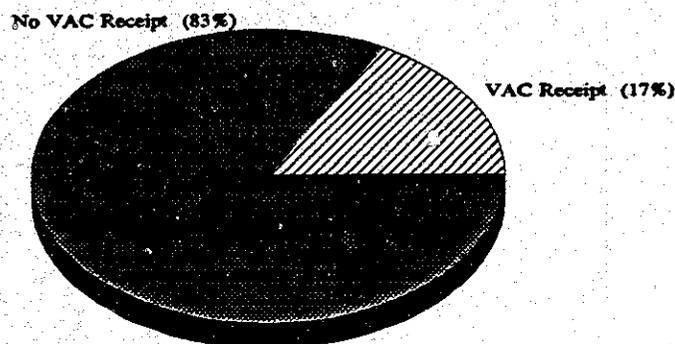
Sixty-seven percent of respondent mothers could identify the capsule and could name at least one role of Vitamin A and its source.

3. Vitamin A Coverage

Mothers

Of 232 respondent mothers who gave birth between October 1988 and July 1991, only 60 (17 percent) confirmed receiving VAC after delivery (Figure 1). None of the respondents brought their maternal card to validate VAC receipt.

Figure 1 - VAC Coverage Among Mothers



The results indicate that a wide knowledge-practice gap regarding Vitamin A still exists among mothers.

Most VAC recipients were given VAC within 30 days of delivery as seen in Table D:

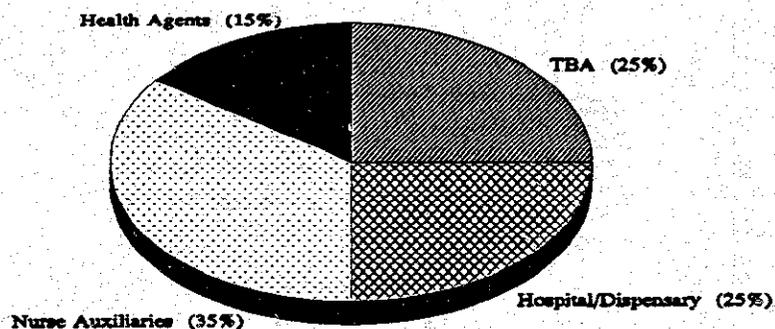
Table V. Schedule of VAC Administration to Respondent Mothers

Schedule	Frequency	%
0-30 days	50	84.4%
over 30 days	5	8.3%
Don't know	5	8.3%
TOTAL	60	100.0%

When the 50 recipients were analyzed further for site of delivery and specific time of administration, most of them received VAC during the day of delivery at home.

Forty-five of the recipients obtained VACs from project auxiliaries, health agents, and trained TBAs. Figure 2 shows the distribution of VAC source by personnel:

Figure 2 - Maternal Source of Vitamin A Capsules



Children 6-83 Months

Sex Distribution. There were more males (53 percent) than females (293/623) in the studied sample of children who came to the rally posts.

Age Distribution. Table IV shows the age distribution of sampled children:

Table VI. Distribution by Age of Sampled Children

Age (months)	Frequency	%	Cumulative %
6-12	110	17.7%	17.7%
13-24	129	20.7%	38.4%
25-36	93	14.9%	53.3%
37-48	109	17.5%	70.8%
49-60	85	13.6%	84.4%
61-83	96	16.4%	99.8%
Do not know	1	0.2%	100.0%
TOTAL	623	100.0%	

About 66 percent (414/623) of sampled children have a road-to-health (RTH) card, while 28 percent (91/623) have other health cards.

Out of those children with RTH cards, only 317 have weights recorded. The results are given below:

Table VII. Nutritional Status of Sampled Children 6-59 Months Old

Nutritional Status	Frequency	%	Cumulative %
M1	136	42.9%	42.9%
M2	39	12.3%	55.2%
M3	2	0.63%	55.83
N	140	44.17%	100.0%
TOTAL	317	100.0%	

About 43 percent of these children are breastfed, the majority of whom are between six to 23 months old. Further analysis within this age group does not reveal any case of severe protein-energy malnutrition. Cases of moderate-to-severe malnutrition are observed among those over two years old.

Coverage

Vitamin A Capsule (VAC) coverage target for FY91 stated in the DIP is 65 percent. About 69 percent (431/623) of target children received at least one dose of VAC between July 1990 and July 1991, based on cards (508) and history (115). Out of 623 studied children, 192 children did not receive VAC. Only two children received four doses of VACs as seen in this table:

**Table VIII. Vitamin A Capsules Coverage Among
Children 6-83 Months By Doses
July 1990-July 1991**

No. of Doses	Frequency	%	Cumulative %
1	294	68.21%	68.21%
2	123	28.54%	96.75%
3	12	2.71%	99.54%
4	2	.046%	100.0%
TOTAL	431	100.0%	

Dropout Rate Between Doses. The dropout rate between the first and second doses is 58% and becomes higher as the number of dose increases (99% between the first and fourth dose). This is indicative of poor social mobilization, and may not necessarily be attributed to inaccessibility of services.

Dose Interval. The MOH policy states that each eligible child receives a single dose of 200,000 IU VAC every three months. The survey shows there is a wide range of interval between doses—from less than three months (19.3%) to 26 months (0.5%). Forty-two percent have three- and four-month intervals and are considered acceptable.

4. Garden Promotion

Less than 50 percent of respondents have small nutritional gardens planted with Vitamin A-rich vegetables, especially green leafy ones—spinach and cabbage, and others such as carrots, squash, tomatoes, and fruits, e.g., papaya.

Twice a year, World Vision distributes fruit seeds and plant seedlings to the residents on the island. However, 179 of respondents could not raise gardens because of the following reasons:

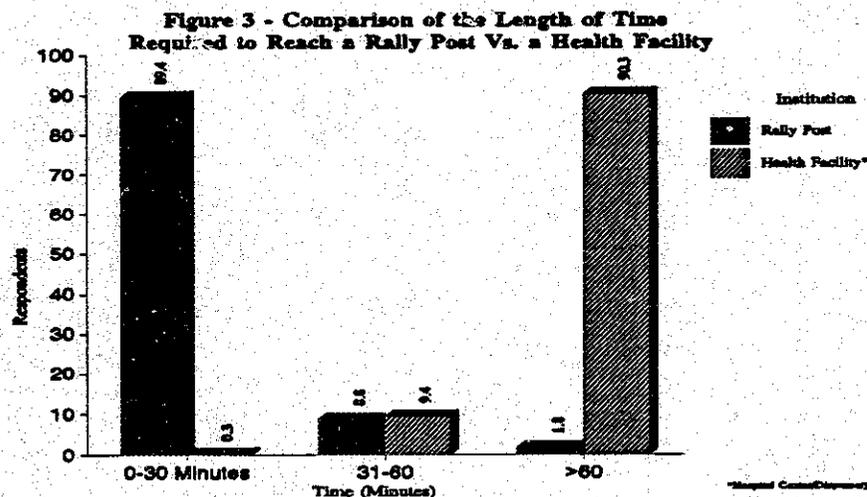
Table IX. Constraints to Gardening

Constraints	Frequency	%	Cumulative %
No water	107	58.5%	58.5%
No grain/seeds	51	27.9%	86.3%
No motivation	12	6.6%	92.9%
No soil or rock	8	4.4%	97.3%
Wild Animals	1	0.5%	97.8%
No answer	4	2.2%	100.0%
TOTAL	183	100.0%	

5. Distance from Source of Health Care

The respondents were asked to estimate the distance they cover to reach the nearest fixed facility and the nearest rally post. Distance was measured according to the time it takes to walk to the center/post.

Figure 3 shows the relevance of rally posts as venues for CS/Vitamin A activities for preventive and promotive activities in order to ensure the health status of the target group. It is obvious that fixed facilities could best function as a second contact point for health care and a supply point for Vitamin A/CS program.



B. Interview

Twelve auxiliaries from two La Gonave institutions (nine from World Vision and three from the Wesleyan Hospital Dispensary) were interviewed. These are the respondent characteristics:

- Are 24-39 years old;
- Have one to five years of service; and
- From South and North La Gonave.

Project staff received training and refresher courses on Vitamin A. They have accurate knowledge about Vitamin A schedules, target groups, Vitamin A sources, and functions. However, not one could correlate Protein-Energy Malnutrition with xerophthalmia. Hence, the team leader took the opportunity to explain the relationship during the evaluation.

The project staff performed creditably well based on the appropriateness in their timing of VAC administration to mothers. This practice correlates well with their level of knowledge. The reverse is observed among the hospital auxiliaries interviewed.

Three auxiliaries out of 17 staff of the Wesleyan Hospital Dispensary (WHD) gave incorrect answers to most questions, although they received training in Vitamin A. Day-shift auxiliaries could not be interviewed because they left early in the morning at the day of the interview.

V. SUSTAINABILITY

A. Status

The Child Survival Project, which has integrated this Vitamin A project, has been extended for another three years, hence it will continue to receive A.I.D. funds until September 1994. Steps geared toward sustainability are being considered by World Vision and La Gonave's communities. A number of steps have been taken to involve local institutions in major project responsibilities and control. These include:

1. The creation of a central management health committee consisting of key representatives from different organizations on the island to ensure an orderly transition of project leadership. A copy of the committee's by-laws is given in Appendix D.

These nongovernment organizations, such as the Wesleyan Mission, Church World Services, the Episcopal Church, the Catholic Church, and World Vision also envisage Section Health Committees to participate in planning and monitoring activities on the island.

2. The Ministry of Health has committed to shoulder the partial payment of the salary of a nurse auxiliary at the project base and the cost of continuing education for middle-level staff. However, the present political climate is very unstable and not much financial assistance could be obtained presently.

B. Plan

Sustainability was a strong consideration in the project's design from the outset in 1988. The first strategy outlined in the DIP was to organize an advisory council consisting of representatives from the MOH, Wesleyan Hospital director, administrator of Pointe-a-Raquette Dispensary, two Section Health and Development Committees (SHDC) chairmen, and the Chief of Commune. This strategy took some time to materialize due to initial doubts and constraints among parties involved. Since 1990, the advisory council has been meeting every quarter. SHDC chairmen attend these meetings on rotation since the seven chairmen could not all be accommodated.

The second strategy was the regular sharing of project achievements with community workers and with the SHDCs and the training of village-level workers. The participation of the community through the SHDC and SHDAs

in project planning and activities, e.g., monthly meetings, training sessions and organization of activities, have been well accomplished.

To continue project activities once funding ceases, a third strategy was developed—a financing mechanism for health through income-generating activities (IGAs). Initial meetings have been conducted in communities from three sections.

The MOH at the national, regional and district levels has always been appraised of project activities and has taken an active role in providing material support for CS and Vitamin A activities, e.g., VAC coverage, EPI, ORT, growth monitoring.

The Ministry of Education has been supportive of Vitamin A activities. In fact, 74 school teachers and 557 schoolchildren from 31 schools have been trained in Vitamin A. In the past, the government agrotechnician has participated in the training sessions on vegetable gardening.

C. Community Participation and Perception of Project Effectiveness

Communities were mostly beneficiaries of project's services during the first two years of project life. Health agents were volunteers chosen by the communities, but planning of activities were done by the project staff. Since 1990, communities have taken increasing share of project design and implementation. For example, it was upon the communities' request that nurse auxiliaries be distributed throughout the island to facilitate project operations.

SHDC members interviewed are exceptionally conversant of World Vision's CS and Vitamin A activities on the island. Their knowledge about the sources and role of Vitamin A is quite good.

The communities, through their health committees and their health agents, participate in annual, quarterly, and monthly activity planning. Evaluation and reports are discussed with the committees for feed back.

All seven Section and Development Health Committees (SHDCs) are presently functioning in the project area. Each health committee met every month for the past year (September 1990 to August 1991). These committees are located in seven sections: Pointe-A-Raquettes, Petit Anse, Palma, Grande Source, Grand Lagon, Petit Source, and La Source.

The original committee members were selected in 1987. After the presidential election in February 1991, the people of La Gonave conducted their own version of democratic election for Section Health and Development Committees.

The topics/issues discussed during the committees' last meeting, mostly in August 1991, are given in the table below:

Section No.	Health Committee	Topics Discussed	Decisions Made
1	Palma	Stocks for community store	Make a list of supplies and unit volume.
2	Petit Source	Community motivation	Encourage more men to get involved.
3	Grande Source	Planning for a community project.	Hold meetings; encourage more participation.
4	Grande Lagon	Sharing results of CS activities	Continue to participate in CS/Vitamin A activities.
6	La Source	Not recalled by SHDC	Not recalled by SHDC
9	Pointe A. Raquette	Reorganizing subcommittees	Inclusion of more women.
11	Petite Ance	Planning for a fishing cooperative	Disseminate plan to other and hold more meetings.

Overall, the six community leaders interviewed from five out of seven sections perceive Child Survival activities as effective and meet the health needs in their communities.

The SHDC leaders contacted during this evaluation are:

<u>Name</u>	<u>Position</u>	<u>Section</u>
Ramil St. Louis	President	Grande Source
Thero Montilus	Secretary	Petite Source
Seraphin Mardin	President	Pointe-a-Raquette
Vilsaint Clersaint	Vice President	Pointe-a-Raquette
Michel Augustin	Treasurer	Grand Lagon
Louissaint Alexis	Vice President	Petite Anse

However, most respondents felt that the curative ability of the health agents is relatively weak. They expressed the need for these agents to undergo more training in basic curative care.

To help ensure that activities will continue after donor funding ends, the community of La Gonave has contributed the following resources:

1. Human Resource

- a. Four out of six auxiliaries are natives of La Gonave and will continue to live on the island. The project has trained 88 indigenous health agents scattered in the seven target sections and who continue to work as volunteers. These volunteers are further supported by 3,924 mother health assistants of which 443 (12 percent) are known as Vitamin A Mother Promoters.
- b. The community-based infrastructure for delivery and support of CS/Vitamin A interventions consists of a cadre of volunteers who have contributed time to the following activities:

<u>Volunteers</u>	<u>Activities</u>
Health committees	Planning and conducting meetings; mobilizing communities, interest groups.
Health agents	Training, mobilizing communities and assisting during rally posts; educating mothers and other community members; attending health meetings.
Mother Health Assistants	Motivating and educating mothers; attending health meetings; training; assisting SHDAs

2. Land/Facilities

Each of the three sampled sections has donated land to be used as demonstration/nursery gardens during planting season and where water is available.

Occasionally, health committee members' homes have become gathering points for community meetings on health and development.

D. Institutional Sustainability

The CS/Vitamin A Project has established strong ties with these local non government institutions on the island:

Wesleyan Mission The mission runs the only hospital on the island and is now serving as referral center for the project. The Hospital Director requested the CS Vitamin A staff to train hospital staff in Vitamin A programming and in recent advances in Vitamin A.

The Catholic Church Father Bill, church pastor, agreed to inform church goers during Sunday masses to announce and to motivate parents to bring their children to rally posts regularly. Rally posts have been the major venue for VAC distribution.

Church World Services The CRS staff participates in training the committees on social mobilization.

F.A.E.S This institution is planning to open a dispensary at Fong Negre, a locality of Grand Lagon. The organizers committed themselves to collaborate and to engage the services of the auxiliaries and the health agents.

No specific management course has been given to local institutions. The management of project activities in the future is expected to be handled by the health committees who are being trained in management and small business enterprise. A plan is being finalized to retrain health agents through a joint effort of the MOH, Episcopal Church, and Wesleyan Hospital. The MOH personnel slated to run the dispensary at the project base have not been officially named.

Dr. Jean Andre, MOH Maternal and Child Health division chief, has always supported this project. Without much prodding, Dr. Andre actively participated in the presentation of the evaluation results of the CS/Vitamin A project in FY90. Project's activities have always been highly considered by the former MOH director of the West Department, Dr. Gerard Joseph. Dr. Joseph has always been receptive to the project's request for material and sometimes even manpower support to the project.

Presently, local institutions and the MOH are not in a position to offer financial support to the project. However, these institutions are able to continue the training and supervision of project's health agents and trained TBAs. The MOH continues to furnish the project with Vitamin A capsules and educational materials.

Once CS funds end, the project components counterpart organizations will not be able to absorb are largely recurrent costs, e.g., car and motorcycle maintenance, health information forms, and full salary of the Vitamin A coordinator, driver, and agritechnician.

E. Indicators Used to Track Sustainability

The project has developed the following indicators to track progress in achieving sustainability:

Items	Measures
Functional SHDCs	70% functioning after 3 years
Utilization of project service center	300 visits/month*
Service center income	\$450.00/month*
Viability of IGAS	10% IGA earning/year*
ZHDAS supervised	70% at least three times a year
MOH commitment	Regular/prompt delivery of VACs
Collaboration with NGO on La Gonave	Regular coordinating meeting at least three times per year

The indicators with asterisks (*) have not been tracked since the project has just started these activities. The other indicators are being monitored informally.

The in-country agencies who worked with World Vision during this project evaluation are as follows:

Midterm Evaluation

Agency	Representative	Designation
Haitian Child Institute	Dr. Philippe Hirsch	Evaluation Specialist
MOH Bureau of Nutrition	Dr. Jocelyn Marhone	Deputy Director
USAID Mission/Haiti	Dr. Michaelle Amédée Gedeon	Public Health Specialist

Final Evaluation

Agency	Representative	Designation
MOH Bureau of Nutrition	Dr. Fayla Lamothe Charleine Hecdivert	Director Epidemiologist
EYECARE	Dr. Philippe Larco	Computer Analyst
USAID Mission/Haiti	Dr. Alix Fleury P. Vathany	Haiti Project Director Nutrition Specialist

F. Calculation of Recurrent Costs

The Vitamin A project has a combined budget of \$372,991--67 percent USAID funds (\$251,291) with matching funds of \$121,700 from WVRD. Only 59 percent of the planned A.I.D. funds was spent during the last three years. Spending with WVRD matching funds was slightly higher (60.5 percent).

The following were the major line items charged against USAID grant:

	<u>Budgeted</u>	<u>Expended</u>	<u>% Spending</u>
Procurement	\$ 46,880	\$ 24,093	51%
Evaluation	5,150	1,358	26%
Indirect Costs	20,749	18,460	89%
Other Program Costs	178,512	105,239	59%
Total	\$251,291	\$149,150	59%

Some of the reasons for the project's underspending include:

- Delay in project start-up, e.g., hiring of staff.
- Operating costs are shared with the CS project.

The costs and revenues needed to be maintained after funding ends are estimated to be \$27,000 per year. These estimates will cover:

- Cost of supervision
- Travel expenses for continuing education courses
- Incentives for health and development agents
- Supplies such as HIS forms, pens, pencils, etc.
- Maintenance: Gas, repairs, etc., of car and motorcycle

The above estimate, however, is exaggerated because the cost for delivering CS activities is included in the computation. The Vitamin A project shares the CS mechanism for the delivery of its intervention.

If we assume that 25% of the estimated cost (\$27,000 per year) should be shouldered by the Vitamin A project, the cost/beneficiary at this time is US\$.60 per target beneficiary. This amount is reasonable given the environment in which the project operates.

The costs unlikely to be sustained include: Car and motorcycle maintenance, gas, cost of supervision, and travel costs which amount to a total of \$7,500.

G. Cost Recovery Attempts

1. The project has attempted to reduce cost by agreeing to transfer part of the financial burden to the community. Auxiliary nurses, upon the community's request, were deployed in their respective sections. Hence, the cost of travel decreased through the use of local means of transport, such as the donkey. This translates to a reduction in fuel, maintenance, and repairs and an increase in time spent by staff in their catchment communities.
2. At the project base, \$166.66/month was generated this year from patients seen at the project dispensary.

3. Another cost-recovery mechanism was attempted by the health committees—the contribution of US\$.10 per family to cover health agents' cost of travel.

These cost-recovery activities have not hurt the reputation of the PVO on the island since these were designed to pave the way for sustainability of CS and Vitamin A interventions. However, the contribution asked from families at the rally post has created a misunderstanding and inequity in service—those persons who could not afford this contribution (and who might be in need of services) were reluctant to go to the rally posts. The health committee, health agents, and mother health assistants discussed the problem and started brainstorming sessions with the community to address the issue of equity.

Cost-recovery schemes implemented by the project was managed by the project administrator. The time spent by the project administrator did not reduce his time and effort since this is one of his areas of responsibility, while the community scheme was managed by members of the health committee. In fact, it seems to have a positive stimulating effect on the community. The community's sense of ownership is accentuated. The scheme, however, needs to be elaborated and documented.

H. Income Generation

Three health committees were in the process of embarking on income-generating activities as seen below:

<u>Section</u>	<u>IGA</u>
• Pointe-a-Raquettes	Grain storing
• Palma	Community store
• Grande Source	Community Store

The plan is to set aside a certain proportion of the earnings generated to pay for health agent incentives. No quantitative estimate of benefits can be obtained as yet.

The issue of sustainability is being strongly addressed by World Vision and the communities of La Gonave. During discussions with both the CSP core staff and the communities' representatives a very good understanding of the need for sustainability has been noted. Community ownership of project's activities is evident.

VI. CONCLUSIONS

- Contrary to many auxiliaries working alone in private or public dispensaries in Haiti who are used to clinical work, the World Vision auxiliaries on La Gonave are devoted to primary care work, such as CS and Vitamin A activities.

- Vitamin A performance/^{varies}from auxiliary to auxiliary, mother. to mother, student to student. In Boucan Lamarre, the auxiliary, Monicia Francois, stands out for the good quality of service she offers, evidenced by her catchment mothers' and schoolchildren's knowledge of Vitamin A.
- Some auxiliaries expressed their desire for additional training in Vitamin A.
- In spite of the presence of auxiliaries, health agents, and TBAs working in different sections, VAC coverage among target groups remain to be desired.
- Health committees who do not stop to motivate mothers also need to change their behavior in an acceptable manner.
- The prevention of xerophthalmia seems to be a vertical activity without any real integration in the "Child Survival" project that heavily emphasizes vaccination.
- The children possess many cards, such as the Road-to-Health, vaccination cards from hospital/dispensary, which are incompletely or irregularly filled out and sometimes ignored.
- An appreciable percentage of mothers have good knowledge about Vitamin A and its sources and functions but need to apply its usefulness.
- The multi-sectorial approach is largely desired—these manifest a need for water and grains and seeds to develop vegetable gardens.
- Health committees are quite conversant of health problems in their communities—xerophthalmia prevention, in particular. They count on technical and some financial assistance from World Vision and promise their financial and social participation in the opportune time.

VII. RECOMMENDATIONS

- Plan to improve the quantity and the quality of xerophthalmia services on La Gonave.
- Consider extending activities to the four remaining sections of the island. Redefine target groups and plan appropriate strategies through the following mechanisms:
 - Identify, train, and integrate TBAs who conduct a majority of home deliveries to ensure adequate VAC coverage of postpartum mothers.
 - Intensify Vitamin A education, especially of mothers, during their first pregnancy to ensure a potential change in behavior later on.

- Continue to encourage breastfeeding, especially with colostrum, to provide a good Vitamin A start for the newborn.
- Emphasize CS/Vitamin A care for children from birth up to five years old to reduce risk factors that could precipitate Vitamin A deficiency.
- Continue to reinforce Vitamin A teaching in schools since, indirectly, these children will become future parents.
- Reinforce health personnel's training on the following areas:
 - Methods of community education, e.g., demonstrations, home visits;
 - How to obtain mother's active participation;
 - Choice of subjects related to food habits and food availability;
 - R&D on selected topics, such as improvement in nutritional status, behavior change, and reduction or elimination of risk factors; and
 - Choice of appropriate channels of communication.
- Use only the "Road to Health" card for VAC receipt and keep in plastic bag. Make sure card is regularly filled out for vaccine and Vitamin A receipt and recent weighings.
- Integrate xerophthalmia activities into a complete package of services at the primary health care level, specifically offering it as a mother and child package.
- Intensify the training of every health center employee working on the island, encouraging their real participation in the program against nutritional blindness.
- Assist mothers with water and grains necessary for vegetable gardens that will ensure the availability of sources rich in Vitamin A.
- Accelerate the plurisectorial promotion activities, particularly agriculture in the fight against causes and consequences of malnutrition.
- Consider the communities' request to permanently deploy the auxiliaries to the different sections.
- Define quantifiable objectives by quarter to facilitate monitoring of project achievements.
- Improve the health information system for Vitamin A activities incorporating:
 - Number of protected children and mothers
 - Number of doses by child
 - Problems
 - Proposed solutions

- Put in place a feedback system which is effective and functional.
- In the medium-term, plan for a gradual shift from VAC distribution to a enhanced and sustained consumption of Vitamin A-rich foods. Consider the use of capsules only as a supplement in the presence of factors that could precipitate xerophthalmia.
- World Vision should assist health committees accelerate their motivational work.
- Establish a system of rewards each year for the best auxiliary using the criteria based on performance, service coverage, and human relations.

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./HAITI VITAMIN A
#OTR-0284-A-00-8255-00

CONSOLIDATED

**Actual Expenditures To Date
(8/31/88 to 8/31/91)**

**Projected Expenditures Against
Remaining Obligated Funds
(9/01/91 to 9/30/92)**

**Total Agreement Budget
(Columns 1 & 2)
(8/31/88 to 8/31/91)**

COST ELEMENTS

	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Supplies	13,276	742	14,018	11,724	(742)	10,982	25,000		25,000
B. Equipment	9,817	50,707	60,524	(4,817)	9,293	4,476	5,000	60,000	65,000
C. Services/Consultants	1,000	0	1,000	15,880	0	15,880	16,880		16,880
SUBTOTAL I	24,093	51,449	75,542	22,787	8,551	31,338	46,880	60,000	106,880
II. EVALUATION/SUB-TOTAL II	1,358	0	1,358	3,792	5,790	9,582	5,150	5,790	10,940
III. INDIRECT COSTS Overhead on HQ/HO (%)	18,460	7,080	25,540	2,289	3,203	5,492	20,749	10,283	31,032
SUBTOTAL III	18,460	7,080	25,540	2,289	3,203	5,492	20,749	10,283	31,032
IV. OTHER PROGRAM COSTS									
A. Personnel	57,451	5,995	63,446	8,099	8,005	16,104	65,550	14,000	79,550
B. Travel	15,916	7,568	23,484	29,084	10,432	39,516	45,000	18,000	63,000
C. Other Direct Costs	31,872	1,500	33,372	36,090	12,127	48,217	67,962	13,627	81,589
SUBTOTAL IV	105,239	15,063	120,302	73,273	30,564	103,837	178,512	45,627	224,139
TOTAL CONSOLIDATED	149,150	73,592	222,742	102,141	48,108	150,249	251,291	121,700	372,991

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./HAITI VITAMIN A PROJECT
#OTR-0284-A-00-8255-00

FIELD	Actual Expenditures To Date (8/31/88 to 8/31/91)			Projected Expenditures Against Remaining Obligated Funds (9/1/91 to 8/31/92)			Total Agreement Budget (Columns 1 & 2) (8/31/88 to 8/31/91)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Supplies	13,276	742	14,018	11,724	(742)	10,982	25,000	0	25,000
B. Equipment	9,817	50,207	60,024	(9,817)	9,793	(24)	16,880	60,000	60,000
C. Services/Consultants	1,000	0	1,000	15,880	0	15,880	16,880	0	16,880
SUB-TOTAL I	24,093	50,949	75,042	17,787	9,051	26,838	41,880	60,000	101,880
II. EVALUATION/SUB-TOTAL II	0	0	0	5,150	0	5,150	5,150	0	5,150
III. INDIRECT COSTS									
Overhead on Field (X)	18,460	1,451	19,911	2,289	(851)	1,438	20,749	600	21,349
SUB-TOTAL III	18,460	1,451	19,911	2,289	(851)	1,438	20,749	600	21,349
IV. OTHER PROGRAM COSTS									
A. Personnel	35,654	0	35,654	4,896	40,550	4,896	40,550	0	40,550
B. Travel/Per diem	13,109	6,518	19,627	6,891	(3,518)	3,373	20,000	3,000	23,000
C. Other Direct Costs	29,264	0	29,264	3,698	0	3,698	32,962	0	32,962
SUB-TOTAL IV	78,027	6,518	84,545	15,485	(3,518)	14,967	93,512	3,000	99,512
TOTAL FIELD	120,580	58,918	179,498	40,711	4,682	45,393	161,291	63,600	224,891

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1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./HAITI VITAMIN A
#OTR-0284-A-00-8255-00

HEADQUARTERS

Actual Expenditures To Date
(8/31/88 to 8/31/91)

Projected Expenditures Against
Remaining Obligated Funds
(9/1/91 to 8/31/92)

Total Agreement Budget
(Columns 1 & 2)
(8/31/88 to 8/31/91)

COST ELEMENTS

I. PROCUREMENT

A. Equipment/Supplies
B. Consultants

SUBTOTAL I

II. EVALUATION/SUB-TOTAL II

III. INDIRECT COSTS

Overhead on HQ/HO
(%)

SUBTOTAL III

IV. OTHER PROGRAM COSTS

A. Personnel
B. Travel
C. Other Direct Costs

SUBTOTAL IV

TOTAL HEADQUARTERS

	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Equipment/Supplies	0	0	0	0	0	0	0	0	0
B. Consultants	0	500	500	5,000	(500)	4,500	5,000		5,000
SUBTOTAL I	0	500	500	5,000	(500)	4,500	5,000	0	5,000
II. EVALUATION/SUB-TOTAL II	1,358	0	1,358	(1,358)	5,790	4,432	0	5,790	5,790
III. INDIRECT COSTS									
Overhead on HQ/HO (%)	0	5,629	5,629	0	4,054	4,054	0	9,683	9,683
SUBTOTAL III	0	5,629	5,629	0	4,054	4,054	0	9,683	9,683
IV. OTHER PROGRAM COSTS									
A. Personnel	21,797	5,995	27,792	3,203	8,005	11,208	25,000	14,000	39,000
B. Travel	2,807	1,050	3,857	22,193	13,950	36,143	25,000	15,000	40,000
C. Other Direct Costs	2,608	1,500	4,108	32,392	12,127	44,519	35,000	13,627	48,627
SUBTOTAL IV	27,212	8,545	35,757	57,788	34,082	91,870	85,000	42,627	127,627
TOTAL HEADQUARTERS	28,570	14,674	43,244	61,430	43,426	104,856	90,000	58,100	148,100

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APPENDIX A
SURVEY QUESTIONNAIRES - MOTHERS/CARETAKERS & SCHOOLCHILDREN
(in French)

EVALUATION DE LA COUVERTURE DES SERVICES DE PREVENTION
DE LA XEROPHTALMIE OFFERTS A LA POPULATION DESSERVIE
PAR WORLD VISION A L'ILE DE LA GONAVE
HAITI - JUILLET 1991

FICHE D'INFORMATIONS GENERALES

DATE : _____ LOCALITE : _____

EQUIPE : _____ FAMILLE : _____ CODE : _____

NOM DE LA MERE OU RESPONSABLE D'ENFANTS : _____

AGE : 1. MOINS 18 ANS 2. 18 - 20 ANS 3. 21 - 30
4. 31 - 40 5. + 40 ANS 9. NE SAIT PAS

NO. ENFANTS VIVANTS DE MOINS DE 7 ANS : _____

DATE DERNIER ACCOUCHEMENT : _____

MERE A RECU VITA : 1. OUI 2. NON 3. NE SAIT PAS DATE : _____

DISTRIBUEE PAR : 1. CENTRE 2. ADS 3. MATRONE *Amelior*

SOURCE D'INFORMATION : 1. MERE 2. CARTE

DISTANCE EN MINUTES DE MARCHÉ POUR ALLER AU 1. CENTRE DE SANTE
DISTANCE EN MINUTES DE MARCHÉ POUR ALLER AU 2. POSTE DE RASSEMBLEMENT
1. MOINS DE 15 MINUTES
2. 15 - 30 mn
3. 31 - 60 mn
4. + 60 mn

CONNAISSANCES DE LA MERE

- A IDENTIFIE LA CAPSULE DE VIT.A 1. OUI 2. NON
- A CITE DES SOURCES DE VIT.A 1. OUI 2. NON

- a) FRUITS ET LEGUMES JAUNES
- b) FEUILLES VERTES
- c) FOIE
- d) OEUFS
- e) AUTRES (SPECIFIER)

- CONNAIT LE ROLE DE LA VIT.A 1. OUI 2. NON

- a) PROTEGE LES YEUX
- b) EMPECHE CECITE
- c) EMBELLIT PEAU
- d) AUTRES (SPECIFIER)

POSSEDE UN JARDIN POTAGER A LA MAISON 1. OUI 2. NON *Parquion?*

LEGUMES CULTIVES
1. EPINARD 2. GIRAUMON 3. CAROTTE 4. AUTRES (SPECIFIER)

EVALUATION DE LA COUVERTURE DES SERVICES DE PREVENTION
DE LA XEROPTALMIE OFFERTS A LA POPULATION DESSERVIE
PAR WORLD VISION A L'ILE DE LA GONAVE
HAITI - JUILLET 1991

FICHE INDIVIDUELLE POUR ENFANT DE MOINS DE 7 ANS

Date _____ Code _____ Numero enfant _____ codeenfant _____

Nom _____ prenom _____ sexe _____

date de naissance _____

Age en mois 1. 6 - 12 mois 2. 13 - 24 3. 25 - 36

4. 37 - 48 5. 49 - 60 9. ne sait pas 6. 60+

Carte chemin de la sante 1. oui 2. non N M _ _

Dates 2 dernieres doses vit.a _____

Sources d'information 1. mere 2. carte _

Nombre de doses recues de juillet 90 juillet 1991 _

Sein 1. Oui 2. Non

FICHE INDIVIDUELLE POUR ENFANT DE MOINS DE 7 ANS

Date _____ Code _____ Numero enfant _____ codeenfant _____

Nom _____ prenom _____ sexe _____

date de naissance _____

Age en mois 1. 6 - 12 mois 2. 13 - 24 3. 25 - 36

4. 37 - 48 5. 49 - 60 9. ne sait pas 6. 60+

Carte chemin de la sante 1. oui 2. non N M _

Dates 2 dernieres doses vit.a _____

Sources d'information 1. mere 2. carte

Nombre de doses recues de juillet 90 juillet 1991

Sein 1. Oui 2. Non

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EVALUATION DE LA COUVERTURE DES SERVICES DE PREVENTION
 DE LA XEROPHTALMIE OFFERTS A LA POPULATION DESSERVIE
 PAR WORLD VISION A L'ILE DE LA GONAVE
 HAITI - JUILLET 1991

FICHE INDIVIDUELLE POUR ECOLIER

DATE _____ EQUIPE _____ ELEVE _____ CODE _____

ENQUETEUR _____ LOCALITE _____

NOM ET PRENOM _____ AGE _____ SEXE _____

ECOLE _____ CLASSE _____

A RECU FORMATION SUR VIT.A 1. OUI 2. NON _____

CONNAISSANCE DE L'ELEVE

- A IDENTIFIE LA CAPSULE 1. OUI 2. NON

- A CITE DES SOURCES DE VIT.A 1. OUI 2. NON

a) FRUITS ET LEGUMES JAUNES

b) FEUILLES VERTES

c) FOIE

d) OEUFS

e) AUTRES (SPECIFIER)

- CONNAIT LE ROLE DE LA VIT.A 1. OUI 2. NON

a) PROTEGE LES YEUX

b) EMPECHE CECITE

c) EMBELLIT PEAU

d) AUTRES (SPECIFIER)

DONNE DES CONSEILS SUR LA VIT.A 1. SOUVENT 2. PARFOIS 3. JAMAIS

L'école possède un jardin potager 1. oui 2. non

Si oui, légumes cultivés

1- épinard

2 - Cresson

3 - carotte

*4 - autre
spécifier _____*

Si non, pourquoi -

APPENDIX B
KEY INFORMANT INTERVIEW SHEET - HEALTH COMMITTEES & AUXILIARIES
(in French)

Évaluation de la participation communautaire dans le cadre des activités de
prévention de la Xérophtalmie - W.V. La Gonâve - Haiti - août 1991.

RENCONTRE AVEC LES COMITÉS DE SANTÉ

Date _____ Localité _____

Durée d'existence du comité _____ (mois)

Nombre de membres _____

Nombre de sous comités _____

Membre(s) questionnés: Nombre _____

Fonctions _____

A - Projet de santé de W.V. connaissance et participation au volet Vit. A

1- Ki sa W.V. ap fè nan zafè sante La GonaveÉ

a _____ c _____

b _____ d _____

2- Pale nou sou pwojè Vit. A- Ki sa li ye?

3- Eske ou te la nan diskisyon pou komanse pwojè Vit. A a?

Wi _____ non _____

Pou ki? _____

Ki patisipasyon ou te bay _____

4- Depi pwojè a komanse, ki jan ou kolabore ladan'l?

B- Activités des comités

1. Konbyen sou komite ki genyen nan seksyon an _____

2- Konbyen fwa komite a reyini nan ou mwa _____

chak ki lè _____

Ki dènye fwa li te reyini (dat) _____

Ki moun ki pa nan komite ya ki te la

Kirezilta ki te soti nan reyinyon sa a

3- Ak ki moun memb komite yo pale?

paran: Wi _____ Non _____ ; Jèn: Wi _____ Non _____

matròn: Wi _____ Non _____ ; Manman: Wi _____ Non _____

Ki lòt moun _____

Ki bà yo rankontre

lekòl _____ Mache _____ legliz _____ ou byen _____

4- Ki aktivite komite ap fè ki fè li rantre lajan?

Kotizasyon (eksplike) _____

pwojè (eksplike) _____

5- Si ta gen bezwen, ki jan aktivite sa a ta ka ede pwojè a kontinye?

Handwritten mark

C- Autres

1- Ki jan ou wè miss la ap travay ak kominote a?

2- Ki valè pwojè Vit. A pou komite ya?

Pou ki sa? _____

3- Konye a ki sa komite a kapab ofri?

Pou kontinye pwojè a: _____

Pou amelyore pwojè a: _____

4- Ki sa komite a swete?

Réponses recueillies par: _____

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EVALUATION DE LA COUVERTURE DES SERVICES DE PREVENTION
DE LA XEROPHTALMIE OFFERTS A LA POPULATION DESSERVIE
PAR WORLD VISION A L'ILE DE LA GONAVE
HAITI - JUILLET 1991

FICHE INDIVIDUELLE POUR PERSONNEL DE SANTE

DATE _____ EQUIPE _____ PERSONNEL _____ CODE _____

ENQUETEUR _____

NOM ET PRENOM _____ AGE _____ SEXE _____

LOCALITE D'ORIGINE _____

PROFESSION 1. AUXILIAIRE 2. AGENT DE SANTE 3. AUTRE (SPECIFIER) _____

NOMBRE D'ANNEES DE SERVICE A L'INSTITUTION _____

A RECU FORMATION SUR VIT.A 1. OUI 2. NON _____

DATE DERNIER RECYCLAGE SUR VIT.A _____

RESPONSABILITES/VIT.A _____

- 1. EDUCATION
- 2. DISTRIBUTION
- 3. FORMATION
- 4. RAPPORT D'ACTIVITES
- 5. AUCUNE
- 6. AUTRES (SPECIFIER)

CONNAISSANCE DU PERSONNEL DE SANTE _____

INTERVALLE DES DOSES 1. OUI 2. NON _____
CIBLES : AGE DES ENFANTS 1. OUI 2. NON _____
MERES (Moment) 1. OUI 2. NON _____
CONNAIT LA RELATION AVEC PROTEINES ET GRAISSES (MPE) 1. OUI 2. NON _____
CITE LES FONCTIONS DE LA VIT.A 1. OUI 2. NON _____
a) YEUX
b) MUQUEUSES
c) PEAU
d) AUTRES (SPECIFIER)

UTILITE DU PROJET 1. OUI 2. NON _____

POURQUOI _____

PROBLEMES RENCONTRES _____

SUGGESTIONS _____

REMARQUES DE L'ENQUETEUR _____

APPENDIX C
QUESTIONNAIRE FOR ASSESSMENT OF LOGISTICS & PROCUREMENT
(in French)

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EVALUATION DE LA COUVERTURE DES SERVICES DE PREVENTION
DE LA XEROPHTALMIE OFFERTS A LA POPULATION DESSERVIE
PAR WORLD VISION A L'ILE DE LA GONAVE
HAITI - JUILLET 1991

FICHE INSTITUTIONNELLE

DATE _____ CODE _____

ENQUETEUR _____ NO. INSTITUTION _____

NOM DE L'INSTITUTION _____ LOCALITE _____

NO. ANNEES D'EXISTENCE A LA GONAVE _____

RESPONSABLE _____

DATE DEMARRAGE DE LA DISTRIBUTION DE LA VIT.A _____

SOURCE D'APPROVISIONNEMENT EN VIT.A _____

DATE DERNIERE RECEPTION _____ QUANTITE DE FLACONS _____

BALANCE ACTUELLE (NO. FLACONS) _____

CONDITIONS DE STOCKAGE 1. BON 2. MAUVAIS _____

PREVISION 1. NO. DE MERES PREVUES _____
PREVISION 2. NO. D'ENFANTS PREVUS _____

COUVERTURE 1. MERES COUVERTES _____
COUVERTURE 2. ENFANTS COUVERTS _____

DATE DERNIER RAPPORT _____

AUTRES ACTIVITES DE PREVENTION
1. EDUCATION 2. JARDINS POTAGERS 3. AUTRES (SPECIFIER)

PROBLEMES / CONTRAINTES -----

SUGGESTIONS -----

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APPENDIX D
BY-LAWS OF THE CENTRAL MANAGEMENT COMMITTEE
(in French)

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APPENDIX D
LE COMITE CENTRAL DE LA GONAVE

- A) Il est crée un comité central de santé à La Gonave, ce 1er juillet 1991.
- B) • Ce comité, à but non lucratif, est formé des représentants des organisations missions oeuvrant dans le domaine de to santé à La Gonâve.
- A cette date, les membres de l' organization sont:
- World Vision - Service Chretien - Eglise Catholique - Mission Wesleyenne.
- C) Les objectifs de ce comité central sont les suivants:
1. Identifier et coordonner toutes missions et organisations travaillant sur l'île dans le domaine de la santé.
 2. Promouvoir la collaboration entre ces missions et organisations afin d'éviter la duplication des activites et de multiplier l'impact de ces organisations et missions sur le developpement de La Gonâve.
 3. Créer et maintenir un solide systeme de communication et de participation avec le ministère de la Santé Publique.
 4. Motiver et maintenir la participation des comités et groupement des habitants de l'île dans les activités des missions/organisations.
- D) Les membres de ce comité central repondront aux critères suivants:
1. Etre officiellement accredité par le ministère de la Santé Publique, a travailler sur l'île comme organisation ou mission.
 2. Avoir travailler continuellement sur l'île avec les familles, eglises ou ecoles pendant au moins 1 an (12 mois).
 3. Etre disposé a collaborer avec les autres organisations ou missions pour le plus grand bien de La Gonâve.
- E) Le comité se reunira chaque 4 mois pour informations, discussions, problème a resoudre etc. . . Il peut se reunir en session extraordinaire si il y a cause.
- F) Les comité de santé et de developpement organisés seront invités a envoyer un representant aux reunions.
- G) Les organisations non membres pourront demande à l'écrit, la permission d'assister ou de participer à une reunion specifique.

- H) Chaque année, pendant la dernière réunion annuelle le comité élira un président.
- I) Le président organisera les réunions et les présidera. Il fera un compte rendu de chaque réunion et une copie de ce rapport sera donnée à chaque membre avant la prochaine réunion.

Signature:

World Vision _____

Service Chrétien _____

Wesleyen _____

Eglise Catholique _____

Episcopale _____

APPENDIX E
EVALUATION WORKPLAN

Annexe
Echéancier

Date	: Activités et siège		: Responsables
7 juin 1991	Rencontre d'informations	UCPP	Dyer/Lamothe
9 juin "	Réception lettre	-	Dyer
3 juillet	Rencontre de Planification	UCPP	Fleury/Dyer/Lamothe
5 "	Rencontre de discussions	EYE CARE	Fleury/Pierre Louis Lamothe
9 "	Matinée de travail	W. V.	Dyer/Lamothe
et 22"	Elaboration protocole	Domicile	Lamothe
3 "	Collecte d'informations	W. V.	Dyer/Lamothe
	Révision du protocole	"	Fleury/Lamothe
4-25 "	Codage des formulaires	"	Hecdivert
4-26 "	Activités préparatoires diverses	"	Dyer et collaborateurs
0 "	Voyage à La Gonâve		Dyer/Hecdivert/Vathany/ Lamothe - (Equipe centrale)
	Formation des enquêteurs.		
1 juillet	Réalisation de l'enquête	La Gonâve	Equipes locales
2 août	dans les localités prévues		Equipe centrale
"	Retour à Port-au-Prince		
"	Analyse formulaires écoles et inst.	Domicile	Lamothe
"	Préparation base pour entrée des données	O.M.S.	Larco/Hecdivert/Lamothe
au 9 août	Entrée et Analyse des données	W. V.,	Hecdivert
	Présentation à Staff La Gonâve	W. V.	/Lamothe
10-11 août	Préparation rapport final	Domicile	Lamothe
12 "	Finalisation 1er draft rapport final	W. V.	Hecdivert/Lamothe
	Préparation formulaire pour collecte inform./groupes Comm.	W. V.	Dyer/Lamothe
13 "	Retour à La Gonâve et rencontre avec groupes/Comm.	La Gonâve	Dyer/Lamothe
16 août 91	Remise du Rapport final après adjonction des informations communautaires		Lamothe