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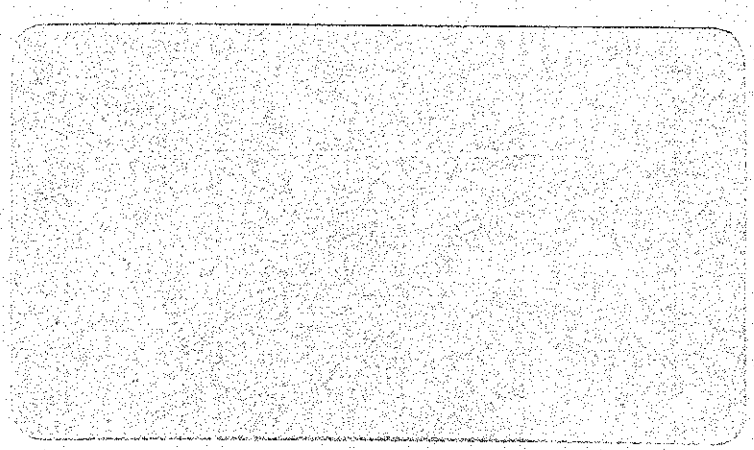

World Vision Relief & Development, Inc.

WORLD VISION RELIEF & DEVELOPMENT INC.

FINAL EVALUATION REPORT
LA GONAVE CHILD SURVIVAL PROJECT
LA GONAVE ISLAND, HAITI

Beginning Date: October 1, 1987
Ending Date: October 15, 1991

Submitted to:

Child Survival and Health Division
Bureau for Food and Humanitarian Assistance
Office of Private and Voluntary Cooperation
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December 27, 1991

WORLD VISION RELIEF & DEVELOPMENT, INC.

PART I
KNOWLEDGE-PRACTICE SURVEY
LA GONAVE CHILD SURVIVAL PROJECT

Dr. Florence Dyer, Health Officer, WV Haiti
in coordination with
Dr. Ciro Franco, Survey Trainer—PVO Child Survival Support Program

September 1991

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ACKNOWLEDGMENTS

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The Health Officer expresses her deep appreciation to the World Vision Child Survival Project staff, especially the community health workers, clinic health staff, and the drivers. This survey would have been impossible without the generosity and cooperation of the people of La Gonave.

EXECUTIVE SUMMARY

In September 1991, WV Haiti carried out on the Island of La Gonave two overlapping Knowledge and Practice surveys: (1) a final assessment of the interventions in 7 sections where the CS III project has been active since 1988; and (2) a baseline survey in 11 sections where the extended project will be working. The latter survey will be used as a tool for future planning and will be submitted as part of the Detailed Implementation Plan (DIP). Only the CS III final survey will be discussed in this report.

The survey followed the WHO model of 30 clusters focusing on mothers of children under two years old. Two hundred and forty mothers were interviewed. Data entry and data analysis were done in EPI INFO 5.1.

The results showed that the levels of knowledge and coverage were generally consistent with the project's objectives stated in the DIP. Seventy-four percent of children 12-23 months were completely immunized compared to the project objective of 75 percent. The project objective called for 80 percent of mothers to use ORT in case of diarrhea. Survey results revealed that 70 percent of mothers with children experiencing a diarrhea episode in the last two weeks gave the child ORT packets. Only maternal care fell short of project's objective—42 percent of mothers had received tetanus toxoid (TT) two immunizations, whereas the project objective was 70 percent TT2 coverage.

These results highlight the priorities the project should focus on in the future: diarrheal disease control, maternal care, and breastfeeding.

I. INTRODUCTION

A. Background Information

The Republic of Haiti is one of the nations in the Caribbean. It consists of a main island and a smaller one, the Island of La Gonave.

In 1987, World Vision Relief and Development received $361,000 to carry out a PVO Child Survival Project on the island of La Gonave. The island has a land area of 855 square Kms distributed in 11 rural sections, each section divided into zones/villages.

The project started its activity in 1988 in seven of the 11 sections with the following interventions: immunization, control of diarrheal disease, growth monitoring, nutrition, and family planning. After one year, the project added a Vitamin A component.

In October 1991, the project will receive $410,000 for CS VII expansion from USAID for a three-year extension to the other four sections and the addition of another intervention treatment of Acute Lower Respiratory Infection.

B. Intervention Area

The intervention area for FY91-94 will cover the whole island, 70 percent of which is mountainous. The population on the island is estimated at about 65,000 (1985).

The majority of household heads are farmers (69 percent). Infant mortality rate is believed to be 128 per 1,000 live births. On the island, health services are provided by religious organizations, which include two dispensaries and a hospital, in addition to the services provided by World Vision (WV).

II. PURPOSE OF THE KAP SURVEY

A standardized survey was carried out following an agreement between WVRD and the PVO Child Survival Support Program (CSSP) at Johns Hopkins University. Subsequent arrangements were made by the project staff in collaboration with WVRD for Dr. Ciro Franco, a survey trainer from PVO CSSP, to train the project staff in Haiti and to provide the necessary technical assistance for the survey.

The survey WV Haiti carried out on the Island of La Gonave [illegible] two purposes: (1) a final assessment of knowledge and practice regarding the n[illegible]tion, diarrhea case management, immunization, and maternal care interventions in the seven sections where the project had been active since 1988; and (2) a baseline assessment in the 11 sections of the knowledge and practice regarding nutrition, diarrhea case management, immunization, acute respiratory infections, and maternal care interven-

tions. Only the CS III final survey will be discussed in this report. The baseline survey will be used as a tool for planning the CS VII DIP and will be appended in the DIP.

The CS III final survey provided the following information:

- Mothers' knowledge about the management of diarrheal episodes, immunization, and birth spacing.
- Coverage rates of children (12-23 months) with BCG, DPT, OPV, and measles vaccine.
- Mothers' practice in the following interventions: nutrition, diarrheal management, birth spacing, and immunization.
- Coverage rate with TT for mothers of children under two years of age.

Schedule of Activities

First-Second Day	-	Arrival of Dr. Ciro Franco in Port-au-Prince - Orientation to project and preliminary work with survey project coordinator(s) on the questionnaire in the local version and survey schedule
Third Day	-	Training of supervisors
Fourth Day	-	Training of interviewers; pilot test questionnaire; of pilot test, last adjustments and reproduction of the questionnaire
Fifth-Eighth Day	-	Data collection
Ninth-Twelfth Day	-	Data entry; write report; feedback to WV Staff; departure of Dr. Ciro Franco

III. METHODOLOGY

A. The Questionnaire

There was one questionnaire used for both final and baseline survey administered to mothers aged 14 to 49 with a child under 24 months of age.

The questionnaire was first designed at the PVO CSSP according to the objectives of the WV Haiti project. During this process many discussions were held with WV Haiti staff and WV California to come to an agreement about the content of the questionnaire.

The questionnaire contains 40 questions. Questions 1-6 deal with nutrition, weaning practice and consumption of food containing Vitamin A. Questions 7-10

cover growth monitoring and Vitamin A capsule administration. Questions 11-20 include knowledge and practice regarding management of diarrheal disease. Questions 21-25 deal with ALRI. Questions 26-40 concern vaccination knowledge and coverage, TT immunizations, practice of family planning, and delivery assistance.

The questionnaire was first written in English, translated into French and, finally into Creole, the official language of the Republic of Haiti.

B. Determination of Sample Size

Since two separate impact areas were covered by the two surveys, we should have ideally drawn one sample from the seven sections for the CS III final assessment and another sample from the eleven sections for the CS VII baseline survey. However, in doing so, there would have been problems in logistics and potential to interview the same household for both surveys.

For the CS III final evaluation, it was decided to draw a sample from the seven sections using the cluster methodology.

To determine the sample size, the following formula was used:

$$n = z^2 pq/d^2$$

where n = the sample size; z = statistical certainty chosen; p = coverage rate; level of knowledge, and q = 1-p; d = degree of precision.

The sample size was established in the following way: the degree of precision (d) was set up at 0.1 and the p was set up at 0.5. The resulting minimum sample size was 210, but it was increased to 240 taking non-respondents into account.

The number of clusters for the final assessment was 30 with a sample size equal to 240.

For the four sections d = 0.1, p = 0.2. The resulting sample size was at 120. Thus, for the baseline survey, there were 41 clusters with a sample size equal to 370.

C. Method of Data Analysis

Data entry and analysis were carried out by Haitian MOH personnel on EPI INFO 5.1. The data tabulation generated frequency, distribution and cross tabulations.

D. Selection of Sample

The WHO model of 30 clusters was followed for each intervention area. The Bureau of Census has a list of zones/villages with the population size. The following methodology was used: the sampling interval was calculated by dividing the total population by 30. A random number provided a starting point for 30 clusters was chosen. The starting point in each cluster was determined in the following manner: the center of the villages/zones was located and a random direction was selected. The first household encountered in the randomly chosen direction was the starting point. The second and subsequent households were the ones which were nearest to the previous one. There were 8 mothers interviewed for each cluster.

IV. THE SURVEY

A. Training

The survey team was composed of a team evaluator (three MOH health professionals and two WV field staff), 11 clinic health staff (CHS) and 12 Community Health Workers (CHWs).

The survey trainer trained two of the MOH personnel on how to train the CHSs and CHWs prior to the training of supervisors and interviewers.

The training of supervisors and interviewers lasted two days. There were 11 supervisors and 12 interviewers. The training covered the purpose of the survey and the understanding of the questionnaire. Discussion and role play were the main points of the training. The survey trainer was present during the training and intervened when needed.

A pilot test was carried out in a village not chosen in the sample. After the pilot test, a discussion was held between the team evaluator, the survey trainer, and the interviewers and supervisors to focus on the concerns they had about the questions. Minor adjustments were made.

B. The Interviews

The core evaluation team decided to set two levels of supervision because of geographic constraints. The CHSs assured the first level of supervision, observing at least one interview by the CHW once every day, and verifying the quality of their questionnaires. Some CHSs also conducted interviews. The ratio of supervisor to interviewers was 1:2 (one supervisor had two interviewers).

The MOH professional and WV field staff supervised the clinic health staff. Their supervision was performed through the observation of an interview of the clinic health staff each day, and verifying the questionnaire of both the CHSs and CHWs.

Since the interviewers and CHSs staff were employed by the project, there were some concerns about the validity of the data collection process. To minimize any kind of bias in this process, both the clinic health staff and the CHWs were sent to the zones/villages where they did not work.

V. SURVEY RESULTS

A. Tabulated Findings of CS III Final Survey

Number of People per Cluster

Cluster	Frequency	Percent	Cum.
1	8	3.3%	3.3%
2	8	3.3%	6.5%
3	8	3.3%	9.8%
4	8	3.3%	13.1%
5	8	3.3%	16.3%
6	8	3.3%	19.6%
7	8	3.3%	22.9%
8	8	3.3%	26.1%
9	8	3.3%	29.4%
10	8	3.3%	32.7%
11	8	3.3%	35.9%
12	9	3.7%	39.6%
13	8	3.3%	42.9%
14	8	3.3%	46.1%
15	8	3.3%	49.4%
16	8	3.3%	52.7%
17	8	3.3%	55.9%
18	8	3.3%	59.2%
19	8	3.3%	62.4%
20	8	3.3%	65.7%
21	9	3.7%	69.4%
22	8	3.3%	72.7%
23	8	3.3%	75.9%
24	8	3.3%	79.2%
25	8	3.3%	82.4%
26	8	3.3%	85.7%
27	8	3.3%	89.0%
28	10	4.1%	93.1%
29	8	3.3%	96.3%
30	9	3.7%	100.0%
Total	**245**	**100.0%**	

List of Localities

Localite

BAUDIN	LA PALMISTE	PETITE ANSE
BOIS BRULE	MARE COCHON	PLAINE MAPOU
BOIS NOIR	MARE SUCRIN	PLAISANCE
CHERISSABLE	NAN BAKA	POINTE LATANIER
DEBALEINE N	NAN CAFE	TERRE SECHE
ETROITS	NAN KOTUN	TI PLAMISTE
FOND-NEGRE	NAN LEBRUN	TI SOUS
FONTUNA	NAN MANGOT	TROU BIGAY
GRANDE SOURCE	NAN PLUME	TROU LOUIGENIE
GROS MAPOU	PALMA	ZILEBOIS

AGE DISTRIBUTION OF RESPONDENT MOTHERS

Age of Mother	Frequency	Percent	Cum.
15-19	18	7.3%	7.3%
20-24	63	25.7%	33.1%
25-29	73	29.8%	62.9%
30-34	51	20.8%	83.7%
35-39	27	11.0%	94.7%
40-44	9	3.7%	98.4%
45-49	4	1.6%	100.0%
TOTAL	**245**	100.0%	

AGE DISTRIBUTION OF SAMPLED CHILDREN 0-23 MONTHS

Age of Child Month	Frequency	Percent	Cum.
0 to 5	61	24.9%	24.9%
6 to 11	90	36.7%	61.6%
12-17	50	20.4%	82.0%
18-23	44	18.0%	100.0%
TOTAL	**245**	**100.0%**	

Feeding Practice for Each Age Group* by Type of Food Given

	1 %	2 %	3 %	4 %	5 %	6 %	7 %	8 %
Breastfed	100[1]	100	96	89	81	57	24	0
Bottle	23	67	69	74	67	64	60	70
Semi-solid	51	95	95	95	95	96	92	100
Fruit Juice	8	74	93	100	90	100	100	100
Vitamin A	13	72	91	92	90	100	100	100
Leaf-green	5	64	89	92	90	96	96	100
Meat fish	5	66	91	89	95	100	96	100
Bean peas	8	74	82	89	90	90	88	100
Peanuts	0	13	33	47	52	57	88	80
Eggs	3	51	69	79	71	82	92	90
Add Sugar	56	92	96	92	100	89	100	100
Add Fat	15	84	98	94	95	100	100	100

* AGE GROUP 1 = 0-3 months; 2 = 4-6 months; 3 = 7-9 months; 4 = 10-12 months; 5 = 13-15 months; 6 = 16-18 months; 7 = 19-21 months; 8 = 22-23 months.

1. Are you breastfeeding **(name of child)**?

Breastfed	Frequency	Percent
Yes	194	79.2%
		C.L. .74-.84
No	51	20.8%

2. Have you ever breast-fed **(name of child)**?

Breastfed	Frequency	Percent
Not-applicable	193	78.8%
Yes	50	20.4%
No	2	0.8%

[1]The exclusive breastfeeding percentage for children 0-3 months is: 31%

3. a. Are you giving **(name of child)** bottle milk?

	Frequency	Percent
Yes	148	60.4%

b. Are you giving **(name of child)** bottle (biberon)?

	Frequency	Percent
Yes	101	41.2%

c. Are you giving **(name of child)** semisolid foods **(akamil)** such as gruels, porridge or semolina?

	Frequency	Percent
Yes	216	88.2%

d. Are you giving **(name of child)** fruits or juices?

	Frequency	Percent
Yes	194	79.2%

e. Are you giving **(name of child)** carrot, squash, mango or papaya?

	Frequency	Percent
Yes	191	78.0%

f. Are you giving **(name of child)** leafy green vegetables, such as spinach?

	Frequency	Percent
Yes	182	74.3%

g. Are you giving **(name of child)** meat or fish?

	Frequency	Percent
Yes	185	75.5%

h. Are you giving **(name of child)** lentils, peanuts, or beans?

	Frequency	Percent
Yes	181	73.9%

i. Are you giving **(name of child)** peanuts, pinebutter?

	Frequency	Percent
Yes	95	38.8%

j. Are you giving **(name of child)** eggs ?

	Frequency	Percent
Yes	152	62.0%

k. Are you adding honey or sugar to **(name of child)**'s meals?

	Frequency	Percent
Yes	217	88.6%

1. Are you adding fat (lard) or oil to **(name of child)**'s meals?

	Frequency	Percent
Yes	202	82.4%

4. What can a mother do in the baby's first three or four days of life to keep on breast-feeding? **(multiple answers possible)**

		N	%
a.	Doesn't know	20	8.2
b.	Breastfeed as soon as possible after delivery (don't discard colostrum)	125	51
c.	Avoid bottle feeding of baby	3	1.2
d.	Frequent sucking to stimulate production	6	2.4
e.	Care of breasts, nipples	49	20
f.	Other (specify) _____	42	26

5. When should a mother start adding foods to breastfeeding?

		N	%
a.	Start adding between 4 and 6 months	8	
b.	Start adding earlier than 4 months	228	93.1
c.	Start adding 6 months or later	6	2.4
d.	Doesn't know	3	1.2

6. Which foods contain vitamin A to prevent "night blindness"? **(multiple answers possible)**

		N	%
a.	Doesn't know or other	49	20
b.	Green leafy vegetables	117	47.8
c.	Yellow-type fruits	131	53.5
d.	Meat/fish	33	13.5
e.	Breast milk	100	40.8
f.	Egg yolks	22	9

Growth Monitoring

7. Children (0-23) who have a growth monitoring card.

N	%	
220	90	C.L.0.86-0.94

8. Has the child been weighed in the last four months? (According to the growth card)

	N	%
Yes	149	67.7

9. Children (0-23) who received Vitamin A in the last four months

	N	%	
Yes	104	42.4	CL. 034046

Diarrheal Diseases

11. Children (0-23) who had diarrhea during the last two weeks?

	N	%
Yes	104	42.4CL 034046

12. During **(name of child)'s** diarrhea did you breast-feed

		N	%
a.	More than usual?	42	40.4
b.	Same as usual?	31	29.8
c.	Less than usual?	17	16.3
d.	Stopped completely?	0	0
e.	Child not breastfed	15	14.4

13. During **(name of child)'s** diarrhea, did you provide **(name of child)** with fluids other than breast-milk

		N	%
a.	More than usual?	51	49.0
b.	Same as usual?	27	25.9
c.	Less than usual?	25	24.0
d.	Stopped completely?	1	0.9
e.	Exclusively breastfeeding	1	0.9

14. During **(name of child)'s** diarrhea, did you provide **(name of child)** with solid/semisolid foods

		N	%
a.	More than usual?	51	49.0
b.	Same as usual?	27	25.9
c.	Less than usual?	25	24.0
d.	Stopped completely?	1	0.9
e.	Exclusively breastfeeding	1	0.9

15. When **(name of child)** had diarrhea, what treatments, if any, did you use? **(multiple answers possible)**

		N	%
a.	Nothing	8	7.7
b.	ORS sachet	71	68.3
c.	Sugar-salt solution	21	20.2
d.	Cereal-based ORT	12	11.5
e.	Infusions of other fluids	12	11.5
f.	Anti-diarrhea medicine or antibiotics	5	4.8
g.	Other	4	3.8

16. When **(name of child)** had diarrhea, did you seek advice or treatment for the diarrhea?

	N	%
Yes	46	44.2

17. From whom did you seek advice or treatment for the diarrhea of **(name of child)? (multiple answers possible)**

		N	%
a.	General hospital	3	6.5
b.	Health center/clinic/post	8	17.4
c.	Private clinic/doctor	2	4.3
d.	Pharmacy	10	21.7
e.	Village health worker	12	26.1
f.	Traditional healer	0	.0
g.	Traditional birth attendant	0	.0
h.	Midwife	0	.0
i.	Relatives & friends	13	28.3
j.	Other	0	.0

18. What signs/symptoms would cause you to seek advice or treatment for **(name of the child)'s** diarrhea? **(multiple answers possible)**

		N	%
a.	Doesn't know	9	3.7
b.	Vomiting	31	12.7
c.	Fever	62	25.3
d.	Dry mouth, sunken eyes, decreased urine output	64	26.1
e.	Diarrhea of prolonged duration (at least 14 days)	50	20.4
f.	Blood in stool	34	13.9
g.	Loss of appetite	74	30.2
h.	Weakness or tiredness	55	22.4
i.	Other	10	4.1

19. What are important actions you should take if **(name of child)** has diarrhea? **(multiple answers possible)**

		N	%
a.	Doesn't know	8	3.3
b.	Take the child to the general hospital/health center	203	82.9
c.	Give the child more to drink than usual	38	15.5
d.	Give the child smaller more frequent feeds	12	4.9
e.	Withhold fluids	2	0.8

f.	Withhold foods	0	.0
g.	Other	52	21.2

20. What are important actions a mother should take when a child is recovering from diarrhea? **(multiple answers possible)**

		N	%
a.	Doesn't know	6	2.4
b.	Give the child smaller more frequent feeds	46	18.8
c.	More foods than usual	129	52.7
d.	Give foods with high caloric content	146	59.6
e.	Other	14	5.7

Immunizations

26. Has **(name of child)** ever received any immunizations?

	N	%
Yes	224	91.4
No	19	7.8
Doesn't know	2	0.8

27. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?

		N	%
a.	To protect both mother/newborn against tetanus	165	67.3
b.	To protect only: the woman against tetanus	13	5.3
c.	To protect only: the newborn against tetanus	56	22.9
d.	Doesn't know or other	11	4.5

28. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus?

		N	%
a.	One	11	4.5
b.	Two	23	9.4
c.	More than two	199	81.2
d.	None	1	4.5
e.	Doesn't know	11	4.5

29. Children who have an immunization card

	N	%
Yes	224	91.4

30. The denominator population is children 12-23 months old in the sample.

	N	%
BCG	88	94%
OPV1	90	96%
OPV2	85	90%
OPV3	81	86%
DPT1	90	96%
DPT2	84	89%
DPT3	80	85%
Measles	74	79%
Drop Out Rate (DPT1-DPT3/DPT1)		11%
Fully Immunized	70	74%
Correctly Immunized	56	60%

Maternal Care

31. Mothers with a maternal health card?

	N	%
Yes	122	49.8

32. Mothers who received TT vaccinations (according to the card)

		N	%
a.	One	19	15.6
b.	Two or more	103	84.4
c.	None	0	.0

33. Are you pregnant now?

		N	%
a.	Yes	28	11.4
b.	No	213	86.9
c.	Don't know	4	1.6

34. Do you want to have a child in the next two years?

		N	%
a.	No	178	82.0
b.	Yes	39	18.0
c.	Doesn't know	3	1.4

35. Are you currently using any method to avoid/postpone getting pregnant?

		N	%
a.	Yes	130	73.0
b.	No	48	27.0

36. What is the main method you or your husband are using now to avoid/postpone getting pregnant?

		N	%
a.	Tubal ligation	2	1.5
b.	Norplant	3	2.3
c.	Injections	16	12.3
d.	Pill	59	45.4
e.	IUD	2	1.5
f.	Barrier method/diaphragm	0	.0
g.	Condom	3	2.3
h.	Foam/gel	0	.0
i.	Exclusive breast-feeding	42	32.3
j.	Rhythm	2	1.5
k.	Abstinence	1	0.8
l.	Coitus interruptus	0	.0
m.	Vasectomy	0	.0
n.	Other	0	.0

Modern contraceptive prevalence: 39% C. L. .32-.47
(The denominator is all the women in the sample less the pregnant women)

37. How soon after a women knows she is pregnant should she see a health professional (physician, nurse, midwife)?

		N	%
a.	First trimester:		
	1-3 months	57	23.3
	4-6 months	165	67.3
	7-9 months	12	4.9
b.	Middle of pregnancy		
c.	Last trimester		
d.	No need to see health worker	7	2.9
e.	Doesn't know	4	1.6

38. What foods are good for a pregnant woman to eat to prevent pregnancy anemia? **(multiple answers possible)**

		N	%
a.	Doesn't know	17	6.9
b.	Proteins rich in iron (eggs, fish, meat)	151	61.0
c.	Leafy green vegetables, rich in iron	174	71.0
d.	Other	155	63.3

39. Mothers who went to any health site (dispensary/health center, aid post) for pregnancy/prenatal care

	N	%
Yes	191	78.0

40. At the delivery of (**name of child**), who tied and cut the cord?

		N	%
a.	Yourself	1	0.4
b.	Family member	9	3.7
c.	Traditional birth attendant	83	33.9
d.	Midwife	129	52.7
e.	Health professional (physician, nurse)	22	9.0
f.	Other	1	0.4
g.	Doesn't know	0	.0

B. Summary of CS III Final Survey

This data provides an overview of the level of attainment of knowledge and practice regarding the following project interventions:

Breastfeeding 79 percent of all mothers are currently breastfeeding their child but only 24 percent of mothers with children in the age group 19-21 months breastfeed their child. Only 31 percent of mothers with a child in the age group 0-3 months exclusively breastfeed their child. Half of those interviewed (51 percent) know they have to breastfeed their child as soon as possible after delivery.

Nutrition/Vitamin A 95 percent of mothers with a child in the age group 4-6 months give semisolid food to their children. Fifty percent of all mothers know that yellow type fruits, preventing "night blindness", contain Vitamin A. Almost all the mothers (93 percent) know they should give food in addition to breast milk before four months.

Diarrheal disease 42 percent (104) of children had diarrhea in the last two weeks. About 70 percent of mothers whose children had diarrhea use the ORS package, and 20 percent use a homemade solution. Respondent mothers (with children who have diarrhea) continue breastfeeding, (40 percent); give the child more liquid, (49 percent); and give the child more food than usual, (49 percent).

With regard to knowledge of symptoms of diarrhea, 26% of all mothers in the sample know that dehydration is an important sign of their children's diarrhea. When their child has diarrhea, 83 percent of mothers take the child to the hospital, but only 15% give the child more to drink.

Growth monitoring 90% of children in sample had a growth monitoring chart. Among children with the chart, 68 percent were weighed in the last three months. Sixty-one percent of all children in the sample—those with a growth monitoring chart and those without—were reported to have been weighed at least once in the last three months.

EPI 74 percent of children 12-23 months are fully immunized, 60 percent correctly[2] immunized, with a dropout rate (DTP1-DTP3/DTP1) of 11 percent.

Maternal care 67 percent recognize the importance of TT immunization, but only 42 percent of the mothers have received at least 2 TT vaccinations. Twenty-seven percent of mothers (excluding pregnant women and the mothers who want to have a baby in the next two years) do not know any means to avoid/postpone pregnancy. The use of the modern contraceptive methods[3] among mothers in the sample (excluding the pregnant women) is 39 percent. The use of modern contraceptives among women who do not want a baby in the next two years is 48 percent. Almost four-fifths (78 percent) of the mothers go to the health site for prenatal care but 67 percent go for the first time in the middle of their pregnancy. Concerning delivery assistance, 52 percent of the mothers declare that they are assisted by a midwife.

C. Comparison of Final Survey Results with Project Objectives

The final survey results show that the levels of attainment are consistent with the project's objectives, although the target population is different from the one specified initially in the Detailed Implementation Plan (DIP).

The survey showed that:

- Seventy-four percent of children 12-23 months were completely immunized; project objective was 75 percent as mentioned in the DIP.
- Forty-two percent of mothers had received two tetanus toxoid immunizations, whereas the project objectives called for 70 percent coverage.
- Survey results revealed that 70 percent of mothers with children experiencing a diarrhea episode in the last two weeks gave the child ORS packets. The project objectives called for 80 percent of mothers to use home mix solution in case of diarrhea.

---

[2]Correctly immunized children are those who received DPT1-DPT2-DPT3 at correct time: DPT1 after 6 weeks of age; DPT2 at 4 weeks after DPT1; DPT3 at 4 weeks after DPT2.

[3]Modern methods are the following:tubal ligation, Norplant, Injections, Pills, IUD, Diaphragm, Condom, Vasectomy.

- The survey showed that 95 percent of mothers introduce weaning foods by four months of age against the stated objective of 40 percent weaning practice.

- With regard to family planning, the survey revealed a contraceptive prevalence of 39 percent while the DIP called for 50 percent of women 15-49 years of age to be using modern methods.

- For Vitamin A capsule distribution, the DIP called for 60 percent of children to receive Vitamin A capsules every four months. The survey results showed that 55 percent of children 6-23 months had received a Vitamin A capsule within the last four months.

- It was not possible to assess the level of Vitamin A coverage of mothers, as the project was not using the Vitamin A card for mothers. With regard to Vitamin A food intake, the DIP called for 60 percent of children to be ingesting foods rich in Vitamin A by four months of age; the survey showed the results to be 72 percent.

VI. SURVEY COSTS (BOTH SURVEYS)

Meals during training and data collection	1,070.00
Papers/other material	382.00
Fuel for boat, jeep,motorcycle	496.00
Per diem interviewers and supervisors	2,160.00
Per diem for local technical assistance	4,500.00
Hotel for external assistance	2,800.00
Airplane ticket	500.00
TOTAL	**$11,908.00**

The exchange rate is 5 Gourdes to $1 U.S. dollar

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ANNEX 1

PVO/COUNTRY ___ IDNUM: _____

PVO Child Survival Knowledge & Practice Questionnaire
WORLD VISION/HAITI

All questions are to be addressed to the mother (women 15-49 years old) with a child under two (less than 24 months old)

Interview date __/__/91 (dd/mm) Reschedule interview __/__/91 (dd/mm)
Interviewer name _____
Supervisor _____

Name and age of the mother

Name _____ Age (years)_____

Name and age of the child under two years old

Name _____

Birth date __/__/__ (dd/mm/yy) Age in months_____

Community _____

Breastfeeding/Nutrition

1. Are you breastfeeding **(name of child)**?
   1. Yes [ ] **---> go to 3**
   2. No [ ]

2. Have you ever breast-fed **(name of child)**?
   1. Yes [ ]
   2. No [ ] **---> go to 10**

3. a. Are you giving **(name of child)** bottle milk?
   1. Yes [ ]
   2. No [ ]

3. Doesn't know [ ]

b. Are you giving **(name of child)** bottle (biberon)?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

c. Are you giving **(name of child)** semisolid foods (akamil) such as gruels, porridge or semolina?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

d. Are you giving **(name of child)** fruits or juices?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

e. Are you giving **(name of child)** carrot, squash, mango or papaya?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

f. Are you giving **(name of child)** leafy green vegetables, such as spinach?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

g. Are you giving **(name of child)** meat or fish?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

h. Are you giving **(name of child)** lentils, peanuts, or beans?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

i. Are you giving **(name of child)** peanuts, pinebutter?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

j. Are you giving **(name of child)** eggs ?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

k. Are you adding honey or sugar to **(name of child)**'s meals?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

l. Are you adding fat (lard) or oil to **(name of child)**'s meals?
   1. Yes [ ]
   2. No [ ]
   3. Doesn't know [ ]

4. What can a mother do in the baby's first three or four days of life to keep on breastfeeding? **(multiple answers possible; record all answers)**
   a. Doesn't know [ ]
   b. Breastfeed as soon as possible after delivery (don't discard colostrum) [ ]
   c. Avoid bottle feeding of baby [ ]
   d. Frequent sucking to stimulate production [ ]
   e. Care of breasts, nipples [ ]
   f. Other (specify) _____ [ ]

5. When should a mother start adding foods to breastfeeding?
   a. Start adding between 4 and 6 months [ ]
   b. Start adding earlier than 4 months [ ]
   c. Start adding 6 months or later [ ]
   d. Doesn't know [ ]

6. Which foods contain vitamin A to prevent "night blindness"? **(multiple answers possible; record all answers)**
   a. Doesn't know or other [ ]
   b. Green leafy vegetables [ ]
   c. Yellow type fruits [ ]
   d. Meat/fish [ ]
   e. Breast milk [ ]
   f. Egg yolks [ ]

Growth Monitoring

7. Does **(name of child)** have a growth monitoring/promotion card?
   a. Yes [ ] **(must see card)**
   2. Lost card [ ] **---> go to 11**
   3. No [ ] **---> go to 11**

8. **Look at the growth monitoring card of the child, and record the following information: has the child been weighted in the last four months?**
   1. Yes [ ]
   2. No [ ]

9. **Did the (name of the child)** take vitamin A capsule?
   1. Yes [ ]
   2. No [ ]
   3. Do not know [ ]

10. **Record the dates of all vitamin A capsules given to this child in the space below**
   (dd/mm/yy)

   1st __/__/__
   2nd __/__/__
   3rd __/__/__
   4th __/__/__

Diarrheal Diseases

11. Has **(name of child)** had diarrhea during the last two weeks?
    a. Yes [ ]
    2. No [ ] **---> go to 18**
    3. Doesn't know [ ] **---> go to 18**

12. During **(name of child)'s** diarrhea did you breast-feed **(read the choices to the mother)** . . . .
    a. More than usual? [ ]
    b. Same as usual? [ ]
    c. Less than usual? [ ]
    d. Stopped completely? [ ]
    e. Child not breastfed [ ]

13. During **(name of child)'s** diarrhea, did you provide **(name of child)** with fluids other than breast-milk . . . . **(read the choices to the mother)**
    a. More than usual? [ ]
    b. Same as usual? [ ]
    c. Less than usual? [ ]
    d. Stopped completely? [ ]
    e. Child not breastfed [ ]

14. During **(name of child)'s** diarrhea, did you provide **(name of child)** with solid/semisolid foods . . . . **(read the choices to the mother)**
    a. More than usual? [ ]
    b. Same as usual? [ ]
    c. Less than usual? [ ]
    d. Stopped completely? [ ]
    e. Child not breastfed [ ]

15. When **(name of child)** had diarrhea, what treatments, if any, did you use? **(multiple answers possible; record all answers)**
    a. Nothing [ ]
    b. ORS sachet [ ]
    c. Sugar-salt solution [ ]
    d. Cereal-based ORT [ ]
    e. Infusions or other fluids [ ]
    f. Anti-diarrhea medicine or antibiotics [ ]
    g. Other **specify** _____ [ ]

16. When **(name of child)** had diarrhea, did you seek advice or treatment for the diarrhea?
    a. Yes [ ]
    b. No [ ] **---> go to 18**

17. From whom did you seek advice or treatment for the diarrhea of **(name of child)?** **(multiple answers possible; record each answer)**

a.	General hospital	[ ]
b.	Health center/clinic/post	[ ]
c.	Private clinic/doctor	[ ]
d.	Pharmacy	[ ]
e.	Village health worker	[ ]
f.	Traditional healer	[ ]
g.	Traditional birth attendant	[ ]
h.	Midwife	[ ]
i.	Relatives & friends	[ ]
j.	Other **(specify)**	[ ]_____

18. What signs/symptoms would cause you to seek advice or treatment for **(name of the child)'s** diarrhea? **(multiple answers possible; record all answers)**

a.	Doesn't know	[ ]
b.	Vomiting	[ ]
c.	Fever	[ ]
d.	Dry mouth, sunken eyes, decreased urine output (dehydration)	[ ]
e.	Diarrhea of prolonged duration (at least 14 days)	[ ]
f.	Blood in stool	[ ]
g.	Loss of appetite	[ ]
h.	Weakness or tiredness	[ ]
i.	Other **(specify)** _____	[ ]

19. What are important actions you should take if **(name of child)** has diarrhea? **(multiple answers possible; record all answers)**

a.	Doesn't know	[ ]
b.	Take the child to the general hospital/health center	[ ]
c.	Give the child more to drink than usual	[ ]
d.	Give the child smaller more frequent feeds	[ ]
e.	Withhold fluids	[ ]
f.	Withhold foods	[ ]
g.	Other **(specify)** _____	[ ]

20. What are important actions a mother should take when a child is recovering from diarrhea? **(multiple answers possible; record all answers)**

a.	Doesn't know	[ ]
b.	Give the child smaller more frequent feeds	[ ]
c.	More foods than usual	[ ]
d.	Give foods with high caloric content	[ ]
e.	Other **(specify)** _____	[ ]

Respiratory Illness

21. Has **(name of child)** been ill with cough or difficult breathing in the last two weeks?
    a. Yes [ ]
    b. No [ ]

22. Did **(name of child)** experience rapid and difficult breathing (dyspnea) when ill?
    a. Yes [ ]
    b. No [ ] **---> go to 25**
    c. Doesn't know [ ] **---> go to 25**

23. Did you seek advice or treatment for **(name of child)'s** when ill with these respiratory problems?
    a. Yes [ ]
    b. No [ ] **---> go to 25**

24. From whom did you seek advice or treatment for **(name of child)'s** when ill with difficult breathing and/or cough?
    (multiple answers possible; record all answers)
    a. General hospital [ ]
    b. Health center/clinic/post [ ]
    c. Private clinic/doctor [ ]
    d. Pharmacy [ ]
    e. Village health worker [ ]
    f. Traditional healer [ ]
    g. Traditional birth attendant [ ]
    h. Relatives & friends [ ]
    i. Other [ ]

25. What are the signs/symptoms of respiratory infection that would cause you to take **(name of child)** to a health facility?
    (Multiple answers possible; record all answers)
    a. Doesn't know [ ]
    b. Fast or difficult breathing [ ]
    c. Chest indrawing [ ]
    d. Loss of appetite [ ]
    e. Fever [ ]
    f. Cough [ ]
    g. Other **(specify)** _____ [ ]

Immunizations

26. Has **(name of child)** ever received any immunizations?
    a. Yes [ ]
    b. No [ ]
    c. Doesn't know [ ]

27. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?
    a. To protect both mother/newborn against tetanus [ ]
    b. To protect **only** the woman against tetanus [ ]
    c. To protect **only** the newborn against tetanus [ ]
    d. Doesn't know or other [ ]

28. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus?
    1. One [ ]
    2. Two [ ]
    c. More than two [ ]
    4. none [ ]
    5. doesn't know [ ]

29. Do you have an immunization card for **(name of child)?**
    1. Yes [ ] **(must see card)**
    2. Lost it [ ] **---> go to 31**
    c. Never had one [ ] **---> go to 31**

30.

Look at the vaccination card and record the dates of all the immunizations in the space below

(dd/mm/yy)

BCG		_ _/_ _/_ _
OPV	1st	_ _/_ _/_ _
	2nd	_ _/_ _/_ _
	3rd	_ _/_ _/_ _
DPT	1st	_ _/_ _/_ _
	2nd	_ _/_ _/_ _
	3rd	_ _/_ _/_ _
Measles		_ _/_ _/_ _

Maternal Care

31. Do you have a maternal health card?
    a. Yes **(must see card)** [ ]
    b. Lost it **---> go to 33** [ ]
    c. No **---> go to 33** [ ]

32. Look at the maternal health card and record the number of TT vaccinations in the space below:
    1. One [ ]
    2. Two or more [ ]
    3. None [ ]

33. Are you pregnant now?
    a. Yes [ ] **---> go to 37**
    b. No [ ]
    c. Do not know [ ]

34. Don't you want to have a child in the last two years
    a. Yes [ ]
    b. No [ ]**---> go to 37**
    c. Doesn't know [ ]

35. Are you currently using any method to avoid/postpone getting pregnant?
    a. Yes [ ]
    b. No [ ] **---> go to 37**

36. What is the main method you or your husband are using now to avoid/postpone getting pregnant?

a. Tubal ligation [ ]
b. Norplant [ ]
c. Injections [ ]
d. Pill [ ]
e. IUD [ ]
f. Barrier method/diaphragm [ ]
g. Condom [ ]
h. Foam/gel [ ]
i. Exclusive breast-feeding [ ]
j. Rhythm [ ]
k. Abstinence [ ]
l. Coitus interruptus [ ]
m. Vasectomy [ ]
n. Other [ ]

37. How soon after a women knows she is pregnant should she see a health professional (physician, nurse, midwife)? **(probe for months)**

a. First trimester, 1-3 months [ ]
b. Middle of pregnancy, 4-6 months [ ]
c. Last trimester, 7-9 months [ ]
d. No need to see health worker [ ]
e. Doesn't know [ ]

38. What foods are good for a pregnant woman to eat to prevent pregnancy anemia? **(multiple answers possible; record all answers)**

a. Doesn't know [ ]
b. Proteins rich in iron (eggs, fish, meat) [ ]
c. Leafy green vegetables, rich in iron [ ]
d. Other (specify) _____ [ ]

39. When you were pregnant with **(name of child)** did you visit any health site (dispensary/health center, aid post) for pregnancy/prenatal care?

a. Yes [ ]
b. No [ ]

40. At the delivery of **(name of child)**, who tied and cut the cord?

a. Yourself [ ]
b. Family member [ ]
c. Traditional birth attendant [ ]
d. Midwife [ ]
e. Health professional (physician, nurse) [ ]
f. Other (specify) _____ [ ]
g. Doesn't know [ ]

ANNEX 2

PVO/PEYI
Kestyonne PVO sou Konnesans e Aibitid de Suivi Timoun

IDNUM _____

Se pou ou poze tout kesyon a tout manman (fanm ki genyen ant 15 e 49 an) ki genyen yon timoun ki poko rive genyen 2 an (setadi, mwens ke 24 mwa)

Dat antrevi:_____Nouvo dat antrevi si prenmye-a rate:_____
Non moun k'ap poze kesyon-an:
Sipevize:
Ekip ___ Grap _____ Lokalite _____

1. Non e laj manman-an
   Kijan li rele? _____
   Kilaj li genyen?_____ (dat fet si posib) _____

2. Non e laj timoun ki poko rive genyen 2 an (timoun ki pi piti a)
   Kijan li rele? _____
   Ki dat li fet? __/__/__ (jou/mwa/anne)

Laj (an mwa): _____ mwa

BEBE NAN TETE / NITRISYON

1. Eske [non timoun-nan] nan tete?
   a. Wi [ ] ---> pase a kesyon 3
   b. Non [ ]

2. Eske ou te kon'n bay [non timoun-nan] tete?
   a. Wi [ ]
   b. Non [ ]
   c. Pa konnen [ ]

3. a. Eske ou konn bay [non timoun-nan] bwe let?
      (1) Wi [ ]
      (2) Non [ ]
      (3) Pa konnen [ ]

   b. Eske ou konn bay [non timoun-nan] bwe na bibwon?
      (1) Wi [ ]
      (2) Non [ ]
      (3) Pa konnen [ ]

c. Eske ou konn bay [non timoun-nan] manje lot bagay tankou labouwi, akamil oswa soup?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

d. Eske ou konn bay [non timoun-nan] manje fwi tankou mango, cerise, kachiman, korosol, zoranj, sitwon ou bwe ji fwi?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

e. Eske ou konn bay [non timoun-nan] manje kawot, **joumon**, mango ou papay?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

f. Eske ou konn bay [non timoun-nan] manje legim fey vet tankou epina, lyann panye?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

g. Eske ou konn bay [non timoun-nan] manje vyann (vyann bef, kochon, kabrit, poul, kodend) ou pwason?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

h. Eske ou konn bay [non timoun-nan] manje nenpot kalite pwa?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

i. Eske ou konn bay [non timoun-nan] manje pistach ou manba?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

j. Eske ou konn bay [non timoun-nan] manje ze?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

k. Eske ou konn mete siwo ou sik nan manje ou fe pou [non timoun-nan]?
(1) Wi [ ]
(2) Non [ ]
(3) Pa konnen [ ]

1. Eske ou konn mete gres ou lwil nan manje ou fe pou [non timoun-nan]?
   (1) Wi [ ]
   (2) Non [ ]
   (3) Pa konnen [ ]

4. Ki sa yon fanm ki fek akouche ka fe pou let li monte? (Plizye repons posib - Endike tout repons li bay)
   a. Pa konnen [ ]
   b. Konmanse ba li tete osi to ke posib apre akouchman-an. [ ]
   c. Evite bay timoun-nan bwe nan bibwon. [ ]
   d. Tete souvan pou fose tete-l fe plis let. [ ]
   e. Byen swen (okipe) tete e bout tete-l-yo. [ ]
   f. Lot (presize) [ ]_____

5. Kile yon manman ta dwe konmanse bay timoun-ni lot manje **(pandan timoun-nan toujou nan tete?)**?
   a. Kat (4) a sis (6) mwa. [ ]
   b. Anvan kat (4) mwa. [ ]
   c. Apre sis (6) mwa ou anko pita. [ ]
   d. Pa konnen. [ ]

6. Ki manje ki bon pou pwoteje zye timoun nan?
   a. Pa konnen [ ]
   b. Legim fey vet [ ]
   c. Fwi ki genyen koule jonn [ ]
   d. Vyann (nenpot kalite)/Pwason [ ]
   e. Let tete [ ]
   f. Jonn ze [ ]
   g. Let [ ]

SWIVI KWASANS

7. Eske [non timoun-nan] genyen yon kat chimen sante?
   a. Wi [ ] --------> (Fok ou we kat-la)
   b. Kat pedi [ ] ---> Pase a kesyon 11
   c. Non [ ] --------> Pase a kesyon 11

8. Gade kat chimen sante timoun-nan epi ekri ranseyman sa yo: Eske timoun nan pese (setadi yo te pran pwa-li) nan 3 denye mwa?
   a. Wi [ ]
   b. Non [ ]

9. Eske ti moun nan kon'n pran vitamin A.
   a. Wi [ ]
   b. Non [ ]
   c. Pa konnen [ ]

10. Si wi, ekri jist anba dat timoun-nan te bwe chak grenn vitamin A. (jou/mwa/anne)
    1ye __/__/__
    2enm __/__/__
    3enm __/__/__
    4enm __/__/__

MALADI DYARE

11. Eske [non timoun-nan] genyen dyare nan 2 denye senmenn ki sot pase-yo?
    a. Wi [ ]
    b. Non [ ] --->Pase a kesyon 18
    c. Pa konnen [ ] ---> Pase a kesyon 18

12. Pandan [non timoun-nan] te genyen dyare, eske ou... (Li a ot vwa repons ki anba-yo pou manman-an)
    a. Te bay li tete pliske dabitid? [ ]
    b. Te bay li tete kom dabitid? [ ]
    c. Te bay li tete mwens ke dabitid? [ ]
    d. Te sispann ba li tete net? [ ]
    e. Timoun-nan pa te nan tete. [ ]

13. Pandan [non timoun-nan] te genyen dyare, eske ou... (Li a ot vwa repons ki anba-yo pou manman-an)
    a. Te bay li bwe lot bagay pliske dabitid? [ ]
    b. Te bay li bwe lot bagay kom dabitid? [ ]
    c. Te bay li bwe lot bagay mwens ke dabitid? [ ]
    d. Te sispann ba li bwe lot bagay net? [ ]
    e. Timoun-nan konn tete selman. [ ]

14. Pandan [non timoun-nan] te genyen dyare, eske ou... (Li a ot vwa repons ki anba-yo pou manman-an)
    a. Te bay li manje lot bagay pliske dabitid? [ ]
    b. Te bay li manje lot bagay kom dabitid? [ ]
    c. Te bay li manje lot bagay mwens ke dabitid? [ ]
    d. Te sispann ba li manje lot bagay net? [ ]
    e. Timoun-nan konn tete selman. [ ]

15. Le [non-timoun-nan] te genyen dyare, ki sa ou te fe pou li?
    (Plizye repons posib; endike tout repons li bay)
    a. Anyen, Oken [ ]
    b. Sewom oral - sache [ ]
    c. Sewom lakay [ ]
    d. Diri ak karot, dlo diri, la bouwi lanmidon [ ]
    e. Enfizyon ou te, rafrechi [ ]
    f. Medikaman pou dyare [ ]
    g. Lot (presize) [ ] _____

16. Le [non-timoun-nan] te genyen dyare, eske ou te cheche konsey ou tretman nan men yon lot moun?
    a. Wi [ ]
    b. Non [ ] ---> Pase a kesyon 18.

17. Kimoun?
    (Plizye repons posib; endike tout repons li bay)
    a. Lopital Wesleyen [ ]
    b. Sant sante/Dispense [ ]
    c. Pos rasambleman [ ]
    d. Miss [ ]
    e. Ajan sante konminote [ ]
    f. Dokte fey [ ]
    g. Houngan [ ]
    h. Fanm saj [ ]
    i. Paran, Fanmi [ ]
    j. Lot (presize) [ ] _____

18. Le [non timoun-nan] ta genyen dyare-a, ki lot bagay (siy) ki ta fe ou al cheche konsey ou tretman/remed nan men yon lot moun?
    (Plizye repons posib; endike tout repons li bay)
    a. Pa konnen [ ]
    b. Vonmisman [ ]
    c. Lafyev [ ]
    d. Bouch sech, je antre, pa pipi (dezidratasyon) [ ]
    e. Dyare ki dire lontan (14 jou ou plis) [ ]
    f. San nan wate timoun-nan [ ]
    g. Pa vle manje [ ]
    h. Febles; Fatig [ ]
    i. Lot (presize) [ ] _____

19. Dapre ou, ki sa ki enpotan pou ou fe si [non timoun-nan] genyen dyare?
    (Plizye repons posib; endike tout repons li bay)
    a. Pa konnen [ ]
    b. Mennen timoun-nan nan lopital ou sant medikal [ ]
    c. Ba timoun-nan bwe pliske dabitid [ ]
    d. Ba timoun-nan manje repa ki pi piti men plizye fwa pa jou. [ ]
    e. Pa ba timoun-nan bwe anyen [ ]
    f. Pa ba timoun-nan manje anyen [ ]
    g. Lot (presize) [ ] _____

20. Dapre ou, ki sa ki enpotan pou yon manman fe **le dyare-a fin pase**
(Plizye repons posib; endike tout repons li bay)

a. Pa konnen [ ]
b. Ba timoun-nan manje repa ki pi piti men plizye fwa pa jou. [ ]
c. Ba timoun-nan manje pliske dabitid. [ ]
d. Ba timoun-nan manje ki chaje ak enneji. [ ]
e. Lot (presize) [ ] _____

MALADI BWONCH

21. Eske [non timoun-nan] gripe, ap touse, gen nen-l bouche nan 2 denye semenn ki sot pase-yo?

a. Wi [ ]
b. Non [ ]

22. Eske [non timoun-nan] te soufle anle le li te gripe a?

a. Wi [ ]
b. Non [ ] ---> Pase a kesyon 25
c. Pa konnen [ ] ---> Pase a kesyon 25

23. Eske ou te cheche konsey ou tretman le [non timoun-nan] te malad?

a. Wi [ ]
b. Non [ ] ---> Pase a kesyon 25

24. Kiles ou te we?
(Plizye repons posib; endike tout repons li bay)

a. Lopital Wesleyen [ ]
b. Sant sante/Dispanse [ ]
c. Pos rasanbleman [ ]
d. Miss [ ]
e. Ajan sante konminote [ ]
f. Dokte fey [ ]
g. Oungan [ ]
h. Fanm saj [ ]
i. Paran, Fanmi, zanmi [ ]
j. Lot [ ] (presize) _____

25. Le [non timoun-nan] gripe ki sak fe ou kouri kay dokte avek li?

a. Pa konnen [ ]
b. Li pran souf rapid ou ak difikilte [ ]
c. Tout zo nan kot-li paret le li rale souf-li [ ]
d. Pert dapeti; Pa vle manje [ ]
e. Tous, grippe rhume [ ]
f. Lot [ ]

VAKSINASYON/IMINIZASYON

26. Eske [non timoun-nan] konn pran vaksen?
    a. Wi [ ]
    b. Non [ ]
    c. Pa konnen [ ]

27. Dapre ou, pou ki sa yon fanm ki ansent bezwen pran vaksen tetanos?
    a. Pou pwoteje ni manman-an ni bebe k'ap fet-la kont tetanos [ ]
    b. Pou pwoteje manman-an selman kont tetanos [ ]
    c. Pou pwoteje bebe k'ap fet-la selman kont tetanos [ ]
    d. Pa konnen; Lot [ ]

28. Konbyen piki vaksen tetanos yon fanm ansent bezwen pran pou pwoteje bebe k'ap fet-la kont tetanos?
    a. Youn (1) [ ]
    b. De (2) [ ]
    c. Pliske de (2) [ ]
    d. Oken [ ]
    e. Pa konnen [ ]

29. Eske ou genyen yon kat vaksinasyon pou [non timoun-nan]?
    a. Wi (Fok ou we kat-la) [ ]
    b. Li pedi [ ] ---> Pase a kesyon 36
    c. Non, pa t janm genyen youn [ ] ---> Pase a kesyon 36

30. Sevi ak kat vaksinasyon-an pou we kile timoun-nan te pran chak vaksen epi ekri dat-yo nan plas apwoprie anba.

		(jou/mwa/anne)
BCG		__/__/__
Vaksen Polio	1e	__/__/__
	2enm	__/__/__
	3enm	__/__/__
DPT	1e	__/__/__
	2enm	__/__/__
	3enm	__/__/__
Woujol		__/__/__

SWEN MATENEL

31. Eske ou genyen yon kat vasen?
    a. Wi (Fok ou we kat-la) [ ]
    b. Li pedi [ ] ---> Pase a kesyon 33
    c. Non, pat janm genyen youn [ ] ---> Pase a kesyon 33

32. Sevi ak kat vaksen pou anrejistre nan plas anba nonm vaksen tetanoz fanm-nan te resevwa:
    a. Youn (1) [ ]
    b. De (2) ou plis [ ]
    c. Oken [ ]

33. Eske ou ansent kounye-a?
    a. Wi [ ]--->Pase a kesyon 37
    b. Non [ ]
    c. Pa konnen [ ]

34. Eske ou ta vle kanpe sou fe timoun nan 2 zan kap vini yo?
    a. Wi [ ]
    b. Non [ ] --->Pase a kesyon 37
    c. Pa konnen [ ]

35. Eske w'ap fe plannin? Setadi, eske w'ap fe yon jan pou anpeche ou pa tonbe ansent?
    a. Wi [ ]
    b. Non [ ] --->Pase a kesyon 37

36. Ak ki metod planin ou-menm oubyen msye-ou sevi?
    a. Ligati [ ]
    b. Norplant [ ]
    c. Piki [ ]
    d. Grenn, Pilil [ ]
    e. Filaman (esterile) [ ]
    f. Diafragm [ ]
    g. Kapot [ ]
    h. Jel, Krenm [ ]
    i. Bay tete? [ ]
    j. Metod almannak [ ]
    k. Pa fe bagay menm [ ]
    l. Msye retire anvan li voye [ ]
    m. Vazektonmi [ ]
    n. Lot [ ]

37. Apre yon fanm aprann ke li ansent, kile li ta dwe we yon dokte, miss ou fanm saj pou prenmye fwa? (Presize mwa nan gwoses)
    a. Nan prenmye twa (3) mwa [ ]
    b. Nan mitan gwoses-la (4,5, ou 6 mwa) [ ]
    c. Nan denye twa (3) mwa gwoses-la (7,8, ou 9 mwa) [ ]
    d. Pa janm bezwen we yon dokte, enfirmye ou fanm saj [ ]
    e. Pa konnen [ ]

38. Ki manje ki bon pou fanm ansent?
    a. Pa konnen [ ]
    b. Ze, pwason ou vyann [ ]
    c. Legim fe ki chaje ak fe [ ]
    d. Diri mayi pitimi pwa [ ]
    e. Lot [ ]

39. Le ou te ansent [non timoun-nan], eske ou te konsilte nan yon sant?
    a. Wi [ ]
    b. Non [ ]

40. Kiles ki te koupe e mare lombrik [non timoun-nan]?
    a. Ou-menm [ ]
    b. Youn moun nan fanmi-ou [ ]
    c. Matron [ ]
    d. Fanm-saj [ ]
    e. Dokte ou enfirmye [ ]
    f. Lot (Presize) [ ]
    g. Pa konnen [ ]

WORLD VISION RELIEF & DEVELOPMENT, INC.

PART II
SUSTAINABILITY ASSESSMENT REPORT
LA GONAVE CHILD SURVIVAL PROJECT

Submitted by:

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September 1991

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INTRODUCTION

The La Gonave Child Survival Project (CSP) is a three-year project which began in October 1987 after it received a $300,000 grant from the A.I.D. Bureau for Food for Peace and Voluntary Cooperation, matched by WVRD ($200,000). In 1988, it received reprogrammed money from the A.I.D.-funded Sudan CSP to run it for a fourth year.

The goal of the project is to reduce the mortality and mortality among under-fives by expanding and strengthening preventive and promotive services on the island. Over the past years, the project has managed to develop a community-based health system through the training of a cadre of community workers who will assume responsibility for sustaining CS activities under the guidance and support of government and nongovernment agencies operating on the island.

METHODOLOGIES

The objective of this evaluation is to review the progress of its sustainability strategies and to suggest actions/solutions to strengthen them. The external consultant/evaluator, Dr. Fayla Lamothe, assisted by Dr. Florence Dyer, WV Haiti Health Officer/CSP Technical Adviser, conducted an evaluation of the sustainability aspect of the La Gonave Child Survival Project. They reviewed project records, discussed project operations with the staff and community health workers, and interviewed Section Health and Development Committees (SHDCs) using a questionnaire (Appendix 1). The content of the questionnaire was designed using the sustainability assessment guideline from FVA/PVC. Six health committee members representing five sections served as respondents. Also interviewed were representatives from NGOs operating on the island.

FINDINGS

A. Status

A.1 The Child Survival Project has been extended for another three years, hence it will continue to receive A.I.D. funds until September 1994.

A.2 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:

a. 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 2.

Presently, there is no representation from the Ministry of Health on the island because the subdistrict medical officer is on study leave. A temporary replacement, Dr. Etriplet, stayed briefly and later joined

the health project of the Episcopal Church. Nongovernment organizations, such as the Wesleyan Mission, Church World Services, the Episcopal Church, the Catholic Church, and World Vision also envisage Section Health Development Committees (SHDCs) to participate in planning and monitoring activities on the island.

b. Project reports are shared with the Ministry of Health in Port-au-Prince. The former subdistrict medical officer occasionally joins the CSP team in rally posts and staff meetings. 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 no financial assistance could be obtained presently. The extension phase of the project (FY92-94) provided for a gradual phasing in and out strategy, but the specifics have not been worked out.

B. Plan

B.1 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. However, no concrete steps on "preparing tasks for project phaseout" have been taken yet. The other strategies proposed in the DIP included:

- Intensive social sensitization activities (second strategy).
- Training a cadre of health workers with different tasks, e.g., SHDCs, SHDAs, TBAs, and MHAs (third strategy).
- Assisting communities to develop their own networking system with MOH and other NGOs—intra- and intersectorial agencies (fourth strategy).

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

Another strategy implemented 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

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SHDC and Section Health and Development Agents (SHDAs) in project planning and activities, e.g., monthly meetings, training sessions and organization of activities, have been well accomplished.

B.2 Only the fourth strategy—enabling communities to network—needs to be strengthened. The other strategies, especially the training of grassroots worker to form the nucleus of the community team-based system, have been put in motion.

B.3 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 activities, e.g., vaccines, road-to-health cards, pamphlets, etc. In 1990, the MOH/EPI office in Port-au-Prince gave $3,000 to the project to immunize children from four sections not covered by the project.

B.4 Counterpart institutions tend to keep their commitment once the project proves its mettle—the project delivered what it promised to deliver and kept them on the loop, updated through regular meetings. Presently, the MOH is unable to keep its commitment because of financial constraints, the political situation, and the difficulty of finding staff to work on the island.

C. Community Participation and Perception of Project Effectiveness

C.1 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 was 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 were distributed throughout the island to facilitate project operations.

SHDC members interviewed are exceptionally conversant with World Vision's Child Survival activities on the island. 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 feedback.

C.2 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.

C.3 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 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.

C.4 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:

Name	Position	Section
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.

C.5 To help ensure that activities will continue after donor funding ends, the community of La Gonave has contributed the following resources:

a. Human Resource

(1) 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 (MHAs).

(2) 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:

Volunteers	Activities
Health committees (SHDCs)	Planning and conducting meetings; mobilizing communities, interest groups.
Health agents (SHDAs)	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

SHDCs were trained and given increasing responsibility for the administrative and functioning of the multipurpose center in Ti Palmiste. SHDAs work at least two hours each week to cover enough households to remind them of the rally post schedule and to motivate them to bring their children for immunization and growth-monitoring. Community members support a significant "opportunity cost" in terms of time devoted to attend rally posts and educational meetings and the cost of transportation.

b. 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

D.1 The Child Survival 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.

D.2 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.

D.3 At the time of evaluation, all MOH positions were suspended and offices closed so the evaluators were not able to interview them. Nonetheless, management reports showed that 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 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 been receptive to the project's request for material and sometimes even manpower support to the project.

D.4 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 vaccines, educational materials, etc.

D.5 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 salaries of the CS staff, incentives for CHWs, and food during training sessions for health workers.

E. Monitoring and Evaluation of Sustainability

E.1 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 supply of vaccines
Collaboration with NGO on La Gonave	Coordinating meetings at least three times per year

E.2 The indicators with asterisks (*) have not been tracked since the project has just started these activities. The other indicators are being monitored informally.

E.3 The in-country agencies who worked with World Vision during this project evaluation are as follows:

Midterm Evaluation

Agency	Representative	Designation
Ministry of Health	Dr. Eric Ferdinand	La Gonave Subdistrict Medical Officer
Haitian Child Institute	Dr. Antoine Augustin	Director
A.O.P.S. (Private Health Agency)	Dr. Philippe Hirsch	Evaluation Specialist

Final Evaluation (3rd year)

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

Final Evaluation (4th year)

Agency	Representative	Designation
MOH Bureau of Nutrition	Dr. Fayla Lamothe	Director
	Charleine Hecdivert	Epidemiologist

F. Calculation of Recurrent Costs

F.1 The La Gonave Child Survival Project has a combined budget of $723,464—42 percent USAID funds ($464,284) for four years. The fourth year A.I.D. funds came from reprogrammed money from the Sudan CSP. WVRD's match totaled $259,180 (35.8%). This match increased by $58,445 because of the cost incurred by the purchase of a vehicle of non-U.S. source (waiver not granted) and the salaries of personnel from the water development project partly working for CSP and the two CSP auxiliary aides.

The project has been on budget except for an overspending in the travel/per diem line item. The overspending was largely due to an underestimation of staff travel during rally posts and unprogrammed adjustment for fuel cost. During the last year, however, the frequency of travel by nurse auxiliaries to their respective catchment areas has decreased because of their deployment. Only the core team moves around to supervise, follow up and collect data from each section.

The following cost items were charged against the USAID grant:

Procurement	10.3%	$ 47,815
Field Cost Overhead	8.3%	$ 38,335
Other Program Cost	81.4%	$378,134
Total Field Cost	**100.0%**	$464,284

F.2 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, basic pharmaceuticals, etc.
- Maintenance: Gas, repairs, etc., of car and motorcycle

The above estimate includes the cost for delivering Vitamin A activities because it shares the CS mechanism for the delivery of its intervention.

F.3 Project calculation of recurrent cost does not include start-up cost, and inputs from other agencies, e.g., MOH.

F.4 If we assume that 75% of the estimated cost ($20,250 per year) should be shouldered by the Child Survival project, the cost/beneficiary at this time is US$.91 per target beneficiary, i.e., 10,704 children 0-59 months and 11,346 women 15-49 years old. This amount is very reasonable given the achievements made by the project and the environment in which the project operates. Community members, especially mothers, have adopted child protective behaviors and been moved to partly take responsibility for their children's health—all at a reasonable cost.

F.5 The costs unlikely to be sustained include: Car and motorcycle fuel, maintenance, repair, and cost of supervision.

G. Cost Recovery Attempts

G.1 The project has attempted the following approaches:

a. Cost reduction by transferring part of the financial burden to the community.
b. Revenue mobilization from these two categories:
   - Potential revenues for recurrent cost financing, e.g., sales of basic pharmaceuticals, service prepayment fees, and income-generating activities.
   - Revenues for start-up cost, e.g., community donated land for staff house and the multi-purpose service center and provided voluntary labor.

G.2 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.

At the project base, $166.66/month was generated this year from patients seen at the project dispensary.

The health committees began implementing a scheme—the contribution of US$.10 per family to cover health agents' cost of travel.

G.3 Cost-recovery schemes implemented by the project were 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.

G.4 The following schemes generated an estimated amount of money for FY91:

Scheme	**Revenues**
Sales of basic pharmaceuticals	$ 699.72
Service center charges	466.90
Charges at rally posts*1	690.00
Income-generating activities *2	.00
Total	**$1,856.62**

*1 Rally posts ranging from 79 - 146 each quarter are held at each target section. The SHDCs charge U.S.$0.10 per family at every rally post.

*2 The IGAs have just taken off the ground.

The above computation does not include the cost of labor volunteered by the grassroots workers and the land donated to the project. These mechanisms generated enough money to provide travel incentive to the SHDAs @ $10 per month.

G.5 The potential success of the above cost-recovery mechanisms could be attributed to these factors:

a. Communities' felt "ownership" of CSP activities that evolved over time. SHDCs have become the basic unit of empowerment in these communities. They have taken more responsibilities to ensure that services are continued.

b. Support from collaborating agencies—this was also a very slow process. The project had to prove that it will deliver what it promised to deliver before these agencies took a second look at the project. Establishing credibility before the eyes of the community and the other agencies on the island is key.

Some factors which hampered the implementation of the above mechanisms include:

a. Improper approach to development activities.
b. Expectation of continuing support which created an attitude of dependency.
c. Concepts of cost-recovery are not clear to the staff and the communities.

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.

H. Income Generation

H1. The project has recently started three income-generating activities:

Section	Type of IGA
Pointe-a-Raquette	Grain Storing
Palma	Community Store
Grande Source	Community Store

Each section was given a "seed" fund of US$5,000 signed by the members of the SHDC. Funds were provided after many weeks of discussion with the communities and orientation by the administrative coordinator.

Grain Storing. During harvest time, the SHDC will buy grains and store them in silos that the community will build. The stored grains will then be sold during lean periods at price less than what one will pay for in retail but also at a profit. Ten percent of the profit each month will be collected to partially defray recurrent cost, e.g., cost of weighing scales.

Community Store. Each of the store will purchase basic commodities such as soap, beans, oil, sugar, etc. and sell it at 5% cost less than what people will pay for if they buy them on retail. There are not much stores in these areas and private store owners have been apprised of the purpose of these IGAs. Ten percent of the profit will also be kept to partially support recurrent costs.

H2. These IGAs are expected to generate revenues within a year's time.

H3. Some potential reasons why these IGAs will fail are:

a. resistance by some community members; some might sabotage the scheme
b. local island politics might come into play
c. the IGA concept is not clearly communicated by the project staff to the communities
d. poor planning and implementation

The success of these IGAs will depend upon these factors:

a. the present reconstituted SHDCs were elected democratically by the people in their community. These communities have trust and confidence in the SHDCs and subsequently expected to support these IGAs.
b. these IGAs were suggested schemes by the communities themselves.
c. the support and encouragement provided by the project and other agencies
d. the knowledge and skills of the SHDCs and the communities to implement these type of activities.
e. the constant feedback by the SHDCs to their constituencies regarding the progress and problems encountered in the implementation of the IGAs
f. communities' "ownership" of the activities.

H4. These IGAs have reinforced communities' perception of the project - the project is willing to partner with them and when applicable, to respond to their needs. Since the IGAs are community-owned and managed, all members of the community will have access to CS services.

LESSONS LEARNED AND RECOMMENDATIONS

1. Social mobilization using face-to-face encounters with mothers and their families by the grassroots workers e.g., SHDCs, SHDAs, MHAs, and TBAs have been quite effective. This is evidenced by an increased demand for CS services, the achievement of high EPI coverage and low dropout rates, narrowing of knowledge-practice gaps in certain child "protective" behaviors.

   * Continue to build on the ability of the SHDCs as the basic unit of empowerment in the community. Equip them with minimum essential management skills.

2. Self-sufficiency in health in poor communities will be hard if not impossible to achieve. Nonetheless, these communities should be encouraged and moved to share the cost to sustain CS services.

3. It is difficult to develop a sustainability action plan with multiple collaborators but it is absolutely necessary.

   * Draw up a sustainability action plan and include it in the detailed implementation plan.

4. Improve the tracking of project finances; attempt to track expenditures by interventions.

   * Obtain technical assistance on costing analysis.

5. Document the processes involved in community participation and the project's progress toward achieving sustainability.

6. Obtain technical assistance on income-generating activities.

APPENDIX 1

EVALUATION DE LA PARTICIPATION COMMUNAUTAIRE DANS LE CADRE DES ACTIVITIES DE PROJECT DE SURVIE DE L'ENFANT VISION MUNDIAL HAITI AOUT 1991

Rencontre Avec Les Comites De Sante
(Interview with the Health Committees)

Date _____ Localite _____
Duree d'existence du comite _____
(Length of time committee is in existence—in months)
Nombre de membres _____ Nombre de sous comites _____
(Name of members) (Name of Your Committee)
Membre(s) questinnes: Nombre (Name) _____
Fonctions (Functions) _____
_____
_____

A. **Projet de Sante de V.M. Connaisance et Participation au volet Survie de L'Enfant**
(Knowledge and Participation in the Child Survival Project)

1. Ki sa V.M. ap fe nan zafe sante La Gonave?
(What is WV doing in the area of health on La Gonave?)

a. _____ c. _____
b. _____ d. _____

2. Pale nou sou pwoje Survie de L'Enfant, Ki sa li ye?
(Tell us about the Child Survival Project, what is it?) _____
_____
_____

3. Eske ou te la nan diskiyon pou komanse pwoje Survie de L'Enfant a?
(Where you here when the Child Survival Project started?)

Wi (Yes) _____ Non (No) _____
Pou ki? (Why?) _____
Ki patisipasyon ou te bay? (What participation did you give?) _____
_____
_____

B. Activites des Comites
(Activities of the Committee)

1. Konbyen sou komite genyen nan seksyon an? (How many local committees are there in your section?) _____

2. Konbyen fwa komite a reyini nan ow mwa? (How many times did the committee meet in the last month?) _____

   a. Ki denye fwa li te reyini dat. (Date of last committee meeting.) _____

   b. Ki moun ki p nan komite ya ki te la? (What decisions were taken in the last meeting?) _____

   _____

   c. Kirezilta ki te soti nan reyinyon sa a? (What decisions were taken in the last meeting?) _____

   _____

3. Ak ki moun memb domite yo pale? (With whom did the committee meet?)

   Paran (Parents): Wi ____ Non ____ Jen (Youths): Wi ____ Non ____
   Matron (Midwife): Wi ____ Non ____ Manman (Mothers): Wi ____
   Non ____

   Ki lot moun? (Who else?) _____
   Ki bo yo rankontre? (Where did you meet?) lekol (school) _____
   mache (market) _____ legliz (church) _____ Ou byen (others) _____

4. Ki aktivite komite ap fe ki fe li rantre lajan? (What income-generating activities [IGAs] is the committee involved in?)

   a. Kotizasyon-eksplike (Contribution-explain) _____

   _____

   b. Pwoje-eksplike (Project-explain) _____

   _____

5. Sita gen bezwen, ki jan aktivite sa a ta ka ede pwoje a kontinye? (If necessary, how can IGAs help the CS project continue?) _____

   _____

   _____

   _____

C. Autres (Others)

1. Ki jan ou we miss la ap travay ak kominote a? (How does the project nurse auxiliary work or collaborate with the committee?) _____

2. Ki vale pwoje Survie de L'Enfant pou komite ya? (What is the importance or value of the Child Survival Project to the committee?) _____

   Poukisa? (Why?) _____

3. Konye a ki sa l/komite a kapab ofri pou kontinye pwoje a? (Right now, what can the committee offer to continue the project?) _____

   Pou amelyore pwoje a? (To improve the project?) _____

4. Ki sa komite a swete? (What does the committee which/hope?) _____

Response recueillies par: _____

LE COMITE CENTRAL DE LA GONAVE

A) I1 est crée un comité central de santé à La Gonave, ce ler juillet 1991.

B) • Ce comité, à but non lucratif, est formé des representants des organisations missions oeuvrant dans le domaine de to santé à La Gonâve.

• A cette date, les membres de 1' organization sunt:

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'ile dans le domaine de la santé.

2. Promouvoir la collaboration entre ces missions et organisations afin d'eviter la duplication des activites et de multiplier l'impact de ces organisations et missions sur le developpement de La Gonâve.

3. Créer ct 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 activitès 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 imformations, discussions, probléme a resoudre etc. . . I1 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 to derniére reunion annuelle le comité élira un president.

I) Le president organisera les reunions et les presidera. I1 fera un compte rendu de chaque reunion et une copie de ce rapport sera donné à cahque membre avant la prochaine reunion.

Signature:

World Vision _____ Service Chretien _____

Wesleyen _____ Eglise Catholique _____

Episcopale _____

WORLD VISION RELIEF & DEVELOPMENT, INC.

PART III
END-OF-PROJECT PIPELINE ANALYSIS
LA GONAVE CHILD SURVIVAL PROJECT

December 1991

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./HAITI LA GONAVE CHILD SURVIVAL PROJECT
#OTR-0527-A-00-7216-00

FIELD	Actual Expenditures To Date (10/01/87 to 10/15/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (10/01/87 to 10/15/91)		
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	31,270	1,009	32,279	(2,883)	(1,009)	(3,892)	28,387	0	28,387
B. Equipment	0	170,370	170,370	0	899	899	0	171,269	171,269
C. Services/Consultants	16,545	0	16,545	2,455	0	2,455	19,000	0	19,000
SUB-TOTAL I	47,815	171,379	219,194	(428)	(110)	(538)	47,387	171,269	218,656
II. EVALUATION/SUB-TOTAL II			0	0	0	0	0	0	0
III.INDIRECT COSTS									
Overhead on Field (Current Prov.=20%)	38,335	62,575	100,910	0	(42,325)	(42,325)	38,335	20,250	58,585
SUB-TOTAL III	38,335	62,575	100,910	0	(42,325)	(42,325)	38,335	20,250	58,585
IV. OTHER PROGRAM COSTS									
A. Personnel	268,776	46,763	315,539	12,969	(11,763)	1,206	281,745	35,000	316,745
B. Travel/Per diem	43,448	24,782	68,230	(11,253)	(7,121)	(18,374)	32,195	17,661	49,856
C. Other Direct Costs	65,910	12,126	78,036	(1,288)	2,874	1,586	64,622	15,000	79,622
SUB-TOTAL IV	378,134	83,671	461,805	428	(16,010)	(15,582)	378,562	67,661	446,223
TOTAL FIELD	464,284	317,625	781,909	0	(58,445)	(58,445)	464,284	259,180	723,464