

**World Vision Relief & Development Inc.**

**FIRST ANNUAL REPORT  
LA GONAVE CHILD SURVIVAL  
VII PROJECT  
LA GONAVE ISLAND, HAITI**

**Starting Date: October 1, 1991  
Ending Date: September 1994**

**Submitted to:**

**Child Survival and Health Division  
Office of Private and Voluntary Cooperation  
Bureau of Food and Humanitarian Assistance  
Agency for International Development  
515 22nd Avenue, N.W., Room 103C, SA-2  
Washington, D.C. 20523**

**PVO Headquarters Contact:**

**Milton Amayun, MD., M.P.H.  
World Vision Relief & Development, Inc.  
919 W. Huntington Drive  
Monrovia, CA 91016**

**October 15, 1992**

# TABLE OF CONTENTS

	<u>Page #</u>
<b>ABBREVIATIONS</b> .....	ii
<b>1. RESULTS IN YEAR ONE</b> .....	1
1.1 Major Results .....	1
1.2 Change in Approach to Individuals at Higher Risk .....	3
1.3 Staffing .....	3
1.4 Continuing Education .....	4
1.5 Technical Support .....	4
1.6 Community Participation .....	5
1.7 Linkages to Other Health and Development Activities .....	6
<b>2. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED</b> .....	6
2.1 Constraints .....	6
2.2 Unexpected Benefits .....	8
2.3 Lessons Learned .....	9
<b>3. CHANGES IN PROJECT DESIGN</b> .....	10
3.1 Perceived Health Needs .....	10
3.2 Project Objectives .....	10
3.3 Planned Interventions .....	10
3.4 Potential and Priority Beneficiaries .....	11
<b>4. PROGRESS IN HEALTH INFORMATION SYSTEM (HIS)</b> .....	11
4.1 Characteristics of the Health Information System .....	11
4.2 Special Capacities of the Health Information System .....	11
4.3 Management of the Health Information System .....	13
<b>5. SUSTAINABILITY</b> .....	14
5.1 Recurrent Costs .....	14
5.2 Strategies for Increasing Post-Project Sustainability .....	14
5.3 Cost-Recovery .....	15
<b>6. PROJECT EXPENDITURES AND JUSTIFICATION TO BUDGET CHANGES</b> .....	16
6.1 Pipeline Analysis .....	16
6.2 Budget Changes .....	16
<b>7. 1992/1993 WORK SCHEDULE</b> .....	17
7.1 1992/1993 Work Schedule .....	17
7.2 FY93/94 Budget .....	19

## ABBREVIATIONS

<b>A.I.D.</b>	Agency for International Development
<b>ALRI</b>	Acute Lower Respiratory Tract Infection
<b>AOPS*</b>	Association of Private Health Organizations
<b>BCG</b>	Bacillus Calmette Guerin
<b>CWS</b>	Church World Service
<b>CS/CSP</b>	Child Survival/Child Survival Project
<b>DPT</b>	Diphtheria-Pertussis-Tetanus
<b>EPI</b>	Expanded Program of Immunization
<b>HDC</b>	Health and Development Committee
<b>HIS</b>	Health Information System
<b>IHE*</b>	Haitian Institute for Children
<b>MHA</b>	Maternal Health Assistants
<b>MSPP*</b>	Ministry of Public Health and Population
<b>NGOs</b>	Non-Governmental Organizations
<b>OPV</b>	Oral Polio Vaccine
<b>ORT/ORS</b>	Oral Rehydration Therapy/Oral Rehydration Solution
<b>PVO</b>	Private Voluntary Organization
<b>TBA</b>	Traditional Birth Attendant
<b>VAC</b>	Vitamin A Capsule
<b>WHO</b>	World Health Organization
<b>WP</b>	Water Project
<b>WVH</b>	World Vision Haiti
<b>WVRD</b>	World Vision Relief & Development
<b>ZHDA</b>	Zonal Health and Development Agents

\* French acronyms were given English translations.

## 1. RESULTS IN YEAR ONE

### 1.1 Major Results

In April 1991, World Vision Haiti (WVH) received a matching grant from the Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance to expand and extend its current CS activities to all sections on the island and to incorporate Acute Lower Respiratory Infection (ALRI) and malaria control interventions. This year, the La Gonave Child Survival Project (CSP) has functioned under very difficult conditions brought about by political turmoil and economic embargo. This resulted in a slowing down of CS activities, restricted mobility of staff, and attrition of community-based health workers.

In spite of these challenges, the project has achieved the following:

- ▶ Extension of CS activities to four additional sections: Grand Vide, Picmy, Trouis Louis, and Gros Mangles. The section of La Source has also been included in the "new sections" since La Source did not have a nurse auxiliary last year. ALRI and malaria control have been added to existing interventions which include immunization of 0-4-year old children against six vaccine-preventable diseases, growth monitoring, Oral Rehydration Therapy (ORT) and diarrheal control, community health education, family planning, and Vitamin A capsule (VAC) distribution.

The table below shows the level of attainment of FY92 project objectives against this year's target: (source: service records)

Indicator	FY92 ATTAINMENT		FY92 TARGET	
	Number	Percent	Number	Percent
No. of children 0-11 months vaccinated with:				
BCG	2,136	70.8%	2,413	80%
DPT3	1,241	41.1%	2,413	80%
OPV3	1,644	54.5%	2,413	80%
Measles	1,261	41.8%	2,413	80%
Fully Immunized	1,199	39.7%	2,112	70%
No. vaccinated with TT2:				
Pregnant women	619	15.6%	3,375	85%
WCBA	1,301	6.8%	15,246	80%
No. given Vitamin A Capsules:				
Children 6-89 months	17,183	N/A	N/A	N/A
(4th doses only)	18.1%	N/A	N/A	60%
Post-partum mothers	710	17.9%	794	20%

Indicator	FY92 ATTAINMENT		FY92 TARGET	
	Number	Percent	Number	Percent
No. of contraceptives given:				
Cycles	2,134	N/A	N/A	N/A
Condoms	4,544	N/A	N/A	N/A
Injections	200	N/A	N/A	N/A

*a. Immunization*

Satisfactory progress has been made toward our objective to immunize infants 0-11 months with EPI vaccines despite problems of transportation and shortage of vaccines. TT<sub>2</sub> coverage among pregnant women and other women of childbearing age is low.

*b. Diarrheal Diseases Control*

The promotion of ORT and the selling of ORS packets at numerous rally posts has increased the number of children treated with ORT during diarrhea. Community teachings and demonstrations were boosted by a fear of a cholera epidemic.

*c. Family Planning*

Fear of contracting AIDS has precipitated an increase in the use of condoms. Over 4,000 condoms were distributed by community health workers during the year. The project has forged an agreement with another PVO, *Profamil*, for continuing training of CSP staff and health workers and supporting surgical sterilization at the Wesleyan hospital in *Anse a Galets* for couples desiring this method.

*d. Health Education*

*Transfer of knowledge* at all levels has been one of the most important activities this year. Extensive training sessions were held for the following cadre of workers:

- ▶ 94 Zonal Health and Development Agents (ZHDA)
- ▶ 11 Health and Development Committees (HDC)
- ▶ 2 Health agents in primary eye care
- ▶ 98 Mother Health Assistants (MHA)
- ▶ 30 Traditional Birth Attendants (TBA)
- ▶ 10 CSP staff members in Acute Respiratory Infections and treatment of malaria.

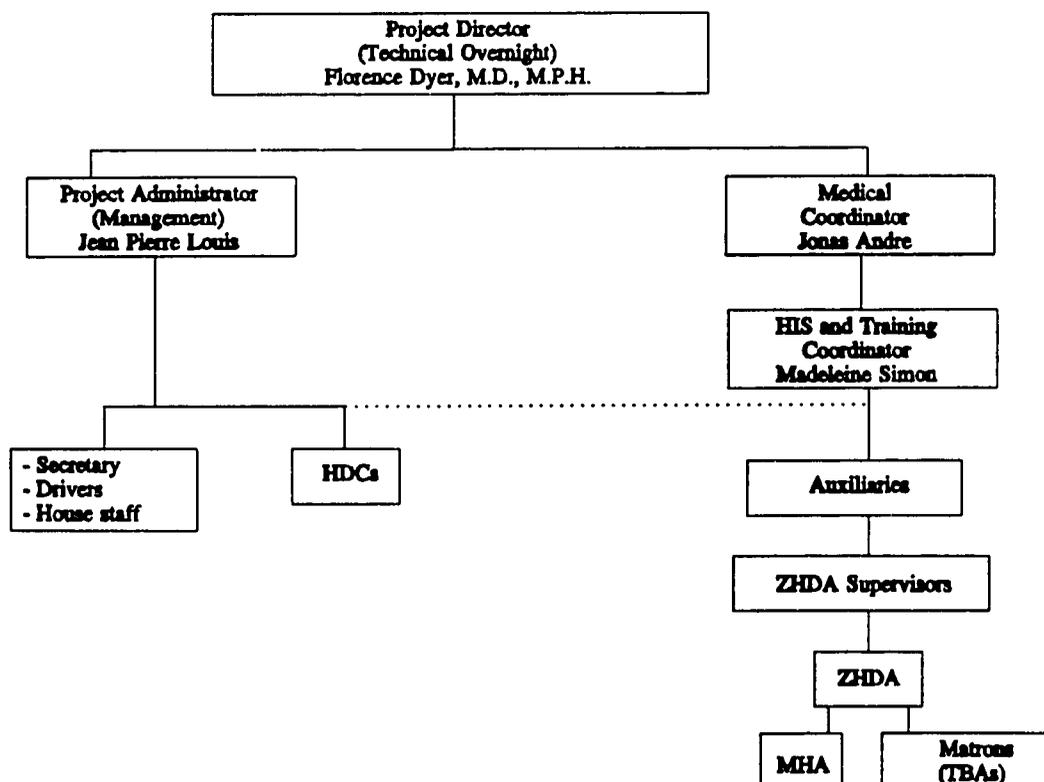
- ▶ 20 CSP staff members and community leaders in health program management.
- ▶ 25 teachers and all primary schoolchildren from 15 schools informed of Vitamin A issues; staff from 4 health centers educated in Vitamin A.

## 1.2 Change in Approach to Individuals at Higher Risk

There are no changes in the definition of "high risk" groups. Our approach remains the same. During this past year, however, the embargo has had considerable effect on the availability of food, resulting in a rise in the number of undernourished children. The project staff, through its growth-monitoring activities, has become keenly aware of the plight of severely malnourished children. We have attempted to reach them through *nutrition centers* which conducted feeding and Vitamin A supplementation and followed through with growth-monitoring. We also made sure that the child's immunization status is checked. In July, a field survey on the nutritional status of children 0-4 years old has been completed in collaboration with the Haitian Child Health Institute. The results are being finalized.

## 1.3 Staffing

The organizational chart and job descriptions have remained unchanged.



## 1.4 Continuing Education

The staff benefited from the following continuing education activities:

Subject	Date	Trainers	Trainer/Venue
1. Sustainability Planning	October	CSP Staff	Center for Development of Human Resources in Kaliko
2. Training in Malaria, AIDS, and ALRI	October	8 Auxiliaries 4 Health Agents	INHSAC in Port-au-Prince
3. Vitamin A Malnutrition and PEM; Use of the Road-to-Health card	March	Staff of all Health Centers	Ti Palmiste Project based in La Gonave
4. Data Collection and CSP Interventions	April	Health Agents	Project based in Ti Palmiste
5. Visit/Observation of SCF's Solar Food Drying System	April	Medical Coordinator and Auxiliary Nurse	Save the Children/Maissade
6. TBA Training	Monthly	TBAs	CSP staff in respective localities
7. The importance of family planning on women's development	August	Two Nurse Auxiliaries	Profamil in Port-au-Prince
8. Primary Eye Care	August Sept.	Two Health Agents	EYE CARE Port-au-Prince

In April, Dr. Florence Dyer, Project Director, participated in a two-day conference on Community Participation and Health. The conference was run by the Center for Development of Human Resources in Port-au-Prince. In June, Dr. Dyer also attended the INMED Conference on the Fight Against Hidden Hunger Among Children, held in Washington, D.C. While in Washington, she had the opportunity to network with other NGOs and to learn from health sessions going on at the conference sponsored by the National Council for International Health.

## 1.5 Technical Support

1.5.1 In-country technical support was provided by the following organizations/specialists:

### a. *Ministry of Health*

- ▶ Training on Cholera—its control, prevention, and treatment (August)
- ▶ Health Program Management (June)

In April, as part of the celebration of World Health Day, the MOH staff joined the CSP team and served as facilitators during a one-week health fair in the three largest sections of the island.

- b. *Child Health Institute*** — In the design, implementation, and analysis of an island-wide survey of the nutritional status of children under five (July).
- c. *Mrs. Ines Quitel*** — Training of La Gonave CSP's Zone Health and Development Agents (ZHDAs) and Mother Health Assistants (MHAs). Mrs. Quitel is a nurse and educator responsible for the training of health workers and community members in CARE projects for 15 years.
- d. *Mrs. Mona Prismo*** — Training and evaluation of the performance of the CSP staff. Mrs. Prismo, a nurse who specialized in health education and program management, heads the MOH's health education department.
- e. *Center for Development of Human Resources*** — A USAID-funded NGO which conducted a preliminary assessment of project IGAs on the island.

1.5.2 Technical support from headquarters was provided by:

- a. *Dr. Fe Garcia*** — Senior Program Development Officer who met with the Project Director, the La Gonave Administrator for Integrated Development Project, and the CSP Administrator to assess the progress of the CS and Vitamin A projects and to assist the staff determine the need for a no-cost extension of the Vitamin A project.
- b. *Ms. Sandra Jenkins*** — CSP Finance Grant Coordinator who conducted a workshop in the Dominican Republic for the Barahona CSP team. The workshop was attended by the Administrative Coordinator for La Gonave. The workshop was on grant accounting and financial reporting for CSPs funded by USAID.

## **1.6 Community Participation**

There are nine active community health committees supporting CSP activities. The other committees which are relatively new need sustained motivation. This year, the committees were actively involved in the following activities:

- ▶ Plan and implement the rally posts;
- ▶ Ensure that needed materials such as vaccines, cold chain, Vitamin A, medication, etc., are available at the rally post sites;
- ▶ Monitor their respective sections to report problems such as epidemics, disasters, etc.;
- ▶ Continue to motivate their communities;

- ▶ Meet with ZHDAs and MHAs every month;
- ▶ Share with community members the progress of CS activities; and
- ▶ Provide moral support to ZHDAs, MHAs, and TBAs.

These committees met monthly, i.e., three times during the last 90 days. Last month, they met with CS staff and representatives from other NGOs on the island to reflect on the issue of sustainability.

## **1.7 Linkages to Other Health and Development Activities**

Project collaboration with MOH, UNICEF, and all NGOs on La Gonave has steadily improved through the years.

- ▶ During a measles (?) outbreak in the locality of Trou Marassa, project staff worked side-by-side with a team from MOH in the investigation, immunization, and education of the community.
- ▶ All NGOs and MOH representatives on the island participated in a CSP-sponsored three-day workshop on the sustainable development of La Gonave. The workshop is one of the initial steps in the project's strategy for sustainability.
- ▶ The project staff participated in an "emergency relief action" for La Gonave—they distributed food and medications donated by UNICEF.
- ▶ The project staff worked closely with other World Vision-sponsored projects to increase the availability of clean water, latrines, and schools for the communities.
- ▶ The Central Health Committee of La Gonave, initiated by the project, continues to meet regularly to share experiences and lessons learned.

## **2. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED**

### **2.1 Constraints**

These were some of the problems faced by the staff and the actions taken:

- a. *Cessation of CS Activities:*** Just as FY92 was about to begin, the democratically elected government of Haiti was overthrown, resulting in temporary cessation of CS activities for two weeks. This was followed by an embargo which further derailed project implementation.

**Strategy:** Two weeks after the military coup, the project administrator met with the local police and the health committees to discuss the resumption of

activities, staff safety and mobility. Health committees and ZHDAs accompanied the staff during home visits and education sessions until it was deemed safe for staff to travel unescorted.

Vitamin A capsule distribution in schools came to a halt because schools were closed for a while.

**Strategy:** The ZHDAs proceeded to the water points where children fetch water and administered VACs. We also resorted to door-to-door VAC distribution. This strategy has increased VAC coverage and lowered the dropout rate for dose-specific coverage.

- b. *Lack of Transportation:*** The CSP mini-yacht used to ferry staff and supplies to and from Port-au-Prince and around the coastal areas of La Gonave was made inoperative temporarily to prevent it from being hijacked by islanders planning to flee the country.

**Strategy:** A small wooden motorized boat was assembled at a cost of \$4,000 to continue CSP/Vitamin A activities in the coastal areas. Meanwhile, supplies and staff to and from Port-au-Prince were transported using over-crowded public boats.

The life span of a motor vehicle on the island is two years. In between this period, machine parts have to be replaced very often. The embargo caused these parts to have to be purchased at almost triple the pre-embargo price.

**Strategy:** In the absence of a functioning motor vehicle, we made use of donkeys to ferry vaccines and staff.

- c. *Potential Break in the Cold Chain:*** Hoarding of oil and gasoline was rampant, and severe blackouts occurred on the island.

**Strategy:** The project made sure that it had enough supply of propane gas. This enabled the vaccines refrigerators to function for at least four months.

- d. *Shortage of DPT Vaccines:*** In May, the MOH suffered from a severe shortage of DPT vaccines and cold boxes due to the embargo. We tried to canvass pharmacies, but they also ran out of supplies.

**Strategy:** There was not much we could do. We will, however, continue to educate, persuade, and motivate the health committees to set aside some funds from the earnings at the dispensary to pay for vaccines in cases of shortages or other contingencies.

We will try to explore with the management committee on La Gonave the feasibility of piloting a "scaled pre-payment insurance scheme" as a financial base for continuing CS activities on the island.

- e. An Increase in the Number of Undernourished Children:* Food supply to La Gonave comes largely from Port-au-Prince. Hence, quite a number of families with small children suffered from a shortage, or, at times, unavailability of food. Health committees requested the CSP team to open up nutrition rehabilitation centers.

**Strategy:** The CSP team and health committees identified three sites and conducted Akamil feeding and demonstrations for two months.

- f. Measles Outbreak:* In May, the Wesleyan Hospital reported over 100 cases of measles among children over seven years old and in adults. This is the CSP's fifth project year. Its priority target for immunization are infants 0-11 months. It is safe to assume that children who had measles in this outbreak were at least over two years old when the project began. There is a lesson to be learned here which we have included in Section 2.3.

There was also a reported outbreak of measles among children two years and above in Trou Marassa, a far, isolated locality where 75 families reside. No deaths were reported. Three members of the CS team along with the MOH Epidemiologist came to investigate. The course of the disease and some signs and symptoms were not compatible with measles, but could possibly be meningococemia or other eruptive disease. Unfortunately, no blood tests were done to confirm the diagnosis. Nonetheless, the CSP team proceeded to vaccinate children and to educate the families. Food supplementation using Akamil was provided to children who were moderately to severely undernourished.

- g. Attrition of Community-Based Health Workers:* The project lost ZHDAs, MHAs, and health committee members to the mass migration of islanders who fled the country due to political instability. For example, in Grand Lagon, five committee members left.

**Strategy:** We have now increased the membership in the health committees, ensured that ZHDAs train one or two assistants with the help of the nurse auxiliary assigned in the locality, and trained more Mother Health Assistants.

## **2.2 Unexpected Benefits**

There are a number of unexpected benefits to the project this year. The project strategy of a community-based health infrastructure consisting of Health and Development Committees, Zonal Health and Development Agents, TBAs, and Mother Health Assistants, plus the deployment of nurse auxiliaries in their respective catchment areas, have galvanized communities to work as a community, to view the importance of mothers as key players in the area of health, and to gradually take up responsibility for their own health. Other benefits include:

- a. Improvement and maintenance of roads by the community.

- b. Empowerment of women—more women are now members of health committees and more women have been trained as Mother Health Assistants.
- c. Recognition and trust afforded to CSP staff by NGOs and the Wesleyan Hospital in such a manner that they were invited to assist in the training of their own staff; NGOs have responded to CSP invitations in workshops/-coordinating meetings; and the project has become a supply point for VAC distribution all over the island.
- d. Provision of running water in Ti Palmiste, the project base location, after almost five "fetching" years, so that lush, green vegetation now surrounds the project base.

## **2.3 Lessons Learned**

2.3.1 CS projects cannot stand alone; they have to be integrated with development activities—activities which respond to felt needs expressed by the community, e.g., for water, food, etc.

2.3.2 Communities should be encouraged and intensely motivated to partly share (even financially) the burden of ensuring the availability of basic CS supplies to continue delivery of CS services.

2.3.3 Blackouts and shortages of fuel could occur and could put the vaccines at risk. It is imperative that a three- to four-month supply of gas, fuel, and material, especially vaccines, are in stock at the principal site of the project.

2.3.4 Whenever a CS project begins its activities, specifically immunization in an underserved community, it should also target older children for measles vaccination, even if the project focuses on children 0-11 months.

2.3.5 Door-to-door distribution of Vitamin A and door-to-door motivation for completion of immunization has a noticeable impact in the attainment of project targets. ZHDAs and MHAs are key players in this strategy.

2.3.6 Trained CVs such as ZHDAs should train one or two assistants as a hedge against attrition or turnover of volunteers. This strategy also increases community participation and transfer of knowledge, while ensuring that activities continue when a health agent leaves. This strategy will be emphasized during the next two years and shared with other NGOs.

2.3.7 Recognition and trust from peers/other agents working in the same project area takes time, quality work, patience, and sometimes subservience. One must not be viewed as a threat, but rather as a facilitator/co-trainer.

### **3. CHANGES IN PROJECT DESIGN**

#### **3.1 Perceived Health Needs**

Focus groups conducted in different communities revealed the following needs:

**3.1.1 Medical surveillance and care for pre-eclamptic/eclamptic mother**—The project is planning to train auxiliaries and health agents in the management of eclampsia in the absence of a doctor. The project also plans to make basic medication available in most localities after this training.

**3.1.2 Unavailability of medical eye care on the island**—Two health agents received training from EYE CARE to address common eye diseases. An agreement for referral of severe cases to the EYE CARE clinic in Port-au-Prince has been reached. Four more health agents will be trained in FY92/93.

#### **3.2 Project Objectives**

These are the changes in project objectives:

**Immunization** — To increase immunization coverage with EPI vaccines to 85% (instead of 95%) in children 12-23 months by September 1994.

**Intermediate Objective** — To establish a correct cold chain for the entire island by January 1993.

**ALKI Intermediate Objectives** — To develop a standard for treatment of ALRI for all health centers on the island and to develop a standard strategy for active disease surveillance in all rural sections with health committee participation.

**Nutrition Intermediate Objectives** — To establish one nutrition center for education, growth monitoring, and food supplementation in each rural section.

**Others** — Fifty percent of staff time will be devoted to the training of health agents in curative care and the establishment of a community drugstore (to provide basic drugs as well as for the drugstore to serve as an income-generating venture to pay the health agents).

#### **3.3 Planned Interventions**

During the last three months, project activities centered in nutrition—food supplements were given at fixed points to help a great number of children suffering from malnutrition. These nutrition centers received 30 children at a time who were given a cooked meal of Akamil and vegetables twice a week. Children were weighed and their immunization status checked. Mothers were trained in growth monitoring and preparation/cooking of nutritious locally available food. The project plans to expand this activity next year.

Another project plan is to open a clinic in each rural section in response to requests from the communities and eventually to use clinic earnings to generate income to finance selected aspects of the CSP.

### **3.4 Potential and Priority Beneficiaries**

Beneficiaries remain the same. However, nutrition activities will be intensified following an increase in cases of malnutrition among children 12 to 59 months old. The project plans to open two nutrition centers in the most populated sections, namely Palma, Grand Lagon, Gros Mangle, Trouis Louis, Grande Source, Pte-a-Raquette, and at least one nutrition center in another section to be identified. These centers will serve as a focal point for monitoring the health and nutrition status of children.

## **4. PROGRESS IN HEALTH INFORMATION SYSTEM (HIS)**

### **4.1 Characteristics of the Health Information System**

4.1.1 At the community level, the nurse auxiliary, along with the health committee and the health agents, keeps the immunization record book for target children and women of reproductive age. Emphasis is placed especially if the woman is pregnant. The book is updated monthly. The health agents' supervisor records births and infant deaths each month.

4.1.2 This system is very useful in tracing high-risk women and children. It enables the health worker to visit them at their home if necessary. The project has not made any changes in the system this year.

4.1.3 The project reports the activity at its main clinic in Ti Palmiste. These reports are useful since they allow the project to evaluate the extent to which resources are used, to monitor infectious diseases, and to provide a picture of the changing health needs in the communities.

4.1.4 Monthly meeting in each rural section allows the monitoring of health workers' activities. This is useful for project management since it allows the evaluation of cost efficiency of project activities and the need for training of community-based health workers.

### **4.2 Special Capacities of the Health Information System**

4.2.1 We monitor service standards such as the number of planned rally posts vs. actual rally posts held. These are described in the monthly reports. Our monthly report contains four parts, one of which is the plan of action for the next month. For example: Out of 90 rally posts planned in July 1992, 86 were actually held; four were canceled because of heavy rains.

#### 4.2.2 The project monitors sustainability indicators using four categories:

**a. *Transfer of Knowledge***

Indicator: Number of trained CHWs still active in the communities. For example, we know that we lost five trained health agents this year. They left for Miami on boats. They have been replaced, and training has started for new community volunteers, while the older CHWs continue to assist needy localities.

**b. *Collaboration with NGO and Government Agencies***

Indicator: Number of meetings and/or joint activities between project staff, MOH representatives, and staff from all NGOs working on the island. For example, this year the project organized a sustainability workshop attended by different agencies on the island.

**c. *Community Participation***

Indicator: Activities carried out by community members. For example, community members lent their donkeys to health agents for the transportation of vaccines during a fuel shortage. Communities continue to maintain the roads to make it easier for our vehicles to maneuver the roads.

**d. *Income-Producing Activities***

Indicator: Number of CS-supported activities financed from IGAs. For example, the dispensary at the project base generated enough money to restock the pharmacy and pay for the pharmacy aide.

4.2.3 The project focuses its attention on 0-4-year-old children. ZHDAs monitor cases of acute paralysis for tetanus and polio; fevers for measles, malaria, ALRI; diarrhea specifically for cholera; and coughs for pertussis and tuberculosis. These cases, if they occur, are referred to the auxiliaries, then to the hospital if necessary.

4.2.4 The project staff plans, implements, and monitors the time spent in project activities and education of CHWs.

4.2.5 The population census has been most difficult to collect, since in- and out-migration on the island was exaggerated this year. Lack of roads and a tense political climate made it impossible to complete the census to date.

*Infant mortality* is quite difficult to assess for a number of reasons:

- a. Two-thirds of deliveries are attended by TBAs at home. A majority of these deliveries continue to be unreported.

- b. Quite a few infants do not have birth certificates.
- c. Most neonatal deaths occur at home and remain unreported.

### **4.3 Management of the Health Information System**

4.3.1 For FY92, approximately ten percent of project expenditures have been spent on design, management, and strengthening of the HIS. Expenses incurred covered the following:

- a. Partial salary—HIS Coordinator
- b. Nutrition survey (shared with Vitamin A project)
- c. Workshop on data collection and analysis
- d. Computer supplies
- e. Photocopies—maps, forms, notebooks
- f. Purchases—plastic bags to protect health cards
- g. Production of reports—monthly, quarterly, DIPs, etc.

4.3.2 In March 1992, the project indicators were reviewed. We noted that coverage for CS activities was low, and mothers and their children do not come to the rally posts regularly. *Decision Taken:* Door-to-door motivation and tracking of defaulters.

4.3.3 In July 1992, during the monthly staff/committee meeting, data collected were shared with health agents and committee members.

4.3.4 Data collection is a responsibility of the nurse auxiliaries supported by the zonal health and development agents, matrons, and the health development committee members.

The HIS coordinator compiles the data, while analysis and monitoring of the quality of the data is the responsibility of the project director.

4.3.5 To improve the staff's skills in data collection, continuing training is given to the health agents in their own zones. In April, CSP staff and ZHDAs held sessions on HIS, its importance and uses, reporting formats, system for collection and feedback, and their roles in the HIS.

The project plans to intensify and obtain greater involvement of health committees and health workers in the HIS by encouraging competition between each rural section on data collection and utilization. Family heads are motivated to keep the health cards safe and secure. This is reinforced by periodic announcements during church services and public gatherings.

## 5. SUSTAINABILITY

### 5.1 Recurrent Costs

The project had many reflection days and workshops on sustainability. The specific recurrent costs that will continue after AIDS Child Survival funding ends are:

<i><u>Items</u></i>	<i><u>Projection</u></i>
a. Transportation costs (fuel, car maintenance)	Unlikely to continue. Could use donkeys as replacements.
b. Vaccines, immunization, and cold chain materials, Vitamin A capsules.	Can be taken over by MOH.
c. Community health agents' training and supervision.	Could be continued by MOH.
d. Health agents' fees to continue the HIS.	Could be paid by MOH.
e. Medical supplies.	Could be shouldered by community.

### 5.2 Strategies for Increasing Post-Project Sustainability

5.2.1 Sustainability was a strong consideration in the design of the project since 1988. A number of approaches were tried initially at a gingerly pace and are continuing. The approaches include:

- a. The creation of a central committee for health which will serve as an advisory/coordinating body for health activities on the island. The committee consists of representatives from all NGOs operating on the island, chairmen from two Health and Development Committees (HDC), a MOH representative, and the Chief of Commune. The committee was constituted in July 1991 and continues to meet every quarter.

The MOH has not had regular representation because the post for the subdistrict health officer has not been permanently filled. We continue to network with MOH through project reports, joint undertakings such as the April health fair, training activities, and visits to MOH.

- b. The establishment of an indigenous infrastructure which could serve as a community-based institution to ensure the continued delivery of CS services and to maintain linkages with relevant local resources from the communities, the government and non-government entities. This nucleus of community-based health workers consists of the SHDCs, ZHDAs, MHAs, TBAs, schoolteachers and selected schoolchildren.

WV Haiti's Integrated Development project has started a local "Management Team" comprising key leaders including members of HDCs on the island. This team could provide the overall management structure for health once the project phases out. The central health committee could then assume a project advisory status on matters pertaining to health.

- c. Intensive training and education of mothers on CS "protective behaviors." Groups of mothers called Mother Health Assistants have been trained on CS interventions and have served as motivators/educators in their respective localities. They also assist ZHDAs in the performance of the ZHDAs' job.
- d. The establishment of a dispensary at the project base which services unreached communities and which has generated funds to potentially pay the salaries of three ZHDAs/nurse auxiliary assistants. ZHDAs who have done exceptionally well as ZHDAs are gradually being promoted as project nurse auxiliary assistants. To date, the project dispensary has accumulated about \$5,000 from service fees and sale of basic medication.

This year, the Vitamin A project started income-generating activities to pay the health agents' fees and transportation. Three section health committees each received an average of \$2,000 to start businesses: two community stores began selling basic necessity products, and the other committee engaged in a grain storage scheme.

These had started well, but the benefits were progressively reduced because of the soaring price of goods and transportation following the embargo.

5.2.2 In order to cut recurrent costs, the project undertook/continued these activities:

- a. Nurse auxiliaries continued to be deployed in their catchment sections, thereby reducing the cost of travel such as fuel, maintenance, and repair. Donkeys were used instead of vehicles. This translates into more time spent by staff in their communities.
- b. Well-performing ZHDAs are now being trained to assume the role of nurse auxiliary aides. This could eventually reduce the cost for personnel salary and, at the same time, contribute to sustainability.
- c. The project utilized the services of local consultants instead of accessing external technical assistants.

### **5.3 Cost-Recovery**

5.3.1 About \$5,000 was generated from the sale of basic pharmaceuticals and fee-for-service charged at the project base dispensary. This revenue was deposited in a savings account. The plan is to use it to open satellite multipurpose clinics in underserved sections and to start a revolving fund for MHAs in FY93.

5.3.2 The communities have been receptive to the project's cost-recovery strategies. After all, it was the communities' desire that nurse auxiliaries be deployed in their areas and it was their request (since 1988) to have a dispensary in the middle of the island. The decision as to the management of the dispensary and the use of revenues are discussed with the health committees and transmitted to the communities. No patient is turned down for financial reasons. Hence, project activities do not create inequities in service delivery.

5.3.3. The staff and many CHWs attended a workshop on small business management in January 1992. Further training and local assistance is planned for the next year.

## **6. PROJECT EXPENDITURES AND JUSTIFICATION TO BUDGET CHANGES**

### **6.1 Pipeline Analysis**

(Format A is submitted separately from the body of this report.)

At the field level, the combined budget for the project life is US\$626,071. USAID contribution amounts to \$379,960 (60.68%) with a 39.32% (\$246,111) match from WVRD. The actual expenditure for FY92 (up to August 31, 1992) is \$184,845 against a planned budget of \$234,278, leaving unspent funds amounting to \$49,433. There could be some underspending, even if the September 1992 financial reports come in, because of the following reasons:

6.1.1 The purchasing power of the US dollar has almost doubled.

6.2.2 Some operating costs are shared with the Vitamin A project.

6.2.3 CSP activities were halted for the first two to three weeks in October and were implemented at a minimum capacity for a few months before activities resumed at full scale.

Spending with WVRD matching funds was lower (64.75%) against USAID funds (92.8%). The following were the major line items charged against USAID grant (USD):

	<u>Budgeted</u> (FY92)	<u>Expended</u> (until 8/31)	<u>% Spending</u>
Procurement	\$12,900	\$4,107	31.8
Evaluation	2,500	0	0.0
Indirect Cost	19,596	18,267	93.2
Other Program Costs	82,080	87,232	106.27

Most of the spending under Other Program Costs could be attributed to travel/per diem during training/workshops and coordinating meetings, communications charges for telephones and faxes. A wooden boat has been purchased to facilitate the movement of staff in target communities along the coast.

## **6.2 Budget Changes**

There are no major changes to the budget.

## **7. 1992/1993 WORK SCHEDULE**

### **7.1 1992/1993 Work Schedule**

#### **October 1992-December 1992**

- ▶ Conduct workshop on HIS for CSP staff (October 1992).
- ▶ Conduct workshop on HIS for SHDCs and ZHDAs.
- ▶ Install one nutrition center and one clinic.
- ▶ Continue rally posts for Child Survival services.

#### **November 1992**

- ▶ Continue rally post and continue school health education activities.
- ▶ Hold one week for ferrying couples to Wesleyan Hospital for surgical sterilization.
- ▶ Evaluate the HIS.
- ▶ Train groups of mothers for small, revolving fund activities.
- ▶ Train CS staff and ZHDAs on malaria.
- ▶ Develop a standard management of ALRI in collaboration with staff from other health facilities in La Gonave.

#### **December 1992**

- ▶ Continue rally posts' activities—continue health education of schoolchildren.
- ▶ Hold a workshop on family planning for staff and ZHDAs.
- ▶ Conduct a workshop for all health center staff on management of ALRI.
- ▶ Start two nutrition centers and two clinics.

#### **January 1993**

- ▶ Continue rally posts' activities—continue health education of schoolchildren.
- ▶ Train health agent in basic curative services such as diagnosis and management of fevers, how to put on dressings, etc.
- ▶ Train health agents in the use of antibiotics.
- ▶ Develop a standard management procedure for malaria and diarrhea.
- ▶ Start two nutrition centers and two clinics.

### **February 1993**

- ▶ Continue rally posts' activities—continue health education of schoolchildren.
- ▶ Hold a workshop with staff from health centers on standard management of malaria and diarrhea.
- ▶ Train groups of mothers for small business management.
- ▶ Start two nutrition centers and two clinics.

### **March 1993**

- ▶ Continue rally posts activities—continue health education of schoolchildren.
- ▶ Train health agents with health committees on HIS and evaluation.
- ▶ Conduct one week on surgical sterilization of couples desiring the method.
- ▶ Start two nutrition centers and two clinics.

### **April 1993**

- ▶ Continue rally posts activities—continue health education of schoolchildren.
- ▶ Hold an island-wide health fair on child survival during the week of World Health Day.
- ▶ Evaluate nutrition centers and clinics.

### **May 1993**

- ▶ Continue rally posts and health education of schoolchildren.
- ▶ Continue nutrition center activities.
- ▶ Train health agents and mother health assistants in family planning and community health education.

### **June 1993**

- ▶ Continue rally post and health education of schoolchildren.
- ▶ Continue nutrition center activities.
- ▶ Conduct a workshop on sexually transmitted diseases for youth.
- ▶ Train staff and CHWs on sustainability.

### **July 1993**

- ▶ Continue rally posts.
- ▶ Hold a workshop on health education for teachers.
- ▶ Continue nutrition center activities.
- ▶ Conduct a workshop on sustainability for all NGOs on La Gonave.

**August 1993**

- ▶ Continue rally posts.
- ▶ Hold a workshop for church leaders on health education.
- ▶ Continue with nutrition centers' activities.
- ▶ Train health committees on project management and monitoring.

**September 1993**

- ▶ Continue rally posts.
- ▶ Conduct a midterm evaluation of the project.

**7.2 FY93/94 Budget**

COST ELEMENT		A.I.D.	WVRD	TOTAL
<b>I.</b>	<b>PROCUREMENT</b>			
	A. Supplies	15,408	(1,145)	14,263
	B. Equipment	500	26,676	27,176
	C. Services/Consultants	8,485	3,600	12,085
	SUB-TOTAL I	24,393	29,131	53,524
<b>II.</b>	<b>EVALUATION</b>			
	SUB-TOTAL II	15,256	-0-	15,256
<b>III.</b>	<b>INDIRECT COSTS</b>			
	Overhead on Field (%)	44,976	120,606	165,582
	SUB-TOTAL III	44,976	120,606	165,582
<b>IV.</b>	<b>OTHER PROGRAM COSTS</b>			
	A. Personnel	169,309	8,789	178,098
	B. Travel/Per diem	4,741	1,036	5,777
	C. Other Direct Costs	11,679	11,310	22,989
	SUB-TOTAL IV	185,729	21,135	206,864
<b>TOTAL FIELD</b>		270,354	170,872	441,226

**APPENDIX**  
**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 la santé à La Gonave.
- A cette date, les membres de l'organisation 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 activités et de multiplier l'impact de ces organisations et missions sur le développement de La Gonave.
  3. Créer et maintenir un solide système 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 répondront aux critères suivants:
1. Etre officiellement accrédité par le ministère de la Santé Publique, à travailler sur l'île comme organisation ou mission.
  2. Avoir travaillé continuellement sur l'île avec les familles, églises ou écoles pendant au moins 1 an (12 mois).
  3. Etre disposé à collaborer avec les autres organisations ou missions pour le plus grand bien de La Gonave.
- E) Le comité se réunira chaque 4 mois pour informations, discussions, problèmes à résoudre etc. . . Il peut se réunir en session extraordinaire si il y a cause.
- F) Les comités de santé et de développement organisés seront invités à envoyer un représentant aux réunions.
- G) Les organisations non membres pourront demander à l'écrit, la permission d'assister ou de participer à une réunion spécifique.

- H) Chaque année, pendant to dernière reunion annuelle le comité élira un president.
- I) Le president organisera les reunions et les presidera. Il 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 \_\_\_\_\_

**HAITI CHILD SURVIVAL PROJECT STATUS REPORT  
LA GONAVE CHILD SURVIVAL GRANT FY92-94  
3RD QUARTER REPORT FY92**

**Significant Achievements (Year 1):**

1. The staff completed 203 (94 percent) out of 216 planned rally posts in spite of heavy rains, health worker attrition, and the embargo. Nine out of ten planned nutrition rehabilitation centers catered to 270 children under five years old who presented moderate to severe undernutrition. The children's diets were supplemented three times per week with Akamil, green vegetables, and milk. Mothers were taught to monitor their children's weights using the Direct Weighing Scale, and to prepare nutritious food using low-cost, local ingredients. Other project achievement statistics are given on a separate page.

Four children were found with Bitot's spots—two by Wesleyan Hospital staff and two by project nurse auxiliaries. Vitamin A capsules (VACs) were administered following the treatment protocol for Vitamin A.

In May, Wesleyan Hospital reported over 100 cases of measles. The cases all occurred in children over seven years and in adults. No fatalities were reported. In the second quarter of FY92, there were also reports of measles cases. An investigation was made by an epidemiologist from the MOH who determined that the case histories were not compatible with measles and hypothesized that the cases might have been meningococemia instead.

2. World Health Day was celebrated at the four largest sections on the island: Palma, Pte-a-Raquette, Grande Source, and Ti Anse. Health fairs were organized by the staff with Vitamin A as the theme. Activities included booth displays of foods rich in Vitamin A, slide projections, songs, and dances. Focus group sessions were held separately with mothers, teachers, and schoolchildren.

At the end of the fair, the staff quizzed the participants about Vitamin A. Participants who scored high received Vitamin A tee shirts. Staff from five health facilities—Wesleyan Hospital, dispensaries at Pte-A-Raquette, Episcopal Church, Gros Mangle, and La Source—were given posters and VACs.

3. The CSP staff conducted a one-day follow-up training session on Vitamin A for nine nurses at Wesleyan Hospital. At the end of the session, a decision was reached to implement the Vitamin A treatment schedule for cases of measles.
4. The Center for Development of Human Resources, a USAID-funded indigenous NGO, conducted a preliminary assessment of income-generating activities, e.g., community stores and grain storage, on the island. Training workshops for IGA participants were planned for August and September.
5. Training of new health agents and health committees in four new sections was completed. Promising health agents from the other seven sections began their training as replacements for project nurse auxiliaries. This is part of the phasing in/out strategy for sustainability.
6. Running water is finally available in Ti Palmiste (project-base location) after almost five "fetching" years—thanks to WV Haiti's water development project. Lush, green vegetation now surrounds the project base. Similar water projects also exist in three other areas on the island.

**Project Staff:**

1. Versyl Sylvestre, nurse auxiliary, reported to work after a safe delivery.

2. Dr. Florence Dyer, CSP Medical Coordinator, participated in a two-day conference on Community Participation and Health. The conference was run by the Center for Development of Human Resources in Port-au-Prince. Dr. Dyer also attended the National Council for International Health (NCIH) Conference held in Washington, D.C., in June.

**Project Expenditures:**

	<u>Quarter Actual</u>	<u>YTD Actual</u>	<u>YTD Budget</u>
Project Expenditures	\$45,358	\$159,522	\$177,505
USAID Grant Chargeable	\$25,178	\$ 89,307	\$ 88,484

**Project Needs/Concerns:**

1. The project continues to lose health agents, mother health assistants, and health committee members to the mass migration of islanders fleeing the country. In Grand Lagon, five committee members left the island. This migration of people also posed monitoring difficulties to project staff.
2. The CSP mini-yacht used to ferry staff and supplies to and from Port-au-Prince was temporarily put out of commission to prevent it from being hijacked by islanders planning to flee the country. A small wooden motorized boat was assembled at a cost of \$ 4,000 to continue CSP/ Vitamin A activities in the coastal areas of La Gonave.
3. Staff mobility and transport of supplies to and from Port-au-Prince were limited. Orders for a new CSP vehicle were placed months ago. The embargo has resulted in a shortage of fuel and spare parts, in a lack of vehicles for sale, and consequently, in soaring costs of these items.
4. In June, there was a shortage of DPT vaccines nationwide. Vaccines will be available by the end of July, according to reliable sources from the MOH.

7/31

**PROJECT STATISTICS - 3RD QUARTER FY92**

<u>Indicators</u>	<u>This Quarter</u>	<u>Year To-Date</u>	<u>Project Target for FY92</u>
<i>Vaccinations (0-11 months)</i>			
DPT3	528	923	(80%) 2,413
Polio	516	1,170	2,413
BCG	685	1,627	2,413
Measles	426	963	2,413
TT2 (Pregnant Women)	166	400	(85%) 3,375
<i>VAC Distribution</i>			
Children 6 mos. to 7 years	8,103	13,668	
New mothers	211	553	
<i>Family Planning</i>			
No. of cycles given	276	1,913	
No. of condoms given	1,376	3,543	
No. of injections	100	100	
<i>Training</i>			
No. of matrones trained or recycled	190	420	
No. of ZHDA recycled	179	331	
No. of ZDHC trained	36	121	
No. of active health agents	98	98	
No. of active committees	10	11	
No. of new matrones	25	50	
<i>No. of Education Sessions for Communities</i>			
Immunization	15	45	
Vitamin A	46	179	
Growth Monitoring/Breastfeeding	1	51	
AIDS	0	3	
ORT	99	119	
Family Planning	0	1	
ARI	40	40	

24



**Dr. Florence Dyer, CSP Director, talking to schoolchildren during one of the nutrition sessions on sources and preparation of Vitamin A-rich foods**



**Schoolchildren singing "Vitamin A" songs  
in one of the school presentation  
attended by the community**