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USAID/HAITI

PRIVATE SECTOR FAMILY PLANNING PROJECT NO. 521-0189

SECOND INTERIM EVALUATION

Port-au-Prince, Haiti
5 June, 1993

SECOND INTERIM EVALUATION

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GLOSSARY OF TERMS USED

<i>Acceptant</i>	:	New Acceptor of Modern Contraceptive Methods
A.I.D.	:	U.S. Agency for International Development
AIDS	:	Acquired Immune Deficiency Syndrome
AIDSTECH, AIDSCAP	:	A.I.D. centrally-funded project concerned with AIDS awareness and prevention
AOPS	:	Association des Oeuvres Privées de Santé (Association of Private Health Organizations)
CAPS	:	Centre d'Analyse des Politiques de Santé (Center for Analysis of Health Policies)
CBD	:	Community-Based Distribution (of contraceptives)
CDS	:	Centres de Développement et de Santé (Centers for Development and Health)
CHI	:	Haitian Child Health Institute (Institut Haitien de l'Enfance)
ColVol	:	Collaborateur Volontaire (Voluntary Collaborator)
CPFO	:	Centre de Promotion des Femmes Ouvrieres (Factory Women's Promotion Center)
CPR	:	Contraceptive Prevalence Rate
CPS	:	Contraceptive Prevalence Survey
CRS	:	Contraceptive Retail Sales
CSM	:	Contraceptive Social Marketing
CY	:	Calendar Year
CYP	:	Couple Year of Protection
DHS	:	Demographic and Health Survey
FHI	:	Family Health International
FOSREF	:	Fondation pour la Santé Reproductrice et l'Education Familiale (Foundation for Reproductive Health and Family Education)
FP	:	Family Planning
FY	:	Fiscal Year
GOH	:	Government of Haiti
Gourde	:	Haitian Currency; in May 1993, US\$1.00 = 13.5 Gourdes
HPNO	:	Health, Population, Nutrition Office
<i>Hougan</i>	:	Traditional priest
IEC	:	Information, Education, and Communication
INHSAC	:	Institut Haitien pour la Santé Communautaire (Haitian Community Health Institute)
<i>Inscription</i>	:	New User of Contraceptives at a given center
IPPF/WHR	:	International Planned Parenthood Federation/Western Hemisphere Region
IUD	:	Intra-Uterine Device
LOP	:	Life of Project
L-T	:	Long-Term
MCH	:	Maternal and Child Health

GLOSSARY OF TERMS USED - Continued

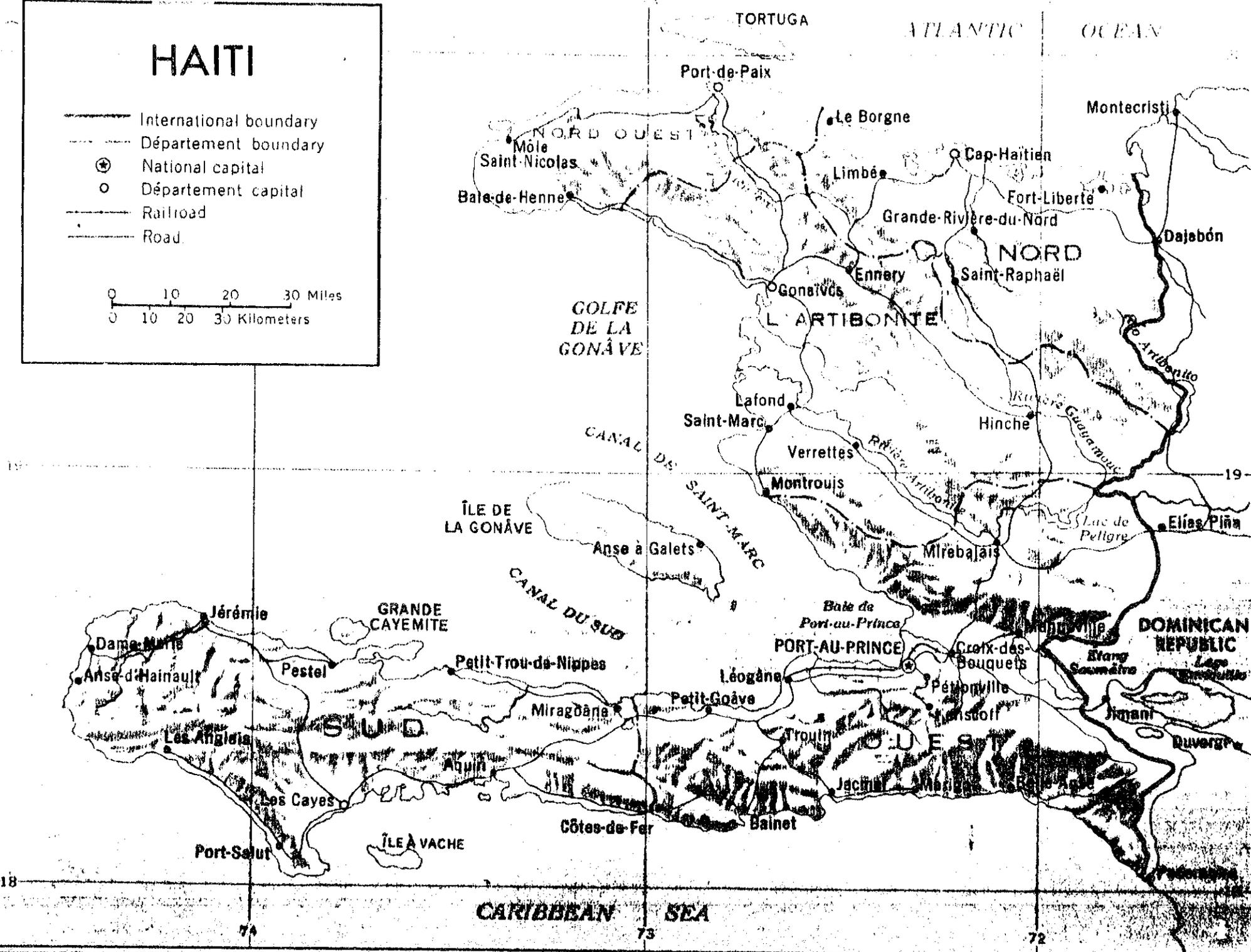
MFD	:	Manufacture Date
MSPP	:	Ministere de la Santé Publique et de la Population (Ministry of Health and Population)
MWRA	:	Married Women of Reproductive Age
NFP	:	Natural Family Planning
NGO	:	Non-Governmental Organization
Norplant ^R	:	Five Year Hormonal Contraceptive Implant
OAS	:	Organization of American States
OR	:	Operations Research
OPTIONS	:	Options for Population Policy II (A.I.D. centrally-funded project)
PAC	:	Project Advisory Committee
PACD	:	Project Assistance Completion Date
PAHO	:	Pan-American Health Organization (WHO affiliate)
PAPFO	:	Port-au-Prince Field Office of IPPF/WHR
PCS	:	Population Communication Services (A.I.D. centrally-funded project)
PROFAMIL	:	Association pour la Promotion de la Famille Haitienne (IPPF-affiliate Association for the Promotion of the Haitian Family)
PP	:	Project Paper
PSC	:	Personal Services Contract(or)
PSFP	:	Private Sector Family Planning Project
PVO	:	Private and Voluntary Organization
SEE	:	Suivi, Encadrement, Evaluation (Monitoring, Reinforcement, Evaluation)
SOMARC	:	Social Marketing of Contraceptives (A.I.D. centrally-funded project)
S-T	:	Short-Term
STD	:	Sexually Transmitted Disease(s)
SYLOS	:	Systeme Local de Santé
TA	:	Technical Assistance
TFR	:	Total Fertility Rate
TIPPS	:	Technical Information on Population for the Private Sector (A.I.D. centrally-funded project)
UNFPA	:	United Nations Fund for Population Activities
USAID, USAID/Haiti	:	A.I.D. Mission in Haiti
USFDA	:	U.S. Food and Drug Administration
Utilisateur	:	Continuing User of Modern Contraceptives
VACS	:	Voluntary Agencies for Child Survival project
VFT	:	Vaginal Foaming Tablet
VSC	:	Voluntary Surgical Contraception

CUBA

HAITI

- International boundary
- - - Département boundary
- ⊕ National capital
- Département capital
- Railroad
- Road

0 10 20 30 Miles
 0 10 20 30 Kilometers



PRIVATE SECTOR FAMILY PLANNING PROJECT NO. 521-0189
SECOND INTERIM EVALUATION

1. INTRODUCTION

1.1 Project Evolution

Family planning services have been offered in Haiti since at least 1971. Data from the Haitian Fertility Survey of 1977 showed a very low rate of five percent for use of modern contraceptive methods by women in union. Six years later, the Haitian Contraceptive Prevalence Survey of 1983 demonstrated a decline in this rate, to four percent. USAID/Haiti determined that its support to public sector family planning activities under the Family Planning Outreach Project (521-0124) did not adequately reach all possible beneficiaries. To help arrest this declining rate, the Mission designed a project to provide complementary family planning program support to Haiti's active private sector.

The Private Sector Family Planning Project (PSFP) was authorized on August 20, 1986. The goal of the project was, and still is, to reduce the population growth rate in Haiti, and its purpose remains to increase the availability and effectiveness of family planning services delivery. The project emphasis was initially on mobilizing the large community of non-profit private and voluntary organizations (PVOs) active in health care in Haiti, although over time the commercial sector has become involved as well.

The original project had a project assistance completion date (PACD) of September 30, 1989, and life-of-project (LOP) funding of US\$3.250 million. In 1988, following the aborted elections of November 1987, the U.S. government discontinued assistance to the Government of Haiti (GOH) and the public sector Family Planning Outreach Project was terminated. USAID/Haiti extensively amended PSFP at that time, with certain key family planning functions, including receipt and distribution of contraceptive commodities, moved to the PVO community, and support to other functions, such as overall population policy development, reduced. It extended the PACD to March 31, 1991, and increased the LOP budget to US\$8.250 million.

By 1989, the project-funded 1989 Contraceptive Prevalence Survey (CPS) showed a twofold increase in the contraceptive prevalence rate, to 10.5 percent of women in union nationally. Based on these encouraging results, as well as the recommendations of a generally-favorable mid-term evaluation, and on the U.S. Congress's authorization to resume support to the GOH, PSFP was again amended. The PACD was extended to June 30, 1992, and LOP funding was increased to US\$16.4 million, which included substantial support for GOH population and family planning activities. Based on the anticipated increase in U.S. assistance levels to Haiti following the successful democratic

1.2 Summary Description of Project Actors and Structures

Figure 1 overleaf provides a summary of key actors and structural relationships within the five major components of the project. The components and organizations portrayed in the figure are briefly described in the following sections.

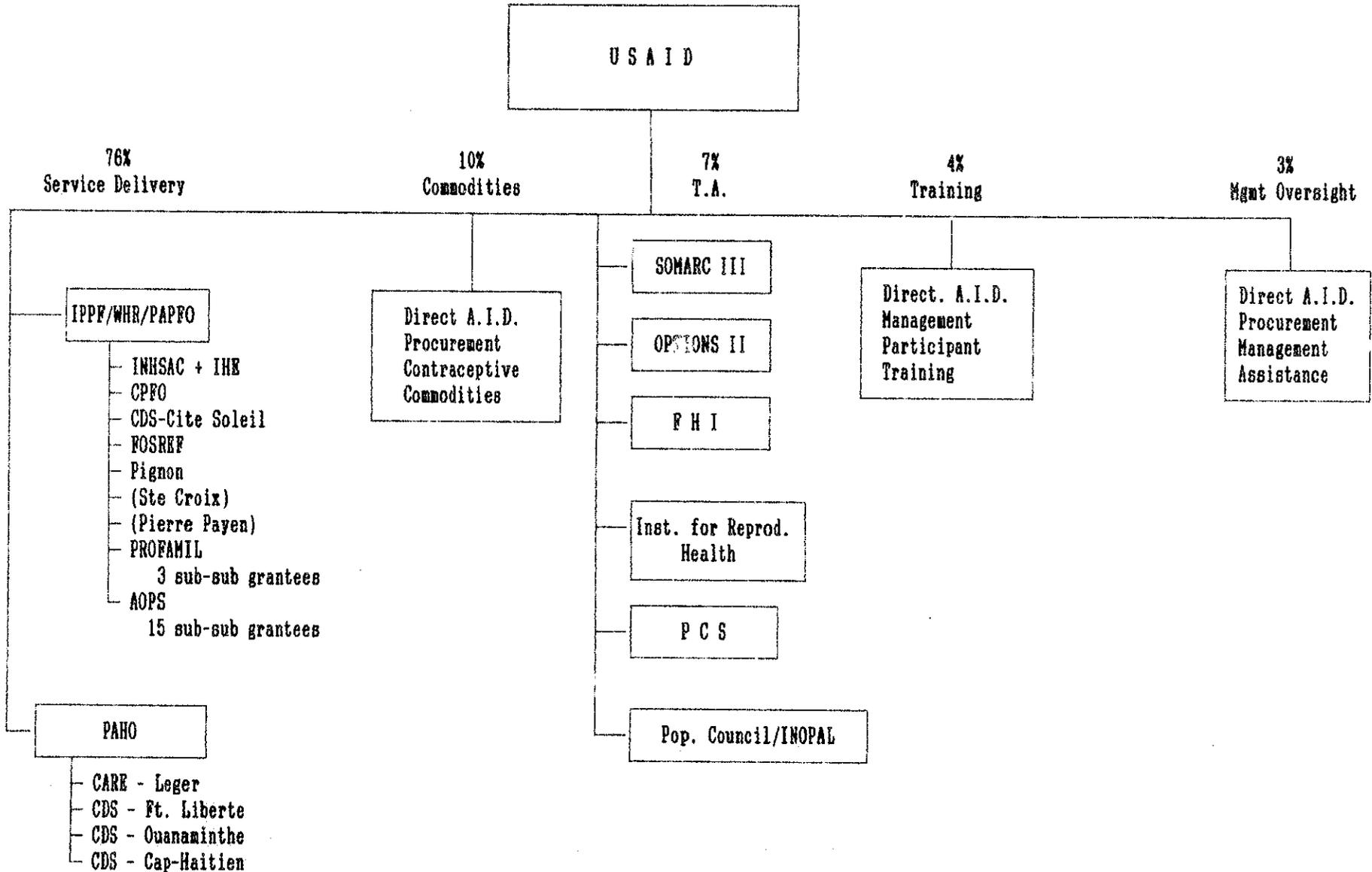
1.1.1 Family Planning Services. Funding for provision of family planning services is the largest component of the project, accounting for 76 percent of LOP funding, or about US\$20.5 million. These services are made available to an estimated population of over 1.450 million persons throughout Haiti through the work of 33 PVOs in over 45 fixed service delivery points nationwide. Financial support to PVO programs is provided by the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), which currently provides sub-grants to seven PVOs under the terms of a Cooperative Agreement between IPPF/WHR and USAID/Haiti, and by the Pan American Health Organization (PAHO), which provides similar funding arrangements to four PVOs through an International Organization grant.¹

Although IPPF/WHR initially placed more management responsibility with its New York office, over time much of the project management function has shifted to the IPPF/WHR Port-au-Prince Field Office (PAPFO), with a staff of 18 professional and support staff. PAHO has a much smaller program, with oversight provided on a part-time basis by PAHO staff involved in regular PAHO programs, and one project-funded Administrative Assistant.

Funding under this component includes support for technical assistance (TA) and financial management support through IPPF/WHR & PAPFO, and PAHO, as well as by permanent staff of the membership-based Haitian Association of Private Health Organizations (AOPS), as per the terms of its IPPF/WHR sub-grant. In addition to providing TA to its member organizations, AOPS also provides, and monitors, sub-sub grants to 15 very small PVOs that undertake community-based programs. The total beneficiary population for these AOPS sub-sub-grantees is estimated at 572,000.

¹ The PAHO grant was executed in 1990 with the purpose of providing assistance to the PVO network through the MSPP. Following the coup, the grant was amended to enable PAHO to provide direct support to CARE International and 3 northern affiliates of CDS without the involvement of the MSPP. While the amendment was logical from an administrative point of view, it has resulted in a more fragmented PVO grant management function than might be desirable under "normal" circumstances.

FIGURE 1: SUMMARY PSFP COMPONENTS AND MANAGEMENT



The larger PVOs that get direct IPPF/WHR and/or PAHO sub-grants are:

- PROFAMIL is the IPPF affiliate in Haiti which operates 3 urban clinics (Port-au-Prince, Port de Paix, Mirebalais), 10 community based distribution (CBD) programs, a 42 member physician's network, a factory distribution program, and a voluntary surgical contraception (VSC) mobile team program, for a total estimated beneficiary population of 434,000. IPPF/WHR is also in the process of moving management of sub-sub-grants of three small PVOs which focus on VSC and clinical methods from AOPS to PROFAMIL (Dugué, Fertilité, and La Fanmi).

- The Comité Bienfaisance de Pignon (Pignon), located in the central plateau, has a central full-service hospital and five rural "satellite" clinics covering a beneficiary population of 125,400. The Pignon program has a strong community orientation, with a network of 54 paid FP promoters, 66 child survival ColVols, 495 unpaid but upgraded and supported traditional birth attendants (matrones), and 70 active Mothers' Clubs, of which 27 maintain revolving credit funds.

- The Foundation for Reproductive Health and Family Education (FOSREF) is a major clinic in Port-au-Prince which estimates a total beneficiary population of 140,000. FOSREF has traditionally focussed on clinical activities, and is just beginning an expanded community outreach program.

- The Centres de Développement et Santé (CDS) operate family planning clinics in Cité Soleil in Port-au-Prince, Ouanaminthe, Fort Liberté, Cap Haitien, and Gonaives (two clinics). Due to the exigencies of various A.I.D. requirements associated with the post-coup legislation, CDS-Cité Soleil receives a sub-grant from IPPF/WHR, the two clinics in Gonaives receive funding from IPPF/WHR via AOPS, and the three northern clinics are funded through PAHO. Each of the five is considered a separate PVO. CDS-Cité Soleil estimates its beneficiary population as 178,600 and is characterized as having a clinic-based approach. The other programs combined have relatively strong urban and rural community-based distribution programs.

- The Factory Women's Center (CPFO) is a small PVO in Port-au-Prince's industrial zone which focusses on women's education. With project funding through IPPF/WHR, it supports CBD and basic clinical services for the assembly sector workers, the majority of whom are women. CPFO's activities were badly disrupted due to the total shut-down of factories following the September 1991 coup, and it has

slowly rebuilt its program as the factories have begun rehiring.

- CARE International operates a small CBD program in the remote rural community of Léger, about four hours from Port-au-Prince. The program is undertaking operational research of two approaches to CBD, and may expand to a site in the Grand Anse in the coming year.

- The Hôpital Sainte Croix, in Léogane, is a small hospital which has maintained a competent clinic-based program for a number of years. It has recently come under new management, and is in the process of transferring from the AOPS umbrella to full sub-grantee status with IPPF/WHR.

- Hôpital Pierre Payen is a small hospital operated by Project HELP which is in the process of expanding its community outreach activities. It has very recently signed a contract to provide integrated family planning and child survival outreach services, to be jointly funded through the PSFP and VACS projects. This activity will serve as a pilot for the proposed integrated family planning/child survival project to be designed during FY 1994.

This component additionally includes funding for in-country training and production of information, education and communications (IEC) materials through an IPPF/WHR sub-grant to the Haitian Institute for Community Health (INHSAC), and for research and evaluation, through study-specific contracts, to the Haitian Child Health Institute (CHI).

1.1.2 Contraceptive Commodities. The second largest project component, procurement and shipping of contraceptive commodities, accounts for approximately 10 percent of project funding, or US\$2.5 million over the LOP. This procurement is managed by USAID/Haiti, through standard central A.I.D. contraceptive procurement procedures. The storage, distribution, and end-use monitoring of contraceptive commodities has until quite recently been undertaken at the central level by PROFAMIL. USAID recently decided to transfer responsibility for about half of all future contraceptives -- with the exception of Norplant[®] -- to the new non-profit essential drugs company, PROMESS, although management norms and procedures have yet to be worked out.

1.1.3 TA/Buy-Ins. The third project component comprises a number of project buy-ins to contracts implementing A.I.D. centrally-funded population/family planning projects. Due to the exigencies of U.S. legislation which allowed support only to PVO

programs following the coup, they were suspended in October 1991 and have only recently begun to be reactivated.

As summarized below, three of the buy-ins -- SOMARC, FHI/Norplant^R, OPTIONS -- were active prior to the coup, and one -- SOMARC III -- maintained an active Haiti program for the 15 months of suspension in the absence of A.I.D. funding. Three others -- The Population Council, Population Communication Services (PCS), and the Institute for Reproductive Health -- were in advanced stages of planning when the coup occurred. USAID/HPNO believes that the absence of these vital technical partners has been a key contributor to a slower implementation pace than might otherwise have occurred.

- SOMARC III: Social marketing support is provided through a buy-in to the SOMARC III project, implemented by The Futures Group. To date, SOMARC III has promoted a low-dose oral contraceptive, Minigynon, through over 200 retail commercial outlets. Between its operational inception in July 1990 and its suspension in October 1991, sales increased from 300 cycles/month to 6,000 cycles/month. During suspension, when no A.I.D. funds were available to the commercial importer, sales were maintained at almost 2,000 cycles/month. With the reinstatement of the program, sales are now back to pre-coup levels. USAID/HPNO is processing a new buy-in which will provide support for geographic expansion of Minigynon sales, at a new, lower price; marketing of IUDs through the PROFAMIL private physician's network; marketing of family planning services with PROFAMIL and PAPFO; marketing of the injectable Noristerat, in coordination with UNFPA and The Population Council (see below); and possible expansion into other new product lines as experience is gained.

- FHI/Norplant^R: The project's original support to Family Health International (FHI) for successful Norplant^R trials led to eventual adoption of Norplant^R as an approved family planning method in Haiti. Approximately 2,600 women in Haiti are currently Norplant^R users. Given the popularity of the method, USAID/Haiti has ordered 20,000 sets over the next two years. It is also processing a new buy-in under which FHI will work closely with the newly-formed project Medical Committee for the Quality of Care, and will provide training to medical and counseling personnel throughout the country to ensure continuing quality of services as the method's availability is increased.

- OPTIONS: The original buy-in to The Futures Group for OPTIONS I focussed on preparation of a POPDEV model projecting the future development of population in Haiti under various fertility scenarios, and the impact of this

development on other sectors like the environment, food requirements, or social program needs. The completed model and an accompanying booklet were disseminated to a wide variety of audiences, including showings to high level decision makers, the private sector, and the health community. USAID/HPNO is processing a new buy-in to OPTIONS II which will focus on operational policy, including strategic planning, legal and regulatory reform, and constituency building. The buy-in will provide flexible support to policy development, so that the national program (comprise of the public, non-profit private, and commercial service providers) can bring data such as DHS into program expansion by considering consumer needs, contraceptive methods, and sources of services; can liberalize restrictions on service providers to expand certain methods; can conduct market segmentation analyses of the niche of each major type of service provider; and can continue constituency building activities.

- The Population Council/INOPAL: A new buy-in to the Population Council/INOPAL I is being processed to provide a resident advisor and short-term TA in operations research (OR) activities. The general objective of the buy-in is to develop and test strategies to improve availability and quality of services provided by family planning organizations supported by PSFP. The specific objectives of The Population Council's proposal are: 1) to develop new research-based strategies for delivering acceptable and accessible family planning service in Haiti; 2) to provide TA to agencies to incorporate operation research for management and evaluation; 3) to conduct at least two operations research and evaluation projects, as well a training course and seminars; and 4) to foster inter-institutional collaboration among family planning institutions in Haiti. The buy-in should be operational in July-August 1993.

- Population Communication Services (PCS): A new buy-in to the Johns Hopkins University/PCS is being processed. The purpose of the buy-in is to upgrade Haiti's health/IEC program, to complement both PSFP and VACS activities. Planned activities include: 1) fielding of a Resident Advisor; 2) promotion of the national family planning logo with motivational messages; 3) production of radio drama/comedy series with health messages; 4) IEC coordination committees for the three major health sectors, e.g. family planning, child survival/nutrition, and AIDS; 5) production of three training videos; 6) training workshops in quantitative data analysis; and 7) the establishment of a media and materials clearinghouse, probably at INHSAC, for IEC in Haiti. Activities should begin in July-August 1993.

- Institute for Reproductive Health/Natural Family Planning: A new buy-in is in process with the Institute for Reproductive Health of Georgetown University to provide PVOs with assistance to upgrade the teaching of NFP methods and to integrate existing exclusive breastfeeding activities for nutritional purposes with the lactational amenorrhea method (LAM) of child spacing.

- TIPPS: The John Snow, Incorporated TIPPS project provided TA to factories and private commercial health care providers, equivalent to health maintenance organizations (HMOs), to encourage family planning programs. This buy-in was successfully completed in September 1990. Planned follow-on activities involving fee-for-service programs by PVOs working in the factories (DASH, CPFO, PROFAMIL) could not be implemented due to the coup and subsequent major decreases in employment in the formal wage sector.

1.1.4 Participant Training. A limited amount of long-term, and substantial short-term academic and non-academic participant training accounts for about four percent of LOP funding. As discussed in more detail in section 2.5.4, to date 22 men and 19 women have received overseas training under the project. The major emphasis has been on health program management and IEC, which are areas of highest need. As a result of this training, an "IEC Core Group" has evolved which should give impetus to this important project element.

1.1.5 A.I.D. Management and Oversight. Approximately three percent of project funding provides for USAID/Haiti management and oversight, including provision of a Population Advisor and secretarial support in the Health, Population, Nutrition Office (HPNO), this and prior evaluations, and periodic audits.

1.3 Scope of Work and Methodology

This evaluation was conducted over a six week period in April-May 1993 by a team of five persons independently contracted by USAID/Haiti. The goal of the evaluation was to assess project accomplishments to date, and the purpose was to provide direction for the remaining period of the project and for the design of the follow-on project. The Scope of Work, which is reproduced as Annex A, specified key issues to address: barriers to family planning, quality of services, institution building and technical assistance, cost of services and cost recovery, current strategies to deliver services, and project management systems and processes. These issues form the primary section headings in sections 2 and 3 of the report.

Team members spent the first week undertaking briefings and literature review in New York, with IPPF/WHR, and in Port-au-Prince, with primary grantees and support institutions. Drawing from the Judith Bruce Situational Analysis Survey methodology, the team spent two days in Port-au-Prince developing field information collection guides, and one day in Fermathe pre-testing the instruments. Dividing into two groups, team members spent 10 days conducting field interviews with individuals, focus groups, and large groups of clients and provider staff at 16 additional PVC service points throughout Haiti. The team spent the fourth week drafting and synthesizing findings, with preliminary conclusions presented to major grantees at a debriefing at the end of the week. The team incorporated the grantees' inputs' into a second debriefing, for the USAID Project Committee, at the beginning of week five. Based on the USAID review, the team completed the full report in weeks five and six.

A copy of the team schedule is attached to the Scope of Work at Annex A. A list of persons contacted is found as Annex D, and of documents reviewed as Annex E.

The team wishes to emphasize that it is keenly aware that the relatively brief period available to assess the accomplishments of such a complex project has probably resulted in some omissions and/or distortions in its findings. In the course of both oral debriefings and reviews of this document in draft, key personnel told the team "we've been planning that, we have a scope of work" or "we were thinking about that before the coup, that's not new." The team recognizes that it has not come up with many new or exciting remedies to enhance family planning in Haiti, and it has tried where possible to incorporate its knowledge of PSFP management's awareness of project needs into the body of this report. Where the team's recommendations coincide with these planned activities, so much the better. The point is not who thought of them; it is simply that they get done.

2. FINDINGS OF THE EVALUATION

2.1 Annotated Logical Framework

Figure 2 overleaf provides a summary of the status of achievement of the project outputs and purpose. The figure shows that substantial and positive progress has been made toward all indicators. This is particularly impressive given the major socioeconomic upheavals during the life of the project.

Figure 2: Private Sector Family Planning Project Annotated Logical Framework

LOGFRAME PER AMENDMENT NO. 3

CURRENT STATUS

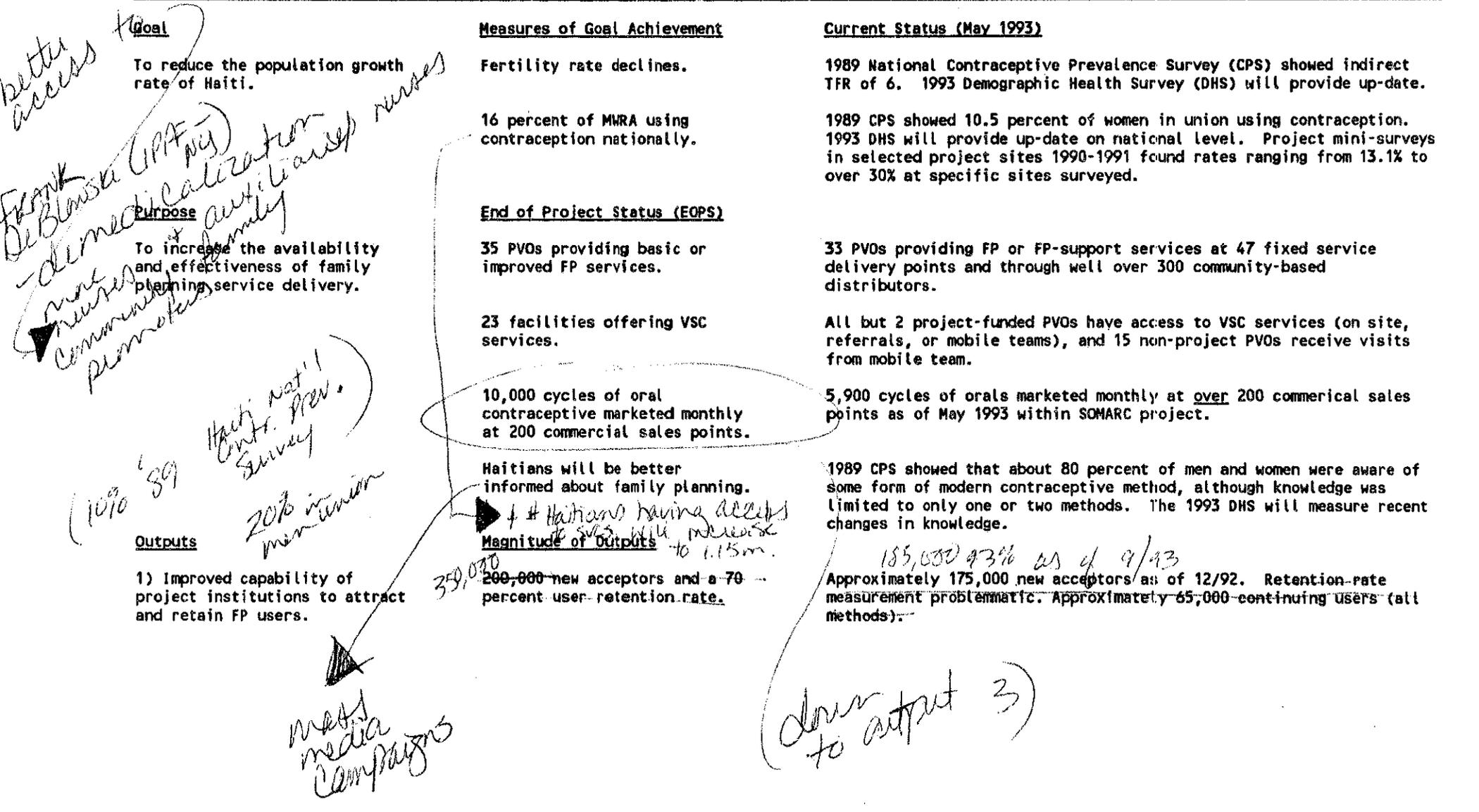


Figure 2 Continued: Private Sector Family Planning Project Annotated Logical Framework

LOGFRAME PER AMENDMENT NO. 3

CURRENT STATUS

Handwritten: AOP JWD?

Outputs - Continued

Magnitude of Outputs

Current Status (May 1993)

2) Expanded institutional capacity of project assisted agencies to plan and deliver family planning services.

a) Major FP donor coordinating committee functional.

a) Coordinating committee meeting monthly on substantive topics.

b) AOPS managing 20 sub-grants; CHI has established research and evaluation capacity; PROFAMIL providing contraceptive support to 40 PVOs; and INSHAC has trained 1,200 FP provider staff.

b) AOPS managing 15 sub-grants; CHI providing limited research and evaluative support to FP program; PROFAMIL providing contraceptive support for project PVOs as well as for non-project FP providers and for STD-AIDS programs; INSHAC has trained a total of 2,500 personnel.

c) Reduced PVO administrative costs per CYP.

c) Cost per CYP has decreased from US\$181 in 1987 to US\$47 in 1992. Efforts are underway to reduce overall costs and to increase cost recovery through fee-for-service schemes.

d) Two PVOs have signed fee-for-service agreements with 10 private companies.

d) Promising initiatives put on hold due to 9/91 coup d'etat and subsequent decrease in wage employment; support to DASH, a major HMO used by factories, terminated due to financial inconsistencies.

3) Expanded family planning service coverage and contraceptive method mix.

a) 50,000 persons served by CBD.

a) 30,000 served by CBD as of 9/92.

b) Natural family planning (NFP) added to method mix.

b) Contract signed with Georgetown University to provide TA in strengthening counselling for NFP.

c) Norplant[®] research finalized and method launched nationally; 3,000 insertions to be provided thru Amendment 4.

c) Pilot successful and method accepted nationally. 2,682 continuing users as of 12/92. USAID has ordered 20,000 sets to be inserted between 7/93 and 6/95.

d) CSM program trained 300 pharmacy staff and CSM Phase II implemented.

d) Over 200 staff trained and selling low-dose orals. Phase II plans in process for expansion to provinces and increase in method mix available.

Handwritten notes:
 need PROFAMIL/HO admin to be build to PPPF - PROFAMIL
 funds to contribute to innovation of success for INSHAC

Handwritten: (oral 49) per CYP by PACS

? *Handwritten mark*

Handwritten notes:
 Completed ramp up program to meet present economic realities. Price cuts? 12/92/1993 Phase III

Figure 2 Continued: Private Sector Family Planning Project Annotated Logical Framework

LOGFRAME PER AMENDMENT NO. 3

CURRENT STATUS

Outputs - Continued

4) Research results applied to improve family planning service delivery.

See blank

Magnitude of Outputs

*cost recovery
of met. ~~documentation~~*

a) Four operations research projects to test new CBD approaches developed.

b) Six mini-prevalence surveys completed.

5) ~~National~~ IEC strategy formulated and implemented.

*ask
go all
to ask
IPPF
about
how
many
new
planned*

a) Intersectoral IEC team operational.

b) IEC training manual developed and distributed.

c) HPNO IEC plan developed.

Current Status (May 1993)

a) CARE in Leger has tested only 2 CBD service delivery models. CBD is carried out throughout the country at sites not considered "operations research."

b) Five mini-prevalence surveys completed by CHI. Additional research includes the ongoing "mystery client" program by PAPFO, three problem-specific studies by CHI, and SOMARC marketing studies.

a) "Task Force" operational since mid-1990.

b) Training manual distributed in May 1993.

c) HPNO buy-in with PCS to develop IEC plan spanning child survival/family planning portfolio of HPNO in process.

The figure is based on the logframe as it is presented in PP Amendment 3 of August 1992. The most significant changes to the logframe were made between the original PP of 1986 and Amendment 2 of July 1990. The only significant substantive change between Amendment 2 of July 1990 and Amendment 3 was excluding mention of the public sector under the project.

The successive amendments have modestly increased the measure of goal achievement.² It was originally "Contraceptive Prevalence Rate (CPR) of 12.5 percent in the target population by PACD," with a total population coverage of 1.7 million. This figure was later shown to be grossly over-optimistic. Amendment 2 changed this to "16 percent of women of reproductive age in union using contraception nationally." This clarification of the original target population seems reasonable based on the 10.5 percent CPR found in the 1989 Contraceptive Prevalence Survey and the intent, under Amendment 2, to work with the GOH as well as the PVO community.

Amendment 3, in which the GOH is once again absent, retains the same goal achievement measure for the national level. Achievement of this rate nationally is clearly beyond the manageable interests of the PVO community alone. However, a project goal is by definition an objective to which a project contributes, but is not expected to achieve itself. The retention of the national level measure is therefore not inappropriate, and up-to-date information for the national level will be available by the end of 1993 through the Demographic Health Survey.

The CPR may be an appropriate goal for the overall project, and can be measured through periodic, statistically sophisticated national surveys such as the planned 1993 Demographic Health Survey. When a PVO's catchment area population is well-defined and can be enumerated, site-specific mini-surveys can also be useful in determining site-specific CPR. However, where catchment populations are difficult to define, as at many urban sites, or are unknown, as at some rural sites, CPR is more difficult to determine. In such cases, the use of other measurable indicators, such as "X number of new acceptors," "X number of continuing users," or "X number of couple years of protection (CYP)" may make the planning exercise more relevant to participating staff. A number of PVOs have done this for operational purposes, and the team commends this trend.

² For a comprehensive description of the evolution of these targets for Amendments 1 and 2, see Sherif Rushdy, "Analysis and Projection of Costs and Outputs for the Private Sector Family Planning Project as Implemented by the Cooperative Agreement with IPPF," IPPF/PAPFO, January 24, 1990.

Accurate data on the achievements of the overall project in terms of these indicators are difficult to assess over time due to changes in reporting standards and means of measurement. Table 1 provides a summary that should be considered indicative.

Table 1: PSFP New Acceptors, Continuing Users, and Couple Years of Protection for PVOs financed through IPPF/WHR Sub-Grants, 1989 - 1992

<u>Year</u>	<u>New Acceptors</u>	<u>Continuing Users</u>	<u>CYP</u> ¹
1987 ²	3,588	3,558	3,868
1988 ²	15,336	17,475	24,417
1989 ²	27,333	28,959	41,578
1990 ³	43,678	48,324	60,479
1991 ⁴	38,418	33,245	110,812
1992 ⁵	43,380	60,570	72,032
TOTALS	171,733	not additive	313,186

Notes & Sources

1. Traditional CYP conversion factors applied. For more detail, see the full IPPF/WHR/PAPFO Fourth Quarter 1992 Report.
2. Data for 1987, 1988, 1989 from Rushdy, "Analysis and Projection of Costs and Outputs for PSFP," January 24, 1990, Table 3.8. Note that Rushdy uses "contraceptors" rather than "continuing users", based on different definitions. The figures are included as relative indicators in the absence of more precise data.
3. Data from 1990 PAPFO Quarterly Reports. Six AOPS organizations reported only one out of four quarters, and CPFO reported only three quarters out of four. Many organizations reporting only temporary methods.
4. Data from 1991 PAPFO Quarterly Reports. FOSREF, DASH, and CPFO had no activities fourth quarter. This was during post-coup closure. Again, some organizations reporting only temporary methods.
5. Data from 1992 PAPFO Quarterly Reports. All organizations reporting all quarters and all methods. Note that DASH, with approximately 2000 continuing users, dropped out of program in 1992 although it continues to receive commodities.

The table does not show the change in target population over time as new sites were added and/or dropped, but it does provide a relative indication of overall positive growth. As reflected in the figures, growth was particularly significant in 1991 in spite of major upheaval the last quarter of the year and the fact that there was a major stock-out of Depo-provera from February through September of that year. The absolute decrease in CYP in 1992 is probably due to the severely reduced outreach activities, including mobile VSC teams, during the first three-four months, and the time needed to gear back up to full activities. The decrease in 1992 CYP relative to the significant increase in continuing users probably reflects this short-term decrease in VSC, which has the highest CYP conversion factor, coupled with a sharp increase in use of condoms, which have the lowest.

With reference to Figure 2, achievements at the purpose level of the project have been generally positive, although again targets have changed through successive amendments. The number of new acceptors has increased gradually through successive amendments, and is currently at a modest 200,000, with the stated intention of focussing on retention rates rather than new acceptors. Based on the data in Table 1, which excludes an LOP estimate of 10,000 new acceptors for the social marketing program and an additional 2,000 or so for the PAHO sub-grantees, it is likely that the target for new acceptors will be exceeded in CY 1993.

Measurement of the degree of achievement of the target retention rate of 70 percent is fraught with problems. Despite the accepted importance of better retention, few field-ready methodologies exist worldwide to track return visits, and Haiti is no exception. Some operations research projects in other countries have developed custom-made approaches, and in Haiti PAPFO sponsored one follow-up survey. However, there is no standardized, documented or "canned" approach for easy transferability to other sites. Section 2.4 describes some of the efforts underway in Haiti in this regard, and the problems encountered. It is an area to which much more attention must be given, and at this time the team has no confidence in stating any project-level retention rate.

The number of PVOs to be "providing basic or improved FP services" decreased from 60 in the original PP to 40 in Amendment 2 to 35 in Amendment 3. This change is based on a realistic assessment of PVO capabilities, particularly in regard to increased A.I.D. and IPPF/WHR concern about financial management capabilities. The decreased PSFP target also reflects USAID's desire to emphasize quality of programs as opposed to sheer quantity of organizations. Project objectives for PSFP's sister VACS project underwent the same order of decrease due to similar reasons.

As described above and shown in Figure 2, in fact 33 separate PVOs are providing services at 47 fixed delivery points with over 300 community-based distributors (promoters and/or paid "voluntary" collaborators, or ColVols). Given the effort involved in developing PVO financial management systems adequate to manage A.I.D. funds, and the difficulties of managing anything in Haiti over the past 3 years, the team considers this emphasis on organizational quality appropriate. Indeed, the operational strategy to expand coverage under proven participating PVOs, such as PROFAMIL or Pignon, as opposed to increasing the number of PVOs overall, appears very management-efficient. *

Amendment 3 included a slight increase in the number of PVOs offering VSC services, and a significant increase in the quantity of contraceptives being marketed through the social marketing program. VSC provides the highest number of CYP per method and has proven appropriate to the Haitian environment. As stated in section 2.2, the team recommends that a strong effort be made to expand the successful VSC mobile teams of PROFAMIL in parallel with this modest increase in fixed site capabilities. In both cases, it is understood that systems of technical supervision would need to be expanded as well.

The social marketing program has been one of the real success stories of the project, with 2,000 continuing users maintained for over 15 months in the absence of A.I.D. funding. The new target of 10,000 cycles/month through 200 retail sales points will meet the "break-even" point for Minigynon, and make that portion of the program self-financing. SOMARC III staff are in the process of developing a strategy for broadening the method mix under social marketing, starting this month with the T 380A IUD, which is known to be a preferred method for educated women. SOMARC plans to eventually branch out into commercial sales for Noristerat and Norplant^R as well, and will undertake a pilot for marketing PROFAMIL services. Given the slow pace of activity with PVO IEC programs, the work of SOMARC in this latter area is particularly exciting. |
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The last purpose-level indicator, "Haitians will be better informed about family planning," will be reassessed in the DHS starting later this year. As stated in several other sections of this report, the team was struck by the noticeable lack of posters and other didactic material on family planning throughout its field trips. The recent issuance of a new flip-chart by INHSAC and the new Population Communication Services (PCS) buy-in both bode well for IEC in the future. Given the significant success of multi-media work under the AIDS Panthé condom and the SOMARC Minigynon campaigns, the team suggests that project management continue to encourage cross-over activities and enhanced collaboration between the commercial and PVO marketing and IEC efforts.

At the output level, the current target population which is to have access to family planning (FP) services is 1.150 million. This does not seem an unreasonable decrease from the original 1.7 million, given the exclusion of public sector delivery points from the project. The current estimated target population for IPPF/WHR-funded PVOs alone has exceeded this at 1.450 million, although this number is being verified through site-specific census up-dates.

Other achievements at the output level are reflected in Figure 2, and discussed where appropriate in subsequent sections of the report. Of particular interest is the significant decrease in cost-per-CYP, from US\$181 in 1987 to US\$47 in 1993. While section 2.6 points out that these are ballpark estimates, they demonstrate a high pay-off of initial investment and increasing cost-efficiencies over time.

In summary, the project is making reasonable and positive progress toward achieving stated objectives. The team notes, however, that the quantitative measures for many of these objectives have been decreased over time, thus increasing the likelihood of achievement. The team accepts that some of these decreases were necessary because original targets were unrealistically high, and that these decreases are rational responses of project management to the constantly changing Haitian environment. The team understands that the exigencies of A.I.D. programming since the coup, when overlaid on this unstable sociopolitical and economic environment, render standard long-term planning processes almost futile. It recommends, however, that more detailed analyses of potential target populations for various institutions and various methods be undertaken based on information obtained in the FY 93 DHS. Only then can the project begin to look at really improving effectiveness. JA

2.2 Barriers to Family Planning

The team was asked to examine the continuing barriers to increased adoption of modern family planning methods in Haiti. The following comments are based primarily on review of project documents combined with focus group and individual interviews during fieldwork. The following types of barriers were assessed: geographic, economic, socio-cultural, medical, organizational, and political. Findings on each are summarized below.

2.2.1 Geographic Barriers. One of the principal geographic barriers is the vast size of the zones in rural areas that are assigned to specific fieldworkers (promoters, ColVols, and supervisors). In Léger, for example, one promoter was responsible for 33 scattered localities and had to spend the

night away from home in order to cover his territory. At Ouanaminthe, there are only five supervisors and 14 promoters trying to cover a population of more than 55,000 persons. On average, one supervisor is responsible for one rural section, with approximately 11,000 inhabitants (55,000/5).

The situation is aggravated by the poor condition of roads and the dispersed location of houses in the largely mountainous terrain. Neither the promoters nor the supervisors are provided transport to facilitate coverage. The situation in Léger is particularly difficult, although Ouanaminthe, Figuiers, and Pierre Payen are also limited in this regard. In Pignon, the situation is less severe, with one promoter responsible for about 300 - 400 families (e.g. about 2,000 - 3,000 persons). In all rural sites, however, many promoters simply cannot cover their assigned zone. At the same time, clients who are located far from service delivery sites find it difficult to both enroll and continue resupply. The team did not find many cases where field workers resupplied hormonal methods to clients.

2.2.2 Economic Barriers. Fieldworkers, particularly promoters and their supervisors, stated that they were dissatisfied with salaries, given the workload and the rising cost of living. These complaints were particularly acute at Léger and Ouanaminthe, where promoters earn only 300 gourdes/month. The promoters work about four days/week in disparate locations often far from their homes, and complained about not have enough time to tend their own fields.

In many programs, the low economic level of clients prevents them from being able to pay for transport to service delivery sites. The problem of distance is particularly difficult for those who want VSC. This problem has been resolved at some PROFAMIL CBD sites, where PROFAMIL provides round-trip transport to reference sites for VSC. At other sites, clients must pay high transport costs and spend the night due to distance to avail themselves of VSC services. This is the case for Fort Liberté and Ouanaminthe, which must refer to PROFAMIL mobile teams operating out of Trou de Nord two hours away.

Additionally, the instability of recent years and concomitant economic depression is believed to have accelerated migration, both of fieldworkers and of clients looking for increased opportunities. At some sites undertaking cost-recovery trials, such as CDS/Ouanaminthe and CDS/Gonaives, auxiliaries and promoters stated that the 5 gourdes fee discouraged new clients. The team was told of extremely poor clients in other project areas (Deschappelles) who travelled great distances to clinics outside of the district in order to get free food for their children. At other sites, such as CDS/Cap-Haitien, Clinique Dugué, and Hôpital Pierre Payen, informants claimed that

introduction of fee-for-service, with an exoneration policy, seemed to have no effect on attendance. As discussed in section 2.6, affordability of services is an area that needs further careful attention.

2.2.3 Socio-Cultural Barriers. Rumors concerning negative consequences of family planning and side effects of certain methods are circulated by word of mouth throughout project areas, which greatly constrains adoption of FP. The lack of knowledge of the largely illiterate population increases the importance of these rumors in all efforts to promote FP.

Several programs, notably Pignon and PROFAMIL-CBD, have organized groups of "Satisfied Clients," to serve witness to the benefits of family planning and to demystify certain rumors. In the north, modern contraception -- particularly VSC -- has been available over a decade, and satisfied beneficiaries continue to serve as living examples of the utility and benefits of FP, with consequent strong demand. Unfortunately, few other areas of Haiti have the same history. USAID/HPNO plans to have The Population Council/INOPAL buy-in undertake more operations research in this regard.

It appears that the effect of husbands vetoing a wife's adoption of FP is decreasing in importance. The influence of the church on adoption of methods also seems less a factor, as does the tendency of the culture to reward a pronatalist vision. At Léger, however, the team still found peasants who valued many children as extra farm labor.

Finally, socio-cultural sexual taboos and the confidentiality surrounding use of contraceptive methods must be highlighted. This indicates a particular need for attention to privacy during counseling at clinics. It also indicates a need for increased tact and discretion on the part of medical and paramedical personnel involved in promoting FP services, with particular emphasis on developing improved approaches to dealing with younger women.

2.2.4 Medical Barriers. The side effects of certain contraceptive methods constitute a barrier to use of FP in areas where communication with medical personnel is difficult, and the medicines to treat or eliminate the side effects are not available. This is of particular importance for post-VSC treatment, and/or rumors about post-VSC effects.

The predominance of male doctors in reference hospitals or clinics can also be a barrier, according to certain informants, in that some women are afraid of pelvic exams from male doctors. Additionally, at some sites, pelvic exams are required for all methods, even condoms and vaginal foaming tablets. Outside of

having questionable health benefits, insistence on this requirement means that women must travel to a clinic or other location to find a doctor prior to getting an FP method. As discussed further in section 2.3 under quality of services, international and Haitian experience have demonstrated that such exams are not essential and may constitute more of a barrier than a benefit to the women's health. 

The team also heard of incomplete or inadequate counseling sessions which fostered misunderstandings. For example, the team spoke with one young woman who came to get Norplant^R who understood that the nurse told her that she could not work hard ever again after getting it, and must rest at home and conserve her strength forever more. In sum, it appears that many counselors over-emphasize health problems and side effects of specific methods, which tends to foster false rumors.

At some sites the team found that there were other non-project health providers in the same area distributing contraceptive commodities with no counselling or educational sessions (i.e. near CDS/CAP). This practice will also foster multiplication of rumors and could have negative effects on the program overall.

2.2.5 Organizational Barriers. The lack of community organization and social structures in most of the areas under the project is important barrier to the promotion of FP. The team notes the positive impact of Mothers' Clubs in Pignon on family planning, and the involvement of different community organizations in that zone in the crusade to promote improved health and FP. The lack of these broadbased efforts to involve the community in most of the sites visited by the team limits the achievements of the project.

At Léger, for example, there are several community groups and also health committees which need to be restructured and made more dynamic in order to play an effective role in the promotion of FP. Although there is a health committee in each of the sub-zones of the project, most are not representative of the community and some members expect to become employees of the project.

Another organizational barrier is that many of the fieldworkers do not really know the extent of the territory they are supposed to cover and have not tried to undertake a systematic reconnaissance of their zone. It would be useful for them to inventory, for example, collective equipment and institutions, as well as identifying community leaders, who could be used to mobilize populations. For the most part the fieldworkers are not aware of the full array of physical and

human resources in their zones, and have not developed strategies to progressively cover their territories (e.g. CDS sites). The simple fact of having contact with different leaders in the community would constitute a sort of social pressure for the fieldworker, in that the leaders could call them to account at any moment.

2.2.6 Political Barriers. The inability of A.I.D. to provide support to the public sector constitutes a barrier to project success. In principal there should be some complementarity between the public sector and the PVOs involved in health/FP service delivery, in order to effect adequate geographic and medical coverage. As stated in sections 1 and 2.1, USAID had planned to provide public sector support through PAHQ, and had in fact done so prior to 1987 and for a short period of time in 1990-1991. The lack of support at this juncture, coupled with significant support through VACS and PSFP to selected PVOs, creates distortions in provision of services. Simply, some of the MSPP facilities which should serve as reference facilities are barely functioning.

The inability of A.I.D. and other donors to work with the GOH in other sectors constitutes a second barrier in this regard. In theory, population and family planning activities cannot be isolated from other sectors. Over the last few years, however, the suspension of donor assistance across-the-board -- of reforestation programs, of assistance to agricultural production, of the drilling of new wells, etc. -- has served to isolate FP personnel and programs in most areas. The continuation of child survival program activities through VACS, and the continued ancillary activities of PVOs that are successful in attracting private funding (e.g. Pignon, Deschappelles), are the only positive reinforcements currently around.

Finally, the political context of the last few years has not always allowed local organizations to function, or has required that they function on a strictly limited basis, and has at times precluded organized meetings necessary to promoting FP.

2.3 Quality of Services

The team visited 17 project-funded service delivery points and assessed the following key elements in terms of quality of services: 1) if clients were allowed and able to make an informed decision in choosing a method of contraception; 2) if the services they received were provided under good conditions, with compassion and competency; and 3) if clients were satisfied with the services and continued to use them. Other key elements influencing the quality of services, including the contraceptive distribution system, service statistics, and training and

technical assistance, are discussed in other sections of this report.

2.3.1 Method Choice. Figure 3 shows the contraceptives observed by the evaluation team during its fieldwork, and demonstrates that the project offers a rich array of methods of contraception to support free choice.

**Figure 3: Contraceptives Observed by Evaluation Team at 17 Sites
May 1993**

<u>Type</u>	<u>USAID</u>	<u>Other Donor</u>
Pills	Lo-femenal (combined low dose) Ovrette (progestin)	Eugynon (IPPF) Ovcon (?) Ortho-Novum (?)
IUD	T 380A One site still had Lippes Loops	
Condoms	Sultan Panthe (AIDS program - PSI)	Rosetex (UNFPA) Hi-Life (IPPF)
Spermicides	Concepterol (VFT)	Delfen Cream
Injectables	[USFDA approved Depo-provera 12/92]	Depo-provera (UNFPA) Noristerat (IPPF & UNFPA)
Implants	Norplant ^R	Norplant ^R (UNFPA)
VSC	Vasectomies, Minilap (common) Laparoscopy (infrequent)	

The commodities for these methods are provided by USAID, with project funding, and by IPPF and the United Nations Fund for Population Activities (UNFPA). An Inter-Agency Committee for Contraceptives coordinates procurement to avoid stock-outs or excess supply. As described in more detail in section 2.8, the system works reasonably well at current levels, although problems at the base in ordering and resupply continue.

Evaluators recorded only minor situations of expired stock and stock out.³ One or two sites reported shortages of vaginal tablets in the last six months; none of the 17 sites visited reported other stock-outs during that period. Almost every site has an informal system to get emergency stock "in a crunch". Section 2.8 includes additional information on contraceptive commodity management and stock-outs.

The team was impressed with the high degree of awareness of the need for free choice of methods at all of the sites it visited, and it commends project management (USAID, IPPF/WHO, PAHO, and the PVOs) for this achievement. In spite of this awareness, however, individual service delivery sites do not yet have systematic access to all methods available under the project.

Specifically, in many rural areas where FP services are supposed to be provided through ColVols, Promoters, and Village Health Workers, the distribution of hormonal contraceptives is often impaired because the PVO requires that each woman receiving a hormonal contraceptive must get a pelvic exam, done by a doctor. This means that the woman must wait for her contraceptives until she has the time and/or money to travel to a clinic or other fixed delivery site to see the doctor. As stated in section 2.2 above, this practice constitutes a medical barrier to adoption as well as a barrier to free choice.

The long and positive experience of the PROFAMIL programs, which allow field workers to provide pills, has demonstrated that pelvic and breast exams, although desirable to enhance a woman's health (along with Pap smears), should not be mandatory to obtain the pill. Many international studies also document that there is a greater danger to women's health from unwanted pregnancies than from the pill. Stated MSPP National Norms, and the project-level Medical Advisory Committee, state as policy that a pelvic exam is not a prerequisite for the pill and that promoters should be allowed to provide pills to interested clients. It is unclear why this policy is not enforced, and why the practice is still the norm in many of the institutions of the AOPS network and at FOSREF. Changing this practice is of the highest priority in terms of decreasing barriers and promoting free method choice.

³ The team found a few expired IUDs (T 380A) in Figuiers, two cycles of Lo-femenal with a manufacture date (MFD) of 6/88 at the bottom of a field bag at Bonne Fin, a small stock of old Delfen (expiration date 12/92) in Ouanaminthe, a few foaming tablets MFD 7/88 at the clinique Dugué, some Lippes Loops in Petit Goave, and some old Sultans MFD 10/88 at the CRDSPP. There is still a lot of Ovrette MFD 10/89, which needs to be monitored.

Additionally, evaluators noted at a few sites that clients are pressed into choosing before they have really understood all the methods and have had a chance to ask all the questions they want. There is always a certain amount of provider bias, especially against IUDs. Program managers and supervisors should continue to remind providers at all levels that it is very important for women to be able to make their own informed choice.

Some comments on specific methods follow.

Depo-provera: Prior to approval of Depo-provera by the U.S. Food and Drug Administration (USFDA) in late 1992, USAID could not provide injectables. The method was available to project PVOs through UNFPA, and has been an important component of the program at many sites. IPPF/WHR/PAPFO reported that injectables contributed 31 percent of hormonal methods for the PVOs it financed in the last quarter of 1992.

Injectables are well suited to the Haitian sociocultural setting where injections are valued. The method requires only a minimal education level for the user, and side effects are well-accepted by users when counseling is properly done. Resupply (a new injection) is required only every three months, in contrast to pills, which tend to be provided one cycle at the time in too many institutions. As described in section 2.8, there was a supply interruption of about eight months in 1991; this was very damaging for many sites, in particular at CDS/Cité Soleil. Now that Depo-provera can be provided by A.I.D. as well as UNFPA, the donors, working through the Inter-Agency Committee for Contraceptives, should be able to ensure that this problem does not recur.

Spermicides: Until quite recently, USAID had considered canceling its purchase of vaginal foaming tablets (VFT) because the method is not very popular and overall program use is very small. It thus commissioned a small study to provide it with information concerning the acceptability and utilization of VFT under the project. The April 1993 report concluded, "it is evident that there is a demand for VFTs at the clinic level. This demand is less based on actual client demand, however, than on the practice of clinics to prescribe VFTs as a temporary method of family planning while clients wait to receive their preferred choice." (Dix, Executive Summary). USAID has thus decided to continue to provide VFT, which the evaluation team finds appropriate.

⁴ Dix, Stephan J., "Vaginal Foaming Tablets Utilization and Acceptability Assessment," for HPNO-USAID-Haiti, April 1993.

Norplant^R: The introduction of Norplant^R as an accepted method is one of the great successes of A.I.D. in Haiti. The method was field-tested at three sites in Haiti under an A.I.D.-financed grant with Family Health International (FHI). This controlled research program began in 1985 under the public sector Family Planning Outreach Project, and was transferred to PSFP when the former was terminated. The research was successful, and Norplant^R became an officially approved method in Haiti in July 1989. It appears to be a method that will have enormous success in Haiti. The demand is already very high and side effects are well-tolerated. USAID/HPNO has worked hard to obtain assurance from A.I.D./Washington that sufficient supplies will be made available for Haiti for an aggressive program, and 20,000 sets of implants have been ordered for the 1993-1994 period. Because it has taken longer than anticipated to secure supplies, wide-scale introduction is behind schedule. Unmet expectations may create problems if further delays occur.

IUDs: IUDs have a long history of poor success in Haiti. While they are available in principle to all the institutions, in reality, few doctors insert them and practically no nurse has been trained in insertion. This low level of use is unfortunate, but given the problems in Haiti with sexually-transmitted diseases (STDs) and AIDS, and the rate of frequent partner change, caution must be taken to promote this method in the right situation and for low-risk users. The current strategy of promoting IUDs among stable couples of PROFAMIL's Private Physician Network is excellent, and CPFO seems to promote them with relative success. The SOMARC III program has also just initiated a new product line targeting educated middle class women for IUDs which bears watching.

Mobile Clinics: The PROFAMIL (with some AOPS assistance) sterilization and Norplant^R mobile clinic program is an excellent approach to making both of these methods widely available to those who want them in rural areas with no family planning clinics. This program could easily double in size because demand is high. PROFAMIL has developed a referral system to provide VSC to its CBD areas, and most of the AOPS institutions either provide VSC, refer elsewhere, or invite the mobile clinics. CDS/Cité Soleil and Gonaives are the only two sites left under the project which have no referral agreement with other institutions for VSCs. Project management should work with these sites to ensure that a referral system is developed. (The team recognizes that this recommendation has already been made as part of a separate analysis of the CDS program, and it hopes mentioning it again will result in management action.)

2.3.2 Information and Counseling Provided to Clients.

Education Sessions: In general the education sessions observed by the evaluators were good. Educators were interactive, demonstrated condom use with a prop, showed other methods, sang songs, and engaged the crowd. The larger clinics, such as PROFAMIL, FOSREF, CDS, and CPFO, tend to be more rigorous about conducting systematic education sessions at the beginning of the day. Many smaller clinics, where clients dribble in all day, do not hold education sessions at all. At several sites, systematic sessions were reported to be cancelled frequently, and the team observed several sites where clients who arrived late did not benefit from any presentation at all. (An unintended positive result of this is that clients are not made to wait for long periods of time.)

In rural areas, education sessions are held at a service delivery points, at rally posts, and other central locations, such as churches, festivals, and community meetings. The efforts to capitalize on community participation to reinforce counseling messages and education are very uneven. In some areas, such as Pignon, this is done successfully; in others, such as Léger, much would be gained by more community involvement. In urban areas, there is almost no trace of community organization, with the notable exception of CPFO. Clearly, the political climate is a limiting factor. Section 2.2 discusses community participation in more detail.

Individual Counseling: Counseling by nurses and auxiliaries observed by the team clearly emphasized individual free choice. The counseling sessions observed were in general good, although counselors sometimes pressed the client for a choice before they fully explained the methods. Evaluators did not note any significant error in the information provided to clients in the sessions observed. However, in discussing Depo-provera, not enough emphasis was placed on explaining the potential side effect of amenorrhea. Evaluators heard numerous reports of women interrupting use of Depo for a few months or permanently to resume bleeding. This is not particularly good for the women or the program, and better training of counselors would help arrest the practice.

Unfortunately, evaluators were not able to observe many doctors providing counseling, and the few observations made were very unsatisfactory. Doctors observed assumed that counseling had already been done before the client reached them, and did not bother to verify if the client understood the side effects of her chosen method. This is not acceptable. Doctors should always rehearse with the clients the understanding of side effects and what to do if a problem occurs.

The team found many sites where community outreach workers were not allowed to provide clients with hormonal contraception, including periodic resupply. At one site, the worker explained that she could not provide the contraceptive due to the possibility of diseases. The provision of contraindication details on methods not available to the client is unproductive and spawns rumors which damage the program overall.

Educational Materials: All the clinics visited were adequately identified by the national family planning logo. Besides the logo, however, educational materials are conspicuous by their absence. Except for Figuiers and CDS/Cap-Haitien, the team found only one or two FP posters per site. In most cases, they were the handmade constructions prepared by PROFAMIL describing each method. While colorful, these are old and still have a Lippes Loop as the IUD model.

INHSAC is in the process of distributing a very professional laminated desktop flip-chart describing all methods for use by educators and counselors. The team asked numerous people why it had taken five years to produce this one product. The explanations include the fact that the project originally designated the MSPP as the lead for educational materials; that the need to develop consensus about the message among all players was as important as the message itself; and that political and economic uncertainties hampered all activities. In spite of these problems, the team hopes that production of future materials will not take quite as long. IPPF/WHR/PAPFO has developed a strategy to distribute, monitor use, and evaluate the booklet, and the team supports this excellent initiative.

INHSAC has also produced 100,000 copies of a small brochure describing methods; it will be distributed at the same time as the flip-chart to reinforce counselling sessions. Although some new plans are underway, until now INHSAC has provided trainees with very few materials to reinforce course work, especially for fieldworker training. Given that many fieldworkers are barely literate and cannot be assumed to take complete notes, this absence should be redressed.

Mass Media: It is not entirely clear why there has been so little mass media associated with the program. The billboards with the FP logo are attractive and generally well-placed, and PROFAMIL does advertise for its services and has engaged in an active constituency building effort that has recently included traditional priests (*Hougans*). The SOMARC successes with Minigynon have been noted. However, the Panthé condom media blitz under the AIDSTECH project clearly opened the way for more aggressive radio and television campaigns. PROFAMIL is in the process of initiating a more formal advertising campaign with SOMARC III personnel. Given the success of the SOMARC Minigynon marketing effort, this new initiative is very encouraging and

should be supported. The new PCS buy-in should prove quite useful in this regard.

2.3.3 Interpersonal Relations between Providers and Clients. Extensive efforts have been deployed by IPPF/WHR/PAPFO and participating PVOs to improve the overall quality of services provided. The "Mystery Client" activity is well designed and captures well interpersonal relationships between provider and clients. Most centers have been visited and definitely pay attention to the reports. Evaluators were proudly showed clean toilets in several locations, and, at Pierre Payen, a special new room had been constructed for counseling clients in response to a negative report.

One evaluator had the opportunity to observe a provider who was dealing with a "Mystery Client" and to later compare impressions with the "Mystery Client" report. At another location the "Mystery Client" visited the clinic the same day as evaluators, and again, comparison was possible between evaluators observations and "Mystery Client" report. In both cases the concurrence between observations was high. This ongoing study is probably the single most important thing PAPFO can do to continue improving provider/client interactions.

An interesting point is that "Mystery Clients" are reported (personal communication from the PAPFO evaluation division) to be reluctant to criticize doctors. Doctors are so respected in Haiti that even when they provide marginally acceptable services, are insensitive and even rude to patients, they are not found at fault. For example, two of the doctors observed by the evaluation team were cold, did not converse with the client, and spent their time writing prescriptions with only cursory questions and very little courtesy. They did not seize the occasion to nurture or educate. The client in both cases was visibly intimidated.

Nurses and auxiliaries observed behaved much better. In almost all clinics, the first contact person is an auxiliary who has been trained in FP. This is good and least intimidating. The auxiliaries observed by evaluators appeared to have good contacts with clients and to treat clients with respect. However, respect for the client's modesty and concern for her comfort could improve at most sites.

Almost all clinics processed clients reasonably quickly and had some concern about not wasting clients' time. In fact, Pignon even had a specific objective of no more than 20 minutes for resupply clients. However, efforts to improve should continue especially in processing resupply clients with speed.

Evaluators were only able to observe community workers in group situations at rally posts and dispensaries. In this limited setting the community workers observed appeared to have good contacts with clients.

Persons interviewed claimed no real difference in acceptor rates or suitability based on the gender of provider. However, data on gender collected during the team's site visits, when compared with the assessment above, suggests there may be correlations. In terms of medical practitioners, at the 17 sites visited, over 90 percent of doctors were men, while 100 percent of nurses and over 90 percent of auxiliaries were women. In terms of field workers, about 60 to 70 percent of supervisors (those that were not auxiliaries), village health workers, ColVols, and promoters were men, and 30 to 40 percent were women. It should be noted that this latter category varied considerably, with some sites, Figuiers and CDS/CAP, having significantly more women. The relationship of fieldworker gender to adoption or retention rates is an area where more operations research could be fruitfully conducted.

2.3.4 Technical Competence of Service Providers. National norms and procedures have been developed by a Project Advisory Committee (and many have been endorsed as national norms by the MSPP), and efforts are being made to implement them. Many of the staff interviewed had not necessarily read the norms and procedures, but reported that AOPS coordinators discussed these issues with them. As mentioned above, two key areas where there are still major differences among sites are the role/responsibility of community workers and the methods they are allowed to dispense or resupply. Also, despite a stated project policy to provide three cycles of pills per resupply visit, too many providers still give only one cycle at a time. 

Evaluators were not able to observe many clinical procedures and it is difficult to generalize on one or two observations. One doctor performed a pelvic exam without inserting a speculum and did such a cursory bimanual exam that the only thing that can be said for sure is that he ascertained that the client was menstruating. Another doctor said nothing to the client while inserting Norplant^R. There was no reassuring exchange nor discussion of side effects. The insertion technique was good and the procedure was completed quickly but the doctor did not even wait for one full second to allow for the local anesthetic to take effect before proceeding with the trocar insertion.

Incidentally, the "Mystery Client" reported having met a woman on the way out of the same clinic the same day who said that when inserting her Norplant^R the doctor had to make several attempts before succeeding. Rather than a poor insertion technique this

probably reflects that the inserter did not explain to the client that there are six rods to set in place. Each rod placement was probably mistaken for a failure. This is not good and may lead to rumors about the clinic.

The team undertook structured exit interviews with clients at 15 locations and did not find any reason to question the level of competency of the personnel.

There have been no reported VSC problems since 1989, although infections are not monitored per se. Casual reports suggest that they are infrequent.

2.3.5 Follow-Up Systems. In principle, community workers are supposed to visit clients and make sure they come back to the center or resupply them (depending on the PVO's definition of the role of the community worker). In reality, the territory of most community workers is so vast that evaluators calculated that it would be very difficult and sometimes impossible for many community workers to visit their clients at least every eight weeks. As a result domiciliary visits are somewhat haphazard and not well supervised, and clients may or may not get supplies when they need them.

The data collected by service providers (community workers, auxiliaries) are designed to demonstrate not only how many FP visits are made but who is a new user ever (*acceptant*); a new user at this center (one of the many definitions of *inscription*); and an ongoing user (*utilisateur*). As described in more detail in section 2.4, these concepts are not uniformly understood and the quality of the data collected is questionable.

Based on these data, efforts are made to determine the drop-out rate for each center. These efforts are generally undertaken by data analysts and not by direct service providers. Although the latter have the basic instruments to undertake follow-up of drop-outs, this seemed to be done on a very haphazard basis. It appears that all the elements are present to do active follow-up but evaluators could not find the trace of an overall or local plan to address the issue.

2.3.6 Constellation of Services and Facilities. As summarized in section 1, the project aims to increase access to services to as many people as possible through a wide range of delivery mechanisms, including clinic-based services, community outreach, and CBD sites. In addition, the mobile clinic program is providing long-term methods in areas with practically no health care. Finally, the project has supported social marketing, with initial success with a low-dose oral. Plans to

expand both geographic coverage and method mix in the social marketing program in the near future are encouraging.

The demand for FP services is high and clinic clients report travelling long distances to obtain services. Clinic hours almost everywhere appear to be long and conveniently scheduled according to client needs. VSC clinics in the north -- both fixed and mobile -- have long waiting lists. The practice of not allowing community workers at some locations to provide hormonal contraception creates a problem with access.

In general, the facilities visited by the evaluation team were acceptably kept and had the minimal required equipment in place. Evaluators found that AOPS coordinators review minimal equipment requirements and follow up on sites with deficiencies. PAPFO's "Mystery Clients" also identify inadequate facilities and make recommendations for change. The team saw efforts to improve the facility settings in several locations. These efforts should continue.

Several of the institutions visited by the evaluation team also offer child survival and safe motherhood services. With the exception of Pignon, family planning is either poorly integrated or not integrated at all to other mother/child health activities. Almost everywhere FP is run as a vertical program. None of the institutions visited has a post-partum program. It is hoped that more integration will be emphasized in new project design activities.

2.4 Monitoring, Evaluation, Research, and Service Statistics

The team assessed project monitoring, evaluation, and research efforts, with special emphasis on the service statistics intended to provide primary data for these efforts. The original PP envisioned that the Child Health Institute (CHI) would be responsible for these functions. However, CHI became increasingly occupied with child survival activities. In response to findings of the 1989 evaluation, to a critical review of problems with the statistics in early 1990 (Rushdy, January 1990), and to the lack of involvement by CHI, in 1990 PAPFO took over those functions itself. PAPFO added two staff positions to take care of these important functions, one for monitoring and service statistics, and one for small studies and operations research. CHI's involvement in FP has become that of a periodic contractor to PAPFO for specific studies, rather than that of a primary sub-grantee.

It is important to note that the PAPFO efforts are generally only directed to those organizations financed by PAPFO. The service delivery efforts financed outside of the IPPF/WHR umbrella, including CARE, the 5 northern CDS sites, and the

SOMARC social marketing work, are not part of the system. With the exception of the management oversight by USAID/HPNO, there is thus no system for continuous monitoring of overall project results.

The following sections discuss the PAPFO service statistics system (2.4.1), and its research and evaluation activities (2.4.2). Comments regarding an overall system are summarized in section 2.4.3.

2.4.1 Service Statistics. As graphically demonstrated in the evolution of statistics, and notes, in Table 1, the service statistics system has improved greatly since 1990 when PAPFO took it over. The 1989 evaluation, in fact, had to reconstruct data from a variety of sources, including field trip memoranda by IPPF/WHR staff. The comprehensive report by Rushdy in early 1990 set the stage for a major effort in data collection and analysis, which has yield greatly improved data. This evaluation team thus stresses that PAPFO has accomplished a great deal in terms of design, preparation of an Information Systems Manual, installation and training, and continuous quality-control of the system since that time. The comments that follow are made within this context.

Definitions In General: The 1990 Rushdy report and several subsequent PAPFO quarterly reports stress problems with basic definitions used in the service statistic system, and the team agrees with these problems. Most sites and most personnel interviews understand the concept of new acceptor ever (*acceptant*) and continuing user (*utilisatrice/teur*). However, understanding and use of another key term, *inscriptions*, is varied. The manual includes no definition of the concept of *inscriptions*, and, indeed, the team found it was used in several ways in the field. The generally accepted definition is "new user at this site."

Uniform use of these terms is important if a site is to be able to compute its overall performance in term of drop-out or retention rates (*taux d'abandon*). The Information System Manual clearly states that "drop-out rates should generally be calculated on a monthly basis." It also clearly defines a drop-out as "...a client that does not take contraceptives or who is not covered for contraceptives for the month." The drop-out rate is to be determined by dividing the number of drop-outs for a given month by the "expected users" for the preceding month, and multiplying by 100.

Unfortunately, there are numerous problems in terms of this definition and calculation. For example, the concept of "expected users" (*utilisatrices/teurs attendues*) is extremely important in determining drop-out rates. It is defined in the

manual as follows: "expected users for the current month are the expected users of the preceding month to which must be added the *inscriptions* of the current month." As an illustration, for the reference month of April, by definition the expected users would be the expected users for the month of March, who are none other than the observed users for the month of February to which one adds the *inscriptions* from April. Unfortunately, the drop-outs become cumulative in this manner. That is, those from March and those from April are both imputed to April.

The end result of these definitional problems is that there is probably over-reporting of drop-outs, and thus under-reporting of program success. However, given a lack of coherence in application of what definitions there are, it is difficult to know with any certainty.

Service Statistic Instruments: Each service delivery point has a number of information collection and collation instruments, which are maintained with varying degrees of accuracy. At the 17 sites visited by the team, for example, a number of problems were observed.

The cornerstone of the whole system is the Family Planning Register, which is filled out by auxiliaries trained as documentalists or statistical clerks (*archivists*) at each site. The team observed a number of problems in terms of the register:

- not all sites automatically included new acceptors as continuing users, which they become (at least for one month) by definition;
- different personnel use different symbols to mean the same thing, or the same symbols to mean different things, on the same form;
- some registers have lists of names with no other information; different institutions have different norms about how long names are carried, and when people become drop-outs;
- the sites which have Norplant^R, such as Pignon, can have pages and pages of names with a row of 12 "Xs" for the five year method, which makes the manual system extremely cumbersome; as this method becomes more widespread, some form of sorting will need to be developed so that other clients don't get lost.

The team also noted problems with the Monthly Family Planning Reports, which are sent to AOPS and PAPFO and are supposed to be uniform:

- there were numerous errors in basic addition;
- the intermediate reports developed by promoters and ColVols are frequently late, and if late, are often simply

disregarded by the central documentalist/clerk, so these data are lost to the system.

Finally, a number of published reports which state the Contraceptive Prevalence Rate for a given site or group of sites use difference target population figures as the denominator, and rarely give the source of the figures, beyond, perhaps, "census." It is important for readers to know the exact sources and dates of the data if any useful comparisons or time-series analyses can be done.

Many of the documentalist/clerks are sincere and hardworking people, manipulating hundreds of names and data points manually, under difficult conditions. Many of the sites have no electricity and many have poor lighting. The pages (and pages) of names are kept in loose file folders, often in stacks on shelves. The team found less than five filing cabinets at delivery sites, among the 17 sites visited. Several of the documentalists did calculations manually, frequently with not so much as a hand-held calculator as a tool. Some simple purchases of file organizers (*classeurs*) and calculators would contribute greatly to the morale of these important staff.

The documentalist/clerks, and their supervisors, also require increased training. Although most have received base training, and PAPFO requires semi-annual training in their annual plans, it simply has not been absorbed and more on-the-job work is necessary. Section 3 includes recommendations for additional staff at PAPFO to assist in this regard.

Drop-Out Rates⁵: Given the stated project objective of a 70 percent retention rate, PAPFO and some of the PVOs are understandably placing great emphasis on the importance of improved retention rates. These rates are important first because of the expected link between counseling, quality of service, and continuation. Better communication is hypothesized to mean better counseling, better service, and greater satisfaction. Further, more fertility impact comes from CYP from effective, continuing users than from CYP from new acceptors who quickly drop out. Finally, considerable program effort is required to recruit and counsel new acceptors to replace drop-outs just to stay even, much less to increase contraceptive prevalence.

Despite the accepted importance of better retention, few field-ready methodologies exist worldwide to track return visits. Some operations research projects in other countries have

⁵ The team gratefully acknowledges the assistance of Dr. Janet Smith, Director, OPTIONS II, for her assistance in putting the problem of "drop-out" rates in a broader perspective.

developed custom made approaches to serve the research objectives of the specific activity. But these have not been standardized, largely due to the enormity of the task at the lowest level of service delivery, where human resources and record-keeping conditions are least up to the task. This is an acknowledged gap in the evaluation methodologies which exist worldwide, not only in Haiti.

Given the problems described above with the PSFP service statistics system in particular, and "drop-out" rates in particular, the needs in PSFP for this type of data might best be served by careful collaboration between PAPFO and The Population Council/INOPAL under the latter's new buy-in. The Population Council could mobilize information on the most successful previous efforts at measuring retention and help develop workable approaches. In the meantime, the quarterly efforts to calculate rates which are known to be unreliable could be abandoned.

2.4.2 Research and Evaluation. The research and evaluation work under the project should be complementary to the monitoring possible through the service statistics system. PAPFO, frequently through activity-specific contracts with CHI, has supported the following special studies:

- Five mini prevalence surveys in project areas (CHI)
- An ongoing study of "Mystery Clients" (PAPFO)
- A study of the causes of abandon of contraception in the Léogane area (CHI)
- A study on cost recovery programs (IPPF/WHR financed local consulting firm)
- A study of one year of VSCs conducted by the mobile clinics (PROFAMIL)
- A study of the feasibility of using satisfied clients as promoters in the factory setting (CHI)

Outside of PAPFO, the project has also supported studies of clinical monitoring of Norplant^R (FHI) and studies to test advertizing concepts (SOMARC).

All of these are useful and interesting and contribute to enhanced program performance. However, outside of the Mystery Client program, which provides on-going feedback to PVOs, the work has been undertaken on more of an *ad hoc* basis without an overall plan. Some comments on the overall evaluation efforts follow.

Evaluation Strategy: Evaluators only found a workplan for the current project year. Although the workplan describes a number of activities that appear useful and are related to project problems, the document is not a strategy. It does not

analyze the relationship between project problems and research proposed. This gives the impression that the studies scheduled for implementation are a collection of activities without much relationships.

Use of Service Statistics: In spite of the problems noted above, the service statistics system is now producing useable quarterly statistics on all IPPF/WHR-financed service delivery points, in quite a bit of detail. The overall evaluation strategy, and internal monitoring and evaluation plans, do not seem to correlate the statistics and special studies into an overall information set.

Special Analyses of Service Statistics and Clients: Individual records to explore various issues such as no show clients, method continuation, temporary interruptions, client profiles by method, clients preferences need to be developed and implemented. Services statistics reports have a number of graphs presenting the same data in various forms. There is unfortunately no other analysis except for the excellent report on VSCs conducted by the mobile clinic program.

Mini-prevalence studies: In 1990 and 1991 five mini-prevalence studies were conducted. These produced useful data to enhance site-specific promotion strategies, and to feed into overall program analysis. It is unclear why this type of activity has been discontinued and is not seen as a priority of the evaluation division, especially in view of the problems of service statistics. The two would appear to be complementary, and serve a cross-checks on each others' validity.

Small studies: As stated above, a number of useful small studies have been conducted in the last few years. The workplan for 1993 proposes greatly increasing the number of activities. It was not clear to the team how all of these studies fit within the overall evaluation strategy.

Operations Research: The original PP intended that CHI provide TA to sub-grantees in operations research, but this has not been possible due to institutional overload. This has left a gap in project activities which PAPFO's Evaluation Division -- also short-staffed -- has only partially filled. There is a need for the project to develop a research agenda and to assist sub-grantees in developing simple operations research capabilities of their own. PAPFO should work with the proposed Resident Advisor under The Population Council's buy-in to develop such an agenda as a priority activity. A number of project-supported persons attended the MORE Project (Maximizing Results of Operations Research) conference and workshop in Washington in 1990. The types of research described then and proposed for the future should be the springboard for the agenda.

Summary: In summary, PAPFO's efforts at evaluation seem to emphasize research more than on-going monitoring and utilization of research results to improve service delivery. There also needs to be increased attention to feedback systems and small-scale "research" at the level of service delivery institutions to help them measure of their own performance.

2.4.3 Overall Project Monitoring and Evaluation, and the Role of CHI. The team was specifically asked to comment on the role of CHI under this project, and the following paragraphs do so. It is understood that these are more recommendations than straight findings, but the team believes them most appropriately placed in this section. They will be summarized in section 3 as a recommendation.

From the point of view of the project, the team finds it unfortunate that CHI could not be more involved in evaluation and research, in order to have an overall project perspective. However, from the point of view of CHI's institutional growth, the team notes that it has developed strong capabilities and an institutional identity in child survival and health survey research, and that it is fully occupied with a number of high priority contracts from other projects. PAPFO's relatively small and relatively piecemeal approach to studies with CHI simply doesn't attract as much CHI management attention as does, for example, a three year contract for the DHS. At this point in its existence, CHI is operating much more like the research foundation it wants to be than the consulting firm it once looked like it might become. If PAPFO wants more attention from CHI, it will need to develop longer-term studies programs, such as a 3 or 4 mini-surveys/year package, so that CHI can contract and train the necessary additional staff.

Given: a) CHI's growth in directions not foreseen at the design of this project; b) the availability of other channels for undertaking small studies and research; and c) the development of service statistics and research oversight capacity at PAPFO; the team does not recommend major structural changes at this time. Rather, it recommends that PAPFO be instructed to add CARE and the northern CDS sites funded under PAHO to its service statistic system, and to include reporting and analysis of those programs in its quarterly statistical summaries. It further recommends that PAPFO request data from the SOMARC III project to its quarterly summaries for continuing users and CYP. This will provide USAID with an overall picture of project accomplishments.

There are a number of local consulting firms that have proven ability to undertake small studies, and many of the PVOs have the capacity -- with tailored TA -- to undertake small studies and operations research themselves. In order to complement the still-fragile service statistics system, the team

suggests that PAPFO develop a research agenda and operate with other groups (e.g. TAG, GREFE, Capital Consult, etc.) as it operates with CHI, offering small study contracts to the most responsive offerors.

The issue of where national FP services statistic systems should eventually be housed should be an issue for the follow-on project design.

2.5 Institutional Strengthening

Although the term "institutional development" encompasses a variety of components, the project has placed the major emphasis on the training and technical assistance aspects of the term. Staff at various institutions understand the terms "training" and "technical assistance" in a variety of meanings, from believing them to be "really just the same thing," to distinguishing formal instruction in groups as "training" and individual advice-giving as "technical assistance". The discussion that follows uses the common understanding of "training" to be workshops, courses, and seminars, and individualized instruction as "TA".

The key providers of in-country TA and training under the project are IPPF/WHR & PAPFO, AOPS, PROFAMIL, and INHSAC, and the following discussion includes a section on the activities of each of these organizations. TA provided through buy-ins in other sections of this report relevant to the particular buy-in. A final section discusses participant training, which has been managed primarily by USAID.

2.5.1 IPPF/WHR/PAPFO. Technical assistance to participating agencies⁶ has taken various forms, including formal training (workshops and seminars), specific one-on-one technical assistance from internal or external experts, and ongoing "regular" support/backstopping. This is described in Annex B in seven categories. Under a "family planning" heading, there has been TA in IEC, evaluation/service statistics, contraceptive management, and medical/quality of care. Under an "institutional development" heading, there has been TA in human resources, finance/accounting, and project management. Underway or planned for 1993 is a management assessment of PROFAMIL; help to INHSAC to broaden its curriculum and to undertake strategic planning; an institutional assessment of CPFO; pre-audit help to AOPS sub-sub-grantees; design of PROFAMIL's Documentation Center;

⁶ Although IPPF/WHR uses the term "TA" for internal assistance by its New York office to PAPFO, the team considers this internal management assistance within the recipient agency and has not evaluated it as "institutional development" *per se*.

training of a PAPFO person in EPI-INFO (computerized service statistics) who will in turn provide TA to sub-grantees; and other broader concerns.

Many of the PVOs interviewed noted that they found the IPPF/WHR TA useful, and that they would like more interaction with PAPFO. Whether it is called "TA" or simply "monitoring", there seems to be consensus that more frequent interaction by PAPFO technical staff (e.g. the Program Coordinator or equivalent) is desirable. The team engaged in considerable discussion about whether PAPFO should take more initiative in this regard, or whether the various institutions should take more initiative in requesting assistance. "Both" is probably the consensus answer to this question, but the issue of who asks, who offers, and who identifies both training and TA needs requires more open discussion.

Planning: IPPF/WHR recognizes that the time has come to focus more on program planning. To date, "planning" has been an interactive process between PAPFO and the sub-grantees (and AOPS and the sub-sub-grantees) which has focussed on developing detailed annual budgets, and summary annual program plans, for USAID approval. These are usually prepared by PVO directors and financial staff; the team found little evidence of participation by other personnel. During the team's field interviews, outside of program directors, most personnel could not name what the institutions' objectives were. No center visited had targets or specific objectives concerning recovery of no-shows (beyond vague and general concerns that efforts should be made, and in some cases are being made, to visit and re-recruit them). Objectives everywhere appear to focus entirely on prevalence and/or CYP rates; no objectives were found relating to appropriate overall institutional method mix, or declines in rates of staff turnover, or increases in proportions of continuing users or recovery of drop-outs or "no-shows," for example. This report includes recommendations for increased emphasis on participatory planning as a means of enhancing program effectiveness.

Control Systems: Although there has been considerable emphasis on financial accountability (surely an essential first step from the perspective of foreign donors), the setting up of personnel systems (largely VACS-funded), and the establishment of fixed asset registers, little more has been done to encourage, for example, improved supervision on a routine basis, appropriate follow-up procedures when substandard performance is noted, meaningful annual personal evaluations and appropriate disciplinary action, and carrot-stick/reward-sanction systems. The team found few instances of recognition for good performance. PAPFO is about to launch an Employee of the Year certificate program, but as yet no PVO has initiated a Promoter of the Month program. There has been little TA in control systems provided

beyond financial and inventory control and some basic personnel systems such as contracts, job descriptions, personnel files.

Evaluation: PAPFO provides participating institutions with quarterly feedback reports, including pie charts and bar graphs, based on the data submitted directly by sub-grantees and by sub-sub-grantees to AOPS. In order to make any comparisons, however, it would be necessary for a director to take the latest-arriving report, match it with the previous one from the files. There is no way for the director to compare the data from his/her center with that from other centers, or nationwide data. Directors do not believe that the pie charts and bar graphs are understandable to anyone below their level and thus do not generally share them, although they may pass along to their staff some overall conclusions concerning the institution's recent performance.

The upcoming PAPFO (June 1993) workshop on uses of data for decision-making bears watching. Hopefully this workshop will be replicated if found useful. It is to be hoped also that the workshop will include some discussion on the linkages between participatory planning, the setting of realistic institutional objectives that will add up to the externally-determined national objectives, the setting of unit (sub-grantee or department within an agency) mini-objectives, and the setting of individual objectives (i.e., yearly objectives, from which monthly or weekly work plans are then derived). By linking objectives-setting to feasible work plans, the data that are then obtained on progress will be more meaningful at all levels.

2.5.2 AOPS. AOPS provides TA to member institutions, particularly sub-sub-grantees, in financial, administrative (stock management and inventory), and technical matters. In the last year, visits have become quite regular, with each sub-sub-grantee visited once each month by both an AOPS financial coordinator and an AOPS technical (program) coordinator. The financial assistance has clearly yielded results, with funds flowing on a timely basis and virtually all audit problems resolved. The technical oversight/assistance was uniformly lauded in the field, although results were less visible to the team.

One AOPS initiative that appears promising is the introduction of a new 14-page supervisor's checklist. The four physicians who serve as FP Program Coordinators are expected to use this on their regular (and problem-oriented) visits to sub-sub-grantees. It covers a wide range of areas, including revision of objectives, targets and work norms; staff participation in planning; performance monitoring; management of supplies; presence of needed personnel, their training and needs for additional training; etc. This checklist is intended to uncover problems, including poorly performed (or non-performed)

Table 2: INHSAC Training 1987 - 1992

<u>Family Planning Specific</u>	<u>No. of Trainees</u>
Level A, Family Planning (1 month courses):	104
Level B, Family Planning (1 month courses):	149
Level A at MSPP, Family Planning:	57
Level B at MSPP, Family Planning:	167
TOT in Family Planning:	44
TOT in IEC:	20
Level C, Family Planning Supervision:	14
Promoters, Family Planning:	379
Promoters, IEC in family planning:	234
Sub-total	1,168
<u>Non-family planning Specific</u>	
Level A, Community Health (approx. 1 year):	102
Level B, Community Health (approx. 1 year):	119
Level A, Health Education (approx. 1 month):	45
Level B, Health Education (approx. 1 month):	15
Level A, Health Management (approx. 1 month):	67
Community Health, Med. General	17
Nurse/Hygienists	51
Level C, Community Health	568
Health Management, MSPP/IDA	114
Puericulture	27
Cholera	207
Sub-total	1,332
GRAND TOTAL	2,500

Source: INHSAC, May 1993.

PROFAMIL is a key player in the training activities for level A. Its Model Clinic provides hands-on experience for trainees, and experienced PROFAMIL physicians provide training in specialized clinical procedures. The evaluation team was particularly pleased to learn that the Faculty of Medecine at the National University of Haiti has recently decided to required its obstetrician/gynecologists to spend one month practical training at the PROFAMIL clinic as well. These sorts of activities not only increase skills, but build a broader FP constituency overall.

In 1991-1992, targets in terms of numbers of male and female course participants were exceeded. INHSAC intended to train 85 men and 125 women; in fact, 129 and 213, respectively were trained. Over the life of the project, INHSAC planned to train

212 men and 366 women; in fact, 273 and 479 were trained in family planning. The achievement LOP represents 160 percent for men and 187 percent for women.

Trainees are proposed by sending institutions. When an inappropriately prepared trainee shows up, s/he is encouraged to return for more experience and reapply at a future date, or, if admitted to the course, may be denied a certificate on conclusion if s/he has not satisfactorily completed the course.

The team found in the field that INHSAC's variety of courses is not usually perceived as such by course attenders; that is, when asked what type of family planning training they had had, virtually all responded "family planning." Even when probed concerning what aspect, the response routinely was "just general family planning." More probing, including suggested aspects, nearly always produced answers such as "contraceptive methods and their side effects", and "management" was invariably interpreted to mean "management of supplies" and not the broader meaning of management.

Curricula: INHSAC's emphasis has been on broad training in contraceptive technology (in the case of longer courses, with additional material on population/demography, anatomy and physiology, and a bit of management). There are encouraging signs that the need for more training in IEC and various aspects of management is urgent; the team would add that IEC should encompass not only in-clinic communications (group education, individual counseling, use of materials etc.) but also community outreach, in-home communication, public speaking etc.

Natural methods are mentioned during the basic course, but are not taught in detail. The Institute for Reproductive Health buy-in will provide assistance in this regard.

It seems unnecessary to train physicians and nurses in the calculations of demographic statistics; 10 hours devoted to this (in contrast to only 2 devoted to program planning) in the basic family planning course would seem to be both too much and too little -- too much in terms of what is needed, and too little in terms of whether anyone, doctors included, can be expected to master the curriculum in only 10 hours.

The 2-hour session devoted to social aspects of family planning focuses entirely on religious aspects and cultural history; there is no discussion of gender issues, education and fertility, employment and fertility, local organizations, stimulating community participation, poverty, dispersion of the population, and so on. It is unclear why the social aspects module is being taught by a physician.

The curriculum for the Anatomy and Physiology session indicates that it is necessary to include these so that providers can "make a method choice" for the client! This approach may be part of the problem of client choice and provider bias still found throughout the system, despite widespread acknowledgement of the need to assist the client in making her or his own choice.

The weakest of all curricula the team reviewed was that concerned with family planning program administration, which is only 15 hours in duration, including both theory and practice, from planning to evaluation. That there is such a course at all is a good beginning, but there needs to be more time devoted to this important subject, and considerably more attention paid to practical applications of planning theories.

Very few have been trained thus far in counseling, but there is a general recognition of the need to stop up this aspect of training. There are no graduated levels of courses (e.g., Contraceptive Methods 101, Methods 102; IEC 101, IEC 102, etc.).

Training Planning and Follow-Up: INHSAC has just (1/93) begun a new initiative called "Suivi, Encadrement, Evaluation" (SEE, figuratively translated as Monitoring, Reinforcement, Evaluation). A detailed questionnaire⁷ has been administered by two physicians from the FP unit during field visits, one each to about 30 sites (AOPS' 15 sub-sub-grantees plus other sub-grantee sites); the series is nearly completed and results will soon be analyzed. It is intended to ascertain training needs at several levels so that INHSAC can move from offering basic courses (plus a few on request, as is presently done) to designing courses and curricula that more directly respond to training needs. These would include such areas as quality of care, with emphasis on IEC and interpersonal relations, and management. The evaluation team applauds this promising development.

It is not clear how the results of the SEE process will feed into the strategic and annual planning process. INHSAC's training objectives are currently stated in terms of numbers of courses given and numbers of students attending, by gender. A "competency based training" approach would take that a step further and insist that attenders emerge with measurable skills.

⁷. The SEE questionnaire has components that are overlapping with AOPS' recently created Checklist for Supervisors. INHSAC circulated its SEE questionnaire to AOPS, PROFAMIL, and PAPFO for comment, but this similarity was not mentioned. AOPS, PAPFO, and INHSAC are thus all involved in identifying needs for TA and training. This is not necessarily bad, but the effort needs proper coordination. The Quality of Services Committee should adopt this as a priority.

Evaluation of the courses given at INHSAC is based on the students' appraisal and the judgment of the attenders' supervisors during subsequent field visits. The objectives do not include a system for determining when re-training is needed (e.g., a regular schedule of updates for everyone, or a graduated series of related courses leading to a cluster certificate, or a problem-oriented system for identifying individuals in need of re-training ahead of an overall schedule).

Criteria for admission to each course, criteria for attendance, passing, discipline concerning those who fail are all in the planning stages; INHSAC recognizes the need to go beyond student evaluations of their courses, combined with pre- and post-tests, as measures of their training success.

Quality of Teaching: INHSAC also recognizes the need to measure and improve the quality of teaching -- e.g., program management courses will be taught by specialists in management. INHSAC and trainers in participating institutions are now evaluating the training; results are not yet available.

The team was not able to observe a training course. Trainees' end-of-course evaluations are generally positive, with some suggestions (taken seriously, it seems, by INHSAC) given for their improvement.

INHSAC is also already aware of the need to produce didactic materials for distribution during courses so that trainees are not totally dependent on their own notes.

IEC Training: INHSAC and AOPS are both involved in IEC training. INHSAC trained 20 trainers in FP IEC, while AOPS was responsible for training promoters. INHSAC's training list includes their indirect role in AOPS' training of 234 promoters in FP IEC. After INHSAC has trained other institutions' trainers in IEC, the former provides support to the latter by preparing workshop materials, suggesting the workshop agenda, sitting in on the training either as observer, resource person, or co-facilitator until the trained trainer can handle it on his/her own. INHSAC is lead agency/coordinates the work of the interagency Task Force on IEC. IEC FP Training-of-Trainers is believed to be the most successful IEC training, more so than cholera and other health IEC training as evidenced by positive feedback from trainees, particularly those from PROFAMIL. Many observers believe this success is due to the work of the Task Force.

The difficulties experienced in getting INHSAC's IEC production unit underway and producing have been many. Equipment, staffing, etc. were serious problems noted in the 1989 evaluation, but appear to have been overcome very recently. As stated elsewhere, the imminent distribution of a new flip-chart

and pamphlets is encouraging. It is hoped that the reinforcement provided through the PCS buy-in, including establishment of an IEC media and materials center at INHSAC, will continue to strengthen this work.

2.5.4 Participant Training. Figure 4 summarizes the list of participants financed under the project and presented in detail in Annex C.

Figure 4: Summary PSFP Participants, FY 1989 - FY 1993

- FY 1989 - 2 M, 1 F, 1-t academic (MPH), UCLA
FY 1990 - 1 M, 1 F, s-t non-academic NCIH Conference
FY 1991 - 3 M, 3 F, s-t non-academic Advanced Training FP
Trainers
- 1 M, s-t non-academic FP Program Management
- 1 M, s-t non-academic Mgmt for Primary MCH/FP Care, Francophone Africa and Caribbean
- 1 M, s-t non-academic statistics, U.S. Bureau of the Census
- 2 F, s-t non-academic, computer systems
- 1 M, 4 F, s-t non-academic, Wkshp on Int'l Communication and Education for Health, Tunis
- 1 F, s-t academic research methods
- 1 M, s-t non-academic, Int'l Health Mgmt
- 4 M, 1 F, s-t non-academic, Mgmt of Training Programs in Health and FP
FY 1992 - 1 M, 2 F, s-t non-academic, Workshop on Int'l Communication and Education for Health
- 2 F, s-t non-academic, FP Program Mgmt and Supervision
FY 1993 - 1 M, 1 F, s-t non-academic, Education and Communication in Program Mgmt
- 2 M, s-t non-academic, Mgmt du Developpement Sanitaire
- 1 F, s-t non-academic, Health Care in Dev. Countries
- 2 M, s-t non-academic, Resource Economics and Mgmt in Health Programs
- 1 M, s-t non-academic, Managing Health Program in Dev. Countries

Note: U.S. visas were not available to Haitians in FY 1992 and USAID's training management contract was in suspension in FY 1992, so levels decreased substantially.

Source: USAID/GDO and HPNO, May 1993

The table shows that 22 men and 19 women have received training under the project. Outside of the 3 MPH degrees in FY

1989, emphasis has been on short-term, non-academic training in health program management and IEC, which continue to be areas of need. The IEC Task Force, in fact, relies on the IEC "core group" trained under this program. As shown in Annex C, many of the programs have been given in the French language, either in the U.S. or in institutions in North or West Africa. The program thus appears to have the proper focus and is using appropriate venues for this higher level type of training.

It was not clear to the team exactly how participants were selected, although it seems some discussion among USAID, PAPFO, and key sub-grantees takes place. It is clearly a separate exercise than selection of trainees for in-country course at INHSAC, and it is not clear there is any relationship between the two. Design of the new project should include development of an overall FP training strategy.

2.6 Cost of Services and Cost Recovery

The original PSFP PP did not address cost as a factor in project decision-making, and simply stated that financial sustainability in a country such as Haiti was a very long-term proposition and could not be considered within a 15 year timeframe at a minimum. Concerns such as cost-effectiveness and cost-recovery were understandably not major issues for the first three-to-four years of the project.

The 1989 Evaluation recommended extending the PACD and increasing the LOP budget by \$2.5 million, based on rapid preliminary estimates developed by the team. USAID contracted one of the team members to perform a subsequent more detailed analysis of costs in relation to proposed new outputs. The resultant report, by Sherif Rushdy, has been previously cited in this evaluation in a number of contexts. It also provides the first detailed analyses the cost of FP services, against which other estimates can now be measured.

Table 3 on the next page summarizes Rushdy's findings in January 1990 in comparison to more current information on CYPs included in Table 1 of this evaluation.

Rushdy originally estimated that cost-per-CYP would be down to US\$43 by 1992, which is quite close to the US\$47 in Table 3. As shown in the table, costs had decreased to US\$30 per CYP in 1991. As has been described elsewhere, the total CYP decreased significantly in late 1991 and the first two quarters of 1992 due to the coup and subsequent suspension of funding. All are hopeful that the program is now back on track, and it is likely that CYP will increase significantly in 1993. Expenditures are likely to increase as well, due to the reinstatement of several buy-ins. However, the team believes that the project will

achieve an LOP cost-per-CYP of under US\$50, and should reach an average of about US\$25-US\$30 per CYP by the PACD. This is a very reasonable cost by international standards. It is also significantly below the Year 1 cost of US\$181, demonstrating a high payoff of early investments and increasing cost-efficiencies over time.

Table 3: PSFP Estimated Actual Cost per CYP

<u>Year</u>	<u>CYP</u> ¹	<u>Total Cost</u> ² (US\$)	<u>Cost per CYP</u> (US\$)
1987	3,868	701,728	181
1988	24,417	1,534,478	63
1989	41,578	2,129,765	51
1990	60,479	3,447,885	57
1991	110,812	3,372,103	30
1992	72,032	3,626,963	50
TOTALS	313,186	14,812,923	47

Notes & Sources

1. CYP based on traditional conversion factors. These figures are reproduced from Table 1 in this report, which provides detail on their source and derivation.

2. Figures for 1987, 1988, and 1989 exact. Figures for 1990, 1991, 1992 estimates from Rushdy report as the evaluation team did not have time for detailed analysis of actuals from USAID. Based on information in other reports, the Rushdy estimates appear to be extremely close to actual expenditures.

The team recognizes that the analyses discussed above are gross estimates and provide only indicative figures. As stated in the table, the team did not obtain the detailed annual USAID expenditures, which would provide slightly more accurate estimates. Beyond more refined figures from A.I.D., the detailed cost data necessary to arrive at more valid cost-per-CYP estimates per year or per institution are simply not available. Non-A.I.D. funding, including private donations or generated revenues, are not currently tracked by most of the PVOs involved, so total cost attributable to FP programs is difficult to ascertain. Only one PVO -- Pierre Payen -- undertakes cost-centered accounting which would allow for more detailed analyses.

Unless A.I.D. or IPPF/WHR/PAPFO wishes to invest a significant amount of time to generate better data, the project will need to rely on such ballpark estimates for the immediate future.

IPPF/WHR/PAPFO has undertaken a number of financial exercises on a per institution basis, arriving at a 1991 cost per CYP of US\$65, and a range of \$36 for AOPS institutions to \$550 for CPFO. The PAPFO figures, however, cannot be compared with those in Table 3 because they are based on different assumptions of CYP and costs. PAPFO should continue to develop the per-institution analyses, but should over time try to develop better estimates of total attributable costs, and to note the source/derivation of data on CYP and "contraceptive users" in its tables so that they can be used in comparative terms.

The team did not assess in detail the costs of the SOMARC effort, which is possibly the most cost-effective service delivery mechanism under the project for a specific market segment. Haiti was the first, and the team believes it is still the only, country in which A.I.D. is not subsidizing commodity costs at all under the social marketing program. That is, A.I.D. covers the marketing and TA cost, but the importer advances and pays for the product (Minigynon) itself. SOMARC III's policy in Haiti is that all products should become self-financing after 5 years, and Minigynon is well on its way to achieving that objective. The activities proposed under the new SOMARC III buy-in to develop consumer profiles, coupled with a broader perspective provided through proposed OPTIONS II work on market segmentation, should provide project planners with greatly increased ability to forecast how much of Haiti's FP program can be commercially self-financing in future years.

Independently of these global planning and evaluative exercises, a number of the PVOs have begun to look at cost-efficiencies, cost-effectiveness, and cost-recovery themselves. Several were forced to do so in November 1991, when A.I.D. suspended all but core funding and the PVOs had a choice of generating revenues or closing their doors. Because of this trauma, the PVOs have developed a strong appreciation for the desirability of being able to cover their costs. Project management has begun to react to this PVO initiative, and with some encouraging activities underway and planned.

PAPFO has begun a small initiative to look at some of the cost-recovery efforts, which it classifies as operations research. It is working with three PVOs to document the introduction of fees on different bases, and the impact of the introduction of such fees on the program, in terms of new acceptors and retention rates. In collaboration with the local consulting firm TAG, PAPFO sponsored a seminar on cost recovery in January 1993. The seminar produced some useful discussion and a general agreement to continue the dialogue. PAPFO is in

contact with the A.I.D. centrally-funded Health Financing and Sustainability Project (Abt Associates Inc.) to further these aims.

The team supports the PAPFO initiatives and the accessing of central expertise to assist in further analysis. Based on its fieldwork, however, it notes that there is a lot more experience and many more initiatives underway than the three "OR" experiences discussed at the January seminar. The team was particularly impressed with the positive efforts and spirit at Pierre Payen, CDS-Cap Haitien, and Clinique Dugué in terms of cost-recovery. Conversely, it was also impressed with the expressed concerns about affordability and costs mentioned in Ouanaminthe, Pignon, and CDS-Raboteau. The team suggests that IPPF/WHO/PAPFO undertake a broad-based review of existing initiatives and cost structures to provide a context in which future OR can be developed. The review should include not only fee-for-service or fee-for-commodity initiatives, but other revenue-generating measures, such as solicitation of private funds, as well. 

The efforts that are underway are useful as far as they go, and may be considered "pre-strategic" in terms of raising consciousness about cost issues. There is, however, very little common understanding of relevant terms, e.g. the difference among cost containment, cost recovery, cost efficiency, cost effectiveness, etc., among the FP community. There is near-universal misunderstanding of concepts associated with "sustainability." This report includes a number of recommendations to further common understandings prior to embarking on development of a cost strategy for the future.

2.7 Validity of Project Strategy

Within the current sociopolitical environment, the project strategy appears sound. Following the theoretical framework included in the 1989 evaluation, and most international norms, all elements that are necessary to a family planning program designed to increase contraceptive prevalence rates are basically in place.

The last explicit statement of a USAID/Haiti population/family planning strategy was produced in May 1990, and had as its goal "to support the GOH/MSPP to achieve the development of an effective, national program of family planning which maximizes the involvement of the public, PVO, and the for-profit commercial sectors" (Smith, p. 20). That strategy formed the basis for Amendment 2. Since that time, USAID has had to discontinue all activities with the public sector, and Haiti has spent 19 months under a major international embargo, both of which effect availability of equipment and services for PVO and

commercial providers. Given the temporary nature of the crisis, USAID has not developed (nor has it perhaps had the time to develop) a new strategy. It has instead focussed its efforts on keeping funds flowing to PVO programs so that services continue to be delivered, essentially keeping all actors functioning during this difficult time.

This more ad hoc approach has created some distortions in the overall support for and delivery of services under the project. This has created problems for the short- and long-term, which, while understandable, need to be made explicit in the planning process. Some specific examples follow:

- Policy formulation: A cornerstone of the 1990 strategy was the statement that "An effective national program must function in a supportive population policy climate." USAID had planned to provide assistance to the GOH population policy organ, CONAPO, under Amendment 2. Instead, the project has provided assistance in building a private sector constituency for GOH policy formulation through the OPTIONS buy-in. It has also relied on the effective "revolving door" between the public and private sector to assure cross-fertilization of ideas. While not ideal, this has allowed USAID and its PVO partners to maintain a policy dialogue of sorts with key players who may have influence in GOH policy formulation. For the short term, this appears to have been effective and support for family planning remains a stated GOH policy. No specific long term policy agenda is possible, however, until the GOH can be more directly engaged, and somewhat of a vacuum remains.

- Coverage: Public sector facilities were estimated to account for about half of all health/family planning facilities at the time of the second amendment (July 1990). These facilities were known to have particular expertise in clinical methods, such as VSC and Norplant^R. The prohibition against U.S. assistance to the GOH has decreased the quantity of coverage nationally, in that these GOH facilities receive no financial or contraceptive commodity support. It has also effected the ability of PVO providers who do not provide clinical methods and/or VSC to undertake referrals, as GOH clinics are often understaffed and undersupplied. This lack of reliability for referrals will become more important if demand for Norplant^R increases as expected. These factors contribute to less coverage, lower CYP, and much less efficiency in overall service delivery than might otherwise be possible, as PVOs have had to try to fill the gap. Project managers must be explicit about the fact that while this is USAID's only family planning project, it cannot possibly meet all demand for services and coverage will remain constrained.

- Service statistics: As described in section 2.4, the original PP identified CHI as the institution that would develop a system for collecting and reporting service statistics for all the project's service institutions. As documented in the 1989 evaluation, CHI was overburdened with other work under child survival projects, and did not give adequate attention to the family planning work. IPPF/WHR thus began developing its own system, which only covers the PVOs receiving funding through IPPF/WHR. By design the system does not and cannot provide any comparative measure within the national perspective of relative contributions of public and private providers to overall CYP or CPR. The team believes it is imperative that the DHS questionnaire and coding include reliable means of attributing non-profit private (PVO), commercial, or public sector providers in order to be able to measure relative impact overall.

These and related distortions are not critical to achievement of project objectives, but should be explicitly acknowledged in any discussion of strategic achievements.

There are a number of elements of the project strategy which have not been affected by the discontinuation of public sector support. A full range of methods is available at most service points, and one new method -- Norplant^R -- was tested with project funding and approved by the GOH/MSPP as an approved method in Haiti. As discussed in section 2.3, now that Depo-provera has been approved by the USFDA and will be provided in the commodity mix, USAID should more carefully consider its optimal use and encourage the development of a strategy to guide providers. Of specific interest in terms of increasing coverage and decreasing costs is allowing non-medical personnel to give the injections.

The mix of types of service delivery mechanisms has improved considerably over time, with important increases in community-based and outreach programs, away from fixed facility offerings. Of interest to some team members is the fact that most CBD in Haiti has been undertaken in the more difficult rural areas with poor transport and logistics, as opposed to the logistically easier urban CBD found in many countries of the world. The success of the mobile VSC teams, and demand in general for VSC, coupled with cost considerations suggest that mobile teams for clinical procedures should also be emphasized in the future. Given difficult infrastructure in rural areas, and unmet need in urban areas, both CBD and the mobile teams appear to be particularly suited to helping to expand coverage for a relatively low investment.

In terms of strategic focus, the marked success of the commercial sector social marketing program with Minigynon bears

watching as it expands into other product lines. As stated earlier, it provides an interesting perspective both in terms of affordability measures and in terms of marketing and IEC. The approach of developing consumer profiles through focus group interviews, and then gearing the marketing to that profile, might be particularly appropriate to forthcoming IEC effort.

As stated in 2.6 above, much more work needs to be done on identifying measures to increase cost-consciousness, and to increase cost-effectiveness over time. While cost should not be the only factor in method choice or method promotion, program planners must begin to include it as one important factor in their long-term program decision-making.

In the same manner, the project must begin to address cost recovery issues on a more rigorous basis. All partners agree that the trauma of having funding suspended after the coup was an effective means of emphasizing the need for diversification of revenues if the program is to continue over time. If there is any major gap in the project strategy, particularly given the current lack of public sector involvement, it is the long-range perspective on financing. The on-going and planned operations research activities may be considered "pre-strategic" information-gathering efforts toward this end. Creating increased demand will serve no purpose if supply cannot be increased to meet the need.

2.8 Adequacy of Project Management

As stated above, all elements essential for a family planning program are more or less in place, and are more or less functioning. Given the upheavals of the past few years, however, most management emphasis has been placed on simply keeping all of these individual elements functioning. This is commendable, and the administrative creativity at USAID/Haiti, IPPF/WHR & PAPFO, and PAHO, and the perseverance of PVO partners is to be lauded. The team understands that it is difficult for outsiders to comprehend the frustrations of the Haitian PVOs, IPPF/WHR & PAPFO, and PAHO, in attempting to get item-by-item exemptions from the U.S. Department of the Treasury (in Washington D.C.) in the early days of the embargo. It is equally difficult for non-A.I.D. people to comprehend the number of meetings, memoranda, and specialized communications that were required to sign one grant budget amendment under the U.S. Congressional restrictions. The fact that no PVO disappeared, and that almost all maintained some level of program continuity, is impressive and reflects committed staff and capable management at all levels.

Comments on specific management concerns follow.

2.8.1 Financial Management. The project has resolved early problems with financial management procedures admirably, and currently only 2 PVOs are still in suspension due to audit problems. Both of these have reconstructive audits in process, and all are hopeful problems will soon be resolved. With the exception of those with audit problems, the team heard few complaints about IPPF/WHR or AOPS financial procedures or requirements. Indeed, several persons commended the AOPS financial personnel for making useful suggestions during field visits. The only criticisms made were that due to devaluation the funding ceiling for informal procurement procedures was now too low at H\$250, and needed to be raised, and that multi-year budgets should be allowed. Both of these are easily allowable within A.I.D. procedures, and should be pursued by IPPF/WHR.

The team reviewed the pilot contract with Pierre Payen, which provides joint VACS/PAPFO financing for an integrated child survival/FP program, and is encouraged by this innovative attempt at results-oriented (as opposed to audit-driven) administrative management. The team has also discussed some more innovative methods of implementation and financing, including the Fixed Amount Reimbursement (FAR) system, with key personnel. The team concludes that, beyond the Pierre Payen pilot, no major change in financial systems is indicated at this time. It has taken a very long time to train personnel to carry out the current system. Based on experience at Pierre Payen, USAID should consider innovative methods as part of the new, follow-on project. Under the current project, given everything else going on in Haiti, standard grant management systems should continue to be used.

2.8.2 Technical Supervision. As described in section 2.5, technical supervision from PAPFO and AOPS received positive reviews from field personnel. They were equally appreciative of supervisory visits by PROFAMIL staff to CBD sites and by CDS-Port-au-Prince staff to the north and northeast. As discussed in sections 2.2 - 2.5, there seems to be an effort by supervisory staff at this level to improve the productivity of such trips, and this is commendable. As noted in 2.4, there seems to be a particular need at this time to improve supervision of service statistics. As noted in 2.5, there is a general sense that sub-grantees would like more involvement by PAPFO technical personnel. Outside of reporting on "Mystery Client" visits -- which are in general very well received in the field -- the team found very little evidence of feedback from the center outside of direct comments during supervisory visits.

Technical and financial supervision from PAHO for its 6 sites has only been possible for a few months, so no comments can be made. The PAHO involvement, as the team understands it, has added these 6 sites which would otherwise have lost family planning programs. Although this is curious from an

administrative standpoint, the benefits to coverage in the north and northeast are expected to outweigh the management costs.

2.8.3 Contraceptive Commodities. As described in section 2.4, the monthly service statistics for IPPF/WHR grantees are sent to and collated by PAPFO. These statistics include "contraceptives distributed," which form the basis for calculation of CYP. The contraceptive commodities are inventoried, warehoused, and distributed to the PVOs by PROFAMIL. The recent study of VFT by Dix (April 1993) revealed problems at the clinic/provider level with commodity management and accountability, understanding of expiration dates and shelf life, and stock procurement. The evaluation team did not undertake the same detailed inquiries as did Dix, but confirmed these problems in general. At the project level, it also found little evidence until quite recently that PROFAMIL or PAPFO related service statistics to commodity draw-down as part of any overall commodity planning process.

For example, much has been said about the impact on the program of the Depo-provera stock-out for eight months, from February through September, in 1991. The team carefully reviewed the IPPF/WHR quarterly reports for 1991. The first quarter report had 1,304 new acceptors for injectables, and no mention of a stock-out. In fact, the first quarter report noted that the IPPF/WHR Regional Supplies Coordinator had made an inventory of all project contraceptives in March 1991, and "...found the distribution and control systems worked well, although there could be management and storage improvements in the provinces." (1991 First Quarter report, p. 17).

The second quarter report did note, in one sentence, a decrease in Depo's share in relation to the pill in the method mix due to the stock-out. The third quarter report did not discuss the stock-out or the arrival of new supplies in September. This is understandable given the coup at the end of that quarter, but still highlights the lack of a formal system of relating stock use (as in service statistics) to availability.

According to a summary of stock-outs over the LOP (Sullivan, 5/93), Depo was available throughout 1992. The Project Performance Overview for the Period January-September 1992, prepared by PAPFO as part of the October 1992-September 1993 Workplan/Budget Request, however, stated that "Depo provera stock-outs continued to plague the project." These stock-outs were not reported in any on-going formal system; they apparently were at the level of very small AOPS sub-sub-grantees, who were not captured in aggregate report. This lack of correlation between commodity warehouse records and service delivery statistics must be corrected if data are to become useful for planning purposes. Simply, if the service data are to become a

useful tool, events such as major stock-outs affecting method use should be footnoted to statistical tables.

To illustrate this point, Table 4 provides information on the change in continuing users and acceptors during the period of the 1991 stock-out. Note that the data are for "injectables" and not just Depo, although the largest share of injectables is Depo.

**Table 4: Continuing Users and New Acceptors of Injectables
Fourth Quarter 1990 - Second Quarter 1992**

	<u>1990</u>	<u>1 9 9 1</u>				<u>1992</u>	
	Q 4	Q1	Q2	Q3	Q4	Q1	Q2
<u>Continuing Users</u>							
PROFAMIL	2218	2115	936	1720	1417	1656	1672
All others	2345	2847	2478	477	81	2069	2716
TOTALS	4563	4962	3414	2197		3333	4388
<u>New Acceptors</u>							
PROFAMIL	331	582	280	558	243	443	356
All Others	455	722	445	129	21	714	903
TOTAL	786	1304	725	687		1157	1259

Source: IPPF/WHR/PAPFO Quarterly Reports for relevant periods.

Note: The fourth quarter of 1991 was the period immediately following the coup, when A.I.D. funding was suspended, three institutions closed completely and many others were operating on skeleton staff. Data for that period are likely incomplete and presented only as indicative.

The data indicate a significant decrease in both acceptors and continuing users of Depo-provera during the period of the stock-out. As can be seen, users and new acceptors increased, the latter significantly, between fourth quarter 1990 and first quarter 1991, with the method gaining an increasing share of all temporary methods. Both categories decreased for all institutions between the first and second quarters, 1990, when the stock-out at the PROFAMIL warehouse started (February 1991), and then began to rebound in the third quarter as stock again became available (September 1991). Although data from the first two quarters of 1992 demonstrate that the method had rebounded to near pre-stock-out levels by that time, it must be assumed that the method, and the FP program, lost some credibility among users during that period.

Part of PROFAMIL's commodity distribution network is AOPS, which maintains a smaller depot to supply its 15 sub-sub-grantees. AOPS maintains a sound inventory system, but does not get involved in overall quantitative planning. It was, in fact, not clear to the team what the value-added of AOPS' involvement in the process is, in that it is located less than five miles from PROFAMIL.

USAID has also recently decided to send half of its contraceptives to the essential drug non-profit company PROMESS. A commodities consultant worked with the key players in December 1992 to develop consolidated contraceptive requirements table for the next two years, and raised a number of questions regarding various roles. In line with the consultant's comments, the team confirms that is not yet clear how PROMESS will relate to PROFAMIL, AOPS, and PAPFO in terms of assuring inventory levels and controls. While the commodity supply system has thus far generally worked in terms of what can be controlled in Haiti, this fragmented set of players with no systematic communications and feedback is worrisome if the program gets much larger.

USAID has developed a scope of work for a commodities consultant, which it currently proposes to hire at USAID for a period of one year. The team questions whether a full year is necessary, and suggests 3 months may be adequate for developing systems which PAPFO and PROFAMIL would then operate and monitor. The team also suggests that PAPFO might be a more appropriate base for the consultant than USAID.

2.8.4 Overall Project Management. In general, the individual actors throughout the project are its strength, and the key management issue question is really whether or not the whole exceeds the sum of its parts. What seems to be missing is a hierarchy of supervision, or direction, that fosters communication and working together toward common, explicit goals. IPPF/WHR has formed a Project Advisory Committee (PAC) which seems to share some of the information, but how much of the PAC deliberations flow out to other players is not clear. The chain of command that might provide more cohesive program direction, receive and synthesize information on program performance, and then act on that information through revised direction, is in many cases badly overburdened and/or highly fragmented.

For example, IPPF/WHR/PAPFO is responsible for managing 7 sub-grants, two of which have a total of 19 additional sub-sub grants. PAPFO has a capable financial management staff of 4, which works hard but manages to keep up with monthly financial reporting reviews. Its Program Coordination staff to provide technical and programmatic assistance to the same 7 plus 19 PVO partners is a capable one person. Its Service Statistics staff to maintain quality supervision for all service statistics and to

provide feedback on such statistics is a capable one person. The emphasis on financial management has yielded positive results, but a balance with technical and programmatic results must be obtained. More technical program and statistical supervisory staff are urgently needed.

The office that is supposed to ensure that all of this works in harmony is HPNO at USAID, with one full time Project Coordinator, part of the time of the Humanitarian Assistance Coordinator, and a small part of the time of the Deputy Office Chief. These less-than-two-person-equivalents are responsible for A.I.D. oversight functions for: 1 International Organization grant (PAHO); 1 major Cooperative Agreement (IPPF/WHR) with several sub-grants; 6 U.S. contractor buy-ins for varying types of TA and training activities; annual direct procurement of contraceptive commodities, which are consigned to USAID/Haiti and thus must be monitored and cleared by USAID/Haiti; annual direct short-term participant training, involving development of direct financing instruments and processing of each trainee; and all of the memoranda, clearances, waivers, approvals, reviews, briefings, and problems that come with each of them. Even by A.I.D.'s standard of "doing more with less," this is a very large workload indeed. USAID/Haiti should explore ways to allocate more staff time to this project to ensure a tighter technical/programmatic coordination.

3. CONCLUSIONS AND RECOMMENDATIONS

As directed in the Scope of Work the following sections of the report include a summary of project achievements followed by issue-by-issue summary conclusions and recommendations. The team has tried to synthesize the recommendations into a short, priority list. It hopes that important recommendations have not been lost in the process.

The priority recommendations for the remaining years of this project may be summarized in three cross-cutting categories:

- "Demedicalization," or liberalization of service delivery is of the highest priority. This category includes: increased attention to training and supervision of fieldworkers (promoters, ColVols, auxiliaries) to enable them to provide as many methods as possible directly to clients; elimination of the practice of requiring physician visits and pelvic exams for hormonal methods; etc.

- Definition of terms and establishment of parameters for retention rates ("drop-outs", "no-shows", etc.), and follow up of clients, in order to develop an empirical basis for judging project success at the institution-specific and project level. This category includes: increased attention

to quality of services; vastly improved client follow-up and consequent improvements in fieldworker supervision; revision of service statistics systems; conduct of tracer studies; increased use of OR to inform management, etc.; and

- Improved management attention to assuring more cohesive strategic and tactical planning, monitoring, evaluation at all levels of the project, with particular attention to linking institution-specific plans within an overall strategic framework. This category includes: developing improved institution-specific plans which include attention to individual objectives; improved technical and program supervision within service delivery institutions and by project oversight organizations (AOPS, PAPFO, PAHO); increased attention to feed-back mechanisms, again at all levels; increased coordination between and among players outside of the PAPFO umbrella, etc.

These recommendations are offered within the context of the current project and based on the assumption that it will be extended one year, until September 1995, to allow for adequate overlap with the planned new project to be designed during FY 1994. A fourth cross-cutting issue, long-term sustainability and short-term efforts to influence it, is more appropriately considered within recommendations for design of a follow-on project.

3.1 Summary of Project Achievements

The project is making reasonable and positive progress toward achieving stated goal and purpose indicators. The 1989 CPS showed 10.5 percent of women in union using contraception, against a LOP target of 16 percent. There were approximately 175,000 new acceptors as of December 1992, as compared to an LOP target of 200,000. The retention rate could not be measured, and the target is of questionable value as it is possibly unmeasurable. There were approximately 65,000 continuing users (all methods) as of December 1992. This is impressive for the LOP, given political and social upheavals in Haiti during the LOP. The cost-per-CYP has decreased from about US\$181 per CYP in 1987 to about US\$47 per CYP in 1993, demonstrating significant returns to early investment and increased cost-efficiencies over time.

Thirty-three PVOs are providing FP or FP-support services as compared to an LOP target of 35. All but two participating PVOs have or have access to VSC facilities, as compared to an LOP total of 23, thus exceeding the target. Almost 6,000 cycles of low-dose orals are marketed monthly at over 200 commercial sales points.

The 1989 CPS showed that about 80 percent of men and women were aware of some form of modern contraceptive method, although knowledge was limited to only one or two methods. The planned 1993 DHS will measure recent changes in knowledge, which are expected to be positive.

The team notes that the quantitative measures for many of these objectives have been decreased through successive project amendments. The team accepts that these decreases are rational responses of project management to the constantly changing Haitian environment. The team understands that the exigencies of A.I.D. programming since the coup, when overlaid on this unstable sociopolitical and economic environment, render standard long-term planning processes almost futile. As elaborated in sections below, it recommends, however, that USAID and PAPFO support detailed analyses of potential target populations for various institutions and various methods based on information obtained in the FY 93 DHS and before the design of any follow-on project. (This activity is planned for OPTIONS II). These analyses would include site-specific censuses, follow-up studies of both users and "drop-outs", and development of user profiles for specific methods. Only then can the project begin to look at improving its impact.

3.2 Barriers to Family Planning

Conclusions: There are in general no insurmountable barriers to increasing use of modern contraceptive methods. Certain constraints that used to be important, such as the belief that children represent wealth for their parents, as well as the opposition of the church, husbands' vetoes, have decreased in importance. Other factors, such as poor economic conditions and general instability have limited community organization and outreach activities during the last few years. Certain barriers derive from the mountainous topography of Haiti and poor road conditions. The long distances that fieldworkers and/or clients must cover to give or receive services, and the excessive area assigned to some fieldworkers, all limit access to services. The "medicalization" of services in relation to the lack of medical personnel in some zones is another relatively important barrier. Additionally, rumors spread about both real side effects and imagined side effects, based on the general public's lack of knowledge, are also an obstacle to increased use.

Recommendations

- Project management (USAID/HPNO and PAPFO, with PAHO, AOPS and/or PROFAMIL where indicated) should place highest priority on instructing/providing assistance to participating PVOs to undertake systematic descriptions of their catchment areas and the specific zones covered by

respective fieldworkers. These descriptions should include inventories of human, institutional and natural resources in each locality, in order first, to ensure that the worker knows the area, and over time to increase the worker's potential use of these resources to increase adoption in the community;

- The project Medical Quality of Services Committee should strictly enforce existing medical norms and standards which do not require a pelvic exam for provision of hormonal methods, and which allows properly trained fieldworkers to distribute as many methods as possible, and specifically pills, without a physician's examination;

- Project management should undertake pilot efforts at provision of transport for fieldworkers, such as mules or bicycles or weekly allowances for tap-taps, depending on the site; experience from other programs, wherein bicycles were "sold" to agents over time at subsidized prices, might be applied to ensure quality maintenance and use (this is being done under the Pierre Payen contract, but needs to be more widespread);

- Fieldworkers' salaries and benefits should be harmonized and aligned with the requirements of their position; this harmonization should, as stated above, include provision for payment of per diem for overnight and/or transport (work has begun on this under the VACS project);

- PVO partners should be encouraged to stimulate community participation to improve roads, develop income-generating activities, and mobilize community leaders to put pressure on public services to assist in relevant activities.

3.3 Quality of Services

Conclusions: In general, the quality of services provided by project institutions falls within acceptable averages. It is clear that project management is placing a lot of emphasis on improving the determinants of quality of services. The elements contributing to quality of services are understood and almost all the elements have corresponding activities in place to improve services. Some of these efforts are still new and have not yet borne results.

Client access to the full range of method choice offered by the program is limited by lack of training of service providers for the more clinically oriented methods such as IUDs and Norplant^R. Insistence of some institutions on pelvic exams for hormonal contraception is a barrier to free method choice and in

some case promotes rumors on the danger associated with hormonal contraception.

In general great progress has been made in the area of education and counseling provided by nurses, auxiliaries and community workers since the last evaluation, but doctors are far behind in counseling skills. In the fifth year of the project, there are still virtually no education materials at the client level. The progress of this activity is too slow.

Not surprisingly interpersonal relations between clients and providers follows the same pattern as is observed almost everywhere around the world. When there is a wide social gap between provider and client the relationship tends to be poorer than when the gap is smaller. The more alike the client and the provider are the easier the contact is. This strongly mediates for using community workers and auxiliaries as much as possible to dispense services.

Recommendations

- The Medical Advisory Committee must reconsider the norm on pelvic exam requirements for hormonal contraception and make sure that the norm is not a barrier. The committee should consider initiating experimental programs to determine the lowest level of paramedical staff capable of dispensing injectables safely and to train auxiliaries and nurses to do pelvic exams. All community workers should be allowed to dispense pills.
- The mobile clinic program should be dramatically increased. This program should have access to sufficient equipment to make sure that no sterilization is necessary in the field.
- The project should develop a specific Depo-provera strategy taking into account the role of UNFPA as a partner. Given the popularity of the method, Depo should be provided by the lowest possible level of personnel especially in remote rural areas.
- A study of nurses versus doctor insertion of Norplant^R should be conducted to demonstrate feasibility.
- Doctors who work in the program should be selected for their interpersonal skills as well as for their medical capacity. PAPFO supervisors and AOPS coordinators should observe clinical procedures (i.e. physician-client interaction) to identify problem practices.

- More women should be involved in the program at all levels.
- All the participating institutions with on-site intrapartum care should be asked to develop a postpartum program.

3.4 Monitoring, Evaluation, Research, and Service Statistics

PAPFO has made significant progress in the collection, collation, analysis, and synthesis of service statistics since the last evaluation. The design, preparation of an Information Systems Manual, installation and training, and continuous quality-control of the system have evolved considerably since that time. There are still problems with basic definitions used in the service statistic system, and uniform use of these terms is critical if a site is to be able to compute its overall performance. There is a particular problem with the definition and computation of "drop-out" rates, which must be rectified if the individual sites and the project overall are to be able to measure progress and impact over time. There are also problems with training, supervision, and thus performance of documentalist/clerks who carry out the system in the field. The end-result of these definitional problems is that there is probably over-reporting of drop-outs, and thus under-reporting of program success. However, given a lack of coherence in application of what definitions there are, and problems with training and performance of documentalists/clerks, it is difficult to know with any certainty.

The research and evaluation work under the project should be complementary to the monitoring possible through the service statistics system, and this unfortunately has not been the case. This work was initially to be conducted by CHI, which has progressively gotten less and less involved in the project due to the demands of other work. Many of the small studies conducted by or through PAPFO are useful and interesting and contribute to enhanced program performance. However, outside of the Mystery Client program, which provides on-going feedback to PVOs, the work has been undertaken on more of an *ad hoc* basis without an overall plan. There is much less operations research under the project than would be desirable.

Recommendations

- PAPFO, with USAID or consultant assistance if necessary, should work to more closely link the on-going monitoring and evaluation made possible by the services statistics system with its special studies and surveys, currently in its research division. It should develop an overall strategy for evaluation which includes all of these inputs and

methods and which demonstrates the intended strategic results;

- PAPFO and the relevant partners should be instructed to begin including CDS/North and CARE in the services statistics system, and reports should also include SOMARC data in summaries of continuing users and CYPs;

For the on-going monitoring and service statistic system:

- PAPFO should follow through with its stated intent of reviewing the system, and should work to redefine key concepts which are currently problematic, such as *utilisatrice attendues* and *inscriptions*. As part of this system revision, the definition and parameters for retention rates must be reconsidered. When the service statistics system is revised and some pilot efforts have proven successful, the Manual should be revised, made short and succinct, and be redistributed.

- Any calculation by anyone under the project of CPR should be presented with footnotes on data sources which state the denominator used and its source and date; all tables and charts prepared under the project should also include dates and sources of information, and note where estimates are used;

- Late contributions to a PVO's quarterly report by a field agent should not be discarded, but should form an addendum so the data are not lost;

- Each institution should up-date its catchment area census every five years at a minimum;

- Priority should be given to increased basic and on-the-job training for documentalist/clerks, and their supervisors immediately and as the revised system comes on line; supervision should be more rigorous and should be documented;

- In this regard, PAPFO should be encouraged to review staffing of the services statistics function in particular, and consider adding additional staff to aid in analysis of data at the central level and on-the-job training and supervision at field sites.

For the periodic monitoring and evaluation/research:

- PAPFO should continue valuable and well-received the Mystery Client system as part of an overall evaluation strategy that emphasizes pertinent and useful feedback to participating organizations;

- As part of a new evaluation strategy, PAPFO should give high priority to the following types of surveys which have proven useful in Haiti and/or elsewhere: additional site-specific mini-prevalence surveys, and annual analysis of users, with a view toward developing user profiles/methods; these should be undertaken by CHI or local consulting firms, depending on interest, availability, and capabilities;
- Training should be provided to service delivery institutions to teach them how to analyze their own performance, with emphasis on use of service statistics and the conduct of "mini" operations research.
- As part of the strategy, PAPFO or The Population Council should increase emphasis on evaluation/OR of clinical procedures, with consideration given to the following:
 - An experimental program to determine the lowest level of health worker capable of safely dispensing injectables;
 - An experimental program to train auxiliaries and nurses to do pelvic exams; and
 - A study of nurses versus doctor insertion of Norplant^R should be conducted to demonstrate feasibility.

3.5 Institutional Strengthening

Conclusions: There is significant evidence of successful training and TA provided under the project:

- the PAPFO Mystery Client activity has almost universally been found to be useful;
- Nurses', auxiliaries', and community workers' interpersonal skills with clients are generally positive, more so than those of many physicians;
- There is widespread understanding of the importance of free choice, although this is not always translated into fact;
- Contraceptive management practices (inventory, supply) have notably improved since the 1989 evaluation.
- There were important obstacles to the creation and dissemination of IEC materials in to training in their use; many of these have passed or been overcome;

Less easy to measure, or conspicuous by the apparent weakness of the results, are other aspects of TA and training:

- The evaluation/service statistics component shows some evidence of improvement; there has been considerable increase in timeliness and accuracy; problems persist in the matter of agreement on use of terms (acceptor, inscription, user, no-show vs. drop-out/abandon etc.) and accuracy in filling in forms;
- The medical/quality of care component embraces not only technical competence but the psycho-social aspects of client care as well; in the case of the latter, there has been visible progress in a widespread acknowledgement of the importance of improving quality of care. However, client contact, from welcome, to group education, to individual counseling need a great deal more attention.
- The project management/sub-grantee management component also encompasses a variety of skills, some of which have clearly benefited from TA and training (especially financial management and reporting), but planning (both strategic and annual), reasonable setting of objectives at both institutional and individual levels, and supervision at all levels still leave much to be desired.

Recommendations

Training: Project management, specifically USAID/HPNO and PAPFO, should assist INHSAC in the following:

- Increasing the local level courses in management of family planning programs, especially planning, supervision, and self-evaluation/monitoring.
- Increased attention to counseling and motivational techniques as well as information-transfer for all levels of personnel, especially doctors;
- Establishing minimal standards for admission, passing, and subsequent performance;
- Creation of a series of courses on the same topic -- i.e., not just adapting basic FP to levels A, B, and C, but developing graduated courses so that trainees can move forward from their initial course level.
- Encourage efforts to evaluate the quality of teaching and to adopt measures beyond student appraisal of courses;
- Encourage development of materials for distribution during training;

- INHSAC's training objectives should go beyond numbers of hours offered and numbers of participants trained, to indicate a desired altered state of either people or things -- i.e., at least improved skills, possibly improved practices resulting from those skills.

Participatory planning/objectives-setting/training/TA: The 3-day AOPS workshop on Planning, Evaluation, and Programming should be considered only a beginning. Project management, including USAID/HPNO, PAPFO, and AOPS and PROFAMIL, as appropriate, should give more time, and more practical applications, to each of these topics. The current emphasis on setting objectives only with respect to CYP or prevalence rates should be expanded, with the addition of specific measurable objectives relating to no-show recovery rates, reduced staff turnover rates, etc. Over the long-term, project-supported TA and training should link:

- a genuinely participatory planning process, involving level C workers in the setting of their own annual objectives (this goes beyond a weekly or monthly work plan of home visits, for example);
- individual objectives that add up to feasible institutional objectives;
- individual institutional objectives that add up to a feasible overall project objective;
- regular monitoring and periodic self- and external evaluations, with appropriate feedback to the field;
- improved supervisory/support visits so that gaps in skills and systems necessary to achieve the planned objectives can be identified and rectified; and
- a system to adapt training and TA offered, training and TA requested, and training and TA provided to the objectives-related deficiencies that have been identified continued, and increased emphasis on the continuous loops among problems identified, control systems to identify and rectify the problems, and feedback in the form of supervision visit reports, comparative quarterly reports to providers, and seminars on data use for participating agencies.

3.6 Efforts at Cost Recovery

Conclusions: The original PP did not include a strategy for cost-recovery, and in fact stated that program sustainability in a country such as Haiti was a very long-term proposition and couldn't be considered within a 15 year timeframe. The 1990-

1992 Strategy does not mention sustainability or cost factors, beyond stating that Haiti as a pre-emergent country requires significant assistance. The 1990 analysis by Rushdy developed a preliminary approach to analyzing cost-per-CYP, and PAPFO has recently undertaken some very preliminary analyses of cost-per-user by institution. There is very little common understanding of relevant terms, e.g. the difference among cost containment, cost recovery, cost efficiency, cost effectiveness, etc., and near-universal misunderstanding of concepts associated with "sustainability."

A number of PVOs have initiated fees as part of new cost-recovery pilots, and three are participating in an operations research program on cost-recovery conducted by PAPFO. Overall, there is increased interest in considering cost as one of many elements in program planning, and the team finds this increased interest encouraging. No PVO has a cost recovery strategy for FP programs which would decrease dependence on the project over time.

Recommendations:

- USAID and PAPFO should continue to encourage pilot efforts at cost recovery during the remainder of this project;
- USAID follow through on its stated intent to work with an appropriate centrally-funded project (John Snow Incorporated's SEAT, or Abt Associates' Health Financing) to host workshops and/or provide materials to develop common understanding of various terms and concepts related to costs, so that there is more general understanding and communication among parties;
- USAID should continue to strongly encourage expansion of the social marketing program into new geographic areas and new product lines, and should make sure that market analyses and profiles developed by SOMARC are available to and absorbed by other agencies interested in developing cost-recovery strategies;
- Over the longer-term, and to be included in the new project design, USAID should encourage all PVOs to establish strategies that demonstrate plans to decrease dependence on A.I.D. financing over time (but not necessarily within the IOP); these strategies should include: increasing cost-consciousness and analyzing cost-per-method and service; cost-recovery, with a well-defined practice of exemption; and revenue diversification, including fee-for-service, other income-generating activities, endowments, and active solicitation of grants from other sources.

3.7 Validity of Project Strategy

Conclusion: Within the current sociopolitical environment, the project strategy appears sound, and all elements that are necessary to a family planning program designed to increase contraceptive prevalence rates are basically in place. Because of the inability of A.I.D. or other donors to provide support to the GOH/MSPP during most of the LOP, there are some distortions in the overall support for and delivery of services under the project. These include lack of significant and specific support to the GOH population policy process; decreased potential coverage, including support to reference facilities; and lack of a central structure of statistical research and analysis, including the absolute lack of valid or current census and migration data. These and related distortions are not critical to achievement of project objectives, but should be explicitly acknowledged in any discussion of strategic achievements.

The project provides a wide variety of methods. USAID can take pride in funding the research that led to the introduction of Norplant^R as an approved method in Haiti. It now needs to work on a strategy for use of Depo-provera, which has been provided to Haiti by the UNFPA but only recently was approved for use by the U.S. Food and Drug Administration.

The success of the social marketing program is significant and should be carefully monitored.

The strategy lacks any attention to prospects for financing in the absence of A.I.D.

Recommendations

- Given the current uncertain socio-political environment, and the existence of a comprehensive project strategy which seems to be achieving some positive results, it is recommended that USAID proceed with extending the PACD one year, to September 1995, without making major modifications to project elements or strategy. This will allow adequate time to develop a new strategy for the new project, currently targeted for design in FY 1994, and hopefully under better socio-political conditions.

- If conditions do not improve, the current project must increase efforts in sustainability, particularly in regard to financial factors.

- Where possible, USAID should make use of targets of opportunity through OPTIONS and other means to maintain active dialogue with key players on the need for a proactive population policy; consideration should be given to

providing modest support to the scientific journal INFO-POP, and to the conduct of internal migration studies which will help in tracing users.

3.8 Adequacy of Project Management

Conclusions: All elements essential for a family planning program are more or less in place, and are more or less functioning. Given the upheavals of the past few years, however, most management emphasis has been placed on simply keeping all of these individual elements functioning. This is commendable. The fact that no PVO disappeared, and that almost all maintained some level of program continuity, is impressive and reflects committed staff and capable management at all levels.

The project's financial management systems, after some difficult beginnings, are functioning smoothly and the team does not recommend significant changes. The technical management/supervision systems, including both clinical and statistical monitoring and supervision, have received less attention, and need increased definition and staffing levels. Contraceptive commodity management merits a review due to the entry of a new player, PROMESS, into the field.

Recommendations

- USAID/HPNO must reconsider staff allocation to PSFP. The size and complexity of the project requires two full-time-equivalent professionals providing management oversight at USAID/HPNO. These professionals should be supported on a part-time basis with technical inputs from specialized HPNO colleagues and from fellow project managers with complementary project (e.g. Urban Health for CDS, VACS, AIDSTECH). If this allocation cannot be accommodated within current staffing patterns, USAID/HPNO should consider an additional position with particular emphasis on carrying out the basic A.I.D. contract/grant management functions, including review of plans and budgets, which appear to take a great deal of management time of current staff;

- PAPFO should be instructed to add as soon as possible at least one professional to its technical supervision (Program Coordination) division to focus on increased clinical supervision and quality of services for the sub-grantee sites not benefitting from AOPS supervision; there is a particular need to improve coordination among USAID, PAPFO, AOPS, and INHSAC in training and TA needs assessment, training and TA planning, and training and TA supervision, monitoring, and evaluation, and PAPFO's Program Coordination Division is the locus of this coordination.

- PAPFO should also be instructed to add as soon as possible at least one professional to its monitoring/evaluation efforts; the latter should specifically focus on either undertaking almost full-time service statistics field supervision and on-the-job training or increased useful comparative analysis, synthesis, feedback, and distribution of data that exist. One individual simply cannot carry out both of these functions for all the institutions involved.

- Short- or medium-term consultants should be brought in to assess: a) the service statistics system, with emphasis on assessing definitions and on developing an appropriate and useable approach to measuring retention rates, either within the system or through other means; b) the contraceptive commodity management system, with emphasis on delineating organizational roles and responsibilities among PROFAMIL, PROMESS, AOPS, and the MSPP (the team recognizes that USAID has a Scope of Work for such a position and simply recommends that USAID act on it); and possibly c) alternatives for developing more awareness and consensus about the need to include cost factors in program management decision-making at all levels (again, follow through with the proposed Abt or another buy-in).

3.9 Concerns for the Follow-On Project

The evaluation team focussed primarily on evaluative activities, with recommendations cast in terms of making what exists function more effectively within the current project context. USAID/Haiti has initiated design of a combine child survival/nutrition/population/family planning project, with authorization targeted for about one year from now, in third quarter FY 1994. The evaluation of PSFP's sister project, VACS, provided a number of recommendations for the design of that project with which the PSFP evaluation team generally concurs. It wishes to emphasize the following for design guidance.

- Project design should fully explore the benefits of the concept of SYLOS (Système Local de Santé) summarized in the VACS evaluation and promoted by PAHO in Haiti. The PSFP team believes it to be a workable and useful system, which stresses the integration of Haiti's "three-legged stool" of the public, non-profit private (PVO), and commercial provider in an overall health care system. This emphasis on maximizing utilization of Haiti's vast network of "institutions mixte" is management and resource efficient and should have very high pay-offs in terms of medium-term impact and long-term technical and financial sustainability.

- Project design should emphasize vertical integration of services at appropriate levels, using staffing and

supervision models developed at Pignon as a guide. The experience of Pignon in mobilizing community participation is also to be emulated.

- In promoting vertical integration, however, designers should pay careful attention to explicit definition of expectations and realities of the roles and responsibilities of base-level fieldworkers, i.e. ColVols and promoters. USAID should strongly consider sponsoring a workshop on the role of these key personnel in future integrated efforts. Of particular interest is ensuring that PSFP policies regarding provision of hormonal contraceptives by fieldworkers are maintained and do not get lost in the shuffle.

- Project design should be based to the extent possible on empirical data to become available through the DHS in December 1993. The design strategy for FP should evolve from market segmentation revealed in the DHS, in terms of method choice and delivery modes.

- Project design should include provision for definition and development of cost recovery policies and practices over the long term.

ANNEX A
PSFP SECOND INTERIM EVALUATION
SCOPE OF WORK & SCHEDULE

11

**SOW OF WORK FOR TEAM LEADER
PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION**

I. Objective

The overall objective of this scope of work is to engage the services of a team leader for the Private Sector Family Planning evaluation.

II. PROJECT BACKGROUND

The Private Sector Family Planning Project (PSPF, 521-0189) was authorized on August 20, 1986 with the purpose of increasing the availability and the effectiveness of family planning services delivery. The original project has a life-of-project (LOP) funding of \$3,250,000 and a project assistance completion date (PACD) of September 30, 1989. The project included two major elements:

- a \$3,016,000 Cooperative Agreement (CA) with the International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR) to develop a network of private sector family planning providers; and
- a \$234,000 fund to purchase contraceptives through the A.I.D. procurement system.

This project was designed to complement USAID assistance to the Ministry of Public Health and Population (MSPP) to develop family health services for the population of Haiti.

The first amendment, signed in August of 1988, was an outcome of the failed elections of November 1987. This resulted in the discontinuation of USAID assistance to public sector programs and in the reliance on private voluntary organizations (PVOs) to provide critically needed family health services. The first amendment extended the PACD from September 30, 1989 to March 31, 1991; increased the LOP budget total by \$5 million to \$8.25 million; and added new elements. These included:

- A buy-in with FHI for \$234,250 to develop a Norplant^R research program
- A buy-in with The Futures Group for \$100,000 to strengthen the population policy environment
- \$90,000 for long term training
- \$180,000 for a population advisor at USAID/Haiti
- \$50,000 to fund CPFO's factory workers' center.

The second amendment, which was signed in July of 1990 and extended the PACD from March 31, 1991 to June 30, 1992, was designed after

the project midterm evaluation in November of 1989. The evaluation suggested the reinforcement of institutional development activities to strengthen PVOs and the enhancement of the efforts to retain family planning acceptors and lessen drop out rates. Another key element was the reinstatement of a public sector activities through a \$1 million grant to PAHO in anticipation of resumption of normal relations with the government of Haiti. Other important changes included:

- A budget increase of \$8,138,000, bringing the new LOP total to \$16,388,000
- \$100,000 to the Population Council for operations research
- The further development of social marketing activities with the SOMARC project for \$200,000 (originally social marketing development was included in the CA with IPPF/WHR, it was separated when SOMARC became involved)
- The development of a buy-in with TIPPS for \$30,000 for work with the private commercial sector

As a result of the coup of September 30, 1991, US sponsored development assistance programs in Haiti were suspended for several months. Design for the follow-on population project were also interrupted. When partial project implementation resumed in the spring of 1992 under the Haitian Humanitarian Assistance Program, the PACD was extended from June 30, 1992 to September 30, 1992 as prospects for longer term assistance were studied.

After considering various options, USAID/Haiti decided to amend the ongoing project a third time and to extend the PACD for the fourth time. **The third amendment** was thus processed during the fall of 1992. This amendment brought the LOP total to \$26,931,394 and included the following changes:

- The PACD was changed from September 30, 1992 to September 30, 1994
- A new focus emphasized improving acceptor retention rates, improving PVOs management capacities, and enhancing method choice options
- The buy-ins with FHI, SOMARC, and The Futures Group were continued and new buy-ins with JHU/PCS and JHU/PIEGO were developed to enhance program activities

Throughout these changes, the goal of the project has remained the same: "To reduce population growth in Haiti". Progress towards achieving this goal is measured by increases in the number of users of modern contraceptive methods in project catchment areas measured through service statistics; by the growth of contraceptive use as measured through periodic nation-wide and local contraceptive prevalence surveys (CPS); and through changes in fertility rates.

The prevalence of contraceptive use by the end of the project is expected to reach 16% nation-wide. In 1989, a CPS was conducted and reported a contraceptive prevalence rate (CPR) of 10.5%

(urban/rural average). This CPR suggested that contraceptive use had nearly doubled over the first three years of the project. A Demographic and Health Survey (DHS) is planned for FY93. This survey will provide an update on the current CPR.

The three amendments to the project have raised the number of persons who will gain access to family planning services by the end of the project to 1,150,000 potential beneficiaries (men and women of reproductive age). This represents about one third of all reproductive age people in Haiti.

The purpose of the project is to increase the availability and effectiveness of family planning services. Services are provided through a network of PVOs monitored by IPPF/WHR staff at the Port-au-Prince field office (PAPFO). The project was originally designed to develop a network of over 65 service delivery institutions. Over time, such a large number proved to be unwieldy and too extensive to manage properly, and the target number of PVOs was reduced while each PVO increased its field of intervention to reach a greater population. The present network includes six major FP service institutions (AOPS, PROFAMIL, CDS, FOSREF, CPFO and the CBP-the Comité de Bienfaisance-Pignon). These major institutions provide support for a network of 38 service delivery points, including several community based distribution (CBD) areas.

Project support activities include: technical assistance for institution building and sustainability; training, both long and short term, to develop the skills of service providers at several levels (surgeons, physicians, nurses/midwives and community outreach workers); an information, education, and communication (IEC) program to develop knowledge of service delivery points and to facilitate changes in behavior among the target population; a service statistics system to monitor service coverage; and a commodity distribution and storage system. To implement these support activities, IPPF/WHR-PAPFO collaborates with INHSAC (the Haitian Institute of Public Health), CHI (Child Health Institute), and PROFAMIL.

The project also supports buy-ins to develop Norplant use, to strengthen population policies, to study service costs, and to develop contraceptive social marketing. Over the upcoming months, new buy-ins will be developed to strengthen communication for behavior change and for operations research.

Despite enormous impediments created by continued political unrest, the project has progressed without major setbacks. Infrastructure was developed during the first three years of the project as IPPF/WHR established a field office in Port-au-Prince and developed a service delivery network. The following three years have seen the consolidation of services delivery institutions and the increase in access to services by many more Haitians.

PSFP is a complex strategy which has evolved to fill the void left by the unravelling of public sector family health services in

Haiti. Through the private sector, USAID has tried to develop a network capable of providing critically needed family planning services to the Haitian population. To implement this strategy, efforts have concentrated on developing a structure which is flexible and resilient and which can provide services to the population despite political unrest.

III. PURPOSE OF THE EVALUATION

The sociopolitical circumstances in Haiti have greatly changed over the past seven years and USAID/Haiti has adopted a pragmatic approach to the implementation of PSFP in a highly volatile environment. The project has been amended several times to fit successive new situations. The original PSFP design called for a midterm evaluation which was conducted during October and November of 1989. The proposed evaluation was not envisioned in the original design but was planned when the project was amended in 1992.

The goal of the present evaluation is to assess project accomplishments to date, and the purpose of the evaluation is to provide direction for the remaining period of the project and for the design of the follow-on project. It is recommended that in assessing the achievements of the project to date, evaluators take into consideration the sociopolitical challenges faced by all concerned.

In assessing project accomplishments to date, evaluators will:

- A. Using the quality of services framework, assess the quality of care at service delivery institutions.
- B. Assess the medical and social barriers on the delivery and acceptance of family planning services in Haiti.
- C. Assess institution building efforts with emphasis on the availability and quality of the technical inputs and their contributions to both the financial and technical sustainability of the PVOs. Financial sustainability will include, but will not be limited to, the assessment of cost recovery efforts. Technical sustainability will be gauged by the ability of different program components to sustain themselves without or with limited external assistance
- D. Determine the cost of services and implications of method mix on projected costs to the Project.
- E. Evaluate the suitability of current strategies to deliver FP services in Haiti. This task will include an assessment of the mix of service delivery components, medical norms and procedures, method mix, policy environment, and unmet need. Evaluators will make

recommendations on whether current strategies should be supported or if new ones should be initiated.

- F. Assess the project's management structure to ascertain its appropriateness to meet current objectives. This assessment will include grant and subgrant management and monitoring, and the flow of commodities and contraceptives. Evaluators will determine if the Project structure is adequate and solid, and will assess its capacity to expand.
- G. Assess service delivery support functions and institutions. These include IEC, operations research, internal evaluation, training, commodities management, service statistics collection, and information dissemination. Technical Project support capacity will be assessed at CHI and INSHAC to determine if it is suited to meet the current and future needs of service delivery institutions and of the project as a whole.

IV. SCOPE OF THE EVALUATION

This evaluation will focus on the processes and outcomes of the project. The evaluators will also comment on the actions that were taken after the midterm evaluation to redirect project interventions. The evaluation process and report will be developed in accordance with the guidance of the A.I.D. Evaluation Handbook. When possible, and as data are available, evaluators will look at activities that have been ongoing for several years to appraise their impact.

A. Quality of Services: The assessment of the quality of services provided is a complex notion that involves the appraisal of many program components including clients satisfaction, personnel training, method mix, availability of services and client-patient interaction. Evaluators will draw on the methodology developed by Judith Bruce from the Population Council to study quality of services provided under the project. Particular attention will be devoted to determine if the project service delivery network delivers quality services and respects individual choices because, ultimately, the success of the program rests on the satisfaction of those who use services.

B. Barriers to Family Planning: Evaluators will study the sociocultural, political, and economic environment of the project to determine the nature and magnitude of barriers to the development of family planning services. The analysis will include broad policy issues, institutional policies, and attitudes of medical personnel as they affect patient/client interactions.

C. Institutional Building and Technical Assistance: IPPF/WHR-PAPFO provides technical assistance to the family planning institutions funded under the project. Evaluators will identify

and compile a list of the technical assistance (TA) provided to service delivery institutions under the project since the midterm evaluation. They will evaluate the quality and responsiveness of the TA to participating institutions needs. Evaluators will comment on the actions taken by management to identify and diagnose weaknesses in services delivery institutions and the resulting interventions.

D. Cost of Services and Cost Recovery Programs: The project has supported the development of cost recovery and social marketing activities. Evaluators will study the progress of these efforts and comment on their suitability to enhance contraceptive use and to retain regular users. Evaluators will also study data collected by IPPF/WHR-PAPFO concerning the cost of services and make recommendations regarding cost effectiveness of services in general and for participating institutions. The cost of services will lead to an analysis of the method mix offered under the project and projected costs for the future of the project.

E. Assessment of current strategies to deliver FP services: Evaluators will analyze the current overall strategy adopted by PSFP to determine if it responds to the country's needs and capitalizes on environmental constraints and opportunities. They will also focus on identifying unmet needs.

Evaluators will assess the mix of service delivery components including clinic-based services, mobile clinics, CBD and social marketing efforts, and the geographic distribution of service delivery points. They will analyze the medical aspects of FP services including the contraceptive mix (use of Norplant, VSC, and Depo-Provera) as it relates to the health profile, the needs, and the desire of beneficiaries. They will also evaluate the clinical training provided under the project and determine if the clinical norms and procedures are suitable. The current population policy environment will be assessed to identify the areas where policy interventions can be useful.

F. Assessment of Project Management Systems and Processes Evaluators will determine if management systems are adequate to meet the needs of participating organizations and if they are appropriate to the social, political, and economic context. The evaluation will underline the strengths and weaknesses of institutions participating in the service delivery network and will propose practical action oriented solutions. Progress of participating institutions to attain sustainability will be assessed.

The services statistics system and the commodity flow monitoring system will be analyzed to determine if they are suited to the needs of those who plan project interventions and if they are responsive to service delivery institutions.

Project administrative processes will be examined and the administrative and financial management of subagreements will be

appraised. Evaluators will comment on the financial management of the project as a whole. In particular, evaluators will assess the AOPS umbrella structure and will determine its responsiveness to the needs of small PVOs.

V. TASKS TO ACCOMPLISH

The evaluation will be conducted in six phases that may be conducted sequentially or concurrently at the discretion of the team leader in agreement with USAID and the institutions evaluated.

Phase One: Document Review/Logistics Planning. This phase will consist of the review of project documentation and the selection of sites to be visited. USAID and PAPFO will provide the evaluation team with relevant reports and the work plans of institution visited. Prior to the beginning of the evaluation, the team leader will assemble and prepare for the team a basic set of documents to review. The team leader will select a sample of service delivery sites to be visited and will arrange appointment times for the visits.

Phase Two: Evaluation Team Briefing. This phase of the evaluation will include a briefing visit to IPPF/WHR headquarters in New York where two team members will meet with US-based project staff. This visit should occur after team members have reviewed project documents so that they already understand the project. Briefing will continue in Haiti with USAID and PAPFO.

Phase Three: Field Visits and Observations. This phase of the evaluation will consist of the observation visits themselves. During this phase of the evaluation, other collaborating institutions, including buy-in institutions, will also be assessed for their contribution to project activities. CHI has been involved in the monitoring of service delivery institutions and in operations research and evaluation activities. INHSAC has provided training for various levels of FP service providers. PROFAMIL is managing the flow of commodities for the entire network. AOPS manages sub-grants to 19 small PVOs delivering FP services.

Phase Four: Summary of Observations and Recommendations. During this phase of the evaluation, the team will draft a summary of their observations and a set of recommendations. These will be precise and action oriented rather than general.

Phase Five: Debriefing. Recommendations will be discussed with collaborating institutions during a debriefing meeting at the end of the evaluation field work. Meeting attenders will receive a copy of the document, in French, describing the recommendations one day prior to the meeting, to have sufficient time to study them. Efforts will be made to make the debriefing meeting an interactive process.

Phase Six: Final Report Finalization. During this phase of the evaluation, team members will draft their observations and findings and submit them to the team leader for editing and finalization of the evaluation report. The team leader will work with the USAID Evaluation Officer and with HPNO to assure that all comments and corrections have been incorporated into the final report.

VI. REPORTING REQUIREMENTS

A list of issues, an evaluation plan, including a proposed schedule for site visits, and a draft outline of the evaluation report will be submitted to USAID by the team leader on day five of the evaluation field work.

After completion of the fieldwork, the evaluation team will draft a summary of observations, conclusions (e.g. lessons learned), and a list of recommendations. The first draft, in French, of this document will be ready one day before the debriefing meeting. After the debriefing meeting, this draft will be amended and the recommendations will be provided to USAID and PAPFO before expatriate team members leave the country.

Each co-team member will submit a final copy of the technical sections for which s/he is responsible to the team leader at the end of the fifth week. A complete report will be submitted by the team leader to USAID and IPPF/WHR no later than two weeks after the debriefing meeting.

The finished report should include the following elements:

- A cover page
- A table of contents
- A glossary
- Acknowledgements (optional)
- An executive summary
- The main body of the report containing findings and observations
- A summary of observations and a recommendations section (this part of the report should be ready before the team leaves the country)
- Appendices (this section should include a list of persons contacted, the team agenda, this scope of work, and a list of the documents consulted by the team).

A. CONTENT OF THE REPORT

Executive summary: This section should be about two to three pages long. It will receive prime attention and should convey the major messages of the report in an effective and concise manner. The opening statement should provide an overall assessment of the project performance, highlighting major

constraints and facilitating factors.

The summary should contain a review of the major topics covered in the rest of the report and provide a capsule of the major conclusions with minimal reference to supporting findings. The principal recommendations should be presented here.

Introduction: The introduction to the report should provide a succinct project description, state the goal of the evaluation, summarize the scope of work, present the evaluation team, and describe the methodology of the evaluation.

Topics of the report; Evaluators findings and observations: The analysis of the various topics of the report should follow a logical progression. The observations or findings of the team during site visits and interviews should lead to conclusions or a summary of the observations, which form the foundation for the recommendations.

The findings are the evidence, the facts that the team observed. These should be presented objectively and should strive to keep a good balance between successful outcomes and remaining problems. The conclusions will follow as the team's interpretation of the evidence leading directly into the recommendations.

Recommendations should be viewed as a prescribed course for action, not as a wish list. In developing recommendations the team should strive to be practical and realistic. Recommendations should describe the means as well as the course to be taken and if several alternatives are possible, it may be prudent to set forth all options.

Summary of observations and recommendations: For logical consistency, recommendations are best placed at the end of each section to which they pertain. It is convenient, however, to pull together the list of recommendations with the summary of observations in a special chapter at the end of the report. This final section should be ready before the team leaves the country and should be discussed in a meeting with the principal project partners to ensure that the observations of the team are correct and that the recommendations are understood by the project staff. This section will enable the project team to proceed immediately with implementing the recommendations, while the report is being polished.

B. STYLE OF THE REPORT

The team leader should provide teammates with a style sheet at the beginning of the evaluation period to ensure that the various pieces of the report are prepared in a consistent style. This will facilitate editing.

Writing should be concise and repetitions should be eliminated (it is not necessary for the report to be over 35 pages long); writers should avoid colloquialisms, jargon and cliches; comments should focus on factors and not people. Authors should state their opinion in an authoritative but courteous tone. It is understood that the report reflects the views of the authors.

VII. LEVEL OF EFFORT

The evaluation will be carried out in Haiti over a period of three weeks. There will be five evaluators: Three will be expatriate professionals and two will be Haitian professionals. In addition to time in the field, evaluators will be allowed two more weeks each to read documents, conduct the briefing meeting at IPPF/WHR, and to finish drafting their analysis section. The team leader will be given two extra weeks to assemble edit and finalize the report. Given the complexity of the project and the large number of sites to evaluate, the team will be authorized to work a six day work-week. The team leader will also prepare the abstract for A.I.D. project evaluation summary form.

VIII. RESPONSIBILITIES/QUALIFICATIONS OF THE TEAM LEADER

In addition to FP technical expertise, the person selected as chief of party should be an evaluation specialist with previous experience in conducting evaluations of international family planning/health projects. S/he should possess good communication and writing skills in English and French. Familiarity with Haitian Creole is desirable. It is also desirable for this individual to have good leadership skills and to be a skilled mediator.

The team leader will be responsible for:

- Coordinating the work of other team members and facilitating logistical support of the team.
- Submitting a work plan to USAID after reviewing the scope of work, consulting with the team, and consulting with the institutions evaluated.
- Representing and introducing the team in meetings and during field visits.
- Ensuring that the team agenda is respected, including the submission of the report.
- Reviewing and editing the report for fitness with the scope of work, internal consistency, and sharing the report with other members of the team for comments prior to final submission.

IX TECHNICAL DIRECTION

The Evaluation Officer, the Deputy Chief of HPNO, and other HPNO technical staff will provide the necessary technical direction for the team leader.

PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION
Schedule 4/29/93

Week 1 (19-25 April)

T, 4/20 McPherson arrives PAP
Docs review, formulation of Workplan
W, 4/21 McPherson docs review, planning
Th, 4/22 - Burton and Moore interviews with IPPF
Sa, 4/24 McPherson docs review, planning
Su, 4/25 Burton and Moore arrive Haiti

Week 2 (26 April - 2 May)

Mon, 4/26 08:00 - Breakfast at Villa Creole with USAID/HPN
for full team, begin Team Planning Meeting (TPM):

- Introductions and TPM schedule - McPherson
- Purpose of Evaluation/USAID Agenda - O'Rourke
- Discussion of overall Scope of Work and individual roles and responsibilities therein;
- Preliminary review of Report Outline and Draft Evaluation Schedule (McPherson lead);
- Briefing by Burton and Moore on trip to IPPF/WHR

LUNCH - with R. Magloire and other IPPF/WHR-PAPFO

- Briefing by IPPF/WHR-PAPFO;
- Begin formulation of fieldwork information collection guide(s), and individual work assignments/plans
- Documents review by team as time permits

PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION
Schedule 4/29/93 - Page 2

- Tues, 4/27 08:00 - Breakfast at Villa Creole with Gail Spence, USAID/Haiti Evaluation Officer (8-9 AM)
- Continue TPM: a) documents review; b) continue drafting information collection guide; c) draft project issues
- LUNCH
- Finalize and submit draft information collection guide, issues, revised evaluation plan/schedule, and revised report outline to USAID
- Wed, 4/28 07:30 - Breakfast at Villa Creole with David Eckerson and John Burdick
- Continuous docs review
 - Revise issues, workplan/schedule, outline in consultation with USAID & PAPFO
- 11:00 - INHSAC: Dr. Jean-Robert Brutus et al
- 14:00 - PAPFO: Moore and Clerisme with Sullivan and Racine
- [note PAHO coordinator J. Espindola out of country until 1 May, thus have arranged meeting after fieldwork on 13 May; UNFPA Director Heidi Swindles also out of PAP, so team will also meet with her 13 May]
- Thur, 4/29 09:00 - AOPS Meeting: Dr. Jean Andre et al
- 11:00 - CHI Meeting: Dr. Michel Cayemittes et al
- 14:00 - PROFAMIL Meeting: Dr. Serge Pentro et al
- 16:00 - Joseph & Burton with K. Laurenceau, PAPFO
- Fri, 4/30 (08:00 - Joseph & Burton with K. Laurenceau, PAPFO)
- 09:15 - Depart Villa Creole for Fermathe with Dr. Agenor, et. al., to pre-test information collection guide; visit to include site meetings with "Clients Satisfaits"
- Sat, 5/1 - Revise information collection guides, field trip planning completed

PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION
Schedule 4/29/93 - Page 3

Week 3 (3 May - 9 May)

Team 1, South (Burton, Joseph):

- Mon, 5/3 - Depart very early
08:00 Visit Hopital St. Croix, Leogane, en route to Cayes; o'night Cayes
- Tues, 5/4 - Hopital Lumiere, Bon Fin, Cavaillon (all day), return o'night Cayes
- Wed, 5/5 - Clinique La Fami in Cayes, o'night Cayes
- Thurs, 5/6 - Visit Clinique Lolagne, Petit Goave, en route back to PAP
- Fri, 5/6 PAP site visits: CPFO and FOSREF
Ingrid Ackenbourg, 22 49 93
Burton (and spouse) rendezvous with Team 2 at Kyona Beach

Team 2, North (McPherson, Moore, Clerisme):

- Mon, 5/3 - Overland North straight to Pignon
- Tues, 5/4 - Pignon CBD and matrone training overnight Ft. Liberte
- Wed, 5/5 - CDS Ouanaminthe, return to CAP
- Thur, 5/6 - Clinique Dugue & CDS/CAP
- Fri, 5/7 - CDRSSP in morning (outside CAP)
- to Kyona Beach rendezvous with Team 1

Full Team

- Sat, 5/8 Full team meetings, information collation, and debriefings at Beach Hotel (Joseph drives out from PAP for day; USAID/HPNO to join)
- Sun, 5/9 Rest and recupe at beach
Burton, Clerisme return to PAP; Joseph drives out late afternoon to be ready for early start

PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION
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Week 4 (10 May - 16 May)

Mon, 5/10 Clerisme, Claude, Moore, and Burton from PAP to Leger, overnight Leger
McPherson and Joseph visit Clinique Pierre Payen en route to Gonaives, overnight Gonaives

Tues, 5/11 Clerisme, Claude, Moore, and Burton fieldwork Leger, return to PAP
McPherson, Moore and Joseph to CBD Figuier, CDS Rabauteau, return to PAP

Wed, 5/12 Begin drafting and synthesis

Thur, 5/13 10:00 Inter-Agency Contraceptive Committee
12 NOON (after sub-committee): UNFPA Heidi Swindles and Edith Lataillade

Fri, 5/14 Various site visits, other meetings as needed

Sat, 5/15 Collating notes, drafting

Sun, 5/16 Rest

Week 5 (17 May - 23 May)

Mon, 5/17 Team Members submit technical drafts of key sections of report to McPherson

Tues, 5/18 (Haitian Holiday) Drafting French summary of findings, conclusions, and recommendations

Wed, 5/19 11:00 Dr. Javier Espindola, PAHO
* Distribute French summary of findings, conclusions, recommendations

Thurs, 5/20 Preparation for debriefing; Haitian Holiday

Fri. 5/21 09:00 * Debriefing with collaborating institutions

Sat, 5/22 Revise summary; Burton departs

PRIVATE SECTOR FAMILY PLANNING PROJECT EVALUATION
Schedule 4/29/93 - Page 5

Week 6 (24 May - 30 May)

- Mon, 5/24 AID Project Committee meeting with * Amended
summary of findings, conclusions, and
recommendations submitted to USAID/Haiti and PAPFO
- Tues, 5/25 Moore departs afternoon
- Thurs 5/27 McPherson, Clerisme, Joseph finish report and *
distribute draft English report to PAPFO and USAID
- Sat. 5/29 Clerisme and Joseph complete contract

Week 7 (31 May - 5 June)

- * McPherson edits report and prepares abstract for
A.I.D. project evaluation summary, submits both
NLT Saturday 5 June

ANNEX B

PAPFO TA/TRAINING

ANNEX B
PAPFO TA/TRAINING

Family Planning

1. IEC

10/87 preliminary review of IEC needs; nothing in 1988; 7/89 (unspecified); 2/90 preparation of IEC plan and presentation to USAID; 4/90 training WS (for whom?) and development of an IEC strategy; another IEC workshop (for whom?) 9/91; TA to INHSAC's print shop twice in 3/93. [Sullivan and Wedeen, 1991:12-14]

Specific IEC support to AOPS (Association des Oeuvres Privées de Santé) first occurred 10/87 (unspecified), then not again until 7/89 (also unspecified); more IEC TA 4/90 (also unspecified) and 9/91 (unspecified). [Ibid.:15-16]

Specific IEC support to PROFAMIL (Association pour la Promotion de la Famille Haitienne in 10/87 (unspecified); nothing in 1988; development of a media campaign 5/89; more TA 7/89 and 4/90 and 9/91 (all unspecified). [Ibid.: 17-18]

Specific IEC support to HBP (Hopital de Bienfaisance de Pignon) 7/89, 4/90, and 9/91 (all unspecified). [Ibid.: 19-20]

Specific IEC support to CDS (Centre pour le Developpement et la Sante (Cite Soleil) 10/87, 4/90, and 9/91 (all unspecified). [Ibid.:21]

Specific IEC support to FOSREF (Fondation pour la Sante Reproductive et l'Education Familiale) 7/89 development of operational strategy to attract clients to model clinic; 9/89 4/90 and 9/91 (all unspecified). [Ibid.:22]

Specific IEC support to CPFO (Centre de Promotion des Femmes Ouvrieres) 4/90 and 9/91 (unspecified). [Ibid.:23]

Specific IEC support to INHSAC (Institut Haitien de Sante Communautaire) 6/87 needs assessment for the production of health related materials plus recommendations for equipment and personnel; 10/87, 7/89, and 4/90 (unspecified); 8/91 training in desktop publishing; 9/91 (unspecified). [Ibid.:26-27]

Specific IEC support to CHI (Child Health Institute)/ IHE (Institut Haitien pour l'Enfant? 10/87, 7/89, 4/90, and 9/91 (all unspecified) [Ibid.:28-29]

Additional support in IEC and other categories was provided to DASH, no longer included in the project.

2. Evaluation & Service Statistics

TA assessment in evaluation (of whom?) 10/87 and again 3/88; analysis of service statistics & new acceptor targets 1/89; acceptor target-setting and investigation of high drop-outs 9/89; assessment of service statistics 8/90. [Ibid.:12-14]

Specific Evaluation & SS (ESS) support to AOPS 10/87 (unspecified); review of sub-grantee data collection systems 3/88; 1/89, 9/89, and 8/90 (unspecified). [Ibid.:15-16]

Specific ESS support to PROFAMIL 10/87, 3/88, 1/89, 9/89, and 8/90 (all unspecified). [Ibid.:17-18]

Specific ESS support to HBP 1/89, 9/89, and 8/90 (all unspecified). [Ibid.:19-20]

Specific ESS support to CDS 10/87, 3/88, 1/89, 9/89, and 8/90 (all unspecified). [Ibid.:21-22]

Specific ESS support to FOSREF 1/89 (unspecified); 9/89 strategy to attract clients to model clinic [already noted under IEC]; 8/90 review of efforts to attract clients. [Ibid.:22]

Specific ESS support to CPFO 2/90 training in data collection and reporting provided by IHE; 8/90 (unspecified). [Ibid.:23]

Specific ESS support to INHSAC 10/87, 3/88, and 1/89 (unspecified); 9/89 review of institutional objectives and performance; 8/90 (unspecified). [Ibid.:26-27]

Specific ESS support to IHE 10/87, 3/88, 1/89, 10/89, and 8/90 (all unspecified). [Ibid.:28-29]

3. Contraceptive Management

Technical assistance in contraceptive management 3/87 needs assessment to develop contraceptive supply network; 9/87 supervision of contraceptive warehousing; 4/88 contraceptive management unspecified; 5/89 supervision of distribution and controls; 5/90 (unspecified) 10/90 contraceptive management (unspecified); 9/91 logistics workshop for supervisors. [Ibid.: 12-14]

Specific CM support to AOPS 3/87 and 9/87 (unspecified); 4/88 monitor storage, distribution and resupply of contraceptives; 5/89 (unspecified); 5/90 storage, distribution, supply; 10/90 and 9/91 (unspecified). [Ibid.:15-16]

Specific CM support to PROFAMIL 3/87 and 9/87 (unspecified); 4/88 storage, distribution, resupply; 5/89, 5/90, 10/90 (unspecified);

6/91 assesement of CM practices at Port-de-Paix; 9/91 (unspecified). [Ibid.:17-18]

Specific CM support to HBP 5/89, 5/90, 10/90, and 9/91 (all unspecified). [Ibid.:19-20]

Specific CM support to CDS 3/87, 9/87, 4/88, 5/89, 5/90, 10/90, and 9/91 (all unspecified). [Ibid.:21]

Specific CM support to FOSREF 5/89, 5/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:22-23]

Specific CM support to CPFO 5/90, 10/90, and 9/91 (unspecified). [Ibid.:23-24]

Specific CM support to INHSAC 3/87, 9/87, 4/88, 5/89, 5/90, 10/90, and 9/91 (all unspecified). [Ibid.:26-27]

Specific CM support to IHE: none. [Ibid.: 28]

4. Medical/Quality of Care

Begun 2/89 with evaluation of VSC activities; 7/89 Q of C (QC) guidelines; 8/90 counseling workshop; 9/90 QC workshop in Miami with Tulane; 10/90 (unspecified); 6/91 counseling workshop; 7/91 preparation of sexuality workshop; 9/91 sexuality workshop. [Ibid.: 12-14]

Specific QC support to AOPS 2/89 (unspecified); 5/89 development of AVSC/AOPS expansion of VSC services project; 7/89 preparation of AOPS subgrant and TA memo of understanding with AVSC; 11/89, 8/90, 9/90, 10/90, 6/91, 8/91, and 9/91 (all unspecified). [Ibid.:15-16]

Specific QC support to PROFAMIL 10/88 supervisory visits to Mirebalais and PAP model clinics; 1/89 medical supervision of VSC program (norms, surgical techniques, supervision); 2/89 evaluation of VSC activities; 7/89, 11/89, 8/90, 9/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:17-18]

Specific QC support to HBP 7/89, 11/89, 8/90, 9/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:19-20]

Specific QC support to CDS 7/89, 11/89, 8/90, 9/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:21]

Specific QC support to FOSREF 7/89, 11/89, 8/90/9/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:22]

Specific QC support to CPFO 8/90/ 9/90, 10/90, 6/91, and 9/91

(all unspecified). [Ibid.:23-24]

Specific QC support to INHSAC 7/89, 11/89, 8/90, 9/90, 10/90, 6/91, and 9/91 (all unspecified). [Ibid.:26-27]

Specific QC support to IHE 7/89, 8/90, 9/90, 6/91, and 9/91 (all unspecified). [Ibid.:28-29]

Institutional Development

5. Institutional and Human Resource Development

7/91 one-day workshop to review results of salary survey and train participants in the development of personnel policies and pay scales

Specific HRD support to AOPS 1/89 follow up of audit recommendations re human resource development. [Ibid.:15-16]

Specific HRD support to PROFAMIL 7/90 human resource development; 5/91 (unspecified). [Ibid.:17-18]

Specific HRD support to HBP 7/91 (unspecified). [Ibid.:19-20]

Specific HRD support to CDS 7/91 (unspecified). [Ibid.:21]

Specific HRD support to FOSREF 8-9/90 in-depth review of management and administrative systems (including, presumably, HRD); 7/91 (unspecified). [Ibid.:22]

Specific HRD support to CPFC 7/91 (unspecified). [Ibid.:23]

Specific HRD support to INHSAC 7/91 (unspecified). [Ibid.:27-27]

Specific HRD support to IHE 1/89 follow up of audit recommendations including HRD; 7/91 (unspecified). [Ibid.:28-29]

5. Finance/Accounting

9/87 preparation of expenditure reports; 5/90 compliance of OMB Circular A133; 9/90 follow up of audit recommendations; 3/91 workshop on USAID Standard Provisions. [Ibid.:12-14]

Specific Finance support to AOPS 5/87 accounting and internal control systems; 1/89 follow up of audit recommendations -- financial and accounting procedures; 5/90 and 9/90 (unspecified); 1/91 sub-grantee management and expense reporting; 3/91 (unspecified); 6/91 assessment of AOPS accounting system. [Ibid.:15-16]

Specific finance support to PROFAMIL 9/87 (unspecified); 5/90 review of audit related issues; 9/90 (unspecified); 12/90 training for 2 Profamil staff at IPPF-sponsored workshop in Belize on Planning, Programming, Budgeting and Reporting System; 3/91 (unspecified); 4/91 accounting for employee benefits; 6/91 financial management for Port-de-Paix model clinic. [Ibid.:17-18]

Specific finance support to HBP 1/89 accounting system assessment; 5/90, 9/90, and 3/91 (unspecified). [Ibid.:19-20]

Specific finance support to CDS 9/87, 5/90/9/90, and 3/91 (all unspecified). [Ibid.:21]

Specific finance support to FOSREF 5/90 (unspecified); 9/90 (presumably part of in-depth assessment of management and administrative systems); 3/91 (unspecified). [Ibid.:22]

Specific finance support to CPFO 3/90, 5/90, 9/90, 3/91 (all unspecified). [Ibid.:23]

Specific finance support to INHSAC 5/87 accounting and internal control systems; 9/87, 5/90, 9/90, and 3/91 (all unspecified); 4/91 follow-up on implementation of RIG sponsored audit recommendations; assistance in job costing of production unit and accounting of unit income. [Ibid.:26-27]

Specific finance support to IHE 5/87 accounting and internal control systems; 9/87 (unspecified); 1/89 follow-up on implementation of audit recommendations (automatied financial systems); 4/90 establishment of purchase order system; 5/90, 9/90, 3/91 (all unspecified). [Ibid.:28-29]

7. Project Management and Sub-grantee Management

These two are sometimes indicated together, sometimes separately in the Sullivan-Wedeen overview.

11/86 review of 86-87 work plans and budget reviews; management assessment and development of TA plan for sub-grantees; 10/87 management workshop for sub-grantee executive directors; 4/90 workshop on strategic planning and PPBR systems; 9/90 strategic planning and work plan and budget; no such assistance in general is indicated since then. [Ibid.:12-14]

Specific PM support to AOPS 10/87 sub-grantee management; 1/89, 1/90, 4/90, and 9/90 (unspecified); 10/90 sub-grantee management; 1/91 sub-grantee management; 8/91 sub-grantee management. [Ibid.:15-16]

Specific PM support to PROFAMIL 10/87 workshop for sub-grantee executive directors; 3/88, 1/90, 4/90, 9/90 (all unspecified).

[Ibid.:17-18]

Specific PM support to HBP 1/89, 1/90, 4/90, 9/90 (all unspecified). [Ibid.:19-20]

Specific PM support to CDS 1.90, 4.90, 9/90 (all unspecified). [Ibid.:21]

Specific PM support to FOSREF 1/90, 4/90 (unspecified); 7/90 management and organizational development; 9/90 (part of in-depth assessment of management and administrative systems). [Ibid.:22]

Specific PM support to CPFO 9/89 assessment of organizational structure, financing management system, budgeting, reporting and forecasting procedures; 1/90 (unspecified); 3/90 assistance in preparation of 1990 WP/B; 4/90, 9/90 (unspecified). [Ibid.:23-24]

Specific PM support to INHSAC 10/87 workshop for sub-grantee executive directors; 9/89 review of institutional objectives and performance (already noted under ESS); 1/90 (unspecified); 2/90 strategic planning, WP/B; 4/90, 9/90, and 2/91 (unspecified). [Ibid.: 26-27]

Specific PM support to IHE 10/87 workshop for sub-grantee executive directors; 1/90 and 4/90 (unspecified); 5/90 follow-up on implementation of action plans; 9/90 (unspecified). [Ibid.:28-29]

ANNEX C
PARTICIPANT TRAINING UNDER PSFP

PRIVATE SECTOR FAMILY PLANNING
 PARTICIPANTS TRAINING REPORT
 FROM FY89 to FY93
 PROJECT NO. 521-0189 /PD&S POP

FY 93

PARTICIPANT NAME (Last, First)	:Gender	PIO/P NUMBERS	TRAINING LOCATION	PROGRAM TITLE AND DATES	ESTIMATED TRAINING COST	DATE RETURNED
PIERRE, Wilner	:M	521-0000.2-1-20087	Western Consortium for Public Health Santa Cruz, CA	Education and Communication Program Management (in French) Nov16/Dec11, 1992	\$16,560	Dec.14. 92
APOLLON, Belab Evelyn	:F	Same as above	Same as above	Same as above	Same as above	Same as above
DRSPAGNE, Pierre Prevu	:M	521-0189-1-30024	Clark Atlanta Univ. Atlanta, Georgia (HBCU) March23/May8, 1993	Management du Dev.Sanitaire March 23/May 8, 1993	\$21,920	May 12, 1993
JOSEPH, Yvacito	:M	Same as above	Same as above	Same as above	Same as above	Same as above
BOIS, Iderle	:F	521-0189-1-30047	Washington, DC	Maridian Int'l Center (MIC) Orientation May 10/May 14, 1993	\$16,290	Est.Aug 15, 93
			Boston Univ. School of Public Health	Health Care in Dev.Countries May 18/Aug.14		
LAMARRE, Pierre-Charles	:M	521-0.34-1-30056	Boston Univ. School of Public Health	Economie et Gestion des Ressources dans les programmes de Sante June2/July 30, 1993	\$25,670	Dep. date 06/2, 93 Est.return 07/31,93
TASSY, Edvard	:M	Same as above	Same as above	Same as above	Same as above	Same as above
SAINT LOUIS, Georges	:M	521-0189-1-30061	Harvard of Public Health Boston, MA	Managing Health Programs In Developping countries	\$10,230	Dep. date 06/20, 93 Est.Return 08/14, 93

FY92

PARTICIPANT NAME (Last, First)		PIO/P NUMBERS	TRAINING LOCATION	PROGRAM TITLE AND DATES	ESTIMATED TRAINING COST	DATE RETURNED
ARVELO, Nazlie	:F	521-0000.2-1-20079	Johns Hopkins Univ. School of Hygiene and Public Health Baltimore, MD	Workshop on Int'l Communication and Education for Health Sept.28/Oct.1992	\$23,303	Oct 17, 1992
EVEILLARD, Roberte	:F	Same as above	Same as above	Same as Above	Same as above	Same as Above
PAUL, Jean-Robert	:M	Same as Above	Same as Above	Same as Above	Same as Above	Oct. 24, 1992
THOMAS, Gina	:F	521-0000.2-1-20064	Western Consortium For Public Health Santa Cruz, CA	Family Planning Program Management And Supervision Sept.14/Oct.23, 1992	\$20,316	Oct. 28, 1992
SINAI, Liliane	:F	Same as Above	Same as Above	Same as Above	Same as Above	Oct. 31, 1992

FY91

PARTICIPANT NAME (Last, First)		PIO/P NUMBERS	TRAINING LOCATION	PROGRAM TITLE AND DATES	ESTIMATED TRAINING COST	DATE RETURNED
LOLAGNE, Fritz	:M	521-0189-1-10021	Western Health For Public Health Santa Cruz, CA	Family Planning Program Management And Supervision March 4/April, 1991	\$9,200	April 20, 91
VINCENT, Raoul Emmanuel	:M	521-0189-1-10182	Centre Africain d'Etude Superieur en Gestion (CESAC) Dakar, Senegal	Management for Primary Care (including Maternal Child Health and FP for Francophone Africa and the Carribbean) July 8/Aug.2, 1991	\$7,652	Est.09/12,91
ALCE, Quesnel	:M	521-0189-1-10196	US Bureau of the Census Washington, D.C.	Integrated Micro Computer Processing systems (INPS) in French July 15/Aug.23, 1991	\$8,229	Est. 08/23,91
BOX, Marthe St.Vil	:F	521-0189-1-10198	Washington, D.C Western Health For Public Health Santa Cruz, CA	Meridian Int'l Center (MIC) Orientation July 22/July 26, 1991 Advance for FP Trainers July 29/Aug. 23, 1991	\$46,364	Est. 10/19,91
DEAS, Joel	:F	"	Same as Above	Same as above		Same as Above
JEANIS, Lucito	:M	"	Same as Above	Same as above		
MERCIER, Pierre	:M	"	Same as Above	Same as above		
MONERO, Yanick	:F	"	Same as Above	Same as above		
PIERRE-LOUIS, Jean Harry	:M	"	Same as Above	Same as above		

FY91 (CONT'D)

BELLAMOUR, Mariette	:F	521-0189-1-10131	Univ. of Conn at Storrs Storrs, CT	Micro Computer Uses for Dev. Project Management (in French) June 1/June 30, 1991	\$13,300	July 1, 1991
JEAN, Imene	:F	Same as Above	Same as Above	Same as Above		Same as Above
BOIS, Iderle	:F	521-0189-1-100199	Centre Africain de perfectionnement des Journalistes et	Worshop on Int'l Comm. and Education for Health Aug.3/Aug21, 1991	\$23,220	Aug. 24, 91
BRUTUS, Jean-Robert	:M	Same as Above	Same as Above	Same as Above		Aug. 23, 91
SOUVENIR, Monique	:F	Same as Above	Same as Above	Same as Above		Sept.11, 91
LAURENCEAU, Kettly	:F	521-0189-1-10213	Univ. of Conn at Storrs Storrs, CT	Research Method and Dev. Program/Project Evaluation (In French) Aug.1/Aug. 31, 1992	\$7,250	Sept. 2, 91
DOLCY, Joseph	:M	521-0189-1-10220	Georgia State Univ. (INSA), Atlanta, GA	Int'l Health, Management (in French) Aug.5/Oct 25, 1991	\$8,400	Oct. 26, 91
BERTRAND, Marie Christine	:F	521-0000-1-001166	Centre Africain de perfectionnement des Journalistes et Communicateurs, Tunis	Worshop on Int'l Comm. and Education for Health Nov. 3/Nov.23, 1990	\$14,960	Nov. 26, 90
LAUREDENT, Elsie	:F	Same as Above	Same as Above	Same as Above	\$14,960	Same as Above
AMBROISE, Yanick	:F	521-0189-1-10221	Management Sciences for Health Boston, MA	Management of Training Program In Health and FP Sept 16/Oct. 18, 1991	\$51,100	Oct 25, 91
BIEN-AIME, Jean-Ferrer	:M	SAME AS ABOVE				
BUTRAU, Ronald	:M	"				
JEAN, Jacqueline	:M	"				
JEAN-MARY Jn-Baptiste	:M	"				

FY90

PARTICIPANT NAME (Last, First)		PIO/P NUMBERS	TRAINING LOCATION	PROGRAM TITLE AND DATES	ESTIMATED TRAINING COST	DATE RETURN
LAROCHÉ, Ronald	:M	521-0000.2-1-00098	HYATT Regency Hotel Crystal City Arlington, VA	NCIH June 7/June 20, 1990	\$3,428	June 23, 90
VERLY, Adeline	:F	"	"	"		July 8, 90

FY89

PARTICIPANT NAME (Last, First)		PIO/P NUMBERS	TRAINING LOCATION	PROGRAM TITLE AND DATES	ESTIMATED TRAINING COST	DATE RETURNED
FERRUS, Arsene Andre	:M	521-0189-1-90015	Univ. of California Los Angeles	English Language Training (In Country) 5/ 30 to 8/31, 89 English Language Training Sept. 19, 89/Dec 19, 89 Master in Public Health FP Jan 19, 90/June 19, 91	\$42,367	June 22, 91
MOISE, Fritz	:M	521-0189-1-90150		Same as Above	\$42,531	June 28, 91
EVEILLARD, Roberte	:F	521-0189-1-90149		Same as Above	\$42,044	July 2, 1991

ANNEX D

LIST OF PERSONS CONTACTED

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LIST OF PERSONS CONTACTED

P V O P A R T N E R S

Association des Oeuvres Privées de Santé (AOPS)

Dr. Jean André, Directeur
Dr. Maryse Narcisse, Directeur Technique
Dr. Philippe Hirsch, Directeur d'Evaluation
Dr. Pierre Mercier, Chief Service, PF
Dr. Marsan Schiller, Coordonnateur Technique PF
Dr. Dunbar Lesly, Coordonnateur Technique PF
Dr. Jeannis Lucito, Coordonnatuer PF
Mr. Jean Joseph Augustin, Chef Service Administratif et
Financier
Mr. Jean Claude Laforest, Financial Controller
Mr. Julio Cadet, Responsable des Services Generaux
Ms. Sandra Kernisan, Responsable Depot

CARE International

Ms. Susan Igras, Project Director, RICHES
Ms. Mireille Bruno, Coordonnateur Régional, Léger
M. et Mme. Bernard, "Couple Model", Léger

CDS-Cap Haitien, Cité du Peuple

Dr. Jean Jacques, Médecin et Directeur Adjointe
Ms. Francois Edreith, Archiviste
Ms. Marie-Joscelyne Guerrier, Statisticien
Mr. Jacque Du Fresne, Comptable

CDS-Cité Soleil

Dr. Pierre Despaigne, Program Director
Dr. Joseph Marzouka, Directeur du Clinique

CDS-Ouanaminthe

Ms. Lysette Jean-Bernard, Auxilliaire and Co-Responsable du
Programme PF
Ms. Gracieuse Arné, Auxilliaire and Co-Responsable du
Programme PF
Ms. Nicole Garbeau, Auxilliaire en Santé Communautaire
Ms. Jeantillia Bouloute, Agent de Santé, Superviseuse de
Promoteurs
Ms. Florencia St. Juste, ColVol
Mr. Manigat Montas, ColVol

Complexe Médico-Social Raboteau

Ms. Weslene Henri, Auxilliaire et Responsable du Programme PF

Clinique Duqué, Cap Haitien

Dr. Guy Duqué, Directeur

Clinique Contrôle de Fertilité, Petit Goave

Dr. Fritz Lolagne, Directeur

P V O P A R T N E R S - Continued

Clinique La Fanmi, Cayes

Dr. Joseph Serge Louissaint

Clinique Pierre Payen

Dr. Victor Binkley, Project HELP Director and Medical Director
Ms. Estelia Francois, Auxilliare et Responsable du Programme
PF a.i.

Centre de Promotion des Femmes Ouvrieres (CPFO)

Mme. Djenane Montas, Directrice

CRDSSP- Cap Haitien

Dr. Marc Angrand, Directeur

Fondation pour la Santé Reproductrice et l'Education Familiale (FOSREF)

Dr. Adeline Verly, Directeur

Hôpital de Fermathe

Mrs. Turnbull, Hospital Administrator
Dr. Agenor, Director of Family Planning Program

Hôpital Bienfaisance de Pignon

Dr. Guy Théodore, Director
Dr. Darlene Carré Théodore, Director du Programme PF
Dr. Drice, Physician
Mr. Lélío Formilous, Formateur du CBP
Ms. Marianne Augustin, Monitrice
Mr. Paul David, Assistant Coordonnateur, IPPF
Ms. Rose Andrée Michel, Archivist/Responsable de Clinique
Pignon

Hôpital Lumiere, Bonne Fin

Hôpital Ste. Croix de Léogane

Dr. Judith Brown, Director

Institut Haitien pour la Santé Communautaire (INHSAC)

Dr. Jean-Robert Brutus, Directeur
Ms. Elsie Laurédent, Directeur de l'IEC
Ms. Marie Christine Bertrand, Directeur de la Formation

P V O P A R T N E R S - Continued

Institut Haitien de l'Enfance (IHE or CHI)

Dr. Michel Cayemittes, Directeur

Association pour la Promotion de la Famille Haitienne (PROFAMIL)

Dr. Serge Pintro, Directeur

Dr. Gadner Michaud, Directeur Technique

Mr. Robert Thermil, Directeur Administration et Finance

Dr. Jean Robert Paul, Responsable des Equipes Mobiles

CBD - Fiquiers

Ms. Jocelyne Smith, Responsable du Clinique

Ms. Omiga Jeunita, Animatrice

O T H E R P A R T N E R S

AIDSCAP Contraceptive Retail Sales, Population Services
International (PSI)

Mr. Bob Clark, Country Representative, Haiti

Dr. Judith Timyan, Director of Health Services (Worldwide)

Johns Hopkins University School of Hygiene and Public Health

Dr. Barbara O. De Zalduondo, Culture and Sexuality Project of
the NIH/USAID/FHI AIDS Behavioral Resaerch Program

OPTIONS, The Futures Group

Dr. Janet Smith, Project Director

SOMARC III "Santé Plus", Commerce S.A.

Ms. Ingrid C. Hackenbruch, Directrice de Projet

United Nations Fund for Population Activities (UNFPA)

Ms. Heidi Swindells, Directeur

Ms. Edith Lataillade, Chargée de Programme

University Research Corporation (URC) VACS Office

Mr. Dennis Martin, Chief of Party

P R O J E C T M A N A G E M E N T

**International Planned Parenthood Federation Western Hemisphere
Region - Port-au-Prince Field Office (IPPF/WHR & PAPFO)**

Mr. Francisco Di Blasi, PSFP Project Director, New York

PAPFO

Dr. Rudolph Magloire, Project Manager
Ms. Audrey Sullivan, Deputy Project Manager
Ms. Dominique Leveille, Executive Secretary
Ms. Nicole Racine, Program Coordinator
Ms. Laura Wedeen, Research and Evaluation Coordinator
Ms. Kettly Laurenceau, Monitoring and Evaluation Coordinator
Mr. George Saint-Louis, Finance Manager
Mr. Patrick Schutt, System Finance Analyst
Ms. Monique Dumoulin, Administrator
Ms. Marie Josette Roles, Receptionist Secretary
Ms. Evelyne Polynice, Receptionist Assistant

Pan American Health Organization (PAHO)

Dr. Javier Espindola, MD, MPH, Humanitarian Assistance
Coordinator

USAID

Mr. Gerald Bowers, Deputy Director

Health, Population, Nutrition Office (HPNO)

Mr. David Eckerson, Chief
Mr. John Burdick, Deputy Chief & Population Officer
Ms. Shelagh O'Rourke, Humanitarian Assistance Coordinator
Ms. Gisele Balmir, PSFP Project Coordinator
Dr. Brad Barker, TACS Advisor
Mr. Frantz Louis, VACS Project Coordinator
Ms. Jocelyne Belizaire, PSFP Administrative Assistant

Project Development and Implementation Office (PDI)

Mr. Gary Imhoff, Chief
Ms. Gail Spence, PDO and Evaluation Officer
Mr. Vixamar Jean-Philippe, Project Development Assistant

General Development Office

Ms. Chantal Wooley, Training Specialist

Controller's Office

Mr. Robbin Burkhardt, Controller

EVALUATION TEAM

Ms. Laura McPherson, Team Leader, Project Management
Specialist
Ms. Nadine Burton, Co-Team Leader, Public Health/Clinical Care
Specialist
Dr. Emily Moore, Sociologist, Program Planning Specialist
Prof. Calixte Clérismé, Sociologist, Directeur du Department
des Science du Developpement de la Faculte d'Ethnologie,
Universite d'Etat d'Haiti
Mr. Wesner Joseph, Demographer
Mr. Theophin Claude, Research Assistant

ANNEX E
DOCUMENTS REVIEWED

ANNEX E
DOCUMENTS REVIEWED

Agency for International Development, "Report of the Subcommittee on Quality Indicators in Family Planning Service Delivery," submitted to the A.I.D. Task Force on Standardization of Family Planning Program Performance Indicators, October, 1990.

Association des Oeuvres Privées de Santé, "Informations Utiles," April 1993.

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Augustin, Antoine, et Marlene Gay, "Rapport d'Enquete Abandon des Methodes Contrceptives," IPPF/PAPFO et IHE, Janvier 1991.

Burton, Nadine, et. al., "Midterm Evaluation Private Sector Family Planning Project (PSFP)," report prepared for the Human Resources Office, Population Section, USAID/Haiti, and The International Planned Parenthood Federation, Western Hemisphere Region, December 1989.

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Cayemittes, Dr. Michel, et. al., Haiti National Contraceptive Prevalence Survey 1989, Final English Language Report, Haitian Child Health Institute and U.S. Centers for Disease Control, June 1991.

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International Planned Parenthood Federation/Western Hemisphere Region/Port-au-Prince Field Office:

Annual Workplans/Budgets:

Calendar Year 1991

January - September 1992

October 1992-September 1993

Rapports Trimestriel:

1 Janvier - 31 Mars 1990

1 Avril - 30 Juin 1990

1 Juillet - 30 September 1990

1 October - 31 December 1990

1 Janvier - 31 Mars 1991

1 Avril - 30 Juin 1991

1 Juillet-30 September 1991

1 Octobre - 31 Decembre 1991

Janvier a Mars 1992

Juillet a September 1992 (2 September 1992, October 29, 1992)

Octobre - December 1992

Letter from Francisco Di Blasi, Project Director, to David Eckerson, Chief Health & Population, dated February 9, 1990 regarding January 1990 report by Sherif Rushdy.

Memorandum from Audrey A. Sullivan to Frank De Blasi Re: Contraceptive Management, dated September 29, 1992.

Joseph, Patrice, MD/MPH, "Diagnostic de Situation et Evaluation des Besoins en Assistance des Institutions de PF," Direction Plan/Eval AOPS, March 1993.

Joseph, Patrice, MD/MPH, "Diagnostic de Situation et Evaluation des Besoins en Assistance Technique des Institutions de PF: Synthese de la Direction Générale pour les Décisions et le Suivi," Direction Plan/Eval AOPS, March 1993.

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Lataillade, Edith memorandum to Evaluation Team, "Contraceptives received by PROFAMIL from UNFPA in 1992," May 14, 1993.

Michaud, Gadner, MD/MPH, "De l'Organisation des Cliniques Mobiles de Contraception Chirurgicale Volontaire (CCV)," PROFAMIL, Mars 1992.

Perry, Steve memorandum to Shelagh O'Rourke, John Burdick, & Dave Eckerson, "Contraceptive Procurement Tables for Haiti 1993," including fax coversheet with additional issues, John Snow, Inc., February 16, 1993.

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Prudent, Dr. Maryse Narcisse, "Rapport du Seminaire de Planification et d'Evaluation Organise Conjointement par la Direction Technique et la Direction de Planification et d'Evaluation de l'AOPS a l'Intention des Institutions Finacees par l'AOPS dans le Cadre des Projet VACS et IPPF," AOPS,

Rushdy, Sherif, "Analysis and Projection of Costs and Outputs for the Private Sector Family Planning Project as implemented by the Cooperative Agreement with IPPF," January 24, 1990.

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Sullivan, Audrey, and Laura Wedeen, "A Review of Activities under the Private Sector Family Planning Project: August 1986 - September 1991," IPPF/WHO/PAPFO, March 1992.

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