PD-ABI-316
ISN 87617

MID-TERM EVALUATION

EXPANDED URBAN HEALTH SERVICES

(EUHS) PROJECT

Haïti

Prepared for: USAID/Haïti, June 1992

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I. INTRODUCTION

A. PROJECT BACKGROUND

The Expanded Urban Health Services (EUHS) Project was initiated in June 1989. It is a five year $10.8 million activity designed to provide primary health care and child survival services to about half a million people in urban slums in Port-au-Prince, Gonaïves, Cap-Haïtien, Fort-Liberté and Ouanaminthe. The EUHS project is executed by the Centres de Santé (CDS) a Haïtian Private Voluntary Organization. CDS has perfected an intervention model to provide health care to urban disadvantaged populations through a combination of community outreach and clinic-based services. Through this project CDS offers primary health care, child survival services, family planning services, AIDS prevention and control and human resources development. The project also funds institutional strengthening of CDS. In 1990 the cooperative agreement was amended to allow CDS to provide community outreach health services to the people who live in La Saline, Port-au-Prince. No budget change was made at that time. It was anticipated the La Saline add-on would be funded from gain in foreign exchange (the dollar went from 5 to 7.5 gourdes).

B. PURPOSE OF THE EVALUATION

The Project paper calls for a mid-term evaluation. Originally scheduled earlier in the year, the evaluation was postponed for a few months due to political events in Haïti at the end of 1991. The purpose of the evaluation is to assess CDS' effectiveness in implementing the activities of the EUHS Project and to monitor progress toward achievement of project service delivery targets. This is a process evaluation. The evaluation scope of work is presented in Appendix A.

C. EVALUATION METHODOLOGY

The evaluation team was composed of two professionals who visited eight project sites over a period of two weeks during June 1992. The sites visited were:

1. Gonaïves: Ka-Soleil
2. Gonaïves: Raboteau
3. Ouanaminthe
4. Fort-Liberté
5. Cap-Haïtien: La Fossette
6. Port-au-Prince, Cité Soleil: Boston Center, Chapi Center, the Cité Soleil Family Planning Clinic and CMSCS (Complexe Médico-Social de la Cité Soleil)Administrative Offices
7. Port-au-Prince: La Saline
8. Port-au-Prince: CDS headquarters

At each service delivery site visited, the team met with selected staff and observed the delivery of services, routine administrative processes and food distribution. They visited the archive section, the pharmacy, the laboratory, the family planning clinic, the tuberculosis clinic and the accounting section of all the site visited.

Discussion with staff included description of services provided at the center, supervision of activities, data collection instruments and methods, reports and archive system, community

outreach activities, problems encountered over the last few months, work load and constraints to program activities. In addition staff were asked to describe their job, their training, their supervision and to comment or ask questions about the evaluation.

In addition to visits to service delivery sites, evaluators visited the offices of CDS to meet with project managers and technical coordinators. During the evaluation period the evaluators consulted frequently with the project management team and were given access to project records, baseline data, service statistics, periodic reports and accounting files. The team worked closely with CDS' evaluation coordinator for the entire process. The lists of documents consulted and of persons contacted are presented in Appendices B and C.

The evaluation team did not visit the following CDS sites:

- Port-au-Prince, Cité Soleil: Brooklyn Center, Mamayo and Papayo, Sainte Catherine Labouré
- Petite Place Cazeau
- Mont-Organisé.

These sites are also part of the CDS operation. However, the evaluation team did not have sufficient time to visit all the sites involved in the EUHS project.

II. EVALUATION FINDINGS

Overall the evaluators were impressed everywhere with the level of activities, the good organization of services and the competence and dedication of CDS personnel. Despite crowded facilities and in some cases (Gonaïves in particular) buildings that could use extensive repairs, activities were orderly and patients were processed as quickly as their large number permitted.

Everywhere the socio-economic situation and the embargo are complicating the work of health care providers. Most centers are experiencing electricity rationing/shortages. This results in complications in maintaining the vaccine cold chain and for laboratory and office equipment operations. Shortages of all kind due to the embargo and the weakening of the local currency (gourdes) are also an added burden.

The political situation has resulted in the closing of most of the Haïtian factories. Consequently there is an enormous rate of unemployment nationwide. Many people are moving around from urban area to urban area, and from rural settings to urban slums back to rural settings in search of basic survival sustenance. Most of the population served by CDS is deeply affected by this situation and is becoming more and more dependent on humanitarian food distribution and assistance. These population movements complicate the work of community outreach workers.

A. THE INTERVENTION MODEL

CDS has developed and perfected a model of community health for disadvantaged urban areas. Based on the experience gained in Port-au-Prince in Cité Soleil, CDS expanded to Gonaïves where the model was easily adapted with minimal changes. CDS' model is based on the following elements:

1. A workforce of semi-volunteer community health workers called "Collaborateurs Volontaires" (Col-Vols)

2. Training and motivation for the Col-Vols

3. Each Col-Vol monitors the health of about 200 families through frequent visits to their home

4. Col-Vols provide simple health education and motivation to change the health prevention and curative services seeking behavior of the people served

5. An integrated and comprehensive yet simple record keeping system, maintained by the Col-Vols, and completed by service providers and archivists

6. Intensive supervision of the Col-Vols, through spot check visits, and through monitoring of their record keeping system

7. The provision of clinic-based preventive services including immunizations, prenatal care, growth monitoring, family planning and health, nutrition, breastfeeding, sanitation, diarrhea control and prevention education

8. The provision of free or low cost out-patient curative clinic-based services of quality including tuberculosis treatment.

9. Intrapartum care and various other basic in-patient curative services and surgery are also provided at some project sites

10. Provision of essential medications at subsidized costs.

The expansion to Cap-Haïtien was similar to the expansion to Gonaïves and presented no unanticipated problems. However, when CDS moved into the Fort-Liberté and Ouanaminthe catchment areas the situation was somewhat different. Firstly, CDS could not limit its services to the urban area proper of these locations because no other health services were available within easy reach. This lead CDS to provide services to population that are semi-urban and rural. Secondly, CDS had to provide more curative services than it originally had planned to persons out of the project catchment area (non-registered). Thirdly, CDS had to provide some in-patient curative services, because there is no easily accessible referral tertiary facility within easy reach of the populations of Ouanaminthe and For-Liberté. This situation has created the need to modify the standard CDS urban service delivery model to adapt it to the needs of these communities. In addition, CDS is subjected to mounting pressure from neighboring communities to expand services to them. This is how Mont- Organisé was started.

As a result, some of the estimations in personnel needs have proved to be insufficient. Col-Vols cannot always take care of as many as 200 families because some of their people live over a large area not easily accessible on foot. Similarly it is difficult for users to come to the clinic to obtain services. As a result CDS has experimented with service delivery at "Postes de Rassemblement" but this results in unplanned staff time and expenses in gasoline and vehicle maintenance. Supervision visits are more difficult to plan and more expensive and time consuming to conduct.

CDS is aware of all these issues and is experimenting with creative solutions. CDS' efforts to adapt its urban community health model to peri-urban and rural settings could be better documented.

B. THE PROJECT CATCHMENT AREA

As soon as the project started CDS began to conduct census in the project intervention areas. Once the basic population of each area was known CDS assigned approximately 200 family per Col-Vol. CDS estimates that 200 family represent about 1000 individuals (mother, father, children and other household relatives) for whose health the Col-Vol is responsible. Through experience CDS has learnt that one Col-Vol can manage about 200 families and adequately keep track of their health events and needs. According to Dr Mode, CDS' expert for the community outreach program, each family has to be contacted once per 6 to 8 weeks to ensure proper follow-up.

Table 1: CDS Target Population

SITE	1989	1990	1991	1992 Mid-Year Estimate	BaselinePop. Estimate
CITE SOLEIL	171,800	175,216	178,636	182,000	150,000
LA SALINE		59,880[1]	22,523[2]	60,000	60,000
GONAIVES	69,739	71,126	72,506	73,000	50,000
CAP-HAITIEN		86,826[1]	82,814[2]	87,000	87,000
FORT-LIBERTE	36,875	36,589	37,303	38,000	34,000
OUANA-MINTHE	60,813	62,023	63,240	65,000	46,000
MONT-ORGANISE			18,081	18,438	18,000
TOTAL	338,227	509,741	475,460	**523,000**	445,000[3]
PACD Est Total Popltn.					**510,000**

1. Census of target population
2. Population registered and receiving services
3. Includes La Saline and Mont-Organisé

Beyond this number Col-Vols are often stressed and the population is no longer optimally served.

The ratio of family per Col-Vol has evolved from CDS' experience in urban settings, in peri-urban and semi-rural areas this ratio does not always work well depending on terrain difficulty and modes of transportation available to the Col-Vol to visit families.

The census of project areas has revealed that population estimates made during project design were low as seen in Table 1 above.

CDS anticipated providing services for approximately 510,000 people (450,000 original target plus the 60,000 La Saline add-on) by PACD. To date, at the project mid-point, the population served is already reaching 520,000. In addition to the people who are enrolled in the project, clinics and health centers also provide services to persons who are not registered in the community outreach program. A quick spot check made in Cap-Haïtien, La Fossette during the visit of the evaluation team showed that about one third of vaccination clinic attendees were women and children who did not hold a registration card for the community outreach program.

The population of urban disadvantaged areas is very volatile. When factories are opened, job opportunities are available and urban slums populations grow fast. When factories close due to political disturbances, economic opportunities are no longer beneficial in urban areas and people tend to return to their village of origin. These movement of population are monitored by the Col-Vols who maintain an accurate census of the people who live in their assigned geographic area.

C. SITE VISITS

The evaluation team spent four days visiting CDS facilities in Gonaïves, Ouanaminthe, Fort-Liberté, and Cap-Haïtien. In addition, visits were made to CDS facilities in La Saline and Cité Soleil in Port-au-Prince. In general the facilities in Port-au-Prince, Gonaïves and Cap-Haïtien fit the large urban poor environment upon which the CDS service delivery model is based. Ouanaminthe and Fort-Liberté are smaller towns and the catchment areas served by those facilities include some rural areas as well.

In Gonaïves, the team went to both the curative and preventive centers at Raboteau and Ka-Soleil facilities. Doctor Jean-Marie Jean-Baptiste, the Director gave them tours of the Raboteau facilities, allowing the team to observe a well-baby clinic (including vaccinations) and routine family planning consultations that were in progress. The team interviewed several staff members, including the archivists, a family planning auxiliary, several community health workers (Col-Vols), a maternity nurse and a few patients.

At the Ka-Soleil facility, the team spoke with the accountant (who is also responsible for accounting at Raboteau on a shared basis), the pharmacy staff, nurses and auxiliaries and Col-Vols. All preventive activities and most curative services had been completed for the day by the time the team arrived at the facility. The team spent some time understanding the record keeping system and how Col-Vols, supervisors and archivists keep track of the servic eeded by the people they serve.

The team observed a well-baby clinic and the tuberculosis treatment services at Ouanaminthe and met with the accountant, two nurses who are family planning coordinators, the pharmacy staff, the staff of the maternity, the auxiliary in charge of the tuberculosis treatment program, the archivist,

the cashier and several Col-Vols. After observing some weaknesses with the community outreach activities, the evaluation team requested that an impromptu meeting of Col-Vols be convened to better understand the nature of the problem. Approximately 20 Col-Vols could be reached on short notice and they attended the meeting. Discussions clarified that the problem was rooted in the overload of some Col-Vols in the urban part of Ouanaminthe who are managing more than 200 families to enable lighter loads for the peri-urban and rural Col-Vols. Many rural families are scattered over difficult terrain and are not easily reachable. This situation results in weakened supervision. During a recent visit of the evaluation division to Ouanaminthe this problem was identified and Dr Mode and Dr Saint-Jean have planned an extensive technical assistance visit to Ouanaminthe to solve the problem.

In Fort-Liberté, the team visited a community outreach post ("Poste de Rassemblement") that was approximately one hour away by car from the hospital. At the post, a Col-Vol gave a lively health education session and organized baby weighing and vaccinations. While the mobile team was working, the evaluation team talked with some clients. The distance to the site and the nature of this activity underscored the urban/rural mix of populations being served by the facility in Fort-Liberté. At the hospital, the team spoke to the accountant and cashier, the archivists, the family planning auxiliaries, and several doctors.

At La Fossette, in Cap-Haïtien, the team met with Dr. Duguet, the Medical Director, who gave them a tour of the facility. There was a well-baby clinic in progress and the team spoke with several of the auxiliaries in charge. The health eduction session planned for the day was canceled due to crowding and high noise levels. The team observed that it would be extremely difficult to conduct effective group education sessions in the area designated for that purpose. It was clear to the team that the volume of services being delivered at La Fossette was close to, if not exceeding, the maximum possible given the current physical structure available. The team also met with the accountant, the cashiers, the pharmacy staff, the physician in charge of the tuberculosis treatment and AIDS/sexually transmitted disease program, the archivists, the staff of the laboratory and the administrator. The team leader visited the Cap-Haïtien family planning clinic, which is held at a separate location.

In Port-au-Prince team members visited CDS operated facilities in La Saline and Cité Soleil. At La Saline and at the administrative offices of the CMSCS the team met with a cross-section of the staff including nurses, physicians, auxiliaries and support staff and discussed current constraints to the program and how the recent economic problems are affecting community health and personnel. At the Boston Center, the team observed the food distribution and visited the archives.

Throughout these site visits the team had the opportunity to meet with a wide range of CDS personnel including medical staff, nurses and auxiliaries, guardians and maids, archivists and accountants and other administrative personnel. All these individuals were chosen at random from payroll lists and with most of them the conversation included questions on their job description and supervision, on job satisfaction training and professional growth including future salary expectations.

D. PRIMARY HEALTH CARE AND CHILD SURVIVAL SERVICES

The focus of the services offered by CDS is placed on child survival. In addition to immunization

of young children CDS conducts safe childbirth activities including prenatal care, tetanus vaccination, obstetric care and post-natal care; family planning including Norplant and sterilization; diarrhea control and prevention including ORT, health education, clean water use, and breastfeeding promotion; nutrition including nutrition education, growth monitoring, nutrition deficiency management, food distribution, vitamin A supplements and nutrition rehabilitation; tuberculosis identification, treatment and prevention; AIDS prevention and control; and a wide range of other clinic-based, in-patient and out-patient curative services.

1. Immunizations

CDS vaccinates young children under five years of age against Diphtheria, pertussis, and tetanus (DPT), tuberculosis (BCG)and measles (M). The immunization program is already reaching a good proportion of the target population as shown in table 2 below.

Unfortunately some of these early gain in vaccination coverage may be slowed in 1992. In Cap-Haïtien, the embargo has resulted in daily electricity shortages. CDS must rely on the MSPP cold chain to keep vaccines in good condition. Over the last few months MSPP has experienced vaccines shortages. The evaluation team calculated that in the first quarter of 1992 out 139 vaccination days, CDS could not obtain some vaccines (mostly DPT) from the MSPP for 60 days. at other sites, there were anecdotal reports of BCG shortages, vaccination syringes shortages and small inoculation needles stock-out.

Table 2: Immunizations for Children (DPT, M, BCG)

Site	1989/A	1989/B	1990/A	1990/B	1991/A	1991/B	1995 GOAL A&B
Cité Soleil	48.7%	30.0%	46.4%	45.0%	49.5%	70.0%	85.0%
Gonaï.	82.0%	30.0%	60.8%	45.0%	45.3%	70.0%	85.0%
Ouana.	24.1%	29.0%	62.6%	48.0%	32.6%	65.0%	85.0%
F-Lib.	42.2%	32.0%	18.9%	35.0%	39.0%	45.0%	85.0%
C-Haï.			62.0%	50.0%	39.5%	60.0%	85.0%
M-Org.			5.1%	30.0%	56.9%	45.0%	85.0%
La Sal					20.1%	30.0%	
CDS	52.4%	30.0%	40.5%	45.0%	43.0%	60.0%	85.0%

A. Children 0-1
B. Children less than 5

2. Safe Childbirth

(Prenatal care, parturient tetanus immunization, intrapartum care, breastfeeding promotion)

CDS safe childbirth program includes prenatal care and tetanus vaccination at all project sites. Intrapartum care is also available at Sainte Catherine Labouré in Cité Soleil, at Raboteau in Gonaïves, Ouanaminthe and Fort-Liberté. In Gonaïves and Ouanaminthe complicated births are referred. CDS has an extensive post-natal care program that includes breastfeeding promotion, diarrhea prevention and growth monitoring. Table 3 and 4 below show the progress of two safe childbirth indicators since the project began.

Table 3: Tetanus Protection for Pregnant Women

Site	1989	1990	1991	1995 Goal
Cité Sol.	48.0%	62.0%	95.0%	90.0%
Gonaïves	40.0%	36.6%	54.0%	90.0%
Ouanamint.	13.0%	68.6%	50.0%	90.0%
Fort-Lib.	100.0%	68.2%	47.0%	90.0%
Cap-Haït.		14.6%	42.0%	90.0%
Mont-Org.		16.7%	72.0%	
La Saline				90.0%
CDS	54.8%	48.5%	60.0%	90.0%

Table 4: Prenatal Care Coverage

Site	1989	1990	1991	1995 Goal
Cité Sol.	98.6%	93.6%	95.0%	90.0%
Gonaïves	45.0%	61.1%	74.0%	90.0%
Ouanamint.	45.9%	45.3%	44.0%	90.0%
Fort-Lib.	29.2%	52.3%	53.0%	90.0%
Cap-Haït.		16.7%	28.0%	90.0%
Mont-Org.		18.0%	36.0%	
La Saline				90.0%
CDS	66.3%	60.6%	57.0%	90.0%

CDS should think about developing postpartum FP where they provide intrapartum care.

3. Family Planning

CDS family planning (FP) activities are funded through a variety of mechanisms. In Cité Soleil, CDS receives funding from IPPF/WH from the USAID/Haïti Private Sector Family Planning Project (PSFPP). In Gonaïves, the FP clinic is funded by AOPS with PSFPP moneys. In Cap-Haïtien, CDS received a very short-lived grant from FPIA. EUHS project funds were earmarked to provide funding for FP activities in Ouanaminthe and Fort-Liberté for the first two years of the project. After this, the PSFPP was to have been replaced by a new project that would continue to support CDS FP activities. No plan for FP in La Saline was mentioned.

In Cité Soleil and in Gonaïves FP services were ongoing at the beginning of the EUHS project. CDS initiated FP activities in Fort-Liberté, Ouanaminthe and Cap-Haïtien concurrently with other health services at these new project locations. The program includes clinic-based services for a wide range of temporary methods including Norplant, with referral for sterilization to a clinic in Cap-Haïtien funded by AVSC for northern sites. In Gonaïves sterilizations are referred to the hospital and in Port-au-Prince there are many options to receive such services. Community motivation, was conducted by promoters who are the equivalent of Col-Vols for FP. the goal of the program was to achieve a prevalence of 10% by PACD at all project locations.

The new family planning project was postponed as a result of the political disturbances and CDS funding for FP in the northern sites vanished when the EUHS project moneys were spent at the end of Y2. CDS canceled the community outreach program but maintained clinic-based services. Although this resulted in a marked drop in users initially, after a few months, the number of clients is starting to grow again at all three clinics. CDS should be commended for keeping the clinics opened and continuing to offer these services that are such a priority need for Haïti.

4. Diarrhea Control and Prevention

(ORT, Health Education, Clean water use, Breastfeeding Promotion)

Diarrhea prevention is an urgent concern for CDS because so many Haïtian babies are affected. Education on how to prepare and use ORS is one of the major task of Col-Vols. Education is supposed to take place in the home when the Col-Vol visits the family and at the health center when mothers bring their babies for post-natal and growth monitoring services and immunizations. During previous visits to CDS facilities the evaluation team leader had been able to observe the delivery of health education. During this visit, despite efforts of the team to arrive early at health centers to be able to attend education sessions, the evaluation team was only able to observe one session. The evaluation team travelled with a mobile team to a "poste de rassemblement" near Fort-Liberté and attended the education session that preceded the weighing of babies. Elsewhere, facilities appeared so crowded and so noisy that education was not possible. The education session observed was good and very interactive. Clearly, the educator knew how to engage the crowd and how to communicate. The educator had no support materials. It would be too bad if group health education slipped back and was given a less prominent role in the CDS community outreach program.

5. Nutrition

(Nutrition Education, Growth Monitoring, Nutrition Deficiency Management, Food Distribution, Vitamin A supplements, Nutrition rehabilitation)

Prevention of malnutrition is another major concern of CDS especially during the current period of economic stress. In recent months growth monitoring is starting to show more and more babies moving from normal status to malnutrition level one and beyond. Humanitarian food distribution is becoming very important. The evaluation team observed food distribution at the Boston center in Cité Soleil. Food distribution is not available to CDS sites outside of Port-au-Prince. CDS has developed a very efficient and cost effective food distribution program. CDS tries to make sure that most poor families have access to at least one ration of food. Priority for food is given to babies, pregnant women and old people. However, CDS does not want to penalize mothers who feed their children properly and does not give preference to malnourished babies. All babies less than five have access to a ration.

CDS technical coordinators explained to the evaluation team that they are concerned about creating too much dependency on donated food and to tie the food distribution too closely to clinic attendance for preventive services for fear that when food distribution stops preventive health is affected.

6. Tuberculosis Identification, Treatment and Prevention

CDS tuberculosis management program is rooted in research. CDS has developed and tested treatment protocols easy to administer and cost effective. Treatment is delivered at each center and CDS is proud of the compliance level of its patients. It is interesting to note that as CDS is educating people on how to prevent tuberculosis it ties the prevention to AIDS prevention. In a recent community survey in Port-au-Prince people linked AIDS and tuberculosis and believed that tuberculosis was sexually transmitted.

Table 5 below shows the number of tuberculosis cases identified and treated since the project began.

Table 5: Tuberculosis Cases Identified and Treated

Site	1988	1989	1990	1991	1992 6/92	Total	1995 Goal
C S	249	267	367	392	137	1421	
Gon.			105	43	14	162	
Ouana.			86	70	30	186	
F-L			96	94	40	230	
C-H			80	228	182	490	
M-O			41	34		75	
La Sal			33	125	41	199	
CDS	249	267	817	986	444	**2763**	**7200**

7. AIDs Prevention and Control

About $150,000 of EUHS project funds were given to CDS to conduct AIDS prevention and control activities in the northern sites. For activities in its southern sites, CDS received funding from JHU for AIDS research in Port-au-Prince and from FHI/AIDSTECH for AIDS prevention and control activities in Gonaïves. EUHS project funds were earmarked for activities for the first two years of the project, until USAID/Haïti develop the ABASIDA project managed by FHI/AIDSTECH and AIDSCAP. Although CDS is deeply interested in AIDS prevention and control and indeed has been at the forefront of AIDS research in Haïti the accomplishments of this aspect of the EUHS project are not as visible as other programs. The EUHS AIDS funds were supposed to sponsor training for counselors and community outreach workers and clinical sites renovations. Training and renovations took place but the program was disrupted by the political events. The continuation grant with AIDSTECH was not developed and last fall CDS ran out of money to continue community-based activities. The people who had been trained were released. All that remains of the program now is a weak linkages with the tuberculosis activities and a will to get things going again. The AIDS coordinator is very busy since he also manages the JHU AIDS research grant to CDS. Little had been done to rekindle activities when the evaluation team conducted its assessment. An AIDSCAP team is planned to come to Haïti during the month of August and hopefully the CDS AIDS prevention and control program in the northern sites will resume.

8. Other Curative Services

All of the CDS facilities included in the EUHS project offer curative services to patients from their registered and extended target communities. All facilities draw significant numbers of patients from outside their defined, registered communities; a quick check of out-patient receipts at two different facilities indicated that between 25 and 50 of out-patients percent were not from the registered community.

Table 6: Services at CDS Facilities

SITE	OUT-PATIENT	DENTISTRY	IN-PATIENT	MATERNITY	SURGERY
Cité Soleil	Y	Y	Y	Y	Y
Fort- Liberté	Y	Y	Y	Y	Y
Gonaïves	Y	N	N	Y	N
La Fossette	Y	Y	N	N	N
La Saline	Y	Y	Y	N	Y
Ouanaminthe	Y	N	Y	Y	Y

Not all CDS facilities offer the same services. Several locations offer only out-patient services (CHAPI, La Fossette, Raboteau, Ka-Soleil) while others combine those services with in-patient curative and/or maternity services (Ouanaminthe, Boston). Two facilities, Sainte Catherine Labouré and Fort-Liberté, offer (relatively) sophisticated surgical services and act as reference

hospitals for areas that reach far beyond the project target populations. Table 6 below indicates the curative services offered at each facility.
The EUHS cooperative agreement was designed to provide limited support to primary care services at all facilities except Cité Soleil where limited resources were allocated to support the maternity and pediatric wards at Sainte Catherine Labouré with a focus on child survival. For the purposes of the Project Paper (PP), primary curative care was defined as: out-patient and hospitalization; pharmacy; dentistry and ophthalmology; malaria, leprosy and tuberculosis identification and treatment. The PP anticipated that by Year 3 of the project, each facility would provide some primary curative services to about 50 percent of its target population each year. Table 7 below shows projected and actual number of curative visits for year two. These data show that most facilities have met or exceeded the projected number of curative visits for that period. Only Ouanaminthe appears to be delivering less curative services than projected. Parallel data could not be obtained during the evaluation visit for 1991 and for the first half of 1992. The information system in use at CDS does not allow for the prompt tabulation and reporting of routine service delivery statistics. Further development of CDS Management Information System (MIS) should emphasize the standardization of methods to tabulate in-patient and out-patient statistics on the delivery of curative services to facilitate analysis and interpretation of project achievements.

TABLE 7: Projected and Actual[1] Primary Curative Care Visits

Facility	**Projection Curative Visits Year Two**	**Actual Curative Visits Year Two (June 90 - May 91)**
Raboteau	12,500	16,598
K. Soleil	12,500	11,689
La Fossette	34,800	28,117
Ouanaminthe	18,400	7,976
Fort-Liberté	13,600	12,504
La Saline	N/A	9,469
Total	**91,800**	**86,354**

CDS does not limit the delivery of curative services to those primary services defined in the PP and in reality delivers a significant number of needed in-patient, maternity and other curatives services to target populations. With the recent opening of the operating room at Fort-Liberté, the number of services not anticipated in the PP will, in all likelihood, increase.

The delivery of these services clearly meets a demand on the part of the population that would in

[1] Setzer and Cross, "A Study of User Fees at CDS Facilities in Haiti", Abt Associates March 1992

all likelihood otherwise remain unmet. These services support the community outreach preventive services of CDS by completing the range of services available to the target population and contribute to build a climate of confidence in CDS commitment to the area. These services are clearly justified by their complete absence elsewhere in Fort-Liberté and Ouanaminthe. In Gonaïves, Cap-Haïtien and Port-au-Prince referral services do exist and CDS works closely with local MSPP facilities to refer patients who need such services.

The financing of these additional services is stressing CDS' Cooperative Agreement budget, especially with respect to expenditures for personnel to operate the facilities. The original projections of personnel requirements at all facilities, including CDS central administration, were underestimated.

The relative success of CDS in providing curative out-patient services has some draw backs. High patient volume at all facilities puts pressure on clinical personnel to deliver high quality and sensitive care. This situation appears to be especially acute with respect to physicians. High patient volume limit the time physicians spend with each patients. It is apparent that in such situations the quality of provider-patient contact and clinical services delivered both suffer.

Given current overspending on personnel costs it appears that hiring more physicians to alleviate this pressure is not feasible. It would appear that CDS must experiment with new systems of patient management that will place greater responsibility on non-physician providers. This may take the form of systems for better patient triage or the increased use of physician's assistants. The supervision of clinical personnel involved in curative care delivery should continue to emphasize the need to deliver quality services and maintain adequate provider-patient relationships. CDS should include this issue as part of any ongoing in-service training programs for physicians and other clinical personnel.

9. Pharmacy

The ability of CDS to deliver high quality curative services as well as recover costs through user fees requires a stable supply of low cost essential drugs at all facilities. At all the sites visited by the evaluation team, staff reported shortages and stock-outs of essential drugs during the last few months. The prices of essential drugs is rising fast due to the inflation resulting from the embargo. CDS procurement and drug management practices do not appear in all instances to be successful in procuring and delivering essential drugs at the lowest possible cost. The ability of the CDS user fee system to generate revenues capable of covering drug costs is threatened by these factors.

The PP anticipated 6% per annum inflation on drug prices over the five years of the cooperative agreement. It also estimated an average drug cost per patient of 7 Gourdes at the start of the project, rising to 8.85 Gourdes by PACD. At the completion of EUHS Year Two, Setzer and Cross calculated average out-patient drug expenditures ranging from 8 Gourdes to 14.4 Gourdes. The CDS "Rapport d'Activités des CDS - 1991" indicates that the price of Ampicillin, a basic antibiotic, had risen 89% between June 1990 and April 1992 and that Dextrose/W 5% I.V. solution had gone up 83 % during the same period. Data were not available at the time of the evaluation to permit a recalculation of per patient drug expenditures for out-patient visits. This calculation should be made when complete Year 3 data are available. CDS will need to examine the effect of inflation on drug costs and the ability of user fees to recover drug and other

operating costs. Available data on drug expenditures and user fees receipts for selected facilities are given in Table 8 below. The table must be interpreted with caution since it is based on incomplete data.

Table 8: User Fee Revenues and Drug Costs at Selected Facilities: June 1991 - May 1992

Facility	User Fee Revenues	Drug Expenditures
Fort-Liberté (9 months data)	194,344 Gdes	92,815 Gdes
La Saline (10 months data)	223,010 Gdes	119,295 Gdes
La Fossette (10 months data)	374,123 Gdes	224,842 Gdes
Ka-Soleil (9 months data)	83,732 Gdes	80,741 Gdes
Raboteau (8 months data)	148,589 Gdes	90,741 Gdes

The rates of cost recovery are similar to those calculated by Setzer and Cross the previous year. All facilities show user fee revenues in excess of reported drug expenditures. However it appears that the average monthly expenditures for drugs are lower than during the previous year. There are several possible explanations for the apparent decrease in drug expenditures:

1. Improved prescribing practices on the part of CDS clinical personnel have resulted in lower average per patient expenditures for drugs

2. Reduced patient numbers at all facilities

3. Decreased drug purchases by the facility despite constant or increasing patient volume

4. Decreased availability of drugs from suppliers

5. Decreased drug purchases because user fee revenues are utilized to cover other unintended operating costs.

Data were not available to the evaluation team to eliminate any or all of these hypotheses. It would appear, however, that the later three (in combination) are the most plausible.

The suspension of EUHS reimbursement of all non-personnel costs over the last few months, has placed unexpected pressure on user fee revenues to cover operating costs originally covered by EUHS. This situation has made revenues unavailable for drug purchases. The evaluation team

was unable to assess whether this situation has adversely affected drug availability at CDS facilities.

Drug management practices at the facility level have improved during the last year. However, a great deal remains to be done in order to improve the availability of essential drugs. Facility level pharmacies appear organized and neat. They now employ stock control cards for all products. They appear to purchase most drugs in generic, bulk packaging from local suppliers. Pharmacy staff repackage these drugs for individual patients in the afternoon when patient volume is low. Efforts are under way to develop an essential drug list and treatment protocols for use by clinical and pharmacy personnel for the most common conditions.

Most facilities order drugs and supplies on a monthly basis. Although it is a "pull" system (i.e. individual facilities calculate their own needs and place orders based on patient volume and existing stocks) there do not appear to be standard formulae or methods for the calculation of drug needs. Stock-outs due to individual errors or weaknesses in drug management at the local level is possible.

Space available for drug storage varies from facility to facility. At several location visited by the evaluation team the pharmacy staff indicated that they would like to order and stock a three months supply of drugs but storage facilities are insufficient. They also indicated that their user fee account was not large enough to cover such a large purchase. Smaller, more frequent orders increase costs and the possibility for delays and stock-outs.

CDS facilities did not receive an initial large drug stocks to start a drug revolving fund at the initiation of the user fee system. User fee accounts and pharmacies lead a "hand to mouth" existence. The small existing drug stocks must be drawn down in order to generate sufficient revenues to place orders for replacements. Any delay in the process results in a stock-out or requires the facility to make "emergency" purchases at local retail outlets at the highest possible prices. CDS central staff estimate that it would require approximately US $150,000 to purchase a three month supply of drugs for the entire system in order to capitalize it adequately (if somewhat after the fact). Actual drug expenditures between June 1990 and May 1991 indicate that three months supply of drugs for CDS curative services may require even less of an initial investment (based upon total reported expenditures of approximately 2.1 million Gourdes and the exchange rate of 7.5 Gourdes to US $1 in effect at the time). Any planning in this regard must consider the space requirements to stock drugs at each facility.

CDS has apparently started discussions with a Dutch relief agency that has indicated its interest in providing such an infusion of essential drugs. This is encouraging and demonstrates CDS' willingness and ability to widen the base of its financial support.

Facility staff do not have access to drug price lists when making their monthly orders. Staff calculate drug needs and place orders based on a notion of the cost (usually the last purchase price for the same drug). Staff often do not know if the current balance in their user fee accounts will cover the cost of the order. Orders are sent to CDS's purchasing department which then requests pro-forma from local suppliers. The majority of drugs purchased by CDS appear to come from the "Pharmacie Vallières". CDS staff indicated that more than one pro-forma is obtained for all orders and that decisions are made based upon price, quality and availability of products.

The CDS purchasing department does not maintain stocks of essential drugs to ship to individual facilities. Upon receipt of the pro-forma, CDS's purchasing department attempts to verify whether sufficient funds are available in the facility's user fees account. Based upon information requests made by Setzer and Cross and the evaluation team it appears that the ability of the CDS central accounting department to accurately track facility user fee account balances is in doubt.

The quantities of drugs ordered are adjusted based upon the availability of user fee account funds and the order is finally placed. The drugs are delivered by the supplier to the CDS central warehouse and then shipped to the individual facility. Often, the order waits until the facility can send its own vehicle to Port-au-Prince to take delivery.

CDS does not gain from economy of scale through its current purchasing system. Prices are subject to frequent changes. Local suppliers do not ship until payment is received adding to possible delays. Local suppliers also experience stock-outs of essential drugs from time to time. Patient satisfaction with the user fee system is based upon the availability of drugs. Unavailable drugs undermines the reputation of CDS.

CDS administrative staff indicate that the drug procurement and supply system is undergoing change in order to address many of the difficulties cited above. The CDS purchasing unit is being reorganized according to the recommendations of the 1990 report by COGESA. CDS also hopes to fully capitalize its purchasing unit. Individual facilities would then purchase supplies from it rather than dealing directly (or through the Purchasing Department) with local suppliers. All transactions between Purchasing Unit and facility would be on a purely cash and carry basis using pre-printed order forms which indicate the prices of essential drugs. Facilities would not be able to order drugs in excess of their user fee accounts balance. CDS hopes to stabilize both the supply and (hopefully) prices of drugs in this manner.

In-kind donations of drugs and other medical supplies play an important role in the availability of drugs at CDS facilities. The value of donations is not currently established nor used in estimating drug utilization or costs. As part of the reorganization of the purchasing and supply system, CDS should initiate procedures to do so at this time. In-kind donations should be integrated into CDS Purchasing Department stocks, and facilities granted credit from the purchasing department corresponding to the value of the donation. These credits could be used to purchase donated drugs or any others required by the facility and stocked by the Purchasing Department. Donations of non-essential drugs (such as the bottles of Plax mouthwash seen by the evaluation team in Ouanaminthe) would be distributed directly to facilities and need not be included in the accounts of either the Purchasing Department or individual facilities. These changes in the accounting systems were recommended by Setzer and Cross and should be implemented as part of efforts to reorganize the Purchasing Department. CDS may require technical assistance to carry out the reorganization.

Plans to reorganize the CDS drug supply system coincide with PAHO efforts to establish a National Drug Supply Company (NDSC) in Haïti. This unit will be housed in a CDS managed warehouse in Port-au-Prince with rent initially paid by PAHO. The NDSC will be created through the purchase of drug stocks worth US $1 million and will initially provide drugs at subsidized prices to approved facilities. After the initial period of subsidy (which will be reduced gradually over time), it will continue to sell drugs to approved facilities. Prices will be kept low through the exclusive provision of bulk, generic drugs and the use of either international tenders

or negotiated purchases. It appears that the initial period of subsidized sales to approved facilities may allow CDS to purchase the required initial stocks for its purchasing department at even lower costs than estimated. PAHO indicates that this unit will become fully operational as of 1 August 1992.

E. HUMAN RESOURCES DEVELOPMENT COMPONENT

The human resource development and vocational training component of the EUHS Project was funded at $0.5 million for the first two year of the project for CMSCS only. The objective was to improve the standard of living of low income residents through basic education, vocational skills training, and income-generating activities. An evaluation of the component was carried out at the conclusion of USAID/Haïti funding (Russell, 1991).

The human resource development programs at CMSCS evolved through concern for mothers of severely malnourished children, adolescent students, and unskilled and/or illiterate adults. The HRD component was designed to:

1. Improve the quality, level, content, and relevance of CMSCS training programs

2. Strengthen the relationship between private sector employers and the training program

3. Upgrade the management and efficiency of training centers.

Following is a summary of the findings of the 1991 evaluation:

1. There is no evidence of improved relationship between CMSCS and the local business community. A private-sector oriented steering committee has not been established, nor has a job placement center or automated student record and follow-up system been developed. The lack of job placement services results in low placement rates of approximately 30 to 50 percent among graduates.

   The evaluation recommended immediately establishing a private sector advisory committee as a step toward developing a strong relationship with local employers, and developing a job placement center that would offer referral services to those seeking assistance in self-employment. A student record and follow-up system would complement the job placement center. The evaluation advised that some of the remaining project improvement funds be spent on technical assistance to help with these efforts.

2. There is a very efficient administrator/instructor ratio (1:13), but this "top-light" structure gives the directors little time to address the more complex management and technical issues associated with their programs. An Employment/Training Coordinator has been hired, as recommended in previous evaluations. However, the coordinator also serves as the Director of the Boston Vocational Center, a job which demands about 80 percent of his time. This has prevented him from giving significant attention to improvements at the other centers.

The evaluation concluded that an additional administrator should be hired at Boston to allow at least 50 percent of the current Director's time to be spent on his employment/training coordinator responsibilities.

3. No in-service training of the HRD staff has taken place since 1986, and none of the centers plans to upgrade staff. The overall student/teacher ratio is acceptable, but can vary widely between classes, indicating an improper allocation of staff. The evaluation recommended that serious consideration be given to reallocating instructors at the Boston center to provide more equitable student/teacher ratios in the technical classes.

4. Training programs have not been significantly upgraded. The programs need capital and training equipment: telephones at all three centers, a generator at the Boston center, and additional welding machines, computers, and electronic kits at Boston and Papayo. An additional classroom at Boston may also be needed. However, the relevance of the training programs offered is unclear, as no linkage exists between industry and the centers to test their validity. The evaluation recommended that telephones and a generator be purchased immediately, but advised that other purchases be deferred until the training currently offered has been validated.

5. No courses in micro-enterprise development are offered for the significant number of graduates who enter self-employment. The evaluation concluded that CMSCS should consider offering such courses, and coordinate them with the business training that will be offered to graduates of the HRD program under the recently formed CMSCS credit program for new entrepreneurs.

6. The CMSCS programs operate at a relatively low cost, due in part to the small administrative structure and the shortage of training equipment. The project has been economically sound and justified: the computed benefit-cost ratio of the investment in training during the two-year project was 2.8, and there was a 35.3 percent internal rate of return. Even Boston, the most expensive center at a cost of $1792 per student, possesses a more favorable internal rate of efficiency than other comparable vocational schools in Haiti. The project also produces non-quantifiable benefits such as better personal and family health care, a more civic minded society, and better schooling among children of graduates.

In summary, the evaluation recommended that CMSCS consider expanding the existing student user fee system to cover additional students at Boston, as well as the trainees at Papayo. It also suggested that project improvement funds be used to purchase technical assistance to help develop a marketing strategy to expand the sales of crafts made at the Brooklyn center and some of the products made at Boston. However, the evaluation concluded that these funds would never cover the total costs of the HRD program, and advised that USAID/Haïti seriously consider assisting CMSCS with the creation of an endowment fund to lessen their dependence on USAID funding.

F. CDS MANAGEMENT

Over the last three years CDS has implemented a number of changes to its organizational structures to meet the administrative challenges of increased size and expanded scope of activities. CDS is now managed by a core team that includes many skills and that has learnt a lot in the process of developing activities in the new sites. CDS structure is not frozen and is able to change when new challenges are encountered. This flexibility creates an entrepreneurial atmosphere with a lot of loyalty to the organization, its mandate and leaders.

Some technical areas are still less developed than eventually will be needed. CDS will soon need to strengthen its evaluation division and in the not too distant future may need to separate AIDS research from AIDS prevention and control. One area is still undeveloped: communication, IEC (counseling and material conceptualization and production).

CDS provides its staff with training at all levels, the evaluation team found that almost all the staff they talked with had been through some form of training since joining CDS. Senior staff are learning about accounting, junior staff studied family planning, AIDS, counseling techniques...Most of the training is conducted or coordinated by INHSAC. The school has also undergone a lot of change in the past three years and appears to be in a much better positions to serve the needs of CDS. Curricula have been developed in modular forms and training of lower level workers is now happening in the field thus permitting to train more people in a more cost-effective manner.

Another important component to the administrative success of CDS is that everybody is accountable for their work and supervision is not an empty concept. The community outreach program success rests on intensive supervision of the Col-Vols and supervision of the supervisors by the local community health coordinator and the Port-au-Prince technical coordinator for community health services. When a problem is encountered at one of the facilities a team is sent out to diagnose and solve the problem. However, there is a price attached to this success. Overall, by the end of Year 3, CDS employs 77 percent more persons with EUHS project funds than planned in the PP. Including La Saline, 1883 persons are actually employed versus 1064 planned. Actual EUHS-supported personnel expenditures for Year Three (July 91 - June 92) are US $2,118,442 (based upon an exchange rate of 7.5 Gourdes = US $1). This is compared to US $1,608,642 (exchange rate: 5 Gourdes = US $1) projected personnel costs in the PP for the same period. This is approximately 32 percent over budget. The devaluation of the Gourde has allowed CDS to appear to overspend less if a constant exchange rate of 5 Gourdes = US $1 CDS had continued CDS would have overspent its personnel budget for Year 3 by 97.5 percent. It appears that the true personnel costs associated with the current levels of services offered by CDS is close to double the estimates found in the PP.

Year 3 personnel costs overspending of US $509,840) was in fact greater than the entire US $385,173 Year 3 cost overrun experienced by the whole project (total Year 3 actual expenditures were US $2,362,010 versus US $1,976,837 budgeted). Actual Year 3 expenditures for other categories were below PP budget estimates. Table 9 shows personnel budget and actual expenditures. The effects of this overspending are discussed further in the section on financial sustainability below.

Table 9: EUHS Personnel Budgets and Expenditures

Year	Personnel Budget[1]	Personnel .. Expenditures	Difference - under, + over
Year 1	$1,691,136	$1,510,999	- $180,137
Year 2	$1,839,048	$1,959,492	+ $120,444
Year 3	$1,608,642	$2,118,442	+ $509,800
Year 4	$1,630,806	$2,356,242[2]	+ $725,436
Year 5	$1,649,220	$2,499,105[2]	+ $849,885
Total	$8,418,852[3]	$10,444,280	+$2,025,428

1. Includes personnel costs for La Saline
2. Based on calculations provided by CDS. Includes a 5% salary increase between Y3 and Y4.
3. The yearly personnel figures by facility/program do not add up to the total personnel figure given of the summary budget of the project paper

This projected shortfall could become even larger if CDS needs to increases salaries more than we have projected during the last two years of the project. The PP included a two percent per annum salary increases for CDS employees, so far, CDS has not raised salaries. Many employees interviewed by the evaluation team raised the issues of salary as a major concern especially with recent increased inflation. CDS needs to address this issue soon. The evaluation team asked CDS to provide projections for the Year 4 and 5 salaries shown in Table 9 above that would include a five percent salary increase between Years 3 and 4. In its own projections CDS estimates that it is currently overspending at a rate that will create a shortfall ranging between US $1.3 million and US $2 million by PACD depending on the future rate of exchange for the Gourde. CDS projections are lower than the evaluation team calculations shown in Table 9 above in which we project a shortfall of US $2,025,428 for personnel costs alone.

G. MANAGEMENT INFORMATION SYSTEM AND EVALUATION

The information system employed by CDS is designed for several functions and to provide information for a variety of purposes. The system supplies the following type of information:

- Information on individual patient/client
- Information for supervision and management of activities
- Information to monitor and evaluate programs and facilities operations and decision making
- Information for accounting and financial management.

In general, the system works extremely well in providing information of the first two types. It is rare to see a medical records system in a developing country as detailed and well maintained as the one in use by CDS. The system appears, in almost all cases, to be capable of matching

arriving patients with their records (a great many systems do not even try this, and facilities keep no patient records whatsoever). The evaluation team did note a few errors or oversights in a sample of records but, in all cases, staff were able to reconstruct the correct information once the error was identified. Most of the errors resulted from families moving from one part of the project area to another. Continued supervision of record-keeping personnel (archivists) is essential to maintain the level of accuracy currently in evidence.

The record keeping system employed by Col-Vols functions extremely well. They allow Col-Vols to identify families and individuals that are due to receive preventive services. The Col-Vols use the system to document their efforts to visit the family or individual and encourage the patient to visit the center for the required services. Supervisors are able to quickly and completely assess and monitor the activities of their Col-Vols by examining these records.

Maintenance of the system and the number of files, records and forms that it requires is not without cost. Facilities employ personnel assigned to maintaining the information system. Their dedication is obvious and admirable. The operation of this level of the CDS information systems is, no doubt, an important factor in the overall success of the community outreach program and the levels of health and prevention coverage achieved.

The ability of the system to produce the information required to monitor and evaluate operations is less impressive. At the time of the evaluation (late June 1992) the annual report for calendar year 1991 had still not been finalized. The computerized systems in place do not yet seem to be able to produce either this type of routine reporting or periodic requests for specific information. The evaluation team requested basic service delivery data based on the deliverable described in the logical framework of the project paper; this request was filled on the last day of their visit and not without great difficulty and efforts.

This aspect of the information system suffers from a lack of dedicated personnel and the absence of a clear internal evaluation strategy. The evaluation unit consists of a single person who, although well trained (MD from Haiti plus M.P.H. from the University of Miami), is relatively inexperienced in the design of information systems of this type. The unit is relatively new and the evaluation coordinator has been with CDS for about 8 months. The unit does not appear to have plans to carry out periodic surveys and small studies to complement information generated by the basic service statistics system. In fact there may be a need to discuss with the evaluation coordinator the line between supervision and evaluation and how the two responsibilities work jointly to improve project activities.

The evaluation unit does not appear to have a fully developed vision of the final information system needed. The system is being constructed in bits and pieces and is not integrated. Many operations that could easily be carried out by an integrated system are still performed by hand. The system does not appear to rest on well developed indicators of performance that go beyond simple totals of services delivered. There is no attempt to draw links between separate components of the system, such as Col-Vol visits/coverage and number of family planning acceptors.

The evaluation unit will need technical assistance if CDS is to design and implement a suitable system in sufficient time to be of use to project operations by PACD. The evaluation unit could study examples of health information systems developed elsewhere and adapt them to the needs

of CDS. The evaluation team suggests that Tulane University be requested to send a demonstration version of the national health statistics information system developed in Niger to be studied by the CDS evaluation unit.

CDS needs to devote additional thought to the design of its reporting system. First, there is a need to define the information most needed for management purposes and to monitor the quantity and quality of health services provided. Not all information for monitoring and evaluation needs to be produced through routine data collection and service statistics. Many indicators may best be studied using periodic surveys, either of patient records or through population based studies. Record keeping is expensive and key indicators of performance and/or impact required by managers should be the object of intensive discussions that include USAID and all the technical coordinators at CDS. Some attention should be paid to the indicators of the logical framework and if they are deemed unsuitable, in agreement with USAID, new indicators should be identified.

Discussions with CDS personnel indicate that a new financial reporting and accounting system will be installed as of July 1992. At the time of the evaluation, therefore, systems were essentially unchanged from those in operation in July 1991. At that time Setzer and Cross documented a number of weaknesses and recommended some changes. It appears that the recommendations will be addressed in the new system. The evaluation team recommends that efforts to install and refine the new accounting and management information system be considered a top priority for CDS. CDS should seek outside technical assistance, if necessary.

H. CDS FINANCIAL MANAGEMENT AND PROGRESS TOWARDS ACHIEVING SUSTAINABILITY

1. CDS Financial Management

At the time of the evaluation, the CDS accounting system still suffers from an almost complete lack of standardization. All facilities keep their books and file reports in different and often confusing manners. The reports filed are for individual accounts (EUHS, user fee, etc.) and no facility prepares a true financial comprehensive report. Facilities do not develop or have comprehensive budgets. The only financial guidelines available are the budget EUHS allocations for each facility in the PP. These allocations are, however, often ignored when actual expenditures are made (one facility, Fort-Liberté, has virtually exhausted its entire five year EUHS allocation by the end of project Year 3). Most of the accounting staff interviewed drew no distinction between the EUHS allocations for a given facility and that facility's budget. It was never the intent of the EUHS project budget to cover all of the operating costs at CDS facilities.

At the central level accounts are not integrated and the CDS accounting department does not produce periodic reports of user fee revenues or expenditures made using those revenues. CDS still has no notion, beyond that contained in the report produced by Setzer and Cross, of the ability of its user fee systems to recover the costs intended. It does not even know the magnitude of those costs. Given the current economically precarious environment in which CDS continues to operate this would appear to be a serious weakness and must be corrected immediately.

CDS does not yet have an overall, comprehensive budget for either CDS as a whole or individual facilities that allows it to track all inputs and expenditures. CDS does not appear to adequately

track MSPP contribution in personnel, in-kind donations or user fee revenues. It does not know how much it spends on drugs. Financial records for Cité Soleil are not kept at CDS central offices and information on Cité Soleil operations is not easily accessed by CDS accounting or administrative personnel. It is truly remarkable that given all of these weaknesses, CDS continues to operate as well as it has until now. There is currently very little financial information available upon which to base routine or periodic management decisions let alone major decisions concerning expansion, etc.

Periodic surveys in the form of external audits should play an important role in the financial information system operated by CDS. Periodic surveys are intended to provide information that may not change frequently or is too costly to collect on a routine basis. The EUHS PP provides for annual audits of CDS's accounting systems. This has not been done to date. CDS senior management indicated that a Scope of Work for the first audit has been written in collaboration with the Controller's Office at USAID/Port-au-Prince. Tenders have been offered. CDS must be encouraged to carry out this audit as quickly as possible. It must attach the highest importance to the recommendations made by the audit team. CDS should plan to conduct audits on an annual basis.

Important progress has been made by the accounting staff at many of the facilities visited. Record keeping and accounting systems have been improved, mostly through the efforts of individuals. Ouanaminthe suffers from major accounting problems due to the loss of over US $20,000 in user fee revenues and all accounting documents in a theft last year. It may become necessary to write off many of Ouanaminthe's outstanding, and unaccounted for, debts and accounts as "bad debt".

CDS accounting staff at the central level have made progress in the computerization of many of their operations. Monthly payroll records are now computerized as are all EUHS accounts for all facilities. These efforts are to be encouraged and should be integrated into the overall financial management system that will serve the new accounting system. The evaluation team noted that there was an apparent lack of coordination and collaboration between the central accounting and administrative offices. CDS management must address this problem and seek to build the necessary team atmosphere between these important units.

2. CDS Financial Self-Sufficiency

Financial management and financial sustainability are linked. All discussions of CDS financial management system and sustainability must be undertaken against the backdrop of the deteriorating economic situation in Haïti. The OAS sanctioned trade embargo has produced an economic crisis in the country that is effecting CDS' ability to deliver health services and makes it difficult for the population to contribute financially to their own health maintenance. This situation was not anticipated at the time the project was developed. As stated in the logical framework, CDS' ability to progress toward financial self- sufficiency was dependent on political and economic stability in Haïti.

The inflation associated with the embargo is having a major impact on the cost of drugs and other medical supplies. Even before the imposition of the embargo, the rate of inflation was estimated to be 30 percent for the first six months of 1991. The PP projected drug price inflation rates of six percent per year. The price of ampicillin rose 89 percent between June 1990 and April 1992.

Dextrose IV solution prices rose 83% during the same period. CDS staff reported that many drug shortages at the facility level have been due to shortages experienced by local suppliers.

As part of the United States' reaction to the September 1991 coup, USAID notified CDS that it would suspend reimbursement for non-personnel operating costs. Facilities have reduced expenditures to cover only major operating costs. They have been using their user fee account to cover these costs. This has strained those accounts during a period of high inflation. It has reduced the funds available for the replenishment of drug stocks at the facility level. In the short run this probably means that some of CDS patients do not receive all of the drugs required for adequate treatment. In the short run enormous stress is placed on facilities' revolving drug funds that were insufficiently capitalized to begin with.

The general economic decline has an adverse effect on the ability of many patients to pay CDS user fees. At a time when all indications would dictate fee increases the population has become less able to pay even current fees. All CDS personnel interviewed indicated that the populations served by CDS could not, at present, support even modest fee increases.

Ultimately then, CDS' financial sustainability rests on its ability to forge a partnership between its many supporters to adequately cover the cost of its operations. Currently, the partnership is heavily dependant upon USAID/Haïti and one of the objectives of the EUHS project was to reduce the overall percentage of CDS operations funded by A.I.D (from 59 to 56 percent over the life of the project). The current economic crisis in Haïti is making it extremely difficult to achieve this objective.

CDS does an admirable job of fund raising from a wide range of sources. It does not do an adequate job, however, of documenting all of the many inputs it receives. It is currently nearly impossible to develop a comprehensive picture of the total cost of CDS operations. CDS administration has recently developed a comprehensive picture of its many funding sources (in Gourdes). There is however, no accounting for MSPP contributions for personnel, user fee revenues or in-kind donations of drugs and medical supplies. CDS indicates that for the coming year it receives the inputs presented below in table 10.

Although CDS does not estimate the value of user fee revenues that may be generated, FY91 revenues were 2,843,259 Gourdes (or an additional 8.1 percent based on the total shown above). The EUHS project PP anticipated that user fee revenues would increase from 10 to 15 percent of CDS operating costs over the life of the project. It must be remembered that the operating costs referred to by the EUHS project PP represent an unknown percentage of the total cost of operation of all CDS activities.

The MSPP personnel contribution must not be ignored. The PP anticipated that the MSPP would contribute about 2,897,377 Gourdes (based upon an exchange rate of 7.5 Gourdes = US $1 of the US $386,317 budgeted for the year 4). This represents an additional 8.2 percent of the overall estimated costs.

There have been questions as to whether the MSPP is actually keeping its end of the bargain and provides CDS with the promised numbers and types of personnel. In bilateral projects signed by host country governments clearly define local government contributions. The EUHS project budget is only an estimate of anticipated support from the MSPP. CDS payroll data from a

sample of facilities (Fort-Liberté, Ka-Soleil, Raboteau, Ouanaminthe, CDS Administration and La Fossette) show that the MSPP is currently providing less support for CDS personnel costs than anticipated in the PP.

Table 10: Sources (incomplete) of CDS Support July 1992 - June 1993

Source	Amount (Gdes)	Percent
USAID (EUHS)	20,136,540	57.2%
Plan de Parrainage	1,863,977	5.3%
TB 1	179,518	.5%
TB 2	3,324,032	9.4%
NIH	846,168	2.4%
Macy	805,627	2.3%
FHI	465,531	1.3%
AOPS	46,556	.1%
WHO/TB	140,194	.4%
WHO/BF	191,250	.5%
CECI	524,895	1.5%
BID	5,107,143	14.5%
Plan Marché	1,050,000	3%
IPPF	517,185	1.5%
Total	35,198,616	99.9%

The MSPP dollar contribution for Year 3 to personnel costs at the facilities cited above converted to Gourdes at the rate of 7.5 Gourdes = US $1 (this rate is chosen since CDS converted dollar resources to Gourdes at this rate during Year 3) is estimated at 2,050,470 Gourdes. CDS payroll information for May 1992 showed that the actual MSPP contribution was 147,250 Gourdes. If MSPP support to these facilities were constant throughout the year, it would represent annual support of 1,707,000 Gourdes. This amount is approximately 17 percent lower than budgeted. CDS may wishes to reopen discussions with the MSPP concerning the levels of support provided as soon as possible.

There are no data or estimates of the value of in-kind donations of drugs and medical supplies. Since the start of the embargo, these donations have been limited. CDS staff reports that at the time of the evaluation two containers of supplies were "en route". These are the first donations received since the start of the embargo. It is impossible to estimate the percentage of total operating costs represented by donations but anecdotal evidence indicates that they may represent

between 10 and 20 percent of total CDS drug expenditures.

Using available data it may be possible to estimate total CDS operating costs for July 1992 - June 1993 as 40,939,252 Gourdes (plus drug donations). Using this estimate, USAID/Haïti represents 49.2% of total operating costs. If the assumptions used are valid (user fee revenues equal to 90-91 levels, MSPP contribution maintained at current levels), it would appear that CDS is making significant progress towards overall financial sustainability.

Given the difficulty described above in estimating the total cost of CDS operations it is difficult to attempt to estimate the average cost of services. Services delivered are a mix of both in-patient and out-patient. Recent data (1991) on the number of patient visits of each type of service were not available to the evaluation team. Setzer and Cross did estimate the average cost of out-patient services at several facilities by dividing total expenditures by number of out-patient visits.

It must be remembered that the total operating budget estimated above includes a significant research component that may inflate the average cost of services or per family or community member covered.

Dividing the estimated total operating cost of CDS as indicated above (40,939,252 Gourdes not including in-kind donations) it is possible to roughly calculate the cost of coverage of the target communities. If a target population of 500,000 is used, the average cost per person is calculated to be 81.88 Gourdes. Exchange rates of 7.5 and 9.5 Gourdes to one US dollar produce estimates of between US $10.92 and US $ 8.62 per person respectively. This figure of course is lower for higher estimates of the CDS target population. Using a population of 610,000 persons the average cost per person covered becomes 67.11 Gourdes or between US $7.06 and US $ 8.95.

Table 11: Average Monthly User Fee Revenues at Selected CDS facilities

Site	Project Year 2[2]	Project Year 3
Fort-Liberté	21,593 Gdes	16,978 Gdes
La Saline	22,301 Gdes	28,959 Gdes
La Fossette	37,412 Gdes	29,369 Gdes
Raboteau	18,573 Gdes	22,036 Gdes
Ka-Soleil	9,303 Gdes	11,342 Gdes
Overall	22,256 Gdes	21,824 Gdes

As indicated above, and by Setzer and Cross, user fees collected at CDS facilities continue to make a significant contribution to financing service delivery. Complete data on user fee revenues for project Year 3 were not available to the evaluation team. Available data suggest that user fees continue to generate revenues in excess of drug purchases at most facilities. Slightly lower

[2] Setzer and Cross, 1992

monthly revenues during Year 3 of the project as compared to Year 2 at several of the facilities may be due to a greater number of exemptions being granted or reduced patient loads. Both reasons may be explained, in part, to the general economic crisis in Haïti.

The accounting systems make it impossible to accurately estimate the cost of out-patient and in-patient services at those facilities which offer both. This problem is well documented by Setzer and Cross. While this information is not necessary on a continual basis and therefore need not be included in routine data collection and reporting systems, it would be beneficial for CDS to carry out periodic studies of the cost of services. Such studies are essential in making decisions on future fee changes.

No CDS facility has raised its user fees during the last year. CDS personnel unanimously indicated that the current economic hardships caused by the embargo and the resultant loss of purchasing power of the average Haïtian have created an environment where fee increases would result in significant drops in the utilization of services. Personnel felt that many of CDS' current patients could not support an increase of even one Gourde in the consultation or pharmacy fees charged by facilities. Current user fees and charges are well documented in Appendix 4 of Setzer and Cross. Available data indicate that facilities continue to generate revenues in excess of drug expenditures.

3. Technical Sustainability

CDS model of community health for Haïti's urban poor appears well developed and highly sustainable from a technical standpoint. CDS has achieved impressive levels of coverage for its preventive services and in several areas is the only available source of primary curative care.

The urban model works well in Port-au-Prince (Cité Soleil, La Saline), Gonaïves (Ka-Soleil, Raboteau) and Cap-Haïtien (La Fossette). These are large urban areas and the catchment areas for the services that these facilities deliver appear to go well beyond the registered communities. In all of these areas there are other health facilities that provide backup secondary and tertiary care to the package of primary care services offered.

In Ouanaminthe and Fort-Liberté the EUHS model is undergoing modification to respond to the peri-urban and rural nature of these two areas. One modification of the model has meant that CDS must provide secondary and tertiary care in support of its primary care package. One of the implications of this modification on the cost of service delivery (increased personnel costs) has been discussed above. CDS should document all cost implications of any change in the model in order to assess the relative cost of service delivery.

4. Human Resources Sustainability

CDS has made significant strides in improving the sustainability of its operations from the standpoint of human resources. This has been due to an extensive program of training for personnel at all levels; impressive levels of supervision of field personnel; and the building of a true central level technical/administrative team. The evaluation team feels that these efforts have been highly successful and that CDS now has a management team that is of high quality and field personnel who deliver high quality services under admittedly difficult conditions.

Efforts to strengthen and reinforce the quality and capacity of the team must, however, be continued. Recent in-service training programs for central level personnel in management and accounting are encouraging signs in this direction.

III. CONCLUSIONS AND RECOMMENDATIONS

1. Conclusion: Consolidation

In the third year of the EUHS, CDS has made extensive progress toward its objectives and appears to be headed toward surpassing project service delivery targets. In the Project Paper it was anticipated that by the PACD 450,000 persons would be reached by project interventions. This was increased to 510,000 with the inclusion of La Saline. To date nearly 523,000 persons are enrolled in community outreach programs and a significant number of services are provided to persons who are not enrolled in the community outreach programs through CDS out-patient and in-patient care facilities.

Coverage varies by service and community but the indicators are clearly headed towards achieving and even surpassing all project targets. These progresses have been achieved despite political disruptions, economic hardships, country-wide shortages of vaccines and depo-provera and the ever-mounting AIDS epidemic.

> **Recommendation**: In light of the current economic and socio-political situation in Haïti, CDS needs to protect its accomplishments and should approach future expansion cautiously. Efforts should focus on consolidating services in existing sites and on trying to achieve the highest service delivery targets possible with vaccination, child survival, nutrition, diarrhea prevention and control, family planning, AIDS/STD prevention and control... as the country hopefully emerges out of the economic and political crisis.

2. Conclusion: Expansion

CDS is a very active, dynamic and growth-oriented organization, headed by an entrepreneurial team. On the one side, CDS growth is fueled by the need of the Haïtian population who lobby CDS intensely to provide services to their communities. On the other side CDS' constant exploration of avenues for fund diversification to achieve sustainability provides opportunities for growth in many areas. This creates a dynamic environment but has a tendency to stir the organization towards opportunistic moves.

> **Recommendation**: To continue to balance its growth CDS needs to develop a 5 year plan and develop long range strategies for its expansion. This exercise should be accompanied by a comprehensive budget planning process irrespective of the expected sources of funds. The next step will be to fund raise with this plan in hand.
>
> Successful diversified fund-raising has been a key element of CDS' achievements; as the agency grows the president will undoubtedly include his core team in the enormous task of fund raising for CDS projects. Rational planning of CDS' expansion will facilitate the team's work.

3. Conclusion: CDS Community health model

The CDS intervention model was developed for an urban setting. In developing the community

outreach programs in Fort-Liberté, Ouanaminthe and Mont-Organisé, CDS has been faced with the need to adapt the urban model to a rural setting to serve the peri-urban and rural populations of these "communes". The staff projections made for Ouanaminthe and Fort-Liberté were based on CDS experience in Cité Soleil and Gonaïves. They are clearly insufficient in rural settings if the same level of services is to be achieved. More Col-Vols are needed to cover peri-urban/rural populations dispersed over difficult terrain. Also, more supervisors are needed to monitor their work. Rural settings also mandate a different organization of the outreach PHC services. The extension of services through "Postes de Rassemblements" and community-based dispensaries appears to be an appropriate and cost effective modification of the urban model. More vehicles and gasoline are needed in rural areas. In addition, in the Fort-Liberté and Ouanaminthe locations, CDS has had no choice but to provide the community with some clinic-based, curative in-patient services since such services are very much needed and are not available at any other facility within reach of the population.

Recommendations: CDS should conduct an operation research study to identify the best way to adapt the urban model to rural settings, using Ouanaminthe, Fort-Liberté and Mont-Organisé to test various modifications.

More Col-Vols should be added at Ouanaminthe and Fort-Liberté to make sure that each family is contacted at least every other month. An appropriate supervisory plan needs to be developed to make sure that the work of the rural Col-Vols is monitored with the same intensity as in the urban settings. Transportation solutions for supervisors should be identified (subsidized bicycles purchases may be?).

4. Conclusion: In-patient currative services

The availability of some clinic-based, in-patient, curative services is a key component of the community outreach model. Members of a community are much more likely to use preventive services when their needs for curative services are also met. In the CDS sites in Port-au-Prince, Gonaïves and Cap-Haïtien in-patient, curative services are available at either CDS or through MSPP sites. In Fort-Liberté and in Ouanaminthe the only source of curative services for miles around is through CDS. Despite the cost of these services and USAID's reluctance to underwrite them they are extremely important to maintain the population's confidence level in CDS' commitment to their welfare. Clearly, a careful check needs to be maintained to avoid the Ouanaminthe and Fort-Liberté facilities becoming far-reaching reference curative in-patient centers subsidized by CDS, but a modest amount of appropriate in-patient curative services enhances the outreach programs.

Recommendation: CDS should vigorously pursue its negotiations with Plan International to study how Plan can increase its support to CDS and include Fort-Liberté and Ouanaminthe in a scheme similar to that operating in Cité Soleil.

In preparation for these negotiations CDS needs to conduct a comprehensive budgeting exercise for these facilities, and reflect on the ideal mix of curative/preventive, in-patient/out-patient services.

5. Conclusion: Quality of servccies

Over the last three years CDS has placed a lot of emphasis on meeting project service delivery objectives, and on providing a lot of services at low cost. Physicians have large patient loads and this affects the overall quality of services provided. CDS' Technical Director has recently initiated a program to improve the quality of services. This effort includes the development of patient management protocols and of essential drug lists to improve treatment modicum, facilitate staff work, and streamline patient management and treatment costs. Physicians' bedside manners with patients are often brusque and rushed. While this is sometimes understandable considering patient case loads it is regrettable because it projects an image of CDS physicians as uncaring and depersonalizes the physician/community member interaction that the CDS community outreach program is intended to improve.

> **Recommendation**: CDS should explore more extensive uses of nurses and auxiliaries where physicians are currently used (triage and other appropriate simple medical acts). This should free up some physician time that can then be devoted to improving patient/physician interaction.
>
> CDS Physicians should receive continued training to enhance their sensitivity to patients' emotional needs and teach them how to empower patients through counseling.

6. Conclusion: Family planning

In the project paper and according to the original project design, CDS received funding for family planning activities at the Ouanaminthe, Fort-Liberté and Cap-Haïtien sites for only the first two years of the EUHS project. Family planning activities in Cité Soleil and Gonaïves are funded through the Private Sector Family Planning Project. CDS is a direct subgrantee for Cité Soleil activities, and is an indirect subgrantee, through AOPS, for the program in Gonaïves.

It was planned that all CDS family planning activities after 1991 would be picked up by a "new" family planning initiative. This project has been delayed indefinitely. When USAID funding stopped in the fall of 1991, and CDS funding was not picked up by the PSFPP, CDS had to discontinue the community outreach family planning program at the three northern sites but, it continued providing clinic-based services through the tenacity of the CDS FP coordinator. To date no family planning services are available at La Saline although the clinic of Dr Adeline Verly is easily accessible to the population of La Saline.

In addition to the discontinuation of the community outreach services in the Northern sites, the entire program has experienced a shortage of Depo-Provera from April to September 1991. Despite these extremely disruptive events, family planning services have continued and the demand is resuming growth.

> **Recommendation**: USAID needs to continue support for CDS' family planning activities because CDS has demonstrated that it can generate a large number of CYP at reasonable cost and with a relatively low management burden to USAID. It would also be beneficial if USAID could consolidate CDS' funding sources for family planning activities. This would lighten the administrative burden of CDS, USAID, IPPF/WH/PAPFO and AOPS.

With approximately $250,000 to $300,000 per annum CDS could continue serving the same populations and add services at La Saline.

7. Conclusion: AIDS

Under EUHS, CDS received approximately $140,000 to conduct AIDS/STD prevention and control activities for the first two years of the project. This amount was expected to cover clinic renovations, staff time, staff training, supervision, and program evaluation in Fort-Liberté, Ouanaminthe and Cap-Haïtien. AIDS prevention and control activities in Gonaïves and Port-au-Prince were financed through other mechanisms. The accomplishments of this element of CDS' program are very modest and somewhat disappointing considering the importance of the problem in Cap-Haïtien in particular. The few people who had been trained were furloughed in the fall of 91 and since then the program has been in a state of suspension waiting for continued funding through AIDSTECH/AIDSCAP. Of all the interventions conducted by CDS, this activity has been the most affected by the political situation of the end of 1991. The program was just starting and had not yet reached momentum when it was cut due to the change in funding mechanism. It has not yet resumed.

> **Recommendation**: CDS needs to work closely with the AIDSTECH/AIDSCAP team to revitalize this extremely important program. The CDS' AIDS/research coordinator needs to focus a lot of attention on developing intensive education programs in Cap-Haïtien, Cité Soleil and Gonaïves. If the AIDS/research coordinator is overloaded, CDS should consider either adding a communication specialist to develop the AIDS education program or separating the two functions and having an AIDs prevention coordinator. The AIDS/research coordinator recommends designating a person at each location who will be responsible for the AIDS prevention and education program. This is a desirable move.

8. Conclusion: Drugs

Many CDS facilities have experienced repeated drug shortages during the past year. Facilities never received an initial, revolving stock of essential drugs at the time that user fees were implemented. Most facilities keep only limited stocks on hand due to financial and storage constraints. Facilities are required to make frequent and small orders from local suppliers in Port-au-Prince. CDS does not gain economies of scale by grouping its drug purchases.

Many of these shortages could be reduced or eliminated through improved procurement, distribution and drug management systems at both CDS central and individual facilities. Efforts are underway, in collaboration with PAHO, to establish a steady supply of low cost generic, essential drugs.

> **Recommendation**: CDS must continue efforts to reorganize its central Purchasing Department in collaboration with PAHO's central drug supply project. These efforts should include the integration of in-kind donations of drugs into a comprehensive warehouse and procurement system. CDS should seek technical assistance in the design of this system and the training or personnel that must accompany its implementation. It must implement accounting and procurement recommendations outlined by the COGESA

report. CDS should accurately estimate the value of drugs required to fully capitalize the system. It should continue to seek funds for such a one time infusion of drugs into the system. Efforts to define an essential drug list for use by CDS facilities and improve drug utilization by clinical staff should be continued and encouraged.

9. Conclusion: HRD

Funding for HRD activities was limited to the first two years of EUHS, at Cité Soleil. An evaluation of the program revealed that, despite many shortcomings, the HRD program is cost efficient and deserves continued USAID support. While there is undeniably much room for improvement to the program, it is clearly serving a much needed function in the community.

In recent months A.I.D has increased its interest in the linkages between literacy and empowerment of people to modify health related behaviors. UNICEF has recently issued a report on the effect of primary schooling on family planning and health.

> **Recommendation**: Under the Humanitarian Assistance Plan and in view of the recent thought process on literacy, USAID should revisit its decision to terminate the funding of HRD activities at Cité Soleil.

10. Conclusion: CDS administration

Over the last three years CDS has matured a great deal as an organization. Most of the organizational adjustments suggested in the project paper have been put in place or are scheduled for implementation. CDS has decentralized decision making and financial management. Almost all the staff of CDS have been through some form of training over the last three years to improve both technical and management skills.

Although extensive planning of staff needs to manage CDS' took place during project design, as implementation proceeded, additional needs have been identified. The original staff estimation are no longer valid. Currently CDS has over 1800 employees. A comprehensive program is underway to develop a personnel management filing system. All the employees interviewed by the evaluation team clearly knew their job description, and in most cases had received a written copy describing their function. They knew their supervisors and although they had not always been through a formal performance evaluation they reported that their supervisors kept in close contact with their work and dealt with problems as needed. According to casual reports absenteeism is low, motivation and loyalty to CDS is high. The central offices at CDS are fully occupied with no space to spare. Additional crowding may prove disruptive. The team did not identify unnecessary positions but in several cases found people assigned to too many tasks or supervising too many people.
The evaluation team found that the MSPP did not meet its agreement to provide CDS with appropriate staff in the facilities that it released to CDS to operate.

> **Recommendation:** Budget and facilities limitations may not permit increases in the number of full time staff. However, CDS needs to conduct an assessment of staff needs above and beyond those already in place to serve a population that is larger than

anticipated in the localities served by the project. CDS and USAID should revisit their salary increase policy in view of the mounting inflation of the last few months and make plans for the last two years of the project.

CDS should actively lobby the MSPP to live up to its contract/commitment regarding staff seconded to CDS. The best solution would be for CDS to obtain money for the positions that the MSPP cannot fill at a given location.

CDS management should rely more on short term technical assistance local or otherwise, to speed up the development of programs and tools it needs.

11. Conclusion: CDS internal evaluation

The Evaluation Division of CDS is still developing and evaluation activities are just starting. CDS collects good and useful data and the data generated is used for planning and supervision. The MIS is still weak and needs work to become even more useful to CDS decision makers and supervisors.

Recommendation: The Evaluation Division needs to be strengthened. The staff of the evaluation division should add the following skills to those of the existing coordinator: a part/full time programmer, a part/full time epidemiologist, a project assistant and a data entry clerk.

CDS should retain some technical assistance to develop a program evaluation strategy and implementation plan, and to work closely with the evaluation coordinator until the MIS has been refined and can produce print-outs of the key indicators by site according to logical framework specifications.

The existing MIS needs to be further developed and should be able to deliver the indicators described in the logical framework of the project.

Data should be given back to the sites to facilitate supervision and planning.

Plans should be made for end-of-project impact evaluation.

12. Conclusion: CDS financial management

Financial management and planning at CDS continue to suffer from the lack of an adequate accounting and financial information system. Efforts to adopt new, standardized accounting and reporting procedures at all facilities appear on track.

Recommendation: Continued emphasis must be placed on the development and implementation of improved, standardized accounting systems. CDS must implement plans for regular internal audit and place high priority on implementation of audit recommendations.

13. Conclusion: IEC

IEC material support is not very strong. While the communications skills and experience of the persons who conduct health education activities are adequate, education sessions are often less than optimal because of noise, overcrowded conditions and the absence of visual aids.

> **Recommendation:** CDS needs to create a communications coordinator position. CDS should use technical assistance to develop communication strategies and implementation plans for all of CDS' activities. Educational sessions should be adapted to compensate for the limitations of some settings. Materials should be developed with existing technical resources at INHSAC.

14. Conclusion: Sustainability

CDS gets good marks on progressing toward achieving sustainability. CDS is a stronger institution than it was at the beginning of the project. The urban intervention model has been refined and successfully replicated outside of Cité Soleil and CDS is well on its way to adapting its urban model to a rural setting. CDS staff are being trained. CDS has made substantial progress toward developing its user fees program and until the political events of late 1991, was recovering costs more or less according to the schedule specified in the project paper. While the policy environment of CDS has not changed dramatically, and while CDS still has a good relationship with the MSPP, the ministry has not really lived up to its contract with CDS to provide/replace staff. This has created tensions and forced CDS to hire personnel that they thought would be provided by the MSPP.

> **Recommendation:** The events of the last few months are slowing CDS' progress towards financial self-sufficiency and USAID should take the extenuating circumstances into consideration.

15. Conclusion: Humanitarian food distribution

Given the economic situation of the country, and under the embargo, food distribution has taken on a new dimension in Haïti. Continued food supplementation is a must and has become a key element of the community outreach program. However, CDS is very concerned about not creating a dependency on the food program to promote health. CDS has developed an efficient and cost effective food distribution system. CDS would like to have its own food program.

> **Recommendation:** CDS provides health services for 10% of the Haïtian population and should receive a proportional amount of food and distribution overhead.

APPENDICES

MID-TERM EVALUATION OF THE EXPANDED URBAN HEALTH SERVICES PROJECT

SCOPE OF WORK

I. PURPOSE

This evaluation will be conducted to assess CDS' effectiveness in implementing the proposed activities and project impact under the Cooperative Agreement with USAID/Haiti, the Expanded Urban Health Project. This evaluation will focus on CDS's progress in the delivery of health services, training and technical assistance inputs, development of program information systems, management improvements and achievements in cost recovery. This evaluation will also examine AIDS and Family Planning components of the project.

II. BACKGROUND

The Expanded Urban Health Services project, authorized in June 1989, is a five-year $10.8 million project with five components: a) primary health care; b) family planning; c) AIDS prevention and control; d) human resources development; and e) institutional strengthening. Together, these components support an integrated primary health care program that has provided basic health services to residents of urban slums in Cité Soleil for two years. The project is also strengthening the ability of CDS to manage an expanded program and to increase the sustainability of the program.

III. EVALUATION

The evaluation will: (1) review the project's progress to date toward the planned outputs; (2) assess CDS effectiveness in (a) delivering primary health care and child survival services; (b) integrating family planning services in all program sites and; (c) incorporating AIDS education and prevention in the health activities. The evaluation will also review CDS efforts in strengthening and improving its management capacity.

The evaluation will begin o/a June 15, 1992 for a period of three (3) weeks. The evaluation team shall be composed of two key members, a team leader, public health specialist, and a financial management expert, as described below:

- a team leader with a bachelor's degree in health policy and administration, extensive experience in health and development fields, experience in the evaluation of health and family planning projects. Should speak French or Haitian Creole at the FSI-3 level, and should have experience in similar projects in Haiti or other developing countries.

- a financial management expert with expertise in the assessment of financial management procedures, demonstrated familiarity with PVO operations. Should speak French or Haitian Creole at the FSI-3 level and should have experience in similar projects in Haiti or other developing countries.

The USAID Health, Population and Nutrition Office will be available to provide needed background information. The team leader will be reponsible for assigning tasks and completing the final report.

IV. STATEMENT OF WORK

In conducting the evaluation, the team should assess CDS efforts in:

- replicating and expanding the Cité Soleil model in Gonaives, Cap-Haitien, La Saline, Ouanaminthe and Fort Liberté;

- delivering primary health care and child survival services including pre-natal and post-natal care, immunization, oral rehydration therapy, growth monitoring, and birth-spacing programs;

- establishing a network of community health workers and integrating health education in the activities;

- implementing family planning activities at all seven (7) sites including information, education and communication on child spacing and high risk births; provision of birth control methods; training of selected staff and community health workers in family planning;

- establishing AIDS education, counselling and prevention activities;

- implementing systems for efficient and effective organizational and financial management particularly, on the maintenance of information systems which ensure that CDS staff has timely access to data to make sound management decisions.

The evaluation will examine the progress to date toward the planned outputs, primarily in the area of:

- population and immunization coverage, ORT use, tuberculosis treatment and control, prenatal and post natal coverage, nutritional surveillance;

- contraceptive prevalence and family planning education among target population;

- implementation of AIDS epidemiology surveillance and prevention;

- design and implementation of management information system, financial information system, manual of administrative procedures, organizational structure and staffing suitable to program needs.

The team should also assess the accounting, personnel, organizational and information systems efficiency and functionality, to determine whether the objectives of the projects are being met and whether CDS is making progress towards becoming a sustainable institution.

V. METHODOLOGY AND PROCEDURES

The evaluation team will be required to perform on a 6-day work week including holidays, for a period of three weeks. However, the period may be longer depending on local conditions.

The evaluation team will use the evaluation techniques as stated in the AID Publications Evaluation Guidelines and the AID Evaluation Handbook. The evaluation shall examine the relationship between the inputs, outputs and purpose.

VI. REPORTING

The team leader will prepare a complete draft report (eight copies), based on the terms of the scope of work detailed above, for submission to USAID/Haiti Health Office at least 3 days prior to departure from the country.

The team leader will be required to include in the final report the evaluation team's findings, conclusions and recommendations based on evidence and their judgement. The report should distinguish clearly between the team's findings, conclusions and recommendations. The final report shall be prepared in English (5 copies) and French (10 copies), and be submitted to USAID no later than two weeks after receipt of USAID/CDS comments for the English version, and no later than one month, for the French version.

The required format for the evaluation report is as follows:

- Executive summary (no more than three pages, single spaced)

- Project Identification Data Sheet

- Table of Contents

- Body of the report: The report should include a description of the country context in which the project was developed and carried out and provide the information (evidence and analysis) on which the conclusions and recommendations are based. The body of the report should not be more than 70 pages. The report should end with a full statement of conclusions and recommendations. Conclusions should be short and succint, with the topic identified by a short subheading relating to the questions and issues posed in the Statement of Work. Recommendations should correspond to the conclusions.

- Appendices should include the evaluation scope of work, a description of the methodology used in the evaluation, a bibliography of documents consulted, a list of organizations visited and people interviewed.

The evaluator will also draft the abstract for the AID Evaluation Summary.

VII. DEBRIEFING

The evaluator shall debrief USAID staff members as identified by the HPN office at least two days before departure from Haiti.

VIII. FUNDING

The evaluation team will be contracted directly by CDS since funds have already been obligated to the project for that purpose.

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Appendix A

LIST OF DOCUMENTS CONSULTED

Project Paper for Haiti Expanded Urban Health Services. USAID, June 1989.

La Saline Project Amendment Description. PIO/T 521-0218-3-00176.

A Study of User Fees at CDS Facilities in Haiti. James C. Setzer and Glendon Cross, Abt Associates Inc., March 1992.

Financial Review of the Complexe Medixo-Socail de Cité-Soleil. Holly Wong and Marty Maniken, Abt Associates Inc., October 1988.

INHSAC'S Evaluation. Glen Bouchard andGinette Desse-Prosper, July 1989.

Project Evaluation Urban Health and Community Development II, Extended Community Health and Family Planning, and Community Health Outreach. Polly Harrison, Catherine Overholt and Maggie Huff, PRITECH. April, 1986.

Rapport Technique. CDS for USAID, Janvier-Décembre, 1989.

Rapport Technique. CDS for USAID, Janvier-Décembre, 1990.

Draft Rapport Technique. CDS for USAID, Janvier-Décembre, 1991.

Rapport d'Activités des CDS- 1991. CDS for the Evaluation team, June 1992.

Evaluation of the Human Resources Development Component of the Expanded Urban Health Services Project. Gary Russel for USAID. August, 1991.

Enquête Nationale Haitienne sur la Contraception- 1989. Rapport Final. Institut National de l'Enfance/CDC. September, 1991.

Recensement de la Commune de Mont-Organisé. CDS, 23 Avril-6 Juillet, 1990.

Best Available Copy

Appendix B

CONTACT LIST

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David Eckerson, Division Chief, HPN-USAID/Haiti.

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Frantz Modé, Directeur Exécutif Associé, CDS.

Serge Fernandez, Financial and Administrative Consultant, CDS.

Gilbert Saint-Jean, Director Evaluation and Statistics Unit, CDS.

xx Desormeau, Coordinator AIDS Activities, CDS.

xx Despagne, Coordinator Family Planning Acitivities, CDS.

Malcolm Donald, Consultant PSI.

Edy Génécé, AIDSTECH/FHI.

Audrey Sullivan, IPPF-WH/PAPFO.