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**End of Project Evaluation  
Matching Grant 1985-1988  
PDC-0703-G-SS-5040-00  
Haiti**

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**Submitted to  
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by

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This evaluation report was written by the two consultants, who are solely responsible for its contents. We sincerely thank the ADRA/Washington staff and the ADRA/Haiti staff for their tireless assistance, unflagging hospitality, and good cheer. Finally, we wish to recognize the many anonymous Haitian mothers whose patience and gracious candor we savor still.

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ABBREVIATIONS AND GLOSSARY

ADRA	Adventist Relief and Development Agency (formerly SAWS)
CDSS	Country Development Strategy Statement
CIDA	Canadian International Development Agency
CNG	National Governing Council
CRS	Catholic Relief Services
CS	Child Survival
CWS	Church World Service
EOP	End of Project
EPI	Expanded Program of Immunization
FFP	Food for Peace
FY	fiscal year
GNP	Gross National Product
GOH	Government of Haiti
MCH	Maternal Child Health
MGP	Matching Grant Program/Project
MOH	Ministry of Health
NGO	Non-government Organization
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PVC	USAID Office of Private and Voluntary Cooperation
PVO	Private Voluntary Organization
RDA	Recommended Daily Allowance
RHC	Road to Health Card
SAWS	Seventh-day Adventist World Service
SDA	Seventh-day Adventist Church

<b>SFP</b>	<b>Supplementary Feeding Program</b>
<b>USAID</b>	<b>AID Overseas Mission</b>
<b>USG</b>	<b>U. S. Government</b>
<b>WHO</b>	<b>World Health Organization</b>

## 1.0 Introduction to Haiti

The republic of Haiti occupies about 10,000 square miles of the western end of the mountainous Caribbean island of Hispaniola, while the Dominican Republic occupies the eastern 20,000 square miles. (See Figure 1, next page). Of Haiti's 10,000 square miles of territory, 80% is mountainous. Plains, plateaus and piedmonts are rare, found mostly in the north. Its population of 6.8 million is still 70% rural, engaging in small-scale cash cropping. The population density is greater than that of India.

More than four centuries of misuse of the fragile mountainous top-soil and over-cutting of the forest cover, coupled with uncontrolled subdivision of land, has left the rural Haitian family with little, though technically Haiti is still primarily an agrarian economy. The GNP per capita in 1987 was \$280, but only \$80 in the rural areas. Haiti has an adult literacy rate of only 40% for males and 35% for females.

For the masses of Haiti, the hold on life is tenuous. Life expectancy at birth is fifty-four years, the lowest for any country in the Western Hemisphere. With only 79% of the daily caloric requirements available per capita, it's small wonder that 65% of Haiti's children under five suffer from mild to moderate malnutrition. The infant mortality rate is 119/1,000 and for under fives 174/ 1,000. More than a third of these infant deaths under one year occur during the first month of life, due in part to a lack of adequate prenatal care for the pregnant woman.

The causes of death for Haitian children have changed little since colonial times. They are tetanus, diarrhea, and malnutrition. In recent years, measles, upper respiratory infections and low birth weight have been officially added to this list.

### 1.1 The Evaluation

#### 1.1.1 Purpose and Scope

The evaluation was to address five central questions:

1. To assess the degree to which project objectives were realistic and achieved.
2. To review the implementation process, with particular attention to organizational modifications which might improve management and extend field coverage.
3. To assess the overall development of ADRA's ability to plan and implement primary health care programs in various settings--hospitals, schools, clinics, communities--in collaboration with government services. This includes staff recruitment and training.
4. To identify constraints, both internal and external to the project, that have impeded effective implementation.
5. To examine the sustainability of the project.
6. To derive recommendations based on the lessons learned from the evaluation.

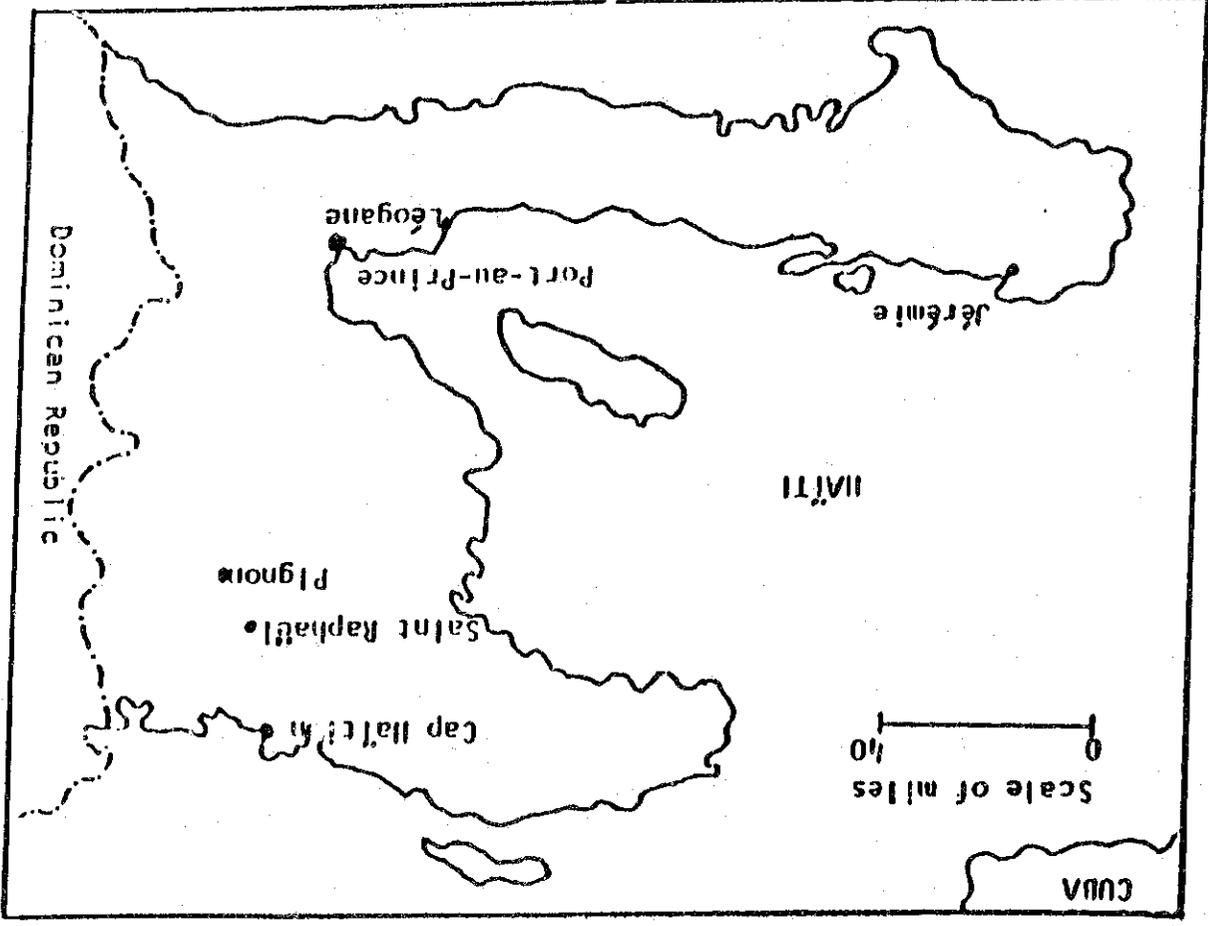


Figure 1 - HAÏTI

Figure 1  
Map of Haiti

Its scope was to be ADRA's Matching Grant Project activity, including its interface with the closely related activities of the Child Survival Project and FFP program.

### 1.1.2 Methodology

The evaluation process extended over four days of pre-trip discussion and preparation by Drs. Wiese and Whitehouse at ADRA/International headquarters in Takoma Park, Maryland, and eleven days of field work in Haiti. During the pre-trip work, much data was gathered using intensive record search of documents relevant to the ADRA/Haiti Matching Grant. Once in the field, the consultants gathered data by record search, small group discussions, observation, and individual interviews. (See Appendix A for list of individuals interviewed). All interviews were conducted in either French or Haitian Creole, unless the informant chose to speak English. The consultants and one other evaluation team member, Stella Brown, the ADRA/Haiti MCH Director, visited and interviewed recipient mothers at six of the program's rural centers (Petit Goave, Leogane, Pignon, Savanette de Pignon, San Raphael, and Carp Coq), as well as the center right at Di-quin. (See Appendix B for narrative of daily activities).

In all phases of the data collection and discussion, there was enthusiastic cooperation by ADRA staff. The only apparent problems in data collection were: 1) in the area of financial administration of the project, as the ADRA controller, Fred Emmanuel, did not return to Haiti from a meeting in Martinique until Wednesday afternoon, July 28, so was only available for a brief period on Thursday morning, the 29th, the last day of field work; and, 2) in the area of ADRA/Haiti's interface with the ADRA board, as its president, Elder Napoleon Grunder, did not return to Haiti from Martinique until the afternoon of July 29th, after the departure of the evaluation consultants.

## 1.2 Historical Background

### 1.2.1 Regional Background

The Haitian government is well aware of the severe health problems afflicting its populace, but is virtually unable to effectively address them. Since the ouster of President Jean Claude Duvalier in February, 1986, Haiti has been the scene of political struggle. The interim government of General Namphy was followed by a brief transfer of power to President Manigat, winner of a highly publicized and violent public election in 1987. In spring of 1988, however, General Namphy overthrew Manigat and established a military dictatorship.

For the average Haitian, the net effect of this period of political turmoil has been the worsening of his plight. Foreign governments, USG in particular, alarmed by the violence and political instability, withdrew their financial aid to Haiti while discouraging U.S. travel there on November

29, 1987. Humanitarian aid was permitted to continue through non-governmental organizations. This has intensified the economic crisis of the country, even further limiting the Haitian government's ability to assist its citizenry in improving their lot. The percentage of the population below the absolute poverty level has gone from 55% in 1985 to 78% in 1988. As Dr. Antoine Augustin of the L'Institut de l'Enfance in Port-au-Prince points out, the entire annual budget of the Haitian Ministry of Public Health and Population is only about \$30 million. This is to serve six million people.

At this dismal impasse, attention focuses on the several major donor agencies which are participating in humanitarian aid to the Haitian people, AID, PAHO, UNICEF, and CIDA, to mention a few. It is through an AID matching grant that the Adventist Relief and Development Agency (ADRA) continues a program in Haiti. This matching grant program is the central object of this evaluation.

#### 1.2.2 ADRA's Experience in the Region

In 1976, SAWS (Seventh-day Adventists World Service - the former name of ADRA) became involved in relief work in northwestern Haiti in response to a severe regional drought. Though the SDA church had been active in Haiti for more than 100 years, this was their first organized relief effort. Their interest in this type of work increased. In March of 1981, SAWS submitted a matching grant proposal to the PVC office of AID for a health, nutrition and agricultural project in sixteen countries, one of these was Haiti. The proposal was approved for funding in October of 1981 for a three-year period, from FY 1981-1982 to FY 1983-1984.

The plan was to use the distribution of PL 480 Title II foods to encourage mothers with young children to come to village centers where education on nutrition, growth monitoring, and kitchen gardens would take place. In 1983, this project was evaluated positively by MSH. In 1985, ADRA applied to AID, and was granted, a three-year renewal of the Matching Grant Project PDC-0703-G-SS-5040-00). The new proposal, in addition to the existing MCH nutrition centers, included provisions for intensive growth surveillance in Bizoten, a zone around the Adventist hospital, as well as appropriate referral to the Child Survival Recuperation Center at the hospital. This report is the result of an evaluation of the second Matching Grant Program.

#### 1.2.3 Other Organizations' Development Activities in the Region

ADRA is not the only PVO operating health programs in Haiti. In 1987, there were more than 200, many of which, like ADRA, are supported, at least in part, by religious groups. In 1982, it was estimated that such PVO activities accounted for some 49% of the rural health care in Haiti. Among the largest of these are CARE, Catholic Relief Services, International Child

Care, International Foster Parent Plan, and The Salvation Army.

### 1.3 Relevant Policies

#### 1.3.1 Donor Policies and Strategy

The ADRA MG Project appears to be directly in line with the policies and strategies of AID and of the GOH. In the FY 1989-1990 USAID/Haiti Action Plan, it is stated that in spite of the suspension of government-to-government aid, the basic "sectoral strategies" of the agency have not changed in regard to the PVO activities in the country; ". . . our program will focus on one goal - i.e., a wider sharing of the benefits of growth". The eight goals targeted by the ADRA/Haiti are the following:

- 1) Increase Agricultural Production
- 2) Preserve and Manage Natural Resources
- 3) Strengthen the Private Sector
- 4) Promote Exports
- 5) Increase Access to Voluntary Family Planning Services
- 6) Reduce Infant and Child Mortality
- 7) Improve Educational Opportunities
- 8) Increase Participant Training

Of these, the most pertinent to the ADRA Matching Grant Project is number six, the reduction of infant and child mortality. The strategies to be used are, ". . . basic nutrition education, along with immunization and ORT, at maternal/child health centers" with the explicit target the child under five years of age. It is also suggested that PVO's tie the distribution of PL 480 commodities to other components of existing AID-funded work, e.g., MCH programs in conjunction with child survival and family planning activities. The promotion of condom usage by the family planning education in the MG centers is directly in line with the AIDS prevention campaign of the Department of Preventive, Social, and Community Medicine at the University of Haiti's College of Medicine and Pharmacy.

#### 1.3.2 Government of Haiti Development Policies

The MOH of Haiti published its own set of goals and targets for various child-related programs. Those relevant to the activities of the ADRA Matching Grant are:

- 1) ORT Intervention
- 2) Immunization
- 3) Nutrition, for children under five
- 4) Improving Pregnancy Outcome
- 5) Family Planning
- 6) Vitamin A

All of these goals, with the exception of number four, the pre-natal care, are directly implemented in the ADRA MGP/CS activities.

## 2.0 The Project

### 2.1 Overview

#### 2.1.1 Purpose and Goals

The problem addressed by the Matching Grant is Haiti's high infant and child mortality rate, 151/100,000, with deaths in this age group accounting for 50% of the total annual mortality in the country as a whole. Nutrition is felt to be the most basic point of health change intervention for this age group because it so severely exacerbates the endemic health problems such as diarrhea, typhoid, malaria, and upper respiratory infections. In 1988, it was estimated that 65% of the children under five could be classified as mild to moderately malnourished, and 5% as severely. In the country as a whole, it is calculated that there is only 79% of daily caloric requirements available per capita. Conditions in Haiti, both physical and political, continue to deteriorate.

In view of these statistics, the programs's target populations are mothers and children under five years of age. The purpose is to reduce the prevalence of malnutrition among this group through an organized system of nutritional education, growth surveillance, and referral to recuperation centers. The distribution of PL 480 Title II food is used for immediate alleviation of infants in crisis malnutrition and as a general incentive for mothers to bring their children to the MCH centers to be weighed and to receive health instruction.

#### 2.1.2 Objectives

The objectives for the Matching Grant MCH centers have been extensively modified since the writing of the 1984 proposal. The development of the present logical framework and objectives, as begun by Sandra Benton in 1987 and completed by Stella Brown in 1988, can be seen in Appendices C and D. The modifications have, for the most part, been an attempt to restate the somewhat lofty ideals of the original goals and objectives in more realistic applicable terms.

The first objective, for example, has been restated from "increasing health status of mothers and children in the Republic of Haiti" to "improved health status of young children ages 0-5 in Haiti by December 1988, which is, in fact, more realistic. The specific objectives are to, a) immunize 80% of the target group (children 0-5), b) have 65% of the children in the target group growing at the approved local standard on RHC, c) have all self-selected children receive Vitamin A and parasite control, and d) have all self-selected beneficiaries receive education in six areas related to child health.

The second objective is the establishment of three new centers, one at Diquini, and two at Gressier, plus eighty rural clinics. For each of the clinics, the target group was to be the children 0-5 and their mothers, with:

- 1) 65% of the children growing at approved local standard rate on RHC;
- 2) 60% of the self-selected mothers having a working knowledge of:
  - a. Road to Health Card,
  - b. breast-feeding/weaning,
  - c. hygienic food preparation;
- 3) 75% attendance record for weighing growth-surveillance maintained by each child 0-5 years during the determined participation phase;
- 4) 80% of the mothers in each center would know how to:
  - a. do effective personal hygiene,
  - b. infant bathing,
  - c. be bathing their children once a day.

The third objective was the establishment of the Manpower Training Center to be operational by December of 1986. By June of 1988, this center was to have trained a total of 600 community health agents, 100% of whom would demonstrate satisfactory knowledge and teaching skills in 1) ORT, 2) EPI, 3) growth monitoring in community clinics, 4) family planning, 5) nutrition, and 6) hygiene.

In addition, there was an objective stating that clinic sessions would include education in the areas of ORT, EPI, growth monitoring, family planning, nutrition, and hygiene. In the promotion of ORT:

- 1) 60% of all individuals in target communities were to have knowledge of ORT, (where to obtain, how to administer) by December of 1988;
- 2) 80% of self-selected mothers were to have received ORT at least once;
- 3) 80% of the mothers were to have given ORT following a third consecutive diarrheal incident;
- 4) distribution points were to have ORT available 90% of the time through December, 1988.

The objective for the EPI program was that:

- 1) four vaccinators be trained by June of 1987;
- 2) 100% of the vaccinators satisfactorily demonstrate knowledge and skill in:
  - a. EPI promotion,
  - b. immunization delivery,
  - c. Cold Chain maintenance,
  - d. sterility control;
- 3) 80% of self-selected parents in target communities have knowledge of:
  - a. EPI importance,
  - b. availability,

c. side effects,

d. importance of immunization of future children;

- 4) maintain a constant supply of immunization vaccines;
- 5) have three cold boxes to maintain effective cold chain by June of 1987;
- 6) 80% of all self-selected children complete the protocols for immunizations;
- 7) 90% of all self-selected women 15-45 in the community would comply with tetanus protocol.

In Family Planning, the objective was to have:

- 1) 80% of the women 15-45 in the clinic knowledgeable of at least one child spacing technique,
- 2) 50% of self-selected women receive a condom supply at least one time,
- 3) 80% of women in the clinic program would know where to get family planning help/supplies.

Finally, the objective for the PL 480 food was that 90% of the mothers with their children in the program be reached by it.

The original 1984 objectives concerning the use of agricultural extension agents to demonstrate kitchen gardens and the development of mothers' clubs were deleted in the 1987 rewrite.

### 2.1.3 Strategy

The stated strategy of the MG MCH clinics is:

- 1) to give participants a nutritional education in a caring and constructive atmosphere.
- 2) Each center was to receive 100 children divided into four groups of twenty-five. The assistance to be given must be accessible to all, with no consideration of background, color, sect, or religion.
- 3) Each group was to meet once a week for educational sessions. The clinic was to work four times a week from 9:00 a.m. 1:00 p.m.
- 4) The mothers were to accompany their children. The nutritionist was to record the names of all those present at each session.
- 5) Mothers were to receive food rations every two weeks. The apparent cases of malnutrition such as Kwashiorkor and marasmus were to be given the highest priority.
- 6) The nutritionist must thoroughly understand that the food must be only considered as a supplement; care will last for eight months only, after which the child will be discharged; and how to explain the "road to health" card to the mothers.
- 7) To keep the food supplies, the depot must be in good condition and free of rodents and excessive humidity.
- 8) The records of the reports must be well-kept and ready to be presented at any time to the inspectors of ADRA and USAID.

## 2.2 Process

### Present Project:

The present ADRA Matching Grant-MCH project is difficult to discuss without also describing the CS and the FFP programs, as they work closely together. There are eighty MCH clinics on paper, including the four in and around the Diquini area. All these centers are scheduled to meet daily, from 9:00 a.m. to 1:00 p.m., except Saturday and Sunday.

Each center is to serve 150 malnourished children age 0-5 and their mothers who present themselves to the facility. Of these 150, the fifty most severely malnourished children are put on the "intern program". The interns are divided into four groups of twenty-five. Each group of twenty-five mothers and their children meet once every two weeks, or twice per month, to receive nutrition and oral rehydration instruction and food. In the extern group, the 100 mothers, again divided into groups of twenty-five, attend the program once a month for instruction and a ration of milk. The duration of each group's program is 4-6 months, at which point everyone is terminated to give another group an opportunity to profit from the program.

Within a reasonable distance of Diquini, those children in immediate danger of dying from malnutrition are referred to the Recuperation Center at the SDA hospital.

The rations for each group are set at a rate which is felt will benefit the nutritional status of both mother and child, (Table 1, next page). Vitamin A, parasite medicine, cough medicine, multivitamins, and oral rehydration packets are to be distributed to all recipients of the centers. Each of these centers is supposed to have a secure depot for storage of foods and supplies, a storage area free of rodents and undue dampness. The distribution of food supplies in the centers is supposed to be done under the supervision of three members of a community committee who sign the appropriate forms after the distribution. In addition to the other services, in the four centers in and around the Diquini area, immunizations are to be given to all appropriate program recipients. All the center activities, whether food distribution, teaching, or family planning, are to be recorded on monthly report forms, which are due in the ADRA office at Diquini the first of each month to be tabulated by the MCH director and training director.

The personnel of these centers, their assistants, and the various inspectors all were to be trained initially at the ADRA training facility in Diquini. The training seminars last from two to four days and are supposed to have about twenty individuals in attendance. Some of the center nutritionists and their assistants are "paid" with rations in the ADRA FFW program.

TABLE 1

RATION JOURNALINRE CALORIQUE ET PROTEIQUE RECOMMENDEE AUX ETATS UNIS

<u>Beneficiaire</u>	<u>Cal (kcal)</u>	<u>1/3 a 1/2</u>	<u>Proteine (gms)</u>	<u>1/2 plus</u>
Age 1-3	1300 (1360)*	429- 650	23 (16)	11.5 +
4-6	1700 (1830)	561- 850	30 (20)	15 +
Femme enceinte	2400 (2550)	792-1200	74 (38)	37 +
Femme allaitante	2600 (2750)	858-1300	64 (46)	32 +

Washington, D.C. 1980: National Research Council. Recommended Daily Allowances.

RATION MENSUELLE RECOMMENDEE PAR PERSONNE (programme MCH en Haiti)

Ble fortifie au soya	1.5 kg
Mais " " "	1.5 kg
Huile	0.7 kg
Lait	1.33 kg

RATION MENSUELLE RECOMMENDEE PAR FAMILLE

Ble fortifie au soya	4.5 kg
Mais " " "	4.5 kg
Huile	2.1 kg
Lait	4.0 kg

RATION A DISTRIBUER CHAQUE 15 JOURS

Ble fortifie au soya	1 marmite raze
Mais " " "	1 marmite raze
Huile	1 bouteille de rhum pleine et 1 bouteille de koa pleine
Lait	1 boite ou 1 marmite raze

### 2.2.1 Project Chronology

The daily functioning of the MGP is less than the ideal portrayed above, though heroic in view of the major impediments it has faced over the last two years. To begin with, in February of 1986, the Jean-Claude Duvalier regime was overthrown, which plunged the country into eight months of rioting and strikes, hopelessly snarling daily activities and communications. A three-man National Governing Council (CNG) under the direction of Lt. Gen. Henri Nanphy, took interim control.

To heighten the distressing effects of national disorder on the morale and function of ADRA project staff, the directorship changed hands in the fall of 1986. James Fulfer left the position and Barry Benton assumed it. Barry's wife Sandra took over as director of the MCH program from Olive Fulfer. There were problems from the outset. Apparently, there was a miscommunication between ADRA/I and Barry Benton as to his precise title in Haiti, whether he was the director of the entire ADRA/ Haiti program, or only part of it. He perceived his role as the former, while ADRA/I felt it was the latter. Though they had taken some Creole lessons in the States prior to their going to Haiti, the Bentons came to their new posts essentially unable to speak or read French or Haitian Creole. (The Fulfers, though unable to use either French or Creole effectively, had managed to develop a communication system over their years of experience in the country.)

Further political upheaval and violence, combined with some personal health problems which necessitated long absences from Haiti, prompted the Bentons to resign their posts in the Fall of 1987. Yet another change of command came when Orval Scully, a retired ADRA director from Chile, assumed the Directorship on a temporary three-month basis, to hold the program together until a permanent director could be found. This "temporary" directorship had endured, at the time of this evaluation site visit, some eight months, with a new director scheduled to come on board some time in the Fall.

### 2.2.2 Management

When Pastor Scully took over the project, he was faced with demoralized, disorganized and somewhat defensive ADRA staff. He and his wife had years of field experience with ADRA in Chile and are fluent in Spanish, but had no knowledge of French or Haitian Creole. The day-to-day function of the project was in jeopardy, as two of the administrative positions were vacant, namely Sandra Benton's MCH position, and Beth Hanlon's training position. Pastor Scully's first act was to name Mme Ghislaine Calixte, an MCH educator and inspector, as director of the MCH program. The daily decisions of operation were delegated to Fred Emmanuel, the controller, in whom Pastor Scully had confidence. This last move is most easily understandable in view of Pastor Scully's lack of French or Creole and his Chile experience, where ADRA/Chile

has a co-directorship. A national ADRA director is largely in charge of day-to-day operations, while the foreign director is responsible for more long-range administration.

In the case of ADRA/Haiti, however, there was no precedent for this administrative model. The staff seemed insecure about their own positions, in view of the rapid turn-over of directors and the interim director's reluctance to make administrative decisions. Fred Emmanuel, on the other hand, was presented with the additional responsibilities of daily management. Mme Calixte, in turn, was met with a geometric expansion of her responsibilities, which now included distilling the monthly reports from the eighty plus clinics, compiling statistics for reports to ADRA/I, overseeing the inspectors for the MCH centers, as well as manning the training.

In April of 1988, Stella Brown, a registered dietician, was brought over from the SDA hospital's CS program to head up the MCH program. Even though Stella had been associated with the Hospital for two years, and is able to converse in a French/Creole mixture, her arrival in the ADRA office was met with mixed emotions. Pastor Scully's appointment of her as "director of the MCH program", the same position which Mme Calixte already held, compounded the problems. Mme Calixte was offended that another, an ex-patriate at that, would suddenly be given her position. Her distress was heightened by the decision to give Stella Brown the MCH director's office and move Mme Calixte to an adjoining storage room office. When Stella arrived for her new duties, she got a cool reception. Mme Calixte had gone on vacation and no one introduced themselves to her or offered to help her get oriented to the job. Her office was devoid of furniture and there were no records to be found for the MCH program's activities.

At the time of the field visit of the evaluation team, July of 1988, Stella Brown had carved a niche for herself and was doggedly negotiating a cooperative working relationship with the besieged Mme Calixte. By having fluency in Creole, the evaluation team was able, with minimal effort, to improve the interaction of these co-workers. They had one brief discussion in Creole with Mme Calixte, encouraging her to freely air her concerns and clarifying Stella's to her. After a similar discussion with Stella, the two were interacting more positively. Mme Calixte, for example, was surprised to learn that Stella had been mortified when she discovered she was displacing Mme Calixte from her office, and had vigorously but vainly protested.

The MCH program management, therefore, is beginning to function more smoothly. Stella has located some records from the period of Sandra Benton, though some job descriptions and signed contracts for the staff have completely disappeared. There is a list of some eighty plus clinics on the board in Mme Calixte's office, with stars indicating which have sent

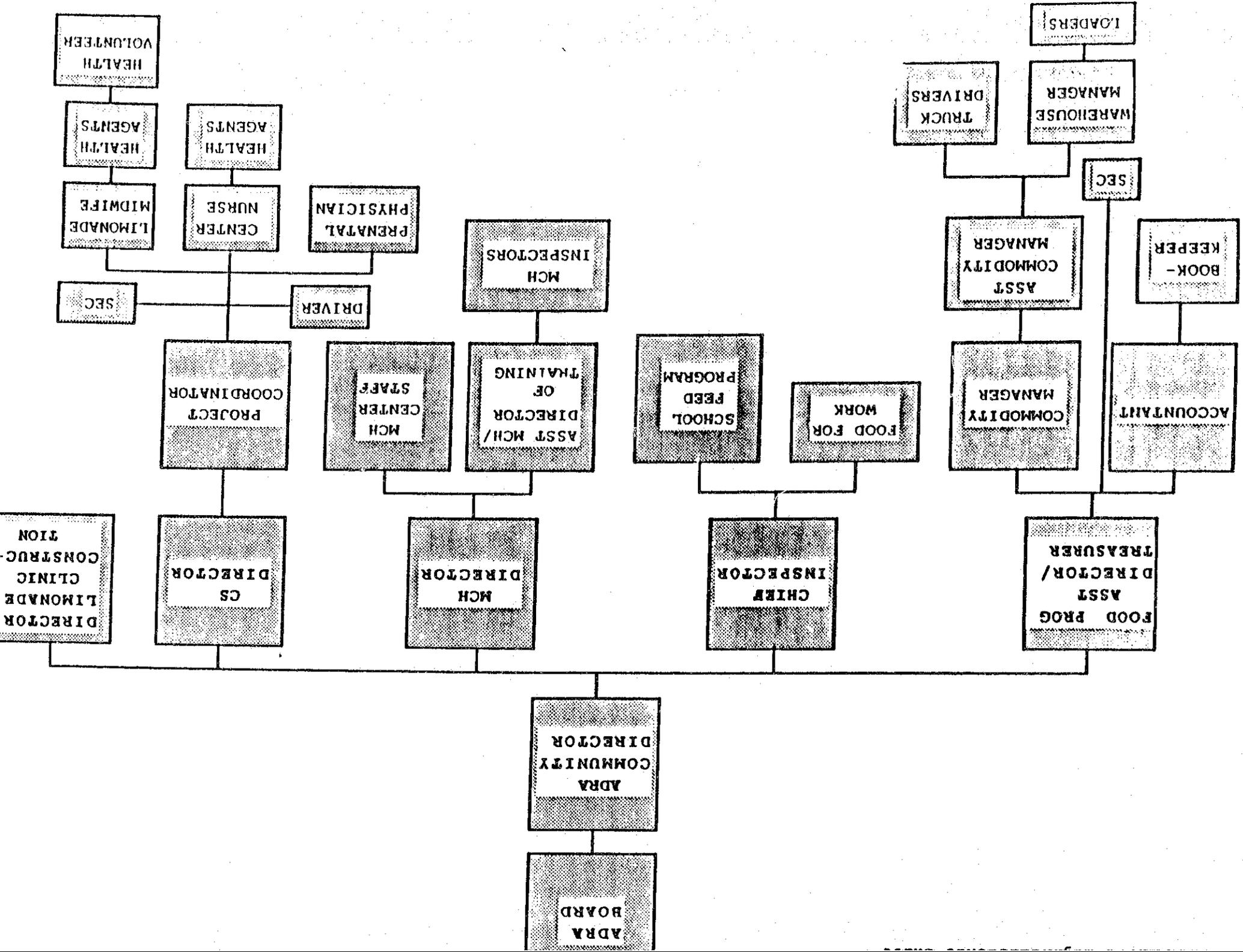
reports for each month. (The two in Gressier were never opened, and about twenty had to close during the rioting and looting of the revolution.) She is supplying Stella with lesson plans for upcoming training seminars. Together, they are trying to make sense out of the morass of forms in varying editions completed to varying degrees of accuracy which filter in from outlying clinics. The two women are working together on the cumulative MCH reports for ADRA/I. Even though these two individuals have negotiated a workable relationship, the ADRA/Haiti chain of command remains involuted. (See figure 2) Are Stella Brown and Mme Calixte co-directors of MCH, or is Mme Calixte, in fact, responsible to Stella? Do the MCH inspectors answer to Mme Calixte or to Stella?

### 2.2.3 Monitoring, Reporting, and Accounting

The problems are most dramatically apparent if one looks at vehicle access. The number, type, and state of small vehicles are patently inadequate for the volume and rigor of travel necessary to operate a project of this scope in a country such as Haiti. (Appendix E) The large trucks are more easily accounted for than the small vehicles. There is one International, however, which was sold to four ADRA staff when Barry Benton was director, because, according to Fred Emmanuel, the truck had become too unreliable for further project service. Interestingly enough, however, this truck is kept in the ADRA compound, serviced at the garage, and functions well enough to be hired by ADRA for commodity transport whenever an additional large truck is needed. Without vehicles assigned to specific programs, and with virtually all the small ADRA vehicles being driven home at night by staff, the outreach functions of all programs are compromised.

Fred Emmanuel decides who will use which vehicle on a particular day, with no apparent systematic priority. In just the two weeks of the evaluation field visit, the MCH program vaccinator missed three days of scheduled immunization because the small vehicles were all collecting an ADRA controller from the airport. The FFW, SFP and MCH inspectors are under separate directors with no cooperative scheduling of field travel. The vaccination team operates on yet another independent schedule. There is no evident orchestrating to maximize effective use of limited transportation. The resulting sporadic contact from the central office is not confidence-building for the field staff of remote centers in this country where physical presence is the only certain communication. It is small wonder, then, that reporting from these centers is spotty and of doubtful validity, and when inspection trips are made it is often found that a center is no longer functioning at all, not functioning as scheduled, or with greatly compromised effectiveness because of lack of supplies.

A further source of confusion in the transportation arena is the apparent lack of control over the ADRA garage at the



warehouse facility. No maintenance record could be produced on each vehicle. Of those in for repairs, there is no record of what precisely is wrong with which vehicle, who is to be working on it, what parts are necessary,, whether such parts are on order, when the repairs are due to be completed, or for that matter, who owns the vehicle since none of the small vehicles bear ADRA logos. At the time of the evaluation, there were several vehicles under repair which were not even ADRA vehicles. (The last day of the evaluation visit, a box of ADRA logo decals arrived from ADRA/I for the small vehicles.) All project functions, but especially those involving outreach, are further hampered by Haiti's continuing political instability which often precludes rural travel or commodity transport.

Not only are the vehicles loosely controlled, but the staff themselves appear to come and go at irregular hours. During the two week evaluation visit, the attendance at 7:30 morning worship ran about 15, when there ought to be closer to 35 present. During the day staff, were usually visible after about 8:00 or 8:30, but regularly disappeared for the day about noon. It was rare to have staff present in the afternoon. From the point of view of cost-effectiveness, this presents a problem.

This apparent laxity of control in ADRA's administration may have an even more sinister side. The week before the evaluation team arrived in Haiti, it came to Pastor Scully's attention that some of the ADRA personnel had been selling PL480 food by the truck load on the black market while conspirators forged appropriate entries on commodity manifests to cover the theft. This allegation immediately cast suspicion on the entire staff. Pastor Scully has resolved to get to the bottom of the charge and clear up any existing problem before the new director comes on board.

His task, however, is greatly hampered by his lack of contact with the day-to-day functioning of the staff, not only from the point of view of sheer knowledge of procedure, but also that of close personal knowledge of the national staff themselves. By the end of the field visit, one driver and an inspector were conspicuously absent while another was warily walking around accompanied by an armed personal bodyguard. The investigation of this situation is difficult, as the warehouse manifests, accurate or not, are not all available.

To make matters worse, because of the political instability, loss of containers in shipment, changes in administrators, changes in staff, and changes in commodities available, the shipments to MCH clinics in the last six months have been erratic. If there was only oil and wheat in the warehouse, then these might be shipped to rural clinics, rather than total rations. Food is supposed to be delivered to the clinics in three-month batches. At the time of the evaluation, how-

ever, Pastor Scully had halted all shipments of food until all expected incoming shipments had been assembled and accounted for. This means, of course, that many clinics have been without food for some months.

In general, the warehouse control was loose. The evaluation team observed a warehouseman "supervising" the unloading of a container. The man was supposed to be tallying the number of sacks of each commodity as it was unloaded. He was paying no attention to the unloading, rather chatting with friends on the dock. When Fred Emmanuel was asked about a discrepancy found on a warehouse manifest, his explanation was that there must have been an error in the warehouseman's counting, or that maybe that figure represented what the warehouse was supposed to send...that it was not really a problem. In view of the recent disclosure to Rev. Scully of wholesale in-house theft, this lack of concern is remarkable.

There is similar apparent lack of control over the accounting of fuel vouchers. The ADRA project purchases fuel, tax-free, from Shell Oil. They receive coupon books, each coupon being worth \$10 in fuel. There appears to be no accounting made of the coupons; there is no record of who issued how many coupons, and no logs on the vehicles' destination, daily mileage or fuel consumption. The stubs in the fuel coupon books are blank, no date, driver's name, vehicle, or amount of fuel purchased. If an entire \$10 is not purchased in fuel, the driver receives change in Haitian currency for the remainder. Given the present lack of records, there is no way of assessing the actual amount of fuel consumed for project work.

Tight financial management does not appear to be in force either in ADRA itself or in related programs. The accounting of funds is somewhat curious. In the evaluators' brief meeting with Fred Emmanuel on the last day of their visit, it was unclear how he separates the funds for the Matching Grant from those of other programs, as was dictated by the 1987 ADRA audit. When the evaluation team visited the recuperation center at the SDA hospital, it was curious to find that the center director receives only \$100 per month for all her operating expenses and often has to supplement out of her own pocket to purchase enough food for the mothers and children, and supplies such as hand soap, even though the grant, administered by the hospital director, appears to have ample funds. The yearly budget for this grant is some \$32,000. The actual running of the recuperation center, including all staff salaries and the physician, accounts for a yearly expenditure of only \$13,000.

**Table 2: SDA Hospital Recuperation Center Expenses**

<b>Employee Salaries per month:</b>	
Director	\$160
Assistant	160
Sub-assistant	150
Cook	80
Gardener	80
Physician	310
<b>Food and supplies per month:</b>	<u>100</u>
<b>Total per month:</b>	<b>\$1040</b>
	<u>X 12</u>
<b>Center costs per year:</b>	<b>\$12,480</b>

How are these funds separated from other hospital-administered grants? Pastor Scully has repeatedly requested a total systems audit and is hoping that the upcoming August auditing team will explore all ADRA projects including the Child Survival project and its accounts with the hospital. From the team's brief visit with Fred Emmanuel, and a look at the June 31, 1988, MG project expense report to ADRA/I (Appendix F), it is difficult to account for particular individual items, because the six categories are so encompassing:

1. Personnel
2. Training
3. Equipment/Materials
4. Project supplies
5. Transportation
6. Evaluation

#### 2.2.4. Relations of ADRA project to GOH and other Agencies and Technical Support

The level of in-country technical support to the ADRA project has been very good. The MOH of Haiti, through its Division of Hygiene and Family Planning, supplies Vitamin A and condoms. This division, along with the Institut de l'Enfants, coordinates ADRA and other PVO's and gives permission for the project to operate in specific sections of the country. The GOH grants the project tax exempt fuel and importation of equipment, vehicles and supplies, in addition to 3 guards for the warehouse, valued at \$150 each per month. The Child Survival Program gives much technical support. USAID, through its Title II and III funds, provides for medicines, medical supplies, and training materials, as well as travel and equipment.

The relationship of ADRA to other PVO's is less well-defined. While there are good working relations at the top levels between them, such as the assumption by ADRA of some 50 CWS nutrition centers, and ADRA's willingness to serve as the distributor of food for many small PVO operations, when it comes down to collaborating with local NGO's at the field level, there is a gap. It came to light during the field visit

to Pignon that ADRA staff were aware of Guy Theodore's AID-funded agricultural project in the area, but had never toured it. When the team visited the farm, the agronomist pointed out that they were encouraging villagers to grow an improved version of "pig weed", which is hearty, nourishing and above all, known and accepted in the Haitian diet. This one fact could easily be used as a major building block if the objective of kitchen gardens is revived.

Another example of the lack of communication at the field level is the fact that the project was unaware of the long-standing Schweitzer hospital project using local midwives as change agents in their drive to reduce neonatal tetanus. When a well-known midwife from the San Raphael zone was interviewed by the evaluation team, it became apparent that with minimal ADRA effort, this route of village contact could easily be used in the teaching of ORT as well as a referral network for nutrition surveillance. This lack of intimate knowledge of the activities of other groups can result in the "re-invention of the wheel". In this respect, ADRA/Haiti, and probably most other PVO's, tends to be insular in its daily activities. This situation is due in large part to the continued lack of language and cultural facility of the ex-patriate staff. This is not to imply conscious disdain for local culture by ADRA ex-patriates, far from it. Stella Brown, for example, as a dietician was delighted to be introduced to the delicacies of breadfruit and to discover that it is a cheap source of iron (2mg/100g) for center nutrition agents to recommend.

## 2.3 Outcomes

### 2.3.1 Achievements

The achievements of the ADRA MGP are significant. In view of the last two years of political turmoil in Haiti and the rapid turnover of ADRA directors, they are positively heroic. It is somewhat difficult to document these achievements, however, using the existing information system.

Looking at the summary report of the second quarter of 1988, one finds that there were 5,217 "child weighings" in April and 4,037 in May, among the "intern" group. Since each child in this group comes to the clinic twice a month, do these figures represent two weighing per child or were some children weighed once and others weighed twice? The most valuable inference to draw from these figures is that of the 4,609 "child weighings" done in April, 60.1% were gaining weight, only 16.4% were losing and 8.9% were showing no change. We do not know how the child's original weight compared with the local recommended growth rate, and it is impossible to say what percentage of these "weighings" were growing at an acceptable rate, i.e., it could be that all of those who had gained weight were still well within the second degree of malnutrition. At least, however, one can say that the 60.1% were gaining ground.

As this percentage remains fairly consistent throughout the quarter, averaging to 60.9%, it is safe to say that regardless of the level of malnutrition at which these children entered the program, they are improving steadily. Even though this is not the same as having "65% growing at the accepted local rate", it is a close percentage and should be seen as a significant achievement, especially in this most severely malnourished group. This rate is similar for the extern group, who are seen only once per month, and, therefore, can only be weighed once. For these, it averages 59% gaining weight during this quarter.

From the monthly reports, it is likewise impossible to see if the stated objective of 100% of the enrolled children received Vitamin A. There is simply a total figure given for number of "Vitamin A distributions" done during that month. The same problem is present with the single monthly figure for total number of "piperazine doses" given during the month. Interpretation of this figure is even less feasible, as two doses of this worm medication must be given on consecutive days. The distribution figures for family planning methods suffer the same problem, i.e., are they counting condoms issued or women to whom they were given? The achievements in immunization are also impossible to assess. Stella Brown labored valiantly to interpret the figures since the evaluation team left Haiti, but finally wrote saying:

"...the number of persons vaccinated is how many times they were vaccinated, and they may have received two different vaccines in one visit...and the number of children in attendance is not accurate either because that includes growth monitoring and all the interns come twice a month which is too often for the vaccination program...I don't think you can use these figures..(received 8/11/88)

While there are definitely three cold boxes in working order, and the MOH has vaccines available at most major centers around the country, even when the vaccination team gets out into the countryside, one cannot really tell what has been accomplished. The present information system does not render useful data for evaluation.

The achievements of the teaching program, both in the staff training and community teaching, are more readily apparent. Mme Calixte's training seminars take place on the average of once per month. A sample curriculum for the initial training of MCH clinic managers and assistants is in Appendix G. Once trained, these staff are offered continuing education seminars or "recycling" every six months. A sample curriculum of a "recycling" seminar is in Appendix H. These training seminars, though none were in session during the evaluation,

are well-attended and popular. These seminars appear to be quite effective from the point of view of the content taught.

The evaluation team observed several clinic directors instructing mothers. The information given was accurate-- though the didactic style was typical lecture format emphasizing rote memory. This is the style of most Haitian public education and it is hardly surprising that it permeates the MCH teaching. In the few instances where the trainer attempted to engage the mothers in discussion and free association of ideas, it was difficult for the mothers to participate freely. When this was accomplished it was impressive. The use of songs to emphasize principle points was demonstrated most effectively. The cycle of topics taught in the MCH center at Diquini for the month of June, 1988, is Appendix I. It is apparent that while there were some 13 separate topics addressed during the month, there is no regular schedule for their presentation. This might present a problem of some mothers hearing the same message several times and others not hearing that one at all.

### 2.3.2 Impact

The evaluation team with the assistance of Stella Brown, Alice Jean Pierre, Ghislaine Calixte and Verna Philomene, constructed a field survey instrument designed to tap the impact of the MCH clinics on the women who frequent them. (Appendix J) Though the selection of clinics in which to interview mothers was based on time and transport limitations, data was collected from 10 mothers at the Diquini clinic, within the main ADRA compound, as well as 2 at Pignon, and 10 at Camp Coq, both in the Cape Haitian zone. The sample was hardly statistically random, though there is no reason to assume the mothers interviewed were in any systematic way different from those not interviewed.

The first issue which was addressed was the basic attraction of these clinics for these women, many of whom walked several hours carrying small children. In a climate and terrain such as Haiti's, this is an indication of considerable motivation, especially for a person more than likely malnourished herself. The team was especially interested to see if it was the free food or less tangible items which drew the mothers. The Pignon mothers, though there was only time to interview two here, were of special interest, as that clinic has been without food for about six months and still has good attendance. Of the 22 respondents in all, 15 (68.1%) indicated they came for the good advice of the clinic staff, concerning general questions of child health. The other 7 (31.8%) indicated they came because they had received assistance with a particularly sick child, in the form of both ORT education and food supplements.

The fact that these women are continuing to come to the ADRA MCH centers, in spite of lack of food supplements, is probably the single most significant achievement of the ADRA MGP. As

was noted by Harrison King in the 1983 evaluation, much of the initial acceptance of this program came from its having been largely grafted on existing SDA church infrastructure widely present and accepted in Haiti. Through this chain of nutrition centers, a sufficient bridge of trust and respect has been forged in the realm of health information, that it constitutes a firm foundation on which to build sustained community development.

The impact of the clinic teaching effort has, in general, been positive. Of the 22 mothers surveyed, 100% knew what the "road to health" card is and that it is important. (See copy of the card in Appendix K) The explicit understanding of the symbolic representation of weight progression shown on the card was not as widespread. Nine (40.9%) had no comprehension of the colors or the graph in the chart. One mother believed that the colors equated with the three food groups, another the child's vaccination status. The health educators, however, should not be dismayed. Whether or not these mothers, many of whom are illiterate, comprehend the symbolic representations on this graph may well be related to their lack of familiarity with graphic images rather than the quality of teaching. The essential message is really that growth surveillance, in the form of routine weighing, is essential to the continued improvement of the children. This message has come across very well. Of the 22 mothers, only 3 (13.6%) did not understand the need for monthly weighing. 12 (54.5) of them even connected identified malnutrition as the major cause of children with bloated abdomens and spindly arms and legs. There is no question that the connection between adequate nutrition and growth has been conveyed.

The MCH clinics' efforts in promoting ORT have had an enormous impact as evidenced by the mothers interviewed. Every mother reported having used ORT in a recent bout of diarrhea with her child, and 20 (90.9%) knew how to mix ORT correctly without a packet of powder. The ORT powder packets are readily available throughout Haiti, for about 12 cents, even in the rural areas. In every rural village the evaluators passed through, GOH signs promoting ORT were visible. So even the 2 (9%) of the clinic mothers who did not remember how to concoct the ORT mixture were not severely restricted in its use. (It is impressive that even two somewhat abstract concepts related to ORT have been accepted). ORT is supportive rather than curative, and the closely related fact, that the child is ultimately killed by the fluid loss from diarrhea, rather than the bacteria causing the diarrhea. Of the 22 mothers, 15 (68.1%) realized that the fluid loss is what kills a child with severe diarrhea, and 18 (81.8%) indicated that ORT is useful because it protects the child from the dehydration rather than curing the diarrhea.

The impact of the clinic's education on breast-feeding and weaning has been substantial. It must be acknowledged right

off, of course, that the MOH has also been promoting these issues. Nonetheless, of the 22 mothers surveyed, 100% indicated that nursing was healthier for the baby than bottle feeding, and 14 (63.3%) said that the mother should begin nursing immediately after birth. 8 (36.3) of the mothers felt that the mother should not begin nursing until the traditional third day after birth. An encouraging note among these more traditional mothers is that 4 (50%) of those 8 felt the first milk was important for the baby and should not be expressed and discarded, a common traditional practice. When asked about the traditional practice of giving the newborn a laxative, called "loc", 16 (72.7%) said they did not believe in this practice. One mother even pointed out that the first milk served this purpose. 18 (81.8%) indicate that if possible, a woman should continue to nurse her infant for at least 18 months. 9 (40.9%) went so far as to recommend at least two years nursing.

Suffice it to say, this sample of mothers is indicating a preferred duration of nursing longer than the current Haitian nutrition statistics show for the nation as a whole. In 1986, the percentages of infants still nursing in the age groups of 3, 6, and 12 months were 90%, 71% and 29% respectively. It would appear, therefore, that part of the MCH clinics' impact has been to at least increase the preferred span of nursing in the eyes of the women whom they serve. As Alvarez and Murray demonstrate in their monograph, economic constraints on the mother as the commercial agent for the family often preclude extended nursing of an infant.

Less progress has been made on the issue of the weaning process. 15 (68.1%) still feel that weaning, at whatever age, should be sudden, totally, enforced decision, by sending the child to a grandmothers' home, absenting herself, or by rubbing an extremely bitter substance on her nipples--in short, not a gradual process.

In sum, the impact of the ADRA MGP centers appears to be profound. The centers are well-received and trusted, and heavily used. The essential messages of the educational programs are being well-understood and accepted by the mothers. With this in mind, however, the very last question in the survey revealed a basic limitation to the program as it exists. To the query about what additional things would the person like to see the clinic offer, 62.5% had not one specific idea to proffer. Of these individuals, the most common response was either, "I don't know", or "Anything they want to do". The fact that the rate of this type of response was not higher is reassuring, but it does give one cause for concern in light of sustainability. In terms of the "empathy theory" proposed by Daniel Lerner in the late 1950's, this type of response indicates that these women are having trouble even imagining any situation different from the one in which they find themselves, i.e., cannot empathize with any reality

other than the present one. This ability to imagine oneself in some circumstance other than the present one is felt by Lerner to be a prerequisite to conscious change. The fact that such a high proportion of these women could not imagine anything else which this clinic might do for them, even given the total destitution of their circumstances, raises the concern that they do not really consider another situation even possible.

### 3.0 Discussion and Recommendations

#### 3.1 Issues: Strengths and Limitations

The first and most dramatic recommendation proposed by the evaluators is that ADRA/Haiti phase out, over the next three years, their involvement with food. This is suggested for two major reasons. First, the giving away of food, even on a strictly supplemental basis where it is never meant at most to constitute more than 1/2 to 1/3 of the requirements for that individual, still promotes passive dependence and contributes to a self-image of helplessness. As the Pignon clinic demonstrates, ADRA does not need to use food as an incentive for women to come to the MCH centers. The centers are well-established and valued on their own.

The second concern with food is the problem of controlling the operation. In a poor country where food is equated with life, handling, storing and transporting large quantities of this priceless commodity is certain to invite trouble, namely theft and blackmarketeering. No amount of religious cohesion and zeal can immunize a total organization against greed in the face of such monumental temptation. Just one dishonest individual in such a project, can cause economic havoc and serious morale problems. To perpetuate food supplementation programs beyond their need for incentive or disaster relief is to operate on an anachronistic colonial model the wealthy nations taking care of the less fortunate ones-- a form of "noblesseoblige". Since the food is no longer needed as incentive, it would seem so much wiser to phase it out except in response to specific crisis situations.

This is where the issue of sustainability enters the picture. Now that ADRA has won the trust and respect of the populace around their centers, it is time to phase into real community development, the type which breeds self-esteem and self-reliance. ADRA/I needs to locate an individual experienced in third-world community development to assist for an extended period of time. This individual needs to have at least a fluent command of French to be effective. There are several promising points at which to begin this work. Dr. Antoine Augustin described an interesting project in Mirebalais where mothers of malnourished children were reintegrated into the social fabric of the community by means of "mothers' groups" plan which incorporated small financial projects for each

group. The resulting improvement in self-esteem was then a cornerstone for further self-help. Another existing system of community networks and education is the indigenous midwives, or "matrons" like the one interviewed at St. Raphael. Finally, the "pig weed" project at the demonstration station at Pignon could be the backbone of a revived kitchen garden project. There are so many possibilities for community self-help with only minimal outside assistance.

A prerequisite for ADRA's successful phasing into true community development is the installing of a language-able director, conversant in both French and Haitian Creole before he enters Haiti. To avoid entanglement in Haitian social structure, it would be best that this individual not be either a Haitian or an ex-patriate reared in Haiti. For any French speaker, Haitian Creole is not difficult to acquire. Without these language facilities, the individual directing ADRA is prey to the petty paranoias of linguistic isolation as well as the conscious deceptions of false translations. For truly effective collaboration individuals need to be able to converse on an abstract level as well as a concrete one.

ADRA/I needs to utilize more than simply pastoral criteria in its selection of a director for ADRA/Haiti. Even the finest pastor, without proficiency in French and English, cannot effectively direct this project. Without a working knowledge of the language, one cannot hope to be attuned to the culture of the people. Learning French and Creole once a director has come to Haiti is patently not feasible. The crush of demanding issues and daily overload is such that the requisite concentration of time and energy to really take command of a new language is simply not available to the individual. In addition to pre-entry language training, the new director should be supplied with copies of available AID publications such as the Alvarez/Murray and Allman documents on basic Haitian culture. Given language proficiency and cultural knowledge, such a new director would be in a much stronger position to cooperate actively with the GOH and the MOH in providing health assistance in the rural areas. In his personal relationship with the ADRA staff, there needs to be more than simply work place socialization. A truly effective director of a community development project should arrange informal group interactions between ex-patriot and national staff on a regular frequent basis, e.g., potluck suppers, beach outings.

Before a new director can effectively assume the helm of this project, however, every phase of ADRA/Haiti should be audited by ADRA/I. The operations and funds are so interlocking and poorly accounted for that assessing cost-effectiveness is out of the question. Just a glance at the financial statement for June of 1988 (Appendix F) shows that categories are vast and vague, and figures do not balance.

Even if the director were fluent in the language and, therefore, culturally attuned, without proper transportation, a project such as this cannot function. The vehicles need to be diesel, manual transmission, four-wheel drive, heavy-duty in all respects, but especially cooling, suspension and tires. The Toyota Land Cruiser in the long wheelbase is the evaluators' first choice. In view of rapid repairs, Toyotas are difficult to procure or repair in Haiti, the Mitsubishi appears to be a second choice, though again, it need to be long wheelbase, diesel and manual transmission. The two-wheel drive, automatic, short wheelbase, open bed, or gasoline engine vehicles are an inefficient liability.

The management of the project as a whole, needs to be greatly tightened. All vehicles should bear large ADRA logos on the door panels. Once proper vehicles are procured and in sufficient numbers and labeled, each should be assigned to a particular division of the program. A strict priority needs to be established in view of any potential vehicular breakdowns. If vehicle X assigned to program X is out of commission there needs to be an established procedure for reallocating transportation. The vehicles themselves need to have a log maintained on each; when it received service, what service, the mileage, daily use, destination, fuel intake, etc. In this same vein, the ADRA garage needs to be tightly regulated. If outside vehicles are serviced when time permits, separate detailed records of time and materials used must be kept and reimbursed by the owners. A log of all vehicles under repair must be kept such that at a glance, an individual can tell when the vehicle was put in for repair, who is working on it, what is felt to be wrong, the stage of the repair, what is yet to be accomplished, and a reasonable target date for its completion. There should be no private use of the garage or its facilities without proper documentation and billing. The only ADRA repair tools and equipment to leave the compound should be those sent to the rescue of project vehicles broken down on the road.

The evaluators advise against the present system of fuel vouchers. Ideal would be to have a metered bulk tank under lock and key within the ADRA compound over which close supervision could be kept. If such a bulk tank cannot be arranged, there must be some non-cash system arranged with Shell for the fuel needs of the project, and detailed daily records must be kept. The compound and all the non-travelling vehicles should be locked securely at night. There must be strict policy concerning vehicles off in the countryside which arrive back in Port-au-Prince after the closing of the compound. There should be no private use of ADRA vehicles by anyone, including administration.

Not just the accounting systems for money and fuel need to be overhauled and tightened, but the information system in general. The MCH clinic directors and their assistants are faced

with a bewildering and overlapping pile of forms, in varying stages of revision, from which they must copy and recopy figures to be sent into the ADRA office. Figures such as the number of "weighing" are useless. The forms need to be reduced in number and simplified in form to where the information assembled on them is both essential to constant surveillance and useful in policy making.

The training of the staff, both at the level of inspectors and clinic staff, needs to include such items as updates on dealing with the revised forms, or changes of forms. They also need specific training in communication skills, with much role playing, demonstrating the finer points of non-verbal communication as well as verbal. There should be some regular system of periodic staff evaluation at all levels, with clearly understood criteria and immediate feedback. It is difficult to strive effectively toward an undefined goal. The education program for the clinics needs to be organized around several key messages which are presented in a regularly rotating order so there is greater probability that any given group of mothers will have heard all key messages. Likewise, a survey instrument, similar to the one used by this evaluation but greatly simplified, should be developed by the MCH field staff. It should be administered on a regular periodic basis to evaluate the direction and impact of the education program.

ADRA/Haiti has much potential. As a religiously based group, it has an advantage in that the vast majority of its staff share a deeply binding system of beliefs which override petty individual goals to the benefit of all. It operates largely through a well-established and respected church-affiliated infrastructure in the countryside which, from all the evaluators could assess, ministers to the people in a wholly non-sectarian manner. If this body of deeply dedicated staff were given a linguistically and culturally effective director, and solid long-term technical expertise from ADRA/I, including effective transport, the project could phase out of food supplementation and realistically move toward true sustainability in community development.

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**Appendix A**  
**Individuals Interviewed by Team**

## APPENDIX A

Individuals Interviewed by Team

Ken Flemmer, ADRA/I: Director of Community Development  
 Gordon Buhler, ADRA/I: Director of Evaluation  
 Lucia Tiffany, ADRA/I: Assistant Director of Evaluation  
 Orville Scully, ADRA/Haiti: Director  
 Fred Emmanuel, ADRA/Haiti: Controller  
 Stella Brown, R.D., ADRA/Haiti: Director MCH  
 Ghislaine Calixte, ADRA/Haiti: Director of Training  
 Alice Jean-Michel, ADRA/Haiti: MCH inspector  
 Nirva Philogene, ADRA/Haiti: MCH inspector  
 Piegnot Dorno, ADRA/Haiti: driver and FFP inspector  
 Marc Bonzil, ADRA/Haiti: Chief Inspector, FFP  
 Ramah Theodore, ADRA/Haiti Board Member & Legal Council  
 Antoine Augustin, M.D., l'Institut Haitien de l'Enfance  
 Bonnie Kittel, USAID/Haiti: CSP Manager  
 Ginette Merentie, USAID/Haiti: PL480 Title II Manager  
 Lila A. Clark, Haitian American Friendship Foundation  
 Guy Theodore, M.D., Hospital Director, Pignon  
 Ariel Henry, M.D., ADRA/Haiti: CS Director  
 Mme Eddie Jerome, Nutrition agent, MCH Center Pignon  
 Mme Dorcius Edouard, Regional Midwife, San Raphael  
 Mme Came Pierre, Manager Recuperation Center, Diquini  
 nutrition agent, staff and recipient mothers, MCH centers:  
     Diquini, Pignon, San Raphael,  
     Savanette de Pignon, Camp Coq,  
     and Leogane

Appendix B  
Narrative of Daily Activities

APPENDIX B

Narrative of Daily Activities, Principal Contacts:

Monday, July 18, 1988:

- 7:10 - arrival at Port-au-Prince, met by Mr. & Mrs. Scully, Mrs. Stella Brown and Drs. Ariel and Anne Henry - Proceeded to the Scullys' home where we visited with Dr. Ariel Henry and Stella Brown
- Dr. Whitehouse stayed with the Scullys
- Dr. Wiese stayed with the Browns

Tuesday, July 19:

- 7:30 - morning worship at ADRA
- introduction to the staff
- morning
  - orientation inhouse with Stella Brown
  - discussion with Stella, Orville Scully and Dr. Ariel Henry
  - tour of ADRA facilities
- afternoon
  - further review of program with Stella Brown (NOTE: Elder Grunder and Fred Emmanuel are already in Martinique for Franco-Haitian Union Mission Mid-year Meetings. Mr. & Mrs. Scully and Dr. Ariel Henry left at noon today for same meetings.)
- evening
  - further work on itinerary with Stella Brown

Wednesday, July 20:

- 7:30 - morning worship at ADRA
- morning
  - interviews with Bonnie Kittel, USAID, CS Program Officer and Ginette Merentie, USAID PL480 Program Officer
  - Research on pertinent documents at USAID library
- afternoon
  - interviews with Mme Calixte, MCH Program Assistant for Training and Marc Bonzil, Chief Inspector FFW and SFP
- evening
  - discussion of impressions and itinerary, Wiese/Whitehouse

Thursday, July 21

- 7:30 - morning worship at ADRA
- morning
  - discussion and preparation of field survey instrument with Mme Calixte, Alice and Nerva
  - observation in Diquini MCH clinic
- afternoon
  - field visit to MCH centers at Petit Goave and Leogane, former was not operating, latter was with about six first-time mothers
- evening
  - discussion of impressions, Wiese/Whitehouse

Friday, July 22

7:30 - morning worship at ADRA

morning - interview with Dr. Antoine Augustin, Director, 1' Institutue Haitien del'Enfance

- visit to recuperation center at Adventist Hospital, interviewed Mme Came Pierre, center manager

afternoon

- review and discussion of materials, Wiese/Whitehouse

evening

- reception for Mr. & Mrs. Ralph Watts at the Scullys' home. Others present were Stella, Norman and Julie Brown, Mr. Oren Nelson, Beth and Dwight Hanlon

Saturday, July 23

morning

- attended Bethel SDA church in Port-au-Prince with M. and Mme Calixte
- potluck with foreign SDA community at the Scullys' house, the Watts were there

afternoon

- Dr. Whitehouse went with the Scullys and the Watts to a SDA school at Vallmont (there is an MCH center and a FFW program there)
- Dr. Wiese remained at the Browns and reviewed documents obtained at the USAID Mission

Sunday, July 24

morning

- left 9:00 am on field trip into northern plateau. Dr. Whitehouse drove the 4-WD Mitsubichi containing Jean Wiese, Alice, Nerva and Mme Calixte; Dorno drove the 2WD Ford Ranger with Stella Brown

afternoon

- travelling

evening

- arrived at Pignon (via Cap Haitien) 7:00 pm. Stayed on grounds of Lila Clark's school

Monday, July 25

morning

- visit to Guy Theodore's hospital and MCH center. Discussion with staff there about their 18 rally posts in the area
- interviewed four mothers at Mme Eddie Jerome's MG/MCH center, using field survey instrument

afternoon

- visit to Savanette de Pignon MG/MCH center
- visit to agricultural extension farm owned by Dr. Theodore near Pignon, discussion with two American workers at the project

Tuesday, July 26

morning

- 8:45 am left Mrs. Clark's compound, Dr. Whitehouse driving the Mitsubishi with Stella Brown, Alice, Verna and Mme Calixte along, Dorno driving the Ford Ranger with Dr. Wiese
- visited San Raphael MG/MCH center
- interviewed several mothers and an area mid-wife
- ate lunch on grounds of SDA school at Cap Haitien

afternoon

- continued on to Camp Coq MG/MCH center, interviewed six mothers

evening

- arrived Port-au-Prince 9:15 pm

Wednesday, July 27

7:30 - morning worship ADRA

morning

- interview with Orville Scully
- inquired about Elder Grunder, but he was not expected to return until Friday morning
- interviewed mothers at the Diquini MCH center

afternoon

- preparation of verbal report to ADRA staff

evening

- dinner at the home of Drs. Ariel and Anne Henry in the company of Stella and Norman Brown

Thursday, July 28

7:30 - morning worship ADRA

morning

- interview with Fred Emmanuel
- inquired again about Elder Grunder, not expected back until Friday morning
- review of impressions in preparation for verbal report to staff

afternoon

- 2:00 verbal report to administrative staff including Dr. Ariel Henry and Ramah Theodore
- 3:00 verbal report to entire ADRA staff

evening

- final discussion with Stella Brown
- visit with Drs. Ariel and Anne Henry at the Browns' home

Friday, July 29

morning

- Scullys took us to the airport
- Pan Am flight delayed 3.5 hours

afternoon

- arrived in Miami 3:00, had to rebook connections

evening

- Dr. Wiese arrived back in Lexington at 10:00 pm
- Dr. Whitehouse arrived in Sacramento at 11:00 pm

Appendix C  
Revised Logical Framework Matrix

## NARRATIVE SUMMARY

## OBJECTIVELY VERIFIABLE INDICATORS

## MEANS OF VERIFICATION

## MAJOR ASSUMPTIONS

Higher Goal

Improved health status of young children ages 0-5 years in Haiti by December 1988.

- 1) Immunize 80% of target group
- 2) 65% of children in target group growing at approved local standard on RHC.
- 3) All self-selected children will receive vitamin A and parasite control
- 4) Self-selected beneficiaries will receive education in six areas related to child health.

Clinic records

No major epidemics

Random questioning of participants at end of lecture and at end of participating period.

Dependable source of vaccine.

## Goal

- 1) Immunization of self-selected children 0-5 years in following areas:

- a) Diquini
- b) Gressier (1)
- c) Gressier (2)
- d) Selected rural MCH

- 1a) 80% of self-selected children age 0-5 years will have completed immunization protocol by Dec. 88

- 1b) 80% of self-selected women ages 15-45 will complete T.T. immunization by Dec. 88.

Clinic records

No major food shortage

No natural disaster

- 2) Children 0-5 years will grow at approved local rate on RHC in:

- a) Diquini
- b) Gressier (1)
- c) Gressier (2)
- d) 80 rural clinics of Haiti

- 2a) 65% of enrolled children ages 0-5 years will grow at approved local standard rate on RHC

No political unrest

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

MAJOR ASSUMPTIONS

3) All the self-selected children will receive vitamin A and parasite control in:

3a) 100% of all the children in target group will receive vitamin A on their 1st visit and parasite medicine at least once during their enrollment.

- Clinic records
- No chronic cases of vitamin A deficiencies in target group.

Dependable source of vitamin A

- a) Diquini
- b) Gressier (1)
- c) Gressier (2)
- d) 80 rural clinics in Haiti

4) Self-selected beneficiaries will receive education in the following areas related to child health:

4a) Clinic sessions will include education in areas listed.

- Random questioning of participants on these subjects.

That CHA's have basic knowledge in all areas.

- a) ORT
- b) EPI
- c) growth monitoring
- d) family planning
- e) nutrition
- f) hygiene

(Revised February 1987)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	MAJOR ASSUMPTIONS
<p><u>Outputs:</u></p> <p>1) Manpower Training Center Operational by Dec. 86.</p> <p>2) ORT promotion program</p>	<p>1a) Training staff hired by December 1986.</p> <p>1b) Two hundred new community health agents trained by June 88.</p> <p>1c) Six hundred CHA's attended continuing Education Seminars by June 88.</p> <p>1d) 100% of CHA's trained satisfactorily demonstrating knowledge and teaching skills in:</p> <ul style="list-style-type: none"> <li>a) ORT</li> <li>b) EPI</li> <li>c) growth monitoring in community clinics</li> <li>d) family planning</li> <li>e) nutrition</li> <li>f) hygiene</li> </ul> <p>2a) 60% of all individuals in target communities have knowledge of:</p> <ul style="list-style-type: none"> <li>a) ORT</li> <li>b) where to get ORS packages</li> <li>c) how to administer ORS by Dec. 1988.</li> </ul>	<p>Class enrollment records</p> <p>- Site visitations</p> <p>- Testing</p> <p>- Performance report of employee</p> <p>- Random questioning of target population</p> <p>- Clinic records</p>	<p>No political unrest</p> <p>That suitable responsible persons can be engaged for each site.</p>

(Revised February 87)

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

MAJOR ASSUMPTIONS

(ORT Promotion Program  
Functioning--cont.)

2b) 80% of self-selected mothers with children in target community have received ORT at least once.

2c) 80% of mothers giving ORT following 3rd consecutive diarrheal incident.

2d) Distribution points have ORS available 90% of time through December 88.

3) EPI Program Delivered

3a) Two vaccinators trained by Dec. 1986; additional vaccinator trained by June 1987.

3b) 100% of vaccinators satisfactorily demonstrating knowledge and skills:

- a) EPI promotion
- b) Immunization delivery
- c) Cold chain maintenance
- d) Sterility control

- Clinic records

- Questioning of mothers

Functioning of 3 vaccinators by June 1987

3 vaccinators receive vaccinator training certificate and meet criteria of the local Health Department for vaccinators.

- CHA has had necessary training and is able to communicate these principles to participants.

- Supplies are available

Once they have received their training they will work in one of the centers.

(Revised February 87)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	MAJOR ASSUMPTIONS
3) EPI program delivered--cont)	3c) 80% of self-selected parents in target communities have knowledge of:	<ul style="list-style-type: none"> <li>- Vaccination records</li> <li>- Questioning of participants</li> </ul>	That participants are willing and able to learn.
	- EPI importance		
	- Availability		
	- Side effects		
	- Importance of immunization of future children.		No political unrest
	3d) Maintain a constant supply of immunization vaccines.	Stock inventory	
	3e) 3 service units maintain effective cold chain by June 87.	Vaccination records	No major electrical and fuel failure
	3f) 80% of all self-selected children complete the protocols for immunizations.	Records	MOH and UNICEF maintain constant and sufficient supply of vaccines
	3g) 90% of all self-selected women 15-45 community comply with tetanus protocol		

(Revised February 87)

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

MAJOR ASSUMPTIONS

4) Growth Surveillance Program Delivered

4a) 60% of all self-selected mothers in target communities have a working knowledge of:

- a) RHC
- b) Breast feeding/weaning
- c) Hygiene food preparation

4b) 40% of all self-selected children 0-6 months enrolled in the program being breast fed and eating semi-solid foods at six months of age.

4c) 75% attendance record for weighing growth-surveillance maintained by each child 0-5 years during the determined participation phase.

4d) 65% of all self-selected children 0-5 years participating in the program growing as fast as the approved local standard on the RHC.

Growth Surveillance Records

Questioning of mothers and observation

Clinic records

No food shortage

No political unrest

(Revised February 87)

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

MAJOR ASSUMPTIONS

5) Family Planning Program  
Functioning

- 5a) 80% of women 15-45 in the clinic will know at least child spacing technique.
- 5b) 50% of self-selected women receive a condom supply at least 1 time.
- 5c) 80% of women in clinic program know where to get family planning help/supplies.

6) PL 480 Outreach Support  
Delivered

- 6a) 90% of mothers with their children in the program reached with a nutritional education message using PL 480 foods by Dec. 1988.
- 6b) 70,000 beneficiaries will receive PL 480 food as dietary supplements.
- 6c) 80% of mothers in the program know the 3 basic food groups and can name at least 2 in each group.
- 6d) 80% of the MCH clinics will have PL-480 foods at time of clinic activities.

Teaching session records

Clinic records

Random questioning of beneficiaries

Food distribution records

Political stability

Availability of commodities

(Revised February 87)

**NARRATIVE SUMMARY**

**OBJECTIVELY VERIFIABLE INDICATORS**

**MEANS OF VERIFICATION**

**MAJOR ASSUMPTIONS**

7) Rudimentary hygiene practice taught

7a) 80% know how to do effective personal hygiene

7b) 80% of mothers know infant bathing

7c) 80% of mothers bathe their children once a day.

7d) 80% of mothers in clinic know 2 techniques of hygiene food preparation.

Random questioning of participants

(Revised February 87)

Appendix D  
Project Objectives

## DEVELOPMENT OF SCOPES OF WORK

### I. OBJECTIVES

#### 1. Restate objectives.

- a. The Matching Grant's goal is to improve the health status of children 0-5 and mothers.

In 1984 the Proposal to USAID Matching Grant Program states:

#### NARRATIVE SUMMARY

##### HIGHER GOAL:

Increase health status of mothers and children in Republic of Haiti

#### OBJECTIVELY VERIFIABLE INDICATORS

1. Decrease national infant mortality rates
2. Decrease national maternal mortality rates
3. Decrease national disease specific morbidity rates for children 0-5
4. Decrease national disease specific morbidity rates in mothers 15-45

##### PROJECT GOAL:

Decreased prevalence of malnutrition in children between ages 0-5 in six target communities of rural Haiti

1. Decrease from 13% to 6% prevalence of malnourished children (Gomez category III) in 6 target communities by June 1988.
2. Decrease from 30% to 20% prevalence of malnourished children (Gomez category II) in six target communities by June 1988.
3. Decrease from 35% to 30% the prevalence of malnourished children (Gomez category I) in 6 target communities by June 1988.

b.

REVISED FEBRUARY 1987  
NARRATIVE SUMMARY

##### HIGHER GOAL:

Improved health status of young children ages 0-5 years in Haiti by December 1988

#### OBJECTIVELY VERIFIABLE INDICATORS

1. Immunize 80% of target group
2. 65% of children in target group gr at approved local standard on RHC
3. All self-selected children will receive Vitamin A and parasite control
4. Self-selected beneficiaries will receive education in six areas related to child health

In 1987 the midterm objectives were as follows:

- Change the nutritional knowledge and practices of the mother.
- Improve the nutritional status of preschool children and/or lactating women.
- Achieve greater access and utilization of health services.
- Reduce fertility.
- Involve women in community development and income generating activities.
- Strengthen local, private or governmental institutions in the delivery of nutrition and health services.
- Institutionalize a nutrition planning/training capability at the national level.
- Stimulate agriculture production.

**NARRATIVE SUMMARY**

**Outputs - 1986**

1. Six nutrition training centers established by January 1986
2. Nutrition recuperation skill training center established in target area by June 1986
3. Nutrition assistant trained for each nutrition center by January 1986 (total 6)
4. 600 mothers in each training center community trained in child growth monitoring by January 1988 (total 9000)

**OBJECTIVELY VERIFIABLE INDICATORS**

1. Six nutrition training centers established by January 1986
1. Minimum average daily occupancy of center 5 severely malnourished children coming for care by June 1986
2. 100 mothers per year trained in one of the following income generation skills:
  - a. sewing
  - b. knitting
  - c. vegetable production
  - d. basketry
1. At completion of each 4 months training the nutrition assistant will actively apply knowledge and acquired skills in each center by January 1986
1. 50% of all mothers trained able to:
  - a. weigh child
  - b. record weight on growth chart
  - c. identify early signs of malnutrition

**NARRATIVE SUMMARY**

**c. Outputs - REVISED FEBRUARY 1987**

1. Center established in the following areas:
  - a. Diquini
  - b. Gressier (1)
  - c. Gressier (2)
  - d. 80 rural clinics of Haiti
2. \_\_\_\_\_
3. Manpower Training Center operational by December 1986
4. Children 0-5 years will grow at approved local rate on RHC in:
  - a. Diquini
  - b. Gressier (1)
  - c. Gressier (2)
  - d. 80 rural clinics of Haiti

Growth Surveillance Program delivered

**OBJECTIVELY VERIFIABLE INDICATORS**

1. Training staff hired by December 1986
2. Two hundred new community health agents trained by June 1988
3. Six hundred CIA's attended continuing education seminars by June 1988
4. 100% of CIA's trained satisfactorily demonstrating knowledge and teaching skills in:
  - a. ORT
  - b. EPI
  - c. Growth monitoring in community clinic
  - d. Family planning
  - e. Nutrition
  - f. Hygiene
1. 65% of enrolled children ages 0-5 years will grow at approved local standard rate on RHC
1. 60% of all self-selected mothers in target communities have a working knowledge of:
  - a. RHC
  - b. Breast feeding/weaning
  - c. Hygiene food preparation
2. 40% of all self-selected children 0-6 months enrolled in the program being breast fed and eating semi-solid foods at six months of age
3. 75% attendance record for weighing growth surveillance maintained by each child 0-5 years during the determined participation phase.
4. 65% of all self-selected children

**NARRATIVE SUMMARY**

**OBJECTIVELY VERIFIABLE INDICATORS**

**NARRATIVE SUMMARY**

**OBJECTIVELY VERIFIABLE INDICATORS**

**c. Outputs - 1984 (cont'd)**

5. 600 mothers in each training center community trained in food sanitation and preparation by January 1988 (total 9000)
6. 600 mothers in each training center community trained in production of vegetable garden production by January 1988
7. 600 mothers in each training center community trained in good nutrition habits by January 1988
8. 600 mothers in each training center community trained in healthful sanitary practices by January 1988
9. 400 mothers in each target community participating bimonthly in Mother's Clubs by January 1988
10. Agriculture Extension Officers trained
11. Home table garden production implemented

1. At end of 4 months training 50% of mothers able to:
  - a. boil water
  - b. sanitize hands, utensils
1. AEO's given 100 hours of continuing education by June 1987 in:
  - a. principles of vegetable and fruit production
  - b. soil fertility
  - c. soil/water conservation
  - d. plant diseases
1. 25% of target households with access to land will maintain a home garden by May 1988
2. 100% of participants of access to needed inputs

**c. Outputs - REVISED FEBRUARY 1987 (Cont'd)**

5. Rudimentary hygiene practice taught
6. \_\_\_\_\_
7. Self-selected beneficiaries will receive education in the following areas related to child health:
  - a. ORT
  - b. EPI
  - c. Growth monitoring
  - d. Family planning
  - e. Nutrition
  - f. Hygiene
8. See number 7
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_

1. 80% know how to do effective personal hygiene
2. 80% of mothers know infant bathing
3. 80% of mothers bathe their children once a day.
4. 80% of mothers in clinic know 2 techniques of hygiene food preparation
1. Clinic sessions will include education in areas listed

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

c. Outputs - 1984 (cont'd)

12. \_\_\_\_\_

13. \_\_\_\_\_

14. \_\_\_\_\_

15. \_\_\_\_\_

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

Outputs - REVISED FEBRUARY 1987 (cont'd)

12. Immunization of self-selected children 0-5 years in following areas:
  - a. Diquinl
  - b. Gressier (1)
  - c. Gressier (2)

13. All the self-selected children will receive Vitamin A and parasite control in:
  - a. Diquinl
  - b. Gressier (1)
  - c. Gressier (2)
  - d. 80 rural clinics in Haiti

14. ORT Promotion Program

15. EPI Program delivered

1. 80% of self-selected children age 0-5 years will have completed immunization protocol by December 1988
2. 80% of self-selected women ages 15-45 will complete T.T. immunization by December 1988

1. 100% of all the children in target group will receive Vitamin A on their first visit and parasite medicine at least once during their enrollment

1. 60% of all individuals in target communities have knowledge of:
  - a. ORT
  - b. Where to get ORS package
  - c. How to administer ORS by December 1988
2. 80% of self-selected mothers with children in target communities have received ORT at least once
3. 80% of mothers giving ORT following third consecutive diarrheal incident
4. Distribution points of ORS available 90% of time through December 1988

1. Two vaccinators trained by December 1986; additional vaccinator trained by June 1987
2. 100% of vaccinators satisfactorily demonstrating knowledge and skill:
  - a. EPI promotion
  - b. Immunization delivery
  - c. Cold chain maintenance
  - d. Sterility control
3. 80% of self-selected parents in target communities have knowledge of:
  - a. EPI importance
  - b. Availability
  - c. Side effects
  - d. Importance of immunization of future children
4. Maintain a constant supply of immunization vaccines
5. 3 service units maintain effective cold chain by June 1987
6. 80% of all self-selected children complete the protocols for immunizations
7. 90% of all self-selected women 15-45 community comply with tetanus

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

c. Outputs - 1984 (cont'd)

16. \_\_\_\_\_

17. \_\_\_\_\_

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

c. Outputs - REVISED FEBRUARY 1987 (cont'd)

16. Family Program functioning

17. PL 480 Outreach support delivered

1. 80% of women 15-45 in the clinic will know at least child spacing technique
  2. 50% of self-selected women receive a condom supply at least one time
  3. 80% of women in clinic program know where to get family planning help/supplies
1. 90% of mothers with their children in the program reached with it

Appendix E  
ADRA/Haiti Vehicles Present

ADRA/Haiti: Vehicles Present:

<u>Big trucks:</u>	<u>License No:</u>	<u>Condition:</u>
4 Ford two-axle 2WD:	H 6919	- operable
	E 8347	- operable
	C 6172	- operable
	I 4732	- operable
1 Ford two-axle 2WD:	C 5986	- inoperable with side out of box
1 Ford two-axle 2WD:	A 8117	- operable, but owned by 4 ADRA employees (sometimes leased)
<u>Small vehicles:</u>		
1 grey Jeep SWB	H 2211	- <u>inoperable</u>
1 brown Jeep LWB	I 3213	- operable, but <u>not</u> reliable
1 brown Cherokee	B 9346	- <u>inoperable</u>
1 additional Cherokee	- (no information)	
1 Toyota Land Cruiser SWB	E 7766	- operable
1 Mitsubishi SWB		- operable
1 brown Ford 4WD pkup	C 5981	- operable
1 white Ford 2WD pkup		- operable
1 Ford Bronco 4WD	I 6043	- operable (but now <u>overheating</u> under light use)

Appendix F  
ADRA/Haiti Financial Statement-June, 1988

ADRA International	<u>HAITI</u> Country	<u>Matching Grant</u> Name of Grant or Proposal	Report Number <u>2</u> Date <u>June 30, 1988</u>	1
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Expense Report June 30, 1988

(Note: All financial figures have to be in U.S. dollars unless otherwise requested)

Month	1 Personnel	2 Training	3 Eqpt./ Mats.	4 Project/ Supplies	5 Transportation	6 Eval.	7	8	9 Total	10 ADRA/local	11 ADRA/
April 1988	3,179.00	2,444.00		194.99	1,384.00				7,201.99		7,201.99
May 1988	3,209.00	378.75		1,680.00	622.70				5,890.45	1,680.00	4,210.45
June 1988	3,094.00	120.98		62.00	1,149.40				4,426.38		4,426.38
TOTAL Qtr. A/B/C	9,482.00	2,943.73		1,936.99	3,156.10				17,518.82	1,680.00	15,838.82
Total expense: last report	17,408.72			2,690.88	3,492.81				23,592.41	8,718.30	14,874.11
Total Up to date	23,890.72	2,943.73		4,627.87	6,648.91				41,111.23	10,398.30	30,712.93

ADRA International

HAITI

Matching Grant

Report Number

2

Country

Name of Grant

Date

June 30, 1988

2

## FINANCIAL STATUS

## Income/Expense Summary

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
ADRA/1	30,861.09	12,923.00			43,784.09
ADRA/local pl D10	8,718.30	1,680.00			10,098.30
Total Income A + B	38,579.39	14,603.00			53,182.39
Expenses pl D9	23,592.41	17,518.82			41,111.23
Balance Carried to Date	15,986.98	( 2,915.82)			13,071.16
U.S. Dollars received	25,000.00	12,923.00			37,923.00
Exchange rate	5 Gdes = 1 U.S.				
Amt. of local currency thru exchange					
TOTAL amt. of currency held (local & U.S. \$)	15,986.98	13,071.16			13,071.16

Appendix G  
MCH Program: Training Session

MCH PROGRAM

Training Session

- I. GOAL: Reduce the incidence of severe malnutrition in children 0-5 years.
- A. Growth surveillance
  - B. Teach health/nutrition classes to the mothers
  - C. Provide food supplements
  - D. Supplies and their use.

II. Monthly reporting

- A. Food distribution form
- B. Report of Activities

LESSONS    Points of emphasis

III. Good Nutrition

- A. Three food groups
- B. Acamil
- C. Kitchen garden

IV. Three critical stages in feeding the child

- A. Before he is born -- prenatal
  - 1. Importance of good nutrition for the mother
- B. After he is born -- breastfeeding mother's milk is best (from Day)
  - 1. 0-4 months, breast milk only
- C. The period of weaning
  - 1. Add solid food gradually, one at a time
  - 2. Crush foods well or press through a strainer
  - 3. Make sure the child is thoroughly used to adult #3 foods before weaning.

4. Nursing while pregnant is not harmful to the other child.
5. Position baby with head elevated while feeding. Why?

V. Growth Surveillance

The importance of weighing the baby each month.

1. Failure to gain weight is a danger sign.
2. Teach progress concept on road to health chart.
3. Early detection prevents serious illnesses.
4. Emphasize the importance of having the mother take the record with her for all the child clinic or doctor visits.

VI. Management and treatment of sick children

A. Diarrhea

1. When does a child have diarrhea?

Three loose watery stools

2. What do you do about it?
  - a. Begin oralits at once if you have it.
  - b. If not, make your own with:
    - 1 glass of water
    - three finger pinches of salt
    - 2 spoons of sugar
  - c. Continue with plenty of fluids and soft foods.
  - d. Give a glass of serum oral after each loose stool.
  - e. This is also good for a child with dehydration from fever or vomiting.

## B. WORMS

1. Rx with piperazine at clinic is good. Rx regime
2. Causes
  - a. Failure to wash hands after defecating
  - b. Impure drinking water  
Defecate on ground & rain washes it into water supply
  - c. Typhoid and diarrhea also transmitted this way
3. Prevention
  - a. Wash own and child's hands before handling food
  - b. Bury fecal matter
  - c. Cover food to protect from flies -- Describe transfer of germs - stool to food

Appendix H  
MCH: Recycle

MCH

RESUME DES RECYCLAGES

Malnutrition et Mortalite - Malnutrition et Maladies

Les infections chez l'enfant

Que peut-on faire pour un enfant ou adulte ayant la diarrhee?

Controle des cahiers roses etc.

- 1- Qu'est-ce-que la diarrhee?
- 2- Pourquoi est-elle dangereuse?
- 3- Quelles sont les causes de la diarrhee?
- 4- Quelle est la cause de la deshydratation?
- 5- Depistage des enfants qui ont perdu beaucoup d'eau et de sels par suite de diarrhee (enfants deshydrates)  
Poser des questions - regarder - tater - peser
- 6- Comment aider une mere a prevenir la deshydratation  
(demonstration - 2 sachets plastiques)

Evaluation de la malnutrition

- 1- Forme aigue (malnutrition recente de breve duree)
- 2- Forme chronique anterieure (mal developpes) (enfants)
- 3- Forme aigue ou chronique (malnutrition recente prolongee)
- 4- Les cas & les plus graves (kw et Ma)
- 5- Les groupes sociaux les plus vulnerables
- 6- Enfants exposes au risque de malnutrition dans les pays en voie de developpement
- 7- Groupe de femmes exposees au risque de malnutrition

## Physiologie de la femme

- 1- La Grossesse normale
- 2- Organes reproducteurs de l'homme (exterieurs)
- 3- Organes genitaux feminins (interieurs)
- 4- Physiologie de la femme (details)  
Sur la grossesse du debut a la fin - Ses differentes phases.
- 5- Grossesse extra-uterine  
La trompe (ses differentes parties)
- 6- Les chromosomes  
Les differentes periodes du foetus
- 7- Le placenta et ses 3 roles
- 8- L'ecographie - Son importance pour la femme enceinte
- 9- L'apport des protides, des lipides et des glucides dans la nutrition de la mere pour le plein developpement de l'enfant.
- 10- Grossesse a risque - en 21 points
- 11- Hemorragie (pendant et apres l'accouchement)
- 12- Grossesses anormales  
Signes: Crise d'eclampsie - de paludisme

### 2e partie, 2e jour

#### La contraception

- 1- Les differentes methodes
  - a) Abstinence - pas facile pour tout le monde
  - b) Thermometre - tres difficiles pour les malheureuses
  - c) Glaire (les catholiques l'aiment et la pratiquent)
  - d) Preservatif masculin: condom
  - e) feminin (diaphragme pour les filles)
  - f) Les pilules (differentes groupes)
  - g) La sterilisation (vasectomie et ligature des trompes)
  - h) Les spermicides locaux (creme pour detruire les spermatozoides)
- 2- Les 3 groupes d'aliments - tableaux distribues.
- 3- La nutrition de l'enfant de 0-5 ans
- 4- Surveillance nutritionnelle
  - Pesee mensuelle (poids) lait maternel
  - Les parasites a eviter, ils mangent la vitamine chez l'enfant
  - L'enfant malnourri est expose a la malnutrition
  - Analyses des selles, 2 fois par an.
  - Sevrage (bon procede a suivre)
- 5- La malnutrition et ses consequences
- 6- La malnutrition et la croissance
- 7- La malnutrition et developpement cerebral
- 8- Developpement normal du cerveau
  - Le cerveau
  - La naissance - 10 jours en plus
  - Conclusion

Appendix I  
MCH Teaching: Diquini Clinic

MCH Teaching June 1988: Diquini Clinic

<u>Date</u>	<u>Topic</u>	<u>Number present</u>	<u>Time</u>
1 June	care of baby	52	10 min
	house hygiene	"	5 min
	personal hygiene	"	5 min
	impor. of dossier	"	5 min
2 June	care of baby	53	10 min
	feeding of baby	"	10 min
	baby's hygiene	"	5 min
	ORT and song	"	5 min
3 June	3 food groups	40	10 min
	Family planning	"	5 min
6 June	feeding of baby	50	10 min
	personal hygiene	"	5 min
	personal hygiene song	"	5 min
7 June	impor. of vaccination	44	10 min
	ORT	"	5 min
	personal hygiene	"	5 min
8 June	public hygiene	?	8 min
	nursing	"	5 min
	bottle feeding	"	6 min
9 June	ORT	50	10 min
	ORT demonstration	"	5 min
	public hygiene	"	10 min
	nursing	"	5 min
10 June	hygiene during pregnancy	30	5 min
	3 food groups	"	10 min
13 June	impor. of dossiers	43	5 min
	ORT	"	5 min
	impor. of vaccination	"	5 min
14 June	nursing	57	10 min
	ORT	"	5 min
15 June	impor. of dossiers	33	5 min
	ORT	"	5 min
	impor. of vaccination	"	5 min

<u>Date</u>	<u>Topic</u>	<u>Number present</u>	<u>Time</u>
16 June	ORT	"	5 min
	ORT demonstration	"	3 min
	public hygiene	"	5 min
	nursing	"	10 min
19 June	3 food groups	32	5 min
20 June	vitamins A & C	49	10 min
	impor. of vaccination	"	5 min
	impor. of dossier	"	5 min
21 June	family planning	52	10 min
	vitamins A & C	"	5 min
22 June	vitamin A & C	32	5 min
	ORT	"	5 min
	ORT demo. & song	"	10 min
23 June	impor. of dossier	21	5 min
	vitamins A & C	"	7 min
24 June	3 food groups	32	10 min
27 June	personal hygiene	32	5 min
	ORT demonstration	"	5 min
	public hygiene	"	5 min
28 June	impor. of vaccination	45	5 min
	public hygiene	"	5 min
	3 food groups	"	5 min
29 June	impor. of dossier	?	10 min
	impor. of vaccination	"	5 min
30 June	impor. of dossier	30	5 min
	ORT	"	5 min
	public hygiene	"	5 min

Appendix J  
Informal Field Survey

Questionnaire used in informal field survey:

I. Weight/health

1. Do you feel this clinic is doing useful work?
2. What are you most interested in here? Why do you come here?
3. Do you have a "road to health" card for your child? Do you understand it?
4. What does each of these colors on the card mean to you?
5. Why is it important to weigh the child each month?

II. Diarrhea/ORT

1. Does your child have diarrhea from time to time?
2. What can be done to prevent diarrhea?
3. What can one do for diarrhea?
4. What kills the child in diarrhea cases, the germs causing the diarrhea or the severe loss of body fluids?
5. How does one prepare oral serum?
6. Does the oral serum treat the condition or protect the child?

III. Vaccination

1. Why does a mother have her child vaccinated?
2. Are there different types of vaccinations?

IV. Tuberculosis

(this section, though suggested by ADRA field staff, was omitted to shorten the interview time)

1. Which is the vaccination against tuberculosis?
2. Who generally gets this disease?
3. What measures can be taken to reduce the frequency of this disease?

V. Nursing/Nutrition/Weaning

1. Which is better for the baby, mother's milk or bottle feeding?
2. At what point after birth should a mother begin nursing her baby?
3. Is the "first milk" important for the baby?
4. Can one give a laxative to the baby? Is it necessary?
5. For at least how long should a mother nurse her child?
6. How should one wean a child?
7. In the village, do you ever see bloated children?
8. What causes this condition?

VI. Child feeding

1. What special care should a mother take in the preparation of her family's meals? Especially those for her small child?
2. What is the best point at which to begin giving the baby food?
3. How many times a day should a baby eat?
4. At what age can one begin giving the child table food?

VII. Expectations

1. What other services would you like to see offered in our center?

Appendix K  
Chemin La Sante (Road to Health Card)

