PLAN INTERNATIONAL CROIX-DES-BOUQUETS

CROIX-DES-BOUQUETS, HAITI

REPORT OF THE

CHILD SURVIVAL VI PROJECT

FINAL EVALUATION AND SUSTAINABILITY

ASSESSMENT

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ABBREVIATIONS AND ACRONYMS

BCG	Bacille Calmette-Guerin (tuberculosis vaccine)
CDB	Croix-des-Bouquets
CHW	Community Health Worker
CS	Child Survival
CDD	Control of Diarrheal Diseases
COLVOL	Voluntary Collaborator
DPT	Diphtheria-Pertussis-Tetanus vaccine
EMMUS	Enquete Mortalite, Morbidite et Utilisation des Services (Mortality, Morbidity and Service Use Survey)
EPI	Expanded Program on Immunization
MSPP	Ministry of Health (Ministere de la Sante Publique et Population)
NGO	Non-governmental organization
PAHO/WHO	Pan American Health Organization/World Health Organization
PHC	Primary Health Care
PLAN	Foster Parents Plan International
PROMESS	Program of Essential Drugs
ROCCA	PLAN International Caribbean/Central American Region
TBA	Traditional birth attendant (femmes-sage)
TT	Tetanus toxoid
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

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I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A1. Project objectives were as outlined in the Detailed Implementation Plan of the revised Child Survival project. The accomplishments of the project as presented in the final evaluation survey follow:

Immunization

Objective:

- Forty percent of children aged 12-23 months will be fully immunized.

Accomplishments:

- Twenty-four percent of children between 12 and 23 months had completed their immunization schedule.
- Among 12 to 23 month old children 42% had received BCG, 37% had received OPV3, 37% had received DPT3 and 36% had received measles vaccine. The drop-out rate between DPT1 and DPT3 was 18%.
- Fifty-five percent of mothers interviewed presented the child's immunization card, 30% had lost it.

Maternal Care

Objectives:

- Thirty percent of women aged 15-49 years will receive five doses of tetanus toxoid.
- Thirty percent of the last year home deliveries will use a clean birth kit.
- Forty percent of last year pregnancies will receive iron tablets for at least three months and vitamin A supplements.
- Twenty-five percent of last-year pregnancies will receive food supplementation during the third trimester of pregnancy.

Accomplishments:

- Nineteen percent of mothers of children under 24 months had received two or more doses of tetanus toxoid.
- Thirty-three percent of mothers had one or more prenatal visits prior to the last birth.
- Twenty-eight percent of mothers presented the maternal immunization card.

A2. In order to understand the circumstances which may have aided or hindered the project in meeting its objectives it is important to remember what the general situation of Haiti has been in the past three years. After elected President J.B. Aristide was deposed by a military coup in September 1991 the international community imposed political and economic sanctions on Haiti in order to press the military regime and allow Aristide's return to power. Sanctions gradually toughened, and by June 1993 an oil embargo approved by the UN Security Council was being enforced.

By January 1994 the political and socio-economic situation had turned critical, affecting the most basic needs of the population. The food price index for Port-au-Prince rose approximately 180% as compared with November 1991, and the number of moderate and severe cases of malnutrition among children under five years of age sharply increased (Haiti USAID Monitoring Report, October 1994). The Ministere de la Santé Publique et la Population (MSPP) had to reduce its activities to a minimum, particularly the provision of supplies (vaccines, oral rehydration salts, drugs, even vaccination cards).

The effects of the embargo were many, but those affecting the PLAN CS VI project directly included:

- Difficulty in obtaining petrol, propane gas and gasoline due to extreme high prices, as well as adulteration of fuel with harmful substances.
- Frequent electrical blackouts.
- Frequent telecommunications interruptions.
- Difficulty in obtaining supplies (drugs, vaccines, needles, syringes).
- Increased price for drugs and reagents.
- Difficulty in repairing or replacing cold chain equipment.
- Difficulty in repairing damaged vehicles.

There were added intangible consequences such as stress, social instability, and fear of random attacks.

Health center staff often could not arrive at clinics and communities on time as a consequence of this dramatic situation. Meetings between institutions were postponed indefinitely, outreach activities (vaccination, supervision) became almost impossible, and generators could not be used.

These circumstances forced many other NGOs to halt work or reduce substantially their activities. The PLAN CS VI project's activities were also reduced, but to a much lesser degree. They adapted surprisingly well to a critical situation, as suggested by the number of vaccines administered at Vaudreuil and Turbe health centers (see Annex 5) during that period. An initial sharp decline in rates occurred during a period between January and February 1994, followed approximately two weeks later by an increase to previous levels. The decline coincided with the toughening of the embargo, suggesting that its initial shock affected the activities of the project. Even though the situation persisted, project activities resumed to previous levels.

Undoubtedly, the circumstance which aided most in meeting the project's objectives were the relationships already established between PLAN and its local partners (a local NGO, HELP, Inc. in Vaudreuil, an MSPP health center in Turbé, and the communities in both areas, see Section II.A1). These institutions were managing the project locally with PLAN/CDB's support, allowing flexibility in managerial systems to cope with problems (as suggested by the rapid recuperation of vaccination activities in the first trimester of 1994). It also indicated a strong commitment both from staff and the community to continue working together in order to overcome the crisis and, obviously, the increased efforts of the partners to overcome obstacles.

Many unintended project benefits began to show up after the project ended, particularly in terms of additional support from other institutions. ADRA will now provide food for approximately 150 children per day for at least one year in Croix-des-Bouquets. In the last three months PLAN/CDB's partners, especially HELP, have begun to establish links with other institutions (the European Economic Community, UNICEF, Eye Care Provax, CONCERN) in order to explore partnerships in health and other areas.

Credit institutions (the Fond Haitien pour Aider les Femmes and the Fond Haitien de Developement) started working with PLAN/CDB nine and six months ago, respectively, in order to provide funds for household income generation activities.

A3. See Annex 4.

B. **Lessons Learned**

The main lessons learned regarding the project include the following:

1. Partnerships with local institutions promote long-term sustainability if they are based on common objectives, mutual respect, and strengthening of local institutional/organizational capacity building.

2. A project may remain operational despite very unfavorable conditions if there is a strong partnership established with local institutions and the community which enables flexible management of the project's activities. Even during the most difficult months of the embargo prior to the military intervention, project activities continued because measures could be taken rapidly in different areas of management (transport, communications, supplies, etc).

3. Successful partnerships may also be useful as a learning process. Present partners have enriched their experience and improved their skills for building other partnerships in the future. PLAN/CDB has established partnerships in other areas (education, agriculture, income generating projects); HELP and MSPP/Turbe are starting partnerships with other institutions; and the communities are being empowered to manage their own efforts.

4. Recognition at various levels of the successes achieved by the project may maintain and increase the motivation of the staff involved. During FY94 and after the project's end, recognition from local communities and from international level institutions was noted during presentations of project activities at the 122nd APHA Annual Meeting (1994), during a global conference "Community Impact of PVO Child Survival Efforts: 1985 - 1994," in Bangalore, India, and at a professional forum in Mexico (Annex 5).

5. Human relations are important to the creation and continuation of a partnership. It should also be highlighted that local communities in the project area, despite their extreme poverty, acknowledged the importance of paying for health services in order to continue receiving adequate health assistance.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A1. The PLAN International Child Survival VI (CS VI) project was begun in the Croix-des-Bouquets district, distant 16 km from Port-au-Prince, on September 1, 1990. After the first project year the need to revise project design was demonstrated. A revised CSVI project was prepared jointly by PLAN/CDB and PLAN International Headquarters between September and November 1992. In 1993 USAID granted a one-year unfunded extension to the project, until August 31, 1994.

A new target population of 17,400 persons living in two areas was selected (reduced from 81,255) for two main interventions, immunizations and maternal care. In Vaudreuil, a local NGO (HELP,Inc.) runs the health center and serves eight communities. In Turbe the health center is part of the MOH system and serves 12 communities. The approach proposed held for PLAN/CDB to carry out the project through partnerships with the MOH (in Turbe), HELP (in Vaudreuil) and the respective communities in both project areas. A major transition in PLAN's strategy, begun in 1992, allowed for "community empowerment" by placing greater responsibility in the hands of the communities for project development, management, and donor relations.

A2. Current PLAN/CDB agreements with HELP and the Turbe Health Center will expire five years after collaboration was initiated. This will take place in August, 1997 for HELP, and in March, 1998 for MSPP-Turbe. A new four-year CS XI project proposal was submitted to USAID in December, 1994.

A3. The project has devoted considerable and permanent efforts towards strengthening local institutional capacity since Memorandums of Understanding were signed with HELP (August, 1992) and MSPP-Turbe (March, 1993). Project responsibilities and control have been phased over to these local institutions almost completely.

Control of the decision-making process:

Most key decisions concerning the project were made at the local level (HELP and Turbe Health Center) from the start. This helped during the most difficult periods of the embargo, when decisions had to be taken quickly and locally in order to adapt to situations as they arose.

HELP had to review its budget in order to allocate additional funds for vehicle fuel and transport. The afternoon and night staff were combined to cover the attending hours at the health center. At one point, the working schedule was to be reduced to three days per week, and key staff were ready to stay at the health center for several days to ensure the continuation of project activities. As the political situation improved and President J.B. Aristide returned to power, these extreme measures were not adopted.

In Turbe Health Center the situation was similar, with the added issue of transient MOH-paid staff. Many MOH staff sought to be assigned to health centers near Port-au-Prince, as MOH positions were not specifically allocated to Turbe. The project had to ask a high-ranking MOH official to assist with this situation.

Financial control and management:

Both local institutions made and implemented financial decisions at their level. Annual budgets were proposed to PLAN/CDB, where they were reviewed technically and approved accordingly. Once approved, budgets were managed at the local level. PLAN/CDB performed audits of both institutions during FY94 with positive results.

Improvement of management systems:

It was noted during the midterm evaluation in June 1993 that some areas of management (communication, transport, maintenance and personnel) were better developed than others (vaccine supplies and health information system). A radio system established by PLAN approximately three years ago included HELP, and is still very effective. In fact, it has been very useful in overcoming the telecommunications difficulties present in Haiti during the past year. Unfortunately the system could not be expanded to Turbe due to bureaucratic issues in the public sector, but it is expected that an expansion will soon be implemented.

Transport and maintenance of motor vehicles has deteriorated as a result of external factors, including adulteration of gasoline, lack of motor parts for replacement, and excessively high gasoline prices. These factors affected the entire country, and PLAN/CDB, HELP and Turbe Health Center were not excluded. Even after the embargo was lifted problems remained. Bicycles are used by health agents and colvols (voluntary collaborators), but a main complaint is that bicycles are easily broken and health agents maintained that they needed motorcycles. The acquisition of other vehicles reaches beyond CS VI project means, and is partly seen by local managers as non-sustainable. Maintenance of cold chain equipment has also been difficult.

Human resources management in HELP and Turbe Health Center are not dependent on PLAN/CDB's system. Both institutions are responsible for staff selection and payment, and salaries are not higher than those from other institutions. Salaries are in fact lower than average, a positive factor towards sustainability.

In Turbe Health Center five persons are paid by the MOH and the remainder (13, including general services) are paid by health center revenues. An additional positive factor is that both health centers offer favorable conditions for staff. In Turbe one nurse and two auxiliary nurses stay overnight from Monday to Friday, and the health center provides bedrooms and meals. In Vaudreuil the community nurse lives in the area, and health center policy is to hire staff who live nearby. A physician and an auxiliary nurse are on duty every night.

An important factor affecting sustainability is staff turnover. Although the Chief of Turbe Health Center (Dr. Peck Dubois) was absent temporarily during the duration of the project, she was replaced by a highly prepared and committed pediatrician (Dr. Mireille Peck). As these two physicians shared a common primary health care approach, the continuity of the project both inside and outside the institution was ensured and the project's potential for sustainability was not overtly affected. The principal staff responsible for project implementation have remained in place. In the case of Vaudreuil some position replacements occurred (program coordinator, community nurse). Health agents/colvols turnover has not been substantial. Staff in both institutions are very highly committed.

Due to their different institutional backgrounds, HELP and MSPP-Turbe have assumed somewhat different finance systems. HELP has developed a more dynamic accounts system that responds to requirements of partners (not only PLAN/CDB) while Turbe Health Center, having had fewer obligations with institutions other than MOH, responds slowly to requests. In that sense, an audit was carried out more easily in HELP than in Turbe Health Center.

Despite the difficulties associated with obtaining vaccines, syringes and needles, the supply system has improved substantially due to improved coordination with suppliers, increased efforts to obtain supplies, and resource sharing between HELP, Turbe Health Center and the district MOH. In order to continue providing vaccines regularly without a refrigerator HELP had to transport vaccines daily to and from the district MOH refrigerator.

Health information system:

Some improvements have been made in both project areas since the mid-term evaluation. The health information system was modified after PLAN/Santo Domingo's Health Coordinator provided technical assistance in December 1993, mainly directed at improving the registration of project beneficiaries.

At the community level information on vaccinated children, growth monitoring, diarrhea cases, household visits, and group education is gathered by health agents/colvols. TBAs register the number of pregnant women they refer and the number of births they assist. In Vaudreuil two "collecteurs de donnés" (data collectors) visit each locality to compile information and bring data to the health center for processing. Monthly reports are submitted at the MOH district level and to PLAN/CDB. HELP established a computerized health information system and began using it a few months ago.

In Turbe information gathered in the community is compiled by the auxiliary nurse responsible for outreach activities, and monthly reports are prepared manually for the MOH district level and PLAN/CDB. In both project areas information is used locally for decision-making by the health team (e.g. concentrating efforts on vaccinations, joint action with the MOH as malaria rates increase, increases in ORS distribution as diarrhea rates increase).

Censuses were carried out in Vaudreuil and Turbe in 1994. Both health agents/colvols and community leaders received training and participated in these activities. Unfortunately, data obtained in Vaudreuil were not complete (individuals could not be grouped by age). Data were processed manually in Turbe.

It is clear that actions have been taken to improve the health information system following the mid-term evaluation, with relative success. Given that considerable effort is being dedicated to the collection of information in Vaudreuil (colvols, data collectors), it would be helpful to have newborns and pregnant women in the community registered by name. This would facilitate follow-up by health agents. Since most of the TBAs are illiterate, registration could be done by a literate person in her family or the patient's family.

In order to attract partners and increase potential sustainability the project must demonstrate efficiency in reaching its objectives; this can be achieved with a good health information system. Census data should be readily available and the referral system should be improved.

Training:

Despite general difficulties during the last year efforts for improving training increased. Main staff participated in international workshops, including WHO briefings organized by the Expanded Programme on Immunization (EPI) and the Programme for the Control of Diarrheal Diseases (CDD) in Geneva, as well as Child Survival workshops organized by PLAN International in Sucre and La Paz, Bolivia.

The Plan of Action for the PLAN CS VI project (see Annex 9), prepared by PLAN/CDB, HELP and Turbe Health Center following the mid-term evaluation, outlined the main training activities to be executed. HELP and Turbe Health Center have been responsible for implementation of this plan. PLAN/CDB has provided technical support where required. Personnel received very little in-service training due to the crisis; the director of obstetrics in Vaudreuil conducted in-service training with personnel on hospital management and hygiene in June, 1994, after attending a seminar on the topic.

Health agents and colvols were trained during formal and in-service sessions. Nine formal courses were organized for colvols in Vaudreuil (see Annex No 9), but it appears that some were organized following a traditional approach emphasizing standard training, and using artificial examples rather than attacking real problems.

Some colvols discussed their difficulty in teaching the community theoretical hygiene measures to avoid diarrhea when community members lacked the means to directly apply the lessons. Courses with direct application to colvols tasks were provided in EPI norms, immuno-preventable disease, the use of registration forms and supervision guides, and community census techniques. There is evidence that these courses prepared colvols to perform some tasks at the community level, including the organization of EPI posts and management of registration forms. Colvols expressed a need to expand training, as their skills for delivering education interventions (in groups or face-to-face) were still limited.

Turbe organized three courses for health agents (EPI, HIV/AIDS, and community census) which were directly related to community problems and needs. Turbe's health agents have received basic and extensive training from the MOH, and performed education sessions routinely. TBAs were also trained, mainly in Family Planning.

B. **Estimated Recurrent Costs and Projected Revenues**

B1. The most effective Child Survival technical activities, as seen by the project's Health Coordinator, were EPI and pre- and post-natal follow-up.

The most effective activity of the project with regard to management has been the transfer of control of financial and decision-making processes to the local level. Staff motivation has also been important to all levels of the project. Local partners have remained in place and continued their activities despite serious external difficulties, and demonstrated great ability to adapt and a very high level of commitment. These factors have been the most important in terms of sustainability.

B2. In order to continue activities in the present project area for at least three years after external funding ends expenditures will be needed to cover core personnel salaries, supplies, transport and training.

Core personnel are local managers, professional staff involved in prenatal care and immunizations, and staff involved in outreach activities (nurse/auxiliary nurse and data collectors/health educators). At present this item is covered by the MOH in Turbe and by HELP's "corpus fund" in Vaudreuil, as specified in project Memorandums of Understanding.

Service delivery supplies, health education materials and training materials have been covered by the project through August, 1994. The Haitian political situation, again, has restricted the acquisition of supplies. At present PLAN/CDB covers these items, but will gradually reduce funding over the next three years. PLAN/CDB will continue the search for additional partners in order to expand Child Survival activities to other communities.

Transport is considered essential for child survival activities to continue, given the importance of supervision and outreach activities. Transportation is also needed to bring staff from the city to both health centers, due to relatively long distances and the difficulties associated with to public transportation.

The need for training will continue, particularly refreshment courses for health center staff and community health workers. Basic in-service training will continue to be needed for colvols in Vaudreuil.

B3. To sustain minimal project benefits an estimated amount of US$ 120,000 would be needed by HELP for three years after child survival funding ends. A similar amount would probably be needed by Turbe Health Center.

B4. Haiti being the poorest country in the Americas, the capacity of the MOH to absorb the cost per beneficiary of child survival activities is in absolute terms very low. The MOH does not have the resources to absorb the costs of child survival activities, and it will probably be some years before it does. Even prior to the political crisis the MOH in Haiti depended largely on external funding to implement its activities.

The population in the project area live in extreme poverty, and their ability to absorb the cost per beneficiary is also very low. Despite extreme poverty, however, the community accepts user fees as a means of maintaining health services quality at a reasonable level.

It must be emphasized that as compared with other projects in the environment in which PLAN Child Survival projects operate, the costs of the CSVI project are very reasonable. Salaries and administrative costs are much lower than those of similar private institutions.

B5. In the case of HELP, user fees and the "corpus fund" will cover 25% of present recurrent costs after Child Survival funding has ended (US$ 24,000 during the third year of agreement). According to the agreement signed between HELP and PLAN/CDB, financial support will be reduced to 50% on the fourth year and to 40% on the fifth. A "corpus fund" was created when the agreement was signed in order to accumulate user fees, (during the first two years of agreement), and other eventual funds. This fund will hopefully provide revenues to cover recurrent costs.

On the other hand, two local NGOs working as PLAN/CDB partners in the area of women's credit (the Fond Haitien pour Aider les Femmes and the Fond Haitien de Development) have proposed, and endorsed, the possibility of paying the health insurance for beneficiaries of credit. A strong possibility exists that this health insurance would be managed by the local health institutions and that services would be provided by them. This would increase revenues in HELP and Turbe Health Center, as these would be the implementing institutions. It is expected that such an agreement will be signed within the next few months.

HELP is working on a potential partnership with Eye Care PROVAX, and will probably include funding for vitamin A deficiency activities. Other potential partnerships are being studied in the areas of health, agriculture, education, and housing. In the unlikely event that no other revenues are obtained, HELP would use part of its land (10,000 sq.m) to obtain funds.

In Turbe Health Center, it is expected that the MOH will continue to cover five staff salaries for at least three years. Projected revenues from user fees will likely fund some child survival activities for at least three years. Specific amounts were not available, but projected revenues are less than those projected by HELP as the MOH limits the fee increases in its health facilities. User fees cover present staff salaries and stipends for health agents, and are expected to continue for three years or more. As for Vaudreuil, following the second year of its agreement with PLAN/CDB financial support for operational costs will be reduced gradually each year (75% third year, 50% fourth year, and 40% fifth year).

B6. Drugs are not likely to be completely sustainable. At present drugs are donated to the local institutions. Vitamin A, iron tablets, and multivitamins are distributed free of charge. Other drugs are sold at subsidized prices and revenues are used for covering various expenses. An additional item which may not be sustainable is fuel/transport.

B7. The lessons to be learned from this projection of costs and revenues include:

- A gradual reduction of financial support to local partners may be possible if it is clearly outlined at the beginning of each agreement and worked out accordingly.
- If local partners are able to cover core personnel salaries, a minimum of activities may continue, thus increasing chances for sustainability.

C. **Sustainability Plan**

C1. Project staff interviewed were Mr. Aloysius Pereira, PLAN/CDB's Field Director, and Dr. Marie Mercy Jean-Louis Zevallos, PLAN/CDB's Health Coordinator. Mr. Pereira participated very actively in the review of the PLAN Child Survival VI project, especially in the reformulation of relationships with partners (including local institutional capacity building). Mr. Pereira has assumed the general management of the project, including all aspects related to local institutional capacity building. He has been actively involved in the mid-term and final evaluations.

Dr. Zevallos has participated very actively in the review of the project, its monitoring and evaluation, and the preparation of the mid-term evaluation Plan of Action. Her involvement has included the provision of technical assistance to local institutions when required (more frequently with Turbe Health Center).

C2. The project's plan for sustainability, as discussed in the midterm evaluation's Plan of Action and the FY93 report, has been oriented mainly towards community empowerment and the development of partnerships at the local level, including strengthening local institutional capacity.

The plan for empowering communities has been based on working with health committees at the local and regional levels to involve them in project activities. An important element of community involvement was the health agent (in Turbe) or colvol (in Vaudreuil), who as a community member carried out preventive child survival activities.

PLAN/CDB selected partners based on the criteria of common objectives. Strengthening of local institutional capacity was planned through transfers of project management to the local level, beginning with control of the decision-making process and finance. Existing management systems at the local level (communication, transport, maintenance, personnel, supplies, and the health information system) were improved by providing resources relevant to field responsibilities.

Another important aspect of partnerships has been the phase-down of financial support. Local partners have to cover 25% of expenditures during the third year of the agreement, specifically core personnel salaries.

A diversification of the project funding base through additional partnerships has also been sought during the project lifetime.

The mid-term evaluation Plan of Action proposed actions oriented towards the functional integration of project activities within the local health system. Periodic coordination meetings with MOH officials, meetings between PLAN/CDB, Turbe Health Center, and HELP, and resource sharing (personnel, local expertise) between centers, has allowed for coordination, technical assistance and Plan of Action follow-up.

Other activities proposed by the mid-term evaluation Plan of Action were: improvement of the health information system, improvement of the supervision system and periodic training for health agents/colvols. Periodic supervision by PLAN/CDB of partners and a bi-annual evaluation of the project by an external consultant was planned.

C3. The main sustainability-promoting activity carried out by PLAN/CDB over the lifetime of the project has been the development of solid partnerships based on three main factors: common objectives, mutual respect, and strengthening local institutional capacity building. Partners were carefully selected in order to assure shared common objectives existed. It should be mentioned that two potential partners were not involved in the Child Survival VI project because of their exclusively curative health approach.

Agreements were reached which clearly defined the responsibilities of all partners (PLAN/CDB, HELP, Turbe Health Center, and local communities), including phase-downs of financial support during specified periods. Project management was transferred to local partners as soon as agreements were signed.

C4. PLAN/CDB has satisfactorily brought about institutional strengthening of local partners (HELP and Turbe Health Center), as observed through project successes, including positive local leadership, a moderate level of beneficiary involvement, use of local human and material resources, flexibility and responsiveness to needs, autonomy and accountability, and a "learning process" approach to project planning and management. It must be emphasized that this strengthening was achieved despite very negative political environment. Project management has been transferred almost completely to the local level, and management systems were improved in local institutions.

HELP began fund-raising and formed a "corpus fund" from the first year of its agreement. During the second year it increased user fees and abolished exemptions (EPI and antenatal care are free of charge). By the third year HELP was able to cover 25% of costs, including core personnel salaries.

In terms of human capacity building, emphasis was placed on training to improve both technical skills (EPI, CDD) and managerial skills. PLAN's Regional Headquarters organized trainings characterized by an action-oriented approach (note Section II, F5).

Steps were initiated towards empowerment of local communities through their health committees, but apparently these efforts have not been very active in past months as they are perceived to be dependent on "specialized" institutions (health centers). Nevertheless, PLAN/CDB has been working on a more integrated initiative of community empowerment which deals with community organization, credit, housing, basic education, water/sanitation, and skills training.

Incentives for community health workers (health agents, colvols and TBAs) continued in order to maintain motivation in non-monetary terms, except for a very low stipend given to health agents in Turbe (the equivalent of US$ 20 per month).

Joint meetings and joint actions were initiated between HELP and Turbe Health Center in an effort to functionally integrate project activities with the local health system. These meetings were halted due to lack of fuel and transport. Resource sharing was initiated between HELP, Turbe Health Center, the MOH district and PLAN/CDB, including vaccine supplies, cold chain, vitamin A, and transport. MOH district personnel continued to provide technical assistance to Turbe Health Center, and began providing it to HELP.

The health information system was reviewed in December, 1993, and suggestions were made. Changes were apparently applied less than three months before project funding ended. A review and epidemiological analysis of the baseline survey carried out in Vaudreuil in 1993 was not performed.The supervision system at the local level (from health center staff to CHWs) has improved. Turbe Health Center was regularly supervised, but HELP was not. Bi-annual evaluations were not initiated.

A diversification of the project funding base was not possible because of the embargo and diplomatic isolation of Haiti, which became worse during the last six months of the project.

The relationship established between local NGOs and PLAN/CDB for credit activities in the project area was an unplanned beneficial activity, beginning three months before the end of the project.

C5. With project Memorandums of Understanding HELP and Turbe Health Center agreed to support child survival activities financially after the second year of agreement (in September, 1994, and March, 1995, respectively). HELP has kept its commitment and is presently covering 25% of child survival expenditures. Turbe Health Center has begun work to keep its commitment as well.

No other counterpart institutions made any financial commitment to sustain project benefits during the design (proposal or DIP) or the review of the project. ADRA and the French Embassy made commitments (not financial) for the provision of food supplements used for the nutrition component of the project, and these have been kept.

C6. The reasons given for the success of HELP in meeting its financial commitment include: (a) a clear agreement outlining the transfer of the project was signed at project initiation, and (b) mechanisms were developed from the onset for financial self-sufficiency.

Turbe Health Center also signed a clear agreement at project inception, but present mechanisms for financial self-sufficiency remain weak. As part of the MOH the health center can not increase user fees freely (but is able to reduce exemptions) or open a "corpus fund" to be used in the future. Turbe Health Center has proposed community income-generating activity (a shop run by the community for selling tools), but funding has not been obtained. The health center will probably need to be more active in terms of public relations and information sharing if other sources of funding are to be gained.

D. Monitoring and Evaluation of Sustainability

D1. The documents reviewed did not specifically mention indicators for tracking sustainability outputs and/or outcomes. Nevertheless, some indicators related to sustainability were mentioned in documents and in interviews with the project director (at different stages of the project).

Indicators related to institutional strengthening:

- Proportion of key decisions (and responsibilities) concerning the project taken by local partners.
- Number of flexible rules established by the project to enable local partners to maintain stability under adverse general circumstances.
- Number of joint meetings between PLAN/CDB, HELP, Turbe Health Center, and MOH district officials to coordinate child survival actions.
- Number of resources shared (technical assistance, supplies, equipment) between local partners or with the MOH district.

Indicators related to mobilization of financial resources:

- Degree of compliance with the financial commitments established in agreements signed with local partners.
- Proportion of core personnel salaries among local institutions paid with local funding.
- Number of partnerships established to diversify funding base.

Other indicators have also been used for the final evaluation (Stefanini and Ruck, 1992).

Indicators related to institutional strengthening (in addition to those mentioned above):

- Number of mechanisms established by the project for information sharing between partners and other local health institutions (MOH, local NGOs); joint actions (informal agreements, workshops); and use of information in monitoring project processes and outputs.
- Number of public relations/diffusion activities regarding project goals, processes and achievements.
- Community involvement at different project stages, and community sense of ownership.

Indicators related to human capacity building:

- Training: local development of curricula, inclusion of community needs in training, proportion of in-service and new skills training.
- Local management knowledge of human resource strengths and weaknesses, and of physical resource capacity.
- Methods of communication between managers and staff.
- Staff awareness of, and receptivity to, managers goals and strategies.

D2. Indicators demonstrate accomplishments with regard to sustainability in some aspects of the project, especially in terms of institutional strengthening and mobilization of financial resources. Rules have been flexible and useful in enhancing the staying power and stability of local partners, particularly during periods when other institutions were unable to do so. HELP has begun to cover a portion of project expenditures, and is covering core personnel salaries with its "corpus fund". The MOH covers core personnel salaries in Turbe Health Center, other salaries are covered with user fees.

Human capacity building has also improved. Local managers understand the strengths and weaknesses of human resources, methods of communication have substantially improved, and staff are aware and receptive to the project's goals and strategies. Training has continued but there is still room for improvement.

Considerable efforts have been devoted recently to the improvement of the health information system, but it is still too early to determine whether information is being used appropriately in monitoring project processes and outputs.

D3. Data indicating a change in the sustainability potential of project benefits were based on the following qualitative methods:

- Semi-structured interviews with PLAN/CDB's Field Director and Health Coordinator, HELP's director and Turbe Health Center's director.
- Informal interviews with district MOH officials and health center staff.
- Focus groups organized for each project area, with health center staff, health agents (in Turbe), colvols (in Vaudreuil), TBAs, community leaders, and community members (mainly women). PLAN/CDB's Training Coordinator acted as moderator for most of the groups. All the sessions were held in creole, and recorded and transcribed/translated to french.
- Review of relevant documents: DIP, FY93 report, midterm evaluation's Plan of Action, Memorandums of Understanding between PLAN/CDB and each local institution (HELP and Turbe Health Center), and site visit reports from the PLAN International Headquarters Child Survival Coordinator.
- Observation.

D4. Local partners (HELP and Turbe Health Center) participated actively in the implementation and analysis of the midterm evaluation. PAHO/WHO participated in the analysis of aspects related to immunizations in the midterm evaluation.

HELP and Turbe Health Center participated also in the design, implementation and analysis of the final evaluation. No other in-country agencies participated.

D5. PLAN/CDB received no feedback by the reviewers of the proposal or DIP concerning sustainability.

D6. Immediately after the recommendations were received joint meetings and joint actions began to be carried out, but could not continue because of serious transport problems.

E. **Community Participation**

E1. Focus group sessions with area leaders and community members (separately) were planned both in Turbe and in Vaudreuil. In Turbe the sessions were held with more than the recommended number of participants (17 leaders in one session and 15 mothers in another). This was due in part to the community's willingness to collaborate. In Vaudreuil sessions were held with seven leaders and seven mothers. The participants were church leaders, school teachers, representatives of locality organizations, etc. One "houngan" (voodoo healer) participated.

E2. Community leaders perceive food supplementation and vaccinations as the most effective child survival activities. Although not technically a child survival activity, consultations in general were perceived as very effective.

E3. PLAN/CDB has been working at the community level, where it has revised activities in order to enable communities to better meet their basic needs. Efforts with communities include work towards improving community strategies.

PLAN has begun to increase the coverage of its agriculture, education, skills improvement, housing/latrines, water system and credit projects utilizing an integrated approach (empowering community organizations and widening their base). At the institutional level it is working together with partners in the formulation and implementation of new projects. This integrated approach will also contribute towards increasing the ability of communities to sustain child survival activities.

In order to increase the ability of communities to sustain effective child survival activities the health education component of the project has been emphasized. In Turbe, health agents frequently cover various child survival topics during face-to-face and group sessions. In Vaudreuil colvols principally cover immunizations and the promotion of health services. Health agents and colvols are continuously being trained to better cope with community health problems.

E4. Communities involved with the project have participated in the design, implementation and evaluation of child survival activities, mainly through meetings with health center staff and the discussion of specific topics. They have also participated in focus group discussions during both the midterm evaluation and final evaluation.

The results of the project final evaluation will be presented and discussed with community leaders, and a Plan of Action will be developed.

E5. One health committee has existed in Turbe for over six years, and meets monthly with health center staff; members of this committee seem representative of their communities. Their role is to analyze health problems, collaborate with the community census (when needed), provide health education in their localities and motivate the community towards health improvement.

No health committees exist in the Vaudreuil area as such, but health issues are presented by the colvols when the "Water Committee" (a very important organization in the area) meets. Regular meetings are organized in the community with HELP's staff to discuss health issues.

E6. The most significant issues currently being addressed are those related to the overall political situation, mainly malnutrition. The high cost of food supplies, the lack of water for irrigation and the reduced productivity of food crops are among the problems the community faces. Malnutrition has increased significantly in the country in general, and Croix-des-Bouquets is no exception. At present malnutrition affects not only children but women as well. There is a generalized perception that solving the irrigation problem will provide enough food to alleviate malnutrition and other diseases.

E7. In spite of its extreme level of poverty the community has been able to contribute substantial funds for the continuation of project activities after donor funding ends. The community is also involved through the participation of health agents and colvols, who have been selected by the community itself and are part of it. With proper supervision, continuous training, and adequate supplies health agents and colvols will be able to sustain the outreach activities of the project. TBAs are also part of the community and cooperate with project health centers in child survival activities.

The community has also dedicated time to health activities, as expressed by leaders, mothers and health agents.

E8. Health committees do not play a predominant role in the communities in part because, as mentioned, their priorities are primarily agriculture and nutrition. Nevertheless, less "specialized" organizations in the community are being strengthened and will eventually be able to contribute resources for the effective continuation of project activities.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Staff were interviewed in local institutions, including Dr. Lizie Peck Dubois, Director of the Turbe Health Center. Dr. Lesly Henry, Chief of Obstetrics and Gynecology, and Ms. Gerda, the auxiliary nurse responsible for outreach activities were also interviewed. Dr. Dubois has participated actively in project implementation, project monitoring, and the final evaluation. Dr. Mireille Peck, who replaced Dr. Dubois temporarily, participated actively in the project review, in project implementation, the midterm evaluation, and the preparation of the midterm evaluation Plan of Action. Dr. Henry is responsible for the quality of services offered at the health center, and has participated in the project's implementation at the service delivery level as well as in monitoring and evaluation. Ms. Gerda has participated in project implementation, especially immunization and outreach activities (at the health center and community levels). She has also participated in project monitoring, and partly in the evaluation (midterm and final) of project activities.

For HELP, both Dr. Michel Brutus, Director, and Ms. Nerlyne Pelissier, nurse in charge of outreach and child survival activities were interviewed. Other staff interviewed were: Dr. Georges Blemur (Chief of the maternity ward), Ms. Yanique Dupon (auxiliary nurse in

charge of immunizations), Ms. Rosenive St. Vilus (auxiliary nurse in charge of nutrition), Ms. Fidelia (systems operator), and Lamartine Cebea and Nelzy Solange (child survival data collectors). Dr. Brutus has participated very actively in the project review, project implementation, and in monitoring/evaluation. Ms. Pelissier has participated actively in implementation, including training of community health workers during the project's last months as well as in project monitoring and the final evaluation.

Dr. Antonio Narcisse, the Croix-des-Bouquets district-MOH director of Community Health and Dr. Wilfred Thenor, Chief of the Croix-des-Bouquets MOH health center, were interviewed together. Dr. Narcisse is responsible for child survival activities at the district level, including vaccine supplies. He provides technical support to HELP and Turbe Health Center. Dr. Thenor does not have a direct relationship with the PLAN CS VI project.

F2. HELP and the MOH Turbe Health Center are the key local health institutions with which PLAN/CDB has been working as partners. At the local level, HELP has started partnerships with several NGOs (Double Harvest, PROFAMIL) and institutions (ADRA, the French Embassy, FAF), and is working on potential partnerships with the European Economic Community, Eye Care PROVAX, Concern, the World Bank, United Nations Development Fund, UNICEF, AOPS and the Canadian International Development Agency.

At present the French Embassy provides food for the nutrition activities in Vaudreuil. The MOH health center in Turbe also receives food supplies for its nutrition activities. Linkages do not involve financial exchanges. HELP and Eye Care PROVAX are preparing agreements in order to work on blindness prevention, with an important vitamin A component. It has been suggested during this final evaluation that, following an integrated approach, partnerships may be established with agricultural agencies in order to promote the production and consumption of foods rich in vitamin A.

At the district level the MOH is the key local institution. The MOH pays five essential staff in Turbe, provides vaccine and other supplies to Turbe Health Center and partly to HELP, collects information from both health centers, supervises child survival and other activities, and provides assistance for training. A nurse from the MOH district provides support for outreach activities in Vaudreuil (HELP). The MOH considers Turbe Health Center to be a "mixed institution" because it receives external support in addition to MOH support.

At the national level PAHO/WHO and PROMESS have had formal linkages with the project, but in real terms the cooperation received has not been adequate. During the embargo PAHO/WHO was in charge of distributing fuel for humanitarian activities. PLAN/CDB received fuel but HELP did not, as "it did not provide humanitarian aid."

F3. PLAN/CDB expects its partners (HELP in Vaudreuil, the MOH health center in Turbe, and both communities) to take part in sustaining project activities, as outlined in project Memorandums of Understanding. It is also expected that the MOH at higher levels (district, central) will eventually sustain these activities.

F4. CHWs and personnel working with HELP agreed that the most effective child survival project activities were: prenatal care (the most important), consultations (not a child survival activity), immunizations, and nutrition. In Turbe, CHWs and personnel thought that immunizations, nutrition, household visits, education, and family planning (although not part of the project) were the most effective activities.

F5. PLAN/ROCCA and PLAN International Headquarters organized child survival training workshops in Santo Domingo (Dominican Republic), Sucre, and La Paz (Bolivia), where staff from HELP, Turbe Health Center and PLAN/CDB attended. Topics included Maternal Care and Acute Respiratory Infections, Ensuring Effectiveness and Sustainability, and Technical Update on Child Survival Programs.

A workshop on Health Information Systems will be held in the first semester of 1995. These workshops have included training of CHWs.

Four members of PLAN/CDB and its partners attended the two-week Technical Briefings on Diarrhea Disease Control, Immunizations and Control of Acute Respiratory Infections organized by the World Health Organization (Geneva, November 1993), with the support of PLAN. Following these briefings training courses on management of EPI and Control of Diarrheal Diseases were held in HELP and Turbe Health Center.

F6. Human resources (five staff members) as well as vaccines and limited material supplies are currently provided by the MOH to the Turbe Health Center. According to Dr. Thenor (Chief of the CDB Health Center, not directly involved in the Child Survival project) there is still a possibility that the MOH will halt funding to Turbe Health Center, taking into account that it is considered a "mixed institution".

By the time the final evaluation was conducted (December, 1994) the possibilities for the MOH to increase its support to Turbe were minimal. The view of MOH officials regarding the general situation in Haiti was one of "prudent optimism." They recognized that political stability had improved, but it was impossible to envisage the future clearly.

Following the midterm evaluation HELP improved its relationship with the MOH at the district level, and has received technical support for its training and outreach activities. In Turbe the health center has maintained a good relationship with the district MOH. In order to improve potential sustainability both project areas would need to involve district level MOH staff more actively by increasing means of information sharing (meetings, seminars), joint action (task forces, teams), and use of information for monitoring the project's processes and outputs. This is also true for other relevant local health institutions (Croix-des-Bouquets MOH health center, Double Harvest) and the community.

F7. MOH officials perceived EPI to be the most effective Child Survival project activity. HELP's manager believed EPI and pre-natal care to be the most effective activities, and would like to see them sustained. In the case of Turbe the director perceived nutrition and CDD (although not part of the CS VI project) as the most effective. EPI was perceived as weak because of logistics problems (the supply deficiencies, lack of vehicles, and lack of fuel which were faced).

G. **Project Expenditures**

G1. See Annex 10.

G2. The actual expenditures for supplies were much higher than originally planned, due to an extremely high increase in fuel costs. Expenditures for other categories of procurement (mainly services and consultants) were much lower than planned, however, allowing compensation of these differences.

Other categories with actual expenditures much higher than planned included "other personnel" and "international travel/per diem".

G3. Finances were handled in a competent manner, given the difficulties faced in Haiti. As mentioned before (see Section A3), decisions were mostly taken by local partners. Changes were effected quite rapidly so project activities could continue without being sharply reduced. It would have been impossible to continue the most basic project activities without having fuel for transportation of personnel and supplies.

The "international travel/per diem" expenditures might be seen as an investment for the development of local managerial and technical capacity.

PLAN/CDB conducted audits in HELP and Turbe Health Center with good results.

G4. It is possible to handle finances in a competent manner when the general situation surrounding the project turns critical if: (a) strengthened local institutions play an important role in decision-making, (b) flexible rules are used, and (c) changes are made as quickly as needed.

H. **Attempts to Increase Efficiency**

H1. The main strategy implemented by PLAN/CDB to reduce costs and make the project more efficient was the establishment of solid partnerships with local institutions (HELP and Turbe Health Center). This strategy increased the coverage of child survival activities through already existing health services and outreach activities performed by CHWs in coordination with health center staff.

Another important strategy was the expansion of health services to non-PLAN affiliated families. In the past the beneficiaries of health care offered by PLAN/CDB included only affiliated families (i.e. with a foster child) or communities where a Mobile Health Clinic visited. Additionally, PLAN/CDB installed a radio system which included vehicles.

Local institutions implemented their own strategies to reduce costs, increase productivity and make the project more efficient:

- Promotion of health services (especially maternal care) at the community level to increase demand.
- Routine rally posts in every community to increase immunization coverage.

- Modification of patient flow at the health center to cope with increased demand, including reductions in waiting time and reduction of missed opportunities for immunization.
- Extension of the maternity ward's opening hours to 24 hours per day to promote the use of health services (in Vaudreuil).
- Search for less expensive fuel (provided by PAHO/WHO).

H2. The reasons for success in these attempts to reduce costs, increase productivity and efficiency include:

- Partners were carefully chosen and supported to accomplish their objectives.
- Demand was successfully increased because of the active role played by CHWs and TBAs in promoting health services.
- Immunization coverage was improved (although not to the levels initially planned) because rally posts were maintained despite previously mentioned difficulties. Missed opportunities were reduced as vaccination schedules and false contraindications were emphasized during training and routine work.
- The radio system was useful not only as a tool for increasing efficiency and reducing costs, but also for security reasons during critical periods of political instability. It was the most reliable and quick means of telecommunications at times when telephones were not operating.

The reasons for the failure or partial success of some attempts were:

- Excessively high fuel costs.
- Child survival activities within the health center and the community were not always performed on time due to difficulties associated with transportation of personnel and supplies (late arrival, lack of fuel, etc).
- Only PLAN/CDB received fuel from PAHO/WHO. HELP was not eligible because it was not considered a humanitarian organization.
- Health services were provided to patients coming from communities not covered by the project, because both health centers (in Vaudreuil and Turbe) were accessible to these areas.

H3. Efficiency may be substantially increased through local partners that are capable of increasing health coverage with local health services and outreach activities. CHWs further play an important role in increasing coverage at the community level.

I. Cost Recovery Attempts

I1. The cost-recovery mechanisms implemented to offset project expenditures include:

- Implementation of user fees in both Turbe and Vaudreuil. In Turbe patients pay five gourdes (1 USD = 12 gourdes) per visit, including consultation, drugs, and laboratory fees. In Vaudreuil patients used to pay the same amount but fees have been recently increased to 10 gourdes (0.83 USD) per consultation, 10 gourdes for pharmacy, and 10 gourdes for laboratory examinations (if needed).

- Reduction of user fee exemptions (in Vaudreuil). In the past HELP offered incentives to CHWs, TBAs and staff by exempting them from paying for health services. When it was realized that the amount of these exemptions was quite high (up to 40% of users' fees) they were eliminated. Nevertheless, when a patient arrives and has no money he/she can pay afterwards but is not denied assistance. This is, in a sense, a selective fee exemption scheme.

- Drugs programs were designed to cover part of the recurrent costs of local institutions but they are still deficient because of a general lack of drug supplies in the country, frequent failure to collect payment, inflation, and inclusion of drugs like cyproheptadine.

Implementation was managed by local partners (Turbe Health Center and HELP).

I2. The cost recovery obtained by HELP has begun to cover 25% of recurrent costs (approximately 25,000 gourdes per month, or US$ 2,083), justifying the efforts and funds required to implement these mechanisms. This can also be said about Turbe Health Center, where fee recovery mechanisms were already in place and the costs recovered paid salaries of non-professional staff.

I3. Cost recovery activities are seen by the community as necessary. Community leaders and mothers stated their support for these activities with some resignation. Typical statements included: "it's a favor the health center is providing us," "the health center sells very cheap medicines," "no problem, because health is priceless," or "other clinics are more expensive." Health workers mentioned that very exceptionally people think that "staff come here to make money." These statements have to be taken cautiously. Experiences in Zaire (Bethune, 1988), Sierra Leone (Fabricant et al, 1990), Ghana (Waddington, 1990) and Swaziland (Yoder, 1989) and a review by Creese (1991) have reported that an increase in users fees reduces demand, affecting mainly preventive services.

According to mother's statements, some had to delay their visits to the health center (in Vaudreuil) because of a lack of money. This did not happen if severe health problems prompted a visit. Staff in Vaudreuil indicated that after users fees were increased the number of prenatal consultations dropped from 40-50 per day to 15-30 per day. The Executive Director of HELP explained that this drop in consultations coincided with the "bad" period in agriculture and that approximately 75% of the population can pay users fees.

I4. The project did not involve household income generation activity.

I5. - In spite of the level of extreme poverty present in the project area, community members accept users fees as a necessary means of having access to good quality health care. HELP has been more successful than Turbe HC with its cost recovery mechanisms through increasing users fees and reducing exemptions to a minimum.
- The local community needs to learn that health care is not cheap in order to understand the reason for the implementation of users fees.

J. Household Income Generation

The project did not implement household income-generating activities. However, an integrated approach is used by PLAN/CDB for the implementation of development projects, which includes skills training, water and sanitation, housing, agriculture, and credit. A credit program is now being implemented by PLAN/CDB, and is expected to cover part of the cost of health activities.

K. Summary of Sustainability

K1. The project's accomplishments in enabling communities to meet their basic health needs are principally those related to community education and training of CHWs. Health agents in Turbe were trained eight years ago and are well prepared to conduct group and face-to-face community education in various aspects of Child Survival. They also provide health services at the community level. Colvols (voluntary collaborators) in Vaudreuil are being trained by HELP and are able to conduct group education in a limited number of aspects of child survival. PLAN/CDB is working actively in the strengthening of community organizations, which will empower them to meet their basic health needs.

The project's accomplishments in promoting sustainability of effective child survival activities may be summarized by mentioning the success achieved with local partners, who have assumed complete responsibility and control of the decision-making process. The fact that staff salaries are being covered by recovery mechanisms (in Vaudreuil) and/or by the MOH (in Turbe) is in favor of sustainability.

The project's competence in carrying out its sustainability-promoting activities has been tested during the critical political situation present in Haiti through most of the lifetime of the project. Activities continued without a substantial reduction because of an increased effort made by PLAN/CDB and partners along with adequate changes in management. The gradual reduction of financial support, already in effect, is another measure of the project's efforts towards sustainability.

The main lessons learned regarding the total project are the following:

1. Partnerships with local institutions promote long-term sustainability if they are based on common objectives, mutual respect, and strengthening of local institutional/organizational capacity building.

2. A project may remain operational despite very unfavorable conditions if there is a strong partnership established with local institutions and the community, which enable a flexible management of the project's activities. Even during the hardest months of embargo and before the military intervention, the activities continued because measures could be taken quite rapidly in different areas of management (transport, communications, supplies, etc).

3. A successful partnership may also be useful as a learning process. Present partners have enriched their experience and improved their skills for building other partnerships in the future. PLAN/CDB has initiated partnerships in other areas (education, agriculture, income generating projects); HELP and MSPP/Turbe are starting partnerships with other institutions; and the communities are being empowered to manage their own efforts.

4. Recognition at various levels of the successes achieved by the project may maintain and/or increase the motivation of the staff involved. During FY94 and during the period after project end recognition from local communities and international level institutions was noted (APHA Annual Meeting, presentations of project activities in Mexico and India).

5. Human relations are very important for the creation and continuation of a partnership. It should also be highlighted that the local communities in the project area, despite their extreme poverty, acknowledge the importance of paying for health services in order to continue receiving adequate health assistance.

III. EVALUATION TEAM

A1. The members of the final evaluation team included:

- Constanza Vallenas, MD, MSc.
- Gustavo Tapia, MD, MSc, Health Coordinator, ROCCA, PLAN International.
- Marie Mercy Jean-Louis de Zevallos, MD, Health Coordinator, PLAN/CDB.

A2. Dr. Constanza Vallenas is the author of the evaluation report.

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Stefanini A. A selected annotated bibliography on Sustainability of Health Care in Developing Countries. International College for Health Cooperation in Developing Countries, Padova, Italy (1993).

ANNEX # 1

FINAL EVALUATION GUIDELINES

FHA/PVC GUIDELINES FOR FINAL EVALUATION & SUSTAINABILITY ASSESSMENT OF CHILD SURVIVAL PROJECTS ENDING IN 1993 (CS-VI)

The final evaluation team should address each of the following points. If at all possible, respond to each point in sequence.

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A1. State the objectives of the project, as outlined in the Detailed Implementation Plan, and state the accomplishments of the project related to each objective.

A2. Describe any circumstances which may have aided or hindered the project in meeting these objectives, and explain any unintended benefits of project activities.

A3. Attach a copy of the project's Final Evaluation Survey, and state the results for each relevant indicator (see Table 1).

B. Lessons Learned

B1. Outline the main lessons learned regarding the total project that are applicable to other PVO C.S. projects, and/or relevant to A.I.D.'s support of these projects.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A1. At what point does A.I.D. funding for this child survival grant end?

A2. At what point does the organization plan to cease child survival project activities?

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

B. Estimated Recurrent Costs and Projected Revenues

B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

B5. What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?

B6. Identify costs which are not likely to be sustainable.

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

C. Sustainability Plan

C1. Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

C2. Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

D. Monitoring and Evaluation of Sustainability

D1. List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes.

D2. Do these indicators show any accomplishments in sustainability?

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

D4. Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

E. Community Participation

E1. Please identify community leaders and members interviewed and indicate which group(s) the leaders represent.

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Do these linkages involve any financial exchange?

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once A.I.D. funding terminates?

F6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

F7. Are there any project activities that counterpart organizations perceive as effective?

G. Project Expenditures

G1. Attach a pipeline analysis of project expenditures.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

G3. Did the project handle the finances in a competent manner?

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

I3. What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

I4. What are the reasons for the success or failure of the household income generating activities of this project?

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

J2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.

J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

K. Summary of Sustainability

K1. Please give a brief (no more than one page), succinct summary of the responses to the previous questions concerning:

- the project's accomplishments (in terms of outputs and/or outcomes) in enabling communities to meet their basic health needs, and in promoting sustainability of effective child survival activities;

- the project's competence in carrying out its sustainability promoting activities;

- any lessons to be learned regarding sustainability that might be applicable to other PVO child survival projects, and/or relevant to A.I.D.'s support of these projects.

III. EVALUATION TEAM

A1. Attach a list of all members of the final evaluation team and indicate institutional affiliation.

A2. Indicate who is the author of the evaluation report.

ANNEX # 2
TIME FRAMEWORK

TIME FRAMEWORK
FINAL EVALUATION AND SUSTAINABILITY ASSESSMENT OF THE
CHILD SURVIVAL VI PROJECT
PLAN INTERNATIONAL CROIX-DES-BOUQUETS, HAITI
December 5 - 18, 1994

DATE	ACTIVITY	RESPONSIBLE	SUPPORT
Mon Dec 5 (9 am)	General meeting with Drs Zevallos, Dubois, Brutus and Vallenas to outline agenda.	Dr. Zevallos	
Tue Dec 6	Meeting to discuss questionnaires for focus groups.	Dr. Vallenas	Translation into creole
Wed Dec 7	Focus groups (Turbe): Staff, health agents. Bibliography review.	Dr. Vallenas Dr. Dubois Dr. Zevallos Dr. Vallenas	Room, cassette recorder Refreshments
Thur Dec 8	Focus groups (Turbe): Community leaders, TBAs.	Dr. Vallenas Dr. Dubois Dr. Zevallos	Room, cassette recorder Refreshments
Fri Dec 9	Meeting to reformulate time frame. Field visits, interviews with key informants.	Dr. Tapia Dr. Zevallos Dr. Vallenas Dr. Vallenas Dr. Zevallos	Translation Transport
Sat Dec 10	Analysis of qualitative data (Turbe).	Dr. Vallenas	
Mon Dec 12	Focus groups (Vaudreuil): Personnel.	Dr. Vallenas Dr. Brutus	Room, Cassette recorder
Tue Dec 13	Focus groups (Vaudreuil): Community leaders + community members + CHWs.	Dr. Vallenas Dr. Brutus	Room, Cassette recorder Refreshments

Wed Dec 14	Field visits (Vaudreuil), interview with key informants.	Dr. Vallenas Dr. Brutus	Transport Translation
Thur Dec 15	Preparation of draft.	Dr. Vallenas	
Fri Dec 16	Workshop for the analysis and discussion of qualitative results.	Dr. Vallenas Dr. Tapia	
Sat Dec 17	Analysis of final quantitative results.	Dr. Tapia Dr. Vallenas	Printer
Mon Dec 19	Trip to Geneva.		
Dec 20 - 22	Preparation of final report.	Dr. Vallenas	
Fri Dec 23	Submission of final report to PLAN CDB.	Dr. Vallenas	

ANNEX # 3

DATA COLLECTION INSTRUMENTS

FOCUS GROUP QUESTIONNAIRES

Objectives:

-To provide qualitative information complementary to the data obtained through the KAP survey for the Final Evaluation of the Croix-des-Bouquets CS VI project.

-To assess the sustainability of the project.

Role of the recruiters:

-To contact and invite the participants in the focus group.
-To explain the participants, as clearly as possible, the objective of the meeting.
-To introduce the participants to the moderator and observer.

Role of the moderator:

-To welcome the participants at the beginning.
-To favor the exchange between participants and between participants and moderator.
-To encourage feedback (by asking individuals to react to an idea) and expression of their own experience.
-To summarize the main issues discussed.
-To end the session by thanking the participants and stressing the importance of it.

Role of the observer:

-To ensure that the session if being recorded.
-To take notes.

I. HEALTH CENTER STAFF

1. WHAT ARE THE ACTIVITIES OF THE HEALTH STAFF: NURSE, AUXILIARY NURSE, OTHERS?

2. WHAT ARE THE LIMITATIONS TO COMPLETE YOUR ACTIVITIES?

3. WHAT ARE THE MINIMAL REQUIREMENTS TO COMPLETE YOUR ACTIVITIES?

4. HOW MANY COURSES HAVE YOU ATTENDED IN THE LAST 12 MONTHS? WHO ORGANIZED THEM, WHAT WERE THEY ABOUT? WHO TRAINED?

5. WHAT DOES THE HEALTH AGENT (OR COL VOL) DO?

6. WHO SUPERVISES THE HEALTH AGENT OR COL VOL? HOW OFTEN? WHAT ARE THE CRITERIA USED? WHAT ARE THE ACTIVITIES SUPERVISED? IS THERE A GUIDE FOR SUPERVISION? IS IT THE SAME FOR ALL? HOW LONG HAS IT BEEN IN USE? WHAT DO YOU THINK ABOUT IT?

7. DO YOU TRAIN HEALTH AGENTS OR COL VOLS? THE COMMUNITY? WHO PROVIDES SUPPORT?

8. HOW ARE THE COMMUNITIES ORGANIZED?

9. WHAT ARE THE ACTIVITIES OF THE COMMUNITY CONCERNING HEALTH: LEADERS, MOTHERS GROUPS, AUTHORITIES?

10. ARE THERE HEALTH COMMITTEES IN THE COMMUNITIES YOU SERVE? WHAT DO THEY DO? HAVE THEY MET IN THE PAST 6 MONTHS? HOW OFTEN?

11. HOW DO YOU USE THE COMMUNITY REGISTRATION BOOKS? AND THE HEALTH AGENTS OR COL VOL? DO YOU THINK THEY ARE USEFUL OR COMPLEX? IS THIS INFORMATION USED FOR THE MSPP REPORTS?

12. ARE THE MSPP REPORTS USED FOR DECISION-MAKING?

13. HAVE YOU BEEN SUPERVISED BY THE HEALTH AREA IN THE LAST 12 MONTHS?

14. WHAT ARE THE ACTIVITIES OF THE HEALTH PROGRAMME WHICH YOU THINK ARE THE MOST EFFECTIVE? WHY?

15. HAVE YOU PARTICIPATED IN THE PLANNING, EXECUTION AND/OR EVALUATION OF THE ACTIVITIES OF THE HEALTH PROGRAMME. HOW?

16. WHAT WOULD HAPPEN IF PLAN'S SUPPORT ENDS? WOULD IT BE POSSIBLE TO CONTINUE WITH HEALTH ACTIVITIES? HOW? HAS THE COMMUNITY CONTRIBUTED RESOURCES TO CONTINUE WITH HEALTH ACTIVITIES IF FUNDING ENDS? WHICH ACTIVITIES ARE SUPPORTED BY PLAN? WHICH HAVE ADVANCED AND WHICH HAVE NOT?

17. DOES THE HEALTH CENTER CHARGE FOR SERVICES? WHICH ONES? WHAT DOES THE COMMUNITY THINK ABOUT IT? WHAT IS THE MONEY USED FOR? WHY?

II. HEALTH AGENTS / COL VOLS

1. WHAT INSTITUTIONS DO YOU COLLABORATE WITH?

2. WHAT ARE THE ACTIVITIES OF THE HEALTH AGENT/COL VOL?

3. ARE THERE LIMITATIONS TO COMPLETE THESE ACTIVITIES?

4. WHAT ARE THE MINIMAL REQUIREMENTS TO COMPLETE YOUR ACTIVITIES?

5. WHAT COURSES HAVE YOU RECEIVED IN THE LAST 12 MONTHS? ABOUT WHAT TOPICS? WHO ORGANIZED THEM? WHO TRAINED?

6. WHO SUPERVISES THE HEALTH AGENTS/COLVOLS? HOW OFTEN? WHAT ARE THE CRITERIA? WHAT ARE THE ACTIVITIES SUPERVISED?

7. DO YOU PROVIDE TRAINING OR HEALTH EDUCATION TO THE COMMUNITY? WHO SUPPORTS THESE ACTIVITIES?

8. WHY ARE YOU HEALTH AGENTS/COL VOLS? DOES THE COMMUNITY RECOGNIZE YOUR WORK? WHAT INCENTIVES WOULD YOU NEED TO IMPROVE YOUR WORK?

9. HOW ARE THE COMMUNITIES ORGANIZED? WHAT ARE THE ACTIVITIES OF THE COMMUNITY CONCERNING HEALTH: LEADERS, MOTHERS GROUPS, AUTHORITIES?

10. IS THERE A HEALTH COMMITTEE IN YOUR COMMUNITY? WHAT DOES IT DO? HAS IT MET IN THE PAST 6 MONTHS? HOW OFTEN?

11. DO YOU REGISTER THE INFORMATION CONCERNING YOUR HEALTH ACTIVITIES? SINCE WHEN? DO YOU KNOW HOW TO REGISTER AND USE THE INFORMATION? WHAT DO YOU THINK ABOUT THE REGISTRATION FORM?

12. DO YOU PRESENT THE INFORMATION OF THE COMMUNITY REGISTER TO THE COMMUNITY? HOW OFTEN? HOW DO THEY RESPOND?

13. WHAT WOULD HAPPEN IF EXTERNAL SUPPORT ENDS? WOULD IT BE POSSIBLE TO CONTINUE WITH HEALTH ACTIVITIES? HOW? HAS THE COMMUNITY CONTRIBUTED RESOURCES TO CONTINUE WITH HEALTH ACTIVITIES IF FUNDING ENDS? WHICH ACTIVITIES ARE SUPPORTED BY PLAN/ EXTERNAL INSTITUTION ? WHICH HAVE ADVANCED AND WHICH HAVE NOT?

14. DOES THE HEALTH CENTER CHARGE FOR SERVICES? WHICH ONES? WHAT DOES THE COMMUNITY THINK ABOUT IT? WHAT IS THE MONEY USED FOR? WHY? SHOULD THE COMMUNITY PAY FOR THE SERVICES THEY RECEIVE IN THE HEALTH CENTER? WHY?

III. COMMUNITY LEADERS

1. WHAT ACTIVITIES RELATED WITH THE IMPROVEMENT OF HEALTH ARE EXECUTED IN YOUR COMMUNITY?

2. WHO PERFORMS THESE ACTIVITIES?

3. WHICH OF THEM DO YOU THINK HAVE BEEN MOST EFFECTIVE FOR IMPROVING THE HEALTH OF THE PEOPLE IN YOUR COMMUNITY?

4. HAVE YOU RECEIVED TRAINING IN ANY ASPECT OF HEALTH? WHICH?

5. WHO ORGANIZED THE TRAINING?

6. WHAT DO YOU THINK ABOUT THE ROLE OF THE HEALTH AGENT/COL VOL?

7. WHAT DO YOU THINK ABOUT THE ROLE OF THE AUXILIARY NURSE?

8. IS THERE A HEALTH COMMITTEE IN YOUR COMMUNITY? WHO ARE THE MEMBERS? WHEN DID IT START? HOW OFTEN DO THEY MEET? WHAT IS THEIR MAIN ROLE?

9. WHEN THE COMMUNITY MEETS, DOES SOMEONE INFORM ABOUT THE HEALTH SITUATION OR HEALTH ACTIVITIES CONCERNING PREGNANT WOMEN OR CHILDREN? WHO? HOW OFTEN?

10. ARE DECISIONS TAKEN CONCERNING HEALTH PROBLEMS? WHAT TYPE OF DECISIONS?

11. HOW COULD THE COMMUNITY WORK TO MAINTAIN THE HEALTH ACTIVITIES IF PLAN/EXTERNAL INSTITUTION WOULD END ITS SUPPORT?

12. WHAT DOES THE COMMUNITY THINK ABOUT HAVING TO PAY FOR HEALTH SERVICES? WHY?

13. WHICH ARE THE RESPONSIBILITIES OF THE COMMUNITY CONCERNING THE IMPROVEMENT OF HEALTH?

14. HOW CAN THE HEALTH SERVICES BE IMPROVED IN YOUR COMMUNITY? WHO SHOULD SUPPORT THE COMMUNITY? HOW CAN THE COMMUNITY CONTRIBUTE?

IV. COMMUNITY MEMBERS

1. WHAT ACTIVITIES RELATED WITH THE IMPROVEMENT OF HEALTH ARE EXECUTED IN YOUR COMMUNITY?

2. WHO PERFORMS THESE ACTIVITIES?

3. WHICH OF THEM DO YOU THINK HAVE BEEN MOST EFFECTIVE FOR IMPROVING THE HEALTH OF THE PEOPLE IN YOUR COMMUNITY?

4. HAVE YOU RECEIVED INFORMATION IN ANY ASPECT OF HEALTH? WHICH?

5. WHO ORGANIZED THE SESSION(S)?

6. WHAT DO YOU THINK ABOUT THE ROLE OF THE HEALTH AGENT/COL VOL?

7. WHAT DO YOU THINK ABOUT THE ROLE OF THE AUXILIARY NURSE?

8. IS THERE A HEALTH COMMITTEE IN YOUR COMMUNITY? WHO ARE THE MEMBERS? WHEN DID IT START? HOW OFTEN DO THEY MEET? WHAT IS THEIR MAIN ROLE?

9. WHEN THE COMMUNITY MEETS, DOES SOMEONE INFORM ABOUT THE HEALTH SITUATION OR HEALTH ACTIVITIES CONCERNING PREGNANT WOMEN OR CHILDREN? WHO? HOW OFTEN?

10. ARE DECISIONS TAKEN CONCERNING HEALTH PROBLEMS? WHAT TYPE OF DECISIONS?

11. HOW COULD THE COMMUNITY WORK TO MAINTAIN THE HEALTH ACTIVITIES IF PLAN WOULD END ITS SUPPORT?

12. WHAT DO YOU THINK ABOUT HAVING TO PAY FOR HEALTH SERVICES? WHY?

13. WHICH DO YOU THINK ARE THE RESPONSIBILITIES OF THE COMMUNITY CONCERNING THE IMPROVEMENT OF HEALTH?

14. HOW CAN THE HEALTH SERVICES BE IMPROVED IN YOUR COMMUNITY? WHO SHOULD SUPPORT THE COMMUNITY? HOW CAN THE COMMUNITY CONTRIBUTE?

INTERVIEWS

I. LOCAL MANAGERS

1.- How has the socio-economic and political situation affected the project?
2.- How have logistic problems affected the project?
3.- What is the proportion of key decisions taken at local level (including those related to financial aspects)?
4.- Are the rules (regulations, policies) established by the project concerning supply, maintenance, transport, communication, personnel, finance and health information system workable?
5.- Do you share information or communicate with other local institutions? How?
6.- Do you use information for monitoring the project's process and outputs? How?
7.- Do you share resources (loans, secondment of personnel or equipment)?
8.- Do you act jointly with other institutions for seminars, teams, committees?
9.- Have you performed activities related with diffusion /dissemination /public relations about the project's goals, process and achievements? How many?
10.- What in-service training have the personnel and CHWs received? What proportion was related to new skills?
11.- Have identified community needs been included in training? Examples.
12.- Who developed the curricula and materials?
13.- Has any training been developed after the WHO briefings?
14.- Is there a health profile of the area? Local objectives?
15.- What are your human resources' strengths and weaknesses?
16.- How do you communicate with staff and viceversa?
17.- What are your recurrent costs (the expenses you continue to have always) at present?
18.- What is the ratio of internal to external sources of the project funding?
19.- What is the difference between your local available resources and those necessary to fund the project's costs (i.e. "resource gap")?
20.- Is there any plan to phase-down external assistance? How long will it take?
21.- What is the total amount of money (US$) you calculate will be needed to continue obtaining a minimum of project benefits for three years after CS funding ends?
22.- Which costs are not likely to be covered without external funding?
23.- What child survival activities do you perceive as most effective and would like to continue even without external funding?
24.- Are there any circumstances that may have hindered or aided the project in meeting its objectives? Are there any unintended benefits?
25.- What linkages exist between the child survival project and the activities of key health development agencies at all levels? Any financial exchange?
26.- What training have you received from the project?
27.- Cost recovery : How much was it obtained during the project? Did the cost recovery activities result in any inequities in service delivery? Are there any lessons to be learned from it?
28.- Are there any household income-generating activities?

PROJECT DIRECTOR

Summary

A2. Are there any circumstances that may have aided or hindered the project in meeting its objectives? Any unintended benefits?

B1. Main lessons learned.

Sustainability Status

A1. At what point in the process of sustainability does AID funding end?

A2. Does Plan think to cease CS project activities at some point?

A3. How have major project responsibilities and control been phased over to local partners? In terms of management: supply, maintenance, transport, communication, personnel, finance and health information system.

B4. Are recurrent costs concerning CS activities reasonable? Is there local capacity to absorb cost per beneficiary?

B5. Projected revenues likely to fund some CS activities for at least 3 years after funding ends.

B6. Any lessons learned from this projection of costs and revenues?

Sustainability plan

C3. Sustainability-promoting activities carried out.

C4.Which aspects of the sustainability plan were carried out and which were never initiated? Unplanned but important?

C5. Any financial commitment from counterpart institutions? Were they kept?

Monitoring and evaluation of sustainability

D3. Any data indicating a change in sustainability potential?

Counterpart institutions and sustainability

F3. What key local institutions are expected to participate in sustainable activities?

Project expenditures

G2. Planned versus actual expenditures.

G4. Lessons learned?

H1. Attempts to reduce costs, increase productivity or make project more efficient? Reasons for success or failure?

H3. Lessons learned?

I1. Cost recovery mechanisms? Who managed implementation?

I4.J1. Any household income generating activities in the project? Successful? How much do they add to annual income?

I5. Lessons learned?

ANNEX # 4

KPC SURVEY RESULTS

Child Survival VI Project
Croix-des-Bouquets

September 1, 1990 - August 31, 1994

Final Evaluation

Knowledge, Practices and Coverage Survey

Implementing Agency:

CHILDREACH (PLAN USA)
PLAN International

with funding from USAID

Location:

Croix-des-Bouquets, Haiti

Submission Date:

January, 1995

This report has been prepared by:
Gustavo Tapia MD. MSc.

Acknowledgement

It is a blessing to work with highly motivated persons working to improve the quality of life and the health of children in Croix-des-Bouquets even in times of crisis. My sincere acknowledgement to them.

Table of Contents

List of Acronyms

ARI	Acute Respiratory Infections
CDB	Croix-des-Bouquets
CDC	Centers for Disease Control
CSSP	Child Survival Support Program
EPI	Expanded Programme on Immunizations
FY	Fiscal Year
HC	Health Coordinator
IC	International Headquarters
KPC	Knowledge, Practice and Coverage
MSSP	Ministry of Health in Haiti
NGO	Non Governmental Organization
ROCCA	Regional Office for the Caribbean and Central America
USAID	United States Agency for International Development

Final Evaluation

Knowledge, Practices and Coverage Survey
Child Survival VI Project in Croix-des-Bouquets, Haiti

Executive Summary

A knowledge, Practice and Coverage (KPC) Survey was conducted in Croix-des-Bouquets, Haiti, as part of the final evaluation of the Child Survival VI Project funded by USAID and implemented by PLAN International and its local partners (HELP Inc. and Turbe Health Care Center).

The purposes of the study were to evaluate the achievements of the project (in two components: Immunizations and Maternal Care), to provide a baseline for new interventions and to empower local staff of the involved organizations. Eighteen localities of Vaudreuil and Turbe (Two areas of Croix-des-Bouquets covered by the project) were studied. The form used in this study is based on the KPC survey form developed by Johns Hopkins University (version 1993), and it was adjusted and translated by the core evaluation team and the regional health coordinator. The core team was constituted by members of the involved organizations (PLAN/Croix-des-Bouquets, HELP Inc. and Turbe Health Care Center). The members of the core team, 5 supervisors and 15 interviewers were trained in order to build the internal capacity to conduct the KPC survey. Motivation among the members of the core team is high.

Thirty clusters within the eighteen localities were randomly selected using the procedures described by WHO. Three hundred mothers of children of 12 to 23 months were interviewed (10 per cluster). The information was processed in a PC computer using EPI Info (Version 5), and core indicators for immunizations and maternal care were calculated. Although the project was focused on Immunizations and Maternal care, indicators for appropriate infant feeding, diarrheal disease control and pneumonia control are also presented.

The study revealed that EPI coverage and some maternal care indicators were slightly increased despite the constraints resulting form the Haitian crisis. Protection levels against epidemics have not been achieved yet. The current EPI coverage in children of 12 to 23 months according to their immunization cards is: BCG = 42.1 %; OPV 3 = 37.2 %; DPT 3 = 37.2 %; Measles vaccine 35.5 %. For women of children under 34 months the coverage for TT 2 or more is 19.4 %. Consequently, there is an urgent need to continue the support to this child survival interventions in the area.

I. Introduction

A. Background

PLAN International as a private, non-profit and non-sectarian international organization received a grant from USAID to implement a Child Survival project VI in Croix-des-Bouquets (Haiti). The Project started on September 1, 1990 and ended on August 31, 1994. PLAN International continues supporting the Project. Despite the Haitian crisis caused by the embargo, the invasion and natural disasters, the project continues its activities (1). **The ongoing project is focussed on child immunization and maternal care** for 18 communities and it is carried out in partnership with a local NGO (HELP. Inc.) in the Vaudreuil area (8 communities) and with the Ministere de la Sante Publique et de la Population (MSPP) in the Turbe area (10 communities). A new proposal has been presented to USAID (2) to expand the project to other communities and to reinforce four interventions: Diarrheal disease control, vitamin A supplementation, breastfeeding promotion and birth spacing. Partners of PLAN/Croix-des-Bouquets are working in these interventions but there is an urgent need to reinforce them.

The final evaluation of the CS VI project took place in December, 1994. Two components were included in this evaluation, an assessment of effectiveness and an assessment of sustainability. The core of the former component is a cluster sample survey, a methodology recommended by USAID and developed by Johns Hopkins University, which measures the knowledge, practice and coverage (Rapid KPC survey).

Building the internal capacity to conduct the KPC survey, Plan International ROCCA (Regional Office for the Caribbean and Central America) representatives have participated in two training workshops. The first was held in Sucre, Bolivia in May/1993 and was organized by PLAN International Headquarters to prepare the baseline surveys and evaluations of the child survival projects. During one week the Health Coordinators of Central and South America learned about the methodology and prepared the upcoming Rapid KPC surveys. The second was the Training of Survey Trainers Workshop organized by Johns Hopkins University CSSP and held in Baltimore from May 9 to 20, 1994. During this course, PLAN's regional health coordinator started the preparation of the KPC survey for the final evaluation of the CS VI project of Plan Croix-des-Bouquets.

A1. Project Objectives

In the revised CS Project (3) the following objectives were included:

Immunization
By the end of August, 1994, 40% of the children between 12 to 23 months of age will be fully immunized.

Maternal Care
Thirty percent of women aged 15 - 49 years will receive five doses of Tetanus Toxoid.

Forty percent of last year pregnancies will receive iron tablets (with folic acid) for at least 3 months and vitamin A supplements.

Twenty five percent of last year pregnancies will be receiving food supplementation during the third trimester of pregnancy.

A2. Baseline Survey (PLAN/CDB FY 1990):

According to the Situation Analysis and GOAL Establishment Report (SAGE Report, 1993) of PLAN/Croix-des-Bouquets (4), a baseline survey was conducted during FY 1990. The results of this survey were based on information gathered from 537 caretakers of children under 5 years of age. Ninety eight percent of the caretakers were women averaging 29.5 years of age. The main results follow.

Literacy. 66% of this caretakers responded that they could not read or write.

General Morbidity:

Morbidity of Children	%
Fever	71.3
Flu	15.8
Measles	5.2
Other	7.5

Nutritional Status
Fifteen percent of children were below -2 SD.

Diarrhea
Forty percent of the children under one year of age had diarrhea during the last two weeks. The prevalence of diarrhea for children under two years of age was 51 %. Sixty six percent of families have to walk from 15 minutes to 1 hour to collect water.

Immunization:
According to this baseline survey, immunization coverage of EPI vaccines for children 12-23 months of age were:

Vaccines	Croix-des-Bouquets
BCG	35
DPT3	20
OPV3	21
Measles	22

Maternal Care
When asked about where their last babies were delivered, 71% of the mothers/caretakers answered at home and 27% answered in the hospital. Thirteen percent of women reported that they were pregnant, 84% reported that they were not pregnant, and 3% were uncertain. Only 5% reported the use of a contraceptive method (47% of these using oral contraceptives, 30% an IUD, and 13% tubal ligation).

B. Purpose of the Study

* To evaluate both the level of knowledge and practice of mothers and the coverage of child survival interventions implemented in the target areas covered by PLAN/Croix-des-Bouquets through a Rapid KPC survey.

* To provide a baseline for new child survival interventions.

* To promote the empowerment of the staff of Plan and of local counterparts (HELP, MSPP, and community organizations) through training in the design, delivery, and use the Rapid KPC survey in the decision making process.

C. Population

The target area (18 communities) of the PLAN/USAID VI child survival project is in the District of Croix-Des-Bouquets. Croix-des-Bouquets as a district includes a periurban area and a rural area. Its administrative center (known by the same name) is located 16 kilometers from Port-au-Prince (note list of communities in **Appendix 1**).

Area	Counterpart	# of Communities
Vaudreuil	HELP. Inc.	8
Turbe	MSPP	10
Total		18

II. Methodology

A. The Survey Form

The form used in this survey is based on the KPC survey form developed by the PVO CSSP of Johns Hopkins University (version of 1993) (5). The first version was developed by the health staff of PLAN/CDB during the Workshop on KPC surveys organized by PLAN/IH and held in Sucre, Bolivia in 1993. The second draft of the questionnaire was developed by the regional health coordinator and revised by the trainers during the Training of Survey Trainers workshop held in Baltimore and organized by the CSSP of Johns Hopkins University in May, 1994. A copy of this form is included in Appendix 2. The form was translated to the local language (Creole) by the field staff and reviewed by members of community organizations. Finally it has been tested in the field by the staff of the child survival project before the training of interviewers and supervisors (See **Appendix 3**).

B. Sample

Three hundred mothers of children under 2 years of age were interviewed. A sample of thirty clusters (each cluster including 10 mothers of children under 2 years of age) was randomly selected among all communities, following the procedures described by the Expanded Programme on Immunization of WHO (6). A list of this communities and clusters is attached (**Appendix 1**).

Within each cluster the first household was randomly-selected using a map (the starting point). Subsequent households of the cluster were selected following distance criteria. The second household was the one which was nearest to the first, the third household was the nearest to the second and so on. Household was defined as a group of people sharing the same kitchen.

C. The Survey Team

C.1 Core team

The core team in charge of the survey was the Health Coordinator of PLAN/Croix-Des-Bouquets, the director of HELP Inc. and the head of the MSPP in Turbe. This core team received technical assistance from the Health Coordinator of PLAN International's Region of Central America and the Caribbean (ROCCA). Please note participant names in **Appendix 4**.

C.2 Supervisors and Interviewers

Fifteen interviewers were selected according to the following criteria:

* Interviewer active as a community health worker.
* Schooling: At least 6th grade of elementary school.
* Previous experience conducting interviews
* Good interpersonal skills
* Acceptable performance during the training period.

The main role of an interviewer was:

1. To complete the training course on required procedures of data collection.
2. To conduct the interviews and record accurate information. Each interviewer was to complete a cluster during each working day.

Five supervisors oversaw the data collection and validated the information recorded by the 15 community health workers. Each supervisor was in charge of 3 interviewers.

The supervisors were selected using these criteria:

* Supervisor active as a rural health technician (or an equivalent technician)
* Previous experience supervising surveys
* Senior high school graduate
* Acceptable performance during the training period.

A list of supervisors and interviewers is included in Appendix 4.

D. Training of the Survey Team

Two activities were completed at the field level in order to train the team after the arrival of the Plan International ROCCA Health Coordinator:

1. Training of the core team and preparation of final survey (Day 2).
2. Training of supervisors and interviewers (Day 3 - 5).

D.1 Training of the Core team and Final Survey Preparations

The person responsible for the training was the PLAN/ROCCA Health Coordinator. The objective of this training was to transfer to the core team the knowledge and skills needed to:

* train supervisors and interviewers
* adapt the generic questionnaire to the local situation
* monitor the conduct of the survey
* tabulate and analyze the survey results
* write a survey report
* apply lessons learned to future surveys.

D.2 Training of Supervisors and Interviewers

The members of the core team were responsible for this training. With adjustments to local circumstances, training was completed using the following plan for teaching sessions:

Course for Supervisors and Interviewers (Days 3-5)
Day 3 (12-12-94)

Time	Subject	Method	Responsible
7:30 - 8:30	Opening. Introductions and Administrative.	Group Dynamics. Dialogue	PLAN/CDB's HC
8:30 - 8:45	Introducing the Survey (Purpose, sample, validity, tasks and general procedures).	Lecture Dialogue	ROCCA's HC and local translator
8:45 - 9:30	Role of supervisors and interviewers	Brainstorming, Role Play and discussion.	PLAN/CDB's HC
9:30 - 10:30	Survey Methodology: - Sample size - Selection of clusters & of households	Dialogue Exercise	ROCCA's HC and local translator
10:30 - 12:30	The survey form (1st half)	Reading, group discussion.	PLAN/CDB's HC
12:30 - 13:00	Lunch		
13:00 - 14:30	The survey form (2nd half) Immunization card, Grow chart and other cards.	Dialogue. Exercises with real vaccination cards.	Head of a MSPP in Turbe
14:30 - 15:00	Techniques for interviewing the mother and recording accurate data.	Role play. Analysis of positive and negative practices.	ROCCA's HC and local translator
15:00 - 16:00	Practice interviews in the classroom (I)	Each participant to be involved in two (as an interviewer and as a respondent).	Head of a MSPP in Turbe
16:00 - 16:30	Feedback regarding practice (I)	Group discussion: Analysis of positive and negative practices.	ROCCA's HC and local translator.

Course for Interviewers and Supervisors
Day 4 (12-13-94)

Time	Subject	Methodology	Responsible
7:30 - 8:00	Review of Day 2	Dialogue.	ROCCA's HC
8:00 - 9:00	Practice Interviews in the classroom (II)	Interviewers: conduct two interviews avoiding mistakes made in the first practice. Supervisors: observe and provide feedback	PLAN/CDB's HC
9:00 - 9.30	Feedback regarding practice (II)	Brainstorming to identify common mistakes in second practice. Dialogue about how to prevent common mistakes	PLAN/CDB's HC
9:30 - 10:00	Movement to field exercise site		
10:00 - 12:30	Field practice: Conducting interviews	Interviewers: conduct three supervised interviews in the field. Supervisors: conduct one interview and observe two interviews. Core team: observe performance of supervisors.	Director of Help Inc.
12:30 - 13:00	Movement to training site		
13:00 - 13:30	Lunch		
13:30 - 14:30	Feedback regarding field practice. Review of the questionnaire.	Brainstorming and group discussion: analysis of positive and negative practices.	ROCCA's HC Core Team
15:30 - 16:30	Identification of the cluster and household selection process	Dialogue; practice with maps of communities.	ROCCA's HC

Course for Interviewers and Supervisors
Day 5 (12-14-94)

Time	Subject	Methodology	Responsible
13:00 - 13:45	Review of the final version of the questionnaire	Group discussion: analysis of positive and negative practices.	ROCCA's HC Core Team
13:45 - 14:15	Evaluation	Interviewers: test and report on supervisors Supervisors: reports of the core team.	PLAN/CDB's HC
14:15 - 15:00	Final team assignments. Review of protocols and check lists.	Dialogue, negotiation	PLAN/DCDB's HC
15:00 - 16:30	Final preparation for the survey: - Transport - Supplies	Dialogue, distribution of supplies (Copies of questionnaires, pencils, sharpeners, etc.).	PLAN/CDB's HC

E. The Collection and Analysis of data

E.1 Source of information

The main source of information was the mother of children under 2 years of age and the health cards of the child (immunization card, growth chart) and the mother (immunization and prenatal care card) (5, 6).

E.2 The Survey Protocol

The supervisor was in charge of three interviewers. Each interviewer completed one cluster (10 interviews) per day. The starting point (the first house) of each cluster was determined by the supervisor (5, 6).
The following steps were taken to conduct the survey:

The interviewer

1. The interviewer is left in the **starting point** (the first house) of the cluster.

2. He(she) knocks the door, introduces himself (herself), asks to talk to the mother and briefly explains to her the purpose of his(her) visit.

3. He(she) asks if there is a child under two years of age and verifies the age of the child by checking the birth certificate. **If there are two or more children under two years of age, the interviewer selects the younger one.**

4. The interviewer completes the interview of the mother following the questions and instructions contained in the survey form (the **interviewer being neutral, observing carefully, and always mentioning the name of the younger child under two years of age).**

5. Once the interview is completed, the interviewer checks to see if the survey form has been **completely filled before leaving the house.**

6. He(she) gives thanks for the significant contribution of the family, leaves the house and moves to the next house, **which is nearest to the first.**

7. The interviewer follows the same steps (2 to 5) in the second house and repeats these procedures in subsequent houses until he(she) has found ten children under two and completed the **10 required interviews.**

8. He(she) delivers the revised survey forms to his(her) supervisor.

The supervisor

1. The supervisor receives the revised survey forms from the interviewer.

2. The supervisor checks the survey forms again and provides feedback to the interviewer. If the supervisor finds mistakes, he(she) asks the interviewer to correct them before leaving the community.

3. He(she) randomly selects two survey forms from each interviewer to validate the information by interviewing the mothers again and checking the recorded data.

4. If needed, the supervisor will help the interviewer to complete the required interviews of the cluster on time.

5. The supervisor ensures that all interviews have been successfully completed before leaving the community.

6. The supervisor delivers the survey forms (revised at this point by the interviewer and the supervisor) to the computer center by the end of the day.

E3. Data Analysis

All information was processed on a microcomputer, using EPI Info version 5 (7). A ".QES file" and a ".REC file" were made to enter the data. One computer operator entered all data collected in the previous day. Programs developed or adjusted by the external evaluator (ROCCA's Health Coordinator) were used to analyze the information.

F. Chronology of Activities

Evaluation Activities	No. of days	Scheduled time
Prior to the arrival of ROCCA's Health Coordinator to the FO.		
I Preparation A. Core team orientation. B. Begin planning. C. Select, adapt, and translate forms. D. Select samples. E. Coordinate administration and logistics.	30 days	November, 94
After the arrival of ROCCA's Health Coordinator to the FO.		
II Core Team Training (Days 1 - 2) A. Brief PLAN/Haiti Country Manager, PLAN/ CDB Field Director and Health Coordinator (Day 1). B. Finalize survey preparations (Day 1). C. Core team training: Empowering the local manager and project supervisors (Day 2).	2 days	December, 94 12/09 12/10 12/10
III Training of Supervisor and Interviewers A. Training of survey interviewers and supervisors (Days 3 - 5). B. Final preparations for survey (Day 5).	3 days	12/12 - 12/14 12/14
IV The Survey (Days 6 - 8) A. Survey teams carry out interviews. B. Supervisor monitors interviewers to assure integrity of the data. C. Core team provides secondary-level supervision.	3 days	12/15 - 12/19
V Data entry (Days 8 - 11) A. Adjust the QES file. B. Enter data.	4 days	12/16 - 12/22
VI Development of an Action Plan A. Feedback at local level. B. Feedback at national level. C. Develop a Plan of Action: Define objectives and strategies. D. Evaluate survey training process.	15 days	January, 95

The ROCCA health coordinator and the core team managed each of these phases. Following the survey PLAN/Croix-des-Bouquets and its partners will develop a Plan of Action to address the concerns and constraints identified by the final evaluation.

III. Results

A. General Information

Three hundred mothers of children were interviewed. During data analysis one record was annulled, as the file was incomplete.

Age of the Mother

The range of maternal age was from 15 to 49 years with an average of 28 years; 7.5% of the mothers were younger than 20 years and 14.7 % were older than 35 years (see figure 1).

Maternal Literacy

Only 39.7% of mothers were literate (see figure 2). Six out of ten mothers could not read. Health education materials for non-literate women are greatly needed.

Age of Children

The average age of children surveyed was 9.9 months. 59.5% of children were less than 12 months of age (in households with more than one child less than 24 months of age, the youngest child was interviewed).

Age group	Frequency	%
0 - 5 months	99	33.1
6 - 11 months	79	26.4
12 - 17 months	68	22.8
17 - 24 months	53	17.7
Total	299	100.0

Who takes care of children when the mother is away from home?

Figure 3 shows that the most frequent caretakers of children when the mother is away from home are relatives (49.5 %), husbands (27.1 %), and neighbors or friends (22 %).

Families affiliated to PLAN/Croix-des-Bouquets

PLAN and Non PLAN families receive benefits from the Child Survival Project. PLAN families receive additional benefits provided by PLAN. Forty-five percent of families in the project area were found to be affiliated with PLAN (**see figure 4**).

B. Interventions conducted by the Child Survival Project

B1. Immunizations

Immunization Card. More than half of mothers (54.5 %) presented the immunization card during the interview. A high percentage of mothers (45.5 %) did not present the immunization card; 15.5 % of these mothers reported that they never had one and 30.0 % claimed to have lost it (**see figure 5**).

Immunization Coverage. Coverage with EPI vaccines in children 12 to 23 months according to their immunization cards is presented in **figure 6.** 42.1 % of the children received BCG, 37.2 % received OPV 3, 37.2 % received DPT 3 and 35.5 % received measles vaccine.

Twenty-four percent of children 12 to 23 months have completed the EPI schedule.

Age group	Fully Immunized		Total
	No	Yes	
0 - 11 months	171	7	178
12 - 23 months	92	29	121
Total	263	36	299

EPI Access. 46.3 % of children 12 to 23 months received DPT 1 (see figure 7).

Drop Out Rate. The percentage of "drop outs" between DPT 1 and DPT 3 was 17.9% (see figure 8). This rate was calculated for children 12 to 23 months using the following formula (5):

$$\frac{\text{Number of Children who have received DPT 1 minus the number of children who have received DPT 3}}{\text{Number of Children who have received DPT 1}} \times 100 = \text{Percent of drop outs between DPT 1 and DPT 3}$$

B2. Maternal Care

Mothers with Maternal Card. Figure 9 reveals that 28.3 % of mothers presented the maternal card during the survey; 46.6 % of mothers claimed to have lost the card, and 27.1 % never had one. Maternal cards in Croix-des-Bouquets contain information regarding immunizations. These cards did not record data about pre-natal visits.

Tetanus Toxoid Coverage. In reviewing the cards it was found that 19.4 % of mothers of children under 24 months had received two or more doses of tetanus toxoid (see figure 10). Mothers who did not present the card were considered not immunized (6).

Prenatal Care. Figure 11 reveals that 33.5 % of mothers had one or more pre-natal visits prior to their last birth (self-report).

Modern Contraceptive Usage. Only 14.4 % of mothers who desire no additional children in the next two years (or are not sure) are using a modern contraceptive method (see figure 12).

B3. Knowledge of Mothers

Immunization Knowledge of Mothers. Figure 13 demonstrates that 46.1 % of mothers know that vaccinations should be started at birth and 36.6 % of mothers know that measles vaccine should be given at nine months.

Maternal Care Knowledge of Mothers. 15.4 % of mothers know how many doses of tetanus toxoid are needed to protect both the child and mother; 92.6 % of mothers know that pregnant women should start ante-natal care before the third trimester (see figure 14).

C. Other child survival interventions not included in the Project.

Although the following interventions were not included in the CS project, PLAN's partners have begun work on these components and have presented a proposal to reinforce them. The results of this study will be used as a baseline for these interventions.

C1. Appropriate Infant Feeding Practice

Breastfeeding. All infants under 4 months were breastfeeding (see figure 15) but only 4.5 % of these children were breastfeeding exclusively (see figure 16); 54.6 % of children were breastfed within eight hours of birth; 94.9 % of children between 20 and 24 months were still breastfeeding.

Introduction of Foods. 77.8 % of children between five and nine months of age were receiving solid or semisolid foods (see figure 16).

C2. Diarrheal Disease Control

Prevalence of diarrhea. 42.6 % of children had at least one episode of diarrhea during the past two weeks (see figure 17); 22.3% of these children presented a diarrhea that had lasted two or more weeks suggesting persistent diarrhea, and 24.0 % presented blood in their stool suggestive of dysentery (see figure 18).

Management of Diarrheal Disease: Continued Breastfeeding. Figure 19 shows that 80.3 % of children less than 24 months with a diarrheal episode in the past two weeks were given the same amount or more breast-milk.

Management of Diarrheal Disease: Continued Fluids. 63.9 % of children with a diarrheal episode in the past two weeks were given the same amount or more fluids other than breast-milk (see figure 19).

Management of Diarrheal Disease. Continued Foods. 50.8 % of children with a diarrheal episode in the past two weeks were given the same amount or more food (see figure 19).

Management of Diarrheal Disease: ORT Usage. 69.9 % of children with a diarrheal episode in the past two weeks received Oral Rehydration Therapy (ORS, sugar-salt solution or home made infusions as treatment, see figure 19).

Management of Diarrheal Disease. Use of Medicines. 13.8 % of children with a diarrheal episode in the past two weeks received antibiotics or anti-diarrheal medicines (see figure 19).

Source of Advice or Treatment for Diarrhea. Most mothers (43.1 %) of children with a diarrheal episode in the past two weeks seek advice or treatment for diarrheal disease in a Health Center/Clinic/Post. The second major source of advice was relatives and/or friends (13.8 %); 6.5 % of mothers received advice from a Traditional Birth Attendant. Only 5.7 % of mothers received advice from a Village Health Worker. These and other sources of advice for diarrhea are presented in figure 20.

C3. Pneumonia Control

Cough and Rapid, Difficult Breathing.

The prevalence of cough and rapid, difficult breathing among children was 27.4 %.

Source of Treatment for Cough and Rapid, Difficult Breathing. 43.9 % of mothers went to a Health Center/Clinic/Post when their children presented with cough and rapid, difficult breathing. 6.1 % visited a private clinic or practitioner. Only 5.7 % of mothers received advice from a Village Health Worker (see figure 22).

Medical Treatment. 48.8 % of mothers of children with cough and rapid, difficult breathing sought medical treatment. This figure represents a selection of mothers of children with cough and rapid, difficult breathing that received advice or treatment for their children from at least one of the sources listed above (some mothers of children with these signs had received advice or treatment for their children from more than one source).

Treatment	Frequency	Percent
Medical Treatment	42	51.2
Other	40	48.8
Total	82	100.0

IV. Discussion

A. General Situation

Low literacy rates among women persist. In the baseline survey (1989) it was observed that only 34 % of mothers or caretakers of children were literate (4); in this study the situation is similar, as 39.7 % of the mothers were literate. The relationship between education (particularly of women) and health is well known. Better education helps to ensure better health (9). This figures suggests that strong education programs benefitting girls should be implemented in the area. In the meantime health educational materials for illiterate mothers, as well as strategies to reach them, should be developed.

Husbands and older children are frequent caretakers of children when the mother is away from home. They should be involved in health education programs not only as trainees but as trainers.

The project's strategy of involving both PLAN and Non PLAN families is appropriate. Since the majority of families in the area are Non PLAN families, the Field Office should consider the possibility of increasing its sponsored family enrollment in order to provide additional benefits available through PLAN/Croix-des-Bouquets.

B. Interventions conducted by the Child Survival Project

B1. Immunization Coverage

A comparison between the EPI coverage obtained by this study (final evaluation), the baseline survey, and coverage reported for the entire country is presented in **figure 23** (4, 9). Although the methodologies used to conduct both surveys were different, the data suggest that EPI coverage has been slightly improved. The coverage for all EPI vaccines found in this study exceed the coverage reported during the baseline survey. National coverage for OPV 3, DPT 3 and measles vaccine has been exceeded.

Since EPI coverage was measured using the immunization card and not through verbal reports, the high percentage of lost cards (30.0 %) affected the estimation of EPI coverage. It is very important to encourage

mothers to preserve their children's immunization cards.

According to the core team of evaluators some immunization cards were lost when Tropical Storm Gordon affected the project area. Furthermore, the high cost of transportation and the lack of gasoline and other basic supplies produced by the embargo affected immunization activities.

Despite the Haitian political crisis, the project is close to achieving its EPI objective (40% coverage). EPI coverage is still too low to prevent epidemics, however (7, 8). Due to the present low national EPI coverage the country was in fact dealing with a measles epidemic at the time of the survey (10). PLAN/Croix-des-Bouquets, its local partners, and international agencies must continue and enhance their efforts to achieve useful EPI coverage (80% or more) in the Croix-des-Bouquets area.

Since the major source of advice and treatment for children's diarrhea and cough with rapid, difficult breathing are Health Centers/Clinics/Posts (see figures 20 and 23), PLAN should attempt to learn if children brought to the clinic with these diseases are leaving the facility without vaccinations. Missed opportunities for vaccination of children and women should be measured and corrected in these facilities (8, 11).

B2. Maternal Care

As mentioned before, 33.5 % of mothers had one or more prenatal visits and only 19.4 % of mothers received two or more doses of tetanus toxoid. This would suggest missed opportunities to immunization, but it is important to remember that TT coverage was measured by reviewing immunization cards (only 28.3 % of mothers presented the card) and prenatal visits were measured by self report (not all had the two visits that are needed to complete the TT schedule).

A comparison between the percentages of contraceptive use and coverage with TT 2 between this study (final evaluation), the baseline survey, and national reports for the entire country is presented in figure 15 (4, 9). Unfortunately, TT coverage was not measured during the baseline survey. The objective for TT 2 has not yet been achieved, but the coverage found in this study (although low) exceeds the national average.

Progress towards other family planning objectives were not measured during this study. Use of family planning is now higher than before, and exceeds the national average.

Mothers know well that pregnant women should begin ante-natal care before the third trimester (92.6 %), but their knowledge about tetanus toxoid is very poor. Are they receiving appropriate information about tetanus toxoid during their visits to the health facilities and at community meetings? There is a discrepancy between expressed knowledge of ante-natal care and the actual practice; a qualitative study may clarify the causes of this discrepancy (12).

C. Other child survival interventions not included in the project.

C1. Appropriate Infant Feeding Practice

Appropriate breast feeding of infants appears not to be a problem in Croix-des-Bouquets. Nearly all mothers breastfed their children. Mothers rarely provide exclusive breastfeeding to infants during the first 4 or 6 months of life, however. Only 4.5 % of infants less than four months are fed only breast milk. A very high proportion of mothers (95.5 %) provides liquids other than breast milk or foods to their children under 4 months.

The strong promotion of exclusive breastfeeding and early initiation of breastfeeding is needed, as well as reinforcement of the introduction of semisolid or solid foods between the 5th or 9th month of life.

C2. Diarrheal Disease Control

Area prevalence of diarrhea is very high (42.6 %). The high proportion of children with signs that suggest persistent diarrhea (22.3 %) or dysentery (24.0 %) indicates that diarrheal disease treatment protocols should include nutritional management of persistent diarrhea and appropriate management of dysentery (13, 14, 15).

Since a high proportion of children with diarrhea are seen in a health facility, it is very important to provide training on diarrheal disease management (including persistent diarrhea and dysentery) to health staff. Training should be given in a second phase to Village Health Workers and Traditional Birth Attendants.

A high proportion of mothers do not interrupt breastfeeding (80.3 %) or fluids (63.9 %) during a diarrheal episode. Half of mothers give less foods than usual to their children with diarrhea. ORT usage is unexpectedly high (69.9 %), and exceeds the national percentage (20 %; UNICEF, 1994). Qualitative studies towards a better understanding of these practices are needed.

C3. Pneumonia Control

Cough and rapid, labored breathing in children 12 to 23 months indicates pneumonia; 27.4 % of the children presented these signs, and half of these children received medical treatment. This indicates a need for health staff training in ARI management (WHO, Standardized treatment of children with cough or difficult breathing) (16).

V. Recommendations

1. Education programs benefitting women, particularly girls, are needed in the area. These programs should be promoted and should interact with PLAN's educational sector and with local institutions.

2. Development of strategies and health educational materials to reach illiterate mothers.

3. Conduct qualitative research to assess the knowledge, the attitudes and practices of mothers about immunization and maternal care in order to develop appropriate information/education messages.

4. Involve husbands and older children in health education programs. Older children can be reached in schools and can share with their parents what they have learned.

5. Promote health education programs for mothers at nursery schools. Ensure that the health messages delivered in nursery schools are consistent with the essential messages given by the project.

6. Review EPI objectives and strategies in a participatory fashion (with the field staff involved, village health workers, and community leaders), state objectives to reach useful coverage, and set year-by-year achievable targets. Allocate more resources if needed.

7. **Monitor achievements using linear graphics to reveal the progress toward year-by-year targets.**

8. **Encourage mothers to preserve the immunization cards of their children and their own maternal cards.**

9. **Investigate missed opportunities for maternal and child vaccination at health facilities. Adoption of procedures described by WHO would assist development of a Plan of Action to handle missed opportunities for vaccination.**

10. **Reinforce education on tetanus toxoid during pre-natal visits and community meetings of mothers.**

11. **Focus nutritional interventions on the promotion of exclusive breastfeeding and early initiation of breastfeeding.**

12. **Conduct qualitative studies to assess the knowledge, attitudes and practices of mothers regarding management of diarrheal disease and pneumonia control (formative research), in order to identify appropriate IEC strategies and materials for illiterate mothers.**

13. **Provide training on diarrheal disease management (including persistent diarrhea and dysentery) and pneumonia control to the health staff of participating health facilities.**

14. **Adoption of WHO protocols on management of diarrheal disease and acute respiratory infections.**

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Appendices

Appendix 1

List of Localities and Selected Clusters

PLAN
INTERNATIONAL
Croix-des-Bouquets

KPC Survey
List of Localities and Selected Clusters

Localities	Population	Cumulated	Clusters
HELP Inc.			
Vaudreuil	3,500	3,500	1 - 2
Lassere	3,500	7,000	3 - 5
Latremblay	3,500	10,500	6 - 7
Ti-Davanne	2,500	13,000	8 - 9
Cuvier	2,500	15,500	10 - 11
Lepine/Desvareux	2,500	18,000	12 - 13
Bas-Vaudreuil	3,000	21,000	14 - 15
Drouillard	3,000	24,000	16 - 17
Turbe			
Campeche	2,909	26,909	18 - 19
Hatte Lisiere Jonc	1,018	27,927	20
Bois Dumay	2,322	30,249	21 - 22
Turbe I et II	1,042	31,291	23
Pierroux	1,434	32,725	24
La Tremblay	1,308	34,033	25
Dame Marie	3,415	37,448	26 - 27
Delmas Rampe	709	38,157	28
Masseau Lamothe	1,241	39,398	29
Detre - Jonc	1,296	40,694	30
Total	40,694		

Appendix 2

English Version of the Survey Form

IDNUM: _____

Plan International/Croix-des-Bouquet
Child Survival Project
Rapid Knowledge, Practice & Coverage (KPC) Questionnaire

All questions are to be addressed to the mother with a child under two (less than 24 months of age)

General Information

G1. Interview date: __/__/9_ **(dd/mm/yy)**

G2. Interviewer name _____

G3. Supervisor _____

G4. Community _____

Name and age of the mother

G5. Name _____ G6. Age (years) _____

Name and age of the child less than 24 months of age

G7. Name _____

G8. Birth date __/__/__ **(dd/mm/yy)** G9. Age in months_____

G10. Affiliation:
1. Plan family [ ]
2. non Plan family [ ]

Mother's Education/Occupation

E1. What was the highest educational level you attained?
1. none [ ]
2. primary **does not** read [ ]
3. primary reads [ ]
4. secondary & higher [ ]

E2. Do you work away from home?
1. yes [ ]
2. no [ ]

E3. Do you do any "income generating work"?
(multiple answers possible; record all answers)
a. nothing [ ]
b. handicraft, weaving, rugs, etc [ ]
c. harvesting, fruit picker [ ]
d. selling agricultural products [ ]
e. selling foods, dairy products [ ]
f. servant/household services [ ]
g. shop keeper, street vendor [ ]
h. salaried worker [ ]
i. other (specify) _____ [ ]

E4. Who takes care of **(name of child)** while you are away from home?
(multiple answers possible; record each one)

a. mother takes child with her [ ]
b. husband/partner [ ]
c. older children [ ]
d. relatives [ ]
e. neighbors/friends [ ]
f. maid [ ]
g. nursery school [ ]

Nutrition

Breastfeeding/Weaning feeding

N1. Are you breastfeeding **(name of child)**?
1. yes [ ] **---> go to N3.**
2. no [ ]

N2. Have you ever breast-fed **(name of child)**?
1. yes [ ]
2. no [ ] **---> go to N4.**

N3. After the delivery, when did you breast-feed **(name of child)** for the first time?
1. during the first hour after delivery [ ]
2. from 1 to 8 hours after delivery [ ]
3. more than 8 hours after delivery [ ]
4. do not remember [ ]

N4. a. Are you giving **(name of child)** water (or herbal teas)?
1. yes [ ]
2. no [ ]
3. doesn't know [ ]

b. Are you giving **(name of child)** cow milk, goat milk, or formula?
1. yes [ ]
2. no [ ]
3. doesn't know [ ]

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

d. Are you giving **(name of child)** fruits?
1. yes [ ]
2. no [ ]
3. doesn't know [ ]

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

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

g. Are you giving **(name of child)** meat or fish?
   1. yes [ ]
   2. no [ ]
   3. doesn't know [ ]

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

i. Are you giving **(name of child)** eggs or yogurt?
   1. yes [ ]
   2. no [ ]
   3. doesn't know [ ]

j. Are you adding leafy green vegetables, such as spinach, to **(name of child)**'s food?
   1. yes [ ]
   2. no [ ]
   3. doesn't know [ ]

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

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

m. Are you adding iodized salt (local brand name) to **(name of child)'s** meals?
   1. yes [ ]
   2. no [ ]
   3. doesn't know [ ]

N5. Health workers believe that it is very important to breastfeed during the first two years of the baby's life. What can a mother do in the baby's first four months of life to keep on breastfeeding?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. breastfeed as soon as possible after delivery (don't discard colostrum) [ ]
c. care of breasts, nipples [ ]
d. frequent sucking to stimulate production [ ]
e. exclusive breastfeeding during the first four months [ ]
f. avoid bottle feeding of baby [ ]
g. relactation (if had to stop, mother can resume breastfeeding again) [ ]
h. other (specify) _____ [ ]

N6. When should a mother start adding foods to breastfeeding?

1. start adding between 4 and 6 months [ ]
2. start adding earlier than 4 months [ ]
3. start adding 6 months or later [ ]
4. doesn't know [ ]

N7. Which vitamin helps you prevent "night blindness"?

1. vitamin A [ ]
2. doesn't know or other [ ]

N8. Which foods contain vitamin A to prevent "night blindness"?
(multiple answers possible; record all answers)

a. doesn't know or other [ ]
b. green leafy vegetables [ ]
c. yellow type fruits [ ]
d. meat/fish [ ]
e. breast milk [ ]
f. egg yolks [ ]

Growth Monitoring

N9. Does **(name of child)** have a growth monitoring/promotion card?

1. yes [ ] **(must see card)**
2. lost card [ ] **---> go to D1.**
3. no [ ] **---> go to D1.**

N10

Look at the growth monitoring card of the child, and record the following information: has the child been weighed in the last four months?

1. yes [ ]
2. no [ ]

N11

Look also at the growth monitoring card, and indicate if there is a space to record vitamin A capsules

1. yes [ ]
2. no [ ] -----> **go to 20**

N12

If yes, record the dates of all vitamin A capsules given to this child in the space below

(dd/mm/yy)

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

Diarrheal Diseases Control

D1. Has **(name of child)** had diarrhea during the last two weeks?

1. yes [ ]
2. no [ ] **---> go to D10.**
3. doesn't know [ ] **---> go to D10.**

D2. How long this diarrhea lasted?

1. Less than 2 weeks (0-13 days) [ ]
2. Two or more weeks ago (14 days or more) [ ]

D3. Did **(name of child)** had stools with blood during this diarrhea?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

D4. During **(name of child)'s** diarrhea did you breast-feed **(read the choices to the mother)** .....

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. child not breastfed [ ]

D5. During **(name of child)'s** diarrhea, did you provide **(name of child)** with fluids other than breast-milk ..... **(read the choices to the mother)**

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

D6. During **(name of child)'s** diarrhea, did you continue to provide **(name of child)** with solid/semisolid foods ..... **(read the choices to the mother)**

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

D7. When **(name of child)** had diarrhea, what treatments, if any, did you use? **(multiple answers possible; record all answers)**

a. nothing [ ]
b. ORS sachet [ ]
c. sugar-salt solution [ ]
d. cereal based ORT [ ]
e. infusions or other fluids [ ]
f. anti-diarrhea medicine or antibiotics [ ]
g. other **specify** _____ [ ]

D8. When **(name of child)** had diarrhea, did you seek advice or treatment for the diarrhea?

1. yes [ ]
2. no [ ] **---> go to D10.**

D9. From whom did you seek advice or treatment for the diarrhea of **(name of child)?**
(multiple answers possible; record each answer)

a. general hospital [ ]
b. health center/clinic/post [ ]
c. private clinic/doctor [ ]
d. pharmacy [ ]
e. village health worker [ ]
f. traditional healer [ ]
g. traditional birth attendant [ ]
h. relatives & friends [ ]
i. other **(specify)** [ ]_____

D10. What signs/symptoms of danger would cause you to seek advice or treatment for **(name of the child)'s** diarrhea?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. vomiting [ ]
c. fever [ ]
d. dry mouth, sunken eyes, decreased urine output (dehydration) [ ]
e. diarrhea of prolonged duration (at least 14 days) [ ]
f. blood in stool [ ]
g. loss of appetite [ ]
h. weakness or tiredness [ ]
i. other **(specify)** _____ [ ]

D11. What are important actions you should take if **(name of child)** has diarrhea?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. initiate fluids rapidly [ ]
c. give the child more to drink than usual [ ]
d. give the child smaller more frequent feeds [ ]
e. proper mixing and administration of ORS [ ]
f. take child to the hospital/health center [ ]
g. feed more after diarrhea episode so that child can re-gain weight [ ]
h. withhold fluids [ ]
i. withhold foods [ ]
j. other **(specify)** _____ [ ]

D12. What are important actions a mother should take when a child is recovering from diarrhea?
(multiple answers possible; record all answers)

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

Respiratory Illness

R1. Has **(name of child)** been ill with cough or difficult breathing in the last two weeks?

1. yes [ ]
2. no [ ] **---> go to R5.**

R2. Did **(name of child)** experience rapid (fast) difficult breathing (dyspnea) when ill?

1. yes [ ]
2. no [ ] **---> go to R5.**
3. doesn't know [ ] **---> go to R5.**

R3. Did you seek treatment when **(name of child)** was ill with these respiratory problems?

1. yes [ ]
2. no [ ] **---> go to R5.**

R4. From whom did you seek treatment for **(name of child)'s** when ill with difficult breathing and/or cough?
(multiple answers possible; record all answers)

a. general hospital [ ]
b. health center/clinic/post [ ]
c. private clinic/doctor [ ]
d. village health worker [ ]
e. traditional birth attendant [ ]
f. traditional healer [ ]
g. pharmacy/chemist/shop keeper [ ]
h. relatives & friends [ ]
i. other [ ]

R5. What are the signs/symptoms of respiratory infection that would cause you to take **(name of child)** to a health facility?
(Multiple answers possible; record all answers)

a. doesn't know [ ]
b. fast or difficult breathing [ ]
c. chest indrawing [ ]
d. loss of appetite [ ]
e. fever [ ]
f. cough [ ]
g. other **(specify)** _____ [ ]

Immunizations

I1. Please tell me at what age should **(name of child)** receive his first vaccine?

1. at birth/first month of life [ ]
2. doesn't know or other [ ]

I2. At what age should **(name of child)** receive measles vaccine?

1. specify in months [__ __]
2. doesn't know or otheer [ ]

I3. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus?

1. one [ ]
2. two [ ]
3. more than two [ ]
4. none [ ]
5. doesn't know [ ]

I4. Do you have an immunization card for **(name of child)?**

1. yes [ ] **(must see card)**
2. lost it [ ] **---> go to M1.**
3. never had one [ ] **---> go to M1.**

I5.

Look at the vaccination card and record the dates of all the immunizations in the space below **(dd/mm/yy)**

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

Look at the immunization card, and indicate if there is a space to record vitamin A capsules If yes, **---> go to 19** and record the dates of all vitamin A capsules given to this child in boxes 18 and 19

MATERNAL CARE

M1. Do you have a maternal health card?

1. yes **(must see card)** [ ]
2. lost it **---> go to M5.** [ ]
3. no **---> go to M5.** [ ]

M2.

Look at the maternal health card and record the number of TT vaccinations in the space below:

1. one [ ]
2. two or more [ ]
3. none [ ]

M3.

M4.

M4. When you were pregnant with **(name of child)** did you visit any health site (dispensary/health center, aid post) for pregnancy/prenatal care? How many times?

1. one or [ ]
2. two or more [ ]
3. none [ ]

M5. Are you pregnant now?

1. yes [ ] **---> go to M9.**
2. no [ ]

M6. Do you want to have another child in the next two years?

1. yes [ ] **---> go to M9.**
2. no [ ]
3. doesn't know [ ]

M7. Are you currently using any method to avoid/postpone getting pregnant?

1. yes [ ]
2. no [ ] **---> go to M9**

M8. What is the main method you or your husband are using now to avoid/postpone getting pregnant?

1. tubal ligation [ ]
2. vasectomy [ ]
3. Norplant [ ]
4. injections [ ]
5. pill [ ]
6. IUD [ ]
7. barrier method/diaphragm [ ]
8. condom [ ]
9. foam/gel [ ]
10. lactational amenorrea method (exclusive breast-feeding) [ ]
11. rhythm [ ]
12. abstinence [ ]
13. coitus interruptus [ ]
14. other [ ]

M9. When should an pregnant women see a health professional (physician, nurse, midwife)? **(probe for months)**

1. first trimester, 1-3 months [ ]
2. middle of pregnancy, 4-6 months [ ]
3. last trimester, 7-9 months [ ]
4. no need to see health worker [ ]
5. doesn't know [ ]

M10. What foods are good for a pregnant woman to eat to prevent pregnancy anemia?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. proteins rich in iron (eggs, fish, meat chicken, leaver) [ ]
c. leafy green vegetables, rich in iron [ ]
d. other (specify) _____ [ ]

M12. How much weight should a woman gain during pregnancy?

1. 10-12 kilos [ ]
2. gain weight of baby [ ]
3. doesn't know [ ]
4. other (specify) _____ [ ]

M14. When you were pregnant with **(name of child)** did you visit any health site (dispensary/health center, aid post) for pregnancy/prenatal care?

1. yes [ ]
2. no [ ]

M15. During **(name of child)'s** pregnancy, was the amount of food you ate .....
(read the choices to the mother)

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. doesn't know [ ]

M16. At the delivery of **(name of child)**, who tied and cut the cord?

1. yourself [ ]
2. family member [ ]
3. traditional birth attendant [ ]
4. health professional (physician, nurse or midwife) [ ]
5. other **(specify)** _____ [ ]
6. doesn't know [ ]

Appendix 3

Creole Version of the Survey Form

IDNUM:_____

Plan Entenasyonal / Kwa-dè-Boukè
Pwojè Pou Amelyore Egzistans Timoun yo.

Kesyonè sou konesans Rapid, Pratik ak kouverti (K.P.K)
(Draf - 19/07/94).

Kesyon sa yo se Pou Manman yo ak timoun yo ki gen mwens ke 24 mwa.

Enfòmasyon Jeneral

G1. Dat ankèt la ___/___/9_
(dd/mm/yy)

G2. Non anketè a _____

G3. Sipèvizè _____

G4. Kominote _____

Non ak laj manman an

G5. Non _____ G6. Laj (ane) _____

Non ak laj timoun nan ki gen mwens ke 24 mwa.

G7. Non_____.

G8. Dat nesans ___/___/___(J/M/ane). G9. Laj li an mwa_____.

G9. Afilyasyon: (Relasyon)

1. Fanmi PLAN [ ]
2. Fanmi Non-PLAN [ ]

Edikasyon ak Okipasyon Manman-an.

E1. Eske ou te ale lekòl? Ki clas ou rive?

1. Okenn [ ]
2. Primè men li pa konn li [ ]

3. Primè men li kon li [ ]

4. Segondè ou inivèsite [ ]

E2. Eske w-ap travay lwen kay - wou?

1. Wi [ ]

2. Non [ ]

E3. Eske w-ap fè lòt travay ki rapòte-w lòt lajan?
(**gen plizyè repons posib, tcheke tout repons yo**)

a. anyen
b. atisana, tisaj, tapi [ ]
c. rekòt, ramasaj pwodui [ ]
d. vant pwodui agrikòl [ ]
e. sèvant [ ]
f. magazinye / vandè anbilan [ ]
g. travayè salarye [ ]
h. machan manje [ ]
i. lòt bagay (espesifye yo) _____ [ ]

E4. Ki moun ki pran swen (non timoun nan) lè wap deplase?

(**gen plizyè repons posib, tcheke chak**).

a. manman an mennen timoun nan ak li [ ]
b. mari-w. / conpayon-w. [ ]
c. pi gran timoun nan [ ]
d. paren-w [ ]
e. vwazen / zanmi [ ]
f. bòn [ ]
g. nan lekòl timoun [ ]
[ ]

Nitrisyon

Alètman / Nouriti aprè sevraj.

N1. Eske wap bay (non timoun nan) tete? [ ]

1. Wi [ ]--> ale nan No.3

2. Non [ ]

N2. W-te toujou bay (non timoun nan) tete?

1. Wi [ ]

2. Non [ ]--> gade nan No.4

N3. Aprè akouchman, ki lè w te commence bay (non timoun nan) tete pou premyè fwa.

1. depi premye inè aprè akouchman [ ]
2. depi premye è jiska 8 è aprè akouchman [ ]
3. plis ke 8ède tan aprè akouchman [ ]
4. mwen pa sonje [ ]

N4. a) Eske w-te bay (non timoun nan) dlo (ou te fèy)?

1. wi [ ]
2. Non [ ]
3. mwen pa konnen [ ]

b) Eske w-te bay (non timoun nan) lèt bèf, lèt kabrit ou lèt an poud?

1. wi [ ]
2. non [ ]
3. mwen pa konnen [ ]

c) Eske w-te kay (non timoun nan) manje ki pa twò solid tankou labou-yi diri, bannann, la bouyi avwan ou semolina.

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

d. Eske w-te bay (non timoun nan) fri?

1. Wi [ ]

2. Non [ ]

3. Mwen pa konnen [ ]

e. Eske w-te bay (non timoun nan) kawòt, mango ou papay? orange

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

f. Eske w- bay (non timoun nan) legim fey vèt, tankou zépina.

1. Wi [ ]
2. Non [ ]
3. Mwem pa konnen [ ]

h. Eske w-bay (non timoun nan), pistach ou byen (pwa wouj, pwa nwa).

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

i. Eske w-bay (non timoun nan) ze ou byen lait caillé ?

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

J. Eske w-mete legim ki gen fèy vèt tankou zepina nan manje ou bay (non timoun nan)?

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

k. Eske w- ajoute meyel ou byen sik nan mangé w- bay (non timoun nan)?

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

l. Eske w- ajoute grès (la kochon) ou lwil nan manje (non timoun nan)

1. Wi [ ]
2. Non [ ]
3. Mwem pa konnen [ ]

m. Eske w- mete sèl fin ou grosel nan manje (non timoun nan)?

1. Wi [ ]
2. Non [ ]
3. Mwen pa konnen [ ]

N5. Moun yo kap travay nan domèn la sante kwè ke li trè enpòtan pou manman yo bay timoun yo tete pandan 2 premyè ane yo. Kisa yon manman kapab fè pandan 4 premye mwa yon ti moun ap tete?

(**Gen plizyè repons posib, tcheke repons sa yo**).

a. mwen pa konnen [ ]
b. bay tete pi vit ke posib aprè akouchman [ ]
(pas jete dlo jaune qui coulé avant lèt la).

c. manman an dwe netwoye tete li avan li bay timoun nan li, li dwe fè sa pou bout tete yo tou [ ]
d. fè ti bebe ya souse tete souvan fè lèt la koule. [ ]
e. bay timoun nan tete sèlman pandan 4 premye mwa yo [ ]
f. evite bay timoun yo bibwon [ ]
g. rekòmanse bay tete (siw-te kanpe li, manman kapab bay tete ankò [ ]
h. lòt posibilite (espesifye yo) [ ]

N6. Ki lè yon manman kapab kòmanse bay ti moun nan manje en plis tete a?

1. li kapab kòmanse bali manje ant 4 ak 6 mwa [ ]
2. li kapab kòmanse pi bonè ke 4 mwa. [ ]
3. li kapab kòmanse tou a 6 mwa ou pita [ ]
4. li pa konnen [ ]

N7. Ki vitamin ki kapab pwoteje li kont sa yo rele " pa wè lè li pral aswè-w pandan nan nuit "? (Pliziè repons posib).

1. Vitamin A [ ]
2. li pakonnen ou lòt [ ]

N8. Ki manje ki genyen vitamin A la-dan yo e ki kapab pwoteje kont sa yo rele " pa wè pandan nan nuit" (Plizyè Repons posib, tcheke chak).

a) li pa konnen ou lòt [ ]
b) fèy legim vèt [ ]
c) yon seri fri ki jòn [ ]
d) vyann / pwason [ ]
e) lèt tete manman yo [ ]
f) jòn ze [ ]

Kontwòl kwasans

N9. Eske (non timoun nan) gen yon kat chemen sante?

1. wi [ ] (ban-m mwè kat la)
2. kat la pèdi [ ] ---> **ale nan D1**
3. non [ ] ---> **ale nan D1**

N10. ═══════════════════════════════════

gade kat chemen sante timoun nan, e gade si enfòmasyon sa yo la: Eske timoun nan te peze pandan 4 dènye mwa yo?

1) Wi [ ]
2) non [ ]

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N11 gade tou nan kat chemen sante la, verifye pou wè. Si gen yon espas pour an rejistre kantite kapsil vitamin A.

1. wi [ ]
2. non [ ] ----> **alenanD1**.

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N12 ═══════════════════════════════════

Si wi, an rejistre dat yo te bay timou nan kapsil vitamin A yo nan espase anba-a.
(J/m/ane)

1) ___/___ /___
2) ___/___ /___
3) ___/___ /___
4) ___/___/____

Kontwòl Maladi Dyare

D1. Eske (Non timoun nan) te gen dyare pandan 2 dènye semèn yo.

1. wi [ ]
2. non [ ]-----> **gade nan D10**
3. li pa konnen [ ]-----> **gade nan D10**

D2. Konbyen tan dyare sa te dire?

1. Mwens ke 2 semèn (0 - 13 jou) [ ]
2. 2 semen ou plis (14 jou ou plis) [ ]

D3. Eske (non timoun nan) pandan li te gen dyare a li te konn poupou san?

1. wi [ ]
2. non [ ]
3. li pa konnen [ ]

D4. Pandan (non timoun nan) te gen dyare, w-te bali tete. (li chwa yo pou manman an) 1 repons

1. plis ke sa w-te kon bali avan? [ ]
2. menm jan w-te konn bali li a? [ ]
3. w-bali-li pi souvan kavan [ ]
4. w-te rete nèt [ ]
5. timoun nan pat tete [ ]

D5. Pandan dyare-a te avek (non timoun nan), w-te bay. (non timoun nan) lòt likid ki pa lèt manman....

(**li chwa yo pou manman an**) 1 repons

1. pi plis kem dabitud? [ ]
2. menm jan w-te konn bali li? [ ]
3. mwen souvan kòm dabitid? [ ]
4. w - pa bali-l menm? [ ]
5. li kontinye bali tete selman [ ]

D6. Pandan (non timoun nan) te gen dyare-a, eske w-kontinye bay (non timoun nan) manje ki di ou sa ki demidi... (**li chwa-a pou manman an**) 1 repons

1. plis ke dabitid? [ ]
2. kòm dabitid? [ ]
3. mwen souvan ke dabitid? [ ]
4. w-pa bali-l menm [ ]
5. li kontinye bali tete selman [ ]

D7. Lè (non timoun nan) te gen dyare-a, ki trètman ou te fè, si w-te fè youn, ki sa-a w-te itilize?

(**w-kapab plizyè repons posib, tcheke tout repons yo**).

a. anyen [ ]
b. sachè sewòm oral [ ]
c. dlo sik ak sèl [ ]
d. Dlo diri + carrot [ ]
e. te ou lòt likid [ ]
f. pwodui nan famasi ki kont dyare ou byen remed kont infeccion [ ]
g. lòt bagay (espesifye yo) [ ]

D8. Lè (non timoun nan) te gen dyare-a, eske w-te chèche konsèy ou fè yon tretman pou dyare-a?

1. wi [ ]

2. non ale nan D10 [ ]

D9. Ki kote-w te ale chèche konsèy ou trètman pou dyare (non timoun nan) a?
(w-kapab bay plizyè repons posib, tcheke chak repons).

a. lopital jeneral [ ]

b. sant sante/klinik/post sante [ ]

c. klinik prive/doktè [ ]

d. famasi [ ]

e. travayè sante ki nan vilaj la [ ]

f. gerisè [ ]

g. fanm saj [ ]

h. gran paran ak zanmi [ ]

i. lot posibilite (espesifye yo) [ ]

D10. Ki siy / danje-a ki ka pouse-w al chèche konsèy ou trètman pou dyare (non timoun nan).
(w-kapab bay plizyè repons posib, tcheke tout).

a) li pa konnen [ ]

b) vomisman [ ]

c) fyèv **(dezidratasyon) (lap pèdi dlo)**

d) dezidratasyon, lap pèdi dlo, lèv li sèk, zye li te fon, pipi li diminye [ ]

e) dyare-a te dire sou li (a mwens 14 jous) [ ]

f) poupou li gen san [ ]

g) Li pèdi apeti-li [ ]

h) feblès ou fatig [ ]

i) lòt bagay (espesifye yo)_____ [ ]

D11. Ki aksyon ki pi enpòtan w-te ka poze lè (non timoun nan)[ ] ta gen dyare a-?
(w-kapab bay plizyè repons posib, tcheke tout repons yo).

a) pa konnen [ ]

b) w-te kòmanse rapidman bali likid [ ]

c) w-te bay ti moun nan plis likid pou li bwè ke avan[ ]

d) w-te bay timoun nan manje ki pi piti pi souvan [ ]

e) w-te prepare byen pwòp sewòm oral e w-bay ti moun nan li. [ ]

f) w-te mennen timoun nan lopital / nan sant sante [ ]

g) w-te bay timoun nan plis manje aprè dyare-a fin pase e konsa lap reprann pwa li. [ ]

h) w-te refize bay timoun nan likid [ ]

i) w-te refize bali manje [ ]

j) w-te fè lòt bagay ankò (espesifye yo)_____ [ ]

D12. Ki sa ki pi enpòtan pou yon manman kapab fè lè yon timoun frape pa maladi dyare-a?

a. pa konnen [ ]

b. bay timoun nan ti manje ki pi piti-a pi souvan [ ]

c. bali plis manje kòm dabitid [ ]
d. bali lòt manje ki pi nourrisan [ ]
e. lòt bagay (espesifye yo) _____ [ ]

Maladi Respiratwa

R1. Eske (non timoun nan) te tousse ou byen li te gen difikilte pou li respire pandan 2 dènyè semèn ki sot pase la?

1. wi [ ]
2. non [ ] --> **alé nan repons No.5**

R2. Lè (non timoun nan) te malad la eske li te respire byen ou vit?

1. wi [ ]
2. non [ ] ---> **alé nan R5**
3. pa konnen [ ] ---> **alé nan R5**

R3. Eske w-te chèche trètman lè (non timoun nan) te gen pwoblem respirasyon an?

1. wi [ ]
2. non [ ]--->**alé nan R5**

R4. Ki kote w-tal chèche trètman pou (non timoun nan) lè li te gen pwoblèm respirasyon an ou lè li te gripe-a?
(**gen plizyè repons posib, tcheke tout repons yo**)

a. Lopital jeneral [ ]

b. Sant sante / klinik / post sante [ ]

c. klinik prive / doktè [ ]

d. Ajan sante ki nan vilaj [ ]

e. fanm saj [ ]

f. gerisè [ ]

g. nan famasi / famasyen / magazinye [ ]

h. paran e zanmi [ ]

i. lòt bagay [ ]

R5. Ki siy/dange ki ta few menen (non ti moun nan) kay dotè si li pata ka respire byen.
(gen plizyè repons posib, tcheke tout repons yo).

a. pa konnen [ ]

b. respirasyon difisil ou fasil [ ]

c. biskèt li fè oun trou fond lè lap respiré [ ]

d. pèdi apeti [ ]

e. fyèv [ ]

f. touse [ ]

g. lòt bagay espesifye yo_____ [ ]

Iminizasyon ou Vaksinasyon

I1. Sil vouplè dimwen aki laj (non timoun nan) te resevwa premye vaksen?

1. Lè li te fèk fèt / premye mwa-a [ ]

2. Li pa konnen ou lòt [ ]

I2. Aki laj (non timoun nan) dwe resevwa vaksen kont lawoujòl?

1. Espesifye li an mwa [.....]

2. Pa konnen ou byen lòt [ ]

I3. Kombyen dòz vaksen tetanòs yon fanm ansent bezwen pou pwoteje yon ti moun ki nan vant li kont tetanòs?

1. Youn [ ]
2. 2 [ ]
3. plis ke 2 [ ]
4. pa konnen [ ]

I4. Eske ou gen yon kat vaksinasyon pou (non timoun nan)?

1. wi [ ] (ou dwe wè kat la)
2. li pèdi [ ] ---> **alé nan M1**
3. pa janm gen yen [ ] ---> **alé nan M2**

I5. ═══════════════════════════════════

gade kat vaksinasyon an e tcheke tout dat vaksinasyon nan espas ki anba.

BCG		___/___/___
POLIP	0 dòz	___/___/___
	1e dòz	___/___/___
	2e dòz	___/___/___
	3e dòz	___/___/___
DPT	1e dòz	___/___/___
	2e dòz	___/___/___
	3e dòz	___/___/___
Woujòl		___/___/___

SWEN MATENEL

M1. Eske w gen yon kat vaccin pou ou?

1. wi (ou dwe wè kat la [ ]
2. li pèdi -------> ale nan M5 [ ]
3. non ----------> ale nan M5 [ ]

M2. _____

gade nan kat sante manman-an e mete kantite vaksen TT li pran nan espas anba-a':

1) yon [ ]

2) 2 ou plis [ ]

3) anyen [ ]

M3.

M4. ═══════════════════════════════════════

Lè ou ansant, eske ou te suiv doktè? konbyen fwa?

1. youn
2. 2 ou plis
3. okenn

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M5. Eske w-ansent kounye-a?

1. wi [ ]----> **alé nan M9**
2. non [ ]

M6. Eske w vle gen lot timoun nan 2 lot ane yo kap vini la?

1. wi [ ] ---> **alé nan M9**
2. non [ ]
3. li pa konnen [ ]

M7. Kouramman eske w-pa janm fè izaj de oken metòd ki pou fè w-pa ansent.

1. wi [ ]
2. non [ ] ---> **alé nan M9**

Ki pi bon metòd ke ou menm ou mari itilize kounye a pou evite ke w ansent?

M8
1. ligati twonp. [ ]
2. operasyon sou mari-w (vazektomi) [ ]
3. patch nan powou (Norplant) [ ]
4. piki [ ]
5. grèn [ ]
6. estérile - filaman [ ]
7. capòt [ ]
8. pomade en dedan-w [ ]
9. bay timoun tete san rete [ ]
10. moun kap veye lalin [ ]
11. pa fè bagay [ ]
12. voye deyò [ ]
13. lot bagay [ ]

M9. Ki lè fanm ansent yo dwe wè yon pwofesyonel nan zafè la sante?

1. premye trimès 1 - 3 mwa [ ]
2. nan mitan gwosès li, 4 - 6 mwa [ ]
3. dènye trimes la, 7 - 9 mwa [ ]
4. li pa bezwen wè yon travayè sante [ ]
5. li pa konnen [ ]

M10. Ki manje ki bon pou yon fanm ansent manje pou pwoteje'lont anemi pandan li ansent la?
(gen plizyè repons posib, tcheke repons sa yo).

a) pa konnen [ ]
b) manje ki rich an fè tan kou (ze, pwason, poul) [ ]
c) fèy legim vèt, ki rich ak fè [ ]
d) lòt bagay (espesifye yo) [ ]

M12. Combyen yon Fanm kapab peze pandan gwozès li?

1. 10 - 12 kilo [ ]
2. ogmantasyon pwa pandan li pote bebe-a [ ]
3. pa konnen [ ]
4. lòt bagay (espesifye yo) _____ [ ]

M14. Lè w-te ansent (non timoun nan) eske w-te vizite yon sant sante tankou (dispansè / sant sante / post) pou te pran swen timoun w pote-a?

1. wi [ ]

2. non [ ]

Appendix 4

List of Participants in the KPC Survey

PLAN
INTERNATIONAL
Croix-des-Bouquets

List of Participants
KPC Survey. December,1994

Core Team

Dr. Marie Mercy Jean Louis Zevallos
Health Coordinator
PLAN/Croix-des-Bouquets

Dr. Michel-Henry Brutus
Executive Director
H.E.L.P. Inc.

Dr. Lizie P. Dubois
Director
Turbe Health Care Center

Supervisors

1. Jn Ronal Belfort
2. Noel Claudy
3. Maxime Solince
4. Nelson Nerva
5. Wilson Falaise

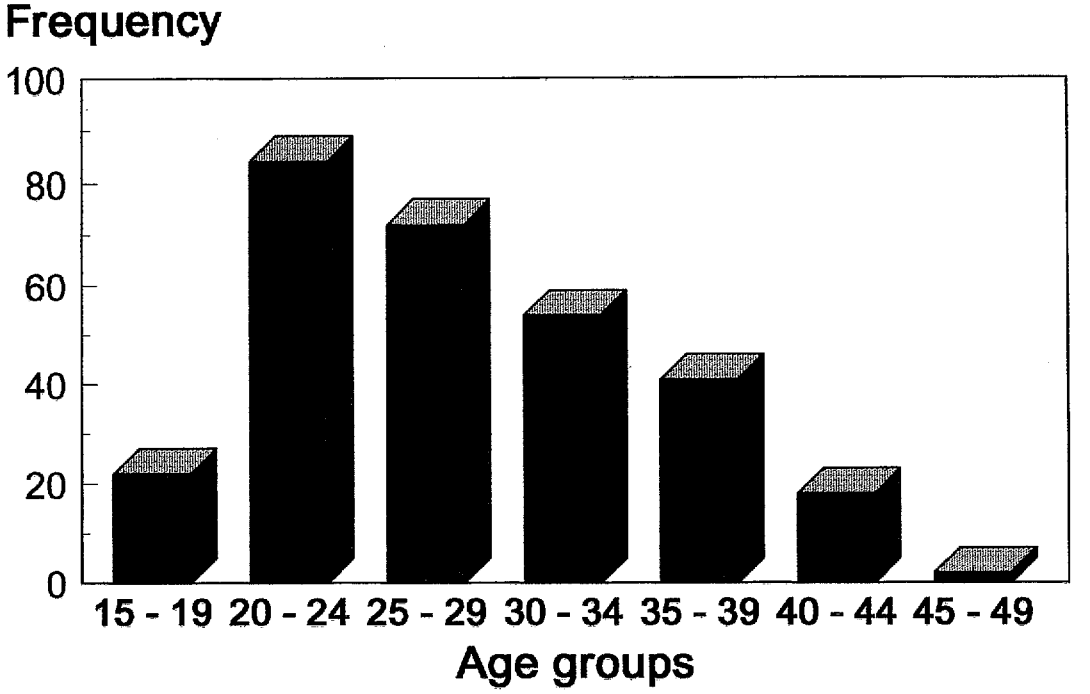
Interviewers

1. Adrice Desire
2. Bastien Jean A. Lamartine
3. Chiler Romulus
4. Fenelon Jn. Fritzner
5. Ives Herman Narcisse
6. Michel Jean Jaccquelin
7. James Jean Pierre
8. Jean Wileme Delphe
9. Laurius Marki
10. Luc Jn Evens
11. Mark Elie Gearlus
12. Michel
13. Paul Andre
14. Thomas Jan Frantz
15. Thyler Romulus

Appendix 5

Figures

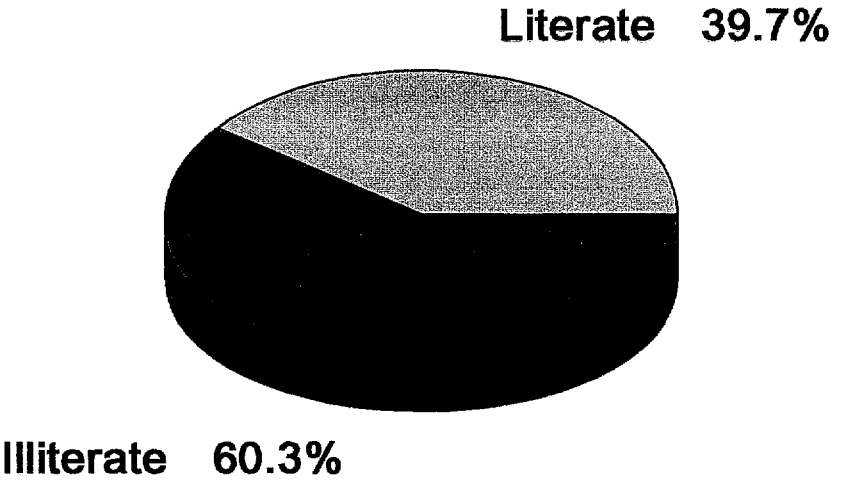
Figure 1. Age of Mothers. Distribution of Interviewed mothers by groups of age.



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

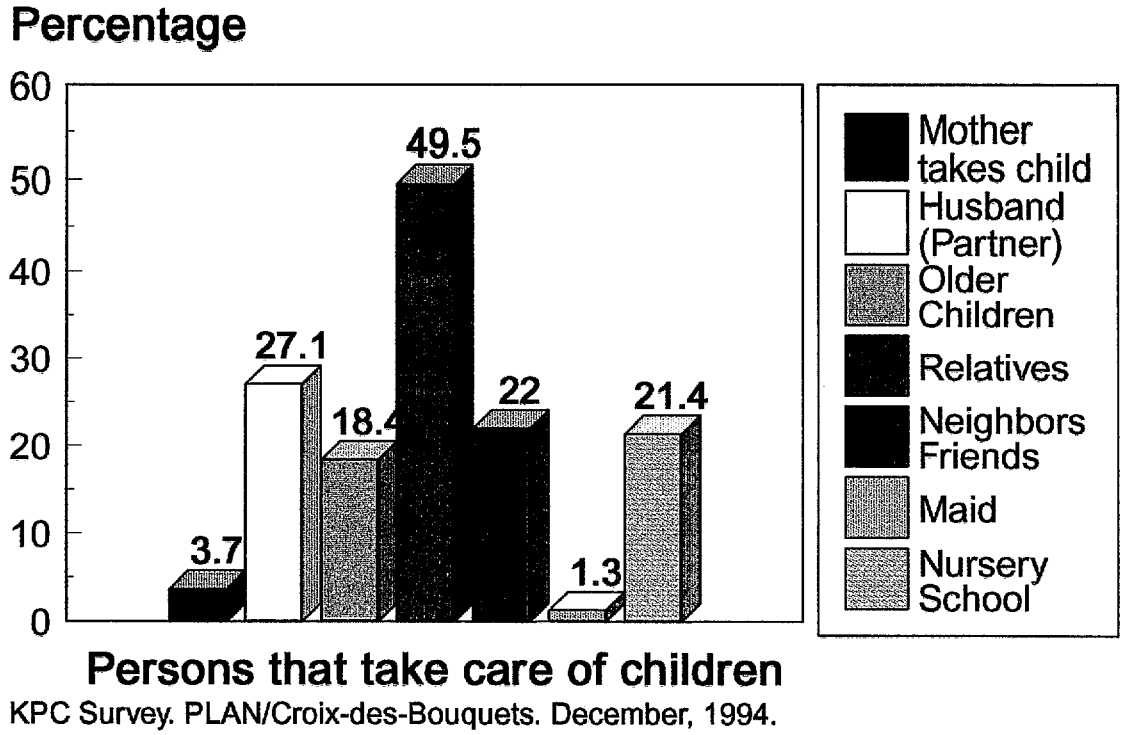
Figure 2. Mothers Literacy.

Percent of mothers who are literate.



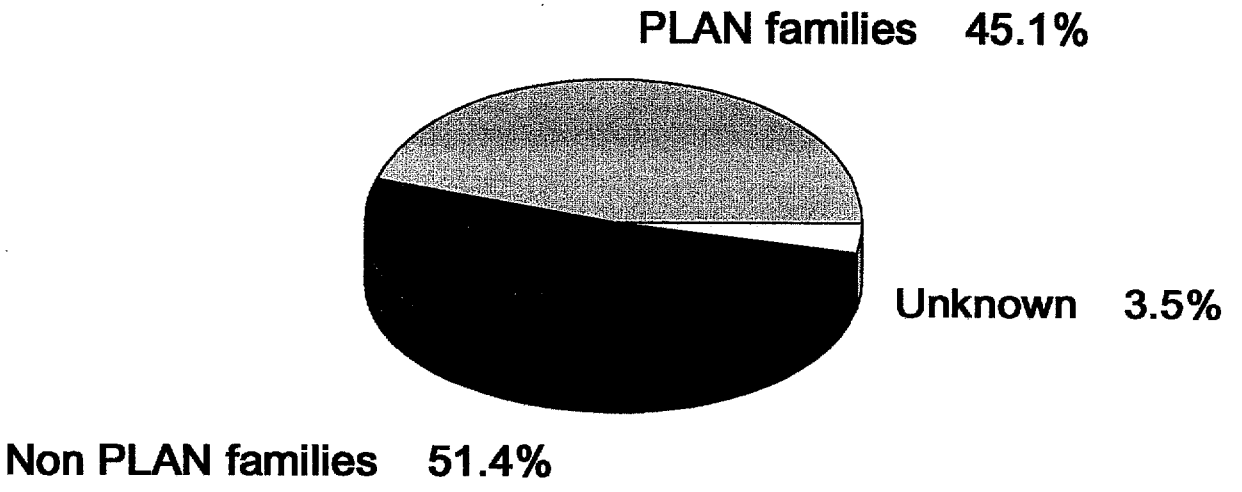
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 3. Who takes care of children when the mother is away from home?



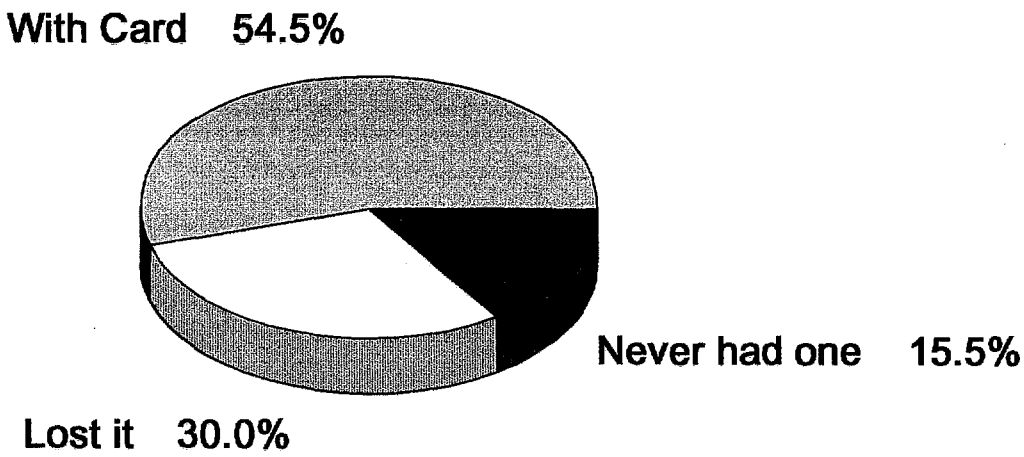
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

Figure 4. Percent of families affiliated to PLAN/Croix-des-Bouquets



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

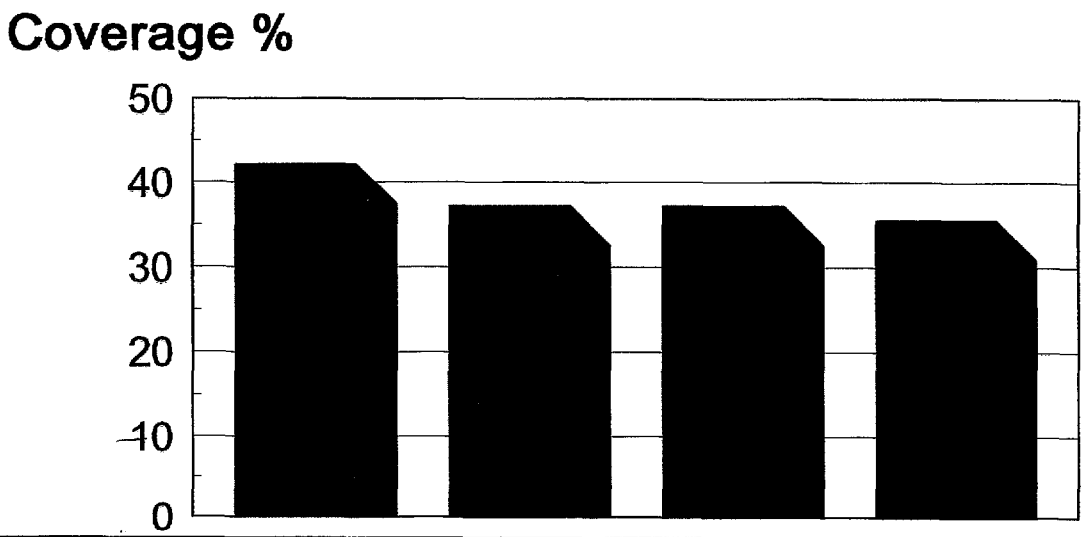
Figure 5. Children with Immunization Card



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 6. Immunization Coverage.

Percent of children 12 to 23 months who received EPI Vaccines.

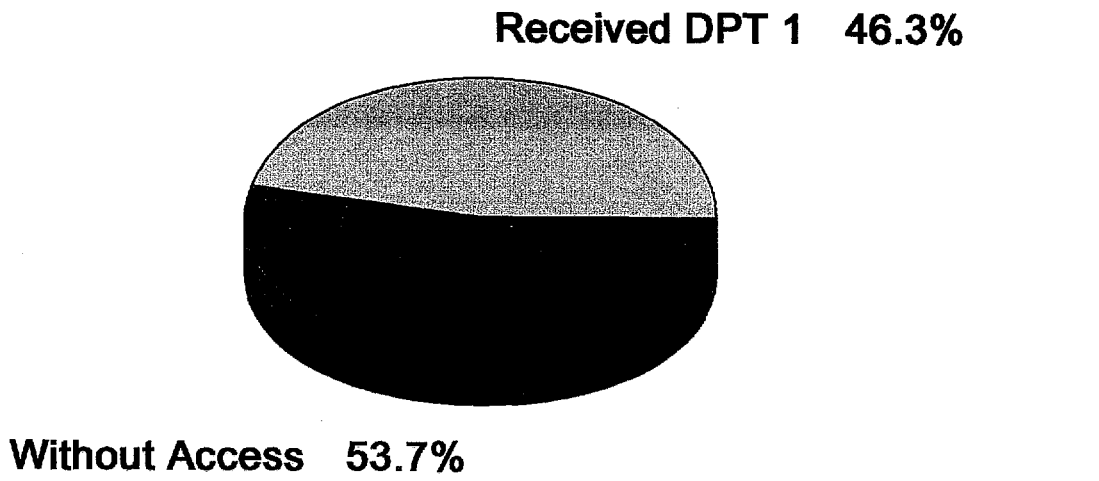


EPI Vaccines	BCG	OPV 3	DPT 3	Measles
Coverage (%)	42.1	37.2	37.2	35.5

KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

Figure 7. EPI Access.

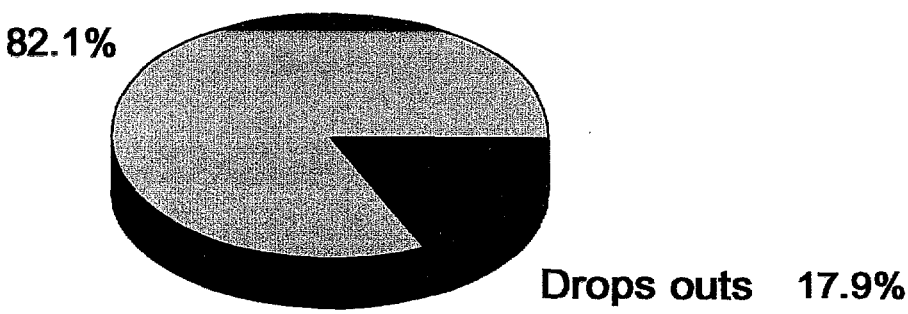
Percent of Children 12 to 23 months who received DPT 1.



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

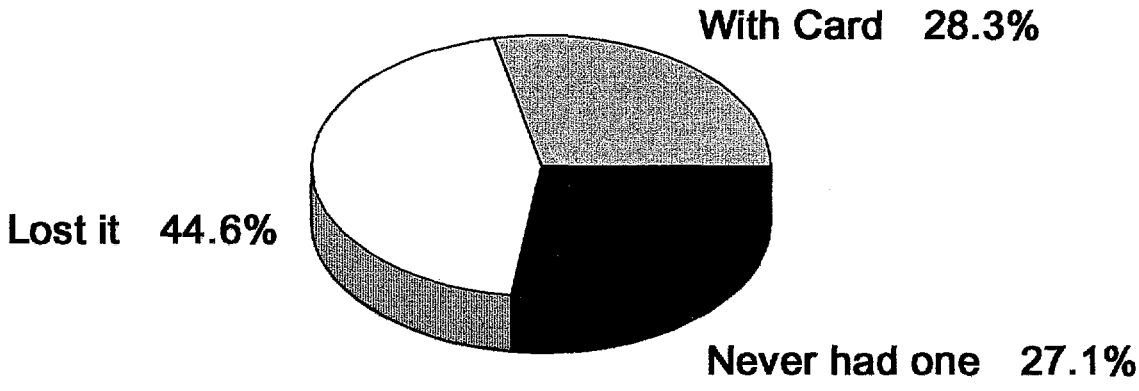
Figure 8. Drop Out Rate.

Percent of "drop out rates between DPT 1 and DPT 3



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

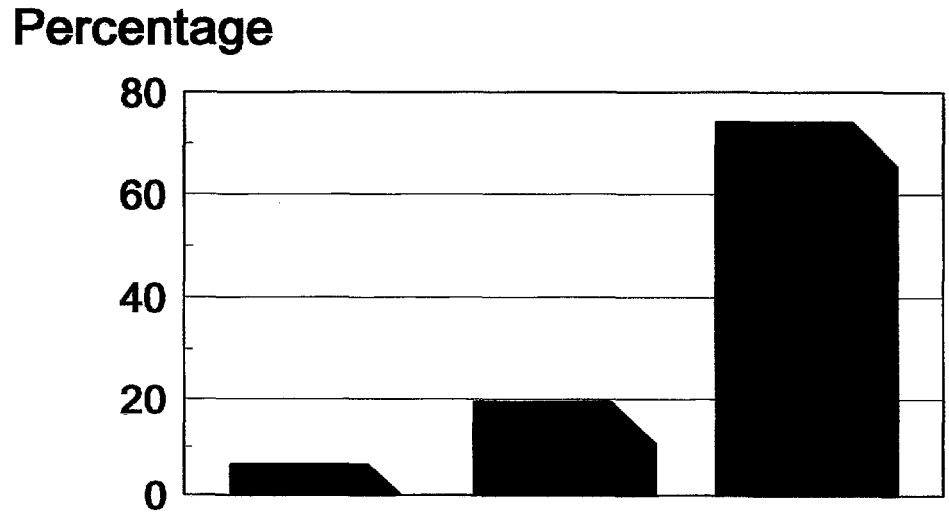
Figure 9. Mothers with Maternal Card



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 10. Tetanus Toxoid Coverage.

Percent of mothers who received two doses of TT.

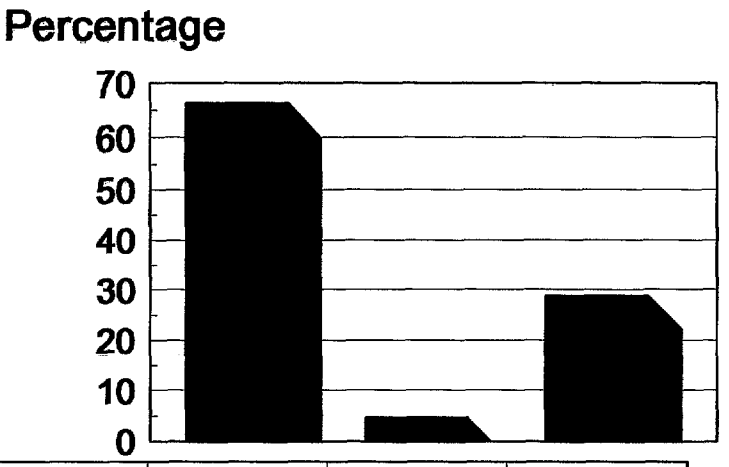


Number of TT doses	One	Two or more	None
Percentage of Mothers	6.4	19.4	74.2

KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 11. Prenatal care

Percent of mothers who had one or more pre-natal visits prior to the birth of their last child..

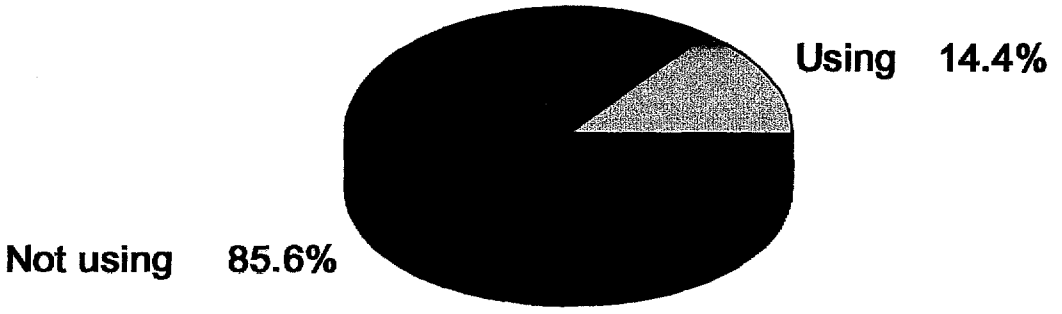


Number of Prenatal visits	None	One	Two or more
Percentage of Mothers	66.5	4.7	28.8

KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

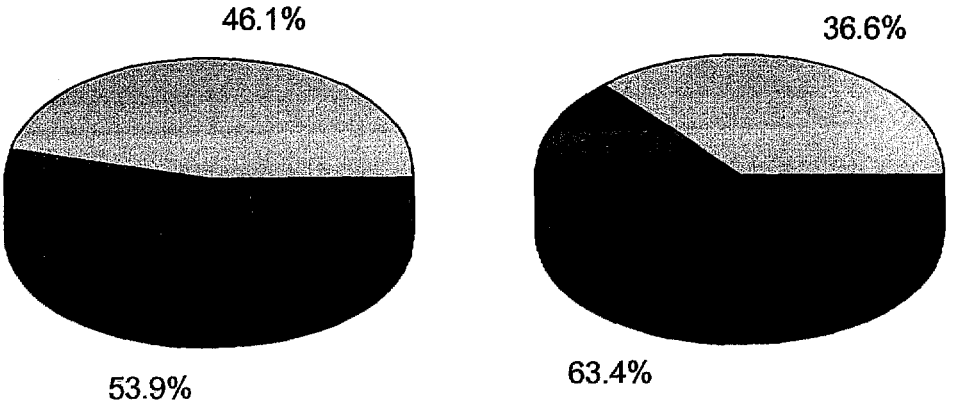
Figure 12. Modern Contraceptive Usage

Mothers who desire no more children, or are not sure who are using a modern contraceptive method.



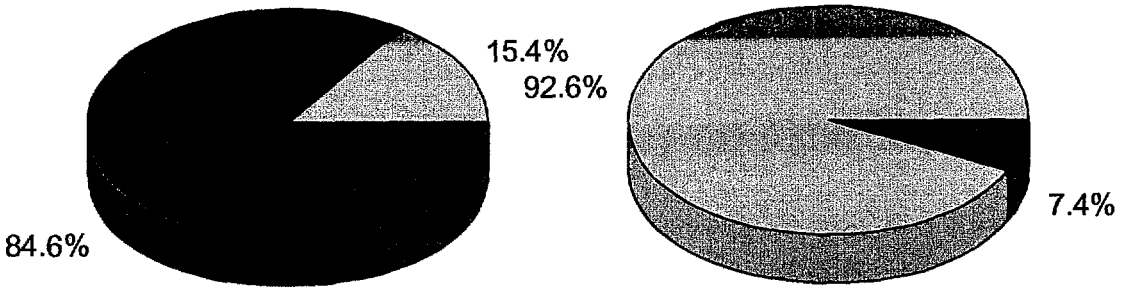
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 13. Immunization Knowledge of Mothers.



KPC Survey. PLAN/ Croix-des-Bouquets. December, 1994

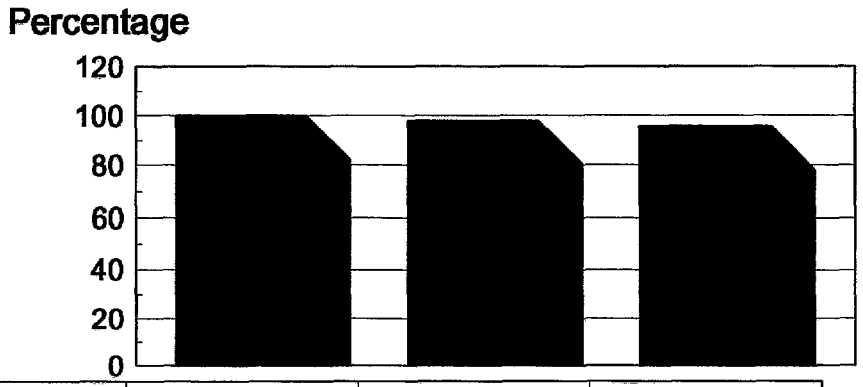
Figure 14. Maternal Care Knowledge of mothers.



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 15. Children receiving breastfeeding.

Percent of children who are breastfed by age group.

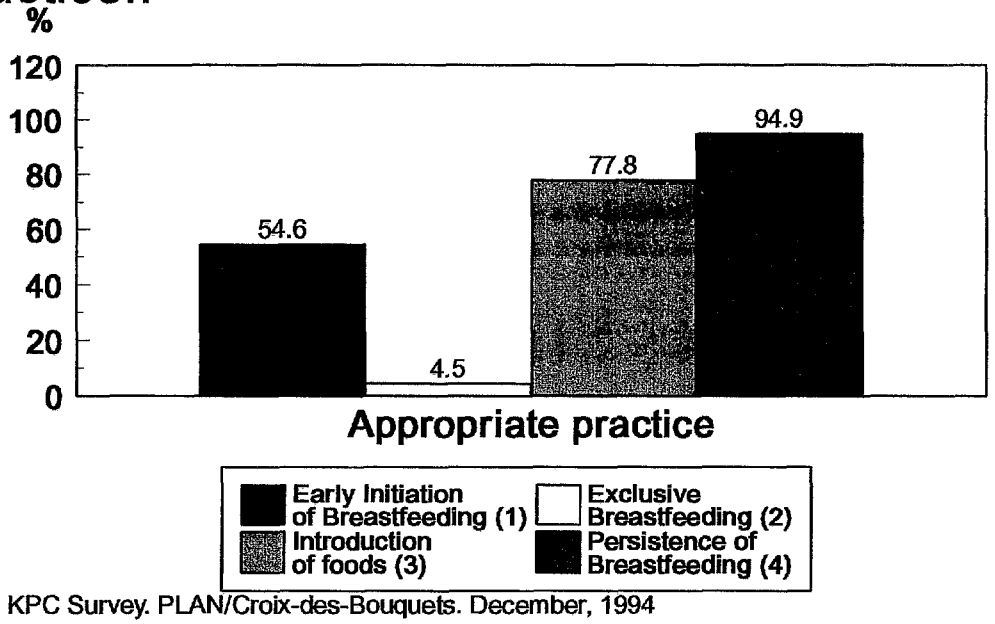


Age Group	< 4 months	5 - 11 months	12 - 23 months
Breastfed ■	100.0	98.1	95.9

KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 16. Appropriate Infant Feeding Practice.

Percent of infants benefited from appropriate feeding practice..



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

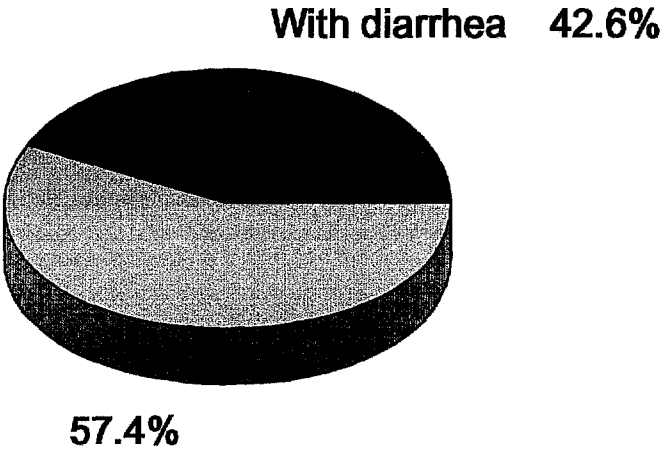
(1) Breastfeeding initiated within first 8 hours after birth

(2) Infants less than four months who are being given only breast milk.

(3) Infants between 5 and 9 months who are being given solid or semisolid foods

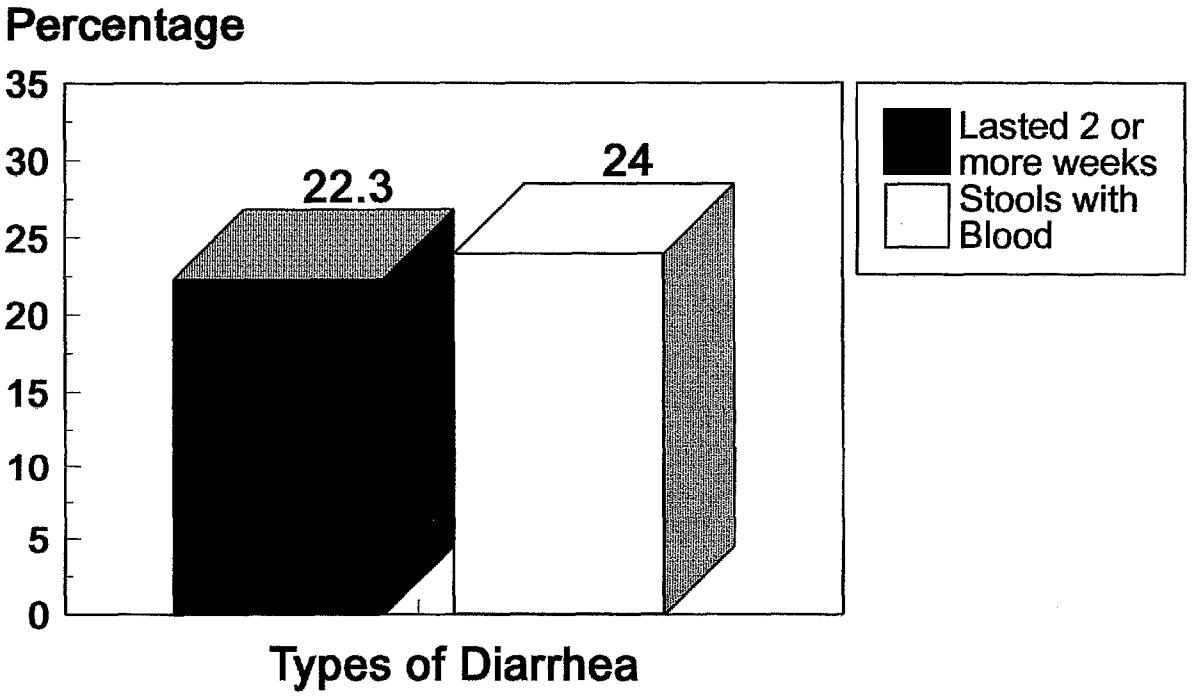
(4) Children between 20 and 24 months who are still breastfeeding.

Figure 17 . Percentage of children with diarrhea in the last two weeks.



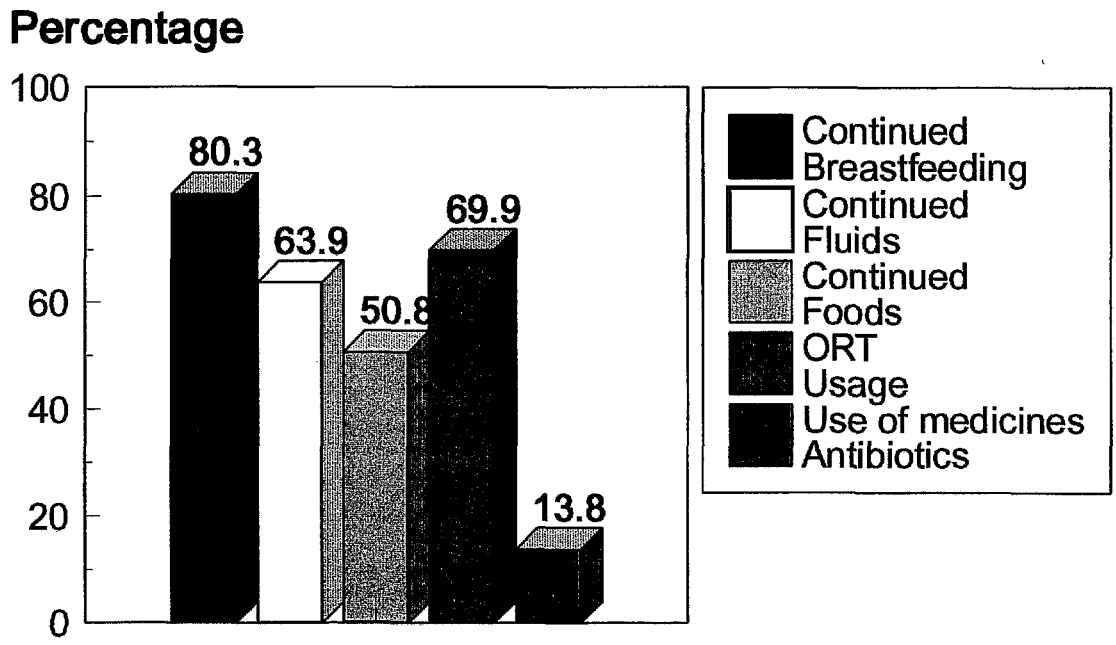
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 18 . Types of diarrhea in children with diarrhea in the last two weeks



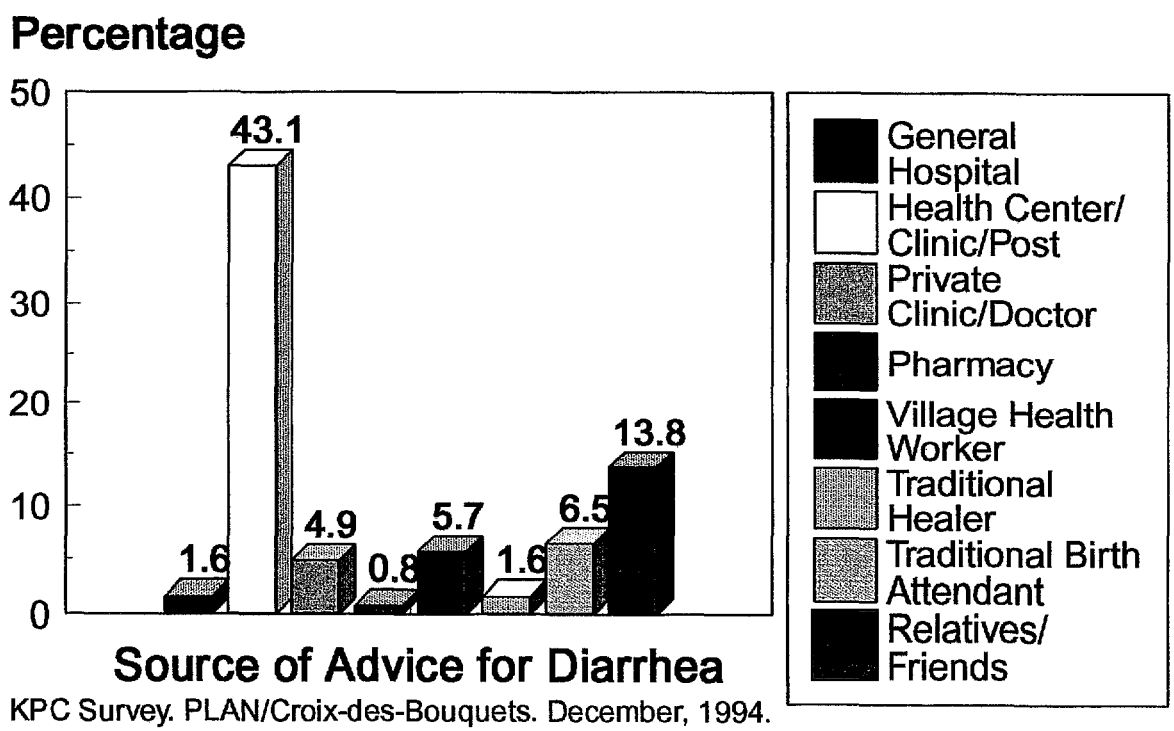
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 19 . Management of Diarrheal disease.



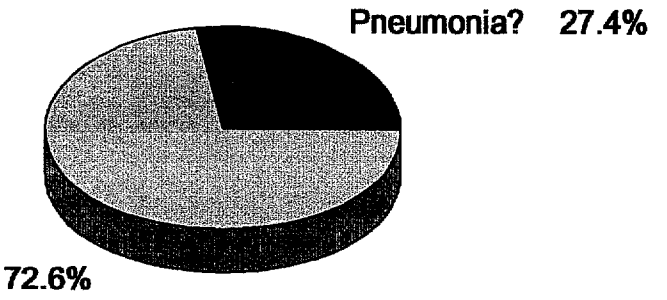
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

Figure 20 . Source of Advice for Diarrhea.



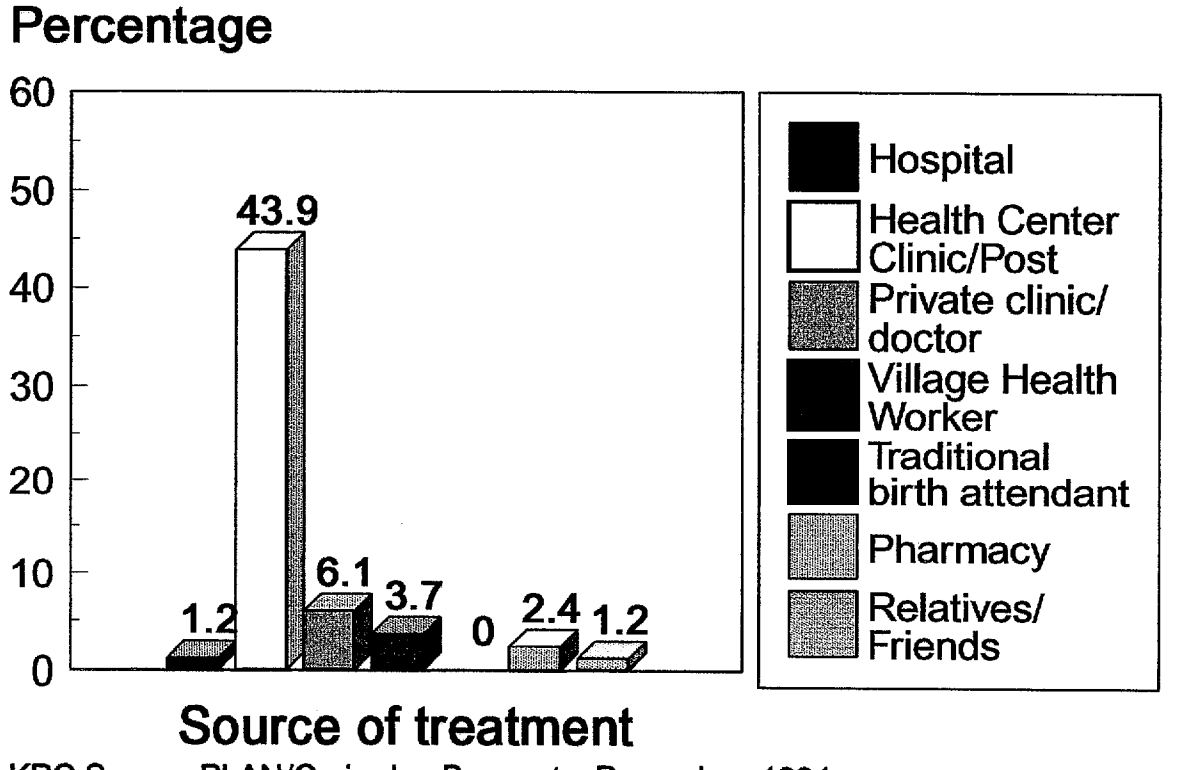
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

Figure 22.. Percentage of children with cough and rapid, difficult breathing (suggesting pneumonia) in the last two weeks.



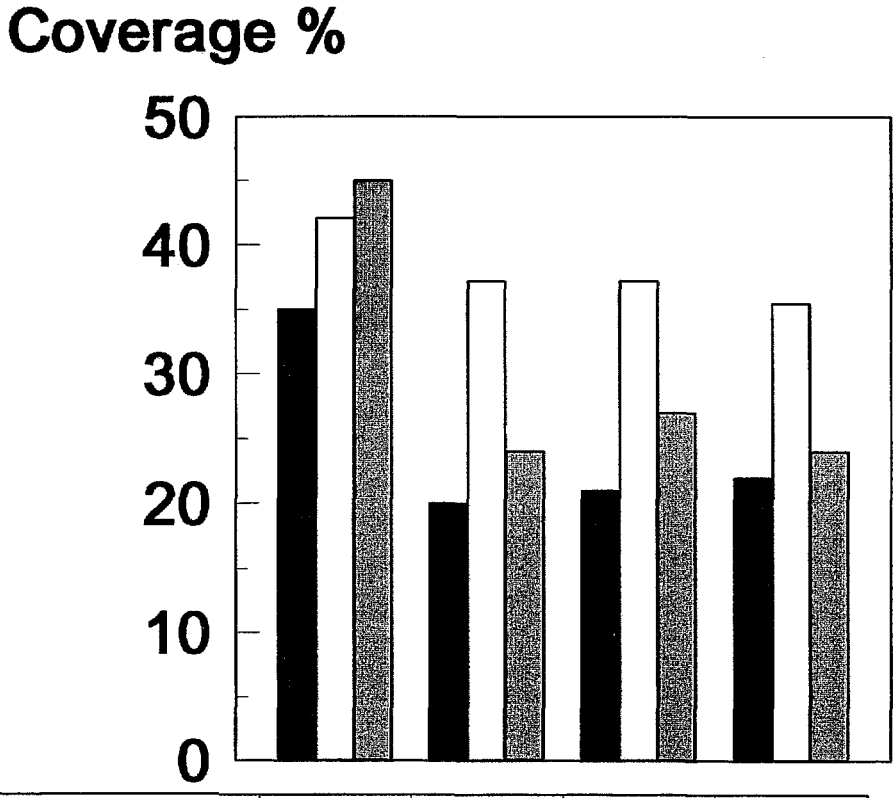
KPC Survey. PLAN/Croix-des-Bouquets. December, 1994

Figure 23. Pneumonia Control : Source of Treatment for cough and or, difficult breathing.



KPC Survey. PLAN/Croix-des-Bouquets. December, 1994.

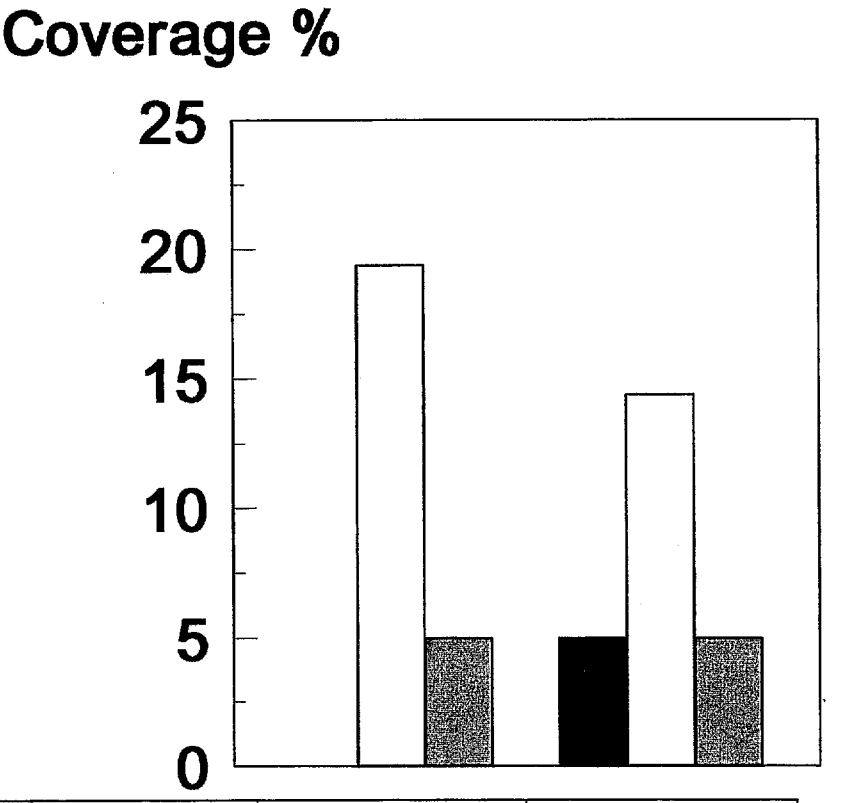
Figure 23. EPI Coverage. Comparison between baseline, final evaluation and national coverage.



Vaccines	BCG	DPT 3	OPV 3	Measles
Baseline Survey (1) ■	35.0	20.0	21.0	22.0
Final Evaluation (2) □	42.1	37.2	37.2	35.5
National (3) Haiti-wide ▒	45.0	24.0	27.0	24.0

(1) PLAN/Croix-des-Bouquets. SAGE Report. Baseline Survey.
(2) KPC Survey. PLAN/Croix-des-Bouquets. December, 1994
(3) UNICEF. The State of the World's Children 1994

Figure 24. Maternal Care. Comparison between baseline, final evaluation and national coverage.



Vaccines	TT 2 or more	Using FP
Baseline Survey (1) ■		5.0
Final Evaluation (2) □	19.4	14.4
National (3) Haiti-wide ▒	5.0	5.0

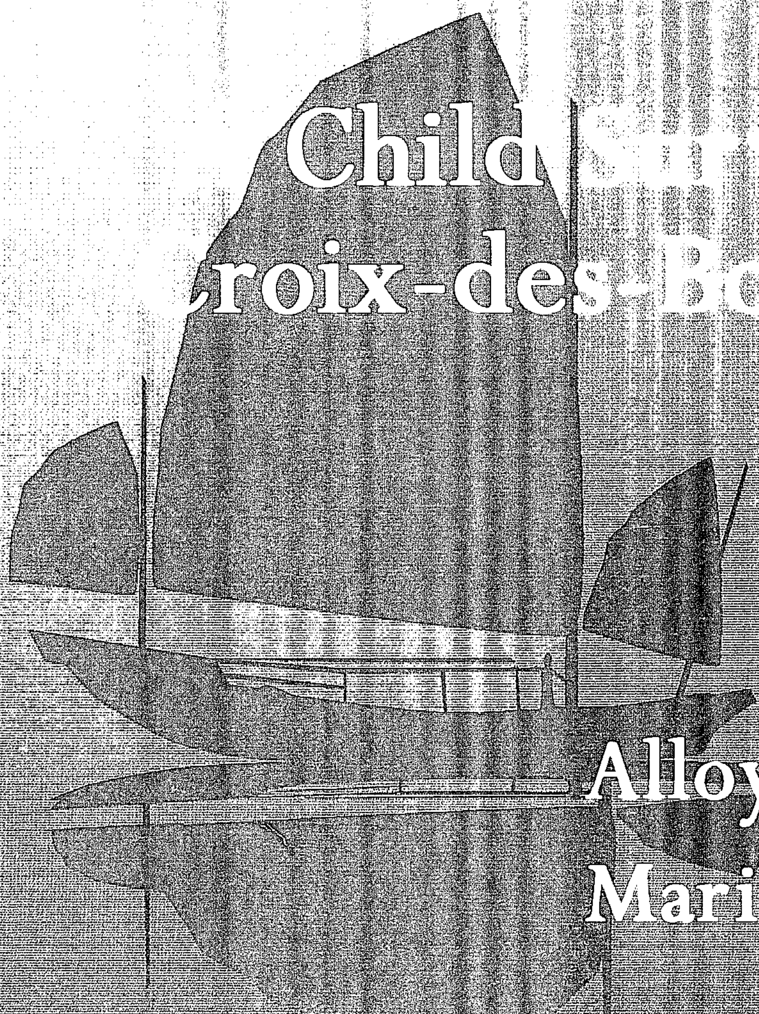
(1) PLAN/Croix-des-Bouquets. SAGE Report. Baseline Survey.
(2) KPC Survey. PLAN/Croix-des-Bouquets. December, 1994
(3) UNICEF. The State of the World's Children 1994

ANNEX # 5

POSTER PRESENTATION AT THE 1994 APHA MEETING

Partnership for Sustainability

Child Survival Project in Croix-des-Bouquets, HAITI



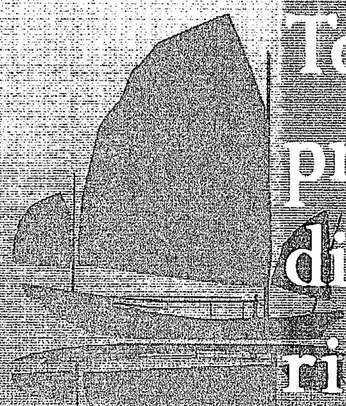
Presented by:

Alloysus Pereira

Marie Mercy Zevallos

The Purpose of these Presentation

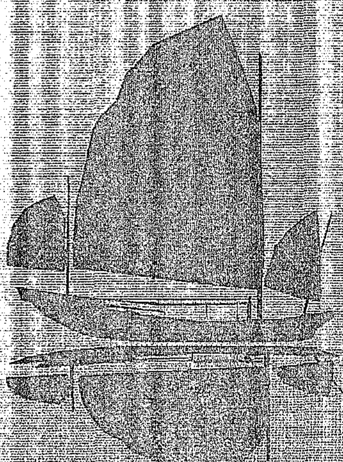
To narrate the experiences in the [illegible] Program of PLAN International in Croix-Des-Bouquets, vis-a-vis the U.S. sponsored Child Survival Program.



To share the message that good health programs can be established even in difficult conditions such as ours, given the right design complimented by the right commitment.

PLAN International

PLAN International, is a child focused [illegible]arian development organization [illegible] ensuring positive changes in the [illegible] children, their families and communities throughout the developing world.

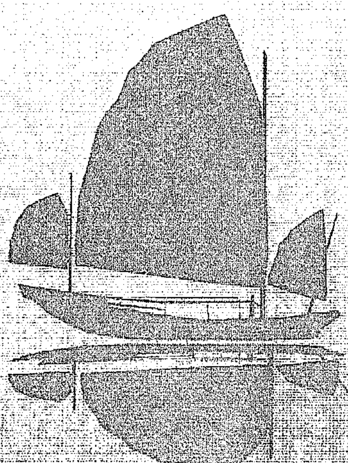


Its work in Croix-des-Bouquets started in 1976. Now is serving 11,300 affiliated families in the area.

Croix-des-Bouquets

Croix-des-Bouquets is an administrative District known by the same name. Its is located 16 Km from the capital Port-au-Prince.

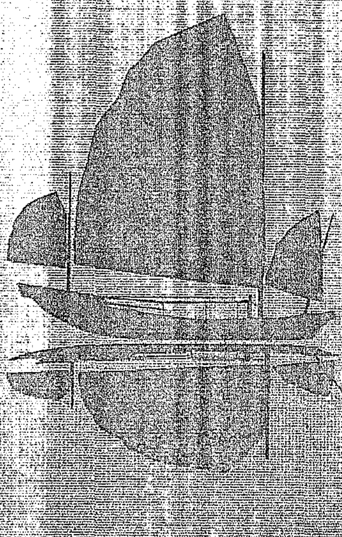
It is both, a peri-urban and a rural area.



The Past Approaches

[illegible] approach: Only for [illegible] of health PLAN [illegible] [illegible] medicine [illegible] on a cas[illegible]

[illegible] approach ([illegible]) [illegible] clinic which made ro[illegible] [illegible] to the communities.



Results:

* Low Coverage.
* Frequent work days because of constant civil strife.
* Low sustainability.

Partnership started with :

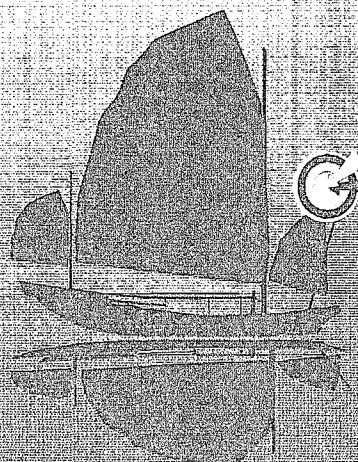
- ➡ HELP - A local NGO (For the Vaudreuil Area)
- ➡ MOH - (For the Turbe Area)

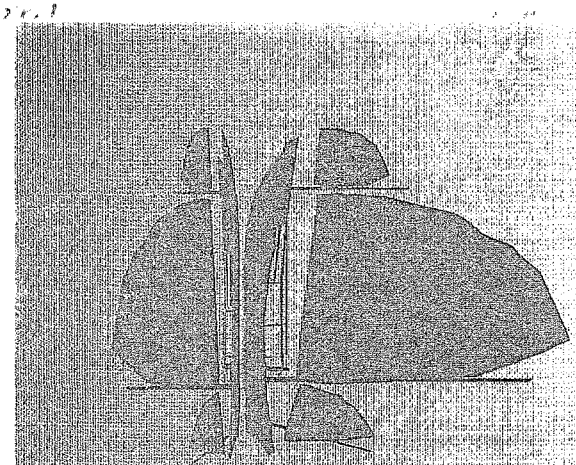
Process of Partnership in Haiti

1. Identification of possible partners.
2. Assessment of the capabilities and constrains of possible partners.
3. Preparation of a draft of collaboration with the best potential partner (HELP).
4. Preparation and approval of a "Memo of Understanding" with the partner (HELP, 1992).
5. Elaboration of administrative and financial policies and organizational details.
6. Implementation of key child survival activities.
7. Evaluation and involvement of other partners (MOH, 1993)

Advantages of Partnership

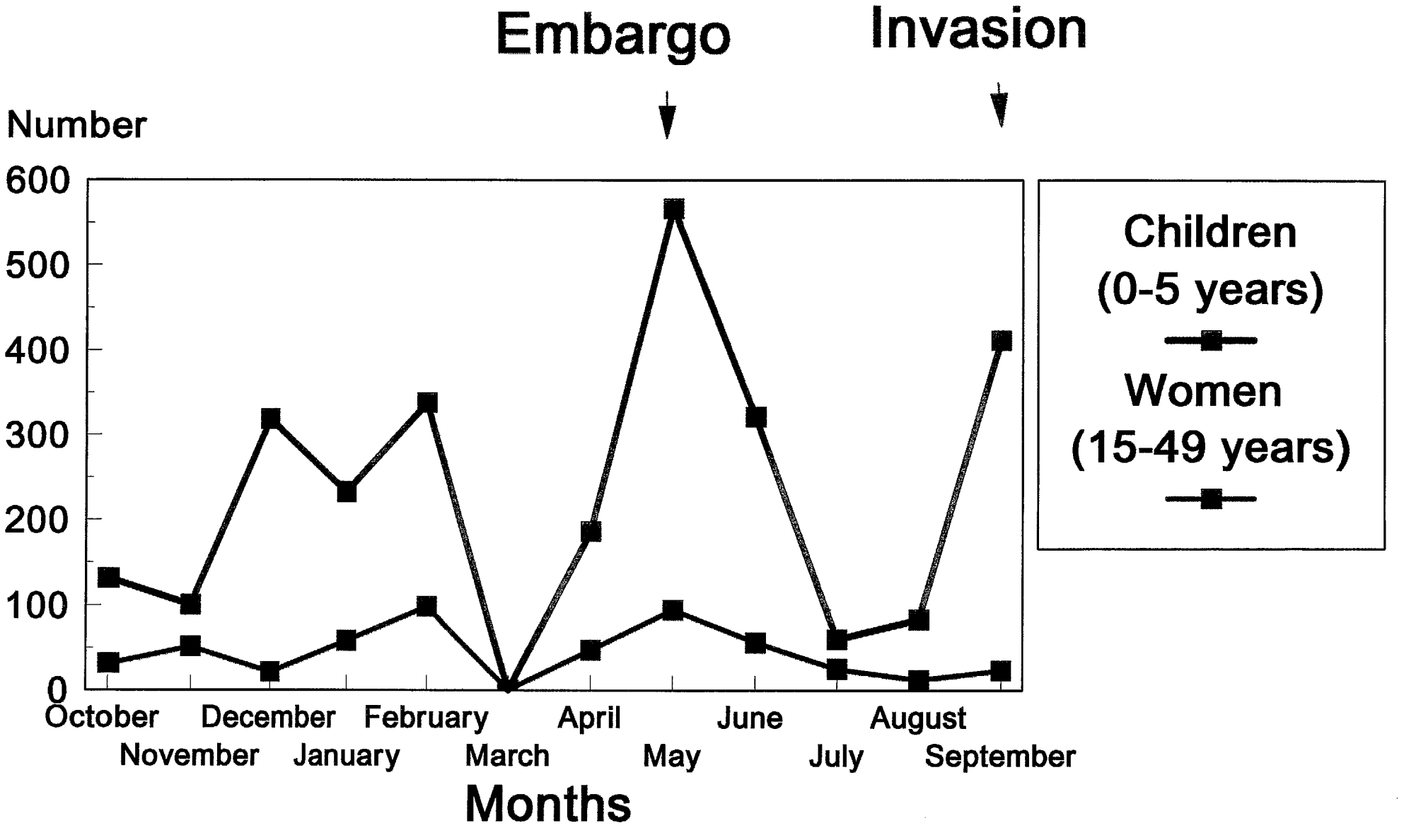
- Increases the coverage of services, lowers operational costs.
- Provides a real long-term commitment to the partners and their programs.
- Organizations did not have to compete with each other. Avoids duplications, increases complementation.
- Greatly increases the possibility of continuity of the program even during hard times (embargo, evacuations, etc.) or after the PLAN phaseout.





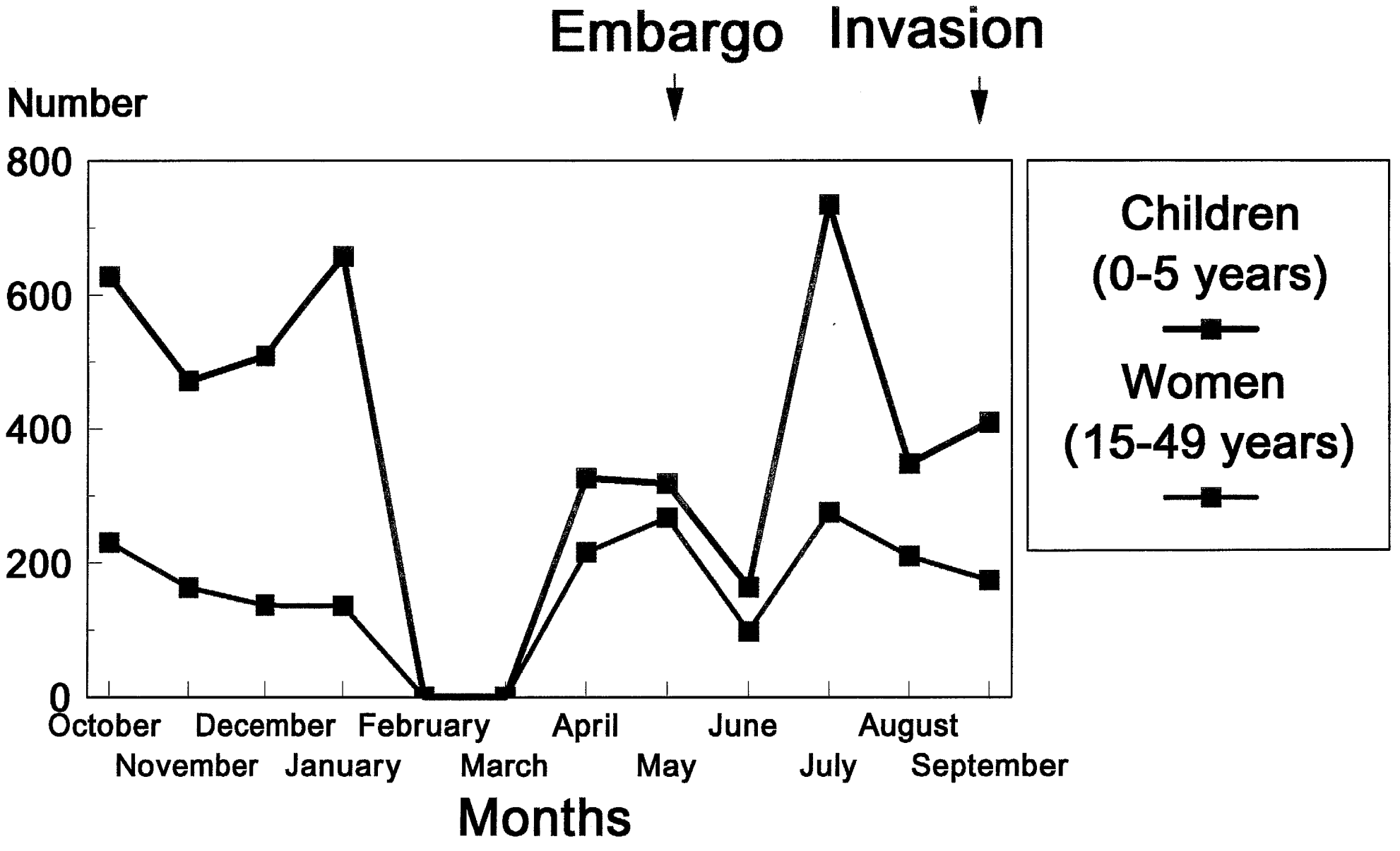
Does the Haitian crisis interrupt the immunization activities in Croix-des-Bouquets?

Children and Women receiving immunizations by month in Turbe.
MOH. October/93 to September/1994.



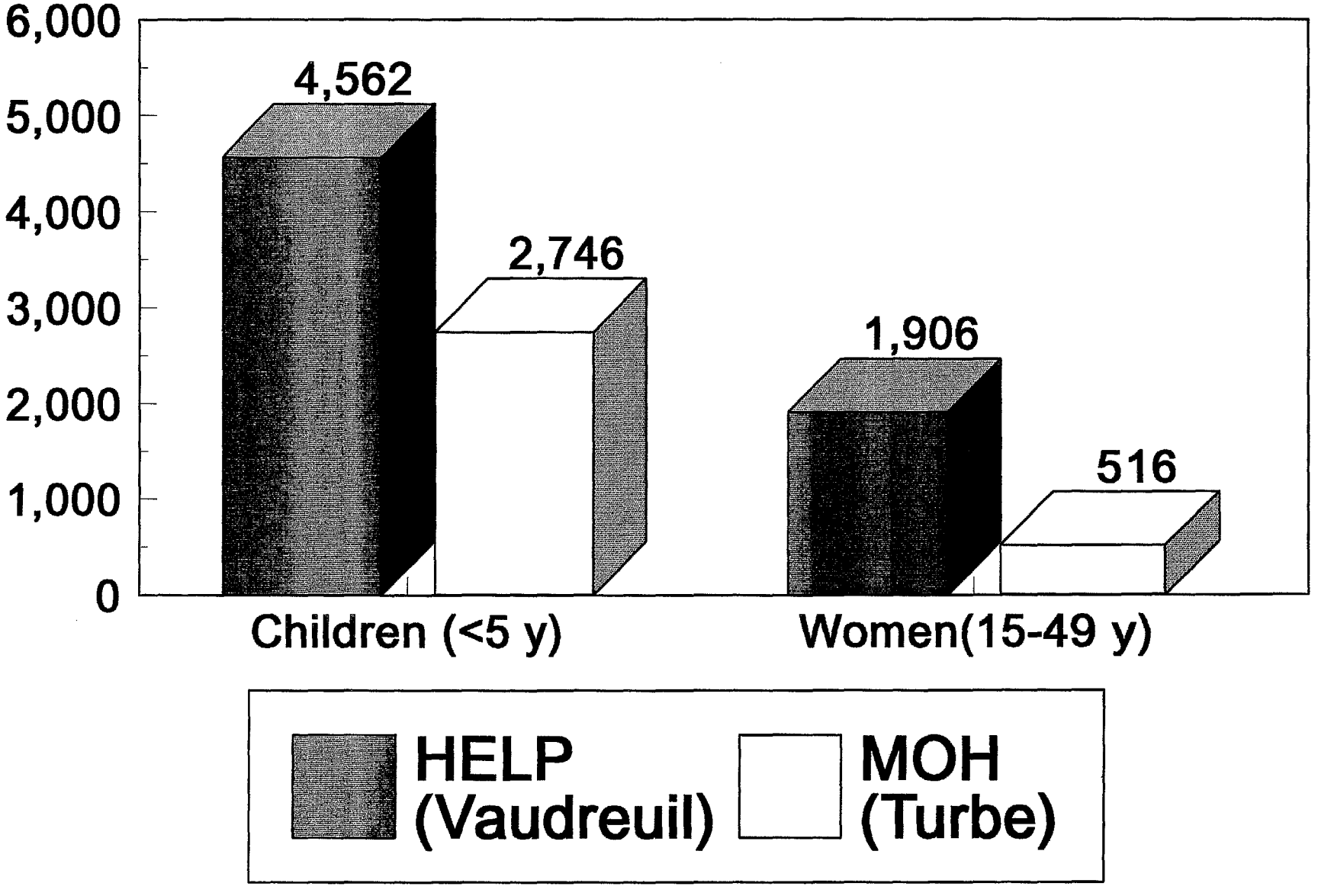
Children and Women receiving immunizations by month in Vaudreuil.

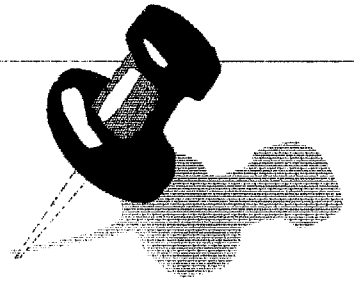
HELP. October/93 to September/1994.



Immunization Activities of Local Institutions supported by PLAN in Croix-des-Bouquets.

October/93 - September/94

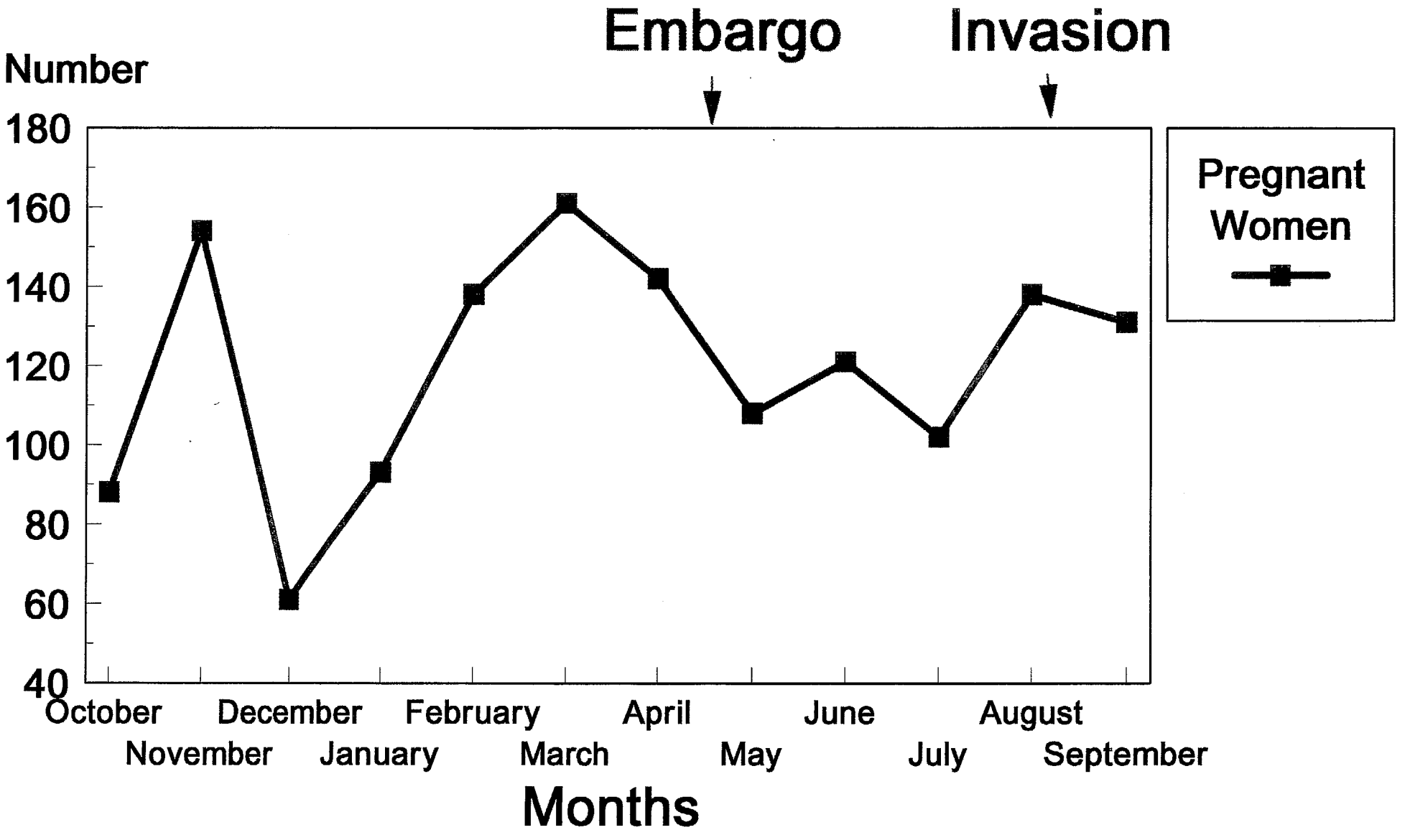




Does the Haitian crisis interrupt the Maternal care activities in Croix-des-Bouquets?

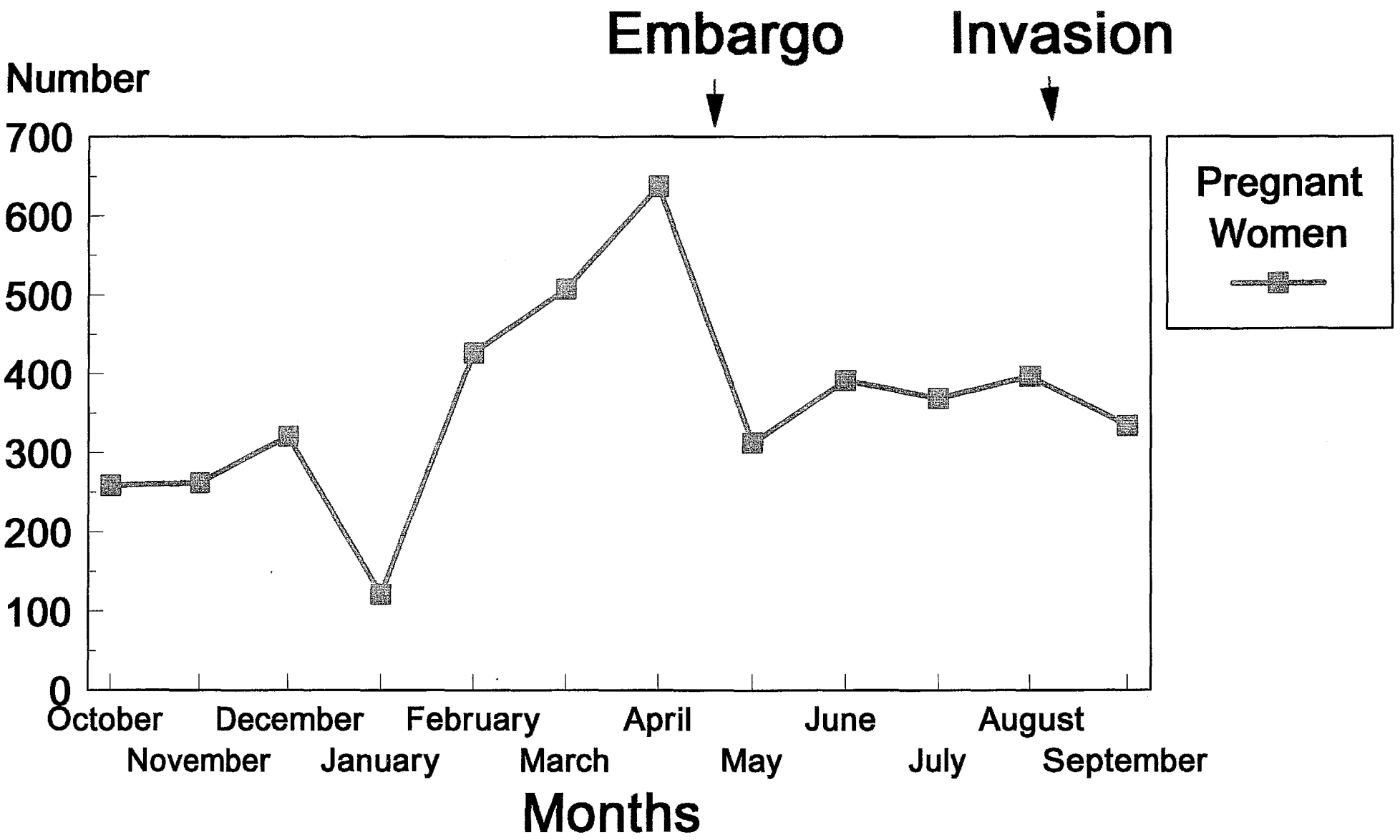
Pregnant Women receiving Prenatal Care by month in Turbe.

MOH. October/93 to September/1994.

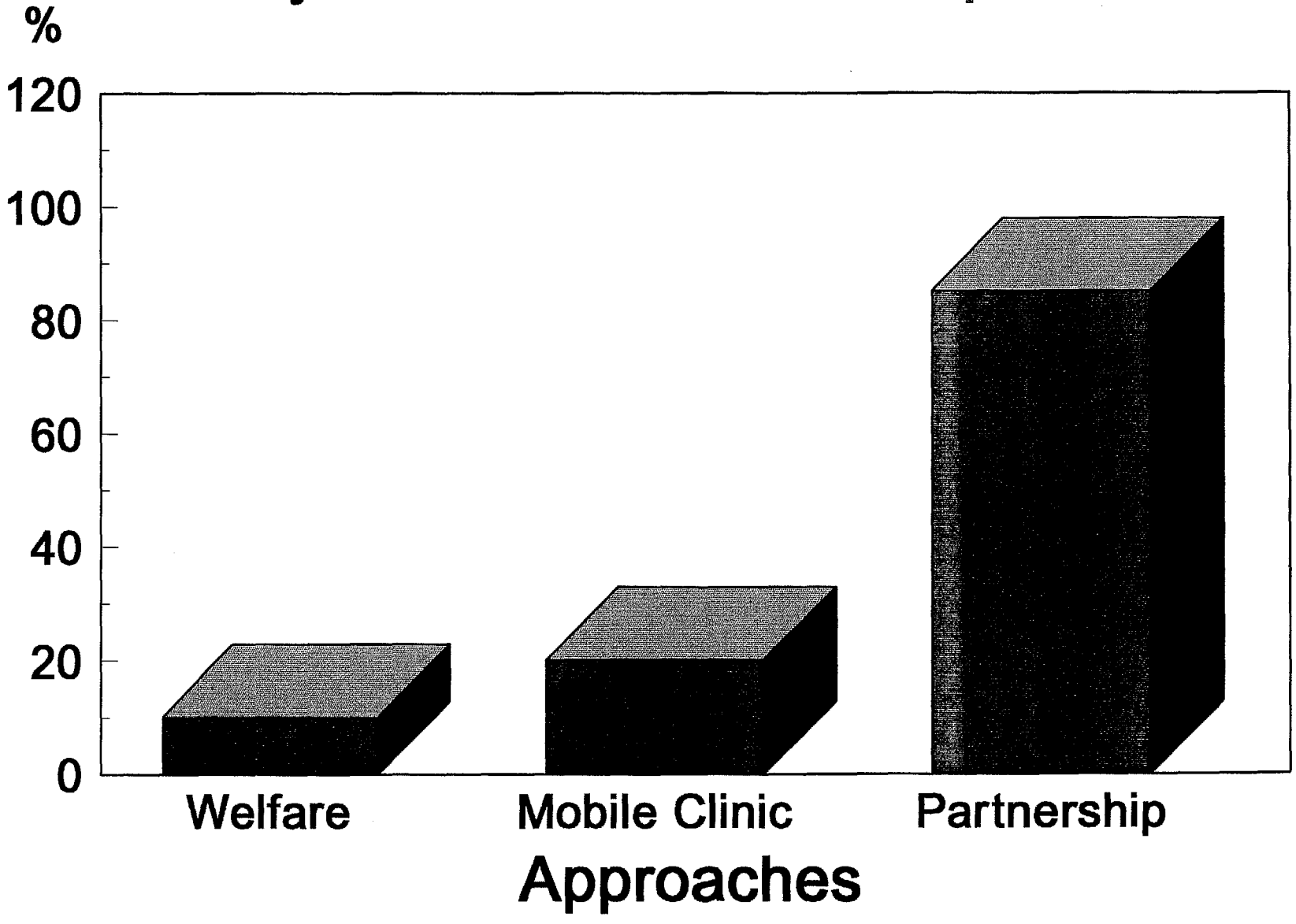


Pregnant Women receiving Prenatal Care by month in Vaudreuil

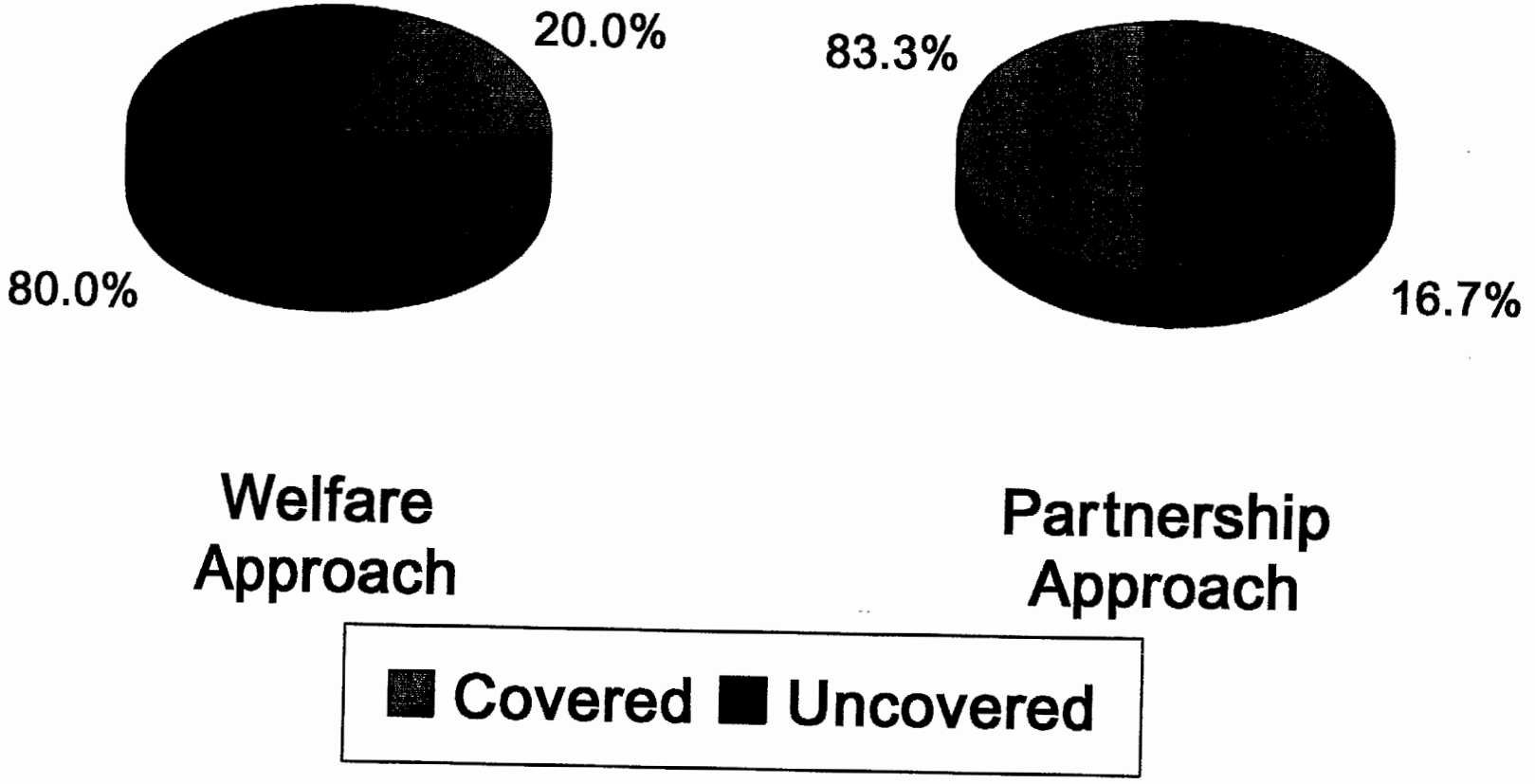
HELP. October/93 to September/1994.



Population covered with basic health services through the different approaches implemented by PLAN/Croix-des-Bouquets



Population covered with Health Interventions implementing different approaches. PLAN/Croix-des-Bouquets, Haiti



ANNEX # 6

LIST OF PERSONS INTERVIEWED

LIST OF PERSONS INTERVIEWED

PLAN/CDB

Mr. Aloysius Pereyra, Field Director
Dr. Marie Mercy Jean-Louis Zevallos

Turbe HC

Dr. Lizie Peck Dubois, Director
Dr. Lesly Henry, obstetrician
Miss Gerda, auxiliary nurse in charge of outreach activities
Miss Denise, nurse
Miss Amesfort, auxiliary nurse

MOH Officials (district level)

Dr. Antonio Narcisse
Dr. Wilfred Thenor

1.- Dr Antonio Narcisse - MSPP Consultant (Mardi)
2.- Dr Georges Blémur - Directeur de la Maternité (Mercredi, Jeudi, Vendredi)
3.- Dr Michel Euphonise - Pédiatre
4.- Miss Pélissier - Responsable activités Communautaires et C.S
5.- Miss Tanique Dupon - Auxilliaire en Vaccination
6.- Miss Dorisca Carline- Auxil. Infirmière en Education Prénatale
7.- Miss Rosenive St-Vilus - Auxilliaire en Nutrition
8.- Jn Lamartine Cébéa - Collecteur de données C.S
9.- Jn Nelzy Jn Solange - Collecteur de données C.S
10- Miss Fidélia - Opératrice du Système C.S

ANNEX # 7

LIST OF DOCUMENTS REVIEWED

LIST OF DOCUMENTS REVIEWED

1. Detailed Implementation Plan (DIP)

2. FY93 report

3. Midterm evaluation's Plan of Action

4. Memos of Understanding between PLAN/CDB and each local institution (HELP and Turbe HC)

5. Visit reports from PLAN/International Headquarter's Child Survival Coordinator

ANNEX # 8

MEMOS OF UNDERSTANDING WITH
HELP Inc AND TURBE HEALTH CENTER

H.E.L.P Inc.
CENTRE HOSPITALIER
Dr. Edith Irby Jones

Vaudreuil, Nov - 16, 1994.

Mr Aloysius Pereira F.D
Plan CDB.

Dear Mr. Pereira,

It is a great pleasure to write this letter on benalf of H.E.L.P. INC. the previous experience with PLAN CDB regarding the implementation of the immunization and Prenatal Care Program in Vaudreuil has been very positive. H.E.L.P. INC. will be willing to collaborate with PLAN CDB for the coming years (95 - 99) to implement new C.S projects (CDD, Suppl. Vit. A, Family Planning Breast Feeding) provided that:

A- The project approach is similar to last year's agreement which means that the two organizations (H.E.L.P. INC. and PLAN CDB) will make joint planning and programming activities. Plan CDB will provide the funding and technical assistance while H.E.L.P. INC. will carry out the programmed activities in Vaudreuil.

B- The project outputs are very specific as well as the interventions.

C- PLAN and H.E.L.P. modify their current agreement (M.O.U) to accomodate the new C.S Projects.

Based upon this mutual understanding, I will strongly support all additional activities in the C.S Program . These activities will make a significant difference in the quality of life of all the children in the community.

H.E.L.P. INC. DIRECTION VAUDREUIL-HAITI

DR MICHEL-HENRY BROUS
EXECUTIVE DIR. H.E.L.P.INC.

Route de Malpasse, Entrée La Tremblay # 5
Vaudreuil, Croix-des-Bouquets
Tél: 23-6011

MEMORANDUM OF UNDERSTANDING

This is a document on the basic understanding between HELP Inc. (Health Education Learning Resources Project Inc.) on one side and PLAN International Inc. (Foster Parents Plan International Inc.) on the other. This association is being formed to support and sustain the health center at Vaudreuil, a commune of Croix-des-Bouquets. This partnership effort will hereinafter be called the H.E.L.P./PLAN Project or simply "The Project"

This charter is not a formal contract but a fundamental working manuscript which supports a humanitarian effort done in the voluntary spirit. Both parties however, have the option of selecting to go in for a formal contract in future should one become desirable or necessary. The memorandum of understanding itself may need changes and could be negotiated at the request of any one party. But this document at present, is considered by both parties sufficient enough to activate the project.

BACKGROUND STATEMENT

The background for this association has been the existing situation of a health infrastructure, owned by HELP, in a very needy PLAN target area. The land, building and equipment have become unusable due to problems related to the funding of the running costs. Funds committed or promised by other agencies had to be withdrawn after the recent political crisis in the country. The request for assistance, in a document dated 22nd June 1994 and presented by Dr. Michael H. Brutus, Executive Director of HELP Inc., explains the rest of the background statement. The same document will also be used for other references as appropriate.

VISION

The vision of this association between HELP and PLAN is to build this project as a model, that could be replicated, with the objective of having low budget, self-supporting, community managed, local health centers, as needed, all over the Croix-des-Bouquets project area.

DESIGN AND APPROACH

Both HELP and PLAN are committed to have self-supporting health structures in the general program area. This project is designed to have the participation of the government and the community on the planning and implementation. Representatives from both these institutions will be included in the advisory committee to start with. Our vision is to someday (see time frame) phaseout our active participation and hand over the management of this project to the government and community. Our job of empowering completed we will then take a strictly advisory role and try to replicate the same model in other areas of Croix-des-Bouquets.

OBJECTIVE

To improve the general health conditions of the targeted residents of Vaudreuil (approximately 5,000 inhabitants.

ACTIVITIES

The health care activities of the project include but are not limited to:

* Health related consultations (@ 50 patients a day including children, adults and senior citizens)

* Common pathologies characteristic of the area such as: Hypertension, Bronchitis, Tuberculosis, Anemia, Arthritis, Gastroenteritis, Parasitosis, Malnutrition, Diarrhea, Pneumonia.

* Laboratory testing and analysis facilities for blood, urine, stools, x-ray. The center will take at least 25 cases a day.

* Medication to all patients at subsidized/controlled prices.

* Dental care for 25 patients a day. Emphasis will be given to prevention of tooth decay and gum disease.

* Health promotion and training to village health workers, groups of mothers, on basic and personal hygiene, oral rehydration, nutrition, child birth/care, family planning, immunization, prevention of AIDS etc.

* A complete immunization program for children in the appropriate age groups.

* Nutrition supplements to pregnant mothers, severely malnourished children, TB patients, and others suffering from assorted critical vitamin deficiencies. (total limited to 150 a day).

* Hospitalization facilities will be provided for minor surgery and delivery purposes with a capacity of 12 beds.

OTHER ACTIVITIES

Other activities would include:

* Local fund raising activities (in cash and kind).

* Use of the 5 acres of land in agricultural production (grain, vegetable and fruits). Part or this produce would be used to maintain and sustain the health center.

* Give a boost to the environment activities of the area. These include, setting up of plant nurseries, tree planting, soil and water conservation, environment protection, etc.

* Support other sector activities of Education, Community organization, source of skills development and cooperative credit.

JOINT DUTIES AND RESPONSIBILITIES

* Fund raising for the joint project. (refer to the time frame)
(This relates to both international funding and local funding. PLAN will provide the necessary running costs as per budget proposed and approved. HELP will raise funds both locally and internationally. HELP would also build up a "corpus" fund for the project.)

* Selection of the Office Manager.
(PLAN will provide its input in the selection of the Office Manager.)

* Providing linkage and liaison activities for the project.

* Serving on the Advisory Board.

HELP - DUTIES AND RESPONSIBILITIES

HELP undertakes to:

* Provide the basic infrastructure.
(5 acres of land and the existing building and equipment, including the medical vehicle)

* Run the day to day operations of the project.

* Participate in the budget preparation/proposal.

* Hire, appoint and train all staff (except hiring of office manager)

* Conduct or help in the conducting of evaluation activities as appropriate.

* Maintain appropriate medical records of client families.

* Maintain appropriate systems of accounting transactions with appropriate support documents. (The accounts would be subject to audits from HELP, PLAN and Government auditors as appropriate.)

* Provide and supply the nutrition activity.

* Provide and supply the training activity.

* Solicit voluntary services from medical doctors and specialists, internally and externally.

* Provide the funding (jointly) as agreed after the second year of the project

* Provide a 50% subsidy in the first two years to all PLAN sponsored families benefitting from the program.

* Provide technical assistance in health to other PLAN areas in Croix-des-Bouquets and other Field Offices (on request only).

* Provide reports as necessary from time to time

PLAN - DUTIES AND RESPONSIBILITIES

PLAN undertakes to:

* Repair and maintain the present infrastructure, including the building, equipment and vehicle.

* Provide running costs for the first two years based on an approved budget. (see time frame)

* Provide and supply the electrification of the center.

* Provide and supply one borewell to take care of the potable water and irrigation needs.

* Provide and supply pharmacy and laboratory equipment as appropriate.

* Provide and supply infrastructure improvement as budgeted and approved.

* Provide training and technical assistance as desired or required: This includes:

    * Project/program evaluation.
    * Administrative/accounting systems procedures.
    * Agriculture, and related activity.

* Provide a 50% subsidy to PLAN for every client family treated after 2 years of the project.

As stated in the project design and approach we will canvass government and community participation/support. We expect this effort to prosper and bear fruit. For the moment we can envision the following :

FROM THE GOVERNMENT (Ministry of Health)

* Supply of medical doctors/specialists on a periodic basis.

* Two medical nurses assigned permanently to the project.

* Two ex-officio members to serve on the advisory board.

* Vaccines.

FROM THE COMMUNITY (of Vaudreuil)

* Consultation fees (at subsidized rates) to build a fund that would contribute to the project running costs.*

* Provide for membership fees (which will be used to print identification cards)

* The cleaning of the center, on rotation basis.

* Cooking, on a rotation basis.

* Supply of candidates for community health volunteer training.

* Supply of 4 community health volunteers to the project.

* Supply of 4 nurse assistants to the project.

* Culture of the land.

* Provide free labor to any construction activity of the project

* Provide representation on the advisory board.

ADMINISTRATIVE STRUCTURE

The project will be supported/supervised by an Advisory Board. This board will be formed by:

* 3 representatives of HELP.

* 3 representatives from PLAN.

In addition the advisory board will consist of:

* 2 representatives of the government.

* 2 representatives of the community.

It is to be noted here that the government and community representatives will have observer status in the first year of the project and will be considered for full time membership from the second year of the project and onwards. A fresh agreement will have to be drawn up at that time.

The Advisory Board will appoint an Office Manager who will carry out the day to day routine functions of the project as per the budget approved and will carry out other directives as defined by the Advisory Board in the minutes documented.

The Advisory Board will meet periodically as mutually agreed or as convened. A meeting can be convened by either one party (PLAN or HELP) or on the request of the Office Manager. The Office Manager is responsible for making all arrangements necessary such as informing the members, drawing up the agenda, recording and distribution of the minutes etc.

To have a quo-rum, for any such meeting needs at least one member from each institution to be present. Guests, invitees and specialists are permitted from all parties provided, it is not more than two persons per meeting, and prior information is given to the other parties, of the visitors participation.

TIME FRAME

The basic assumption is that this partnership will work towards self-sufficiency from day one, from the commencement of the project. This is the spirit in which this framework is written. It will require initiative from all sides, ie, the community, the government, HELP, PLAN and most importantly the office manager. The sooner we can do it (provide self-sufficiency) the better.

With this as the background PLAN will guarantee operational costs for the first two years and will continue to pay operational costs on a sliding scale 60% - 50% - and 40%, for the next three years.

Five years, has been the time fixed for a complete phase-out, by which time the community and government will be enabled to fund the project activities. HELP and PLAN, will at that point, take on the role of working in an advisory capacity.

This agreement is, as mentioned earlier, a basic working document. However, at the same time, we do not want it to be a limiting document. Initiatives from either sides, that will result in achieving the objectives, realizing the vision, or improving the quality of the activities, are recommended, encouraged and welcome.

PUBLICITY

HELP and PLAN agree to mutually recognize the partner whenever there is any publicity material being printed or through any other media when it relates to the joint project.

LIABILITY RELEASE

HELP, as the executing partner, will ensure that the present assistance does not create any obligation, legal, financial or otherwise on the part of PLAN Croix-des-Bouquets to any person claiming entitlement to compensation or other remedies relating to personal injuries, economic harm or otherwise, including but not limited to any contractor, sub-contractor or beneficiary and or any other project users before, during and after the completion of the project. In the event any claim is asserted against PLAN, HELP will defend PLAN and indemnify PLAN from all costs occasioned thereby, including any assessment of damages or imposition of legal obligations.

HELP on its side can acquire the same kind of liability release from its clients and beneficiaries.

We agree to bide by this agreement in the spirit or voluntarism and respect for human values.

HELP Inc.
Represented by:
Dr. Michael H. Brutus
Executive Director.

PLAN INTERNATIONAL Inc.
Represented by:
Mr. Aloysius Pereira
Field Director
Croix-des-Bouquets

Witness: Dr Alix Moise.

Witness: Marie Mercy St Zerallo

Witness: Ludovic Brutus

Witness:

Dated: 31st August 1992

PLAN INTERNATIONAL
CROIX-DES-BOUQUETS, HAITI

PLAN INTERNATIONAL
CROIX-DES-BOUQUETS, HAITI

COOPERATION AGREEMENT BETWEEN THE MINISTRY OF PUBLIC HEALTH (TURBE HEALTH CARE CENTER) AND PLAN INTERNATIONAL OF CROIX-DES-BOUQUETS

CENTRE DE SANTE COMMUNAUTAIRE DE TURBE

Médecine Générale et Préventive •• Pédiatrie • Psychiatrie
Obstétrique - Gynécologie

Route de Malepasse entrée la Tremblay #12, Haiti

Turbé, November - 16, 1994

Mr Aloysius PEREIRA F.D,
PLAN CDB.

Dear Mr. PEREIRA,

It is a great pleasure to write this letter on behalf of Turbé the previous experience with PLAN CDB regarding the implementation of the immunization and Prenatal Care program in Turbé has been very positive. Turbé will be willing collaborate with PLAN CDB for the coming years (95 - 99) to implement new C.S projects (CDD, Suppl. Vit. A, Family Planning Breast Feeding) provided that:

A- The project approach is similar to last years's agreement which means that the two organizations (Turbé and PLAN CDB) will make joint planning and programming activities. PLAN CDB will provide the funding and technical assistance while Turbé will carry out the programmed activities in Turbé.

B- The project outputs are very specific as well as the interventions.

C- PLAN and Turbé modify their current agreement (M.O.U) to accomodate the new C.S projects.

Based upon this mutual understanding, 1 will strongly support all additional activities in the C.S Program. These activities will make a significant difference in the quality of life of all the children in the community.

Dr Baudain Lahens
Directeur Médical

PLAN INTERNATIONAL
CROIX-DES-BOUQUETS, HAITI

MEMORANDUM OF UNDERSTANDING

This document is a specific agreement between the TURBE Health Care Center and PLAN INTERNATIONAL of Croix-des-Bouquets. This collaboration is designed to support health care and community development activities in TURBE, DAME MARIE, CAMPECHE, and other surrounding areas.

BASIC PRINCIPLES

The purpose of this cooperation is to promote preventive and curative health care in TURBE and its surrounding areas. The Health Care Center, a facility of the MSPP, submitted a partnership request in a basic document entitled "Turbé Health Care Action", which shall serve as a reference document.

OBJECTIVE

The purpose of this association between PLAN and the MSPP (Turbé Health Care Center) is to provide low-cost primary and curative health care to the community in a nearby location and in a spirit of community participation in order to improve the health conditions of the inhabitants of these areas (20,000 inhabitants).

ACTIVITIES

Although the activities to be carried out will be primarily health care-related activities, they will not be limited to such activities.

- Physical examination of patients seen at the health care center.
- Laboratory examinations and urine, blood and stool analyses.
- Medication for all patients seen.
- Advice on hygiene and health care every day at the Center.
- Community health care activities conducted by health care personnel in the areas of ORS, nutrition, prenatal care, family planning, immunization, AIDS prevention and

education, and the program for immunization of children and women in their childbearing years as part of the Maternal and Child Survival Project.

- Nutritional monitoring of pregnant women and malnourished children.
- Curative health care activities in mobile clinics at two locations.

OTHER ACTIVITIES

Establishment of three community projects capable of generating income:

1. Raising broiler chickens
2. Community hardware store
3. Shop for rental of farming tools

RESPONSIBILITIES OF THE HEALTH CARE CENTER

- Provide the basic infrastructure.
- Perform daily project activities.
- Participate in the budget submitted and approved.
- Assist in and/or conduct the evaluation of activities.
- Maintain a medical history of all patients.
- Maintain a project accounting system; the books of the project shall be made available to PLAN and to its affiliated agencies.
- Implement the nutritional activities.
- Implement training activities for the staff of the center.
- Take in 50% of the cost of treatment and laboratory exams from PLAN families.
- Submit regular reports to PLAN.

PLAN RESPONSIBILITIES

- Repair and maintain the infrastructure of the houses used as mobile clinics.
- Contribute to the operating expenditures of the activities in accordance with the basic budget.
- Provide and stock the pharmacy and laboratory of the center and the mobile clinics.
- Contribute to the purchase of a vehicle to serve as an ambulance for the community.
- Contribute for a definite period to part of the payment of mobile clinic personnel.

RESPONSIBILITIES OF THE GOVERNMENT MSPP

- Pay the center's medical personnel.
- Guarantee the necessary quota of vaccinations for the project.
- Provide supervision over the medical activities performed in the facilities.
- Provide educational materials as available.
- Provide the premises for the mobile clinics in Campeche and Dame Marie.
- Clean both of these houses.
- Prepare the food for the Nutrition Program.
- Pay the two caretakers of these premises.
- Pay the two pharmacy managers.
- Work in the community hardware store.
- Promote the farm tools shop.

ADMINISTRATIVE STRUCTURE

The administrative structure currently existing at the Center will be maintained but will be supported and supervised jointly by the Croix-des-Bouquets health care district and PLAN/C.D.B.

PERIOD OF PERFORMANCE

The project shall begin after the signing of this agreement, with the participation of PLAN, the MSPP, and the people of the community.

PLAN shall be the principal partner of the MSPP (Turbé Center) for the first two years and shall provide for the operational costs of the project.

This Cooperation is renewable at the request of the parties. The renewal initiative may be taken by the community, the center, or the MSPP.

LEGAL RESPONSIBILITIES

The Turbé Center shall be the prime contractor; the center shall perform all the activities and, hence, shall be legally and financially liable to any such person it may have wronged. PLAN shall not incur any physical, legal or financial liability in this project in the event of damages, accidents or any other breach that may have been caused by the project implementor.

This document was approved and signed in Croix-des-Bouquets on March 9, 1993.

/signatures/

Dr. Lizie P. Dubois Director of the Turbé Center	Mr. Aloysius Pereira Director of PLAN INTERNATIONAL of Croix-des-Bouquets
Witness	Witness
Witness	Witness

Ce document a été lu, approuvé et signé à la Croix-des-Bouquets le 9 Mars 1993 par

Dr Lizie P. Dubois
Directeur du Centre de
Turbé.

Mr Aloysius PEREIRA
Directeur du PLAN INTL.
de la Croix-des-Bouquets

Témoin

Témoin

PLAN INTERNATIONAL ★ DIRECTEUR ★ CROIX-DES-BOUQUETS

Témoin

Témoin

Pierre-Louis J-Li Paul

ANNEX # 9

PLAN OF ACTION FOR THE CHILD SURVIVAL PROJECT

PLAN D'ACTION

DE SANTE

SUR C.S.P.

CROIX-DES-BOUQUETS

PLAN INTERNATIONAL
CROIX-DES-BOUQUETS, HAITI.

SOMMAIRE

DRAFT

PLAN D'ACTION

En vue de relever les points défaillants vus lors du Mid - Terme Evaluation de Juin 93.

A) OBJECTIF

Optimaliser les activités de " Survie de la Mère et de l'Enfant " et Améliorer les systèmes déjà en place pour la vaccination et l'attention pré et post - natale à Vaudreuil et Turbé.

B) STRATEGIES

Pour atteindre cet objectif des stratégies seront implémentées et serviront principalement à :

a Renforcer le programme déjà sur pied.

b Entreprendre des activités supplémentaires afin d'augmenter la couverture vaccinale et l'attention pré et post-natale.

C) LES ACTIVITES ENGLOBERONT SEPT RUBRIQUES:

a) Exploitation de toutes les opportunités de vaccination des enfants de 0 à 2 ans et des femmes de 15 à 45 ans.

b) Récyclage du personnel affecté au programme / survie de l'enfant en commençant par le personnel du centre jusqu'au personnel de terrain.

c) Supervision des activités sur le terrain - encadrement du personnel de terrain.

d) Augmentation de la couverture vaccinale - diminution du taux d'abandon.

e) Amélioration du taux de fréquentation des services pré et post nataux.

f) Relevement de l'efficacité des services nutritionels.

g) Acquisition de matériels, équipements, fournitures pour le programme.

h. Système d'information.

- RUBRIQUE A : EXPLOITATION DES OPPORTUNITES DE VACCINATION.

Dans le cadre du programme de vaccination, il a été remarqué à Turé et à Vaudreuil des opportunités manquées (ex : La mère vient avec son bébé pour être vacciné - Le bébé a reçu son vaccin et la mère n'a jamais été vaccinée, de sa vie, contre le tétanos). Un système de vaccination quotidien doit être mis sur pied.

Tout enfant se présentant à la consultation doit avoir sa carte de vaccination.

Une peine de Gde 0,25 sera réclamée à tout responsable d'enfant ayant perdu sa carte et les femmes avec leur carte seront reçues d'abord.

Des séances audio-visuelles sur la nécessité de la vaccination seront organisées à l'intérieur même du centre à l'intention de tous les malades (TV - Appareil vidéo - Cassettes sur la Santé - Vaccination en créole).

Distribution de tâches spécifiques pour l'équipe de vaccination: avant à Vaudreuil, l'équipe était affectée à d'autres tâches à la clinique du centre: préparation de dossiers - Accueil des patients... désormais elle aura pour seule tâche: l'immuni sation, planification et exécution. Programmation de visites communautaires pour la supervision des agents.

La communauté prendra en charge la motivation, l'organisation et la discipline lors de la réalisation de séances de vaccination dans les localités.

En vue d'augmenter la cocuverture vaccinale, des séances d'immunisation seront faites chaque mois au cours des cliniques Mobiles du PLAN.

- <u>RUBRIQUE 3</u> : **RECYCLAGE DU PERSONNEL.**

  - Formation sur le remplissage des formulaires.

  - Formation sur le remplissage des cartes de vaccination.

  - Formation sur les priorités du programme " Survie de la mère et de l'enfant ".

- Actualisation des concepts sur l'immunisation.

Aussi un récyclage sur l'importance du remplissage de la carte s'avère nécessaire.

Le personnel possède des connaisances minimes sur la conservation des vaccins : chaine de froid - lecture thermomètre, moniteur se feront à tous les niveaux; au niveau du personnel :

- Ressource Technique : medecins

- Ressource Intermédiaire : Infirmière responsable chaine de froid - Infirmière - auxilliaire.

- Ressource de terrain : agents de santé - promoteurs.

- Ressource Communautaire : Leader et spécialement les TBA's.

La formation devra être continue, trimestrielle au moins. Ce qui servira à la motivation et la valorisation des agents de sante, qui en faite, sont des piliers dans l'implantation du programme de survie de l'enfant. Tout le personnel ne peut pas être mobilisé pour un séminaire à moins de bloquer le suivi du programme. Aussi, plusieurs séminaires à des intervalles courts permettraient à tout le personnel d'en bénéficier, d'augmenter leur connaissance. Ceci deboucherait sur une meilleure application du programme.

Formation trimestrielle des agents de santé et ou des promoteurs à effectuer par le MSPP ou d'autres institutions spécialisées spécifiquement en Vaccination et surveillance épidémiologique.

Recherche des cours de Médecine Communautaire et d'épidémiologie de courte durée pour le staff médical en Haïti ou à l'extérieur.

Nomination d'un pédiatre à Vaudreuil afin d'avoir le contrôle des maladies infantiles.

RUBRIQUE C. SUPERVISION

Elle se réalisera à tous les niveaux où le programme s'implante. S'il est très difficile d'éffectuer des supervisions hebdomadaires, des structures seront mises en place (déplacement en voiture) afin qu'elle soit au moins mensuelle. Elle comprendra la coopération des instances supérieures : MSPP/PLAN de Parrainage - responsables médicaux des centres (medecin responsable - infirmière responsable - infirmière hygiéniste).

Cette supervision se fera à 2 niveaux:

- Du PLAN aux partners.

- Des responsables des centres de Santé au personnel de terrain.

Toujours dans le cadre des recommandations de l'évaluation, il s'est développé entre Turbé et Vaudreil une étroite collaboration dans la coordination des activités EX: Séminaire / Matrones effectué à Turbé a eu comme participant - superviseur le médecin responsable de Vaudreuil. La distribution du matériel au T.B.A de Vaudreuil a été réalisée avec l'assisstance du personnel responsable de Turbé.

Dans ce même esprit, les supervisions seront conjointes (Turbé - Vaudreuil).

AUTRES :

- Utilisation de formes plus appropriées au programme.

- Analyse des données des enquêtes.

- Evaluation semestrielle du programme par un consultant externe.

- Supervision journalière par l'éducateur sanitaire aux agents de Santé, promoteurs et TBA's des localités de Vaudreuil.

RUBRIQUE D : AUGMENTATION COUVERTURE VACCINALE

DIMUNITION TAUX D'ABANDON

Des campagnes de vaccination auront lieu. Pour assurer leur réussite elles s'accompagneront de distribution sèche de produits alimentaires et de vitamine A aux allaitantes et enfants malnourris. Les données seront consignées dans le carnet de vaccination.

Une semaine de mobilisation par les agents de santé précedera le jour de la campagne.

Des séances d'éducation sanitaire presentant les maladies pour lesquelles les vaccins sont disponibles avec support de matériel éducatif doivent être réalisées. Les agents de santé exploiteront les lieux de rassemblement : église - marché - réunions familles / plan. Ils profiteront pour faire savoir à la population la disponibilité des vaccins dans les centres.

Les messages éducatifs seront tirés des informations fournies par l'étude ethnographique faite à Vaudreuil et dont l'analyse doit être réalisée.

RUBRIQUE E : AMELIORATION DU TAUX DE FREQUENTATION DES SERVICES PRE ET POST NATAUX.

La formation des TBA se revèlera importante dans ce domaine. Ils seront des agents mobilisateurs pour la promotion de la consultation pré et post natale. Le TBA sera mis en valeur et deviendra un agent de collaboration. Il recrutera les femmes en âge de procréer pour la vaccination, et les femmes enceintes pour le contrôle pre et post natal. Il exigera que toutes les femmes enceintes de sa localité soient vaccinées. Les femmes enceintes anémiées recevront de la vitamine A, du fer au centre. Ex: Dietal. Un système de prime pour le TBA ayant referé le plus de femmes enceintes en consultations sera envisagé.

RUBRIQUE F : NUTRITION POUR FEMMES ENCEINTES ET ALLAITANTES

Les services nutritionnels existent (cantine distribution sèche / femmes enceintes); mais, vu la conjonture économique, ils doivent être renforcés. Les prix des produits augmentent parallèlement à une augmentation des cas de malnutrition. Ce qui entraine un accroissement des besoins nutritionnels. Il y a plus de femmes anémiées et plus de cas d'hypoprotéinemie sans parler de malnutrition franche. La cantine accuse une augmentation accrue de demandes. Les services doivent être renforcés. Les mères ne recevant pas de distribution sèche ne sont pas intéressées à amener leur petit à manger à la cantine; quotidiennement.

Pour réussir le plein épanouissement de la cantine, une distribution sèche pour ces mères doit être implantée.

D) ACTIONS A ENTREPRENDRE EN VUE DE RENFORCER LE PROGRAMME

a) Coordination avec le MSPP

- Réunion mensuelle de direction et de Coordination.
- Participation de l'infirmière du Centre aux réunions mensuelles des agents de santé du MSPP.
- Participation à la planification ou à la programmation des journées de vaccination et de visite communautaire.

b) Coordination entre les Centres

- Réunion de direction et de Coordination
- Echange ou Participation aux activités entre le personnel des 2 centres.

c) Coordination avec le PLAN

- Visite hebdomadaire de la coordonnatrice en Santé aux 2 programmes pour un support technique (chaine de froid - registre de vaccination - couverture des objectifs du PLAN d'action etc...).
- Réunion périodique entre le PLAN et les 2 Centres.
- Réunion périodique de direction et coordination pour le suivi du plan d'action.

II.- PROGRAMMA AMPLIADO DE IMMUNIZACIONES

OBJETIVOS DEL PROGRAMA :

A nivel de hogar:

a) 90% de los ninos en edades 12-23 meses estaran completamente immunizados (DPT3, Polio3 y Antisarampionosa).

b) 80% de las mujeres embarazadas recibiran 2 doses de toxoide tetanico durante su embarazo.

A nivel de proveedores comunitarios de salud (PCS):

a) 100% de los PCS reportaran mensualmente la ocurrencia de casos de polio, tetanos neonatal y sarampion en su area de trabajo.

A nivel de puesto de salud / subcentro de salud:

a) 100% de los ninos y embarazadas que acudan a los servicios de salud seran preguntadas sobre su estado de vacunacion. Si falta alguna vacuna, esta sera administrada.

b) 100% de los casos de sarampion, tetanos neonatal y polio reportados por los promotores / locales de salud seran investigados.

ESTANDARES DE CUIDADO ADECUADO:

4. CUIDADO ADECUADO EN EL HOGAR SIGNIFICA:

4.1 La madre o el cuidador / a de todo nino menor de 12 meses lo llevara a vacunarse de acuerdo al calandario de vacunacion.

4.2 La madre conoce los principales efectos secundarios de la vacunacion y sabe como manejarlos.

4.3 La mujer embarazada acudira a ser vacunada por lo menos 2 veces.

4.4 La madre reportara al PCS todos los casos sospechosos de polio, tetanos o sarampion que ocurran en su hogar o vecindad.

5. CUIDADO ADECUADO DEL PCS SIGNIFICA:

5.1 Educara a la madre sobre la importancia de las vacunas, el calendario de vacunacion, las contraindicacicones de la vacuna, los efectos secundarios de las vacunas y como prevenirlos.

5.2 Promovera en su " Grupo de Desarrollo " la realizacion de las actividades de vacunacion.

5.3 * Mantendra la cadena de frio de acuerdo a estandares nacionales.

* Aplicara rigurosamente las contraindicaciones de la vacunacion, para evitar las " oportunidades perdidas ".

- Administrara la vacuna en forma adecuada y aseptica.

- Proveera educacion a la madre, incluyendo la fecha de la siguiente vacuna, los efectos secundarios y como manejarlos.

- Registrara el evento en el Carnet de Vacunacion y en el registro de NInos del grupo de Desarrollo.

5.4 Registrara y reportara mensualmente todos los casos posibles de polio, sarampion y tetanos neonatal ocurridos en su " Grupo de Desarrollo.

6. CUIDADO ADECUADO PARA EL PERSONAL DE INSTITUCIONES LOCALES SIGNIFICA.

6.1 Todo nino/a y embarazada que accuda a este personal sera investigado por su estado de vacunacion. Si es eligible, la vacuna sera administrada.

6.2 Para el acto de vacunacion, se usaran los estandares mencionados en 5.3.

6.3 Investigara in-situ todos los casos posibles de polio, sarampion y tetanos neonatal reportados por los " Grupo de Desarrollo ".

)GRAMME	ACTIVITES	COURT TERME	MOYEN TERME	LONG TERME	RESSOURCES NEC.	SUPERVISION
IMUNISATION	Contrôle régulier de la chaine de froid au centre.	X	X	X	Personnel PLAN Personnel Centre Personnel MSPP	Hebdomadair chaque semaine.
	Registre de vaccination au centre et dans la communauté.	X	X	X	Personnel centre et MSPP. Registres disponibles	Mensuel chaque mois.
	Chaine de froid: Utilisation adéquate de l'immunisation dans localités.	X	X	X	Personnel du centre Personnel du PLAN	Quotidienne chaque jour de travail
	Distribution de tâche spécifique à l'équipe de vaccination.	X			Personnel du Centre	Hebdomadair
	Participation du centre aux journées de vaccination du MSPP.		X	X	Personnel du centre et du MSPP	Lors de la réalisation des activités.
	Visites communautaires par les agents de santé pour identifier les occasions manquées, des abandons et ceux qui ne viennent pas.	X	X	X	Agents de Santé infirmière aide infirmière	Trimestriel le par coordonnateur Programme

PROGRAMME	ACTIVITES	COURT TERME	MOYEN TERME	LONG TERME	RESOURCE NECESS.	SUPERVISIO
nunization (suite)	Formation du personnel du centre en vaccination en attention pré et post natale.	X	X	X	MSPP - PLAN Institution de formation en Santé.	Semestrie le.

PROGRAMME	ACTIVITES	COURT TERME	MOYEN TERME	LONG TERME	RESOURCE NECESS.	SUPERVISIO
nunization	Elaboration de matériel éducatif sur immunisation pour les agents de santé promoteurs.		X	X	Centre spécialisé	Semestrielle.
	Obligation aux mères des enfants de se présenter avec la carte de vaccination de leurs enfants.	X	X	X	Personnel des centres	Mensuelle par MSPP PLAN
	Contracter les services d'un épidémiologiste pour analyser les données de Turbé et Vaudreuil. Etude ethnographique à analyser.				consultant en épidémiologie	Evaluation à la fin du contr par les ce tres.

PROGRAMME	ACTIVITES	COURT TERME	MOYEN TERME	LONG TERME	RESOURCE NECESS.	SUPERVISIO
-Natal et st - Natal.	Formation des agents de santé et le personnel du centre sur pré et post natale. Care .		X	X	MSPP - PLAN	Trimestre
	Formation ou récyclage semestriel selon le ccentre des TBA'S.	X	X	X	MSPP Centre de Santé PLAN	Trimestre
	Elaboration de matériel éducatif sur pré et post natal care pour les agents de santé et les TBA'S.	X	X	X	Agence spécialisée en éducation personnel du centre MSPP - PLAN.	Trimestre

PROGRAMME	ACTIVITES	COURT TERME	MOYEN TERME	LONG TERME	RESOURCE NECESS.	SUPERVISION
ɛ-Natal et ɔt - Natal.	Distribution et renouvellement clean birth Kit.	X	X	X	Personel centre.	MSPP PLAN
	Achat de matériels éducatifs et fournitures pour l'éducation au centre TV, VCR, tableau flanellographe etcc...	X	X	X	PLAN MSPP	Mensuelle
	Acquisition d'un plus grand stock de Nourriture pour distribution à femmes et mèrres du Programme.	X	X	X	Personnel des centres	Mensuelle

Court terme : 3 prochaines mois

Moyen terme . 6 mois

Long terme 9 - 12 mois

PLAN INTERNATIONAL
CROIX-DES-BOUQUETS, HAITI

PROPOSITION D'IMPLEMENTATION D'ACTIVITES ANTI DIARRHEIQUES A TURBE

A) OBJECTIF

Renforcer les activités du programme " Survie de la Mère et de l'enfant " pour une nette amélioration de l'état sanitairre des enfants de la zône de Turbé.

B) STRATEGIES

1.- Recyclage du personnel du centre et de terrain sur les activités de Réhydration orale.

2.- Education sanitaire au centre et sur le terrain (Réunion mensuelle, post rassemblement etc) sur la thérapie de réhydratation et les données sur la prévention.

3.- Amélioration des services fournis en TRO au ccentre de Turbé et les localités avoisinnantes.

4.- Acquisition de matériels, fournitures, équipements pour le programme.

5.- Supervision des activités sur le terrain et encadrement du personnel.

6.- Enquête sur l'acceptation de la T R O en sachets.

RUBRIQUE I

Cette activité se fait déjà au centre mais dans des propositions réduites selon les possibilités du ministère. Ainsi, il serait bon dans un premier temps de recycler tout le personnel médical, para médical du ccentre et le personnel de terrain sur la thérapie de réhydratation orale selon les dernières données de l'Organisation Mondiale de la Santé (O.M.S.). Une agence spécialisée pourrait être contractée pour assurer périodiquement cette formation suivie: chaque six (6) mois en des groupes différents.

RUBRIQUE II

Après avoir reçu leur formation, le personnel de santé assurerait des séances d'éducation sur la T R O au centre et sur le terrain par les agents de santé obligatoirement chaque semaine. Ils utiliseraient du matériel éducatif imprimé à cet effet. Le matériel du M S P P serrait éfficace; s'il n'y en a pas de disponible, le PLAN appuierait le centre dans la reproduction et dans le cas contraire, le centre et le PLAN discuteraient avec une agence pour l'élaboration de matériels adéquats.

RUBRIQUE III

L'infirmière ou l'aide infirmièrre du centre serait responsable de recevoir tous les cas de diarrhée vus au centre tout en ayant soin de mentionner le degré, la quantité de liquide pris oral ou IV et la localité ou vit le patient pour un suivi efficace par l'agent de santé de sa zône qui aura pour tâche de faire des séances d'éducation avec les responsables du patient.

RUBRIQUE IV

Du matériel de démonstration sera acheté pour tous les agents de santé tels: Gobelet - Cuiller - Pot à eau - Bouteille vide - Savon - Serviette - Petite cuvette en plasstique - Boîte de sel et paquet de sucre - Sérum oral en sachets - Thermos - Eau. Tout le matériel nécessaire à la démonstration du Sérum maison et du sérum en sachet.

En ce qui a trait au centre de santé, en plus de ce matériel, des poches de solutions IV sseraient achetées pour les cas très graves de déshydratation.

RUBRIQUE V

Les supervisions effectuées au centre et sur le terrain devront désormais englober les activités de thérapie par sels de réhydratation.

Le PLAN servira de support au personnel de Turbé en lui rendant disponible toutes les informations, la documentation, l'entrainement nécessaires à cce sujet tant pour le personnel cadre que de terrain.

RUBRIQUE VI

Afin d'améliorer la présentation du sachet de réhydratation, une enquête serait effectuée dans deux (2) zônes. Une aire d'utilisation et une zône témoin afin d'étudier le processus d'utilisation, la perception des sels sans autres médicaments et enfin la possibilité de le présenter en bouteille comme les autres sels importés plus facilement acceptés par la Communauté.

I.- CONTROL DE ENFERMEDADES DIARREICAS

OBJETIVOS DEL PROGRAMA:

A nivel de hogar :

a) 30% de los ninos en edades 0-36 meses que experimentaron un episodio de diarrea sin deshidratacion en las ultimas 2 semanas, seran hidratados en forrma adecuada y se les continuara su alimentacion habitual (incluyendo lactanccia materna). Durante la convalesccencia, estos ninos comeran por encima de sus niveles habituales.

b) 30% de las madres con ninos 0-36 meses reconoceran los signos de referencia para casos con diarrea.

A nivel de proveedores comunitarios de salud (PCS):

a) 30% de los ninos en edades 0-36 meses y referiddos por diarrea seran manejados en forma adecuada.

b) 30% de las PCS reconocceran los signos de referencia para casos con diarrea.

A nivel del personal de instituciones locales:

a) 30% de los ninos en edades 0-36 meses y referidos por diarrea serran manejados en forma adecuada.

ESTANDARES DE CUIDADO ADECUADO:

1.- Administracion temprana (desde el inicio del episodio) de liquidos caserros disponibles en cantidad y frecuencia adeccuanda para reemplazar los liquidos corrporales perdidos durante la diarrea.

1.2 Continuacion de la alimentacion (incluyendo lactancia materna) durante el epidodio diarreico, seguido de aumento de la alimentacion durante la convalescencia.

1.3 Referencia oportuna de casos severos y complicados a proveedores de salud capacitados.

1.3 Rreferencia oportuna de casos severos y complicados a proveedores de salud capacitados.

Son signos de severidad y complicaciones los siguientes:

a) Deposiciones frecuentes (p.e mas de 6 al dia).

b) Vomito repetido.

c) Signos que sugieran enfermedad seria, p.e falta de apetito, dificultad para despertarse, convulsiones.

d) Sangre en las heces.

e) Fiebre.

f) Cualquier signo de deshidratacion, p.e sed intensa, ojos (o fontanela) hundidos, boca seca.

1.4 No administrara antibioticos ni antidiarreicos por iniciativa propia. Antibioticos solo se administran en casos especificos (colera, disenteria) y por prescripcion del proveedor de salud. Antidiarreicos no se recomiendan en ningun tipo de diarrea.

2. CUIDADO ADECUADO DEL PCCS SIGNIFICA:

2.1 Diagnosticara los casos en tres tipos:

- Sin deshidratacion.
- Con deshidratacion moderada.
- Con deshidratacion severa. Si el nino tuviera fiebre, sangre en las heces, dificultad para despertarse o convulsiones, tambien sera clasificado en este grupo.

2.2 En los casos sin deshidratacion, comunicara a la madre como es el cuidado adecuando en el hogar (puntos 1.1 a 1.4) y entregara 1-2 sobre sobres de rehidratacion oral.

2.3 En los casos con deshidratacion moderada, le administrara suero de rehidratacion oral (SRO) hasta que el nino este completamente rehidratado. Luego, repetira los pasoss descritos en 2.2 y en 1.1 - 1.4.

2.4 En los casos con deshidrracion severa o complicaciones, iniciara rehidratacion con SRO y lo referira al establecimiento de salud mas cercano.

2.5 Registrara los casos atendidos en formulario ad-hoc.

3. CUIDADO ADECUADO POR EL PERSONAL INSTITUCIONES LOCALES SIGNIFICA:

3.1 Ejecutara los puntos del 2.1 al 2.5.

3.2 En los casos con deshidratacion severa o complicaciones, iniciara rehidratacion endocevosa y tratara las complicaciones.

3.3 Referira los casos que no respondan al tratamiento.

MIDIDAS PARA PREVENIR LA DIARREA

1.- Lavado de manos.

2.- Promocion de lactancia materna, sobre todo exclusiva en los primeros 6 meses.

3.- Practicas higienicas para la preparaccion, conservacion y consumo de comidas del destete.

4.- Mejora en el suministro de agua y saneamiento ambiental.

5.- Administracion de vacuna antisarampionosa.

ANNEX # 10

PIPELINE ANALYSIS

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A
PVO/COUNTRY PROJECT: Plan International USA, Inc./Croix-des-Bouquets, Haiti
FOR PERIOD ENDING: 31 AUGUST 1994

17-Nov-94

FIELD	ACTUAL EXPENDITURES TO DATE (09/01/90 TO 08/31/94)			REMAINING OBLIGATED FUNDS (as of 08/31/94)			TOTAL AGREEMENT BUDGET (COLUMNS 1 & 2) (09/01/90 TO 08/31/94 includes extension)		
COST ELEMENTS	AID	PLAN	TOTAL	AID	PLAN	TOTAL	AID	PLAN	TOTAL
I. PROCUREMENT									
A. Supplies	147,185	100,251	247,436	(89,185)	(55,251)	(144,436)	58,000	45,000	103,000
B. Equipment	0	26,613	26,613	0	29,087	29,087	0	55,700	55,700
C. Services	18,507	269	18,776	11,493	42,731	54,224	30,000	43,000	73,000
D. Consultants	5,867	0	5,867	60,133	9,000	69,133	66,000	9,000	75,000
SUB-TOTAL I	171,559	127,133	298,692	(17,559)	25,567	8,008	154,000	152,700	306,700
				Due to the political situation in Haiti, the final evaluation could not be completed before the grant ending date.					
II. EVALUATION	7,759	1,113	8,872	17,941	30,103	48,044	25,700	31,216	56,916
SUB-TOTAL II	7,759	1,113	8,872	17,941	30,103	48,044	25,700	31,216	56,916
III. INDIRECT COSTS									
Overhead 10% @ beg. of grant 17.5% @ end of grant	38,770	35,966	74,736	(8,478)	(9,837)	(18,315)	30,292	26,129	56,421
SUB-TOTAL III	38,770	35,966	74,736	(8,478)	(9,837)	(18,315)	30,292	26,129	56,421
IV. OTHER PROGRAM COSTS									
A. Personnel									
1. Technical	70,001	0	70,001	(9,130)	0	(9,130)	60,871	0	60,871
2. Other	0	127,382	127,382	21,851	(62,006)	(40,155)	21,851	65,376	87,227
B. Travel/Per Diem									
1. In-Country	21,238	5,548	26,786	4,262	(5,548)	(1,286)	25,500	0	25,500
2. International	0	20,132	20,132	0	(20,132)	(20,132)	0	0	0
C. Other Direct Costs	25,689	0	25,689	(10,689)	12,000	1,311	15,000	12,000	27,000
SUB-TOTAL IV	116,928	153,062	269,990	6,294	(75,686)	(69,392)	123,222	77,376	200,598
TOTAL FIELD	335,016	317,274	652,290	(1,802) *	(29,853)	(31,655)	333,214	287,421	620,635

* Offset by funds remaining in total grant budget