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DETAILED IMPLEMENTATION PLAN

Child Survival XII

(Project #FAO-0500-A-00-6030-00)

Carrefour, West Department
Haiti
1996-2000

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Attached Document: Baseline Survey

GLOSSARY OF TERMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
AN	Auxiliary Nurse
ARI	Acute Respiratory Infection
BCG	*Bacille Calmette Gerin* (Tuberculosis Vaccine)
BMI	Body Mass Index
CAPS	*Centre d'Analyse des Politiques de Santé* (Center for Analysis of Health Strategy)
CBD	Community-based Distributor
CERA	*Centre d' Evaluation et de Recherche Appliquée* (Center for Evaluation and Research Application)
CDC	Centers for Disease Control and Prevention
CDD	Control of Diarrheal Disease
CHA	Community Health Agent
CHC	Community Health Committee
CHI	Child Health Institute
CHV	Community Health Volunteer
CHW	Community Health Worker
CO	Central Office
CS	Child Survival
DCM	Diarrhea Case Management
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus Vaccine
FGD	Focus Group Discussion
FP	Family Planning
GM	Growth Monitoring
HECS	Household Economic and Consumption Survey
HH	Household
HIV	Human Immune Deficiency Virus
HIS	Health Information System
HP	Health Post
HS 2004	Health Systems 2004 Project
ICU	Intensive Care Unit
IEC	Information, Education & Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INSAC	Haitian Institute of Community Health Training
IPA	Independent Provider Association
IOM	Institute of Medicine
IU	International Unit
IUD	Intra-uterine Device
JHU	Johns Hopkins University
KAP	Knowledge, Attitude and Practice
KPC	Knowledge, Practice and Coverage
MCH	Maternal and Child Health
MOH	Ministry of Health
MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Health)

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NCHS	National Center of Health Statistics
NGO	Non-Government Organization
OMS	*Organisation Mondiale de la Santé* (World Health Organization)
OPS	*Organisation Panaméricaine de la Santé* (Pan American Health Organization)
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PL 480	Public Law 480
PROMESS	*Programme de Médicaments Essentiels* (Program for Essential Drug Supply)
PVO	Private Voluntary Organization
PSI	Professional Services International
RN	Registered Nurse
RTH	Road to Health
SCM	Standard Case Management
SD	Standard Deviation
TOT	Training of Trainers
TT	Tetanus Toxoid
UCS	*Unité Communautaire de Santé* (Community Health Unit)
USD	*Unité de Stockage et de Distribution* (Regional Vaccine and Community Distribution Center)
USAID	United States Agency for International Development
WCBA	Women of Child Bearing Age
WFP	World Food Program
WHO	World Health Organization

Section A. **Field Program Summary**

DIP Table A: Field Program Summary

PVO/Country: Haiti

Cooperative Agreement No.: FAO-0500-A-00-6030-00

Program Duration (from/to mm/dd/yy): October 1,1996 to September 30, 2000

1. Program Effort and USAID Funding by Intervention

INTERVENTIONS	PERCENT TOTAL EFFORT (%)	USAID FUNDS IN US $
Immunization	20%	$164,900
Nutrition/Micronutrients	20%	$164,900
Breastfeeding Promotion	15%	$123,675
Diarrhea Case Management	20%	$164,900
Family Planning	25%	$206,126
TOTAL	**100%**	**$824,502**

2. Beneficiaries Population per Year

POPULATION AGE GROUP	ESTIMATED NUMBER OF BENEFICIARIES
Infants (0-11 months)	2,100
12-23 Month Old Children	1,900
24-72 Month Old Children	16,000
Total 0-72 Month Olds	**20,000**
Men (15-49 years)	14,000
Women (15- 49 years)	14,000
TOTAL Beneficiaries	**48,000**

Important Note: There is no official demographic information in the project area or in the Carrefour district. Although the above demographic information is presented, ADRA believes the actual beneficiaries will be much more. The situation will be corrected during the HH registration/census currently underway in the project catchment area.

Section B. **Program Goals and Objectives**

DIP Table B: Program Goals and Objectives

PROJECT GOALS:

1. To improve the health status of WCBA in the project area.
2. To improve the health and nutrition status of children less than two years of age in the project area.

(*) = The measurement method for the indicators/objectives listed in the table below is the rapid KPC Survey.

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
EPI - 20.0% 1.0) Increase the % of 12-23 months old children fully immunized from 8% to 25%.	1.0) % of children 12-23 months who received DPT1 1.1) % of children 12-23 months who received OPV3 1.2) % of children 12-23 months who received measles vaccine 1.3) % of children 12-23 months fully immunized 1.4) % of children 12-23 months who dropped out between DPT1 and DPT3	1.0) TOT training on EPI 1.1) Community selection of CHV 1.2) Initial and refresher training of CHVs/CHAs on IEC/EPI 1.3) EPI promotion and key messages by CHVs/CHAs 1.4) Follow-up of drop outs/home visits 1.5) Periodic EPI mass campaigns 1.6) Radio/TV EPI ads 1.7)Training HP staff on EPI promotion	1.0) Key ADRA field staff trained 1.1) 24 CHVs recruited 1.2) 24 CHVs, 8 lead CHAs, 4 ANs and 16 CHAs trained in EPI/IEC 1.3) 14000 WCBA receive key EPI messages/promotions and 6850 households visited 1.4) Homes of dropouts visited 1.5) 2 big EPI mass campaigns held every year 1.6) 12 radio ads on EPI run/month 1.7) 4 HP vaccinators trained on EPI/IEC	1.0) Training report 1.1) CHC monthly report 1.2) Training report 1.3, 1.4) CHV monthly report 1.5) HP EPI registry 1.6) Mass media records 1.7) Training report
2.0) Increase TT coverage of WCBA from 10% to 35%	2.0) % of WCBA who received at least 2 TT doses	2.0) TOT training on EPI 2.1) Community selection of CHVs (by CHCs) 2.2) Initial and refresher training of CHVs/CHAs on IEC/EPI 2.3) EPI promotion and key messages by CHVs/CHAs 2.4) Follow-up of drop-outs/home visits 2.5) Periodic EPI mass campaigns 2.6) Radio EPI ads 2.7) Training HP staff on EPI promotion	2.0) Key ADRA field staff trained 2.1) 24 CHVs, 4 ANs, 8 lead CHAs and 16 CHAs recruited 2.2) 24 new CHVs trained in EPI/IEC (initial and refresher training) 2.3) 14000 WCBA receive key EPI messages/promotions and -6850 HH visited 2.4) Homes of dropouts visited 2.5) 2 big EPI mass campaigns held every year 2.6) 12 Radio ads on EPI run 12 times/year 2.7) 4 HP staff trained on EPI/IEC	2.0)Training report 2.1) CHC monthly report/minute 2.2) Training report 2.3, 2.4) CHV/CHA monthly report 2.5) EPI registry 2.6) Mass media records 2.7) Training report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
Breastfeeding Promotion- 15%, Nutrition, GM and Micronutrients - 20% 1.0) Increase the % of children: 1.1) 4 to 6 months exclusively breastfeeding from 7% to 25% 1.2) between 6 to 9 months who are being given solid/semi-solid foods from 43% to 60% 1.3) between 20-24 months in the project area who are still breastfeeding from 6% to 30% 1.4) less than 24 months old whose mothers report avoiding bottle feeding from 1.4% to 25%	1.0) % of infants <24 months who were breastfed within the first 8 hours. 1.1) % of infants 4 to 6 months who are given only breast milk 1.2) % of infants between 6-9 months who are given solid/semi solid foods 1.3) % of infants between 20-24 months still breastfeeding 1.4) % of mothers of children less than 24 months old who report avoiding bottle feeding	1.0) TOT training on breastfeeding, nutrition and GM 1.1) Training HP staff on Nutrition, GM and breastfeeding 1.2) Community selection and recruitment of CHVs 1.3) Training CHVs on breastfeeding nutrition and GM IEC	1.0) Key ADRA field staff trained on breastfeeding, nutrition and GM 1.1) 4 HP staff trained on BF, nutrition and GM IEC 1.2) 24 CHVs recruited 1.3) 24 CHVs, 4 ANs, 16 CHAs and 8 lead CHAs trained in breastfeeding, nutrition, GM IEC 1.4) 14000 WCBA receive key nutrition messages/promotions and 6850 households visited 1.5) 24 CHVs and 16 CHAs self-monitor with checklists	1.0) Training report 1.1) Training report 1.2) CHC monthly report/minute 1.3) Training report 1.4) CHV monthly report 1.5) CHV monthly report/checklists
2.0) Increase the % of children < 2 years with GM card and weighed in the past 3 months from 38% to 55%	2.0) % of children 0-23 months weighed in the past 4 months	2.0) Monthly weighing at HP 2.1) Monthly weighing at the Adventist Hospital 2.2) Provide weighing scales as needed	2.0) 4 HPs conduct monthly GM and counseling 2.1) 1 hospital conducts monthly GM and counseling 2.2) 10 new salter scales given to HPs and hospital (old once replaced as necessary)	2.0) Monthly HP report 2.1) Monthly CHV/CHA report (pop.-based roster of enrolled children and follow up records) 2.2) Inventory report
3.0) Improve the nutritional status of children < 59 months who were referred to the nutrition rehabilitation facility for acute malnutrition by 50% (measured through the nutrition rehabilitation records)	3.0) % of children < 59 months whose nutrition status improved (measured by nutrition rehabilitation records)	3.0) Continued promotion of GM, referral of the acutely malnourished and follow-up of growth defaulters by CHV/CHA at home visits	3.0) 14000 WCBA receive key nutrition and GM messages/promotions and 6850 households visited 3.1) Acutely malnourished children referred for supplementary and therapeutic feeding and medical care 3.2) Growth faltering children followed up	3.0) CHV monthly report 3.1) Nutrition rehabilitation monthly report 3.2) Monthly HP report

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
4.0) Increase the % of children < 6 years who received vit. A capsules (HP records, CHA reports)	4.0) % of children < 6 years who received vit. A capsules (evaluated by HP records, CHA reports)	4.0) Training CHVs on vit. A education and distribution 4.1) Obtain vit. A capsules from PROMESS	4.0) 24 CHVs, 16 CHAs, 4 ANs, and 8 lead CHAs trained on vit. A promotion and education 4.1) 24 CHVs, 16 CHAs, 8 lead CHAs and 4 ANs distribute vit. A capsules 4.2) 24 CHVs and 16 CHAs self-monitor with a checklist	4.0) Training report 4.1) Inventory report 4.2) Monthly CHV report 4.3) HP records
Diarrhea Case Management - 20% 1.0) Increase the % of mothers who continue to: 1.1) Give the same or more amount of foods to their children < 2 years during diarrheal episodes from 50% to 70.0% 1.2) Treat their children < 2 years with ORT during diarrheal episodes from 10% to 30% 1.3) Breastfeed (same or more amount) their children < 2 years old during diarrheal episodes from 87% to 92% 1.4) Give the same or more amount of fluids to their children < 2 years during diarrheal episodes from 67% to 78%	1.0) % of children < 2 years with diarrhea in the past two weeks who were given: -same/more amount of food -treated with ORT -same/more amount of breast milk -same/more amount of fluids	1.0) TOT and refresher training on DCM 1.1) Selection/recruitment of CHVs 1.2) Initial and refresher training of CHVs on DCM IEC: sanitary waste disposal, clean water supply, hand washing after toilet and before handling food 1.3) Education of mothers 1.4) Key messages check list for CHVs/CHAs 1.5) Strengthen ORT posts at CHV/CHA homes 1.6) Cooperate with community sanitation campaigns 1.7) Distribute/sell ORS during home visits 1.8) Establish a referral protocol	1.0) Key ADRA field staff trained in DCM 1.1) 24 CHVs selected 1.2) 24 CHVs trained in SCM and IEC skills 1.3) 6850 households/monthly visits receive key messages 1.4) Key messages checklist used by 24 CHVs and 16 CHAs 1.5) 70% of the CHVs establish ORT corner at home 1.6) At least 2 community sanitation campaigns held/year 1.7) Total # of ORS distributed/sold 1.8) 4 HPs and 1 hospital provide care for referred cases	1.0) Training report 1.1) CHC monthly report/minute 1.2) Training report 1.3)CHV monthly report 1.4) CHA monthly report 1.5) Observation 1.6) CHC monthly report 1.7) CHV monthly report, inventory report 1.8) HP and hospital monthly report
2.0) Reduce the % of children < 2 years experiencing diarrhea in the past 2 weeks from 49.7% to 35%	2.0) % of children < 2 years who had a diarrheal episode in the past two weeks before the survey 2.1) % of mothers with children < 2 years who know 2 or more correct dehydration symptoms indicating the need to seek professional help	2.0) Education of mothers on sanitary waste disposal, use a clean water supply, hand washing after toilet and before handling food 2.1) Strengthen ORT posts at CHV homes/HPs 2.2) Distribute/sell ORS during home visits	2.0) 6850 households/monthly visits receive key messages 2.1) 70% of the CHVs establish ORT corner at home 2.2) Total number of ORS distributed/sold	2.0) CHV monthly report 2.1) Observation 2.2) CHV monthly report, inventory report

will not prevent
DB

Project Objectives by Intervention	Measurement Indicators/Method for Objectives (*)	Major Planned Inputs	Outputs	Measurement Method for Outputs
3.0) Increase the % of mothers of children aged 0-23 months with severe/bloody diarrhea who were referred to a health care facility for SCM	3.0) % of children < 2 years with severe/bloody diarrhea who were referred to a health care facility (Measured by health facility records, i.e., Adventist Hospital and HP records) and CHV/CHA records (the person who referred the case)	3.0) Training of CHAs/CHVs on diarrhea referral protocols 3.1) Training HP and Adventist Hospital staff on diarrhea SCM	3.0) 24 CHVs, 16 CHAs, 8 lead CHAs and 4 ANs trained on diarrhea SCM and referral protocols 3.1) 10 Adventist Hospital RNs trained on diarrhea SCM	3.0) Training records 3.1) Hospital DCM records
4.0) Increase the number of mothers who can correctly demonstrate the preparation and use of ORT (measured through HP records and CHA/CHV monthly reports)	4.0) Number of mothers who can correctly demonstrate the preparation and administration of ORT (measured by HP records and CHA/CHV monthly records)	4.0) Education of mothers on correct preparation and administration of ORS	4.0) Number of mothers trained on correct preparation and administration of ORS	4.0) Training records 4.1)CHV and CHA monthly reports
Family Planning - 25% 1.0) Increase the % of mothers of children < 2 years of age who wish to delay their next pregnancy by two years who use a modern birth control method from 19% to 35%	1.0) % of mothers who desire no more children in the next 2 years/or are not sure and are using a modern contraceptive method	1.0) Contraceptives obtained 1.1) TOT and refresher training on FP 1.2) Initial and refresher training for CHVs/CHAs on IEC FP 1.3) Education of mothers on key FP messages 1.4) Key messages checklist for CHVs/CHAs	1.0) # of contraceptives distributed/sold, dependable supply 1.1) Key ADRA field staff trained on FP 1.2) 4 HP ANs trained on FP 1.3) 24 CHVs selected and 16 CHAs recruited 1.4) 24 CHVs, 16 CHAs and 8 lead CHAs trained in FP IEC and use checklist for education 1.5) 14000 WCBA receive key MCH messages	1.0) Contraceptive inventory 1.1) Training report 1.2) Training report 1.3) CHC monthly report/minute 1.4) CHV and CHA monthly report, and training report 1.5) CHV monthly report
2.0) Increase the % of men using a modern contraceptive method (measured by HP record, clinic record, CHV/CHA record)	2.0) % of men using a modern contraceptive method (measured by HP record, clinic record, CHV/CHA record)	2.0) Initial/refresher training for CHVs on IEC FP 2.1) Education of mens on FP 2.2) Training CHAs/CHVs on referral protocols 2.3) Develop a social marketing program and supply system for contraceptives	2.0) 24 CHAs/CHVs trained on FP IEC to men and on referral protocols 2.1) # of men referred to a health facility for contraception 2.2) A social marketing program developed, contraceptives become readily available for sale 2.3) Number of men using a modern contraceptive method	2.0) Training records 2.1) CHV and CHA monthly reports 2.2) Clinic or HP records 2.3) Inventory of contraceptive sale

Important Note: See Appendices G and H for cover pages of training manuals, and Appendix I for one of the manuals that ADRA Haiti will use for IEC and training on each of the CS interventions above. These manuals contain key health messages with pictorial illustrations.

Section C. Program Location

C.1 Location Maps

See Appendix A for maps indicting project location.

C.2 Location Description

The project, in Carrefour, Haiti, covers only one impact area. Carrefour is a densely populated urban area that, although part of the Port-au-Prince metro system, is incorporated as a separate township, with its own mayoral commission and separate administrative structure. The Adventist Hospital in Carrefour, a key partner in this project (see Appendix B for a letter indicating partnership), serves the entire Carrefour area, bringing the overall beneficiary level to close to 350,000 people. More intensive efforts will be directed to the people living in the immediate surroundings of the hospital, which is a mixed neighborhood called Diquini, with a population of 60,000. Most of these people live in substandard (slum) houses, while a very small minority is scattered in pockets of better homes. Intense commercial activity in the area is carried out by individual street sellers and small stores. Few people in the neighborhood hold regular salaried jobs (2.7 percent of mothers in the baseline survey are salaried employees). Many run a tiny business and/or are street vendors. Practically all people are nominally Catholic or Protestant. Fifty percent of mothers are literate (*KPC Survey),* and a number of primary and secondary schools are in the neighborhood. The national female literacy rate is 42 percent (*State of the World's Children,* 1997). Ethnically, the population is mostly black. However, some Mestizo's (mixture of white and black) inhabit the island. The national IMR is 71 per 1000 live births while the under five mortality rate is as high as 124 per 1000 live births. Nationally, 28 percent of the children < five years old is underweight. Of these, 8 percent are severely malnourished (ibid., 1997).

There are no health indicators specific to the project area or Carrefour. Extrapolating from urban area data, the principal causes of death of children under one year of age in Carrefour are diarrhea, malnutrition, acute respiratory infections, obstetrical causes, low birth weight and neonatal tetanus. For children 12-59 months old, the causes of death are diarrhea, malnutrition, acute respiratory infections and measles. Maternal causes of death are hemorrhage, obstructed labor, infections and eclampsia. Haiti suffers a national maternal mortality rate of 1000 per 100,000 live births (ibid., 1997).

The principal service providers in the project area are the Adventist Hospital; Hands of Love, an NGO located close to the project area; and ADRA. The Adventist Hospital employs 39 physicians, of whom nine are regular staff (three gynecologists, two pediatricians, two anesthesiologists, a radiologist and an internist), and forty nurses, fifteen of whom are registered. In addition, the hospital has 28 FP promoters, seven lab technicians, three radiologists and six pharmacists. The hospital infrastructure incorporates a pharmacy; laboratory; an attached FP clinic with surgical capability and a community outreach coordination office; cafeteria; ICU ward; a surgical theater; and units for maternity and pediatric out patient services. Hands of Love employs thirteen physicians and a number of health workers. ADRA employs two physicians and staffs twelve MCH centers in the Carrefour area as part of its PL 480 project. At the Adventist Hospital, up to fifty patients are seen per day. Forty women visit the FP clinic per day. Up to 50 percent of the hospital's 72 beds are occupied on any given day. The MOH has no health infrastructure in the project area. However, there are a few private pharmacies and drug vendors who provide limited medical services for high cost.

Interventions include vaccinations (Adventist Hospital, Hands of Love); nutrition (Hands of Love, ADRA); prenatal and postnatal care (Hands of Love, Adventist Hospital); deliveries (Adventist Hospital); FP (Adventist Hospital, Hands of Love); ARI management (Hands of Love, Adventist Hospital); DCM (Hands of Love, Adventist Hospital); and health education (Adventist Hospital, Hands of Love, ADRA). Lack of running water in the house and inadequate latrines facilities cause poor sanitation and diseases that directly affect CS activities. Due to poor economic conditions, the migration rate of population from rural to urban areas of Port-au-Prince is increasing. The unskilled nature of these immigrants inflates unemployment. As a result, women and children become vulnerable, and husbands cannot support their families. Although distance from health care facilities is not a major

problem, accessibility is hampered by cost of services and lack of community-based outreach effort.

Section D. Overall Program Design

D.1 Summary of Overall Program Design

Designed to initiate and develop the provision of community-based health services, the project will target mainly WCBA and children. Project intervention strategy calls for "all available channels" to mobilize the community in favor of its children and mothers. The project will be akin to an IPA program in the U.S., an independent provider association of ADRA-supported service delivery entities networking with other NGOs, private practitioners, and private pharmacies under the leadership of ADRA. The bulk of CS services will be provided through an ADRA-supported network of community HPs that will focus primarily on preventive services but will have some capability for the case management of sick children (on a referral basis).

The interventions to be carried out are the following: A) vaccination of children under one with DPT, oral polio, measles and BCG vaccines; B) vaccination of women 15 to 49 years old with TT; C) nutrition support beginning with the prevention of fetal malnutrition; the promotion of exclusive breastfeeding during the first six months of life; support to the mother during the weaning period; and nutritional rehabilitation for malnourished children using supplemental food, therapeutic outpatient feeding and the provision of vitamin A capsules to children six months to six years; D) DCM; and E) promotion and provision of modern methods of contraception.

The project focuses on mothers as the primary care givers for the family. Mothers are given training and support in maintaining health by the project's trained CHWs (CHVs/CHAs). These CHWs will provide education and services on an individual basis during home visits and work through existing community organizations such as mothers' groups. The CHVs will be supervised by CHAs, and CHAs by an ADRA field supervisor who will work closely with the lead CHAs (based at the HP), who also play a supervisory role. As a direct service, lead CHAs will weigh infants and children regularly (only at the HP), focusing on < two years at GM sessions, with results plotted on growth charts kept by mothers. Infants, children < 24 months, and children 24-60 months who are not gaining weight will be weighed every month. High risk or growth faltering children will be referred to the hospital for further attention. The GM event provides a regular opportunity for nutrition instruction, especially early breastfeeding and exclusive breastfeeding until six months of age, and appropriate introduction of an adequate, balanced diet thereafter. The special nutritional needs of pregnant and lactating women are also being emphasized during these educational sessions, which provide opportunity for promoting TT immunizations for pregnant mothers and EPI for under ones. The CHAs/CHVs will continue to receive refresher training on each intervention. In addition, ADRA will work to establish quality assurance in DCM targeting children < two years.

FP will be promoted during home visits, postnatal visits and at mothers' group meetings, through CHAs and CHVs who will receive training in FP messages, including the need for birth spacing and the use of contraceptives. CHVs and CHAs will be supplied through the HPs, with a small supply of condoms and pills for sale at low cost. The project will also include FP communication targeted to males through specially trained male health promoters and CHVs.

Direct services will be provided by the project through initial training and several refresher training sessions for CHVs in DCM messages to be given to mothers. These messages will include increased breastfeeding, use of other foods and fluids, use of ORS during diarrheal episodes, and early referral in cases of severe dehydration of < two year olds. CHVs will also be trained to give sanitation and hygiene messages to mothers. Training for CHVs will be organized by the ADRA training coordinator.

The project will also provide direct services through training of CHVs in key EPI messages. CHVs/CHAs will promote immunizations primarily at the monthly GM sessions. Children < one year old will be targeted for EPI. CHVs will be expected to record and follow-up defaulters. The project will focus on areas of particular need for EPI mass campaigns in

conjunction with the community leaders. Another way the project will provide direct services is in the distribution of vitamin A mega-doses by project CHAs/CHVs during home visits. Children between age six months and six years old will be targeted. Supplies of vitamin A capsules will be provided by the PROMESS.

The existence of three well-established service providers in the area (ADRA, the Adventist Hospital and Hands of Love) creates the opportunity for complimentary partnership. ADRA runs a PL 480 Title II nutrition program which includes GM and supplemental food to families of children in moderate to severe malnutrition while Hands of Love maintains a nutrition rehabilitation center. In addition, the Hands of Love center and the Adventist Hospital provide prenatal and postnatal care. The hospital is available to treat complicated pregnancies and deliveries, and can perform cesarian sections. Both Hands of Love and the hospital have a FP program, and the hospital offers surgical contraception. The hospital is an excellent backup for curative care.

The main weaknesses in the project area are inadequate community mobilization and participation, and inadequate outreach services. The hospital employs community agents only for FP outreach. The ADRA PL 480 program is concerned primarily with nutrition. As noted before, there seems to be hidden barriers to the use of preventive and curative services as reflected (in the KPC Survey) by the low level of use of ORT, contraceptives and the minimal coverage rates for vaccinations. There is no discernible community-based IEC program except FP. There is a need for a strong community outreach effort to improve health services and use rates which are the rationale behind the choice of this program design and interventions.

The selected *target groups*, in order of importance, are the following: A) for vaccination and nutrition: children under two and pregnant women; B) for DCM: children under two and their mothers; and C) for FP: WCBA and adult men.

The selection was made on the following basis: A) Data from the National Haiti DHS (Cayemittes et al, 1995) document that the prevalence of malnutrition rises steeply between the ages of six months to two years, to plateau after two years; thus, effective interventions to prevent child deaths must be provided as early as possible in the life of the child, and preferably before the child's first birthday; B) Fetal malnutrition is manifested by a low-for-gestational age birth weight, and low birth weight is in turn related to an adverse perinatal outcome. Weight gain during pregnancy is particularly important for women with low pre-pregnancy weight (*Institute of Medicine,* 1990). In Haiti, 45 percent of women are underweight by the time they become pregnant (Cayemittes et al, 1995); and C) A low contraceptive prevalence rate leads to an increase in short interval births. Short birth intervals are associated with an increased risk of malnutrition and mortality (Devlin et al, 1996).

High risk populations are the following: A) for vaccinations: children under one and pregnant women; B) for nutrition: children under two; C) for DCM: children six months to two years old; and D) for FP: women who have recently lost a child or a fetus, and women under twenty and over 35 years old.

As noted before, the program structure is akin to that of an IPA Managed Care program incorporating a network of participating providers, a minimum package of services, and enrolled beneficiaries. ADRA plans to formally enroll its beneficiaries through door-to-door family registration which will identify each household member. Rosters of specific target groups will be created from family register forms (i.e., a pregnancy register, follow-up rosters of children under one, and a listing of all women who are candidates for contraceptive services).

ADRA has run an MCH program under the PL 480 Title II Mission-sponsored activities since 1979. Through this program, malnourished children are identified and their families become eligible to receive a dry food ration. Under the CS program, children identified as malnourished through routine GM activities will be able to benefit from dry food supplementation. Malnourished children needing special nutritional and medical attention will be referred to the Adventist Hospital nutrition rehabilitation center and the Hands of Love nutrition

center for monitored therapeutic feeding and medical care.

The Adventist Hospital maintains an active reproductive health division which offers prenatal, intrapartum and postpartum care to pregnant/lactating women, and contraceptive services including surgical contraception to clients in the Carrefour area. While the CS program will implement FP promotion, and distribute condoms and oral contraceptives through community marketing channels, it is expected to refer to the hospital women requesting Depo-Provera, Norplant or surgical contraception.

D.2 Collaboration and Formal Agreements

The ADRA program will operate in collaboration and under the overall guidelines of the MOH policy initiative which calls for the implementation of community health units (UCS) throughout the country. These UCS' are health care subsystems which emphasize the networking of health facilities in a given region to offer a minimum package of integrated health services to a geographically and demographically defined population. Within the planned Carrefour UCS, ADRA will concentrate on the neighborhood surrounding the Adventist Hospital and will observe MOH guidelines regarding the minimum package. The hospital will be a key part of the network and already has a formal operating agreement with the MOH (see Appendix F). ADRA has participated in a number of strategic meetings with MOH authorities regarding the Carrefour UCS and has received clearance to implement the activities it is proposing as they fall in line with overall MOH policy. In so doing, ADRA is expected to elicit the assistance of a private local firm (CERA) to implement its family enrollment program and develop its health information system. Linkages will also be established with UNICEF (Baby-Friendly Hospital Initiative), PSI (Social Marketing of Contraceptives), PROMESS, the local PAHO/WHO-run supply network (ORS packets, vitamin A, Norplant and pharmaceuticals), and CAPS (program sustainability).

In terms of financial engagements, ADRA will hire, in addition to consultants from CERA and CAPS, a medical anthropologist to conduct focus group KAP surveys. It expects to purchase selected commodities at the PROMESS (Essential drugs) facility, such as mebendazole for deworming.

In its efforts to network with service delivery providers and other potential outlets for its social marketing program, ADRA will establish formal and informal agreements with private physicians and pharmacies, grocery store owners, street sellers, schools, churches, and community organizations active in its catchment area.

Organizations involved in the process of development of the DIP include CAPS, the USAID/Haiti Mission, a consultant with excellent knowledge of the Haitian health care system (Dr. Antoine Augustin), key ADRA Haiti CS XII project staff, the MOH office in Carrefour, Hands of Love, the Adventist Hospital, the mayor of Carrefour, and several community groups including religious and opinion leaders in the project area. The process of eliciting participation of community groups in the development of the DIP included the following steps: A) feedback information obtained from mothers attending ADRA PL 480 Title II MCH centers; B) dialogue with key community leaders on the need to facilitate access to health services by setting up community HPs which would be more accessible to the population. This led to the suggestion of actual sites/buildings offered by the community to house such posts; and C) discussion with local political, religious and opinion leaders and presentations of findings of the Baseline Survey.

In summary, the project involves collaboration among the community, MOH, UNICEF, Hands of Love, the Adventist Hospital, and local and international NGOs in one form or another. The community will select CHVs. ADRA participates through promotion and facilitation of the processes. ADRA also trains these CHVs. The criteria for selecting the CHVs include the following: being between the ages of 18 to 50; acceptance by the community; public relations ability; availability of time to spend in the community; willingness and motivation to work with the community; residence in the community; and literacy. CHVs meet monthly at the community HP facility. ADRA provides stationery and participates in these meetings. There will be a $15.00 financial transaction between ADRA

and each CHV as an incentive. The incentive will be provided in proportion to the CHV's training and output.

UNICEF Haiti will provide technical assistance in breastfeeding and educational materials. CARE, INSAC, CAPS and CERA are among the local NGOs/PVOs who will collaborate with ADRA in providing training, and sharing information and educational materials. The Adventist Hospital specializes in FP and will serve as a referral center for tubaligation procedures.

PROMESS will continue to provide vitamin A to be distributed/sold by CHVs/CHAs. If clients do not show up to collect their vitamin capsules, the CHV/CHA, who has a record of all the homes under his or her assignment, visits the home. There is no financial exchange planned between ADRA and any of the above collaborating agencies except CAPS and CERA. No other organization is subcontracted to help implement this project.

D.3 Technical Assistance

As noted before, the following technical assistance in HIS/HH registration, social marketing of contraceptives, sustainability (see Appendix U for consultant scope of work), and FGD for each intervention is planned from local sources:

Source, Type and Schedule of Technical Assistance

Source	Type	Schedule
CERA	HH Registration/HIS	April 1997
PSI	Social marketing of Contraceptives	Sept. 1997
CAPS	Sustainability (Dr. Antoine Augustin)	Jan., Dec. 1998
UNICEF	Breastfeeding	June 1997, June 1998
Private consultant	Focus Group Discussion	Sept. 1997

D.4 Detailed Plans by Interventions

D.4.1 Immunization

1. Incidence and Outbreaks: The national polio surveillance program has elicited no cases in the project area. An outbreak of measles occurred in 1992, but following a nationwide vaccination program in 1995, the number of cases reported over the past two years has been negligible.

2. Baseline Coverage: Estimates for the following antigens are as follows (percentage of children 12-23 months old):

Immunization Coverage Rates

Antigen	*ADRA (%)	<Port-au-Prince (%)	>National (%)
DPT1	49	83.7	
DPT3	9	52.5	34
OPV3	9	52.5	34
Measles	31	58.9	31
Dropout rate (between DPT1 and DPT3)	39		
Fully immunized	8	38.3	
TT	10		49

Source: * = ADRA KPC Survey; < = Cayemittes et al op. '94; > = *State of the World's Children*, '97.

3. MOH Policies: Current policy focuses on the creation of UCS' where child oriented services are provided in an integrated manner (integrated case management). The tendency is thus to get away from vertical programs but rather to minimize lost opportunities and provide routine services. Communal (local) campaigns are organized occasionally for making up missed immunizations. MOH policies do not differ from WHO/UNICEF guidelines. See Appendix S for the official immunization schedule, which is identical to the WHO recommended schedule. Also, see Appendix X for the draft copy of MOH norms and guidelines for EPI, nutrition, GM and DCM.

4. Knowledge/Practice: The level of maternal knowledge with regard to immunization is poor: only 9 percent know that the measles vaccine is due at age nine months. On the other hand, 59 percent of mothers state that the TT vaccine protects both the mother and infant. Sixty-two percent of mothers feel that more than two doses of TT injection are necessary to protect the newborn (KPC Survey). The project needs to emphasize health messages in EPI to raise awareness of the importance and timeliness in maintaining the EPI schedule.

5. Approach: Interviews with selected mothers suggest that one major barrier to the utilization of vaccination services at the hospital is the opportunity cost of a lost day: the time to dress-up mother and child, the time to get to the hospital, waiting time at the busy outpatient department clinic, and time to return home. Another barrier is lack of maternal compliance with the vaccination schedule due to simple forgetfulness, poor motivation or lack of alternate care for other siblings. The number of mothers who can avail themselves of vaccination services by private physicians is very small. While the quality of services is good at the Adventist Hospital, EPI services are given only half a day, Monday to Friday. Not all private physicians have the necessary cold chain equipment to ensure that vaccines are stored in a safe environment.

ADRA has no data on the quality of services at the Hands of Love facility or at private physicians offices. The Adventist Hospital provides services of quality on a fixed facility basis. ADRA will use a pro-active approach for the provision of services, in the sense that it will not passively wait for mothers to bring their children to vaccination posts. Steps leading to a high coverage include: A) motivation at churches, schools, through community organizations, the media and word of mouth communication. There will be an orientation/training session once a year for church pastors, teachers and community leaders on how to promote EPI in their respective institutions. Radio messages promoting EPI will be broadcast from the Adventist radio station located in the project area three times per week; B) invitations to mothers for a specific date and hour at the HP. This will be done by the CHA and CHV during home visits; C) vaccination at community HPs close to the home of mothers. This will help improve accessibility; and D) follow-up of no-shows (all children will be registered by name and address during the community HH registration). This list of addresses of children will be used to track those who missed EPI by CHVs/CHAs during home visits and referred for vaccination. The follow-up will not stop until the child is fully immunized.

Good

ADRA will focus on community mobilization by having a pro-active outreach program where mothers will be specifically invited to attend immunization sessions at community HPs. These posts will be open during working hours to any mother regardless of whether this was her appointment day or not. ADRA, through its outreach activities, and the hospital, through its static program, will thus provide vaccination services. Some private physicians in the area also provide vaccination at cost. Thus, beneficiaries will be able to obtain vaccinations all year long and every working day. Since the area is compact and densely populated, there will be no need for mobile vaccination posts.

For vaccinations, all children under one will be considered high risk from an epidemiologic point of view. From an operational point of view, high risk children are those whose mothers are away from home or deceased. A special invitation will be made to the caretakers of these children to motivate them to bring the child for vaccination.

The Adventist Hospital was assigned by the MOH the task of being a regional vaccine and commodity

distribution center (USD). The ADRA program will obtain vaccines from the hospital USD and will collaborate with the hospital on a program to provide vaccines to private physicians under conditions which ensure their safe conservation. All staff active in the program will receive instruction on protection to blood-borne infections based on WHO guidelines.

6. Documentation: The program will use home-based records for both mothers and children. The MOH "Road to Health" growth monitoring chart (see Appendix O) has a space to record vaccinations, as does the mother's health card (see Appendix O). Both cards will be kept by the mothers who will receive plastic bags for that purpose. This will encourage retention, especially since mothers will be charged a nominal fee for card replacement. Health service contacts will also be recorded on follow-up sheets maintained by CHAs/CHVs. The information on vaccination status will thus be available for each child in two separate documents: the home-based record and the follow-up sheet. These records are not cheap (about US$ 0.80 per card) and adequate provision has been made in the budget for their purchase (to supplement erratic MOH supply). During mass campaigns, the child's vaccination status will be recorded on the card, and a copy will be filed in the main EPI registry. Mothers will be taught to bring the EPI card for each session. Appropriate retention of both cards will be promoted through education. See Appendix Q for all EPI-related HIS forms and charts.

7. Drop-outs and Missed Opportunities: Effective barriers to vaccinations, as covered above, explain the dropout phenomenon. Since all children are registered by name, and their addresses are known to CHV/CHAs, dropouts will be identified and followed up and personally invited/referred to a HP to be vaccinated. These centers will function with a schedule which makes it feasible for mothers to bring their child at convenient hours, and will apply the MOH policies regarding the integration of services. Thus, any mother or child coming to the center for any purpose will have his or her vaccination status checked and updated if necessary. This strategy is hoped to increase vaccination coverage; that is giving the right dose at the right time, and giving all doses before the first birthday.

8. Drop-outs - Women: Demand for TT vaccination will be developed using the same type of approach as for children (i.e., motivation though churches, schools, Adventist radio station, community organizations, etc.). Invitations to a given HP will be extended not only to mothers of young children, but to all eligible women. No-shows will be identified through registration forms and follow-up invitations will be made to them. Again, CHVs/CHAs have a list of addresses of all eligible women in the project area and will use it during home visits to identify and refer dropouts for vaccination at the nearest HP. The monthly women's meeting will also be used to promote the importance of compliance to EPI.

9. Population: On a yearly basis, ADRA plans to vaccinate 1700 children under one (there are 2100 newborns per year), and 14,000 women of childbearing age. This implies 8500 visits per year for infants, and close to 70,000 visits over the life of the project for WCBA, the target being five doses of TT for lifetime protection.

10. Cold Chain Support: Vaccines are procured from the WHO Essential Drugs facility (PROMESS), which is located in Port-au-Prince (1/2 an hour ride from the Adventist Hospital). Because of the location, there is no weak link in the cold chain between the Adventist Hospital and PROMESS. So far, there is no problem in the supply of vaccines. The principal regional storage unit will be the hospital USD. This unit will supply individual community HPs with vaccines on a periodic basis. Propane gas refrigerators will be obtained from the national vaccination program free of charge. ADRA will collaborate with the Adventist Hospital staff in charge of cold chain maintenance and monitoring, and will adhere to standard USD protocols developed by the MOH for that purpose. The refrigerators are equipped with external dials which register internal vaccine temperature. This will facilitate the monitoring and recording of vaccine temperature (see Appendix Q for daily cold chain temperature monitoring chart). Especial emphasis will be placed on training and supervising HP staff in maintaining the cold chain, monitoring storage and handling vaccines. The supervision will be provided by the AN on a daily basis to assure appropriate temperature.

There are no available estimates of vaccine efficacy at the district level.

11. Surveillance: The Adventist Hospital has been requested by the MOH to participate in its national *surveillance system* as a sentinel site. Diseases to be reported include measles, polio, tetanus and meningitis. The specific surveillance protocols and definitions are being developed by a special MOH committee. Surveillance will be facility-based and carried out actively by MOH personnel as trained by the MOH experts. Suspected cases will be identified either at the community HPs or at the Adventist Hospital outpatient clinic. If the case is first seen at the community HP, it will be referred to the hospital for an examination by a physician who will confirm the clinical diagnosis and report it via the hospital medical director to MOH authorities. These authorities will send a team who will take the requisite laboratory samples for the proper examination and develop a strategy for controlling the outbreak. ADRA will provide two dozes of vitamin A on consecutive days for all cases of measles. The follow-up will be the joint responsibility of the hospital, aided by ADRA CHWs, and MOH authorities. ADRA's role may thus be summarized as follows: initial identification of suspected cases at community HPs; referral of suspected cases to the hospital; and community follow-up of cases. ADRA will train project CHAs/CHVs on the above described surveillance protocols.

12. Community Support/Sustainability: The community will make four buildings available to ADRA. These buildings will serve as the HPs and will be the principal sites for vaccination services. In addition, numerous community organizations contacted by ADRA have agreed to promote EPI through their respective institutions (i.e., CHC, sports clubs, churches, schools, etc.).

13. Other Issues:

(a) Staff Expertise. The program director holds a degree in public health and is fully cognizant of vaccination issues. The project health coordinator (who will supervise the AN) is a RN with ample training and experience in EPI promotion, IEC and vaccination administration. See Appendix D for key project staff resumes. At the time of the DIP preparation, the service delivery staff had not been recruited. Training and experience with vaccination will be a prerequisite for the recruitment of ANs (the national AN curriculum includes vaccination administration and IEC). Similarly, an effort will be made to recruit health agents already experienced in vaccination. All field personnel will receive a pretest to detect any weakness in vaccination knowledge, and the program will develop a competency-based approach to training which specifically addresses identified weakness areas.

(b) Baseline Survey Results. (See the Baseline Survey document.)

(c) Current Services. Currently, two NGO sites (Hands of Love and the Adventist Hospital) and a few private physicians provide vaccination services. At the two NGO facilities, strengths include a well-trained staff, and a functioning cold chain which follow the MOH norms. Private physicians by and large do not fully comply with cold chain requirements, especially since there are frequent electrical shortages in the area. Another weakness is the lack of community outreach in support of vaccination programs.

(d) Complementarity. The project has adopted a strategy which takes into account the comparative advantage of each institution: the Adventist Hospital will continue to serve as a USD for vaccination and will serve as the main supply point for all other service providers. Hands of Love will continue its fixed facility-based vaccination program. ADRA will implement a community-based outreach program which uses specific invitations to mothers to bring their children to one of the four ADRA community HPs for vaccination on a specific day. Private physicians will be invited to become partners in the program, and the hospital will supply them with vaccines. The EPI activities of each institution will be coordinated to improve accessibility/utilization rates and referral of defaulters to the nearest vaccination site. Immunizations will not be provided as a separate vertical intervention. When the child is seen at the HP or hospital, the opportunity will be used to weigh, educate, deworm and distribute vitamin A capsules, etc.

(e) Staff Training. The focus of the training will be the new Community health workers (CHVs, CHAs and ANs). See Appendix V for the cover page of the MOH training guideline for CHAs/CHVs. At the end of the training, each worker will be able to: A) convey the prime messages relating to vaccinations to a mother, using a vaccination poster; B) explain to a mother in simple language why vaccinations are important to every infant, young child and mother; C) name the six childhood diseases which are preventable through immunization, and describe the main symptoms of each; D) clearly explain to the mother how many vaccination doses are necessary for every infant, child and mother, and at what time intervals or ages; E) explain to a mother the common side effects after immunization (which do not cause any harm); F) explain to the mother the difference between immunization and an antibiotic injection; and G) explain to the mother the importance of the vaccination card and where to go locally for immunizations. The health worker should be aware of which HP the mother should be referred to and the working hours of the post.

The EPI portion of the training will cover three, two-hour sessions for the initial program and one, two-hour session once every six months. See Appendix G for the cover page of the CHA training manual to be used, and Appendix Z for training plans. After the training, the CHW will be accompanied by a supervisor during the initial work of field activities. The evaluation will be carried out in two ways. During the training, health workers will carry out three exercises focusing on the following: A) why vaccination is important; B) the six vaccine preventable diseases and vaccination schedules, using a quiz show game; and C) the common side effects of vaccinations, a 45-minute group discussion. In addition, since this is a competency-based training program, direct supervision will continue until the supervisor is satisfied that the trainee has mastered all relevant points pertaining to his training, or is unable to function effectively in the field.

(f) Quality Monitoring and Improvement. In this document, quality is defined as "doing the right thing right." The program will focus particularly on the prime health messages which are important for the health worker to communicate to the mother. The CHVs/CHAs will need to demonstrate full knowledge of the messages pertaining to measles and tetanus vaccination. Health worker supervisors must also know the standards so that they can effectively evaluate the health worker performance. Quality monitoring for vaccinations will be facilitated by the use of a checklist which itemizes critical steps in the encounter between a health worker and mother pertaining to vaccination-specific message delivery. These steps will detect errors (by the supervisor) in the encounter and these errors will be recorded in the form. The reason for the error will be analyzed and discussed with the health worker. Training will be considered completed when an error-free encounter is observed by the supervisor. Spot checks of CHV/CHA encounters will occur at least every three months after that. See Appendix T for CHA/CHV quality monitoring, and supervisory review forms.

(g) MOH versus International Practice. There is no difference between the MOH policies and the international practice.

D.4.2 Nutrition/Micronutrients

Nutritional Improvements for Infants/Children

1. Nutrition Status: There are no nutrition status data specific to the project area or Carrefour. Available data pertaining to Haiti and the Port-au-Prince metro area are based on NCHS/CDC/WHO studies. Children with two standard deviations below the median height for age of the reference population are considered to be chronically malnourished, while children with a weight for height below two standard deviations of the reference median are considered acutely undernourished. The results by gender are as follows for all Haitian children:

Location	Height for Age (-2 SDs)	Weight for Height (-2 SDs)
Male (national)	31.8	8.4
Female (national)	32.0	7.2
Both genders (Port-au-Prince)	20.4	8.2

Source: Cayemittes et al, 1995

According to UNICEF studies, 28 percent of children < five in Haiti suffer from a moderate to severe degree of malnutrition *(State of the World's Children,* UNICEF, 1997*)*. These estimates are based on below -2 SD from the median weight for age of the reference population for moderate malnutrition, and below -3 SD from median weight for age of the reference population for severe malnutrition.

In rural areas, food availability is worsened during the period of July to September *(*Augustin, 1997*)*. In urban areas, food availability is a function of price and purchasing power, and prices appear to be higher during the period in August and September. Trends in food cost show a strong inflationary tendency, prices having gone up by 200 percent since 1991 while the per capita income has declined from about $350 in 1990 to $260 in 1995 *(USAID Monitoring Reports,* 1992-1996*; IMF,* 1996*)*.

Food Availability and Food Security. Total food supplies in Haiti have been inadequate for many decades, with per capita calorie supplies fluctuating between 1900 and 2100 calories per person per day for the past forty years. The quality of the Haitian diet has deteriorated, with the absolute number of calories coming from grains declining from about 900 calories per person per day in 1960 to 700 calories per person per day in the 1990s. The most significant factor limiting access to food in Haiti is the very low purchasing power of the Haitian population. When the per capita income is used as a proxy, one may note the following trends: a period of stagnation between 1955 and 1970, a slight rise between 1970 and 1980, and a steady fall since 1980. By 1991, the per capita income, in constant dollars, was the same as it was in 1955 ($260.00).

Food purchases use up about 48 percent of the income of the average household, and as much as 59 percent of the income of the poorest households (with income of less than US$40 per capita per year). Estimates for urban areas are 42 percent. The purchase of cooked meals represents about 10 percent of all household food purchases. The poorer the family, the more likely it will buy food from street sellers *(UNICEF,* unpublished data*)*.

In summary, the root causes of childhood malnutrition are poverty, which restricts the capacity of households to purchase the requisite food for children; ignorance; the opportunity cost of breastfeeding (mothers must leave home to make a living); unsanitary environmental conditions which contribute to the high incidence of infectious diseases (lack of potable water and food contamination); and fertility-related factors. Knowledge of which foods are the most cost effective and nutrient dense is low. In addition, the prevalence of intestinal parasites and low frequency of feeding per day increase the likelihood of infant and child morbidity and mortality. An increase in malnutrition is correlated with diarrheal episodes which occur mainly during rainy seasons. According to the CDC/WHO data quoted earlier, there is no significant age or sex difference in malnutrition rates of children.

? Surely 90% dep not leave home

2. Current Beliefs and Practices: The nutrition problems begin in the first few days of life. One cultural practice is to give the child a strong purgative after birth to get rid of meconium and to discard colostrum. Fluids other than breast milk are provided to infants four months old in 97 percent of cases *(State of the World's Children,* 1997*)*. In the project area, only 7 percent of < four months old children are exclusively breastfed *(KPC Survey)*. This is followed by a delayed introduction of semi-solid food (in the project area only 43 percent of mothers have introduced semi-solids by the time the child is nine months old), an inadequate weaning diet, and the premature cessation of breastfeeding (only 6 percent of mothers in the project are still breastfeeding when infants reach 20-24 months). At six to eleven months, the child is eating semi-solids, and at age one year, the child eats the same food as the rest of the family. By and large, the amount of food given to the child while he is sick is reduced, primarily because the child loses his appetite, a matter of great concern to mothers. Mothers seek to feed the child more after the illness, but this will depend on how fast the child regains his appetite

LBW 14% in Urban areas.

Data on Current Breastfeeding Practices in Haiti

Age in Months	*Project Area (%)	#National (%)
< 4	7	3
6-9	43	83
20-23	6	25

* = KPC Survey; # = *State of the World's Children*, UNICEF, 1997.
Note: Project area rates are lower because in the urban areas bottle feeding is more popular than the rural areas.

The household diet provides on the average 1800 calories per person per day, with 33 grams of protein, 4000 units of vitamin A, and 16 mg of iron *(HECS,* 1989; Augustin et al, 1993*)*. Cereals make up 38 percent of the calorie contents of the diet, fruits and vegetables 22 percent, fat 16 percent, roots and tubers 8 percent, sugars 8 percent, and animal proteins 5 percent. Over the years, food consumption patterns have changed somewhat: wheat and flour consumption (bread, pasta) has increased considerably, while the consumption of sugar has declined. Per capita availability of protein has declined despite an increase in meat availability. Protein from plant sources has also increased in availability, but this has been insufficient to offset the overall trend.

In poorer households, children may be fed twice a day. Infants are generally bottle fed, and data suggest that in households where mothers are absent, the frequency of feeding may be limited to two or three times a day (usually coinciding with the number of times the mother or caretaker eats per day). Mothers feed their children from a plate using a spoon or their fingers. They do not always supervise their children so children, may eat anything they find on the floor when they are hungry. Sometimes mothers buy "junk" foods (sweets, soda) for their children. Feedings are prepared using powdered milk and water obtained from a public fountain (usually contaminated). Children are fed by another sibling or by the father or any other caretaker who stays behind. Mothers start adding food other than breast milk during the first month and the added foods are usually banana flour mixed with milk or a local mixture called AK1000 made of ground corn and beans. Other foods mentioned by mothers include meat, mangos and other fruits. Oil is usually added to cooked food. In most households where the father is present, he is favored to get the most and best meal and smaller children do not fare well.

According to the KPC Survey, in the ADRA catchment area, 66 percent of mothers are not at home to feed the child. Alternative care takers include relatives (44 percent), older children (14 percent), neighbors (14 percent), and the husband (9 percent).

3. MOH Policy and Nutrition Activity in the Area: The MOH has established a National Council on Breastfeeding which sponsors breastfeeding promotion activities. No new MOH policy on nutrition has been formulated in recent years. The old policy, focusing on GM and targeted supplemental feeding, coupled with community-based intervention in sanitation, income generation, etc., is the standard. The MOH has no specific nutrition program in the ADRA project area. The project will follow the MOH breastfeeding policy and receive guidance from the national breastfeeding committee.

4. Program Approach: The basic strategy for improving children's nutritional status addresses the *four major determinants of poor nutritional status* in Haitian children. They are as follows: 1) lack of maternal knowledge regarding nutrition; 2) lack of purchasing power; 3) infectious processes; and 4) short interval births, particularly in households where the mother is absent. Improvement in knowledge will focus on "best-buy strategies," i.e., the utilization by mothers of locally available food which provides the best nutritive value for low cost. For older children six months to 24 months, ADRA will address the problem of weaning foods by researching

what is currently available on the market, and by promoting a "best-buy" social marketing strategy. The objective is to encourage mothers to purchase nutritious mixtures available at relatively low cost. Because mothers and care takers have little time at hand, ready-to-eat instant mixtures which can be easily prepared even by older children will be favored. The focus of breastfeeding interventions will be on practical approaches to promote breast milk accessibility to the baby during the first six months of age.

CHAs and CHVs will be trained on counseling techniques with an emphasis on initiation, continuation and persistence of breastfeeding, and the introduction of semi-solid foods at age six months. These practices will be encouraged during illness and catch-up feeding.

The second aspect of the strategy is the distribution of supplemental food to families harboring malnourished children and the referral of acutely malnourished children to the Hands of Love nutrition rehabilitation center and the Adventist Hospital therapeutic wet feeding center. The program will also coordinate its efforts with those of the ADRA PL 480 Title II activities.

Services will be provided on an integrated basis, and two infectious processes with a negative impact on nutritional status, i.e., measles and diarrhea, will be addressed by the program through immunization activities (measles) and the promotion of ORT (diarrhea). The integration within the nutrition activities of specific messages on how to feed a sick child (see below) will also be addressed. The integration will occur principally at the level of community HPs which ADRA will set up in the neighborhood surrounding the hospital. These posts will be the sites for weighing, vaccinating, deworming, treating diarrhea and promoting ORT. There will be a vigorous FP promotion, distribution/selling of contraceptives at the community HPs complemented by hospital-based services such as IUD insertions, Depo-Provera injections, Norplant insertions and surgical contraception. All enrolled children will be weighed periodically at community HPs. Children exhibiting signs of malnutrition (as determined by the entry criteria to be discussed later) will be referred to the ADRA PL 480 Title II MCH program for a family allocation of supplemental food. As with vaccinations, the weighing will be done by invitation.

Key nutrition messages to improve the content and frequency of complementary feeding to small children during the weaning period will be as follows: A) begin additional supplementary food at six months of age but continue to breastfeed until the child is two years old (Introduce new foods one at a time. Make the food soft by mashing or straining it. Give small amounts with a clean spoon just before breastfeeding. Slowly increase to six spoonfuls, six times a day. The baby may have a little diarrhea or constipation from the new food, but this is normal. By one year of age, the child should eat the same food as the family.); B) practice the four cleans (clean hands, clean surface, clean instruments, clean coverings); C) breast milk is a natural immunization; and D) continue to breastfeed a sick infant or child and increase food (an extra meal per day) for two weeks following an illness. See Appendix I for the manual CHAs/CHVs will use to train/educate mothers on nutrition and other CS interventions. This manual, developed and tested by ADRA, is complete with illustrations, pictures and key messages.

Community support systems will rely on home visits by community health workers (CHVs/CHAs) to deliver the messages and reinforce them. In addition, mothers will be organized into peer-to-peer groups for self support and encouragement (community women's groups). Food demonstrations will be conducted by trained CHV/CHAs for mothers during monthly women's meetings. Finally, as noted before, the program will research current weaning food mixtures on the market and will use social marketing tools for promoting a "best-buy" weaning mixture. This "mixture" will be developed jointly with UNICEF and the WFP. As part of the strategy to reduce malnutrition among children in Haiti, WFP and UNICEF are jointly developing a nutritionally appropriate, locally available "food mix" at low cost. Included among the constraints to improving the child's nutrition status are economic problems, inadequate food distribution in the family, and sanitation problems. Attempts to reduce these constraints include the following: teaching mothers to

buy nutritional foods (not junk foods); encouraging the feeding of children adequately, meaning children first and adults last; encouraging an increase in frequency of eating for children; discouraging bottle feeding (expensive practice but widely accepted); and educating on sanitation principles.

Monitoring of Quality. Quality monitoring for nutrition education (at both the HP and home level) will be facilitated by the use of a checklist which itemizes critical steps in the encounter between a health worker and a mother, pertaining to nutrition-specific message delivery. These steps will detect errors in the encounter. The errors will be recorded in the form by the supervisor who will be present during counseling/education. The reason for the error will be discussed with the health worker immediately after the incidence and during monthly meetings and corrective action will be taken. Training will be considered completed when an error-free encounter is observed by the supervisor. Spot checks of CHW encounters will occur at least every three months. See Appendix T for the supervisory review form which will be used to monitor the quality of IEC.

The overall quality of the intervention activities will be monitored through monthly CHV/CHA reports, supervision of CHA/CHVs, and monthly feedback meetings when a performance evaluation will be conducted.

Growth Monitoring, Counseling and Follow-up

5. Approach to Growth Monitoring, Counseling and Follow-up: The MOH promotes the use of a "Road to Health" GM card with curves which follow the Gomez classification. See Appendix O for MOH GM card. According to current MOH protocol, children with moderate (M2) or severe (M3) malnutrition are to be referred either for supplemental food or for formal rehabilitation at a center which combines feeding the child with education sessions for the benefit of the mother. The MOH recommends quarterly GM visits for < five children who are normal or healthy. If the child is ill or malnourished, the frequency of GM visits will be increased to once a month or more.

Currently, facility-based GM activities are conducted by the Adventist Hospital. Children under five are weighed on a monthly basis and those suffering from moderate or severe malnutrition are referred to the ADRA PL 480 program for dry food distribution. Specific focus areas will be as following: A) access to effective medical care. Medical care for malnourished children will be available at the Adventist Hospital (in case a severe infection is the precipitating factor for the deterioration in nutritional status), or at Hands of Love clinic, which operates a nutrition rehabilitation center; B) extra food for growth faltering children. ADRA will continue its current PL 480 Title II food distribution program which will be integrated with CS activities in the sense that children with growth faltering screened during GM at the HPs will be referred to the PL 480 team for supplemental dry ration; and C) follow-up plans. Children enrolled in the PL 480 program are part of a community-based follow-up system to ensure that they are gaining in a satisfactory manner. Hospitalized children or children who "graduate" from the Hands of Love nutrition rehabilitation center will be discharged to the care of the CHW assigned to that neighborhood. The project will track those children who do not gain weight by monitoring the records kept by the CHA/CHV made during their home visits. The child's GM card will be the primary source of information on his nutrition status. The project HIS coordinator will monitor monthly GM reports and instruct the CHV/CHV to follow up on growth faltering children. The counseling provided to mothers with growth faltering children will be continued breastfeeding, provision of a variety of foods, regular GM and referral if indicated. The nutrition education will underscore the value of weight gain rather than nutrition status, and accurate plotting and interpretation of a growth chart.

One anticipated constraint will be the level of compliance in attendance and counseling. Some of the better GM programs in the country do not achieve a greater than 50 percent to 60 percent rate of attendance at weighing sessions. ADRA expects high attendances because of the potential availability of PL 480 food for distribution. The biggest drawback is the lack of purchasing power of much of the target population. Data from other parts of Haiti (Augustin et al, 1994) suggest that up to two-thirds of the mothers may permanently benefit from well-organized educational and counseling sessions. The

Needs Nut TA.

remainder will have either insufficient resources to feed their child (they will be referred to the food supplementation program), or the child may suffer from a chronic illness (usually tuberculosis). These children will be referred to the hospital for further evaluation.

Training on GM will be provided for ANs and lead CHAs to strengthen their GM skills. The GM system established by the MOH uses weight for age and will be the method used for measurement of nutrition status of beneficiaries and for educating of mothers on appropriate intervention. ANs will be given additional training on the use of the "master chart" to help determine the degree of malnutrition. See Appendix O for GM master chart. The role of CHVs will be limited to counseling and referral of all children falling below the normal curve of the standard RTH card. Its the trend!

ADRA's general responsibility will include the following: A) enrollment of children and screening for nutrition status at the HP and GM; B) periodic weighing of all children 0- 59 months (every three months) at ADRA community HPs; C) deworming of all children every four months at the HP (mebendazole is the drug of choice) and recording on the GM card; D) identification of no-shows through registration files (by CHA/CHV during home visits) and referral; E) educating mothers and other care givers (by CHA/CHV during home visits) on the use and interpretation of the RTH card, including the identification of growth faltering, the principal criterion being failure to gain weight from the last visit; and F) determination of the cause of growth faltering. In the absence of an obvious acute illness such as diarrhea, a trial of supplemental food will be given to the child. Children who fail to gain weight when there is evidence they actually consumed the supplemental food will be investigated for a chronic illness, particularly tuberculosis, or infectious disease (on a referral basis at the Adventist Hospital), and treatment will be administered. The CHA will revisit the child after he is discharged from the hospital or nutrition rehabilitation center to reevaluate the situation.

The prerequisite for the approach includes the *training* of health workers at the community HPs in proper weighing, charting and interpreting. Good interpersonal skill is also an asset.

At the end of their training, CHWs will be able to do the following: A) explain to the mother the importance of GM; B) use a scale well; C) graph the weight of the child on a growth card; D) explain to the mother how to interpret the card; E) identify a child requiring referral to the PL 480 program (M1 and M2 or M2 children) or to a nutrition rehabilitation center (M3 or severely malnourished; F) list and recognize signs of malnutrition; G) question the mother on what she feeds her child; and H) describe what to do in case a child does not gain weight (< six months old, 6-12 months old, 12-23 months old).

The CHAs/CHVs and HP staff will be under the direct *supervision* of the field supervisor who will in turn be supervised by the project health coordinator. They will ensure adequate quality control. In particular, supervision will focus on the accuracy of the weighing and recording, the quality of counseling, and the nature of the follow-up.

Quality Assurance. In this instance, quality assurance will focus on the eight training items noted above. The method will be direct observation of the lead CHAs at the HP while they weigh, record, counsel and refer. These activities will be carried out right at the HP under the direct supervision of an AN. The AN will take some time during the day to observe the lead CHA in the process of carrying out these activities and will record her observations on a special form designed by the program for that purpose. The quality of the counseling and follow-up activities in the community by the CHA/CHVs will be monitored through their monthly reports and quality assurance check lists that they fill out each time they visit a home. A feedback session will be held to evaluate their performance and provide "on the spot" training for those who may need it. The work of both the field-based and HP-based health workers will be supervised by ADRA's field supervisor and/or project health coordinator.

The program will cover children under five. All children under two will be considered at high risk, as about 50 percent are anticipated to suffer from some

degree of malnutrition. Within that group, children with moderate and severe malnutrition will be on highest priority. They will be identified through the routine population-based monitoring and screening activities at the HPs, and the criterion used for faltering will be a flattening out of the growth curve on the monitoring graph.

Growth cards are home based records which will be kept by the mothers. They will be placed in plastic bags for maternal *retention.* Mothers who lose the card will need to purchase one to continue in the program. The information on the original record is kept in the main registry at the HP and with the CHA and will be transferred to the new card. Experience shows that most mothers keep their GM cards secure to avoid paying for a replacement. The card has space for vitamin A recording. It has also advice on EPI, sanitation, nutrition and GM, and is complete with illustrations and important dates. (See Appendix O for MOH GM/EPI Card.) To supplement erratic supply by MOH, ADRA will have the cards printed at the Adventist Press in Port-au-Prince.

GM data will be used on an individual basis to counsel mothers and refer malnourished children, and on a population basis to assess program impact. The data will also be used to fulfill MOH reporting requirements.

Each health worker will be made aware of the following points derived from data assessment: A) the level of attendance of mothers and children at growth monitoring sessions; B) the distribution of the nutritional status of children; and C) the trends in nutritional status indicators.

Community organizations and leaders will be invited to special briefing sessions (every three months) where these data will be presented in a user-friendly form. Suggestions of approaches to improve attendance or compliance will be solicited.

Pregnancy and Lactation

6. Nutrition Status: Data from the nationwide health survey (Cayemittes et al, 1885) document that 48 percent of mothers have a BMI (kg/m2) below 20.5, a level deemed by the Institute of Medicine of the United States to signify an underweight status. The average BMI in the Port-au-Prince metro area is 22.5, as opposed to 22.1 for the country as a whole (Cayemittes et al, 1995). The birth weight distribution in the area is not known. The program plans to measure the height and weight of all pregnant women and will seek to provide supplemental food to all such women during the last six months of pregnancy.

7. Current Beliefs and Practices: There are no recent data on food consumption patterns of pregnant women. The question on the percentage of pregnant women who eat more, the same or less than usual during pregnancy was omitted by mistake from the Baseline Survey questionnaire, and ADRA will correct this void by undertaking focus group qualitative surveys in the early phases of the project. The information to be gathered will concern the amount of food taken by the pregnant woman; the variety of food consumed and their content in iron, vitamin A, vitamin C and iodine; work habits during pregnancy and lactation; and the source of advice during pregnancy and lactation. In addition, there will be questions related to what foods women introduce to their breastfeeding infants before six months; why they introduce these foods; culturally promoted diets during pregnancy and lactation; and beliefs about food that limit a woman's acceptance of the variety/quantity of food that the project is advocating. Technical assistance and educational materials will be obtained from UNICEF and INSAC to train CHV/CHAs engaged in breastfeeding promotion.

Haitian pregnant women consider a number of foods to be taboo during pregnancy and do not necessarily wish to gain much weight for fear that the fetus will be too big, thus leading to a difficult delivery. Pregnant women do not change their work patterns until practically the day of delivery. During the first month after delivery, they remain at home under the care of their family and do not work. Lactating mothers may not breastfeed if they feel they are weak or if they have an infection. During pregnancy and lactation, they seek advice from their own mother or grandmother, and more rarely, from their stepmother.

Other likely causes of maternal nutritional problems

Iron supplements? MOH is not in area - where is get them?

include lack of appetite, particularly in the first three months, continued energy expenditure which is not compensated by increased food intake (lack of iron resulting in anemia and a heavy work overload coupled with inadequate caloric intake), and the lack of variety in the diet due to economic constraints.

8. MOH Policy and Nutrition Activities in the Area: MOH policy in this area focuses on the monitoring of weight gain during pregnancy, using a maternal health card, supplementation with iron and folic acid, detection of complications of pregnancy during prenatal visits, and referral of complicated cases. The MOH makes available iron and folic acid tablets as well as scales for weighing pregnant women. It has no specific requirements pertaining to supplemental food, and there is no food fortification program.

9. Program Approach: The overall approach focuses on assigning specific number of homes to CHAs/CHVs living in the neighborhood of the beneficiary population. They will register the names and addresses of every woman in their territory (done through HH registration at the start of the project). This way both pregnant and lactating women will be identified, enrolled, referred and followed up for education, counseling and promotion of prenatal and postnatal care and distribution of vitamin A. Women will also be reached by CHVs during monthly meetings. High risk groups will be reached through home visits and monthly women's gatherings.

The specific approach comprises the following elements: A) door-to-door identification and registration of all pregnant women in the catchment area by the CHV/CHA; B) creation of a pregnancy register which records pertinent information for each woman and the newborn through age one month by the CHA/CHV; C) systematic invitation or referral of pregnant women to prenatal visits at community HPs by the CHA/CHV; D) screening of pregnant women at HPs (height, weight, quick examination to detect obvious signs of edema or anemia) by the AN; E) iron and folic acid tablet administration at HP by the AN; F) TT vaccination at HP by the AN; G) counseling pertaining to nutrition during pregnancy, postpartum contraception, care of the newborn and breastfeeding by the CHV/CHA at the home level and by the AN at the HP; H) referrals of all pregnant women to the Adventist Hospital to see a gynecologist by the AN; and I) promotion of iodized salt by health workers at all levels.

Messages to be communicated to pregnant women include the following: A) eat a variety of foods; B) eat foods rich in iron, vitamin A, and calories; C) drink several glasses of water; D)avoid alcoholic drinks; E) to avoid nausea or vomiting, eat several small meals every day; F) get extra rest and food; and G) refrain from hard labor.

The messages will be delivered via all available channels including the following: A) churches--through women's ministry's groups at church; B) community organizations--through monthly women's gatherings by the CHA/CHV; C) radio--three times per week through the Adventist radio station located in the project area by the project director; D) community HPs--through the AN and CHAs during prenatal visits; E) the hospital--through the FP clinic and prenatal visits by RNs and gynecologists when referred; and F) private physicians--during prenatal care by the physician.

A number of qualitative assessments on food habits of pregnant women have been done in Haiti, leading to the publication of two nutrition guides. One published by the National Child Survival Alliance under MOH, USAID, PAHO/WHO and UNICEF sponsorship (*Learn How to Eat Well to be in Good Health*), and the second one by CARE (*Guide for the Collaborator for Health Education*, 1989). These guides are thorough and adequate for ADRA's needs. Thus, much of the work in message development has already been done, and the program will not seek to reinvent the wheel. Nonetheless, specific problems encountered by pregnant women in the ADRA catchment area will be explored through focus group interviews as noted above. good

Educational methods to be used include street theaters (the PL 480 project staff have a drama group that the project will coordinate with) and role playing videos, songs, IEC materials (posters, flip charts, pictures, stories, etc.), and games. This is in addition to individual face to face encounters between pregnant women and CHWs at home, and pregnant

Supplies of Vit A in?

women and ANs at community HPs. The documentation is already available for these *(CARE RICHES*, 1989*)*. Lectures and participatory dialogue will occur during women's monthly meetings where mothers will be involved in the message design. One to one counseling will take place during CHV/CHA home visitations and at the HP. Here counseling cards and action posters that provide advice for specific nutrition conditions will be used. Videos will be shown in the Adventist Hospital waiting/conference room area. This will be followed by mother to mother exchange of ideas. CHAs/CHVs will be trained on IEC skills to facilitate this process.

good

Trainees to provide counseling to mothers will be ANs and CHWs. The effectiveness of the training will be measured on an input and output basis. Effectiveness of messages in terms of behavior change will be monitored via compliance regarding the number of visits including physician referrals; compliance with the use of iron and folic acid tablets; and documentation of weight gain during pregnancy.

Input-wise, health workers will fill out monthly monitoring forms which summarize their contact and the type of health education or other service provided. Outputs will be assessed through data on weight gain recorded on the maternal health card, a home based record similar to the GM chart used for children (see Section F on HIS).

Major constraints to improving maternal nutrition status are primarily socioeconomic in nature. Pregnant women continue to work hard and have little added opportunity to rest. It will be difficult for ADRA to deal with this constraint. However, education and counseling are hoped to reduce the problem. Other constraints pertaining to women's knowledge concerning nutritional concerns will be overcome via the program described above. In addition, the provision of supplemental food as well as dietary supplements of iron and folic acid to pregnant women is expected to correct much in terms of nutritional deficits.

10. Program Approach to Micronutrients: The WHO classifies the severity of vitamin A deficiency among preschool children in Haiti as "clinical." The term "clinical" indicates the prevalence of night blindness at > 1 percent; Bitot's spots at > 0.5 percent; corneal xerosis and/or ulceration at > 0.01 percent; or xerophthalmia related corneal scars at > 0.05 percent *(Micronutrient Deficiency Information System,* WHO, Global Prevalence of VAD MDIS Working Paper #2, WHO/UNICEF, Geneva, 1995).

For anemia, PAHO/WHO reports that 35 percent of pregnant women and 33 percent of children in Haiti suffer from nutritional anemia (PAHO/WHO, 1993). The prevalence of goiter in Central Haiti is around 10 percent, and no data are available for goiter in urban areas such as Carrefour (PAHO/WHO, 1996*)*. The MOH recommends that all children twelve months to six years old receive a capsule of 200,000 units of vitamin A every six months. The MOH also recommends that all pregnant women receive iron and folic acid tablets. Vitamin A, iron and folic acid tablets are available through PROMESS, the essential drug supplier (see below for specific doses to be used in the program).

ADRA will provide vitamin A capsules using the MOH schedule to all children six months to six years at the HP through the AN, and at the home level on a door-to-door basis (during home visits by the CHA/CHV). The purpose is to reduce the incidence of xerophthalmia and lower the mortality of children one to four years old. The schedule followed would be 100,000 IU for children six months to twelve months, and 200,000 IU for children twelve months to 72 months. Mothers will also receive 200,000 IU (vitamin A) once during the first month after pregnancy. Pregnant/lactating women will receive iron and folic acid tablets from the AN as they visit the community HPs. Iron is needed to supply the growing fetus and placenta and to increase maternal red cell mass. The higher hemoglobin concentration which occurs as a result of an improved iron supply "not only increases the oxygen-carrying capacity, but it also provides a buffer against the blood loss that will occur during delivery" *(*Hallberg, 1988*)*. Iron supplementation will begin at about week twelve of gestation (the beginning of the second trimester), when the iron requirements for pregnancy begin to increase. Iron administration at a dose of 60-120 mg per day in divided doses will be provided until there is evidence that the hemoglobin level is normal. At that time, supplementation will be 30 mg per day.

Will project do this?

Folate supplementation is provided to prevent megaloblastic anemia of pregnancy. In addition, some evidence is available showing that folate may prevent neural tube defects in the fetus and small for gestational age births. The dose provided to pregnant women will be 300 micrograms daily (from midterm to term). The project will also promote use of iodized salt.

The standard RTH card will be used to document vitamin A distribution to children (also during mass immunization). For mothers, both vitamin A and iron/folate supplementation will be recorded on the maternal card. If any of these cards are lost, they will be replaced following the same procedure described earlier. GM and EPI visits at HP's will coincide with vitamin A distribution activities. This will reduce the need for an excessive number of visits. PROMESS is a reliable source of supply, and the program will distribute dietary supplements on a routine basis.

As noted above, educational messages for pregnant women will contain a dietary component focusing on the importance of consuming foods rich in iron, folate and vitamin C. For children, messages focusing on vitamin A rich food (dark-green leafy vegetables and locally available fruits) will be disseminated to the beneficiaries using the same approach discussed under section number nine above.

Quality Assurance. As noted before, quality assurance will focus on a high risk condition for which standards of care will be defined and monitored. The high risk condition is anemia of pregnancy. Given the intensity of the program, the occurrence of severe anemia during pregnancy should be prevented. However, any case of anemia identified during prenatal visits or at the time of delivery will be addressed. Quality assurance will be achieved in the same manner described under the quality assurance section of number five above.

11. Supplementary Foods

Program Approach: As noted earlier, the program will be integrated to that of the ADRA PL 480 Title II activities which will be the source of the supplementary food. All mothers harboring a child with moderate or severe malnutrition, or pregnant women with one child at M1 level will be eligible for supplemental food. At the time of writing this DIP, the PL 480 program was considering expanding eligibility criteria to cover all pregnant/lactating women and all mother of children < two years old. Criteria for entry are residence in the catchment area; presence of a malnourished child (M2 or M3); pregnancy/lactation maternal status (under consideration); and pregnant mothers with an M1 child. Criteria for exit are supplementation lasting eight weeks, and satisfactory weight gain.

Food will be provided twice per month for four distributions (eight weeks) through referral to the PL 480 centers located in the project area. Mothers will be counseled at the referral point by the PL 480 staff. Supplementary food given to a family will be recorded on follow-up sheets used by the PL 480 program to monitor its activities. The record gives an indication of the number of persons in the household, the number of children under five, and the name, age and weight of the index child at the time the family is enrolled in the food supplementation program. The program ensures that the food reaches the target beneficiary by giving enough food for the entire family, not just the malnourished child. To discourage mothers from selling the food, the ration is divided into small portions and distributed twice per month. The nutrition value of the ration includes fats/energy, proteins and carbohydrates (a bottle of oil, and wheat and soybean blend in a flour form).

12. Home Gardens: Not planned intervention.

13. Other Issues

(a) Staff Expertise. The field program director holds a degree in public health and is fully cognizant in nutrition issues. Prior to becoming director of the ADRA Haiti CS Program, Dr. Annie Henry was in charge of the MCH PL 480 Title II food supplementation program and director of the nutrition rehabilitation program at the Adventist Hospital. The project health coordinator, who supervises ANs and the field supervisor, is an RN with extensive nutrition training and experience. At the time of DIP preparation, the service delivery staff had not been recruited. Experience with nutrition will be a prerequisite for the recruitment of ANs. Similarly, an effort will be made to recruit CHAs already experienced in nutrition. All field personnel will

LINKAGES

receive a pretest to detect any weakness in nutrition knowledge, and the program will develop a competency-based approach to training which specifically addresses identified weakness areas. A cover page of the training syllabus is provided in Appendix G. Also, see Appendix M for the generic project training form.

(b) Baseline Survey Results. (See Baseline Survey document.)

(c) Current Services. Currently, Hands of Love and the ADRA PL 480 program provide nutrition services. Strengths include a well-trained staff with extensive experience in GM and counseling. Existing weaknesses pertain to a lack of community outreach services and the absence of effective follow-up and referral protocols for growth defaulters.

(d) Complementarity. Given this state of affairs, project will adopt has adopted a strategy which takes into account the comparative advantage of each institution. The Adventist Hospital will treat children whose malnutrition is complicated by another illness, usually an infection. Hands of Love will receive children in need of rehabilitation. The project will refer M2 and M3 cases for nutrition rehabilitation to both institutions. Discharged children will be followed up in the community by CHA/CHVs to assure that they are not faltering in growth. The ADRA PL 480 program will be used to refer children in need of supplementation based on the criteria discussed earlier. The ADRA CS program will maintain a pro-active approach to surveillance where mothers are actively invited to participate.

(e) Staff Training. Same as in other interventions. See Appendix Z.

(f) Quality Monitoring and Improvement. Same as in other interventions.

(g) MOH versus International Practice. There is no difference between MOH policies and international practice.

D.4.3 Breastfeeding Promotion

1. Current Knowledge and Practices: At the time of the survey, only 18 percent of mothers were breastfeeding, although 92 percent had breastfed at one time or another. Only 7 percent of mothers have breastfed exclusively during the first four to six months of the infant's life, and 88 percent have bottle fed their baby, although 46 percent know the bottle does not give adequate protection against diarrhea, and 64 percent admit that the bottle is difficult to keep sterilized. Only 6.4 percent give colostrum to their babies. (See section D.4.2 for further details.) There is no information on when mothers stop breastfeeding. Only 6 percent of children 21-24 months are still being breastfed. Of the mothers who stop breastfeeding, 1.4 percent resume.

The indicators on the percentage of mothers who can name one or more benefits of breastfeeding for the mother and the child, and the percentage who knows that exclusive breastfeeding is an effective method of birth spacing were omitted by mistake from the KPC Survey. ADRA will conduct qualitative surveys on these issues and determine the current attitudes and beliefs of family members, community leaders, and staff toward exclusive breastfeeding knowledge and practices.

Mentioned breastfed early.

Supplementary liquids are typically introduced in the first month of life (water, cow milk, semi-solid foods at times). Generally, prelacteals are not given except at times with sweetened water. Mothers in the ADRA catchment area, and elsewhere in Haiti, are having a hard time breastfeeding. Elegant research carried out in Haiti (Devlin et al 1996) has documented that the principal *constraint to breastfeeding* is absence of the mother from the home during most of the day. The Carrefour area is no different from the rest of Haiti: 66 percent of mothers are away from home during the day, and during that time, the child is cared for by other relatives, neighbors, siblings or by the father. 33% are home!

The program does not at present have enough information on practical approaches to overcoming the constraints to breastfeeding, and will make it a priority to elicit the participation of mothers and community members in finding a solution to these constraints through qualitative studies.

2. MOH Protocols, and Breastfeeding-related Activity in the Area: The national breastfeeding

WELLSTART curricula

council provides free training in breastfeeding promotion to all health facilities, and seeks to establish a network of baby-friendly hospitals. MOH policy promotes exclusive breastfeeding for the first six months of life. At present, there is no law pertaining to breast milk substitutes. All pharmacies in the area sell formulas, and formulas are heavily promoted through the mass media. There are no current breastfeeding promotion activities in the project area. Nor are there any programs in the area with policies which discourage breastfeeding aside from aggressive promotion on the radio of breast milk substitutes. Infant formula is not provided by the ADRA PL 480 program.

3. Approach: ADRA has determined that a focus on "baby-friendly hospitals" is appropriate but insufficient to promote exclusive breastfeeding effectively. The "baby-friendly" approach will be developed at the Adventist Hospital, with the assistance of UNICEF and the National Council on Breastfeeding (the hospital will follow-up on that). Several potential avenues are open to overcome the constraints faced by mothers interested in breastfeeding.

First, breastfeeding must be promoted and perceived by the mothers to be much more advantageous than bottle feeding, for health and economic reasons. This will be achieved through the use of messages on breastfeeding, using all available communication channels, including churches (through women's ministry groups), schools (through child to parent communication and teachers), and radio spots (through the Adventist radio station in the project area by the project director), as well as individual face-to-face communication at community HPs (through ANs), home visits (through CHVs/CHAs), and at the hospital (through RNs and ANs). The quality of counseling will be assured by using the AN checklist developed from the WHO/UNICEF declaration on breastfeeding. The following key points will be included in the checklist: nutritional needs during lactation; advantages of breastfeeding; means of stimulating lactation; prevention of lactation-related problems such as breast engorgement and inflammation; and follow-up support visits. See Appendix L for key IEC messages on breastfeeding.

Second, a practical solution must be offered to working mothers who want to breastfeed their baby (66 percent of mothers do not stay at home). ADRA will seek to determine the following: A) the possibilities for conservation of breast milk in the home; B) how far mothers go when they leave home; C) the willingness of alternate care takers to give breast milk to the baby; and D) the possibility that the baby could accompany the mother if she were provided with a baby carrier. This information will be obtained via a small scale operations research using qualitative techniques and involving mothers, caretakers, and other community members. The actual cost of bottle feeding and its limitations will also be determined and communicated to mothers.

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Third, depending on the avenues suggested by the research, ADRA may embark on a program to either A) ensure that absent mothers express their breast milk before leaving home and instruct the care taker to use the expressed milk; B) take the child with them wherever they go; or C) come back home frequently enough to breastfeed their child. No breastfeeding promotion activity currently exists in the area.

The quality of counseling by CHWs will be monitored by reviewing the checklist CHVs have to fill out to assure that the key messages have been delivered. Spot checks and intense supervision by lead CHAs during counseling sessions will also improve the quality of breastfeeding counseling provided to mothers.

4. Other Issues

(a) Staff Expertise. The field program director holds a degree in public health and is fully cognizant in nutrition and breastfeeding issues. The project health and training coordinators also have expertise in the field which will be used to strengthen the supervision and training activities of CHWs. Experience with breastfeeding promotion will be a prerequisite for the recruitment of ANs. Similarly, an effort will be made to recruit health agents already experienced in breastfeeding promotion. All field personnel will receive a pretest to detect any weakness in relevant knowledge, and the program will develop a competency-based approach to training which specifically addresses identified weakness areas. The training manual prepared by

UNICEF will be adapted to the level of CHWs and ANs.

(b) Baseline Survey Results. (See the Baseline Survey document.)

(c) Current Activities. This will be a new activity. ADRA will encourage the Adventist Hospital to enroll in the UNICEF "Baby-Friendly Hospital" program. Technical assistance on breastfeeding will be provided by UNICEF.

(d) Complementarity. See section D.4.2.

(e) Staff Training. The training will cover three, two-hour sessions for the initial program, and one, two-hour session once every six months. See Appendix Z. After the training, the CHWs will be accompanied by the field supervisor and lead CHAs during the initial work of field activities to assess their counseling capabilities with regard to breastfeeding. The field supervisor doing the training/supervision will use a check list for this purpose.
The focus of the training will be the new community health workers (CHVs/CHAs/ANs). At the end of the training, each worker will be able to explain to a mother the following important points about breastfeeding: when to start, how often, how long to continue, practices that promote milk production, and whom to see and where to go if there are problems.

(f) Quality Monitoring and Improvement. As noted earlier, quality is defined as "doing the right thing right." In the case of breastfeeding, doing the wrong thing will be the introduction of water or other fluids in the diet of an infant less than six months old. Thus, the program will use a standard (i.e., a prime health message) checklist which is important for the health worker to communicate to the mother. The relevant supervisor (see section E.3) must review the checklists in the evaluation of the health worker performance.

The standard message which will be used as a proxy to assess the quality of breastfeeding counseling is as follows: *Feed your infant only breast milk immediately after birth; continue feeding only breast milk, with no water, for the first six months.* ANs at the HP, during supervisory exercises, will verify whether lead CHAs give the message appropriately and whether the mother fully understood, through observation and exit interviews.

(g) MOH versus International Practices. There is no difference between MOH policies and international practice.

D.4.4 Diarrhea Case Management

1. MOH Protocols. The MOH protocols on diarrhea emphasize the reduction of diarrhea-associated mortality and malnutrition through prompt and appropriate case management of all episodes at home with fluid and dietary management, and appropriate treatment of more severe episodes by health workers. The MOH has developed teaching aids which summarize the protocol in question and directs the mother to assess the gravity of diarrhea by observing the baby's condition and pinching his skin, to prepare ORS (three soda bottles of water mixed with an ORS packet), and to administer the appropriate quantity of ORS solution to the baby after each diarrhea episode.

The first choice recommended by the MOH during diarrhea is ORS. The second choice, in the absence of ORS, is the use of available food-based fluids such as guava water (guava leaves, water, salt, sugar mixture), carrot water (grated carrots, water sugar, salt mixture), or rice water (socked rice water, salt, water mixture), which should be replaced by ORS solution. The protocol also teaches mothers how to recognize when the baby should be taken to a health establishment for further care. The MOH protocol for dysentery and bloody/persistent diarrhea in children is to manage it with medication at the health facility.

2. Incidence and Distribution. In Haiti, each child has on the average seven episodes of diarrhea per year (WHO/PAHO, 1993). EMMUS (Cayemittes et al, 1995) data suggest that the incidence of diarrhea (two-week recall) is 27 percent for children under five, and that 12 percent of children with diarrhea have signs suggestive of dysentery (3 percent of all children). Corresponding data for the ADRA catchment area are 49.7 percent, suggesting that 5-6 percent of cases may be dysentery. At the Adventist Hospital, 10 percent of children with diarrhea are

reported to manifest dysentery (hospital records). There is no information on antibiotic-resistant dysentery. Generally, patients respond well to deworming drugs and antibiotics in the project area. Children 6-11 months are most prone to diarrhea. There is no information on the incidence of persistence of diarrhea. Health centers tend to report more diarrhea cases in May and June which correspond to a rainy period. There is no specific information on dysentery and persistent diarrhea as causes of death in children.

3. Knowledge and Practice. During a diarrhea episode, 34 percent of mothers claim they breastfeed more than usual, and 31 percent claim they breastfeed the same as usual. Thirty-three percent of mothers claim they gave more fluids than usual, and 41 percent claim they gave the same amount or more semi solid food. While 18 percent gave only breast milk, the remainder decreased the amount of food or stopped completely *(KPC Survey)*. The national ORT usage rate is 31 percent *(State of the World's Children,* 1997*)*.

In terms of treatment, 18.5 percent of mothers did nothing, while 45.2 percent used ORS packets, and 11.6 percent used sugar-salt solutions. Eleven percent used anti-diarrhea medicine *(KPC Survey)*. When the flavor of ORS is resisted by children, mothers do not force feed them. Often when mothers do not see an immediate cure for diarrhea with the use of ORT, they lose confidence and revert to other forms of treatment including anti-diarrheal medications and antibiotics, or any injection they can obtain from the local pharmacy. Although illegal, antibiotics are freely sold on the streets and markets. In health centers, the tendency is to treat children who require hospitalization for diarrhea with intravenous fluids even when the child could take an oral solution. Pharmacies offer ORS in packets and bottles (very expensive), as well as numerous anti-diarrheal preparations which are very popular.

4. Approach. Again, the overall approach is to use "all available channels" to promote ORT. This includes messages at church (through women's ministry groups); schools (through child to parent communication, teachers); radio station (through Adventist radio by the project director); contact with private physicians and private pharmacies to encourage them to prescribe ORS to their patients when indicated; and the sale of ORS packets at as many points as possible—pharmacies, street vendors, grocery stores, supermarkets, HP community, etc.

The specific approach will begin by A) training CHVs/CHAs and ANs to identify, recognize and treat dehydrated children due to diarrhea using the MOH standard protocol; B) training CHVs/CHAs on DCM IEC skills; C) educating mothers on DCM through CHVs/CHAs with emphasis on sanitary waste disposal, clean water supply, hand washing after toilet use and before handling foods; D) strengthening the ORT corners at HPs and establishing new ORT corners at CHV/CHA homes; E) selling ORS during home visits by CHVs and at HP at a relatively reduced cost; F) participating in community sanitation campaigns organized by community groups; and G) build 80 pit latrines in cooperation with the community. Where - Who gets them?

The principal focus will be on the home management of diarrhea. The protocol for home management is illustrated through a list of key points the mothers will need to learn about ORT. These points are elaborated in subsection seven below. The main target group for these messages will be mothers. To reach them more effectively, ADRA will organize a refresher session on ORT for local private pharmacy staff as well as local private physicians who will be collaborating with the program, in addition to distributing flyers ("fiches techniques") in the guise of posters to be affixed at the door of pharmacies and in physicians waiting rooms. ADRA does not intend to monitor DCM practices of private practitioners and retailers. Children with severe cases of diarrhea and with dysentery will be referred to the Adventist Hospital for further care. (See Appendix J for MOH DCM protocol.)

Following the MOH DCM protocol, CHVs/CHAs or mothers will manage all plan A cases. For plan B, CHVs/CHAs will send patient to ORT stations at the HPs for rehydration and further evaluation. If there is progress within two hours, the baby is sent home. If not, he/she is referred to the Adventist Hospital. The hospital will assess the situation and provide plan B treatment. The baby will be closely

monitored. Based on the results of diagnosis for dysentery and persistent diarrhea, medication will be given at the hospital. Antibiotics are used for bloody diarrhea/cholera and deworming drugs for parasites. The project will reach high risk populations through CHVs/CHAs during home visits. All the children < two years of age assigned to the CHV will be registered by the CHV responsible. The target children will be reached during home visits for DCM education and ORT distribution/sell. The CHV/CHA will make the necessary follow-up visits, in case ORS is needed. The home of the CHV will also serve as an ORT post for the neighborhood. Although the quality of the case management of dysentery at the hospital/referral levels is good, ADRA has discussed some quality assurance issues with the hospital medical director and as a result, a quality control program will be gradually introduced, including the following: A) monthly evaluation of the chart of the child who received ORT, to determine the effectiveness of the diagnosis and treatment given by the health care providers; B) accepting complaints from mothers during exit interviews and following up on them with the care giver; C) providing sensitization training on patient care to the hospital care givers by the medical director; and D) conducting monthly meetings to discuss ways of improving patient satisfaction. Patients will obtain free consultancy from the referral facility, and then purchase drugs at a low cost from the community drug stores, the hospital itself or private pharmacies for those who can afford it.

At each community outreach post, mothers invited for the day (for vaccination, FP, nutrition or for other purposes) will be asked if their child has diarrhea at the moment. Mothers who answer positively will be assembled at a special corner and taught on the spot to prepare and give ORS to their child. CDD activities will be phased in as part of the global phasing in of the entire program on a sector by sector basis. High risk populations, i.e., children under two, will be reached through systematic door-to-door invitations to attend comprehensive well baby sessions at the community HPs, which will also be the site for ORT training for mothers.

At the referral level, i.e., the Adventist Hospital, the quality of case management of dysentery is good as the hospital employs fully trained pediatricians. The procedure followed for referred children is as follows: start with antibiotics and rehydrate with ORT; take stool culture; administer the appropriate antibiotic regimen depending on stool result; monitor progress; and follow-up. Hospital staff will also receive training from ADRA on DCM. At the outpatient ward, ADRA will install a VCR/TV monitor for educating mothers on ORT and other CS interventions.

5. ORS. ADRA will promote the use of ORS packets which are easily available from the central drug authority which is managed by PAHO/WHO (PROMESS). The chain of ORS distribution follows from PROMESS to ADRA storage to HPs to CHAs/CHVs to mothers and finally to the child. Packets will be purchased for resale through the various outlets mentioned above. The cost will be equivalent to $0.10 (much cheaper than at pharmacies). Mothers' use of ORS at the facility level will be monitored by asking what treatment they had initiated in the home (if they used ORS, they should describe how they prepared and administered it), and by (at the home level) the CHV/CHA, who will explain to the mother how ORS is prepared and watch how the mother administers it to the child. If there is a mistake, it will be corrected on the spot. Also, if the mother brings the child to the CHV's home during diarrhea, the mother will be asked to administer it under the CHV's supervision. These questions will be incorporated into medical records/checklists maintained by the various HPs in the area. Private physicians will be requested to maintain the same types of records.

6. Home-available Fluids. The program will not place a major emphasis on teaching mothers to make a salt-sugar solution because the preparation of this solution by mothers is frequently incorrect and unsanitary. In the absence of ORS, mothers will be advised to use available food-based fluids such as carrot water, guava tea or rice water to be replaced by a standard ORS solution as soon as possible. The recipe for making food-based fluids to be promoted in the absence of ORS is as simple as follows (example using carrot water): grate about five sticks of carrots; add one coca cola bottle of water; add two teaspoons of sugar; add one pinch of salt; boil and

wait until it is cool. The solution should be kept in a cool and clean place. The solution once prepared should be used within six to eight hours, after which it should be discarded. Mothers will be told that the mix is not food.

7. Health Education. Health education will be provided at two levels. First, at the facility level, there will be on-site preparation of ORS solution and treatment of diarrhea cases at the community HP and/or Adventist Hospital; on-site teaching of mothers on ORT administration and prevention of diarrhea at the hospital and/or the HP; and teaching the ORT to mothers conducted by private pharmacies and clinics.

Second, at the community level, there will be messages on ORT delivered via schools and churches (methods described earlier); messages on diarrhea delivered through street theaters; and messages on diarrhea delivered through CHVs/CHAs at the home level during visits. The messages to be disseminated through various channels include the following: A) continue breastfeeding during diarrhea. Increase the frequency of breastfeeding during and after diarrhea for two weeks; B) give more fluids and foods; C) to replace fluid lost during diarrhea, start giving extra fluid as soon as the child has the first loose stool. Home fluids should always be given with a spoon and cup. They should be given in small amounts and frequently. For example, give one cup after every loose stool; give it slowly with a spoon; give more if the child wants more; if the child vomits, wait ten minutes, then give fluids again but more slowly, a teaspoon every two to three minutes; and D)if the child has increased thirst, a dry mouth or is unusually irritable, start ORS. See Appendix L for Key IEC messages on ORT.

Mothers will be taught to refer the child to a health facility if he shows the following danger signs: great thirst; fever; eating or drinking poorly; blood in the stool; very frequent stools (more than ten in 24 hours); repeated vomiting; child does not get better after several days or gets worse; no urine; skin that stays wrinkled when pinched; very weak, extremely tired, or very irritable; and does not respond.

The educational methods used to communicate with mothers will include one-to-one dialogue with CHVs during their home visits, story telling with pictures, actual feeding of the sick child, ORS demos, group presentations and informal discussions during women's groups meetings. Periodic FGDs with women's groups during monthly women's meetings, and other special educational sessions, will be arranged by the CHV and ADRA staff. In addition, videos and films available at UNICEF and ADRA will be used to teach DCM concepts at the Adventist Hospital. These educational sessions would be organized by the CHVs/CHAs during their home visits. During visits, women will be reminded of the upcoming monthly meeting by the CHV (time, date and place of the meeting).

The quality of health education will be evaluated through unannounced home visits by the ADRA field supervisor and the health coordinator, who will ask the mother what the CHV/CHA taught and assess the mothers' knowledge of the information. The CHV/CHA will receive feedback on these evaluations during the monthly meeting. Careful analysis of the monthly CHV report and discussion with the CHVs during the monthly meeting will provide an opportunity to address quality assurance issues. This will be followed by CHV refresher training to improve skills on DCM. The ADRA supervisor and the health coordinator will also observe the CHVs as they present health education messages. The project has, through its PL 480 MCH project, developed educational materials for mothers. There are also materials already tested, developed, approved and endorsed by the MOH and local NGOs. These include key messages on DCM in the form of posters, leaflets and flip charts, and a complete manual.

Also, the quality of the education will be measured via "on the spot" assessment of mothers capability to prepare and administer ORS. This will be done at the ORT corner where mothers bring their children for treatment. It is anticipated that four contacts will be necessary to cover all the mother needs to know.

8. Prevention. Messages concerning prevention will also be disseminated, and they will focus on sanitation principles (stool disposal, garbage disposal, use of latrines, and hand washing) coupled with other

messages pertaining to breastfeeding, weaning practices, and the use of a safe water supply. Again, these topics will be broached in the same way as noted in section seven. As part of the matching fund, ADRA is planning to help the community construct up to eighty pit latrines to promote sanitation. The community will provide labor and land, and ADRA will provide the materials and equipment. This effort is believed to improve potable water supply indirectly.

9. Other Issues

(a) Staff Expertise. The field program director is a physician fully cognizant in DCM; as well as the project health coordinator and the ANs. An effort will be made to recruit health agents already experienced in DCM. All field personnel will receive a pretest to detect any weakness in knowledge, and the program will develop a competency-based approach to training which specifically addresses identified weakness areas.

(b) Baseline Survey Results. (See Baseline Survey document.)

(c) Current Services. The strengths of existing programs are reflected by the specialized care available to severe cases of diarrhea at the Adventist Hospital. As for other interventions, the main weakness resides with the lack of community outreach efforts and the fact that ORS packets are not universally available within easy reach of mothers. To correct the situation, ADRA will use all available channels for its social marketing of ORS, including churches, schools, and radio stations for messages, and street sellers, grocery stores, and pharmacies for the sale of ORS packets

(d) Complementarity. There will be a complimenting relationship between the HPs, the Adventist Hospital, private pharmacies/clinics, grocery stores and street vendors in that each institution will make ORS packets available for sale to mothers. The Adventist Hospital will serve as the referral point, and its services will compliment those of the community-based HPs in the treatment of dehydration and education of caretakers in DCM principles.

(e) Staff Training. The focus of the training will be the new CHWs. At the end of the training, each worker will be able to do the following: A) teach the prime messages related to the prevention and treatment of diarrheal diseases to a mother; B) describe, in simple language, at least three actions which people can take to prevent diarrheal diseases, and explain how or why those actions prevent diarrhea; C) explain to a mother what causes diarrhea and why it is dangerous; D) describe how and when treatment can be given at home; E) demonstrate to a mother how to make ORS and administer it; and F) explain what dehydration is and how to identify the danger signs of dehydration and severe diarrhea requiring referral.

The training will cover three, two-hour sessions for the initial program, and one, two-hour session once every six months. After the training, the CHW will be accompanied by a supervisor during the initial work of field activities to assess their counseling capabilities with regard to this intervention. The AN doing the supervision will use a check list for this purpose.

(f) Quality Monitoring and Improvement. Same as in other interventions.

(g) MOH versus International Practice. There is no difference between MOH policies and international practice.

D.4.5 Family Planning

1. Baseline Information: Currently 19 percent of mothers who desire no more children over the next two years or are not sure use a method of contraception *(KPC Survey)*. Based on the 1995 DHS data *(*Cayemittes et al, 1995*)*, 97.8 percent of Haitian women know at least one contraceptive method. The most frequently mentioned method is the condom (90 percent) followed by oral contraceptives (90.3 percent) and injections (84.9 percent). Among married women living in the Port-au-Prince metro area, 21.8 percent use a modern method of contraception. The main reason for not using a modern method is religious or philosophical in nature. Contraceptive prevalence rate in Haiti is 18 percent *(State of the World's Children,* 1997*)*. ADRA will seek to determine what mothers think

about the current quality of FP services by having a rapid exit interview type survey of FP clients leaving the Adventist Hospital, and by incorporating into its qualitative survey questions on that topic.

2. Current Family Planning Services and Constraints: Nationwide, FP services are coordinated by the Reproductive Health Division of the MOH. FP is considered one of the key elements of the package of health series to be provided at the UCS level. A method mix is favored in order to give an adequate choice to all potential clients. Much of the FP service delivery network is demedicalized as CHWs are used frequently to distribute pills and condoms. Usually, Depo-Provera injections are performed by nurses at health centers, or physicians at private clinics, while IUDs and Norplant are usually inserted by physicians. Surgical contraception is carried out by gynecologists and surgeons.

Only about two-thirds of health facilities in the country provide FP services and facilities with capabilities for Norplant insertion and surgical contraception are very limited. The Adventist Hospital, the only facility with FP services in the ADRA project area, runs a busy FP clinic with a community outreach program. The clinic manages 28 FP promoters (six men, 22 women) at the community level. The clinic-based staff include two supervising RNs, two ANs, a pharmacist, a logistician/distributor, and two gynecologists. Some contraceptives are available at the local private pharmacies. The hospital is the local distributor of contraceptives for area providers. Contraceptives are currently being obtained from PROMESS. Through the Adventist Hospital, FP services currently available include counseling, provision of IUD, Norplant, pills, Depo-Provera, condoms, foams and sterilization for both men and women. Thus in the area, access to commodities is not the major problem as a number of outlets exist, commercial and noncommercial. The FP promoters of the hospital distribute condoms and pills freely at the community level, and refer for other FP services to the clinic

Costs for FP Services at the Clinic

Type of FP Service	Cost in $
1. A packet of condoms (3 condoms)	0.3
2. A packet of pills (for 3 months)	0.3
3. Norplant (for 5 years)	2.0
4. Depo-Provera (1 shot for 3 months)	0.5
5. Tubaligation or vasectomy (for life)	2.0
6. Foam tablets (3 months supply)	0.3
7. IUD	1.9

The maintenance of a supply of contraceptive commodities does not constitute a problem as PROMESS is located in Port-au-Prince. The hospital and ADRA will obtain commodities from PROMESS on a quarterly basis. ADRA will release them to the HPs from where CHVs/CHAs receive the supplies for distribution/sell to men and women in the communities. Similarly, clients have enough of a choice in deciding where to obtain contraceptives and what kind to obtain. The constraints have been alluded to above: if one excludes pregnant women, women who desire a child and women who for some reason or another do not believe they need contraception, one accounts for 70 percent of nonusers. Of the remainder, 19 percent already employ a method. What is left are women who object to FP for philosophical or religious reasons, and women who have insufficient information. These will be the target of the ADRA FP program. Other constraints include the following: A) some men reject condoms because they lack sensation or are too oily and smelly. UNICEF has changed the brand of

condoms and acceptance of the new brand is being studied; B) in some women, the Depo-Provera causes hemorrhage, and they are afraid of using it. When complaints in this regard occur, women will be advised to change to other methods of contraception; C) the acceptance and compliance rates of pills is low among women. A FGD will be conducted to identify the reasons and devise solutions; and D) not many men come to the hospital for FP services. ADRA will continue to educate and promote the importance of FP to men, women, children and the family.

3. Approach. The program will address issues of FP promotion, education, identification of potential clients, distribution of commodities, referral, and maintaining a constant supply of contraceptives.

Promotion will be done using "all available channels," including the radio station, community HPs, and women's and community groups using standard mass media messages, as well as face-to-face communication techniques. The promotional campaign will emphasize the advantages of birth spacing for the health of the child and the family, and will use ready-made materials prepared by agencies involved in social marketing of contraceptives (PSI), particularly oral contraceptives, condoms and Depo-Provera. These agencies will be asked to share their promotional material and techniques with ADRA.

Education and counseling will be done on a face-to-face basis at the HPs and during home visits. In keeping with the notion of integrated services, all women invited to a HP session will be briefed on contraceptive matters and offered oral contraceptives or condoms, or will be referred to the Adventist Hospital for other methods.

This project will be involved in educating and promoting FP activities in the communities through CHV/CHV home-to-home educational visits, monthly women's group meetings and during EPI mass campaigns. The CHVs will be trained in FP communication skills. The CHVs and CHAs will also refer mothers who wish to have tubaligation to the Adventist Hospital and those needing contraceptives other than condoms and pills to the Adventist clinic. Mothers will be told where FP devices can be obtained (HPs, CHVs/CHAs, Adventist Hospital, pharmacies, and even shops for condoms). Mothers and fathers can also purchase condoms from the CHV's/CHA's homes any time to guarantee an uninterrupted supply of condoms over time. During their monthly report to the HP and ADRA, CHVs/CHAs will give an inventory of their contraceptive stock, at which time it will be decided if replenishment is necessary. This will help maintain a constant supply of FP commodities.

The quality of FP services will be monitored and improved through the monthly reports of CHVs/CHAs. Key indicators to be monitored in the report will be trends in the number of mothers using contraceptives, FP drop-off rates, maintaining constant supplies of contraceptives, permanence of services and referrals made for bisectomy. See Appendix R for FP-related HIS forms and charts to be adopted. Using male CHVs and targeting men for education during home visits and community gatherings may help reduce the problem. The project will include as many men as possible in promoting FP usage, and will recruit and train men CHVs as promoters of FP (the Adventist Hospital already has six of them), in particular the husbands of CHAs. FP classes for both genders will be given as a whole family and separately during CHV home visits. The educational approach to FP services followed by the community-based workers and facility-based practitioners is similar. The only difference is that CHVs are limited to the distribution and sale of condoms and pills, and refer to the hospital for other FP services. This project's FP intervention is in harmony with MOH policies for promoting contraceptives. Couples will be told of the pros and cons of using contraceptives during counseling sessions, and the final decision to use it or not will be theirs. There will be no imposition on them.

All women coming to the HP will be considered potential clients. Interested women will be asked to invite their male partners to the post where they can both be counseled. In addition, ADRA will pay particular attention to sexually active adolescents who will be reached through existing youth groups and community organizations in the area. They will also be invited to participate in discussions centering on family life topics at the nearest HPs, and offered the opportunity of obtaining contraceptive supplies.

ADRA will enter into an agreement with suppliers of condoms and oral contraceptives under the aegis of the social marketing program supported by the USAID/Haiti Mission. ADRA will seek assistance in the following areas from these agencies: forecasting contraceptive need; maintaining an adequate supply; storage; and record keeping. ADRA will seek to give some degree of sustainability to the FP component of its program by selling these contraceptives at the retail price suggested by the distributor. Couples will have a variety of sources for the procurement of contraceptives: ADRA, the hospital, pharmacies, street sellers etc. ADRA will maintain a constant supply of commodities by reaching an agreement with the two social marketing agencies and will rely on the hospital logistic systems for clients who require Norplant, Depo-Provera, IUDs or surgical contraception.

Monitoring for quality will be done in two ways: A) periodic exit interviews of mothers leaving HPs, conducted by temporary employees, and focusing on the content and thoroughness of the counseling provided, as well as the degree of client satisfaction; B) "mystery client" techniques whereby collaborating mothers will be recruited to observe the behavior of health workers at the post and their competence in the provision of FP services. Items to be covered using the two techniques include information provided and degree of understanding by the client; the type of choice discussed; interpersonal communication skills; and information concerning the methods themselves (mode of utilization, side effects, follow-up, referral, etc.).

As noted above, *both men and women will participate in activities for the promotion of birth spacing.* Women will receive counseling with regard to FP when they come for their invitational sessions at the HP. Interested women will be asked to *bring their partner along.* In addition, the men will be specifically targeted during home visits, when health workers will seek to discuss FP issues *with the couple* if both partners are available during the visit. While health workers will primarily do promotion, the community HPs will distribute/sell condoms and oral contraceptives, and the hospital will distribute IUDs, Depo-Provera and Norplant, and perform surgical contraception. These activities are in keeping with government policies and programs, the focus being on the integrated delivery of services at the community HP.

Training. After being trained in FP IEC, CHVs/CHAs, will be able to explain to mothers the importance of spacing births; teach the mother two natural methods to space births; and explain to the mother where she could go to obtain contraceptives. ADRA will use messages and methods of education developed by the CARE RICHES program which conducted extensive tests of these messages. The key messages are as follows: A) too many pregnancies spaced close together can be dangerous. It is desirable to wait at least two years after the baby is born; and B) breastfeeding and using the "safe time" are natural methods which help space births. (See Appendix X for MOH documentation method.)

4. Other Issues

(a) Staff Expertise. The field program director is a physician fully cognizant in FP issues. ANs will need refresher courses in FP technology. These will be provided by the program. CHWs will need to be formally trained in techniques of FP promotion, using social marketing techniques. The assistance of PSI will be obtained in this area. The Adventist Hospital maintains fully trained clinic and field staff.

(b) Baseline Survey Results. (See Baseline Survey document.)

(c) Current Services. The strengths and weaknesses of the hospital-based program have been covered. The Adventist Hospital currently distributes pills and condoms freely in the community. ADRA and the hospital will jointly be developing a plan to introduce selling contraceptive commodities according to the social marketing techniques recommended.

(d) Complementarity. The hospital FP promoters and ADRA CHV/CHA will coordinate their FP community outreach activities to compliment each others functions in a profitable manner.

(e) Staff Training. See Appendix Z for staff training plans. The training will cover three, two-hour sessions for the initial program, and one, two-hour session once every six months. After the

training, the CHW will be accompanied by a supervisor during the initial work of field activities to assess their counseling capabilities with regard to FP. The AN doing the supervision will use a check list for this purpose

(f) Quality Monitoring and Improvement. Same as other interventions. Also, see under number three above.

(g) MOH versus International Practice. There is no difference between MOH policies and international practice.

D.5 Innovations Which May Be Scaled Up

The major innovation will be the design of the program itself which involves networking with a variety of partners. To our knowledge, this will be the first time such an approach which incorporates the profit sector including commercial establishments, the nonprofit sector, churches, schools and other entities, will be introduced in Haiti, although official MOH policy calls for it. ADRA believes that many outside parties will be quite interested in monitoring this experience, as it has important implications for the UCS model which the Government seeks to implement.

D.6 Schedule of Field Program Activities

See Appendix Y for the project work plan.

Section E. Human Resources

E1. Organizational Chart

See Appendix K for ADRA Haiti CS project organizational chart.

E2. Health Workers

The program will be staffed by four ANs in charge of the four community HPs. They will be aided by two lead CHAs at each post for a total of eight (all based at the HP). There will be sixteen CHAs who will be based in the community. ADRA will recruit an additional 24 CHVs who will receive a cash incentive of approximately $15.00 per month. Except for the CHVs who will be recruited through CHCs, all the other CHAs and ANs will be employed by ADRA. They will be previously trained and active (have worked for MOH, Adventist Hospital, INSAC, CARE, etc.). Thus, there will be about one health worker for 1000 beneficiaries. This is about the ratio that the MOH uses in areas where it employs health workers. The training ADRA will provide to the CHWs will be very similar to that they received in the past by the MOH or other NGOs (for the most part, these workers were trained in the early 1980s). The only differences would be that ADRA-employed CHWs will be more knowledgeable about FP methods (some methods, such as Norplant, were not available in the early 1980s), and ADRA health workers will be exposed to the integrated case management of the sick child, an approach not developed in the early 1980s in Haiti. See Appendix P for a job description of each health worker.

The program has decided to work with these types and numbers of health workers because the work is oriented primarily to health promotion/prevention, thus there is a need for community-based workers with a strong background in counseling and social marketing skills; and the target population is urban, living in densely populated neighborhoods. There is a need for a well-organized community volunteer corps (col-vol). A health worker/volunteer can cover his or her entire neighborhood with relative ease.

Attrition rate is expected to be low because of the plans to remunerate each volunteer with $15.00/month in cash. CHW replacement, if it occurs, will be due to the fact that the worker will have found a better paying job. Such jobs are few and far between in Carrefour and Port-au-Prince. ADRA will minimize the rate of replacement by careful recruitment, using explicit criteria for worker selection, and through extensive competency-based training.

At each HP, one lead CHA/CHV will be in charge of record keeping and tracking the performance of community-based workers, while the other lead CHA will be aiding the AN in providing services. Each post will serve a direct beneficiary population of about 12,000 people.

The CHAs/CHAs will be responsible for home visits to formally invite mothers to the post, for motivational work and for keeping track of pregnant women and vital events.

Thus, a total of four ANs, eight lead CHAs, and sixteen CHAs will constitute the field staff, for a total of 28 persons. All will be new recruits and all will work full time (a 45-hour week). The additional 24 CHVs will be expected to work at least two to four hours per day. These are community women who do not work for any organization for salary. See Appendix Z for the CHWs associated with the project.

E.3 Supervision Plan

The first point that the supervision plan will stress is a well-defined structure whereby the 24 CHVs will be supervised by the 16 field-based CHAs. All the 16 field-based health workers will report to the eight center-based lead CHAs (who have duties pertaining to the health information system) and the ADRA field supervisor. The eight center-based lead CHAs report to the four ANs. The ANs report to the project health coordinator, and she in turn reports to the project director. In addition, the director supervises a training coordinator and community liaison, as well as a HIS coordinator. See Appendix Z for summary of training/supervision plan and ratio of supervisors to CHWs. All CHVs will be monitored by CHAs through spot checks and reviews of monthly reports. Spot checks with and without the CHV will be done to determine if mothers were visited and given education by CHAs and the ADRA field supervisor. The same procedure will be followed to supervise CHAs by the lead CHAs and the ADRA field supervisor. Feedback will be provided during monthly CHA/CHV meetings. HP data will be analyzed on a monthly basis by the HIS coordinator who supervises ANs and provides feedback to HP staff and CHCs. HP staff will be supervised on a weekly basis.

Second, there will be an emphasis on understanding by supervisors of the purpose of supervision. This will be accomplished at the outset by making sure supervisors at every level have a full comprehension of the job description of those they supervise (see Appendix P).

Third, supervisory schedules will be established. The schedules will begin with the end of the formal training program of CHWs. Supervisors will initially accompany workers during door-to-door visits to assess on the spot the skills of outreach workers in counseling and message delivery. Other skills pertaining to GM and other tasks at the HPs will also be assessed with direct observation. When the probationary period is completed, formal supervision will occur at random in such a way that a worker can be assessed via direct observation once every month. Problem workers (i.e., workers whose performance as measured by output indicators is not satisfactory) will experience more intensive supervision until the supervisor has properly identified the cause of the problem and corrected it. See Appendix T for the CHA/CHV supervisory review form.

The focus of the ADRA supervision structure is twofold: A) quality control. As noted earlier, the supervisor will check, in the working environment, that the health worker has mastered the contents of the intervention-related training, and that the worker can effectively and accurately transmit appropriate health messages to mothers; and B) quantity control. This refers to the volume of services provided by health workers. The data for this form of supervision will come from the various forms utilized by health workers to record their contacts and activities.

Thus, the main tools available to supervisors will be a standard checklist which contains those key critical messages used as a standard for evaluating the quality of a given intervention, and the report form which summarizes the activities and outputs of each health worker. See Appendix T for the CHA/CHV checklist of services provided to the community.

E.4 Community Committees and Groups

ADRA will hire a community liaison coordinator who will also be in charge of IEC activities. The catchment area will be divided into four areas (Coast Guard/Assad, Bizoton, Bergamotte, and Cote Plage). Each of these areas already has organized community groups which have established linkages with ADRA. In the beginning phases of the project, contacts with these groups will be rather frequent as they have agreed to undertake a number of responsibilities including recruiting candidates for CHV positions; providing houses for the community HPs; informing the population about the program goals and objectives; and conducting periodic promotional activities for the project throughout the life of the

program.

Thus, in the first six months of the project, contact is expected to be established at least once a month. After that it is expected that quarterly contacts will be sufficient, supplemented by ad hoc contacts to deal with specific issues. Community women's groups will be formed in each of the four project sites (HPs). They will meet on a monthly basis.

Community Committees

Committees	#OC	TBO	PC/M	M/Y	Purpose/Responsibility of the Committees
Community health ad hoc committees	0	4	As needed	As needed	To work on specific tasks assigned by the main CHC
Community health committees	4	0	.25 - 1	4-12	Planning community health activities, select, monitor and support CHWs, coordinate with ADRA activities, support cleaning/EPI mass campaign, promote interventions
Organized women's groups	0	4	1	12	Teaching, cooking, income generation activities, support CHW and CHC activities, etc.

OC = # of organized committees; TBO = # committees to be organized; PC/M = # of project contact/month; M/Y = # of meetings/year

E.5 Role of Country Nationals

All staff members, aside from the project director (a French citizen), are Haitians. The program will contribute to enhancing their skills in planning, budgeting, accounting, personnel management, financial management and computer use via a series of interventions which incorporate formal classroom training (i.e., computer use); technical assistance by expert consultants (HIS, monitoring and evaluation); and seminars (these will usually be organized by the MOH in an effort to develop its UCS program) in planning, personnel management, financial management, etc. See Appendix Z for training plans for key project staff.

E.6 Role of Headquarter Staff

Mr. Randy Purviance, Senior Grants Administrator at ADRA CO, will provide administrative backstopping to this project. Dr. Jay Edison, Associate Director of Health, will provide technical backstopping from ADRA CO. The following table describes the names and individuals from the PVO/Regional and CO offices who are responsible for technical and managerial backstopping of the project. (See Appendix E for the resumes of staff backstopping this project at the CO level.)

Central Office/Regional Staff Visits

Name	Office	Visit/Year	Days/Visit	Purpose
Dr. Jay Edison	CO	Twice	Up to 10	Technical
Dr. Solomon Wako	CO	0.5	Up to 21	Evaluation
Randy Purviance	CO	Twice	Up to 5	Administration/Financial Compliance
Wally Ammundson	Regional Office	Once	Up to 5	Management

Section F. Program Monitoring/Health Information System

F.1 HIS Plan

The linchpin of the HIS will be the family register form, which is a dynamic HH census form (i.e., a form which is frequently updated). It is also the data source for establishing various registers, including the pregnancy and newborn register, which allows identification and follow-up of cohorts of births, and the follow-up sheets for children under two and WCBA. The registration form contains information

on name and address of all WCBA and children < 5 years old, vital events, vaccination status, gender, etc. See Appendix C for the HH registration form.

Each CHA/CHV will have at his disposal a complete listing of every mother and child in his neighborhood, and it will be his responsibility to update this listing up through home visits. The follow-up sheets are in fact rosters of children and mothers listed by name and identification code, with columns reserved for recording services provided (weighing, vaccinations, FP, vitamin A distribution, deworming, etc.). By consulting the roster, the health worker will know at a glance which child is receiving services and which child is not (no-shows).

The information available to the health worker will be duplicated under a centralized manual system (each community HP will maintain a duplicate roster of their target population), and each mother and child will have an individual record maintained at the post where services will be recorded. All files will be transferred to a computerized system which will provide up-to-date information of the status of any individual child or mother in relation to a given service, as well as population-based information on selected output indicators.

Data will be collected for every intervention to monitor project progress. The CHV collects pertinent data (i.e., number of women visited per month, number of key messages given to mothers using a check list, number of follow-ups made, number of children/mothers referred, number of FP devices distributed/sold, etc.) according to the intervention from mothers after each house visit or encounter with the mother's groups. The information is compiled and summarized in a simple report by the CHV/CHA, and submitted to the ADRA field supervisor and/or HP lead CHA on a monthly basis. See Appendix N for various MOH/project HIS forms and charts. The ADRA field supervisor and HP CHA/AN will review the information together, and determine if any action needs to be taken to augment work strategies or correct errors in data collection and reporting. A feedback activity will take place during the CHV/CHA monthly meeting. The ADRA field supervisor and HP lead CHAs are responsible for ensuring that the CHVs/CHAs are adequately and accurately collecting the information at the community level. Copies of the summary reports will be filed at the HP and ADRA office. A feedback session will be arranged every month with the community through the CHCs. The ADRA HIS facilitator will coordinate these activities and report to the director of the CS project every month.

F.2 Data Variables

Data variables will be collected in the following ways:

A) demographic information: age, sex, zone of residence, etc.
Method: Population HH census/registration
Frequency: One time (at the beginning of the project)
By whom: CHAs/CHVs/ANs/all project staff;
From whom: All targeted beneficiaries (WCBAs, children < two years)

B) performance indicators. These will be selected from the list of indicators in the baseline survey and through daily service or contact-based reporting at HPs. The indicators include EPI access, EPI coverage for each of the antigens, dropout rate, TT coverage, modern contraceptive usage, nutritional status of children under two, and micronutrient coverage.
Method: Service statistics collected longitudinally
Frequency: Continuous/daily
By whom: Lead CHAs at HP, (HP record keeper)
From whom: WCBA, children < two, and adult males for FP

C) select performance indicators (EPI access, EPI coverage for each of the antigens, dropout rate, TT coverage, modern contraceptive usage (both WCBA and adult males), nutritional status of children under two, micronutrient coverage, appropriate feeding practices, ORS use rate, etc.).
Method: KPC surveys
Frequency: Baseline and endline surveys
By whom: Special enumerators with technical assistance from ADRA CO.
From whom: Mothers with children < two

D) qualitative data collection. This includes constraints and hidden barriers to the use of interventions to be carried out under this project: vaccinations, nutrition of children, nutrition during

pregnancy, breastfeeding, weaning foods, DCM and FP).
Method: Focus group interviews
Frequency: One time
By whom: Trained medical anthropologist.
From whom: WCBA and men for FP

E) quality of care surveys. These have been described under each intervention.

F) community-based indicators including number of women visited/month, number of key messages given to mothers using checklist, number of follow ups made (by intervention), number of children/mothers referred, number of FP devices distributed/sold to both WCBA and adult males, number of ORS distributed/sold, etc.
Method: Home visits
Frequency: Daily
By whom: CHVs/CHAs
From whom: WCBA, adult men for FP

F.3 Data Analysis and Use

The main purpose of the information system is to produce data for decision making. This is an eight-step process which may be listed as follows (the process and activities for each of the 8-steps given below have already been discussed):
Step 1: Set objectives
Step 2: List activities
Step 3: Select indicators
Step 4: Set targets
Step 5: Collect data
Step 6: Analyze data
Step 7: Generate and share reports
Step 8: Make decisions, take actions, make adjustments
(Ref: LeSar et al, 1987)

This process will occur continuously at three levels: A) at the community level, where the CHW needs to ensure that mothers use the services available for themselves and their children. The data gathered will allow the CHW to determine which households/mothers are not utilizing the services;

B) at the HP level, where the personnel will need to know the overall performance of the sector that the HP is serving and the individual performance of each of the outreach workers assigned to the post; and

C) the project director, who needs to have information for management purposes.

Data gathered will be analyzed and used to support decision making at appropriate levels of project functions. Results of intervention monitoring/evaluation will be shared at the level where they were generated. Summaries of the monthly reports submitted by each CHV/CHA to ADRA/HP will be compiled, and results will be disseminated to project staff (by the HIS coordinator), MOH authorities (by the ADRA project director), the community committees (by the HIS coordinator), CHVs/CHAs (by the AN/ADRA field supervisor), women's groups (by the CHVs/CHAs), and CHCs (by the HIS coordinator/CHC ad hoc committee representative) during their respective monthly and quarterly meetings. By observing trends, data collected on specific variables will be used to improve coverage rates or quality of specific interventions. This also allows the assessment and evaluation of intervention activities implemented in the field (i.e., coverage rates, drop-off rates, maternal attendance rates, CHV attrition rates, etc.). The PVO home office and donors will receive copies of all quarterly and annual reports, results of midterm and final evaluations, and a final project report. Collaborating organizations will also receive feedback on project progress.

The project will also keep track of maternal and child mortality rates in the project area through local vital events registry. Using Adventist Hospital records, morbidity and mortality trends for diarrhea, measles, polio and neonatal tetanus would be monitored. These indicators will be used to measure impact. The major effect measurement tool is the KPC Survey, which has been conducted as a baseline and will be repeated at the end of the project. (See accompanying Baseline Survey document for further information.) See Appendix AA for report forms to be used for monitoring project progress.

F.4 Other HIS Issues

Personal health data will be recorded on individual forms at HPs. These forms will be accessible only to HP personnel and will be kept under lock when not in

use. Materials and equipment needed for the HIS include the following: family registration forms, individual family ID cards; individual health (medical records); pregnancy register book; sheets for rosters; GM charts (which double as child vaccination cards); maternal home-based chart (which doubles as a maternal vaccination and FP record); various check list forms and health worker activity report forms; calculators; bristol sheets to make graphs for community meetings; computer; printer; and computer software.

Technical assistance will be required for the initial family registration activities and for devising the manual and computerized data management systems. Local computer experts will be hired to provide training on relevant computer programs to the HIS coordinator and project director. The technical assistance in HIS/HH registration will be provided by the CHC. It is anticipated that the HIS will be fully operational by July 1997.

Section G. Sustainability Strategy

G.1 Sustainability Goals, Objectives and Activities

At the end of the four-year grant, the program expects that the four community HPs will be able to support their direct operating costs. This excludes the cost of the community outreach program and overhead costs linked to the operation of the ADRA Haiti CS office. The objective of the HP is to offer vaccination, nutrition, minor curative care and FP services (at project end) on a full cost- recovery basis, assuming that the community continues to provide the housing and that the MOH, through PROMESS, provides commodities, particularly vaccines, free of charge.

At the conclusion of this program, the CS project expects to leave in place the following: A) 24 trained CHVs and close to thirty trained CHAs/ANs; B) four functioning CHCs; C) groups from the community that are supportive of the CS activities including four women's groups; D) national ADRA staff trained in CS interventions and management; E) four functioning community HPs which is part of the UCS system; and F) eighty pit latrines. The local institutions and organizations that will continue to finance and provide support after CS funding is over include PROMESS and MOH as part of the UCS development plan. The Adventist Hospital is committed to continue as the referral center in the project area. ADRA has a long-term commitment and will continue to maintain presence in the project area through the Adventist Hospital. See Appendix F for an accord of agreement between the Adventist Hospital/ADRA and the government of Haiti.

ADRA's sustainability goals are to ensure that the community develops the financial basis for accessing the minimum package of interventions as defined by the MOH UCS program. Ultimately, the posts would be supervised by the local MOH infrastructures. The MOH maintains a team which supervises the Carrefour area as a program area. The team is likely to be significantly expanded as Carrefour is organized into a UCS. The process of setting up a UCS is accompanied by an effort to strengthen the monitoring and supervision capabilities of the MOH team. It is anticipated that technical assistance for this purpose will be offered by the local Mission funded under the HS 2004 health project, managed by Management Sciences for Health. Since ADRA will be a key partner in any future UCS development, it will implement activities designed to strengthen linkages with the MOH office. (ADRA will invite MOH staff in all planning exercise and will review with them the results of all studies as well as the outputs of the HIS system.) ADRA will request feedback from the MOH on reports sent and will apprise the MOH of implementation-related constraints and develop joint solutions.

The activities required are as follows: A) community HP staff fully trained in micro-management techniques (cash and inventory control, requisitions, record keeping, etc.); B) the local MOH Carrefour Office acquires the expertise and personnel for adequate field supervision; C) the local MOH office links up with local community organizations and routinely attends community meetings; and D) the establishment of a direct supply system for commodities between the hospital and the community HPs. See Appendix BB for project sustainability goals, objectives and activities.

G.2 Community Involvement

Plans for community involvement comprise the

following steps: A) meetings with organized community groups to finalize the use of the four community donated houses; B) negotiation with the community on a basic user fee for the posts; and C) setting up cooperating CHCs (ad hoc) which will meet periodically with program staff and MOH personnel to review issues of interest to the three parties.

The community has shown evidence of interest in the program by offering buildings and by actively participating in project planning. Given the current climate of active involvement in all facets of community affairs in Haiti, it is doubtful that the program will be limited in its community mobilization effort. See Appendix B for community support letters. In order to encourage continued public involvement, social marketing and regular meetings will be set up with established community groups and at these meetings the following topics will be reviewed: project objectives, accomplishments to date, problems encountered, and how the community can help resolve the problems.

G.3 Phase-over Plan

At this time, ADRA is not contemplating any phase-over plan. However, should the need to do so arise, the likely institution will be the Adventist Hospital. Such a transition could be a logical step for the hospital to take, as it would strengthen its community outreach activities. The Adventist Hospital, which is part of the UCS system, has been in existence for over twenty years and will continue to maintain a presence. The HPs are designed to become economically self-sustaining, meaning that the HPs may not present an additional financial burden to the hospital. The phase over would occur at the end of the four-year grant, should USAID not renew the program. The close involvement from the start of hospital staff in the design and implementation of the program, and the shared responsibility, will strengthen the capacity of all of the partners in the project and enhance sustainability.

G.4 Cost Recovery

The principal cost recovery mechanism will be a set contribution by mothers to receive the services at HPs. A comprehensive fee covering all services will be charged for each visit. As part of the cost recovery assessment, the feasibility of providing curative care on a fee-for-service basis to other members of the community will also be explored (treatment of minor illnesses and injuries by ANs who are already trained to treat mini illness). By and large, commodities will be sold rather than given (ORS, contraceptives), aside from vaccines, iron/folate tablets and vitamin A tablets, which will be distributed free of charge. The Adventist Hospital will be asked to join ADRA in adopting a social marketing approach to the sale of contraceptives. Currently, the hospital distributes condoms and pills freely in the communities. Clients may actually prefer the brands they have to buy.

The amount to be charged for the overall user fee will be fixed, based on a study of costs against expected use and negotiations with community and MOH representatives. The fees will be charged as soon as the HPs open. The fees will progressively increase during the life of the project while remaining affordable. The person in charge of this aspect of the project will be the community liaison. Technical assistance on cost recovery and sustainability will provided by CAPS, a local entity with expertise on the matter. See Appendix U for scope of work planned in sustainability/cost recovery by the consultant.

Section H. Budget

See Appendix CC.

Note: Please see Appendix W for the response to the proposal review comments.

This DIP was written by:

Dr Antoine Augustine, Consultant
Dr Annie Henry, Project Director
Dr Mekebeb Negerie, ADRA CO Director of Health

Edited by:
Dr Mekebeb Negerie
Gina Meekma, ADRA CO

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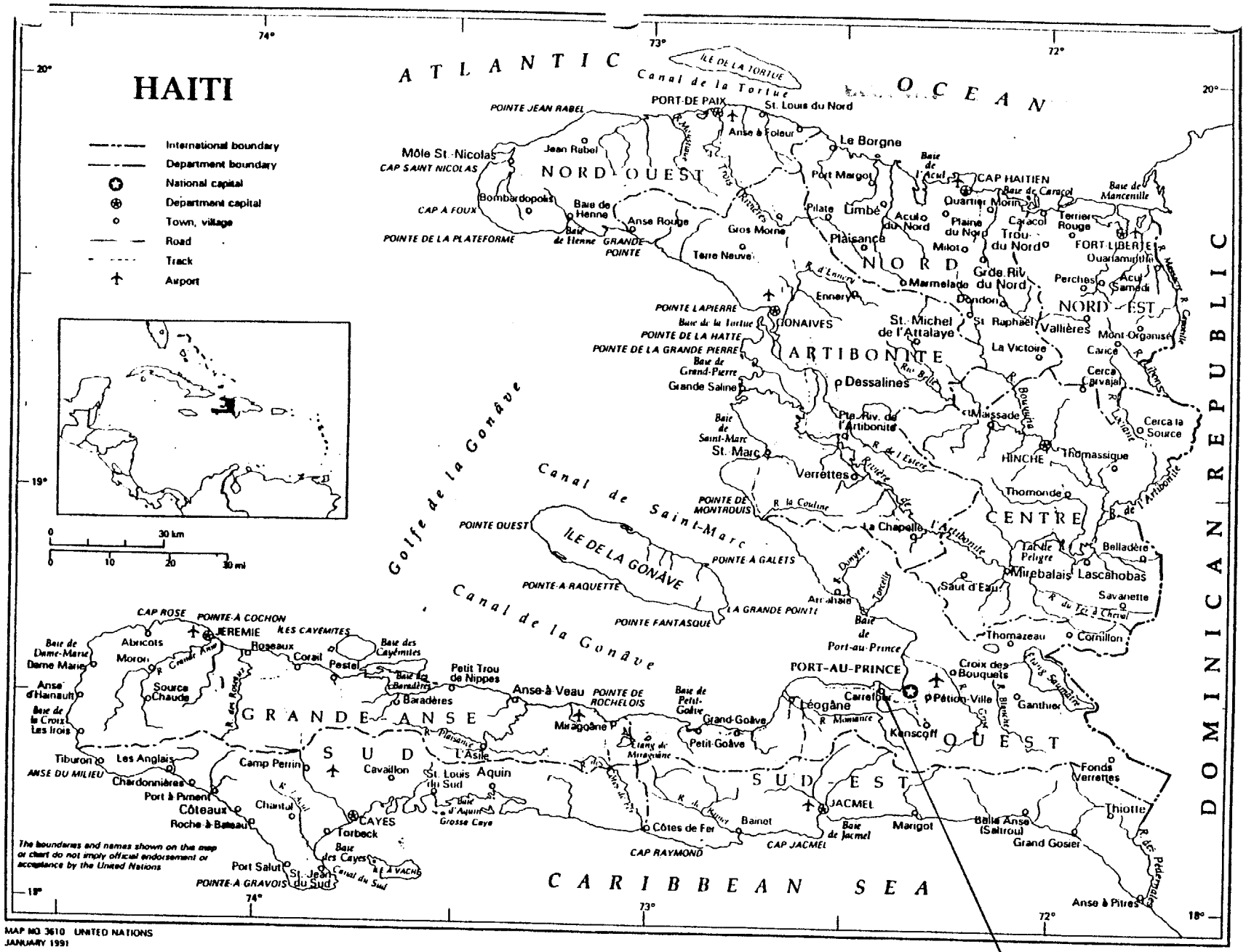
Appendix A

Project Location Maps:

Carrefour in relation to Haiti

Carrefour in relation to Port-au-Prince



Carrefour Township

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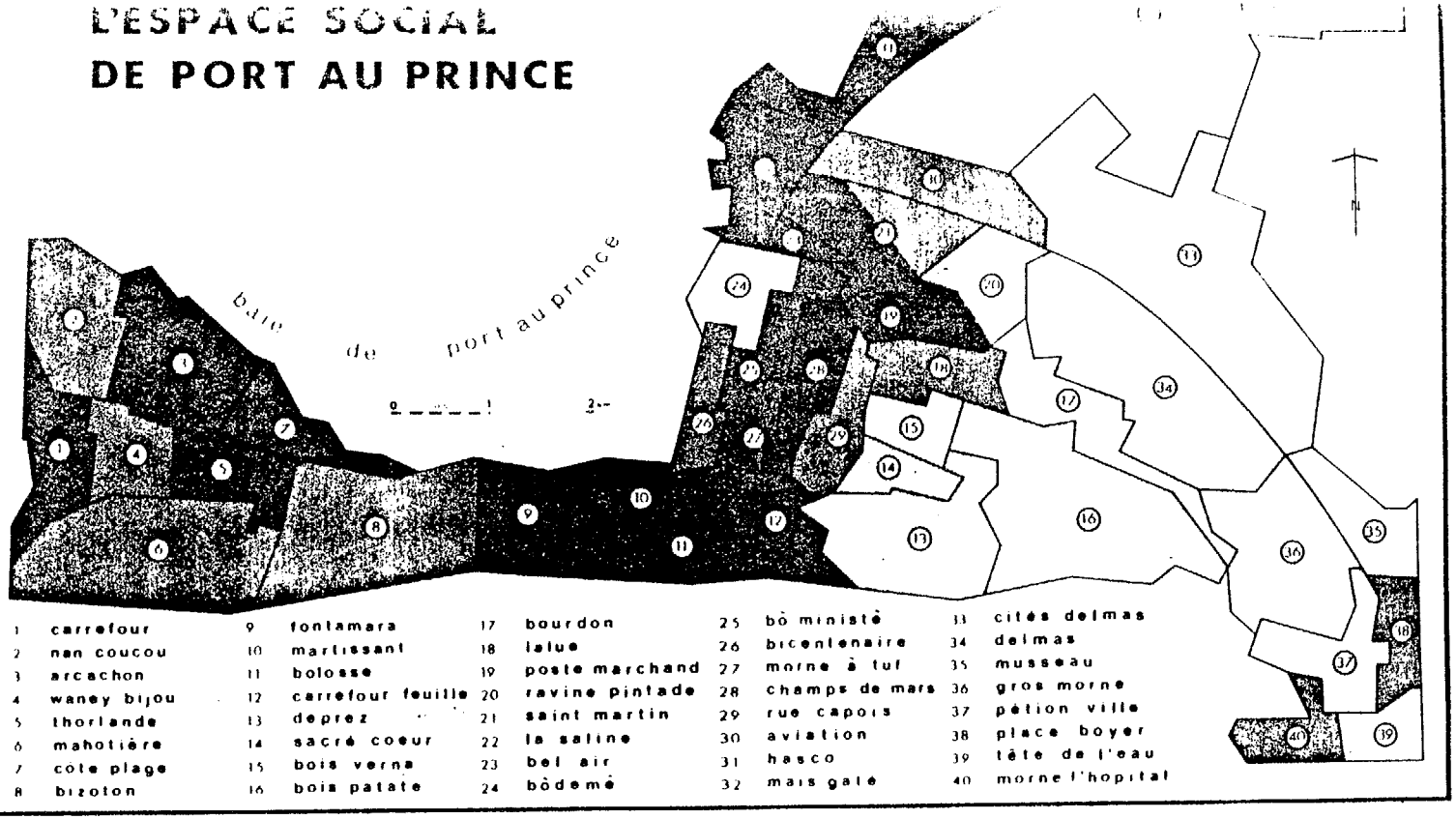
L'ESPACE SOCIAL DE PORT AU PRINCE



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Je remercie pour le matériel et la collaboration l'Atelier de Cartographie de l'UQAM, les PUQ, JC et associés, les

Presses de l'Université du Québec

Appendix B

Support Letters

ASOSIYASYON NOUVO KOMITE TET
ANSAN'M THORLANDE (ANKTAT)

COTE-PLAGE 16 ROUTE RAIL, CARREFOUR

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Port-au-Prince
Le 5-3-97

Aux responsables de l'Adra.

Nous la population de thor 14, côte-plage 16, côte-plage 1
22 et 24, accueillons avec beaucoup d'intérêt l'ini-
tiative qu'avait prise par "ADRA" de nous implanter
un centre de Santé au Service de la population. Nou
exprimons notre plus vive joie envers cette initiat
Car, c'est une toute première.

En conséquence, nous, le comité "tèt ansan'm" Somm
pret à apporter tous nos soutients à ce dit proje
Et, il serait un réel plaisir pour nous de voir
grandir ce beau projet. De Nouveau, et pourquoi
pas?

Veuillez agreer Messieurs les responsables l'ex
pression de Nos Sincères collaborations.

Ainsi Signé:

Jn Camille Gabriel. Serge Terzier. Sylvio Terzier

Fritzner Leonard. Marie Agathe Hector

St. Sauveur Julio Patrick Joseph

ASOSIYASYON NOUVO KOMITE TET ANSAN'M THORLANDE A.N.K.T.A.T

46

Marlene Dautruche

Madame Andremond
chez ti Bob
Postem Hermane Jendy
Benoit Julien
Durand Martinez
Erasa Benoit
Alfred Gob

ASOSIYASION NOUVO KOMITE TET ANSAN.M
THORLANDE
A.N.K.T.A.T

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Port-au-Prince

Le 05-03-97

A. J. P. B.

" Association des Jeunes progressistes de Bizoton"

à ADRA

Cher Bureau d'ADRA

Nous l'A. J. P. B. l'association des jeunes progressistes et la population de Bizoton # 6 et ses environs, sommes très fiers de vous écrire et de vous dire combien nous sommes contents d'avoir dans notre communauté une organisation comme la votre ainsi que l'hopital adventiste de digoni.

Après avoir constaté que votre programme visant à ameliorer la vie sanitaire, écologique, et culturelle de notre cominauté, nous membre de l'A. J. P. B en sommes très fiers et sommes d'accords de vous suivre corps et âmes dans vos projets et nous vous prions d'acepter nos paragraphes les plus distingués.

Signé les comités

A. J. P. B.

Joseph D. Mynthil

Baze Alexis

Paraison Jn chedly

Lazare Pierre Richard

O. C. M. B.

Signature de quelque notables qui font partir de la cominauté

Altenord Zéphir

Louisjeune Jn Louis

Mathéus Pascal

Fabien Daniel

Guy Bonheur

Xavier Smarc

Louis Jn Yves

A Vourete Missoule

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Port-au-Prince
Haiti
March 5, 1997

To ADRA:

We, living in the communities of Thor IX Cote Plage 16, Cole Plage 18, 22 et 24 in Carrfour, receive with great interest, the initiative taken by ADRA to implement a child survival project and serve our population. We want ADRA to know that we are delighted and the community committee "tet ansem'm" agrees to support this project. Please count on our sincere plans to collaborate.

Members of the committee (15)
Signed.

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Adventist Hospital of Haiti

March 10, 1997

ADRA INTERNATIONAL
ATTENTION: CHILD SURVIVAL PROJECT

SUBJECT: PROPOSED AGREEMENT OF MEDICAL SERVICES

Dear ADRA INTERNATIONAL

This letter is to acknowledge our (Adventist Hospital of Haiti) willingness to work in a joint venture with ADRA through the CHILD SURVIVAL PROJECT. It is the sincere desire of this Hospital to serve the Haitian people by participating in the CHILD SURVIVAL PROJECT. We are ready to provide such services as: vaccinations, medications, family planning services, surgical procedures (including vasectomy and tubular ligature), M2-M3 nutrition services, and any other service which we could render to this project.

Once again we are greatly pleased to be considered as an active partner in this extremely important and worthwhile project. If you have any questions or concerns please feel free to contact me personally. Our telephone number at the Hospital is 509-34-0521. May God continue to bless your efforts in accomplishing His work here in Haiti.

Sincerely,

Dr. Jude B. JeanBaptiste
Administrator, Adventist Hospital of Haiti

BUREAU DU
DR. JUDE B. JEAN-BAPTISTE
HOPITAL ADVENTISTE
TEL: 340521 RES: 343 804

Appendix C

Community Household Registration Form

REGISTRE DE MÉNAGE

INSTITUTION ..... DATE ..... Col. Vol. Zone Secteur Famille .....

DEPARTEMENT ..... COMMUNE ..... DISTRICT SANITAIRE .....

ADRESSE: SECTION COMMUNALE ..... HABITATION ..... N° DE SNEM .....

Rue ..... N° .....

CHEF DE MENAGE .....

DESCRIPTION DE LA MAISON

Nombre de Pièces (1, 2, 3, 4 +)

Toiture: Tôle ❑ Paille ❑ Autre ❑

Desservie par latrine: Oui ❑ Non ❑

Appareil radio: Oui ❑ Non ❑

Nombre de personnes dans la maison: .....

MATRONE VIVANT DANS LA MAISON:

Nombre avec boîte ❑ Nombre sans boîte ❑

APPROVISIONNEMENT EN EAU DE BOISSON

Tuyau ❑ Fontaine publique ❑

Source ❑ Puits arthésien ❑

Rivière ❑ Puits ordinaire ❑ Autre ❑

PERSONNES DÉCÉDÉES PENDANT CES 12 DERNIERS MOIS

Précisez nombre et sexe des décès

0-28 jours	1-11 mois	12-59 mois	5-15 ans	15-49 ans	+ 49 ans

FEMMES DÉCÉDÉES AU COURS DE L'ACCOUCHEMENT OU PEU APRES

Age	N. gros.	Lieu acc.	Matr.*	P.S.**	N. Jrs

* Matr. = Matrone ** P.S. = Professionnel de Santé

Au Premier Passage

SERIE	PERSONNES DE 5 ANS ET PLUS AUTRES QUE LES FEMMES DE 15 — 49 ANS	SEXE	NAISSANCE	ARRIVEE	MUTATION	CHANGE	QUITTE LA COHORTE: TRANSFERT	QUITTE LA COHORTE: DEPART	QUITTE LA COHORTE: DECES	Décès
	Nom et Prénom	(M. / F.)		Année		Année		Année		Cause
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

25

CLE

ETAT CIVIL

UA = Union Actuelle
UR = Union Rompue
C = Célibataire
P = Placé
M = Marié

Méthode PF / ENCEINTE

S = Stérilet
C = Condom
P = Pilule
N = Norplant
G = Grossesse
D = Dépo provera
M = Mousse vaginale
T = Tablette vaginale
SV = Stérilisation volontaire

ETAT NUTRITIONNEL

N = Normal
M1, 2, 3 = Malnutrition 1e, 2e, 3e degré
K = Kwashiorkor

Au Premier Passage

SERIE	FEMMES DE 15 — 49 ANS	NAISSANCE	ETAT CIVIL	ENF. VIVANT	VAC. TETANOS	ENCEINTE PF	ARRIVEE	MUTATION	CHANGE	QUITTE LA COHORTE			Décès
										TRANSFERT	DEPART	DECES	
	Nom et Prénom	Année	Clé	Nbre.	Doses	Clé	Année			Année			Cause
11													
12													
13													
14													
15													
16													

SERIE	ENFANTS DE MOINS DE 5 ANS	RESPONSABLE	SEXE	NAISSANCE	PRESCOLAIRE	ETATNUTRITION	VACCIN			NOUV. NAIS	ARRIVEE	CHANGEHAB.	QUITTE LA COHORTE			Décès
							DITEPER	POLIO	ROUGEOLE				TRANSFER	DEPART	DECES	
	Nom et Prénom	Série	(M.F.)	Mois / Année	X	Clé	Doses (0, 1, 2, 3 +)			Année			Année			Cause
17																
18																
19																
20																
21																

Appendix D

Key Project Staff Resumes

ACTING COUNTRY DIRECTOR

William R Holbrook
ADRA Haiti
Diquini 63, Carrefour, BP 11196
Port-au-Prince, HAITI
Tel: 509 3 41035

EDUCATION

1978	MBA - Boston University Boston, Massachusetts
1974	MS, Counseling Psychology - Loma Linda University Loma Linda, California
1972	BS, Sociology and Communication - Columbia Union College Takoma Park, Maryland

EXPERIENCE

1995 - Present	ADRA Haiti; Port-au-Prince, HAITI Title II Program Director; Country Director
1992 - 1995	ADRA/Sudan; Khartoum, SUDAN Deputy Director for Relief
1989 - 1992	Potomac Valley Hospital President
1985 - 1989	Fairfax Hospital Association Vice President
1982 - 1985	Holbrook Associates Hospital Consultant
1980 - 1982	Adventist Health System Sunbelt; Orlando, Florida Vice President
1974 - 1980	New England Memorial Hospital; Stoneham, Massachusetts Vice President

PROJECT DIRECTOR

Annie Henry
ADRA Haiti
Diquini 63, Carrefour, BP 11196
Port-au-Prince, HAITI
Tel: 509 3 41035

EDUCATION

1992	M.P.H., Loma Linda University, Loma Linda, California, USA
1981	M.D., Montpellier University School of Medicine, France
1981	Diploma. Tropical Medicine and Leprology, Montpellier, France

EXPERIENCE

1992-Present	Director of the MCH Program at ADRA Haiti
1992	Director of Child Survival Program at ADRA Haiti
1986-92	Medical Director of the Child Survival Program at ADRA Haiti
1986-90	Medical Director of the Nutritional Rehabilitation Center, Adventist Hospital Port-au-Prince, Haiti

TRAINING/IEC/COMMUNITY COORDINATOR

Marie Maud Cornely
ADRA Haiti
Diquini 63, Carrefour, BP 11196
Port-au-Prince, HAITI
Tel: 509 3 41035

EDUCATION

Jun - Dec 94	Computer courses at CETECOM Word and Excel
Jun - Jul 91	Training in Management of Health Program (INHSAC)
1990 - 1991	Haitian Institute of Communal Health (INHSAC) Specialization in Communal Health
1985 - 1989	Studies in Nursing Sciences, National College of Nursing Port-au-Prince, Haiti (ENIP)
1984 - 1989	Institute of African Research (IERAH), University of Haiti

EXPERIENCE

Dec 94 - Present	Responsible for Child Survival Program for Grac Children's Hospital/ICC (International Children's Care)
Dec 92 - Apr 93	Executive Manager of PRELAS Program (Rural Education Program for the Improvement of Health) in pestel for Medcins sans Frontieres
Jul - Dec 92	Responsible for Vaccination in pestel for the Medcins sans Frontieres (MSF)
Mar - Jun 92	Teacher and monitor of auxiliary nurse students at IEPSH at HUEH Maternity and Pediatric
1989 - 1990	Social Service at Notre Dame de la Paix Hospital of Jean Rable
1988 - 1989	Responsible at I.C.E. at Center Boulard (Arcahaie) for the Haitian Association of mothers and children (MEH)

Languages Spoken and Written:

French: very good
Creole: very good
English: understand

HIS/HEALTH COORDINATOR

Edline Joseph Toussaint
1, Impasse St-Marc, Route de Frères
Pétion-Ville, HAITI
509 57 7243

EDUCATION

1993	BA in Communal Health at Institut Haitien de Sante Communautaire Port-au-Prince, Haiti
1988	BA in Nurses Science at Ecole Nationale d'Infirmieres de Port-au-Prince Port-au-Prince, HAITI
1984	Bacc certificate (section A) at College Canado Haitien Port-au-Prince, HAITI

EXPERIENCE

May - Sept 96	Association for Haitian Family Promotion (PROFAMIL), Port-au-Prince, Community Based Distribution Project Coordinator
Mar 95 - Mar 96	Association for Haitian Family Promotion (PROFAMIL), Port-au-Prince IEC Project Coordinator
1994 - 1995	Association for Haitian Family Promotion (PROFAMIL), Port-au-Prince Coordinator Assistant of IEC section
1989 - 1991	Haitian Children Institute (IHE), Petion-Ville National Coordinator of a study on maternal child mortality

Skills

- ✦ French and Creole fluency - good knowledge in English
- ✦ Responsible of a project at the Haitian Children Institute
- ✦ Responsible of a project at the Association for Haitian Family Promotion (IPROFAMIL)
- ✦ Experience in project management.

FIELD SUPERVISOR

Ronald Calixte
Rue St-Gegard # 48 Bis
Port-au-Prince, HAITI
Tel: 509 23 8013

EDUCATION

1989	Specialization: Communal Health Haitian Institut Option: Communal Health Technician (Graduated)
1986	Gerard Armand Joseph Commercial School Option: Accounting (Graduated)

EXPERIENCE

Jan 97 - Present	ADRA Haiti Child Survival XII Field Supervisor
Nov 95 - Apr 96	Nutrition and Development Office Inspector
1993 -1995	Haitian Children Institute (IHE) and Cornell GHESKIO (Socio-Economical and Psychological Survey) Surveyor and Supervisor
1989 -1991	Humanitarian Help Union Archivist and Accountant
1989	Professional training in Communal Health at Ouanaminthe, Haiti

Languages	French - Creole (written and spoken) English (understanding)

AUXILIARY NURSE

Raymonde Pierre
Diquini 63, rue Tunnel
Carrefour, HAITI

ETUDE PROFESSIONNEI,LE

1989 - 1991	Auxilliare Sanitaire Polyvalente

EXPERIENCES

Juin 92 - Dec 95	Auxilliare dans une Organisation Non Gouvernementale Save the Children (Maissade)

LANGUES PARLEES

Creole et Francais

AUXILIARY NURSE

Micheline Calixte
Bizoton 61, Imp. Bergmothe #7
Port-au-Prince, HAITI

ETUDE PROFESSIONNELLE

1993 Ecole des Aux-Infirmieres Nightingale

EXPERIENCE

Matrone, depuis 1983
Centre de Santi Communautaire,
Child Survival Project, 1986 - 1987
(Vaccination - Education Sanitaire)
Enquetrice de terrain pour le MCH,
depuis 1993 a nos jours, (ADRA)

AUXILIARY NURSE

Julie Adrien
Route de Carrefour
Bizoton 61 # 1 Etage
Port-au-Prince, HAITI

ETUDES UNIVERSITAIRES & PROFESSIONNELLES

- Auxiliaire-Infirmiere
- Receptioniste
- Couturiere Centre d'Etude Professionnel
- Un diploma en sante communautaire a L'INHSAC

EXPERIENCES DE TRAVAIL

- De 1989 @ 1996 (7ans)
Hospital Adventiste de Diquini

SECRETARY/CASHIER

Kettely Pierre-Louis Blaise
Delmas 95, Jacquet Toto #43
Port-au-Prince, HAITI

EDUCATION

Mars - Mai 95	JC Documentation Seminaire sur la documentation (Certificat de documentation)
1994 a nos jours	Institut national d'administration de Cestion et des haus etudes internationales (INAGHEI) (Option: Sciences comptables)
1989-1991	Christ the King secretarial school (Diplome de secretariat bilingue)

EXPERIENCE

Nov 92 @ nos jours	Unite d'appui a la cooperation canadienne Secretaire
1991-1992	Societe de genie Pereira et Associes Secretaire
Dec 90 -Jan 91	Caisse populaire de Sainte Marie Verificateur

Languages	Creole - Parle Francais - Parle/ecrit Anglais - Parle/ecrit

Appendix E

Key Central Office Staff Resumes

Jay Edison
12501 Old Columbia Pike
Silver Spring, MS 20904 USA
301 680 5128

Education

1984	MPH, Loma Linda University, Loma Linda, CA
1962	MD, Loma Linda University, Loma Linda, CA
1958	B.A., Atlantic Union College, South Lancaster, MA

Experience

1997-Present	Associate Director for Health ADRA International, Silver Spring, MD
1995-1996	Country Director ADRA/Kyrgyzstan
1972-1995	Town Health Officer New York State
1973-1994	Clinical Physician and Facility Health Services Director Department of Correctional Services, New York State
1965-1995	Family Physician Whitehall Health Center, Whitehall, NY
1965-1995	School Physician New York State
1973-1995	Coroner Washington County, New York State.
1966-1972	Assistant Medical Examiner Jefferson County, New York State.
1963-1965	Captain, General Medical Officer United States Air Force
1962-1963	Professional Training Intern Washington Adventist Hospital, Takoma Park, MD

Mekebeb (Mike) Negerie
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301 680 5138

Education

1990-1994	DrPH, Health Promotion and Education Loma Linda University, School of Public Health, Loma Linda, CA
1983-1985	MPH, Primary Health Care Philippine Union College, Silang, Philippines
1980-1983	BSc, Agriculture Andrews University, Berrien Springs, MI

Experience

Dec 96-Present	Director of Health, ADRA International Silver Spring, MD
Aug 95-Nov 96	Associate Director of Health, ADRA International Silver Spring, MD
1996-Present	Faculty Member, APLI, Andrews University Berrien Springs, MI
Jun 94-Aug 95	Private Consultant, PHC Planning and Implementing San Francisco, CA
1991-1994	Lab Technician and Counselor, Center for Health Promotion Loma Linda University, Loma Linda, CA (part-time)
1987-1989	Child Survival Project Director for ADRA/Southern Sudan
1987	Mother and Child Health Project Consultant, Egypt (part-time)
1986	Mother and Child Health Coordinator, ADRA/Sudan

Languages English, Amharic, Oromiffa, Arabic (some)

Solomon Wako
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301 680 5118

Education

1984	PhD in Sociology Western Michigan University, Kalamazoo, MI, USA
1979	MSW Western Michigan University, Kalamazoo, MI, USA
1977	MDiv Andrews University, Berrien Springs, MI, USA
1975	MA, Systematic Christian Theology Andrews University, Berrien Springs, MI, USA
1973	BA, Major in Religion, Minor in History Newbold College, Bracknell, Berkshire, ENGLAND

Experience

1992-Present	Director of Evaluation ADRA International, Silver Spring, MD, USA
1988-1990	Coordinator of MSW Program Indiana University at Fort Wayne, Fort Wayne, IN, USA
1987-1988	Assistant Professor of Social Work and Sociology Nebraska Wesleyan University, Lincoln, NE, USA
1984-1987	Assistant Professor of Social Work and Sociology Kearney State College, Kearney, NE, USA
1979-1982	Medical Social Worker Michigan Department of Social Services, USA

Professional Membership

National Association of Social Workers (NASW)
Academy of Certified Social Workers (ACSW)
African Studies Association
Midwest Sociological Society
American Sociological Association (ASA)

Appendix F

Accord of Agreement between ADRA/Adventist Hospital, and the Government of Haiti

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Reconnue d'u[illegible] Puplique selon décret [illegible] du Jeudi 4 Janvier 1979 Ref. Moniteur No 2

ACCORD

Entre le Gouvernement de la République d'Haiti et l'Organisation "Seventh Day Adventist World Service, Inc." (S.A.W.S)

Considérant que le "Seventh-Day Adventist World Service, Inc.", Service Mondial des Adventistes du Septième Jour, Inc, ci-après dénommé S.A.W.S., organisation de secours volontaire, non lucrative, est en mesure de fournir une aide consistant en médicaments, produits alimentaires et autres articles de première nécessité aux régions du monde affectées par la famine et les désastres naturels.

Considérant que le S.A.W.S. a manifesté le désir de signer un accord avec le Gouvernement Haitien afin d'importer et de distribuer, à titre gratuit et de la façon la plus efficace, des médicaments, produits alimentaires et articles de première nécessité à ceux qui en ont besoin.

Considérant que le Gouvernement Haitien (ci-après dénommé le Gouvernement) accepte cette assistance pour les masses nécessiteuses.

Dans le but de mener à bien et de faciliter l'exécution du dit programme, les deux parties en présence, savoir :-

1o) Le Gouvernement Haitien représenté par le Secrétaire d'Etat de la Santé Publique et de la Population et celui des Finances et des Affaires Economiques.

2o) Et le Seventh-Day Adventist World Service, Inc.. représenté par son Secrétaire Exécutif et Administrateur Général, Mr. Howard D. BURBANK

ONT CONVENU ET ARRETE CE QUI SUIT:

Article 1er.- Le Seventh-Day Adventist World Service, Inc., (S.A.W.S.) s'engage à importer en Haiti des biens de consommation, tels que médicaments, matériel pour dispensaires et hôpitaux, produits alimentaires et autres articles de première nécessité, pour être distribués gratuitement et sans discrimination aucune, aux populations démunies.

Article 2.- Le Seventh Day Adventist World Service, Inc. établira un bureau Régional en Haiti pour la supervision et le contrôle de ses services;

BEST AVAILABLE COPY

Article 3.- Le Seventh Day Adventist World Service, Inc. informera les autorités gouvernementales responsables de toute appropriation forcée, des irrégularités dans la distribution de ces articles et des violations des Règlements établis.

Article 4.- Le Seventh Day Adventist World Service, Inc.", adressera un rapport mensuel détaillé au Département de la Santé Publique et de la Population sur le nombre d'Etablissements publics de Santé et d'Institutions de bienfaisance bénéficiaires de la distribution de ces dons et sur la quantité d'articles mis à leur disposition.

Article 5.- Le Gouvernement de la République d'Haiti, tel que représenté, accordera au Seventh Day Adventist Service Inc., l'exonération de tous droits, impots et taxes:-

a) sur les produits alimentaires, médicaments, articles de première nécessité, et aussi sur le matériel, l'équipement, et les véhicules utilitaires importés ou achetés sur le marché local par S.A.W.S. pour le fonctionnement de ses programmes;

b) sur les avoirs, biens, opérations ou transactions de S.A.W.S. ou les salaires ou autres rénumérations pour services rendus et payés par S.A.W.S. à son personnel administratif;

c) sur les effets personnels du personnel administratif étranger travaillant à l'étranger ou en Haiti pour compte du S.A.W.S.

Article 6.- Le Gouvernement de la République d'Haiti s'engage à recevoir et à admettre sur le territoire Haitien, sous réserve des dispositions d'ordre public, le personnel administratif non-haitien de S.A.W.S. et les membres de leur famille, et les exonerera du paiement de tous droits, taxes, sur les visas d'entrée, de sortie, permis de séjour, permis de travail et accordera au dit personnel administratif non-Haitien et aux membres de leur famille des visas multiples sur le sol haitien.

Article 7.- Le Gouvernement de la République d'Haiti s'engage à prendre les mesures adéquates pour empêcher ou prévenir les abus, les fraudes et les détournements dans la distribution des articles importés ou achetés sur le marché local.

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Article 8.- Tous excédents de matériel, d'articles, que S.A.W.S. aura importés pour les besoins de ses opérations, devront, en cas de rupture ou d'expiration de l'accord, rester dans le pays pour être, selon entente entre les parties, gratuitement distribués aux établissements publics de santé et aux Institutions de bienfaisance, les effets personnels du personnel administratif non-haitien exceptés.

Article 9.- Les dépenses généralement quelconques se rapportant au maintien, à l'entreposage, au transport des produits et articles consignés à S.A.W.S., depuis le port d'entrée jusqu'à la livraison aux bénéficiaires, demeurent à la charge exclusive de S.A.W.S.

Article 10.- Pour tout ce qui n'est pas prévu au présent accord les parties contractantes se réfèrent aux normes établies et à la législation régissant la matière.

Article 11.- Le présent accord est valable pour une durée de CINQ (5) Années renouvelable par tacite reconduction.

Néanmoins l'une des parties pourra y mettre fin en donnant à l'autre un préavis de 90 jours par lettre recommandée.

Fait en triple original et de bonne foi à Port-au-Prince le QUATORZE OCTOBRE MIL NEUF CENT SOIXANTE DIX-SEPT, AN 174e DE L'INDEPENDANCE D'HAITI

POUR LE GOUVERNEMENT DE LA REPUBLIQUE D'HAITI:

Dr Willy VARRIER
Secrétaire d'Etat

Emmanuel MROS
Secrétaire d'Etat des Finances et des Affaires Economiques

Pour le Seventh Day Adventist World Service, Inc. S.A.W.S.

Howard D. HURDANK
Administrateur Général

Director of SAWS

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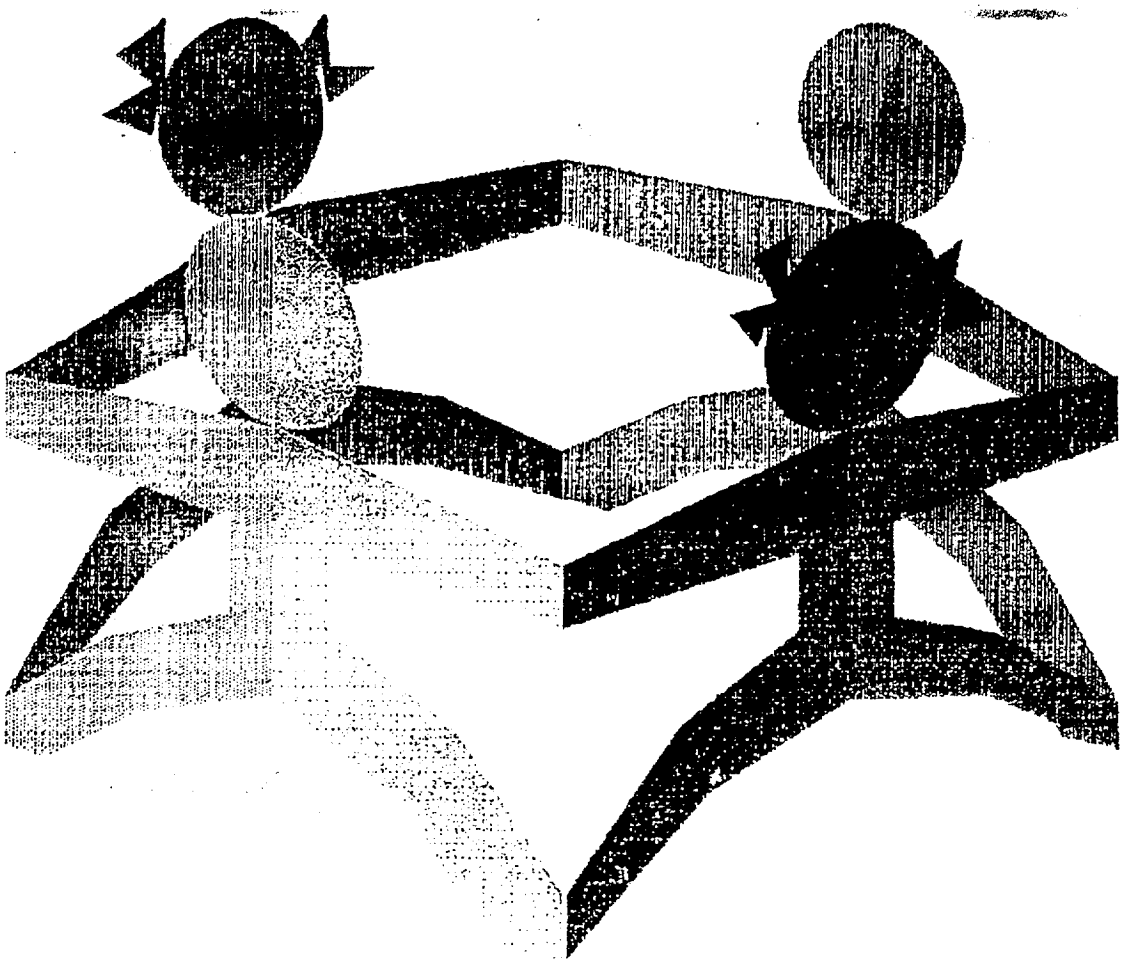
Appendix G

Cover Page of CHA Training Manual on CS Interventions and IEC Materials

Fanmi an Sante

LIV Fòmasyon sou kominikasyon moun ak moun

Kominote kap Bouje



Pwojè: Timoun an Sante Kontan

INHSRC - JHU/PCS

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Appendix H

Cover Pages of CHA Training Manual on FP

Pwojè Timoun an Sante Kontan

INHSAC - JHU/PCS

Liv sa-a te prepare pa:

INHSAC
Direksyon Kominikasyon

ak Asistans:

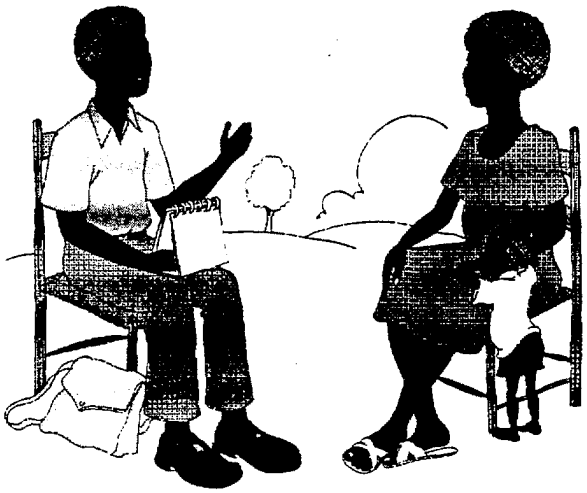
JHU/PCS - BASICS
e
sipò lajan **USAID**

Moun ki te ede ekri ak korije liv sa-a se:

- Petter GOTTERT
- Laurent EUSTACHE
- Danièle BARON
- Elsie LAUREDENT
- Roberte B. EVEILLARD

CHAPIT 4

RANFOSE FONDASYON AN



Seyans I :	Mete patisipan yo alèz	2è 45
Seyans II :	Metòd pran ka Timoun nan kominote yo	2è 45
Seyans III:	Konesans de baz yo	1è 00
Seyans IV:	Mesaj priyoritè yo	4è 45

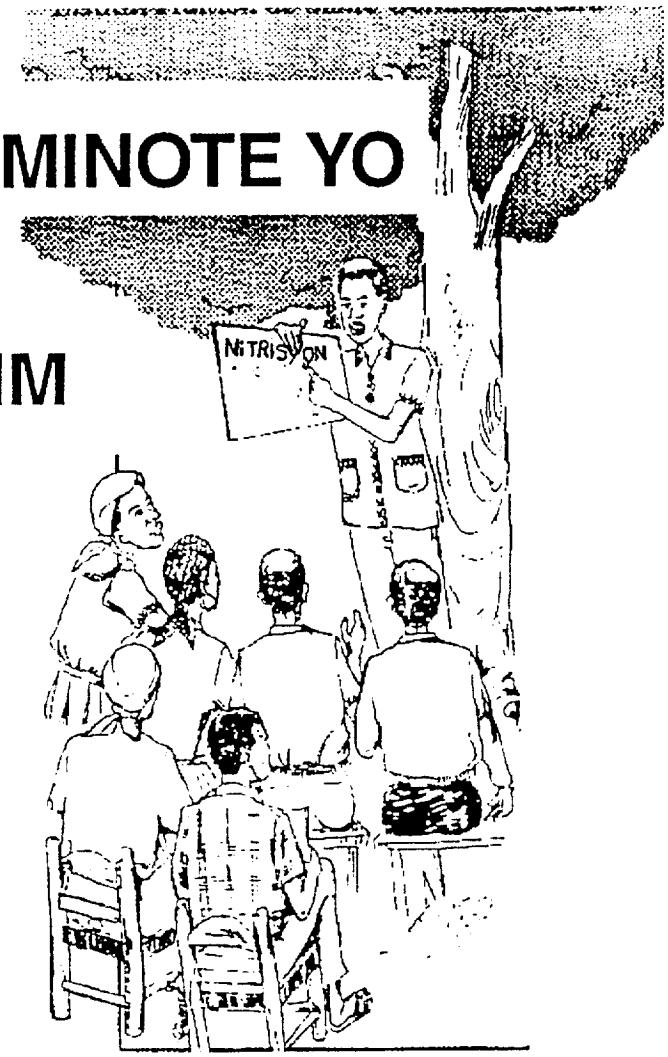
CHAPIT 3

EDE FANMI YO CHANJE KONPOTMAN

Seyans V	: Prensip pou Granmoun aprann	1è 30
Seyans VI	: Kòman fanmi yo pran lòt abitid sou sante	2è
Seyans VII	: Teknik pou moun kominike youn ak lòt	9è 30
Seyans VIII	: Konsèy ki efikas	3è
Seyans IX	: Materyèl pou ede moun kominike pi byen	3è

CHAPIT 4

ANKOURAJE KOMINOTE YO TRAVAY BYEN NAN TET ANSANM



Seyans X :	Aprann òganize kominote w la byen	1è 30
Seyans XI :	Vizit nan kay	2è 15
Seyans XII :	Animasyon Gwoup	2è 15
Seyans XIII :	Fè Pratik sou Teren	5è 15
Seyans XIV :	Planifye epi kontwole aktivite yo byen	6è 15
Seyans XV :	E Apre	

GID EDIKASYON SOU PLANIN

PWOGRAM NASYONAL PLANIN FAMILYAL

PWOJÈ SEKTÈ PRIVE

INITE IEC INHSAC

Février 1993

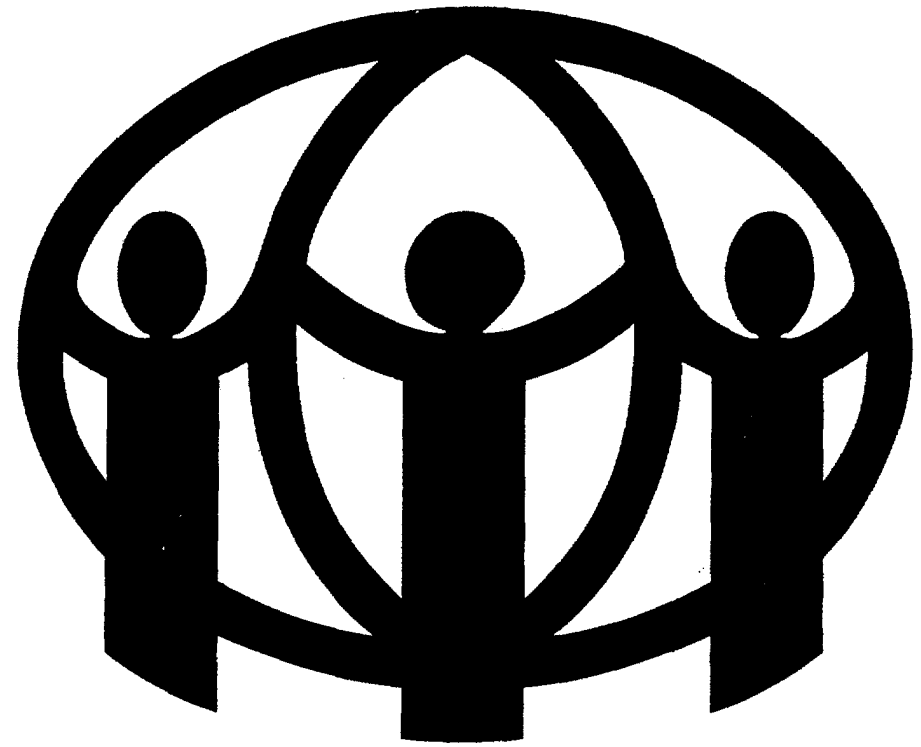
Revizyon Desam 1995

Appendix I

Manual for Training/Educating Mothers on CS Interventions

Areas of Intervention: EPI, FP, Nutrition, Vitamin A, Breastfeeding, DCM, GM, Hygiene, Safe Motherhood

(Developed and field tested by ADRA. Available in Creole.)



ADRA

GID POU FÈ EDIKASYON

SOU LA SANTE

NAN SANT "MCH"

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Sante pou manman ak timoun

(MCH)

Maternal Child Health

Nan MCH nou fè distribisyon manje pou timoun ki fè malnitrisyon ak edikasyon sou la sante. Edikasyon se yon nan sèvis ki gen anpil enpotans nan pwojè sa-a.
Edikasyon fèt nan yon metod yo rele "Metod andragojik ou non fomel" pou pataje nouvo konesans ak enfomasyon bay manman yo. Pou fe mesaj yo pase nou sevi ak pyès teyat, dyalog, histwa, chante elatrye.

Manman ki sakrifye tan yo pou yo vin aprann yon bagay nouvo ap aprann li byen men'n si li kon'n li ou byen li pa kon'n li. Depi responsab la prezante leson an yon fason ki klè e pratik avèk yon bon jan animasyon, mesaj la ap pase.

Men ki leson nou genyen nan gid sa:

	Paj
Preparasyon jounen travay nan sant MCH	1
Chan Animasyon	3
1.- 3 kalite manje	5
2.- Malnitrisyon	7
3.- Alètman	8
4.- Vitamine A	10
5.- Dyare	12
6.- Dezidratasyon	14
7.- Serum Oral	15
8.- Vaksen	17
9.- Siveyans Devlopman Timoun (Kat chemen la sante- Peze)	19
10.- Fanm Ansent	22
11.- Ijyèn	24

Preparasyon Jounen Travay nan Sant MCH

Preparasyon leson yo

Anvan

- Responsab yo ap vin' n anvan lè nan lokal sant la
- Fè netwayaj nan sant la
- Plase materyel
  Ranje ban - chèz - tare balans - mete tab - mete kilòt-ou pre - Kayé roz - Fèy rapò manje - Rapò aktivite - Kalandriye - plim - creyon - mete medikaman ki genyen pre tankou Vit A - fè/folat - siro vè - Serwòm oral - remèd pou gratèl ak materyèl pou fè distribisyon manje elatrye.
- Kole kat ki genyen gwoup laj timoun
- Prepare leson (sijè) n'ap fè pandan jounen travay la.
- Byen resevwa moun ki vini yo e envite yo chita selon laj pitit yo.

Pandan

- Pryè
- Peze timoun ki vin'n anvan yo (ankouraje manman yo pou yo mete kilòt balans la sou timoun yo, retire soulye.)
- Responb la dwe kontwole si balans la tare anvan li peze yon lot timoun
- Enskri pwa-a nan Kat chemin la sante timoun nan (-Mete pwen-fè liy yo-Ekri pwa) e rapote pwa - sa-a nan kayè roz la.
- Avek kat chemen la sante-a montre manman-an nan ki dégwé nitrisyon timoun li ye. Selon pwa timoun nan fè youn ti pale avek mamman e referans si gen timoun malade.
- Fè rapèl sou leson pase-a

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- Chan animasyon

- Fe èdikasyon (Sèvi ak metòd animasyon, patisipasyon tankou pyès teat, istwa, pose kesyon elatrye). Repete plisyè fwa sa pou manman sonje pi byen.

- Ankouraje manman yo patisipe nan seyans lan (poze manman yo kesyon Poze kesyon aplikasyon tou. Mande yo explike espeyans pa yo si yo genyen.

- Chante chan ki ale ak leson pandan jounen sa-a (pou ede patisipan yo aprann pi byen)

- Anonse dat pwochen'n jounen travay nan sant la ke li genyen pou'l patisipe a.

- Fò rapò aktivite - a déplase devan chak gwoup manman pose kesyon ki nan rapò -a

- Fè distribisyon Vitamin ak medikaman selon laj timoun nan. Pou timoun yo n'ap gade si dat li rive pou'l resevwa Vitamin A ak remed Vè, e ekri nan kay chemin la sante - a.

- Fè distribisyon manje-a

- Fè referans

Apre

- Evalye jounen travay la, (lè manman yo fin'n ale, responsab la ansanm ak asistan an ap reflechi sou jan edikasyon an te pase. Fè yon ti rale sou sa ki te pase byen ak sa ki te manke.

- Mete lòd

- Transpòte tout materyel ak medikaman ki pou sant la kote nou abitye dépoze'l

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ESKE NOU PARE

Eske nou pare?
Wi, nou pare O ! (Bis)
Eske tout mou-n la?
Wi, tout mou-n la O! (Bis)
Nou pral **komanse** tout moun dwe mete'n sou sa
ou
Nou pral **kontinye** tout moun dwe mete'n sou sa

ESKE NOU LA?

N'ap mande tout manman MCH eske nou la O ?

N'ap mande tout responsable MCH eske yo la O!

N'ap mande tout moun ki nan komite MCH eske yo la O!

N'ap mande tout mou-n nan lokalite yo eske yo la O!

Nou la na peyi-a.
N'ap oganize nou, n'ap kolabore nou
Pou-n fè pwogram sante-a mache, avanse } bis
Nan seksyon kominal yo.

ANIMASYON

Animasyon se yon nesesite, ki ka pèmèt nou fè bonjan lide pase
Se yon mwayen se yon zoutiy se yon metod
Pou met lavi, pou met nanm nan mitan moun

Animasyon pou mobilizasyon
Animasyon pou konsyantizasyon
Animasyon pou sansibilizasyon
Animasyon pou yon bonjan solisyon
Animasyon se yon nesesite.....

Animasyon se tankou chen frekan
Depi gen moun, li gen tan kwaze pye '1
Paske li di se li k' pou met tout moun sou sa
Li semante anyen pa kab fet san li.

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LA SANTE SE PI GWO RICHES

Refren
La sante se pi gwo RICHES
Ke youn moun kapab posede
Si yon moun pa gen la sante
ou met di ou pi malere.
I
Nan sant MCH nou fe edikasyon
Se yon pwogram ki rich anpil
Li ogmante konesans fanmi yo
Nan enfomasyon yo jwen-n sou la sante
II
Ala bel bagay nan.....
je tout fanmi ouvri sou la sante
Timoun yo vin -n devlope pi byen
Kominote -a byen devlope

CHAN SOU TET ANSANM, KE ANSANM *(inite)*

Lè nou tout mèt tèt ansanm, kè ansanm, men ansanm,
Lè nou tout patisipe,
Nou va fè pwogrè.

Travay mwen se travay ou
Travay ou se travay mwen
Travay nou se travay Dye.

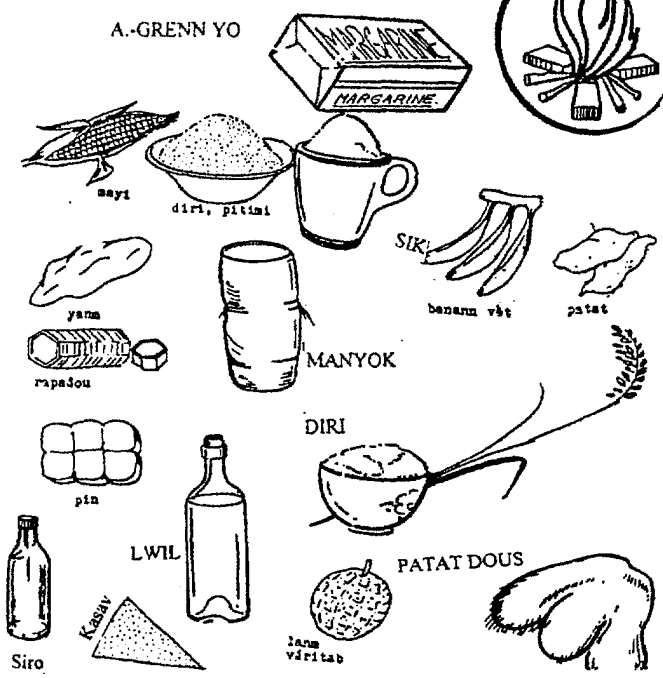
Twa (3) Kalite Manje

Timoun tankou granmoun dwe manje twa kalite manje chak fwa ke ya'p manje pou yo ka rete an fom.
Se tankou 3 roch dife.

Manje ki Bati ou konstri ko nou.

Manje ki pwoteje ko

Manje ki bay ko fos



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Mesaj pou manman yo sonje pi byen
Pou timoun yo devlope pi byen fok yon manje twa kalite manje.

kesyon pou poze manman yo

konbyen kalite manje ki genyen
Site manje ki bati ou konstri ko
Site manje ki pwoteje ko
Site manje ki bay fos

Kesyon pou aplikasyon
Mande yon manman prépare yon manje ki genyen twa kalite manje san li pa monte chodyè.
Mande yon lot prepare yon manje ki genyen twa kalite manje si li monte chodyè

Chan twa kalite manje

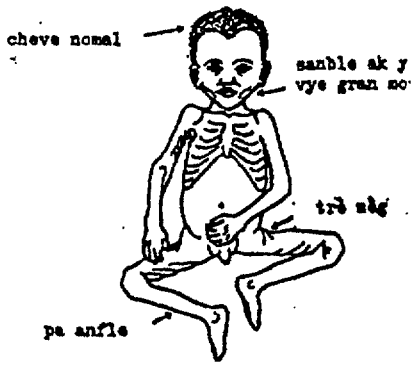
Twa kalite manje, yon moun kapab manje chak jou
Manje 'k grandi ko ak manje ki bay anpil fos
Manje 'k proteje ko, ki genyen vitamin A
Konsa nou sèten nou kapab genyen bon sante.
I
Pou bati ko nou, nou bezwen ze, vyann, manba ak pistach.
Nou genyen lèt, aran avèk fwa di.
Nou genyen nwa, pwason, pwa sèk ak sereyal
Tout manje sa yo, k'ap ede nou bati ko nou.
II
Pou pwoteje ko, gen fig mi, fèy vèt, legim, papay.
Nou gen joumou, kawot avek chadèk.
Nou gen mango, tomat, zoranj ak gwayav.
Ak manje sa yo tout ko nou kapab pwoteje.
III
Pou bay ko nou fos gen pitimi, mayi,diri, patat.
Nou genyen yanm, bannann ak malanga.
Gen mazoubèl, lam veritab, sik, siwo, rapadou.
Tout manje sa yo k'ap ede nou jwen fos trè byen.

Malnitrisyon.

Anpil timoun rive gen malnitrisyon paske yo pa jwen ase manje pou yo manje. Men gen kèk timoun ki rive fè malnitrisyon tou paske yo manje yon sèl kalite manje, ou byen yo gen maladi ki te atake yo tankou: dyare, lawoujòl elatre.

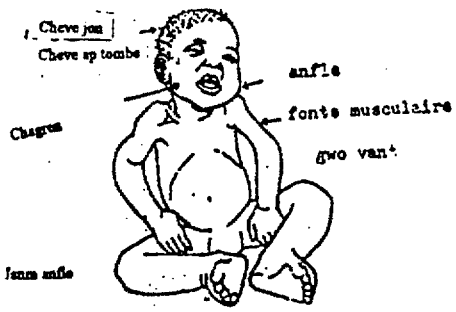
Men ki siy ki ka fe nou konnen ke yon timoun fè Malnitrisyon.

Maras



Timoun sa a bezwen 3 kalite manje
sitou manje ki bay fos.

kwashiorkor



Timoun sa a bezwen 3 kalite manje
Sitou manje ki bati ko.

Timoun sa yo kon'n: Pedi apeti, gen bokye bo bouch, gripe fasil, pa we byen lèswa, ak lot enfeksyon ankò

Mesaj pou manman yo sonje pi byen

Pou evite malnitrisyon se pou 'n bay timoun nou yo 3 kalite manje.

Kesyon pou nou pose manman yo

Kisa n'ap fe pou timoun nou pa fe malnitrisyon
ki lè nou konnen timoun nou fe malnitrisyon
kisa nou kap fe pou timoun ki genyen malnitrisyon

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Lèt manman

Lèt manman se richès tibebe. Se yon manje ki tout pare e ki chaje ak vitamin. Depi tibebe a soti nan vant manman'n mete'l touswit nan tete. Ti bebe-a ap byen nouri e sa ap fasilite manman'n gen plis lèt. Bay tete chaje ak avantaj:

Avantaj pou timoun nan.
-Li fè ti bebe a jete tout goudwon
-Ti moun jwen'n Vitamin A ladan'l
- Li fè timoun lan an sante
(Li anpeche'l gen dyare,enfeksyon elatrye)

Avantaj pou manman.
- Le ti bebe a ap tete sa fè matris fanm'n tounen nan plas li pi vit.
- Fanm ki bay ti bebe-a tete selman pap ansent touswit e l'ap anpeche'l gen maladi nan tete ak nan matris.
- Se you siy afeksyon ak konfians pou manman ak ti bebe-a.

Avantaj pou fanmi-a.
- Fanmi-an fè ekonomi yo pa bezwen achte bibwon ak lèt etc.
- Yo pa depanse lajan kay doktè ni famasi paske timoun nan pa malad fasil le li pran tete selman.

Tout timoun ki fèk fèt dwe pran lèt manman, kèlkeswa aktivite manman 'n. Menmsi manman ap travay deyò, gen mwayen pou tibebe a tete lèt manman. Paske **lèt manman ka konsève 8 èdtan san frijidè.**

MEN KIJAN N'AP FE POU PIRE LET MANMAN METE NAN GODE PWòP

-FE MASAJ NAN TETE
-FE LET DESAN AK MEN
-BESE DO-W E SOUKE POU KEK MINIT
-METE 2 DWET DEYE PWENT TETE-W
-PEZE PWENT E AVANSE TOU PITIT
-PA SEVI AK 2 MEN-W
-PA PEZE FO
-APRE SA FE NAN LOT TETE-A

Lèt manman ka konsève
8 èdtan san frijidè

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Mesaj pou manman yo sonje pi byen

1.- Timoun ki fèk fèt jiska 6 mwa dwe pran lèt manman selman
2.- Premye lèt se pi bon lòk pou bay ti bebe ki fèk fèt?
3.- Lèt manman ka konsève 8 èdtan san frijidè

Kesyon pou poze manman yo.

Ki avantaj lèt manman genyen?
Konbyen tan lèt manman ka konsève san frijidè?
Ki premye jès n'ap fè lè tibebe nou fèk fèt

Kesyon pou aplikasyon pratik:

Mande yon fanm ki sou 9 mwa gwoses "Si w'ap akouche aswè a, ki manje ou pral bay ti bebe ou a?
Mande yon lot manman "Ki sa ou pral fè ak premye lèt ou"?

CHAN LET MANMAN

I
Lèt manman se pi bon manje
Ki genyen pou tibebe
Lèt manman se fotifyan
Ki genyen pou tibebe

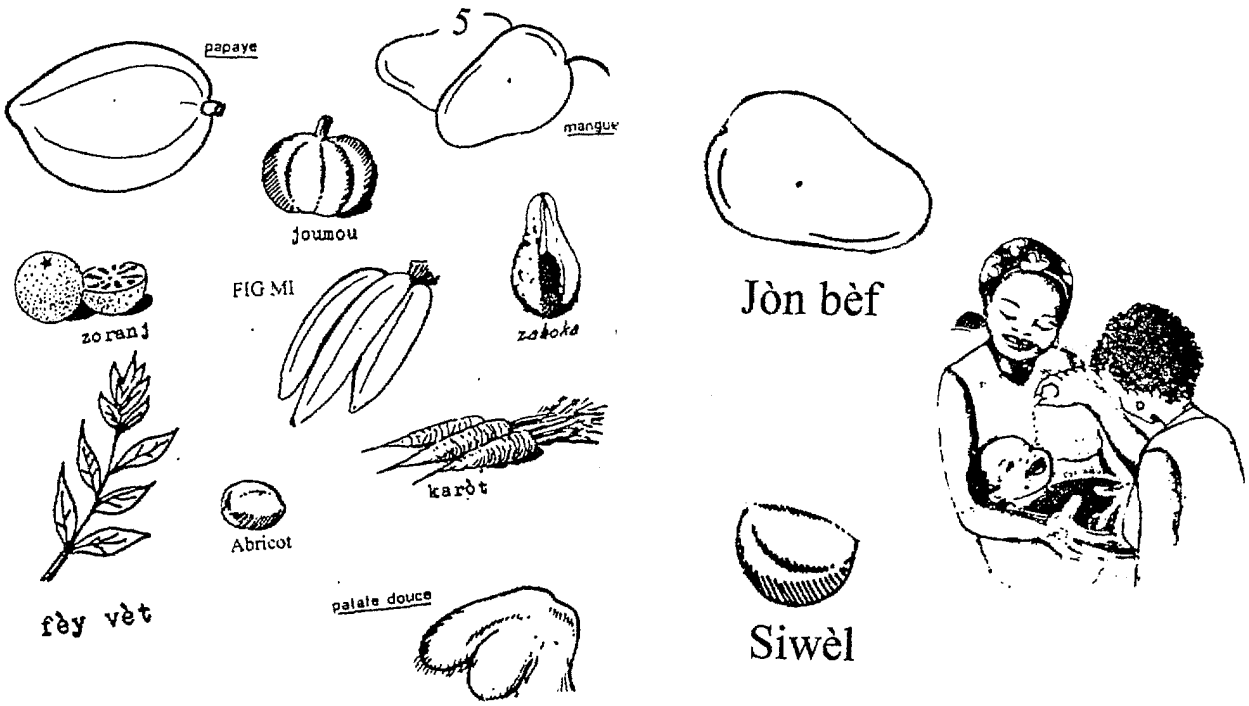
II
Lèt manman se medikaman
Ki pi bon pou tibebe
Lèt manman se nouriti
Kap devlope tibebe

III
Premye lèt la se pa pale
Yo rele lèt sa kolostwom
Nou pap jete premye lèt la
Lèt sila se medikaman
Lèt sila netwaye goudwon
Lèt sila gen Vitamin A
Premye lèt sa se bon bagay

Vitamin A

Vitamin A se yon bagay nou dwe gen nan ko nou. Li anpeche moun gen enfeksyon, li bon pou je nou, Li bay bel po ak bel cheve tou.
Si yon moun manke vitamin A l'ap komanse gen pwoblèm ak je 'l.
Sitou si yon timoun pa gen vitamin A li kap vin avèg bonè.

Nou ka jwen Vitamine A nan manje n'ap manje, sitou manje ki gen koulè jon ak legim vèt e nou ka jwen li sou fòm kapsil nan sant yo.



Men ki kalite moun ki bezwen Vit A

1.- Tout timoun a pati de 6 mwa rive jiska 7 an, dwe pran Vit A chak 4 mwa.

-Timoun ki gen 6 mwa rive 1 an n'ap koupe tet kapsyl la e vide tout likid la lan bouch li.

- Timoun 1 an rive 7 an n'ap bay yo vale tout kapsyl la.

Li kap vale 'l tankou li tap vale you lot gren'n.

2.- Fanm ki fek akouche pandan pwemye (1) mwa selman ap pran yon kapsil vit A.

- Tout fanm akouche ki pran Vit A. Ti bebe-a ap jwen'n Vit A nan let manman. Si fanm lan gentan pase dat sa pa bali Vit A.

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3.- Timoun ki fè maladi infectyes sitou dyare

4.- Timoun ki fè malnitrisyon sou fòm gwav.

5.- Timoun ki gen maladi la woujòl

-Men'n lè ou wè timoun nan malad wa'p bali:

Premye jou-a	1 kapsil Vit. A
Demen you dwe bali you lòt ankò	1 Kapsil Vit. A

Mesaj pou manman yo sonje pi byen

Si nou vle pou timoun yo gen bon je, se pou nou ba yo vitamin A.
Si nou vle pwoteje timoun kont anpil enfeksyon se pou nou ba yo vit A
Manje ki gen vitamin A: se fwi jòn fonse ak legim vèt.

Kesyon pou nou pose manman yo

1. Ki sa pou nou bay timoun yo pou yo ka gen bon je?
2. Si yon timoun manke vitamin A, ki sa ki pral rive'l?
3. Ki manje ki gen vitamin A ladan'l?
4. Poukisa nou bay fanm ki fèk akouche yo vitamin A anvan yo rive sou premye mwa nouris?
5. Nan ki mwa nou bay bebe a vitamin A?
6. Jis ki laj timoun nan dwe kontinye pran vitamin A?

Kesyon pou aplikasyon pratik:

1. Tout manman yo se pou nou di ki lè nou pral pran dòz vitamin A (Touswit lè nou fini akouche anvan nou gen 1 mwa nouris)
2. Eske gen manman ki gen pitit ki pare pou dezyèm dòz la? (Pitit ki gen 10 mwa)

Chan Vitamin A

I

Vitamin A se yon bagay
Tou moun dwe genyen nan ko'l
Si nou vle ti moun nou gen bon je
Se pou'n ba'yo vitamin A
Si yon moun manke vitamin A
Lap genyen pwoblèm ak je'l

II

Men manje ki gen vitamin A
tout legim ak fwi ki jon
Abriko, jomou, karòt
Mango, papay, avèk fig mi (bis)

III

Fanm nouris bezwen vitamin A
Avan ou genyen yon mwa
Lè ti bebe ap tete
Lap jwenn vitamin A nan let manman l'
Si yon ti moun pa gen vitamin A
Li kab vin avèg bonè

IV

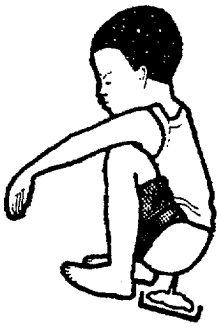
Ti bebe ap pran vitamin A
Jislè li genyen 6 mwa
Apre sa, a chak 4 mwa
N'ap bali vitamin A
Jiskaske li genyen 7 an
nap bali vitamin A

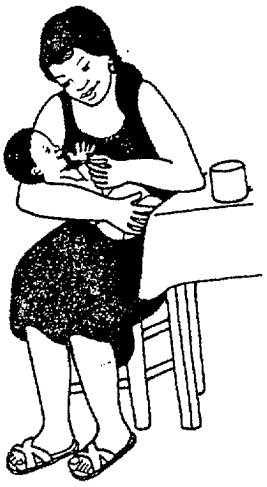
11 bis

Dyare

Kijan nou konnen timoun nou gen dyare?

Timoun gen dyare lè li fè poupou dlo men'm si se yon sèl fwa.
Timoun ki poupou mou plizyè fwa pa jou gen dyare tou.





Mesaj pou manman yo sonje pi byen

Pou remonte yon ti moun ki gen dyare, fok nou kontinye ba li tete, fok nou ba li sewom oral osinon sewon lakay (pou ramplase dlo ki pedi yo). Epi si li gen 6 a 24 mwa, li dwe kontinye ap tete e manje lot bagay mezi li kapab.

Kesyon pou poze manman yo

1. Kijan nou kafe pou evite timoun nou gen dyare
2. Pou ki rezon yon manman bezwen okipe pitit li plis lè li gen dyare?
3. Eske lèt manman bon pou timoun ki gen dyare?
4. ki sa pou timoun nan bwè pou li ranplase dlo li pèdi nan poupou a?
5. Ki kalite manje ki bon pou timoun ki gen dyare?

Kesyon pou aplikasyon pratik

Mande yon manman ki gen yon ti bebe 4-6 mwa omwen "Si pitit ou gen dyare nan mwa sa a, ki sa ou pral ba li pou remonte fòs li?

Chan Dyare

I

Lè yon moun gen dyare, se yon maladi ki grav anpil
Ou bezwen anpeche li avan li vin pi grav
Rezon li vin pi grav se paske li pedi dlo nan ko-l
Ou bezwen ranplase dlo yo avan li vin pi grav (bis)

Refren

Pou anpeche dyare, lave men avan manje
Prepare manje ou byen, kwit vyann ou byen avan ou manje
Lave fwi legim ou byen avan ou manje yo
Si ou pa fe sa ou kapab genyen maladi dyare
Ou bezwen ranplase dlo yo avan li vin pi grav (bis)

II

Le yon moun gen dyare li bezwen bwe anpil likid
Pou li ka'b ranplase dlo ki te pedi nan ko-l
Si li pa fe sa, li kapab vin gen febles
Epi 'l mouri, li lage fanmi-l nan tristes
Ou bezwen ranplase dlo yo avan li vin pi grav (bis)

III

Yon lot bagay ou bezwen bwe fe pou anpeche dyare
Pa sevi ak dlo rivye, sevi ak dlo sous kapte
Epi ou kapab sevi avek dlo ki pi byen okipe
Si ou pa fe sa ou kapab genyen maladi dyare
Ou bezwen ranplase dlo yo avan li vin pi grav (bis)

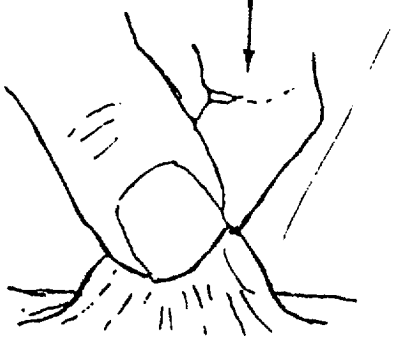
Dezidratasyon

Pifo timoun ki mouri ak dyare se paske yo pa gen kont dlo ki rete nan ko yo a koz yo pa pran sewom oral touswit, ki pou ranplase dlo ki pedi nan ko yo-a.

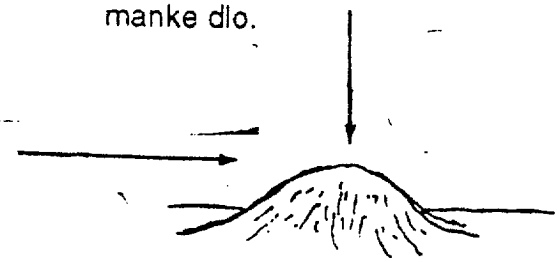
Si timoun ki gen dyare pa pran Serum touswit men kijan li ka vin'n ye:

- Li pa pipi anpil osinon li pa pipi menm, pipi a fonse anpil
- Li rete konsa li pèdi pwa, li desann vit
- Bouch li chèch
- Je li fon, li pa bay dlo lè lap kriye
- Fontenn tèt li vin fon (kay tibebe)
- Po li vin fennen.

Leve po a ak de dwèt konsa....



Lè nou lage po a, po a rete plise, li pa tounen nan plas li touswit, pitit la manke dlo.



Sa rele dezidratasyon

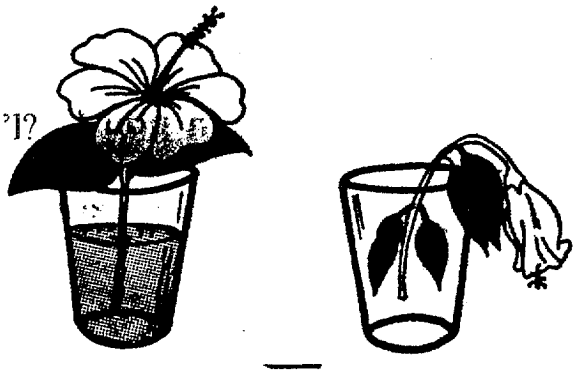
Mesaj pou manman sonje pi byen

Si timoun gen dyare li pa pran sewom oral touswit l'ap dezidrate.

Kesyon pou poze manman yo

Kijan ou konnen pitit ou komanse dezidrate?

Timoun ki pa pran sewom oral touswit ki sa ki ka rive'l?



— Li kap menm mouri menm jan avèk yon plant ki pa aroze.

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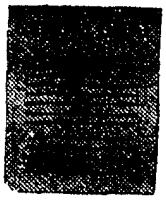
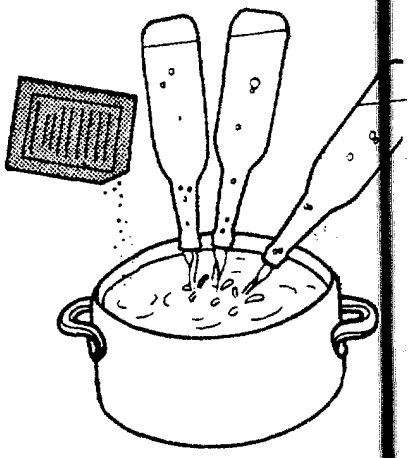
Ki jan pou nou sèvi ak sewòm oral

(Sètadi sewòm ki tou prepare nan Sachè)

Metod: Demonstrasyon devan medam yo

1. Pran yon boutèy kola blan epi lave li byen pwòp
2. Chache yon bon dlo pwop ak yon veso byen pwop
3. Plen boutey la twa fwa, vide dlo a nan veso a
4. Souke sache a byen souke. Si ou wè li fè boul, pa sèvi ak li
5. Chire sache sewòm oral la vide poud la nan dlo-a brase dlo a ansanm ak poud la byen brase epi kouvri li
6. Si se pou yon ti bebe, ba li yon demi gode sewòm oral chak fwa li poupou dlo.
7. Si ou fè sewòm sa a nan maten, lap rete bon pou jis nan aswè.

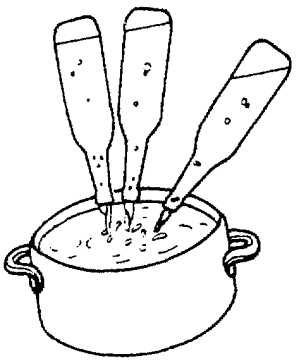


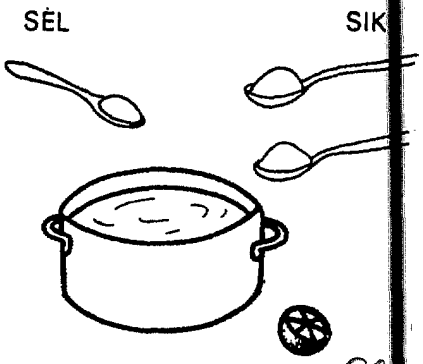


Resèt pou prepare sewom lakay

Metod: Demonstrasyon devan medam yo

1. Pran yon boutèy kola blan epi byen pwòp
2. Chache yon bon dlo pwòp ak yon veso byen pwòp
3. Plen boutèy la twa fwa, vide dlo a nan veso a
4. Mete 2 gwo kiyè sik san tiyon ak yon ti kiyè sèl fen oswa 3 ti grenn sèl gwosè yon mwatye pistach epi kèk gout sitwon. Brase yo byen brase nan dlo-a.
5. Si se pou yon ti bebe, ba li yon demi gode sewòm lakay sa a chak fwa li poupou dlo.
6. Sewòm sa ap rete bon pou douzè tan (pa egzanp, si ou pare li yon jou a sizè dimaten, lap rete bon pou jis sizè diswa)
7. Dlo kokoye se yon bon sewòm natirèl ou jwenn tou pare.





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Mesaj pou manman yo sonje pi byen
Timoun ki gen dyare dwe pran sewòm oral tou swit e pi mennen nan dispansè.

Kesyon pou poze manman
Kisa sewòm oral fè pou timoun ki gen dyare?
Kisa ou bezwen pou fè sewòm lakay?

Kesyon aplikasyon
Mande yon manman si pitit ou gen dyare lanwit kisa ou ap fè pou li.

Chante Sewom oral

I
Lè timoun gen dyare
Se deseche l'ap deseche (Bis)
Mezanmi m'sove
Sewòm lakay antre. (Bis)

II
Li se yon bon sewòm
Li byen fasil pou prepare. (Bis)
Twa kola dlo pwòp
De gwo kiyè sik
Yon ti kiyè sèl
Kèk ti gout sitwon ladan. (Bis)

III
Lè timoun gen dyare
Se deseche l'ap deseche
Mezanmi m' sove
Sewom lakay antre.(Bis)

100

Vaksen Timoun

Vaksen pwoteje timoun kont anpil maladi gwav tankou koklich,difteri, tétanos, polyo, lawoujòl, ak tibèkiloz elatrye. Se pou nou fin vaksine timoun nou avan li gen 1an.

Men ki vaksen timoun yo ap Pran:

Laj	vaksen	Kont ki maladi
Tibebe ki fèk fèt	BCG-Polyo	BCG : Kont maladi tibekiloz Polyo: Kont maladi kokobe
1 mwa edmi	DTP-Polyo	DTP: Kont maladi difteri, tétanos, koklich
2 mwa edmi	DTP-Polyo	" " " " " " " " "
3 mwa edmi	DTP-Polyo	" " " " " " " " "
9 mwa	Woujòl	Woujòl Kont maladi Lawoujòl

Se pou tout manman konnen ke Timoun yo dwe pran:

1 dòz BCG ak Polyo 0 lè timoun yo fèk fèt.
3 dòz DTP a pati de 1 mwa edmi e nan espas 1mwa pou chak lot dòz yo.
3 dòz Polyo a pati de 1 mwa edmi e nan espas 1mwa pou chak lot dòz yo.
1 dòz woujòl lèt timoun genyen 9 mwa.

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Mesaj pou manman yo sonje pi byen
Ti moun dwe fin vaksinen nèt avan 1 an pou yo sa byen pwoteje.
Tout manman dwe mennen timoun yo nan dispanse pou pran vaksen

Kesyon pou poze manman yo
1. Poukisa nou bay pitit nou vaksen?
2. Nan ki laj yon timoun dwe fini pran tout vaksen li yo?
3. Ki vaksen yon ti bebe ki fèk fèt dwe pran
4. Vaksen DiTePè ak polyo pwoteje timoun kont ki 3 gwo maladi? Konbyen doz pou pran nan chak? Nan ki mwa pou li kòmanse pran yo?
5. Ki sa pou manman yo fè ak kat vaksinasyon an?

Kesyon pou aplikasyon pratik
Madan Entèl, pitit ou gen 9 mwa koulyeya, ki vaksen ou pral ba li?

Tout fanm depi yo gen 15 an rive jiska 44 an dwe pran vaksen Kont Tétanòs. Lè yon fanm ansent, fòk li pran vaksen tétanòs pou pwoteje'l ak timoun ki lan vant li a kont maladi kòrèd.

Chante vaksen timoun

Refren
Medam yo bay timoun nou vaksen
Polyo ak Di Te Pe; gen twa dòz ladan
Si yonn pa la, de pa kap sifi
Pou pwoteje yo kont kèk maladi.

I
Mwen gen yon timoun mwen pral vaksine
Pou pwoteje l'kont plizyè maladi
Twa dòz polyo, twa dòz Di Te Pe
Yon dòz BCG ak yon dòz lawoujòl.

II
Mwen gen yon timoun pou mwen vaksine
Se pou m'fin vaksine l' anvan l gen ennan
Pou pwoteje l'kont plizyè maladi
Fòz mwen sere kat la menm jan ak papye tè
Fòz mwen sere kat la menm jan ak papye tè

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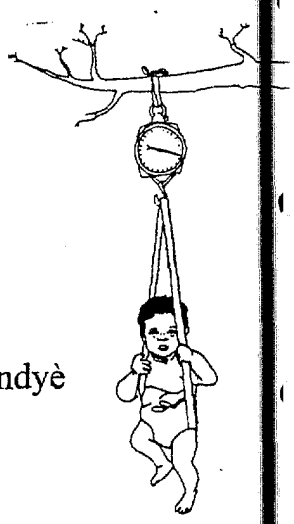
SIVEYANS DEVLOPMAN TIMOUN

(Kat Chemen la sante, Peze)

Se pou tout manman konnen ki inpotans ki genyen nan siveye devlopman timoun yo.
Yon nan responsabilite yo genyen nan la sante timoun yo, se al peze yo chak mwa.



Men kisa n'ap bezwen pou nou fe travay sa-a byen.

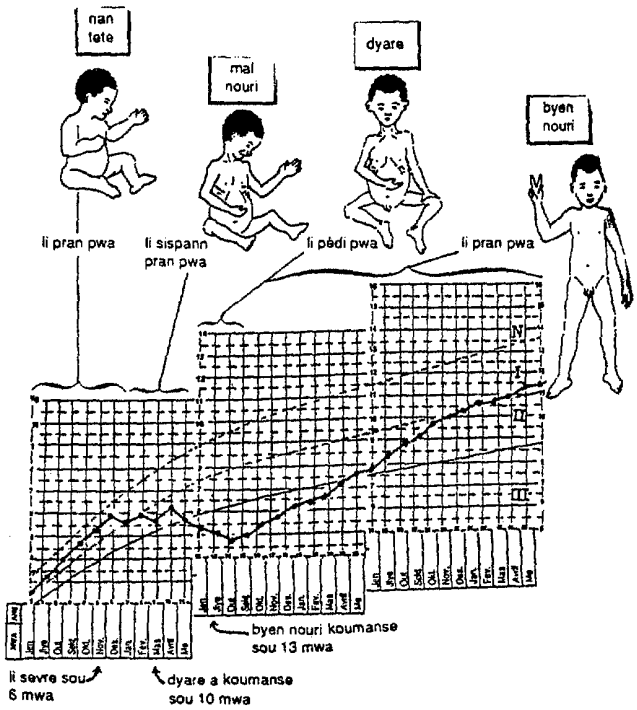
1.- Balans
2.- kòd
3.- kilòt
4.- timoun
5.- kat chemen la sante
6.- Plim ou creyon
7.- Nou bezwen yon bwanch bwa solid ou byen yon travè ki solid pou pandyè balans la.

Men ki metòd nou pral swiv

1.- Mete balans la nan otè je ou
2.- Mete balans la sou zero
3.- Fè manman yo retire tout bagay ki
ka chanje vrè pwa timoun nan tankou:
soulye, chapo, gwo rad. elatrye
4.- Mete kilòt la sou timoun nan
5.- Verifye si balans la byen mare e si kilòt la byen mete sou timoun nan
6.- Veye pou manman-an pa kenbe timoun nan e pou kò timoun nan pa touche ak anyen
7.- Li pwa timoun nan byen, pran swen pou gade tiba yo.
8.- Desanm ' n timoun nan balans la pou ka ekri pwa-a nan kat chemen la sante-a.

9.-Di manman - an pwa timoun nan e felisite'l si pwa-a korek. Ti pale sa-a ta dwe fèt, ant manman ak responsab la sèlman san lòt moun pa bezwen tande, si pwa timoun nan pa nan bon eta, pou manman an pa wont .

Men koman nou pral fe pou nou mete pwa-a nan chemen sante - a.



1.-Moun bezwen konnen dat timoun nan fèt avek dat li vini peze-a
2.- Nou pral nan kazye ki make mwa, ane n'ap rampli yo you'n apre lot depi dat timoun nan te fe la jiskas ke ou rive nan mwa ke li vini peze-a.

3.- Mete pwa a nan kolonn ki apwopriye ak mwa ou peze li a dapre pwa timoun nan.
-Chak koulè yo nan kat la reprezante yon chemen nan devlopman timoun nan.

4.- Explike manman degwe malnitrisyon timoun nan pa rapò-a koule kote pwa timoun nan tombe-a. Felisite ou byen bal konsey selon ka pal la.

Mesaj pou manman yo sonje pi byen
Peze timoun chak mwa pou nou ka swiv devlopeman yo

Kesyon pou pose manman
Poukisa nou vin'n peze timoun yo chak mwa?
Poukisa ou oblije sere kat la yon bon kote?
Nan ki koule nan kat la ou ta rennmen pitit ou ye?

Kesyon pou aplikasyon pratik
Kisa nou pral fe si pitit ou pa pran pwa mwa -sa.

104

Chant peze timoun regilyèman

I

Peze timoun nou yo regilyèman
Pou wè ki jan l'ap devlope byen
Pwa timoun nan fèt poul monte chak mwa
Se lè sa a timoun nan an sante.
Pa bliye, medam, randevou nou.
Lè n'ap vini, mach 'ak chemen sante (bis)

II

Lè nou wè pwa timoun nou monte
Nou konnen pitit nou grandi byen
Si nou wè pwa pitit nou pa monte
Nou pral ba li plis swen, plis manje

III

Si nou wè pwa timoun nou desann
Se lè sa pou nou mennen l'nan dispansè
Mennen l'nan dispansè
Ba li plis swen, plis manje.

Refren

Pa bliye mesye
Lè madanm nou pa la,
Pa pèdi randevou, al peze timoun nou.
Pa bliye, medam, randevou nou.
Lè n'ap vini, mach 'k chemen sante (bis)

105

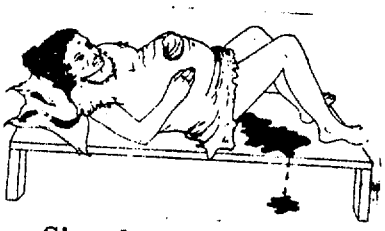
Fanm Ansent

Gen kèk bagay nou dwe konnen nan zafe gwoses tankou yon fanm ansent dwe manje 3 kalite manje, li dwe ale nan dispansè pou konsilte e pou pran vaksen gen kèk lot siy tou lè fanm ansent wè yo fòk li kouri al nan dispansè tankou:

Si ou santi yon gwo tèt fè mal pandan 2 ou 3 jou.

Si ou gen yon lafyèv pandan 2-3 jou.

Si pye ou anfle.



Si ou bay san pa ba.

Si ou bay dlo pa ba.

Gen kèk lot bagay nou dwe konnen toujou tankou fanm ansent pa dwe fimin, pa pran alkòl, pa manje piman, pa pote gwo chay. Ale nan postè na jwen plis esplikasyon

Mesaj pou manman yo sonje pi byen

Tout fanm ansent dwe sonje siy danje yo.
Tout fanm ansent dwe pran vaksen tetanos
Tout fanm ansent dwe manje twa kalite manje.

Kesyon pou poze manman yo

Pou kisa fanm ansent bezwen pran vaksen?
Pou kisa fanm ansent bezwen manje twa kalite manje?
Kisa nou dwe fe si nou wè yon'n nan siy yo pandan gwosès la?

Chan siy danjere pou fanm ansent

I

Gen plizyè siy ki danjere pou fanm ansent
Si ou wè ou genyen siy sa yo
Pa rete de bwa kwaze ap gade
Se pou kouri touswit al nan dispansè!

II

Si ou gen **gwo mal tèt**, de ou twa jou,
Si ou bay **san pa ba**,
Ale nan dispansè
Si **pye ou ap anfle**
Si ou bay **dlo pa ba**
Pa ret chita, kouri al nan dispansè

III

Gen plizyè siy ki danje pou fanm ansent
Si ou wè ou genyen siy sa yo
Pare de bwa kwaze ap gade
Pa rete chita, kouri al nan dispansè

Chant Vaksen

Mwen se yon fanm ansent
Mwen pral vaksine
Mwen se yon fanm ansent
Mwen pral vaksine
De doz tetanos ak twa doz rapèl
Pou pwoteksyon kont maladi ko rèd
Pou pwoteksyon kont maladi ko rèd

107

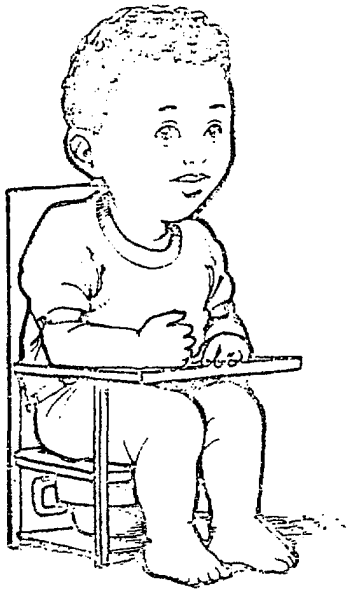
Ijyèn

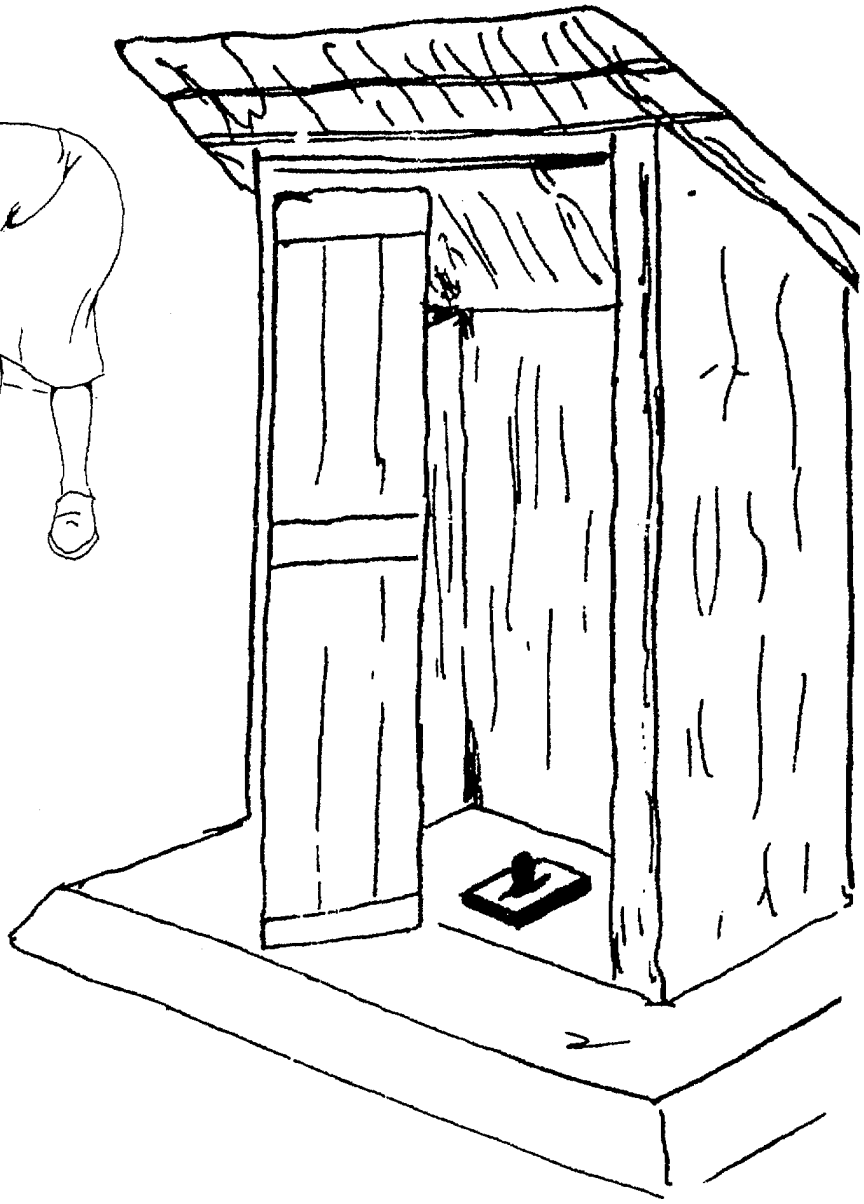
Si nou tout fè atansyon pou kenbe kò nou pwòp kay nou ak lantouraj nou, epi nou pran prekosyon ak timoun yo sa ap fè anpil maladi pa antre sou nou e n'ap depanse mwens.

Pou yon fanmi pwoteje tèt li kont plisyè maladi fòk li ta pran pwekosyon sa yo:

Pa poupou atè ale nan latrin.

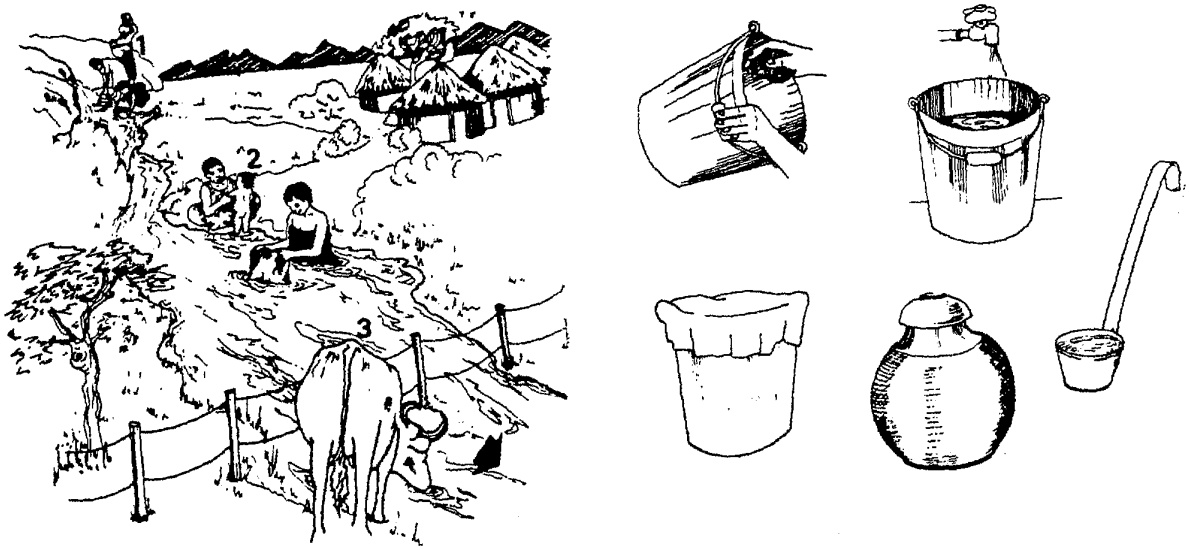
Ankouraje timoun ale nan vaz



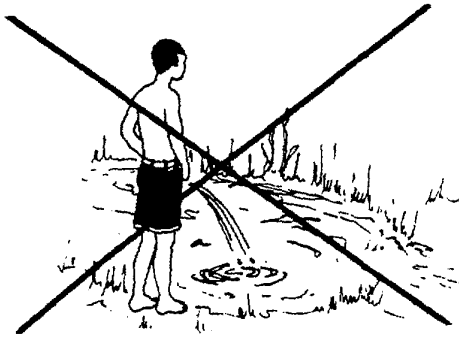


latrin

108



Pran dlo ki nan you sous pwoteje ak veso ki pwop e ki byen kouvri



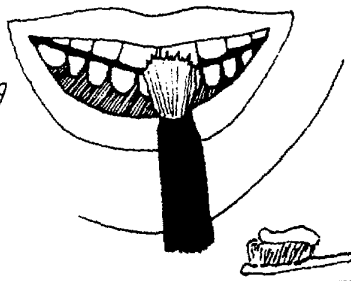
Pa pipi kote n'ap pran dlo-a

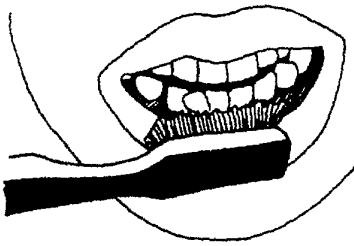
Pa pran dlo pou nou bwè nenpòt kote

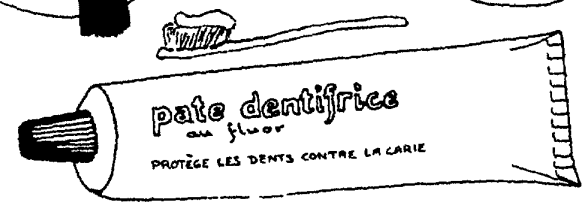
Toujou pwopte timoun

Benyen timoun

Koupe zòng timoun





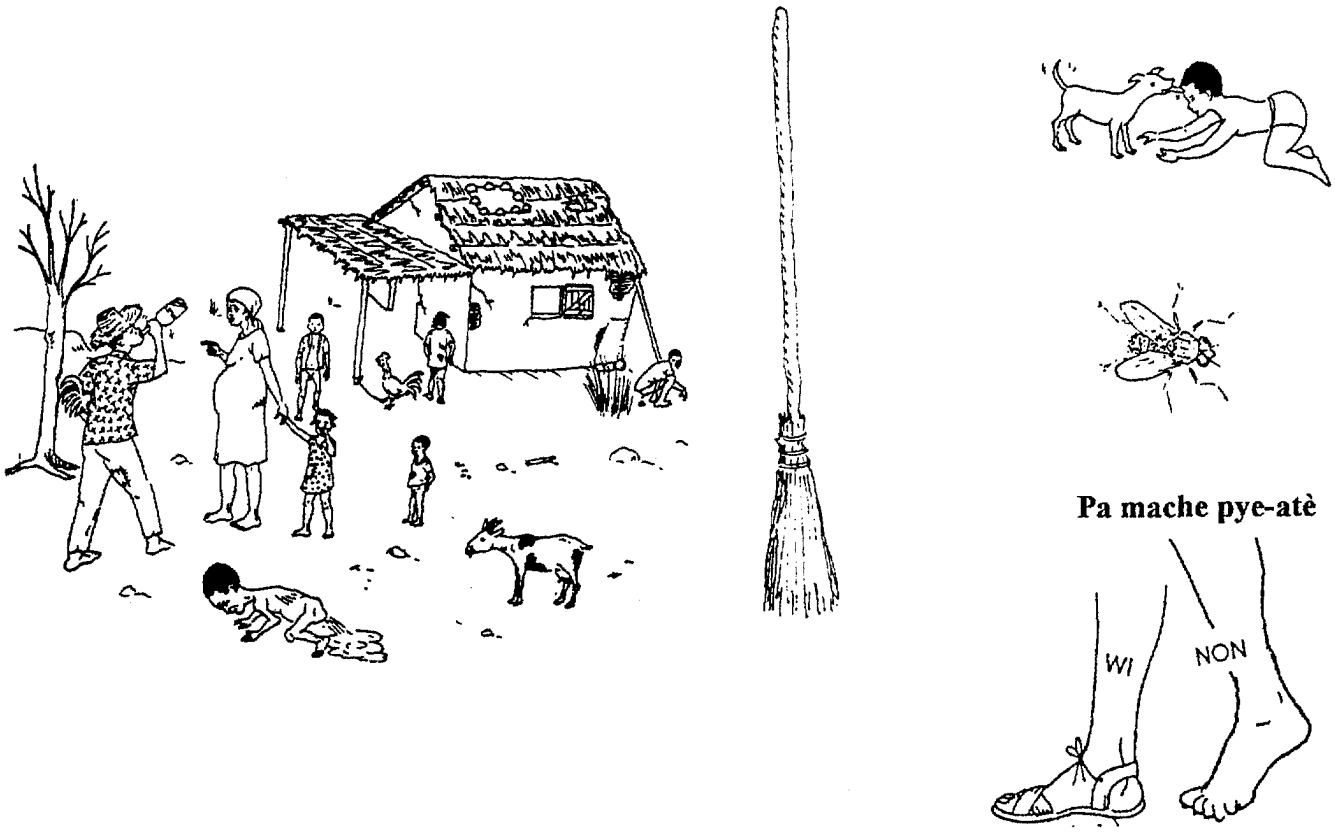


Bwose dan maten ak aswè

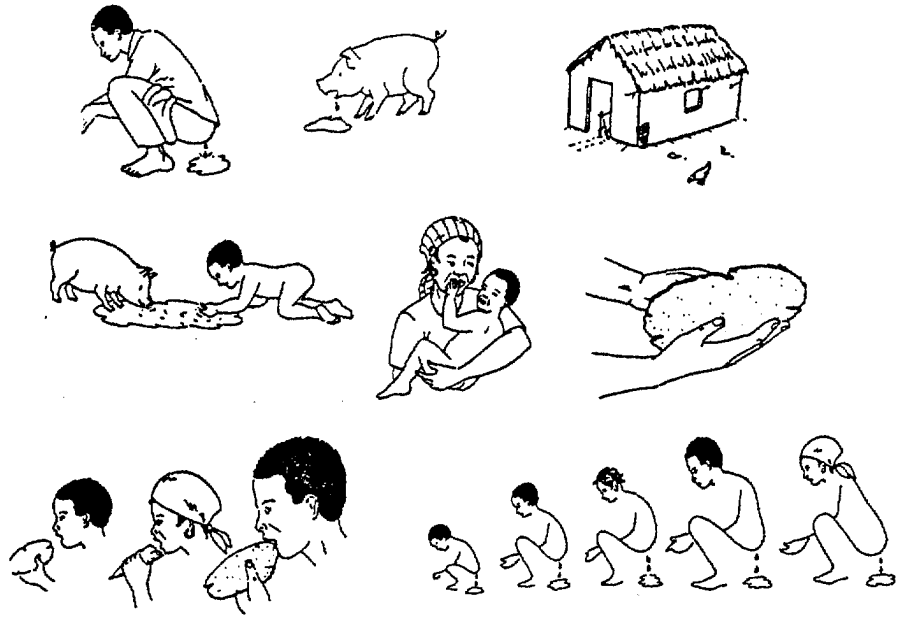
Lè ou soti nan latrin e avan ou manje fòk ou lave men ou.

109

Netwaye kay la ak lakou -a, pa kite bèt antre nan kay la e pa kite timoun yo jwe ak bèt.



Si tout moun nan lokalite-a ale nan latrin, lave men yo, avan yo manje, le yo soti nan latrin, le yo pral kenbe timoun, lè yo pral pwepare manje byen lave fwi ak salad yo avan nou manje yo. Anpil maladi pa'p gaye nan kominote a tankou Vè, dyare.



110

Mesaj pou manman yo sonje pi byen
Nou jwenn ze vè nan watè yon moun ki gen vè. Pi bon pwoteksyon kont vè se lapwopte.

Kesyon pou poze manman yo:
Nan ki bagay nou jwenn ze vè pi fasil?
Ki pwoblem moun ki pa fe pwoprete ka rive genyen?

Kesyon pou aplikasyon pratik:
Mande you manman apre leson ki jan de pwekosyon n'ap pou pwoteje nou ak timoun nou yo.

Chante pou leson sou Vè

I
Vè yo se yon maladi grav yo ye
Se pou nou bat pou nou pa jamm gen vè
Avèk tout prekosyon nou kapab pran,
Nou pap jamm gen vè nan ko nou

II
Evite vè sa mande sakrifis
Fok nou la ve men anvan manje
Pa blye lè nou sot watè tou
Pou nou pa pran tout ze vè sa yo

III
Pa bliye, chak kay bezwen yon latrin
Ki byen kouvri pou mouch pa antre
Nou bezwen bwè yon dlo ki byen pwòp
Pou nou kapab rete an sante

IV
Fwi yo menm yo pote anpil mikwòb
Lè nou manje yo san lave,
Paske atè a te gen poupou moun,
Ki te plen ze vè nan yo tou

Chan Ijyen Koporel

I

Si nou kenbe ko nou pwòp na gen sante (bis)
Paske sante se richès
se yon kado Bondye bay nou
An nou fè efo pou kenbe ko nou pwòp

II

Pou nou kenbe kò nou pwòp benyen chak jou
Brose dan ou lè ou fin manje e avan ou dòmi
Lave men ou avan ou manje ak lè ou sot nan latrin
An nou fè efò pou nou viv an sante

III

Lave tèt ti moun yo lè nou benyen yo..... ak savon
Netwaye zong yo pou yo pa kenbe mikwòb... chak jou
Ann netwaye tout kote ki kapab kenbe mikwòb
Pou pitit nou yo kapab devlope byen .....trè byen

Dlo, savon ak sitwon
Twa bagay nesesè
Mete plis dlo lakay nou
Pou nou lave men nou
Lave men timoun nou yo
Pou yo pa mouri ak dyare
Sitou avan yo manje
Ak lè yo sot nan latrin

Refren

Un, Vide dlo sou men
Deux Savonnen men nou
Twa Netwaye zòng nou
Kat Tout moun dwe fe sa

LET MANMAN

Depi yon ti moun pran nesans
bali premye let jòn nan
se li ki remplase lòk
li fè'l jete tout goudwon

Kè

Bay ti moun yo tété
pou yo ka byen vin
bay ti moun yo tété
pou yo ka byen kenbé
bay ti moun yo tété
pou yo pa malad fasil

11

Kou ti moun nan gen si mwa
let manman sifi pou li
li ka bali lòt manje é
pou'l pa fè endijesyon

111

Let manman tou prepare
E li pa koute senk kòb
bibwon mande sacrifis
E li konnen bay dyare

1V

Bay ti moun nan lòt mange
aprè li fin'n gen si mwa
men kontinye bay tété e
jouk rivé sou dizyèm mwa

SEWOM ORAL

1

Tou patou timoun ap mouri
vant manman mare ap soufwi
dyare san pitye pou tout moun
ap mache touye tout timoun

refren
Sove timoun yo avek sewòm oral
Yo pap jan'm seche aprè pou yo mouri
Se Bon dye nan syèl la ki bay seròm oral
pou'n ka kombat dyare se li pou'n amplwoye

11

Twa boutey kola plen dlo pwò
vide yo nan yon veso pwòp
vide poud seròm nan ladan'l
bwase'l met nan bouch timoun nan

111

chak fwa ou wè timoun poupou dlo
pinga ou ret kouche sou do
preapare sewòm nan bali
pou'ou kapab toujou genyen li

Appendix J

MOH Protocol for Diarrheal Case Management

TRAITER LA DIARRHEE A DOMICILE

UTILISER CE PLAN POUR APPRENDRE A LA MERE A:

- Continuer à traiter à domicile le présent épisode diarrhéique de son enfant
- Commencer rapidement le traitement lors de futurs épisodes diarrhéiques

EXPLIQUER LES TROIS REGLES DU TRAITEMENT DE LA DIARRHEE A DOMICILE:

1. FAIRE BOIRE A L'ENFANT PLUS DE LIQUIDES QUE D'HABITUDE POUR PREVENIR LA DESHYDRATATION:
   - Donner des liquides maison recommandés. Il peut s'agir de préparations à base d'aliments (eau de riz ou yaourt liquide, par exemple) ou d'eau pure.
   - Donner de la solution de SRO aux enfants dont le cas correspond au cas décrit dans l'encadré ci-après.
     Note: Si l'enfant a moins de 6 mois et ne mange pas encore d'aliments solides, lui donner de l'eau ou de la solution de SRO plutôt qu'une préparation à base d'aliments.
   - Donner à boire à l'enfant autant qu'il en a envie. Prendre comme guide les quantités indiquées ci-après pour les SRO.
   - Continuer à lui donner ces boissons jusqu'à ce que la diarrhée cesse.
2. DONNER A MANGER EN ABONDANCE A L'ENFANT POUR PREVENIR LA MALNUTRITION
   - Continuer à lui donner le sein fréquemment.
   - Si l'enfant n'est pas nourri au sein, lui donner le lait habituel. Si l'enfant a moins de 6 mois et ne prend pas encore d'aliments solides, diluer le lait ou la préparation pour nourrisson avec une quantité égale d'eau pendant 2 jours.
   - Si l'enfant a 6 mois ou plus, ou prend déjà des aliments solides:
     - Lui donner aussi des céréales ou des féculents, mélangés si possible avec des légumineuses, des légumes et de la viande ou du poisson. Ajouter une ou deux cuillerées à café d'huile végétale à chaque portion.
     - Lui donner du jus de fruits frais ou des bananes écrasées qui apportent du potassium.
     - Lui donner des aliments fraîchement préparés, bien cuits et écrasés en purée.
     - Encourager l'enfant à manger: lui donner à manger au moins 6 fois par jour.
     - Continuer à lui donner ces mêmes types d'aliments une fois que la diarrhée a cessé et lui donner un repas supplémentaire par jour pendant 2 semaines.
3. AMENER L'ENFANT A L'AGENT DE SANTE S'IL NE VA PAS MIEUX DANS LES 3 JOURS OU S'IL A UN DES SYMPTOMES SUIVANTS:
   - Nombreuses selles liquides
   - Vomissements répétés
   - Soif prononcée
   - Manque d'appétit, absence de soif
   - Fièvre
   - Sang dans les selles

ADMINISTRER DE LA SOLUTION DE SRO A L'ENFANT A DOMICILE SI:

- *Le Plan de traitement B ou C lui a déjà été appliqué.*
- *On ne peut le ramener à l'agent de santé si la diarrhée s'aggrave.*
- *La solution de SRO est la préparation liquide maison recommandée.*
- *Les autorités sanitaires nationales ont adopté pour principe de donner des SRO à tous les enfants amenés à un agent de santé pour une diarrhée.*

SI L'ENFANT DOIT RECEVOIR DES SRO A DOMICILE, IL FAUT MONTRER A LA MERE QUELLE QUANTITE ADMINISTRER APRES CHAQUE SELLE MOLLE ET LUI DONNER ASSEZ DE SACHETS DE SRO POUR 2 JOURS:

Age	Quantité de SRO à donner après chaque selle molle	Quantité de SRO à fournir pour le traitement à domicile
Moins de 24 mois	50-100 ml	500 ml/jour
2 à 10 ans	100-200 ml	1000 ml/jour
10 ans ou plus	Autant qu'il en voudra	2000 ml/jour

- Décrire et montrer, en se servant d'une mesure locale, la quantité à donner après chaque selle.

MONTRER A LA MERE COMMENT PREPARER LA SOLUTION DE SRO

LUI MONTRER COMMENT L'ADMINISTRER:

- Donner une cuillerée à café de solution toutes les 1-2 minutes aux enfants de moins de 2 ans.
- Donner fréquemment à boire dans une tasse aux enfants plus âgés.
- Si l'enfant vomit, attendre 10 minutes. Puis lui donner la solution plus lentement (par exemple, une cuillerée toutes les 2-3 minutes).
- Si la diarrhée continue une fois les sachets de SRO finis, donner à l'enfant d'autres liquides comme ceux qui sont décrits dans la première règle du traitement à domicile ou revenir chercher d'autres sachets de SRO.

Revisé en collaboration avec l'INHSAC

PLAN DE TRAITEMENT B PO TRAITER LA DESHYDRATAT

QUANTITE APPROXIMATIVE DE SOLUTION DE SRO A ADMIN AU COURS DES 4 PREMIERES HEURES:

Age:*	Moins de 4 mois	4-11 mois	12-23 mois	2-4 ans	5-14 ans
Poids:	Moins de 5 kg	5-7,9 kg	8-10,9 kg	11-15,9 kg	16-29,9 kg
En ml:	200-400	400-600	600-800	800-1200	1200-2200
En mesure locale					

Ne se baser sur l'âge du malade que si l'on ne connait pas son poids approximative de SRO nécessaire (en ml) peut aussi être calculée en multiplia malade (en kg) par 75.

- Si l'enfant veut boire plus de SRO, lui en donner plus.
- Encourager la mère à continuer à allaiter son enfant.
- Dans le cas d'enfants de moins de 6 mois qui ne sont pas nourris au sei également 100-200 ml d'eau propre pendant cette période.

OBSERVER SOIGNEUSEMENT L'ENFANT ET AIDER LA ME ADMINISTRER LA SOLUTION DE SRO:

- Lui montrer quelle quantité de solution donner à l'enfant.
- Lui montrer comment la donner - une cuillerée à café toutes les 1-2 minu l'enfant de moins de 2 ans; de fréquentes gorgées à la tasse à l'enfant p
- Vérifier de temps en temps qu'il n'y a pas de problème.
- Si l'enfant vomit, attendre 10 minutes puis continuer à administrer les SF plus lentement, par exemple une cuillerée toutes les 2-3 minutes.
- Si les paupières de l'enfant sont gonflées, cesser de donner des SRO et r l'eau pure ou du lait maternel. Donner des SRO comme indiqué dans le P fois que le gonflement a disparu.

AU BOUT DE 4 HEURES, REEVALUER L'ETAT DE L'ENFANT EN LE TABLEAU DES SIGNES DE DESHYDRATATION, PUIS CHOIS DE TRAITEMENT APPROPRIE (A, B, C).

- S'il n'y a pas de signes de déshydration, appliquer le Plan A. Une fois la déshydratation corrigée, l'enfant urine généralement et peut aussi être fa s'endormir.
- S'il y a encore des signes évidents de déshydratation, répéter le Plan B m commerçant à offrir à l'enfant des aliments, du lait et des jus de fruits cc indiqué dans le Plan A.
- Si les signes d'une déshydratation sévère sont apparus, appliquer le Plan

SI LA MERE DOIT REPARTIR AVANT LA FIN DU PLAN DE TRAIT

- Lui montrer la quantité de solution de SRO à administrer pour terminer l de 4 heures à domicile.
- Lui donner assez de sachets de SRO pour terminer le traitement de réh et pour continuer à administrer des SRO à l'enfant pendant encore 2 jo indiqué dans le Plan A.
- Lui montrer comment préparer la solution.
- Lui expliquer les trois règles du Plan A pour le traitement de son enfant
  - donner des SRO ou d'autres liquides jusqu'à ce que la diarrhée ait ces
  - alimenter l'enfant;
  - ramener l'enfant à l'agent de santé si nécessaire.

UTILISATION DES MEDICAME CHEZ L'ENFANT DIARRHEIQ

- Utiliser les ANTIBIOTIQUES pour les cas de dysenterie et les cas suspec choléra UNIQUEMENT. Dans les autres cas, ils sont inefficaces et NE dc PAS être administrés.
- Utiliser les médicaments ANTIPARASITAIRES pour les cas suivants UNIC
  - amibiase, lorsque le traitemet de la diarrhée sanglante par un antibiotiq contre Sigella a échoué *ou* que l'on a trouvé dans les selles des trophoz de E. histolytica contenant des hématies.
  - giardiase, lorsque la diarrhée dure depuis au moins 14 jours et que l'on trouvé des kystes ou des trophozoïdes de Giardia dans les selles ou le l de l'intestin grêle.
- NE JAMAIS utiliser d'ANTIDIARRHEIQUES ni d'ANTIEMIEQUES. Aucun c médicaments n'a prouvé son efficacité. Certains sont dangereux.

BEST AVAILABLE COPY

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appliquer le Plan de traitement B

appliquer le Plan de traitement C de TOUTE URGENCE

DEMANDER SI L'ENFANT A EU DE LA FIEVRE ET PRENDRE SA TEMPERATURE

SI
• Le r
l'en
SI
• Si la
• S'il
la fi
adm
proc

RRHEE A DOMICILE

(3)

APPRENDRE A LA MERE A:

ent épisode diarrhéique de son enfant
t lors de futurs épisodes diarrhéiques

MENT DE LA DIARRHEE A DOMICILE:

DES QUE D'HABITUDE POUR PREVENIR LA

s. Il peut s'agir de préparations à base
par exemple) ou d'eau pure.
s dont le cas correspond au cas décrit dans

ne mange pas encore d'aliments solides, lui
O plutôt qu'une préparation à base d'aliments.
a envie. Prendre comme guide les quantités

u'à ce que la diarrhée cesse.

L'ENFANT POUR PREVENIR LA

nt.
nner le lait habituel. Si l'enfant a moins de 6
solides, diluer le lait ou la préparation pour
pendant 2 jours.
à des aliments solides:
culents, mélangés si possible avec des
nde ou du poisson. Ajouter une ou deux
que portion.
bananes écrasées qui apportent du

éparés, bien cuits et écrasés en purée.
er à manger au moins 6 fois par jour.
s d'aliments une fois que la diarrhée a cessé
par jour pendant 2 semaines.

E S'IL NE VA PAS MIEUX DANS LES 3
SUIVANTS:
- Manque d'appétit, absence de soif
- Fièvre
- Sang dans les selles

SRO A L'ENFANT A DOMICILE SI:
té appliqué.
si la diarrhée s'aggrave.
ide maison recommandée.
nté pour principe de donner des SRO
santé pour une diarrhée.

O A DOMICILE, IL FAUT MONTRER A
TRER APRES CHAQUE SELLE MOLLE
DE SRO POUR 2 JOURS:

à donner lle molle	Quantité de SRO à fournir pour le traitement à domicile
nl	500 ml/jour
ml	1000 ml/jour
voudra	2000 ml/jour

ure locale, la quantité à donner après

PARER LA SOLUTION DE SRO

RER:

es les 1-2 minutes aux enfants

aux enfants plus âgés.

lui donner la solution plus lentement
inutes).

le SRO finis, donner à l'enfant d'autres
a première règle du traitement à domicile
).

PLAN DE TRAITEMENT B POUR TRAITER LA DESHYDRATATION

QUANTITE APPROXIMATIVE DE SOLUTION DE SRO A ADMINISTRER AU COURS DES 4 PREMIERES HEURES:

Age:*	Moins de 4 mois	4-11 mois	12-23 mois	2-4 ans	5-14 ans	15 ans ou plus
Poids:	Moins de 5 kg	5-7,9 kg	8-10,9 kg	11-15,9 kg	16-29,9 kg	30 kg ou plus
En ml:	200-400	400-600	600-800	800-1200	1200-2200	2200-4000
En mesure locale						

Ne se baser sur l'âge du malade que si l'on ne connait pas son poids. La quantité approximative de SRO nécessaire (en ml) peut aussi être calculée en multipliant le poids du malade (en kg) par 75.

- Si l'enfant veut boire plus de SRO, lui en donner plus.
- Encourager la mère à continuer à allaiter son enfant.
- Dans le cas d'enfants de moins de 6 mois qui ne sont pas nourris au sein, donner également 100-200 ml d'eau propre pendant cette période.

OBSERVER SOIGNEUSEMENT L'ENFANT ET AIDER LA MERE A LUI ADMINISTRER LA SOLUTION DE SRO:

- Lui montrer quelle quantité de solution donner à l'enfant.
- Lui montrer comment la donner - une cuillerée à café toutes les 1-2 minutes à l'enfant de moins de 2 ans; de fréquentes gorgées à la tasse à l'enfant plus âgé.
- Vérifier de temps en temps qu'il n'y a pas de problème.
- Si l'enfant vomit, attendre 10 minutes puis continuer à administrer les SRO, mais plus lentement, par exemple une cuillerée toutes les 2-3 minutes.
- Si les paupières de l'enfant sont gonflées, cesser de donner des SRO et donner de l'eau pure ou du lait maternel. Donner des SRO comme indiqué dans le Plan A une fois que le gonflement a disparu.

AU BOUT DE 4 HEURES, REEVALUER L'ETAT DE L'ENFANT EN UTILISANT LE TABLEAU DES SIGNES DE DESHYDRATATION, PUIS CHOISIR LE PLAN DE TRAITEMENT APPROPRIE (A, B, C).

- S'il n'y a pas de signes de déshydration, appliquer le Plan A. Une fois la déshydratation corrigée, l'enfant urine généralement et peut aussi être fatigué et s'endormir.
- S'il y a encore des signes évidents de déshydratation, répéter le Plan B mais en commerçant à offrir à l'enfant des aliments, du lait et des jus de fruits comme indiqué dans le Plan A.
- Si les signes d'une déshydratation sévère sont apparus, appliquer le Plan C.

SI LA MERE DOIT REPARTIR AVANT LA FIN DU PLAN DE TRAITEMENT B:

- Lui montrer la quantité de solution de SRO à administrer pour terminer le traitement de 4 heures à domicile.
- Lui donner assez de sachets de SRO pour terminer le traitement de réhydratation et pour continuer à administrer des SRO à l'enfant pendant encore 2 jours comme indiqué dans le Plan A.
- Lui montrer comment préparer la solution.
- Lui expliquer les trois règles du Plan A pour le traitement de son enfant à domicile:
  - donner des SRO ou d'autres liquides jusqu'à ce que la diarrhée ait cessé;
  - alimenter l'enfant;
  - ramener l'enfant à l'agent de santé si nécessaire.

UTILISATION DES MEDICAMENTS CHEZ L'ENFANT DIARRHEIQUE

- Utiliser les ANTIBIOTIQUES pour les cas de dysenterie et les cas suspects de choléra UNIQUEMENT. Dans les autres cas, ils sont inefficaces et NE doivent PAS être administrés.
- Utiliser les médicaments ANTIPARASITAIRES pour les cas suivants UNIQUEMENT:
  - amibiase, lorsque le traitemet de la diarrhée sanglante par un antibiotique contre Sigella a échoué *ou* que l'on a trouvé dans les selles des trophozoïdes de E. histolytica contenant des hématies.
  - giardiase, lorsque la diarrhée dure depuis au moins 14 jours et que l'on a trouvé des kystes ou des trophozoïdes de Giardia dans les selles ou le liquide de l'intestin grêle.
- NE JAMAIS utiliser d'ANTIDIARRHEIQUES ni d'ANTIEMIEQUES. Aucun de ces médicaments n'a prouvé son efficacité. Certains sont dangereux.

F
F
L/

SUIVRE LES FLE
SI LA REPONSE
SI

Etes-vous en mesure de procéder immédiatement à une perfusion intraveineuse (IV)

NON

Y a-t-il à proximité (à 30 minutes de distance ou moins) un centre de santé équipé pour procéder la perfusion

=O

NON

Avez-vous la formation nécessaire pour utiliser une sonde nasogastrique pour la réhydratation?

=O

NON

Le malade peut-il boire?

=OU

NON

URGENT: Envoyer le malade dans un service où l'on pourra procéder à la réhydratation par voie intraveineuse ou avec une sonde nasogastrique.

NOTES:
- Une fois la réhydrata
moins 6 heures pou
administrant des SR
- Si le malade a plus d
administrer un antib

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Peser le malade si possible et appliquer le Plan de traitement C de TOUTE URGENCE

raison de 5 ml/kg/heure pendant le transport à l'hôpital.

DEMANDER SI L'ENFANT A EU DE LA FIEVRE ET PRENDRE SA TEMPERATURE

SI L'ENFANT A MOINS DE 2 MOIS:
- Le réhydrater de manière appropriée. Ensuite, s'il a de la fièvre (38° C ou plus), l'envoyer à l'hôpital. Ne pas donner de paracétamol ni d'antipaludique

SI L'ENFANT A 2 MOIS OU PLUS:
- Si la température est égale ou supérieure à 39°C, l'administrer du paracétamol
- S'il y a des cas de paludisme à falciparum dans la région et si l'enfant a de la fièvre (38° C ou plus) ou en a eu au cours des 5 derniers jours, lui administrer un antipaludique (ou le traiter selon les recommandations du programme antipaludique local).

N DE TRAITEMENT B POUR TER LA DESHYDRATATION

PROXIMATIVE DE SOLUTION DE SRO A ADMINISTRER ES 4 PREMIERES HEURES:

loins de 4 mois	4-11 mois	12-23 mois	2-4 ans	5-14 ans	15 ans ou plus
ins de 5 kg	5-7,9 kg	8-10,9 kg	11-15,9 kg	16-29,9 kg	30 kg ou plus
200-400	400-600	600-800	800-1200	1200-2200	2200-4000

ur l'âge du malade que si l'on ne connait pas son poids. La quantité SRO nécessaire (en ml) peut aussi être calculée en multipliant le poids du ar 75.
eut boire plus de SRO, lui en donner plus.
a mère à continuer à allaiter son enfant.
d'enfants de moins de 6 mois qui ne sont pas nourris au sein, donner 00-200 ml d'eau propre pendant cette période.

OIGNEUSEMENT L'ENFANT ET AIDER LA MERE A LUI LA SOLUTION DE SRO:

quelle quantité de solution donner à l'enfant.
comment la donner - une cuillerée à café toutes les 1-2 minutes à noins de 2 ans; de fréquentes gorgées à la tasse à l'enfant plus âgé.
emps en temps qu'il n'y a pas de problème.
omit, attendre 10 minutes puis continuer à administrer les SRO, mais ent, par exemple une cuillerée toutes les 2-3 minutes.
res de l'enfant sont gonflées, cesser de donner des SRO et donner de u du lait maternel. Donner des SRO comme indiqué dans le Plan A une gonflement a disparu.

4 HEURES, REEVALUER L'ETAT DE L'ENFANT EN UTILISANT DES SIGNES DE DESHYDRATATION, PUIS CHOISIR LE PLAN ENT APPROPRIE (A, B, C).

s de signes de déshydration, appliquer le Plan A. Une fois la ion corrigée, l'enfant urine généralement et peut aussi être fatigué et

re des signes évidents de déshydratation, répéter le Plan B mais en t à offrir à l'enfant des aliments, du lait et des jus de fruits comme s le Plan A.
d'une déshydratation sévère sont apparus, appliquer le Plan C.

DOIT REPARTIR AVANT LA FIN DU PLAN DE TRAITEMENT B:

er la quantité de solution de SRO à administrer pour terminer le traitement es à domicile.
r assez de sachets de SRO pour terminer le traitement de réhydratation ontinuer à administrer des SRO à l'enfant pendant encore 2 jours comme ans le Plan A.
er comment préparer la solution.
uer les trois règles du Plan A pour le traitement de son enfant à domicile:
des SRO ou d'autres liquides jusqu'à ce que la diarrhée ait cessé;
er l'enfant;
r l'enfant à l'agent de santé si nécessaire.

ISATION DES MEDICAMENTS EZ L'ENFANT DIARRHEIQUE

ANTIBIOTIQUES pour les cas de dysenterie et les cas suspects de NIQUEMENT. Dans les autres cas, ils sont inefficaces et NE doivent administrés.
médicaments ANTIPARASITAIRES pour les cas suivants UNIQUEMENT:
lorsque le traitemet de la diarrhée sanglante par un antibiotique gella a échoué *ou* que l'on a trouvé dans les selles des trophozoïdes tolytica contenant des hématies.
lorsque la diarrhée dure depuis au moins 14 jours et que l'on a es kystes ou des trophozoïdes de Giardia dans les selles ou le liquide tion grêle.
IS utiliser d'ANTIDIARRHEIQUES ni d'ANTIEMIEQUES. Aucun de ces ents n'a prouvé son efficacité. Certains sont dangereux.

PLAN DE TRAITEMENT C
POUR TRAITER RAPIDEMENT LA DESHYDRATATION SEVERE

SUIVRE LES FLECHES.
SI LA REPONSE A LA QUESTION EST «OUI», FAIRE CE QUI EST INDIQUE A DROITE.
SI C'EST «NON», PASSER A LA QUESTION SUIVANTE.

Êtes-vous en mesure de procéder immédiatement à une perfusion intraveineuse (IV)

OUI →
- Mettre immédiatement en place la perfusion. Si le malade peut boire, lui donner des SRO à boire en attendant que la perfusion commence. Lui administrer 100 ml/kg de solution de Ringer au lactate (ou s'il n'y en a pas, de sérum physiologique) répartis comme suit:

Age	Administrer d'abord 30 ml/kg en:	Puis administrer 70 ml/kg en:
Enfants de moins de 12 mois	1 heure*	5 heures
Enfants plus âgés	30 minutes*	2h30

*Répétez une fois si le pouls est encore très faible ou non décelable
- Réévaluer l'état du malade toutes les 1-2 heures. Si la déshydratation ne se corrige pas, administrer la perfusion plus rapidement.
- Donner aussi des SRO (environ 5 ml/kg/heure) dès que le malade peut boire: généralement au bout de 3-4 heures (nourrissons) ou de 1-2 heures (malades plus âgés).
- Au bout de 6 heures (nourrissons) ou de 3 heures (malades plus âgés), réexaminer le malade en se servant du tableau des signes de déshydratation. Puis choisir le Plan approprié(A, B ou C) pour la poursuite du traitement.

NON ↓

Y a-t-il à proximité (à 30 minutes de distance ou moins) un centre de santé équipé pour procéder la perfusion

OUI →
- Envoyer immédiatement l'enfant dans ce centre pour y être perfusé.
- Si l'enfant peut boire, donner à sa mère de la solution de SRO et lui montrer comment l'administrer pendant le transport.

NON ↓

Avez-vous la formation nécessaire pour utiliser une sonde nasogastrique pour la réhydratation?

OUI →
- Commencer la réhydratation à l'aide de la sonde nasogastrique et administrer de la solution de SRO à raison de 20 ml/kg/heure pendant 6 heures (total 120 ml/kg).
- Réévaluer l'état du malade toutes les 1-2 heures:
  - si les vomissements se poursuivent ou s'il y a distension abdominale, administrer le liquide plus lentement;
  - si l'état du malade ne s'est pas amélioré au bout de 3 heures, envoyer le malade dans un centre où l'on pourra lui administrer le traitement par perfusion intraveineuse (IV).
- Au bout de 6 heures, procéder à un nouvel examen du malade et choisir le plan de traitement approprié.

NON ↓

Le malade peut-il boire?

OUI →
- Commencer la réhydratation par voie orale en administrant de la solution de SRO à raison de 20 ml/kg/heure pendant 6 heures (total 120 ml/kg).
- Réévaluer le malade toutes les 1-2 heures:
  - s'il a vomissements répétés, administrer le liquide plus lentement;
  - si l'état du malade ne s'est pas amélioré au bout de 3 heures, envoyer le malade dans un service où l'on pourra lui administrer le traitement par perfusion.
- Au bout de 6 heures, procéder à une nouvelle évaluation de l'état du malade et choisir le plan de traitement approprié.

NON ↓

URGENT: Envoyer le malade dans un service où l'on pourra procéder à la réhydratation par voie intraveineuse ou avec une sonde nasogastrique.

NOTES:
- Une fois la réhydratation achevée, garder, si possible, le malade en observation au moins 6 heures pour s'assurer que la mère sait maintenir l'hydratation en lui administrant des SRO par voie buccale.
- Si le malade a plus de 2 ans et s'il y a des cas de choléra dans votre région, administrer un antibiotique oral approprié une fois le malade sorti de son pathie.

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D'ABORD, RECHERCHER LES SIGNES DE DESHYDRATATION

	A	B	C
1. OBSERVER: ETAT GENERAL	Normal, éveillé	*Agité, irritable*	*Léthargique ou inconscient apathique*
YEUX	Normaux	Enfoncés	Très enfoncés et secs
LARMES	Présentes	Absentes	Absentes
BOUCHE et LANGUE	Humides	Sèches	Très sèches
SOIF	Boit normalement, n'est pas assoifé	*Assoiffé, boit avec avidité*	*Boit à peine ou est incapable de boire*
2. PALPER: PLI CUTANE	S'efface rapidement	*S'efface lentement*	*S'efface très lentement*
3. CONCLURE:	Le malade n'a PAS DE SIGNES DE DESHYDRATATION	Si le malade a au moins deux de ces signes, dont au moins un *signe*, en conclure qu'il a des SIGNES EVIDENTS DE DESHYDRATATION	Si le malade a au moins deux de ces signes, dont au moins un *signe*, en conclure qu'il a une DESHYDRATATION SEVERE
4. TRAITER:	Appliquer le Plan de traitement A	Peser le malade si possible et appliquer le Plan de traitement B	Peser le malade si possible et appliquer le Plan de traitement C de TOUTE URGENCE

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PUIS, LES SIGNES D'AUTRES PROBLEMES

DEMANDER S'IL Y A DU SANG DANS LES SELLES	S'IL Y A DU SANG DANS LES SELLES • Administrer pendant 5 jours un antibiotique oral recommandé pour le traitement de la dysenterie à **Shigella** dans la région. • Apprendre à la mère à nourrir son enfant comme indiqué dans le Plan A. • Recevoir l'enfant au bout de 2 jours: - s'il a moins d'un an - s'il était déshydraté au départ - s'il a encore du sang dans les selles - s'il ne va pas mieux • Si les selles sont encore sanglantes au bout de 2 jours, passer à un deuxième antibiotique oral recommandé pour le traitement de la dysenterie à **Shigella** dans la région. L'administrer pendant 5 jours
DEMANDER QUAND LE PRESENT EPISODE DE DIARRHEE A COMMENCE	SI L'EPISODE DURE DEPUIS AU MOINS 2 SEMAINES: • Envoyer l'enfant à l'hôpital: - s'il a moins de 6 mois; - s'il est déshydraté (envoyer l'enfant après traitement de la déshydratation). • Sinon, apprendre à la mère à nourrir son enfant comme indiqué dans le Plan A, avec toutefois les modifications suivantes: - diluer tout lait d'origine animale avec un volume égal d'eau ou le remplacer par un laitage fermenté tel que yaourt; - assurer à l'enfant un apport énergétique suffisant en lui administrant 6 repas par jour composés de céréales épaisses additionnées d'huile, mélangées à des légumes, des légumineuses, de la viande ou du poisson. • Dire à la mère de ramener son enfant au bout de 5 jours: - si la diarrhée n'a pas cessé, envoyer l'enfant à l'hôpital; - si la diarrhée a cessé, dire à la mère de: - continuer à donner les mêmes types d'aliments pour l'alimentation normale de l'enfant; - au bout d'une semaine, réintroduire, progressivement le lait animal habituel; - donner un repas supplémentaire par jour à l'enfant pendant au moins 1 mois.
RECHERCHER LES SIGNES DE MALNUTRITION SEVERE	SI L'ENFANT PRESENTE UNE MALNUTRITION SEVERE • Ne pas essayer de le réhydrater: l'envoyer à l'hôpital pour y être traité. • Donner à la mère de la solution de SRO et lui montrer comment l'administrer à raison de 5 ml/kg/heure pendant le transport à l'hôpital.
DEMANDER SI L'ENFANT A EU DE LA FIEVRE ET PRENDRE SA TEMPERATURE	SI L'ENFANT A MOINS DE 2 MOIS: • Le réhydrater de manière appropriée. Ensuite, s'il a de la fièvre (38° C ou plus), l'envoyer à l'hôpital Ne pas donner de paracétamol ni d'antipaludique SI L'ENFANT A 2 MOIS OU PLUS: • Si la température est égale ou supérieure à 39°C, l'administrer du paracétamol • S'il y a des cas de paludisme à falciparum dans la région et si l'enfant a de la fièvre (38° C ou plus) ou en a eu au cours des 5 derniers jours, lui administrer un antipaludique (ou le traiter selon les recommandations du programme antipaludique local).

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PLAN DE TRAITEMENT C
POUR TRAITER RAPIDEMENT LA DESHYDRATATION SEVERE

SUIVRE LES FLECHES,
SI LA REPONSE A LA QUESTION EST «OUI», FAIRE CE QUI EST INDIQUE A DROITE.
SI C'EST «NON», PASSER A LA QUESTION SUIVANTE.

Etes-vous en mesure de procéder

OUI

• Mettre immédiatement en place la perfusion. Si le malade

UR
ON
STRER

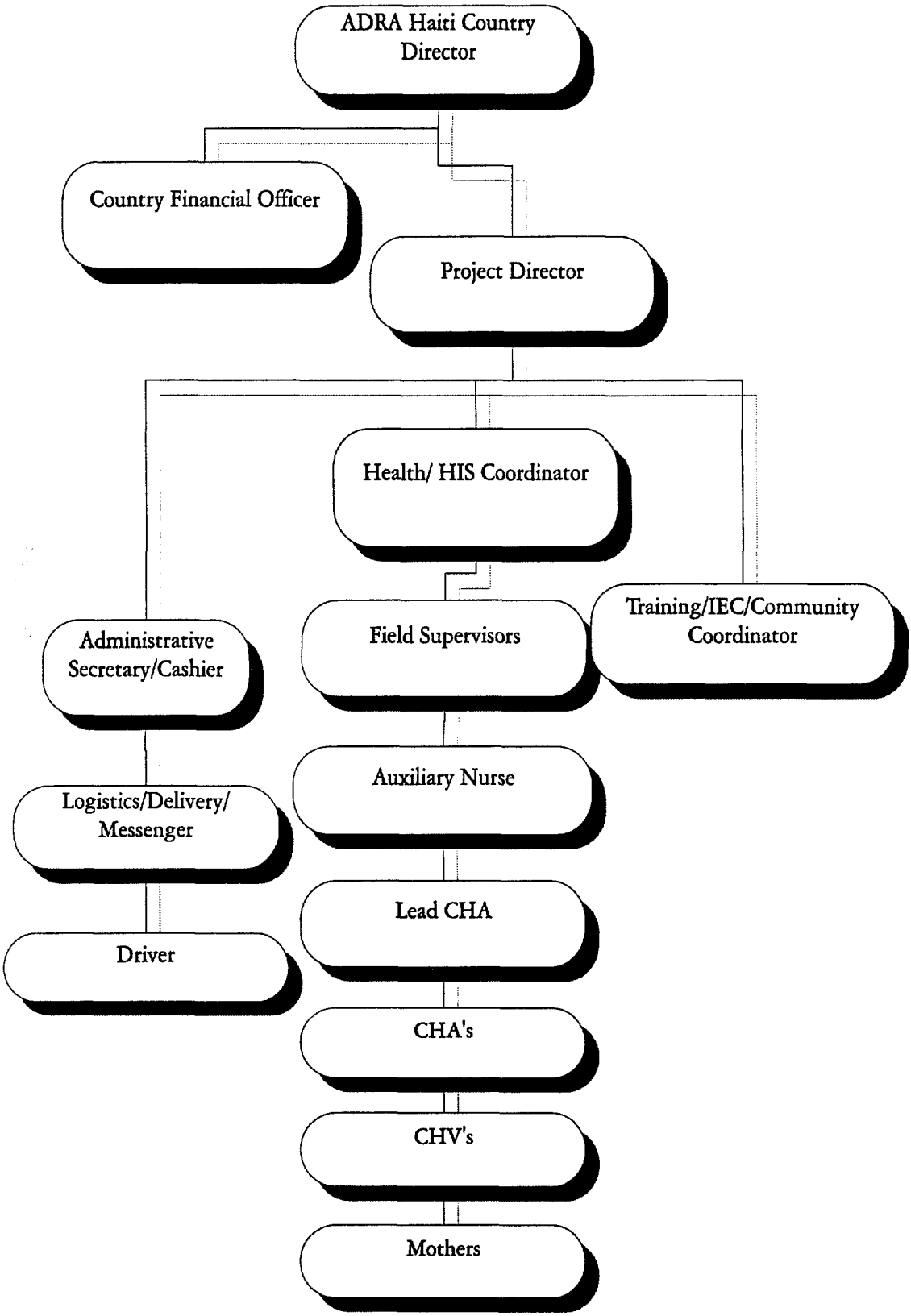
15 ans ou plus
) kg ou plus
200-4000

120

Appendix K

Project Organizational Chart

ADRA Haiti Child Survival XII Project
Organizational Chart



Appendix L

Key IEC Messages on Breastfeeding, ORT, EPI, Nutrition, Sanitation and Child Development

Ti Liv
Pou Fòmasyon Paran

Sante ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

unicef

Fonds des Nations Unies pour l'enfance

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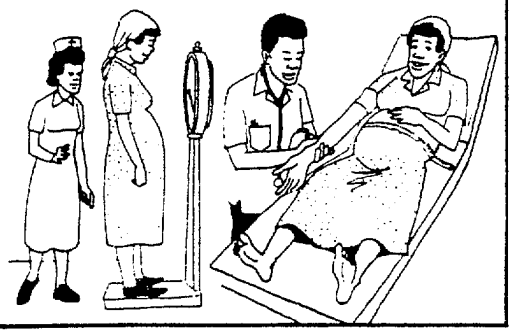
Gwoses ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

Kò m ak sèvo m ap devlope. Manman, fòk ou manje pou m byen vini. Sa ki bon pou ou, bon pou mwen. Se: lèt, bouyon fèy, fwi, vyann, legim, pwason, mayi oswa diri ak sòs pwa. Sa ki pa bon pou ou, pa bon pou mwen tou: evite gwo fatig, bwè bweson, fimen tabak ak pran dwòg.

Pou mwen ka byen vini, fòk doktè oswa enfimyè swiv mwen depi m nan vant. Al nan klinik pou yo kontwole pwa ou, tansyon ou ak mezire vant ou. Fòk ou konnen mwen vivan. Pran ka m.

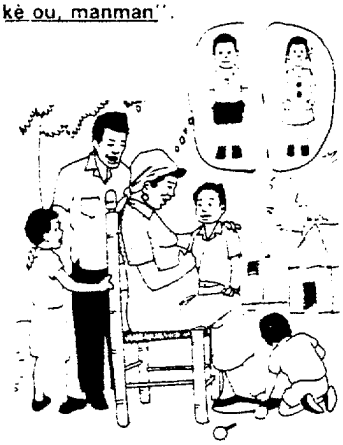


Pran vaksen tetanòs 2 fwa anvan ou rive sou 8 mwa, pou pwoteje lavi nou kont maladi kò rèd. Al vaksinen, manman.

Evite miyò pase mande padon. Si pye ou plen (gonfle) oswa si ou gen doulè kòde anba vant, ak san kap koule sot nan vant ou, ka m grav. Chèche chemen lopital ou byen sant sante a san pèdi tan.

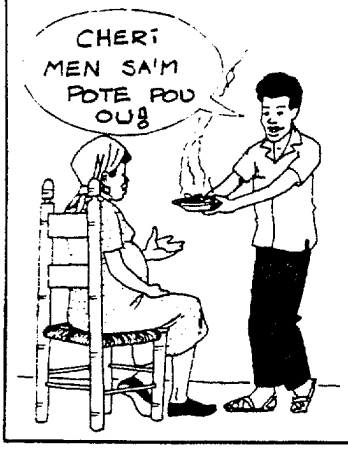
Depi timoun nan nan vant manman l', manman an konnen li la, manman an koumanse reve sou pitit la: kilès l ap sanble, si l ap yon ti fi, oubyen yon ti gason, si l ap entelijan, si l ap pi save pase l: timoun nan deja gen yon plas nan kè manman l, ak nan kè moun nan fanmi an.

"Ban' m tout plas mwen merite nan kè ou, manman".



Gen anpil fanm ki viv pou kont yo, ki gen tout chay leve timoun yo. Menm lè yo gen yon mesye avèk yo, se yon bagay ki pa fasil. Kit li se papa pitit la, kit li se pa papa l.

"Okipe manman an, swen li, pwoteje l. Se madanm ou li ye. Tout rès fanmi an gen menm devwa sa yo.



Depi mwen nan vant manman m, manman m konnen mwen la. Se de moun ki mare ansanm. Lavi youn depann de lòt la. Si manman m byen pòte gwosès li, si li aksepte m: mwen santi m byen.

"Pa pran ka m sèlman, renmen m".

Mwen rive sou 9 mwa. Mwen pare pou m soti. Kouman mwen ye? Mwen pi long, mwen byen an chè paske ou te manje sa k te bon pou mwen. Ak tou sa, sèvo m byen devlope, menm si li poko finn devlope nèt.

"SAK BON POU MANMAN'M, BON POU MWEN"

unicef

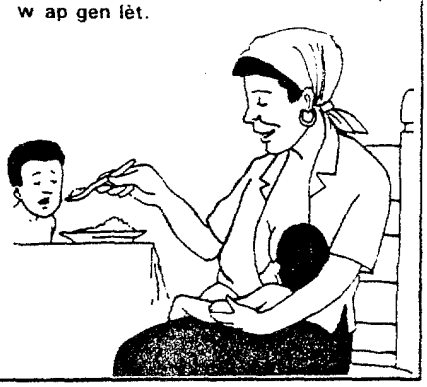
Sant ak Devlopman Timoun

Rive mwa

KONESANS FANMI SE LESPWA TIMOUN

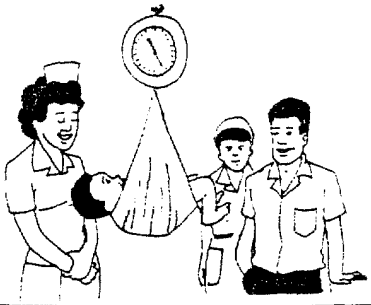
Depi mwen fèk fèt ban mwen lèt ou sèlman, ti lèt jòn nan se pi bon lòk pou mwen. Mwen pa bezwen ni lòt lèt, ni bibwon.
Ban mwen lèt ou tout tan. Manman pa bliye ti bebe a depann de ou pou tout bagay. Lè li nan bra ou li santi l byen, gade l nan je, pale ak li.
Pi bèl plezi l, se lè w ap ba l tete.

Ban mwen tete souvan. Kò mwen gen pou li gwosi jou apre jou. Men sa ou dwe fè pou gen anpil lèt. Ou bezwen bwè anpil dlo epi manje pi plis. plis mwen rale tete, plis w ap gen lèt.



Ti kò mwen fèb anpil, mwen bezwen pwoteksyon. Depi mwen fèt, menmen m al pran vaksen BCG kont maladi tibèkilòz (pwatrinè).

Depi mwen rive sou 6 semenn, mwen bezwen pran premye dòz vaksen polyo ak DTP. Fòk mwen pran 3 dòz vaksen sa yo pou yo pwoteje m kont maladi polyo, koklich, tetanòs (kò rèd) ak difteri. Ti dyare, ti la fyèv, ti tous pa ka anpeche m pran vaksen. Pa bliye vaksen gratis.



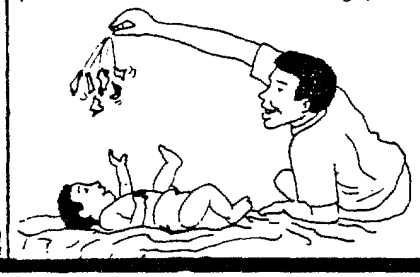
Mwen fèk fèt, se vre, men mwen konnen anpil bagay deja, menm si ou wè m ap dòmi anpil. Mwen konn tete pou kont mwen, ou pa bezwen aprann mwen. Si kouchèt mwen sal ak si mwen grangou, nan jan pa mwen ma p fè ou konnen sa, m ap kriye. Mwen tande bwi, mwen wè si fè nwa, si l fè klè. Mwen wè tou si koulè pa menm. Sa k pi bèl la, mwen ka kenbe rad ou byen di ak dwèt mwen.

Mennen m chak mwa al nan sant, pou pran pèz mwen pou mwen ka toujou an sante.

Mwen poko konn pale se vre, mwen poko konn mache se vre tou, men se yon moun tout bon mwen ye deja. "Timoun se moun". Kidonk, pandan w ap okipe mwen pale ak mwen, jwe ak mwen, karese mwen.

Ti kò m bezwen anpil swen, pwopte, lave kò mwen, lave cheve m, chanje kouchèt mwen souvan, pa janm kite m pou kont mwen.

Sa mwen konnen deja, mwen pral aprann sèvi avèk li : m ap gade, m ap tande lantouraj mwen, mwen kòmanse vle manyen sa ki bò kote m.
Tout bagay m ap wè, m ap tande, m ap manyen fè tèt mwen travay.
Se konsa lespri mwen ap devlope. Fè m pran lè, fè mwen wè divès lòt bagay.



Sou twa mwa, mwen rekonèt figi moun. Depi ou panche sou mwen w ap gade m w ap pale ak mwen, m ap souri ba ou.

"PLIS MWEN PITI, PLIS MWEN BEZWEN SWEN: BAN'M TETE, VAKSINEN'M"

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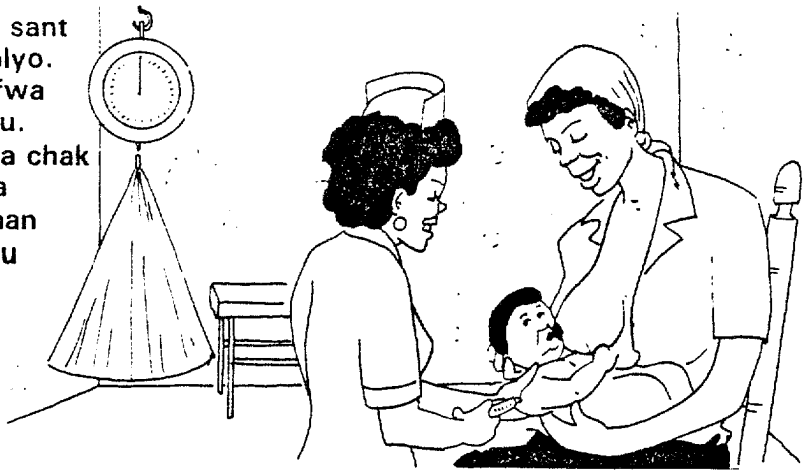
3 rive 6 mwa ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

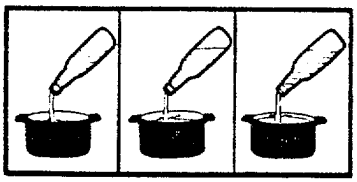
Sou 2 mwa edmi, pa bliye mennen m nan sant lan al pran dezyèm dòz vaksen DTP ak polyo. Kounye a, mwen fèt pou mwen peze de fwa pèz ke lè m te fèt. M ap gwosi jou apre jou.

mwen al peze nan sant ki pi pre a chak mwa pou wè si ma p pwofite. Kontwole sa nan kat chemen la sante mwen. Lèt manman toujou bon pou mwen. Manman, se lèt pa ou la menm ki bon pou mwen.



Bibwon ak veso sal ka ban m dyare. Dyare se maladi ki tiye anpil timoun paske yo pèdi dlo ak anpil lòt bagay ki nesesè pou kò yo.

Depi ou wè m poupou dlo, menm si se yon sèl fwa, ban m bwè anpil dlo, anpil ji ou anpil rafrechi oswa sewòm oral.



Men kijan ou prepare sewòm oral: plen yon boutèy kola vid byen pwòp 3 fwa ak dlo pwòp, vide l nan yon veso pwòp, lage poud ki nan sache sewòm oral la nan dlo a epi brase l byen.

Kounye a, timoun nan pa pase tan l ap manje, dòmi sèlman. Je l byen klere, li kòmanse fè yon dal bagay ak kò l, pye l, men l, li ka chita si ou mete yon zorye dèyè do l.

Li seye atrap, li atrap tout bagay ki bò kote l.

Gen yon seri mouvman li pase tan l ap refè yo. Se aprann l ap aprann. Tankou nan jete, ranmase: l ap aprann sèvi ak men l.

Nan fè, refè mouvman, yon lòt bagay li fè souvan: li met tout bagay ki tonbe anba men l nan bouch li.

Sonje se nan bouch li li jwenn pi gran plezi pa l.

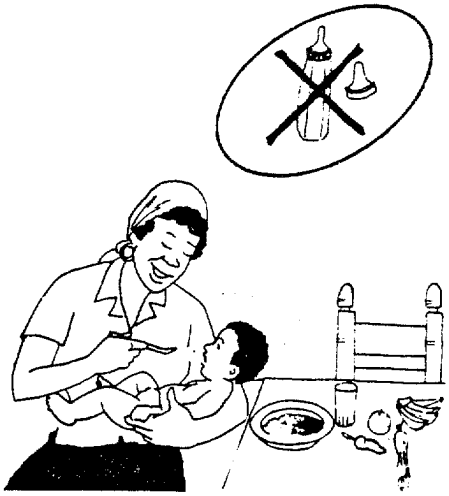
Si ou wè yon timoun pa vle manje, pa fòse l. Chèche konprann poukisa.

"Pa kite bagay sal al nan bouch li.

Bezwen timoun nan chanje; nou wè jan li vinn konn fè yon dal lòt bagay ak kò l, ak pye l, ak men l. Se vre, men se yon timoun piti li ye toujou. Li toujou bezwen manman l. Li toujou depann de li pou tout bagay. Toujou kontinye okipe l, men kite l dekouvri sa ki alantou l.

Ou ka kòmanse ban m ti ji, ti bouyon fèy, ti bouyon viv ak ti labouyi farin.

Se pou ban m manje ak ti kiyè byen pwòp ou byen ti gode byen pwòp. Ou pa bezwen sèvi ak bibwon pou mwen.



"SWEN M, PRAN KA M, RENMEN M:
TI PYEBWA BEZWEN ROUZE POU LI POUSE"

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Brive Gnwa ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

Toujou kontinye ban m tete. Pou m byen devlope, mwen bezwen 3 kalite manje sa yo: manje ki pwoteje kò m, tankou: legim, fwi, kawòt, tomat, fig; manje ki bay fòs, tankou: diri, oswa mayi ak sòs pwa; manje ki bati kò: vyann, ze, lèt, poul, kabrit. Ban m bouyon legim, ze, fwi, mayi moulen, paske m ka manje gwo manje ki gen sèl.

Lè yon timoun pa kenbe yon bagay nan men l ou lè li pa wèl, li pa konn si l la toujou. Se pou sa nan jwe li ren-men lage l pou l pèdi l pou l ranmase l ankò.

Lap chache konnen kouman li fè la toujou paske li te disparèt.
Se menm jan lè l pa wè manman l, lè manman l pa bò kote l, li konnen li pèdi l, li kriye. Se pa kapris l ap fè.

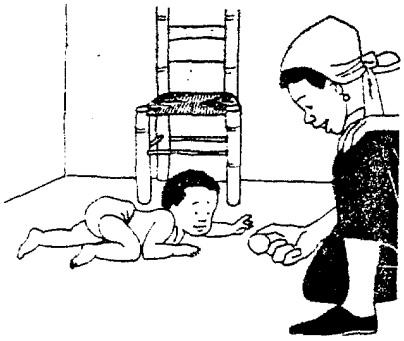
A laj sa a, non sèlman li konn figi moun, men li rekonèt trè byen figi moun ki nan lantouraj li ak figi moun ki okipe l.

Lè yon figi li pa rekonèt parèt sou li, li fè l pè. Li ka menm kriye.

Pa lage l konsa nan men moun li pa konnen.

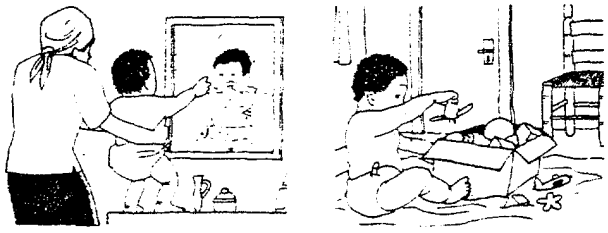
Timoun nan chita fèm e li kòmanse rale. Sa pèmèt li dekouvri yon dal lòt bagay pou kont li. Kenbe kay la pwòp, koupe ti zong li ak yon ti sizo pwòp pou li pa kenbe kras; kenbe l pwòp.

Pa rete l sou kous li, men veye l tout tan; gen danje; ti wòch, dife, eks...



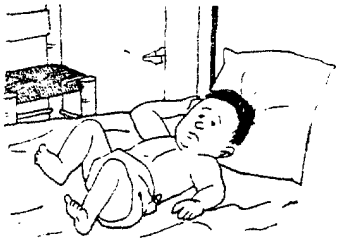
Menm jan timoun nan kapab rekonèt figi moun nan lantouraj li li ka rekonèt tet li nan yon glas. Sa fè l sezi, li ri.

Tou sa fè tèt li travay, li kòmanse chache sa pou l fè lè l bezwen pran ou byen lè l vle yon bagay.



Sonje, manman: yon chodye pa kanpe sou de wòch. Sou 6 mwa, si mwen poko pran twazyèm dòz vaksen ditepè ak polyo, se lè pou mwen al pran yo.

Si mwen mal manje, men sa k ap rive pye m ap plen, figi m ap anfle, po m ap chanje koulè, cheve m ap kase fasil e m ap chagren. Yo rele maladi sa a malnitrisyon. Si mwen gen lafyèv, si souf mwen kout, mennen m nan sant ki pi pre a, pa pèdi tan.



"DEPI'M POUPOU DLO:
BAN'M SEWÒM ORAL KI ANPECHE TIMOUN SECHE ANBA DYARE"

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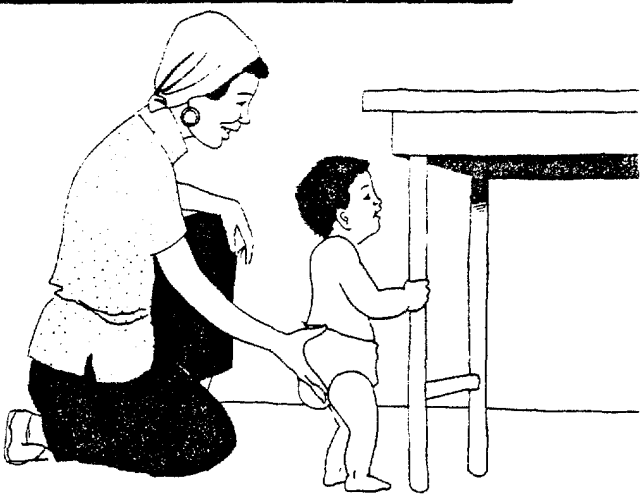
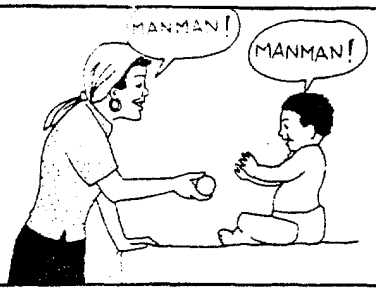
9 rive 12 mwa

Sante ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

Timoun nan kanpe, men li bezwen yo ede l anvan l kapab fè l pou kò l . Lè ou kenbe men l , li pa pè, sa ede l vanse.
Kenbe men l pou l pran fòs.





Tout bagay nèf sa yo ke timoun nan vinn konn fè, sa mande enkourajman ak aplodisman pou li ka kontinye pi devan.

Timoun nan konn di kèk mo, li konprann sans mo pa ou yo tou.

Pale ak li, chante pou li.

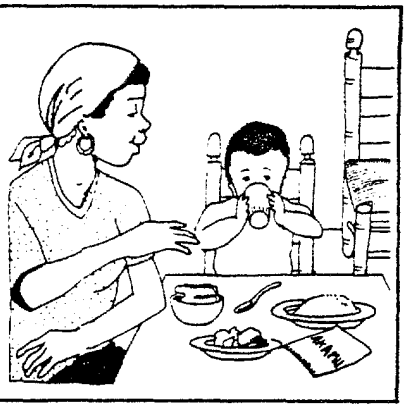
Gen yon lòt jan timoun aprann tou. Se nan gade sa granmoun ap fè pou yo fè menm jan ou byen nan repete sa ou aprann li fè.

Aprann li fè ti jès ak ti jwèt.

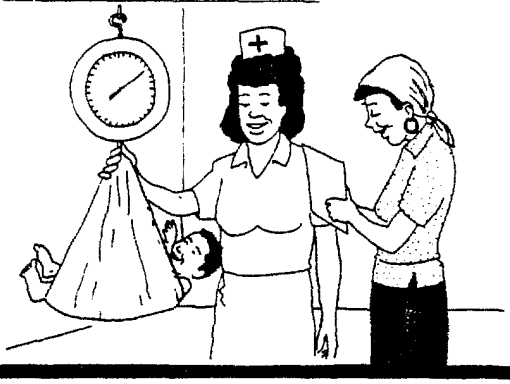
Chak jou, kò m bezwen divès kalite manje.

Ban m manje ki kab pwoteje m, tankou fwi, legim, fèy vèt ak lèt. Ban m manje ki bati kò m tankou vyann bèf, poul, pwason, ze.
Ban m manje ki kab ban m fòs tankou mayi, pwa, pitimi, biskwit ak lòt kalite viv.

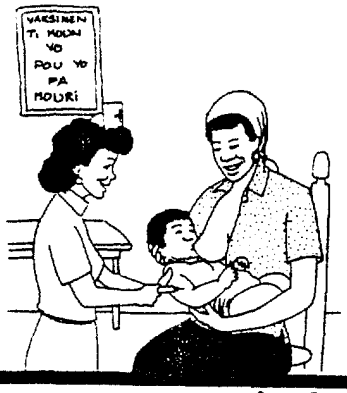
Yon manje ki trè enpòtan pou mwen, se AKAMIL. Li fèt ak 2 mezi mayi, diri oswa pitimi epi yon mezi pwa. Tout moulen ansanm pou fè yon farin. Farin sa a nourisan anpil.



Lè m pa pwofite , ban mwen plis manje. Ban m tou sa mwen renmen. Chak mwa lè ou mennen m al nan pèz, toujou vini ak kat chemen la sante mwen pou wè si m ap pwofite. Pa pèdi l.
Se nan kat chemen la sante m pou wè si m ap pwofite.
Pa pèdi l. Gade l tankou batistè m.



Kounye a mwen gen nèf mwa mwen kab gen saranpyon, maladi lawoujòl. Mennen m pran vaksen ki pou pwoteje m kont maladi sa a. Vaksen sa a, se yon sèl dòz ki nesesè.



"RALE, KANPE, MACHE: VEYE'M PA FRENNEN'M"

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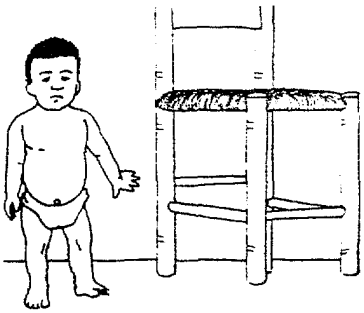
12 rive 18 mwa ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

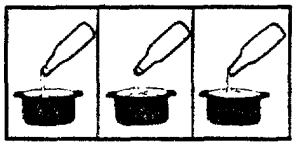
Manman, pa bliye lave men ou chak fwa ou pral ban m manje. Se dlo pwòp pou m bwè. Se manje ki kwit pou m manje. Pa ban m manje ki dòmi.
Si ou pa fè sa, oswa si ou pa ban m bon kalite manje, mwen ka malad grav.

Si mwen mal manje: pye m ap plen, figi m ap anfle, po m ap chanje koulè, cheve m ap kase fasil e m ap chagren. Yo rele maladi sa a malnitrisyon.

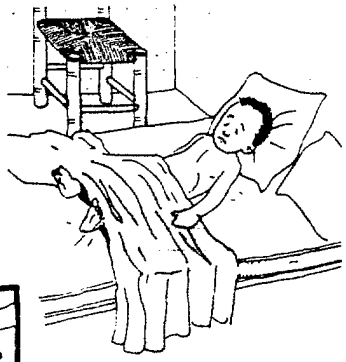


Dyare se maladi ki tiye anpil timoun paske yo pèdi dlo ak anpil lòt bagay ki nesesè pou kò yo. Si ou wè m poupou dlo, ban m yon gode sewòm oral chak fwa m poupou dlo.

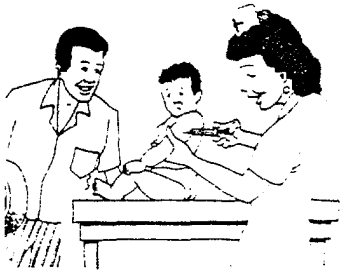
Men kijan ou prepare sewòm oral: plen yon boutèy kola vid byen pwòp 3 fwa ak dlo pwòp, vide l nan yon veso pwòp, lage poud ki nan sache sewòm oral la nan dlo a epi brase l byen.
Si ou pa gen sewòm oral tou fèt la, kijan ou ka prepare l : melanje menm kantite dlo a, swa kantite 3 boutèy kola, nan yon veso pwòp epi melanje l ak 2 gwo kiyè sik, 3 grenn gwo sèl pwòp, ak 5 gout sitwon.



Si ou ta wè, malgre sa, mwen toujou gen dyare, mwen fèb, po vant mwen gen pli, m ap vomi, je m fon, mwen pa pipi, mwen seche: ka m grav, mennen m al lopital san pèdi tan.



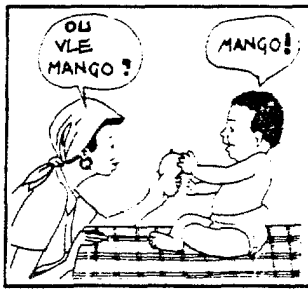
Si m poko finn vaksinen, li pa twò ta pou fè l. Si mwen finn pran tout vaksen mwen, mennen m pran rapèl.



Ou te mèt deplase ou byen ou te mèt kache yon jwèt, li konnen li la, li chache l.
Li pa konprann li pèdi l tankou anvan.

Timoun nan mache, li pran plezi nan sa. li mache tout kote, li manyen tout bagay. L ap dekouvri.

Fòk ou veye l, san ou pa frennen l.



Timoun nan pale pi byen, li di plis mo. Li aprann nan tande lantouraj li. Li pale nan repete sa ou montre l di.

Pale nòmal ak li, li konprann ou. Ou pa bezwen pale yenyen. Chante pou li.

Lè timoun nan gen 18 mwa, li gen abi tid di "non" pou anpil bagay. Eske li di "non" pou tout bon? Se jan sa a li jwenn pou l di ou li pa ti bebe ankò; se yon moun endepandan li vle ye. Se pa yon "non" tout bon. Se yon "non" ki di: ou pa ka fè sa ou vle ak mwen ankò.
Pa bay sa twòp enpòtans, pa move sou li.

"JWE SE PA JWÈT. SE BAGAY SERYE, SE TÈT MWEN KAP TRAVAY"

unicef

10 rive 24 mwa

Timoun

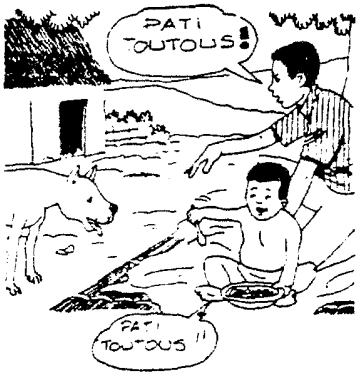
KONESANS FANMI SE LESPWA TIMOUN

Nou te di ou: timoun nan pale pi byen koulye a, li konn plis mo, li fè ti fraz. Li ka pale ak ou. Tout bagay sa yo fè tèt li travay pi plis. Li pare pou l aprann plis bagay.

Pou m pa gen dyare ak vèmin, fòk ou lave men m anvan m manje, epi lè m sot manje.

Pou m pa gen dyare ak vèmin, se pou koupe zong mwen souvan pou yo pa kenbe kras anba yo.

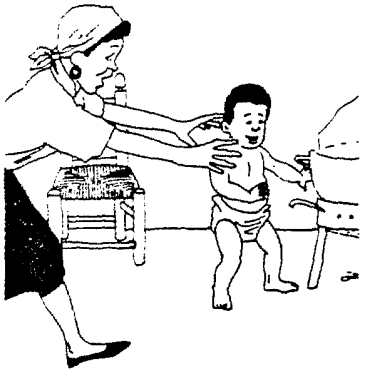
Timoun nan fè lòt kalite jwèt: si ou gade byen wa wè li seye fè tankou granmoun fè, li fè menm jan an. Li repete mo granmoun yo te di nan sitiyasyon sa a. Lap chare ou, men se aprann lap aprann.
Nan zafè pale a, nan zafè jwèt la, se aprann l ap aprann.
Ankouraje l. Sèlman li ta bon pou veye pawòl ou ak jan wap pale devan l.

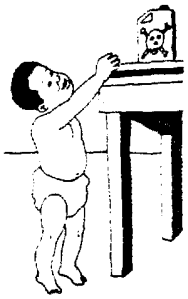


Timoun nan ka fè plizyè bagay pou kont li, tankou: abiye, manje. Men li poko fin fò ladan yo.
Aprann li, montre l ki jan pou l fè.

Mwen finn konn mache, atansyon pou dife pa boule m. Atansyon pou m pa chode. Veye veso ki sot sou dife. Pa kite yo tou pre m.

Boutèy kerozin, boutèy tafya ak boutèy medikaman, mete yo wo, pa kite mwen bwè yo.





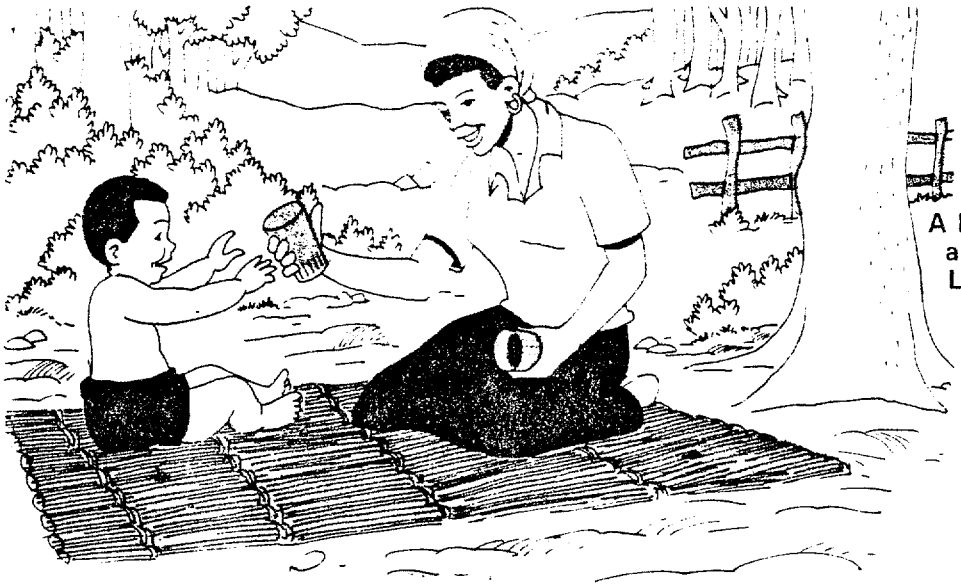
Pou m pa gen dyare ak vèmin fòk mwen sèvi ak yon vaz.
A laj sa a, timoun nan kòmanse ka kontwole kò l. Se lè ou ka mete l sou po (vaz) pou l aprann fè ladann. Si ou wè li pa vle, pa fòse l, esplike l. lap vinn gran, fòk li aprann.

"PALE'M GEN SANS, PA DI'M PE BOUCH MWEN POU DAN RI"

unicef

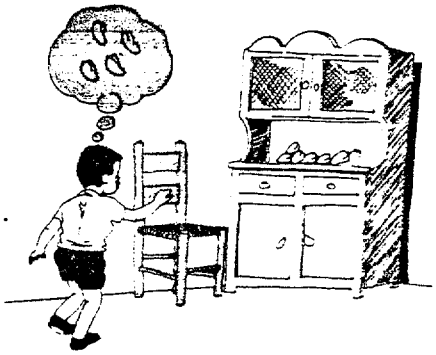
Zan — Zan Edmi ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

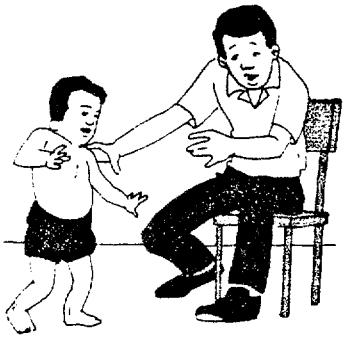


A laj sa a, tèt timoun nan pare pou l aprann yon dal bagay.
Li ta bon pou ta kòmanse aprann li rekonèt koulè ak rekonèt sa k pi gwo ak sak piti.

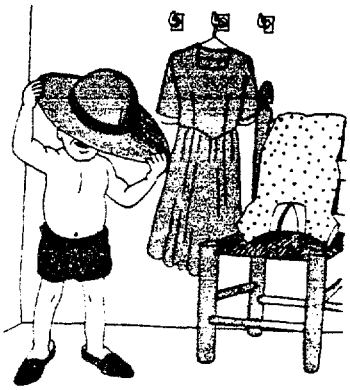
Lè timoun nan pot ko gen dezan, se tout bagay li te wè, tout sa li te fè, ki te fè sèvo l travay.
Kounye a, anvan l fè yon bagay, anpil fwa, li te gen tan reflechi sou li.



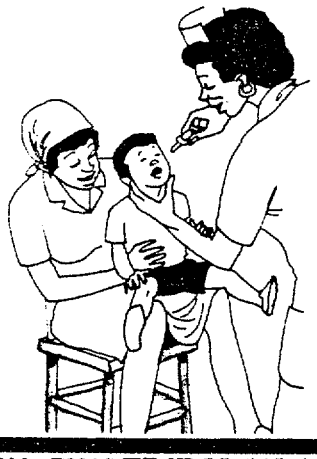
Timoun nan pale pi byen, li fè ti fraz, li konn plis pawòl, li mache pi byen tou, li menm kòmanse kouri.



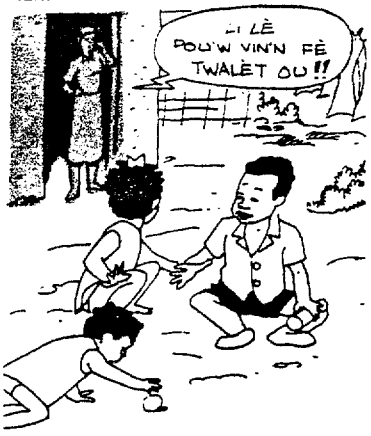
Anvan se lè yon moun te anba je l timoun nan te chare l, kounye a menm si moun nan pa la, li ka imite l.



Piga bliye fwi ak legim bon pou timoun anpil, sitou mango, papay tankou kawòt ak jouroumou. Yo gen anpil vitamin A. W ap jwenn vitamin A nan tout sant yo. Ti lwil la mis la mete sou lang ti bebe a se vitamin A. Li ba l bèl po, bèl je pou l wè pi klè tou.



Li enpòtan pou timoun nan lè gen yon seri de bagay tankou : bal manje, pwòpte l, mete l dòmi, rive fèt chak jou nan menm moman an.
Menm jan pou bagay ki nan kay la ak moun ka p okipe l pa dwe chanje tout tan.



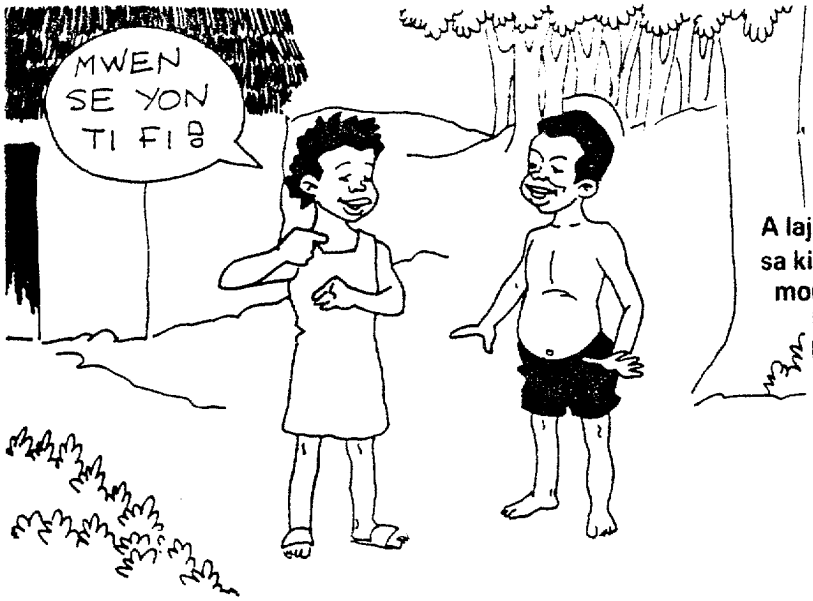
"MANJE'M CHITA SOU 3 WÒCH: PWOTEJE M AK: LEGIM, FWI, KONSTWI KÒM AK: VYANN, ZE, LÈT, BAN M FÒS: DIRI, MAYI"

unicef

3 AN — 4 AN

Sante ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN

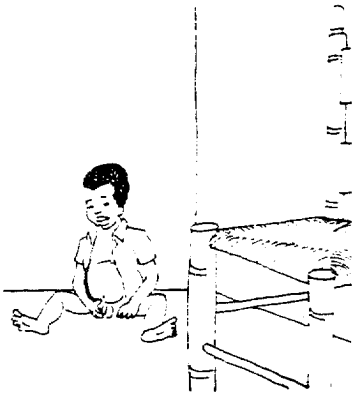


A laj sa a, timoun nan enterese konprann tèt li ak sa ki antoure l. Li poze keksyon sou sa ki fè yon moun fi ak sa ki fè yon moun gason, ansanm ak kote timoun sòti.

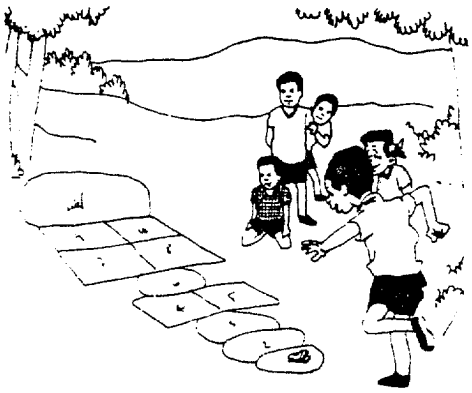
Lè sa yo, ou pa bezwen sezi, se konprann l ap eseye konprann. Reponn li, pa ba l manti.

Menm jan an tou, nan chèche konprann, ou ka wè l ap manyen anba ti vant li. Se yon bagay nòmal, ke tout timoun nan laj sa a fè.

Pa rele sou li, pa bat li, pa montre ou bay sa enpòtans.

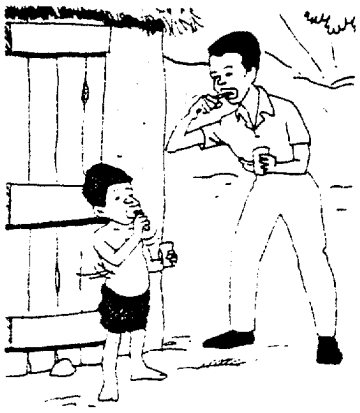


Nan keksyon mache ak kouri a, timoun nan fin bòs nèt, li ka menm kenbe kò l sou yon pye.



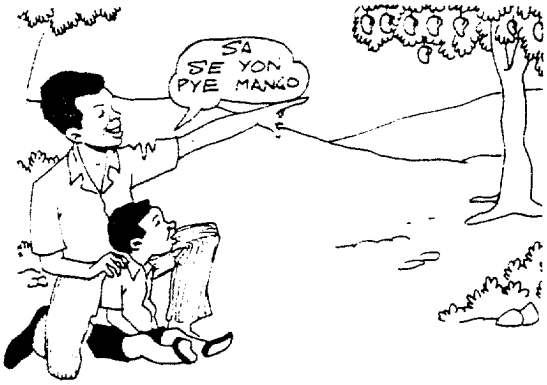
Aprann li bwose dan l chak fwa l finn manje, ak avan l al dòmi. Menm si pat dan an fini, fè l bwose dan l ak bwos la.

Sèvi ak dlo pwòp.



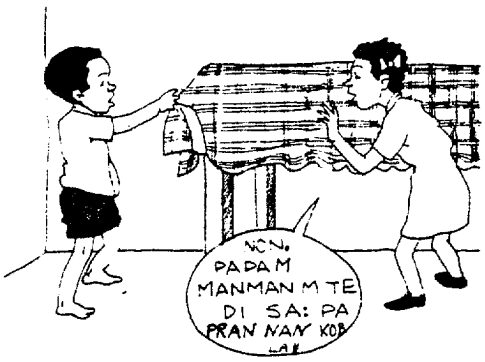
Timoun nan ka konte (rive sou 4) li ka aprann non tout pati nan kò l, li ka rakonte ti istwa, li ka manje pou kont li tou, li ka aprann yon dal lòt bagay ankò.

Ankouraje sa. Voye l nan lekòl timoun (sant preskolè) si genyen bò lakay ou.



A laj sa a, timoun nan vle sanble ak manman l ak papa l, li ta vle tankou yo; se sa ki fè depi lè sa a, fòk ou ba l bon egzanp nan sa k bon ak sa k pa bon.

Se sa ki pral ede l viv byen ak moun.



"TOUT KEKSYON M MANDE REPONS"

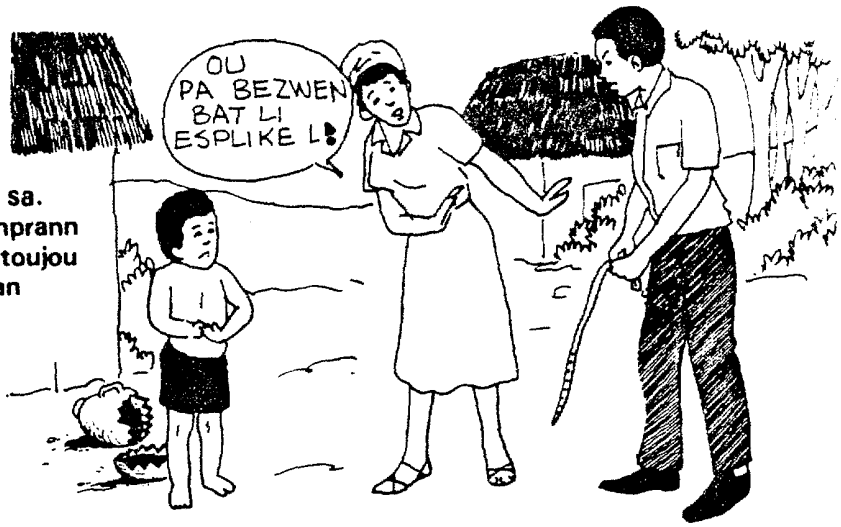
unicef

4 AN — 0 AN

ak Devlopman Timoun

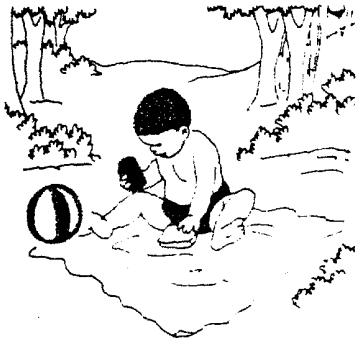
KONESANS FANMI SE LESPWA TIMOUN

Lè timoun nan fè yon bagay ki pa bon, korije l. Korije l pa vle di bat li. Bat timoun nan fè l pè ou; li pa fè l respekte ou pou sa. Lè ou bat li, sa imilye l. Epi sa pa fè l konprann pou ki sa sa l fè a pa bon. Dèyè do ou l ap toujou refè l. Tout bagay sa yo fè relasyon paran ak timoun pa chita sou bon baz.
Pa bat timoun pou dan ri.



A laj sa a, timoun ka aprann anpil bagay tankou: laj li, yon ti chante, yon ti pwezi, fè ti konparezon ant divès kalite bagay.

Se wòl ou pou aprann li, pou ankouraje l aprann tout bagay sa yo.

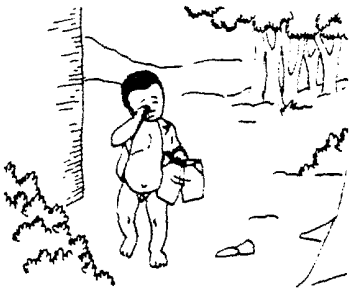


Kounye a, timoun nan ka jwe pi byen ak lòt timoun. Lè gen granmoun la: fòk li ta ede yo aprann jwe ansanm pou yo pa goumen tout tan pou jwèt, epi pou yo pa fè mechanste.

Timoun se moun: li gen menm kalite santiman ak granmoun: chagren, kè kontan, kòlè.

Se dwa l pou l genyen yo ak pou l montre yo. Respekte sa.

Lè nou wè li rete sou manje l, vant li balonnen, la p pèdi nan gwosè l, la p kriye tout tan, se siman vèmin li genyen.



Li pi alèz nan tout mouvman li. Si l ap voye boul, li voye l nan bon direksyon.

"TI FI, TI GASON : MEN'M VALÈ, MEN'M RESPÈ"

unicef

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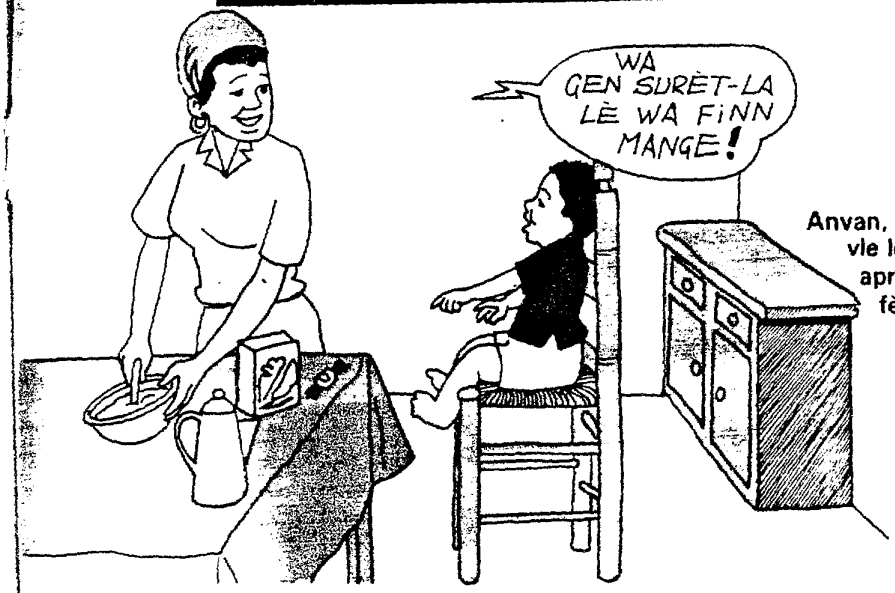
5 AN — 6 AN

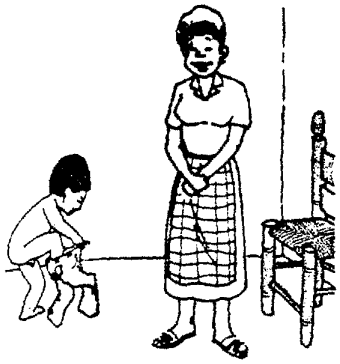
Sante ak Devlopman Timoun

KONESANS FANMI SE LESPWA TIMOUN



Anvan, timoun nan te konprann li te ka fè sa vle lè l vle. Plis l ap grandi, plis li vinn aprann se pa konsa. Kounye a li kòmanse fè diferans nan sa ou vle fè ak sa ou ka fè.

Timoun nan finn gran. Rekonèt sa. Pa kite l konpòte l tankou li ta ti bebe toujou: kriye pou anyen, mande ou fè tout bagay pou li. Se menm jan an, li ka jwe byen ak lòt timoun san granmoun pa mele tout tan.



A laj sa a, fòk li ka rekonèt bò dwat ak bò goch li. Li ka aprann konte rive sou 20 ou menm pi lwen. Lè ou poze l keksyon, li ka ba ou bon jan esplikasyon.

Li bon pou timoun patisipe nan aktivite kay la, fè ti travay, tankou: lave gode, ranje ti zafè l, met lòd. Sa ba l sans responsabilite. Men, fòk chay la pa twòp pou li. Epi tou, pa bliye, se yon timoun. Li bezwen tan pou l jwe, pou l amize l.

Pa janm bliye pou bat "bravo" pou tout bon bagay timoun di ak fè. Sa va ankouraje l kontinye nan menm sans lan. Lè li fè yon bagay ki pa bon, di l sa tou. Men, fòk nou di l se sa l fè a ki pa bon, pa di l se li menm ki pa bon. Sa va ankouraje l chanje konpòtman san li pa konprann se renmen ou pa renmen l ankò.

Jan nou finn wè ansanm nan tout afich sa yo: laj 0-6 an an pou timoun piti se gwo laj: se laj sèvo yo devlope, se laj pèsonalite yo ap fin kanpe, se laj fondasyon pou tout sa k ap vinn pi devan.

Se nan sa paran yo ede yo. Ositou, si timoun nan nan sant preskolè, l ap bon pou li. Se kote timoun nan pral aprann yon dal lòt bagay k ap ba l pi bon chans pou l devlope. Si pa gen sant preskolè bò lakay nou, wè si na voye l lekòl lè l gen 6 an, nan gran lekòl la. Anvan li rantre lekòl, toujou mennen l nan sant sante pou yo kontwole sante l e pou yo wè si l pran tout vaksen l.

Imprimerie Henri Deschamps – Ulysse City Contractor – Magasin et Ateliers – Rue de l'Hôpital

Appendix M

Generic Project Training Form

GENERIC PROJECT TRAINING REPORT FORM
ADRA CHILD SURVIVAL PROJECT
PORT-AU-PRINCE, HAITI

Date:_____ Venue:_____ Training #:_____

1. Type of training held/for whom

2. Number of health workers trained

3. Number of hours of training on (fill as applicable)

    EPI
    CMD
    Nutrition/GM
    FP
    Vitamin A
    Supervision/IEC
    HIS

4. Names and qualifications of trainers

5. Average score of post-test evaluation

    Average score of pretest evaluation
    Total score percentage difference

6. Number of field trips made, if any

    Site/s

7. Total budget used in US$

8. Type/s of resource materials used

9. Reported by:

    Job title:
    Date:

Appendix N

MOH/Project Forms and Charts

Important Note: These forms and charts will be adapted to project needs. ADRA will not use all of the charts as they appear. Adjustments will be made to simplify and meet the project's HIS needs (in consultation with CERA, the local HIS consultant).

VHS Monthly Monitoring Form

for period _____ to _____

	Products		Health Education							Referrals					
	Soap	ORS	Hygiene and Sanitation	Control of Diarrheal Disease	Immu-nization	Nutrition	Common Cold and Pneumonia	Safe Mother-hood	Injury Prevention and First Aid	Female Health Worker	Basic Health Worker	(BHC or CHC) Clinic	MCH Clinic	Hospital	
		VHS's name: _____					Facility #: _____								
		Trainer/Supervisor's name: _____					Village: _____								
		Local Supervisor's name: _____					District: _____								
							Province: _____								
Total															

6-Month Summary Form

VHS Service Outputs

Number of people provided service between _____ and _____ (dates)

	Products		Health Education							Referrals				
	Soap	ORS	Hygiene/Sanitation	Control of Diarrheal Disease	Immunization	Nutrition	Common Cold and Pneumonia	Safe Motherhood	Injury Prevention & First Aid	Female Health Worker	Basic Health Worker	BHC/CHC	MCH Clinic	Hospital
Women/Girls over 5														
Men/Boys over 5														
Subtotal Persons over 5														
Girls < 5														
Boys < 5														
Subtotal Children < 5														
Total per category														

To determine total amount of ORS distributed, multiply # of ORS packets X 3 = _____

Comments:

Facility #: _____
Village/Town: _____
District: _____
Province: _____

Signature: _____

Ministère de la Santé Publique et de la Population
Rapport mensuel Hopital/Centre de Santé avec lits

Mois/Année_____

Région_____ District_____ Commune_____

Localité_____ Institution_____

Type: Public ☐ Privé ☐ Mixte ☐

Code ☐☐☐☐☐
R D Com Inst

1) AMELIORATION NUTRITIONNELLE

ENFANTS PESES

a) NIVEAU COMMUNAUTAIRE

	AGES (En Mois)	0-11	12-23	24-59	TOT
NOUVEAUX	Subtotal				
	Normaux				
	M1				
	M2				
	M3				
	Kwash				

	AGES (En Mois)	0-11	12-23	24-59	TOT
ANCIENS	Subtotal				
	Normaux				
	M1				
	M2				
	M3				
	Kwash				

EVOLUTION DU POIDS

Augmente				
Dim/Stat.				

b) NIVEAU INSTITUTIONNEL

NOUVEAUX	Subtotal				
	Normaux				
	M1				
	M2				
	M3				
	Kwash				

ANCIENS	Subtotal			
	Normaux			
	M1			
	M2			
	M3			
	Kwash			

EVOLUTION DU POIDS

Augmente				
Dim/Stat.				

Cas hospitali.				
Cas décédés				

SUPPLEMENTATION NUTRITIONNELLE

	Enfants	Femmes allaitantes	Femmes enceintes
Fer			
AK1000			
Alim. Importe			
VIT A			
Lait enrichi			

2) PRONACODIAM

CAS AVEC DIARRHEE

AGES (En Mois)		0-11	12-23	24-59	TOT
NIVEAU	Inst.				
	Comm.				

CAS HOSPITALISES / DECEDES

HOSP.				
DCD				

UTILISATION DU SRO

CAS AYANT REÇU SRO	NIVEAU Inst.	NIVEAU Comm.
Avant la visite		
Pendant la visite		

Cas traités mixte SRO-IV		

Sachets SRO vendus		
Sachets SRO donnés/dem.		

POSTES DE VENTE DE SRO

Existants	
Installes	
Approvisionnés	

3) TUBERCULOSE/LEPRE

	TB	LEPRE
Cas Probables		

BACILLOSCOPIES DE DIAGNOSTIC

positives		
negatives		
BACCIL. DE CONTROLE		
NOUVEAUX CAS		
Cas contact		
CAS MIS SOUS RX		
avec bacil. (+)		
avec X-Ray thorax		
TB extra-pulm.		
sans paraclinique		
Cas abandonnés		
Abandons retrouvés		
Rechutés		
Cas guéris		
Cas hospitalisés		
Cas décédés		

4) MALARIA

AGES (En Mois)	0-59	60 +
Fébriles traités avec chloroquin		
Lames examinées		
Lames positives		
Cas hospitalisés		
Cas décédés		

5) PLANIFICATION FAMILIALE

UTILISATEURS/TRICES	HOMMES	FEMMES
TOTAL		
Pilules		
M. vag.		
T. vag.		
Injections		
Sterilets		
Implants		
Condoms		

Méthodes naturelles		

Steril. volontaire		

NOUVEAUX/VELLES		

CONTRACEPTIFS DISTRIBUES

Pilules (cycles)	
M. Vag. (Tubes)	
T. Vag. (unitaires)	
Injection (doses)	
Sterilet (unitaires)	
Implants (unitaires)	
Condoms (unitaires)	

6) CONSULTATIONS

	NOUVEAU	ANCIEN
Prénatales		
Postnatales		
Pédiatriques		
Générales (adultes)		
Odontologie		
Autres		

VACCINATION

NIVEAU.....

	AGES (En Mois)	0-11	12-23	24-59	INC.	TOUS LES AGES
TYPE/DOSE VACCIN	BCG dose unique					
	Roug. dose unique					
	DiTePer 1					
	DiTePer 2					
	DiTePer 3					
	RAPPEL					
	POLIO 1					
	POLIO 2					
	POLIO 3					
	RAPPEL					

	TETANOS TOXOID	FEMMES ENCEINTES	FEMMES NON ENC.	AUTRES	TOUTES CATEGORIES
TYPE/DOSE VACCIN	TETANOS 1				
	TETANOS 2				
	RAPPEL				

NIVEAU.....

	AGES (En Mois)	0-11	12-23	24-59	INC.	TOUS LES AGES
TYPE/DOSE VACCIN	BCG dose unique					
	Roug. dose unique					
	DiTePer 1					
	DiTePer 2					
	DiTePer 3					
	RAPPEL					
	POLIO 1					
	POLIO 2					
	POLIO 3					
	RAPPEL					

	TETANOS TOXOID	FEMMES ENCEINTES	FEMMES NON ENC.	AUTRES	TOUTES CATEGORIES
TYPE/DOSE VACCIN	TETANOS 1				
	TETANOS 2				
	RAPPEL				

Date préparation:_____ Signature:_____

Reçu par:_____ Date:_____ Signature:_____

Reçu par:_____ Date:_____ Signature:_____

MORBIDITE

MORBIDITE CLINIQUE

	1an	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 +	INC.	TOT
AMYGDALITE																
BRONCHO-PNEUM																
CHARBON																
COQUELUCHE																
DENGUE																
Febr. Rx a clq.																
GASTRO-Enterite																
DIPHTERIE																
GRIPPE																
LEPRE																
OTITE																
POLIO																
RAGE																
ROUGEOLE																
Sympto. resp.																
TETANOS																
TETANOS NN																
VARICELLE																

MORBIDITE PAR CONTROLE LABORATOIRE

FILARIOSE																
MALARIA																
MENINGITE																
PARASITOSE Int.																
SIDA																
SYPHILIS																
TB EXTRA-PULM																
TB PULMONAIRE																
TYPHOIDE																

11) TABLEAU D'OCCUPATION

	MED	PED	MAT	GYN	CHIR	AUTR	TOTAL
Nb de lits							
Jours/lits							
Admissions							
EXEATS (tot)							
Vivants							
Décédés (tot)							
Tx mort brut							
- 48 hrs							
+ 48 hrs							
Tx mort net							
Jours/patients.							
Jours d'hosp.							
Durée moy séjour							
% occupation							

7) ACTES MEDICO-CHIRURGICAUX

Pansements	
Injections	
Chirurgie mineure	
Chirurgie majeure	

ACCOUCHEMENTS

	INST	MAT	TOT
Normaux			
Césariennes			
Forceps			

NAISSANCES VIVANTES

Moins de 2,5 kg			
2,5 kg et plus			
poids non specif.			

MORTS-NES			

Avortements			
Décès maternels			
" néo-natals			

8) EXAMENS PARACLINIQUES

8a) LABORATOIRE

Hématologie	
Bactériologie	
Parasitologie	
Biochimie	
Sérologie	
Urines	
Autres	

8b) RADIOLOGIE

Clichés utilisés	
Examens effectués	

9) SOINS BUCCO-DENTAIRES

Patients vus pour extractions	
Dents extraites	
Amalgames	
Prophylaxies	
Autres	

10) ACTIVITES COMMUNAUTAIRES

Postes de rassemblement	
Points de rassemblement	

Visites domiciliaires	
Réunions communautaires	

Supervisions reçues	
Supervisions faites	

MATRONES

Supervisées	
Certifiées	
en formation	

CLINIQUE MOBILE

Nombre	
Patients vus	

PUERICULTURE

Elèves certifiés	
Elèves en formation	

FAMILY PLANNING REGISter

Ministère de la Santé Publique et de la Population
Direction d'Hygiene Familiale et de Nutrition

Registre de Planification Familiale

Femmes ☐ Hommes ☐

Région: _____ District: _____ Secteur: _____

Distributeur: _____ Année: _____

NOMS & PRENOMS	Année de Naissance	Début de la Contraception (Mois/Année)	Methode en Déc. dernier	Enfants Viv.	JANVIER	FEVRIER	MARS	AVRIL	MAI	JUIN	JUILLET	AOUT	SEPTEMBRE	OCTOBRE	NOVEMBRE	DECEMBRE	Mois en Réserve
		/															
		/															
		/															
		/															
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		/															

TOTAL	Utilisateurs/Utilisatrices											
	Nouveaux Acceptants/Acceptartes											
	Stérilisations Volontaires											

CLE:
- S= Stérielt ou Filament
- P= Pilule
- C= Condom ou Capote
- SV= Stérilisation Volontaire
- M= Mousse Vaginale ou Crème
- D= Depo-Provera, Injection, Piqûre
- T= Tablette Vaginale ou Sampoon

CONTRACEPTIVE USE

REGISTRE JOURNALIER/RAPPORT
CLIENTS SERVIS & CONTRACEPTIFS DISTRIBUES

NOM DE LA CLINIQUE _____ MOIS/ANNEE Aout 88

Date (Jour/Mois)	No. Série du Client	Nouveaux Acceptants	Nouvelles Visites	Contraceptifs										Stérilisation		AUTRES SERVICES DISPENSES						
				Pilule	Stérilet	Condom	Injectables	Implant	Spermicides	Diaphragm	AUTRES			Male	Female	FP Conseil	Serv. Médical	Test Grosse	Pap Smear	AUTRES		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)				(13)	(14)	(15)	(16)	(17)	(18)			
1/8																						

This page totals																						
	Nouveaux																					
	Contraceptifs Distribués																					
	Total Accept. Visités																					

Cumul. totals																						
	New FP acceptors																					
	Contraceptives distributed																					
	Total acceptor																					

BEST AVAILABLE COPY

AGENT DE SANTE _____

COLLABORATEUR _____

PROGRAMME	ZONE	SECTEUR	C.V.	N. FAMILLE

REGISTRE DE MENAGE

Chef de ménage _____ Sexe _____

Occupation _____

Département _____

Commune _____

Section Rurale _____

Habitation _____ No. EM _____

Date de 1er passage: Mois _____ Année _____

Adresse _____

	PRENOM ET NOM Inscrire les prénoms et noms des personnes âgées de plus de 5 ans (excepté les femmes de 15-45 ans)	SEXE	AGE	TB SUSPECT		* PF		Déménagement et Décès	DATE
				OUI	NON	OUI	NON		
01									
02									
03									
04									
05									
06									
07									
08									
09									

No. Série	PRENOM ET NOM Inscrire les prénoms et noms des enfants âgés de moins de 5 ans	SEXE	NAISSANCE		BCG	VACCIN DI TEPER				VACCIN POLIO				VACCIN Anti-Rougeoleux	VITAMINE A Croissez un rond à chaque dose administrée	STATUT Nutritionnel				Déménagement et Decès	DATE
			MOIS	ANNEE		0	1	2	3	0	1	2	3			N	M1	M2	M3		
10															000 000 000 000						
11															000 000 000 000						
12															000 000 000 000						
															000 000 000 000						
14															000 000 000 000						

*** Code**

A : Arrivée
P : Parti
D : Décès
PF : Planning Familial

CENSUS FORM

CENTRE _____

BEST AVAILABLE COPY

SUIVI DES ENFANTS DE 0 A 5 ANS

LONGITUDINAL FOLLOW_UP FORM

IDENTIFICATION				SUIVI DE LA VACCINATION										SUIVI NUTRITIONEL															MOUVEMENT DE LA POPULATION				
CODE	NOM ET PRENOM	SEXE	Date de Naiss	BCG	ROUG	DI TI PER				POLIO-SABIN				JANV	FEV	MARS	AVR	MAI	JUIN	JUIL	AOUT	SEPT	OCT	NOV	DEC	VIT. A			ARR	DEP	RET	DCD	DATE ET CAUSE
						D_1	D_2	D_3	Rap	D_1	D_2	D_3	Rap													D_1	D_2	D_3					

Mouvements de la Population ARR - Date d'arrivée RET - Retour
DEP - Départ DCD - Décès

X

ORDRE DE PRESENTATION

INTRODUCTION (avec Activites d'Apprentissage par Module)

MODULES DE FORMATION

:	Recensement	19-20
:	Organisation Communautaire	40-41
:	Hygiène de l'Environnement	55-56
:	Nutrition	67-68
:	Santé Materno-Infantile	89-90
:	Planning Familial	106-107
:	Diarrhée	121-122
:	Tuberculose	134-135
:	Malaria	151-152
:	Premiers Soins	161-162
:	Visite Domiciliaire	188-189

Appendix O

MOH GM/EPI Card

MOH Maternal Card/EPI

GM Master Chart

CHEMEN LA SANTE

BAY TIMOUN YO TETE
Lèt manman se pi bon lèt

AJ: 0 - 1 NAN

AJ: 1 - 2 ZAN

AJ: 2 - 3 ZAN

Kg

N

I

II

III

ANE

MWA

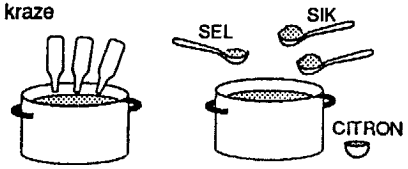
Konble kolo-n sa avek mwa e ane ti moun nan fèt la.
Konble lot kolo-n yo ak tout mwa ki swiv yo.

Timoun sa profite

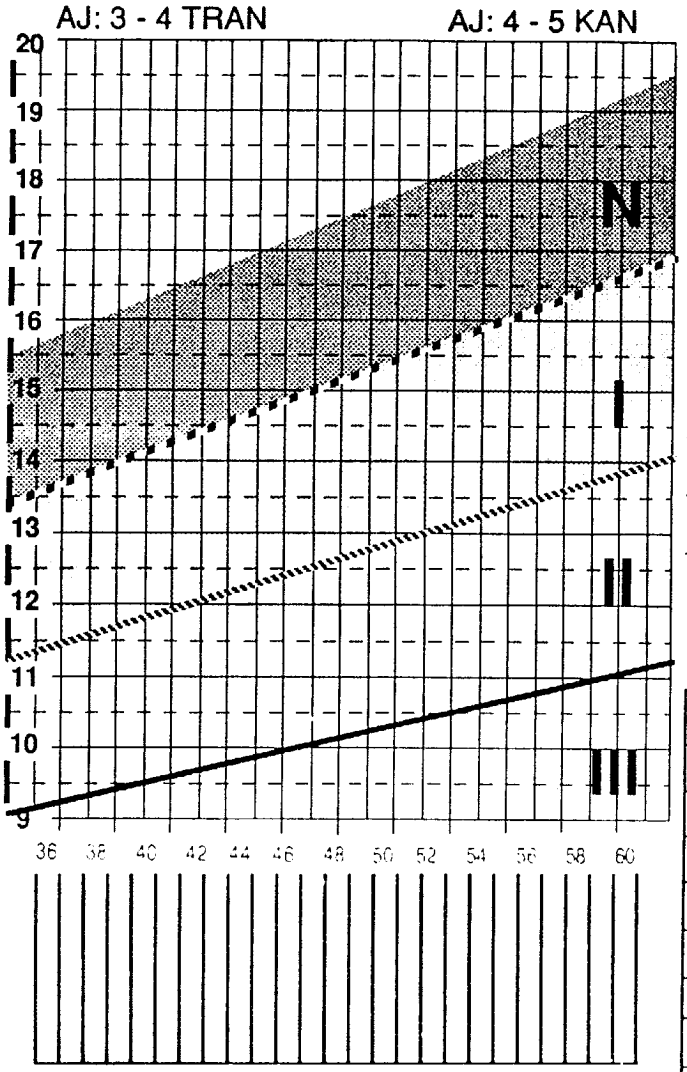
Timoun sa pa profite
Bali plis manje

Timoun sa malad. Bali plis manje e minnin li nan sant

Kijan pou nou prepare seròm nan bouch si nou pa jwenn sache tou pare?
Mete ansanb nan yon veso pròp:
- 3 boutèy kola vid plen dlo pròp (se yon lit dlo)
- yon ti kiyè sèl byen kraze
- 2 gro kiyè sik
- kèk gout ji sitron



(seròm sa-a pa dwe genyen ni gou sik ni gou sèl)



Fè Planing

AK PLANING-NAN
GASON PROTEJE SANTE
MADANM-LI
AK PITIT-LI YO

CARTE NATIONALE DE VACCINATION

VACCIN	Dose zéro	1ère dose	2ème dose	3èmedose	Rappel
Di Te Per					
Polio					
Tétanos					
Autres					

	Dose unique	
Rougeole		
BCG		

RENDEZ-VOUS VITAMINE A

DATE	VIT A	DATE	VIT A

AKAMIL

FOS AK ENEJI POU TIMOUN
TANKOU GRANMOUN

MINISTERE DE LA SANTE PUBLIQUE ET DE LA POPULATION

CARTE CHEMIN DE LA SANTE

1.- Commune _____

2.- Etablissement _____

3.- Poste de rassemblement _____

4.- Nom de Famille _____ Prénom _____

5.- Sexe M ☐ F ☐ 6.-Date de Naissance _____

7.- Immatriculation _____

Vacc. Rang. _____ Page _____

FE PRAN PEZ TI MOUN YO CHAK MWA
KONSA NA WE SI YO PROFITE

Ce projet a été réalisé avec la Coopération de l'Organisation Panaméricaine de la Santé (OPS / OMS)

Ministère de la Santé Publique et de la Population
Programme national de Vaccination

Carte de Vaccination

Nom _____ Prénom _____

Sexe _____ Date Naissance _____

Adresse _____

Etablissement de Santé
(Poste de vaccination) _____

Commune _____

N°. du Registre de Vaccination _____

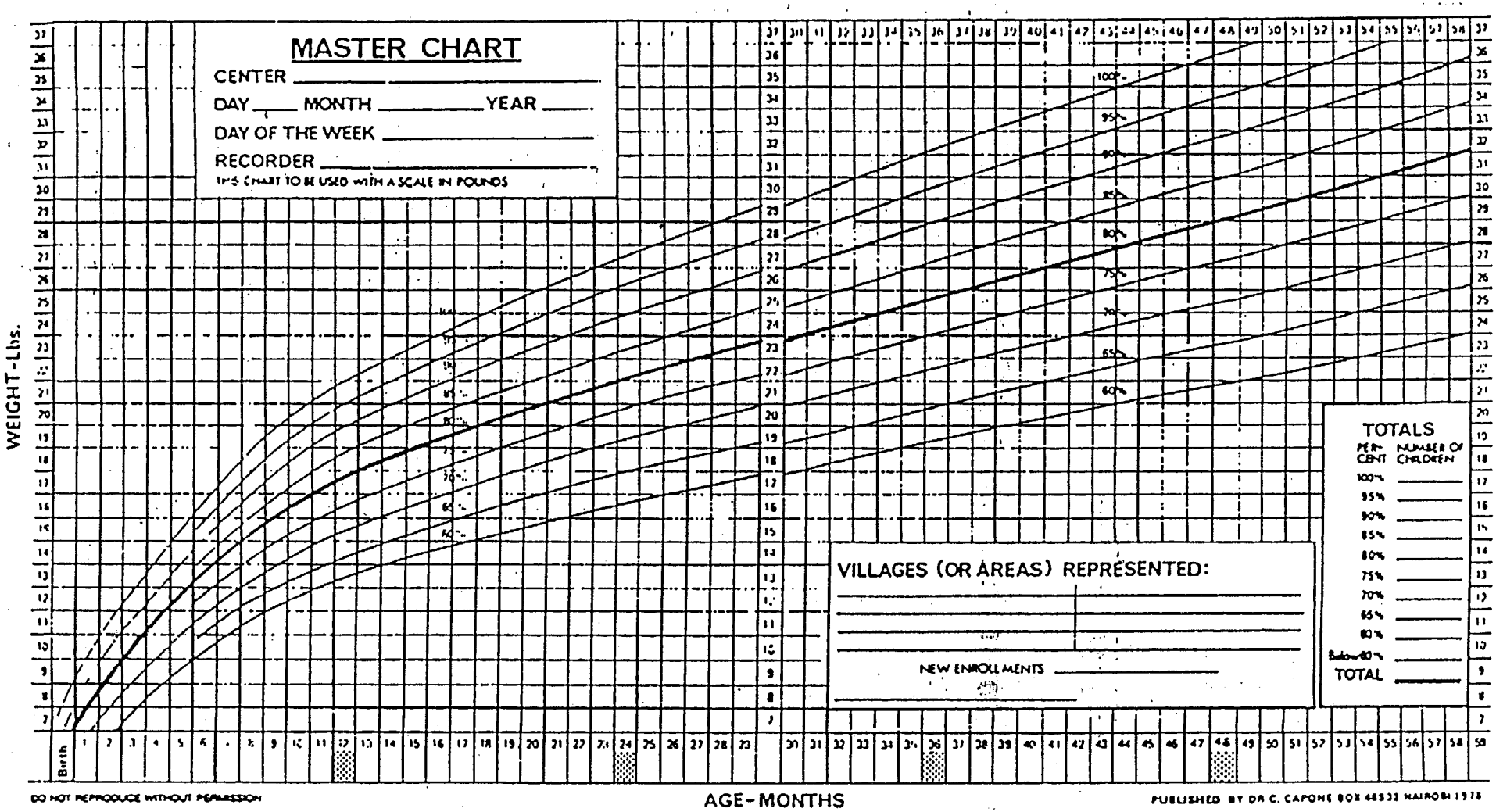
Tout fanm ki nan laj fè pitit dwe pwoteje tèt li ak timoun li kapab fè yo kont maladi Tetanos

Doses de Tetanos Toxoid

TT1	TT2	Rappel 1	Rappel 2	Rappel 3

Ed des Antill

155



[redacted] Master chart, showing weight levels at 10 per cent intervals for use in collecting information from mothers attending clinic(s) or in an area. This could be simplified using reference (100 per cent), −2 SD (approximately 80 per cent), −3 SD (approximately 70 per cent), and −4 SD (approximately 60 per cent). (Courtesy of Dr C. Capone, Catholic Relief, Nairobi, Kenya.)

INDIVIDUAL PATIENT RECORD

FICHE INDIVIDUELLE

N° DE CODE

Nom _____ Sexe _____ Taille _____ cm (adulte) Date de naissance _____ (mois / année)

DATE J/M/A	TYPE (S M P G)	POIDS KILO	Nutrition (N, M1, M2, M3, GR)	Alimentation SMGP	T/A	T° C°	Condition principale (Dx) Si grossesse, spécifiez mois et hauteur utérine	CIM	Autre Condition	CIM	Autre Pathologie	CIM	*PF	Vaccins: DPT	POLIO	TET	BCG	ROUG	Rx médicaments	MD
														Votre patient est-il maintenant complètement vacciné ? _____ Si non, pourquoi pas ?						

CODE

DATE
J = jour
M = mois
A = année

TYPE DE VISITE
S = surveillance
M = maternité
P = planning
G = générale

NUTRITION
N = normal
M1 = 1er degré
M2 = 2ème degré
M3 = 3ème degré
GR = grossesse à risque

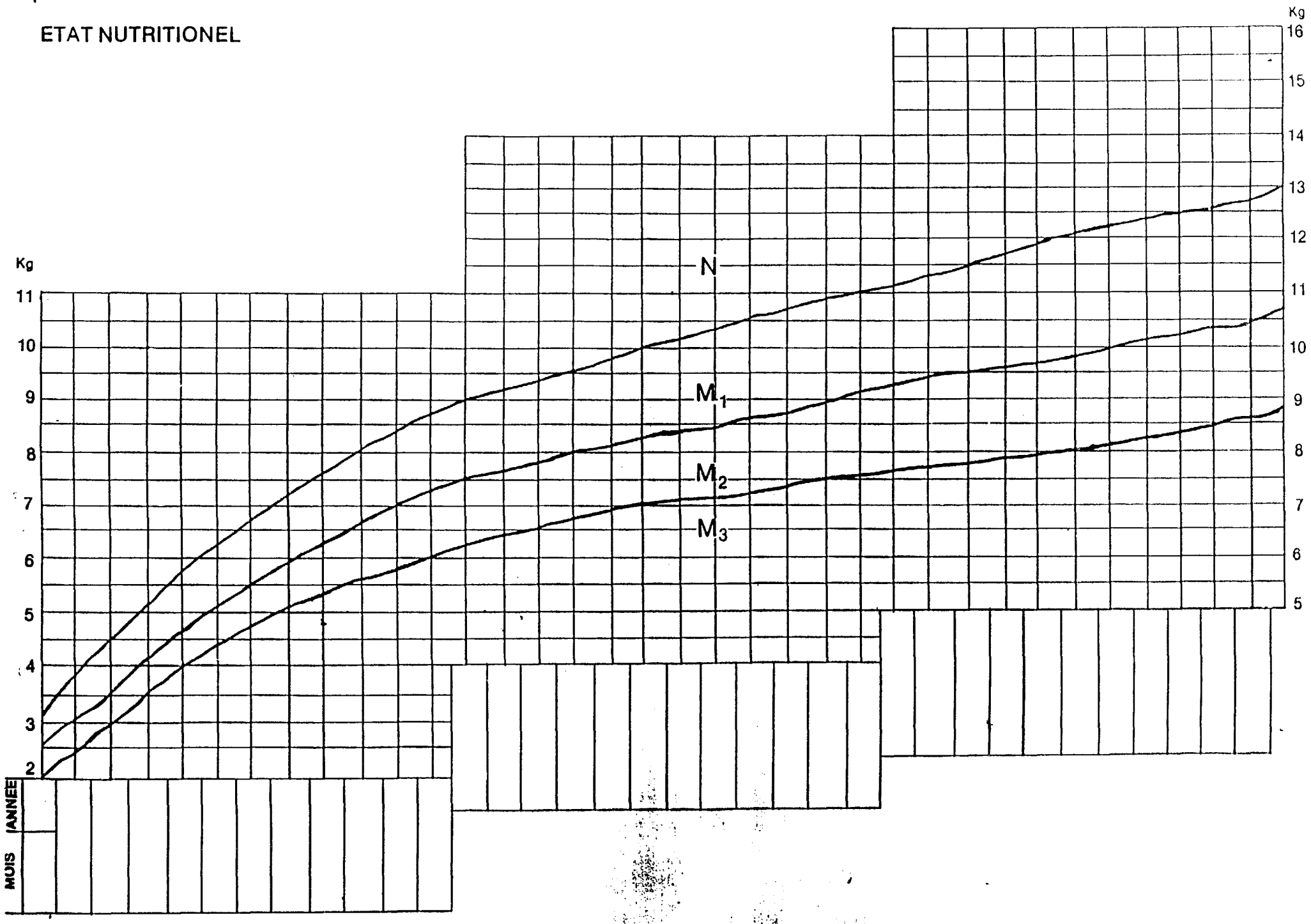
CODE DE QUELQUES MALADIES
Anémie (non spécifiée) 285
Ascaris 133
Diarrhée 009
Pneumopathie 465
Malaria 084
Tétanos 037
TB 011
Fièvre 780
(o. I)

*CODE PF
0 = pas de méthode
1 = pillule
2 = condom
3 = stérilet
4 = crème
5 = naturelle
6 = autre

© S.C.S.

T

ETAT NUTRITIONEL



Appendix P

Job Descriptions of Key Project Staff

Job Description

Child Survival XII Project, ADRA Haiti

Position: Country Director

Qualification: Graduate level education relevant field.

Experience: See resume

Skills: English fluency (knowledge of Arabic), administrative, organization and planning, analytical, reporting, financial management, leadership/team oriented, morale building, communication (verbal and written), computer literate, delegation and facilitation.

Reports to: ADRA Haiti Board of Directors, ADRA/Inter-American Division, and Senior Grants Administrator at ADRA Central Office.

Supervises: The Child Survival Project Director and Financial Officer

Job Summary: Administers all aspects of the country project.

Duties/Responsibilities:

Organizing and strategy development, planning, implementing policies, donor liaison, coordinating all departments, consulting on budgets, consulting on project proposal writing, project compliance, project research and development, overseeing project reporting, project tracking, government liaison, NGO liaison, developing working policies, personnel management, position descriptions, fund raising and publicity.

Relates to: Health Director and Associate Health Director at ADRA Central Office on all the technical aspects of the CS project.

Training: The country director will have opportunity to participate in various training and continuing education programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Project Director

Qualification: MD and MPH

Experience: Minimum of eleven years experience in managing a health related project in Haiti.

Skills: French, Creole and English fluency, administration, organization, planning, analytical, reporting, financial management, leadership/team oriented, communication (both written and spoken), delegation or responsibility, coordination with local civic and private organizations, good interpersonal relationship.

Reports to: Country Director

Supervises: All project staff

Job Summary: Administers all aspects of the child survival project

Duty/Responsibilities:

Responsible for overall planning and direction of the CS project, tracking project achievements in relation to stated goals, objectives and budget. Will provide leadership, management and coordination of all CS entities. Responsible for reporting on a regular basis to ADRA/Haiti country director, ADRA Central Office, ADRA/Inter-American Division, MOH, USAID and others as required. Will oversee hiring of all project personnel and maintains authority in all project related personnel decisions. Is responsible for proper usage, care and maintenance of all project related equipment and facilities.

Relates to: Health Director and Associate Health Director at ADRA Central Office on all technical issues pertaining to the CS project.

Training: The project director will have opportunity to participate in various training and continuing education programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: IEC/Community Liaison/Training Coordinator

Qualification: RN

Experience: Nine years experience in teaching and organizing training programs in a community health related field. Experience in managing a child survival program for Medicins Sans Frontieres in Haiti.

Skills: French and Creole fluency (a bit of English), administration, organization, planning, analytical, reporting, leadership/team oriented, communication (both written and spoken), delegation or responsibility, coordination with local community organizations, good interpersonal relationship.

Reports to: Project Director

Supervises: Related to community health workers HP staff.

Job Summary: Planning, organizing and coordinating the CS and training activities.

Duty/Responsibilities:

Coordination of all training and IEC activities undertaken by the project including all HP and community based, volunteer health workers. Will assist the project director in all administrative duties and in maintaining relationships with local communities. Relating to field health workers including regular field visits to assess quality assurance of the CHWs. Regular reporting of activities and holding regular monthly meetings with community. Coordinating with the MOH and the community on project training issues. Identifying, securing and distributing training and educational materials. Reporting on periodical basis.

Training: The training/IEC/Community Liaison will have opportunity to participate in various training and skills upgrading programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Field Supervisor

Qualification: Junior college level of education in nutrition/health

Experience: Minimum of two years in a health or nutrition related field at the community level.

Skills: French and Creole fluency, supervising, reporting, communication, coordination with local community leaders and CHWs, good interpersonal relationship.

Reports to: Health Coordinator

Supervises: Community health workers (CHAs/CHVs).

Job Summary: Reporting on the CS activities and supervising the community health workers.

Duty/Responsibilities:

Supervising all community based, volunteer and non-volunteer health workers. Will assist the heath coordinator in all supervision duties and in maintaining relationships with local community authorities. Regular reporting of activities and holding regular meetings with the community health workers. Giving feed-back on a monthly basis to the CHWs.

Training: The field supervisors will have opportunity to participate in various training and skills upgrading programs.

Job Description

Child Survival XIII Project, ADRA Ethiopia

Position: Health Information Systems/Health Coordinator

Qualification: BA in nursing and BA in Community Health

Experience: Eight years experience in various health fields including national coordinator of a study on maternal child mortality, assistant coordinator of IEC for the Association for Haitian Family Promotion, CBD project coordinator for PROFAMIL.

Skills: French and Creole fluency, organization and planning, analytical, reporting, communication (both written and spoken) and computer literate.

Reports to: Project Director

Supervises: Community health workers (CHAs/CHVs), HP staff and field supervisor.

Job Summary: Developing testing, follow-up and tabulation of HIS, including vital events and key disease surveillance reporting. Providing technical assistance and supervision to all CS staff at functioning at the HP and community levels.

Duty/Responsibilities:

Coordination of health information strategy activities undertaken by the project including networking with local leaders, MOH; develop a sustainable, "community-friendly" data collection system. Coordinates with the MOH HIS; develops and tests information gathering tools; analyzes results and gives regular feedback to project staff and representatives of the MOH, and the community; organizes and conducts training on HIS for project staff and all other staff members involved in the HIS process; assists in the preparation of monthly, quarterly and annual reports for the CS project; coordinates activities relating to midterm and final evaluations including organizing, training, implementation, tabulation and analysis of the KPC Survey; incorporates appropriate changes to project interventions according to research results and modifications made as a result of lessons learned.

Training: The HIS/health coordinator will have opportunity to participate in various training and skills upgrading programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Finance Officer

Qualification: BA degree in Accounting/Business Administration

Experience: Minimum of fifteen years in financial management, accounting and auditing for ADRA Haiti and the Adventist church.

Skills: French, English and Creole, organization and planning, reporting, communication (both written and spoken), financial management, time management, administration and interpersonal relationship.

Reports to: Country Director

Supervises: Project Accountant

Job Summary: Coordinate all aspects of the project finance and budget.

Duty/Responsibilities:

Manages and coordinates the accounting department; assures project financial compliance; financial reporting; oversees posting, banking and other reconciliations; preparation of financial statements; verification of financial documents; procurement for project; personnel training; personnel records maintenance; insurance implementing policies and inventory and fixed assets control.

Training: The financial officer will have opportunity to participate in various training and skills upgrading programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Administrative Secretary/Cashier

Qualification: College diploma in secretarial and accounting

Experience: Minimum of four years in office management and cashiers activities

Skills: French, English and Creole fluency. Reporting, communication (both written and spoken), typing skills, friendly and personable character, conscientious and detailed, computer literate, financial management, time management and interpersonal relationship.

Reports to: Project Director/Financial Officer

Supervises: Driver and delivery staff

Job Summary: General secretarial management in the CS project office and payroll.

Duty/Responsibilities:

Scheduling of appointments and knowing staff movement; typing and distribution of office correspondence; receptionist for telephone and visitor inquires; management of central filing system and security of records; recording, typing, and distribution of minutes of meetings; maintenance of office supplies and equipment; supervision of custodial personnel; general typing and translations; responsible for postal services; maintenance of petty cash box, and disbursement of petty cash; maintenance of log books for telephone/fax, vehicles and photo copiers; maintain attendance records; makes arrangements for the accommodation of visitors and travel arrangements of project staff; staff entertainment; general understanding of project functions goals and objectives.

Training: The secretary/cashier will have opportunity to participate in various training and skills upgrading programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Field-based Community Health Agent (CHA)

Qualification: At least elementary education (preferably a high school level education)

Experience: Exposure and training in community health development

Skills: French and Creole fluency, dedication to work with mothers and children, responsibility, orderliness, public relation skills, politeness and ability to communicate.

Reports to: Health post based CHA and ADRA filed supervisor

Supervises: Community health volunteers

Job Summary: Visit homes, educates mothers, refers mothers and children for services to the health facility, supervises CHVs, reports on a monthly basis.

Duties/Responsibilities:

Assisting during household registration, organizing mothers groups, orienting and supervising the work of CHAs, identifying problems related to the health of the community, home visits, education of mothers on each intervention, referrals, training CHAs, etc.

Relates to: The lead CHA and ADRA field supervisor

Training: CHAs will have opportunity to participate in various training and continuing education programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Facility-based Community Health Agent (CHA)

Qualification: At least elementary education (preferably a high school level education)

Experience: Exposure and training in community health development

Skills: French and Creole fluency, dedication to work with mothers and children, responsibility, supervision and leadership, orderliness, public relation skills, politeness and ability to communicate.

Reports to: Auxiliary Nurse

Supervises: Field-based community health workers

Job Summary: Educates mothers, refers mothers and children for services to the hospital (when needed), supervises CHAs, assists the AN, reports on a monthly basis.

Duties/Responsibilities:

Assisting during household registration, assisting the auxiliary nurse, organizing educational sessions for mothers on each intervention, growth monitoring, vitamin A distribution, orienting and supervising the work of CHAs, referrals, record keeping, reporting and giving feedback to CHAs, organizing mothers groups, etc.

Relates to: The auxiliary nurse and ADRA field supervisor

Training: Lead CHAs will have opportunity to participate in various training and continuing education programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Community Health Volunteer (CHV)

Qualification: Literacy (needs to meet the criteria for selection of CHVs)

Experience: Exposure and training in community health development.

Skills: French and Creole fluency, dedication to work with mothers and children, responsibility, leadership, orderliness, public relation skills, politeness and ability to communicate.

Reports to: Community-based health agents

Supervises: None

Job Summary: Educates mothers, refers mothers and children for services to the health post and follows up, distributes vitamin A, assists the CHA in organizing women's groups, promote and sell ORS/contraceptives, reports on a monthly basis, etc.

Duties/Responsibilities:
Same as above.

Relates to: Community health agents

Training: The CHAs will have opportunity to participate in various training and continuing education programs.

Job Description

Child Survival XII Project, ADRA Haiti

Position: Auxiliary Nurse

Qualification: At least elementary education (preferably a high school level education)

Experience: Experience and training in community health development (immunizing, educating, treating minor illnesses and managing a health post.

Skills: French and Creole fluency, ability to vaccinate, dedication to work with mothers and children, responsibility, organization and leadership, public relation skills, ability to communicate, supervision, etc.

Reports to: Project health coordinator

Supervises: Community health agents

Job Summary: Educates mothers, refers mothers and children for services to the hospital, supervises lead CHAs, immunizes, reports on a monthly basis.

Duties/Responsibilities:

Assisting during household registration, managing the HPs, orienting and supervising the work of lead CHAs, immunizing, education/counseling of mothers on each intervention, referrals to hospitals, training lead CHAs, vitamin A and iron/folic acid distribution, etc.

Relates to: The project health and HIS coordinator and ADRA field supervisor

Training: ANs will have opportunity to participate in various training and continuing education programs.

Appendix Q

EPI-related HIS Forms and Charts

EPI Supply Request Form

Daily Vaccine Temperature Monitoring Sheet

Monthly EPI Summary Report Form

EPI Registration Form (Children/WCBA)

EPI Gas Supply Request Form

Forms for Management of Vaccine Stock

PROGRAMME ÉLARGI DE VACCINATION

BON DE REQUISITION VACCINATION

NO:

DÉPARTEMENT : **COMMUNE :**

NOM DE L'INSTITUTION :

NO	DESCRIPTION	CONSOMMATION DERNIER MOIS	QUANTITÉ DEMANDÉE
1	VACCIN DPT INJ FLAC 20 DOSES		
2	VACCIN ANTITETANIQUE INJ FLAC 20 DOSES		
3	VACCIN ANTIROUGEOLE INJ FLAC 10 DOSES		
4	EAU POUR DILUTION ROUGEOLE		
5	SERINGUE 5ml + AIGUILLE		
6	VACCIN ANTIPOLIOMELIQUE BUV 20 DOSES		
7	COMPTE GOUTTES POLIO		
8	VACCIN BCG INJ 10 DOSES		
9	EAU POUR DILUTION BCG		
10	SERINGUE 5ml + AIGUILLE		
11	SERINGUE 0,5ml (TYPE SOLESHOT) BTE 100		
12	SERINGUE BCG BTE 100		
13	SAVON LIQUIDE 250ml		
14	COTON HYDROPHYLE 450g		
15	CARTE CHEMIN DE SANTE		
16	CARNET TETANOS TOXOIDE		
17	FORMULAIRE D'ENREGISTREMENT JOURNALIER		
18	FICHE DE GESTION DE STOCK PEV		
19	BON DE COMMANDE		
20	FEUILLE DE CONTROLE DE TEMP. REFRIGERATEURS		
21	RAPPORT MENSUEL DE VACCINATION		

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PROGRAMME ÉLARGI DE VACCINATION

TABLEAU DE CONTROLE DES TEMPÉRATURES DE RÉFRIGÉRATEURS

INSTITUTION: _____ MOIS : _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
T° ENREGISTRÉE LE MATIN																															
T° ENREGISTRÉE L'APRES MIDI																															
ENTRETIEN																															

REMARQUES :

1. CONTROLER LA TEMPÉRATURE CHAQUE MATIN. A VOTRE ARRIVÉE ET L'APRES MIDI AVANT VOTRE DÉPART

2. UNE FOIS PAR MOIS DÉGIVRAGE DU RÉFRIGÉRATEUR. BIEN NETTOYER L'INTÉRIEUR. DÉPOUSSIÉRAGE DES TUBES PLACÉS DERRIERE. NETTOYAGE DES JOINTS DE PORTES. LES TALQUER. MARQUER LA DATE LORSQUE VOUS FAITES CE TRAVAIL DANS LA LIGNE ENTRETIEN.

3. LORSQUE VOUS CHANGEZ LA BOUTEILLE DE GAZ, MARQUER LA DATE D'INSTALLATION SUR LA NOUVELLE BOUTEILLE.

4. OUVRIR LA PORTE DU RÉFRIGÉRATEUR SEULEMENT POUR METTRE OU ENLEVER LES VACCINS.

5. GARDER DES ACCUMULATEURS DE FROID DANS LE COMPARTIMENT CONGÉLATEUR ET DES BOUTEILLES D'EAU DANS LA PARTIE BASSE DU RÉFRIGÉRATEUR.

6. VEILLER A CE QUE LES VACCINS SOIENT EN QUANTITÉ SUFFISANTE.

7. NE JAMAIS CONSERVER DE BOISSONS OU DE NOURRITURES A L'INTÉRIEUR DU RÉFRIGÉRATEUR.

8. NE PLACER JAMAIS LES VACCINS SUR LES CASIERS DE LA PORTE DU RÉFRIGÉRATEUR.

9. DANS LA CAS D'UN RÉFRIGÉRATEUR FONCTIONNANT AU KÉROZENE, REMPLIR CHAQUE JOUR LE RÉSERVOIR ET GARDER TOUJOURS DU KÉROZENE EN RÉSERVE

10. DANS LE CAS D'UN RÉFRIGÉRATEUR FONCTIONNANT A L'ÉLECTRICITÉ. VEILLER A CE QU'IL SOIT TOUJOURS BIEN BRANCHÉ A LA FICHE MURALE.

11. DANS LE CAS D'UN RÉFRIGÉRATEUR FONCTIONNANT AU GAZ PROPANE CONTROLER CHAQUE JOUR LE NIVEAU DE LA BOUTEILLE ET GARDER DEUX BONBONNES EN RÉSERVE.

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PROGRAMME ÉLARGI DE VACCINATION

RAPPORT MENSUEL DE VACCINATION

DISTRICT SANITAIRE : _____ MOIS : _____

TYPE DE VACCIN	DOSES	ROUTINIERE		POSTE DE RASSEMBLEMENT		JOURNEE COMMUNALE		JOURNEE URBAINE		AUTRE		TOTAL
		- 1 AN	1 - 4 ANS	- 1 AN	1 - 4 ANS	- 1 AN	1 - 4 ANS	- 1 AN	1 - 4 ANS	- 1 AN	1 - 4 ANS	
DPT	1ère											
	2ème											
	3ème + Rap.											
POLIO	1ère											
	2ème											
	3ème + Rap.											
BCG	DOSE UNIQUE											
ROUGEOLE	DOSE UNIQUE											
TÉTANOS		GESTANTE	NON GEST.	GESTANTE	NON GEST.	GESTANTE	NON GEST.	GESTANTE	NON GEST.	GESTANTE	NON GEST.	
	1ère											
	2ème + Rap.											

JOURNEES NATIONALES DE VACCINATION, HAITI 1993
FORMULAIRE D'ENREGISTREMENT JOURNALIER F1

DISTRICT : _____ POSTE : _____ DATE : _____ PAGE _____ DE _____

COMMUNE : _____ LOCALITE/ADRESSE : _____

CENTRE : _____ RESPONSABLE : _____

NOMS ET PRENOMS	AGE AN	CATEGORIE		CARTE DISTRIBUEE	ANTI-POLIO							DITEPER						ANTI-ROUG. UNIQUE		TETA. TOX		VIT. A À PARTIR DE 6 MOIS
	0 1 2 3 4	E	F		0 an			1-4 ans			RAP.	0 an			1-4 ans			0 an	1-4 ans	FEMMES 15-49 ans		
					1	2	3	1	2	3		1	2	3	1	2	3			1	2	
1.																						
2.																						
3.																						
4.																						
5.																						
6.																						
7.																						
8.																						
9.																						
10.																						
SUBTOTAL																						

FORM 1

PREPARE PAR : _____

LEGENDE

0-11 mois	=	0 an	36-47 mois	=	3 ans
12-23 mois	=	1 an	48-59 mois	=	4 ans
24-35 mois	=	2 ans	15-49 ans	=	Adulte (A), si âge inconnu

Imp. H. Deschamps

P.E.V. / OPS/OMS

CONTRÔLE DE LA DISTRIBUTION DES BONBONNES DE GAZ PROPANE AU NIVEAU DES USD

DÉPARTEMENT : _____

INSTITUTION (USD) : _____

DATE	INSTITUTION	NBRE BON-BONNES REMPLIES DEMANDÉ	NBRE BON-BONNES REMPLIES LIVRÉ	NBRE BON-BONNES VIDES RETOURNÉ	BONBONNES LIVRÉES PAR		BONBONNES REÇUES PAR	
					NOM/PRÉNOM	SIGNATURE	NOM/PRÉNOM	SIGNATURE

MJB / MARS 1994

PROGRAMME ÉLARGI DE VACCINATION

STOCK DE VACCINS AU NIVEAU DES UNITÉS SATELLITES ET DES USD

INSTITUTION : _____ MOIS : _____ DU: _____ AU : _____

	NBRE DE DOSES DE BCG				NBRE DE DOSES DE POLIO				NBRE DE DOSES DE ROUGEOLE				NBRE DE DOSES DE DTP				NBRE DE DOSES DE T.T.				LIEU
DATE	RECUES	UTIL. OU DIST.	DÉ-TRUITES	BALANCE	RECUES	UTIL. OU DIST.	DE-TRUITES	BALANCE	RECUES	UTIL. OU DIST.	DÉ-TRUITES	BALANCE	RECUES	UTIL. OU DIST.	DÉ-TRUITES	BALANCE	RECUES	UTIL. OU DIST.	DÉ-TRUITES	BALANCE	

UTIL = UTILISÉES
BALANCE = RECUES - UTILISÉES OU DISTRIBUÉES - DÉTRUITES

N.B.: CONSIDÉRER TOUT VACCIN RETOURNÉ COMME "DÉTRUIT"

Appendix R

Family Planning-related HIS Forms and Charts Used at the Adventist Hospital

Facility-based Summary of Daily FP Services

Community-based Summary of Daily FP Services

CHV/CHA Form for Community-based Contraceptive Distribution/Registration

Note: These forms will be adapted to meet the project's HIS needs (in consultation with CERA, the local HIS consultant).

Registre de Planification Familiale

Département : _____ Institution : _____

Distributeur : _____ Année : _____

Nom, Prénom	Année de Naissance	Début de la Contraception Mois/Année	Méthode en Décembre dernier	Enfants Vivants	JANVIER	FEVRIER	MARS	AVRIL	MAI	JUIN	JUILLET	AOUT	SEPTEMBRE	OCTOBRE	NOVEMBRE	DECEMBRE	Mois en Réserve
		/															
		/															
		/															
		/															
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		/															
		/															
Total Utilisatrices/ Utilisateurs																	
Total Nouvelles/ Nouveaux Acceptants																	
Total Stérilisations Volontaires																	

CLE:
- L = Loféménal
- O = Ovrette
- A = Autres Pilule
- C = Condom ou Capote
- SV = Stérilisation Volont.
- M = Mousse Vaginale
- N = Noristérat
- D = Dépo-provéra, inject.
- S = Stérilet/filament
- T = Tablette vaginale

ASSOCIATION DES OEUVRES PRIVEES DE SANTE

A.O.P.S. — "LA SANTÉ POUR TOUS"

41, Rue Borno, Pétion-Ville
P.O. Box 13489 Delmas, Haïti • Tél. : 57-1085

FORMAT DE CONTROLE DU MATERIEL CONTRACEPTIF

DISTRIBUTION DIRECTE

Mois

	Quantité distribuée		
Date	**Tablette**	**Condoms**	**Pilules**
TOTAL			

	Tablette	Condoms	Pilules
Inventaire au début du mois			
Approvisionnement au cours du mois			
Total stock disponible			
Inventaire stock fin du mois			

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Ed. des Antilles (1316-3

PROJET DE PLANIFICATION FAMILIALE DU SECTEUR PRIVE
RAPPORT MENSUEL DU DISTRIBUTEUR COMMUNAUTAIRE

DEPARTEMENT_____ COMMUNE_____

AGENT DISTRIBUTEUR: NOM_____

CATEGORIE_____

MOIS/ANNEE_____

INSTITUTION (de référence)_____

ACCEPTATION/UTILISATION/CONTRACEPTIFS DISTRIBUES

METHODE	ACCEPTANTS	UTILISATEURS	CONTRACEPTIFS
LOFEMENAL			
OVRETTE			
AUTRES PILULES			
PILULES NON SPEC			
TABLETTE VAG.			
MOUSSE VAG.			
CONDOM (Femme)			
SUB-TOTAL			
CONDOM (Homme)			
TOTAL GENERAL			

PREPARE PAR_____ LE_____

EXPEDIE LE_____ RECU PAR_____

RAPPORT MENSUEL DE PLANIFICATION FAMILIALE

DISTRICT SANITAIRE ..... INSTITUTION ..... MOIS/ANNEE .....

AGENT DISTRIBUTEUR COMMUNAUTAIRE	FEMMES								HOMMES		CONTRACEPTIFS DISTRIBUES				INSCRIPTION	
	ACCEPTANTES				UTILISATRICES				ACCEPT	UTILIS.						
	PIL	COND	MOUS	TAB	PIL	COND	MOUS	TAB	COND	COND	PIL	COND	MOUS	TAB	F	H
TOTAL COMMUNAUTE																
TOTAL INSTITUTION																
TOTAL COMMUNAUTE + INSTIT.																

Ed. des Antilles (1086)

METHODES CLINIQUES	ACCEPT	UTILIS.	QTE. UTIL.
IUD			
NORPL			
INJ			
TOTAL			

STERILISATION VOLONTAIRE

MINI LAP .....

LAPAROSC .....

VASECTOM .....

TOTAL .....

H = HOMMES. F = FEMMES.

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Appendix S

WHO Immunization Schedule

Vaccination Schedules

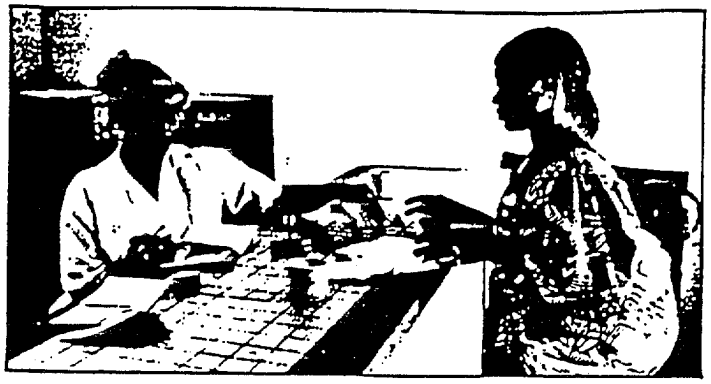
1. Schedule recommended by WHO to assure protection at an early age is as follows:

AGE	VACCINE	REASON
Birth	BCG, OPV_0^*	BCG given at the earliest possible age protects against the possibility of infection from other family members. The extent of protection against polio is increased the earlier the OPV is given.
6 weeks	DPT_1, OPV_1	An early start with DPT reduces the chances of severe pertussis.
10 weeks	DPT_2, OPV_2	Four week intervals between doses give effective protection, and reduce the time a child is exposed without protection, particularly to pertussis.
14 weeks	DPT_3, OPV_3	
9 months	Measles	At least 80% of measles in children in the third world can be prevented by vaccination at this age.

*OPV: Oral Poliovirus Vaccine (dose at birth is *in addition* to the standard schedule of 3 doses)

2. WHO sample schedule for contacts at intervals from four weeks to four months:

AGE	VACCINE	REASON
Less than 6 weeks	BCG, OPV_0	This schedule is useful where populations are dispersed and accessible mostly to outreach services; protection is not optimal
Above 6 weeks	BCG (if not already given) OPV_1, OPV_2, OPV_3, DPT_1, DPT_2, DPT_3,	
Above 9 months	Measles	



VERONIQUE LEGER

Careful screening is essential if women and children are to receive every vaccine they are eligible for when they visit a clinic.

3. WHO sample schedule for contacts every six months:

AGE	VACCINE	REASON
Less than 3 years	OPV as often as contacted; DPT up to three doses; BCG once	Semi-annual schedules inadequately protect against pertussis, polio, and measles. These schedules should only be used in the most remote areas where it is infeasible to vaccinate more often.
From 6 months to 3 years	Measles, two doses if the first is given below 9 months, otherwise one dose	

4. Semi-annual single day "pulse" campaigns (as used in Brazil):

AGE	VACCINE	REASON
All children 0-59 months old	OPV (up to 10 doses)	After mass vaccination with OPV, the vaccine virus replaces the naturally occurring disease-causing virus in the environment.
All children 9-23 months old	measles (up to 2 doses)	Giving a second dose of measles vaccine increases effective coverage.
All children 2-11 months old	DPT (2 doses)	Third DPT through regular primary health care services in clinics; 2 doses of DPT are partially effective (50-60%) against pertussis.

Continued

5. Special vaccination for women against tetanus with tetanus toxoid:

AGE	VACCINE	REASON
Puberty or as early in any pregnancy as possible.	TT_1	Begin as close to childbearing age as possible (no protection against neonatal tetanus with one dose unless DPT previously given in childhood)
At least four weeks later	TT_2	Gives 3 years protection
At least six months later, or in next pregnancy	TT_3	Gives 5 years protection
At least one year later, or in the next pregnancy	TT_4	Gives 10 years protection
At least one year later, or in the next pregnancy	TT_5	Expected to protect all infants born to that mother

Tetanus toxoid schedules for women are more flexible than childhood vaccination schedules. Women should be vaccinated at least twice with tetanus toxoid before the first birth, or anytime during pregnancy. Note that the first dose can be given as soon as early puberty when girls may still be in school. A woman who received three doses of DPT in childhood and/or two doses of DT at school age may need only one TT booster when she reaches childbearing age.

Vaccination Session Records

All vaccination sessions need a record of vaccinations performed by vaccine and age group. The easiest way to maintain records is to keep a simple tally, as shown in the form at the right. Tally records should also show the number of vials of vaccine used. In addition to recording vaccine stocks, the record allows vaccinators to compare the number of doses used to the number of children vaccinated. This gives an estimate of wastage which is used to estimate future vaccine orders.

Appendix T

Checklists, Supervisory and Evaluation Forms

CHA/CHV Checklist for CS Services Provided in the Community

Training Evaluation Form

CHV/CHA Supervisory Review Form

ADRA

AGENCE DE DEVELOPPEMENT ET DE SECOURS ADVENTISTE

SURVIE DE L'ENFANT

SANTE COMMUNAUTAIRE

FEUILLE JOURNALIERE DE L'AGENT DE SANTE

DATE.....

ACTIVITES	Réalisation	
	OUI	NON
Visites Domiciliaires réalisées		
Nombre d'enfants référés au centre pour vaccination		
Nouveaux-nés référés au centre pour BCG		
Cas de diarrhée rencontrés		
Nombre de cas référés au centre pour deshydratation		
Nombre de sachets de SRO distribués		
Séance de démonstration de SRO		
Cas d'enfants malnouris rencontrés		
Nombre d'enfants malnouris référés au centre		
Nombre de capsules de VIT A distribuées		
Nombre de femmes acceptantes en PF		
Nombre d'hommes acceptants en PF		
Clients réapprovisionnés sur le terrain		
Quantité de condoms distribués		
Femmes Enceintes réferées au centre		

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EVALYASYON PEDAGOJIK FOMASYON AN

1.- Kesyon sou kou a menm

A- Ki sa ou pran nan seminè a

Anyen di tou ☐

Yon ti kras konesans ☐

Anpil konesans ☐

B- Eske kou sa w pran ka sèvi w

Nan anyen ditou ☐

Nan aktivite pèsonèl ou ☐

Nan aktivite pwojè w ap travay la ☐

Nan aktivite gwoupman nan zòn travay ou ☐

C- Ki sa w santi kou a manke men ke ou ta bezwen anplis

D- Ki pati nan seminè a ou pat rive byen konprann?

KEKSYON SOU EKZESIS PWATIK

A- Eske materyèl pedagojik yo te

Mal prezante ☐

Klè e ou te byen konprann yo ☐

Yo merite yon ti pase men pou yo pi klè ☐

B- Bay ki bò ki merite yon pase men

_____

_____

_____

_____

_____

_____

_____

VHS Supervisory Review Form

Name of VHS: _____

Name and Signature of Supervisor: _____

Date of Review: _____

Service Village of VHS: _____

Module Reviewed: _____

I. Format	Good	Needs improvement
1. Opening/Introduction		
2. Statement of Purpose		
3. Opportunity for Questions		
4. Closing		

II. Content	Good	Needs improvement
1. Prime Messages (list by #)		
2. Note inaccuracies or parts omitted for every prime message observed		

III. Techniques used	Good	Needs improvement

List # of prime message next to the technique used

1. Role Play
2. Demonstration
3. Discussion

Continued

Continued

4. Lecture

5. Question and Answer

6. Other (please specify)

IV. Teaching aids

List each type of teaching aid or item used; note the number of the prime message for which it was used. Note whether or not it was supplied by the VHS Program.

Type/Item	# Prime Message	Supplied by VHS Program
1.		
2.		
3.		
4.		
5.		
6.		
7.		

V. Rapport	**Good**	**Needs improvement**
1. Polite		
2. Handled problems well		
3. Established comfortable communication		
4. Used simple words		
5. Other (describe)		

VI. Additional Comments

Appendix U

Project Sustainability Strategy

Note: This scope of work was developed by Dr. Antoine Augustin, who will be consulting for ADRA on project sustainability strategy and cost recovery.

ADRA CHILD SURVIVAL SUSTAINABILITY STRATEGY

S OPE OF WORK

1. Background

ADRA proposes to strengthen Child Survival interventions in the Carrefour area of Haiti, under the CS XII program. The main vehicle for the provision of services will be a network of four to five community health posts, each staffed by one auxiliary nurse, 2 on-site health workers, and 4 community-based health workers. ADRA seeks to develop a model to ensure the sustainability of its Child Survival program, and in particular, that of the individual community health posts. The purpose of the consultation is to assist ADRA in the development of the sustainability strategy.

2. Objective

The objective of this procurement action is to obtain the services of a contractor to assist ADRA-Haiti in elaborating a strategic management plan focusing on the sustainability component of its Child Survival project for Carrefour, Haiti, and to make recommendations to ADRA on the configuration of the service delivery package needed to maximize the potential for sustainability.

Specially, this action is to contract with an organization to provide three consultants having experience in facility management and cost recovery mechanisms and NGO management operations.

The consultant team will:

A, Develop an overall strategic framework for the sustainable operation of the community health posts

B. Define the specific management and financial control parameters to be used by ADRA, including a viable approach to develop the envisioned network of self-financed centers

C. Propose a plan of action for implementing the strategy

3. Group tasks

A. organize meetings with ADRA staff, community members and MSPP representatives to describe the objectives of the consultation and solicit feedback on the preliminary recommendations

B. visit potential community health post sites

C. prepare a report detailing:

-the steps needed for the transfer of capabilities for facility management to the ADRA community health post staff, including the capacity for financial control, inventory, assets management and limited cost analysis;

-the financial control methods to be used;

- a proposed fee structure

- a community health post operations system with a brief manual of operations (inventory, requisitions, commodity procurement, receiving reports, utilization, bookkeeping and report writing).

4. Individual tasks

A. Team leader and design specialist

The team leader will be responsible for the general oversight and coordination of the work and for the preparation of the final report, reviewing the contributions of the two other team members and providing direction to assure a complete and well integrated report.

B. Operations specialist

This individual will design all technical and managerial aspects of the basic operations of a health post with an orientation on financial self-sustainability, including pricing policies and pricing strategies, development of a simplified management information system.

C. Accountant

This individual will design the basic bookkeeping requirements for controlling receipts (fees), petty cash and expenses, as well as describe a simple inventory system for keeping track of all commodities used.

5. Deliverables

1) Sustainability Strategy document

2) Operational procedures document

3) Financial procedures document

6. Timing

The consultation will take place in May 1997.

.DRA/HAITI CHILD SURVIVAL SUTAINABILITY STRATEGY BUDGET

Personnel	
Team leader/design specialist 5 days @ 327.40/day	1637
Operations specialist 5 days @ $150.00/day	750
Accountant 3 days @ $100/day	300
Office expenses	300

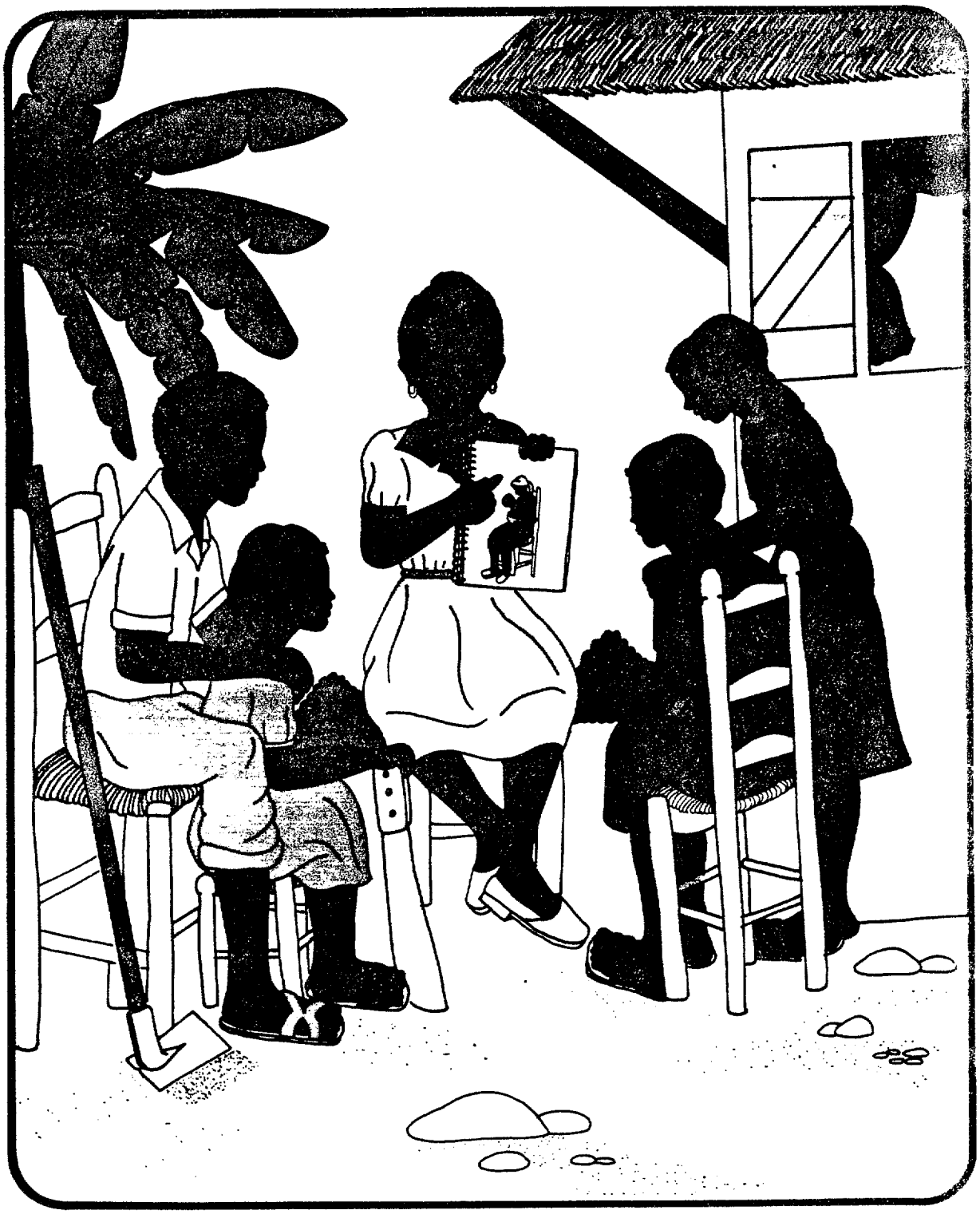
	2987
Oversight/management	299
TOTAL	**$3,286**

Appendix V

Cover Page of MOH Training Guidelines for CHAs

Dépatman Sante Piblik ak Popilasyon

GID EDIKASYON POU TRAVAYÈ SANTE



Seksyon Ansèyman Medikal e Paramedikal
Divizyon Dijyèn Familyal
Divizyon Nitrisyon

MAS 91

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Appendix W

Response to Proposal Review Comments

Response to Proposal Review Comments

Below is a narrative explanation of how the DIP responds to each concern submitted to ADRA as a result of the program proposal's technical review. For details, please refer to the sections in the DIP addressing the concerns.

General

1. Yes, ADRA has an alternative plan if USAID does not approve an extension. ADRA has already contacted a local consultant/expert in the filed of sustainability (Dr. Antoine Augustine) to develop a plan that maximized the chances for sustainability right from the start of the project. The consultant will focus on the health post facility management, cost recovery mechanisms and linkages with the UCS and community groups as part of the sustainability strategy. Please see Appendix U for details on the strategy and scope of work for the consultant, and Section G1 for the overall sustainability strategy.

2. ADRA has obtained letters of support from the community (see Appendix B) as well as PROMESS (also Appendix B). See Appendix F for a memorandum of agreement between ADRA/Adventist Hospital and the government of Haiti. This agreement permits ADRA to function in the country without any hindrance. A letter of support from the MOH for this project was not obtained because at the time of writing the DIP, the MOH developed a policy of releasing letters to NGOs only after the DIP is translated in the local language (French or Creole) and submitted to the local, regional and central MOH officers. Obviously, this was not done as the DIP is not translated or submitted to the named MOH offices yet. The DIP is currently being translated and will be submitted shortly at which time ADRA will obtain the letter of support.

Immunization

1. The project is planning to conduct extensive FGDs in the third quarter of the first implementation year. However, to obtain an overall picture of the barriers to immunization, a "mini" operations research in the form of FGD targeting different segments of the population was conducted. See section D.4.1.

2. There should not be any concern about PROMESS/PAHO's commitment to supply vaccines, vitamin A, iron and folic acid. The Adventist Hospital was designated as the regional depot for vaccine supply, and the system has been functioning for numerous years. ADRA will obtain its vaccine supply from the Adventist Hospital located in the project area. See Appendix B for a letter indicating this linkage or partnership.

3. Special emphasis will be given to training HP staff on maintaining the cold chain, monitoring vaccine storage and handling. Supervision will be made by the AN or health coordinator on a daily basis to monitor vaccine handling using the daily vaccine temperature monitoring form. See D.4.13, under section "e" (staff training).

4. Using the KPC Survey and HP EPI registration books, ADRA will measure not only the project's overall immunization coverage but also coverage rates for individual antigens. See Section F2.

5. ADRA has plans for assisting the MOH in disease surveillance. Please see section D.4.11 (under "surveillance") for ADRA's role and the Adventist Hospital's role in EPI surveillance.

Diarrhea Case Management

ADRA has added objectives regarding referral of severe and bloody diarrhea cases and mothers demonstration of correct ORT preparation and use. Please see DIP Table B, under the Diarrhea Case Management section for the objectives, and DIP section D.4.4. #4 (approach) f or the protocol to be followed.

Nutrition

1. ADRA has added an objective regarding referral children with acute malnutrition. See DIP Table B, under the Nutrition section. Also, see DIP section D.4.2 for the strategy used to rehabilitate children with acute malnutrition.

2. ADRA plans to deworm all children coming for services to the HP (for EPI, GM or vitamin A) once every four months.

Human Resources

1. ADRA plans to remunerate CHVs working for this project with $15.00 per month. See section E.2 in the DIP. In addition, ADRA will provide training opportunities to CHAs.

2. ADRA plans to provide initial training and numerous refresher courses every year. Please see Appendix Z for details on schedule, frequency and duration of training for each type of health worker.

Health Information System

The issue of "in-depth interviews" or FGD was discussed in the "immunization" section above. However, ADRA plans to conduct FGD's on immunization, nutrition and DCM in the first year of project implementation. This plan is discussed under each intervention section of the DIP.

Appendix X

Draft Copy of MOH Norms, Policies and Guidelines for EPI, Nutrition and DCM

Note: ADRA will closely follow the MOH policies and guidelines in implementing the CS project.

DRAFT

DRAFT

4.1 PRISE EN CHARGE DE L'ENFANT DIARRHEIQUE

Pour tout enfant se présentant au niveau de la consultation avec des signes évidents de diarrhée mentionnés par la mère, les responsables de santé au niveau des dispensaires, centres de santé, hôpitaux, procèderont de la manière suivante:

A. Recherche systématique des signes

1. Se renseigner sur les motifs de la consultation.
   Diarrhée : plus de 3 selles molles ou liquides/24 hres

2. Rechercher les signes d'alarme. S'il n'y a pas d'actions urgentes à prendre, se renseigner auprès de la mère sur:

   . La durée de la maladie.
   . La présence de sang dans les selles.

   L'enfant est-il capable de boire? A-t-il soif
   (Noter les informations sur le dossier).

3. Procéder à l'examen de l'enfant. Pour ce:

(a) Apprécier la condition générale de l'enfant:

. L'enfant est-il somnolent?
. L'enfant est-il irritable?
. L'enfant est-il alerte?

(Noter les signes trouvés sur le dossier).

(b) Examiner les yeux de l'enfant:

. Les yeux sont-ils très excavés et secs?
. Les yeux sont-ils excavés?
. Les yeux sont-ils normaux?
. L'enfant produit-il des larmes?

(Noter l'information sur le dossier de l'enfant).

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3. Interprétation des signes et classification de la maladie

Signes identifiés	Interprétation
Diarrhée évoluant depuis moins de 14 jours	Diarrhée aigue
Diarrhée évoluant depuis 14 jours ou plus	Diarrhée persistante
Diarrhée avec selles sanguinolentes	Dyssenterie
Diarrhée avec: 2 ou plus des signes suivants: . Somnolence . Yeux excavés et secs . Absence de larmes . Sécheresse des lèvres et de la langue . Difficulté ou impossibilité de boire . Signe du pli à l'abdomen	Diarrhée avec signes évidents de déshydratation
Diarrhée avec 1 ou plus de ces signes: . Irritabilité . Pas de signe du pli Accompagnés ou pas de . Yeux excavés . Absence de larmes . Sécheresse des lèvres et de la langue	Diarrhée avec déshydratation
Diarrhée avec: . Enfant alerte . Yeux normaux . Larmes présentes . Lèvres et langues humides . Enfant boit normalement Non assoiffé . Pas de signe du pli	Diarrhée sans déshydratation

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Diarrhée sans signes de deshydratation	. Appliquer le Plan de traitement A.	. Idem	. Idem	Idem
	. Soigner l'enfant pour la malnutrition et l'anémie. S.O.S	. Idem	. Idem	Idem
	. Former la mère			
	. Référer l'enfant si la diarrhée persiste ou si l'enfant se déshydrate sévèrement.	. Idem	. Idem	Idem
		. Examen paraclinique si la diarrhée persiste et Traitement approprié.	. Idem	Idem

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Diarrhée aigue avec signes évidents de déshydratation	. Appliquer le Plan de traitement B. . Traiter l'enfant pour la malnutrition et l'anémie. . Demander à la mère de revenir après 2 jours. . Former la mère. . Référer l'enfant à un centre de santé ou un hôpital si l'état de l'enfant ne s'améliore pas ou si la déshydratation devient sévère.	. Appliquer le Plan de Traitement B. . Traiter l'enfant pour la malnutrition et l'anémie. . Demander à la mère de revenir après 2 jours. . Former la mère. . Si l'état de l'enfant ne s'améliore pas, effectuer des examens paracliniques et initier le traitement approprié.	Idem	Idem

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L	NIV. C.A.L	NIV. HOP.
Diarrhée aigue avec déshydratation sévère	. Référer l'enfant à un centre de santé. . Donner du SRO à l'enfant s'il peut boire . Recommander aux parents de continuer à administrer le SRO en cours de route. Enfant: < 2 ans: 1/2 tasse après chaque selle liquide. > 2 ans: 1 tasse après chaque selle liquide.	. Appliquer le Plan de Traitement C. . Après la réhydratation de l'enfant, le traiter pour la malnutrition et l'anémie. . Former la mère. . Si la diarrhée demeure persistante, effectuer des examens paracliniques et initier le traitement approprié. Au besoin, référer l'enfant à un établissement mieux équipé.	. Idem	Idem

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Dyssenterie sans déshydratation	. Prescrire le Cotrimoxazole Sirop: -Enfant de 3-5 Kg/P 1/2 Cac Bid pendant 5 jours. -Enfant de 6-9 Kg/P 1 Cac Bid pendant 5 jours. -Enfant de 10-14Kg/P 1 1/2 Cac Bid. Pendant 5 jours. Comprimé pour enfant -Enfant 3-5 Kg/P: 1 Co. Bid pendant 5 jours. -Enfant 6-9 Kg/P: 2 Co. Bid pendant 5 jours. -Enfant 10-14 Kg/P: 3 Co. Bid pendant 5 jours. . Appliquer le Plan de Traitement A. . Former la mère. . Rendez-vous dans 2 jours. . Référence si le traitement échoue.	. Traiter la dyssenterie avec du Cotrimoxazole pendant 5 jours. . Appliquer le Plan de Traitement A. . Former la mère. . Rendez-vous dans 2 jours. . Si après 2 jours les signes de dyssenterie persistent, remplacer le Cotri moxazole par l'Ampicilline. . Si le traitement échoue, faire des examens à la recherche d'amibes et ajuster le traitement aux résultats.	. Idem . Idem . Idem . Idem . Idem . Idem	Idem Idem Idem Idem Idem Idem

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Dyssenterie avec déshydratation	. Appliquer le Plan de Traitement B. . Initier le traitement de la dyssenterie avec le Cotrimoxazole (Sirop ou Comp.). . Continuer le traitement ambulat. au Cotrimoxazole pendant 5 jours. . Former la mère. . Rendez-vous dans deux jours. . Référence à un centre de santé si l'état de l'enfant ne s'améliore pas ou empire après 2 jours.	. Appliquer le Plan de Traitement B. . Traiter la dyssenterie au Cotrimoxazole (Traitement ambulatoire) pendant 5 jours. . Former la mère. . Revoir l'enfant après 2 jours. . Remplacer le Cotrimoxazole par l'Ampicilline s'il n'y a pas d'amélioration après 2 jours. . Appliquer le Plan C si la déshydratation devient sévère. . Faire des examens complémentaires si le traitement de la dyssenterie échoue, et prendre les mesures appropriées.	. Idem . Idem . Idem . Idem . Idem . Idem . Idem	Idem Idem Idem Idem Idem Idem Idem

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LA MALADIE EST CLASSEE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Dyssenterie avec déshydratation sévère	. Donner du SRO à l'enfant. . Référer l'enfant à un centre de santé. . Demander aux parents de continuer à administrer du SROen cours de route.	. Appliquer le Plan de Traitement C . Une fois l'enfant réhydraté, procéder comme pour la dyssenterie sans déshydratation.	. Idem . Idem	Idem Idem

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CONTENU DE LA FORMATION DES MERES D'ENFANTS DIARRHEIQUES

- Former les mères pour l'application à domicile du Plan de Traitement A.
- Apprendre aux mères à identifier les signes d'aggravation de la diarrhée.
- Apprendre aux mères à préparer et administrer le SRO.
- Apprendre aux mères à administrer les médicaments prescrits.
- Apprendre aux mères à alimenter leur enfant.
- Recommander à la mère de faire vacciner ou de compléter la vaccination de son enfant.
- Recommander à la mère de continuer à fréquenter le centre pour le contrôle nutritionnel de son enfant.

NORMES DE PREPARATION DU SRO:

Les sachets de sels de réhydratation orale doivent être mélangés à un litre d'eau saine.

Convenablement préparée et administrée, la solution de SRO fournit à l'organisme des quantités adéquates d'électrolytes pour corriger les déficits dus à la diarrhée aigue. La teneur en potassium permet de compenser les pertes potassiques importantes liées à la diarrhée aigue, en particulier chez le nourisson, et donc d'éviter une hypokaliémie grave. Le citrate, ou le bicarbonate, présent dans la solution a pour fonction de corriger l'acidose. Le glucose est essentiel car lorsqu'il est absorbé, il favorise l'absorption du sodium et de l'eau par l'intestin grêle : ce fait est toujours vrai quelle que soit la cause de la diarrhée. Sans lui, la solution de SRO serait inefficace.

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PLAN DE TRAITEMENT "A"
POUR TRAITER LA DIARRHEE A DOMICILE

UTILISER CE PLAN POUR APPRENDRE A LA MERE A:

- Continuer à traiter à domicile le présent épisode diarrhéique de son enfant
- Commencer rapidement le traitement lors de futurs épisodes diarrhéiques.

EXPLIQUER LES TROIS REGLES DU TRAITEMENT DE LA DIARRHEE A DOMICILE

1. FAIRE BOIRE A L'ENFANT PLUS DE LIQUIDES QUE D'HABITUDE POUR PREVENIR LA DESHYDRATATION:

Donner des liquides maison recommandés. Il peut s'agir d'une solution de SRO, de préparations liquides à base d'aliments (soupe, eau de riz ou yaourt liquide, par exemple) ou d'eau pure. Donner de la solution de SRO aux enfants dont le cas correspond au cas décrit dans l'encadré ci-après.

(Note: Si l'enfant a moins de 6 mois et ne mange pas encore d'aliments solides, lui donner de la solution de SRO ou de l'eau plutôt qu'une préparation à base d'aliments).

Donner à boire à l'enfant autant qu'il en a envie. Prendre comme guide les quantités indiquées ci-après pour les SRO.
Continuer à lui donner ces boissons jusqu'à ce que la diarrhée cesse.

2. DONNER A MANGER EN ABONDANCE A L'ENFANT POUR PREVENIR LA MAL NUTRITION:

Continuer à lui donner le sein fréquemment.
Si l'enfant n'est pas nourri au sein, lui donner le lait habituel.
Si l'enfant a 6 mois ou plus, ou prend déjà des aliments solides:

- Lui donner aussi des céréales ou des féculents, mélangés si possible avec des légumineuses, des légumes et de la viande ou du poisson. Ajouter une ou deux cuillérées à café d'huile végétale à chaque portion.
- Lui donner du jus de fruits frais ou des bananes écrasées qui apportent du potassium.
- Lui donner des aliments fraichement préparés, bien cuits et écrasés en purée.
- Encourager l'enfant à manger: lui donner à manger au moins 6 fois par jour.
- Continuer à lui donner ces mêmes types d'aliments une fois que la diarrhée a cessé et lui donner un repas supplémentaire par jour pendant 2 semaines.

3. AMENER L'ENFANT A L'AGENT DE SANTE S'IL NE VA PAS MIEUX DANS LES 3 JOURS OU S'IL A UN DES SYMTOMES SUIVANTS:

- Nombreuses selles liquides. Manque d'appétit, absence de soif.
- Vomissements répétés. Fièvre
- Soif prononcée. Sang dans les selles

ADMINISTRER DE LA SOLUTION DE SRO A L'ENFANT A DOMICILE SI:

- Le Plan de traitement B ou C lui a déjà été appliqué.
- On ne peut le ramener à l'agent de santé si la diarrhée s'aggrave.
- Les autorités sanitaires nationales ont adopté pour principe de donner des SRO à tous les enfants amenés à un agent pour une diarrhée.

SI L'ENFANT DOIT RECEVOIR DES SRO A DOMICILE, IL FAUT MONTRER A LA MERE QUELLE QUANTITE ADMINISTRER APRES CHAQUE SELLE MOLLE ET LUI DONNER ASSEZ DE SACHETS DE SRO POUR 2 JOURS:

Age	Quantité de SRO à donner après chaque selle molle	Quantité de SRO à fournir pour le traitement à domicile
Moins de 24 mois	50-100 ml (1/2 tasse)	500 ml/jour
2 à 10 ans	100-200 ml (1 tasse)	[illegible] ml/jour
10 ans ou plus	Autant qu'il en voudra	[illegible] ml/jour

Décrire et montrer, en se servant d'une mesure locale, la quantité à donner après chaque selle.

MONTRER A LA MERE COMMENT PREPARER LA SOLUTION DE SRO

LUI MONTRER COMMENT L'ADMINISTRER

Donner une cuillerée à café de solution toutes les 1 à 2 minutes aux enfants de moins de 2 ans.
Donner fréquemment à boire dans une tasse aux enfants plus âgés.
Si l'enfant vomit, attendre 10 minutes. Puis lui donner la solution plus lentement (par exemple, une cuillerée toutes les 2 à 3 minutes).
Si la diarrhée continue une fois les sachets de SRO finis donner à l'enfant d'autres liquides comme ceux qui sont décrits dans la première règle du traitement à domicile ou revenir chercher d'autres sachets de SRO.

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LA DESHYDRATATION

QUANTITE APPROXIMATIVE DE SOLUTION DE SRO A ADMINISTRER AU COURS DES 4 PREMIERES HEURES:

Age*	Moins de 4 mois	4-11 mois	12-23 mois	2-4 ans	5-9 ans	10 ans plus
Poids	Moins de 5 Kg	5-7,9 Kg	8-10,9 Kg	11-15,9 Kg	16-25,9 Kg	30 Kg ou plus
En ml	200-400	400-600	600-800	800-1200	1200-[illegible]	2200-4000
En mesure locale						

* Ne se baser sur l'âge du malade que si l'on ne connait pas son poids. La quantité approximative de SRO nécessaire (en ml) peut aussi être calculée en multipliant le poids du malade (en Kg) par 75.

. Si l'enfant veut boire plus de SRO, lui en donner plus.
. Encourager la mère à continuer à allaiter son enfant.
. Dans le cas d'enfants de moins de 6 mois qui ne sont pas nourris au sein, donner également 100-200 ml d'eau pure pendant cette période.

OBSERVER SOIGNEUSEMENT L'ENFANT ET AIDER LA MERE A LUI ADMINISTRER LA SOLUTION DE SRO

. Lui montrer quelle quantité de solution donner à l'enfant.
. Lui montrer comment la donner : une cuillerée à café toutes les 1 à 2 minutes à l'enfant de moins de 2 ans; de fréquentes gorgées à la tasse à l'enfant plus âgé.
. Vérifier de temps en temps qu'il n'y a pas de problème.
. Si l'enfant vomit, attendre 10 minutes puis continuer à administrer les SRO, mais plus lentement, par exemple, une cuillerée toutes les 2 à 3 minutes.
. Si les paupières de l'enfant sont gonflées, cesser de donner des SRO et donner de l'eau pure ou du lait maternel. Donner des SRO comme indiqué dans le Plan A une fois que le gonflement a disparu.

AU BOUT DE 4 HEURES, REEXAMINER L'ENFANT EN UTILISANT LE TABLEAU DES SIGNES DE DESHYDRATATION, PUIS CHOISIR LE PLAN DE TRAITEMENT APPROPRIE (A,B,C).

. S'il n'y a pas de signes de déshydratation, appliquer le Plan A. Une fois la déshydratation corrigée, l'enfant urine généralement et peut aussi être fatigué et s'endormir.
. S'il y a encore des signes évidents de déshydratation, répéter le Plan B mais en commençant à offrir à l'enfant des aliments, du lait et des jus de fruits comme indiqué dans le Plan A.
. Si les signes d'une déshydratation sévère sont apparus, appliquer le Plan C.

SI LA MERE DOIT REPARTIR AVANT LA FIN DU PLAN DE TRAITEMENT B:

. Lui montrer la quantité de solution de SRO à administrer pour terminer le traitement de 4 heures à domicile.
. Lui donner assez de sachets de SRO pour terminer le traitement de réhydratation et pour continuer à administrer des SRO à l'enfant pendant encore 2 jours comme indiqué dans le Plan A.
. Lui montrer comment préparer la solution.
. Lui expliquer les trois règles du Plan A pour le traitement de son enfant à domicile:

-- donner des SRO ou d'autres liquides jusqu'à ce que la diarrhée ait cessé;
-- alimenter l'enfant;
-- ramener l'enfant à l'agent de santé si nécessaire.

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PLAN DE TRAITEMENT C POUR TRAITER RAPIDEMENT LA DÉSHYDRATATION SÉVÈRE

SUIVRE LES FLÈCHES. SI LA RÉPONSE À LA QUESTION EST « OUI », FAIRE CE QUI EST INDIQUÉ À DROITE. SI C'EST « NON », PASSER À LA QUESTION SUIVANTE.

COMMENCER ICI

Êtes-vous en mesure de procéder immédiatement à une perfusion intraveineuse (IV) ?

OUI →

- Mettre immédiatement en place la perfusion. Si le malade peut boire, lui donner des SRO à boire en attendant que la perfusion commence. Lui administrer 100 ml/kg de solution de Ringer-lactate (ou s'il n'en a pas, de sérum physiologique) réparts comme suit :

Age	Administrer d'abord 30 ml/kg en :	Puis administrer 70 ml/kg en :
Nourrissons de moins de 12 mois	1 heure*	5 heures
Enfants plus âgés	30 minutes*	2h 30

- Répétez une fois si le pouls est encore faible ou imperceptible.
- Réexaminer le malade toutes les 1 à 2 heures. Si la déshydratation ne s'atténue pas, accélérer la perfusion.
- Donner aussi des SRO (environ 5 ml/kg par heure) dès que le malade peut boire ; généralement au bout de 3 à 4 heures (nourrissons) ou de 1 à 2 heures (malades plus âgés).
- Au bout de 6 heures (nourrissons) ou de 3 heures (malades plus âgés), réexaminer le malade en se servant du tableau des signes de déshydratation. Puis choisir le Plan approprié (A, B ou C) pour la poursuite du traitement.

NON ↓

Y a-t-il à proximité (à 30' minutes de distance ou moins) un service de santé équipé pour procéder à la perfusion ?

OUI →

- Envoyer immédiatement l'enfant dans ce service pour y être perfusé.
- Si l'enfant peut boire, donner à sa mère de la solution de SRO et lui montrer comment l'administrer pendant le transport.

NON ↓

Avez-vous la formation nécessaire pour utiliser une sonde nasogastrique pour la réhydratation ?

OUI →

- Commencer la réhydratation à l'aide de la sonde nasogastrique en administrant de la solution de SRO à raison de 20 ml/kg par heure pendant 6 heures (total 120 ml/kg).
- Réexaminer le malade toutes les 1 à 2 heures
  - en cas de vomissements répétés ou de distension abdominale, administrer le liquide plus lentement ;
  - si la déshydratation ne s'atténue pas au bout de 3 heures, envoyer le malade dans un service où l'on pourra le traiter par perfusion intraveineuse (IV).
- Au bout de 6 heures, réexaminer le malade et choisir le plan de traitement approprié.

NON ↓

Le malade peut-il boire ?

OUI →

- Commencer la réhydratation à l'aide de la sonde nasogastrique en administrant de la solution de SRO à raison de 20 ml/kg par heure pendant 6 heures (total 120 ml/kg).
- Réexaminer le malade toutes les 1 à 2 heures
  - en cas de vomissements répétés ou de distension abdominale, administrer le liquide plus lentement ;
  - si la déshydratation ne s'atténue pas au bout de 3 heures, envoyer le malade dans un service où l'on pourra le traiter par perfusion intraveineuse (IV).
- Au bout de 6 heures, réexaminer le malade et choisir le plan de traitement approprié.

NON ↓

URGENT : Envoyer le malade dans un service où l'on pourra procéder à la réhydratation par voie intraveineuse ou avec une sonde nasogastrique.

NOTES :

- Une fois la réhydratation achevée, garder, si possible, le malade en observation au moins 6 heures pour s'assurer que la mère sait maintenir l'hydratation en lui administrant des SRO par voie buccale.
- Si le malade a plus de 2 ans et s'il y a des cas de choléra dans votre région, administrer un antibiotique oral approprié une fois le malade sorti de son apathie.

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4.1 NORMES ET PROCEDURES POUR LA SURVEILLANCE DE LA CROISSANCE ET PRISE EN CHARGE DES PROBLEMES NUTRITIONNELS (MPE, Avit A, Anémie)

4.1.1 Contrôle méthodique de la santé des enfants

Il est généralement recommandé en bonne pratique pédiatrique de suivre régulièrement le développement et la croissance des enfants. Pour arriver à implanter ce système chez nous, il est conseillé :

A. Une visite postnatale dans les 48 à 72 heures au plus tard après l'accouchement. Cette visite comportera outre les soins à la mère, une attention au nouveau-né pour:

- voir s'il est normal
- lui mettre un antiseptique dans les yeux
- vérifier l'état du cordon et le nettoyer au besoin
- vacciner l'enfant au BCG et contre la polio

Puis seront prodigués à la mère:

- des conseils concernant la méthode de planification familiale applicable à la femme allaitante
- des conseils sur l'allaitement maternel qui sont:

  . commencer l'allaitement au sein aussitôt que possible après la naissance de l'enfant
  . nourrir son bébé entièrement au sein jusqu'à l'âge de six mois
  . donner le sein fréquemment, de jour et de nuit, chaque fois que l'enfant à faim. L'intervalle entre les têtées ne devrait pas dépasser quatre à six heures en cas d'allaitement maternel exclusif
  . éviter l'emploi de biberons, de sucettes ou de tétines
  . ne donner aux nouveau-nés aucun aliment ni aucune boisson autre que le lait maternel, sauf indication médicale
  . continuer à allaiter même si elle-même ou son nourrisson tombent malades.
  . commencer par mettre l'enfant au sein même lorsque le moment est venu d'inclure des aliments semi solides dans l'alimentation de l'enfant.

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B. Une visite mensuelle des bébés et enfants jusqu'à trois ans pour évaluation générale à la clinique et vaccination. En effet, le taux le plus élevé de mortalité d'enfants se situe en Haiti avant trois ans. Après cette période critique (4ème, 5ème année), les enfants seront vus chaque trois ou quatre mois pour une évaluation de leur état géneral.

4.1.2 Prise en charge des problèmes nutritionnels

Pour tout enfant se présentant à la clinique, qu'il soit malade ou non, et à moins qu'il y ait des signes de danger qui commandent une évacuation immédiate, le personnel sanitaire fera une évaluation de l'état nutritionnel de l'enfant et procèdera comme suit:

1. Observer l'état général de l'enfant:

   L'enfant est-il très amaigri?
   L'enfant est-il oedematié?
   L'enfant est-il alerte?
   L'enfant est-il apathique?

   (Noter l'information).

2. Vérifier:

   Les conjonctives de l'enfant. Sont-elles pâles ou rosées?
   L'aspect de la cornée. Y-a-t-il opacité cornéenne?
   L'aspect des sclérotiques. Présentent-elles des tâches laiteuses.
   La conjonctive bulbaire est-elle sèche?
   les cheveux sont-ils décolorés, roux, clairsemés et cassants?

   (Noter toutes les informations).

3. Rechercher les signes d'oedème au niveau des membres inférieurs.

   (Noter les informations).

4. Prendre la taille, la circonférence brachiale, le poids de l'enfant et vérifier si le poids correspond à l'âge (réf. courbe Poids/Age).

   (Noter l'interprétation sur la courbe Poids/Age).

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Le contrôle de poids sera réalisé avec le plus grand sérieux avec une balance bien équilibrée et tarée. Le poids sera ensuite enregistré puis comparé au poids idéal correspondant à l'âge de l'enfant. Si le poids est normal, on fera les compliments à la mère et on l'encouragera à continuer l'allaitement maternel le plus longtemps possible, à bien nourrir son enfant.

Si le poids de l'enfant est inférieur ou anormal, on prodiguera des conseils tout en lui montrant sur la grande courbe de poids de démonstration le poids que devrait avoir son enfant compte tenu de son âge.

INTERPRETATION DES SIGNES ET CLASSIFICATION DE L'ETAT NUTRITIONNEL

L'enfant a:	L'état nutritionnel est classé
Amaigrissement sévère	MPE (Marasme) grave
Conjonctives très pâles	Anémies sévères
Tâches laiteuses sur les sclérotiques	Avitaminose A (Xérophtalmie)
Oedème des membres inférieurs.	MPE (Kwashiorkor) grave ou sévère
Faible Poids/Age	MPE légère ou modérée
Conjonctives pâles	Anémies
Tâches de Bitot (tâches laiteuses sur les sclérotiques)	Avitaminose A
Poids/âge normal	Normal
Pas d'autres signes	

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L'ETAT NUTRITIONNEL EST CLASSE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Malnutrition et anémie sévères	. Administrer de la Vitamine A. *	. Evaluation minutieuse de l'état de l'enfant.	. Idem	Idem
	. Référer l'enfant à un centre de santé.	. Traitement approprié. *Voir Normes-Service Nutrition*	. Idem	Idem
		. Formation de la mère.	. Idem	Idem
		. Vaccination SOS.		
		. Référence au dispensaire pour la suite du traitement une fois passée la phase de danger.	. Idem . Idem	Idem Idem

* Dosage de la Vitamine A

AGE	VITAMINE A CAPSULE	
	200.000 UI	100.000 UI
6-12 mois	1/2 capsule	1 capsule
12 mois - 6 ans	1 capsule	2 capsules

Notes : *Ces doses sont administrées chaque 4 mois pour prévenir l'avitaminose A et pendant 2 jours consécutifs dans le cas d'une déficience en vitamine A constatée cliniquement*

L'ETAT NUTRITIONNEL EST CLASSE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
Malnutrition et/ ou anémie et/ou avitaminose A	. Si tâches laiteuses sur les sclérotiques, administrer Vit. A.	Idem	Idem	Idem
	. Si les conjonctives sont pâles, prescrire du: - Sulfate de fer/Acide folique (Sirop). - diète riche en Vit A et fer	Idem	Idem	Idem
	. Administrer de l'Albendazol en 1 prise (enfants ≥ 2 ans) 15 jours au moins après le début du traitement de récupération	Idem	Idem	Idem
	. Former la mère sur la façon d'alimenter l'enfant.	Idem	Idem	Idem
	. Demander à la mère de revenir après 15 jours et ensuite chaque mois pour contrôle.	Idem	Idem	Idem

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L'ETAT NUTRITIONNEL EST CLASSE	CONDUITE A TENIR			
	NIV. DISPENSAIRE	NIV. C.S.L.	NIV. C.A.L.	NIV. HOP.
NORMAL (Pas de malnutrition ni anémie).	. Féliciter la mère. . Renforcer les connaissances de la mère sur l'alimentation de l'enfant. ** . Encourager la mère à emmener l'enfant chaque mois pour le contrôle nutritionnel et la vaccination	Idem Idem Idem	Idem Idem Idem	Idem Idem Idem

** Pour prévenir la malnutrition, il faut que toute mère de famille sache comment nourrir un enfant à ses différents âges et aie les moyens de le faire en utilisant au mieux l'argent et les ressources alimentaires dont elle dispose.

L'information et l'éducation de la population sur la nutrition est indispensable. Elle doit se faire par le personnel de santé à l'école, à domicile, à travers des cours de puériculture et à travers les médias. Elle doit être basée sur la connaissance des disponibilités alimentaires et des coutumes locales.

Recommandations sur l'alimentation de l'enfant selon son âge

- 0 à 6 mois : sein
- 7ème, 8ème, 9ème mois : sein, lait au gobelet bouillie au lait, AK-100 au lait, jus de fruits, purée ou bouillon de légumes, jaune d'oeuf pain, banane ou patate écrasée dans du lait.
- 10ème, 11ème, 12ème mois : sein, lait au gobelet, bouillie au lait, AK-100 au lait, AK-1000 au lait, purée ou bouillon de légumes, oeuf, pain, patate, pomme de terre, avocat, malanga, manioc et pois, riz en pâte et pois, maïs moulu et pois, viande moulue, foie" dur" moulu, poisson désossé.

A partir d'un an, l'enfant en continuant l'allaitement au sein, doit recevoir la nourriture familiale coupée en petits morceaux et faiblement épicée. Evidemment cette nourriture familiale doit être de bonne qualité et en quantité suffisante pour permettre une croissance normale de l'enfant.

A l'âge pré-scolaire (1 à 5 ans), les mélanges de céréales, de pois, de vivres et de légumes verts chaque jour, avec addition de lait, de viande, de poissons ou d'oeuf, le plus souvent que possible aideront à maintenir l'enfant dans un état de nutrition satisfaisante. Et si les mères arrivent à adopter l'habitude de faire contrôler le poids de leurs enfants tous les mois de la naissance jusqu'à trois ans révolus, elles seront sur la voie de nous mener à la disparition des formes graves de malnutrition.

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4.2 NORMES ET PROCEDURES POUR LE PROGRAMME ÉLARGI DE VACCINATION

Pour tout enfant, malade ou non se présentant à la clinique, et qui ne présente pas de conditions nécessitant une évacuation immédiate, le personnel sanitaire à tous les niveaux de prestation de soins déterminera le statut vaccinal et immunisera l'enfant au besoin. Voici la procédure à suivre :

1. Vérifier l'âge de l'enfant sur le dossier médical ou le demander à la mère.

2. Vérifier sur le dossier les informations sur le statut vaccinal de l'enfant.

3. Si ces informations n'existent pas, demander à la mère si l'enfant a une carte de vaccination et si elle l'a apportée.

4. Si l'enfant n'a jamais eu de carte de vaccination, prendre des dispositions pour administrer le jour même les vaccins requis en fonction de l'âge. Donner un rendez-vous pour les doses subséquentes.

5. Si l'enfant a une carte de vaccination et que la mère ne l'ait pas apportée, lui demander de revenir avec la carte et l'enfant dans les 2 jours.

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4.2.1 Calendrier de vaccination

1. Calendrier recommandé par l'OMS pour conférer une protection à un jeune âge :

AGE	VACCIN	RAISON
Naissance	BCG, VPO_0 *	BCG donné dès le plus jeune âge protège contre éventuelle infection par d'autres membres de la famille. Protection contre la polio meilleure si le vaccin est administré très tôt.
6 semaines	$DTCoq_1$, VP_{01}	DTCoq précoce diminue risque de coqueluche grave
10 semaines 14 semaines	$DTCoq_2$, VPO_2 $DTCoq_3$, VPO_3	Quatre semaines d'intervalle entre les doses confèrent une protection efficace et diminue la durée pendant laquelle l'enfant n'est pas protégé, surtout face à la coqueluche et à la polio
9 mois	Rougeole	Au moins 80% des cas de rougeole peuvent être évités en vaccinant à cet âge

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4.2.2 Fiche Technique de vaccination

	B.C.G.	Di Te Per	Anti Polio (Sabin)	Antirougeoleux	Toxoïde Tétanos
Présentation	Sec ou en poudre 10 ou 20 doses	Liquide flacon de 20 doses	Liquide flacon de 20 doses	Sec ou en poudre Flacon de 10 doses	Liquide Flacon de 20 doses
Mode de Conservation	Entre 2°C et 8°C.	Entre 2°C et 8°C. Ne doit jamais être congelé.	Congelé (à placer au congélateur)	Entre 2°C et 8°C. A garder sur partie congelée du réfrigérateur	Entre 2°C et 8°C. Ne doit jamais être congelé
Condition d'utilisation	Délai d'utilisation de la solution préparée: 6 heures. Epuiser toujours un flacon avant de passer à un autre	Epuiser toujours un flacon avant de passer à un autre	Epuiser toujours un flacon avant de passer à un autre	Délai d'utilisation de la solution préparée: 6 heures Epuiser un flacon avant de passer à un autre	Epuiser toujours 1 flacon avant de passer à un autre
Mode d'administration	Bras droit: 0.1 cc par voie intradermique à l'union du 1/3 moyen et du 1/3 supérieur. Bien agiter le flacon à chaque prélèvement	0.5 cc par voie intramusculaire ou sous/cutanée	2-3 gouttes sur la langue selon prospectus sans souiller le compte-goutte	0.5 cc par voie sous-cutanée	0.5 cc par voie sous-cutanée
Age d'administration	Nouveau-né de plus de 5 livres (2.5 Kg)	A partir de 6 semaines	A partir de 6 semaines	A partir de 9 mois	Toutes les femmes adultes

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FICHE TECHNIQUE DE VACCINATION

	B.C.G.	Di Te Per	Anti Polio (Sabin)	Antirougeoleux	Toxoïde Tétanos
Intervalle entre les doses	Dose unique	. Entre 1ère et 2ème dose: 1 à 3 mois; . entre 2ème et 3ème dose 1 à 6 mois; . Rappel: 1 an après 3ème dose.	. Entre 1ère et 2ème dose: 1 à 3 mois; . Entre 2ème et 3ème dose. 1 à 6 mois; . Rappel: 1 an après 3ème dose	Dose unique	4-6 semaines 2 doses pour la vaccination complète Rappel 1 an après 2ème dose et une dose à chaque grossesse.
Réactions secondaires	Plaie au point d'injection 21 jours après et qui guérit tout seul.	Fièvre de courte durée	Aucune	Fièvre et éruption après 8-12 jours guérissant sans traitement	Fièvre légère Douleur légère
Contre-indications	Ne pas administrer le BCG à un enfant de mère sidéenne et présentant des signes évidents de SIDA.	Ne pas administrer les 2ème et 3ème doses de Diteper à un enfant qui a eu des convulsions ou qui a été en état de choc dans une période de trois jours après la première dose.	Aucune	Aucune	Aucune

Remplissage de la Seringue.

Vérifier sur l'étiquette du flacon le type de vaccin et la date de péremption. A

Agiter le flacon pour dissoudre complètement le dépôt.

Retirer le centre du capuchon de métal avec une lime à ampoules.

Poser le flacon de vaccin sur la table dans un récipient plein de glace ou sur un "accumulateur de froid". B

Prendre une seringue stérile de 0.5 ml (soloshot) ou une seringue à insuline selon le cas

Nettoyer avec de l'eau savonneuse le bouchon de caoutchouc du flacon.

Aspirer le vaccin dans la seringue. C

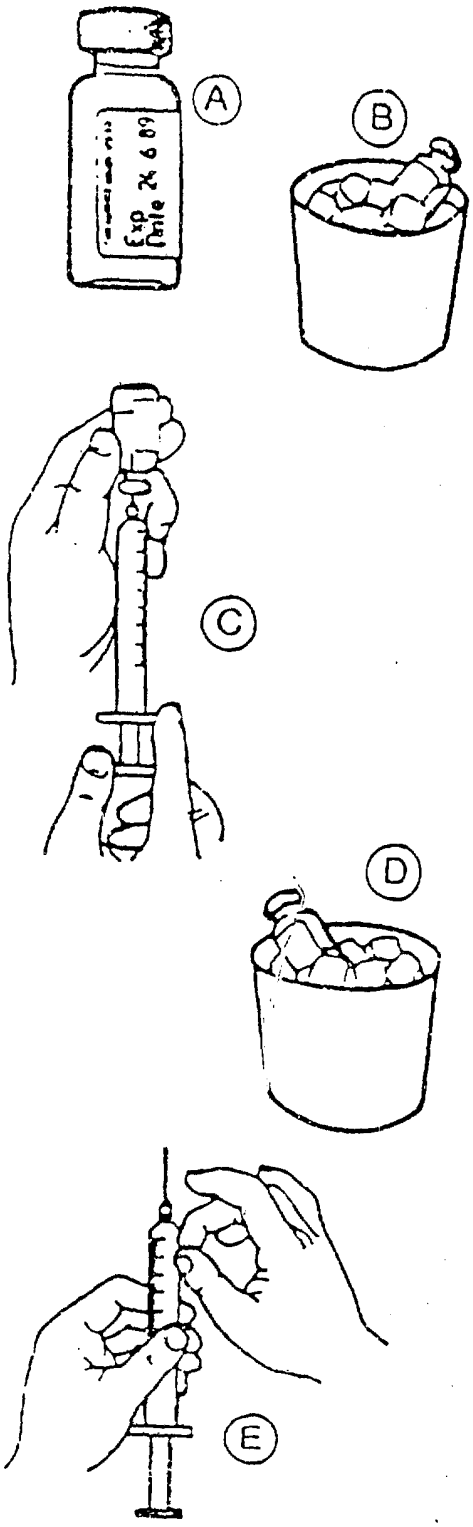
-- BCG: 0,1 ml*
-- DTC: 0,5 ml
-- Rougeole: 0,5 ml.

Remettre le flacon dans la glace. D

Expulser les bulles d'air de la seringue. E

Vérifier que la dose prélevée est correcte.

Injecter immédiatement le vaccin à l'enfant.



* Certains fabricants recommandent 0,05 ml pour les enfants de moins d'un an.

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4.2.3.1 ADMINISTRATION DU BCG

a. Tenez le bras du nouveau-né de la main gauche afin que:

votre main soit sous le bras

votre pouce et vos doigts entourent le bras et tendent la peau.

b. Tenez la seringue et l'aiguille dans la main droite avec le biseau de l'aiguille et les graduations vers le haut.

c. Placez la seringue et l'aiguille pratiquement à plat le long du bras du nouveau-né.

d. Enfoncez l'extrémité de l'aiguille sous la peau -- Un peu au-delà du biseau.

gardez l'aiguille à plat sur la peau, afin de ne la faire pénétrer que dans la couche supérieure de la peau. Maintenir le biseau vers le haut.

N'enfoncez pas trop l'aiguille; ne dirigez pas le biseau vers le bas ou l'aiguille pénétrera la zone sous-cutanée, produisant alors une injection sous-cutanée au lieu d'une intradermique.

e. Maintenant, mettez votre pouce gauche sur l'embout de la seringue afin de la maintenir en position.

tenez le bout du piston entre l'index et le majeur de la main droite et appuyez sur le piston avec le pouce droit.

f. Injectez le vaccin, puis retirez l'aiguille.

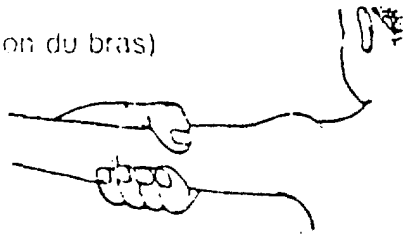
Assurez-vous que la seringue ne fuit pas au niveau de l'embout. Si elle fuit, ajustez l'aiguille plus étroitement.

Si vous avez bien injecté le BCG par voie intradermique:

vous pouvez voir une papule nette pâle avec un aspect de peau d'orange.

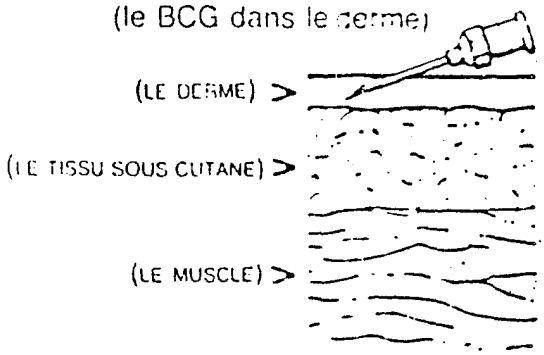
Injection Intradermique

(position du bras)

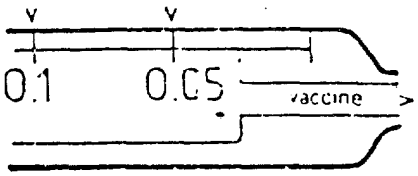


(position de la seringue)

(le BCG dans le derme)



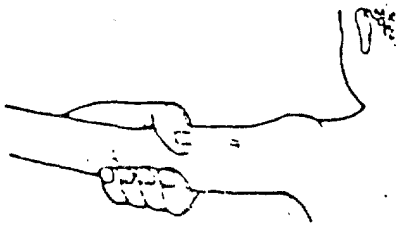
Lisez la graduation ici



Quantité de BCG. Age:

0.05 ml ayant l'âge d'un an

0.1 ml après un an



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2.3.2 ADMINISTRATION DES VACCINS CONTRE LE DTP ET LA ROUGEOLE

Comment installer le bébé:

La description suivante concerne le bras gauche (certains programmes utilisent le bras droit).

Asseyez le bébé sur les genoux de sa mère.

Coincez le bras droit du bébé sous l'aisselle gauche de sa mère.

Le bras gauche de la mère soutient la tête de l'enfant.

Sa main gauche immobilise l'épaule gauche de l'enfant.

Son avant-bras droit maintient les jambes du bébé.

Tandis que sa main droite tient la main gauche de l'enfant.

Administration du vaccin:

Pincez avec les doigts la peau de la face EXTERNE de la partie supérieure du bras de l'enfant.

Enfoncez l'aiguille dans la peau pincée tirée, pas verticalement mais à un angle.

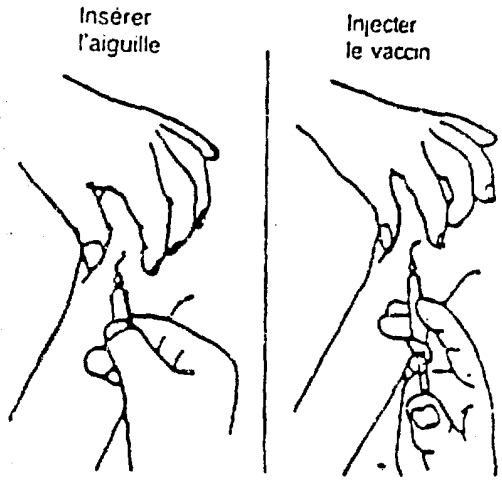
-- Ne pas trop enfoncer l'aiguille.
-- Soutenez le bout de la seringue avec votre pouce et votre doigt pendant que vous enfoncez l'aiguille.

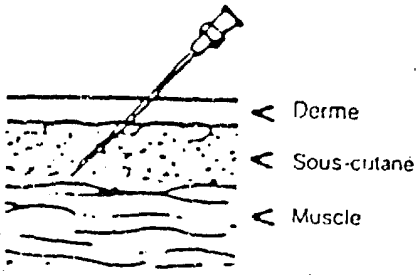
Appuyez sur le piston avec votre pouce pour injecter le vaccin. Retirez l'aiguille.

Pour le vaccin anti-rougeoleux, RAPPELEZ-VOUS qu'il faut injecter une fois 0,5 ml à l'âge de 9 mois. LA CHALEUR ET LA LUMIERE INACTIVENT RAPIDEMENT LE VACCIN RECONSTITUE. GARDEZ LE VACCIN ET GARDEZ-LE DANS UN RECIPIENT PLEIN DE GLACE.

INJECTION SOUS-CUTANEE

POSITION DE L'ENFANT POUR LE VACCIN ANTI-ROUGEOLE





VACCIN CONTRE LA ROUGEOLE DANS LES COUCHES SOUS-CUTANEES

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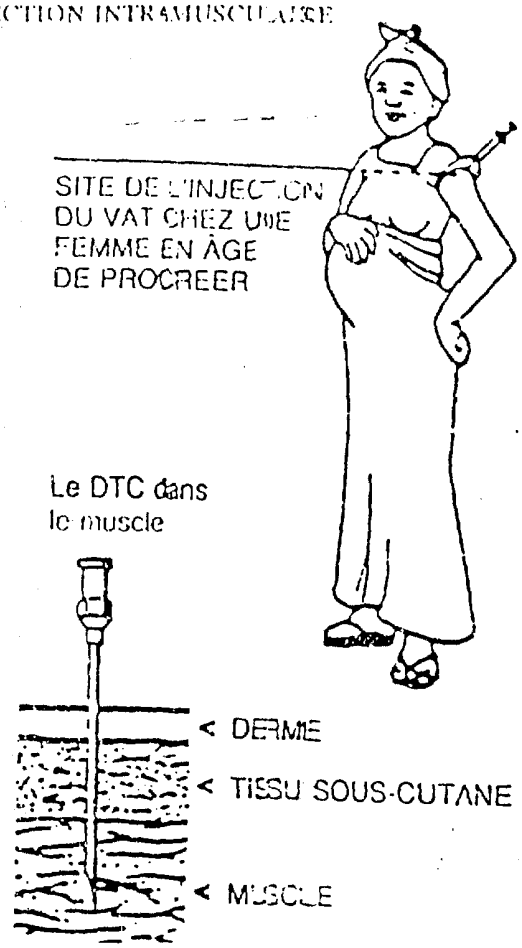
4.2.3 ADMINISTRATION DE L'ANATOXINE TETANIQUE (VAT)

INJECTION INTRAMUSCULAIRE



Le meilleur site d'injection intramusculaire chez la femme est la partie supéro-externe du bras gauche.

Placez vos doigts et votre pouce de chaque côté du site d'injection.

Tendez la peau entre le pouce et les autres doigts.

D'un geste vif, enfoncez l'aiguille à travers la peau entre vos doigts. Pénétrez profondément dans le muscle.

Appuyez sur le piston avec votre pouce pour injecter le vaccin.

Retirez l'aiguille.

Pour le VAT, RAPPELEZ-VOUS de donner avant la première naissance ou pendant la grossesse, deux doses de 0,5 ml à 4 semaines d'intervalle. NE CONGELEZ PAS LE VAT.

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2.4 ADMINISTRATION DU VACCIN POLIO ORAL (VPO)

PAR LA BOUCHE

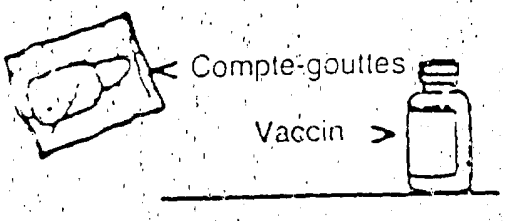
1. Demander à la mère de tenir fermement l'enfant.

2. Ouvrir la bouche de l'enfant puis presser doucement ses joues entre vos doigts pour faire saillir ses lèvres en avant.

3. Faire tomber 2 gouttes* de vaccin directement du compte-gouttes sur la langue de l'enfant.

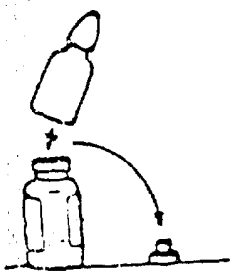
4. S'assurer que l'enfant les avale. S'il crache, recommencer.

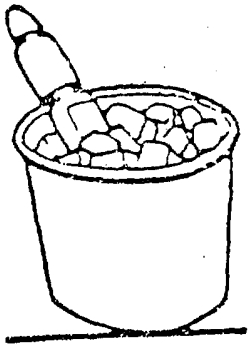
Comment utiliser le compte-gouttes



Pour le vaccin polio, rappelez-vous:

Dose: 2 gouttes,
à la naissance,
à 6 semaines,
à 10 semaines
à 14 semaines.





* Le nombre de gouttes peut dépendre du fabricant. Adapter le compte-gouttes sur le flacon de vaccin.

Flacon de VPO dans la glace.

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4.2.3.5 MATERIEL STANDARD UTILISE POUR LE PEV

SERINGUE A INS + AIG STERILE

BATTERIES POUR MEGAPHONES

BON DE COMMANDE

BRIQUETTE

CARNET TETANOS TOXOIDE

CARTE CHEMIN LA SANTE

CARTE DE VACCINATION

FEUILLE DE CONT.TEMP.FRIGO

FICHE GESTION STOCK PEV

FORM. ENREGISTREMENT JOURN.

RAPPORT MENSUEL VACCINATION

SAVON LIQUIDE.

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4.2.3.6 *La logistique de la gestion des vaccins*

1. La chaîne de froid

La chaîne de froid est un système qui maintient l'activité d'un vaccin depuis sa fabrication jusqu'à son injection à une femme ou à un enfant. Tous les vaccins sont thermolabiles; le BCG et le vaccin antirougeole sont aussi sensibles aux ultra-violets.

2. Les maillons de la chaîne de froid

Le personnel et l'équipement constituent les maillons de la chaîne du froid; chaque million correspond à un niveau de l'acheminement des vaccins. Chaque niveau a ses propres exigences. Des informations plus précises se trouvent dans le supplément consacré à l'équipement de la chaîne du froid.

- Le magasin central et parfois le magasin régional disposent de chambres froides, de réfrigérateurs et de congélateurs.
- Les magasins de district et certains centres de santé ont des réfrigérateurs, et des glacières, et pour le transport des vaccins, des boîtes isothermes.
- Les centres de santé utilisent des porte-vaccins et des boîtes isothermes pour les stratégies avancées.
- Une bouteille thermos ou un porte-vaccins contiennent les doses de vaccins nécessaires à une séance au centre de santé ou sur un site avancé.

3. Température de conservation des vaccins et stabilité

Il n'existe aucun moyen de savoir si un vaccin a été détruit par la chaleur, simplement en regardant le flacon. La stabilité d'un vaccin et son caractère actif dépendent des vérifications répétées - et honnêtes - de la température à chaque maillon de la chaîne et quotidiennement. Les moniteurs contenant des produits thermosensibles facilitent la surveillance de la chaîne du froid. Il n'y a rien de pire pour le moral des agents de santé que de douter de la validité des vaccins qu'ils utilisent.

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NIVEAU	MAGASIN CENTRAL	DEPARTEMENT	CENTRE DE SANTE/ DISP.
Période maximum de stockage	Jusqu'à 8 mois	Jusqu'à 3 mois	Jusqu'à 1 mois
Rougeole Polio Oral	-15°C à -25°C	-15°C à -25°C	+2°C à +8°C
BCG DTP DT VAT	+2°C à +8°C	+2°C à +8°C	+2°C à +8°C

N.B. - Ne jamais congeler le DTC, ou le VAT (qui gèlent au-dessous de 2°C)
- Les temps de stockage sont des limites supérieures. Vérifier toujours les dates de péremption.

4.2.3.7 *Monitorage et supervision*

Le monitorage et la supervision font partie du programme au même titre que la chaîne du froid et la formation. Ils ont en commun, avec l'évaluation, les caractéristiques suivantes:

- une recherche méthodique de l'information;
- un calcul des taux (par exemple, le pourcentage de tâches correctement effectuées); et
- enfin, une analyse des données et une rétro-information destinées à des ajustements périodiques dans le fonctionnement et la gestion du programme.

Si le monitorage et la supervision sont effectués correctement, c'est-à-dire régulièrement, honnêtement, rigoureusement et sans omettre la rétro-information du personnel de santé, on est en droit de penser que le PEV fonctionne, avant même la mise en place d'une évaluation plus approfondie. L'échec essentiel de la supervision cependant, reste que le personnel de santé est rarement récompensé lorsqu'il travaille bien et efficacement sanctionné quand il travaille mal.

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Echantillon d'indicateurs pour
le monitorage et la supervision
Au niveau des institutions de santé

Indicateurs à vérifier chaque semaine:

- Les séances de vaccination prévues ont-elles toutes eu lieu? Sinon, pourquoi?
- A-t-on utilisé une aiguille et une seringue stériles pour chaque injection
- Y avait-il suffisamment de vaccin pour répondre aux besoins?
- A-t-on vérifié quotidiennement le réfrigérateur? Toutes les températures ont-elles été notées? Sont-elles conformes aux normes (+2°C - +8°C)?
- Chaque mère a-t-elle été informée de la nécessité des vaccinations ultérieures et de la date à laquelle elle devrait revenir?

Indicateurs à vérifier chaque mois:

- Quel pourcentage de la population-cible en mois a reçu le Diteper 1 ou le Poliooral 1 pendant le mois écoulé?
- Quel est le rapport Diteper 3 sur Diteper 1?
- Quel pourcentage de la population-cible en mois a été vacciné contre la rougeole? L'âge à la vaccination était-il correct?
- Des cas de maladies-cibles du PEV ont-ils été vus en consultation? Comment éviter leur survenue à l'avenir?
- A-t-on vérifié le statut vaccinal de tous les enfants venant consulter, y compris les malades? Ont-ils reçu les vaccinations nécessaires?
- Y a-t-il eu des ruptures ou des excédents de stock (vaccins, aiguilles, seringues, etc...)?
- Quelle est la fréquence des visites des superviseurs? Quels étaient les obstacles ou les problèmes à résoudre? Ont-ils été résolus?

Indicateurs à vérifier une fois par trimestre ou par an

- L'évaluation de la couverture locale par une enquête étudiant particulièrement la couverture et les taux d'enfants complètement vaccinés.

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AU NIVEAU COMMUNAL ET DEPARTEMENTAL

Indicateurs à vérifier chaque mois

- Quel est le nombre total de doses distribuées pour chaque vaccin?
- Quel est le nombre de vaccinations par âge et par antigène notifié par les centres?
- A quelle fréquence les superviseurs visitent-ils les centres?
- Combien de moniteurs de chaîne du froid ont-ils révélé une défaillance de celle-ci?
- Y avait-il des vaccins périmés dans les stocks ou parmi les vaccins renvoyés par les centres?
- Y a-t-il eu pénurie ou excès de vaccins fournis aux centres?
- Quel est le nombre de cas de rougeole, coqueluche et tétanos notifié par les sites sentinelles?

Indicateurs à vérifier chaque année

- Combien de centres de santé de l'unité administrative ont des activités de vaccination?
- Des enquêtes de couverture vaccinale en grappes ont-elles été menées? Quels en sont les résultats?
- La couverture vaccinale a-t-elle été estimée à partir du calcul des doses administrées?
- Combien de cas de rougeole, polio, coqueluche et tétanos ont été constatés?
- Quel est l'accroissement du nombre de vaccinations administrées par rapport à l'année précédente?

Indicateurs à vérifier tous les deux ans ou selon les besoins

- Une évaluation de la chaîne du froid a-t-elle été conduite?
- Une évaluation régionale exhaustive a-t-elle été menée?

AU NIVEAU NATIONAL

Indicateurs à vérifier mensuellement

- A-t-on reçu les rapports mensuels de toutes les régions?
- Combien de vaccinations ont été effectuées chaque mois?
- Y a-t-il eu des flambées épidémiques des maladies cibles et la réponse du système de santé a-t-elle été adaptée?
- Quel est l'état du stock de vaccins?

Indicateurs à vérifier annuellement

- Les données de couverture sont-elles analysées ? Quels en sont les résultats?

4.3. PRISE EN CHARGE DES INFECTIONS RESPIRATOIRES AIGUES

Pour tout enfant se présentant à la consultation pour des signes évidents d'infection respiratoire aigüe identifiés par la mère, les responsables sanitaires par niveau procéderont de la façon suivante:

A. Recherche systématique des signes principaux et associés.

1. Se renseigner sur les motifs de la consultation.

2. Rechercher les signes d'alarme. S'il n'y a pas d'actions urgentes à entreprendre:

   - se renseigner auprès de la mère sur:

     le temps écoulé depuis l'apparition des premiers signes.

   - prendre la température de l'enfant.
     (noter ces informations sur le dossier).

   - prendre le poids de l'enfant

3. Procéder à l'examen de l'enfant.

   Pour ce:

   (a) Compléter les mouvements respiratoires de l'enfant en une minute (60 secondes).

   Noter cette information sur le dossier.

   (b) Rechercher la présence ou pas de tirage sous-costal.

   Noter l'information sur le dossier.

   (c) Rechercher la présence de stridor laryngé.
   Noter l'information sur le dossier.

   (d) Rechercher la présence de respiration sifflante.

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Appendix Y

Work Plan

ADRA CS XII Haiti Work Plan

Year	Activity	Actors
1997		
February	Recruit key project staff	ADRA
March to May	Recruit CHWs (CHA/CHV) and ANs	ADRA, community
	Locate sites for HPs	ADRA, community
April to May	Train CHWs in census,registration	ADRA, CERA
	Begin door to door registration	CHWs/ADRA staff
	Set up linkages with private physicians, pharmacies, street sellers	ADRA
	DevelopHIS system	ADRA, CERA
	Develop quality assurance guidelines	ADRA, CERA
	Develop monitoring tools	ADRA, CERA
May to June	Continue registration	CHWs
	Develop a cost recovery plan for HPs	ADRA, CAPS
	Train ANs	ADRA
	Order commodities for posts	ADRA
	Seminar for physicians	ADRA
	Seminars for pharmacists	ADRA
	Seminar for street sellers	ADRA
June	Create rosters of target groups	ADRA
	Analyze census data	ADRA, CERA
	Train CHWS in vaccination	CHWs, ADRA
	Train CHWS in contraceptive Social marketing	ADRA, PSI
	Open two HPs	ADRA, community
	Initiate community distribution network for ORS, contraceptives	ADRA, community
July	Train CHWs in nutrition and DCM	ADRA
August	Begin block by block invitation to HPs	CHWs
September	Breastfeeding campaign	CHWs
	IEC campaign	ADRA, churches, schools, communities
October	Progress review, and first annual report	ADRA
November	Open one new HP	ADRA, community
December	Open one new HP	ADRA, community

1998		
1st quarter	Continuing education sessions for CHWS	ADRA
	Continuing education sessions for ANs	ADRA
	Seminars for physicians, pharmacists, street sellers	ADRA
2nd quarter	Assess coverage via service statistics	ADRA
	Continue provision of services	ADRA
	Introduce weaning food social marketing program	ADRA
3rd quarter	Initial assessment of weaning food program	ADRA
4th quarter	Annual report	ADRA
1999		
1st quarter	Continue to strengthen programs	ADRA
	Midterm evaluation	Consultant
2nd quarter	Program re-assessment	ADRA, community
	Continuing education sessions for staff	ADRA
3rd quarter	Assess cost-recovery	ADRA
4th quarter	Annual report	ADRA
2000		
1st quarter	Strategic program review	ADRA
2nd quarter	Plan transition to phase II	ADRA
3rd quarter	Final evaluation	ADRA

Appendix Z

Training and Supervision Plans for Project Staff and CHWs

Training Planned for ADRA Project Staff

Area of Skills	Trainer	Trainee	Length in Days	Venue	Planned Dates
HIS	CERA (consultant)	Key project staff	3	Port-au-Prince	June '97
Formative research	ADRA Central Office	Key project staff	4 (theory and practice	Same	Sept. '97
Management (financial)	Same	CS management staff	3	Same	Sept. '97
CS lessons learned workshop	Consultants	Project director, health/training coordinator	14	Nairobi	Jan. '98
Computer use (on job training)	Local computer firm	HIS coordinator	TBA	Same	June '97, Jan. '98
Management of Childhood Illness	BASICS/ MSH, Haiti	Key project staff	TBA	Same	Jan. '98
TOT (on each intervention and refresher)	INSAC (local health consultant), Dr. Annie Henry	All CS technical staff	4 per session	Same	May, '97, Jan. '98, June '99
Linkage with PL 480	Dr. Annie Henry	All CS technical staff	2	Same	Jan. '98
Sustainability	Dr. A. Augustin (CAPS)	Key project staff	4	Same	TBA
Cost recovery	PSI (social marketing of contraceptives	Key project staff	4	Same	TBA
Therapeutic feeding	Dr. Annie Henry	Adventist hospital nutrition staff	4	Same	Mar. '98
Breastfeeding	UNICEF	All CS technical staff	3	Same	Jan. '98

Community Workers Associated with the Project

Type of CHW	No.	Hours/ week	Management	Remuneration	Summary of Duty
AN	4	45	ADRA	ADRA	Vaccination, HP management, vitamin A distribution, supervision of lead CHAs, IEC on all interventions, reporting and referral
Lead CHA	8	45	ADRA	ADRA	IEC on all interventions, recording, growth monitoring, reporting, referral, supervision of field CHAs and assisting ANs
CHAs	16	45	ADRA/CHC	ADRA	IEC on all interventions, contraceptive/ORT distribution/sell, vitamin A distribution, reporting, supervision of CHVs, identifying EPI and growth defaulters and referral
CHVs	24	10-15	ADRA/CHC	Stipend	IEC on all interventions, contraceptive/ORT sell, vitamin A distribution, reporting, identifying and EPI and growth defaulters and referral
FP promotors	28	45	Adventist Hospital	Adventist Hospital	IEC on FP, contraceptive marketing and distribution and referral

Summary of Training and Supervision Plan for Community Health Workers

CHW Type and Training Objective	Trainer	# of Trainees	Course Content	# of Hours Initial	# of Hours In-service	Curriculum	Evaluation	Supervision
1. AN: To train ANs in IEC, HIS, supervision and vaccine handling (all interventions)	INSAC	4	IEC and HIS skills in all areas of interventions; monitoring and supervision skills, reporting and vaccination administration. (ANs are already received 180 hours of training from INSAC)	6 per intervention	2 per six months per intervention	INSAC, JHU/BASICS/PCS developed curriculum	Written exam	4 ANs supervised by one ADRA health coordinator for a ratio of 4:1
2. Lead CHAs (HP-based): To train CHAs on IEC, HIS and supervision skills on all interventions	Training coordinator	8	IEC and HIS skills in all interventions; referral supervision, recording and reporting and GM.	Same	Same	INSAC, JHU/PCS developed curriculum	Same	8 lead HP based CHAs supervised by 4 ANs for a ratio of 2:1
3. CHAs (field-based): To train CHAs in IEC, HIS and supervision skills on all interventions.	Training coordinator and health coordinator	16	Same	Same	Same	Same	Same	16 field CHAs supervised by a project field supervisor and 8 lead CHAs for a ratio of about 2:1
4. CHVs: To train CHVs on IEC and HIS skills on all interventions.	Training and health coordinators	24	IEC and recording skills, contraceptive/ORT marketing, referral protocols.	36	36 per year	ADRA developed curriculum on each intervention	Interview, observation, checklist	24 CHVs supervised by 16 field-based CHAs and project field supervisor for a ratio of about 5:1
5. FP promotors: To train FP promotors on IEC and contraceptive marketing skills.	Training and coordinator	28	IEC on FP and contraceptive marketing	TBA	2 per six months	RICHES training manual on FP (CARE)	Pre and postest, interview.	28 FP promotors supervised by 4 clinic-based supervisor for a ratio of about 7:1
6. Community leaders: To orient the CHC and other community leaders on the roles that they play in support of the CS project.	Project director and community liaison	NA	NA	TBA	TBA	TBA	None	The CHCs will be supported by ADRA and MOH
7. All community and project staff: To train all project staff on HH registration and census	CERA	70	NA	8	NA	CERA community census protocol	Interview	NA
8. Adventist Hospital nutrition rehabilitation staff: To train on nutrition, GM, therapeutic feeding of malnourished children and counseling skills.	Dr. Annie Henry, Dr. Jean Baptiste	8	IEC on nutrition and GM, therapeutic feeding principles and referral for medical care.	TBA	TBA	MOH curriculum	Pre and postest, written exams	8 ANs and nutritionists supervised by 2 hospital-based RNs for a ratio of 2:1

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Appendix AA

Project Monitoring Report Forms

Report Forms - Monitoring

Report Type	Reporting Frequency	Responsible Entity
Training report on: CHVs, CHAs, TOT, ADRA staff, hospital staff, community orientation	Per training activity	-ADRA training coordinator
CHC minutes and/or CHC ad hoc minutes	Monthly/quarterly	-ADRA training coordinator -CHC ad hoc committee rep
CHV report/checklist	Monthly	-ADRA field supervisor -Lead CHA (supervisor)
CHA report	Monthly	-ADRA field supervisor -Lead CHA (supervisor)
HP general report	Monthly	-AN
Adventist FP clinic records	Monthly	-FP clinic statistician
HP staff/ADRA/CHV/CHA meeting minutes	Monthly	-HIS coordinator
CHV/CHA mothers group meetings report	Monthly	-CHA/CHV
Hospital therapeutic feeding center report	Monthly	-RN/nutritionist
Project report	Quarterly	-ADRA project director and HQ
Project financial statement	Monthly	-ADRA project/country director, HQ

Appendix BB

Sustainability Goals, Objectives and Activities

Sustainability Goals, Objectives, and Activities

Sustainability Goals	Objectives	Activities Required
-Establish functioning CHCs	-100 percent (4) of the CHCs provide support to the CHVs	-4 new CHCs organized, oriented -CHCs supervise CHVs, review CHV reports, recognize CHVs and replace CHV dropouts -Obtain monthly reports from CHCs -ADRA provides technical support to CHVs -CHC chairmanships rotated -CHC reps attend HP/ADRA and CHV monthly meetings
-Establish functioning community womens groups	-100 percent (4) of the mothers groups will be organized	-4 new mothers clubs formed, oriented and trained -Periodic follow up/supervision of all mothers groups by CHVs, HP staff and ADRA -Monthly meetings of mothers groups -Educational activities held
-Strengthen local ad hoc CHCs	-100 percent (4) ad hoc committees oriented and given oversight responsibility of CHVs	-Monitor monthly CHV reports -Reps attend HP/ADRA and CHC monthly meetings -Organize community health events (EPI mass campaigns, pit latrines, cleaning)
-Each community/HP assumes responsibility for running its own CS activities	-100 percent (24) of the CHVs will be active -CHVs are not salaried, only a stipend -A financial system for the upkeep of CS activities/purchase of supplies will be designed -TOT for HP staff on management -Integrate community CS activities with the MOH UCS plan of action	-24 new CHVs recruited/trained -CHVs recognized by CHCs publicly -Monthly CHV meeting held -Fee for service/supplied introduced as decided by the community/MOH -Community and HP staff trained on supervision of CHVs/CHAs -Coordination of existing community organizations -Involvement of CHVs in PIE of CS project
-Improve linkage between HP/MOH/UCS and the community groups	-Open communication between community groups and MOH/UCS -Demonstrate sensitivity to community needs as voiced by CHC	-Regular meeting between MOH, CHC and ADRA -MOH representatives attend monthly CHC committees and vice versa -Sharing information and feedbacks on monthly reports -Referral and communication protocols established with the Adventist hospital
-Empower mothers as primary health giver	-Recruit and train 24 CHVs to educate mothers -recruit/train 16 CHAs to educate mothers	-CHVs and CHAs educate mothers on each CS intervention during monthly home visits and womens group meetings -CHVs/CHAs monitored and supervised

Appendix CC

Budget

ADRA HAITI

CHILD SURVIAL 12

Working Budget (As per cooperative agreement)

3% Inflation

Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	TOTAL	Discription
FIELD BUDGET										Note:
I PERSONNEL										(Most salaries are 8 months
A ***Country***										only, the first year)
Administrative										
a Regional Director		2,292	-	2,361	-	2,432	-	7,084	7,084	2 weeks/year@$4600/month
b Country Administration		7,500	-	7,725	-	7,957	-	23,182	23,182	3 months/year@ $2500/month
c Treasurer/Account	2,700		2,781	-	2,864	-	8,345	-	8,345	4 months/yr.@$675/month
Subtotal Administrativ	2,700	9,792	2,781	10,086	2,864	10,388	8,345	30,266	38,612	
B **Technical**							-	-	-	
1 CS Project Coordinat	18,038		34,503	-	35,538	-	88,079	-	88,079	$2,375/month for 13mo.
2 Aux. Nurses (4)	8,454		14,149	-	14,574	-	37,177	-	37,177	4x$238/month
3 Com. Health Agents	15,203		25,445	-	26,209	-	66,856	-	66,856	16x$107/month
4 HIS/Health coordinato	9,324		15,606	-	16,074	-	41,004	-	41,004	$1050/month
5 Training/Comm./IEC	9,324		15,606	-	16,074	-	41,004	-	41,004	$1050/month
6 Field Supervisor	5,292		8,858	-	9,124	-	23,274	-	23,274	$660/month
7 Lead CHAs(8)	10,159		17,003	-	17,513	-	44,675	-	44,675	8x$143/month
8 Logistics Officer		3,170	-	5,306	-	5,465	-	13,941	13,941	$400/month
9 CHVS (24)		3,623	-	6,064	-	6,246	-	15,933	15,933	24x$18.85/month
Subtotal Technical	75,793	6,793	131,171	11,370	135,106	11,711	342,070	29,874	371,944	
C **Other**							-	-	-	
1 Secretary/cashir	8,880		16,986	-	17,496	-	43,362	-	43,362	$1000/month
2 Driver	3,472		5,811	-	5,986	-	15,269	-	15,269	$391/month
Subtotal Other	12,352	-	22,798	-	23,481	-	58,631	-	58,631	
Sub-Total Person	**90,845**	**16,585**	**156,750**	**21,456**	**161,452**	**22,099**	**409,047**	**60,140**	**469,187**	
II TRAVEL										
A Domestic										
1 Country Administratio	500		515	-	530	-	1,545	-	1,545	Fares/ costs for local travel
3 Aux. Nurses (4)	500		515	-	530	-	1,545	-	1,545	Fares/ costs for local travel
4 Com. Health Agents	1,000		1,030	-	1,061	-	3,091	-	3,091	Fares/ costs for local travel
Subtotal domestic	2,000	-	2,060	-	2,122	-	6,182	-	6,182	

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Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	Total Project TOTAL	Discription
B International							-	-	-	
Air Travel							-	-	-	
a Regional Director		740	-	762	-	785	-	2,287	2,287	2 trips @$370/trip
b Lessons Learned Workshop			5,000				5,000	-	5,000	2 round-trip tickets @$2,500
Subtotal International	-	740	5,000	762	-	785	5,000	2,287	7,287	
Per Diems/Misc.							-	-		
a Lessons Learned Workshop			1,350				1,350	-	1,350	Perdeims/Lodging
Subtotal Perdiems	-	-	1,350	-	-	-	1,350	-	1,350	
Sub-Total Travel/Perdei	**2,000**	**740**	**8,410**	**762**	**2,122**	**785**	**12,532**	**2,287**	**14,819**	
III CONSULTANTS										
A *Local*										
1 DIP	3,500						3,500	-	3,500	Consultant with knowledge of MOH
2 HIS	2,000		2,000				4,000	-	4,000	Develop health information systems
3 HH registration	6,000						6,000	-	6,000	HH/census
4 Social Marketing CBD			3,500				3,500	-	3,500	Contraceptive marketing
5 Sustainability	1,750		1,750				3,500	-	3,500	Strategic Planning/cost recovery
6 Focus Group	1,750		1,750				3,500	-	3,500	Qualitative surveys
Sub-Totals	**15,000**		**9,000**	**-**	**-**	**-**	**24,000**	**-**	**24,000**	
I PROCUREMENT										
a Supplies										
Office Supplies		3,000	-	3,090	-	3,183	-	9,273	9,273	Desk, paper, ink supplies
Medicines (worm, etc.)		2,000		2,000		3,000	-	7,000	7,000	
B Equipment							-	-	-	
1 Office							-	-	-	
a Furniture		3,000					-	3,000	3,000	
b Computers/software/printer		6,500					-	6,500	6,500	3 units
c Video equipment	700						700	-	700	VCR/Monitor for training
2 Vehicles							-	-	-	
a 4-WD Vehicle (2)		48,000					-	48,000	48,000	Administration/logistics use
I) Accessories	3,000						3,000	-	3,000	
b Motorcycle		3,500					-	3,500	3,500	Field Supervisor/Supervision
3 Rally Posts							-	-	-	
a Rally Post furniture		8,000					-	8,000	8,000	
b Scales and bags		1,000					-	1,000	1,000	Growth Monitoring
c GM/registration cards		6,000					-	6,000	6,000	MOH model, GM, HH registration
d Cold Chain boxes	800	800					800	800	1,600	
e ORT Equipment	400	400					400	400	800	Pitchers/pans, cups, spoons
Sub-Total	**4,900**	**82,200**	**-**	**5,090**	**-**	**6,183**	**4,900**	**93,473**	**98,373**	

Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	TOTAL	Discription
V TRAINING/MATERIALS										
A Training of Trainers	4,000		3,000		2,000		9,000	-	9,000	Stationary, rental, food, pereims
B Training - Family Plannin	10,000		5,000		5,000		20,000	-	20,000	Stationary, rental, food, pereims
1 Other CS	30,000		19,000		15,000		64,000	-	64,000	Stationary, rental, food, pereims
2 Com. Motivation	10,000		10,000		10,000		30,000	-	30,000	Stationary, rental, food, pereims
3 HIS	5,000		1,000				6,000	-	6,000	Stationary, rental, food, pereims
Sub-Total	**59,000**		**38,000**		**32,000**		**129,000**	**-**	**129,000**	
V OTHER DIRECT COSTS										
A Telephone, fax, DHL	2,805		2,889	-	2,976	-	8,670	-	8,670	
B Project Office Rental	2,400		2,472	-	2,546	-	7,418	-	7,418	$200/month
C Rally Post Rental		5,000	-	5,150	-	5,305	-	15,455	15,455	Community participation/donation
D Rally Post Renovation		8,000					-	8,000	8,000	Repairs to posts
E Sanitation/Latrines				21,000			-	21,000	21,000	Separate matching project
F Baseline Costs	30,000				11,000		41,000	-	41,000	Transportation, stipends, materials
G Insurance	2,900		2,987	-	3,077	-	8,964	-	8,964	Equipment Insurance
H Vehicle Operations	6,000		6,180	-	6,365	-	18,545	-	18,545	Fuel, Oil, Repairs, Insurance
I Utilities	600		618	-	637	-	1,855	-	1,855	Electricity/water
Sub-Total	**44,705**	**13,000**	**15,146**	**26,150**	**26,601**	**5,305**	**86,452**	**44,455**	**130,906**	
Subtotal Field Costs	**216,450**	**112,525**	**227,306**	**53,458**	**222,175**	**34,371**	**665,930**	**200,354**	**866,285**	

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Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	Total Project TOTAL	Discription
HEADQUARTERS BUDGET										
I PERSONNEL										
a Health Advisor		8,350	-	8,601	-	8,859	-	25,809	25,809	2 months/year @$4750/mo
b Senior Administrator		8,350	-	8,601	-	8,859	-	25,809	25,809	2 months/year @$4750/mo
c Technical Assistant		4,200	-	4,326	-	4,456	-	12,982	12,982	1.5 months/year @$4200/month
d Support Staff		3,600	-	3,708	-	3,819	-	11,127	11,127	2 months/year @$1800/mo
Sub-Total	**-**	**24,500**	**-**	**25,235**	**-**	**25,992**	**-**	**75,727**	**75,727**	
II Travel										
A International										
1 Health Advisor		500	-	515	-	530	-	1,545	1,545	1 round trip/Year
2 Senior Administrator		300	-	309	-	318	-	927	927	60% of 1 round trip/Year
3 Baseline		500					-	500	500	1 round trip/Year
4 Midterm Evaluation				530			-	530	530	1 round trip/Year
5 EOP Evaluation						560	-	560	560	1 round trip/Year
6 Auditor		500	-	515	-	530	-	1,545	1,545	1 round trip/Year
B Per Deims							-	-		
1 Health Advisor		1,120	-	1,154	-	1,188	-	3,462	3,462	Hotel/perdeims 12d@$90/day
2 Management		700	-	721	-	743	-	2,164	2,164	60% Hotel/per/d 12d@$90/day
3 Baseline		1,120					-	1,120	1,120	Hotel/perdeims 12d@$90/day
4 Midterm Evaluation				1,120			-	1,120	1,120	Hotel/perdeims 12d@$90/day
5 EOP Evaluation						1,240	-	1,240	1,240	Hotel/perdeims 12d@$90/day
6 Auditor	700		721	-	743	-	2,164	-	2,164	Hotel/perdeims 7d@$90/day
Subtotal	**700**	**4,740**	**721**	**4,864**	**743**	**5,110**	**2,164**	**14,714**	**16,877**	
III CONSULTANTS										
Auditor	2,500		2,575	-	2,652	-	7,727	-	7,727	A-133 audit
I OTHER DIRECT COSTS							-	-		
A Bid & Proposal Costs		12,800					-	12,800	12,800	Travel, writing, consultant
Subtotal HQ cost	3,200	42,040	3,296	30,099	3,395	31,102	9,891	103,241	105,404	
TOTAL DIRECT COSTS	**219,650**	**154,565**	**230,602**	**83,556**	**225,569**	**65,474**	**675,821**	**303,595**	**971,689**	
I INDIRECT COSTS										
22% Indirect Cost	48,323	34,004	50,732	18,382	49,625	14,404	148,681	66,791	215,472	
5% Unrecovered Idc.		10,982		11,530		11,278	-	33,791	33,791	
Sub-Total Indirect Cost	**48,323**	**44,987**	**50,732**	**29,912**	**49,625**	**25,683**	**148,681**	**100,582**	**249,263**	
TOTAL COSTS	**267,973**	**199,552**	**281,334**	**113,469**	**275,195**	**91,156**	**824,502**	**404,177**	**1,228,679**	
Match	33%									

4/11/97
Cs12bud5

ADRA HAITI

CHILD SURVIAL 12

Working Budget (As per DIP guidelines)

3% Inflation

Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	TOTAL	Discription
FIELD BUDGET										Note:
I SALARIES										(Most salaries are 8 months
A **Country**										only, the first year)
Administrative										-
a Regional Director	-	2,065	-	2,127	-	2,191	-	6,382	6,382	2 weeks/year@$4600/month
b Country Administrati	-	6,757	-	6,959	-	7,168	-	20,884	20,884	3 months/year@ $2500/month
c Treasurer/Accounta	2,432	-	2,505	-	2,581	-	7,518	-	7,518	4 months/yr.@$675/month
Subtotal Administrative	2,432	8,822	2,505	9,086	2,581	9,359	7,518	27,267	34,785	-
B **Technical**									-	-
1 CS Project Coordinator	16,250	-	31,084	-	32,016	-	79,350	-	79,350	$2,375/month for 13mo.
2 Aux. Nurses (4)	7,616	-	12,747	-	13,130	-	33,493	-	33,493	4x$238/month
3 Com. Health Agents (1	13,696	-	22,924	-	23,611	-	60,231	-	60,231	16x$107/month
4 HIS/Health coordinator	8,400	-	14,060	-	14,481	-	36,941	-	36,941	$1050/month
5 Training/Comm./IEC Co	8,400	-	14,060	-	14,481	-	36,941	-	36,941	$1050/month
6 Field Supervisor	4,768	-	7,980	-	8,220	-	20,968	-	20,968	$660/month
7 Lead CHAs(8)	9,152	-	15,318	-	15,778	-	40,248	-	40,248	8x$143/month
8 Logistics Officer	-	2,856	-	4,780	-	4,923	-	12,559	12,559	$400/month
9 CHVS (24)	-	3,264	-	5,463	-	5,627	-	14,354	14,354	24x$18.85/month
Subtotal Technical	68,282	6,120	118,172	10,243	121,717	10,550	308,171	26,913	335,085	-
C **Other**										-
1 Secretary/cashir	8,000	-	15,303	-	15,762	-	39,065	-	39,065	$1000/month
2 Driver	3,128	-	5,235	-	5,393	-	13,756	-	13,756	$391/month
Subtotal Other	11,128	-	20,538	-	21,154	-	52,821	-	52,821	-
Sub-Total Salaries	**81,842**	**14,941**	**141,216**	**19,329**	**145,452**	**19,909**	**368,511**	**54,180**	**422,691**	-
II FRINGE BENEFITS										-
A 11% SS, Payroll	9,003	1,644	15,534	2,126	16,000	2,190	40,536	5,960	46,496	Required taxes
Sub-Total Benefits	**9,003**	**1,644**	**15,534**	**2,126**	**16,000**	**2,190**	**40,536**	**5,960**	**46,496**	Fares/ costs for local travel

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Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	TOTAL	Discription
III TRAVEL										Fares/ costs for local travel
A Domestic										Fares/ costs for local travel
1 Country Administration	500	-	515	-	530	-	1,545	-	1,545	Fares/ costs for local travel
3 Aux. Nurses (4)	500	-	515	-	530	-	1,545	-	1,545	Fares/ costs for local travel
4 Com. Health Agents	1,000	-	1,030	-	1,061	-	3,091	-	3,091	Fares/ costs for local travel
Subtotal domestic	2,000	-	2,060	-	2,122	-	6,182	-	6,182	2 trips @$370/trip
B International							-	-	-	2 round-trip tickets @$2,500
1 Air Travel							-	-	-	-
a Regional Director	-	740	-	762	-	785	-	2,287	2,287	2 trips @$370/trip
b Lessons Learned W	-	-	5,000	-	-	-	5,000	-	5,000	2 round-trip tickets @$2,500
Subtotal International	-	740	5,000	762	-	785	5,000	2,287	7,287	-
2 *Per Diems/Misc.*							-	-		-
a Lessons Learned W	-	-	1,350	-	-	-	1,350	-	1,350	Perdeims/Lodging
Subtotal Perdiems	-	-	1,350	-	-	-	1,350	-	1,350	-
Sub-Total Travel/Perdeim	**2,000**	**740**	**8,410**	**762**	**2,122**	**785**	**12,532**	**2,287**	**14,819**	Consultant with knowledge of MOH
I EQUIPMENT							-	-	-	Develop health information systems
1 Office							-	-	-	#REF!
a Furniture	-	3,000	-	-	-	-	-	3,000	3,000	-
b Computers/software/pri	-	6,500	-	-	-	-	-	6,500	6,500	3 units
c Video equipment	700	-	-	-	-	-	700	-	700	VCR/Monitor for training
2 Vehicles	-	-	-	-	-	-	-	-	-	-
a 4-WD Vehicle (2)	-	48,000	-	-	-	-	-	48,000	48,000	Administration/logistics use
I) Accessories	3,000	-	-	-	-	-	3,000	-	3,000	
b Motorcycle	-	3,500	-	-	-	-	-	3,500	3,500	Field Supervisor/Supervision
3 Rally Posts	-	-	-	-	-	-	-	-	-	-
a Rally Post furniture	-	8,000	-	-	-	-	-	8,000	8,000	-
b Scales and bags	-	1,000	-	-	-	-	-	1,000	1,000	Growth Monitoring
c GM monitoring cards	-	6,000	-	-	-	-	-	6,000	6,000	MOH model, GM, HH registration
d Cold Chain boxes	800	800	-	-	-	-	800	800	1,600	-
e ORT Equipment	400	400	-	-	-	-	400	400	800	Pitchers/pans, cups, spoons
Sub-Total Equipment	**4,900**	**77,200**	**-**	**-**	**-**	**-**	**4,900**	**77,200**	**82,100**	
V SUPPLIES										
1 Office Supplies	-	3,000	-	3,090	-	3,183	-	9,273	9,273	Desk, paper, ink supplies
2 Medicines (worm, etc.)	-	2,000	-	2,000	-	3,000	-	7,000	7,000	-
Subtotal Supplies	**-**	**5,000**	**-**	**5,090**	**-**	**6,183**	**-**	**16,273**	**16,273**	

Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	TOTAL	Discription
V CONTRACTUAL										
A Local										
1 DIP	3,500	-	-	-	-	-	3,500	-	3,500	Consultant with knowledge of MOH
2 HIS	2,000	-	2,000	-	-	-	4,000	-	4,000	Develop health information systems
3 HH registration	6,000	-	-	-	-	-	6,000	-	6,000	HH/census
4 Social Marketing CBD	-	-	3,500	-	-	-	3,500	-	3,500	Contraceptive marketing
5 Sustainability	1,750	-	1,750	-	-	-	3,500	-	3,500	Strategic Planning/cost recovery
6 Focus Group	1,750	-	1,750	-	-	-	3,500	-	3,500	Qualitative surveys
Sub-Totals	**15,000**	-	**9,000**	-	-	-	**24,000**	-	**24,000**	-
V OTHER DIRECT COSTS										
A Training										
1 Training of Trainers	4,000	-	3,000	-	2,000	-	9,000	-	9,000	Stationary, rental, food, pereims
2 Training - Family Planni	10,000	-	5,000	-	5,000	-	20,000	-	20,000	Stationary, rental, food, pereims
a Other CS	30,000	-	19,000	-	15,000	-	64,000	-	64,000	Stationary, rental, food, pereims
b Com. Motivation	10,000	-	10,000	-	10,000	-	30,000	-	30,000	Stationary, rental, food, pereims
c HIS	5,000	-	1,000	-	-	-	6,000	-	6,000	Stationary, rental, food, pereims
B Telephone, fax, DHL	2,805	-	2,889	-	2,976	-	8,670	-	8,670	-
C Project Office Rental	2,400	-	2,472	-	2,546	-	7,418	-	7,418	$200/month
D Rally Post Rental	-	5,000	-	5,150	-	5,305	-	15,455	15,455	Community participation/donation
E Rally Post Renovation	-	8,000	-	-	-	-	-	8,000	8,000	Repairs to posts
F Sanitation/Latrines	-	-	-	21,000	-	-	-	21,000	21,000	Separate matching project
G Baseline Costs	30,000	-	-	-	11,000	-	41,000	-	41,000	Transportation, stipends, materials
H Insurance	2,900	-	2,987	-	3,077	-	8,964	-	8,964	Equipment Insurance
I Vehicle Operations	6,000	-	6,180	-	6,365	-	18,545	-	18,545	Fuel, Oil, Repairs, Insurance
J Utilities	600	-	618	-	637	-	1,855	-	1,855	Electricity/water
Sub-Total	**103,705**	**13,000**	**53,146**	**26,150**	**58,601**	**5,305**	**215,452**	**44,455**	**259,906**	
Subtotal Field Costs	**216,450**	**112,525**	**227,306**	**53,458**	**222,175**	**34,371**	**665,930**	**200,354**	**866,285**	

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Item	YEAR I USAID	YEAR I ADRA	YEAR 2 USAID	YEAR 2 ADRA	YEAR 3 USAID	YEAR 3 ADRA	Total Project USAID	Total Project ADRA	Total Project TOTAL	Discription
HEADQUARTERS BUDGET										
I SALARIES										
a Health Advisor	-	8,350	-	8,601	-	8,859	-	25,809	25,809	2 months/year @$4750/mo
b Senior Administrator	-	8,350	-	8,601	-	8,859	-	25,809	25,809	2 months/year @$4750/mo
c Technical Assistant	-	4,200	-	4,326	-	4,456	-	12,982	12,982	1.5 months/year @$4200/month
d Support Staff	-	3,600	-	3,708	-	3,819	-	11,127	11,127	2 months/year @$1800/mo
Sub-Total	**-**	**24,500**	**-**	**25,235**	**-**	**25,992**	**-**	**75,727**	**75,727**	
II Travel										
A International										
1 Health Advisor	-	500	-	515	-	530	-	1,545	1,545	1 round trip/Year
2 Senior Administrator	-	300	-	309	-	318	-	927	927	60% of 1 round trip/Year
3 Baseline	-	500	-	-	-	-	-	500	500	1 round trip/Year
4 Midterm Evaluation	-	-	-	530	-	-	-	530	530	1 round trip/Year
5 EOP Evaluation	-	-	-	-	-	560	-	560	560	1 round trip/Year
6 Auditor	-	500	-	515	-	530	-	1,545	1,545	1 round trip/Year
B Per Deims	-	-	-	-	-	-	-	-		
1 Health Advisor	-	1,120	-	1,154	-	1,188	-	3,462	3,462	Hotel/perdeims 12d@$90/day
2 Management	-	700	-	721	-	743	-	2,164	2,164	60% Hotel/per/d 12d@$90/day
3 Baseline	-	1,120	-	-	-	-	-	1,120	1,120	Hotel/perdeims 12d@$90/day
4 Midterm Evaluation	-	-	-	1,120	-	-	-	1,120	1,120	Hotel/perdeims 12d@$90/day
5 EOP Evaluation	-	-	-	-	-	1,240	-	1,240	1,240	Hotel/perdeims 12d@$90/day
6 Auditor	700	-	721	-	743	-	2,164	-	2,164	Hotel/perdeims 7d@$90/day
Subtotal	**700**	**4,740**	**721**	**4,864**	**743**	**5,110**	**2,164**	**14,714**	**16,877**	
III CONTRACTUAL										
Auditor	2,500	-	2,575	-	2,652	-	7,727	-	7,727	A-133 audit
I OTHER DIRECT COSTS							-	-		
A Bid & Proposal Costs	-	12,800	-	-	-	-	-	12,800	12,800	Travel, writing, consultant
Subtotal HQ costs	3,200	42,040	3,296	30,099	3,395	31,102	9,891	103,241	105,404	
TOTAL DIRECT COSTS	**219,650**	**154,565**	**230,602**	**83,556**	**225,569**	**65,474**	**675,821**	**303,595**	**971,689**	
V INDIRECT COSTS										
22% Indirect Cost	48,323	34,004	50,732	18,382	49,625	14,404	148,681	66,791	215,472	
5% Unrecovered Idc.		10,982		11,530		11,278	-	33,791	33,791	
Sub-Total Indirect Costs	**48,323**	**44,987**	**50,732**	**29,912**	**49,625**	**25,683**	**148,681**	**100,582**	**249,263**	
TOTAL COSTS	**267,973**	**199,552**	**281,334**	**113,469**	**275,195**	**91,156**	**824,502**	**404,177**	**1,228,679**	
Match	33%									