

CARE-HAÏTI

RICHERS II Project Final Evaluation Report

Comparing knowledge, practices and service coverage
of project communities
in the Moron and Abricots Communes, Grand'Anse,
between the project start in 1994 and the end of project in 1996

January, 1997

TABLE OF CONTENTS

EXECUTIVE SUMMARY

LIST OF TABLES

1 INTRODUCTION

- 1.1 Justification
- 1.2 Specific Objectives

2 METHODOLOGY

- 2.1 Study Site
- 2.2 Sample Population Studied
- 2.3 Sampling Methods

3 DATA COLLECTION

- 3.1 Survey Instrument
- 3.2 Pre-testing and Training
- 3.3 Field Activities
- 3.4 Survey Personnel
- 3.5 Survey Quality Control Methods
- 3.6 Data Entry and Analysis
- 3.7 Ethical Considerations

4 SURVEY RESULTS

- 4.1 Social and Demographic Characteristics of Respondents
- 4.2 Participation in Project Activities
- 4.3 Comparison of Respondents' Knowledge, Practices and Service Coverage
 - 4.3.1 Nutrition and Breast Feeding
 - 4.3.2 Management of Diarrhea Episodes
 - 4.3.3 Acute Lower Respiratory Infections
 - 4.3.4 Vaccinations
 - 4.3.5 Pre-Natal Care and Child Birth
 - 4.3.6 Family Planning
 - 4.3.7 Malaria
 - 4.3.8 HIV and AIDS

5 CONCLUSIONS AND RECOMMENDATIONS

APPENDIX A: Map showing intervention area of RICHES II

APPENDIX B: Sample questionnaire

LIST OF TABLES

Table 1	Selected social and demographic characteristics of respondents
Table 2	Respondents' participation rates in RICHES II activities
Table 3	Nutrition practices of respondents with index children 0 to 24 months
Table 4.1	Comparison of respondents' knowledge of child nutrition
Table 4.2	Types of foods the mothers give to index children by age of child
Table 5	Comparison of practices concerning control of childhood diarrhea
Table 6	Comparison knowledge and practices results concerning childhood ALRI
Table 7	Comparison of tetanus toxoid coverage results for women 15-59 years
Table 8	Comparison of pre- and post-project vaccine coverage rates for children aged 0-2 years, by age groups, vaccine type, and dose
Table 9	Comparison of maternal care knowledge and practices
Table 10	Comparison of respondents' unmet need and actual use of family planning methods
Table 11	Comparison of knowledge of different family planning methods
Table 12	Comparison of family planning utilization rates by method
Table 13	Comparison of respondent knowledge of malaria
Table 14	Comparison of results of respondent knowledge about AIDS and perception of personal risk
Table 15	Comparison of key USAID child survival performance indicators between the baseline and final evaluation

Executive Summary

To measure the impact of the activities of the RICHES II project during the last three years covering a population of 35,000 in the Commune of Moron and in part of the Commune of Abricots, CARE-Haïti conducted a final evaluation survey. This survey, implemented in August of 1996, had a sample of 423 mothers who have a child less than 24 months old and live in the communities served by the project.

The principal findings of this study show that the impact of project activities was very satisfactory in terms of population coverage--fully 74% of respondents had attended a RICHES rally post in the three months prior to the survey. The project was also very satisfactory as measured by the different USAID performance indicators in areas of: infant and child nutrition; diarrhea management; acute respiratory infection recognition; vaccinations for children and women; pre-natal care and preparation for child birth; family planning; malaria prevention; and AIDS prevention. Some of the important findings follow:

1. The prevalence of exclusive breast-feeding for children from 0 to 4 months is 74%, compared to 19% in 1994. It is interesting to note, that in 1994 more than 42% of respondents practiced bottle feeding. In 1996, only 22% of respondents practice bottle feeding.
2. The level of the mothers' knowledge and their practices in terms of child nutrition are judged satisfactory. Mothers are introducing weaning foods later and feeding their young children a greater variety of foods (including more protein-rich foods). According to Road-to-Health cards, the prevalence of vitamin A distribution is approximately 60%. There is no change in knowledge of the frequency of meals given to young children between 1994 and 1995: the majority of mothers state that they should feed their children two or three times per day.
3. Management of childhood diarrhea also improved, even though the prevalence of diarrhea in the index child in the last two weeks remained unchanged (40% in 1996). All respondents report using oral rehydration therapy. More mothers in 1996 also continued or increased breast feeding (97% in 1996 versus 83% in 1994), and continued or increased giving foods (92% versus 72%) and liquids (93% versus 62%) to the sick child.
4. Knowledge of signs of acute respiratory infections and taking children with respiratory distress for treatment also improved. But the reported prevalence of children showing flu-like symptoms in the past two weeks remained high at 62% in 1996.
5. Vaccination coverage improved a great deal but did not reach the expected 60% coverage level. Only 26% of women received the second dose of tetanus toxoid. Only

44% of children received a measles vaccination.

6. Results were more mixed for pre-natal care and delivery preparation practices. During their last pregnancy, more women in 1996 made a pre-natal visit to a health care provider (87% versus 62% in 1994). Knowledge of foods good to eat during pregnancy increased, yet the idea of "eating for two," that is eating more during pregnancy, was cited by only 51% of the respondents. Also, knowledge of what to prepare for childbirth (assembling safe birth kits) was uneven.

7. Respondents' knowledge levels of contraceptive methods is high, a large increase since 1994. The contraceptive prevalence rate (CPR) is estimated at 22%, up from 6% in 1994. The preferred method is the oral contraceptive pill at 10%. Despite the project emphasis on STDs and AIDS, the prevalence of condom use is only 5% but this is very good when compared to national rates for condom use.

8. The means of malaria transmission and of prevention are poorly understood in all the study communities. There is no change in knowledge level between the baseline and final study. Sixty-nine percent of the respondents did not know how malaria was transmitted; fully 75% did not know how to prevent the disease.

8. Regarding knowledge of AIDS, and to the ability to cite AIDS as a "disease" spread through sexual relations, respondents are well informed. In fact, nearly 99% of respondents presently affirm their knowledge of AIDS as opposed to 83% in 1994. A vast majority of respondents cite sexual promiscuity as a main form of AIDS transmission. Unfortunately, AIDS transmission through the use of dirty syringes was cited by only 15% of respondents. The means of AIDS prevention most cited was fidelity (97%), followed by the use of condoms (94%).

1. Introduction

1.1 Justification

RICHEs II is a community-based child survival project targeting 35,000 people in the communes (administrative units like counties in the US) of Moron and Abricots located in the Grand-Anse Department of Haïti. (See map in Appendix A.) The project focus is on preventive health education in an effort to alleviate the absence of health services infrastructure in the area and consequent limited access of the population to preventive health services. The project areas benefit from a diversified packet of mother and child health care services: immunization services for women from 15 to 49 years and children less than 36 months; prevention and control of childhood diarrhea; growth monitoring and promotion for pregnant and nursing women and young children; the distribution of micro-nutrients (vitamin A and iron and folate); prenatal care for pregnant women; family planning; STDs and aids prevention; and referral for high-risk pregnancies, clinic-based family planning methods, and malnourished children.

In keeping with its community development approach, the project works with local health committees to choose and train volunteers to provide preventive health services and education, with a goal of decreasing morbidity and mortality rates. RICHES II focuses on health education to motivate the women living in the communities to take care of their own health concerns and those of their children and their families. RICHES also places an emphasis on working with community leaders in quarterly meetings to discuss problems and service coverage in the areas of intervention. The project staff and community members discuss actions which need to be undertaken to increase participation and to keep the project well functioning.

In the area of intervention, the project works in 262 small communities which are grouped into 26 rally post catchment areas. Each post covers approximately 150 to 200 households, or approximately four square kilometers, depending on the concentration of population in the communities. On average, each household has approximately 5.8 persons. The villages served by the project are located in remote, mountainous areas. About 80% of the population and rally post site are accessible only by walking or by horse back. The majority of the population, or 85 percent, is illiterate, and do not have the possibility to attend school or an alphabetization center.

At the time of the 1994 project baseline census, the various population groups were as presented in the following table:

Children 0-11m	Children 12-36m	Children 36-59m	Youth 12-20yrs	Adults 15-49 yrs	Pregnant Women	Total Population
2,060	2,694	2,063	6,772	13,664	1,382	34,545

At project start-up, CARE conducted a population census and a baseline knowledge, practices and coverage study (KPC) of mothers having children less than 24 months old. The objective of this KPC study was to collect baseline data which would permit measurement of the impact of project activities on the target population and to develop a community education plan which would respond to the needs of the communities.

To evaluate the work accomplished during the project's three year time frame, CARE-Haiti conducted a final evaluation KPC survey which will be discussed in this report.

1.2 Specific Objectives

The specific objectives of the survey were:

1. To determine the social and demographic characteristics of the study population in the RICHES II areas.
2. Determine the rate of participation of women 15-49 years old and their children aged 0-2 years in the educational sessions (defined as having attended at least three sessions in the past year) at RICHES rally posts.
3. Determine the changes in knowledge, practices and service coverage of respondents in terms of the project's key intervention areas of vaccination, treatment and control of diarrhea, malaria, children's nutrition, micronutrients, breast feeding, family planning, and the prevention of AIDS.
4. Determine changes in immunization coverage (against diphtheria, pertussus, tetanus, polio, tuberculosis, and measles) for children 0 to 24 months.
5. Determine changes in tetanus toxoid coverage for women 15-49 years old.
6. Determine changes in contraceptive prevalence rates for women 15-49 years old.

2. Methodology

2.1 Study Sites

The interview sites at which the data were collected were 20 of the 26 RICHES II rally post sites in Moron (the communal sections of Tapion, Sources Chaudes, Chameau) and Abricots (the communal sections of Danglise and Balisiers).

2.2 Sample Population Studied

The population studied were mothers with a child under 24 months who lived in communities served by RICHES II.

2.3 Sampling Method

The study used a systematic sample. A pre-survey census of women with children less than 24 months old was conducted by project personnel and local health volunteers in July 1996. Each local volunteer was given the task of registering all women with children less than 24 months old who lived in the area of her rally post. With these data, a sampling list was created of potential respondents for the study.

2.3.1 Sample Selection

Based on the following criteria, 423 mothers were chosen to be interviewed for the survey:

1. Considering the variation of responses around 50% found in the 1994 baseline study for certain questions
2. A confidence level of 95%;
3. A p-value of plus or minus 5%;
4. A 10% increase in sample size in order to assure that the number of respondents remained sufficient even after controlling for errors in data collection.

2.3.2 Selecting Respondents

The number of mothers identified on the sampling list (2,580 mothers and their children under 24 months) was divided by the sample size of 423 mothers, to determine the systematic sampling interval of every sixth mother on the list.

The mothers were then classified by the rally post closest to their home. Each study supervisor was responsible for six of the 26 RICHES rally posts.

The project health volunteers served as mediators between the interviewers and the selected respondents. Respondents were invited to interview at a pre-determined time at one of the 20 selected interview sites. This process reduced survey costs by reducing the number of interview days. It also permitted direct supervision of

interviewers by survey supervisors. Note, too, that those mothers who did not come to the interview posts as scheduled were visited and interviewed in their homes.

3. Data Collection

3.1 Survey Instrument

The same questionnaire which was used during the base-line survey was employed for this survey, except for the addition of a section on respondent participation in RICHES II activities (see Appendix B). The main sections of the survey are as follows:

1. General information
2. Participation in project activities
3. Infant and child nutrition (including breast feeding)
4. Diarrhea management
5. Acute respiratory infections
6. Vaccinations
7. Pre-natal Care and Childbirth
8. Family Planning
4. AIDS

3.2 Pre-Test and Training

Survey interviewers received three days of training at the CARE field office in Jérémie. The training covered the survey protocol, the sampling methodology, interview techniques, ethical considerations, and questionnaire content.

On the fourth day of training the questionnaire was pre-tested by the interviewers in Saint Hélène, a section of the city of Jérémie. Following this, an interviewer evaluation was conducted to select the most competent of the group to conduct the field interviews.

3.3 Field Activities

Data collection began at the interview posts on 17 August and was concluded on 24 August 1996.

3.4 Survey Personnel

Survey personnel consisted of four teams, each with a supervisor and two interviewers. The local health volunteers informed the potential respondents of their

selection for the interviews, set up interview times, introduced respondents to interviewers, and acted as guides for those house calls made when respondents did not appear at the health posts for the interview.

3.5 Survey Quality Control Methods

The role of the supervisors was to assure the validity of data collected. In this function, the supervisor was present with the interviewer during the interviewing process. If there were problems with the completion of the questionnaire (after review by the supervisor), the information was corrected before the respondent left the interview site.

3.6 Data Entry and Analysis

After completing the data collection, the questionnaires were returned to Port-au-Prince and compiled in the CARE main office. Data entry was organized to reduce data entry errors, following which the data entry was checked for reliability and crossed referenced against the original survey questionnaire. The data were analyzed with SPSS-PC, using an analysis program especially created for this use. The results are presented in the form of simple frequencies and cross tabulations.

3.7 Ethical Considerations

The interviews were conducted in a confidential (in terms of privacy of space) environment with the consent of all respondents. The completed questionnaires were handed to the supervisors and seen only by those people responsible for the data integrity and analysis.

4. Survey Results

Selected socio-demographic characteristics of respondents are discussed first, followed by a discussion of respondents' participation in project activities. Next, we present the results of the respondents knowledge and practices, and service coverage, of the project area, comparing the results of the 1996 final evaluation survey with the results of the 1994 baseline survey. Note, also, that a summary of key USAID child survival performance indicators are presented in the "Conclusion and Recommendations" section.

4.1 Social and Demographic Characteristics

There is not a large difference in the socio-demographic characteristics of

respondents between 1994 and 1996 (Table 1). The average age of respondents is 29 years. The 1996 partition of respondents by age group reveals that 5% of the mothers are adolescents less than 20 years of age. The other age groups are proportionally distributed. Respondents between the ages of 20 and 24 years represent 23% of the sample. Twenty-three percent of respondents are between 25 and 29; 17% are between 30 and 34 years; 17% are between 35 and 39 years; 11% are between forty and 44 years; and 3% are between 45 and 49 years. The mean age for the index child is 13 months, compared with the average age in 1994 of 12 months. Approximately 51% are male and 49% are female. The great majority of the mothers interviewed responded that they were Christians. Approximately 73% are Catholic and 26% are Protestants. The other denominations were infrequently cited (less than 1%).

Due to its importance in terms of health behavior, the educational levels of respondents were analyzed in terms of the number of years of formal schooling. Globally, more than half of respondents, or 57%, have never been to school. Nineteen percent have gone to primary school but can neither read nor write, and 17% have gone to primary school and can read and write. Only 7% of respondents have completed primary school or have several years of secondary school.

**Table 1:
Selected social and demographic characteristics of respondents**

	Baseline survey	Final Evaluation
<u>Average age of mothers</u> (n1=416; n2=423) years	31 years	29
<u>Age of mothers by age group</u> (n1=416; n2=423)		
15-19 years	3 %	5 %
20-24 years	22 %	24 %
25-29 years	21 %	24 %
30-34 years	20 %	17 %
35-39 years	21 %	17 %
40-44 years	11 %	11 %
45-49 years	3 %	3 %
<u>Average age of index children</u>¹ (n1=419; n2=423)	12 m	13m
<u>Sex of index child</u> (n1=419; n2=423)		
Male	55 %	51 %
Female	45 %	49 %

¹ The index child is the youngest child less that 24 four months old of the responding mother.

Religion (n1=419; n2=423)

Catholic	77 %	73 %
Protestant	20 %	26 %
Voodoo	2 %	0 %
Other	1 %	<1 %

Level of Education (n1=419; n2=423)

None	63 %	57 %
Primary (Can not read or write)	30 %	17 %
Primary (Can read and write)	4 %	17 %
Completed primary school	4 %	3 %
Some secondary school attendance	0%	4 %

Note: n1=1994 study population
n2= 1996 study population

4.2 Participation in Project Activities

The principle objective of this study was to measure the impact of the project's educational activities in the communities served by RICHES. It was, thus, important to know if the respondents had heard about the project and had assisted in project activities during rally post days (Table 2).

**Table 2:
Respondents' Participation in RICHES II Activities**

	Number	%
Participation (n2=424)		
Is aware of RICHES II activities	385	92 %
Has attended project educational activities	327	85
Has participated in at least three education session in last year	327	88
Places where respondents attended RICHES activities (n2=327)		
Church	27	6
Cockfighting Pit	7	2
Market	1	1
School	5	1
RICHES Rally Post	249	59
Other Rally Post	32	10
Communal Work Group (<i>Kombit</i>)	1	0
Clinic	2	1
Other	20	6

Note: n1 = 1994 study population
n2 = 1996 study population

Based on the above table, 92% of respondents stated that they knew of RICHES II activities, 85% attended some of the education sessions, and 88% attended RICHES vaccination days. The key indicator of respondent participation was attendance of at least three education sessions during the last year. Approximately 88% of respondents stated that they had done so. Using the number of children who were weighed at least one time in the past three months as a more recent indicator of participation (also supported by a written record, and not recall), we see that 74% of respondents were participating in RICHES education activities at the time of the study.

4.3 Comparison of Respondents' Knowledge, Practices and Service Coverage

4.3.1 Nutrition and Breast Feeding

This section analyses the knowledge and the practices of respondents in terms of the index child nutrition and breast feeding.

Table 3:
Nutrition Practices of Respondents with Index Children 0 - 24 months

	Baseline	Final Evaluation
<u>Among children who are not bf exclusively, % of mothers who use/used a baby bottle (n1=424; n2=423)</u>	42 %	22 %
<u>% of infants 0-4 m who are exclusively breast fed (n1=419; n2=423)</u>	19 %	74 %
<u>Initiation of breast feeding (n1=419; n2=423)</u>		
Just after delivery	64 %	89 %
After the colostrum passes	24 %	3 %
Other	12 %	8 %

*NOTE: n1=study population in 1994
n2=study population in 1996*

In Haïti, a great many of the early child nutrition problems are caused by not feeding the newborn colostrum, very short periods of exclusive breast feeding, and the early introduction of foods and drinks. In 1995, CARE, in collaboration with UNICEF and the Ministry of Health, launched an intensive education campaign promoting exclusive breast feeding for the first six months of an infant's life. The absorption of colostrum which is rich in antibodies is important to infant health. Compared with only 64% in 1994, it is noteworthy in Table 3 that approximately 90% of respondents affirmed that they **initiated breast feeding** just after delivery, which indicates that

women fed their newborn **colostrum**. Note that the rate of **exclusive breast feeding** improved considerably between 1994 and the present, from 19% of women with children 0-4 m in 1994 to 75% in 1996. Finally, less than one-fourth of respondents (22%) reported **using baby bottles** with the index child.

Mothers' **knowledge of practices which facilitate the production of breast milk** were also tested (Table 4.1). Approximately 70% of respondents correctly stated that it is necessary to nurse the infant often to stimulate breast milk production. For about 95%, certain nutritional practices such as eating a type of local squash (mirloton or chayote) is cited as stimulating breast milk. The changes between responses in 1994 and 1996 are great.

What **types of foods (rich in Vitamin A) are good for the eyes?** Vegetables were cited by 91% of respondents. Fruits and yellow vegetables were cited by 96% and 89%, respectively (Table 4.1). Mother's milk was cited by nearly 70% of the mothers. Egg yolks were cited by 82%. These results represent a great improvement in knowledge of Vitamin A food sources over 1994 results.

Respondents' knowledge concerning **infant feeding intervals** is good. Most of the respondents (88%), claim that they feed their child two or three times a day, but it would be better if children ate more frequently. There is no change in this knowledge compared with results found in 1994.

Table 4.1:
Comparison of Respondents' Knowledge of Child Nutrition
(n1=424;n2=423)

	Baseline	Final Evaluation
<u>Practices to increase breast milk production</u>		
Give breast right after delivery	28 %	83 %
Avoid use of baby bottles	98 %	100 %
Give breast more often	21 %	70 %
Take care of breasts	21 %	83 %
Eat food believed to increase milk (mirloton)	44 %	95 %
Do not know	11 %	10 %
<u>Knowledge of foods that protect the eyes (Vit-A rich)</u>		
Green vegetables	37 %	91 %
Yellow fruits (mangoes, papaya)	50 %	96 %
Yellow vegetables (pumpkin, carrots)	42 %	89 %
Mother's milk	11 %	70 %
Meat / fish	2 %	49 %
Egg yolk	40 %	82 %
Other	7 %	3 %

Knowledge of number of times to feed child daily

Once per day	0 %	6 %
Two or three times	90 %	88 %
Four or five times daily	4 %	7 %
Do not know	0 %	1 %

Note: n1= study population in 1994

n2= study population in 1996

The survey also researched the **types of foods introduced during the first six months of the child's life** (Table 4.2). It particularly focused on the foods given to the index child in an attempt to elicit information on the respondent's actual nutritional practices. The percentage of women who say that they give food is very small until the age of four months, and this is corroborated by the fact that 74% infants of this age group are exclusively breast-fed. Note, though, that between 12% and 15% of women with a three month old baby have added various foods to the child's diet, including oil, semi-solid foods, other milk and/or sugar. By five months, between 60% and 90% of mothers with five month old babies have added sugar, fruits, semi-solid foods and/or other mild to the child's diet. Foods rich in Vitamin A are being given by 45% of respondents with a child aged five months. Giving the child protein-rich foods also increases between five and six months.

Table 4.2: Types of foods the mothers give to index children by age of child

	1 m (n1=9, n2=19)	2 m (n1=18, n2=17)	3 m (n1=15, n2=25)	4 m (n1=19, n2=23)	5 m (n1=28, n2=17)	6 m (n1=29, n2=22)
Other milk						
1994	0%	0%	40%	53%	6%	52%
1996	2%	7%	15%	18%	60%	67%
Semi-solid foods						
1994	0%	22%	60%	63%	6%	79%
1996	0%	12%	17%	22%	66%	87%
Fruits, fruit juices						
1994	0%	0%	13%	26%	46%	69%
1996	0%	10%	10%	16%	76%	76%
Vit A-rich foods						
1994	0%	0%	7%	21%	7%	66%
1996	0%	7%	15%	15%	45%	84%
Green vegetables						
1994	0%	0%	7%	16%	36%	41%
1996	0%	4%	13%	17%	45%	89%
Fish, meat						
1994	0%	0%	7%	5%	14%	31%
1996	0%	2%	12%	17%	23%	67%
Beans, peas						
1994	0%	0%	7%	0%	25%	21%
1996	0%	3%	14%	17%	36%	71%
Eggs						
1994	0%	0%	7%	0%	11%	17%
1996	0%	0%	16%	12%	38%	84%
Oil						
1994	0%	11%	47%	63%	61%	76%
1996	0%	9%	17%	16%	45%	83%
Sugar						
1994	11%	39%	60%	74%	86%	90%
1996	7%	14%	12%	12%	89%	93%

Note: n1 = Study population of 1994; n2= Study population of 1996

Comparing this information with consumption information from 1994, it appears that children are eating a greater variety of foods, including protein-rich foods. Semi-solid foods are being introduced later than before.

In 1994, approximately 34% of the index children had a **Road-to-Health card**; in 1996 this rises to 80%. The Road-to-Health cards were examined to determine the **percentage of children weighed** during the three months preceding the survey in 1996. More than 74% of infants, versus 39% in 1994, were weighed. Sixty percent (versus 34% in 1994) received **Vitamin A supplementation** during the three month period.

4.3.2 Management of Diarrhea Episodes

Among RICHES II objectives were ones to improve mothers' attitudes and practices concerning childhood diarrhea. Therefore, the survey determined the percentage of children who experienced diarrhea episodes in the two weeks preceding the survey, and then asked respondents how they managed their child's diarrhea episode (Table 5).

The survey determined respondents' **child feeding behaviors, in terms of breast feeding, and giving foods and liquids, during the diarrhea episode**. Did women increase or maintain, decrease or stop certain nutritional practices during a child's diarrhea episode? It is customary in Haiti to reduce or halt feeding during the bouts of diarrhea. As indicated in Table 5, 97% of respondents continued feeding practices or increased breast-feeding during the bout of diarrhea. A high percentage (92% and 93%) of respondents continued or increased the quantity of liquid or semi-solid foods during diarrhea bouts. In this respect, the base line survey found only 73% and 62%, respectively, who claimed to do so, thus there is a significant increase in these good diarrhea management practices.

Table 5: Comparison of Practices Concerning Control of Childhood Diarrhea

	Base Line	Final Evaluation
<u>Percentage of children with diarrhea during the last 2 weeks (n1=424; n2=423)</u>	41 %	40 %
For children who had diarrhea within last 2 weeks:		
<u>How women gave liquids during diarrhea (n1=168; n2=166)</u>		
Continued or increased quantity of liquid	73 %	92 %
Stopped or decreased quantity of liquid	27 %	9 %

How women gave semi-solids during diarrhea (n1=168; n2=166)

Continued or increased quantity of semi-solids	62 %	93 %
Stopped or decreased quantity of semi-liquids	38 %	7 %

How women treated diarrhea episodes of index child (n1=184; n2=166)

Sweet pap, porridge	0 %	100 %
Teas	0 %	100 %
Medicines	0 %	2 %
ORT packets	89 %	100 %
Home mix of ORT	0 %	100 %
Gave nothing	11 %	0 %

Among women who breast feed, breast feeding practices during diarrhea (n1=168; n2=166)

Continued or increased breast feeding	83 %	97 %
Stopped or decreased breast feeding	17 %	4 %

*Note: n1=1994 study population
n2=1996 study population*

The survey also looked at respondents **utilization of oral re-hydration therapy (ORT)** during the index child's last episode of diarrhea. Results in Table 5 suggest that virtually all respondents give ORT using packets or home mix. (The question allowed multiple responses. It appears that respondents spoke of both home mix and prepared mix.) All respondents also give teas made from local, fresh herbs during diarrhea episodes.

Although not noted on the table, the survey also questioned **how respondents could prevent diarrhea**. A very high percentage of respondents provided responses showing good hygiene would help prevent diarrhea: 91% state that drinking clean water would prevent diarrhea, 95% uncontaminated ("clean") food. More than 50% stated that not using a baby bottle would prevent diarrhea.

The respondents knowledge of the **signs of diarrhea complications** and what makes them seek medical assistance for childhood diarrhea was also solicited. Approximately 97% of respondents in 1996 cited loss of appetite, and weakness and tiredness, as signs of complications. More than 80% cited dry lips as a visible sign of dehydration; and 92% of respondents cited both blood in the infant's stool and diarrhea that lasts more than fourteen days as signs of a serious diarrhea requiring treatment.

Where would a woman take her child for treatment? Approximately 81% of respondents in 1996 stated that they would go to hospitals, 100% to a health center or dispensary. Forty-four percent cited going to rally posts. In 1994, 52% of respondents stated that she would go to a health institution.

Finally, survey results suggest that the **prevalence of diarrhea** for children less than 24 months old during the two weeks preceding the study was 40%, the same percentage as in 1994. Thus, even with greatly improved knowledge and reported practices, the actual prevalence of diarrhea has not decreased.

4.3.3 Acute Lower Respiratory Infections (ALRI)

Acute lower respiratory infections (ALRI) are extremely prevalent in rural areas of Haïti and contribute significantly to the high mortality rates, particularly among infants and young children. According to Table 6, below, 62% of respondents stated that their children had a cold or flu-like conditions (*gripe*) in the preceding two weeks before the survey began. Of this 62%, approximately half of respondents had sought treatment. In describing the **signs of ALRI complication**, approximately 93% cited coughing, runny nose, or flu. And 97% claimed that a child who has difficulty breathing has a sign of respiratory complication. More than 67% cited that the child whose ribs appears when he/she breaths needs treatment.

**Table 6:
Comparison of Knowledge and Practices Results Concerning Childhood ALRI**

	Baseline	Final Evaluation
<u>% of children having flu-like conditions within the last 2 weeks (n1=424; n2=416)</u>	58 %	62 %
<u>Among children having RI during last 2 weeks, % who received treatment (n1=146; n2=256)</u>	49 %	50 %
<u>Danger signs most frequently cited which push a mother to seek treatment/counsel (n1=424; n2=423)</u>		
Breathes with difficulty	39 %	97 %
Ribs appears when breathing	8 %	67 %
Loss of Appetite	52 %	76 %
Cough, Cold, Flu	66 %	93 %

*Note: n1= study population in 1994
n2= study population in 1996*

4.3.4 Vaccinations

Vaccination is one of the preventive services offered to women and children by RICHES II at rally posts.

Vaccination knowledge levels actually decreased between 1994 and 1996 for

tetanus: in 1994, 71% of women could cite the advantages of tetanus vaccination, versus 45% in 1996. Regarding measles, about 73% of the 1996 respondents knew by what age (nine months) a child should have received a measles vaccination, versus 43% in 1994.

On the other hand, **vaccination coverage** rates improved across-the-board (Tables 7 and 8). In 1994, vaccination histories were taken on the household census form for women aged 15-49 years and all children under five. Unfortunately, questions concerning tetanus toxoid immunization were not included in the final evaluation KPC questionnaire. From RICHES II service statistics, though, we estimate that the coverage is as follows: 33% of women have received one dose, 26% have received two doses, and 19% have received boosters Table 7).

**Table 7:
Comparison of Tetanus Toxoid Coverage Results for Women 15-49 Years Old**

	Household Census (n=6,251)			Project Service Statistics (n doses yr 1=2,031 n doses yr 2=1,616 n doses yr 3=1,139)		
Coverage rates	TT1	TT2	TTR	TT1	TT2	TTR
	9 %	6 %	2 %	33 %	26 %	19 %

The pre- and post- project vaccination coverage rates for children less than two years old are compared in Table 8.

**Table 8:
Comparison of Pre- and Post- Project Vaccination Coverage Rates for Children Aged 0-2 Years, by Age Groups, Vaccine Type, and Dose**

	0 - 11 m		12- 24 m		Total	
	1994	1996	1994	1996	1994	1996
Total	849	244	1319	179	2168	423
BCG	24%	62%	31%	34%	17%	38%
DTP1	2%	66%	3%	34%	1%	60%
DTP2	1%	46%	1%	36%	0%	41%
DTP3	0%	39%	0%	27%	0%	38%
Polio 1	1%	32%	0%	36%	0%	37%
Polio 2	0%	35%	0%	31%	0%	29%
Polio 3	0%	26%	0%	25%	0%	21%
Measles	0%	31%	0%	52%	0%	44%

4.3.5 Pre-natal care and childbirth

RICHES II also conducts educational sessions on key maternal care themes, including the need to have prenatal visits, preparation for delivery, and good nutritional practices during pregnancy and while nursing.

**Table 9:
Comparison of Maternal Care Knowledge and Practices (n1=424; n2=423)**

	Baseline	Final Evaluation
<u>% of women who were pregnant at time of survey</u>	6 %	17 %
<u>Knowledge of when a women should make the first prenatal visit</u>		
1st trimester	86 %	86 %
2nd trimester	5 %	8 %
3rd trimester	1 %	3 %
No need of visit	8 %	1 %
<u>Percentage of women who made at least one prenatal visit to a health institution during last pregnancy</u>	58 %	87 %
<u>Types of food which are good for pregnant women</u>		
Eggs, fish, meat	65 %	92 %
Vegetables, green leaves	58 %	98 %
Rice, cornmeal, sorghum	50 %	74 %
Beans	29 %	96 %
Do not know	6 %	1 %
<u>Quantity of food eaten during last pregnancy</u>		
More than usual	53 %	51 %
Same as usual	15 %	14 %
Less than usual	30 %	34 %
Do not know	2 %	0
<u>Who cut the umbilical cord of index child</u>		
Self	3 %	2 %
Member of Family	15 %	4 %
Traditional Birth Attendant	72 %	89 %
Doctor/Nurse	11 %	3 %
Other	0	1 %
<u>Preparation done for last childbirth</u>		
Sterile razor	95 %	86 %
Clean cloth	67 %	55 %
Soap	82 %	49 %
Boiled Water	63 %	32 %
Other	27 %	14 %
Nothing/Don't know	4 %	3 %

Note: n1= 1994 study population; n2=1996 study population

There are few significant maternal care knowledge and practices changes between the 1994 base line and the final evaluation surveys (Table 9). The first trimester was cited as the **correct time to make the first prenatal visit** by 86% of respondents in 1994, and again by 86% of respondents in 1996. On the other hand, in 1996 many more mothers, approximately 87%, stated that they had made prenatal visits at a medical facilities. Only 58% said this in 1994. The **rate of pregnancy** among respondents was 17% in 1996 and only 6% in 1994.

The women know which the **types of food are good for pregnant women**. Foods high in protein such as eggs, meat, and fish were cited by 92% of respondents; beans by 96%; vegetables such as spinach were cited by 98%; and such cereals as rice, corn meal, and sorghum were cited by 74% of the respondents.

Approximately half of the mothers (51%) said that a woman should eat more food during pregnancy, compared with 53% in 1994. Approximately 14% said it is necessary to eat the same quantity and 34% said less food is necessary. This compares with 14% and 30%, respectively, who said so in 1994.

The majority of **deliveries** reported in 1996, some 89%, were assisted by traditional birth attendants (TBAs), compared with 72% in 1994. This increase in the percentage of TBA assisted deliveries in 1996 appears to have occurred at the expense of deliveries assisted by family members and medical personnel. In 1994, 15% and 11% were assisted by family members and medical personnel respectively; in 1996, these percentages had decreased to 4% and 3%, respectively. The mothers' knowledge of **what to prepare and have on hand at the time of delivery** appears to have decreased somewhat significantly. Approximately 86% in 1996 versus 95% in 1994 said that she had a sterile razor present for the delivery. A clean cloth and soap were cited by 55% and 49% of respondents, respectively, in 1996, compared with 67% and 82%, respectively, in 1994. Boiled water was cited by 32% in 1996, compared with 63% in 1994.

4.3.6 Family Planning

The promotion of the advantages of spacing and limiting births and providing community-based access to modern family planning (FP) was an important aspect of RICHES II. This interest was justified by the negative impact that uncontrolled fertility and too frequent child birth can have on maternal and child health. Additionally, RICHES I mothers had long asked the project staff and health volunteers to provide them with information and FP methods; there was an unmet demand. This section presents the results of respondents' knowledge of family planning and their use of family planning methods.

The level of **unmet family planning need** was measured by responses to the following question: Do you want to have a child during the next two years? Approximately 83% of the women answered in the affirmative, versus 60% in 1994 (Table 10). Note that the younger age groups of women are more interested in having children than older women; they also represent a lesser percentage of contraceptive users compared to the older age groups.

**Table 10:
Comparison of Respondents' Unmet Need and Actual Use of Family Planning Methods, by Age Group**

Age Group	Baseline (n1=424)		Final Evaluation (n2=423)	
	Desires to space births	FP User	Desires to space births	FP User
15-19 years	21 %	<1%	14 %	3 %
20-24 years	46 %	<1%	13 %	5 %
25-29 years	64 %	1 %	26 %	3 %
30-34 years	63 %	2 %	67 %	7 %
35-39 years	59 %	1 %	78 %	12 %
40-44 years	84 %	1 %	89 %	9 %
45-49 years	83 %	1 %	92 %	12 %
All women	60 %	6 %	83 %	22 %

*Note: n1=1994 study population
n2=1006 study population*

Knowledge of the different FP methods greatly improved between 1994 and 1996 (Table 11). Using probe questions to improve recall, the respondents revealed that they had a high level of knowledge of various modern family planning method, between 87% and 99%. In 1994, knowledge levels varied between 3% and 80%.

**Table 11:
Comparison of Knowledge of Different FP Methods**

Methods	Baseline (n1= 424)		Final Evaluation (n2= 423)	
	Spontaneous	With probe	Spontaneous	With probe
Tubal Ligation	11 %	38 %	29 %	97 %
Norplant	14 %	38 %	32 %	99 %
Injectables	19 %	38 %	32 %	99 %
IUD	2 %	10 %	4 %	94 %
Diaphragm	<1 %	3 %	3 %	87 %
Condom	68 %	80 %	48 %	99 %
Cream/Tablets	2 %	5 %	21 %	97 %
Breast Feeding	5 %	20 %	9 %	97 %
Per. Abstinence	2 %	10 %	4 %	95 %
Abstinence	11 %	34 %	1 %	95 %
Withdrawal	10 %	33 %	8 %	98 %
Vasectomy	1 %	8 %	7 %	94 %
Pills	62 %	72 %	49 %	99 %

Note: n1=1994 study population
n2=1006 study population

Table 12 suggests a remarkable increase in the contraceptive prevalence rate from 6% in 1994 to 22 percent in 1996. Method mix has also changed. In 1994, the methods most used were the pill (6%) followed by condoms (4%), withdrawal (1%), and injectables (1%). In 1996, the method mix has changed to pills (11%), condoms (5%), exclusive breast feeding (3%), and tubal libation (3%).

Table 12: Comparison of Family Planning Utilization Rates by Method

Method:	Baseline (n1=424)		Final Evaluation (n2=423)	
	Past user	Present user	Past user	Present user
Tubal Ligation	1 %	1 %	< 1 %	2 %
Norplant	0	< 1	< 1	< 1
Injectable	* 0	1	< 1	1
IUD	0	0	0	0
Diaphragm	0	0	1	0
Condom	0	4	3	5
Cream/Tablets	0	0	< 1	< 1
Breast Feeding	< 1	< 1	3	3
Period. Absent.	0	< 1	1	< 1
Abstinence	< 1	< 1	< 1	< 1
Withdrawal	< 1	1	< 1	1
Vasectomy	0	0	0	0
Pills	0	6	0	11
All methods	< 1 %	6 %	4 %	22 %

Note: n1=1994 study population; n2=1996 study population

4.3.7 Malaria

Malaria is an important public health problem in the Grand'Anse. The level of knowledge concerning malaria transmission was very low in 1994 and continued to be so in 1996 (Table 13). Very few persons had an appreciation of the **modes of transmission** of this illness. Sixty-nine percent and 75 % of the respondents, respectively, stated that they did not know how malaria is transmitted, or how to protect themselves against it. The means of prevention most frequently cited was draining standing water, which was cited by 16% of respondents.

**Table 13: Comparison of Respondent Knowledge of Malaria
(n1=424; n2=423)**

	Base line	Final Evaluation
<u>Modes of malaria transmission</u>		
Mosquito	23 %	20 %
Water	15 %	12 %
Other	21 %	14 %
Don't know	39 %	69 %
<u>Means of prevention</u>		
Self protection against mosquitoes	6 %	8 %
Use mosquito nets	1%	1 %
Drain standing water	24 %	16 %
Other	0	6 %
Don't know	69 %	75 %

*Note: n1=1994 study population
n2=1996 study population*

4.3.8 HIV and AIDS

Sexually transmitted diseases (STDs) and AIDS represent serious public health problems in Haïti, and contribute in a significant manner to maternal and child morbidity and mortality rates. The project, with technical assistance from another CARE project promoting education to prevent STDs and AIDS, made a major effort to educate the population in this domain and the results show this in Table 14.

**Table 14:
Comparison of Results of Respondent Knowledge About AIDS
and Perception of Personal Risk (n1=424; n2=423)**

	Base line	Final Evaluation
<u>Have heard about AIDS</u>	83 %	99 %
<u>Modes of HIV transmission</u>		
Sexual relations with a person infected with AIDS	56 %	99 %
Mosquitoes	<1 %	13 %
Prostitutes/Having multiple partners	19 %	90 %
Non-sterile (used before) "dirty" syringes	7 %	15 %
Don't know	15 %	2 %
<u>Means of AIDS prevention</u>		
Fidelity	59 %	97 %
Condom use	10 %	94 %
Visit the Voodoo priest	1 %	0
Don't know	18 %	3 %
<u>Perception of personal risk to contract AIDS</u>	18 %	32 %

*Note: n1=1994 study population
n2=1996 study population*

The vast majority of women know of or have heard about AIDS, almost 99% in 1996 versus 83% in 1994. The survey did not investigate the level of knowledge concerning other sexually transmitted diseases. The research reveals an appreciable level of knowledge concerning the **modes of AIDS transmission**. Sexual relations with a person infected with AIDS and promiscuity are most often cited, 99% and 90% respectively. Unfortunately, in a zone where injections are very much in evidence, utilization of non-sterile syringes is cited only by 15% of respondents. Cited means to prevent AIDS included fidelity (97%) and condom use (94%).

5 Conclusion and Recommendations

This study, which had the objective of evaluating the changes in knowledge, practices and service coverage of the population served by RICHES II, has confirmed the positive impact of the project's IEC activities in different areas of intervention and the impact of improved access to preventive health services. More than three-quarters of the population of women were reached over the period of the project, which should ensure that there is a strong base of positive knowledge and practices in the communities

reached by RICHES II.

The performance indicators which were set out in 1994 (Table 15) have been met or exceeded in almost all cases. The major exception is in the area of vaccination activities for both children and women. As the follow-on project, RICHES 2000, will continue to provide services to the population described in this study until September 97, staff should make improving vaccination coverage one of their major activities.

In terms of knowledge of other practices measured in the study, equally significant gains have been made in areas of nutrition, diarrhea management, acute respiratory infection, pre-natal care, family planning and AIDS. In the remaining year of service, though, staff and health volunteers should focus on improving knowledge in the areas of:

- frequency of feeding young children (three to four times per day);
 - the need for pregnant women to eat more during their pregnancy;
 - preparations for safe childbirth;
 - knowledge of the reasons for vaccinations; and
 - malaria transmission and prevention
- While great strides have been made in encouraging women to extend the period of exclusive breast feeding, effort to promote this practice should also continue.

Table 15:

**Comparison of Key USAID Child Survival Performance Indicators
Between the Baseline and Final Evaluation**

	1994	Expected 1996	1996
Practices Appropriate to Child Nutrition			
Initiates breast feeding in the first 8 hours after delivery	64 %	80 %	89 %
Practices exclusive breast feeding for the first 4 months	49 %	65 %	74 %
Introduces solid or semi-solid food between the 5th and 9th month	89 %	90 %	93 %
Diarrhea Control			
Continues to give the same quantity milk or more milk	83 %	90 %	97 %
Continues to give the same quantities of liquids	73 %	80 %	92 %
Continues to give the same quantity of semi-liquids	62 %	80 %	93 %
Gives oral re-hydration fluids	100%	100 %	100 %
Control of Acute Lower Respiratory Infection			
Seeks treatment for ALRI	85 %	90 %	93 %
Vaccination			
Has received DPT1 and is 12-23 months old	3 %	60 %	60 %
Has received Polio 3 and is 12- 23 months old	0	60 %	21 %
Has received measles vaccination and is 12-23 months old	0	60 %	48 %
Drop-out rate (DPT1 and DPT3)	3 %	10 %	10 %
Maternal Care			
Has received the second dose of tetanus toxoid	6 %	60 %	26 %
Has had one prenatal visit during pregnancy	58 %	80 %	87 %
Has desire to space births over the next two years	68 %	30 %	83 %
Uses a modern method of contraception	6 %	25 %	22 %

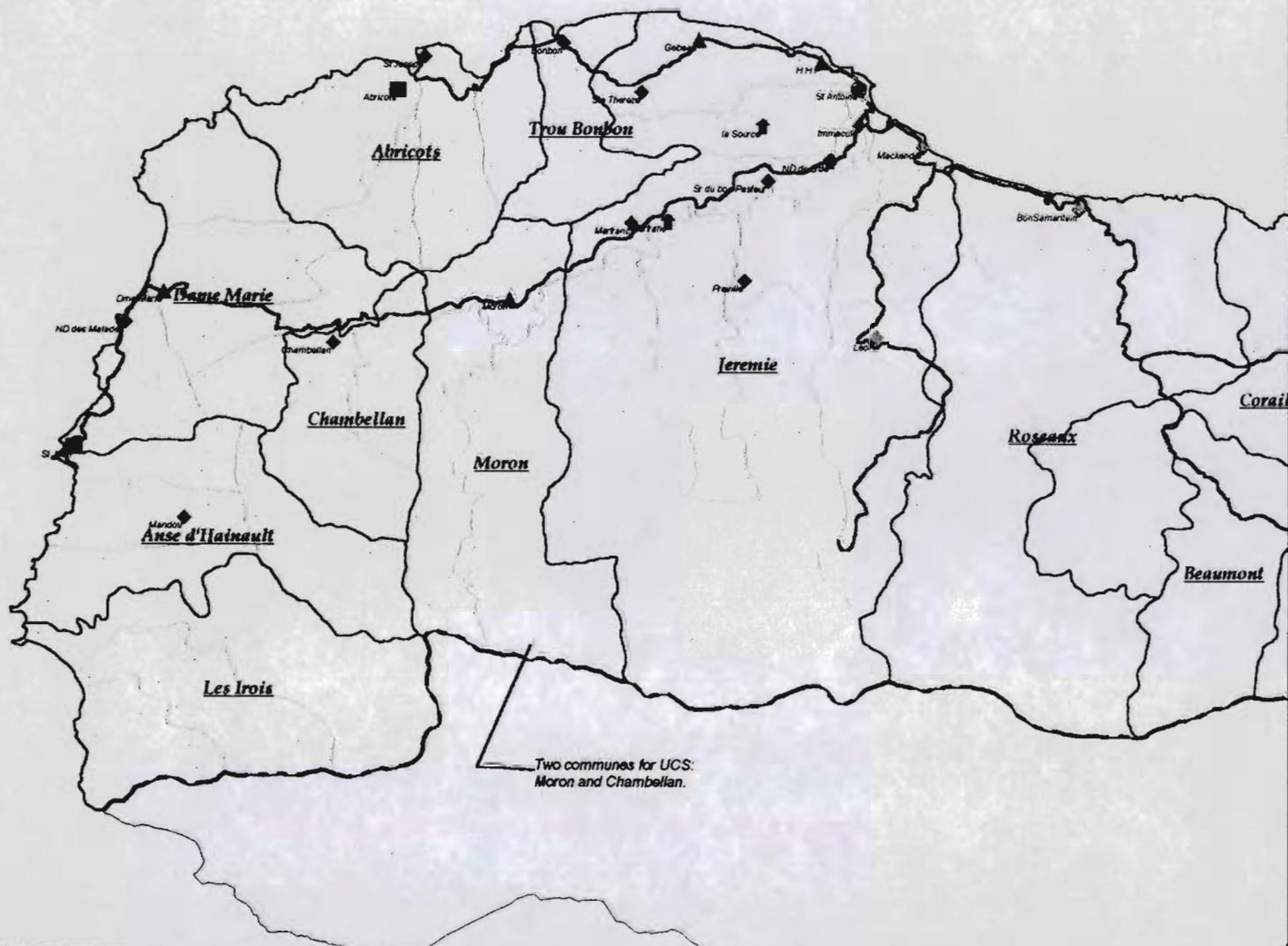
Appendix A

Map Showing Project Intervention Area

CARE-HAITI

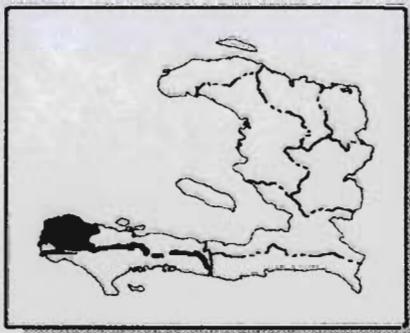
Survie de l'enfant / Zone du projet

REPUBLIQUE D'HAITI

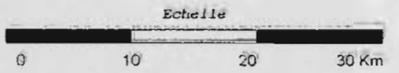


Two communes for UCS:
Moron and Chambellan.

Index



- Limite de commune
- Point d'eau
- Frontiere Haitiano Dominicaine
- Limite cotiere
- Limite departementale
- Réseau routier
- Hopital
- Centre de sante avec lits
- Centre de sante sans lit
- Asile
- Dispensaire



Appendix B

Sample Questionnaire

CARE-Haiti PWOJE RICHES

Kesyonne sou Konnesans e Compotman e Abitid Maman ak Timoun

(REVISÉ LE 1 Juillet 96)

Dat entrevi: 15-8-96 Nom ankete: Nicelkson Jbrndk Kod ankete [05]
Non Komin: Momon Kod Komin [][]
Non seksyon kominal: Tapien Kod Seksyon kominal [][]
Non lokalite: La Ferme Kod lokalite [][]
Nim kay: [0][0][4]

AVAN ANKETE KOMANSE ENTREVI, BAY TI ENTWODIKSYON SOU POUKISA NOU VLE CHITA E KOZE AK MAMMAN AN:

Se pou poze nan zon nou kek kesyon pou manman (famn ki genyen antre 15 e 49 zan) ki genyen yon timoun ki poko rive genyen 2 zan (setadi, ki genyen mwens 24 mwa). Repons ou ap ede Pwoje RICHES evalye pwoje ya ki te pase pase 3 lane ap travay nan kominote yo. Ti koze nap fe ap rete antre nou. Nou pap pataje repons wap bay yo ak lot moun. Donk ou kap reponn ak onetete e verite.

- a. Nom manman an: Mireille Altene b. Laj li: 32 c. Mwa/ane li fet: 1-3-64
- d. Nom timoun ki poko genyen 24 mwa: Manita Altene e. Laj li (mwa): 7
- f. Mwa/ane li fet: 3-15-85
- g. Sexe timoun:
[X] 1. Fi
[] 2. Gason
- h. Religyon manman:
[] 1. Protestan
[X] 2. Katholik
[] 3. Vaudouisan
[] 8. Lot, Presice: _____
- i. Nivo edikasyon manman:
[X] 1. Anyen
[] 2. Kek prime, pa kapab li ou ekri
[] 3. Kek prime, kapab li e ekri
[] 4. Komplete prime
[] 5. Kek segonn ou plis

SEKSYON 1. BEBE NAN TETE / NITRISYON

- 1.1. Eske [*nom timoun nan*] nan tete selman?
[] 1. Wi \implies *pase nan kesyon 1.15*
[X] 2. Non
- 1.2. Eske ou te konn bay [*nom timoun nan*] tete?
[X] 1. Wi
[] 2. Non
[] 9. Pa konnen
- 1.3. Eske ou konn bay [*nom timoun nan*] bwe lot let ki pa let manman?
[X] 1. Wi
[] 2. Non
- 1.4. Eske ou konn bay [*nom timoun nan*] bwe nan bibwon?
[X] 1. Wi
[] 2. Non
- 1.5. Eske ou konn bay [*nom timoun nan*] manje lot bagay tankou labouwi, akamil oswa soup?
[X] 1. Wi
[] 2. Non
- 1.6. Eske ou konn bay [*nom timoun nan*] manje fwi tankou mang, seriz, kachiman, korosol, zoranj, sitwon ou bwe ji fwi?
[X] 1. Wi
[] 2. Non
- 1.7. Eske ou konn bay [*nom timoun nan*] manje kawot, joumon, mango ou papay?
[X] 1. Wi
[] 2. Non
- 1.8. Eske ou konn bay [*nom timoun nan*] manje legim fey vet tankou epina, lyann panye?
[X] 1. Wi
[] 2. Non
- 1.9. Eske ou konn bay [*nom timoun nan*] manje vyann tankou vyann bef, kochon, kabrit, poul, kodend ou pwason?
[X] 1. Wi
[] 2. Non

- 1.10. Eske ou konn bay [*nom timoun nan*] manje nenpot kalite pwa?
 1. Wi
 2. Non
- 1.11. Eske ou konn bay [*nom timoun nan*] manje pistach ou mamba?
 1. Wi
 2. Non
- 1.12. Eske ou konn bay [*nom timoun nan*] manje ze?
 1. Wi
 2. Non
- 1.13. Eske ou konn mete siwo ou sik nan manje ou fe pou [*nom timoun nan*]?
 1. Wi
 2. Non
- 1.14. Eske ou konn mete gres ou lwil nan manje ou fe pou [*nom timoun nan*]?
 1. Wi
 2. Non
- 1.15. Ki le ou te bay [*nom timoun nan*] premye let ou?
 1. Tou swit apre akouchman
 2. Apre nou te ba'l lok la
 3. Lot (*presize*): _____
- 1.16. Ki sa yon fanm ki fek akouche ka fe pou let li monte? (*Plizye repons posib. Endike tout reponse li bay.*)
 1. Konmanse bay li tete tou swit apre akouchman-an.
 2. Evite bay timoun nan bwe nan bibwon.
 3. Tete souvan pou fose tete li fe plis let.
 4. Byen swen (*okipe*) tete e bout tete-l-yo.
 5. Mange militon
 6. Lot (*presize*): _____
 9. Pa konnen
- 1.17. Ki le yon manman ta dwe konmanse bay timoun-li lot manje (pandan timoun-nan toujou nan tete)?
 1. Anvan kat (4) mwa.
 2. Kat (4) a sis (6) mwa.
 3. Apre sis (6) mwa ou anko pita.
 9. Pa konnen

1.18. Dapre ou, konbyen fwa nan jounen ou dwe bay manje/soutnike yon timoun ki genyen 2 zan jiska 5 an? (*Sevi ak dwet ou pou konte si manman pa kap di yon chif.*)

- 1. Youn fwa
- 2. De ou twa fwa
- 3. Kat ou cinq fwa
- 9. Pa konnen

1.19. Ki manje ki bon pou pwoteje zye timoun nan? (*Plizye repons posib.*)

- 1. Legim fey vet.
- 2. Fwi ke genyen koule jonn/zoranj (tankou mang, papay)
- 3. Legim ki genyen koule jonn/zoranj (tankou joumon, kawot)
- 4. Vyann (nenpot kalite) e pwason
- 5. Let tete
- 6. Jonn ze
- 7. Lot (*presize*): _____
- 9. Pa konnen

SEKSYON 2. SWIVI KWASANS TIMOUN

2.1. Eske [*nom timoun nan*] genyen yon kat chemen sante ou kat RICHES?

- 1. Wi (*Fok ou we kat-la*)
- 2. Non ==> *Pase nan kesyon 2.5*
- 3. Kat la pedi ==> *Pase nan kesyon 2.5*

2.2. *Gade kat chemin sante timoun-nan, epi ekri ranseyman sa yo: eske timoun-an te pese nan denye twa (3) mwa (setadi, eske yo te pran pwa-li nan denye twa (3) mwa)?*

- 1. Wi
- 2. Non

2.3. *Eske sou kat la, yo te ekri dat timoun-an te resevwa yon grenn vitamin A?*

- 1. Wi
- 2. Non ==> *Pase nan kesyon 2.5*

2.4. *Si wi, ekri tout dat yo timoun an te resevwa yon grenn Vitamin A:*

jou mwa ane

1e _____ / _____ / _____

2em _____ / _____ / _____

3em _____ / _____ / _____

4em _____ / _____ / _____

2.5. Poukisa li empotan pou timoun gagnye pwa?

[] 1. Pou pa fe malnitrisyon

[X] 2. Pou rete nan bon sante

[] 3. Lot (*presize*): _____

[] 9. Pa konnen

SEKSYON 3. MALADI DYARE

3.1.a Eske [*non timoun-nan*] te genyen dyare nan 2 denye semen ki sot pase-yo?

[] 1. Wi ==> *Pase nan kesyon 3.2*

[X] 2. Non ==> *Pase nan kesyon 3.8*

[] 9. Pa konnen ou pa songe ==> *Pase nan kesyon 3.8*

3.1.b Eske [*non timoun-nan*] te genyen dyare nan 4 semenn ki sot pase yo?

[] 1. Wi ==> *Pase nan kesyon 3.2*

[] 2. Non ==> *Pase nan kesyon 3.8*

[] 9. Pa konnen ou pa songe ==> *Pase nan kesyon 3.8*

3.2. Pandan [*non timoun-nan*] te genyen dyare, eske ou (*Li pou manman repons ki anba-yo, e pwi, cheke repons la manman bay la*):

[] 1. Te bay li tete pliske dabitid?

[] 2. Te bay li tete kom dabitid?

[] 3. Te bay li tete mwens ke dabitid?

[] 4. Te sispann ba li tete?

[] 5. Timoun-nan pa te nan tete.

3.3. Pandan [*non timoun-nan*] te genyen dyare, eske ou (*Li pou manman repons ki anba-yo, e pwi, cheke repons la manman bay la*):

[] 1. Te bay li bwe lot bagay pliske dabitid?

[] 2. Te bay li bwe lot bagay kom dabitid?

[] 3. Te bay li bwe lot bagay mwens ke dabitid?

[] 4. Te sispann ba li bwe lot bagay?

[] 5. Timoun-nan konn tete selman.

3.4. Pandan [*non timoun-nan*] te genyen dyare, eske ou (*Li pou manman repons ki anba-yo, e pwi, cheke repons la manman bay la*):

[] 1. Te bay li manje lot bagay pliske dabitid?

[] 2. Te bay li manje lot bagay kom dabitid?

[] 3. Te bay li manje lot bagay mwens ke dabitid?

[] 4. Te sispann ba li manje lot bagay?

[] 5. Timoun-nan konn tete selman.

3.5. Le [non timoun-nan] te genyen dyare, ki sa ou te fe pou li? (Plisye repons posibl.)

- 1. Anyen, oken
- 2. Sewom oral ak sache
- 3. Sewom lakay
- 4. Diri ak karot, dlo diri, ou bouwi lanmidon
- 5. Te, rafrechi
- 6. Medikaman pou dyare
- 7. Lot (presize): _____

3.6. Le [non timoun-nan] te genyen dyare, eske ou te cheche konsey ou tretman nan men yon lot moun?

- 1. Wi
- 2. Non ==> Pase nan kesyon 3.8

3.7. Si wi, ki moun? (Plisye repons posib. Endike tout repons li bay.)

- 1. Lopital
- 2. Sant sante/dispanse/Miss
- 3. Pos rasambleman-RICHES
- 4. Lot pos rasambleman
- 5. Ajan sante kominote
- 6. Dokte fey
- 7. Houngan
- 8. Matron
- 10. Paran, fanmi, zanmi
- 11. Lot moun (presize): _____

3.8. Si [non timoun-nan] ta genyen dyare-a, ki lot bagay (siy) ki ta fe ou al cheche konsey ou tretman/remed nan men yon lot moun? (Plisye repons posib. Endike tout repons li bay.)

- 1. Vonmisman
- 2. Lafyev
- 3. Bouch sech, je antre, pa pipi (dezidratasyon)
- 4. Dyare ki dire lontan (14 jou ou plis)
- 5. San nan wate timoun-nan
- 6. Pa vle manje
- 7. Febles, fatig
- 8. Lot (presize): _____
- 9. Pa konnen

3.9. Dapre ou, ki sa ki enpotan pou yon manman fe le dyare-a fin pase? (Plisye repons posib. Endike tout repons li bay.)

- 1. Bay timoun-an manje manje ki pi piti men plizye fwa pa jou.
- 2. Bay timoun-an manje pliske dabitid.
- 3. Bay timoun an manje ki chaje ak eneji.
- 4. Bay timoun an plis likid (jis, dlo, eks)
- 5. Lot (*presize*): _____
- 6. Bay timoun plis likid _____
- 9. Pa konnen

3.10. Dapre ou, ki sa ou kapab fe pou [*non timoun-nan*] pa genyen dyare? (Plisye repons posibl.)

- 1. Bwe dlo pwop
- 2. Pa bay li bibwon
- 3. Pwoteje manje pou kembe li pwop
- 4. Lot (*presize*): _____
- 9. Pa konnen

SEKSYON 4. MALADI BWONCH

4.1.a Eske [*non timoun-nan*] gripe, ap touse, gen nen-l bouche nan 2 denye senmen ki sot pase-yo?

- 1. Wi
- 2. Non
- 9. Pa konnen

4.1.b Eske [*non timoun-nan*] te gripe, te touse, te gen nen-l bouche nan 4 denye semen ki sot pase yo?

- 1. Wi
- 2. Non ==> *Pase ne kesyon 4.5*
- 9. Pa konnen

4.2. Eske [*non timoun-nan*] te soufle an le li te gripe a?

- 1. Wi
- 2. Non ==> *Pase nan kesyon 4.5*
- 9. Pa konnen ==> *Pase nan kesyon 4.5*

4.3. Eske ou te cheche konsey ou tretman le [*non timoun-nan*] te malad?

- 1. Wi
- 2. Non ==> *Pase nan kesyon 4.5*

4.4. Ki kote ou te ale? (Plisye repons posib. Endike tout repons li bay.)

- 1. Lopital
- 2. Sant sante/dispanse/Miss
- 3. Pos rasambleman-RICHES
- 4. Lot pos rasambleman
- 5. Ajan sante kominote
- 6. Dokte fey
- 7. Houngan
- 8. Matron
- 10. Paran, fanmi, zanmi
- 11. Lot moun (*presize*): _____

4.5. Le [*non timoun-nan*] gripe, ki sak fe ou kouri kay dokte avek li? (Plisye repons posib. Endike tout repons li bay.)

- 1. Li pran souf rapid ou ak difikilte
- 2. Tout zo nan kot-li paret le li rale souf-li
- 3. Pa gen apeti, pa vle manje
- 4. Tous, gripe, rimn
- 5. Lot (*presize*): _____
- 6. Li pa ale oken kote ak timoun nan
- 7. li pa jam gripe
- 9. Pa konnen

SEKSYON 5. VAKSINZSYON / IMINIZASYON

5.1. Eske [*non timoun-nan*] konn pran vaksen?

- 1. Wi
- 2. Non
- 3. Pa konnen

Si wi, Ki vaksen li pran

BCG	_____	/	_____	/	_____
Roujol	_____	/	_____	/	_____
DTP1	_____	/	_____	/	_____
DTP2	_____	/	_____	/	_____
DTP3	_____	/	_____	/	_____
Polio 1	_____	/	_____	/	_____
Polio 2	_____	/	_____	/	_____
Polio 3	_____	/	_____	/	_____

5.2. Dapre ou, poukisa yon fanm ki ansent bezwen pran vaksen?

- 1. Pou pwoteje manman ak bebe k' ap fet la kont tetanos/ko red
- 2. Pou pwoteje manman an (selman) kont ko red
- 3. Pou pwoteje bebe k' ap fet la (selman) kont ko red
- 4. Lot (*presize*): _____
- 9. Pa konnen

5.3. Konbyen piki vaksen tetanos yon fanm ansent bezwen pran pou pwotege bebe k' ap fet la kont ko red/tetanos?

- 1. Youn
- 2. De
- 3. Pliske de
- 4. Oken
- 5. Pa konnen

5.4. Eske ou kapab di mwen poukisa timoun ta dwe pran tout doz vaksen-l?

- 1. Pou li vaksinen net
- 2. Pou li pwoteje kont maladi yo
- 3. Lot (*presize*): _____
- 9. Pa konnen

5.5. A ki laj [*nom timoun an*] dwe pran vaksen woujeol a? *Presize en mwa*: 7 99 Pa konnen _____

5.6. Ki kote ou ka ale pou vaksine timoun ou oubyen ou-mem? (*Plisye repons posib. Endike tout repons li bay.*)

- 1. Lopital
- 2. Sant sante/dispanse/Miss
- 3. Pos rassembleman-RICHES
- 4. Lot pos rassembleman
- 5. Ajan sante kominote
- 6. Dokte fey
- 7. Houngan
- 8. Matron
- 10. Paran, fanmi, zanmi
- 11. Lot (*presize*): _____
- 9. Pa konnen

SEKSYON 6. SWEN MATENEL

6.1. Eske ou ansent kounye-a?

- 1. Wi
- 2. Non
- 9. Pa konnen

6.2. Eske ou ta vle kanpe sou fe timoun nan 2 zan kap vini yo?

- 1. Wi
- 2. Non
- 9. Pa konnen

6.3. Kombyen timoun w'ap okipe kounye'a? (*Presize*) 3

6.4. Kombyen timoun la'dan yo ki pou ou? (*Presize*) 2

6.5. Apre (*nom timoun-an*) te fet, kombyen tan ou te tann ke ou avan rekomanse relasyon ak mesye-ou? (*Presize tan an semen*): 6 Pa aplikab _____

6.6. Apre yon fanm aprann ke li ansent, ki le li ta dwe we yon dokte, miss ou fanm saj pou prenmye fwa? (*Presize mwa nan gwoses la.*)

- 1. Nan premye twa (3) mwa
- 2. Nan mitan gwoses-la (4em, 5em ou 6em mwa)
- 3. Nan denye twa (3) mwa gwoses-la (7em, 8em our 9em mwa)
- 4. Pa jann bezwen we yon dokte, enfimye ou fanm saj
- 9. Pa konnen

6.7. Ki manje ki bon pou fanm ansent? (Plisye repons posib)

- 1. Ze
- 2. Pwason
- 3. Vyann
- 4. Legim, fey vet ki chaje ak fe
- 5. Diri
- 6. Mayi
- 7. Pitimi
- 8. Pwa (tout kalite)
- 9. Pa konnen

6.8. Pandan ou te ansent [nom timoun an], eske ou (*Li pou manman repons ki anba-yo, e pwi, cheke repons la manman bay la*):

- 1. Te manje pliske dabitid?
- 2. Te manje kom dabitid?
- 3. Te manje mwens ke dabitid?
- 9. Pa konnen ou pa songe

6.9 Dapre ou, eske yon fanm ansent dwe pese plis pandan gwoses li?

- 1. Wi
- 2. Non
- 9. Pa konnen

6.10 Kombyen pwa li dwe pran pendan gwossès la? *Presize:* _____ Kgs PK

6.10a Eske ou te konn ale swiv pwogwam pou fanm ansent lè ou te ansent [non timoun-nan]

- 1. Wi
- 2. Non
- 9. Pa aplikab

6.11. Ki kote ou te ale swiv pwogwam fanm ansent? (*Plisye repons posib. Endike tout repons li bay.*)

- 1. Lopital
- 2. Sant sante/dispanse/Miss
- 3. Pos rasambleman-RICHES
- 4. Lot pos rasambleman
- 5. Ajan sante kominote
- 6. Dokte fey
- 7. Houngan
- 8. Matron
- 10. Paran, fanmi, zanmi
- 11. Lot (*presize*): _____
- 9. Pa konnen

6.12. Kiles ki te koupe e mare lombrik [*nom timoun-nan*]?

- 1. Ou-menm ==> *Pase nan kesyon 6.15*
- 2. Youn moun nan fanmi-ou ==> *Pase nan kesyon 6.15*
- 3. Matron ==> *Pase nan kesyon 6.13*
- 4. Dokte, enfimye, ou Fanm-saj nan matenite ==> *Pase nan kesyon 6.15*
- 5. Lot (*Presize*): _____ ==> *Pase nan kesyon 6.15*
- 9. Pa konnen ==> *Pase nan kesyon 6.15*

6.13. Kouman matron-an rele? Ti Mafi

6.14. Ki kote li rete? La Ferme

6.15. Ki sa ou ak matron te prepare pou akouchman an? (*Plisye repons posib. Endike tout repons li konnen.*)

- 1. Razwa esteril ki pa jamn itilize
- 2. Chifon pwop
- 3. Savon
- 4. Dlo bouyi
- 5. Lot (*presize*): _____
- 6. Anyen
- 9. Pa konnen

6.16. Eske ou ka bay nom tout metod planin ou konnen? (*Plisye repons posib. Endike tout repons li konnen.*)

- | | | | |
|-------------------------------------|-----------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> | 1. Ligati / Rete net pou fi | <input type="checkbox"/> | 8. Bay tete |
| <input checked="" type="checkbox"/> | 2. Noplan / Piki 5 an | <input type="checkbox"/> | 9. Metod almanak ou gle sevical |
| <input checked="" type="checkbox"/> | 3. Piki 2 mwa / Piki 3 mwa | <input type="checkbox"/> | 10. Pa fe bagay menm |
| <input type="checkbox"/> | 4. Filaman / esterile | <input type="checkbox"/> | 11. Mesye retire anvan li voye |
| <input type="checkbox"/> | 5. Diafram | <input type="checkbox"/> | 12. Vasektomi/rete net pou mesye |
| <input checked="" type="checkbox"/> | 6. Kapot | <input checked="" type="checkbox"/> | 13. Grenn planin |
| <input type="checkbox"/> | 7. Jel, krem vajinal | | |

6.17. Eske ou te janm tande pale lot metod m'ap di ou kounye-a? (*Li pou manman lis metod yo. Si li di li te tande pale yon metod, endike li.*)

- | | | | |
|-------------------------------------|-----------------------------|-------------------------------------|----------------------------------|
| <input checked="" type="checkbox"/> | 1. Ligati / Rete net pou fi | <input type="checkbox"/> | 8. Bay tete |
| <input checked="" type="checkbox"/> | 2. Noplan / Piki 5 an | <input checked="" type="checkbox"/> | 9. Metod almanak ou gle sevical |
| <input type="checkbox"/> | 3. Piki 2 mwa / Piki 3 mwa | <input type="checkbox"/> | 10. Pa fe bagay menm |
| <input type="checkbox"/> | 4. Filaman / esterile | <input checked="" type="checkbox"/> | 11. Mesye retire anvan li voye |
| <input type="checkbox"/> | 5. Diafram | <input type="checkbox"/> | 12. Vasektomi/rete net pou mesye |
| <input checked="" type="checkbox"/> | 6. Kapot | <input checked="" type="checkbox"/> | 13. Grenn planin |
| <input type="checkbox"/> | 7. Jel, krem vajinal | | |

6.18. Si ou vle fe planin, ki kote ou ka ale pou jwen li? (*Plisye repons posib. Endike tout repons li bay.*)

- | | |
|-------------------------------------|---------------------------------------|
| <input checked="" type="checkbox"/> | 1. Lopital |
| <input checked="" type="checkbox"/> | 2. Sant sante/dispanse |
| <input type="checkbox"/> | 3. Pos rassembleman-RICHES |
| <input checked="" type="checkbox"/> | 4. Lot pos rassembleman |
| <input type="checkbox"/> | 5. Ajan sante kominote |
| <input type="checkbox"/> | 6. Dokte fey |
| <input type="checkbox"/> | 7. Houngan |
| <input type="checkbox"/> | 8. Matron |
| <input type="checkbox"/> | 10. Paran, fanmi, zanmi |
| <input type="checkbox"/> | 11. Lot moun (<i>resize</i>): _____ |

6.19. Eske w'ap fe planin? Setadi, eske w'ap fe yon jan pou anpeche ou pa tonbe ansent?

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> | 1. Wi |
| <input checked="" type="checkbox"/> | 2. Non => <i>Pase nan kesyon 6.21</i> |

6.20. Ak ki metod planin ou-mem oubyen mesye-ou sevi?

- | | | | |
|--------------------------|----------------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | 1. Ligati / Rete net pou fi | <input type="checkbox"/> | 8. Bay tete |
| <input type="checkbox"/> | 2. Noplan / Piki 5 an | <input type="checkbox"/> | 9. Metod almanak ou gle sevical |
| <input type="checkbox"/> | 3. Piki 2 mwa / Piki 3 mwa | <input type="checkbox"/> | 10. Pa fe bagay menm |
| <input type="checkbox"/> | 4. Filaman / esterile | <input type="checkbox"/> | 11. Mesye retire anvan li voye |
| <input type="checkbox"/> | 5. Diafram | <input type="checkbox"/> | 12. Vasektomi/rete net pou mesye |
| <input type="checkbox"/> | 6. Kapot | <input type="checkbox"/> | 13. Grenn planin |
| <input type="checkbox"/> | 7. Jel, krem vajinal | | |
| <input type="checkbox"/> | 14. Lot (<i>resize</i>): _____ | | |

6.21. Eske nan pase ou-menm oubyen mesye ou te konn sevi ak yon lot kalite metod planin?

1. Wi
 2. Non \implies *Pase nan kesyon 6.23*

6.22. Ak ki metod ou te konn sevi? (Plisye repons posib)

- | | |
|--|---|
| <input type="checkbox"/> 1. Ligati / Rete net pou fi | <input type="checkbox"/> 8. Bay tete |
| <input type="checkbox"/> 2. Noplan / Piki 5 an | <input type="checkbox"/> 9. Metod almanak ou gle sevical |
| <input type="checkbox"/> 3. Piki 2 mwa / Piki 3 mwa | <input type="checkbox"/> 10. Pa fe bagay menm |
| <input type="checkbox"/> 4. Filaman / esterile | <input type="checkbox"/> 11. Mesye retire anvan li voye |
| <input type="checkbox"/> 5. Diafram | <input type="checkbox"/> 12. Vasektomi/rete net pou mesye |
| <input type="checkbox"/> 6. Kapot | <input type="checkbox"/> 13. Grenn planin |
| <input type="checkbox"/> 7. Jel, krem vajinal | |

6.23. Dapre ou, ki jan yon moun kapab trape fyev malarya? (Plisye repons posib)

1. Moustik
 2. Dlo
 3. Lot (*presize*): _____
 9. Pa konnen

6.24. Ki jan yon moun kapab fe pou pa trape fyev malarya? (Plisye repons posib)

1. Pwoteje kont moutik
 2. Sevi ak moustike le nou domi
 3. Seche tout ma dlo
 4. Lot (*presize*): _____
 9. Pa konnen

6.25. Ki kote ou ka ale si ou panse ou te trape fyev malarya? (*Plisye repons posib. Endike tout repons li bay.*)

1. Lopital
 2. Sant sante/dispanse
 3. Pos rasambleman-RICHES
 4. Lot pos rasambleman
 5. Ajan sante kominote
 6. Dokte fey
 7. Houngan
 8. Matron
 10. Paran, fanmi, zanmi
 11. Lot (*presize*): _____

SEKSYON 7. SIDA

7.1. Eske ou konn tande pale de maladi yo rele sida?

- Wi
 Non ==> *Remesye madam-an pou tan li te pran pou koze avek ou a.*

7.2. Ki jan dapre ou yon moun kapab trape maladi SIDA? (Plisye repons posib)

1. Relasyon avek yon gason ki genyen sida
 2. Moustik
 3. Pwostitiye yo
 4. Mesye ou fi ki vagabond
 5. Yo voye mo
 6. Sering sal
 7. Lot (*presize*): _____
 9. Pa konnen

7.3. Dapre ou kijan yon moun kapab fe pou li pa trape maladi SIDA? (Plisye repons posib)

1. Rete ak youn sel mesye
 2. Sevi ak capot
 3. Ale kay houngan
 4. Lot (*presize*): _____
 9. Pa konnen

7.4. Eske ou panse ou kapab trape SIDA?

1. Wi
 2. Non
 9. Pa konnen

7.5. Ki kote ou ka ale si ou panse ou te trape SIDA? (*Plisye repons posib. Endike tout repons li bay.*)

1. Lopital
 2. Sant sante/dispanse
 3. Pos rassembleman-RICHES
 4. Lot pos rassembleman
 5. Ajan sante kominote
 6. Dokte fey
 7. Houngan
 8. Matron
 10. Paran, fanmi, zanmi
 11. Lot (*presize*): _____
 11.1 Pa genyen tretman
 11.2 Rete tan lamò
 11.3 Ap mouri

SEKSYON 8.
PATISIPASYON NAN AKTIVITE PWOJE-A

- 8.1 Eske ou o kouran de aktivite proje CARE-RICHES nan zòn nan?
 1. Wi
 2. Non
- 8.2 Eske ou konn asiste presantasyon sou koze la sante pwoje-a konn fè nan zòn nan?
 1. Wi (*Pase nan seksyon 8.4*)
 2. Non
- 8.3 Eske ou konn asiste nan jounen vaksinasyon nan pos pos RICHES?
 1. Wi (*Pase nan seksyon 8.4*)
 2. Non
- 8.4 Pouki sa:
_____ *ya Pa invite m* _____

- 8.5 Pandan 3 lane ki sot pase la, kombyen fwa ou asiste presantasyon sa yo? _____
- 8.6 Ki kote ou konn asiste prezantasyon sa yo? (Plisye repons posib)
- 1. Legliz
 - 2. Gagè
 - 3. Mache
 - 4. Lekol
 - 5. Pos rasanbleman
 - 6. Kombit
 - 7. Klinik
 - 8. Lot, Precize _____
 - 9. Pa konnen

Remesye madam-an pou tan li te pran pou koze avek ou a.