

World Vision Relief & Development Inc.

**MIDTERM EVALUATION REPORT
LA GONAVE CHILD SURVIVAL PROJECT
LA GONAVE ISLAND, HAITI**

**Beginning Date: October 1, 1991
Ending Date: September 30, 1994**

Submitted to:

**Child Survival and Health Division
Office of Private and Voluntary Cooperation
Bureau of Food and Humanitarian Assistance
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TABLE OF CONTENTS

	Page No.
EXECUTIVE SUMMARY	1
I. INTRODUCTION	2
A. Background	2
B. Project Staff and Activities	2
H. ACCOMPLISHMENTS	3
. Measurable Inputs and Outputs	3
B. Midterm Survey	4
III. HEALTH INFORMATION SYSTEM	8
Iv. SUSTAINABILITY	9
A. Community Participation	10
B. Transfer of Knowledge	11
V. CONCLUSIONS	12
VI. RECOMMENDATIONS	13
ANNEXES	
I. Team and Clusters	
II. Auxiliaires and Sections	
III. Committees and Their Presidents	
IV. Protocol and Forms	
V. Survey Questionnaires	

EXECUTIVE SUMMARY

In October 1987, World Vision Haiti began implementation of a Child Survival Project (CSP) on the island of La Gonave, Haiti. A final evaluation of the initial grant was conducted in September 1991. At that time, the evaluation team had been “pleasantly surprised that in the midst of many difficulties and uncertainties so much could have been accomplished in such a short time” and recommended that World Vision apply for a subsequent grant.

In October 1991, World Vision Relief & Development (WVRD) received a \$379,721 three-year grant from USAID to continue implementation of this CSP, with a match of \$248,247 from WVRD. A midterm evaluation of the second funding phase was conducted in September 1993 to measure the impact of the CSP during the last two years and to make appropriate recommendations to improve the quality of services offered to the population of La Gonave. The team was composed of representatives from the Ministry of Health (MOH) and Save the Children (a PVO working in child survival), an external evaluator, and a World Vision health associate.

From August 25 to September 10, 1993, the team evaluated the progress of the project, using the following tools: (a) a 30-cluster sample survey; (b) interviews with the health committees, project staff, and staff from other PVOs on the island; and (c) semistructured focus groups.

Portions of this report were written by Gretchen Berggren, M.D., M. Sc. Hyg. (consultant); Fayla D. Lamothe, M.D. (coordinator); and Charlene L. Hecldivert, M.A. (assistant for tabulation and analysis).

Overall, the evaluation team concluded that the project has made exceptional progress and accomplished much more than expected given extremely difficult circumstances. Many end-of-project objectives have already been obtained. Among the many noteworthy achievements are antigen-specific coverage rates near 80 percent; ORT use rate during episodes of childhood diarrhea of nearly 70 percent; 73 percent coverage of children with Vitamin A capsules in the past four-month period; nearly 80 percent of children gaining weight over two successive weighings; 88 percent use of colostrum; 81 percent of pregnant women making at least one ANC visit; and 64 percent tetanus coverage.

Key recommendations focused on intensifying measles immunizations for all children; revising the HIS; developing the nutrition intervention further; and increasing community participation through health and development committees.

I. INTRODUCTION

A. Background

The Child Survival Project (CSP) of World Vision Haiti (WVH) is located on the island of La Gonave, 30 kms west of Port-au-Prince, the capital city of Haiti. The project initially started in October 1987 and later received an extension of three years from October 1991 to September 1994.

Nearly 80,000 people (of which approximately 40 percent are children under five years and women of childbearing age) live on La Gonave. The island covers an area of 855 kms² but has no rivers or lakes. Once fertile and covered by rich forests, La Gonave has suffered greatly from the practice of charcoal-making. Its many mountains have naked slopes, and the island is now mostly arid. La Gonave has been largely forgotten by the country's governments, mainly because of its remote geographical location.

Many private organizations have helped to address the abundant needs of the island through the years-**The Wesleyan Mission**, which has the sole hospital on the island; **Church World Services**, which has helped with the creation of roads through a "food for work" program; and the **Episcopal and Catholic churches**, which manage a number of schools and dispensaries. World Vision became involved on La Gonave in 1976 with a child sponsorship program. In 1987, a CSP financed in part by **USAID** and intended to serve the entire island was initiated. Due to a number of logistical difficulties, the project was scaled back in 1989 to cover seven of the 11 sections of the island. During the extension phase (1991-1994), the project service area has once again been expanded to cover the whole island.

B. Project Staff and Activities

The project's main interventions (including EPI, control of diarrheal diseases, nutrition promotion and growth monitoring, maternal care, and management of acute respiratory infections) are carried out by a team consisting of a coordinator, an administrator, seven auxiliary nurses, 11 health and development committees, 100 health agents (agents de **santé**, or ADS), and 800 mother health assistants (**MHAs**) and traditional birth attendants (matrones).

World Vision has employed a nurse-auxiliary in seven of the 11 sections of La Gonave. In the remaining four, the Government of Haiti's Ministry of Health, the "**Ministère de la Sante Publique et de la Population**" (MSPP), has placed a government auxiliary who supervises his section as well as three adjacent ones. The nurse auxiliaries are responsible for training and supervising the community health committees and health agents in all 11 sections.

The health agents serve as resident home visitors, family trainers, and health information reporters. They are responsible for immunizing children, growth monitoring, and supervising the nutrition surveillance program, which also includes

distribution of Vitamin A. Each ADS is meant to cover about 30 households, but in fact, given the size of the population on La Gonave, each ADS is probably covering about 130 families, living in perhaps 100 households. Consequently, World Vision has distributed health agents in such a way that there are about nine per zone.

Trained by the nurse auxiliaries, each ADS has identified, recruited, and trained at least 20 volunteer MHAs, and more are expected to be trained soon. The role of the MHA is to provide motivation to mothers for attending immunization and growth monitoring/counseling sessions; to encourage breast-feeding; to promote the use of trained birth attendants (TBAs); and to reinforce teaching about oral rehydration therapy (ORT).

II. ACCOMPLISHMENTS

A. Measurable Inputs and Outputs

According to monthly reports based on collections of longitudinal service data, the project has achieved the following from October 1, 1991 through August 31, 1993:

Input Indicators	FY92	FY93
No. of rally posts held	626	919
Avg. no. of children 0-11 months seen each month	734	889
Avg. no. of pregnant women seen each month	185	284
Avg. no. of WCBA seen each month	391	541
No. of training sessions:		
Vitamin A	270	110
CDD/ORT	47	127
Nutrition/Breast-feeding	365	28
Family Planning	35	61
ARI	--	27
Use of Health Cards	--	22
Health worker evaluations conducted	N/A	17
No. of Vitamin A capsules distributed to:		
Children 6-89 months (4th doses)	17,183	N/A
Postpartum mothers	710	N/A
No. of contraceptives provided:		
Cycles	2,134	1,340
Condoms	4,544	5,272
Injections	200	606
Health committee meetings held	173	159

Output Indicators	FY92	FY93
No. of children 0-11 months receiving:		
BCG		
OPV3	2,136	2,370
DPI-3	1,644	2,612
Measles	1,241	2,794
Fully immunized	1,261	1,524
	1,199	1,406
No. vaccinated with TT2:		
Pregnant women	619	1,072
WCBA	1,301	2,808
No. given training/education':		
Matrones	652	418
MHAs	829	4,136
Health Agents	440	548
Schoolchildren	N/A	3,810
Teachers	N/A	212
No. of new family planning clients	624	765

* Totals may include double-counting.

These indicators illustrate the significant progress which has been made by the project between FY92 and FY93.

B. Midterm Survey

To further gauge the impact of the project since October 1991, a survey was conducted as part of the midterm evaluation. The survey was conducted over a two-day period (September 1-2, 1993).

1. Methodology

The survey questionnaire included 18 questions and was addressed to seven mothers in each of 30 clusters spread throughout the entire island (see Annex V). It focused on immunization coverage, nutritional status, Vitamin A distribution, feeding/veaning practices, mothers' understanding of the "Road-to-Health" growth-monitoring record, and practices during episodes of diarrhea, respiratory infection, or fever suspected to be malaria.

The 30 interviewers for the survey were chosen from the cadre of volunteer health agents; the best emerged through a training activity and were divided into 15 teams of two each (see Annex I). Four supervisors monitored the activities of the teams during the survey.

Thirty clusters were chosen according to standard WHO-recommended cluster-sampling techniques. Two samples were chosen, including (1) 30 clusters of seven children 12-23 months of age, and (2) 30 clusters of seven children 24-83 months of

age. Different information was collected from each sample (see Annex V); for example, immunization data was collected only for the first sample.

Results were entered into a computer using EPI-INFO software, then tabulated, analyzed, and interpreted. The evaluation team as a whole, including the investigators who conducted the survey, met to discuss the results and compare them with the baseline survey.

2. *Survey Findings*

Overall, the survey revealed that the women who have been involved with the child survival activities have received appropriate attention and education from health personnel at all levels. This is reflected in their increased knowledge and improved practices.

a. *Immunization*

In 1991, the baseline survey showed 53 percent coverage overall in the 11 rural sections covered by World Vision on La Gonave. In collaboration with government health teams serving the area, the project has sought to improve coverage to meet the second-year objective of 70 percent fully immunized and 90 percent coverage for individual vaccines.

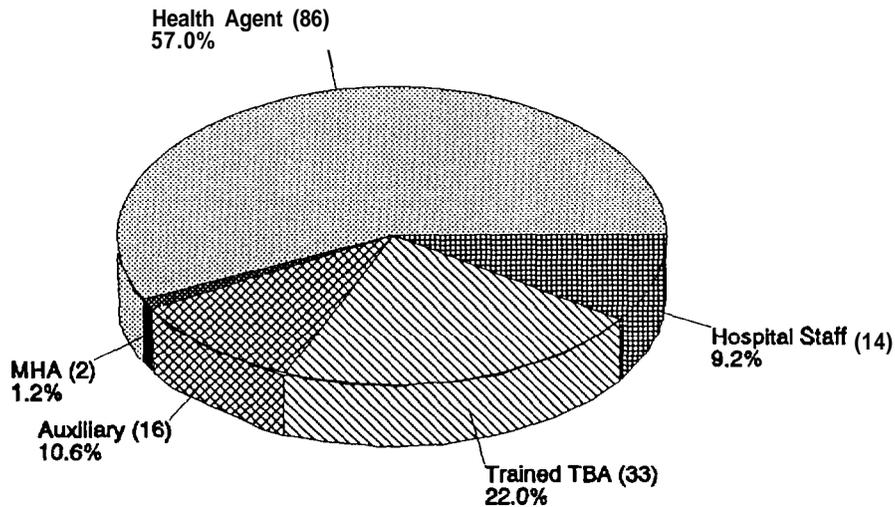
The survey revealed that 139 of 200 children aged 12-23 months (69.5 percent) were completely vaccinated. A completely vaccinated child was defined as one who had received all eight doses of vaccine (BCG, three doses of polio and DPT, and measles), appropriately timed according to the norms of the Haitian Ministry of Health (MSPP). Vaccination coverage by individual antigen was near 80 percent for all vaccines. It is notable that only 22 percent lacked measles vaccination, since measles caused a serious epidemic elsewhere in Haiti where coverage rates were often less than 50 percent. Measles coverage is a particular challenge; xerophthalmia, which often follows measles epidemics, remains a major cause of blindness in children in Haiti.

This result shows substantial improvement over the 1991 survey, when a full coverage rate of 53 percent was found. Though it falls short of the objective, it must be remembered that the project has been operating under the economic embargo, and fuel and supply shortages have been common. Political turmoil has restricted staff mobility while at the same time resulting in increased movement of the target population and attrition of community-based health workers.

Despite the mobility of women and children, 86 percent of children in the sample had only one vaccination card, indicating that they had not *gone* from provider to provider, or that if that were the case, the providers had coordinated their activities and used the same card. This shows good training at all levels, including that for mothers who must carry the cards.

b. *Vitamin A*

Only seven percent of children in the sample had received no Vitamin A in the year preceding the survey, and 73% had received capsules in the past four month period (the FY93 target was 65 percent). The team noted that among women vaccinated for tetanus, 72 percent also received a post-partum dose of Vitamin A within one month of having given birth. The capsules were received from a variety of sources, as shown below:



Project staff members also take this opportunity to provide the newborn with BCG and to remind the mother of the date when she should bring her child for the first DPT and polio vaccinations. This strategy promotes positive ongoing contact with project providers.

Questions regarding the child's diet revealed that 97.6 percent of mothers were giving their child fruits and vegetables containing Vitamin A; 61 percent reported providing such foods three times or more each week.

c. *Growth Monitoring and Nutrition*

During the survey, children in the sample were not weighed, but their "Road-to-Health" card was examined to determine the regularity of growth monitoring and to gain an understanding of general nutritional status.

About 25 percent of the children had not been weighed during the period from October 1992 to July 1993, according to the home-based records of mothers. Another 28 percent had been weighed only once during this period, many of these during the month of July, when a food distribution program started. Weighing of newborns and pregnant women has not yet been initiated. Thus, the goal of weighing 75 percent of children 0-5 years at least four times annually (as stated in the DIP) has proven difficult to meet.

The Gomez classification for the 288 children who had been recently weighed was reported as follows:

Normal weight for age	28%
First degree malnutrition	53%
Second degree malnutrition	18%
Third degree malnutrition	1%

The lower-than-expected numbers of children classified with second or third degree malnutrition may reflect that the distribution did not include those children who were not weighed recently or whose weight was otherwise unavailable. It may also reflect the success of the food distribution program for the poorest families.

Of those children who had been weighed more than one time (177 of the 288), 79 percent had gained weight in the most recent weighings. The FY93 target was set at 40 percent.

According to respondents, the use of colostrum is now highly accepted: 88 percent claimed they gave colostrum to their newborns rather than discarding it. The 12 percent who denied their newborns the benefit of colostrum were not asked why. There is a need to train more traditional birth attendants in this area.

a! *CDD*

The survey (which was conducted at the beginning of the rainy season) revealed a 32 percent incidence of diarrheal episodes. Sixty-nine percent of the mothers whose child had had diarrhea in the last two weeks reported that they provided the child with ORS made from a packet. Nine percent said they made sugar-salt solution.

Feeding practices during the episodes of diarrhea were found to be generally positive. No mothers said they stopped breast-feeding during the most recent diarrheal episode in their breast-fed infant, and 71 percent of mothers said they increased feeding during their child's diarrhea.

Overall, 13 percent of mothers responded inappropriately with regard to their treatment of the diarrhea. This is a serious concern now that Haiti, like other Latin American countries, may be facing a cholera epidemic.

e. *ALRI*

The team was surprised to learn, given the season, that only 20.4 percent of the mothers said that their child had experienced respiratory illnesses in the past two weeks. Sixty-four percent of the mothers could describe signs and symptoms of serious complications of respiratory infections (the end-of-project objective for this is 70 percent).

Staff members from the project and from other PVOs (the Catholic dispensary at Pte. à Raquette and the Episcopal dispensary) have received 16 hours of training in ALRI (examination and treatment following WHO guidelines). However, staff members at the only referral hospital on the island have not participated in the ALRI training course.

f. Maternal Care

The survey revealed that 81 percent of the mothers made at least one prenatal visit during their most recent pregnancy, and 92 percent of these had received at least one dose of tetanus toxoid (TT). Of the women who had been immunized with TT, 85.6 percent had received at least two doses. Of all women in the sample, then, over 64 percent had received TT2. The end-of-project target, as stated in the DIP, is 80 percent.

All health committees interviewed expressed concern over the lack of services for maternal emergencies and complications of deliveries. They have requested a surgery room to be opened at Ti Palmiste.

The birth spacing component was not addressed during this evaluation, since the project is in the process of starting a family-planning program in collaboration with the Association of Private Health Organizations (AOPS).

Although the project did not plan to have a maternal nutrition component, the new food distribution program now offers supplemental food rations to pregnant and lactating mothers.

g. Malaria

With the assistance of the MOH, the project has trained its staff and 90 health agents in conducting examinations and treating malaria and in community education and environmental prevention activities.

Eighty-one percent of mothers in the survey sample had undergone training on malaria, and nearly all of these could describe symptoms of malaria and methods of preventing malaria. In addition, 92.4 percent of the women who had received training on malaria responded appropriately to questions about treatment of malaria during pregnancy. Among those who were afraid of malaria treatment during pregnancy, one thought antimalarials cause abortion, and another believed antimalarials might cause death.

III. HEALTH INFORMATION SYSTEM

In addition to the information collected in surveys, the project has also established an ongoing data collection system, which is composed of a number of components. The key collectors and reporters of this information are the health agents (ADS).

The project has completed a door-to-door family census, developing a project document known as the “Registre de Ménages ‘87,” from which each ADS was to have derived his/her roster of under-fives for tracking immunization and for nutrition surveillance. Such rosters are supposedly updated continually by the ADS; however, another census for the establishment of the “Registre de Ménages ‘92” served the purpose, instead.

That either the old census missed persons, or that the rosters were not updated, became evident when 20 percent more children showed up for food supplementation than had shown up for immunization. When food became available, therefore, a real update of the rosters could have been achieved. Immigration may be affecting the above situation, as well, perhaps significantly.

Theoretically, vital-event reporting should be possible through this project, using these rosters. Addition of a vital-event reporting system would allow World Vision to calculate pregnancy, birth, and death rates and to document mobility. MHAs could provide information on every pregnant woman and pregnancy outcome, as well as on the status of children being followed up. Deaths could be investigated as part of an early warning system. Such information is badly needed for future planning.

As it is, there are only two points on the island where information about pregnant women and/or pregnancy outcome can be gathered professionally. These are the World Vision center at Ti Palmiste and the Wesleyan Methodist Hospital at Anse-à-Galet. More than 80 percent of mothers who are pregnant are seen at least once during their pregnancies at one of these centers. There, the information kept by the nurse on a record form is partially adequate to meet standard prenatal care norms (blood pressure, weight, fundal height). However, if the mother is referred elsewhere, she would not be expected to take this form with her to the next level of care.

In addition, more than half of the pregnant women are seen at least twice during their pregnancies by a trained TBA. Information on the pregnancy is supposed to be kept by the mother in the form of a pictogram card developed for illiterate TBAs. This instrument is being pretested and is in need of revision. However, it is the closest thing to a home-based pregnancy monitoring form in use in Haiti.

A home-based pregnancy monitoring form has been developed by the MSPP; however, it cannot be filled out or interpreted by illiterate midwives, who deliver more than 80 percent of the babies.

IV. SUSTAINABILITY

The sustainability strategy of the La Gonave CSP focuses on two key elements: community participation, and the transfer of skills and knowledge.

A. Community Participation

1. ZHDCs

One of the main channels through which communities participate in project activities are the health and development committees (ZHDCs). The evaluation team met with representatives from eight committees (see Annex III).

During the last two years, the ZHDCs have strengthened their structure and widened their participation in development activities on the island. The size of the committees varies between nine and 11 members according to the number of zones in the section. They hold elections yearly, although there can be changes made (expulsion or admission of members) during the year.

World Vision staff give the ZHDCs technical and financial support as per written request, and the committees work closely with their respective auxiliary and health agents. In addition to general planning for immunization activities, they have been very active in the census activities, road improvement, health fairs, and the establishment of the food program.

The health committee members interviewed by the evaluation staff were all involved in **IGAs** (see Annex IV). These activities have two main objectives: 1) to produce income which will help to ensure the continuity of the health agents' work (contributing to fees and materials), and 2) to enable people of **La Gonave** to form associations, which can take responsibility for community matters, including health, and manage funds. The members involved in **IGAs** have been trained in management, community development, and interaction with governmental and nongovernmental agencies involved on the island and received one week of training in book-keeping to help with monitoring their financial activities.

The ZHDC members interviewed were confident that current activities can be sustained, but they were also very aware of the needs of their respective sections. In order of priority, these needs are as follows:

- a. A delivery/cesarean section room for Ti Palmiste clinic, to address emergencies related to labor.
- b. Potable water trough cisterns and water catchments.
- c. Latrines for market areas, churches, and schools.
- d. Continuing training in management.
- e. A continued supply of Vitamin A capsules.

2. *The Central Committee of **La Gonuve***

Three representatives of the central committee were interviewed during the course of this evaluation:

- a. Dr. Hunter, medical director of the Wesleyan Church Hospital, who has worked in health and education for 35 years on La Gonave;
- b. Mr. Isnel Angrand, coordinator of Church World Services, an organization which has been working for 26 years on La Gonave in health, agriculture, and alphabetization;
- c. Dr. Florence Dyer, director of the Child Survival Project for World Vision, who has been working in La Gonave for 10 years in education, health, and environment.

According to meeting minutes, the central committee met four times during the last 12 months. Their last meeting was in August 1993, to discuss the food distribution program. Attendance at these meetings, however, is poor-there have been at least two members absent from each meeting. In addition, different people have represented the same organization at different meetings, and this has also hindered the continuity and effectiveness of the committee.

According to those interviewed, meetings are not well planned and proceedings are not documented, since there is no specific person assigned responsibility for these activities. Other difficulties identified by the evaluation team include the following:

- a. The meetings are not planned ahead, and the invitations are short-noticed.
- b. The goals and objectives of the committee are not clearly defined.
- c. The committee does not have an executive staff.
- d. The committee has been accused of interfering with other organizations' activities.

B. Transfer of Knowledge

One hundred health and development agents are now involved in community health activities through the project. They have benefited from continuous training and supervision in such areas as cold chain maintenance, immunization, growth monitoring, Vitamin A, diarrhea control, malaria, acute respiratory infections, basic health care, and health education. Training activities have included the following:

- Fifteen health agents have been sent to an official health agents' training offered in Leogane by NSA (a health training organization), supported by the Episcopal Church and the World Health Organization.
- At least 800 MHAs have been trained by their respective health agents in ORT and growth monitoring.
- One health agent is now studying to become a nurse auxiliary in Port-au-Prince, under sponsorship from the project.
- The health committee members interviewed reported several training sessions during the previous year.

V. CONCLUSIONS

The setting of specific operational objectives seems to have had a propitious effect on personnel at all levels of this project.

Target groups have been reached appropriately. Both the quantity and quality of services has improved, as evidenced by information taken from home-based records, project documents, personnel interviews, and survey responses. The high rate of immunization coverage among children aged 12-23 months may well be the best in rural Haiti for a population of this size.

The project has greatly benefited from its close affiliation with the abundance of churches on La Gonave. Pastors announce immunization/growth-monitoring posts from the pulpit. Some also read the names of children who were absent, which puts peer pressure on mothers to get their children to the next health post. It is a truism that all institutions are important to community health/development. In this case the church, as an institution, has provided an important impetus to community participation.

During its six years on La Gonave, World Vision has obviously succeeded in raising the level of community awareness of health problems facing mothers and children. Inroads have been made on preventive solutions to these problems, and strong bridges have been built to curative services (necessary especially in cases of malaria and respiratory illness in children).

The survey brought out the fact that in certain zones some auxiliaries appear to be more effective than others. Their influence on coverage was a cogent point and one that project directors should act upon now that results are available.

To reach desired 1994 objectives, there remain special challenges. The most serious include the need for improved immunization coverage against measles in the face of an epidemic in Haiti and an intervention to combat malnutrition in children under five years of age. For the latter, World Vision staff have responded appropriately with a short-term solution that has no doubt saved lives: the project began distributing food supplements soon after it was seen that in some areas as many as eight percent of under-fives were classified as having third degree malnutrition based on Gomez standards (less than 60 percent of median *wt/age*). A long-term solution will depend on household food security and family ability to make more food available more often to children in the vulnerable age group.

Another problem may be an increase in tuberculosis, endemic in Haiti, due to the increasing number of AIDS cases throughout Haiti. World Vision works in concert with the Wesleyan Hospital which has long had an effective detection and treatment program for tuberculosis. The World Vision staff should consider giving increased attention to this problem.

The team took particular note of the large number of women pregnant for the first time, as well as the number of women continuing to have pregnancies in their later reproductive

years. Family-planning methods are available at the hospital mentioned above; child spacing could also help families to combat malnutrition.

Auxiliary workers brought up the problem of a lack of receptivity in some mothers who seem difficult to motivate. The characteristics of such beneficiaries not yet reached need some research. Are barriers geographic? Are they due to ignorance regarding available services? Are such mothers overburdened with activities and responsibilities? Are there successful mothers who could reach such women?

The Haitian members of the evaluation team felt that the presence of World Vision staff on La Gonave, obviously beneficial, needs to be continued for some time to come. It will be many years before self-sufficiency can be achieved in such a place.

The project has not been expensive in terms of cost per capita so far (see the pipeline analysis). However, sustainability will need to be addressed in the next phase.

The team noted that when food distribution began, a number of previously undiscovered children appeared. This means that WV needs a way of identifying not only the children who have come at least once to an assembly post, but all children in the project area. Each and every mother-child dyad should be followed. World Vision carried out a census, and the names of all beneficiaries, including those who are as yet unreached, are undoubtedly on these census sheets. Beneficiary rosters could be derived from these sheets for follow-up purposes.

Overall, the team concludes that the problems remaining to be solved are allied to the development of a good information system to find those not yet reached, and to assistance for addressing the problems of underdevelopment, poverty, illiteracy in women, and the increasing mobility of a population under economic duress.

VI. RECOMMENDATIONS

- A. Due to the measles epidemic in the rest of Haiti, World Vision staff should intensify efforts to immunize all children under age one with measles vaccine. Other children up to the age of 15 should also be vaccinated or revaccinated in keeping with **UNICEF/PAHO** recommendation for Haiti. (N.B. In Haiti, measles is now a problem in older children and in previously vaccinated children.)
- B. When improved measles immunization coverage has been achieved, auxiliaries should be trained in the specifics of epidemiological surveillance in accordance with their present activities. They can assist in the establishment of an “early warning” system for the island.
- C. A nutrition intervention other than food supplementation should be developed. Nutrition demonstrations and education may be necessary to convince families of the small sacrifices needed on behalf of their preschool-age children. Many are in need of rehabilitation in order to achieve “catch-up growth.” The Haitian diet of mainly rice, millet, or corn with pureed beans added (1/3 beans, 2/3 cereal) has a well-

balanced amino acid ratio, but it is bulky; children cannot consume their daily calorie requirement from such a diet in one or two meals. They need to eat calorie-dense foods four to five times a day (including nutritious snack foods); in general, parents must learn to add more oil to the diets of their children. Suggested models include those of the Albert Schweitzer Hospital at Deschapelles or the Save the Children project in Maissade.

- D. Auxiliaries whose coverage is low should be retrained and closely supervised. Operational objectives specific to the particular areas they cover should be redefined. The project should encourage auxiliaries by reviewing and compiling data from their reports in such a way that each one can see how her work compares to that of others.
- E. In order to further improve service coverage, World Vision staff should revise the HIS to enable utilization of the census forms already completed. Rosters (one per ADS zone) of under-fives and women aged 15-49 should be derived from these census forms so that no beneficiary is left out. Rosters could be arranged by household number derived from a crudely drawn map of each village. In this way the ADS can use the roster in a logical way to find absentees. Newborns and new arrivals to the project area can be added to the rosters with the help of regular communication with **MHAs**. Outmigrants or deceased persons can be crossed out (not erased). The rosters can then be used to help record, in appropriate columns, important indicators for each child (including dates of vaccine doses, age when vaccines are complete, weight of the child, etc.). If the ADS does not go house-to-house on a regular basis, the MHA can assist in the updating of rosters.
- F. Once rosters are in order and made to contain the names of all children and all women aged 15-49, a longitudinal follow-up system which includes vital event reporting should be installed. Since the project reports the immunization status for each child, whether or not the child is alive or dead should not be difficult to discover and report.
- G. Pregnancy reporting should be included among the “vital events” in the roster. Follow-up of pregnancies is required anyway as a project norm. Adding pregnancy outcome will help project staff to assess the problems of pregnancy and will ensure that no live-born baby will be left out of the system; even if the infant dies after only a very short time, the death will still be reported.
- H. The Mothers Health/Pregnancy Follow-up card now being tried out as an instrument for **TBA**s should be revised and made “mother-friendly” like the Road-to-Health record for children. Even illiterate mothers can follow progress in weight gain on such a card.
- I. Community participation through health committees, church activities, and **MHAs** should continue to be developed and promoted. WV staff should increase support and training of the health and development committees. A specific training program

should be designed, including, at least, small business management, leadership, planning, and management of the environment.

- J. Continued assistance should be planned for the committees through a qualified community mobilization specialist. The accomplishments of the committees should be documented so as to show progress over time.
- K. The central committee should increase its participation in the project, should redefine its goal and objectives, and should have an executive staff (president, secretary, etc.).
- L. The **MHAs** should be clearly identified and a specific training program arranged for them. Specific tasks should be assigned.

ANNEX I

**DISTRIBUTION OF TEAMS AND CLUSTERS
La Gonave - CSP Midterm Survey, September 1993**

SUPERVISOR	TEAM			CLUSTERS		
	#	INTERVIEWERS		#	NAME	NAME
Dyer	01	G. Joseph	M. Sagaille	14	La Palmiste	Fond Negre
	02	J. Wesley	J.E. Merisier	11	Nan Plume	Trou Chouc.
	03	B. Sagaille	J. Odrigue	17	Ti Coma	Debaleinord
Ferdinand	04	C. Damus	D. Micilien	02	Grde Plaine	Dorval
	05	W. Desir	F. Mexilus	13	Nan Sema	Tê Sèche
	06	V. Dorelien	S. Mardi	06	Mare Sucrin	Gros Mapou
	07	L. Wilson	M. Abraham	18	Cherissable	Grd Lagon
Lamothe	08	M. Augustin	S. Arleus	01	Sous Saline	Baie Tortue
	09	M. Modesir	E. Terra	23	Debalein Sud	Nan Sylvest
	10	T. Phebe	S. Ocean	20	Nan Coton	Fd. Plaisir
Hecdivert	11	B. Delcarme	A. Altidor	09	Gde Source	Zeb Guinen
	12	F. Lunice	R. St Fleur	25	Grd Vide	Morne Bara.
	13	T. Cemelus	C. St Lot	27	La Source	Gros Mangle
	14	A. Manese	L.J. Francois	04	Nan Mango	Morne J. Jak
	15	E. Luciano	S. Desir	21	Trou Louis	Nan Lacou

ANNEX II

DISTRIBUTION OF AUXILIARIES BY CLUSTER

AUXILIARY		AREA OF SERVICE	EVALUATION CLUSTERS
#	NAME		
1	Marie Lourdes Excellent	Petite Source	Mare Sucrin - Gros Mapou - Baie Tortue
2	Versyle S. Charmant	Grand Lagon	Deux Baleines Nord - Ti Coma Cherissable - Grand Lagon
3	Violette Meradin	Palma	Sous Saline - Grande Plaine Nan Mango - Morne Trou Jacque - Dorval
4	Gertha Joseph	Pte.-à-Raquette	Fond Negre - Nan Sema - La Palmiste - Tè Sèche
5	Monicia Francois	Pickmy & Petite Anse	Trou Chouchou - Fond Plaisir - Nan Coton
6	Evelyne Cesar	Grde Source	Grande Source - Zeb Guinen - Nan Plume
7	Daniel Laguerre	Grande Vide	Grand Vide - Morne Baraque
9	Pas D'Auxiliaire	Gros Mangle - La Source - Trou Louis	Gros Mangles - La Source - Trou Louis - Nan Lacour - Nan Sylvestre - Deux Baleines Sud.

ANNEX III

HEALTH COMMITTEES

SECTION	PRESIDENT
Pointe-à-Raquette	Begin Noel
Grand Vide	Marcel Abraham
Ka Leon Gd Vide	Jean Edmond
Nan Cafe (Gde Source)	Marcelor Boucicot
Mare Sucrin (Pt Source)	Claude Pierre
Palma	J. Elouhode Mersier
Pickmy	Etzer Bébé
Petite Anse	Tilus Duval

ANNEX IV
LIST OF IGAs

Section	Activities	Initial Value (\$US)	Starting Date	Status
Palma	Grain storage	\$ 3,000	10/92	Ongoing; good
Grde Source	Clinic	3,000	12/92	Ongoing; good
Grd Lagon	Two clinics	10,000*	6/93	Just started
Grand Vide	Clinic	8,000*	4/93	Ongoing; average
Trou Louis	Clinic	8,000*	4/93	Ongoing; average
Pte. à Raquette	Grain storage; clinic	3,500	1 0/92	Ongoing; average
Petit Anse	Clinic	800*	6/93	Ongoing; average

* In medication and supplies

ANNEX V

EVALUATION VITAMINE A/CHILD SURVIVAL
QUESTIONNAIRE MANMAN

EKIP _____ GRAP _____ LOKALITE _____

Dat antrevi _____

Non ANKETÈ _____

Non SUPÈVIZÈ _____

Non maman-an _____

1) LB ou te **ansent** (denye fwa) eske ou te konsilte nan yon sant.

1. Wi [] Konbyin fwa _____
 2. Non []

2) **Eské** ou te pran **vaksin** tetanos?

1. Wi [] Konbyin fwa _____
 2. Non []

3) Dat **denye** akoucheman /_____/

4) Eske ou **te** resevwa **vit.A** ?

1. Wi [] date ____/____/____
 2. Non []

- **Eské** ou te bay ti **bebe** ya premie ti let **Jòn** nan?

1. wi []
 2. Non []

5) Ki **lès** ki ba ou **vit.A**?

1. Matron []
 2. **Ajan sante** []
 3. **MHA** []
 4. **Miss** []
 5. Lopital []

6) **Eské** ou konnin pou ki **sa vit.A** bon

1. Wi []
 2. Non []

7) Ki **sa** ou jwen nan zon nan ki genyen **vit.A**?

1. Fwi ak legim jaun []
 2. Fey **vèt** [3]
 3. **Fwa** []
 4. **Zé** []

8- Konbyen fwa nan semen **pasé** a ou **té** manje nan manje sa-a yo?

1. 3 a 7 fwa []
 2. 2 fwa []
 3. 0 a 1 fwa []

9- Eske ou **té** genyen timoun **kité** genyen dyare nan 2 **denye** senmen-n ki sot pase yo?

1. Wi [1]
 2. Non [] pase a kesyon 12

10- **Pandan** [timoun-nan] te genyen dyare eske ou . . . (li a **otvwa** reponss ki anba-yo pou manman-an).

1. te bay li tete pliske dabitid? []
 2. te bay li **tete** kom dabitid? [1]
 3. te bay li **tete** mwens ke dabitid []
 4. te sispann ba li tete net? []
 5. timouin-nan pa te nan tete []

11- LB timoun nan te geyen dyare, ki premye sa ou te **fè** pou li?

1. **Anyen, oken**]
2. Sewom Oral - **sache** E]
3. **Sewon** lakay []
4. **Diri** ak karot, dlo diri, la bouwi lanmidon [3]
5. Enfizyon ou te , rafrechi []
6. Medikaman pou dyare []
7. Lot (**presizé**) []

12- **Eské** ou te jwen infonasyon sou maladi Branch (IRA) nan **ané** sa a (Oktob 92 a Out 93)

1. **Wi** [1]
2. Non [1]

13- **Eské** ou **té** gen ti moun ki te gen IRA nan 2 **deny&** semen ki sot **pasé** yo?

1. Wi []
2. Non []
3. Pa konen []

14- Ki sa ti **moun** nan **té** **présenté**?

1. Li pran souf vit ou **byen** ak difikilte
2. Tout zo kot li **paret lè** lap respire
3. Li pa **vlé manjé**
4. Li **tousé**
5. Li gen la fyev
6. Lot

15- **Eské** ou te pran fbmasyon sou malaria?

1. wi [] kontinue
2. **Non** [] **rété la**

16- Ki sa yon moun ki genyen malaria santi?

1. fyev.
2. frison
3. malt&
4. Ko **fè** mal
5. lot

17- Ki sa ou kapab **fè** pou empeche malaria **gayé** nan zon lan?

1. **Eliminé** fatra.
2. seche ma dlo
3. **Fè** la fimen
4. Lot

18- Eske fann **ansent** kapab **fè** tretman pou malaria?

- wi** []
non [] pouki _____

1993 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A
W.V.R.D./HAITI LA GONAVE CHILD SURVIVAL PROJECT
#PDC-0500-G-00-1065-00

FIELD	Actual Expenditures To Date (10/1/91 to 8/31/93)			Projected Expenditures Against Remaining Obligated Funds (09/01/93 to 9/30/94)			DIP Budget (Columns 1 & 2) (10/01/91 to 9/30/94)		
	A. I. D.	U. V. R. D.	TOTAL	A. I. D.	U. V. R. D.	TOTAL	A. I. D.	U. V. R. D.	TOTAL
COST ELEMENTS									
1. PROCUREMENT									
A. Supplies	3,804	4,145	7,949	12,696	(1,145)	11,551	16,500	3,000	19,500
B. Equipment	132	52,105	52,237	368	1,395	1,763	500	53,500	54,000
C. Services/Consultants	3,015	1,020	4,035	8,485	2,580	11,065	11,500	3,600	15,100
SUB-TOTAL I	6,951	57,270	64,221	21,549	2,830	24,379	28,500	60,100	88,600
II. EVALUATION/SUB-TOTAL II	0	0	0	15,256	0	15,256	15,256	0	15,256
III. INDIRECT COSTS									
Overhead on Field (%)	38,355	110,233	148,588	24,888	50,559	75,447	63,243	160,792	224,035
SUB-TOTAL III	38,355	110,233	148,588	24,888	50,559	75,447	63,243	160,792	224,035
IV. OTHER PROGRAM COSTS									
A. Personnel	128,575	6,642	135,217	103,966	2,147	106,113	232,541	8,789	241,330
B. Travel/Per diem	16,066	3,933	19,999	(7,026)	1,187	(5,839)	9,040	5,120	14,160
C. Other Direct Costs	40,320	8,413	48,733	(8,940)	2,897	(6,043)	31,380	11,310	42,690
SUB-TOTAL IV	184,961	18,988	203,949	88,000	6,231	94,231	272,961	25,219	298,180
TOTAL FIELD	230,267	186,491	416,758	149,693	59,620	209,313	379,960	246,111	626,071