PD-ABW-352

FOCAS

Child Survival Mentoring Partnership - Haiti

Mentor – Curamericas

USAID Cooperative Agreement FAO-A-00-97-00028-00

2001 Annual Report

Submitted to:
United States Agency for International Development
Bureau for Humanitarian Response
Office of Private and Voluntary Cooperation
PVO Child Survival Grants Program

9 November 2001

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ACRONYMS

ADRA	Adventist Development and Relief Agency International
ARHC	Andean Rural Health Care/Curamericas
AOPS	Association des Oeuvres Privées de Santé
ARI	Acute Respiratory Infection
BLM	Bellevue la Montagne (MEI service area)
BM	Baptist Mission
CBIO	Census Based Impact Oriented
CHA	Community Health Agent
CORE	Child Survival Collaboration and Resources Group
CQI	Continuous Quality Improvement
CRS	Catholic Relief Services
CS	Child Survival
CSPM	Child Survival Program Manager
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
ED	Executive Director
EDJ	Etang du Jonc (OBDC service area)
EOC	Emergency Obstetric Care
EPI	Expanded Program for Immunizations
FP/RH	Family Planning/Reproductive Health
FHI	Family Health International
FOCAS	Foundation of Compassionate American Samaritans
HHF	Haitian Health Foundation
HIS	Health Information System
HOPE	Project HOPE (The People-to-People Health Foundation)
HPD	Health Programs Director
IEC	Information, Education and Communication
INHSAC	Institut Haitien de Santé Communautaire
KPC	Knowledge, Practice and Coverage
MEI	Mission Evangelique International
MOH	Ministry of Health
MSH	Management Sciences for Health
MSPP	Haitian MOH
NGO	Non Governmental Organization
OBDC	Ouevres de Bienfaissance et de Development Communitaire
PM	Program Manager
PSI	Population Services International
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant

FOCAS FOURTH ANNUAL REPORT

Summary

FOCAS has just completed the first four years of an innovative Child Survival Mentoring Grant Program in rural and peri-urban areas of Haiti and is just beginning a 2-year extension of this grant. The program approach is community based and utilizes 2 Haitian NGOs, MEI and OBDC, who have deep ties to their communities, and work well as vehicles of change in community development.

The first four years have been productive and have set the stage for additional program improvements and progress towards sustainability. The mentoring concept, with Curamericas as mentor, has proved to be very valuable and has helped FOCAS achieve good performance far earlier than if the project had been undertaken without mentoring.

In the summer of 2001, at the end of the fourth year of the project, a program evaluation was undertaken. The primary objectives were to measure the quantitative results in the field and to make an initial qualitative assessment of the management of the 2 partner NGOs. This report presents a summary of the program to date.

What are the main accomplishments of the program?

" MEI AND OBDC operate successful child survival programs that rely on a population-based system and outreach services. The basic outreach strategy has allowed both organizations to obtain excellent results in vaccination coverage of children. Other coverage parameters with regard to vitamin A, diarrhea management and growth monitoring tend to be better than those obtained from similar programs in other areas of Haiti." [1]

The main accomplishments are these results which followed an evaluation this summer (see Annex A). The most noteworthy accomplishments are within the EPI effort, and as mentioned, the vitamin A coverage, growth monitoring and diarrhea management efforts. The following table highlights results of the evaluation this summer:

[1] FOCAS KPC Evaluation Report, Dr. Antoine Augustin, team leader

OBJECTIVE	MEI	OBDC	OTHERS IN HAITI
1. The percentage of children 12-23 months receiving vitamin A at least once in past 12 months	84.2	81.7	22 (DHS 1994) 15.9 (North- Title II) 12.8 (South- Title II)
2. The percentage of children who were given the same amount or more liquids (other than breast milk) during diarrheal episodes	58	57	37.5 nationwide
3. The percentage of children who were given ORS solutions from packets	73	73.6	31.1 nationwide
4. Increase the percentage of infants who are fully immunized	82.5	80.4	38 (North- Title II) 17.6 (South- Title II)
5. Increase the percentage of children who are immunized with measles vaccine	85.8	86.3	48 (MSPP-OPM/OMS-1999)

Concerning treatment of diarrhea, results were outstanding when looking at the number of women who thought giving more liquids during a bout of diarrhea was appropriate. OBDC found that 57% of the respondents gave this response, while 58% of those surveyed at MEI gave this response. This favorably compares with a national average in Haiti of 37.5%. Vitamin A coverage, as measured by at least one dose of vitamin A in the last 12 months, was high in areas, (84.2% at MEI and 81.7% at OBDC), and again, was remarkable considering the national average of 22% and other programs with averages below 20%. [2] The further development of family planning and reproductive health interventions was accomplished through several intense trainings that were conducted by INHSAC, AOPS and FHI, three of the leaders in training on FP/RH in Haiti.

What has the project done well? What factors have contributed to these accomplishments? The project has done a very good job at meeting the needs of the communities, despite a substantial increase in the population of OBDC (75,000 versus the projected 40,000) and the loss of communities covered by MEI, which was very de-motivating to the community and the remaining health workers. The project has also done well in training the cadre of health workers of MEI and OBDC, and in establishing the CBIO methodology. Rally posts are a great strength of our program, and the beneficiaries continue to benefit from this method of preventive health care outreach. Factors contributing to these accomplishments are the great dedication of the health workers to the communities that they serve, and the consistent focus of the program on Continuous Quality Improvement (CQI). The program began to use the LQAS methodology last year, and has found this tool helpful in

[2] 22% from DHS data (1994) Title II interventions (15.9% in the north, 12.8% in the south) and Title II controls (16.2% in the North and 16.6% in the south) – data obtained from Dr. Antoine Augustin during his work with Title II program evaluations in Haiti

identifying strengths and weaknesses of the health worker, the supervisor and the health center. This methodology was used for a second time this summer for the KPC and was instrumental in assessing the performance at the level of the community health agent. This allowed individual follow up to health agents who were not able to pass the cut-off point for specific objectives of the CSP.

What factors have impeded progress towards achievement of the overall goals of the program and what actions are being taken by the project to overcome these constraints? The government and financial instability continues to have a great effect on the motivation and socio-economic status of our beneficiaries. The decrease in availability of local food resources to our program beneficiaries coupled with the decline in the Haitian economy has hampered our efforts to implement a strong nutrition program. While the Hearth methodology has in the past been successful in some parts of Haiti, currently, most programs countrywide struggle to make this promising intervention successful in the long-term. Despite difficulties with this approach, FOCAS continues to conduct positive deviant studies in project areas to learn to apply the best nutritional practices for each community. Technical assistance for this intervention is mentioned below.

In what areas of the project is technical assistance required?
Technical assistance is required to strengthen the nutritional rehabilitation program, which works with, but sometimes in conflict with the food security programs that each of our NGO partners is operating with CRS. Policy changes with regards to food security programs are underway in Haiti. Currently, efforts are being made to incorporate a sound policy that will bring together the benefits of food security and nutritional rehabilitation. We are eagerly anticipating the synergistic effects that may result from a more integrated program. Secondly, technical assistance is needed to aid the two NGOs in organizational development and management capacity building.

Describe any substantial changes from the program description and DIP that will require a modification to the cooperative agreement. Discuss the reasons for these changes. None other than what has been discussed in execution of the two-year extension.

See **Annex A** for a report on the program indicators assessed during the Summer 2001 Evaluation.

Identify and provide an analysis of an important issue, success, new methodology, or new process that would be of interest to the greater development community.

As part of a sustainability campaign of FOCAS, many initiatives have occurred over the last year to expand the fundraising capabilities and public awareness of the organization. A website (www.focas-us.org) to include all organizational activities, both in Cincinnati and Haiti, has greatly contributed to FOCAS' increasing donor base. Additionally, a video CD-ROM was conceived during a mission trip in January of this year, and details the international programs including Child Survival and Child Sponsorship. Lastly, Dick Taylor, Executive Director of FOCAS, and the Executive Director of MEI, one of our two partners in Haiti, Pastor Octomoliere Liberius, were interviewed about our collaborative programs in Haiti on a television program based in Miami. This program airs in both Miami and Haiti, is a first step in developing awareness of Haitians, Haitian-Americans, and Americans of FOCAS work in Haiti.

Two MPH students from Emory University and the University of Texas aided the summer evaluation activities. They were involved in all levels of the program, including management issues and all steps in the KPC evaluation, including survey design, data collection and data analysis. This was the first experience of its kind for FOCAS, and proved to be valuable for all involved parties.

Next Steps

Meetings were held in Haiti following the evaluation to include the team leader for the evaluation, Dick Taylor, David Shanklin of Curamercas and the 2 NGO Program Mangers, Dr. Micheline Baguidy of MEI and Madame Dilia David of OBDC. Plans were generated for the next steps for the program. Program enhancement plans include:

1. Efforts to increase the effectiveness of the nutritional rehabilitation program, consistent with the strategies of Catholic Relief Services (CRS) for Title II food distribution. This includes a trip by the NGO program managers to observe Haitian Health Foundation's (HHF) nutrition program in Jeremie, one that also collaborates with CRS. Further collaboration will follow to aid strategy re-design for this intervention.
2. A sustainability plan to involve components of the micro credit program with World Relief and the possibility of a health insurance plan for beneficiaries, is being evaluated
3. NGO computerization will be initiated in the two-year extension. This will include both accounting and a Health Information System (HIS). Contact with the Haiti Baptist Mission has been made and plans include use of their well developed computerized HIS.
4. Need for NGO management assessment and training has been identified and several options are being explored, including a CEDPA assessment, a training course offered by MSH and the University of Montreal and use of a local consultant.
5. An experienced member of the Curamericas Bolivia team, Hernan Castro, will facilitate strengthening of the CBIO methodology. He will spend 2 weeks in Haiti this fall to aid in further growth of this important component of our program.

6. Opportunities to intervene in the area of HIV/AIDS will be explored. This will include working with CORE to explore a partnership with IMPACT, research-based opportunities with HORIZONS, and grant opportunities with foundations and businesses.
7. Activities related to the follow on CARE Morr sub-grant through Curamericas are planned for this fall. A peri-natal specialist from Emory University's Rollins School of Public Health will help to lead the activities, which include further investigation of the peri-natal needs of the program, and formulation of strategies to incorporate peri-natal program enhancements.
8. During the summer evaluation, the HIS was analyzed in depth and found to need improvements to better track a highly mobile population. The evaluation provided good perspective on the difficulties encountered with censused based systems, and offered recommendations for more accurately population tracking. Planned improvements include a system to better identify and register pregnant women, enabling more close following to and past delivery and implementation of a verbal autopsy system.

PVO NAME:	FOCAS	DATE of INFO	JULY 2001
LOCATION (COUNTRY):	HAITI	PROJECT AREA	ETANG DU JONC AND BELLEVUE LA MONTAGNE (DISTRICTS OF PETIONVILLE)

ANNEX A

KPC2000+ RAPID CATCH INDICATORS

	INDICATOR	DEFINITION	NUMERATOR	DENOMINATOR	ESTIMATE	CONFIDENCE LIMITS
1.	Percentage of children age 0–23 months who are underweight (<2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	Numerator No. of children age 0–23 months whose weight (**Rapid CATCH Question 7**) is –2 SD from the median weight of the WHO/NCHS reference population for their age. Denominator Number of children age 0–23 months in the survey who were weighed (response=1 for **Rapid CATCH Question 6**)	61	358	17%	(13%, 21%)
2.	Percentage of mothers of children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	Numerator Number of mothers of children age 0–23 months with responses=2 ('twice') or 3 ('more than two times') for **Rapid CATCH Question 9** Denominator Number of mothers of children age 0–23 months in the survey	64	360	18%	(14%, 22%)
3.	Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases)	Numerator Number of children age 12–23 months who received Polio3 (OPV3), DPT3, and measles vaccines, according to the child's vaccination card (**as documented in Rapid CATCH Question 15**) Denominator Number of children age 12–23 months in the survey	292	360	81%	(77%, 85%)

PVO NAME:	FOCAS	DATE of INFO	JULY 2001
LOCATION (COUNTRY):	HAITI	PROJECT AREA	ETANG DU JONC AND BELLEVUE LA MONTAGNE (DISTRICTS OF PETIONVILLE)

KPC2000+ RAPID CATCH INDICATORS (continued)

	INDICATOR	DEFINITION	NUMERATOR	DENOMINATOR	ESTIMATE	CONFIDENCE LIMITS
4.	Percentage of children age 12–23 months who received a measles vaccine	Numerator Number of children age 12–23 months with response=1 ('yes') for **Rapid CATCH Question 16** Denominator Number of children age 12–23 months in the survey	310	360	86%	(83%, 90%)
5.	Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	Numerator Number of children age 0–23 months with response=3 ('more than usual') for **Rapid CATCH Question 22** AND response=2 ('same amount') or 3 ('more than usual') for **Rapid CATCH Question 23** Denominator Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for **Rapid CATCH Question 21**)	80	181	44%	(37%, 52%)

PVO NAME:	FOCAS	DATE of INFO	JULY 2001
LOCATION (COUNTRY):	HAITI	PROJECT AREA	ETANG DU JONC AND BELLEVUE LA MONTAGNE (DISTRICTS OF PETIONVILLE)

INDICATORS DEFINED DIFFERENTLY IN FOCAS KPC THAN IN RAPID CATCH:

	INDICATOR	DEFINITION	NUMERATOR	DENOMINATOR	ESTIMATE	CONFIDENCE LIMITS
6.	Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	Numerator Number of mothers of children age 0–23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for **Rapid CATCH Question 25** Denominator Number of women aged 15 to 29 years of age surveyed.	176	361	49%	(44%, 54%)
7.	Percentage of children age 12 - 23 months who have received at least 2 doses of Vitamin A in the past 12 months	Numerator Number of children age 12-23 months who have received 2 or more doses of vitamin A in the past 12 months Denominator Number of children age 12-23 months who have Road to Health Card	267	332	81%	(76%, 85%)

FOCAS/MEI/OBDC

ASSESSMENT OF THE CHILD SURVIVAL PROGRAM

Dr. Antoine Augustin
2001-09-20

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCG	*Bacille Camille Gérin*
BHR/PVC	Bureau for Humanitarian Response/Office of Private Voluntary Cooperation
CHW	Community Health Worker
CQI	Continuous Quality Improvement
CS	Child Survival
DHS	Demographic and Health Surveys
DPT	Diphtheria/Pertussis/Tetanus
EPI	Expanded Program of Immunization
EMMUS	*Enquête Mortalité, Morbidité, Utilisation des Services*
FOCAS	Foundation of American Compassionate Samaritans
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IUD	Intra-Uterine Device
JSI	John Snow, Inc.
LQAS	Lot Quality Assurance Sampling
MCHN	Maternal Child Health and Nutrition
MEI	*Mission Evangélique Internationale*
MOST	Management and Organizational Sustainability Tool
MSH	Management Sciences for Health
MSPP	*Ministère de la Santé Publique et de la Population*
OBDC	*Oeuvre de Bienfaisance et de Développement Communautaire*
OPV	Oral Polio Vaccine
OPS/OMS	Organisation Panaméricaine de la Santé/Organisation Mondiale de la Santé
ORS/ORT	Oral Rehydration Salt/Oral Rehydration Therapy
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development

INTRODUCTION

Background

This report concerns the FOCAS Child Survival Program being carried out in communities surrounding the town of Pétion-Ville, Haiti. A team made up of Dr. Antoine Augustin, Team Leader, Dr. Arsene Ferrus, Amy Metzger, David Blaney, and Wiline Jean carried out the evaluation. The evaluation was participatory in the sense that all team members as well as other stakeholders participated in the scope, design, methods and assessment of findings.

FOCAS is a recipient of a Child Survival Mentoring Partnership Grant from BHR/PVC/USAID with CurAmericas, formerly known as Andean Health Care, as the mentor. FOCAS in turn is to provide assistance to two Haiti-based organizations: MEI *(Mission Evangelique Internationale)* and OBDC *(Oeuvre de Bienfaisance et de Developpement Communautaire)*. Both agencies work in neighborhoods on the outskirts of *Pétion-Ville*, a suburb of Port-au-Prince, the capital of Haiti. Both implement the standard child survival intervention package with a heavy focus on EPI, growth monitoring, diarrhea management, ARI management, breast-feeding and other aspects of nutrition. Teams of community health workers who work in sectors whose population has been censused and registered carry out activities. Workers organize rally posts, which are places of assembly near the home of mothers, where they can come and obtain the services. Sick individuals are referred to a health center, the Monsanto Petit Center in the case of OBDC and the *Calebasse* Center in the case of MEI. In 2001, it was estimated that OBDC covered nearly 75,000 individuals and MEI 14,000. Instead of being a final evaluation as initially planned, the thrust of the exercise is to provide FOCAS and its partners with key information to help them make management decisions regarding the child survival component of service delivery, and to obtain baseline data on the contraceptive prevalence rate in the target catchment area of the project using sound data collection methods.

Context

Haiti, a country of 8 million people and 10,000 square miles, has the dubious distinction of being the poorest country in the Western Hemisphere. In fact, the Bank of Haiti estimated recently that the country currently produces the same amount of goods and services it did twenty years ago while the population has grown in that length of time from 4.5 to 8 million people, almost halving the per capita income. People would be a lot poorer where it not for remittances from abroad. The catastrophic economic environment has particularly severe consequences on the health and nutritional status of the population : an infant mortality rate of 80/1000 ; an under-five mortality rate of 119/1000 ; high prevalence of infectious diseases ; pervasive malnutrition among children under five ; and HIV/AIDS infection rates of more than 4% among sexually active persons

PART I: SERVICE DELIVERY ASSESSMENT

Scope of Work

In June 2001, under the supervision of the team leader, preliminary meetings were held with FOCAS staff as well as the senior managers of the MEI and OBDC to agree on scope and methods. This was followed by subsequent meetings with field staff (health agent supervisors) to explain the purpose of the evaluation and to solicit their assistance and participation

The team leader was asked to focus on the following operational, coverage and management issues:

- *To what extent does the system of census and family registration represent an accurate view of the population being served? Can true coverage be estimated from current census and registration parameters?*
- *How do patterns of coverage for child survival services vary by health agent, particularly in the area of childhood vaccination and Vitamin A distribution?*
- *What patterns of problems were encountered in the implementation of the project? What are the best practices and guiding principles to improve results in furtherance of the CS Strategic Objectives;*
- *What changes should be made in the management of the grant at the local level*
- *What are the baseline levels for contraceptive prevalence as well as AIDS knowledge and related risk-aversion behaviors?*

Survey objectives

The nine main objectives are as follows:

- Determine the accuracy and completeness of data collected through routine service statistics and census/registration activities;
- Determine coverage rates for vaccination (DPT, OPV, Measles and BCG vaccines) and Vitamin A status for children 12-23 months old living in the project area;
- Assess the individual performance of selected community health workers regarding childhood immunization and Vitamin A coverage;
- Determine the nutritional status (weight-for-age z-scores) of children 12-23 months old;
- Determine the vaccination status (tetanus toxoid) of women in child-bearing age;
- Estimate the contraceptive prevalence rate (modern methods, women 15-49 years of age);
- Assess knowledge of AIDS among women of reproductive age;
- Estimate condom use among women of reproductive age;
- Identify areas for management strengthening.

Survey Design

The study is a cross-sectional static comparison of community health worker performance stratified by the two project areas (OBDC and MEI).

Sample Selection and LQAS

The Lot Quality Sampling methodology was selected in view of the fact that both individual worker comparisons are desired as well as target area coverage estimates. LQAS can reliably meet both objectives, because it provides data on individual lots (in our case, individual health agents), while at the same time, results from individual lots can be combined to provide project area estimates. Unlike the standard cluster survey, LQAS is not subject to the design effect often seen when there is homogeneity within clusters.

In LQAS, the key terms in the procedure are defined as follows:

Production Units: This is an entity that delivers services, in this instance the individual community health worker.

Lot: A lot comprises the sampling frame; that is, the population, or sub-population, served by a community health worker

Lot Sampling: Mathematical theory and experience have shown that a random sample of only 19 per lot is required. In this survey, we used 20 children and 20 women 15-49 for each community health worker.

Decision Rule: Lots are classified as Pass or Fail based on the number of observations in the sample attaining or exceeding a predetermined level. For example, if a level of success for a given indicator is set at 80%, then in a sample of 19, if at least 13 children or women reach this level, the lot is considered to be a "Pass". Tables exist showing the threshold numbers to be reached for targets ranging from 5-95%.

Precision: A sample size of 20 per lot produces statistical errors of less than 8% for both false positives and false negatives. A false positive is a lot classified as "Pass" that really failed and a false negative is a lot classified as "Fail" that really passed. The former is known as Provider Risk and the latter as Client or Community Risk.

Instruments

Two questionnaires were utilized: a questionnaire for children 12-23 months old and a questionnaire for women 15-49 years old.
Women: Women in the reproductive age range (15-49) – socio-economic characteristics, prenatal care, delivery, family planning, AIDS knowledge and practice.
Child: Children in the age range of 12-24 months – use of vaccination services and vitamin A, and weight for age.

Verification of household registration

Step 1. For OBDC and MEI, all sectors corresponding to individual health workers were listed. Sectors that had begun to receive services within the past 12 months were excluded from the

survey. Of the remaining 22 sectors at OBDC, 12 were chosen at random for study, while all 6 remaining MEI sectors were selected.

Step 2. For each community health worker selected for study, all children 12-23 months old listed on the family register form (census form) were listed on a separate sheet of paper.

Step 3. Then the child roster (register of children under five) was consulted to identify children 12-23 months old from the same sector. Nominally, the two lists should match. Both lists were counted and compared to the initial census count for children 12-23 months old,

Step 4 Then the lists were compared to look for matches and omissions, and consolidated into a master list of children 12-23 months old. The master list count was compared to the census count.

Sample Selection

Sampling Method for children 12-23 months old

Applying the LQAS format, a "lot" totaling 20 children 12-23 months old was selected for each community health worker through the following steps:

Step 1. For OBDC and MEI, all sectors corresponding to individual health workers were listed. Sectors that had begun to receive services within the past 12 months were excluded from the survey. Of the remaining 22 sectors at OBDC, 12 were chosen at random for study, while all 6 remaining MEI sectors were selected.

Step 2. For each community health worker, all family register forms (census forms) were assembled and consulted to identify children born between June 1, 1999 and May 31st, 2001.

Step 3. For each community health worker, registers of children under five were consulted to identify children born between June 1, 1999 and May 31st, 2001.

Step 4. The two lists of children were compared and duplicate listings eliminated and the two lists consolidated into a single listing.

Step 5. The sampling rate was calculated by dividing total children 12-23 months old in the consolidated list by 20. To select the first child, a random number between one and the sampling rate number was selected. Each child selected was separated from the previous one on the basis of the sampling rate.

Sampling Method for women 15-49 years old

Similarly, applying the LQAS format, a "lot" totaling 20 women 15-49 years old was selected for each community health worker using the same listing procedure as for the children. The sampling rate was calculated by dividing the total number of women 15-49 years old in the community health worker register by 20. To select the first woman, a random number between

one and the sampling rate number was selected. Each woman selected was separated from the previous one on the basis of the sampling rate.

ENUMERATOR TRAINING

Enumerators were recruited from the corps of community health supervisors, care being taken that the selected enumerator would not survey a sector under his supervision. Enumerators were trained by a team of external survey supervisors recruited by FOCAS under the direction of a field survey coordinator. The training was completed by a field exercise.

DATA COLLECTION

The initial method was modified to take into account major discrepancies in the census and childhood rosters, which would lead to only children having received services being selected. Instead, the enumerators were asked to use the listing of pre-selected women as a basis. After each selected woman was interviewed, the enumerator was asked to visit the nearest household with a child 12-23 months old. Then he would proceed to the next woman and so on and so forth.

DATA ENTRY

The data were entered into a computerized database using EPI-info, verified, cleaned and consolidated into two files (MEI and OBDC). After data cleansing, frequencies for all variables were generated for the entire data set. For the LQAS analysis, analysis by lots representing individual community health workers was undertaken. Individual health workers were defined as passing or failing if they met a given performance level. The following performance levels were considered satisfactory:

- DPT3 > 70% for children 12-23 month old
- OPV 3 > 70%
- Measles vaccination > 70%
- BCG vaccination > 70%
- All antigens received by at least 60% of children (completely vaccinated)
- All antigens received by at least 50% of children before age 1.
- Proportion of children 12-23 months old having received at least two capsules of Vitamin A in the preceding 12 months greater than 80%

RESULTS

OVERALL FINDINGS

MEI and OBDC operate a successful child survival program with some truly outstanding components that are the more noteworthy in view of the difficulties of operating any health program in Haiti, difficulties related to poor communication, bad roads, difficult logistics, and minimal electrical power. The FOCAS program has relied on a population –based system and

outreach services. The basic outreach strategy has allowed both organizations to obtain excellent results in vaccination coverage of children. Other coverage parameters with regard to Vitamin A, diarrhea management and growth monitoring tend to be better than those obtained from similar programs in other areas of Haiti. Nevertheless, current maternal practices concerning diarrhea management need to be improved, and malnutrition continues to be a significant problem in the two areas.

These results have been obtained in spite of a very lean management structure which, if maintained, however, could hamper the growth of the two organizations and make it more difficult to develop a sustainable program.

SPECIFIC RESULTS

Up dating of Family Register forms

The evaluation found that the family register (census) forms were not up-dated consistently at MEI or at OBDC. By and large, there were many more children listed in the child roster than in the family register form. Children get to be on the roster if they come to a rally post. Therefore, a child who does not use services and is not on the family register form is unknown for all practical purposes to the community health worker.

The same situation was seen for women of reproductive age, with discrepancies between the family register form and the women's roster.

The conclusion is that health workers are not systematically up dating family registers. It should be noted that up-dating census data is a very time consuming task in view of the migration patterns of the population. As much as 25% of the entire population may move within one year. In addition, there are births and deaths and other vital events to account for. That is why few programs in Haiti have had much success keeping their rosters up-to-date. Alternatives to this approach will be discussed in the section on recommendations.

A. Child survival

1. Immunization

Vaccination coverage for both MEI and OBDC is very good, as seen by a complete vaccination rate (all antigens) of 82.5% for MEI and 80.4% for OBDC. Table 2.1 lists vaccination coverage by antigen. For comparison purposes, we provide data for Haiti as a whole, and for areas with maternal and child health/nutrition (MCHN) activities under the Title II PL480 program (intervention areas) and similar areas evaluated concurrently (control areas) without Title II resources in the Northern and Southern parts of Haiti:

Table 1.1 Vaccination coverage by antigen, children 12-23 months old, by catchment area

Zone	DPT3	OPV3	Measles	BCG	Complete
MEI	86.7	86.7	85.8	90	82.5
OBDC	86.7	86.7	86.3	89.2	80.4
Title II intervention					38% (North) 17.6% (South)
Title II control					25% (North) 45.1% (South)
Haiti	52	53	48	36	

Sources: 1) this evaluation
2) JSI, 2001 (Title II)
3) MSPP-OPS/OMS, 2001 (Haiti - data for 1999)

The data suggest a much better performance by MEI and OBDC compared to national levels and Title II MCHN intervention programs and control areas. Tables 1.2 and 1.3 summarize individual health worker performance:

Table 1.2. Individual community health worker performance by antigen: number of children with the appropriate dose of antigen, MEI

CHW	DPT3	OPV3	Measles	BCG	ALL	P/F
1	20	20	20	20	20	P
2	19	19	19	19	19	P
3	16	16	16	17	16	P
4	15	15	15	15	14	P (border)
5	17	17	15	17	15	P
17	17	18	18	20	15	P

Table 1.3 Individual community health worker performances by antigen: number of children with the appropriate dose of antigen, OBDC

CHW	DPT3	OPV3	Measles	BCG	ALL	P/F
1	19	19	19	19	19	P
4	18	18	18	19	17	P
6	17	17	16	17	16	P
7	19	19	18	19	18	P
8	18	18	17	18	18	P
10	19	18	18	19	17	P
11	15	15	16	16	14	P (border)
13	15	15	15	16	13	P (border)
16	16	16	13	14	10	F
17	18	20	19	19	18	P
19	15	16	18	19	15	P
22	19	19	19	19	19	P

On the basis of a sample of 20 children per health worker, there is one borderline performance at MEI, 2 borderline performances at OBDC and one failure at OBDC.

2. Vitamin A

For MEI, over 84.2% of children had received at least one dose of Vitamin A and the corresponding number at OBDC was 81.7%

Table 2. 1 Vitamin A coverage of children 12-23 months old

Vitamin A	MEI	OBDC	Title II intervention	Title II control	Haiti
% received Vit A at least once in the past 12 months	84.2	81.7	15.9 (North) 12.8 (South)	16.2 (North) 16.6 (South)	22 (DHS, 1994)

The data suggest a much better performance by MEI and OBDC compared to other programs.

In terms of individual worker performance (LQAS), all workers passed the cut-off point.

Table 2.2 provides some information on appropriate coverage with Vitamin A. MOH norms in Haiti state that a child should receive one dose of Vitamin A every 4 months. The table documents that 59% of children at MEI and 46% of children at OBDC have received at least three doses in the previous 12 months.

Table 2.1 Proportion of children 12-23 months old with 3 or more doses of Vitamin A in the preceding 12 months, by catchment area

Site	3 doses or more	N
MEI	58.7	104
OBDC	47.2	212

3. Growth monitoring and nutritional status

At MEI, 83% of children 12-23 months old were weighed 6 or more times within one year. The performance is 69% at OBDC. All MEI CHAs passed the growth-monitoring test (set at 60% coverage with a decision rule of 9 for 20 children). At OBDC, 1 CHW failed the LQAS test.

TABLE 3.1 MALNUTRITION RATES OF CHILDREN 12-23 MONTHS OLD (WEIGHT/AGE) IN MEI AND OBDC AREAS.

ZONES	Z-SCORE BELOW –2SD (INCLUDES –3SD)	Z-SCORE BELOW -3SD	N
MEI	16.7	5.0	120
OBDC	16.4	2.9	238
NATIONAL	21.6 (DHS 200)	5.1 (DHS 2000)	

SOURCE FOR NATIONAL DATA: DHS 2000 (EMMUS III)

4. DIARRHEA

Diarrhea prevalence

Diarrhea prevalence, at 50%, is high at both sites, probably because of the age group studied (12-23 months old). The levels are slightly higher than national levels as measured by the 2000 DHS survey (40.8%), and similar to findings of the Title II survey (49.4% in Title II MCHN areas compared to 54.2% in control areas for the Title II evaluation). Thus, diarrhea continues to be a major problem for Haitian mothers and their children.

Table 4.1 Percent of children 12-23 months old with diarrhea, 2-week recall, MEI and OBDC, Title II evaluation zones, and Haiti

	MEI	OBDC	Title II	Title II control	DHS
% Children 12-23 m/o with diarrhea, 2 week recall	50	50	49.4	54.2	40.8 (DHS 2000)

Recognition of signs of dehydration

Signs of dehydration recognized by mothers include, in their order of importance, and by institution (MEI and OBDC); weakness (55% and 52%), sunken eyeballs (50% and 48.8%), and dry mouth (25.8% and 34.6%). Less frequently cited are thirst, less urination, and crying without tears.

Treatment of diarrhea

In terms of treatment, appropriate responses as cited by caretakers include

- More liquids 58% (MEI) vs. 57% (OBDC); 40.2% nationwide;
- More food 35% (MEI) vs. 42% (OBDC)
- ORS solution from packets: 73% (MEI) vs. 73.6% (OBDC); 31.1% nationwide
- Home based ORT 6.7% (MEI) vs. 11.6% (OBDC); 11.1% nationwide

Mothers surveyed during the Title II evaluation (JSI, 2001) were more likely to give more liquids (93%) and were as likely to give more food (35%) in control areas (areas with no Title II sponsored interventions) analyzed for the evaluation (55.3%) compared to Title II MCHN intervention areas (31%). This raises the question as to what message health personnel pass on to mothers with regard to feeding during diarrhea.

86% of mothers at MEI and 91.3% at OBDC state they use ORT. These figures compare very favorably to 46.8% for use nationwide (DHS, 2000). 74% at MEI vs. 81% at OBDC state they know how to prepare the solution. 70% at MEI and 79.6% at OBDC state that access to ORS is easy.

5. ARI

The prevalence of ARI, 2-week recall, is 55% at both MEI and OBDC. 66.7% of mothers at MEI and 56.4% at OBDC sought treatment for ARI. The type of help sought is summarized in table 5.1

Table 5.1 Type of care sought by mothers of children with ARI

Care/treatment	MEI	OBDC
Hospital	15.9	26.7
Health center	25	28
Dispensary	2.3	2.7
MD office	25	29.3
Other clinic	0	2.7
Mobile clinic/rally post	0	5.4
Health agent	25	24
Relative	4.5	6.7
Neighbor	9.1	2.7
Traditional healer	2.3	2.7
TBA	0	0
Voodoo	0	0

B. REPRODUCTIVE HEALTH

6. PREGNANCY

The pregnancy prevalence by age group at the two sites is at follows:

Table 6.1 Pregnancy prevalence by age group, MEI and OBDC

Age group	MEI	OBDC
15-19	0	2.9
20-24	3	12.7
25-29	7.4	9.7

Age group	MEI	OBDC
30-34	7.4	2.6
35-39	5.6	4.2
40-44	8.3	0
45-49	0	0
All	5.8	7.1

The data suggest an under-estimation of pregnancy prevalence, which would be expected to be over 11% for this population.

Table 6.2 shows the age distribution of pregnant women in the project area and in Haiti as a whole. The table shows that, among pregnant women, there is an under-representation of women 15-49 and above 30, AND an over representation of women 20-24. A review of the age of all women surveyed does not show this skewing of the age groups; in other words, the age group distribution of all women 15-49 surveyed is as expected. Some of the conceivable reasons for these findings are: 1) adolescents may BE LESS willing to acknowledge being pregnant; 2) BECAUSE of the family planning program, younger women are more likely to delay their first pregnancy and older women have a lowered fertility compared to Haitian women in general

TABLE 6.2 AGE DISTRIBUTION OF PREGNANT WOMEN, MEI, OBDC AND HAITI

AGE GROUP (YEARS)	AGE DISTRIBUTION OF PREGNANT WOMEN, MEI/OBDC	AGE DISTRIBUTION OF PREGNANT WOMEN, HAITI
15-19	4.1	10
20-24	45.8	26
25-29	33	30
30-34	8.3	18
35-39	8.3	12
40-44	0	3
45-49	0	1

7. Union status

The majority of women 15-49 years old at MEI are in union with co-habitation and 18.3% are in union without cohabitation, for a total of 75% of women in some type of union.

The majority of women 15-49 years old at OBDC are in union with co-habitation (66.8%) and 16.6% are in union without cohabitation, for a total of 83.4% of women in some type of union.

The distribution, in percentage, of women by union status is as follows in the two areas:

Table 7 Distribution of women 15-49, in percent, by union status and zone of intervention

Type of union	MEI	OBDC
Marriage	21.7	22
Common law	35	44.8
Engaged	0.8	0.8
Girl friend	9.2	4.1
Live-in	8.3	11.6
No union	25%	16.6%

8. CONTRACEPTION

Table 8.1 provides information of the knowledge by women 15-49 years old of contraceptive methods.

8.1 Knowledge of the various methods of contraception is as follows in the two areas:

Method	MEI	OBDC
Tubal ligation	10.0	13.3
Vasectomy	1.7	7.1
Pills	80.0	80.9
IUD	5.0	10.4
Injectables	79.2	88.4
Norplant	33.3	50.2
Condoms, male	24.2	44.8
Condoms, fem	4.2	16.2
Diaphragm	0.8	0.8
Vaginal. Gels	4.2	5.0
Lactation. Amennorrhea.	0	2.9
Calendar	2.5	2.5
Withdrawal	0.8	0.8
None	9.2	2.9

The contraceptive prevalence rate for modern methods is 19% for all women and 25.5% for women in union at MEI. It is 27% at OBDC for all women and 32.2% for women in union.

Table 8.2. Contraceptive prevalence rate, modern methods, women in union, MEI and OBDC, and Haiti.

	MEI	OBDC	HAITI
RATE	25.5	32	18
N	90	201	

Among users, the utilization of the various methods of contraception is as follows in the two areas:

Table 8.3 Distribution of contraceptive methods, by zone of intervention

Method	MEI	OBDC
Tubal ligation	6.9	0
Pills	34.5	23.3
IUD	0	10.4
Injectables	34.5	41.1
Norplant	3.4	0
Condoms, male	17.2	27.8
Diaphragm	0	0.8
Calendar	3.4	5.6
Withdrawal	3.4	2.2

PREFERRED METHODS INCLUDE INJECTABLES, ORAL CONTRACEPTIVES, AND CONDOMS.

9. AIDS

At MEI and OBDC, 100% of respondents state that they have heard of AIDS and 89.2% claim they know how to protect themselves from AIDS. The most frequent methods of protection cited are:

Table 9.1 Methods of protection against AIDS cited by respondents

Percent respondents citing the method of protection	MEI	OBDC
Condom	87.9	88.2
Abstinence	9.3	16.7
Avoid prostitutes	1.9	8.1
Single partner	38.3	53.8
Avoid transfusions	2.8	13.6
Avoid syringes	5.6	11.8
Avoid same sex partner		0.9

The data suggest that the methods of protection cited correspond to the various IEC messages given through the national AIDS program (Condoms and single partner). Less than 20% of respondent cite abstinence as a method of protection.

At risk behaviors for AIDS cited are sexual relations, which is in first position, and multiple sex partners, in second position. :

Table 9.2 Percent of respondent citing the following at-risk behaviors for AIDS

	MEI	OBDC
Sexual relations	85	86.9
Prostitutes	3.7	12.7
Many partners	38.3	50.7
Blood transfusions	27.1	38.2
Does not know	3.7	5.0

The self-risk assessment shows that about half of respondents do not feel they have any risk of getting AIDS. The distribution of responses with regard to risk status is as follows:

Table 9.3.Distribution of respondents in percent, by perceived risk status for AIDS

	High risk	Medium risk	Low risk	No risk
MEI	6.7	18.3	22.5	52.5
OBDC	15.4	22.0	19.1	43.6

10. CONDOM USE

The use of condom is relatively low. Only 20.8% of respondents at MEI and 21.6% at OBDC report having used a condom to avoid giving or catching an STD or AIDS, and of those, only 36% at MEI and 35.8% at OBDC claim they have used condoms every time. The source of condoms is as follows:

Table 10.1. Distribution of sources of condoms, in percent, as cited by respondents.

	Hospitals	Clinics	Drug-store	Mobile Clinic	Health agent	TBA	Grocery store	Street sellers	Relative	Other
MEI	15	19	55	0	26.7	0	71.7	16.7	0.8	7.5
OBDC	20.3	35.3	57.7	0.4	29.5	0	73	26.1	2.5	9.5

This table emphasizes the effectiveness of the commercial route for selling condoms (drugstores, grocery stores and street sellers)

11. TETANUS TOXOID VACCINE

The proportion of women with a vaccination card that could be produced is 41.7% at MEI and 30.3% at OBDC. At MEI, 18.3% of women never had a card and the proportion at OBDC is 18.7%.

Table 11.1 Percent of respondents capable of producing a vaccination card and percent reporting they never had a card

SITE	PRODUCES CARD	NEVER HAD A CARD
MEI	41.7	18.3
OBDC	30.3	18.7

Based on card inspection alone, the proportion of women with 1, 2 or more doses of tetanus toxoid vaccine is as follows:

Table 11.2 Distribution of women 15-49 years old in percent, by number of tetanus toxoid doses

SITE	TT1	TT2	TT3	TT4	TT5
MEI	40.8	28.3	9	0	0
OBDC	30	21	5	1	1

KEY FINDINGS AND RECOMMENDATIONS

ISSUES	FINDING	RECOMMENDATION
To what extent does the system of census and family registration represent an accurate view of the population being served? Can true coverage be estimated from current census and registration parameters?	*The system of census and family registration is not routinely up-dated. Service statistics data give a fair representation of the volume of services provided but accurate population data need to be available to determine denominators for coverage calculations*	*Re-do a complete census and focus on pregnant women and births to maintain the registration system. Alternatively, do only a census of pregnant women and keep it up-dated.*
How do patterns of coverage for child survival services vary by health agent, particularly in the area of childhood vaccination and Vitamin A distribution?	• *MEI and OBDC are running a successful child survival service delivery program. Coverage for key child survival services such as immunization, Vitamin A, growth monitoring is very good. Baseline levels for contraception are also good.* • *By and large most health workers do a satisfactory job although for one or two, their performance needs to be monitored more closely.*	*The main focus should be on maintaining quality of services and ensuring that those who do not use services (non-users) are identified in a reliable manner so that no one is excluded from service delivery.* *CHAs needing extra help should be identified and their performance assessed to identify barriers to service delivery that might explain any borderline performance level.* *A customer survey to identify barriers to utilization of the two*

	• *Clients seem to go to other health centers besides Calebasse and Monsanto Petit for some of their health needs.*	*health centers should be carried out*

ISSUES	FINDING	RECOMMENDATION
What patterns of problems were encountered in the implementation of the project? What are the best practices and guiding principles to improve results in furtherance of the CS Strategic Objectives?	*There are weaknesses to be corrected in pregnancy registration, vaccination of women of childbearing age, and on care-giving practices for diarrhea, ARI and nutrition.*	*Improve the identification and registration of pregnant women. Strengthen the use of the maternal health card. Strengthen post-natal services. Improve health education by first retraining health providers (CHAs), and then by establishing an IEC plan incorporated into service delivery.*
What changes should be made in the management of the grant at the local level *What are the baseline levels for contraceptive prevalence as well as AIDS knowledge and practice*	• *MEI and OBDC both need extensive technical assistance in institutional development. Basically, they are at level 1 (MOST) in terms of institutional development.* • *Management skills of key staff need to be strengthened.* • *In spite of this, MEI and OBDC have made significant achievements in the provision of health services to their target population, and this, with limited staff. The challenge will be to up-grade this staff qualitatively while maintaining the successful aspects of the program.* • *Baseline levels for contraception are higher than for Haiti as a whole.* • *The level of AIDS knowledge is inadequate in certain risk-avoidance areas and self-risk assessment. Condom use is low.*	*FOCAS should consider hiring an expert in organizational development to help the two institutions strengthen their management system.* *Key staff should attend seminars on various aspects of management.* *(See part II).*

PART II: PROGRAM MANAGEMENT

OBJECTIVE OF THE MANAGEMENT ASSESSMENT

The assignment took shape as the author was in the process of doing a technical evaluation of the two programs (MEI and OBDC). It came about because of concerns from the FOCAS headquarters health officer that the two organizations might need some management strengthening so as to improve their services. This was confirmed by the president of FOCAS who asked the author to carry out a limited management assessment of the two organizations in order to identify specific areas which could be strengthened. In view of the time constraints of the consultation, this was evidently going to be a preliminary exercise which could point to directions where more in-depth evaluations or on-going technical assistance might be in order.

METHODS

To carry out the assignment, the author chose as a tool the MOST tool developed by MSH in Boston. MOST (Management and Organizational Sustainability Tool) looks at four major management functions: mission, strategy, structure, and systems, divided into 12 sub-segments, to assess the maturity of the institution. In the standard mode, MOST is to be used within the context of a workshop with wide participation from staff members. Because of time and budgetary limitations, only the program directors were interviewed. This was supplemented by information from some other key informants (FOCAS senior staff).

THE INSTITUTIONS

A. MEI

STRENGTHS

Structure

The MEI management structure is flexible. There is a church council at the top with various committees, and the council oversees the operation of the health program. The council has been in existence for decades although its membership has varied. The presence of a constant leader over the years has given the council and MEI a measure of stability, guidance, and program consistency and has afforded MEI strong leadership.

Planning

Operationnal planning is carried out by the staff of the communty health program so that the community health staff is well aware of its tasks as well as of planned activities. There is evidence to suggest that this level of planning is sufficiently adequate to ensure appropriate resource availability for service delivery including vaccines, contraceptives, medicines etc.

Coordination

The program Coordinator at MEI appears to have a good rapport with the community health staff and with the oversight council. In addition, there is adequate coodination between MEI and FOCAS

Health information System

The system provides reliable information on the monthly volume of services being provided. In addition, according to FOCAS management, the system also produces accurate and complete financial reports.

Resource utilization

The management and technical staffing pattern at MEI is light, and this is quite remarkable in view of the technical results that have been achieved. The organization draws pratically no overhead from the FOCAS budget, and in fact seems to have a very small overhead in general for its operations.

Community Outreach System

The organization goes beyond the walls of its dispensary and manages an effective network of community outreach workers. This network has made it possible for the organization to achieve remarkable results oin terms of service delivery coverage

AREAS THAT NEED STRENGTHENING

Key management functions

MISSION

Mission : Knowledge

The Mission of MEI may be implicitly derived from its by-laws and from a Vision Statement prepared by its head. However, there is no formal Mission Statement and while the staff generally knows what MEI is all about, their knowledge is hampered by this absence of a formal statement. This puts MEI at level 1 in terms of stages of development

Mission: Application

Program activities and priorities are routinely defined while keeping in mind the implied Mission of the organization, which is primarily religious. No specific and stated linkage between health activities and church goals has been formulated in a formal manner. Thus it is difficult to know whether activities are chosen or planned more on the basis of the needs of the Church or on the basis of the inherent requirements of the health program. What is apparent is that if the two are in conflict, the needs of the Church may receive higher priority.

STRATEGIES

Strategies: Link with the Mission

While there is a certain level of operational planning, the degree of strategic planning being carried out is quite limited. At this time, it appears quite clearly that strategy is donor-driven (i.e. FOCAS) with limited input from the staff of MEI.

Strategies: links to the grassroots and to the client

Client need and client satisfaction surveys are not carried out in a systematic way. Decisions are taken on an impressionistic basis and, as noted before, with the needs of the Chruch being kept in mind.

STRUCTURE

Roles and responsibilities

The MEI management structure provides for confusing lines of authority. For example, an employee under the supervison of the Director might at the same time be a Board member and does not truly answer to his immediate supervisor. In addition, some functions carry inherent conflicts of interests (writing and signing checks, authorizing expenses, and maintaining the books at the same time). It appears that the technical program director has the final word with regard to technical decisions but her real authority in terms of administrative decisions is not as well defined, irrespective of her job description.

Delegation of authority

The organization, like all Churches, has a definite hierarchy. The health program includes a health center as well as community health activities. While it is likely that the input of staff is solicited for major decisions (such as, for example, the need to enlarge the dispensary), no **formal** mechanism exists to bring major issues for discussion with the staff, for recording these discussions and for providing a rational basis for the decisions that are eventually adopted..

SYSTEMS

Organizational Planning

Plans exist for the FOCAS-financed program. Objectives were set predominantly by FOCAS. A five year operational plan does not exist for MEI.

Use of data for decision-making

The Management Information System seems to provide data which reflect the volume of services being offered. In addition, financial reports provide data on expenses. The system has some weaknesses in giving precise infromation on the composition of the population being served, and

in addition, does not incorporate formal features which allow ways to identify customer dissatisfaction with services. No information on the true cost of services is available.

Quality Assurance

The organization has instituted some activities with external advisors to assess and improve quality . Some staff members have been trained in the use of a formal CQI system. It is not clear whether a specific staff member has been assigned the specific overall responsibility for CQI and to what extent these activities are sustainable since it cannot be said that CQI is an integral part of the organization's long term plan ; such a plan does not currently exist.

Management of supplies

We have been unable to identify a systematic approach to supply management that would incorporate supplier performance analysis, cost of procurement, and supply chain management issues such as inventory control and logistics.

Financial management

MEI has a basic bookkeeping system with no significant analytic capability in terms of staff and record-keeping. The accounting system is cash-based and as such does not follow generally accepted accounting principles. In addition, it is not clear to what extent staff are involved in budget preparation, and to what extent the budget reflects MEI goals and long-term objectives. Since most of the budget is funded by FOCAS, it reflects short term objectives of the FOCAS project. Periodic balance sheets and income statements are not prepared and we are not aware that the institution has ever been audited.

Sources of funds

MEI is heavily dependent on FOCAS funding. A financial sustainability plan does not currently exist.

Human Resource Development

While a training plan has been developed in conjuction with the FOCAS project, it reflects project needs rather than institutional development objectives. In the absence of written long-term objectives, such a plan will be difficult to develop. Staff members are retained on the basis of job descriptions and contracts but an employee manual does not currently exist.

Staff has limited means to function. There are no computers at MEI. All management fucntions are manual and staff has no access to the internet.

Marketing and Information, Education and Communication

Patients utilize the Calebasse center but utilization could significantly increase. Formal market analyses have not been carried out to determine customer preferences and health-related behavior. An Information, Education and Communication (IEC) plan does not exist

B. OBDC

OBDC is not a faith-based organization. It has a lay board of directors which oversees all activities. Aside from the fact that at OBDC the Program Director seems to enjoy more authority and responsibility than her counterpart at MEI, the problems are the same.

RECOMMENDATIONS

MISSION development

MEI and OBDC should develop a Mission Statement as well as a Vision Statement; disseminate them among board members, staff, customers, donors and the public at large.

Mission: Application

Once the Mission statement is written, program activities and priorities will be selected on the basis of the Mission.

In the case of MEI, it is suggested that its head, Pasteur Molière, adopt measures to strengthen the capacity of the Church Council to oversee health activities sponsored by the Church.

STRATEGIES

Strategies: Link with the Mission

Again, once the Mission is established, organizational strategies should be adopted in conformity with the Mission.

Strategies: links to the grassroots and to the client

Client need and client satisfaction surveys could be carried out in non-expensive ways (for example exit interviews). Clients and other community members should be actively involved in formulating organizational strategies, perhaps through the organization of community health committees..

STRUCTURE

Roles and responsibilities

The roles and responsibilities of the Church Council in the case of MEI and the Board in the case of OBDC, and that of staff, should be clearly delineated. Council and Board members should attend a seminar on the specific roles and responsibilities of an oversight body.

An organizational chart should be drawn for the two organizations which specifies lines of authority. Confusing lines of authority should be avoided.

Delegation of authority

Staff input should be sought through regular staff meetings where minutes are kept and decisions taken on programmatic matters.

SYSTEMS

Organizational Planning

MEI and OBDC should both develop five-year plans which are not necessarily a reflection of the FOCAS project. The plans should be broken down into yearly components and annual staff meetings organized to review progress against objectives.

Use of data for decision-making

The Management Information System should be computerized and integrated so that all decision-making elements (personnel, material resources, finances) can be analyzed simultaneously for appropriate decision-making. An exercise to estimate the true cost of services could be carried out using a tool on cost recovery called CORE developed by MSH.

Quality Assurance

Once a strategic plan is defined, the CQI component, which should be an important aspect of the plan, should be well-defined as a key on-going element that will need monitoring indicators and resources for its implementation.

Management of supplies

An inventory system , manual at first (Kardexes), and then computerized, could be adopted to identify future requirements and avoid stock-outs.

Financial management

Once the two organizations have computers, we suggest the use of an accounting software (such as Quickbooks Pro) for accounting and bookkeeping. The manual and computerized systems

should co-exist for a while until the staff is fully capable of maintaining the electronic system. Financial reports should be used for management decisions. An annual institutional audit should be performed. More participation from the staff in bugetary decisions is suggested.

Sources of funds

The CORE exercise should identify the true cost of operating the health centers. Once this information is available, a long-term financial sustainability plan should be defined to recover the cost of the curative operations.

Human Resource Development

A significant amount of management training should be planned for key personnel, medical directors, administrators, accountanst etc. All should be computer-savvy (Micorsoft Office). In addition, we recommend health systems management training with courses offered in the US (MSH, Boston University, CEDPA, etc.) or in Canada (Universite de Montreal) for the two program directors.

Marketing and IEC

An IEC plan should be developed based on the customer assessment.

TECHNICAL ASSISTANCE

It is recommended that FOCAS hire a long-term organizational development (OD) person who will work along with a technical person. S/he should focus on the institutional development of MEI and OBDC. Additional short-term technical assistance in the areas mentioned above could be provided depending on the area of expertise of the OD person.

It is not recommended that the MOST exercise be done again, as initially thought, as the expenses involved would be unlikely to provide more information on the status of the institutions. We would recommend instead a staff seminar using the CEDPA Institutional Sustainability Tool. The outputs of the seminar would be a mission statement as well as strategic plans for the two institutions.

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