

Healthy Mothers, Healthy Children: A Child Survival Initiative in Petit-Goave

RFA # M/OP/GH/HSR-04-003 Child Survival and Health Grants Program

**Global Health Action (US PVO)
And
The Methodist Church COD-EMH (Local PVO)
Detailed Implementation Plan (DIP)**

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Abbreviations and Acronyms

AOPS	Association des Ouvres Privées de Santé (Association of Private Health Organizations)
BCC	Behavior Change Communication
CHW	Community Health Worker
COD-EMH	Bureau of Development of the Methodist Church of Haiti
CSHGP	Child Survival and Health Grants Program
CSIPG	Child Survival Initiative in Petit Goave
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
DRPG	Director of the Region of Petit Goave
GHA	Global Health Action
HFA	HFA
KPC	Knowledge, Practices and Coverage survey
MoH	Ministry of Health
NGO	Non-governmental Organization
PM	Program Manager
PMTCT	Prevention of Mother to Child Transmission
PVO	Private Voluntary Organization
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UCS	Unité Communale de Santé (Communal Health Unit)

A. Executive Summary

Global Health Action (GHA), a non-profit private voluntary organization (PVO) based in Atlanta, Georgia, USA will work in partnership with the Haitian based Methodist Development Office (COD-EMH) to improve the health and well being of women of reproductive age and their child in the Petit Goave region of Haiti.

Program Location: The project is located in the region of Petit -Goave, 65 kilometers from Port-au-Prince, the capital city of Haiti. It is a mostly mountainous coastal region, divided into twelve communal sections. The coastal town of Petit -Goave is the administrative center for the region. The project will work in a total of 8 health facilities (7 clinics and 1 hospital) in the region. Six of the facilities are managed by the Ministry of Health (MoH), while the remaining 2 are operated by the COD-EMH.

Problem Statement: Maternal mortality in Haiti (523/100,000 women) is the highest in the Caribbean and Western Hemisphere. Scarce maternal care services and low levels of utilization (only 44% of pregnant women receive adequate and timely health interventions) are major factors responsible for this tragically high rate. At the same time, health facilities records in 2001 show a monthly average of 25 new cases of sexually transmitted infections among female clients in the Petit Goave region. Lack of a male head of household in a large number of families in the community also serves to increase the vulnerability of mothers and young children. These risk factors contribute to create very poor conditions for child survival as well.

Estimated number of beneficiaries: According to the Haitian National Institute of Statistics, the region of Petit -Goave has an estimated population of 125,789 people, of which 11% (13,836) are under five years of age. An estimated 25% of the population (31,447) consists of women of reproductive age.

Project's goal, objectives and major strategies:

Project Goal: *To contribute to the reduction of maternal and infant mortality in the Petit Goave Region of Haiti.*

Broadly, the project will undertake to:

- **improve the availability and quality** of key child survival and maternal and newborn health services; and
- **increase the demand** for and utilization of those same key services.

In doing so it expects to achieve the following objectives:

Objective 1: 75% of mothers of children 0 -23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.

This objective will be achieved through the implementation of two basic strategies:

Strategy 1: Improve quality of pre- and post-natal services available in the region

Strategy 2: Increase demand for, and utilization of, quality pre -/post-natal and infant services in Petit Goave Region

Success of these project strategies will be measured using the following indicators:

Indicator 1) Percentage of mothers of children 0 -23 months in Petit Goave Region who attend at least one pre-natal consultation (card confirmed) prior to the birth of her youngest child

Indicator 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one postpartum checkup (card confirmed)

Indicator 3) Percentage of children 0 -23 months in the Petit Goave Region who receive check-up at the time of mother's first postpartum consultation

Objective 2: Establish a local referral network for quality maternal care in Petite Goave region of Haiti by September 2008.

This objective will be achieved through the implementation of the following basic strategy:

Strategy: Build/strengthen referral network and channels within existing health facilities and community

Success of this project strategy will be measured using the following indicators:

Indicator 1) Percentage of mothers with children 0 - 23 months in Petit Goave Region who had at least one postpartum check up with other health personnel after most recent delivery

Indicator 2) Percentage of mothers of children 0 -23 months in Petit Goave region arriving at health clinic or hospital who were referred through established channels (CHW-clinic-hospital)

Breakdown of Level of Effort:

Child Survival/Health Interventions:

- **Immunization** of pregnant women and women of reproductive age: **20%**
- Promotion of **Breastfeeding: 25%**
- **Maternal and Newborn Care** (with promotion of micronutrient, child spacing and HIV/AIDS integrated into it, as well as complete child vaccination for the first year –BCG, Polio 3, DPT 3 and Measles): **55%**

Proposed Operations Research and/or anticipated documentation strategy for the project: The project has a comprehensive and well -developed monitoring and evaluation (M&E) framework. The framework defines data to be collected by the project in order to allow it to calculate and track indicators of impact/objectives, outcomes and process/activities. This documentation will allow the project to know; 1) “did we do what we said we would do?” and 2) “what happened when we did?” The answers to these fundamental questions will be important to improving the health and well being of women

and children in Petit Goave as well as other health and development projects supported by GHA.

The project is not conceived nor designed as a research project and will not carry out methodologically rigorous operations research. It is first and foremost a project designed to improve access, utilization and quality of key maternal, newborn and child health services. None the less, the M&E framework proposed will allow the project to answer in a structured and well documented fashion, some very important questions about its approach and strategies and their ability to improve the health of women and children in the community.

These questions include:

- How to increase/maximize the role of the community to promote improved health seeking behaviors by women and their infants;
- The role of community health workers (CHWs) and traditional birth attendants (TBAs) in increasing access to key services (especially in the case of obstetric emergencies); and
- The role of community groups and community peer leaders as vehicles for behavior change communication.

Local partners involved in program implementation, including roles and

responsibilities: The principal local partner is the **Bureau for Development of the Methodist Church (COD-EMH)** who will work in partnership with the UCS of Petit - Goave. Partnership with national institutions working specifically on HIV/AIDS, will be established for epidemiological surveillance and management of HIV positive pregnant women. In addition the project will work closely with the MoH. The MoH runs/manages 6 of the 8 targeted health facilities in the region. In addition, the project will develop mechanisms to implement MoH technical policies and guidelines in those facilities. It is essential then that the MoH be seen as a full implementation partner in the project (for a list of project staff, please refer to Annex 5).

Start and end dates:

September 1st, 2004 and end date September 2009

Level of funding:

The budget for the full five years is \$1,637,196 with \$1,061,385 federally funded. The cost share is 35.2%.

Name and position of the local USAID Mission representative with whom the program has been thoroughly discussed:

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B. CSHGP Data Form

Please see Annex 7.b..

C. Description of DIP Preparation Process

This Detailed Implementation Plan (DIP) has been developed after a lengthy (5 months) process of consultation, coordination, analysis and interpretation. Global Health Action Headquarters (GHA-HQ) staff has consulted with USAID/Washington, CSTS, the Bureau for Development of the Methodist Church (COD-EMH), in Port au Prince, Haiti, regional Ministry of Health (MoH) officials, other PVOs implementing child survival projects in Haiti and, perhaps most importantly, community members from the project target area in the Petit Goave Region. This has been done to insure that the project's objectives and strategies benefit from the best technical inputs available as well as benefit from the ownership of its key Haitian partners. Without either of these, the project's chances for success would be compromised. As such, this DIP is presented with the full buy -in of its partners and represents the application of current best practices and strategies to improve the utilization and effectiveness of women's and children's health services. The project and this DIP are ambitious. However, given the problems faced by the communities of Petit Goave, anything less would be inadequate.

In order to begin the process of preparing the DIP, GHA -HQ program staff traveled to Haiti in November, 2004 to introduce new COD-EMH staff, (the national medical coordinator and the Director of the COD had recently stepped down and been replaced), to the project. Neither of these individuals were aware of, or familiar with the project and their support was deemed essential to the planning process.

At the same time, USAID granted permission to GHA to hire the Program Manager PM (PM) directly, in consultation with the ex -Director of COD-EMH, Inette Durandis, (who had worked on the development of the proposal), and the current leadership of COD -EMH. It had been agreed that it was in the interest of the project that the PM would be a Haitian national working in the field and supervising the day -to-day implementation of the project and that s/he would report to COD-EMH/GHA but that GHA would pay their salary. This was done in order to improve accountability and communication with GHA, the grantee.

After interviewing a number of candidates, a PM for the project, Dr. Jean Elliot Pierre, was hired. Dr. Pierre, an alumnus of GHA's leadership and management trainings in 2002 was well known to GHA. He comes with a vast community health and development experience which was recognized first hand by Dr. Melamed when she observed him in his practice on the island of La Gonave at the Bill Rice Community Health Center and then while doing training with community leaders. His clinical experience is also important for the project

given that one of the main goals besides raising community awareness and bringing behavior change is to create a referral network for pregnant women and improve the quality of services they receive.

Once hired, the PM (accompanied by GHA -HQ staff) was then able to meet with representatives of the MoH such as the Director of the West department (Dr. Raymond) and Dr. Byron (coordinator of the UCS of Petit Goave) to inform them that the project had been approved and that planning was underway. At that time, there were discussions regarding the way in which the project could improve the quality of care delivered by MoH health centers in Petit Goave.

The PM has also visited the region of Petit Goave in order to meet with different community leaders and clinic staff at various health centers and let them know about the project. Copies of documents describing the project were distributed in order to make sure that leaders and health center staff throughout Petit Goave were aware of the project and its objectives.

During the first 3 months of 2005, GHA -HQ and the PM occupied themselves arranging the logistics to conduct a number of baseline data collection exercises that would be used to further refine the project's strategies and approaches (Knowledge, Practices and Coverage - KPC- survey, Health Facility Assessment survey –HFA- and focus group discussions).

The KPC survey instrument was developed using the modules from the CSTS website. While developing the questionnaires, Jennifer Luna (M&E specialist from CSTS) provided ongoing feedback to this technical team composed of an external consultant who worked as the KPC coordinator, Angela Thompson, MPH, James Setzer, MPH, Dr. Melamed, Lynda Lattke, MPH, and Dr. Pierre. Extensive communication with Haiti allowed the field -based PM to participate in the development of the questionnaire and KPC survey methodology. Ms. Thompson traveled to Haiti in mid-January 2005 to conduct the training with 18 surveyors and supervise the collection and entry of the data (details of the KPC methodology are found in Annex 3). A summary of the report was translated into French and Creole to be shared with community leaders. Dr. Desinor, USAID/Haiti was given a copy of the summary for feedback at a meeting with the PM and GHA -HQ staff.

In addition to the KPC survey, a HFA survey was carried out in all eight health facilities in Petit Goave using a model instrument provided by the Haitian Health Foundation. This survey was performed to give the project a concrete idea of the condition of the health facilities in the region with respect to infrastructure and utilization of services. Results from the survey are summarized in this DIP document.

Since it is recognized that KPC surveys are well developed to tell us what is happening but not always why, the project has organized a series of informal focus groups and key informant interviews. The results of these activities (which are ongoing) will be used to better focus the messages for behavior change and communication that will be disseminated by the project through a variety of media (community groups and mobilization, radio sports,

etc.).

At the end of March, PM-GHA/HQ (Ms. Lattke) traveled to Petit Goave to carry out a two - day DIP workshop with community members. The PM/field sent out invitation letters to various members of the community including the CS project staff, COD -EMH in Port-au-Prince as well as representatives of the MoH (UCS) clinics in the region.

The purpose of this workshop was to share the KPC survey results, preliminary results from the HFA, and information collected from informal group discussions and key informant interviews. GHA used the workshop to elicit feedback from participants regarding the objectives of the project as well as the different activities that had been proposed and to discuss whether they were realistic, practical and sustainable given the context and current environment in Petit Goave. The project work plan provides more detailed information and highlights the new activities proposed by the community.

A total of 31 people attended the workshop, including two journalists from a local radio station who aired a radio spot on the project and the workshop itself.

Feedback on the workshop was positive and participants expressed appreciation for the participatory format which allowed questions, and group work while learning about community problems (KPC survey results) and openly discussing them.

The draft DIP was submitted to USAID -Washington for review. The DIP review process was another opportunity to gather input and feedback from technical experts in the child survival field. Based upon the review comments and discussions with USAID, GHA hired a consultant, James Setzer, MPH, to assist with the revision of the DIP and preparation of this final draft.

D. Revisions (from original proposal and draft DIP)

Some of the changes made to the DIP include new activities suggested by the community which are highlighted in the work table. Based upon results from the KPC survey and HFA, as well as feedback from the USAID/CSTS technical teams, a number of changes have been made in the sequence of activities found in the work plan as well. In collaboration with COD-EMH and the MoH (UCS), it has been decided that it is most important to do the training of health facility staff, TBAs, CHWs as well as equip the health facilities in the first year of project activities.

Feedback on the DIP and review of KPC results with the communities led to revision of the originally proposed project intervention areas and their relative weighting percentages. After further discussion with the USAID/CSTS technical team, it was decided to change the intervention percentages to the following :

Child Survival/Health Interventions:

- **Immunization** of pregnant women and women of reproductive age: **20%**
- Promotion of **Breastfeeding: 25%**
- **Maternal and Newborn Care** (with promotion of micronutrient, child spacing and HIV/AIDS integrated into it, as well as complete child vaccination for the first year –BCG, Polio 3, DPT 3 and Measles): **55%**

Other noted changes include:

- International training has been replaced by training activities to take place in Haiti rather than in the US. This step will allow for more staff to benefit from the training
- Based upon feedback from the reviewers of the draft DIP, the project objectives have been refined and refocused. There are now only two objectives.
- Due to the new activities and the PM hired through GHA, there have been some changes in the budget which will be annexed to this document. Some of those changes have already been approved by USAID/Washington in February, 2005.

The revised/final budget can be found in Annex 7.a.

E. Detailed Implementation Plan

1. Summary of Baseline and Other Assessments

KEY INFORMANT INTERVIEWS

As part of initial baseline data collection to provide information to allow GHA and COD - EMH to further focus and refine the approach spelled out in the program proposal, the field - PM carried out a number of key informant interviews and focus groups to gather information to supplement the results of the KPC survey. While the number of interviews/groups was not extensive the results do provide added richness and depth to those provided by the KPC. The results of the interviews and focus groups will be used as the project develops messages and behavior change communication strategies.

Important findings from these activities include:

- Few if any women understand the purpose of pre-natal visits as a way to protect their health and that of their infant.
- It is the husband that makes the decision as to where a woman will deliver her baby. Strategies to increase the percentage of births attended by trained personnel and/or those capable of organizing evacuation and referral in the case of an obstetric emergency must therefore target/include men.
- While both men and women understand the role of condoms in preventing the spread

of STIs, they are not used because they represent a level of mistrust of the partner. Some reported that the cost of condoms is a barrier to their use as well.

- The father's perceived role (by women) in the health of their children is largely limited to providing money to handle the financial costs of hospital and clinic visits. Fathers take little active role in the health and well being of their children (i.e. taking children for vaccinations, etc.) and are perceived to know little or nothing about the health of their children. Women did express the view that men might be interested in learning about the health of their children and responsible fatherhood however.
- Traditional medicine still plays a role in the health seeking behaviors of the communities in Petit Goave. We learned that many people will first go to the 'wougan' (traditional healer/practitioner) out of custom and also because it is closer to home and sometimes cheaper than the clinic.

The value of such information is clear to the project partners. The project will continue to use such qualitative methods throughout the project to continue to learn about the "whys" of behaviors by members of the community. Using this information is essential to develop strategies and approaches to addressing the situations which are documented and quantified by other methodologies like the KPC survey.

HEALTH FACILITY ASSESSMENT

The project will work with/through a total of eight health facilities in the region to serve an estimated population of greater than 125,000.

Targeted Health Facilities in Petit Goave Region (affiliation) :

- Notre Dame Hospital (MoH)
- Olivier Health Center (COD)
- Arnoux Health Center (MoH)
- Violet Health Center (MoH)
- Madeleine Health Center (MoH)
- Vallue Health Center (MoH)
- Platon Trou Chou Chou Health Center (COD)
- Cadet Trou Chou Chou Health Center (MoH)

In order to better understand the status of service delivery in each of these facilities, a HFA was performed by the PM-field. The assessment tool was comprehensive and included sections to assess/document:

- human resources (number and level);
- infrastructure including the availability of equipment;
- availability of laboratory services;
- availability of essential drugs, vaccine, supplies and equipment specifically for child survival and maternal health services;
- availability of transportation in the case of emergency;
- community outreach and communication activities; and

- service delivery statistics for family planning, maternal health and child survival services.

A summary of some of the assessment's findings include:

- Many of the health facilities in the region lack even basic equipment and infrastructure for the delivery of services. Many lack refrigerators (and/or have difficulty procuring the gas necessary to operate them and maintain cold chain integrity, for example). Many lack running water or the means to sterilize equipment and tools adequately. The means for disposal of medical waste are not adequate.
- The availability of laboratory services (even for simple tests such as malaria, urine, etc.) is limited to Notre Dame Hospital and Olivier Health Clinic. Distance and lack of affordable transportation makes referrals for these services ineffective.
- Despite the difficulty of cold chain maintenance, many vaccines were available at the time of the assessment. It may be that availability of some vaccines and supplies (vitamin A and iron) are variable. Lack of available vaccines leads to high numbers of "lost opportunities" and consequently, low vaccine coverage.
- Service delivery statistics are available for most child and maternal health services. Without appropriate estimates of denominators, however, they are difficult to interpret. Nevertheless, they do provide a baseline against which these same indicators may be compared as part of the project's ongoing M&E framework. It will be necessary to carry out population based sample surveys in order to estimate coverage or changes in coverage levels. The project will repeat the KPC survey at midterm and end -of-project for this reason.
- Despite the lack of a denominator it would appear from the statistics of the curative consultations that many of the facilities are under utilized given the presumed levels of morbidity in communities such as these.
- Human resources appear to be barely adequate. Several of the facilities are staffed by a single nurse. The networks of CHWs and TBAs have fallen into disuse and most communities have access to neither (contrary of MoH policy).
- There is currently no method available to evaluate the effectiveness or even frequency of referrals for any reason. While the Notre Dame Hospital is the theoretical reference facility for the region, there is currently no way to tell whether referral for complicated conditions, high-risk pregnancy or obstetric emergency actually take place.
- There is a lack of organized or recognized community groups and structures capable of mobilizing or informing the community specifically about health issues and behaviors.

KPC SURVEY

The 2005 KPC Survey conducted in the Petit Goave region of Haiti was useful in establishing baseline indicators from which the program will be able to monitor progress and evaluate changes in knowledge, practice and coverage for the duration of the project implementation. It provides information in the following areas: demographic, health contact/access to health information, maternal parity, child anthropometry, maternal and newborn care, iron supplementation, delivery practices, breastfeeding and nutrition, postpartum care, child spacing/family planning, childhood immunization, malaria prevention, integrated management of childhood illnesses (IMCI), HIV/AIDS, Sexually Transmitted Infections (STI), HIV Screening, and Hand -Washing Practices.

The 2005 KPC Survey is based on a sample representative of the region of Petit Goave. The sample was comprised of 30 clusters of 300 households. A total of 300 women aged 15 -45 years with at least one child 0 -24 months of age participated in the survey. The sampling methodology has been used successfully by UNICEF and WHO to assess immunization coverage and by USAID to provide baseline and final data collection in child survival programs in various countries. However, it is important to remember that responses provided by respondents can be subject to recall bias and willingness to respond to questions may be prejudiced by cultural or social influence.

The Minister of Public Health and Population (MSPP - Ministère de la Santé Publique et de la Population) has conducted several national surveys (EMMUS -II Haiti 1997 and EMMUS - III Haiti 2000) which provided a snapshot of the health of the population. The published results of the EMMUS -III Haiti 2000 are available in a 489 page publication from ORC Macro. It provides comprehensive statistics on maternal and child health covering many of the same topic areas covered by the 2005 KPC Survey in Petit Goave. The 2005 KPC Survey in Petit Goave provided a more recent and specific picture of the situation of maternal and child health in that district.

A copy of the full KPC survey report including a comprehensive table of maternal and child health indicator values from the survey are found in Annex 3.

The survey population

The majority of the region of Petit Goave is rural and residents have lived there for 14 years on average. The median age of women who participated in the study was 28.8 years and the median level of educational attainment was 4.4 years of formal schooling. One quarter (24.1%) of all women in the survey had no formal education. Overall, the level of education is still low among women in this region and throughout Haiti.

Maternal parity and child spacing/family planning

On average women in this region have had 3.7 pregnancies and 3.4 live births and a nearly half of children (46.4%) were born at least 24 months after the previous surviving child. Nationally 73% of women report that at least 24 months separated the birth of their youngest child and the preceding surviving child. While nearly half of women interviewed for this

survey are spacing the births of their children, only a small minority of women are using a modern method of family planning. Most women stated that they do not use any method of family planning. Only 22.3% of respondents said that they use a modern method of family planning, which are predominated by injections, followed by the pill and then condom usage.

Further focus groups and individual interviews could clarify beliefs surrounding utilization, non-utilization or barriers to utilization of family planning. Also, further inquiry should be done to reveal availability and affordability of family planning methods in the region of Petit Goave.

Health contact/Access to health information

Availability of and access to health information can influence maternal and child health outcomes. In the region of Petit Goave it is evident that where one lives may influence how accessible health services are to her. The area around the town of Petit Goave, the area we refer to as Zones 1 and 2 (11eme Ravine Seche, 12eme Des Fouques, 1ere Plaine, 3eme Trou Chou Chou, 2eme Plaine) have the greatest number of women who report that they can get to their nearest health center in less than 1 hour. In Zone 5 (9eme and 10eme Des Palmes), the majority of women report that it takes them over 1 hour to get to the nearest health center. Half of women state that they come into contact with a skilled health worker at least once a month. The vast majority of mothers of children age 0 -24 months reported that they receive their general health and nutrition information from a formal health network including doctors, nurses/midwives, auxiliary midwife, trained birth attendant, health educator, or a growth monitoring person. Approximately half of women in Petit Goave also report that they have received health messages from the radio. While it may be difficult for some women to reach their nearest health care facility, it appears that women trust and rely on the information they receive from the providers at those centers. Since more women receive health messages from the radio than from other media sources this will have implications for dissemination of health and nutrition information in the region.

Child Anthropometry

The nutritional status of children was measured using weight -for-age as an indicator of actual nutritional status. Overall 18.2% are underweight (-2SD from the median weight -for-age according to the WHO/NCHS reference population) and an additional 20.9% of children 0 -24 months are -1 SD from the median weight -for-age. Nationally, 11 -15% of children 0-59 months in urban areas and 27% of children 0 -59 months in rural areas are underweight. There was not statistically significant difference in underweight according to sex.

Maternal and newborn care

Most women reported that they were seen by a skilled health worker for their prenatal care and 69.3% of women stated that they received a tetanus toxoid (TT) injection prior to the birth of their youngest child. There is a discrepancy between the reported and card -confirmed number of prenatal visits and tetanus toxoid injections among mothers of children age 0 -24 months. Recall bias may influence the responses of mothers. Mothers may over -report the

number of pre-natal visits they have had or they may also count visits to traditional practitioners among their prenatal visit. Recall of TT injections may be biased by recall of injections for other purposes or by TT injections received at a different time. Alternately, the bias may be due to provider practices. If not all pre-natal visits or TT injections are recorded on the maternal health card, results will be skewed. A review of records at health centers will provide estimates of frequency of prenatal visits among women in Petit Goave. A review of record keeping practices among health care providers and health centers may also reveal if the discrepancy in reported and card-confirmed prenatal visits is due to maternal misreporting or provider error in record keeping.

The vast numbers of women do not have card-confirmed TT injections prior to the birth of their first child. For many women, the first TT injection occurred the same day as the birth of their child. Knowledge, practices and coverage surrounding TT injections should be reviewed among health care providers in order to determine need.

Iron supplementation

Half of women stated that they received iron supplementation during pregnancy and the median length of time for taking the supplementation was 16.7 days. The median length of time falls short of the recommended amount of time that iron supplementation should be given to a pregnant woman. High levels of pre-existing anemia coupled with poor iron supplementation coverage of women during pregnancy may contribute to poor pregnancy outcomes. A health facilities assessment should be used to determine availability of iron tablets. It may also be used to discover the practices surrounding its utilization or barriers to prescribing iron supplements for pregnant women.

Delivery practices

Women in and around the town of Petit Goave are more likely than women in other areas to have their delivery attended by skilled health personnel and are at least twice as likely to give birth in a health facility than women in other areas of the region of Petit Goave. Regardless of location, women with higher educational attainment are more likely to give birth in a health facility. This trend is similar to that seen nationally whereby there is a strong positive relationship between educational attainment and utilization of health facilities for childbirth. As discussed above, the majority of women in Zones 1 and 2 reported that they can get to the nearest health facility in < 1 hr, whereas it took more time for women in other zones. Therefore it is not surprising that Zone 1 has the highest rates of deliveries in a health facility. This survey does not reveal why women in Zone 2 do not deliver in health facilities at the same rate as women in Zone 1 if their access to the health facilities is approximately equal.

Most women believed that a clean birth kit was used to cut the cord during delivery and a clean razor blade was the most common instrument used to cut the cord. Scissors were the most frequently mentioned alternative instrument used to cut the cord. Further discussion with mothers or birth attendants would elucidate if and how scissors are sterilized prior to use in a delivery. Interviews and research which gather qualitative information should seek to

discover attitudes about delivery practices, perceptions about quality of health services available in each zone, and barriers to delivery in a health facility.

Breastfeeding and nutrition

In the region of Petit Goave, 53.2% of mothers of infants age 0 -5 months reported that their child was exclusively breastfed in the 24 hours prior to the survey. The national average of exclusive breastfeeding among infants age 0 -5 months is approximately 24%. Among children age 6-8 months, 69.9% in Petit Goave receive breastmilk and complimentary foods. Among infants 6-23 months of age, mothers report that 15 -24% were exclusively breastfed in the 24 hours prior to the survey. Focus groups or interviews should be used to determine if in fact women are exclusively breastfeeding or if they are also providing complementary foods but failed to mention them during the survey.

Postpartum care

Slightly more than one -third of women in the region of Petit Goave stated that they received a postpartum check-up from skilled health personnel and the postpartum checks took place in a health facility. Nationally, approximately 40% of women received postnatal check so the rate of postnatal consultation is slightly lower in Petit Goave than the national average. Most women received the visit from skilled health personnel. This post -natal contact between health personnel and skilled health personnel and can be a critical time to convey health information. Further interviews could help discover knowledge, attitudes and practices surrounding postpartum check-ups and potentially identify the barriers to postpartum care.

Childhood immunization

Immunization coverage is high for BCG (65.1%) and Polio 1 (73.4%) among children 12 -23 months of age in the region of Petit Goave however the rate of complete vaccination is low (7.8%). Nationally, one -third of children age 12 -23 months are completely vaccinated. Efforts should be made to improve rates of complete immunization among children 12 -23 months of age in the region of Petit Goave. That there are high levels of vaccination for the BCG and Polio 1 indicate but such low levels of complete coverage indicate that there are significant barriers to complete vaccination. These barriers may include affordability, accessibility or knowledge about the importance of immunization. Facility assessments should determine whether the supplies necessary for routine vaccination are available or if there are interruptions in supply. Additionally, the assessment should determine the availability of trained health personnel, the number of vaccination campaigns that are conducted and how information about immunization is disseminated to mothers. Further discussion with mothers could reveal their perceptions about the importance of childhood vaccinations for their children.

Malaria prevention

A very small proportion of households included in the survey owned bednets to prevent bites from mosquitoes (6.3%). Among households that had the bednets, an even smaller proportion of them had children 0 -24 months who had slept under a treated bednet the previous night (2.43%). The availability and affordability of bednets and treatment for the

nets should be further examined if this area becomes an interest for GHA.

Integrated Management of Childhood Illnesses (IMCI)

While a high number of mothers were able to mention at least signs of childhood illness that indicate the need for treatment, very few women mention that they offer their child more than usual to drink and the same amount or more than usual amount to eat when the child is ill. More commonly mothers reported that they offered less to drink and less than usual to eat. These practices may contribute to poor outcomes during home care of childhood illness. Further study should be conducted to determine if any or how many health messages women are receiving about rehydration and food intake during illness.

HIV/AIDS and HIV Screening

A great majority of mothers of children age 0 -24 months in the region of Petit Goave knew of HIV/AIDS (96.2%). However, only half of these women were able to cite at least 2 known ways to prevent HIV/AIDS transmission. Condoms were the most commonly cited method of preventing transmission of the disease. However, condom usage was very low as reported in the questions pertaining to family planning. There appears to be a disparity between knowledge about how to prevent the transmission of HIV/AIDS and the actual practices required to prevent the spread. The health facilities assessment will help determine if condoms are readily available. Further interviews with women's and men's groups could help determine if and where individuals are able to obtain condoms, the practices surrounding condom use (e.g. with whom are condoms used and with what sexual partners do people not use condoms). Additional educational efforts are needed in the area of knowledge about HIV/AIDS transmission and prevention.

Sexually Transmitted Infections (STI)

Approximately half of women surveyed had heard of infections other than HIV/AIDS which can be transmitted through sexual contact (47.4%). Slightly more than one-third of women know signs and symptoms of an STI in a man however approximately half know signs and symptoms of an STI in a woman. Half of women know at least one method to avoid getting an STI however this survey did not directly explore practices among women. Another survey or further interviews and focus groups could help determine whether knowledge about how to prevent STI translates into practice among women in the region of Petit Goave.

Hand-Washing Practices

Less than one-quarter of women surveyed reported that they wash their hands with soap before food preparation, before feeding children, after defecation and after attending to a child who has defecated. Women commonly acknowledge that they wash their hands from time to time or when their hands are dirty but infrequent washing will not effectively prevent fecal oral contact or transmission of harmful bacteria. Further sanitation education is necessary.

Baseline Information Dissemination

Recognizing the importance of informing the community of the results of these baseline

data collection exercises, a dissemination workshop was organized for community leaders. The purpose of the workshop was to share the KPC survey results, preliminary results from the HFA, and information collected from informal group discussions and key informant interviews. GHA used the workshop to elicit feedback from participants regarding the objectives of the project as well as the different activities that had been proposed and to discuss whether they were realistic, practical and sustainable given the context and current environment in Petit Goave. The project work plan provides more detailed information and highlights the new activities proposed by the community.

A total of 31 people attended the workshop, including two journalists from a local radio station who aired a radio spot on the project and the workshop itself.

Feedback on the workshop was positive and participants expressed appreciation for the participatory format which allowed questions, and group work while learning about community problems (KPC survey results) and openly discussing them.

There is a general paucity of data available to describe the health and well being of the population of Haiti. National programs such as EPI for instance do not regularly publish credible data or estimates of services delivered or coverage. It is therefore difficult/impossible to compare data from the KPC survey in Petit Goave with those derived from other sources. There are no surveillance data available which give estimates of disease incidence or prevalence.

As a result, one of the project's activities (tied to the implementation of its M&E framework) will be to strengthen the ability of the target facilities and clinics to effectively collect and report on data as per MoH information system guidelines and requirements. As with many aspects of these facility's operations, the technical framework for service delivery exists at the MoH level but is not adequately or routinely implemented in the field. The project will, as a start to improved facility performance, seek to simply have the facilities implement what exists already before attempting to implement innovations in data collection, service delivery, community outreach etc.

Another aspect of the baseline assessments carried out was to identify potential constraints to the successful implementation of the project. Haiti is a difficult and often unstable environment in which to work.

Review of Potential Constraints to Project Success

Some of the constraints which have been identified include:

Safety/security: Political instability in Haiti (Petit Goave being one of the most politically active regions of the country, besides Gonaives and Port au Prince) is an all pervasive fact of life. In fact, this was one of the reasons that GHA/HQ staff was unable to visit Petit Goave in November, 2004 to initiate project preparation and planning. The general population's feeling is that since then, insecurity has increased many -fold. The PM/field has repeatedly indicated that one could be assaulted while taking public

transportation (bus), even during day. Random gunfire is a constant concern. While the PM-HQ was visiting at the end of March, 2005, Petit Goave seemed to be calm although she was witness to rapid community mobilization once a well-known journalist who had been in intensive care for almost two weeks was announced dead (this journalist had been hit by a stray bullet from the UN forces during their take over of the ex-armed forces).

The PM himself a Haitian, considers Petit Goave as a dangerous area. In his own words: “one may walk into a locality and not come out alive”. He explains this is due to the presence of gangsters and many beggars and that even as members of the community, they are targeted by indigent people.

Partner Organization Turnover: Since the beginning of the development of the project there has been significant turnover among the staff and leadership of the partner organization, COD-EMH. There have been 2 changes in the position of Director during the last 12 months. In such transition, institutional memory and commitment are difficult to maintain and GHA has had to reintroduce itself to the new director of the partner organization each time. Further complicating matters, the new COD Director arrived, in January 2005, and proceeded to make changes in the Petit Goave’s COD office including the replacement of the regional Director.

The project has finally been able to hire a doctor at 100% time to act as PM. Finding qualified personnel (especially a physician) can be very difficult because of the brain drain in Haiti and/or all other qualified doctors available already work for a given clinic or hospital.

Transportation Difficulties: Petit Goave, like most of Haiti (known as the land of: “mountains behind the mountains”) is a rugged, mountainous area with almost no roads or roads in very poor conditions (especially during rainy seasons). As a result, access can be very difficult to some of the localities. The most difficult sections of the Petit Goave region to reach are the 7th, 10th, 9th, 4th, and 5th. To reach to the 7th section it can take 4 hours in a brand new 4-wheel drive.

Personnel Distribution Involved in the Project: Currently, the project is paying some percentage (and in some cases, 100%) for a mix of 21 positions (besides guardian and housekeeper) (see management table in Annex 6). Of the total project staff, 12 are in Olivier, 7 in Petit Goave town and 2 are in Port-au-Prince. This leaves a skewed distribution of staff such that certain facilities and clinics are not currently adequately staffed to function optimally (for example: one auxiliary nurse from Olivier goes to the COD clinic at Trou Chou Chou once on week on Mondays for consultations. The project would like to increase this number to at least three days a week in order to better serve the needs of that community). GHA expects that before the first year of the project is over, two more auxiliary nurses will be able to go to this clinic on a regular basis and increase the number of days it is opened.

Community Mistrust: Understandably, there is an extremely high level of mistrust

among community members of any public institution. Transparency and accountability are virtually non-existent. People are suspicious of each other and a climate of fear and intimidation exists because of how politicized and unstable the area is. There are several armed gangs in Petit Goave (people telling/spying on others) which serve to intimidate the community and any action or mobilization even for non-political issues such as health.

Review of existing MoH policies, strategies and/or case management policies for project interventions

Pre-natal care: According to the PM/field, for pre-natal consultations clinicians do not currently make appointments or conduct check-ups according to the guidelines and policies established by the MoH. For example, the guidelines indicate that from the beginning of the 3rd trimester, appointments should be every 8 days. However, personnel at the clinic report that the appointments are given for every two weeks. One explanation for this is the possibility that the clinician may be unaware of the protocol. The project will strengthen the capacity of the clinic staff to correctly implement the guidelines and policies.

Lab Exams: Many lab exams are not done (even simple and basic exams like hemoglobin and RPR for STI diagnosis) because of lack of lab equipment. The only centers that currently have adequate laboratory equipment are Olivier and Notre Dame Hospital.

HIV/AIDS: Because the HIV test is not done at any of the health facilities except for Olivier and the Hospital, clinicians are obliged to refer the newborn or the mother to GEISKO in PAP which is where they have ARVs (i.e.: there are no ARVs available in Petit Goave). This represents an almost insurmountable obstacle to receiving these life saving drugs.

Child Spacing is encouraged according to current policy.

Promotion of micronutrient (iron and folic acid, iodine) for pregnant women:

Micronutrient distribution is inconsistent since health centers often are not able to follow guidelines because there are shortages of supplies at the level of the UCS/MoH (the drug supply point for facilities in Petit Goave). This is the reason that, at a meeting with UCS coordinator, Dr. Byron, she proposed this project could have activities that provide an external source of iron to the UCS in case of stock outs at the MoH level.

Immunization of pregnant women and women of reproductive age: Often, the health centers do not vaccinate women on time because of a problem of rupture of supplies of the tetanus toxoid. Additionally, at the health center level, there is an every day problem of storing the vaccines because of not being able to recharge the propane gas bottle to maintain the proper temperature for the vaccine. Although, the MoH is expected to provide the fuel bottles, they are unable to. This has led health centers to look for partners that can help them at this level. Lacking such assistance, the ability to consistently deliver vaccines according to policy and guidelines is limited.

HIV/AIDS: Only Olivier and the hospital are able to offer HIV testing (no counseling is

done). The tests however are very expensive (35 Haitian Dollars= \$US 4.66). Given that the average person in the rural areas earns less than a \$US 1 per day, this represents an unaffordable price to the majority of the population.

STIs: Staff lacks the equipment and ability to perform physical exams as part of STI diagnosis. As discussed above, there are no local laboratories with the equipment to perform any lab tests for STI diagnosis. Staff is not well trained to do a physical exam, and furthermore, the speculum vaginal and headlights – or any lights - are nonexistent (although, they do have some at the hospital). There are some gloves but not many and these are only used for suture, bimanual exam and delivery. Otherwise, they use their bare hands.

Table 1: Rapid Catch Indicators

Indicator	Numerator	Denominator	Percentage	95% Confidence Interval
Percentage of Children age 0-23 months born at least 24 months after the previous surviving child	45	84	53.6%	43.0 – 63.9 %
Percentage of children age 0-23 months who are below 2 standard deviations (-2 SD) from the median weight-for-age, according to the WHO/NCHS reference population.	45	250	18%	13.7 – 23.2%
Percentage of children age 0-23 months whose births were attended by skilled health personnel.	269	293	91.8%	88.1 - 94.7%
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (self-reported)	191	300	63.7%	59.1 – 68.9%
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	20	300	6.7%	4.3 - 10.1%
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours.	49	92	53.3%	43.2 – 63.2%
Percentage of infants age 6-9 months receiving breastmilk and complementary foods.	33	56	58.9%	45.9 - 70.9%
Percentage of children age 12-23 months are fully vaccinated (against the five vaccine preventable diseases) before the first birthday	16	64	25.0%	15.96-36.98%
Percentage of children age 12-23 months who received a measles vaccine.	51	110	46.4%	37.4 – 55.7%
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night	7	287	2.4%	1.1 – 5.1%
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection.	132	282	46.8%	41.07-52.66%
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment.	139	300	46.3%	40.8 - 52.0%
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks.	5	208	2.4%	0.9 - 5.7%

Indicator	Numerator	Denominator	Percentage	95% Confidence Interval
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	70	300	23.3%	18.9 - 28.5%

2. Program Description by Objective, Intervention and Activities

A modified logical framework (log-frame) approach was used to plan project activities and maintain/demonstrate the interval/vertical logic of good project design. In such a scheme the vertical logic can be represented as:

Goal

-

Objective

-

Outcome

-

Activity

A key component of the log-frame is the definition of indicators for each level of this hierarchy. These indicators must be SMART (specific, measurable, achievable, relevant, and time-bound). The completed log-frames then give a concise description of the project, its underlying logic and strategies as well as the basis for a framework to allow the implementer to both monitor its progress and evaluate its impact/effect.

The modified log-frame is found below:

Child Survival Initiative in Petit Goave Logical Framework (log-frame) Analysis

Targeted Health Facilities in Petit Goave Region (affiliation):

- Notre Dame Hospital (MoH)
- Olivier Health Center (COD)
- Arnoux Health Center (MoH)
- Violet Health Center (MoH)
- Madeleine Health Center (MoH)
- Vallue Health Center (MoH)
- Platon Trou Chou Chou Health Center (COD)
- Cadet Trou Chou Chou Health Center (MoH)

Project Goal: To contribute to the reduction of maternal and infant mortality in the Petit Goave Region of Haiti.

Interventions:

- **Immunization** of pregnant women and women of reproductive age: **20%**
- Promotion of **Breastfeeding: 25%**
- **Maternal and Newborn Care** (with promotion of micronutrient, child spacing and HIV/AIDS integrated into it, as well as complete child vaccination for the first year –BCG, Polio 3, DPT 3 and Measles): **55%**

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.

Indicator(s):

- 1) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one pre-natal consultation (card confirmed) prior to the birth of her youngest child
- 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attended at least one postpartum checkup (card confirmed)
- 3) Percentage of children 0-23 months in the Petit Goave Region who received check-up at the time of mother's first postpartum consultation

Strategy: Improve quality of pre- and post-natal services available in the region

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
Five functioning community health workers (CHWs) per health facility	- % of CHWs trained who recognize 2 signs of pregnancy complications and make proper referrals [100%] - % of CHWs providing counseling and education on pregnancy, family planning and STI prevention [100%]	- CHW reports - clinic referral records	- identify existing CHWs - identify additional candidates for CHW training - develop training curriculum/materials - carry out training - review/revise clinic record keeping system - explore and implement models to address CHW incentives and sustainability questions	- # of CHWs trained/clinic [5] - % CHWs with defined knowledge and skills [100%]- operational clinic records system to permit tracking of referrals, etc [y] - retention/turnover rate for active CHWs [20% loss /yr]
Ten functioning traditional birth attendants (TBAs) per health facility [18 at Olivier Health Center]	- % TBAs making proper referrals of pregnant women to health clinics [80%]	- TBA reports - clinic referral records	- identify existing TBAs - identify additional candidates for TBA training - assess TBA skills - review existing/develop training curriculum/materials - carry out training - monitor and supervise TBA activities	- # existing TBAs identified [y] - 5 identified TBAs trained [100%] - % TBAs with defined knowledge and skills [100%] - monitoring and supervision reports ¹ [y]
All 8 targeted health facilities in region delivering key services according to MoH protocols/norms/guidelines	- % of health facility personnel correctly implementing MoH norms, protocols and guidelines for key MCH services [100%] - # of U.S. based medical teams visiting region to provide key MCH services [3]	- health facility services assessment reports - internal QA reports - medical team reports	- identify/review/revise existing protocols - develop new protocols as necessary - health facility staff training needs assessment - develop training curriculum and materials for protocols - develop supervision and	- protocols, norms, guidelines available for specified services[y] - % staff trained [100%] - % staff with defined knowledge and skills [100%] - % planned/scheduled supportive supervision visits carried out [100%]

¹ Monitoring and supervision reports are included as an indicator (yes/no) of whether monitoring and supervision activities have been carried out. These reports may also serve as a data source for other indicators listed. This notion applies in all cases where these reports are listed in the indicator column.

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
	teams/yr as feasible]		<ul style="list-style-type: none"> support mechanisms to ensure proper implementation and support of protocol utilization - organize/conduct pre natal clinics as per norms - organize/conduct immunization services as per norms - organize/conduct postpartum check-ups and services as per norms - implement QA mechanisms in all facilities to support proper application of specified protocols - coordinate and support to visiting US based medical teams 	<ul style="list-style-type: none"> - functioning QA mechanisms in place in all facilities [8] - % pregnant women attending prenatal clinics - # of immunizations delivered (per antigen) - # of postpartum check-ups conducted -# of team visits [3/yr] - number of consultations/patient visits performed
Improved availability of essential drugs at all health facilities in region	- % facilities with no stock outs recorded in essential drugs and supplies for key services [100%]	- pharmacy inventory records	<ul style="list-style-type: none"> - train staff in stock management - improve communication and coordination between facilities and UCS pharmacy - monitoring and supervision of pharmacy drug management 	<ul style="list-style-type: none"> - % staff trained [100%] - % staff with defined knowledge and skills [100%] - monitoring and supervision reports [y]
All health facilities in region with functioning QA program for pre- and post natal services	<ul style="list-style-type: none"> - % of health facilities with ongoing QA program for key services [100%] - % of facilities showing improvements in quality of service indices for pre and post-natal services [100%] 	<ul style="list-style-type: none"> - HFA reports - client exit interviews -supervision and support reports - facility QA reporting 	<ul style="list-style-type: none"> - develop exit interview questionnaire -train interviewers - initiate client exit interviews - train staff - institute supportive supervision as means to QA - institute QA plan and service delivery improvements 	<ul style="list-style-type: none"> - interview questionnaires and reports [30/health center] -# of interviewers trained - monitoring and supervision reports -% of identified staff trained [100%] -# service delivery improvements initiated

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
Improved quality and availability of laboratory services at Olivier Health Center and Notre Dame Hospital	- % of pregnant women requiring lab tests who receive services [60%]	- lab records/reports	- assess availability of lab equipment and supplies - procure necessary equipment and supplies - monitor availability of reagents and supplies - train lab technicians	- % labs with necessary reagents and supplies [100%] - % lab staff trained [100%] - % lab staff with defined knowledge and skills [100%]

Notes on data source(s): All of the forms and reports listed in the data source column do not currently exist. A preliminary step in the implementation of the project M&E framework will be to review existing data collection forms and mechanisms to ensure that data required to calculate chosen indicators will be available.

Strategy 2: Increase demand for, and utilization of, quality pre-/post-natal and infant services in Petit Goave Region

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
Identification of barriers to utilization of key services	<ul style="list-style-type: none"> - # of key informant interviews conducted [50% of patients] - # of barriers identified by interviews [at least 2] 	<ul style="list-style-type: none"> - interview records/reports 	<ul style="list-style-type: none"> - develop key informant interview guides - train interviewers - administer questionnaires as per protocol - analyze data - develop clear statements of identified barriers to be used as basis for BCC activities 	<ul style="list-style-type: none"> - # interviews conducted - number of barriers identified [>2] - # of messages identified for use in BCC radio spots
Increased utilization of key services	<ul style="list-style-type: none"> -% mothers of children 0-23 months who received 2 TT injections before birth of last child [65% card verified] - % mothers of children 0-23 months who received/bought iron supplementation while pregnant with youngest child [80%] - % mothers of children 0-23 who last birth were attended by skilled health personnel [20%] - % children aged 12-23 months who were fully immunized by first birthday [80%] - % non-pregnant mothers of children 0-23 months who desire no more children in next two years (or are not sure) who are using modern method of child spacing [55%] - % of pregnant women 	<ul style="list-style-type: none"> - KPC survey results - maternal vaccination records - maternity and TBA records - EPI child vaccination reports - HIV testing and counseling reports at Notre Dame and Olivier - PMTCT clinic/program records 	<ul style="list-style-type: none"> - design and carry out KPC surveys -media campaign (radio spots promoting the importance of receiving this care) -CHWs and TBAs educate women in reproductive age on the importance of pre-natal, attended delivery and post natal care. - women from the COD-EMH community banks receive training on the importance of these services and talk and encourage women to be seen by CHW, TBA, or clinic staff. - support/facilitate post-delivery home visits by trained health agents (CHW, TBA, nurse, etc.) - support service delivery at clinics - organize/conduct immunization clinics etc 	<ul style="list-style-type: none"> - KPC survey and analysis [y] - media campaign carried out as per plans [y] - # community education and mobilization sessions facilitated per CHW/TBA per week [>1/wk] - # of immunizations (by antigen) administered - # of consultation sessions held - # of immunization sessions held

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
	<p>counseled and tested for HIV [100%] - % of HIV+ pregnant women registered and entered into PMTCT program [100%] - % of children 0-23 months who were breastfed at birth [90%] - % of mothers of children 0-23 months who had at least one postpartum check up after most recent delivery [80%] - average number of days reported by mothers of children 0-23 months between most recent delivery and first postpartum check-up [2 days] - % of children 0-23 months whose birth was attended by health agent [80%]</p>		<p>- refer pregnant women to HIV testing counseling services - organize/conduct prenatal services and TT vaccinations</p>	
<p>Increased knowledge of health risks, health seeking behaviors and services among community members</p>	<p>- # of radio spots produced and aired - % of women of children between 0-23 who can state two ways in which an STI can impact a pregnancy [80%] - % of children 0-5 months who were exclusively breastfed during last 24 hours [80%]</p>	<p>- project activity reports - KPC surveys</p>	<p>- identify topics for radio spots - produce and air spots - conduct KPC survey</p>	<p>- KPC analysis and reports [y] - # of radio spots developed - # of radio spots aired</p>
<p>Creation of community based mechanisms for</p>	<p>- # of community youth, women and literacy groups</p>	<p>- project activity reports</p>	<p>- develop protocol and methods for training</p>	<p>- training protocols available [y]</p>

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
communication and education	trained [5/clinic/yr] - # of peer leaders chosen and trained to deliver health messages [10/clinic/yr]] - # of community leader workshops organized [1 every other quarter] - # of community theatre skits organized [1/month] - # of responsible fatherhood clubs created [1/clinic] - # of men registered in responsible fatherhood clubs [35/club] - # of health related community fairs organized [1/year]		community groups on key topics (family planning, STI/HIV prevention. Etc.) -develop materials for training community groups in key topics - train personnel to carry out community group education, support and facilitation - implement mechanisms for community education	- training materials available [y] - % of identified community education personnel trained [100%] - % of scheduled/planned community education activities taking place [100%]

Objective 2: Establish a local referral network for quality maternal care in Petite Goave region of Haiti by September 2008.

Indicator(s):

- 1) Percentage of mothers with children 0- 23 months in Petit Goave Region who had at least one postpartum check up with other health personnel after most recent delivery
- 2) Percentage of mothers of children 0-23 months in Petit Goave region arriving at health clinic or hospital who were referred through established channels (CHW-clinic-hospital)

Strategy: Build/strengthen referral network and channels within existing health facilities and community

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
2-way radio communication system in place linking health centers with hospital	- # of health facilities with operating radios and communicating regularly with hospital [8]	- installation records - communication records/logs	- procure radios - install radios - develop and implement communications procedures and protocols	- % radios required purchased [100%] - % radios required installed [100%] - communications protocols developed and implemented [y]
All health centers have feasible referral and evacuation plans in place and necessary resources for implementation available	- % of health facilities with plan and resources in place [100%] - # of evacuations and referrals carried out	- review of plans as part of supervision and support to the facilities - facility records and documentation	- develop plans in collaboration with facility personnel - identify and procure resources necessary for referral and evacuation plan implementation	- plans available [y] - % of health centers were identified resources are in place [100%]
Up-to-date database of pregnant and postpartum women available in health centers to monitor health of women and neonates	-# of health facilities with up-to-date data base with all pregnant and postpartum women in catchment area [8 including Hospital]	- review of data base - supervision/monitoring records and reports	- ongoing census of communities and registration of pregnant women - postpartum visits to women carried out by staff/personnel	- census conducted and regularly updated through community outreach [y] - % of planned/scheduled postpartum visits carried out [100%]
Develop standard medical protocols and procedures for referrals for obstetric	- availability of protocols and procedures [y]	- protocol documents - staff/personnel training and supervision records	- develop/adapt protocols for obstetric emergencies and other identified health	- protocol materials available [y] - % of identified personnel

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
emergencies and other women and infant health emergencies	- % of appropriate clinic staff, TBAs and CHWs who know and understand the procedures and protocols for their level [80% staff, 100% CHWs/TBAs]		emergencies - train personnel in implementation/use of protocols	trained in use of protocols [100%]

Strategy: Strengthen health facility capacity to carry out community based education and counseling around family planning, danger signs of pregnancy and health service seeking behavior (and referral)

Outcome(s)	Indicator(s) [target]	Data Source	Activities	Indicator(s) [target]
Improved/enhanced skills of health facility personnel in management and leadership	- % of identified health personnel with defined skills [80%]	- training reports	- develop/adapt leadership and management training course and materials - identify and train appropriate personnel	- materials available [y] - % of identified personnel trained [100%]
Enhanced community outreach capacity for health facility personnel to carry out community mobilization and education activities	- % of planned/scheduled community outreach activities carried out [100%]	- activity reports	- identify obstacles to community outreach	- understanding of outreach obstacles [y]
Operational system of outreach and follow-up pregnant women identified as HIV positive	- % of HIV positive women receiving outreach/follow-up according to protocols and plans [100%]	- outreach activity reports	- define outreach and follow-up strategy for HIV positive pregnant women - initiate systematic testing of pregnant women's HIV status - train appropriate personnel in follow-up and counseling methods and strategies	- agreed upon outreach strategy for pregnant women who are HIV positive [y] - % of pregnant women requiring HIV testing who are tested [100%] - % of identified personnel receiving training [100%]

It is clear from the table above that a major, cross cutting approach to the project is one of building capacity. This will take place at many levels:

- **Institutional:** Through the project, GHA, COD-EMH and the MoH will all expand their capacities to improve the performance and utilization of health services.
- **Technical:** The technical skills of health service providers (from hospital to CHW and TBA) will be strengthened significantly through the course of the project.
- **Community:** Community groups and structures will be created and strengthened with the capacity to act as foci for behavior change communication and mobilization of community resources to support improved health seeking behaviors, preventive behaviors and health seeking behavior/decision making.
- **Individual:** The capacity of individuals to make more informed decisions and actions about their health and well being and that of their children will be enhanced through the project.

Specific capacity building objectives for the project are summarized in the table below:

Table 3: Capacity Building Framework

Who	Objective(s)	Outcome	Notes
<p>Global Health Action (GHA)</p>	<ul style="list-style-type: none"> - program planning methods - management skills and methods - project monitoring, - project evaluation - project reporting and accountability 	<p>Improved capacity to plan, implement, monitor and evaluate effective community- focused-health-service-strengthening projects in difficult environments</p> <p>GHA will significantly expand its ability to translate research data form quantitative and qualitative sources into strategies and actions to resolve barriers to health service utilization and quality.</p>	<p>One purpose of the grant is to provide GHA with a concrete, on-the-job opportunity to develop its ability to plan and manage health interventions capable of improving the health and well being of mothers and infants. GHA will pursue both experience and technical inputs to develop this capacity. It will also further develop its ability to support local partners (COD-EMH and MoH) to strengthen the delivery of key health services. The skills acquired through the grant will strengthen all GHA project efforts worldwide.</p>
<p>Indicators: Quality of project M&E data and reporting % project reports meeting accuracy and completeness criteria Improved quality and utilization of services in project target areas GHA submission of at least one additional child survival grant</p>			

Who	Objective(s)	Outcome	Notes
Development Bureau of Methodist Church (COD-EMH)	<ul style="list-style-type: none"> - project administration - project accounting - project reporting 	<p>Improved capacity to deliver key maternal and child health services to communities in Petit Goave Region</p> <p>Improved capacity to manage donor and local resources</p> <p>Improved capacity to monitor and evaluate projects and activities</p> <p>Improved community based infrastructure of groups capable of mobilizing the community and functioning as an effective vehicle for behavior change communication</p>	<p>The COD-EMH offices in Haiti's capacity to manage project resources and inputs towards defined and well documented outcomes will be expanded significantly. The skills acquired through the grant can be applied to all activities managed by COD-EMH thereby expanding the impact of the grant beyond child survival services in the defined health facilities.</p>
<p>Indicators: % accounting reports meeting accuracy criteria % project reports (technical and accounting) submitted on time % of project technical reports meeting accuracy and completeness criteria</p>			

Who	Objective(s)	Outcome	Notes
Ministry of Health (MoH)	<ul style="list-style-type: none"> - implementation of standard protocols and methods for service delivery - implementation of health information components - supervision and support of community groups and structures - resource management - coordination among partners 	<p>Improved capacity to manage and deliver key maternal and child health services</p> <p>Improved availability of health service delivery information for management and evaluation</p> <p>Improved understanding of potential role for community in increasing demand for and utilization of key maternal and child health services</p>	<p>The ability of the MoH to manage and deliver health services in Haiti is severely limited. Working with partners such as GHA and COD-EMH will provide necessary support to allow the MoH to develop mechanisms to improve the performance of public health facilities which can then be applied elsewhere.</p>
<p>Indicators: % of identified health personnel with defined skills in leadership and management</p> <p>% of planned/scheduled community outreach activities carried out</p> <p>% of facilities showing improvements in quality of service indices for pre and postnatal services</p> <p>% mothers of children 0-3 months who received 2 TT injections before birth of last child</p> <p>% mothers of children 0-3 months who received/bought iron supplementation while pregnant with youngest child</p> <p>% mothers of children 0-3 whose last birth was attended by skilled health personnel</p> <p>% children aged 1-23 months who were fully immunized by first birthday</p> <p>% pregnant mothers of children 0-23 months who desire no more children in next two years (or are not sure) who are using modern method of child spacing</p> <p>% of pregnant women counseled and tested for HIV</p> <p>% of HIV+ pregnant women registered and entered into PMTCT program</p> <p>% of children 0-3 months who were breastfed at birth</p> <p>% of mothers of children 0-3 months who had at least one postpartum check up after most recent delivery</p> <p>average number of days reported by mothers of children 0-3 months between most recent delivery and first postpartum checkup</p> <p>% of children 0-23 months whose birth was attended by health agent</p>			
Community Health Workers (Chews)	<ul style="list-style-type: none"> - recognition of pregnancy complications and referral strategy - counseling information and skills re: pregnancy, family planning and STI prevention 	<p>More effective patient education on key/focus topics</p> <p>Improved referral of high risk pregnancies</p>	<p>Need to review GHA's existing CHW training materials in Haiti. Update and revise as necessary. It is important that the project builds upon materials that already exist. This will provide GHA with the opportunity to strengthen local resources as well as interact effectively with other child health PVOs.</p>

Who	Objective(s)	Outcome	Notes
Indicators: % of CHWs trained who recognize 2 signs of pregnancy complications and make proper referrals % of CHWs providing counseling and education on pregnancy, family planning and STI prevention % of appropriate clinic staff, TBAs and CHWs who know and understand the procedures and protocols for referrals and obstetric emergencies for their level			
Traditional Birth Attendants (TBAs)	- recognition of danger signs and referrals for obstetric emergencies	Improved referral and evacuation of obstetric emergencies	Need to review existing TBA training materials in Haiti and elsewhere. Update and revise as necessary. It is important that the project build upon materials that already exist. This will provide GHA with the opportunity to strengthen local resources as well as interact effectively with other child health PVOs.
Indicators: % TBAs making proper referrals of pregnant women to health clinics % of appropriate clinic staff, TBAs and CHWs who know and understand the procedures and protocols for referrals and obstetric emergencies for their level			
Health Clinic Staff (COD-EMH & MoH staff)	<ul style="list-style-type: none"> - correct implementation of service delivery protocols and norms for key services - QA program operation and implementation - leadership and management - knowledge and skills necessary to implement service quality improvements - data analysis 	Improved quality of services at health facilities Adaptation of KPC and focus group data/analysis to identify and resolve service delivery weaknesses	All capacity building actions here are focused on improved performance of health service personnel in meeting needs of population. Increased demand for services generated through other project activities must be met and satisfied by service providers.
Indicators: % of health facility personnel correctly implementing MoH norms, protocols and guidelines for key MCH services % of health facilities with ongoing QA program for key services % of facilities showing improvements in quality of service indices of pre and post-natal services # of health facilities with up-to-date data base with all pregnant and postpartum women in catchment area % of appropriate clinic staff, TBAs and CHWs who know and understand the procedures and protocols for referrals and obstetric emergencies for their level % of identified health personnel with defined skills in leadership and management			
Pharmacy Staff (COD-EMH & MoH staff)	- improved stock management of essential drugs	Improved availability of essential drugs	Adapt and borrow from existing materials (ex.: see RPM and DELIVER projects).
Indicators: % facilities with no stock outs recorded in essential drugs and supplies for key services			
	- laboratory procedure skills	Improved availability of required	Adapt and borrow from existing materials as

Who	Objective(s)	Outcome	Notes	
Laboratory Staff (COD-EMH & MoH staff)	- laboratory management skills and procedures	laboratory services	available (ex.: see CDC).	
Indicators: % of pregnant women requiring lab tests who receive services				
Interviewers	- correct use of client exit/key informant instrument(s)	Improved availability of data regarding obstacles to service utilization and the need for service quality improvements	Develop training materials based on methodology and instruments.	
Indicators: % of questionnaires completed meeting accuracy and completeness criteria # of key informant interviews conducted				
			<p>The role of the community in increasing demand for and utilization of health services is largely unexplored. The project will attempt to demonstrate the effectiveness of community education and BCC as a means to increase utilization of basic maternal and child health services. Documentation provided through the implementation of the project M&E framework will provide relevant insight into the effectiveness of the project's strategy.</p> <p>The project will borrow and adapt existing materials for this type of community education and action from a number of successful child survival projects (see CSTS and CORE group). The CORE/BASICS "Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCP" provides a model for engaging communities for improved knowledge and health seeking behaviors. This model will provide an important point of departure for the development of this aspect of the capacity building strategy for the project. This will provide GHA with an important</p>	
Community group members (women, youth and literacy groups)	- increased awareness and understanding of health seeking behaviors, preventive health actions and health service utilization	Improved knowledge, preventive health actions and health seeking behaviors among population		
Indicators: - # of community groups trained				
Community peer leaders	-peer leaders to play key role in community mobilization and education around health issues and service utilization	Improved knowledge, preventive health actions and health seeking behaviors among population		
# of peer leaders chosen and trained to deliver health messages # of workshops organized				
Community leaders	- community leaders to play key role in community mobilization and education around health issues and service utilization	Improved knowledge, promotion of preventive health actions and health seeking behaviors among population		
Indicators: # of community leader workshops organized				
Responsible fatherhood club members	- increased awareness and understanding of health seeking behaviors, preventive health actions and health service utilization	Improved knowledge, preventive health actions and health seeking behaviors among population		

Who	Objective(s)	Outcome	Notes
	Indicators: # of responsible fatherhood clubs created # of men registered in responsible fatherhood clubs		opportunity to interact with and learn from other child survival PVOs. The adaptation of existing materials is a skill which GHA will strengthen through this interactive process.

From the above it is clear that the overriding strategy for the project can be summarized as seeking to achieve goals and objectives by actions that will:

- **improve the availability and quality** of key child survival and maternal and newborn health services; and
- **increase the demand** for and utilization of those same key services.

Clearly then, the project will focus on the three key elements of behavior change, quality improvement and increased access. At the same time the project has chosen to focus its efforts on/through three key interventions:

- **Immunization** of pregnant women and women of reproductive age: **20%**
- Promotion of **Breastfeeding**: **25%**
- **Maternal and Newborn Care** (with promotion of micronutrient, child spacing and HIV/AIDS integrated into it, as well as complete child vaccination for the first year –BCG, Polio 3, DPT 3 and Measles): **55%**

Within this framework then, it is possible to discuss how the project will address the key elements of **behavior change, quality and access**.

▪ **Behavior Change & Communication**

There will be two groups that will be targeted for behavior change communication messages under the project: 1) health care providers at all levels and 2) community members.

The project will seek to change behaviors of health care providers at all levels (hospital, health clinic, CHW and TBA). Behavior change messages and strategies will target improvements in service delivery by these persons. In the case of CHWs and TBAs, this may mean, in fact, the delivery of any services as many of these health service providers are largely inactive at present. In the case of those health providers working in facilities it will mean changing behavior in order to improve the quality of the services they provide. These changes will be achieved largely through training and other capacity building activities such as supervision and on-the-job support.

It is important to note that in this instance behavior change communication will be used as a means to improve the quality and access of services (discussed below). The mutually supportive nature of these three elements in the design of the project is an important aspect of its approach and eventual success. For example, one of the behaviors which the project will promote among health care providers is to take on a role as media/vehicle for behavior change communication themselves. Through this project, many health care providers in the region will work directly with communities and community structures that are designed to provide an effective mechanism to transmit important health and health behavior messages to the community.

One of the ways the project will promote behavior change is through the presence of trained CHWs and TBAs who can bring accurate information to the community and be present as a resource. The HFA has shown that there are very few currently in place. As a result, the project will do several trainings to ensure their availability. It is important to recognize that the majority of CHWs have not been able to work due to lack of remuneration. The project

continues to search for alternative ways to compensate the CHWs. This is currently under discussion as a community issue to better understand what other alternatives may exist to ensure the actions of CHWs as vehicles for behavior change communication.

The project will also establish community groups that will act as for a for important behavior change communication. The use of media and radio spots and public events such as mother's day fairs will also play an important role in sending messages to the community about the importance of child survival and create a demand for services. All of these community based efforts will be focused on promoting improved health seeking behaviors and the practice of key preventive behaviors (especially with respect to STIs) by community members. It is interesting to note that these activities were thoroughly discussed with community members during the DIP workshop and they agreed it would have an impact on the population at large.

It is important to note, also, that the project has initiated (and will continue) a highly collaborative/consultative process by which it will identify the key behavior change messages to transmit to the community. Focus groups and key informant interviews will be an ongoing project activity to allow the project to continue to identify health seeking and other behaviors which can be improved through improved knowledge or understanding. These behaviors then become the targets for the ongoing behavior change activities at the community level. The project's M&E framework will serve to allow the project to gain insight into the effectiveness of the messages and approaches being used.

▪ **Quality**

As shown in the project log-frame, the improvement of the quality of health services delivered at facilities in Petit Goave is central to the approach and success of the project. The results of the HFA have enabled the project to document a number of quality concerns with respect to services. The project understands the importance of these quality improvements especially when linked with the project's strategy of increasing demand for services. If demand is increased, clients must feel that they have received adequate/high quality services in order for them to want to continue to utilize the services.

The project will borrow from the TRM resource module on Quality and structure its approach around recognized dimensions of quality such as technical performance, access to services continuity of services/care, etc. For each of these dimensions the project will use facility assessment data to identify concrete actions and activities to address problems. One example with respect to technical performance that has been clearly identified already is the lack of clear and standard protocols and methods for the delivery of many services. The project understands that the MoH does in fact have written protocols and guidelines available for the delivery of client services and the organization/operation of programs. The neglect and lack of support and supervision to the delivery system has meant, however, that these protocols are now largely ignored throughout the system. The project will reintroduce these methods and protocols through in-service training for facility personnel. It will support improved supportive supervision to insure their continued proper implementation. The project M&E system will provide important insight into the effects of these quality improvements on the delivery of services.

The project will improve the quality of laboratory and pharmacy services through training and improved management of stocks. The link between quality and access for these services is clear.

In identifying the actual quality improvements to implement with respect to services the project will not seek to “reinvent the wheel”. The project will rely on technical resources which are already available and which have been used and tested in project contexts around the world. The availability of the TRM materials and other technical materials from the CORE group and other USAID funded projects (BASICS, RPM, DELIVER, etc.) will allow the project to adapt and refine tools capable of improving quality of services.

▪ Access

The project’s approach is based upon recognition of the futility of improving demand for services and access to services without improving their quality. The project will improve access to services through a number of mechanisms. Efforts to install an effective referral (and when necessary, evacuation) system within the project area are also key elements of ensuring access to services at the necessary/appropriate level.

Key elements of the projects approach to improved access are:

- strengthening of the network of CHWs capable of delivering simple but effective services and information to the communities they serve;
- expanding and strengthening the network of TBAs;
- improved availability of laboratory services and essential drugs through training and support to those services;
- improved access to HIV/AIDS services through identification of clients and referral;
- improved access to key services through support to and strengthening of mobile clinic services in the region;
- improved access to important health education and behavior change messages through mass media and community groups;
- delivery of essential (and often complex) services by visiting medical support teams sponsored by PVOs in the United States; and
- improved access to quality services through efforts to improve the quality of services in health facilities.

3. Program Monitoring and Evaluation Plan

Monitoring and evaluation (M&E) of project activities and impact will be a key component of the Child Survival Initiative in Petit Goave (CSIPG) Project. Monitoring will provide the data necessary to manage the project’s input and activities. Evaluation will allow managers to know whether the project is, in fact, bringing about the improvements in health and well being of women and child in the region that it promises. The CSIPG project sees M&E not simply as a stand alone or independent tool to document activities and their effects. M&E is necessarily an integral part of the project’s implementation and will provide information necessary to inform the direction of the project and provide insight into possible changes in project strategies and activities. In doing so the project embraces the classic “program

planning cycle” that promotes M&E feedback as a means to systematically and periodically reassess project goals, objectives, outcomes and strategies. The M&E framework and the tools developed to implement it will, therefore, be conceived and designed with this function in mind.

The M&E framework developed for the CSIPG project contains indicators for three levels of project action. Process indicators which document the ongoing activities of the project are summarized in the log-frame table above (far right column). These indicators will allow managers to track the progress of project implementation and will allow managers to answer the question, “*did we do what we said we would do?*” Impact indicators of project objectives and outcomes are summarized in Table 3 below. Indicators at this level will tell the project and its partners. These indicators allow the project to answer the question, “*and what happened when we did?*”

The process to define these indicators was a dynamic one which involved field personnel from Petit Goave region. During a brainstorming workshop (DIP preparation workshop), members of the UCS analyzed and discussed the data which had been collected as part of the baseline assessments (KPC, HFA, etc.). They agreed that the goal, objectives and chosen interventions for the project were appropriate. Additional information regarding some practices and behavior as well as discrepancies between answers on questions in the KPC survey and clinical data were identified and discussed. Indicators for maternal health care as well as the definition of success for each of the project’s objectives were reviewed and confirmed by the participants. The results of these discussions are found in the M&E framework table below. Ongoing training will be scheduled and completed for monitoring tools, and there will be a bi-annual analysis of collected data, resulting in an annual publication of program accomplishments. The support for regular and systematic analysis and reporting of data and results will be a major step towards inculcating staff in the need to “manage by the numbers” and collect and use data for improved decision making.

Aside from the definition of the appropriate indicators to be used to allow managers to both monitor and evaluate the project’s progress, a number of key actions and decisions must be defined in order for the framework to become operational and provide useful information.

A first step in the implementation of the project M&E framework will be to catalogue the various data collection and reporting forms already in use by MoH facilities in Haiti. Many forms currently exist but facilities do not use them leading to a general lack of data and information for either management or evaluation of programs and services. Currently, each health facility gathers its own information, using privately/independently developed forms and cards. The standardized report forms issued by MoH are often disregarded and there is little quality control. The project will train all the UCS members in the use of standard, existing MoH forms, as well as quality control in data collection. It will allow the UCS to create a health data bank for each zone and also for the district. This will in turn feed into the national data bank mentioned earlier and it will facilitate future epidemiological surveillance and broader goals of monitoring and evaluation of UCS activities more generally.

The re-introduction/support for the use of these routine data collection tools and procedures will be part of a more general project strategy to ensure that health facilities in Petit Goave deliver key services according to existing norms, standards and protocols. An absence of support and supervision to health facilities and their staff over many years has led to a degradation of skills and capacities among facility staff. Much of what the project will do in the region is to simply support health facilities to deliver services that they are already committed to delivering under current MoH policy. This is certainly true for M&E activities and data collection and reporting.

The reintroduction of these tools for monitoring maternal and child services at the level of the Unité Communale de Santé (UCS) will therefore, be one of this project's contributions to the capacity building of the UCS (see capacity building matrix above). The MoH is currently working with partners to develop a national health information system and database. This has been tried many times without success as rural health staff has never been trained in how and why it should collect data for the system.

This project will specifically train the personnel in the Petit -Goave area in collecting and reporting specified data according to standardized methods. Clinic staff will be trained in monitoring and evaluating techniques, as well as data collection and analysis. Each clinic will have a staff person designated to be in charge of supervision, monitoring, and data collection. A data management office will be established in Petit -Goave. Monitoring and evaluation skills and knowledge of health facilities are practically non-existent at the present (as seen in the baseline facility assessment results). In order to ensure good supervision and monitoring throughout the project, a specific person from each health facility will be designated to be in charge of ongoing monitoring. Staff at GHA -HQ will assess the training needs and will develop training materials that will be targeting the needs of the clinical staff in order to provide supervision and monitoring.

As part of the M&E framework, a mid-term external evaluation will be conducted during the third year of the project. The evaluation will replicate the KPC survey which was conducted at baseline in order to evaluate project progress toward goals, identify potential obstacles and determine appropriate action(s) or changes in project strategy necessary to reach the stated five-year goal of the project. Similarly, a final evaluation of the project will take place utilizing internal and external evaluators to conduct the evaluation, which will consist of both qualitative and quantitative components.

The M&E framework will use a number of tools to gather data. These tools are:

- existing MoH service delivery reporting forms;
- new tools and methods developed by the project to track key aspects such as referrals (from all levels), community level activities, capacity building etc.(these are aspects of services which the project will support and strengthen which are not captured by existing MoH forms and reports);
- periodic surveys such as the KPC: The questionnaire has been developed and used as a baseline data collection instrument (the survey will be repeated at mid term and at project completion);
- patient exit/satisfaction interviews;

- focus group and key informant interviews;
- Health worker checklist;
- Health facility checklist; and
- Community health worker checklist.

The health worker checklist will cover topics similar to those addressed in the facility assessment and also include workers' technical knowledge on key topic areas (clean delivery, pregnancy, complications of pregnancy, delivery, postpartum danger signs, breastfeeding, maternal nutrition and micronutrient supplements). This information does not supply data on how those factors translate into results at the beneficiary level. In order to have this information, the project will use the Lot Quality Assurance Sampling (LQAS) strategy to assess patient outcomes. The project will adopt existing or develop a set of instruments that will monitor the progress at the beneficiary level and will provide the project staff with timely information that could be quickly analyzed and, if needed, translated into activity change. In order to facilitate the implementation of LQAS, simple, focused and short questionnaires will be used. This will provide useful information for both monitoring and evaluation purposes. The LQAS will be used to assess coverage by Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs).

There will be different questionnaires for each of the three cohorts of interest. The LQAS questionnaires will be a subset of the baseline KPC and provide the same type of data that the KPC provided. The types of respondents determine the topics of the questionnaires.

Mothers of children age 0 - 11 months

Maternal and newborn care: antenatal, delivery and postnatal care

- Breastfeeding and nutrition
- TT injections for the mother
- Vaccinations

Mothers with children age 12 - 23 months:

- Breastfeeding/nutrition
- Iron and folic acid supplement for the mother
- Extended Program Immunization (EPI)

Women in reproductive age (15 - 49):

- Family planning
- Sexually Transmitted Infection (STI) case management
- HIV/AIDS prevention

It is important to recognize that the project will not just collect data to monitor and evaluate its activities. It will also continue to collect data that will allow it to continuously assess whether it is disseminating the correct messages to various community groups in order to break down barriers to health seeking behaviors, preventive behaviors and utilization of health services. For instance, KPC survey data and the initial facility assessment show that very few pregnant women are visiting the clinics. Additional, ongoing research in the form of focus groups and key informant interviews will help us find the reason for it, and identify

specific activities that will promote the Child Survival (CS) Project in the area. The research results will be analyzed in support of comprehensive multi-level and dynamic behavior change strategy.

In order to ensure effective monitoring and evaluation during the course of this project, GHA has hired an additional staff member that specializes in qualitative evaluation. This new employee will work closely with the PM-HQ and PM-Field and will provide assistance with the analysis of the Knowledge Practice Coverage (KPC) surveys, will develop a plan for additional focus groups and key informant interviews as well as develop training materials and monitoring protocols. This staff member will work part-time during the second year of the project and will work to oversee monitoring and evaluation activities. Throughout the course of the first two years, the new staff member will train other COD-EMH staff in monitoring and evaluation so that the skills required for successful monitoring and evaluation activities are retained in the organization. This new staff member will, however, be on-hand to assist and guide the staff during the mid-term evaluation and the final evaluation upon completion of the project.

Table 3: Monitoring and Evaluation Framework

Objectives/Outcomes	Indicator	Method	Frequency	Baseline Value	EOP Target	Strategy
Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre- and postnatal/infant services during their most recent pregnancy by September 2009	% of mothers of children 0-23 months in Petit Goave Region who attend pre-natal services during most recent pregnancy	KPC Survey	Baseline, midterm, final	65%	80%	Improve quality of pre- and post-natal services available in the region Increase demand for, and utilization of, quality pre-/post-natal and infant services in Petit Goave Region
	% of mothers of children 0-23 months in Petit Goave Region and their infants who attend postnatal/infant services during most recent pregnancy	KPC Survey	Baseline, midterm, final	52.8%	80%	
	% children 0-23 months who received check-up at the time of mother's first postpartum consultation	KPC Survey	Baseline, midterm, final	56.6%	75%	
Outcome 1: Five functioning community health workers (CHWs) per health facility	% of CHWs trained who recognize 2 signs of pregnancy complications and make proper referrals	-CHW records and reports	Quarterly	Training pre-test results	100%	Capacity building
	% of CHWs providing counseling and education on pregnancy, family planning and STI prevention	-clinic referral records	Quarterly	Training pre-test results	100%	Development of referral mechanisms
Outcome 2: Ten functioning traditional birth attendants (TBAs) per health facility	% TBAs making proper referrals of pregnant women to health clinics	- TBA reports - clinic referral records	Quarterly	Training pre-test results	80%	Capacity building Development of referral mechanisms

Objectives/Outcomes	Indicator	Method	Frequency	Baseline Value	EOP Target	Strategy
Outcome 3: All 8 targeted health facilities in region delivering key services according to MoH protocols/norms/guidelines	% of health facility personnel correctly implementing MoH norms, protocols and guidelines for key MCH services	- health facility services assessment reports - internal QA reports	Quarterly	0	100%	Build capacity to correctly implement service delivery protocols
	# of U.S. based medical teams visiting region to provide key MCH services	- medical team reports	As per team visits	N/a	3/yr	Facilitate teams and their effectiveness
Outcome 4: Improved availability of essential drugs at all health facilities in region	% facilities with no stock outs recorded in essential drugs and supplies for key services	- pharmacy inventory records	Quarterly	0	100%	Build capacity of pharmacy staff and improve coordination with procurement sources
Outcome 5: All health facilities in region with functioning QA program for pre- and post natal services	% of health facilities with ongoing QA program for key services	- HFA reports - client exit interviews -supervision and support reports	Quarterly	0	100%	Build staff capacity through functional QA mechanisms
	% of facilities showing improvements in quality of service indices for pre and post-natal services	- facility QA reporting	Quarterly	0	100%	
Outcome 6: Improved quality and availability of laboratory services at Olivier Health Center and Notre Dame Hospital	% of pregnant women requiring lab tests who receive services	lab records/reports	Quarterly	0	60%	Build lab staff capacity Improve availability of necessary supplies and reagents
Outcome 7: Identification of barriers to utilization of key services	# of key informant interviews conducted	- interview records/reports	Ongoing	0	50% of patients	Implement ongoing patient satisfaction mechanism and implement improvements identified
	# of barriers identified by interviews	- survey reports	Ongoing	0	At least 2	
Outcome 8: Increased utilization of key services	% mothers of children 0-23 months who received 2 TT injections before birth of youngest child	- KPC surveys	Baseline, midterm, final	6.7%	65% card verified	Increase demand for, and utilization of, quality pre-/post-natal and infant services

Objectives/Outcomes	Indicator	Method	Frequency	Baseline Value	EOP Target	Strategy
	% mothers of children 0-23 months who received/bought iron supplementation while pregnant with youngest child	- KPC surveys	Baseline, midterm, final	53.8%	80%	
	% mothers of children 0-23 whose last births were attended by skilled health personnel	- KPC surveys	Baseline, midterm, final	91.8%	95%	
	% children aged 12-23 months who are fully immunized by first birthday	- KPC surveys	Baseline, midterm, final	25%	80%	
	% non-pregnant mothers who desire no more children in next two years (or are not sure) who are using a modern method of child spacing	- KPC surveys	Baseline, midterm, final	21.3%	55%	
	% of pregnant women counseled and tested for HIV	- KPC surveys	Baseline, midterm, final	0	100%	
	% of HIV+ pregnant women registered and entered into PMTCT program	- KPC surveys	Baseline, midterm, final	0	100%	
	% of children 0-23 months who were breastfeed at birth	- KPC surveys	Baseline, midterm, final	79.8%	90%	
	% of mothers of children 0-23 months who had at least one postpartum checkup after most recent delivery	- KPC surveys	Baseline, midterm, final	35.9%	80%	

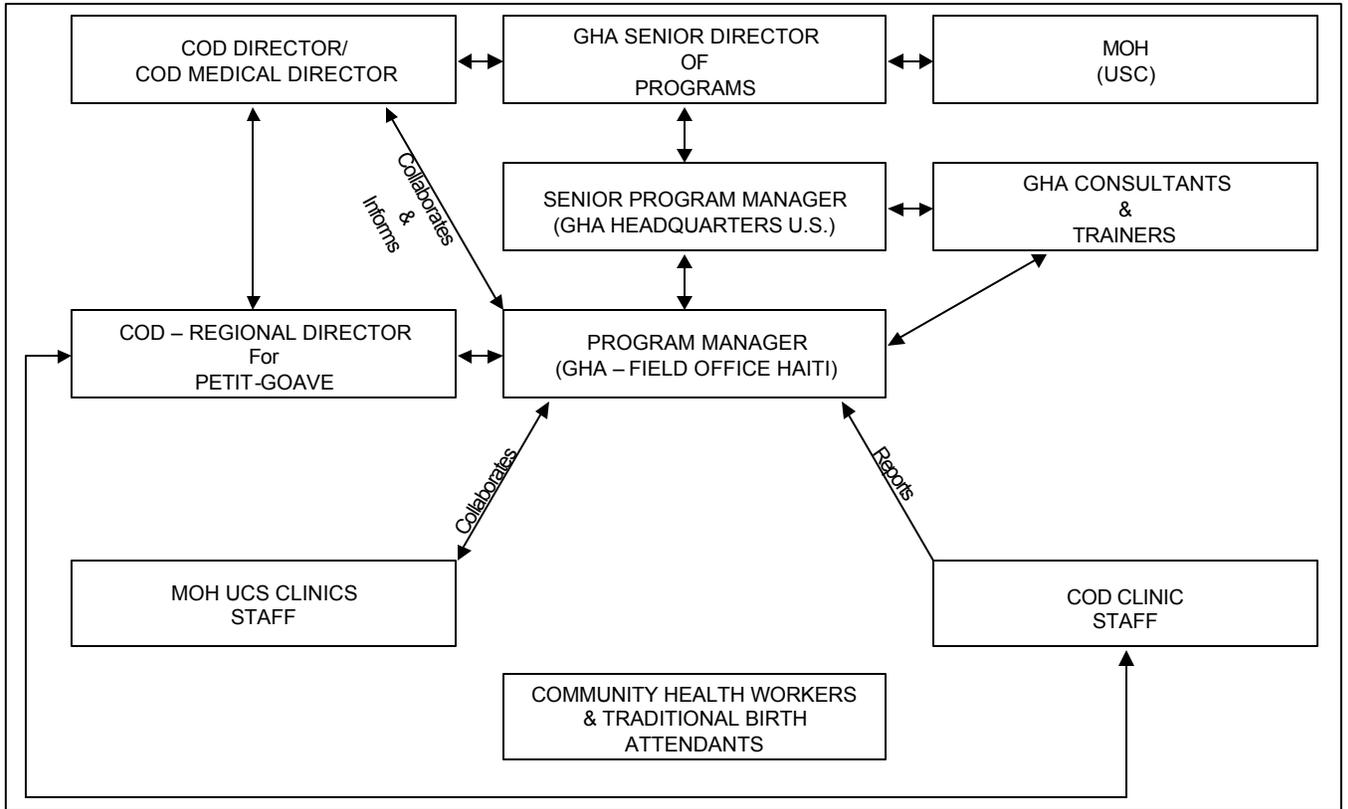
Objectives/Outcomes	Indicator	Method	Frequency	Baseline Value	EOP Target	Strategy
	Average number of days reported by mothers of children 0-23 months between most recent delivery and first postpartum check up	- KPC surveys	Baseline, midterm, final	3.7 days	2 days	
	% of children 0-23 months whose birth was attended by health personnel	- KPC surveys	Baseline, midterm, final	66.5%	80%	
Outcome 9: Increased knowledge of health risks, health seeking behaviors and services among community members	# of radio spots produced and aired	project activity reports	Quarterly	0	No target	Use radio spots as vehicle for BCC
	% of women of children between 0-23 who can state two ways in which an STI can impact a pregnancy	- KPC surveys	Baseline, midterm, final	61.3%	80%	
	% of infants 0-5 months who were exclusively breastfed during the last 24 hours	- KPC surveys	Baseline, midterm, final	53.5%	80%	
Outcome 10: Creation of community based mechanisms for communication and education	# of peer leaders chosen and trained to deliver health messages	- project activity reports	Quarterly	0	10/clinic/yr	Create community mechanisms and structures to act a vehicles for BCC and increase demand for and utilization of key services
	# of community youth groups created/trained			0	5/clinic/yr	
	# of women's groups created/trained			0	5/clinic/yr	
	# of community leader workshops organized			0	1/yr	
	# of community theatre skits organized			0	1/month	
	# of responsible fatherhood clubs created			0	1/clinic	
	# of men registered in responsible fatherhood clubs			0	35/club	
	# of health related community fairs organized			0	2	

Objectives/Outcomes	Indicator	Method	Frequency	Baseline Value	EOP Target	Strategy
Objective 2: Establish a local referral network for quality maternal care in Petite Goave region of Haiti by September 2008.	% of mothers with children 0- 23 months who had at least one postpartum check up with other health personnel after most recent delivery	KPC Survey	Baseline, midterm, final	6.6%	50%	Build/strengthen referral network and channels within existing health facilities and community
	% of mothers of children 0- 23 months arriving at health clinic or hospital who were referred through established channels (CHW-clinic-hospital)	Clinic records	annually	0	50%	Strengthen health facility capacity to carry out community based education and counseling around family planning, danger signs of pregnancy and health service seeking behavior (and referral)
Outcome 1: 2-way radio communication system in place linking health centers with hospital	# of health facilities with operating radios and communicating regularly with hospital	- installation records - communication records/logs	Monthly	0	7	Improve communication to facilitate effective referrals of emergency cases
Outcome 2: All health centers have feasible referral and evacuation plans in place and necessary resources for implementation available	% of health facilities with plan and resources in place		Quarterly	0	100%	Improve planning and readiness as means to improve effectiveness and utilization of evacuation and referral when needed
	# of evacuations and referrals carried out		On going			
Outcome 3: Up-to-date database of pregnant and postpartum women available in health centers to monitor health of women and neonates	# of health facilities with up-to-date data base with all pregnant and postpartum women in catchment area	- review of data base - supervision and monitoring records and reports	Ongoing	0	7	Data base and census will allow staff to improve tracking and service utilization of pregnant and post partum women

Outcome 4: Develop standard medical protocols and procedures for referrals for obstetric emergencies and other women and infant health emergencies	availability of protocols and procedures	- protocol documentation	Once	unknown	available	Standardized service delivery protocols, correctly and rigorously implemented, will provide the basis for improvements in service delivery and patient outcomes
	% of appropriate clinic staff, TBAs and CHWs who know and understand the procedures and protocols for their level	- staff training and supervision reports and records	Monthly	Pre-training test scores	80% staff, 100% CHWs/TBAs	
Outcome 5: Improved/enhanced skills of health facility personnel in management and leadership	% of identified health personnel with defined skills	- training reports	On going	Pre-training test scores	80%	Improved management and leadership will lead to improvements in quality of key services and patient outcomes
Outcome 6: Enhanced community outreach capacity for health facility personnel to carry out community mobilization and education activities	% of planned/scheduled community outreach activities carried out	- activity reports	Monthly	unknown	100%	Reducing resource and other constraints to staff performing community outreach will increase the frequency of outreach and therefore its effectiveness
Outcome 7: Operational system of outreach and follow-up pregnant women identified as HIV positive	% of HIV positive women receiving outreach/follow-up according to protocols and plans	- outreach activity reports	Monthly	unknown	100%	Improved follow up of identified women will improve health outcomes

4. Management Table

The management structure for the project is detailed in the organizational chart below and included in Annex 6 along with a management plan and a list of COD employees and collaborating MoH staff.



5. Work Plan

Child Survival Initiative in Petit Goave

General Workplan

Project Goal: To contribute to the reduction of maternal and infant mortality in the Petit Goave Region of Haiti.

Child Survival/Health Interventions: Immunization 20%, Promotion of Breastfeeding 25%, Maternal and Newborn Care 55%

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
Indicator(s): 1) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one pre -natal consultation (card confirmed) prior to the birth of her youngest child 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attended at least one post -partum checkup (card confirmed) 3) Percentage of children 0-23 months in the Petit Goave Region who received check-up at the time of mother's first post -partum consultation											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
<i>Community level</i>											
Identify existing CHWs	A	X	X							PM/community leaders/project health centers	Census performed
Identify additional CHW candidates by the community	A		X							Person in charge of the health centers in the area/community leaders	5/health facility
Identify existing TBAs	A	X	X							PM/community leaders/project health centers	Census performed
Identify additional TBA	A									Person in charge of the	Candidates chosen with

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
Indicator(s): 1) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one pre -natal consultation (card confirmed) prior to the birth of her youngest child 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attended at least one post -partum checkup (card confirmed) 3) Percentage of children 0-23 months in the Petit Goave Region who received check-up at the time of mother's first post -partum consultation											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
candidates by the community			X							health centers in the area/community leaders	community input
Networking with community leaders and community groups (women, literacy and youth groups)	BC	X	X	X						PM, literacy teacher, coordinator micro enterprises	Ongoing networking with various groups
Workshop to raise awareness amongst community leaders on importance of maternal and child health and responsible fatherhood	BC				X		X		X	Community leaders / project staff / leaders of womens' groups	1 every other quarter
Organize community fairs on safe motherhood, child care and responsible fatherhood					X				X	PM, project staff, community groups and community leaders	1/year
Develop protocols/materials for community groups' training and mobilization on key topics (importance of pre/post natal care – including delivery as well as STI/HIV impact on pregnancy, prevention of	Q		X	X						Community between public health and the project staff	Methods and materials developed

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
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Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
STI/HIV)											
Training of community groups (women, literacy and youth) on safe motherhood, child care and responsible fatherhood	BC			X	X					PM, nurse, literacy teacher, coordinator of micro-enterprises	Training completed, Groups meeting actively.
Organization of community group members to become peer leaders	BC			X	X					PM, nurse, literacy teacher, coordinator of micro-enterprises, community leaders	Training completed, Groups meeting actively.
Organize community theatre skits and activities on importance of maternal and child health and the role of fathers	BC					X	X	X	X	PM, women's groups and community groups	1/month
Organize meetings with fathers related to women from the women's groups	BC					X	X	X	X	PM, project staff and community leaders	Groups meeting actively
Develop consensus on local understanding and definition of "responsible fatherhood"	BC				X	X				Community leaders and project staff	Definition agreed upon
Organization and training of responsible fatherhood	BC					X	X	X	X	PM and project staff	Training completed, Groups meeting

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Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
clubs											actively.
Create community awareness regarding radio health spots	BC				X	X	X	X	X	PM, local clinic staff and CHWs	Community aware and listening to spots
Organize Mother's Day fair	BC					X				PM, project staff and community leaders	1 /year
Health Facility Level											
Assessment of TBA skills	Q		X	X	X	X	X	X	X	Auxiliary nurses	Assessment completed
Training for TBAs	A					X				Community school of Darbone/ Leogane / PM	Training completed
Training for CHWs	A					X				Community school of Darbone/ Leogane / PM	5/health facility
Conduct/continue health facility assessment	Q	X	X							PM/project staff	Assessment completed
Facility staff training needs assessment	Q			X						PM/project staff	Assessment completed
Ongoing exit interviews of health facility clients	Q	X	X	X	X	X	X	X	X	PM	Interviews conducted on 50% of clients
Assessment of use of standard protocols for key services by health facility staff	Q	X	X	X						PM/project staff	Assessment completed
Implementation/training and use of standard	Q				X	X	X	X	X	MoH/GHA-HQ	Training completed.

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
Indicator(s): 1) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one pre -natal consultation (card confirmed) prior to the birth of her youngest child 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attended at least one post -partum checkup (card confirmed) 3) Percentage of children 0-23 months in the Petit Goave Region who received check-up at the time of mother's first post -partum consultation											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
protocols for key services by health facility staff Maternal and Child health services											Staff implementing protocols correctly and consistently
Training on HIV/AIDS Counseling and Testing of pregnant women	Q					X				MoH/GHA-HQ	
Staff training in pharmaceutical management	A				X					MoH/GHA-HQ	Training completed Staff implementing inventory management skills
Assessment of linkages between facilities and UCS pharmaceutical depot to determine gaps and find solutions (including response to weaknesses in cold chain and service delivery)	A				X					MoH, PM and project staff	Assessment completed, analysis done
Implement mechanisms to improve linkages between facilities and UCS pharmaceutical depot	A					X	X	X	X	MoH/PM and project staff	0 stockouts for essential drugs
Staff training for laboratory personnel	Q, A				X					MoH/GHA-HQ	Training completed and lab services available to

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
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Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
											all who require
Organize collection and shipment of medical supplies (*)	A		X	X	X					GHA-HQ/US Methodist church	Medical supplies distributed to each project clinic and Hospital
Organize and support medical mission teams	A	X	X	X	X	X	X	X	X	COD-EMH/US Methodist church/GHA-HQ	3/year conditions permitting
Further training of interviewers for more key informant interviews to continue identifying barriers to services utilization	Q					X				GHA-HQ, PM	Training completed
Carry out survey of key informants on barriers to health service utilization	BC					X	X			PM, interviewers	Survey completed Data analyzed Actions developed to respond to barriers identified
Plans to reduce missed opportunities for child and women immunization	A				X	X				MoH, PM, clinic staff including CHWs	Implementation of plans

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
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Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
Organize immunization services for pregnant women and children	A				X	X	X	X	X	MoH/PM, doctors and nurses	80% pregnant women receiving 2 TT injections (card confirmed) during pregnancy
Organize iron supplementation for pregnant women	A				X	X	X	X	X	MoH/PM, doctors and nurses	80% women receiving supplementation
Provide counseling and referral for HIV testing for all pregnant women who attend the project's clinics and the Notre Dame Hospital	A					X	X	X	X	Clinic and Hospital staff/PM	100% of pregnant women screened
Conduct census/registration of pregnant women who are HIV+	A					X	X	X	X	Statistician/archivist	Census completed and 100% women enrolled
Assess current work and effectiveness of mobile health clinics operating in health facilities	Q,A	X	X	X						PM and project staff	Assessment completed Actions developed and implemented to improve availability of mobile services

Objective 1: 75% of mothers of children 0-23 months of age in the Petit Goave Region of Haiti will have received/utilized high quality pre - and post-natal/infant services during their most recent pregnancy by September 2009.											
Indicator(s): 1) Percentage of mothers of children 0-23 months in Petit Goave Region who attend at least one pre -natal consultation (card confirmed) prior to the birth of her youngest child 2) Percentage of mothers of children 0-23 months in Petit Goave Region who attended at least one post -partum checkup (card confirmed) 3) Percentage of children 0-23 months in the Petit Goave Region who received check-up at the time of mother's first post -partum consultation											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
Improve availability and quality of mobile health services	QA			X	X	X	X	X	X	PM and project physicians	Increase in number of patients treated
<i>District level</i>											
Analysis of data form exit and key informant interviews to develop actions to improve the utilization of services	A						X	X		Statistician/archivist	Analysis completed Actions implemented to improve services
Improve/insure availability of HIV testing and counseling at Notre Dame Hospital and Olivier Health Center	A					X	X	X	X	PM/Medical Director of Notre Dame Hospital	100% of women requiring receive counseling and testing
Develop message for radio spots	BC					X				PM, project staff/MoH and community groups	Spots developed and pretested
Support/organize broadcasting of radio health spots	BC					X	X	X	X	PM/MoH/project staff	Spots aired

Objective 2: Establish a local referral network for quality maternal care in Petite Goave region of Haiti by September 2008.											
Indicator(s):											
1) Percentage of mothers with children 0- 23 months in Petit Goave Region who had at least one post -partum check up with other health pers onnel after most recent delivery											
2) Percentage of mothers of children 0-23 months in Petit Goave region arriving at health clinic or hospital who were referred through established channels (CHW-clinic-hospital)											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
<i>Health Facility Level</i>											
Procure motorcycles to facilitate community outreach activities form health facilities.	A			X	X	X				GHA-HQ/PM	2 motorcycles in place and being used for community outreach activities as planned
Implement program of increased community outreach activities (education sessions at clinics, vaccination campaigns, pre-natal and post natal day at clinic, mobile clinics).	A, BC						X	X	X	PM, clinic staff, CHWs and TBAs	100% of planned activities take place
<i>District Level</i>											
Install radios in 50% of health facilities.	A					X	X			Local radio stations	Radios installed
Develop communications protocol linked to referral and medical evacuation protocols.	A							X	X	UCS/MoH, clinic staff/PM	Regular communication between facilities in support of referral and evacuation of emergencies
Develop plan for referral	A							X	X	UCS/MoH	Plan developed and

Objective 2: Establish a local referral network for quality maternal care in Petite Goave region of Haiti by September 2008.											
Indicator(s):											
1) Percentage of mothers with children 0- 23 months in Petit Goave Region who had at least one post -partum check up with other health pers onnel after most recent delivery											
2) Percentage of mothers of children 0-23 months in Petit Goave region arriving at health clinic or hospital who were referred through established channels (CHW-clinic-hospital)											
Major Activities	Activity Focus	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Personnel	Benchmark/Target
and medical evacuation between health facilities and hospital										clinic staff/PM	referral system operational
Create data base of pregnant women visiting health centers	A					X	X	X	X	MoH and project Statisticians	Data base developed and up to date
Create network to follow-up on HIV+ pregnant women	Q						X			MoH and project statisticians	100% follow up of HIV+ pregnant women

6. Organizational Development:

GHA is in the process of expanding its programs not only on number but in scope. The organization has a long time experience of training in management at community level as well as district and national. This project will contribute to improve the capabilities of GHA to link trainings and technical assistance to a long term to specific projects. GHA has done this in the past (CHW Program at Hospital St Croix in Leogane, Haiti) but not on a big scale. This project is a partnership between a faith-based organization COD-EMH, a nonprofit GHA, and institutions of Haiti's Ministry of Health (MOH). The management of this project will improve GHA's skills to manage such partnerships. Since we have in the past collaborated separately with both institutions, we felt that it is crucial for our organization to be the link between those two organizations. GHA plans to publish the lessons learned from this partnership.

This project has given us the opportunity to hire an additional staff person that specializes in qualitative evaluation methodology. This will have a positive impact on the overall improvement of the organizational capabilities.



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

Dr. Yolanta Melamed
Global Health Action
P.O. Box 15086
Atlanta, GA 30333

APR 15 2004

Ref: RFA No: M/OP/GH/HSR-04-003

Dear Dr. Melamed:

I am pleased to inform you that the Global Health Action application submitted for Haiti for the FY 2004 Child Survival and Health Grants Program (CSHGP) was recommended for funding.

In order to prepare the cooperative agreement for Haiti, the Office of Procurement will be contacting you shortly to begin negotiations and request additional budget information and/or clarifications. Once the Office has established that the application meets the standard U.S. Government regulations and guidelines, official notice will be sent by way of a cooperative agreement for signature. Until that time, you should not incur any expenses attributable to these activities. Once budget negotiations have been completed, the CSHGP team will be contacting you about an orientation meeting for new partners.

I want to congratulate you on your success in this very competitive process. The FY 2004 review process was extremely competitive due to the number and quality of applications submitted this year. Enclosed is a debriefing packet that provides a summary score sheet as well as a summary of the strengths and recommendations for your consideration during development of the detailed implementation plan.

We appreciate the effort that your organization devoted to preparing this application and thank you for your interest in USAID's child survival and health programs.

Sincerely yours,

Richard S. Greene
Director
Office of Health, Infectious Disease and
Nutrition
Bureau for Global Health

GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2004

PVO: GHA
Country: Haiti
Category: Entry

Categories	Entry	Mentoring	Standard	Cost Ext.	Expanded
Number reviewed	12	0	34	8	13
Number funded	3	NA	8	2	5
Highest score	86.61	NA	97.83	94.73	98.91
Lowest score	43.42	NA	78.87	80.26	77.10
Funded upward	80.00	NA	94.00	94.00	95.00
PVO App. Rank	1	NA	NA	NA	NA
PVO App. Score	85.27	NA	NA	NA	NA

Individual Category Scores: (Maximum Points in Parentheses)

Budget	Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Organizational Development	Performance M&B	Management Plan	Collaboration w/USAID Mission	Total Points
(5)	(5)	(10)	(15)	(15)	(15)	(15)	(15)	(5)	(100)
4.53	4.44	7.75	13.03	12.75	12.47	12.19	13.17	4.63	85.27

Name of PVO Applicant: Global Health Action
Name of Country: Haiti
Application Category: Entry

BUDGET INFORMATION

Strengths

The budget is well developed with clear explanations for expenses, including those that will be incurred by the PVO headquarters and those that will be incurred by the contractor. It reflects proposed project activities. The budget is generally low, and the proposed cost share is greater than required. There is a good utilization of donations reflected.

Weaknesses

Transport looks limited if the project will be strong on community support. The time allowed for GHA personnel seems low. The format of the detailed budget doesn't allow for an easy comparison of costs between program years.

EXECUTIVE SUMMARY

Strengths

The executive summary clearly presented all required information.

Weaknesses

Both the executive summary and the proposal as a whole present themselves as lists of activities, as opposed to a clear vision of how coverage will be achieved or how these activities will lead to behavior change in this context.

DESCRIPTION OF THE PVO APPLICANT OR PROGRAM

Strengths

GHA clearly has a track record for capacity building and developing leadership in other organizations. These strengths are consistent with its mission, and are the strengths it proposes to tap into for this project. These are very complimentary to those of the partner organization, COD-EMH.

COD-EMH has a strong history working in health service delivery as well as community-oriented development in the project area. They have integrated literacy and micro-credit activities with other health activities at the community level. The local mission

acknowledges their significance as a potential community partner for other activities in addition to child survival.

Weaknesses

It's unclear what specific activities COD-EMH is currently involved in, how much health service delivery they are actually doing, what their coverage is relative to the proposed project area, and how the project activities will integrate with or enhance their current activities.

With technical strengths and an organizational mission in management and leadership training, it is unclear whether GHA has the technical expertise to provide necessary technical support for a child survival program. A plan for strengthening its own technical capacity was not included in the section on organizational development.

No results are presented from previous similar GHA programs.

SITUATIONAL ANALYSIS

Strengths

The proposal provides a general overview of situational factors that influence child survival programming such as causes for morbidity and mortality, local health practices, and other health initiatives. It also covers other non-health factors such as economics and literacy.

The letters of collaboration and support were thorough, and indicate a significant amount of enthusiasm for the project. COD-EMH and the advisory board for the MOH provincial health services were clearly involved with the development of the proposal.

The application provides a good description of other programs and opportunities for synergy. It is evident that the proposed program would address critical gaps in maternal and neonatal care and HIV/AIDS prevention and care in the area. The application includes a good description of the roles of the two partnering organizations.

Weaknesses

The situational assessment was generally limited and additional effort could have been made to look at area-specific concerns. While the data came from the national surveys, comments could have been added on the local situation. Data from the COD-EMH services or from other health services could have complemented the national surveys.

The RFA guidelines specifically suggest an analysis of barriers and enhancers for projects addressing maternal neonatal health. Such an analysis might have helped with the

formulation of a framework and strategy on which the project could base its MNH interventions.

The population numbers for the under-five target population look questionable. The proposal indicates that 11% of the population is under five (13,836), yet that 25% of women of reproductive age are pregnant at any given time (7,862). (p.3) These two numbers would seem to be inconsistent. It was also unclear in the executive summary whether the 5,580 children under one were a subset of the children under five, or whether the remainder was children age 1-5. (p. 1)

The application leaves doubt as to the usefulness of the community banks, as well as the degree to which incentives will work in implementing this program.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

The proposal demonstrates a focus on maternal health with all the project interventions falling under this rubric. Such focus could be an asset, particularly for a project working through partners.

The intention to focus on local NGO capacity building is a positive strategy for leaving local capacity and utilizing local expertise. It gives the local Methodists the additional support they may need to effectively implement a child survival program, with the potential to influence their activities in the area for years to come. The roles and responsibilities are clearly defined, and the partnership seems to be off to a good start. This strategy is enhanced by the collaborative relationship already existing between COD-EMH and the MOH. As a result, the district will benefit from the strength of three-way collaboration between COD-EMH, GHA, and MOH. This said the relationship and relative roles and responsibilities of MOH counterparts were not addressed at all.

The project has selected generally appropriate objectives, although there may not be justification for the target levels until the baseline is completed. These objectives will be complemented by other activities in the area such as women's credit groups, literacy training, and UNICEF's iodine initiative. These objectives are also consistent with the local Mission priorities.

The link to the HIV/AIDS programs seems realistic and significant.

Weaknesses

As mentioned in the section for the Executive Summary, this proposal seems to lack an overall strategic approach to selecting its activities and interventions. The overall goal of reducing maternal and infant mortality is too broad given the focus on maternal health. There may or may not be a direct relationship between the proposed activities and the

desired results. The activities begin to sound like a menu of program options rather than interventions that have been selected for a reason.

There doesn't seem to be any BCC strategy or plan to develop one. While the development of radio spots is mentioned several times, its integration with other BCC strategies does not seem to have been considered, nor was the necessary analysis of barriers and enhancers mentioned. While responsible fathers and peer educators were mentioned, it is not clear what these will accomplish, or how they will be implemented.

The use of incentives as motivators for behavior change might help with early acceptance, but should be carefully considered from the perspective of sustainability.

There was no mention of newborn care anywhere in the proposal yet maternal health is the largest intervention. Spacing greater than two years (3-5) is currently recommended for maternal and child health, and should be encouraged by the project.

Some of the proposed activities are very general with no indication of *how* the project proposes to accomplish them. Relying on personnel already affiliated with either COD-EMH or MOH may be a good strategy from the perspective of sustainability, but these staff may not have time to pick up additional activities associated with child survival. It was not clear how many people from each cadre were proposed for training and with what content.

It is unclear from the proposal how the project proposes to cover the district. How many villages are targeted? Who and how will outreach workers reach the villages? What will they do when they get there? Even though there was a mention of community health workers in the activity matrix, there was no explanation of who they are or what they will do. The proposal also mentions a variety of mobilization strategies and targets (women's groups, women's group partners, responsible fathers, school groups, peer support people, community health workers, TBAs), but again they start to sound like a list since there is no elaboration of what they will do, how they will be mobilized, and how they will be motivated and supported.

While the establishment of a referral system is one out of the four primary project objectives, the primary strategy seems to be the purchase of an ambulance. An ambulance does not complete a referral system. The proposal needs to outline how different levels will become involved in and become committed to making a referral system work. In addition, management of an ambulance is very challenging given the other demands for vehicles and this was not mentioned.

ORGANIZATIONAL DEVELOPMENT

Strengths

The commitment of GHA to strengthen the local NGO is a definite strength. By leaving child survival skills with an organization that will have a long-term presence in the

project area, the impact will continue. GHA plans to offer two of the COD-EMH significant management and leadership trainings in Atlanta, which has the potential to positively strengthen the whole organization. The inclusion of the MOH advisory board and MOH personnel in the activities offers the potential to make a difference in local health services, although their level of interest and commitment was not addressed, and would significantly influence the outcome.

Weaknesses

Even though the RFA requests it, there is very little explanation of how GHA proposes to use this grant as an opportunity for its own capacity building. Other than reviewing its strategic plan, the proposal does not mention a plan for any kind of baseline institutional assessment, a plan for institutional strengthening, or a plan to document changes. This is particularly relevant since GHA has not highlighted experience in community mobilization, nor use of data for decision making with lower level organizations, or technical child survival experience which might be helpful in supporting this project.

PERFORMANCE MONITORING AND EVALUATION

Strengths

The involvement of the local professional organization in the monitoring and evaluation of this project offers the potential to transfer skills and increase ownership and interest in the project and its interventions.

Weaknesses

The project matrix on pages 21-24 is too general, both for project activities as previously mentioned, and as a guide for monitoring and evaluation. It would be more helpful for management to limit the activities, identify some intermediate indicators, and clearly define where the information will come from to track those indicators. It is not clear what will be collected, or how it relates to current MOH data collection. The occurrence of maternal deaths from hemorrhage as mentioned on page 22 is probably too infrequent to serve as a monitoring indicator.

The proposal mentions hiring a full time M&E advisor for the project who will be phased to half time during year two. The reviewers wonder if this is realistic, unless the other half time might be employed with other money.

The proposal suggests a list of tools for evaluation (p. 21). It would be more useful to limit the different tools to be used and seriously consider how each contributes to the M&E plan.

The proposal suggests it might do operations research on local management of HIV positive pregnant women. This does not seem to be very consistent with other project

emphases or available data, and probably should not be considered, particularly given that this is an entry level proposal.

MANAGEMENT PLAN

Strengths

The work plan was thorough and well developed. However, it should have been included in the annexes to allow for more project explanation in the narrative.

COD-EMH has been given the primary implementation role with the necessary portion of the budget to do so. This is consistent with GHA's commitment to partnering, and will hopefully contribute to their long-term commitment to child survival. COD-EMH seems to have a good track record in Haiti and competent personnel such that this should be a reasonable arrangement.

The roles and responsibilities between GHA and COD-EMH seem well considered and defined through the Memorandum of Understanding.

Weaknesses

Management of a three-way project (GHA, COD-EMH, and MOH) is complex and the plan for management is not adequately explained. While the organogram showing the relationship between GHA and COD-EMH was helpful, it was not adequate. How will the personnel from the MOH (UCS) relate to those of COD-EMH? How will the dual (triple?) reporting work in terms of authority and decision-making? How will the existing MOH and COD-EMH front-line staff (realizing that several project-dedicated staff will be hired) have enough time to also add the child survival activities to their other responsibilities? Who and how will expenditures be controlled and accounted for?

While very complete, the work plan proposes submission of the DIP for November, 2005 with completion of baseline surveys and DIP preparation activities scheduled accordingly. This is probably due to an easily remediable misunderstanding. However, the DIP is due by April 30, 2005 at the latest; the work plan will need to be revised.

COLLABORATION WITH USAID FIELD MISSION

Strengths

The local Mission appreciates the project selection of the implementing partner, involvement of GHA with leadership training, and the selection of interventions that are consistent with USAID priorities. Both the structure and the interventions were discussed with Mission representatives.

Weaknesses

None noted.

ANNEX SECTION

Response to Application Debriefing

Addressing the weaknesses mentioned in the scoring sheets:

Description of the PVO applicant

Activities that COD is Currently Involved In

Health clinics at the project area and in the area of Cap Haitien

- Micro credit programs, literacy groups mainly targeting women
- Agricultural project – goat and pig farms
- Education – schools with every church
- Food for education program – providing hot lunches in the schools

Global Health Action (GHA) Technical Expertise

GHA has over 20 years experience in providing technical assistance to a local partner organization in Bangalore, India.

- GHA has started and provided technical assistance for more than 10 years to the Community Health Worker (CHW) Program at the Hospital St Croix in Leogane, Haiti.
- GHA has designed and implemented a community -based Maternal Health Program at the Bill Rice Community Health Center in Nouvelle Cité , La Gonave, Haiti.
- GHA has hired an additional staff member that specializes in qualitative research, monitoring and evaluation in order to help with design of an effective monitoring system for the project.

Situational Analyses

We are in the process of getting additional information through key informant interviews and focus groups on the barriers and enhancers for this project.

- The numbers that we have for the population groups may have some discrepancies. The one we have used and are using are from the latest census in Haiti is slightly different from the one we obtained at the district level.

Program Strategy and Interventions

Strategies:

- Build the capacity of the local partner (COD) and strengthen its abilities to implement CS projects through trainings on Project planning, data collection, monitoring and evaluation, data management
- Strengthening the capacity of the local partner (COD) to deliver primary health care to mothers in the area of Petit -Goave by improving practical skills and knowledge of the Community Health Worker (CHW), Traditional Birth Attendant (TBA) and clinical staff, reintegrating the CHW into the existing health network and by establishing a referral system.
- Sensitizing community regarding the importance of maternal health, STIs, including HIV/AIDS and Family Planning Practices.

2005 KPC SURVEY – Petit Goave, Haiti

Healthy Mothers, Healthy Children:

A Child Survival Initiative in Petit -Goave, Haiti

Revised: May 24, 2005

COD-EMH/Haiti
Global Health Action
RFA# M/OP/GH/HSR-04-003-CSHGP

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Executive Summary

In January and February 2005, Global Health Action in collaboration with COD/EMH in Haiti conducted a survey in the region of Petit Goave to establish baseline measures of health and health care access in the district. Information from a total of 300 women was included in this report. Women were eligible for participation in the survey if they were age 15 -45 years and had a child who was 0 -24 months of age. Cluster sampling was used to select households. A 78 item questionnaire was used to collect data on 17 different areas in which the project is interested. The following topic areas included: demographic, health contact/access to health information, maternal parity, child anthropometry, maternal and newborn care, iron supplementation, delivery practices, breastfeeding and nutrition, postpartum care, child spacing/family planning, childhood immunization, malaria prevention, integrated management of childhood illnesses (IMCI), HIV/AIDS, Sexually Transmitted Infections (STI), HIV Screening, and Hand -Washing Practices.

Some of the general findings from the study are listed below:

- There is differential access and availability of health care according to area in which a woman lives within the region of Petit Goave. Women in the area around the town of Petit Goave (including 11eme Ravine Seche, 12eme Des Fouques, 1ere Plaine, 2eme Plaine, and 3eme Trou Chou Chou) are able to get to the nearest health care facility in less time than it takes women in other sections.
- There were low rates of tetanus toxoid injections, 6.7% of women surveyed had at least 2 card -confirmed Tetanus Toxoid injections and 12.3% had at least one Tetanus Toxoid injection prior to the birth of their youngest child.
- The mean duration of iron supplementation was 16.7 days and 6.5% of women received iron for 90 or more days during pregnancy.
- A majority of women report receiving prenatal check-ups but there are low numbers of card-confirmed prenatal check-ups.
- Among children less than 6 months of age, 53.2% were exclusively breastfed in the 24 hours prior to the survey compared to 23.6% nationally for this same age group.
- Among children age 0-24 months, 83.7% received breastmilk and 70.4% received a supplement in the 24 hours prior to the survey.
- 46.4% of children age 0-24 months were born at least 24 months after the previous surviving child, however only 22.3% reported using a modern method of family planning.
- Vaccination rates for BCG and Polio 1 are high (65.4% and 73.4% respectively) but rates of complete vaccination coverage among children age 12 -23 months are low (7.8%).
- Among mothers of children who have been ill recently, a high proportion (46.3%) of mothers know several signs of childhood illness but few properly care for their child at home by offering more to drink and the same or more to eat when the child is ill (2.5%).

- Only 23% of women of children age 0-24 months report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.
- Almost all women surveyed have heard of HIV/AIDS but a much smaller proportion of women were knowledgeable about methods to prevent transmission.
- About half of all women surveyed had heard of other Sexually Transmitted Infections (47.4%) but fewer knew about signs and symptoms of STIs among men or women or how to prevent STI transmission.
- Many women know that STIs impact the outcome of pregnancy but few women know in what ways it impacts the outcome.
- Few women were offered HIV screening during pregnancy and even fewer women actually were tested during their most recent pregnancy.

This study established a baseline of knowledge, practices and coverage for various indicators of maternal and child health in the region of Petit Goave. It will be further complimented by additional focus groups, individual interviews and potentially a survey among men to elucidate reasons behind many of the findings.

Background

The program is located in the *Artibonite* region of Petit -Goave, 65 kilometers from Port -au-Prince, the capital city of Haiti. It is mostly mountainous coastal region, divided into twelve communal sections. The coastal town of Petit -Goave is the capital of the district.

Project location



Maternal mortality in Haiti is the highest in the Caribbean (523/100,000). Given the scarce maternal care services, only 44% of pregnant women receive adequate and timely health interventions. In addition, 2001 records from health facilities in the community show a monthly average of 25 new cases of sexually transmitted infections among female clients. Furthermore, the lack of a male head of household in a large number of families increases the vulnerability of mothers and young children in the community. These risk factors combine to create very poor conditions for child survival.

According to the National Institute of Statistics, the *Artibonite* region of Petit -Goave has an estimated population of 125,789 people of which 4.5% (5,580) are children under one year of age and 11% (13,836) are under five years of age. Women of reproductive age make up 25% of the population (31,447).

Goals

The goal of the project is to contribute to the reduction of infant and maternal mortality in the region of Petit Goave. This goal will be achieved using interventions specific to Global Health and CSHGP Strategic Objectives 1, 2, 3 and 4.

Objectives

Objective 1 – By September 2009, 75% of mothers in the region of Petit -Goave, having a child 0-24 months, will have benefited from adequate pre - and post -natal care during their last pregnancy. The following strategies will be used:

Improve access to quality pre - and post -natal care in the rural communities through mobile clinics and by training community health workers.

Improve quality of maternal care in the Unité Communale de Santé (UCS) by improving and expanding human resources and developing standard protocols of care, monitoring and supervision.

Improve the monitoring of maternal care in the district through specific data collection in the region and by training local institutions in monitoring.

Involve local women's groups in the promotion of health -seeking behavior during pregnancy, and child spacing.

Objective 2- By September 2007, 75% of persons of reproductive age in Petit Goave will be correctly informed about the prevention of sexually transmitted infections (STI), their impact on the outcome of pregnancy and the availability of treatment in the UCS. The following strategies will be used:

Train clinic staff to assess and provide integrated STI prevention and treatment.

Conduct workshops on STIs in all organized groups existing in the district.

Safe sex practices will be included in the Responsible Fatherhood workshops.

Objective 3 – By September 2007, 40% of males in reproductive age in the region of Petit Goave will have completed a “Responsible Fatherhood” course. The following strategies will be used:

Promote the concept of “Responsible Parenthood” through workshops in local groups and using radio spots for publicity.

Register male participants as Responsible Fathers

Use Mother's and Father's days to reinforce the concept through district activities related to Responsible Fatherhood.

Objective 4 – By September 2008, a local referral network for quality maternal care will have been established in the UCS. The following strategies will be used:

Reinforce UCS leadership and management skills by providing training and leadership in management to the in-country PVO staff.

Facilitate the accessibility of interventions for obstetric emergencies by procuring an ambulance and creating a referral network through which women with pregnancy complications are referred from local dispensaries to health clinics or hospitals.

Objectives of the KPC survey

The objectives of the KPC survey included the following:

Train community members on the survey and data collection techniques.

Collect baseline information regarding maternal and child health, resources available, access to care, knowledge and practices and how mothers acquire health information using the questionnaire.

Gather information from a random sampling of 300 women throughout the region of Petit Goave regarding the information mentioned above

Assess the information to form recommendations and to guide the DIP process.

Process and Partnership Building

Partnership building was established through the presence of the PM/field in the region of Petit Goave where he met several times with COD staff members involved in the project as well as community members who either work at the health facilities or at various local NGOs

Some of constraints where difficulty in getting baby scales as well as the poor road conditions.

Methods

Questionnaire

The questionnaire utilized for this survey was prepared by Global Health Action with guidance from USAID. The final questionnaire consisted of 15 pages, including the informed consent and cover page and 78 questions. The questions included all 13 RAPID-Catch Indicators and were grouped into 17 categories, including:

1. Demographic Information
2. Health Contacts
3. Maternal Parity Information
4. Anthropometry
5. Maternal and Newborn Care
6. Sub-module on Iron Supplementation During Pregnancy
7. Sub-Module on Delivery Practices
8. Breastfeeding and Nutrition
9. Postpartum Care
10. Child Spacing
11. Child Immunization
12. Malaria Prevention
13. Integrated Management of Childhood Illnesses
14. HIV/AIDS
15. Sexually Transmitted Infections
16. HIV Screening
17. Hand-Washing Practices

The KPC survey used in this study was based on the KPC 2000 Field Guide from USAID. In addition to including all 27 RAPID-Catch questions, additional questions were integrated from Modules 1B, 2, 5A-5C, and 6-8. Several additional questions were created by GHA to obtain information for indicators pertaining to the project objectives.

The original questionnaire was created in English. The English version of the questionnaire was translated into Creole by a Haitian who is bilingual in Creole and English. The English version was also translated into French using the French modules provided by USAID. Both the French and the Creole versions of the questionnaires were utilized during the KPC survey training. Using the French and the Creole versions facilitated understanding of terminology and question intent as the survey training coordinator was not a native Creole speaker. During the three day survey training, the group of interviewers reviewed the Creole version of the questionnaire to ensure that the Creole translation accurately reflected their understanding of the question or item on the survey. Several slight wording changes such as how the informed consent should be worded and read were agreed upon during the training and integrated into the Creole version of the questionnaire. The final Creole version of the questionnaire was utilized by surveyors in the field to collect data from the women in the target areas. Creole is the

first language of the target population and the surveyors. Creole, English and French versions of the questionnaire are found in Appendices 1 -3.

KPC Indicators

A complete list of the KPC indicators utilized for this project and their definitions is found in Appendix 10. These indicators were created for each question using the key indicators provided by USAID at the end of the above listed modules. For all questions in which an indicator was not provided, GHA created the remaining indicator with input from USAID. All RAPID -Catch questions and their indicators were included in this survey.

Sampling design

In the interest of time and monetary constraints, it was determined that cluster sampling would be the most efficient sampling method to provide the best baseline results for the purpose of this project. Clusters were selected using probability proportional to size (PPS) in order to mirror the distribution of the population. We chose a sample size of 300 in order to have 30 clusters. In the final results we have 22 clusters with 10 interviews per cluster, 1 cluster of 8 interviews, 3 clusters of 9 interviews, 3 clusters with 11 interviews and 1 cluster of 12 interviews for a total of 300 interviews.

The latest available map for the region of Petit Goave was obtained from the National Office of Statistics. It was a map from 1982 and showed the distribution of households across the 12 sections of the region. A major limitation to sampling was the outdated population figures from this map. The survey coordinator, the Program Manager and the project statistician calculated the sampling interval based on the number of households shown for each section of the region according to the map. Using PPS the clusters were among the 12 sections.

According to the 1982 map, there were a total of 8,202 household throughout the 12 sections of the region of Petit Goave. Using a 30 Cluster sampling method, we used a sampling interval of 273. Table 1 shows the calculation of the sampling interval.

Table 1: Calculating the Sampling Interval for the Region of Petit Goave

SAMPLING INTERVAL =	Total population to be surveyed	
	Number of clusters	
A = TOTAL POPULATION IN THE PROGRAM AREA	=	8,202
B = TOTAL NUMBER OF CLUSTERS IN THE SURVEY	=	30
C = A ÷ B (8,202 ÷ 30)	=	273

Using this sampling interval, we calculated the number of clusters that were interviewed in each Section. Table 2 shows the distribution of sampling clusters. The number of clusters interviewed in each section was proportional to the number of households in that section according to the 1982 map of the region.

Table 2: Distribution of Clusters in Survey

Selection of 30 Clusters using Systematic Sampling			
Sampling Interval = 273			
Name of Section	Population: total # of HH	Cumulative Households	Cluster
1ere Plaine	864	864	1, 2, 3
2ere Plaine	995	1,859	4, 5, 6
3eme Trou Chouchou	356	2,215	7,8
4eme Fond Arabie	571	2,786	9, 10
5eme Trou Canari	850	3,636	11, 12, 13
6eme Trou Canari	278	3,914	14
7eme Platon	1,571	5,485	15, 6, 17, 18, 19, 20
8eme Platon	475	5,960	21
9eme Les Palmes	909	6,869	22, 23, 24, 25
10eme Les Palmes	232	7,101	26
11eme Ravine Seche	503	7,604	27, 28
12eme Des Fouques	598	8,202	29, 30

The region of Petit Goave was divided into five zones for the purpose of the survey. The 14 interviewers and 4 supervisors were divided into five teams according to the areas with which they said they were most familiar when asked the first day of the training. Table 3 shows the organization of teams, zones, clusters, and cluster numbers as they appeared on the questionnaires.

Zones were divided by roughly the same number of interviews per interviewer per day. Distance to cover and terrain were taken into account when assigning clusters. Zone 5 was both difficult to travel to and travel within. Additionally, homes in Zone 5 are generally farther apart. Therefore the number of interviews per day per interviewers was greatly reduced in Zone 5 to account for the difficulties in travel. Each interviewer in Zone 5 had to complete approximately 5-6 interviews per day in order for the team to complete all 50 interviews over the course of the 3 days of active data collection. In contrast, Zone 1 was relatively urban and contained the Town of Petit Goave and the nearby areas. It was relatively quick and easy to traverse this zone therefore the number of interviews per day per interviewer was increased. The interviewers on team one were each responsible for 8-9 interviews per day in order to complete all interviews for their Zone by the end of the 3 days of data collection.

Table 3: Organization of Survey Teams

Zone #	Section #	Total # of Clusters per section	# of Interviews per section	Actual Assigned Cluster # (# which appears on KPC form)	# of interviews per day per interviewer	Interview Teams
Zone1	11eme Ravine Seche	1	10			<ul style="list-style-type: none"> •Cidael Calixte •Suze Pascal •Dr. E.J. Pierre •Angela Thompson
	12eme Des Fouques	3	30			
	1ere Plaine	1	10			
Total Zone 1		5	50	1, 2, 3, 4,5	8.3	
Zone2	1ere Plaine	2	20			<ul style="list-style-type: none"> *Cidael Calixte *Suze Pascal *Melivert St. Marc *Dr. E.J. Pierre
	3eme Trou Chou Chou	2	20			
	2eme Plaine	3	30			
*Total Zone 2		7	70	*6, 7, 8, 9,10, 11, 12	7.8	
Zone3	4eme Fond Arabie	2	20			<ul style="list-style-type: none"> •Yolette St. Michel •Michel Saintons •Gardel Badette •Melivert St. Marc
	5eme Trou Canari	3	30			
	6eme Trou Canari	1	10			
Total Zone 3		6	60	13, 14, 15, 16, 17, 18	6.7	
Zone 4	7eme Platon	6	60			<ul style="list-style-type: none"> •Chantal Joseph Pluvoise •Arcene Borange •Vergin Jean Raymond •Josué Dorvilias
	8eme Platon	1	10			
Total Zone 4		7	70	19, 20, 21, 22, 23, 24, 25	7.8	
Zone5	9eme Des Palmes	4	40			<ul style="list-style-type: none"> •François Bonhomme •Dessejour Germain •St. Hilaire Marie Carmen •Benoît Jn Baptiste
	10 Des Palmes	1	10			
Total Zone 5		5	50	26, 27, 28, 29, 30	5.6	
<p>* This team did the final data collection in Zone 2. The problems with the data collection from the original team in Zone 2 have been further explained in the ‘Data Collection and Quality Control Procedures’ portion of this report.</p>						

In order to randomly select households without a sampling frame for each community we survey, it was determined that surveyors would flip a coin to determine which house to begin with then continue to question households with mothers between the ages of 15 -45 years with children under the age of 2 years. As the center of town is difficult to determine in these loosely defined, widely dispersed communities, the “center of town” was defined as wherever the church was located in a given community. At the church, the team then flipped a coin to determine which direction to begin walking, employing

the nearest house rule to determine which house to interview. Interviewers were instructed to interview women between the ages of 15 -45 years of age who had at least one child under the age of two years. In the event that the woman being interviewed had more than one child under the age of two years, the interviewer was instructed to ask the questions in the questionnaire about the youngest child under the age of two years. During the data collection process, there were two times that women met the criteria and consented to the interview however, their husbands interrupted the interview before it was complete and forbid the wife to complete the interview. Figure 1 is a sketch of the region showing approximate division of sections, clusters and zones during the KPC Survey conducted in January 2005.

Region of Petit Goave

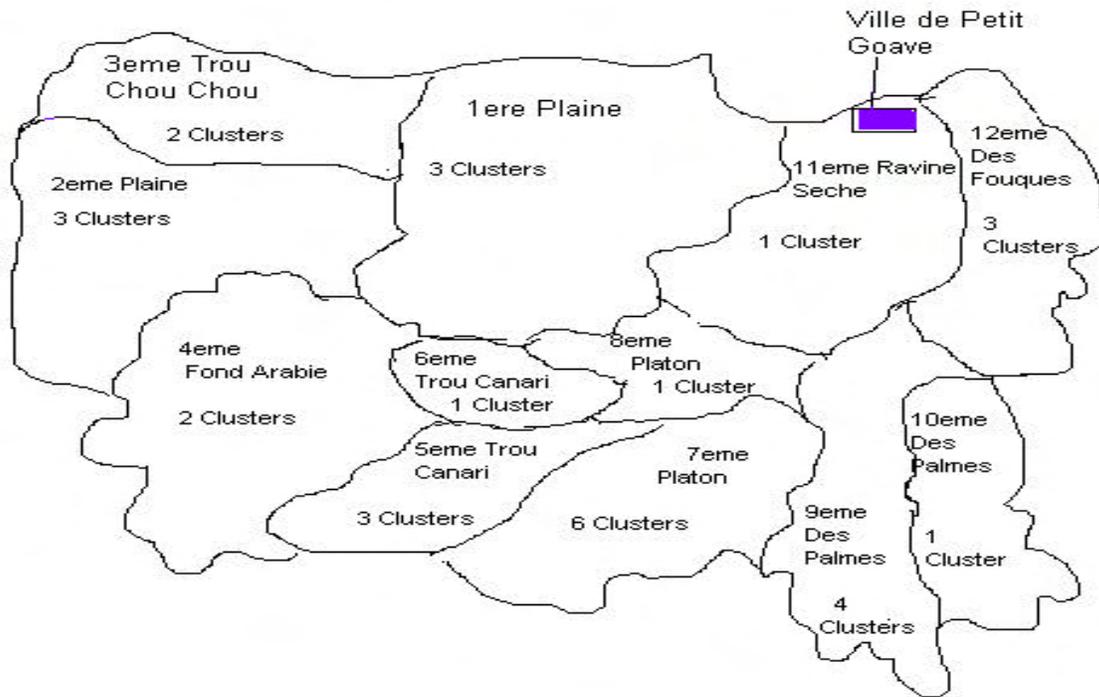


Figure 1: Distribution of Sections, Clusters and Zones during the 2005 KPC Survey

ZONE #	Section #
Zone 1	11eme Ravine Seche
	12eme Des Fouques
	1ere Plaine
Zone 2	1ere Plaine
	3eme Trou Chou Chou
	2eme Plaine

ZONE #	Section #
Zone 3	4eme Fond Arabie
	5eme Trou Canari
	6eme Trou Canari
Zone 4	7eme Platon
	8eme Platon
Zone 5	9eme Des Palmes
	10 Des Palmes

Survey Training

The survey training was hosted in the COD -EMH training center in the town of Petit Goave. The majority of the participants in the survey training lived in the town, could travel easily to their own home, or lodged with someone in the town. One participant was housed at the training center.

The survey training was facilitated by the survey coordinator, the GHA/Haiti project manager and the project statistician. The schedule of training activities can be found in Appendix 6 and the protocol which guided the survey training appears in Appendix 7. Twelve men and six women were selected to attend the training. All participants were literate in Creole and French, could write legibly, were from one of the 12 sections of Petit-Goave, and were dependable and able to participate in all days of training and surveying. Additionally, all participants were physically capable of walking the rough terrain. The supervisors were selected after two days of training had been completed. The supervisors selected demonstrated mastery of the questionnaire and could answer questions posed by the group regarding survey questions. Additionally, the supervisors were health workers or had previously participated in survey data collection.

All participants were involved in 2.5 days of the training. On the third day, the survey teams and the team supervisors were announced. All 18 individuals were retained for the data collection as they had all performed well during training and field testing the questionnaire. It was determined that due to the difficulty of the terrain; it would not be possible to complete data collection in three days covering four zones with 16 personnel (12 interviewers and 4 supervisors). The five zones described in the previous section of the report were determined to be the most efficient method to collect the data.

The training was conducted using adult teaching methods such as participatory teaching and learning, role plays and hands-on learning. Discussion regarding the questionnaire was guided by the protocol manual (Appendix 7). Participants, the survey coordinator and the GHA/Haiti project manager actively facilitated various sections of the training. All training participants practiced interviewing using the questionnaire during day two of the training. The participants' field-tested the questionnaire in the community surrounding the training center during the morning of the third day of the training. All participants practiced reading the infant weighing scale and demonstrated proficiency during the training.

Local staff has the capacity to conduct further trainings however they will need to allocate sufficient time for logistical planning.

Data collection and quality control procedures

Data collection occurred over the course of three days in January, January 21st, 24th and 25th, and 2 days in February including February 21st and 22nd. Data was not collected Saturday due to it being the market day for the region and the interviewers estimated that few women would actually be at their homes. Interviewers did not collect data on Sunday as it would interfere with the religious observance of the interviewers and the

interviewers also said that few women would be at home on this day for various reasons. Data was recollected for Zone 2 during the two days in February due to the problems with the original data that was collected in this zone. It was believed that data was falsified for a portion of the questionnaires from Zone 2. The quality control surrounding the falsified data will be discussed further in this section.

In order to identify them as official surveyors working for GHA and COD, all surveyors were provided with an identification badge, a t-shirt bearing the Global Health Action logo, a canvas bag with the logo, a clip board, pens and pencils for writing and sufficient copies of the questionnaire (the number of questionnaires given to each team varied according to the number of clusters that team was assigned to interview). One infant weighing scale was provided to each team for the three days of the data collection. All scales were calibrated prior to their distribution.

There were a series of quality control procedures put in place to assure the best possible results of the data collection. First, supervisors were provided additional instruction regarding the numbering and cluster sampling in their zones. Additional duties for the supervisors included using their quality control checklist to observe at least one interview per interviewer on their team each day. Additionally, the supervisors were encouraged to hold a team meeting at the start of each day to ensure that all team members understood their duties and resolved any questions. The supervisors from Zones 1-4 turned in their first set of questionnaires prior to beginning data collection on the second day. Questions regarding methodology and problems encountered in the field were discussed with the survey coordinator. Due to the distance, the supervisor from Zone 5 brought in all questionnaires from his region after they concluded data collection for all five clusters in their zone.

The team working in Zone 1 turned in their completed questionnaires each evening, due to their close proximity to the training center. The teams in Zone 2-4 turned in their completed questionnaires from Day 1 during the weekend, prior to collecting for day 2 and 3. The teams in Zone 2-4 turned in surveys from day 2 and day 3 upon completion of all of their remaining clusters. As stated in the prior paragraph, the team from Zone 5, remitted all questionnaires at the same time. Upon receiving the second set of questionnaires, the survey coordinator held a debriefing meeting with each team to review what happened during the survey, any problems encountered. They also looked through the completed questionnaires together in order to answer any questions that arose during data entry from the first set of questionnaires and to anticipate and answer any questions regarding the information recorded on the second set of questionnaires. Clarifications were made regarding short hand that was used.

The supervisor for Zone 4 had written the birthdates of many of the children under age 2 on a separate sheet of paper in lieu of recording the birthdays and names on the questionnaires when a mother requested that the information be separated. This information was reattached to the correct questionnaire during this debriefing session.

During the data entry for Zone 2, the survey coordinator and GHA/Haiti program manager determined that the team from Zone 2 may not have conducted all 70 surveys

and may have falsified some data. It was necessary to verify a random sampling of questionnaires from the zone in order to determine if they were accurate or not. We were able to verify several questionnaires however we were not able to confirm all of the questionnaires we had chosen to resample. At that point it was determined that data for all 7 clusters in Zone 2 would be recollected. Recollection of 70 interviews in Zone 2 was conducted by 3 participants who had performed very well during the first round of data collection and supervision was performed by the program manager. Data was returned to the US to the survey coordinator at the beginning of March for analysis.

Data management/data analysis

All questionnaires were entered into the data analysis program by the survey coordinator. Data analysis was conducted using EPI Info 2004, version 8.0. Results were obtained through computer tabulation. Error checking was conducted prior to data analysis during the debriefing session with each team and with the survey coordinator. Translation of the Creole to French was completed by the GHA/Haiti program manager; the survey coordinator completed translation into English. Several questions were hand tabulated to verify results returned by EPI Info.

Data Collection:

On average the interviews lasted 40 minutes in length, varying from 35 minutes to over 60 minutes depending on the responses of the mother, difficulties locating child's vaccination card or time waiting for the supervisor to weigh the baby. Teams from all zones were able to complete data collection in 3 days.

The major constraints to data collection were lack of scales to weigh the children and distance between homes. The first constraint was overcome by distributing one baby scale to the supervisor of each team and to the team members themselves in the case of the team in Zone 1 who were supervised by the survey coordinator and the program manager. An advantage to having only one person per team, five total, weigh all of the children is that it provided greater consistency in the way in which children were weighed and the scale read. However, this may also have introduced bias in the case of terminal-digit rounding or other such error on the part of the supervisor who was weighing the child. However, because this would be systematic error, it would not be expected to greatly influence the results. Additionally, having only one scale per team required that the team members stay near one another and not advance rapidly from one house to the next until the supervisor weighed the child.

The greatest constraint to conducting the survey was transportation. Interviewers used public transportation to reach distant areas, however many of the communities were located in areas that were impassable by cars. Interviewers were required to walk long distances to capture the appropriate clusters. Frequently the communities were widely dispersed with long distances between homes. Teams proceeded somewhat slowly in these areas in order that they remain in contact with all other members of their team.

The second major constraint to data collection was civil unrest. During the survey training, surveyors were instructed not to put themselves in danger for the sake of the survey. For example in Zone 1, the survey team discovered that a family had recently been murdered and that a retaliatory killing had then taken place in an area that the survey team had intended to interview. For the sake of safety, the survey team did not sample from the area where the killings had occurred, and instead chose households in a different area of the same section in Zone 1.

Quality-control procedures

Supervisors were assigned to each team for the purpose of ensuring that data was collected in a uniform fashion and to ensure that all team members were correctly performing the interviews. Team supervisors completed a Quality Control Questionnaire for each interviewer each day, as well they were responsible for reviewing their team's questionnaires after data collection had ended for the day and correcting errors or verifying with their team members what was written.

During the analysis and control of the data, patterns began emerging. As previously mentioned, irregularities particularly with the data from Zone 2 were identified. Irregularities included nearly all questionnaires followed the identical response and skip pattern with little variability. For example, the surveys demonstrated that all women interviewed in Zone 2 had lost 1 child. Then several questionnaires contained identical information except in the Maternal Parity Section whereby each of the responses diminished by one number on each of the questionnaires. We suspected that some data had been falsified.

The supervisor of the team and the team member whose questionnaires were suspected of being falsified were questioned regarding their work. The survey coordinator, GHA/Haiti program manager, the supervisor from Zone 2 and the interviewer in question returned to the zone on Thursday January 27 to verify some of the information recorded. Among the questionnaires sampled to be verified, it was confirmed that the interviewer had conducted a portion of the interviews. However, we were unable to confirm that all interviews had been conducted. One difficulty in verifying this information at a later time is that there are no maternal identifiers such as name or exact address that allow easy identification of the same woman at a later time. Advice was sought from an independent advisor on the project regarding suspected falsified data. He advised that this entire zone be resurveyed since it would not be possible to filter out which questionnaires were falsified and which questionnaires contained valid information. Data for Zone 2 was recollected to ensure that the information obtained was as correct and representative of the target population as possible.

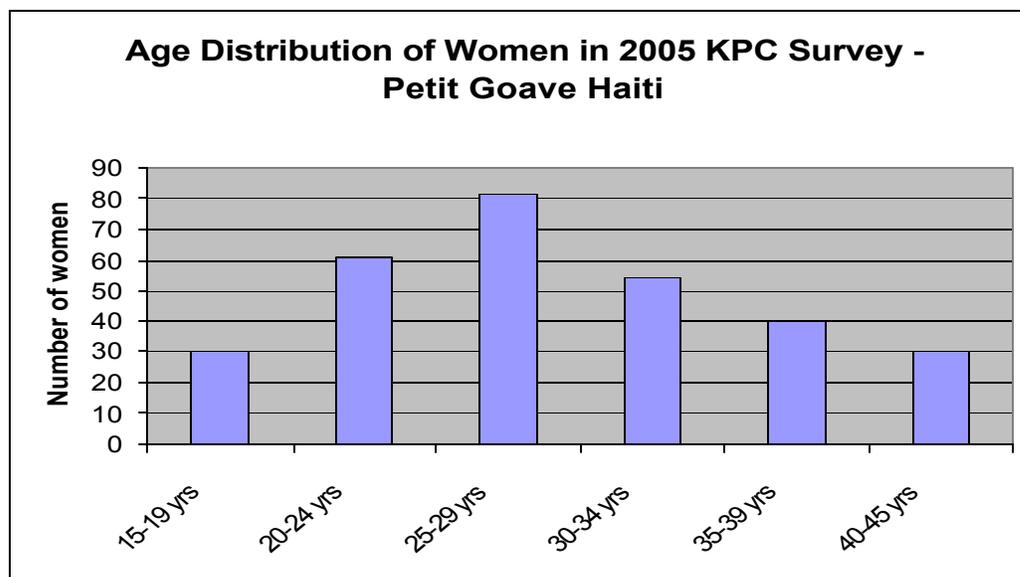
I. Results

The full results of the survey are listed in the Table of survey indicators found in Appendix 13. The results from questions from the 17 categories of information gathered by this survey will be presented in a manner whereby the 13 RAPID CATCH indicators are responded to initially, followed by the objectives and indicators specific to the COD/EMH project in Petit Goave.

Demographic Information

The average age of women with children age 0 -24 months who participated in this survey was 28.8 years of age. The women ranged in age from 15 to 45 years. The distribution of the ages of the participants is represented in Figure 2. On average women had 4.40 years of formal education ranging from no formal education to 17 years of schooling. The length of time a woman has lived in a particular region may influence her knowledge about health services availability or her utilization of those services. The average length of time living in the area of Petit Goave among women in the survey was 14.1 years. Among women surveyed, 77.4% reported that the biological father of their youngest child lives in the same household.

Figure 2: Age distribution of women who participated in the 2005 KPC Survey in the region of Petit Goave, Haiti



RAPID Catch Indicators

The 27 RAPID Catch questions were included in the survey questionnaire and 13 Child Health Indicators are used to measure the following three categories

Priority
of

information: sentinel measure of child health and well-being, prevention of illness and death and management/treatment of illness.

Children in the survey were aged 0-2 years. Figure 3 shows the distribution of ages of the children. Appendix 10 shows the distribution of the ages of children in numeric form. The mean age of the youngest child under two in a household was 9.7 months of age. Children age 0-5 months made up 32.4% of the children surveyed. More than half of the children (60.3%) were age 0-11 months. Children age 12-23 months comprised 38% of the sample population and 1.7% of the survey sample was aged 24 months. Six children were included in the survey were age 24 months at the time of the interview. The information from the mothers of these children was included in the analysis because they did not bias the results. For the analysis of vaccinations we separated the data into children 0-11 months, 12-23 months and 24 months in order to look at the true number of children vaccinated before they reached 24 months of age. For all other questions, these 5 children were included in the category of children age 23 months.

We were missing the date of birth for 10 children. Mothers of those 10 children were interviewed because the interviewers determined through observation and discussion with the mother that the child was under the age of two however, the interviewer failed to record the number of months of age the mother stated that the child had. Data from these children were included in the analysis for most questions. For vaccination coverage, child spacing and exclusive breastfeeding rates, data from these 10 children was not included in the analysis since these questions are age dependent. The survey indicators are found in Appendix 12 and show the denominator and numerator used for each calculation. The denominator varied for questions depending on the response rate for the question. Women who chose not to answer or skip a question were not included on the denominator of that indicator.

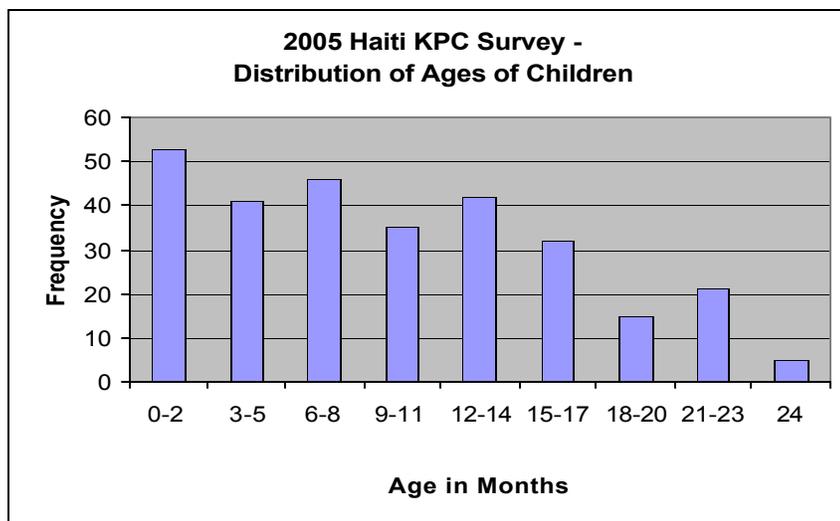


Figure 3: Distribution of Ages of Children included in the survey

RAPID CATCH PRIORITY HEALTH INDICATORS:

A. Sentinel Measure of Child Health and Well-being

Percentage of children age 0–24 months who are underweight

Low-weight-for age is an indication of underweight among children. This measure gives an estimate of the level of nutritional sufficiency or insufficiency at either the population or individual level. The benefit of using weight -for-age is that it can be easily measured at the clinical level and compared to growth charts to distinguish whether the child is growing properly and is an indicator of being properly nourished. The greatest limitation of using weight -for-age as a measure is that it cannot distinguish between chronic malnutrition (measured by insufficient height-for-age) and acute malnutrition (measured by degree of emaciation or insufficient weight -for-height) as it is an indicator of both. Other measures can also be used but for the purpose of this survey, the child’s weight was taken and weight -for-age was calculated using EPI Info Nutrition program (CDC, 2002) to calculate the children who are underweight. In Haiti, the prevalence of childhood malnutrition varies by region and by age of the child. In urban areas, the prevalence of childhood malnutrition ranges from 11 -15% while in rural areas it rises to a prevalence of 27% of children under 5 years. Nationally, 4.6% of infants <6 months of age are underweight while a quarter of all children (24.9%) aged 16 -19 months are underweight. Overall, 17.3% of children under the age of 5 years are estimated to be underweight nationally.

Table 4: Prevalence of Underweight

Frequency and Percent of Children Underweight						
Age of the child (months)	Petit Goave					Total
	-2SD or greater	-1 SD	0 SD Median	+1 SD	+2 SD	
0-2	5 (12.8%)	3 (7.7%)	12 (30.8%)	5 (12.8%)	14 (35.9%)	39
3-5	2 (5.7%)	6 (17.4%)	14 (40.0%)	5 (14.3%)	8 (22.9%)	35
6-8	8 (18.2%)	8 (18.2%)	21 (47.8%)	4 (9.1%)	3 (6.8%)	44
9-11	4 (17.4%)	9 (39.1%)	16 (69.6%)	1 (4.3%)	2 (8.7%)	23
12-14	10 (26.3%)	8 (21.0%)	17 (44.7%)	2 (5.3%)	1 (2.6%)	38
15-17	7 (24.1%)	10 (34.5%)	9 (31.0%)	3 (10.3%)	0 (0%)	29
18-20	5 (33.3%)	5 (33.3%)	4 (26.7%)	1 (6.7%)	0 (0%)	15
21-23	4 (22.2%)	4 (22.2%)	9 (50.0%)	1 (5.6%)	0 (0%)	18
24	1 (33.3%)	0 (0%)	2 (66.7%)	0 (0%)	0 (0%)	3
Total	46 (18.2%)	53 (20.9%)	104 (41.1%)	22 (8.7%)	28 (11.1%)	253
Sex						
Male	26 (19.7%)	24 (18.2%)	52 (39.4%)	13 (12.9%)	17 (12.9%)	132
Female	20 (16.5%)	29 (24.0%)	52 (43.0%)	9 (7.4%)	11 (9.1%)	121

† The sample size for children age 24 months in the district of Petit Goave was n= 5. This small sample may not provide an accurate estimation of the true prevalence of underweight among children age 24 months in the district.

In the region of Petit Goave, the statistics and trends observed are similar. Table 4 shows the frequency and percent of children underweight in Petit Goave. Overall, 18.2% of children 0-24 months are reported to be underweight, defined as -2 SD from the median weight-for-age, according to the WHO/NCHS reference population in the region of Petit Goave. An additional 20.9% of children under the age of 24 months were -1 SD from the median weight-for-age. Greater than half of all the children in the survey met or exceeded the median weight-for-age. The highest prevalence of underweight occurs in children from 12-24 months of age, however the difference in underweight prevalence between children <12 months of age and those aged 12-24 months is not statistically significant. 58.7% of children aged 12-24 months and 41.3% of children aged 0-11 months were at least -2 SD from the median weight-for-age. Including children who are -1 SD and greater from the median weight-for-age, 45.5% of children 0-11 months of age and 54.5% of children 12-24 months of age were underweight. Among children less than 6 months of age, 9.5% of children were -2 SD from the median weight-for age and an additional 12.2% are -1 SD from the median. The rates of malnutrition are similar for male and female children, there is not a statistically significant in malnutrition according to sex.

B. Prevention of Illness/Death

1. Percentage of children age 0–24 months who were born at least 24 months after the previous surviving child

Nationally, 73% of women report that at 24 months separate the birth of their youngest child and the preceding surviving child. In the region of Petit Goave, mothers of children age 0-24 months had an average of 3.7 pregnancies, 3.4 live births and 1.5 biological children under age 5 years in the household. Among mothers who reported the birthdates of two children under the age of five, the average length of time between the births of their children was 24.2 months. For the households where the birthdates were reported for two children under the age of 5 years, 46.4% of the children age 0-23 months were born at least 24 months after the previous surviving child. Table 5 shows child spacing practices by zone and education level. There is not a significant difference in child spacing according to zone or education level of the mother.

Table 5: Child Spacing Practices by Zone

Frequency and Percentage of Children who were born $<$ or $=$ 24 months after the previous surviving child			
Location	<24 Months	$= 24$ Months	Total
Zone 1	9 (52.9%)	8 (47.1%)	17
Zone 2	11 (57.9%)	8 (42.1%)	19
Zone 3	5 (55.6%)	4 (44.4%)	9
Zone 4	8 (42.1%)	11 (57.9%)	19
Zone 5	12 (60.0%)	8 (40.0%)	20
Total	45 (53.6%)	39 (46.4%)	84
Education Level			
0 years	7 (35.0%)	13 (65.0%)	20
1-5 years	17 (60.7%)	11 (39.3%)	28
> 5 years	20 (58.8%)	14 (41.2%)	34
Total	44 (53.7%)	38 (46.3%)	82

2. Percentage of children age 0–24 months whose births were attended by skilled health personnel

The 2000 National Survey on Morbidity, Mortality and Utilization of Services (EMMUS -III) reported that 24% of births in Haiti were attended by trained health personnel, the majority of which were attended by doctors (14%). Utilization in urban and metropolitan areas was 39.8% and 56.5% respectively. Nationally, only 10.6% of women in rural areas had a birth assisted by skilled health personnel. By contrast, the area of Petit Goave showed higher reported number of births attended by skilled health personnel.

For the purpose of this survey, skilled health personnel were defined as a doctor, a nurse/midwife, or an auxiliary midwife. Table 6 shows the proportion of births that were attended by skilled or unskilled health personnel or were unattended. A vast majority of mothers surveyed, 91.8%, reported that their youngest child's birth was attended by skilled health personnel. Another 6.5% of women reported that the birth of their youngest child was attended by unskilled or other health personnel including traditional birth attendants (TBA), Community Health workers (CHW), or a family member. Fewer than 2% of women stated that no one attended the birth of their youngest child. In Zone 1, 98% of women reported that they had skilled health personnel at their delivery. The Notre Dame Hospital is located in this zone and is heavily utilized. Only 84% of women in Zone 4 reported that the birth of their youngest child was attended by skilled health personnel. Unskilled or other health personnel included traditional birth attendants (TBA), Community Health workers (CHW), or a family member. Significantly fewer women reported that an unskilled or other health workers attended the birth of their youngest child. In the region of Petit Goave, 6.5% of women had unskilled or other health personnel at the delivery of their youngest child. Women in Zone 4 relied more heavily on unskilled health personnel during delivery than did women of other regions. Only 1.7% of women reported that no one attended the birth of their youngest child age 0-23 months.

Table 6: Health Personnel Attendance at delivery

Percent of Births attended by Health Personnel by Zone, Education and Type of Health Personnel in the Region of Petit Goave			
	Personnel attending births		
	Skilled Health Personnel	Unskilled or other Health personnel	No One
Location			
Zone 1	98.0	2.0	0.0
Zone 2	92.5	6.0	1.5
Zone 3	93.2	6.8	0.0
Zone 4	85.9	9.9	4.2
Zone 5	91.3	6.5	2.2
Education Level			
0 years	89.7	7.4	2.9
1-5 years	93.0	5.3	1.8
> 5 years	92.3	6.7	1.0
Total	91.8	6.5	1.7

Nationally, 76.3% of women give birth at home. There is a negative association between delivery at home and education level whereby 89.7% of women without any formal schooling gave birth at home versus 11.3% who delivered in a health facility; 78.4% of women with a primary school education and only 37.2% of women with at least secondary school education gave birth at home. In the district of Petit Goave, a slightly higher proportion of women gave birth at home (81.3%). Women in Zone 1 were more likely to deliver in a health facility than women in other zones. In accordance with the national findings, women with higher educational attainment are more likely to give birth in a health facility. Table 7 shows the trends in the region of Petit Goave. Nearly all of the women surveyed (94.8%) stated that a clean birth kit was used during the delivery and 86.7% reported that the cord was cut with a new razor blade.

Table 7: Delivery Location

	Percent of Deliveries which took place in the following locations:		
	Home	Health Facility	Other
Location			
Zone 1	68.0	32.0	0.0
Zone 2	82.6	17.4	0.0
Zone 3	93.2	5.1	1.7
Zone 4	80.0	17.1	2.9
Zone 5	80.4	15.2	4.3
Education Level			
0 years	88.2	10.3	1.5
1-5 years	85.2	13.0	1.7
> 5 years	72.1	26.0	1.9
Total	81.3	17.0	1.7

3. Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Neonatal tetanus is a threat to newborn infants in Haiti. For this reason the Minister of Public Health and Population has recommended that all pregnant women should receive at least two tetanus toxoid (TT) injections during pregnancy, prior to the birth of their child. The 2000 EMMUS-III reported that 71% of live births were completely or partially covered by TT injections: 52% had two doses during pregnancy, and 19% had only 1 dose prior to the birth of their child.

Table 8 shows the self-reported and card-confirmed TT immunization coverage by zone in the region of Petit Goave. Of the 300 women surveyed, 54 women had at least two card-confirmed tetanus toxoid injections. However, of these 54 women, only 20 had two card-confirmed recorded dates prior to the birth of their child. Thirty-four additional women had received a TT injection either on the day of their delivery or within the months following their delivery. Overall, 6.7% of women surveyed had at least two card-confirmed TT injections prior to the birth of their youngest child (20/300). There is a large discrepancy between reported immunization rates and card confirmed immunization rates. Over half of the women (191/300 = 63.7%) surveyed reported that they had received at least one TT injection during their pregnancy while only 12.3% (37/300) had at least one card confirmed TT immunization during their most recent

pregnancy. The difference between reported and card -confirmed TT injections is described in table.

Table 8: Tetanus Toxoid Immunizations during pregnancy among women of reproductive age in the region of Petit Goave, Haiti

	Number of TT Immunizations prior to the birth of the youngest child			
	1 immunization	2 immunizations	More than 2 immunizations	Total
Self-Reported:				
Zone 1	8	8	7	23
Zone 2	20	17	14	51
Zone 3	11	12	17	40
Zone 4	10	17	13	40
Zone 5	7	13	17	37
Total	56	67	68	191
Card-confirmed:				
Zone 1	5	0	0	5
Zone 2	3	1	2	6
Zone 3	1	6	1	8
Zone 4	3	0	5	8
Zone 5	5	4	1	10
Total	17	11	9	37

4. Percentage of children age 0 –5 months who were exclusively breastfed during the last 24 hours

The EMMUS III Haiti 2000 reported that among children age 0-5 months 1.2% were not breastfed during the 24 hours prior to the survey. Nationally, among this same age group, 23.6% were exclusively breastfed. The rate of exclusive breastfeeding for children of this age range is higher in the region of Petit Goave. Among women surveyed, 53.3% reported that they exclusively breastfed their youngest child in the previous 24 hours. 6.5% of children 0-5 months of age were not breastfed and 46.7% reported that their child received complementary foods in the previous 24 hours.

5. Percentage of children age 6 –9 months who received breastmilk and complementary foods during the last 24 hours

The rate of exclusive breastfeeding among children age 6 -9 months is 3.2% nationally according to the EMMUS III Haiti 2000. A greater proportion, 73% of children in this age range received breastmilk and complimentary foods in the 24 hours prior to the survey. In the region of Petit Goave, 83.7% of children age 0 -24 months were breastfed in the 24 hours prior to the survey (241/288). Among these children, 29.5% were exclusively breastfed (85/288) and 70.4% also received a supplement (203/288). Among children under 6 months of age, 6.5% were not breastfed, mothers of 46.7% of these children stated that their child had received a supplement, and 53.2% were exclusively breastfed. Among children 6-8 months of age, 38 children received some type of complimentary feeding (82.6%). Ten percent of children age 9-11 months old were

not breastfed in the 24 hours prior to the survey. In this same age range, 80.0% of children received a supplement and 20.0% were exclusively breastfed. In Six of the 38 children (15.8%) age 6-8 months were not breastfed therefore 32 of the 38 children received breastmilk and complimentary foods (84.2%). Children Among children 12 – 24 months of age, 30.4% were not breastfed in the 24 hours prior to the survey and 18.3% were exclusively breastfed. 81.7% of children aged 12-24 months received a supplement.

Table 9: Breastfeeding Practices in the region of Petit Goave

Frequency and Percent of Feeding Practices among children age 0-24 months				
Age Group (in months)	Not Breastfed	Exclusively Breastfed	Received Supplement	Total
0-2	2 (3.9%)	33 (64.7%)	18 (35.3%)	51
3-5	4 (9.8%)	16 (39.0%)	25 (61.0%)	41
6-8	6 (13.0%)	8 (17.4%)	38 (82.6%)	46
9-11	3 (10.7%)	7 (20.0%)	28 (80.0%)	35
12-14	8 (19.0%)	8 (19.0%)	34 (81.0%)	42
15-17	8 (25.0%)	5 (15.6%)	27 (84.4%)	32
18-20	6 (40.0%)	3 (20.0%)	12 (80.0%)	15
21-23	7 (33.3%)	5 (23.8%)	16 (76.2%)	21
24	3 (60.0%)	0 (0%)	5 (100.0%)	5
Total	47 (16.3%)	85 (29.5%)	203 (70.4%)	288

6. Percentage of children age 12 –23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Nationally, 67.7% of children have received their BCG by age 12 months, 36.2% have received all three DTP injections, and 37.5% have received the series of 4 Polio immunizations. Measles vaccination coverage is only 34.3% among children 0-12 months of age however 44.1% of children had received the measles vaccination by the age of 23 months. The analysis presented by the EMMUS III Haiti 2000 revealed that nationally 30% of children age 12 –23 months had been completely vaccinated according to information from their vaccination card. Card confirmed immunization rates were significantly lower in the region of Petit Goave. Only five children age 12 -23 months (7.8% of children in this age group) were completely vaccinated according to immunization cards presented by mothers during the survey . Table 10 shows coverage in the region of Petit Goave.

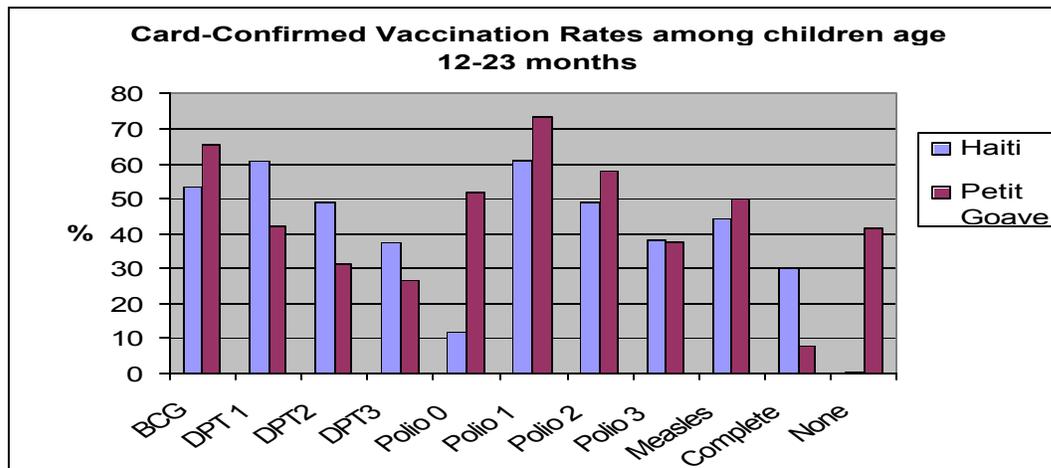
Table 10: Immunization Coverage in the Region of Petit Goave

Frequency and Percent of card-confirmed vaccinations among Children under the age of 24 months											
Age	BCG	DPT			Polio				Measles	Completely Vaccinated	No card – confirmed Vaccinations
		1	2	3	0	1	2	3			
0-11 months	58 69.0%	36 42.9%	22 26.2%	11 13.1%	42 50.0%	56 66.7%	38 54.2%	17 20.2%	9 10.7%	1 1.2%	88 63.3%
12-23 months	42 65.4%	27 42.2%	20 31.3%	17 26.6%	33 51.6%	47 73.4%	37 57.8%	24 37.5%	32 50.0%	5 7.8%	46 33.1%
24mos	0 0%	1 1.6%	1 2.3%	1 3.4%	0 0.0%	1 1.0%	1 1.3%	0 0%	1 2.4%	0 0%	5 3.6%
Total all ages	100 69.9%	64 44.8%	43 30.1%	29 20.3%	75 52.4%	104 72.7%	76 53.1%	41 28.7%	42 29.4%	6 4.2%	139 48.3%

A large proportion of children had received at least one vaccination in a series but had failed to complete the series. Another limitation was the manner in which vaccination dates were recorded on the card. Frequently dates of vaccination were recorded out of order. For example, frequently children have no recorded date for BCG or Polio 0 but their vaccination card has a recorded date for Polio 1. Another example is that several cards have dates written for the DPT 2 or Polio 1 without having a date recorded for the first dose in the immunization series. These inconsistencies are evidenced by the fact that for all groups aged 0-23 months, immunization rates for Polio 1 and Polio 2 are higher than the rate for Polio 0. For the purpose of data analysis, these inconsistencies in dates might be interpreted in one of two ways. First, one could assume that the BCG and Polio 0 were given to the infant at birth for all births attended by skilled health personnel and systematically record missing dates for the first dose of BCG and Polio 0 as the date of birth of the child. Alternately, one can leave the dates blank since health personnel either did not give these immunizations or failed to record the immunization. In these instances, we chose to leave these dates blank. Further surveillance of the health care facilities will reveal vaccination usage and the program will be able to determine if vaccinations are in fact being given but not recorded or if immunization coverage in the region is truly as low as the results of our 300 household survey show.

Figure 4 shows the vaccination rates nationally and in the region of Petit Goave. Petit Goave has increased rates of vaccination for BCG, Polio 0, Polio 1, Polio 2, and Measles among children age 12-23 months. However, the rates of vaccination for DPT 1-3 are lower in Petit Goave than on the national level. Additionally, there are a much higher proportion of children in Petit Goave who have no card-confirmed vaccinations.

Figure 4: Vaccination Rates



7. Percentage of children age 12–23 months who received a measles vaccine

Table 9 shows that fully 50% or half of all children in the age range of 12–23 months have received a measles vaccine according to their vaccination card. Of the 300 mothers surveyed, 46.4% reported that their child had received a vaccine. Nationally, 44.1% of children age 12–23 months had received a Measles vaccination and mothers of an additional 9.8% of children reported that their child had been vaccinated.

8. Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night

Malaria is endemic to the country of Haiti. It has an impact on the morbidity and mortality of young children. A recent national survey revealed that 11.7% of children with fevers are treated with chloroquine, a common antimalarial medication. One method of reducing malaria transmission is to sleep under mosquito treated bednets. The survey revealed that bednets were owned by 6.3% of households. However, only 2.43% of children age 0-23 months had slept under an insecticide treated bednet during the night prior to the survey.

9. Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

HIV and AIDS are considered a major public health problem in the country of Haiti where the prevalence of HIV/AIDS among adults age 15–49 years is 2.5-11.9% (WHO, 2004). In the region of the Americas, Haiti has been hardest hit by the epidemic. The minister of health attributes the rapid growth of HIV and AIDS to certain taboos and traditions that exist within the Haitian culture, low education levels of the general population, poverty, and migration from rural areas of urban slum areas referred to as “bidonvillisation.” (MSPP, 2001)

In the KPC 2005 conducted by GHA/COD, a vast majority of the women, 96.2%, who participated in the survey, stated that they have heard of HIV. Knowledge of HIV significantly differed by education level, see table 11. All respondents with more than 5 years of formal education had heard of HIV/AIDS whereas only 95.6% of respondents with 1-5 years of

education and 92.9% of respondents with no education have heard of HIV/AIDS. These rates are similar to national rates of HIV/AIDS knowledge. There is not a statistically significant difference in HIV/AIDS knowledge due to age alone however. Knowledge of HIV/AIDS is similar among women in all zones.

Table 11: Knowledge of HIV/AIDS

Have you heard of HIV/AIDS?		
Characteristic	YES	NO/No response
All women	96.2%	3.8%
Age Groups		
<25 y	98.9%	1.1%
= 25 y	95.6%	4.4%
Education Level		
No formal education	92.9%	7.1%
1-5 years	95.6%	4.4%
>5 years	100%	0%
Zone		
Zone 1	100.0%	0%
Zone 2	95.6%	4.4%
Zone 3	94.8%	5.2%
Zone 4	94.3%	5.7%
Zone 5	97.9%	2.1%

Despite the large majority of women who state that they have heard of HIV/AIDS, under half (46.8%) of mothers of children age 0 -23 months were able to cite at least 2 known ways of preventing HIV infection. Table 12 shows the distribution of responses by single category. The largest difference appears in condom usage. Among women with >5 years of formal education, 58.7% listed condom usage as a safer sex practice whereas ~38% of women with = 5 years of education stated that using condoms would help a person avoid contracting HIV or AIDS. This is similar to the difference seen at the national level in knowledge about condom usage. For the rest of the categories, there was little variability by education level or by age. For the purpose of this survey, methods to avoid contracting HIV included responses that relate to safer sex or practices involving blood including abstinence, using condoms, limiting the number of sexual partners or remaining faithful to one partner, avoid sex with prostitutes, avoid sex with persons who have sex with many people, avoid sex with persons who inject drugs intravenously, avoid blood transfusions and injections and avoid sharing razor blades.

Table 12: Knowledge about Safer Sex practices or practices involving blood

Percentage of respondents who mentioned the following response to the question: “What can a person do to avoid getting AIDS or the virus that causes AIDS?”										
	Abstinence	Use condoms	Limit # of sexual partners	Fidelity to one partner	Avoid sex with prostitutes	Avoid sex with persons with many partners	Avoid sex with IV drug users	Avoid Blood Transfusions	Avoid Injections	Avoid sharing razor blades
All women	6.3	43.3	7.3	37.3	11.7	25.3	2.3	3.0	7.0	3.7
Age Groups										
<25 y	5.5	52.7	6.6	29.7	8.8	27.5	2.2	3.3	6.6	1.1
= 25 y	6.8	40.0	7.8	41.5	13.2	24.9	2.4	2.9	8.3	4.9
Education Level										
No formal education	5.7	35.7	10.0	40.0	12.9	28.6	0.0	2.9	2.9	4.3
1-5 years	5.1	35.9	7.7	35.0	11.1	23.9	3.4	3.4	10.3	4.3
>5 years	8.7	58.7	5.8	40.4	11.5	24.0	2.9	2.9	8.7	2.9

Related to maternal knowledge about HIV risk reduction is knowledge about Maternal Child transmission (MCT) among women of reproductive age. Table 13 shows that 52.8% of women know that HIV/AIDS can be transmitted during pregnancy but 44% of those women also stated that MCT could be avoided. Among these same mothers, 47.2% stated that HIV/AIDS can be transmitted during delivery but 26.7% of those women also said that it could be avoided. Over half of women interviewed knew that HIV/AIDS could be transmitted to a child during breastfeeding and 31.2% of those women also knew that it was possible to avoid transmission of HIV/AIDS from mother to child. Overall, a majority of women knew that it was possible for HIV/AIDS to be transmitted from mother to child but only about half of those women also knew that it was possible to avoid transmission of HIV/AIDS from mother to child.

Table 13: Knowledge about Maternal Child Transmission of HIV/AIDS

	% of Mothers who know that HIV/AIDS can be transmitted from mother to child:	% of mothers who know that it is possible to avoid transmission of HIV/AIDS from mother to child :
During Pregnancy	52.8	29.9
During Delivery	47.2	26.7
During Breastfeeding	55.3	31.2
Any time/overall	70.6	36.7

10. Percentage of mothers with children age 0–24 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Table 14 shows frequency and percent of women who wash their hands at the time indicated. Only 23% of all women surveyed reported that they washed their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. A majority of women (69.7%) reported that they washed their hands prior to preparing food; 61.3% of women reported that they wash their hands before feeding the children and 75.3% wash their hands after defecation. The greatest problem appears in the number of women who wash their hands after attending to a child who has defecated. Only 33.0% of women reported this behavior. Other common responses were that women wash when “my hands are dirty”, “from time to time” or “all the time.” There was little difference in behaviors by education level however there was greater variability by zone of residence. Women in Zones 4 were more likely to practice these behaviors than women in the other zones.

Table 14: Hand washing practices

Frequency and Percent of Mothers with children age 0-24 months who report that they wash their hands with soap/ash at the following times:						
Location	Before Food Prep	Before feeding children	After defecation	After attending child who defecated	Yes to all 4	Washes at other times
Zone 1	29 (13.9%)	25 (13.6%)	36 (15.9%)	18 (18.2%)	13 (18.6%)	27 (23.3%)
Zone 2	36 (17.2%)	23 (12.5%)	39 (17.3%)	9 (9.1%)	3 (4.3%)	36 (31.0%)
Zone 3	47 (22.5%)	34 (18.5%)	40 (17.7%)	24 (24.2%)	20 (28.6%)	34 (29.3%)
Zone 4	54 (25.8%)	60 (32.6%)	68 (30.1%)	9 (19.2%)	10 (14.3%)	3 (2.6%)
Zone 5	43 (20.6%)	42 (22.8%)	43 (19.0%)	29 (29.3%)	24 (34.3%)	16 (13.8%)
Total	209	184	226	99	70	116
Education Level						
0 years	50 (29.5%)	45 (24.7%)	52 (23.3%)	23 (23.7%)	19 (27.5%)	27 (24.3%)
1-5 years	81 (39.7%)	69 (37.9%)	86 (38.6%)	38 (39.2%)	24 (34.8%)	42 (37.8%)
> 5 years	73 (35.8%)	68 (37.4%)	85 (38.1%)	36 (37.1%)	26 (37.7%)	42 (37.8%)
Total	204	182	223	97	69	111

C. Management/Treatment of Illness

11. Percentage of mothers of children age 0 –23 months who know at least two signs of childhood illness that indicate the need for treatment

Among mothers of children age 0 -23 months who participated in the survey, 46.3% were able to name at least two signs of childhood illness that indicate the need for treatment. The most frequently mentioned signs of illness are fever (mentioned by 59.7% of respondents) and “looks unwell or is not playing normally” (mentioned by 36.3% of respondents). Many women also mentioned the appearance of a rash or stated that the “flu” was a reason to take an infant for treatment. There was not a significant difference in response rates by educational attainment or by age of the mother.

12. Percentage of sick children age 0 –23 months who received increased fluids and continued feeding during an illness in the past two weeks

Among mothers surveyed, 204 reported that their child had been sick at some point during the two weeks prior to the survey. Fever, diarrhea and cough were the most frequently reported illnesses in the two weeks prior to the survey with many mothers reporting several symptoms if their child was sick. Among the survey group, 38.0% reported that their child had had a fever (114/300; CI 32.5 -43.8%), 36.3% reported their child had diarrhea (109/300; CI: 30.9 -42.1%) and 30.3% reported a cough (91/300; CI: 25.2 -35.9%). Table 15 gives the frequency and percentage of reported fever, diarrhea and cough according to age groups of the children. The treatment practices for an ill child are also reported according to age groups in this table.

Ideally, the caretaker should offer an ill child more than usual to drink and the same or more than usual to eat. In all, 14.7% of mothers (CI: 10.5 – 20.3 %) reported that they offered more than usual to drink when their child was ill during the two weeks prior to the survey. Nealy one-fifth of mothers, 17.6% reported that they offered their child the same or more than usual to eat when the child was ill in the previous two weeks (CI: 13.0 – 23.5%)

Table 15: Illness and Treatment of Children age 0-24 months of age

Age Group (in months)	Frequency and Percent			Treatment for Ill Child	
	Fever	Diarrhea	Cough	Offered More than usual to drink	Offered the same or more than usual to eat
0-2	3 (2.7%)	9 (8.5%)	2 (2.3%)	4 (13.3%)	2 (5.5%)
3-5	15 (13.5%)	16 (15.1%)	12 (13.6%)	3 (10.0%)	5 (13.9%)
6-8	15 (13.5%)	18 (17.0%)	16 (18.2%)	6 (20.0%)	6 (16.7%)
9-11	20 (18.0%)	14 (13.2%)	13 (14.8%)	5 (16.7%)	5 (13.9%)
12-14	17 (15.3%)	18 (17.0%)	16 (18.2%)	2 (6.7%)	7 (19.4%)
15-17	18 (16.2%)	15 (14.1%)	15 (17.0%)	6 (20.0%)	5 (13.9%)
18-20	10 (9.0%)	6 (5.7%)	5 (5.7%)	2 (6.7%)	2 (5.5%)
21-23	11 (9.9%)	8 (7.5%)	8 (9.1%)	1 (3.3%)	4 (11.1%)
24	2 (1.8%)	2 (1.9%)	1 (1.1%)	1 (3.3%)	0 (0%)
Total	111*	106*	88*	30	36

*Totals in Table 15 differ from those reported in the paragraph preceeding the table due to missing dates of birth for several children. Those children with a missing date of birth are not included in this table.

However, only 5 out of the 204 children (2.5%) were offered more than usual to drink and the same or more than usual to eat. Table 16 displays the frequency of mothers of children age 0 -24 months and the quantity they offered their sick child to eat or drink during the previous two weeks.

Table 16: Caretaking practices during a recent illness among mothers of children age 0-24 months.

Frequency of mothers of children age 0-24 months and the amount of food and drink offered to children who were reportedly sick during the two weeks prior to the survey			
Amount offered to drink	Amount to eat		
	Less than usual	Same amount as usual	More than usual
Less than usual	135	2	5
Same amount as usual	10	25	0
More than usual	22	1	4

INDICATORS RELATED TO GH/COD PROJECT OBJECTIVES

Indicators related to the project objective made up the remainder of the questionnaire. Four basic topic areas were addressed in Objective 1: accessibility of health care, quality of maternal care, monitoring of maternal care and health-seeking behaviors and child spacing.

A. Health Contact/Health care Accessibility

Women of reproductive age in the region of Petit Goave get their health information in a variety of ways. Contact with health workers is one method of obtaining health information. Half of the women surveyed stated that they have come into contact with a skilled health worker at least once in the last month. Nearly half (46.6%) of the women reported that a doctor was their most frequent health contact, 13.2% stated that it was a nurse, 8.8% listed community health worker, 6.4% cited a health educator and 6.8% stated that the Growth Monitoring Person was their most frequent health contact. Twenty women (6.8%) stated that they have come into contact with a traditional health worker at least once within the last month.

Health messages and general information about health or nutrition are garnered from both formal and informal networks. Formal networks include doctors, nurse/midwife, auxiliary midwife, trained birth attendant, community health worker, health educator, growth monitoring persons. Informal networks include but are not limited to husband or partner, mother/mother-in-law, sister, grandparent, aunt, friend/neighbor, traditional healer and village elder. Among women of children age 0-24 months in the district of Petit Goave, 90.67% stated that they received their general health and nutrition information from someone in the formal network.

Table 17: Percent of women who have received health information from various sources

Location	Percent of women who have received health messages by source of information				
	Radio	Newspaper	Television	Health Education	Community Health Worker
Zone 1	44.9	6.1	8.2	4.1	8.2
Zone 2	46.4	1.4	0.0	1.4	5.8
Zone 3	31.0	5.2	5.2	5.2	18.6
Zone 4	32.4	1.4	1.4	2.8	5.6
Zone 5	70.2	4.3	4.3	4.3	4.3
Total	43.5	3.4	3.4	3.4	8.5

Table 17 illustrates Health messages are also received from sources such as the radio, newspaper, television, health education or from a community health worker. The radio is the most common medium by which women receive health messages. Among women surveyed, 43.5% received health messages from the radio, 3.4% from the newspaper, 3.4% from the television, 3.4% through health education and 8.5% from a community health worker. This differs some by zone in which the women live. Women in Zone 5 rely most heavily on receiving health messages where 70.2% of women in this area stated that they have received a health message from the radio. One-third to one-half of women in all other zones stated that they have received a health message from the radio.

Table 18 shows the distribution of access to health care by several indicators. Of the mothers of children age 0-24 months who were included in this survey, 49.6% of respondents to this question reported that they can get to the nearest health care facility within 1 hour. Among women in all zones, 66.0% stated that they walk or used a non-motorized form of transportation to get to that health facility. Only one woman stated that she uses an animal to arrive at the health center, all others stated that they walk, therefore for the remainder of this section, the term “walk” will be used in lieu of non-motorized transportation. Slightly fewer than half of the women who walk stated that they can arrive at the nearest health center in less than 1 hour, however there is disparity in accessibility by region. Only 11.1% of women in Zone 5 (9eme and 10eme Des Palmes) can arrive at the health center in under 1 hour whereas in Zone 2 (1ere Plaine, 3eme Trou Chou Chou, and 2eme Plaine), 74.1% of women can arrive at the nearest health facility in less than 1 hour. The majority of women in Zone 1 (69.2%) and Zone 4 (52.2%) can reach their nearest health facilities in less than 1 hour. More than half of the women in Zone 3 report that it takes more than 1 hour to get to their nearest health facility.

Table 18: Health Care Accessibility

Location	% of mothers who use non-motorized transportation to get the Nearest Health Center	% of mothers who reported the time required to get to nearest Health center was:			% of mothers who use non-motorized transport and can get to the nearest health center in < 1 hour
		< 1 hr	= 1 hr	Don't Know	
Zone 1	36.0	69.2	25.6	5.1	56.3
Zone 2	39.1	74.1	25.9	0.0	84.6
Zone 3	80.0	36.2	53.2	10.6	37.8
Zone 4	88.7	52.2	44.8	3.0	50.8
Zone 5	84.0	11.1	86.7	2.2	11.9
All zones	66.0	49.6	46.5	3.9	44.3

One third of mothers of children 0-24 years old stated that they are aware that fever, shortness of breath, bleeding and/or swelling of the body, hands or face danger signs that indicate the need to seek health care. Additionally, 33.6% of women stated that they would go to a Health Facility if they experienced any of the danger signs during pregnancy.

2. Maternal Care and Health-Seeking Behaviors

Maternal Care includes several of the components discussed above in the sections pertaining to the RAPID Catch indicators, such as births attended by health personnel and tetanus toxoid injections received during pregnancy. Additional factors included in maternal care include prenatal contact, iron supplementation during pregnancy, delivery practices, and postpartum contact.

1. Prenatal Contact

The frequency of prenatal visits, contact with health personnel before and after the birth of the child and where the delivery took place are also key elements that affect maternal and child mortality rates. Among women of children age 0-24 months, 90.8% of women in the region of Petit -Goave reported that they received at least one prenatal visit prior to the birth of their youngest child. Most of these women (81.0%) stated that they were seen by skilled health personnel, a doctor, a nurse or midwife, or an auxiliary midwife. An additional 5.5% of respondents stated that they were seen by other health personnel such as a Traditional Birth Attendant (TBA) or Community Health Worker (CHW).

Among mothers of children age 0-24 months, 90.8% reported that they had received at least one prenatal visit prior to the birth of their child. The number of prenatal visits reported by mothers ranged from 1-15 with a mean of 3.24 visits per woman. Half of those women possessed a maternal health card (interviewer -confirmed). Among women who had a maternal health card, 65.0% had at least one card confirmed prenatal visit. The number of card -confirmed prenatal visits ranged from 1-9 with a mean of 2.81 visits per woman. Nearly one quarter of all women (23.8%) had 1 card-confirmed prenatal

visit, while another 50% reported 2-3 visits prior to the birth of their youngest child under the age of two years. The national average is 3.5 visits per woman with 19.0% of women receiving no prenatal check-ups, 7.0% having 1 visit, 28.6% received 2-3 visits and 44.2% have four visits. Table 19 compares the percent of women receiving prenatal checks in Petit Goave versus the rates nationally. Within Petit Goave, all women with maternal health cards in Zones 1, 2, and 3 had at least one prenatal check-up.

Table 19: Percent of Women receiving Prenatal Check-Ups during their most recent pregnancy

Number of Prenatal Visits	% OF WOMEN RECEIVING PRENATAL CHECK-UPS							
	Reported Check-Ups Petit Goave	Card-confirmed Check-Ups						
		Region of Petit Goave						HAITI
		Zone 1	Zone 2	Zone 3	Zone 4	Zone 5	Total	Total
0	9.2	0	0	0	2.9	5.0	2.5	19.0
1	13.3	54.5	42.9	12.5	17.6	15.0	23.8	7.0
2-3	46.9	27.3	42.9	75.0	41.2	70.0	50.0	28.6
4 or +	30.6	18.2	14.3	12.5	38.2	10.0	23.8	44.2

Over half of the women who had prenatal checks reported that they were counseled on delivery preparation, 66.5% were counseled on Breastfeeding and 51.4% were counseled on Child spacing. Only 21.2% of these women reported that they received counseling on the Enlarged Program of Immunization (EPI) and 26.6% received counseling on the danger signs of pregnancy. Nearly half of women surveyed (48.6%) possessed a maternal health card and 65% of those women with health cards had at least one prenatal visit recorded on their health card.

2. *Iron Supplementation*

In Haiti 55.1% of women of reproductive age are anemic and among pregnant women, 63.2% are anemic (EMMUS -III Haiti 2000). Anemia among women in Haiti may be caused by nutritional insufficiency or by parasites, hemorrhage or chronic diseases among other causes. Pregnant women are at high risk of anemia since normal nutritional intake of iron is insufficient for the needs of the growing fetus. Nationally, 40.9% of mothers did not receive iron supplementation during the pregnancy of their youngest child. Another 31.7% of Haitian women reported that they received iron supplementation for 1-59 days during their most recent pregnancy and 15.1% states that they received it for at least 60 days during the pregnancy of their youngest child. Among mothers of children age 0-24 months in the region of Petit Goave, half of women reported that they did receive iron supplementation during pregnancy and the median length of time reported for taking the supplementation was 16.7 days. The median time of supplementation is significantly shorter than 3 months of supplementation that is recommended. In Haiti, only 11% of women received supplementation during their most recent pregnancy (EMMUS -III Haiti 2000). In the region of Petit Goave, 6.5% of women surveyed received iron supplementation for 90 or more days during the pregnancy of their youngest child. Paradoxically, women in Zone 4 were most likely to

receive 90 or more days of supplementation than women in other zones however they the second highest rate of no women who did not receive any iron supplementation during pregnancy.

Table 20: Iron Supplementation during most recent pregnancy among mothers of children age 0-24 months in Petit Goave

Petit Goave	Percentage of mothers of children age 0-24 months who received iron supplementation during pregnancy for the following duration:			
	0 days	1 -59 days	60-89 days	90 days or +
Zone 1	47.6	40.5	9.5	2.4
Zone 2	26.2	62.3	3.3	8.2
Zone 3	62.2	33.3	2.2	2.2
Zone 4	59.4	24.6	2.9	13.0
Zone 5	55.2	44.8	0.0	0.0
Total	49.2	40.7	3.7	6.5
Haiti total	40.9	31.7	4.3	10.8

3. *Post-Partum Care*

Nationally, 39.3% of women stated that they received a postpartum visit according to the EMMUS-III Haiti 2000. Among women receiving postpartum visits, 15% of those visits occurred within one week of the birth of their child and 8.6% of those visits were conducted by trained health personnel. In the region of Petit Goave, the percentage of women who received post-natal check ups was lower than those who received pre-natal care during pregnancy ; 35.9% of women stated that they received at least one postnatal check-up. Among women receiving a post-natal checkup, 18.9% stated that they received child spacing information during the visit. On average, post-natal check-ups took place 3.8 days after the birth of the infant and 93.3% of the postnatal visits were conducted with skilled health personnel. Among the women receiving post-natal checks, 86.8% were conducted in a health facility. Half of women (56.6%) who received one post-partum check-up received a second check-up and the vast majority of the second check-ups were conducted by skilled health personnel (94.64%) . (See Appendix 12 for numerators and denominators).

In post-partum care there is a difference by zone in the number of women reporting that they received at least one post-partum check, see table 21. Compared to women in Zones 1, 2, and 3, a higher percentage of women in Zones 4 and 5 reported that they received a check after the birth of their youngest child. 53.2% of women in Zone 5 and 45.1% of women in Zone 4 compared to only about one-third of women in the other three zones reporting that they received Post-Partum Check-Ups.

Table 21: Post Partum Care by zone

Frequency and Percentage of women who reported receiving Post-Partum Care following the birth of their youngest child			
	YES	NO	Total number of women (denominator)
Zone 1	19 (38.0%)	51 (62.0%)	50
Zone 2	11 (38.0%)	58 (84.1%)	69
Zone 3	19 (32.8%)	39 (67.2%)	58
Zone 4	32 (45.1%)	39 (54.9%)	71
Zone 5	25 (53.2%)	22 (46.8%)	47
TOTAL	106 (35.9%)	189 (64.1%)	295

The most qualified health care personnel that checked on the woman also varies by zone. Among the women responding to the question, 106 out of 295 (35.9%) stated that they received post -natal care. Among those 106 women, 104 responded to the question asking who the most qualified health care personnel was who performed the post -natal check. Table 22 displays the frequency and percent of health care personnel performing the post partum checkup by zone.

Among these 104 women 44.2% reported that a doctor did the post -natal check -up and another 42.3% reported that a nurse or midwife did the post -natal check -up. The remaining 14% of postnatal checks were performed by an auxiliary midwife, PVO trained birth attendant or other person. In Zone 1, 3 and 4, a doctor was the most commonly reported person performing post -natal checks. In Zones 2 and 5, a nurse or midwife was the most commonly reported person performing post -natal checks.

Table 22: Health Personnel Performing Post Partum Care

Frequency and Percent of most qualified health care personnel performing the post-partum check-up						
	Doctor	Nurse/ Midwife	Auxilliary Midwife	PVO Trained Birth Attendant	Other	TOTAL
Zone 1	13 (68.4%)	4 (21.1%)	1 (5.3%)	0 (0%)	1 (5.3%)	19
Zone 2	3 (27.3%)	8 (72.7%)	0 (0%)	0 (0%)	0 (0%)	11
Zone 3	12 (63.2%)	3 (15.8%)	0 (0%)	1 (5.3%)	3 (15.8%)	19
Zone 4	13 (43.3%)	12 (40.0%)	3 (10.0%)	0 (0%)	2 (6.7%)	30
Zone 5	5 (20.%)	17(68.0%)	3 (12.0%)	0 (0%)	0 (0%)	25
TOTAL	46 (44.2%)	44 (42.3%)	7 (6.7%)	1 (1.0%)	6 (5.8%)	104

4. *Child-Spacing*

Among mothers of children age 0-24 months in the region of Petit Goave, 85% cited at least one place where she can obtain a method of family planning. Table 23 shows the rates of utilization of various methods of contraceptiveives in the district of Petit Goave and nationally.

The most commonly cited places to obtain a method of family planning included the hospital (43.3%), the health center (36.0%), or the family planning center (24.7%). Among women surveyed, 93.4% stated that they were not -pregnant. Of non -pregnant women, 96.5% stated that they desire no more children in the next 2 years and 22.3% of these women were using a modern method of family planning. A smaller proportion of women in Petit Goave use any method of family planning than women on nationally. Consequently women in Petit Goave have lower rates of using both modern and traditional contraceptive methods.

Table 23: Utilization of Family Planning Methods

Family Planning Method	% of women using Method in the region of Petit Goave	% of women using Method Nationally (EMMUS III, Haiti 2000)
No Method	73.8%	59.4
Any method	26.2%	40.6
Modern Method of Family Planning	22.3%	31.3
Norplant	0.7%	2.8
Injection	18.4%	17.3
Pill	1.8%	9.0
IUD	0%	0.7
Barrier method/ Diaphragm	0%	n/a
Condom	1.1%	10.4
Foam/Gel	0.4%	0.7
Tubal Ligation	0%	1.8
Vasectomy	0%	0.4
Traditional Method of Family Planning	1.4%	19.5
Lactational Amenorrhea (Exclusive Breastfeeding)	0.4%	2.9
rhythm method	0%	7.3
abstinence	0.4%	n/a
withdrawal	0.7%	15.1
Other Methods of Family Planning	2.5%	0.8

Utilization of modern versus traditional methods of family planning differs by level of educational attainment. There is an inverse correlation between not using a method of family planning and educational attainment. Among women with no formal education, 81.2% said that they used no method of family planning whereas 71.3% of women with 1-5 years of formal education and 69.4% of women with more than 5 years of education did not use any method of family planning. There is an inverse correlation between educational attainment and utilization of modern methods of family planning. 26.5% of women with more than 5 years of education, 24.1% of women with 1-5 years of education and 15.9% of women with no formal education utilized a modern method of family planning. Table 24 elaborates these figures.

Table 24: Frequency and use of contraceptive methods by level of education

Educational Attainment (years)	Modern Contraception	Traditional Contraception	Other Contraceptive Methods	No Contraceptive Method	Total Utilization
0 years	2	11	0	56	69
Row %	2.9	15.9	0.0	81.2	100.0
Col %	28.6	17.5	0.0	27.9	25.1
1-5 years	4	26	1	77	108
Row %	3.7	24.1	0.9	71.3	100.0
Col %	57.1	41.3	25.0	38.3	39.3
> 5 years	1	26	3	68	98
Row %	1.0	26.5	3.1	69.4	100.0
Col %	14.3	41.3	75.0	33.8	35.6
Total	7	63	4	201	275
Row %	2.5	22.9	1.5	73.1	100.0
Col %	100.0	100.0	100.0	100.0	100.0

C. Information about STI

Indicators related to the project objective made up the remainder of the questionnaire. The basic topic areas addressed in Objective 2 were knowledge among persons of reproductive age about Sexually Transmitted Infections (STI), their impact on the outcome of pregnancy and availability of treatment. Knowledge about availability of treatment for HIV/AIDS was also address in this portion of the survey but knowledge about HIV/AIDS among mothers of children age 0-24 months will not be further discussed as it was discussed in detail in a previous section. This section of the report will only report on knowledge about other STI s.

Table 25: Knowledge about STIs other than HIV/AIDS among women of reproductive age

Age Groups in years	Percent of women who have heard of STI	
	Petit Goave	Haiti
15-19	43.3%	24.5%
20-24	47.5%	38.3%
25-29	50.6%	40.8%
30-39	48.3%	37.9%
40-45	42.9%	*30.4%
Total	47.4%	33.9%
Educational Attainment		
No formal education	43.3%	16.5%
<5 years	51.2%	28.9%
=5 years	49.2%	57.7%
* In the EMMUS-III Haiti 2000, this age category included women age 40 -49 years.		

There is a greater knowledge about sexually transmitted infections among the women of Petit Goave than in general in Haiti. Nationally, 66.1% of women of reproductive age had not heard of STIs, only 33.9% have heard of STIs. Almost half (47.4%) of women surveyed in the region of Petit Goave knew of infections other than HIV/AIDS that could be transmitted sexually; 52.6% of women surveyed had not heard of STIs other than HIV/AIDS. Table 25 shows that there was little variability due to either educational attainment or to age. Table 26 shows that there is significant variation in knowledge about STIs other than HIV/AIDS according to the geographic location in which the respondent lives. Knowledge about STIs is higher among women from Zones 1 where 82.0% (CI: 68.6 -91.4%) of women stated that they have heard of other STIs versus zone 2 where 66.7% (54.3-77.6%) of women had heard of other STIs. Slightly more than one-third of women in zones 3 and 5 have knowledge of other STIs (zone 3: 37.0%, CI: 24.3 -51.3%); zone 5: 34.1% , CI: 20.5 -49.9%). Women in Zone 4 were least knowledgeable about other STIs with only 20.0% (CI: 11.4 -31.3%) of those women reporting that they knew of other STIs.

Table 26: Knowledge about STIs other than HIV/AIDS among women of reproductive age by Zone

Frequency and Percent of women with knowledge about STIs other than HIV/AIDS by Zones				
	YES	NO	DON'T KNOW	Total number of women (denominator)
Zone 1	41 (82.0%)	5 (10.0%)	4 (8.0%)	50
Zone 2	46 (66.7%)	19 (27.5%)	4 (5.8%)	69
Zone 3	20 (37.0%)	21 (38.9%)	13 (24.1%)	54
Zone 4	14 (20.0%)	28 (40.0%)	28 (40.0%)	70
Zone 5	15 (34.1%)	26 (59.1%)	3 (6.8%)	44
TOTAL	136 (47.4%)	99 (34.5%)	52 (18.1%)	287

In general, women of reproductive age in the region of Petit Goave are less knowledgeable about the signs and symptoms of STIs than women of reproductive age in other areas of

Haiti. Table 27 illustrates that 39% of women in Petit Goave versus 47.3% of women in nationally know at least two signs and symptoms of an STI in a man. Over 22.8% of respondents in Petit Goave versus 39.9% of women nationally were able to cite at least one known sign or symptom of an STI in a man. 38% of women in Petit Goave were unable to name any signs or symptoms of an STI in a man whereas nationally 12.8% of women were unable to name any signs or symptoms.

Knowledge about STIs increased among women of reproductive age in Petit Goave when they were asked about signs and symptoms in a woman. Over half of women surveyed (54.4%) knew at least two signs and symptoms of STI in a woman whereas nationally only 49% of women know this. Knowledge of one sign is higher nationally. The percent of mothers unable to name any signs or symptoms of an STI among in women was nearly three times as high in Petit Goave as in the rest of the country.

Table 27: Knowledge about signs and symptoms of Sexually Transmitted Infections among women of reproductive age who have heard of STI other than HIV/AIDS

INDICATOR	Petit Goave	Haiti
Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a man.	38.97%	47.3%
Percentage of mothers of children age 0-23 months who cite at least one known sign or symptom of an STI in a man.	22.79%	39.9%
Percentage of mothers of children age 0-23 months who were unable to cite at least any know signs or symptoms of an STI in a man.	38.23%	12.8%
Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a woman.	54.4%	49.0%
Percentage of mothers of children age 0-23 months who cite at least one known sign or symptom of an STI in a woman.	14.7%	39.6%
Percentage of mothers of children age 0-23 months who were unable to cite at least any know signs or symptoms of an STI in a woman.	30.88%	11.4%

Among women in Petit Goave who have heard of STIs other than HIV/AIDS, 49.3% were able to cite at least one known method that can be used to avoid getting an STI. The most frequently cited methods of preventing STI transmission included using condoms, abstinence, and remaining faithful to only one partner. Among these same women, 61% stated that an STI can have an impact on a pregnancy, 46.3% stated that it can impact the outcome of a pregnancy during the delivery, and 44.9% stated that an STI can impact an infant during breastfeeding. While a fair number of women know that an STI can impact the outcome of a pregnancy, only 7.4% were able to name any way that it can impact the pregnancy. The most common responses were that it could cause bleeding during pregnancy or cause the baby to be sick. Many women simply stated that if you have an STI during pregnancy you should follow your doctor's order. Among women who have heard of STI, 73.5% know that one can go to a health facility for treatment of the STI.

In Petit Goave, 73.8% of mothers of children age 0-23 months mentioned at least one way that a person can find out if s/he has HIV/AIDS. Among women who knew of a way to find out HIV/AIDS status, 63.7% mentioned that one should "go for test." Table

28 shows the distribution of other responses. Several women marked more than one response.

Table 28: Percentage of mothers of children age 0-24 months who mention at least one way to find out a person has HIV/AIDS

Method of finding out if one has HIV/AIDS	Numerator	Denominator	Percent	Confidence Interval
Go for test	191	300	63.7	57.9-69.1
Go to Health Facility	49	300	16.3	12.3-21.0
Go to Counseling/ Testing Facility	24	300	8.0	5.2-11.7
Other	24	300	8.0	5.2-11.7
Don't Know	65	300	21.7	17.1-26.8

Overall in the region of Petit Goave, 33.8% of mothers of children age 0-24 months stated that they have heard of an HIV/AIDS counseling and testing service. 20% of women stated that they were offered HIV/AIDS testing as a part of their prenatal service. Rates of knowledge about HIV/AIDS counseling and testing services and being offered HIV/AIDS testing did not differ by age or by education level of the mother. However these rates differed by the Zone in which the woman lived. Table 27 shows that women were more likely to respond “Yes” that she has heard of an HIV/AIDS counseling and testing service if she lived in Zone 1, 3 or 5 and “No” if she lived in Zone 2 or 4.

Table 29: HIV/AIDS Counseling and Testing

Location	Frequency and Percent of women who responded Yes and No to each of the following questions about HIV/AIDS counseling and testing:			
	Have you heard of an HIV/AIDS counseling and testing service?		Were you offered a test for the AIDS virus as part of your antenatal care?	
	YES	NO	YES	NO
Zone 1	25 (50%)	25 (50%)	4 (18.2%)	18 (81.2%)
Zone 2	17 (25.4%)	50 (74.6%)	7 (38.9%)	11 (61.1%)
Zone 3	26 (54.2%)	22 (45.8%)	2 (6.7%)	28 (93.3%)
Zone 4	5 (7.8%)	59 (92.2%)	0 (0.0%)	6 (100%)
Zone 5	15 (48.4%)	16 (51.6%)	6 (31.6%)	13 (68.4%)
Total	88 (33.8%)	172 (66.2%)	19 (20.0%)	76 (80.0%)

Overall, 95 women answered the question “were you offered a test for the AIDS virus as part of your antenatal care?” Among respondents, 20% stated that they were offered a test for the AIDS virus as part of their antenatal care. A greater proportion of women in Zones 1, 3, and 5 stated that they were offered the test. In Zone 2, 61.1% of respondents and 100% of respondents in Zone 4 stated that they were not offered the test during their prenatal care. Among women offered the test, 57.9% were actually tested for AIDS as a part of their antenatal care. Among these women, 72.7% were tested for AIDS in a public sector facility and 27.3% were tested in a private sector medical facility as a part of their antenatal care. Among women who were tested for AIDS as a part of their antenatal care, 90.9% received the results of their test.

Discussion

The 2005 KPC Survey conducted in the Petit Goave region of Haiti was useful in establishing baseline indicators from which the program will be able to monitor progress and evaluate changes in knowledge, practice and coverage for the duration of the project implementation. It provides information in the following areas: demographic, health contact/access to health information, maternal parity, child anthropometry, maternal and newborn care, iron supplementation, delivery practices, breastfeeding and nutrition, postpartum care, child spacing/family planning, childhood immunization, malaria prevention, integrated management of childhood illnesses (IMCI), HIV/AIDS, Sexually Transmitted Infections (STI), HIV Screening, and Hand - Washing Practices.

The 2005 KPC Survey is based on a sample representative of the region of Petit Goave. The sample was comprised on 30 clusters of 300 households. A total of 300 women aged 15-45 years with at least one child 0-24 months of age participated in the survey. The sampling methodology has been used successfully by UNICEF and WHO to assess immunization coverage and by USAID to provide baseline and final data collection in child survival programs in various countries. However, it is important to remember that responses provided by respondents can be subject to recall bias and willingness to respond to questions may be prejudiced by cultural or social influence.

The Minister of Public Health and Population (MSPP - Ministère de la Santé Publique et de la Population) has conducted several national surveys (EMMUS -II Haiti 1997 and EMMUS-III Ha iti 2000) which provided a snapshot of the health of the population. The published results of the EMMUS -III Haiti 2000 are available in a 489 page publication from ORC Macro. It provides comprehensive statistics on maternal and child health covering many of the same topic areas covered by the 2005 KPC Survey in Petit Goave. The 2005 KPC Survey in Petit Goave provided a more recent and specific picture of the situation of maternal and child health in that district.

The majority of the region of Petit Goave is rural and residents have lived there for 14 years on average. The median age of women who participated in the study was 28.8 years and the median level of educational attainment was 4.4 years of formal schooling. One quarter (24.1%) of all women in the survey had no formal education. Overall, the level of education is still low among women in this region and throughout Haiti.

Maternal parity and child spacing/family planning

On average women in this region have had 3.7 pregnancies and 3.4 live births and a nearly half of children (46.4%) were born at least 24 months after the previous surviving child. Nationally 73% of women report that at least 24 months separated the birth of their youngest child and the preceding surviving child. While nearly half of women interviewed for this survey are spacing the births of their children, only a small minority of women are using a modern method of family planning. Most women stated that they do not use any method of family planning. Only 22.3% of respondents said that they use

a modern method of family planning, which are predominated by injections, followed by the pill and then condom usage.

Further focus groups and individual interviews could clarify beliefs surrounding utilization, non-utilization or barriers to utilization of family planning. Also, further inquiry should be done to reveal availability and affordability of family planning methods in the region of Petit Goave.

Health contact/Access to health information

Availability of and access to health information can influence maternal and child health outcomes. In the region of Petit Goave it is evident that where one lives may influence how accessible health services are to her. The area around the town of Petit Goave, the area we refer to as Zones 1 and 2 (11eme Ravine Seche, 12eme Des Fouques, 1ere Plaine, 3eme Trou Chou Chou, 2eme Plaine) have the greatest number of women who report that they can get to their nearest health center in less than 1 hour. In Zone 5 (9eme and 10eme Des Palmes), the majority of women report that it takes them over 1 hour to get to the nearest health center. Half of women state that they come into contact with a skilled health worker at least once a month. The vast majority of mothers of children age 0-24 months reported that they receive their general health and nutrition information from a formal health network including doctors, nurses/midwives, auxiliary midwife, trained birth attendant, health educator, or a growth monitoring person. Approximately half of women in Petit Goave also report that they have received health messages from the radio. While it may be difficult for some women to reach their nearest health care facility, it appears that women trust and rely on the information they receive from the providers at those centers. Since more women receive health messages from the radio than from other media sources this will have implications for dissemination of health and nutrition information in the region.

Child Anthropometry

The nutritional status of children was measured using weight-for-age as an indicator of actual nutritional status. Overall 18.2% are underweight (-2SD from the median weight-for-age according to the WHO/NCHS reference population) and an additional 20.9% of children 0-24 months are -1 SD from the median weight-for-age. Nationally, 11-15% of children 0-59 months in urban areas and 27% of children 0-59 months in rural areas are underweight. There was not statistically significant difference in underweight according to sex.

Maternal and newborn care

Most women reported that they were seen by a skilled health worker for their prenatal care and 69.3% of women stated that they received a tetanus toxoid (TT) injection prior to the birth of their youngest child. There is a discrepancy between the reported and card-confirmed number of prenatal visits and tetanus toxoid injections among mothers of children age 0-24 months. Recall bias may influence the responses of mothers. Mothers may over-report the number of pre-natal visits they have had or they may also count visits to traditional practitioners among their prenatal visit. Recall of TT injections may

be biased by recall of injections for other purposes or by TT injections received at a different time. Alternately, the bias may be due to provider practices. If not all prenatal visits or TT injections are recorded on the maternal health card, results will be skewed. A review of records at health centers will provide estimates of frequency of prenatal visits among women in Petit Goave. A review of record keeping practices among health care providers and health centers may also reveal if the discrepancy in reported and card confirmed prenatal visits is due to maternal misreporting or provider error in record keeping.

The vast numbers of women do not have card-confirmed TT injections prior to the birth of their first child. For many women, the first TT injection occurred the same day as the birth of their child. Knowledge, practices and coverage surrounding TT injections should be reviewed among health care providers in order to determine need.

Iron supplementation

Half of women stated that they received iron supplementation during pregnancy and the median length of time for taking the supplementation was 16.7 days. The median length of time falls short of the recommended amount of time that iron supplementation should be given to a pregnant women. High levels of pre-existing anemia coupled with poor iron supplementation coverage of women during pregnancy may contribute to poor pregnancy outcomes. A health facilities assessment should be used to determine availability of iron tablets. It may also be used to discover the practices surrounding its utilization or barriers to prescribing iron supplements for pregnant women.

Delivery practices

Women in and around the town of Petit Goave are more likely than women in other areas to have their delivery attended by skilled health personnel and are at least twice as likely to give birth in a health facility than women in other areas of the region of Petit Goave. Regardless of location, women with higher educational attainment are more likely to give birth in a health facility. This trend is similar to that seen nationally whereby there is a strong positive relationship between educational attainment and utilization of health facilities for childbirth. As discussed above, the majority of women in Zones 1 and 2 reported that they can get to the nearest health facility in < 1 hr, whereas it took more time for women in other zones. Therefore it is not surprising that Zone 1 has the highest rates of deliveries in a health facility. This survey does not reveal why women in Zone 2 do not deliver in health facilities at the same rate as women in Zone 1 if their access to the health facilities is approximately equal.

Most women believed that a clean birth kit was used to cut the cord during delivery and a clean razor blade was the most common instrument used to cut the cord. Scissors were the most frequently mentioned alternative instrument used to cut the cord. Further discussion with mothers or birth attendants would elucidate if and how scissors are

sterilized prior to use in a delivery. Interviews and research which gather qualitative information should seek to discover attitudes about delivery practices, perceptions about quality of health services available in each zone, and barriers to delivery in a health facility.

Breastfeeding and nutrition

In the region of Petit Goave, 53.2% of mothers of infants age 0-5 months reported that their child was exclusively breastfed in the 24 hours prior to the survey. The national average of exclusive breastfeeding among infants age 0-5 months is approximately 24%. Among children age 6-8 months, 69.9% in Petit Goave receive breastmilk and complimentary foods. Among infants 6-23 months of age, mothers report that 15-24% were exclusively breastfed in the 24 hours prior to the survey. Focus groups or interviews should be used to determine if in fact women are exclusively breastfeeding or if they are also providing complementary foods but failed to mention them during the survey.

Postpartum care

Slightly more than one-third of women in the region of Petit Goave stated that they received a post-partum check-up from skilled health personnel and the post-partum checks took place in a health facility. Nationally, approximately 40% of women received postnatal check so the rate of postnatal consultation is slightly lower in Petit Goave than the national average. Most women received the visit from skilled health personnel. This post-natal contact between health personnel and skilled health personnel and can be a critical time to convey health information. Further interviews could help discover knowledge, attitudes and practices surrounding postpartum check-ups and potentially identify the barriers to post-partum care.

Childhood immunization

Immunization coverage is high for BCG (65.1%) and Polio 1 (73.4%) among children 12-23 months of age in the region of Petit Goave however the rate of complete vaccination is low (7.8%). Nationally, one-third of children age 12-23 months are completely vaccinated. Efforts should be made to improve rates of complete immunization among children 12-23 months of age in the region of Petit Goave. That there are high levels of vaccination for the BCG and Polio 1 indicate but such low levels of complete coverage indicate that there are significant barriers to complete vaccination. These barriers may include affordability, accessibility or knowledge about the importance of immunization. Facility assessments should determine whether the supplies necessary for routine vaccination are available or if there are interruptions in supply. Additionally, the assessment should determine the availability of trained health personnel, the number of vaccination campaigns that are conducted and how information about immunization is

disseminated to mothers. Further discussion with mothers could reveal their perceptions about the importance of childhood vaccinations for their children.

Malaria prevention

A very small proportion of households included in the survey owned bednets to prevent bites from mosquitoes (6.3%). Among households that had the bednets, an even smaller proportion of them had children 0-24 months who had slept under a treated bednet the previous night (2.43%). The availability and affordability of bednets and treatment for the nets should be further examined if this area becomes an interest for GHA.

Integrated Management of Childhood Illnesses (IMCI)

While a high number of mothers were able to mention at least signs of childhood illness that indicate the need for treatment, very few women mention that they offer their child more than usual to drink and the same amount or more than usual amount to eat when the child is ill. More commonly mothers reported that they offered less to drink and less than usual to eat. These practices may contribute to poor outcomes during home care of childhood illness. Further study should be conducted to determine if any or how many health messages women are receiving about rehydration and food intake during illness.

HIV/AIDS and HIV Screening

A great majority of mothers of children age 0-24 months in the region of Petit Goave knew of HIV/AIDS (96.2%). However only half of these women were able to cite at least 2 known ways to prevent HIV/AIDS transmission. Condoms were the most commonly cited method of preventing transmission of the disease. However, condom usage was very low as reported in the questions pertaining to family planning. There appears to be a disparity between knowledge about how to prevent the transmission of HIV/AIDS and the actual practices required to prevent the spread. The health facilities assessment will help determine if condoms are readily available. Further interviews with women's and men's groups could help determine if and where individuals are able to obtain condoms, the practices surrounding condom use (e.g. with whom are condoms used and with what sexual partners do people not use condoms). Additional educational efforts are needed in the area of knowledge about HIV/AIDS transmission and prevention.

Sexually Transmitted Infections (STI)

Approximately half of women surveyed had heard of infections other than HIV/AIDS which can be transmitted through sexual contact (47.4%). Slightly more than one-third of women know signs and symptoms of an STI in a man however approximately half

know signs and symptoms of an STI in a woman. Half of women know at least one method to avoid getting an STI however this survey did not directly explore practices among women. Another survey or further interviews and focus groups could help determine whether knowledge about how to prevent STI translates into practice among women in the region of Petit Goave.

Hand-Washing Practices

Less than one -quarter of women surveyed reported that they wash their hands with soap before food preparation, before feeding children, after defecation and after attending to a child who has defecated. Women commonly acknowledge that they wash their hands from time to time or when their hands are dirty but infrequent washing will not effectively prevent fecal oral contact or transmission of harmful bacteria. Further sanitation education is necessary.

Information Dissemination

Information was disseminated through a two -day DIP workshop with community members. A total of 31 people attended the workshop, including two journalists from a local radio station who aired a radio spot on the project and the workshop itself.

The purpose of this workshop was to share the KPC survey results, including some results from the Health Facility Assessment, which PM/field has started, as well as the information collected from informal group discussions and key informant interviews. We wanted to get feedback from participants regarding the objectives of the project as well as the different activities that had been proposed and for them to let us know whether they were realistic given the context and current environment in Petit Goave, sustainable and if they could bring Behavior Change.

The evaluation was positive for many appreciated the participatory format which allowed to ask questions, do group work while learning about community problems (KPC survey results) and openly discussing them.

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Appendices

- Appendix 1: Creole Version KPC Survey Questionnaire
- Appendix 2: English Version KPC Survey Questionnaire
- Appendix 3: French Version KPC Survey Questionnaire
- Appendix 4: Supervisor Quality Control Checklist
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**Appendix 1: Creole Version KPC Survey Questionnaire
MWEN KOMPRAN MWEN AKSEPTE E PREMIE PAJ**

<i>KPC₂₀₀₀ Rapid Core Assessment Tool on Child Health (CATCH)</i> <i>(Zouti vit pou evalie sante ti moun)</i>			
Identifikasyon			
Nimewo gwoup.....			
Nimewo fanmi.....			
Nimewo dossie.....			
Inisyal moun kap poze kesyon.....			

MAKE DAT ENTWETIEN

JOU	MWA	ANE

BAY ON LOT DAT
(si li necese)

JOU	MWA	ANE

Non moun kap poze kesyon yo:
Non sipevize ya:
Kominote:

MWEN KOMPRAN, MWEN AKSEPTE

Bonjou. Mwen rele _____, map travay pou **COD-EMH e Global Health Action**. Nap fe yon anket e nou ta renmen poze o u kek kesyon. Mwen ta renmen poze ou kesyon sou sante ou e sou sante pi piti ti moun ou gen yen ki gen mwens ke de zan. Enfomasyon sa yo wap banm nan ap itil COD/EMH ak GHA pou yo planifye sevis sante e pou evalye si objektif yo genyen yo bon pou po te chanjman pou sante timoun yo.. Anket sa a pran abityelman 45 -60 minit. Tout sa wap di nou ap rete en kachet e pa gen moun kap konnen.

Si ou vle ou reponn si ou pa vle ou pa reponn. Sèlman nou ta pi pito ke ou reponn paske sa ou di nou ap tre zimpotan.

Konye- a mwen ta renmen konnen si ou gen on keksyon ou vle poze mwen sou anket sa a.

Signati moun kap poze keksyon: _____ Dat: _____

Moun nan vle yo poze li keksyon.....1?

Li pa vle.....2?

Kesyon pou manman ti moun ki gen mwèn ke vennkat mwa.

1. MAKE DAT ENTWETIEN

JOU		MWA		ANE			

INFOMASYON DEMOGWAFIK

INFOMASYON DEMOGWAFIK		MAKE KOMBE TAN/MAKE ON CHIF
2.	Ki laj ou? (MAKE LAJ OU EN ANE)	_____
3.	Kombe tan ou ale l'écol?	_____
4.	Depi kombe tan nap viv nan zon' sa a?	_____

MOUN OU WE POU SANTE OU

5.	PENDAN MWA SA KI SOT PASE YO, KOMBE FWA OU KONTAKTE MOUN SA YO:	PLISIE FWA (4 fwa ou plis)	PA ANPIL FWA (1-3 fwa)	JAMAIS (0 fwa)
	DOCTE	1	2	3
	INFIMIE/ SAG FANM	1	2	3
	MOUN KI AP TRAVAY POU SANTE KOMINOTE A	1	2	3
	EDIKATE SANTE	1	2	3
	MOUN KI SUIV KWASANS	1	2	3
	MOUN KI ENTRENE POU FE AKOUCHEMAN	1	2	3
	HOUGAN	1	2	3
6.	Ki kote yo ka ba ou infomasyon general ou bien on avi sou sante ou, koman moun dwè ma nge? MAKE TOUT SA YO DI.	SISTEM FOMEL		
		A. DOCTE		
		B. INFIMIE / SAG FANM		
		C. ED SAG FANM		
		D. MOUN KI ENTRENE POU FE AKOUCHEMAN		
		E. MOUN KI AP TRAVAY POU SANTE KOMINOTE A		
		F. EDIKATE SANTE		
		G. MOUN KI SUIV KWASANS		
		SISTEM ENFOMEL		
		H. MARI / MOUN KAP VIV AVE FANM NAN		
		I. MANMAN / BELME		
		J. SE		
		K. GRANPE / GRANME		
		L. TANT		
M. ZANMI / VWAZEN				
N. HOUGAN				
O. VIE GRANMOUN *				
X. LOT (DIKI SA)				

7. Mwa pase a , es ke ou te recevwa nouvel sou sante de		WI	NON
	RADYO	1	2
	JOURNAL	1	2
	TELEVIZION	1	2
	EDIKASYON SANTE MOUN KAP TRAVAY NAN KOMINOTE A POU SANTE	1	2

MATERNAL PARITY INFORMATION

8. Kombe fwa ou te ancent?	___ ___
9. Kombe ti moun vivan ou fè?	___ ___
10. Kombe ti moun ki gen mwen ke senk an ki viv la kay ou?	___ ___
11. Kombe pitit ke ou fè ou men'm nan tout ti moun ki la kay ou ki gen mwen ke senk an?	___ ___

12. APWE REPONS 10, LI YOUN NAN KESYON SA YO:

SÈLMAN YON TI MOUN KI GEN MWEN KE SENK AN: “Ki non ki sex ki dat ti moun nan fet?”

PLIS TI MOUN KI GEN MWEN KE SENK AN: “Ki non ki sex ki dat nesans de nan ti moun yo ki pi jen?”

	NON	SEX	DAT TI MOUN NAN FET
1		1. GASON 2. FI	___ / ___ / _____ JJ MM AAAA
2		1. GASON 2. FI	___ / ___ / _____ JJ MM AAAA

TOUT KESYON KE MWEN DI OU LA YO KONSENE PI JEN TI MOUN KI GEN ENBA DE ZAN

13. Es ke papa pitit ou yo viv la kay ou?	1. WI
	2. NON
	8. MWEN PA KONNEN

ANTHROPOMETRI

14. Es ke mwen ka pran pwa ti moun nan ?	1. WI
	2. NON ? (GADE K.16)

15. *SI MANMAN TI MOUN NAN VLE PRAN PWA TI MOUN NAN, MAKE PWA LI. MAKE PWA TI MOUN NAN A 100 G. PRE* ____ . ____ Kg

SWEN MANMAN/ SWEN TI MOUN KI FEK FET

16. Ki moun ki te suiv ou lè ou tè ancent? CHECHE KONNEN KI MOUN KI TE SUIV LI. MAKE NON TOUT MOUN KE MANMAN DI OU.	A. Doctè		
	B. Infimiè / Sag Fanm		
	C. Ed Sag Fanm		
	D. Fanm ki gen labitid akouche ti moun		
	E. Moun ki okipe sarte nan kominote ya		
	X. Yon lot moun (Di ki moun)		
	Z. Pa gen moun		
17. Kombe fwa ou konsilte moun pendan ou té ancent?	KOMBE FWA	____	
18. Le ou te ancent moun ou té wè pou konsilte ou la, es ke li te palé ou de		WI	NON
	Pwepare moun pou yo akouche		
	Bay tété		
	Pa fè ti moun yo chak ane		
	Pwogr. Elagi Immunizasyon		
	Sign grosses ki bay pwoblem		
19. Avan ke ou fe ti moun nan, es ke yo te ba ou piki nan bra pou enpeche ti moun nan gen tetanos apre li fet (konvilsyon)	1. WI		
	2. NON ? GADE K. 21		
	3. MWEN PA KONNEN ? GADE K.21		
20. Kombe fwa yo ba ou piki?	1. YOUN		
	2. DE		
	3. PLIS KE DE FWA		
	8. MWEN PA KONNEN		
21. Le w te ansent (non) Eske w te genyen yon kat?	1. WI , WE		
	2. PA GENYEN ? GADE K. 24		
	3. MWEN PA JAM GEN KAT ? GADE K. 24		
22. GADE KAT LA, MAKE KOMBE VIZIT			

MANMAN TE FE LE LI TE ANCENT.		KOMBE VIZIT		
		— — — —		
23. GADE KAT LA E PI MAKE DAT CHAK PIKI KI MAKE SOU KAT LA.		JJ	MM	AAAA
	PREMYE	— —	/	— — / — — — —
	DEZYEM	— —	/	— — / — — — —
	TWAZ.	— —	/	— — / — — — —
	KATW.	— —	/	— — / — — — —
	SENK.	— —	/	— — / — — — —
SIZYEM	— —	/	— — / — — — —	
24. KOMAN OU TE ALE NAN SANT SANTE KI PI PRE LA KAY OU? MAKE TOUT REPONS YO.	A. A PIE			
	B. NAN MACHIN			
	C. NAN MOTOCICLET			
	D. NAN VWATI TIRE PA YON BEF			
	E. NAN KANNOT			
	X. LOT (DI KI SA)			
25. Kombe tan sa te pran ou?	1. MWEN UNE HEURE			
	2. DE YOUN A TWA ZÈ			
	3. PLIS KE TWA ZE			
	8. MWEN PA KONNEN			
26. Ki sa ou santi ki fe ou ale konsilte doctè lè ou ancent? MAKE SA LI DI OU	A. LAFYEV			
	B. RESPIRE MAL			
	C. SENYEN			
	D. KO ANFLE, MEN ANFLE, FIGI ANFLE			
	X. LOT (DI KI SA)			
	Z. MWEN PA KONNEN – GADE K. 28			
27. Ki kote ou tap ale an premye si ou te santi ou pa bien?	01. OPITAL			
	02. SANT SANTE			
	03. POSTE SANTE			
	04. OGANIZASYON VOLONTE PRIVE			
	05. KLINIK			
	06. MOUN KAP TRAVAY NAN SANTE NAN KOMINOTE A			
	07. YON LOT SANT SANTE (DI KI SANT)			
	08. HOUGAN			
	09. BOUTIK			
	10. FAMACI			
	11. DISTRIBITE KOMINOTE			
	12. ZANMI / MOUN OU KONNEN			
88. LOT				

**SUB-MODULE ON IRON SUPPLEMENTATION DURING PREGNANCY
(PATI KI KONSENE MOUN KI PRAN FE PENDAN GROSSES)**

28. Le ou te ancent, es ke ou te recevwa ou achte fe an pilil ou an siwo? MONTRE PILIL OU SIWO.	1. WI	
	2. NON	
	8. MWEN PA KONNEN	
29. Kombe jou ou pran pilil la ou siwo a? SI REPONS LA PA KLE CHECHE KONNEN A PE PRE KOMBE JOU.	KOMBE JOU? _____	
	8. MWEN PA KONNEN	

**SUB-MODULE ON DELIVERY PRACTICES
(PATI SOU PRATIK AKOUCHEMAN)**

30. Kounye a, map poze ou kesyon sou epok ou te akouche ti moun nan. Ki kote ou te akouche? SI SE NAN LOPITAL YO DI OU, OU NAN LOT SANT SANTE, ECRI NON KOTE A. _____ (NON)	NAN YON KAY	
	11. NAN KAY PA OU	
	12. NAN ON LOT KAY	
	SANT SANTE	
	21. OPITAL	
	22. KLINIK	
	23. SANT SANTE	
	24. OGANIZASYON VOLONTE PRIVE	
	25. POSTE SANTE	
31. Ki moun ki te ede ou akouche?	26. LOT SANT SANTE (DI KI SANT)	
	96. LOT (DI KI SA)	
	A. DOCTE	
	B. INFIMIE / SAG FANM	
	C. ED SAG FANM	
	D. HOUGAN	
	_____ (NON)	
	E. MOUN KI AP TRAVAY NAN KOMINOTE POU SANTE	
F. MANB FANMI		
32. Es ke yo itilize zouti pwop pendan yap akouche ou?	_____ (KI MOUN NAN FANMI OU)	
	G. LOT (DI KI SA)	
33. Ki zouti yo te itilize pou koupe kod lombrit ou?	Y. PA GEN MOUN	
	1. WI	
32. Es ke yo itilize zouti pwop pendan yap akouche ou?	2. NON ? GADE K. 35	
	8. MWEN PA KONNEN ? GADE K. 35	
33. Ki zouti yo te itilize pou koupe kod lombrit ou?	1. YON GILET NEF	
	2. ON LOT BAGAY	

34. Ki moun ki te koupe kod lombrit?	1. DOCTE	
	2. INFIMIE / SAG FANM	
	3. ED SAG FANM	
	4. HOUGAN	
	5. MOUN KI AP TRAVAY NAN KOMINOTE A POU SANTE	
	6. MANB FANMI (DI KI MOUN)	
	7. LOT (DI KI MOUN)	
	8. PA GEN MOUN	

BAY TETE E MANGE BIEN POU TOUT MOUN

35. Es ke ou te bay ti moun nan tete?	1. WI	
	2. NON ? GADE K. 37	
36. Kombe tan ou te pran pou bay ti moun nan tete le li te fet?	1. TOUSWIT / NAN PREMYE LE OU TE AKOUCHE	
	2. APRE PREMYE LE	
37. Mwen ta renmen mande ou ki ka li te mange ou bien bwason ou bay ti moun nan joune a e yè swa. Es ke ti moun nan te genyen... LI LIST LA E PI METE ON KWA NAN CHAK KAZ KONSENE	BWASON / MANGE	NAN 24 LE KI PASE Y A?
	A. Let manman?	
	B. Dlo klè?	
	C. Lot bwason?	
	D. Mange moulen, solid, ou bien ki pa solid?	
	E. Nenpot ki lot mange? DI KI SA: _____ _____	

SWEN APRE TI MOUN NAN FET

38. Apre ti moun nan fet, es ke yo te gade sante ou?	1. WI	
	2. NON ? GADE K. 46	
39. SI REPONS LA SE WI A K.38, MANDE: “Es ke yo ba ou infomasyon sou koman ou pa fè timoun chak ane pendan examen sa a?”	1. EXAMINE OU SAN INFOMASYON	
	2. RECEVWA INFOMASYON KOMAN OU PA FE TI MOUN CHAK ANE	
40. Apre kombe jou ou kombe semèn apre akoucheman? MAKE ‘OO’ JOU SI SE MEM JOU A	1. JOU APRE AKOUCH. : ____	
	2. SEMEN APRE AKOUC. : ____	
	8. MWEN PA KONNEN	
41. Ki moun ou te wè pou sante w nan moman sa a? CHECHE KONNEN KI MOUN LI WÈ KI PI KALIFIE	1. DOCTE	
	2. INFIMIE / SAG FANM	
	3. ED SAG FANM	
	4. OGANIZ. VOL. PRIV. - MOUN KI SPESIALIZE NAN AKOUCHEMAN	
	5. LOT MOUN KI KON AKOUCHE TOU	
	6. LOT (DI KI SA)	
42. Le ou te ale pou sante ou, es ke moun nan te examine ti moun nan tou?	1. WI	
	2. NON	
	8. MWEN PAS KONNEN	
43. Es ke ou te genyen lot konsiltasyon apre ti moun nan fet?	1. WI	
	2. NON	
	8. MWEN PA KONNEN	
44. Ki moun ou te konsilte dezyèm fwa? CHECHE KONNEN KI MOUN LI WE KI PI KALIFIE	1. DOCTE	
	2. INFIMIE / SAG FANM	
	3. ED SAG FANM	
	4. HOUGAN	
	5. LOT (DI KI MOUN)	
45. Ki kote ou tal fè premye konsiltasyon apre akouchman ?	NAN YON KAY	
	11. NAN KAY PA OU	
	12. NAN ON LOT KAY	
	SANT SANTE	
	21. OPITAL	
	22. KLINIK	
	23. SANT SANTE	
	24. OGANIZASYON VOLONTE PRIVE	
	25. POSTE SANTE	
	26. LOT SANT SANTE (DI KI SANT)	
96. LOT (DI KI SA)		

KOMAN POU OU PA FE TI MOUN CHAK ANE

<p>46. Kounye a mwen pral poze ou kesyon sou sevis ki di koman pou ou fè pou ou pa fè ti moun chak ane e sou sevis planning familial nan kominote ou.</p> <p>Es ke ou konnen on kote yo ka di ou on metod pou pa fè ti moun chak ane ou on kay yo fè planning familial?</p> <p>SI REPONS LA SE NON, ENTOURE “Z” [MWEN PA KONNEN] SI REPONS LA SE WI, MANDE “Ki kote?”</p> <p>MAKE TOUT SA YO DI OU.</p> <p>SI SE NAN LOPITAL YO DI OU, OU NAN LOT SANT SANTE, ECRI NON KOTE A.</p> <p>_____</p>	A. OPITAL	
	B. SANT SANTE	
	C. OGANIZASYON VOLONTE PRIVE	
	D. POSTE SANTE	
	E. KLINIK PLANNING FAMILIAL	
	F. MOUN KAP TRAVAY POU KOMINOTE SOU PLAS NAN SANTE	
	G. FAMASI	
	H. LOT SANT SANTE (DI KI SA) _____	
	I. BOUTIK	
	J. EGLIZ	
	K. ZANMI / MOUN OU KONNEN	
X. LOT (DI KI MOUN) _____		
Z. MWEN PA KONNEN		
47. Es ke ou ancent kounye a?	1. WI	
	2. NON ? GADE K. 49	
	8. MWEN PA KONNEN ? GADE K. 49	
48. Si wi nan kesyon 47, es ke ou te ale nan klinik la deja?	1. WI	
	2. NON	
49. Ki lè ou vlé fè yon lot pitit?	1. NAN DE ZAN	
	2. NAN PLIS KE DE ZAN	
	8. MWEN PA KONNEN KI LE	
<p>50. Es ke ou te itilize on metod pou evite ou pou retade on grosses?</p> <p>SI REPONS LA SE NON, ENTOURE ‘01’ (PA GEN METOD)</p> <p>SI REPONS LA SE WI, MANDE “Ki sa mari ou bien ou menm te kon fè pou nou evite ou retade grosses?</p> <p>Entoure repons ki apwopwie a.</p>	01. PA GEN METOD	
	02. NORPLANT	
	03. PIKI	
	04. PILIL	
	05. DISPOZITIF ENTRAUTEREN	
	06. DIAFRAM	
	07. KAPOT	
	08. MOUS / JEL	
	09. LIGATIRE TWOMP	
	10. VAZECTOMI	
	11. BAY TETE ESCLUZIF	
	12. RITME	
	13. ABSTINENCE	
	14. RETIRE	
96. LOT		

IMINIZASYON TI MOUN

<p>51. Es ke ou genyen on kat ke nou ka wè vasinasyon ti moun yo?</p> <p>SI REPONS LA SE WI'MANDE POU WE LI SIL VOUE PLE</p>	1. WI, WE PA MOUN KAP POZE KESYON	
	2. PA DISPONIB (pedI, deplase, pa nan kay la)	
	3. PA JAM GEN KAT ? GADE K.53	
	8. MWEN PA KONNEN ? GADE K.53	

52. MAKE INFOMASYON JAN LI PARET SOU KAT LA.

	JOU	MWA	ANE
BCG	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO 0	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO 3	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT 3	<input type="text"/>	<input type="text"/>	<input type="text"/>
ROUJOL	<input type="text"/>	<input type="text"/>	<input type="text"/>
VITAMIN A	<input type="text"/>	<input type="text"/>	<input type="text"/>

<p>53. Est-ce que (NOM) a jamais reçu la vaccine pour la rougeole?</p> <p>SI L'INFORMATION EST SUR LA CARNET NE POSEZ PAS CETTE QUESTION – PASSEZ DIRECTEMENTE A Q.54.</p>	1. WI	
	2. NON	
	8. MWEN PA KONNEN	

KOMAN OU PA PRAN MALARIA

54. Es ke ou gen moustikè nan kay la?	1. WI	
	2. NON (GADE K. 57)	
	8. MWEN PA KONNEN (GADE K. 57)	
55. Ki moun ki domi sou yon moustikè yè swa? (MAKE NON TOUT MOUN)	A. TI MOUN (NON)	
	B. MOUN KI REPON KESYON YO	
	C. LOT MOUN (DI KI MOUN) _____	
56. Es ke moustikè a te plonje nan yon pwodwi ki te chase moustik?	1. WI	
	2. NON	
	8. MWEN PA KONNEN	

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI) (KOMAN OU GERE MALADI TI MOUN)

57. Pafwa ti moun nan malad e li bezwen yon tretman. Ki maladi ki di ou ke ti moun nan bezwen tretman? PA FOCE MOUN NAN REPON. ENTOURE TOUT SA LI DI OU.	A. MWEN PA KONNEN	
	B. TI MOUN NAN SANBLE PA BIEN / LI PA JOUE NOMALMAN	
	C. LI PA MANGE OU LI PA BWE	
	D. LI DIFISIL POU REVEYE	
	E. LA FYEV LA FO	
	F. LAP RESPIRE DIFISILMAN OU RAPIDMAN	
	G. TI MOUN NAP VOMI TOUT BAGAY LI MANGE	
	H. KONVILSYON	
	I. LOT (DI KI SIGN)	
	J. LOT (DI KI SIGN)	
	K. LOT (DI KI SIGN)	
58. Es ke ti moun nan te genyen youn nan maladi sa yo nan de semèn ki pase yo ? LI LIST LA E ENTOUR TOUT SA MOUN NAN DI OU.	A. DIARE	
	B. SAN NAN KAKA	
	C. LE TI MOUN NAN TOUSE	
	D. LAP RESPIRE DIFISILMAN	
	E. RESPIRASYON RAPID / TI RESPIRASYON RAPID	
	F. FYEV	
	G. MALARIA	
	H. KONVILSYON	
	I. LOT (DI KI SA)	
	J. LOT (DI KI SA)	
	K. PA GEN SIGN ? (GADE K.61.)	

59. Le ti moun nan te malad, es ke nou te ba li bwè plis ke dabitid, mem bagay ou mwens ke dabitid ?	1. MWEN KE DABITID	
	2. MEM BAGAY	
	3. PLIS KE DABITID	
60. Le ti moun nan te malad, es ke nou te ba li mange plis ke dabitid, mem bagay ou mwens ke dabitid?	1. MWEN KE DABITID	
	2. MEM BAGAY	
	3. PLIS KE DABITID	

VIH/ SIDA

61. Es ke ou tande pale de Sida?	1. WI			
	2. NON ? GADE K. 65			
62. Ki sa pou on moun fè pou evite genyen virus Sida ou maladi Sida ? ENTOURE TOUT SA YO PWAL DI	A. ANYEN			
	B. OU PA GEN RELASYON SEXUEL			
	C. ITILISE KAPOT			
	D. FE SEX AVE ON SEL MOUN / RETE FIDEL A MOUN NAN			
	E. LIMITE NOMB MOUN OU AP FE SEX			
	F. EVITE SEX AVE BOUZIN			
	G. EVITE SEX AVE MOUN KI GEN ANPIL FANM OU GASON			
	H. EVITE SEX AVE MEM MOUN AVE OU			
	I. EVITE SEX AVE MOUN KAP PRAN PIKI DWO			
	J. EVITE TRANSFUZION SAN			
	K. EVITE PIKI			
	L. EVITE POU MOUN EMBRASE OU			
	M. EVITE PIKI MOUSTIK			
	N. ALE CHECHE PWOTEKSYON KAY HOUGAN			
O. EVITE PATAGE GILET AVE LOT MOUN				
W. LOT (DI SA OU PANSE)				
X. LOT (DI SA OU PANSE)				
Z. MWEN PA KONNEN				
63. Es ke virus ki bay moun Sida ka transmet de manman a pitit? Pendan fi a gross Pendan akoucheman Pendan bay tete		WI	NON	MWEN PA KON.
	Pendan fi a gross			
	Pendan akoucheman			
	Pendan bay tete			
	SI TOUT REPONS SE NON , GADE K. 65			
64. Si manman gen virus Sida, es ke gen mwayen evite manman transmet pitit la Sida?	1. WI			
	2. NON			
	8. MWEN PA KONNEN			

MALADI FANM BAY GASON ou GASON BAY FANM

65. (Aprè SIDA), es ke ou tande pale de lot enfeksyon fanm bay gason ou gason bay fanm?	1. WI	
	2. NON ? GADE K. 72	
	8. MWEN PA KONNEN ? GADE K. 72	
66. Le on neg gen maladi sexuel, es ke ou ka rekonet sa? Lot sign? MAKE TOUT SA LI DI	A. DOULE VANT	
	B. EKOULMAN GENITAL	
	C. DEHAJ MOUN NAN PA SANTI BON	
	D. EKOULMAN KI BOULE LE WAP PISE	
	E. ZON GENITAL ROUJ OU BIEN ANFLE	
	F. ZON GENITAL GONFLE	
	G. ULCE OU DOULE GENITAL	
	H. VERU GENITAL	
	I. SAN NAN PISE A	
	J. OU PEDI PWA	
	K. MOUN NAN PA PWISANS ENCO	
	L. PA GEN SIGN	
	W. LOT (DI KI SIGN) _____	
	X. LOT (DI KI SIGN) _____	
Z. MWEN PA KONNEN		
67. Le on fanm gen maladi sexuel, koman ou konnen ke li malad Lot sign? MAKE TOUT SA LI DI	A. DOULE VANT	
	B. EKOULMAN GENITAL	
	C. SEKESYON FANM NAN KI PA SANTI BON	
	D. BRULE LI LE LAP PISE	
	E. ZON GENITAL ROUJ OU BIEN ANFLE	
	F. ZON GENITAL GONFLE	
	G. ULCE OU DOULE GENITAL	
	H. VERU GENITAL	
	I. SAN NAN PISE LI	
	J. LI PEDI PWA	
	K. PA KAPAB FE TI MOUN	
	L. PA GEN SIGN	
	W. LOT (DI KI SIGN) _____	
	X. LOT (DI KI SIGN) _____	
Z. MWEN PA KONNEN		
68. Site de fason pou on moun pa pran nan maladi sexuel.	1. _____	
	2. _____	
	3. _____	

69	Es ke on maladi sexuel kapab gen enfluans sou on grosses?	WI	NON	MWEN PA KON.	
		Pendan fi a gross			
		Pendan akoucheman			
		Pendan bay tete			
SI TOUT REPONS SE NON , GADE K. 72					
70	SI REPONS LA SE WI A K. 69, MANDE ALO: “De ki manyè on maladi sexuel kapab gen enfluans sou rezilta on grosses?”	1. _____			
		2. _____			
		3. _____			
71.	Ki kote moun ale pou yo swanye maladi sexuel?	A. OPITAL			
		B. SANT SANTE			
		C. OGANIZASYON VOLONTE PRIVE			
		D. POSTE SANTE			
		E. KLINIK PLANNING FAMILIAL			
		F. MOUN KI TRAVAY E SANTE KOMINOTE A			
		G. FAMASI			
		H. LOT SANT SANTE (DI KI SANT) _____			
		I. BOUTIK			
		J. EGLIZ			
		K. ZANMI / MOUN OU KONNEN			
		X. LOT (DI KI MOUN) _____			
Z. MWEN PA KONNEN					

DEPISTAJ LA NAN HIV

72.	Koman on moun ka konnen ke ou genyen virus Sida?	A. FO ALE KONSILTE DOCTE			
		B. ALE NAN SANT SANTE			
		C. ALE NAN SANT SPESIALIZE POU YO CONSEYE E PI DEPISTE SIDA			
		X. LOT (SPECIFIE) _____			
		Z. MWEN PA KONNEN			
73.	Es ke ou tande pale de on sevis de depistaj de Sida?	1. WI			
		2. NON – GADE K. 78			
74.	Es ke yo te pwopoze ou fè on tes Sida pandan ke yo tap swagné ou pou grosses ou?	1. WI			
		2. NON – GADE K. 78			
75	Mwen pa vle kon rezilta a mè es ke yo te fè ou tes Sida pandan ke yo tap swagné ou pou grosses ou?	1. WI			
		2. NON ? GADE K. 78			

<p>76 Ki kote yo te fè tes la?</p> <p>[CHECHE KONNEN KOTE YO TE FE TES LA E ENTOURE KOTE A) APPROPRIATE CODE.</p> <p>_____</p> <p>_____</p> <p>(NAME OF PLACE WERE HIV TEST WAS DONE)</p>	SEKTE PIBLIK	
	01. OPITAL GOUVENMAN	
	02. SANT SANTE GOUVENMAN	
	03. SANT DEPISTAJ	
	04. KLINIK PLANNING FAMILIAL	
	05. KLINIK KI KA DEPLASE	
	06. TRAVAYE SOU PLAS	
	07. LOT PIBLIK _____ (DI KI KOTE)	
	SEKTE MEDIKAL PRIVE	
	08. OPITAL PRIVE/KLINIK/DOCTE	
	09. SANT DEPISTAJ	
	10. FAMASI	
	11. KLINIK KI KA DEPLASE	
	12. FIELDWORKER	
13. LOT PRIVE _____ (DI KI KOTE)		
14. LOT (SPECIFIE) _____		
<p>77 Map repete ou mwen pa vle konnen rezilta yo te ba ou pou tes Sida a, mè es ke yo te ba ou rezilta?</p>	1. WI	
	2. NON	

KOMAN MOUN LAVE MEN OU PWOP

<p>78. Avan nou fini, map poze ou on denye kesyon. Ki lè ou lave men ou ave savon ou bien sand?</p> <p>PA FOSE MOUN NAN POU LI REPON. MAKE TOUT SA LI DI OU.</p>	A. PA JAM	
	B. AVAN M'FE MANGE	
	C. AVAN M'BAY TI MOUN YO MANGE	
	D. APRE M'FINI FE KAKA	
	E. APRE MOKIPE ON TI MOUN KI SOTI FE KAKA	
	X. LOT (SITE ON LOT FASON) _____	
-		

Mèsi pou tan ou pedi ave mwen la a e pou kesyon yo ke ou aksepte repon. Si ou gen kesyon pou poze, mande moun ki tra vaye sante sou plas ou bien on pwofesyonel sante ki nan sant ki pi prèw la.

Appendix 2: English Version KPC Survey Questionnaire

INFORMED CONSENT AND COVER PAGE

<i>KPC₂₀₀₀ Rapid Core Assessment Tool on Child Health (CATCH)</i>			
Identification			
Cluster number.....			
Household number.....			
Record number.....			
Interviewer Initials.....			

RECORD INTERVIEW DATE	DAY	MONTH	YEAR	

RESCHEDULE INTERVIEW (If necessary)	DAY	MONTH	YEAR	

Interviewer's Name:
Supervisor's Name:
Community:

<p>INFORMED CONSENT</p> <p>Hello. My name is _____, and I am working with the COD-EMH and Global Health Action. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help the COD-EMH and Global Health Action to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes <u>45-60</u> minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.</p> <p>Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.</p> <p>At this time, do you want to ask me anything about the survey?</p> <p>Signature of the interviewer: _____ Date: _____</p> <p>Respondent agrees to be interviewed.....1?</p> <p>Respondent does not agree to be interviewed.....2?</p>
--

This questionnaire targets mothers of children less than 24 months of age.

1. RECORD INTERVIEW DATE

DAY		MONTH		YEAR			

DEMOGRAPHIC INFORMATION

		RECORD YEARS/NUMBER
2.	How old are you? (RECORD AGE OF RESPONDENT IN YEARS)	____ _
3.	For how many years have you attended school?	____ _
4.	For how many years have you lived in this area?	____ _

HEALTH CONTACTS

5.	During the last month, how often have you come in contact with each of the following:	FREQUENTLY (4 or more times)	SOMETIMES (1-3 times)	NEVER (0 times)
	DOCTOR	1	2	3
	NURSE/MIDWIFE	1	2	3
	COMMUNITY HEALTH WORKER	1	2	3
	HEALTH EDUCATOR	1	2	3
	GROWTH MONITORING PERSON	1	2	3
	TRAINED BIRTH ATTENDANT	1	2	3
	TRADITIONAL HEALER	1	2	3
6.	Where do you get general information or advice on health or nutrition? RECORD ALL MENTIONED.	FORMAL NETWORK		
		A. DOCTOR		
		B. NURSE/MIDWIFE		
		C. AUXILIARY MIDWIFE		
		D. TRAINED BIRTH ATTENDANT		
		E. COMMUNITY HEALTH WORKER		
		F. HEALTH EDUCATOR		
		G. GROWTH MONITORING PERSON		
		INFORMAL NETWORK		
		H. HUSBAND/PARTNER		
		I. MOTHER/MOTHER-IN-LAW		
		J. SISTER		
		K. GRANDPARENT		
		L. AUNT		
		M. FRIEND/NEIGHBOR		
N. TRADITIONAL HEALER				
O. VILLAGE ELDER				
X. OTHER (SPECIFY)				

7. In the past month, have you received any health messages from the following:		YES	NO
	RADIO	1	2
	NEWSPAPER	1	2
	TELEVISION	1	2
	HEALTH EDUCATION	1	2
COMMUNITY HEALTH WORKER	1	2	

MATERNAL PARITY INFORMATION

8. How many pregnancies have you had?	___ ___
9. How many live births have you had?	___ ___
10. How many children living in this household are under age five?	___ ___
11. How many of those children (living in this household) are your biological children?	___ ___

12. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON MOTHER'S RESPONSE TO Q.10:

- 1.
- 2.

ONLY 1 CHILD UNDER FIVE: "What is the name, sex, and date of birth of that child?"

- 3.
- 4.

MORE THAN 1 CHILD UNDER FIVE: "What are the names, sexes, and dates of birth of your two youngest children?"

5.	6. NAME	7. SEX	8. DATE OF BIRTH
21	9.	1. MALE 2. FEMALE	10. ___ / ___ / ___ 11. DD MM YYYY
22	12.	1. MALE 2. FEMALE	13. ___ / ___ / ___ 14. DD MM YYYY

15.

16. ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD UNDER AGE TWO

17.

13. Does (NAME)'s biological father live in this	1. YES
--	--------

household?	2. NO
	8. DON'T KNOW

ANTHROPOMETRY

14. May I weigh (NAME) ?	1. YES
	2. NO ? (SKIP TO Q.16)

15. *IF MOTHER AGREES, WEIGH THE CHILD AND RECORD WEIGHT BELOW. RECORD TO THE NEAREST TENTH.* ___ ___ . ___ Kg

MATERNAL AND NEWBORN CARE

16. Whom did you see for prenatal care while you were pregnant with (NAME)? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	A. Doctor		
	B. Nurse/Midwife		
	C. Auxiliary Midwife		
	D. Traditional Birth Attendant		
	E. Community Health Worker		
	X. Other (Specify)		
	Z. No One		
17. How many times did you see someone for care during the pregnancy?	NUMBER OF TIMES	___ ___	
18. During your prenatal check, were you counseled on the following:		YES	NO
	Delivery preparation		
	Breastfeeding		
	Child spacing		
	EPI		
19. Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	1. YES		
	2. NO ? SKIP TO Q. 21		
	3. DON'T KNOW ? SKIP TO Q. 21		
20. How many times did you receive such an injection?	1. ONCE		
	2. TWICE		
	3. MORE THAN 2 TIMES		
	8. DON'T KNOW		
21. Do you have a maternal health card for your pregnancy with (NAME)?	1. YES, SEEN		
	2. NOT AVAILABLE ? SKIP TO Q. 24		
	3. NEVER HAD A CARD ? SKIP TO Q. 24		

22. LOOK AT CARD AND RECORD THE	
---------------------------------	--

NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).		NUMBER OF VISITS _____				
23. LOOK AT THE CARD AND RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD.		DD	MM	YYYY		
	FIRST	___	/	___	/	____
	SECOND	___	/	___	/	____
	THIRD	___	/	___	/	____
	FOURTH	___	/	___	/	____
	FIFTH	___	/	___	/	____
	SIXTH	___	/	___	/	____
24. How would you get to the nearest health center? RECORD ALL RESPONSES.	A. WALK					
	B. CAR					
	C. MOTORCYCLE					
	D. OX CART					
	E. CANOE					
	X. OTHER (SPECIFY)					
25. How long would it take you to get there (to the nearest health center)?	1. LESS THAN 1 HOUR					
	2. 1 TO 3 HOURS					
	3. GREATER THAN 3 HOURS					
	8. DON'T KNOW					
26. What are the symptoms during pregnancy indicating the need to seek health care? RECORD ALL MENTIONED	A. FEVER					
	B. SHORTNESS OF BREATH					
	C. BLEEDING					
	D. SWELLING OF THE BODY/HANDS/FACE					
	X. OTHER (SPECIFY)					
	Z. DON'T KNOW ? SKIP TO Q. 28					
27. Where is the first place you would go for care if you had these symptoms?	01. HOSPITAL					
	02. HEALTH CENTER					
	03. HEALTH POST					
	04. PVO CENTER					
	05. CLINIC					
	07. FIELD/COMMUNITY HEALTH WORKER					
	07. OTHER HEALTH FACILITY (SPECIFY)					
	08. TRADITIONAL PRACTITIONER					
	09. SHOP					
	10. PHARMACY					
	11. COMMUNITY DISTRIBUTORS					
	12. FRIEND/RELATIVE					
88. OTHER						

SUB-MODULE ON IRON SUPPLEMENTATION DURING PREGNANCY

28. When you were pregnant with (NAME), did you receive or buy any iron tablets or iron syrup? SHOW TABLET/SYRUP.	1. YES	
	2. NO ? SKIP TO Q. 30	
	8. DON'T KNOW ? SKIP TO Q. 30	
29. How many days did you take the tablets or syrup? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	NUMBER OF DAYS _____	
	8. DON'T KNOW	

SUB-MODULE ON DELIVERY PRACTICES

30. Now I would like to ask you about the time when you gave birth to (NAME). Where did you give birth? IF SOURCE IS HOSPITAL, HEALTH CENTER OR CLINIC, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	HOME	
	11. YOUR HOME	
	12. OTHER HOME	
	HEALTH FACILITY	
	21. HOSPITAL	
	22. CLINIC	
	23. HEALTH CENTER	
	24. PVO CENTER	
	25. HEALTH POST	
31. Who assisted you with (NAME)'s delivery?	26. OTHER HEALTH FACILITY (SPECIFY)	
	96. OTHER (SPECIFY)	
	A. DOCTOR	
	B. NURSE/MIDWIFE	
	C. AUXILIARY MIDWIFE	
	96. TRADITIONAL BIRTH ATTENDANT _____ (NAME)	
32. Was a clean birth kit used?	E. COMMUNITY HEALTH WORKER	
	96. FAMILY MEMBER _____ (SPECIFY RELATIONSHIP TO RESPONDENT)	
	96. OTHER (SPECIFY)	
33. What instrument was used to cut the cord?	Y. NO ONE	
	1. YES	
	2. NO ? SKIP TO Q. 35	
34. Was a clean birth kit used?	8. DON'T KNOW ? SKIP TO Q. 35	
	1. NEW RAZOR BLADE	
	2. OTHER INSTRUMENT	

34. Who cut the cord?	1. DOCTOR	
	2. NURSE/MIDWIFE	
	3. AUXILIARY MIDWIFE	
	4. TRADITIONAL BIRTH ATTENDANT	
	5. COMMUNITY HEALTH WORKER	
	6. FAMILY MEMBER (SPECIFY)	
	7. OTHER (SPECIFY)	
	8. NO ONE	

BREASTFEEDING AND NUTRITION

35. Did you ever breastfeed (NAME)?	1. YES	
	2. NO ? SKIP TO Q. 37	
36. How long after birth did you first put (NAME) to the breast?	1. IMMEDIATELY/ WITHIN FIRST HOUR AFTER DELIVERY	
	2. AFTER THE FIRST HOUR	
37. I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night. Did (NAME) have ... READ EACH OF THE FOLLOWING AND PLACE A CHECK MARK IN THE BOX NEXT TO EACH ITEM CONSUMED	LIQUID/FOOD	CONSUMED IN LAST 24 HOURS?
	A. Breastmilk?	
	B. Plain water?	
	C. Other liquids?	
	D. Mashed, pureed, solid, or semi-solid foods?	
	E. Anything else? SPECIFY: _____ _____ _____	

POSTPARTUM CARE

38. After (NAME) was born, did anyone check on your health?	1. YES	
	2. NO ? SKIP TO Q. 46	
39. IF 'YES' on Q38 ASK: "Were you given information about child spacing during this check?"	1. CHECK-UP, BUT NO INFORMATION	
	2. RECEIVED INFORMATION ABOUT CHILD SPACING	
40. How many days or weeks after the delivery did the first check take place? RECORD 'OO' DAYS IF SAME DAY	1. DAYS AFTER DELIVERY : _____	
	2. WEEKS AFTER DELIVERY : _____	
	8. DON'T KNOW	

41. Who checked on your health at that time? PROBE FOR THE MOST QUALIFIED PERSON	1. DOCTOR	
	2. NURSE/MIDWIFE	
	3. AUXILIARY MIDWIFE	
	4. PVO -TRAINED BIRTH ATTENDANT	
	5. OTHER BIRTH ATTENDANT	
	6. OTHER (SPECIFY)	
42. At that time, did the person check on (NAME)'s health as well?	1. YES	
	2. NO	
	8. DON'T KNOW	
43. Did you have any other postpartum checks?	1. YES	
	2. NO ? SKIP TO Q. 45	
	8. DON'T KNOW ? SKIP TO Q. 45	
44. Who checked on your health the second time? PROBE FOR THE MOST QUALIFIED PERSON	1. DOCTOR	
	2. NURSE/MIDWIFE	
	3. AUXILIARY MIDWIFE	
	4. TRADITIONAL BIRTH ATTENDANT	
	5. OTHER (SPECIFY)	
45. Where did the first post-natal check-up occur?	HOME	
	11. YOUR HOME	
	12. OTHER HOME	
	HEALTH FACILITY	
	21. HOSPITAL	
	22. CLINIC	
	23. HEALTH CENTER	
	24. PVO CENTER	
	25. HEALTH POST	
	26. OTHER HEALTH FACILITY (SPECIFY)	
96. OTHER (SPECIFY)		

CHILD SPACING

<p>46. Now I would like to ask you about child spacing/family planning services in your community.</p> <p>Do you know of a place where you could obtain a method of child spacing/family planning?</p> <p>IF NO, CIRCLE "Z" [DON'T KNOW] IF YES, ASK "Where is that?"</p> <p>RECORD ALL MENTIONED.</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>_____</p>	A. HOSPITAL	
	B. HEALTH CENTER	
	C. PVO CENTER	
	D. HEALTH POST	
	E. FAMILY PLANNING CLINIC	
	F. FIELD/ COMMUNITY HEALTH WORKER	
	G. PHARMACY	
	H. OTHER HEALTH FACILITY (SPECIFY) _____	
	I. SHOP	
	J. CHURCH	
	K. FRIEND/RELATIVE	
X. OTHER (SPECIFY) _____		
Z. DON'T KNOW		
47. Are you currently pregnant?	1. YES	
	2. NO ? SKIP TO Q. 49	
	8. UNSURE ? SKIP TO Q. 49	
48. If 'YES' on Q.47, THEN ASK: "Have you been to the clinic?"	1. YES	
	2. NO	
49. When do you want to have your next child?	1. WITHIN 2 YEARS	
	2. MORE THAN 2 YEARS FROM NOW	
	8. UNSURE WHEN	
50. Have you used or are you using any method to delay or avoid getting pregnant?	01. NO METHOD	
	02. NORPLANT	
	03. INJECTION	
	04. PILL	
	05. IUD	
	06. BARRIER METHOD/DIAPHRAM	
	07. CONDOM	
	08. FOAM/GEL	
	09. TUBAL LIGATION	
	10. VASECTOMY	
	11. LACTATIONAL AMENORRHEA (EXCLUSIVE BREASTFEEDING)	
	12. RHYTHM	
	13. ABSTINENCE	
	14. WITHDRAWAL	
	96. OTHER	
IF NO, CIRCLE '01' (NO METHOD)		
IF YES, ASK "What is the main method you or your husband/partner are using now to avoid/postpone getting pregnant?"		
Circle the appropriate response.		

Child Immunization

51. Do you have a card where (NAME'S) vaccinations are written down? IF 'YES' ASK 'May I see it please?'	1. YES, SEEN BY INTERVIEWER	
	2. NOT AVAILABLE (lost/misplaced, not in home)	
	4. NEVER HAD A CARD ? SKIP TO Q.53	
	8. DON'T KNOW ? SKIP TO Q.53	

52. RECORD INFORMATION EXACTLY AS IT APPEARS ON (NAME'S) VACCINATION CARD.

	DAY	MONTH	YEAR
BCG	18.		
POLIO 0			
POLIO 1			
POLIO 2			
POLIO 3			
DPT 1			
DPT 2			
DPT 3			
MEASLES			
VITAMIN A			
	19.		20.

53. Did (NAME) ever receive an injection to prevent measles? IF MEASLES INFORMATION IS AVAILABLE FROM THE CARD, DO NOT ASK THIS QUESTION – SKIP TO Q.54.	1. YES	
	2. NO	
	8. DON'T KNOW	

MALARIA PREVENTION

54. Do you have any bednets in your house?	1. YES	
	2. NO (SKIP TO Q. 57)	
	8. DON'T KNOW (SKIP TO Q. 57)	
55. Who slept under a bednet last night? (MARK ALL THAT APPLY)	A. CHILD (NAME)	
	B. RESPONDENT	
	C. OTHER INDIVIDUAL(S) (SPECIFY) _____	
56. Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or bugs?	1. YES	
	2. NO	
	8. DON'T KNOW	

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

57. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? DO NOT PROMPT. CIRCLE ALL MENTIONED.	A. DON'T KNOW	
	B. LOOKS UNWELL OR NOT PLAYING NORMALLY	
	C. NOT EATING OR DRINKING	
	D. LETHARGIC OR DIFFICULT TO WAKE	
	E. HIGH FEVER	
	F. FAST OR DIFFICULT BREATHING	
	G. VOMITS EVERYTHING	
	H. CONVULSIONS	
	I. OTHER (SPECIFY)	
	J. OTHER (SPECIFY)	
58. Did (NAME) experience any of the following in the past two weeks? READ CHOICES ALOUD AND CIRCLE ALL MENTIONED BY RESPONDENT.	K. OTHER (SPECIFY)	
	A. DIARRHEA	
	B. BLOOD IN STOOL	
	C. COUGH	
	D. DIFFICULT BREATHING	
	E. FAST BREATHING/SHORT, QUICK BREATHS	
	F. FEVER	
	G. MALARIA	
	H. CONVULSIONS	
	I. OTHER (SPECIFY)	
J. OTHER (SPECIFY)		
K. NONE OF THE ABOVE ? (SKIP TO Q.61.		

59. When (NAME) was sick, was he/she offered less than usual to <u>drink</u> , about the same amount, or more than usual to drink?	1. LESS THAN USUAL	
	2. SAME AMOUNT	
	3. MORE THAN USUAL	
60. When (NAME) was sick, was he/she offered less than usual to <u>eat</u> , about the same amount, or more than usual to eat?	1. LESS THAN USUAL	
	2. SAME AMOUNT	
	3. MORE THAN USUAL	

HIV / AIDS

61. Have you ever heard of an illness called AIDS?	1. YES			
	2. NO ? SKIP TO Q. 65			
62. What can a person do to avoid getting AIDS or the virus that causes AIDS? CIRCLE ALL MENTIONED	A. NOTHING			
	B. ABSTAIN FROM SEX			
	C. USE CONDOMS			
	D. LIMIT SEX TO ONE PARTNER / STAY FAITHFUL TO ONE PARTNER			
	E. LIMIT NUMBER OF SEXUAL PARTNERS			
	F. AVOID SEX WITH PROSTITUTES			
	G. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS			
	H. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX			
	I. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY			
	J. AVOID BLOOD TRANSFUSIONS			
	K. AVOID INJECTIONS			
	L. AVOID KISSING			
	M. AVOID MOSQUITO BITES			
63. Can the virus that causes AIDS be transmitted from a mother to a child?		YES	NO	DON'T KNOW
	During pregnancy?			
	During delivery?			
	During breastfeeding?			
64. If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	1. YES			
	2. NO			
	8. DON'T KNOW			

SEXUALLY TRANSMITTED INFECTIONS

<p>65. (Apart from AIDS), have you heard about (other) infections that can be transmitted through sexual contact?</p>	1. YES	
	2. NO ? SKIP TO Q. 72	
	8. DON'T KNOW ? SKIP TO Q. 72	
<p>66. In a man, what signs and symptoms would lead you to think that he has such an infection?</p> <p>Any others?</p> <p style="text-align: center;">RECORD ALL MENTIONED</p>	A. ABDOMINAL PAIN	
	B. GENITAL DISCHARGE/DRIPPING	
	C. FOUL SMELLING DISCHARGE	
	D. BURNING PAIN ON URINATION	
	E. REDNESS/INFLAMMATION IN GENITAL AREA	
	F. SWELLING IN GENITAL AREA	
	G. GENITAL SORES/ULCERS	
	H. GENITAL WARTS	
	I. BLOOD IN URINE	
	J. LOSS OF WEIGHT	
	K. IMPOTENCE	
	L. NO SYMPTOMS	
	W. OTHER (SPECIFY)	_____
	X. OTHER (SPECIFY)	_____
Z. DON'T KNOW		
<p>67. In a woman, what signs and symptoms would lead you to think that she has such an infection?</p> <p>Any others?</p> <p style="text-align: center;">RECORD ALL MENTIONED</p>	A. ABDOMINAL PAIN	
	B. GENITAL DISCHARGE	
	C. FOUL SMELLING DISCHARGE	
	D. BURNING PAIN ON URINATION	
	E. REDNESS/INFLAMMATION IN GENITAL AREA	
	F. SWELLING IN GENITAL AREA	
	G. GENITAL SORES/ULCERS	
	H. GENITAL WARTS	
	I. BLOOD IN URINE	
	J. LOSS OF WEIGHT	
	K. INABILITY TO GIVE BIRTH	
	L. NO SYMPTOMS	
	W. OTHER (SPECIFY)	_____
	X. OTHER (SPECIFY)	_____
Z. DON'T KNOW		
<p>68. What can a person do to avoid getting a sexually transmitted infection (STI)?</p> <p>DO NOT PROMPT. RECORD ALL MENTIONED.</p>	1. _____	
	2. _____	
	3. _____	

69. Can a sexually transmitted infection impact a pregnancy? During pregnancy? During delivery? During breastfeeding?		YES	NO	DON'T KNOW
	During pregnancy			
	During delivery			
	During breastfeeding			
	IF 'NO' ON ALL , SKIP TO Q. 72			
70. IF 'YES' IN Q. 69, THEN ASK: "In what ways can a sexually transmitted infection impact the outcome of a pregnancy?"	1. _____ 2. _____ 3. _____			
71. Where can a person go for treatment of a sexually transmitted infection (STI)?	A. HOSPITAL			
	B. HEALTH CENTER			
	C. PVO CENTER			
	D. HEALTH POST			
	E. FAMILY PLANNING CLINIC			
	F. FIELD/ COMMUNITY HEALTH WORKER			
	G. PHARMACY			
	H. OTHER HEALTH FACILITY (SPECIFY) _____			
	I. SHOP			
	J. CHURCH			
	K. FRIEND/RELATIVE			
	X. OTHER (SPECIFY) _____			
Z. DON'T KNOW				

HIV SCREENING

72. How can a person find out if he or she has HIV (the virus that causes AIDS)?	A. GO FOR TEST			
	B. GO TO HEALTH FACILITY			
	C. GO TO COUNSELLING/TESTING FACILITY			
	X. OTHER (SPECIFY) _____			
	Z. DON'T KNOW			
73. Have you heard of an HIV/AIDS counseling and testing service?	1. YES			
	2. NO ? SKIP TO Q. 78			
74. Were you offered a test for the AIDS virus as part of your antenatal care?	1. YES			
	2. NO ? SKIP TO Q. 78			
75. I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care?	1. YES			
	2. NO ? SKIP TO Q. 78			

<p>76. Where was the test done?</p> <p>[PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. IF THE SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC, PLEASE WRITE THE NAME OF THE PLACE BELOW].</p> <p>_____</p> <p>(NAME OF PLACE WHERE HIV TEST WAS DONE)</p>	PUBLIC SECTOR	
	01. GOVT. HOSPITAL	
	02. GOVT. HEALTH CENTER	
	03. VCT CENTER	
	04. FAMILY PLANNING CLINIC	
	05. MOBILE CLINIC	
	06. FIELDWORKER	
	07. OTHER PUBLIC _____ (SPECIFY)	
	PRIVATE MEDICAL SECTOR	
	08. PRIV. HOSP/CLINIC/DOCTOR	
	09. VCT CENTER	
	10. PHARMACY	
	11. MOBILE CLINIC	
	12. FIELDWORKER	
13. OTHER PRIVATE _____ (SPECIFY)		
14. OTHER (SPECIFY)		
<p>77. As a reminder, I don't want to know the results, but did you get the results of the test?</p>	1. YES	
	2. NO	

HAND-WASHING PRACTICES

<p>78. Before we end, I'd like to ask you one more question. When do you wash your hands with soap/ash?</p> <p>DO NOT PROMPT. MARK ALL MENTIONED.</p>	A. NEVER	
	B. BEFORE FOOD PREPARATION	
	C. BEFORE FEEDING CHILDREN	
	D. AFTER DEFECACTION	
	E. AFTER ATTENDING TO A CHILD WHO HAS DEFEATED	
	X. OTHER (SPECIFY) _____	

Thank you for your time and for answering these questions.

If you have any questions, please see your local health worker or the health professionals at the nearest health center.

Appendix 3: French Version KPC Survey Questionnaire

CONSENTEMENT INFORMÉ ET PAGE DE COUVERTURE

<i>Enquête Rapide de Connaissance, Pratiques et Couverture (CPC)</i>			
Identification			
NUMÉRO DE GRAPPE.....			
NUMÉRO DE MÉNAGE.....			
NUMÉRO D'ENREGISTREMENT.....			
LES INITIALS D'ENQUÊTEUR.....			

DATE D'INTERVIEW

JOUR		MOIS		ANNÉE			

INTERVIEW REPORTÉE AU
(si nécessaire)

JOUR		MOIS		ANNÉE			

Nom de l'enquêteur :
Nom de superviseur de l'enquêteur :
Communauté:

CONSENTEMENT INFORMÉ

Bonjour. Je m'appelle _____, et je travaille avec le **COD-EMH et Global Health Action**. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à **COD-EMH and Global Health Action** pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement 45-60 minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne.

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête?

Signature de l'enquêteur: _____ Date: _____

L'ENQUÊTÉE ACCEPTE D'ÊTRE ENQUÊTÉE.....1?

L'ENQUÊTÉE REFUSE D'ÊTRE ENQUÊTÉE2?

Ce questionnaire cible les mères d'enfants de moins de 24 mois.

1. DATE D'INTERVIEW

JOUR		MOIS		ANNÉE			

L'INFORMATION DEMOGRAPHIQUE

L'INFORMATION DEMOGRAPHIQUE		NOTER L'AGE EN ANNEES
2. Quel age avez-vous ? NOTER L'AGE DE L'INTERVIEWEE EN ANNEES		___ ___
3. Pendant combien d'années avez-vous fréquenté l'école ¹ ? SI JAMAIS, ENREGISTREZ '00'.		___ ___
4. Pendant combien d'années êtes-vous vécu ici ?		___ ___

CONTACTS ET SOURCES D'INFORMATION EN MATIÈRE DE SANTÉ

5.	Au cours du mois dernier, combien de fois avez-vous été en contact avec chacune des personnes suivantes:	SOUVENT (4 fois ou plus)	DE TEMPS EN TEMPS (1-3 fois)	JAMAIS (0 fois)
	DOCTEUR	1	2	3
	INFIRMIÈRE/SAGE FEMME	1	2	3
	AGENT DE SANTÉ COMMUNAUTAIRE	1	2	3
	ÉDUCATEUR SANITAIRE	1	2	3
	PERSONNE CHARGÉE DU SUIVI DE CROISSANCE	1	2	3
	ACCOUCHEUSE FORMÉE	1	2	3
	GUÉRISSEUR TRADITIONNEL	1	2	3
6.	Où obtenez-vous des informations ou des conseils d'ordre général en matière et de nutrition ? ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.	RÉSEAU FORMEL		
		A. DOCTEUR		
		B. INFIRMIÈRE/SAGE FEMME		
		C. SAGE FEMME AUXILLIARE		
		D. ACCOUCHEUSE FORMÉE		
		E. AGENT DE SANTÉ COMMUNAUTAIRE		
		F. ÉDUCATEUR SANITAIRE		
		G. PERSONNE CHARGÉE DU SUIVI DE CROISSANCE		
		RÉSEAU INFORMEL		
		H. MARI/PARTENAIRE		
		I. MÈRE/BELLE-MÈRE		
		J. SŒUR		
		K. GRANDS PARENTS		
		L. TANTE		
		M. AMIS/VOISINS		
		N. GUÉRISSEUR TRADITIONNEL		
		O. LES ANCIENS DU VILLAGE		

		X. AUTRE (PRECISER)	
7.	Au cours du mois dernier, avez-vous reçu des messages sur la santé par le biais de :	YES	NO
		RADIO ?	1 2
		JOURNAUX ?	1 2
		TÉLÉVISION ?	1 2
		ÉDUCATEUR SANITAIRE ?	1 2
AGENT DE SANTE COMMUNAUTAIRE ?		1	2

MATERNAL PARITY INFORMATION

8.	Combien de grossesses avez-vous eu?	___ ___
9.	Combien de naissances vivant avez-vous eu?	___ ___
10.	Combien d'enfants de moins de cinq ans vivent dans ce foyer ?	___ ___
11.	Combien de ces enfants (vivent dans ce foyer) sont vos enfants biologiques?	___ ___

12. LIRE UNE DES QUESTIONS SUIVANTES EN FONCTION DE LA REPONSE PRESEDENTE DE LA MERE EN Q4 :

UN SEUL ENFANT DE MOINS DE CINQ ANS : "Quel est le nom, l e sexe, la date de naissance de cet enfant ?"

PLUS D'UN ENFANT DE MOINS DE CINQ ANS : "Quels sont les noms, sexes et dates de naissance de vos deux plus jeunes enfants ?"

21.	22. NOM	SEXE	DATE DE NAISSANCE
11		1.MASCULIN 2.FEMININ	___ ___ / ___ ___ / ____ JJ MM AAAA
23.	24.	1.MASCULIN 2.FEMININ	___ ___ / ___ ___ / ___ ___ JJ MM AAAA

TOUTES LES QUESTIONS SUIVANTES FONT REFERENCES AU PLUS JEUNE ENFANT DE MOINS DE DEUX ANS

13. Est-ce que le père biologique (NOM) vit dans ce ménage ?	1. OUI
	2. NON

ANTHROPOMÉTRIE

14.	Puis-je peser (Nom) ?	1. OUI
		2. NON ? (ALLER A Q.16)

15. *SI LA MERE EST D'ACCORD, PESER L'ENFANT ET NOTER LE POIS ICI. NOTER LA DIXIEME PRES.* _____ Kg

SANTÉ DE LA MÈRE ET DU NOUVEAU-NÉ

16.	Qui avez-vous vu pour des soins prénatal pendant que vous étiez enceinte de (NOM)? INSISTIEZ POUR OBTENIR LE TYPE DE PERSONNE ET ENREGISTREZ TOUTES LES PERSONNES MENTIONNESES PAR LA MERE	A. Médecin		
		B. Infirmière/Sage - Femme		
		C. Sage Femme Auxilliare		
		D. Accoucheuse Traditionnel		
		E. Agent de Santé Communautaire		
		X. Autre (Précisez)		
		Z. No One		
17.	Combien de fois avez-vous vu quelqu'un pour des soins durant votre grossesse?	NOMBRE DE FOIS	_____	
18.	Durant vos visites prénatales, avez-vous été conseillée sur: Préparation à l'accouchement ? Allaitement maternel ? Espacement des naissances ? PEV ? Signes de danger durant la grossesse ?		OUI	NON
		Préparation à l'accouchement		
		Allaitement maternel		
		Espacement des naissances		
		PEV		
		Signes de danger durant la grossesse		
19.	Avant de accoucher (NOM), avez-vous reçu une injection dans le bras pour protéger le bébé contre le tétanos, c'est à dire, des convulsions après la naissance ?	1. OUI		
		2. NON ? PASSER A Q. 21		
		3. NE SAIT PAS ? PASSER A Q. 21		
20.	Combien de fois avez-vous reçu cette injection?	1. UNE FOIS		
		2. DEUX FOIS		
		3. PLUS DE DEUX FOIS		
		8. NE SAIT PAS		
21.	Avez-vous un carnet de santé maternel pour la grossesse de (NOM)?	1. OUI, VU		
		2. PAS DISPONIBLE ? PASSER A Q. 24		
		3. N'A JAMAIS EU DE CARNET ? PASSER A Q. 24		
22.	REGARDEZ LE CARNET ET NOTEZ LE NOMBRE DE VISITES PRENATALES	NOMBRE DE VISITES		

EFFECTUÉES PENDANT QUE LA MÈRE ETAIT ENCEINTE DE (NOM).		_____		
23. REGARDEZ LE CARNET ET ENREGISTREZ LES DATES POUR CHAQUE INJECTION DE VAT INSCRITE SUR LE CARET		JJ	MM	AAAA
	1er	___/___/_____		
	2eme	___/___/_____		
	3eme	___/___/_____		
	4eme	___/___/_____		
	5eme	___/___/_____		
	6eme	___/___/_____		
24. Quel moyen de transport utilisez-vous pour vous y rendre? ENREGISTREZ TOUTES LES RÉPONSES.	A. À PIED			
	B. VOITURE			
	C. MOBYLETTE			
	D. CHARRETTE			
	E. PIROGUE			
	X. AUTRE (PRECISEZ)			
25. Combien de temps faut-il pour atteindre l'établissement?	1. MOINS D'1 HEURE			
	2. 1 À 3 HEURES			
	3. PLUS DE 3 HEURES			
	8. NE SAIT PAS			
26. Quels sont les symptômes durant la grossesse qui indiquent qu'il faut rechercher des soins de santé? ENREGISTREZ TOUT CE QUI EST MENTIONNÉ	A. FIÈVRE			
	B. ESSOUFFLEMENT			
	C. SAIGNEMENTS			
	D. ŒDÈME CORPS/MAIN/VISAGE			
	X. AUTRE (PRECISEZ)			
	Z. NE SAIT PAS ? PASSER A Q. 28			
27. Quel serait le premier endroit où vous iriez pour être soigné si vous aviez ces symptômes?	01. HÔPITAL			
	02. CENTRE DE SANTE			
	03. POSTE DE SANTE			
	04. CENTRE ONG			
	05. CLINQUE			
	06. AGENT DE SANTE DE TERRAIN / COMMUNAUTAIRE			
	07. AUTRE ETABLISSEMENT DE SANTÉ (PRECISEZ)			
	08. GUÉRISSEUR TRADITIONNEL			
	09. BOUTIQUE			
	10. PHARMACIE			
	11. DISTRIBUTEURS COMMUNAUTAIRES			
	12. AMI/PARENTS			
88. AUTRE				

SOUS-MODULE SUR LA SUPPLÉMENTATION EN FER DURANT LA GROSSESSE

28. Quand vous étiez enceinte de (NOM), avez-vous reçu ou acheté des comprimés de fer ou du sirop contenant du fer? MONTRER LE COMPRIME/SIROP.	1. OUI	
	2. NON ? PASSER A Q. 30	
	8. NE SAIT PAS ? PASSER A Q. 30	
29. Pendant combien de jours avez-vous pris des comprimés ou du sirop? SI LA REPONSE N'EST PAS NUMÉRIQUE, INSISTEZ POUR OBTENIR UN NOMBRE APPROXIMATIF DE JOURS.	NUMBER OF DAYS _____	
	8. NE SAIT PAS	

SUB-MODULE ON DELIVERY PRACTICES

30. Maintenant j'aimerais vous parler de la naissance de (NOM). Où avez-vous accouché de (NOM) ? SI LA SOURCE EST UN HÔPITAL, UN CENTRE DE SANTÉ OU UNE CLINIQUE, ÉCRIVEZ LE NOM DE L'ENDROIT. _____ (NOM DE L'ENDROIT)	A LA MAISON	
	11. VOTRE DOMICILE	
	12. AUTRE DOMICILE	
	ETABLISSEMENT SANITAIRE	
	21. HOPITAL	
	22. CLINIQUE	
	23. CENTRE DE SANTE	
	24. CENTRE NGO	
	25. HEALTH POST	
	26. OTHER HEALTH FACILITY (SPECIFY) _____	
96. OTHER (SPECIFY)		
31. Qui vous a assisté pour l'accouchement de (NOM) ?	A. DOCTEUR	
	B. INFIRMIERE/SAGE FEMME	
	C. SAGE FEMME AUXILLIARE	
	D. ACCOUCHEUSE TRADITIONNELLE _____ (NOM)	
	E. AGENT DE SANTE COMMUNAUTAIRE	
	F. MEMBRE DE LA FAMILLE _____ (LIEN DE PARENTE SPECIFIQUE AVEC L'INTERVIEWEE)	
	G. AUTRE (PRECISER)	
Y. PERSONNE		
32. Est-ce qu'on a utilisé une trousse propre ?	1. OUI	
	2. NON ? PASSER A Q. 35	
	8. NE SAIT PAS ? PASSER A Q. 35	
	1. LAME DE RASOIR NEUVE	

le cordon?	2. AUTRE INSTRUMENT	
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34. Qui a coupé le cordon ?	1. MEDECIN	
	2. INFIRMIERE/SAGE FEMME	
	3. SAGE-FEMME AUXILLIAIRE	
	4. ACCOUCHEUSE TRADITIONEL	
	5. AGENT DE SANTE COMMUNAUTAIRE	
	6. MEMBRE FAMILLE (PRECISEZ)	
	7. AUTRE (PRECISEZ)	
	8. PERSONNE	

ALLAITEMENT ET NUTRITION

35. Avez-vous toujours allaité (NOM)?	1. OUI	
	2. NON ? PASSER A Q. 37	
36. Combien de temps après la naissance avez-vous mis (NOM) au sein pour la première fois?	1. IMMEDIATEMENT/DANS LES HEURES QUI ONT SUIVI L'ACCOUCHEMENT	
	2. APRES LES PREMIERES HEURES	
37. J'aimerais vous demander quels types de liquides et d'aliments que (NOM) à consommer hier durant la journée ou la nuit. A-t-il reçu ... <i>LIRE CHAQUE PROPOSITION ET COCHER LA CASE CORRESPONDANTE SI L'ELEMENT A ETE CONSOMME.</i>	LIQUIDE/ALIMENT	CONSOMME DANS LES 24 HEURES PASSEES?
	A. Lait maternel?	
	B. Eau simple?	
	C. Autres liquides?	
	D. Aliments écrasés, en purée, solides ou semi-solides?	
	E. Autres choses? PRECISER: _____ _____ _____	

POSTPARTUM CARE

38	Après la naissance de (NOM), est-ce que quelqu'un vous a examinée?	1. OUI	
		2. NON ? PASSER A Q. 46	
39.	SI 'OUI' SUR Q38 DEMANDEZ: "Avez-vous reçu des informations sur l'espace des naissances au cours de cet examen?"	1. EXAMEN MAIS PAS D'INFORMATION	
		2. A REÇU DES INFORMATIONS 2. RECEIVED INFORMATION ABOUT CHILD SPACING	
40.	Après combien de jours ou de semaines après l'accouchement avez-vous été examinée pour la première fois? ENREGISTREZ '00' JOURS SI MÊME JOUR.	1. JOURS APRÈS ACCOUCHER: ____	
		2. SEMAINES APRES ACC : ____	
		8. NE SAIT PAS	
41.	Qui a effectué cet examen à ce moment - là? INSISTEZ POUR OBTENIR LA PERSONNE LA PLUS QUALIFIÉE.	1. MEDECIN	
		2. INFIRMIERE/SAGE FEMME	
		3. SAGE-FEMME AUXILLIAIRE	
		4. ACCOUCHEUSE TRADITIONNELLE	
		5. AUTRE (PRECISEZ)	
42.	A ce moment -là, est-ce que cette personne a aussi examiné (NOM)?	1. OUI	
		2. NON	
		8. NE SAIT PAS	
43.	Avez-vous eu d'autres examens post-partum?	1. OUI	
		2. NON ? PASSER A Q. 45	
		8. NE SAIT PAS ? ALLER A Q. 45	
44.	Qui a effectué l'examen la deuxième fois? INSISTEZ POUR OBTENIR LA PERSONNE LA PLUS QUALIFIÉE.	1. MEDECIN	
		2. INFIRMIERE/SAGE FEMME	
		3. SAGE-FEMME AUXILLIAIRE	
		4. ACCOUCHEUSE FORMEE PAR ONG	
		5. AUTRE ACCOUCHEUSE	
		6. AUTRE (PRECISEZ)	
45.	Où est-ce que la premier examen a été effectué?	A LA MAISON	
		11. VOTRE DOMICILE	
		12. AUTRE DOMICILE	
		ETABLISSEMENT SANITAIRE	
		21. HOPITAL	
		22. CLINIQUE	
		23. CENTRE DE SANTE	
		24. CENTRE NGO	
		25. HEALTH POST	
26. OTHER HEALTH FACILITY (SPECIFY)			

	96. OTHER (SPECIFY)	
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CHILD SPACING

<p>46. Maintenant je voudrais vous poser une question concernant les services d'espacement des naissances/planification familiale dans votre communauté.</p> <p>Connaissez-vous un endroit où vous pourriez obtenir une méthode d'espacement des naissances/planification familiale ?</p> <p>SI NON, ENCERCLEZ 'Z' [NE SAIT PAS] SI OUI, DEMANDEZ : «Où est-ce ? »</p> <p>ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.</p> <p>SI LA SOURCE EST UN HÔPITAL, UN CENTRE DE SANTÉ OU UNE CLINIQUE, ÉCRIVEZ LE NOM DE L'ENDROIT.</p> <p>_____</p> <p>(NOM DE L'ENDROIT)</p>	A. HOPITAL	
	B. CENTRE DE SANTE	
	C. CENTRE ONG	
	D. POSTE DE SANTE	
	E. CLINIQUE PLANIFICATION FAMILIAL	
	F. AGENT DE SANTE DE TERRAIN/COMMUNAUTAIRE	
	G. PHARMACIE	
	H. AUTRE ETABLISSEMENT DE SANTE (SPECIFY)	
	I. BOUTIQUE	
	J. EGLISE	
	K. AMI/PARENTS	
X. AUTRE (PRECISEZ)		
Z. NE SAIT PAS		
<p>47. Etes-vous actuellement enceinte?</p>	1. OUI	
	2. NON ? PASSER A Q. 49	
	8. PAS SÛRE ? PASSER A Q. 49	
<p>48. Si 'OUI' sur Q.47, PUIS DEMANDEZ: "Etes-vous allée à la clinique?"</p>	1. OUI	
	2. NON	
<p>49. Quand souhaiteriez vous avoir votre prochain enfant?</p>	1. AU COURS DES 2 PROCHAINES ANNÉES	
	2. DANS PLUS DE 2 ANS	
	8. PAS SURE QUAND	
<p>50. Actuellement, faites-vous quelque chose ou utilisez-vous une méthode pour retarder ou éviter de tomber enceinte ?</p> <p>SI NON, ENCERCLEZ >01' [PAS DE MÉTHODE]</p> <p>SI OUI, DEMANDEZ : « Quelle est la principale méthode que vous ou votre mari/partenaire utilisez pour retarder/éviter de tomber enceinte ? »</p> <p>ENCERCLEZ OU MARQUEZ LE CODE APPROPRIÉ.</p>	01. PAS DE METHODE	
	02. NORPLANT	
	03. INJECTIONS	
	04. PILULE	
	05. DIU	
	06. METHODE DE BARRIERE/ DIAPHRAGME	
	07. CONDOM	
	08. MOUSSE/GELEE	
	09. LIGATURE DES TROPES	
	10. VASECTOMIE	
	11. ALLAITE, MATERNELLE AMENORRHEE (ALLAIT. EXCLUSIF)	
	12. RHYTHME	
	13. ABSTINENCE	
	14. RETRAIT	
96. AUTRE		

Child Immunization

<p>51. Avez-vous un carnet de vaccinations où sont inscrits les vaccins de (NOM) ?</p> <p>SI OUI DEMANDER "Puis-je le voir, s'il vous plaît ?"</p>	1. OUI, VU PAR L'ENQUETEUR	
	2. PAS DISPONIBLE (perdue/égarée, pas à la maison)	
	N'A JAMAIS EU DE CARNET ? PASSER Q.53	
	8. NE SAIT PAS ? SKIP TO Q.53	

53. REPORTER EXACTEMENT LES INFORMATIONS COMME ELLES SONT INSCRITES SUR LE CARNET DE VACCINATION DE (NOM).

	25.	JOUR	26.	MOIS	27.	ANNE	28.
						E	
	29.	30.	31.	32.	33.	34.	35.
BCG	36.	37.	38.	39.	40.	41.	42.
	43.						44.
POLIO 0							
POLIO 1							
POLIO 2							
POLIO 3							
DPT 1							
DPT 2							
DPT 3							
ROUGEOLE							
VITAMINE A							

<p>53. Est-ce que (NOM) a déjà reçu une injection pour prévenir la rougeole?</p> <p>SI L'INFORMATION DE LA ROUGEOLE EST INSCRIT SUR LA CARNET, NE DEMANDE PAS CETTE QUESTION – PASSER A Q.54.</p>	1. OUI	
	2. NON	
	8. NE SAIT PAS	

Prévention du Paludisme

54. Avez des moustiquaires dans la maison ?	1. OUI	
	2. NON ? PASSER A Q. 57	
	8. DON'T KNOW ? PASSER A Q. 57	
55. Qui a dormi sous une moustiquaire la nuit dernière ? (ENTOURER TOUTES REPONSES CITEES.)	A. ENFANT (NOM)	
	B. INTERVIEWEE	
	C. AUTRE(S) PERSONNE(S) (PRECISEZ) _____	
56. Est-ce que la moustiquaire a déjà été trempée ou plongée dans un liquide qui repousse les moustiques ou insectes ?	1. OUI	
	2. NON	
	8. NE SAIT PAS	

Prise en Charge Intégrée de s Maladies de l'Enfance (PCIME)

57. Parfois les enfants sont malades et ont besoin de soin ou de traitement. Quels sont les signes de la maladie qui vous indiquera que votre enfant a besoin de traitement ? <i>(PRENDRE VOTRE TEMPS. ENTOURER TOUT CE QUI A ETE MENTIONNE PAR L'INTERVIEWEE)</i>	A. NE SAIT PAS	
	B. NE SEMBLE PAS BIEN OU NE JOUE PAS NORMALEMENT	
	C. NE MANGE PAS OU NE BOIT PAS	
	D. SOMNOLENCE OU DIFFICULTE A SE REVEILLER	
	E. FORTE FIEVRE	
	F. RESPIRATION DIFFICILE ET RAPIDE	
	G. VOMITS TOUT	
	H. CONVULSIONS	
	I. AUTRE (PRECISEZ)	
	J. AUTRE (PRECISEZ)	
	K. AUTRE (PRECISEZ)	
58. Est-ce que (NOM) a eu un des signes ci-dessous durant ces deux dernières semaines ? <i>LIRE A HAUTE VOIE LES PROPOSITIONS ET ENTOURER TOUTES CELLES RETENUES</i>	A. DIARRHEE	
	B. SANG DANS LES SELLES	
	C. TOUX	
	D. DIFFICULTE A RESPIRER	
	E. RESPIRATION RAPIDE / ESSOUFFLEMENT	
	F. FIEVRE	
	G. PALUDISME	
	H. CONVULSIONS	
	I. AUTRE (PRECISEZ)	
	J. AUTRE (PRECISEZ)	
	K. RIEN DE MENTIONNER CI-DESSUS ? PASSER A Q.61	

59. Quand (NOM) était malade, a-t-il/elle <u>bu</u> moins que d'habitude ou la même quantité ou plus que ce qu'il/elle a l'habitude de <u>boire</u> ?	1. MOINS QUE D'HABITUDE	
	2. MEME QUANTITE	
	3. PLUS QUE D'HABITUDE	
60. Quand (NOM) était malade, a-t-il/elle <u>mangé</u> moins que d'habitude ou la même quantité ou plus que ce qu'il/elle a l'habitude de manger ?	1. MOINS QUE D'HABITUDE	
	2. MEME QUANTITE	
	3. PLUS QUE D'HABITUDE	

VIH/SIDA

61. Avez-vous déjà entendu parler d'une maladie appelée SIDA ?	1. OUI			
	2. NON ? PASSER A Q. 65			
62. Que peut faire une personne pour éviter d'avoir le SIDA ou le virus qui cause le SIDA ? <i>ENTOURER/MARQUER TOUTES LES REponses MENTIONNEES.</i>	A. RIEN			
	B. ABSTINENCE SEXUELLE			
	C. UTILISATION DE CONDOM			
	D. LIMITER LES RELATIONS SEXUELLES A UN PARTENAIRE/ RESTER FIDELE A UN PARTENAIRE			
	E. LIMITER LE NOMBRE DE PARTENAIRES SEXUELS			
	F. EVITER LES RELATIONS SEXUELLES AVEC LES PROSTITUEES			
	G. EVITER D'AVOIR LES RAPPORTS SEXUELS AVEC UNE PERSONNE QUI PLUSIEURS PARTENAIRES			
	H. EVITER DES RAPPORTS SEXUELS AVEC DES PERSONNES DU MEME SEXE			
	I. EVITER LES RELATIONS SEXUELLES AVEC DES PERSONNES QUI SE FONT DES INJECTIONS INTRAVEINEUSES DE DROGUES			
	J. EVITER LES TRANSFUSIONS SANGUINES			
	K. EVITER LES INJECTIONS			
	L. EVITER DE S'EMBRASSER			
	M. EVITER LES PIQURES DE MOUSTIQUES			
	N. RECHERCHER UNE PROTECTION AUPRES D'UN GUERISSEUR TRADITIONNEL			
O. EVITER DE PARTAGER RASOIRS/LAMES				
W. AUTRE (PRECISEZ)				
X. AUTRE (PRECISEZ)				
Z. NE SAIT PAS				
63. Est-ce que le virus qui cause le SIDA peut être transmission de la mère à l'enfant? Durant Grossesse? Durant Accouchement? Durant Allaitement?		OUI	NON	NE SAIT PAS
	Durant Grossesse			
	Durant Accouchement			
	Durant Allaitement			

64. Si une mère est infectée avec le virus du SIDA, y a-t-il un moyen d'éviter la transmission au bébé?	1. OUI	
	2. NON	
	8. NE SAIT PAS	

INFECTIONS SEXUELLEMENT TRANSMISSIBLES (IST)

65. (Mis à part le SIDA), avez-vous entendu parler d'(autres) infections qui peuvent être transmises par contact sexuel?	1. OUI	
	2. NON ? PASSER A Q. 72	
	8. NE SAIT PAS ? PASSER A Q. 72	
66. Chez un homme, quels sont les signes ou symptômes qui vous feront penser qu'il a une telle infection ? Aucun autre ? ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.	A. DOULEURS ABDOMINALES	
	B. ECOULEMENT/PERT GENITALE	
	C. ECOULEMENT MALODORANT	
	D. BRULURES URINAIRES	
	E. ROUGEURS/INFLAMMATION DE LA ZONE GENITALE	
	F. GONFLEMENT DE LA ZONE	
	G. PLAIE/ULCERE GENITAL	
	H. VERRUE GENITALE	
	I. SANG DANS LES URINES	
	J. PERTE DE POIDS	
	K. IMPUISSANCE	
	L. PAS DE SYMPTOMES	
	W. AUTRE (PRECISEZ)	
67. Chez une femme, quels sont les signes et symptômes qui vous feront penser qu'elle a une telle infection ? Aucun autre ? ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.	X. AUTRE (PRECISEZ)	
	Z. NE SAIT PAS	
	A. DOULEURS ABDOMINALES	
	B. ECOULEMENT/PERTES GENITALE	
	C. ECOULEMENT MALODORANT	
	D. BRULURES URINAIRES	
	E. ROUGEURS/INFLAMMATION DE LA ZONE GENITALE	
	F. GONFLEMENT DE LA ZONE	
	G. PLAIE/ULCERE GENITAL	
	H. VERRUE GENITALE	
	I. SANG DANS LES URINES	
	J. PERTE DE POIDS	
	K. INCAPACITE DE DONNER NAISSANCE	
L. PAS DE SYMPTOMES		
W. AUTRE (PRECISEZ)		
68. Que peut faire une personne par éviter un Infections Sexuellement Transmissibles (IST)? ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.	X. AUTRE (PRECISEZ)	
	Z. NE SAIT PAS	
	1. _____	
	2. _____	
	3. _____	

69. Est-ce que c'est possible que une Infections Sexuellement Transmissibles (IST) peut affecter une grossesse? Durant Grossesse? Durant Accouchement? Durant Allaitement?		OUI	NON	NE SAIT PAS
	Durant Grossesse			
	Durant Accouchement			
	Durant Allaitement			
SI 'NON' SUR TOUT , PASSER A Q. 72				
70. SI 'OUI' SUR Q. 69, PUIS DEMANDEZ: "En que manière peut une Infections Sexuellement Transmissibles (IST) affecter la résultat de une grossesse?"	1. _____ 2. _____ 3. _____			
71. Ou est-ce que une personne peut aller pour la traitement de une Infections Sexuellement Transmissibles (IST) ?	A. HOPITAL			
	B. CENTRE DE SANTE			
	C. CENTRE ONG			
	D. POSTE DE SANTE			
	E. CLINIQUE PLANIFICATION FAMILIAL			
	F. AGENT DE SANTE DE TERRAIN/COMMUNAUTAIRE			
	G. PHARMACIE			
	H. AUTRE ETABLISSEMENT DE SANTE (SPECIFY)			
	I. BOUTIQUE			
	J. EGLISE			
K. AMI/PARENTS				
X. AUTRE (PRECISEZ)				
Z. NE SAIT PAS				

DEPISTAGE DE VIH

72. Comment est-ce que une personne peut découvrir si il/elle a VIH (le virus qui cause SIDA)?	A. ALLEZ POUR UNE TEST		
	B. ALLEZ A LA CENTRE DE SANTE		
	C. ALLEZ A UNE CENTRE DE CONSEILLER OU EXAMINATION		
	X. AUTRE (PRECISEZ) _____		
	Z. NE SAIT PAS		
73. Connaissez-vous une centre de conseiller ou examinateur de VIH/SIDA?	1. OUI		
	2. NON ? PASSER A Q. 78		
74. Est-ce qu'on vous a offert une test du SIDA comme parte de votre soins antenatal?	1. OUI		
	2. NON ? PASSER A Q. 78		
75. Je ne veux pas connaître vos resultats, mais est - ce que on vous a testé pour le SIDA comme parte de votre soins antenatal?	1. OUI		
	2. NON ? PASSER A Q. 78		

<p>76. Ou se faisait le test du SIDA?</p> <p>[ENREGISTREZ TOUT CE QUI EST MENTIONNÉ.</p> <p>SI LE SOURCE EST UNE HOPITAL, CENTRE DE SANTE, OU CLINIQUE, S'IL VOUS PLAIT, ECRIVEZ LE NOM DE LA PLACE CE DESSUS.]</p> <p>_____</p> <p>(NOM DE LA PLACE OU ON SE FAISAIT)</p>	SECTEUR PUBLIQUE	
	01. HOPITAL GOVT.	
	02. CENTRE DE SANTE GOVT.	
	03. CENTRE DE CONSEILLER OU EXAMENATION	
	04. CLINIQUE PLANIFICATION FAMILIAL	
	05. CLIQUE MOBILE	
	06. AGENT DE SANTE DE TERRAIN	
	07. AUTRE PUBLIQUE _____ (PRECISEZ)	
	SECTEUR PRIVEE	
	08. HOP/CLINIQUE/DOCTEUR PRIV.	
	09. CEN TRE DE CONSEILLER OU EXAMENATION	
	10. PHARMACIE	
	11. CLIQUE MOBILE	
	12. AGENT DE SANTE DE TERRAIN	
13. AUTRE PRVEE _____ (PRECISEZ)		
14. AUTRE (PRECISEZ)		
<p>77. Pour vous rappeler, je ne veux pas connaître les résultats, mais avez-vous reçu les résultats du test?</p>	1. OUI	
	2. NON	

PRACTIQUE DU LAVAGE DES MAINS

<p>78. Avant de terminer, j'aimerais vous poser une dernière question. Quand vous lavez-vous les ma ins avec du savon/détergent?</p> <p>PRENDRE VOTRE TEMPS. ENTOURER TOUS CE QUI A ETE MENTIONNE PAR L'INTERVIEWEE..</p>	A. JAMAIS	
	B. AVANT DE PREPARER LE REPAS	
	C. AVANT DE NOURRIR LES ENFANTS	
	D. APRES ETRE ALLER AUX TOILETTES	
	E. APRES AVOIR NETTOYE UN ENFANT QUI A ETE A LA SELLE	
	X. AUTRE (PRECISEZ) _____	

MERCI POUR VOTRE TEMPS ET POUR REpondre A CES QUESTIONS.
SI VOUS AVEZ D'AUTRE QUESTION, S'IL VOUS PLAIT PARLEZ AVEC LES
PROFESSIONELLES MEDICAUX A LA CENTRE DE SANTE LE PLUS PROCHE.

Appendix 4: Survey Personnel and Roles

	Name	Role
1.	Angela Thompson	Survey Coordinator
2.	Dr. Elliott Jean Pierre	Program Manager
3.	M.	Statistician
4.	Mme.	Secretary
5.	Edouard	Driver
6.	Nicole Nelson	**Supervisor, Zone 2
7.	Melivert St. Marc	Supervisor, Zone 3 * Interviewer, Zone 2
8.	Josué Dorvilias	Supervisor, Zone 4
9.	Benoît	Supervisor, Zone 5
10.	Cidaël Calixte	Interviewer, Zone 1 * Interviewer, Zone 2
11.	Suze Pascal	Interviewer, Zone 1 * Interviewer, Zone 2
12.	Fanes Jean Jaques	**Interviewer, Zone 2
13.	Verdine Faublas	**Interviewer, Zone 2
14.	Manius Gerard	**Interviewer, Zone 2
15.	Yolette St. Michel	Interviewer, Zone 3
16.	Michel Saintons	Interviewer, Zone 3
17.	Gardel Badette	Interviewer, Zone 3
18.	Chantal Joseph Pluvoise	Interviewer, Zone 4
19.	Arcene Borange	Interviewer, Zone 4
20.	Vergin Jean Raymond	Interviewer, Zone 4
21.	François Bonhomme	Interviewer, Zone 5
22.	Dessejour Germain	Interviewer, Zone 5
23.	St. Hilaire Marie Carmen	Interviewer, Zone 5
<p>* Interviewers in Zone 2 during the 2nd round of data collection. Data collected by this team was included in the final data analysis and replaced the data collected by the team in Zone 2 during the 1st round of data collection.</p> <p>** Supervisor and Interviewers in Zone 2 during 1st round of data collection. Data collected by this team was not included in the final analysis.</p>		

Appendix 6: Training Schedule

KPC₂₀₀₀ Rapid Core Assessment Tool on Child Health (CATCH) Training of Surveyors and Survey Supervisors

Day 1

Objectives-- By the end of this training session, participants will be able to:

- Explain the purpose of this survey
- Identify participating organizations, personnel, and role of personnel
- Explain the role of the supervisors and surveyors
- Identify whether s/he would like to be considered for a role as surveyor, supervisor, or either position
- Explain the Informed consent including how and when to use it.
- Be familiar with data collection protocol
- Demonstrate proper interview techniques
- Be familiar with the first 1/3 of questions on questionnaire and demonstrate capability to fill out the questionnaire
- Demonstrate ability to properly read and use baby weighing scale
- Explain why questions in each section are important

Materials required:

- 20 pencils
- 20 pens
- 20 Training manuals including:
 - Chart of organizations and personnel
 - Role of supervisors, surveyors
 - Copy of informed consent
 - Copy of training version of questionnaire
 - Survey protocol
- 12 baby weighing scales

Methods:

- In class instruction/discussion
- Role plays

Day 2

Objectives-- By the end of this training session, participants will be able to:

- Be familiar with all questions on questionnaire
- Demonstrate capability to fill out the questionnaire
- Demonstrate proper interview techniques

Materials required: (distributed in Day 1 of training)

- 20 pencils
- 20 pens
- 20 Training manuals including:
 - Chart of organizations and personnel

Appendix 6: Training Schedule

- Role of supervisors, surveyors
- Copy of informed consent
- Copy of training version of questionnaire
- Survey protocol

Methods:

- In class instruction/discussion
- Role plays
- Field testing of questionnaire

Day 3, part I : all participants

Objectives--

- Identify supervisors and surveyors
- Identify 4 person survey teams
- Survey teams will know the time and place that they will meet the following day to begin data collection

Day 3, part II : supervisors only

Objectives-- By the end of this training session, survey supervisors will be able to:

- Use the supervisor quality control checklist
- Explain their additional duties including
 - Reviewing every questionnaire from their survey team each day for errors prior to turning them into Survey coordinators
 - Observe at least one interview per interviewer each day.
 - Team meetings

Materials required: (distributed in Day 1 of training, except for QC checklist which should be distributed now.)

- 20 pencils
- 20 pens
- 20 Training manuals including:
 - Chart of organizations and personnel
 - Role of supervisors, surveyors
 - Copy of informed consent
 - Copy of training version of questionnaire
 - Survey protocol
- Supervisor quality control checklists

Appendix 7: Training Protocol

LES OBJECTIFS DE L'ENQUETE

**LE BUT SUPREME DU PROJET EST DE REDUIRE LA MORBIDITE
ET LA MORTALITE DES ENFANTS MOINS DE 5 ANS.**

LES BUTS DE CE PROJET INCLU ENT :

- IMMUNISATION OPPORTUNE ET COMPLETE DES ENFANTS EN BAS AGE,
- AUGMENTEZ LA PRATIQUE DES COMPORTEMENTS QUI REDUISENT LE RISQUE DE MALADIES INFANTILES COMMUNES,
- AMELIOREZ L'ASSURANCE PRENATALE DE SOIN,
- AUGMENTEZ LES ACCOUCHEMENTS SAIN (DIMINUER LES ACCOUCHEMENT EN HAUT RISQUE),
- AUGMENTEZ LE CONTACT POST-PARTUM AVEC UN PROFESSIONNEL DE SANTE,
- AUGMENTEZ LA CONSCIENCE AU SUJET D'ESPACEMENT DE NAISSANCE DES ENFANTS.
- AUGMENTEZ LA CONNAISSANCE AU SUJET DE LA PREVENTION ET DE LA DETECTION DE VIH ET DES INFECTIONS SEXUELLEMENT TRANSMISSIBLES

LE BUT DE L'ENQUETE :

- LE CPC EST L'UNE DES DIVERSES METHODES DE RASSEMBLEMENT DE L'INFORMATION QUI SERONT EMPLOYEES POUR IDENTIFIER DES PROBLEMES ET POUR MONITER LE PROGRES.
- CET ENQUETE AIDERA COD-EMH ET ACTION GLOBALE DE SANTE DANS L'IDENTIFICATION ET LA PRIORITIZATION DES PROBLEMES DE SANTE DANS LA POPULATION DE LA ZONE DU PROJET - LES 12 SECTIONS DANS LA ZONE DE PETIT GOAVE.

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LE PROTOCOLE

QUI PEUT PARTICIPER EN CETTE ENQUETE ?

- Les mères entre l'âge de 15 -45 ans ET con au moins un(e) enfants qui a l'âge moins que 2 ans.

LES POINTES IMPORTANTE DE SOUVENIR

- Toujours, soyez poli, respectueux, et ne vous enclin pas à juger
- Avant de commencer l'interview, présentez vous -même et nous organisations et le but général de l'enquête. Lisez le **Consentement Informé**.
- Les réponses de mères son confidentiel. Si il y a d'autres personnes au tour de la participant, demandez avec politesse de parler seulement avec la mère.
- Au debut, posez chaque question exactement com me on lui écrit. Quand des questions doivent être répétées, employez les expressions et les changements mineurs de mots qui ont été convenus pendant la formation.
 - **Pourquoi ?**
 - NOUS DEVRONS UTILISER TOUTES LES MEMES QU ESTIONS POUR TOUS LES 300 MENAGES A FIN DE COMPARER TOUS LES REPNSES.
- Assurer l'interviewée que vous êtes intéresse en ses avis et ses expériences. Ne suggérez pas que une reponse est meilleur que l'autre.
 - **Pourquoi ?**
 - RAPELLEZ-VOUS LES BUT DU PROJ ET. SI NOUS VOULONS AMELIORER LA SANTE E NFANTILE ET MATERNELLE , NOUS DEVONS SAVOIR SES COMPREHEN SIONS ACTUALLES AU S UJET DE LA SANTE . SI NOUS SAVONS CE QU 'ILS COMPRENENT MAIN TENANT, NOUS POUVONS MIEUX FORMUL ER DES PROGRAMMES PO UR VISER LEURS BESOINS DE SANTE.
- Si une participante en l'enquête a des inquiétudes, questions, ou il y a quelque chose qui se présente pendant une interview :
 - notez-la et comment vous avez répondu
 - Si vous n'avez pas la réponse pour ces inquiétudes/questions, referez -elle a votre superviseur ou à Dr. Pierre ou a Angela Thompson.
 - Nous pouvons discuter ces inquiétudes et ces questions pendant la prochaine réunion.

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CONTENU ET FORMAT DE QUESTIONNAIRE

CONSENTEMENT INFORMÉ

Avant d'interroger une mère, vous devez obtenir son consentement pour effectuer l'interview. Vous lirez le consentement informé exactement comme il est rédigé. Dans cette phrase, nous expliquons les objectifs de l'enquête et le caractère volontaire de la participation de l'enquêtée; ensuite nous lui demandons sa coopération. Après avoir lu cette phrase, vous (et non l'enquêtée) devez signer dans l'espace prévu pour signifier que vous avez lu le consentement à la mère.

- Encerclez '1' si la mère accepte d'être enquêtée et commencez à poser les questions du module.
- Si la mère ne donne pas son accord, encerclez '2', remerciez-la de vous avoir consacré un peu de son temps et terminez l'interview.

PAGE DE COUVERTURE : NUMÉROS D'IDENTIFICATION

Les informations enregistrées dans le cadre intitulé « Identification » sont les seules qui permettent de « rattacher » l'enfant à sa mère dans tous les modules. En plus de la case qui figure sur la page de couverture, il y a une case d'identification en haut de chaque module de l'enquête. Il est important que vous enregistriez toutes les informations nécessaires avant de poser les questions à la mère. Votre superviseur vous fournira les numéros d'identification appropriés pour chaque grappe, ménage et enquêtée (enregistrement).

PAGE DE COUVERTURE: INFORMATION SUR L'INTERVIEW ET L'ENQUÊTEUR

Dans le cadre 2, vous inscrirez la date de l'interview, en enregistrant le jour puis le mois et enfin l'année dans les cases prévues. Ensuite, vous inscrirez votre nom, le nom de votre superviseur et le nom de la communauté dans laquelle vous effectuez l'interview.

COMPLÉTER LES INFORMATIONS D'IDENTIFICATION

Avant de commencer à poser les questions à la mère, enregistrez les numéros de grappe, de ménage et d'enregistrement en haut du questionnaire. Il s'agit des mêmes informations que celles que vous avez enregistrées sur la page de couverture de l'enquête.

- C = Numéro de Grappe
- H = Numéro de ménage
- R = Numéro d'enregistrement
- I = Les initiales d'enquêteur

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Information Demographique

Ce section comprend trois questions concernant des caractéristiques générales importantes des enquêtées.

- POSER LES QUESTIONS ET ENREGISTRER LES RÉPONSES

Les informations que vous allez enregistrer dans ce module sont basées uniquement sur les réponses données par la mère. Il est très important que vous posiez chaque question exactement de la façon dont elle est écrite dans le questionnaire. En plus des questions, **il y a des phrases écrites en lettres capitales, ce qui indique qu'il s'agit d'instructions données aux enquêteurs et qui ne doivent pas être lues à la mère.**

Q.2: NIVEAU D'INSTRUCTION DE LA MÈRE

Enregistrez l'âge de la mère en années révolues qui est son âge à son dernier anniversaire. Il est important que vous enregistriez un âge pour la mère et vous pouvez procéder de trois manières, cela dépendant du type d'information dont vous disposez.

- 1) Si la femme connaît son âge, inscrivez -le tout simplement dans l'espace prévu.
- 2) Si la femme ne connaît pas son âge, mais connaît son année de naissance, utilisez le tableau de conversion suivant pour déterminer son âge actuel.

Q.3: NIVEAU D'INSTRUCTION DE LA MÈRE

Le terme « 'école » utilisé ici se rapporte uniquement à l'école formelle qui inclut les niveaux primaire, secondaire et supérieur, ainsi que d'autres niveaux scolaires intermédiaires du système scolaire formel. Dans cette définition, les écoles bibliques ou coraniques ainsi que les cours pour apprendre à taper ou à coudre ne sont pas pris en compte. Par contre, les formations techniques ou professionnelles après l'école primaire, comme des formations à long terme de mécanique ou de secrétariat sont comprises dans la définition. Si la mère déclare qu'elle n'a jamais fréquenté l'école, enregistrez '00'. Dans tous les autres cas, enregistrez le nombre d'années effectuées.

L'Information Demographique

Ce partie comprend trois questions dont l'objectif est d'évaluer quel est le niveau de contact des enquêtées avec les agents de santé du secteur formel et du secteur informel. Le module fournit également des renseignements sur les sources d'informations en matière de santé et de nutrition. Notez que ce module ne contient pas de plan de tabulation ni de liste proposition d'indicateurs.

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Q.5: FRÉQUENCE DES CONTACTS

À la Question 5, vous estimez la fréquence à laquelle la mère entre en contact avec différents types de prestataires, du secteur formel ou informel. Pour chaque type de prestataire, demandez à la mère si elle entre en contact avec cette personne souvent, de temps en temps ou jamais. Marquez le code correspondant à la réponse pour chaque prestataire.

Q.6 : SOURCES D'INFORMATION

À la Question 6, vous demanderez à la mère où elle obtient des informations ou des conseils d'ordre général en matière de santé et de nutrition. Cette question utilise des codes alphabétiques et non numériques pour vous rappeler qu'il est possible d'obtenir plus d'une réponse. Marquez tous les codes correspondant à ce qui est mentionné par la mère.

Q.7: MASS MEDIA ET ÉDUCATEURS SANITAIRES

A la Question 7, vous demanderez à la mère si elle a reçu des messages en matière de santé par le biais de : la radio, télévision, journaux, par le biais d'éducateurs sanitaires et par les agents de santé communautaire. Vous devez encercler 1 (OUI) ou 2 (NON) pour chaque catégorie.

Informations sur la Mère

Ce que nous savons : l'intervalle de naissance d'au moins 24 mois (le temps minimum recommande entre deux grossesses successives) est associé à de faibles risques de mortalité et de morbidité chez les enfants. Le tableau en question 12 sera utilisé pour estimer le nombre de temps passé entre les naissances des deux plus jeunes enfants de l'interviewée. Il est à noter, cependant, que cette question ne tient compte que des enfants survivants et par conséquent ne reflète pas exactement l'espacement des naissances dans la communauté ciblée.

Q.8-11: NOMBRE D'ENFANTS

Le nombre d'enfants de moins de cinq ans donne une indication de l'espacement des naissances et de la compétition qui peut exister, dans un ménage, entre les enfants pour accéder aux ressources. Dans la question 10, enregistrez le nombre total d'enfants de moins de cinq ans vivant dans le ménage. Dans la question 11, enregistrez le nombre de ces enfants qui sont les enfants biologiques de l'enquêtée.

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Q. 13: PÈRE BIOLOGIQUE

Cette question est pour l'objectif de fournir des informations sur la structure du ménage.

B. Anthropométrie

Ce que nous savons : Dans les pays pauvres, la malnutrition est un facteur qui contribue à plus de la moitié des décès des enfants de moins de cinq ans. Les mensurations corporelles (taille et poids) reflètent l'état de santé et de bien-être des individus et de la population. Le taux de prévalence des faibles poids selon l'âge (petit -poids) peut être utilisé pour mesurer les interventions en nutrition et c'est un indicateur requis pour tous projets financés par l'USAID (Programme d'Assistance Alimentaire) Titre II

- Pendant la formation, nous allons pratiquer la technique pour peser l'enfant.

Santé de la mère et du nouveau-né

Ce que nous savons : Le tétanos néonatal est la plus grande cause de décès au sein des enfants, maladie qui aurait pu être prévenue par un vaccin. Une femme en état de grossesse doit recevoir au moins deux injections anti-tétaniques pour protéger son bébé du tétanos. Les accouchements assistés par des professionnels de santé sont aussi recommandés pour apporter un maximum de sécurité à l'accouchement dans des conditions d'hygiène optimale et dans la reconnaissance rapide, le traitement et/ou la référence des cas de complications au niveau de la mère et/ou du bébé.

Allaitement et Nutrition

Ce que nous savons : L'allaitement exclusif du nourrisson jusqu'à six mois, alimentation complémentaire à partir de 6 mois et poursuite de l'allaitement maternel jusqu'à 24 mois sont des habitudes alimentaires essentielles qui visent à améliorer l'état nutritionnel et de santé du nourrisson et du jeune enfant. La mise au sein immédiate réduit les risques d'hypothermie du nouveau-né et permet au nourrisson de bénéficier des bienfaits nutritionnels et antibactériens/anti-viraux du colostrum de la mère. Par ailleurs la mise au sein immédiate est idéale, débiter l'allaitement dans les premières heures de vie laisse peu de chance à l'introduction d'aliments lactés et conduit à adopter les bonnes habitudes de nutrition du nourrisson.

Q.36: QUAND A COMMENCÉ L'ALLAITEMENT ?

L'allaitement maternel immédiat permet à l'enfant de bénéficier des avantages nutritionnels du lait maternel et de la protection des anticorps de la mère contenus dans le

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colostrum. Le colostrum est un liquide jaune et plus épais que le lait qui vient plus tard, et il est riche en anticorps et en globules blancs. Il donne à l'enfant une protection contre les bactéries et les virus auxquels il peut être exposé. L'allaitement immédiat permet également au corps du bébé de garder sa chaleur après l'accouchement. À la Question 2, enregistrez si le bébé a été mis au sein dans l'heure qui a suivi l'accouchement ou après la première heure qui a suivi la naissance

Q37: LIQUIDES ET ALIMENTS DONNÉS HIER

L'objectif de ces questions est d'obtenir la meilleure liste possible de tous les aliments pris par le nourrisson. Vous demanderez à la mère quels sont les types de liquides et d'aliments qui ont été donnés à l'enfant le jour précédant l'interview. Les éléments sont groupés selon qu'ils sont liquides ou solides/semi-solides. Lisez lentement la question et ensuite lisez les éléments sur la liste. Attendez la réponse de la mère et enregistrez si l'enfant a mangé chaque élément (ou un ensemble d'éléments).

Si aucun élément dans une catégorie n'a été donné à l'enfant le jour précédant l'interview, laissez la case en blanc et allez à la catégorie suivante.

Q.38, 40-45 : EXAMEN POSTPARTUM

Il est important que l'état de santé de la mère et du bébé soit évalué durant les premières semaines qui suivent l'accouchement. À la Question 38, vous encerclez 1 si la mère déclare que quelqu'un a l'a examinée. Si (NOM) est né dans un établissement de santé (Q45) et si la mère a eu un examen post-partum dans l'établissement avant qu'elle parte, on considère qu'elle a bénéficié de soins post-partum. Cette question ne porte que sur l'examen de santé de la mère. À la Question 40, vous enregistrez combien de temps après l'accouchement a été effectué le premier examen de santé. Si la mère donne une réponse en jours, encerclez 1 et complétez le nombre de jours dans les cases prévues. Si la réponse est en semaines, encerclez 2 et complétez le nombre de semaines. N'oubliez pas d'inscrire un zéro dans la première case si la mère déclare un nombre inférieur à 10.

Aux Questions 41 et 44, vous insisterez pour savoir qui est la personne qui a examiné la mère. Si la mère mentionne plus d'une personne, encerclez le code de la personne la plus qualifiée qui figure sur la liste. Par exemple, si la mère déclare que l'examen a été effectué par une infirmière/sage-femme et une accoucheuse traditionnelle, vous encerclez 2 (infirmière/sage-femme) puisque cette personne est la plus qualifiée des personnes mentionnées.

Q. 42 : EXAMEN DU BÉBÉ

Un examen médical après l'accouchement est aussi important pour la mère que pour l'enfant. Aux Questions 42, demandez à la mère si la personne qui a contrôlé son état de santé a aussi vérifié dans quelles conditions se trouvait (NOM).

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Q.39 : A REÇU DES INFORMATIONS SUR LA SANTÉ ET SUR L'ESPACEMENT DES NAISSANCES AU MOMENT DE L'EXAMEN POSTPARTUM

L'examen après l'accouchement est l'occasion d'informer les mères sur l'espacement des naissances, sur les vaccinations et sur la santé des enfants. Ces questions permettent de se rendre compte si les prestataires profitent de cette occasion pour leur donner des conseils.

Q.46: CONNAISSANCE D'UN ENDROIT OÙ OBTENIR DES MÉTHODES D'ESPACEMENT DES NAISSANCES/PLANIFICATION FAMILIALE

À la Question 46, vous demanderez à la mère si elle connaît un endroit où elle pourrait obtenir une méthode d'espacement des naissances/planification familiale. Si la réponse est OUI, demandez: « Où est -ce? » Si elle donne plus d'une source d'espacement des naissances/planification familiale, enregistrez toutes les sources mentionnées. Cette question utilise des codes alphabétiques pour vous rappeler qu'il est possible d'obtenir plus d'une réponse. Si l'une des sources est un hôpital, un centre de santé ou une clinique, écrivez le nom de cet établissement dans l'espace prévu à cet effet dans la première colonne.

Q.47: ACTUELLEMENT ENCEINTE

La Question 47 permet d'identifier les mères qui sont enceintes au moment de l'enquête. Si la mère n'est pas sûre si elle est enceinte ou non, encerclez 8 [PAS SÛRE].

Q.49: DÉsir D'AVOIR UN AUTRE ENFANT ET À QUEL MOMENT

Vous ne posez la Question 49 que si la mère n'est pas actuellement enceinte ou si elle n'est pas sûre si elle est enceinte ou non.

Q.50: UTILISATION ACTUELLEMENT D'UNE MÉTHODE D'ESPACEMENT DES NAISSANCES

Comme les méthodes sont efficaces pour des périodes plus ou moins longues, vous pourrez avoir des difficultés à décider si certaines mères utilisent ou non, actuellement, une méthode. Les méthodes en rapport direct avec l'acte sexuel, comme le condom, les méthodes de barrière et le retrait sont utilisées au cours de chaque acte sexuel : les utilisatrices actuellement de ces méthodes sont les femmes qui les ont utilisées au cours de l'acte sexuel le plus récent. Les utilisatrices actuelles de la pilule sont celles qui prennent actuellement la pilule chaque jour. Les autres méthodes fournissent une protection continue sans que la femme ait à faire quelque chose quotidiennement ou régulièrement. Par exemple, les injections contraceptives peuvent avoir été faites 2-6 mois plus tôt mais toujours fournir une protection ; le Norplant fournit une protection

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pendant 5 ans ou jusqu'à ce qu'il soit retiré. Le DIU, une fois inséré, fournit une protection contre la grossesse jusqu'à ce qu'il soit retiré ou expulsé. Si la femme est stérilisée, vous enregistrez LIGATURE DES TROMPES comme méthode actuelle : ou si le partenaire actuel de la femme a été stérilisé, vous enregistrez VASECTOMIE comme méthode actuelle. Par contre, si elle n'est plus mariée à (ou ne vit plus avec) un ancien partenaire qui a eu une vasectomie, ceci ne doit pas être considéré comme une méthode actuelle.

Vaccination Infantile

Ce que nous savons : (1) Certaines grandes causes de morbidité, handicap et mortalité au sein des enfants sont prévenues par vaccination. La période est très importante : un enfant doit être complètement vacciné contre les cinq maladies prévenues par vaccination (poliomyélite, diphtérie, coqueluche, tétanos et rougeole) avant son premier anniversaire. (2) Dans un cadre où le déficit en vitamine A est problématique, l'apport supplémentaire en vitamine A a aussi un intérêt coût-efficace dans l'amélioration des résultats de la santé de l'enfant

La rougeole est une des premières causes de mortalité au sein des enfants dans le Monde. Par conséquent, la prévention de la rougeole a été identifiée comme une priorité majeure pour la survie de l'enfant dans la communauté. Ce questionnaire apporte deux options aux projets de Survie de l'Enfant :

A) Evaluer la couverture complète de vaccination avant un an [Qs 14 et 15] en utilisant les informations notées sur le carnet de vaccination des enfants.

B) Evaluer la couverture vaccinale de la rougeole [Q 16] en fonction des réponses des mères au sujet de la vaccination contre la rougeole

Alors que la couverture complète de vaccination avant un an ne peut être évaluée au niveau des enfants qu'avec le carnet de vaccination, les projets qui choisissent l'Option B doivent demander à toutes les mères – qu'elles aient ou non un carnet de vaccination – si leur enfant a reçu le vaccin contre la rougeole..

Q.51 : CARNET DE VACCINATION

Si la mère dit qu'elle possède un carnet de vaccination pour (NOM), demandez -lui alors : « Puis -je le voir ? » Il se peut que la mère ne veuille pas prendre le temps de chercher le carnet, pensant que vous êtes pressé. Encouragez -la à chercher le carnet de (NOM). Il est essentiel d'obtenir un document écrit des vaccinations de l'enfant. Cependant, soyez patient si l'enquêtée doit chercher le carnet.

Si la mère vous montre le carnet, marquez 1 [OUI, VU]. Marquez 2 [PAS DISPONIBLE] si la mère dit que (NOM) a un carnet mais qu'elle ne le trouve pas parce a) elle l'a perdu, b) c'est quelqu'un d'autre qui l'a, ou c) elle n'y a pas accès durant l'interview. Si la mère

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dit qu'elle n'a jamais eu de carnet pour (NOM), marquez 3 [N'A JAMAIS EU DE CARNET].

Q.52 : ENREGISTRER LES VACCINATIONS

Si la mère vous montre un carnet de vaccination, complétez les informations de la Question 52, en prenant les informations directement du carnet. Avant d'enregistrer les informations, soyez sûr qu'il s'agit bien du carnet de (NOM). Quand vous lisez le carnet de vaccination, faites très attention. Les dates doivent être enregistrées en inscrivant en premier le jour, puis le mois et ensuite l'année. Regardez bien le carnet pour vérifier l'ordre dans lequel les dates sont enregistrées, parce que parfois le mois peut être inscrit en premier, suivi du jour et de l'année. Veillez à inscrire correctement les dates.

En plus d'enregistrer les dates des vaccinations sur le carnet, certains établissements de santé inscrivent aussi les dates (rendez-vous) auxquelles la mère doit ramener l'enfant pour les vaccinations suivantes. Faites attention à ne pas enregistrer une date de rendez-vous à la place d'une date de vaccination. Il est possible qu'une date pour un rendez-vous ait été fixée mais que l'enfant n'ait jamais reçu la vaccination. Enregistrez seulement les dates quand les vaccinations ont été effectivement données et pas les dates de rendez-vous. Soyez patient et lisez bien les carnets.

Si le carnet indique qu'une vaccination a été effectuée mais que la date n'est pas inscrite, enregistrez 44 à la colonne JOUR à côté du vaccin et laissez le mois et l'année en blanc. Cependant, si une date est inscrite pour le DTCoq et qu'il n'y a qu'une simple marque qui indique que le vaccin de la polio a été effectué, enregistrez la date du vaccin du DTCoq sur la ligne de la polio, car cette marque signifie très probablement que les deux vaccins ont été effectués le même jour. Certains carnets de vaccination ne comprennent qu'une seule ligne pour le DPCoq 1 et la Polio1, le DPCoq2 et la Polio2, etc. Si il y a une date sur l'une de ces lignes, enregistrez la même date pour les vaccins du DPCoq et de la polio.

Q.53 : VACCINATION POUR LES ENFANTS QUI N'ONT PAS DE CARNET

Si vous n'avez pas vu le carnet de vaccination de l'enfant et que la mère déclare que l'enfant a reçu au moins un vaccin, posez la question 53 sur la rougeole.

Lisez la question 53 (« Est-ce que (NOM) a déjà reçu une injection pour prévenir la rougeole ? ») Il y a plusieurs types de vaccins et il est important que la mère sache à quel vaccin se rapporte la question. Lisez entièrement la phrase avant d'accepter la réponse de la mère.

Appendix 7: Training Protocol

Prévention du Paludisme

Ce que nous savons :

Dans les pays où le paludisme existe de manière endémique, la maladie a des effets nefastes sur la santé et la survie des jeunes enfants. Un des moyens de réduire la transmission du paludisme est l'utilisation des moustiquaires imprégnées

Prise en Charge Intégrée des Maladies de l'Enfance (PCIME)

Ce que nous savons : Ces dernières années, il a eu une tendance vers la prise en charge intégrée des principales causes de décès durant l'enfance : pneumonie/infection respiratoire aigue, diarrhée, rougeole, paludisme et malnutrition.

La PCIME communautaire nécessite la reconnaissance de signes clés des maladies pour garantir le traitement, la prise en charge effective des maladies infantiles à domicile et rechercher les soins adéquats et à temps, en dehors de la maison quand nécessaire.

C. VIH/SIDA

Du fait de l'impact du SIDA sur les différents facteurs de développement et sur plusieurs générations au niveau mondial, un nombre croissant d'Organisations Privées (ONGs) ont ajouté des activités relatives au VIH/SIDA dans leurs projets de Survie de l'Enfant. Habituellement, la stratégie des ONGs est axée sur le développement des connaissances et de prise de conscience des communautés. Certaines ONGs ont commencé à explorer les moyens d'améliorer l'impact néfaste de la maladie sur les enfants et les communautés. Quoiqu'il en soit, une large diffusion d'informations sur le mode de transmission du VIH est un premier pas important dans l'arrêt de la propagation du VIH/SIDA.

D. Pratique du lavage des mains

Ce que nous savons : Le lavage des mains aux moments adéquates est une façon de prévenir la diffusion de maladie. L'OMS et l'UNICEF reconnaissent le lavage approprié des mains comme étant une pratique clé des familles pour améliorer la santé et la nutrition de l'enfant dans les communautés. Le projet de Santé Environnemental de l'USAID admet aussi que le grand changement des communautés dans les pratiques d'hygiène est important dans la réduction des maladies et décès au niveau des jeunes enfants.

Appendix 7: Training Protocol

L'AGE DE LA MERE

Enregistrez l'âge de la mère en années révolues qui est son âge à son dernier anniversaire. Il est important que vous enregistriez un âge pour la mère et vous pouvez procéder de trois manières, cela dépendant du type d'information dont vous disposez.

- 1) Si la femme connaît son âge, inscrivez -le tout simplement dans l'espace prévu.
- 3) Si la femme ne connaît pas son âge, mais connaît son année de naissance, utilisez le tableau de conversion suivant pour déterminer son âge actuel.

ANNÉE DE NAISSANCE	ÂGE ACTUEL	
	N'a pas eu son anniversaire en 2005	A déjà eu son anniversaire en 2005
1995	9	10
1994	10	11
1993	11	12
1992	12	13
1991	13	14
1990	14	15
1989	15	16
1988	16	17
1987	17	18
1986	18	19
1985	19	20
1984	20	21
1983	21	22
1982	22	23
1981	23	24
1980	24	25
1979	25	26
1978	26	27
1977	27	28
1976	28	29
1975	29	30

ANNÉE DE NAISSANCE	ÂGE ACTUEL	
	N'a pas eu son anniversaire en 2005	A déjà eu son anniversaire en 2005
1974	30	31
1973	31	32
1972	32	33
1971	33	34
1970	34	35
1969	35	36
1968	36	37
1967	37	38
1966	38	39
1965	39	40
1964	40	41
1963	41	42
1962	42	43
1961	43	44
1960	44	45
1959	45	46
1958	46	47
1957	47	48
1956	48	49
1955	49	50

Appendix 8: Population Data for Cluster Sampling

Table 1. Calculating the Sampling Interval for the District of Petit Goave	
SAMPLING INTERVAL =	$\frac{\text{Total population to be surveyed}}{\text{Number of clusters}}$
A = TOTAL POPULATION IN THE PROGRAM AREA	= 8,202
B = TOTAL NUMBER OF CLUSTERS IN THE SURVEY	= 30
C = A ÷ B (8,202 ÷ 30)	= 273

Table 2. Selection and distribution of 30 Clusters using Systematic Sampling			
Sampling Interval = 273			
Name of Community	Population (total # of HH)	Cumulative Population	Cluster
1ere Plaine	864	864	1, 2, 3
2ere Plaine	995	1,859	4, 5, 6
3eme Trou Chouchou	356	2,215	7,8
4eme Fond Arabie	571	2,786	9, 10
5eme Trou Canari	850	3,636	11, 12, 13
6eme Trou Canari	278	3,914	14
7eme Platon	1,571	5,485	15, 6, 17, 18, 19, 20
8eme Platon	475	5,960	21
9eme Les Palmes	909	6,869	22, 23, 24, 25
10eme Les Palmes	232	7,101	26
11eme Ravine Seche	503	7,604	27, 28
12eme Des Fouques	598	8,202	29, 30

Appendix 9: Sampling: Organization of Teams, Zones and Clusters

Zones were divided by roughly the same number of interviews per interviewer per day. Distance to cover and terrain were taken into account when assigning clusters. Zone 5 was both difficult to travel to and travel within. Additionally, homes in Zone 5 are generally farther apart therefore the number of interviews per day per interviewers was greatly reduced. In contrast, Zone 1 contained the Town of Petit Goave and the nearby areas. It was relatively quick and easy to traverse this zone therefore the number of interviews per day per interviewer were increased.

Zone #	Section #	Total # of Clusters per section	# of Interviews per section	Actual Assigned Cluster # (# which appears on KPC form)	# of interviews per day per interviewer	Interview Teams
Zone 1	11eme Ravine Seche	1	10			<ul style="list-style-type: none"> •Cidael Calixte •Suze Pascal •Dr. E.J. Pierre •Angela Thompson
	12eme Des Fouques	3	30			
	1ere Plaine	1	10			
Total Zone 1		5	50	1, 2, 3, 4,5	8.3	
Zone 2	1ere Plaine	2	20			<ul style="list-style-type: none"> *Cidael Calixte *Suze Pascal *Melivert St. Marc *Dr. E.J. Pierre
	3eme Trou Chou Chou	2	20			
	2eme Plaine	3	30			
*Total Zone 2		7	70	*6, 7, 8, 9,10, 11, 12	7.8	
Zone 3	4eme Fond Arabie	2	20			<ul style="list-style-type: none"> •Yolette St. Michel •Michel Saintons •Gardel Badette •Melivert St. Marc
	5eme Trou Canari	3	30			
	6eme Trou Canari	1	10			
Total Zone 3		6	60	13, 14, 15, 16, 17, 18	6.7	
Zone 4	7eme Platon	6	60			<ul style="list-style-type: none"> •Chantal Joseph Pluvoise •Arcene Borange •Vergin Jean Raymond •Josué Dorvilias
	8eme Platon	1	10			
Total Zone 4		7	70	19, 20, 21, 22, 23, 24, 25	7.8	
Zone 5	9eme Des Palmes	4	40			<ul style="list-style-type: none"> •François Bonhomme •Dessejour Germain •St. Hilaire Marie Carmen •Benoît Jn Baptiste
	10 Des Palmes	1	10			
Total Zone 5		5	50	26, 27, 28, 29, 30	5.6	

Appendix 10: Age Distribution of Children in Survey

Ages of Children in Months	Frequency	Percent	Cumulative Percent
0	16	5.56	5.56
1	18	6.25	11.81
2	19	6.6	18.41
3	10	3.47	21.88
4	15	5.21	27.09
5	17	5.9	32.99
6	11	3.82	36.81
7	18	6.25	43.06
8	16	5.56	48.62
9	11	3.82	52.44
10	8	2.78	55.22
11	13	4.51	59.73
12	14	4.86	64.59
13	15	5.21	69.8
14	11	3.82	73.62
15	10	3.47	77.09
16	11	3.82	80.91
17	12	4.17	85.08
18	8	2.78	87.86
19	7	2.43	90.29
20	4	1.39	91.68
21	2	0.69	92.37
22	9	3.13	95.5
23	7	2.43	97.93
24	6	2.08	100.01
TOTAL	288	100	

Appendix 11: Distribution of Vaccinations

Age in months	BCG	DPT			Polio				Measles	Completely Vaccinated	No Card-confirmed Vaccinations
		1	2	3	0	1	2	3			
0	3	0	0	0	2	0	0	0	0	0	12
1	9	1	0	0	6	1	1	0	0	0	9
2	6	2	0	0	4	4	1	0	0	0	11
3	3	3	1	0	3	4	2	0	0	0	5
4	8	4	2	1	5	8	6	2	1	0	5
5	4	2	1	1	4	7	5	1	1	0	9
6	4	3	3	3	5	5	4	4	1	0	5
7	7	4	5	1	4	9	6	2	0	0	7
8	5	5	3	0	4	5	5	3	1	0	10
9	1	3	0	0	2	3	0	0	1	0	6
10	4	3	3	3	1	3	3	3	1	1	5
11	4	6	4	2	2	7	5	2	3	0	4
12	8	4	3	2	4	8	7	2	5	1	4
13	7	3	3	2	7	8	6	3	6	1	5
14	3	4	3	2	4	5	3	2	2	0	4
15	3	4	3	3	3	5	5	4	2	0	5
16	6	4	3	3	5	5	4	4	4	1	3
17	2	2	0	0	2	5	2	1	3	0	5
18	2	0	0	0	2	2	0	0	0	0	6
19	3	2	2	2	2	2	2	2	2	1	3
20	2	1	1	1	1	1	2	2	2	1	2
21	0	0	0	0	0	1	0	0	1	0	1
22	4	1	0	0	3	3	4	2	3	0	3
23	2	2	2	2	0	2	2	2	2	0	5
24	0	1	1	1	0	1	1	0	1	0	5
Total 0-11 mos	58	36	22	11	42	56	38	17	9	1	88
Total 12-23 mos	42	27	20	17	33	47	37	24	32	5	46
Total 24 mos	0	1	1	1	0	1	1	0	1	0	5
Total all ages (0-24 mos)	100	64	43	29	75	104	76	41	42	6	139

Appendix 12: Indicators

INDICATORS * Denotes Indicators for Rapid CATCH Questions Rows written In fuschia (■) = USAID Indicators Unshaded rows denote indicators written by GHA	NUMERATO R	DENOMINATO R	PERCENT	CONFIDENCE LIMITS
* Average age of mothers of children age 0-23 months	8515	296	28.77 years	SD: ±7.20
Average education level of mothers of children age 0-23 months	1281.10	291	4.40 years	SD: ±3.58
Average length of time living in the area among mothers of children age 0-23 months	4142	294	14.09 years	SD: ±11.2559
Percent of mothers of children age 0-23 months who have come into contact with a skilled health worker at least once in the last month.	Total: 148	296	Total: 50%	44.35-55.68%
Percent of mothers of children age 0-23 months who have come into contact with a traditional health worker at least once in the last month.	20	296	6.8%	4.2-10.2%
Percent of mothers of children age 0-23 months who get their general information or advice on health or nutrition from a Formal Network.	272	300	90.67%	86.81-93.52%
Percent of mothers of children age 0-23 months who have received any health messages from the <u>radio</u> .	128	294	43.5%	37.8-49.4
Percent of mothers of children age 0-23 months who have received any health messages from the <u>newspaper</u> .	10	294	3.4%	1.6-6.2
Percent of mothers of children age 0-23 months who have received any health messages from the <u>television</u> .	10	294	3.4%	1.6-6.2
Percent of mothers of children age 0-23 months who have received any health messages from <u>health education</u> .	10	294	3.4%	1.6-6.2
Percent of mothers of children age 0-23 months who have received any health messages from a <u>community health worker</u> .	25	295	8.5%	5.6-12.3
Average number of pregnancies among mothers of children age 0-23 months	1114	298	3.74 preg- nancies	SD: ±2.52
Average number of live births among mothers of children age 0-23 months	1004	298	3.37 births	SD: ±2.24
Average number of children under 5 years of age in a household among mothers of children age 0-23 months	457	297	1.54 children	SD: ±0.9076
Average number of biological children under 5 years of age in a household among mothers of children age 0-23 months	432	297	1.45	SD: ±0.7314
* percentage of Children age 0-23 months who were born at least 24 months after the previous surviving child	45	84	53.6%	43.0-63.9%
Indicator	Numerator	Denominator	Percent	Confidence Limits

Appendix 12: Indicators

Percentage of Children age 0-23 months whose biological father lives in the same household.	223	288	77.4%	72.2-82.1%
* Percentage of children aged 0-23 months who were weighed for the survey.	250	300	83.33%	78.7-87.2%
* Percentage of children age 0-23 months who are below 2 standard deviations (-2 SD) from the median weight-for-age, according to the WHO/NCHS reference population.	45	250	18.0%	13.7-23.2%
Percentage of mothers of children age 0-23 months who were seen by skilled health personnel for their prenatal care	234	289	81.0%	76.0-85.3%
Percentage of children age 0-23 months whose births were attended by other health personnel.	16	289	5.5%	3.2-8.8%
Percentage of mothers of children age 0-23 months who saw No One for prenatal care	39	289	13.5%	9.8-18.0%
* Percent of mothers who received at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	246	271	90.8%	86.7-93.9%
Percent of mothers who were counseled on Delivery preparation during her prenatal check	128	228	56.1%	49.4-62.7%
Percent of mothers who were counseled on Breastfeeding during her prenatal check	151	227	66.5%	60.0-72.6%
Percent of mothers who were counseled on Child Spacing during her prenatal check	114	222	51.4%	44.6-58.1%
Percent of mothers who were counseled on EPI during her prenatal check	40	189	21.2%	15.6-27.7%
Percent of mothers who were counseled on Danger Signs of Pregnancy during her prenatal check	50	188	26.6%	20.4-33.5%
Percentage of mothers of children age 0-23 months who received a tetanus injection before the birth of their youngest child.	193	274	70.4%	64.7-75.8%
* Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (self-reported)	191	300	63.7%	59.1-68.9%
Percent of mothers with a maternal card (interviewer-confirmed) for the youngest child less than 24 months of age.	135	300	45.0%	39.5-50.7%
Percent of mothers who had at least one prenatal visit (card-confirmed) prior to the birth of her youngest child less than 24 months of age	78	120	65.0%	56.13-73.00%
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	20	300	6.7%	4.3-10.1%
Indicator	Numerator	Denominator	Percent	Confidence Limits

Appendix 12: Indicators

Percentage of mothers of children age 0-23 months who use non-motorized transportation to get to the nearest health center	214	300	71.33%	65.97-76.18%
Percentage of mothers of children age 0-23 months who can get to their nearest health center in less than 1 hour.	127	256	49.6%	43.54-55.72%
Percentage of mothers of children age 0-23 months who use <u>non-motorized transportation</u> to get to the nearest health center and can get to their nearest health center in less than 1 hour.	86	127	67.72%	59.17-75.28%
Percentage of mothers of children age 0-23 months who know of at least one danger sign during pregnancy indicating the need to seek health care.	99	300	33.0%	27.93-38.53%
Percentage of mothers of children age 0-23 months who would go to a Health Facility first if they experienced any of the danger signs during pregnancy.	85	253	33.60%	28.06-39.65%
Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	155	288	53.8%	47.9-59.7%
Average number of days mothers took iron supplements while pregnant with her youngest child less than 24 months of age.	4117.0	246	16.74 days	SD: ±33.2141
Percentage of children age 0-23 months whose births occurred in a health facility.	50	294	17.0%	12.9-21.8%
* Percentage of children age 0-23 months whose births were attended by skilled health personnel.	269	293	91.8%	88.1-94.7%
Percentage of children age 0-23 months whose births were attended by other health personnel.	19	293	6.5%	3.9-9.9%
Percent of children aged 0-23 months whose delivery involved the use of a clean birth kit .	275	290	94.8%	91.6-97.1%
Percent of children aged 0-23 months whose cord was cut with a new razor.	242	279	86.7%	82.2-90.5%
Percent of children aged 0-23 months whose cord was cut by a health professional.	263	281	93.6%	90.1-96.2%
Percentage of children 0-23 months who were ever breastfed.	282	296	95.3%	92.2-97.4%
* Percentage of children age d 0-23 months who were immediately breastfed at birth	205	257	79.8%	74.3-84.5%
* Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours.	49	92	53.3%	43.2-63.2%
Percentage of infants age 6-9 months receiving breastmilk and complementary foods.	33	56	58.9%	45.91-70.92%

Appendix 12: Indicators

Indicator	Numerator	Denominator	Percent	Confidence Limits
Percentage of mothers who had at least one postpartum check-up	106	295	35.9%	30.67-41.58%
Percent of mothers who received child spacing information during a postpartum check-up.	20	106	18.87%	12.50-27.48%
Average number of days after the delivery that the first check took place.	162	43	3.7674%	SD: ±6.2253
Percentage of mothers who had at least one postpartum check-up with a Skilled Health Professional.	97	104	93.3%	86.6-97.3
Percentage of mothers who had at least one postpartum check-up with other health personnel.	7	106	6.6%	3.03-13.28
Percentage of children who were checked during their mother's first postpartum check	60	106	56.6%	47.12-65.69
Percentage of mothers who had at least one <u>additional</u> postpartum check-up.	56	106	52.83%	43.42-62.11
Percentage of mothers who had at least one <u>additional</u> postpartum check-up with a Skilled Health Professional.	53	106	94.64%	84.89-98.78
Percentage of mothers who had at least one <u>additional</u> postpartum check-up with other health personnel.	2	56	3.57%	0.31-12.93%
Percentage of mothers of children age 0-23 months whose first post-natal check-up occurred in a health facility.	92	106	86.79%	78.95-92.12%
Percent of mothers who report at least one place where she can obtain a method of child spacing/Family planning	255	300	85.0%	80.50-88.64%
Percentage of women of children 0-23 months who are currently pregnant.	19	287	6.6%	4.0-10.1%
Percentage of women who are currently pregnant who have been to the clinic.	7	19	36.84%	19.18-59.26%
Percentage of non-pregnant mothers who desire no more children in the next two years, or are not sure.	250	259	96.5%	93.45-98.27%
Percentage of non-pregnant mothers who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing.	51	239	21.3%	16.61-27.01%
* Percentage of children age 0-23 months who have a Vaccination Card.	144	270	53.3%	47.2-59.4%
* Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	16	64	25.0%	15.96-36.98%

Appendix 12: Indicators

* Percent of children aged 12-23 months with DPT1 vaccine (card-confirmed)	27	64	42.19%	30.90-54.47%
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Indicator	Numerator	Denominator	Percent	Confidence Limits
Percent of drop-outs between DPT1 and DPT3	9	64	14.06%	7.39-24.92%
* Percentage of children age 12-23 months who received a measles vaccine.	51	110	46.36%	37.35-55.69%
* Percentage of children whose mothers report the presence of bednets in the house	18	287	6.3%	3.8-9.7%
* Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night	7 (7)	287 (18)	2.43% (38.9%)	1.09-5.07 (17.3-64.3%)
* Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment.	139	300	46.33%	40.78-52.01%
* Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks.	5	208	2.4%	0.88-5.69%
* Percentage of mothers of children age 0-23 months who have heard of AIDS.	282	293	96.2%	93.4-98.1%
* Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	132	282	46.8%	41.07-52.66%
Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>pregnancy</u> .	149	282	52.84%	47.02-58.61%
Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>delivery</u> .	133	282	47.16%	41.42-53.01%
Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>breastfeeding</u> .	156	282	55.32%	49.49-61.03%
Percentage of mothers of children age 0-23 months who know that mother-to-child transmission of HIV/AIDS can be avoided.	73	199	36.68%	30.30-43.60%
Percentage of mothers of children age 0-23 months who have heard of infections other than AIDS which can be transmitted through sexual contact	136	287	47.4%	41.5-53.3%
Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a man.	53	136	38.97%	31.20-47.41%
Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a woman.	74	136	54.4%	46.05-62.58%
Percentage of mothers of children age 0-23 months who cite at least one known method that can be used to avoid getting an STI	67	136	49.26%	41.02-57.61%

Appendix 12: Indicators

Indicator	Numerator	Denominator	Percent	Confidence Limits
Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy <u>during pregnancy</u> .	83	136	61.03%	52.65-68.85%
Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy during <u>delivery</u> .	63	136	46.32%	38.18-54.73%
Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy during <u>breastfeeding</u> .	61	136	44.85%	36.77-53.28%
Percentage of mothers of children age 0-23 months who cite at least one known way that an STI can impact the outcome of a pregnancy	10	136	7.35%	3.91-13.19%
Percentage of mothers of children age 0-23 months who know that they can go to a Health Facility for treatment of a sexually transmitted infection	100	136	73.53%	65.53-80.28%
Percentage of mothers of children age 0-23 months who mention at least one way a person can find out if/s/he has HIV/AIDS.	208	282	73.76%	68.33-78.58%
Percentage of mothers of children age 0-23 months who have heard of an HIV/AIDS counseling and testing service	88	260	33.8%	28.1-39.9%
Percentage of mothers of children age 0-23 months who were offered a test AIDS as part of their antenatal care.	19	95	20.0%	12.5-29.5%
Percentage of mothers of children age 0-23 months who were tested for AIDS as part of their antenatal care.	11	19	57.89%	36.39-77.06%
Percentage of mothers of children age 0-23 months who were tested for AIDS in a <u>public sector facility</u> as a part of their antenatal care.	8	11	72.73%	43.16-91.01%
Percentage of mothers of children age 0-23 months who were tested for AIDS in a <u>Private sector medical facility</u> as a part of their antenatal care.	3	11	27.27%	9.40-57.43%
Percentage of mothers of children age 0-23 months who were tested for AIDS as a part of their antenatal care and received the results of the test.	10	11	90.91%	60.40-99.99%
* Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	70	300	23.33%	18.90-28.47%

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Indicator	Q #	Description/ Definition		Study Findings			
				Numerator	Denominator	Percentage	Confidence Limits
Age: Average age of mothers of children age 0-23 months	2	Total number of years of age of mothers of children age 0-23 months for Question 2 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	8515	296	28.77 years	SD: ±7.20
Education level: Average education level of mothers of children age 0-23 months	3	Total number of years of education of mothers of children age 0-23 months for Question 3 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	1281.10	291	4.40 years	SD: ±3.58
Length of time living in area: Average length of time living in the area of mothers of children age 0-23 months	4	Total number of years that mothers of children age 0-23 months have lived in the area for Question 4 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	4142	294	14.0884 years	SD: ±11.2559
Health Contacts: Percent of mothers of children age 0-23 months who have come into contact with a skilled health worker at least once in the last month.	5	Number of mothers of children age 0-23 months with response='1' or '2' for category = 'Doctor', 'Nurse/Midwife', 'Community Health Worker', 'Health Educator' or 'Growth Monitoring Person' for Question 5 <hr/> Total number of mothers of children age 0-23 months in the survey	X 100	Total: 148 Dr: 137 Nurse: 39 CHW: 26 HE: 19 GM: 20	296	Total: 50% Dr: 46.6 Nurse: 13.2 CHW: 8.8 HE: 6.4 GM: 6.8	44.35-55.68%
Health Contacts: Percent of mothers of children age 0-23 months who have come into contact with a traditional health worker at least once in the last month.	5	Number of mothers of children age 0-23 months with response='1' or '2' for category = 'Traditional Birth Attendant' or 'Traditional Healer' for Question 5 <hr/> Total number of mothers of children age 0-23 months in the survey	X 100	20	296	6.8%	4.2-10.2%

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Health Information: Percent of mothers of children age 0-23 months who get their general information or advice on health or nutrition from a Formal Network.	6	Number of mothers of children age 0-23 months with response='A' through 'G' for Question 6 <u>Total number of mothers of children age 0-23 months in the survey</u>	X 100	272	300	90.67%	86.81-93.52%
Health Information: Percent of mothers of children age 0-23 months who have received any health messages from the <u>radio</u> .	7	Number of mothers of children age 0-23 months with response='1' for category='radio' Question 7 <u>Total number of mothers of children age 0-23 months in the survey</u>	X 100	128	294	43.5%	37.8-49.4%
Health Information: Percent of mothers of children age 0-23 months who have received any health messages from the <u>newspaper</u> .	7	Number of mothers of children age 0-23 months with response='1' for category='newspaper' for Q. 7 <u>Total number of mothers of children age 0-23 months in the survey</u>	X 100	10	294	3.4%	1.6-6.2%
Health Information: Percent of mothers of children age 0-23 months who have received any health messages from the <u>television</u> .	7	Number of mothers of children age 0-23 months with response='1' for category='television' for Question 7 <u>Total number of mothers of children age 0-23 months in the survey</u>	X 100	10	294	3.4%	1.6-6.2%
Health Information: Percent of mothers of children age 0-23 months who have received any health messages from <u>health education</u> .	7	Number of mothers of children age 0-23 months with response='1' for category='health education' for Question 7 <u>Total number of mothers of children age 0-23 months in the survey</u>	X 100	10	294	3.4%	1.6-6.2%

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Health Information: Percent of mothers of children age 0-23 months who have received any health messages from a <u>community health worker</u> .	7	Number of mothers of children age 0-23 months with response='1' for category=' <u>community health worker</u> ' for Question 7 <hr/> Total number of mothers of children age 0-23 months in the survey	X 100	25	295	8.5%	5.6-12.3%
Maternal Parity: Average number of pregnancies among mothers of children age 0-23 months	8	Total number of pregnancies among mothers of children age 0-23 months for Question 8 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	1114	298	3.74 pregnancies	SD: ±2.52
Maternal Parity: Average number of live births among mothers of children age 0-23 months	9	Total number of live births among mothers of children age 0-23 months for Question 9 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	1004	298	3.37 live births	SD ±2.24
Children Under Age 5 in a Household: Average number of children under 5 years of age in a household among mothers of children age 0-23 months	10	Total number of children in the household among mothers of children age 0-23 months for Question 10 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	457	297	1.54 children	SD: ±0.9076
Children Under Age 5 in a Household: Average number of biological children under 5 years of age in a household among mothers of children age 0-23 months	11	Total number of biological children in the household among mothers of children age 0-23 months for Question 11 <hr/> Total number of mothers of children age 0-23 months in the survey	X 1	432	297	1.45 children	SD: ±0.7314
Birth Interval between two youngest surviving Children: percentage of Children age 0-23 months who were born at least 24	12*	Number of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth <hr/> Number of children age 0-23 months in the survey who have an older sibling	X 100	45	84	53.6%	43.0-63.9%

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months after the previous surviving child		survey who have an older sibling					
Presence of biological father: Percentage of Children age 0-23 months whose biological father lives in the same household.	13	Number of children age 0-23 months with response='1' ('yes') for Question 13 <u>Number of Children age 0-23 months in the survey</u>	X 100	223	288	77.4%	72.2-82.1%
Underweight (low weight-for-age) prevalence: Percentage of children aged 0-23 months who were weighed for the survey.	14	Number of children age 0-23 months in the survey who were weighed (response=1 for Question 14 and <u>have a weight recorded in Question 15)</u> Number of children age 0-23 months in the survey	X 100	250	300	83.33%	78.7-87.2%
Underweight (low weight-for-age) prevalence: Percentage of children age 0-23 months who are below 2 standard deviations (-2 SD) from the median weight-for-age, according to the WHO/NCHS reference population.	15*	Number of children age 0-23 months whose weight (Question 15) is -2 SD from the median weight of the WHO/NCHS reference population for their age <u>Number of children age 0-23 months in the survey who were weighed (response=1 for Question 14)</u>	X 100	45	250	18.0%	13.7-23.2%
Skilled Prenatal Care: Percentage of mothers of children age 0-23 months who were seen by skilled health personnel for their prenatal care	16	Number of children age 0-23 months with responses = A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') <u>Number of children age 0-23 months in the survey</u>	X 100	234	289	81.0%	76.0-85.3%
Other personnel Prenatal Care: Percentage of mothers of children age 0-23 months who were seen by other personnel for their prenatal care	16	Number of children age 0-23 months with responses = D ('TBA'), E ('CHW'), X ('Other') <u>Number of children age 0-23 months in the survey</u>	X 100	16	289	5.5%	3.2-8.8%

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No Prenatal Care: Percentage of mothers of children age 0-23 months who saw No One for prenatal care	16	Number of children age 0-23 months with responses = Z <hr/> Number of children age 0-23 months in the survey	X 100	39	289	13.5%	9.8-18.0%
Prenatal Care Coverage: Percent of mothers who received at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	17	No. of mothers with response =1 for Question 17 <hr/> Total number of mothers with children less than 24 months of age	X 100	246	271	90.8%	86.7-93.9%
Prenatal Care Counseling: Percent of mothers who were counseled on Delivery preparation during her prenatal check	18	Number of mothers with response =1 for Question 17 AND response='yes' for 'Delivery Preparation' for Question 18 <hr/> Total number of mothers with children less than 24 months of age	X 100	128	228	56.1%	49.4-62.7%
Prenatal Care Counseling: Percent of mothers who were counseled on Breastfeeding during her prenatal check	18	Number of mothers with response =1 for Question 17 AND response='yes' for 'Breastfeeding' for Question 18 <hr/> Total number of mothers with children less than 24 months of age	X 100	151	227	66.5%	60.0-72.6%
Prenatal Care Counseling: Percent of mothers who were counseled on Child Spacing during her prenatal check	18	Number of mothers with response =1 for Question 17 AND response='yes' for 'Child Spacing' for Question 18 <hr/> Total number of mothers with children less than 24 months of age	X 100	114	222	51.4%	44.6-58.1%
Prenatal Care Counseling: Percent of mothers who were counseled on EPI during her prenatal check	18	Number of mothers with response =1 for Question 17 AND response='yes' for 'EPI' for Question 18 <hr/> Total number of mothers with children less than 24 months of age	X 100	40	189	21.2%	15.6-27.7%

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Prenatal Care Counseling: Percent of mothers who were counseled on Danger Signs of Pregnancy during her prenatal check	18	Number of mothers with response =1 for Question 17 AND response='yes' for 'Danger Signs of Pregnancy for Question 18 <hr/> Total number of mothers with children less than 24 months of age	X 100	50	188	26.6%	20.4-33.5%
Tetanus toxoid coverage: Percentage of mothers of children age 0-23 months who received a tetanus injection before the birth of their youngest child.	19	Number of mothers of children age 0-23 months with responses = 'Yes' for Question 19 <hr/> Number of mothers of children age 0-23 months in the survey.	X 100	191	300	63.7%	59.1-68.9%
Tetanus toxoid coverage: Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child.	20*	Number of mothers of children age 0-23 months with responses = 2 ('twice') or 3 ('more than two times') for Question 20 . <hr/> Number of mothers of children age 0-23 months in the survey.	X 100	135	300	45.0%	39.5-50.7%
Maternal Health card Possession Percent of mothers with a maternal card (interviewer-confirmed) for the youngest child less than 24 months of age	21	No. of mothers with response=1 for Question 21 <hr/> Total number of mothers with children less than 24 months of age.	X 100	120	247	48.6%	42.2-55.0%
Prenatal Care Coverage: Percent of mothers who had at least one prenatal visit (card-confirmed) prior to the birth of her youngest child less than 24 months of age	22	No. of mothers with response =1 for Question 22 <hr/> Total number of mothers with children less than 24 months of age	X 100	78	120	65%	56.13-73.00%
Tetanus toxoid coverage: Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	23	Number of mothers with at least 2 recorded dates before (NAME)'s date of birth (Question 23) <hr/> Total No. of mothers with children less than 24 months of age	X 100	20	300	6.7%	4.3-10.1%

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<p>Transportation to Health Center:</p> <p>Percentage of mothers of children age 0-23 months who use non-motorized transportation to get to the nearest health center</p>	24	<p>No. of mothers with response='A' ('Walk'), 'D' ('Ox Cart'), 'E' (Canoe) or 'X' ('other' if 'other'= non-motorized mode of transportation) for Question 24</p> <hr/> <p>Total No. of mothers with children less than 24 months of age</p>	X 100	214	300	71.33%	65.97-76.18%
<p>Health Center Accessibility:</p> <p>Percentage of mothers of children age 0-23 months who can get to their nearest health center in less than 1 hour.</p>	25	<p>Number of mothers of children age 0-23 months with response='1' for Question 25</p> <hr/> <p>Total number of mothers with children less than 24 months of age</p>	X 100	127	256	49.6%	43.54-55.72%
<p>Health Center Accessibility:</p> <p>Percentage of mothers of children age 0-23 months who use <u>non-motorized transportation</u> to get to the nearest health center and can get to their nearest health center in less than 1 hour.</p>	25	<p>No. of mothers with response='A' ('Walk'), 'D' ('Ox Cart'), 'E' (Canoe) or 'X' ('other' if 'other' = non-motorized mode of transportation) for Question 24 AND response='1' for Question 25</p> <hr/> <p>Total No. of mothers with children less than 24 months of age</p>	X 100	86	127	67.72%	59.17-75.28%
<p>Awareness of Danger Signs during pregnancy:</p> <p>Percentage of mothers of children age 0-23 months who know of at least one danger sign during pregnancy indicating the need to seek health care.</p>	26	<p>Number of mothers with response= 'A' or 'B' or 'C' or 'D' for Question 26</p> <hr/> <p>Total number of mothers with children less than 24 months of age</p>	X 100	99	300	33.0%	27.93-38.53%
<p>Health Facility Usage:</p> <p>Percentage of mothers of children age 0-23 months who would go to a Health Facility first if they experienced any of the danger signs during pregnancy.</p>	27	<p>Number of mothers with response= 'A' or 'B' or 'C' or 'D' for Question 26 AND response='01' through '07' for Question 27</p> <hr/> <p>Total number of mothers with children less than 24 months of age</p>	X 100	85	253	33.5968%	28.06-39.65%

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Iron Supplementation Coverage: Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	28	No. of mothers with response=1 ('Yes') for sub-module Question 28 <hr/> Total number of mothers with children less than 24 months of age	X 100	155	288	53.8%	47.9-59.7%
Iron Supplementation Coverage: Average number of days mothers took iron supplements while pregnant with her youngest child less than 24 months of age.	29	Total number of days iron supplementation was taken while mothers with children less than 24 months of age were pregnant <hr/> Number of mothers with children less than 24 months of age who gave a number of days = 1 for Question 29	X 1	4117.0	246	16.74 days	SD: ±33.2141
Delivery in health facility: Percentage of children age 0-23 months whose births occurred in a health facility.	30	Number of children age 0-23 months with responses 21('hospital'), 22 ('clinic'), 23 ('health center'), 24 ('PVO center'), 25 ('Health Post'), 26 ('Other Health Facility') for Question 30 <hr/> Number of children age 0-23 months in the survey	X 100	50	294	17.0%	12.9-21.8%
Skilled delivery assistance: Percentage of children age 0-23 months whose births were attended by skilled health personnel.	31*	Number of children age 0-23 months with responses = A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') <hr/> Number of children age 0-23 months in the survey	X 100	269	293	91.8%	88.1-94.7%
Delivery assistance: Percentage of children age 0-23 months whose births were attended by other health personnel.	31 GH A	Number of children age 0-23 months with responses = D ('TBA'), E ('CHW'), F ('Family member'), G ('Other') <hr/> Number of children age 0-23 months in the survey	X 100	19	293	6.5%	3.9-9.9%
Clean Cord Care:		Number of mothers with response=1 ('Yes') for Question 32	X	275	290	94.8%	91.6-97.1%

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Percent of children aged 0-23 months whose delivery involved the use of a clean birth kit .	32	Total number of mothers with children age 0-23 months in the survey	100				
Clean Cord Care: Percent of children aged 0-23 months whose cord was cut with a new razor.	33	Number of mothers with response=1 ('New razor blade') for Question 33 <hr/> Total number of mothers with children age 0-23 months in the survey	X 100	242	279	86.7%	82.2-90.5%
Cord Care: Percent of children aged 0-23 months whose cord was cut by a health professional.	34	Number of children age 0-23 months with responses= '1' ('doctor'), '2' ('nurse/midwife'), or '3' ('auxiliary midwife') <hr/> Total number of mothers with children age 0-23 months	X 100	263	281	93.6%	90.1-96.2%
Breastfeeding rate: Percentage of children 0-23 months who were ever breastfed.	35	Number of children age 0-23 months with response=1('yes') for question 35 <hr/> Number of infants age 0-23months in the survey	X 100	282	296	95.3%	92.2-97.4%
Immediate Breastfeeding Rate: Percentage of children aged 0-23 months who were immediately breastfed at birth	36	Number of children with response=1 ('immediately/within first hour after delivery') <hr/> Total number of children aged 0-23 months	X 100	205	257	79.8%	74.3-84.5%
Exclusive breastfeeding rate: Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours.	37*	Number of infants age 0-5 months with only response = A ('breastmilk') for question 37 <hr/> Number of infants age 0-5 months in the survey	X 100	49	92	53.3%	43.2-63.2%
Complementary feeding rate: Percentage of infants age 6-9 months receiving breastmilk and complementary foods.	37*	Number of infants age 6-9 months with responses = 'A' ('breastmilk') <u>and</u> 'D' ('mashed, pureed, solid, or semi-solid foods') for question 37 <hr/> Number of infants age 6-9 months in the survey	X 100	33	56	58.9%	45.91-70.92%

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Postpartum Contact: Percentage of mothers who had at least one postpartum check-up	38	Number of mothers with response=1 ('yes') for Question 38 <u>Total number of mothers with children less than 24 months of age</u>	X 100	106	295	35.9%	30.67-41.58%
Provision of Child Spacing Information during a Postpartum Check-up: Percent of mothers who received child spacing information during a postpartum check-up.	39	Number of mothers with response=2 for Question 39 , submodule on Postpartum Care <u>Total number of mothers with responses to Q.39</u>	X 100	20	76	26.3%	16.9-37.7%
Provision of Child Spacing Information during a Postpartum Check-up: Percent of mothers who received child spacing information during a postpartum check-up.	39	Number of mothers with response=2 for Question 39 , AND response=1 ('yes') for Question 38 <u>Total number of mothers with responses to Q.39</u>	X 100	20	106	18.8679%	12.50-27.48%
Postpartum Check-up: Average number of days after the delivery that the first check took place.	40	Total number of days for mothers with response='1' (days after delivery) for question 40 <u>Total number of mothers with response=1 ('yes') for question 38</u>	X 1	162	43	3.7674 days	SD: ±6.2253
Postpartum Contact: Percentage of mothers who had at least one postpartum check-up with a Skilled Health Professional.	41	Number of children age 0-23 months with responses = 1 ('doctor'), 2 ('nurse/midwife'), or 3 ('auxiliary midwife') <u>Total number of mothers with response=1 ('yes') for question 38</u>	X 100	97	104	93.3%	86.6-97.3%
Postpartum Contact: Percentage of mothers who had at least one postpartum check-up with other health personnel.	41	Number of children age 0-23 months with responses = 4 ('PVO-trained birth attendant'), 5 ('Other Birth Attendant'), or 6 ('Other') <u>Total number of mothers with response=1 ('yes') for question 38</u>	X 100	7	106	6.6%	3.03-13.28%

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Antenatal Contact: Percentage of children who were checked during their mother's first postpartum check	42	Number of children aged 0-23 months with response=1 ('Yes') for Question 42 <u>Total number of mothers with response=1 ('yes') for question 38</u>	X 100	60	106	56.6%	47.12-65.69%
Postpartum Contact: Percentage of mothers who had at least one <u>additional</u> postpartum check-up.	43	Number of mothers with response=1 ('yes') for Question 43 <u>Total number of mothers with children less than 24 months of age</u>	X 100	56	106	52.83%	43.42-62.11%
Postpartum Contact: Percentage of mothers who had at least one <u>additional</u> postpartum check-up with a Skilled Health Professional.	44	Number of children age 0-23 months with responses = 1 ('doctor'), 2 ('nurse/midwife'), or 3 ('auxiliary midwife') <u>Total number of mothers with response=1 ('yes') for question 43</u>	X 100	53	106	94.64%	84.89-98.78%
Postpartum Contact: Percentage of mothers who had at least one <u>additional</u> postpartum check-up with other health personnel.	44	Number of children age 0-23 months with responses = 4 ('Traditional Birth Attendant'), or 5 ('Other') <u>Total number of mothers with response=1 ('yes') for question 43</u>	X 100	2	56	3.57%	0.31-12.93%
Check-up in a health facility: Percentage of mothers of children age 0-23 months whose first post-natal check-up occurred in a health facility.	45	Number of mothers of children age 0-23 months with responses 21 ('hospital'), 22 ('clinic'), 23 ('health center'), 24 ('PVO center'), 25 ('Health Post'), 26 ('Other Health Facility') for Question 30 <u>Number of children age 0-23 months in the survey</u>	X 100	92	106	86.79%	78.95-92.12%
Knowledge of sources of Child Spacing/Family Planning Methods: Percent of mothers who report at least one place where she can obtain a method of child spacing/Family planning	46	Number of mothers with response='A through X' for Question 46 <u>Total number of mothers with responses to Q46</u>	X 100	255	300	85.0%	80.50-88.64%

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Pregnancy rate: Percentage of women of children 0-23 months who are currently pregnant.	47	Number of mothers of children age 0-23 months with response='1' ('yes') for Question 47 <hr/> Total number of mothers with children less than 24 months of age	X 100	19	287	6.6%	4.0-10.1%
Clinic Usage: Percentage of women who are currently pregnant who have been to the clinic.	48	Number of mothers with response='1' ('yes') for Question 47 AND Question 48 <hr/> Total number of mothers with response='1' ('yes') for Question 47	X 100	7	19	36.84%	19.18-59.26%
Child Spacing/Family Planning: Percentage of non-pregnant mothers who desire no more children in the next two years, or are not sure.	49	Number of mothers with response='2' or '8' for Question 47 <hr/> Total number of mothers with responses='2' or '8' for Question 49	X 100	250	259	96.5%	93.45-98.27%
Contraceptive Use among mothers who want to limit or space births: Percentage of non-pregnant mothers who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing.	50	Number of mothers with response='2' or '8' for Question 47 and 49 AND response=('02 – 10') for Question 50 <hr/> Total number of mothers with responses='2' or '8' for Question 47 and 49	X 100	51	239	21.3%	16.61-27.01%
Possession of a Vaccination Card: Percentage of children age 0-23 months who have a Vaccination Card.	51	Number of children with response='1' for Question 51 <hr/> Total number of children age 0-23 months in the survey	X 100	144	270	53.3%	47.2-59.4%
Full immunization coverage before the first birthday:		Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to		16	64	25.0%	15.96-36.98%

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Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	52*	the child's vaccination card (as documented in Question 52) <hr/> Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100				
EPI Access: Percent of children aged 12-23 months with DPT1 vaccine (card-confirmed)	52	<hr/> Number of children aged 12-23 months with DPT1 vaccine (card-confirmed) <hr/> Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	27	64	42.19%	30.90-54.47%

Drop Out Rate: Percent of drop-outs between DPT1 and DPT3	52	(No. of children age 12-23 months who received DPT1) - (No. of Children age 12-23 months who received DPT3) <hr/> Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	9	64	14.06%	7.39-24.92%
Immunization coverage: Percent of children age 0-11 months with BCG vaccine (card-confirmed)		Number of children age 0-11 months who received BCG according to the child's vaccination card (as documented in Question 52) <hr/> Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	58	84	69.04%	58.51-78.00
Immunization coverage: Percent of children age 0-11 months with DPT1 vaccine (card-confirmed)		Number of children age 0-11 months who received DPT1 according to the child's vaccination card (as documented in Question 52) <hr/>	X 100	36	84	42.86%	32.84-53.58

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		Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	100				
Immunization coverage: Percent of children age 0-11 months with DPT2 vaccine (card-confirmed)		Number of children age 0-11 months who received DPT2 according to the child's vaccination card (as documented in Question 52) <hr/> Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	22	84	26.19%	17.95-36.60
Immunization coverage: Percent of children age 0-11 months with DPT3 vaccine (card-confirmed)		Number of children age 0-11 months who received DPT3 according to the child's vaccination card (as documented in Question 52) <hr/> Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	11	84	13.10%	9.74-28.47%
Immunization coverage: Percent of children age 0-11 months with Polio 0 vaccine (card-confirmed)		Number of children age 0-11 months who received Polio 0 according to the child's vaccination card (as documented in Question 52) <hr/> Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	42	84	50.0%	39.57-60.51%
Immunization coverage: Percent of children age 0-11 months with Polio 1 vaccine (card-confirmed)		Number of children age 0-11 months who received Polio 1 according to the child's vaccination card (as documented in Question 52) <hr/> Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)	X 100	56	84	66.67%	56.06-75.90%

Appendix 14: Project Resource Requirements

<p>Immunization coverage: Percent of children age 0-11 months with Polio 2 vaccine (card-confirmed)</p>		<p>Number of children age 0-11 months who received Polio 2 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	38	84	45.24%	35.06-55.91%
<p>Immunization coverage: Percent of children age 0-11 months with Polio 3 vaccine (card-confirmed)</p>		<p>Number of children age 0-11 months who received Polio 3 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	17	84	20.24%	12.97-30.20%
<p>Immunization coverage: Percent of children age 0-11 months with Measles vaccine (card-confirmed)</p>		<p>Number of children age 0-11 months who received Measles vaccination according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	9	84	10.71%	5.56-19.40%
<p>Immunization coverage: Percent of children age 12-23 months with BCG vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received BCG according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	42	64	65.63%	53.41-76.17%

Appendix 14: Project Resource Requirements

<p>Immunization coverage: Percent of children age 12-23 months with DPT1 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received DPT1 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	<p>X 100</p>	<p>27</p>	<p>64</p>	<p>42.19%</p>	<p>30.90-54.47%</p>
<p>Immunization coverage: Percent of children age 12-23 months with DPT2 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received DPT2 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	<p>X 100</p>	<p>20</p>	<p>64</p>	<p>31.25%</p>	<p>21.22-43.51%</p>
<p>Immunization coverage: Percent of children age 12-23 months with DPT3 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received DPT3 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	<p>X 100</p>	<p>17</p>	<p>64</p>	<p>26.56%</p>	<p>17.26-38.64%</p>
<p>Immunization coverage: Percent of children age 12-23 months with Polio 0 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received Polio 0 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	<p>X 100</p>	<p>33</p>	<p>64</p>	<p>51.56%</p>	<p>39.62-63.43%</p>

Appendix 14: Project Resource Requirements

<p>Immunization coverage: Percent of children age 12-23 months with Polio 1 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received Polio 1 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	47	64	73.44%	61.48-82.84%
<p>Immunization coverage: Percent of children age 12-23 months with Polio 2 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received Polio 2 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	37	64	57.81%	54.64-69.20%
<p>Immunization coverage: Percent of children age 12-23 months with Polio 3 vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received Polio 3 according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 0-11 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	24	64	37.50%	26.69-49.84%
<p>Immunization coverage: Percent of children age 12-23 months with Measles vaccine (card-confirmed)</p>		<p>Number of children age 12-23 months who received Measles vaccination according to the child's vaccination card (as documented in Question 52)</p> <hr/> <p>Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by the interviewer' for Question 51)</p>	X 100	32	64	50.00%	38.14-61.97%

Appendix 14: Project Resource Requirements

<p>Measles vaccination coverage based on maternal report:</p> <p>Percentage of children age 12-23 months who received a measles vaccine.</p>	53	<p>Number of children age 12-23 months with response=1 ('yes') for Question 53</p> <hr/> <p>Number of children age 12-23 months in the survey</p>	X 100	51	110	46.36%	37.35-55.69%
<p>Household Bednet Possession:</p> <p>Percentage of children whose mothers report the presence of bednets in the house</p>	54	<p>Number of children aged 0-23 months with response=1 ('Yes') for Question 54, sub-module on Malaria Prevention</p> <hr/> <p>Total number of children aged 0-23 months</p>	X 100	18	287	6.3%	3.8-9.7%
<p>Child bednet use:</p> <p>Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night</p>	55* 56*	<p>Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Question 55 AND response=1 ('yes') for Question 56</p> <hr/> <p>Number of children age 0-23 months in the survey</p>	X 100	7	287	2.43%	1.09-5.07%
<p>Maternal knowledge of child danger signs:</p> <p>Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment.</p>	57*	<p>Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Question 57</p> <hr/> <p>Number of mothers of children age 0-23 months in the survey</p>	X 100	139	300	46.33%	40.78-52.01%

Appendix 14: Project Resource Requirements

Increased fluids and continued feeding: percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks.	58* 59* 60*	Number of children age 0-23 months with response=3 ('more than usual') for Question 59 <u>AND</u> response=2 ('same amount') or 3 ('more than usual') for Question 60 Number of children surveyed who were reportedly sick in the past two weeks (children with any responses other than K ['none'] for Question 58)	X 100	5	208	2.4%	0.88-5.69%
Knowledge of AIDS: Percentage of mothers of children age 0-23 months who have heard of AIDS.	61	Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61 Total number of mothers of children age 0-23 months in the survey	X 100	282	293	96.2%	93.4-98.1%
Maternal knowledge of HIV risk reduction: Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	62*	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 for Question 62. Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61	X 100	132	282	46.8%	41.07-52.66%
Knowledge of Mother-to-Child transmission of HIV/AIDS: Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>pregnancy</u> .	63a	Number of mothers of children age 0-23 months with response='Yes' for 'During <u>Pregnancy</u> ' for Question 63. Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61	X 100	149	282	52.84%	47.02-58.61%
Knowledge of Mother-to-Child transmission of HIV/AIDS: Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>delivery</u> .	63b	Number of mothers of children age 0-23 months with response='Yes' for 'During <u>delivery</u> ' for Question 63. Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61	X 100	133	282	47.16%	41.42-53.01%

Appendix 14: Project Resource Requirements

<p>Knowledge of Mother-to-Child transmission of HIV/AIDS:</p> <p>Percentage of mothers of children age 0-23 months who know that HIV/AIDS can be transmitted during <u>breastfeeding</u></p>	63c	<p>Number of mothers of children age 0-23 months with response='Yes' for 'During <u>breastfeeding</u>' for Question 63.</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61</p>	X 100	156	282	55.32%	49.49-61.03%
<p>Knowledge of Mother-to-Child transmission of HIV/AIDS:</p> <p>Percentage of mothers of children age 0-23 months who know that mother-to-child transmission of HIV/AIDS can be avoided.</p>	64	<p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 64</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61 and response='Yes' on Question 63a or 63b, or 63c</p>	X 100	73	199	36.68%	30.30-43.60%
<p>Knowledge of Sexually transmitted Infections:</p> <p>Percentage of mothers of children age 0-23 months who have heard of infections other than AIDS which can be transmitted through sexual contact</p>	65	<p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p> <hr/> <p>Total number of mothers of children age 0-23 months in the survey</p>	X 100	136	287	47.4%	41.5-53.3%
<p>Knowledge of STI Signs and Symptoms:</p> <p>Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a man.</p>	66	<p>Number of mothers of children age 0-23 months who mention at least two of the responses that relate to signs and symptoms of STI in a man for Q. 66</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	53	136	38.97%	31.20-47.41%
<p>Knowledge of STI Signs and Symptoms:</p> <p>Percentage of mothers of children age 0-23 months who cite at least two known signs and symptoms of an STI in a woman.</p>	67	<p>Number of mothers of children age 0-23 months who mention at least two of the responses (A- H) that relate to signs and symptoms of STI in a woman for Q. 67</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	74	136	54.4%	46.05-62.58%

Appendix 14: Project Resource Requirements

<p>Knowledge of STI Signs and Symptoms:</p> <p>Percentage of mothers of children age 0-23 months who cite at least one known method that can be used to avoid getting an STI</p>	68	<p>Number of mothers of children age 0-23 months who mention at least one known method that can be used to avoid getting an STI for Question 67</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	67	136	49.2647%	41.02-57.61%
<p>Knowledge of Sexually Transmitted Infections:</p> <p>Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy <u>during pregnancy</u>. (The impact is on the baby.)</p>	69a	<p>Number of mothers of children age 0-23 months with response='Yes' for 'During <u>Pregnancy</u>' for Question 69.</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	83	136	61.0294%	52.65-68.85%
<p>Knowledge of Sexually Transmitted Infections:</p> <p>Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy during <u>delivery</u>. (The impact is on the baby.)</p>	69b	<p>Number of mothers of children age 0-23 months with response='Yes' for 'During <u>delivery</u>' for Question 69.</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	63	136	46.3235%	38.18-54.73%
<p>Knowledge of Sexually Transmitted Infections:</p> <p>Percentage of mothers of children age 0-23 months who know that an STI can impact a pregnancy during <u>breastfeeding</u>.</p>	69c	<p>Number of mothers of children age 0-23 months with response='Yes' for 'During <u>breastfeeding</u>' for Question 69.</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	61	136	44.85%	36.77-53.28%

Appendix 14: Project Resource Requirements

<p>Knowledge of STI Signs and Symptoms:</p> <p>Percentage of mothers of children age 0-23 months who cite at least one known way that an STI can impact the outcome of a pregnancy</p>	70	<p>Number of mothers of children age 0-23 months who mention at least one known way that an STI can impact the outcome of a pregnancy for Question 70</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	10	136	7.35%	3.91-13.19%
<p>Treatment for Sexually Transmitted Infections:</p> <p>Percentage of mothers of children age 0-23 months who know that they can go to a Health Facility for treatment of a sexually transmitted infection</p>	71	<p>Number of mothers of children age 0-23 months with responses A('hospital'), B('health center'), C('PVO center'), D('Health Post'), E('Family Planning Clinic'), F('Field/Community Health Worker), G('Pharmacy'), or H('Other Health Facility) for Question 71</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 65</p>	X 100	100	136	73.53%	65.53-80.28%
<p>HIV Screening:</p> <p>Percentage of mothers of children age 0-23 months who mention at least one way a person can find out if s/he has HIV/AIDS.</p>	72	<p>Number of mothers of children age 0-23 months with response='A', 'B', 'C' for Question 72</p> <hr/> <p>Number of mothers of children age 0-23 months with response=1 ('Yes') for Question 61</p>	X 100	208	282	73.76%	68.33-78.58%
<p>HIV Screening:</p> <p>Percentage of mothers of children age 0-23 months who have heard of an HIV/AIDS counseling and testing service</p>	73	<p>Number of mothers of children age 0-23 months with response='A', 'B', 'C', or 'X' for Question 73</p> <hr/> <p>Number of mothers of children age 0-23 months in the survey</p>	X 100	88	260	33.8%	28.1-39.9%
<p>HIV Screening:</p> <p>Percentage of mothers of children age 0-23 months who were offered a test AIDS as part of their antenatal care.</p>	74	<p>Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 74</p> <hr/> <p>Number of mothers of children age 0-23 months in the survey</p>	X 100	19	95	20.0%	12.5-29.5%

Appendix 14: Project Resource Requirements

HIV Screening: Percentage of mothers of children age 0-23 months who were tested for AIDS as part of their antenatal care.	75	Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 75 Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 74	X 100	11	19	57.89%	36.39-77.06%
HIV Screening: Percentage of mothers of children age 0-23 months who were tested for AIDS in a <u>public sector facility</u> as a part of their antenatal care.	76	Number of mothers of children age 0-23 months with response='1' through '7' for Question 76 Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 75	X 100	8	11	72.73%	43.16-91.01%
HIV Screening: Percentage of mothers of children age 0-23 months who were tested for AIDS in a <u>Private sector medical facility</u> as a part of their antenatal care.	76	Number of mothers of children age 0-23 months with response='8' through '14' for Question 76 Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 75	X 100	3	11	27.27%	9.40-57.43%
HIV Screening: Percentage of mothers of children age 0-23 months who were tested for AIDS as a part of their antenatal care and received the results of the test.	77	Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 77 Number of mothers of children age 0-23 months with response='1' ('Yes') for Question 75	X 100	10	11	90.91%	60.40-99.99%
Maternal hand-washing behavior: Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	78*	Number of mothers of children age 0-23 months who mention responses B through E for Question 78 Number of mothers of children age 0-23 months in the survey	X 100	70	300	23.33%	18.90-28.47%

MEDICAL FACILITY ASSESSMENT

INTERVIEWERS

Name : _____

IDENTIFICATION OF FACILITY

Name : _____

Address : _____

Category:

MSPP

Private: Organization: _____

Joint: Organization: _____

Other : Organization : _____

PERSONS INTERVIEWED

Name : _____

Title : _____

Number of years in the Institution : _____

Name : _____

Title : _____

Number of years in the Institution : _____

Distance facility -

By car or by truck: _____ hours _____ minutes

On foot or on a donkey: _____ hours _____ minutes

Can emergency care be provided beyond the working hours? Yes - No

FACILITY OPERATING HOURS

DAYS	OPENING HOURS	ACTIVITIES
Monday	24 hours a day	Consultation Education Vaccination
		Laboratory-Radiology TB PF Pharmacy Hospitalization Administration
		Surgical operations
Tuesday	24 hours a day	Consultation Education Vaccination
		Laboratory-Radiology TB PF Pharmacy Hospitalization Administration
		Surgical operations
Wednesday	24 hours a day	Consultation Education Vaccination
		Laboratory-Radiology TB PF Pharmacy Hospitalization Administration
		Surgical operations
Thursday	24 hours a day	Consultation Education Vaccination
		Laboratory-Radiology TB PF Pharmacy Hospitalization Administration
		Surgical operations
Friday	24 hours a day	Consultation Education Vaccination
		Laboratory-Radiology TB PF Pharmacy Hospitalization Administration
		Surgical operations
Saturday	24 hours a day	Emergency Surgical operations Hospitalization
Sunday	24 hours a day	Emergency Surgical operations Hospitalization

FACILITY CHARACTERISTICS

1	CONDITION of BUILDING	Good	Poor
2	CLEANLINESS	Good	Poor
3	RUNNING WATER ?	Available	N/A
4	LATRINES ?	Available	N/A
5	DRINKING WATER ?	Available	N/A
6	MODERN W.C. ?	Available	N/A
7	BATHROOM SINK ?	Available	N/A
8	WASHING HANDS SOAP?	Available	N/A
9	LIGHTING SYSTEM ?	Generator	
		Other (specify) :	

10	REFRIGERATOR	Solar Propane	N/A
		Other (specify) :	
11	CONDITION of REFRIGERATOR	Functional	
12	MOVEMENT of CLIENTS	Regular	
13	EDUCATION ROOM	Yes	No
14	WAITING ROOM	Yes	

INFECTION PREVENTION & WASTES MANAGEMENT

1	AVAILABILITY OF GARBAGE	CONTAMINATED MATERIALS	Yes	No
	CANS in EACH SERVICE	NON-CONTAMINATED MATER.	Yes	No
2	SOLUTION of DECONTAMINATION		Available	
3	STERILIZATION MATERIALS		Available	
4	ENCAPSULATION MATERIALS		Available	
5	RUBBER GLOVES		Yes	No
6	CLEAN LATEX GLOVES		Yes	No
7	STERILE LATEX GLOVES		Yes	No
8	INCINERATOR		Functional	N/F
9	WASTE PITS		Yes	No
10	OTHER METHODS TO CLEAN OUT WASTES		specify : 1- 2-	
11	Protective clothes	Overall	Available	N/A
		Glasses	Available	N/A
		Gloves	Available	N/A
		Slippers	Available	N/A
12	Precautions in handling of sharp articles		Yes	No
13	Avoid any contact with body fluids		Yes	No
14	Equipment	Decontamination in chlorous solution during 10 minutes	Yes	No
		Wash in soapy water	Yes	No
		Disinfect or Sterilize	Yes	No
15	Cleaning up of rooms/furniture with solution of disinfection		Yes	No
16	Appropriate destruction of wastes: burn or bury placenta and needles		Yes	No

LABORATORY TESTS

TYPE of TEST	AVAILABLE	N/A
MALARIA TEST		
BACILLOSCOPY		
HIV		
RPR		
URINE ALBUMIN		
URINE, MICROSCOPY		
HEMOGLOBIN		

1	Verification and diagnosis of infections	Breasts	Yes	No
		Womb	Yes	No
2	Available antibiotics		Yes	No
3	Intravenous injections available		Yes	No
4	Anti-protease data List (when/what) to use		Yes	No
5	Reflexes test		Yes	No
6	Kidneys sensitivity test (CVA)		Yes	No
7	Start with IV - woman		Yes	No
8	Give IV – new born		Yes	No
9	Give rectal IV		Yes	No
10	Give intra-peritoneal IV		Yes	No

11	Give blood transfusion	laboratory identifies blood type and correspondent	Yes	No
		Equipment & accessories for blood test	Yes	No
		Blood bank or mobile blood bank		No
12	Hemoglobin checked If yes, what method was used?	Yes	No	
	Speculum test done	Yes	No	
	Bi-manual test done	Yes	No	

CHILD SURVIVAL

1	AVAILABLE VACCINES ?	TT	Yes	No
		DTC		
		BCG		
		POLIO		
		MEASLES		
2	VITAMIN « A »?			
3	SCALES ?			
4	HEALTH CARD ?			
5	VACCINATION RECORD?			
6	PCIME FORM ?			
7	REFERRAL FORM ?			
8	ORAL REHYDRATION ?			
9	SALT SERUM?			
10	NUTRITIONAL RECOVERY PROGRAM ?			
11	DISTRIBUTION OF DRY FOOD ?			
12	TIMERS ?			
13	ACETAMINOPHENE ?			
14	PEDIATRIC COTRIMOXAZOLE ?			
15	AMOXICILLIN SP ?			
16	MALAQUN SP OR CHLOROQUINE SP ?			
17	ANTI- PARASITICAL MEDICINES ?	PIPERAZINE		
		ALBENDAZOLE		
		MEBENDAZOLE		
18	ALGORHYTHM	Undertaking of child suff. from MALNUTRITION ? DRY INTAKE ?		
19	EQUIPMENT FOR MEDICAL EXAMINATION	TONGUE DEPRESSOR		
		STETHOSCOPE OTOSCOPE		
		FLASH		
20	CHILD CARE EDUCATION :	EDUCATION ROOM		
		TRAINED TEACHING STAFF		
		CURRICULUM on INFANT NUTRITION		
21	Breastfeeding tools and capacities	Available	N/A	
22	Feeding tubes and syringes	Available	N/A	
23	Skin to skin : warming method	Yes	No	

MATERNAL HEALTH

HEALTH CARD - WOMAN	Available	N/A
ANTENATAL CONSULTATION ROOM	Appropriat.	N/AP
TETANUS VACCINE	Available	
ANTENATAL RECORD		
ANTENATAL FILE		
POST NATAL FILE		
REFERRAL CARD		
AMOXICILLIN		
ANTIACID		
CHLOROQUINE ce 250mg		
COTRIMOXAZOLE ce		
VAGINAL CLOTRIMAZOLE		
DIBENZYL PENNICILLIN inj. 2.400.000 u.		
METRONIDAZOLE ce 250 mg		
ALBENDAZOLE ce 200 mg		
ANTIECLAMPSIA MEDICINE		
MAGNESIUM SULPHATE		
List anti-hypertensor currently available :		
NIFEDIPINE – ALDOMET – HCTZ -		
ERGOTAMIN inj amp 0.2mg	Available	N/A
PITOCIN inj (ainsi que son Protocole écrit)		
TETRACYCLIN ophth		
IRON / FOLIC ACID ce		
ANTENATAL VITAMINS		
ORAL REHYDRATION SALTS		
EQUIPMENT FOR	OBSTETRICAL STETHOSCOPE	
MEDICAL	VAGINAL SPECULUM	
EXAMINATION :	LIGHTING SYSTEM	
	BANDAGE - COMPRESS	
	STERILE WATER (in gallon)	
	EXAMINATION TABLE	
	ADULT SCALE	
	METRIC RIBBON	
	TENSIOMETER	
	HEIGHT GAUGE	

H
B
L
S
C
A

CAPACITY		YES	NO	Comments
1	Personnel trained to manage cases of post-partum bleeding			
a	Bladder emptied with catheter			
b	Stimulation of nipples			
	- baby on breast			
	- roll the nipples			
c	Hydration available			
	- intravenous fluid and links			
	- rectal fluid and tube			
d	Do compression bi-manual			
	- External			
	-Internal			
2	2. Oxytocin correctly stored up			
3	3. Rehydration therapy including IV for mother and new born			

TRAINING

PREGNANT WOMEN EDUCATION :	PLAN for DELIVERY and PUERPERUM	Available	N/A
	TEACHING STAFF TRAINED		
	CURRICULUM on NUTRITION		
	AT RISK PREGNANCY SIGNS		

H
B
L
S
C
A

Anemia : prevention and treatment	Available	N/A
Prevention : STI, HIV, Reproductive System Infection		
When was counseling on family planning given?	Antenatal consultation	
	After birth	
	After abortion	
	During post abortion care	

List of villages served by this facility:

DEMOGRAPHY

Including target groups

	Total population /year	Women (15 – 49 year)	Pregnant women	Children (0 - 1 year)
Population of area of responsibility				
Pop. living within 1 km				
Pop. living within 1 to 5 km	±			

TRANSPORTATION

Emergency transportation plan

- ✓ Ambulance available
- Other vehicle available
- Training of local committees in planning of emergency transportation for women
- Telephone or radio

Referral place	Name of closer referral	Distance
A. Hospital		
B. Clinic		

Transportation methods (circle most used method)	Number of hours to referral ?	Fare
A. Car (Ambulance)		
B. Bus		
C. Motorcycle		
D. Boat		
E. Horse		
F. On foot		
G. Other methods		

Does this facility do follow up activities with matronly women ? yes/no

If yes, how many women are appointed to the facility? _____ NO _____

Are the women ? :

- Supervised ? yes/no ;
- Equipped ? yes/no ;
- With what?

F
B
L
S
S

PERSONNEL

PERSONNEL CATEGORY	NURSING	NON-NURSING
DOCTOR		1
NURSE MIDWIFE		
MALE NURSE		
AUXILIARY		
RECEPTIONIST		
ARCHIVIST		
PHARMACY ASSISTANT		
BACILLOSCOPIST		
HEALTH WORKER		
GUARD		
UNSKILLED WORKER		
SUPPORT STAFF		
MATRONLY WOMAN		
TOTAL PAID STAFF		
VOLUNTARY STAFF (indicate qualification)		
MOTHERS CLUB		
FATHERS CLUB		
YOUTH CLUB		
HEALTH COMMITTEE		
COVOL		
FACILITATOR		
OTHER		
TOTAL VOLUNTARY STAFF		



**Global
Health
Action**

Memorandum of Understanding (MOU)

ANNEX 4

Between Global Health Action (GHA) and The Community Outreach and Development branch of L'Église Methodiste d'Haïti (COD-EMH)

INTRODUCTION

GLOBAL HEALTH ACTION, (GHA) founded in 1972, is a private voluntary organization located in Atlanta, Georgia. The mission of the PVO is: "Creating healthier communities around the globe through education and training in leadership, management and health promotion." The COD-EMH, an outreach and development branch of the Methodist Church, has been involved in development in Haiti and specifically in Petit-Goave since 1965. Their mission is to work with community grassroots groups through integrated programs, offering health care and preventive health services support through literacy programs, formal education, economic development, appropriate agricultural technologies. GHA has served as a health training resource for the Methodist Church of Haiti for over 20 years, providing health-related training programs to Community Health Workers (CHWs), Lay Pastors, and Goat Farmers. Following a series of meetings and discussions, GHA and COD-EMH, hereafter referred to as the parties, agreed to closely collaborate for a Child Survival project. The two parties agreed to jointly apply for a USAID Child Survival Grant. If the project is funded, this Memorandum of Understanding (MOU) will serve to formalize the collaborative efforts of the two parties.

BACKGROUND OF GHA

Since 1972, GHA has conducted courses in leadership, management, project planning and communications skills for health professionals and community leaders throughout the world. The organization currently has programs in Africa, China, Bolivia, Haiti and the United States, that address HIV/AIDS, maternal and reproductive health, nutrition, primary health care, leadership and capacity building. GHA has worked in Haiti since 1980 and works collaboratively with many different organizations, including churches, private clinics, and governmental and nursing associations. Particularly in Haiti, GHA has formed a long-standing positive and productive relationship with both the Methodist and Episcopal Churches. This relationship dates back to the early 1980s, when GHA trained Community Health Workers and Lay Pastors for the Methodist Church. The organization has now trained over 1,000 Community Health Workers overall, and is currently managing a privately funded maternal health project on the island of La Gonave, Haiti.

GHA is funded primarily through private donors, foundations, and churches. The organization also receives grants from corporations and governments.

1902 Clairmont Road • Decatur, GA 30033 U.S.A.

Mailing Address: P.O. Box 15086 • Atlanta, GA 30333 • Phone: 404/634-5748 • Fax: 404/634-9885
gha@globalhealthaction.org • www.globalhealthaction.org

BACKGROUND OF LOCAL PARTNER

The local partner is the Methodist Church of Haiti (COD-EMH), which has a bureau for development programs. The COD-EMH has been involved in development in Haiti and specifically in Petit-Goave since 1965. COD-EMH is a member of the Unité Communautaire de Santé (UCS) of Petit-Goave, and runs a health program in the locality of Olivier, situated in the second rural section of the district.

COD-EMH is currently implementing a health care program in the second communal section of Petit-Goave. This program includes immunization of children and pregnant women, health education, nutrition surveillance and distribution of micronutrients, tuberculosis diagnosis and referral to the hospital, dental and ophthalmic care. They also have initiatives to assist malnourished children. These programs are partly supported through a gifts-in-kind program. The gifts come from teams of US volunteers that provide medical supplies and make annual visits to help improve the facilities.

SCOPE OF THE PROJECT:

The two parties agree to join efforts to work on the USAID Child Survival Grant Application. If funded, the project will contribute to the reduction of maternal mortality in Petit-Goave. The project will have a heavy emphasis on the promotion of good health seeking behaviors and a referential health system in the region of Petit-Goave. The project will also serve to build the capacity of both organizations, primarily the COD-EMH. The intent of this MOU is to enhance the effectiveness of both GHA and COD-EMH activities throughout the implementation of the USAID Child Survival Project in Petit-Goave. However, it is understood that if any terms of this MOU or any supplemental agreement are found to be in conflict with the terms of either the COD-EMH, the GHA or the USAID mission, the terms of these organizations' respective mission will supercede the terms of this document.

GHA has a well-established presence in Leogane and a long-standing relationship with the Methodist Church of Haiti. Likewise, the COD-EMH developed a strong base in Petit-Goave, a near-by region. With their physical proximity in Haiti, their organizational histories of collaboration, and their clear, common goals for the health of children and mothers in Haiti, the choice to work together at this site was an easy one for both organizations.

GHA'S ROLE:

Act as the liaison with USAID, providing reporting and financial management for the project.

GHA/COD-EMH

- GHA's Field Program Manager will help with the everyday management of the project, will report to GHA and COD on a weekly basis and ensure the timely delivery of the reports to headquarters
- Help build the management capacity of the local partner.
- Provide technical assistance and support to develop local partner's capacity in management, communication, monitoring and evaluation
- Help the partner organization with identification of training needs.
- Provide technical assistance for the consolidation of project outcome and sharing of experience with other national and international partners.

COD-EMH'S ROLE:

Integrate project activities in the national health plan. Maintain productive relations with the MOH, the UCS institutions, AOPS, and other national institutions sharing the same interests.

- Ensure community participation and mobilization around the project goals.
- Identify local training needs.
- Manage day-to-day activities on the field, ensure the running of the clinics in order to accomplish the project's specific objectives
- Report program activities and finances to the GHA Field Program Manager and GHA headquarters in a timely manner.
- Provide GHA field staff with the necessary documents and administrative assistance that will ensure good project management and monitoring in the field and reporting to headquarters.
- Ensure that the medical donations and physicians teams come in a timely and regular manner.

The local partner's capacity in logistics, information system, leadership and management will be improved to implement and sustain program activities after the end of the project.

COLLABORATION WITH OTHER ORGANIZATIONS:

The two parties recognize that this partnership is part of a collaborative effort involving many groups related to health and community development, such as the Association des Ouvres Privées de Santé (Association of Private Health Organizations) (AOPS), the Unité Communale de Santé (UCS), the USAID mission in Haiti, and various local women's groups in Petit-Goave.

EFFECTIVE DATE FOR THE AGREEMENT START AND TERMINATION

The agreement will be in effect on the date of the last signature and shall continue to be in force throughout the duration of the USAID funding and until the completion of the proposed activities.

PROVISIONS FOR THE AMENDMENT OF AGREEMENT

The terms of this agreement can be amended, with the approval of GHA, COD-EMH, and USAID Haiti, by means of exchange of letters through the authorized officials at each institution. The amendments shall not affect the execution and conclusion nor publication and dissemination of results of the proposed activities, if the USAID funding is disbursed. Either party may initiate the exchange of letters.

Any notice, request and official action required by or resulting from this Memorandum of Understanding or specific activity shall be addressed accordingly to the following:

Robin C. Davis
Executive Director,
Global Health Action
Atlanta, Georgia, U.S.A.

OR

M. Durand Jeanty
Director of Programs
Community Outreach and Development,
Église Methodiste d'Haiti

IN WITNESS THEREFORE, in the interest of an effective cooperation of mutual benefit to the contracting parties, four copies of the Memorandum of Understanding are signed by the respective officers on the day, month, and year below.

Executive Director,
Global Health Action,
Atlanta, Georgia, USA

Name: Robin C. Davis
Title: Executive Director
Signature: Robin C. Davis
Date: April 11, 2005

Program Director,
Community Outreach and Development,
Église Methodiste d'Haiti
Portau Prince, Haiti

Name: Durand R. Jeanty
Title: Director General
Signature: [Signature]
Date: 8/04/2005

GHA/COD-EMH

Yolanta S. Melamed, M.D., M.P.H

EDUCATION

MPH degree, Rollins School of Public Health, Emory University, Atlanta, Georgia 1996

M.D. degree, Medical School, Sofia, Bulgaria, 1985

EMPLOYMENT

Senior Director of Programs, Global Health Action, Decatur, Georgia (2001 – Present)

- Directs the design, implementation and coordination of all initiatives, programs, and courses.
- Directs all programs and courses and serves as Chief Trainer
- Directs and leads program staff as they develop programs and courses and write contract proposals and content for grant proposals.
- Oversees training and fosters professional development and coaching for the Program staff. Responsible for outcomes of all work produced by the Program Managers or vendors, volunteers, interns and work study students under their management.
- Provides creative and technical supervision and monitors consistency, quality and integrity of all verbal, written and graphically oriented program descriptions and materials created and distributed by GHA.
- Develops, oversees and maintains written instructions and policies regarding program procedures.
- Implements programs and conducts courses overseas to reinforce and complement the knowledge and expertise of other program staff or consultants.
- Determines relevance of information based on research of best practices in international health.
- Fosters and develops knowledge of health, leadership, and management information among GHA staff for organizational use.
- Directs generation of tuition-based and training materials revenue.
- Travels overseas and in country in order to network, build partnerships, and gather written information and visual aids for programs and courses.
- Directs and oversees the creation of budget for program initiatives.
- Participates in the drafting of GHA's operating budget.
- Develops, oversees and maintains written instructions and policies regarding organizational procedures as needed.

Program Manager, Global Health Action, Decatur, Georgia (2000-2001)

- Managed all aspects of the Primary Health Care Initiative in Haiti.
- Coordinated veterinary technical assistance visits to Haiti.
- Travels to current and potential French-speaking program sites on as-needed basis and assists with in-country workshops and training programs, as requested by DP.
- Designs, develops, and manages database of program participants, applications, partners, and prospective audiences.
- Participated in ongoing project and program strategy, planning, proposal research/writing, and implementation.

Consultant to SAO (Community Agency). Paris, France (1999)

Consultant to the Ministry of Health, Sofia, Bulgaria (1998)

Emory University, Rollins School of Public Health (1995-1996), *Consultant to PAMM (Program Against Micronutrient Malnutrition) International Health Department.*

Visiting scientist at Columbia University, Department of Pediatrics, Division of Gastroenterology and Nutrition, New York City (1993-1994).

International Public Relations Director, Investex, Ltd. Winter Springs, Florida (1989-1993)

Medical Resident, Department of Obstetrics and Gynecology, Edith Wolfson, Israel (1986-1988)

Assistant Manager to a Family Planning Program, Regional Hospital Monastir, Tunisia (1977-1978)

LANGUAGES

- Fluent in five languages, including French and Russian

LYNDA LATTKE, MPH**QUALIFICATIONS SUMMARY:**

- Over 5 years experience as a HIV/sexuality/reproductive health educator, counselor and program coordinator and manager, serving culturally diverse populations while working for organizations such as Global Health Action, Inc. (GA, U.S.); The Cambridge Health Alliance (MA, U.S.); Boston Medical Center (MA, U.S.); U.S. Peace Corps (Niger, West Africa).
- Native Spanish speaker. Fluent in English and French. Working knowledge of Portuguese and Djerma (W. African language)

EDUCATION:**Master in Public Health, Concentration in International Health (September 2000)**

Boston University School of Public Health (Boston, MA)

Certificate in International Health (August 2000)

Boston University School of Public Health

Management Methods in International Health (April 2000)

Boston University School of Public Health

BA in Urban Anthropology, Minor in Economics (December 1993)

University of Massachusetts, Boston, MA

WORK EXPERIENCE:**Senior Program Manager (2003-Present)**

Global Health Action, Inc.; Atlanta, GA

- Manage all aspects of the Primary Health Care Initiative in Haiti, including proposal content and report writing, expense budgeting and monitoring, program evaluation, curriculum development, and communications with English-speaking program partners and Haitian staff.
- Coordinate visits of veterinary and voluntary health teams to Haiti.
- Provide logistic support to Africa-based trainings, including managerial, financial and administrative aspects.
- Prepare course material and train Public Health professionals (including Doctors and Nurses), as well as Community leaders from Churches and Non-Government Organizations, on the design, management and evaluation of community-based HIV/AIDS programs in Africa.
- Develop and design evaluation tools and procedures to be used with all Global Health Action's international courses.

Health Counselor and Educator (2001-2003)

The Cambridge Health Alliance; Somerville, MA

- Provided HIV counseling and testing as well as sexual and reproductive health education and counseling on sexually transmitted infections, birth control methods, pregnancy tests and pregnancy options at 3 culturally and socio-economically diverse clinics in Somerville.
- Prepared and taught sexuality education classes to elementary, middle, junior and high school students from the Spanish, Haitian Creole, Portuguese and ESL bilingual programs while ensuring curriculum was culturally competent and developmentally appropriate.
- Developed and implemented education and outreach programs with Community Based Organizations, Social Service agencies and substance abuse programs to increase awareness and access to Sexual Health and Family Planning Services.

- Coordinated workshops for parents only as well as parents and teens around issues of sexuality and communication.

Patient Advocate and Medical Interpreter (1999-2003)

Boston Medical Center, Boston, MA
Cambridge Health Alliance, Cambridge, MA

- Facilitated communication between Spanish speaking patients, families, community members and the health care providers at the Boston Medical Center and within the Cambridge Health Alliance.
- Advocated for Spanish speaking patients to ensure patients' access to the full range of health care services available.
- Educated providers about relevant cultural issues to improve patient care.

Consultant

International Planned Parenthood Federation/Western Hemisphere Region, Inc.; 2000
New York, NY Latino Health Institute; Boston, MA

- Researched and wrote about Family Planning Associations and their projects in Latin America in order to make information accessible via the internet.
- Translated educational and technical materials on HIV/AIDS for training programs applied statewide.

AIDS Project Coordinator/Technical Adviser (1997-1998)

Lux-Development (Cooperation Luxembourgeoise)
United States Peace Corps, Niamey (Niger)

- Organized, implemented and managed AIDS project in collaboration with the Ministry of Health in Niger.
- Developed culturally appropriate messages for educational programs with different target groups.
- Recruited and trained artists on AIDS prevention.
- Planned, supervised and managed budget for AIDS awareness campaign which included musicians, theater artists and technical crew.
- Evaluated information, education and communication (IEC) programs conducted by religious leaders, health agents and NGO members.

Community Health Educator (1995-1997)

United States Peace Corps, Bélandé (Dosso), Niger

- Conducted community survey and health needs assessment for the village of Bélandé (approximately 4,000 inhabitants).
- Worked at rural health clinic with Nigerian counterparts on the improvement of maternal and child health which included a sheep loan project which helped 33 women and their children.
- Developed and presented health education lessons in local language –Djerma- during home visits, village meetings and at the rural health clinic. Family Planning sessions were also conducted for men between the ages of 17-30 along with theater presentations on the consequences of early marriage and pregnancy.

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Name: JAMES C, SETZER, MPH
Profession: Epidemiologist/Health Planner
Years Associated with Firm: 3
Languages: French (FSI S3+/R3) (1983)
Tshiluba, Lingala, KiKongo (limited)
Some Spanish

Key Qualifications

Senior Associate with Abt Associates, Inc. and an epidemiologist/health systems planner with twenty years experience in promoting the availability and use of quality data and information to improve health services delivery and strengthen their foundations in health policy. Has worked to develop health information and surveillance systems in a number of countries (Zaire, Niger, Ghana, and Republic of Georgia). Has extensive experience in the use collection of health data and information to improve program design, implementation and evaluation (Kenya, Tanzania, Niger, DRC/Zaire, Burkina Faso, Cameroon, Togo, Bangladesh and Zambia) and has played a role in data analysis and interpretation for policy review and reform (Kenya, Zambia, Republic of Georgia, and Egypt). Has extensive experience in the use of survey and analytic methods in the designing, management and evaluation of child survival and primary health service delivery programs (DRC/Zaire), Niger, Kenya, Bangladesh, Madagascar, Tanzania, Togo, and Mali). Has worked and collaborated extensively with multi- and bi-lateral donors, PVOs and NGOs, governments and private foundations.

Education

M.P.H., Tulane University School of Public Health and Tropical Medicine, New Orleans, LA, Epidemiology.
B.A., Haverford College, Haverford, PA, Biology

Relevant Professional Experience

Experience with Abt Associates Inc.

May 2002 -
present

Senior Associate. Full time senior associate primarily assigned to provide technical leadership and oversight to country technical assistance activities for PHR *plus* Project, a USAID 5 -year global flagship project to provide assistance to missions and countries in health policy analysis, reform, evaluation, health systems strengthening and improvement of health information systems (primarily infectious disease surveillance systems). Served as Team Leader for Ghana infectious

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disease surveillance strengthening (including quality of data improvements), senior technical advisor to Republic of Georgia vaccine preventable disease surveillance and EPI MIS activity (including quality of data management program) and team leader for DRC/Zaire health zone management strengthening activity. Development of information system (including procedures to assure data quality) for Zambian ART program nationwide roll-out. Reviewed project technical documents.

April 1990-
August 1992

Senior Health Analyst. Provided short term technical assistance in collection, analysis and use of epidemiologic and service delivery data for improved health planning, health sector finance, program design and evaluation, and policy reform. Review of technical documents. Short term assignments included: design of non -project assistance grant to the health sector for USAID/Cameroon; design of non -project assistance grant to the health sector for USAID/Togo; evaluation of cost recovery efforts for primary care in Haiti; assistance in the design of a cost recovery mechanism for public health services in Central African Republic; evaluation of the USAID health finance project in Kenya; and development of a plan for more rational deployment and utilization of health manpower in Niger. Managed and backstop all technical assistance and applied research activities for the Health Financing and Sustainability (HFS) Project in Congo, Togo, Fiji and the South Pacific, Eastern Caribbean, Central African Republic, Cameroon, Burkina Faso and Haiti.

Other Professional Experiences

July 1992-
May 2002

Program Coordinator/Senior Associate Faculty. Department of International Health, Rollins School of Public Health, Emory University. Management and coordination of research, academic and service programs and projects for the Department of International Health. Coordination of grant development and management activities. Active ongoing research and technical assistance portfolio in collaboration with important health system and health policy development programs, surveillance and health information system development and improved availability and use of epidemiologic data. Participation in curriculum review and course design within Department's academic program. Coordination of program for student internships and practical in international health. Liaison with Centers for Disease Control and Prevention, CARE, The Carter Center and other collaborating institutions and donor organizations. Course Coordinator for International Health

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core course: "Strategies in International Health" and "Case Studies in International Health Program Management". Teach/lecture in "International Health Policy" and "International Health Finance". Chair of department admissions committee. Developer and coordinator of joint program with Peace Corps (second largest of its kind in its first year). Co-developer of summer long field based course in "Applied Field Methods in International Health Research and Program Planning" taught and conducted in Guatemala (summer 1998).

June 1999 -
November 2000

Senior Child Health Advisor. Health and Population Unit, CARE, Atlanta, Georgia. Manage and support growing portfolio of international child survival projects. Provide technical assistance in areas of project design, M&E program design (including data quality and availability) management, implementation and evaluation of CARE health and population projects. Integration of child survival goals, objectives and interventions within CARE household livelihood security approach. Liaison with donor agencies and collaborating institutions (USAID, CDC, Emory University, CORE PVO group, BASICS project, etc).

September 1995 -
May 2002

Adjunct Senior Associate Faculty . Center For African Studies, Emory University. Assist graduate students in development of research methodologies, protocols and proposals. Participate in seminars.

October 1992 -
October 1993

Expert Appointment Centers for Disease Control and Prevention, International Health Program Office (IHPO). Short-term technical assistance in data collection, quality, analysis and interpretation to improve health planning, program management and health finance of MOH/USAID/CDC child survival project activities in Central African Republic.

February 1988 -
April 1990

Chief of Party/Senior Public Health Policy Advisor. Niger Health Sector Support Grant-USAID Project 683-254, Tulane University School of Public Health and Tropical Medicine. Leader of three person team of long term technical assistants assigned to Ministry of Health's Directorate of Studies and Programming to assist MOH in research and analysis for review and reform of national health policies in areas of: cost recovery, cost containment, financial and human resource allocation, planning of health services and planning of family planning

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programs. Review, strengthening and reform of MOH policy and planning processes. Continued development of all aspects of MOH national and regional information systems including use for planning. Provide assistance to MOH in the identification and development of appropriate projects to be financed and implemented using Niger Health Sector Support Grant counterpart funds. Development of analytic/data based framework for monitoring and evaluation of funded projects.

September 1985-
December 1987

Epidemiologist/Microcomputer Expert. Rural Health Improvement Project, USAID, Project 683208, Niamey, Niger, Tulane University School of Public Health and Tropical Medicine.

Design and implementation of nationwide health and management information system using microcomputers for Ministry of Public Health in Niger. Development of specialized software to be used with the system. Development of microcomputer applications for epidemiologic surveillance. Use of surveillance system results in health planning and development of health and nutrition policy. Development of microcomputer applications to monitor and evaluate delivery of rural health and maternal and child health services. Assistance to the Ministry of Public Health in the design and analysis of several major epidemiologic studies. Training of host country personnel in microcomputer use and research methods.

July 1983-
July 1985

Field Food and Nutrition Coordinator . Zaire Area Nutrition Improvement Project, USAID Project 660 -079, Kikwit, Zaire.

Organization of regional nutrition planning council to integrate nutrition components into multidisciplinary development projects. Coordination of nutrition interventions sponsored by council. Design and implementation of methodology to assess impact of nutrition interventions using microcomputers. Design and testing of regional nutrition surveillance system. Development of microcomputer based epidemiologic/nutritional data collection and analysis system.

August 1981-
June 1983

Research/Teaching Assistant. Department of Biostatistics and Epidemiology, Tulane University School of Public Health and Tropical Medicine.

Data handling, editing and analysis of infant and child nutrition surveys. Assisted in tabular presentation of results. Design and analysis of survey work conducted by the Louisiana Council for Physician Manpower Planning. Assisted in development and teaching of new course "Epidemiology of Protein-Energy Malnutrition".

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May 1982-
August 1982

Co-investigator. Rural Health and Infant Nutrition Survey, Musienene, Zaire. Project and survey instrument design, supervision of data collection activities in the field and data analysis for a community-based health and infant nutrition survey in Musienene, Zaire. Data analysis using statistical software packages. Report preparation and presentation of results.

April 1980-
July 1981

Occupational Safety and Health Organizer . Brown Lung Association, Spartanburg, S.C. Development and implementation of community based occupational health and safety education program under a grant from Occupational Safety and Health Administration (OSHA).

August 1979-
November 1979

Logistics Coordinator . Zaire National Committee on Cholera, Kinshasa, Zaire. Organization and supervision of 20 emergency cholera treatment centers in Kinshasa, Zaire. Organization and administration of nationwide depot for drugs and medical materials. Collection and analysis of epidemiologic data.

July 1978-
August 1979

Peace Corps Regional Representative?Peace Corps Volunteer Leader. Peace Corps, Kasai Occidental, Zaire. Material, logistical and technical support of 30 Peace Corps Volunteers in Kasai Occidental Region, Zaire.

July 1976-
July 1978

Rural Health Coordinator. Peace Corps, CEBEC Rural Health Improvement Project, Mwene Ditu, Zaire. Organization of primary health and nutrition activities (including mobile team) in Mwene Ditu Zone (population 90,000), Zaire. Support and supervision of 4 rural health centers in the zone. Training, supervision and coordination of village health workers. Development and management of cost recovery efforts.

Selected Short Term Assignments

Selected Technical Assistance/Consulting Assignments (1995-present):

February 2001 Development of detailed implementation plan (DIP) for CARE/Kenya child

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survival grant project

November 2000, Design of Child Survival Grant proposal for CARE/Rwanda

January 1999, health sector review and development of strategic options for CARE/Niger, CARE

August 1998, development of population based survey to assess determinants of health services utilization and household expenditures for health care in Republic of Guinea, BASICS/USAID

November 1997, development of health policy reform agenda in collaboration with USAID and MOH in Zambia, PHR Project/USAID.

January 1998, member of final evaluation team of USAID/REDSO East Africa Networking to Improve health Services project, BASICS/USAID.

August 1997 and August 1999, mid-term and final evaluation of CARE/Niger North Agadez Child vaccination Project, CARE.

June 1996, development of agenda and benchmarks for health policy reform in Egypt, PHR Project and USAID/Cairo

February 1997, assessment of Guinea Worm eradication program in Mali and Niger, Global 2000 Program of the Carter Center of Emory University

November 1996, analysis of Madagascar baseline household child health and nutrition survey and development of options for child survival interventions, BASICS project

June 1996, team member for final evaluation of Kenya Health Care Finance Project, USAID/Nairobi

June 1995, design of technical cooperation grant to support basic health policy reform and implementation in Guyana, Inter-American Development Bank

November 1994, development of implementation plan for health finance reform in Republic of Togo, JSI and USAID/Lome

March 1995, assessment of organization, finance, delivery and epidemiologic priorities for improving maternal and child health services in the Republic of Georgia, World Bank

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Selected Papers, Reports, Publications and Presentations

Goff, C. and Setzer, J. "ADP Ribosylation of E. coli RNA Polymerase is Nonessential for Bacteriophage T4 Development", Journal of Virology, January 1980, p. 547-549.

Bertrand, Frere, Manchester, Setzer: "Microcomputer Use in Health Planning in Niger: Some Preliminary Results", Presented at APHA Annual Meeting, Las Vegas, Nevada, September 1986.

Frere, Manchester, Magagi, Chaibou, Idrissa, Setzer: "Enquête Nationale sur la Morbidité et la Mortalité Infantile au Niger", Médecine d'Afrique Noire, January 1987, p. 59-69.

Setzer, J., Boulos, R., Jaar, S.: "Towards Financial Sustainability of Health Services for the Poor in Haiti: The CDS Experience", Presented at APHA Annual Meeting, Washington, D.C., November 1992.

Mock, Nancy B.; Mercer, David M.; Setzer, James C.; Magnani, Robert J.; Tankari, Kadri; Brown, Lianne. "Prevalence and Differentials of Low Birth Weight in Niamey, Niger", Journal of Tropical Pediatrics, April 1994, Vol 40, pp. 72-77.

Mock, Nancy; Setzer, James; Sliney, Ian; Hadizatou, Gado; Bertrand, William. "Development of Information Based Planning in Niger", International Journal of Technology Assessment in Health Care. 9:3 (1993), p. 360-368.

Mock, N., Setzer, J., Sliney, I., Hadizatou, G., Bertrand, Wm.: "Development of Information-Based Planning in Niger", presented at International Conference on the Transfer of Health Care Technology, Boston, MA. October 1990.

Setzer, James C., "The Use of USAID's Non-Project Assistance to Achieve Health Sector Reform in Africa; A Discussion Paper", Policy Paper No. 12 Health Finance and Sustainability Project, USAID 1994.

Setzer, James; "The Puzzle and Challenge of Sustainability in the Finance and Delivery of Health Services", invited presentation at "REDSO Workshop on Health Financing and Sustainability in West and Central Africa" sponsored by USAID, Saly Portudal, Senegal, February 1994.

Setzer, James: "The Collection and Analysis of Health Information", invited presentation at Forum on "Access to Health Information in Guyana", Georgetown, Guyana, July 1993.

Setzer, James; Yazipo, D.; Redd, S.: "Management of Essential Drugs for the Treatment of Malaria in the Central African Republic", presented at APHA annual meeting, San Francisco, October 1993.

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Setzer, James C., McFarland, D., Waters, H., Simonet, M., "Access to and Utilization of Publicly Financed Health Services Among the Indigent and Poor in Republic of Guinea: A Study in Equity" , BASICS Project, Arlington, VA, 1996.

Setzer, James C., Wilder, E., Andrianarisata, J., "Madagascar Household Child Health and Nutrition Survey" , BASICS Project, Arlington, VA, 1997.

Setzer, James; "Protecting Equity Within Health Finance Policy Reform Programs; Five Country's Experiences" invited presentation at West African Regional Workshop on Health Finance Reform, Dakar, Senegal, September 1996.

McFarland, Deborah A., Setzer, J., Delozier, D., Nathan, R., "Final Assessment Report: Health Systems Reform in Republic of Georgia", AIHA, Washington, D.C., 1996

Honors and Awards

- | | |
|------------|--|
| 2001- 2002 | Student Government "Professor of the Year" Award, Rollins School of Public Health, Emory University |
| 1996- 1997 | Thomas F. Sellers, Jr., M.D. Faculty Award for Exemplifying the Ideals of Public Health, Rollins School of Public Health, Emory University |
| 1982-83 | Outstanding Student Service Award, Tulane University School of Public Health and Tropical Medicine |
| 1982-83 | Tulane Medical Alumni Association Student Recognition Award |
| 1983 | Elected to Tulane Chapter of Delta Omega National Public Health Honor Society |
| 1982 | Tulane University, School of Public Health and Tropical Medicine. Research fellowship for Field Studies in Zaire |
| 1981-83 | Public Health General Purpose Traineeship Grant |

Abt Associates Inc.

Other Information

Board member, Dikembe Mutombo Foundation, Atlanta, GA.

Special Student, McGill University, Montreal, Quebec, Biochemisrty

Work experience in:

Europe: Republic of Georgia.

Africa: Cameroon, CAR, Egypt, Ethiopia, Ghana, Guinea, Kenya, Madagascar, Mali, Mozambique, Niger, Rwanda, Senegal, Tanzania, Togo, Zambia, and Zaire (now D.R. Congo).

Asia: Bangladesh

Americas: El Salvador, Guatemala, Guyana, and Haiti.

Jean-Eliot Pierre

75, Rue Cameau, Bas peu de chose, Port-au-Prince, Haïti
Tel : 222-0241 ; 413-2505 ; 558-1223

Date of Birth:

Place of Birth:

Marital Status:

Languages: Créole, French, English (spoken and written)

Education

1993-2000 Université Lumiere, Mission Baptiste Sud d'Haïti
(MEBSH), Rue O #29, Port-au-Prince, Haïti
Faculty of Medicine

1991-1992 Ecole Professionnelle Saint-Esprit, Cap-Haitien
Computer Science – Diploma

Certificates and Diplomas

- Certified in community development from L.A.E.D.A.P
- Certified in first aid
- Certified in STI diagnosis and treatment
- Diploma in computer science
- Diploma in medicine

October 1997 Certificate of Training in Automotive Basic Skills and Knowledge, from the security assistance of the United States Army (AIRBONE)

March 1998 Certificate of Participation in the Congress on Tuberculosis and AIDS organized by International Child Care, Grace Children's Hospital

June 1998 Certificate of Participation in the International Medical and Scientific Conference organized by Sainte-Croix de Léogâne Hospital

June 1998 Certificate in Community Based Health Project Planning from Gregory P. Loos, MPH EdD BRACH Chief, Training and education systems, National Institute of Occupational Safety and Health, Centers for Disease Control and Prevention. University of Miami School of Medicine.

October 2000	Certificate of Participation in a continuing education training course on Medical Activities and Progress in the 21 st Century, organized by AMH-Hospital Lumière de Bonne Fin and Mayo Clinic, Minnesota
February 2001	Certificate of participation in a training course on prevention of mother-to-child transmission of HIV, organized by GHESKIO/MSP Centers, Ministry of Public Health and Population
April 22-26, 2002	Certificate of participation in a training course in reproductive health organized by INHSAC ET PHI Haïti
Aug. 5- Sept 13, 2002	International Health Management Course given by Global Health Action. Affiliate of Georgia State University in Atlanta, Georgia

Experiences:

February - March, 2000	Internship in otolaryngology at the Brenda Strafford Institute, Cayes- Haïti, W.I
May 1999 - June 2000	Rotation at the Lumière de Bonne Fin Hospital, Cayes
January - June 2001	Appointed doctor at the external clinic of Sainte-Croix de Léonage Hospital
July 2001 - July 2003	Medical Director of the Bill-Rice Community Health Center in Nouvelle Cité, La Gonâve, an Episcopal Insistute of Haïti.
September 2003 - present	Medical Director of Lanage Maison de Naissance. An institute of the Episcopal Church of Haïti and Healthy Mothers-Healthy Babies (Kansas City, USA).

References:

1. Dr. Jean Ronel Joseph
119 Medical Rue Kapois
Cell: 411-1979; 222-4486

2. Dr. Jean Yonel
512-7105
415-5224

Job Descriptions

Full time Program Manager for Child Survival Initiative (Petit Goave, Haiti)

The PM will work in collaboration with the COD-EMH, MoH (UCS) and GHA-HQ.

Qualifications:

- Insure community mobilization and participation according to the project objectives as well as the project implementation
- Manage daily activities with the purpose of reaching project objectives
- Monitor the project and provide monthly reports on project progress and expenses made each quarter. This information will be submitted to the Director of the COD-EMH and GHA-HQ

Mandatory Qualifications:

- Masters in Public Health or Medicine with an experience of at least 5 years in the area of Public Health and community health.
- Experience in the coordination of public health projects and especially, at the level of the design, management and monitoring of the Child Survival project.
- Computer use knowledge (Microsoft Office Suite –Word, Excel, etc.)

Preferred Qualifications:

- Interest in improving women's health
- Knowledge of project management
- Experience with USAID projects
- Knowledge of English

Position Title: Full-time Medical Doctor

The Full time doctor works in collaboration with the PM under the direction of the COD Medical Director and Director of the region of Petit Goave.

His duties are to:

- Ensure that all personnel is familiar with the goal and objectives of the CS health initiative.
- Consistently provide regular follow-up reports to COD/PM on all related CS health program activities. He must ensure the availability of monthly and annual technical and financial reports.
- Organize regular meetings for self- evaluation each trimester.
- Identify the training needs of personnel members and work to increase their skills.
- Collaborate with other sectors on how to integrate all health related activities.
- Represent the institution when deemed necessary.
- Accomplish all other tasks required for successful implementation of the duties described above.
- Collaborate with other clinic staff involved in project.
- Assume responsibility for patients' quality of care.
- Provide treatment and follow-up care.

Job Descriptions

Profile:

1. Must hold a degree in Medicine.
2. Must have at least five years of experience in the medical field or knowledge issues concerning public health, in particular child and maternal health.
3. Must have good communication skills.
4. Must be available to travel both locally and abroad.
5. Must be able to speak, write and read Creole and French. Knowledge of English desired.
6. Must have a good knowledge of word processing programs (Word-Excel).
7. Must possess strong leadership skills.

Position Title: Medical Doctor (Part-time/25%)

This position requires 440 hours of service per year at 10 hours per week. In collaboration with the project coordinator, the part-time Medical Doctor is responsible for:

1. Assume responsibility for patients' care.
2. Provide health education.
3. Provide consultations.
4. Provide treatment and follow-up care.
5. Participate in training sessions for nurses and assistants as needed to ensure the success of the project.

Position Title: Nurse (Full-time/100%)

The nurse will work in collaboration with the Doctors and PM. This position is full time, and the Nurse is responsible for:

1. Provide care to patients in absence of doctor
2. Making available documents which describe the mission and objectives of the program; and providing a plan of action which will be distributed monthly, annually and each trimester.
3. Ensuring that all personnel members know the goal and objectives of the CS health program.
4. Collaborate in all CS activities with community groups
5. Supervise the auxiliary nurses' work.
6. Consistently providing a regular follow-up report to the Doctor/PM for all program activities and assisting in the development of the following documents: monthly and annual technical and financial reports.
7. Organizing regular meetings for self- evaluation each trimester.
8. Identifying the training needs of personnel members and working to increase their skills.
9. Representing the institution when deemed necessary.
10. Accomplishing all other tasks required for successful implementation of the duties described above.

Job Descriptions

Profile:

1. Must hold a degree in Nursing.
2. Must have at least five years of experience in the medical field or knowledge of issues concerning public health.
3. Must have good communication skills.
4. Must be able to speak, write and read Creole and French.
5. Must be prepared to be transferred from one Methodist site to another.
6. Must have a good knowledge of word processing programs (Word-Excel).
7. Must possess strong leadership skills.

Position Title: Nurse (Part-time/25%)

This position requires 440 hours of service per year at 10 hours per week. In collaboration with the project coordinator, the part-time Nurse is responsible for:

1. Provide care to patients in absence of doctor
2. Assist in the supervision of the Auxiliary nurses' work
3. Plan the program of activities (mobile clinic, home visits, health information sessions at clinic)
4. Participate in community health information sessions
5. Participate in community meetings which address health questions that concern the local population.
6. Submit monthly reports to the full time Nurse.

Profile:

1. Must hold a degree in Nursing.
2. Must have at least 5 years of experience in the field of Nursing.

Position Title: Auxiliary Nurse (Part-time/75%)

In collaboration with the Nurse, the Auxiliary Nurse is responsible for:

1. Provides care for patients in the absence of the Doctor or Nurse.
2. Supervises the work of CHWs and TBAs (monthly visits, on-site job visits).
3. Participates in daily education sessions for patients and for mobile clinics.
4. Actively works with community groups on CS project
5. Prepares files to record information from patient consultations (vital signs, vaccinations for women and children)
6. Represents the institution when deemed necessary.
7. Submits a monthly activity report to the Nurse.
8. Accomplishes all other tasks required for successful implementation of the duties described above.

Job Descriptions

Profile:

1. Must hold an Auxiliary Nurse degree from a recognized institution.
2. Must have at least 3 years of experience in the field of Nursing.
3. Must be available to change from one Methodist clinic to another.

Position Title: Auxiliary nurse (part-time/25%)

This position requires 440 hours of service per year at 10 hours per week. In collaboration with the Attending nurse, the Assistant is responsible for:

1. Preparing files for patients.
2. Providing home visits, perform services for the mobile clinic, and for conducting community health information sessions.
3. Participating in patient education sessions.

Chief Accountant

Services provided for this position account for either 10 percent of a full-time work-load, or consist of 352 hours of work per year. In collaboration with the Chief Accountant, the part-time Accountant is responsible for:

1. Maintaining daily expenses of the CS program activities.
2. Maintaining as carefully as possible all backup information (receipts).
3. Preparing bank statements that reflect program account balances.

Financial Manager: assures the availability of financial documents on a monthly and yearly basis. He supervises the Chief accountant.

Archivist: keeps track of the records for Maternal and Child health and works with the Statistician to create the database. Currently, the Archivist is in the clinic of Olivier.

Statistician: works with the PM in keeping track of data collected for the M&E plan.

Bookkeeper: he works with the Chief accountant and keeps the books for the clinic of Olivier and Platon Trou Chou Chou, as well as searches for funding for mobile clinics. He pays the personnel once the chief accountant provides him with the checks.

Regional Coordinator Literacy: coordinates the work between the different literacy community groups and supervises the literacy teachers.

Literacy teacher: does mobilization of community members and will collaborate with the PM in the development of the Responsible Fatherhood curriculum.

Job Descriptions

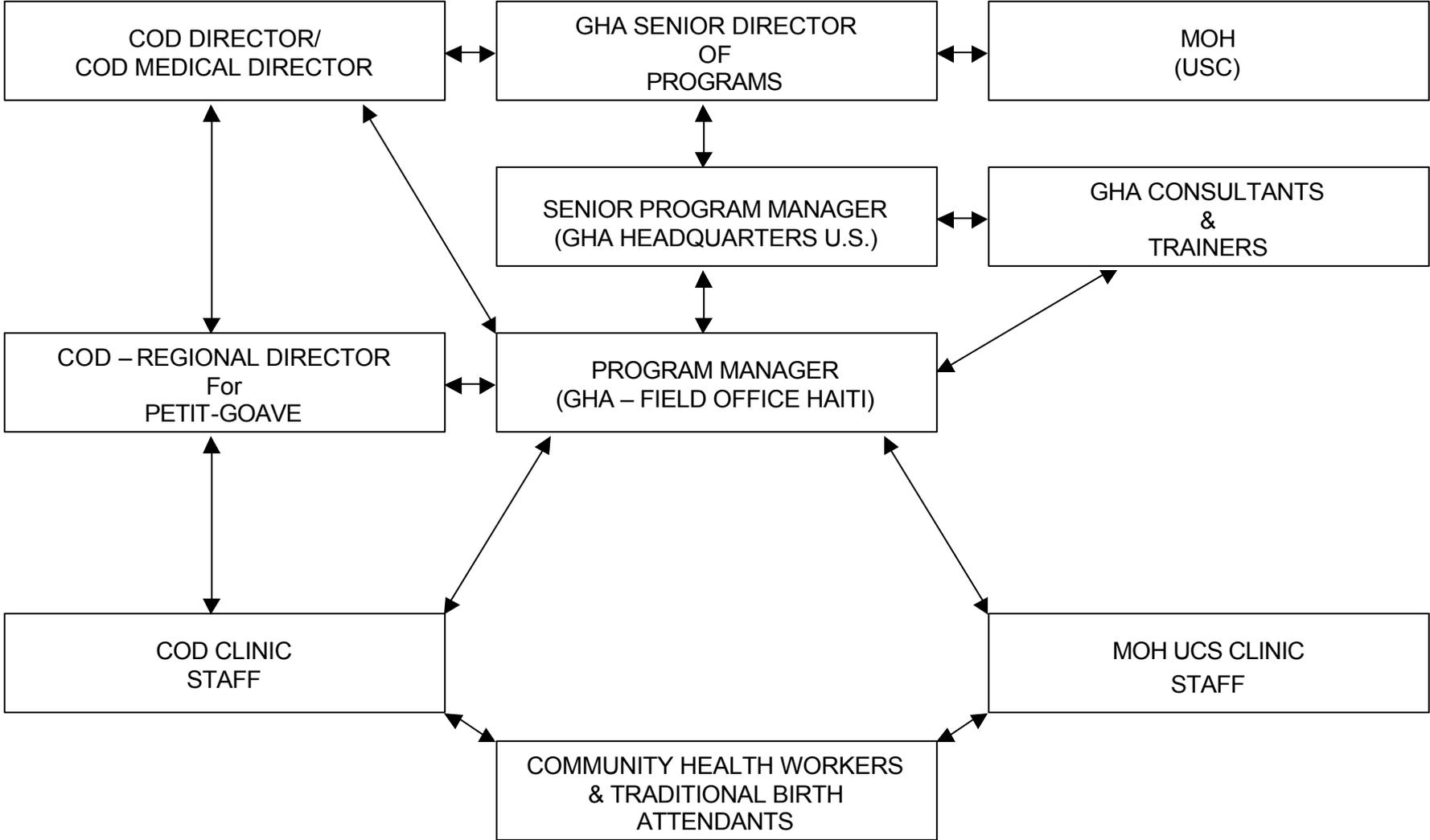
Chief Micro-enterprise: Oversees the activities of the different community banks (women's groups) and provides feedback to the coordinator.

Coordinator of Micro-enterprise: coordinates and trains the different COD community banks (women's groups) on how to do micro credit and collaborates with the PM to do the out reach for CS activities.

CHWs: will be chosen by the community and will have the following responsibilities:

- 1- accompany medical staff to mobile clinics
- 2- carry out home visits
- 3- complete two meeting points/month, in villages chosen by nurse or auxiliary nurse vaccination of children aged 0-5
- 4- vaccination of women of child bearing age and of pregnant women
- 5- distribution of vit. A to children aged 6 months - 7 years and new mothers (up to 45 days after delivery)
- 6- weighing of children aged 0 – 5 years
- 7- identify children suffering from malnutrition and refer them to clinic
- 8- encourage pregnant women to go to the clinic
- 9- return materials to clinic same day if possible
- 10-meet nurse or auxiliary nurse for month reports and planning

ORGANIZATIONAL CHART
DIAGRAM OF THE RELATIONSHIP BETWEEN US PVO (GHA)
LOCAL PARTNERS (COD-EMH) & MOH (UCS)



CHILD SURVIVAL MANAGEMENT TABLE

ANNEX 6 b

GHA STAFF	Level of Effort YEAR 1	Level of Effort YEAR 2	LINE OF AUTHORITY
Senior Director of Programs (SDP)	14%	8%	Reports to GHA Executive Director & USAID
Senior Program Manager-Headquarters (SPM)	24%	15%	Reports to SDP
Director of Administration & Finance (DAF)	12%	12%	Reports to SDP & SPM
Administrative Assistant	8%	8%	Reports to SDP, SPM & DAF
Project Manager-GHA Field Office Haiti (PM)	100%	100%	Reports to SDP & SPM
Intern-Headquarters	20%	20%	Reports to SPM

CHILD SURVIVAL MANAGEMENT TABLE

ANNEX 6 b

COD-EMH STAFF	Level of Effort YEAR 1	Level of Effort YEAR 2	LINE OF AUTHORITY	COD-EMH STAFF
COD Director	10%	10%	Reports to President of the Methodist Church	COD Director
COD Medical Director	10%	10%	Works with PM, COD Director and COD Director of RPG	COD Medical Director
COD Director of the Region of Petit Goave (RPG)	10%	10%	Reports to COD Director/COD Medical Director and works with PM	COD Director of the Region of Petit Goave (RPG)
Financial Manager	25%	25%	Reports to COD Director	Financial Manager
Chief Accountant	10%	10%	Reports to COD Director	Chief Accountant
Secretary/Receptionist	10%	10%	Reports to COD Director of RPG	Secretary/Receptionist
1 Driver	25%	25%	Reports to COD Director of RPG	1 Driver
1 Doctor	25%	25%	Reports to PM/MoH	1 Doctor
1 Doctor	100%	100%	Reports to PM/COD Director RPG/COD Medical Director	1 Doctor
1 Nurse	100%	100%	Reports to Doctor/PM/COD Director RPG	1 Nurse
1 Nurse	25%	25%	Reports to Doctor/PM/COD Director RPG	1 Nurse
3 Auxiliary nurses	75%	75%	Reports to full time Nurse/PM/COD Director (RPG)	3 Auxiliary nurses

CHILD SURVIVAL MANAGEMENT TABLE

ANNEX 6 b

3 Auxiliary	25%	25%	Reports to full time Nurse/PM/COD Director (RPG)	3 Auxiliary
1 Lab technician	50%	50%	Reports to Doctor/PM/COD Director RPG	1 Lab technician
1 Statistician	50%	50%	Reports to Doctor/PM/COD Director RPG	1 Statistician
1 Archivist	100%	100%	Reports to Doctor/PM/COD Director (RPG)	1 Archivist
1 Bookkeeper	100%	100%	Reports to PM/COD Director (RPG)	1 Bookkeeper
1 Guardian	20%	20%	Reports to Secretary	1 Guardian
1 Housekeeper	20%	20%	Reports to Secretary	1 Housekeeper
1 Regional Coordinator Literacy	20%	20%	Reports to PM/COD Director (RPG)	1 Regional Coordinator Literacy
1 Literacy teacher	20%	20%	Reports to PM/COD Director (RPG)	1 Literacy teacher
1 Chief Micro-enterprises	25%	25%	Reports to PM/COD Director	1 Chief Micro-enterprises
1 Chief Micro-enterprises	25%	25%	Reports to PM/COD Director	1 Chief Micro-enterprises
1 Coordinator Micro-enterprises	25%	25%	Reports to PM/COD Director (RPG)	1 Coordinator Micro-enterprises

COD STAFF for CHILD SURVIVAL

PAGE 1

Last Name	First Name	Clinic	Title
Eddras	Bérote	Olivier	Statistician
Marie-Claudette	Lucas	Olivier	Archivist
Joseph	Derline	Olivier	Auxiliary
Joanis	Déshormeau Mirliane	Olivier	Nurse
Florvil	Marlaine	Olivier/Tou- chouchou	Auxiliary
Monice	Téline	Petit Goave	Secretary
Faublas	Anes	Petit Goave	Chief Accountant
Thélistier	Elysée	Petit Goave	Regional Director for Petit Goave
Jeannedie	Similién	Olivier	Nurse
Cedmé	Nirva	Olivier	Lab technician
Hercina	Doviliass	Olivier	Auxiliary
Melina	Cadet	Olivier	Auxiliary
Cilophane	Guerrier	Olivier	Auxiliary
Fablas	Triano	Petit Goave	Regional Coordinator Literacy
Joseph	Alfrance	Petit Goave	Literacy teacher
Louis	Mirlande	Olivier	Auxiliary
Seguere	Josue	Port au Prince	Financial Manager
Baptichon	Merlande	Port au Prince	Chief Micro-Enterprise
Godard Jules	Roseline	Petit Goave	Coordinator Micro- Enterprise
Louis	Noé	Olivier	Bookkeeper

Dr.	Paul	Port au Prince	COD Medical Director
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PAGE 2

Last Name	First Name	Clinic	Title
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MoH (UCS) staff collaborating with CS project

Roussel	Toussaint	Petit Goave town	Doctor-Notre Dame Hospital
Toussant	Docilus	3rd section	Arnoux health center
Innocent	Cezaire	1st section	Violet health center
Charlemagne	Colbert	2nd section	Madeleine health center
Antoine	Nadege	12 section	Vallue health center

ANNEX 6 c

IRS Number
001-239-996-1
005-353-011-1
005-356-004-8
003-450-352-5
005-357-180-7
001-591-364-1
005-656-003-7
003-176-742-3
006-647-482-0
001-931-881-7
006-512-409-0
005-350-534-7
001-266-236-7
001590-252-2
005-351-875-7
NA
003-272-224-6
005-354-492-0
001-592-758-7
005-353-260-4

NA

ANNEX 6 c

IRS Number

t

001-631-548-1

NA

**APPLICATION FOR
FEDERAL ASSISTANCE**

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED 4/15/2005	Applicant Identifier
Pre-application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
5. APPLICANT INFORMATION			
Legal Name: Global Health Action, Inc.		Organizational Unit: Department:	
Organizational DUNS: 052415718		Division:	
Address: Street: 1902 Clairmont Road		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Dr. First Name: Yolanta	
City: Decatur		Middle Name S.	
County: DeKalb		Last Name Melamed	
State: GA	Zip Code 30033	Suffix:	
Country: U.S.A.		Email: ymelamed@globalhealthaction.org	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 23-7241142		Phone Number (give area code) 404/634/5748	Fax Number (give area code) 404/634/9685
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input type="checkbox"/> Continuation <input checked="" type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) Other (specify) <input type="checkbox"/> <input type="checkbox"/>		7. TYPE OF APPLICANT: (See back of form for Application Types) 501(c)(3) PVO Other (specify)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		9. NAME OF FEDERAL AGENCY: USAID/BHR/PVC	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Petit-Goave, Haiti		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Healthy Mothers, Healthy Children: A Child Survival Initiative in Petit-Goave	
13. PROPOSED PROJECT Start Date: 10/1/2004 Ending Date: 9/30/2009		14. CONGRESSIONAL DISTRICTS OF: district 4 a. Applicant N/A b. Project N/A	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 1,060,801 ⁰⁰	a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:	
b. Applicant	\$ 40,200 ⁰⁰	b. No. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$ ⁰⁰	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
e. Other	\$ 576,943 ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
f. Program Income	\$ ⁰⁰		
g. TOTAL	\$ 1,677,944 ⁰⁰		
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.			
a. Authorized Representative			
Prefix Ms.	First Name Robin	Middle Name C.	
Last Name Davis		Suffix R.N., M.N.	
b. Title Executive Director		c. Telephone Number (give area code) 404/634/5748	
d. Signature of Authorized Representative <i>Robin C. Davis</i>		e. Date Signed 4/15/2005	

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Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

SECTION C - NON-FEDERAL RESOURCES					
(a) Grant Program M/OP/GH/HSR-04-003	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS	
8. Headquarters	\$169,603	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
9. Field	\$1,124,079	40,200.00	576,943.00	617,143.00	0.00
10. N/A					0.00
11. N/A					0.00
12. TOTAL (sum of lines 8-11)		\$ 40,200.00	\$ 0.00	\$ 576,943.00	\$ 617,143.00

SECTION D - FORECASTED CASH NEEDS						
	Total for 1st Year		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	13. Federal	\$ 258,341.00	\$ 42,000.00	\$ 70,000.00	\$ 80,000.00	\$ 66,341.00
14. Non-Federal	125,921.00	15,000.00	35,000.00	30,921.00	110,921.00	111,341.00
15. TOTAL (sum of lines 13 and 14)	\$ 384,262.00	\$ 57,000.00	\$ 105,000.00	\$ 110,921.00	\$ 110,921.00	\$ 111,341.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT					
(a) Grant Program M/OP/GH/HSR-04-003	FUTURE FUNDING PERIODS (Years)				
	(b) First	(c) Second	(d) Third	(e) Fourth	
16. Headquarters	\$169,603	\$ 42,150.00	\$ 38,657.00	\$ 42,047.00	\$ 46,749.00
17. Field	\$1,124,079	275,459.00	271,090.00	305,357.00	272,173.00
18. N/A					
19. N/A					
20. TOTAL (sum of lines 16-19)	YR2-YR5 \$1,293,682	\$ 317,609.00	\$ 309,747.00	\$ 347,404.00	\$ 318,922.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges: All COD-EMH is "Contractual"	22. Indirect Charges: Fixed 8.8%

23. Remarks: See Budget Narrative for IN-KIND contributions, contractual, and indirect cost explanations.

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		Total (g)
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	
1. Headquarters		\$ 0.00	\$ 0.00	\$ 206,791.00	\$ 0.00	\$ 206,791.00
2. Field		0.00	0.00	854,010.00	617,143.00	1,471,153.00
3.		0.00	0.00	0.00	0.00	0.00
4.		0.00	0.00	0.00	0.00	0.00
5. Totals		\$ 0.00	\$ 0.00	\$ 1,060,801.00	\$ 617,143.00	\$ 1,677,944.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY					Total (5)
	(1)	(2)	(3)	(4)	(5)	
a. Personnel	\$ 329,435.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 329,435.00
b. Fringe Benefits	37,818.00	0.00	0.00	0.00	0.00	37,818.00
c. Travel	84,176.00	21,002.00	0.00	0.00	0.00	105,178.00
d. Equipment	37,500.00	0.00	0.00	0.00	0.00	37,500.00
e. Supplies	17,170.00	0.00	0.00	0.00	0.00	17,170.00
f. Contractual	417,325.00	516,323.00	0.00	0.00	0.00	933,648.00
g. Construction	0.00	0.00	0.00	0.00	0.00	0.00
h. Other	53,040.00	29,900.00	0.00	0.00	0.00	82,940.00
i. Total Direct Charges (sum of 6a-6h)	976,464.00	567,225.00	0.00	0.00	0.00	1,543,689.00
j. Indirect Charges	84,337.00	49,918.00				134,255.00
k. TOTALS (sum of 6i and 6j)	\$ 1,060,801.00	\$ 617,143.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 1,677,944.00
7. Program Income	\$	\$	\$	\$	\$	0.00

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Child Survival and Health Grants Program Project Summary

Aug-29-2005

Global Health Action (Haiti)

General Project Information:

Cooperative Agreement Number: GHS-A-00-04-00021-00
Project Grant Cycle: 20
Project Dates: (9/30/2004 - 9/29/2009)
Project Type: Entry/New Partner

GHA HQ Backstop: Yolanta Melamed

Field Program Manager Information:

Name: Jean-Eliott Pierre
Address: RHT Building
Port-au-Prince
Phone: 509-413-2505
E-mail: jepdoc1@hotmail.com

Funding Information:

USAID Funding:(US \$): \$1,061,385

PVO match:(US \$) \$11,315

Project Information:

Description:

The project goal is to contribute to the reduction of infant and maternal mortality in the region of Petit-Goave (Haiti). The interventions will include: immunization of pregnant women and women of reproductive age; promotion of breastfeeding and Maternal and Newborn Care which will include the promotion of micronutrients, child spacing and HIV/AIDS as well as complete child vaccination for the first year -BCG, Polio 3, DPT 3 and Measles. In order to reach its goal, the project will undertake to improve the availability and quality of key child survival and maternal and newborn services as well as increase demand for and utilization of those same key services. The project will also build and strengthen the referral network and channels within existing health facilities and in the community. All these strategies will take place in coordination with the local PVO, the staff from the dispensaries and the hospital of the district as well as community members who are involved in community groups. The health activities in the area will continue providing a very important framework of child survival intervention package and a pathway for ensuring the continuity of the project's achievements.

Project Partners:

COD-EMH and MoH (UCS)

General Strategies Planned:

Social Marketing
 Advocacy on Health Policy

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Organizational Capacity Assessment with Local Partners
 Lot Quality Assurance Sampling

Behavior Change & Communication (BCC) Strategies:

Social Marketing
 Mass Media
 Interpersonal Communication
 Peer Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
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US HQ (General) Field Office HQ CS Project Team	Local NGO Networked Group	(None Selected)	Health Facility Staff	Health CBOs CHWs
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Interventions/Program Components:

Immunizations (20 %)

(CHW Training)

(HF Training)

- Polio
- Classic 6 Vaccines
- Surveillance
- Cold Chain Strengthening
- New Vaccines
- Injection Safety
- Mobilization

(CHW Training)

(HF Training)

Maternal & Newborn Care (55 %)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- STI Treat. with Antenat. Visit
- Control of post-partum bleeding
- PMTCT of HIV
- Emergency Transport

(CHW Training)

(HF Training)

Breastfeeding (25 %)

(CHW Training)

(HF Training)

- Promote Excl. BF to 6 Months
- PMTCT of HIV

(CHW Training)

Target Beneficiaries:

Infants < 12 months:	5,580
Women 15-49 years:	31,447
Population of Target Area:	125,789

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
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)	45	250	18.0%	7.1
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	45	84	53.6%	18.9
Percentage of children age 0-23 months whose births were attended by skilled health personnel	269	293	91.8%	11.4
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	191	300	63.7%	10.5
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	49	92	53.3%	18.1
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	33	56	58.9%	23.9
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	16	64	25.0%	16.2

Percentage of children age 12-23 months who received a measles vaccine	51	110	46.4%	15.8
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	7	287	2.4%	2.5
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	139	300	46.3%	9.5
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	5	208	2.4%	3.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	132	282	46.8%	9.9
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	70	300	23.3%	7.3

Comments for Rapid Catch Indicator
