AWARENESS Project
Haiti Country Report
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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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Acronyms

CBD	Community-based Distributor
CHW	Community Health Worker
FBO	Faith-based Organization
HHF	Haitian Health Foundation
IEC	Information, Education, and Communication
IRH	Institute for Reproductive Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
SDM	Standard Days Method®
USAID	United States Agency for International Development

Country Program Summary
Haiti

Family planning use remains very low in Haiti (28% of married women according to the DHS), and the fertility rate is the highest in the western hemisphere. Persistent sociopolitical problems created a chronic shortage of reproductive health supplies and lessened the motivation of health personnel and decision makers. The USAID mission invited IRH to address these needs, anticipating available funding for training and technical assistance to include the SDM in its program. Due to changes in mission staffing and strategy, funding was not forthcoming, so IRH primarily provided long-distance technical assistance for SDM integration to Management Sciences for Health (MSH), the cooperating agency tasked with developing family planning capacity in the public sector, and the Haitian Health Foundation (HHF), a FBO with a strong community health system.

After extended delays due to civil unrest, MSH and the MOH officially launched the SDM in November 2005, with IRH participation. At that time, a total of 141 key Haitian trainers and service providers received general training. MSH also conducted official launches in each province and trained trainers in some provinces, using materials developed by IRH that MSH translated and adapted. MSH procured 25,000 sets of CycleBeads, some of which were distributed at regional launches and trainings, and provided technical assistance to the MOH for follow-on cascade training. The 14 institutions where MSH offers direct support initiated SDM services, as did a number of government sites and clinics of some FBOs.

HHF incorporated the SDM into home visits by community health workers (CHWs) in the Grand Anse region, provided technical input to the regional MOH, and supplied some clinics with a limited number of CycleBeads. As a result of HHF efforts, the Grand Anse has the highest number of SDM users in Haiti, and most are first-time family planning users.

In February 2007, IRH conducted a service assessment that showed SDM integration in Haiti did not follow an optimal process due to the weak central government, lack of stakeholder commitment, lack of a central supervision system, insufficient funding for technical assistance, and the lack of an organized commodities procurement system. Many providers had not been formally trained but were offering the SDM with incomplete information. Although some services collect SDM data, the SDM has not been included in the national database for family planning. The SDM is sporadically available in more than 20 clinics countrywide, and more than 700 users have been registered (although the actual number is unknown). Interest is high on the part of clients and providers, but there is little coordinated effort on the part of stakeholders. Introducing the SDM in an unstable environment without consistent technical assistance is extremely difficult. Further discussions with the USAID mission on implementing organizations are needed to assess the potential for future success.

Source: CIA World Factbook 2008

I. Introduction

Contraceptive use remains very low in Haiti while fertility rates are the highest in the western hemisphere. Only 28% of married women reported using family planning in the most recent Demographic and Health Survey, with less than 23% using modern, effective methods. Awareness of family planning is high in Haiti and 55% of women, when surveyed, did not want to have any more children.[1] Many rural Haitians have limited accessibility to family planning methods, partially due to sociopolitical problems that have created a chronic shortage of contraceptive commodities and lessened the motivation of both health personnel and decision makers.

In August 2004, to respond to the unmet need for family planning and with the support of the Haitian government, the USAID/Haiti Mission invited the Georgetown University Institute for Reproductive Health (IRH) to introduce the Standard Days Method® (SDM) into the Haitian health system. Due to political unrest in the country, an initial needs assessment did not take place until January 2005, when IRH conducted an orientation on the SDM for nine organizations (seven in Port au Prince, one in Jérémie, and one in Leogane). Partners, providers, and clients greeted the SDM with enthusiasm. Given the positive response, USAID/Haiti and the Ministry of Health (MOH) requested that IRH work with Management Sciences for Health (MSH) and the Haitian Health Foundation (HHF) to introduce the SDM in Haiti. The mission indicated that funding would be available for training and technical assistance, and IRH proceeded on that basis. When this did not occur, due to shifts in mission personnel and priorities, IRH continued to offer long-distance technical assistance to MSH and HHF to include the SDM in their work. This proved to be challenging, given the broad work scope of these organizations and the need for a strategic process to ensure SDM integration and scale up. Nonetheless, there appears to be continuing interest in the SDM in Haiti on the part of the MOH, providers, and clients.

II. Objectives and Strategy

The purpose of IRH activities in Haiti was to contribute to increasing the availability and use of good-quality family planning/reproductive health services in Haiti. Specifically, IRH sought to increase the use of modern family planning by introducing the SDM in selected family planning programs in Haiti.

USAID/Haiti requested that IRH introduce the SDM in Haiti through MSH, the cooperating agency developing public health sector management and service delivery capacity, and HHF, a faith-based organization (FBO) with a strong community health system and history with IRH. The MOH, MSH, and HHF planned to make the SDM a regular part of the service delivery system, with help from IRH, by:

- Training trainers and providers to screen and counsel clients
- Providing information about the SDM to men and women in the community

[1] Collymore, Yvette. 2004. "Haiti's Health Indicators Reflect Its Political and Economic Pains". Population Reference Bureau. http://www.prb.org.

- Ensuring CycleBeads®—the tool that helps women learn and use the SDM—are available where services are offered
- Collecting data on SDM clients and services for reporting and management purposes
- Building the SDM into the ongoing supervision system
- Creating a supportive policy environment to facilitate sustainability, and
- Conducting evaluations to inform quality services

IRH's role was to provide technical assistance and help partners address issues such as ensuring quality of care, adapting training and educational materials, developing curricula for pre-service and in-service training, collecting service statistics and other basic information, and evaluating the program.

III. Activities and Accomplishments

IRH's primary partners for SDM implementation were MSH and HHF. MSH's role was to coordinate the SDM integration at the national level, while HHF would concentrate efforts in the Grand Anse region. MSH took responsibility for all SDM implementation, including adaptation and translation of SDM materials; training and information, education, and communication (IEC) activities; and oversight of the supply and distribution of CycleBeads to partner organizations. HHF was to work, through its existing community health system, in the Grand Anse region and support the regional health department, as feasible.

MSH, in collaboration with the MOH, officially launched the SDM in November 2005. The event was held in Port au Prince and chaired by the Minister of Health, Dr. Josette Bijou, who thanked partners for introducing a low-cost, easy-to-use, natural method of family planning that reinforced the MOH's commitment to making family planning available to all Haitians. Soon after the launch, IRH sent a team to train trainers. HHF organized three training sessions in Jérémie (76 participants), and MSH held three sessions in Port au Prince (65 participants) for a total of 141 trained trainers and providers. Trainees came primarily from the MOH, MSH, and HHF partner organizations, including church clinics, nonprofit organizations, and private clinics.

MSH conducted official launches in each province and trained trainers in some provinces. MSH also translated and adapted some client materials developed by IRH into French and Creole and procured 25,000 sets of CycleBeads, some of which were distributed at the regional launches and trainings. MSH provided technical assistance to the MOH, which was supposed to continue the cascade training and train providers. The MOH assumed responsibility for the distribution of CycleBeads and other SDM-related materials from MSH. The 14 institutions where MSH offers direct technical assistance initiated SDM services. A number of government and FBO clinics also included the SDM in service delivery.

> *"SDM is a choice you make for yourself and your husband…You say, yes, we will use CycleBeads…We put our heads together and decided to use family planning."* **– Focus group participant**

HHF offers the SDM through home visits by community health workers (CHW) in the Grand Anse. At the time of this report, HHF collaborated with the MOH and the Sisters of the Good Shepherd on a USAID-funded child survival project, KOMBIT. (KOMBIT is the Haitian name

for a community practice of neighbors working a piece of land today and moving to help the next person tomorrow). Through KOMBIT, HHF has provided technical assistance to the regional MOH on the SDM and supplied some clinics with a limited number of CycleBeads. HHF also developed IEC materials and adapted SDM supervision tools. Building on HHF's experience with natural methods of family planning and their existing network of community-based distributors (CBDs), the SDM has been well accepted. As a result, the Grand Anse has had the highest number of SDM users in Haiti, and most are first-time family planning users.

Table 1: Partners and Activities

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health (MOH)	• SDM official launch • SDM integration into family planning repositioning strategy	• Cascade training • Policy change • SDM integration into reference manuals (norms, training, etc.) • Regular field supervision visits	• Orientation • Training • Technical assistance • Assessment	• SDM officially launched • Services available in selected clinics • CycleBeads available in selected clinics
Management Sciences for Health (MSH)	• Official launches • Cascade trainings • Supervision • CycleBeads distribution	• Adaptation of training and IEC materials • Integration of CycleBeads into national logistics system	• Initial donation of CycleBeads • Initial training of trainers • Sample IEC materials	• Procurement of 25,000 CycleBeads • SDM services in 14 institutions • Limited number of providers trained • SDM brochures and calendars produced
Haitian Health Foundation (HHF)	• Training of providers (Grand Anse) • Supervision • SDM integrated into CHW program • Technical assistance to regional MOH	• Development of IEC materials • Adaptation of supervision tool • Supply of some CycleBeads	• Initial donation of CycleBeads • Initial training • Sample IEC materials • Assessment and evaluation of SDM integration	• SDM services provided • Increased number of SDM users • Successful CHW program • Good supervision and recording mechanism

A. Research

IRH conducted an assessment in February 2007 to evaluate how well SDM services were taken to scale by MSH and HHF after the initial provision of technical assistance. Evaluation elements included the level of SDM integration into family planning services; acceptability of the method to stakeholders, providers, and clients; and provider knowledge. The assessment consisted of key informant interviews, site visits using a checklist to measure SDM integration, in-depth interviews, and focus groups with providers and clients. Areas for site visits were chosen for easy access from Jérémie or Port au Prince. In the Jérémie area, the evaluation team visited one MOH clinic, one mixed clinic, one NGO/FBO clinic, and two CBD sites. In the Port au Prince area, they visited four NGO/FBO clinics.

The main conclusions of the assessment were that the SDM integration in Haiti did not follow the desired process due to the weak central government, lack of stakeholder commitment, lack of a central supervision system, insufficient funding for technical assistance, and the lack of an organized commodities procurement system. Many providers interviewed had not received formal trained but were offering the SDM with incomplete information. Recommended corrective measures included meeting with key family planning players to strategize on SDM integration, a refresher training of trainers and providers, a well-coordinated follow-up of implementation to ensure the SDM is integrated into all national reference manuals, the MOH procurement system, and activities to raise awareness of the method.

B. Building awareness of and support for SDM

Toward the beginning of the Haiti program, the IRH team presented the SDM to nine organizations that had been identified by the mission as appropriate for building support for the method and they were enthusiastic. IRH provided MSH with SDM materials, including IEC materials, posters, and electronic files of training documents. MSH developed an SDM poster, a calendar, flipcharts, and a brochure. All materials developed by MSH were shared with the MOH for distribution to MOH and partner organization clinics. During the assessment, few of these materials were found in the field. HHF's CHWs, however, utilized skits and songs to raise awareness of the SDM in their communities.

C. Developing the capacity of local organizations

In April 2005, IRH oriented MSH and HHF-affiliated staff on the SDM in six initial sessions reaching 141 trainers and providers. MSH and HHF partner organizations, including FBO, NGO, and MOH clinics from many regions in Haiti provided most of the participants. Participants were eager to start offering the method, but were advised to wait for an organized training of master trainers. The initial orientation covered a general introduction to the SDM, client screening processes, the use of CycleBeads, identification of issues in SDM training and service delivery, and how to replicate the training. Usually, after such an orientation, IRH participates or co-trains in the first of a series of cascade trainings. The MOH did not have the means to continue trainings, and other in-country implementing and technical support organizations did not take the SDM on. After the initial orientation, the training of master trainers did not occur and the cascade training was not well implemented. Many providers interviewed have been offering the SDM based on the initial orientation they received from IRH. In most cases, they have also obtained information from the CycleBeads inserts or on the leaflet produced for the launch by MSH.

Health care providers learn that the white beads signify the days when women are most likely to get pregnant.

The MOH had not supervised the providers interviewed during the assessment for some time, as Haiti was undergoing government changes and the MOH was reorganizing. Although MSH has a

general supervision mechanism for activities it supports, it was not clear whether the SDM has been incorporated into it. HHF, on the other hand, conducts supervision visits using an adapted Knowledge Improvement Tool, a supervision aid developed by IRH.

MSH and HHF requested and received limited technical assistance from IRH, primarily consisted for the initial needs assessment, the partner orientation meetings, telephone and email communications, and two follow-up visits to Haiti. The Institute used central funding for these activities, as the anticipated funds from USAID/Haiti did not materialize.

Table 2: SDM Training and Service Delivery Statistics

Name of Organization	Number of Providers Trained	Number of Sites with Trained Providers	Number of Trainers Trained	Number of SDM Acceptors Dec. 04–Aug. 07
MOH	Data not reported, due to persistent unrest	Data not available	Data not available	Data not available
MSH	65	14	Unavailable	100*
HHF	76	8 clinics, 60 CHW sites	15	600

***3 months of service delivery (October to December 2006)**

D. Incorporating the SDM into reporting systems

The initial orientation emphasized the importance of data collection. As determined during the assessment, providers were entering SDM users in the daily client register and reporting SDM users monthly at all sites. The monthly reporting form, however, did not include the SDM, so the data had to be entered by hand. MSH collected this information for its reporting but only shared limited information with IRH. It was not clear whether the MOH collects data on the SDM. The SDM has not been included in the national family planning database.

E. Generating commitment of resources to SDM by governments, NGOs, or donor agencies

During the initial discussion of the SDM introduction in Haiti, it was understood that the Haiti mission would support SDM integration through field support to IRH. Due to changes at USAID/Haiti, funding for SDM was included in the MSH bilateral, assigning the responsibilities of SDM implementation to MSH and HHF. In addition, the USAID/Haiti family planning strategy shifted to focus on long-term methods, so there is little incentive for organizations funded by USAID to commit resources to the SDM. Besides the 25,000 sets of CycleBeads initially purchased by MSH and the IEC materials developed by HHF and MSH, there have been no other commitments to support SDM services.

F. Incorporating SDM into the logistics system

The initial 2,000 sets of CycleBeads donated by IRH were used for training and advocacy. MSH later purchased 25,000 sets, used some for launches and trainings, and deposited the rest at the MOH distribution center where other commodities are kept. However, the assessment revealed that providers did not know where to obtain CycleBeads.

G. Summary of SDM introduction and expansion experiences

The SDM appears to be an acceptable addition to the method mix in Haiti, as it meets the needs of couples who would like to space births but who prefer not to use hormonal, surgical, or barrier methods. To date, the method has been sporadically available in more than 20 clinics countrywide, and more than 700 users have been registered in addition to an unknown number of users served by the MOH. Interest is high on the part of clients and providers, but there is a lack of coordinated effort on the part of stakeholders.

IV. Challenges

Chronic unrest and violence have had a severe impact on the Haitian health system. However, the biggest challenge faced by the SDM expansion program in Haiti was the lack of funding and support for technical assistance. IRH oriented partners on the SDM, and they began offering the SDM without appropriate training. IRH's two follow-up visits were not sufficient to address the situation, and partners lacked both commitment and organized coordination of SDM implementation.

V. Lessons Learned

- Careful attention must be given to quality of care during the method introduction process. Training is not a stand-alone intervention; the entire implementation process must be followed carefully to achieve high-quality, sustainable services.
- It is important to coordinate partner efforts to maximize resources and avoid duplication. HHF translated SDM documents into Creole, although MSH had already translated them. HHF also developed IEC materials for their catchment areas, although MSH had already developed IEC materials for the whole country.
- Introducing the SDM in an unstable environment is not impossible, but requires flexibility and strong local partners who are committed to including the SDM in their work.
- Although partners may be generally supportive of including the SDM in their programs, without specific SDM deliverables in their projects, their commitment to doing so may not materialize.
- The success of project implementation depends on ongoing training and staff development.

VI. Future plans

Sustainable, high-quality SDM services in Haiti will only be achieved with a commitment of resources to support the integration process. Further discussions should be held with the Mission and MSH, which is now implementing a new bilateral that include deliverables on family planning services in Haiti, on how best to approach SDM integration. IRH will continue to work with the MOH and engage other partners, including the United Nations Population Fund (UNFPA) in the discussion regarding SDM integration.