PN-AAT-607
50946

MANAGEMENT DEVELOPMENT PLAN FOR

FAMILY PLANNING MANAGEMENT TRAINING

IN HAITI

Sara Seims

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May-June 1987

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

LIST OF ACRONYMS

PERSONS CONTACTED

EXECUTIVE SUMMARY

I. INTRODUCTION

II. USAID/GOH POPULATION PROJECTS

III. THE GOH MANAGEMENT STRUCTURE FOR FAMILY PLANNING

IV. THE GOH MANAGEMENT STRUCTURE FOR THE BILATERAL POPULATION PROJECT

V. RECOMMENDATIONS FOR FPMT ACTIVITIES IN HAITI

A. Review of FP Management Areas

B. Seminar to Introduce the Project

C. Workshop on Workplan Development for the RFPOs and DFPOs

D. Workshop on Supervisory Training for the RFPOs

E. Establishment of a Family Planning MIS

F. Seminar on Financial Management

G. Study Tour Program

ANNEX A: Scope of Work for a Resident Technical Advisor

ANNEX B: Country Profile - Haiti

ANNEX C: Tentative Agenda of GOH/FPMT "Brainstorming" Program

Acknowledgements

The FPMT Team was very fortunate to receive extensive guidance and collaboration from the Health and Population Staff of USAID/Port-au-Prince and from the Division of Family Health and Nutrition of the Ministry of Public Health and Population. In particular, we would like to express our appreciation of the kind assistance and invaluable technical input we received from Dr. Mike White, Ms. Leslie Curtin, and Madame Gisele Balmir of USAID and from Dr. Jean Claude Garnier, Dr. Lamotte and Dr. G. Michaud of the Ministry. Our visit was also aided by the opportunity to collaborate with Mrs. Solange Smreka of Development Associates who provided many useful insights. We would also like to thank Ms. Estelle Quain of the Pathfinder Fund who prepared background materials for us on the socio-economic and demographic situation in Haiti.

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EXECUTIVE SUMMARY

During the period May 25 - June 5, 1987, FPMT team members Jean-Georges Dehasse, Consultant, and Dr. Sara Seims, FPMT Deputy Director for Operations, worked with officials of the Ministry of Health and of the USAID mission to design a management development plan for family planning service provision in Haiti. The team arrived just two days after the signing by the GOH and USAID Mission Director of an amendment to the ongoing Family Planning Outreach Project.

Among the main objectives of the project under the newly signed amendment are:

- the setting into place of a new organizational structure, essentially:
  - (i) the installation of a National Coordinator for Family Planning (NCFP)at the Unit of Regional Coordination at the MOPHP with the specific responsibility to ensure that FP activities be planned, executed, monitored and evaluated in a proper and efficient manner, and
  - (ii) the reassignment of regional and district health officers as regional and district Family Planning Officers;

- the design and development of a new management information system and the updating of the present supply system;

- renovation of health facilities and the training of FP personnel to ensure the expansion of the delivery system with the aim of reaching a prevalence rate of 11 percent from the present level of 6 percent.

After careful review of the objectives of the Family Planning Project under the Amendment, on the one hand, and of relevant management issues and problems in the Family Health sector in Haiti on the other, the FPMT team has proposed a management development plan including the following training and TA activities:

1. Review of FP management areas

It is proposed that the NCFP and the Director of the Division of Family Hygiene and Nutrition (DFHN) spend two weeks at MSH, during which time they will work with FPMT staff to:

(a) review and clarify the roles and responsibilities of the different parties involved in FP service delivery including the NCFP, DFHN, DESE (Division of Health Education), Regional Health Directors, Regional Family Planning Officers (RFPOs), District FPOs, etc.

(b) examine training materials developed by FPMT which may be of particular relevance to Haiti, including supervisory protocols, goal setting for FP programs, workplans, project monitoring, job descriptions, plus a review of the family planning MIS developed for Brazil and Senegal.

(c) review team building approaches which can be used to integrate the regional and district FPOs into the ongoing health teams.

(d) strategies for integrating family planning into the other priority health areas of the GOH.

(e) plan the upcoming activities described below:

(i) Seminar to Introduce the Project

(ii) Workshop on Workplan Development for the RFPOs

(iii) Workshop on Supervisory Training for the RFPOs

(iv) Establishment of a FP MIS

(v) Seminar on Financial Management

(vi) Study Tour Program

2. Seminar to Introduce the Project

This two or three day seminar should coincide with the official launching of the amended project. The participants should include the parties involved in the delivery of FP services, including the Regional Health Directors, RFPOs, DFPOs, DESE, and Conapo (Population Commission). The seminar should be organized and implemented by the NCFP and the DFHN with assistance, as necessary, from FPMT. The seminar should review the objectives and goals of the amended project and the roles of the various individuals and organizations concerned.

3. Workshop on Workplan Development for the RFPOs and DFPOs

The two week workshop will follow immediately after the above seminar. Participants will review concepts and techniques pertaining to:

- establishment of objectives for the delivery of family planning services in their regions;

- component activities which comprise the family planning system at the regional level;

- timing of activities and tasks;

- determination of resources necessary to reach objectives and preparation of corresponding budget line items and estimates;

- preparation of workplans;

- establishment of monitoring and evaluation procedures of the regional FP program.

This workshop will include an analysis of the reason why contraceptive prevalence has declined and a discussion on lessons learned from this experience. The participants will also review all factors and resources (renovations, clinical training, IEC, etc.) which must be considered when expanding family planning services in

the regions. They will review their roles and responsibilities as RFPOs in the planning of FP activities in their region, as well as the roles and responsibilities of the District Officers.

The NCFP should request the RFPOs attend the workshop with certain key data, e.g. the number of centers at each level in the region, since these data are indispensible to conducting practical planning exercises. A standard list of such key data will be prepared with the NCFP during the planning meeting in Boston.

4. Workshop on Supervisory Training for the RFPOs

The goal of this workshop will be to help the RFPOs work with their respective DFPOs so that the district level personnel will better understand their work and prepare acceptable workplans. The training will include:

(a) the RFPO as planner, supervisor and motivator; case study exercises may be used;

(b) development of supervisory protocols;

(c) techniques of motivating district level volunteers;

(d) assessing management training needs of DFPOs.

The RFPOs will be expected to effectively assist the DFPOs with their planning and to supervise and evaluate the work of the district level personnel.

5. Establishment of a Family Planning MIS

In collaboration with CDC, FPMT could provide the training and follow on technical assistance for a computerized MIS. This system would include the inventory control currently being prepared by CDC as well as service statistics, financial accounting and data necessary for project evaluation. This training will take place in Haiti with participation from each region and one representative from the DFHN.

6. Seminar on Financial Management

This five day seminar will work with those MOPHP accountants at the national and regional levels to review budgeting and financial management procedures for AID projects.

7. Study Tour Program

In order to help the MOPHP improve their family planning service delivery, it is proposed that the members of the FP Committee visit model public sector programs to see decentralized activities, supervision and control techniques, collaboration between public and private sectors, etc. The committee members could prepare a plan of action based on their observations. Thailand and Indonesia would be ideal places for the study tour. Other possibilities include Mexico and Morocco. FPMT could organize the study tour, arrange the

in-country program, provide a facilitator to accompany the participants and help develop the in-country follow up program. (It should be noted that study tours, especially to Asia, are very expensive and thus can only take place on a limited basis.)

The mission is also considering a "buy-in" to FPMT to place a resident technical advisor as a counterpart to the NCFP. A tentative scope of work for this position can be found in Annex A.

I. Introduction

The Republic of Haiti has an estimated population of 5.9 million. The crude birth rate is around 36 per thousand and the crude death rate around 13 per thousand. Haiti's rate of natural increase is therefore approximately 2.3 percent annually - leading to a doubling time of about thirty years if present trends continue. A very large number of Haitians have emigrated to other countries in the Caribbean and North America. Several hundred thousand Haitians are thought to be living in the United States.

Limited family planning services have been available for many years. The GOH policies towards the delivery of services have been characterized by themselves as "very liberal." Both the public and private sectors are involved in family planning - contraceptives are available in pharmacies and outreach workers play an active role in improving access to FP. In addition, family planning has been named by the GOH as one of their seven health priorities (along with nutrition, malaria, tuberculosis, AIDS, maternal and child health, and vaccinations).

However, the public sector program is beset by a wide variety of problems which have greatly inhibited its effectiveness to meet the existing demand for services. The GOH is absolutely committed to the integration of family planning and the decentralization of all health activities. These admirable goals have not as yet been implementable because of the inherent weakness in the health structures and the somewhat confusing lines of authority among the national, regional and district levels.

Contraceptive prevalence levels are currently about 6 percent. However, in certain areas where well run pilot outreach projects have been in effect (such as in the catchment area of the Hospital Albert Schweitzer or using malaria volunteers in the Miragoane district), prevalence rates of around 20 percent have been obtained.

FPMT was requested to send a team to work with USAID and the GOH to prepare a training and technical assistance plan to reinforce the management structures for family planning. A modified bilateral population project agreement had been signed just two days before our arrival. The team's work was greatly facilitated by the excellent support we received from USAID and by the fact that the two key Ministry officials were already affiliated with MSH/FPMT (the head of the DFHN is a member of the FPMT Francophone Regional Advisory Committee and the new NCFP is a graduate of MSH training programs in microcomputers).

The following sections of this report will include a brief review of the past and current bilateral population programs in Haiti, a mapping of the management structure in place to undertake FP activities, and suggested interventions for FPMT. An overview of the socio-economic and demographic situation of Haiti is provided in Annex B.

II. USAID/GOH Population Projects

The current project began in September 1981 with a $9.615 million budget. The bilateral project concentrated on the following five areas:

- improving management of the national FP program;
- improving the quality of FP services;
- increasing the participation of PVOs and community groups;
- establishing a commercial retail sales program;
- formulating a national FP program.

The MOPHP underwent several structural changes during the initial years of the project. The implementing agency, the Division of Family Health, became responsible for nutrition. These new responsibilities, plus the loss of some key staff, complicated the management of the program. This loss of management initiative is considered to be one of the major reasons why contraceptive prevalence declined from its modest earlier levels of around 12 percent. The rate of contraception is not absolutely clear even now, but a 1983 Contraceptive Prevalence Survey indicated about 6-7 percent prevalence - clearly out of line with the surrounding Caribbean countries.

During the 1980s, the GOH decided on two major changes in the delivery of health services. One of these changes was the integration of FP into the health structure; the other was decentralization.

The overall goal of the amended bilateral project is to improve the system which delivers family planning so that during the next two years, prevalence will be increased to 11 percent and the management structure will be in place for an expanded bilateral effort. The amendment allows for the following:

- extension of the PACD of the current program from 9/30/87 to 9/30/89;

- nomination of a National Coordinator for Family Planning (NCFP) who will develop and monitor FP activities;

- nomination of an FP Project Committee chaired by the NCFP and consisting of the Director of the DFHN, the regional health directors or their family planning officers, the Executive Secretary of the National Population Committee and the USAID project officer;

- placement of regional family planning officers who will develop and supervise family planning activities in their regions;

- addition of district level family planning officers who will come under the direction of their regional counterparts;

- equipping, renovating and training personnel in at least one central clinic in each of Haiti's 15 districts;

- expansion of non-surgical FP service delivery to all 163 public health facilities;

- a "buy-in" to the Johns Hopkins Population Communication Project to help improve FP IEC;

- research studies on NORPLANT and relative uses of various contraceptive methods as well as socio-demographic research which will help the GOH formulate a population policy.

Management training was also envisaged in the revised project paper. For example, training in supervision, logistics, MIS, as well as study tours were also included. The FPMT team agreed that these areas were the key ones to address, and the proposed project activities described later in this report build upon these initial propositions in the revised PP.

III. The GOH Management Structure for Family Planning

Family planning services are offered in four types or levels of health care centers under the Ministry of Public Health and Population:

(1) the rural "dispensaries";

(2) the health centers without beds (outpatients);

(3) the health centers with beds;

(4) the hospitals.

Treatment for sexually transmitted disease is rarely offered. IUDs are not popular with Haitians. Sterilization is offered only in hospitals or in health centers where there is a doctor and trained auxiliary personnel.

The four basic types of health centers are present in varying proportions within the five regions and 15 districts of the country. There is at least one hospital per district.

The Rural Dispensaries are staffed by two auxiliaries; the out patient health centers include one physician plus one auxiliary; the in patient health centers are staffed by one to two physicians as well as auxiliary personnel.

Health Care Centers in each region, as well as responsibility for the seven priority preventive health programs, are managed by a regional team headed by a Regional Director. His staff includes the following: an Administrator for Finance and Personnel; a Medical Director in charge of the health care centers, mainly the hospitals; and two or three Regional Nurses, each in charge of two or more of the seven priority programs.

The Regional Director is the overall authority in his region. He is directly accountable to the General Director of the MOPHP. The General Director is assisted by a Coordination Unit which is responsible for liaison and harmonization of the activities and health policies among the five regions. This coordination unit is not very developed.

Regional Directors are sometimes referred to as mini-ministers to underscore the extent of their power to implement health programs and manage health activities in the region - regional autonomy has come of age with the fall of the Duvalier regime in Haiti. This autonomy has its limits, however, since the region has no financial autonomy and no resources of its own. Although the region does go through the motion of preparing a budget, the budget approved at the central level bears little relation to the budgets prepared at the regional level. For example, 95 percent of budgetary resources are for personnel and only 5 percent for operations. All regional personnel are still appointed from the central Ministry in Port-au-Prince, thus leaving only a minor amount of money for discretionary use at the regional level.

Regions are also short in expertise and human resources in general: they are understaffed, especially in relation to their implementation responsibilities. There are numerous complaints that money is spent as it comes on the basis of emergency and expediency, no matter what the intended destination of the funding. Well trained accountants are a rarity to such an extent that it is virtually impossible to trace expenditures by program based on accounting records.

Regional activities and staff can be supported by central divisions of the MOPHP. The two important divisions regarding family planning are the Division of Family Hygiene and Nutrition (DFHN) and the Division of Health Training and Education (DESE). The DFHN was the main implementor of the Family Planning Project and also of a nutrition project. Before the regional autonomy policy, DFHN had organized a system of local "animators". These still exist and are now managed by the Regional Directors and their staff. They usually play an important role in the spread of family planning activities in the local communities in which they operate. However, their distribution in the regions is uneven.

Regional nurses and regional staff are of two minds when it comes to the use of resources available at the central level. This became apparent to the FPMT team when conducting, with regional nurses from the five regions, the exercise of mapping the distribution of responsibilities at the regional level: only one of them indicated that she systematically refers to the central divisions in the conduct of certain activities such as training and IEC, while the others contended that almost all can be done at the regional level.

Given the understaffing and the lack of technical expertise to develop promotional messages and training materials, it seems unlikely that promotional IEC and training activities are conducted at regional levels with the required intensity and efficiency. The only notable IEC activity which has been mentioned was the preparation and the taping of IEC messages and the diffusion of these messages by local radio stations. Information on training activities are scarce and management aspects of training are certainly not emphasized.

A key issue when discussing the problems of managing the family planning program in Haiti is integration versus verticality. Officials from central divisions of the MOPHP as well as from the regions insist that integration must be protected and maintained, meaning that all the activities under the seven priority preventive programs must be conducted simultaneously at health center levels and managed as an integrated set by the Regional Director and his team. Verticality takes over when one of these seven programs becomes a privileged target, is conducted and managed through a distinct organizational structure, and when supplementary privileges or benefits are allocated to those who implement this particular program. While several Ministry officials stated that verticality might be advantageous in the short run by boosting the program for a while, they all believed that it would be detrimental in the long run. The problems of integrating family planning in the weak MOPHP structure is probably the single most important dilemma facing the GOH and USAID.

IV. The GOH Management Structure for the Bilateral Population Project

The table which follows presents the activities under the amended project and the allocation of responsibilities to conduct these activities.

The table is self-explanatory. It had been prepared to verify that all the partners in the execution of the project have the same understanding of their responsibilities in project activities. It was presented to and discussed with Haitian officials from the DFHN, and it takes into account the few changes they have proposed.

Some inconsistencies can be noted such as in the last page of the table where the NCFP is assigned the responsibility to approve annual action plans, to provide assistance to regions regarding the implementation of activities approved (by himself), and to assure that financial, human and material resources be available to the regions. However, the NCFP has no control over resources. Such control is in the hands of the DFHN, the other implementor of the amended project.

Such inconsistencies should be corrected to facilitate collaboration between the NCFP and the DFHN.

ACTORS

Activities	MOPH	DFHN	NCFP	RD	RFPO	External Agencies
1. Setting up new organizat'l structure						
- appointing CNFP	X					
- reassigning RFPOs	X					
- specify role and responsibilitie of various FP actors			X			
- develop operational procedures and mechanisms of coordinators	THIS VERY IMPORTANT RESPONSIBILITY HAS NOT BEEN ASSIGNED TO ANYONE					
2. System to collect management data						
- design MIS		X		X		
- putting MIS into place		X		X		
3. Supply system						
- review and improve the logistics of the supply system		X				CDC
4. Supervisory protocols (design forms, ect.)		X	X	X		
5. Studies and Surveys		X				Contractors
6. Strengthen and expand delivery system						
- plan expansion			X	X	X	
- inventory of renovation			X	X	X	
- training needs assessment			X	X	X	

ACTORS

Activities	MOPH	DFHN	NCFP	RD	RFPO	External Agencies
7. Renovation of Health Centers		X				USAID/ENG
8. Training						
- surgeons and nurses (for sterilizations)		X				JHPIEGO/AVSC
- paramedicals (clinical/IEC)	DESE	X				
- training for RFPOs		X	X			
- training for RDs		X	X			
- training overseas		X				Population TA
9. Developing IEC	DESE	X		X		PCS
10. Research		X				FHI
11. Population policies	CONAPO	X (funding)				Futures Group
12. Support to the private sector		X			X	
13. Distribution of equipment and material		X				
14. Payments under Title III		X				
15. Periodic reports (3 month) to USAID		X	X			
16. Preparing meetings of the Project Committee		X	X			

ACTORS

Activities	MOPH	DFHN	NCFP	RD	RFPO	External Agencies
17. Routine (after all systems are in place						
- identify FP personnel job description/supervision of FP personnel			X	X		
- coordination between Central Division and between central and regional levels			X			
- draft annual workplan			X	X	X	
- approve annual workplan		X	X			
- provide assistance to regions for plan execution/ guarantee resource availibility (financial, material, human) for the region			X			
- control and evaluation of FP activities within regions			X	X		Population TA
- provide DFHN with info in preparing reports; carry through collecting this information			X			

V. Recommendation for the FPMT Activities in Haiti

Based upon the observations described earlier in this report, FPMT proposes a series of activities designed to reinforce collaboration among the different actors involved in the nation, regional, and local delivery of services, as well as address specific management needs articulated by the GOH and USAID. It would be particularly useful if FPMT could work with the GOH to help prepare the annual workplans in time for Title III funds to be released in September 1987. The Title III monies pay for the majority of local costs but, of course, need to be justified by an appropriate workplan.

Before the activities suggested below can be implemented, the regional and district family planning officers must be nominated. The amended project states that all necessary personnel will be assigned within 90 days of the signing of the agreement. There appears to be a reasonable degree of optimism that this timetable will be respected.

The proposed activities are described below.

A. Review of FP management areas

It is proposed that the NCFP and the Director of the Division of Family Hygiene and Nutrition (DHFN) spend two weeks at MSH, during which time they will work with FPMT staff to:

(1) review and clarify the roles and responsibilities of the different parties involved in FP service delivery including the NCFP, DFHN, DESE, Regional Health Directors, RFPOs, DFPOs, etc.

(2) examine training materials developed by FPMT which may be of particular relevance to Haiti, including supervisory protocols, goal setting for FP programs, workplans, project monitoring, job descriptions, plus a review of the family planning MIS developed for Brazil and Senegal.

(3) review team building approaches which can be used to integrate the regional and district FPOs into the ongoing health teams.

(4) develop strategies for integrating family planning into the other priority health areas of the GOH.

(5) plan the upcoming activities described below:

(i) Seminar to Introduce the Project

(ii) Workshop on Workplan Development for the RFPOs

(iii) Workshop on Supervisory Training for the RFPOs

(iv) Establishment of a FP MIS

(v) Seminar on Financial Management

(vi) Study Tour Program

It is proposed that this activity begin at the end of June 1987. A tentative agenda is attached as Annex C.

B. Seminar to Introduce the Project

This two or three day seminar should coincide with the official launching of the amended project. The participants should include the parties involved in the delivery of FP services including the Regional Health Directors, RFPOs, DFPOs, DESE, Conapo. This seminar should be organized and implemented by the NCFP and the DFHN with assistance, as necessary, from FPMT. The seminar should review the objectives and goals of the amended project and the roles of the various individuals and organizations concerned. Tentative timing would be the end of July 1987.

C. Workshop on Workplan Development for the RFPOs and DFPOs

The two week workshop will follow immediately after the above seminar. Participants will review concepts and techniques pertaining to:

- establishment of objectives for the delivery of family planning services in their regions

- component activities which comprise the family planning system at the regional level

- timing of activities and tasks

- determination of resource necessary to reach objectives and preparation of corresponding budget line items and estimates

- preparation of workplans

- establishment of monitoring and evaluation procedures of the regional FP program

This workshop will include an analysis of the reason why contraceptive prevalence has declined and a discussion on lessons learned from this experience. The participants will also review all factors and resources (renovations, clinical training, IEC, etc.) which must be considered when expanding family planning services in the regions. They will review their roles and responsibilities as RFPOs in the planning of FP activities in their region, as well as the roles and responsibilities of the District Officers.

The NCFP should request the RFPOs attend the workshop with certain key data, e.g. the number of centers at each level in the region, since these data are indispensable to conducting practical planning exercises. A standard list of such key data will be prepared with the NCFP during the planning meeting in Boston.

D. Workshop on Supervisory Training for the RFPOs

The goal of this workshop will be to help the RFPOs work with their respective DFPOs so that the district level personnel will better understand their work and prepare acceptable workplans. The training will include:

(1) the RFPO as planner, supervisor, and motivator: case study exercises may be used;

(2) development of supervisory protocols;

(3) techniques of motivating district level volunteers;

(4) assessing management training needs of DFPOs.

The RFPOs will be expected to effectively assist the DFPOs with their planning and to supervise and evaluate the work of the district level personnel. The tentative timing for this activity is December 1987.

E. Establishment of a Family Planning MIS

In collaboration with CDC, FPMT could provide the training and follow on technical assistance for a computerized MIS. This system would include the inventory control currently being prepared by CDC as well as service statistics, financial accounting, and data necessary for project evaluation. This training will take place in Haiti with participation from each region and one representative from the DFHN.

F. Seminar on Financial Management

This five day seminar will work with those MSPP accountants at the national and regional levels to review budgeting and financial management procedures for AID projects. Specifically, the seminar

will provide assistance on how to prepare budgets which are in line with annual workplans, develop financial accountability procedures for each budget line item and develop appropriate monitoring systems.

G. Study Tour Program

In order to help the MSPP improve their family planning service delivery, it is proposed that the members of the FP Committee visit model public sector programs to see decentralized activities, supervision and control techniques, collaboration between public and private sectors, etc. The committee members could prepare a plan of action based on their observations. Thailand and Indonesia would be ideal places for the study tour. Other possibilities include Mexico and Morocco. FPMT could organize the study tour, arrange the in-country program, provide a facilitator to accompany the participants and help develop the in-country follow up program. (It should be noted that study tours, especially to Asia, are very expensive and thus can only take place on a limited basis.)

The mission is also considering a "buy-in" to FPMT to place a resident technical advisor as a counterpart to the NCFP. A tentative scope of work for this position can be found in Annex A.

Annex A

DRAFT SCOPE OF WORK FOR THE RESIDENT TECHNICAL ADVISOR (RTA)

The RTA will be the counterpart of the National Coordinator for Family Planning (NCFP) and will work with him to oversee the establishment of the management system necessary to ensure expanded and improved decentralized family planning services. This will include working with the NCFP to assist:

(a) clarify the role of the different parties involved in the delivery of family planning services (DFHN, DESE, Regional Directors, FP Project Committee, Regional Family Planning Officers, District Family Planning Officers, etc.)

(b) prepare the functioning workplans and actions plans at the regional and district levels. These workplans must be submitted on time and in an appropriate form the USAID/PAP.

(c) identify training needs covering clinical, IEC, and management areas and coordinate and follow-up on the centrally funded contractors who will be charged with this training. The RTA will, under the direction of the USAID Population Officer, prepare a workplan and calendar of these centrally funded interventions.

(d) oversee the establishment of a functioning MIS which will help provide timely feedback at all levels of the FP delivery system.

(e) prepare agenda and arrange for regular meetings of the family planning project committee.

(f) develop a study tour program appropriate for the GOH to develop a population policy and for the MSPP to expand its role in FP service delivery.

(g) prepare USAID required progress reports.

(h) prepare, as requested, population strategy documents.

During the course of their work, the RTA will be expected to make frequent field visits with the NCFP. The RTA will be expected to provide at least bi-monthly informal briefings to USAID on the status of the project activities and to inform USAID of any situation requiring mission action.

A vehicle, secretarial and other support services (including a messenger) and communication facilities will be made available to the RTA by the project. The RTA will be provided with an office which will be in close proximity to the office of the NCFP.

Country Profile: Haiti

A. Economic, Social and Demographic Indicators of Development

1. Background

The Republic of Haiti, covering an area of 27,700 square kilometers, occupies the western third of the island formerly known as Hispaniola. It is bordered by the Dominican Republic on the east and faces the Atlantic Ocean to the North and the Caribbean Sea to the west and south. The capital city is Port-au-Prince; the second largest city is Cap Haitien, in the north. Total population was estimated at 5.9 million in 1986 and is expected to reach 8.4 million by the year 2000.

Only a small portion of the land is arable. Of the country's 27,700 square kilometers, only 8000 are cultivated and possible an additional 3,000 are cultivable. Much of the land suffers from deforestation, soil erosion and exhaustion. Violent hurricanes hit the country every few years. The northern part of the country suffers periods of severe drought which have caused famines, especially in the last few years. In 1986 the population was estimated to be 26 percent urban and 74 percent rural, which makes Haiti Latin America's most rural nation. The population density exceeds 540 and 390 persons per square kilometer of cultivated and cultivable land respectively.

In geographic and political terms, the country is currently divided into five regions, the North, the Northwest, the Artibonite, the West and the South.

2. Economic Situation

Haiti, the poorest country in the Western Hemisphere and one of the 30 poorest in the world, had a per capita GNP in 1983 of US$290. Industry provides 13 percent of Haiti's GNP but employs only 6 percent of the labor force, leaving 80 percent dependent on agriculture for their livelihood. Unemployment is estimated at 14 percent. The annual average income of rural Haitians in 1986 was less than $100.

Non-subsistence income in rural Haiti has always depended on the success or failure of exports such as coffee, sugar and sisal. Although 30 years ago these crops represented 88 percent of total exports; by the mid 1970s, their proportion of total exports had dropped to less than 50 percent, thus diminishing the importance of agricultural exports to farming family income.

Industry draws workers to the capital city which is responsible for 80 percent of the country's industrial production and is clearly the economic center of Haiti. The major industries in the capital are

manufacturing (assembly industries, cement, soap, flour and fibers), construction, commerce and services.

3. Politics and Government

Until the coup d'etat in February 1986, Haiti was theoretically a presidential republic; in practice, however, the president help absolute power. In April 1961, President Francois Duvalier ("Papa Doc") dissolved the bicameral legislature and combined the Senate and Chamber of Deputies into a unicameral Legislature Assemble, elected by popular vote. Elections were not held, however, until February 1973, after Duvalier's death. Under the 1964 constitution, Francois Duvalier was appointed president for life and in 1971 he named his son, Jean-Claude, as his successor. The teenager "Baby Doc" became president for life in April 1971, and remained in office until February 1986 when he was overthrown.

Political life under the "Papa Doc" regime was characterized by plots against the government and governmental counterterrorism, carried out by the security force known as the Tontons Macoutes ("bogeymen") and by other thugs known as "cagoulards". Opposition leaders went into hiding or exile in Colombia, Puerto Rico and Venezuela. Invasions in the late '60s met with failure. Throughout this period, no party operated openly in Haiti except the Duvalierist Party of National Unity (Parti de l'Unite NDationale). Political dissent continued to be silenced under "Baby Doc".

Since the overthrow of 1986, the National Governing Council (CNG) - the provisional government headed by Lieut. General Henri Namphy - has managed to stave off total anarchy. But the government is not trusted. Full civil liberties have not been restored, though civil freedoms have been vastly increased, including that of a relatively free press. There have also been outbreaks of violence reminiscent of the recent dictatorial past. The current political mood is less than enthusiastic about government. Fewer than 20 percent of Haiti's eligible voters bothered to vote on October 19 in the first democratic national election held in thirty years, to choose members for a team to draft a new constitution. The Namphy government's reticence to purge its ranks of former Duvalier henchmen and associates, an understandable reluctance considering that Namphy himself was chief-of-staff of the army under Jean-Claude Duvalier and was his hand-picked successor. Interior Minister Colonel William Regala and Jacques Francoise, two of the three current members of the CNG, were also closely linked to "Baby Doc". With presidential elections promised by the end of 1987, no contender who seems able to draw a substantial degree of public support has yet emerged from the many opposition parties.

4. Cultural and Religious Characteristics

The official religion is Roman Catholicism, but Haiti has freedom of worship. In 1980, affiliated Roman Catholics represented an estimated 88 percent of the population and Protestants 12 percent. However, voodoo (vaudou), a mixture of ceremony and belief from West Africa, is still widely practiced; in 1983, it was estimated that

there were about 60,000 voodoo priests (houngans) in Haiti, compared with 440 Roman Catholic priests. Almost 95 percent of the people of Haiti are of African descent. The rest are of mixed African-Caucasian ancestry except for a small number of European or Levantine ancestry.

Marriage patterns are complex in Haiti. Most women begin their marital careers in unions that do not entail cohabitation. Several types of consensual unions exist, and women are more likely to be in these than in a legal union. Throughout marital careers, nonlegal unions prevail; there is no tendency for commonlaw or non-cohabitating unions to evolve into legal marriage.

Haitian women tend to have several types of unions, often with several different partners. The woman ever in union interviewed by the Haiti Fertility Survey (1977) had an average of 2.17 unions and 1.52 partners. Urban women had higher average numbers of both unions and partners, suggesting more complex union patterns in the cities compared with rural areas.

Although entry into sexual unions is almost universal for Haitian women by age 30, first union is relatively late. Of the representative samply of women aged 15-49 interviewed in the HFS, 31 percent had never been in union. These were primarily younger women: 80 percent of the 15-19 year olds, 40 percent of the 20-24 year olds, and 14 percent of the 25-29 year olds had never been in union. The singulate mean age at union was calculated at 21.6 years. Because of the late entry into unions, adolescent fertility is practically the lowest in Latin America.

5. Social Characteristics

In-school education in Haiti is characterized by a number of recognized problems and limitations. Haiti lacks the teachers, schools, and educational materials required to provide a basic education to even a small percentage of Haitian children. Indications are that in rural areas, as little as 12 percent of the children between ages 6-11 years are enrolled in school. At the secondary school level, the disparity between enrollment in rural and urban areas is even greater than at the primary school level. In 1980 the AID Mission estimated that the situation had not improved from the mid 1960s when only two of the country's 105 secondary schools were located in rural areas. Recently, it has been estimated that 80 percent of Haiti's people are unable to read and write.

6. Health Characteristics

The infant mortality rate in Haiti was estimated in 1986 to be 108 per thousand live births. Life expectance at birth was only 37.6 years in 1950-55. Although this rose to 52.7 by 1980-85, it is still well behind the average for Latin America.

The government considers levels and trends of morbidity and mortality to be unacceptable. It is particularly concerned with the

high levels of infant and child mortality caused by such illnesses as umbilical tetanus (which accounts for approximately 80 percent of all infant deaths) and various infectious diseases, to which the country's malnourished children have a low biological resistance. As reported in the government's Five Year Plan for 1976-1981, protein-calorie malnutrition affects 69 percent of children under five, of whom 7 percent suffer from first-degree malnutrition. The government is equally concerned with the high incidence of acute respiratory infections, which can be prevented by vaccination, and malaria, of which there has been a resurgence in recent years. Poor sanitary facilities and a lack of potable water have been acknowledged as principal causes of typhoid, paratyphoid, dysentery, and other diarrhoeic diseases.

7. Present Demographic Situation

The crude birth rate was estimated in 1986 to be 36 per thousand population; the death rate was estimated to be 13 per thousand population. The RNI is therefore 2.3 percent. There is a large and continual outflow of Haitians from their homeland. The Haitian Fertility Survey, conducted in 1977, conceded that it is difficult to arrive at an exact figure, but that since 1950 around 350,000 Haitians have definitely emigrated, in largest numbers to the U.S., Dominican Republic, Bahamas, Canada, and France. Not only is immigration slight, it is also hindered by the fact that Haitian nationals must secure an entry visa prior to repatriation. Within the country, migration to the capital city is constant, especially from the south and northwest, giving it a growth rate of 5.28 percent (1981).

B. History and Current Status of Family Planning

1. History of the Family Planning Effort

A small Family Planning Association was established in 1962 with the assistance of the International Planned Parenthood Federation (IPPF). Briefly operating a single clinic, the Association ceased operation in 1964 when the Government established a Department of Family Planning with the Ministry of Social Affairs. Since 1969, the private Centre for Family Hygiene has offered family planning services in rural villages in an area known as the rural triangle. Subsequently, in March 1971, the Government ordered a moratorium on all family planning programs in order to enable the Department of Public Health to issue standards and to assume control of health services delivery, including family planning services. A few months later, the Government issued an ordinance creating the Division of Family Hygiene (DFH) within the Department of Public Health and Population (DPHP), and in January 1972 the Secretary of Public Health issued regulations governing all future family planning activities, which henceforth had to receive the approval of the Division of Family Hygiene and had to be developed within the framework of maternal and child health.

The DHF program began operating in 1973 through hospitals and health clinics. The DHF has been responsible for maternal and child health care, as well as family planning. It initially operated almost exclusively through fixed facilities in urban centers. Mobile clinics and community outreach workers were added to the program in 1977. In 1978, 22 clinics were providing family planning services, and 24,000 women were incorporated into the program as new acceptors during that year. Condoms have proven to have excellent acceptance. It is estimated that 43,000 men were supplied with 4.3 milion condoms during 1978. At the present time, condoms are provided free in the clinics. All types of contraceptives are available to the public in Haitian pharmacies. Oral contraceptives are sold without medical prescriptions since there is no law regulating their sale. The prices vary according to brand. The average cost of one cycle of orals is from U.S. $1.40 to $2.00, while condoms cost from $.30 to $.50 apiece. (IPPF/WHR Forum, April 1982).

In 1978, the DFH, with IPPF's financial and technical support, began to implement a project for the distribution of condoms through vending machines in the capital city, Port-au-Prince. The program was intended to introduce commercial vending of family planning commodities as a feasible and attractive alternative for delivering needed products to the Haitian population and thereby create a route for greater consumer accessibility. Further the project was designed as a pilot to be expanded in scope and intensity once community acceptance was tested.

2. Current Population Policies and Laws

The government has established the following research and planning commissions which integrate population within development planning: the Haitian Constitution authorized the establishment of a Central Planning Authority in 1957. Following a number of reorganizations, the National Development and Planning Council (Conseil National de Developement et de Planification, or CONADEP) was created in 1963. Although the Haitian Government has been progressively building its planning machinery since that date, it is only in recent years that highly integrated social programs have replaced vertical and sectoral programming. CONADEP was enlarged and reorganized by Presidential Decree in December 1973, and at the end of 1978 was converted into a Secretariat of State for Planning, an agency composed of various specialized directories. Under the new institutional setting, the Haitian Institute Statistics, which was formerly a dependency of the Finance Ministry, is now ranked as one of the directorates within the Planning Ministry.

In 1975, with assistance from UNFPA, the Government established a population unit (the Unit for Demographic Analysis) within the Haitian Institute of Statistics. Among its tasks were the preparation of population projections and the provision of necessary demographic data for the Government's economic and social development plans.

Sterilization is legal and is being increasingly promoted. For example, in its 1979-80 budget, the Government reported that it planned to promote voluntary sterilization through such means as informational campaigns and household visits. Auxiliary nurses provide information about family planning services, distribute condoms, and prescribe and supply oral contraceptives. Health agents, at the lowest level of health hierarchy, supply oral contraceptives and condoms, and provide MCH/FP information.

3. Family Planning Service Delivery

As of 1979-80, the GOH intended to extend services throughout the country through the distribution of contraceptives to individual households, the use of mobile units, and the sale of condoms in vending machines. In addition to family planning programs, the Government sponsored information, education, and communication (IEC) programs, chiefly as a means of improving maternal child health.

A family planning association, Association pour la Promotion de la Famille Haitianne (PROFAMIL), formed in 1985 to provide family planning information and services, was supposed to start implementing programs in January 1986 with assistance from IPPF WHR. The political upheaval and violence at the time delayed activities which were finally rescheduled to begin late last year.

OBJECTIFS ET METHODOLOGIE DE L'ATELIER DE DISCUSSIONS LIBRES ET D'APPROFONDISSEMENT DE LA COMPREHENSION DES PROBLEMES DE GESTION DES ACTIVITES DE PLANNING FAMILIAL DANS LE SECTEUR PUBLIC DE HAITI

Du 29 juin au 10 juillet 1987
Boston, Massachusetts

I. LES OBJECTIFS

Les objectifs de cette réunion de discussions libres et d'échanges de vues sur les problèmes de la gestion des activitiés de planification familiale en Haiti sont les suivants:

1) Procéder à la définition d'une stratégie d'intervention en vue de l'amélioration des systèmes de gestion dans quatres domaines:
   - les systèmes de gestion informatisée;
   - les systèmes de supervision;
   - les systèmes de gestion financière;
   - les systèmes d'approvisionnement en matériel contraceptif

2) Définir une stratégie en vue d'assurer la collaboration effective entre les responsables PF et les responsables des autres programmes prioritaires du Ministère de la Santé Publique et de la Population.

3) Elaborer un plan détaillé des interventions FPMT/MSH en Haiti en coopération avec le MSP en matière de formation et d'assistance technique.

Ces objectifs opérationnels (ou outputs) s'inscrivent dans le cadre du but plus général assigné à ce type de rencontre et qui est d'offrir aux visiteurs responsables de la planification familiale dans leur pays un cadre et des conditions propres à stimuler la réflexion afin:

- d'approndir leur compréhension des problèmes typiques de gestion des programmes de planification familiale;
- de réexaminer leurs conclusions et leur perceptions des problèmes de gestion propres à leur pays;
- de mettre au point des approches et des stratégies appropriées;
- et finalement de renforcer, si besoin en est, la compréhension et l'estime mutuelle entre eux et les responsables MSH avec lesquels ils sont appelés à collaborer.

II. METHODOLOGIE DE LA RENCONTRE

Le principe à la base de la méthodologie utilisée pour la rencontre de discussions libres et s'appronfondissement est le "brainstorming", une expression intraduisible de façon littérale en français et qui signifie que l'on va passer en revue tous les aspects possibles d'un problème sans à priori ni préconception. De cette libre expression des idées et suggestions peuvent sortir des approches et des stratégies nouvelles et qui intègrent des aspects jusqu'ici ignorés ou mal perçus, ou qui combinent les ressources disponibles selon des formules originales.

Pratiquement cinq domaines différents de la gestion serviront de lieux de confrontation des idées et analyses: systèmes de gestion informatisées, systèmes de gestion financière et systèmes d'approvionnement ainsi que le problème de l'intégration des responsables PF dans les équipes de santé.

La discussion et l'analyse des problèmes dans le cadre de chacun des domaines seront précédées de deux introductions:

1) une introduction par les visiteurs sur leur perceptions des problèmes de gestion propres àleur pays en ce qui concerne le domaine de gestion particulier;

2) une introduction par une spécialiste MSH sur les concepts de base ou sur les points clés à considérer pour la mise en place de systèmes de gestion dans chaque domaine spécifique. Cette seconde introduction est destinée à fournir un dacre conceptuel minimal à la discussion libre que s'en suivra.

La discussion proprement dite portera sur une analyse en profondeur des problèmes: elle associera les visiteurs; le ou les spécialistes du jour; et d'autres responsables MSH qui ont une connaissance spéciale ou un intérêt particulier soit dans le programme du pays, soit dans le domaine de gestion. Après une heure ou une heure et demie de discussion le groupe tirera les conclusions de l'exercise.

Après interruption la discussion reprendra mais cette fois elle portera sur la définition d'une stratégie ou de la démarche à suivre pour résoudre les problèmes indentifiés plus tôt, ou pour contourner les obstacles infranchissables.

Finalement la dernière étape sera accomplie avec la présentation, par un responsable MSH, des ressources et matériels de formation que MSH peut mettre en oeuvre pour contribuer à l'amélioration de la gestion des programmes de Planning Familial.

Outre les visiteurs deux responsables MSH prendront part de façon permanente aux activités et aux débats. Ce sont le Dr. Sara Seims, Directrice Adjointe du projet FPMT et Mr. Jean-Georges Dehasse, Consultant en Gestion et en Formation.

Le programme des activités de la rencontre est attaché en annexe.