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Rapid Assessment of the Haiti EPI Campaign Prepatory Phase

USAID/Port-au-Prince
July 1988

Resources for Child Health Project

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PN-AEL-029

RAPID ASSESSMENT
OF THE HAITI EPI CAMPAIGN PREPARATORY PHASE
REACH/HAITI STRATEGY DESIGN

USAID/Port-au-Prince

July 1988

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ACKNOWLEDGEMENTS

I would like to thank first all the health personnel in country who welcomed this investigation as if I had been part of the team for a long time. In particular, Dr. Jean Andre and his collaborators at the national level, and Dr. David at the District level who were quite helpful to give me good insights of the situation. A long list of people mentioned in Appendix have been most helpful to answer the questions asked, and share their knowledge of the needs, and priorities in EPI for the country.

It was particularly enjoyable to work in a good atmosphere were all partners to Child Survival, the Ministry of Public Health and Population, the International Agencies (multilateral, bilateral, PVOs, and Mix), are working closely together to reach one goal.

Finally I must thank in particular Dr. Serge Toureau and Mr. Luca Spinelli who were able to provide support, and technical insights into this work.

EXECUTIVE SUMMARY

During the two week visit in Haiti, under USAID authorization, REACH has conducted a rapid assessment of the EPI campaign in its preparatory phase. In addition, four days at the REACH office in Arlington, working with the Haiti Chief of Party, were used for drafted the REACH/Haiti Strategy Paper for activities until the end of 1989.

The assessment has been carried out using observational methods (attending the National Executive Meeting, the AOPS meeting), visiting sites (Jacmel District in the rural areas, Cite Soleil in Port-au-Prince), interviewing MOH counterparts and international agencies involved in the intervention including USAID, and reading related reports/papers.

The report summarizes important trip activities related to the methods previously described and gives the basis for the evaluation of the three intensive vaccination days. Then the results/conclusions/recommendations are divided for managerial purposes into the preparatory, implementation, and post phases of the campaign. Attached in the appendix is a calendar of important activities/consultants linked to the campaign and specific scopes of work for each consultant were handed to the National Coordinator.

In summary, the campaign looked promising in terms of its objectives and success, and the EPI organization was being consolidated daily at the national level, with several districts already benefiting from direct inputs for the campaign. However several points which needed immediate attention were highlighted:

- strengthening the overall and specific management and organization of the campaign;
- need to define and resolve the cold chain quality issues;
- address target and time specific communication messages;
- train the volunteers and health personnel also in relation to their role after the campaign'
- use the evaluation system set-up on the spot, and assure proper feedback mechanisms.

A series of recommendations was also oriented specifically to strengthen the institutions after the campaign.

In regards to REACH Strategy in Haiti for the second semester 1988 and all of 1989, based upon the MOH priorities, other donors' interventions, and the USAID/Haiti Action Plan, the strengthening of the Health Information System, and the Communication and Social Marketing strategies were retained as the main specific activiti . to bring expertise to, and calendars related to these have been outline.. Other strategies proposed are in the areas of coordination between public and private sector, health financing of EPI/ORT, cold chain monitoring, support to local health bulletins and reports, training and supervision.

I. PURPOSE OF THE VISIT

The purpose of this visit was first, to assist the National Executive Committee for acceleration of EPI in finalizing activities to support the national campaign and to bring in a critical review of its organization and implementation; secondly the visit was to assist in drafting REACH strategy paper.

More specifically, the objectives of the visit were:

- to set-up basis a for the epidemiologic evaluation of the 3 intensive vaccination days;
- to review the execution and timing of the campaign, and to assess its human, financial and material resources mobilization, and its operation and logistics support;
- to recommendation strategies to strengthen the campaign impact; and
- to assist the REACH staff in drafting the strategy paper.

II. BACKGROUND

Numerous documents and reports give good descriptions of the country situation, and its global health care status (ref. Appdx C, USAID's Evaluation of the health care sector in Dec. 1986, or REACH's Situation Analysis of EPI and CDD in June 1987, or the MOH's Evaluation of 1987 Activities, for example). Haiti is ambitiously preparing for the national days of immunization. A few remarks can help one get a sense of the ambiance in which the work is currently being performed. Despite the recent change in government, the newly appointed Minister of Health, who was formally the Minister at in previous time when the strategy of accelerated EPI activities was was discussed. During this appointment the campaign strategy was discussed therefore he has a clear understanding of the issues and understands the campaign. The National Days of Immunization in Haiti will promote the acceleration of routine activities and there is full support from all the donors and the MOH to make the days a success. In addition, the example of many other surrounding countries' campaign experiences appear to stimulate and challenge the enthusiastic MOH personnel, PVOs, donors, and people from other sectors. The Haitian mother and child are the ffocus of the days: knowing this, it is significant to see several major donor agencies bring in consultants who have experienced and participated in campaigns in other countries, and who are eager to share difficulties experienced inorder to anticipate problems which Haiti might experience. Finally, there is a genuine interest and concern among all partners involved in the campaign that long term institutional strengthening is as important as the short term boost in coverage figures. This visit can be placed quickly in light of the foundations which had launched the preparatory work already in the pre-campaign phase.

The "Pre-Phase Document for the Acceleration of the National Programm for Immunization" presented to the Minister of Public Health on April 8 th 1988, led to a preparatory meeting of the Technical Committee of the MOH, with the various Donors and the Private Sector (AOPS) in April 1988 ("Project of Acceleration of the National Programme for Immunization, Advancement Report No 1). This meeting led to the Creation of a National Executive Committee whose mandate is to mobilize the various sectors involved, and to coordinate the activities between the private and public sector. The Cayes meeting was instrumental in designing the key actors and the role of the National Executive Committe (NEC), and its five technical sub-committees (Evaluation, Statistics and Research; Communication Promotion and Public Relation; Logistics and Cold Chain; Transport and Telecommunication; Training and Learning) on May 10 and 11 1988 ("MOH, Acceleration of the National Programm for Immunization, National Days of Immunization, Working Plan of the Technical Committee, May 1988").

III. TRIP ACTIVITIES

1) Setting up Basis for the Evaluation of the 3 Intensive Vaccination Days:

a) Evaluation

5 methods of on-going and post evaluation activities proposed to the Sub-Committee on Evaluation and Statistics (ref. "Acceleration of the EPI in Haiti: Comments on the Evaluation of Planned National Vaccination Days," F.M. LaForce, July 11-15, 1988):

- cold chain;
- data collection at vaccination sites;
- sample survey of vaccination sites on the first day;
- country-wide evaluation; and
- outcome measures.

b) Calendar and Scope of Work of the Activities

Based on the above evaluation activities a planning calendar (Appdx D) was developed for the Sub-committee, with specific scope of works outlined. A computerized spreadsheet to manage these specific technical inputs has been submitted to the Coordination Unit.

2) Review of the Organization and Implementation of the Different Phases of the EPI Acceleration:

This rapid assessment and overview peformed during five days highlights where major activities are standing at less than 2 months over the first day of the immunization campaign. The analysis carried out further (ref. para IV) with recommendations is not exhaustive, but can be used as a pre-campaign benchmark and give a feeling of how the preparatory phase is functioning. In addition, the analysis it may provide guidance to program managers where to emphasis the important steps which are about to

begin. The following examples show progress made in the execution, timing, human, financial, material resources, operation, and logistics and in parallel may bring to surface some existing constraints and weaknesses.

a) National Executive Committee (NEC):

The National Executive Committee for Immunization met for the second time on July 13 th 1988 for 3 and 1/2 hours in Portau-Prince. Over 25 participants attended the meeting, including the Minister of Health, the members of the NEC, all the Directors responsible for the 5 different technical SubCommittees in charge to coordinate the National Days of Immunization (JNV), the Directors from the 4 regions, and the donor agencies. During the meeting USAID was recognized for their active participation in the campaign effort. The purpose of this meeting was first to have an update and follow-up of the advancement of NEC program activities the subcommittees, and the Regional Medical Directors, then to discuss and recommend some areas of concern brought up, including the training and selection of volunteers. (ref. to "Minutes of the Meeting" on 7/13/88, for details).

The **National Coordinator for EPI and PRONACODIAM** outlined important activities which had already taken place and important decisions which were made and reasons why: Interagency Committee meeting on 6/17/68; costs of lunch for personnel; 3 days over 3 months vs. 2 days; order, reception and distribution of materials; coordination meetings which took place already and important planned meeting (for ex. all medical personnel from private institutions registered at the AOPS, are to meet this month with the Director of the AOPS, and the Coordinator for EPI/PRONACODIAM, by regions). Several documents which outlined the commandable effort made to plan and implement activities were presented and distributed to each participant.

- a calendar of EPI activities from May to December 1988;
- a computerized spreadsheet budget for the campaign;
- a computerized spreadsheet by regions of objectives by target groups, antigenes and materials and human resources needs, and vaccination sites;
- a computerized spreadsheet of total population and target groups by regions and by communes;
- a computerized spreadsheet of training needs (human resources including volunteers, and courses, and trainers) by regions, and communes.

SUBCOMMITTEE REPORTS:

The **Directors** responsible for the various **Technical SubCommittees'** work reported the following:

Training and Learning Committee: The tasks specific Manual for **Volunteers is finished; it still needs to be translated into Creole,** and 25,000 copies to be printed. 35 volunteers per course will be trained, and 20,000 Volunteers trained. The Module for the Training of Trainers is finished too. 131 trainers will be trained. The accompanying flipcharts for this course have also been completed. The section acknowledged the great benefit gained from the input of the Dominican Republic team in terms of the materials adapted, and the planning of the training activities. A detailed Plan of the Promotion of Volunteers (selection criteria and execution of the training activities) has been **accomplished too.**

Logistics and Cold Chain Committee: The ordering of materials had been placed. A team is currently completing a list of existing and missing materials in the different regions. A distribution plan of materials has been drafted. A UNICEF consultant is presently working with the Committee to resolve some problematic areas.

Promotion, Communication and Public Relations Committee: The Plan for Promotion/Communication has been drafted. The list of all supportive organization and their role has also accomplished. The contracting of a local advertising/communication agency to carry out the campaign was to be selected in the next 48 hours.

For Evaluation and Statistics: A REACH consultant was presently finalizing with the team the data collection form, and evaluation forms for the rapid assessment of the quality. Various on-going monitoring instruments and post evaluation tools were designed during the consultant visit. (ref. "Acceleration of the EPI in Haiti: Comments on the Evaluation of Planned National Vaccination Days", F. Marc Laforce, July 11-15, 1988). Identical EPI cards as the one presently existing would be used. Special emphasis would be placed on data collection.

Transport and Telecommunications Committee: This was the only committee which did not have its representant and was excused because of conflicting committments. However, the National Coordinator confirmed that the contacts were established and 300 to 350 vehicles would be mobilized for the days. The vehicles are necessary to distribute the vaccines, the volunteers, and the food. The Coordinator reaffirmed to the Minister the urgency to immediately install a telephone line in his building in order to facilitate the work. He announced a hotline in another MOH building is now open every 2 hours each morning only for EPI matters until that line is installed.

The 4 Directors of Regions presented details of each of their activities to date. Every region has made a genuine effort to place the regional technical sub-committees, and an Intersectorial Committee. Many district staff have been briefed and already oriented in all regions. Several districts have already selected the posts and volunteers. The Southern Region has even taken the position that this campaign would allow them to more actively promote Tetanus Toxoid (T.T.) among all women who would attend the sessions. However, several difficulties have been brought up by different regions:

- one region could not set up its Intersectorial Committee by lack of participants;

- several regions mentioned that they need better orientation from the central level on why and how their local technical sub-committees could support their efforts;

- delays in several activities had taken place in different regions due to the rainy season, change in government, rumours about delaying the first day of the campaign, malfunctioning radio which delayed announcements/promotion;

- common concern of logistics, in particular shortages of vehicles and gasoline and chauffeurs, missing cold chain equipment, difficulty in finding and selecting volunteers, health personnel on holiday (one region had already taken the initiative and gained support to have all personnel on holiday at that time work exceptionaly for these days), timely distribution of all equipment and materials, zones extremely difficult to reach with posts and materials and a short time to intervene;

- one region would prefer delaying the dates by a few weeks to leave allow for more preparation time and sensitization reflecting also the District Directors proposition.

Discussion and clarification were brought up for the following points: the possibility that the volunteers would not be well accepted among the community to inject (criteria of selection re-discussed); too many posts and too few volunteers (open posts based on the number of personnel available, if not enough refer to the closest immunization post); the importance of having lunch provided (it would be provided instead of cash compensation); the organization of vaccination posts (importance of screening/registration of the personnel which often cause bottle necks in mass campaigns; importance of keeping program credibility, momentum and enthusiasm gained by respecting the calendar planned).

b) Meeting with the Private Health Sector (AOPS):

The purpose of this meeting which took place at the AOPS office with a variety of Western Region health personnel from private health care institutions was first, to sensitize, explain, and discuss the reasons for this campaign and how it should be implemented; second, to explain the importance of reporting and filling up the requested Health Information System (see Minutes of the Meeting for details) Over 45 participants were present, including the Coordinator for EPI and PRONACODIAM, the Assistant Director for the Western Region, the UNICEF Representant, a WHO/PAHO technician for the EPI/PAHO, Washington D.C. Office. Out of 124 health institutions in that region, 72 are private, or close to 60%, which reflect the importance of that sector in any health intervention. 65% of the total number regularly return HIS information. The AOPS Director placed great emphasis in explaining the administrative obligations of each institution to fulfill the MOH requirements, and the various reasons why completing the HIS is useful. A Manual on the HIS is soon to be published by AOPS to outline the procedures on the HIS.

c) Meeting Various Donors and Agencies:

Both WHO/PAHO, and UNICEF Representatives and staff, were quite helpful in providing guidance for the REACH stragegy design. In addition, viewpoints, information were exchanged, particularly in regards to collaboratively providing consultants for the national days of immunization.

The Haitian Institute for Children, and the Cite Simone Center both part of the **Child Survival Committee**, were helpful in sharing their points of view on EPI strategies, progresses, and support that REACH could provide in the next year.

CARE shared some field experiences, particularly in the communication's area. The Port-au-Prince office offered to share their EPI field tested health education materials and songs, to the technical sub-committee.

d) Field Visit in the Western Region - District of Jacmel:

As described in details (Appdx E), this field trip allowed local people involved in the implementation of the campaign to express problms they have encountered and ones they anticipate. Concerns of the Directorys of Regions where already outlined during the National Executive Committee meeting previously described

Based on the local district level concerns, it would be benficial that before the end of July, 2 members of each of the 5 technical sub-committees take a trip to implement action with the District Director the local technical sub-committees. Based on that experience, with in 48 hours, the national committee could produce a simple one to two page checklist of guidance for each district sub-committee. In addition, the same should be done for the **doctor of the "Communes," the lowest middle management key personnel** to the immunization sites, and of course its hierarchical

superior, the **Director of district**. This could solve some of their questions, build up their confidence as managers, and increase their efficiency for that campaign.

e) Field Visit to the Complexe Medico-Social of Cite Soleil:

This urban medical complex is well known for delivering preventive and curative health services to a population of 150,000 inhabitants in the slums of Port-au- Prince. No special strategies will be used for the JNV, except to use the existing networks.

The referral system of mothers to pre-natal care clinics, and children to immunization services is sophisticated with trained community agents (the "collaborateurs") in charge of the task. The data are uniformly and well collected, including denominators ("registre de menage") by zones. Special attention should be given to this setting,in terms of the impact of the campaign in an urban area which already benefits from quality on-going services, and probably has higher immunization coverage than other urban areas.

IV. RESULTS/CONCLUSIONS/RECOMMENDATIONS

All these previous steps, including the background information, and the important meetings which took place during the visit are evidence towards the solid ground laid for the implementation of the campaign. The campaign looks promising in terms of its objectives and success, and of the organization of the EPI is being consolidated at a national level daily, and is trickling down already to the communal level in several sites.

Based on the above observation and meetings, the proposed recommendations may be explored for action. These are limited to the National Days of Immunization, and for practical management purposes are sub-divided into 3 categories (the preparatory phase before Sept. 11 th., the implementation phase between Sept. 11 th. and Dec. 4 th. 1988, and the post phase after Dec. 4 th. 1988 on. This approach allows to account for the MOH's view that the campaign is geared towards fulfilling its goal of accelerating EPI rather than an end by itself. Thanks to the experiences gained over other recent campaigns (R.I. Mauritania, P. R. Congo, Togo, Senegal, R. Turkey for example) and their careful evaluation, (ref. to enclosed documents in Appdx C) many pitfalls can be highlighted, and measures can be taken to prevent. Although some examples of remedies are being proposed here, these can be adapted and modified as needed, and new ones adapted. The results have been prioritized for each phase by order of importance at this point in time, and are by no means comprehensive. They are based on the limited observations made, and weaknesses found. That ordering is somewhat subjective and should not be viewed as a critique, but much more where immediate and/or special attention could be focused.

SUMMARY OF CRITICAL POINTS TO THE OVERALL PREPARATORY PHASE OF THE NATIONAL DAYS OF IMMUNIZATION:

1. Late start for the planning of the campaign: at two months from the first day of the campaign, important activities are yet to be carefully put into place in relation to the overall and specific management and organization of the campaign, cold chain issues, communication, training, and evaluation.

   ACTION: The next campaign can start these activities 4 to 5 months in advance. For this campaign special attention to some management issues can alleviate the problem in order to allow for the national coordination to concentrate on some technical issues related to local level takes.

2. Ill defined criteria for immunization sites selection: a topdown approach has been used to select the number of sites which would cover the country, based on the EPI objectives, and the number of women and children to immunize, making 5000 sites to function in one day an unrealistic strategy. given the logistical constraints which are perceived at the district level.

   ACTION: Bottom-up planning needs to be urgently suggested to the medical chief of districts based on field realities (sites which will function; sites likely to function; sites unlikely to function specifying the reasons why), and letting the communes and districts the ultimate choice of the sites they will be responsible for. Other alternative strategies can be suggested ("journees communales" the following week for the remote sites/pockets which were not covered on the immunization days).

3. Unclear role and expectations of the district technical subcommittees, and of the Medical Chief of Districts and of Communes.

   ACTION: The role and expectations of the sub-committees and doctors at the district and commune level are to be clearly described and distributed by the national sub-committee and the national coordination office. For example, each chief of commune is responsible to visit each site and personnel working on the site one week before the campaign to make sure that all resources are available for the normal functioning of the site.

4. Cold Chain and Logistics Constraints: these are assessed presently which is somewhat late due to the fact that it can be an important limiting factor (e.g., number. of refrigerators, coolers for vaccine transportation and frozen "accumulateurs de froid", and vehicles for transportation of personnel and materials) for the planning of the functioning of 5000 sites in one single day, three times in a row.

ACTION: However, 516 facilities in the country may be able to handle on a single day the responsibility of 3 to 4 sites on each day (approx. total of 2000 sites) which means that each site would be responsible still for another 4 to 5 sites (approx. cumulative total of 5000 sites) the following weeks(s).

5. Late start for the Communication Strategy using and "outside firm: although some initiatives with the local radio have been already taken to inform the public, no systematic precise strategy has been used for the campaign on a national scale.

   ACTION: The next campaign can start this strategy 4 to 5 months in advance. Specific target and time specific tested messages designed with the EPI technicians can still help to compensate the time lag existing, and the fact an advertising firm has been contracted for the job.

6. An ambitious training scheme for 20,000 volunteers to be trained in 35 sessions in the last 2 weeks of August: can present difficulties because of the selection criteria of "volunteers" which does not always match the acceptance of health personnel at the district level, and the difficulty to quickly select the correct people or to coordinate such a training in such a short period of time. In addition, this training diverts the essential role and direction which the regular health personnel will play during the campaign which has been somewhat neglected.

   ACTION: Based on an assessment of what is feasible, the next campaign can revise this strategy. For the time being, the number of volunteers trained should be limited to the number which the district can reasonable select based on their availability and capability. Health personnel should be carefully informed of their role and expectations, and briefed by their supervisors beforehand.

7. Evaluation purpose and strategy needs to be made available to all health personnel in advance:

   ACTION: All health personnel which will work on sites need to be informed in a written fashion of the purpose of the evaluation system put into place, and their roles need to be defined. Their supervisors need to make sure that at each site the personnel understands the outlined guidance forms which have been distributed to them, and need to answer the health personnel's questions before the campaign for clarifications if necessary.

The above summary points can be expanded upon in detail in the next three phase approach.

A. PREPARATORY PHASE

1) Overall Management and Organization:

The nature of the challenge to have 5000 immunization posts functioning correctly the same day and 3 times in a row at one month of interval should not be underestimated. For that reason the Coordinator's Office may necessitate **special temporary management** support for 3 months in order to facilitate the smoothness of this complex operation, in a difficult environment. This could be done by hiring a local talented manager who could also facilitate communication/dialogue between the different technical sub-committees. This could also leave more time to the National Coordinator to be able to concentrate and focuss on technical questions at the district and communcal levels, and less on administrative and managerial issues.

At this point in time, it may be important for overall management purposes to possess from each technical branch a **detailed overall plan of activities under the form of a continuous calendar, and people responsible,** as the one outlined already on the **spreadsheet in regards to REACH's support** (appdx D). All these plans could be merged together in one large **computerized spreadsheet.** This would allow the Coordination Office to be better able to monitor progresses, and address the bottlenecks. This computerized spreadsheet has been left already to the Unit at the MOPHP.

Urgent matters that need to be addressed by the beginning of JNV1 should not let anybody forget the overall long term goal of the campaign which is institutional strengthening of EPI. For that purpose, each **technical committee** should submit by midAugust clear **post campaign operational plans** on how they will be responsible to follow-up activities monthly after the campaign for the first trimester, and then by trimesters until the end of 1989 (some examples have been included further along on communication, and cold chain).

2) Specific Management Organization:

An important weakness which was brought up by the various regional directors appeared in the lack of orientation of what they could or should do to coordinate activities with their subcommittees. Each sub-committee could provide brief **written guidelines** (including for example the evluation package for which each chief of districts and of communes will be responsible to have explained or filled up at their level) designed for the regional, and district, and communal levels. (ref. Appdx D Field Trip Report, and previous comments in para. III) Each region should be encouraged and responsible to give **feedback to the national levels** of orginal ideas, and experience, and of any documents printed along these lines in order that these can be shared with other regions.

Based on the numerous vaccination sites to be functionning each day, criteria for the non-opening of a site **and written contingency plans** should be outlined for the medical chiefs of district so that they know well enough in advance what options and alternatives they may have (e.g., in the

immediate to refer people to the closest sites, and on the long term to follow the policy of the "Journees Intensives Communales" in early 1988, as outlined in the MOPHP EPI Plan; or immediately follow-up the JNV1 by 3 days in various sites; or move all personnel from health institutions/health centers 2 to 3 hours away where outreach is a must because of the isolation of the community; or draw surrounding communities 2 to 3 hours away by a specail mobilization campaign), and that they are able to propose to the communities which should have benefitted from a site and did not. The reasons for the non-opening of a planned site at either day should be carefully documented for evaluation purposes, and in order to design next year's strategy.

A key manager at the local level during AND AFTER each day of vaccination will be the health personnel site chief, and he/she appears to be somewhat neglected in his/her orientation. It could be handy, even if he/she does not participate in any training for these JNV as the volunteers do, that he/she receives a leaflet specifying the purposes of these **national days, his/her role before, during, and after the campaign. A key** to success during the campaign will be how well the service is given, and therefore organized. One or several **real trial sessions** (at least 100 to 150 children plus their mothers, with all antigenes, specific verbal messages, and specific screening techniques including data forms) could be organized in the next 2 weeks to check on the best uniform techniques chosen, which will be included in the training of volunteers (and communicated to all health personnel in a written form).

3) **Cold Chain:**

With UNICEF, the MOPHP technicians are paying already close attention to that key area to the success of the campaign. There is an **urgent need to have the cold chain specialist** in country at least 1 month before the campaign, given the new materials are due the first two weeks of August. A specific S.O.W. describing his tasks has already been done. Some **plans for post operation** will have to be designed too on the use, training, and maintenance of the materials which has been distributed.

4) **Communication:**

The EPI from the MOH and donors recognize the lack of education programms addressed to parents as one of the 2 major constraints to high coverage. Consequently, special attention should be directed to that intervention. Carefully designed campaigns usually start their sensitization at least 3 months before hand. The late selection (on July 15 th) of a company contracted to carry out the campaign, should multiply the efforts to gain time, and even a high turnover on JNV2 or JNV3 could be successfull. Regions have already passed along messages by local radio stations.

Messages should be **target specific and time specific** (depending of the day of vaccination), and based on the latest research findings (ref. Appdx C, "Characteristics of Non-Users of Immunization Services" Draft) **and EPI technicians inputs and review**, and if possible tested. For example some of the messages should certainly insist on the fact that: before JNV1, there

will be only one chance this month and not to miss it (the fact that there is only one day instead of three per month reduces the possiblity of word of mouth communication each time); participating will prevent serious diseases and eventually deaths, and will keep your child in good health. At each JNV, some catchy slogans could be passed along such as "next time bring a friend too!" Before JNV2, mothers should understand that even if they missed the first opportunity they are welcome and should come to the immunization site. Before JNV3, all mothers who have come should follow-up in order to protect better their child. After JNV3, the importance for mothers' follow-up for boosters is important given the high drop out rates documented and that could be emphasized during the campaign, especially against measles.

The company contracted should be fully responsible to design post campaign messages **too.** Some original but carefully adapted and tested visual aids (in some countries a singer's message promoting EPI, with his picture, were highly popular). However, the media campaign should not fall in a common mistake of overdoing (quick and easy) promotional messages to the detriment of immunization (careful and difficult) specific messages. Health personnel and volunteers can be reminded by a leaflet of the messages they can promote on word to mouth along the lines of what has been already said. Some follow-up action could be based on the MOPHP's concept of "parrainage" outline in the Plan (ref. Appdx D, "Project of Universal Immunization of Children from 1987 to 1990").

5) **Training:**

Along the lines of the above, the training of volunteers can include some original ways of keeping them active and useful **before, during AND AFTER** the campaign. For example, immediately after the training, they could be responsible to go and contact 5 community leaders they have identified during the training who can promote the JNV beforehand, and become knowledgeable about the immunization calendar. After the campaign, they could be responsible to search actively the cases missing, based on the registration sheets used during the campaign. Their collaboration post campaign can only be gained if they are explained and oriented beforehand, and not caught by surprise afterwards.

The Guide for the Volunteers should be kept as simple possible and not be overhelmed with technical information, based on a common mistake which has been identified in several campaigns.

All Health Personnel should receive orientation, and explanation materials, and communication leaflets. Their role vis-a-vis the volunteers, and how they can organize and supervise a session, should be specified to avoid confusion, and increase efficiency.

6) **Evaluation:**

Two critical areas to the success of the evaluation which will need constant reinforcement throughout the campaign is **the correct filling up of information** by all levels of personnel, and its **rapid on the spot analysis and use** before it is transmitted at a higher level.

All evaluation instruments (e.g. report sheets, immunization cards...) will have to be available at all sites at all times.

B. IMPLEMENTATION PHASE

1) Overall Management and Organization:

Based on the evaluation format selected by the MOPHP (ref. M. Laforce's Report), special attention will have to be given to the analysis, rapid feedback and application. Important decisions can be discussed in common between the Coordination Office and the Regional Medical Directors, early on the 3 rd week after JNV1.

Roughly, the evaluation (data collection form at vaccination sites) between JNV1 and JNV2, and JNV2 and JNV3 can be based on the following calendar: week 1, local analysis and first decisions and transmittal at the district and region; week 2, region analysis and transmittal at the national level; week 3, overall analysis and feeback to the Regional Medical Directors, and then feedback from the Region to the Districts; week 4, from the District to the sites, application.

2) Specific Management Organization:

In turn, the Medical Directors can have a staff meeting with the Director of the Districts by the end of the 3 rd week so that decisions can be taken on time for their application to be carried out. For example, based on the guidelines handed before the campaign, and based on the feedback from the 1st day, they will evaluate each post, and if necessary can reinforce some in certain areas, or even close a few if necessary.

3) Cold Chain:

The resupply of vaccines and equipment will be easier to address if the initial plan contains plans that can be applied after JNV1, JNV2, AND JNV3 on the how, who, when of the procedures to follow.

4) Communication:

As outlined in the previous phase the long term impact of the campaign will be greatly increased if messages are time specific and target specific. Given the word to mouth messages can be given to a captive audience at each site, the opportunity must be used correctly by each individual in contact with mothers. This is a unique opportunity to develop health education interest and skills among health personnel.

5) Training:

The built-in monitoring/evaluation system during the JNV includes a quality of services component ("immunization site survey") which will be modeled upon health facility surveys which already exist (C.D.C. 30 Health Facility Survey). The fact volunteers' trainers, student nurses or teachers will be selected for the survey, with the District Medical Chiefs should be a boost towards improving supervision methods, and training evaluation.

6) **Evaluation:**

The evaluation of JNV1 based on the built in mechanism for evaluation ("data collection at vaccination sites") will be strengthened the first time around also by a "sample survey of vaccination sites" as presented previously. However, the evaluation will need to be monitored closely in terms of the "data collection at vaccination sites" on JNV2 AND JNV3 too, and of course of its feedback and use on JNV2 in particular.

C. POST PHASE

1) **Overall Management and Organization:**

The careful review of the overall operations based on the country wide evaluation, and technical post phase plans will alllow to refine the strategies to be used for 1989-90. If feasible, the complexity of the tasks can become more sophisticated (for ex. UNICEF suggests to promote ORS use at the sites while the mothers wait), and the health personnel would need to know the important messages to pass along to mothers during the demonstration, and the evaluation instrument for the campaign would need to include that component too.

2) **Specific Management Organization:**

Large pockets which were not covered during the campaign may have to be covered in a special strategy.

Any constructive written critique after JNV3 addressed to the regional and/or central levels should be encouraged, especially from the chief of posts of different sites. Any evaluation form or any critique of any kind should be transfered from the district to the region, and to the central EPI Coordination Unit.

3) **Cold Chain:**

Monitoring systems for inventory of vaccines can be installed at the district level, and 3-M indicators used extensively.

Common understanding that correct use and maintenance of any equipment distributed for the JNV, including the cold chain equipment, is essential to the long term goal of the program will need to be reinforced by the Medical Chief of Districts.

4) **Communication:**

Volunteers or community leaders will need to be reminded and encouraged to **follow-up immediately**, during the first two weeks of January especially, the cases who need to complete their vaccination based on the lists. Mothers are **more responsive immediately after** a campaign, and the

national coverage survey is scheduled around mid-January which still gives a chance to boost up the coverage, and have a rough idea of post campaign effects.

The media can promote then the following messages for the next 3 to 4 months at least, following the campaign:

- mothers still have a chance to receive immunization to protect their children or themselves against diseases at their closest health post;

- even if mothers were present at the national days, they should be reminded that any newborn needs to be immunized, and that this is a good protection for the all family against diseases;

- a minimum of 5 visits per year to your closest vaccination site is necesary for your child **under one** for him to receive full protection;

- mothers should be asked to receive at least 2 T.T. shots to be fully protected and that they do not need to wait to be pregnant to receive those.

UNICEF would encourage the use of a "10 Commandments" type of list on child survival rules that each health center could have as a poster. This could be designed during the campaign by a special team (Nov. may have less activities scheduled), and used immediately after to encourage the continuation of activities.

5) **Training:**

Positive reinforcement and public **recognition, and appraisal** should be given immediately after the campaign by radio, and any other means at the local level to the volunteers and health personnel for their good work, especially if the campaign is to be repeated.

Training for correct use and maintenance of materials can be accomplished too during the following months, even during supervision visits if necessary.

6) **Evaluation:**

After the country-wide evaluation, all **health personnel** should receive a simple **written technical feedback** with useful comments and examples on how the campaign went, at a micro level in particular. This is a perfect time to stimulate personnel for their work, and data collection, by a concrete feedback. It may help them to understand the importance of data collection.

V. FOLLOW-UP ACTIONS RECOMMENDED

The following follow-up actions regarding the JNV can be taken:

- Follow-up on consultants. (appdx D)

- Discussion of recommendations in relation to the pre,during, and post phases, contained in this document by the technical subcommittees, and prompt action on the ones retained.

- Need to set-up the computer still in one region of the country for the regional epidemiologist.

- Need for all computers to be set up with lotus, dbase, and the COSAS programs.

- Health facility survey (French versions of the Burundi, or Togo or any latest version including the computerized questionnaires set-up) models to be requested at the International Health Office of the Centers for Disease Control; the analysis of the these should be provided too.

- Need for the Evaluation campaign system to be set up, and carefully implemented.

VI. APPENDICES

APPENDIX A

ACRONYMS

AOPS:	Association des Oeuvres Privees de Sante Association for Private Health Organization
BCPP:	Bureau de Coordination du PEV et du PRONACODIAM Coordination Office for EPI and Diarrheal Diseases
CEN:	Comite Executif National du PEV Executive National Committee for EPI
DHFN:	Direction d'Hygiene Familiale et Nutrition Family Hygiene and Nutrition Department
DESE:	Direction d'Education Sanitaire et d'Entrainement Health Education and Training Department
DHP:	Direction d'Hygiene Publique Disease Surveillance Department
JNV:	Journees Nationales de Vaccination National Days of Immunization
MSPP:	Ministere de la Sante Publique et de la Population
MOPHP:	Ministry Of Public Health and Population
OPS/OMS:	Organisation Pan-Americaine de la Sante/Organisation Mondiale de la Sante
PAHO/WHO:	Pan American Health Organization/World Health Organization
PEV:	Programme Elargi de Vaccination
EPI:	Expanded Program for Immunization
SIS:	Systeme d'Informations de Sante
HIS:	Health Information System
UPE/MSP:	Unite de Planification et d'Evaluation du Ministere de la Sante Publique et de la Population
UCDR:	Unite de Coordination des Directions Regionales

APPENDIX B

PERSONS VISITED:

Dr. Adrien Hilaire, Directeur General de la Sante, MSPP
Dr. Jean Andre, Coordonateur National PEV et PRONACODIAM, MSPP
Dr. Maryse Narcisse, Assistante a la Coordination PEV, MSPP
Dr. Lambert Jasmin, Directeur DHFN, MSPP
Dr. Leopold Bonhomme, Directeur DESE, MSPP
Dr. Guy F. Celestin, Directeur DHFN, MSPP
Dr. Laurent Eustache, Directeur DESE, MSPP
Mr. Descartes Andry, DHP, MSPP
Dr. S. David, Directeur du District de Jacmel, MSPP
Ms. Marie Carolyne Jean Baptiste, Infirmiere Responsable PEV, MSPP
Dr. Monsanto, Directeur Amosse, Oeuvres Privees de Sante du SudEst
Mme. Marie-Jose Castera, Plan Parrainage, International Foster Parent Plan
Dr. R. Boulos, Directeur du Centre Cite Simone, MSPP
Dr. Serge Pintro, Directeur AOPS
Dr. Xavier Leus, Representant OPS/OMS
Dr. Joachim Salcedo, Consultant en Epidemiologie OPS/OMS
Monsieur Carlos Castillo, Representant UNICEF
Dr. Lenin Guzman, Consultant UNICEF
Dr. Eddy Genece, UNICEF
Ms. S. O'Rourke, CARE
Mr. David Eckerson, Charge des Programmes de Sante, USAID
Dr. Michaelle Amede Gedeon, Conseiller Technique, USAID
Ms. Bonnie Kittel, Assistante Charge des Programmes de Sante, USAID
Dr. Elizabeth Holt, John Hopkins University
Dr. Pierre Claquin, Assistant Directeur, REACH/Wash.D.C., REACH
Dr. Serge Toureau, Directeur REACH/Haiti, REACH
Mr. Luca Spinelli, Conseiller Technique REACH/Haiti, REACH
Ms. A. Yanoshik, Project Officer, REACH/Wash. D.C., REACH

APPENDIX C

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APPENDIX D

REACH/HAITI EPI Activities
1988 - 1989 (First Trimester)
Proposed Technical Assistance (STC)
From August 1988 - February 1989

TA needed for: EPI Acceleration 1988 National Vaccination Days (NVD)
Health Information System Computer Workshop for Regional Epidemiologists
Coordination between Public and Private Sector
Costing and Financing of the EPI
Administrative

Consultancy Field	Type	1988 Aug	Sept	Oct	Nov	Dec	1989 Jan	Feb
1. EPI Acceleration 1988								
1.1 Overall Management	Local	15-31						
1.2 Transport/Logistics	Local	1-31						
1.3 Cold Chain Evaluation monitoring/set up	Int'l	1-31						
1.4 Evaluation/Planning	Int'l	15-22						
1.5 JNV1 Evaluation	Int'l		5-23					
1.6 JNV2,JNV3 Evaluation	Local				7-11	19-23		
1.7 Socio-Anthrop Study	Local			7-28				
1.8 Vaccination Post Eval	Local						9-20	
1.9 National Coverage Survey	Int'l						9-27	
1.10 Global Evaluation of JNV1	Int'l							1-19
2. HIS Computer Workshop for Regional Epidemiologists	Int'l					12-23		
3. Coordination Private/Public Sector	Int'l							
4. Costing/Financing EPI/ORT	Int'l	15-22			1-10			1-19
5. Administrative	REACH		18-24					

Termes de Reference pour un support technique
a l'acceleration du Programme Elargi de Vaccination.

Domaine: Qualite de la Chaine de Froid.

Titre: Specialiste en Qualite de Chaine de Froid.

Objectif: Renforcer le systeme national, regional et districtal de la chaine de froid par la methode des indicateurs colores type 3-M de l'OMS, en vue de l'evaluation de la qualite de la chaine du froid pendant et apres les trois journees intensives de vaccination.

Duree: 2 semaines du 8 au 19 aout 1988 (ou sinon apres la premiere JNV, du 12 au 23 sept. 1988).

Activites a realiser:

1. Etablir avec les responsables nationaux du MSPP, charge de la chaine du froid, un protocole d'evaluation de la qualite de la chaine du froid a l'aide de la methode 3-M, en particulier pour la campagne, et egalement pour apres la campagne.

2. Preparer le materiel pedagogique necessaire, adapte pour Haiti a l'aide des modules OMS deja existant, qui permettra de former le personnel cle a chaque etape (national, regional, districtal, et centre/site de vaccination) afin de remplir et d'utiliser ces indicateurs.

3. Mettre en place avec le personnel de sante responsable au niveau national le systeme dans au moins une region a l'aide d'un mini-atelier de travail de 2 jours.

4. Former le personnel au niveau central qui sera charge de l'analyse informatisee des donnees a l'aide du programme OMS deja existant.

Qualifications:

- Connaissance et experience de cette methodologie.

- Experience en chaine du froid (gestion, operation, evaluation) dans les pays en developpement.

Termes de Reference pour un Support Technique
l'Acceleration du Programme Elargi de Vaccination.

Domaine: Evaluation 1 ere journee.

Titre: Evaluation/Epidemiologiste du PEV.

Objectif: Participer et orienter l'evaluation de la 1 ere journee nationale de vaccination, suivant le protocole d'evaluation etabli par le MSPP.

Duree: 3 semaines du 1 au 22 septembre 1988.

Activites a realiser:

1. Raffiner le protocole global d'enquete par echantillonage du MSPP propose pour l'evaluation (choix des sites, equipes d'investigation etc...).

2. Etablir avec le responsable de la Formation du MSPP le l'instrument d'enquete de la qualite des services par observation qui sera utilise, base sur le protocole du C.D.C. (type "30 health facility survey").

3. Former les 5 equipes chargees d'evaluation aux methodes d'evaluation arretees.

4. Participer a la collecte des donnees, puis a leur analyse.

Qualifications:

- Formation dans l'evaluation de programmes, et les aspects methodologiques qui y sont lies.

- Experience preferable dans des enquetes d'evaluation dans les pays en voie de developpement, et si possible dans le type d'enquete propose ("30 health facility survey").

Termes de Reference pour un Support Technique
a l'Acceleration du Programme Elargi de Vaccination.

Domaine: Informatique.

Titre: Specialiste en Informatique destinee a renforcer les Systemes d'Informations de Sante.

Objectif: Renforcer les capacites techniques des epidemiologistes nationaux et regionaux, dans le traitement et l'analyse des donnees du PEV.

Duree: 2 semaines, du 12 au 23 decembre 1988.

Activites a realiser:

1. Le specialiste etablira la methode d'analyse des donnees (type d'antigenes, tranches d'age, sites, districts etc...) necessaire pour l'evaluation au MSPP, et preparera l'enseignement necessaire pour le personnel de sante.

2. Le specialiste fera un mini atelier de travail de 5 jours, avec les 4 equipes regionales et l'equipe centrale (une douzaine de personnes), y compris le personnel charge d'entrer les donnees. Le but de cet atelier sera d'enseigner aux equipes a entrer les donnees, les traiter et analyser.

Qualifications:

- Formation en Informatique (en particulier DBaseIII, Lotus 123), et enseignement de l'informatique.

- Experience en enseignement de l'informatique, et une certaine connaissance des systemes d'informations de sante, et du PEV dans les pays en voie de developpement.

Termes de Reference pour un Support Technique
a l'Acceleration du Programme Elargi de Vaccination.

Domaines: Couvertures Vaccinales PEV.

Titre: Specialiste en Evaluation PEV.

Objectif: Orienter, superviser et analyser avec l'aide des epidemiologistes nationaux 5 differentes couvertures du PEV.

Duree: 3 semaines, Janvier 9-27, 1989.

Activites a Realiser:

1. Determiner la methodologie a adapter avec l'equipe du MSPP, et preparer le materiel en consequence.

2. Selectionner et former le personnel d'investigation.

3. Former et faire rentrer les donnees par le personnel du MSPP (utilisation de COSAS et DBase III).

4. A l'aide des epidemiologistes qui font partie de l'equipe analyser les donnees avec l'aide du programme COSAS, pour au moins une region.

Qualifications:

- Formation en epidemiologie, et en methodologie d'enquetes de sante publique.

- Experience dans les couvertures par grappes, type OMS, et en informatique.

Termes de Reference pour un Support Technique
a l'Acceleration du Programme Elargi de Vaccination.

Domaine: Evaluation Globale Campagnes PEV.

Titre: Specialiste en Planning et Evaluation du PEV.

Objectif: Evaluer dans son ensemble la Campagne des Journees Nationales de Vaccination, et son impact, a la lumiere des differentes donnees collectees au cours de l'evaluation.

Duree: 3 semaines, du 1 au 19 fevrier 1989.

Activites a realiser:

1. Avec le MSPP et l'equipe locale des partenaires du Ministere, ce chef d'equipe determinera le protocole d'evaluation a suivre, et en consequence les taches seront reparties.

2. Avec le Coordonateur du PEV, il coordonera l'evaluation.

3. Tous les differents resultats de l'evaluation seront analyses meticuleusement.

4. Un rapport global d'evaluation global sera redige, et des recommandations sur les orientations/strategies immediates et a long terme du PEV en Haiti formulees et proposees.

Qualifications:

- Formation dans l'evaluation de programmes de sante publique, et du PEV en particulier.

- Solide experience de telles evaluations.

Termes de Reference pour un Support Technique a l'acceleration du Programme Elargi de Vaccination.

Domaine: Gestion Continue.

Titre: Specialiste en Gestion ("Management").

Objectif: Renforcer la gestion de tous les aspects de "management", y compris administratif, la Coordination des Journees Nationales de Vaccination au niveau central, regional, districtal et soulager par la-meme le travail des responsables nationaux qui pourront se consacrer essentiellement au cote technique des JNV. Travailler etroitement avec la Coordination PEV et PRONACODIAM, et le Comite Executif des JNV.

Duree: 4 mois, du 15 aout au 14 decembre 1988.

Activites a realiser:

1. Etablir le calendrier global des activites principales, y compris appui technique local ou international, par ordre chronologique, par domaine des sous-comites techniques.

2. Gerer ces activites a l'aide d'utilisation d'instruments de management telle que Gant ou Perth Chartes, et manager les grandes activites des sous-comites par objectifs. (Management by Objectives)

3. Orienter et briefer la Coordination Nationale, et le Comite Executif Nationale de l'avancement des activites, et pointer aux priorites urgentes lors de reunions hebdomadaires avec les membres.

4. Assurer en permanence la coordination administrative et de gestion entre ces sous-comites et la Coordination nationale.

5. Trier, prioritiser, et recommander des solutions soit aux bloquages qui arrivent, soit a la retro-information venant du niveau regional et local.

6. Identifier les points de faiblesse et proposer des recommandations a la gestion des JNV1 et JNV2 et JNV3, et les documenter pour l'evaluation.

Qualifications:

- Former en gestion (type diplome "Management Business Administration" ou MBA), et experience dans l'application des methodes a utiliser, sans forcement avoir d'experience dans la sante publique.

- Aime travailler en equipe, et peut s'adapter a de nouvelles taches facilement, et interesse a la sante publique, en particulier a l'objectif des JNV.

Termes de Reference pour un Support Technique
pour l'Acceleration du Programme Elargi de Vaccination.

Domaine: Socio-Anthropologique.

Titre: Sociolgogue/Anthropologue Enqueteur.

Objectif: Par une petite enquete sur un echantillon de personnel travaillant dans les sites de vaccination, et par les meres ayant participe ou non aux Journees Nationales de Vaccination, determiner leur satisfaction de cet evenement, et comment ces populations percoivent celui-ci.

Duree: 10 jours du 17 au 28 octobre 1988.

Activites a Realiser:

1. Realiser une enquete par une approche liee a la sociologie et l'anthropologie et par des methodes qui sont frequemment utilisees dans ces domaines (type enquete par "focus groups", ou observation directe passive, ou enquete individuelle par exemple).

2. Preparer la methodologie d'enquete, l'echantillonage, et les instruments d'enquete comme necessaire.

3. Analyser et presenter dans un bref rapport oral et ecrit aux MSPP et donateurs les resultat.

Qualifications:

- Formation d'anthropologue ou de sociologue, avec experience d'enquetes.

- Connait bien Haiti, et sa population.

- A eu si possible de l'experience relative a la sante publique, et est particulierement interesse a contribuer aux JNV.

Termes de Reference pour un Support Technique
a l'acceleration du Programme Elargi de Vaccination.

Domaine: Evaluation.

Titre: Specialiste en Evaluation de Programmes.

Objectif: Participer avec le Sous-Comite Technique a la tache de depouillement, classification, et analyse des informations d'evaluation qui seront renvoyees du niveau districtal, et regional.

Duree: 3 semaines du 12 au 16 septembre, du 7 au 11 novembre, et du 19 au 23 decembre 1988.

Activites a realiser:

1. Depouiller les fiches venant des venant des 5000 postes deux semaines apres les JNV1, 2, et 3 et qui concerne les quelques domaines cles de fonctionnement des differents sites (qualitatifs), base sur le premier triage et informations/rapports venant des districts.

2. Classer et analyser les informations sous forme d'un formulaire pre-etabli au JNV1.

3. Travailler etroitement lors de JNV1 avec l'epidemiologiste charge de l'evaluation pour developer l'instrument d'analyse et assimiler la methode de depouillement.

Qualifications:

- Meticuleux, precis et avec de l'experience dans le depouillement d'enquetes. Pourra etre un etudiant universitaire.

30'

APPENDIX E

RAPPORT DE MISSION.

Au cours de la journee du 20 Juillet 1988, j'ai eu l'occasion de faire une visite sur le terrain sous les auspices du MSPP et de REACH, comme souhaite par le Coordinateur National PEV et PRONACODIAM. Le but de cette visite etait dans le cadre de la planification des Journees Nationales de Vaccination de voir ou en etait celle ci pour le District de Jacmel, et de voir comment la coordination fonctionnait entre le MSPP et le secteur mixte/ prive (en l'occurence le Projet AMOSSE et le Plan de Parrainage).

L'accueil, l'information et les echanges d'idee ont ete excellentes etant recu successivement par le Dr. David, Directeur du District, et Mme. Marie Carolyne Jean Baptiste, Infirmiere Responsable du PEV; puis le Dr. Monsantos, Eye/CARE d'Amosse; finalement, Mmme. Marie-Jose Castera, International Foster Parent Plan du Plan Parrainage.

1) Le **District** constitue d'un total de 20 institutions dans son secteur (1 hopital, 7 institutions, 19 centres de sante dont 1 mixte) pense pouvoir etablir en plus une vingtaine de postes, ou une total d'une quarantaine de sites de vaccination aux jours de vaccination.

Le plan prevoit 235 sites ("postes") a mettre en place ce jour la. Les plus grandes contraintes soulignees par le District pour arriver a mettre en place tous ces postes sont les suivantes:

- defaut cruel de personnel de sante disponible pour faire les injections;

- les injecteurs/vaccinateurs autre que personnel de sante risquent fort d'etre tres mal accepte par le personnel de sante et la population;

- difficulte anticipee de coordoner 235 sites le meme jour.

Neanmoins le District a deja fait tout l'effort possible pour informer et responsabiliser les collaborateurs locaux de la Campagne, notamment:

- les medecins responsables des 5 communes du District;

- au cours d'une autre reunion, les personnes qui seraient impliquees dans les sous-comites techniques d'execution;

- contacts individuels avec des responsables locaux importants de differents services publiques;

- reunions deja faites pour la commune de Jacmel avec les 13 chefs des sections communales (CASEC), et identification des canalisateurs, enregistreurs (pour les zones rurales trouver ces gens la sur place, alphabete, semble beaucoup plus difficile).

Certains domaines importants d'activites (transport et communication, par example) ont deja bien avance ou la Police, l'Armee, les projets AMOSSE et Plan de Parrainage, le Rotary, les scouts, tele/radio ont promis leur participation et appui. La reunion qui devait nommer et determiner les taches de chaque sous-comite technique pour le district et devait avoir lieu hier, a ete quant a elle, reportee a une date ulterieure par defaut de personnes presentes a la reunion. Malgre tout de nombreuses personnes qualifiees et interessees sont d'accord pour preter main forte dans ces sous-comites. Par example, pour l'evaluation statistiques, les personnes suivantes: le statisticien du district, celui de l'hopital, celui du bureau du commissariat (logement/plan), deux officiers sanitaires, et un economiste. Concernant la **chaine du froid**, il manque a present 4 frigos pour les institutions, et 213 thermos, si tous les sites doivent fonctionner. L'equipe centrale n'est pas encore passee, mais les besoins ont ete transmis a la region. Le district voit son role comme superviseur et pouvant donner les moyens d'execution lors de la campagne. Il pense que les **urgences** sont les suivantes **du niveau central:**

- besoin d'une decision uniforme et claire sur les normes de selection des sites de vaccination;

- idem, pour la selection des volontaires vaccinateurs/injecteurs locaux compte tenue des contraintes (facteur limitant principal);

- propositions d'alternatives possibles pour la strategie a utiliser;

- definition plus precise que celle qui a ete donnee du role exact des sous-comites techniques locaux du district (pourquoi, comment, quand?)

- besoin de circulaires des Ministeres concernes (Agriculture, Finances, Education nationale, Communication) pour qu'une autorisation officielle emanant de leurs chefs hierarchiques directs leur demande officiellement leur collaboration (les vehicules devront etre utilises un dimanche par example).

La Coordonation avec le secteur prive/mixe et relations sont apparues comme bonne. Quelques frictions semblent avoir ete crees par le fait que les auxiliaires oeuvrant dans ces centres recoivent des primes pour leur travaux dans les postes de rassemblement, ce qui a tendance a augmenter leur absence des dits centres, et decouragerait ceux qui n'ont pas la possibilite de participer a ces projets.

2) Le Projet **AMOSSE** a pu presenter sa **strategie orientee plus sur le renforcement institutionel.** En 2 a 3 ans, le Directkuer du Projet pense avoir augment l'efficience du personnel dans une demi-douzaine de centres ou travaille le personnel du MSPP par 10. Pre de 30,000 personnes sont maintenant couvertes dans la zone de c[illegible]ation des centres et postes de rassemblement. Il pense qu'en investissant dans la **supervision meilleure** et **l'evaluation**, on peut motiver et rendre les activites bien meilleures.

L'appui sera apporte comme il se doit a cette campagne. Il ne faut pas compter que les meres marchent plus que d'habitude (1 heure environ) pour recevoir la vaccination ce jour la. La seule facon d'avoir vraiment l'appui de la population est de trouver les **collaborateurs** sur place qui peuvent identifier les familles dans les zones concernees, et le jour de la vaccination puevent aider les enregistreurs a distinguer les gens par leurs noms (parfois ils en ont trois differents), et savent le prononcer (l'intonation compte). Tout en reconnaissant la difficulte de coordoner les 235 postes au cours d'une journee, il a pense que les coordoner sur 4 jours,en 4 fois 50 sites, semblaient dans le domaine du possible en faisant deplacer les equipes dans les zones a couvrir.

En regardant les archives, le systeme de collecte des donnees (**numerateurs et denominateurs,** y compris des **indicateurs socio-economiques** adaptes par famille) pour chaque centre parait a la fois simple, faisable, peu couteux, et efficace. Combine au fait que la strategie presente utilisee renforce l'**institutionalisation de services preventifs** dans les centres et postes, peut-etre que l'**etude cout-efficacite (il existe egalement d'autres centres qui ne fonctionnent pas dans ce systeme a proxmitie)**, et a long terme le renforcement du SIS (recensement de la population pour un centre coute environ $50 y compris la formation du personnel charge du recensement qui necessite un mois environ), et la recherche de strategies de renforcement du PEV pourront se pencher sur cette experience egalement.

3) Le Plan de Parrainage a explique comment il pourrait soutenir le secteur ces jours la avec les 58 agents disponibles pour la mobilisation sociale, le pret de vehicules, et de la stencileuse par example. Une contrainte d'augmentation de couverture du PEV, remarquee egalement par AMOSSE, est que meme si on refere les meres a certains centres, le fait que le personnel soit parfois absent ne facilitait pas la confiance des meres. Certains centres sont toutefois exemplaires dans leur collaboration avec les agents de sante, et tres dedies a leurs taches.

Le souci principal exprime pour les JNV est que les souscomites techniques ne se soient pas encore reunis pour discuter concretement du travail. La phase de preparation semble etre trop courte. De plus la mobilisation de toutes ces ressources humaines parait extremement difficile en un lapse de temps si court.

Finalement, j'ai remercie chacun pour son franc-parler et ses conseils qui aideront le niveau central a pouvoir mieux diriger son effort, tout en assurant que je partagerai les soucis de tout a chacun.

APPENDIX E

RAPPORT DE MISSION.

Au cours de la journee du 20 Juillet 1988, j'ai eu l'occasion de faire une visite sur le terrain sous les auspices du MSPP et de REACH, comme souhaite par le Coordinateur National PEV et PRONACODIAM. Le but de cette visite etait dans le cadre de la planification des Journees Nationales de Vaccination de voir ou en etait celle ci pour le District de Jacmel, et de voir comment la coordination fonctionnait entre le MSPP et le secteur mixte/ prive (en l'occurence le Projet AMOSSE et le Plan de Parrainage).

L'accueil, l'information et les echanges d'idee ont ete excellentes etant recu successivement par le Dr. David, Directeur du District, et Mme. Marie Carolyne Jean Baptiste, Infirmiere Responsable du PEV; puis le Dr. Monsantos, Eye/CARE d'Amosse; finalement, Mmme. Marie-Jose Castera, International Foster Parent Plan du Plan Parrainage.

1) Le **District** constitue d'un total de 20 institutions dans son secteur (1 hopital, 7 institutions, 19 centres de sante dont 1 mixte) pense pouvoir etablir en plus une vingtaine de postes, ou une total d'une quarantaine de sites de vaccination aux jours de vaccination.

Le plan prevoit 235 sites ("postes") a mettre en place ce jour la. Les plus grandes contraintes soulignees par le District pour arriver a mettre en place tous ces postes sont les suivantes:

- defaut cruel de personnel de sante disponible pour faire les injections;

- les injecteurs/vaccinateurs autre que personnel de sante risquent fort d'etre tres mal accepte par le personnel de sante et la population;

- difficulte anticipee de coordoner 235 sites le meme jour.

Neanmoins le District a deja fait tout l'effort possible pour informer et responsabiliser les collaborateurs locaux de la Campagne, notamment:

- les medecins responsables des 5 communes du District;

- au cours d'une autre reunion, les personnes qui seraient impliquees dans les sous-comites techniques d'execution;

- contacts individuels avec des responsables locaux importants de differents services publiques;

- reunions deja faites pour la commune de Jacmel avec les 13 chefs des sections communales (CASEC), et identification des canalisateurs, enregistreurs (pour les zones rurales trouver ces gens la sur place, alphabete, semble beaucoup plus difficile).

Certains domaines importants d'activites (transport et communication, par example) ont deja bien avance ou la Police, l'Armee, les projets AMOSSE et Plan de Parrainage, le Rotary, les scouts, tele/radio ont promis leur participation et appui. La reunion qui devait nommer et determiner les taches de chaque sous-comite technique pour le district et devait avoir lieu hier, a ete quant a elle, reportee a une date ulterieure par defaut de personnes presentes a la reunion. Malgre tout de nombreuses personnes qualifiees et interessees sont d'accord pour preter main forte dans ces sous-comites. Par example, pour l'evaluation statistiques, les personnes suivantes: le statisticien du district, celui de l'hopital, celui du bureau du commissariat (logement/plan), deux officiers sanitaires, et un economiste. Concernant la **chaine du froid**, il manque a present 4 frigos pour les institutions, et 213 thermos, si tous les sites doivent fonctionner. L'equipe centrale n'est pas encore passee, mais les besoins ont ete transmis a la region. Le district voit son role comme superviseur et pouvant donner les moyens d'execution lors de la campagne. Il pense que les **urgences** sont les suivantes **du niveau central:**

- besoin d'une decision uniforme et claire sur les normes de selection des sites de vaccination;

- idem, pour la selection des volontaires vaccinateurs/injecteurs locaux compte tenue des contraintes (facteur limitant principal);

- propositions d'alternatives possibles pour la strategie a utiliser;

- definition plus precise que celle qui a ete donnee du role exact des sous-comites techniques locaux du district (pourquoi, comment, quand?)

- besoin de circulaires des Ministeres concernes (Agriculture, Finances, Education nationale, Communication) pour qu'une autorisation officielle emanant de leurs chefs hierarchiques directs leur demande officiellement leur collaboration (les vehicules devront etre utilises un dimanche par example).

La Coordonation avec le secteur prive/mixe et relations sont apparues comme bonne. Quelques frictions semblent avoir ete crees par le fait que les auxiliaires oeuvrant dans ces centres recoivent des primes pour leur travaux dans les postes de rassemblement, ce qui a tendance a augmenter leur absence des dits centres, et decouragerait ceux qui n'ont pas la possibilite de participer a ces projets.

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