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Strategy for the Population Sector

USAID/Haiti 1990-1992

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## Acronyms and Non-Standard Terms

ADIH	Haitian Association of Industries
AIDS	Auto-Immune Deficiency Syndrome
AOPS	Association d'Ouevres Privés de Santé
AVSC	Association for Voluntary Surgical Contraception
CBD	Community-Based Distribution
CDC	Centers for Disease Control
CHI	Child Health Institute
Colvols	Collaborating Volunteers
CONAPO	Commission National de la Population
Cu-T 380A	Copper T 380A IUD
DHFN	Division d'Hygiene Familiale et de Nutrition
EMMUS	Enquete Mortalite, Morbidite et Utilization de Service
FDA	Food and Drug Administration
FP	Family Planning
FPSD	Family Planning Services Division of the Office of Population, AID/W
GOH	Government of Haiti
IEC	Information, Education and Communication
IHSI	Institut Haitien de Statistique et d'Informatique
INHSAC	Institut Haitien de Santé Communautaire
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	Intra-uterine Device
JHPIEGO	Johns Hopkins Program of International Education in Gynecology and Obstetrics
JSI	John Snow Incorporated
LOP	Life of Project
MCH/FP	Maternal-Child Health/Family Planning



MPH	Master of Public Health
MSPP	Ministere de la Sante et de la Population
NORPLANT	Five Year Contraceptive Implants
OYB	Operating Year Budget
PACD	Project Assistance Completion Date
PAHO	Pan-American Health Organization
PCS	Population Communications Service
PID	Project Identification Document
PP	Project Paper
PSI	Population Services International
PSFP	Private Sector Family PLanning Project (521-0189)
PVO	Private Voluntary Organization
TA	Technical Assistance
TIPPS	Technical Information on Population for the Private Sector
UNFPA	United Nations Fund for Population Activities
VSC	Voluntary Surgical Contraception

## EXECUTIVE SUMMARY

Haiti faces a significant problem devolving from population growth, especially in view of recent increases in fertility to the level of 6.4 children per woman. With a population of 6 million, Haiti already faces an ecological crisis and a chronic inability to feed its populace without external assistance. Infant mortality is the highest in the region. Migration epitomizes a classic push case, in which the dire conditions of life have pushed educated and uneducated Haitians to seek new lives outside of Haiti. Given these circumstances, the population will double or triple by the year 2025.

Many Haitians know of family planning services and express the wish to have had fewer children. An old saying, "children are a riches" is being changed to say "children are the riches of the unfortunate". The demand for family planning services is there: according to the 1977 Haitian Fertility Survey, 42% of women in union declared they wanted no more children; in the 1983 Contraceptive Prevalence Survey that percentage rose to 48%. Yet the family planning service delivery system has never been strong enough to make quality services and information consistently available to families who wish to use family planning.

Many ingredients now are in place for the development of an effective, national program of family planning. USAID/Haiti has maintained a substantial presence in the population sector through a private sector program during the recent hiatus in assistance to the Government of Haiti, after the aborted elections of November, 1987. UNFPA is gearing up for substantial increases in its involvement in population, with a larger program and the assignment of a new country representative. The World Bank is coming in with a family planning component of its new health sector loan to address family planning needs in the West Region, including Port-au-Prince. The responsible Ministry is very supportive both at the policy and at technical levels.

Yet much remains to be done. For many years, the contraceptive prevalence rate stagnated at 6%. In 1989, the CDC/CHI joint survey showed in the preliminary results that this had edged up to 10.4%. Haiti is a pre-emergent country: no real, national program yet exists. Further, fledgling programs are functioning in an ambivalent policy climate at the national level. The programmatic and budgetary requirements to develop a national family planning program (and capture the momentum of the present program) are too great for any one donor, or any one service provision sector, to develop alone. A strong participation of all donors will be required, as will be involvement of the public, private voluntary and commercial sectors, each according to its comparative advantage. A recent change in the Foreign Assistance Act now allows USAID/Haiti to provide direct assistance to the Government of Haiti in family planning. This provides USAID/Haiti with a significant opportunity to begin building the effective, national program so needed in Haiti.

The USAID/Haiti strategy for 1990-1992, which is presented in this document, is comprehensive, addressing donor commitment, policy needs, and development of service delivery in the three key service delivery sectors -- public, private voluntary and private commercial sectors. The program laid out is ambitious, but no less than required by the situation in Haiti, where overpopulation and lack of resources to fulfill basic needs mark the lives of the vast majority of the population. The strategy will require a long-term Mission commitment to a large, complex program. In tandem with that is the need for increased resources to be devoted to population by AID/W through increases to the Mission's operating year budget.

Programmatic and budgetary planning will merge in the development of successor activities to the ongoing Private Sector Family Planning Project (521-0189), which has a PACD of March, 1991. Prior to that time, however, USAID/Haiti will move expeditiously to implement an interim program of public sector activities, following the adoption of the exception permitting direct assistance to the Government of Haiti in family planning. This means that a complete program now can be implemented, involving all relevant service delivery entities, and involving the public sector in population policy development.

## I. INTRODUCTION

o Purpose of Strategy. The USAID/Haiti population program addresses a very serious need in the population and family planning sector, given the recent increases in fertility. These increases stem from the fact that women are entering into stable unions at younger ages. The population program is now in a position to grow dramatically. The purpose of this strategy is to lay out, for the three-year period 1990-1992, the steps to be taken to see the program achieve this potential growth, in terms of programmatic expansion and its budgetary ramifications.

Because of the magnitude of prospective population growth, a multi-donor, multi-sectoral approach is essential. Thus the strategy addresses the present and future plans for USAID/Haiti and other donor involvement, and development of policy and services in the public, private voluntary (PVO) and commercial sectors. Thus, the strategy document for population should serve lay out an overarching strategy for intervention in the sector. However, while it provides guidance for the three-year period, it cannot substitute for detailed work plans from which a program would actually be implemented.

o Definition of Population Sector. As defined by USAID/Haiti, the population sector is concerned with family planning, fertility, demography and population policy. These terms all capture aspects of fundamental behavior patterns: desire for children and families of a certain size, willingness to use family planning to space or limit births, age at union, level of education, religious influences, pressures to migrate, etc. Programs which bear on these must be cognizant of the fundamental underpinnings of these behaviors. Further, these programs are supported or restrained by national policies, which also are based on interpretation of these behaviors and influences and how they fit into national development.

USAID/Haiti is supporting currently a diverse range of programs in the population sector. These programs are being carried out with PVO and commercial entities and increasingly will involve the public family planning program. The population sector also has links to work involving AIDS, since, at the practical level, use of condoms is important in the prevention of transmission of AIDS.

There is wide diversity of programs in which USAID/Haiti is working: there are family planning programs in model, urban clinics supporting voluntary surgical contraception along with other methods; factory-based and community-based distribution programs; rural PVOs supplying contraceptives as part of child survival programs; and programs to introduce new methods like NORPLANT and a progestin-only pill. To increase the involvement of the commercial sector in family planning service delivery, a social marketing program will launch commercial pill sales in July of this year.

With respect to demography and population policy, there also are a number of initiatives: support of the entry of the UNFPA-sponsored demography curriculum into the fifth and sixth grade classes of a large Catholic school system; support of an effort to develop a private population interest group; policy dialogue with the public sector about the importance of developing a national population policy; encouragement of close collaboration between the public and private sectors to insure comprehensive family planning coverage; and introduction of cost-benefit analysis of family planning services into the light assembly and insurance sectors.

## II. BACKGROUND

Population growth poses a serious problem in Haiti in view of natural resource limitations and difficulties of the economy to provide employment for the present/future labor force. Haiti has at present a population of 6 million people, and a total fertility rate of 6.4 children per women. That represents an increase in fertility from the level ten years ago of 5.5 children per women. The increase in fertility, along with declines in mortality, means the rate of natural increase has grown from 2% to 3% per year over the last decade. Migration to the cities is growing, but many migrants must contend with settlement in slum areas, devoid of services such as clean water.

Haiti, thus, has the profile of socioeconomic development and program implementation of countries termed pre-emergent. Haiti is categorized as such in the paper "Moving Into the Twenty-First Century: Principles for the Nineties", prepared by the Family Planning Services Division (FPSD) of the AID Office of Population. Haiti is the only pre-emergent country in the Latin American/Caribbean region. A discussion of Haiti as a pre-emergent country is contained in Appendix 1.

The prospects for population growth in Haiti call for sizeable increases in the population, starting from the fertility parameter given above. Using the RAPID model software, projections for high, medium and low scenarios of population growth have been developed. These projections (Ref. Table 1) build on fertility reduction patterns observed in other Caribbean nations -- the rapid or 'type Martinique', the medium or 'type Dominique', and the slow decline or 'type Ste-Lucia'. For international migration, three patterns are supposed. First is the most favorable one of continued migration of 40,000 Haitians per year on a constant basis (as at present). Second is the medium assumption of migration of 40,000 Haitians per year tapering to 20,000 per year by the year 2000. The low assumption is that migration drops immediately to 20,000 Haitians per year, declining to 0 in the year 2000. For life expectancy, there is one assumption; life expectancy increases from 55 to 67 years by 2035. As shown in Table 2, under the low scenario, the population of Haiti will be 9.3 million in 2035; under the medium scenario, it will be 12.4 million, and under the high, it would reach 15.5 million.

The consequences of this rapid population growth are daunting. As shown in Table 3, deforestation will continue apace, with the probability of precipitating an ecological crisis. Rice production, while increasing, will in no way be able to keep up with this population growth, even under the low scenario. This will necessitate ever-increasing food imports. Urban migration will continue; Port-au Prince will grow from its present population of 800,000 to 3.8 million in 2025 under the low scenario, or 6 million under the high (Table 4). The population requiring MCH/FP services will grow to between 3.5 million and 6 million in the year 2025 from its present level of 2.2 million.

# POPULATION PROJECTIONS FOR HAITI

**BASE YEAR DATA (1985)**

Base Population: 5.343 million  
 TFR 1985: 6.5 children per woman  
 Life Expectancy at birth (both sexes): 55 years

## PROJECTION ASSUMPTIONS

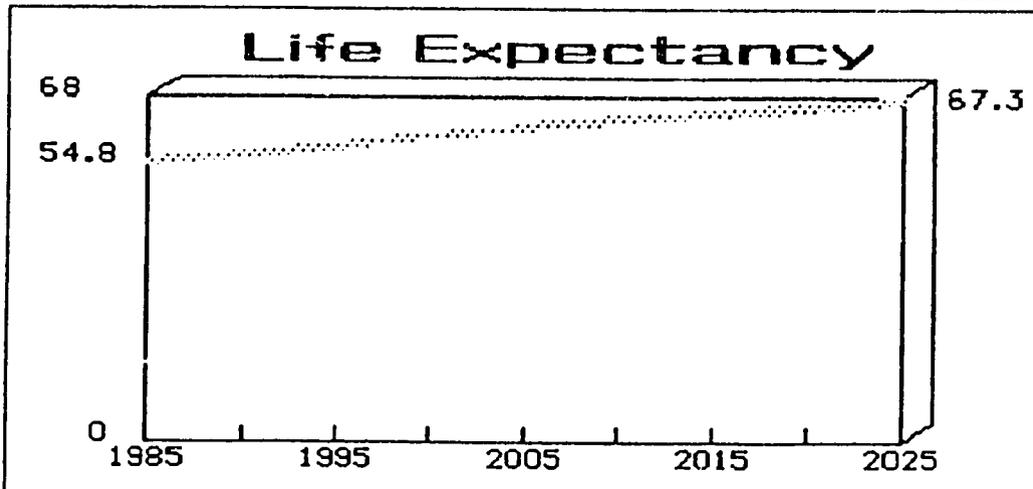
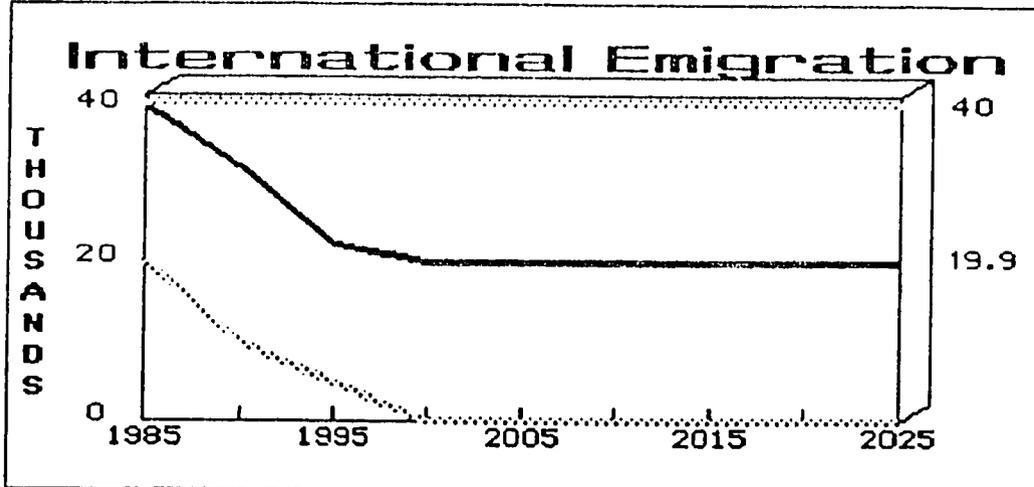
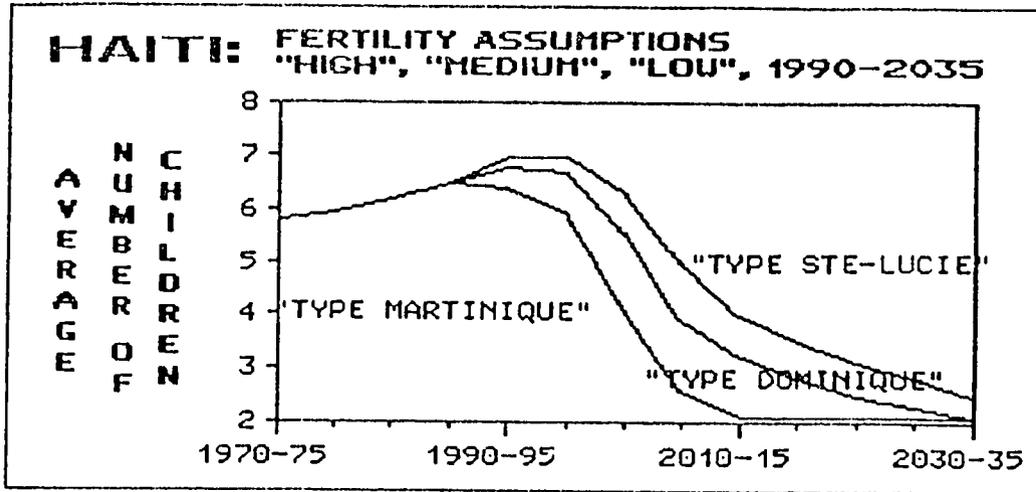


Table 2

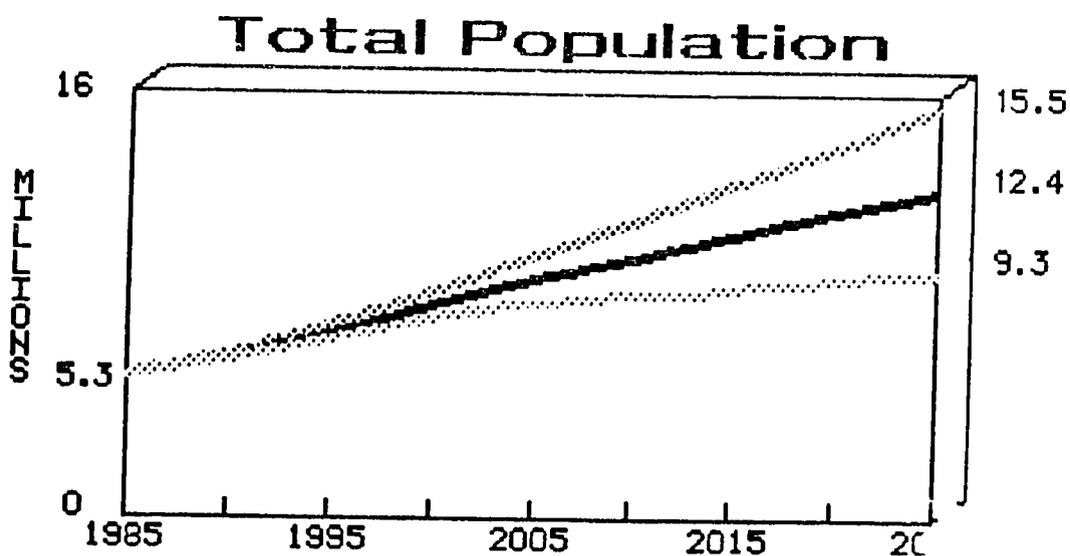
**PROJECTION SCENARIOS (Combinations of assumptions)**

- High:** TFR reaching 7.0 in 1990-2000 before declining to 2.5 in 2030-35. Emigration at 20,000 migrants annually, then no emigration from year 2000.
- Medium:** TFR reaching 6.7 in 1990-2000 before declining to 2.1 in 2030-35. Emigration reduced from 40,000 to 20,000 migrants annually by year 2000.
- Low:** TFR begins declining immediately, reaching 2.1 in 2030-35. Emigration constant at 40,000 migrants annually throughout the projection period.

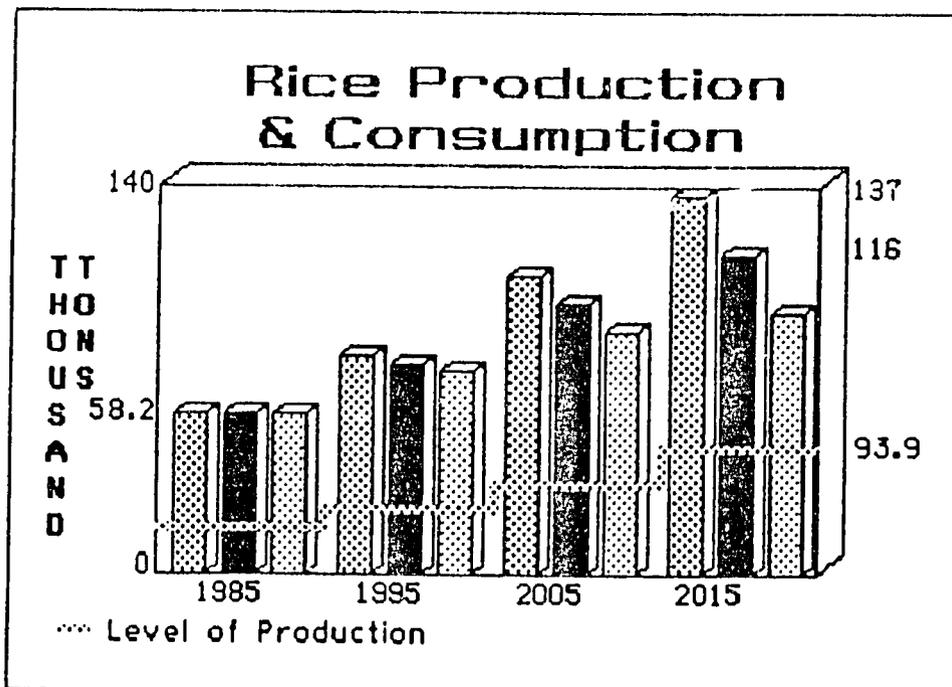
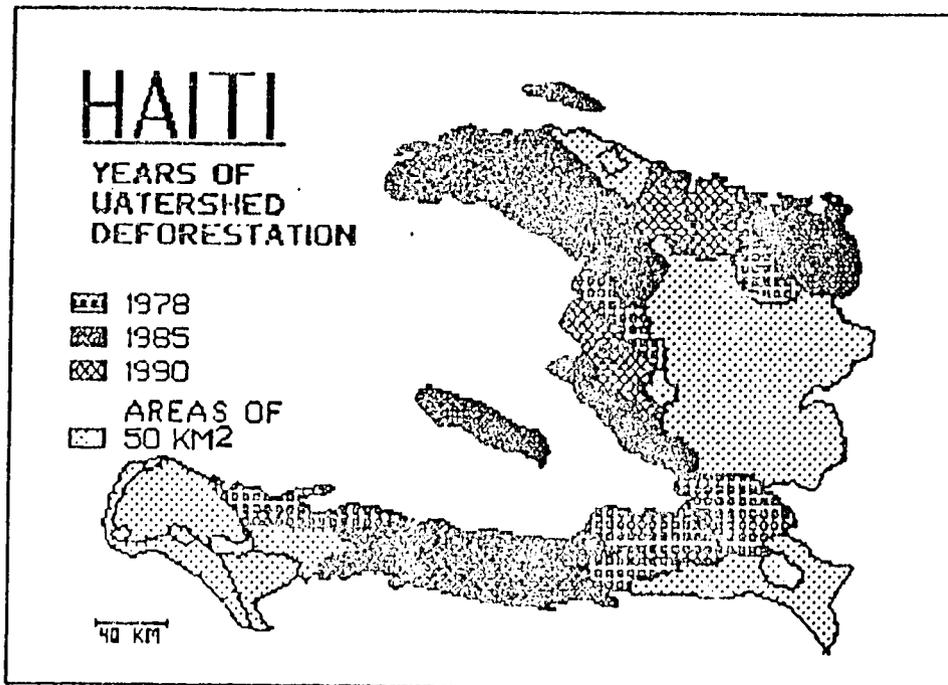
In all scenarios, life expectancy at birth will increase from 55 to 67 years by 2035. Increase in life expectancy may be less depending on demographic impact of AIDS.

**PROJECTION RESULTS (Total population in thousands)**

	1995	2005	2015	2025	2035
High	7,188	9,892	12,575	15,532	18,378
Medium	6,910	9,047	10,704	12,462	13,925
Low	6,765	8,118	8,702	9,483	9,997



CONSEQUENCES OF RAPID POPULATION GROWTH



Outmigration is a serious problem and is likely to remain so as long as the conditions of life are so difficult. This is addressed in the book, Escape from Violence: Conflict and the Refugee Crisis in the Developing World, by Zolberg, Suhrke, and Aguayo (1989, p. 194). They summarize the situation as follows:

"One of the distinctive features of this migration is its extreme inelasticity. Glenn Perusek convincingly argues that 'Haiti is a classic push case-factors in receiving countries do not determine whether there will be migrants from Haiti.' That is, Haiti's economic and political conditions expelled its people and made migration a part of the popular culture and a symbol of social status."

Thus, until life conditions improve, Haitians in large numbers will continue to seek to migrate to neighboring countries. To the extent that the conditions of life become increasingly difficult and pressure to migrate grows with increased population, there are geopolitical issues which the twin population/migration problems pose to the receiving nations.

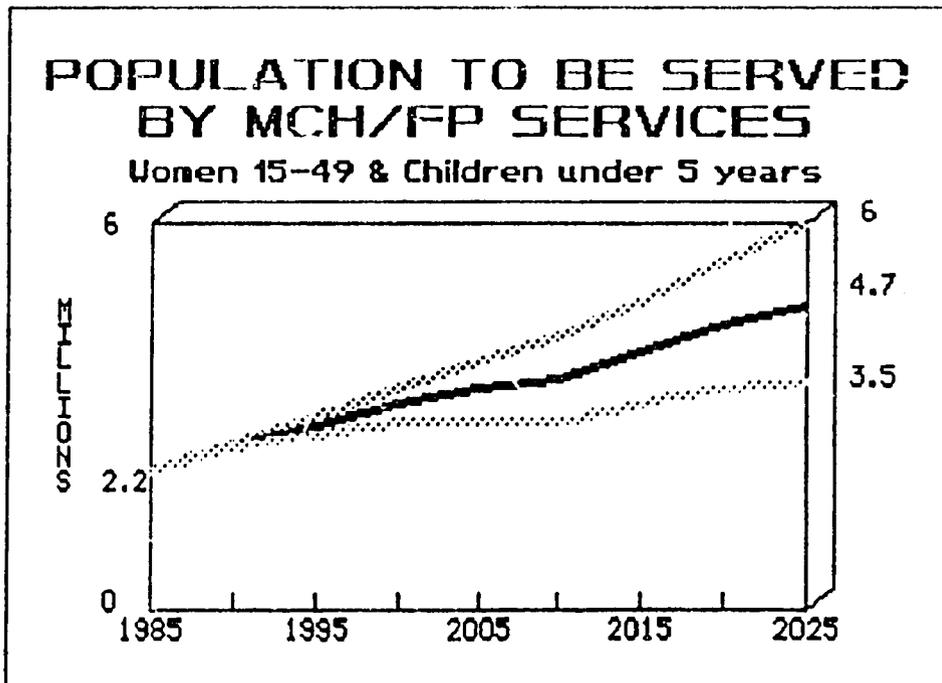
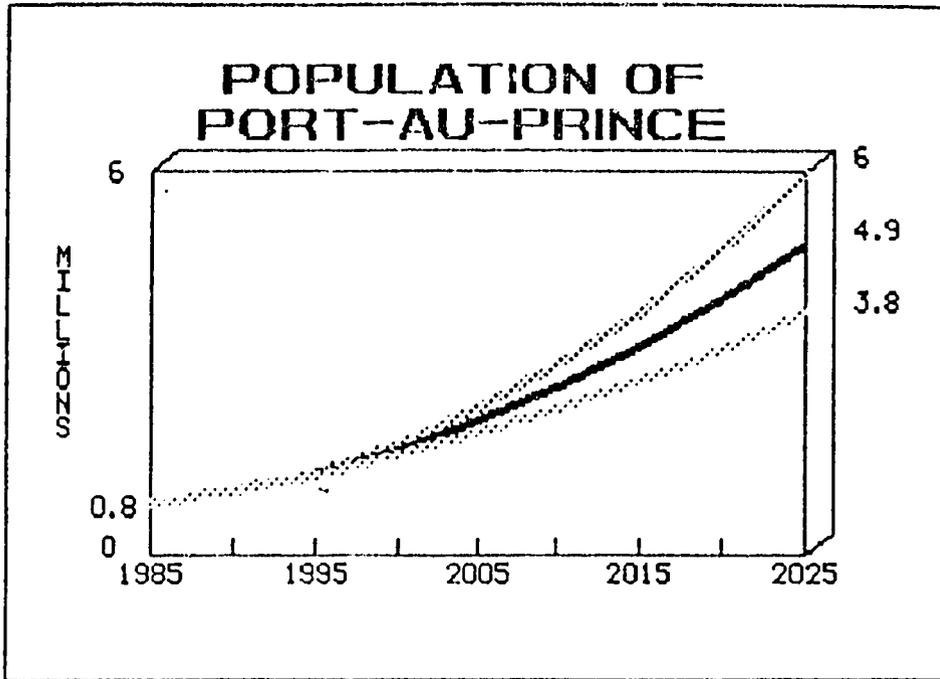
#### Ila. History of AID Assistance to the Population Sector

Ila. History through November, 1987: AID has traditionally been the largest donor in the population sector in Haiti. AID assistance in population was, for example, \$5.5 million in FY '86. By comparison, UNFPA, the next largest donor, has provided a total of \$15.4 million since 1972.

Although AID's presence was large, efforts to increase contraceptive prevalence were not uniformly successful. During the mid-80s, the policy climate, as well as the organizational structure of the Ministry of Health and Population (French acronym-MSPP), militated against the development of a broadly effective program. During those years, no effective unit to support implementation of population policy existed. Within the MSPP, the Division of Hygiene, the Family and Nutrition (DHFN), the unit charged with establishing family planning services, was not committed to the program and was weak organizationally.

The program's peak was in the late 70's-early '80's, when it took a vertical form, with dedicated workers who received salary supplements for work in family planning. When, with donor assistance in the period 1983 - 1985, the program became horizontal, delivery of services and contraceptive prevalence declined notably.

Table 4



This is relevant to the present strategy statement, in that the MSPP organizational structure does not, at present, provide for front-line, community-based workers to promote family planning. This should be viewed as a potential constraint to making the MSPP fixed facilities fully operational, since front-line workers play a key role in demand creation and encouragement of current users to go to fixed facilities. A fully vertical program is not being advocated here; however, front-line promoters, with family planning as a key task, will be needed as public sector program implementation proceeds.

In mid-1987, USAID/Haiti was negotiating a large amendment to the bilateral project. Family Planning Outreach (521-0124). This amendment built on two previous successes 1) nascent efforts to strengthen the population policy unit at the MSPP (Commission National de la Population - CONAPO) headed by a strong, young leader who had worked well with external TA resources, and 2) strengthening of family planning service delivery with the identification of a dynamic, U.S.-trained Haitian physician as program manager. Work under the new amendment had barely started, however, by Fall of 1987. At that time the public sector program for voluntary surgical contraception (VSC) was one of the most successful components.

In November, 1987, national elections were violently disrupted and the elections themselves postponed. This led to rupture of virtually all US bilateral assistance to the Government of Haiti (GOH), with the exception of food and medicines. Family Planning Outreach, which at that time was valued at \$13.95 million, along with all other bilateral projects, was terminated. Private Sector Family Planning (521-0189) continued, as will be discussed below, but initially in an environment of political instability which imposed limitations on field work. At that time, the other major donor in the sector, UNFPA, maintained its presence, but reduced its level of activity partly in response to the political instability.

Ii.ii. Present context. The climate for intervention in family planning has changed greatly since November, 1987, both with respect to stability permitting field operations and in terms of organizational structure at the MSPP. The MSPP has disbanded the DHFN and replaced it with a priority programs office, of which family planning is a unit, responsible directly to the second-in-command at the MSPP. The orientation is that of primary health care, and family planning has been made a major priority of the Ministry since the Minister's visit to Washington in February, 1989. The family planning counterpart at the MSPP is first rate. Furthermore, the Ministry has adopted a strategy of public-private partnerships, to make use of private sector organizations, such as Private Voluntary Organizations (PVOs), to deliver basic services, and as part of this to supervise Ministry staff.

Throughout the period of the rupture of assistance, USAID/Haiti maintained an active policy dialogue with the MSPP to facilitate the delivery of family planning services. With the goal of developing an effective, national program of family planning, USAID/Haiti sought to conduct certain small activities with the public sector. These were first an expansion of the NORPLANT pre-implementation trials from 3 PVOs to include 3-5 public sector clinics. Second was the introduction of Ovrette, a progestin-only pill suitable for breastfeeding mothers, simultaneously into the PVO and public sector programs. In consultation with AID/Washington, USAID/Haiti began to implement these in late Fall, 1989.

The recent period has also been characterized by policy dialogue with other international donors as will be described below.

#### IIb. Donor History and Present Involvement

The necessary elements to mount an effective, national program in family planning in Haiti are too great for any one donor to provide alone. For that reason, multi-donor participation and coordination are essential. Table 5 shows the historic and present levels of donor assistance in population. USAID/Haiti has been included in this Table for completeness sake, but USAID/Haiti's historical involvement has been previously reviewed and the current USAID/Haiti portfolio will be described in greater detail below.

IIbi. UNFPA. As described above, UNFPA traditionally has been the second major donor in the national health and family planning area. However, during the period November, 1987 - November, 1988, UNFPA has confined its efforts to small activities focussing on maternal health and to supplying the public sector with contraceptive commodities. UNFPA is beginning to implement a \$2.4 million, four year project, but plans to increase that level of assistance if the need can be demonstrated, and if political stability and absorptive capacity are conducive to such an increase. UNFPA, through the executing agency of WHO/PAHO, has focussed its efforts on the public sector. USAID has maintained and continues to conduct a policy dialogue with UNFPA to put emphasis on the needs of the national family planning program (as contrasted to maternal health). UNFPA will be adding a resident representative to its staffing in FY 1990.

The adoption of a formal population policy is one of UNFPA's strongest initiatives at the present time. This involves a great deal of consensus building since elements within the Haitian government, such as the Institut Haitien de Statistique et Informatique (IHSI), are not fully convinced of the place of family planning in socioeconomic development of the family and the nation.

Table 5

DONOR INVOLVEMENT  
HISTORICAL AND PRESENT ACTIVITIES

	USAID	UNFPA	WORLD BANK	CANADIAN ASSISTANCE
Historic involvement	High before rupture of assistance after Nov '87	High but scaled down in 1988 to focus on maternal health	No previous involvement	
Present funding commitment	\$8.25 million	\$2.4 million	\$1.5 million	
Timeframe	8/1986-3/1991		1990-1995	
Sector	PVO/Private commercial	Public sector	Public sector West Region	Public sector AIDS program
Commodities	Yes	Yes	No	Condoms
Policy component	Policy dialogue with public sector, plus development of private sector interest group	Pop. policy development through public sector	No	No (or with public sector AIDS program)

BEST AVAILABLE DOCUMENT

Ibii. World Bank. In 1988 - 1989, the World Bank developed its first health sector loan, on soft terms, for approximately \$32 million to cover the period 1990 - 1995. The loan will go to signature in February, 1990. AID has, at all levels, conducted a policy dialogue toward the Bank's inclusion of a family planning component. Such a component, valued at \$1.5 million, will be included in the loan. Activities under the loan will be conducted in the West Region of Haiti, which includes Port-au-Prince. Neither commodities nor population policy figure in this program. Commodities will be obtained through the UNFPA supply system.

The World Bank program will be divided roughly as follows: one-third TA, and two-thirds budget support for service delivery; equipping of VSC and other family planning facilities; information, education and communication (IEC) local costs; training and safe motherhood conferences. Technical assistance will focus on four areas: IEC, maternal mortality and abortion (data collection and IEC about family planning), screening of high risk pregnancies both before and after conception, and improvement of family planning service delivery.

The health sector loan has a major policy dialogue element related to management and efficiency of staffing in the MSPP. As an overarching objective, this may help greatly to reduce the MSPP's burden of staff, which make up 80% of its operating budget. However, this may hurt in the family planning area, since the MSPP's staffing does not provide for front-line community-based promoters. Resolution of this problem should be the subject of joint MSPP-World Bank-AID discussions.

Ibiii. Canadian Assistance Agency. Canadian assistance to the national AIDS prevention program is included here, because of its planned role in the provision of condoms. The assistance for AIDS will include an IEC campaign and provision of a sizeable number of condoms. Since UNFPA, USAID and the Canadians will all be bringing in condoms, this is an important area of donor coordination. It may be useful for condom quantities to be the subject of inter-donor meetings or of meetings of the PAHO/MSPP-sponsored, joint donor and implementing organization, family planning group.

Ibiv. Other Donors. There is interest in working with other donors as well. It would be valuable to approach the Japanese with requests for assistance; initial needs are for vehicles, mobile clinics, and equipment for VSC facilities. The French, who have an active program in health and AIDS prevention, have expressed an interest in being involved in population policy work in Haiti. This possibility should be explored, especially with respect to timeframes and coordination with present work.

Two other donors should be mentioned. The GDZ is providing assistance in the Central Plateau in primary health care. They would be interested in collaborating with other donors in family planning, but have not been aggressively involved on their own. The IDB will be coming in with a health sector loan on soft terms, but it is too late in the development of the loan paperwork to include a family planning component. However, representatives of the IDB indicate that family planning is an area of interest.

#### IIc. USAID/Haiti Portfolio

The objective of AID assistance in the population sector is to increase access to voluntary family planning in Haiti. Since November, 1987, USAID/Haiti has had a private sector strategy, primarily based on PVOs, but increasingly emphasizing the commercial sector. Haiti has, it is estimated, approximately 200 PVOs providing local primary health care services. In August of 1986, USAID/Haiti began the Private Sector Family Planning Project (alongside the bilateral Family Planning Outreach Project) to determine whether PVOs could be an effective provider of family planning services.

Private Sector Family Planning (PSFP-521-0189) is funded at \$8.25 million with a PACD of March 31, 1991. IPPF/WHO is the implementing agency for this project. The project, which has recently undergone an interim evaluation, presently has about a 14% contraceptive prevalence rate in the areas in which it is working. When fully implemented, this project should reach approximately 50,000 acceptors. This number is small for two reasons, first funding constraints relative to the great needs to put into place everything for PVO service providers -- logistics systems, community-based distribution systems, IEC programs, training, programs of VSC in selected PVOs, etc. Second, the present funding level only puts project-funded services into the catchment areas of PVOs reaching approximately 25% of Haitian families.

The potential for success of family planning programs in Haiti is demonstrated by previous special intervention projects. For example, under the Columbia University operations research project, prevalence rates in the Miragoane area rose to 34% from a baseline prevalence of 7%.

The evolution of the present private sector program has been based on strategic opportunities to maximize sectoral and donor involvement, in a situation where the only limits are those of creativity and diplomacy. With the generally weak government managerial and enforcement structure, there are very few institutional constraints as to what can be tried. However, all new initiatives must be developed in open communication with GOH and PVO counterparts so that the initiatives respond to the Haitian cultural, political and religious reality. Despite the low contraceptive prevalence rate, the present method mix is highly effective, and includes active service delivery of non-clinical and clinical methods, including depo-provera, vasectomy, tubal ligation and NORPLANT. The interim evaluation of PSFP suggests that the umbrella project mechanism, with service delivery through PVOs, is an effective approach and additional resources should be devoted to this mechanism.

The private commercial sector is a major force for stability and its success has, historically, been partially due to the laissez-faire system of controls. This is favorable for the expansion of efforts with the commercial sector and for launch of the new social marketing activity. Activities under the Technical Information on Population for the Private Sector (TIPPS) Project are very promising for initial success and future expansion as well.

The social marketing activity will begin with the launch of an oral contraceptive product in February, 1990. While USAID/Haiti is funding the marketing and managerial aspects of the activity, private sector involvement is maximized in that the pill product itself is not subsidized in any way. This activity is designed to eventually incorporate a number of methods, with phasing in of progestin-only pills appropriate for breastfeeding mothers and detailing of IUDs to private practitioners, followed by NORPLANT introduction among private practitioners (once FDA approval is gained for that method). Additional resources will be needed to incorporate other methods as planned.

The small TIPPS buy-in is designed to accomplish two major objectives: 1) to teach PVO service providers to perform cost-benefit analysis for firms in the light assembly sector and 2) to work with insurance companies, using their actuarial data, to demonstrate the profitability of incorporating family planning services into their health insurance packages. Initial work with TIPPS has been very positive; the PVOs are very motivated to participate in the cost benefit analysis training and two insurance companies will collaborate in the activity. There are good possibilities for expansion under TIPPS, including collaboration with the Association des Industries d'Haiti (ADIH) to present the TIPPS approach to member companies, and work with OFATMA, the parastatal organization responsible for workers compensation and maternal health programs in private sector enterprises. Expansion to include these tasks will require additional resources.

USAID/Haiti has maintained an active policy dialogue with the MSPP through the period of prohibition of direct assistance, beginning November, 1987. This policy dialogue has been marked by open communication about USAID/Haiti's activities with the private sector. Further, some PL-480 funding has been made available to the MSPP family planning program -- \$150,000 in FY 89 and \$500,000 slated for FY 90. This enabled the MSPP to do two things -- 1) to begin to mount a program in family planning in a situation where MSPP funds are 80% committed to staff, and 2) to work in concert, to a limited extent, with new initiatives of USAID/Haiti, for example to have participation in the new IEC task force established for the private sector project. Another outgrowth of this policy dialogue was that the MSPP formally entered NORPLANT into the national family planning program, in July, 1989. USAID/Haiti in conjunction with AID/W was able to initiate two small, exceptional activities with the public sector -- the expansion of the NORPLANT pre-implementation trials to a few public sector facilities and the simultaneous introduction of a progestin-only pill into the public and PVO programs. With the new exception in the Foreign Assistance Act, allowing direct assistance to the GOH in family planning, these and other initiatives should be institutionalized.

To summarize the above discussion, the portfolio of activities by sector, including the amount and source of funding and mechanism for implementation, is shown in Table 6.

The historical stream of funding in population in Haiti is shown in Table 7. This Table indicates that the population portfolio received considerable funding in the years prior to the rupture in assistance, ranging from \$3-5 million per year for the three previous years. It was appropriate for this funding level to decrease significantly with the rupture in assistance, since USAID/Haiti was embarking on a private sector strategy which was then untested.

It is appropriate now to seek funding at levels like those prior to the rupture or higher. As indicated above, the climate for intervention has changed dramatically in favor of program implementation. PVO service delivery has proven itself to be an effective component of a national family planning program, as shown by the recent interim evaluation. The potential of the private commercial sector is considerable, and efforts such as the development of a multi-method social marketing program and the work with private enterprise should continue apace. Lastly, with the change in US policy toward Haiti, to allow direct assistance to the government in family planning, public sector activities should resume. For these reasons, greatly increased resource levels will be required.

Population Funding by Sector  
 USAID/Haiti - FY 89 & FY 90  
by Sector, Amount and Mechanism

<u>Public Sector</u>	<u>Private Commercial Sector</u>	<u>Private Voluntary Sector</u>
1. <u>Support to Family Planning Program</u> <ul style="list-style-type: none"> <li>o \$150,000 PL-480 FY '88</li> <li>o \$500,000 PL-480 FY '90</li> </ul>	1. <u>Social Marketing</u> <ul style="list-style-type: none"> <li>o \$550,000 (Jan. 1989- March 1991) Central Funds and Private Sector Family Planning</li> </ul> 2. <u>TIPPS</u> <ul style="list-style-type: none"> <li>o \$60,000 (June, 1989- Jan., 1990) Central Funds and Private Sector Family Planning</li> </ul>	1. <u>Umbrella Project Imple- mented by IPPF/WHR thru PVOs</u> <ul style="list-style-type: none"> <li>o \$6.25 million (Aug. 1986-March, 1991) Private Sector Family Planning*</li> </ul> 2. <u>NORPLANT pilot in PVOs by FHI</u> <ul style="list-style-type: none"> <li>o \$334,000 (June, 1988- March, 1991)</li> </ul>

\* Private Sector Family Planning (521-0189) is authorized at the level of \$8.25 million; PACD of March 31, 1991; IPPF/WHR implementing agent. Balance of funding not shown on this chart is as follows: Commodities \$893,000; long term training \$90,000; PSCs \$180,000.

Table 7

POPULATION FUNDING  
USAID/HAITI  
BY FISCAL YEAR AND SECTOR  
U.S. \$THOUSANDS

SOURCE	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
<hr/>						
Bilateral						
Public Sector	2,280	3,234	1,700 *	500 **	-0-	-0-
Private Sector	3,250	-0-	1,857	1,055	3,350	5,000 ***
<hr/>						
Sub-total	5,530	3,234	3,557	1,555	3,350	5,000
<hr/>						
Central						
Public Sector	?	?	?	0	0	0
Private Sector	0	0	0	75	150	75
<hr/>						
Sub-total	?	?	?	75	150	75
<hr/>						
P.L. 480						
Public Sector	?	700	0	150	500	?
Private Sector	0	0	0	710	150	?
<hr/>						
Sub-total	0	700	0	860	650	0
<hr/>						
Total	5,530	3,934	3,557	2,490	4,150	5,075

\* Portion deobligated

\*\* FTIIC - General training for Haitian long-term participants

\*\*\* Through March, 1991

**BEST AVAILABLE DOCUMENT**

### III. STRATEGY

#### IIIa. Strategy Overview

USAID/Haiti's strategy is to support the GOH/MSPP to achieve the development of an effective, national program of family planning (FP) which maximizes the involvement of the public, PVO and the for-profit commercial sectors. This supports the MSPP's policy of developing private partnerships for the delivery of public services and allows each sector to perform according to its comparative advantage.

An effective national program must function in a supportive population policy climate. Public and private sector family planning programs require a clear, defined population policy climate in which to flourish. In an ambiguous policy climate, cross-Ministerial collaboration is weaker, and commitment within the implementing Ministry to program implementation is ambivalent. Thus, such a policy needs to be formally adopted by the GOH. Within the MSPP, an explicit strategy related to program development and support for family planning should be developed to carry out such a policy.

With respect to priorities of intervention, USAID/Haiti's immediate term strategy for the period 1989-1992 will emphasize support for the continuous user, although priority will continue to be given to attracting new acceptors. This represents a shift in USAID/Haiti's strategy for the PVO sector during the period 1987-1989 which focussed primarily on new acceptors. There is momentum now in demand creation, and it is appropriate now to focus more on supporting the continuing user, in order to sustain their use of family planning. Haitian families are generally knowledgeable about one or more methods, and the "ever-used" rates are nearly double current use rates (these were 11.9% vs. 6.5% according to the 1987 EMMUS survey). This indicates that support to the continuing user must be a major priority for the upcoming years. Issues of quality services will be addressed to assure that the standards for IEC, counselling, voluntarism are met, and that the circulation of myths and rumors becomes less salient. But as a lesser priority, demand creation will continue to be important as it is in all pre-emergent countries. Qualitative research will continue to be needed to develop understandings of the gap between knowledge and practice of family planning.

As part of the continuing user strategy, an emphasis will be placed on developing quality services. To support the continuing user, services must be responsive to the client and uniform in their relationship to basic standards of care developed jointly by a collaborative group of public and private sector representatives.

The emphasis on quality services will include objective and complete promotion of all methods building on the acceptability of the wide range of contraceptive methods in Haiti. From an administrative point of view, services must be well managed, free or reasonably priced, and geographically accessible.

Maintenance of consistent supply lines is another element of USAID/Haiti's strategy. Historically, abandonment of FP methods has been partly related to breaks in the supply system. USAID/Haiti will seek to provide, on a timely basis, contraceptives as needed in the growing public, private and commercial sector programs. Methods will be effectively targeted by sector (see Table 8). Since this is an area of participation of other donors, namely UNFPA and the Canadian assistance agency (re condoms for AIDS), the strategy calls for close collaboration to assure that adequate supplies are coming in and being distributed, but that excessive supplies (for example, of condoms) do not develop at any point in the supply chain.

Donor participation and coordination, beyond the level of commodities, is also an element of the strategy. No one donor, working alone, will be able to support Haiti and the GOH to develop an effective, national program of family planning. The international donor community must be broadly involved, but with that involvement comes the necessity of coordinating activities and resources, etc. One particular area where donor coordination will be sought will be the expansion of the present social marketing project to include other methods in addition to orals.

Lastly, USAID/Haiti's population strategy includes emphasis on coordination of family planning and AIDS prevention. Prevention of the transmission of AIDS is a major public health concern in Haiti. Since condoms are one of the major tools available in preventing the transmission of AIDS, AIDS prevention could well become an integral part of family planning service delivery. It may be appropriate, after proper exploration, for family planning programs to offer acceptors simultaneously an effective contraceptive method and condoms for the prevention of sexually-transmitted diseases. The family planning/AIDS interface, particularly as it involves condom supplies from donors and condom distribution, will require considerable donor and MSPP/FP/AIDS program coordination and documentation.

### IIIb. Elaboration of the Strategy

IIIbi. Plans for growth of use of contraceptive methods. Table 8 shows the plans for growth of use of contraceptive methods by sector. These have been grouped into long and short-term methods, and each method will be discussed below.

Table 8

PRESENT STATUS AND FUTURE PLANS FOR  
CONTRACEPTIVE METHODS BY SECTOR

Public	PVO	Private Commercial
<hr/>		
LONG-LASTING METHODS		
<hr/>		
VSC - Mobile VSC teams, VSC in fixed facilities to be strengthened, Post-partum strategy to be developed	VSC in model urban clinics, VSC to be expanded to model rural clinics	Private physicians to their private patients
NORPLANT - NORPLANT to be offered in 5 public sector facilities	NORPLANT in 3 PVO centers	NORPLANT training to private physicians to be included in expanded social marketing activity (Phase IV of social mktg.)
Injectibles - Inject. provided by UNFPA	Injectibles provided by UNFPA	Injectibles to be included in expanded social marketing if donor/private funds can be obtained (Phase IV)
IUDs - IUDs Type & source??	Cu-T 380A prov. by USAID but targeted promotion needed	Cu-T 380A detailed to priv. physicians through social marketing (Phase III)
<hr/>		
TEMPORARY METHODS		
Pills - Low-Femeral provided by UNFPA	Low-Femeral provided by USAID	Pill social marketing to be launched in early 1990 (Minigynon)
Ovrette to be provided by USAID, with a national/regional introduction	same	Pill social marketing expanded to rural areas (Phase II)/ Commercial sec. progestin-only pill to be included in expanded social marketing (Phase III)
Condoms - UNFPA, Canadians to provide for AIDS	Condoms - USAID, IPPF/WHR to Profamil USAID to AIDS PVOs	Condom social marketing through PSI since Summer, 1988
Sperm./Barrier Meth.		
Spermicidals provided by UNFPA	Provided by USAID	Spermicidals, sponge, etc. of of interest for addition to soc. mktg. activ.

## Long-Term Methods

o VSC. According to the 1987 EMMUS survey, VSC was the second most used method among survey respondents. The GOH's VSC program was one of the stronger components of the program prior to the rupture of assistance in 1987. The program service statistics, broken down by female VSC and vasectomy, are shown in Table 9. The recent small vasectomy figures represent the informal continuation of the concerted MSPP/JHPIEGO effort in the North, in the mid-80's. The GOH has, during the rupture of assistance, continued to support mobile VSC teams to the extent very limited resources permitted. The GOH is very favorable to VSC, both for women and men. It will be important to support the GOH to offer VSC in its network of fixed facilities; and it would be appropriate to do this in conjunction with the development of a post-partum strategy for longlasting methods like NORPLANT and VSC in the public sector program. More work in male VSC, building on the previous success in the North, is also needed.

PVO programs in VSC are also growing. At present, three model urban clinics offer this service (although one of these, FOSREF, has had a serious problem with promotion of its facility and services). One more model clinic will be developed in the North (Port-de-Paix). Through the Association d'Oeuvres Privées de Santé (AOPS) stable, local PVOs in rural or semi-urban areas will be equipped, trained and supervised to provide VSC services.

It is presumed that private, stand-alone physicians offer VSC services to their private patients, but this should be investigated in developing a picture of service delivery in the private, for-profit sector.

o NORPLANT. The GOH formally entered NORPLANT into the national family planning program in July, 1989. Since NORPLANT is effective for five years, the method is viewed as an excellent method for a woman in her twenties, with a completed family, to limit births into her thirties, when Haitian norms allow VSC.

NORPLANT will be offered in 3 - 5 public sector facilities (including the large urban and semi-urban maternities of the University Hospital) in a continuation of the pre-implementation trials underway in a select group of PVOs. The theoretical training for five public and PVO practitioners has been conducted, and two of these individuals (one public and one private) have had intensive practical training in insertion and removal at one of the participating PVOs (Pignon). Another group of four practitioners will begin training in January, 1990, and plans are to train a new group every six months.

Table 9

Voluntary Surgical Contraception (VSC)  
by Type of Procedure and Year

	<u>1976-82</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>
Female VSC	4028	2199	3011	3867	3388	2529
Vasectomy	39	303	387	882	200	194
Total	4067	2502	3398	4749	3588	2723

TABLE 10  
 Family Planning Users Needed to Meet  
 Fertility Targets by Sector  
 Present and Future Projections  
 (00's)

	CY 90	CY 91	CY 92	CY 95
Medium Scenario	74.51	78.2	82.0	106.8
Modern Methods	59.90	64.4	69.0	96.1
Low Scenario	95.01	106.5	117.7	190.4
Modern Methods	77.01	88.0	99.1	171.4
Public Sector	22.	25.	28.0	37.0
PVO Sector	24.0	32.0	40.5	48.0
Commercial Sector				
CSM (CYP)	4.7	7.9	9.8	11.4 **
Other	2.3	2.4	2.5	2.9
<b>TOTAL</b>	<b>53.</b>	<b>67.3</b>	<b>80.8</b>	<b>99.3</b>

\* Based on extrapolations to fill missing years.

\*\* Based on expansion of 5% per annum (CY '92 - CY '95).

The curriculum for this training has been developed by a group of MSPP and PVO representatives, in conjunction with the Institut Haitien de Sante Communautaire (INHSAC), a PVO dedicated to training in health.

Within the PVO sector, pre-implementation trials have been underway for some time in three organizations, although one of these, Fond-de-Negres, has been less successful than the other two -- Pignon and Cite Soleil. From this effort has grown the development of an attractive, Creole-language booklet for NORPLANT promotion.

For the commercial sector, it is hoped that NORPLANT will become a method supported by the contraceptive social marketing activity. Once NORPLANT is approved by the FDA, it will be possible to expand promotion of the method, from the present pre-implementation trials. Detailing of NORPLANT to private physicians would be a component of Phase IV of the social marketing activity (April, 1992-March, 1993), which would include arrangements for training these physicians. Note that with the provision of NORPLANT in the maternities of the University Hospital, new private physicians would have received training in the method's use. It is interesting to note that one pharmaceutical distributor has had on hand a supply of NORPLANT for some time; this distributor sees eventual commercial potential of the method once the training requirements can be fulfilled. With the ongoing establishment of the training capacity in Haiti, both theoretical and practical, the training needs of private physicians can be met through private, paid participation in training. As plans for this go forward, market research into the demand for such training will be needed.

o Injectibles. Depo-provera was cited as the fourth most used method in the 1987 EMMUS survey. UNFPA supplies injectibles to both the public and PVO sectors. Injectibles can account for a significant portion of a clinic's activities; in Cite Soleil, for example, nearly 75% of acceptors rely on depo-provera. This phenomenon of reliance on one method may be symptomatic of the fact that, at present, real, objective promotion of all methods is not being done in Haiti. In programs such as this, which rely disproportionately on certain methods, it seems that satisfied acceptors are the main promoters, bringing in their friends and families for the same method they are using.

Injectibles have a firm place in the family planning program in Haiti. Depo-provera is popular as described above. A local pharmaceutical house is considering whether to package depo-provera for the local economy. This might be advantageous for the social marketing activity. With respect to Noristerat, there is some highly preliminary data to show that Noristerat is even more acceptable than depo-provera to Haitian women. Given that the distributor for the social marketing activity also handles Noristerat, that may be another attractive option for the social marketing activity and would help with product differentiation in the social marketing program. Injectibles may be included in Phase IV of the social marketing activity, if private or other donor funds can be identified to cover the costs.

o IUDs. At present, IUDs are not an important method in Haiti; historically, the IUD has accounted for only 5.2% of prevalence or 3,500 users. For the public sector, IUDs are supplied by UNFPA; for the PVO project, USAID/Haiti supplies the Cu-T 380A. Targeted promotion of the IUD, as described in the later Section "Short-Term Cross-Cutting Actions to Support the Strategy", is needed in both the public and private sector programs.

The Cu-T 380A, possibly supplied by USAID/Haiti, may be entered into the multi-method social marketing program, during Phase III. The timing of this in the period, March, 1991-March, 1992, is advantageous, because this should follow on the targeted promotion of the IUD in the public and PVO sectors.

### Temporary Methods

o Pills. The contraceptive pill was cited by respondents in the 1987 EMMUS survey as the most used method.

Low-dose, combined pill. Lo-Femenal is provided by UNFPA to the public sector. This pill was chosen by the MSPP, in order to standardize the low-dose pill in the public sector and PVO programs. USAID/Haiti provides Lo-Femenal to the PVOs. Through the PVO program, Cite Soleil has developed an attractive, Creole-language booklet for promotion and for the use of pill acceptors.

An affordable, quality pill will be made available to C and D class consumers in the commercial market in February, 1990, through the contraceptive social marketing activity. This pill will be Minigynon, manufactured by Schering/West Germany. The distribution system of the participating distribution firm, Commerce SA, will focus on urban areas in the initial distribution system. In Phase II (September, 1990-February, 1991), it is planned to expand the distribution system, perhaps to include selected rural areas, which depend on urban areas covered by the main distribution system.

The model of an expanded distribution system, using non-retail promotion through community-based distributors, will be tested through an operations research activity. This would look at a variety of distribution schemes, such as using community-based distributors to either educate and refer consumers to commercial distribution outlets or alternatively to serve as door-to-door sales agents.

Progestin-only pill. Ovrette, a progestin-only pill suitable for use by breastfeeding mothers, will be introduced into the national family planning program in Spring, 1990. A series of national and regional workshops will be held to familiarize practitioners with the pill, which has to be taken on a schedule somewhat more rigorous than that of the low-dose, combined pill. In the course of these seminars, breastfeeding as a contraceptive method and as a factor in child survival also will be stressed.

A recent analysis conducted by the MSPP showed that the mean duration of breastfeeding has increased from 11.7 months in 1983 to 17.3 months in 1987, due to breastfeeding promotion. While this may not represent an absolute increase in the duration of complete breastfeeding, progestin-only pills are particularly well adapted to the needs of women who partially breastfeed their infants for a long duration but not intensively enough to remain anovulatory.

It is planned that a progestin-only pill will be introduced into the social marketing activity in Phase III.

o Condoms. As described in the later Section "Short-Term Cross-Cutting Actions to Support the Strategy", condoms traditionally have been brought into Haiti in great excess compared to their reported rates of use. As part of the 1989 CDC/CHI survey of Haitian men and women, condom use was explored in depth to probe use patterns and to understand the disposition of the large quantities of condoms that donors have previously brought in. UNFPA currently provides condoms to the public sector; Canadian assistance also will be providing condoms to the national AIDS-prevention program. USAID/Haiti also provides some condoms to PVOs focussing on AIDS prevention among high risk groups.

In the PVO program, USAID/Haiti is the major supplier of condoms, although IPPF/WHR supplies a small quantity independently to its nominal affiliate, PROFAMIL. In the PVO project, condoms make up 19% of the reversible methods supplied. Whether these condoms are provided alone or in conjunction with a more effective contraceptive method is not known. A small survey to determine this will be conducted by CHI/CDC in 1990.

o Spermicidals and barrier methods. Spermicidals are supplied to the public sector by UNFPA and to the PVOs by USAID/Haiti. Spermicidals, sponges, etc. are of interest for addition to the multi-method social marketing program. These can be added at any point at which a commercial distributor expresses serious interest in taking part.

IIIbii. Sectoral goals in acceptor numbers. Table 10 describes the number of users needed to achieve the medium and low population growth scenarios. For Calendar Year (CY) '90, 74,500 users are needed to achieve the medium scenario; in CY '92, 82,000 are needed; in CY '95 106,800 will be required. To achieve the low projection, 95,000 users would be needed in CY '90; 117,000 in CY '92; and in CY '95 190,400.

Under the present and planned program, how many acceptors will each sector contribute to this? The public sector estimates that it served 20,000 acceptors in CY '89, and hopes to serve 25,000 in CY '91, 80,800 in CY '92 and 37,000 in CY '95. Unfortunately, the service statistics system for the public sector has not been fully operational, therefore these public sector projections must be considered as estimates.

For the private sector PVO program, it is projected that 24,000 active acceptors will be served in CY '90, 32,000 in CY '91 and 40,500 in CY '92. Estimates are not available yet for 1995. The planned evolution of this program, in terms of active acceptors and catchment areas of the PVOs, is shown in Tables 11 and 12. A more detailed discussion of this evolution is given in the later Section, "Projections of growth in the PVO sector". Active acceptors are defined as those individuals who received a VSC or NORPLANT implants, plus the number of CYP in temporary methods. This is a stringent measure of program activity, in that it counts those receiving the long-term methods on a year-by-year basis for as long as the method lasts (estimated at 12 years for a VSC and 5 years for NORPLANT), instead of the CYP for the long-term methods being taken up front in the year of the procedure. Many mature programs use the total couple years of protection (CYP) to describe program productivity, in that temporary and long-term method distribution are both strong components. This would yield levels much higher for the PVO program than the number of active acceptors given above. However, the decision was made to use a more conservative estimate which would not be pumped up by the relatively stronger VSC/NORPLANT component of the Project.





For the commercial sector, the social marketing activity is projected to generate 4,650 CYP in CY '90, growing to 9,815 in CY '92 (Minigynon sales only). If the program grows at the level of ordinary pharmaceutical sales in Haiti (5% per year, a conservative assumption in view of the active marketing of the CSM product), this will be 11,360 CYP in 1995. Estimates developed from marketing data in Haiti suggest that other pharmaceutical distribution houses sold in 1989 the equivalent of 2,310 CYP in pills; at a growth rate of 5% this would mean 2,540 CYP in CY '92 and 2,940 CYP in CY '95.

Calculations of present acceptors and future demand will be greatly facilitated when the results of the 1989 CDC/CHI survey of contraceptive prevalence are made available. This survey was conducted in Fall, 1989 and preliminary results indicate that 10.4% of Haitian families are using modern family planning. This increase, over the 6% rate at which Haiti had stagnated for several years, will now have to be factored in to estimates of current acceptors and of growth potential for the near future.

The estimates of acceptors by sector should be the subject of a serious, collaborative refinement effort by the public and private sectors. Tentative steps toward launching such a collaborative effort have already started under Private Sector family Planning, involving the MSPP, IPPF/WHO, and the Futures Group. But projections of the annual activity by sector should be developed and a mapping exercise conducted showing where active elements of the public sector and PVO programs are located. Thus, plans could be made to strengthen programs where the mapping exercise suggests no program exists or where existing programs are weak. Decisions could be made about the division of labor according to the comparative advantage of each sector. For example, if in the geographical area of a weak program, the public sector has a fixed facility which is not geared up in family planning, it may make sense to give priority to making that facility operational. On the other hand, if a PVO seems a better basis for strengthening the program in a local area, then the PVO could be selected. The commercial sector may be a viable alternative as well.

Analysis of Acceptor Numbers. As seen in table ten, the numbers fall far short of those needed to achieve the medium and low scenarios of growth. This indicates the importance of expanding the program to additional facilities, shoring up the continuation rates of current acceptors, and generating additional demand for all program facilities. The latent demand is there: as summarized by the "Haiti Population Strategy Paper (1989-1990) Phase I" (page 14), despite the young age structure of women in union, 42% of them declared in 1977 (Haitian Fertility Survey) that they did not want any more children; in 1983 (Contraceptive Prevalence Survey), that percentage rose to 48%. Moreover, according to the 1977 HFS survey, the average desired number of children was 2.8 among women aged 15-19, and 3 among those aged 20-24. In this context, as pointed out in the 1983 Haiti Population Policy draft, it is correct to say that: "the objectives of decreasing the birth rate are in symbiosis with the marked preferences of the population - urban and rural - for reduced family size."

This is confirmed by the reactions of participants in the 1988 focus groups conducted to develop the advertising campaign for the social marketing activity. It has been said traditionally in Haiti, "timoun se riches", or children are wealth. Respondents in the focus groups changed this to "Timoun se riches malere", children are the wealth of the unfortunate, (Haitian Attitudes Toward Family Planning, p. 59). This is a sad commentary, because Haitian families are very loving toward children, but this reflects the reality of the situation -- families realize they cannot care for, feed and school large numbers of children.

There was also considerable recognition that it is the poor who are having more children than desired. In many ways this theme was expressed; one of the most vivid expressions, however, was that it is not the engineers, doctors, army colonels, and big (rich) guys who are having many children (Haitian Attitudes Toward Family Planning, p. 59).

But the problem of disuse of family planning goes back to two major themes -- first, unavailability of services and on again-off again supplies, and second, misinformation and rumors about methods, side effects and the ability of the acceptor to change methods. As is discussed in Appendix 1, "Haiti as a Pre-emergent Country", the rural and urban rates of contraceptive use differ substantially, probably due to unavailability of services in the rural areas. Urban facilities also are likely to be hit with disruption of supply. Anecdotal data are plentiful with respect to the proliferation of myths and rumors about contraception, in the absence of an effective ongoing IEC program.

If the problems of unavailability/disruption of services and weak IEC can be resolved, it may be possible that a demographic transition like that achieved in many other Latin American countries could occur in Haiti. For example, in a twenty-year period, Brazil has achieved the fertility decline which had been predicted to require 100 years to occur (James Brooke, *New York Times*, dated August 8, 1989). This change has occurred in the absence of a national population policy or great economic advances, but with great reliance on PVO and commercial sector services (93% of Brazilian women who use the pill get it from a pharmacy without a prescription). Similar fertility declines have occurred in Colombia and Mexico; in those countries strong, effective public sector programs have led the way. Economic stagnation, and the realization that families cannot support large numbers of children, may be important factors in those declines. Thus it is possible to imagine precipitous fertility declines over short periods of time. Haiti, with the high knowledge of family planning and strong expressed desires to limit family size, has many of the elements which would be associated with such rapid declines.

IIIbiii. New public sector assistance. With the exception in the 1990 Foreign Aid legislation, permitting direct assistance to the GOH in the area of family planning, a new bilateral program can be planned and implemented. Table 13 shows the areas of activity which would be appropriate to include in that program and approximate planning levels and phasing of each. In the paragraphs which follow, the activities will be briefly discussed.

o Commodities, logistics, and monitoring. This is a major area of activity in view of the complicated situation of sources of supply and distribution. As previously described, UNFPA has for the past two years supplied the public sector program. To forecast future needs, UNFPA conducted a full inventory of contraceptive supplies, medications (for VSC) and equipment in the Spring of 1989. In addition, there are multiple sources of supply of commodities such as USAID/Haiti's provision to PVOs and to groups active in AIDS prevention. It also will be recalled that the Haiti program traditionally has received condoms far in excess of what would be expected to be consumed. For these reasons, prior to USAID/Haiti's resumption of supply of the public sector, TA in commodities, logistics, and monitoring, and correlative funding of local systems of management and monitoring, will be an important ingredient of the program. TA resources for this work could come from the centrally-funded Family Planning Logistics Management Project at John Snow Inc.

o Community-level promotion systems. As has been described elsewhere, a community-level promotion system to bring new and continuing acceptors to the MSPP's fixed facilities is vital.

Table 13

Public Sector Assistance  
Interim and Initial Bilateral  
January 1, 1990-December 31, 1992  
(In \$000)

	Year 1		Year 2		Year 3		TOTAL BY LINE ITEM
	TA and \$ based Costs	Budget Support & Local Costs	TA and \$ based Costs	Budget Support & Local Costs	TA and \$ based Costs	Budget Support & Local Costs	
Commodities							
Logistics and Monitoring	60	100	120	150	120	200	750
Community Level Promotion Systems	80	200	150	300	150	500	1380
IEC	80	60	120	60	120	60	500
VSC Service Delivery	80	150	20	300	120	400	1170
Post Partum Program	80	50	150	250	150	250	930
Norplant and New Methods	100	80	100	100	100	100	580
MSPB Resident Advisor & Program Development Coordinator	75	-----	150	-----	150	-----	375
Population Policy	120	100	150	100	150	100	720
Family Planning Curriculum	-----	-----	100	60	100	60	320
Invitational Travel & Training	40	20	90	60	90	60	360
Umbrella Intermediary	400	-----	533	-----	533	-----	1466
Contraceptives	-----	(UNFPA)	500	-----	1000	-----	1500
Sub-Total	1115	760	2283	1380	2783	1730	
					Grand Total		\$10,051

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o IEC. It has been difficult to mount active IEC programs and to develop appropriate materials with the MSPP during the rupture of assistance. One element of the cancelled Family Planning Outreach Project was a buy-in to Population Communications Services (PCS) for materials for illiterate acceptors. These materials are very much needed; but, of course, work in this area should dovetail with that in the private sector of development of pill and NORPLANT booklets for promotion and for method acceptors. This activity will have a large TA component. Training and supervision of promoters will also be important under this component.

o VSC service delivery. This had been a very successful area of the GOH program prior to the rupture of assistance. Since the GOH supports this method very strongly where appropriate, is capable of delivering these services and has the infrastructure to do so, this is an important element of a future bilateral program. TA is built into this component to address development of a quality program, based on delivery of services according to a basic but comprehensive protocol for quality services. Quality in VSC covers not only clinical care, but also objective promotion, voluntary acceptance, counseling, and other aspects.

o Post-partum program. It may well be appropriate to develop a post-partum program with the GOH. The MSPP MCH/FP programs have indicated an interest in this, given their network of maternity facilities. This program should include stress on breastfeeding for child survival, breastfeeding as a contraceptive method, progestin-only methods like progestin-only orals and NORPLANT for breastfeeding mothers, and post-partum VSC where that is the woman's optimal choice. Development of a post-partum program should be considered a long-term objective, and external TA in the planning of it should be included in the public sector program.

o NORPLANT and new methods. NORPLANT has demonstrated a high acceptability and has the full support of the GOH. A joint effort to introduce a progestin-only pill into the public and private sector programs is ongoing. A targeted promotion of the IUD is needed, as described elsewhere, but introduction of these methods requires qualitative research, careful planning, collaborative deliberations, and supervision after introduction, to insure that methods are properly promoted and dispensed. For these reasons, TA as well as local costs are factored into this element. With respect to the introduction of new methods, operations research will be useful in determining how to introduce these methods, to whom, under what circumstances, etc.

o MSPPP resident advisor and program development coordinator. Because of the new priority being given to population and family planning by the MSPPP and the donor community, it is foreseen that a resident advisor to the MSPPP should be deployed to help the MSPPP develop a master plan for family planning, addressing such things as coordination of programs across geographic areas, coordination of TA resources, etc. This person would assist the MSPPP in coordinating activities under the master plan. This person would also be important in helping the MSPPP to coordinate with donors active in family planning and population.

o Population policy. The UNFPA is taking the lead in the process of development and adoption of a formal, national population policy. However, additional resources are needed in the medium term for institution building in the population policy area. For example, the cadre of professionally-trained demographers, experienced in consensus building, needs to be expanded. (At present, CONAPO's executive director is virtually the only staff member fulfilling the above criteria). Furthermore, the staff at IHSI should become involved in looking at the larger population ramifications of Haiti's socioeconomic development and the place of family planning in it. Lastly, the long-term issue of placement of the CONAPO (in the MSPPP or alternatively in a cross-cutting agency such as the Ministry of Plan) needs to be addressed. To achieve the population policy objectives, assistance will be provided under Private Sector Family Planning to the Ministries of Health, Planning, Finance and Education for the implementation of the national population policy.

o Family planning curriculum. As a long-term priority, a serious development activity to integrate family planning into the medical, nursing and pharmacy curricula is vital. USAID/Haiti's strategy seeks to actively involve the public, PVO and private commercial sectors in the delivery of family planning services. The medical school and paramedical programs, graduating as they do physicians, nurses and pharmacists who will work in all three sectors (public, PVO, and private practice), is therefore an important place to locate training in contraceptive technology, counseling, voluntarism, etc. The NORPLANT work in the two university maternities is one step in this direction. This should be considered a long-term objective because it will require planning and consensus building to achieve. TA and local costs are included for this, phasing in as of the second year of bilateral work.

o Invitational travel and training. This is included to cover all aspects of family planning and population. Many Haitian professionals in these fields do not have state-of-the-art training for their work nor interchange with colleagues outside of Haiti. Haiti has been isolated in the Latin American/Caribbean region and information-starvation is endemic. To combat this, external TA has been provided in all the above activities, but also travel and training, by getting Haitian professionals out to see how similar issues are handled in other countries, would help to redress this situation. With respect to training, it may be useful to conduct a comprehensive training needs assessment, perhaps in conjunction with the Centrally-funded Family Planning Management Training Project.

o Umbrella intermediary. The bilateral program will be a large, complex undertaking. For this reason, to coordinate logistics, TA resources and for programmatic planning, the involvement of an umbrella intermediary to keep everything on track is included. It is anticipated that an international PVO would be sought as the umbrella intermediary and procurement would be through a cooperative agreement and/or and operational program grant. (In addition to the umbrella intermediary, buy-ins to existing AID/W contracts would be developed to access their special areas of expertise. Examples are the Centrally-funded Family Planning Management Development, Family Planning Logistics Management, Population Communications Services Projects, as well as the new Enterprise Project (to continue the TIPPS activity.)

o Contraceptives. In coordination with UNFPA, contraceptive needs of the public sector must be addressed. Between the two donors, the spectrum of contraceptive needs should be able to be met.

USAID/Haiti may have better access to some methods (for example, NORPLANT when FDA approved), and UNFPA may be able to supply popular methods, such as injectibles, which USAID/Haiti cannot provide. Phasing of contraceptive provision is planned for the second year of bilateral assistance since UNFPA is presumably covering 1990. In the long term cost recovery will be a target but not until contraceptive prevalence exceeds 45%.

IIIbiv. Projections of growth in the PVO sector. The planned evolution of the program in terms of active acceptors and of catchment areas of the PVOs is shown in Tables 11 and 12. These two spreadsheets have been developed to facilitate monitoring of program growth and calculation of contraceptive prevalence rates in the areas in which the PVO program is operating.

Table 11 shows how the parameter "active acceptors" is calculated. Again, to avoid overstating the activity of a new program such as this, the total CYP is not used for this parameter. Instead, the long-term acceptors of VSC or NORPLANT are shown year by year, in the years covered by their methods (12 years for VSC, 5 for NORPLANT). Then the CYP in reversible methods is added to yield a measure of total activity of the PVOs.

To illustrate the difference that this calculation makes in comparison to the use of total CYP, refer to the projections for 1989 (1989 statistics are not yet available at this writing - December, 1989). The total number of active acceptors as calculated by the method described above is 25,389. If total CYP were used, this would yield 35,389.

In mature programs, studies have shown that total CYP is a good proxy for active acceptors, because mature programs are equally strong in offering temporary and long-lasting methods. In the relatively new PVO program, where establishing the network required to provide 100 condoms for each condom CYP, has just recently started, it did not seem as meaningful to use the total CYP. The reason for this is that the total CYP gives considerable weight to long-lasting methods. Instead, it has been felt that the active acceptors calculation described above was a fairer, more conservative means of showing the program's activity.

Note that in 1989, the actual numbers will be lower than those given above, because the AOPS VSC program has been very delayed in its commencement.

Table 12 parallels the Active Acceptors Table, in that it shows the PVO areas for each type of activity. This Table shows the planned phasing-in of new large and small PVOs, of the AOPS VSC activity, etc. Thus, by using both Tables, contraceptive prevalence rates for the PVO program as a whole can be calculated. These tables need to be updated regularly, because actual program implementation, of course, differs from projections. Thus, these Tables should be installed at the local office of IPPF/WHR for use in regular program monitoring.

#### IV. MEDIUM AND LONG-TERM OBJECTIVES AND ACTIONS

##### IVa. Objective: Increase Access to Voluntary Family Planning Services Provided by the Public Sector.

This is a major element of the USAID/Haiti strategy for the period, 1990 - 1992, because of the important role that government programs should play in the provision of family planning programs. USAID/Haiti supports a strategy maximizing the participation of all sectors, according to their comparative advantage to provide the spectrum of services required. The GOH has a network of fixed facilities, staffed with trained providers. Furthermore, the GOH infrastructure contains a network of hospitals and maternity units. The utility of the fixed facilities would be greatly increased by the addition of an active promotion system, such as family planning colvols. Given the government's interest in delivering a quality program of VSC, GOH infrastructure and its ability to provide services should be strengthened. The network of maternity units would also be a good basis for development of a post-partum strategy of service delivery.

As a rough rule of thumb, the public sector program should be planned so that half of the funding is for external, dollar-funded elements such as TA and invitational travel, and the other half for local costs. The emphasis on TA and travel would respond to the problems of information privation and isolation, which affect every aspect of the program from commodity logistics to IEC and VSC.

The previous curtailing of assistance to the GOH, as a result of the aborted elections of 1987, meant that the public sector program lost a lot of momentum, for example, in the area of VSC. With the Congressional mandate to work with the public sector to provide family planning services, USAID/Haiti has an opportunity to strengthen public sector programs as one element in a global service provision system. The ingredients are in place, in the sense that the MSPP counterpart is strong, the MSPP is committed to family planning, the national population policy program is moving along, and the donor community is increasingly involved.

IVai. Interim program of assistance. An interim program of assistance should be implemented starting immediately, as a bridge, because the timeframe to develop a bilateral long-term assistance program is about one and a half years. There are many things which can be done with the public sector immediately, and the more the public sector program can grow along side the private sector program, the better the private sector program can function. Although not an exclusive list, the immediate activities which could be considered are: commodities logistics and management, IEC, VSC, restarting the colvol network of promoters to bring acceptors to public sector facilities, training of promoters in all-method promotion and in counseling, targeted promotion of the IUD, and initiation of a post-partum strategy. Support to the CONAPO for the adoption and implementation of the national population policy is also key.

o Actions to support objective. A mini-design effort will be required to put together the basket of interim activities. Public sector activities will be included in the upcoming amendment of Private Sector Family Planning (521-0189). The rationale for the inclusion is that the development of the private sector program would be enhanced by an active public sector program. Many things are being done in the private sector program -- implementation trials of NORPLANT, introduction of a progestin-only pill for breastfeeding mothers, and all-method promotion and counselling to name a few -- which would be bolstered by simultaneous implementation in the public sector. To the acceptor, the services are not identified as public or private, and one month an acceptor may turn left to a public sector facility and the next month right to a private sector one. If the acceptor can get the same choice and the same, accurate information wherever served, the acceptor is much more likely to keep coming back. Furthermore, mutually coordinated services will be much more acceptable to the Government of Haiti in view of the unusual and relatively large responsibility PVOs bear in Haiti for the delivery of primary health care services.

Two small activities to make the programs grow in tandem are already being implemented. First is the joint introduction of a progestin-only pill into both the public and private sector programs simultaneously through a series of national and regional, two-day seminars to begin in Spring, 1990. Second is the expansion of the pre-implementation trials of NORPLANT to include public sector facilities in addition to the present select private sector facilities. This activity began in November, 1989 with the training of the first public sector practitioners on theoretical and practical use of NORPLANT, including both insertions and removals of the implants.

The interim program of activities will be managed by PAHO through a Handbook 13 grant from USAID/Haiti. This mechanism is being successfully used in the expanded immunization program. This will also respond to PAHO's concerns about donor coordination, since PAHO will be taking an active role in management of AID's interim assistance to the public sector. But USAID/Haiti should backstop the small PAHO staff to assure that the flow of TA, training and program development continues unabated.

It may be advisable for PAHO to identify an intermediary to assist with day-to-day implementation. The demands of implementing a program with significant TA and invitational travel components are enormous. If a small organization such as PAHO attempts to go it alone, this could serve as a brake on the activities, just because managing the activities places such a heavy burden on staff time. While PAHO would manage the donor coordination and overall program development, the umbrella intermediary would be responsible for travel arrangements, billing, audits, etc.

The umbrella intermediary could be procured through a cooperative agreement with one of the international PVOs with which AID/W has long-standing relationships (such as IPPF/WHR or Pathfinder) to manage funds and implement the program. The advantage of using this mechanism is that a grant could be expedited by using an existing buy-in mechanism.

Iviii. Bilateral or other long-term program. A bilateral or other mechanism for implementing public sector activities over the long term also will be needed. This will formalize the program of activities, and base it on necessary prior design work. This program will continue efforts built into the interim program which focus on family planning service delivery and support to population policy development and implementation.

o Actions to support objective. For this objective, the formal AID design process will be followed. This will include development of a Project Identification Document (PID) and of a Project Paper (PP). Because the umbrella private sector project will be concluding at about the same time as the formal, public sector design process, one project, Comprehensive Family Planning (521-0129), will commence in FY '92 encompassing both private and public sector activities. Comprehensive Family Planning will have a life of project funding of \$20 million, with an initial obligation of approximately \$5 million.

Table 13 shows a preliminary plan for funding and activities with the public sector for the period January, 1990 through December, 1992. This Table includes both interim activities and the initial implementation of the bilateral program. The major areas of activity are -- 1) commodities logistics and monitoring, 2) community-level promotion systems, 3) IEC, 4) VSC, 5) post-partum program, 6) NORPLANT and other new methods (that is, new to real use in the Haitian environment, such as the progestin-only pill and the IUD), 7) family planning curriculum in the medical school, and 8) population policy. To implement this program, other expenditure items are -- 1) MSPP resident advisor and program development coordinator, 2) invitational travel and training, 3) an umbrella intermediary organization, and 4) contraceptives.

IVb. Objective: Continue to Strengthen PVO Programs Providing Family Planning Services.

Another major element of USAID/Haiti's strategy is to continue to build on the effective base of service delivery by PVOs which has been built in the period 1986-1989. The interim evaluation of the Private Sector Family Planning Project has noted the very successful program which has been developed, but also pointed to refinements which need to be made. The program is at the stage where an emphasis on the continuing user (IEC about correct usage, side effects to be expected, resupply, changing contraceptive needs, etc.) should be placed, while sustaining the effort to generate demand. Three important areas related to continuation and demand creation are: 1) improved all-method promotion, to inform fully acceptors about methods which may be appropriate along with the pluses and minuses of each, and about the ability of the acceptor to change methods to suit changing contraceptive needs, 2) counseling to insure that the acceptor is indeed making a personal choice, and 3) quality service provision, emphasizing client-responsiveness and sustained "backstopping" by providers of acceptors when they have questions, side effects, etc. Objective, all-method promotion is vital because currently programs tend to emphasize one method due to weakness in promotion and default reliance on satisfied acceptors to promote methods.

o Actions to support objective. The private sector project has recently been evaluated, and focus must be placed on how to implement the recommendations. The recommendations should be translated into a workplan, spelling out the tasks ahead and the responsible organizations. A near-term priority (as will be described below) is that of amending the project to add funds for activities proceeding at full speed and for immediate expansions of scope.

One of the major recommendations is to sustain PVO activities after the project's PACD of March 31, 1991, due to the effectiveness of this form of service delivery. Plans for development of a PID, PP and for identifying and contracting with an implementing organization are presently being made.

Efforts to develop a private sector interest group in population also should continue. As previously indicated, there is ambivalence in the various arms of the government as to the importance of a population policy and of family planning services. The many PVOs and the private, commercial sector made up of light assembly firms, banking, and import-export companies (just to name a few) can be effective in changing viewpoints in the government and in the community at large about the population question. This activity is presently a component of the private sector project and should be sustained.

IVc. Objective: Maximize the Participation of the Private Commercial Sector in the Provision of Family Planning Services.

The commercial sector should be viewed as a major partner in the global population strategy. Not only can this sector play a role in serving families who can afford private services, but it can also be influential in providing or facilitating services through the various enterprises and in participating in raising awareness of the population problem.

At present, USAID/Haiti is conducting under the private sector project two activities which involve the commercial sector. It appears that both would profit from expansion to a greater or lesser degree. The smaller of the two activities is that with the Technical Information in Population for the Private Sector (TIPPS) Project. This activity is designed to accomplish two things, first to train PVOs to use business analysis as a way of interesting entrepreneurs in facilitating the provision of family planning services. Interestingly, Haiti has an ingredient most countries do not have when TIPPS comes in to do business analysis. Haiti has the service providers already in place to provide the services. The second objective of the present TIPPS buy-in is to work with the insurance sector to determine the costs and benefits of including family planning in their insurance plans. The TIPPS activity merits a small increase in scope immediately, as will be described in the Section "Short-Term Cross-Cutting Actions in Support of the Strategy".

The second activity is social marketing. The project is on track to launch a pill product in the social marketing program in February, 1990. This activity is notable for two things -- first, there is no subsidization of commodities by AID, and second, the commercial firm managing the activity is assuming the financial risk, in hard currency, of importing the required commodities. This is a first in social marketing projects around the world. At present distribution of the social marketing product will be through the existing distribution network of the distributor; this network covers all the urban areas. Therefore, as the activity develops, it should be expanded to include community-based distribution interventions in semi-urban areas and new product introductions.

If the contraceptive social marketing program is successful in Haiti, it could be a very useful vehicle, over the long run, for the marketing of other health products. These include, among others, anti-malarials, oral rehydration salts, deworming medications, and bed nets impregnated with mosquito repellent.

o Actions to support objective. USAID/Haiti will act this fiscal year to expand the TIPPS buy-in and will incorporate into the amendment of Private Sector Family Planning the planned, major expansion of the social marketing activity. In FY '90, no additional funds are required for social marketing; however, after that considerable new funding will be needed from USAID/Haiti resources (\$686,000 and \$837,000 in the period 3/31/91-3/31/92 and 4/1/92-4/1/93 respectively). Prior to the implementation of the expanded activities, USAID/Haiti will facilitate new product introduction research in November, 1990. The schedule for implementation of expanded activities is shown below:

Schedule for Implementation  
of Expansion of Social Marketing

<u>Phase</u>	<u>Dates</u>	<u>Type of Activity</u>
Phase I	Sept. '88- Sept. '90	Development of activity/ Pill launch
Phase II	Sept. '90- Feb. '91	Research and planning
Phase III	Mar. '91- Mar. '92	Expanded distribution to PVOs/ Progestin-only pill/ IUD detailing to physicians
Phase IV	Apr. '92- Mar. '93	NORPLANT detailing to phys./ Injectibles with non-AID funding

An ultimate goal of the social marketing activity is to disseminate commodities to all parts of the country.

IVd. Objective: Sustain Policy Dialogue with Donors to Insure Participation and Effective Donor Coordination.

Both UNFPA and the World Bank are stepping up their involvement in the population area. UNFPA will be assigning a new resident representative to the Haiti mission. In view of UNFPA's past commitment to maternal health in contrast to family planning, and the newness of the World Bank's participation, it is vital to continue policy dialogue with these two donors. Furthermore, there is an unfamiliarity among the other donors about the mechanics of implementing family planning programs and the great needs in Haiti for TA and invitational travel.

PAHO and the MSPP have launched a joint donor/major implementing organization group to address population and family planning issues. This group includes representatives of the major donors, the MSPP, and the larger PVOs involved in service delivery. This will be a very useful coordinating mechanism, and will follow on the heels of a donor coordinating group active up until 1988. This group is developing an agenda of major coordinating issues such as condoms, IEC, etc. to address in the upcoming months.

One concrete form of donor collaboration which would be useful to achieve would be participation in the funding of the addition of injectibles to the social marketing activity. Injectibles are a very popular method of family planning in Haiti, but because they are not FDA approved, AID would not be able to fund their introduction into the social marketing activity. Perhaps with enhanced donor coordination, this problem could be resolved. It may be appropriate to plan for incorporation of Noristerat to provide a distinct injectible product for use in the social marketing effort.

o Actions to support objective. USAID/Haiti will continue the policy dialogue which is ongoing. A variety of short-term activities for this are identified below. As part of the policy dialogue, USAID/Haiti will continue to search for a non-AID funding source for the introduction of injectibles into the social marketing program.

IVe. Objective: Increase AID Resources in the Population Sector so that the Programs Described Above may be Implemented.

The program in Haiti is dynamic and can grow by leaps and bounds in all areas -- logistics systems, community-based distribution systems, IEC programs, new methods, training and programs of VSC. Table 14 shows the projected funding needs, including a quick start on public sector interim activities. But the funding is not there to meet these great needs and allow this expansion, as indicated by the USAID/Haiti OYB projections which also are shown. Funding requirements are great at this juncture, and USAID/Haiti will seek to increase funding levels to those prior to the rupture of assistance or higher (funding levels for the period FY '86 to FY '91 have been shown in Table 7).

Based on the recent very positive evaluation of the private sector project, another \$2.5 million will be needed to fully fund the present activities through the PACD of March 31, 1991. Expansions in scope for the two commercial sector activities will also need to be funded. Further, now that direct assistance to the GOH is permissible in family planning, an active program of collaboration is needed here. This activity should commence quickly in response to the Congressional mandate to resume family planning assistance.

Table 14

RESOURCE REQUIREMENTS FOR POPULATION  
 SECTOR CY '90 - CY '92  
 IN 000

	CY '90	CY '91	CY '92
Maquila FVO activity			
Mission OYB/PL-480	2,000	2,000	2,000
Central	200	200	200
Social Marketing			
Mission OYB/PL-480	---	513	799
Central	41	21.0	---
Public Sector			
Mission OYB/PL-480	1,875	3,663	4,513
Central	---	---	---
TOTAL	4,116	6,397	7,512
Central as a %	5.9%	3.4%	2.7%
Planned OYB Inv. (FY)	3,350	5,000	5,100

*Handwritten notes:*  
 12,000  
 13,400

\* AVSC to both public and private sectors

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However, in view of the cut-off of aid to the GOH in general, USAID/Haiti's program is modest in the key areas of agriculture and private sector. Thus, to support the expansion in population, two things will be needed -- allocation of additional funds designated for the population sector, and an increase in USAID/Haiti's OYB so that these funds can be absorbed without decreases in the other key areas in USAID/Haiti's portfolio.

USAID/Haiti has an excellent record of buy-ins in the population sector. Historically, USAID/Haiti has paid its own way in joint work with the cooperating agencies under centrally-funded projects. As shown in Table 14, little in the way of Central funding goes into the Haiti program at present. Now that the momentum of the portfolio is expanding so dramatically and funding requirements increasing correspondingly, more Central funds should be allocated to Haiti. Funding is indeed tight all over the world, and the cooperating agencies are seeking to increase the financial participation of USAIDs in the countries in which they work. However, given the new priority AID is putting on Haiti, it may be appropriate for cooperating agencies to plan on central funds for increased activity in Haiti.

o Actions to support objective. USAID/Haiti will work with AID/Washington to seek the appropriate increases in funds for the population sector, and, in tandem, to obtain an increase in USAID/Haiti's OYB so that these new funds will be absorbed.

USAID/Haiti will work with AID/W to encourage cooperating agencies to apply Central funds to activities in Haiti.

#### IVf. Objective: Conduct Operations Research to Make Program More Responsive.

In a pre-emergent country such as Haiti there is much learning about and tailoring of programs needed to make them successful. This process represents the domain of operations research to determine how, why and what works in a given situation. There are many data needs in Haiti indicating the priority that must be put on this area. Research issues such as the following need to be addressed: pill discontinuation, dissatisfaction/satisfaction with the IUD, the reputation of VSC and vasectomy, the content of myths and rumors about methods, the side effects of depo-provera, how to appeal to men, etc.

o Actions to support objective. USAID/Haiti will continue to support the operations research component of the Private Sector Family Planning Project, in order to progress on this research agenda through the joint work of IPPF/WHO and of the Child Health Institute. As part of this, IPPF/WHO will continue to be encouraged to bring on board in the local office a researcher who can dynamize this activity and serve as a TA resource in the process.

IVg. Objective: Increase the Collaboration of Family Planning and AIDS Programs.

As previously described, AIDS is a major public health concern in Haiti. Through a small buy-in to AIDSTECH, USAID/Haiti is performing a collaborative modelling of the AIDS epidemic in Haiti and projections of its future spread. This work has been commissioned for two reasons -- first, routinely when the RAPID model projections of population growth are shown in Haiti, the question is asked, "Will the spread of AIDS defuse the population problem in Haiti?"; second, the data coming out of the modelling task will be very useful in understanding and planning for future interventions. This will be the first time that the centrally-funded, joint AID/W-Census Bureau AIDS model will be applied practically (as opposed to theoretically) to the parameters of an existing Third World country. The buy-in should yield an AIDS-sector analysis to be added to the RAPID model presentation on population and development in Haiti.

All initial evidence is that AIDS will not resolve the pressing population problem. Therefore, the emphasis on family planning remains unchanged. Furthermore, an effective, national family planning program can be a strong mechanism for AIDS prevention through condom distribution. If the health sector wishes to invest resources in interventions to prevent the spread of sexually-transmitted diseases, this would be readily feasible given an existing network of family planning service providers. Donor coordination related to provision of condoms to Haiti should continue to receive priority.

o Actions to support objective. USAID/Haiti will actively strive to coordinate its family planning and AIDS prevention programs. A system of regular, routine meetings for planning and monitoring purposes will be instituted. As far as donor coordination is concerned, the condom provision question should be formally addressed, perhaps as an outgrowth of 1) review of new data on contraceptive prevalence, condom use, and knowledge, attitudes and practices related to AIDS and 2) synthesis in the updating of the summary analysis of condom supplies and distribution. The review and synthesis regarding condom supplies in Haiti is described below, in the Section "Short-Term Cross-Cutting Actions in Support of the Strategy".

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## V. SHORT-TERM CROSS-CUTTING ACTIONS IN SUPPORT OF THE S STRATEGY

o Support UNFPA and the GOH in the formal adoption of a population policy. UNFPA, in conjunction with the MSPP/CONAPO, is making a concerted effort to convince the GOH to adopt a national population policy. This effort requires considerable consensus building, since not all relevant units of the GOH see population/family planning as an integral part of the socioeconomic development of Haiti and of Haitian families, nor as a health problem. USAID/Haiti will strive to support this effort to a successful conclusion.

Furthermore, USAID/Haiti will program some resources in the population policy area since, at present, the CONAPO (the policy unit of the MSPP) is thinly staffed. Development of additional professional resources is needed and staff should be trained not only in the technical areas of demography, but in leadership and consensus building.

o Continue present activities and TA/Coordinate TA with other donors. To cut through the isolation and critical lack of information, TA resources are essential. They bring the outside world of burgeoning programs and high prevalence rates into a situation which has been perennially starved of up-to-date information and outlook. Thus, the flow of TA resources in USAID/Haiti's program will be continued, although, it must be acknowledged that this increases backstopping requirements.

As UNFPA and the World Bank programs in family planning gear up, the need for donor coordination of TA increases. The donor community should seek to coordinate TA visits, to make the visits maximally effective, minimally burdensome and, for the purpose of cross fertilization of TA resources, consultants should coordinate their activities.

o Continue to encourage PAHO/MSPP-sponsored coordinating body. PAHO and the MSPP have recently set up a coordinating body including the relevant donors and the major private sector family planning providers. This could be a very effective force in the process of developing an effective, national program of family planning. The group is already planning a number of meetings on cross-cutting issues such as condoms, IEC, etc. USAID/Haiti will actively support and participate in this group.

o Work with PAHO/UNFPA/MSPP to hold an IEC summit conference. A number of IEC activities are currently underway or in the planning stages, including the USAID/Haiti private sector IEC working group, condom social marketing (privately-sponsored by PSI), USAID/Haiti's pill social marketing, the national AIDS program and Canadian assistance in IEC, UNFPA and the World Bank. USAID/Haiti will work with PAHO, UNFPA and the MSPP to coordinate visits of the responsible persons involved in these activities, so that a one or two day workshop could be held to ventilate future plans, data bases, research findings, etc. to achieve synergistic implementation of the plans.

o Actively support the IEC working group created under Private Sector Family Planning (521-0189). In Summer, 1989, an IEC working group was created under the PVO component of the Project. In addition to representatives of the large PVOs, a representative of the public sector family planning IEC program has been an integral part of this group. This group is significant for two reasons. First it is the first time that the PVOs have actively collaborated in an endeavor, and second it is the first time that the second and third levels of command have come together to take leadership. This activity should be vigorously supported by USAID/Haiti, although it will require careful backstopping.

There are several reasons why this activity is important. IEC is now a primordial concern of the program, for reasons described elsewhere in this paper. But, in addition, territoriality is a big issue in program implementation in Haiti. Thus, collaboration across organizations is a major milestone toward the goal of building an effective, national family planning program. Furthermore, with a group of relatively young organizations, empowering the sub-directorate level is a major step forward in institution building within the organizations. It is recognized that this group may not come up with as sophisticated plans as would an experienced intermediary working in the IEC area. However, a small, local collaborating body is being built, capable of making plans appropriate and needed in their own institutions. Because it is theirs, the organizations will be invested in the plans. It is from this kind of basis that a self-sustaining IEC group can be formed, which will have momentum even if outside TA support ceases.

o Update summary analysis of condom supplies and distribution. Haiti has traditionally received and distributed a large number of condoms, greatly in excess of what the contraceptive prevalence estimates would suggest would be needed. USAID/Haiti, in February, 1989, conducted an analysis of the condom picture -- who is bringing them in, in what numbers, what are current stocks, which organizations are distributing them, to which groups, etc. This proved to be a very useful exercise in beginning to develop an understanding of this situation. Since that time, several more things have been done bearing on the condom situation. CDC/CHI has conducted a contraceptive prevalence survey with men and women which specifically addresses condom use. Results of this will be available in early 1990. Further, USAID/Haiti is carrying out a program through AIDSTECH which will be working closely with AIDS intervention agencies. The Canadian assistance program is now in the field with a large knowledge, attitudes and practices survey about AIDS from which their AIDS IEC program will be designed.

Given this new information, USAID/Haiti will update the 1989 analysis, reconvening the multidisciplinary team which looked at condom social marketing, logistics and distribution, and condom supplies and use. It may also be useful to plan to update this analysis annually while the programs are growing and changing so dramatically.

o Implement the recommendations of the interim evaluation of the private sector family planning project. An interim evaluation of the Private Sector Family Planning (521-0189) Project was conducted in Fall, 1989. The recommendations for this Project will be implemented and particular emphasis given to the major recommendations related to 1) amendment of the Project, 2) emphasis placed on continuing users (especially as this regards IEC) while maintaining activities to increase demand, and 3) stepping up of management participation of IPPF/WHR, the implementing agent for the Project. The amendment will add \$7.1 million to the authorized level for a new Life of Project (LOP) total of \$15.4 million and will extend the PACD to March 31, 1992. Additional funding for PVO activities proceeding at full speed will be included and for expanded scopes of work for some intermediary organizations. It is expected that the amended project will achieve a significant additional increase in contraceptive prevalence to as high as 16%.

o Incorporate into program planning the results of the CDC/CHI contraceptive prevalence survey. A major survey of contraceptive prevalence, condom use, contraceptive knowledge and practices among Haitian men and women has recently concluded field work. USAID/Haiti has sponsored this survey, conducted by CDC and a local PVO for research and evaluation, the Child Health Institute. The results of this survey will be available in early 1990; USAID/Haiti will incorporate these results into program planning and reporting.

o Initiate targeted promotion of the IUD in a collaborative process with the PVO and public sector programs. The IUD is little used in Haiti now. However, the effective method mix needed to reach fertility targets under the medium and low scenarios call for the IUD to have a small, but significant place. As the national program develops and post-partum strategies are put in place, it will be useful to have the IUD take its proper place. In a country such as Haiti, where sexually-transmissible diseases are a serious health problem, the IUD will not become one of the top methods in the program. But with the availability of the Cu-T 380A IUD, a highly effective, long-lasting and well-tolerated IUD, there is little doubt that for a defined group of Haitian women, the IUD may be an appropriate method.

Thus, USAID/Haiti will start a process with MSPP and private sector representatives to develop a protocol for the use of the IUD. The protocol is to identify through a consensual process that group of women for whom the IUD would be appropriate. Following the development of the protocol, a series of national/regional workshops like those currently planned for the introduction of the progestin-only pill suitable for breastfeeding mothers should be conducted. A TA resource such as Family Health International's new product introduction program could usefully become involved in this process.

o Facilitate the expansion of the social marketing program by conducting the new product introduction research in November, 1990 and by providing for funds needed in FY' 91. The private, commercial sector in Haiti is very important in the role it plays in providing pharmaceuticals to a wide range of consumers. This is an asset in a situation where the public sector and donor communities would never be able to take on this responsibility in addition to their present mandates. The pill social marketing is off to a good start, with launch planned for February, 1990.

USAID/Haiti envisions the social marketing activity becoming a multi-method program, with gradual phasing in of a progestin-only pill, the Cu-T 380A, NORPLANT and other long-term methods to be distributed through private physicians. It is foreseen that these methods, with the exception of the Cu-T 380A, would be supplied by the private, commercial sector. USAID/Haiti would likely supply the Cu-T 380A, if it is included in the social marketing activity.

In order to plan for the multi-method program, USAID/Haiti will conduct a systematic research effort to screen new product options and distribution strategies. This research is to be conducted in November, 1990. In planning for the multi-method program, USAID/Haiti will provide in the amendment of Private Sector Family Planning (521-0189) for the additional funding required for this expanded scope.

o Continue to work with private enterprises and insurers. Several expansion opportunities present themselves in this area -- 1) collaboration with the Haitian Association of Industries (French acronym - ADIH) to present to its members the financial merits of incorporation of family planning services, 2) work with other trade associations such as those in insurance and transportation, and 3) collaborate with parastatals such as OFATMA, responsible for worker's compensation and maternal health, to incorporate family planning into their programs.

A small expansion of the TIPPS buy-in should be effected to permit the activity to take advantage of additional opportunities which exist. It would be useful to accomplish the expansion now, in view of the fact that the TIPPS project is reaching its ceiling. Further, the successor to the TIPPS project is likely to be a long time in development, so it would be prudent to take advantage of the remaining ceiling to expand the activity now. USAID/Haiti, in conjunction with AID/W ST/Pop/PDD, will increase the scope of the TIPPS buy-in to allow for the expanded scope.

o Conduct the study of condom distribution. One recommendation of the condom team in February, 1989 was that research should be done to determine the extent to which acceptors were being given a more effective method such as the pill, in addition to condoms to protect against disease transmission. This is important to determine since, if acceptors are being given two methods, this would affect service statistics such as CYP. There is no issue with such distribution of two methods -- it is very prudent where sexually-transmitted disease is prevalent, as it is in Haiti. However, given the potential impact on service statistics, it is important that the presence or absence of this pattern be determined. A small study of various distribution outlets is planned to be conducted by CDC/CHI in early 1990. USAID/Haiti will continue to facilitate the conduct of this study.

o Backstop the implementation of the AOPS VSC activity. As mentioned above, the AOPS VSC activity was delayed in its commencement. Delays may also be experienced with the necessity of equipping the new centers either partially or completely. USAID/Haiti will work closely with AOPS and with IPPF/WHO to assure that the implementation of this activity continues smoothly.

## VI. CONSTRAINTS

In the section which follows, constraints to mounting an effective, national program will be discussed. Few actual constraints exist at the present. However, political instability in Haiti is a constant backdrop of program implementation and could potentially be a constraint in the future. This would come about if political instability again created a climate in which field work could not be undertaken, or if it lead to a change of leadership at the MSPP which could affect programs negatively. The actual and potential constraints are briefly discussed below.

### Via. Actual Constraints

o Lack of a formal population policy. No formal population policy has been adopted by the government. There are, at present, conflicting views of the importance of family planning to socioeconomic development stemming from the IHSI (under the Ministry of Finance) and from individuals at the Ministry of Plan. This is detrimental to the operation of family planning programs, in that it is translated into ambivalence about the program's priority at the Ministerial and operational levels. A concerted effort by all friends of population in Haiti will be required to see the present UNFPA population policy activity into fruition in early 1990.

o No front-line promoters in MSPP organizational chart. As previously mentioned, the MSPP organigramme does not include a category of front-line, community-based promoters. The only class of worker similar to this is the malaria-control (SNEM) workers who are generally males. Furthermore, the World Bank in its policy dialogue component of the new health sector loan is seeking to formalize and decrease MSPP staff levels, which militates against the creation of this new category of worker.

This worker is badly needed to make effective the MSPP staff working in fixed facilities. Family planning acceptors, both new and continuing users, need a lot of encouragement, reinforcement and readily available information to adopt, and stick with, family planning. A program built on the model of the acceptors "coming to us" will never be as effective in terms of contraceptive prevalence as one where "we go to them". Part of the success of Private Sector Family Planning has been that programs have local collaborating volunteers (colvols), earning minimal subsistence, who have been an integral part of service delivery. Whether this worker is a dedicated outreach worker in family planning, or has multiple responsibilities including ORT, immunization, etc., is a design issue, but this level of worker should be provided for, and the donor community must ultimately face the costs of supporting it. Based on previously successful tests of the colvol system (for example, in Miragoane), the actual subsistence compensation of the worker can be quite reasonable. But hands-on supervision for these workers is essential and will be costly.

o Currency revaluation and hard currency needs of social marketing. The unit of currency in Haiti, the gourde, is now changing at a gray market rate of approximately 50%. This represents a significant devaluation from the rate of 19% through December, 1988. The devaluation has come about as a result of lack of confidence in the government's approach to the private sector, as symbolized by the punishing restrictions on currency exchange imposed briefly in Summer, 1989.

This situation may, as time goes by, become a constraint on the social marketing activity. As presently designed, the activity will be implemented relying on the workings of the private sector to bring in products and make them commercially available to consumers. No subsidized products are planned and USAID/Hait's funding goes strictly to marketing and management of the activity. However, the erosion of the conversion value of the gourdes derived through sales of the product may ultimately hurt social marketing and should be carefully monitored.

o IEC. Few culturally-appropriate, Creole language IEC materials exist and little in the way of active IEC programs is being carried out at present. The lack of materials and of operational IEC activities is a substantial brake on the program's ability to attract new acceptors and to sustain current users. Under Private Sector Family Planning, a recent activity to implant an active IEC program, using appropriate materials, is getting started. All IEC activities should be developed from a basis of qualitative research. MSPP representatives have been involved in planning the IEC task force, so some correspondence of activity in the two sectors can be foreseen. In addition, under the social marketing activity, IEC materials appropriate to the C&D class pill user are being developed for mass media and point-of-sale use. IEC must, however, become a major priority both in terms of commitment of time (at every level - TA, donor, PVC/MSPP management and local facilities) and of resources, and all donors should participate in this activity.

o Financial resources. Resources have been very constrained in the period 1987 - 1989, as described above. To address the needs in population and family planning in the only pre-emergent country in the Western Hemisphere, resources must be greatly expanded. This applies to all donors -- USAID and the return to funding levels at or above those before the rupture of assistance, UNFPA and the commitment to greatly expand their involvement in family planning service delivery, the World Bank in the new loan component, etc.

## Vib. Potential Constraints

With respect to the background situation in Haiti, there are two potential constraints which should be mentioned.

o Political instability and changes of leadership. Haiti's recent history has been marked by frequent changes of government, sometimes accompanied by changes at the Ministerial level. Needless to say, political instability is a constraint on program implementation, especially where it is accompanied by violence. If a situation such as this recurs, it can be expected to curtail service delivery to a greater or lesser degree.

Changes at the Ministerial level also could be a potential constraint. At present, the program enjoys warm support of the present Minister who has both a PVO and a primary health care orientation. A change in the incumbency of this position would mean changes to the program. In the worst case scenario, the MSPP could, for example, seek to shut down primary health care/family planning service provision by the PVOs or seek to restrict the range of methods in use. Either of these would decrease the program's range.

o Sociocultural constraints. Haiti traditionally has been isolated from its English and Spanish-speaking neighbors, and this isolation has retarded development of a consciousness of the role of family planning in socioeconomic development which those neighbors have long appreciated. Furthermore, the Catholic church always must be taken into consideration in this regard. At present the Catholic Church is not an active opponent of family planning, but may take a negative position if confronted. Again, changes of leadership are relevant here, because if more conservative leaders were in place, this could be a barrier to program growth. Thus, every effort should be made to base program growth and new initiatives on a clear understanding and broad-based deliberations prior to program commencement.

## VII. FEASIBILITY

The strategy to establish an effective national program in population is feasible at the present time due to a number of factors conducive to implementation. These are noted below.

o Population policy. The UNFPA effort to develop a population policy, and, through policy dialogue, to achieve formal adoption is moving along well. The policy should be written in early 1990, with formal adoption to follow the period of development. This would help to remove the constraint that programs presently face functioning in an ambivalent policy setting.

o MSPP commitment. The present leadership at the MSPP is strongly favorable to family planning, as a key primary health care/child survival intervention. This leadership is putting into place a number of basic supports toward the establishment of a national family planning program. One example is that of the public/private partnerships to provide primary health care through the PVOs, using MSPP staff. At the level of program implementation, the MSPP counterpart in the family planning area is dynamic, knowledgeable and committed to the establishment of an effective, national program in family planning. But a strong family planning/population office in the MSPP will be needed to institutionalize the program, as a buffer to changes in leadership above at political levels.

o Laissez-faire environment. With the present laissez-faire environment toward the commercial sector and the climate of cooperation between the MSPP and the PVOs, the strategy of implementing a program maximizing participation of the three sectors, including the public sector, is feasible. However, all new initiatives should be developed in an open and collaborative manner, so that the MSPP is fully informed at every step. Further, this will insure that an appropriate approach is taken in terms of the Haitian cultural, political and religious context.

o Lack of constraints. No constraints exist in the Haitian program with respect to prohibition or unacceptability of methods, controls on pharmaceutical products, etc. In addition, there is a generally weak level of enforcement on the part of the GOH. Thus, taking into consideration the caveat stated above referring to open collaboration, the program can move ahead freely.

## VIII. RESOURCE REQUIREMENTS

The resource requirements for the population sector in calendar years '90 through '92 have been shown on Table 14. Note that the public sector portion of this Table is based on the assumption that USAID/Haiti would move very quickly to implement an interim public sector activity, in response to the Congressional exception permitting assistance to the GOH in family planning. This Table is structured to show activities under three major headings -- 1) Umbrella PVO, 2) Social Marketing and Commercial Sectors, and 3) Public Sector. Mission Operating Year Budget (OYB) and Central funding are shown.

Table 14 showed the umbrella PVO component level funded at approximately \$2 million per year in Mission OYB and PL-480 funds. In addition, Central funding of \$200,000 per year, to fund technical assistance from the Association for Voluntary Surgical Contraception (AVSC) to both the PVO and public sector programs would be useful.

With respect to the social marketing activity, no additional Mission funds would be required in CY '90. However, in CY '91 and '92 significant increases in Mission funding would be required (\$513,000 and \$799,000 respectively) to fund Phase 3, to introduce a progestin-only pill, detail the copper-T 380A (Cu-T 380A) IUD to physicians, and expand the distribution mechanism, and Phase 4, in which long-term temporary methods such as NORPLANT would be introduced. A small amount of Central funding would be programmed for this activity -- \$41,000 in CY '90 and \$20,500 in CY '91. Central funding would phase out after that year. Financial self-sufficiency would be a goal after another five years.

For the public sector, a major, new funding commitment for USAID/Haiti would be required. In CY '90, this would be on the order of \$1.875 and would increase to \$4.513 million in CY '92. This would return population funding to the levels before the rupture of AID assistance (for example, FY '86, in which \$5.53 million was obligated in the population sector. By comparison, recent funding levels in population have been on the order of \$1.350 million per year.

Table 14 does not program Central funding to the public sector. To the extent that Central funds could be committed to this, some of the burden on Mission funds could be alleviated. It would be appropriate for increased Central funding to go to this program, in view of USAID/Haiti's excellent record in working through buy-ins. Many better-endowed programs have enjoyed Central support at levels far greater than USAID/Haiti has. An overview of the present commitment of Central funds to activities in Haiti is given in Table 15. Mechanisms appropriate for Central funding would include JSI/Family Planning Logistics Management (to address supply and distribution needs of commodities in the public sector) and Johns Hopkins/Population Communications Service (to meet the program's great needs for IEC materials).

Table 15

S&T/POP CENTRALLY FUNDED ACTIVITIES IN HAITI

COOPERATING AGENCY	PURPOSE	GRANTEE	CURRENT FUNDING		DATES
			S&T/POP	BUY-INS	
FMI	PREIMPLEMENTATION TRIALS OF NORPLANT	NGO-CITE DE SOLEIL HOSPITAL; PUBLIC SECTOR	NONE	321,000	10/31/87-3/31/91
OPTIONS	POPULATION POLICY ANALYSIS	NGO-HAITIAN CHILD INSTITUTE	50,000	235,000	4/88-9/90
SOMARC	COMMERCIAL CONTRACEPTIVE SALES	FOR PROFIT DISTRIBUTOR COMMERCE S.A.	154,000	400,000	4/5/89-9/30/91
AVSC	TECHNICAL ASSISTANCE TO PVOs	NGOs-PROFAMIL, AOPS, AINHSAL	20,000	NONE	6/14/89-6/14/90
TIPPS	POLICY ASSISTANCE IN FINANCIAL SUSTAINABILITY TO PVOs; BUSINESS ANALYSIS SKILLS TO NGOs FOR FOR-PROFIT COMPANIES	CDS-CENTRES POUR LE DEVELOPMENT ET SANTE DASH-DEVELOPMENT DES ACTIVE EN SANTE PROFAMIL ALIGO	7,034	50,000	3/27/89-8/28/90
FPIA	SERVICE DELIVERY IN THE NORTH	NGO-CDS	70,000	NONE	9/89-9/90
TOTAL			301,034	1,006,000	

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## Appendix 1. HAITI AS A PRE-EMERGENT COUNTRY

Program funding levels and possibilities have been reviewed in the body of this document. However, any design effort should be based on consideration of the specific needs of a program. These needs may be best addressed by consideration of the type of program implementation existing in Haiti, in relation to the level of socioeconomic development.

AID recipient countries recently have been categorized into five groups according to their contraceptive prevalence in modern methods. These levels range from the pre-emergent countries with less than 8% contraceptive prevalence to the mature countries where prevalence is over 45%. This categorization, and the analysis which accompanies it, are presented in the paper "Moving Into the Twenty-First Century: Principles for the Nineties", prepared by the Family Planning Services Division (FPSD) of the AID Office of Population.

According to the categorization and analysis, Haiti is a pre-emergent country. Haiti is the only pre-emergent country in the Latin American-Caribbean region. How Haiti stacks up on a variety of program characteristics, socioeconomic characteristics and program needs is shown in Appendix Table 1.

### A1a. Program Characteristics

As discussed above, contraceptive prevalence is low in the pre-emergent countries, which generally have less than 8% prevalence in modern methods. According to the 1987 Survey of Mortality, Morbidity and Service Use (French acronym EMMUS), the contraceptive prevalence rate in Haiti was 6.5%. The contraceptive prevalence rate stagnated at this level for many years but edged up in 1989 to 10.4% in the recent CDC/CHI survey.

Furthermore, in pre-emergent countries the use of modern contraception tends to be higher among urban elites. Family planning services are limited, with services available from a limited number of government and private providers. The availability of services is also not well known.

These traits describe the present situation in Haiti. According to the EMMUS survey, contraceptive use in the urban areas is 8.4% compared to 4.8% in rural areas. This is apparently due more to uneven distribution of services, rather than to differences in demand within the two groups (Cayemittes, Michel and Anouch Chanazarian, "Survie et Sante de l'Enfant en Haiti", Institut Haitien de l'Enfance, Port-au-Prince, 1989).

Appendix Table

Haiti - Profile of Pre-emergent Country

Program Characteristics	Pre-emergent Countries Overall	Haiti
Contraceptive (CP %) prevalence	8	6.5 (EMMUS survey, 1987) 10.4 (CDC/CH1, prelim, 1990)
Use higher among urban elites	Yes	Metropolitan CP = 10.9 vs. (EMMUS) Rural CP = 4.8
Status of family planning services	Only limited services avail. through govt. and private providers	Yes
	Services not widely known	Yes
Socioeconomic characteristics	Methods are not widely known	Methods are widely known; 89% know one or more methods. (World Fertility Study of 1983)
Total fertility rate	6.4	6.4 (EMMUS)
Life expectancy	49	55 (Pop. Reference Bureau, 1989)
Infant mortality (/1000)	116	101    ** **
Labor force in Ag. (%)	76	65 (People Review, IPPF/London John May, Futures Group forthcoming)
GNP per capita/per year	347	(World Bank, 360 World Development Report)
Urban (%)	26	26 In 1982 (People Review, op. cit)

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Haiti-Profile of a  
Pre-emergent Country (2)

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Program Needs	Overall	Haiti
Building Support and Credibility for FF	Yes	Pop. policy (public sector formal policy, private sector interest group); quality service provider (not fancy but standardized based on appropriate protocol).
Training for Personnel	Yes	Instructional travel and training to combat isolation and information starvation.
Develop Policies and Strategies	Yes	Formal adoption of pop. policy; MSPP strategy, re: resource allocation and commitment; strategy for public-private commercial/PVO sector involvement; MSPP post-partum strategy.
Meet Needs of Urban Elite	Yes	Yes, but rural program development also. Urban: urban model clinics, social marketing to urban CVD class consumers Rural: rural PVOs, rural CBD/eventual social marketing to rural areas linked to smaller urban zones.
Generate Demand	Yes	Yes, promotion of methods and correct use, promotion of facilities, front-line promotion in public sector (lacune in World Bank staffing pattern), private enterprise/insurer promotion, social marketing.
Develop Clinical Services Service Provision, Training and Referral	Yes	Development of PVO network of services, quality service provision in PVOs/MSPP, MSPP to sustain current acceptors, MSPP fixed facility VSC, expansion of NORPLANT in PVO/MSPP network; targeted promotion of the IUD; MSPP post-partum strategy.
Donor Participation/Coordination	Yes	No one donor can do this alone. Coordination of activities required for efficient implementation.  Donor coordination needed for expansion of social marketing to a multi-method program including injectibles/NORPLANT.

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### A1b. Socioeconomic Characteristics

With respect to socioeconomic characteristics, Haiti also shares the profile of the pre-emergent countries. In general, pre-emergent countries average a total fertility rate of 6.4 children per woman; according to the 1987 EMMUS survey, the total fertility rate for Haitian women is likewise 6.4. Life expectancy, in pre-emergent countries, is 49 years and infant mortality 116 per thousand. In Haiti, these estimates are slightly higher; life expectancy is 55 years and infant mortality is 101 per thousand.

For economic and urbanization estimates, pre-emergent countries, in general, have 76% of the labor force in agriculture; per capita GNP is \$347 per year and just over a quarter of the population lives in urban areas. In Haiti, somewhat fewer are involved in agriculture (65%), and the GNP per capita is \$360 per year. More Haitians live in urban areas: 26% lived in urban settings in 1982 and migration to the cities has continued apace.

### A1c. Program Needs

According to the FPSD categorization, pre-emergent countries have a broad range of needs in developing their programs. These include building support and credibility for family planning; training key personnel; policy improvements; meeting needs of urban elites; generating demand; developing clinical services for service provision, training and referral; and donor participation/coordination. In the paragraphs which follow these needs will be broadly described as they apply to Haiti.

A1ci. Building support and credibility for family planning. This is a major area of need in Haiti and includes both the population policy climate in which service provision goes on and service provision itself. Discussions and information dissemination leading to the formal adoption of a national population policy and development of a private sector population interest group will support the eventual expansion of family planning services. Quality services should be provided which are responsive to clients and which conform to protocols for promotion, counseling, voluntarism, and clinical care which grow out of joint public-private sector deliberations.

A1cii. Training key personnel. This is important for both population policy and family planning service provision staff. Haiti has a long history of isolation in the region, partly due to its history and to its status as one of the few Francophone countries in Latin America. Invitational travel and training, and external TA to programs in Haiti can help to combat this isolation and the situation of information starvation.

A1ciii. Developing policies and strategies. As described above, the formal adoption of a national population policy and development of an active private sector population interest group would be very helpful in the establishment of an effective national program of family planning. These would also provide the basis for the development of a strategy within the MSPP in terms of resource allocations and commitment to family planning. An action plan for delivery of services by the public sector, PVO and private commercial sectors, and for funding by the donor community taking into account the contribution of the individual sectors, is very important. Development of a planning strategy may also help the MSPP to develop its activities in family planning.

A1civ. Meeting needs of urban elites. This continues to be an important need in Haiti but rural program development is also a priority. For urban acceptors, the USAID/Haiti program presently offers urban model clinics able to provide long-lasting methods in addition to temporary methods. Soon the launch of the social marketing activity will make an affordable, quality low-dose pill available to C&D class consumers. In the rural areas, the USAID/Haiti program is building a network of rural PVOs which can deliver non-clinical services; also three to six model VSC facilities are in development in larger, stable rural PVOs. Eventually the social marketing activity will be expanded to include intensive promotion in rural areas abutting urban zones.

A1cv. Generating demand. This is a key need, since most Haitian families know about family planning methods (87%, EMMUS Survey) but relatively few use them. There is a substantial need for qualitative research to address the reasons why this situation exists. To generate demand, the USAID/Haiti program is concerned with objective promotion of all methods and their correct use as well as promotion of facilities. For the public sector, front-line community-based promoters will be needed to link acceptors with fixed program facilities. Since the MSPP staffing pattern does not provide for this type of worker, exploration of how this role can be fulfilled will be needed.

A1cvi. Developing clinical services for service provision, training and referral. This is a clear need for a program trying to sustain current acceptors and attract new users. Thus, the development of quality services (that is services which are responsive to clients and meet basic standards related to promotion, counseling, voluntarism, and clinical care) in the MSPP and the PVOs is critical. The USAID/Haiti program, at present, focuses on the PVO sector but can now develop public sector activities. Additional specific needs in this area include (but are not limited to): continued development of MSPP VSC facilities, expansion of NORPLANT in the PVO/MSPP network, targeted promotion of the IUD, male VSC, and development and implementation of an MSPP post-partum strategy.

A1cvii. Increasing donor participation/coordination. This is vital, because no one donor can meet all the current needs of the program in Haiti. Coordination of activities is required for efficient implementation and to maximize the utility of external TA. Donor coordination will be needed for expansion of social marketing to a multi-method program, including injectibles and NORPLANT.

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